HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

CHAPTER 4, ACCESS TO HEALTH SERVICES FOR REMOTE FIRST NATIONS COMMUNITIES, OF THE SPRING 2015 REPORT OF THE AUDITOR GENERAL OF CANADA

Report of the Standing Committee on Public Accounts

David Christopherson
Chair

JUNE 2015

41st PARLIAMENT, SECOND SESSION

CHAPTER 4, ACCESS TO HEALTH SERVICES FOR REMOTE FIRST NATIONS COMMUNITIES, OF THE SPRING 2015 REPORT OF THE AUDITOR GENERAL OF CANADA

Report of the Standing Committee on Public Accounts

David Christopherson
Chair

JUNE 2015

41st PARLIAMENT, SECOND SESSION

STANDING COMMITTEE ON PUBLIC ACCOUNTS

CHAIR

David Christopherson

VICE-CHAIRS

John Carmichael

Yvonne Jones

MEMBERS

Dan Albas

Malcolm Allen

Jay Aspin

Ted Falk

Alain Giguère

Bryan Hayes

Stephen Woodworth

CLERK OF THE COMMITTEE

Angela Crandall

LIBRARY OF PARLIAMENT

Parliamentary Information and Research Service

Édison Roy-César, Analyst

Alex Smith, Analyst

THE STANDING COMMITTEE ON PUBLIC ACCOUNTS

has the honour to present its

TWENTY THIRD REPORT

Pursuant to its mandate under Standing Order 108(3)(*g*), the Committee has studied Chapter 4, Access to Health Services for Remote First Nations Communities, of the Spring 2015 Report of the Auditor General of Canada and has agreed to report the following:

REPORT 4—ACCESS TO HEALTH SERVICES FOR REMOTE FIRST NATIONS COMMUNITIES, *SPRING 2015 REPORTS OF THE AUDITOR GENERAL OF CANADA*

INTRODUCTION

In remote First Nations communities, individuals have limited access to provincial health services. Based on the 1979 Indian Health Policy, Health Canada provides funding for the delivery of health services in remote First Nations communities. Health Canada's funding supports 85 health facilities, which have collaborative health care teams that are led by approximately 400 nurses. The facilities provide services to approximately 95,000 First Nations individuals. When health services are not available within First Nations communities, Health Canada provides medical transportation benefits to First Nations individuals. In 2013–2014, Health Canada spent $103 million for clinical and client care services in Manitoba and Ontario, and $175 million for medical transportation benefits in the two provinces.[1]

First Nations individuals face significant health challenges. While the life expectancy of the First Nations population increased between 1980 and 2010, it was about eight years shorter than the life expectancy of other Canadians in 2010. First Nations communities also have higher rates of chronic infectious disease, and mental health and substance abuse issues. Poor social determinants of health in First Nations communities, such as overcrowded housing, high unemployment and unsafe drinking water, also contribute to poorer health outcomes.[2]

In its spring 2015 reports, the Office of the Auditor General of Canada (OAG) released a performance audit that examined whether Health Canada had reasonable assurance that eligible First Nations individuals living in remote communities in Manitoba and Ontario had access to clinical and client care services and medical transportation benefits.[3] The OAG did not examine the quality of health services and benefits provided, or the adequacy of federal resources spent.[4] The OAG also did not examine health services in British Columbia, because it has recently put in place a different operating

1 Auditor General of Canada, "Report 4–Access to Health Services for Remote First Nations Communities," *2015 Spring Reports of the Auditor General of Canada*, Ottawa, 2015, para. 4.3.

2 Ibid., para. 4.4.

3 Ibid., para. 4.5.

4 Ibid., para. 4.7.

model through the First Nations Health Authority, nor the delivery of health services in Quebec and Alberta.[5]

The House of Commons Standing Committee on Public Accounts (the Committee) held a hearing on this audit on 1 June 2015.[6] From the OAG, the Committee met with Michael Ferguson, Auditor General of Canada and Joe Martire, Principal. Health Canada was represented by Sony Perron, Senior Assistant Deputy Minister, First Nations and Inuit Health Branch; Valerie Gideon, Assistant Deputy Minister, Regional Operations, First Nations and Inuit Health Branch; Scott Doidge, Acting Director General, Non-Insured Health Benefits Directorate, First Nations and Inuit Health Branch; and Robin Buckland, Executive Director, Office of Primary Health Care, First Nations and Inuit Health Branch.

NURSING STATIONS

Nursing stations are typically the first point of contact for accessing clinical and client care services for First Nations individuals living in remote communities.[7] In Manitoba and Ontario, there are 51 federally funded nursing stations: 46 stations are operated by Health Canada nurses and 5 by First Nations communities.[8]

A. Training

The OAG selected a sample of 45 Health Canada nurses working at nursing stations in remote First Nations communities and reviewed documentation to determine whether the nurses were registered with the relevant provincial regulatory body and had completed Health Canada's five mandatory training courses in areas such as immunization, cardiac life support and the handling of controlled substances.[9]

The OAG found that all nurses examined were registered with the provincial regulatory bodies; however, only one nurse had completed all of Health Canada's five mandatory training courses.[10] This issue was previously raised in a 2010 Health Canada internal audit report.[11] The OAG expressed concern that having nurses who have not completed the mandatory training specified by Health Canada could negatively affect the

---

5 House of Commons, Standing Committee on Public Accounts, *Evidence*, 2nd Session, 41st Parliament, 1 June 2015, Meeting 62, 1550.

6 Meeting 62.

7 Auditor General of Canada, Report 4, para. 4.14.

8 Ibid., para. 4.16.

9 Ibid., para. 4.22

10 Ibid., paras. 4.23-4.25.

11 Ibid., para. 4.26.

health services provided to First Nations individuals.[12] The OAG recommended that Health Canada ensure that its nurses complete the mandatory training courses.[13]

Robin Buckland, Executive Director of the Office of Primary Health Care at Health Canada, explained the need for the mandatory training courses. She told the Committee that nurses graduate as generalists, and as they are often the only health care provider in a community, they need to be able to respond to whatever comes in the door, such as an emergency or a trauma.[14] Sony Perron, Senior Assistant Deputy Minister of the First Nations and Inuit Health Branch at Health Canada, informed the Committee that the overall compliance rate for Health Canada nurses in Ontario, Quebec, Manitoba and Alberta with the five mandatory training courses as of April 2015 was 46%. More specifically, the compliance rate in these provinces for the training on controlled substances was 88%; for advanced cardiac life support, it was 63%; for trauma support, it was 59%; for pediatric advanced life support, it was 64%; and for immunization, it was 61%.[15]

Mr. Perron said Health Canada's goal is to have 100% compliance with the training requirements, but Health Canada always has new nurses entering service.[16] In fact, he said:

> The main reason for being behind on the training is the recruitment and retention. We have a high turnover of nurses. Our first order of priority is to make sure we have nurses in the position to deliver the service on an ongoing basis. This is not a justification for not meeting our own mandatory training standards. I would agree; this is a problem we are trying to fix. At the same time that we are investing a lot of energy on training to improve our numbers there, we are also running a really aggressive recruitment strategy. We are hopeful that we will be able to stabilize the workforce [...] Each time we lose a nurse, we need to start back, and a new nurse may come into an employment position without that nursing background or the mandatory training met. […] Our recruitment strategy is starting to produce results right now, so this should help to stabilize the workforce and help improve our numbers in terms of training.[17]

Ms. Buckland noted:

> We're working hard—and I think this responds in part to your colleague's question about how have we come this far and not had our training done—but our turnover rates are very high. We recruit ten nurses and we lose five. It's very difficult. When you have a nurse going out of the community to obtain their training, we work hard to get a

12 Ibid.

13 Ibid., para. 4.27.

14 Meeting 62, 1600.

15 Ibid., 1540.

16 Ibid., 1655.

17 Ibid., 1600.

> replacement so that the community is not missing access to services. We do that in a number of different ways, to make sure that service is continued.[18]

Mr. Perron observed that Health Canada currently uses a lot of nurses from agencies, and greater retention of nurses would allow Health Canada to reinvest resources into the clinical care program.[19] He also said:

> As part of the recruitment and retention strategy, one thing we are trying to do more and more is inform the nurses about the working conditions and the type of work they will be asked to do in the communities. We want to make that when we invest in training and integrating these people into the health team, they will stay in the business, and there won't be surprises for them up there.[20]

In response to this issue, Mr. Perron told the Committee that Health Canada has implemented a Nurse Recruitment and Retention Strategy, which has four components: the nurse recruitment marketing plan, the nursing development program, the student outreach program and the on-boarding program. [21] Part of the recruitment strategy is to accurately describe the working conditions, as well as a marketing campaign to explain the benefits of living closer to nature, working in small teams and facing challenges.[22] Additionally, Health Canada promotes the fact that there are housing arrangements in most communities, and nurses receive an isolated post allowance, a retention bonus and overtime and call-back benefits through measures in collective agreements.[23]

Mr. Perron indicated that the key is getting the right kind of people and preparing them for the type of nursing they will be facing.[24] In addition, Health Canada is actively seeking to recruit more health workers with an Aboriginal background because they are more sensitive to the cultural dimension of health services in First Nations communities.[25] According to Mr. Perron, since February 2015, Health Canada has received over 500 nursing applications, with 200 of these moving to the next stage of screening.[26]

As recruitment and retention of nurses is an issue for access to health services in remote First Nations communities, it is important to monitor the success of Health Canada's recruitment and retention strategy. The Committee recommends:

---

18 Ibid., 1605.

19 Ibid., 1625.

20 Ibid., 1635.

21 Ibid., 1540.

22 Ibid., 1650.

23 Ibid., 1650.

24 Ibid., 1650.

25 Ibid.

26 Ibid., 1540.

RECOMMENDATION 1

That, by 30 September 2016, Health Canada provide the Standing Committee on Public Accounts with its annual turnover rate for nursing working in remote First Nations communities.

B. Scope of Practice

Provincial regulatory frameworks define the activities that nurses are allowed to perform when they provide health services. Nurses are accountable for practicing in compliance with standards and employers must establish policies that allow nurses to do so.[27] The OAG examined whether nurses performed activities that were beyond their scope of practice as defined by provincial legislation.[28]

The OAG observed that according to Health Canada, nurses sometimes worked outside their legislated scope of practice, such as prescribing and dispensing certain drugs and performing X-ray imaging, in order to provide essential health services.[29] Nonetheless, Health Canada had not put in place supporting mechanisms, such as medical directives to allow nurses to perform specific tasks in particular circumstances, that would authorize nurses to perform activities outside their scope of practice.[30] The OAG recommended that Health Canada ensure that its nurses are provided with appropriate supporting mechanisms that allow them to provide services that are outside their legislated scope of practice.[31]

When asked, Mr. Perron confirmed that neither Health Canada nor its employees had been sued as the result of nurses working outside their scope of practice. Also, the rating for professional liability insurance had not been affected by the shortcomings noted in the audit.[32]

Mr. Perron told the Committee that Health Canada is trying to address this issue, in part, by incorporating more nurse practitioners, who perform a larger span of duties, into their clinical health care teams. In Ontario, Health Canada will be recruiting ten nurse practitioners.[33] Health Canada is also working to improve electronic infrastructure, notably electronic medical records and telehealth, because these tools allow a small clinical care

---

27 Auditor General of Canada, Report 4, para. 4.33

28 Ibid., para. 4.32.

29 Ibid., para. 4.34.

30 Meeting 62, 1530.

31 Auditor General of Canada, Report 4, para. 4.37.

32 Meeting 62, 1620.

33 Ibid., 1635.

team to connect with the rest of the health system by transferring files, making referrals, and receiving the results of exams and tests electronically.[34]

C. Nursing Station Conditions

Health Canada requires nursing stations to undergo an inspection at least once every five years.[35] Nursing stations that are not in compliance with health and safety requirements or building codes can put patients and nursing staff at risk.[36] The OAG examined a sample of eight nursing stations built before 2009 to determine whether they had been inspected in the five-year cycle and whether deficiencies related to health and safety requirements identified by the inspections had been addressed.[37]

Of the eight nursing stations built before 2009, the OAG found that five stations had been inspected in the required time frame, two were last inspected in 2004, and one had never been inspected.[38] The OAG reviewed 30 deficiencies identified by the inspections related to health and safety requirements and found that 26 deficiencies had not been addressed.[39] During its community visits, the OAG noted health and safety issues, such as the lack of an emergency back-up generator, improper door seals for an X-ray room, and a septic system for a residence that had not been repaired for more than two years.[40] The OAG recommended that Health Canada work with First Nations communities to ensure that nursing stations are inspected on a regular basis and that deficiencies in health and safety requirements or building codes in nursing stations are addressed in a timely manner.[41]

When asked, Mr. Perron confirmed that Health Canada had not been investigated by provincial occupation health and safety officers as a result of violations.[42] Mr. Perron noted that Health Canada invests, through contribution agreements with First Nations, approximately $30 million annually for repairs, renovation and construction of health facilities, as well as an additional $44 million for maintenance and operations. Health Canada is also implementing a more robust tracking system to monitor inspections and whether deficiencies have been addressed.[43]

---

34 Ibid., 1640.

35 Auditor General of Canada, Report 4, para. 4.46.

36 Ibid., para. 4.42.

37 Ibid., para. 4.44.

38 Ibid., para. 4.48.

39 Ibid., para. 4.50.

40 Ibid., paras. 4.51 and 4.52.

41 Ibid., para. 4.53.

42 Meeting 62, 1620.

43 Ibid., 1540.

For the nine nursing stations built since 2009, the OAG examined whether they were constructed according to applicable building codes.[44] While Health Canada had certificates of substantial completion for five of the nine facilities, the documentation did not specify whether the facilities had been built according to applicable building codes.[45] The OAG recommended that Health Canada work with First Nations communities to ensure that new nursing stations are built according to applicable building codes.[46]

While health facilities built on reserve are owned by First Nations in accordance with the *Indian Act*, Mr. Perron told the Committee that Health Canada funds the construction of one or two projects a year to build nursing stations, which cost between $12 million and $15 million. It takes two to three years to plan the projects to ensure building material is delivered to isolated communities.[47] Health Canada has updated its requirements for attestations that new nursing stations are built according to building codes. Valerie Gideon, Assistant Deputy Minister of Regional Operations at Health Canada, said:

> We've always required that the buildings be signed off by the professional engineers and architects who actually worked on the project. What we're doing now, though, in light of the report, is making sure that it's explicitly written in our capital protocol agreement with the community, so that we'll get a report at the end that demonstrates that, yes, it absolutely meets the building codes. But it was always part of our requirement.[48]

D. Capacity to Provide Essential Services

Health Canada needs to know whether nursing stations can provide essential services, and First Nations individuals need to know what services nursing stations in their communities provide.[49] The OAG examined whether Health Canada had defined the essential services provided at nursing stations and whether it had communicated to First Nations individuals about the essential services provided.[50]

The OAG found that while Health Canada had defined the essential services that each nursing station should provide, it had not assessed whether each nursing station was capable of providing those services and had not communicated to First Nations individuals what essential services were provided.[51] The OAG recommended that Health Canada work with First Nations communities to ensure that nursing stations are capable of

---

44 Auditor General of Canada, Report 4, para. 4.54.

45 Ibid., para. 4.55.

46 Ibid., para. 4.56.

47 Meeting 62, 1555.

48 Ibid., 1705.

49 Auditor General of Canada, Report 4, para. 4.59.

50 Ibid., para. 4.61.

51 Ibid., para. 4.63.

providing essential health services and communicate what services each nursing station provides.[52]

In its response to the recommendations, Health Canada indicated that it would review the clinical care complement in an effort to move toward the creation of inter-professional teams and would provide, in collaboration with First Nations, a list of all clinical care services offered at each nursing station.[53]

MEDICAL TRANSPORTATION BENEFITS

Health Canada provides medical transportation benefits to enable First Nations individuals to access medically required health services that are not available in remote First Nations communities. Transportation benefits may include ground, air and water travel, living expenses, transportation costs for health professionals, emergency transportation, and transportation and living expenses for an escort.[54] The main reasons for medical transportation are emergency—24%, hospital services—10%, appointments with a general practitioner—7%, and dental services—5%.[55] The OAG examined a sample of 50 requests to access Health Canada's medical transportation benefits to determine whether First Nations individuals were registered in Aboriginal Affairs and Northern Development Canada's Indian Registration System and in Health Canada's Status Verification System. The OAG also examined a sample of 21 births reported in Manitoba during the 2013 calendar year to determine whether these children had been registered in the Indian Registration System.[56]

The OAG found that all requests for transportation benefits were made for registered First Nations individuals.[57] However, not all children were registered by their parents after birth.[58] As individuals who are not registered may be denied access to medical transportation benefits, the OAG recommended that Health Canada work with First Nations communities and Aboriginal Affairs and Northern Development Canada to facilitate the registration of First Nations individuals.[59]

The OAG also examined whether Health Canada's regional offices maintained sufficient documentation to demonstrate that medical transportation benefits were administered in accordance with Health Canada's 2005 Medical Transportation Policy

---

52 Ibid., paras. 4.64 and 4.65.

53 Ibid., paras. 4.64 and 4.65.

54 Auditor General of Canada, Report 5, para. 4.68.

55 Meeting 63, 1540.

56 Auditor General of Canada, Report 5, para. 4.74.

57 Ibid., para. 4.78.

58 bid., para. 4.79.

59 Ibid., para. 4.80.

Framework and the Treasury Board's 2009 Directive on Recordkeeping.[60] The OAG found that the regional offices had insufficient documentation[61] and recommended that Health Canada maintain sufficient documentation to demonstrate that medical transportation benefits were administered according to policy.[62]

Mr. Perron described the process for obtaining access to medical transportation benefits. He stated:

> Every time someone needs to leave a remote community, they will go to their nursing station. The nursing station will contact the Health Canada regional office to say that the patient needs to travel to a place for an appointment with a physician, let's say, or go for an X-ray. Our officer will verify that the client is registered, that this is eligible under the framework, and will confirm to all the providers who will need to assist the client to get to the appointment that we will pay and cover the fee for the services.[63]

He explained that if an individual needs emergency transportation, it will be provided, and Health Canada will subsequently confirm registration, saying, "Wherever it is possible that we can have a protocol with the regional health authority or the provincial health system we will let them make the call about the transportation and will only be there after the fact to deal with the administrative and financial sides so that people get the services."[64]

With respect to the issue of documentation, Mr. Perron told the Committee that guidelines have been issued to resolve discrepancies between practice and the framework in terms of the level of documentation required.[65] More broadly, Health Canada is undertaking a joint review with the Assembly of First Nations of the non-insured health benefits program.[66]

SUPPORT ALLOCATION AND COMPARABLE ACCESS

Health Canada's stated objective is to ensure that First Nations individuals living in remote communities have comparable access to clinical and health care services as residents living in similar geographic locations.[67] Through a review of a sample of First Nations community health plans, the OAG examined whether Health Canada had taken

---

60 Ibid., para. 4.86.

61 Ibid., para. 4.89

62 Ibid., para. 4.91.

63 Meeting 62, 1615.

64 Ibid.

65 Ibid., 1540.

66 Ibid., 1545.

67 Auditor General of Canada, Report 4, para. 4.95.

into account the health needs of remote First Nations communities when allocating support for clinical and client care services.[68]

The OAG found that the nursing staff were assigned based on what had been allocated in the past, plus increments, rather than on the basis of need.[69] The OAG recommended that Health Canada work with First Nations communities and take into account health needs when allocating nursing staff levels.[70]

In response to this concern, Mr. Perron told the Committee that Health Canada will improve its "support to community health planning to enhance integration of the community-based programs and clinical services where these services are delivered by Health Canada."[71] Health Canada will also engage with First Nations communities to review the current service delivery model and clinical resource allocations.[72]

The OAG also examined whether Health Canada had reasonable assurance that First Nations in remote communities had access to clinical services comparable to services available to provincial residents living in similar geographic locations.[73] The OAG found that Health Canada had not established specific and measurable criteria for its objective of comparable access to clinical and client care services.[74] This issue was also raised in Health Canada's 2010 internal audit report.[75] The OAG recommended that Health Canada ensure that First Nations individuals living in remote communities have comparable access to clinical and client care services.[76]

Mr. Perron informed the Committee that Health Canada will improve its support to community health planning to enhance the integration of community-based programs and clinical services.[77] Also, one way of ensuring the quality of service provided by health institutions is through accreditation, as it involves applying consistent standards.[78] Ms. Buckland told the Committee that, to date, only one nursing station is accredited and it

---

68 Ibid., para. 4.100.

69 Ibid., para. 4.105.

70 Ibid., para. 4.107.

71 Meeting 62, 1545.

72 Ibid.

73 Auditor General of Canada, Report 4, 4.112.

74 Ibid., para. 4.113.

75 Ibid. para. 4.115.

76 Ibid., para. 4.116.

77 Meeting 62, 1545.

78 Ibid., 1625.

is run by a First Nation in Quebec. Health Canada has committed to having 18 nursing stations accredited by 2018.[79]

COORDINATION OF HEALTH SERVICES AMONG JURISDICTIONS

The responsibility for providing health services to First Nations individuals is shared among federal departments, provinces and territories, and First Nations organizations and communities. Failing to clearly delineate roles and responsibilities can lead to service gaps and problems of access to care for both federally and provincially funded health services.[80] The OAG examined whether Health Canada had identified workable solutions to inter-jurisdictional challenges, such as the lack of integrated services, difficulties in sharing medical information, and unclear responsibility for funding the transfer of individuals between medical facilities.[81]

The OAG found that there were formal committees and working groups in place in Manitoba and Ontario to address this issue, and meetings were held and some draft reports produced.[82] However, clear results for First Nations individuals had not yet been achieved. For example, committees comprising representatives of Health Canada and other stakeholders in Manitoba had not proven effective in developing workable solutions to intra-jurisdictional challenges.[83] The OAG recommended that Health Canada work with First Nations organizations and communities to establish effective coordinating mechanisms.[84]

According to Mr. Perron, Health Canada engages with other jurisdictions through co-management and trilateral “tables” to advance common practices and resolve systemic issues.[85] Ms. Gideon described the tables:

> [W]e have a trilateral table in Ontario with the Ontario Ministry of Health and Long-Term Care. We also have a specific northern table that the northern first nations have asked for, and in that table, which has just started this year, we do anticipate that we're going to be talking quite a bit about clinical and client care and medical transportation and engaging them in terms of our follow-up actions on that plan.In Manitoba, we've had a committee for several years that was at a more junior officials level. We've now bumped it up to an assistant deputy minister level, with the Province of Manitoba, the Grand Chief of the Assembly of Manitoba Chiefs, and me. As well, we will be using that table to

79 Ibid., 1625.

80 Auditor General of Canada, Report 4, para. 4.120.

81 Ibid., paras. 4.122 and 4.123.

82 Ibid., para. 4.124.

83 Ibid., paras. 4.126-4.128.

84 Ibid., para. 4.131.

85 Meeting 62, 1545.

engage first nations in Manitoba with respect to our actions on this report to ensure that we're also monitoring progress and partnership of first nations.[86]

PROGRESS REPORT

In its audit, the OAG made 11 recommendations to Health Canada in order to improve access to health services for First Nations individuals in remote communities. Mr. Ferguson explained why the OAG made 11 recommendations, stating, “Those issues lent themselves to very specific and very concrete recommendations for which it should be easy to determine whether the department is able to put in place some measures to deal with those recommendations.”[87] He also described how the recommendations could help, “If they can put measures in place to deal with those issues we found, to deal with the recommendations we made, we certainly feel that it's possible for them to significantly improve the services to these remote First Nations.”[88]

Health Canada provided the Committee with a detailed action plan that outlines how it intends to address each of the recommendations. As most of the proposed actions have expected completion dates prior to September 2016, the Committee recommends:

RECOMMENDATION 2

That, by 30 September 2016, Health Canada provide the Standing Committee on Public Accounts with a report outlining its progress in addressing the Office of the Auditor General of Canada’s recommendations contained in Report 4 of the Spring 2015 Reports.

CONCLUSION

As First Nations individuals living in remote communities have limited access to provincial health care systems, it is important that the federal government ensure that they have access to essential health services, whether through clinical and client care services provided by nursing stations within First Nations communities or through transportation benefits to access health services outside their communities.

Overall, the OAG concluded that Health Canada did not have reasonable assurance that First Nations individuals living in remote communities had access to clinical and client care services and medical transportation benefits.[89] The OAG identified concerns with the completion of mandatory training courses by nurses and their working outside their legislated scope of practice. Also, Health Canada had not ensured that

---

86 Ibid., 1625.

87 Meeting 62, 1705.

88 Ibid., 1615.

89 Auditor General of Canada, Report 4, 4.132.

deficiencies in health and safety requirements or building codes for nursing stations had been addressed, and had not assessed whether each nursing station was capable of providing essential health services.[90] With respect to medical transportation benefits, some First Nations individuals had not registered and were thereby ineligible for benefits, and Health Canada had not maintained sufficient documentation to demonstrate that benefits were delivered according to policy.[91] Lastly, Health Canada did not take community needs into account when allocating support and had not implemented its objective of ensuring comparable access to clinical and client care services as provincial residents living in similar geographic locations.[92]

In response to the audit, Health Canada has committed to improving the compliance rate for the completion of mandatory training by nurses, which will also require improving the recruitment and retention of nurses. It has implemented a new tracking system to monitor whether deficiencies in nursing stations identified by inspections have been addressed and has clarified the requirements for attestations that new nursing stations are built according to the applicable building codes. Health Canada has also issued guidelines to resolve discrepancies between its practice and its policy framework in terms of the level of documentation required for medical transportation benefits. Health Canada has committed to engage with First Nations communities to review the current service delivery model and clinical resource allocations and is working with other jurisdictions to improve the coordination of services. The Committee expects that Health Canada will continue to make improvements to ensure that First Nations individuals living in remote communities have access to necessary health services.

90 Ibid., para. 4.133.

91 Ibid., para. 4.134.

92 Ibid., para. 4.135.

APPENDIX A
LIST OF WITNESSES

Organizations and Individuals	Date	Meeting
Department of Health	2015/06/01	62
Robin Buckland, Executive Director, Office of Primary Health Care, First Nations and Inuit Health Branch		
Scott Doidge, A/Director General, Non-Insured Health Benefit Directorate, First Nations and Inuit Health Branch		
Valerie Gideon, Assistant Deputy Minister, Regional Operations, First Nations and Inuit Health Branch		
Sony Perron, Senior Assistant Deputy Minister, First Nations and Inuit Health Branch		
Office of the Auditor General of Canada		
Michael Ferguson, Auditor General of Canada		
Joe Martire, Principal		

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the Committee requests that the government table a comprehensive response to this Report.

A copy of the relevant *Minutes of Proceedings* (Meetings Nos. 62 and 67) is tabled.

Respectfully submitted,

David Christopherson

Chair