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Chair

Mr. David Christopherson

Standing Committee on Public Accounts

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● (1530)

[*English*]

The Chair (Mr. David Christopherson (Hamilton Centre, NDP)): I now call this 62nd meeting of the Standing Committee on Public Accounts to order.

Colleagues, our business is fairly straightforward today. We have a public hearing on another one of the chapters from the Auditor General's spring reports.

Today it's chapter 4, Access to Health Services for Remote First Nations Communities, of the spring 2015 reports of the Auditor General of Canada. Unless there's some particular reason not to, we will move straight to our opening remarks. I see none, and therefore, I will turn to our Auditor General, Mr. Ferguson.

Sir, I offer you an opportunity to introduce your delegation and give us your opening remarks.

[*Translation*]

Mr. Michael Ferguson (Auditor General of Canada, Office of the Auditor General of Canada): Mr. Chair, thank you for this opportunity to discuss our Spring 2015 Report on Access to Health Services for Remote first nations Communities. Joining me at the table is Joe Martire, the principal responsible for the audit.

In this audit, we looked at what Health Canada has done to support first nations access to health services in remote communities. first nations individuals living in remote communities have significant health needs and face unique obstacles in obtaining health services. We found that Health Canada had not adequately managed its support of access to health services and medical transportation benefits for remote first nations.

[*English*]

According to the department, its support to these communities extends to 85 health facilities where health services are delivered through collaborative health care teams led by approximately 400 nurses. These health facilities serve approximately 95,000 first nations individuals. For these individuals, initial access to health services is usually provided by nurses at nursing stations.

We found deficiencies in the way nursing staff and stations are managed. For example, while all 45 nurses included in our sample were registered, only one of the 45 had completed all five of Health Canada's mandatory training courses we examined.

Health Canada acknowledges that its nurses sometimes work outside their legislated scope of practice to provide essential health services to remote first nations communities. Examples of such activities include prescribing and dispensing certain drugs and performing X-ray imaging of chests and limbs. Nevertheless, we found that Health Canada had not put in place supporting mechanisms that would authorize the nurses to perform activities outside their legislated scope of practice, for example, medical directives to allow nurses to perform specific tasks under particular circumstances.

We also found that Health Canada could not demonstrate whether nursing stations built since 2009 had been constructed according to applicable building codes. Moreover, the department had not addressed 26 of 30 health and safety or building code deficiencies that we examined in seven nursing stations built before 2009.

These deficiencies included malfunctioning cooling and ventilation systems and unsafe stairs, ramps, and doors. In one community, health specialists cancelled their visits to the residence intended for their use because issues with the septic system caused the residence to be closed. These issues dated back more than two years.

● (1535)

[*Translation*]

In addition, we found that Health Canada did not take into account the health needs of remote first nations communities when allocating support. For example, we noted that the number of nurses assigned to nursing stations was based on past practice, and not on each community's current health needs.

We also found that Health Canada had recently defined essential health services that should be provided in nursing stations. However, the department had not assessed whether nursing stations had the capacity to provide the services, nor had it informed first nations individuals of the essential services that each nursing station provided.

[*English*]

With respect to access to health services outside the community, we found that medical transportation benefits were available to first nations individuals who were registered in the Indian registration system, but those individuals who were not registered may have been denied access to benefits.

We also found that Health Canada's documentation concerning the administration of medical transportation benefits was insufficient. For example, there was a lack of documentation to demonstrate that the requested transportation was medically necessary and to confirm that individuals attended the appointments for which they had requested transportation.

Furthermore, Health Canada committed to providing first nations individuals living in remote communities with access to health services comparable to that provided to other residents of Manitoba and Ontario living in similar locations. Even so, we found that the department had not gathered the information it needed to know whether it was achieving its objective.

We also noted weaknesses in the coordination of health services among jurisdictions. For example, we found that committees comprising representatives of Health Canada and other stakeholders in Manitoba have not proven effective in developing workable solutions to interjurisdictional challenges that negatively affect first nations individuals' access to health services.

[*Translation*]

This finding is important because the lack of coordination among jurisdictions can lead to the inefficient delivery of health care services to first nations individuals and to poor health outcomes for these individuals.

Workable solutions are needed to improve accountability and ensure that individuals in first nations communities have access to health services comparable to those offered to other residents.

Our report contains 11 recommendations aimed at improving access to health services for remote first nations communities and the health outcomes of individuals, and Health Canada has agreed with all of them.

Mr. Chair, this concludes my opening remarks. We would be pleased to answer any questions the committee members may have.

Thank you.

[*English*]

The Chair: Very good. Merci, Mr. Ferguson.

Now, from the Department of Health, we have Mr. Perron, who is the senior assistant deputy minister of the first nations and Inuit health branch.

I'll give you an opportunity now, sir, to read your opening remarks and, if you would, to also introduce your delegation.

Mr. Sony Perron (Senior Assistant Deputy Minister, First Nations and Inuit Health Branch, Department of Health): I would like to thank the committee chair and the rest of the committee members for the invitation to appear here today.

[*Translation*]

I, and other officials at Health Canada, have reviewed the Auditor General's 2015 Report, and we have paid a great deal of attention to his recommendations. We take the findings seriously and are addressing each of them through an action plan. This plan will continue to be refined and defined in collaboration with first nations. Indeed, as you know, we work in cooperation with first nations. This plan can therefore only be completed with an additional commitment by our first nations partners.

The health care system serving first nations is highly complex. Provincial health systems do not directly extend to first nations reserves. To support first nations, Health Canada provides the delivery of a range of effective, sustainable and culturally appropriate programs and services. We work with first nations to increase their control of health services and collaborate with provinces to increase access and promote system integration.

● (1540)

[*English*]

We also support programs that address first nations health priorities in the areas of mental health, chronic disease, maternal and child health, and health benefits providing coverage for prescription drugs, dental care, vision care, mental crisis intervention, and medical supplies and equipment.

Most of the community-based programs have been transferred in varying degrees to over 400 first nation communities. This number does not include British Columbia, where in 2013 Health Canada transferred its role in the design, management, and delivery of first nations health programming in British Columbia to the new First Nations Health Authority.

Health Canada provides funding to first nations to deliver clinical care in 27 remote and isolated communities, again, outside British Columbia. In an additional 53 remote and isolated first nation communities, Health Canada continues to deliver clinical care. The delivery model varies based on the specifics of each province and geographic conditions. The clinical care teams are located in nursing stations, along with community health workers delivering other programs.

Because of the importance of these services, it is imperative that Health Canada ensure that remote communities have access to clinical and client care, that nursing stations are staffed with registered nurses, and that nurses work in a safe environment, have access to physicians to support them, and have access to tools.

Registered nurses and nurse practitioners are predominantly the first point of contact in isolated communities and are highly educated and qualified individuals. To ensure that our nurses are prepared for the unique demands of working in remote stations, a mandatory training requirement has been defined and is now part of the national education policy.

I can report that we currently have an 88% compliance rate on Health Canada's nursing education model for controlled substances in first nations health facilities, while advanced cardiac life support is at 63%, trauma support is at 59%, pediatric advanced life support is at 64%, and immunization is at 61%. The overall compliance rate is at 46% as of the end of April 2015. We still have work to do, and we are doing it while ensuring that we have resources in place to backfill these important positions while incumbents are in training.

Health Canada is committed to ensuring that nurses working in remote first nations communities meet established public service requirements on top of these workers' already robust credentials.

[*Translation*]

Remote and isolated practice environments sometimes require nurses to respond immediately to life-threatening or emergency situations. Nurses therefore need appropriate mechanisms to perform these important duties.

[*English*]

Clinical practice guidelines assist nurses to address clinical care situations and provide instruction on whether and when consultation with a physician or a nurse practitioner is required. There are arrangements in place for all nursing stations to access physicians when physicians are not located in the community. We also continue to collaborate on region-specific solutions with provinces to advance access to health services and with regulatory bodies to support nurses practising within their scope of practice.

A key challenge is the need for more nurses. Health Canada has implemented a nurse recruitment and retention strategy, which involves a number of initiatives: a nursing recruitment marketing plan, a nursing development program, a student outreach program, and an onboarding program.

Since its February launch, we have received over 500 nursing applications, with 200 of these moving to the next level of screening. As well, the strategy aims to increase the number of nurse practitioners, which will provide greater stability in the clinical teams, assist in meeting training objectives, and enhance the level of services available at the community level.

Nurses and other community health professionals require facilities to conduct their work. Currently, we invest approximately $30 million annually for repairs, renovation, and construction of health facilities, plus an additional $44 million for maintenance and operations. The nursing stations are owned by first nations communities, and we collaborate with them to support their operation.

We work with first nations communities to ensure buildings are inspected and deficiencies are addressed. In response to the audit, we are implementing a more robust tracking system to capture this work. We will also enhance our process in order to use facility condition reports as a tool to better plan maintenance and renovation work with the owners.

In addition, to ensure new nursing stations are built to code, we have updated our requirements for attestations and have communicated the change to facility management staff. The audit rightly noted that the requirements, such as the station as defined currently, did not provide the necessary level of assurance.

Another area reported on was the management of medical transportation; medical transportation that provides coverage to support access to insured health services. Health Canada spends over $300 million on medical transportation per year, and approximately 60% of that is in remote and isolated communities. The main reasons for transportation are emergencies, at 24%, hospital services, at 10%, appointments with general practitioners, at 7%, and dental services, at 5%.

The program provides coverage for transportation to the nearest appropriate professional or facility that takes place when the needed service is not locally available. Our goal is to provide timely coverage for medical transportation to avoid an undue burden for clients and health care professionals. Decisions are based on a national program framework and are made with a solid understanding of the health services available and the transportation options at the regional level.

In response to the audit observations, the program has already modified and disseminated guidelines to resolve discrepancies observed between our practices and the medical transportation framework in terms of the level of documentation required.

● (1545)

[*Translation*]

Regarding the transportation of children who are not registered, Health Canada has a long practice of allowing coverage for a child up to one year of age to be covered for medical transportation under the registration number of their parents. Health Canada will continue its efforts with partners to inform parents and make available registration material in nursing stations and health centres.

[*English*]

Health Canada and the Assembly of First Nations are undertaking a joint review of the non-insured health benefits program, of which medical transportation is a component, and I am pleased to report that the work is well under way. It will identify strengths, weaknesses, including inefficiencies in administration, and recommendations for action.

Given that the geographic location, the size of the community, and the need to ensure cultural safety influence the range of programs and services funded or provided by Health Canada, comparing one community to the other is not always possible or the best approach. Community health planning, investing in the integration of services with provincial systems, and the development of community programs and capacity have proven to be more effective and more responsive to community needs over time.

As indicated earlier, Health Canada funds a number of community programs aimed at addressing specific needs and working as a complement to the clinical and client care program. These programs are funded to support community health needs and mostly managed by the communities themselves. In response to the audit, we will improve our support to community health planning to enhance integration of the community-based programs and clinical services where these services are delivered by Health Canada. We will also engage with the communities to review the current service delivery model and clinical care resource allocations.

[*Translation*]

The last area I would like to discuss is coordination among health system jurisdictions.

We work closely with partners to build health service delivery models that take into account community needs.

[*English*]

We have made significant progress with health service integration over the last 10 years. We see examples in various regions where there are more physicians' visits, provincial services are being extended on reserve, and there are more collaborative arrangements between community health services and regional health authorities. Co-management and trilateral tables exist in most regions to formally engage with provincial and first nations partners to advance common practices and resolve systemic issues. We will formally engage these tables in order to make progress on the important issues raised in the report.

Health Canada will continue to collaborate with our partners to develop and implement other models of first nations-led health systems across the country, as we have celebrated in B.C. We have presented an overview of our action plan, which requires further engagement and collaboration with first nation partners. We believe the next update will be more comprehensive as it will benefit from our partners' input.

In closing, we are working on a number of actions in response to the audit, and we will continue to do so.

I would note that I am accompanied today by three senior officials from Health Canada's first nations and Inuit health branch: Valerie Gideon, assistant deputy minister, regional operations; Robin Buckland, executive director, office of primary health care; and Scott Doidge, acting director general, non-insured health benefits.

We would be pleased to answer your questions. Thank you.

● (1550)

[*Translation*]

The Chair: Thank you.

[*English*]

Colleagues, we'll begin questions and comments in the usual rotation, beginning with Mr. Albas.

You now have the floor, sir.

Mr. Dan Albas (Okanagan—Coquihalla, CPC): To our witnesses, thank you for bringing forward your expertise and for the work you do for our country.

Auditor General, I always appreciate the opportunity to discuss your reports directly with you. In this report, there seems to be very much a focus on Ontario and Manitoba, but I don't see a lot of other examples such as we heard about British Columbia. Of course, I'm a proud citizen of British Columbia.

Could you share with us why that is?

Mr. Michael Ferguson: Certainly. I think every time we have to do an audit, we have those types of scoping decisions to make about what we can look at, what we can include in a particular audit. In this case, we wanted to look at the services Health Canada is providing to those remote first nations. The model in British Columbia that has been put in recently is significantly different. We're doing a little bit of work right now to try to understand that model so that maybe it will be the subject of something that we could do in the future.

It was really a matter of trying to identify the types of remote first nations that we could include and the amount of work that we could do over the course of one audit. We decided to scope this audit to the services provided in Manitoba and Ontario.

Mr. Dan Albas: I can certainly appreciate that. It's just that it is helpful, when we have a national auditor general do a report, to give comparables right across the country. As we know, Health Canada works with first nations. I think there are over 660, if my recollection is correct. As our guest said earlier, there are many different areas of jurisdiction in managing these services. I'm quite hopeful that at some point we'll be able to see some results of some of your investigations into British Columbia. I have many first nations in my riding, and the new health authority has received some initial good reviews, but again, those are initial, so I would appreciate that.

Mr. Perron, with regard to the ownership of these nursing stations themselves, are they owned by Health Canada, or by the individual first nation, or are they leased through a different provider? Could you give us a little analysis on that?

Mr. Sony Perron: Yes. These health facilities built on reserve are owned by the first nation. This is according to the Indian Act. Ownership is really with the first nation community. The way we are working with the first nation community on these buildings is that basically we are funding them through contribution agreements to do the maintenance, the operations, the renovations, the repairs, and the construction.

Mr. Dan Albas: When we talk about first nation communities, Westbank First Nation, for example, is in my riding. They actually do a lot of lease arrangements. When someone goes into a store on reserve...they actually are leased out to private individuals.

Do all the first nations own the facilities that Health Canada operates in, or do they sometimes lease out to private operators? How does that work?

Mr. Sony Perron: As far as I can tell, the nursing stations are owned by first nations in all regions. I would perhaps ask my colleague Valerie if she knows of any exception to this rule.

Usually the nursing station is owned by the first nation community and will be operated by a health director who is hired by the community as well. All Health Canada nurses, where we deliver clinical care directly, will be located in that facility, along with community health workers.

● (1555)

Mr. Dan Albas: The reason I raise this is that, as a member of Parliament, I've been in both the Confederation Building and the Valour Building. One is owned and operated by Public Works and the other one is leased. The rules and the processes in each building are completely unique one from the other. I just wanted to see if there was that issue there.

When it comes to the governance, you mentioned in your opening statement that you're working with first nations communities. I imagine every community is different. They have different populations, different budgets, and different priorities. For example, some big issues for the Penticton Indian Band are dental care and diabetes.

How do you work with that? Is it a challenge to make sure that these facilities are working with the standards that Health Canada has put forward but also with individual first nations and their priorities?

Mr. Sony Perron: You have a number of questions in there. I will try to answer some of them.

First, a construction project like a nursing station is a pretty big project, ranging from $12 million to $15 million. Some communities won't see projects like that come along very often. We need to work with them on the planning, the capacity building, and the governance to handle these projects. The fact that we're doing one or two projects a year gives us lead time to work with them to set the contribution agreement and to do the phases of the project.

We also provide, in some areas, some lead time to do the design and to consult with our team. We have some resources located in each and every region—except in British Columbia, where now this function is delivered by the first nations health authority—to provide the expertise needed to advance these projects. We work side by side. The model is really with contribution agreements. At the end, the general contractor or the plumber or the electrician will be hired by the community to do the building. That includes the architect and the engineer, if needed.

One of the challenges is in bringing the material up north to really isolated communities, which is what we are talking about here today. For these nursing stations we need to plan two or three years ahead to start these projects. When it's time to construct, the material has to have been delivered.

The Chair: Very good. Thank you. The time has expired.

Mr. Allen, you have the floor, sir.

Mr. Malcolm Allen (Welland, NDP): Thank you to our guests.

Mr. Perron, let me start with you. On page 3 of your written testimony, you give some statistical numbers. I have a pretty simple question: does that include B.C., or is that just Manitoba and Ontario?

Mr. Sony Perron: It does not include B.C., because we do not monitor what is happening on the operational side in British Columbia anymore. We can ask, though, because we have a relationship with them.

Mr. Malcolm Allen: No, it's just that apples and oranges can get confusing. I want to make sure, when I look at your numbers and I look at the Auditor General's report, I'm looking at the same two places.

Mr. Sony Perron: Just to clarify, it will include statistics for Quebec and Alberta as well, where we do deliver clinical care. So it will be Ontario, Quebec, Manitoba, and Alberta.

Mr. Malcolm Allen: So I really am looking at an apple and a pear. I'm not actually looking at two apples.

When I compare your numbers and the Auditor General's, they're not the same. Statistically they're not the same but they're not the same comparators. You're looking at four jurisdictions. He's looking at two. He says quite clearly on page 5 under “What we examined”, that they selected a sample of 45 Health Canada nurses, 24 in Manitoba and 21 in Ontario.

Mr. Ferguson, I'll put the question to you. Did you study Quebec or Alberta or anywhere else when it came to that particular chart, exhibit 4.2, on page 6 in the English version?

Mr. Michael Ferguson: No, we didn't. I do just want to clarify that in the section “About the Audit”, we indicate that we had looked at 64% of the 85 remote first nations. So by looking at just Ontario and Manitoba, we were able to cover off 64% of these first nations.

Mr. Malcolm Allen: Okay.

The dilemma I have, Mr. Perron, is that I'm looking at a number that says your compliance rate overall is 46%. The Auditor General has a compliance rate in Manitoba and Ontario that is significantly less than that. The problem is that I can't actually break out what you've given us and what the Auditor General's report says, unless you want to supply that to the committee for Manitoba and Ontario. I really don't know if you have it in front of you or not.

Are you any better, as of April of this year, than what this report indicates, and if so, what are the numbers?

● (1600)

Mr. Sony Perron: I'm sorry. We could have provided the breakdown by provinces. I don't have that with me.

Robin, do we have it? Okay. I will let Robin give you the details for Manitoba and Ontario.

One thing I will add is that when the audit team did their work, one thing we had a deficiency in was the supply of evidence as well. For some of the numbers in terms of the deficiency, it's due to our own lack of organization for that. Our numbers are—

Mr. Malcolm Allen: I hate to interrupt you, but that doesn't speak well to your department if you can't supply your own evidence to support the systems you're actually working with. The whole idea of being able to tell the Auditor General and then Parliament whether your system works is that by having the evidence you can actually prove it. That's actually a deficiency of your department, sir. I don't think it's anyone else's deficiency.

Mr. Perron, on page 5 of the Auditor General's report, in paragraph 4.26, he talks about how the issue of nurses not having completed mandatory training goes back to a previous report in 2010. Also, later in his report, a similar comment is made on page 23 in the English version, in paragraph 4.115. It's a similar idea: "The need to measure whether Health Canada provides comparable access was also raised in...2010."

The Auditor General said in both of those paragraphs that you were told in 2010 that you needed to do this. I'm not suggesting, Mr. Perron, that you might have been the person there—I don't know—but clearly your department was there. Here we are five years later and at the time you did supply an action plan to this committee for the 2010 report that said "thou shalt do". Some of the timelines are June 2011, April 2010, December 2010, and March 2011. This is May 2015. If I were your teacher, I'd say that you've all flunked.

Do you have any response as to why this didn't get completed and the Auditor General is now back and asking you how come? You're before us and we're asking you, how come?

Mr. Sony Perron: Thank you for the question.

The main reason for being behind on the training is the recruitment and retention. We have a high turnover of nurses.

Our first order of priority is to make sure we have nurses in the position to deliver the service on an ongoing basis. This is not a justification for not meeting our own mandatory training standards. I would agree; this is a problem we are trying to fix.

At the same time that we are investing a lot of energy on training to improve our numbers there, we are also running a really aggressive recruitment strategy. We are hopeful that we will be able to stabilize the workforce, because to be able to deliver the mandatory training that has to be repeated every year, or every two years for some of the courses, we need to have a stable workforce. Each time we lose a nurse, we need to start back, and a new nurse may come into an employment position without that nursing background or the mandatory training met.

This is a fundamental issue we have with the training. It's the ability to stabilize the workforce. We still have a high turnover of nurses, but our recruitment strategy is starting to produce results right now, so this should help to stabilize the workforce and help improve our numbers in terms of training.

The Chair: Very good. Thank you. The time has expired.

We'll go to you, Vice-Chair Carmichael. You have the floor, sir.

Mr. John Carmichael (Don Valley West, CPC): Thank you, Chair.

Welcome to our witnesses today and to Auditor General Ferguson.

Mr. Perron, I'd like to begin with you with a question following up on the line of questioning by my colleague opposite. I want to talk about qualifications that nurses must have through their provincial certifications before they are employed in nursing stations. We can start there. Could you expand on that and talk to what it takes in terms of the qualifications that are going to produce somebody who is clearly capable of doing the job?

Mr. Sony Perron: Mr. Carmichael, I'll do the introduction and let Robin Buckland add to this.

To be employed by Health Canada, you need to be a registered nurse in one of the provinces where we are operating and in the province where the service will be delivered. Sometimes we have nurses who are registered in more than one province, and then we can have them practising in more than one province.

Robin is probably better placed than I am to tell you a bit more about the credentials these nurses need to have to be able to work at Health Canada.

Ms. Robin Buckland (Executive Director, Office of Primary Health Care, First Nations and Inuit Health Branch, Department of Health): Thanks, Sony.

I am a registered nurse, and I have been for the last 27 years. To become a registered nurse, you have to complete a nursing program. In the vast majority of the country, it's at the baccalaureate level; you have to have a degree in nursing. In Quebec, the entry to practise is actually a diploma, so you can obtain a nursing diploma from the CEGEP in Quebec. Basically, through nursing school, you obtain the core competencies that are required to function as a registered nurse.

Generally speaking, nurses come out of nursing school and they are generalists. They're able to practise in a wide variety of areas.

In remote and isolated locations, there are additional competencies that are required. As the report indicated, they are often the only provider in the community and they are the first point of contact for the patient. They need to be able to respond to what comes in the door. If it's an emergency, a trauma, they need to have the competencies to deal with it. That is why Health Canada has identified advanced cardiac life support, pediatric life support, trauma, and the other courses you'd see listed as our five courses. Those are the key competencies that RNs will require to meet the needs of the community, in addition to so much more.

● (1605)

Mr. John Carmichael: Robin, you explained—and, again, I'm from a long way outside of the medical profession—about the core competencies. When they move into first nations and isolated communities as the sole provider of health care in that area, are the types of qualifications they're required to have fairly common across the country, or is this the entry level and then we have to increase the standard from there?

Ms. Robin Buckland: Our expectation is that they have those competencies. That's where it begins; it's not where it ends. In addition to those, I would say more highly technical skills, there are also a lot of additional skills that are required, including cultural competencies, to be able to offer safe health care services.

They are often the only provider and the first point of contact, but we do work toward having a team within the nursing station. Nurses have access to nurse practitioners, to physicians, either in person or via telephone or e-health. We do like to make sure that they have access to an interprofessional team.

I'm going to stop. I'm not sure that I've fully answered your question.

Mr. John Carmichael: It's clear as you explain it and from the report that each of these individuals is very integral and very important to the care in that community.

You talked about turnover. You lose one nurse, one key individual, and you have a major gap.

Could you talk a bit about the recruitment process and how you deal with the loss? You talked about a team. How many teams are out there, and how many locations are there with a single practitioner?

Ms. Robin Buckland: We have very few nursing stations with less than two nurses within them. Generally speaking, we like to make sure there's at least a team of two. We have 53 nursing stations that we deliver nursing services in, which as Sony indicated are in Alberta, Manitoba, Ontario, and Quebec.

I forgot the second part of your question. I apologize.

Mr. John Carmichael: Could you talk about recruitment briefly? Obviously, that's integral.

The Chair: Very briefly.

Go ahead, please.

Ms. Robin Buckland: Okay.

We're working hard—and I think this responds in part to your colleague's question about how have we come this far and not had our training done—but our turnover rates are very high. We recruit ten nurses and we lose five. It's very difficult. When you have a nurse going out of the community to obtain their training, we work hard to get a replacement so that the community is not missing access to services. We do that in a number of different ways, to make sure that service is continued.

The Chair: Very good. Thank you. The time has expired.

Over now to Monsieur Giguère.

[*Translation*]

Mr. Alain Giguère (Marc-Aurèle-Fortin, NDP): Thank you, Mr. Chair.

My question is for Mr. Ferguson. It is a little more general.

This is not the first report you submit to us on matters pertaining to first nations. Very unfortunately, these reports tell us time and again that first nations don't have all of the services they might expect. Promises made are hardly, if ever, kept.

In Canada, in terms of services, would it be that there is one set of criteria for Canadians and another for first nations? In fact, given the number of reports tabled in recent years indicating that first nations still have poor quality services, the question arises. Are there two standards for the public service? If not, how do you explain that once again a report is indicating that first nations are not receiving what they should?

● (1610)

Mr. Michael Ferguson: I think that, generally speaking, what we see here is similar to other problems we have observed in other audits concerning first nations.

[*English*]

I think of things like departments having said there are certain standards that they have to meet, that they have to live up to, but not doing that. Again, in this case, it was a situation of nurses who were supposed to have the training and not getting the training.

Again, it was mentioned earlier that some of these problems have been known for a while but have not been fixed. Over the last few years, we've done audits on policing services on first nations and also on emergency response on first nations, and I would say that the types of problems we are identifying here are similar to the problems we've identified in those other audits.

We haven't done anything to look at it from the global perspective to try to understand why those problems are persistent. Certainly, we're dealing with first nations that are remote, but nevertheless, I don't think that excuses the fact that departments are not living up to their own set of standards, the expectations they've set for themselves for the services to provide on the first nations.

[*Translation*]

Mr. Alain Giguère: Mr. Ferguson, in point 4.4, you talk about social determinants as one of the essential aspects that harm the health of first nations' members the most. You talk specifically about overcrowded housing, high rates of unemployment and problems with access to drinking water. The problems mean that first nations currently have a considerably lower life expectancy than the general Canadian population. Statistics Canada data indicate that these problems are very serious and that, unfortunately, with the very significant population growth of first nations, they are worsening rather than resolving themselves.

You told us about coordination among the different stakeholders. Since prevention and public health are important aspects of access to health care, I would like to know if, in terms of coordination, the department is making an effort to resolve problems that aggravate the health of first nations individuals, for example the lack of access to drinking water, overcrowded housing and poor follow-up for psychological care, which results in very high suicide rates.

Are efforts really being made to address these problems? I won't even get into problems with food, which are significant all over Canada.

[*English*]

Mr. Michael Ferguson: I don't want to downplay the issues, certainly, that were found here. I think when you look at our conclusion, you see that we have said that the department does not have reasonable assurance that these first nations had access to the services and the medical transportation benefits that we examined. But I don't want to downplay the complexity of the environment that the nurses are operating in and the challenges they face, including these types of social determinant challenges.

Fundamentally, in the course of this audit, we found that there were a number of things that the department could have been doing better that were within their power to do better. Despite the complexity of the situation and those problems they face, there's more that they could do.

Now, the department has agreed with our recommendations. They've said that they're going to implement our recommendations. In this audit, we made 11 recommendations, which is more than we make in a lot of audits. If they can put measures in place to deal with those issues we found, to deal with the recommendations we made, we certainly feel that it's possible for them to significantly improve the services to these remote first nations.

● (1615)

[*Translation*]

The Chair: Mr. Giguère, your time is up. Thank you.

[*English*]

We'll move over to Mr. Hayes. You have the floor, sir.

Mr. Bryan Hayes (Sault Ste. Marie, CPC): Mr. Perron, I'm looking at page 18 of the Auditor General's report, exhibit 4.3. That's a chart, and there's something I don't understand on the chart.

In terms of pre-authorization of non-medical escorts, in all circumstances that occurred, in Manitoba 18 of 18, in Ontario 14 of 14, I'm confused as to how there could be a pre-authorization of non-medical escorts without even knowing that medical transportation was required. I want to understand that pre-authorization.

Mr. Sony Perron: The non-insured health benefits program is a quasi-insurance program. It confirms that coverage and payment will be provided to the provider, whether it is the airline, the bus, the hotel, or the restaurant for the meals for the client.

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

Mr. Bryan Hayes: In that particular case, all 50 requests, can we assume that all of the individuals were registered in Aboriginal Affairs and Northern Development Canada's Indian registration system, as well as Health Canada's status verification system?

Mr. Sony Perron: Yes. It's the same database. They are connected. We are using the Indian registration system from AANDC as our source of information.

Mr. Bryan Hayes: With respect to registration, does anybody get turned down if they're in a dire medical situation and they need transportation and they're not registered? Do they get that transportation?

Mr. Sony Perron: Especially in these remote and isolated communities when someone needs to be evacuated in an emergency situation, we do not get in the way of health services with administrative considerations.

The person is medevaced or will get an ambulance service and get to the point of services. It's only after the fact that we will confirm that the person is registered. If it happens that it is someone who is not registered, then we'll have to send the bill for the ambulance service to someone else, but it doesn't get in the way of accessing emergency transportation.

Mr. Bryan Hayes: Then why isn't registration mandatory?

Mr. Sony Perron: This is an individual choice. If people want to register and become an Indian under the Indian Act, they need to make the decision. Usually it's the parents when the newborn comes who will make the decision to fill out the paperwork, provide all the pieces of evidence, and get registered with Indian Affairs, but once you're registered as a first nations person, you cannot deregister.

It's an important decision, and we understand that various factors influence the decision to register or not.

Mr. Bryan Hayes: You talked in your opening statements about I think it was $300 million that was appointed for transportation services. What portion of that is for medevac access? Can you talk a little about the medevac access program that's in place for remote reserves?

Mr. Sony Perron: In all regions of the country we are trying to work as closely as possible to the provincial or the territorial health system to make sure that clients, whether they are first nations or Inuit, will benefit from the same access to emergency transportation wherever they live. In some provinces there is a model whereby everybody residing in the province will be covered by the province and will only pay the co-payments for them. Some of the other provinces exclude de facto first nations or Inuit, so we will assume 100% of the bill.

There is a protocol in place to avoid having to call us beforehand, so the evacuation goes first. It's only an administrative procedure to decide who is going to pay the invoice for emergency transportation. We have a really solid arrangement in some provinces where I would say it's seamless. In some others we are working to make it even more seamless.

Wherever it is possible that we can have a protocol with the regional health authority or the provincial health system we will let them make the call about the transportation and will only be there after the fact to deal with the administrative and financial sides so that people get the services.

● (1620)

The Chair: You have 15 seconds.

Mr. Bryan Hayes: That's fine.

Thank you, Mr. Chair.

The Chair: I appreciate your consideration. Thank you, Mr. Hayes.

I see we have Mr. Casey with us, not a regular member, but sitting in today. Welcome, sir, and you now have the floor.

Mr. Sean Casey (Charlottetown, Lib.): Thank you, Mr. Chair, anything but regular I can assure you.

Mr. Ferguson, you found in your report that we had nurses working outside their scope of practice. You found some pretty profound shortcomings in their compliance with the mandatory training program.

My background before coming here was in defending lawsuits, many of them involving medical malpractice. When I read your conclusions, it looked to me like a field day for the plaintiffs bar.

I don't know if my question is for you, Mr. Ferguson, or if it may be best for Mr. Perron. In view of the shortcomings identified with respect to the compliance with mandatory training and the instance of working outside the scope of practice, has the department or its employees been sued as a result of what's been identified by the Auditor General?

Mr. Sony Perron: No. When there is an incident, we review the incident in collaboration with the regulatory authorities or the coroner to make sure we learn from these situations, but no.

Mr. Sean Casey: The nurses in your employ would be obligated to carry liability insurance, I presume. Correct me if I'm wrong. If this is the case that they are obliged to carry professional liability insurance, has their insurance rating been affected by the shortcomings identified in this report prior to the publication of the report?

Mr. Sony Perron: Again, the answer on this one as far as I can tell is no. I'm not aware of that.

Robin, do you have anything to add on this question?

Ms. Robin Buckland: The question I believe was do they carry mandatory insurance.

Mr. Sean Casey: Yes, and has it been rated up because of the shortcomings identified?

Ms. Robin Buckland: Nurses are obliged to carry coverage, as you would know. The federal government does provide that coverage for all of the nurses who work for us in the first nations and Inuit health branch. That's the same for nurses working elsewhere within the federal government as well. I'm not aware of any increase because of any situation.

Mr. Sean Casey: Okay, so their professional liability rates have not increased based on experience in recent years. Is that right?

Ms. Robin Buckland: That's correct.

Mr. Sean Casey: Thank you.

We saw recently where the RCMP ran afoul of the occupational health and safety regulations in New Brunswick because of how ill-equipped their members were. When we see in the report things like a septic system that prevented the availability of nurses for two years, or faulty seals on an X-ray room door, I ask you the same question. Has the department been investigated by provincial occupational health and safety officers as a result of these violations?

Mr. Sony Perron: No.

Mr. Sean Casey: Certainly, in the last four years the government has been extremely preoccupied with balancing the books. They have gone through the deficit reduction action plan. There have been deep cuts in the civil service.

Has your department been immune, and if not, how have they impacted the types of things that have been identified in the report?

Mr. Sony Perron: There has not been any reduction to the clinical care programming or the non-insured benefit for medical transportation, which were the two elements in the scope for this audit. In fact, we have had reinvestment in 2012-13 into clinical care because the costs were getting higher mainly due to the fact that we had a high turnover, a high dependency on agency nurses. We are still using a lot of agency nurses to compensate for the fact that we have vacancies in the branch for these services. So, no, instead of a reduction, there has been additional investment to meet the increased costs.

If I could add to this, we are really hopeful that our investment in retention and recruitment will allow us to use some of these resources that currently go to agencies to improve services in the communities as well, because it's a very costly model to rely on agency nurses to complement our staffing in the nursing station.

This is something we are really hopeful we can do better with the money because I know the public accounts committee is pretty concerned about efficiencies as well. There is a potential there to change the model of business to reinvest the resources that currently we spend on agency nurses in the clinical care program, in enhancing our services.

● (1625)

The Chair: Very good. Thank you. The time has expired.

Moving along, Mr. Aspin, you now have the floor, sir.

Mr. Jay Aspin (Nipissing—Timiskaming, CPC): Welcome, Auditor General Ferguson and officials of the health department.

I have an overview question to begin with. What are the engagement processes at the national and provincial levels with first nations and provinces?

Mr. Sony Perron: This is an important question, because we believe that the best way to improve health services, not only clinical care but all health services, through integration of health services is by creating more first nations control over these services. I think one of the honourable members mentioned the model in British Columbia, which is probably the furthest advanced transformation that we have in the works. Since 2013 we have transferred all operations, and this model is now fully under the control of the First Nations Health Authority, with the important participation of the provincial government in that.

This is the best way to integrate the services to maximize the impact of the investment and to get rid of some of the challenges we have with jurisdictions on who is doing what and why. I think that when you get to the kind of model we have in B.C., these kinds of questions are not important anymore. What matters is the continuum of services and the continuum of care in the community.

In all provinces we have co-management tables with first nations, and in most provinces we have trilateral tables to deal with service integration. Unfortunately, I would say that in the last few years, the focus has not been much on clinical care. One of the most important priorities for our first nations partners, and often for the provinces as well, has been on the mental health side, but we have made great progress there.

I will ask my colleague Valerie Gideon to give you a sense of where we are with the main initiatives in various regional and trilateral tables.

Ms. Valerie Gideon (Assistant Deputy Minister, Regional Operations, First Nations and Inuit Health Branch, Department of Health):

Very quickly, we have a trilateral table in Ontario with the Ontario Ministry of Health and Long-Term Care. We also have a specific northern table that the northern first nations have asked for, and in that table, which has just started this year, we do anticipate that we're going to be talking quite a bit about clinical and client care and medical transportation and engaging them in terms of our follow-up actions on that plan.

In Manitoba, we've had a committee for several years that was at a more junior officials level. We've now bumped it up to an assistant deputy minister level, with the Province of Manitoba, the Grand Chief of the Assembly of Manitoba Chiefs, and me. As well, we will be using that table to engage first nations in Manitoba with respect to our actions on this report to ensure that we're also monitoring progress and partnership of first nations.

Those are just two examples that are more relevant to this audit, but there are many more across the country. We also have national partnership agreements with the Assembly of First Nations and the Inuit Tapiriit Kanatami, which we signed this year.

Mr. Jay Aspin: Thank you.

What is the benefit of accreditation in improving health services in first nations communities? In your view, what progress have you made in that direction?

Mr. Sony Perron: The accreditation is something that is being used in provincial and territorial health systems to ensure quality of service in health institutions. We were talking about comparability earlier, and applying the same standards in the nursing stations in remote and isolated communities is the way to go to make sure that services are similar in terms of quality.

Robin, maybe you want to add to that in terms of where we are with our accreditation process.

Ms. Robin Buckland: Yes. We're working hard to increase the uptake of accreditation in health services delivered to first nation communities. As of 2014, we actually have 87 health centres—this is outside of the nursing stations—that have been accredited and 43 treatment centres that have been accredited as well.

Accreditation is really about a continuing improvement process and working with a set of standards that the health service or the nursing station can compare itself against and then constantly work with to improve the quality of the care they are delivering.

Again, a big focus for us since 2013 has been building capacity in first nations community members in delivering health services themselves. As for where we're going in the next component of our strategy, it's actually looking at what we can do to increase the uptake of nursing stations, both Health Canada-delivered and first nation-run, for the accreditation process. In Canada, we only have one nursing station that is accredited, and it's run by aboriginal community members in Quebec. So we have a lot of work to do, but there's a lot of promise, and there has been a commitment to increase that number to 18 between now and 2018.

● (1630)

The Chair: Time has expired, Mr. Aspin. Thank you.

We'll move now to Mr. Allen.

Mr. Malcolm Allen: Mr. Ferguson, I noticed that your spring report chapter 4 has 11 recommendations. I've been here for a number of years and I don't remember the last report that had 11 recommendations. Maybe it was the F-35 and even that one I don't think had 11 recommendations. Is that on the high side for recommendations from your department? It's not an average in my experience, but I was wondering if it was an average in the department's experience.

Mr. Michael Ferguson: I think certainly in recent practice having 11 recommendations is on the high side. I think in the course of this audit the type of things that we were noticing were at specific levels so it lent itself to being able to make recommendations at each of the things that we looked at.

Mr. Malcolm Allen: Mr. Perron, I don't think you said this; I think Ms. Buckland gave me the number. You talked about retention. I think you said on average you recruit ten and lose five. Was that right?

Ms. Robin Buckland: That's correct.

Mr. Malcolm Allen: I can imagine you do. I have no idea what you pay them and I don't want to know. But when I look at the Auditor General's report he talks about supporting mechanisms that support the scope, working outside the scope.

Personally, my wife's a nurse. She's licensed in the province of Ontario. If she works outside her scope, she will lose her licence if she gets caught. I can imagine nurses get nervous when they're asked to work outside their scope, not necessarily by the department but by a patient in a remote region who can't get service. Looking at someone who's critically ill or injured and doing what they need to do to serve the patient at the time is outside their scope. What a dilemma they're placed in, Ms. Buckland. You're a registered nurse with a licence. You know exactly what that means to them. I can imagine the stress they go through with that.

Then we hear about a residence that doesn't have a septic system for two years. I live in the country. I had three kids who used to live in my house. I can imagine that septic system being down for two days, never mind two years, and there being a riot. Can you imagine living in those conditions, Mr. Perron? Do you wonder why you have retention issues?

By working outside the scope as a professional you can lose your licence. You're asking them to do that. You're placing them in a position to have to do that. Having them reside in a place that isn't fit for human health.

Then the Auditor General goes through a litany of other things like ventilation and cooling systems that don't work. Working in an environment where the X-ray door may not seal properly and you're asking them to give X-rays to people. And you wonder why you have retention issues? It's lucky you have any.

It's amazing you don't have nine out of ten leave, never mind five out of ten. Who would work in those kinds of conditions? You would have strikes across southern Ontario and every major manufacturer if this is how they treated their employees and these sorts of things weren't addressed.

That's why you have retention issues. It isn't about how much you pay. It's about asking them to work outside the scope of their professional ability to do so and that their licence could be revoked. You place them in a place where it's unfit to live. You don't train them properly before they go. And then you say you have retention issues.

Yes, you have retention issues. You have major problems. You have 11 recommendations of which two go back to 2010, five years ago, that you promised to complete, that you didn't get completed. You said then that you had a retention issue. You still have a retention issue.

Quite frankly, your department, sir, has failed. You've failed this Parliament, because your obligation is to us, but more importantly you've failed first nations people. That's who you've really failed.

This wouldn't happen in Welland, let me tell you. Never would we put up with this service in Welland. It wouldn't happen. There would be a riot in the street if we thought this was the kind of service we were going to get. Nurses would not go to work in the places that you're asking them to go to work in if it were in southern Ontario. It wouldn't happen. That's why you have retention issues.

You have a lot of work to do, sir, and you need to start soon. In fact you needed to start five years ago and you didn't get started then. Quite frankly, I have no idea how you're going to make this up and how quickly you're going to make it up, but you need to make it up in a hurry. I don't know what resources you need, whether it be people or money, but if you intend to have a service that's equivalent or reasonably equivalent to what our expectations are, including your department's expectations.... Could you put them in writing?

I don't know when you intend to get started, but my goodness, you needed to get started a long time ago. The people of this country, our first nations people, deserve better, and we've failed. Hopefully, sir, when the next report from the Auditor General comes we won't be seeing the same thing, because quite frankly, to be truthful, in any other major industry or other place, heads would roll. My friend across the way and I worked in the auto sector. If this were an indictment of our sector, heads would roll for that kind of performance.

● (1635)

The Chair: Thank you, Mr. Allen.

Mr. Falk, you have the floor, sir.

Mr. Ted Falk (Provencher, CPC): Just to go a little bit further on Mr. Allen's comments, your department has talked a lot about, and the Auditor General has talked a lot about, the whole issue of employee retention. Is that something that your department has addressed?

Maybe just to help you with the direction I want to go in, when people leave the employment of the department, do you conduct exit interviews? If you do that, what is the primary reason for people leaving the employment of the department?

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

We're spending a fair bit of energy up front to describe the situation. These are locations with really small teams. They're not part of large teams where they will have connections. There are infrastructure challenges in the communities in terms of access. These conditions need to be well known. This is an important component of the strategy.

There has been an important reaction from our marketing campaign. A lot of people have come to us to ask for information about this program, these services, and how this will work up there. We are really confident that we will be able to attract a new group of workers.

Within this, to address one of the issues around scope of practice, we are also trying to integrate nurse practitioners as part of the team. One of the issues with scope of practice was that our model was relying a lot on registered nurses. Nurse practitioners have the ability to perform a larger span of duties and support registered nurses to do more work as well, addressing a portion of the issue with scope of practice. I'm happy to say that in Ontario, for example, we're trying to recruit 10 more nurse practitioners to place them in remote northern communities in Ontario that will address that.

This is also about reinforcing the team, creating a cement for people to want to stay in the community in these health teams, because they will be better supported. In all nursing stations, whether in Ontario, Manitoba, or the other provinces, there are arrangements in place with physician services. While nurses there are isolated physically and in really small teams, they always have access to a physician or a nurse practitioner for consultation, helping with the scope of practice. We are trying to clarify these roles so that people are less afraid to come and work at Health Canada and will understand that they are not left alone in the field with such challenging and demanding work.

Robin, would you like to add a little bit on where we are with the recruitment strategy at this time?

● (1640)

Ms. Robin Buckland: Yes.

I want to start by underlining that scope of practice is a big issue in terms of recruitment and retention. It is really important that we have a safe practice environment for our nurses to work in. As you indicated, nurses will not want to come and work for us if they think they're going to lose their licence, but as Sony indicated, in the vast majority of situations that nurses find themselves in, they are working within their scope of practice. We do have these other supports where they're able to call a doctor and get that order so that what they've done is not outside their scope. Having that safe practice environment is really important in terms of recruitment and retention.

We're increasing the visibility of this as a place to work. Despite what the report says, there are nurses who are excited about the idea of coming and working in first nations communities. It provides an opportunity to do stuff that they wouldn't necessarily see in downtown Toronto. It provides them with an opportunity to work in another environment, learn another culture. There are some really exciting things about working in first nations communities.

In addition to our mandatory training, we're also working, in terms of recruitment, on a development program that's helping in a couple of areas. Number one is training the nurses in charge. You need to have that leadership if you're going to have a good practice environment for nurses in which the processes are followed and everything runs smoothly.

That's one part of the development program. The other part of the development program is bringing in those new grads and making sure, as Sony indicated, it's the right kind of person we're recruiting and then training them up, making sure they have what it takes to work in this kind of environment. It does take a special person.

As well, there's student outreach, connecting with new grads, going to universities and encouraging them to apply. Working at optimizing our staffing mix is another part of our recruitment strategy, making sure we have doctors, nurses, nurse practitioners, and paramedics so that we don't run into the scope of practice issues.

The Chair: Do you have a really short follow-up? I'll allow it if it's really short.

Mr. Ted Falk: Yes.

I have some good news for you. Last week in Manitoba, 60 new oral health professionals graduated from the university: 35 dentists and 25 dental hygienists. The majority of them come from the province of Manitoba. They were born and raised there. There's an opportunity for you there.

Can you speak about your new oral health initiative that's happening among the first nations people?

Mr. Sony Perron: We have an oral health initiative that focuses on zero to seven-year-olds, mainly focusing on prevention to avoid decay, dealing with early problems, putting sealant on teeth to prevent further problems in the future, and changing behaviour.

We rely heavily on dental hygienists to practise in the community. We are bringing them for visits in the communities. I was in northern Ontario last week, or two weeks ago, and there was a dental hygienist there with kids in the clinic doing treatments.

This is a very aggressive strategy that has been in place for a number of years. We are bringing the health and dental professionals into the communities. I'm really pleased to hear that there are more graduates that can practise in the community.

The Chair: Mr. Casey.

Mr. Sean Casey: Mr. Perron, Mr. Allen took quite a rip at you and your department, and didn't give you a chance to respond. He told you in no uncertain terms what he thinks is the reason that you have a problem with turnover and retention. This is your chance to respond.

Do you agree with his critique, or is there some other reason that you can put your finger on that retention is such a challenge for you?

Mr. Sony Perron: I agree with some of his points, obviously, that work in the communities is challenging. It's not an easy task. The isolation factor, as I mentioned before, with its small teams and lack of connection, is a challenge.

The infrastructure is a challenge as well, because it is really far to go there and to have problems fixed. I think the Auditor General's audit pointed out the fact that some of the repairs were needed but not done on time.

As for the example of the Deer Lake residence that you mentioned, this was fortunately not the nurses' residence. It was one of the residences, but it's not the one used by the nurses. There were other residences for them. Having good residences for the nurses is an important factor for retention, and we have invested in the last few years in the maintenance and construction of residences.

Those factors are all in there, but the problems and the issues appeared to be a bit different in the different locations. I would say that what has made a huge difference over time is the ability to create a team that is well integrated in the community.

One of the recommendations is about the integration of clinical care into the health planning of the community. We have in many communities where Health Canada delivers the clinical care services a situation where we deliver services and the community runs everything else in terms of health programs. There is a need to have really good integration, because the nurses are essential to the delivery of some of the community health programs, and the community health worker can also be a great support to the nurses to deliver what they are doing and deal with what they see in their day-to-day consultations with clients.

This element of integration and making sure that the nurses' work fits well with the community health plan is an important element going forward that we have tried to invest in, and we have to do it again. There is a divide there in terms of what we are doing and what the community is doing, but there is attention being put on that.

I think improving the infrastructure is also on the electronic side, electronic medical records and telehealth. We have made a lot of progress in various provinces and regions to deploy telehealth in the communities so that a patient can consult with a nurse or a physician over telehealth, or they can access mental health workers through telehealth. This is an important element of our strategy to improve the quality of the service and the connection between the nursing team, the community, and health professionals elsewhere.

Implementing electronic medical records is essential. I was talking to a physician who practises in one of the nursing stations. What they want is, when they visit for a week or so in the nursing station working with nurses, the ability to continue their practice on electronic medical records that is part of the provincial system. They will be able to advance their work and make sure that the client's next step in terms of treatment will be in the system that they know when they practise in the south.

We have to invest more and we are into the enabling infrastructure, not only the physical infrastructure but also the IT infrastructure. This is one place where the nurses have complained about connectivity for years. In northern Ontario we have five communities where the high-speed large bandwidth is not yet available. We are getting there working with partners so that these communities will be well connected going forward.

It's building this infrastructure that allows a small team into an isolated community to be connected with the rest of the health system, to transfer files, do referrals, and receive results of exams and tests electronically. This has been more and more visible in the community in the last five to ten years. We still have some issues to deal with to build that in some of the remote northern communities in Ontario and Manitoba, but we are getting there. By building the enabling infrastructure I think we'll also have a better chance to retain nurses. That can't compare because sometimes they work part-time for us and part-time elsewhere, and they say they're missing some things there that, if they had them, would work way better.

They do not dream about having road access. There won't be road access there in the near future, but they dream about having access to information that allows them to practise with their full capacity there.

Adding nurse practitioners on the team is also a way to reinforce the nursing team so that they don't feel that they are isolated, because they can get guidance from nurse practitioners in terms of doing some of these actions that otherwise they wouldn't be able to do or they wouldn't be able to do without breaching their scope of practice.

● (1645)

The Chair: Sorry, but there are two seconds left, enough time for me to say thank you.

Mr. Woodworth, you have the floor, sir.

Mr. Stephen Woodworth (Kitchener Centre, CPC): Thank you to the witnesses.

There are two areas I'd like to ask about. I'll at least start by directing my questions to you, Mr. Perron. You can pass them on if it's appropriate to do so. You've already touched on both of the things I'd like to ask you about, so I'm essentially just going to try to get a few more details.

One of them has to do with recruitment. I noticed in your opening remarks that there are at least four new tools, or initiatives, that have been mentioned. One is the nurse recruitment marketing plan. Another is the nursing development program. Third is the student outreach program. Fourth is the onboarding program.

I also know you have to look after about 91,000 people. I seem to recall seeing somewhere in the material that there may be something in the order of 400 locations, or at least many locations, many of them in remote areas. It's that remoteness I'd like to ask about, because I think that in itself creates a challenge for recruitment, apart from everything else we've heard here today. I can think of a number of different ways whereby one can try to attract people to remote areas, but I'd like to hear what, if anything, you're doing to try to make it easier to attract people to more remote, isolated areas.

● (1650)

Mr. Sony Perron: Thank you.

One of the things we have done for almost 15 years now is we have invested in health human resources not only to attract people from the south to working in first nation communities, but also to increase the number of aboriginal health workers. This has been an important investment for the branch. While most of them may not come to work in the first nations and Inuit health branch, in the end they may decide to go to work for the provinces or for the first nation communities themselves, which is great. Having more health workers who have an aboriginal background is one element of the strategy, because we do have employees who come from first nation communities working in first nation communities. We are really proud of that, because the cultural dimension of the health services is very important.

Something all of you are probably aware of is that we have a lot of people who, when they go to the south to visit a hospital or see a physician, are a bit nervous about that contact, because they are not used to it. We are trying to bring the cultural appropriateness of the service into the community, thinking that this will also create a more resilient and stable workforce there. It's very important to invest there.

In terms of better informing the nurses, if you have not done so, I invite all of you to go to the Health Canada website to see the video and information we have displayed there since February of this year in terms of what it is like to be a nurse in a first nation community. We do this to try to attract more workers to Health Canada, but we also use that to bring those people who prefer to work for first nation communities there. It's an aggressive marketing campaign to show what it is like to work there. There are also advantages for people who like to live closer to nature, work in small teams, and face challenges. There is value. We are also trying to amplify the positive side of this. There is not only the negative.

I think working in this environment might also bring a lot of satisfaction for the health worker. In fact, we see that when we meet with our staff who are in these locations, they are very dedicated, highly professional, and highly conscientious people, and they like their work. Some will go there for a while because.... The bad side of that—and we're trying to be very transparent with that—is that there is a lot of overtime. For people working in these communities, if there is someone who is sick at night and the nursing station is not open, they will go there and be on overtime. Sometimes there are really long shifts and it's really intense at times in the community. Some people are attracted to that. We are trying to profile this, as well.

Robin, I don't know if you want to add something about the onboarding or the training action we do to prepare nurses to go to work in the communities.

Ms. Robin Buckland: Yes, I think the onboarding is going to be quite important in making sure we are recruiting the right kind of person and preparing them for the type of nursing they're going to be facing. I think that's really quite important.

Mr. Stephen Woodworth: May I just ask about a few other issues?

I don't know what the pay and benefits structure allows. If you hire someone from the south, do you assist them at all by giving them some form of occasional leave to go back, and if so, transportation assistance? Do you provide a residence for all your nurses or give some kind of housing allowance? Can you tell me a little bit about those incentives, if you have them?

Mr. Sony Perron: There are housing arrangements in most communities. Health Canada has built with the first nations a nursing residence near the nursing station, and those are considered to be facilities we support. They are owned by first nations, but we invest in there and nurses have access to these residences. They will receive an isolated post allowance in addition to their pay. They will receive a retention bonus in addition to their pay to attract people and retain them in the north. They will be eligible for overtime and callback measures that are all planned in the collective agreement and are highly used in these kinds of settings. Robin was talking about a nursing station with two or three nurses. It means that team might be on very long shifts. We are trying to profile that.

Nurses going into a nursing station expect to do a certain level of overtime, because they will be posted there for a number of weeks and then will go out. We also have a lot of nurses that work part time and will want to do two months with us during the year. They go back to work elsewhere and they come back the year after for another two months or two weeks. We have a lot of flexible arrangements to allow every nurse that wants to practise in these communities to work with us.

● (1655)

Mr. Stephen Woodworth: I want to switch gears, if I have time.

The Chair: No, sorry. We are going to switch gears, but—

Mr. Stephen Woodworth: My second point will wait. Thank you.

The Chair: —it doesn't involve you, I'm afraid.

Thank you very much.

Monsieur Giguère.

[*Translation*]

Mr. Alain Giguère: Thank you, Mr. Chair.

Mr. Perron, on page 3 of your presentation, you indicate an 88% compliance rate for controlled substances. I did a bit of medical law during my internship and if the non-compliance rate was close to 1%, the Order of Pharmacists of Quebec would intervene. You say that the non-compliance rate is 24 times higher than what is accepted in a hospital. I wouldn't be pleased with that.

Can you explain to me how your service came to distribute such a high rate, 12%, of non-compliant medications? That is really huge. That is between 24 and 36 times higher than what is acceptable in a hospital in Montreal or Toronto.

Mr. Sony Perron: It's not a question of non-compliant medication being distributed, but of the number of Health Canada nurses who were working in remote nursing stations who have the training concerning controlled medications. It is possible to renew that training. I will ask Robin to confirm if that happens every year or every two years.

We hope that 100% of our nurses will update their training with us so that they will know how to distribute the available medication in nursing stations, which are not pharmacies. In these stations, medications and the use of medications are extremely controlled. There is a form for every medication used. We provide training to the nurses so that they know how to use the pharmacy counter appropriately in these nursing stations.

Mr. Alain Giguère: The overall compliance rate for your service is 46%. That kind of percentage won't get you a degree. Even 65% won't get you the kind of degree that you would want to boast about.

Mr. Sony Perron: That is not really a satisfactory result, and I think that we admitted that in our response. The Auditor General's report, which was based on a sample from Manitoba and Ontario, gave us an overall compliance grade of 1%, but that was a very small sample. After having reviewed our files and attempted to provide a certain level of training, we now have 46% of nurses in nursing stations who have completed the five points of training which are listed in the policy.

We want to reach 100%. We will always be in training mode in the sense that this training expires after a certain time and new nurses always join our service. The goal is to maximize the level of compliance for all training and to ensure that every year, nurses follow a training plan to maintain their level on the subject.

Mr. Alain Giguère: We've been talking about administering care, but in health care, there's also the aspect of prevention. I don't know if you if you read the documents from the Cree Board of Health and Social Services of James Bay concerning nutrition problems in Canada. Unfortunately, there are people who are dying because they don't have decent drinking water, because they don't have healthy food to eat, and because there is no follow-up for major psychological care. People are really dying. These people can't wait five years.

There needs to be a change in attitudes, because we can't function this way. You can't ask us to look elsewhere when people are dying.

Mr. Sony Perron: Nurses are an important part of the health services provided in remote communities. But they are not the only part of the services provided. We provide funding for a certain number of programs. You mentioned nutrition. We fund a prenatal nutrition program. We also fund nutrition education programs and the diabetes prevention program and the diabetes support program.

Nurses are not necessarily at the hub of the service points. Often, it is the community workers who are properly trained to provide these programs.

In addition to the services mentioned in the Auditor General's report, there are a whole series of programs that aim to prevent problems, to change behaviour and to educate people. This is done in communities and we ensure that there is always an important cultural component.

● (1700)

Mr. Alain Giguère: Excuse me, but there is a problem here. Everything you're saying is all well and good. But as concerns the problem and the solution, if you look at this situation from a statistical point of view, you can see that the situation is getting worse. It is not improving. This is a major problem. We are able to prove statistically that communities are in danger. What will it take for the situation to improve even a little bit? I'm not talking about stabilizing things, but improving things. We can't go backwards.

Mr. Sony Perron: I agree with you, we need to have a comprehensive approach based on determinants of health. We are working on providing health care services and we are working on prevention and promotion. We need to change people's lifestyles, encourage physical activity and support good nutrition. There are also a certain number of other factors that are not necessarily included in Health Canada's programs and on which I cannot comment. Obviously, these are social determinants of health.

[*English*]

The Chair: Mr. Perron, you may conclude.

Mr. Sony Perron: I may conclude?

[*Translation*]

I was going to add that we work to ensure that these aspects are linked to our work. We work on community planning with the communities so that we can develop new strategies. We talked about accommodation and water quality. We have to solve these problems because if we want better health results, we obviously can't only focus on health services. We need to tackle the determinants of health that fall outside the scope of the programs we are discussing today.

The Chair: Thank you.

[*English*]

Mr. Albas, you have the floor, sir.

Mr. Dan Albas: Thank you, Mr. Chair. I look forward to the testimony here.

I want to go back to something my colleague referred to earlier. It is interesting that he is talking about the importance of safe drinking water. I think we all understand that. We passed the Safe Drinking Water for First Nations Act, which actually allows a first nation to choose whether it wants to have a system that is equivalent to a provincial one, to follow provincial laws, or to follow federal ones. It can do that, but that member's party voted against all of those changes. Sometimes it's a little shocking to me.

Mr. Perron, Mr. Allen also raised some concerns around the specific example that was given of a septic field that basically made a facility unusable. You said earlier, sir, that many of these facilities are owned, operated, and maintained by individual first nations, and I think you said we have to work within the longer scope to make sure your priorities match their priorities. Is that correct, sir?

Mr. Sony Perron: And we have to support the process when there is a joint priority, to make it happen.

Mr. Dan Albas: It's interesting. The members opposite in the House say that we are being paternalistic all the time by putting forward acts on safe drinking water etc., yet when we actually say we need to work with individual first nations to plan these things out, they get all upset that we aren't suddenly marching in and fixing septic fields and stuff that are not even federal assets but are owned by the first nations community. I don't want to isolate one particular example, because these things do happen on reserve, and septic fields go bad in many other areas, at least in my province where they're used in rural areas.

I also know that in many rural areas in my province, when I speak to mayors, including the mayors of such places as Keremeos, Merritt, and Logan Lake, they are always working with their provincial members of the legislative assembly to try to deal with doctor shortages, and I'm sure the same goes for nursing shortages. I can appreciate, specifically when I hear that some provinces have offered large raises and are attracting professionals from right across the country, that it makes operating in isolated areas very difficult for the provincial system, as some of the examples Mr. Perron gave show.

Could I just ask a quick question? Are we also trying to recruit from first nations to take these positions? Obviously they would have cultural understanding. They would be serving their communities. They would be making very good money. Is that something that continues to happen with recruitment?

● (1705)

Ms. Robin Buckland: Absolutely. It's an important part of our strategy.

Mr. Dan Albas: Okay. I'm very happy to hear that.

Going back to codes and whatnot, the national building code is voluntary. Provinces then can adopt.... For example, British Columbia has its own building code, but a lot of people don't know that the City of Penticton in my riding has its own building code on top of that, which makes further revisions to the provincial building code.

Can we just explain how building codes work or don't work in the context of the Auditor General's report, Mr. Perron?

Mr. Sony Perron: I will ask Valerie to get on this one.

Ms. Valerie Gideon: Sure. There's an easy one.

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

Now, we have buildings that pre-date the national building code requirement, so those need to be upgraded over time. When we're building new nursing or nursing station facilities, we will now, of course, follow the code of the moment, so that these are updated over time. We have facilities that are 25 to 35 years old. Part of this is making sure that we're upgrading and renovating them in partnership with the community so that they can meet the standards.

Mr. Dan Albas: Auditor General, I've criticized some of your recommendations for sometimes being a little wishy-washy or a little too general. But in cases in which we have specific recommendations over a wide arch of issues—there is a spectrum of issues raised in this report—I think it's important that your office give very specific feedback. I don't see why having a quantity of recommendations somehow qualifies this report as different. I think your office is trying to be as helpful and instructive as possible in unique areas in which you think Health Canada could make a difference.

Earlier, Auditor General, you stated that this is a very complex environment to work in, and so I would see you as making these 11 recommendations with that in mind. Is that true?

Mr. Michael Ferguson: As I said earlier, the types of things we found here lent themselves to specific recommendations on specific issues. We would identify an issue, whether it be training, dealing with the scope of practice issue, or the building code issue. Those issues lent themselves to very specific and very concrete recommendations for which it should be easy to determine whether the department is able to put in place some measures to deal with those recommendations.

That was certainly an aspect explaining why there ended up being 11 recommendations in this audit.

The Chair: Very good. Thank you.

That concludes our usual rotation and therefore concludes our hearing.

Let me pose one quick non-partisan question, in light of the fact that this is our last public hearing before the election of a new Parliament.

Tomorrow we will have the Truth and Reconciliation Commission report. Mr. Auditor General, I've been on this committee 11 years now consecutively, and this one file, involving services for remote communities, first nations people and Inuit has been a colossal failure across the board.

This is not partisan. I've been here under different governments, minority and majority. Your predecessor, the wonderful Sheila Fraser, as one of her last comments as she left office, raised this issue and talked about it as a remaining challenge for Canada, in her view.

I'm rather putting you on the spot, but I wonder whether you have any thoughts at all to give to the incoming Parliament, the 42nd Parliament. From that Parliament will be chosen the next government, and they're going to have to deal with these files.

Given the fact that we as a country—because I believe most of the people on these files are people of good will—have tried to overcome these challenges and give our sisters and brothers in the remote north the quality of life they deserve and that being a Canadian is supposed to guarantee, can you give any advice or thoughts to the next Parliament, as we adjourn here in this, the main accountability committee of Parliament, for both candidates and the next MPs to consider as they form government and move on this agenda?

What we don't want is another decade of failure. Do you have any thoughts or words of wisdom to give to that incoming Parliament on how we can have different outcomes from those we've been having?

● (1710)

Mr. Michael Ferguson: I think there are perhaps a couple of things that I would like to mention.

First of all, I was very happy with the fact that the committee decided to have a hearing on this report. Since I've been in this position, we've also issued the audit on policing services and the one on disaster assistance, and in neither case was there a hearing on those subjects. The fact that we've had the chance to talk about this, and that the department has had a chance to explain the issues they face, I think has been important.

I think, though, that the other thing is very much to get an understanding of what the departments that are involved have said—and there are many departments involved in providing services to first nations—and what they've committed to do in terms of providing services to first nations, so that we can get an understanding of whether they're living up to that.

Also, I think the other thing we've talked about today is that many of the types of issues we've talked about are issues that have been known for a while. They have come up in various other reports. For a future Parliament, I think perhaps it's important to go back and reflect on some of those studies and reviews that have been done on this file to determine where the departments are on them.

I think there's a lot that can be done to improve the situation. It's a very complex problem, obviously, with many departments involved and facing a lot of challenges, but I think one thing that has been a common thread for me in these audits is that it is possible, and it is within the power of the departments, to improve a lot of the services they're providing to these types of first nations.

The Chair: Very good. Thank you very much, sir. We appreciate that.

Colleagues, I have a reminder that we will meet again on Wednesday to begin report writing.

With that, and with thanks to our Auditor General, his staff, and the departmental staff, we now stand adjourned.

Thank you.