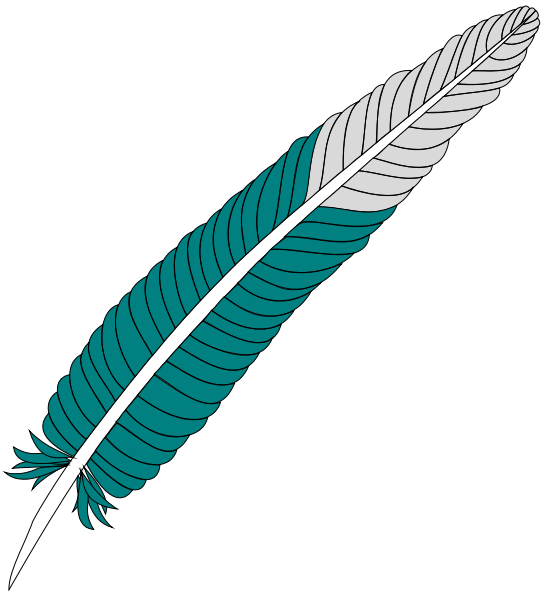
Health Canada Santé Canada

Transfer of Health Programs to First Nations and Inuit Communities

Handbook 1
An Introduction to Three Approaches



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Transfert des programmes de santé aux communautés des Premières nations et Inuits: Guide 1 - Introduction à trois approaches

Business Planning and Management Directorate
First Nations and Inuit Health Branch
Health Canada

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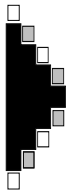
About This Handbook

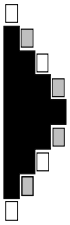
Purpose

This Handbook is number one of three providing information about the transfer of control of Indian and Inuit health programs from the federal government to First Nations and Inuit communities. It provides a summary for Band Councils, Tribal Councils, and other First Nations and Inuit organizations, as well as for managers and Regional Officers in the First Nations and Inuit Health Branch of Health Canada.



This handbook is an introduction to transfer of control of health programs and resources. Each section answers important questions that communities often ask when they are first interested in gaining more control.

Using This Handbook



Handbook 1 introduces three approaches for transferring control of health programs to First Nations and Inuit communities south of the 60th parallel across Canada:

- ***Health Services Transfer,***
- ***Integrated Community-Based Health Services, and***
- ***Self-Government.***

This Handbook summarizes First Nations and Inuit Health Branch (FNIHB) policies concerning control of health programs by First Nations and Inuit communities across Canada. Some regional variations may exist such as regulations governing certain health professionals and environmental protection under provincial jurisdiction.

Information You Will Need in the Future

Handbook 2 provides information about the Health Services Transfer process, and procedures and policies for planning under the Transfer approach. Handbook 3 explains what happens after a Health Services Transfer Agreement is signed. The titles of Handbooks 2 and 3 are:

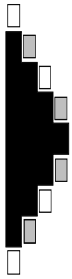
- *Transfer of Health Programs to First Nations and Inuit Communities: Handbook 2 - The Health Services Transfer,* and
- *Transfer of Health Programs to First Nations and Inuit Communities: Handbook 3 - After the Transfer—the New Environment.*

Keeping Up to Date

The three Handbooks together update earlier FNIHB documents on transferring health programs to First Nations and Inuit Organizations.

If there are any other handbooks or documents providing policy statements that conflict with the contents of these National Handbooks, the policies in this Handbook are the ones to follow.

The relationship between the federal government and Aboriginal people across Canada is evolving. FNIHB regularly reviews its policies on transfer of control of health programs to make sure they support this renewed relationship.



To ensure that you have the most current version of Handbook 1, 2, or 3, contact the Regional Office of FNIHB or go to the FNIHB website:

http://www.hc-sc.gc.ca/FNIHB/

Handbooks 1,2 and 3 can be downloaded from the FNIHB website. Changes which affect the Handbooks will be posted regularly on the website.

Introduction

Toward Greater Control by First Nations and Inuit Communities

Figure 1 shows the various ways that delivery of health services is being administered in First Nations and Inuit communities. As the extent of control by the community increases the higher the community is on the ladder.

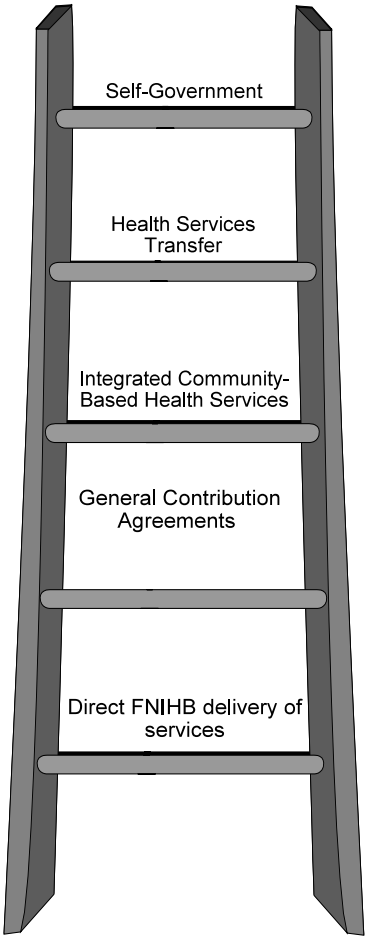
First Nations and Inuit communities interested in having more control of their health services can decide among three different approaches based on their eligibility, interests, needs and capacity. This Handbook summarizes the three approaches:

- Health Services Transfer,
- Integrated Community-Based Health Services, and
- Self-Government.

A preliminary discussion with an FNIHB Regional Officer provides information to assist Band Councils to decide on the approach that is best for their community.

Only First Nations and Inuit communities situated *south of the 60th parallel* are eligible to enter into the health services transfer process managed by FNIHB. Other communities work with the relevant federal department as described below:

Mechanisms for Delivery of Health Services in First Nations and Inuit Communities



- First Nations, Inuit and Métis groups located *north of the 60th parallel,* i.e., in Nunavut, the Northwest Territories, Yukon, and the northern most parts of Quebec and Labrador, negotiate all aspects of proposed self-government, including responsibility for health services, with Indian and Northern Affairs Canada (INAC).
- Some communities north of the 60th parallel manage certain aspects of health services through contribution agreements with the Northern Secretariat of FNIHB.
- Métis living south of the 60th parallel and Aboriginal people who reside off a land base, whether north or south of the 60th parallel, negotiate all aspects of self-government including health services with the federal Interlocutor for Métis and Non-Status Indians.

Mission and Vision of the First Nations and Inuit Health Branch

The Mission and Vision of FNIHB illustrate the Branch's commitment to transferring control of health programs to First Nations and Inuit communities.

First Nations and Inuit Health Branch

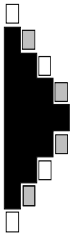
Our Mission…to establish a "renewed relationship with First Nations and Inuit that is based on the transfer of direct health services, and a refocused federal role that seeks to improve the health status of First Nations and Inuit".

Our Vision…First Nations and Inuit people will have autonomy and control of their health programs and resources within a time-frame to be determined in consultation with First Nations and Inuit people.

First Nations Control: Historical Perspective

The transfer of health programs and services from First Nations and Inuit Health Branch (FNIHB) to control by First Nations and Inuit communities has a long history. Since the early 1970s, organizations representing First Nations and Inuit communities have been negotiating with the federal government to regain control of all aspects of the lives of First Nations and Inuit people including health.

In the mid-1980s, a number of communities took part in a series of demonstration projects sponsored by FNIHB. Their experiences became the basis for the policy framework for health transfer.



On March 16, 1988, Cabinet approved the transfer of federal resources for First Nations health programs south of the 60th parallel to First Nations control.

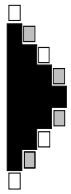
On June 29, 1989, Treasury Board approved the financial authorities and resources to support pre-transfer planning and to fund community health management structures.

At first, Transfer was the only option communities had for increasing their control over health programs and services beyond General Contribution Agreements. But the experiences of communities in the early 1990s, both those which completed the Health Services Transfer process and those which did not, led to agreement that not all communities were ready to move into this level of control of health services so quickly. As a result, in late 1994, Treasury Board approved the Integrated Community-Based Health Services approach as a new option for communities to move into a limited level of control over health services. In 1995, the federal government announced the Inherent Right to Self-Government Policy which introduced a third option for communities to further increase their control of health services. (See Appendix A, First Nations Control – Historical Perspective, for a brief description of key documents, approvals and authorities from 1969 to 1995.)

Three Approaches to Increased First Nations and Inuit Control

Depending on their eligibility, a community may choose any of the three approaches to enter into the process of increasing their control over health programs and services:

- Health Services Transfer approach
- Integrated Community-Based Health Services approach
- Self-Government.



Each community differs as to when it will take control and responsibility for its health programs and services. Communities take control and responsibility for health services at a pace determined by their interest, needs, and management capacity.

For example, communities with many years of experience with General Contribution Agreements, administering a number of FNIHB programs themselves, may be ready for the Health Services Transfer approach—they already have considerable experience managing employees and administering and delivering services. They may also have some experience in customizing programs to meet certain community priorities. However, because the FNIHB programs they have administered were designed by the federal government, communities may have had few opportunities in planning, developing and setting up new programs and services.

Although a community using the Integrated Community-Based approach has less control of its health programs than under Health Services Transfer, they gain a health management structure, on-the-job experience delivering programs and services, and increased power in decision-making about program activities to meet their community's unique needs.

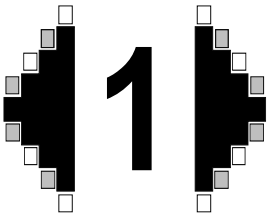
First Nations and Inuit communities operating under a Self-Government arrangement have the greatest control. They may be entitled to make certain laws governing their community with respect to health. The range of resources for health programs is broader than those included in a Health Services Transfer arrangement. Flexibility in terms of how resources are allocated is also greater and reporting requirements are fewer.

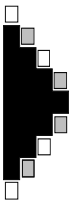
Sometimes, two or more communities work together under Transfer or an Integrated arrangement and share the responsibility of providing health programs and services to their members. These multi-community arrangements are very similar to those for single communities with a few differences that are noted as they apply throughout this Handbook.

The Transfer process in FNIHB provides the flexibility for communities to take control of their health services at a pace that best suits their needs. It also provides the flexibility to change direction from one approach to another. Communities can move from the Integrated Community-Based Health Services approach to the Health Services Transfer approach (in Pre-Transfer Planning or Bridging Phases) and vice versa, subject to some conditions. For example, if a community is in the Pre-Transfer Planning or Bridging Phase of Transfer and decides that they are not ready to continue on to the next phase, they may opt for the Integrated Community-Based approach. Also, communities may move from the Integrated approach directly to the Bridging Phase of the Transfer approach.

Each of the next three chapters of this Handbook focuses on one of the three approaches to increased First Nations and Inuit control.

The Health Services Transfer Approach





Health Services Transfer involves a process that gradually moves control of resources and responsibility for community health services and programs into the hands of First Nations and Inuit communities. The process includes the transfer of knowledge, capacity and funds so that communities can manage and administer their health resources based on their own community needs and priorities.

What Are the Goals of the Transfer Approach?

The primary goals of this approach are:

- to enable communities to design health programs, establish services and allocate funds according to community health priorities;
- to ensure that communities have flexibility in the delivery of health programs and services;
- to ensure that public health and safety are maintained through the provision of mandatory health and treatment programs; and
- to strengthen and enhance the accountability of community leaders to community members.

(See the section in this chapter, "After the Health Services Transfer Agreement Is Signed" for an overview of the accountability framework for Transfer.)

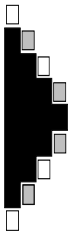
What Are the Benefits of Transfer for First Nations and Inuit Communities?

In the 1995 evaluation of the Transfer process, communities mentioned benefits such as the following:

- increased community involvement and decision making in community issues
- increased awareness of health issues
- community identifies its unique needs and strengths and establishes its own priorities
- increased management skills and capacity to direct programs and services
- development of new programs, services and approaches
- improved quality of life for elders and their families
- more integration of programs and services and joint planning approaches with social services, education, and justice
- greater priority of community health issues with the community leadership

- increased use of services by community members
- more culturally-based programs and services
- more flexibility in how health funds are spent
- more responsibility and accountability to community
- significant economic impact for some communities including the creation of jobs
- a shift in the relationship with other governments from hierarchical dependency to more open, intergovernmental relationships.

Community Eligibility



To be eligible to begin the planning process for the Transfer approach, a community must provide:

- ***a mandate as evidenced by a Band Council Resolution (BCR) or other form of approval appropriate to the Band(s) or Inuit group(s) granting the mandate***
- ***evidence of successful financial and administrative experience in program management.***

Summary of Resources for the Community That Chooses the Transfer Approach

The amount of funding that is transferred to a community to manage its health programs and services is based on a number of factors:

- the community population as approved by FNIHB,
- the programs and services to be undertaken,
- the value of moveable assets transferred, and
- other considerations determined in discussions between FNIHB and the community.

Financial and human resources are available for pre-transfer training and an array of planning activities. It may take up to 21 months to complete the planning process for Transfer. (For details, see the section, "Planning Activities and Related Resources for Transfer", and Table 1 in this Handbook.) When planning activities are completed, FNIHB enters into a Health Services Transfer Agreement of up to five years. This Agreement is renewable.

Programs and Services Eligible for Transfer

Figure 2 provides a list of services and programs which are eligible for community control through a Transfer arrangement.

Figure 2: Eligible Health Programs and Services Under the Transfer Approach

- **Brighter Futures**
- **Building Healthy Communities - Mental Health Crisis Management**
- **Building Healthy Communities - Solvent Abuse**
- **Canada Prenatal Nutrition Program** (excluding Development Funds)
- **Community Health Promotion and Injury/Illness Prevention**
  - Community Health Representatives
  - Community Nursing
  - Nursing Training
  - Support Services to Community Health
  - Health Education
- **Community Health Primary Care**
  - Community Nursing *
  - Support Services to Community Health
- **Dental Therapy ***
- **Environmental Health Program**
- **Health Careers** (excluding bursaries and scholarships)
- **Health Services**
  - Operations and Maintenance of Facilities and Residences
  - Communicable Disease Control
  - Health Board and Health Co-ordinators
- **National Native Alcohol and Drug Abuse Program**

* Limitations apply in some provinces because of the absence of applicable legislation. See Handbook 2.

Dental therapists and nurse practitioners (acting in expanded roles) cannot work directly for communities in certain provinces where they are not recognized under the Provincial Health Acts and, therefore, are unable to secure liability protection. A Special Interchange arrangement may be possible whereby these health professionals continue to be employed by FNIHB, but receive day-to-day direction from the community and are part of the community health team. For details see Handbook 2, CHP-11.

Figure 3 provides a list of services and programs which are ***not eligible*** for community control through a Transfer arrangement.

Figure 3: Programs and Services Not Currently Eligible *for Community Control*

- Fixed assets (health facilities)
- CPNP Development Funds
- Health Consultation
- Health Careers (bursaries and scholarships to Aboriginal peoples)
- Non-Insured Health Benefits Program*

* Treasury Board Authority is currently being sought to transfer the full compliment of NIHB to First Nations' control. NIHB pilot projects are in place with special Treasury Board Authorities as an interim measure.

What About Transfer of 2nd and 3rd Level Services?

Second and third level services are those services provided at the regional or zone level, respectively. Generally, 2nd and 3rd level services are of a coordination, consultative and supervisory capacity as opposed to direct community-based services (1st level).

Typical positions in a Region providing 2nd and 3rd level services to communities include the following. Positions may vary somewhat from Region to Region.

- Regional Dental Officer
- Regional Nutritionist
- Community Health Coordinator
- Community Medicine Consultant
- Regional Nursing Officer
- Assistant Regional Nursing Officer
- Regional Nurse - Epidemiology
- Regional NNADAP Coordinator
- Brighter Futures Coordinator
- Regional Environmental Health Officer
- Zone Environmental Health Officer
- Regional Health Education Officer
- Zone Nursing Officer
- Zone NNADAP Consultant
- Zone Community Health Representative (CHR) Advisor
- Community Development Officer
- Maintenance Officer
- Maintenance Worker

Some communities may decide not to transfer 2nd and 3rd level services and in these cases, another First Nations or Inuit organization or FNIHB will provide these services on behalf of the community. A community or group of communities which has demonstrated the ability to deliver 2nd and 3rd level services may consider the transfer of mandatory and non-mandatory 2nd and 3rd level services as part of their Transfer Agreement.

When communities choose to have another organization manage 2nd and 3rd level services on their behalf, the 2nd and 3rd level services Transfer Policy will apply. This policy is available from FNIHB Regional Offices.

What Are Mandatory Services?

Certain programs have been identified as mandatory to meet legislated standards which ensure public health and safety:

- Communicable Disease Control
- Environmental Health
- Treatment Services.

To ensure delivery of these mandatory programs, certain services have been identified as essential to meet mandatory program requirements. They are:

- Environmental Health Services (EHO)
- Medical Officer of Health Services (MOH)
- Professional Nursing Supervision.

What About Services Provided Under the Non-Insured Health Benefits (NIHB) Program?

The Transfer Framework and related authorities for the Non-Insured Health Benefits (NIHB) Program, such as dental and drugs, is currently under assessment. In 1997, a number of communities entered into NIHB pilot projects to be evaluated jointly by First Nations and FNIHB. The results of the pilot projects are to be used in the creation of a NIHB Transfer Policy. In 1998, Health Canada received Cabinet approval for the transfer of NIHB. FNIHB is currently seeking Treasury Board authority to transfer the full compliment of NIHB services. A separate handbook for NIHB is currently being developed and will be issued once the appropriate authorities and program framework are finalized.

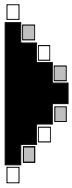
What About Transfer of Treatment Programs for Alcohol, Other Drugs and Youth Solvent Abuse?

The National Native Alcohol and Drug Abuse Program (NNADAP) Treatment Centres and National Youth Solvent Abuse Treatment Program (NYSATP) are treatment programs funded by FNIHB. The first NNADAP treatment centre program transfer occurred in 1993. The process for transfer of these treatment programs differs from Transfer for other health programs and services. For treatment programs, the transfer initiative involves an administrative transfer between FNIHB and the corporate recipient for the treatment centre, as opposed to a community-based transfer with a Band or Tribal Council. The "Policy for the Transfer of Treatment Programs for Alcohol, Other Drugs and Youth Solvent Abuse" is available from FNIHB Regional Offices.

Planning Activities and Related Resources for Transfer

Early in the process for Transfer, the community leadership designates a member to be the contact for health issues and creates a team of community members responsible for managing the planning process and hiring a coordinator if needed. Throughout all planning phases, FNIHB Program Managers provide ongoing consultative and technical support to help communities prepare their planning documents and assume greater control.

The main community planning activities for Transfer are a comprehensive Community Health Needs Assessment, establishment of a health management structure and researching and developing the Community Health Plan (CHP). For more information on establishing a Health Management Structure, see "Guide to Health Management Structures for First Nations", an appendix in Handbook 2.



The Community Health Plan (CHP) is the key document for discussions between the community and FNIHB to work toward a Transfer Agreement. The CHP provides details about the community, its health needs identified in the Community Health Needs Assessment, and all aspects of how the community will deliver health services and programs under a Transfer Agreement.

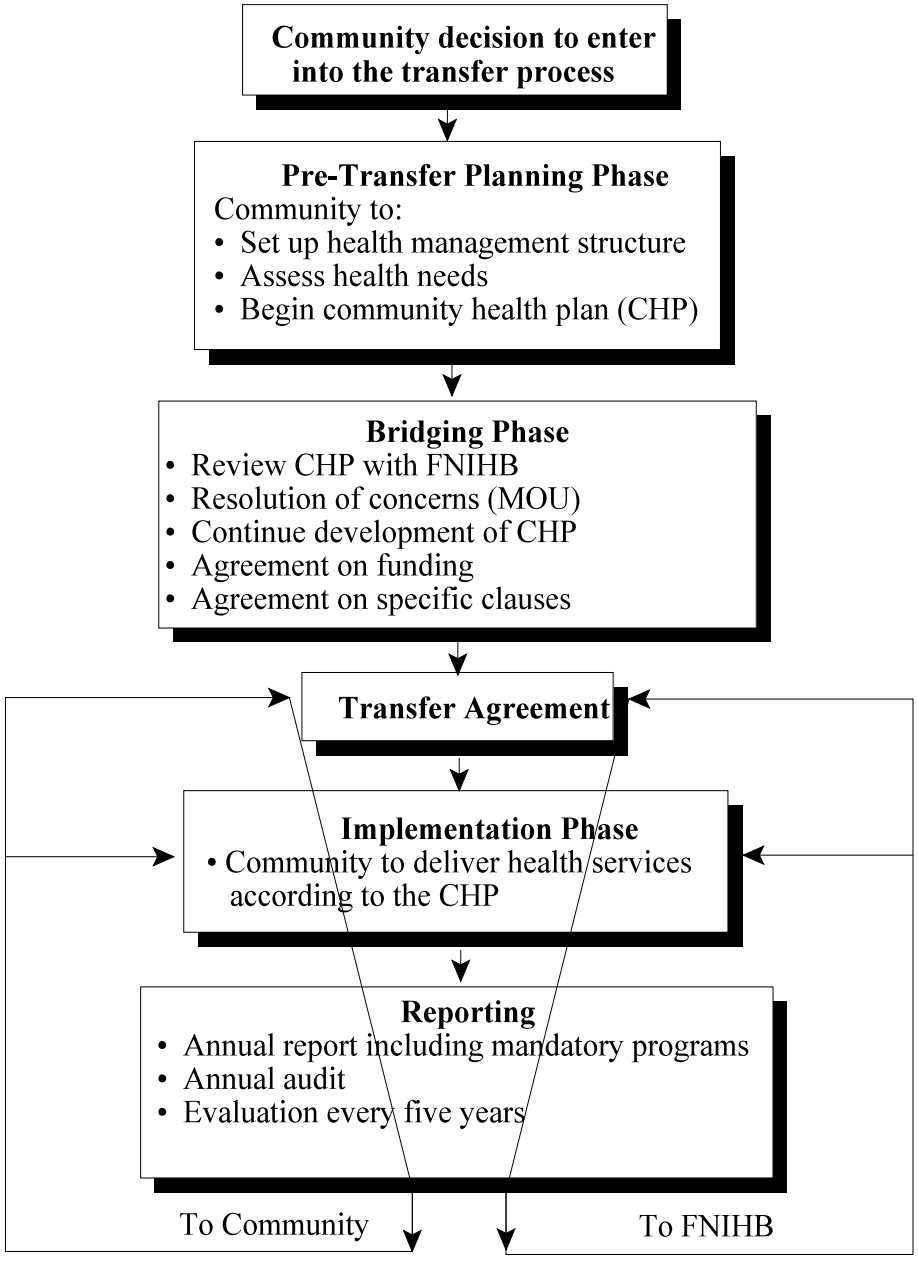
During the planning phases for Transfer, the CHP is put together by the community to describe what health services are most needed, how those services will be provided and how health care money will be spent.

The CHP belongs to the community and is developed to guide the community health structure as it operates programs. Because it is the key planning document, the CHP must be updated regularly to keep it current with whatever changes are made or needed in health programs and services. The CHP is an essential document for the community to evaluate its health programs and services every five years.

The steps involved in achieving a Transfer arrangement are shown in Figure 4.

Figure 4

Framework for Transferring Health Programs to Community Control



Based on Exhibit 13.11, Report of the Auditor General of Canada to the House of Commons, October 1997, Chapter 13, Health Canada - First Nations Health, pg. 13-17.

The CHP consists of 15 components that the community develops in stages over the three phases of Transfer as follows:

Pre-Transfer Planning Phase

- ***Community health priorities and needs as identified in the Community Health Needs Assessment (CHNA)***
- ***Health Management structure***
- ***Management and delivery of mandatory programs***
- ***Management and delivery of community health programs***

Bridging Phase

- ***Medical Officer of Health Services***
- ***Liability and malpractice insurance***
- ***Drugs and medical supplies***
- ***Moveable Assets Reserve (MAR)***
- ***Confidentiality procedures***
- ***Accountability and reporting mechanisms***
- ***Professional supervision***
- ***Comprehensive budget***

Implementation Phase

- ***Training plan for after transfer (may be completed in the Bridging Phase)***
- ***Emergency Preparedness plan (may be completed in the Bridging Phase)***
- ***Evaluation plan (completed in the first year of Transfer).***

Handbook 2 focuses on the Community Health Plan and provides explanations and detailed requirements for each of the components.

Ongoing review by the community of its program and service delivery is important for determining success and areas that need changes or extra attention. Even though the final plan for ongoing evaluation is not required until the Implementation phase, work to develop the evaluation plan begins in the Pre-Transfer Planning phase.

Communities must keep evaluation in mind throughout all stages of preparing their CHP. For example, the CHP sections on mandatory programs and community health programs must include objectives and desired outcomes of programs and services and the indicators of these outcomes. Communities must determine what records to keep on a daily basis to make sure they have the indicators they need.

Table 1 provides a summary of the key planning activities for Transfer and the related resources available to carry them out. See Handbook 2 for explanations and detailed requirements.

Table 1: Planning Activities and Related Resources for the Transfer Approach

Transfer Approach[1]	
Key Planning Activities	**Planning Resources**
Pre-Transfer Planning Phase Time Frame: 1 year • Submit planning proposal with BCR (or other approval appropriate to Band(s) or Inuit group(s) granting the mandate) and letter of audit • Conduct Community Health Needs Assessment (CHNA) • Establish community health management structure and provide training • Develop first 4 components of Community Health Plan (CHP): identify community health priorities; describe health management structure; describe management and delivery of mandatory programs; describe management and delivery of community health programs. • Decide on technical support needed from FNIHB staff.	• $38,000 - $96,000 (CHNA)[2] (per project) • One-time funds for pre-transfer training: $10,000 (per community) • $9,000 (per project) for 4 CHP components • 50% of management formula funding[3]
Bridging Phase Time Frame: 9 months • FNIHB reviews CHP to date • Develop 8 components of CHP to describe provisions for: Medical Officer of Health; liability and malpractice insurance coverage; obtaining drugs and medical supplies; moveable assets reserve; confidentiality procedures; accountability and reporting; professional supervision; comprehensive budget. • FNIHB reviews CHP. • Memorandum of Understanding.	• $15,000 for 8 CHP components • 100% of management formula funding[4] prorated for 9 months
Implementation Phase • 3 to 5 year Transfer Agreement signed. • During first year of agreement, develop final 3 components of CHP to describe plans for: training after transfer[5]; emergency preparedness[5] and evaluation.	• $2,000 for training plan • $5,000 for emergency preparedness plan • $11,000 for evaluation plan

[1] Throughout all of the planning activities funding continues for delivery of programs and services.
[2] See Appendix B
[3] See Appendix C
[4] See Appendix D
[5] Training and emergency preparedness plans may be completed in the Bridging Phase.

Resources for Planning Activities

Funding and technical support are provided to communities during all of the planning phases for Transfer as shown in Table 1. Funding is provided for the following planning activities:

- conducting the initial Community Health Needs Assessment (CHNA)
- establishment of a health management structure
- training needed during the planning process
- preparation of the 15 components of the Community Health Plan (CHP).

Communities planning for Transfer have access to one-time funds for conducting the initial Community Health Needs Assessment. This funding is based on the population of the community. (See Appendix B for the formula used to calculate this funding.)

Funding to support the establishment of a health management structure is determined by a Health Management Formula based on the population of the community and how remote it is. During the Pre-Transfer Planning Phase, the 50% Health Management Formula is used to calculate the support. (See Appendix C for the 50% formula used to calculate this funding.) Regardless of how long the community takes to complete the activities in the Pre-Transfer Planning Phase, the funding given for the health management structure is the 50% formula amount for one year. During the Bridging Phase, the 100% Health Management Formula is used to calculate the support. (See Appendix D for the 100% formula used to calculate this funding.) Similarly, regardless of how long the community takes to complete the activities in the Bridging Phase, the funding given for the activities is the 100% formula amount pro-rated for nine months.

One-time funding is given for training needed during the planning process. Communities also receive funding to prepare their CHP. Funding for the various activities is given in separate installments in each of the three Phases.

Multi-Community Transfer Agreements

A group of communities can work together on the planning, management and delivery of health programs and services to their members. Together the group conducts the Community Health Needs Assessment (CHNA) for all of its members, and establishes one health management structure and Community Health Plan (CHP). The CHP should specify the services to be provided in the communities, which of those services will be provided by the individual communities and which by the multi-community group, and how frequently the services will be provided.

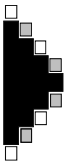
Details of funding for planning activities are provided in Table 1. In the Pre-Transfer Planning Phase, one-time funding for multi-community groups is determined as follows:

- **Community Health Needs Assessment:** the funding is calculated with the formula in Appendix B using the total population of the participating communities.
- **Development of the Community Health Plan:** the funding specified in Table 1 is for development of a CHP for all of the participating communities.
- **Pre-Transfer Training:** the funding for training specified in Table 1 is provided to each community in the group.
- **Health Management Structure:** the funding is calculated using the 50% formula in Appendix C. The total amount provided to the multi-community group for its health management structure is calculated by applying the population of each community to the formula and then taking the sum of those amounts.

In the Bridging and Implementation Phases, the funding for the health management structure is calculated using the 100% formula in Appendix D. Again, the total amount provided to the multi-community group for its health management structure is calculated by applying the population of each community to the formula and then taking the sum of those amounts. During the Bridging Phase, the funding for the health management structure is pro-rated for 9 months.

Where a Transfer agreement is signed with a multi-community group, the responsibility for the management of this agreement lies with the group, whether or not the group provides all services directly. The responsibility for resolving differences within the group lies with all communities who are party to the agreement. A process for handling differences should be developed by each multi-community group.

After the Health Services Transfer Agreement Is Signed



After the Transfer Agreement has been signed, communities maintain an ongoing relationship with FNIHB.

The focus of Handbook 3 is the relationship between FNIHB and the community after a Transfer Agreement is signed. The following is a summary of the responsibilities of FNIHB and the community.

After a Transfer Agreement is signed, the roles of FNIHB relate primarily to the following areas:

- ***Protection against health risks (in collaboration with provinces and territories)***
  - ***in cases where an immediate response is required, e.g., communicable disease, environmental health threat, disaster, epidemic, crisis or other emergencies***
  - ***long-term, ongoing prevention of risk, e.g., service delivery problems***
- ***Assessment of program and financial impacts on community, e.g., assessing the effectiveness of programs and services against the Community Health Plan; reviewing and renewing Agreements***
- ***Ongoing functions as a result of special relationship, e.g., linkages to provincial health systems; support to the Minister for reporting to Parliament and Cabinet; advisory and consultative capacity, i.e., environmental health officer, medical officer of health, nursing officer, dental officer.***

The Regional Offices of FNIHB provide ongoing technical support to the community in meeting its new commitments. They also serve as a liaison with other resource people such as staff in the provincial government and the national office of FNIHB.

The primary responsibilities of the community under a Health Services Transfer Agreement are summarized in Figure 5.

Figure 5: Community Responsibilities After a Transfer Agreement Is Signed

After a Health Services Transfer Agreement is signed, a community is fully responsible for administering health programs and services:

- ✓ ***delivers community -based programs and services based on its current Community Health Plan (CHP)***
- ✓ ***is responsible for mandatory programs (i.e., communicable disease control including immunization; environmental health; and treatment services)***
- ✓ ***prepares an emergency preparedness plan and ensures first response to emergencies***
- ✓ ***employs or contracts the service providers and manages their work***
- ✓ ***develops a training plan and provides for professional development of service providers***
- ✓ ***manages finances and is accountable to the community for how money is spent and how programs are run***
- ✓ ***plans and develops new programs or redesigns existing programs based on community health priorities and subsequent health evaluation results***
- ✓ ***Updates the CHP regularly and provides copies to FNIHB***
- ✓ ***provides regular required reports to the province on mandatory services (specific reporting requirements are legislated in each province for these public health and safety programs)***
- ✓ ***provides financial progress reports for targeted programs***
- ✓ ***is required to submit three annual reports to FNIHB:***
  - ***a copy of the annual report made to the community***
  - ***a copy of the report on the provision of mandatory programs***
  - ***a financial audit report by an independent auditor chosen by the community***
- ✓ ***keeps any surplus funds at year end but is also responsible for any deficit***
- ✓ ***keeps records and conducts an annual review of the transfer arrangement together with FNIHB to determine the success of the community's delivery of health services and programs***
- ✓ ***develops an evaluation plan and carries out an evaluation of its delivery of health services and programs in every five-year period of transfer with funding from FNIHB to remain accountable to community members and to identify successes and changes needed in programs; the evaluation is conducted in the fourth year of the transfer period to allow time for assessment and discussions for renewal by the end of the fifth year of the transfer period***
- ✓ ***reports on the evaluation to the community and FNIHB***
- ✓ ***renews the Transfer Agreement based on the results of the community program evaluation and achievement of the health priorities identified in the current Community Health Plan.***

Accountability Framework

Under a Transfer arrangement, the accountability relationship between the community leadership and the Minister of Health reflects an approach based on greater financial and program flexibility within a framework requiring more visibility and accountability to community members and to Parliament.

Accountability of the Community Leadership to community members…

A Transfer Agreement will vest primary responsibility and authority in the community leadership or their designated health organization, for assessing health needs, determining priorities, designing and operating programs and allocating resources. Community members will hold community leaders responsible for the success of the health program in meeting community needs and for ensuring fair and equal access to service for all community members. This includes a process for handling service complaints and appeals by community members, and providing a copy of the annual report to community members.

Accountability of the Community Leadership to the Minister…

The community leadership is accountable to the Minister for meeting the terms and conditions of the Transfer Agreement. An annual audit of transferred and targeted programs is required.

Accountability of the Minister to Parliament…

The Minister continues to be accountable to Parliament for prudent financial management of community health resources and for overall program results to protect the health and safety of Aboriginal people. Ministerial accountability is maintained by ensuring from the outset that communities entering into Transfer Agreements have the necessary management structures and processes for community accountability and by monitoring, through the annual audit and other reports and mechanisms, community performance with respect to mandatory program requirements and terms and conditions in the Transfer Agreement.

Accountability mechanisms include:

- Community Health Plan and updates
- community emergency preparedness plan
- annual audits and reports
- evaluation every five years
- intervention in emergencies when the responsible health authority cannot or does not act.

What Do We Do to Get Started?

A community wishing to explore Transfer expresses interest by contacting the nearest Regional or Zone office of FNIHB. An FNIHB Director or Regional Officer meets with the Chief and Council or Inuit leadership or with community members designated by the leadership or with both. They discuss the information contained in this Handbook to help them decide on their approach. The community needs to carefully think about a number of considerations before making their decision.

Figure 6 provides a detailed checklist of items for early consideration before the community begins the planning process for Transfer.

To be eligible to begin the planning process for Transfer, the community submits

- ***a mandate as evidenced by a Band Council Resolution (BCR) or other form of approval appropriate to the Band(s) or Inuit group(s) granting the mandate***
- ***evidence of successful financial and administrative experience in program management.***

Figure 6: Preparing for Pre-Transfer Planning - What You Need to Consider

The following checklist outlines information you will need and some things to think about as you prepare to work through the three phases of the Transfer planning process.

General Information You Will Need:

- ❑ a Band Council Resolution (BCR) or other form of approval appropriate to the Band(s) or Inuit group(s) granting the mandate to proceed with Transfer
- ❑ the name of the person who will be the Band contact for FNIHB
- ❑ if multiple communities are applying together:
  - the name and population of each community
  - whether any of the member communities intend to submit separate, individual requests for Pre-Transfer funding
  - the future roles of the Tribal Councils and individual communities in managing and delivering health services

❑whether the community is discussing other funding arrangements or a self-government arrangement with Indian and Northern Affairs Canada; how advanced these discussions are; whether the community intends to include health in its Self-Government arrangement; and when the arrangement is expected to be in place.

The Community's Management Experience:

- ❑ any previous experience the community has in managing programs or money
- ❑ the names of the programs and how much money was involved
- ❑ how many people the community employs
- ❑ whether the community already has a Health Board, Authority, Council or Committee (i.e., Health Management Structure)
- ❑ how often the Board, Authority, Council or Committee meets
- ❑ whether there are other health management staff and, if so, what type and how many.

Financial Matters:

- ❑ the community's experience in financial management (the community needs a sound track record in financial administration to be able to manage its health resources effectively)
- ❑ a copy of the most recent Audit Report or a letter from an auditor
- ❑ whether the community is receiving other money from FNIHB for community liaison and consultation, and if so, the amount and what the funds are being used for.

A Workplan for Pre-Transfer Planning Activities:

• A workplan will be needed for the following activities:

- ❑ establishing and training a Health Board, Authority, Council or Committee;
- ❑ the Community Health Needs Assessment (CHNA) assessing health needs and priorities;
- ❑ reviewing existing services; and
- ❑ developing a Community Health Plan.

A workplan should include for each activity:

- ❑ what the activity will accomplish;
- ❑ how it contributes or relates to moving toward Transfer;
- ❑ a time frame for completion and a schedule of tasks;
- ❑ who will be responsible for carrying out the activity; and
- ❑ what it will cost.

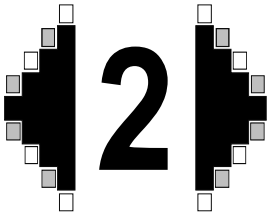
- If a community plans to hire staff to help with the activities of Pre-Transfer Planning, the community will need:
  - ❑ a job description that describes the responsibilities for each person; and
  - ❑ who each person is accountable to (e.g., the community leadership, Health Committee, or other health staff in the community).
  - ❑ how the FNIHB Region will be involved in the Pre-Transfer Planning Phase.

Pre-Transfer Training Needs

- FNIHB provides money for three types of short-term training activities during the Pre-Transfer Planning Phase:
  - training members of the Health Board or Health Committee;
  - training community members who will be helping to plan for Transfer and to develop the Community Health Plan; and
  - community health information workshops.
- The community needs to consider:
  - ***Training for members of the Health Board or Health Committee:***
    - ❑ the number of people who will need training;
    - ❑ the number of days or hours needed;
    - ❑ who will provide the training;
    - ❑ where the training will take place;
    - ❑ what will be taught; and
    - ❑ the budget.

- ***Training for Community Members:***
  - ❑ who will be trained and the role of each in planning for Transfer and developing the Community Health Plan;
  - ❑ how the training will contribute to Transfer;
  - ❑ where the training will take place;
  - ❑ how the training will be carried out (e.g., workshops, seminars);
  - ❑ how long the training will take;
  - ❑ the extent to which trained people in the community will be used to train others; and
  - ❑ the budget.
- ***Community Health Information Workshops:***
  - ❑ how the workshops will contribute to Transfer;
  - ❑ where they will take place;
  - ❑ who will run the workshops; and
  - ❑ the budget.

The Integrated Community-Based Health Services Approach



What Is the Integrated Community-Based Health Services Approach?

FNIHB received the authority from Treasury Board in February 1994 for the "Integrated Community-Based Health Services Contribution Program". This approach to First Nations and Inuit control of health services and related resources involves the community signing one Contribution Agreement for specific types of community health services which the community wishes to manage.

The two key components of the Integrated approach are the establishment of the community health management structure and the creation of a global budget funding arrangement. The community health management structure can take the form of a health committee or board, or a health coordinator. The funding agreement can be approved for a period of three to five years, with the budget renewable annually.

The Integrated approach offers an opportunity for communities to receive on-the-job training in the administration and delivery of community health programs. Rather than completing a planning period and then embarking upon program delivery, the community begins immediately to manage community health programs and to look at community priorities. As well, communities are able to make some program adjustments, to reallocate resources, and to set up health management structures that receive funding on a permanent basis. This approach proposes a closer involvement of FNIHB staff, at least in the initial phase. Consequently, communities should expect increased support from FNIHB in assisting them to identify community priorities.

For some communities, operating under the Integrated approach may be a starting point for assuming greater control through Transfer or Self-Government. For other communities, the Integrated approach may be the most appropriate way to deliver health services to their community members because their level of health resources makes them ineligible for Transfer, or they require more development work at the community level, or they decide that this method of operation works best for them.

What Are the Objectives of the Integrated Community-Based Health Services Approach?

The objectives of the Integrated Community-Based Health Services approach are:

- to support First Nation and Inuit communities in enhancing their capacity to direct and take control of health resources; and
- to facilitate and promote community involvement in planning and implementing health programs and services.

What Are the Benefits of the Integrated Community-Based Health Services Approach for First Nations and Inuit Communities?

The benefits of the Integrated Community-Based approach include:

- one-time financial support for planning and for management training
- ongoing funding for a new health management structure
- on-the-job experience managing programs and services
- opportunities to review community program priorities
- greater power in decision making about
  - program objectives
  - allocation of program resources
- the opportunity to consider an enhanced process of community control of health programs and services such as Transfer.

Summary of Responsibilities and Resources for the Integrated Community-Based Health Services Approach

A community that chooses the Integrated approach gains less control than with Transfer but greater control than if they continued to operate under General Contribution Agreements. A community operating with the Integrated approach sets up its own health management structure but shares responsibility for delivering services with FNIHB. As long as mandatory health services are provided, communities have the flexibility to change the objectives and activities of a program, increase the resources dedicated to one service and reduce resources for another according to community priorities.

The resources available for initial training and planning activities and the level of funding provided once the community has entered into an Agreement are less than for Transfer. (For details, see the section, "Planning Activities and Related Resources for the Integrated Community-Based Approach" and Table 2 in this Handbook.) Planning needed to enter into an Integrated Community-Based Health Services Agreement for the Implementation Phase takes about one year.

Community Eligibility

For First Nations and Inuit communities located south of the 60th parallel...

To be eligible for the Integrated Community-Based Health Services approach, the community must:

- ***already operate health programs and services funded through FNIHB Contribution Agreements***
- ***agree to establish a health management structure with trained personnel***
- ***agree to enter into a planning process resulting in a workplan which identifies the changes the community wishes to make in programs and/or resource allocations to respond to community-based health priorities.***

Communities who previously have received Transfer planning resources, but who have discontinued Transfer preparations, may wish to enter into the Integrated approach. If a health management structure was already in place and a workplan completed, the community would proceed directly into the Implementation Phase. If these preconditions were not in place, then they would enter into the Planning Phase.

Health management funds provided under the Integrated approach would be adjusted for communities who already receive health management funds for the salary of a Health Coordinator or for the support of a Health Committee.

Programs and Services Eligible for the Integrated Approach

Figure 7 shows the programs and services originally funded through General Contribution Agreements that are eligible for community control under the Integrated approach.

*Figure 7: Eligible Health Programs and Services Under the Integrated Approach***

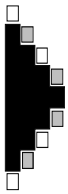
- **Brighter Futures**
- **Building Healthy Communities - Mental Health Crisis Management**
- **Building Healthy Communities - Solvent Abuse**
- **Canada Prenatal Nutrition Program** (excluding Development Funds)
- **Community Health Promotion and Injury/Illness Prevention**
  - Community Health Representatives
  - Community Nursing
  - Nursing Training
  - Support Services to Community Health
  - Health Education
- **Community Health Primary Care**
  - Community Nursing *
  - Support Services to Community Health
- **Dental Therapy** *
- **Environmental Health Program**
- **Fetal Alcohol Syndrome/Fetal Alcohol Effects**
- **Health Services**
  - Operations and Maintenance of Facilities and Residences
  - Communicable Disease Control
  - Health Board and Health Co-ordinators
- **National Native Alcohol and Drug Abuse Program**

* Limitations apply in some provinces because of the absence of applicable legislation. See Handbook 2

** Services under the Non-Insured Health Benefit Program (NIHB) ***cannot be included*** in the Integrated Community-Based Health Services Agreement (e.g., dental, drugs) but may be part of a separate General Contribution Agreement.

Non-insured health services, i.e., those provided under the Non-Insured Health Benefits Program (NIHB), ***cannot*** be included in an Integrated Community-Based Health Services Agreement. Also, it should be noted that dental therapists and nurse practitioners (acting in expanded roles) in some provinces cannot work directly for communities because they are not recognized under some Provincial Health Acts and, therefore, are unable to secure liability protection. The resources associated with nurse practitioners and dental therapists who are unable to work directly for communities can be included in an Integrated Agreement if a Special Interchange Agreement is in place. The current Special Interchange arrangement used for Transfer can be used under the Integrated approach whereby these health professionals continue to be employed by FNIHB, but may receive day-to-day direction from the community and be part of the community health team.

What Do We Do to Get Started?



To begin the process for an Integrated Community-Based Approach, the community submits a Band Council Resolution or a letter of intent to the FNIHB Regional Director.

Communities are not required to prepare a proposal or submit any formal documentation other than a First Nations Band Council Resolution or an Inuit community letter of intent to begin the process. Once notification has been received from the community, the FNIHB Regional Office enters into an Integrated Community-Based Health Services Agreement for the Planning Phase.

Planning for the Integrated Approach

The key planning activities for the Integrated approach, and the resources available to carry them out, are shown in Table 2. The focus of planning for the Integrated approach is establishing and training a health management structure and preparing a community workplan to be completed during the Planning Phase. Appendix E provides a sample of a workplan.

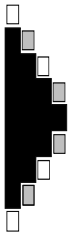
Table 2: Planning Activities and Related Resources for the Integrated Approach

Integrated Approach[1]	
Key Planning Activities	**Planning Resources**
Planning Phase • Time frame: 1 year • Submit a letter or proof of community mandate • Establish a community health management structure and provide training • Develop community health workplan including: health priorities of community; objectives; activities; mechanism for delivery of mandatory programs; indicators of success. • Develop budget to support activities in workplan. • Review community workplan together with FNIHB. • Community signs Integrated Agreement for the Planning Phase.	• One-time funding for developing workplan: $10,000 • 50% of management formula funding available under transfer[2]
Implementation Phase • Community signs Integrated Agreement that supports the management structure and workplan. • Community allocates resources based on workplan. • Community changes the objectives and activities of programs according to community health priorities.	• 50% of management formula funding available under transfer[2] • funding for the annual audit

[1] Throughout all of the planning activities funding continues for delivery of programs and services.

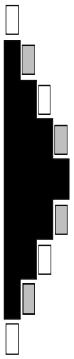
[2] See Appendix C.

Note: The formula for calculating the amount of funding for the audit for Integrated Agreements is: Apply 0.5% to the total agreement, excluding one-time items, with a minimum of $2,500.00



The workplan for the Integrated Approach is based on the programs and services that the community already provides to its members through Contribution Agreements with FNIHB. The workplan describes the program goals, objectives and activities; how mandatory public health services will be delivered; and how the community would like to re-allocate funds among the various health services to reflect their community's health priorities.

Communities *may not* create new programs outside the FNIHB mandated services under the Integrated approach although there is an opportunity for the reallocation of funds and the re-configuration of the health programs through the workplan. The flexibility to reallocate resources does not come into effect until the Implementation Phase. This phase begins after the workplan is reviewed and the proposed reallocation of resources is approved by the FNIHB Regional Office.



The required components of the workplan are:

- ***current community health priorities***
- ***goals, objectives, activities, and outcome measures for each program area (program goals must be within the general scope of FNIHB approved health programs and services) and***
- ***how mandatory public health and safety programs will be delivered, i.e., communicable disease control (including immunization), environmental health, and treatment services (if applicable)***
- ***a resource plan indicating how resources will be allocated among the various programs.***

Communities may change the objectives and activities of a program or service in line with community priorities, but the objectives and activities must stay within the FNIHB program mandate. For example, a community could choose to have a CHR spend more time on health education activities, or decide to have no NNADAP workers and use the related resources for mental health. Any reallocation of resources must be reviewed and agreed upon by the community and FNIHB before becoming part of the workplan.

The community and FNIHB meet to review the workplan. If it includes all the required components, an Integrated Community-Based Health Services Agreement for the Implementation Phase is signed.

Funding for Planning Activities

The Agreement for the Planning Phase includes funding for health programs and services currently administered or delivered by the community plus $10,000 in one-time funding to prepare the workplan. In addition, ongoing funding is provided to support a community health management structure including training. The level of this ongoing funding is 50% of the health management funding provided in Transfer arrangements. The health management funding formula is based on the population of the community and how remote it is. See Appendix C for the 50% health management funding formula used to calculate the funding.

With respect to Tribal Council or multi-community initiatives, the one-time funding for the workplan and the ongoing funding for the health management structure are determined on a community-by-community basis.

Implementation Phase

After the Integrated Community-Based Health Services Agreement for the Implementation Phase is signed, the community implements the approved workplan including any reallocation of resources among programs or services as approved. The duration of an Integrated Agreement is for a period of three to five years with the budget renewable each year. This Agreement includes resources for community health programs, health management support, and liability and malpractice insurance (if necessary).

Communities are required to submit reports to the FNIHB Regional Office as follows:

- ***financial reports of actual expenditures by program component to be submitted in October and January of each year. (A sample financial report is provided in Appendix F.)***
- ***an annual financial audit due 120 days following a community's fiscal year end.***
- ***annual program reports on the health services provided and on program achievements based on the workplan. (A sample annual program report is provided in Appendix G.)***

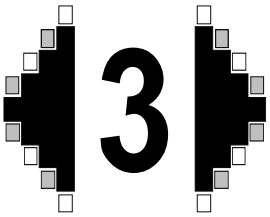
The primary responsibilities of the community under an Integrated Community-Based Health Services Agreement are summarized in Figure 8.

Figure 8: Community Responsibilities After an Integrated Agreement Is Signed

After an Integrated Agreement is signed, a community:

- ✓ ***continues to deliver those programs and services previously covered by General Contribution Agreements***
- ✓ ***implements the approved community-based health workplan and associated resource plan (budget)***
- ✓ ***works in conjunction with FNIHB employees who may continue to provide the services they did before the Integrated Agreement was signed, e.g., FNIHB may continue to deliver programs related to communicable diseases (including immunization), environmental health, and emergency preparedness***
- ✓ ***has its own health management structure which receives funding on a permanent basis***
- ✓ ***has flexibility to change aspects of programs to better meet community health priorities, with FNIHB approval***
- ✓ ***has the financial flexibility to move funds from one program to another to meet community health priorities***
- ✓ ***is required to submit an annual report to community and FNIHB on the outcome indicators of the programs it delivers***
- ✓ ***is required to submit regular financial reports to FNIHB during the period of the Agreement and pay back any surplus funds at the end of the year***
- ✓ ***is required to submit an annual audit report prepared by an independent auditor chosen by the community***
- ✓ ***keeps records and conducts an annual review together with FNIHB of the community workplan to determine the success of the community's approach***
- ✓ ***renews the Integrated Community-Based Health Services Agreement with FNIHB every year or at the end of the Agreement period for multi-year agreements.***

The Self-Government Approach



In 1995, the federal government announced the Inherent Right to Self-Government Policy. This Policy supports First Nations Inuit control over all aspects of their lives. Self-Government thus introduces a third approach for First Nations and Inuit communities to increase their control over health programs and services. Under this Policy, First Nations may be entitled to make certain laws governing their community with respect to health. Furthermore, the range of resources for health programs which can be included in a Self-Government arrangement is greater than those included in a Health Services Transfer arrangement and may include fixed assets and services under the Non-Insured Health Benefits Program. The flexibility in terms of how resources are allocated is also greater and the reporting requirements are fewer.

The main features of the Inherent Right to Self-Government Policy include:

- ***recognition that the inherent right is an existing Aboriginal right under Section 35 of the Constitution;***
- ***inherent right will be exercised within the existing constitutional framework, harmonized with other jurisdictions and worked out through negotiations;***
- ***provinces and territories must be involved in negotiations where matters affecting their jurisdiction are being discussed;***
- ***financing should be a shared responsibility among federal, provincial, territorial and Aboriginal governments.***

Within the federal government, the Minister of Indian and Northern Affairs has a mandate to enter into Self-Government negotiations with First Nations, Inuit and Métis groups north of the 60th parallel. The federal Interlocutor for Métis and Non-Status Indians has a mandate to enter into Self-Government negotiations south of the 60th parallel with Métis and Indian people who reside off a land base. Ministers of other federal departments have mandates to enter into negotiations in their respective areas of responsibility. Thus, Health Canada has the lead in negotiations of health. The nature of the role of the Department under a Self-Government arrangement would be subject to the negotiations between the two parties. Given the level of control available to communities through a Self-Government arrangement, it is expected that the role of FNIHB would likely be minimal.

For more information about Self-Government, contact the following:

Self-Government Secretariat
Strategic Policy, Planning and Analysis Directorate
First Nations and Inuit Health Branch, Health Canada
Postal Locator: 1921C
Ottawa, Ontario K1A 0L3
Telephone: (613) 957-3457

A Comparison of the Approaches

4

The Main Differences Between Transfer and the Integrated Approach

The differences between Transfer and the Integrated Approach that are presented here are based on material provided earlier in this Handbook. For details on specific topics, refer to the relevant sections.

The Primary Goals of Transfer and of the Integrated Approach

Transfer

- ***to enable communities to design health programs, establish services and allocate funds according to community health priorities;***
- ***to ensure that communities have flexibility in the delivery of health programs and services;***
- ***to ensure that public health and safety are maintained through the provision of mandatory health and treatment programs; and***
- ***to strengthen and enhance the accountability of community leaders to community members.***

Integrated Approach

- ***to support First Nations and Inuit communities in enhancing their capacity to direct and take increasing control of health programs, services and resources; and***
- ***to facilitate and promote community involvement in planning, implementing and reviewing health programs and services.***

The Transfer approach and the Integrated approach differ in several important ways:

- eligibility of the community to participate
- programs and services that the community may control
- planning activities and time required to complete them
- resources provided to carry out the planning activities
- flexibility the community gains to manage programs
- the roles and responsibilities of the community and FNIHB after an agreement has been signed.

Community Eligibility

To be eligible to begin the planning process for the Transfer approach, a community must provide

- ***a mandate as evidenced by a Band Council Resolution (BCR) or other form of approval appropriate to the Band(s) or Inuit group(s) granting the mandate***
- ***evidence of successful financial and administrative experience in program management.***

To be eligible for the Integrated Community-Based Health Services approach, the community must:

- ***already operate health programs and services funded by FNIHB General Contribution Agreements***
- ***agree to establish a health management structure with trained personnel***
- ***agree to enter into a planning process resulting in a workplan which identifies the changes the community wishes to make in programs and/or resource allocations to respond to community-based health priorities***
- ***provide proof of community mandate or letter of intent to begin the process.***

Eligible Programs and Services

Table 3 compares the programs and services eligible for inclusion in a Health Services Transfer Agreement and an Integrated Community-Based Health Services Agreement. The terminology used to describe certain services may vary from region to region. Check with the Regional Office of FNIHB to clarify what applies in your Region.

Planning Activities and Associated Resources

Table 4 briefly summarizes and compares the planning processes to reach a Health Services Transfer Agreement and an Integrated Community-Based Health Services Agreement. The Table includes the key planning activities and the resources available to carry them out.

Table 3: Health Programs and Services Eligible for First Nations or Inuit Control for the Transfer Approach and the Integrated Approach

General Contribution Agreements	Health Services Transfer Agreement	Integrated Community-Based Health Services Agreement**
• Brighter Futures • Building Healthy Communities - Mental Health Crisis Management • Building Healthy Communities - Solvent Abuse Program • Canada Prenatal Nutrition Program • Community Health Prevention and Health Promotion • Community Health Primary Care • Dental Therapy * • Environmental Health Program • Fetal Alcohol Syndrome/Fetal Alcohol Effects • Health Careers • Health Consultations • Health Services • Some services under the Non-Insured Health Benefits program, e.g., medical transportation • National Native Alcohol and Drug Abuse Program	• Brighter Futures • Building Healthy Communities - Mental Health Crisis Management • Building Healthy Communities - Solvent Abuse Program • Canada Prenatal Nutrition Program • Community Health Prevention and Health Promotion • Community Health Primary Care • Dental Therapy * • Environmental Health Program • Health Careers (excluding bursaries and scholarships) • Health Services • National Native Alcohol and Drug Abuse Program	• Brighter Futures • Building Healthy Communities - Mental Health Crisis Management • Building Healthy Communities - Solvent Abuse Program • Canada Prenatal Nutrition Program • Community Health Prevention and Health Promotion • Community Health Primary Care • Dental Therapy * • Environmental Health Program • Fetal Alcohol Syndrome/Fetal Alcohol Effects • Health Services • National Native Alcohol and Drug Abuse Program

* Limitations apply in some provinces because of the absence of applicable legislation. See Handbook 2.

** Services under the Non-Insured Health Benefit Program (NIHB) ***cannot be included*** in the Integrated Community-Based Health Services Agreement (e.g., dental, drugs) but may be part of a separate Contribution Agreement.

Note: The compliment of programs and services will evolve as new programs are introduced and services expanded.

Table 4: Planning Activities and Related Resources for the Transfer Approach and the Integrated Approach

Transfer Approach[1]		Integrated Approach[1]	
Key Planning Activities	**Planning Resources**	**Key Planning Activities**	**Planning Resources**
Pre-Transfer Planning Phase Time Frame: 1 year • Submit planning proposal with BCR or approval appropriate to the Band(s) or Inuit group(s) granting the mandate and letter of audit • Conduct Community Health Needs Assessment (CHNA) • Establish community health management structure and provide training • Develop first 4 components of Community Health Plan (CHP): identify community health priorities; describe health management structure; describe management and delivery of mandatory programs; describe management and delivery of community health programs. • Decide on technical support needed from FNIHB staff.	• $38,000 - $96,000 (CHNA)[2] (per project) • One-time funds for pre-transfer training: $10,000 (per community) • $9,000 (per project) for 4 CHP components • 50% of management formula funding[3]	**Planning Phase** • Time frame: 1 year • Submit a letter of intent or Band Council Resolution • Establish community health management structure and provide training • Develop community health workplan including: health priorities of community; objectives; activities; mechanism for delivery of mandatory programs; indicators of success. • Develop budget to support activities in workplan. • Review community workplan together with FNIHB. • Community signs Integrated Agreement for the Planning Phase.	• One-time funding for developing workplan: $10,000 • 50% of management formula funding available under transfer[3]
Bridging Phase Time Frame: 9 months • FNIHB reviews CHP to date • Develop 8 components of CHP to describe provisions for: Medical Officer of Health; liability and malpractice insurance; obtaining drugs and medical supplies; moveable assets reserve; confidentiality procedures; accountability and reporting; professional supervision; comprehensive budget. • FNIHB reviews CHP. • Memorandum of Understanding.	• $15,000 for 8 CHP components • 100% of management formula funding[4] prorated for 9 months		

Transfer Approach[1]		Integrated Approach[1]	
Key Planning Activities	**Planning Resources**	**Key Planning Activities**	**Planning Resources**
Implementation Phase • 3 to 5 year Transfer Agreement signed. • During first year of agreement, develop final 3 components of CHP to describe plans for: training after transfer[5]; emergency preparedness[5], and evaluation.	• $2,000 for training plan • $5000 for emergency preparedness plan • $11,000 for evaluation plan	**Implementation Phase** • Community signs Integrated Agreement that supports the management structure and workplan. • Community allocates resources based on workplan. • Community changes the objectives and activities of programs according to community priorities.	• 50% of management formula funding available under transfer[3] • funding for the annual audit

[1] Throughout all of the planning activities funding continues for delivery of programs and services.
[2] See Appendix B
[3] See Appendix C
[4] See Appendix D
[5] Training and emergency preparedness plans may be completed in the Bridging Phase.

Roles and Responsibilities After An Agreement Is Signed

After a Transfer Agreement is signed...

The community is fully responsible for administering health programs and services under the agreement – they employ or contract the service providers, deliver mandatory programs and services, plan and develop new programs, manage finances and are solely accountable to the community for how money is spent and how programs are run. They are responsible for making sure that mandated programs that protect public health and safety are run effectively, e.g., immunization and environmental health services. They are required to prepare annual financial and program reports. Communities conduct ongoing evaluation of how successful they are in managing their own health services to remain accountable to community members.

After an Integrated Community-Based Health Services Agreement for the Implementation Phase is signed...

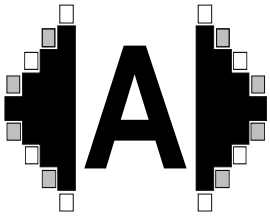
The community has less control than under Transfer but greater control than if they continued to operate under General Contribution Agreements. A community operating with the Integrated Community-Based approach sets up its own health management structure but shares responsibility for delivering services with FNIHB. The Integrated approach provides "on-the-job" training for communities in managing and administering their health programs. As long as mandatory health services are provided, communities have the flexibility to change the objectives and activities of a program, increase the resources dedicated to one service and reduce resources for another according to community priorities. They are required to prepare annual financial and program reports.

The Main Differences Between Transfer and Self-Government

Table 5 briefly outlines the differences in key policy areas for the Transfer approach and Self-Government.

Table 5: Differences in Key Policy Areas for Transfer and Inherent Right to Self Government

Transfer	Inherent Right to Self-Government
1. Policy applies to status Indians registered under the Indian Act.	1. Policy applies to Aboriginal peoples which includes Indian, Inuit and Métis people.
2. Policy provides for only delegated administrative authority.	2. Policy provides for jurisdictional authority including law-making powers.
3. Transfer agreements are reached on a bi-lateral basis between FNIHB and First Nations.	3. Self-Government agreements are negotiated on a tripartite basis (Canada, First Nations, Provinces/Territories) although dual bi-lateral agreements may be possible.
4. FNIHB represents Health Canada and leads the process.	4. DIAND leads comprehensive Self-Government negotiations. Health Canada leads health negotiations.
5. Transfer involves only FNIHB health programs and resources.	5. Self-Government negotiations involve a multitude of federal programs and resources and also provincial programs and resources.
6. Ministerial responsibility for implementation and impacts of health services continues after health transfers.	6. Corresponding diminution of Crown's role as jurisdiction or authority of Aboriginal governments and institutions is increased.
7. Health transfer is primarily a land-based application.	7. Self-Government will apply to settlement lands and may include administration of non land-based programs.
8. Health transfer has developmental and capacity building resources for First Nations.	8. Self-Government has no developmental resources but can provide negotiation resources to First Nations.
9. NIHB services included only as pilots and through specific contractual arrangements for transportation services.	9. NIHB services are listed as negotiable.
10. Financing transfer agreements in health is the responsibility of FNIHB.	10. Financing Self-Government Agreements is a shared responsibility of federal, provincial, territorial and Aboriginal governments.
11. Financial accountability is to the Minister.	11. Aboriginal governments and institutions will be accountable to parliament and provincial legislatures.
12. Transfer agreements require Ministerial approval.	12. Self-Government Agreement-in-Principle and Final Agreements require Cabinet approval and Self-Government treaties require parliamentary approval.
13. Transfer agreements do not become rights and are not constitutionally entrenched.	13. Fundamental elements of Self-Government Agreements, with the approval of the provinces, can be constitutionally entrenched



First Nations Control - Historical Perspective

First Nations Control - Historical Perspective

To put Health Transfer in context, it is useful to understand from a historical perspective how First Nations and the Federal Government have worked together to respond to First Nations' expressed desire to manage and control their own health programs.

1969 White Paper

Federal Government Policy Paper advocating the increased assimilation of Native people into Canadian Society.

1970 Red Paper

First Nations' response to the White Paper emphasizing plans to strengthen community control of their lives and of government-delivered community programs.

1975 Federal Government/Indian Relationships Paper

The White and Red Papers served as an impetus for the collaborative effort of the Federal Government and First Nations to begin serious planning for the future. This resulted in the 1975 paper, *The Canadian Government/The Canadian Indian Relationships*, which defined a policy framework for strengthening Indian control of programs and services.

1979 Indian Health Policy

The Federal Indian Health Policy is based on the special relationship of the Indian people to the Federal Government, a relationship which both the Indian people and the Government are committed to preserving. It recognizes the circumstances under which many Indian communities exist, which have placed Indian people at a grave disadvantage compared to most other Canadians in terms of health, as in other ways.

Policy for federal programs for Indian people (of which the health policy is an aspect), flows from constitutional and statutory provisions, treaties and customary practice. It also flows from the commitment of Indian people to preserve and enhance their culture and traditions. It recognizes the intolerable conditions of poverty and community decline which affect many Indians, and seeks a framework in which Indian communities can remedy these conditions. The Federal Government recognizes its legal and traditional responsibilities to Indians, and seeks to promote the ability of Indian communities to pursue their aspirations within the framework of Canadian institutions.

The Federal Government's Indian Health Policy reflects these features in its approach to programs for Indian people. The over-riding concern from which the policy stems is the intolerably low level of health of many Indian people, who exist under conditions rooted in poverty and community decline. The Federal Government realizes that only Indian communities themselves can change these root causes and that to do so will require the wholehearted support of the larger Canadian community.

Hence, the goal of the Federal Indian Health Policy is to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves.

This increasing level of health in Indian communities must be built on three pillars. The first, and most significant, is community development, both socio-economic development and cultural and spiritual development, to remove the conditions of poverty and apathy which prevent the members of the community from achieving a state of physical, mental and social well-being.

The second pillar is the traditional relationship of the Indian people to the Federal Government, in which the Federal Government serves as advocate of the interests of Indian communities to the larger Canadian society and its institutions, and promotes the capacity of Indian communities to achieve their aspirations. This relationship must be strengthened by opening up communication with the Indian people and by encouraging their greater involvement in the planning, budgeting and delivery of health programs.

The third pillar is the Canadian health system. This system is one of specialized and interrelated elements, which may be the responsibility of Federal, Provincial of Municipal Governments, Indian bands, or the private sector. But these divisions are superficial in the light of the health system as a whole. The most significant federal roles in this interdependent system are in public health activities on reserves, health promotion, and the detection and mitigation of hazards to health in the environment. The most significant Provincial and private roles are in the diagnosis and treatment of acute and chronic disease and in the rehabilitation of the sick. Indian communities have a significant role to play in health promotion, and in the adaptation of health services delivery to the specific needs of their community. Of course, this does not exhaust the many complexities of the system. The Federal Government is committed to maintaining an active role in the Canadian health system as it affects Indians. It is committed to promoting the capacity of Indian communities to play an active, more positive role in the health system and in decisions affecting their health.

These three pillars of community development, the traditional relationship of the Indian people to the Federal Government, and the interrelated Canadian health system provide the means to end the tragedy of Indian ill-health in Canada.

1983-86 Community Health Projects

First Nations and Inuit Health Branch sponsored demonstration projects for First Nations. The experiment was initiated to provide both Federal and First Nation authorities with the same substantive information with respect to First Nation control of health services.

1988 Cabinet Approval for Health Transfer South of the 60th Parallel

In order for FNIHB to proceed with health transfer to First Nations as part of administrative reform, the policy framework, authorities and resources had to be developed and secured. A Subcommittee on the Transfer of Health Programs to Indian control was established with representation from First Nations with experience in health care. The Subcommittee incorporated the experiences from the Community Health Projects and recommended a developmental and consultative approach for health transfer. These recommendations were then used to finalize the health transfer policy framework.

On March 16, 1988, the Federal Government Cabinet approved the health transfer policy framework for transferring resources for Indian health programs south of the 60th parallel to Indian control through a process which:

- permits health program control to be assumed at a pace determined by the community, i.e., the community can assume control gradually over a number of years through a phased transfer;
- enables communities to design health programs to meet their needs;
- requires that certain mandatory public health and treatment programs be provided;
- strengthens the accountability of Chiefs and Councils to community members;
- gives communities:
  - the financial flexibility to allocate funds according to community health priorities and to retain unspent balances;
  - the responsibility for eliminating deficits and for annual financial audits and evaluations at specific intervals;
- permits multi-year (three to five year) agreements;
- does not prejudice treaty or Aboriginal rights;
- operates within current legislation;
- is optional and open to all Indian communities within provincial boundaries.

1989 Treasury Board Authorities for Transfer

In 1989, Treasury Board approved the financial authorities and resources to support pre-transfer planning and to fund community health management structures.

1994 Treasury Board Authorities for Integrated Community-Based Health Services

In 1994, Treasury Board approved the financial authorities and resources to support the Integrated Community-Based Health Services approach. The program was created to provide an alternative to Bands which are not ready for or not interested in the Transfer program.

1995 Inherent Right to Self-Government Policy

In 1995, the federal government announced the Inherent Right to Self-Government Policy. The main features of the Policy include:

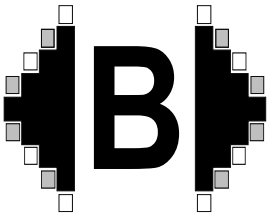
- recognition that the inherent right is an existing Aboriginal right under Section 35 of the Constitution;
- inherent right will be exercised within the existing constitutional framework, harmonized with other jurisdictions and worked out through negotiations;

- provinces and territories must be involved in negotiations where matters affecting their jurisdiction are being discussed;
- financing should be a shared responsibility among federal, provincial, territorial and Aboriginal governments.

1997 Health Transfer in the Yukon

Since October 1954, the administration and delivery of Universal health programs in Yukon Territory had been the responsibility of Health Canada. On April 1, 1997, Yukon Territory resumed the administration and delivery of these programs by mutual agreement of both governments. The Council of Yukon First Nations was a party to the agreement.

Earlier, in April, 1993, Health Canada transferred the operation of the Whitehorse General Hospital to the Yukon Territorial Government.

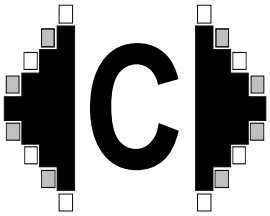


Formula for Determining Funding for the Community Health Needs Assessment in the Transfer Approach

Appendix B

Formula for Determining Funding for the Community Health Needs Assessment (CHNA) in the Transfer Approach

Population	Funds Available for Planning	Preparation	Implementation	Analysis	TOTAL
0-500	$4,000	$7,000	$10,000	$17,000	$38,000
501-1,000	$5,000	$9,500	$19,000	$18,000	$51,500
1,001-2,000	$5,000	$14,000	$31,000	$23,000	$73,000
Greater than	$5,000	$19,000	$49,000	$23,000	$96,000



50% Formula for Determining Annual Health Management Support Funds for Pre-Transfer Planning Phase and the Integrated Approach

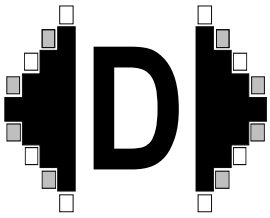
Appendix C

50% Formula for Determining Annual Health Management Support Funds for Pre-Transfer Planning and the Integrated Approach

Population*		(C) For the First	Amount for Population Shown in Column (C)	For Each Additional Member
From	To			
0	100	N/A	For populations of 100 or less, the 50% funding amount is $138	$138.00
101	400	101	$13,800	$43.00
401	3000	401	$26,700	$15.50
3001	5000	3001	$67,000	$10.50
5001	7000	5001	$88,000	$7.50
Greater than 7000		7001	$103,000	$5.00

NOTE: A portion (80%) of the funding provided for management support is adjusted by a remoteness factor to compensate for the disadvantages created by isolation of a community.

*** Population figures used to calculate funding must be approved by FNIHB.**



100% Formula for Determining Annual Health Management Support Funds for Transfer

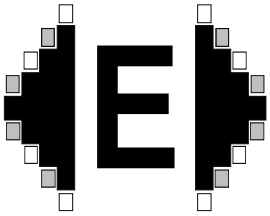
Appendix D

100% Formula for Determining Annual Health Management Support Funds for Transfer

Population*		(C) For the First	Amount for Population Shown in Column (C)	For Each Additional Member
From	To			
0	100		For populations of 100 or less, the 100% funding amount is $276	$276.00
101	400	101	$27,600	$86.00
401	3000	401	$53,400	$31.00
3001	5000	3001	$134,000	$21.00
5001	7000	5001	$176,000	$15.00
Greater than 7000		7001	$206,000	$10.00

NOTE: A portion (80%) of the funding provided for management support is adjusted by a remoteness factor to compensate for the disadvantages created by isolation of a community.

*** Population figures used to calculate funding must be approved by FNIHB.**

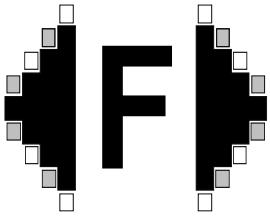


Sample Workplan for the Integrated Approach

Appendix E

Sample Workplan for the Integrated Approach

Goal **What the program is intended to achieve**	***Objectives*** **What needs to be done to achieve the goal?**	***Activities*** **List of possible actions designed to meet the objective**	***Outcome Measures*** **How will you know you are successful?**
Example 1 • to reduce the incidence of vaccine preventable diseases in infants	• to immunize 95% of children under one year of age in community "x" between July 1 and September 1, 1995	• to provide immunization educational sessions for parents of children under one year of age • to increase the number of immunization clinics at flexible times	• incidence of vaccine preventable diseases in infants • # of children immunized
Example 2 • to decrease smoking related adverse outcomes of pregnancy (e.g., low birth weight)	• to decrease the percentage of women smoking during pregnancy by 30% by December 2004	• to provide prenatal education sessions on the effect of smoking during pregnancy • to organize smoking cessation groups for pregnant women	• number of women smoking during pregnancy • incidence of low birth weight and other smoking related adverse outcomes of pregnancy



Sample Report on Actual Program Expenditures
for the Integrated Approach

Appendix F

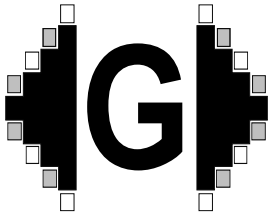
Sample Report on Actual Program Expenditures for the Integrated Approach

Note: This report is to be received by FNIHB in October and January each year. In addition, an annual audit report is due 120 days after a community's year end.

Expenditures:

1. Health Services Program (excluding NIHB costs) $ _____
2. NNADAP (prevention) $ _____
3. Brighter Futures $ _____
4. Mental Health, Solvent Abuse and Home Nursing $ _____
5. Management and Support $ _____

Total Expenditures $ _____



Sample Annual Program Report
for the Integrated Approach

Appendix G

Sample Annual Program Report for the Integrated Approach

Note: This report should identify the progress of each program in achieving what it was set out to do, as indicated in the workplan.

Goals	Objectives	Outcome Measures	Progress