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The Cost of Doing Nothing

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THE COST OF DOING NOTHING: IMPLICATIONS FOR THE MANITOBA HEALTH CARE SYSTEM

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ABSTRACT

This study reports on a financial analysis of current and prospective First Nations health expenditures, and documents areas of cost shifting from the federal government onto provincial health budgets. The loss of status related to Bill C-31 (which regulates Indian status) and exogamous parenting mean larger numbers of children not eligible for Indian status and its associated funding. In this context, the cost shifting not only affects provincial budgets, but also First Nations organizations and individuals. The study highlights the need to invest in primary health care in order to address the projected rising costs and meet Manitoba First Nations' needs. The study also underlines the need for cross-jurisdictional cooperation.

Keywords: primary health care, Aboriginal, policy, expenditures, equity

INTRODUCTION

Numerous studies, from the 1966 Hawthorn report (Hawthorn, 1966) to the more recent Royal Commission on the Future of Health Care in Canada (Romanow, 2002) and the report of the National Advisory Committee on SARS and Public Health (National Advisory Committee on SARS and Public Health, 2003), have pointed out that the federal-provincial jurisdictional fragmentation over Indians' health care is a public health concern and creates barriers to access health services. The current jurisdictional environment is rooted in the *British North America Act, 1867*. The *BNA Act* gave legislative authority over Indians and Indian Bands to the federal government, and the authority over health care to the provinces. This was to be the beginning of a jurisdictional debate over *Indian/First Nations* health that remains current today.

The Manitoba Intergovernmental Committee on First Nations Health (ICFNH) was set up in 2003 specifically to address jurisdictional issues related to First Nations health policy in Manitoba. The ICFNH brings together senior representatives from the Assembly of Manitoba Chiefs (AMC), Manitoba Health (MH), the First Nations and Inuit Health Branch of Health Canada Manitoba region (FNIHB), Indian and Northern Affairs Canada (INAC), the provincial Departments of Aboriginal Affairs (DAA) and Family Services and Housing (FSH). The Public Health Agency of Canada is a more recent addition.

In January 2005, the authors were asked by the ICFNH to undertake an analysis of First Nations health expenditures for the 2003–04 fiscal year, and to project these costs to 2029, given population growth projections and current prevalence patterns. The purpose of this exercise was to provide the ICFNH with a tool to explore innovative solutions to documented inefficiencies in the delivery of health care for Indian people living in Manitoba. The overall mandate of that study was broader than what can be reported here. The full report is available online (Lavoie and Forget, 2006). This article documents current and prospective public sector health expenditures for Manitoba First Nations. It also suggests areas where efficiencies might be found, and concludes with policy recommendations.

BACKGROUND: WHO IS AND WHO IS NOT AN “INDIAN”

The collective term Aboriginal people is an umbrella term encompassing First Nations, Inuit, and Métis, and is entrenched in the Constitution as amended

in 1982. The term, however, glosses over cultural, legislative, and administrative complexities. The term First Nations is the preferred self-referent used by the Indigenous peoples of Canada, historically known as *Indians*. The term is broader, since it includes those individuals of First Nations ancestry who are and those who are not eligible for registration as *Indians* under the Indian Act. The term *Indian* is itself a legally defined category. Having *Indian status* refers to an individual being registered as an *Indian* as defined under the terms and conditions of the Indian Act.

The *Indian Act* historically and currently defines in rather limiting ways the legal category of *Indian*, which determines the right to live on reserve and to qualify for certain individual-based benefits. Specifically, from the turn of the last century until 1985, an Indian woman who married a man who did not have Indian status lost her status. The same applied to children from this marriage. As a result, they could vote but lost the right to live on reserve with their relatives. In contrast, a nonstatus woman (of European or other origin) who married an Indian man gained Indian status. A provision added to the *Indian Act* in 1920 allowed for the compulsory enfranchisement of any Indian aged 21 years old or older judged fit to be enfranchised by a Board appointed by the Superintendent of Indian Affairs. Provisions to that effect remained a part of the *Indian Act* until 1951 (Royal Commission on Aboriginal Peoples, 1996, p. 150). Voluntary enfranchisement provisions also existed for Indians who wanted to

- a. legally consume alcohol (partially repealed by the adoption of Bill 267, [1950], and fully repealed by Bill C-31 [1985]);
- b. cut wood, sell agricultural products, attend meetings, or circulate outside the reserves without the written approval of the Indian Agent (eliminated by the 1960s);
- c. vote in Canadian elections (repealed with changes to the Canada Elections Act in 1960).

Discriminatory provisions were repealed from the *Indian Act* over time. The provision regarding marriage was finally removed with the adoption of the 1985 Bill C-31. As the legislation stands now, First Nations that never lost their Indian status are registered as *Indians* under the *Indian Act* article 6(1). Those who lost status by marriage or other discriminatory means prior to 1985 are eligible for registration under the *Indian Act* article 6(2). Both 6(1) and 6(2) classification categories imply full status and benefits. Children of parents classified as 6(1) are classified as 6(1). Children of a 6(1) parent and

6(2) parent are classified 6(1). Children of a 6(1) parent and a nonstatus are considered 6(2). Finally, children of a 6(2) parent and nonstatus parent are considered nonstatus.¹ Although the recent British Columbia Supreme Court challenge to section 6 of the *Indian Act* (*McIvor et al. v. The Registrar*, Indian and Northern Affairs Canada [2007], BCSC 26) could potentially change registration rules, the impact of this ruling has yet to be determined.

According to provincial and territorial policies, nonstatus or nonregistered First Nations have the same rights to access to programs and services such as health care, income assistance, and education as any other Canadian resident as provided for by their province or territory of residence. Because nonregistered First Nations are considered a “provincial or territorial jurisdiction,” First Nations communities do not receive funding to extend services to them. In theory, the jurisdictional carving is neat.

In practice, however, Bill C-31 will result in generations of First Nations not eligible for registration, who may be born on reserve, and share the culture, language, practices, and needs of their cultural peers, but who are denied access to the same culturally appropriate services, including the right to

1. The actual provision reads as follows:

6(1) Subject to section 7, a person is entitled to be registered if

- (a) that person was registered or entitled to be registered immediately prior to April 17, 1985;
 - (b) that person is a member of a body of persons that has been declared by the Governor in Council on or after April 17, 1985 to be a band for the purposes of this Act;
 - (c) the name of that person was omitted or deleted from the Indian Register, or from a band list prior to September 4, 1951, under subparagraph 12(1)(a)(iv), paragraph 12(1)(b) or subsection 12(2) or under subparagraph 12(1)(a)(iii) pursuant to an order made under subsection 109(2), as each provision read immediately prior to April 17, 1985, or under any former provision of this Act relating to the same subject-matter as any of those provisions;
 - (d) the name of that person was omitted or deleted from the Indian Register, or from a band list prior to September 4, 1951, under subparagraph 12(1)(a)(iii) pursuant to an order made under subsection 109(1), as each provision read immediately prior to April 17, 1985, or under any former provision of this Act relating to the same subject-matter as any of those provisions;
 - (e) the name of that person was omitted or deleted from the Indian Register, or from a band list prior to September 4, 1951,
 - (i) under section 13, as it read immediately prior to September 4, 1951, or under any former provision of this Act relating to the same subject-matter as that section, or
 - (ii) under section 111, as it read immediately prior to July 1, 1920, or under any former provision of this Act relating to the same subject-matter as that section; or
 - (f) that person is a person both of whose parents are or, if no longer living, were at the time of death entitled to be registered under this section.
- (2) Subject to section 7, a person is entitled to be registered if that person is a person one of whose parents is or, if no longer living, was at the time of death entitled to be registered under subsection (1) (Government of Canada, 1985).

live on reserve, as a result of a bureaucratic provision (Clatworthy and Four Directions Project Consultants, 2001; 2005). In the context of this study, jurisdictional issues compounded by the impact of Bill C-31, are resulting in disinvestment in on-reserve primary health care and shifting growing costs onto the provincial health care systems, First Nations communities, and individuals.

METHODS

Our analysis required us to first, delineate jurisdictions; second, identify baseline population figures and project them to 2029; and third, identify expenditures for each agency responsible for health services to First Nations and project these to 2029, based on current policies and utilization rates.

JURISDICTION

In the First Nations context, five separate agencies have responsibilities for health care, as shown in Table 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 (Health Canada, 2003). The only program to extend off reserve is the Non-Insured Health Benefits program that provides all status Indians access to health care services not included under the Canada Health Act, such as eye care, medications, medical transportation, and dental care. The Department of Indian and Northern Affairs Canada (INAC) has limited responsibilities in the area of health, beyond that of infrastructure and long-term care. 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. These programs operate off reserve only, with the exception of some costs paid for adult care in long-term care facilities on reserve. Manitoba Family Services and 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 do 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, and other services are not dependent on a participant's Indian

Table 1. Funding Map Showing the Primary Responsibility for the Funding of First Nations Health Programs and Services

<i>Types of Services</i>	<i>Payers of services for population living on reserve</i>				<i>Payers of services for population living off reserve</i>			
	<i>Manitoba Health/RHAs</i>	<i>FNIHB</i>	<i>INAC</i>	<i>Others</i>	<i>Manitoba Health/RHAs</i>	<i>FNIHB</i>	<i>INAC</i>	<i>Others</i>
<i>Professional Services</i>								
Physicians	PF	SF			PF			
Allied Professions		PF				PF		
<i>Acute Care Hospital Services</i>								
Primary Level	PF				PF			
Secondary Level	PF				PF			
Tertiary Level	PF				PF			
Quaternary Level (e.g., transplant)	PF				PF			
Emergency Services (out of hospital)		PF			PF			
Promotion of health and prevention of illness and injury		PF			PF			
<i>Protection of Health</i>								
Public Health inspector and monitoring (environmental contaminants, transportation of dangerous goods)		PF	SF		PF			
Immunization: Includes community-based and physician-based immunization services	PF, OFF-R	PF, ON-R			PF			
Communicable Disease	PF, OFF-R	PF, ON-R			PF			
<i>Home/Community-based services</i>								
Nursing, care coordination, assessment		PF			PF			
Personal care services		PF			PF			
Home support/homemaking			PF		PF			
Chronic care hospitals	PF		PF		PF			
Respite care	UNCL	UNCL			PF			PF
Palliative care (home-based)		LTD			LTD			
<i>Community Rehabilitation</i>								
Physiotherapy	PF, H	LTD			PF, H			
Speech and language	PF, H				PF, H			
Other rehabilitation	PF, H				PF, H			
<i>Aids to persons with physical disabilities</i>								
Supplies and equipment		PF			PF	SF		
Children/adults with special needs		PF	SF		PF	SF	PLR	
<i>Mental Health Services</i>								
Community-based (family or individual)		PF			PF	PF		
Psychiatric care	PF				PF			
Institutional mental health services	PF				PF			
Family violence			PF		PF			
<i>Services for alcohol and other drug abuse</i>		PF			PF	PF		
<i>Drug benefits</i>	SF	PF			SF	PF		
<i>Medical transportation including ambulance services</i>	SF, D	PF			SF, D			
<i>Diagnostic services</i>	PF				PF			

Abbreviations:

PF: Primary funder; PF, H: Primary funder if services are delivered in hospital; SF: Secondary funder, complements the above; SF, D: Secondary funder, some area of debate; ON-R: On reserve; OFF-F: Off reserve; LTD: Limited; PLR: Payer of last resort

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 Nations living off reserve, but rather serve to reach vulnerable population including First Nations.

Other organizations also extend health and health-related services to Manitoba First Nations: the 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 in two institutions; the Workers Compensation Board provides services to individuals injured through employment; and Medical Transportation expenditures are provided by the RCMP under the Mental Health Act. These expenditures were considered out of scope for this exercise.

POPULATION FIGURES

The population figures used came from two studies completed by Clatworthy (2001; 2005). These projections take into consideration a number of key factors, including: a. trends in population size by location (on and off reserve) and mobility; b. annual rates of population growth by location (on and off reserve); c. annual additions to the population through births and reclaimed status under Bill C-31; d. trends in the composition of the population by location (on and off reserve); and e. 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. These estimates are based on the total number of registered First Nations and people of First Nations descent who are not eligible for registration under current interpretations of the *Indian Act*.

For the purpose of this analysis, we assumed that registration rules are a blunt proxy for ethnicity, identity, and health care needs, and have included all descendants of First Nations whether eligible for registration or not under the *Indian Act*.

ESTIMATING EXPENDITURES

Sources of expenditures included Annual Reports as well as financial information provided by the agencies. 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. Projections are based on constant 2003–2004 dollars.

RESULTS

According to Manitoba Health, in 2003–04, the total Manitoba population was 1,169,667 (Manitoba Health, 2003). According to figures provided to us by Health Canada (FNIHB, Manitoba region), the First Nations population living on reserve was 73,346, and off reserve was 43,034. The overall percentage of the Manitoba population identified as First Nations was 9.9 percent.

Figure 1 summarizes trends in the Manitoba First Nations 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 Nations ancestry will not be entitled to First Nations status. This is nearly 5 times the numbers of individuals not entitled to registration in 2004.

Figure 1, First Nation population projections, 2004 to 2029

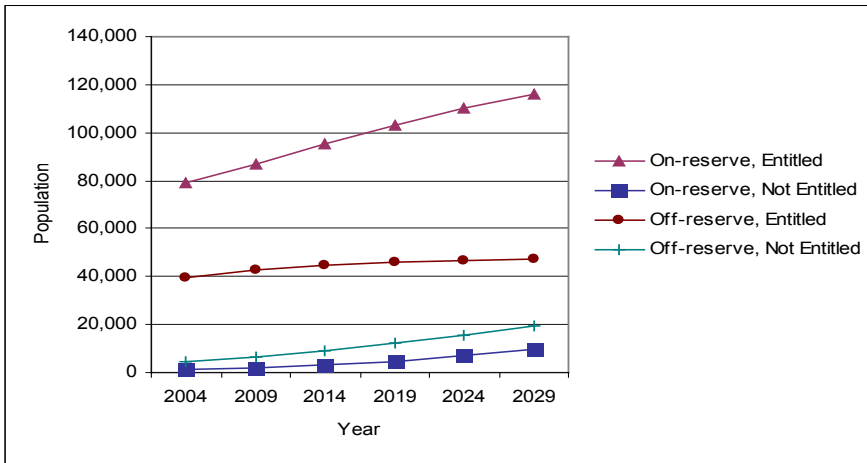


Table 2 summarizes the cost implications. In 2004, First Nations health expenditures required 18.6% of the public sector health expenditures. Given current trends, we estimate that this will grow to 23.6% by 2029, if current per capita expenditures and prevalence patterns persist. That is, this is just the impact of population growth. Both on-reserve and off-reserve figures take into account expenditures for all people of First Nations descent, whether they have Indian status or not. We assumed current jurisdiction among agencies would persist, as would current prevalence and health care utilization patterns which show higher costs associated with this population.

Table 2. Projected Manitoba First Nations Health Expenditures (constant 2004 dollars)

	On reserve			Off reserve			Comparative analysis		
	Population	Total health expenditures for population living on reserve	Annual growth rate %	Population	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 (Canadian Institute for Health Information 2006)	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

The impact of Bill C-31, however, is made especially clear in Table 3. As the population of First Nations descent grows, current patterns of exogamous parenting mean that an increasing proportion of children, both on and off reserve, will no longer be eligible for registration under the *Indian Act*. This means that an increasingly larger proportion of expenditures, currently provided by the federal government, will shift,

1. to FSH, for those individuals off reserve collecting social assistance;
2. to INAC, which will assume responsibility for providing children in families that collect income assistance on reserve with Non-Insured Health Benefits no longer provided by FNIHB;
3. to First Nations communities that will provide primary health care on reserve to everyone who lives there even though funding may not reflect the growing number of children without status; and
4. to individuals and families who will be responsible for Non-Insured Health Benefits in cases where the family is not participating in income support programs.

DISCUSSION

What opportunities might there be to address these growing costs, and the human cost these expenditures underline? A combination of much poorer health status and poorer access to primary care means that registered Manitoba First Nations people have higher hospitalization rates and spend

Table 3. Total Projected Health Care Costs by Payers, Based on Clatworthy's Projected Bill C-31 Impact, in Constant 2004 Dollars (\$1,000)

	Population living on reserve					Population living off reserve					Costs no longer covered by FNIHB/INAC				
	MH/RHAs	FNIHB	INAC	AHF	Cost shifted to FN & Org.	Total	MH/RHAs	FNIHB	PHAC	INAC		AHF	FSH	Unpaid invoices	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*	\$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%

*The Aboriginal Healing Foundation (AHF) 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.

more days in hospital than other Manitobans. In 2002, the Manitoba Centre for Health Policy estimated that registered First Nations people have twice the hospitalization rate of other Manitobans (348 vs. 156 per thousand per year). The total days of hospital care for registered First Nations 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 Manitoba First Nations people than for other Manitobans. If the number of days spent in hospital by registered First Nations people could be reduced to the number of hospital days required by the rest of the population, Manitoba Health could save \$989 per First Nations 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 Nations people will cost Manitoba Health almost \$3.8 billion dollars.

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.

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 Nations people by 2025 (Hallett et al., 2000; Jacobs et al., 2000, pp. 298–301).

Type II diabetes is a chronic disease with a complicated aetiology. Heredity, obesity, physical activity, diet, and metabolism 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.

Martens and colleagues (2002) 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 Nations people in Manitoba relative to the rest of the population. There is, as yet, no estimate available of the total costs associated with lower limb amputations due to complications of diabetes. 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. Jurisdictional issues, however, intervene even here. Most of the costs associated with lower limb amputations are borne by the province; whereas the costs of providing primary health care (including foot care programs) on reserve rest with the federal government.

Costs associated with complications due to diabetes can be addressed through improved coordination in the delivery of health care services, which depends on cooperation among 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.

ACCIDENTS AND INJURIES

Approximately 11% of all hospitalizations among First Nations people are due to accidents and injuries (Martens et al., 2002). No data is 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.

Over 25 years, hospital costs associated with accidents and injuries in the registered First Nations population will exceed \$713 million. Nearly one-third of hospitalizations among registered First Nations 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 affect hospitalization rates due to accidents and injuries, there are significant savings to be gained.

CONCLUSIONS AND RECOMMENDATIONS

The potential costs associated with providing health services to First Nations people 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 human cost should not be overlooked.

The examples considered above focus on hospital costs — the largest component of health care costs. Hospital costs may be affected significantly over the next 25 years by two factors. First, adequate primary health care can significantly reduce hospitalizations due to “ambulatory care sensitive conditions” — 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.

Second, 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. In the context at hand, gains will be realized only if we look for improving efficiency in the system as a whole, and with the establishment of cross-jurisdictional cooperative processes of planning and decision-making. Such mechanisms have emerged in a number of provinces: the Manitoba Intergovernmental Committee on First Nations Health, the Saskatchewan Northern Health Strategy and the British Columbia First Nations Health Advisory Committee are recent developments that hold promises.

Still, these mechanisms can be effective only if supported by federal and provincial policy frameworks that harmonize, or failing that, remain flexible enough to allow for joint decision-making focusing on the overall efficiency of the health care system, rather than on narrowly defined federal/provincial jurisdiction, priorities, and mandates. While intuitively appealing, it is important to recognize that this recommendation goes against current trends in Canadian public administration, especially at the federal level, where centralized decision-making and an ever growing focus on accountability has led

to the emergence of inflexible regulations and eroded opportunities for collaborative cross-jurisdictional decision-making (Savoie, 1999). While we recognize that accountability is an important objective, current accountability frameworks have resulted in significant compromises on efficiency and rising costs. In the context of Manitoba and all First Nations, opportunities for narrowing the inequity gap are being compromised.

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