Annual Report

Health Funding Arrangements

First Nations & Inuit Control

2002 - 2003

Health Canada Santé Canada

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Annual Report on

First Nations & Inuit Control

2002 - 2003

Health Canada

First Nations and Inuit Health Branch

Business Planning and Management Directorate

Health Funding Arrangements Division

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Introduction

In May 2002, changes within the First Nations and Inuit Health Branch (FNIHB) were implemented with the objective of strengthening the Branch's organizational capacity to contribute to the improvement of the health of First Nations and Inuit people across Canada. With the new accountability models in place and Health Funding Arrangement Division's (HFAD) role in the review and approval process of Health Services Transfer Agreements, it was determined that the placement of these functions was better positioned within the Business Planning and Management Directorate. This provided for better working relationships with the Accountability and Reporting units.

In this Annual Report for fiscal 2002 - 2003, we highlight, for our stakeholders, the various activities the HFAD has undertaken and the many linkages that HFAD has with other Departments and Divisions on various issues. One of HFADs objective is to provide First Nations and Inuit communities with the tools to effectively manage and deliver their own health programs. This year in review, which covers April 1, 2002 to March 31, 2003, highlights those activities which FNIHB has accomplished as well as the expected outcomes for the upcoming 2003 - 2004 fiscal year.

On behalf of the staff of the Health Funding Arrangement Division, we hope that you find this information useful.

Health Funding Arrangement Division

Business Planning and Management Directorate

First Nations and Inuit Health Branch

Health Canada

http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/bpm/hfa/index.htm

Accomplishments

Throughout fiscal 2002 - 2003 we have been working on a number of priorities. Some of those priorities are listed here and described in more detailed throughout the report.

- "Back to the Basics" Transfer Workshops;
- Updating and developing new policies/guidelines and publications;
- Participating in the development of a Branch Intervention Policy;
- Health Plan Demonstration Projects;
- Evaluation of Transfer; and
- Renewal of the Treasury Board Transfer of Health Services Authority.

Back to Basics Workshop

Due to the number of new FNIHB staff working in the transfer environment, the HFAD designed a "Back to the Basics" workshop to provide both training and orientation on the various mechanisms of control for First Nations and Inuit health initiatives. This comprehensive workshop gave new staff members, as well as seasoned staff, a chance to review policies and procedures to ensure that transfer issues are handled consistently across the country.

The workshop was divided into two sessions: eastern and western. The western session took place in August of 2002 in Edmonton, Alberta. The eastern session is scheduled to take place in spring 2003.

Ratification Process

A new concept entitled Ratification, the action of preparing and processing Consolidated Contribution Agreements (CCA) after the intended start date of the Agreement, was introduced by the Accountability and Capacity Development Division in an effort to cover delays in preparing CCA's. For a number of valid reasons, it is not always feasible or possible to have the actual agreement prepared in time to coincide with the start date of service delivery. The Ratification process is the mechanism utilized to ensure that the terms and conditions of the CCA are finalized. In this case, regions are required to route the request to the Headquarters Contracts and Contributions Unit for processing and approval at the appropriate levels. This new initiative also involved the development of a clause, referred to as a "pre-agreement" clause, which is necessary when the recipient has already begun the program requirements and expended funding. This pre-agreement clause enables the Department to accept and pay for "Prior Rights and Obligations" which is commonly referred to as Pre-Agreement work.

Branch Intervention Policy

It is recognized by the Branch that exceptional or problem situations in CCA's may arise. Building from the existing Branch guidelines, an Intervention Policy was developed and implemented in 2002. Branch intervention is triggered when the recipient is unable, lack the capacity or is unwilling, to address a problem situation. Intervention can take three different forms: assisting the recipient to develop and implement a plan of action, requiring the community to enter into a co-management arrangement, or requiring the community to enter into a third party management arrangement. A key component of this policy is the Branch's obligation to work closely with recipients to determine the nature of the problem and obtain the recipient's perspective and input regarding the solution. The intervention policy ensures the continuity of service delivery and helps to protect the integrity of health programs.

Information Systems

Community Planning Management System (CPMS)

With the development of the system completed, the focus in 2002 - 2003 was to provide training to regional staff and to enter community data in the system.

The system is still accessed by the Branch as one means of flowing and tracking resources to First Nations and Inuit communities which are approved by Senior Management. In 2003/2003 the CPMS system was used to gather data to aid the Branch in determining a methodology to flow additional resources for band employed nurses.

The system is continually called upon to provide national pictures of population growth, as well as to identify agreement status, and community remoteness classification. On-going annual updates are still

required in order to provide accurate information and the system relies on regional participation.

HFAD Access Database

The HFAD Access database is an application used for tracking a recipient's agreement history while in the First Nations and Inuit Control Continuum. More specifically, the system captures agreement information on recipients that are in Transfer contribution agreements such as the programs delivered, the funding provided, and the reporting requirements set out in their respective agreements. This database was developed and fully implemented in March 2002.

Due to the fact that more and more communities are opting for an Integrated approach, HFAD has expanded the database to include Integrated agreements. This enhancement to the database will enable HFAD to have a more complete tracking tool.

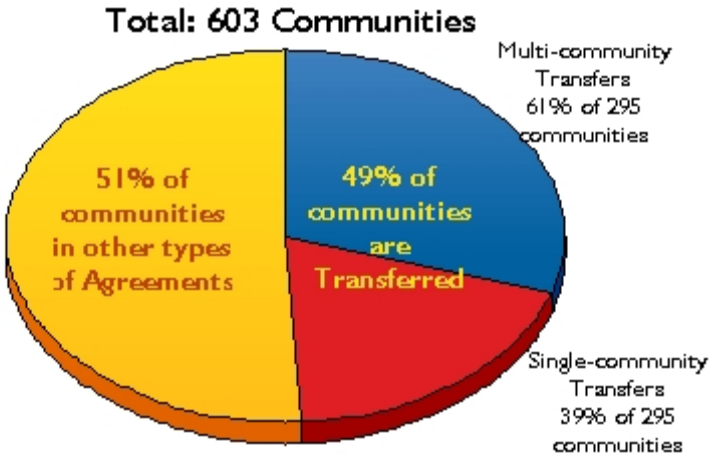
This database enables the HFAD to monitor these specific types of agreements for compliance to reporting requirements, to perform assurance reviews, to address the various information retrieval, and presentation demands placed on them which resulted in this database collection.

Management of Contracts and Contribution System (MCCS)

MCCS is an electronic system implemented nationally to enhance the Branch's ability to report, monitor, and audit its contracts and Contribution Agreements (CCA's). As of April 1, 2002, all agreements were required to be routed through MCCS. While there were some bumps in the road where the processing of transfer agreements was concerned, most of the issues raised have been addressed. Regions are required to route their agreements through the system electronically and then submit to Headquarters for review. All accountability documents are to be scanned into MCCS.

Figure 1: Single and Multi-Community Transfers

This figure shows that as of March 31, 2003, 295 (49%) out of the 602 communities, across Canada that were eligible for Transfer, signed Health Services Transfer agreements. 180 (61%) were multi-community transfers and 115 (39%) were single-community transfers.



Health Plan Demonstration Projects

The 1997 report of the Auditor General of Canada questioned the degree of accountability in place for First Nations and Inuit health funding. The Auditor General noted the need for improvement in the ability to determine the impact of expenditures on First Nations and Inuit health status. The Health Plan Demonstration Project was initiated in response to this development and as another step toward First Nations and Inuit having a greater role in planning their health programs and services. The Health Plan Demonstration Project is designed to:

> increase community capacity to meet the health needs of members;
>
> to improve accountability; and
>
> to achieve integration of planning, services and reporting

In 2002 - 2003, FNIHB continued to develop tools that might assist First Nations and Inuit communities in the health planning process. A Process Summary Chart was developed as a tool that gives First Nations and Inuit communities, as well as Regional and Headquarters Staff, a "snapshot look" at the Health Planning cycle. FNIHB continues to develop new tools that will assist First Nations and Inuit communities in the health planning process.

A quarterly newsletter is being published that provides some detail on the health planning process. It provides information on activities that took place, such as workshops or training sessions on the demonstration project. The newsletter is a valuable tool for keeping the communities up-to-date on what is happening at Headquarters, the Regions, as well as in other communities. The newsletters are available on the FNIHB website.

In 2002 - 2003, a workshop was held to bring together FNIHB staff and representatives from communities involved in the Demonstration projects. This allowed the communities the opportunity to build capacity through training, to share in success and failures, and to suggest new and different ways of doing things that would allow the project to be a success.

Demonstration Projects

In 2002 - 2003, Phase I of the Demonstration Project was implemented in the following communities:

- Saskatchewan Region: Gordon First Nation
- Northern Secretariat (Yukon): Liard First Nation
- Alberta Region: Blood Tribe
- Pacific Region: Kitasoo First Nation (Regional Development Project)

Phase I of the Health Plan Demonstration Project requires the First Nation community to establish a Health Management structure and to provide training to the management team. One of the key activities of this phase is to assess the health needs and resources and to identify health priorities of the community.

Phase II of the Health Plan Demonstration Project requires the First Nation community to set goals and objectives for addressing their health priorities, to choose programs and services or design new ones to meet the needs, and to make the best use of resources. They will also be required to deal with financial and human resource issues, for example, develop a budget, develop job descriptions, prepare training plans, develop a human resource framework, etc. One of the main activities of this phase is the establishment of an accountability framework that includes establishing a program review cycle and an evaluation cycle, record keeping, monitoring programs and services, adjusting programs as needed, producing reports on progress, etc.

In 2002 - 2003, the following communities began Phase II of the Demonstration Project:

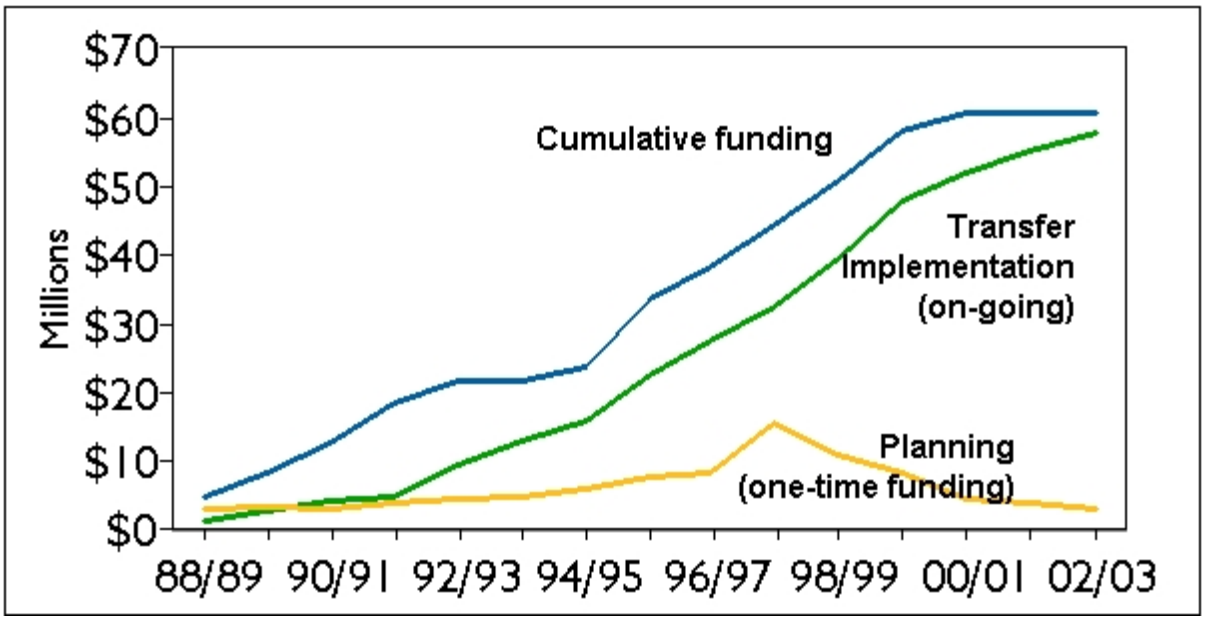
- Quebec Region: Eagle Village First Nation (Kipawa)
- Manitoba Region: Little Grand Rapids First Nation
- Pacific Region: Kitselas First Nation

It is expected that four First Nations will begin Phase II of the Health Plan Demonstration Project in 2003 - 2004. They are:

- Saskatchewan Region: Gordon First Nation
- Alberta Region: Bigstone Cree First Nation
- Alberta Region: Blood Tribe
- Pacific Region: Kitasoo First Nation (Regional Development project)

Figure 2: Funding to Support First Nation and Inuit Control

This figure shows the increase in funding available for First Nation and Inuit communities. As of March 31, 2003, a total of $61 million was the cumulative amount, $58 million in transfer implementation funding and $3 million in pre-transfer planning.



Agreements

Consolidated Contribution Agreements - Transfer (CCA-Transfer) / Integrated (CCA-Integrated)

With the introduction of the new standard agreements, which helped to clarify the roles and responsibilities of all parties, improve risk management, and allow the Department and First Nations and Inuit communities to better reflect accountability for the prudent use of public funds, the beginning of the 2002-2003 fiscal year was a busy time for the division and for the regional offices. A contingency plan was developed by FNIHB for use by regions for those recipients who were opting not to sign their new or renewal agreements due to objections with the content in the new standard agreements. The Branch contingency plan involved implementation of a third party manager.

Canada/First Nations Funding Agreement

Indian and Northern Affairs Canada released a new version of their CFNFA in November 2002. As result of this roll-out FNIHB updated its existing Health Canada Schedule.

Health Canada Schedule revised and implemented in January 2003.

This exercise served to ensure that there was no duplication of clauses or conflicts between the main body of the CFNFA and the main body of FNIHB CCAs. The update also served to strengthen certain clauses in the FNIHB schedule without superceding clauses found in the main body of the CFNFA.

This review was completed and implemented in January 2003 and will continue on an annual basis following the roll out of the FNIHB CCAs.

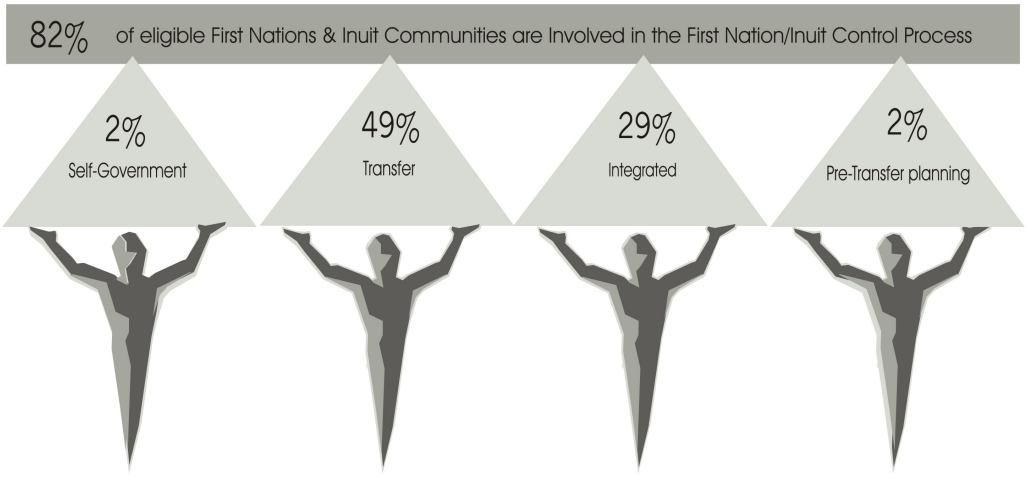
Transition to Self-Government

Self-Government is the highest level of management control available to communities. FNIHB Headquarters and Regional Offices have been actively involved in self-government negotiations over the past year.

Some communities that have active Transfer agreements and are currently in negotiations for self-government agreements include: Labrador Inuit Association (Labrador); Meadow Lake Tribal Council (Saskatchewan); and, Sioux Valley (Manitoba).

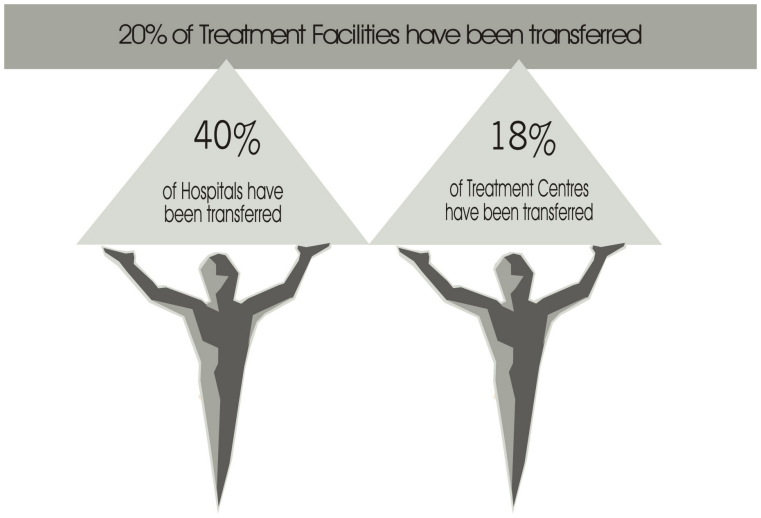
Due to the linkages between transfer and self-government, many of the policy related initiatives are of great interest to HFAD. For example; Historic treaties, Intergovernmental fiscal issues, and institution building.

Figure 3: Status of First Nations and Inuit Control Activity



Agreement Type	# of Agreements	# of Communities
Self-Government	9	12
Transfer	165	295
Integrated	148	176
Pre-Transfer	9	13

Figure 4: Transfer of Treatment Facilities



Agreement Type	# of Agreements
National Native Alcohol and Drug Abuse Program (NNADAP)	10
FNIHB Hospitals	2

Report of the Auditor General of Canada - Chapter 1 Streamlining First Nations Reporting to Federal Organizations, December 2002

In 2002, the Office of the Auditor General (OAG) launched an exploratory study, involving several Federal Departments and Crown Corporation, intending to develop an understanding of First Nations and Inuit perspective toward reporting requirements. In December of 2002, the OAG released three recommendations, none of which were specific to Health Canada, however, initiatives have already been undertaken by the department to improve its practices.

R. 1.50 The federal government should consult with First Nations to review reporting requirements, on a regular basis and to determine reporting needs when new programs are set up. Unnecessary duplicative reporting requirements should be dropped.

Health Canada, FNIHB, is currently analyzing the program reporting requirements to identify gaps and any areas of overlap in order to streamline the process and develop tools for First Nations communities.

FNIHB has program-based joint steering committees with First Nations and Inuit, at both the national and regional levels, to oversee the management, implementation and evaluation of programs.

The FNIHB Branch Executive Committee includes members from First Nations and Inuit organizations.

R. 1.53 The federal government should use the most efficient procedures to submit and process reports required from First Nations, and should work with First Nations communities to file reports electronically where it is practical to do so.

Health Canada, FNIHB, has implemented an automated Management of Contracts and Contributions System (MCCS) in all Regions in April 2002. MCCS is facilitating the electronic monitoring, follow-up and management of reports submitted by First Nations and Inuit communities.

Health Canada, FNIHB, has electronic templates (in WordPerfect or other software) which are provided to communities for several programs, to allow for the completion of program reports. In some regions, First Nations and Inuit recipients have been informed that they have the option to submit their reports electronically, via e-mail.

R. 1.73 The federal government should undertake a review of program authorities, to streamline the programs and better allocate program responsibilities among Departments and other federal organizations.

The Program Authority Renewal Initiative which is currently underway in Health Canada will provide an opportunity for the Branch to renew and improve its program structure and strengthen accountability for results. The key objectives of this initiative are not only to fulfill the new Treasury Board policy requirements but also to:

- review the structure of the contribution authorities to modernize the program structure;
- align with other departments' authorities;
- build logic models for programs and initiatives; and
- develop Results-Based Management Accountability Frameworks (RMAF) and Risk Based Audit Frameworks (RBAF) that will enable a better management for results, performance measurement and risk management with First Nations and Inuit communities.

The development of RMAF is an opportunity to streamline reporting requirements based on a clear understanding of expected results with First Nations recipients.

Evaluation of Transfer

Synthesis of Community Evaluation Reports: Transfer of Health Services

A review of the synthesis report, completed on the community evaluation reports conducted on 13 transfer projects involved in Transfer from 1994 - 1999 and 21 projects in 2000/2001, raised issues relating to the standardization of data collection and reporting. The majority of community evaluation reports commented on the effectiveness of transfer and could be construed as positive or highly positive.

From this synthesis it was found that the reports varied markedly in scope, comprehensiveness and scientific rigour, which made it difficult for comparison. The Branch's strategic direction toward improved accountability and standardized reporting opens the door for a more standardized evaluation reporting model which communities can follow.

An important observation made in the report was that most communities were able to implement their community health activities in accordance with the priorities of their health plan.

A review is underway for reports completed in 2000, which will not only synthesize the evaluation reports but will identify trends and/or gaps which are being, or need to be, addressed.

Renewal of Authorities

On June 1, 2000, the Treasury Board Secretariat released a revised policy on transfer payments which required all federal departments to implement measures to ensure due diligence in the management of all contracts and contribution agreements. Included in this requirement is for program authorities to be renewed within five years to ensure relevance and effectiveness, thereby resulting in the expiry of the existing Transfer and Integrated authorities on March 31, 2005. The Branch is working diligently toward renewing those authorities. There are several initiatives underway which support the renewal process which includes looking at our reporting requirements. The HFAD is involved in the development of the new authorities.

National Evaluation of Transfer

Health Canada has been working since the early 1980's with First Nations and Inuit communities to transfer control of health services to the communities. The transfer initiative is part of the Department's effort to help First Nations and Inuit people gain a greater measure of self-determination.

In 1989, Treasury Board approved an evaluation strategy for the Transfer Initiative which would examine how well transfer operated as a means of turning over control of health services to First Nation and Inuit communities. This strategy consisted of a short-term evaluation (in year 3) and a long-term evaluation (in year 5) of First Nations and Inuit health transfer which would document whether transfer was accomplishing its goals and to identify areas of transfer that needs to be revised or strengthened.

The short-term evaluation findings were based on community case studies which were completed on the eight communities that had signed Transfer agreements prior to March 31, 1991. The evaluation assessed four key areas of Transfer: the transfer process itself, the pre-transfer planning, the post-transfer administration, and the impact of transfer on the transferred communities. The overall conclusions were that the process more than adequately enable First Nations and Inuit to effectively plan the transfer of health services and that First Nations and Inuit, although aware of the limitations of Transfer, were generally supportive of the process.

The long-term evaluation was initiated in June 1994. The main focus of the long-term evaluation was to assess the overall success of the Transfer initiative. The three primary areas studied in this evaluation were whether or not Transfer achieved its objectives, the impacts and effects of Transfer, and the identification of alternatives for further First Nations and Inuit control in regards to health other than the Transfer process. The evaluation in year five, did not measure the impact and effects of Transfer on the health status of First Nations and Inuit peoples since changes in health status are the result of many intervening factors, and occur over a longer period of time.

Some of the reported findings of the long term evaluation were that: the objectives of Transfer have been achieved at the community level for communities that entered the post-transfer phase; community members had an increased awareness of health issues and health care was a higher priority in transferred communities; social and community development strategies using a variety of culturally sensitive and relevant methods of health delivery were in place; and community health services were found to be integrated with other programs and services such as social services, mental health, home care, education and non-insured health benefits.

After 12 years of operation, there is a need to review the appropriateness and effectiveness of the Policy due to both the changing needs of communities and the experience gained by all parties. Since the last evaluation of the Policy in 1994, FNIHB has been actively engaged in addressing the issue of how best to adapt the Health Services Transfer Policy to meet the needs of the communities and the programs that they deliver. Some other issues to address are:

- Long-term direction,
- Sustainability,
- Impact on the Health Status of First Nations and Inuit,
- Capacity building for those First Nations and Inuit that have chosen not to enter into transfer due to lack of capacity.

Considering that the Department must renew all of its Treasury Board Authorities by March 31, 2005, it is appropriate to have an in-depth look at the Policy and what has been achieved over the years. Additionally, under the authority renewal requirements, the department will have to present, to the Treasury Board Secretariat, a submission which must include:

- an updated Terms and Conditions;
- a Results-based Management and Accountability Framework (RMAF) which includes performance indicators, expected results and outcomes, and methods for reporting on performance and evaluation criteria to be used in assessing the effectiveness of the Policy and/or policy implementation,
- a Risk-based Audit Framework (RBAF) which includes a risk-based framework for auditing recipients of contributions and an internal audit plan, and
- an evaluation plan.

It is for these reasons, that FNIHB set aside resources for performing an evaluation of the Health Services Transfer Policy and, as such, will create a committee to oversee this initiative. The work of the Committee will be supported by the Business Planning and Reporting Division.

The Mandate of this committee is to conduct this evaluation in two phases:

- Phase 1 - The development of an evaluation framework that focusses on the outcomes of the transfer policy, the overall impact of First Nation and Inuit empowerment on the health of First Nations and Inuit people, the success factors, challenges, and issues related to the management and delivery of each eligible program under the transfer authority.
- Phase 2 - A comprehensive evaluation based on the evaluation framework.

Figure 5: Trends in First Nation and Inuit Control

This figure illustrates the trend of direct service delivery by the Branch, over the years. First Nations and Inuit have assumed greater control of health services, through self-government, transfer, integrated and other types of contribution agreements. As of March 31, 2003, the total amount of funding under First Nation and Inuit control was $678 million. FNIHB direct delivery costs include: salaries; operating; and, minor capital. (Fiscal Years 1999 - 2000 and 2001 - 2002 experienced increases in budgets for direct service delivery due to the infusion of new programs resources announced in the 1999 and 2001 budgets).

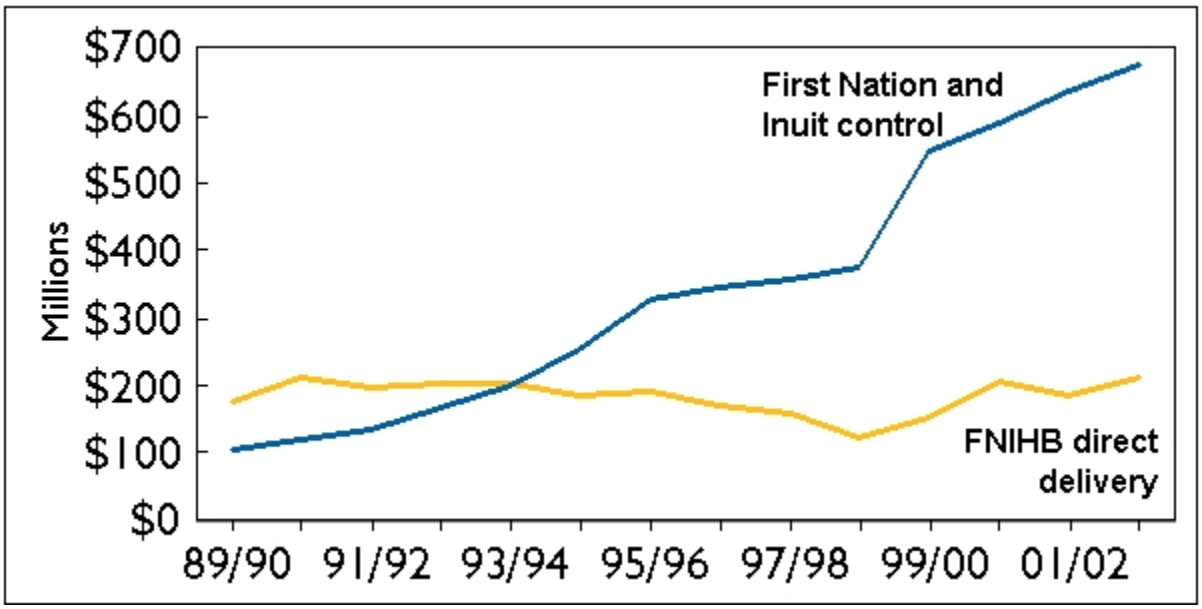
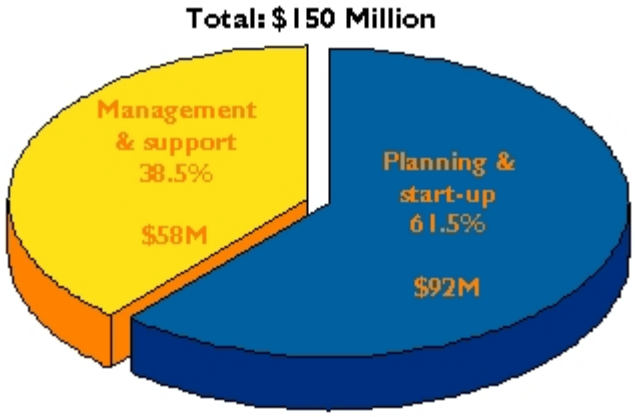


Figure 6: Funding to Support First Nation & Inuit Control

As of March, 2003 FNIHB has provided First Nation and Inuit communities and organizations with $92 million for planning, capacity building and start-up costs involved with the Transfer and Integrated approach. Ongoing funding in the amount of $ 58 million was provided to First Nations and Inuit communities to support the delivery of programs ans services in Transfer and Integrated agreements.



Challenges

As part of Health Canada, the First Nations and Inuit Health Branch supports the delivery of primary care, public health, and health promotion services to more than 600 First Nation and Inuit communities across Canada. Due to this fact, the branch is facing similar financial and management challenges as those experienced by the provincial and territorial health care systems such as nursing shortages, rapidly rising drug costs, and the cost of acquiring new technologies. In addition, there are the specific challenges posed by factors that particularly affect our management of First Nations and Inuit health services such as the remoteness and isolation of many of the communities served.

Accountability - performance measurements and outcomes

Accountability within Transfer has been more clearly defined over the past fiscal year. The issue of better accountability practices was raised by the Auditor General in 1997. There are two broad types of accountability that are required: accountability for the result/outcomes of programs, and accountability for compliance with the laws, regulations, and standard practices that control the use of public funds. Accountability relationships must be maintained and respected. FNIHB is accountable to parliament and to the First Nations and Inuit communities/organizations. The First Nations and Inuit communities / organizations are accountable to their members as well as FNIHB.

HFAD has been working with the regional transfer officers to ensure that the communities that are in transfer are meeting their accountability requirements as outlined in their agreements, however, the ability to gather comprehensive health information is challenged by the multi-jurisdictional complexity of health services delivery to First Nations and Inuit. In many provincial jurisdictions no mechanism exists to flag data on First Nations and Inuit health. Since it is possible for First Nations and Inuit to access physician services in a number of locations, (e.g., different communities, cities, or provinces) data becomes fragmented and not amenable to comprehensive reporting. This results in one of the major accountability issues at present, a lack of information on the performance and outcomes of current community health programs. This has limited the ability of community members to make informed judgements regarding the efficiency of various health services and activities.

Sustainability

First Nations and Inuit are increasingly expressing concerns that transfer funding is not keeping pace with actual costs of health delivery including increases in costs associated with staff salaries, recruitment costs, staff training, contracted health services, health supplies, equipment, and facility operating costs such as energy costs and others.

First Nations and Inuit are requesting more assurance of the long-term sustainability of their locally delivered health services. Issues related to sustainability include;

- price and volume increases,
- program overlap and duplication,
- the negative impacts of high profile "stove pipe" funding initiatives,
- the existence of a basic threshold of community health capacity as pre-requisite in assuming management control of services delivery, and,
- new service delivery relationships among federal, First Nations, Inuit, and provincial governments.

Capacity

Successful integration of the First Nations and Inuit health system with the broader health care system can only take place when First Nations and Inuit health services achieve a certain level of maturity, integrity and stability.

Health Canada, in response to these challenges, is renewing its policies and programs to improve quality of service to, First Nations and Inuit through new and modernized primary care and public health services. Health Canada is also committed to:

- improving the integration of the First Nations and Inuit health system with the broader health care system,
- strengthening of the health information

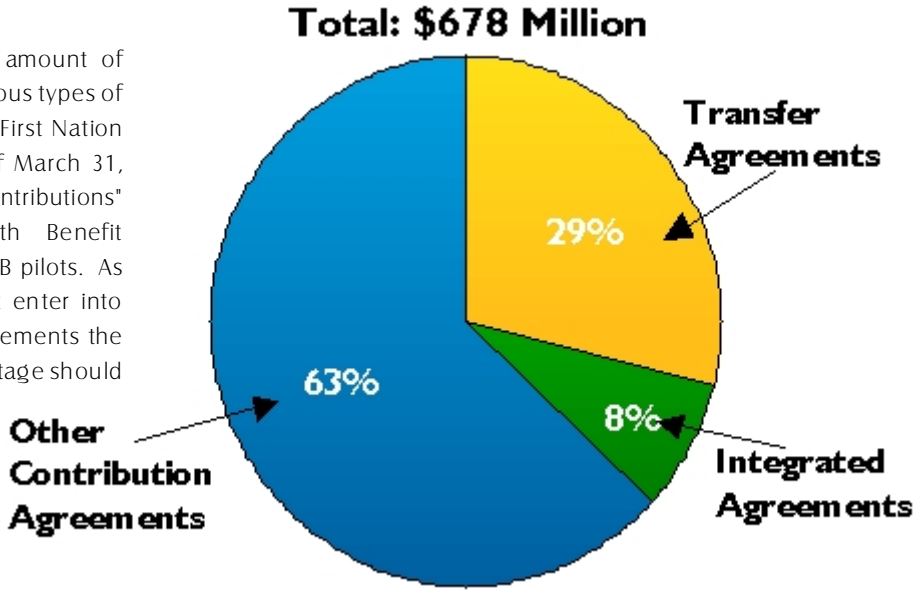
and knowledge capacity to support evidence-based decision making,

- supporting greater control and accountability of the health system by First Nations and Inuit, and, expanding early childhood development programs with a particular focus on Fetal Alcohol Syndrome and Fetal Alcohol Effects.

The overall goal is sustainable health services and programs for First Nations and Inuit and support for the people that address health inequalities and disease threats within the First Nations and Inuit population. This is to be done in collaboration with the provinces and territories so that the First Nations and Inuit can attain a level of health comparable with that of other Canadians, within a context of First Nations and Inuit autonomy and control.

Figure 7: Resources Under First Nation & Inuit Control

This figure shows the total amount of funds managed through various types of contribution agreements by First Nation and Inuit communities as of March 31, 2003 ($678 million). "Other Contributions" include Non-Insured Health Benefit (NIHB) contributions and NIHB pilots. As more First Nations and Inuit enter into Transfer and Integrated agreements the "Other Contributions" percentage should



Updated Policy/Guideline Papers

The following is a list of papers which were updated in 2002 - 2003.

Pension and Benefits for Health Services Transfer Agreements

These guidelines will help regional transfer officers and communities understand the roles and responsibilities of communities in transfer in terms of providing pension and benefits to their employees.

Insurance Guidelines under Transfer Agreements

These guidelines will assist communities to better determine what type of coverage they need to obtain when entering into the transfer process.

The Policy on the Transfer of Non-Medical Residential Treatment Programs

The purpose of this document is to articulate the policy and guidelines for the transfer of Treatment Programs, and how the operation of these treatment programs differs from the community-based program under transfer. This document covers NNADAP and NYSATP treatment program transfers.

Transfer MAR Policy

The purpose of this policy is to describe the Branch's approach to the provision of moveable assets and related resources for their replacement under the community-based Transfer process.

Disengagement Policy for Multi-Community Transfers

To outline general policy issues where a First Nation or Inuit community, who has signed a multi-community Transfer agreement, wishes to withdraw from such an agreement.

Upcoming Policies/Guidelines for 2003 - 2004

The following policy/guidelines are planned for review in 2003 - 2004:

- Drug Distribution Guidelines;
- Dispute Resolution Guidelines;
- Auditing and Reporting Guidelines; and
- Transfer Handbooks - with an emphasis on revising Handbook 3.

Communication

To obtain copies of any of the documents referred to herein contact the Health Funding Arrangements Division (HFAD).

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Our website:

http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/bpm/hfa/index.htm

Some publications / information of interest which can be accessed through our website are:

- Transfer Handbooks;
- A Guide for First Nations on Evaluating Health Programs;
- Reporting and Auditing Guidelines.

Overview - First Nations and Inuit Control

The following tables provide a more detailed summary of the status of First Nations and Inuit control activity.

Table 1: Number of Communities in First Nations and Inuit Control Activity

(as of March 31, 2003)

Region	Self-Government	Transfer	Integrated	Other
Atlantic	0	22	12	6
Quebec	0	22	4	2
Ontario	0	39	44	41
Manitoba	0	31	5	26
Saskatchewan	0	62	9	13
Alberta	0	4	47	7
Pacific	5	114	49	38
Yukon	7	1	6	0
Total	12	295	176	133

Table 2: First Nation and Inuit Population by Community Type

This table shows for communities in transfer the distribution of population by community type. The total population of eligible First Nation and Inuit communities is 403,302, of which 210,934 or 52% are living in transferred communities.

Community Type	# of communities	Population of communities	# of communities under transfer	Population under transfer	% of communities transferred	% of population transferred
Non-Isolated	402	266,075	205	143,748	51%	54%
Semi-Isolated	88	41,954	41	20,762	47%	49%
Isolated	91	89,586	39	44,734	43%	50%
Remote-Isolated	22	7,291	10	3,294	45%	45%
Total	603	404,906	295	212,538	49%	52%

Table 3: Current and Projected Transfers - Communities

This table shows the status of transferred communities as of March 31, 2003. As of fiscal year end 2002 - 2003, 294 (49%) of these communities have signed a Health Services Transfer Agreement.

Transfers by Region/Communities			
Region	Total Eligible Communities Number	Transferred as of March 31, 2003	
		Number	% Total
Atlantic	40	22	55%
Quebec	28	22	79%
Ontario	124	39	31%
Manitoba	62	31	50%
Saskatchewan	84	62	74%
Alberta	58	4	7%
Pacific	206	114	55%
Yukon	1	1	100%
Total	603	295	49%

Table 4: Transfer Agreements as of March 31, 2003

The following information summarizes the total number of Transfer agreements to date, including any new transfer agreements signed in fiscal year 2002 - 2003. This includes: 2 single community transfer agreements; and 1 treatment centre agreement, for a total of 5 new transfer agreements by the end of the fiscal year 2002 - 2003.

Region	New Agreements 2002-2003	Total # Transfer Agreements to Date	# of Communities Represented	Total # of First Nations and Inuit Communities Eligible
Atlantic	2	17	22	40
Quebec	0	24	22	28
Ontario	1	25	39	124
Manitoba	0	32	31	62
Saskatchewan	0	23	62	84
Alberta	0	5	4	58
Pacific	0	38	114	206
Yukon	1	1	1	1
Total	4	165	295	603

Type of Transfer Agreement	Quantity
FTA/Health Transfer Agreements	6
Canada/First Nations Funding Agreement (CFNFA)	9
Community-Based 1st Level Transfer Agreements	130
2nd & 3rd Level Transfer Agreements	7
3rd Level Transfer Agreement	1
National Native Alcohol and Drug Abuse Program (NNADAP)	10
Hospitals	2
TOTAL	165

Table 5: Pre-Transfer Activity as of March 31, 2003

Region	Total # of Pre-Transfer Projects	Total # of First Nations & Inuit Communities Represented
Atlantic	0	0
Quebec	0	0
Ontario	0	0
Manitoba	3	4
Saskatchewan	4	6
Alberta	0	0
Pacific	2	3
Total	9	13

Table 6: Integrated Agreements as of March 31, 2003

Region	Total # Integrated Agreements	Total # of First Nations & Inuit Communities Represented
Atlantic	12	12
Quebec	4	4
Ontario	42	44
Manitoba	5	5
Saskatchewan	9	9
Alberta	30	47
Pacific	40	49
Yukon	6	6
Total	148	176

Table 7: New Transfer Agreements - Fiscal Year 2002 - 2003

Band Name/Authority	Community Name	Community Type	Band #	Transfer Date	# of Communities Represented
Atlantic Region					
Membertou	Membertou	Non-Isolated	026	April 1, 2002	1
Millbrook	Millbrook	Non-Isolated	027	April 1, 2002	1
Ontario Region					
Dilico Ojibway Child and Family Services (NNADAP Treatment Centre)	n/a	n/a	n/a	August 1, 2002	n/a
Yukon Region					
Kwanlin Dun First Nation	Mt. McIntyre	Non-Isolated	500	April 1, 2002	1

Table 8: New Pre-Transfer Agreements - Fiscal Year 2002-2003

Band Name/Authority	Community Name	Community Type	Band #	# of Communities Represented
Manitoba Region				
Anishnaabe Mino-Ayawin	Kinonjeoshtegon	Non-Isolated	268	1
Pacific Region				
Burrard Inlet	Burrard Inlet	Non-Isolated	549	1
Little Shuswap	Little Shuswap Lake	Non-Isolated	689	1
Pauquachin	Pauquachin	Non-Isolated	652	1

Table 9: New Integrated Agreements - Fiscal Year 2002-2003

Band Name/Authority	Community Name	Community Type	Band #	# of Communities
Ontario Region				
Anishinaabeg of Naongashiing	Big Island	Non-Isolated	125	1
Aroland	Aroland	Non-Isolated	242	1
Eagle Lake	Eagle Lake	Non-Isolated	148	1
Fort Severn	Fort Severn	Isolated	215	1
Manitoba Region				
Ebb and Flow	Ebb and Flow	Non-Isolated	280	1
Alberta Region				
Duncan	Duncan	Non-Isolated	451	1
Horse Lake	Horse Lake	Non-Isolated	449	1
Sucker Creek	Sucker Creek	Non-Isolated	456	1
Tall Cree First Nation	Beaver Ranch	Semi-Isolated	446	3
	North Tall Cree	Semi-Isolated		
	South Tall Cree	Semi-Isolated		
Pacific Region				
Blueberry River	Buick Creek	Semi-Isolated	547	1
Fort Nelson	Fort Nelson	Non-Isolated	543	1
Katzie	Katzie 1	Non-Isolated	563	1
Saulteau	Moberly Lake	Non-Isolated	542	1
Soowahlie	Cheam	Non-Isolated	584	2
	Cultus Lake	Non-Isolated	572	
Toosey Indian Band	Toosey	Non-Isolated	718	1
Tl'etinqox-Tin Government Office	Anaham	Semi-Isolated	712	1
Ts'ilhqot'in National Government	Stone	Semi-Isolated	717	2
	Alexandria	Non-Isolated	709	

Table 10: National Summary Reporting Requirements for the period of April 1, 2002 - March 31, 2003

Summary of Reports	Atlantic	Quebec	Ontario	Manitoba	Sask.	Alberta	Pacific	National Total
Audit Report								
Total Reports Due	15	24	23	31	24	5	35	157
Reports Received	15	24	23	31	24	5	30	152
Reports Outstanding	0	0	0	0	0	0	5	5
Annual Report								
Total Reports Due	15	24	23	32	24	5	35	158
Reports Received	15	23	23	32	23	4	22	142
Reports Outstanding	0	1	0	0	1	1	13	16
Evaluation Report								
Reports Due	4	1	2	7	4	1	9	28
Reports Received	3	0	2	3	1	1	6	16
Reports Outstanding	1	1	0	4	3	0	3	12
Transfer Agreements/Communities								
Total # of Agreements	17	24	25	32	23	5	38	164
Total # of Communities	22	22	39	31	62	4	114	294

Table 11: Transfer Agreement Renewal Schedule - Fiscal Year 2003 - 2004

Band Name/Authority	Community	Band #
Atlantic Region		
Tobique First Nation	Tobique	016
Union of New Brunswick Indians	Edmunston	006
	Eel Ground	007
	Eel River Bar	008
	Fort Folly	009
	Pabineau	013
	Abeqweit	001
Quebec Region		
Conseil de la nation Anishnabe du Lac Simon	Lac Simon	063
Conseil des Atikamekw de Manawan	Atikamekw de Manawan	078
Conseil des Atikamekw de Wemotaci	Atikamekw de Wemotaci	077
Ontario Region		
Garden River First Nation	Garden River	199
Moose Cree First Nation	Moose Cree	144
Naotkamegwanning	Whitefish Bay	158
Manitoba Region		
Bloodvein First Nation	Bloodvein	267
Dauphin River First Nation	Dauphin River	316
Keeseekoowenin First Nation	Keeseekoowenin	286
Nelson House Medicine Lodge Inc.	Treatment Centre Transfer	n/a
Lake Manitoba	Lake Manitoba	271
Norway House Cree Nation	Norway House	278
Rolling River First Nation	Rolling River	291

Band Name/Authority	Community	Band #
Saskatchewan Region		
Peter Ballantyne Cree Nation Health Services Inc.	Deschambault	355
	Opawakoscikan	
	Sturgeon Lake	
	Pelican Narrows	
	Southend	
	Kinoosao	
Battleford Tribal Council Management Corporation	Little Pine	340
	Luckyman	341
	Moosoomin	342
	Mosquito	343
	Sweetgrass	348
	Red Pheasant	346
	Saulteaux	347
	Poundmaker	345
File Hills Agency Inc.	Little Bear	379
	Okanese	382
	Peepeekisis	384
	Star Blanket	387
	Carry the Kettle	378
Alberta Region		
Nunee Health Authority	Peace Point	461
	Fort Chipewyan	463
Pacific Region		
BC Aboriginal Network on Disability Society	2nd and 3rd level transfer	
Xeni Gwet'in First Nations Government	Nemiah Valley	714
North Thompson Indian Band	Chu-Chua	691
Gitxsan Treaty Society	Gitanmaax	531
	Kispiox	532

Band Name/Authority	Community	Band #
	Glen Vowell	533
	Gitsegukla	535
	Gitwagak	536
	Gitanyow	537
Canim Lake Band	Canim Lake	713
Interior Native Alcohol and Drug Abuse Society	Treatment Centre Transfer	n/a
Kitamaat Village Council	Kitamaat	676
Ktunaxa/Kinbasket Tribal Council	Columbia Lake	604
	Lower Kootenay	606
	St. Mary's	602
	Shuswap Band	605
	Tobacco Plains	603
Tsow-Tun Le Lum Society	Treatment Centre Transfer	n/a