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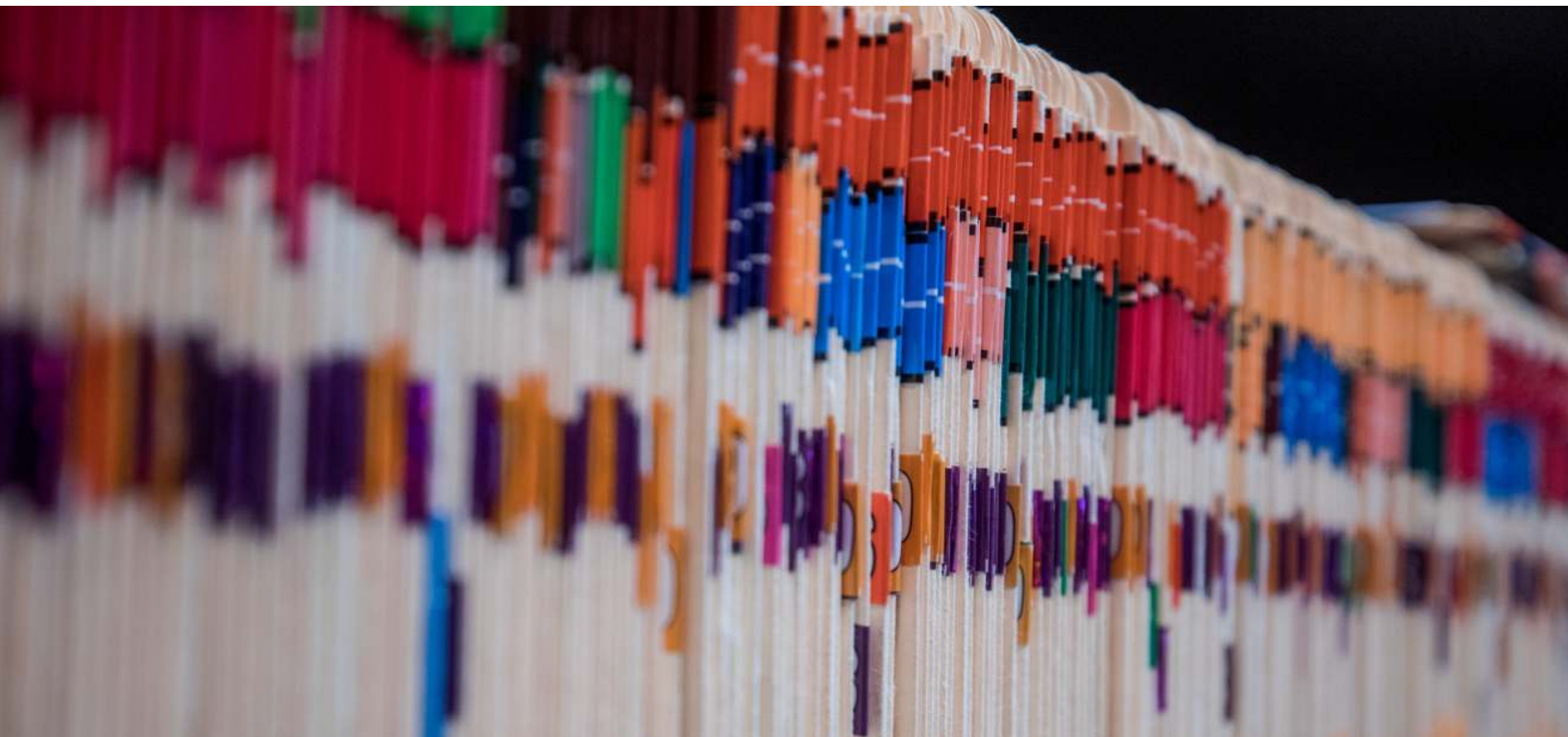
FEDERAL SPENDING ON FIRST NATIONS AND INUIT HEALTH CARE



OFFICE OF THE PARLIAMENTARY BUDGET OFFICER
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The Parliamentary Budget Officer (PBO) supports Parliament by providing economic and financial analysis for the purposes of raising the quality of parliamentary debate and promoting greater budget transparency and accountability.

Several parliamentarians expressed interest in a PBO analysis, in both dollar and per-capita terms, of provincial/territorial health care funding and funding for First Nations and Inuit by Indigenous Services Canada through the First Nations and Inuit Health Branch.

This report provides an analytical overview of federal and provincial/territorial government health spending for the First Nations and Inuit population. It does not attempt to establish a spending gap between federal government health spending for First Nations and Inuit and provincial/territorial government health spending for all residents of Canada.

Lead Analysts:
Robert Behrend, Advisor-Analyst
Jamie Forsyth, Analyst

Contributor:
Salma Ahmed Mohamed, Research Assistant

This report was prepared under the direction of:
Xiaoyi Yan, Director, Budgetary Analysis

Nancy Beauchamp, Carol Faucher and Rémy Vanherweghem assisted with the preparation of the report for publication.

For further information, please contact pbo-dpb@parl.gc.ca

Yves Giroux
Parliamentary Budget Officer

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Executive Summary

This report provides an overview of federal and provincial/territorial government health spending on the First Nations and Inuit population.

This report does not attempt to establish a spending gap between federal government health spending for First Nations and Inuit and provincial/territorial government health spending for all residents of Canada. This is not possible because spending by the federal government for First Nations and Inuit health is complementary to health spending by provincial/territorial governments on publicly insured health services for all residents, including First Nations and Inuit.[1] In addition, the delivery of health services on-reserve is shared among the federal and provincial/territorial governments, First Nations organizations and communities, and third-party services providers.[2] [3] [4]

Generally, differences in health spending for First Nations and Inuit exist between and within regions. However, spending comparisons alone cannot be used to determine funding inequalities.[5] Factors that influence funding levels across provinces and territories must all be considered when making comparisons, such as demographics (age), geographic locations, frequency of disease, trauma, and socio-economic discrepancies.

PBO analyzed federal and provincial/territorial government health spending between 2011-2012 and 2018-2019 for First Nations and Inuit as well as for the general Canadian population from several perspectives. PBO found:

- Federal government spending on First Nations and Inuit health in 2018-2019 represented 33 per cent of the spending by Indigenous Services Canada (ISC), whereas provincial/territorial government health spending made up between 24 and 40 per cent of provincial or territorial government program spending.
- Adjusted for inflation, federal government health spending for First Nations and Inuit increased by an average of almost 9.0 per cent per year between 2011-2012 and 2018-2019. Similarly, provincial/territorial government health spending for the general population increased by an average of 2.1 per cent.
- Across all regions, health spending by both levels of government is, by and large, proportional to the recipient population.
- Combined, federal and provincial/territorial government health spending for First Nations and Inuit on a per capita basis grew at an average rate of 3.5 per cent per year between 2011-2012 and 2018-

2019. By itself, the per capita provincial/territorial portion grew by an average rate of almost 1.0 per cent per year.

- Overall, ISC's grants and contributions spending for First Nations and Inuit on a per capita basis is much higher in remote communities than in non-remote communities.

1. Introduction

This report focuses on examining federal health spending for First Nations and Inuit population on reserve, in rural and non-rural areas and compares it to health spending by provincial/territorial governments for the general population.

First Nations and Inuit health care and funding is complex. This report does not attempt to establish a spending gap between federal and provincial/territorial government health spending for First Nations and Inuit and the same spending for all residents of Canada. While First Nations and Inuit health care is predominately a federal responsibility, it is complementary to health spending by provincial/territorial governments for all residents including First Nations and Inuit.[6] In addition, the delivery of health services on-reserve is shared among the federal and provincial/territorial governments, First Nations organizations and communities, and third-party services providers.[7] [8] [9] For these reasons, it is difficult to define a health care spending gap.

2. First Nations and Inuit Health Care in Canada

Canada's constitution outlines the jurisdictional authorities over health care between federal and provincial/territorial governments. While provincial/territorial governments are responsible for health care delivery, the federal government provides transfer payments to support their delivery of health services to the residents, including First Nations and Inuit.

The division of health care responsibility for First Nations and Inuit communities on-reserve is less straightforward. Provincial/territorial governments provide hospitals, physicians, and public health programs, but rarely operate direct health services on-reserve. The federal government, via the First Nations and Inuit Health Branch (FNIHB) of Indigenous Services Canada (ISC), funds and, in some cases, delivers health programs and services for the First Nations and Inuit populations living on-reserve or traditional territory.[10] These federally funded programs and services are intended to be complementary to health services provided by provincial/territorial governments.[11]

Box 1-1 First Nations and Inuit Health Branch

The First Nations and Inuit Health Branch (FNIHB) supports the health needs of First Nations and Inuit by:

- ensuring availability of, and access to, quality health services;
- supporting greater control of the health system by First Nations and Inuit; and,
- supporting the improvement of First Nations health programs and services through improved integration, harmonization, and alignment with provincial/territorial health systems.

FNIHB also provides eligible First Nations and Inuit, regardless of where they live, with supplementary health benefits not covered by provincial or territorial health insurance or private programs such as prescription drugs, medical supplies and equipment, dental and vision care, short-term mental health crisis counselling and medical transportation.

3. Federal and Provincial/Territorial Government Health Spending

In this section we examine the federal and provincial/territorial government health spending between 2011-2012 to 2018-2019.

Federal Health Spending

The federal government, through the First Nations and Inuit Health Branch (FNIHB) of Indigenous Services Canada (ISC), administers three main programs related to First Nations and Inuit health care. Primary Care and Health Infrastructure Support programs provide funding for registered First Nations living on reserve and the Inuit population living on traditional territory. The Supplementary Health Benefits program funds services for the entire registered First Nations and Inuit population, regardless of where they live.[12]

Table 3-1 First Nations and Inuit Program Areas

Program Areas	Sub-Program	Sub-Sub Program
Primary Care	Health Promotion and Disease Prevention	Healthy Child Development* Healthy Living* Mental Wellness
	Public Health Protection	Communicable Disease Control and Management** Environmental Health
	Primary Care	Clinical and Client Care Home and Community Care* Jordan's Principle
Health Infrastructure Support	Health System Capacity	Health Planning and Quality Management* Health Human Resources** Health Facilities*
	Health System Transformation	Systems Integration* E-Health Infostructure* Nursing Innovation
	Tripartite Health Governance	BC Tripartite Initiative*
Supplementary Health Benefits	Non-Insured Health Benefits	

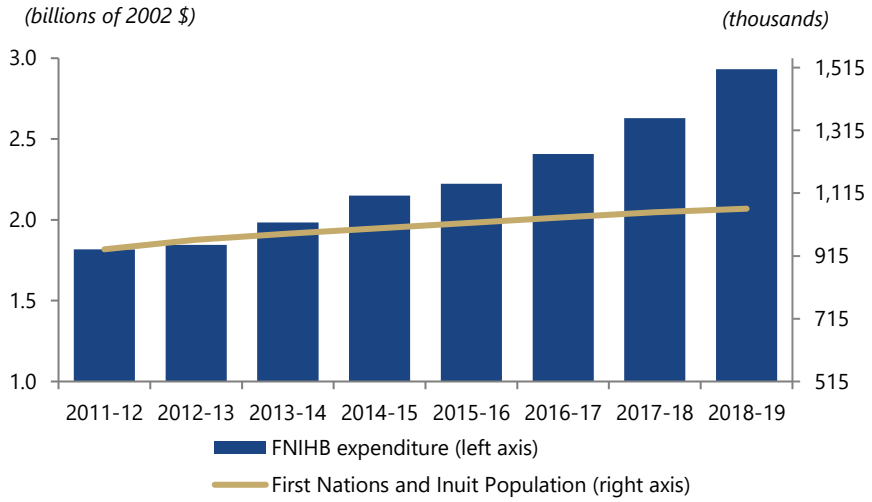
Source: Indigenous Services Canada.

Notes: * Core/on-going funding. ** Some programs within the sub-sub program are core/on-going funding. No asterisk implies it is not core/on-going or the information was not identified by Indigenous Services Canada.

Federal government spending on First Nations and Inuit health amounted to $2.2 billion in 2011-2012. This represented about 30 per cent of total federal health program spending.[13] By 2018-2019, the spending exceeded $3.8 billion, representing, respectively, about 40 per cent of total federal health program spending and roughly 33 per cent of ISC's budget.

Adjusted for inflation, health spending increased by an average of almost 9.0 per cent per year from about $1.8 billion in 2011-2012 to over $2.9 billion 2018-2019 (Figure 3-1). The growth significantly outpaced that of the First Nations and Inuit population during the same period at an average of 2.0 per cent per year.

Figure 3-1 Adjusted federal government health spending for First Nations and Inuit population



Sources: Indigenous Services Canada, PBO calculations.
Notes: FNIHB expenditure excludes spending on Employee Benefit Plan and Oversight and Delivery. Population counts are based on residency codes for individuals affiliated with federally recognized First Nations and Inuit communities.

Spending grew more significantly in recent years compared to earlier in the same decade. As Figure 3-1 indicates, between 2012-2013 and 2015-2016, health spending increased in real terms by an average of 6.8 per cent per year. Since 2016-2017, it increased by an average of 10.6 per cent per year. This is likely a reflection of expanded funding for Primary Care and Health Infrastructure Support programs since Budget 2016, as well as implementing Jordan's Principle[14] and decisions from the Canadian Human Rights Tribunal.

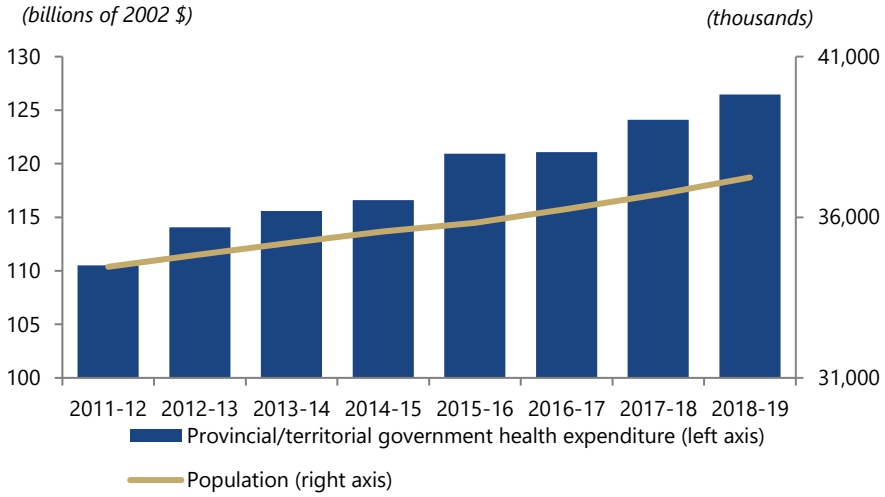
Provincial/Territorial Government Health Spending

Spending on health care made up the largest share (between 24 per cent and 40 per cent) of program spending by provincial/territorial governments in

2018-2019.[15] In 2011-2012, provincial/territorial government health spending approached $132 billion. By 2018-2019, the spending exceeded $167 billion.

Figure 3-2 indicates that, between 2011-2012 and 2018-2019, inflation adjusted provincial/territorial government health spending increased by an average of 2.1 per cent per year, less than one-quarter of the increase in federal government spending on First Nations and Inuit health. During the same period, the Canadian population grew at an average of 1.2 per cent per year, just over half the growth rate for the First Nations and Inuit population.

Figure 3-2 Adjusted provincial/territorial government health spending and population



Sources: Canadian Institute for Health Information (CIHI), PBO calculations.

Note: Provincial health-related spending includes all public spending by provincial/territorial governments.[16]

4. Analysis of Health Spending

In this section we analyze government health spending from several perspectives in more detail. First, we examine the relation between economic growth and health spending with an emphasis on the spending growth for First Nations and Inuit health care. Second, we analyze health spending in aggregate for the First Nations and Inuit population and for the entire Canadian population. Third, we analyze health spending, on a per capita basis, over 2011-2012 to 2018-2019 period and regionally for the 2018-2019 year. Lastly, we analyze per capita federal health spending for First Nations and Inuit in remote and non-remote areas for the 2018-2019 year.

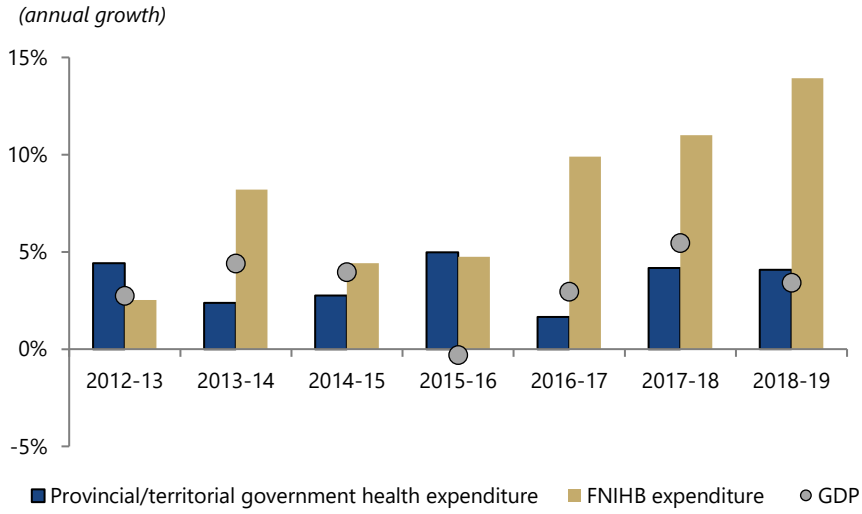
For any regional analysis we exclude British Columbia due to the British Columbia Tripartite Framework Agreement[17] as it provides a funding model that is not present in most other jurisdictions. In addition, we exclude the territories as the health service delivery in the territories differs from that of provinces.[18]

4.1. Economic Growth and Health Spending

Growth in provincial/territorial government health care spending generally increases during periods of higher economic growth, as shown in Figure 4.1, probably due to the additional fiscal flexibility generated by that growth. Recent trends show annual growth rates in federal government spending for First Nations and Inuit health at or above economic growth rates, with double-digit growth observed since 2016-2017. This growth seems driven by policy decisions rather than economic growth and the fiscal room thus generated.

Furthermore, changes in the growth of the Canada Health Transfer are correlated to corresponding changes in the growth of provincial/territorial government health spending.[19] Uncertainty leading up to the renewal of the Canada Health Transfer in 2014-2015 likely contributed to the restraint observed in provincial/territorial government health spending in 2013-2014 and 2014-2015 (Figure 4-1).

Figure 4-1 **Annual growth in government health spending and nominal GDP, 2012-13 to 2018-19**



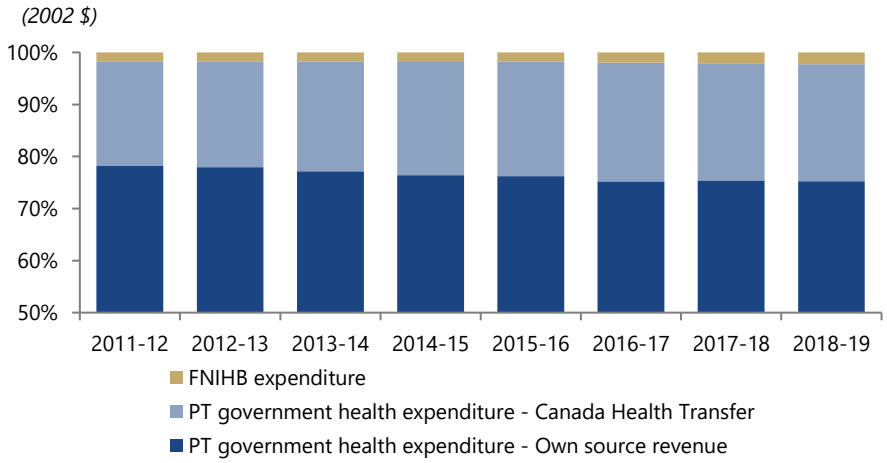
Sources: Canadian Institute for Health Information, Indigenous Services Canada, PBO calculations.

Notes: FNIHB expenditure excludes spending on Employee Benefit Plan and Oversight and Delivery. Provincial/territorial government health expenditure includes health spending from provincial/territorial government funds, federal health transfers to provinces/territories and provincial/territorial government health transfers to municipal governments.[20]

4.2. Aggregate Health Spending

Figure 4-2 shows that, in 2011-2012, federal health spending for First Nations and Inuit health care made up 1.7 per cent of total health spending across Canada. By 2018-2019, this proportion increased to 2.3 per cent. In comparison, the First Nations and Inuit population represented roughly 2.7 per cent of the total Canadian population in 2011-2012, increasing to 2.9 per cent by 2018-2019.

Figure 4-2 Share of total health spending by source of funds

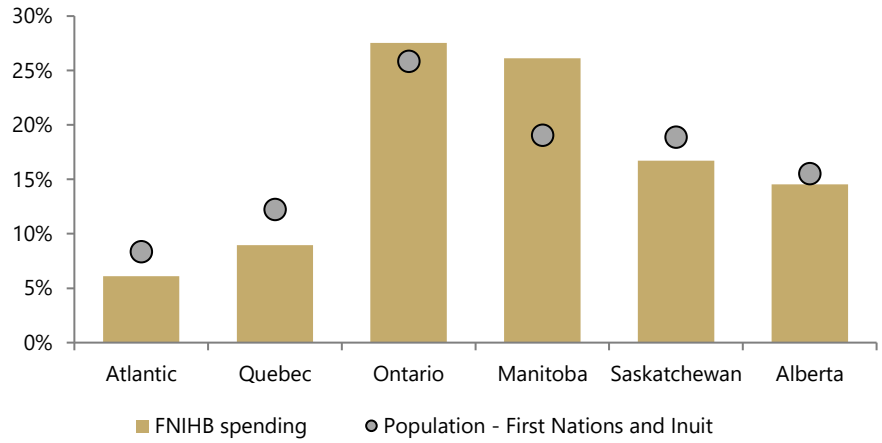


Sources: Canadian Institute for Health Information, Indigenous Services Canada, PBO calculations.

Notes: FNIHB expenditure excludes spending on Employee Benefit Plan and Oversight and Delivery. Provincial/territorial government health expenditure includes health spending from provincial/territorial government funds, federal health transfers to provinces/territories and provincial/territorial government health transfers to municipal governments.[21]

Excluding British Columbia and the territories, an examination of federal and provincial government health spending in 2018-2019 by region revealed that aggregate funding for the First Nations and Inuit population was concentrated in Ontario and Manitoba. This is not surprising since these two provinces, followed by Saskatchewan and Alberta, have the larger number of First Nations individuals in Canada. Comparatively, Quebec has a smaller First Nations population (smaller also than the Atlantic region); it is nevertheless home to a higher Inuit population. There was a positive correlation between aggregate health funding and the size of the First Nations and Inuit population in regions, as shown in Figure 4.3.

Figure 4-3 Share of federal government health spending and First Nations and Inuit population, by region, 2018-19



Sources: Canadian Institute for Health Information, Indigenous Services Canada, PBO calculations.

Notes: FNIHB expenditure excludes spending on Employee Benefit Plan and Oversight and Delivery. Provincial government health expenditure includes health spending from provincial/territorial government funds, federal health transfers to provinces and provincial government health transfers to municipal governments.[22]

Ontario accounts for 25.9 per cent of the First Nations and Inuit population in Canada and 27.5 per cent of total federal government health spending for First Nations and Inuit; Manitoba, Saskatchewan, and Alberta account for 53.5 per cent of the total First Nations and Inuit population and 57.4 per cent of total federal government health.

Box 4-1 FNIHB allocation methodology - Management Operational Plan

Most federal government funding is allocated using a Management Operational Plan that links planned activities to a source of funds. The Regions and Directorates of FNIHB collect planning information and engage partners in identifying and informing future funding requirements. Each Region and Directorate then plans future spending against a detailed notional budget allocation provided by Branch Services Financial Office at ISC National Headquarters.

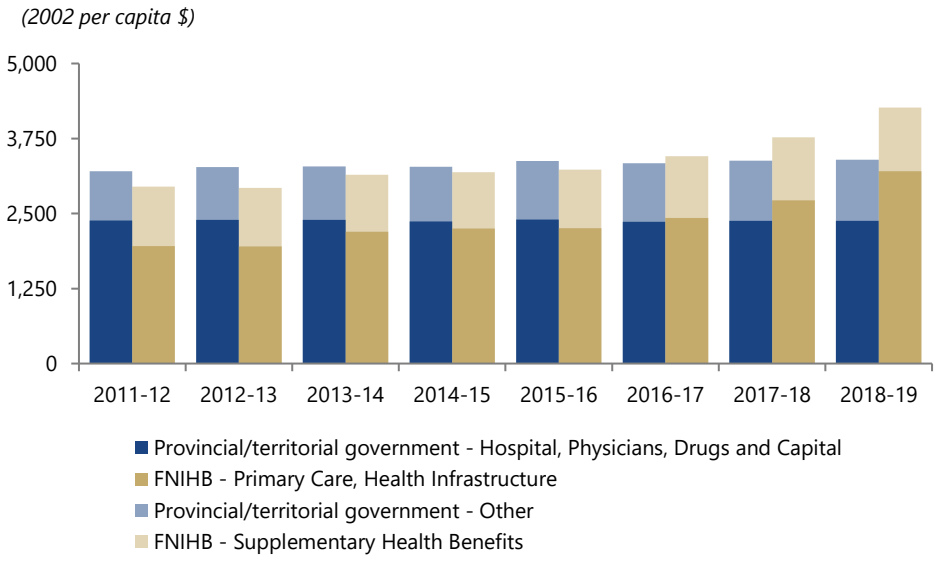
To reflect its distinct demand-driven funding model and allocation process FNIHB uses a Multi-Year Business Plan to determine funding, map the progress and track the evolution of program spending over a five-year period.

4.3. Health Spending on a Per Capita Basis

Health spending on a per capita basis considers federal, as well as provincial/territorial government health spending for the entire population, as most provincial/territorial health data cannot distinguish outlays specific to First Nations and Inuit from expenditures for other residents. Federal spending is meant to address different health needs of First Nations and Inuit and improve access to the health services provided by provincial/territorial governments. Thus, the spending figures represent provincial/territorial government health spending on a per capita basis for the general population and federal government health spending analyzed on a per capita basis for the First Nations and Inuit population, not how much each level of government spent for the health care of each First Nations and Inuit person.

Adjusted for inflation, growth in spending on a per capita basis increased over the observed period from 2011-2012 to 2018-2019. Federal government health spending increased by $1,315 and grew at an average annual rate of 6.4 per cent, with the much of this growth occurring after 2016-2017. This compares to a $189 increase in provincial/territorial government spending and growth of almost 1.0 per cent per year over the same period. (Figure 4-4).

Figure 4-4 **Adjusted per capita health spending by level of government**



Sources: Canadian Institute for Health Information, Indigenous Services Canada, PBO calculations.

Notes: FNIHB expenditure excludes spending on Employee Benefit Plan and Oversight and Delivery. Provincial/territorial government health expenditure includes health spending from provincial/territorial government funds, federal health

transfers to provinces/territories and provincial/territorial government health transfers to municipal governments.[23]

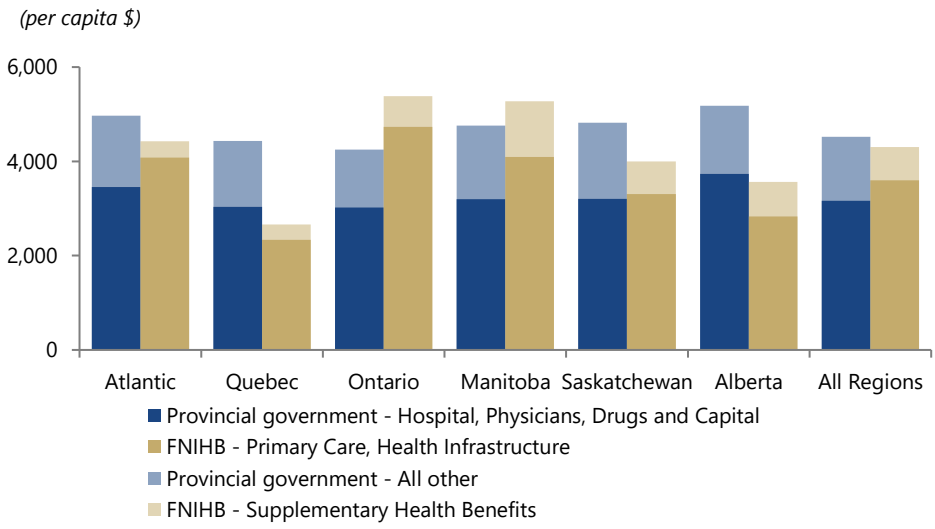
As in the case of aggregate funding, health funding on a per capita basis varies across regions in Canada. Health programs and services available to First Nations and Inuit and the cost of their health care are largely dependant on the region they live in, how funding is allocated and to whom funds are transferred. For more information, see Self Governing Agreements in Appendix B.

At the provincial/territorial level, government spending variations are unsurprising; regional differences in demography, rural-urban distribution and density, labour market conditions etc. can all affect provincial/territorial government health spending.[24]

In 2018-2019, the regional difference between the minimum and maximum spending by provincial/territorial governments was about $925 on a per capita basis. (Figure 4-5). This was largely due to differences in health spending policies in areas of hospital, physicians, drugs, and capital across provinces/territories.

In the same year, regionally, the difference between minimum and maximum per capita federal government spending on First Nations and Inuit health programs and services exceeded $2,700. Two-thirds of this difference is due to differences in Primary Care and Health Infrastructure spending across regions. Spending on these health programs and services for on-reserve populations in the Atlantic, Ontario and Manitoba exceeded $4,000 on a per capita basis. Quebec has the lowest federal health spending for programs and services on-reserve with the per capita amount being just over $2,300. (Figure 4-5).

Figure 4-5 Per capita government health spending by region, 2018-19



Source: Canadian Institute for Health Information, Indigenous Services Canada, PBO calculations.

Notes: FNIHB expenditure excludes spending on Employee Benefit Plan and Oversight and Delivery. Provincial/territorial government health expenditure includes health spending from provincial/territorial government funds, federal health transfers to provinces/territories and provincial/territorial government health transfers to municipal governments.[25] First Nations and Inuit population counts are based on residency codes for individuals in federally recognized First Nations and Inuit communities. Inuit population counts in 2016 are used.

Regional comparisons of total and per capita spending cannot be used to explicitly state whether a spending gap exists between regions or funding sources. There are other underlying factors that influence funding levels. A direct comparison of per capita spending is difficult given jurisdictional complexities.

Federal programs and services in health care are expected to address the health care needs of First Nations and Inuit populations which differ from the remainder of the population. Indigenous Services Canada attributes differences in funding to the impact of demographics (age), geographic locations, frequency of disease, trauma, and socio-economic discrepancies.[26]

4.4. Remote First Nations and Inuit Communities

Per capita federal health spending for First Nations and Inuit populations living in remote and non-remote areas is of particular interest and warrants a closer examination.

In 2018-2019 for example, over $1.1 billion (or almost 50 per cent) of federal government health spending went to First Nations and Inuit communities or Tribal Councils. The remaining amount was transferred to a mix of Indigenous organizations, health authorities, educational institutions, hospital or treatment centres, nongovernment organizations and other service delivery entities.

Where possible, federal government health spending for grants and contributions (Vote 10) transferred to recipient First Nations and Inuit communities was linked with its associated population counts and the remoteness index.[27] Each community or Council was determined to be either urban, rural, or remote based on the Jenks natural breaks remoteness index classification developed by Statistics Canada.[28] Excluding British Columbia and the territories, 251 communities were linked.

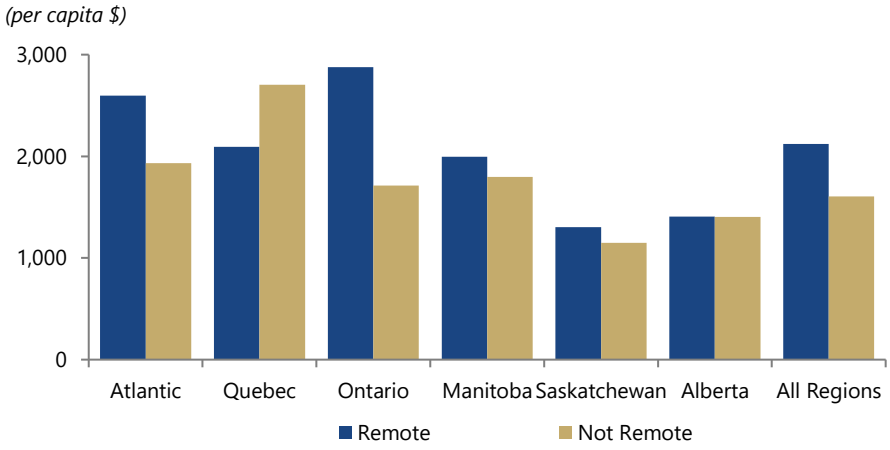
Of these linked communities, 182 are considered remote (defined as either being less accessible, remote, or very remote). These remote communities

received 72 per cent of federal government health spending and represented nearly 65 per cent of the First Nations and Inuit population.

On a per capita basis, federal government health spending was approximately $1,950 in the 251 communities. Excluding non-remote (urban) communities, the spending increased to $2,120. Figure 4-6 shows that, in 2018-2019, Saskatchewan had the lowest per capita spending transferred to remote communities ($1,300), while Ontario was more than twice as high ($2,880).

This analysis shows that grants and contributions (Vote 10) spending on a per capita basis is generally higher in remote communities than non-remote communities. (Figure 4-6). First Nations and Inuit communities in rural, remote, and isolated locations may have limited or no access to primary care services in their communities. This may have driven up the cost of health care programs and services for residents in these communities.

Figure 4-6 Federal government health spending per capita in 251 remote and non-remote communities, 2018-19



Source: Indigenous Services Canada, Statistics Canada, PBO calculations.

Notes: FNIHB expenditure data represents Vote 10 spending transferred to identified recipient First Nations and Inuit communities. First Nations and Inuit population counts are based on residency codes for individuals in federally recognized First Nations and Inuit communities.

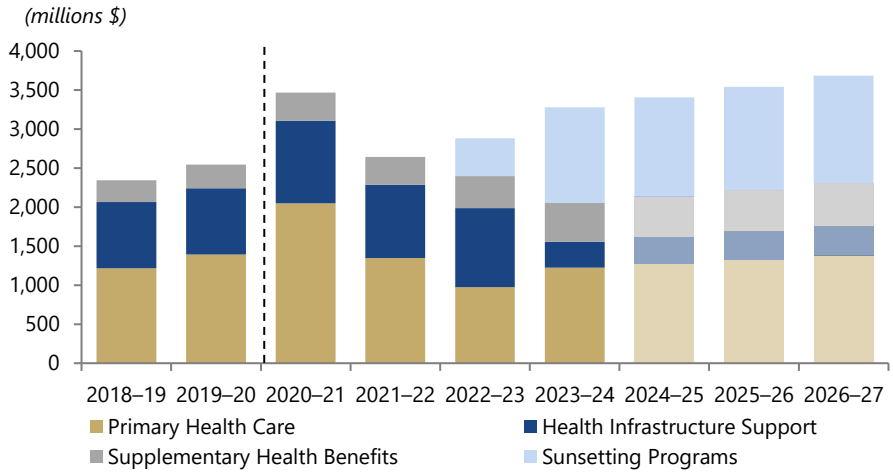
It should be noted that FNIHB allocates some core/on-going program funding based on the First Nations and Inuit population in each region, using the Modified Berger Formula that adjusts the population based on the distribution of people across each region in terms of remoteness and size of community.[29] About $100 million, or 8.0 per cent, of core/on-going program funding in 2018-19 was identified as being allocated using the Formula.

In summary, differences in spending on a per capita basis do exist between and within regions. However, results from such comparisons by themselves cannot be used to determine whether funding inequalities exist.[30]

5. Planned Health Spending of the Federal Government

Federal government health spending on the First Nations and Inuit population is projected to grow in the medium-term, assuming that sunsetting programs get renewed under existing parameters and uptake.[31] Based on this scenario, the ISC 2021-2022 Departmental Plan and Budget 2019, PBO estimates grant and contribution spending in FNIHB programs to increase by over $1 billion between 2019-2020 and 2026-2027.

Figure 5-1 Spending plans and projections – FNIHB programs



Sources: Indigenous Services Canada, Budget 2019, PBO calculations.

Notes: Figures for 2020-21 and 2021-22 include one-time funding for COVID-19 responses. Spending plan estimates from 2021-22 to 2023-24 are based on published 2021-22 Departmental Plan. Spending projections for 2024-25 and beyond are based on the Budget 2019 announcement that funding for core programs and services will be escalated to address key cost drivers including inflation and population growth.

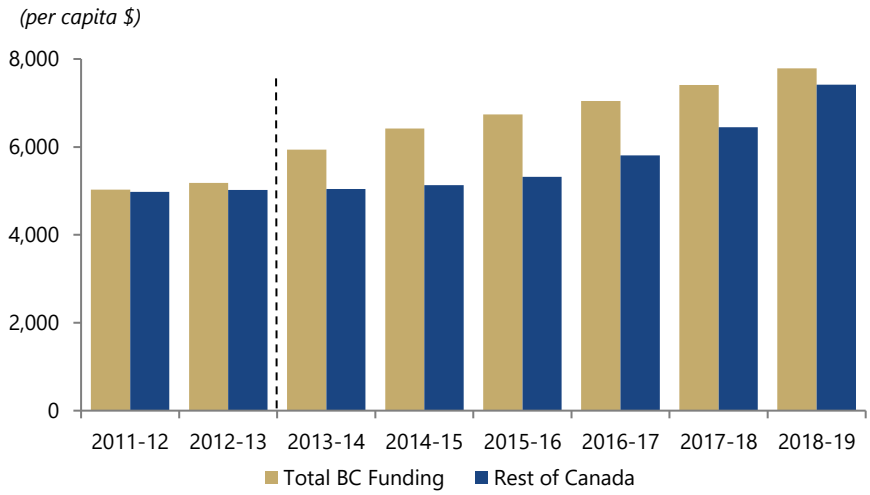
Appendix A: British Columbia Tripartite Framework Agreement

In 2011, the First Nations Health Authority (FNHA) signed an agreement with Health Canada and the Minister of Health in British Columbia.[32] [33] [34] It enabled the FNHA to develop and deliver health services to First Nations living on-reserve (or to all First Nations residing in British Columbia in the case of the First Nations Health Benefits Program). With closer collaboration among all parties, this health governance structure works to improve access to health services by First Nations in all regions of British Columbia that are at a minimum comparable to those available to other Canadians living in similar geographic locations.

In 2013, responsibility and funding for all Health Canada First Nation and Inuit Health Branch (FNIHB) activities in British Columbia was transferred to FNHA. A 10-year funding arrangement established the terms of contribution payments the federal government makes to the FNHA each fiscal year. As part of the main Framework Agreement, funding for new programs introduced by Canada after 2013 are provided to FNHA in a separate contribution agreement.[35]

Figure A-1 illustrates the results of the funding arrangement. The dotted line denotes the point at which the 10-year funding agreement was established. The estimated per capita funding increased, on average, about 7 per cent within the first 5 years of implementing the Agreement.[36]

Figure A-1 Estimates of per capita FNIHB funding: British Columbia



Sources: ISC administrative data, PBO calculations.

Notes: First Nations and Inuit population counts reflect residency codes for individuals affiliated with federally recognized First Nations and Inuit communities. Only on-reserve population counts were used.

British Columbia continues to be the only region with a province-wide First Nations health authority that plans, designs, manages, and funds the delivery of First Nations health programs and services.[37] According to Indigenous Services Canada, in 2018-2019 there were approximately 147,000 First Nations people residing in British Columbia, including just over 63,000 (or 43 per cent) living on reserves.[38]

An evaluation report on the first five years of British Columbia Tripartite Framework Agreement on First Nations Health Governance was released in January 2020. It highlighted the transition to an integrated framework of health services for First Nations through the inclusion of the FNHA and First Nations in the decision-making process regarding health systems and services. While it was determined that five years was an insufficient amount of time for observable shifts in health outcomes, the report showed the level of federal and provincial funding that would not have been secured without the existence of the First Nations health governance structure.[39]

Appendix B: Self-Governing Agreements

Self-Government Agreements (SGAs) enable Indigenous governments to have decision-making power in service delivery and management across a spectrum of policy areas, such as health and education. First Nations and Inuit Health Branch (FNIHB) funds the Indigenous government to provide health programs (comparable to health programs offered to other non-self-governing communities) via Fiscal Financing Agreements.

Currently, there are 25 SGAs across Canada involving 43 Indigenous communities, of which 22 grant Indigenous governments jurisdiction over health.[40] Since each SGA is unique to the community, the health programs funded are not identical, which renders any comparison difficult.

Quebec – The Cree Board of Health and Social Services and the Nunavik Regional Board of Health and Social Services both have jurisdiction to provide health services to Quebec's Cree and Inuit communities, respectively. While FNIHB funds some health programs through contribution agreements with both Boards, it also funds the Cree communities individually for the administration and provision of the Mental Wellness program on-reserve. Individual Inuit communities do not receive funds directly.[41]

British Columbia –Since 2013, the First Nations Health Authority (FNHA) assumes responsibility over planning, managing, funding, and delivering health programs (including non-insured health benefits (NIHB)) to meet the needs of British Columbia First Nations and address health services gaps in a culturally relevant manner.[42] The FNHA does not replace the role of the British Columbia Ministry of Health nor the regional health authorities. It integrates and coordinates its health programs and services to achieve better health outcomes for British Columbia First Nations.[43]

British Columbia's self-governing First Nations communities receive funding for some health programs from FNIHB in conjunction with contributions from the FNHA. For example, the Maa-nulth First Nations in British Columbia receive FNIHB funding for most health programs (including NIHB and medical transportation) as well as FNHA funding to provide MCH, NAYSPS, and AHSOR programs.[1] In contrast, Westbank First Nation receives its health funding exclusively from FNHA and does not receive any funding for NIHB.

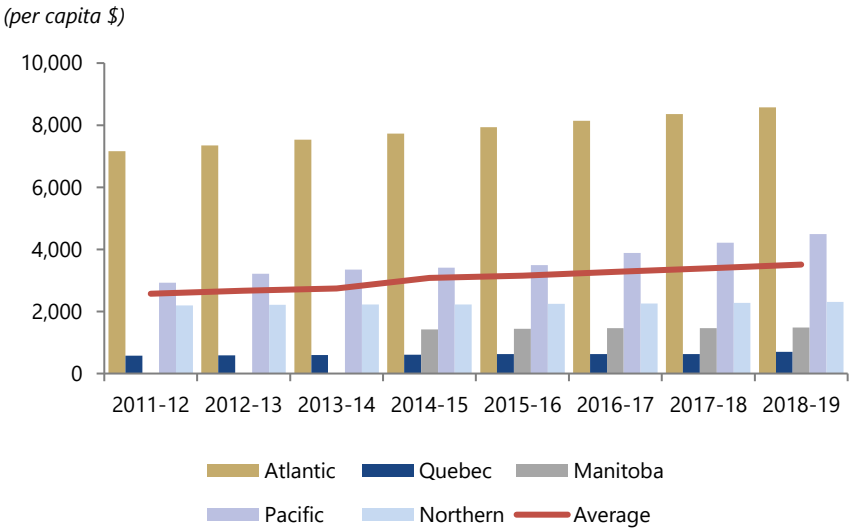
Newfoundland and Labrador – The Nunatsiavut Government has jurisdiction over health and receives funding from FNIHB for all health programs, except medical transportation (under NIHB). In response to the

[1] MCH: Maternal and Child Health, NAYSPS: National Aboriginal Youth Suicide Prevention Strategy, AHSOR: Aboriginal Head Start on Reserve.

unique challenges faced by the Nunatsiavut Government in providing non-insured health benefits comparable to those received by First Nations and Inuit elsewhere in Canada, FNIHB provides additional funding for NIHB.

Figure B-1 describes FNIHB transfers on a per capita basis to show the provincial variance in funded health programs. Where some provinces might receive additional funding for NIHB (such as Newfoundland and Labrador, with the highest per capita transfer), others receive no NIHB funding (such as Quebec). However, over this period, per capita SGA funding appeared to be stable, averaging at 4 per cent growth.

Figure B-1 Federal government per capita transfers to Self-Governing First Nations



Sources: Indigenous Services Canada, PBO calculations.

Notes : First Nations and Inuit population counts reflect residency codes for individuals affiliated with federally recognized First Nations and Inuit communities.

Appendix C: Data Considerations

Based on its experiences with this subject matter, Indigenous Services Canada noted some important issues in the collection and organization of data related to per capita comparisons with provincial/territorial government spending, as part of its response to PBO's information request IR0506.

Provincial/Territorial Funding Comparison (General)

First Nations and Inuit Health Branch (FNIHB) provides financial information to the Canadian Institute for Health Information's (CIHI) National Health Expenditure Database (NHEX). However, the mapping of FNIHB information to NHEX categories do not allow for a comparison at the FNIHB program level. While it does give the ability to compare spending in the federal and provincial/territorial health systems for similar categories of spending; there are limitations for a comparative analysis.

Although First Nations have access to physicians, hospitals and other provincial/territorial health services and provincial/territorial government health spending includes spending on First Nations, these expenses cannot be systematically tracked across provincial/territorial jurisdictions. This is because most provincial/territorial health data cannot distinguish outlays specific to First Nations or other population groups.

Population Data

Population counts are extracted from INAC's Indian Registration System (IRS) and have not been adjusted for late reporting of births or deaths. Counts reflect residency codes for individuals affiliated with the First Nations only. On-reserve population numbers for each First Nation should not be taken to represent the true population for the following reasons:

1) They contain no information on any non-Registered individuals who may be living on reserve or crown lands;

2) Similarly, they contain no information on any individuals registered to other bands who may be living on reserve or crown lands;

3) On-Reserve and On Crown Land are roll-ups of more than one residency field. They may include counts pertaining to registrants residing on reserve or crown lands belonging to other bands;

4) Total On-Reserve/Crown Land population counts may also include individuals living on lands affiliated with First Nations operating under SGAs;

5) Bands with population of less than 40 were supressed from the datasets for confidentiality; and,

6) The On-Reserve/Crown Land and off reserve population counts for a band were supressed if either was less than 10 for confidentiality.

There are also limitations on the data in the IRS:

1) Late reporting of life events to the First Nation's Indian Registry Administrator (IRA) to update an individual's information on the IRS. According to recent history, about 70 per cent of all births reported in any particular year occurred in a prior year. Individuals can also remain on the Indian Register for some time after they are deceased. A certificate of death or a confirmation of presumed death is normally required to remove a name from the system.

2) Residency codes tend to be updated by the IRA when a life event is reported. As a result, it is possible for an individual to move back and forth between on and off reserve, and never has his/her information updated if a life event was not reported. In addition, the residency field is optional when the IRA updates the system.

Federal Funding Allocations by Recipient

In its response to PBO's IR0545, ISC only released data for Vote 10 (grants and contributions). Vote 1 (operational funding) and Vote 5 (capital funding) data were not released due to the following considerations:

1) Privacy concerns – under Vote 1, program recipients represent primarily individual persons. For example, Jordan's Principle uses Vote 1 and Vote 10 (contribution agreements) to provide programs, services, and supports to individuals and groups. Regional aggregate data was provided under the initial Information Request IR0506; and,

2) Scale – Vote 5 represents approximately or less than 5% of the total annual expenditures depending on the fiscal year in the range between 2014-2015 and 2018-2019. Regional aggregate data was provided under the initial Information Request IR0506.

Notes

1. Non-insured services include eligible prescription drugs, long-term and home care, dental care, and vision care. For non-insured services many Canadians receive private insurance benefits through an employer or through social programs for certain demographic groups (seniors, children, people with disabilities, and low-income residents).
2. Health Canada, First Nations and Inuit Strategic Health Plan: A shared path to improved health (2012).
3. House of Commons, The Challenges of Delivering Continuing Care in First Nations Communities (2018).
4. National Collaborating Centre for Aboriginal Health, The Aboriginal health legislation and policy framework in Canada.
5. Lavoie, J.G., Forget, E., and O'Neil, J.D. (2007). Why Equity in Financing First Nations On-Reserve Health Services Matters: Findings from the 2005 National Evaluation of the Health Transfer Policy. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2585472/
6. Ibid, Note 1.
7. Ibid, Note 2.
8. Ibid, Note 3.
9. Ibid, Note 4.
10. In 2017, First Nations and Inuit Health Branch was transferred from Health Canada to become part of Indigenous Service Canada.
11. Ibid, Note 3.
12. Indigenous Services Canada, Who is eligible for the Non-Insured Health Benefits program (2019).
13. Total federal health spending includes spending on health care services for special groups, such as Indigenous peoples, members of the Canadian Armed Forces and veterans, as well as expenditures for health research, health promotion and health protection.
14. A description of Jordan's Principle is available in a recent PBO report, Compensation for the delay and denial of services to First Nations children (2021).
15. The large share of provincial/territorial government spending devoted to health care is contrasted with that of the federal government. Total federal direct program spending on health care (Indigenous peoples, members of the Canadian Armed Forces and veterans, as well as expenditures for health research, health promotion and health protection) comprises less than seven per cent of the total federal direct program expenditures. This difference is due to the type and size of programs provided by each level of government.

    Canadian Institute for Health Information (CIHI) national health expenditures are reported based on the principle of responsibility for payment rather than

on the original source of the funds. As a result, federal direct program spending does not include federal health transfers to the provinces/territories since it is the responsibility of provincial/territorial governments to expend federal transfers on health services.

16. For a description of heath expenditures by source of finance, see Canadian Institute for Health Information. National Health Expenditure Trends, 2020 - Methodology Notes (2021).
17. Indigenous Services Canada, British Columbia Tripartite First Nations Health Plan (2020).
18. Indigenous Services Canada, Working within the territorial health context: a framework to understanding and applying the northern lens (2020).
19. Canadian Institute for Health Information, National Health Expenditure Trends, 1975 to 2019 (2019).
20. Ibid, Note 15.
21. Ibid, Note 15.
22. Ibid, Note 15.
23. Ibid, Note 15.
24. Ibid, Note 16.
25. Ibid, Note 15.
26 IR0506, https://www.pbo-dpb.gc.ca/web/default/files/Documents/Info%20Requests/2020/IR0506_ISC_First-Nations_request_e.pdf
27. IR0545, https://www.pbo-dpb.gc.ca/web/default/files/Documents/Info%20Requests/2020/IR0545_ISC_FNIHB_2_request_e.pdf
28. Statistics Canada, Developing Meaningful Categories for Distinguishing Levels of Remoteness in Canada (2020).
29. Ibid, Note 23.
30. Ibid, Note 5.
31. Indigenous Services Canada, 2021-22 Departmental Plan.
32. At the time of signing the First Nations Health Authority (FNHA) was known as the First Nations Health Society. Eighty-seven per cent of the chiefs voted overwhelmingly in favour of taking control of health services in 2011. A larger majority, 94 per cent, voted to create a permanent First Nations Health Authority. The FNHA receive federal, provincial, and other health funding for or to support the planning, design, management, and delivery of First Nations Health programs in collaboration with the BC Ministry of Health and BC Health Authorities.
33. Ibid, Note 16.
34. Ibid, Note 10.
35. The annual federal amount is not reduced if the FNHA obtains additional funding for any of the FN Health Programs from other sources, including British Columbia or other federal government departments. See Indigenous Services Canada, British Columbia Tripartite framework agreement on First Nations health governance (2020).

36. As part of the initial five-year review of the general and specific provisions in the Canada Funding Agreement, the value of the annual escalator for the remaining five fiscal years were negotiated by all parties. Renewal negotiations of the 10-year agreement will commence no later than one year prior to the expiry date of the current Canada Funding Agreement in fiscal year 2022-23. See Indigenous Services Canada, British Columbia Tripartite framework agreement on First Nations health governance (2020).

37. Across Canada, 25 self-governing arrangements have been negotiated with the federal government involving 43 Indigenous communities, of which 22 grant Indigenous Governments jurisdiction over health. Self-governing agreements are described in more detail in Appendix B.

38. Except for Newfoundland and Labrador, all provinces have a higher percentage of First Nations people living on reserves.

39. The report also shows some improvements in health system performance and signs that the accessibility of health services is improving for First Nations. Remaining challenges include jurisdictional issues concerning roles and responsibilities of service delivery in-community and away from home and ensuring First Nations are making health gains as quickly as the rest of the population.

    Please see Executive Summary: Evaluation of the British Columbia Tripartite Framework Agreement on First Nation Health Governance and Evaluation of the Tripartite Framework Agreement on First Nations Health Governance, Key Findings.

40. Additionally, there are two education SGAs involving 35 indigenous communities. Refer to OPBO's report Federal Spending on Primary and Secondary Education on First Nations Reserves (2016), Appendix A.

41. National Collaborating Centre for Health Public Policy, https://www.ncchpp.ca/en/popup.aspx?sortcode=2.10.23.32

42. The British Columbia Tripartite Agreement is described in more detail in Appendix A this report.

43. First Nations Health Authority, Transition and Transformation.