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FEDERAL RESPONSIBILITY FOR THE HEALTH CARE OF SPECIFIC GROUPS

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14 December 2004

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INTRODUCTION

Most discussions about health care in Canada and the role of the federal government focus on the government's responsibilities in assuring a nationwide system available to all Canadians. Thus, the federal government's role is generally seen in national terms as a promoter, facilitator, and partial funder of health care services across the country. The differentiation between its national role for all Canadians and its federal role in ensuring that health care services are provided to specific groups that fall under its jurisdictional authority is seldom explored.

This paper focuses specifically on the federal role as a health care services provider. This role is additional to the government's role in administering national principles or standards for the health care system through the *Canada Health Act* and in assisting with the financing of national health care services through fiscal transfers and equalization payments to provinces and territories.

HOW DOES THE FEDERAL GOVERNMENT DESCRIBE ITS ROLE?

The Government of Canada itself now asserts that it is "the fifth largest provider of health services," fulfilling functions for which it is constitutionally responsible. In 2002, it was serving approximately 950,000 clients at an annual cost of $3.4 billion.(1) Two years later, it declared that it was serving approximately 990,000 people at a cost of almost $4.0 billion.(2)

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(1) Health Canada, *Healthy Canadians – A Federal Report on Comparable Health Indicators 2002*, Ottawa, September 2002, http://www.hc-sc.gc.ca/iacb-dgiac/arad-draa/english/accountability/indicators.html.

(2) Health Canada, *Healthy Canadians – A Federal Report on Comparable Health Indicators 2004*, Ottawa, November 2004, http://www.hc-sc.gc.ca/iacb-dgiac/arad-draa/english/datadevelop/health_indicators_e.pdf.

The federal government reported that it has the responsibility to ensure that health care services are provided directly or indirectly to five specific groups in Canada: First Nations and Inuit; Canadian Forces personnel; veterans; Royal Canadian Mounted Police; and inmates in federal penitentiaries. This paper also provides information on the health services provided through the federal government to some refugee claimants.

WHERE DOES THE FEDERAL MONEY GO?

In providing health care services to those specific groups, the federal government does not do the work alone. It relies on a range of other participants, including health care professionals, provincial and territorial governments, and health claims administrators.

The money allocated for health care services can cover costs for health personnel such as physicians and nurses, health facilities such as hospitals and clinics, and health supplies such as drugs and equipment. The level of health care delivered may be primary care, where treatment, health promotion and maintenance as well as continuing care are provided at first contact with a health care professional. It may also be secondary care, involving specialists and including hospital services; or it may be tertiary care, for more difficult problems involving specialist care located in university teaching hospitals.

The federal government has a different mode of operation for each group. In the case of some groups, the federal government takes responsibility after the provincial plan has met its obligations. In other instances, the federal government takes responsibility from the client's first entry into the health care system. It should also be noted that, for certain groups, the federal government covers services such as pharmacare and long-term care that are not available to other Canadians under provincial plans.

The following table summarizes overall federal government investments in health services for specific groups, as outlined in two Government of Canada reports on comparable health indicators.

Specific Group	Estimated Expenditures, 2004[3]	Estimated Expenditures, 2002[4]	Approximate Population
First Nations and Inuit	$1.4 billion	$1.3 billion	400,000 First Nations clients living on reserves; 300,000 First Nations clients living off reserves; 40,000 Inuit clients.
Veterans	$636.6 million (2002-2003)	$541.7 million (2001-2002)	133,400 clients eligible for health care benefits.
Canadian Forces	$306 million (2002-2003)	$450 million (2001-2002)	60,000 Regular Forces and 33,000 Reserve (while on duty) members.
Federal Offenders	$118.4 million (2002-2003)	$98.5 million (2000-2001)	12,600 inmates and 8,000-9,000 offenders on conditional release.
Royal Canadian Mounted Police	$38 million (2002-2003)	$30 million (2000-2001).	15,900 members were eligible to receive health benefits in 2002-2003.
Refugee Claimants	No information provided in source document.[5]	No information provided in source document.	Specific number unknown.[6]

In addition, in November 2004, the Auditor General of Canada tabled a report specifically on federal drug benefit plans under the six federal programs – in Citizenship and Immigration Canada, Correctional Service Canada, Health Canada, National Defence, the Royal Canadian Mounted Police, and Veterans Affairs Canada. The report noted that the federal government is the fourth-largest payer of prescription drug benefits in Canada, providing such benefits to one million beneficiaries at a collective cost of more than $430 million in 2002-2003.[7]

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(3) *Ibid.*

(4) Health Canada, *Healthy Canadians* (2002).

(5) Citizenship and Immigration Canada, *Report on Plans and Priorities, 2003-2004*, indicated an amount of $50 million (p. 42); see http://www.tbs-sct.gc.ca/est-pre/20032004/pdf/ci-e.pdf.

(6) Citizenship and Immigration Canada's Web site indicates that more than 26,800 government-assisted refugees were resettled in the three years from 2000 to 2002; see: http://www.cic.gc.ca/english/department/brochure/service.html.

(7) Auditor General of Canada, "Management of Federal Drug Benefit Programs," Chapter 4, November 2004, http://www.oag-bvg.gc.ca/domino/reports.nsf/html/20041104ce.html/$file/20041104ce.pdf.

HOW DO THE SPECIFIC GROUPS GET HEALTH CARE?

The following sections identify specific groups under federal responsibility and describe the health care services, the departmental authority for the provision of the services, and any relevance to the *Canada Health Act*.

A. First Nations and Inuit

1. Departmental Description of Health Care Services

Health Canada provides:

- Health services – considered to be medically necessary but not covered by private or provincial/territorial health plans – offered through the Non-Insured Health Benefits (NIHB) Program, such as vision and dental care, drugs, crisis intervention mental health counselling, transport, and medical supplies and equipment; these services are offered to eligible First Nations and Inuit clients regardless of residence.

- Community-based health programs such as disease prevention and health promotion programs; health education; drug, alcohol and substance abuse programs; and mental health and child development programs. These are offered through nursing stations, health centres, environmental health services, and National Native Addiction and Drug Abuse Program (NNADAP) treatment centres.

- Urgent care, short-term in-patient care and primary care in nursing stations and health centres staffed by community health nurses and Community Health Representatives, with physicians providing services on a visiting basis.(8)

- Limited hospital services in small northern towns, staffed by several doctors, nurses, and community health workers (Sioux Lookout Zone Hospital, Norway House Hospital and Percy E. Moore Hospital).(9)

2. Departmental Authority and Relevance to the *Canada Health Act*

Health Canada outlines the base for its health care service provision as follows: "The program policies and practices follow the 1979 Indian Health Policy and the 1997 NIHB

(8) Health Canada, First Nations and Inuit Health Branch, Program Policy Transfer Secretariat and Planning, "Operations and Information Management," http://www.hc-sc.gc.ca/msb/pptsp/info_e.htm.

(9) Information collected from Health Canada, First Nations and Inuit Health Branch, various Web sources including First Nations and Inuit Control, *Annual Report, 2001-2002*, http://www.hc-sc.gc.ca/fnihb/bpm/hfa/fnic_annual_report_2001_2002.htm#Figure%203.

Renewed Mandate."[10] The 1979 policy states that: "Policy for federal programs for Indian people, (of which the health policy is an aspect), flows from constitutional and statutory provisions, treaties and customary practice."[11]

Under the Constitution, the federal government is vested with jurisdiction over Indians and Inuit. The federal government has exercised this legislative authority primarily with respect to the registered (status) Indian and Inuit population.

Both federal and provincial governments are responsible for providing health services for First Nations and Inuit. Provincial involvement in First Nations and Inuit health is primarily through provision of physician and hospital services, as required under the *Canada Health Act*. The federal government appears to fund its services primarily through Health Canada's First Nations and Inuit Health Branch as direct programs and as contribution agreements. When a benefit is covered under another plan, the federal government requires the coordination of benefits to ensure that the other plan meets its obligations.

Federal services are provided to First Nations and Inuit who have a Recipient Identification Number or a Band or family number that was assigned by Indian and Northern Affairs Canada, usually at birth. The status card is an identification card for status Indians. It provides evidence that a person is entitled to receive programs and services which include non-insured health care and certain tax exemptions.[12]

Since 1998, claims under the Non-Insured Health Benefits Program have been administered by First Canadian Health (FCH), a joint venture of the Tribal Councils Investment Group and Aetna Health Management.

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(10) Health Canada, *Non-Insured Health Benefits Program Information Booklet*, http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/nihb/consent/infobook.htm#NIHB.

(11) Health Canada, "Indian Health Policy 1979," http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/bpm/hfa/transfer_publications/indian_health_policy.htm.

(12) Indian and Northern Affairs Canada, "Indian Registration," http://www.ainc-inac.gc.ca/gol-ged/faq_e.html.

B. Veterans

1. Departmental Description of Health Services

Veterans Affairs Canada (VAC) pays for:

- Health care (including a comprehensive range of health care benefits not provided provincially) for war and Canadian Forces veterans who meet service and income requirements or have been awarded disability pensions resulting from military service; medical, surgical, dental, psycho-geriatric, palliative and respite care may be provided along with other community health care services and benefits.

- Institutional health care provided to eligible veterans in the departmental hospital at Ste-Anne-de-Bellevue, Quebec, in contract hospital beds located in provincial health care institutions, and in hospitals of choice.

- Health care for clients with general mental health needs as well as post-traumatic stress syndrome and operational stress, through services offered jointly with the Department of National Defence.(13)

2. Departmental Authority and Relevance to the *Canada Health Act*

According to the department, the principal legislative authority is found in the *Department of Veterans Affairs Act*. Additionally, a significant part of the mandate for veterans' health care is embodied in the many orders in council and federal-provincial agreements that: (a) authorized the transfer of veterans' health care institutions to provincial jurisdictions; and (b) set out veterans' continuing rights to long-term care in contract beds within those institutions.(14)

Both federal and provincial governments have responsibilities in providing health services to veterans. According to Veterans Affairs Canada, income-qualified veterans may be eligible for treatment benefits not provided under a provincial health insurance plan, while pensioners with a disability receive treatment for their pensioned condition. Others are served through provincial plans.

Clients eligible for federal health care benefits or services are provided with a VAC Health Care Identification card and have access to more than 85,000 providers across the country. Eligibility for benefits depends on factors such as pensioned condition and provincial coverage.

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(13) Information is drawn from several sources, including Web site descriptions such as Veterans Affairs Canada, "Ste. Anne's Hospital," http://www.vac-acc.gc.ca/general/sub.cfm?source=steannes and *Veterans Program Policy Manual*, http://www.vac-acc.gc.ca/providers/sub.cfm?source=vppm.

(14) Veterans Affairs Canada, *Veterans Program Policy Manual*.

Issues such as payments for institutional care are based on the lowest monthly user charge for accommodation and meals permitted by a province, under section 19 of the *Canada Health Act*, on 1 July of the same year.(15)

Since 2002, payments for client services have been administered by Atlantic Blue Cross Care.(16)

C. Canadian Forces

1. Departmental Description of Health Services

The Department of National Defence (DND) provides health care services for Canadian Forces (CF) members whether at home or abroad:

- Through 51 CF Health Care Clinics located throughout Canada, staff provide primary health care services such as diagnosing and treating non-life-threatening illnesses and injuries, performing minor surgical procedures, and promoting wellness. Most clinics also have basic laboratory and diagnostic imaging capabilities, an out-patient pharmacy, an optical services section, and a physiotherapy service. Larger clinics incorporate a number of specialty services, such as mental health, internal medicine, cardiology, and dermatology.

- Most tertiary care services are made available, by purchasing them from the provinces.(17)

- Through the DND-VAC Centre for the Support of Injured and Retired Members and Their Families, individuals are directed to appropriate services.

2. Departmental Authority and Relevance to the *Canada Health Act*

Under subsection 91(7) of the *Constitution Act, 1867*, sole responsibility for all military matters, including military health care, is assigned to federal authority. The *National Defence Act* gives the Minister of National Defence management and direction of the Canadian Forces. The Minister, in turn, gives management and direction of the Medical and Dental Services to the Canadian Forces.(18)

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(15) Veterans Affairs Canada, *Veterans Health Care Regulations*, http://laws.justice.gc.ca/en/V-1/SOR-90-594/text.html.

(16) Veterans Affairs Canada, *Veterans Program Policy Manual*.

(17) Department of National Defence, “Health Services Delivery,” Health Services Factsheet, http://www.forces.gc.ca/health/news_pubs/hs_factsheets/engraph/sheet-04_e.asp?Lev1=4&Lev2=9&Lev3=5.

(18) Department of National Defence, “Canadian Forces Health System,” Health Services Factsheet, http://www.forces.gc.ca/health/news_pubs/hs_factsheets/engraph/sheet-01_e.asp?Lev1=4&Lev2=9&Lev3=2.

The 1984 *Canada Health Act* specifically excludes CF members from the definition of "insured persons."(19) As well, CF members are excluded from insurance coverage under provincial health care plans.

Members are provided with a CF health care identification card and are to make the CF clinics their first point of contact, unless there is a medical emergency or geographical location makes the use of CF services impractical or unsafe.

Atlantic Blue Cross Care now processes health benefits for the Canadian Forces.

D. Federal Offenders

1. Departmental Description of Health Services

Correctional Service Canada (CSC) provides in-house health care services for individuals sentenced to prison for two years or more and sent to federal correctional institutions offering minimum, medium, or maximum levels of security. The health services are available in three settings:

- In health care units at 53 penitentiaries, nurses and general practitioners provide primary health care. Specialists provide secondary health care through institutional visits or from outside.
- Regional hospitals in four of the five regions (except the Prairie Region) provide in-patient care at the tertiary level. In the Prairie Region, patients are placed in the chronic care wing of the in-patient psychiatric facility.
- Six regional psychiatric treatment centres offer diverse programs. Additional tertiary care (specialist, diagnostic and hospital services) in the community is provided as required.(20)

2. Departmental Authority and Relevance to the *Canada Health Act*

The *Constitution Act, 1867*, gives the federal government exclusive jurisdiction over criminal law and procedure, as outlined in subsection 92(27). This was interpreted to cover federal penitentiaries where offenders serve two or more years. The 1992 *Corrections and Conditional Release Act* states that: "The Service shall provide every inmate with: (a) essential

(19) *Canada Health Act*, section 2: Interpretation, http://laws.justice.gc.ca/en/c-6/16839.html#rid-16883.

(20) Jane Laishes *et al.*, "A Health Care Needs Assessment of Federal Inmates in Canada," *Canadian Journal of Public Health*, Vol. 95, Supplement 1, March/April 2004, p. S11.

health care; (b) reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community."[21]

Once inmates are released on parole into the general population, the CSC is not responsible for their health services. If an offender is on conditional release in one of the 17 community facilities operated by the CSC, the CSC continues to pay for essential services. The CSC also pays for medications or dental services if an offender on conditional release is unable to do so. In addition, it pays for non-insured mental health programs that are required either by the National Parole Board or by the offender's correctional plan.[22]

Under the *Canada Health Act*, insured persons are eligible residents of a province or territory. A resident of a province is defined in the *Canada Health Act* as "a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province." Inmates of federal penitentiaries are excluded from insurance under the *Canada Health Act.* Federal offenders on parole are considered to be residents of the province where they are placed.

E. Royal Canadian Mounted Police

1. Departmental Description of Health Care Services

The Royal Canadian Mounted Police (RCMP) provides:

- Comprehensive health services to ensure that members are emotionally and medically fit to perform duties.
- Payment for personal health care provided to members by providers that meet specified RCMP criteria.[23]
- Medical treatment for Cadets at the Medical Treatment Centre at the RCMP Training Academy in Saskatchewan. The Centre consists of a health clinic, an infirmary with several patient beds, and various treatment and therapy rooms. It has full-time daytime medical staff that include a medical doctor, nurse, psychologist, and physiotherapist.[24]

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(21) *Corrections and Conditional Release Act*, section 86, http://laws.justice.gc.ca/en/c-44.6/39880.html.

(22) Laishes (2004), p. S10.

(23) Royal Canadian Mounted Police, "Organization of the RCMP," http://www.rcmp-grc.gc.ca/html/organi_e.htm.

(24) Royal Canadian Mounted Police, "Orientation for Course Candidates," p. 12, http://www.rcmp-grc.gc.ca/clet/cletweb/doc/clet_orient.pdf.

2. Departmental Authority and Relevance to the *Canada Health Act*

Serving members of the RCMP are specifically excluded under the *Canada Health Act*. The *Royal Canadian Mounted Police Regulations, 1988* pursuant to the *Royal Canadian Mounted Police Act* specify that medical and dental treatment programs for a regular member or special constable member are subject to approval by the Commissioner.(25)

Serving RCMP members use the health identification card issued by the RCMP. When a serving member of the RCMP uses provincial services, the member presents his or her client registration number and ensures that authorization is obtained from an RCMP Health Services Officer. The provincial service then bills the RCMP for services.

Atlantic Blue Cross Care processes general health benefits for the RCMP. Veterans Affairs Canada with Atlantic Blue Cross Care jointly provide administrative services for the delivery of health care benefits for RCMP members who are pensioned for service-related injuries and illnesses.(26)

F. Refugee Claimants

1. Departmental Description of Health Care Services

The Interim Federal Health Program administered by Citizenship and Immigration Canada (CIC) covers emergency and essential health services for needy refugee claimants and for refugees in Canada who are not yet eligible for provincial health care. Benefits are limited to:

- Essential health services for the treatment and prevention of serious medical/dental conditions (including immunizations and other vital preventative medical care).
- Essential prescription medications.
- Contraception, prenatal and obstetrical care.
- Immigration medical examination.

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(25) *Royal Canadian Mounted Police Regulations, 1988*, http://laws.justice.gc.ca/en/r-10/sor-88-361/index.html.

(26) Veterans Affairs Canada, *Veterans Affairs Canada Five-Year Strategic Plan 2001-2006 – Update 2003*, p. 33, http://www.vac-acc.gc.ca/content/department/reports/fiveyearplan03/strategic_plan03.pdf.

2. Departmental Authority and Relevance to the *Canada Health Act*

Under section 95 of the *Constitution Act, 1867*, immigration is an area of concurrent jurisdiction, with the Parliament of Canada having the paramount authority in the case of any conflict. According to CIC's manual for immigration officers titled *Processing Claims for Refugee Protection in Canada*, the Interim Federal Health program was created pursuant to a 1957 order in council that authorizes the federal government to pay for in-Canada health care services for certain migrants who are unable to pay for urgent and essential services.(27) It covers refugee claimants – individuals who do not have landed immigrant status but arrive in Canada requesting to be accepted as refugees for various reasons.

The program coverage is temporary, usually lasting for no more than a year. The program was transferred to CIC in 1995 from Health Canada, where it was administered through the Non-Insured Health Benefits Program. It is not intended to replace provincial health plans, and claimants are asked if they are in a position to pay for health care or if they are eligible for private or public health insurance.

While refugee claimants are eligible to be residents of a province for health insurance purposes, they may have to wait for three months before they are considered an insured person with eligibility for or entitlement to insured health services. As indicated above, a resident of a province is defined in the *Canada Health Act* as "a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province."

Eligible refugee claimants receive an Interim Federal Health certificate showing that they are entitled to receive the coverage. They can show the Citizenship and Immigration Canada Form IMM 1442 to the doctor, hospital or dentist when they register.(28)

After prior approval from the Medical Director at CIC, medical bills are forwarded by the health care provider to FAS Benefit Administrators Ltd. in Edmonton for payment.

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(27) Citizenship and Immigration Canada, *Processing Claims for Refugee Protection in Canada*, section 15:14, http://www.cic.gc.ca/manuals-guides/english/pp/pp01e.pdf.

(28) Citizenship and Immigration Canada, "Refugee Protection," Operations Memoranda, IP 98-16, Interim Federal Health Program, http://www.cic.gc.ca/ref-protection/english/infocentre/settlement-etablissement/comm-prof/appendix_i.htm.

WHAT ARE SOME GENERAL COMPARISONS?

The agreement by the First Ministers in September 2000 to report on comparable indicators served as a major impetus for the development of a comparative profile of federal health care services. The Government of Canada, along with provincial and territorial governments, made a commitment to clearer accountability and to improved reporting about health.

In both its 2002 and 2004 reports on health indicators, the Government of Canada indicated that it is the fifth-largest provider of health services to Canadians. Neither report, however, includes a clear profile of the health care delivery that falls directly under federal jurisdiction, or of the 18 featured indicators for measuring performance related to each of the six groups discussed in this paper. As the 2004 report states: "limited information on the Aboriginal populations is included, and no data are available on other populations under federal responsibility for health care."(29)

The following sections identify some variables that could be considered in comparing federal program costs, service provision, and compliance with the *Canada Health Act*.

A. Program Costs

The Canadians who are clients of federal health services are a diverse population of almost 1 million people. They live in all regions of the country and are served at a cost of some $4-5 billion. A cursory look at the various groups and the associated health care costs suggests that there are important distinctions among the six groups that affect the ultimate program costs. While more detailed analysis is needed to fully understand any differences in per capita expenditures for the federal client groups, the following findings provide a preliminary framework for further comparison.

- *Size*: The First Nations and Inuit population is the largest and most costly group, consisting of individuals who are clients from "cradle to grave"; RCMP members, a much smaller client group, must be in good basic health as a prerequisite for employment, and entail the least costs.

(29) Health Canada, *Healthy Canadians* (2004), p. 5.

- *Program Coverage*: There are variations in the federal government's coverage of health care costs. For groups specifically excluded from the *Canada Health Act*, such as federal inmates and members of the Canadian Forces or RCMP, the federal government covers all the costs. For other groups, such as First Nations and Inuit and veterans, the federal government states clearly in several of its departmental plans that participants must first take advantage of benefits provided by their provincial/territorial health insurance plan or other third-party sources of assistance with health care expenses. It expects that these groups will have access to health services covered by provincial or territorial governments, in line with other residents. For these groups, the federal government aims to cover services and products falling outside provincial and territorial insurance plans.

- *Health Status*: First Nations and Inuit individuals generally have a lower health status than other Canadians, and remain clients throughout their lives. Members of the RCMP undergo regular health assessments and are discharged from active service if their health is impaired. Members of the Canadian Forces, like the RCMP, tend to be relatively healthy adult males; federal offenders, on the other hand, tend to be less mentally and physically healthy adult males.

- *Age and Gender*: While First Nations and Inuit populations tend to be younger on average than the overall Canadian population, women have a longer life expectancy; both factors create particular health needs. Veterans are older, and many have disabling, chronic health problems that require specialized and longer-term care. As noted earlier, RCMP and Canadian Forces members are predominantly young adult males in prime physical health.

B. Service Provision

The Canadian health care system is largely built around services delivered by physicians and services provided in hospitals, as stipulated in the *Canada Health Act*. Provincial and territorial governments' health insurance plans typically cover physician services offered on a fee-for-service basis and hospital services offered in institutions run by private, not-for-profit boards and operating on global budgets. Pharmaceuticals, except for those dispensed in hospitals, are not insured under the *Canada Health Act*. To meet the needs of seniors and low-income Canadians, provincial and territorial plans also provide some degree of drug benefits.

Each of the federal programs offers services in a different way, and departmental information sources indicate that there is increasing pressure on the responsible federal departments to provide a more complex and more costly range of health care services. The following highlights some of the factors that create different service requirements at the federal level.

- *Service Needs*: First Nations and Inuit, federal inmates and refugee claimants can have serious and multiple health problems requiring intensive and varied health services. Others, such as veterans, face a growing number of chronic illnesses with diverse, long-term service implications. Canadian Forces and RCMP members undertake activities dangerous to their physical and mental health and may require specialized services.

- *Hospitals and Physicians*: As the federal government has increasingly transferred its hospitals for First Nations and for veterans to provincial authorities, the public not-for-profit management of hospital services has changed to private not-for-profit management. In addition, the providers of physician services within some departments have changed from salaried federal employees to contract and fee-for-service employees, sometimes managed by private human resources companies.

- *Provincial Service Organization*: Those federal clients who must first access provincial services must be integrated into the area covered by provincially designated regional health authorities. With the exception of Ontario, regional authorities have been given the responsibility for allocating funds among hospitals, continuing care facilities, community health services, and public health programs. It is unclear how regional authorities might factor in the needs of the diverse federal clients when considering possible resource allocations.

- *Location*: The federal government's ability to provide services also varies depending on the location of the population being served and the arrangement of services. For example, First Nations and Inuit generally live in geographical areas that are hard to reach, while federal offenders live in clearly defined institutions. Also, the federal government has developed a specific health infrastructure for certain groups, such as the Canadian Forces with its multiple regional clinics, and some First Nations and Inuit with multiple nursing stations. Veterans, however, rely on available provincial infrastructure.

- *Drugs*: The federal government is the fourth-largest payer of prescription drug benefits in Canada, covering all clients under its health programs. Most other Canadians pay for prescription drugs, with some coverage by private or provincial drug benefit plans. In addition, most of the federal programs cover the cost of over-the-counter drugs.

C. *Canada Health Act*

The departmental authority for health programs is derived primarily from explicit federal constitutional authority with respect to the client population. The clearest client responsibility is for those groups specifically excluded from the *Canada Health Act* – the Canadian Forces, the RCMP and federal offenders. In certain areas, such as immigration, there are some shared jurisdictional elements. In others, the authority is largely the result of a mixture of policy evolution and jurisdictional flexibility.

The *Canada Health Act* establishes criteria and conditions for insured health services that the provinces and territories must fulfill in order to receive cash contributions under the Canada Health Transfer. The question then arises as to whether the federal government adheres to the *Canada Health Act* even though it is not covered by the legislation. Whether or not the federal government conforms to the five principles of the Act – public administration, comprehensiveness, universality, portability, and accessibility – in providing health services to federal clients, as is required of the provinces and territories, has never been fully examined. The following factors may be considered for further analysis:

- *Integrated Planning and Reporting to Parliament*: Unlike each provincial and territorial jurisdiction, the federal government does not have a single federal health insurance plan; instead, it has separate ones for each client group. The Government of Canada as a whole is not required, nor is any responsible federal department required, to report annually to Parliament on the administration and operation of the respective plans.

- *Principles*: The Act's public administration criterion requires that the health care insurance plan be administered and operated on a not-for-profit basis by a public authority. This raises questions about recent federal actions to engage large, private, for-profit insurance companies to administer the claims and payments of various federal health plans. With respect to other principles, various client groups, including veterans and First Nations, who seek care through regional health authorities in different parts of the country have argued that the resources for their health services have diminished or been fragmented, leading to differential access and treatment depending on their geographical location. It is also suggested that individual federal departments' negotiation of separate agreements with provinces about specific programs such as Aboriginal sweat lodges within federal penitentiaries, or selected health programs for veterans, creates uneven service provision across the country.

CONCLUSION

This paper provides an overview of federal health service responsibilities with respect to First Nations and Inuit, veterans, Canadian Forces, federal offenders, the RCMP and refugee claimants. The questions that it raises indicate that more detailed reporting to Canadians on the health responsibilities of the federal government is needed.

In both the 2002 and 2004 comparable indicators reports, the Government of Canada clearly acknowledged that it has a role as a health care services provider. This role is different from its more visible and vigorously debated action in transferring funds for a national system of provincial and territorial health care services. Moreover, in spite of the comparable

indicators reports, this federal health care provider role is still not clearly reported or comprehensively understood.

At present, the federal government has six different plans and provides varying levels of detail about each one. Although the funding derives from a single source, the six departments have not worked together to establish comparable objectives and health outcome measures appropriate to their client populations. Moreover, in spite of the development of extensive claims processing databases, they have not used these to provide insights into client health status.

While the *Canada Health Act* requires provincial and territorial compliance with the five key principles – public administration, comprehensiveness, universality, portability, and accessibility – there is currently no mechanism for measuring the federal government's adherence with respect to its specific client groups. In the absence of a comprehensive annual report to Parliament, it is difficult to assess whether the respective federal departments are ensuring equitable and effective treatment of their client groups.