

AFN Position Paper: Advancing First Nations Health and Healing Through System Reform

Prepared for the First Nations-First Ministers Meeting (FN-FMM)

For the consideration by First Nation Chiefs

At a Glance

First Nations possess inherent, Treaty, and constitutionally protected rights and authority in relation to the health and well-being of their citizens. These rights are recognized and affirmed by section 35 of the *Constitution Act*, 1982. First Nations hold their own understandings of health and healing, grounded in their laws, languages, cultures, lands, ceremonies, traditional medicines, family and community relationships, and knowledge systems.

First Nation citizens rely on services delivered through First Nation, federal, provincial, and territorial systems. These systems operate through different laws, mandates, funding arrangements, eligibility rules, and accountability structures. When governments fail to coordinate or attempt to shift responsibility, First Nation people experience delays, denied services, disrupted care, and poorer outcomes.

Immediate FN-FMM Commitment

1. Secure permanent, First Nations participation in relevant federal, provincial, territorial, health ministers' tables on health and healing and associated officials' processes, including agenda setting, policy development, implementation, monitoring and accountability. This commitment should be an immediate and tangible outcome of the FN-FMM and an early demonstration of the broader political processes required to advance long-term structural reform.

Longer-Term Reform Agenda

Building from this commitment, First Nations and governments should establish a longer-term process to:

2. Create the political conditions and structures necessary for First Nations, Treaty partners and regions to advance their own health and healing governance models.
3. Support a First Nations-led process to develop options for a modern health and healing policy framework grounded in rights and self-determination.
4. Strengthen First Nations participation in decisions related to health funding, transfers, and bilateral agreements that affect First Nations health and healing.
5. Advance sustainable and equitable funding alongside meaningful First Nations influence over systems that affect First Nations health outcomes.
6. Establish First Nations-led approaches to accountability and data sovereignty.

AFN is not proposing a single national First Nations health governance model. The objective is to secure the political space, structures, and commitments necessary for First Nations, Treaty partners, and regions to advance their own models according to their rights, priorities, and circumstances.

1. Position Statement

First Nations are sovereign peoples and rights holders with inherent, Treaty, and constitutionally protected rights. First Nations have never surrendered their authority to define health and healing or to determine how the health and well-being of their citizens will be advanced. Section 35 of the Constitution Act, 1982 recognizes and affirms existing Aboriginal and Treaty rights. It does not grant those rights.

First Nations understand health and healing in wholistic ways that connect physical, mental, emotional, and spiritual well-being with family, community, land, language, culture, ceremony, traditional medicines, food systems, and self-determination. These understandings differ among First Nations and must be defined by rights holders themselves. Health-system reform must create space for First Nation laws, knowledge systems, healing practices, and governance to guide the design, delivery, and evaluation of care.

Federal, provincial, and territorial decisions shape access to health services for First Nation citizens. First Nations must therefore be able to exercise meaningful influence wherever those decisions are made. Permanent participation in relevant intergovernmental health processes is a practical and immediate step toward that objective. Such participation must respect direct Crown and Treaty relationships, modern treaties, self-government agreements, regional diversity, and First Nation-determined approaches to representation and accountability.

The First Nations-First Ministers Meeting (FN-FMM) is an opportunity to redefine this relationship. The immediate political objective should be to secure a long-term political process through which First Nations participate directly in decisions affecting First Nations health and healing, beginning with permanent, First Nations-based participation in relevant federal, provincial, and territorial processes. This would provide an immediate and tangible demonstration of a broader commitment to structural reform and establish a new pathway for First Nations participation in decisions affecting First Nations health and healing.

Permanent participation is not intended to establish or prescribe a single national First Nations governance model. First Nations health governance approaches differ across Nations, Treaty areas, and regions and must continue to be determined by First Nations themselves. The objective is to create the political space and structures through which First Nations, Treaty partners, and regions can advance their respective health and healing models while participating as rights-holders in the broader systems that affect First Nations health and healing.

Without structural reform, renewed and new health investments will continue to flow through systems that do not reflect First Nations priorities, rights, or realities, reinforcing

the very outcomes those systems were designed to produce. Additional funding within an unchanged structure will not deliver different results; structural transformation will.

At the same time, lasting improvements in First Nations health and healing depend on more than health system reform alone. Health outcomes are shaped by the social determinants of health, including housing, clean water, education, infrastructure, language, culture, and self-determination. The FN-FMM provides a unique opportunity to advance structural health system reform alongside broader commitments that strengthen the conditions necessary for First Nations to achieve equitable health and healing outcomes.

The immediate priority is to establish permanent First Nations participation in intergovernmental health decision-making, followed by a sustained political process through which First Nations governments can address governance, policy, funding, and accountability. Together, these reforms will redirect a fragmented system toward one that is coordinated, equitable, and culturally responsive to support care closer to home.

2. Summary

As currently structured, the health system delivers fragmented and substandard care, exposing a two-tier system in which First Nations consistently experience poorer access and outcomes than the general Canadian population. Federal programs, provincial and territorial services, and First Nations-led community services operate through separate funding arrangements, accountability structures, and administrative processes that do not function as an integrated continuum of care.

The consequences are measured not only in health outcomes but also in delayed diagnosis, denied care, avoidable suffering, and the loss of lives prematurely. The experiences of Jordan River Anderson, Mary Bull-Sinclair, Joyce Echaquan, Harlen Laboucan, Jaali Sutherland-Weenie, and many others continue to demonstrate the human cost of fragmented systems and jurisdictional failures.

Although First Nations populations are included in the calculations used to allocate the Canada Health Transfer (CHT), First Nations hold limited influence over the decisions that shape health priorities, resource allocation, and performance measurement. Inclusion in the population count is not the same as inclusion in how funding is allocated or services are delivered.

The renewal of long-term federal health funding agreements presents both a risk and an opportunity. The risk is that new investments simply flow through existing arrangements that have never resolved long-standing inequities, which leaves the structure and outcomes unchanged. The opportunity is that renewal is leverage and can be the catalyst for renewed relationships that strengthen First Nations decision-making authority,

improve coordination across jurisdictions, and establish mechanisms needed for equitable and culturally responsive health and healing.

The FN-FMM provides an opportunity to establish that new direction. Immediate commitments should include permanent, First Nations participation in relevant federal, provincial, territorial, health ministers' tables on health and healing and associated officials' processes, including agenda-setting, policy development, implementation, monitoring and accountability. This participation should not be treated as a stand-alone initiative or as the creation of a single national First Nations health governance model. Rather, it should be the first step in a longer-term political process that creates space for First Nations, Treaty partners, and regions to advance their own governance approaches and address broader questions of policy, funding and accountability.

3. Background and Context

Health services for First Nation citizens are delivered through intersecting First Nation, federal, provincial, and territorial systems. Provinces and territories generally organize and deliver insured hospital and physician services to residents, including First Nation people. They also make decisions about health-system planning, regional service delivery, health workforces, emergency and acute care, specialist services, and many mental health, addictions, rehabilitation, home care, continuing care, and public health services.

The federal government establishes national conditions for insured health services through the Canada Health Act (CHA) and supports provincial and territorial systems. It also funds or administers supplementary benefits and community-based programs for eligible First Nation people and communities. These federal roles arise within a wider constitutional, Treaty, statutory, policy, and historical context and must not be interpreted or applied in ways that narrow or displace the Crown's constitutional, Treaty, and fiduciary obligations.

First Nations are rights holders and governments. Their authority in health and healing is grounded in inherent rights, Treaties, their own laws and governance, and, where applicable, modern treaties and self-government agreements. First Nation authority is not a program delegated by another government. The form and exercise of that authority differ among First Nations and must be determined by rights holders.

Territorial arrangements require distinct treatment. Territorial governments deliver broad health services and may also administer federally funded benefits or programs through contribution agreements. Modern Treaty and self-governing First Nations may hold additional authorities and decision-making roles. National reform must therefore allow for Nation-specific, Treaty-based, regional, tripartite, and territorial arrangements.

The Canada Health Transfer (CHT) is the largest major federal transfer and is designed to provide long-term, predictable support to provincial and territorial health systems while upholding the principles of the Canada Health Act.¹ The Canada Health Act establishes the foundational principles for provincial and territorial health systems, but it does not address First Nations jurisdiction, governance, or rights in health system planning. Provincial and territorial health funding is legislatively anchored and predictable, while much of the funding for First Nations health is delivered through separate federal arrangements that do not carry the same protection. The contrast in security matters. The result is a fractured system with multiple funding authorities, reporting requirements, and jurisdictional responsibilities that, taken together, create overlapping mandates, jurisdictional disputes, service gaps, delays, and accountability challenges. First Nations continue to navigate these fragmented systems despite being disproportionately affected by health inequalities.

The federal policy framework guiding First Nations health has remained largely unchanged for decades. There is an opportunity to undertake a First Nation-led process to develop options for a modern health and healing policy framework that replaces outdated federal policy. Any modernization must uphold inherent and Treaty rights, support self-determination, and avoid imposing a single national governance model.

These structural challenges are evident across the continuum of care. Mental wellness services, Jordan's Principle, and the Non-Insured Health Benefits (NIHB) program each demonstrated how fragmented responsibilities, separate funding streams, and differing government mandates create barriers to access, laden with administrative burdens and service gaps. These programs frequently respond to gaps and failures in the health system, rather than addressing the structural causes of those gaps or strengthening the system itself.

The mental wellness and addictions continuum of care shows how fragmented responsibilities produce service gaps. First Nation communities may deliver prevention, cultural supports, land-based healing, counselling, crisis response, and treatment services through federal contribution agreements or their own resources. Provincial and territorial systems generally oversee emergency departments, hospitals, psychiatry, regulated treatment services, specialist referrals, and much of the broader health workforce. A person may move between these systems during a single episode of care. Without shared protocols, sustainable funding, and First Nation authority in planning, people can face interrupted referrals, unsafe discharge, weak follow-up, and no clear accountability for continuity of care.

Jordan's Principle similarly highlights the consequences of jurisdictional fragmentation. Provinces and territories are responsible for insured hospital and physician services for

¹Department of Finance Canada. Canada Health Transfer.

residents, including First Nation people. Jordan's Principle requires First Nation children to receive needed government services without gaps, delay, or denial and requires the government of first contact to pay where responsibility is disputed. NIHB provides specified benefits that are not otherwise covered through provincial or territorial insurance, private plans, or other public programs, including pharmacy, dental care, vision care, mental health counselling, medical supplies and equipment, and medical transportation.

These systems are interdependent. A provincial specialist appointment may require federally funded medical transportation. A child may need a provincial assessment before Jordan's Principle supports equipment, therapy, or another service. A hospital discharge plan may depend on benefits, transportation, community capacity, and follow-up funded by different authorities. When eligibility rules, approvals, referrals, or discharge processes do not align, First Nation families and communities carry the burden of navigation. The policy response must assign responsibilities, service standards, escalation routes, and accountability before gaps occur.

Recent federal initiatives, including the distinctions-based health legislation discussions of 2020 and the bilateral health funding agreements of 2023, demonstrate growing recognition of First Nations health priorities. Recognition alone, however, has not translated into participation in decision-making or shared governance. Although First Nations priorities may be acknowledged in policy commitments and action plans, First Nations continue to have limited influence over how priorities are set, investments directed, outcomes evaluated, or how governments are held accountable. The bilateral agreements negotiated between Canada and provincial and territorial governments underscore the point. They may reference First Nations priorities, but acknowledgement is not participation, and reference is not shared governance.

AFN is not proposing a single national mechanism for reallocating the Canada Health Transfer. Where future transfer arrangements, bilateral agreements or other intergovernmental health funding decisions affect First Nations health priorities, services or outcomes, First Nations should meaningfully participate in relevant priority-setting, implementation, monitoring and accountability processes. The appropriate mechanisms should reflect regional circumstances, Treaty relationships, and First Nations-determined approaches.

4. Legal and Rights Foundation

First Nations' inherent rights and authority arise from their existence as sovereign peoples and are not granted by the Crown. Section 35 of the *Constitution Act, 1982*, recognizes and affirms existing Aboriginal and Treaty rights. It provides constitutional protection for rights that pre-date the provision itself and includes rights arising through modern land claims agreements. Despite this constitutional foundation, federal health policy has not

established a comprehensive, rights-based framework for First Nations health governance. Existing authorities, including provisions under the Indian Act and the 1979 Indian Health Policy, offer limited direction and create no clear obligations for coordinated governance, accountability, or shared decision-making across federal, provincial, territorial, and First Nations systems.² First Nations ground health rights and responsibilities in their own inherent rights, laws, oral histories, Treaty understandings, historic Treaties, modern treaties, land claims agreements, and self-government arrangements. The federal position must respect these distinct foundations and must not impose a single interpretation of the right to health.

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), the Truth and Reconciliation Commission (TRC) Calls to Action, and Joyce's Principle collectively establish a clear expectation that First Nations must have equitable access to culturally safe health services and meaningful participation in decisions affecting their health and well-being. The United Nations Declaration on the Rights of Indigenous Peoples affirms the right of Indigenous Peoples to traditional medicines and health practices, access to health services without discrimination, and the highest attainable standard of physical and mental health. It also affirms self-determination and participation in decisions affecting rights. Together these frameworks reinforce principles of self-determination, substantive equality, First Nation-led decision-making, and accountability which, recognize that improved health outcomes require more than enhanced funding and service delivery. They require structural reforms that enable First Nations to participate as rights-holders in governance, planning, and oversight of health and healing systems.

This policy and legislative context reinforce the need for First Nations health agreements that clarify roles and responsibilities, close jurisdictional gaps, strengthen accountability, and secure First Nations participation across the full cycle of health system planning, implementation, monitoring, and evaluation.³ These foundations require health-system reform that respects First Nation authority, protects Treaty and Crown obligations, supports First Nation-defined approaches to health and healing, and secures equitable access to the full continuum of care.

5. The Issue

Despite decades of policy initiatives and targeted investments, significant health inequities persist between First Nations and non-First Nations populations. These disparities are rooted not only in insufficient funding, but in the design of the systems through which services are planned, delivered, and evaluated.

²Lavoie, J. G. (2013). Policy silences: Why Canada needs a National First Nations, Inuit and Métis health policy. *International Journal of Circumpolar Health*, 72(1), 22690.

³Lavoie, Josée G. *The Treaty Right to Health and the Legacy of the Indian Health Policy (1979): Contemporary Legislative and Policy Considerations* (Assembly of First Nations, 2023).

A system will consistently produce the outcomes it is designed to produce. Canada's health system was not built with First Nations as equal partners in governance, decision-making, or accountability. The result is that First Nations are forced to navigate a multi-tiered system of governments, funding streams, and administrative requirements simply to access services that should function as an integrated system of care. This fragmentation undermines continuity of care, delays access to treatment and constrains the ability of First Nations to develop their own approaches reflecting community priorities and cultural perspectives.

First Nations continue to be excluded from many of the intergovernmental tables and processes where decisions affecting First Nations health are made. Addressing that exclusion is a practical and achievable first step towards broader reform.

6. Strategic Considerations

Relationships between First Nations and provincial and territorial governments continue to shape opportunities for First Nations health and healing system reform. Governance approaches differ across regions, reflecting Treaty relationships, histories, and priorities.

There is no single governance model that will meet the needs of all First Nations. The role of the Assembly of First Nations is not to advocate for a single national health governance model, but rather to secure the political commitments and governance structure necessary for First Nations, Treaty partners, and regional First Nations organizations to advance their respective health and wellness models that reflect their rights and priorities.

A national political commitment to permanent First Nations participations at relevant Health Ministers' tables and officials' processes would create an ongoing mechanism through which First Nations can influence broader systemic decisions while governance arrangements continue to develop at Nation, Treaty, and regional levels.

Experience has demonstrated that important advances in First Nations health and healing can lose momentum as governments and political priorities change. Building trust and achieving meaningful, long-term reform requires governance arrangements that endure beyond electoral cycles and provide continuity and stability. First Nations must have confidence that commitments made today will be sustained over time, allowing governments and First Nations to build meaningful change for improved long-term outcomes.

The First Nations Health Authority in British Columbia demonstrates the benefits of First Nations leadership in First Nation health governance. Its structure shows how transferring decision-making authority to First Nations improves access, coordination, and cultural

safety in ways that federal and provincial systems, on their own, have not achieved.⁴ However, it should not be taken as a model to be replicated nationally. First Nations in other regions must determine governance approaches appropriate to their own rights, priorities, and circumstances.

The Kelowna Accord showed that political commitments, however significant, cannot endure without governance arrangements built to protect them over time. First Nations cannot rely on the goodwill of any single government to sustain reform, which is why governance arrangements, and not political commitments alone, must anchor the outcomes of the FN-FMM.

At the same time, existing intergovernmental mechanisms, including the Council of the Federation, continue to shape national health policy and funding priorities without any formal First Nations decision-making authority.

As governments consider future reforms and funding arrangements, the opportunity is to ensure that decisions affecting First Nations health are made with First Nations, and informed by First Nations rights, priorities, and perspectives. The First Nations-First Ministers Meeting provides an opportunity to establish this principle in practice by securing permanent First Nations participation in intergovernmental decision-making and ensuring that future reforms are developed with First Nations.

7. Strategic Policy Recommendations

Addressing persistent health inequities requires more than incremental program enhancements or short-term funding commitments. Meaningful progress depends on structural reforms that secure First Nations participation in health system decision-making and create the conditions through which First Nations can advance their own governance, policy, funding, and accountability priorities.

The FN-FMM should focus on one immediate and achievable political commitment, supported by longer-term processes for structural reform.

Immediate FN-FMM Commitment

- 1. Secure permanent, First Nations participation in relevant federal, provincial, territorial, health ministers' tables on health and healing and associated officials' processes, including agenda setting, policy development, implementation, monitoring and accountability, as an early demonstration of the longer-term political processes emerging from the First Nations-First Ministers Meeting.**

⁴First Nations Health Authority, British Columbia. The FNHA is widely cited as the first and only First Nations-led provincial health authority in Canada and has been recognized internationally as a model for self-determination in health.

The First Nations-First Ministers Meeting should commit to permanent, First Nations participation in relevant federal, provincial and territorial health ministers' tables and associated officials' processes. Participation should extend beyond engagement and include agenda setting, policy development, implementation, monitoring, and accountability on matters affecting First Nations health and healing. This commitment should serve as an immediate demonstration of the broader long-term political process for advancing structural health and healing system reform.

Longer-Term Reform Agenda

Building from the immediate commitment, First Nations and governments should establish a sustained process to address the following areas:

2. Create the conditions for First Nations-determined health governance arrangements.

Federal, provincial, and territorial governments should work together to establish First Nations health and healing governance structures in which First Nations participate as equal partners in planning, implementation, monitoring, accountability, and dispute resolution. These structures may include Nation-specific, regional, tripartite or other collaborative approaches determined by First Nations. They should set out clear roles and responsibilities, accountability measures, data-sharing agreements, and pathways to resolve jurisdictional gaps where federal, provincial, territorial, and First Nations systems intersect. The objective is to ensure that First Nations participate as rights holder and partners in decisions affecting First Nations while respecting regional diversity and existing governance structures. This recommendation is grounded in First Nations-led policy direction.^{5,6,7}

3. Support a First Nations-led process to develop options for a modern First Nations health and healing policy framework grounded in rights and self-determination.

Canada should support a First Nations-led process to develop options for a modern First Nations health and healing policy framework to replace the outdated federal policy. The framework should be grounded in inherent and Treaty rights, self-determination, and First Nations approaches to health and healing. It should consider how future policy will better support integrated planning, sustainable funding,

⁵Assembly of First Nations. *Our Right to Health: First Nations' Perspectives Across the Generations* (2021).

⁶Assembly of First Nations. *Sharing Honouring Practices in the Continuum of Care* (2023).

⁷Assembly of First Nations. *First Nations Policy Recommendations for the Development of a Wholistic Long-term and Continuing Care Framework* (2024).

coordinated service delivery, and culturally grounded models of care across the full continuum of health and healing.⁸

4. Strengthen First Nations participation in health funding, transfer and bilateral agreements.

Future Canada Health Transfer agreements, bilateral health arrangements and other intergovernmental funding agreements that affect First Nations health and healing should embed mechanisms that ensure First Nations participation in priority-setting, implementation, evaluation, and accountability. These agreements should also support greater coordination across jurisdictions and recognize First Nations as equal partners in shaping the systems that serve First Nations.

This recommendation does not propose a single national mechanism for reallocating the Canada Health Transfer. It recognizes that First Nations must have meaningful influence over intergovernmental health funding decisions where those decisions affect the systems, services, and outcomes experienced by First Nations.

5. Advance sustainable funding alongside meaningful system influence.

First Nations should have direct access to sustainable and equitable funding while also exercising real influence over the provincial and territorial systems that affect access, continuity of care, and outcomes. Direct funding without influence leaves First Nations as recipients of systems designed by others. Influence without direct and sustainable funding leaves First Nations dependent on intermediaries and decisions made elsewhere. Both are necessary to advance self-determination and equitable outcomes.

6. Establish integrated, First Nations-led accountability frameworks that uphold data sovereignty.

Federal, provincial, and territorial governments should establish integrated accountability frameworks that uphold First Nations data sovereignty, ensure transparent reporting, and measure outcomes against First Nations priorities. Governments should support the development and sustainability of First Nations-owned and controlled regional health data infrastructure, including regional data centres, where identified by First Nations. Strengthened capacity to collect, steward, analyze, and use health data will advance data sovereignty, improve evidence-informed decision-making, support service planning and evaluation, and ensure that health information reflects First Nations priorities and realities.

⁹Lavoie, Josée G. *The Treaty Right to Health and the Legacy of the Indian Health Policy (1979): Contemporary Legislative and Policy Considerations* (2023).

8. Conclusion

The First Nations-First Ministers Meeting provides an opportunity to recognize First Nation authority in health and healing and to change how decisions affecting First Nation citizens are made. First Nations enter this work as rights holders and governments with their own laws, knowledge systems, Treaty relationships, and understandings of health. As governments consider future funding and policy arrangements, the moment is right to establish structures that genuinely support First Nations leadership, collaboration, and accountability rather than reproduce the arrangements that have failed First Nations for many generations.

The immediate political commitment to establish permanent First Nations participation in relevant federal, provincial, and territorial Health Ministers' tables and associated officials' processes is both tangible and achievable. That commitment must lead to clear federal, provincial, and territorial responsibilities, sustainable funding, protection of Treaty and Crown obligations, First Nation-determined governance, and accountability for equitable access and outcomes.

Meaningful change will require sustained commitment from federal, provincial, territorial, and First Nations governments. Establishing permanent First Nations participation in health decision-making is a practical first steps where governments can begin to address the systemic barriers that persist and support more equitable health and healing outcomes for First Nations, and where decisions affecting First Nations health and healing are no longer made without First Nations.

Annex A: Key Messages, Proposed Announcements and, Political Objective

A. Key Messages for Health and Healing

1. AFN seeking political space and structures required for health system reform.

AFN is not seeking a single national First Nations health governance model. The objective is to secure the political space and structures necessary for First Nations, Treaty partners, and regions to advance their own health and healing governance approaches.

2. Long-term health and healing outcomes require structural reform.

Improving First Nations health and healing requires more than new funding. It requires reforms to governance, accountability, and decision-making.

3. First Nations must be partners in system reform.

Long-term health and healing system reform must be developed with First Nations as rights-holders and partners in intergovernmental decision-making, consistent with inherent, Treaty, and Constitutionally protected rights.

B. Proposed Announcements

1. First Ministers commit to permanent, First Nations participation in relevant federal, provincial and territorial health ministers' tables and associated officials' processes, including agenda-setting, policy development, implementation and accountability.
2. First Ministers direct Health Ministers to work with First Nations to establish the appropriate participation mechanism and initial workplan within six months.

C. Political Objective

The immediate objective of the FN-FMM is to secure permanent First Nations participation in intergovernmental health decision-making as the first step in a longer-term process of structural health and healing system reform.

The longer-term process should respect Treaty relationships, regional diversity, existing First Nations governance structures, and the right of First Nations to determine the approaches that best reflect their priorities and circumstances.

This commitment would demonstrate a fundamental shift from engagement and consultation towards sustained First Nations participation in the decisions that shape health policy, funding, implementation, and accountability.