

# **CONTRACTING IN FIRST NATION CONTEXTS:**

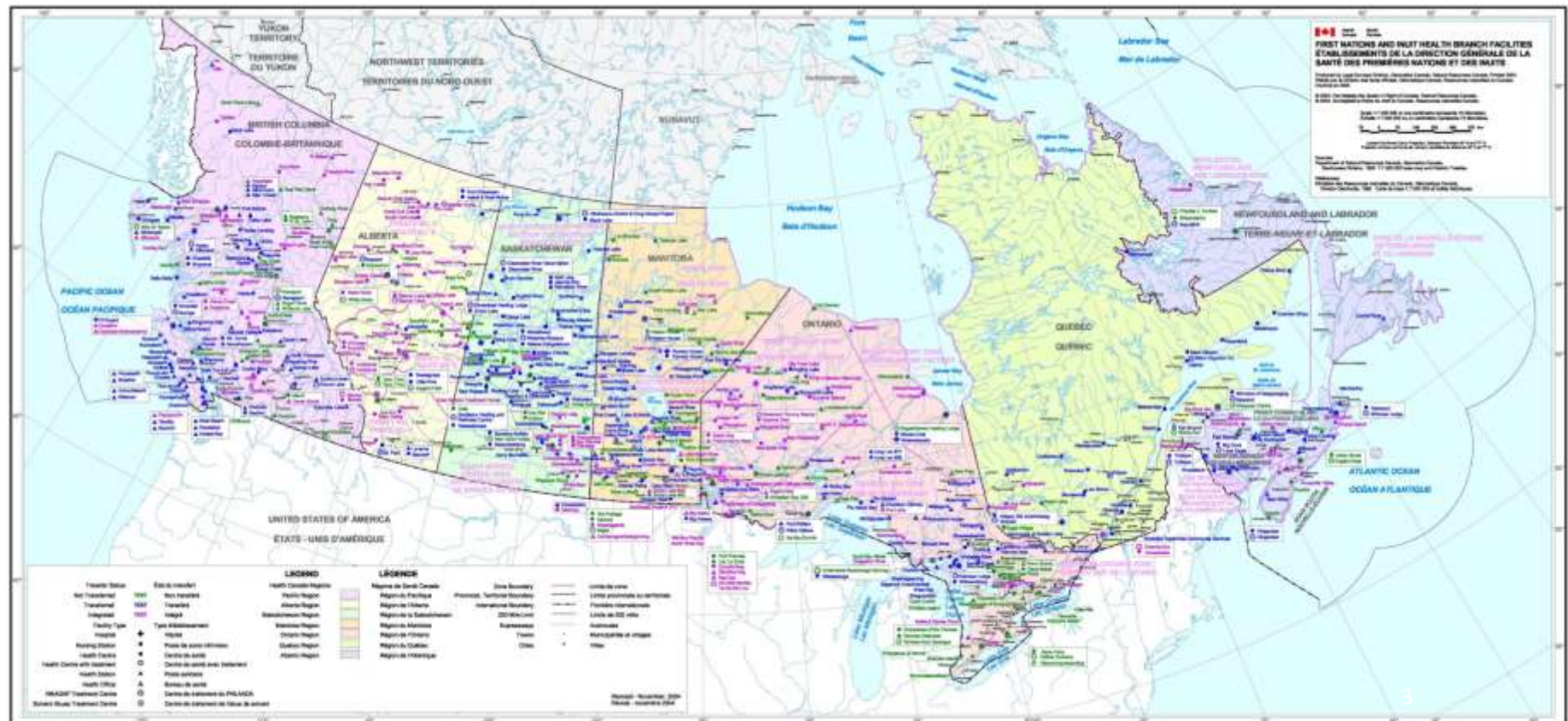
## **Pragmatic considerations**

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# Background

- Contracted out system from the federal government since 1974/1989
- 1974, single small classical contract (Community Health Rep and Addiction Workers)
- Since 1989, 3 options:
  - ✓ **A collection of classical contracts**
  - ✓ **Integrated: one relational contract for 3 to 5 years based on a community defined health services plan, with limited autonomy (60% of funding)**
  - ✓ **Transfer: one relational contract for 5 years, based on community defined health services plan, with full budgetary line flexibility (60% of funding)**

## Uptake: 89 percent as of 2008



# Accountability framework for the relational contract

- Community health plan (5 years) and 5 year evaluation
- Audited financial statements (yearly)
- Activity-based reporting (yearly)
- Reporting on essential services (yearly):
  - ✓ Communicable disease control and immunization
  - ✓ Environmental health (water quality monitoring)
  - ✓ Treatment services (where this exists)

# Accountability framework

- In 2003-04 alone, BC First Nation alone submitted 5,813 reports to fulfill their accountability requirements.
- “We are entrusted with the health of the forest, so we count trees. When we feel that we need more information about the health of the forest, we count trees more often.”
- “There is not point in trading dollars for data that no one can use” (Sheila Fraser, former Auditor General of Canada, Auditor General of Canada (2002). *Chapter 1, Streamlining First Nations Reporting to Federal Organizations* Ottawa: Auditor General of Canada.
- <http://www.oag-bvg.gc.ca/internet/docs/20021201ce.pdf>

# Risk management

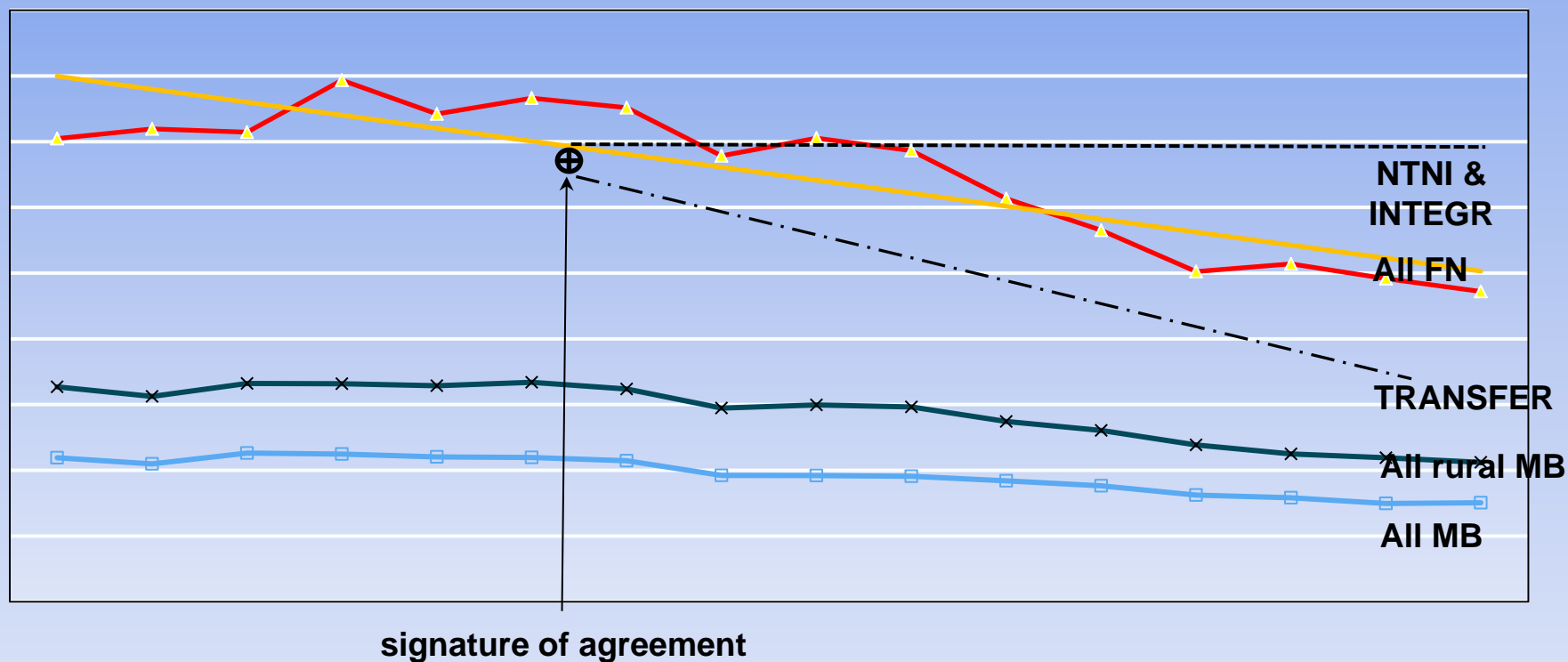
Dispute resolution mechanism in each agreement, mediation, court system.

Third party management kicks in when a First Nations deficit exceeds 25% of its yearly revenue:

1. Remedial plan must be developed. Approved and implemented
2. If this fails, a federally appointed administrator is named and takes over the administration of services until the budget is balanced again.

# Does it work?

## Impact of signing a transfer agreement on rates of avoidable hospitalization

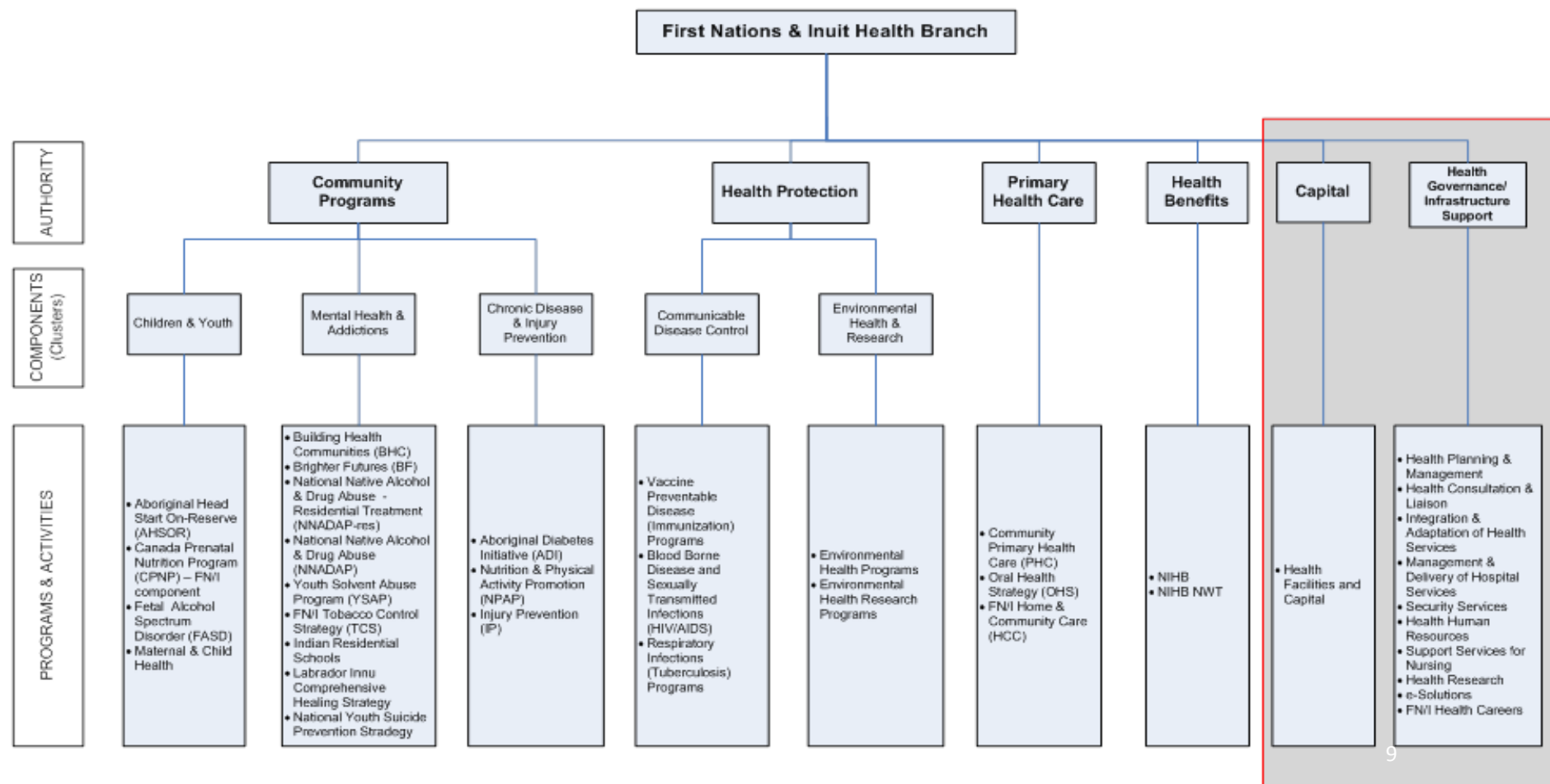


## Developments since 2008

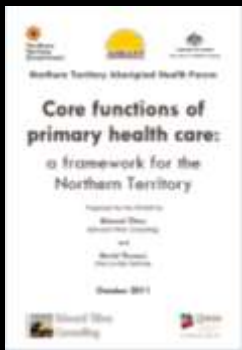
- Moving to 10 year agreements
- Expand the number of programs included under the relational contract
- Shifting from activity reporting to core indicators (no consensus yet on indicators)
- From 3 options to 7, a graduated scale where demonstrated capacity results in increased autonomy
- Still being rolled out



# FNIHB Program Authority Structure



# Accountability Framework for the ACCHS sector?



5 years Community health plan created by the ACCHS to meet local priorities and a framework for reporting to communities



## Yearly:

- Audited financial statement
- Minimal activity reporting
- Reporting to community



## 5 years:

- 5 year evaluation
- Community health and evaluation plans for the next 5 years

# FNIHB's Residual Role

- Was initially conceived as a “turning off the lights”
- Initially capacity building was in contract management, with the elimination of program expertise (nursing, medical, etc)
- Program expertise now rebuilt to some extent, to support:
  - ✓ the translation of new evidence into new programs,
  - ✓ seeking support from finance and Treasury Board for an appropriate financial allocation,
  - ✓ New programs are rolled out nationally as pilots funded under classical contracts, evaluated, and
  - ✓ then rolled out under the relational contract.

