



A Financial Analysis of the Current and Prospective Health Care Expenditures for First Nations in Manitoba

Conducted for:
Intergovernmental Committee on First Nations Health

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The conclusions and recommendations are those of the author. No official endorsement by federal or provincial departments or First Nations organizations is intended or should be implied. This report is presented for information purposes only and consideration of ICFNH partners in their discussions aimed at developing innovative solutions and strategic projects to achieve better health outcomes for Manitoba First Nations people.

Regional Websites:

Assembly of Manitoba Chiefs – www.manitobachiefs.com

Southern Chiefs Organization Inc. – www.scoinc.mb.ca

Manitoba Keewatinook Ininew Okimowin – www.mkonorth.com

Indian & Northern Affairs – www.ainc-inac.gc.ca/mb

Aboriginal & Northern Affairs – www.gov.mb.ca/ana

Health Canada / First Nations & Inuit Health Branch – www.hc-sc.gc.ca

Manitoba Health – www.gov.mb.ca/health

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Abbreviations

AFM:	Addictions Foundation of Manitoba
AHF:	Aboriginal Healing Foundation
AHS:	Aboriginal Headstart
CAPC:	Community Action Program on Children
CFS:	Child and Family Services
CHR:	Community Health Representative
CHST:	Canada Health & Social Transfer
CIHI:	Canadian Institute of Health Information
CPNP:	Canada Prenatal Nutrition Program
CSC:	Correctional Service of Canada
CWIS:	Community Workload Information System, a system by FNIHB to estimate the workload of nurses working in First Nation communities. This is also used to estimate community based funding.
DPPI:	Diabetes Prevention and Promotion Initiative
EIA:	Employment & Income Assistance, program delivered by Manitoba Family Services and Housing
FASD:	Fetal Alcohol Syndrome Disease
FNIHB:	First Nations and Inuit Health Branch of Health Canada
FSH:	Manitoba Family Services and Housing
HQ:	The Central office of FNIHB, located in Ottawa
IA:	Income Assistance, program delivered by Indian and Northern Affairs
IBB:	Insured Benefits Branch of Manitoba Health
ICFNH:	Manitoba Intergovernmental Committee on First Nation Health
INAC:	Indian and Northern Affairs
MFN - CAHR:	Manitoba First Nations Centre for Aboriginal Health Research
MH:	Manitoba Health
NIHB:	Non-Insured Health Benefits, a FNIHB program that applies on- and off-reserve
NNADAP:	National Native Alcohol & Drug Addictions Program
NPTP:	Northern Patient Transportation Program
PHAC:	Public Health Agency of Canada
PHF:	Population Health fund
RHA:	Regional Health Authorities
TLE:	Treaty Land Entitlement
WCB:	Workers Compensation Board

Executive Summary

This *Financial Analysis of the Current and Prospective Health Care Expenditures for First Nations in Manitoba* is, to our knowledge, a first of its kind. This study makes a number of key contributions:

- It documents the current health expenditures for all key health funders, including the First Nations and Inuit Health Branch of Health Canada (FNIHB), Manitoba Health and the Regional Health Authorities (RHAs), Family Services and Housing Manitoba (FSH), the Aboriginal Healing Foundation (AHF), the Public Health Agency of Canada (PHAC) and Indian and Northern Affairs Canada (INAC).
- It shows that Manitoba Health and the RHAs contribute 40.3 percent of all health expenditures for First Nations living on-reserve, and 71.8 percent of all health expenditures for First Nations living off-reserve. FNIHB, another major contributor, is responsible for 47.6 percent of expenditures for First Nations living on-reserve, and 19.5 percent of expenditure for First Nations living off-reserve.
- The total health expenditures for First Nations for the year 2004 was estimated to be \$479 million for those living on-reserve, and \$211 million for those living off-reserve.
- The study projects total annual health expenditures measured in 2004 dollars to grow to \$754 million for those living on-reserve, and \$315 million for those living off-reserve by the year 2029.
- Overall, health expenditures for First Nation people will account for a larger proportion of total public sector health expenditures in Manitoba, from 18.6 percent in 2004 to 23.6 percent in 2029.
- As a result of Bill C-31, a growing number of individuals of First Nation ancestry will be ineligible for registration under the Indian Act. This will result in significant cost shifting, estimated at \$40 million dollars per year by 2029 (measured in 2004 dollars). These expenditures, which would otherwise be the responsibility of FNIHB and INAC, will either fall to Manitoba Health or be absorbed by First Nation Health Organizations or individuals themselves. Without adjustments to the Manitoba Health or First Nation budgets, access to primary health care may be strained.
- **The cost of doing nothing:** Maintaining the current level of services, given current trends in health status and utilization, will result in a 57% increase in health expenditures for First Nations living on-reserve, and in a 49% increase for those living off-reserve by 2029.

These findings assume that the current policies and associated ambiguities will remain in place over the next 25 years, and that no new funding will be invested to address primary health care service gaps on-reserve. All figures are reported in constant 2004 dollars.

The study makes two broad recommendations:

Adequate primary health care can significantly reduce hospitalizations for ambulatory care sensitive conditions” – that is, complications that depend on whether adequate primary health care is in place. An example is the lower limb amputation rate associated with diabetes. Even if the prevalence of diabetes is constant or increases over 25 years, adequate primary health care can reduce lower limb amputations.

Cooperation among agencies can facilitate the efficient delivery of health services. For example, reductions in the hospitalization rate will be of particular benefit to Manitoba Health, but the provision of better primary health care will cost FNIHB. If gains to one agency exceed the costs to the other, the system is made more efficient. Cooperation, however, is necessary to realize those gains. Reduced jurisdictional ambiguities and improved data keeping and sharing are key principles to follow.

We would like to encourage policy makers from all agencies to review this document in detail. It presents an opportunity to improve the overall performance of the First Nation health care system, and to define innovative solutions that can help close the gap that exists between the health of First Nations and other Manitobans.

Introduction

In January 2005, Drs Josée Lavoie and Evelyn Forget were asked by the Manitoba Inter-governmental Committee on First Nation Health (ICFNH) to undertake a financial analysis of all health expenditures related to First Nations for the 2003-04 fiscal year.

The purpose of this exercise was to provide the ICFNH with a tool that would help explore "innovative solutions" to documented inefficiencies in the delivery of health care for First Nation people living in Manitoba. This objective reflects recommendations no. 42 and no. 43 of the Royal Commission on the Future of Health Care in Canada (Romanow 2002).

The specific objectives of this report fall into three broad categories, as itemized below.

1, Documenting current expenditures

- To describe all Manitoba and Canada health programs for First Nations;
- To identify federal health transfers to the Manitoba government;
- To identify Manitoba and Canada health program funding; and
- To document Manitoba and Canada health program expenditures for First Nations both on- and off-reserve.

2, Future trends

- To incorporate a 20 years population projection of First Nation residents of Manitoba;
- To project future health service utilization for First Nation residents based upon existing prevalence rates; and
- To project future health service utilization for First Nation residents based upon reduction in prevalence rates based upon explicit assumptions.

3, Recommendations: Planning to improve data linkage

- To identify limitations (shortcomings) of existing health care data systems for future fiscal analyses of health care utilization for First Nation residents of Manitoba;
- To review fiscal data sources regarding the future ability to link expenditure levels to utilization levels of health care treatment services;
- To provide recommendations for improved departmental reporting for such future fiscal analysis and health care utilization; and
- To provide recommendations for improved management information systems for both Canada and Manitoba for future fiscal analyses of health care utilization for First Nation residents of Manitoba.

This report is organized in four broad sections. The first section outlines all current programs and First Nation health expenditures for the year 2003-04. A second section builds on the population projections produced by Clatworthy (Clatworthy & Four Directions Project Consultants 2001, 2005), and highlights the projected cost of health

care for First Nations. A third section speaks to issues related to data limitations and linkages, and presents our recommendations. The report ends with the appendices and references.

Section 1, Documenting Current Expenditures

This section will address the first four objectives of this exercise, namely:

- a. To describe all Manitoba and Canada health programs for First Nations;
- b. To identify federal health transfers to the Manitoba government;
- c. To identify Manitoba and Canada health program funding; and
- d. To document Manitoba and Canada health program expenditures for First Nations both on- and off-reserve.

a. Health Programs for First Nations

Five separate agencies have responsibilities in the financing of health care for First Nations.

Manitoba Health (MH), through the Regional Health Authorities, is responsible for acute care costs and physician services for the entire population through its insured benefits branch. The Regional Health Authorities also deliver a number of community-based services for Manitobans living off-reserve, and there are some provincial programs accessible to First Nations on- or off-reserve. A description of core health services is provided in Appendix 1.

The **First Nations and Inuit Health Branch of Health Canada (FNIHB)** has the primary responsibility to fund all services delivered on-reserve. In 2003-04, FNIHB delivered funding and/or services through 28 separate programs. These are summarized in Appendix 2, based on information contained in the FNIHB Program Compendium (Health Canada 2003a). The only program to extend off-reserve is Non-Insured Health Benefits.

The **Department of Indian and Northern Affairs Canada (INAC)** has limited responsibilities in the area of health, beyond that of infrastructure. Only four programs are reported in Appendix 3. These programs operate on-reserve only, with the exception of some costs paid for adult care in long term care facilities off-reserve.

Manitoba Family Services & Housing (FSH) provides services to some First Nations who live off-reserve and participate in the Employment and Income Assistance program. In families where one or more members does not have Indian status, non-insured health benefits may be paid on behalf of an individual otherwise entitled to receive benefits through FNIHB. Some health-related expenditures including therapeutic diets, transportation (bus passes, taxi, handi-transit, mileage) and other services are not dependant on a participant's Indian status and are available to all recipients of income assistance.

The **Public Health Agency of Canada (PHAC)** offers a number of off-reserve health programs. These do not specifically target First Nation residents living off-reserve, but rather serve to reach vulnerable populations including First Nations. Eight programs are provided by PHAC and are listed in Appendix 4.

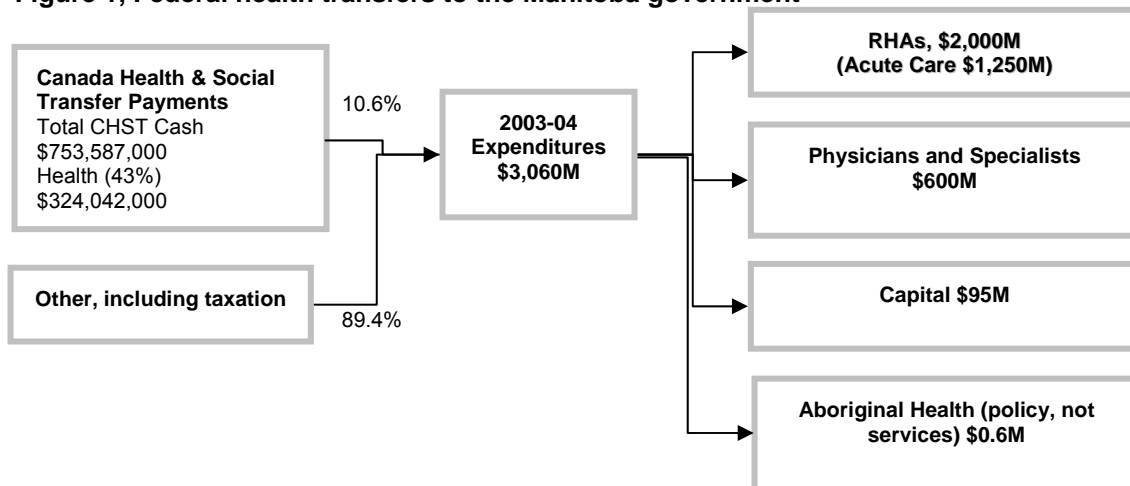
Other organizations also extend health and health-related services to Manitoba First Nations. These include:

- **Manitoba Public Insurance** covers health expenditures related to motor vehicle accidents;
- **Private Insurance Carriers** provide additional health coverage;
- **Corrections Services of Canada** provides health services to the inmate population of the Stony Mountain and Rockwoods Institutions;¹
- **Both Health Canada and FNIHB national offices** administer some small programs nationally. The Métis Off-Reserve Aboriginal Urban Inuit Prevention and Promotion (MOAUIPP) program for example, is managed nationally;
- **Workers Compensation Boards;**
- Medical Transportation expenditures expended by the **Royal Canadian Mounted Police (RCMP) under the Mental Health Act;**
- Expenditures from different programs and private sources, managed by the **Public Trustee** for First Nations declared mentally incompetent.²

b. Federal health transfers to the Manitoba government

Figure 1 shows that for the year 2003-04, the Canada Health & Social Transfer (CHST) Payment was \$753,587,000. Of this, Manitoba allocated roughly 43 percent to health (\$324,042,000), and 57 percent to Social Services (\$429,544,000). This breakdown was provided to us by Manitoba Finance.

Figure 1, Federal health transfers to the Manitoba government



¹ Aboriginal peoples constitute a disproportionate and therefore important proportion of the inmate population (18 percent of the overall inmate population, Correctional Services of Canada 2003). The Correctional Service of Canada (CSC) reports a total of 598 inmates in Manitoba in 2003. In the prairie region, the First Nation inmate population (self-declared, may include non status) is estimated at 25.7 percent of the overall inmate population. This means an estimated 151 First Nation inmates in Manitoba in 2003. It is not possible to access information on their province of origin. The CSC provides primary health care at the institutional level. Secondary care is provided by provincial facilities, on a cost-recovery basis. This is included in the overall Manitoba Health budget.

² These expenditures are likely to be overall minor. It is beyond the scope of this exercise to quantify private/personal health expenditures. A significant proportion of funding administered by the Public Trustee will come from private or personal sources, including for example, insurance settlement as a result of an injury sustained in a car accident. Health related expenditures that may come from other government programs have been captured already.

The total Manitoba Health budget for 2003-04 was \$3,060M. Thus, the CHST contributed 10.6 percent to the total Manitoba Health budget, or approximately \$277 for every person in Manitoba.

In April 2004, there were significant changes in the organization of federal health transfers to the provinces. The CHST was divided into the Canadian Social Transfer (CST) and the Canadian Health Transfer (CHT). Other federal funding was made available to increase the focus on primary care and to allow the purchase of diagnostic equipment. Special funding was also set aside to enable a process of health reform. The 2004-05 breakdown in funding is shown in Table 1.

	2005/06	2005/06 (per capita)	2004/05	2004/05 (per capita)
CHT	\$726,400,000	\$611	\$495,600,000	\$420
Health Reform			\$55,000,000	\$47
Health (other)	\$31,212,000	\$26	\$46,510,100	\$39
Total Health Transfers	\$757,612,000	\$637	\$597,110,100	\$506

These changes occurred after the end of the period under study, and although acknowledged, were not factored into our analysis.

c. Manitoba and Canada health program funding

Before estimating First Nation health expenditures, we first had to identify each agency's role and responsibilities in the financing of health services. Table 2 summarizes the information presented in Appendix 5. This resource is based on official Health Canada, INAC, Manitoba Health and the RHA documentation supplemented with discussions with program staff from agencies (Addictions Foundation of Manitoba 2004, Assiniboine Regional Health Authority 2005, Brandon Regional Health Authority 2004, Burntwood Regional Health Authority 2004, CancerCare Manitoba 2004, Churchill Regional Health Authority 2004, Health Canada 2003b, Indian and Northern Affairs Canada 2004, Interlake Regional Health Authority 2004, Manitoba Health 2005a, 2005b, 2005c, 2005d, 2005e, 2005f, 2005g, 2005h, 2005i, 2005j, 2005k, 2005l, Nor-Man Regional Health Authority 2004, North Eastman Health Association 2004, Parkland Regional Health Authority 2004, Regional Health Authority Central Manitoba 2004, South Eastman Health 2004, Winnipeg Regional Health Authority 2004).

Table 2 and the tables provided in Appendix 5 reflect program commitments for all communities except those which, as a result of the *1964 Agreement*, receive their health services through Manitoba Health (Department of National Health and Welfare & Department of Health of the Province of Manitoba 1964). As a result of this Agreement, the First Nations of Fox Lake, Grand Rapids, Mosakahiken (Moose Lake) and Chemawawin (Easterville) receive their clinical and public health services from Manitoba Health, through their local RHA. In contrast, the on- and off-reserve population living at Nelson House, Mathias Colomb (Pukatawagan), South Indian Health, Brochet,

³ Based on Selinger (2005). We used the entire MB population to calculate per capita figures, assuming an annual growth rate of 0.8% (Manitoba Bureau of Statistics 2005).

Tatakweyak (Split Lake), York Landing, Shamattawa, Opaskwayak (The Pas Reserve), Nisihchawayasihk (Norway House), Cross Lake, Bunibonibee (Oxford House), God's Lake, Island Lake, Ste. Theresa Point and Granville Lake were designated as federal jurisdictions.

Missing information: First Nation health expenditures from Manitoba Public Insurance, Veterans Affairs, The Public Trustee's Office, the RCMP, WCB, other private insurance carriers, Corrections Services of Canada, and administrative costs associated with the national offices of Health Canada, FNIHB and INAC were not documented.

Funding provided under the Indian Residential Schools Resolution Canada program was also excluded, because this funding is being provided by the Government of Canada in acknowledgement of and compensation for the wrongs that occurred as a result of the Indian Residential Schools policy. This funding is not being provided to ensure on-going access to health services.

Table 2, Funding map for First Nations health programs

Types of Services	Payers of services for population living on-reserve				Payers of services for population living off-reserve			
	Manitoba Health/RHAs	FNIHB	INAC	Others	Manitoba Health/RHAs	Health Canada	INAC	Family & Services and Housing/ Others
1. Professional Services:								
1.1 Physicians	√	√, guaranteed payment			√			
1.2 Chiropractic	√ (12 visits/yr)				√ (12 visits/yr)			
1.3 Optometric/ ophthalmologic care (examination)	√ (limited coverage)	NIHB (better coverage)			√ (limited coverage)	For FN not on Social Assistance: NIHB (better coverage)		FNs on Social Assistance: Jurisdiction unclear
1.4 Audiology	√ (hospital-based services only)	NIHB			√ (hospital-based services only)	FNs who are not on Social assistance:		FNs on Social Assistance: Jurisdiction unclear
1.5 Podiatry/ Chiroprody	√ (hospital-based services only)	Sporadic coverage			√ (hospital-based services only)			
1.6 In-hospital dental care (oral surgery)	√ (hospital-based services only)	NIHB			MH covers the cost associated with hospital use	FNIHB NIHB		
1.7 Dental Treatment outside of hospital		NIHB				FNIHB NIHB for FN not on Social Assistance		FNs on Social Assistance: Jurisdiction unclear
2. Acute Care Hospital Services:								
2.1 Primary Level	√ (night bed utilization on-reserve)	FNIHB (client stabilization).			√			
2.2 Secondary Level	√	√, for Norway House and Nelson House			√			
2.3 Tertiary Level	√				√			
2.4 Quarternary Level (eq, transplant)	√				√			
2.5 Emergency Services (out of hospital)		FNIHB (client stabilisation)			RHAs Emergency responses	FNIHB for FN not on Social Assistance: Ambulance services paid via		FNs on Social Assistance: Jurisdiction unclear

Table 2, Funding map for First Nations health programs

Types of Services	Payers of services for population living on-reserve				Payers of services for population living off-reserve			
	Manitoba Health/RHAs	FNIHB	INAC	Others	Manitoba Health/RHAs	Health Canada NIHB	INAC	Family & Services and Housing/ Others
3. Promotion of Health & Prevention of Illness & Injury:								
3.1 Birthing & Parenting		√			RHAs	PHAC (proposal-drive programs)		
3.2 Family Health		√			RHAs			
3.3 Dental Health		√						
3.4 School Health		√			RHAs			
3.5 Screening & Counseling for Heredity Disease	RHAs, services accessible off-reserve				RHAs			
3.6 Suicide Prevention		√			RHAs			
3.7 Nutritional Health		√			RHAs			
3.8 Sexual & Reproductive Health		√			RHAs	PHAC (proposal-drive programs)		
3.9 Prevention of Chronic Disease		√			RHAs	FNIHB Ottawa (MOAUIPP)		
3.10 Healthy Lifestyles		√			RHAs	PHAC (proposal-drive programs)		
3.11 Workplace Safety		Unclear			RHAs			Provided by the Manitoba Dept of Labour
4. Protection of Health:								
4.1 Public Health Inspector & Monitoring (environmental contaminants, transportation of dangerous goods)		√	√		RHAs			
4.2 Immunization: Includes community-based and Physician-based immunization	MH, physicians RHA immunization by public health nurses	FNIHB, if the immunization occurs on-reserve			MH, physicians RHA immunization by public health nurses			

Table 2, Funding map for First Nations health programs

Types of Services	Payers of services for population living on-reserve				Payers of services for population living off-reserve			
	Manitoba Health/RHAs	FNIHB	INAC	Others	Manitoba Health/RHAs	Health Canada	INAC	Family & Services and Housing/ Others
services (see vaccines under the category "drug")								
4.3 Communicable Disease	√	FNIHB for on-reserve contact tracing.			RHAs			
4.4 Food and Drug Safety		√			Dept of Conservation			
5. Home/Community-Based Services:								
5.1 Nursing, Care Coordination/ Assessment		√			RHAs			
5.2 Other Professional Health Services	√ (hospital-based, off-reserve)	√ (depends on community)			RHAs			
5.3 Personal Care Services		√			RHAs			
5.4 Home Support/Homemaking			√		RHAs			
5.5 Nursing Homes/Homes for the Aged/Special Care Homes Personal Care Homes	√ (cost of care in provincially-licensed facilities only)	√	INAC provides for residential costs for levels I and II.		√ (cost of care)			
5.6 Chronic Care Hospitals	MH				MH			
5.7 Respite Care	Services available unclear	Services available unclear			√			√
5.9 Palliative Care (home-based)		√, scope of practice issues.			RHAs (education mostly)			

Table 2, Funding map for First Nations health programs								
	Payers of services for population living on-reserve				Payers of services for population living off-reserve			
	Manitoba Health/RHAs	FNIHB	INAC	Others	Manitoba Health/RHAs	Health Canada	INAC	Family & Services and Housing/ Others
6. Community Rehabilitation:								
6.1 Physiotherapy	√ (hospital-based)	√, some through NMU			√ (hospital-based)			
6.2 Speech & Language	√ (hospital-based)				√ (hospital-based)			
6.3 Other Rehabilitation	√ (hospital-based)				√ (hospital-based)			
7. Aids to Persons with Physical Disabilities								
7.1 Hearing Aids ⁴	√	√			√	√ FNIHB: FNs who are not on Social Assistance:		FNs on Social Assistance: Jurisdiction unclear
7.2 Visual Aids	√ (partial reimbursement).	√			√ (partial reimbursement).	√		
7.3 Communication Aids	√ (partial reimbursement).				√ (partial reimbursement).			
7.4 Orthotic/ Prosthetic Devices	√ (some)	√			√ (some)	√ FNIHB for FN not on Social Assistance		
7.5 Respiratory Equipment & Supplies	√	√			√	√ FNIHB for FN not on Social Assistance		
7.6 Wheelchair, Mobility Aids & Seating		√				FNIHB NIHB for FN not on Social Assistance		
7.7 Other Supplies & Equipment	√ (some)	√			√ (some)	FNIHB NIHB for FN not on Social Assistance		
7.8 Children/Adults with special needs		√ (NIHB)	Bands receive a 3% allocation.		√	√ (NIHB)	√, as payer of last resort.	

⁴ Although First Nation children under the age of 18 could get partial coverage through Manitoba Health, in practice, Manitoba Health's requirement that the cost be paid up front and refunded means that First Nations utilize the NIHB program instead.

Table 2, Funding map for First Nations health programs

Types of Services	Payers of services for population living on-reserve				Payers of services for population living off-reserve			
	Manitoba Health/RHAs	FNIHB	INAC	Others	Manitoba Health/RHAs	Health Canada	INAC	Family & Services and Housing/ Others
8. Mental Health Services:								
8.1 Community-Based (family or individual)		√, community-based and up to 12 visits to psychologists/yr			RHA	FNIHB NIHB covers up to 12 visits to psychologists/yr		FNs on Social Assistance: Jurisdiction unclear
8.2 Psychiatric care	√				√			
8.3 Institutional mental health services	√				√			
8.4 Family Violence			√		RHAs			
9. Services for Alcohol & Other Drug Abuse:								
9.1 Services for Gambling Addiction		√			√ (AFM activities)	√ (Provincial treatment centers)		
9.2 Alcohol and Drugs		√			√ (AFM activities)	FNIHB √ (Provincial treatment centers) PHAC funds FASD.	√ (CFS children, payer of last resort).	
9.3 Tobacco		√			√			
9.4 Other		√			√ (AFM activities)		Unclear	
10. Drug Benefits:	√ (Pharmacare, in Personal Care Homes, in hospital, palliative care drugs)	√	N/A	FSH, for on-reserve non-FN on social assistance.	√ (Pharmacare, in Personal Care Homes, in hospital, palliative care drugs)	√		
11. Medical transportation including ambulance Services:	√, some areas of debate	√		FSH, for on-reserve non-FN on social assistance.	√, some areas of debate	√		
12. Health Services to Children with Special Needs		√	√				√, case per case	Additional coverage for FN on Social Assistance living off-reserve but not in foster care
13. Diagnostic Services	RHAs				RHAs			

Table 2, Funding map for First Nations health programs

Types of Services	Payers of services for population living on-reserve				Payers of services for population living off-reserve			
	Manitoba Health/RHAs	FNIHB	INAC	Others	Manitoba Health/RHAs	Health Canada	INAC	Family & Services and Housing/ Others
14. FNs leaving the reserve to access health care		Coverage for meals, accommodations and in-city transportation provided for up to three months.			√	Unclear jurisdiction: Medical transportation within the city (off-reserve) is no longer covered by NIHB.	On a case per case basis	

Table 2 provided above highlights three broad areas of jurisdictional ambiguity.

1. Extent of Manitoba Health Coverage: According to the Manitoba Health website and official documentation on coverage, all Manitobans have access to the same coverage for Manitoba Health programs. In practice however, the responsibilities for coverage are at times cost-shared (in exceptional cases) or covered by FNIHB. This is the case for wheelchairs.

2. Long Term Care: The jurisdictional issues associated with higher levels of long term care, that is care provided outside the home or hospital (special care homes), are well documented (Indian and Northern Affairs Canada 2004, Allec 2005, Roscelli 2005). According to INAC, health services are of provincial jurisdiction, and funded through the Canada Health and Social Transfers (CHSTs), on a per capita basis (Indian and Northern Affairs Canada 2004). Neither INAC nor Health Canada acknowledge a responsibility for providing on-reserve institutional care for levels 4 and 5. Manitoba Health funds levels 4 and 5 care provided on-reserve if the facility is licensed provincially.

3. Non-Insured Health Benefits: Three main ambiguities have been documented.

a. It appears that ambiguities remain as to who will take responsibility for non-insured health benefits for First Nations living off-reserve who are also beneficiaries of the Manitoba Employment and Income Assistance program (EIA). The EIA program literature clearly states that health benefits are provided for people who do not have health benefits through other programs (Manitoba Family Services and Housing 2005). FNIHB claims that the NIHB program is also a payer of last resort. It remains unclear who actually is the payer of last resort in terms of legislation, policy and practice for First Nation residents living off-reserve and on social assistance. It however seems that NIHB remains accessible to these individuals. Manitoba Family Services & Housing does not cover costs associated with services insured under the NIHB program for First Nations, except in some cases where some members of a family do not have Indian status and consequently do not have access to NIHB. In those cases, coverage will be available to all family members under EIA. Family Services & Housing has provided data documenting use of benefits under EIA by individuals eligible to receive NIHB through FNIHB.

b. According to INAC, FNIHB's delisting of drugs and services under the NIHB program has had a direct impact on INAC's budget, as INAC picks up the cost of care not provided by FNIHB. As well, First Nations may be impacted, since special needs are covered from Band funds through the IA program (3% top up) which is based on historical trends, and capped. Increased expenditures under this program may reduce the ability of Bands to offer other programs.

c. There remain some unpaid medical transportation 2003-2004 invoices for off-reserve First Nations on EIA. Neither FNIHB nor FSH appears to be willing to cover these costs. This issue remains under discussion.

Air	\$581,997
Ground, Winnipeg	\$1,394,054
Ground, outside Winnipeg	\$59,959
Total	\$2,036,010

d. Manitoba and Canada health funding for First Nations both on- and off-reserve, 2003/04

Appendices 6 and 7 show actual program expenditures for Manitoba Health, the RHAs, and FNIHB, which together contribute 94 percent of health funding for the on-reserve population and 98 percent of the funding for the off-reserve population. Tables 4 through 9 show per person expenditures.

For each agency providing health services, per person costs were calculated by dividing the total program expenditure by the relevant population. If we had specific data concerning differential utilization, we took that into account. Otherwise, we assumed that utilization by all people eligible to use a particular program was the same.

The population figures we used were:

Manitoba Total – 1,169,667

First Nations on-reserve – 72,330

First Nations off-reserve – 42,489

First Nations total – 114,819

Aboriginal population total (including First Nations on- and off-reserve, Métis and non-status) – 172,700

The population figures from various sources differed in minor ways. The reconciliation is in Appendix 8.

Details of per capita calculations are in Appendix 9. Per capita costs were calculated over the whole relevant population, rather than just the people who used a particular program. This allowed us to add together expenditures on different programs to estimate total expenditure per person. For example, when we calculated acute care costs for each First Nation person living on-reserve, we started with the total acute care budget of Manitoba Health. We took into account differential utilization patterns, and estimated the total expenditure for First Nations living on-reserve. Then we divided that total by 72,330 in order to estimate per person costs. The figure in Table 4 for per capita acute care costs (\$1,734) is the average cost for each First Nation person living on-reserve, including those people who did not use hospitals in 2003/04. It is not the average cost for a person who was admitted to hospital in that year. If we limited the calculation to those who were admitted to hospitals, we would be over-estimating the total health expenditure.

Similarly, when we calculated costs for the Northern Patient Transportation Program (NPTP) attributable to First Nations off-reserve, we started with the total program expenditure on NPTP. We calculated the proportion of the off-reserve population in the four affected Regional Health Authorities that were First Nations, and assumed that the proportion of the total NPTP budget used by First Nations off-reserve was in proportion to their representation in the population. First Nation individuals represent about 10% of the population living off-reserve in these four RHAs, consequently so we attributed 10% of the total budget to First Nations off-reserve. To calculate per capita costs, we divided this number by 42,489, or the total off-reserve First Nation population in Manitoba. That is, we calculated the costs of this program per First Nations off-reserve, and not only for those living in the north. If we had limited the calculation to those living in the north, we would have over-estimated the total health expenditure.

Table 4, Manitoba Health Expenditures for 2003-04

	On-reserve (per capita)	Off-reserve (per capita)
Acute Care (hospitals) ⁵	\$1,734	\$1,552
Medical Care (physician services)	\$522	\$738
Long Term Care	\$5	\$412
Home Care	\$0	\$178
Land Ambulance	\$0	\$22
Northern Patient Transportation Program	\$0	\$24
1964 agreement (RHA community programs)	\$18	\$0
RHA – community based programs	\$0	\$286
Provincial programs	\$60	\$80
MH – central administration costs	\$32	\$32
CancerCare	\$46	\$46
Addictions Foundation of Manitoba ⁶	\$0	\$12
Total – MH	\$2,417	\$3,382

⁵ MB Health Acute Care costs include MB Health expenditures at Nursing Stations, Norway House and Percy Moore Hospitals.

⁶ The figure for AFM is only an estimate, because some of the expenditures were recovered from FNIHB. AFM received \$12,834,700 from the provincial government in 2003-04. The practice is to bill FNIHB for all residential treatment of off-reserve First Nations. Unfortunately, we do not have a breakdown between residential and non-residential programs, or between First Nations and non-First Nations users. We did not track monetary flows between agencies. Therefore, we allocated costs on a per capita basis to everyone off-reserve in the province, whether they are First Nations or not.

Table 5, FNIHB Health Expenditures for 2003-04

	On-reserve (per capita)		Off-reserve (per capita)
	Unadjusted	Adjusted for non-status utilization	
NNADAP – residential	\$12	\$12	\$0
NNADAP – prevention	\$79	\$76	\$0
Solvent Abuse	\$46	\$44	\$0
NNADAP training	\$0	\$0	\$0
Tobacco Control	\$3	\$3	\$0
Aboriginal Head Start	\$72	\$69	\$0
Prenatal Nutrition	\$28	\$27	\$0
FAS/FAE	\$3	\$3	\$0
Diabetes Initiative	\$18	\$17	\$0
Comm. Diseases	\$1	\$1	\$0
HIV/AIDS	\$5	\$5	\$0
Tuberculosis	\$10	\$10	\$0
Brighter Futures	\$95	\$91	\$0
Mental Health	\$82	\$78	\$0
Community health – prevention (CHR)	\$59	\$56	\$0
Community health – prevention (Nursing)	\$484	\$462	\$0
Community health – primary care, care and treatment	\$10	\$10	\$0
Planning and evaluation	\$2	\$2	\$0
Medical Health Officer	\$8	\$8	\$0
Norway House and Percy Moore Hospitals	\$97	\$93	\$0
Dental/Oral Health	\$42	\$40	\$0
Home Care/Home & Community Care	\$192	\$184	\$0
Health Facilities. – maintenance & security	\$52	\$49	\$0
Support services, liaison, coordination	\$33	\$32	\$0
Environmental health	\$27	\$26	\$0
Environmental contaminants	\$1	\$1	\$0
Health Careers	\$2	\$1	\$0
Health Info Sys	\$12	\$12	\$0
Indian Residential Schools	\$1	\$1	\$0
Health consultations	\$8	\$8	\$0
Directorate – transfer and integrated agreements	\$158	\$151	\$0
Nursing Administration	\$14	\$13	\$0
Directorate – Transfer Program Administration	\$10	\$10	\$0
Directorate – Regional HQ	\$11	\$11	\$0
FNIHB programs – subtotal	\$1,677	\$1606	\$0
NIHB – transportation	\$552	\$552	\$309
NIHB – pharmacy	\$423	\$423	\$421
NIHB – dental	\$168	\$168	\$121
NIHB - mental health	\$56	\$56	\$35
NIHB – vision care	\$29	\$29	\$19
NIHB – referrals	\$5	\$5	\$0
NIHB – administration	\$14	\$14	\$9
NIHB subtotal	\$1,247	\$1,247	\$914
FNIHB Per Capita Expenditures	\$2,924	\$2,853	\$914

In isolated and remote-isolated communities, FNIHB's Community Workload Information System (CWIS) funding formula includes non-status/non-indigenous users. This applies to the communities of Berens River, Bloodvein, Barren Lands (Brochet), Cross Lake, Garden Hill, God's Lake, God's River, Granville Lake, Northlands (Lac Brochet), Little Grand Rapids, Nelson House, Norway House, Oxford House, Pauingassi, Poplar River, Pukatawagan (Mathias Colomb), Red Sucker Lake, Shamattawa, South Indian Lake, Split Lake, St. Theresa Point, Sayisi Dene (Tadoules Lake), Wasagamack and York Landing. The estimated percentage of non-status/non-indigenous users for 2003-04 is 4.4%.

	On-reserve (per capita)	Off-reserve (per capita)
Drugs/Dental/Optical	\$0	\$24
Chiropractic	\$0	\$0
Therapeutic Diets	\$0	\$15
Health Transport	\$0	\$17
Other	\$0	\$7
Total	\$0	\$63

	On-reserve (per capita)	Off-reserve (per capita)
National Child Benefit	\$26	\$0
Children - complex needs	\$1	\$1
Adult Care	\$340	\$18
Family Violence	\$25	\$0
Administration	\$4	\$4
Total	\$396	\$23

	On-reserve (per capita)	Off-reserve (per capita)
Community Action Program on Children (CAPC)	\$0	\$31
Aboriginal Headstart (AHS)	\$0	\$61
Canada Prenatal Nutrition Program (CPNP)	\$0	\$1
Fetal Alcohol Syndrome Disease (FASD)	\$0	\$0
AIDS/HIV	\$0	\$0
HepC	\$0	\$0
DPPI	\$0	\$0
PHF	\$0	\$0
Administration	Not provided	Not provided
Total	\$0	\$94

	On-reserve (per capita)	Off-reserve (per capita)
AHF	\$327	\$191
Administration	Not provided	Not provided
Total	\$327	\$191

Table 10, Summary of First Nations Health Expenditures (\$ per capita)

Types of Services	Payers of services for population living on-reserve					Payers of services for population living off-reserve							
	Manitoba Health/RHAs	FNIHB	INAC	AHF	Total	Manitoba Health/RHAs	FNIHB	PHAC	INAC	AHF	Family Housing & Services	Unpaid invoices	Total
Medical services	\$522	\$10			\$532	\$738							\$738
Community-based health services	\$18	\$1,072	\$25		\$1,115	\$286		\$94					\$380
Hospital care	\$1,840 ⁷	\$93			\$1,933	\$1,678							\$1,678
Home care		\$184			\$184	\$178							\$178
Long term care	\$5		\$340		\$345	\$412			\$18				\$430
Alcohol, Drug and Solvent Addictions		\$132			\$132		\$0						\$0
Tobacco		\$3			\$3	\$12							\$12
Mental health/traditional healing (NIHB & Programs)		\$134		\$327	\$461	\$12	\$35			\$191			\$238
Drug Benefits		\$423			\$423		\$421				\$24		\$445
Dental care coverage		\$168			\$168		\$121						\$121
Medical transportation	\$0	\$552			\$552	\$46	\$309				\$17	\$48	\$420
Vision care		\$29			\$29		\$19						\$19
Other non-insured health benefits		\$5	\$27		\$32				\$1		\$22		\$23
Administration	\$32	\$48	\$4		\$84	\$32	\$9		\$4				\$45
Total	\$2,417	\$2,853	\$396	\$327	\$5,993	\$3,394	\$914	\$94	\$23	\$191	\$63	\$48	\$4,727
Percentage of total	40.3%	47.6%	6.6%	5.5%		71.8%	19.3%	2.0%	0.5%	4.0%	1.3%	1.0%	

⁷ This figure includes CancerCare and Manitoba Health provincial program expenditures.

As discussed earlier, in 2003/04 the CHST contributed only 10.9 per cent of the overall Manitoba Health budget, or \$277 per Manitoba resident. In contrast, Manitoba Health's costs for 2003-04 are estimated at \$2,417 per First Nation person living on-reserve, and \$3,394 per First Nation person living off-reserve.

Figures 2 and 3 show the breakdown of expenditures by program category. Some caution should be exercised in interpretation, for the following reasons:

1. As will be discussed in Section 2, the data we received from different agencies, and even across RHAs, is not organized following standardized categories of expenditures; and
2. The expenditures listed under programs such as home care or community-based health services may include a substantial and varying amount of funding for administration.

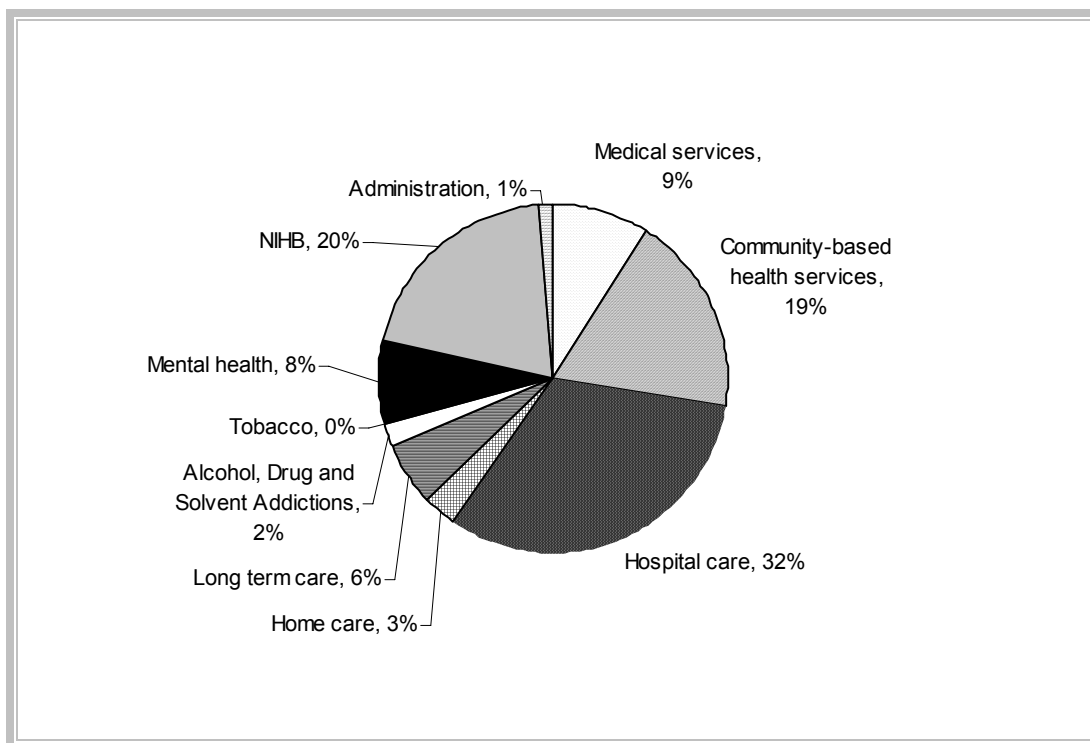


Figure 2, Breakdown of total per capita health expenditures for First Nations living on-reserve per program area (\$5,993)

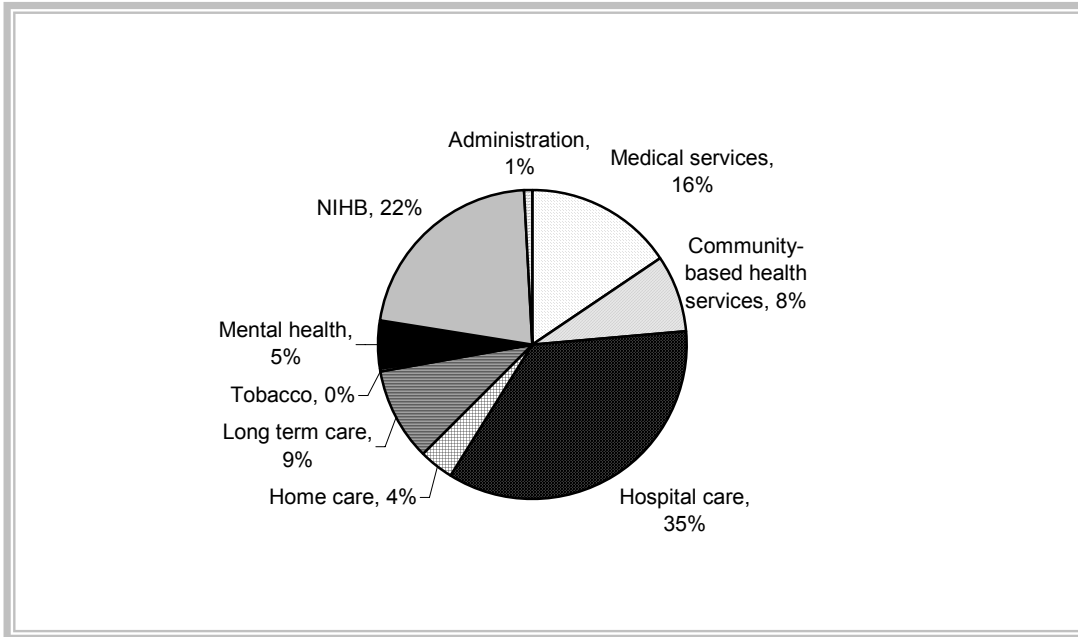


Figure 3, Breakdown of total per capita health expenditures for First Nations living off-reserve per program area (\$4,727)

Nevertheless, it appears that the ratio of per capita health expenditures for First Nations living on-reserve to those living off-reserve is 1.24:1. Previous studies have generally suggested a higher ratio of 1.6:1 (Royal Commission on Aboriginal Peoples 1996). Our findings echo those from the National Evaluation of the Health Transfer Policy, which showed lower per capita funding for transferred communities located in Manitoba than in other regions, with the exception of the Maritimes (Lavoie et al. 2005).

Section 2, Projections of First Nation Health Expenditures

This section will address the three objectives related to future trends, namely,

1. To incorporate a 20 years population projection of First Nations in Manitoba;
2. To project future health service utilization for First Nations based upon existing prevalence rates; and
3. To project future health service utilization for First Nations based upon reduction in prevalence rates based upon explicit assumptions.

It is important to note that projections are not forecasts. Forecasts attempt to estimate what will be the case in twenty years, by trying to determine which policies will be adopted and how underlying factors such as prevalence rates might change. Forecasts let all factors change simultaneously, and try to determine what will happen.

Projections, by contrast, are based on a set of assumptions. They try to answer “if-then” questions. For example, a projection might ask: “if those communities currently in Treaty Land Entitlement (TLE) negotiation become reserves, what will that mean for INAC costs?” When a projection tries to answer that question, it assumes nothing else changes at the same time.

a. Population Projections

The 2004 population figures we used are those outlined in Appendix 8 and agreed upon by the ICFNH through previous reviews of this report.

Manitoba Population	1,169,667
First Nations on-reserve	72,330
First Nations off-reserve	42,489
First Nations total	114,819

In terms of projecting the First Nation population over the next 20 years, we were able to draw from the work already completed by Clatworthy (2001, 2005). These projections were developed for both northern and southern First Nation populations, to assess the long term impact of Bill C-31. The figures for Table 11 were provided by Stewart Clatworthy.⁸

The Clatworthy projections take into considerations a number of key factors, including:

- Trends in population size by location (on and off-reserve), including migration;
- Annual rates of population growth by location (on and off-reserve);
- Annual additions to the population through Bill C-31 registrations;
- Trends in the composition of the population by section 6 registry category and location (on and off-reserve); and

⁸ Clatworthy's 2004 population estimates differ very slightly from those used in the previous section. Because his projections are more detailed than others, we used his figures for this section.

- The rate of exogamous parenting, that is parenting between someone who is (or is entitled to be) legally registered under the Indian Act and someone who is not entitled to be registered.

In addition to the assumptions included in the Clatworthy analysis, we also considered the impact of the TLE process. In Manitoba, 19 First Nations signed a TLE Framework Agreement in 1997. Seven signed individual agreements. At the time of writing, another four First Nations were still negotiating their settlement. According to the November 2005 report of the Auditor General of Canada, 88 percent of Manitoba TLE land acquired has yet to be converted into reserve land (Auditor General of Canada 2005). According to the same report, it appears that most land used under TLE has been for economic development purposes, not for housing. As a result, TLE is not expected to significantly change on- and off-reserve distributions.

Table 11 and figure 4 summarize trends in First Nation population growth, both on- and off-reserve. According to the Clatworthy projections, the on-reserve population will continue to grow much faster than the off-reserve population. Both will experience a decreasing growth rate, associated with entitlement loss. By 2029, a total of 29,186 individuals of First Nation ancestry will not be entitled to First Nation status. This is nearly 5 times the numbers of individuals not entitled to registration in 2004.

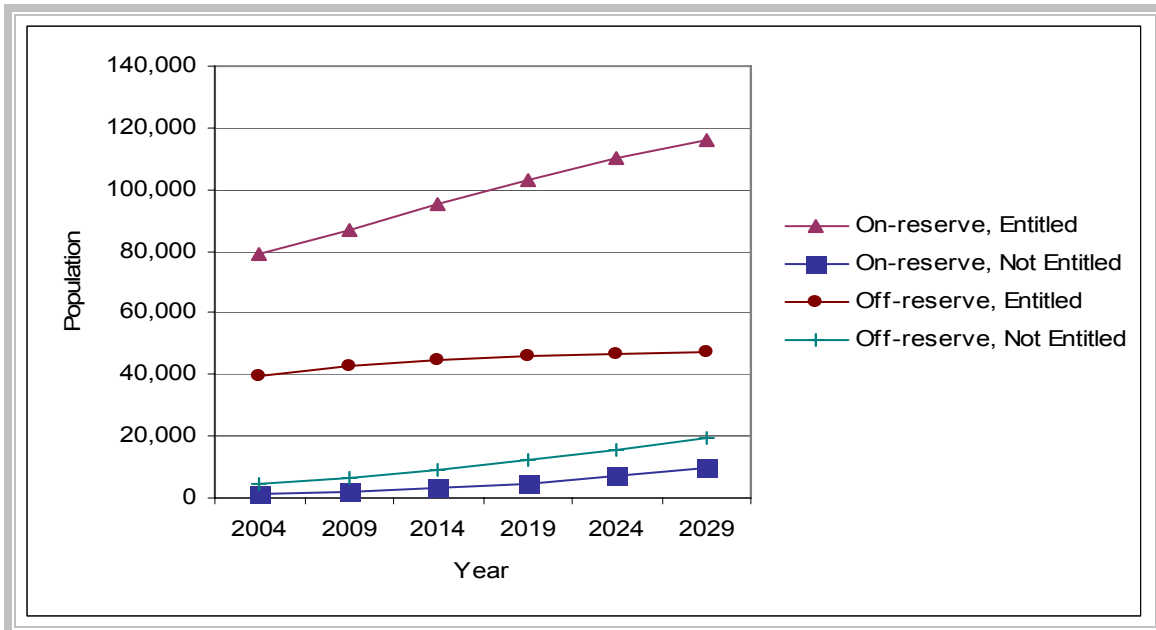


Figure 4, First Nation population projections, 2004 to 2029

The following findings are reported in constant 2004 dollars, meaning that we did not factor a yearly indexation to reflect cost of living increases.

Table 11, Manitoba First Nation population projections based on numbers provided by Clatworthy

Year	On-reserve					Off-reserve			
	Total	Entitled	Not Entitled Northern MB	Not Entitled Southern MB	% Entitled	Total	Entitled	Not Entitled	% Entitled
2004	79,880	78,814	480	585	98.7	44,662	39,856	4,806	89.2
2009	88,813	87,042	757	1,015	98.0	49,150	42,566	6,584	86.6
2014	98,188	95,165	1,292	1,731	96.9	53,666	44,623	9,043	83.1
2019	107,635	102,866	2,073	2,696	95.6	58,127	46,063	12,063	79.2
2024	116,926	109,956	3,118	3,852	94.0	62,470	46,898	15,572	75.1
2029	125,778	116,133	4,465	5,180	92.3	66,616	47,074	19,541	70.7

b. Future Expenditures

Table 12 projects health expenditures for the on- and off-reserve population. This projection is based on the total per capita expenditures reported in table 10. Health expenditures are expected to grow faster on-reserve, reflecting more rapid on-reserve population growth.

Table 13 shows the impact of First Nation population growth (registered and non-registered) on health expenditures by each agency. Assuming no Bill C-31 impact, health care expenditures are expected to grow by an average of 54.9 percent (constant 2004 dollars) reflecting the overall population growth rate.

In contrast, Table 14 takes into consideration the impact of Bill C-31. The figures reflect a number of assumptions:

- That all current policies regarding jurisdictions over health care, including the 1964 Agreement, will continue to apply;
- That the level of services provided on a per person basis by each agency on- and off-reserve will remain constant (that is, per capita expenditure remains constant);
- That INAC will continue to assume the responsibility for Social Assistance for all individuals ordinarily living on-reserve;
- That non-insured health benefits for non-registered individuals living off-reserve on Social Assistance will continue to be paid by FSH;
- That reliance on Social Assistance for individuals ineligible for registration living on-reserve can be estimated based on current data for registered individuals living on-reserve, at 36.5 percent (Statistics Canada 2005);
- That reliance on Social Assistance for individuals ineligible for registration living off-reserve can be estimated based on current data for registered individuals living off-reserve, 26.9 percent (Statistics Canada 2005); and
- That FNIHB will continue to assume the responsibility for non-registered individuals living in the isolated and remote-isolated First Nation communities.⁹ For this exercise, we used the non-registered figures provided by Clatworthy for northern Manitoba First Nations as a proxy.

⁹ Berens River, Bloodvein, Barren Lands (Brochet), Cross Lake, Garden Hill, God's Lake, God's River, Granville Lake, Northlands (Lac Brochet), Little Grand Rapids, Nelson House, Norway House, Oxford House, Pauingassi, Poplar River, Pukatawagan (Mathias Colomb), Red Sucker Lake, Shamattawa, South Indian Lake, Split Lake, St. Theresa Point, Sayisi Dene (Tadoule Lake), Wasagamack and York Landing.

Table 12, Projected Manitoba First Nation Health Expenditures (constant 2004 dollars)

	On-reserve			Off-reserve			Comparative analysis		
	Popn	Total health expenditures for population living on-reserve	Annual growth rate	Popn	Total health expenditures for population living off-reserve	Annual Growth rate	Total FN health expenditures (on and off-reserve)	Total projected public sector health expenditures ¹⁰	Proportion of total pub sector health exp. for FNs
2004	79,880	\$478,719,574		44,662	\$211,118,708		\$689,838,282	\$3,866,900,000	18.6%
2009	88,813	\$532,259,022	11.2%	49,150	\$232,332,060	10.0%	\$764,591,082	\$4,088,713,365	19.8%
2014	98,188	\$588,438,808	10.6%	53,666	\$253,679,143	9.2%	\$842,117,951	\$4,187,629,613	21.0%
2019	107,635	\$645,055,746	9.6%	58,127	\$274,765,587	8.3%	\$919,821,333	\$4,357,836,407	22.0%
2024	116,926	\$700,738,125	8.6%	62,470	\$295,297,257	7.5%	\$996,035,382	\$4,534,961,280	22.9%
2029	125,778	\$753,786,192	7.6%	66,616	\$314,893,462	6.6%	\$1,068,679,654	\$4,719,285,418	23.6%

Table 13, Total projected health care costs by payers, assuming no Bill C-31 impact, in constant 2004 dollars (\$1,000)

	Population living on-reserve						Population living off-reserve								
	Pop'n	MH/ RHAs	FNIHB	INAC	AHF	Total	Pop'n	MH/ RHAs	FNIHB	PHAC	INAC	AHF	FSH	Unallocated expenses ¹¹	Total
2004	79,880	\$193,069	\$227,897	\$31,632	\$26,121	\$478,720	44,662	\$151,584	\$40,821	\$4,198	\$1,027	\$8,530	\$2,814	\$2,144	\$211,119
2009	88,813	\$214,662	\$253,385	\$35,170	\$29,042	\$532,259	49,150	\$166,815	\$44,923	\$4,620	\$1,130	\$9,388	\$3,096	\$2,359	\$232,332
2014	98,188	\$237,320	\$280,129	\$38,882	\$32,107	\$588,439	53,666	\$182,142	\$49,051	\$5,045	\$1,234	\$10,250	\$3,381	\$2,576	\$253,679
2019	107,635	\$260,153	\$307,082	\$42,623	\$35,197	\$645,056	58,127	\$197,283	\$53,128	\$5,464	\$1,337	\$11,102	\$3,662	\$2,790	\$274,766
2024	116,926	\$282,610	\$333,590	\$46,303	\$38,235	\$700,738	62,470	\$212,024	\$57,098	\$5,872	\$1,437	\$11,932	\$3,936	\$2,999	\$295,297
2029	125,778	\$304,005	\$358,844	\$49,808	\$41,129	\$753,786	66,616	\$226,094	\$60,887	\$6,262	\$1,532	\$12,724	\$4,197	\$3,198	\$314,893

¹⁰ Based on 2004 public sector expenditures in Manitoba (Canadian Institute for Health Information 2006). These figures include public expenditures only, including expenditures from FSH, INAC and FNIHB. Out of pocket and third party expenditures were not included. The projections were calculated based on total 2004 public sector health expenditures per capita in Manitoba, multiplied by the MBS projected Manitoba population growth of 0.8 percent per year (Manitoba Bureau of Statistics 2005).

¹¹ Figures include expenses for unpaid invoices incurred in 2003-04, as itemized in Table 3. We understand that these items remain under discussions.

	Population living on-reserve						Population living off-reserve								
	MH/RHAs	FNIHB	INAC ¹²	AHF	Cost shifted to FN & Org. ¹³	Total	MH/RHAs	FNIHB ¹⁴	PHAC	INAC	AHF	FSH ¹⁵	Unpaid invoices	Costs no longer covered by FNIHB/INAC ¹⁶	Total
2004	\$193,070	\$225,597	\$31,720	\$25,772	\$2,559	\$478,717	\$151,583	\$36,428	\$4,198	\$917	\$7,612	\$4,114	\$2,144	\$4,121	\$211,117
2009	\$214,661	\$249,498	\$35,317	\$28,463 ¹⁷	\$4,321	\$532,260	\$166,815	\$38,905	\$4,620	\$979	\$8,130*	\$4,595	\$2,359	\$5,646	\$232,050
2014	\$237,320	\$273,498	\$39,132	\$31,119*	\$7,371	\$588,441	\$182,142	\$40,785	\$5,045	\$1,026	\$8,523*	\$5,260	\$2,576	\$7,754	\$253,112
2019	\$260,154	\$296,673	\$43,017	\$33,637*	\$11,575	\$645,057	\$197,283	\$42,102	\$5,464	\$1,059	\$8,798*	\$6,077	\$2,790	\$10,344	\$273,917
2024	\$282,610	\$318,512	\$46,878	\$35,956*	\$16,782	\$700,738	\$212,023	\$42,865	\$5,872	\$1,079	\$8,958*	\$7,027	\$2,999	\$13,352	\$294,174
2029	\$304,005	\$338,212	\$50,604	\$37,975*	\$22,990	\$753,788	\$226,095	\$43,026	\$6,262	\$1,083	\$8,991*	\$8,101	\$3,198	\$16,756	\$313,510
% growth	57.5%	49.9%	59.5%	47.4%*	798.5%	57.5%	49.2%	18.1%	49.2%	18.1%	18.1%	96.9%	49.2%	306.6%	48.5%

¹² Figures included non-insured health services for non-registered individuals on IA, estimated at 36.5%, the same level as IA for FN on-reserve.

¹³ Figures include (1) FNIHB-funded on-reserve primary health services in all First Nation communities, with the exception of those mentioned in footnote 7, (2) NIHB for individuals not eligible for registration and FSH IA, (2) INAC and AHF health expenditures for all non-registered individuals.

¹⁴ Figures include NIHB for First Nations.

¹⁵ Figures include non-insured health benefits for non-registered individuals on IA, estimated at 29.6%, the same level as IA for First Nations off-reserve.

¹⁶ Figures include services and programs funded off-reserve by INAC, AHF and NIHB for all individuals not eligible for registration or FSH IA.

¹⁷ *The Aboriginal Healing Foundation funds community-based projects that address the mental, emotional, physical and spiritual realms of life. This program is due to sunset by 2007. Given the scarcity of investments in mental health services for First Nations, we assume that the expenditures associated with this program will be taken on by another funder thereafter. On-reserve, given the scarcity of investment in mental health services, we assume that unmet needs may result in greater emergency services as a result of harm to self and to others. Off-reserve, we assume a greater reliance on mental health services provided by the RHAs. These shifts in the type of services were not quantified and expenditures were not reallocated for this exercise.

Based on these assumptions, it appears that,

1. Bill C-31 will result in a rapid growth in the number of non-registered individuals living on-reserve (at least as children).
2. **Impact on Manitoba Health** Assuming that current policies remain constant, there will be no direct financial impact.
3. **Impact on FNIHB-funded on-reserve primary health care services in isolated and remote isolated communities (NIHB not included)** Currently, FNIHB assumes the financial responsibility for the delivery of on-reserve health services (excluding NIHB) for isolated and remote isolated communities. In all other communities, FNIHB assumes that provincial access to care is sufficient and expects these individuals to seek care within the provincial system. Assuming status quo in policy, Bill C-31 will not impact FNIHB's obligations for isolated and remote isolated communities for any programs except NIHB.
4. **Impact on on-reserve First Nation health organizations and individuals in non-isolated and semi-isolated communities (NIHB not included)** Many First Nation organizations extend their services beyond the population for which they are funded, for compassionate or practical reasons (Lavoie et al. 2005). Bill C-31 will increase the on-reserve population that may be served by First Nation Health Organizations without corresponding funding, thereby stretching already limited resources. **This implies a potential reduction in access to primary health care.**

The alternative is that these non-status individuals will be directed to access primary health care through the RHAs. This will either necessitate an increase in RHA funding to accommodate increased demand, or increased demand can be expected to stretch RHA resources.

5. **Non-insured health benefits, on-reserve** Bill C-31 will shift the responsibility for non-insured health benefits from FNIHB to INAC for non-registered individuals on IA. Individuals not eligible for IA will have to cover their own costs or acquire private insurance. This shift may place some pressure on on-reserve social assistance programs, which may find themselves unfunded yet morally obligated to provide services to non-registered children of First Nation members for compassionate or practical reasons.
6. **Non-insured health benefits, off-reserve** Bill C-31 will shift the responsibility for non-insured health benefits from FNIHB to FSH for non-registered individuals on IA. Individuals not eligible for IA will have to cover their own costs or acquire private insurance.
7. **Overall impact on FNIHB (on and off-reserve expenditures)** Bill C-31 will slow down the growth of FNIHB health expenditures from 57.5 percent to 45.5 percent over 20 years.
8. **Impact on INAC (on-reserve)** Bill C-31 will increase the growth of INAC health expenditures on-reserve from 57.5 percent to 59.5 percent over 20 years.
9. **Impact on FSH (off-reserve)** The rapid growth in the number of individuals not eligible for registration will impact FSH, which provides non-insured health benefits for those on IA living off-reserve. For these benefits alone, FSH will be responsible for an estimated additional \$4 million annually by 2029, in non-insured health benefits alone.

10. Impact on individuals Bill C-31 will shift the responsibility for NIHB onto individuals and private insurance carriers.

11. Sunsetting of the Aboriginal Healing Foundation The Aboriginal Healing Foundation funds community-based projects that address the mental, emotional, physical and spiritual realms of life. This program is due to sunset by 2007. Given the scarcity of investments in mental health services for First Nations (Elias & Greyeyes 1999, Mignone et al. 2003) and the documented needs (First Nation and Inuit Regional Health Survey National Committee 2005), expenditures associated with this program may be taken on by another funder after the program ends. If not, financial responsibility will either fall to individuals or they will do without the care. Given current programs and policies, it is fair to assume that on-reserve residents' mental health needs will continue to be largely unmet, and that residents will continue to express distress through self-harm or harm to others, with associated higher hospitalization. It is likely that off-reserve residents will place more pressure on RHA mental health services.

c. Projections of First Nation Health Expenditures taking into account changes in prevalence rates

We were asked to project future health service utilization for First Nation residents based on reductions in prevalence rates based on explicit assumptions.

We did not attempt to forecast prevalence or utilization rates over the next 25 years, for which no data exist. Instead, we attempted to answer a series of questions that may be useful for planning purposes.

1. Since people are living longer, do we need to expand the number of beds in long term care facilities for seniors? Do we know whether those facilities or beds should be located on- or off-reserve, or in the north or south? What further data is necessary?
2. If First Nation people used hospitals at the same rate as the rest of the population, how much money could be saved by 2029? Does it make sense to invest some of the potential savings now to provide better primary health care in order to keep people out of the hospital?
3. If hospitalizations for complications due to diabetes could be reduced to the same rate as that of the rest of the population, how much money could be saved? Should some of that potential savings be reallocated to primary health care?
4. If hospitalizations for accidents and injuries could be reduced to the same rate as that of the rest of the population, how much money could be saved? Should some portion of that potential savings be spent on education programs to reduce such hospitalizations?
5. The number of hospitalizations due to violence towards self or others is much higher in the First Nation population than in the rest of the population. Should we spend more on community-based mental health services to avoid some of those hospital days?

For each of these exercises, the answer is complicated by the fact that different agencies are responsible for providing hospital services, primary health care and long-term care for registered and non-registered First Nation residents. To realize potential savings requires an extraordinary degree of cooperation between agencies. Will FNIHB

be prepared to increase expenditure on primary health care in order to reduce Manitoba Health expenditure on hospital beds?

i. Personal Care Homes and Long-Term Care

Little research has been done on how First Nation residents of Manitoba make decisions about long-term care. Do people want to stay in place as they age, or would they rather return to their home communities or move to a larger centre? Does where their children live affect their decisions? Is a Personal Care Home an appropriate model of housing, or would families prefer to keep aging family members in their own home? What are the current practices? How are jurisdictional issues impacting these practices? Planning housing for seniors involves more than demographic projections.

Nevertheless, some things are known. According to the Manitoba Bureau of Statistics, there are currently 6,500 First Nation people over 65. By 2026, those numbers are expected to increase to 19,000, a 300% increase over 22 years. MBS did not provide north-south or on- off-reserve breakdowns (Manitoba Bureau of Statistics 2005). Bill C-31 will have little impact on this group.

Some research on family preferences for location of housing is required to know where facilities should be built or expanded.

ii. Costs associated with hospital care

A combination of much poorer health status and poorer access to primary care means that registered First Nation people have higher hospitalization rates and spend more days in hospital than other Manitobans. In 2002, the Manitoba Centre for Health Policy estimated that registered First Nation people have twice the hospitalization rate as other Manitobans (348 vs. 156 per thousand per year). Total days of hospital care for Registered First Nation people are 1.7 times that of other Manitobans (1.75 days per person vs. 1.05 days per person) (Martens et al. 2002).

Assuming that hospital costs are roughly proportional to days in the hospital, per-person costs for hospital care are currently 70% higher for First Nation people than for other Manitobans. If the number of days spent in hospital by registered First Nation people could be reduced to the number of hospital days required by the rest of the population, Manitoba Health could have saved \$989 per FN person, or \$113 million dollars in 2004. By 2029, the potential savings in 2004 dollars would increase to more than \$190 million per year. Over 25 years, this excess cost imposed by poorer health and poorer access for First Nation people will cost Manitoba Health almost \$3.8 billion dollars.

These estimates are based on the total number of registered First Nations and people of First Nation descent who are not eligible for registration under current interpretations of Bill C-31. There is no reason to believe that the health of people will improve simply because they are denied eligibility for registration, and Manitoba Health is responsible for providing hospital care to all Manitobans.

If some portion of that \$190 million dollars per year, or \$3.8 billion dollars over 25 years, were to be reallocated to primary care programs of demonstrated efficacy, then overall savings for Manitoba Health could be significant. Some of these higher costs are associated with longer hospital stays for people from remote communities. Greater efficiencies in the delivery of health services should be explored.

iii. Costs associated with Diabetes

In 1995, the cost of diabetes and its complications to the Manitoba health care system was estimated to be \$193 million per year, or 18% of the total health care budget. Costs were estimated to increase by 130% for all Manitobans and by 330% for Registered First Nation people by 2025 (Hallett et al. 2000, Jacobs et al. 2000).

Type 2 diabetes is a chronic disease with a complicated aetiology. Heredity, obesity, physical activity, diet and metabolic factors have all been identified as risk factors. While there is some evidence that education programs focusing on diet are having some effect (Hallett et al. 2000), it is unlikely that the prevalence of this condition can be reduced significantly in 25 years.

Much of the morbidity associated with diagnoses of diabetes, however, can be prevented much more directly. Complications due to diabetes are significant and debilitating. They include kidney failure, cardiovascular disease, blindness, lower limb amputation, increased susceptibility to infection, and increased risk of tuberculosis reactivation. None of these are inevitable, and all can be significantly reduced by appropriate management in a primary care setting.

The Manitoba Centre for Health Policy estimated that amputation related to diabetes complications is sixteen times higher (3.1 vs. 0.19 per thousand for ages 20 through 79) for Registered First Nation people in Manitoba relative to the rest of the population (Martens et al. 2002, p. 155). There is, as yet, no estimate available of the total costs (including transportation and rehabilitation) associated with lower limb amputations due to complications of diabetes in Manitoba. It would be useful to know by how much the costs of avoidable lower limb amputations would exceed the costs of funding an adequate foot care program.

Costs associated with complications due to diabetes can also be addressed through a more seamless delivery of health care services, which depends on the cooperation between different agencies providing health services. For example, cooperation has, in recent years, led to the creation of dialysis units near where people live. Such initiatives will not only reduce the personal hardship associated with relocation for medical services, it will significantly reduce overall costs to the system. This model might be used to reduce costs associated with other complications due to diabetes.

iv. Accidents and Injuries

Approximately 11% of all hospitalizations among First Nation people are due to accidents and injuries (Martens et al. 2002, Tables C-4 and C-5).¹⁸ No data are available about the costs or the number of hospital days associated with accidents and injuries among this population. If we can assume that 11% of hospital costs are associated with accidents and injuries, that translates into approximately \$185 per person, or \$21 million in 2004. By 2029, that will increase to approximately \$36 million in 2004 dollars.

¹⁸ The Martens et al. study defined injury based on the ICD-9CM E Codes, and included all injuries resulting from an external cause: motor vehicle accidents, all other vehicle accidents, poisoning, falls, fire related accidents, accidents related to natural and environmental factors (exposure for example), drowning, suffocation or choking, violence to self or by others, etc. (Martens et al. 2002).

Over 25 years, hospital costs alone associated with accidents and injuries in the Registered First Nation population will exceed \$713 million.

Nearly one-third of hospitalizations among registered First Nation people are associated with violence by others (17.1%) and violence towards oneself (14.5%). Violence by others is estimated to account for approximately \$122 million in hospital costs alone over 25 years, and violence towards oneself will be responsible for \$103 million, measured in 2004 dollars.

To the extent that community-based mental health programs, and education programs, can be shown to impact hospitalization rates due to accidents and injuries, there are significant savings to be gained.

v. Opportunities and Challenges Facing First Nation Health Expenditures Over 25 Years

Potential costs associated with providing health services to First Nations residents in Manitoba over the next 25 years are significant. Delivery is complicated by jurisdictional issues whereby the federal government is responsible for the provision of primary health care on-reserve, the province off-reserve and the province for most hospital and physician services.

The examples considered above focus on hospital costs – the largest component of health care costs.

Hospital costs can be impacted significantly over the next 25 years by two factors:

1. Adequate primary health care can significantly reduce hospitalizations due to “ambulatory care sensitive conditions”¹⁹ – that is, complications that depend on whether adequate primary care is in place. An example is the lower limb amputation rate associated with diabetes. Even if the prevalence of diabetes is constant or increases over 25 years, adequate primary care can reduce lower limb amputations.
2. Cooperation between agencies can facilitate the efficient delivery of health services. For example, reductions in the hospitalization rate will benefit Manitoba Health, but the provision of better primary care will cost FNIHB. If gains to one agency exceed the costs to the other, the system is made more efficient. Cooperation, however, is necessary to realize those gains.

¹⁹ Namely asthma, angina, pelvic inflammatory disease, gastroenteritis, congestive heart failure, severe ear, nose and throat (ENT) infections, epilepsy, bacterial pneumonia, pulmonary/other tuberculosis, iron deficiency anemia, dental conditions and cellulitis (Manitoba Centre for Health Policy 2003).

Section 3, Recommendations

The purpose of this concluding Section is to speak to four related objectives, namely,

1. To identify limitations (shortcomings) of existing health care data systems for future fiscal analyses of health care utilization for First Nation residents in Manitoba.
2. To review fiscal data sources regarding the future ability to link expenditure levels to utilization levels of health care treatment services.
3. To provide recommendations for improved departmental reporting for such future fiscal analysis and health care utilization; and
4. To provide recommendations for improved management information systems for both Canada and Manitoba for future fiscal analysis and health care utilization for First Nation residents in Manitoba.

a. Limitations to existing health care data systems

1. Manitoba Health cannot readily track utilization of its programs by First Nation residents because of inconsistent identification of Status. In practice, this means that, while estimates can be made:
 - a. we cannot reliably track differential use of Manitoba Health programs such as long term care facilities,
 - b. we cannot know where and how First Nation residents access health care services (in their communities, in their RHAs, in other RHAs, in Winnipeg, out of province),
 - c. we cannot document access limitations to such specialized programs such as those offered by CancerCare,
 - d. we cannot use administrative data from Manitoba Health to estimate incidence and prevalence of particular health states among First Nations,
 - e. we cannot document differences in treatment protocols for First Nations and other Manitobans, and
 - f. we cannot track people moving between their communities and larger centres to access health care services.
2. Public data from Manitoba Health reports costs by cost centres, such as hospitals, medical remuneration, and so on. It does not report expenditure in categories meaningful for this type of fiscal analysis, where we would like to distinguish between primary care, secondary care, and so on.
3. Reporting categories are inconsistent across the RHAs, between the RHAs and Manitoba Health, and between all Manitoba Health programs and FNIHB. In practice, this means that:
 - a. we cannot compare administrative costs between providers in a meaningful way,
 - b. we cannot easily compare similar types of expenditure for on-reserve and off-reserve populations.
4. Public data from the various agencies is often not detailed enough to allow us to follow billings and reimbursements between agencies. For example, we know

that the Addictions Foundation of Manitoba is supposed to be reimbursed by FNIHB for residential treatment of First Nations. Neither AFM nor FNIHB reports in sufficient detail to allow us to follow the money.

5. Data is missing from a number of agencies, the Manitoba Public Insurance; Private Insurance Carriers, Corrections Services of Canada, Health Canada and FNIHB national offices who administer some small programs nationally, Workers Compensation Boards, Medical Transportation expenditures expended by the RCMP under the Mental Health Act, and expenditures from the Public Trustee for First Nations declared mentally incompetent. In some cases, the data do not exist because there is no First Nation identifier. In other cases, we became aware of these agencies' role later in the study. Most of these expenditures represent only a small portion of overall First Nation health expenditures. The role played by private insurance carriers, which may be significant, is out of scope for this exercise.
6. Finally, there are areas of fiscal dispute over roles and responsibilities arising from jurisdictional ambiguities. When it is not clear who has the responsibility to pay for a program, it is often difficult to determine in practice who does pay for the program, or even whether the program is available. For example, it is still unclear whether NNADAP beds for solvent addictions treatment are available to off-reserve First Nations. Similarly, EIA has documented expenditures for First Nations entitled to receive NIHB from FNIHB who nonetheless received coverage through EIA. In most cases it seems that individuals are receiving the care they try to access, but that the various agencies may be less than clear about who exactly is paying for it, or who ought to be paying for it.

b. Recommendations: Future improvements to data collection in view of facilitating linkage

There are three issues that must be considered when contemplating an expansion of existing data linkages. First, there is the matter of technical capacity. Can we find the data we need? Second, there is the issue of cost. In many cases, changing the way data are collected or presented costs little; in other cases, there are substantial costs involved. It only makes sense to contemplate changes when the additional information that would be generated is important enough to outweigh the costs involved. Third, some contemplated data linkages have a political component that extends far beyond the scope of this exercise. Here, we consider only matters of technical possibility and cost.

1. We recommend that the various agencies involved continue to explore the possibility of a linkage between the Manitoba Health administrative data and the Indian Registration System for Status verification (a process known as the Status Verification System or SVS). This linkage would allow:
 - a. reasonable estimates of prevalence and incidence of health conditions for First Nations, and comparisons between First Nations and all other Manitobans;
 - b. tracking of individuals as they access health services across systems and across the province;
 - c. estimates of whether First Nations use facilities such as personal care homes at the same rate as all other Manitobans, which would allow us to determine whether on-reserve facilities meet the needs of the population;

- d. identification of access difficulties for particular types of Manitoba Health services, such as those offered by CancerCare;
 - e. exploration of whether individuals living in communities under transfer are healthier or less healthy than individuals living in communities where care is delivered through other models;
 - f. exploration of potential or perceived differences in the ways that First Nations receive follow-up care relative to all other Manitobans;
 - g. detailed projections linking changes in health status to changes in utilization patterns over time.
2. As an extension of recommendation (1), we suggest that all agencies consider advocating the proposition that all health policy analysis and policy simulation in Manitoba **explicitly** consider the impact on First Nations. Gender-based analysis has become the norm at Health Canada and, as a consequence, much evidence concerning issues of gender equity and gender differences in health care has accumulated. In Manitoba, the same consideration should be extended to First Nations because of the size of the community. However, it is only feasible if the data exist in the first place.
 3. Manitoba Health could estimate, and make public, its expenditure on Primary Health Care, including primary care received from family physicians. Most people living off-reserve first access the health care system through their family physician. Investments in primary health care are generally recognized as cost-effective mechanisms to contain secondary and tertiary care costs. Because of the national focus on changing the ways in which primary care is delivered, this estimate would be useful. This would require aggregating existing data in a different manner for public release.
 4. All public agencies are criticized for administration costs. It would be beneficial if all agencies represented in this report could standardize their reporting of administrative costs. In many cases, administration costs are included in program costs. Where they are split out, there are significant differences in the ways that the costs are estimated. For example, only some of the RHAs report separately administration costs for community programs. Manitoba Health is quite clear about its central administration costs. Clear estimates, with clear documentation of the methodology provided, would no doubt allay some fears about unreasonable administration costs. We found no evidence of unreasonably high administrative costs.

c. Recommendations for further studies

1. Foot care: As mentioned earlier, Martens et al documented a very high number of amputations following complications from diabetes (Martens et al. 2002). On-reserve investment in foot care may yield considerable benefits. Current research undertaken by Dhiwya Attawar and Dr. Sharon Bruce,²⁰ Department of Community Health Sciences, University of Manitoba also show that changes in NIHB policies are hampering timely access to appropriate foot wear, a significant

²⁰ Attawar and Bruce, 2006, The politics of shoes, presentation made to the Society for Applied Anthropology, Vancouver.

contributor. A study should be conducted, to weight the potential savings that may be made by investing in appropriate foot care for diabetics.

2. The third goal of the Inter-governmental Primary Health Care Policy Framework on First Nation Health Care (The Inter-governmental Committee on First Nation Health (ICFNH) 2005) is to promote improved access to primary health care services. Alternative models of service delivery that minimise the need for transportation should be investigated. This could include an assessment of the costs, both in terms monetary and Quality of Life, of medical relocation.

Several policy makers stated that shifts between jurisdiction, i.e. when coverage for certain expenditures shifts from the province to the federal government or vice versa, are not always smooth. It appears that in at least some cases, agencies do not communicate or coordinate shifts in jurisdiction and coverage to ensure seamlessness. Clients may be advised that they no longer qualify for their coverage by one agency, and told to contact another government to ensure continued coverage. The extent of the problem remains unknown. The impact these issues have on First Nation individuals and their health coverage is also unknown. This should be investigated. All agencies have raised this as an issue. The barrier to resolving this appears to be the inflexibility built into more stringent accountability frameworks.

Appendix 1, Summary of Manitoba Health Core Health Services

This summary is based on the document *Core Health Services in Manitoba* published by Manitoba Health (Manitoba Health 1997). This document highlights services in 10 key areas, including:

1. Health Promotion /Education

Health promotion on lifestyle choices and practices, support to community groups and the promotion of smoke-free environments is provided in all health regions. Some communities also benefit from programs targeting specific risk factors or specific populations.

2. Health Protection

Health protection services safeguard the health and safety of the public, and are enforceable under the Manitoba Public Health Act. Each health region offers immunization programs; strategies for the management, control and prevention of communicable diseases; outbreak management, control and prevention; Medical Officer of Health services; and mandated environmental health services.

3. Prevention & Community Health Services

Prevention and community health services are directed at persons, families and groups in communities who are at risk of developing a health problem, disease or disorder, and at reducing hazardous environments. Specific services included reproductive health, pregnancy/childbirth and parenting; services to seniors; nutrition education; prevention of injury, chronic diseases and substance abuse/addictions (including tobacco); family health; oral health; hearing services; and diabetes education.

4. Treatment, Emergency and Diagnostic Services

The purpose of these services is to provide active treatment to reduce the impact of medical conditions or disorders. Services include primary care generally provided by general practitioners; secondary care provided by specialists; tertiary care requiring specialised diagnostic and treatment services provided by hospitals; quaternary services involving technically demanding level of acute inpatient care for people with rare or complex medical conditions; emergency services including ambulance services; and diagnostic services such as ECG and laboratory, for examples.

5. Developmental & Rehabilitation Support Services

These services are provided to improve and maintain the functional independence of clients with impaired functioning from injury, chronic disorder or disability. The services provided include rehabilitation (physiotherapy, occupational therapy, audiology, respiratory therapy, speech pathology, recreational therapy for examples) and early childhood intervention.

6. Home-based Care Services

These services include assessment; care planning and coordination; direct services including nursing services, therapy assessment, health teaching, personal care, meal preparation, respite and family relief, and access to adult day care; and process for managing long-term care placement.

7. Long Term Care

These services provided include personal care home, personal care home services for persons with special needs (e.g. Alzheimer), respite care in personal care homes, adult day care programs.

8. Mental Health Services

Services include assessment and identification services, acute care treatment, mobile crisis intervention services, crisis stabilization units, supportive housing, safe house, crisis lines, community day and ambulatory psychiatric care programs, etc.

9. Substance Abuse/Addictions

Services include access to detoxification, treatment and support, including temporary residence.

10. Palliative Care

Palliative care services are provided both in hospitals and in the home.

These services are accessible in all health regions. In addition, some services are in some communities only, to address specific common needs.

Appendix 2, Summary of Programs offered by the First Nations and Inuit Health Branch of Health Canada

Table 15, Summary of the FNIHB's Health Programs	
Addictions	National Native Alcohol and Drugs Addiction Program (NNADAP)- Residential Treatment Program: The NNADAP Residential Treatment Component is a national network of fifty-three treatment centers operated by First Nation organizations and/or communities to provide culturally appropriate in-patient and out-patient treatment services for alcohol and other substance abuse. There are three such Centres in Manitoba.
	National Native Alcohol and Drugs Addiction Program - Community-Based Program: Community-based prevention program that employs addiction prevention workers (NNADAP workers) in the provision of education and counseling services to First Nation and Inuit communities. Primary, secondary and tertiary prevention strategies are directed to community members.
	Solvent Abuse Program (SA): This program provides community-based prevention, intervention and in-patient treatment to youth solvent abusers. This includes a network of 10 solvent addictions treatment centers that provide culturally appropriate in-patient and out-patient treatment services to First Nation youth. One of these Centres operates in Manitoba.
	Tobacco Control Strategy (TCS): The overall purpose of the First Nation and Inuit Tobacco Control Strategy, a sub-component of the National Tobacco Control Program, is to reduce smoking rates among First Nation and Inuit with the long term goal of reducing tobacco induced illness and death among First Nation and Inuit. The First Nation and Inuit tobacco initiative focuses on: reducing consumption, especially among First Nation and Inuit youth, addressing preventable conditions through promotional activities, building on awareness levels, and respecting traditional tobacco use.
Children	Aboriginal Head Start On-Reserve (AHS): This initiative is an early intervention strategy that addresses the needs of young First Nation children, up to six years of age, who live in First Nation communities.
	Canada Prenatal Nutrition Program (CPNP): The Canada Prenatal Nutrition Program – First Nation and Inuit Component is a comprehensive community-based program that supports pregnant women who face conditions of risk that threaten their health and the development of their babies. The overall goal is to improve maternal and infant nutritional health with a particular focus on those at risk.
	FAS/FAE Initiative: This project-based initiative allows for a sustained national focus on FAS. It promotes improvements in the health of pregnant women at risk and their babies. The program is delivered through a number of national and regional projects. This is not a universal program and targeted calls for proposals are conducted yearly. Project activities focus on: prevention of FAS/FAE births, public awareness and education, FAS/FAE training and capacity building, development of practical tools for community-based programs, increased early identification and diagnosis, coordination and integration of services, and surveillance.

Table 15, Summary of the FNIHB's Health Programs

Chronic diseases	<p>Aboriginal Diabetes Initiative (ADI): As one of four components of the Canadian Diabetes Strategy (CDS), the Aboriginal Diabetes Initiative (ADI) addresses the epidemic of diabetes among Aboriginal people in three main areas: care and treatment; prevention and promotion; and lifestyle support. FNIHB regions administer the on-reserve portion of this program.</p>
Communicable Diseases	<p>Communicable Disease Control (CDC): This program provides the communicable disease component of public health services, including immunization, to First Nations on-reserve and Inuit in Inuit communities, consistent with communicable disease requirements of provincial/territorial health legislation. This includes surveillance activity, as well as, the reporting of communicable disease identified in the health acts of each province.</p> <p>HIV/AIDS Strategy: This program provides community-based HIV/AIDS education, prevention and related health services to First Nation people living on-reserve and Inuit living in Labrador and Quebec.</p> <p>Tuberculosis Elimination Strategy (TES): The Tuberculosis Elimination Strategy was introduced in 1992 to enhance the TB control program delivered within the communicable disease control program. The program includes typical elements of most national programs, such as case finding and holding, contact tracing and chemoprophylaxis, surveillance, immunization, health education and training, and research. As recommended by the World Health Organization, Directly Observed therapy (DOT) and Directly Observed Prophylaxis (DOP) is the standard of care. National responsibilities include policy-making, surveillance, and the production of an annual report. Activities such as case management, drug supply, maintenance of a TB registry, outbreak management, and community health education are centralized at the regional level, and implemented through primary health services at the community level.</p>
Community Health Services	<p>Brighter Futures (BF): Brighter Futures is a Canada-wide multifaceted program with an Aboriginal component designed to foster the health and social development of children, particularly young children at risk. The Aboriginal component is designed to assist First Nation and Inuit communities in developing community-based approaches to managing mental health and child development programs.</p> <p>Building Healthy Communities (BHC): Building Healthy Communities is designed to assist First Nation and Inuit communities in developing community-based approaches to managing mental health crisis management. This initiative provides funding for youth solvent abuse (see Solvent Abuse), home nursing, (see Home and Community Care) and transfer (see Health Services Transfer).</p> <p>Community Health Prevention & Promotion (CHPP): Community health prevention and promotion services offer a broad range of community-based activities that enhance the health and well-being of First Nation and Inuit. The activities are focused on health promotion and injury/illness prevention and include such programs as maternal and infant health, child health, school health, adolescent health and elder health.</p>

Table 15, Summary of the FNIHB's Health Programs

Community Health Services	<p>Community Health Primary Care (CHPC): Community health primary care services are provided to remote and/or isolated First Nation and Inuit communities where primary care services are not provided by provincial or regional health authorities. The first point of contact is the community health nurse practicing in an expanded scope of practice who is responsible for the assessment, intervention and determining the need for consultation for emergent, urgent and non-urgent health problems in these communities. Client education about prevention and health promotion is part of primary health care (see Community Health Prevention and Promotion). These services are based in nursing stations and community health centres with a treatment component. Physician visits constitute part of the primary health care team in First Nation and Inuit communities. This service is available 24/7 in the remote, isolated communities.</p> <p>Community Nutrition (CN): Nutrition expertise is provided to support First Nation and Inuit achieve optimal levels of nutritional health. Nutrition expertise is in place at the national and regional levels to provide advice, promotion and education focused in nutrition-related health and social issues. These issues include: chronic diseases, dental health, specific nutrient concerns, food security, traditional foods, etc. as they apply through the life cycle in a population health and health determinants context. A variety of levels of activity related to capacity building, advocacy, surveillance and research also fall within the purview of community nutrition.</p> <p>Dental/Oral Health Strategy (DOHS): The objective of the dental/oral health strategy is to improve the oral health status of the First Nation and Inuit peoples at a level comparable to other Canadians. To achieve this goal the dental/oral health program provides a broad range of preventive, restorative and oral health promotion programs and activities to support First Nation and Inuit communities in their efforts to reduce, eliminate or prevent oral diseases. This includes supporting the delivery of community based dental care services provided through salaried dental staff or contract providers. It also includes the promotion of First Nation and Inuit individuals on oral health professional training programs such as dental therapists.</p> <p>First Nations and Inuit Home and Community Care Program (FNIHCCP): The objective of the First Nation and Inuit Home and Community Care program is to implement or enhance home and community care. This is comprised of a continuum of services, under First Nation and Inuit control, that are culturally sensitive, accessible, comprehensive and effective and which responds to the unique health and social needs of First Nation and Inuit.</p> <p>Health Facilities Construction, Operations and Maintenance: FNIHB requires health facilities from which to provide health services to assist First Nations and Inuit to obtain a standard of care comparable to that of other Canadians. The program can include the construction, repair, renovation and replacement of health facilities such as: nursing stations, health centre, health stations, health offices and National Native Alcohol & Drug Abuse Treatment Centres and, staff accommodations in isolated locations.</p>
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Table 15, Summary of the FNIHB's Health Programs

Community Health	<p>Support Services to Nursing: Support services are provided to regional managers and nurses to enhance the delivery of nursing services. These services are centrally or regionally funded and include: national nursing human resource planning, Critical Incident Stress Management Services (CISMS), a national education program designed to meet the competencies for Nursing Scope of Practice for nurses in First Nation and Inuit communities, a national competency assessment program, and provision of national clinical guidelines for primary care.</p>
Environmental Health	<p>Environmental Health Program: Environmental health is a proactive and preventive program which serves as a primary line of defense against environmental and occupational diseases, contaminants and injuries. It involves the identification of hazards, risk assessment, risk communication and prevention.</p> <p>Environmental Contaminants Program: This is a research program to assess health risks associated with environmental contaminants and to assess environmental contaminant exposure and associated risk in First Nation and Inuit communities.</p> <p>Transportation of Dangerous Goods: This program provides for the management of biomedical waste and the transportation of dangerous goods that occur as a result of the delivery of health services in First Nation communities. This is done by training and certifying regional FNIHB health care facility staff and environmental health officers under the Transportation of Dangerous Good Regulations in order to handle and prepare these substances for transport and dispose of substances.</p>
Capacity Development	<p>Health Careers: The Indian and Inuit Health Careers Program (IIHCP) provides program contributions to support Aboriginal participation in education leading to professional careers in the health field. The program is designed to address career needs at the national, regional and community levels. At the Regional level annual allocations are provided to support community based IIHCP activities, which include: education in health sciences; the promotion of health careers; the coordination of cooperative post secondary programs; the coordination of career related summer employment; the implementation of special native student support programs; and Indian and Inuit community initiatives for post secondary education in the health services.</p> <p>Health Services Transfer: This is a program designed to transfer control of health programs from regional or national control to the First Nation and Inuit communities.²¹</p> <p>Integrated option: This program is an alternative to transfer, and share similar features which providing somewhat less flexibility in local financial allocation.²²</p>

²¹ FNIHB program compendium includes transfer as a program under capacity development.

²² FNIHB Program Compendium does not include information on the integrated model. This was added by the authors.

Table 15, Summary of the FNIHB's Health Programs

Health Information	<p>First Nations and Inuit Health Information System (FNIHIS): This is an initiative designed to contribute to the development of a First Nation and Inuit Infostructure. The FNIHIS provides First Nation and Inuit communities with the basic infrastructure and capacity to track and manage health issues on par and in cooperation with other systems accessible to other client groups. The FNIHIS begins automating what was once a completely paper-based system of record keeping. It contains information about Status and non-status First Nation and Inuit residents of all provinces who access health services on-reserve. Information includes name, address, gender, date of birth, residency and status. It may also include Band registration number, Provincial health car number, immunization status, as well as data pertaining to reportable and chronic diseases, mortality, medication, medication allergy and adverse reaction, medical test and exams, maternal and psycho-social indicators.</p>
NIHB	<p>Non-Insured Health Benefits: The Non-Insured Health Benefits (NIHB) program provides a range of medically necessary goods and services, which supplement benefits provided through other private or provincial/territorial programs, medical supplies and medical equipment, short term mental health services and transportation to access medical services. This program is offered to First Nations living on- and off-reserve.</p>

Appendix 3, Summary of Indian and Northern Affairs Canada's Health-related Programs

Table 16, Summary from INAC health-related programs

First Nations Water Management Strategy: NAC and Health Canada developed the First Nation Water Management Strategy to ensure that water and wastewater facilities in First Nation communities are brought up to standards. This program focuses on infrastructure upgrade.

National Child Benefit Reinvestment: The First Nations' National Child Benefit Reinvestment (NCBR) initiative provides an opportunity to First Nations to develop projects that will address child poverty which exist in their individual community. The initiative is flexible enough to allow First Nations to choose different ways to improve the well-being of low-income families. Communities can decide which priority they would like to see addressed during the course of a given year. There is a wide range of activities that can be undertaken, such as hot lunch program for school children, improving employability of parents, cultural awareness, etc.

Adult Care Program: The main objective of the Adult Care program is to assist First Nation people with functional limitations (because of age, health problems or disability), to maintain their independence, to maximize their level of functioning, and to live in conditions of health and safety. There are three components to the Adult Care program: in-home care, which provides homemaker services; foster care, which provides supervision and care in a family setting; and institutional care, which provides services in Types I and II institutions. Type I is residential care for individuals requiring only limited supervision and assistance with daily living activities for short periods of time each day, and Type II is extended care for individuals requiring some personal care on a 24 hour basis, under medical and nursing supervision. Individuals requiring more intensive levels of medical care (ie. Types III, IV and V) are considered the responsibility of health authorities.

Family Care: The DIAND First Nation Family Violence Prevention Program is one component of Social Policy & Programs, which include Child & Family Services, Social Assistance, Adult Care, the National Child Benefit program and other social services that address individual and family well-being. As part of the 1991-1995 Family Violence Initiative, DIAND was provided funds to provide shelter services and family violence prevention projects for First Nation people living on-reserve. When Cabinet authority for funding the original initiative expired in 1995, DIAND continued to fund the Family Violence Prevention Program as a priority.

Appendix 4, Summary of Programs delivered by the Public Health Agency of Canada

Table 17, Programs offered by PHAC (off-reserve only)
<p>The Community Action Program for Children (CAPC) provides long term funding to community coalitions to deliver programs that address the health and development of children (0-6 years) who are living in conditions of risk. It recognizes that communities have the ability to identify and respond to the needs of children and places a strong emphasis on partnerships and community capacity building.</p>
<p>The Aboriginal Head Start (AHS) program is a Health Canada-funded, early intervention strategy for First Nations, Inuit and Métis children and their families living in urban centres and large northern communities. Aboriginal Head Start projects typically provide structured half-day preschool experiences that prepare young Aboriginal children for their school years by meeting their spiritual, emotional, intellectual and physical needs.</p>
<p>The Canada Prenatal Nutrition Program (CPNP): CPNP funds community groups to develop or enhance programs for vulnerable pregnant women. Through a community development approach, the CPNP aims to reduce the incidence of unhealthy birth weights, improve the health of both infant and mother and encourage breastfeeding.</p>
<p>The Fetal Alcohol Spectrum Disorder (FASD) funds community-based activities related to coordination; public awareness and education; training and capacity development; early identification and diagnosis of FAS.</p>
<p>AIDS Community Action Program (ACAP) supports the continuing local, provincial and territorial community-based response to the existing and emerging issues associated with HIV/AIDS.</p>
<p>The Hepatitis C Prevention, Research and Support Program (HepC) funds both Manitoba-wide intersectorial initiatives and community-based programs. Intersectorial programs target Hep C prevention in the inmate (federal and provincial) population by focusing on fostering partnerships and awareness amongst care givers (Partners in Caring program) and promoting harm reduction after release (Harm Reduction initiative). Community-based initiatives focusing on prevention and community-based support are also funded.</p>
<p>The Diabetes Prevention and Promotion Initiative (DPPI) complements two programs: the Aboriginal Diabetes Initiative (ADI, administered by FNIHB) and the Métis, Off-Reserve Aboriginal and Urban Inuit Prevention and Promotion Program (MOAUIPP, administered by FNIHB-Central office). Accordingly, the mandate of DPPI focuses on non-Aboriginal Canadians. PHAC is clear that Aboriginal organizations should apply to ADI or MOAUIPP for community-based prevention activities. PHAC is however aware that Aboriginal people may be users of community-based services under DPPI, but does not collect data to that effect.</p>
<p>The goal of the Population Health Fund (PHF) is to increase community capacity for action on or across the determinants of health. Current priorities are announced during project solicitation processes, generally in a Request for Proposals or a solicitation letter.</p>

Appendix 5, Funding Map of Service Payers for First Nations living on- and off-reserve

Table 18, Payers of services for First Nation population living on-reserve				
	Manitoba Health/RHAs	FNIHB	INAC	Others
1. Professional Services:				
1.1 Physicians	MH, paid through fee for service (F/S) & Alternate payment	FNIHB pays a guaranteed payment for F/S.	N/A	N/A
1.2 Chiropractic	MH up to 12 visits per year limited to spinal column, pelvis and extremities.	N/A	N/A	N/A
1.3 Optometric/ ophthalmologic care (examination)	MH provides \$32.40 towards the cost of an examination once every two years for patients under the age of 19 and over 64. MH also provides free examination for all ages if deemed medically necessary. Medical necessity is defined in very limited terms.	NIHB will cover the cost of a routine eye exam every two years. NIHB covers the costs associated with examinations not covered by Manitoba Health (most optometric or ophthalmology examination costs exceeds \$32.40. Eyeglasses are provided once every two years. Eye glasses repairs are covered. Lenses may be replaced sooner if the prescription changes by 0.5 diopter	N/A	N/A

Table 18, Payers of services for First Nation population living on-reserve				
	Manitoba Health/RHAs	FNIHB	INAC	Others
1.4 Audiology	MH pays only for in hospital based programs, no F/S	NIHB will cover the cost of assessment, fitting (ear mold), and follow-up. Ottawa-based consultants assist in selection, approval, and follow-up.	N/A	N/A
1.5 Podiatry/Chiroprody	Foot care is paid for if provided in hospital. MH does not pay for podiatry or chiroprody	On-reserve podiatry may be available if prioritised by the FN.	N/A	N/A
1.6 In-hospital dental care (oral surgery)	MH covers the cost associated with hospital use	FNIHB NIHB covers the cost of the dental procedure	N/A	N/A
1.7 Dental Treatment outside of hospital	No MH coverage (same for all Manitoban residents).	FNIHB NIHB, for services provided outside of hospitals. Coverage includes diagnostic, preventive, restorative, endodontic, periodontic, prosthodontic services, oral surgery, orthodontic services and adjunctive services (sedation).	N/A	N/A
2. Acute Care Hospital Services:				
2.1 Primary Level	All night bed utilization that occurs on-reserve is paid by MH to FNIHB on a F/S.	FNIHB for client stabilisation before transportation.	N/A	N/A
2.2 Secondary Level	MH, physician and in-hospital services covered through IBB	FNIHB has hospital financing commitments in Norway House and Nelson House.	N/A	N/A
2.3 Tertiary Level	MH, physician and in-hospital services covered through IBB	N/A	N/A	N/A
2.4 Quarternary Level (eq, transplant)	MH, physician and in-hospital services covered through IBB	N/A	N/A	N/A
2.5 Emergency	N/A	FNIHB for client stabilisation in	N/A	N/A

Table 18, Payers of services for First Nation population living on-reserve				
	Manitoba Health/RHAs	FNIHB	INAC	Others
Services (out of hospital)		view of transportation.		
3. Promotion of Health & Prevention of Illness & Injury:				
3.1 Birthing & Parenting	N/A	FNIHB	N/A	N/A
3.2 Family Health	N/A	FNIHB	N/A	N/A
3.3 Dental Health	N/A	FNIHB	N/A	N/A
3.4 School Health	N/A	FNIHB	N/A	N/A
3.5 Screening & Counseling for Heredity Disease	RHAs, services accessible off-reserve only through specialists	N/A	N/A	N/A
3.6 Suicide Prevention	N/A	FNIHB	N/A	N/A
3.7 Nutritional Health	N/A	FNIHB	N/A	N/A
3.8 Sexual & Reproductive Health	N/A	FNIHB	N/A	N/A
3.9 Prevention of Chronic Disease	N/A	FNIHB	N/A	N/A
3.10 Healthy Lifestyles	N/A	FNIHB	N/A	N/A
3.11 Workplace Safety	N/A	Unclear	N/A	N/A
4. Protection of Health:				
4.1 Public Health Inspector & Monitoring (environmental contaminants, transportation of dangerous goods)	N/A	FNIHB provides on-reserve Environmental Health programs, including water monitoring, the transportation of dangerous goods, and the Green Plan	First Nation Water Management Strategy (infrastructure development and upgrade)	N/A

Table 18, Payers of services for First Nation population living on-reserve				
	Manitoba Health/RHAs	FNIHB	INAC	Others
4.2 Immunization: Includes community-based and Physician-based immunisation services (see vaccines under the category "drug")	MH if the immunization occurs off-reserve. MH, physicians are covered through IBB, public health nurses can provide immunisation (RHA)	FNIHB, if the immunization occurs on-reserve	N/A	N/A
4.3 Communicable Disease	Notification and follow up is MH Public Health.	FNIHB for on-reserve contact tracing.	N/A	N/A
4.4 Food and Drug Safety (restaurant, institution and food preparation)	N/A	FNIHB	N/A	N/A

Table 18, Payers of services for First Nation population living on-reserve				
	Manitoba Health/RHAs	FNIHB	INAC	Others
5. Home/Community-Based Services:				
5.1 Care Coordination/ Assessment	N/A	FNIHB funds the Home and Community Care program in communities that have applied for the funding. This program provides assessment and nursing services to eligible clients. Communities that do not apply for this program have no Home Care program.	N/A	N/A
5.2 Nursing	N/A		N/A	N/A
5.3 Other Professional Health Services	MH if services are accessed in hospital, off-reserve.	May include nutrition, podiatry, or other services provided by the FN.	N/A	N/A
5.4 Personal Care Services	N/A	FNIHB funds home care workers to assist in home living.	N/A	N/A
5.5 Home Support/Homemaking	N/A	N/A	Assisted Living program provides non-medical support to clients with regard to daily activities.	N/A
5.6 Nursing Homes/Homes for the Aged/Special Care Homes Personal Care Homes	According to FNIHB and INAC, MH is responsible for the cost of care for levels III & IV even if delivered on-reserve. However, most/all on-reserve facilities are not provincially licensed, therefore MH refuses to cover the cost of care.	FNIHB funds home and community care services that may in practice support on-reserve personal care home clients. However, FNIHB's position is that institutional services are provincial jurisdictions.	INAC provides for residential costs for levels I and II.	N/A
5.7 Chronic Care Hospitals	MH	N/A	N/A	N/A
5.8 Respite Care	Respite care available through Personal Care Homes??	Is this program used by FN living on-reserve? FNIHB coverage?	N/A	N/A

Table 18, Payers of services for First Nation population living on-reserve				
	Manitoba Health/RHAs	FNIHB	INAC	Others
5.9 Palliative Care (home-based)	N/A	On-reserve services provide some level of palliative care (Home and Community Care program), however this can create some scope of practice issues.	N/A	N/A
6. Community Rehabilitation:				
6.1 Physiotherapy	Hospital-based programs only.	FNIHB pays for some physiotherapy services through the NMU contract.	N/A	N/A
6.2 Speech & Language	Hospital-based programs only.	N/A	N/A	N/A
6.3 Other Rehabilitation	Hospital-based programs only.	N/A	N/A	N/A
7. Aids to Persons with Physical Disabilities				
7.1 Hearing Aids ²³	MH covers 80% of the cost of hearing aids for children under the age of 18 up to a defined maximum.	NIHB will cover the hearing aid (analog, digital, no attachments), dispensing fee NIHB will not pay hearing aids selected for cosmetic reasons (smaller and more expensive) but may cost share with the client.	N/A	N/A
7.2 Visual Aids	MH provides partial reimbursement for prosthetic eyes and infant contact lenses.	NIHB covers the cost for eye prosthesis (artificial eye)	N/A	N/A
7.3 Communication Aids	MH provides profoundly deaf or speech impaired residents partial assistance with the cost of communication devices	Not provided	N/A	N/A

²³ Although First Nation children under the age of 18 could get partial coverage through Manitoba Health, in practice, Manitoba Health's requirement that the cost be paid up front and refunded means that First Nations utilise the NIHB program instead.

Table 18, Payers of services for First Nation population living on-reserve				
	Manitoba Health/RHAs	FNIHB	INAC	Others
	(adapted telephones).			
7.4 Orthotic/ Prosthetic Devices	MH provides no reimbursement for breast prosthesis for First Nations. MH does provide surgical brassieres, orthopaedic shoes if under the age of 18, limb prosthetic devices and services (100% reimbursement), limb and spinal orthotic devices and services (100% reimbursement).	NIHB provides certain orthotic, custom footwear and prosthetic devices.	N/A	N/A
7.5 Respiratory Equipment & Supplies	MH provides home oxygen supplies. MH provides equipment to assist clients with sleep apnea.	NIHB provides oxygen, respiratory therapy as well as portable tanks to ensure continued mobility. NIHB covers the cost of rental for the treatment of sleep apnea while clients are on the provincial waiting list.	N/A	N/A
7.6 Wheelchair, Mobility Aids & Seating	According to program specs, Manitoba Wheelchair services Society for Manitobans with Disabilities provides wheelchairs to all Manitoba residents. (Manitoba Family Services and Housing 2005) This benefit is however not extended to First Nations.	NIHB provides wheelchairs and walkers. NIHB covers the cost of chair repairs, although the service is provided by the province.	N/A	N/A

Table 18, Payers of services for First Nation population living on-reserve				
	Manitoba Health/RHAs	FNIHB	INAC	Others
7.7 Other Supplies & Equipment	MH covers the cost of ostomy bags up to \$300 per year. Other supplies are limited.	NIHB costs additional costs associated with ostomy bags. It also covers bandages, dressings, pressure garments. Tray fees are covered by NIHB for out-patient procedures.	N/A	N/A
7.8 Children/Adults with special needs	N/A	Eligible NIHB benefits only.	Bands receive a 3% allocation above their IA budget to cover special needs. Decisions are made by the Bands, who must submit justification. The IA provides additional funding for dietary needs, including special diets and supplements (Ensure, Boost). INAC will cover necessary items not covered under NIHB.	N/A
8. Mental Health Services:				
8.1 Community-Based	N/A	Limited services provided with funding from FNIHB, by paraprofessionals (NNADAP+BHC/BF program). NIHB covers up to 12 sessions per year for counseling (provided by psychologist or social workers).	N/A	N/A
8.2 Family-Based or individual	N/A	Limited services provided with funding from FNIHB, by paraprofessionals (NNADAP+BHC/BF program). NIHB covers up to 12 sessions per year for counseling (provided by psychologist or social workers).	N/A	N/A

Table 18, Payers of services for First Nation population living on-reserve				
	Manitoba Health/RHAs	FNIHB	INAC	Others
8.3 Psychiatric care	MH under IBB	N/A	N/A	N/A
8.4 Institutional mental health services	MH	N/A	N/A	N/A
8.5 Family Violence	N/A	N/A	Family Violence Prevention Program for First Nations funds activities and shelters on-reserve	N/A
9. Services for Alcohol & Other Drug Abuse:				
9.1 Services for Gambling Addiction	N/A	FNIHB for counseling and in-patient treatment	N/A	N/A
9.2 Alcohol and Drugs	N/A	FNIHB for counseling and in-patient treatment	N/A	N/A
9.3 Tobacco	N/A	Tobacco Control Strategy program can provide some funding to communities.	N/A	N/A
9.4 Other	N/A	FNIHB (solvent) for counseling and in-patient treatment	N/A	N/A
10. Drug Benefits:	MH, Coverage through Pharmacare, in Personal Care Homes, in hospital. Palliative care drugs available through the palliative drug program (100%) coverage)	FNIHB, NIHB, coverage includes lowest cost alternative prescription drugs and approved over-the-counter medication	N/A	FSH covers the cost of FNIHB for on-reserve non-FN on social assistance.

	Manitoba Health/RHAs	FNIHB	INAC	Others
11. Medical transportation including ambulance Services:	Interfacility transfer covered by MH if the transfer is for less than 24 hours (diagnostic services). Air ambulance may be insured if under Manitoba Lifeflight Air Ambulance. Under the Northern Patient Transportation Program, patients located north of the 53rd parallel are covered.	FNIHB through NIHB, covers the costs of land and water transportation, scheduled and chartered airlines, road and air ambulance, meals and lodging, escort and interpreters. Interfacility transfer covered by FNIHB if the transfer is from a lower to a higher level of care centre. FNIHB will not cover transfers from a higher to a lower level of care centre. Out of province transportation is covered only if MH covers hospital and treatment costs. NIHB covers urban accommodation and in-city transportation. ²⁴	N/A	FSH covers the cost of FNIHB for on-reserve non-FN on social assistance.
12. Health Services to Children with Special Needs	N/A	Regular level of services available within the community. Eligible NIHB are covered.	The Assisted Living Program provides additional health-related support to children with higher needs.	N/A
13. Diagnostic Services	Provided off-reserve and funded through the RHAs	N/A	N/A	N/A
14. FNs leaving the reserve to access health care	N/A	FNIHB covers the costs associated with meals, accommodation and in-city transportation if not covered by the province for up to a three month transition period only. A weekly food allowance may be provided.	N/A	N/A

²⁴ Patient boarding homes are funded through financial agreements with the Department of Public Works.

Table 18, Payers of services for First Nation population living on-reserve				
	Manitoba Health/RHAs	FNIHB	INAC	Others
15. Telehealth	To be determined	To be determined	N/A	N/A
16. Health services administration ²⁵	Estimated based on level of responsibilities for services delivered on-reserve	Estimated based on level of responsibilities for services delivered on-reserve	Estimated based on level of responsibilities for services delivered on-reserve	N/A?

²⁵ Prorated figure based on First Nation population.

Table 19, Payers of services for First Nations living off-reserve				
Type of services	Manitoba Health/RHAs	Health Canada	INAC	Family Services & Housing/Others
1. Professional Services:				
1.1 Physicians	MH, paid through fee for service (F/S) & Alternate payment	N/A	N/A	N/A
1.2 Chiropractic	MH up to 12 visits per year limited to spinal column, pelvis and extremities.	N/A	N/A	N/A
1.3 Optometric/ ophthalmologic care (examination)	MH provides \$32.40 towards the cost of an examination once every two years for patients under the age of 19 and over 64. MH also provides free examination for all ages if deemed medically necessary. Medical necessity is defined in very limited terms.	FNIHB: NIHB will cover the cost of a routine eye exam every two years. NIHB covers the costs associated with examinations not covered by Manitoba Health (most optometric or ophthalmology examination costs exceeds \$32.40. Eyeglasses are provided once every two years. Eye glasses repairs are covered. Lenses may be replaced sooner if the prescription changes by 0.5 diopter	N/A	<u>FNs on Social Assistance:</u> FNIHB contends that it is the payer of last resort, and refuses to cover FN on social Assistance for this service. FSH also claims to be the payer of last resort and refuse to cover FN on EIA. Jurisdiction unclear
1.4 Audiology	MH pays only for in hospital based programs, no F/S	<u>FNs who are not on Social assistance:</u> FNIHB NIHB will cover the cost of assessment, fitting (ear mold), and follow-up. Ottawa-based consultants assist in selection, approval, and follow-up.	N/A	<u>FNs on Social Assistance:</u> FNIHB contends that it is the payer of last resort, and refuses to cover FN on social Assistance for this service. FSH also claims to be the payer of last resort and refuse to cover FN on EIA. Jurisdiction unclear

Table 19, Payers of services for First Nations living off-reserve				
Type of services	Manitoba Health/RHAs	Health Canada	INAC	Family Services & Housing/Others
1.5 Podiatry/Chiroprody	Foot care is paid for if provided in hospital. MH does not pay for podiatry or chiroprody	N/A	N/A	N/A
1.6 In-hospital dental care (oral surgery)	MH covers the cost associated with hospital use	FNIHB NIHB covers the cost of the dental procedure	N/A	N/A
1.7 Dental Treatment outside of hospital	No MH coverage (same for all Manitoban residents).	FNIHB NIHB, for services provided outside of hospitals. Coverage includes diagnostic, preventive, restorative, endodontic, periodontic, prosthodontic services, oral surgery, orthodontic services and adjunctive services (sedation).	N/A	<u>FNs on Social Assistance:</u> FNIHB contends that it is the payer of last resort, and refuses to cover FN on social Assistance for this service. FSH also claims to be the payer of last resort and refuse to cover FN on EIA. Jurisdiction unclear
2. Acute Care Hospital Services:				
2.1 Primary Level	MH, physician and in-hospital services covered through Insured Benefit Branch (IBB)	N/A	N/A	N/A
2.2 Secondary Level	MH, physician and in-hospital services covered through IBB	N/A	N/A	N/A
2.3 Tertiary Level	MH, physician and in-hospital services covered through IBB	N/A	N/A	N/A
2.4 Quarternary Level (eg, transplant)	MH, physician and in-hospital services covered through IBB	N/A	N/A	N/A
2.5 Emergency Services (out of hospital)	RHAs Emergency responses	FNIHB : Ambulance services paid via NIHB	N/A	N/A
3. Promotion of Health & Prevention of Illness & Injury:				
3.1 Birthing & Parenting	RHAs	PHAC funds the Community actions Program for Children	N/A	N/A

Table 19, Payers of services for First Nations living off-reserve				
Type of services	Manitoba Health/RHAs	Health Canada	INAC	Family Services & Housing/Others
		(CAPC), the Canadian Prenatal Nutrition Program (CPNP) and Aboriginal Head Start (AHS).		
3.2 Family Health	RHAs		N/A	N/A
3.3 Dental Health	None provided	N/A	N/A	N/A
3.4 School Health	RHAs	N/A	N/A	N/A
3.5 Screening & Counseling for Heredity Disease	RHAs	N/A	N/A	N/A
3.6 Suicide Prevention	RHAs	N/A	N/A	N/A
3.7 Nutritional Health	RHAs	N/A	N/A	N/A
3.8 Sexual & Reproductive Health	RHAs	PHAC funds proposal-driven community-based programs in areas of Hep C and HIV/AIDS.	N/A	N/A
3.9 Prevention of Chronic Disease	RHAs	FNIHB Ottawa funds the Métis, Off-Reserve Aboriginal and Urban Inuit Prevention and Promotion Program (MOAUIPP).	N/A	N/A
3.10 Healthy Lifestyles	RHAs	PHAC funds the Population Health Funds for community-based initiatives.	N/A	N/A
3.11 Workplace Safety	RHAs	N/A	N/A	Provided by the Manitoba Dept of Labour

Table 19, Payers of services for First Nations living off-reserve				
Type of services	Manitoba Health/RHAs	Health Canada	INAC	Family Services & Housing/Others
4. Protection of Health:				
4.1 Public Health Inspector & Monitoring (environmental contaminants, transportation of dangerous goods)	RHAs	N/A	N/A	N/A
4.2 Immunization: Includes community-based and Physician-based immunisation services (see vaccines under the category "drug")	MH, physicians are covered through IBB, public health nurses can provide immunisation (RHA)	N/A	N/A	N/A
4.3 Communicable Disease	This service is provided by RHAs.	N/A	N/A	N/A
4.4 Food and Drug Safety (restaurant, institution and food preparation)	Dept of Conservation	N/A	N/A	N/A
5. Home/Community-Based Services:				
5.1 Care Coordination/ Assessment	RHAs	N/A	N/A	N/A
5.2 Nursing	RHAs	N/A	N/A	N/A
5.3 Other	RHAs	N/A	N/A	N/A

Type of services	Manitoba Health/RHAs	Health Canada	INAC	Family Services & Housing/Others
Professional Health Services				
5.4 Personal Care Services	RHAs	N/A	N/A	N/A
5.5 Home Support/Homemaking	RHAs	N/A	N/A	N/A
5.6 Nursing Homes/Homes for the Aged/Special Care Homes Personal Care Homes	The cost of care is provided by MH.	N/A	INAC covers FN ordinarily living on-reserve only. ²⁶ Further, INAC covers costs only for FN under 65 and on Income Assistance (IA, through INAC). ²⁷ In exceptions, INAC will cover residential costs for clients under 65 and not on IA if it is shown that they cannot cover the residential costs from an alternative source (income, insurance, etc.). In such cases, INAC sees itself as the payer of last resort.	Residence and comfort allocations are covered either from the provincial EIA if the client is eligible, or from their pension.
5.7 Chronic Care Hospitals	MH	N/A	N/A	N/A
5.8 Respite Care	Respite care available through the Dept of Family Services, Personal Care Homes and Family Respite through Home Care.	N/A	N/A	N/A

²⁶ According to the new INAC Assisted Living Program Manual, "Ordinarily Resident On-Reserve" refers to individuals who, although they may be absent for a period of time for purposes related to education, health or other services of a temporary nature unavailable on-reserve, maintain their primary residence on-reserve. (Indian and Northern Affairs Canada 2004)

²⁷ FN's over 65 are expected to cover residential costs through their pension.

Table 19, Payers of services for First Nations living off-reserve

Type of services	Manitoba Health/RHAs	Health Canada	INAC	Family Services & Housing/Others
5.9 Palliative Care (home-based)	RHAs (education mostly)	N/A	N/A	N/A
6. Community Rehabilitation:				
6.1 Physiotherapy	Hospital-based programs only.	N/A	N/A	N/A
6.2 Speech & Language	Hospital-based programs only.	N/A	N/A	N/A
6.3 Other Rehabilitation	Hospital-based programs only.	N/A	N/A	N/A
7. Aids to Persons with Physical Disabilities				
7.1 Hearing Aids ²⁸	MH covers 80% of the cost of hearing aids for children under the age of 18 up to a defined maximum.	<u>FNIHB: FNs who are not on Social Assistance:</u> the hearing aid (digital, no attachments), dispensing fee NIHB will not pay for hearing aids selected for cosmetic reasons (smaller and more expensive) but may cost share with the client.	N/A	<u>FNs on Social Assistance:</u> FNIHB contends that it is the payer of last resort, and refuses to cover FN on social Assistance for this service. FSH also claims to be the payer of last resort and refuse to cover FN on EIA. Jurisdiction unclear
7.2 Visual Aids	MH provides partial reimbursement for prosthetic eyes and infant contact lenses.	FNIHB NIHB covers the cost for eye prosthesis (artificial eye)	N/A	<u>FNs on Social Assistance:</u> FNIHB contends that it is the payer of last resort, and refuses to cover FN on social Assistance for this service. FSH also claims to be the payer of last resort and refuse to cover FN EIA. Jurisdiction unclear
7.3	MH provides profoundly deaf or	Not provided	N/A	<u>FNs on Social Assistance:</u>

²⁸ Although First Nation children under the age of 18 could get partial coverage through Manitoba Health, in practice, Manitoba Health's requirement that the cost be paid up front and refunded means that First Nations utilize the NIHB program instead.

Type of services	Manitoba Health/RHAs	Health Canada	INAC	Family Services & Housing/Others
Communication Aids	speech impaired residents partial assistance with the cost of communication devices (adapted telephones).			FNIHB contends that it is the payer of last resort, and refuses to cover FN social Assistance for this service. FSH also claims to be the payer of last resort and refuse to cover FN on EIA. Jurisdiction unclear.
7.4 Orthotic/ Prosthetic Devices	MH provides partial reimbursement for breast prosthesis and surgical brassieres, orthopaedic shoes if under the age of 18, limb prosthetic devices and services (100% reimbursement), limb and spinal orthotic devices and services (100% reimbursement).	FNIHB NIHB provides certain orthotic, custom footwear and prosthetic devices.	N/A	<u>FNs on Social Assistance:</u> FNIHB contends that it is the payer of last resort, and refuses to cover FN on social Assistance for this service. FSH also claims to be the payer of last resort and refuse to cover FN on EIA. Jurisdiction unclear
7.5 Respiratory Equipment & Supplies	MH provides home oxygen supplies. MH provides equipment to assist clients with sleep apnea.	FNIHB NIHB provides oxygen, respiratory therapy as well as portable tanks to ensure continued mobility. NIHB covers the cost of rental for the treatment of sleep apnea while clients are on the provincial waiting list.	N/A	<u>FNs on Social Assistance:</u> FNIHB contends that it is the payer of last resort, and refuses to cover FN on social Assistance for this service. FSH also claims to be the payer of last resort and refuse to cover FN on EIA. Jurisdiction unclear

Table 19, Payers of services for First Nations living off-reserve

Type of services	Manitoba Health/RHAs	Health Canada	INAC	Family Services & Housing/Others
7.6 Wheelchair, Mobility Aids & Seating	According to program specs, MH provides wheelchairs to all residents. This benefit is however not extended to First Nations.	FNIHB NIHB provides wheelchairs and walkers. NIHB covers the cost of chair repairs, although the service is provided by the province.	N/A	<u>FNs on Social Assistance:</u> FNIHB contends that it is the payer of last resort, and refuses to cover FN on social Assistance for this service. FSH also claims to be the payer of last resort and refuse to cover FN on EIA. Jurisdiction unclear
7.7 Other Supplies & Equipment	MH covers the cost of ostomy bags up to \$300 per year. Other supplies are limited.	FNIHB NIHB costs additional costs associated with ostomy bags. It also covers bandages, dressings, pressure garments. Tray fees are covered by NIHB for out-patient procedures.	N/A	<u>FNs on Social Assistance:</u> FNIHB contends that it is the payer of last resort, and refuses to cover FN on social Assistance for this service. FSH also claims to be the payer of last resort and refuse to cover FN on EIA. Jurisdiction unclear
7.8 Children/Adults with special needs	Regular costs of care.	FNIHB: Eligible NIHB only.	INAC will cover additional costs from children in care if these children come from reserves. The costs covered are for necessary items not covered by MH or FNIHB NIHB, as identified by CFS agencies. In such cases, INAC sees itself as the payer of last resort.	N/A
8. Mental Health Services:				
8.1 Community-Based	RHA based community mental health workers, with child & adolescent, adult, elderly and proctor services.	FNIHB NIHB covers up to 12 sessions per year for counseling (provided by psychologist or social workers.	N/A	Unclear whether the off-reserve FN population of social assistance is covered via NIHB or FSH.

Table 19, Payers of services for First Nations living off-reserve

Type of services	Manitoba Health/RHAs	Health Canada	INAC	Family Services & Housing/Others
8.2 Family-Based or individual	RHA based community mental health workers	FNIHB NIHB covers up to 12 sessions per year for counseling (provided by psychologist or social workers.	N/A	Unclear whether the off-reserve FN population of social assistance is covered via NIHB or FSH.
8.3 Psychiatric care	MH under IBB	N/A	N/A	N/A
8.4 Institutional mental health services	MH	N/A	N/A	N/A
8.5 Family Violence	RHAs	N/A	N/A	N/A
9. Services for Alcohol & Other Drug Abuse:				
9.1 Services for Gambling Addiction	MH funds Addictions Foundation of Manitoba which provides counseling and offer in-patient treatment services.	FNIHB pays for FN accessing off-reserve AFM-provided treatment.	N/A	N/A
9.2 Alcohol and Drugs	MH funds Addictions Foundation of Manitoba which provides counseling and offer in-patient treatment services.	FNIHB pays for FN accessing off-reserve AFM-provided treatment. PHAC funds the Fetal Alcohol Spectrum Program (FASD).	INAC will pay for CFS children in need to alcohol/drug treatment if NNADAP beds are already filled (payer of last resort).	N/A
9.3 Tobacco	RHAs provide tobacco cessation programs	N/A	N/A	N/A
9.4 Other	MH funds Addictions Foundation of Manitoba which provides counseling and offer in-patient treatment services.	N/A	Unclear whether solvent abuse treatment centers are accessible to the off-reserve First Nation population. INAC will pay for CFS children in need to alcohol/drug treatment if NNADAP beds are already filled (payer of last resort).	N/A

Type of services	Manitoba Health/RHAs	Health Canada	INAC	Family Services & Housing/Others
10. Drug Benefits:	MH, Coverage through Pharmacare, in Personal Care Homes, in hospital. Palliative care drugs available through the palliative drug program (100%) coverage)	FNIHB, NIHB, coverage includes lowest cost alternative prescription drugs and approved over-the-counter medication	N/A	N/A
11. Medical transportation including ambulance Services:	Interfacility transfer covered by MH if the transfer is for less than 24 hours (diagnostic services). Air ambulance may be insured if under Manitoba Lifelight Air Ambulance. Under the Northern Patient Transportation Program, patients located north of the 53rd parallel are covered. FNIHB through NIHB apparently provides	FNIHB: Medical taxis are not available through NIHB for off-reserve/outside community First Nations. Ambulance costs are however covered. FNIHB: Interfacility transfer covered by FNIHB if the transfer is from a lower to a higher level of care centre. FNIHB will not cover transfers from a higher to a lower level of care centre. Out of province transportation is covered only if MH covers the hospital treatment costs.	N/A	N/A
12. Health Services to Children with Special Needs	N/A	Eligible NIHB are covered.	May be some responsibilities associated with children living in a foster care situation	Additional coverage for FN on Social Assistance living off-reserve but not in foster care
13. Diagnostic Services	Provided off-reserve and funded through the RHAs	N/A	N/A	N/A

Type of services	Manitoba Health/RHAs	Health Canada	INAC	Family Services & Housing/Others
14. FNs leaving the reserve to access health care	Costs of primary, secondary and tertiary care delivered off-reserve.	FNIHB covers the costs associated with meals, accommodation and in-city transportation if not covered by the province for up to a three month transition period only. A weekly food allowance may be provided.	INAC will cover the costs of means and accommodations for the first three months under the IA program. Thereafter, INAC assumes that the provincial EIA will provide coverage. This is however contentious, as FSH now requires FN to have a permanent home off-reserve in order to assume coverage. ²⁹	N/A
15. Telehealth	Services provided through the provincial network for off-reserve population.	N/A	N/A	N/A
16. Health services administration³⁰	Estimated based on per capita off-reserve population	FNIHB: Estimated based on per capita off-reserve population, for NIHB only	Estimated based on per capita off-reserve population, for LTC only	Estimated based on per capita off-reserve population

²⁹ There is no funding provided to help the family relocate to access health care. This is an important gap. Although numbers are not available, it appears that some families are placing their child with special health care needs in care off-reserve to ensure that the required health services are accessible.

³⁰ Prorated figure based on First Nation population.

Appendix 6, Manitoba Health and RHAs expenditures

a. Manitoba Health

Total estimate 2003/04 = \$3,036,988.9

Appropriation	2003/04 (\$000s)
21-1A Minister's Salary	
21-1B Executive Support	
21-1C Finance	
21-1D Central Services	
21-1 Total	7,429.9
21-2 Health Accountability, policy and planning	20,430.4
21-3 Health Workforce	9,800.0
21-4 Regional Programs and Services	9,565.5
21-5 Provincial Health Programs	62,164.2
21.6 Health Insurance Fund	2,840,249.3
21.7 Addictions Foundation Manitoba	12,834.7
21.8 Capital Grants	95,058.4
21.9 Amortization and other costs related to capital assets	2,827.4
Total Appropriation 21	3,060,359.8

Manitoba Health Services Insurance Plan

Program	2003/04 \$000
Facilities and Health Authorities ³¹	2,070,904
Medical ³²	588,112
Provincial Programs ³³	91,487
Pharmacare	184,805
Total	2,935,308

³¹ Includes federal hospitals/nursing stations, Northern Medical Unit and others.

³² Includes fee-for-service, alternate payments, private laboratory and x-ray facilities, Oral, Dental, and Periodontal Surgery, as well as Chiropractic and Optometric.

³³ Includes out of province facilities, blood transfusion services, federal hospitals, prosthetic and Orthotic devices, healthy communities development, and nursing recruitment and retention initiatives.

Line 1 above (facilities and health authorities) includes:

	2003/04 (\$)
Amocs Inc	538,513
Canadian Blood Agency	44,570,045
Centre de Santé St. Boniface	1,566,840
Community Therapy Services Inc.	84,319
Department of Clinical Health Psych (UM)	319,636
Locum Tenens Program	307,200
Out-of-province	24,167,003
Pinaow Wachi	276,770
UMG	1,861,594
Northern Medical Unit	6,381,999
Total	80,073,919

Federal Hospitals/Nursing Stations

Hodgson-Percy E. Moore, Hospital	810,590
Norway House Hospital	662,570
Bloodvein NS	3,630
Brochet NS	2,604
Cross Lake NS	34,942
Garden Hill NS	13,655
God's Lake NS	12,826
Lac Brochet NS	5,332
Little Grand Rapids NS	8,904
Nelson House NS	4,712
Oxford House NS	13,059
Poplar River NS	1,860
Pukatawagan NS	39,928
Red Sucker Lake NS	3,472
Shamatawa NS	13,640
South Indian Lake NS	7,552
Split Lake NS	29,748
Ste Theresa NS	16,093
Wasagamack NS	7,139
Total Federal Hospitals/Nursing Stations	1,692,256
All facilities and Regional Health Authorities	2,293,437,619

b. RHA total budgets and expenditures

RHA Expenditure, Fiscal 2003-04

	WRHA	Brandon	North Eastman	South Eastman	Interlake	Central	Assiniboine	Parkland	Norman	Burntwood	Churchill
Acute Care	843,921,734 ³⁴	87,460,371	9,344,840	15,234,690	20,994,203	48,013,132	38,067,038	36,214,377	26,234,876	23,050,565	5,966,038
LTC	273,190,214	20,061,634	11,502,267	14,925,705	18,236,029	39,418,457	41,592,307	26,601,272	7,008,047		
Home Care	129,105,000	4,784,925	4,627,352	9,460,723	9,326,738	13,466,163	9,618,233	9,003,968	4,196,023	1,183,188 ³⁵	82,686
Medical Remuneration	107,269,000	8,100,788	2,209,643	3,252,187	5,135,003	10,086,678	9,944,685	3,402,463	7,918,551	11,030,423	592,054
Community-based health services	24,127,000	3,258,701	4,293,129	3,754,691	6,627,372	5,336,456	4,247,241	8,944,991	2,681,148	4,147,993	499,408
Land Ambulance	5,231,376	213,708	1,536,651	1,354,339	3,566,503	4,029,593	3,638,322	2,216,927	1,429,786	227,928	221,209
Community-based mental health	7,510,000	9,242,859		1,446,226	3,012,496	6,971,498	1,408,012		829,988	473,863	501,420 ³⁶
Community-based therapy	698,000				N/A separately	1,382,935	741,497		343,845		
NPTP			142,480						4,120,624	4,835,520	855,764
Community-based services administration		805,116	1,989,490	1,015,423	N/A separately	N/A separately	493,983	1,266,100	507,437	1,559,668	
Other/ undistributed		14,274,674	4,084,130	2,856,867	11,752,613	15,183,915	12,437,146	9,060,289	4,661,964 ³⁷	1,926,097	591,714
Total	1,512,802,000³⁸	148,202,776	39,729,982	55,570,851	78,650,959	143,888,827	122,188,464	96,710,387	62,437,773	48,425,245	9,310,313³⁹

³⁴ WRHA estimates for acute care, LTC and emergency response/land ambulance come from the MB Health estimates. WRHA financial statements do not allow these to be separated out.

³⁵ Home Care plus support to seniors.

³⁶ Includes funding for addictions program of \$62,863.

³⁷ Includes 625,558 for Rosaire House Addictions Centre.

³⁸ The entries do not sum to the total because of differences in categories reported.

³⁹ Excludes separately funded programs: Receiving Home (335,969), Nunavut services (77,431), Baby First and Healthy Baby (37,961).

RHA Revenues—2003-04

	WRHA	Brandon	North Eastman	South Eastman	Interlake	Central	Assiniboine	Parkland	Norman	Burntwood	Churchill
MB Health Operating	1,435,483,000	128,892,140	32,934,000	47,758,604	68,207,938	119,540,771	100,254,602	82,316,118	48,662,711	44,416,562	7,603,744
Authorized/ residential charges	9,122,000		1,627,110	664,819	2,815,643	10,951,177	11,704,727	6,723,949		361,584	
Non-insured income	3,093,000	6,125,360	2,543,431	3,773,909	4,819,922				5,411,912		
Amortization of deferred contributions/ Interest/ donations	30,683,000	5,246,214	1,555,877	2,259,716	2,488,893	5,675,549	4,030,958	3,269,651	2,345,731	1,052,563	451,780
Other Income	38,761,000	4,173,319				4,423,318	3,017,548	4,012,753	3,418,477	949,563	741,903
Ancillary		3,061,868	350,641		166,536	2,218,050	1,298,735		1,602,061	798,383	5,783
NPTP Recovery										1,242,689	989,448
Federal Gov't				495,417							414,104
Province of MB				578,449		1,257,159	1,332,189				139,130
Total	1,517,142,000	147,498,901	39,011,059	55,530,914	78,498,932	144,066,024	121,638,759	96,322,471	61,440,892	48,821,344	10,345,892

RHA COSTS OF ADMINISTRATION FOR COMMUNITY PROGRAMS
(where available)

(where available)	admin costs	population	per capita admin
Brandon	805116	48612	16.56
North Eastman	1989490	39837	49.94
South Eastman	1015423	58618	17.32
Assiniboine	493983	69371	7.12
Parkland	1266100	42396	29.86
Norman	507437	24902	20.38
Burntwood	1559668	45238	34.48
Total	7637217	328974	23.22

Appendix 7, FNIHB Health Expenditures

Table 20, Summary from FNIHB programs budget and expenditures

PROGRAM NAME	Expenditures				Per cap	Per cap	
	Contribution Agreements	Transfer & Integrated	Salaries	O&M	Total	72330	adjusted
Addictions							
National Native Alcohol and Drugs Addiction Program - Residential Treatment Program	\$761,211		\$59,273	\$70,432	\$890,916	\$12	\$12
National Native Alcohol and Drugs Addiction Program - Community-Based Program	\$1,666,171	\$4,054,296			\$5,720,467	\$79	\$76
Solvent Abuse Program	\$2,612,153	\$694,599			\$3,306,752	\$46	\$44
Tobacco Control Strategy	\$74,000		\$55,733	\$100,791	\$230,524	\$3	\$3
Children					\$0		\$0
Aboriginal Head Start On-Reserve	\$4,983,366		\$99,198	\$119,080	\$5,201,644	\$72	\$69
Canada Prenatal Nutrition Program	\$949,386	\$652,867	\$208,848	\$226,597	\$2,037,698	\$28	\$27
FAS/FAE Initiative	\$200,000		incl under NNADAP		\$200,000	\$3	\$3
Chronic diseases					\$0		\$0
Aboriginal Diabetes Initiative	\$1,155,965		\$95,270	\$57,409	\$1,308,644	\$18	\$17
Communicable diseases					\$0		\$0
Communicable Disease Control			\$25,693	\$78,263	\$103,956	\$1	\$1
HIV/AIDS Strategy	\$335,976			\$42,062	\$378,038	\$5	\$5
Tuberculosis Elimination Strategy			\$355,087	\$396,178	\$751,265	\$10	\$10
Community Health Services					\$0		\$0
Brighter Futures	\$2,359,360	\$4,280,964	\$111,084	\$145,019	\$6,896,427	\$95	\$91
Mental Health	\$2,170,678	\$3,528,031			\$5,698,709	\$79	\$75
Mental Health (NIHB)			\$89,633	\$111,967	\$201,600	\$3	\$3
Community Health Prevention & Promotion (CHR)	\$1,555,795	\$2,714,010			\$4,269,805	\$59	\$56
Community Health Prevention & Promotion (Nursing)	\$930,512	\$5,000,000	\$15,661,486	\$13,398,872	\$34,990,870	\$484	\$462
Community Health Primary Care, Care & Treatment	\$518,392		\$43,559	\$157,122	\$719,073	\$10	\$10
Planning and Evaluation			\$163,756	\$10,488	\$174,244	\$2	\$2
Medical Health Officer			\$490,185	\$84,932	\$575,117	\$8	\$8
Norway House & Percy Moore Hospitals			\$5,109,478	\$1,938,851	\$7,048,329	\$97	\$93
Dental/Oral Health Strategy		\$790,039	\$1,490,165	\$756,151	\$3,036,355	\$42	\$40
First Nations and Inuit Home and Community Care Program, including home care nursing	\$13,302,332	\$349,942	\$196,612	\$72,194	\$13,921,080	\$192	\$184
Health Facilities Construction, Operations and Maintenance	\$2,372,818	\$1,371,977			\$3,744,795	\$52	\$49
Support Services (Nursing, Health Liaison, Coordinator)	\$992,135	\$1,394,615			\$2,386,750	\$33	\$32

Table 20, Summary from FNIHB programs budget and expenditures

PROGRAM NAME	Expenditures					Per cap	Per cap
	Contribution Agreements	Transfer & Integrated	Salaries	O&M	Total	72330	adjusted
Environmental Health					\$0		\$0
Environmental Health Program	\$883,003	\$215,320	\$369,363	\$498,432	\$1,966,118	\$27	\$26
Environmental Contaminants Program	\$70,000				\$70,000	\$1	\$1
Capacity Development					\$0		\$0
Health Careers	\$83,958	\$27,500			\$111,458	\$2	\$1
Health Information					\$0		\$0
First Nations and Inuit Health Information System	\$317,306		\$351,504	\$201,919	\$870,729	\$12	\$12
Others					\$0		\$0
Indian Residential Schools	\$25,000		\$27,085	\$17,055	\$69,140	\$1	\$1
Health consultations	\$595,754				\$595,754	\$8	\$8
Directorate - Transfer & Integrated Agreements		\$11,412,486			\$11,412,486	\$158	\$151
Nursing Administration			\$436,491	\$566,117	\$1,002,608	\$14	\$13
Directorate - Transfer Programs Administration			\$510,552	\$237,419	\$747,971	\$10	\$10
Directorate - Regional HQ			\$338,252	\$462,632	\$800,884	\$11	\$11
Subtotal - Community service delivery	\$38,915,271	\$36,486,646	\$23,729,919	\$17,478,177	\$116,610,013	\$1,644	\$1,571
Subtotal - Regional Service Coordination			\$1,273,093	\$1,005,637			
Subtotal - FNIHB Administration expenditures			\$1,285,295	\$1,266,168	\$2,551,463	\$35	\$34
Total Expenditures	\$38,915,271	\$36,486,646	\$26,288,307	\$19,749,982	\$121,440,206	\$1,679	\$1,605

Table 21, Summary from FNIHB NIHB expenditures on- and off-reserve

							Per cap on-reserve	Per capita off-reserve
Non-Insured Health Benefits Category	Contribution Agreements	Pilot Projects	Expenditures	Salaries	O&M	Total	72330	42489
Transportation	\$15,391,730	\$2,218,433	\$35,472,531			\$53,082,694	\$552	\$309
Pharmacy		\$146,834	\$48,371,966			\$48,518,800	\$423	\$421
Dental	\$3,055,404	\$328,982	\$13,928,961			\$17,313,347	\$168	\$121
Mental Health	\$1,282,826	\$273,899	\$3,984,871			\$5,541,596	\$56	\$35
Vision Care	\$537,574	\$131,339	\$2,218,718			\$2,887,631	\$29	\$19
Medical Premium			\$17,672			\$17,672	\$0	\$0
Referrals	\$367,728					\$367,728	\$5	\$0
Administration	\$120,080		\$24,014	\$778,549	\$217,252	\$1,139,895	\$14	\$9
Total	\$20,755,342	\$3,099,487	\$104,018,733			\$127,873,562	\$1,248	\$914

Appendix 8, Population Estimates

These numbers reconcile:

Manitoba Bureau of Statistics. 2005. *Manitoba's Aboriginal Community. A 2001 to 2026 Population and Demographic Profile*. MBS 2005-4.

Manitoba Health, Health Information Management Branch, 2004. *Population Report June 1, 2004*

Indian Affairs and Northern Development. 2005. *Registered Indian Population by Sex and Residence 2004*. Rep. QS-3620-010-EE-A1, Catalogue No.: R31-3/2004E, Minister of Public Works and Government Services Canada, Ottawa

a. Population Estimates – Various Sources

Table 22, Summary of population estimates, various sources		
	2003-04 Population	Annual Growth (2001-2017)
MB Population	1,169,667 ⁴⁰ 1,170,268 ⁴¹	MB 0.8% ⁴²
First Nations -- Manitoba	118,410 ⁴³ 77,145 ⁴⁴ 108,400 ⁴⁵ 116,380 ⁴⁶	MB 2.3% ⁴⁷ Winnipeg 2.3% ⁴⁸ North 1.2% ⁴⁹ South 2.8% ⁵⁰
First Nations – off-reserve	43,833 (37%) ⁵¹ 43,034 (37%) ⁵²	
First Nations – on-reserve	74,577 (63%) ⁵³ 73,346 (63%) ⁵⁴	

The apparent discrepancy between INAC and MBS estimates of the total FN population may stem from an undercount of Bill C31 reinstatements by MBS (see MBS 2005, p. 9).

⁴⁰ (Manitoba Health 2003).

⁴¹ (Manitoba Bureau of Statistics 2005)

⁴² 2001-2017 Average Annual Growth Rate (Manitoba Bureau of Statistics 2005).

⁴³ (Indian Affairs and Northern Development 2005)

⁴⁴ (Manitoba Health 2003)

⁴⁵ (Manitoba Bureau of Statistics 2005)

⁴⁶ Health Canada (FNIHB, Manitoba Region): SVS Population by RHA (June 2004).

⁴⁷ 2001-2017 Average Annual Growth Rate (Manitoba Bureau of Statistics 2005).

⁴⁸ 2001-2017 Average Annual Growth Rate (Manitoba Bureau of Statistics 2005).

⁴⁹ 2001-2017 Average Annual Growth Rate (Manitoba Bureau of Statistics 2005).

⁵⁰ 2001-2017 Average Annual Growth Rate (Manitoba Bureau of Statistics 2005).

⁵¹ (Indian Affairs and Northern Development 2005)

⁵² Health Canada (FNIHB, Manitoba Region): SVS Population by RHA (June 2004).

⁵³ (Indian Affairs and Northern Development 2005)

⁵⁴ Health Canada (FNIHB, Manitoba Region): SVS Population by RHA (June 2004).

b. Manitoba Health Population Estimates by RHA

Table 23, Manitoba Health population estimates by RHAs (Manitoba Health 2003)			
RHA	Non-FN and off-reserve FN ⁵⁵	On-reserve FN	Reserves
Winnipeg	663,443		
Brandon	48,612		
North Eastman	34,736	5101	Berens River, Bloodvein, Hollow Water, Little Black River, Little Grand Rapids, Poplar River, Sagkeeng (Fort Alexander)
South Eastman	58,613	5	Buffalo Point
Interlake	71,087	5,313	Brokenhead, Dauphin River, Fisher River, Kinonjeoshtegon (Jackhead), Lake Manitoba, Lake St. Martin, Little Saskatchewan, Peguis, Pinaymootang (Fairford)
Central	96,239	3,635	Dakota Plains, Dakota Tipi, Long Plain, Roseau River, Sandy Bay, Swan Lake
Assiniboine	66,684	2,687	Birdtail Sioux, Conupawakpa Dakota (Oak Lake), Gamblers, Keeseekoowenin, Rolling River, Sioux Valley, Waywayseecappo
Parkland	39,749	2,647	O-Chi-Chak-Ko-Sipi (Crane River), Ebb&Flow, Pine Creek, Sapotaweyak (Shoal River), Skownan (Waterhen), Tootinaowazibeeng (Valley River), Wuskwi Sipiik (Indian Birch)
Norman	21,228	3,674	Chemawawin (Easterville), Grand Rapids, Mathias Colomb (Pukatawagan), Mosakahiken (Moose Lake), Opaskwayak (The Pas)
Burntwood	22,843	22,395	Barren Lands, Cross Lake, Fox Lake, Garden Hill, Gods Lake, Minto Sipi (God's River), Marcel Colomb, Nisichawayasihk (Nelson House), Northlands, Norway House, Bunibonibee (Oxford House), Red Sucker Lake, Sayisi Dene (Tadoule Lake), Shamattawa, St. Theresa Point, Tataskweyak (Split Lake), War Lake, Wasagamack, York Factory
Churchill	976		
Total	1,124,210	45,457	1,169,667

The overall population estimate is credible, but there seems to be an undercount of on-reserve First Nations when these figures are compared to INAC estimates. Overall, MB

⁵⁵ This report does not distinguish between off-reserve and non-FN population. **

Health underestimates the FN population both on- and off-reserve, compared with INAC and MBS.

c. RHA Population Estimates adjusted by 2004 INAC Population Figures

Since MB Health total provincial population estimates are credible, we adjusted on-reserve FN estimates in each RHA to accord with INAC estimates, and reduced the non-FN/off-reserve estimates by the same amount. FNIHB on-reserve estimates, accurate as of June 2004) are bracketed.

RHA	Non-FN and off-reserve FN	On-reserve FN	Reserves
Winnipeg	663,443		
Brandon	48,612		
North Eastman	30,764	9,073 (8,256)	Berens River, Bloodvein, Hollow Water, Little Black River, Little Grand Rapids, Poplar River, Sagkeeng (Fort Alexander)
South Eastman	58,575	43	Buffalo Point
Interlake	66,422	9,978 (9,314)	Brokenhead, Dauphin River, Fisher River, Kinonjeoshtegon (Jackhead), Lake Manitoba, Lake St. Martin, Little Saskatchewan, Peguis, Pinaymootang (Fairford)
Central	93,416	6,458 (6,340)	Dakota Plains, Dakota Tipi, Long Plain, Roseau River, Sandy Bay, Swan Lake
Assiniboine	65,265	4,106 (4,040)	Birdtail Sioux, Conupawakpa Dakota (Oak Lake), Gamblers, Keeseekoowenin, Rolling River, Sioux Valley, Waywayseecappo
Parkland	37,309	5,087 (5,090)	O-Chi-Chak-Ko-Sipi (Crane River), Ebb&Flow, Pine Creek, Sapotaweyak (Shoal River), Skownan (Waterhen), Tootinaowazibeeng (Valley River), Wuskwi Sipiik (Indian Birch)
Norman	16,616	8,286 (8,256)	Chemawawin (Easterville), Grand Rapids, Mathias Colomb (Pukatawagan), Mosakahiken (Moose Lake), Opaskwayak (The Pas)
Burntwood	15,939	29,299 (30,424)	Barren Lands, Cross Lake, Fox Lake, Garden Hill, Gods Lake, Minto Sipi (God's River), Marcel Colomb, Nisichawayasihk (Nelson House), Northlands, Norway House, Bunibonibee (Oxford House), Red Sucker Lake, Sayisi Dene (Tadoule Lake), Shamattawa, St. Theresa Point, Tataskweyak (Split Lake), War Lake, Wasagamack, York Factory
Churchill	976		
Total	1,097,342	72,330 (73,346)	1,169,667

For one small part of the fiscal analysis, we need off-reserve population estimates by RHA:

1. INAC estimates the total off-reserve FN population at 43,833.
2. Neither Manitoba Bureau of Statistics, INAC nor Manitoba Health estimate off-reserve population by RHA.
3. Therefore, we need to allocate these people to the various RHAs based on some set of assumptions.

One suggestion:

In 2002, MCHP (in collaboration with AMC and CAHR) published a report on health and health care use of registered First Nation people living in Manitoba (Martens et al. 2002). They used population figures from 1998, and allocated a total of 37,923 FN people living off-reserve.

If we apply the Manitoba-wide growth rate for First Nations of 2.3%, then 37,923 people will have increased to 42,489 people. We lose only 1344 people (~3%) which is well within reasonable error bounds. Using FNIHB figures, the total off-reserve population is 43,034, which means that our estimate would lose only 545 people (1.28%).

RHA	FN on-reserve	FN off-reserve	Non-FN population
Winnipeg	0	23,757	639,686
Brandon	0	2,401	46,211
North Eastman	9,073	1,150	29,614
South Eastman	43	320	58,255
Interlake	9,978	2,752	63,670
Central	6,458	2,262	91,154
Assiniboine	4,106	654	64,611
Parkland	5,087	1,796	35,513
Norman	8,286	1,805	14,811
Burntwood	29,299	5,306	10,633
Churchill	0	286	690
Total	72,330	42,489	1,054,848

d. Financial Projections: the Clatworthy Studies

All per capita analyses (section 1) were conducted based on the numbers provided above. We used a different source for the population and financial projections (section 2), namely two studies produced by Stewart Clatworthy (Clatworthy & Four Directions Project Consultants 2001, 2005). We were able to secure copies of these studies late in the project, January 2006. Since the above estimates and those provided by Clatworthy show only a 3.4 percent variance, these are not considered significant.

Appendix 9, Methodology

a. Population Figures

Manitoba Total – 1,169,667

First Nations on-reserve – 72,330

First Nations off-reserve – 42,489

First Nations total – 114,819

Aboriginal total (including First Nations) – 172,700

There were small discrepancies between the estimates by the Manitoba Bureau of Statistics and the much closer FNIHB and INAC numbers. MBS estimated the First Nation population to be 7.7% smaller than did either INAC or FNIHB, possibly because of an undercount of Bill C31 reinstatements. The number we have is midway between MBS and INAC estimates, and we chose to use it because we need the breakdown of the First Nation population by Regional Health Authority and by community.

The total Manitoba population figure here is from Manitoba Health, and is smaller than the MBS estimate of the total Manitoba population by 601 people (less than 1%) Again, we chose to use this figure primarily because we need the population breakdown by Regional Health Authority.

In all cases, the estimates are very close and well within acceptable error bounds.

b. Manitoba Health Expenditures

Acute Care: Manitoba Health is responsible for acute care costs for the entire population through its insured benefits branch. To estimate total expenditure on Acute Care, we summed the expenditure on Acute Care by each Regional Health Authority (\$1,154,501,864).

The actual cost of acute care for individuals was not available to us, but a reasonable assumption is that costs are related to the total number of days spent in hospital.

In 2002, the Manitoba Centre for Health Policy (Martens et al. 2002) found that total days of hospital care for Registered First Nations (including hospitalizations for childbirth) are about 1.7 times that total days of all other Manitobans (1.75 versus 1.05 days per person per year). Only in Parkland and in North Eastman is there a statistically significant difference in the number of hospital days for First Nations living on-reserve and those living off-reserve, with those living on-reserve having 1.6 times the total number of hospital days of those living off-reserve.

To calculate the per capita expenditure on acute care for First Nations, we used the following procedure:

First, we calculated per capita Acute Care costs:

$$\text{(Total Acute Care Costs in Manitoba in 2003/04) / (Non-First Nation population + 1.7 (First Nation Population – FN on-reserve population in Parkland and North Eastman) + 2.72 (FN on-reserve in Parkland and North Eastman))$$

Second, we multiplied per capita costs by 1.7 to get per capita costs for First Nations off-reserve.

Then we multiplied per capita costs by 2.72 to get the per capita costs for First Nations on-reserve in Parkland and North Eastman. Per capita costs for on-reserve First Nations equals $1.7(\text{total on-reserve population}) + 1.6(\text{on-reserve population in Parkland and North Eastman}) / \text{total on-reserve population}$.

Note that the MB Health acute care budget includes all MB Health expenditures for Nursing Stations, as well as Norway House and Percy Moore Hospitals. These were not separated out in the calculation, because our calculation above took into account differential usage by First Nations on- and off-reserve, relative to the rest of the Manitoba population.

Medical Remuneration: This heading includes physicians (salaried and fee-for-service) as well as private laboratories and X-ray facilities.

Martens et al. (2002) found that Registered First Nations visited physicians 6.1 times per year (7.4 for off-reserve and 5.2 on-reserve) versus 4.9 times per year for all other Manitobans. That implies that off-reserve First Nations visit physicians 1.5 times as often as all other Manitobans, while on-reserve First Nations visit physicians 1.06 times as often as all other Manitobans. The referral rates to specialists are approximately equal between Registered First Nations and all other Manitobans.

We do not have access to actual billings, but it is reasonable to allocate costs according to the number of visits per year. The lower proportion of First Nations billings related to specialist referrals might imply that the billings are slightly lower on average for First Nations, but that is probably balanced by the higher proportion of Northern physicians who are paid a salary and, consequently, tend to under-report billings.

To calculate per capita costs, we used total expenditure by Manitoba Health on physician services (\$588,112,000).

$\text{Total medical expenditure} / 1.06 (\text{on-reserve population}) + 1.5 (\text{off-reserve First Nation population}) + (\text{non-First Nation population}) = \text{per capita medical expenditure}$

$\text{Per capita expenditure on-reserve First Nations} = 1.06 (\text{per capita expenditure})$.

$\text{Per capita off-reserve First Nations} = 1.5 (\text{per capita expenditure})$.

Long Term Care: We have no data on how registered First Nations move on- and off-reserve to access long-term care. Nor do we have data on differential use of long-term care facilities between First Nations on-reserve, First Nations off-reserve and other Manitobans.

Long-term care facilities are provided by Manitoba Health through the Regional Health Authorities. To allocate the costs, we first separated out expenditures for personal care homes in Norway House and Nelson House (Pinaow Wachi and Nisichawayasihk Personal Care Homes) from the MB Health 2003-04 Annual Report (p.92). This totaled \$372,336, which we divided by the total on-reserve population for a per capita figure of \$5.

For long term care facilities off-reserve, we assumed that on-reserve First Nations do not make use of these provincial facilities, and that off-reserve First Nations use them at the same rate as all other Manitobans. **Note that this is an area where further research is required.**

To get total provincial expenditure on Long-Term care, we summed the expenditures made by each RHA. To get per capita expenditure, we divided total expenditure by the sum of First Nations living off-reserve and other Manitobans.

Home Care: Manitoba Health provides home care services through the RHAs. It does not provide home care on-reserve. We have no data on differential usage of home care services by Registered First Nations living off-reserve and other Manitobans. Nor do we have data on how First Nations may move on- and off-reserve to access care. **Note that this is an area where further research is required.**

To allocate per capita costs, we summed expenditure on home care by each RHA and divided by the sum of the non-First Nation population and the First Nation off-reserve population.

Land Ambulance: This is a highly disputed issue.

In order to allocate the **costs** of land ambulances, we divided the total expenditure on land ambulances by each RHA, by the sum of the non-First Nation population and the First Nation population living off-reserve.

This does not mean, however, that Manitoba Health necessarily pays the costs. For non-First Nation people not on social assistance, individuals are typically billed for the ambulance service unless it is for an individual to access tests at a different facility where the individual will stay for less than 24 hours. For non-First Nations on social assistance, the EIA will pay. For First Nations, FNIHB is billed. For mixed status families living off-reserve and receiving social assistance, it is not clear whether FNIHB or EIA is or ought to be paying. **We do not have sufficient data to sort this out. It is a significant jurisdictional dispute, especially in the City of Winnipeg.**

Northern Patient Transport Program: This program is available to all patients living north of the 53rd parallel, except those living in First Nation communities.

To allocate costs, we summed expenditure on NPTP by North Eastman, Norman, Burntwood and Churchill (\$9,954,388). We then calculated the proportion of the total off-reserve population of these four RHAs that is First Nation (10.1%), and allocated 10.1% of the costs to the off-reserve First Nation population (\$1,005,393).

To calculate per capita costs, we divided this total by the total FN population living off-reserve (42,489), for a total per capita expenditure of (\$24).

1964 Agreement RHA costs: As a result of the 1964 agreement, 4 communities – Fox Lake (Burntwood RHA), Grand Rapids (Norman RHA), Moose Lake (Norman RHA) and Easterville (Norman RHA) receive their primary and public health services from Manitoba Health through their RHA.

To allocate these costs, we took total RHA expenditure of the two RHAs affected, less the categories listed separately above (acute care, long-term care, etc.). We divided the total expenditure by the sum of the non-First Nation population in these two RHAs, the off-reserve First Nation population in these two RFAs, and the on-reserve population in these four communities. We multiplied the per capita expenditure by the population of the four communities to get total expenditure attributable to the on-reserve population. Then, we divided by the total on-reserve population of Manitoba to attribute total dollars spent on these four communities by MH due to the 1964 agreement to the entire on-reserve population.

RHA costs for community-based programs: To allocate these costs, we summed total RHA expenditure on all other items, excluding capital costs such as amortization and depreciation. We then divided the total by the total non-First Nation population plus the off-reserve First Nation population.

Provincial Programs: There are a number of provincial programs that are not funded through the RHAs. These include payments made to out of province facilities and federal hospitals, blood transfusion services, prosthetic and orthotic devices, healthy communities' development, and nursing recruitment and retention initiatives. We identified expenditure on those programs that are used by all First Nations, including that on-reserve, and calculated per capita costs by dividing program expenditure by the population of Manitoba. Some of the programs, such as healthy community development and nursing recruitment and retention benefit primarily off-reserve populations. To calculate per capita costs, we divided program expenditure by total off-reserve population, including First Nations and other Manitobans.

Manitoba Health – administrative costs: We summed expenditures on Finance, Central Services, Administrative Support, Health Accountability, Policy and Planning and Health Workforce (which includes development and recruitment costs). We allocated these costs to the entire population of Manitoba on a per capita basis.

Addictions Foundation of Manitoba: Addictions services are funded by Manitoba Health through the Addictions Foundation of Manitoba. However, FNIHB reimburses AFM for First Nations (on and off-reserve) who access residential treatment. Non-residential programs are available to the entire off-reserve population. AFM received \$12,834,700 from the provincial government in 2003-04. Unfortunately, we do not have a breakdown between residential and non-residential programs, or between First Nation and other Manitobans. Therefore, we allocated costs on a per capita basis to everyone off-reserve in the province.

Cancer Care Manitoba: CancerCare is funded primarily by Manitoba Health, and provides physician services, counseling, diagnosis and treatment associated with cancer. These services are, in principle, available to all residents of Manitoba, although there may be access issues for people living in remote areas. **We do not have any data on differential access to CancerCare programs for First Nations. This is an area that requires further research.**

In the absence of utilization data, all costs associated with CancerCare are allocated to all residents of Manitoba (including on- and off-reserve First Nations) on a per capita basis. We divided total expenditure (less amortization and building occupancy costs) by

total population of Manitoba, and attributed the per capita costs to on- and off-reserve First Nations.

C. FNIHB – Manitoba Region

We used actual expenditures, rather than budgeted numbers, to determine per capita funding by FNIHB for on- and off-reserve health expenditures. For on-reserve programs, we summed expenditures made for consolidated, transfer and integrated communities, and divided by the total on-reserve population of Manitoba. We then adjusted per capita figures to reflect the use of on-reserve services by non-First Nations. For off-reserve expenditures, we divided total expenditure by the off-reserve First Nation population. Where programs are offered primarily on-reserve, such as solvent abuse treatment centres, we allocated all costs to the on-reserve population.

We have no data on how people move on- and off-reserve in order to access services. Nor do we have data on the accessibility of residential treatment programs to the off-reserve population. These are areas that require further investigation.

For Non-Insured Health Benefits, data were not available showing the breakdown between expenditures for First Nations on-reserve and First Nations off-reserve. Consequently, total expenditures were allocated to both on a per capita basis.

The administrative costs associated with the Directorate were allocated to First Nations on-reserve based on the proportion of the total budget accounted for by on-reserve expenditure. The remainder was allocated to off-reserve First Nations.

d. EIA Expenditures for First Nations off-reserve

The Social Allowances Health Services (SAHS) card is issued to Employment and Income Assistance (EIA) participants that do not have Indian status. The card may be presented to health care providers (dentists, opticians, pharmacists, chiropractors) to cover the costs of non insured health benefits within approved guidelines.

SAHS cards are not issued to EIA families where all members have Indian status. These cases are advised to obtain non insured health benefits through the First Nations Inuit Health Branch. In situations where one or more family member does not have Indian status, a SAHS card is issued to the family. This is done because Eva's computer system does not currently have the capacity to identify which family members may or may not be eligible for SAHS benefits based on their individual Indian status.

SAHS card	Total Cases	Total Persons
No	5087	8607
Yes	2717	5206
Total	7804	13813

Some health related expenditures including therapeutic diets, health transportation (bus passes, taxi, handi transit, and mileage) and health other are not paid through the SAHS program, and are not dependant on a participant's Indian status

Health related expenses	Total cost
Drugs, Dental, Optical	\$ 106,591
Chiropractic	\$ 1,188
Therapeutic Diets	\$ 396,775
Health Transportation	\$ 351,284
Health Other*	\$ 188,416
Total	\$1,044,254

or eligibility for the SAHS card. Participants are required to provide doctor's confirmation of their health related need. Assistance to cover the cost of the item are either added to a participant's monthly EIA budget, or paid directly to the service provider by EIA.

*Health other - includes health related expenses for telephone, out of province expenses, orthopedic shoes, oxygen, home care, physician fees, physiotherapy, and miscellaneous expenses that do not have a related code in Eva's computer system.

Health related expenses	Total cost
Drugs, Dental, Optical	\$ 898,683
Chiropractic	\$ 1,213
Therapeutic Diets	\$ 232,603
Health Transportation	\$ 357,452
Health Other*	\$ 111,931
Total	\$1,601,882

To calculate per capita expenditure on health-related costs for First Nations living off-reserve, we summed expenditure by EIA on First Nations, and divided by the total off-reserve First Nation population in Manitoba.

D. INAC – Manitoba Region

For each component of INAC expenditure, we divided total regional expenditure by the on-reserve First Nation population to get per capita funding. Two programs pay for off-reserve services – adult care in personal care homes, and care for children with complex medical needs. In the case of adult care, off-reserve expenditure was divided by the off-reserve population, and on-reserve expenditure was divided by the on-reserve population. For “children with complex medical needs”, the breakdowns between on and off-reserve expenditures was not available, so we divided total expenditure by total First Nation population.

Since there are on- and off-reserve components of INAC expenditure, we allocated administrative costs to both the on- and off-reserve First Nation populations.

E. PHAC – Manitoba Region

The Canadian Action Program for Children (CAPC) collects actual data on utilization, and reports that 50% of its users are off-reserve First Nations. Therefore, 50% of total program expenditure was attributed to off-reserve First Nations, and divided by total off-reserve First Nation population to get per capita expenditure. Similarly, AHS reports that

70% of its users are off-reserve First Nations, so 70% of total program expenditure was divided by total off-reserve First Nation population to get per capita costs.

CPCN did not provide breakdown by users, so total program expenditure was divided by the total off-reserve population (First Nations and other Manitobans) to get per capita costs. This assumes that First Nations and other Manitobans use the program at the same rate. Our figures probably underestimate the expenditure for off-reserve First Nations. Similarly, expenditures for FASD, AIDS/HIV, and HepC were allocated to the total off-reserve population (First Nations and other Manitobans) on a per capita basis. The Diabetes Prevention Program Initiative focuses on other Manitoban users, so no costs were attributed to the First Nation population. Public Health Funding was allocated to the total off-reserve population (First Nations and non-First Nations) on a per capita basis.

f. Aboriginal Healing Foundation

The Foundation funds community-based projects that address the mental, emotional, physical and spiritual realms of life (Aboriginal Healing Foundation 2004). The total contribution by Aboriginal Healing Foundation to Aboriginal peoples in Manitoba was \$48,386,630 in 2003-04. The same report shows that of all projects across Canada,

- 57.9 percent funded direct healing activities;
- 15.8 percent funded prevention and awareness activities;
- 7.0 percent funded training activities;
- 3.3 percent funded projects honoring history;
- 9.5 percent funded projects building knowledge;
- 3.3 percent funded projects assessing needs;
- 1.6 percent funded projects' design and set-up; and
- 1.6 percent funded conferences.

Of these, we assume that only the two first categories fit into the concept of health services utilized in this report. It is unclear whether the breakdown provided above reflects how funds were used in Manitoba.

Based on figures provided in the 2004 Annual Report, it is estimated that the Aboriginal Healing Foundation funding was distributed as follows:

	Percent % all projects	Funding all projects	Funding for "health" projects only	Per capita contribution
Projects serving all Aboriginal Groups (N=43,870) ⁵⁶	23.44%	\$11,341,826	\$8,358,926	\$190.54
Projects serving First Nations (N=72,330)	66.41%	\$32,133,561	\$23,682,434	\$327.42
Projects serving Métis communities (N=56,500)	10.16%	\$4,916,082	\$3,623,152	\$64.13
Total	100.01%	\$48,391,469	\$35,664,512	N/A

⁵⁶ Calculated as the total Aboriginal population 172,700 – the Métis population estimated at 56,500 and – the First Nation off-reserve population estimated at 42,489.

- From this breakdown, we have assumed that,
- all Aboriginal Groups is meant to imply all off-reserve projects provided to non-Métis; and
- First Nations is meant to include status Indians living on-reserve only.

Although it is difficult to “classify” healing-oriented activities within the western service grid developed for this project, we opted to include these expenditures under “mental health” services.

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