GOVERNMENT RESPONSE TO THE STANDING COMMITTEE ON PUBLIC ACCOUNTS TENTH REPORT ON THE OCTOBER 2000 REPORT OF THE AUDITOR GENERAL OF CANADA: HEALTH CANADA - FIRST NATIONS HEALTH: FOLLOW-UP

MAY 2002

GOVERNMENT RESPONSE TO THE STANDING COMMITTEE ON PUBLIC ACCOUNTS TENTH REPORT ON THE OCTOBER 2000 REPORT OF THE AUDITOR GENERAL OF CANADA: FIRST NATIONS HEALTH

The Government of Canada extends its appreciation to the Standing Committee on Public Accounts for its Tenth Report on the October 2000 Report of the Auditor General of Canada (*Chapter 15:Health Canada – First Nations Health Follow-up*). The Government shares the Standing Committee and the Auditor General's belief that health programs for First Nations and Inuit must be well managed and accountable.

In its Report, the Committee recognized that Health Canada - First Nations and Inuit Health Branch (FNIH Branch) had made a commitment to phase in the development and implementation of new accountability frameworks for Community Health Programs (CHP)[1] and the Non-Insured Health Benefits Program (NIHB)[2]. The Committee also indicated it would continue to monitor the Department's progress in these areas. To assist Parliament in its oversight, Health Canada will supplement its annual Departmental Performance Report with an electronic annex on progress made towards fulfilling the Auditor General's and the Committee's recommendations, beginning with the report for 2001-2002.

Several important milestones were reached in 2001-2002 as Health Canada - FNIH Branch worked to implement its new measures. The Department began to phase in new accountability frameworks for its First Nations and Inuit Health (FNIH) programs. As well, departmental capacity was increased through the creation of the Business Planning and Management Directorate, which serves to implement and support accountability and management measures.

Milestones for CHP in 2001-2002 included the introduction of new standard agreements and other types of contribution agreements which clarified roles and responsibilities. An electronic system to manage contracts and contributions was implemented nationally. This single management system for contribution agreements will enhance the ability to report, monitor and audit. In March 2002, an Intervention Policy was introduced to to guide Health Canada-FNIH Branch's actions in communities which have been unable or unwilling to address exceptional or problem situations.

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[1] **Community Health Programs** deliver services in three key areas: primary care, public health and health promotion, and children`s programs. Programs are delivered at the community level by Health Canada's First Nations and Inuit Health Branch or by First Nations and Inuit communities through agreement.

[2] The **Non-Insured Health Benefits Program** provides to registered Indian and recognized Inuit and Innu a range of medically required goods and services that supplement benefits provided through other private or provincial or territorial programs. Benefits include drugs, dental care, vision care, medical supplies and equipment, short term mental health services, and transportation to access medical services.

In 2001-2002, the NIHB program also improved its overall accountability and management. In 2001, the NIHB program, with the Assembly of First Nations (AFN) and the Inuit Tapiriiksat Kanatami (ITK), established a framework to gather client consent for the use of personal medical information in claims processing and reimbursement. In 2002-2003, consent will be gathered nationally to permit retrospective and online drug utilization monitoring to be reintroduced in 2003-2004.

In 2001, the NIHB program established a results-based management and accountability framework. As benefits are primarily delivered to individuals through a third-party claims administrator and health practitioners, the NIHB program requires an accountability framework which includes auditing of providers. The framework features a risk management initiative, introduced in 2000, to address financial and management risks, using a more transparent process. The initiative allows the program to better target and manage benefits. The comprehensive audit program is a key component of the risk management activities.

The NIHB program management and accountability framework will improve the reporting of outcomes and results achieved by the program. As the framework is further developed and phased in, assessment and evaluation elements will be introduced. The program has undertaken evaluations of specific program components, including the drug benefit management process and the dental benefit review process.

Although considerable progress has been made in developing and phasing in new measures to improve its performance, the Government also recognizes that more remains to be done and is committed to undertaking this work.

The Government has chosen to respond to the 26 recommendations by grouping information under five topics: Community Health Programs accountability; supporting capacity development; measuring performances, outcomes achievement, and managing information; NIHB control and prevention measures; and reporting to Parliament on progress. A general statement for each of the subject areas precedes the detailed responses to each recommendation. This thematic format is consistent with the Committee Report which clusters its observations and recommendations.

Community Health Programs (CHP) Accountability

Health Canada - FNIH Branch's introduction of new standard funding agreements for the delivery of health programs and services coincided with the release of the revised Treasury Board *Policy on Transfer Payments*, which obliged all federal government departments, including Health Canada, to ensure that agreements comply with the new financial policy. The new standard agreements were one of the first accountability measures to be implemented with First Nations and Inuit communities, as part of a comprehensive Accountability Framework.

The new standard agreements streamline 16 agreements into seven. They help clarify the roles and responsibilities of all parties involved, improve risk management, and allow the Department and First Nations and Inuit communities to better reflect accountability for the prudent use of public funds.

The review of all funding agreements and the subsequent adoption of new standardized agreements is just one part of the comprehensive Accountability Framework. Health Canada has already begun the implementation of a departmental Management Control Framework (MCF) for Grants and Contributions which will also serve to strengthen internal and external governance and accountability mechanisms, through improved information systems and risk management. The MCF emphasizes government-wide control objectives that relate to Modern Comptrollership and the Results for Canadian Management Framework. It addresses control practices to provide assurance that grants and contributions are well managed, and aims at streamlining processes across the Department's Branches and Regions. Health Canada - FNIH Branch continues to work closely with First Nations and Inuit communities on all aspects of the Accountability Framework, including the development of its major elements.

To support implementation of the MCF relating to reporting, auditing and monitoring aspects of the FNIH accountability framework, Health Canada - FNIH Branch introduced the Management of Contracts and Contributions System (MCCS). MCCS was introduced in all regions of the Health Canada - FNIH Branch in December 2001, with full implementation in April 2002. MCCS will facilitate active monitoring of compliance and performance, results-based management, continuous learning and progress at both community and departmental levels. The system will increase transparency, leading to more effective action should problems with reports and audits arise.

Health Canada - FNIH Branch recognizes that exceptional or problem situations under health funding arrangements may arise, and in response to this an Intervention Policy Framework has been developed. When there is an inability due to lack of capacity, or an unwillingness/lack of commitment to address a problem situation, Health Canada - FNIH Branch will act to correct the situation, with the appropriate level of intervention required. Intervention may range from assisting the recipients to develop and implement a plan of action to requiring a co-management arrangement to a third party management. Health Canada - FNIH Branch is committed to working closely with communities, and recognizes that this is one of the most important aspects in determining the nature of the problem and in obtaining the communities' perspective and input. The intervention policy helps ensure the protection of health programs and service delivery, and the adherence by communities to the accountability principles of transparency, disclosure and redress. The policy parallels that of the Department of Indian Affairs and Northern Development.

Health Canada - FNIH Branch pays particular attention to developing its internal administrative capacity, and on supporting First Nation and Inuit authorities in strengthening their capacity to create a basis for accountability, risk-management, and continuous learning. The new Business Planning and Management Directorate oversees ongoing management of funding agreements, staff development, and business planning and reporting.

While it is important to ensure that reports are provided by First Nations and Inuit recipients and are consistent with the terms and conditions of funding agreements, Health Canada - FNIH Branch also uses on-site visits along with regular contacts and discussions to ensure permanent efficient and active accountability.

RECOMMENDATION 2

That Health Canada ensure that it receives all accountability documents, including all reports and audits required under Community Health Program delivery arrangements, in a timely manner.

Response:

Health Canada - FNIH Branch, during 2001-2002, developed national tools and processes to ensure that it receives accountability documents. In response to the need for a nationwide standardized system for monitoring contribution agreements, the MCCS, was developed and fully implemented in all regions in April 2002. MCCS keeps all documents, including financial and activity reports provided by the recipients, in one place. The system includes features such as the capacity to generate reports showing all overdue activity or financial reports. It highlights all outstanding reports, and requires that an explanation as to why the information is missing be entered by Departmental officials in order that payments to the recipient continue. MCCS does not replace the role of Departmental officials in monitoring accountability documents, and regular communication with all recipients is maintained. Officials continue to work with recipients to ensure that the understanding and capacity to meet requirements exists.

RECOMMENDATION 3

That Health Canada conduct risk-based monitoring of all required accountability documents to ensure that they are accurate and address all terms and conditions specified in delivery agreements.

Response:

Based on audit and reporting guidelines issued in June 2000, Health Canada - FNIH Branch is moving toward the utilization of a comprehensive reporting handbook for the CHP which will include both financial and program reporting requirements. The financial reporting requirements will be distributed in the Fall of 2002, and program reporting requirements will be available by the Spring of 2003.

Starting in 2002-2003, Health Canada - FNIH Branch, as part of its quality assurance plan, will review Reporting Procedures, including assessing the value, the accuracy and the appropriateness of the information received in these reports to assess compliance with terms and conditions specified in the agreements as well as the consistency of the report review exercise and follow-up performed.

RECOMMENDATION 4

That when, as a consequence of its monitoring activity, Health Canada finds that accountability documents are incomplete or contain information that is inaccurate, or that there are problems in service delivery, it work closely with the First Nation or Inuit community concerned to take timely action to correct deficiencies identified.

Response:

Health Canada - FNIH Branch recognizes that exceptional or problem situations under health funding arrangements may arise, and in response to this an Intervention Policy Framework has been developed. The Policy has been made available to Departmental officials, and an operating handbook to assist in implementing the policy is being finalized, and will be distributed by the Summer of 2002.

When there is an inability due to lack of capacity, or an unwillingness/lack of commitment to address a problem situation, Health Canada - FNIH Branch will act to correct the situation, with the appropriate level of intervention required. The Intervention Policy is designed to ensure the protection of health programs and service delivery, and the adherence to the accountability principles of transparency, disclosure and redress. Health Canada - FNIH Branch is committed to consultation with communities, and recognizes that this is one of the most important aspects in determining the nature of the problem and in obtaining the communities' perspective and input. Health Canada - FNIH Branch uses this consultative process to determine the level of intervention required, and acts accordingly. This Intervention Policy parallels the Department of Indian Affairs and Northern Development.

Supporting Capacity Development

Health Canada shares the Committee's belief that capacity development be a priority. In Health Canada - FNIH Branch, the Accountability and Capacity Development Division was established in 2001 as part of the Business Planning and Management Directorate. Capacity development is listed as a planned activity in Health Canada's *Report on Plans and Priorities* for 2002-2003.

The Government recognizes that a participatory approach contributes to community capacity development. The Transfer Policy (1988) and 1994 Treasury Board authorities for the Integrated Community-Based Health Services Approach provide for Health Canada's CHP to engage First Nations and Inuit for arrangements that permit various levels of control ranging from general contribution agreements to integrated contribution agreements to transfer contribution agreements.

Before Health Canada - FNIH Branch and First Nations and Inuit communities enter into transfer

agreements, an extensive two-year planning and capacity development process, including capacity assessments, is undertaken. Communities entering this pre-transfer phase receive funding for a health needs assessment, for training, for development of a health plan, and for establishment of a health management structure. During the intensive two-year planning process, the communities develop their own community health plans. The plan and its components are evaluated by regional assessments teams, consisting of transfer managers, program managers and financial services. The plan is reviewed for its effectiveness and completeness. Health Canada - FNIH Branch then consults with its regional Department of Indian Affairs and Northern Development counterparts with respect to financial situations with particular communities. Finally, a decision is made with respect to a community's readiness and capacity to undertake transfer. In the event that sufficient capacity for full transfer is not present and cannot be put in place within the planning phase, communities are offered the opportunity to enter into an arrangement with less flexibility and more federal control (general contribution or integrated agreements) that is commensurate with their existing capacity. When the pre-transfer process is successful, communities are given further support for capacity development during a bridging phase leading to a transfer implementation phase and a post-implementation reporting, evaluation and adjustment phase.

At present 47% of First Nations and Inuit eligible communities have entered into full transfer agreements, and 23% into integrated agreements. In the past 12 years, Health Canada has provided $85.2 million to support planning, capacity development and start-up costs for the community-based transfer and integrated agreement approaches.

Communities administering or delivering community health programs on a program-by-program basis represent 29% of First Nations and Inuit communities. Through these arrangements, communities gain valuable experience managing employees, meeting accountability requirements, and delivering programs. Health Canada - FNIH Branch works closely with communities to monitor progress and provide support when needed. Recently implemented accountability measures, particularly the new standard agreements, will provide greater clarity to communities about responsibilities and will support growth of capacity through training. A new intervention policy allows Health Canada - FNIH Branch to intervene when problems arise, in a way that minimizes disruption of service while assuring capacity to deliver services in the longer term.

Health Canada has other programs that also support the development of the capacity of First Nations and Inuit to deliver health programs. A prime example is the Indian and Inuit Health Careers Program, through which Health Canada provides financial support to encourage Aboriginal participation in education leading to professional careers in the health field. Several of Health Canada's community health programs also include training and educational components that are intended to strengthen the capacity of First Nations and Inuit communities to deliver health programs. An example is the First Nations and Inuit Addictions Program. It has developed national best practices and protocols for treatment, and is expanding treatment program accreditation on a national scale. Major components of the Addictions Program include the National Native Alcohol and Drug Abuse Program, and the Solvent Abuse Program.

Each community's capacity to enter into a health transfer or integrated health agreement is a combined outcome of the efforts and initiatives of the Government and its First Nations and Inuit partners. With a view to making these combined contributions most effective, the Accountability and Capacity Development Division has initiated a dialogue with First Nations and Inuit organizations and established an interdepartmental forum to share information, coordinate capacity development efforts, and develop an integrated approach.

The development of health services administration and delivery capacity of First Nations and Inuit communities is also directly and indirectly supported by the initiatives of other federal departments and agencies. Through Interchange Canada, for example, the Government supports the development of the Aboriginal public service. Through the First Nations Policing Policy and the Aboriginal Justice Initiative, First Nations communities are given a strong role in the administration of justice as they assume greater control and responsibility for matters that affect their communities.

RECOMMENDATION 6

That, working with First Nations and Inuit, Health Canada begin an immediate assessment of the capacity of First Nations and Inuit communities to administer community health programs and comply with required reporting requirements.

Response:

Prior to Health Canada - FNIH Branch and First Nations and Inuit communities entering into transfer agreements, an extensive two-year planning and capacity building process, including assessments, is undertaken by communities. During the intensive two-year planning process, the communities develop their own Community Health Plans. The plan and its components are evaluated by regional assessment teams, consisting of Transfer Managers, Program Managers and Financial Services. The plan is reviewed for its effectiveness and completeness. Health Canada - FNIH Branch then consults with its regional Department of Indian Affairs and Northern Development counterparts with respect to financial situations in particular communities and then a decision is made with respect to a community's readiness or capacity to undertake transfer.

Health Canada - FNIH Branch does not transfer programs unless First Nations and Inuit communities have the capacity to administer community health programs and comply with reporting requirements.

Where Health Canada - FNIH Branch recognizes that administrative and delivery capacities of the recipients do not meet the requirements for a transfer agreement, it offers the opportunity to enter into other types of agreements that are commensurate with their existing capacity. These agreements also provide to recipients an opportunity to increase their capacity to eventually assume more responsibilities in the management of their health services.

RECOMMENDATION 7

That, following this assessment, Health Canada, working with First Nations and Inuit communities, develop and implement a strategy designed to build or reinforce administrative and delivery capacity in communities where it is weak, and provide necessary resources where required.

Response:

Building on the capacity development efforts in the transfer process, Health Canada - FNIH Branch has initiated a broader capacity development approach that has four elements.

Health Canada - FNIH Branch works with First Nations to build capacity at the community level through pilot projects whereby communities are developing their own health plans. Health Canada will be investing approximately $4 million over 3 years (about $1.3 million for 2002-2003) to support this initiative. The results will be used to develop a long-term capacity development strategy for all First Nations and Inuit communities.

Also, a new Accountability and Capacity Development Division has been created within the Health Canada - FNIH Branch, which will strive to develop a capacity strategy designed to build or reinforce administrative and delivery capacity in communities by January 2003.

An internal Steering Committee made up of regional Health Canada - FNIH Branch Accountability Officers and representatives from headquarters will discuss the implementation of the Accountability Framework, which also addresses administrative and delivery capacity issues and needs.

Health Canada - FNIH Branch has also initiated a dialogue with First Nations and Inuit organizations and other federal departments on developing an integrated and interdepartmental strategy on capacity development.

RECOMMENDATION 8

That pending the completion of an assessment of capacity in conjunction with First Nations and Inuit communities, and implementation of a strategy to address it, Health Canada refrain from negotiating any further transfer agreements.

Response:
Health Canada recognizes that capacity of First Nation and Inuit communities is an important element in their management and delivery of health programs. Under the Transfer Policy (1988), eligible First Nations and Inuit communities do not automatically enter into transfer agreements. The transfer process is determined and undertaken on a community-by-community approach, based on an intensive two-year planning and capacity building process. Even after the completion of the planning process, the First Nation or Inuit community may not proceed with implementation based on their level of capacity and/or willingness to assume a transfer arrangement, with the resources available. Either party to a transfer agreement has the opportunity to: (1) terminate negotiations if such an agreement is not in their best interest; and (2) terminate or not renew an existing agreement if the terms and conditions are not met.

If the decision is made that a community is not ready to undertake the transfer process following the two-year planning period, the community has the option of entering into an integrated arrangement, during which the community works together with the Regional office to increase capacity and community readiness. Funding is also provided through integrated agreements for capacity development.

Prior to renewal, agreements are monitored on an annual basis for compliance of accountability requirements. Also, the updated Community Health Plan and Evaluation Report are reviewed by Health Canada - FNIH Branch. These reports provide essential information on the capacity of the recipients to manage and deliver health services and form the basis of the renewal decision.

RECOMMENDATION 10

That where the Department has concerns about the capacity of a First Nation community to deliver services in the short term, it revoke the delegated authority in order to protect the health of First Nations individuals, until such time as sufficient capacity to administer, deliver, and report on services and programs delivered can be created.

Response:

The March 2002 adoption and national implementation of a FNIH Intervention Policy provides Health Canada - FNIH Branch the means to take necessary action to correct problem situations. This policy was developed in consultation with the Department of Indian Affairs and Northern Development and is consistent with that department's policy. Intervention will follow a series of steps when an identified trigger or problem situation arises. Following a meeting with the recipient to discuss and assess the situation, there will be an assessment of the capacity and willingness of the recipient to address the situation. Where there is an inability due to lack of capacity, or an unwillingness or lack of commitment to address a problem situation, Health Canada - FNIH Branch will act with the appropriate level of intervention required to correct the situation. Intervention may range from assisting the recipient in the development of a plan of action, through a co-management arrangement, to third party management. This intervention policy will be reviewed in three years.

Measuring Performance, Outcomes Achievement and Managing Information

Health Canada is developing a multifaceted performance measurement strategy that, once fully tested, will be made available to all First Nations and Inuit communities across Canada by 2005. The strategy rests on three pillars:

1. Annual program reporting on short-term outcomes
2. Intermediate national program evaluations (done every five years)
3. Long-term health surveillance activities

The performance measurement strategy is complex and must be fully tested before it can be implemented in all First Nations and Inuit communities. Pilot testing of the performance measurement strategy will be conducted in the 10 *Community Health Plan* demonstration sites across Canada for a two-year period, beginning in 2002. It is estimated that health planning and program implementation will run for 18 months. Information collection on the pilots, evaluation and reporting are anticipated in the first half of 2005.

1. Annual Program Reporting

Using a Balance Scorecard approach, the annual reports will track information generated through a core set of program indicators related to client health, program administration, staff education and capacity building, and financial management. This process begins with the six-month community health planning phase, one year of delivery of health programs, and is followed by annual reporting on results achieved. Once fully tested in the demonstration sites, reporting templates will be used annually to collect information on the health programs delivered. Information requested in these reporting templates will be consistent with the objectives stated in the original Treasury Board submissions for program funds, and with the requirements found in other parts of the accountability model such as the *Community Health Plan Compendium of Programs* and the new *Contribution Agreement Schedules.*

2. Intermediate National Program Evaluations

Under the new performance measurement strategy, national evaluations will expand on the core indicators set out in the annual reporting templates in order to provide more comprehensive and risk-based program assessments. In accordance with Treasury Board requirements, national program evaluations will follow a program life-cycle. The number and timing of the individual national program evaluations will depend on the start date of the health programs being evaluated. For instance, program evaluations for the Canada Prenatal Nutrition Program for First Nations on reserves, Aboriginal Head Start for First Nations on reserves, and the Canadian Strategy on HIV/AIDS for First Nations on reserves will be undertaken by March 31, 2003. Evaluation results will be available by 2004.

Past evaluations of both non-insured health benefits and community health programs have shown increased awareness of health issues and improved community program delivery. While useful at the community level, the evaluations were not structured in a way to enable Health Canada - FNIH Branch to aggregate the results at the regional and national levels. Current work is focussed on providing guidelines that will enable evaluations to be consolidated for different information needs and at different levels (e.g., community members to tribal council, tribal council to Health Canada, and Health Canada to Parliament).

3. Long-term Health Surveillance

On-going surveillance activities involve the continuous collection, analysis and interpretation of population health information. Health Canada plans to use three sources of surveillance information.

1. Administrative data held in case management systems such as the First Nations and Inuit Health Information System (FNIHIS).

   FNIHIS is a community-based computerized case management tool developed by Health Canada - FNIH Branch in partnership with the Chiefs of Ontario. As a case management tool, FNIHIS is able to provide limited population health data on such things as immunization rates and communicable disease, but it cannot supply a complete picture of health outcomes because it is present only in First Nations and Inuit communities who request it. The FNIHIS can only provide information on individuals who receive care in that community; it has no data on First Nation and Inuit patients who obtain health care from provincial or territorial hospitals, private practice physicians, and privately run clinics outside the community. These data, held by provincial or territorial health systems (e.g., hospitalization rates, incidence of cancer), are not accessible without data sharing protocols. New privacy legislation and the legal issues of jurisdiction, ownership, access, and control of information complicate the structure of sharing agreements with First Nations communities, provinces and territories. Health Canada - FNIH Branch is working with the provinces, territories and First Nations and Inuit to develop mechanisms to share this health information.

2. Disease registries held by provinces and other federal departments

   This source of surveillance information uses databases such as the Vital Statistics Registry and the Canadian Cancer Registry. These databases routinely collect information about births, deaths and incidence of disease, but most of them are not generally structured to identify people by ethnicity. Health Canada - FNIH Branch is currently undertaking a process to identify First Nations in surveillance databases. Memoranda of understanding for data sharing are being negotiated with an anticipated completion by 2005.

3. Survey data collected by First Nations and Inuit organizations

   Although disease and vital statistics registries supply a considerable amount of data, they do not provide information about non-medical factors that influence health status. Survey data will examine non-medical factors such as the effects of risk behaviours, lifestyle, economic conditions and environmental circumstances on health. Health Canada - FNIH Branch is working with Statistics Canada and the National Aboriginal Health Organization to support the First Nations Regional Longitudinal Survey, which will provide health information about on-reserve populations beginning in 2004 that will be comparable to national surveys conducted by Statistics Canada.

The multifaceted performance measurement strategy described above will strengthen Health Canada's ability to demonstrate program relevance, success and cost-effectiveness in accordance with the Government of Canada's evaluation policy. Health Canada - FNIH Branch can draw on the Department's evaluation capacity to generate reliable, timely and objective information to support planning, priority setting, and reporting.

Health Canada is working with other federal departments and with provincial and territorial jurisdictions as well as new Aboriginal institutions such as the National Aboriginal Health Organization, the Institute for Aboriginal Peoples' Health, and the Survey Centre for Aboriginal Health to improve the availability, access and quality of data.

RECOMMENDATION 12

That Health Canada use data collected by the First Nations Health Information System to demonstrate the health outcomes achieved by community health programs and the Non-Insured Health Benefits program. This analysis must appear in Health Canada's performance reports beginning with the report for the period ending 31 March 2002.

Response:

Health Canada is developing a multifaceted performance measurement strategy for the CHP and NIHB programs that draws on a wide range of data sources, including surveillance, surveys and administrative data. This multifaceted strategy seeks to fulfil accountability requirements as well as to build a comprehensive knowledge base that will facilitate health planning, identify newly emerging health problems, and track changes in health status. This information will be reported in the annex to the Departmental Performance Report beginning with the 2003-2004 report.

FNIHIS will be an important data source for the CHP strategy. However, FNIHIS will not be used in the NIHB performance measurement strategy. NIHB provides proxy information on drug utilization, while FNIHIS provides case management information on the patient. Information on drug utilization will be better captured by national surveys such as the First Nations Longitudinal Regional Health Survey.

RECOMMENDATION 13

That Health Canada apply the requirements specified in the Evaluation Policy of the Government of Canada to its management of community health programs and the Non-Insured Health Benefits program.

Response:

Health Canada is applying the requirements of the 2001 Government of Canada Evaluation Policy. The Deputy Minister has identified a senior Head of evaluation to work with branch managers. Health Canada - FNIH Branch will work with this department head of evaluation to ensure that reliable, timely and objective information is available to support decision making and continuous learning/improvement. To help facilitate this, Health Canada - FNIH Branch has established a new Audit, Evaluation and Review Committee which will support the Branch's implementation evaluation plans and ensure that follow-up, quality control and corrective actions are taken. The committee provides advice on all audit, evaluation and review matters to FNIH Branch's Assistant Deputy Minister, who in turn represents the Branch at Health Canada's Departmental Audit and Evaluation Committee.

RECOMMENDATION 14.

That Health Canada, in consultation with First Nations and Inuit communities, develop and implement formal evaluation plans for the community health programs, including the transfer initiative, and the Non-Insured Health Benefits program.

Response:

A multi-year comprehensive evaluation plan for First Nations and Inuit Health programs will be developed in the context of the work required for the renewal of Treasury Board authorities which must be completed by April 2005. This evaluation plan will be developed in consultation with First Nations and Inuit.

All CHP initiated after 1997 have evaluation frameworks. Evaluation plans are currently being implemented for Aboriginal Head Start and the Canada Prenatal Nutrition Program. Program evaluations for the Canada Prenatal Nutrition Program, Aboriginal Head Start for First Nations on reserve, and the Canadian Strategy on HIV/AIDS for First Nations on reserves will be undertaken by March 31, 2003. Evaluation results will be available by 2004.

Health Canada has recently developed a full evaluation framework for the NIHB program and has had external evaluations conducted on the NIHB drug, dental and pilot project components.

The First Nations and Inuit Health Branch Audit, Evaluation and Review Committee will oversee these evaluations activities.

NIHB Control and Prevention Measures

The NIHB Program provides eligible registered Indians, recognized Inuit and recognized Inuit with a range of medically required health-related goods and services not provided through other private or provincial/territorial health insurance plans. Benefits include drugs, transportation to access medically required services, dental care, medical supplies and equipment, crisis intervention counselling, vision care and medical premiums in selected provinces.

The NIHB Program draws its authority from Cabinet approval of the 1979 Indian Health Policy, the 1997 NIHB Renewed Mandate, and the Government's general spending power as evidenced by the annual allocation of funding pursuant to the *Appropriations Act*.

In 1997, the NIHB introduced retrospective drug utilization reviews to identify misuse of specific prescription drugs by individuals. In consultation with the Department of Justice beginning in 1999, it was determined that, in the absence of specific legislative authority or consent of beneficiaries to use and share personal information, the NIHB Program had to limit benefit utilization reviews due to privacy concerns. As a result, the Program was unable to share client specific identifiable information, target benefits, or develop disease management programs.

Two options were identified to address this situation. One option was to introduce legislation and establish clear statutory authority for the use and disclosure of personal information under the NIHB Program. However, it was not clear that legislation would preclude the need for client consent. A legislative approach would also be perceived by First Nations and Inuit as circumventing the opportunity to inform NIHB clients about how their personal information would be used. Also, the time required to put such legislation in place would be considerable.

A second option was to develop a process to secure written consent from eligible NIHB clients for the use, collection, disclosure, distribution, and protection of personal information. The client consent option presents several advantages. It supports the transparency and accountability of the Program, and further involves the clients in the responsibility for the provision of their benefits. Consent will enable the NIHB Program to share information, when warranted, with prescribers, providers and their regulatory/disciplinary bodies in support of optimal drug therapy and to better target benefits. Consent will also permit the Program to reinstate Drug Utilization Review (DUR) activities to assist in reducing the abuse or misuse of benefits by allowing information to be shared, and will permit direct interactions with providers and clients.

In order to ensure the success of the consent option, a Joint Consent Advisory Sub-Committee was established involving AFN, ITK, and FNIHB staff in the spring of 2001. An advisory committee was also established with the Canadian Pharmacists Association (CPhA). (Over 65% of all eligible clients receive at least one pharmaceutical benefit in any year on the NIHB Program.) The committee provides advice to the Program on the development of consent materials and operations.

Communications materials approved by the Joint AFN/ITK/FNIHB Consent Advisory Sub-Committee were tested at 14 sites in various parts of the country from 11 December 2001, to 31 March 2002. Evaluations of the test initiatives will be carried out in May 2002, and results will be used in implementing the national rollout of the consent initiative in July 2002.

A comprehensive information and communications package has been developed that targets 34 stakeholder groups, from clients to providers. As well, information outlining the consent initiative will be provided to Members of Parliament. The principal elements of the package are a pamphlet with a detachable postage paid consent form, a booklet explaining the NIHB Program, public service announcements for television and radio, and advertisements in newspapers, bulletins and other periodicals serving First Nations, Inuit and provider communities.

The consent initiative is scheduled to be completed in April 2003. At that time, the NIHB Program will be re-establishing the comprehensive DUR protocol. This will include both real time and retrospective drug utilization reviews that were previously in place for the Program. The enhanced DUR protocol will involve sharing information with prescribers, providers and their regulatory/disciplinary bodies.

RECOMMENDATION 17

That Health Canada immediately upgrade the point-of-service system for pharmacies under the Non-Insured Health Benefits Program so that the system provides the dates, quantities, and drugs prescribed of at least a client's last three prescriptions and information on doctors visited.

Response:

The Point-of-Sale system or Pharmacy Electronic Communication Standard (PECS) Version 3 is the current industry standard. The standard has been developed by the CPhA in consultation with all industry stakeholders. Currently over ninety-nine percent of providers on the NIHB Program are utilizing this system.

A technical advisory group representing the CPhA and a broad spectrum of users including Health Canada - FNIH Branch has been tasked with developing enhancements to Version 3. The capacity to facilitate communications between pharmacists and all other health care professionals and facilities has been identified as an important consideration for all stakeholders for the next version of the system.

Version 4 of the PECS is still in the development phase. Once implemented, the enhanced standard will streamline claims administration, facilitate efficient coordination of benefits, improve access to patient medication history (including drug utilization review data) and provide interactive communication with other health professionals. The release of Version 4 will also result in increased costs for providers to ensure systems capabilities are in place to process claims through this new standard. Some providers may opt to remain with the earlier standard.

RECOMMENDATION 18

That Health Canada regularly analyse overrides of warnings generated by the point-of-service system to determine whether warning messages are effective, whether prescriptions rejected by some pharmacists have been filled by others, and how and why clients with very large numbers of prescriptions are getting through the system.

Response:

The NIHB Program does regularly analyse overrides of warnings at the provider level and will continue to do so and has implemented a comprehensive provider audit program, including an on-site audit component.

In 2000, over 7.6 million claims were processed on the NIHB Program. Of this total, about 280,000 claims (4.0%) were rejected. Of the claims rejected, approximately 98,000 (1.3%) were overridden and paid. The explanation for overriding the rejection message used most frequently by pharmacists using their professional judgement (42%) was that the physician was consulted and the prescription was filled as written.

A quarterly report is provided by region, and nationally on the number of DUR claims submitted, accepted and rejected. In addition to the number of claims rejected, the report provides details on the rejection type and number of claims that were overridden and paid, including the reason the claim was overridden. A second report provides information on the top providers in each region by the number of claims that were overridden and paid, including the reason the claim was overridden.

The NIHB Program analyses these two reports and other information to determine which providers should be audited. The NIHB Program analyses this information and instructs the claims administrator to contact providers who are consistently overriding DUR rejected claims, to review the overrides and determine appropriate follow up activities. During the on-site visit, one of the areas of investigation for the auditor is the pharmacist's use and documentation of override codes. Recoveries are identified for all claims where the pharmacist has not adequately documented the reason for overriding rejected claims.

RECOMMENDATION 20

That Health Canada implement a centralized analysis of drug use similar to that found in the provinces in order to identify misuse, abuse, and multiple use on a real-time basis.

Response:

In order to implement a centralized analysis of drug use similar to provincial programs, it is necessary to share client-specific information with pharmacists and physicians. The NIHB Program is unable to share this information until the recipient has provided his or her consent (see response to Recommendation 21 for further details).

The client consent initiative is underway. Once client consent has been provided, the NIHB program will be re-establishing the comprehensive DUR protocol in early 2003-2004. This will include both real time and retrospective drug utilization reviews that was in place previously. The DUR protocol involves sharing information with prescribers, providers and their regulatory / disciplinary bodies.

As well, the NIHB supports activities promoting the appropriate use of prescription drugs by continuing to work with prescriber and provider associations and colleges and with provincial and territorial governments. These activities include informing prescribers, providers and other stakeholders of drug utilization concerns.

RECOMMENDATION 21

That Health Canada develop a policy to guide its response in cases where it is unable to obtain the consent of recipients of Non-Insured Health Benefits to share information on use of pharmaceuticals with health care professionals and make that policy known prior to the implementation of a client consent arrangement under the Non-Insured Health Benefits Program.

Response:

Health Canada - FNIH Branch has a policy for client consent. In 2002-2003, the NIHB program will be conducting a national campaign to gather general consent. The campaign will outline the purpose of consent, the options for giving consent and how the information will be used, collected and disclosed.

If the recipient does not sign the general consent form, covering all benefit areas in conjunction with the consent campaign (2002-2003), the recipient can complete an NIHB program reimbursement form for the processing of a single claim or multiple transactions. The NIHB reimbursement form includes authorization for the NIHB program to review the client's personal medical information. Original receipts and other supporting documents must be attached to the reimbursement form.

In all cases, the Program will review the submitted documents, update client history, and reimburse the client if the request meets NIHB policies and benefits. The reimbursement process will permit the Program to use the claim information for management purposes and allow the sharing of information with health professionals when warranted.

Without consent, the claims administrator for the NIHB Program will not be able to receive claims for processing and reimbursement.

RECOMMENDATION 22

That Health Canada review the option of obtaining specific enabling legislation for the Non-Insured Health Benefits Program that would, among other things, permit sharing information about client drug prescription patterns among health care professionals, and report the conclusions of that review to the Committee by 31 March 2002.

Response:

The establishment of legislation was reviewed carefully as a mechanism to address the legal requirement for consent. However, it was not clear that legislation would preclude the need for client consent. A legislative approach would also be perceived by First Nations and Inuit as circumventing the opportunity to inform NIHB clients about how their personal information would be used. As well, the time required to put such legislation in place would be considerable.

RECOMMENDATION 25

That Health Canada explore ways of facilitating the sharing of information between individual pharmacists and physicians providing services under the Non-Insured Health Benefits Program and report its conclusions to the Committee by 31 March 2002.

Response:

The NIHB Program is unable to share client specific information with pharmacists and physicians until the recipient has provided consent. Following the client consent campaign, full DUR activities will be resumed in 2003-2004 which will facilitate information sharing among pharmacists and physicians. Health Canada will report on DUR activities in the 2003-2004 electronic annex to the Departmental Performance Report.

In the meantime, the NIHB Program continues to work with prescriber and provider associations/colleges and provincial/territorial governments in activities to support the appropriate use of prescription drugs. These activities inform prescribers, providers and other stakeholders of drug utilization concerns.

RECOMMENDATION 26

That Health Canada ask the government to amend the *Privacy Act* if necessary in order to clarify that health care providers can share the personal medical information of individuals among other health care providers.

Response:

The Government does not intend, at this time, to amend the *Privacy Act* with respect to sharing of personal medical information. Sharing of information involves the retrieval, analysis and potential release of specific recipient benefit utilization data. These data contain information regarding recipients, prescribers, and providers, which is personal and sensitive in nature.

Personal information under government control is subject to the right of privacy. This right of privacy is protected under the *Privacy Act*. This legislation outlines the manner in which the federal government may use, collect and disclose personal information. The right to privacy is a fundamental civil liberty which is guaranteed under the *Charter of Rights and Freedoms.* Section 8 of the *Charter* protects from intrusion on the reasonable expectation of an individual's right to privacy. Section 8 applies to all Government activity regardless of whether it is exercising a criminal or civil power. A change to the *Privacy Act* will not change the recipients' right to privacy under the *Charter*.

Canada's *Personal Information Protection and Electronic Documents Act (PIPEDA)* also impacts the NIHB program, as it extends to the use, collection and disclosure, use, or disclosure of personal information in the course of any commercial activity, including pharmacists' activities. For the NIHB program, this commercial activity involves the transmission of personal information to the program for the purposes of claims adjudication, payment, and program management. While there are *Privacy Act* considerations, there are also *PIPEDA* implications and constraints regarding the sharing of information with the NIHB Program.

Reporting to Parliament on Progress

Health Canada acknowledges the importance of regularly informing Parliament of the progress it is making in addressing concerns raised in reports from the Auditor General and the Standing Committee on Public Accounts. As a general principle, the Department strongly supports the use of Reports on Plans and Priorities and Departmental Performance Reports as planning and reporting documents, as management tools for departments, and as a means of fostering greater transparency in government.

Therefore, Health Canada will provide an overview of progress in its annual Departmental Performance Report (DPR). In addition, the Department will include an annex to the Departmental Performance Report, beginning with the report for fiscal year 2001-2002, on progress made towards Auditor General and Public Accounts Committee recommendations. The annex will be web-based, and electronically linked to Departmental annual reports. The continuing need for this additional reporting will be reviewed with the Auditor General after three years.

The timing of the Standing Committee on Public Accounts report did not permit Health Canada - FNIH Branch to respond to all of the Committee`s reporting-related recommendations in its Report on Plans and Priorities for fiscal year 2002-2003. However, some items were included, for example, the identification of evaluations for community health programs planned for the 2002-2003 fiscal year.

RECOMMENDATION 1

That Health Canada inform Parliament of the progress it is making in implementing the recommendations contained in chapter 13 of the 1997 Report and chapter 15 of the 2000 Report of the Auditor General of Canada and in the Committee's 5th Report (36th Parliament, 1st Session) and also this report. This information must make specific reference to progress in implementing each recommendation and be provided annually in Health Canada's performance reports, beginning with the report for the period ending 31 March 2002.

Response:

Clear and accessible reporting permits Canadians, Parliamentarians, First Nations and Inuit communities and other stakeholders the opportunity, not only to develop a stronger understanding of the activities of departments and branches, but serves as a focal point for discussion regarding outstanding issues. Effective reporting also permits stakeholders to communicate their views and concerns regarding the conduct of programs and activities.

Health Canada agrees that specific reporting with respect to First Nations and Inuit health needs to be improved. Health Canada acknowledges that, while overall progress has been made, other improvements on reporting must be implemented.

In order to achieve consistency in reporting, Parliament, through Treasury Board, sets out reporting guidelines for Reports on Plans and Priorities and Departmental Performance Reports applicable for all departments. Respecting these guidelines, Health Canada will provide an overview of the response to the Standing Committee on Public Accounts in the main text of the Departmental reporting documents. Health Canada will include an Annex to the Departmental Performance Report on progress made towards Auditor General and Public Accounts Committee recommendations. While the first annex will be prepared for 2001-2002, full reporting will not begin until 2002-2003. This reporting medium will be web-based and electronically linked to departmental annual reports. Paper copies will be available upon request. The ongoing need for this special reporting requirement will be reassessed with the Auditor General, in three years,

after her next audit on First Nations and Inuit health programs.

This response also applies to the reporting requirements identified in Recommendations 5, 9, 11, 15, 16, 19, 23 and 24.

RECOMMENDATION 5

That Health Canada include, in its annual performance report to Parliament, a discussion of the status of the accountability framework for community health programs including the status of reporting requirements that addresses timeliness, completeness, and accuracy. This discussion should also describe actions taken by the Department to correct deficiencies in reporting and in service delivery and should start with the performance report for the period ending 31 March 2002.

Response:

Health Canada, in the Annex to the Departmental Performance Report, will provide information on the status of implementation of the accountability framework for CHP. This annex will include the status of reporting requirements that address time-lines, completeness and accuracy. As the accountability framework is implemented in 2002-2003, actions taken by Health Canada to correct deficiencies will be reported in the 2002-2003 electronic annex to the Departmental Performance Report.

RECOMMENDATION 9

That Health Canada start specifying the human, financial, and technological resources that it devotes to building the capacity of First Nations and Inuit communities, both at the departmental and community levels, commencing with its report on plans and priorities for fiscal year 2002-2003.

Response:

Health Canada will report, in the Annex to its Departmental Performance Reports, on resources devoted to capacity development efforts for First Nations and Inuit communities.

In the 2002-2003 Report on Plans and Priorities, the Department identified the following Planned Activity - “By 2004, increase capacity development for First Nations and Inuit partners focussing on reporting and financial controls, performance management, and complaints and allegations management” (Page 59). Furthermore, FNIHB in June 2001, created a new Directorate (Business Planning and Management Directorate) which includes the mandate to build internal and external capacity and improve reporting.

(Note: Information on resources devoted to capacity development is included in the response to recommendations 6, 7 and 8).

RECOMMENDATION 11

That Health Canada report the results of its capacity-building efforts in its annual performance report, beginning with the report for the period ending 31 March 2002.

Response:

Health Canada concurs that assessing the results of capacity building efforts would be valuable. Health Canada will conduct a review of its capacity development activities. This review will be undertaken to determine how services and support provided by Health Canada contribute to First Nations capacity.

Results from the capacity building review will be included in the Annex to the Departmental Performance Report for fiscal year 2002-2003.

RECOMMENDATION 15

That Health Canada include the evaluation plans for community health programs and the Non-Insured Health Benefits program in its Report on Plans and Priorities, beginning with the report for fiscal year 2002-2003.

Response:

Health Canada identified three evaluations planned for community health programs in its 2002-2003 Report on Plans and Priorities (listed on page 58).

No evaluations were planned for the NIHB program for 2002-2003. In 2001-2002, three external evaluations were conducted for drug, dental and pilot project components.

A multi-year comprehensive evaluation plan for First Nations and Inuit Health programs will be developed in the context of the work required for the renewal of Treasury Board authorities which must be completed by April 2005. This information will be included in the Report on Plans and Priorities for 2003-2004.

RECOMMENDATION 16

That Health Canada list all completed evaluation reports for community health programs and the Non-Insured Health Benefits program in its annual performance reports commencing with the Report for the period ending 31 March 2002.

Response:

Health Canada will list all completed evaluation reports for health programs in its annual performance reports commencing with the report for the period ending March 31, 2002.

RECOMMENDATION 19

That Health Canada include a discussion of its analysis of pharmacists' overrides along with subsequent action taken in response to that analysis in its performance reports beginning with the report for the period ending 31 March 2002.

Response:

Health Canada agrees to report on the analysis of pharmacists' overrides and action taken in the annual annex to the Departmental Performance Report, beginning with the period ending March 31, 2002. Pharmacists' overrides are further discussed in the response to Recommendation 18.

RECOMMENDATION 23

That Health Canada include, in its report on plans and priorities for 2002 -2003, a detailed description of the project it is testing with the College of Physicians and Surgeons of Saskatchewan to facilitate the sharing of information between pharmacists and the College under the Non-Insured Health Benefits Program. This description should include: a discussion of the nature of the information being shared; time lines for project implementation; and the human, financial, and technological resources devoted by the Department to this project.

Response:

The requested information will appear in the Annex to the Departmental Performance Report for the period ending March 31, 2002, and subsequent Departmental Performance Reports as appropriate.

As Health Canada has completed these steps during Fiscal Year 2001-2002, this information could not be included in the 2002-2003 Report on Plans and Priorities. (Please refer to recommendation 24 below)

RECOMMENDATION 24

That Health Canada discuss the progress of the project being tested with the College of Physicians and Surgeons of Saskatchewan, including the outcomes achieved, in its performance report for the period ending 31 March 2002.

Response:

Health Canada will include, in its Annex to the Departmental Performance Report for the period ending March 31, 2002, the progress of the project being tested with the College of Physicians and Surgeons of Saskatchewan including the outcomes achieved.