Chapter 15

Health Canada

First Nations Health: Follow-up

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Health Canada

First Nations Health: Follow-up

Main Points

15.1 Health Canada has initiated action to address our observations and recommendations on First Nations Health (1997 Report, Chapter 13). However, we are concerned that the Department has not yet made sufficient progress to fix many of the problems we identified. Continued and sustained effort is required to ensure that all the recommendations are fully implemented.

15.2 We found that:

- the point-of-service system, a key mechanism in the administration of pharmacy benefits and the control of prescription drug use, is now fully operational. It provides drug utilization warning messages to assist pharmacists in deciding whether to dispense prescriptions. As a result, a number of prescriptions have not been filled; and
- a pre-determination process for dental benefits, implemented nationally since 1997, has resulted in substantial savings.

15.3 However, we observed that:

- the management of contribution agreements for the delivery of community health programs is still weak;
- the management of transfer agreements still needs improvement; and
- Health Canada has not adequately monitored the drug utilization warning messages that pharmacists have overridden. Nor has it undertaken sufficient analysis of the effectiveness of the messages to determine whether any adjustments are warranted.

Background and other observations

15.4 Health Canada delivers health services and other related services to over 600 First Nations communities. It delivers them mainly through community health programs (including those transferred to community control) and the Non-Insured Health Benefits program, which covers such benefits as prescription drugs, dental care, medical transportation, and other benefits. Together, these services represented spending of just over $1.0 billion in 1998–99.

15.5 Our 1997 audit found that Non-Insured Health Benefits program expenditures were not well managed and, in most areas, not properly controlled. In particular, significant weaknesses in the management of pharmacy benefits allowed clients to access extremely high levels of prescription drugs. We noted numerous reports of prescription drug addiction and prescription-drug-related deaths of First Nations individuals in several provinces. We also found weaknesses in the management of contribution agreements for the delivery of community health programs as well as in the management of transfer agreements.

15.6 Our follow-up found that the Department has made limited progress in ensuring that reports required under separate contribution agreements are provided. We also found that the Department's performance reports contain limited information on the status of community health programs, including outcomes achieved.

15.7 With respect to transfer agreements, we found that community health plans are still not being updated when agreements are renewed, and requirements for audits, annual reports and evaluations often are not met.

15.8 The Department developed and implemented a protocol for following up with clients, physicians, pharmacists and professional bodies on cases that suggest possible prescription drug misuse. This has had some positive impact, with some regions starting to show a decline in the number of cases of individuals accessing large amounts of prescription drugs. However, as management was unsure of the appropriateness of the approach in the absence of either client consent or specific statutory authority for the Non-Insured Health Benefits program, this intervention was stopped in May 1999. There are still cases of program clients accessing large amounts of prescription drugs, and these require follow-up.

15.9 The Department was slow to develop and incorporate an audit strategy based on an appropriate assessment of risks in its new pharmacy and dental claims-processing contract. It also failed to ensure that the contractor perform the on-site audits of pharmacies and dental providers that the contract requires. We found few such audits undertaken since December 1998 to provide assurance that expenditures claimed had been incurred for the intended purposes.

15.10 Progress to improve efficiencies in administering medical transportation benefits has been limited.

Health Canada's responses to our recommendations are included in this chapter. The Department is continuing with corrective action in response to our 1997 recommendations and has agreed to take action in response to our two new recommendations.

Introduction

15.11 In 1997 we examined the way Health Canada managed the health programs it delivered to First Nations and Inuit people. This chapter follows up on the Department's progress in correcting the weaknesses we had identified.

15.12 There are significant differences in health status between the First Nations population and the Canadian population overall. *Toward a Healthy Future: Second Report on the Health of Canadians*, published in 1999 by the Federal, Provincial and Territorial Advisory Committee on Population Health, notes that the First Nations population compares poorly with that of the Canadian population along several indicators (see Exhibit 15.1). The *Report of the Royal Commission on Aboriginal Peoples* observed that health problems are many, serious and persistent, and that whatever diseases and problems are plaguing Canadians generally are likely to be more serious among Aboriginal people. The Canadian Institute for Health Information notes in *Health Care in Canada 2000: A First Annual Report* that Aboriginal people have life expectancies significantly shorter than those of the total Canadian population. It states that this large difference probably reflects the fact that the Aboriginal population is disproportionately more likely to be unemployed, less educated, poorly housed and living in poverty.

15.13 At March 1999, there were approximately 672,000 status (or registered) Indians and recognized Inuit in Canada. This represents about two percent of the Canadian population. The First Nations population is growing by three percent annually — more than double the growth rate in the general population. This population growth is exerting significant pressure on the present infrastructure for delivering services. Other pressures on the delivery of health services to First Nations include rising drug costs, high incidence among First Nations of some chronic diseases such as diabetes and cardiovascular diseases, a shortage of nurses, and provincial health care reforms.

Delivery of health services to First Nations still presents considerable challenges

15.14 A number of governments deliver health services to the First Nations population — provincial and territorial governments, the federal government through Health Canada, and First Nations local governments. Some provinces have included First Nations in programs beyond the provision of basic health services, while others have not. As we reported in 1997, the federal government maintains that it provides health services to status Indians and recognized Inuit as a matter of policy and not under treaty or other legal obligations. However, most First Nations generally consider that all necessary health services must be provided to them under Aboriginal and treaty rights and, as such, represent a fiduciary obligation owed to them by the Crown.

15.15 Health Canada's First Nations and Inuit Health Branch (formerly Medical Services Branch) delivers health services to over 600 First Nations communities. The Branch has a staff

Exhibit 15.1

Selected Indicators of First Nations Health Status

- The infant mortality rate is twice as high among First Nations people as in the Canadian population as a whole.
- The life expectancy of the status Indian population is seven years less than that of the overall Canadian population.
- Suicide rates among Aboriginal groups have been reported at two to seven times higher than in the population at large.
- The prevalence of all self-reported major chronic disease is significantly higher in Aboriginal communities than in the general population, and it appears to be increasing.

Source: Toward a Healthy Future: Second Report on the Health of Canadians, 1999.

complement of just under 1,400 full-time equivalents, headed by an assistant deputy minister. There are three main directorates at headquarters in Ottawa (First Nations and Inuit Health Programs; Program Policy, Transfer Secretariat and Planning; and Non-Insured Health Benefits) and seven regional offices (Atlantic, Quebec, Ontario, Manitoba, Saskatchewan, Alberta and Pacific).

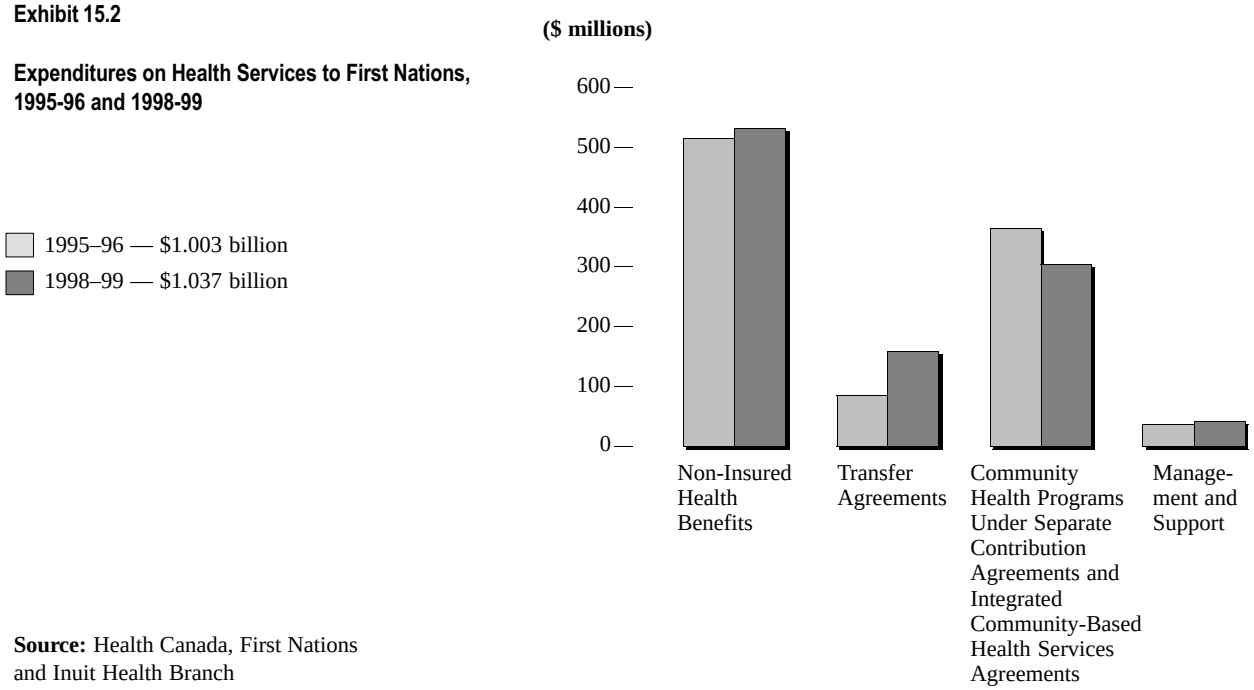
15.16 The Branch vision statement says that First Nations and Inuit people will have autonomy and control of their health programs and resources within a time frame to be determined in consultation with First Nations and Inuit people. The Branch objective is to assist First Nations and Inuit communities in addressing health inequalities and disease threats and attaining a level of health comparable with that of other Canadians living in similar locations, and to ensure the availability of, or access to, health services. The health services are provided mainly through community health programs (including those transferred to community control) and the Non-Insured Health Benefits program, which covers the costs of prescription drugs, dental care, medical transportation and other benefits. Total spending on these services was just over $1.0 billion in 1998–99 (Exhibit 15.2).

15.17 Community health programs delivered through separate contribution agreements and through transfer agreements. Community health programs comprise programs and activities related to public health, health education and promotion, as well as strategies to address specific health problems such as alcohol and drug abuse.

15.18 The mechanisms for delivery of community health programs have changed over time. Initially, these programs were delivered directly by the Department. Most programs are now delivered through arrangements in partnership with First Nations organizations. The Department uses three basic types of agreements that give First Nations varying degrees of flexibility, control and responsibility to design programs. In order of increasing flexibility, these are separate contribution agreements, integrated community-based

Exhibit 15.2

Expenditures on Health Services to First Nations, 1995-96 and 1998-99



Source: Health Canada, First Nations and Inuit Health Branch

health services agreements and transfer agreements.

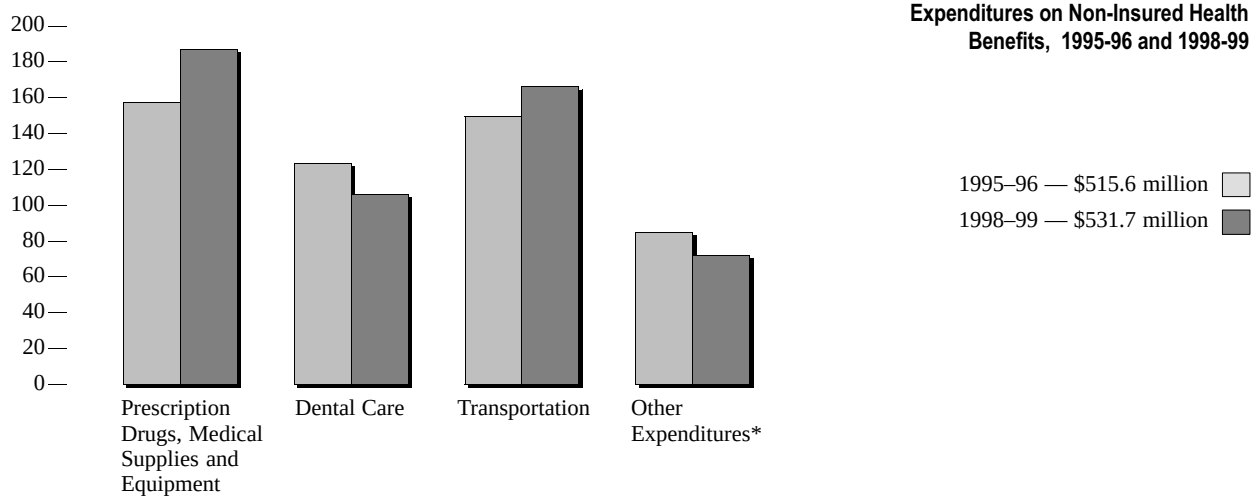
15.19 More and more First Nations are managing their own health programs under transfer agreements. The current trend in Health Canada is to continue this devolution and to move out of direct delivery of health services. In March 1997 about 27 percent of First Nations had signed a transfer agreement; by October 1999 this had risen to 44 percent of First Nations. The percentage of First Nations with contribution agreements showed a corresponding decrease — from 60 percent to 37 percent. There were integrated agreements with 13 percent of First Nations in 1997, and with 19 percent in 1999. In 1998–99, spending on community health programs through agreements totalled about $464 million (Exhibit 15.2).

15.20 Non-insured health benefits. The Non-Insured Health Benefits program covers a number of health-related benefits and services such as pharmacy, dental, medical transportation and other benefits. The purpose of the program is "to provide non-insured health benefits to First Nations and Inuit people in a manner that is appropriate to their unique health needs; contributes to the achievement of an overall health status for First Nations and Inuit people that is comparable with that of the Canadian population as a whole; is sustainable from a fiscal and benefit management perspective; and facilitates First Nations and Inuit control at a time and pace of their choosing." In 1998–99, Non-Insured Health Benefits expenditures totalled almost $532 million (see Exhibit 15.3).

15.21 In keeping with the federal government's commitment to a new relationship with First Nations and Inuit, the Department has embarked on a partnership approach with First Nations and Inuit in decision making on new program initiatives, funding, and program changes. The Department believes that this approach helps to enhance capacity among the First Nations and Inuit participants and helps ensure that their positions are reflected in the final decisions.

Exhibit 15.3

Expenditures on Non-Insured Health Benefits, 1995-96 and 1998-99



* These include health premiums, vision benefits, other health care, and management and support.

Source: Health Canada, First Nations and Inuit Health Branch

In 1997 we made 12 recommendations; the Department agreed with them and committed to taking corrective action.

Departmental commitment to improve

15.22 In 1997 we identified weaknesses in the management of community health programs delivered through separate contribution agreements, the transfer of health programs to community control, and non-insured health benefits. We made 12 recommendations; the Department agreed with them and committed to taking corrective action.

15.23 The Standing Committee on Public Accounts held a hearing in late 1997 to discuss our audit. The Committee stated that it was anxious that the Department fulfil its commitment to take timely and complete corrective action and that the changes result in better management of health services and improved health for First Nations. The Committee made 10 recommendations in its Fifth Report, tabled in February 1998. In its July 1998 response to the Committee, Health Canada indicated that it was committed to continuous improvement in the effectiveness and efficiency of health programs for First Nations and Inuit. It provided an updated action plan in response to the Committee's recommendations.

The lack of timely and complete implementation of corrective action has serious implications for the delivery of health services to First Nations.

Focus of the follow-up

15.24 The follow-up focussed on our 1997 recommendations and on those made subsequently by the Public Accounts Committee. We looked at the Department's commitments and its actions taken in response to our 1997 audit, including the progress it reported to the Public Accounts Committee and the updated status report it provided to us in 1999. We also looked at several new initiatives that are being delivered using funding mechanisms similar to those of other community health programs. Further details on the follow-up are found in **About the Follow-up** at the end of this chapter.

Observations and Recommendations

Health Canada has not made sufficient progress to correct deficiencies

15.25 The Department has initiated action to respond to our observations and recommendations. However, we are concerned that the Department has not yet made sufficient progress to fix many of the problems we identified in 1997. The lack of timely and complete implementation of corrective action has serious implications for the delivery of health services to First Nations. Our overall assessment of progress made by the Department is summarized in the Appendix.

Community Health Programs Delivered Through Separate Contribution Agreements

15.26 In 1997 we found that the Department's management of separate contribution agreements was weak. The required reports on community health programs were not being produced and the Department was doing little follow-up with First Nations to build capacity. We recommended that it review the structure of community health programs, clarify program objectives, ensure that it received the required reports, and work with First Nations to improve their reporting to include information on results achieved. The Public Accounts Committee recommended that the Department monitor community health programs in accordance with departmental policies, supported by thorough evaluation of risk and targeted accordingly. The Committee also recommended that in its annual departmental performance reports Health Canada provide information on the status of community health programs, including information on its monitoring activities and on health outcomes achieved. The

Department agreed with the recommendations.

15.27 The Department committed to take steps to reduce program overlap. It indicated that it would develop guidelines to ensure that agreements have clearly defined objectives and activities to be undertaken. It stated that it would ensure that it received annual reports and would review all reports to identify any corrective action necessary. It also stated that it would implement new mechanisms, such as the automated contribution system, to improve the monitoring of activity reporting.

Continuous and sustained effort is required to fully implement our recommendations

15.28 Overlapping of programs. Health Canada has made changes to its Planning, Reporting and Accountability Structure, but the authorities for programs delivered under contribution agreements are unchanged. Our follow-up review of documentation for 35 contribution agreements found that there is still some overlap between program objectives. The Department has initiated a project that will identify specific objectives for each program, and it believes this will alleviate the overlap of program objectives. Objectives will be refined and the manner in which programs are delivered will change, as core objectives and programs are redefined. This project has the potential to reduce overlap of program objectives. However, at the time of our audit this work had not been completed and overlap continued to exist. The Branch will need to ensure that once the project is completed, these new objectives are reflected in contribution agreements.

15.29 Health Canada should ensure that its program structure reflects the manner in which community health programs are actually delivered.

Department's response: *Agreed. The program structure was changed to better reflect how programs are delivered. It provides the flexibility for reallocation of program dollars to other health areas of greater need. Work will continue to refine and further define the core (mandatory) and the discretionary programs under the program structure and program transfer initiative in order to facilitate a clearer understanding of the program structure. This is being done in partnership with First Nations and Inuit.*

15.30 Clear objectives and activities. Our follow-up found that the Department has been working with some First Nations to encourage them to clearly define program objectives and measures of success, with departmental staff working directly with these First Nations on specific programs. Our review of 35 contribution agreements, however, found that in over half of the cases, programs still do not include clear objectives and activities specific to the community (Exhibit 15.4). In many cases, contribution agreements gave no indication of how the community would know whether the activities were successful. As well, the Department has not yet developed formal guidelines to assist First Nations in ensuring that agreements include clear objectives.

15.31 Health Canada should continue to work with First Nations to ensure that the contribution agreements are clear about specific objectives and activities that First Nations will undertake. It should continue its efforts to encourage First Nations to define measures of success.

Department's response: *Agreed. The Department is developing a program compendium that will identify, for each program area, the objectives, program reporting requirements and program indicators. Once finalized, the compendium will form the basis for objectives and activities of contribution agreements. This work is being done in partnership with First Nations and Inuit.*

We found some encouraging improvement in the provision of activity reports required under contribution agreements.

15.32 Activity reports. We found some encouraging improvement in the provision of activity reports required under contribution agreements (Exhibit 15.4). In 1997 we found in a sample of contribution agreements we examined that the Department had received 33 percent of the required activity reports. Our follow-up review of 35 contribution agreements found that the Department now has 51 percent of required activity reports. However, this improvement is largely due to improved reporting on the Brighter Futures program — activity reports were provided for 71 percent of agreements, up from 32 percent in 1997. There is still some distance to go before all the required activity reports are completed for all programs. The success we noted in the Brighter Futures program needs to be carried over to other programs. We also noted that Health Canada has worked with some First Nations to ensure that activity reports provide information on results, but mostly the reports are still lists of activities undertaken. More Branch support is needed to build First Nations' capacity to meet their reporting requirements under these agreements. In addition, the Branch recognizes the need for systematic follow-up to ensure that the agreements are monitored.

15.33 Health Canada should ensure that it receives all the activity reports required under contribution agreements. It should work closely with First Nations to improve the activity reports so that they provide information on results achieved.

***Department's response**: Agreed. The Department is actively working with First Nations to develop and implement tools to improve program reporting and completion rates. At the same time, the Department will continue to work with First Nations to find ways of developing the capacity to ensure that all communities are able to use the reporting tools and the data being reported and are capable of analyzing the impact of activities on community health programs. Monitoring and follow–up requirements will be incorporated in the planned automation of the national contribution system to regulate the receipt of activity reports.*

Exhibit 15.4

Assessment of Contribution Agreements

Program	Agreements with clear objectives and activities for the specific community		Agreements with activity reports	
	1997 Audit	2000 Follow-up	1997 Audit	2000 Follow-up
Community Health Representatives	15%	28%	39%	41%
National Native Alcohol and Drug Abuse Program	19%	28%	32%	44%
Brighter Futures	59%	61%	32%	71%
Building Healthy Communities	59%	50%	27%	48%
For all programs	38%	42%	33%	51%

Note: 1997 observations based on analysis of contribution agreements from 40 communities; 2000 observations based on analysis of contribution agreements from 35 communities.

Management of contribution agreements is still weak

15.34 We expected that the Department would have taken steps to improve its management of contribution agreements. Our follow-up found that the Department's monitoring of reporting requirements remains weak. The proposed automated contribution system, which the Department had indicated would improve its monitoring of reporting requirements by tracking whether reports were provided, is operational in only two regions. The Department recognizes that it must give more attention to providing support to help First Nations improve their capacity to meet reporting requirements under contribution agreements.

15.35 The Department's internal audits of contributions have confirmed the need for improved reporting. In some cases, these audits have also observed the need to ensure that program policies and objectives are respected and that expenditures meet program terms and conditions.

15.36 There are indications that the Department has become more proactive in monitoring contribution agreements. For example, in two instances it stopped payments until it received the required reports. One region has improved its tracking of the reports required from each First Nation. However, not all regions have taken these actions.

15.37 Performance information on community health programs. Apart from a 1998 evaluation of the National Native Alcohol and Drug Abuse Program, a 1999 review of the Tuberculosis program, and a 1999 evaluation of the Indian and Inuit Health Careers Program, there is little information at the national level on the results of individual community-based programs. It is still difficult to attribute results to specific community health programs. Health Canada's recent departmental performance reports to Parliament have provided limited information on the status of community health programs, including outcomes achieved.

Transfer of Health Programs to Community Control

Management of the transfer initiative needs improvement

15.38 In 1997 we found that the Department had developed a sound transfer framework but had not fully implemented it, leaving some gaps and deficiencies. We recommended that it ensure that First Nations meet the requirements for audits, annual reports and evaluations under transfer agreements and that updated community health plans meet the basic requirements and form the basis of both initial and renewed transfer agreements. We also recommended that the Department ensure that future evaluations of the transfer initiative determine the extent to which it has contributed to improving the health of First Nations. As well, the Public Accounts Committee recommended that Health Canada monitor the transfer of the delivery of community health programs to First Nations communities and work with the communities to ensure that they meet the conditions set out in the accountability framework. The Committee also recommended that the Department ensure that the audit and evaluation requirements of all transfer agreements are satisfied. The Department agreed with all of the recommendations.

15.39 In response to our recommendations, the Department updated its transfer handbook, including the requirements for community health plans. It revised the reporting and auditing guidelines to clarify the comprehensive audit requirements specified under transfer agreements. It also revised the requirement for evaluations, which now are to be completed in the fourth year of a five-year agreement to facilitate review and implementation of new strategies as required. This evaluation is intended to

The Department recognizes that it must give more attention to providing support to help First Nations improve their capacity to meet reporting requirements under contribution agreements.

serve as the basis for negotiating the renewal of the transfer agreement. The Department is now developing a new accountability framework that it considers will be appropriate as more First Nations take greater control of their health programs through transfer agreements and self-government. The Department stated that a phased implementation of the framework will commence in 2001–02, once it has obtained input from First Nations and completed consultation with them.

15.40 Updated community health plans. In 1997 we observed that about three quarters of renewed transfer agreements we reviewed were based not on updated community health plans but on plans developed at the beginning of the transfer process, more than five years earlier. Our follow-up found that the situation remains the same. We reviewed a sample of 13 agreements that had been renewed for a subsequent term in the period since our 1997 Report. Our analysis identified nine of them (69 percent) that were signed without an updated community health plan.

15.41 Health Canada should work more closely with First Nations to ensure that updated community health plans that meet the basic requirements are prepared, and that they form the basis of both initial and renewed transfer agreements.

Department's response: *Agreed. The Department will establish a more timely and rigorous process to ensure that community health plans are updated as the health priorities of First Nations communities change and, as a minimum, the community health plans will be updated prior to the renewal of transfer agreements.*

15.42 Audits. In 1997 we found that the Department had received an annual audit report on most agreements but that very few of these covered all the aspects required by the Department's comprehensive audit guidelines. The Department subsequently revised the guidelines to clarify the nature and scope of comprehensive audit requirements. Our follow-up found that most First Nations (70 percent) had provided an audit report for 1998–99. However, these reports provided conclusions only on the fairness of the financial statements and not on non-financial commitments, such as compliance with the terms and conditions of the agreement as the guidelines require.

15.43 Health Canada should ensure that the audit requirements under transfer agreements are met.

Department's response: *Agreed. Audit requirements have been clarified. The Department will establish a rigorous monitoring and follow–up process to ensure that the appropriate audit reports are received on a timely basis.*

15.44 Annual reports. In 1997, we reported that while most First Nations prepared annual reports, the Department needed to work with First Nations under transfer agreements to improve the measurement of services provided and of changes to health. Our follow-up found no notable improvement: just under two thirds of the files we reviewed contained an annual report for fiscal year 1998–99. Moreover, the reports were mostly lists of activities undertaken and often did not include performance information.

15.45 Health Canada should continue to work with First Nations to improve the measurement of the services provided and of expected changes to health. These measures should be included in the annual reports and the Department should ensure that these reports are provided.

Department's response: *Agreed. The Department continues to work on the development of measurements and outcomes as part of a new accountability framework. However, it is difficult to establish a direct correlation between services provided and changes expected in health status, because health services are*

just one determinant of health status. Nonetheless, health indicators are being developed and they will be incorporated into appropriate reports as part of the reporting required of communities. The full impact of these improvements will not be known for at least five years, given the length of the evaluation period. The framework is currently being completed in partnership with the Assembly of First Nations (AFN) and the Inuit Tapirisat of Canada (ITC) to help ensure its successful implementation over two fiscal years.

15.46 Evaluations. The Department agreed with our recommendation that future evaluations of the transfer initiative determine the extent to which the initiative has contributed to improving the health of First Nations. It stated that recent improvements in both methodology and technology would assist it in working with First Nations to produce useful and meaningful measurements. The Public Accounts Committee had asked whether a future national evaluation of the transfer initiative was a possibility and whether an evaluation framework had been established. The Department indicated that in its view, more emphasis on community-based evaluations would lead to better health information to determine whether health status had improved. It added that the national perspective on improvement in health status would be derived from an aggregation of community-based evaluations from across the country.

15.47 Only two of four transfer agreements we reviewed in 1997 had been evaluated as required by the transfer agreements. In our follow-up we reviewed the documentation for 14 transfer agreements renewed since 1997. Six were renewed without having the evaluations completed, contrary to the Department's framework.

15.48 The eight evaluations that had been completed varied in quality. They were often hampered by a lack of clear objectives for health programs and, more important, by limited availability of data on which to base an analysis.

15.49 As well, the Department faces challenges in ensuring the timely completion of evaluation plans required of First Nations under transfer. The framework requires that First Nations submit evaluation plans by the end of the first year of the transfer agreement. We found that just over one third of the agreements we reviewed included evaluation plans, and sometimes they had been submitted later than one year into the five-year agreement. It is important that these evaluation plans be completed early on to ensure that adequate data are routinely collected during the course of the agreement.

15.50 Health Canada should ensure that First Nations conduct the required evaluations of the achievement of program objectives and that future evaluations will determine the extent to which the transfer initiative contributes to improving the health of First Nations.

Department's response: *Agreed. The Department will establish a more timely and rigorous approach to ensure that community–based evaluations are completed by communities prior to the renewal of transfer agreements. Improvement in the health of First Nations is difficult to determine, given that First Nations' management of community-based health services, which is the goal of the transfer initiative, is not the only factor that contributes to the health of First Nations. The community–based evaluations will be analyzed and will form the basis of a national perspective on how the transfer initiative contributes to the health of First Nations.*

The Department has underestimated the support needed by First Nations

15.51 Over the past five years, the delivery of community health programs has seen a significant shift from contribution agreements to transfers to

Reporting requirements under transfer agreements are still not met.

community control. Changes in the Branch organizational structure have included staff reductions and zone closures. Although the Branch's budget has increased each year since 1992–93, the number of full-time-equivalent staff has generally decreased. In 1992–93 the Branch had 1,965 full-time-equivalent staff. By 1998–99 this had dropped to 1,263. Health Canada now recognizes that it may have underestimated the ongoing work required to support First Nations as they take on transfer agreements. The Department has been largely focussed on program delivery, and it recognizes that it could have been more diligent in ensuring that reporting requirements were met. It also realizes that it needs to devote more attention to ensuring that First Nations have the capacity and tools to manage and report on their programs and, in some cases, that it needs to sustain this attention over a significant period of time.

Non-Insured Health Benefits

Significant concerns remain about the management of non-insured health benefits

15.52 In 1997 we found that Non-Insured Health Benefits program expenditures were not well managed and, in most cases, not properly controlled. Program benefits were subject to abuse by clients and providers. Systems and controls, including verification of claims and audits of providers, were inadequate.

15.53 We also reported in 1997 that prescription drug misuse was not unique to First Nations. However, it had serious implications for First Nations health, particularly when the program was intended to improve it. We noted that there were numerous reports of prescription drug addiction and prescription-drug-related deaths of First Nations individuals in several provinces between 1986 and 1996, and that one region reported 42 prescription-drug-related deaths during 1986–88.

15.54 In addition, we observed in our 1997 chapter that by pharmacy and doctor "shopping", program clients could obtain extremely large amounts of prescription drugs over short periods of time, including mood-altering drugs. The Department was also concerned that some physicians might have been overprescribing mood-altering drugs to First Nations patients. We recommended that Health Canada ensure that the point-of-service system it was implementing for prescription drugs facilitate timely intervention when potentially inappropriate prescription drug use was identified. We also recommended that it provide a clear protocol to guide intervention and closely monitor pharmacists' overrides of warning messages. In cases where it identified a significant pattern of inappropriate use of prescription drugs, we recommended that the Department perform a more rigorous follow-up with clients, physicians, pharmacists and professional bodies. Finally, we recommended that it take appropriate steps to improve controls and edits in the claims-processing system and strengthen the verification of claims. Health Canada agreed with these recommendations.

15.55 Similarly, the Public Accounts Committee recommended that the Department monitor the use of overrides and step up its efforts to devise an incentive scheme for those pharmacists who do not fill prescriptions when warning messages are issued. It also recommended that Health Canada explore with various jurisdictions the possibility of having access-to-information and privacy legislation amended in order to allow its point-of-service system to provide more information on recent prescriptions. Health Canada also agreed with these recommendations.

The point-of-service system for prescription drugs is now fully operational

15.56 At the time of our 1997 audit, the Department was testing a point-of-service system — a key mechanism in the administration of pharmacy benefits and the control of prescription drug use. The system was to be fully implemented in the fall of 1997. However, the use of the point-of-service system was contingent upon pharmacies enrolling in the system, and the take-up was much slower than anticipated. The Department indicated that some pharmacy associations were reluctant at first to endorse the system. By May 1998, only 60 percent of the pharmacies that serve First Nations clients were on-line.

15.57 On 1 April 2000 the system became mandatory, and virtually all pharmacies serving Non-Insured Health Benefits clients are now connected to this system. The Department has reached agreements with three provincial pharmacy bodies on compensating pharmacists for professional services in cases where they have not filled a prescription for valid reasons. However, few pharmacists are taking advantage of this provision.

Inadequate monitoring of drug utilization warning messages

15.58 In 1997 we noted that the point-of-service system then being tested would provide the dates of the client's last three prescriptions. As the system would not provide a client's full drug profile or complete information on doctors visited at the time of dispensing, the Department stated that it intended to strengthen the drug utilization warning messages to pharmacists. We cautioned the Department that it would need to closely monitor pharmacists' overrides of drug utilization warning messages.

15.59 As implemented, the point-of-service system for prescription drugs is not designed to provide detailed information on previous prescriptions obtained or doctors visited. Nor does it provide the dates of the client's last three prescriptions. Drug utilization warning messages remain essentially the same as those proposed. When a pharmacist enters the details of a prescription into a computer, the system may generate any of three drug utilization warning messages (drug-to-drug interaction potential; duplicate drug; duplicate drug–other pharmacy) to which the pharmacist must respond — either to accept the message that the claim is rejected or to override the drug utilization warning message and dispense the prescription. The system may also generate two "soft" messages (duplicate therapy, and duplicate therapy–other pharmacy) that allow for automatic overrides by pharmacists.

15.60 In 1999, nearly seven million pharmacy claims were processed. Data provided by the claims-processing contractor show that the system had generated drug utilization warning messages on 297,693 claims, representing approximately 4.2 percent of all claims. The prescriptions were not filled in 183,914 (61.8 percent) of these cases, representing a total of approximately $5.3 million not claimed.

15.61 Drug utilization warning messages on the remaining 113,779 claims were overridden by pharmacists and the claims were therefore paid by the program — a total of about $3.0 million. The system requires the pharmacist to enter a code that signals the reason for overriding a drug utilization warning message. The reasons provided most often were that the pharmacist had consulted the prescribing physician and filled the prescription as written (42 percent); the client had given an adequate explanation and the prescription was filled as written (25 percent); the pharmacist had cautioned the client and filled the prescription as written (16 percent); and the pharmacist

had consulted another source and filled the prescription as written (11 percent).

We did not find sufficient analysis to indicate whether the drug utilization warning messages are effective.

15.62 However, the Department has not adequately monitored pharmacists' overrides of drug utilization warning messages. In fact, until early 2000 the claims-processing contractor had provided no information to the Branch on the frequency of either the drug utilization warning messages or the overrides. Since March 2000, the Branch has begun to analyze the data. However, we did not find sufficient analysis to indicate whether the drug utilization warning messages are effective, to identify which pharmacists are overriding the warning messages and whether their actions are appropriate, and to determine whether prescriptions rejected by some pharmacists have been filled by other pharmacists. Nor did we find sufficient analysis to indicate how clients with very large numbers of prescriptions are getting through the system and whether there are valid reasons for why this happens.

15.63 Clients are still accessing large amounts of prescription drugs. While the Department has implemented a point-of-service system and some new controls, some program clients are nonetheless still able to access extremely large quantities of prescription drugs. Based on the criteria used by some provincial bodies to monitor prescription drugs, we analyzed departmental data up to the end of the third quarter of 1999–2000. The data show some reduction in some regions in the number of clients going to three or more pharmacies and in the number of clients getting over 15 different drugs over a 90-day period. However, the number of clients getting at least 50 prescriptions filled within a 90-day period has increased in most regions. Overall, the numbers remain high (Exhibit 15.5).

Exhibit 15.5

Analysis of Access to Prescription Drugs by Non-Insured Health Benefits Clients

Region	Number of clients going to 3 or more pharmacies			Number of clients getting over 15 different drugs			Number of clients getting at least 50 prescriptions		
	1st quarter 1996	1st quarter 1999	3rd quarter 1999	1st quarter 1996	1st quarter 1999	3rd quarter 1999	1st quarter 1996	1st quarter 1999	3rd quarter 1999
Pacific	1,931	1,836	1,745	107	126	118	97	137	158
Alberta	5,354	4,693	4,522	867	527	500	387	234	259
Sask.	2,960	3,618	3,130	199	260	233	22	31	124
Manitoba	1,991	2,301	2,225	129	185	170	37	70	62
Ontario	1,728	1,743	1,600	121	145	121	63	97	124
Quebec	373	486	496	39	96	54	84	227	254
Atlantic	678	367	359	137	48	48	20	14	17
Total	**15,015**	**15,044**	**14,077**	**1,599**	**1,387**	**1,244**	**710**	**810**	**998**

Notes:

1. At March 1996 there were approximately 620,000 eligible clients and at March 1999 approximately 672,000.
2. The following criteria (for a 90–day period) are used by some provincial bodies to identify cases for review:
   - going to three or more pharmacies to get prescription drugs dispensed
   - obtaining more than 15 different prescription drugs
   - obtaining 50 or more prescriptions

Source: Health Canada

15.64 Health Canada should more closely monitor pharmacists' overrides of drug utilization warning messages and undertake rigorous analysis on an ongoing basis to assess the effectiveness of the messages.

Department's response: *Agreed. Delays were experienced in the start of the Non–Insured Health Benefits claims–processing contract. Delays in receiving reports from the contractor further held up the implementation of the strategy. The Department uses 19 indicators against which the pharmacists are profiled. As of March 2000, the Department uses this profile when monitoring pharmacists' overrides of drug utilization messages on a three–month retrospective basis. Additionally, the messages themselves will be subject to review and, as part of the strategy, will continue to be changed as required.*

Early success of direct intervention under the drug utilization protocol was not sustained

15.65 In 1997 we found that the Department was slow to intervene in cases of prescription drug misuse. It has since updated and implemented its drug utilization review protocol to better identify and follow up on cases that suggest prescription drug misuse. This intervention — involving following up with clients, physicians, pharmacists and professional bodies — has had some positive impact: in particular, evidence from the Alberta and Saskatchewan regions up to early 1999 shows a decline in the number of cases involving access to large amounts of central nervous system drugs.

15.66 Because management was unsure of the appropriateness of the approach in the absence of either client consent or specific statutory authority for the program, this intervention was stopped in May 1999. The Department issued a revised protocol that states that misuse of benefits will be identified primarily through the point-of-service system (and the drug utilization warning messages that the system generates). Evidence from some regions shows that the number of cases of access to large amounts of central nervous system drugs has started to increase again, and these cases require follow-up.

15.67 In our 1993 Report, we noted that the absence of specific enabling legislation for the Non-Insured Health Benefits program left a gap in the definition of purpose, expected results, and outcomes of program benefits. We recommended that the Department seek a renewed mandate from the government to clarify the program's authority base, purpose and objective. Our 1997 audit found that the renewed policy mandate defined the nature of the program, including its purpose and objective as well as the principles governing it. However, it did not address the need to clarify the authority base for the program. There is still no specific legislation recognizing non-insured health benefits.

15.68 Health Canada is currently considering options to deal with this situation. These include recommending legislation and regulations that would authorize it to use client information in the administration and management of the program, and pursuing positive or voluntary enrolment of clients (one-time signed consent to the use of their personal health information by the program). The option it will choose to pursue will be determined after discussions with First Nations.

15.69 In cases where it identifies a significant pattern of inappropriate use of prescription drugs, Health Canada should continue to perform a rigorous follow-up with Non-Insured Health Benefits clients, physicians, pharmacists and professional bodies. Health Canada should ensure that it has the means to implement this action.

Department's response: *Agreed. The Department will continue to monitor and profile pharmacists and physicians through its Drug Utilization Review (DUR) initiative. The Department is working with the First Nations on the issue of consent with respect to Drug Utilization Review. Once consent is obtained, Drug Utilization Review will be fully reinstated.*

15.70 As part of our current follow-up we asked for the most recent information the Department had available on prescription-drug-related deaths. It provided us with information from only one region, and, moreover, only to the end of 1997. We believe that the Department needs to collect this information systematically in all regions for use in assessing prescription drug misuse and addiction problems.

15.71 Health Canada should systematically gather data on prescription-drug-related deaths of First Nations individuals in all regions.

Department's response: *The data are collected by provincial/territorial bureaus of vital statistics and may or may not provide sufficient information related to First Nations and Inuit. The Department agrees to review provincial/territorial information to determine if this information is available and will explore the feasibility of integrating the available information into regional and national comparisons. The Department will continue to liaise with the provinces and territories with respect to prescription–drug–related deaths.*

Work on addressing multiple addiction problems is ongoing

15.72 In 1997 we recommended that the Department build on its existing strategies to address the combined problem of prescription drug abuse and solvent and alcohol abuse, and increase efforts in community health programs for prevention, community education and treatment of prescription drug addiction.

15.73 The Department recognized that multiple addiction is a long-term and complex problem. It has developed a national educational program on prescription drug use and misuse. Work is ongoing with National Native Alcohol and Drug Abuse Program treatment centres to define the complexities of the problem. Training in dealing with multiple addictions has been initiated for treatment centre staff. Continuing effort to integrate community health programs is needed to deal with multiple addictions.

15.74 Health Canada should continue to build on its existing strategies to address the combined problem of prescription drug abuse and solvent and alcohol abuse, and increase efforts in community health programs relating to prevention, community education, and treatment of prescription drug addiction.

Department's response: *Agreed. Work continues with First Nations and Inuit communities on the correct use of prescription drugs and the problems of prescription drug misuse. Two educational videos were produced and distributed to all First Nations and Inuit communities. As a result of the positive responses to the videos, additional prevention and promotion activities are under way. These include the development of tools to facilitate community–level discussions of prescription drug misuse, televised public service announcements that will be aired in late fall 2000 or early in 2001, and community drug profiles that will allow community health professionals to identify and address potential issues surrounding prescription drug use and misuse. In addition, the Department has targeted National Native Alcohol and Drug Abuse Program (NNADAP) Centres to deal specifically with issues of multiple or cross addiction, and it agrees to continue building on existing strategies and programs to ensure a consistent approach*

to the combined problem of prescription drug, solvent and alcohol abuse. The Department will ensure that prevention and promotion materials and community education address the combined problem.

Health Canada has been slow in developing an appropriate strategy for audit of providers

15.75 In 1997 we identified significant risks associated with the Non-Insured Health Benefits program. We found weaknesses in claims-processing controls and edits and stressed the need to strengthen verification of claims and audits of providers. In particular, we found that on-site audits of providers did not provide a reasonable degree of assurance that expenditures had been made for the intended purposes. The audit strategy was not based on an appropriate assessment of risks, and audits were targeted mainly at a small number of high-volume providers. In addition, we recommended that the Department clarify and enforce compliance with the contract requirement for audit of pharmacy and dental providers by the contractor. The Department agreed, stating that improvements had been made to the audit provisions of the new claims-processing contract.

15.76 The new claims processor's contract was signed on 16 October 1997, with claims-processing services commencing 1 December 1998. The signing of a new contract gave the Department an opportunity to specify requirements that would fill some of the deficiencies identified in our 1997 audit. However, our follow-up found that a number of those deficiencies have not yet been corrected.

15.77 The contractor proposed an overall audit approach that included applying criteria to profile pharmacies and dental providers for audit and conducting 60 on-site audits of both pharmacies and dental providers annually; and undertaking reviews of claims submissions — referred to as next-day on-line audits — that would meet specified criteria. In addition, the Department also considered dental predetermination (described in paragraphs 15.90 and 15.91) to be an important component in reducing risks related to dental benefits.

15.78 The Department advised the Public Accounts Committee, in a letter dated 12 February 1998, that audit provisions had been strengthened in the new claims-processing contract. On 30 April 1998, the Chair of the Committee asked for details about the new contract, including the number of provider audits that would be undertaken; how the audits would be conducted; what steps would be taken to ensure that providers comply with audit requirements; how conditions set forth in the new contract would provide assurance that expenditures are made for the intended purposes; and whether the audit strategy under the new contract would be based on an appropriate assessment of risks.

15.79 The Department responded in May 1998 that it had contracted with a national consulting firm to help develop a plan for improving audit capacity. This would include providing advice on a new audit strategy based on assessment of risks, audit coverage and how audits would be conducted. The firm completed its examination in November 1998. The examination identified significant gaps between what the new claims-processing contractor was contracted to deliver and what is required to adequately address issues facing the Non-Insured Health Benefits program.

15.80 The consulting firm concluded that because of limitations in the contract and the contractor's mandate, the overall level of audit activity mutually agreed upon by the contractor and the Department would not be sufficient to accomplish the Department's goals and objectives and to adequately address the issues raised by the Auditor General. The

firm stated that there is a significant gap between the depth of the audit coverage and the overall risk of the program, and that the contract does not promote increased levels of audit activity to minimize that risk.

15.81 In response to the consulting firm's recommendations, the Branch decided in October 1999 to establish a risk management team in the fourth quarter of 1999–2000. In the first quarter of 2000–01 the team would identify the risks to the program, and in the second quarter it would develop and implement risk controls.

Few of the required on-site audits of providers have been completed

There is a significant gap between the depth of the audit coverage and the overall risk of the program.

15.82 Approximately 7,000 pharmacies and 22,000 dental providers serve First Nations clients. The contractor is required to perform no fewer than 60 on-site audits of pharmacies and 60 on-site audits of dental providers annually. Even though the consulting firm concluded that the audit coverage was inadequate, we found in our follow-up that the Department had not ensured that the contractor complied with this existing requirement. Only 29 on-site pharmacy audits were undertaken in 1998–99, and another 24 were initiated in 1999–2000. Only one on-site audit of a dental provider has been performed in the last two fiscal years. Health Canada has indicated that it expects the contractor to make up for the shortfall in on-site audits by the end of fiscal year 2000–01.

15.83 In addition to routine audits of providers, some investigations into suspected fraudulent practices have been undertaken with the involvement of the Department's internal audit directorate. These investigations recently resulted in two convictions. Several other investigations are under way.

15.84 The contractor has carried out next-day on-line audits since December 1998. These are done the day after a claim is submitted, and they focus on a sample of claims above a specific dollar threshold to determine if further investigation is warranted. We note that this threshold is several times higher than the average value of a pharmacy claim. Of the nearly seven million pharmacy claims submitted in 1999, about 150,000 or 2.2 percent were above the threshold. Of these, the contractor reviewed a sample of around 12,000 or 8.0 percent — only 0.2 percent of all claims submitted in 1999. The Department reported that a total of approximately $159,000 was recovered as a result of this procedure. This is an important component of the audit strategy but given the limited coverage, it is important that the other components of the audit strategy be fully implemented.

Other problems with claims-processing contract

15.85 Non-compliance with reporting requirements. As part of its contractual obligation, the contractor is to generate a series of monthly and quarterly reports on activities related to pharmacy benefits (for example, lists of all claims that were adjusted/reversed and recoveries made as a result of system edits) so the Department can monitor the contractor's performance. However, the contractor did not provide any of these reports in 1999 although the Department asked for them. The first reports were not provided until January 2000. To date, the Branch has withheld from the contractor a total of approximately $1.6 million in monthly payments for not fulfilling its contractual obligations.

15.86 In 1997 we identified problems with the system edits used to identify duplicate claims. In our follow-up, we were encouraged to find that those problems have been resolved. A departmental report indicates that in 1999, system edits prevented almost 100,000 duplicate claims totalling $3.1 million from being processed.

15.87 We noted in our 1997 Report that the contractor had not performed any procedures to confirm that Non-Insured Health Benefits clients had received the benefits for which claims had been submitted. Our follow-up found that the contractor incorporated a procedure in its audit program for on-site audits of pharmacies to confirm that clients have received benefits. However, it did not follow up on cases where no confirmation was received from the client. We believe there is a need to follow up on such cases and to pursue client confirmations on a broader basis.

15.88 We also found in 1997 that the system field identifying the doctor who wrote the prescription was not subject to any system edits but rather accepted anything that was input. Therefore, it was not possible for the Department to accurately track "doctor shopping" — individuals visiting multiple doctors to obtain a large number of prescription drugs. The Department has not yet corrected this problem. It is currently working with pharmacy associations to encourage pharmacists to fill out the prescriber identification field correctly. In addition, it has begun tracking pharmacists who do not fill in this field properly and it has indicated that it will take steps to recover funds for claims that do not have correct prescriber identification, beginning in July 2000.

15.89 Health Canada should enforce the contract requirements for audit of pharmacy and dental care providers and reporting by the contractor. The Department should continue to take steps to strengthen verification of claims and audits of providers.

Department's response: *Agreed. The development and full implementation of the audit strategy has taken longer than initially expected. The Department continues to enforce the contract requirements. The Department withheld approximately $1.6 million in monthly payments to the contractor for not fulfilling its contractual obligations. The contractor will make up in fiscal year 2000–01 the audits that were to have been completed since 1998. The dental predetermination process ensures that virtually all dental claims exceeding $600 are reviewed against the dental history of each client. A Risk Management Committee ensures that the audit strategy is reviewed on a regular basis. As noted earlier, the development of the full audit strategy took longer than expected but will be fully implemented by the fall 2000. At that time, the fully implemented comprehensive strategy will greatly exceed existing standards of private benefits management. The Department is committed to the continuous improvement of the audit strategy.*

Needs-based approach for dental benefits has resulted in substantial savings

15.90 In 1997 we reported that in response to concerns about overservicing by dental care providers, the Department was piloting a predetermination process. It required prior approval and a treatment plan for performing dental services above a prescribed dollar threshold. Predetermination was implemented nationally in late 1997 as a needs-based approach to providing dental care. The Department estimated that predetermination, combined with changes to the benefit schedule, would result in a 15 percent reduction of dental costs in 1996–97.

The predetermination process for dental benefits has reduced both overservicing and program costs.

15.91 With predetermination, the Department has taken steps to respond to overservicing. Any treatment that exceeds the threshold of $600 and/or that includes selected procedures must be reviewed by a regional dental officer before treatment begins. In 1999 the Department reviewed almost 200,000 treatment plans. It is confident that predetermination has reduced both overservicing and program costs. It has also resulted in substantial savings: a 15.4 percent reduction in dental

costs was realized in 1996–97. In 1995–96, before the approach was introduced, dental expenditures were over $123 million. In 1998–99 they had dropped to just over $106 million, whereas the population being served has increased by almost 8 percent.

Limited progress made to improve efficiencies in medical transportation

15.92 In 1997, we recommended that the Department establish clear program criteria and minimum standards for medical transportation benefits. We also said that it should undertake audits of medical transportation expenditures based on an assessment of risks.

15.93 Working with First Nations, the Department has begun to clarify program criteria and minimum standards for medical transportation benefits. It is also attempting to address criticisms that First Nations are not treated consistently from one region to another. However, it has not yet updated the national transportation directives.

15.94 Approximately 54 percent of medical transportation expenditures are administered by First Nations communities under contribution agreements, which are subject to planned departmental audits. The other 46 percent of expenditures are administered by Branch regional offices, with payments made directly to providers by the Department. While we noted more daily monitoring and prior approval of certain categories of transportation in some regions, the Department has not conducted any audits of transportation expenditures paid directly to providers.

15.95 An internal review of the medical transportation program in one region was completed in March 1999. It concluded that the medical travel program in that region was not being managed well overall. It found major problems in several areas: weaknesses in managing the use of taxis or contracted vehicles; use of ground ambulances for more than emergencies; poor controls over gas support; and little or no information on the use and costs of the medical travel program. In addition, it found that program spending was not based on need; rather, in many cases, it was based on use, so the more a community spent on medical travel, the more money it received.

15.96 The region subsequently developed a needs-based transportation model to profile the realistic transportation needs of individual First Nations. The Department has set a target date of spring 2001 for national implementation of the needs-based transportation model.

15.97 Health Canada should establish clear program criteria and minimum standards for medical transportation benefits without delay. It should also undertake audits of medical transportation expenditures based on an assessment of risks.

Department's response: *Agreed. To facilitate better control over medical transportation benefits, a review of the transportation directive is under way with First Nations and Inuit, as is the development of an information system to support profiling and audit. Fifty–four percent of medical transportation costs are managed primarily through contribution agreements with First Nations, which are subject to audit as part of the Department's planned auditing requirements. The Department will audit the direct medical transportation expenditures, based on an assessment of risks, cost effectiveness and monitoring profiles.*

Most Non-Insured Health Benefits transfer pilot projects have not been evaluated

15.98 In 1994, Health Canada received a five-year authority to proceed with

Non-Insured Health Benefits pilot projects with interested First Nations and Inuit communities. The primary objectives were to test various management and delivery options, to improve the program's efficiency and effectiveness, and to facilitate First Nations and Inuit involvement in, and control of, the program. The pilot projects were to operate for two years with an optional third year. An interim evaluation of each pilot was required after the first year, and a final evaluation when each project ended. At the end of the pilot exercise, an overall evaluation of its effectiveness would be conducted, including an assessment of the objectives, impacts and effects.

15.99 Health Canada approved 16 pilot projects, mainly involving transportation benefits but also covering pharmacy, dental, and vision benefits. So far, only five of the projects have been evaluated and there has been no overall evaluation of the effectiveness of the pilot exercise. The original authority for these pilots has expired, and the Department has requested Treasury Board approval to extend it.

15.100 Health Canada should ensure that it completes an evaluation of each of the Non-Insured Health Benefits transfer pilot projects, as well as an overall evaluation of the pilot exercise.

Department's response: *Agreed. The Department completed evaluations of five of the pilot projects to pretest the evaluation tool. The pretest indicated that additional development of the tool was required. This development is ongoing and the Department has met with all communities undertaking the pilot projects to discuss the evaluation tool and upcoming evaluations. Once all projects have been evaluated, an overall evaluation of the pilot exercise will be conducted.*

New Initiatives

Attention has to be given to monitoring new initiatives

15.101 In response to our concerns in 1997 about unclear objectives, Health Canada indicated that new programs would have clear requirements for accountability and performance reporting. The Department has begun a number of new initiatives and programs since our 1997 audit (Exhibit 15.6). These are important initiatives with the potential to fill significant gaps in First Nations health programming.

15.102 Because these initiatives are in their early stages, we reviewed their design and early implementation. We found that the Department is taking steps to ensure that their objectives and accountability structures are clear and there is an emphasis on measuring results. For example, the Aboriginal Head Start (On-Reserve) Program has a national evaluation framework, and there is an accountability framework for the Home and Community Care Program. However, our review of files found that not all reports required under the various contribution agreements were in the files. As with other community health programs, it is important that full attention be given to monitoring contribution agreements under these new initiatives to ensure that requirements are met.

15.103 First Nations Health Information System. The system's focus is on creating an epidemiological database to support program delivery, priority setting, planning and evaluation in each community. There are 13 subsystems available and they cover a wide range of areas, from immunization to chronic diseases. Health Canada is acting to provide the systems and necessary training to any First Nation who indicates an interest in voluntarily participating in this system.

15.104 Implementation of the system across the country has just begun — most participating First Nations are so far inputting data for only the immunization subsystem. It will be a complex task to harmonize the diverse needs of First Nations and create a system that allows for the collection of comparable data to facilitate the objective of eventually developing a comprehensive First Nations health surveillance program. Critical tasks for Health Canada will be to bring all parties together to ensure that this is accomplished, and to identify mandatory data to be collected where applicable. The Department is now working with First Nations and provinces to develop uniform standards and protocols for collecting and reporting data in order to ensure comparability with other jurisdictions. The Department also recognizes that linkages to other systems are essential.

Exhibit 15.6

Health Canada Initiatives Since 1997 Audit

Initiative	Overall Objective and Funding	Progress to date as of 31 March 2000	Delivery Mechanism	Accountability Framework & Evaluation Component
First Nations Health Information System • additional funding announced in 1999 Budget	• To improve the management of health services within First Nations communities as an initial version of a comprehensive community health information system • $23 million over four years and then $20 million annually	• early implementation • system installed in 265 First Nations	• Health Canada provides infrastructure and training • contribution agreements with First Nations for data entry	• evaluation framework established
Aboriginal Head Start (On-Reserve) Program • announced by Minister of Health in October 1998	• To support early child development strategies designed and controlled by First Nations • $100 million over four years and then $25 million annually	• early implementation • 156 projects funded and additional 47 First Nations completed needs assessments	• contribution agreements with First Nations	• national evaluation framework developed
Home and Community Care Program • announced in 1999 Budget	• To provide improved care for the elderly, disabled, chronically ill and those requiring short-term acute care services • $62 million over two years and then $90 million annually	• early implementation • over 400 First Nations communities participating	• contribution agreements with First Nations	• accountability framework completed but evaluation framework still outstanding
Aboriginal Diabetes Initiative • announced in 1999 Budget and launched by Minister of Health in November 1999	• To decrease diabetes and its complications in First Nations and Inuit communities • $58 million over five years	• planning phase	• contribution agreements with First Nations	• to be developed

15.105 Aboriginal Diabetes Initiative. In 1997 the Department completed a study that included constructing a preliminary estimate of the cost of health care for First Nations persons with diabetes. The study noted the greater prevalence of diabetes and the higher mortality rate among First Nations peoples than among the general population. It pointed to the importance of policies for reducing the prevalence of diabetes through primary prevention, and treating those diagnosed to reduce the impact of complications. In November 1999, the Department announced its Aboriginal Diabetes Initiative, aimed at decreasing the incidence of diabetes and its complications in First Nations and Inuit communities. At the time of our audit, an evaluation framework had not yet been developed. This initiative addresses a very serious disease, and it is important that it be implemented effectively to ensure that work undertaken contributes to meeting its objectives.

Conclusion

15.106 The action Health Canada has taken in response to our 1997 audit of First Nations Health has not adequately addressed our observations and recommendations or those of the Public Accounts Committee. Continued and sustained effort is needed to ensure that all the recommendations are fully implemented.

15.107 The management of separate contribution agreements for the delivery of community health programs is still weak. There has been limited improvement in reducing program overlap, ensuring that programs have clear objectives, and ensuring that the required reports are provided. The Department needs to fulfil its responsibilities in a way that helps First Nations establish programs and services likely to improve their health.

15.108 Management of transfer agreements still needs improvement. Sound monitoring is needed to ensure that updated community health plans are prepared and that the requirements for audits, annual reports and evaluations are met. These are required not only to meet the accountability obligations of First Nations and the Department but also to improve the programs and services.

15.109 We still have significant concerns about the management of non-insured health benefits. While a point-of-service system for prescription drugs is now operating, the Department needs to adequately monitor pharmacists' overrides of drug utilization warning messages. It also needs to undertake sufficient analysis of the effectiveness of the warning messages. The Department needs to find appropriate means to continue to follow up rigorously on cases where it identifies a significant pattern of inappropriate use of prescription drugs. In addition, it needs to ensure that required on-site audits of pharmacies and dental providers are undertaken. Finally, it needs to improve efficiencies in administering medical transportation benefits.

Continued and sustained effort is needed to ensure that all the recommendations are fully implemented.

15.110 Improving the health of First Nations is a complex task. The programs that Health Canada delivers either directly or in partnership with First Nations organizations represent a key component of this task. We believe that timely and complete implementation of our recommendations would contribute to improving the health services to First Nations.

Department's overall response: *In responding to the recommendations, the Department feels it is important to set out some context around the responses. In particular, the Department remains committed to implementing the actions set out in our responses to both the 1997 and 2000 reports. While action has been taken on all the recommendations from the 1997 report, and this has been acknowledged in the 2000 report, there are a number of*

reasons for the time it has taken to fully implement the action plan.

First, the development of the overarching accountability framework, which was initiated in response to the 1997 report, has proved to be more complex than was initially foreseen. The framework will enable the Department to demonstrate value for the investment made in programs, identify gaps, manage risks to health, improve capacity to deliver services, and improve overall management practices. This is being carried out through 10 working groups in partnership with First Nations and Inuit. The recommendations are being addressed through this process.

Second, implementing the Non-Insured Health Benefits claims–processing contract has also proved to be more complex than anticipated, as the Department sought to ensure that the recommendations relating to Non-Insured Health Benefits management were fully addressed. Systems edits and drug utilization messages required considerable attention, as the Department attempted to ensure that the claims–processing system would better any system in the private sector. The Department believes it will soon achieve the goal, and by fall 2000 the system will be fully implemented. It should be noted that the Department's management of Non-Insured Health Benefits expenditures in 1999–2000 outperformed that of the private and public sector benefits plans in both pharmacy and dental benefits.

Finally, the Department has worked on the recommendations in partnership with First Nations and Inuit. Ultimately, this partnership approach will help ensure that the recommendations are responded to in a way that supports First Nations and Inuit goals of responsive, community–based programming, appropriate reporting requirements that also meet their needs, and a strong Non-Insured Health Benefits management process that can support the transfer of Non-Insured Health Benefits to First Nations.

About the Follow-up

Objective

The objective of this audit was to determine the progress made by Health Canada in taking corrective action on the observations and recommendations in our 1997 chapter on First Nations Health and on recommendations made by the Public Accounts Committee in 1998.

Scope

The follow-up covered the recommendations made in our 1997 Report, Chapter 13, First Nations Health, as well as recommendations made by the Public Accounts Committee. These recommendations relate to Health Canada's health programs directed at First Nations, including community health programs delivered through separate contribution agreements, transfer of health programs to community control, and Non-Insured Health Benefits. We also undertook a follow-up of outstanding recommendations reported in Chapter 19 of our 1993 Report on the Non-Insured Health Benefits program.

We reviewed a departmental status report on the action taken in response to the recommendations. With respect to community health programs delivered to First Nations using separate contribution agreements and transfer agreements, we performed a detailed analysis of a sample of 35 agreements in each category. We also looked at the design and early implementation of several related new initiatives and the First Nations Health Information System. In addition, we reviewed current systems, controls and management practices relating to the delivery of non-insured health benefits.

We carried out extensive interviews with program managers at First Nations and Inuit Health Branch headquarters and selected regional offices, and with the contractor for claims processing of dental and prescription drug benefits. We also met with selected representatives of First Nations communities and organizations. In addition, we reviewed program documentation and related literature.

Criteria

We expected that the Department would have implemented the recommendations it committed to do in its responses to our 1997 chapter and to the Public Accounts Committee.

Audit Team

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Appendix

First Nations Health – Follow-up: Overall Assessment of Progress Made

Reference[1]	Recommendation	OAG Assessment
Community Health Programs Delivered Through Separate Contribution Agreements and Transfer of Health Programs to Community Control		
13.36	Health Canada should review its program structure and ensure that it reflects the manner in which the programs are actually delivered.	Satisfactory progress. The Department has initiated a project that will identify specific objectives for each program, and it believes this will alleviate overlap of program objectives. At the time of our audit this had not been completed; we found that there is still some overlap between program objectives.
13.40	The Department should ensure that the contribution agreements are clear about specific objectives and activities that the First Nations will undertake. It should encourage First Nations to define measures of success.	Unsatisfactory progress. In many cases, programs still do not include clear objectives and activities for the specific community.
13.44	The Department should ensure that it receives the activity reports required under contribution agreements. It should work with First Nations to improve these activity reports so that they provide information on results achieved.	Satisfactory progress. Some improvement, but not all required activity reports are completed for all programs. Reports remain mostly lists of activities undertaken.
PAC No. 2	That Health Canada monitor those aspects of the community health programs that are not affected by transfer agreements. This monitoring function must be done in accordance with departmental policies, be supported by thorough evaluation of risks, and targeted accordingly.	Unsatisfactory progress. Monitoring of reporting requirements remains weak. The proposed automated contribution system to track reports is not yet operational in all regions.
13.58	The Department should ensure that updated community health plans that meet the basic requirements are prepared, and that they form the basis of both initial and renewed transfer agreements.	Unsatisfactory progress. Many renewed agreements were signed without an updated community health plan.
13.65	The Department should work with First Nations to improve measurement of the services provided and of expected changes to health. These measures should be included in the annual reports. In addition, the Department should ensure that First Nations conduct the required evaluations of the achievement of program objectives.	Unsatisfactory progress. Under two thirds of transfer agreement files reviewed had an annual report for 1998–99. Those provided tended not to include performance information. Some transfer agreements were renewed without evaluations having been completed. Some completed evaluations had quality problems.
13.70	The Department should clarify the nature and scope of audit requirements under transfer agreements and ensure that the required audit opinions are provided.	Satisfactory progress. The Department has revised its audit guidelines to clarify the nature and scope of comprehensive audit requirements. Not all transfer agreements had audits completed as required. Audit reports provided did not meet all requirements.

[1] These refer to recommendations made in our audit on First Nations Health (1997 Report, Chapter 13) and to recommendations made in the Public Accounts Committee's Fifth Report, tabled in February 1998.

Reference	Recommendation	OAG Assessment
Community Health Programs Delivered through Separate Contribution Agreements and Transfer of Health Programs to Community Control (continued)		
13.74	The Department should ensure that future evaluations will determine the extent to which the transfer initiative contributes to improving the health of First Nations.	Unsatisfactory progress. The Department believed that more emphasis on community-based evaluations would lead to better health information to deal with the issue of improved health status. As noted above, community-based evaluations were either not done or inadequate.
PAC No. 1	That Health Canada monitor the transfer of the delivery of community health programs to First Nations and work with the communities to ensure that the conditions set forth in the accountability framework are met. In particular, the Department must ensure that the audit (both financial and comprehensive) and evaluation requirements of all transfer agreements are satisfied.	Unsatisfactory progress. The accountability framework is still under development. As described above, audit and evaluation requirements have not been met satisfactorily.
PAC No. 3	That Health Canada provide information on the status of community health programs in its annual Performance Reports. Information on the status of the transfer process, the Department's monitoring activities, audits and reports completed, and health outcomes achieved under the programs should be included.	Unsatisfactory progress. Recent departmental annual performance reports have provided limited information on the status of community health programs, including outcomes achieved.
Non-Insured Health Benefits		
13.114	In cases where it identifies a significant pattern of inappropriate use of prescription drugs, the Department should perform a more rigorous follow-up with Non-Insured Health Benefits clients, physicians, pharmacists and professional bodies.	Satisfactory progress. A protocol was implemented to follow up on cases of suspected drug misuse, with some success. However, officials stopped following the protocol in May 1999 as management was unsure of the appropriateness of the approach in the absence of either client consent or statutory authority. The Department is currently considering options to deal with this situation.
13.120	In implementing the point-of-service system for prescription drugs, the Department should ensure the system will facilitate timely intervention where potentially inappropriate prescription drug use is identified. The Department should provide a clear protocol to guide intervention and should closely monitor pharmacists' overrides of warning messages.	Unsatisfactory progress. The point-of-service system provides limited information in the form of warning messages to assist pharmacists in making decisions on dispensing prescriptions. This resulted in rejection of a number of claims. But Health Canada has not adequately monitored the warning messages that were overriden by pharmacists. Nor has it undertaken sufficient analysis of the effectiveness of warning messages. The Department has agreed with three provincial pharmacy bodies on compensating pharmacists for professional services in cases where they have not filled a prescription for valid reasons, but few pharmacists have taken advantage of the provision.
PAC No. 4	That Health Canada explore the possibility, with various jurisdictions, of having access to information and privacy legislation amended in order to allow its point-of-sale system to provide more information on recent prescriptions.	
PAC No. 5	That Health Canada monitor the use of overrides by pharmacists and step up its efforts to devise an incentive scheme for those pharmacists who do not fill prescriptions when warning messages are issued.	

Reference	Recommendation	OAG Assessment
Non-Insured Health Benefits (continued)		
13.123	The Department should build on its existing strategies to address the combined problem of prescription drug and solvent and alcohol abuse, and increase efforts in community health programs relating to prevention, community education, and treatment of prescription drug addiction.	Satisfactory progress. Multiple addiction is a systemic, long-term and complex problem. Departmental efforts are ongoing.
13.140	Health Canada should clarify, and enforce, the contract requirement for audit of pharmacy and dental care providers by the contractor. The Department should take appropriate steps to improve claims-processing system controls and edits and strengthen verification of claims and audits of providers.	Unsatisfactory progress. The Department was slow to develop and incorporate an audit strategy based on appropriate assessment of risks in its new claims-processing contract. It failed to ensure that the contractor would perform the required on-site audits of pharmacy and dental providers. Problem with system edit to identify duplicate claims has been resolved.
13.149	Health Canada should establish clear program criteria and minimum standards for medical transportation benefits. It should also undertake audits of medical transportation expenditures based on an assessment of risks.	Unsatisfactory progress. Work on updating national transportation directives has not yet been completed. No evidence of any audits of transportation expenditures paid directly to providers.
PAC No. 6	That Health Canada fix systemic problems with the Non-Insured Health Benefits program before the program becomes available for transfer to First Nations communities.	Unsatisfactory progress. As described above, many problems have not yet been fixed.
PAC No. 7	That Health Canada adopt and apply the framework for transferring community health programs when it conducts the transfer of the Non-Insured Health Benefits program to the First Nations.	Unsatisfactory progress. Most Non-Insured Health Benefits transfer pilots have not been evaluated. A new accountability framework is still under development.
PAC No. 8	That Health Canada submit a copy of the new contract for processing pharmacy and dental claims under the Non-Insured Health Benefits program to the Committee by 1 June 1998.	Fully addressed. A copy of new contract was provided to the Committee.
PAC No. 9	That Health Canada work with First Nations communities to establish optimal therapy as the central goal of the Non-Insured Health Benefits program and include references to this effort in its annual Performance Report.	Unsatisfactory progress. Predetermination process for dental benefits implemented. As described above, officials stopped following the drug utilization review follow-up protocol, which forms a part of a strategy to improve drug therapy. Limited information contained in the Department's recent annual performance report referencing this effort.

Reference	Recommendation	OAG Assessment
Non-Insured Health Benefits (continued)		
PAC No. 10	That Health Canada provide the Committee with a copy of its action plan for carrying out the recommendations made by the Auditor General by 30 April 1998. This plan should include target implementation dates, and a discussion of how the Department proposes to monitor and report the changes and the results that are achieved.	Fully addressed. An action plan was forwarded to the Committee in February 1998. The Department advised the Committee that it intended to update this plan on a semi-annual basis until full implementation is achieved.

Key:

Fully addressed – the Department has fully addressed the original audit finding and thus need not take additional action. Our Office will not follow up further.

Satisfactory progress – the Department has made reasonable progress in addressing the original finding, but must take some additional action. Our Office will do further follow-up work.

Unsatisfactory progress – the Department has not made reasonable progress in addressing the original finding, and must take considerable additional action. Our Office will do further follow-up.