Transforming First Nations' health governance in British Columbia

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Abstract

Purpose – The purpose of this paper is to present a study of the transformation of First Nations' health governance, describing the development of partnerships between First Nations and provincial and federal governments for co-creating solutions to address First Nations' health inequities in British Columbia (BC). The paper frames this transformation in the context of a Canada-wide reconciliation initiative stimulated by the Truth and Reconciliation Commission.

Design/methodology/approach – This qualitative case study was a joint initiative between Simon Fraser University and the BC First Nations Health Authority (FNHA), involving interviews with senior leaders within the BC health system, FNHA and First Nations communities. In addition, a policy roundtable was held in February 2015 which gathered 60 participants for further dialogue on the process.

Findings – Key themes included: partnership and relationships, governance and reciprocal accountability, First Nations perspectives on health and wellness, and quality and cultural safety. Findings indicate that significant transformational changes have happened in the relationship between First Nations and the mainstream health system. The creation of the FNHA has led to more

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representation for First Nations people at all levels of governance and health service planning, which will ultimately lead to more culturally safe health services that incorporate a First Nations perspective of wellness.

Social implications – The transformation of First Nations health governance in BC can serve as an example in other indigenous health settings both within Canada and internationally.

Originality/value – This paper describes a transformative health governance process in First Nations communities that is an historical first in Canada.

Keywords Health policy, Health governance, Partnerships, First nations, Federal governments, Provincial governments, Health inequities, British Columbia, Truth and Reconciliation Commission, Reconciliation initiative

Paper type Research paper

1. Introduction

First Nations[1] in British Columbia (BC) have a rich history of health and wellness, underpinned by a philosophy of the interconnectedness of physical, mental, emotional, and spiritual aspects of life. As with many other indigenous populations throughout the world, colonial acts of assimilation including residential schools disrupted the holistic health and wellness perspectives that First Nations people have traditionally known and followed (Lavoie *et al.*, 2008; Adelson, 2005). First Nations' perspectives on health were absent from the design and delivery of First Nations' health services, which were guided by the Indian Act and controlled by distant federal government offices with little or no insight into the health needs of the communities they served (Abele and Prince, 2006; Lavoie *et al.*, 2010). Over the last decade, a transformation process has been underway to reincorporate First Nations perspectives and decision making into the design and delivery of health services (Lavoie *et al.*, 2015). A hallmark of this journey of transformation, and the focus of this paper, is the creation of partnerships for change within the broader health system.

Health governance as it relates to First Nations populations in Canada is jurisdictionally complex. Health services for First Nations people on-reserve are considered a federal responsibility through the Indian Act, administered by Health Canada's First Nations and Inuit Health Branch (FNIHB) (Gallagher *et al.*, 2015). While the 1984 Canada Health Act outlines the responsibility of each province to provide health services for all citizens residing within provincial boundaries, the act is silent on its relevance to on-reserve. This lack of clear accountability and responsibility has led to jurisdictional overlaps, gaps, and disputes between the federal and provincial health systems, resulting in inefficient and fragmented services, lacking a population health focus, and not informed by any engagement with the communities served (Gallagher *et al.*, 2015). To address these issues, a partnership and transformation process began in 2005 in BC, with a series of agreements between First Nations and federal and provincial governments (BC Assembly of First Nations Leadership Council/Government of British Columbia, 2006; First Nations Health Authority, n.d., 2016b). As Johnson *et al.* (2016) describe:

> These were foundational agreements and commitments[2] in the process of creating a new partnership environment – amongst First Nations in BC, and between First Nations and the federal and provincial governments. In the last ten years, these partnerships have matured significantly in the health context, and can be tracked through a set of milestone agreements advancing First Nations health in BC and representing the growth, evolution, and maturing of partnered commitments over time.

Figure 1 maps out the timeline of these agreements that demonstrate this evolving partnership, situated alongside significant developments in First Nations health

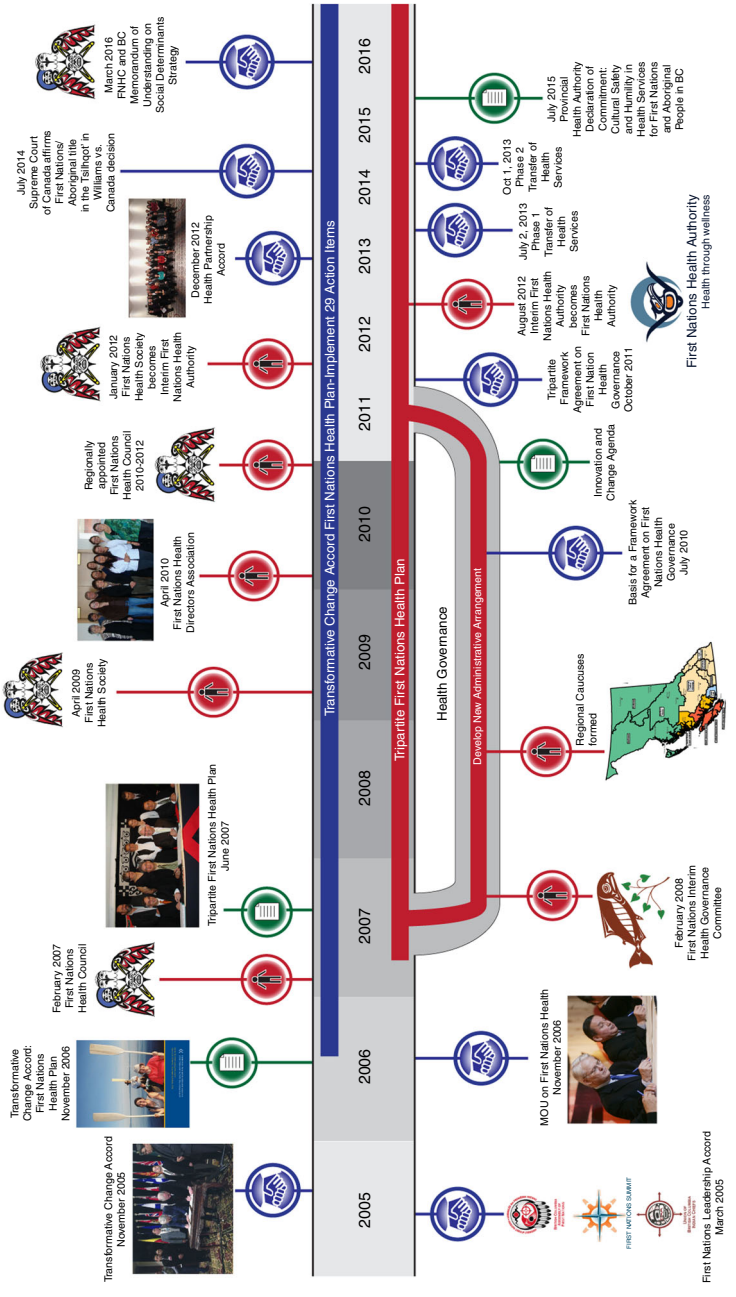

Figure 1.
British Columbia (BC) First Nations Health Governance Timeline – copyrighted by First Nations Health Authority, used with permission

organization and governance. These milestone agreements set the stage for the creation of the First Nations Health Authority (FNHA), as well as the implementation of new health administrative and governance models to ensure First Nations people are driving this transformative process. Today, BC First Nations have assumed responsibility for the design and delivery of First Nations health services, through a transfer of FNIHB-BC operations to the FNHA and collaborative partnerships with the BC Ministry of Health and the province's Health Authorities, to improve provincial health services accessed by First Nations and Aboriginal people (Kelly, 2011) throughout all regions of BC. In addition to this direct service transfer, the Health Partnership Accord (First Nations Health Council, British Columbia Ministry of Health & Health Canada, 2012) outlines a set of principles that encapsulate the shared commitments and vision of the partners to engage in ongoing service improvements, including the responsibility to monitor and evaluate progress through a process of reciprocal accountability.

Through the creation of a new First Nations health governance structure, new relationships and shared planning processes are leading to an improved understanding of First Nations views of health and well-being, and to improved safety and acceptability of health programs and services for First Nations. Improved coordination, relationships, and understandings between various health organizations and jurisdictions will support an improved continuum of care for First Nations. This transformation process is unprecedented in the history of First Nations health in Canada and beyond, and features of this approach create a framework to support change in other settings facing similar challenges.

The health system in BC is led by the BC Ministry of Health, which provides direction, leadership, and support to the regional health authorities (RHAs), responsible for service delivery in five geographic regions of BC. The ministry determines the policy direction for health care and sets province-wide goals, expectations and standards, while the RHAs, offer the full continuum of health services and are responsible for identifying patient needs, planning appropriate programming and services as well as ensuring that services are properly funded, managed and meeting performance standards. In addition, the Provincial Health Services Authority (PHSA) is also a key partner and provides specialized health services throughout the province. Although the FNHA has been created to lead First Nations health initiatives within the province, the mainstream system partners still maintain responsibility to serve all BC residents regardless of residing on or off reserve. This joint responsibility further highlights the priority of long-term sustainable partnerships to improve the health of First Nations in BC (Government of British Columbia, 2016).

This transformational process in BC First Nations health was occurring within a broader context of reconciliation. The Truth and Reconciliation Commission (TRC) in Canada was established in 2009 to review the colonial legacy of the residential schools on Aboriginal communities in Canada and develop a framework for renewing and rebuilding relationships between Aboriginal and non-Aboriginal Canadians (Truth and Reconciliation Commission of Canada, 2015; Truth and Reconciliation Commission of Canada, 2012). "Reconciliation" has many meanings, but for the commission it "is about establishing and maintaining a mutually respectful relationship between Aboriginal and non-Aboriginal peoples in Canada" to move forward in true partnership (TRC report, p. 6). The TRC outlined the history of residential schools, a set of reconciliation principles, and 94 calls to action across a broad spectrum of sectors to catalyze a movement toward reconciliation, and redress the legacy of residential schools. The new

health governance structure and associated partnerships in BC can be understood as an enactment of many of the aims, principles and calls to action outlined by the TRC (Gallagher *et al.*, 2015). This paper will outline the findings of a study on health partnerships and shared decision making between First Nations and federal and provincial governments in BC, and discuss the alignment of this transformative change with the recommendations of the TRC report.

2. Purpose and significance of the research

The subject of this study is the new First Nations health governance structure in BC, which operates in partnership with the federal, provincial, and regional health systems to share decision making for First Nations health improvement, informed by the voices and interests of First Nations in BC – through the "co-creation of solutions", a term to describe these partnerships used at the policy roundtable organized as part of this study.

Co-creation of solutions is a process that requires the development of shared perspectives, and implies building a relationship through dialogue, goal alignment, and reconciliation of differences. In the context of First Nations health governance in BC, processes of negotiations and relationship-building over the past decade have led to many examples of co-created solutions at the strategic level between political representatives of federal, provincial, and First Nations governments, and at the operational and service level through shared health and wellness planning. The main purpose of the research is to examine this partnership in order to understand the key features of its approach, its impacts, and its challenges through initiating dialogue and telling the story from the multiple perspectives of those engaged in the process. With this historic transformation, one of the first of its kind, it becomes increasingly important to document this journey and the transformation of the relationships between partners as we move toward reconciliation within the area of First Nations health in BC, and as other jurisdictions nationally and internationally contemplate undertaking similar processes of reconciliation (Johnson *et al.*, 2016).

3. Methods

The current study was a joint initiative between Simon Fraser University (SFU) and the FNHA. Ethical approval was obtained from SFU as well as the BC Ethics Harmonization Initiative which included: Vancouver Coastal Health Authority, Fraser Health Authority, Vancouver Island Health Authority, Interior Health Authority, and Northern Health Authority. Ethical approval was also obtained from the University of Northern BC.

Key informant interviews were conducted with individuals involved in the transformation of First Nations governance in BC, representing the FNHA, provincial health services and First Nations communities. The informants were initially identified by the research team as senior representatives from each sector. Each informant contacted was also asked to suggest other senior decision makers in their organization that had direct experience in working with the FNHA. A total of 34 in-person and telephone interviews were conducted between February and July 2014. Interviews typically were between 60 and 90 minutes in length and respondents were generally inclined to expound in detail and with enthusiasm to questions about the changing relationship in delivering health care to First Nations communities. Interviews were conducted over a period of three months. All interviews included a standard set of questions asking respondents to reflect on key issues such as shared governance, partnerships, relationship-building, reciprocal accountability, and perceived changes in

the quality and quantity for health services for First Nations communities. Of the 34 participants, 14 were from the FNHA or the First Nations Health Council (FNHC) (the political arm of the First Nations health governance structure), seven were from the First Nations Health Directors Association (FNHDA)(the professional association arm of the First Nations health governance structure) and 13 were from the provincial health system (BC Ministry of Health or Health Authorities). Virtually all of the informants held senior executive positions within their various organizations and sectors (i.e. CEOs, VPs, directors, etc.).

In February 2015, a policy roundtable was held in Vancouver with 60 participants, including representatives from:

- FNHA – 11;
- FNHC – two;
- FNHDA – ten;
- RHAs – eight;
- PHSA –two;
- BC Ministry of Health – two;
- academic institutions (nine including study investigators and research associates)
- students, community and organization leaders (six);
- chiefs and elders (two); and
- three international guests: two from New Zealand and one from Australia.

The purpose of the roundtable was to primarily to validate the results from the interviews through an open dialogue. Results from the interviews were coded and written up as a preliminary report, identifying most of the themes described below. This report was circulated to all participants in advance and the roundtable was structured around the themes in the report. The roundtable was held in the Wosk Centre for Dialogue at SFU, a facility designed in the round with state of the art technical support. Discussion was managed by a professional facilitator who had extensive experience facilitating meetings with First Nations participants. All dialogue was recorded verbatim. Participants of the interviews and the roundtable provided consent to participate, and all interviews and the roundtable were audio recorded, transcribed, anonymized, and then coded and analyzed using NVivo 10. Coding involved all members of the research team reviewing a selection of transcripts, exchanging and standardizing the keyword list and then one investigator with a research associate completing the coding with frequent checking for consistency. Although we report quotes in this paper, we opted not to use identifiers or codes to address the at times heightened sensitivity associated with issues of confidentiality. We can however assert that the quotes presented are representative, and draw from a broad number of participants. Our analysis demonstrated a very high level of consensus on the governance issues discussed across government, RHAs, FNHA, and the First Nations health directors. The roundtable results also validated the results from the interviews in that our final report on the project was essentially identical to the preliminary report. Roundtable dialogue tended to expand on and clarify perspectives that were articulated in the interviews.

4. Results

4.1 Governance and reciprocal accountability[3]

A key theme in the research is that partnerships need to be enabled by administrative and structural changes within and between various partners to align with commitments; reciprocal accountability requires each partner to effectively position themselves and build their capacity to support shared commitments.

Respondents acknowledged that the real work of reciprocal accountability was to facilitate the partners taking responsibility to address common issues in First Nations health. This meant dedicated efforts to work together to develop shared actions aimed to meet the common commitments outlined in the partnership accords, and to monitor progress on these commitments made at all levels of the partnership:

> We're doing a lot of shared work around developing the processes, mechanisms, policy enablers, for the successful implementation of the agreement (FNO No. 34).

> "You can set out any kind of policy you want as long as it's coming from a good place, the best intentions. Always keeping focus on what's the difference we're trying to make. What's the change we're trying to accomplish? Are we going to be transparent? That whole reciprocal accountability piece is very important to me (PHS No. 27).

> We've identified priorities. We've got suicide rates and we look at them, we monitor them and they're getting worse. We're not there to blame one another, we have to jointly figure out how we're going to address these, right? […] Reciprocal accountability means we've agreed we're going to monitor it and come together to come up with ways to address problem areas (PHS No. 3).

Several participants emphasized the significance of this governance model in putting First Nations "into the driver's seat," in order to "do for ourselves" what federal and provincial organizations have for many decades tried to do "on our behalf," giving primacy to the agency of First Nation communities and leaders. The old ways of federal and provincial governments making decisions on behalf of First Nations people, based on a colonial mentality that saw First Nations people as unable to take care of themselves, is no longer the norm. First Nations people are being "hard-wired" into the decision-making processes, rather than tacked on in a token consultative role:

> We look forward, every time we're coming to a difficult issue and we're sitting across from the government and internally within my own community, I will say isn't this an awesome problem? Isn't this issue in front of us, isn't it awesome that we're at the table? At one time, not too long ago, the governments were coming in with the solutions to our problems and now we have a chance to have a say in that solution. We have to work together to find a solution that's going to be the most beneficial for our communities (PRT No. 1).

The development of the new health governance structure was seen as the basis for a decolonization and nation building process for all BC First Nations:

> There are many situations where people don't appreciate the complexity of what is really happening here. For something that is this historic, in a lot of ways, I've heard some of our leaders talk about decolonization, I hear a lot people talk about the impacts of colonization and we talk about not only the health system, but nation building. We're talking about such a rich time for us in British Columbia for First Nations people and all Aboriginal people in the province because of the way that B.C. First Nations people are looking to take care of everyone that is in our traditional territories (PRT No. 2).

> There has been an emphasis […] on nation building because it's really about largely bringing our nations to the table to nurture their creative spirit and how they're going to embrace this change and in fact, to draw on the metaphor, becoming the driver of that change. The relationship that we're developing I think has made some improvements over the last year and has helped to facilitate a stronger connection to the nations that are involved to facilitate the change in the communities (PRT No. 3).

4.2 Partnerships and relationships

Another key theme emerging from this research was the importance of building relationships in order to strengthen the partnerships created in the context of the governance agreements. The governance transformation process has affirmed that the FNHA is an equal partner to the provincial Ministry of Health and the RHAs, and building new relationships in the spirit of the TRC was seen as essential for these partnerships to work. Participants commented on the importance of taking the time to get to know each other and being present in the process of creating a shared commitment to the transformative work in First Nations health. This true engagement with each other was seen as important in ensuring the co-creation of solutions. The common points made about building on relationships include:

- relationships depend on the development of trust – trust among various First Nations groups, trust between First Nations and levels of government, and trust among various levels of government;
- relationships require continuous adjustment – parties need to be willing to learn and adapt in order to be "good partners";
- relationships and consensus building take time, but there is strong evidence that in two short years there has been transformational change;
- sustained commitment from senior leadership is required to model the importance of these new relationships;
- partners are acting with integrity, demonstrating due diligence and following through with commitments;
- there is now better cohesion in the regions between First Nations and health authority representatives;
- communication among the partners has improved;
- First Nations are becoming empowered in the process; and
- there is now a more collaborative approach to decision making and service planning, involving local communities:

> I think that building on a foundation of relationship is really important. So what are the things you need to do to build the relationship and build the trust? And that probably isn't what you usually see in a policy framework (PHS No. 21).

> So for the first couple of years […] the focus was really about negotiations […] There was a bit of an adversarial environment around the negotiations. The tone changed over time as trusts were built, and especially when lawyers weren't in the room (PHS No. 20).

> I think it's really important for us to be present with each other when we are having the opportunity to talk about our relationship, and whether it is at the Partnership Accord Steering Committee table, or at an Executive meeting of our two organizations looking to

> create some alignment and support to move some of our interests forward collaboratively […] Being present, being honest and transparent. […]. I think being truly committed to this change and recognizing that we do need to acknowledge the successes we have created, but there is a tremendous amount of work to do if we're honest with one another, we're able to tackle some of those items so that the alignment can be refined as we learn about the work (PRT No. 4).

Respondents emphasized the importance of ceremony in setting the stage for the partnership work, to ensure that the work will get done in a good way, and to bring together the partners toward a shared commitment:

> "When you take care of the spirit, everything else will go right. When you take care of the spirit, it's not just the Creator, its recognition of all living things. It goes back to our laws, how we pay respect to all living things […] So we have to remember that the ceremony not only encompasses the physical, and the emotional, the spiritual, but it goes back to our relationship to all things (PRT No. 5).

A common point made by participants was that high level partnerships at both the provincial and regional levels must now be supplemented with the development of partnerships at the level of service delivery. This included getting service providers working both within the RHA and those working for First Nations to get to know each other, understand how their respective systems work, and through the development of this shared understanding create new approaches to service delivery:

> At the end of the day everyone's roles have changed, finding a new place for them within the new structure. It really is community driven now, we have regional health plans that are identifying community priorities and you can't get away from that. They are not handpicked by the federal government or the RHA just because they have some money; it is going to be directed by the regional health authorities themselves (FNO No. 1).

> It seems like this is a first that we have a strong direct working relationship between those who are providing health services across the region for aboriginal populations (PRT No. 6).

> Part of the agreements should say they may or may not because it depends on the sub-region, it depends on what can be delivered. So for example, in my area you know in my community we would say we are better suited to provide that service. Therefore we are asking you just give us the funding. But other communities might feel different; they may feel they want you to bring existing services into their community (FNO No. 19).

4.3 First Nations perspectives on health and wellness

A strong theme emerged around the uniqueness of a First Nations'-driven health system compared with the existing mainstream approach. Incorporating the First Nations' perspective on wellness into the health care system was seen as an important priority and contribution of this work (First Nations Health Authority, 2016c). Holistic care emphasizes physical, social, mental and emotional wellness, rather than simply responding to illness:

> Health begins with the person themselves and the way they are. Not what they are. Where are they in terms of their culture and their spirituality, their family, themselves (FNO No. 9).

> The wellness model that First Nations Health Authority has adopted and very much under direction and with guidance from the First Nations Health Council […] has been very much looking at a broader wellness piece that isn't just about more access to health care services (PHS No. 20).

Many participants emphasized the interconnectedness of all living things – that these connections impact upon health and well-being. Following this perspective would result in greater emphasis on the social determinants of health and a population health approach. Engaging other programs and services aimed to improve the social determinants of health of First Nations communities will make an important contribution to improving health status:

> "Wee-nut-saw"[4], we are all one. And I hear other Coast Salish say: "Nut-saw-mat", we're one family". When I first heard that term "Wee-nut-saw", I knew that it meant more than just one with other human being, but with all of creation. That's a foundation of our people, to live in harmony with the land and within our families (PRT No. 7).

> We are connected to everything around us as a principle whether that connectedness is through the four legged, the winged ones, the water, all of those things that non First Nations people see as inanimate. We see as alive and full of spirit. That's why we're here. If we die today, all the two legged on this part of the world, those things would thrive actually. They can live without us, but we can't live without them. So those kinds of principles are really important when we begin to talk about, as we move forward in this issue of our health because our health is not just the physical health, it's the mental, emotional and spiritual which is really, really important (PRT No. 8).

> One of the biggest issues is that it's not just about getting the health authorities and the First Nations Health Authority and the First Nations Health Council working together. It's the cross sector stuff so it's about transportation, it's about education, it's about housing, it's about other social services. All of the dots have to be connected to be-, I think to really have an impact on health status. (PHS No. 33).

> The legal commitment, is that the deputy minister of health, both at the federal and the provincial level will call us together once a year, deputy ministers of other ministries and departments to talk about the social determinants of health or policies etcetera that link to health outcomes (PHS No. 20).

> "Now what we're saying is that when you look at mental health, we can't look at it in terms of this many dollars provides you with this many hours of mental health services in the community. You have to look at it in collaboration with early childhood development. You have to look at it in collaboration with homecare. You have to look at it in collaboration with prenatal nutrition. All of those things are part of mental wellbeing (FNO No. 9).

Participants emphasized the importance of taking a community and family centered approach to health and wellness. System-level changes and the development of health services that are responsive to the needs of Aboriginal peoples are only possible when there is engagement of individuals, communities and families and consideration of future generations:

> So when we talk about vibrant children, families and communities, we have to invest in that unit. Not at a high level, right in the communities. When we talk of collaboration and cooperation, we have to think about it in terms of our ancestors, in terms of interconnectedness (PRT No. 9).

Participants noted that integrating a health and wellness approach, and being responsive to the needs of First Nations individuals, families and communities means ensuring traditional healers are part of the model of care:

> The work that we want to do to make things better, which is around the integration of services, ensuring that we blend in and build in our traditional medicines, our ancestral teachings, all of those things that are important to our sense of wellbeing, that all of those things are incorporated into our authority and the work that we do (FNO No. 4).

Respondents noted the value of First Nations' perspectives and practices on health and wellness, providing an innovative approach that can improve the health system as a whole:

> There is opportunity not only for the work that's being done to improve, as a primary goal, the health of First Nations and aboriginal people in the province, but that there are elements of First Nations wellness perspectives that could potentially benefit all of BC (PHS No. 20).

> One of the areas that has begun to show real promise is at the level of engagement with the provincial Ministry of Health […] There have been significant discussions at the level of the deputy and other senior officials within the Ministry of Health and he feels that the First Nations Health Authority and First Nations priorities, values, etc. will be reflected in the innovation and change policy agenda, which is very positive. Not just in terms of the impact it'll have on First Nations communities, but in terms of the broader understanding of health and wellness (FNO No. 7).

4.4 Quality and cultural safety

Culturally safe and appropriate care is an important component of defining quality of services accessed by First Nations, and therefore is a central tenet of the partnership work to improve health services for First Nations (First Nations Health Authority, 2016a). Respondents emphasized the importance of developing culturally appropriate programming that responds to the specific needs of local First Nations communities, drawing upon best-practices models to improve access and service utilization for First Nations patients:

> So when they talk about […] birthing, they have this whole policy that only two people in the birthing room. Well, that's against a lot of the protocols of First Nations, their cultural protocol. You know […] a lot of birthing practices they want to have baby welcomed by song. You know, they have a ceremony that comes with the birth of a baby. So it's just stuff like that, like wow, what a difference that would be if they could change and be a little bit more flexible in some of their policies (FNO No. 12).

> I think that's part of the benefit of the partnership tables at the regional levels that I think some of the CEOs and board members in particular may not have quite understood how it feels on the other side, when you end up in a hospital and your mother is dying and you're not allowed to have the ceremony or a group of people with you. And so a lot of those things that maybe just were, decisions were made at a lower level where, that's not acceptable, kick them out, security risk or a health risk or whatever, and now that the CEO is more sensitized to it, he or she is not allowing those decisions to happen that way, you know, and that's just one example that we saw in one hospital that we're hoping that as time goes on we're seeing more and more of that (PHS No. 20).

> It's a mindset that the community has and that our staff has, that it's all about community. It's all about ensuring we have a culture that's recognized right from whatever beginning of anything is starting with the culture. And so we work with that, with the strength and with the people and we build on what we have (FNO No. 9).

Providing cultural safety training for health professionals throughout the system is an important way to ensure that First Nations receive respectful and culturally appropriate care across the spectrum of care. In addition, expectations must be linked to mandates regarding adherence to the principles of culturally safe practice:

> The more people we engage in cultural competency training, the more we work with advanced education to make sure that there is knowledge in the health professionals being trained about what the realities are so that people are part of a system that is changing, rather than stuck in the system that was (PHS No. 20).

> Cultural awareness, competency […] can be policy. Guidelines are implemented where people can look at it and use it as part of their employee improvements or performance planning that I think would be useful from a policy perspective in terms of setting the rules (FNO No. 29).

Participants also spoke to providing access to Aboriginal Patient Navigators and transition case managers, in improving the health care journey for First Nations people:

> You know we've got patient navigators and we're expanding that program that can really help Aboriginal patient navigators. So we're going to have to do a much better job of looking at how we provide care, how we provide continuity of care with communities, and I think that the First Nations Health Authority, having them there is going to help us do that because we now have a forum to talk about some of these issues (PRT No. 10).

Integrated service delivery models that support culturally safe, integrated services across the continuum of care are happening in communities across BC, supported by the partnership process. These were cited as examples of on-the-ground change in service quality:

> So for example public health nurses in First Nations communities, public health nurses in the neighbouring community, figuring out how they were going to deliver immunization programs together for example. Or they were going to do school health services together, and trying to erase some of those jurisdictional boundaries. So there was some of that kind of work happening. But it was much more ad hoc and under the table. It was kind of – we've got to do something to make this work. So how do we do that? (PHS No. 21).

> We have a partnership with the band to run this facility […] And what it turned out is the local village which is a mixture of Aboriginal people and, you know, Caucasian and immigrants from other races they have very poor health services locally in the village. And so what's happened is the First Nations health centre run by the First Nations band actually provides the health services to the local town (PHS No. 5).

5. Discussion

This study has documented significant transformational changes that have taken place in the relationships between and among First Nations organizations and communities with other levels of health system authority in BC, Canada, within the short span of two years following the creation of the FNHA. Further, we have highlighted some significant system and service changes that are occurring as a result of these relationship changes. We suggest that the transformation in relationships occurring in BC exemplifies the relationship-building recommendations of the TRC report of 2015, which outlines a number of principles and calls to action to set an agenda for Canada to transform the historical inequities of the relationship between Indigenous peoples and the state. In this final section we will link our findings back to some of the key recommendations in the TRC report (Truth and Reconciliation Commission of Canada, 2012, 2015).

5.1 Governance and reciprocal accountability

Principle 9 of the TRC Report states that reconciliation needs political will, joint leadership, trust building, accountability and transparency, and a substantial investment in resources. FNHA respondents argued that this focus was foundational to their work with their Health Authority and community partners. Although the study has only documented two short years of implementation, there were nonetheless many examples of reciprocal accountability, political leadership, relationship and trust

development, and significant and sustained collective resourcing (Truth and Reconciliation Commission of Canada, 2015). Perhaps most importantly, the conversation among partners shifted away from a preoccupation with politics and history (the dominant characteristic of past discussions), to address resourcing and decision-making processes that align to those partnerships and relationships, putting the intention into clear action with processes for assessing impact and outcome.

5.2 Partnerships and relationships

TRC Principle 6 is about relationships – the key focus of this paper. The TRC has defined reconciliation as "an ongoing process of establishing and maintaining respectful relationships" with a focus on "reconciliation as relationship". It goes on to say "together, Canadians must do more than just talk about reconciliation; we must learn how to practice reconciliation in our everyday lives […]. To do so constructively, Canadians must remain committed to the ongoing work of establishing and maintaining respectful relationships" (Truth and Reconciliation Commission of Canada, 2015).

Our respondents not only articulated a strong sense that with the creation of the FNHA, the relationship among health sector partners has fundamentally changed, but they took real pride in the view that this new relationship was based on mutual trust and respect. Virtually every respondent enthusiastically stated that there was a strong sense of commitment to working together and listening to the views and perspectives of all participants when representatives of the Health Authorities and FNHA came together.

Reconciliation and relationships are about people making shifts in their own thinking and accommodating one another. Our study has shown that many individuals at a leadership level have developed a new sense of what relationship means in working with one another, making decisions and setting a tone that enables others to emulate their actions. Over time we expect this shift to filter through the different organizations to all levels reaching a critical mass of people.

The new BC First Nations governance structure is built upon six core and shared values, which arose from the stories of co-creating solutions in this study. The shared values include respect and relationships, which specifically refers to building respectful relationships with tripartite partners and working together to achieve the shared vision of building healthy, self-determining and vibrant BC First Nations (First Nations Health Authority, 2016b).

Principle 3 of the TRC report speaks to public truth sharing, apology, and commemoration. To some degree the focus on ceremony in relationships described above speaks to this, with the respectful inclusion of prayer and acknowledgment of indigenous history and values in management meetings. Roundtable participants described how ceremony and honoring traditional values and cultural laws provided a framework for negotiations around providing services in urban areas. Ceremony and its importance is a core shared value of the FNHA which asserts that First Nations gain their strength, wisdom, and guidance from ceremony and culture and the incorporation of traditional approaches is required for holistic health (First Nations Health Authority, 2016b).

5.3 First nations perspectives on health and wellness

The FNHA has incorporated a First Nations perspective on health and wellness into systems' transformation and governance, articulated in the Health Partnership Accord (First Nations Health Authority, n.d.). This First Nations perspective on health and

wellness entails a holistic vision which incorporates all aspects of life and spans across all determinants of health, in contrast to narrow views of physical health traditionally used in the mainstream system (First Nations Health Authority, n.d.) Although the TRC report has seven specific recommendations for improvements in the health sector, this study has demonstrated that the work of the FNHA and partners actually aligns with a significantly larger number of TRC calls to action. The study also demonstrates that the partnership is enabling much broader-based change in the social determinants and other factors that impact health and well-being. The new relationship has made possible the negotiation of agreements, such as the MoU between the BC Government and the FNHC describing a ten-year Social Determinants of Health strategy, that articulate a framework for action on the social determinants that enshrines the broader wellness perspective of the FNHA tagline "health through wellness."

5.4 Quality and cultural safety

Perhaps the most important "outcome" of the implementation of the FNHA and the transformation in relationships within the health sector will be the impact on the promotion of cultural safety and humility in the health care system (First Nations Health Authority, 2016a). Although two years is insufficient time to undo decades of structural racism in a largely colonial system, there are early signs of constructive action on addressing the ongoing legacies of colonialism. The Declaration on Cultural Safety and Humility has been drafted by the FNHA and signed by health leaders in BC, including the FNHA, RHAs, CEOs, and senior health officials within the BC Ministry of Health (First Nations Health Authority, 2016a). In addition to the FNHA declaration, each RHA in BC has signed a commitment to Indigenous cultural safety and declared to work with the FNHA to make all of their services more culturally safe and responsive. Recommendations 7 and 8 of the TRC report talk about "incorporating traditional knowledge" and "cultural revitalization" as important principles for enhancing cultural safety in institutional environments for First Nations people (Truth and Reconciliation Commission of Canada, 2015). At the most senior levels of the provincial Ministry of Health, officials are now promoting a First Nations perspective as integral to the health system for all British Columbians.

The TRC report declares that "reconciliation begins with each and every one of us"; this value is embedded in the cultural safety and humility framework with the tagline "it starts with me." The TRC Principle 4 calls for constructive action to advance this approach. The relationships that have been built through this transformative process have enabled a systemic commitment to cultural safety and humility which will in turn create local environments for interpersonal reconciliation through encouraging cultural humility and greater safety for those individual conversations (Truth and Reconciliation Commission of Canada, 2015).

6. Conclusion

The creation of the new First Nations health governance structure in BC, including the creation of the FNHA in 2013, represents an historical transformation in the approach to First Nations involvement in the delivery of health services. It represents nearly a decade of systematic work by all partners – federal and provincial governments and First Nations political organizations and communities to transform the historic colonial system and restore health governance to First Nations peoples. Although the initiative pre-dates the release of the TRC's final report, the motivation for both processes are

embedded in the need to address the legacy of colonization and the impact of residential schooling in Canada. The transformational changes that are occurring in the relationship among First Nations, provincial and federal partners are changes that exemplify the call for action from the TRC. Further research to document these changes, and their impact on health outcomes, over the long term is required. The experience in BC may serve as an example for other indigenous communities in Canada and worldwide in the ongoing struggle for transformation of health governance and self-determination.

Notes

1. The term "First Nations" has largely become the preferred terminology for indigenous peoples of North America in what is now Canada, and their descendants, who are neither Métis or Inuit. First Nations people may be "Status" (registered) or "non-Status Indians" as defined under the Indian Act.
2. Foundational documents important to the development of the FNHA are listed in the References section and information is provided as to where to source these documents for the interested reader.
3. Quotations are reference by the stakeholders affiliation as: Provincial Health System, PHS; First Nations Organization, FNO, and Policy Roundtable, PRT. For PHS and FNO the numbers refer to a different respondent. For PRT, the numbers reflect a different participant.
4. These terms were transcribed phonetically as spoken by the participant.

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