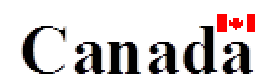
Health Canada   Santé Canada

Final Audit Report

Audit of the Transfer Payments for First Nations and Inuit Public Health Protection

December 2013



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Executive summary

The focus of the audit was on the transfer payment for First Nations and Inuit public health protection (approximately $63.9 M). Aboriginal health is a priority shared by the federal, provincial/territorial governments and First Nations and Inuit communities. Health Canada's First Nations and Inuit Health Branch works with its partners to support a public health protection system that aims to prevent and/or reduce risks to human health associated with communicable diseases and exposure to hazards within the natural and built environment.

The objective of this audit was to provide assurance that the public health protection transfer payments are effectively managed and in compliance with Treasury Board of Canada *Policy on Transfer Payments.* Sufficient and appropriate procedures were performed and evidence gathered to support the accuracy of the audit conclusion. The audit findings and conclusion are based on a comparison of the conditions that existed as of the date of the audit against established criteria that were agreed upon with management.

The current governance framework for the public health protection transfer payments provides for strategic direction and oversight. Roles and responsibilities between headquarters and the regions related to the transfer payments are also clear. The program has a performance reporting strategy. However, there is an opportunity to improve reporting by recipients to align it with other reporting frameworks and program and service delivery standards.

Program risks related to public health protection are identified at the corporate level. While program managers at headquarters and regional offices are risk conscious, both program clusters (Communicable Disease Control and Environmental Public Health) should initiate a specific risk assessment/risk management process to identify and respond to unique program risks related to communicable disease control and environmental public health.

There are controls in place to ensure proper recipient assessment, recipient monitoring and payment release. However, there are three areas where changes can be made to strengthen the internal controls. More specifically, all clauses listed in the *Directive on Transfer Payments* should be included in the contribution agreements; the eligible expenditure categories should be more clearly defined; and efforts to resolve outstanding payables at year-end should continue.

The audit report includes three recommendations to further strengthen the management of transfer payments for First Nations and Inuit public health protection program.

A - Introduction

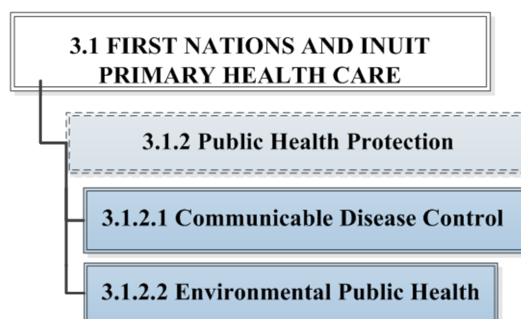
1. Background

Aboriginal health is a priority shared by the federal, provincial/territorial governments and First Nations and Inuit communities. Health Canada's First Nations and Inuit Health Branch works with its partners to support a public health protection system that works to prevent and/or reduce risks to human health associated with communicable diseases and exposure to hazards within the natural and built environment.

This is accomplished through a range of activities at the individual, community and population levels including: provision of health services to prevent, manage and control communicable diseases and to help assure the safety of food, water and living environments; promotion and education efforts to encourage healthy behaviours; research to identify and reduce environmental health risks; strengthening of community capacity to take greater control over public health protection; and collaboration with partners to address the determinants of health.

Health Canada's role in First Nations and Inuit health is based on the *Department of Health Act* (s.4) and the *Indian Health Policy 1979*. Public health protection aligns with the departmental mandate related to First Nations and Inuit communities receiving health services and benefits that are responsive to their needs to improve their health status. Within this program activity, the operational mandate falls within the Primary Health Care Program activity. The Public Health Protection sub-activity includes two program clusters: Communicable Disease Control and Environmental Public Health. Expenditures for these two clusters in the past two years have averaged $63.9M, of which $29.4M (approximately 46 percent), is made up of transfer payments.

First Nations and Inuit Primary Health Care



The **Inter-Professional Advisory and Program Support Directorate**, at headquarters, manages programs under the public health protection umbrella and works with: eight regional offices; First Nations and Inuit organizations; and health authorities to support and improve a wide range of public health programs and initiatives in communities. This Directorate oversees programs and initiatives through its two program clusters: Communicable Disease Control and Environmental Public Health (see Appendix C).

Communicable disease control is a core component of public health protection and is of particular concern for on-reserve First Nations and Inuit communities where the burden of infectious disease is higher than it is for other Canadians. Programming is delivered directly by Health Canada and through contribution agreements. Program activities aim to reduce the incidence, spread and human health effects of communicable diseases. Programming delivered by contribution agreements focuses on vaccine and preventable diseases, while aiming to improve health through disease prevention and health promotion activities among on-reserve First Nations and Inuit communities. Approximately $12M is transferred to recipients annually to support the communicable disease control activity.

The Environmental Public Health cluster is the other core component of public health protection. Programming is delivered directly by Health Canada and through contribution agreements. The Directorate supports the regional offices in the delivery of programs in First Nations communities, in activities such as drinking water safety, food safety and indoor air quality, as well as in the identification of health risks from climate change and environmental contaminants. Approximately $17M is transferred to recipients annually to support the environmental public health activities.

The Communicable Disease Control and the Environmental Public Health clusters have a direct impact on the health and safety of community members and the broader population. As Health Canada does not have public health legislation that applies on-reserve, it is guided by provincial legislative frameworks and supplements and supports provincial and territorial health programs for First Nations and Inuit based on policy rather than legislation.

2. Audit objective

The objective of the audit was to provide assurance that the public health protection transfer payments are managed through an effective control framework; and the transfer payments are in compliance with Treasury Board's *Policy on Transfer Payments*.

3. Audit scope

The audit focused on the management controls within the First Nations and Inuit Health Branch related to governance, risk management and internal controls for the transfer payments under the Public Health Protection program. Tests included aspects of the contribution agreements from the last two fiscal years: 2011-12 and 2012-13.

4. Audit approach

The audit was conducted in conformity with the Treasury Board of Canada's *Policy on Internal Audit* and in collaboration with the First Nations and Inuit Health Branch. Audit methodology consisted of multiple audit steps aimed at confirming the lines of enquiries and criteria presented in Appendix A and encompassed:

- interviews with key headquarters and regional personnel involved in managing the program clusters;
- review of documentation related to governance, stewardship, risk management, results and performance;

- evaluation of the systems of governance, risk management and internal controls within the First Nations and Inuit Health Branch for the three benefits within the audit scope; and
- conduct a detailed review of a sample of transfer payment transactions.

The audit was planned and conducted through the development of a risk assessment and audit program. The audit examined a strategically chosen sample of 28 contribution agreements and 32 payments on which multiple analyses was performed. Additional tests were also performed on 12 payables at year-end.

Fieldwork was performed at headquarters and in Saskatchewan and Manitoba offices. Fieldwork locations were determined after an analysis of the number of contribution agreements (see Appendix E), the number of recipients who received more than $500,000 over the last two fiscal years (see Appendix F) and program risks. Together, these three locations represent 53 percent of the total dollars spent in public health protection transfer payments over fiscal years 2011-12 and 2012-13.

5. Statement of conformance

In the professional judgment of the Chief Audit Executive, sufficient and appropriate procedures were performed and evidence gathered to support the accuracy of the audit conclusion. The audit findings and conclusion are based on a comparison of the conditions that existed as of the date of the audit, against established criteria that were agreed upon with management. Further, the evidence was gathered in accordance with the *Internal Auditing Standards for the Government of Canada* and the *International Standards for the Professional Practice of Internal Auditing*. The audit conforms to the *Internal Auditing Standards for the Government of Canada*, as supported by the results of the quality assurance and improvement program.

B - Findings, recommendations and management responses

1. Governance

1.1 Strategic direction

Audit criterion: *The First Nations and Inuit Health Branch plans for the strategic allocation of resources to the Public Health Protection program.*

Planning and prioritization is part of the process to strengthen public health protection and should be used as an aid in making decisions for resource allocation. The First Nations and Inuit Health Branch communicates its objectives and priorities through the Branch's *Strategic Plan: A Shared Path to Improved Health*. Feeding from the Strategic Plan is the Branch Operational Plan, which communicates in further detail management's expectations for six First Nations and Inuit Health Branch departmental priorities and 22 key initiatives. Both Communicable Disease Control and Environmental Public Health clusters have a program framework which lists the key priorities and initiatives for their respective programs derived from the Branch Operational Plan. The First Nations and Inuit Health Branch's Accountability Framework consists of three objectives: population health and quality focused service delivery; enabling service delivery to be made at the local level based on population needs; and maximizing resources with cost effective measures.

Funding allocation amongst regions (for both Communicable Disease Control and Environmental Public Health clusters) is based historically and lies in the 1976 Indian health envelope. The allocation process involves a formula commonly called the *Berger formula* after Justice Berger, who designed it in 1982 after consultations with First Nations as part of the *Brighter Futures Initiative.* It takes into account population and the number of communities and has been used for allocating funding since that time. The formula for Communicable Disease Control was reviewed in 2006 to take into account differences in the burden of infectious diseases in some regions, based on 2001 data but has not been changed since. For environmental public health, there has not been a systematic review besides First Nation and Inuit population size. Currently, the Branch allocates funding based on differences in provincial requirements and remoteness/isolation of communities.

The audit concludes that the Branch plans for the allocation of public health protection resources using a specified formula however it would be beneficial to review the formula periodically to reflect any year-to-year changes. Any significant changes should be identified as a part of a risk management exercise (see recommendation 2).

1.2 Roles and responsibilities

Audit criterion: *Roles and responsibilities as they relate to transfer payment governance and accountability are documented.*

Transfer payments represent a large part of Health Canada's spending and touch the lives of the First Nation's communities every day. In order for the Department to work as efficiently and effectively as possible, it is important to have clearly defined roles and responsibilities especially in programs that are centrally managed but delivered regionally.

The First Nations and Inuit Health Branch's role and responsibilities are documented in Health Canada's *Grants and Contributions Standard Operating Procedures Manual* and in the First Nations and Inuit Health Branch's "*Knowledge in a Book.*" Both are available on the intranet. There are four units that impact directly on the management of the transfer agreements: the Inter-Professional Advisory and Program Support Directorate; the Strategic Policy, Planning and Information Directorate; the Health Funding Arrangements Division; and regional offices.

The **Inter-Professional Advisory and Program Support Directorate** is responsible for primary health care delivery in partnership with First Nations and Inuit health authorities Within this directorate, both the Communicable Disease Control and Environmental Public Health programs are responsible for overall policy development and for the coordination of committees.

The **Strategic Policy, Planning and Information Directorate** provides strategic policy and planning support and advice to senior management and to regional offices on key health related issues and initiatives. It is also involved in horizontal, cross-branch policy analysis, coordination and integration; quantitative analysis; policy coordination; intergovernmental relations; performance measurement; audit liaison; operational planning and reporting; and, strategic planning.

The **Health Funding Arrangements Division's** role is to develop tools and processes, to provide funding models for contribution agreements and develop accountability policies and practices. The Division also maintains the First Nations and Inuit Health Branch's *Management of Contracts and Contributions System* which provides information about the delivery and management of grants and contributions to more than 1,100 users across the country. Finally, it plays a role in adopting the new *Grants and Contributions Information Management System*, which is supported by Aboriginal Affairs and Northern Development Canada.

The **regional offices** are responsible for direct program delivery with the First Nations and Inuit communities. Each region has a unit responsible for incorporating all programs into contribution agreements with each community. These units are generally staffed by community liaison officers. Each program, like Environmental Public Health and Communicable Disease Control, has program officers monitoring the delivery of the program in each community. In December 2011, the Department re-integrated First Nations and Inuit health regional activities into the First Nations and Inuit Health Branch to enable its support for regional operations. The most significant change affecting regional operations is that regions now report to the Assistant Deputy Minister of Regional Operations. As a result of the First Nations and Inuit Health Branch's reorganization, the delegation of the accountability for some controls was transferred to the regional offices. Interviews and documentation indicate that information flows regularly between headquarters and the regional offices.

The roles and responsibilities between headquarters and the regional operations was documented and validated with program managers in all sites visited and the audit notes that

both are aware of their roles and responsibilities as it relates to the management of transfer payments.

1.3 Performance reporting

Audit criterion: *Governance and accountability for the Public Health Protection transfer payments are achieved through a performance measurement strategy.*

Reporting on performance is an important part of effective management and accountability. Performance reporting should help promote an attitude of continuous improvement and create a feedback loop where reports on activities and performance provide important information to allow for the best possible decision-making in the next planning cycle.

The Performance Measurement Strategy was revised in 2010-11 as a joint effort by the First Nations and Inuit Health Branch headquarters and the regional representatives. Responsibility for the implementation of the strategy rests with program management, mostly in the regional offices through interactions with communities. The strategy focuses on client access to programs and services, awareness of health issues, health workers capacity building, collaboration and partnerships, and service provision. The performance measurement tool has expected results and performance indicators that align with the expected outcomes submitted to Treasury Board in 2010 towards the renewal of programs.

Financial results within each contribution agreement are tracked in a number of ways, mainly through semi-annual financial statements as per the recipient's agreement reporting requirements. Non-financial results are tracked through the Community-Based Reporting Template. The collected information serves various purposes: to monitor progress in achieving results; to report on mid-year and year-end reviews; and to include in departmental performance reports as well as submissions to Treasury Board for program renewal.

Annual community-based reporting

The community-based reporting is an annual collection and analysis of the program performance information in an ongoing effort to support recipients. It is a mandatory requirement of the recipient. The First Nations and Inuit Health Branch uses some of the information to develop reports at the community, regional and national levels. The assembled information may also be shared with Treasury Board to demonstrate compliance with the *Policy on Transfer Payments*.

Guidance for completing the reporting expectations is provided in the *Community-Based Reporting: A Guide for First Nations and Inuit*. The guide provides detailed instructions, definitions, examples of answers and lists of acronyms to assist in reporting. The report is approximately 50 pages and contains numerous questions and open tables which require completion.

Regional offices receive the completed report from the recipients and upload it into the Management of Contracts and Contributions System. The First Nations and Inuit Health Branch has the capability to retrieve it from this database. However, it is evident from an analysis of the community-based reports sections, as well as interviews with program managers, that while the information collected serves the expected reporting requirements,

the process could be strengthened to collect more meaningful information for program management. The questions within the report are very structured and do not take into account individual context such as explanations related to service gaps. For example, "yes" or "no" answers do not always indicate the reason for a particular situation in a community. Program managers often have to go back to the community to get additional information in order to better provide necessary program support. Due to the limitations of the reporting process, most regions rely on information collected from other surveillance and reporting systems.

Within the Strategic Policy, Planning and Information Directorate, the Performance Management Unit produces a summary report of national and regionally aggregated results for six general program areas, including Communicable Disease Control. This summary report supplements information obtained from annual regional performance management reports submitted by regional programs.

The community-based reporting process should be improved to better align with other reporting frameworks and with program and service delivery standards. This could be done while reducing reporting burden and increasing the comparability of data over time and with other sources.

Recommendation 1

> *It is recommended that the Assistant Deputy Minister, First Nations and Inuit Health Branch revise the community-based reporting tool to capture information related to program performance.*

Management response

Management agrees with the recommendation.

The community-based reporting tool is being revised so that the final analysis allows for improved reporting on program objectives and outcomes, to better track improvements over time, and to better link outcomes to program activities.

The exercise to revise the reporting tools requires the development of several new performance indicators related to communicable disease control and environmental public health as well as indicators for several other primary care programs (such as mental wellness). Revision of questions for reporting purposes will occur alongside individual program reviews of their performance measurement strategies.

The revised reporting tool will be implemented over three phases. Phase I will pilot 20-40 communities, Phase II will pilot a larger sample and Phase III will capture the remaining communities. The first phase is scheduled to be launched March 2015.

2. Risk management

2.1 Risk management

Audit criterion: *External and internal risks associated with the Public Health Protection program are identified, assessed and managed.*

According to the Chief Public Health Officer, public health is about preventing disease and optimizing health. By working to keep First Nations/Inuit healthy, the public health system can help to relieve some of the pressures on the hospital and acute health care system. Identifying and assessing the program risks associated with communicable diseases and environmental health would be an important step towards meeting these public health program objectives.

As part of the annual Departmental Integrated Operational Planning Process, the First Nations Inuit Health Branch identifies risks associated with the activities planned for the year, including detailed risk assessments and mitigation strategies. These risks are reviewed by the Senior Management Committee according to the impact and likelihood of the risk occurring. The list covers risks that are common to all programs in the Branch.

Some risks pertaining to public health protection were identified by the Branch during the 2010 program renewal exercise, such as risks related to capacity to deliver, activities aligning with the contribution agreements and communication. However there is not a specific risk registry related to public health protection at the cluster level. To provide a more fulsome risk review, the current exercise should consider external risks such as natural events and inter-relationships with other federal entities, and internal risks such as legal risks and compliance with various regulations such as the *Financial Administration Act*) and policies such as the *Policy on Transfer Payment*. A risk assessment exercise performed by each program cluster, would serve as a more methodical approach to manage risks specific to the Environmental Public Health or Communicable Disease Control programs.

Recommendation 2

> *It is recommended that the Assistant Deputy Minister, First Nations and Inuit Health Branch develop a risk registry for the Environmental Public Health program and update the risks for the Communicable Disease Control program.*

Management response

Management agrees with the recommendation.

Risk management is an important activity for the First Nations Inuit Health Branch. As such, management identifies Branch risks on an annual basis. New in the 2014-15 planning cycle, each cluster (Communicable Disease Control and Environmental Public Health) will identify and align all cluster activities in relationship to the Branch risks. This will better position the Branch to: plan according to risks identified; and to report activities and funds associated with each Branch risk at the Program Alignment Architecture level (or cluster).

3. Internal controls

3.1 Compliance

Audit criterion: *Contribution agreements, including funding models, follow the Policy on Transfer Payments.*

The objective of the *Policy on Transfer Payments* is to ensure that transfer payment programs are managed with integrity, transparency and accountability in a manner that is sensitive to risks; are citizen and recipient-focused; and are designed and delivered to address government priorities in achieving results for Canadians.

The *Directive on Transfer Payments*, more specifically its appendices G (Funding Agreement Provisions for Contributions), H (Funding Agreement Provisions for Up-Front Multi-Year Funding) and K (Transfer Payments for Aboriginal People), provides a list of requirements that are relevant to the contribution agreements under review. The elements therein are either mandatory or must be considered where relevant.

A total of 28 contribution agreements were sampled and examined: 10 from the National Capital Region, 9 from Manitoba and 9 from Saskatchewan. Three of the 28 samples were initiated prior to the 2008 *Policy on Transfer Payments* and were therefore exempted from some of the requirements. For the remaining 25 agreements, there are 36 clauses expected in the agreements. Test results indicate that not all the agreements included all clauses required by the *Directive on Transfer Payments*. The clause on:

- ‘Recognition of federal funding’ was present in 68 percent of the agreements reviewed (17 out of 25).
- ‘Notification to recipient that information may be made public’ was found in only 40 percent of the agreements (10 out of 25).
- ‘Dispute Resolution’ was included in 50 percent of the agreements (14 out of 28). None of the 10 agreements in the National Capital Region contained a dispute clause and 2 in Manitoba and 2 in Saskatchewan also omitted the clause.
- ‘Official languages’ was included in 75 percent of the agreements (21 out of 28). Six of the 7 without that clause were in Manitoba.
- ‘Lobbying’ was found in 89 percent of the agreements (25 out of 28). Three agreements missing this clause were in Saskatchewan. The more likely consequences of missing clauses are disputes between the recipients and the Department, or possibly public incidents.

Overall, the contribution agreements sampled had the majority of the required clauses as per the Treasury Board *Directive on Transfer Payments.* However, only one file had all the required clauses. In regard to the remaining 27 files examined, each one had at least one clause missing. Going forward, contribution agreements should include all the clauses in order to be compliant with Treasury Board expectations.

Recommendation 3

It is recommended that the Assistant Deputy Ministers of the First Nations and Inuit Health Branch update the contribution agreements to include all relevant clauses listed in the Directive on Transfer Payments.

Management response

Management agrees with the recommendation.

The 2008 Directive on Transfer Payments was integrated into the 2010-11 contribution templates in 2009. Recently, the Branch adopted and implemented Aboriginal Affairs and Northern Development Canada's 2012-2013 Year-End Reporting Handbook and Consolidated Audited Financial Statement templates for its Aboriginal recipients.

In the next year, these templates will be reviewed to include all relevant clauses, as the Branch moves towards a collaborative contribution agreement template with Aboriginal Affairs and Northern Development Canada (AANDC). The new collaboration with AANDC is a large undertaking resulting in a major transformation in the way the First Nations and Inuit Health Branch will manage and administer its transfer payment programs. The Branch, in partnership with stakeholders, has a two-year implementation strategy.

3.2 Recipient assessment

Audit criterion: *The First Nations and Inuit Health Branch has procedures to assess recipient capacity in determining funding model decisions.*

Proper management of contribution agreements relies on the capacity of the recipient to manage the funds. Recipient capacity and readiness is contingent on eligibility, past performance, legal status and mandate. The choice of funding model and its inherent flexibility level for recipient activities flows from the recipient assessment.

The *Directive on Transfer Payments* refers to three funding models for Aboriginal recipients: set; flexible; and block. Set agreements allow for the *least* flexibility while block agreements allow for the *most* flexibility. Since public health protection activities are mandatory, the money transferred for the Communicable Disease Control and for the Environmental Public Health programs must be spent in those activities. As such, public health protection activities are set portions within flexible of block agreements. In this instance recipient capacity is less of a factor as there is no flexibility in how the money is to be spent. That said, financial and program management assessments must be performed on the overall agreements with the communities.

Prior to entering a new flexible or block funding model, the First Nations and Inuit Health Branch assesses a recipient's past performance, financial and program management capacities. Based on the funding model selected, the recipient must complete either a multi-year work plan or health plan for the Department's review and approval. The plan is reviewed by a multi-disciplinary team and recommendations are made to the Regional Director.

3.3 Recipient monitoring – Risk analysis

Audit criterion: *The First Nations and Inuit Health Branch analyses recipient risk to establish the need for intervention and to adjust monitoring levels.*

The *Policy on Transfer Payments* emphasizes the need for effective risk management in the administration of grants and contributions programs and clarifies accountabilities for ministers and deputies in order to ensure that they are managed in a citizen and recipient focused way. In response to the Policy, Health Canada, the Public Health Agency of Canada, and the Canadian Institutes of Health Research implemented the Health Portfolio Integrated Risk Management Framework for grants and contributions. The Framework reflects senior management's risk tolerance and establishes the mandate for risk management tools and processes, including using the automated tool - Enterprise Risk Management.

The Enterprise Risk Management is a computer tool that allows program officers to assess risks associated with grants and contributions. The aim is to assist program areas in managing risks associated with funding agreements (projects) and recipients. The Enterprise Risk Management system currently includes the Agreement/Recipient Risk Assessment Tool module for assessing and managing risks related to individual funding agreements/projects and recipients.

The Enterprise Risk Management-Agreement/Recipient Risk Assessment Tool exercise classifies risks in three categories: low, medium, or high. In addition, the Enterprise Risk Management-Agreement/Recipient Risk Assessment Tool provides for a risk tolerance strategy for risk levels in three categories of overall risk, performance, and audit and finance risk. As a result, various actions may be undertaken such as restrictions in advances, withholdings of payments or even a recipient audit of high risk recipients.

A risk assessment was documented in 27 of the 28 sampled agreements. Overall, the First Nations and Inuit Health Branch analyses recipient risk to establish the need for intervention and to adjust monitoring levels.

3.4 Recipient monitoring - Accountability

Audit criterion: *The First Nations and Inuit Health Branch receives accountability documents in accordance with the terms and conditions of the agreement.*

Each contribution agreement has reporting requirements that the recipient must provide in a timely manner to allow program managers to keep track of the recipient's activities. If a recipient's reporting is late beyond an agreed upon time frame (generally 45 days), the program may withhold funding on non-mandatory programs. In the sampled contribution agreements, reporting requirements included interim and annual financial statements and an annual activity report. For flexible and block agreements, a third reporting requirement was an annual audit report.

There were instances of late reporting: two financial statements, one activity report, and one audit report. In each case, action was taken by the First Nations and Inuit Health Branch to follow-up with the recipient to obtain the late reports.

Therefore, the sampled contribution agreements provided evidence that the First Nations and Inuit Health Branch receives accountability documents in accordance with the terms and conditions of the contribution agreements.

3.5 Recipient monitoring – Eligible expenses

Audit criterion: *The First Nations and Inuit Health Branch has a process to approve and validate the eligibility of expenses as per the terms and conditions of the agreement.*

The audit found evidence that eligible expenditures had been reported and approved. Contribution agreements included a health plan or proposal prepared by the recipient and the assessment by program managers, describing what the recipient intends to achieve with the funding as well as various reporting requirements.

However, while examining reported expenses, confirming the eligibility of the reported expenses was challenging because neither the plans nor the annexes clearly specified the eligible expense categories. For example, the contribution agreements described eligible expenditures as "*goods and services directly related to the carrying out of the Recipient's responsibilities under this Agreement*". With this definition, the recipient may not be clear on what constitutes a permissible expenditure.

Management notes that the approved Terms and Conditions allow for broad generic categories of eligible expenditures. However for program design purposes, permissible expenditures should be defined for contribution agreement purposes. Appendix G of the *Directive on Transfer Payments* prescribes that the contribution agreements should include the type and nature of expenditures that are considered eligible as well as any limits on the amounts payable for particular categories of eligible costs, and the flexibility for recipients to redirect funding among cost categories. Moreover, in recent recipient audits (2011-12), the most common recommendation made by the auditors included the need for the recipients to clearly identify activities and eligible expenditures. For that to happen, eligible expenditures would have to be well defined in the agreement to avoid inconsistencies or misinterpretations in reporting expenses by recipients. Going forward, management reports that the new contribution agreement templates should allow for First Nations and Inuit Health Branch to more clearly specify the eligible expense categories.

3.6 Release of payments

Audit criterion: *The First Nations and Inuit Health Branch releases payments in accordance with the funding agreement and the Financial Administration Act.*

To provide assurance that the payments were made in compliance with the requirements of the *Financial Administration Act* and in compliance with the terms and conditions of the contribution agreement, a sample of 32 payment transactions from 28 contribution agreements were tested. The audit team tested to determine that the documentation submitted was in accordance with the requirements established in the agreements and to determine that the documentation was sufficient to support payment. Also, payments were tested for accuracy and compliance with Section 32 (commitment of funds) and Section 34

(certification that goods and services have been delivered as per the funding agreement and Act).

All sampled payment transactions showed evidence that the process and controls were operating consistently and that payments were released in accordance with the Act and the funding agreement. In addition, approval was performed by an authorized officer.

The audit also examined a sample of payables at year-end because such transactions require Section 34 certification from the responsible managers. Payables at year-end are financial obligations to contractors, recipients or employees as a result of transactions, services rendered or verifiable events that occur before the end of the fiscal year. The purpose of payables at year-end is to match expenses with the parliamentary votes of a given fiscal year. For contribution agreements that are paid through instalments, the last instalment of a given year may be delayed and set up as a payable at year-end. However, they should not be based purely on open commitments or used towards expenses of the subsequent year.

In a random sample of eight payables at year-end recorded in April 2011, seven were outstanding after four months. Of the seven, six were cleared in the following month; however, one payable at year-end (with a value of $29,610) was still outstanding on July 9, 2013 (27 months later). Furthermore, in half of the cases, justification for accruing those payables at year-end was not explicit. In addition, in one of the regions, a 2010-11 payable at year-end schedule showed $209,000 outstanding from the previous year. Outstanding payable at year-end have an impact on expenses reported and therefore, should be resolved in a timely manner.

In 2009, the Chief Financial Officer Branch implemented enhancements to the payable at year-end set up process. The process requires program officers complete a payable at year-end setup request form and to certify that the service is rendered under Section 34 of the Act. The branch senior financial officers or the regional senior financial officers must then determine if the documentation and justification for setting up the liability are reasonable. Once the new fiscal year starts, payments are matched against their respective payables at year-end when the conditions of the agreement are met and unused amounts are closed. In the months of August and September, the Central Accounting and Reporting Section of the Chief Financial Officer Branch sends a request to branch senior financial officers or the Regional Senior Financial Officer to review outstanding payables at year-end. As a result of the new enhancements, balances in payables at year-end from transfer payments have gone down 52 percent since 2007-08. Payables at year-end carried over from previous years have also been reduced by 80.3 percent over the same period. At the beginning of April 2013, there were less than $10.5 M in transfer payment payables at year-end carried from previous years; however $2.8M were more that two years old.

At the time of the audit, monitoring of the payables at year-end was the responsibility of each regional senior financial officer along with some monitoring from headquarters. Since that time the accounting operations have been consolidated from 14 district accounting offices into two accounting hubs with more standardized accounting methods. In that regard, the two accounting hubs will soon be responsible for the recoding and settlement of the payables at year-end. However, branch senior financial officers and regional senior financial officers will continue to have a role in the review and sign-off of payable at year-end requests and in the

subsequent monitoring of the payable at year-end balances throughout the year to oversee that payables are cleared in a timely manner. Given the new approach has only recently been implemented, the operating effectiveness should be further monitored. A recent audit completed during the same timeframe - *Audit of Regional Internal Services,* December 2013, has a similar finding and makes a recommendation for the Chief Financial Officer to monitor the operating effectiveness of the payable at year-end process within the new accounting hubs. The recommendation and management action plan which agrees to monitor the payable at year-end process in the hubs will serve to address the similar finding in this audit report.

C - Conclusion

Health Canada's key objectives in relation to First Nations and Inuit health are to improve health outcomes; to ensure the availability of, and access to, quality health services and to support the greater control of the health system by First Nations. One of the means to meet this objective is through the Public Health Protection contribution agreement where funds are provided to recipients for programs to control and manage communicable diseases and for programs related to environmental health to monitor the safety of drinking water and environmental health and contaminant issues.

Activities related to the transfer payment within the Public Health Protection sub-activity are well planned. The First Nations Inuit Health Branch administers the program through a strategic plan and the funds are allocated using a funding formula. While staff is risk conscious, the program should conduct a formal risk exercise to identify and assess specific program risks for both Environmental Public Health and Communicable Disease Control clusters. Once the risks are identified and assessed, management will be better positioned to develop mitigating strategies to reduce the risks associated with First Nations and Inuit public health.

Management has in place a mechanism which allows the communities to report on the performance of health programs and services. Community-based reporting is an annual collection and analysis of the program performance information in an ongoing effort to support recipients. The report should be reviewed and updated to capture pertinent performance information.

In relation to the contribution agreements, they were found to be generally compliant with the Treasury Board’s *Policy on Transfer Payments*. However, some required clauses were not found and the agreements could be made clearer on eligible expenses/activities. Finally, payments are released in accordance with the funding agreement and the *Financial Administration Act* however, efforts to reduce payables should continue. As well, management monitors the transfer payments by receiving and reviewing, in a timely manner, sufficient recipient accountability reports.

The audit report includes three recommendations to further aid in strengthening the management of transfer payments for First Nations and Inuit public health protection.

Appendix A – Lines of enquiry and audit criteria

Audit of the Transfer Payment for First Nations and Inuit Health Protection	
Criteria Title	**Audit Criteria**
	Line of Enquiry 1: ***Governance and Accountability***
1.1 Strategic direction[1]	The First Nations and Inuit Health Branch plans for the strategic allocation of resources to the Public Health Protection program.
1.2 Roles and responsibilities[2]	Roles and responsibilities as they relate to transfer payment governance and accountability are documented.
1.3 Performance reporting [1,2]	Governance and accountability for Public Health Protection transfer payments are achieved through a performance measurement strategy.
	Line of Enquiry 2: ***Risk Management***
2.1 Risk management[3]	External and internal risks associated with Public Health Protection program are identified, assessed and managed.
	Line of Enquiry 3: ***Internal Control***
3.1 Compliance[3]	Contribution agreements, including funding models, follow the *Policy on Transfer Payments*.
3.2 Recipient assessment[3]	The First Nations and Inuit Health Branch has procedures to assess recipient capacity in determining funding model decisions.
3.3 Recipient monitoring – Risk analysis[3]	The First Nations and Inuit Health Branch analyses recipient risk to establish the need for intervention and to adjust monitoring levels.
3.4 Recipient monitoring – Accountability[3]	The First Nations and Inuit Health Branch receives accountability documents in accordance with the terms and conditions of the agreement.
3.5 Recipient monitoring – Eligible expenses[3]	The First Nations and Inuit Health Branch has a process to approve and validate the eligibility of expenses as per the terms and conditions of the agreement.
3.6 Release of payment[3]	The First Nations and Inuit Health Branch releases payments in accordance with the funding agreement and the *Financial Administration Act*.

[1] Office of the Comptroller General – Core Controls
[2] Treasury Board *Policy on Transfer Payments* and approved funding documentation
[3] Sections 32.33 and 34 of the *Financial Administration Act*

Appendix B – Scorecard

Criterion	Rating	Conclusion	Rec #
Governance and Accountability			
1.1 Strategic direction	**NMI**	Strategic plans and directives aimed at achieving operating effectiveness of the program are in place. The funding allocation formula should be reviewed.	2
1.2 Roles and responsibilities	**S**	Roles and responsibilities are clearly defined, documented, and understood.	
1.3 Performance reporting	**NI**	Reporting exists, tools to gather information from recipients need to be enhanced.	1
Risk management			
2.1 Risk management	**NMO**	Profiling and documenting program risks specific to Communicable Disease Control and Environmental Public Health is required.	2
Internal controls			
3.1 Compliance	**NMO**	All required clauses of the *Directive on Transfer Payment* should be in the agreements.	3
3.2 Recipient assessment	**S**	Procedures are in place to properly assess recipient capacity to support the financial model decisions.	
3.3 Recipient monitoring – Risk analysis	**S**	Recipient risk is analyzed to establish the need for intervention and to adjust monitoring levels.	
3.4 Recipient monitoring – Accountability	**S**	Accountability documents are received in accordance with the terms and conditions of the contribution agreements.	
3.5 Recipient monitoring – Eligible expenses	**NMI**	Eligibility of expenditures is verified before payment but permissible expenses should be clearly defined.	
3.6 Release of payment	**NMI**	Payables at year-end should be reviewed and challenged for validity and accuracy. See similar finding and recommendation in the 2013 *Audit of Regional Internal Services.**	

S	NMI	NMO	NI	U	UKN
Satisfactory	Needs Minor Improvement	Needs Moderate Improvement	Needs Improvement	Unsatisfactory	Unknown; Cannot Be Measured

Appendix C – Expenditures for Primary Health Care

Expenditures by Program Alignment Architecture

	Fiscal Year 2011-12		Fiscal Year 2012-13	
Expenditures by Program Alignment Architecture	**Contributions**	**Operations & maintenance Salaries & Capital**	**Contributions**	**Operations & maintenance Salaries & Capital**
3.1 - Primary Health Care	$698, 521, 455	$228,646,370	$700, 514,842	$223,754,579
3.1.1 Public Health Promotion	$442, 055, 417	$58,487,964	$444, 490, 145	$51,788,128
3.1.2 Public Health Protection	$ 91, 816, 193	57,379,665	$ 87, 564, 638	$51, 387,815
Communicable Disease Control*	$13, 240, 015	13, 270, 544	$10, 689, 177	$12, 858,269
Environmental Public Health*	$17, 328, 958	22, 579, 173	$17, 551, 485	$20, 254,680
Subtotal	**$30, 568, 973**	**35, 849, 717**	**$28, 240, 662**	**$33, 112, 949**
KZ2 Program oversight	1,800, 523	4,383,105	2, 262, 235	3, 840,909
KZ11 Nursing service delivery	59, 446, 697	17, 146, 843	57, 061, 741	14, 433, 957
3.1.3 Primary Care	$ 164, 649, 845	$112,778,741	$168, 460,059	$120,578,636

***Shaded area in scope – Program activity: First Nations and Inuit Health Care - Covered under approved funding for Public Health Protection activities**

Appendix D – Expenditures by program elements

Expenditures by Program Elements for Communicable Disease Control

	FY 2011/2012		FY 2012/2013	
Communicable Disease Control	**CA funding ($)**	**O&M, Salaries and Capital ($)**	**CA funding ($)**	**O&M, Salaries and Capital ($)**
Communicable Disease Control - Policy & Program Development	116,931	3,721,454	41,802	3,525,219
Immunization Prevention & Promotion & Education	1,243,585	930,630	1,086,265	720,104
Immunization Coordination Planning & Reporting	102,637	1,213,414	71,638	1,632,941
Vaccine Preventable Disease Outbreak Management	101,086	650	144,040	3,218
Tuberculosis (TB) Prevention & Promotion & Education	3,845,366	1,560,995	2,065,908	1,668,313
Tuberculosis (TB) Coordination Planning & Reporting	502,526	1,986,285	247,989	1,554,803
Tuberculosis (TB) Outbreak Management	29,508	1,184,005	50,000	1,155,529
Communicable Disease Emergencies Planning & Response	1,389,109	921,185	913,844	810,879
Communicable Disease Infection Prevention & Control	294,517	74,100	86,663	226,138
Blood Borne Diseases and Sexually Transmitted Infections (BBSTI) -HIV/AIDS Prevention & Promotion & Education	4,452,970	473,916	5,395,968	267,063
Blood Borne Diseases and Sexually Transmitted Infections (BBSTI) – HIV/AIDS Surveillance and Research for Knowledge Development	420,419	19,659	104,170	3,015
Blood Borne Diseases and Sexually Transmitted Infections (BBSTI) -HIV/AIDS Coordination Planning & Reporting	701,361	1,118,280	440,890	1,186,145
Emergency Preparedness	40,000	65,971	40,000	104,908
CDC Total	**13,240,015**	**13,270,543**	**10,689,177**	**12,858,276**

Expenditures by Program Elements for Environmental Public Health

	FY 2011/2012		FY 2012/2013	
Environmental Public Health	**CA funding ($)**	**O&M, Salaries and Capital ($)**	**CA funding ($)**	**O&M, Salaries and Capital ($)**
Chemical Trade Food Safety	1,218,000	369,117	1,414,900	150,073
Climate Change	103,411	232,740	1,829,836	294,547
Drinking Water & Wastewater	11,239,674	8,638,399	11,106,571	8,504,980
Environmental Health Research - Policy & Program Development	52,800	902,916	-	674,235
Environmental Public Health - Policy & Program Development	46,257	4,771,905	40,229	3,789,134
EPH-Comunicable Disease Control	237,547	1,075,462	76,747	750,556
First Nations Biomonitoring & Guides	1,290,000	739,565	350,000	293,309
First Nations Enviromental Contaminant Programming	2,369,405	228,039	1,828,731	112,894
Other EPH Programming	771,864	5,621,030	904,471	5,684,952
EPH Total	**17,328,958**	**22,579,173**	**17,551,485**	**20,254,679**

CDC and EPH Grand Total	**30,568,973**	**35,849,717**	**28,240,662**	**33,112,955**

Appendix E – Expenditure profile by region

In order of largest 2-year percentage of total contribution funding

	Fiscal Year 2011-12			Fiscal Year 2012-13			Transfer Payments 2-Year % of Total
Region	**CA funding ($)**	**O&M, Salaries and Capital ($)**	**# of CAs**	**CA funding ($)**	**O&M, Salaries and Capital ($)**	**# of CAs**	
SASK	**7, 242, 413**	2,983,096	70	**7, 274, 041**	3,171,173	55	**24.7%**
NCR	**5, 271, 738**	7,689,849	25	**3, 888, 295**	6,124,053	11	**15.6%**
Pacific	**4, 126, 515**	5,934,107	144	**4, 267, 257**	5,545,038	146	**14.3%**
Manitoba	**4, 550, 877**	4,015,627	63	**3, 043, 724**	3,682,982	61	**12.9%**
Ontario	**3, 273, 694**	5,416,978	100	**3, 236, 056**	5,593,069	116	**11.1%**
Alberta	**2, 368, 183**	4,785,662	52	**2, 412, 997**	4,456,193	54	**8.1%**
Quebec	**1, 842, 140**	1,899,894	32	**1, 338, 703**	1,603,073	30	**5.4%**
Atlantic	**1, 652, 607**	2,033,938	41	**1, 547, 789**	2,193,620	41	**5.4%**
Northern	**240, 806**	7	3	**960, 612**	-	10	**2.0%**
Yukon	**-**	-	4	**271, 188**	-	4	**0.5%**
Grand Total	**30, 568, 973**	**34,759,158**	**534**	**28, 240, 662**	**32,369,201**	**528**	**100%**

Contribution Agreements: 2-Year Total **$58, 809, 635**

CA	Contribution Agreements
O&M	Operations & Maintenance
# of CAs	Number of Contribution Agreements
SASK	Saskatchewan
NCR	National Capital Region