Health Canada and the Public Health Agency of Canada
Santé Canada et l'Agence de la santé publique du Canada
Canada

Evaluation of The Territorial Health Investment Fund 2014-15 to 2016-17

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June 2018

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List of Acronyms

CHA	*Canada Health Act*
FNIHB	First Nations and Inuit Health Branch
NIHB	Non-Insured Health Benefits Program
TFF	Territorial Formula Financing
THIF	Territorial Health Investment Fund
THSSI	Territorial Health System Sustainability Initiative

Executive Summary

This evaluation covers the Territorial Health Investment Fund (THIF) for the period of 2014-15 to 2016-17, and is required in accordance with section 42.1 of the *Financial Administration Act*.

Evaluation Purpose and Scope

The purpose of the evaluation was to assess the relevance and performance of the THIF contribution agreement. The evaluation scope includes activities funded during the three-year period of 2014-15 to 2016-17, as well as activities that took place in 2017-18 due to funding carry-over.

While federal program evaluations typically cover a five-year period, this evaluation covered three years due to the time-limited nature of the contribution agreement. As a result, the evaluation did not review THIF's predecessor, the Territorial Health System Sustainability Initiative (THSSI), or activities under the renewed THIF grant, which began in 2017-18. However, the evaluation does refer to the design of the grant where appropriate.

The grant agreement included significant changes to the design and delivery of THIF, informed by the results of an external review of the program completed in 2017. In consideration of changes already introduced to the funding program, no recommendations were included in this evaluation. Instead, the evaluation sought to highlight results achieved to date, as well as the successes and challenges of administering THIF within the three territories.

Program Description

The Government of Canada introduced THIF in 2014 to replace THSSI, which aimed to build capacity by investing in territorial health care systems, supporting health promotion activities, and improving access to health care services. The objective of THIF was to support territorial governments' efforts to innovate and transform their health care systems, and ultimately ensure Northerners have access to the health care they need.[1] To accomplish this, THIF provided a contribution of $70 million dollars over three years to Canada's three territories to support the provision of quality health care.[2] THIF projects received funding through three proposal-based streams: (i) mental wellness, (ii) chronic disease management, and (iii) children's oral health. THIF also funded pan-territorial initiatives and supported the provision of medical travel through a declining subsidy over the three-year period.

The First Nations and Inuit Health Branch (FNIHB) at Health Canada administered the THIF contribution agreement during the period covered by the evaluation; however, following the FNIHB transition to Indigenous Services Canada, the Strategic Policy Branch at Health Canada took over responsibility for THIF in December 2017.

Conclusions – Relevance

There continues to be a need for funding to support territorial initiatives that address high health care costs and lower health outcomes. THIF is aligned with previous government priorities to increase services in key health areas and reduce reliance on medical travel and outside health care systems. The contribution agreement reflected a targeted, time-limited initiative aimed at addressing health gaps identified by federal and territorial governments. As federal priorities have shifted, the new THIF grant is expected to allow territorial governments greater flexibility in allocating resources to a wider variety of initiatives.

Although provinces and territories are responsible for administering health care for most residents within their jurisdiction, a federal subsidy for the increased medical costs associated with health care in the North is consistent with the Government of Canada's role under the *Canada Health Act* (CHA) principle of 'Accessibility.'

Conclusions – Performance

THIF has enabled some systems-level changes, which are expected to increase the ability of territorial governments to manage their health services within existing resources, though it is too early to determine impact. The evaluation found that the expected result of a reduction in medical travel could not realistically be achieved during THIF's three-year timeframe.

THIF funding has contributed to improved services related to key health gaps by facilitating professional development activities and the hiring of service coordinators, as well as introducing pilot projects targeting innovative technologies. It is too early to assess the extent to which THIF-funded activities have affected overall health outcomes in the territories.

The design of the THIF contribution agreement introduced additional reporting requirements that created additional administrative work for both Health Canada and territorial governments. The design of the new THIF grant is expected to improve efficiency by removing some reporting requirements to allow for more flexibility on the part of funding recipients. Remote service delivery technologies may help ensure that Northern health care providers have access to a similar level of diagnostic and screening options as are available elsewhere in Canada. Though it is not possible to eliminate the need for medical travel, further investments in innovative service delivery methods and technologies may enable territories to connect clients more efficiently to necessary care options.

Additionally, further investments in remote service delivery technologies and telehealth are expected to increase the availability of routine health care services in communities, such as screening, diagnostic, and treatment services. As screening and diagnosis options improve, there may be an increased demand for access to medical services both in and out of territory, though they may, in time, also reduce the need to travel to access some of these services.

1.0 Evaluation purpose

The purpose of the evaluation was to assess the relevance and performance of the THIF for the period of 2014-15 to 2016-17. This evaluation is required in accordance with section 42.1 of the *Financial Administration Act*.

2.0 Program Background

In 2005, the Federal Government introduced the THSSI to support sustainable management of health systems in Canada's three northern territories. THSSI's overall objectives were to build capacity by investing in territorial health care systems, support health promotion activities, and improve access to health care services. Grant funding was allocated for an operational secretariat, medical travel, and the *Territorial Health Access Fund*, which dedicated funding to support health care reform that would strengthen community-level services and promote the ability to provide services in-territory. The program was limited to five years in duration, but was extended by two years in 2010, and again in 2012.[3]

Budget 2014 announced the THIF as a replacement for THSSI. The objective of the THIF contribution agreement was to support territorial governments' efforts to innovate and transform their health care systems, and ultimately ensure Northerners have access to the health care they need.[4] To accomplish this, THIF provided a transfer of $70 million to Canada's three territories to support the provision of quality health care from 2014-15 to 2016-17.[5] THIF's terms and conditions were extended by one year with no additional funds until March 2018, in order for the territories to complete projects that were already underway.[6]

THIF provided proposal-based funding to Yukon, Nunavut and the Northwest Territories to address gaps in health care programming for their residents in three targeted areas:

- chronic disease;
- children's oral health; and
- mental wellness.

During the period covered by this evaluation, Health Canada provided THIF funding through three streams:

- The *Territorial Stream*, which allocated $4.33 million per territory each fiscal year to fund projects to strengthen health services in-territory for the identified target areas;
- The *Pan-Territorial Stream,* which provided $2 million per fiscal year for collaboratively developed projects addressing health systems challenges with innovative solutions; and
- The *Medical Travel Stream*, which provided a subsidy to support medical transportation costs. The medical travel subsidy declined over the three-year period, from $12 million in 2014-15 to $5 million in 2016-17. This subsidy was designed to incentivize territories to reduce reliance on transportation and increase service capacity in-territory.[7]

While THIF was initially intended as a time-limited program, the Government of Canada proposed an additional $108 million investment over four years, beginning in 2017-18, to renew and expand THIF in the 2017 Budget, albeit this time as a grant.[8]

2.1 Program Alignment and Resources

THIF is aligned under Health Canada's Program Alignment Architecture under 1.1 'Canada Health System Policy' and the sub-program 1.1.1 'Health System Policy.' THIF supports the Department's overall strategic outcome: "a health system responsive to the needs of Canadians."[9] During the period covered by this evaluation, Health Canada's FNIHB managed the THIF contribution program. With FNIHB's transition to Indigenous Services Canada, the Strategic Policy Branch at Health Canada took over responsibility for the renewed THIF in December 2017.

THIF's financial data for the years 2014-15 through 2016-17 are presented below (Table 1). Overall, THIF had a budget of approximately $70 million over three years.

Table 1: Territorial Health Investment Fund Program Resources ($) [a]

	Planned			Actual			
Year	Grants & Contributions (G&Cs)	Operations and Maintenance (O&M)	Total	G&Cs	O&M	Total	Variance
2014-15	26,190,000	0	26,190,000	26,190,000	0	26,190,000	0
2015-16	23,000,000	0	23,000,000	22,990,300	0	22,990,300	9,700
2016-17	20,000,000	0	20,000,000	20,000,000	0	20,000,000	0
Total	**69,190,000**	0	**69,190,000**	**69,180,300**	**0**	**69,180,300**	**9,700**

a Data Source: Chief Financial Officer Branch.

3.0 Evaluation Description

3.1 Evaluation Scope, Approach and Design

The scope of the evaluation covered the period from April 2014 to September 2017. The evaluation reviewed activities conducted and projects delivered under the THIF initiative occurring throughout this period. Activities or projects delivered under the predecessor THSSI were out of scope for this evaluation.[10]

The evaluation assessed the relevance, performance, efficiency, and economy of THIF's activities during the period included in its scope. The THIF contribution agreement ended in 2017-18 and was replaced with a grant agreement. The new grant agreement introduced significant changes in the design and delivery of THIF based on the recommendations of an external review. In consideration of these recent changes, no recommendations were included in this evaluation. Instead, the evaluation sought to highlight results achieved to date, as well as the successes and challenges of administering THIF within the three territories.

Evaluation questions were developed with consideration of the core issues identified under the Treasury Board of Canada's *Policy on Results* (2016).
[a] The evaluation team collected evidence using complementary research methods, including:

- **Document Review**: Evaluators reviewed a total of 54 internal documents. The FNIHB provided internal program documentation, which evaluators supplemented with publically available grey literature. Documents included THIF funding proposals, THIF recipient annual reports, federal budget plans, federal mandate letters, and Health Canada's performance information reporting, including Departmental Performance Reports (DPR) and Departmental Reports on Plans and Priorities (RPP). Where relevant, evaluators also consulted peer-reviewed publications to supplement information provided in internal documents.

- **Review of Financial Data**: Evaluators reviewed financial information provided by the Department's Chief Financial Officer Branch. Evaluators also considered activity-based financial information provided by funding recipients through THIF annual reports.

- **Key Informant Interviews**: Evaluators conducted a small number of key informant interviews with senior management responsible for delivering THIF-funded programming in Nunavut, Yukon, and the Northwest Territories. Key informants were selected based on their unique insight into the successes and challenges of administering THIF within the three territories.

By using multiple lines of evidence, evaluators were able to triangulate the findings to increase their reliability.

3.2 Limitations and Mitigation Strategies

Most evaluations face constraints that may have implications for the validity and reliability of their findings and conclusions. The following table outlines the limitations encountered during the implementation of the selected methods for this evaluation. Also noted are the mitigation strategies put in place to ensure that the evaluation findings can be used with confidence to guide program planning and decision making.

[a] A description of the evaluation questions and lines of evidence used to address them are shown in Appendix 1.

Table 2: Limitations and Mitigation Strategies

Limitation	Impact	Mitigation Strategy
Due to the timeframe associated with collecting and analysing health outcome data, recent statistics demonstrating changes in health outcomes in Canada's north were not available.	The evaluation is not able to make conclusions on changes in health outcomes associated with THIF-funded activities.	The evaluation assesses the relevance and performance of THIF based on intermediate-level outcomes, and refers to the most recent health data available, where relevant.
THIF annual reporting applied inconsistent and varied performance measurements between territories and across each year.	Limited quantitative performance data were available based on existing territorial activity and financial reports.	Evaluators triangulated information in annual reports with key informant feedback, and with data from literature, internal documents, and financial records.

4.0 Findings – Relevance

4.1 Continued Need for the Program

Finding: There continues to be a need for funding to support territorial initiatives that address high health care costs and lower health outcomes in Nunavut, the Yukon, and the Northwest Territories.

Similar to other circumpolar regions, there are substantial differences in health costs and health outcomes in the North compared to more southerly regions in Canada.[11] The unique demographic and geographic features of the territories, as well as limited health human resources in the North, contribute to these differences.

The demographic and geographic features of the territories differ greatly from the rest of Canada. The three northern territories have a broad geography with a relatively small population. In addition to low population density, many communities, particularly in Nunavut and the Northwest Territories, are rural and isolated. Many of these communities have limited, seasonal, or no road access to urban centres.[12] In addition, a high proportion of the total population in the three territories are Indigenous. In the Yukon, 23% of the total population is Indigenous, while in the Northwest Territories the proportion is 51%. In Nunavut, 85% of the population is Inuit. This is in contrast to Canada as a whole, where Indigenous people make up approximately 5% of the population, and Inuit less than 1%.[13]

Territorial health systems must also cope with lower access to primary care physicians and specialists. The doctor-to-patient ratio (Table 3) for both primary and specialist caregivers is markedly lower in the territories than the Canadian average. For example, in 2015 the average number of primary care physicians per 100,000 residents in Canada was 228, while in Nunavut there were 27 doctors per 100,000 residents. All three territories have a markedly lower specialists-to-residents ratio when compared to the rest of Canada.

Table 3: Primary Care Physicians and Specialist Physicians per 100,000, 2013-2015

	Primary Care Physician Ratio [a]			Specialist Physician Ratio [b]		
	2013	2014	2015	2013	2014	2015
Canada	220	224	228	108	110	113
Yukon	183	197	212	27	27	30
Northwest Territories	99	101	84	25	23	16
Nunavut	30	33	27	3	3	3

[a] Ratio expresses number of primary care physicians per 100,000 population, based on Canadian Medical Association (CMA) data retrieved from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/12-Phys_per_pop.pdf.
[b] Ratio expresses number of specialist providers per 100,000 population, based on CMA data retrieved from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/15-Spec_per_pop.pdf.

It is important to note that northern health care services use a nurse-based system of primary care delivery outside of regional centres, whereby there are networks of health centres staffed with nurses and community health representatives, and supported by visiting physicians.[14] Therefore, it is reasonable to conclude that the use of physician services is lower under this model when compared to the Canadian average. Considering this, the gap in access to care is somewhat narrower, though it is still markedly lower than elsewhere in Canada. For example, the proportion of Inuit people in Nunavut who had contact with a family doctor or nurse in the previous year was 65%, as opposed to 44% who had contact with a doctor alone. This is well below the average for non-Indigenous people in that territory (76%) and the national average of 80%.[15]

Anecdotal evidence from key informants suggests that territorial governments also experience high job vacancy and turnover rates within health human resources, which presents additional challenges for health care delivery and health promotion over time. Because of these factors, territorial health care systems tend to make use of medical travel, both within the territory to an urban centre, and outside the territory to a neighbouring province, to connect clients with appropriate care options.

THIF addresses a continued need to accommodate elevated health costs in the territories while addressing persistent gaps in health outcomes for residents. Health care costs in territories are significantly higher than the Canadian average. In 2014, the per-capita cost for health care in the Yukon was $10,000 (1.7 times the average), in the Northwest Territories it was $13,000 (or 2.1 times the average), and in Nunavut it was $14,000 (2.3 times the average).[16] Medical travel can be a significant cost driver for territorial health care costs, particularly in Nunavut and the Northwest Territories. In Nunavut, medical travel accounted

for up to $1,500 of per-capita health care costs, an amount that is expected to continue to rise in the future.[17]

While territories experience the reality of elevated health care costs, they must also manage persistent health gaps and challenges in achieving comparable health outcomes with other Canadian provinces. Residents in the territories generally experience lower health outcomes related to mental wellness, chronic diseases, and oral health among children.

a) Mental Illness

Mental illness has remained an area of acute need in Canada's North, particularly among Indigenous peoples. While the rates of diagnosed mood disorders in the territories are similar to those observed elsewhere in Canada, the rates of suicide and hospitalization for intentional self-harm are significantly higher. [b] Inuit youth in particular are at risk: suicide rates for Indigenous youth in the North are nearly six times higher than elsewhere in Canada. Among Inuit youth aged 10 to 19 living in Inuit Nunangat,[c] rates of acute care hospitalization for intentional self-harm are 101 per 100,000 people and the proportion of Inuit youth who die by suicide is nearly 11 times the national average. In Nunavut, suicide is the cause of approximately 64 of every 100,000 deaths. If Nunavut were its own country, it would have the highest suicide rate in the world.[18] Taken together, these statistics indicate a need for improved access to prevention and treatment options to promote mental wellness among residents in the territories, and to address underlying socio-economic disparities contributing to these outcomes.

b) Chronic Disease

As with other areas in Canada, chronic illness is a significant cause of death in the territories. However, mortality rates associated with chronic disease, including diabetes, heart disease, and cancer, tend to be higher in the territories when compared to the rest of Canada. In Nunavut, cancer mortality was two times higher[d] than the national rate.[19] Chronic disease accounts for 7 out of 10 deaths in the Northwest Territories.[20] In the Yukon, rates of hospitalization for chronic illness tend to be higher than the rest of Canada. In 2014, the rate of hospitalizations associated with chronic illness was 414 per 100,000 hospitalizations, compared to the Canadian average of 283.[21] These statistics indicate a continued need for improved screening and management options for chronic illnesses in the territories.

[b] In 2014, the proportion of residents reporting a mood disorder was 7.7% in the Northwest Territories and 8.7% in Yukon, compared to 7.8% across Canada. Rates for Nunavut were not available. Data from: https://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/health114b-eng.htm.

[c] Inuit Nunangat refers to the traditional Inuit territory in the circumpolar north. This includes Nunavut, as well as some northern areas of the Northwest Territories, Quebec and Labrador.

[d] This number represents the average from 2009 to 2011, which is the most recent available data.

c) Children's Oral Health

Children's oral health remains an important area of concern in the territories, particularly in Nunavut. Between 2010-11 and 2013-14, approximately 111 children per 1,000 under the age of four in Nunavut underwent surgery to treat cavities each year, followed by 47.6 per year in the Northwest Territories and 24.3 in the Yukon.[22] For Nunavut, this rate is nearly 10 times the national average of approximately 12.1 per 1,000 each year. Inuit children had significantly elevated rates of dental caries.[e] According to the most recent data available, 85% of Inuit preschoolers were affected by dental caries, and for many these went untreated into adolescence.[23] Inuit are also less likely than other Canadians to have accessed dental care.[24]

In Nunavut, oral health outcomes are influenced by the fact that many residents do not have regular access to dental care, as well as poor nutrition and limited prevention activities for many communities. [25] When THIF was introduced in 2014, there were over 600 children on a waiting list to undergo dental surgery in Nunavut and in most of these cases, medical travel was required.[26]

THIF responds to these challenges by providing dedicated funding to implement strategic improvements to territorial health care systems designed to improve access to services. Furthermore, the *Medical Travel Stream* addresses a continued need to connect residents to necessary care, both inside and outside of their territory.

4.2 Alignment with Government Priorities and Strategic Outcomes

The THIF contribution agreement was aligned with previous government priorities to increase services in key health areas and reduce reliance on medical travel and outside health care systems. As federal priorities have shifted, the THIF grant will allow for more flexibility.

The THIF contribution program was well aligned with Government of Canada priorities and strategic outcomes when initiated in 2014. The Government of Canada announced funding to support activities in the priority area "Asserting Canada's Sovereignty by Investing in the North" in Budget 2014. The Budget proposed a contribution-based program, which would provide $70 million over three years in a targeted and time-limited fund to increase health services in three priority areas for Nunavut, the Northwest Territories, and the Yukon. THIF was designed to deliver on this priority.

[e] Dental caries is the medical term to describe tooth decay, which leads to cavities in teeth. The terms 'caries' and 'cavities' are often used interchangeably, however the decay can continue if cavities are not treated, and may cause further complications for the inner layers of the tooth.

Over time, THIF has remained in alignment with the goals and priorities of the Government of Canada. Health Canada's 2017 *Report on Plans and Priorities* includes THIF as a component of the sub-program 1.1. 'Canadian Health Systems Policy.' Through grants and contribution agreements with key health partners, the Canadian Health Systems Policy sub-program aims to support improvements in health care systems to help Canadians maintain and improve their health.[27] By providing financial support and guidance to partners, this program contributes to Health Canada's strategic outcome of achieving "a health system responsive to the needs of Canadians."[28] Furthermore, a 2017 independent review of THIF's performance found that it continues to be well aligned with the priorities of the territorial governments, and has enabled them to dedicate scarce resources to system-wide changes which would otherwise by overshadowed by other urgent priorities.[29]

According to internal documentation, THIF was created to support territorial governments' ability to deliver necessary health care services within existing resources. A diminishing *Medical Travel Stream* between 2014 and 2017 also signalled the Government of Canada's intent to reduce territorial reliance on medical travel.

As of 2017-18, funding for THIF went from a contribution agreement to a grant. To reflect changing federal priorities towards innovation and lessons learned from the first three years of THIF, the grant is expected to deliver funding through an *Innovation Stream* and provide stable medical travel funding over a four-year period through a *Medical Travel Stream.* Furthermore, while the grant will continue to allocate project-based funding, it will no longer specify specific health areas where funding must be spent. This model is expected to allow territorial governments more flexibility to respond to issues related to social determinants of health, complex health care delivery, and unique local needs. The pan-territorial funding stream was also eliminated.

4.3 Alignment with Federal Roles and Responsibilities

Although provinces and territories are responsible for administering health care for most residents within their jurisdiction, a federal subsidy for increased medical costs associated with health care in the North is consistent with the Government of Canada's role under the CHA principle of 'Accessibility.'

The Government of Canada does not provide direct service delivery of health care in the provinces and territories; however, it does have a mandate to support access to care under the CHA. Additionally, Health Canada in particular has a mandate to ensure availability of, and access to, health services for Indigenous communities.[30]

Under the CHA, provinces and territories are responsible for the administration and delivery of health services within their jurisdiction. The Government of Canada provides support for these activities through fiscal transfers and programming:

- The **Canada Health Transfer** (CHT), which provides long-term predictable funding for health care in support of the principles in the CHA. The value of the CHT for each province is calculated on an equal-per-capita basis;[31]
- The **Territorial Formula Financing** (TFF) transfer, which provides an additional unconditional transfer for the purpose of financing essential public services in Canada's three territories, based on a recognition of the elevated costs associated with service provision in the North. The TFF for each territory is calculated based on the difference between the individual territory's financial capacity to generate revenue, and a proxy for its expenses;[32] and
- The **Non-Insured Health Benefits** (NIHB) Program is a national program that provides insurance coverage for registered First Nations and recognized Inuit for medically necessary services that are not covered by other plans and programs. This includes financial support for medical transportation to access medically necessary services.[33]

The CHA further states that health care delivery within the provinces and territories must meet five principles, including "Accessibility." Accessibility is interpreted as ensuring all residents have access to medically necessary services. Provinces and territories must provide these services based on medical need, not ability to pay.[34]

While the CHT and TFF transfers provide funding to ensure that territories are able to provide medical care to their residents, the transfers do not include specific funding to address known health gaps, nor do they provide dedicated funding for the purposes of medical travel. Though the NIHB program does provide specific funding for medical travel to eligible beneficiaries, it is provided on a case-by-case basis and is not available to all residents of the territories.[35] Key informants described the THIF program as highly complementary to existing transfer programs between the federal and territorial governments.

These respondents noted that THIF allows them to 'level the playing field' to access care regardless of which governmental body provides funding for a resident's health care. Considering these factors, the THIF complements existing funding agreements designed to achieve similar goals and helps Canada meet the principle of 'Accessibility' for all Canadians living in the territories.

5.0 Achievement of Expected Results

5.1 Improved Capacity to Deliver Health Care In-Territory

THIF enabled some strategic and systems-level changes, which are expected to increase the ability of territorial governments to manage their health services within existing resources, although it is too early to determine impact. The evaluation found that the expected result of a reduction in medical travel was not realistic in the short term.

A key objective of THIF during this period was to enable territorial governments to introduce strategic changes which would improve their capacity to provide health care services within existing resources. Territorial proposals for THIF funding identified a range of activities to

meet that objective. Key informants stated that THIF funding was incredibly valuable, allowing the governments to invest in strategic or systems-level changes without diverting resources away from other key areas, such as service delivery.

For example, the Yukon used THIF funding to operate working groups in support of the *Forward Together* mental wellness strategy, as well as working groups to facilitate access to spirometry, wound care, and home health monitoring.[36] In Nunavut, residential treatment coordinators were hired to help connect residents to out-of-territory mental health and addiction treatment services, and the territorial government established a client database to enhance discharge planning and monitoring of clients. In the Northwest Territories, THIF funding was used to design and implement changes to the *Health and Social Services Administration Act*, wherein the territorial government consolidated six separate health care administration systems into one. This is expected to reduce fragmentation in health care services across the territory.[37]

That being said, feedback from key informants and information contained in territorial annual activity reports indicate that there was slow progress in implementing some of the THIF proposed activities due to three main factors. Firstly, territories faced difficulties recruiting and retaining qualified human resources to implement programs. This was particularly challenging in Nunavut, where there is typically a vacancy rate of approximately 30% in public administration and high reliance on temporary contracts with employees from the south or other countries. Nunavut also faces challenges recruiting and retaining oral health service providers, which contributes to gaps in access to services. [38] In Canada, there is an average of 60 licensed dentists per 100,000 residents, while Nunavut has 34 per 100,000.[f]

Secondly, funding for year one of THIF (2014-15) was not released until January 2015, as the territories and the Government of Canada signed the contributions late in the fiscal year. This left very little time for territories to begin planned activities outlined in THIF proposals. As a result, funding was carried over to the following fiscal year. This resulted in funding carry-overs over the following years.

Finally, some planned activities were delayed or cancelled due to changing priorities for territorial governments and their key partners. Territorial administrators responded by reallocating funding to activities that generally aligned with the three key health gap areas.

While the territories faced delays in implementing some of the proposed activities in key strategic areas, they were able to spend the total allocated funds for medical travel in the three fiscal years without needing to carry over funds. As shown below (Table 4), expenditures on medical travel in each territory continued to increase each year, while the value of funding provided through THIF to subsidise medical travel expenses declined on schedule. The anticipated goal of reducing expenditures on medical travel in the territories was not achieved and is not expected to be attained in the near future.

[f] Calculation based on the most recent Canadian Dental Association data available (2013), and population estimates from Statistics Canada. For more information, see: https://www.cda-adc.ca/en/services/fact_sheets/dentistincanada.asp.

Table 4: Territorial Expenditures on Medical Travel and Contribution to Medical Travel Funded by THIF, 2014-15 to 2016-17 ($)[a]

Territory	Year 1 2014-15			Year 2 2015-16			Year 3 2016-17		
	Total [b]	THIF [c]	%Total [d]	Total	THIF	% Total	Total	THIF	% Total
NU	77.8 M	8.2M	10.5 %	86.1M	5.5 M	6.3 %	91.9 M	3.4 M	3.7 %
NWT	32.5 M	2.6 M	8 %	34 M	1.7 M	5 %	50 M	1 M	2 %
YK	12.2 M	1.2 M	9.8 %	12.5 M	0.8 M	6.4 %	12.4 M	0.6 M	5 %

[a] Expenditure data retrieved from territorial annual activity and financial reports, THIF *Medical Travel Stream*.
[b] "Total" refers to the total value of territorial expenditure on medical travel.
[C] "THIF" refers to the value of funding provided to the territory through the THIF *Medical Travel Stream*.
[d] "% Total" refers to the proportion of a territory's total expenditure on medical travel covered by THIF *Medical Travel Stream*.

The continued rise in medical travel costs over the short term is attributed to two key factors. First, the improved outreach to underserved communities in the North can be expected to result in an increased need for medical travel, as these clients are connected to care options earlier. Second, the population base in the territories is too small to support access to a full range of health care services, particularly outside of regional centres in the territories. Limited infrastructure is a particular challenge for Nunavut, whose medical travel expenditures increased by nearly 10% from year one to three of THIF. According to Nunavut's annual activity reports, "Nunavut's population, vast territory, lack of access by road and rail, limited health infrastructure, and lack of access to specialist medical services contribute to the growing need for medical travel benefits. At current service levels, the medical travel costs are expected to continue increasing."[39] To access equitable care, some level of medical travel will be required until remote service delivery options become more easily available. [40]

It is important to note that if THIF was to be discontinued, in particular the medical transportation subsidy component, there is a possibility that this would result in increased NIHB medical travel costs for First Nations and Inuit populations in the Northwest Territories and Nunavut. In Nunavut and the Northwest Territories, territorial governments pay most of the air transportation costs for all residents, including Indigenous persons, and charge individuals requiring air transportation a $250 co-pay charge, regardless of the total cost associated with the individuals' travel. For eligible Indigenous residents, this co-pay charge is reimbursed by NIHB. Without dedicated medical travel funding from the Government of Canada, these two territories could treat First Nations and Inuit populations as separate in regards to medical travel cost, and request that Canada pay the total cost of airfare associated with medical travel, rather than the co-pay amount covered by the NIHB program. In this case, program estimates indicate that the NIHB costs for medical travel in the Northwest Territories could increase from $7.5M to $16.4M per year, and from $27.4M to $83.8M in Nunavut.[41]

5.3 Improved Ability to Address Key Health Gaps in the Territories

THIF funding has contributed to improved services related to key health gaps by facilitating professional development activities and the hiring of service coordinators, as well as introducing pilot projects using innovative technologies. It is too early to assess the extent to which THIF-funded activities have affected health outcomes in the territories.

Another key goal of THIF was to improve health outcomes for territorial residents in the areas of mental wellness, chronic disease management, and children's oral health. Each territory identified activities aligned with these key health gaps in their proposals for THIF funding. Territories also implemented pan-territorial initiatives using innovative approaches to address mental wellness collaboratively. Due to the delays in funding release for the first year of the THIF contribution, most projects remained in planning, engagement, and implementation phases. For this reason, there is limited evidence to assess each territory's progress against stated objectives.

Annual reports demonstrate that all territories used a portion of THIF funding on professional development to improve the skills of existing front-line service providers and supporting staff. Training was provided on a range of topics related to caring for clients with chronic diseases and mental illnesses, as well as the delivery of culturally appropriate care. For example, Nunavut delivered two four-week training sessions on non-violent crisis intervention to front-line mental health staff in 2015-16, and provided 12 employees with one-day training on the same topic in 2016-17. Annual reports indicate that, due to high staff turnover, ongoing training in non-violent crisis intervention is important to maintain skills for staff.[42] Similarly, to support their Children's Oral Health initiative, the Northwest Territories Department of Health and Social Services used THIF funding to develop draft protocols and training materials to support the provision of fluoride therapy, and tested these protocols with community health representatives to ensure they were effective.[43] During the three-year period, the Yukon offered a total of 48 training sessions with over 850 participants, more than 100 of which participated in communities outside of Whitehorse. Training covered a variety of issues related to mental wellness, including clinical skills for front-line providers.[44]

THIF funding was also used for activities aimed at improving access to existing services. For example, Nunavut hired Community Oral Health coordinators serving 17 communities to provide preventative oral health services, such as fluoride varnishes. [45] These coordinators are also able to provide oral health promotion services in Inuktitut. By providing preventative treatments, the Government of Nunavut expects to reduce the need over time for oral surgery under general anesthesia for children living in the territory.

Under the *Pan-Territorial Stream*, territories launched several pilot projects using innovative technologies such as telehealth and e-health platforms to improve access to mental wellness services. Pilots included app-based interventions such as "SPARX" and "Breathing Room" aimed at providing Cognitive Behavioural Therapy (CBT) strategies to cope with mental illness among youth in the North, and the launch of telehealth services in Yukon and Nunavut. Nunavut and the Northwest Territories both have helplines providing access to counsellors that are open 24 hours a day, 7 days a week, and supported through THIF pan-territorial funding.[46,47]

As territorial governments continue to work to address structural issues through innovative approaches to health care delivery, annual reports indicate some early successes resulting from short-term project-based funding. For example, when Nunavut initiated the Children's Oral Health project in 2014-15, there were nearly 600 children on a waiting list to receive oral surgery under general anesthesia. After one year in 2015-16, that number was reduced to 400. Anecdotal evidence from key informants suggests that the number fell further in 2016-17. These early results indicate that THIF funding has supported some improvements in access to services for residents.

5.4 Efficiency and Economy

The design of the new THIF grant is expected to improve efficiency by removing some reporting requirements, allowing for more flexibility on the part of funding recipients. Remote service delivery technologies may help ensure that Northern health care providers have access to a similar level of diagnostic and screening options as are available elsewhere in Canada. Though it is not possible to eliminate the need for medical travel, further investments in innovative service delivery methods and technologies may enable territories to connect clients more efficiently to necessary care options.

The THIF contribution agreement introduced several elements of design intended to improve program efficiency relative to the previous THSSI grant program. The THIF contribution provided the Government of Canada with a greater ability to influence project design and outcomes and introduced several methods to limit administrative costs associated with projects. For example, THIF contained limits on administrative funding for recipients, including a 10% cap on project travel and a 10% cap on evaluation costs. The administrative caps were intended to ensure a significant proportion of the contribution would flow directly to projects included in the proposals.[48] THIF also established a minimum budget of $1 million for project proposals. Under the THSSI grant, there was no budget minimum for proposals, and as a result, a higher value was attributed to administrative costs among multiple smaller projects. While these program design elements were expected to improve efficiency, a review of performance over the three-year period revealed opportunities for improvement. Many of these have already been incorporated into the new THIF grant.

Partners in the territories noted that annual reporting requirements for the contribution agreement introduced an additional reporting burden that outweighed any potential gains in transparency or accountability. Feedback from key informants indicated that territorial health and social service administrations had to reallocate human resources away from service delivery to complete annual activity reports. This sentiment was echoed by Health Canada staff, who noted that reviewing and approving reports also resulted in a reporting burden. For this reason, THIF partners were supportive of the transition back to a grant model to deliver THIF funding, and described this change as a step in the right direction.

Findings from the 2017 independent performance review of THIF suggest that territorial partners viewed the funding cap on project travel as “unrealistic” considering the Northern context.[49] A review of territorial activity reports indicate that Nunavut in particular faced challenges staying within the 10% cap on project travel, spending over budget on project travel for the Mental Wellness stream by nearly $150,000 in 2016-17, approximately 18% of the annual territorial THIF budget.[50] The new THIF grant program has removed the administrative caps, including those for program travel.

Key informants also indicated that the short-term funding model contributes to challenges in attracting and retaining human resources. When positions are linked to short-term funding agreements, the organizations must staff using temporary contracts with no guarantee of longer-term employment for the candidate. This reality makes it difficult to attract qualified applicants and links to ongoing challenges of high turnover and reliance on a transient workforce. Key informants were generally supportive of the transition to a grant program, but indicated that longer-term funding would be beneficial for enabling partners to undertake longer-term planning, including recruitment and retention of qualified staff.

Finally, key informants in all three territories indicated that medical travel continues to be a necessary expense for territorial governments, but noted opportunities to use medical travel more efficiently in the future. In particular, there were suggestions related to the use of innovative health technologies, including remote diagnostic tools and telehealth triaging services. Remote service delivery technologies may help ensure that Northern health care providers have access to a similar level of diagnostic and screening options as are available elsewhere in Canada. These services can help health care providers make decisions about care options for clients, including potentially avoiding more costly emergency medical travel (such as medivacs) in favour of earlier treatment options.

Without adequate access to triaging to determine the severity and level of risk associated with a patient, community health care providers must err on the side of caution when unsure if they can treat an illness locally. Innovative health technology may also increase the ability to provide more routine health services in community, which could also result in an increased demand for medical travel to access treatment for conditions that would otherwise have gone undetected. As a result, it is not reasonable to expect the overall need for medical travel to decline in the short-term.

6.0 Conclusions

6.1 Relevance

Similar to other circumpolar regions, Canada's three territories face higher than average health care costs, yet residents in the territories fare worse on indicators of health. Increased costs are driven by the broad geography and relatively small population in the territories, coupled with a scarcity of primary care physicians and specialists. There is a need for improved access to services among the population living in the territories, particularly in the areas of mental wellness, chronic disease management, and children's oral health. To respond to this challenge, there is a continued need to implement innovative strategies that connect clients with medically necessary services.

The THIF program remains aligned with Government of Canada priorities and contributes to Health Canada's strategic outcome of achieving a health system that is responsive to the needs of Canadians. Territorial partners view the program as responsive to their needs, and note that improved flexibility under a grant model will allow them to better target funding to where it is needed most.

Although provinces and territories are responsible for administering and delivering health care within their jurisdictions, the Government of Canada helps support equitable access and quality of care across Canada through fiscal transfers. The THIF program is aligned with this role and compliments other fiscal transfers provided specifically for health care delivery in the territories. THIF also aligns with Health Canada's mandate to ensure availability of, and access to, health services for Indigenous communities, as well as Canada's responsibilities under the CHA.

6.2 Performance

THIF funding enabled territorial governments to implement strategic and systems-level changes to support better service delivery. Furthermore, territories were able to use THIF funding to improve existing services by investing in professional development and initiatives related to mental wellness, chronic disease management, and oral health.

However, evidence suggests that some proposed THIF activities are slow to progress due to delays in the release of funding in year one, difficulties in recruitment and retention for all territories, and changing priorities for territorial governments and their key partners. While THIF documents indicated a goal of reducing medical travel over the three-year period, the evaluation found this was not a realistic goal, as costs for medical travel in the territories will continue to rise until remote service delivery options become more easily available.

While it is too early to measure impacts on patient health outcomes, THIF funding has contributed to improved services related to key health gaps by facilitating professional development activities and the hiring of service coordinators, as well as introducing pilot projects using innovative technologies.

The recent redesign of THIF to a grant model has addressed several opportunities to improve efficiency and economy, as the reporting requirements in the contribution agreement mechanism for THIF introduced an additional administrative workload for both Health Canada and territorial partners. Key informants viewed the targeted areas of mental wellness, chronic disease management, and children's oral health as relevant, however the disease-specific funding model limited the flexibility of territorial governments to allocate funding towards areas where it was needed most, and to respond to changing priorities over time.

In recognition of these lessons learned, the THIF grant no longer requires proposals to align with key health gap areas by disease, and instead funds projects that promote innovative approaches to health human resources and health technology. Furthermore, the *Medical Travel Stream* for the current four-year THIF grant program will be stable, in recognition that reduced reliance on medical travel is a longer-term goal for territorial partners. As THIF continues to evolve, consideration may be given towards longer-term funding agreements to address high rates of staff turnover associated with short-term projects, and to facilitate longer-term strategic planning.

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