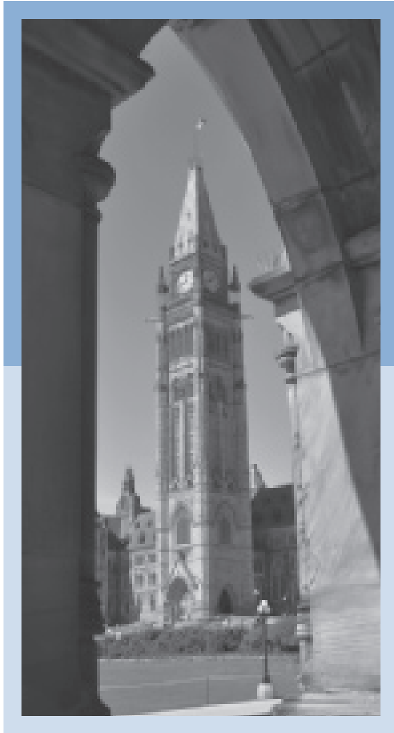

Fall 2015

Reports of the Auditor General of Canada

REPORT 7
Establishing the First Nations Health Authority in British Columbia

OAG

Office of the Auditor General of Canada

The Report is available on our website at www.oag-bvg.gc.ca.

Ce document est également publié en français.

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Cat. No. FA1-2015/2-7E-PDF
ISBN 978-0-660-03547-5
ISSN 1701-5413

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Introduction

Previous audits of programs and services for First Nations people

7.1 The Office of the Auditor General has conducted audits of federal programs and services for First Nations people in areas such as education, health, water, housing, child and family services, and reporting requirements. These audits reported various deficiencies, including

- persistent gaps between the secondary school completion rates for First Nations people on reserves and for other Canadians;
- problems in the administration of non-insured health benefits (health-related goods and services that are not insured by provinces or private insurance plans) to First Nations people living on and off reserves;
- the absence of regulations for monitoring water quality on reserves, despite the existence of such regulations in every province and territory;
- a significant housing shortage on reserves and the need for major renovations of existing housing, because of mould and contamination;
- rates of removal of First Nations children from their homes that far exceeded the rates for other Canadian children; and
- federal government reporting requirements for First Nations communities, many having fewer than 500 residents, that imposed a significant administrative burden without serving a clear purpose.

7.2 In the 2011 June Status Report of the Auditor General of Canada, Chapter 4—Programs for First Nations on Reserves, the Office reported on an audit on progress made by the federal government in implementing a selection of recommendations we had made in previous audits in these areas. The 2011 audit found that progress in response to several recommendations was unsatisfactory. It also found that, even in areas in which federal actions had led to satisfactory progress in the implementation of our recommendations, the results in many cases had not led to significant improvements in the lives and well-being of First Nations people living on reserves.

7.3 The preface of the 2011 report highlighted four structural impediments that, in our opinion, severely limited the delivery of public services to First Nations communities and impeded improvements to living conditions on reserves:

- lack of clarity about the type and level of services the federal government supports;

- the absence of a legislative or regulatory framework for programs to support First Nations communities;
- the absence of an appropriate funding mechanism for programs delivered in communities; and
- the absence of organizations to support local service delivery.

7.4 The preface of that report elaborated on why overcoming each of these structural impediments was important for improving program and service delivery. For example, it noted that the federal government supported many services on reserves that provincial and municipal governments normally provided off reserves. However, it was not always evident that the federal government was committed to providing services of the same range and quality on reserves as those provided off reserves. The preface also commented on the need for a legislative basis for programs and services. A legislative basis would help improve accountability by specifying roles and responsibilities, would clarify eligibility requirements, and would constitute an unambiguous commitment on the part of government to deliver those programs and services.

7.5 The preface of the 2011 report also commented on how an appropriate long-term funding mechanism for programs and services delivered by First Nations could better enable long-term planning. This proposed funding mechanism was in contrast with many federal contribution agreements with First Nations, which typically had to be renewed yearly. Finally, the preface emphasized the importance for organizations to support local service delivery. Although the provinces have school boards, health service boards, and social service organizations to support local delivery, there were few similar organizations to support service delivery within First Nations.

7.6 In our audits of First Nations programs since 2011, we have observed that these structural impediments continue to affect service delivery on reserves. For example, in the 2014 Spring Report of the Auditor General of Canada, Chapter 5—First Nations Policing Program—Public Safety Canada, we examined policing on reserves. We found that some agreement holders (First Nations or First Nations organizations) had less than one month's notice to complete negotiations of their policing agreements. These agreements provide funding to First Nations communities to enhance existing police services or to deliver their own policing services.

7.7 In the 2015 Spring Reports of the Auditor General of Canada, Report 4—Access to Health Services for Remote First Nations Communities, we found that Health Canada did not know whether its support was providing comparable access to services for First Nations individuals in remote communities, and that it had not assessed whether nursing stations had the capacity to provide the services that it had

defined as essential. In the audits since 2011, we also found an ongoing lack of coordination among federal and provincial jurisdictions, which led to a lack of clarity as to what services are to be provided at what service levels, and what legislation applies.

7.8 On the basis of audits reported up until 2011 and since then, the Office remains of the opinion that change is needed if First Nations are to experience better outcomes from the services they receive. We recognize that the issues are complex and that solutions require concerted efforts by both the federal government and First Nations, in collaboration with provincial governments and other parties. We also recognize that the federal government cannot put all of the required structural changes in place by itself, as First Nations have a key role to play.

7.9 We have seen an example in British Columbia of how structural impediments can be overcome. The developments associated with the 2013 transfer of responsibility for health programs and services from the federal government to First Nations in British Columbia illustrated how such impediments can be addressed. This initiative took almost 10 years to achieve, and it led to the establishment of the First Nations Health Authority. Although it is still too early to assess the impact of this development, and whether the health of First Nations people in British Columbia will be improved because of it, the establishment of the Authority was an important milestone in the evolving relationship between British Columbia First Nations and the federal government.

The First Nations Health Authority

7.10 The Province of British Columbia is home to a diverse First Nations population. There are over 200 First Nations, including about 40 remote First Nations communities (some of which are located over 350 kilometres from the nearest service centre). Some of these 40 communities have year-round access by road to service centres, while other communities do not have year-round access by road to any service centres. According to Statistics Canada, in 2011 there were approximately 155,000 First Nations people residing in British Columbia, including just over 60,000 individuals with registered Indian status living off reserves. First Nations people in the province, like those across the country, face a variety of economic, social, and health challenges.

7.11 According to provincial statistics, health outcomes for First Nations people living in British Columbia are poor when compared with those of the wider provincial population (Exhibit 7.1). Youth suicide rates for Status Indians, for example, are just over four times those of other British Columbia residents. The federal and provincial governments, as well as First Nations leaders in British Columbia, have acknowledged that these disparities are partly due to poorly coordinated parallel federal and

provincial health systems, fragmented services, and numerous federal funding agreements with small, geographically dispersed communities. First Nations leaders, the Government of Canada, and the Government of British Columbia have all agreed that the status quo was unacceptable.

Exhibit 7.1 Health outcomes for Status Indians compared with other British Columbia residents

Indicator	Status Indians	Other British Columbia residents
Life expectancy at birth (five-year average, 2006–10)	74.7 years	81.1 years
Age-standardized mortality rate (2010)	76.3 per 10,000	45.5 per 10,000
Youth suicide rate, ages 15–24 years (five-year aggregate, 2006–10)	3.0 per 10,000	0.7 per 10,000
Infant mortality rate (five-year aggregate, 2006–10)	7.2 per 1,000	3.5 per 1,000
Age-standardized prevalence rate for diabetes (2010–11)	8.0 per 100	5.8 per 100

Source: Data from the British Columbia Provincial Health Officer's Special Report, *The Health and Well-being of the Aboriginal Population* (2012)

7.12 The First Nations Health Authority, a province-wide, not-for-profit organization, was established to

- design, deliver, and fund delivery of First Nations health programs province-wide;
- enhance First Nations involvement in decision making about health care;
- improve access to available health services and address quality issues;
- facilitate integration between federal and provincial health services; and
- provide health services and support to over 200 First Nations, many of them having populations of fewer than 500 residents.

7.13 The First Nations Health Authority has its headquarters in West Vancouver. It assumed full responsibility for program and service delivery in 2013 after almost 10 years of negotiations among British Columbia

First Nations, the Government of Canada, and the Government of British Columbia. The British Columbia Tripartite Framework Agreement on First Nation Health Governance, signed in 2011, committed to funding the Authority for a 10-year period. Subsequently, through the Canada Funding Agreement (signed in 2013), the Government of Canada committed to providing the Authority up to $4.7 billion from 2013–14 to 2022–23. In the Tripartite Agreement, the Government of British Columbia also committed to providing $83.5 million to the Authority over 9 years.

7.14 The Authority took over responsibility for federal health programs and services previously delivered by Health Canada's First Nations and Inuit Health Branch–Pacific Region. This totalled 11 programs, including primary care, mental health and addictions programs, and the administration of non-insured health benefits. It also assumed responsibility for coordinating health programs and services with the province's existing regional health authorities and for funding and supporting the delivery of health services at the local level in First Nations communities. The Authority established some of its own goals to guide the transition, including minimizing disruption of services to First Nations communities.

Focus of the report

7.15 We undertook this work to inform Parliament about how efforts by British Columbia First Nations and Health Canada overcame the structural impediments identified in the 2011 June Status Report of the Auditor General of Canada, Chapter 4—Programs for First Nations on Reserves, as they established the First Nations Health Authority in British Columbia.

7.16 As part of this work, we identified success factors that, in our opinion, helped to overcome the structural impediments we had identified in our 2011 audit and that helped to establish the First Nations Health Authority. Our identification of success factors is not meant to be prescriptive, but it may be useful to First Nations and other governments that are considering similar transfers. Although we did not formally examine the Province of British Columbia's activities as part of the report, we noted its significant and ongoing support in the process, and have referred to the Province's contribution in this report.

7.17 This report includes a study that covers the period from 2005 to Health Canada's finalization of the transfer of control to the First Nations Health Authority in 2013. During work on the study, we added to the scope by conducting an audit of selected aspects of the Authority's accountability and governance framework. We examined its early implementation of that framework, over the period from 2013 to 2015. We conducted this audit in response to an anonymous document we

received, making allegations against the Authority in relation to its accountability and transparency. The objective of this audit was to determine whether the First Nations Health Authority had established and implemented selected elements of an accountability and governance framework.

7.18 The study (detailed in paragraphs 7.20 to 7.52) is largely descriptive and was based on research and interviews with officials from the First Nations Health Authority, Health Canada, and selected stakeholders. We conducted the audit of selected elements of the Authority's accountability and governance framework (detailed in paragraphs 7.53 to 7.102) through document and file review, and through interviews with officials from the First Nations Health Authority and Health Canada. Neither the study nor the audit comments on how well the First Nations Health Authority is planning for and delivering programs and services to First Nations communities.

7.19 More details about the objectives, scope, and approach are in **About the Report** on pages 29 and 30.

Study

7.20 The objective of this study was to inform Parliament about how efforts by British Columbia First Nations and Health Canada overcame the structural impediments identified in the 2011 June Status Report of the Auditor General of Canada, Chapter 4—Programs for First Nations on Reserves, as they established the First Nations Health Authority in British Columbia.

Establishing the First Nations Health Authority

7.21 Overall, British Columbia First Nations, Health Canada, and the Province of British Columbia successfully collaborated over a period of almost 10 years to develop a new model for providing health services to First Nations in British Columbia. Specifically, efforts to establish the Authority were facilitated by

- a sustained commitment of British Columbia First Nations leaders, and of leaders from the Government of Canada and the Government of British Columbia;
- a single British Columbia First Nations point of contact to negotiate with the federal and provincial governments; and
- the Tripartite Framework Agreement on First Nation Health Governance and the related 10-year Canada Funding Agreement that addressed challenges related to the four structural impediments we identified in the 2011 June Status Report of the Auditor General of Canada, Chapter 4—Programs for First Nations on Reserves: the lack of clarity about the type and level of services the federal government supports; the absence of a legislative or regulatory framework for programs to support First Nations communities; the absence of an appropriate funding mechanism for programs delivered in communities; and the absence of organizations to support local service delivery.

Sustained commitment of leaders was critical to establishing the Authority

7.22 Sustained commitment over a period of almost 10 years by key leaders from British Columbia First Nations, the Government of Canada, and the Government of British Columbia served to build a climate of trust and respect. This allowed the parties to discuss and negotiate an approach to transferring responsibility for health programs and services to British Columbia First Nations. A series of accords and agreements reflected the evolution of the relationship and spelled out how change was to be facilitated, the goals and milestones to be achieved, and the responsibilities of each party (Exhibit 7.2).

Exhibit 7.2 Key milestones led to the establishment of the First Nations Health Authority

Milestone	Description
Leadership Accord (2005)	An accord among the Union of British Columbia Indian Chiefs, the First Nations Summit, and the British Columbia Assembly of First Nations (together referred to as the First Nations Leadership Council), which affirmed mutual respect and formalized a collaborative working relationship on issues of common concern.
New Relationship statement (2005)	An accord between the First Nations Leadership Council and the Province of British Columbia, as represented by the Premier, which set out a shared vision, goals, and principles, and committed to establishing processes and institutions for sharing decision making between British Columbia First Nations and the Province.
Transformative Change Accord (2005)	An accord among the Province of British Columbia, the First Nations Leadership Council, and the Government of Canada, which outlined the need to work together for the next 10 years to close gaps between First Nations and non–First Nations people in several areas, including health.
Transformative Change Accord: First Nations Health Plan (2006)	A plan developed by the First Nations Leadership Council and the Province of British Columbia that identified priorities for action to close the health gap between First Nations and non–First Nations people in British Columbia.
First Nations Health Plan Memorandum of Understanding (2006)	An agreement whereby Health Canada agreed to work with First Nations and the Province of British Columbia to close the health gap between First Nations and non–First Nations people in British Columbia.
Tripartite First Nations Health Plan (2007)	A plan signed by the First Nations Leadership Council, the Province of British Columbia, and the Government of Canada that established and coordinated a tripartite partnership for improving the health of First Nations people and their communities in British Columbia.
First Nations Health Society (2009)	A body established under the British Columbia *Society Act* to execute the Health Plan at arm's length from First Nations political organizations. The Society (which became the First Nations Health Authority in 2012) was responsible for providing strategic direction on health matters.
Tripartite Framework Agreement on First Nation Health Governance (2011)	An agreement between the First Nations Health Society (endorsed by the First Nations Health Council), the federal Minister of Health, and the Province of British Columbia, setting out specific commitments related to improving the health and well-being of First Nations individuals and communities.

Exhibit 7.2 Key milestones led to the establishment of the First Nations Health Authority (continued)

Milestone	Description
Health Partnership Accord (2012)	An accord between the First Nations Health Council, Health Canada, and the British Columbia Ministry of Health to confirm the partnership and its commitment to First Nations health.
Establishment of the Joint Project Board (2012)	A board that serves as a senior bilateral forum between the assistant deputy ministers of the British Columbia Ministry of Health and senior officials within the Authority. A primary focus of the Board is to enhance primary care services and delivery through collaborating on strategic priorities, overcoming policy barriers, supporting regional initiatives, and integrating services across the province.
Adoption of the Authority's title (2012)	The Society had the word "interim" removed from its title to reflect official recognition of the Authority's title.
Canada Funding Agreement (2013)	An agreement between Health Canada and the First Nations Health Authority, which provided funding to the Authority for a 10-year period to support the transfer of health programs from Health Canada to plan, design, manage, deliver, and fund the delivery of First Nations health programs. The Agreement provided up to $4.7 billion in funding from the 2013–14 to 2022–23 fiscal years and included specific corporate governance requirements for the Authority.
Formal transfer of Health Canada's responsibilities to the Authority (1 October 2013)	Full assumption of responsibility by the First Nations Health Authority for the administration of federal health programs and services previously delivered by Health Canada's First Nations and Inuit Health Branch–Pacific Region.

7.23 The leaders of First Nations in British Columbia, as represented by the Union of British Columbia Indian Chiefs, the First Nations Summit, and the British Columbia Assembly of First Nations, demonstrated a commitment over several years to championing change. By agreeing to work together, they played a key role in facilitating negotiations on health-related matters with the other levels of government.

7.24 First Nations officials stated that early support of the Premier of British Columbia was essential to getting negotiations started, as was support from the federal Minister of Health. This support was maintained by subsequent premiers and federal ministers, and was key to sustaining the momentum of the negotiations and the transfer of responsibilities in 2013.

7.25 As part of the negotiations, federal and provincial leaders agreed in the New Relationship statement (2005) that British Columbia First Nations people, as residents of the province, were entitled to the

same level of services as all provincial residents were. This agreement provided the basis to engage fully with First Nations, which had the effect of creating and sustaining a new relationship between First Nations people and the Government of British Columbia. This engagement supported innovation by senior public servants at both the federal and provincial levels and enabled them to adhere to and advance the vision articulated by the ministers and chiefs.

First Nations identified a single point of contact, which facilitated negotiations with other levels of government

7.26 In 2005, First Nations across British Columbia agreed that a unified approach to negotiating with other levels of government would be preferable to negotiating as individual First Nations.

7.27 The leadership required to achieve this unified negotiating approach was provided by the three British Columbia First Nations political organizations: the Union of British Columbia Indian Chiefs, the First Nations Summit, and the British Columbia Assembly of First Nations. In 2005, the three organizations signed a Leadership Accord. The Accord formalized a cooperative working relationship for political representation of the interests of First Nations in the province. The three organizations formed the First Nations Leadership Council, comprising the political executives from its founding organizations. Its goal was to implement its agenda for change, which included closing the gap in health outcomes between First Nations people and other residents in British Columbia.

7.28 Acting as a single point of contact, the First Nations Leadership Council negotiated with the federal and provincial governments about matters of common concern, including health. Having a single point of contact allowed the federal and provincial governments to work directly with the Council instead of having to negotiate with over 200 individual First Nations across the province. This single point of contact helped to support consensus-building activities and enabled the First Nations of British Columbia to discuss ways to improve health care for their people.

7.29 In 2007, First Nations leaders established the First Nations Health Council, an organization separate from the First Nations Leadership Council. Its objective was to provide dedicated political leadership for health planning and facilitate dialogue in support of improved health outcomes for First Nations people. Starting in 2010, the Council comprised 15 representatives (3 members from each of the province's 5 regions).

7.30 The Council carried out intensive community engagement and consultation between 2007 and 2013. It did so in keeping with the principle of reciprocal accountability, through which all parties involved in a plan, action, or agreement share responsibility for their conduct

(Exhibit 7.3). This process was critical to establishing the legitimacy of new approaches to health service delivery for First Nations people in British Columbia.

Exhibit 7.3 Reciprocal accountability was a core principle in the establishment of the Authority

Traditional First Nations social systems were founded on reciprocal accountability. This is the idea that each member of the community is accountable for the impact of their decisions and actions, and for their contributions to the community's wellness as a whole. In assuming collective responsibility for the health system, British Columbia First Nations believe that the quality of care provided through their health system depends on what they collectively contribute to that system. Central to this concept is the idea that British Columbia First Nations are simultaneously owners and customers of the health system they are creating together.

Source: First Nations Health Council and First Nations Health Authority

7.31 This community engagement included the annual Gathering Wisdom for a Shared Journey conferences, for which First Nations and partners came together to discuss and develop approaches—articulated in the form of consensus papers—to delivering services that could better meet the needs of their people. In 2011, the chiefs voted overwhelmingly in favour of taking control of health services (87 percent); in 2012, a larger majority voted to create a permanent First Nations Health Authority (94 percent).

7.32 In addition to developing a health governance framework that derived its authority and legitimacy from consultation with First Nations people, these meetings resulted in another key outcome: the establishment of regional partnership accords, signed by the regional representatives of the First Nations Health Council, the First Nations Health Authority, and the province's regional health authorities.

7.33 These partnership accords were the basis for shared decision making between regional representatives of the First Nations Health Council, the First Nations Health Authority, and the regional health authorities. The intent of these accords was to strengthen these relationships, and to enable better alignment in health care planning at the regional level. According to Authority officials, these accords and the corresponding regional health and wellness plans are intended to enable the organization to leverage existing resources in the regional health authorities, to support the improvement of health outcomes for First Nations people.

7.34 Two significant developments in particular facilitated the unified approach to negotiating with governments and subsequent developments: clarification of the Crown's duty to consult and accommodate First Nations, and the fact that individual First Nations in British Columbia had a long history of taking on responsibility for delivering health programs and services in their own communities.

7.35 In 2004, two Supreme Court cases involving First Nations in British Columbia led to the beginning of a new relationship between the Province of British Columbia and First Nations: *Haida Nation v. British Columbia (Minister of Forests)* and *Taku River Tlingit First Nation v. British Columbia (Project Assessment Director)*. A court case in 2005, *Mikisew Cree First Nation vs. Canada (Minister of Canadian Heritage)* reinforced this changed relationship. Taken together, these cases clarified roles, responsibilities, and the duty of the Crown to consult with First Nations and accommodate their rights and titles to lands and resources affected by government decisions. First Nations recognized that they would be able to take advantage of this opportunity through unity among themselves.

7.36 Furthermore, Health Canada had been transferring some responsibilities for health programs and services to individual First Nations since the 1980s. This meant that a greater proportion of First Nations in British Columbia than elsewhere had already taken on increased responsibilities for program delivery in their own communities. This process contributed to First Nations in the province supporting the goal of transferring health services, and to preparing them to do so.

The agreement establishing the Authority addressed challenges related to structural impediments to service delivery

7.37 The Tripartite Framework Agreement on First Nation Health Governance and the Canada Funding Agreement that established the First Nations Health Authority addressed challenges related to the four structural impediments we identified in 2011. Through these agreements, the parties committed to establishing service levels, identified existing health legislation to guide activities and the need to explore how legislation may need to change as circumstances evolve, established a long-term funding mechanism, and developed organizations and structures to support local capacity for program delivery in communities.

7.38 **Steps for establishing service levels for health programs.** Setting clear service levels was a cornerstone of the Tripartite Framework Agreement on First Nation Health Governance. Indeed, one of the aims of the Agreement was to ensure that First Nations in all regions of British Columbia have access to health services that are comparable to those available to other British Columbia residents living in similar geographic locations.

7.39 Work to establish service levels in support of improved health outcomes is difficult. Officials at the Authority told us that this has been made more difficult because of a lack of baseline data on First Nations health and of access to that data. Notwithstanding these difficulties, we noted that the Authority had taken important steps to improve data quality, including signing a data quality and sharing agreement with the federal and provincial governments.

7.40 The Authority also informed us that it was in the process of developing a more comprehensive approach to gathering and managing data, to ensure that it would have the information it needed to identify gaps in services and improve health outcomes over time. Furthermore, the Tripartite Framework Agreement on First Nation Health Governance established a Deputy Provincial Health Officer, who would work with partners across the health system to improve data quality and measurement of health outcomes.

7.41 The Authority also informed us that it was taking important first steps to map what services were available across British Columbia's First Nations communities, to assist in the identification of gaps in access to services. This mapping consisted of gathering information on what types of practitioners and services were available across communities. The Authority told us that it intended to use this information to develop models for services in support of improving health outcomes.

7.42 **Identification of an appropriate legislative base.** The identification of the need for a legislative base for programs and services is an element of the Tripartite Framework Agreement on First Nation Health Governance. The Agreement specifically defined roles and responsibilities of the parties to the agreement for health service delivery for First Nations people in British Columbia. The Agreement referred to the *Canada Health Act*, the British Columbia *Medicare Protection Act*, and the British Columbia *Hospital Insurance Act* in the context of Status Indians as residents of the province, being provided services available to all residents. The Agreement also referenced a commitment to exploring how the Authority could make use of both provincial and federal legislation and to keeping legislation and regulations up to date to address evolving circumstances, such as the need for better data management.

7.43 **Establishing long-term funding.** British Columbia First Nations cited stable long-term funding as an important reason for their decision to assume responsibility for delivering health programs and services. The Tripartite Framework Agreement on First Nation Health Governance and the Canada Funding Agreement provided up to $4.7 billion in funding to the Authority over 10 years, from the 2013–14 fiscal year to the 2022–23 fiscal year.

7.44 These agreements include an annual 5.5 percent escalator (increase) for the first five years to account for rising health care costs. The escalator is to be renegotiated during the fourth fiscal year, and if agreement is not reached by the fifth year, the Authority will receive annual funding equivalent to the fifth year's funding until an agreement is reached. The agreements also include a provision for starting renewal negotiations no later than one year before the expiry date, to ensure continuity in funding after the 2022–23 fiscal year. The presence of such an escalator clause in the agreements is similar to the provision in the Canada Health Transfer,

through which the Government of Canada transfers funds to the provinces and territories.

7.45 Long-term funding provided the First Nations Health Authority with more certainty about its operating budget. In contrast with some federal contribution agreements with individual First Nations, which provided funding for shorter durations or were funded through programs that had predetermined end dates, these provisions gave First Nations a basis on which to conduct some long-term planning.

7.46 As part of the Tripartite Framework Agreement on First Nation Health Governance, Health Canada acknowledged the importance of transferring to the Authority not only funding directly for program delivery, but also resources for planning, monitoring, and administration. Officials at Health Canada engaged in a comprehensive process to calculate the baseline funding required to establish and operate the Authority, based on the proportion of expenditures historically dedicated to the Pacific Region of the First Nations and Inuit Health Branch.

7.47 In particular, the Tripartite Framework Agreement provided funding for costs associated with overhead functions, such as management of human resources, assets and software, and information management and information technology, which assisted the Authority in establishing its foundations as a new organization. In the interest of transparency, Health Canada shared these calculations and the assumptions behind them with the negotiating team. These estimates were accepted as best efforts at the time, with actual cost estimates evolving throughout the negotiation process. It should be noted that Health Canada provided $56 million from the 2007–08 to the 2012–13 fiscal years to help the Authority set itself up before responsibilities for programs and services were transferred to it.

7.48 **Support for local service delivery.** There have been several changes to increase support to local service delivery since the establishment of the Authority. For example, before the transfer, Health Canada made payments to the British Columbia Ministry of Health for Medical Service Plan (MSP) premiums for Status Indians resident in the province. This funding was transferred to the Authority and, in 2013, the Authority and Ministry of Health entered into an agreement whereby 25 percent of the annual contribution made by the Authority in lieu of MSP premiums would be set aside for the purposes of improving MSP funding services accessed by First Nations. Several projects have been approved since 2013 as part of this new agreement's focus on expanding access to primary care, maternity care, programs for mental wellness and substance abuse, and youth wellness and suicide prevention and intervention.

7.49 Moreover, the Authority hired senior medical officers and regional directors to provide advice and guidance to the province's regional health authorities on how to improve programs and services for First Nations people. Authority officials told us that, through this arrangement, the Authority was able to assist the regional health authorities in, for example,

maximizing turnout at community immunization clinics. The Authority has also carried out a significant amount of work in cultural sensitivity training, which was mandatory for all of its staff. It was also working with the regional health authorities to ensure that their front-line staff were trained as well.

7.50 In conjunction with its ongoing work to better understand the health needs and service gaps in communities, the Authority has been working to expand access to electronic health services, which has enabled physicians and other health care providers to deliver services remotely, through camera systems and related diagnostic tools.

7.51 Authority officials informed us that more than 20 remote communities had gained access to electronic health services and to about 100 health care service providers. Officials noted that this coverage had allowed for real-time intervention in crisis situations and had the potential to reduce medical evacuation costs considerably.

7.52 The Authority noted that electronic health service delivery had also been important for delivering training to people who deliver health services locally in communities. In early 2015, the Authority delivered training to individuals in remote communities through videoconferencing. Students received training as health care aides to provide home support to the elderly. Authority officials told us that participants had graduated from the program and were employed in providing those services.

Audit

7.53 During work on the study, we received an anonymous document making allegations against the Authority, in connection to its management of conflict of interest, its investigation of workplace misconduct, and its staffing of key positions. We did not examine the Authority's entire accountability and governance framework. Instead, we decided to examine the elements of the policies in the Authority's framework that related to these allegations, to assess whether the policies provided adequate guidance for the Authority to address the allegations. The objective of this audit was to determine whether the First Nations Health Authority had established and implemented selected elements of an accountability and governance framework. This included examining the Authority's compliance with these policies as they related to the allegations.

Establishing an accountability and governance framework at the First Nations Health Authority

Overall finding

7.54 Overall, we found that the First Nations Health Authority had established an accountability and governance framework to guide its operations and to promote transparency and accountability. This framework included a range of policies setting out how the Authority was to be managed. However, we found gaps in the policies we examined, pertaining to conflict of interest, recruitment, personnel security, administrative investigations, financial information and disclosure, and employee relocation. We also found that the Authority's guidance on implementing these policies was limited. In our examination of the Authority's response to allegations made against it in relation to its accountability and transparency, we found that the Authority complied with its policy on conflict of interest. However, it did not fully comply with requirements set out in its policies on investigating misconduct and on staffing positions on the basis of merit. We also found that justifications for the considerable variation in allowances provided in senior management employment agreements were not documented.

7.55 This is important because a sound accountability and governance framework would allow the Authority to demonstrate that it is conducting its operations in keeping with its obligations set out in the Tripartite Framework Agreement on First Nation Health Governance, and with its obligations to British Columbia First Nations, its Board of Directors, the provincial health care system, and the federal and provincial governments.

Context

7.56 The First Nations Health Authority assumed full responsibility for operations in October 2013. It assumed responsibilities for planning, designing, managing, and funding the delivery of First Nations health programs across British Columbia. Almost three quarters of its operating budget was used to fund its Health Benefits Program, and to fund First Nations health organizations across the province through contribution agreements to deliver programs and services in communities.

7.57 The Authority managed a staff that grew from under 50 employees in 2009 to almost 500 employees in 2015, including the transfer of about 200 employees from Health Canada in 2013. This transition involved merging different organizational cultures and information technology and financial management systems, and establishing an accountability and governance framework that reflected its expanded and increasingly complex operations.

7.58 As a publicly funded not-for-profit organization, the Authority had a key role in the delivery of health services to First Nations people. Like other health authorities, it had, in our opinion, an obligation to ensure

that public confidence in its decision making and operations was maintained. More particularly, it had to ensure that it was serving the best interests of First Nations people.

7.59 Consequently, its accountability and governance framework had to support the Authority's accountability to British Columbia First Nations, to its Board of Directors, and to the federal and provincial governments that provide its funding; and its responsibilities as a health service provider within the provincial health care system. The framework also had to help the Authority manage the contribution agreements it would sign with individual First Nations and their health organizations, through which funding was provided to support community-based health programs and services.

7.60 In particular, the Tripartite Framework Agreement on First Nation Health Governance that the Authority signed with the federal and provincial governments set out specific requirements related to governance, accountability, and transparency that the Authority agreed to implement. These included commitments to establishing

- strong internal control systems;
- sound budgeting and allocation processes;
- strong conflict of interest and ethical standards (and policies and mechanisms to monitor compliance);
- strong internal accountability mechanisms; and
- a human resource function that hires the most qualified individuals.

The Authority was also required to provide to the federal and provincial governments annual reports on its activities, and to promote reciprocal accountability by ensuring that the needs and priorities of the First Nations communities it serves were reflected in its planning and delivery approach. The Authority has publicly committed to meeting these requirements.

There were some weaknesses in the Authority's policies that we examined

What we found

7.61 We found that there were some weaknesses in the Authority's policies we examined. We also found that the corresponding guidance for Authority management and employees on how the policies were to be implemented was limited.

7.62 Our analysis supporting this finding presents what we examined and discusses

- the accountability and governance framework,
- the conflict of interest policy, and
- other policies.

Why this finding matters

7.63 This finding matters because policies and their consistent application are the basis upon which an organization successfully manages its activities and demonstrates its transparency and accountability. In this case, given the size of its budget (up to $4.7 billion over 10 years) and the increase in its number of employees (from under 50 to almost 500), the Authority must have policies to support the nature and complexity of the work it is responsible for carrying out.

Recommendation

7.64 Our recommendation in this area of examination appears at paragraph 7.70.

Analysis to support this finding

7.65 **What we examined.** We conducted a preliminary assessment of the allegations described in the document we received. We focused on the allegations related to the Authority's management of conflict of interest, its investigation of workplace misconduct, and its staffing of key positions. We examined the elements of the policies that covered these allegations, to assess whether they contained sufficient guidance on how to deal with these issues. Specifically, we reviewed

- the Standards of Conduct, Conflict of Interest and Confidentiality Policy;
- the Recruitment and Selection Policy;
- the Personnel Security Policy;
- the Administrative Investigations Policy;
- the Financial Information Approval and Disclosure Policy; and
- the Relocation Policy.

7.66 **The accountability and governance framework.** The Authority established a framework that includes 42 policies to guide its operations and to promote accountability and transparency. In 2013 and 2014, the Authority's Board of Directors approved the six policies that we reviewed. We found that the Authority clearly communicated these policies to employees: They were available on the Authority's intranet and leadership blog, and some training sessions have been held. However, we found that the corresponding guidance to managers and employees on implementing the policies was limited.

7.67 **The conflict of interest policy.** The Authority established its Standards of Conduct, Conflict of Interest and Confidentiality Policy in March 2013. The Policy required each employee to disclose to his or her supervisor any interests or personal or family relationships that could be perceived as a conflict of interest. Although the policy stated that compliance was a condition of employment, it did not require new employees to formally declare whether they had conflicts of interest. Nor

did it require existing employees to periodically declare whether they had conflicts of interest. We also found a lack of guidance (such as specific directions, forms for employees to complete to declare whether they had conflicts of interest) on how to follow the policy. In our opinion, such declarations should be completed by new employees, and then periodically thereafter, or immediately if circumstances change. This would ensure that the declarations are up to date.

7.68 We also noted that the policy did not detail specific measures that could be used to prevent conflicts of interest or address them when the organization becomes aware of them. Moreover, the Authority did not have mechanisms to monitor compliance with this policy. In our opinion, the policy did not meet the requirements set out in the Tripartite Framework Agreement on First Nation Health Governance, which specified that the Authority was to have strong internal conflict of interest and ethical standards, as well as mechanisms to monitor compliance.

7.69 **Other policies.** We also found weaknesses in the other policies we examined. For example:

- The guidance in the Recruitment and Selection Policy on how to assess candidates for positions and how to document those decisions was limited. It did not specify how to determine the most qualified candidate, nor did it specify in what situations external (instead of internal) recruitment should be pursued. This type of guidance is required to support the fairness and competency considerations expected of organizations that are publicly funded.
- The Personnel Security Policy stipulated that employees working with vulnerable people were required to undergo a criminal record check. However, the policy did not contain provisions for ensuring that security clearances were updated periodically. Periodic updating of security clearances serves to ensure that individuals acting in the public interest are suitable for roles involving interactions with the public.
- The Administrative Investigations Policy did not specify under what circumstances complainants' supervisors (as opposed to others) should carry out investigations. This guidance would be needed to help support the objectivity of investigations. Furthermore, the policy did not specify the type of documentation needed to demonstrate that investigations had been properly carried out. Such guidance is important, because it would help to protect the organization and prevent repercussions for people who raise allegations in good faith. This is common practice for many organizations that are publicly funded.
- The Financial Information Approval and Disclosure Policy did not require the Authority to disclose the amounts spent on professional and service contracts, hospitality and travel, and salaries for senior officials. Organizations that are publicly funded typically require the

disclosure of this sort of information. For example, we found that regional health authorities in British Columbia publicly disclosed the salaries of senior managers. We noted that the Authority posted Board members' remuneration, audited financial statements, and annual reports and service plans, but not amounts spent on professional and service contracts, hospitality and travel, and senior executives' salaries. Although it is not required under provincial legislation or under the Tripartite Framework Agreement on First Nation Health Governance to disclose this information, it is our opinion that such disclosure would constitute an important element of transparency and maintaining public confidence in the organization.

- The Relocation Policy set out relocation allowances for employees, but not for senior executives. Guidelines on the amounts that can be reimbursed to senior executives would help to ensure fairness and consistency in how they are compensated.

7.70 **Recommendation.** The First Nations Health Authority should review the policies that form its accountability and governance framework, to ensure that they are consistent with requirements set out in the Tripartite Framework Agreement on First Nation Health Governance and comparable to those of similar publicly funded organizations. The Authority should also develop specific guidance on how each policy is to be followed and monitored.

The Authority's response. *Agreed. The First Nations Health Authority is in the process of undertaking a review of its policies and required procedural guidance for the implementation of its policies to ensure compliance with the Tripartite Framework Agreement; incorporating First Nations cultural perspectives and approaches; considering industry best practices; and taking into account procedures found in other public and private organizations.*

The Authority did not comply fully with all of the policies we examined

What we found

7.71 We found that the Authority responded adequately to the conflict of interest allegation, but not to the allegations raised about the investigation of workplace misconduct and the staffing of key positions with the most qualified candidates. We also found that the Authority had not documented justifications for variations in senior management employment agreements.

7.72 Our analysis supporting this finding presents what we examined and discusses

- management of conflict of interest,
- investigation of workplace misconduct,

- staffing key positions on the basis of merit, and
- senior management employment agreements.

Why this finding matters

7.73 This finding matters because policies and their consistent application are the basis upon which an organization successfully manages its activities. They are important to demonstrating that the Authority is accountable to stakeholders and the public.

Recommendations

7.74 Our recommendations in these areas of examination appear at paragraphs 7.81, 7.84, 7.86, and 7.89.

Analysis to support this finding

7.75 **What we examined.** We examined how the Authority investigated the allegations made against it by interviewing senior Authority management and members of the Board of Directors, and reviewing documentation related to the allegations, including personnel files. We did not audit the merit of the allegations; rather, we assessed the Authority's responses to them.

7.76 We found that weaknesses in the Authority's accountability and governance framework (the six policies we assessed in paragraphs 7.65 to 7.69) contributed to inadequacies in its responses to the allegations.

7.77 **Management of conflict of interest.** One of the allegations concerned a conflict of interest situation involving Authority employees.

7.78 We found that both senior Authority officials and the Board of Directors acknowledged that there was a conflict of interest. Senior Authority officials informed the Board of Directors of this situation in late 2013. In response, the Board sent letters to the affected individuals, outlining conditions that would have to be met to manage the conflict.

7.79 The Board informed us that it believed that the letters sufficiently mitigated the conflict of interest. Although we found that the Board had not formally monitored whether the conditions set out in the letters were respected, it told us that it relied upon a senior Authority official not involved in the conflict of interest to manage it. In our opinion, the approach taken in this situation was adequate, provided that the conditions set out in the letters were followed and that a senior official remained responsible for managing it.

7.80 It is important in such situations that the Authority can demonstrate that perceived or real conflicts of interest are dealt with transparently. Perceived conflicts of interest may have the same impact on the reputation and functioning of the organization as actual conflicts of interest do. Likewise, as we stated in paragraph 7.68, it is important that a conflict of interest policy detail specific measures that may be used to prevent a conflict of interest from occurring. In this context, it is critical

for the Board of Directors to ensure that any conflicts of interest are actively managed and monitored.

7.81 **Recommendation.** The First Nations Health Authority should review the conflict of interest raised by the allegation, as well as any other actual or perceived conflicts of interest regularly, to determine whether they are adequately mitigated. It should also regularly report the results of its reviews to the Board of Directors.

The Authority's response. *Agreed. The First Nations Health Authority is in the process of improving our policy and procedural guidance related to conflict of interest, including preventative measures. The First Nations Health Authority will ensure appropriate documentation is maintained including the issuance of procedural letters where conflicts are identified.*

7.82 **Investigation of workplace misconduct.** Another allegation about the Authority pertained to several incidents of workplace misconduct. We examined actions taken by the Authority in response to the allegation of workplace misconduct on the part of senior officials. Senior officials told us that they had asked managers across the organization whether they knew of these incidents, and stated that accounts of such incidents were not brought forward. However, we found that the Authority had completed no documentation setting out steps taken, including whether it had conducted any additional investigation beyond asking managers whether these incidents had taken place. In our opinion, these actions did not meet the requirements of the Authority's Administrative Investigations Policy. This policy states that investigations are to be undertaken to assist in determining whether an incident has occurred as alleged, while respecting employee rights.

7.83 We found that Authority officials did formally investigate another allegation of workplace misconduct made in 2014. This allegation was not included in the document we received. In this instance, the Authority acted in accordance with its policy. It decided to hire a lawyer to examine the allegation. The lawyer conducted a formal investigation, interviewing the complainant and the accused, as well as other employees. A formal report was written, which included several recommendations. One of the recommendations was to train managers on how to interact more effectively with employees. The Authority has since offered some training to managers in this area.

7.84 **Recommendation.** The First Nations Health Authority should ensure that all allegations of workplace misconduct are investigated in accordance with its Administrative Investigations Policy, that adequate steps are taken to investigate them according to pre-established guidelines, that there is adequate documentation of investigations, and that corrective actions are taken when necessary.

The Authority's response. *Agreed. All complaints will be investigated by the First Nations Health Authority following a standardized approach.*

Enhancements to documentation of administrative investigations are under way, and a Whistleblower Policy is being communicated to First Nations Health Authority employees.

7.85 **Staffing key positions on the basis of merit.** The allegation document raised questions as to whether the most qualified individuals were being hired by the Authority. The Tripartite Framework Agreement on First Nation Health Governance required the Authority to hire the most qualified individuals. We reviewed 14 personnel files of managers working within the Authority, to determine whether there was evidence that the most qualified candidates had been hired in each case. We found that evidence was limited, in most of these files, to demonstrate that the most qualified candidate was the one hired (Exhibit 7.4). We also reviewed whether additional files included documentation related to filling these positions with the most qualified candidates and did not find additional information.

Exhibit 7.4 The evidence in personnel files to demonstrate qualifications of individuals hired was limited

Documentation in personnel file	Finding
Position publicly posted (or rationale for why not posted)	For 3 of 14 positions
Evidence that the successful candidate possessed the required qualifications (file contained resumé and documentation on level of education attained)	In 6 of 14 files (resumé) In 2 of 14 files (documentation on level of education attained)
Evidence that background checks had been performed	In 3 of 14 files

7.86 **Recommendation.** The First Nations Health Authority should ensure that it has documentation to demonstrate that the most qualified candidates are hired, in keeping with the requirements set out in the Tripartite Framework Agreement on First Nation Health Governance.

The Authority's response. *Agreed. The First Nations Health Authority recruited the required staff to the best of its abilities through an initial policy framework in order to meet the aggressive time frames required to successfully achieve this unique transfer, the first of its kind in Canada. The Authority is now undertaking further work to improve its policies in the area of recruitment and selection that target the most qualified candidates, including enhancements to procedures and documentation.*

7.87 **Senior management employment agreements.** During the course of our review of personnel files, we found considerable variation in employment agreements of senior executives, in areas such as allowances

provided. In the files we reviewed, we found no documentation setting out rationales for the allowances or for their extensions.

7.88 During our examination, the Authority indicated that it was in the process of developing a remuneration policy for executives, aimed at addressing variations and inconsistencies in executives' pay and benefit packages.

7.89 **Recommendation.** The First Nations Health Authority should finalize its remuneration policy for senior executives and bring it before the Board of Directors for its approval.

The Authority's response. *Agreed. The First Nations Health Authority is in the process of implementing a board-approved executive compensation policy that outlines our pay and benefits guiding principles, pay position, and practices. It is important to note that the executive compensation review commissioned by the First Nations Health Authority indicates that executive pay at the Authority is consistent with other organizations of its size and service scope. Historically (spring 2013 and spring 2014), two additional objective executive compensation reviews were done to ensure Authority practices were competitive and in line with comparable organizations.*

The Authority was taking steps to strengthen accountability and governance

What we found

7.90 We found that the Authority was taking steps to update its accountability and governance framework by revising its policies and procedures and establishing additional oversight mechanisms.

7.91 Our analysis supporting this finding presents what we examined and discusses

- policies and procedures,
- oversight mechanisms,
- the Authority's consolidation of Vancouver office space, and
- the role of Health Canada in providing oversight.

Why this finding matters

7.92 This finding matters because a sound and up-to-date set of policies to support the Authority's accountability and governance framework, and mechanisms to ensure compliance with it, are essential to its ability to carry out its mandate and to build public trust, especially as a new organization. The framework should help the Authority as its works to consolidate its office space.

Recommendation

7.93 Our recommendation in this area of examination appears at paragraph 7.102.

Analysis to support this finding

7.94 **What we examined.** We examined efforts by the First Nations Health Authority to improve its accountability and governance framework. We also examined Health Canada's role in providing oversight to the Authority.

7.95 **Policies and procedures.** We found that the First Nations Health Authority was revising its policies and procedures and creating new ones. For example, it established a Whistleblower Policy. It also established an Enterprise Risk Management Policy, and it had taken steps to identify risks and articulate related mitigating measures. We also found that the Authority was in the process of determining what type of information the Board should receive to carry out its stewardship obligations. Authority officials also informed us that it was working to update its entire policy framework and to finalize its strategic plan.

7.96 **Oversight mechanisms.** We also noted that the Authority was developing additional oversight mechanisms. The Authority is in the early stages of establishing an audit capacity, which is intended to provide it with additional assurance that risks are being managed and that programs are functioning effectively. The Authority also indicated that it was in the early stages of preparing for health care accreditation, a process that involves having a third party determine whether the Authority has appropriate standards and policies (for governance and risk management) in place to support effective health services. As part of this work, the Board had recently established a new subcommittee on quality-related matters to support the improvement of service delivery.

7.97 **The Authority's consolidation of Vancouver office space.** We found that the Authority was planning to consolidate its office space in Vancouver, as it is being required to vacate existing office space. The Authority told us that this will save funds in the long term. In March 2015, it issued a request for proposal for the construction of the new space, and has forecast a completion date of June 2018 for the new building. This is a major capital project that will cost millions of dollars and take several years to complete.

7.98 This is a complex undertaking, especially for a new organization that has been given significant responsibilities for the planning and delivery of health care in First Nations communities across the province and that does not have extensive expertise related to office space acquisition. In our opinion, it will be important for the Authority to have finalized its work on updating its accountability and governance framework, in particular its procurement policies, before it proceeds with the consolidation, so that decisions related to the consolidation can withstand external scrutiny.

7.99 **Role of Health Canada in providing oversight.** The Tripartite Committee on First Nations Health, which is co-chaired by senior representatives from the First Nations Health Authority Board of

Directors, Health Canada, and the British Columbia Ministry of Health, is mandated through the Tripartite Framework Agreement to coordinate and align planning, programming, and service delivery among the First Nations Health Authority, British Columbia regional health authorities, the British Columbia Ministry of Health, and Health Canada. Moreover, under the Agreement, an Implementation Committee was established, with representatives from the First Nations Health Authority, Health Canada, the British Columbia Ministry of Health, and the First Nations Health Council. Among the Committee's responsibilities is the monitoring of the implementation of the Agreement.

7.100 The Tripartite Framework Agreement on First Nation Health Governance requires the Authority to establish sound corporate governance. The Agreement also requires reporting on health indicators and evaluating performance against the Agreement every five years. The first evaluation, for the initial five-year period of the Agreement, must be completed by 2019.

7.101 As a member of the Tripartite Committee, as well as a signatory to the Canada Funding Agreement, Health Canada has an obligation to ensure that the Authority is abiding by the terms and conditions that govern its operations. Notwithstanding the considerable and important work carried out to date, our observations in this audit indicate that the Authority needs to do more work to strengthen its accountability and governance framework. This suggests to us that Health Canada has to become more involved in helping the Authority meet this obligation.

7.102 **Recommendation.** Health Canada should work with the First Nations Health Authority to ensure that a sound accountability and governance framework is established and implemented, in keeping with requirements set out in the Tripartite Framework Agreement on First Nation Health Governance.

The Department's response. *Agreed. Health Canada expects that all of the accountability and governance requirements set out in the Tripartite Framework Agreement on First Nation Health Governance and the Canada Funding Agreement be fully satisfied. To date, the First Nations Health Authority has been diligent in providing Health Canada with quality and timely deliverables against all its obligations and meeting the accountability and governance requirements set out in the framework agreement. In a spirit of continuous improvement, Health Canada's intention is to continue collaborating with the First Nations Health Authority to achieve the highest management standard set in its own policies.*

In addition, the First Nations Health Authority and Health Canada have formally established processes in order to advance joint priorities, monitor progress in resolving issues, and work toward continuous improvement. In response to the observations and recommendations of the Office of the Auditor General, a specific provision will be included in the annual

executive operational agenda (Shared Vision and Common Understanding) between the First Nations and Inuit Health Branch Senior Assistant Deputy Minister and the First Nations Health Authority Chief Executive Officer. This provision will formalize the Annual Assistant Deputy Minister meeting with the First Nations Health Authority Board to discuss accountability and governance.

Health Canada will also assist the First Nations Health Authority in accessing departmental expertise to finalize the development and implementation of its Human Resources Policy Framework.

Conclusion

7.103 Efforts by Health Canada to work with First Nations in British Columbia to establish the First Nations Health Authority represented a different approach to resolving a long-standing health issue: the poorer health outcomes of First Nations people in British Columbia than those of other residents. All parties—Health Canada, First Nations, and the Province of British Columbia—recognized from the start that they would have to work together, and in a different manner than before, if they hoped to make meaningful strides toward improving First Nations health.

7.104 The hard work is only beginning. Improving health outcomes is not easy. However, as other governments and First Nations from across the country consider how to improve programs and services to First Nations, we note that taking stock of what has worked, and why it has worked, may be an important place to start. This assessment will be particularly important as the Authority embarks on plans to expand its activities.

7.105 Our study noted that the sustained commitment of leaders from British Columbia First Nations, the Government of Canada, and the Government of British Columbia was important to establishing the First Nations Health Authority, as was the identification of a single First Nations point of contact to negotiate with the federal and provincial governments. Furthermore, the Tripartite Framework Agreement on First Nation Health Governance and the Canada Funding Agreement addressed challenges related to

- establishing service levels,
- legislation to guide activities and the need to explore how legislation may change as circumstances evolve,
- a long-term funding mechanism, and
- support for local capacity for program delivery in communities.

7.106 Our audit concluded that the First Nations Health Authority did not establish and implement selected elements of an accountability and governance framework. Although the Authority had policies in place to

guide its operations, there were some weaknesses in the Authority's policies that we examined, and a lack of guidance surrounding how they were to be implemented. We also concluded that the Authority was not fully complying with some of its existing policies. As the Authority shifts from a period of transition to the delivery of programs and services, its success will depend on its ability to demonstrate that it has the accountability and governance framework in place and on its compliance with its policies.

About the Report

The Office of the Auditor General's responsibility was to conduct an independent examination of how efforts by British Columbia First Nations and Health Canada overcame the structural impediments identified in the 2011 June Status Report of the Auditor General of Canada, Chapter 4—Programs for First Nations on Reserves, as they established the First Nations Health Authority in British Columbia. The Office also conducted an independent examination of whether The First Nations Health Authority had established and implemented selected elements of an accountability and governance framework.

The report contains a study and an audit.

All of the audit work in this report was conducted in accordance with the standards for assurance engagements set out by the Chartered Professional Accountants of Canada (CPA) in the CPA Handbook—Assurance. While the Office adopts these standards as the minimum requirement for our audits, we also draw upon the standards and practices of other disciplines.

As part of our regular study and audit process, we obtained management's confirmation that the findings in this report are factually based.

Objective

The objective of the study was to inform Parliament about how efforts by British Columbia First Nations and Health Canada overcame the structural impediments identified in our 2011 June Status Report of the Auditor General of Canada, Chapter 4—Programs for First Nations on Reserves, as they established the First Nations Health Authority in British Columbia.

During our work on the study, we received an anonymous document that contained allegations against the First Nations Health Authority in relation to its accountability and transparency.

The objective of the audit was to determine whether the First Nations Health Authority had established and implemented selected elements of an accountability and governance framework.

Scope and approach

The study included Health Canada and the First Nations Health Authority in British Columbia, and included activities starting in 2005 that led to the full transfer of First Nations health programs from Health Canada to the Authority in 2013. The approach included interviews with senior officials at the First Nations Health Authority and Health Canada, as well as with selected stakeholders. We also reviewed key documents, including agreements, planning and consultation documents, and committee minutes that led to the signing of the Tripartite Framework Agreement on First Nation Health Governance and to the signing of the Canada Funding Agreement.

The audit included an examination of selected aspects of the Authority's accountability and governance framework from 2013 to 2015. We conducted interviews with officials at the First Nations Health Authority and Health Canada, and reviewed documents and selected files.

Criterion

Criterion	Source
To determine whether the First Nations Health Authority established and implemented selected elements of an accountability and governance framework, we used the following criterion:	
The First Nations Health Authority established and implemented key elements of an accountability and governance framework. Key elements include human resource management, the management of conflicts of interest or ethics, internal accountability processes, and risk management.	British Columbia Tripartite Framework Agreement on First Nation Health Governance, 2011

Management reviewed and accepted the suitability of the criterion used in the audit.

Period covered by the study and the audit

The study covered the period between April 2005 and October 2013. Study work for this report was completed on 21 August 2015. The study involved the examination of material from later periods, as required.

The audit covered the period between October 2013 and August 2015. Audit work for this report was completed on 21 August 2015. The audit involved the examination of material from earlier periods, as required, to gather evidence to conclude against the criterion.

Team

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List of Recommendations

The following is a list of recommendations found in this report. The number in front of the recommendation indicates the paragraph where it appears in the report. The numbers in parentheses indicate the paragraphs where the topic is discussed.

Recommendation	Response
Establishing an accountability and governance framework at the First Nations Health Authority	
7.70 The First Nations Health Authority should review the policies that form its accountability and governance framework, to ensure that they are consistent with requirements set out in the Tripartite Framework Agreement on First Nation Health Governance and comparable to those of similar publicly funded organizations. The Authority should also develop specific guidance on how each policy is to be followed and monitored. **(7.61–7.69)**	**The Authority's response.** Agreed. The First Nations Health Authority is in the process of undertaking a review of its policies and required procedural guidance for the implementation of its policies to ensure compliance with the Tripartite Framework Agreement; incorporating First Nations cultural perspectives and approaches; considering industry best practices; and taking into account procedures found in other public and private organizations.
7.81 The First Nations Health Authority should review the conflict of interest raised by the allegation, as well as any other actual or perceived conflicts of interest regularly, to determine whether they are adequately mitigated. It should also regularly report the results of its reviews to the Board of Directors. **(7.71–7.80)**	**The Authority's response.** Agreed. The First Nations Health Authority is in the process of improving our policy and procedural guidance related to conflict of interest, including preventative measures. The First Nations Health Authority will ensure appropriate documentation is maintained including the issuance of procedural letters where conflicts are identified.
7.84 The First Nations Health Authority should ensure that all allegations of workplace misconduct are investigated in accordance with its Administrative Investigations Policy, that adequate steps are taken to investigate them according to pre-established guidelines, that there is adequate documentation of investigations, and that corrective actions are taken when necessary. **(7.82–7.83)**	**The Authority's response.** Agreed. All complaints will be investigated by the First Nations Health Authority following a standardized approach. Enhancements to documentation of administrative investigations are under way, and the Whistleblower Policy is being communicated to First Nations Health Authority employees.

Recommendation	Response
7.86 The First Nations Health Authority should ensure that it has documentation to demonstrate that the most qualified candidates are hired, in keeping with the requirements set out in the Tripartite Framework Agreement on First Nation Health Governance. **(7.85)**	**The Authority's response.** Agreed. The First Nations Health Authority recruited the required staff to the best of its abilities through an initial policy framework in order to meet the aggressive time frames required to successfully achieve this unique transfer, the first of its kind in Canada. The Authority is now undertaking further work to improve its policies in the area of recruitment and selection that target the most qualified candidates, including enhancements to procedures and documentation.
7.89 The First Nations Health Authority should finalize its remuneration policy for senior executives and bring it before the Board of Directors for its approval. **(7.87–7.88)**	**The Authority's response.** Agreed. The First Nations Health Authority is in the process of implementing a board-approved executive compensation policy that outlines our pay and benefits guiding principles, pay position, and practices. It is important to note that the executive compensation review commissioned by the First Nations Health Authority indicates that executive pay at the Authority is consistent with other organizations of its size and service scope. Historically (spring 2013 and spring 2014), two additional objective executive compensation reviews were done to ensure Authority practices were competitive and in line with comparable organizations.
7.102 Health Canada should work with the First Nations Health Authority to ensure that a sound accountability and governance framework is established and implemented, in keeping with requirements set out in the Tripartite Framework Agreement on First Nation Health Governance. **(7.90–7.101)**	**The Department's response.** Agreed. Health Canada expects that all of the accountability and governance requirements set out in the Tripartite Framework Agreement on First Nation Health Governance and the Canada Funding Agreement be fully satisfied. To date, the First Nations Health Authority has been diligent in providing Health Canada with quality and timely deliverables against all its obligations and meeting the accountability and governance requirements set out in the framework agreement. In a spirit of continuous improvement, Health Canada's intention is to continue collaborating with the First Nations Health Authority to achieve the highest management standard set in its own policies. In addition, the First Nations Health Authority and Health Canada have formally established processes in order to advance joint priorities, monitor progress in resolving issues, and work toward continuous improvement. In response to the observations and recommendations of the Office of the Auditor General, a specific provision will be included in the annual executive operational agenda (Shared Vision and Common Understanding) between the First Nations and Inuit Health Branch Senior Assistant Deputy Minister and the First Nations Health Authority Chief Executive Officer. This provision will formalize the Annual Assistant Deputy Minister meeting with the First Nations Health Authority Board to discuss accountability and governance. Health Canada will also assist the First Nations Health Authority in accessing departmental expertise to finalize the development and implementation of its Human Resources Policy Framework.