Health Canada Santé Canada

Evaluation of the Non-Insured Health Benefits (NIHB) - Pilot Projects

First Nations and Inuit Health Branch

Final Synthesis Report

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Evaluation of the Non-Insured Health Benefits (NIHB) Pilot Projects

Final Synthesis Report

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NOTE TO FILE

Non-Insured Health Benefits (NIHB) Pilot Project Evaluation

The purpose of the pilot projects was to test management delivery models for transferring Non-Insured Health Benefits from Health Canada to First Nations and Inuit.

The authorities for the NIHB Pilots ended March 31, 2005, with only the Bigstone Cree Nation project receiving an extended authority by Treasury Board. The decision by Health Canada Senior Management was made in March 2005 to extend the project by two years with a performance and financial review based on audit to be conducted by 2006. The results of the audit will inform the decision on the future of the Bigstone pilot project.

NIHB no longer has the authority to initiate any more pilot projects.

February 6, 2006

EXECUTIVE SUMMARY AND RECOMMENDATIONS

Introduction

The Non-Insured Health Benefits (NIHB) Program of Health Canada's First Nations and Inuit Health Branch (FNIHB) provides supplementary non-insured health benefits to eligible First Nations and Inuit individuals across Canada. These benefits include: prescription and over-the counter medications, medical supplies and equipment, dental services, vision care services, medical transportation and crisis intervention counselling. The NIHB Program has grown considerably over the ten year period from April 1993 to March 2003. Over this period, the number of eligible recipients increased by approximately 26%, but expenditures rose by over 53%. This growth seems to be due to a number of factors, including: an increase in utilization rates; an increase in benefit costs; and changes to provincial health care systems. Funding for the NIHB Program comes from the First Nations and Inuit Health Program Envelope which also provides funding for community health services and FNIHB hospitals. As a result, expenditures related to the NIHB Program have a substantial impact on the funding available for other First Nations and Inuit health programs.

In March 1988, Cabinet approved the Transfer of Health Services to First Nations and Inuit control. This decision was subsequently approved by Treasury Board in June 1988. However, neither the Cabinet decision nor the Treasury Board approval included the transfer of the NIHB Program. In June 1994, Cabinet decided that management and delivery options for the transfer of NIHB could be tested on a pilot basis and in September 1994 Treasury Board granted approval for a maximum of 30 pilot projects. In September 2000, Treasury Board approved an extension to continue the original 1994 Treasury Board Pilot Project authority to March 31, 2005.

A total of 17 pilot projects were established between April 1996 and February 2003. Thirteen of the pilot projects have reverted to Contribution Agreements, one went into self-government, one joined with a larger pilot (which subsequently reverted to a Contribution Agreement), and one has recently been discontinued[1] but has not reverted to a Contribution Agreement at this time. The remaining pilot project is still in operation and has a Pilot Agreement that runs until March 31, 2005.

Two previous evaluations were conducted on the pilot projects. Both were designed to strengthen the management and delivery of the NIHB Program in order to meet Treasury Board requirements. However, both of the previous evaluations were incomplete. The current evaluation was intended to build on these earlier evaluations. It is anticipated that it will be the baseline for future evaluations.

[1] The term "discontinued" is used in this document to indicate that a pilot project is no longer in operation. The term does not indicate what organization(s) made the decision that one or more non-insured health benefits would no longer be administered at the community level.

The purpose of this evaluation was to provide input regarding the future transferability of the NIHB Program from Health Canada's control to First Nations and Inuit control. The key research questions for this evaluation were:

- Does the NIHB Pilot Project make sense?
- What impacts have the NIHB pilot projects had?
- How successful have the NIHB pilot projects been?
- How cost-effective were the NIHB pilots?

The evaluation was carried out in three phases. Phase 1 involved the development of a comprehensive understanding of the NIHB Program and the previous evaluations of the pilot projects. Phase 2 involved the development of an in-depth understanding of the issues and challenges regarding the transferability of the NIHB Program. This phase also involved the administration of the Annual Administrative Survey in two pilot sites. Phase 3 involved a case study of the only remaining pilot project, the Bigstone Cree Nation NIHB Pilot Project. The findings from each of the three phases are presented in separate documents.[2] This synthesis report provides highlights of the findings from the three study phases as well as recommendations regarding the transferability of the NIHB Program.

Methodology

The evaluation was conducted using four different methods: a document review; interviews with key stakeholders at the national, regional, and community levels and with clients; surveys of pilot project coordinators as well as providers of non-insured health benefits; and a review of financial data related to the administration and delivery of non-insured health benefits at the national and local levels.

A review of documents related to the development and implementation of the NIHB Pilot Projects was conducted in Phase 1 in order to develop a broad understanding of the NIHB Program and the various pilot projects. The documents reviewed in this phase included background materials, annual reports, and reports from the two previous evaluations of the pilot projects. A document review was also used in Phase 3 as part of developing the case study on the Bigstone Cree Nation NIHB Pilot Project. The review included background materials, previous evaluation reports, quarterly reports, and some financial data.

There was not a lot of written information available on the previous pilots. As a result, the current evaluation relied very heavily on interviews. Interviews were used in all three phases

[2] See the following documents: *Final Phase 1 report: Background and historical context and detailed methodology for Phases 2 and 3* (dated August 10, 2004); *Final Phase 2 report: Issues and challenges with respect to the transfer of NIHB* (dated December 7, 2004); *Report on the Annual Administrative Surveys at Southeast Resource Development Council and Bigstone Cree Nation (2004)* (dated August 3, 2004); and *Final Phase 3 report: An in-depth examination of the Bigstone Cree Nation pilot project* (dated December 14, 2004). All documents were prepared by Hollander Analytical Services Ltd. and Adrian Gibbons and Associates Ltd.

of the evaluation. In Phase 1, interviews were conducted with 17 representatives of Health Canada and First Nations organizations at the national and regional levels. In Phase 2, interviews were conducted with a total of 46 First Nations and Inuit individuals (as well as with the national and regional representatives interviewed in Phase 1). The First Nations and Inuit individuals interviewed in this phase of the study fell into four groups. The first group consisted of representatives of First Nations and Inuit organizations who had had a previous NIHB pilot project. The second group consisted of representatives of First Nations who applied for NIHB pilot project funding but were not successful in obtaining funding. The third group consisted of representatives of First Nations that are providing all of the non-insured health benefits, but which were not involved in a pilot project; these individuals were from the Mohawk Council of Akwesasne and the Nisga'a Nation. The fourth group consisted of representatives of First Nations in Saskatchewan. In Phase 3, interviews were conducted with a total of 160 individuals. The respondents fell into three groups. The first group consisted of officials, project coordinators and consultants who have been actively involved with the development and implementation of the pilot project at the Bigstone Cree Nation. This group included representatives from both the Bigstone Health Commission and the regional Health Canada office. The second group consisted of staff who work for the Bigstone Health Commission; many were administrators in the various benefit areas. The third group consisted of Bigstone Cree Nation members who had used one or more non-insured health benefits in the past 12 months. The interview tools used in the evaluation were designed specifically for this project and were intended to enable comparisons with the previous evaluations (as appropriate), to clarify issues raised by the previous evaluations, and to address the research questions for this evaluation.

Surveys were used in Phases 2 and 3. As part of Phase 2 activities, the Pilot Project Coordinators and Regional Pilot Coordinators for two of the pilot sites were asked to complete an administrative survey. The survey had been used as part of the second evaluation of the pilot projects. In Phase 3, surveys were conducted with providers of non-insured health benefits as part of developing the case study of the Bigstone Cree Nation's NIHB Pilot Project. The survey was intended to build on the previous evaluations of the Bigstone NIHB pilot project, obtain individuals' perceptions of how well the pilot project was working, and establish a baseline for future evaluations.

A review of financial data regarding the NIHB Program in general was conducted as part of Phase 1. A review of financial data regarding the administration and delivery of non-insured health benefits at the local level was also conducted as part of the case study of Bigstone Cree Nation's NIHB Pilot Project in Phase 3.

The findings from the evaluation and recommendations regarding the future transferability of the NIHB Program were based on all of the above approaches using a process called "triangulation". Triangulation is an approach in which different methods are used to study the same question. It is a strategy for ensuring that evaluation findings are not the artifact of a single method, single source of data or single investigator's bias. Triangulation can be used to check the consistency of information derived at different times, by different methods, and from different individuals and sources and can be used to increase one's confidence in evaluation data and its interpretation. Thus, even if each method used has some shortcomings, if one finds

similar results using different methods (as was the case in this project) the level of confidence one can have in the overall findings is increased.

Findings and Discussion

The findings from each phase of the evaluation were similar, despite the different methodologies that were used. A summary of the findings from all three phases of the evaluation is provided in this section.

Appropriateness of the NIHB Pilot Project Process

The concept of conducting NIHB pilot projects to determine what factors may impact the transfer of non-insured health benefits appears to have been reasonable and is consistent with other programs developed by FNIHB (e.g., the Home and Community Care Program). However, valuable lessons can be learned from how the pilot projects were carried out.

Representativeness of the Pilot Project Sites: The majority of the pilot projects were in the Manitoba region and the majority of the projects were conducted with large organizations. As a result of the existing distribution, the extent to which the pilot project sites were representative of, and therefore generalizeable to, all First Nations/Inuit organizations in Canada is not clear. A mixture of management options (e.g., individual First Nations, Tribal Councils, Regional Councils, and Health Commissions) were involved in the pilot projects. All of the pilot sites had a substantial number of members living off reserve or out of community, but there was no reason to believe that the pilot sites differed substantially from non-pilot sites with respect to this issue. Most of the pilot sites tried to provide services to members both inside, and outside, of First Nations/Inuit communities.

Choice of Non-Insured Health Benefit(s) Included in the Pilot Projects: In the first two groups of pilot projects, pilot sites were able to specify which non-insured health benefits they wished to administer. The earlier pilot projects did not have to administer all of the non-insured health benefits. All but three of the pilot sites included Medical Transportation and for three sites, this was the only non-insured health benefit that was piloted. Only one pilot site (Bigstone Cree Nation) has included all of the non-insured health benefits. Thus, the extent to which the findings from the previous pilot projects can be generalized across all non-insured health benefit areas is also not clear.

Preparedness to Conduct Pilot Project(s): In general, neither Health Canada (at either the regional or national levels) nor the First Nations and Inuit pilot sites appeared to be fully prepared to take on a pilot project. For example, in order to obtain funding for a NIHB pilot project, interested First Nations and Inuit first had to develop a preliminary proposal. If the proposed approach was considered appropriate, the First Nations/Inuit organization was provided with funding to develop a business plan. The business plans were intended to identify how the pilot projects were to be implemented. However, in some cases, the business plans for the pilot projects were inadequate, incomplete, or lacked the support of the local administration and/or members. In addition, it did not always appear that adherence to the business plans was monitored.

The Importance of Appropriate Administrative Support: The pilot projects showed that a NIHB pilot project cannot be adequately developed, and that the adequate administration of non-insured health benefits at the local level cannot occur, without the interest and commitment of a First Nation/Inuit organization and support from the regional Health Canada office. In some pilot sites, there appeared to be good support from the administration, health care staff and clients for the pilot project. When the pilot projects lacked support from the administrative level, major administrative, resource and funding issues were encountered. In some regions, knowledgeable NIHB staff in the regional FNIHB offices were actively involved in the pilot projects, while in other regions, support from the regional FNIHB office appeared to be insufficient. In general, pilot sites indicated that they did not have sufficient support from the national FNIHB office. This was also indicated by some regional FNIHB personnel.

The Need for Training: NIHB staff in all of the previous pilot project sites noted that training was inadequate and/or insufficient. This view was supported by representatives of national First Nations and Inuit organizations as well. The Bigstone Cree Nation NIHB pilot project indicated that all new staff need to receive training and that training for all staff needs to occur on an ongoing basis. The need for initial and ongoing training was also commented on by respondents from the Nisga'a Nation and the Mohawk Council of Akwesasne. Respondents noted that training was required on: various aspects of the NIHB program; computer programs; management and administrative issues; working with people; and health related areas (e.g., First Aid and CPR).

Funding Issues: The financial resources provided for the pilot projects were often considered inadequate. The resources were allocated based on previous budgets, but did not allow for population growth, increased utilization, or increased benefit costs. In addition, it appears that no additional funding was provided to conduct the NIHB pilot projects over and above what was available to provide the non-insured health benefits *per se*. Both Akwesasne and the Nisga'a also felt that funding for the administration of non-insured health benefits was insufficient. In addition, the First Nations in Saskatchewan indicated that one of the reasons they (collectively) chose not to participate in the NIHB pilot project process related to concerns that funding would be insufficient to administer the projects. It is noted that Health Canada was under considerable pressure to manage the NIHB program within budget through most of the pilot project process.

The Need for Appropriate and Accessible Policies and Procedures: Policies and procedures regarding the administration of non-insured health benefits sometimes appeared to be lacking or incomplete during the pilot projects. For example, policies regarding maintaining client confidentiality needed to be developed by the pilot sites. Appeal and exceptions processes, while recognized under the federal NIHB Program, needed to be developed more specifically at the local level. Because such policies and procedures were not developed, there was (and still is) the potential for different individuals in different locations across the country to obtain different non-insured health benefits. Several First Nations/Inuit organizations noted that the national NIHB Program currently has policies for several aspects of the program, but that these are not always appropriate for the local level. What is needed are *general*, core policies and procedures that can be *adapted* to meet the local conditions.

Length of Time for the Pilot Projects: The pilot projects were intended to operate for a two year period, with an option to operate for one additional year. Most of the previous pilot projects appear to have operated for two and a half to three years. One pilot project operated for approximately one year, while another has operated for almost eight years. Several respondents in the various phases of the evaluation commented that the length of time for the NIHB pilot projects was too short. It is interesting to note that the Bigstone Cree Nation has taken on full administrative control of all but one of the non-insured health benefits after eight years. Akwesasne and Nisga'a both administer all non-insured health benefits, but again, both have been doing so for over eight years. Finally, it is noted that the Transfer of Health Services involves a two year planning process and a five year operational phase before the first evaluation is conducted.

Impact of the NIHB Pilot Projects

Increased Access to Non-Insured Health Benefits: Approximately 80% of the NIHB pilot sites indicated that their delivery system had been very effective. Respondents commented on the fact that some services can be provided faster and more reliably at the local level, and that people are familiar with NIHB staff in their own communities. Akwesasne and the Nisga'a agreed with these perspectives. Most, but not all of the NIHB pilot project sites administered non-insured health benefits for individuals living both on and off reserve (or inside and outside of the community). Respondents from the NIHB pilot sites which administered non-insured health benefits to individuals residing both on and off reserve (or inside and outside of the community) identified several issues regarding the delivery of non-insured health benefits for individuals living off-reserve/outside the community (e.g., maintaining up-to-date information on eligible individuals and communicating with eligible individuals regarding changes in the delivery and/or administration of benefits). The provision of non-insured health benefits to all eligible individuals regardless of place of residency was a major issue for the pilot projects and is an area that will need to receive further consideration if and when the NIHB Program is transferred more broadly. It is noted that Akwesasne and the Nisga'a both provide non-insured health benefits to individuals both on and off reserve. Neither First Nation indicated that they had experienced difficulties in providing services to individuals living off-reserve.

Improved Administration of Non-Insured Health Benefits: First Nations and Inuit who had a NIHB pilot project provided several reasons for wanting to participate in a pilot project, including a belief that non-insured health benefits could be administered better by First Nations and Inuit than by Health Canada, and a belief that the needs of individuals could be addressed better by having local control. The First Nations who had been unsuccessful in obtaining funding for a NIHB pilot project, Akwesasne and the Nisga'a all indicated that they had been interested in administering non-insured health benefits for these reasons, and the First Nations in Saskatchewan indicated that these were just two of the advantages of having First Nations and Inuit administer non-insured health benefits. Respondents in the NIHB pilot sites were asked, whether, in comparison to the previous administration of non-insured health benefits by Health Canada, they felt that the administration of non-insured health benefits had improved during the operational life of their pilot project. All respondents from the previous pilot sites indicated that they felt it had improved. The majority of respondents from the Bigstone Cree Nation's NIHB

pilot project felt that administration had stayed the same or improved. Both Akwesasne and the Nisga'a felt that administration of non-insured health benefits had improved under their control.

Impact on Health Status: Respondents in this evaluation were asked whether the administration of non-insured health benefits by First Nations and Inuit had contributed to improved health status. Respondents noted that improvements in one area (such as non-insured health benefits) can have an impact in other areas (for example, collaboration with other health providers and health agencies) and that non-health related areas (such as local responsibility and community empowerment) can influence health status. However, respondents also noted that it is difficult to assess health status and that health status needs to be assessed over a period of time. These views were supported by both Akwesasne and the Nisga'a. The short time allowed for the NIHB pilot projects was insufficient to realize any changes in overall health status, at either the individual or community levels. In addition, it is not clear that a change in the administrative arrangements for providing non-insured health benefits alone would be sufficient to impact health status. Data regarding the utilization of non-insured health benefits and prevention and intervention services need to be collected over several years.

Increased Use of Other Community Health Services: The administration of non-insured health benefits at the local level may result in linkages being made with other community health programs. It may be beneficial for communities that are interested in, or have taken on, transfer of health services to also consider taking on non-insured health benefits, and to consider integrating the two areas to improve overall efficiency and effectiveness.

Success of the NIHB Pilot Projects

Defining Success: Whether the NIHB pilot projects have been successful or not depends on how one chooses to define "success". One way to define success is to determine the degree to which the objectives of the NIHB pilot projects have been met. A second way to define success is to determine what intended and unintended impacts the NIHB pilot projects have had. A third way to define success is to determine how well the NIHB pilot projects are currently functioning. The fact that the majority of the NIHB pilot projects are no longer operating does not necessarily mean that they were not successful. In fact, several of the pilot projects were successful in terms of demonstrating that First Nations/Inuit can administer at least some of the non-insured health benefits (such as Medical Transportation) quite successfully at the local level; other non-insured health benefits (such as Dental Services or Pharmaceutical Services) may be more difficult for some First Nations/Inuit to administer. Many of the pilot projects found that more people accessed non-insured health benefits when they were administered at the local level. Some of the pilot projects were able to improve cost-effectiveness substantially. Some of the pilot projects were discontinued, not because the First Nations/Inuit organization was unable to administer non-insured health benefits, or were not interested in doing so, but because the organization was concerned about having sufficient funds to administer the non-insured health benefits appropriately.

Advantages and Disadvantages of Local Administration: In general, First Nations and Inuit organizations felt that it was very important that non-insured health benefits be administered and delivered at the local level. Respondents indicated several opportunities to

improve service delivery by having First Nations and Inuit administer non-insured health benefits including: a better understanding of local issues; a greater ability to focus on clients' health; having First Nations and Inuit assume responsibility for the health of their people; being able to integrate services across several areas; being able to build capacity at the local level; and having the opportunity to benefit economically. Respondents also noted that there were challenges to having First Nations and Inuit administer non-insured health benefits. These challenges included: having sufficient expertise and capacity at the local level to administer and deliver non-insured health benefits; needing to apply policies that may not be appropriate for the local situation; and issues related to the potential loss of federal fiduciary responsibility and potential abrogation of existing treaty rights.

The Ability to Administer Non-Insured Health Benefits Locally: The experiences of some of the NIHB pilot sites, the Bigstone Cree Nation, Akewesasne and the Nisga'a all indicate that First Nations and Inuit are able to administer non-insured health benefits successfully at the local level. It appears that several factors may be required for success, including: support from the management and administrative level of the First Nation/Inuit community; support from the membership of the community; support from the regional FNIHB office regarding all aspects of the NIHB program; support from local providers of non-insured health benefits; a willingness to work collaboratively with other areas; and availability of (or willingness to obtain) necessary resources.

Communication: Various NIHB pilot sites, the Bigstone Cree Nation, Akwesasne and the Nisga'a all indicated that they had used a variety of methods to provide members (both inside and outside of the community) with information regarding non-insured health benefits. This was in addition to information provided on Health Canada's website. These methods included: flyers, pamphlets, and brochures; newsletters; presentations at conferences, community forums, public conventions/exhibitions and Annual General Meetings; a community-relevant website; presentations on local radio; identification of an "in-town expert" who provides one-on-one information; and a toll-free telephone information line that was accessible to individuals across Canada. Despite the variety and number of communication methods that were used, individuals in many of the pilot sites expressed a desire to have more information regarding the NIHB program, particularly regarding what is covered and what is not. The majority (90%) of NIHB staff from the pilot sites indicated that they were not provided with sufficient information or data prior to the implementation of the pilot project. Respondents from Akwesasne and the Nisga'a agreed. Respondents noted that: it took a long time to obtain some critical information (e.g., policy manuals, historical information); information regarding some aspects of the administration of non-insured health benefits was sometimes provided on very short notice (e.g. reporting and record-keeping requirements); and some information (such as policies and procedures) was still being developed at the time the pilot projects started. The researchers understand that pilot projects were provided with a core information package to assist them with their decision making, but it appears that First Nations and Inuit communities did not feel that they had all the information they needed. Lack of communication was often cited as one of the major reasons for dissatisfaction with personnel in both the regional and national FNIHB offices.

Cost-Effectiveness of the NIHB Pilot Projects

Putting "Cost-Effectiveness Into Context: The term "cost-effectiveness" is often equated with an analysis only of costs, and a method for determining expenditure reductions. However, this is *not* what cost-effectiveness analysis is, or should be, all about. Cost-effectiveness analysis is a means by which funders and service providers can analyze how services are being delivered and if, and how, they can be delivered more effectively. It is *not* only about costs. There is an equal weighting on ***costs*** *and* consequences, or ***outcomes***. Thus, outcome indicators such as the satisfaction with care services, as perceived by clients and their informal caregivers, and the quality of life of clients, are as important as the costs of providing such services. The comparative analysis of costs and outcomes may also reveal new information which can be used to change policies, procedures, and clinical practices, in order to provide more efficient and effective services.

Cost-Saving Measures: Many of the pilot projects were able to develop cost-effective ways to manage the administration and delivery of non-insured health benefits, including: providing a mix of delivery options for medical transportation; coordinating travel arrangements for clients with similar needs; shopping around for the best price and negotiating with providers for lower prices; providing goods and services within the community; and controlling expenditures by modifying policies, enforcing existing policies and monitoring costs. Several respondents also indicated that having appropriate computer software may also produce cost-savings in the long run. It is noted that some of these cost-savings measures (e.g., improved management of medical transportation costs in several regions) have been implemented in the national NIHB Program in an effort to control the costs of the program.

Potential Efficiencies From the Integration of Non-Insured Health Benefits with Other Services: Several respondents commented on the fact that non-insured health benefits could be integrated with other services. The Bigstone Cree Nation and Akwesasne, in particular, are focusing on integrating non-insured health benefits with other health-related services, social services, and educational programs. The integration of non-insured health benefits with other areas may not only result in improved health on an individual and community level, it may also result in cost-savings for non-insured health benefits.

Client Satisfaction Outcomes: In previous evaluations of the NIHB pilot projects, it was noted that clients were generally satisfied with the way pilot project staff helped them to obtain non-insured health benefits, although they also expressed a need for more information regarding benefits and services. Clients in several of the study sites commented that project staff needed more training with regard to interpersonal relationships. In the current evaluation, respondents were generally staff, not clients, and few respondents commented on clients' satisfaction with the administration of non-insured health benefits. An exception is the in-depth examination of the Bigstone Cree Nation's pilot project. Over 60% of clients in the Bigstone Cree Nation pilot project felt that: they did not have sufficient information regarding benefits and services available under the NIHB program; felt that the administration of non-insured health benefits had stayed the same or improved since the implementation of the pilot project; felt that the transfer of responsibility for non-insured health benefits had been successful; and supported the continued

administration of non-insured health benefits by the Bigstone Cree Nation in the future. These findings suggest that clients were satisfied with the administration of non-insured health benefits in this pilot site. It is not known if similar findings would be observed for other First Nations/Inuit organizations that are administering non-insured health benefits.

Provider Satisfaction Outcomes: In previous evaluations of the NIHB pilot projects, providers for many of the pilot sites indicated they: were satisfied with the claims and bill payment services provided by the pilot sites; wanted to have billing time improved; and were willing to continue working with the pilot projects. Although providers for some of the pilot sites indicated that communications had improved, providers for some of the other pilot sites indicated that there was a need for increased communications, particularly regarding changes in the NIHB Program. In the current evaluation, the input from providers was not generally sought. In addition, the majority of respondents did not comment on providers' satisfaction with the local administration of non-insured health benefits. Again, an exception was the in-depth examination of the Bigstone Cree Nation's pilot project. Over 80% of providers in the Bigstone Cree Nation pilot project felt that: the administration of non-insured health benefits had stayed the same or improved since the Bigstone Cree Nation had taken on the administration; were very or somewhat satisfied with the claims and bill payment processes; and felt that the transfer of responsibility for the administration of non-insured health benefits to the Bigstone Cree Nation had been successful. Over 66% of providers supported the continued administration of non-insured health benefits by the Bigstone Cree Nation. It is not known if similar findings would be observed for other First Nations/Inuit organizations that are administering non-insured health benefits.

Recommendations

Given the nature of the findings in this study, it is possible to make some evidence-based recommendations regarding future directions for the NIHB Program. In moving forward, senior management from Health Canada and First Nations and Inuit organizations will need to consider a number of key issues. The recommendations in this report are therefore clustered under four broad topics. These are:

- The relative appropriateness of transferring non-insured health benefits and services from Health Canada's control to First Nations and Inuit control;
- Possible transfer models which should be considered in the future;
- The steps to be taken before non-insured health benefits and services are transferred (if they are to be transferred in some form); and
- Operational and administrative issues.

Transferring Non-Insured Health Benefits from Health Canada to First Nations and Inuit

Based on the information collected, there appears to be a desire among (at least some) First Nations and Inuit to have greater ownership and control over the administration and delivery of non-insured health benefits. There also appears to be a desire on Health Canada's part to facilitate a transfer process. ***Thus, it is reasonable to assert that, in principle, Health Canada and First Nations and Inuit should work together to facilitate a NIHB transfer process.*** However, there are a number of important policy and operational issues which need to be addressed before a clear strategic plan for transfer can be initiated.

Recommendation #1: Steps should be taken at the national, regional and local levels to ensure that the transfer of non-insured health benefits to First Nations and Inuit who wish to take on non-insured health benefits directly is done in an appropriate manner (including at a reasonable time and pace). This may include, but is not limited to: providing the First Nations and Inuit with appropriate support from the FNIHB regional and national offices; ensuring that the First Nations and Inuit have the necessary information to take on transfer (e.g., historical information, policy manuals, and training opportunities); and incentives to ensure that the administration and delivery of non-insured health benefits is cost-effective (e.g., being able to keep surplus funds to off-set cost over runs in future years and/or being able to apply the funds to other health programs).

Recommendation #2: If and when non-insured health benefits are transferred to the local level, appropriate and separate budget envelopes should be developed to cover the costs of implementation, the administration of non-insured health benefits, and the delivery of non-insured health benefits, regardless of which transfer option is implemented.

Possible Transfer Models

Alternative Approaches: Based on the current evaluation, it would seem that different First Nations/Inuit would like to have different transfer options, and that different options are (at least to some extent) feasible from Health Canada's perspective. It is unclear, however, how many different options may be feasible for the administration, management and delivery of non-insured health benefits, given current fiscal and management constraints for Health Canada, and environmental, resource, and support limitations[3] for First Nations and Inuit communities. The potential disadvantages for Health Canada of having multiple management options for the NIHB Program must be weighed against the advantages of having First Nations and Inuit communities administer non-insured health benefits at the local level (should they wish to do so).

[3] Environment limitations may include, but not be limited to, geographic location, population size, and prevalence of chronic diseases at the community level. Resource limitations may include, but not be limited to, personnel, space and financial resources. Support limitations may include, but not be limited to, support from the Chief and Band Council, Band members, health care providers, and regional Health Canada office.

Recommendation #3: Health Canada, in collaboration with First Nations and Inuit organizations (at the national, regional and local levels), should consider several alternative approaches for the delivery of non-insured health benefits to First Nations and Inuit individuals.

Recommendation #4: If alternative approaches for the delivery of non-insured health benefits to First Nations and Inuit are considered potentially desirable and feasible by both Health Canada and First Nations and Inuit organizations, additional pilot projects should be conducted to assess the practical benefits and challenges of such approach(s).

Additional Pilots: Based on the findings from this evaluation, ***the researchers feel that it is not reasonable to replicate the previous pilot process. Unless issues related to overall funding, funding for the pilot process, and issues related to policies are addressed, the outcome of any future pilots may well be similar to the previous pilot projects.*** Assuming such matters can be addressed, one could consider: continuing with an enhanced and improved pilot process; developing a phased in approach in which the pilots are essentially the initial, implementation phase of the transfer of non-insured health benefits; and/or piloting new approaches to the administration and delivery of non-insured health benefits.

Recommendation #5: Health Canada, in collaboration with First Nations and Inuit organizations (at the national, regional and local levels) should consider whether additional NIHB pilot projects should be conducted.

Recommendation #6: If additional pilot projects are to be conducted in the future, Health Canada, in collaboration with First Nations and Inuit organizations at the national, regional, and local levels should ensure that realistic goals and expectations for the pilot projects are identified and clearly communicated to all key stakeholders.

Recommendation #7: If additional pilot projects are to be conducted in the future, Health Canada, in collaboration with First Nations and Inuit organizations, should ensure that documentation regarding the development, implementation, and maintenance of the pilot projects exists and is kept up-to-date for the length of time the pilot projects are in operation. This would include, but not be limited to: documentation regarding how to apply for pilot project funding; the expectations of the pilot projects (e.g., reporting and accountability aspects); historical information (e.g., funding and utilization information); core policies that could be adapted to the local situation (e.g., appeals processes); policy and training manuals; and communication materials for key stakeholders.

Recommendation #8: If additional pilot projects are to be conducted in the future, steps should be taken at the national, regional, and local levels to ensure that the pilot projects, as a group, are representative of contextual issues (e.g., size and geographic location), management structures, transfer options, and so on.

Recommendation #9: If additional pilot projects are to be conducted in the future, steps should be taken at the national, regional and local levels to ensure that the projects are developed, implemented and maintained in an appropriate manner. This includes, but is not limited to: having staff at all levels who are specifically assigned to the pilot project process; having FNIHB staff at the national and regional levels who are knowledgeable about the NIHB Program, as well as local circumstances, and who can provide support to the local First Nations/Inuit staff; having sufficient time to develop and implement the pilot project before an evaluation is conducted; ensuring that individuals both inside and outside of the communities are included; and ensuring that all non-insured health benefit areas are piloted.

Recommendation #10: If additional pilot projects are to be conducted in the future, steps should be taken at the national, regional, and local levels to ensure that meaningful evaluations of the pilot projects can be conducted. This would include, but not be limited to, an evaluation of how the pilot projects were implemented as well as evaluations of the short and long term impacts of the pilot projects from the perspectives of key stakeholders (e.g., officials, staff, clients, and providers). The evaluations should focus on the impact of the pilot projects on: the utilization and costs of non-insured health benefits; the utilization of other health services; health status at the individual and community levels; and so on. Planning for the evaluations should occur as part of the development of the pilot projects.

Recommendation #11: If additional pilot projects are to be conducted in the future, appropriate funding envelopes should be developed for the pilot process at all levels. These funding envelopes should include, but not be limited to, resources for: the delivery of non-insured health benefits; the administration of non-insured health benefits (e.g., space, computer systems); and the training of staff.

Steps to be Taken Before Non-Insured Health Benefits are Transferred

The NIHB Program and Health Services: The transfer of the NIHB Program to First Nations and Inuit control could follow a process that is similar to that used for community health

transfers, and thus lessons learned as part of that process may be applicable here as well.[4] However, there are four major differences between the NIHB Program and Health Services that may present substantial challenges for the transfer of the NIHB Program: the resources required to provide the non-insured health benefits are influenced by utilization rates and market increases; the provision of non-insured health benefits is dependent on private sector providers; the provision of non-insured health benefits requires knowledge of health benefit management which may not exist at the community level; and the provision of non-insured health benefits requires the ability to ensure that all eligible individuals have equal access to benefits regardless of residency (e.g., on-reserve/off-reserve) or income level. Given these differences, the following recommendations are made.

Recommendation #12: Utilization and costing data should be collected and analyzed at the local, regional and national levels for a period of several years in order to identify trends that can be used to develop appropriate health programs, allocate funding appropriately and so on.

Recommendation #13: Steps should be taken at the national, regional and local levels to encourage appropriate health care providers to become involved, and to stay involved, with the NIHB program. This may include, but not be limited to: providing incentives for First Nations and Inuit individuals to train and work in various health disciplines (e.g., dentistry, ophthalmology); hiring or contracting with health providers (e.g., opticians, dentists and pharmacists) to provide services in First Nations and Inuit communities on a regular basis; and paying providers using a variety of options (e.g., alternative payment plans rather than fee-for-service).

Recommendation #14: Steps should be taken to ensure that individuals who are responsible for the administration, management, and/or delivery of non-insured health benefits at the local level are provided with appropriate resources to ensure that they have the capacity to carry out the necessary activities. This may include, but not be limited to: receiving training when the individuals first start with the NIHB program; receiving ongoing training on non-insured health benefits on a regular (e.g., annual basis); receiving information regarding what is covered and what is not covered in all non-insured health benefit areas on a regular basis; and being able to access identified resource people at the regional and national FNIHB office (by e-mail, a toll-free telephone information line, and so on) regarding specific issues related to the NIHB program.

[4] An evaluation of the Health Transfer Policy has recently been completed. See the document: Lavoie, J.G., O'Neil, J., Sanderson, L., Elias, B., Mignone, J., Bartlett, J., Forget, E., Burton, R., Schmeichel, C., & McNeil, D. (2004). *The evaluation of the First Nations and Inuit Health Transfer Policy*. Winnipeg, MB: Centre for Aboriginal Health Research.

Recommendation #15: Steps need to be taken at the national, regional and local levels to ensure that all eligible individuals have access to non-insured health benefits, regardless of residency (e.g., on or off reserve), and regardless of who is administering the non-insured health benefits. This may include, but is not limited to, providing information to all eligible individuals regarding what non-insured health benefits are available and how they can be accessed, and enabling approvals to be obtained 24 hours a day, seven days a week.

Financial Issues: Currently, the NIHB Program appears to be a demand service operating under capped budgets. If the NIHB Program is going to continue to provide all of the current non-insured health benefits to individuals who meet the current eligibility criteria, sufficient funding must be made available to do so.

Recommendation #16: Health Canada, in collaboration with First Nations and Inuit, should conduct a review of the current funding and resource allocation methodology for the NIHB Program to ensure that all key factors are included in the funding formula. Examples of key factors would include, but are not limited to: historical age and sex adjusted utilization; a factor for increased utilization resulting from local administration; estimated future age and sex population distributions; an allocation for ongoing administration and training; an inflation factor for key cost drivers; regional cost and utilization patterns; provincial health reforms; and other related factors.

Recommendation #17: Annual budgets for the NIHB Program, at the national, regional and local levels, should include funding increases which reflect the key factors in the funding formula (e.g., increased utilization).

Objectives and Policies: The objectives and policies of the NIHB Program appear to be inconsistent with the provision of non-insured health benefits within a capped budget, particularly since the current funding envelope is designated for other health services in addition to non-insured health benefits. In addition, the findings from this study suggest that there are a number of policy issues that need to be addressed if the transfer process is to be successful.

Recommendation #18: Health Canada, in collaboration with First Nations and Inuit should review (and revise as necessary) the objectives and policies of the NIHB Program, to be consistent with the way funding for the program is allocated.

Recommendation #19: Health Canada, in collaboration with First Nations and Inuit should conduct ongoing reviews of key policies, and/or develop flexible policies to ensure that policies regarding the administration of non-insured health benefits are relevant for local circumstances.

Recommendation #20: Health Canada, in collaboration with First Nations and Inuit, should develop general policies and procedures that both protect the privacy of clients as well as ensure that their health care needs are met.

Operational and Administrative Issues

Documentation: Respondents involved in the current evaluation commented on the need for documentation regarding the NIHB Program in several contexts. Any lack of up-to-date documentation on the NIHB Program makes it difficult for FNIHB staff at the national and regional levels to stay current on what is covered and what is not, to support local First Nations and Inuit and so on. It also makes it difficult for First Nations and Inuit organizations at the local level to administer non-insured health benefits in a consistent manner to all eligible individuals regardless of residency. And, it makes it difficult for evaluations of the NIHB Program, the NIHB pilot process and similar activities to be conducted in a comprehensive manner.

Recommendation #21: Changes to the NIHB Program should be well documented and the relevant information should be circulated to key stakeholders, through a variety of means, on a regular basis.

Recommendation #22: Documentation regarding the NIHB Program should be kept in an easily accessible location for a minimum of five years.

Communication: There seems to be a need for enhanced communication at several levels (e.g., at the senior policy levels and at the working level).

Recommendation #23: Representatives from FNIHB (at both the national and regional levels) should meet with representatives from First Nations and Inuit organizations (at the national, regional and local levels) on a regular basis to discuss issues of policy, funding, and administration of non-insured health benefits.

Recommendation #24: Both FNIHB and First Nations/Inuit organizations and communities should develop, as appropriate, enhanced communications plans and materials related to the NIHB program.

Recommendation #25: Health Canada (at the national and regional levels) should ensure that all First Nations and Inuit health staff are directly informed of any changes to the NIHB Program. This could include regular updates on Health Canada's website as well as regular newsletters, e-mail/fax/phone notification, annual workshops, and so on.

Recommendation #26: First Nations and Inuit health staff across Canada should ensure that all relevant individuals (e.g., Band administration, all eligible individuals, providers, and so on) are informed of any changes to the NIHB program.

Training: Many respondents in the current evaluation commented on the need for First Nations and Inuit individuals who are responsible for administering non-insured health benefits at the local level to be adequately trained. This training needs to occur when individuals first start with the NIHB program and should be provided on an ongoing and regular basis after that. First Nations and Inuit individuals who are responsible for the administration and delivery of non-insured health benefits at the local level rely on FNIHB personnel for information and support. Therefore, it is very important that FNIHB personnel at both the national and regional levels have ongoing and regular training as well.

Recommendation #27: Health Canada should ensure that all FNIHB staff, at the national and regional levels, who are directly involved with the administration, management, and delivery of non-insured health benefits receive training on the NIHB program, on other related programs, and on factors that may impact the NIHB Program on an ongoing basis.

Recommendation #28: First Nations and Inuit staff who are directly involved with the administration of non-insured health benefits at the local level should receive both "formal" and "informal" training when they begin working with the NIHB program, and on an ongoing basis. Formal training may involve, but is not limited to working closely with relevant NIHB personnel at the regional Health Canada office and attending seminars on current guidelines, procedures and policies. Informal training may involve, but is not limited to: working closely with relevant NIHB personnel at the regional Health Canada office; attending seminars on current guidelines, procedures and policies; discussions with other First Nations and Inuit organizations; and discussions with staff in other health related areas.

Recommendation #29: Basic provider and staff training manuals should be developed, updated and maintained on a regular basis for all non-insured health benefit areas. These manuals should contain core information that can be adapted for use at the local level.

Recommendation #30: Funding for staff training at all levels should be explicitly included in annual budgets for the NIHB program.

Computer Software: Many respondents in the current evaluation commented on the need to have accessible, up-to-date computer systems and software programs to enable them to administer non-insured health benefits in a more cost-effective manner. It is also noted that some of the NIHB management initiatives that have been implemented to control the costs of the NIHB Program require computer systems and software. It is recognized that some of the following recommendations may be quite costly to implement, but it is thought the initial expense will be outweighed by long-term cost-savings.

Recommendation #31: Computer systems and appropriate software should be accessible to staff at all levels (that is, national, regional, and local) who are involved with non-insured health benefits (including those who are responsible for paying invoices). This includes staff of the national and regional FNIHB offices as well as First Nations and Inuit individuals at the local level.

Recommendation #32: An electronic database should be developed or adapted for all non-insured health benefit areas for use by all First Nations and Inuit at the local level, regardless of the transfer option they are operating under. This database should be compatible with systems and programs used by providers across the country, Health Canada (at both the regional and national level) and others.

Recommendation #33: The electronic database should be constructed in such a manner as to enable analyses and summaries to be conducted for accounting and administrative purposes at all levels (i.e., national, regional, and local). The database should also enable First Nations and Inuit organizations to obtain and maintain an up-to-date list of all individuals from their organization who are eligible to receive non-insured health benefits.

Recommendation #34: Written documentation and training manuals should be developed for the database and should be updated on a regular basis. This documentation needs to be provided on a regular basis to individuals at the national, regional and local levels who are directly involved with the administration and management of non-insured health benefits.

Recommendation #35: Funding for updating and improving computer systems and software should be explicitly included in annual budgets for the NIHB program at all levels (i.e., national, regional, and local).

Quality Assurance and Accountability: First Nations and Inuit representatives and federal officials should work together to develop standardized software, or standards for data collection and reporting, so that it will be possible to have good data, and comparable data, across all NIHB programs. In addition, in order to ensure that the NIHB Program, at the national, regional and local levels, meets the needs of eligible First Nations and Inuit individuals it is important that the impact of changes be monitored on an ongoing basis. Several respondents commented on the importance of integrating non-insured health benefits with other programs in order to improve overall health at the individual and community levels as well as the efficiency and effectiveness of all programs.

Recommendation #36: Representatives from Health Canada and First Nations and Inuit organizations should work together to develop standardized software, and data collection and reporting tools for the non-insured health benefits program. The tools need to be relatively easy to use and appropriate utilization needs to be monitored on a regular basis. In addition, the tools need to provide the information required by Health Canada (at both the national and regional levels) and by First Nations and Inuit organizations (at the national, regional and local levels) to: ensure that non-insured health benefits are being provided in a similar manner to all eligible individuals across the country; that the objectives of the NIHB Program are being met; and that both FNIHB and First Nations and Inuit organizations are accountable for how NIHB funds are being spent.

Recommendation #37: The impact of changes in the NIHB program on various key stakeholders should be monitored on a regular (e.g., annual) basis.

Recommendation #38: The impact of changes in other FNIHB health-related programs on the delivery and administration of non-insured health benefits should be monitored on a regular (e.g., annual) basis.

Recommendation #39: Consideration should be given to including some of the current non-insured health benefits in other health-related programs (e.g., Medical Supplies and Equipment into Home and Community Care).

Recommendation #40: First Nations and Inuit organizations which have, or are interested in, taking on the transfer of health services should also consider whether it is feasible to take on the administration of non-insured health benefits.

Broader Federal Issues: From a political and legal perspective, there appears to be a difference of opinion as to whether the provision of non-insured health benefits to First Nations and Inuit individuals constitutes a right or is a matter of policy. The issue of fiduciary responsibilities was beyond the scope of this project, and it is recognized that it cannot be addressed by Health Canada alone. However, the researchers note that this issue may have a substantial impact on the NIHB transfer process.

Recommendation #41: Appropriate government organizations (at both the national and provincial levels) should work with First Nations and Inuit organizations to resolve the issue of the federal government's responsibility to provide non-insured health benefits to First Nations and Inuit individuals.

Conclusion

The opportunity to improve the delivery of non-insured health benefits to First Nations and Inuit individuals presents great challenges, but also presents great opportunities for providing needed health care services in a more responsive and effective manner. It is the researchers' hope that the knowledge developed through this study can be used to inform the key decisions that will need to be made to enhance the future delivery of non-insured health benefits.

ACKNOWLEDGEMENTS

We express our thanks to all of the individuals who participated in the evaluation of the NIHB pilot project process. We also thank the members of the Project Working Group, Greg Reiser and Julie Mackenzie for their assistance with this project.

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TABLES

1. INTRODUCTION

1.1 The Non-Insured Health Benefits Program

The Non-Insured Health Benefits (NIHB) Program of Health Canada's First Nations and Inuit Health Branch (FNIHB) provides supplementary non-insured health benefits to eligible First Nations and Inuit individuals across Canada. These benefits include: prescription and over-the counter medications, medical supplies and equipment, dental services, vision care services, medical transportation and crisis intervention counselling. The 2002/2003 Annual Report on the NIHB Program (the last year for which published data are currently available) notes that the purpose of the NIHB Program is to provide a variety of health benefits to First Nations and Inuit individuals in a manner that:

- is appropriate to their unique health needs;
- contributes to the achievement of an overall health status for First Nations and Inuit that is comparable to that of the Canadian population as a whole;
- is sustainable from a fiscal and benefit management perspective; and
- facilitates First Nations and Inuit control at a time and pace of their choosing.[1]

Health Canada's Information Booklet regarding the NIHB Program includes two additional objectives, namely that the program:

- is cost-effective; and
- will maintain health, prevent disease, and assist in detecting and managing illnesses, injuries or disabilities.[2]

The principles of the NIHB Program are that:

- all registered Indians and recognized Inuit normally resident in Canada are eligible for non-insured health benefits regardless of location in Canada or income level;
- benefits will be provided based on professional, medical or dental judgement, consistent with the best practices of health services delivery and evidence-based standards of care;

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[1] Health Canada. (2003). *Non-Insured Health Benefits Program.2002/2003 annual report,* p. 3. Ottawa: Health Canada.

[2] Health Canada. (2003). *Non-Insured Health Benefits Program information booklet,* p. 4. Ottawa: Health Canada. Available on-line at http://www.hc-sc.gc.ca/fnihb/nihb/consent/infobook.htm. One might argue that a cost-effective program will be sustainable from a fiscal and benefit management perspective and thus that being cost-effective is included as part of the purposes of the program noted in the 2002/2003 Annual Report. However, being cost-effective does not guarantee that a program will be retained. In addition, a program that is not cost-effective may be retained if it continues to receive sufficient funding.

- there will be national consistency of mandatory benefits, equitable access and portability of benefits and services;
- the Program will be managed in a sustainable and cost-effective manner;
- management processes will involve transparency and joint review structures whenever agreed to by First Nations and Inuit organizations; and
- in cases where a benefit is covered under another plan, the NIHB Program will act as the primary facilitator in coordinating payment in order to ensure that the other plan meets its obligations and that clients are not denied service.[3]

To be eligible under the program, an individual must be identified as a resident of Canada and one of the following:

- a registered Indian according to the *Indian Act*;
- an Inuk recognized by one of the Inuit Land Claim organizations; or
- an infant less than one year of age, whose parent is an eligible recipient.[4,5,6]

The NIHB Program also provides some benefits to post-secondary students training at recognized institutions outside of Canada, to migrant workers, and to legal dependents of individuals in one of these groups (that is, a student training outside of Canada or a migrant worker).

The NIHB Program provides a "limited range of medically necessary health-related goods and services"[7] which are not covered by provincial, territorial or other third party health plans. An item or service is considered for coverage under the NIHB program when:

- it is included on a NIHB benefit list;
- it is intended for use in a home or other ambulatory care setting;
- prior approval or predetermination is obtained, if required;

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[3] Health Canada. (2003). *Non-Insured Health Benefits Program. 2002/2003 annual report*, p. 3. Ottawa: Health Canada.
[4] Health Canada. (2003). *Non-Insured Health Benefits Program information booklet*. Ottawa: Health Canada.
[5] Inuit in Northern Québec, Métis, and non-status (non-registered) Indians are not eligible for benefits and services under the program.
[6] In order to obtain benefits under the program, individuals must provide their nine or ten digit identification number (treaty/status, 'N' or 'B' number), band name and family number, Government of Northwest Territories health care number or Government of Nunavut health care number.
[7] Health Canada. (2003) *Non-Insured Health Benefits Program 2002/2003 annual report*, p.3. Ottawa: Health Canada.

- it is not available through any other federal, provincial, territorial, or private health care program;
- the item is prescribed by a physician, dental care provider, or other health professional licensed to prescribe; and
- the item is provided by a recognized provider.[8]

In some cases, an item not listed on a NIHB benefit list may be considered under the program with written medical or dental justification. These exceptions are considered on an individual basis. If a benefit is denied, an individual may appeal the decision. Three levels of appeal are available. Individuals are responsible for initiating the appeal process and for ensuring that supporting documentation from health care providers is made available, as required.

1.2 Growth in the NIHB Program

Tables 1, 2 and 3 summarize trends in NIHB program growth for the ten year period from April 1993 to March 2003. Table 1 presents the growth in the number of First Nations and Inuit individuals, by region, who are eligible to receive benefits under the NIHB Program. Table 2 illustrates expenditures, across all benefit categories, by region. Table 3 presents expenditures, across all regions, by benefit category. Over the ten year period, the number of eligible recipients increased by approximately 26%, but expenditures rose by over 53%.

As shown in Table 1, between April 1993 and March 2003, Ontario had the largest eligible population, followed by the Pacific, Manitoba and Saskatchewan regions. Over the ten year period, the largest growth occurred in the Manitoba and Saskatchewan regions (32.8% and 30.8%), while the smallest growth occurred in the Yukon and Pacific regions (15.4% and 17.3%, respectively). The Ontario, Northwest Territories and Nunavut, Atlantic and Québec regions showed increases of 26.6%, 25.9%, 23.0% and 20.0%, respectively.

As shown in Table 2, between April 1993 and March 2003, the Ontario, Manitoba and Alberta regions had the largest expenditures.[9] Expenditures increased in all regions over the ten year period from April 1993 to March 2003, with the largest increases occurring in the Northwest Territories and Nunavut region (94.9%), the Manitoba region (78.3%), the Ontario region (65.8%) and the Saskatchewan region (63.7%). The smallest increase occurred in the Alberta region (21.8%). The Atlantic, Québec, Pacific and Yukon regions showed increased expenditures of 39.1%, 41.7%, 43.2% and 50.8%, respectively, over the ten year period.

As shown in Table 3, between April 1993 and March 2003, the largest expenditures occurred for Pharmaceutical Services, Medical Transportation and Dental Services. The largest increases in expenditures over the ten year period from April 1993 to March 2003 occurred in Pharmaceutical Services (117.3%), in Medical Transportation (59.3%), and in Vision Care (57.9%). Growth rates for Dental Services have been much smaller (at 18.7%) but are still

[8] Health Canada. (2003). *Non-Insured Health Benefits Program information booklet*. Ottawa: Health Canada.
[9] As shown in the table, the rank order of these regions has changed slightly over this time period.

Table 1: Number of Eligible Clients by Region by Fiscal Year

Regions	1993/1994	1994/1995	1995/1996	1996/1997	1997/1998	1998/1999	1999/2000	2000/2001	2001/2002	2002/2003	% Change 93/94 – 02/03
NWT & Nunavut	37,902	39,099	41,032	42,122	42,710	43,906	44,738	45,667	46,794	47,708	25.9
Yukon	6,563	6,725	6,799	6,937	7,063	7,159	7,272	7,373	7,477	7,571	15.4
Pacific	98,234	98,598	100,863	103,260	105,475	107,512	109,847	111,562	113,366	115,204	17.3
Alberta	70,732	72,529	74,752	76,905	78,901	80,981	83,596	85,908	88,160	90,356	27.7
Saskatchewan	85,898	90,356	93,041	95,759	98,481	101,639	104,180	107,105	109,659	112,325	30.8
Manitoba	85,205	89,318	92,234	95,769	98,725	101,319	104,821	107,777	110,517	113,180	32.8
Ontario	126,771	132,021	135,376	139,898	143,603	147,385	151,741	155,443	158,086	160,496	26.6
Quebec	44,258	45,873	46,954	48,012	48,905	49,791	50,745	51,593	52,365	53,114	20.0
Atlantic	28,763	29,910	30,813	31,664	32,514	32,484	33,211	33,910	34,662	35,389	23.0
Total	584,326	604,429	621,864	640,326	656,377	672,176	690,151	706,338	721,086	735,343[10]	25.8
% Change	2.7	3.4	2.9	3.0	2.5	2.4	2.7	2.3	2.1	2.0	N/A

Sources: The Joint AFN/MSB Task Force on the Future Management of the Non-Insured Health Benefits Program. (1996). *Report on the future management of the Non-Insured Health Benefits Program. Volume 1.* Ottawa: Assembly of First Nations and Health Canada; Health Canada, (2002). *Non-Insured Health Benefits Program. 2000/2001 annual report.* Ottawa: Health Canada; Health Canada. (2003). *Non-Insured Health Benefits Program. 2001/2002 annual report.* Ottawa: Health Canada; Health Canada. (2003). *Non-Insured Health Benefits Program. 2002/2003 annual report.* Ottawa: Health Canada.

[10] It is estimated that 94.6% (695,983 individuals) are First Nations clients, while 5.4% (39,360 individuals) are Inuit clients (see the *Non-Insured Health Benefits Program* 2002/2003 *annual report*, p. 6).

Table 2: Total Expenditures by Region by Fiscal Year ($ 000s)[11]

Regions	1993/1994	1994/1995	1995/1996	1996/1997	1997/1998	1998/1999	1999/2000	2000/2001	2001/2002	2002/2003	% Change 93/94 – 02/03
NWT & Nunavut	21,016	22,838	25,547	26,854	27,651	28,508	29,575	29,940	32,595	40,960	94.9
Yukon	4,291	4,596	4,737	4,198	4,320	4,503	5,313	5,463	6,165	6,470	50.8
Pacific	63,216	67,211	72,014	67,603	68,893	71,140	73,302	74,421	79,330	90,510	43.2
Alberta	89,285	94,409	97,880	87,432	81,361	83,655	88,390	93,678	99,939	108,706	21.8
Saskatchewan	57,386	60,435	65,063	64,981	67,382	67,840	70,031	77,017	83,586	93,927	63.7
Manitoba	65,973	72,363	81,905	81,315	89,192	86,388	92,032	98,420	107,600	117,638	78.3
Ontario	79,671	88,105	87,127	85,368	91,061	94,670	104,720	112,262	126,068	132,097	65.8
Quebec	38,133	38,862	39,637	38,296	42,019	42,013	44,352	47,068	50,966	54,041	41.7
Atlantic	19,498	19,906	21,222	21,622	22,801	22,216	21,972	23,701	25,704	27,128	39.1
Total	438,469	468,725	495,132	477,669	494,680	500,933	529,687	561,970	611,953	671,477	53.1
% Change	8.0	6.9	5.6	-3.5	3.6	1.3	5.7	6.1	8.9	9.7	N/A

Source: Health Canada. (2003). *Non-Insured Health Benefits Program. 2002/2003 annual report.* Ottawa: Health Canada.

[11] Does not include Headquarters expenditures.

Table 3: Expenditures by Category by Fiscal Year ($ 000s)[12]

Benefit Category	1993/1994	1994/1995	1995/1996	1996/1997	1997/1998	1998/1999	1999/2000	2000/2001	2001/2002	2002/2003	% Change 93/94-02/03
Transportation	128,007	139,400	150,019	157,472	165,686	166,229	177,078	182,851	195,719	203,952	59.3
Pharmacy[13]	133,481	146,131	157,297	166,541	180,105	187,105	206,869	228,861	252,846	290,112	117.3
Dental	110,346	116,273	123,303	104,302	104,420	106,417	106,975	109,852	124,468	131,021	18.7
Other Health Care[14]	36,735	32,150	27,307	21,824	21,748	19,847	16,108	16,775	14,135	16,894	- 54.0
Premiums	26,350	28,610	30,094	22,125	17,131	17,476	18,030	17,779	18,596	23,902	- 9.3
Vision Care	14,101	16,040	17,242	17,017	18,576	18,490	19,843	19,748	22,020	22,259	57.9
Total	449,020	478,604	505,262	489,281	507,666	515,564	544,903	575,866	627,784	688,140	53.3
% Change	8.3	6.6	5.6	-3.2	3.8	1.6	5.7	5.7	9.0	9.6	N/A

Source: Health Canada. (2003). *Non-Insured Health Benefits Program. 2002/2003 annual report.* Ottawa: Health Canada.

[12] Includes Headquarters expenditures related to automated claims payments. This accounts for the differences in the Total and % Change rows between Tables 2 and 3. Claims for medications, medical supplies and equipment, and dental services for all eligible clients are processed through the national Health Information and Claims Processing System which is operated by First Canadian Health Management Corporation Inc.
[13] Includes prescribed medications, over-the-counter medications, and medical supplies and equipment.
[14] Includes crisis intervention counselling and selected other health services.

substantial. Rates of growth for Other Health Care Services[15] and Premiums have declined (by 54.0% and 9.3%, respectively) over the same time period.

Although the rate of change has varied over the ten year period for both the eligible client population and program expenditures, the overall pattern has been one of increasing growth. This growth seems to be due to a number of factors, including:

- an increase in the number of eligible clients (because of changes in the Indian Act as well as a higher than average birth rate);[16]
- an increase in utilization rates;
- an increase in benefit costs;
- inflation; and
- changes to provincial health care systems.

1.3 Implications of Growth in the Program

Funding for the NIHB Program comes from the First Nations and Inuit Health Program Envelope.[17] The First Nations and Inuit Health Program Envelope also provides funding for community health services and FNIHB hospitals.[18] Annual growth levels for the envelope were set at 3% for the period 1999/2000 to 2001/2002. Expenditures related to the NIHB Program accounted for 40.1% of total envelope expenditures in fiscal year 2002/2003. By comparison, in this same time period, expenditures related to community health services accounted for 58.2% of the total envelope and expenditures related to the operation of FNIHB hospitals accounted for 1.7%.[19] Thus, expenditures related to the NIHB Program have a substantial impact on the funding available for other First Nations and Inuit health programs.

Given the growth in the NIHB Program as well as the impact this growth has on other health programs, it is not surprising that several NIHB management initiatives have been implemented to control the costs of the NIHB Program. These include: automation of client benefit claims payment processes; improved financial and management practices; and improved audit and accountability measures.[20]

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[15] Other Health Care Services includes crisis intervention counselling and selected other health services.

[16] The growth rate for the eligible First Nations and Inuit client population is approximately 2.7 times higher than for the Canadian population (see the *Non-Insured Health Benefits Program 2002/2003 annual report* produced by Health Canada).

[17] This envelope, along with resources approved for specific initiatives, represents the maximum resources available to fund all federal First Nations and Inuit health programs.

[18] Health services include: community nursing, alcohol/drug counselling, Brighter Futures, transfer initiatives and management/support at the zone, regional and headquarters levels. Hospital services include the operation of First Nations and Inuit Health Branch hospitals.

[19] Health Canada. (2003). *Non-Insured Health Benefits Program. 2002/2003 annual report*. Ottawa: Health Canada.

[20] Ibid

1.4 The NIHB Pilot Projects

Since the early 1970s, First Nations and Inuit organizations have been negotiating with the federal government to regain control of all aspects of the lives of First Nations and Inuit people, including health.[21] In March 1988, Cabinet approved the Transfer of Health Services to First Nations and Inuit control. This decision was subsequently approved by Treasury Board in June 1988. Since then, many First Nations and Inuit communities have taken over control of the delivery of community health programs and services for their members.[22] However, neither the Cabinet decision nor the Treasury Board approval included the transfer of the NIHB Program. In June 1994, Cabinet decided that management and delivery options for the transfer of NIHB could be tested on a pilot basis and in September 1994 Treasury Board granted approval for a maximum of 30 pilot projects.

The NIHB Pilot Projects were designed to test various management and delivery options for transferring the NIHB Program from Health Canada's control to First Nations and Inuit control. The specific objectives of the NIHB Pilot Projects were to:

- test the viability of possible management options;
- test various types of organizational models and structures;
- test the influences of regional diversity on similar pilots;
- provide information from which the efficiency and effectiveness of the pilots could be improved; and
- provide a basis for recommendations for the future management of the NIHB program.

In addition to these objectives, the pilot projects were expected to continue to meet the objectives of the NIHB Program as delivered by Health Canada.[23] In September 2000, Treasury Board approved an extension to continue the original 1994 Treasury Board Pilot Project

[21] Minister of Public Works and Government Services Canada. (2001). *Non-Insured Health Benefits. Handbook for Pilot Projects*. Ottawa: Minister of Public Works and Government Services Canada. It is noted that this document was produced after the second set of pilot projects were conducted. The researchers understand that an earlier version of the handbook existed, although no mention of this earlier document is made in the handbook. It is cautioned that some of the information contained in 2001 version of the handbook may not have existed in the earlier version.

[22] Ibid

[23] Health Canada. (2003). *Request for proposal (RFP). Evaluation of the Non-Insured Health Benefits (NIHB) Pilot Projects, Appendix A.* Ottawa: Health Canada. The 2002/2003 Annual Report on the NIHB Program notes that "In general, pilot projects are expected to meet the following criteria: assume all benefit areas; manage the current national benefit levels; and serve all members regardless of residency." It is noted that the assuming all benefit areas was not a requirement for the first two groups of pilot projects.

authority to March 31, 2005.[24] The handbook for NIHB Pilot Projects notes that, although the NIHB Program is currently not eligible for transfer, the

> NIHB Pilot Projects are providing valuable information to assist FNIHB and the AFN to jointly decide on policy and procedures for the management of the NIHB Program should transfer to First Nations and Inuit control eventually become available. The NIHB Pilot Projects will provide a practical comparison of the various management options for delivery of NIHB and will assist other First Nations and Inuit communities in choosing the option that is appropriate for increasing their control in the future…Undertaking a Pilot Project provides a community or group of communities with business opportunities to reduce the costs of benefits and thereby have funds to put towards other health programs.[25]

Following initial discussions with the FNIHB regional office, and receipt of a clear mandate to proceed, First Nations and Inuit organizations interested in taking on a pilot project needed to prepare a preliminary proposal. A Joint Regional Review Committee assessed the preliminary proposal and recommended whether applicants should proceed with the preparation of a business plan. Funding was provided for the development of the business plan. Once the business plan was approved, the organization entered into a pilot agreement and funding for start-up costs was provided.[26]

A total of 17 pilot projects were established between April 1996 and February 2003. Of these, one pilot project was discontinued[27] when the First Nation went into self-government. Another pilot joined with a larger pilot project. Of the other 15 pilot projects, three were conducted in British Columbia, three were conducted in Alberta, six were conducted in Manitoba, one was conducted in Ontario, one was conducted in Québec and one was conducted in Atlantic Canada. All but three of the pilot sites included Medical Transportation. For four of the pilot sites, this was the only non-insured health benefit that was piloted. Most pilot sites tried to provide services to members both inside and outside the community. Thirteen of the fifteen pilot projects have reverted to Contribution Agreements, one has recently been discontinued but has not reverted to a Contribution Agreement at this time, and one has continued as a pilot (and has a Pilot Agreement that runs until March 31, 2005).

Two previous evaluations were conducted on the pilot projects. Both were designed to strengthen the management and delivery of the NIHB Program in order to meet Treasury Board requirements. However, both of the previous evaluations were incomplete. They provided

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[24] Health Canada. (2003) *Request for proposal (RFP). Evaluation of the Non-Insured Health Benefits (NIHB) Pilot Projects*, p. 3. Ottawa: Health Canada.

[25] Minister of Public Works and Government Services Canada. (2001). *Non-Insured Health Benefits. Handbook for Pilot Projects,* p. 6. Ottawa: Minister of Public Works and Government Services Canada.

[26] Preliminary proposals could be submitted by individual First Nations or Inuit communities, by a grouping of several First Nations or Inuit communities, by a Provincial/Territorial organization, by a Tribal Council, or by other First Nations or Inuit organizations. For more information on the required content of the preliminary proposal and business plan, see *Non-Insured Health Benefits. Handbook for Pilot Projects.*

[27] The term "discontinued" is used in this document to indicate that a pilot project is no longer in operation. The term does not indicate what organization(s) made the decision that one or more non-insured health benefits would no longer be administered at the community level.

commentary on how various stakeholders felt the pilot projects were operating but for the most part failed to identify how the management and delivery of the NIHB Program could be strengthened. The current evaluation was intended to build on these earlier evaluations. It is anticipated that it will be the baseline for future evaluations.

1.5 Overview of This Evaluation

The purpose of the evaluation was to provide input regarding the future transferability of the NIHB Program from Health Canada's control to First Nations and Inuit control.[28] This included an examination of lessons learned from the previous pilots as well as a consideration of management issues regarding the delivery of the NIHB Program as it related to the pilot projects. The key research questions for this evaluation were:

- Does the NIHB Pilot Project make sense?
- What impacts have the NIHB pilot projects had?
- How successful have the NIHB pilot projects been?
- How cost-effective were the NIHB pilots?[29]

The evaluation focused on:

- the overall NIHB Pilot Project process;
- the individual pilot projects that were implemented; and
- the extent to which the results from the pilot projects could provide further information about the NIHB Pilot Project process as well as the transferability of the NIHB program to First Nations and Inuit control.

The evaluation was carried out in three phases. Phase 1 involved the development of a comprehensive understanding of the NIHB Program and the previous evaluations of the pilot projects. Phase 2 involved the development of an in-depth understanding of the issues and challenges regarding the transferability of the NIHB Program. This phase also involved the administration of the Annual Administrative Survey in two pilot sites.[30] Phase 3 involved a case study of the only remaining pilot project, the Bigstone Cree Nation NIHB Pilot Project. The

[28] Health Canada. (2003) *Request for proposal (RFP). Evaluation of the Non-Insured Health Benefits (NIHB) Pilot Projects*, p. 3. Ottawa: Health Canada.
[29] Health Canada. (2003). *Request for proposal (RFP). Evaluation of the Non-Insured Health Benefits (NIHB) Pilot Projects, Appendix A.* Ottawa: Health Canada.
[30] As required by national FNIHB personnel, the survey was conducted with representatives of the pilot project site that was recently discontinued and with representatives from the only pilot project site that is still in operation.

findings from each of the three phases are presented in separate documents.[31] This synthesis report provides highlights of the findings from the three study phases as well as recommendations regarding the transferability of the NIHB Program.

1.6 Organization of this Report

Chapter 2 describes the methodologies used in the evaluation project as a whole, and their strengths and weaknesses. The methodology used in each phase of the study is included as part of the relevant chapter. Chapter 3 presents the highlights from the document review and interviews with representatives from Health Canada and First Nations and Inuit organizations that were conducted in Phase 1.[32] Chapter 3 presents highlights from interviews conducted with representatives of various First Nations and Inuit organizations (and from Health Canada) that were conducted in Phase 2. Chapter 4 presents highlights from the annual administrative survey that was conducted with the Pilot Project Coordinators and the Regional Pilot Coordinators for both the Southeast Resource Development Council and Bigstone Cree Nation pilot projects as part of Phase 2 activities. Chapter 5 presents highlights from various stakeholders involved with the Bigstone Cree Nation's NIHB Pilot Project (that is, officials, project coordinators, consultants, staff, non-insured health benefits providers and clients). Chapter 6 provides a discussion of the findings from the evaluation with respect to the key research questions. Chapter 7 presents recommendations for the future.

[31] See the following documents: *Final Phase 1 report: Background and historical context and detailed methodology for Phases 2 and 3* (dated August 10, 2004); *Final Phase 2 report: Issues and challenges with respect to the transfer of NIHB* (dated December 7, 2004); *Report on the Annual Administrative Surveys at Southeast Resource Development Council and Bigstone Cree Nation (2004)* (dated August 3, 2004); and *Final Phase 3 report: An in-depth examination of the Bigstone Cree Nation pilot project* (dated December 14, 2004). All documents were prepared by Hollander Analytical Services Ltd. and Adrian Gibbons and Associates Ltd.

[32] As noted, a document review was conducted in Phase 1. The findings from this review were used, as appropriate, in Phases 2 and 3. File reviews were not conducted in either Phase 2 or Phase 3.

2. METHODS AND THEIR LIMITATIONS

2.1. Introduction

The evaluation of the Non-Insured Health Benefits Pilot Projects was conducted using four different methods: a document review; interviews with key stakeholders at the national, regional, and community levels and clients; surveys of pilot project coordinators as well as providers of non-insured health benefits; and a review of financial data related to the administration and delivery of non-insured health benefits at the national and local levels. Detailed information regarding each of these approaches as well as their strengths and weaknesses in the context of the current evaluation is provided below.

The findings from the evaluation and recommendations regarding the future transferability of the NIHB Program are based on all of these approaches using a process called "triangulation". Triangulation is an approach in which different methods are used to study the same question. It is a strategy for ensuring that evaluation findings are not the artifact of a single method, single source of data or single investigator's bias. Triangulation can be used to check the consistency of information derived at different times, by different methods, and from different individuals and sources and can be used to increase one's confidence in evaluation data and its interpretation. Thus, even if each method used has some shortcomings, if one finds similar results using different methods (as was the case in this project) the level of confidence one can have in the overall findings is increased.

2.2. Document Review

2.2.1 Phase 1

A review of documents related to the development and implementation of the NIHB Pilot Projects was conducted in Phase 1 in order to develop a broad understanding of the NIHB Program and the previous evaluations on the various pilot projects. The documents reviewed in Phase 1 included background materials (e.g., policy documents, an evaluation framework and minutes from meetings), annual reports on the NIHB Program, and reports from the two previous evaluations of the pilot projects. Over 55 documents were reviewed for this phase of the study. Together, the documents provided a reasonable picture of what the NIHB Program involves, why the NIHB Pilot Projects were developed and some of the benefits and challenges that were experienced by the pilot sites. However, the documents had limitations.

Much of the information on the NIHB program was obtained from documents produced by the FNIHB. The material in the various FNIHB documents appeared to be conceptually consistent, but was not always consistent with respect to specific wording (for example, there are slight discrepancies between the information booklet on the NIHB Program and recent annual reports). In some cases, the discrepancies may result in misunderstandings regarding the program. The researchers recommend that all current public documents regarding the NIHB Program be reviewed to ensure that the text across the various documents is consistent with respect to concepts and wording.

Some of the documents regarding the NIHB Program appear to be relatively old. For example, the program directive regarding mental health services is titled "Interim Program Directive" and is dated March 1994. A more recent or final version of this document could not be obtained. Other program directives are dated 1990 or are not dated. Several documents produced by Health Canada are not dated. It may be that the various documents are still applicable and therefore have not been revised. However, it is not clear that the documents have been reviewed to ensure that this is the case. If a review has been conducted, the researchers recommend that the document note this (for example, "Reviewed: January 2005").

Because many of the FNIHB documents emphasize the NIHB Program *per se*, the impacts of the NIHB Pilot Projects are not clearly identified. For example, the annual reports on the NIHB Program do not provide any information on the pilot projects *per se* (such as what it cost to conduct the pilot projects on a regional or national basis or what effect the pilot projects had on the cost of various non-insured health benefits).

The documents on the previous evaluations of the NIHB pilot projects were not always consistent or complete thus making it difficult at times to draw comparisons across the various pilot sites. The reports on the evaluations of the first NIHB pilot projects were labeled "Draft" suggesting that the content of these reports may never have been finalized. As an aside, it is noted that these particular reports were also not available electronically.

2.2.2 Phase 3

A document review was also used in Phase 3 as part of developing the case study on the Bigstone Cree Nation NIHB Pilot Project. The review included background materials (such as the pilot project agreement and information regarding the Bigstone Cree Nation), previous evaluation reports, quarterly reports, and some financial data. Over 10 documents were reviewed for this phase of the study. Together, the documents provided a good picture of what the Bigstone Cree Nation wanted to accomplish with the NIHB Pilot Project, what has been accomplished to date, and how funds have been allocated. Detailed funding information was not provided in the written documents (although specific questions regarding funding were answered by individuals) and the researchers were referred to Health Canada for the necessary information.

2.3. Interviews with Key Stakeholders at the National, Regional and Community Levels

2.3.1 Introduction

There was not a lot of written information available on the previous pilots. As a result, the current evaluation relied very heavily on interviews. Interviews were used in all three phases of the evaluation.

2.3.2 Phase 1

In Phase 1, a list of 22 potential informants was developed jointly by the researchers and personnel of the FNIHB and the AFN. These individuals represented Health Canada or First Nations/Inuit organizations at the national, regional and local levels and were responsible for policies regarding the administration and/or management of non-insured health benefits within their respective organizations. One individual referred the researchers to someone else on the list, one referred the researchers to someone else who was interviewed in Phase 2 and three individuals could not be reached despite repeated attempts to do so. In total, interviews were conducted with 17 individuals. Ten respondents represented Health Canada and seven represented First Nations and Inuit organizations (including the AFN). Nine respondents were from the national level and eight were from the regional level.

There had been several relatively recent staff changes at both Health Canada and the AFN at the time the Phase 1 interviews were conducted. As a consequence, some of the national respondents were unable to provide much information regarding some of the issues. In addition, many of the national respondents referred the researchers to the regional level for additional information.

Some of the information gathered from national and regional respondents in the Phase 1 interviews was applicable to Phase 2 (and was therefore not reported in Phase 1).

2.3.3 Phase 2

In Phase 2, interviews were conducted with a total of 46 First Nations and Inuit individuals (as well as with the national and regional representatives interviewed in Phase 1). The First Nations and Inuit individuals interviewed in this phase of the study fell into four groups.

The first group consisted of representatives of First Nations and Inuit organizations who had had a previous NIHB pilot project. Respondents from 13 of the 14 previous NIHB pilot projects were interviewed. (Representatives from the Bigstone Cree Nation were not contacted for this phase of the evaluation as the Bigstone Cree Nation's NIHB pilot project was examined in depth in Phase 3.) A total of 20 individuals were interviewed in this group.

The second group consisted of representatives of First Nations who applied for NIHB pilot project funding but were not successful in obtaining funding. Three First Nations were identified as belonging to this group. How representative these organizations are of the full range that fit this group (for example, with respect to location, population size, type of non-insured health benefit(s) to be piloted, management structure to be piloted, and so on) is unknown as a list of all the First Nations/Inuit organizations that fit this group could not be provided to the researchers. Respondents were interviewed from two of the three First Nations that were identified as belonging to this group. Potential respondents from the third First Nation did not respond to the researchers' repeated requests to have them participate in the study. A total of four individuals were interviewed in this group.

The third group consisted of representatives of First Nations that are providing all of the non-insured health benefits, but which were not involved in a pilot project. Only two First Nations were identified as belonging to this group. Interviews were conducted with representatives of both First Nations. A total of four individuals were interviewed in this group.

The fourth group consisted of representatives of First Nations in Saskatchewan. Individuals from five relatively large organizations were contacted. One individual was relatively new to his/her position and did not feel knowledgeable enough to comment on the NIHB Pilot Projects. Four interviews involving a total of eighteen individuals were conducted.

2.3.4 Phase 3

In Phase 3, interviews were conducted with a total of 160 individuals. The respondents fell into three groups.

The first group consisted of officials, project coordinators and consultants who have been actively involved with the development and implementation of the pilot project at the Bigstone Cree Nation and included representatives from both the Bigstone Health Commission and the regional Health Canada office. A total of seven individuals were interviewed in this group.

The second group consisted of staff who work for the Bigstone Health Commission; many were administrators in the various benefit areas. A total of seven individuals were interviewed in this group. All but one of these individuals had been involved with Bigstone's NIHB pilot project for two years or less.

The third group consisted of Bigstone Cree Nation members who had used one or more non-insured health benefits. In order to be included in the sample, individuals had to: be a member of the Bigstone Cree Nation; be 18 years of age or older; have used at least one non-insured health benefit in the past 12 months; and have a phone number.[33] A total of 146 individuals were interviewed in this group.[34] The respondents included individuals living off-reserve as well as individuals living on-reserve. The respondents also included individuals from all of the communities who receive health services from the Bigstone Cree Nation.

2.3.5 Interview Tools

The interview tools used in the three evaluation phases were designed to build on the previous evaluations, and were intended to provide both qualitative and quantitative data. The tools used in the evaluation were designed specifically for this project and were intended to enable comparisons with the previous evaluations (as appropriate), clarify issues raised by the

[33] It was recognized that the requirement for potential respondents to have a telephone number may have introduced a bias into the client sample. It was the researchers' understanding that many individuals on-reserve had telephones and thus this was not considered particularly problematic for the on-reserve sample particularly since interviewers were told they could conduct the interviews in person, if necessary. The lack of a telephone may have been more problematic for the off-reserve sample, particularly since the interviews for this group needed to be conducted by phone due to time and funding constraints.

[34] The researchers were authorized to obtain approximately 150 completed interviews.

previous evaluations, and address the research questions for this evaluation. All of the interview tools were reviewed by members of the Project Working Group prior to being used in the study.

It is noted that the interview data reflect respondents' *perceptions* of the way things are, not necessarily the objective situation. Much of the information provided by the respondents could not be confirmed through other sources (because of the researchers' mandate as well as time and financial constraints). Despite these cautions, it is noted that respondents in the various phases of the study identified similar benefits and challenges regarding the transfer of non-insured health benefits. It is anticipated that the information obtained in these interviews can be used as a baseline for future evaluations.

2.4. Surveys

2.4.1 Phase 2

As part of Phase 2 activities, the Pilot Project Coordinators and Regional Pilot Coordinators for two of the pilot sites were asked to complete the Annual Administrative Survey.[35] Both the respondents to be interviewed and the tool to be used were specified in the Request for Proposal for the evaluation and were confirmed in discussions with the Project Manager. The Annual Administrative Survey was used as part of the second evaluation of the pilot projects. It was reviewed by the researchers to ensure that it was applicable for the current evaluation.

2.4.2 Phase 3

Surveys of providers of non-insured health benefits were conducted as part of the case study of Bigstone Cree Nation's NIHB Pilot Project in Phase 3. Each benefit clerk was asked to provide a list of five to ten major suppliers in their benefit area.[36] Providers were identified for each of the non-insured health benefit areas except for Crisis Intervention Mental Health Counselling (although an effort was made to identify providers for this area as well). In total, a list of 29 non-insured health benefit providers was compiled with each area (except Crisis Intervention Mental Health Counselling) identifying between three and nine providers.

Twenty-five of the 29 providers agreed to participate in the study. A total of 18 provider organizations completed the Provider Survey. In several cases, particularly for larger companies, the responses on the survey reflected the comments from several individuals. An additional seven individuals indicated that they did not have the time to complete the survey, but provided general comments. Of the four potential respondents that did not participate, one could not be reached, one indicated that the company provided very few benefits to members of Bigstone Cree Nation, and two did not respond (despite repeated reminders to do so), and did not offer an explanation for their lack of interest.

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[35] As required by national FNIHB personnel, the survey was conducted with representatives of the pilot project site that was recently discontinued and with representatives from the only pilot project site that is still in operation.

[36] With people being spread out all over the country, there are numerous providers who provide non-insured health benefits to members of Bigstone Cree Nation. However, the researchers felt it would be best to try to contact major providers for each benefit area.

The survey was intended to build on the previous evaluations of the Bigstone NIHB pilot project, obtain individuals' perceptions of how well the pilot project was working, and establish a baseline for future evaluations. Members of the Project Working Group reviewed the survey before it was used in the current evaluation. It was possible to make some comparisons between responses provided by the providers in the current evaluation and those provided by fewer (and possibly different) providers in a previous evaluation of the Bigstone pilot project. It was noted, however, that the previous evaluation was different in many ways from the current evaluation.

2.5. Review of Financial Data

A review of financial data regarding the NIHB Program in general was conducted as part of Phase 1. As noted above, many of the FNIHB documents reviewed in this phase emphasize the NIHB Program *per* se and the impacts of the NIHB Pilot Projects were not clearly identified. A review of financial data regarding the administration and delivery of non-insured health benefits at the local level was also conducted as part of the case study of Bigstone Cree Nation's NIHB Pilot Project in Phase 3. In both Phases 1 and 3, the financial data included in the evaluation were provided by FNIHB (at the regional and headquarters levels) and were very general; detailed financial data were not reviewed as part of this evaluation. Financial data were not provided in the evaluation reports of the previous pilot projects. When such data were requested from the previous pilot projects as part of the current evaluation, the researchers were referred back to FNIHB (at the regional and/or headquarters levels).

3. HIGHLIGHTS FROM THE PHASE 1 REPORT – BACKGROUND AND HISTORICAL CONTEXT

3.1 Introduction

This chapter presents highlights from Phase 1. This phase involved a review of several documents (for example, background materials, annual reports and reports of the previous evaluations of the pilot projects) as well as interviews with representatives of Health Canada and First Nations and Inuit organizations at the national and regional levels.

3.2 Review of Background Materials and Annual Reports

The review of the background materials and annual reports included an examination of: the number of First Nations and Inuit individuals, by region, who are eligible to receive benefits under the NIHB Program; expenditures, across all benefit categories, by region; and expenditures, across all regions, by benefit categories. As noted in the previous chapter, between April 1993 and March 2003, Ontario had the largest eligible population, followed by the Pacific, Manitoba and Saskatchewan regions. In the same time period, the Ontario, Manitoba and Alberta regions had the largest expenditures. Between April 1993 and March 2003, the largest expenditures occurred for Pharmaceutical Services, Medical Transportation and Dental Services. Although the rate of change varied somewhat over the ten year period from April 1993 to March 2003, the overall pattern was one of increasing growth. This growth seems to have occurred for several reasons.

Funding for the NIHB Program comes from the First Nations and Inuit Health Program Envelope which also provides funding for other health services. As a result, expenditures related to the NIHB Program can have a substantial impact on the funding that is available for other health programs. Expenditures related to the NIHB Program accounted for 40.1% of the total envelope expenditures in fiscal year 2002/2003. Several management initiatives have been implemented by FNIHB to control the costs of the NIHB Program, including automation of client benefit claims payment processes, improved financial and management practices, and improved audit and accountability measures.[37] While any efforts to manage NIHB expenditures are commendable, it is not clear how many of these initiatives may be achievable by a First Nations or Inuit community that wishes to administer non-insured health benefits.[38]

3.3 Review of Previous Evaluations of the Pilot Projects

The reports of previous evaluations of the pilot projects were also reviewed. The material provided in the various reports was not always consistent or complete. Nevertheless, the review of the previous evaluation reports indicated that:

- First Nations and Inuit individuals in the pilot sites were not always aware of the non-insured health benefits to which they were entitled, nor were they aware of appeals or exceptions processes;
- project staff at the pilot sites needed more training on several issues related to the provision of non-insured health benefits;
- providers wanted to be kept better informed regarding changes in the program, but were generally satisfied with the ability of the pilot sites to manage claims processing and bill payments;
- project coordinators (both at the local and regional levels) needed more support;
- there were often dissenting opinions regarding what was being piloted and/or who was being served by the pilot project;
- it was perceived that funding for most of the pilot projects was insufficient; and
- there seemed to be differences in the nature, scope, and quality of program operations across the pilot projects.

[37] Health Canada. (2003) *Non-Insured Health Benefits Program 2002/2003 annual report*. Ottawa: Health Canada.
[38] First Nations and Inuit communities may not be able to implement similar management initiatives due to smaller economies of scale, availability of appropriate resources, and similar limitations. However, as discussed later in this report, they may be able to control NIHB costs in other ways (and in ways which may not be feasible at a national level).

3.4 Interviews with Key Stakeholders

As part of Phase 1 activities, interviews were conducted with 17 representatives of Health Canada and First Nations and Inuit organizations (including the Assembly of First Nations).[39] Nine respondents were from the national level and eight were from the regional level. Two interview schedules were developed for this phase of the project – one for individuals at the national level and one for individuals at the regional level. A similar set of questions was asked on each interview schedule to enable comparisons to be made between respondents at the national and regional levels.

The interviews with the key stakeholders indicated that:

- There were substantial discrepancies in the perceptions of Health Canada representatives and First Nations/Inuit representatives with respect to many of the issues examined. For example, national First Nations/Inuit representatives unanimously agreed that training for project staff in the pilot sites was not adequate, both with respect to the amount of training available and with respect to the amount of funding available. However, the majority of national Health Canada representatives indicated that they felt training was adequate.

- The previous pilot projects had a number of strengths. For example, respondents noted that First Nations/Inuit communities were able to take on more responsibility for (and control of) the delivery, management and administration of non-insured health benefits, were better able to respond to client needs, and were also able to work with providers.

- Several challenges were encountered as part of the previous pilot projects. Many of the challenges had to do with the need to have adequate time, capacity, resources, and understanding of the complexity of the NIHB Program. For example, First Nations/Inuit representatives indicated that training, facilities, equipment and supplies, and funding for the pilot projects were inadequate.

- There are several changes that could be made to increase the feasibility of future pilot projects. For example, expectations for the pilot projects need to be clear, and communication between Health Canada and the pilot sites needs to be increased.

- The majority (71%) of respondents (First Nations/Inuit and Health Canada representatives at both the national and regional levels) indicated that more pilot projects should be conducted, but that changes needed to be made. For example, it was noted that the goals for the pilot projects should be reviewed, adequate resources should be made available, and pilot projects should run for a longer period of time.

[39] Each interview was approximately 45 to 90 minutes long. All but two of the interviews were conducted by phone; the remaining two were conducted in person.

4. HIGHLIGHTS FROM THE PHASE 2 REPORT – ISSUES AND CHALLENGES WITH RESPECT TO THE TRANSFER OF NIHB

4.1 Introduction

This chapter presents highlights from Phase 2. The selected pilot sites were not representative of all possible First Nations and Inuit communities. As a result, the information available from them (for example, from the previous evaluations) cannot necessarily be generalized to all communities. In order to address this limitation, the current evaluation gathered information from five groups of key informants: national and regional representatives; First Nations and Inuit that had a pilot project; First Nations and Inuit who wanted to have a pilot project but were not successful in obtaining funding; First Nations who are providing all non-insured health benefits but which were not involved in a pilot project; and First Nations (in Saskatchewan only) who chose not to participate in the pilot project process.

Interviews were conducted with representatives of the five groups of key informants in order to: obtain information regarding what worked well and what did not work well with regard to the previous pilot projects; provide information regarding whether more pilot projects should be conducted in the future, and if so, under what conditions; and provide information regarding the impact First Nations and Inuit representatives felt the transfer of the administration of the NIHB program could have on other health services.[40] Separate interview schedules were developed for each group of respondents. However, a similar set of questions was asked on each interview schedule to enable comparisons to be made among the various groups.

4.2 Findings from Group 1 – National and Regional Representatives

Group 1 consisted of national and regional representatives from Health Canada and from First Nations and Inuit organizations (these were the same individuals who were interviewed as part of Phase 1). This group was included in order to understand how the individuals responsible for policies regarding the administration and/or management of non-insured health benefits within their respective organizations view the NIHB Program in general and the NIHB Pilot Projects in particular. Seventeen interviews with a total of seventeen individuals were conducted.

Overall, it appeared that the national and regional First Nations/Inuit and Health Canada representatives did not feel that the processes for establishing the pilot projects were adequate. Approximately one-third of respondents indicated that the review process for selecting the pilot sites was inadequate. Respondents noted that, in some cases, regional review committees may not have conducted sufficient technical analyses and that First Nations and Inuit communities may not have always understood what a pilot project would involve. It is noted, however, that approximately another third of respondents indicated that they did not know if the review process was adequate. This finding may reflect the fact that several respondents were relatively new to their positions and may not have been aware of what the review process had involved. Approximately half of the respondents indicated that they did not feel that the original business

[40] All but two of the interviews were conducted by phone. The interviews varied in length from 30 to 90 minutes, depending on which group the respondent was in.

plans for the pilots were adequate. This finding is important, as the business plans were intended to identify how the pilot projects were to be implemented.

In general, the national and regional respondents did not appear to know whether management and administrative aspects of the pilot projects (including record-keeping) were adequate. While First Nations/Inuit respondents provided comments that suggested that Health Canada was perceived to be responsible for management and administration issues, half of the respondents from Health Canada indicated that they did not know whether the management and administration of the pilot projects was adequate. Approximately one-third of respondents indicated that record-keeping was inadequate, suggesting that monitoring of the pilot projects may have been difficult, at least in some cases. It is noted, however, that a further one-third of respondents (approximately an equal number of national Health Canada and national First Nations/Inuit representatives) indicated that they did not know if record-keeping was adequate. This finding may reflect the fact that several respondents were new to their positions and may not have been aware of what records were kept or by whom.

Overall, approximately 60% of the national and regional representatives responded to questions regarding the goals of the pilot projects. Of these, the majority of individuals felt that the goals for the pilot projects were appropriate, clear, and achievable. While several individuals also felt that the goals were adequately communicated to the main reference groups, there was more disagreement among respondents with respect to this issue. These findings need to be interpreted with caution, however, as approximately 40% of respondents did not answer these questions.

Approximately 60% to 75% of the national and regional representatives responded to various questions regarding the viability of the pilot projects. Based on the responses of those individuals who did respond, having health management infrastructure in place, being able to employ key providers, having a larger population, having communities that are located close together and having the support of local health providers were all perceived to have a positive effect on the viability of the pilot projects. Many of the individuals who responded did not know what impact the previous transfer of community health services may have had on the viability of the pilot projects. Again, these findings need to be interpreted with caution as a relatively large proportion of respondents did not answer these questions.

Overall, respondents indicated that key factors that contributed to the discontinuance of the majority of the pilot projects included: a lack of adequate resources (including time, capacity, personnel, and funding); the willingness and/or perceived ability to take on some of the non-insured health benefits (such as dental services and pharmaceutical benefits); the willingness and/or perceived ability to serve the entire target population; the complexity of some of the pilot projects; and concerns regarding how administration of one or more of the non-insured health benefits would affect the treaty process.

Respondents indicated that more resources could have improved the chances of success for the pilot projects. National and regional First Nations/Inuit representatives noted that more funding (especially for administration), more policies, and more support from Health Canada (at both the regional and national levels) could have had a positive impact on the success of the pilot

projects. National and regional Health Canada representatives noted that more training, more support, the ability to process claims automatically, more information regarding the NIHB program and its complexity, more funding, and more time to conduct the pilot projects could have improved the chances of success for the pilot projects. Both First Nations/Inuit and Health Canada representatives appeared to feel that the discontinuation of the majority of the pilot projects had had a negative impact.

Respondents noted that the major issues that could affect the transfer of NIHB to First Nations/Inuit control included: the agenda of the current government; the availability of adequate funding; and a recognition of the long term impact that the transfer of NIHB could have, both on First Nations/Inuit and on Health Canada. Respondents noted that several options could be used to transfer non-insured health benefits. It was also suggested that consideration should be given to transferring only some of the non-insured health benefits (for example, Medical Transportation, Medical Supplies and Equipment, and Short-term Crisis Intervention Counselling).

4.3 Findings from Group 2 – First Nations and Inuit That Had a Pilot Project

Group 2 consisted of representatives of First Nations and Inuit organizations who applied for NIHB pilot project funding, were successful in obtaining funding, but then reverted back to a Contribution Agreement (these were the previous pilot sites). This group was included in order to gain an understanding of what worked well and what did not work well in the previous pilot projects and to identify any issues that will need to be addressed if additional NIHB pilot projects are to be conducted in the future.[41] Thirteen interviews with a total of twenty individuals were conducted.

The previous pilot sites that participated in the current evaluation varied with respect to size, location, target population and type of non-insured health benefits included in the pilot project. Nevertheless, the previous pilot sites appeared to be similar in several ways. For example, all of the previous pilot sites felt that it was important that non-insured health benefits be administered by First Nations and Inuit at the local level. Respondents commented that local staff are more familiar than Health Canada with what is needed and what is appropriate for individuals in the local community. They also noted that some services can be provided faster and more reliably at the local level, thus potentially increasing access to health services. In addition, there is an opportunity to build capacity at the local level which may have a positive impact on the community in general. Furthermore, First Nations and Inuit are able to assume responsibility for their own communities. (Many of these perceived advantages were also why the pilot sites were interested in having a pilot project initially.) However, respondents also noted (probably as a result of their experience with a pilot project) that there are several disadvantages to having First Nations and Inuit administer non-insured health benefits at the local level. These include concerns regarding: having sufficient funding; having sufficient information (for example, historical information, information about non-insured health benefits in general, information about policies, and information regarding changes in the program); having appropriately trained staff; having good computer programs and systems to assist with

[41] Representatives from the Bigstone Cree Nation were not contacted for this phase of the evaluation as the Bigstone Cree Nation's NIHB pilot project was examined in depth in Phase 3.

administering benefits; needing to apply rules which may not be appropriate to the local situation; and needing support from Health Canada.

The similarities among the previous pilot projects suggest that size and location may not have had much impact on the local administration of non-insured health benefits. However, some respondents provided comments that suggested that size may be important. For example, respondents noted that, in general, non-insured health benefits should be delivered at the local level by First Nations and Inuit. It was also recognized, however, that it may be appropriate to administer some benefits (such as Medical Transportation and Vision Care) at the local level (regardless of population size) because it may be possible to realize cost-efficiencies relatively easily by being innovative. However, large populations may be required to realize cost-efficiencies for more complex benefits (such as Dental Services and Pharmaceutical Services).

The majority of the previous pilot projects have reverted back to Contribution Agreements.[42] There appear to be several reasons why this has occurred. Some pilot projects may have wished to continue, but were unable to do so because Health Canada did not consider it feasible. Pilot sites in this group do not always appear to have understood why the pilot projects were being discontinued. Other pilot sites chose to discontinue their pilot project because of concerns regarding: an expectation that all non-insured health benefits be administered; having sufficient funding; and having a sufficient population base.

The discontinuation of the majority of the pilot projects should not necessarily be viewed as negative. There were several areas where improvements were made during the pilot projects and which may also be applicable now under the Contribution Agreements. Approximately 80% of the previous pilot sites indicated that their NIHB delivery system had been very effective. Respondents commented on improved efficiencies in some areas, the development of quality assurance measures, and the use of various methods to provide members with information regarding non-insured health benefits.

Respondents from the previous pilot sites felt that, in general, the discontinuation of the majority of the pilot projects had had a negative impact. When asked if there should be more pilots in the future, some respondents said “Yes” while others said “No”. Some respondents commented that pilot projects could be used to try different ways of addressing community needs. Others commented on the preference to have non-insured health benefits transferred to the local level. Respondents noted that several options could be used to transfer non-insured health benefits. As with the national and regional respondents in Group 1, Group 2 respondents suggested that consideration should be given to transferring only some of the non-insured health benefits (for example, Medical Transportation). Group 2 respondents also suggested that partnerships should be established at different levels and among different organizations.

[42] As noted earlier, 13 of the 15 pilot projects have reverted back to Contribution Agreements. A recently discontinued pilot project has not reverted back to a Contribution Agreement at this time. The remaining pilot project is still in operation.

4.4 Findings from Group 3 – First Nations/Inuit Who Wanted to Have a Pilot Project

Group 3 consisted of representatives of First Nations who applied for NIHB pilot project funding but were not successful in obtaining funding. This group was included in order to gain an understanding of why some First Nations are interested in taking on a NIHB pilot project and what factors may influence whether they are able to do so. Only three First Nations were identified for this group.[43] Of these, only two participated in the study. It is not known how representative these two First Nations are of the full range of organizations that fit this group. Nevertheless, the First Nations who participated in the study provided some helpful insights. Two interviews with a total of four individuals were conducted.

Both First Nations indicated that they had been interested in having a NIHB pilot project because they saw it as an opportunity to consolidate resources and to prioritize activities and resources. Both First Nations felt they had developed good proposals for a NIHB pilot project, based on knowledge of their local situations and both felt they were ready and prepared to administer non-insured health benefits at the local level.

Awareness of the local situation was seen as an advantage to having non-insured health benefits administered by First Nations. However, needing to work within a structured pilot framework (which was considered to be rigid) was considered to be a disadvantage. Both of the First Nations in this group felt that the administration of non-insured health benefits by First Nations could contribute to improved health status and could enhance the delivery of community health services.

When asked what changes to the pilot project process they would recommend, respondents commented on financial aspects and computer software needs. Respondents also raised several issues regarding the NIHB Program in the future; many of these had to do with funding.

4.5 Findings from Group 4 – First Nations Who Are Providing All Non-Insured Health Benefits

Group 4 consisted of representatives of First Nations that are providing all of the non-insured health benefits, but which were not involved in a pilot project. This group was included in order to gain an understanding of what benefits and challenges these First Nations have experienced with respect to developing and implementing a non-insured health benefits program at the local level. Only two First Nations were identified as belonging to this group - the Mohawk Council of Akwesasne in Québec and the Nisga'a Nation in British Columbia. Two interviews with a total of four individuals were conducted.

[43] In an effort to identify communities, tribal councils, health commissions and similar organizations that fit this group, the researchers contacted project staff at both FNIHB and the AFN. It appeared that while one or more lists of organizations may have existed at one time, it was not possible for the list(s) to be provided to the researchers. The researchers also contacted regional NIHB Managers/Directors and Pilot Contacts. Again, however, it was difficult to obtain the necessary information.

The Akwesasne and Nisga'a differ substantially from one another with respect to their location and the size of the population served. However, there were also a number of similarities between the two First Nations. For example, both First Nations felt it was important that non-insured health benefits be provided at the local level because: there is greater awareness of local issues; clients and administrators are able to relate to one another more effectively; and there is an opportunity for the community to benefit economically as local individuals can be hired to administer the program. Both Akwesasne and the Nisga'a also felt that local administration of non-insured health benefits by First Nations can contribute to improved health status and enhanced delivery of community health services as there can be closer monitoring of health status, earlier intervention to respond to health needs, and the development of prevention programs and other initiatives to respond to, or reduce, these needs. The respondents from both Akwesasne and the Nisga'a Nation indicated that they had experienced these advantages. In addition, both First Nations felt that the following had improved under local administration: access to non-insured health benefits by clients; communication between local NIHB staff and community members; communication between local NIHB staff and service providers; timely payments to service providers; cost-effectiveness of NIHB services; general effectiveness of NIHB; and handling of problems and concerns.

Both First Nations also commented on some of the challenges they had experienced with respect to the administration of the NIHB program. For example, both Akwesasne and the Nisga'a commented on the need to have appropriate information regarding the program, particularly with respect to current policies and procedures. They also commented on the need to have adequate funding for the delivery of non-insured health benefits as well as for administration, staff training, and resources (such as office space, computers and software programs).

4.6 Findings from Group 5 – First Nations in Saskatchewan

Group 5 consisted of representatives of First Nations in Saskatchewan. This group was included in order to obtain an understanding of why none of the First Nations in Saskatchewan applied for NIHB pilot project funding. Four interviews with a total of eighteen individuals were conducted.

Collectively, First Nations in Saskatchewan chose not to apply for NIHB pilot project funding because of three major concerns: that funding would not be sufficient to administer the pilot project; that the pilot projects would have to comply with NIHB policies that were (and are) considered very rigid; and that participation in a pilot project would affect the responsibility of the federal government to cover the costs of all health services for First Nations and Inuit according to need rather than a funding formula.

Despite not participating in a NIHB pilot project, the First Nations in Saskatchewan who participated in the study indicated that they felt it was important that non-insured health benefits be administered by First Nations. Perceived advantages included: ownership by, accountability to, and responsibility for, First Nations; being able to implement flexible policies that reflected the local situation; and being able to employ local individuals to administer the program. Perceived disadvantages included a lack of: sufficient funding; flexible policies; and sufficient

expertise and capacity (currently) to deliver the program in many communities. The First Nations in Saskatchewan also felt that the administration of non-insured health benefits by First Nations could contribute to improved health status and the delivery of community health services since there could be stronger integration of non-insured health benefits with other health services and staff could respond more quickly and more appropriately to the need for non-insured health benefits.

The respondents in this group felt that, overall, the discontinuation of the majority of the pilot projects had had a negative impact. When asked if there should be more pilots in the future, the First Nations in Saskatchewan said that funding needed to be improved and that there needed to be more flexibility with respect to the application of policies. Respondents also commented on the need to examine the whole NIHB system. Respondents cautioned that models for the delivery of the NIHB Program by First Nations must be tailored to the individual circumstances of each province and each band, tribal council, health authority and so on.

5. HIGHLIGHTS FROM THE REPORT ON THE ANNUAL ADMINISTRATIVE SURVEY

5.1 Introduction

This chapters highlights the findings from the Annual Administrative Survey which was conducted with the local pilot project coordinators and the regional FNIHB pilot project coordinators for two of the pilot sites – the Southeast Resource Development Council (SERDC) in Manitoba and the Bigstone Cree Nation in Alberta.[44] It is noted that although the survey is intended to be administered annually, this was the first time it had been administered to SERDC (although this particular pilot project operated for less than one year) and only the second time it appeared to have been administered to the Bigstone Cree Nation (the survey was administered the first time as part of the second evaluation of the Bigstone Cree Nation pilot project).

5.2 Findings from SERDC

The SERDC Pilot Project and FNIHB held different opinions regarding several aspects of the implementation and operation of the pilot project. For example, there was disagreement on basic issues such as whether or not the pilot project was needed by the communities, whether the objectives of the pilot project had been met, on the management option chosen, and on whether or not access to non-insured health benefits and services had improved for clients after SERDC took on the administration of non-insured health benefits. There appeared to have been some degree of discord between the SERDC Pilot Project and FNIHB, between the SERDC Pilot Project and the SERDC Tribal Council administration and leadership, and between the SERDC Pilot Project and some service providers and provider groups.

Both the SERDC Pilot Project and FNIHB questioned whether SERDC had the capacity to successfully undertake the transfer of non-insured health benefits. Funding and cash flow problems appeared to present substantial barriers to the successful implementation and operation of this pilot. It also appeared that more substantive front-end training and capacity development should have been completed prior to the implementation of the pilot. It was recognized that the terms, conditions, funding and cash flow arrangements should have been worked out in more precise detail prior to the start-up of the pilot and been adhered to over the course of the pilot project.

In the view of the SERDC Pilot Project, the major issues affecting the pilot project were: the almost complete lack of support from FNIHB; the lack of support from the SERDC administration, and some SERDC leadership; and inadequate funding and cash flow arrangements. In the view of FNIHB, the major issues impacting the pilot project were: the lack of capacity within the SERDC Pilot Project to deliver benefits effectively; a lack of skills and knowledge about benefits administration by the project's management and program staff; the lack of communication with, and participation by, community members; cash flow problems; the impact of a "one stop shopping" development; and the inadequate time frame available for front-end capacity development and implementation of the pilot project.

[44] National FNIHB personnel had specified that the Annual Administrative Survey needed to be conducted with these two pilot sites as part of the current evaluation.

5.3 Findings from the Bigstone Cree Nation

The Bigstone Cree Nation's pilot project was characterized by a strong, cooperative relationship between the Bigstone Health Commission and the FNIHB regional office. There was substantial agreement between the Bigstone Cree Nation Pilot Project and FNIHB regarding the achievements and successes of the pilot project and its ongoing challenges.

It was felt that the pilot project was meeting the general goal of delivering non-insured health benefits in an effective, efficient and appropriate manner. However, the Bigstone Cree Nation Pilot Project felt that, in general, NIHB pilot projects should focus more on the relation between NIHB program interventions and health outcomes. Both the Bigstone Cree Nation Pilot Project and FNIHB felt that services to clients had improved under the pilot project. It was also felt that the NIHB pilot project was needed by the Bigstone Cree Nation and that it was very important that certain non-insured health benefits be administered locally.

A substantial part of the success of the Bigstone NIHB pilot project appears to have resulted from the support that the pilot project received from the regional FNIHB office, the expertise provided by FNIHB's knowledgeable personnel, and the support and commitment from the Bigstone Cree Nation's leadership. There was a large amount of satisfaction with the level of support provided to the pilot project by the regional FNIHB office. Both the Bigstone Cree Nation Pilot Project and FNIHB felt that the management structure had proved to be flexible, viable, efficient, effective and satisfactory.

The Bigstone Cree Nation Pilot Project did not feel that costs and other factors that affected the administration of non-insured health benefits were adequately taken into account. It was noted that the budget did not take into account either general inflation or cost/price increases.

Both the Bigstone Cree Nation and FNIHB were satisfied that the technological resources of the pilot project were sufficient to facilitate the administration of the benefits and both were somewhat satisfied with the adequacy of the human resources available to deliver benefits. FNIHB felt that additional staff training should be provided to cover staff turnover. The Bigstone Cree Nation Pilot Project noted that Bigstone had substantial human resources to draw on (such as the Chief and Band Council, the Bigstone Health Commission, consultants, and FNIHB staff), but had to develop their own local capacity.

It was felt that the pilot project had been affected by several external influences, including general inflation and cost/price increases, the shifting priorities and management focus of the Bigstone Health Commission, staffing changes at FNIHB, and the impact of new privacy laws which necessitated revised consent approaches.

Both the Bigstone Cree Nation Pilot Project and FNIHB felt that there was sufficient capacity to conduct the pilot. In addition, both felt that training needed to be ongoing in order to plan for staff replacements and program expansion and to develop new and/or enhanced skills and expertise in areas such as electronic record-keeping, utilization review and outcome evaluation.

It was suggested that the objectives of the pilot project should be reviewed to ensure that they are accurate and reasonable, the timelines for development and implementation should be extended substantially, and stronger monitoring/outcome evaluation processes should be developed for all First Nations health programs.

5.4 Insights Regarding the NIHB Pilot Project Process

The information provided by the coordinators working with the SERDC and Bigstone Cree Nation pilot projects provided some insights regarding the NIHB pilot project process. These include:

- the importance of a strong working partnership between staff of the pilot project and FNIHB;
- the importance of access to ongoing technical expertise regarding the development, implementation and administration of benefit delivery systems;
- the need for the leadership of the First Nations/Inuit organization involved with the pilot project to be fully committed to, and supportive of, the pilot (including the program staff and management team);
- the need for substantial capacity development prior to the implementation of the project;
- the importance of ensuring that community members are fully informed of the NIHB program, including the types of benefits that are available and the procedures for accessing these benefits;
- the need for an increased focus on assessing the relation between NIHB interventions and community health outcomes within the overall framework of the NIHB pilot projects;
- the need to review the adequacy of funding for program administration, front-end and ongoing training and capacity development, equipment and other small capital items, quality assurance monitoring, general inflation and specific price/volume increases, and general project cash flow;
- the need to have personnel within regional FNIHB offices who are knowledgeable about the NIHB program and who are prepared to assist with the implementation of the NIHB pilot project(s); and
- the need for practical project time lines which respect the principle of facilitating First Nations (and Inuit) control at a time and pace of their own choosing.

6. HIGHLIGHTS FROM PHASE 3 – IN-DEPTH EXAMINATION OF THE BIGSTONE CREE NATION PILOT PROJECT

6.1 Introduction

This chapter presents highlights from Phase 3. This phase included a review of documents related to the Bigstone Cree Nation Pilot Project, site visits to the pilot site and interviews/surveys with key stakeholders to determine how well the NIHB pilot project is working from various perspectives.

The interviews/surveys were conducted with four groups of key stakeholders. Group 1 included officials, project coordinators and consultants who have been actively involved with the development and implementation of the pilot project at the Bigstone Cree Nation. This group included representatives from both the Bigstone Health Commission and the regional Health Canada office. Group 2 included staff who work for the Bigstone Health Commission. Many of these individuals are administrators in the various benefit areas and all but one individual had worked with Bigstone's NIHB program for two years or less. Group 3 included individuals and organizations who provide non-insured health benefits to members of the Bigstone Cree Nation. Providers represented all areas except Crisis Intervention Mental Health Counselling. Group 4 included members of the Bigstone Cree Nation (clients) who had used non-insured health benefits within the past year. This group included individuals from all of the communities that receive health services from the Bigstone Cree Nation. Separate interview/survey schedules were developed for each group of respondents. However, a similar set of questions was asked on each tool to enable comparisons to be made among the various groups.

6.2 The Bigstone Cree Nation's NIHB Pilot Project

Bigstone Cree Nation is located in north central Alberta. The Bigstone Traditional Territory consists of several communities but functions under one administrative structure. As of November 2004, the Bigstone Cree Nation had a registered population of 6,324.

In 2001, the Bigstone Health Commission was incorporated as a not-for-profit organization by the Bigstone Cree Nation. The Commission's Vision is to improve the quality of life for members of the Bigstone Cree Nation and others living within the Bigstone Traditional Territory. The Bigstone Health Commission is currently in the process of taking on responsibility for federally funded health services for all members of the Bigstone Cree Nation. The commission is currently involved in a number of projects in addition to the NIHB Pilot Project. It is beginning preparations for Health Services Transfer, is one of FNIHB's Integrated Demonstration Project sites, and is involved with a primary health care initiative with the local health region.

The Bigstone Cree Nation has taken on various non-insured health benefits gradually, and currently has full administrative control of all benefit areas except Crisis Intervention Mental Health Counselling (administrative management of this benefit is done by Health Canada's regional office). Benefits are administered for all members of Bigstone Cree Nation, regardless of where they are located in Canada. For the most part, Health Canada's policies and procedures,

reimbursement and appeal guidelines are followed. However, there appear to be some important differences between the Bigstone Health Commission's NIHB program and Health Canada's NIHB Program. These differences illustrate ways in which a national program can be tailored to meet the needs of individuals at the local level.

The researchers understand that the Bigstone NIHB pilot project has operated within budget every year and that no amendments have been necessary to achieve this goal. The Bigstone Health Commission is able to retain surplus funding at the end of the fiscal year (rather than return the surplus as is normally done under a Contribution Agreement). This is important as it provides an incentive for the Bigstone Health Commission to: try to obtain cost-efficiencies in its NIHB program; apply the surplus(es) gained in one or more years to cost over runs in future years; and apply the surplus(es) to other health programs.

6.3 Findings from the Interviews with Officials, Project Coordinators, Consultants and Staff

A NIHB pilot project cannot be developed, and the administration of non-insured health benefits at the local level cannot occur, without the interest and commitment of a First Nation and support from the regional Health Canada office. Once a NIHB pilot project is developed, staff are needed to ensure that individuals meet eligibility criteria, to process claims for non-insured health benefits, and so on. The interviews conducted in this phase of the study included respondents in both Groups 1 and 2 (that is, officials, project coordinators, consultants and staff). A total of fourteen individuals were interviewed (seven from each group). All interviews were conducted in-person. Interviews with officials, project coordinators, and consultants took approximately 1.5 to 2 hours to complete. Interviews with staff took approximately 1 to 1.5 hours.

With respect to the Bigstone Cree Nation's NIHB pilot project, a very positive relationship has developed between staff of the Bigstone Health Commission and Health Canada's regional office. While the relationship between the Bigstone Cree Nation and Health Canada's regional office has changed over time, it has been critical for the development and expansion of the pilot project. In the beginning, the regional office was very involved with providing training, support and so on. While these activities are still provided to some extent, it appears that staff in the regional office are beginning to serve more as resources, as staff at the Bigstone Health Commission try to take on more of the administration of non-insured health benefits themselves.

Front-end training on the NIHB program was a collaborative effort of the Bigstone Cree Nation and Health Canada's regional office. However, most of the staff did not feel that the training was sufficient. This finding may reflect the fact that the administration of non-insured health benefits is quite complex and technical, that changes continue to be made at the national level, and that products within some of the benefit areas (such as Medical Supplies and Equipment) continue to change. Respondents noted that training needs to be ongoing.

Overall, officials/project coordinators/consultants and staff felt that the administration of non-insured health benefits had stayed the same or improved since the implementation of the

Bigstone Cree Nation's pilot project. This finding suggests that the transfer of responsibility for the administration of the benefits had not had a negative impact. Respondents commented favourably on increased accessibility, more flexibility with providers, the ability to cost-share with the provincial system, and the ability to share information and data with the local health region in order to improve the health of members.

Officials, project coordinators and consultants indicated that funding for the pilot project was insufficient. These respondents also noted that, despite the length of time the pilot project has been in operation, and despite the fact that the Bigstone Cree Nation is able to keep any surplus funds, a funding crisis would have a serious impact on the Bigstone Health Commission's ability to administer non-insured health benefits. Staff gave more mixed responses when asked if they felt that the funding was adequate.

All of the staff respondents indicated that they were satisfied with the claims and bill payment processes that have been developed by Bigstone Cree Nation, although several respondents noted that many billings are done manually, which can be time-consuming. Officials, project coordinators and consultants noted that the Bigstone Cree Nation was developing its own software in several areas to try to improve the claims and bill payment processes. While it was recognized that this was an expensive activity, it was also felt that it would ultimately result in cost-savings.

Communication with stakeholders was considered to be important by both officials/project coordinators/consultants and staff. The Bigstone Cree Nation has used many different approaches to communicate information regarding the non-insured health benefits program (including a local meeting, information on the local FM radio station, a handbook that went to all households, door-to-door contract, a newsletter, and contact with program staff). However, respondents felt that more needed to be done and suggested putting information on the internet, preparing pamphlets and keeping them at the clinic and the hospital, and hosting a workshop to answer questions from the community.

Officials/project coordinators/consultants as well as staff commented on the importance of having local providers, such as dentists and pharmacists. Officials, project coordinators and consultants recognized that being able to hire local providers may be quite difficult, however, primarily due to the number of available individuals.

All of the respondents felt it was important that the Bigstone Cree Nation deliver non-insured health benefits to its members. It was noted that the local administration of non-insured health benefits had many advantages, including familiarity with the local situation, the opportunity to monitor utilization rates and so on. Officials/project coordinators/consultants noted that information on the use of non-insured health benefits is critical for identifying trends that can be used to make informed policy, funding, resource and program decisions, and for realizing the Bigstone Health Commission's vision of improving quality of life for members of the Bigstone Cree Nation and others living within the Bigstone Traditional Territory.

6.4 Findings from the Survey of Non-Insured Health Benefits Providers

Non-insured health benefit providers (that is, respondents in Group 3) were included in the study in order to gain an understanding of how well the Bigstone NIHB pilot project was working from their perspective. A total of 18 providers completed the survey and faxed it back to the researchers. An additional seven providers did not complete the survey but provided verbal comments to the researchers.

Some 89% of providers felt that the administration of non-insured health benefits had stayed the same or improved since the Bigstone Cree Nation had taken it on. This finding suggests that, as with the officials/project coordinator/consultants and staff, providers were not impacted negatively by the change in administration from Health Canada to the Bigstone Cree Nation.

The majority (94%) of providers were satisfied with the claims and bill payment processes. Despite their general satisfaction, respondents made several specific suggestions for improving the processes, including increasing access to staff, using a well-functioning electronic system, and providing specific information when paying bills.

Providers generally felt that the Bigstone Health Commission had provided them with sufficient information regarding non-insured health benefits policies and procedures. All of the individuals who indicated that they had not received sufficient information were representatives of Pharmaceutical Services and all commented on the need to have written guidelines or a manual. This finding may reflect the complexity of this particular non-insured health benefit area and/or the fact that the Bigstone Health Commission had only attained full administrative control of this benefit within the past 12 months.

Providers commented on some of the advantages of having the Bigstone Health Commission administer non-insured health benefits, including having local staff that are familiar with local needs and clients having increased access to health services. Providers also commented on some of the disadvantages of having the Bigstone Health Commission administer non-insured health benefits. These include confusion regarding billing procedures, extra administrative aspects, and concerns regarding the sustainability of the program.

The majority (83%) of respondents felt that the transfer of responsibility for the administration of the non-insured health benefits to Bigstone Health Commission had been successful; the remaining respondents felt that it had not been successful. Some respondents commented on growing pains, including issues pertaining to changes in procedures, access to information, system compatibility and claims processing procedures, but indicated that the issues had been addressed. Other respondents commented on ongoing issues such as staff knowledge, timeliness of payments and software problems.

Two-thirds of respondents (67%) indicated that they supported the continued administration of non-insured health benefits by the Bigstone Health Commission. This finding

is important as, without the support of providers, it will be difficult for Bigstone to continue to administer non-insured health benefits.

Respondents were asked what advice they would have for other First Nations who may be considering taking on similar pilots, based on their (that is, the providers') experience with the Bigstone Health Commission. Respondents commented on the need to be prepared to take on the administration of non-insured health benefits, on the need for staff to be well trained, and on the importance of accessing companies that are experienced in administering insurance plans.

6.5 Findings from the Interviews with Clients

The input of clients (that is, respondents in Group 4) is important for understanding how well the local administration and delivery of non-insured health benefits is working from a users' perspective. Telephone or in-person interviews were conducted with 146 adult members of the Bigstone Cree Nation who had used one or more non-insured health benefits within the past 12 months.[45] As several of the questions on the interview tool applied to the respondent and/or a member of the respondent's immediate family, the findings from these individuals are believed to reflect the experiences of more than 146 members of the Bigstone Cree Nation. The interviews were conducted with members living both on and off reserve (65% of respondents lived on-reserve, 35% lived off-reserve).

One of the eligibility criteria for the study was that clients had used at least one non-insured health benefit in the past 12 months. On average, each person had used three non-insured health benefits in this time period. The most commonly used benefits were Prescription Drugs (used by 95% of respondents), Dental Care (used by 62% of respondents), Vision Care (used by 51% of respondents) and Medical Transportation (also used by 51% of respondents).

Respondents living on-reserve were more likely to use the Medical Transportation benefit than respondents living off-reserve (60% versus 35%, respectively).[46] These findings are consistent with the fact that some of the communities in the Bigstone Traditional Territory have limited access to health services in their communities. Respondents living off-reserve were more likely to use Vision Care and Dental Care benefits than respondents living on-reserve (71% of off-reserve respondents compared to 41% of on-reserve respondents for Vision Care and 73% of off-reserve respondents compared to 57% of on-reserve respondents for Vision Care). Overall, respondents aged 55 to 64 used fewer Dental Care benefits than individuals 25 to 44 years old or 65 years of age and older (29% for 55 to 64 year olds, 66% for 25 to 34 year olds, 73% for 35 to 44 year olds and 90% for individuals 65 and older). Medical Supplies and Equipment were used more by separated and widowed respondents than by respondents who were married or living common-law, or by single respondents (44% for individuals who were separated or widowed, 20% for individuals who were married or living common-law, and 6% for single respondents). Individuals 55 years of age or older used Medical Supplies and Equipment more than younger individuals (54% versus 9%, respectively).

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[45] The researchers were authorized to obtain approximately 150 completed interviews. The interviews required approximately 15 minutes to complete.

[46] All comparative differences reported in this section were statistically significant at the .05 level or better using χ^2.

Despite the fact that all Bigstone Cree Nation members (living both on and off reserve) have been provided with a copy of a booklet containing general information about Bigstone's NIHB Program and that several other communication methods have been used to inform members about the program, 62% of client respondents indicated that they did not feel that the Bigstone Health Commission had provided them with sufficient information regarding the benefits and services available under the NIHB program.[47] It is noted, however, that these individuals had enough knowledge to be able to access the non-insured health benefits at least once during the year. While it may be reasonable to expect that individuals living off-reserve may feel less informed about Bigstone's NIHB program than those living on-reserve, this was not observed. Of the individuals who felt that they *had not* received sufficient information, 61% lived on-reserve. It is also not the case that individuals living on-reserve generally do not feel informed regarding non-insured health benefits; 71% of the individuals who felt that they *had* received sufficient information regarding non-insured health benefits lived on-reserve. Of the individuals who felt they had received sufficient information regarding non-insured health benefits, 82% felt that they were provided with sufficient information about the procedures to access these benefits. It is not clear why some of the respondents felt they had received sufficient information regarding non-insured health benefits (and/or how to access them) while others did not. It is also not clear what additional information respondents may like to have regarding the benefits or how to access them.

Despite the fact that the majority of respondents did not feel that they had sufficient information regarding either the benefits and services available under the NIHB program or how to access the benefits, the majority (90%) of respondents indicated they were satisfied with the administration of the benefits.

Overall, there were relatively few instances in which respondents noted that they, or a member of their immediate family, had been denied a benefit. In the 12 months prior to the study, respondents reported a total of 54 denials (compared to 2687 benefit claims). Individuals living off-reserve were denied pharmaceutical services more frequently than individuals living on-reserve (18% versus 6%, respectively). Rates of denials for all other types of benefits were similar for individuals living on and off-reserve. As well, women were denied prescription services more frequently than men (14% versus 2%, respectively). The frequency of denials of the different types of benefits did not differ by age or by marital status.

The majority of respondents (82%) indicated that they were not aware of the appeals process. It is important that clients be aware that they can appeal a decision regarding the provision of non-insured health benefits if they so wish. However, many individuals may not pay attention to what the process involves until they wish to use it. It is interesting to note that information regarding Bigstone's appeal process is contained in the NIHB information booklet. Thus, the comments noted above regarding what individuals know and what they wish to know also apply here.

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[47] Representatives of the Bigstone Health Commission indicated that all members of the Bigstone Cree Nation (both those living on-reserve as well as those living off-reserve) had been provided with a copy of the following publication: Bigstone Health Commission and Health Canada First Nations and Inuit Health Branch. (nd). *Non-Insured Health Benefits Program. General Program Information.,* Wabasca, AB: Bigstone Health Commission. It is also noted that similar information is contained on Health Canada's website.

Some 83% of respondents indicated that the administration of non-insured health benefits had stayed the same or improved since the implementation of the NIHB Pilot Project. This finding is similar to what was observed with the officials/project coordinators/consultants, staff and providers. It should, however, also be noted that 17% of clients felt that the administration of benefits and services had become worse since the implementation of the Bigstone pilot project. While it may be reasonable to expect that off-reserve respondents might feel that the administration of non-insured health benefits had become worse while on-reserve respondents might feel that it had improved or stayed the same, this was not observed.

Overall, 68% of respondents felt that the transfer of responsibility for the non-insured health benefits to the Bigstone Health Commission had been successful while 15% of respondents felt that the transfer of responsibility had not been successful (the remaining respondents indicated that they were not sure if the transfer had been successful). Both on-reserve and off-reserve respondents felt similarly about the transfer of responsibility (34% of on-reserve and 34% of off-reserve respondents felt that the transfer had been somewhat or very successful).

Some 64% of respondents indicated that they supported the continued administration of non-insured health benefits by the Bigstone Health Commission in the future, while 10% of respondents indicated that they did not support it (the remaining respondents indicated they were not sure whether they supported the continued administration of non-insured health benefits). Individuals living on and off reserve felt similarly about this aspect of the program. Single people (82%) were more supportive of continued administration of non-insured health benefits by Bigstone Health Commission than were individuals who were married or living common-law (60%) or individuals who were separated, divorced or widowed (33%). Approximately a third of individuals who were married/common-law or separated/divorced/widowed indicated that they were not sure if they supported continued administration by the Bigstone Health Commission.

Individuals who were critical of the transfer of responsibility for non-insured health benefits to Bigstone Health Commission questioned the qualifications of the staff. They also noted that the rules for obtaining benefits had become stricter. Respondents who had a more positive view of the transfer: supported the local administration of the program; felt that the staff could do the job; felt it was easier to obtain answers to questions locally; and noted that the local staff could communicate in Cree. Both groups of respondents expressed concerns regarding the financial sustainability of the program.

7. DISCUSSION

7.1 Introduction

The purpose of the current evaluation was to provide input regarding the future transferability of the NIHB Program to First Nations and Inuit control.[48] The findings from each phase of the evaluation were similar, despite the different methodologies that were used.

7.1.1 Key Research Questions

This chapter includes a discussion of lessons learned from the previous pilots as well as a discussion of management issues regarding the delivery of the NIHB Program. The key research questions for the current evaluation were:

- Does the NIHB Pilot Project make sense?
- What impacts have the NIHB pilot projects had?
- How successful have the NIHB pilot projects been?
- How cost-effective were the NIHB pilots?[49]

In addition to these questions, several major issues were identified during the process of conducting the evaluation. Many of these issues were related to more than the NIHB Pilot Project process and/or the NIHB pilot projects. For example, some of the issues relate to the transfer of non-insured health benefits to First Nations and Inuit organizations in general, some relate to the management and administration of the NIHB Program at the FNIHB national and regional levels, and some relate to the provision of health services to First Nations and Inuit individuals at a broad federal level. Findings related to the research questions and related issues are discussed in this chapter. The implications of the findings are discussed in the next chapter.

Given that the NIHB Program is intended to provide eligible First Nations and Inuit individuals with non-insured health benefits, an overview of the perceptions of First Nations and Inuit regarding the transfer of the administration of non-insured health benefits, which integrates all of the findings from Phases 1 to 3, is provided in the next section.

7.1.2 Summary of Key Issues Identified by First Nations and Inuit Regarding the Administration of Non-Insured Health Benefits

The NIHB Program is intended to be used by eligible First Nations and Inuk. The NIHB pilot projects were designed to: test various management and delivery options for transferring the NIHB Program from Health Canada's control to First Nations and Inuit control; facilitate First

[48] Health Canada. (2003) *Request for proposal (RFP). Evaluation of the Non-Insured Health Benefits (NIHB) Pilot Projects*, p. 3. Ottawa: Health Canada.
[49] Health Canada. (2003). *Request for proposal (RFP). Evaluation of the Non-Insured Health Benefits (NIHB) Pilot Projects, Appendix A.* Ottawa: Health Canada.

Nations and Inuit involvement and control of the program; and improve the efficiency and effectiveness of the NIHB Program in general. Because of this emphasis on First Nations and Inuit, this evaluation (as well as the previous two evaluations) focused largely on First Nations and Inuit respondents.

First Nations and Inuit respondents identified a number of key issues regarding the administration of non-insured health benefits. It is noted that regional and national FNIHB staff and providers of non-insured health benefits (for the Bigstone Cree Nation's pilot project) often made similar comments. The key issues are:

- First Nations and Inuit respondents felt that there were many advantages to having First Nations and Inuit organizations administer non-insured health benefits at the local level including: better understanding of local issues; a greater ability to focus on client's health needs; more timely provision of services; improved ability to integrate non-insured health benefits with other services; improved cost effectiveness for many non-insured health benefits; the ability to support local decision-making on health matters as a result of the knowledge acquired; improved accountability to members and leaders; and opportunities for employment and economic benefits.

- First Nations and Inuit want a flexible non-insured health benefits system that allows them to develop policies and procedures that are appropriate to their needs.

- First Nations and Inuit felt that the funding available for the NIHB pilot projects was insufficient to meet their needs. Initial funding levels did not include price and volume increases, provincial health reforms and similar aspects. It is thought that the federal government should cover costs for all health services according to need, not according to a capped funding formula.

- First Nations and Inuit felt they had successfully implemented a substantial number of cost-effective policies and approaches to the delivery of non-insured health benefits.

- In addition to adequate funding, to be successful in administering non-insured health benefits, First Nations and Inuit feel they must have access to: substantial support from FNIHB; background information from FNIHB, including historical information on utilization and costs that can be used to make appropriate decisions on policies and funding levels; appropriately trained staff; and appropriate computer resources, including software for administering claims.

- First Nations and Inuit feel that a longer time frame is required (at least three to five years) to successfully implement the administration of non-insured health benefits at the local level.

- First Nations and Inuit feel that the integration of locally delivered non-insured health benefits with other community health services can contribute to an integrated approach which may result in improved health services and improved health outcomes for community members.

- First Nations and Inuit feel that local control of non-insured health benefits (and other programs) is empowering and may contribute to positive health outcomes.

These findings are reflected, as appropriate, in the following discussion and in the recommendations presented in the next chapter.

7.2 Appropriateness of the NIHB Pilot Project Process

7.2.1 Introduction

The NIHB Pilot Projects were designed to test various management and delivery options for transferring the NIHB Program from Health Canada's control to First Nations and Inuit control. In addition, the pilot projects were intended to improve the efficiency and effectiveness of the NIHB Program and to facilitate First Nations and Inuit involvement and control of the program.

The concept of conducting NIHB pilot projects to determine what factors may impact the transfer of non-insured health benefits appears to have been reasonable and is consistent with other programs developed by FNIHB (e.g., the Home and Community Care Program). However, valuable lessons can be learned from how the pilot project process was carried out.

7.2.2 Representativeness of the Pilot Project Sites

As noted earlier, for the ten year period between April 1993 and March 2003, the Ontario Pacific, Manitoba and Saskatchewan regions had the largest eligible NIHB populations and the Ontario, Manitoba and Alberta regions had the largest expenditures for the NIHB Program. It would seem, therefore, that there were two major options for selecting pilot project sites. One option was to take a broad, national perspective and include pilot sites from all regions in order to determine how community location, size and so on could affect the ability of First Nations and Inuit to meet the non-insured health benefit needs of their members and to be fiscally sustainable. The second option was to focus primarily on those regions where the population and/or expenditures were the highest, in order to determine how utilization rates could be affected by different management and/or delivery options. The second option would have provided more information regarding factors influencing cost-effectiveness and financial sustainability. Within each of these options, there were three additional options: to include large First Nations/Inuit organizations only; to include small First Nations/Inuit organizations only; or to include a mixture of First Nations and Inuit organizations. A mixture of small, medium and large communities would likely have provided a good indication of the extent to which community size may affect the transferability of the non-insured health benefits.

Table 4 presents a summary of what actually occurred.[50] As can be seen, the majority of the pilot projects were in the Manitoba region and the majority of the projects were conducted with large organizations. There may be a reasonable explanation for this distribution of the pilot

[50] Neither the pilot project that went into self-government nor the pilot project that merged with another one are included in the table. SERDC is included in the table, even though it never had a fully developed NIHB pilot project.

projects. However, as a result of the existing distribution, the extent to which the pilot project sites were representative of, and therefore generalizeable to, all First Nations/Inuit organizations in Canada is not clear.

Table 4: Distribution of Pilot Project Sites

Region	Population of First Nation/Inuit Organization Involved in the Pilot Project				Total
	Small (2000 or less)	Medium (2001 to 5000)	Large (5000 to 10,000)	Very Large (more than 10,000)	
NWT & Nunavut	0	0	0	0	0
Yukon	0	0	0	0	0
Pacific	0	1	1	1	3
Alberta	1	0	2	0	3
Saskatchewan	0	0	0	0	0
Manitoba	1	2	2	1	6
Ontario	0	0	0	1	1
Quebec	1	0	0	0	1
Atlantic	0	0	1	0	1
Total	**3**	**3**	**6**	**3**	**15**

A mixture of management options were involved in the pilot projects. The projects included individual First Nations, Tribal Councils, Regional Councils, and Health Commissions. All of the pilot sites had a substantial number of members living off reserve or out of community, but there was no reason to believe that the pilot sites differed substantially from non-pilot sites with respect to this issue. Most of the pilot sites tried to provide services to members both inside, and outside, of First Nations/Inuit communities.

7.2.3 Choice of Non-Insured Health Benefit(s) Included in the Pilot Projects

As noted earlier, between April 1993 and March 2003, the largest expenditures occurred for Pharmaceutical Services, Medical Transportation and Dental Services. It would, therefore, have made sense for the pilot projects to include one or more of these benefits. The pilot project authority approved by Cabinet in 1994 did not initially include the pharmacy and dental components of the NIHB Program. Cabinet approved the phasing in of pharmacy and dental benefits for pilot project management in 1997.

In the first two groups of pilot projects, pilot sites were able to specify which non-insured health benefits they wished to administer. The earlier pilot projects did not have to administer all of the non-insured health benefits (although this is not the case for current pilot projects). All but three of the pilot sites included Medical Transportation and for three sites, this was the only non-insured health benefit that was piloted even though two of the pilot projects started in 1997 or later. Three pilot sites included Pharmaceutical Services; all three included Medical Transportation as well and two of the three also included Dental Services.[51] Another pilot site included Dental Services (for a total of three sites with Dental Services) but did not include

[51] One of these was a medium sized pilot site, the other two were large pilot sites. SERDC was included in these counts, even though it never really operated as a pilot project.

Pharmaceutical Services.[52] Only one pilot site (Bigstone Cree Nation) has included all of the non-insured health benefits. Thus, the extent to which the findings from the previous pilot projects can be generalized across all non-insured health benefit areas is also not clear.

7.2.4 Preparedness to Conduct Pilot Project(s)

7.2.4.1 Introduction

In general, neither Health Canada (at either the regional or national levels) nor the First Nations and Inuit pilot sites appeared to be fully prepared to take on a pilot project. Although it is recognized that it is not always possible to identify what is required prior to starting a project (which is one of the reasons for conducting a pilot project), it seems that the pilot project process itself may have been incomplete.

7.2.4.2 Business Plans

In order to obtain funding for a NIHB pilot project, interested First Nations and Inuit first had to develop a preliminary proposal. If the proposed approach was considered appropriate, the First Nations/Inuit organization was provided with funding to develop a business plan. The business plans were intended to identify how the pilot projects were to be implemented. However, in some cases, the business plans for the pilot projects were inadequate, incomplete, or lacked the support of the local administration and/or members. In addition, it did not always appear that adherence to the business plans was monitored. Incomplete business plans may have been particularly difficult to monitor. Without appropriate and regular monitoring of the business plan, by the pilot project site and the regional FNIHB office, it was difficult to identify and address any issues early in the implementation process.

7.2.4.3 Administrative Support for the Pilot Projects

The pilot projects showed that a NIHB pilot project cannot be adequately developed, and that the adequate administration of non-insured health benefits at the local level cannot occur, without the interest and commitment of a First Nation/Inuit organization and support from the regional Health Canada office.

In some pilot sites, there appeared to be good support from the administration, health care staff and clients for the pilot project. In other pilot sites, this did not appear to be the case. When the pilot projects lacked support from the administrative level, major administrative, resource and funding issues were encountered.

In some regions, support from the regional FNIHB office appeared to be insufficient. In some cases, this may have occurred because staffing for the NIHB pilot projects in the regional FNIHB offices may have been stretched because of other responsibilities. In other regions (such as the Alberta region), knowledgeable NIHB staff in the FNIHB offices were actively involved in the pilot projects. Support from the regional office was wanted and needed by the First Nations/Inuit organizations. It is noted that having regional FNIHB staff who are specifically

[52] This was a very large pilot site.

assigned to assist the pilot project(s) is unlikely to be sufficient; staff also need to be knowledgeable about the NIHB Program and the needs of local First Nations/Inuit communities.

In general, pilot sites indicated that they did not have sufficient support from the national FNIHB office. This was also indicated by some regional FNIHB personnel. Staff changes, a lack of understanding regarding local situations, and the fact that staff in health program areas are not always knowledgeable about health issues may collectively have limited the support that personnel in the national FNIHB office were able to provide to the NIHB pilot projects.

7.2.4.4 Staff Training

NIHB staff in all of the previous pilot project sites noted that training was inadequate and/or insufficient. This view was supported by representatives of national First Nations and Inuit organizations as well. In addition, despite the fact that the Bigstone Cree Nation NIHB pilot project has been in operation for much longer than any of the other pilot projects, there is a recognition that all new staff need to receive training and that training for all staff needs to occur on an ongoing basis. The need for initial and ongoing training was also commented on by respondents from the Nisga'a Nation and the Mohawk Council of Akwesasne, even though neither of these First Nations participated in a NIHB pilot project. Respondents noted that training was required on: various aspects of the NIHB program; computer programs; management and administrative issues; working with people; and health related areas (e.g., First Aid and CPR).

7.2.4.5 Financial Resources

The financial resources provided for the pilot projects were often considered inadequate. The resources were allocated based on previous budgets, but did not allow for population growth, increased utilization, or increased benefit costs. In addition, it appears that no additional funding was provided to conduct the NIHB pilot projects over and above what was available to provide the non-insured health benefits *per se*. For example, resources (such as computer software, office equipment and other capital resources) were often not available in the pilot project sites, and no provision was included in the funding for the pilot projects to obtain them. Thus, funding for staff training was seen to be insufficient.

It is noted that both Akwesasne and the Nisga'a (neither of which were involved in a NIHB pilot project) also felt that funding for the administration of non-insured health benefits was insufficient. In addition, the First Nations in Saskatchewan indicated that one of the reasons they (collectively) chose not to participate in the NIHB pilot project process related to concerns that funding would be insufficient to administer the projects. It is also noted that at least one of the First Nations which was not successful in obtaining funding for a NIHB pilot project was turned down because their projected program and administrative costs were considered to be too high by Health Canada, although the First Nation felt that its proposal was based on knowledge of the population and sound financial costings.

The researchers understand that Health Canada was under considerable pressure to manage the NIHB program within budget through most of the pilot project process. The program was limited to providing historical funding plus equitable growth and administration funding of 8% to the pilot projects. Both headquarters and the regions had to find the funding within existing resources. As a result, they were unable to provide more flexible funding to pilot projects.[53] If pilot projects are conducted in the future, it will be important to ensure that sufficient funds are made available for the pilot process at all levels, over and above the funds provided for service delivery.

7.2.4.6 Policies and Procedures

Policies and procedures regarding the administration of non-insured health benefits sometimes appeared to be lacking or incomplete during the pilot projects. For example, policies regarding maintaining client confidentiality needed to be developed by the pilot sites. Appeal and exceptions processes, while recognized under the federal NIHB Program, needed to be developed more specifically at the local level. It would seem that some core policies and procedures regarding the administration and delivery of non-insured health benefits and services should have been developed at the national level and adapted at the local level. Because such policies and procedures were not developed, there was (and still is) the potential for different individuals in different locations across the country to obtain different non-insured health benefits.

Several First Nations/Inuit organizations (including ones that were involved in the previous pilot projects and ones in Saskatchewan who were not involved in any pilot project) noted that the national NIHB Program currently has policies for several aspects of the program, but that these are not always appropriate for the local level. What is needed are *general*, core policies and procedures that can be *adapted* to meet the local conditions. Having basic national policies would eliminate the need for each First Nations/Inuit organization to develop their own (and thus duplication of effort would be reduced). Having policies that could be adapted to the local level would enable First Nations/Inuit organizations to meet the "unique health needs" of the individuals in their communities.

7.2.5 Length of Time for the Pilot Projects

The pilot projects were intended to operate for a two year period, with an option to operate for one additional year. Most of the previous pilot projects appear to have operated for two and a half to three years.[54] One pilot project operated for approximately one year, while another has operated for almost eight years.

[53] It is noted that while several respondents commented on the need for additional funding in general and some noted that the funding for management/administrative activities was especially insufficient, no one mentioned that the funds had to be found within existing resources, nor that pilot projects were aware of the 8% administration funding level prior to beginning the pilot project. The relevant information was provided by members of the Project Working Group and FNIHB personnel.

[54] Although the Phase 2 report contains some information regarding the length of time the various pilot sites were anticipated to operate, specific information regarding the length of time each pilot project actually operated is not well documented.

Several respondents in the various phases of the evaluation commented that the length of time for the NIHB pilot projects was too short. It is interesting to note that the Bigstone Cree Nation has taken on full administrative control of all but one of the non-insured health benefits after eight years. Akwesasne and Nisga'a both administer all non-insured health benefits, but again, both have been doing so for over eight years. Finally, it is noted that the Transfer of Health Services involves a two year planning process and a five year operational phase before the first evaluation is conducted.

7.3 Impact of the NIHB Pilot Projects

7.3.1 Increased Access to Non-Insured Health Benefits

One of the objectives of the NIHB Program is to provide health services to First Nations and Inuit in a manner that is "appropriate to their unique health needs." Thus, one can look at the impact that the administration of non-insured health benefits at the local level has had on people's ability to access non-insured health benefits, as well as what impact it has had on people's use of other community health services. The first issue is examined in this section; the second issue is examined in Section 6.3.4.

Approximately 80% of the NIHB pilot sites indicated that their delivery system had been very effective. Respondents commented on the fact that some services can be provided faster and more reliably at the local level, and that people are familiar with NIHB staff in their own communities. Akwesasne and the Nisga'a agreed with these perspectives.

As noted earlier, most, but not all of the NIHB pilot project sites administered non-insured health benefits for individuals living both on and off reserve. Respondents from the NIHB pilot sites which administered non-insured health benefits to individuals residing both on and off reserve (including the Bigstone Cree Nation) identified several issues regarding the delivery of non-insured health benefits for individuals living off-reserve. These included: maintaining up-to-date information on eligible individuals; communicating with eligible individuals regarding changes in the delivery and/or administration of benefits; differences between individuals living on and off reserve (or inside and outside of communities); and obtaining approvals, necessary forms, answers to queries, and so on outside of regular office hours for the relevant administrative office (which could be located in a different time zone). Respondents from First Nations who wanted to have a pilot project but were not successful in obtaining funding also noted that allowable rates for different benefits may vary among provinces and that it may be difficult (but not impossible) for First Nations and Inuit to properly serve their members with respect to non-insured health benefits, regardless of where they live in Canada. The provision of non-insured health benefits to all eligible individuals regardless of place of residency was a major issue for the pilot projects and is an area that will need to receive further consideration if and when the NIHB Program is transferred more broadly.

It is noted that Akwesasne and the Nisga'a both provide non-insured health benefits to individuals both on and off reserve. Neither First Nation indicated that they had experienced difficulties in providing services to individuals living off-reserve.

7.3.2 Improved Administration of Non-Insured Health Benefits

First Nations and Inuit who had a NIHB pilot project provided several reasons for wanting to participate in a pilot project, including a belief that non-insured health benefits could be administered better by First Nations and Inuit than by Health Canada, and a belief that the needs of individuals could be addressed better by having local control. The First Nations who had been unsuccessful in obtaining funding for a NIHB pilot project, Akwesasne and the Nisga'a all indicated that they had been interested in administering non-insured health benefits for these reasons, and the First Nations in Saskatchewan indicated that these were just two of the advantages of having First Nations and Inuit administer non-insured health benefits.

Respondents in the NIHB pilot sites were asked, whether, in comparison to the previous administration of non-insured health benefits by Health Canada, they felt that the administration of non-insured health benefits had improved during the operational life of their pilot project. All respondents from the previous pilot sites indicated that they felt it had improved. The majority of respondents (officials, project coordinators, consultants, staff, providers, and clients) from the Bigstone Cree Nation's NIHB pilot project felt that administration had stayed the same or improved. Both Akwesasne and the Nisga'a felt that administration of non-insured health benefits had improved under their control.

7.3.3 Increased Health Status

One of the objectives of the NIHB Program is to "contribute to the achievement of an overall health status for First Nations and Inuit that is comparable to that of the Canadian population as a whole." Respondents in this evaluation were, therefore, asked whether the administration of non-insured health benefits by First Nations and Inuit had contributed to improved health status. Respondents noted that improvements in one area (such as non-insured health benefits) can have an impact in other areas (for example, collaboration with other health providers and health agencies) and that non-health related areas (such as local responsibility and community empowerment) can influence health status. However, respondents also noted that it is difficult to assess health status and that health status needs to be assessed over a period of time. These views were supported by both the Akwesasne and the Nisga'a.

It is likely that the short time allowed for the NIHB pilot projects was insufficient to realize any changes in overall health status, at either the individual or community levels. In addition, it is not clear that a change in the administrative arrangements for providing non-insured health benefits alone would be sufficient to impact health status. The Nisga'a, who have been administering non-insured health benefits longer than any of the pilot sites (and longer than Akwesasne) noted that it has been difficult to demonstrate that administration of non-insured health benefits has had a positive impact on health status. It would appear from the Bigstone Cree Nation, the Mohawk Council of Akwesasne and the Nisga'a Nation (all of which are trying to integrate non-insured health benefits with other health programs) that data regarding the utilization of non-insured health benefits and prevention and intervention services need to be collected over several years.

7.3.4 Increased Use of Other Community Health Services

As noted earlier, one of the issues of interest in this evaluation was whether the administration of non-insured health benefits at the local level would have an impact on the use of other community health services. Some respondents from the NIHB pilot projects indicated that personnel who were involved with the NIHB program had been able to identify issues (e.g., an increase in the number of individuals with diabetes) that had then resulted in more specialized programs and clinics being developed. Other respondents suggested that the administration of non-insured health benefits is only a small part of what would be required to improve community health services. These findings suggest that the administration of non-insured health benefits at the local level may result in linkages being made between programs, and that First Nations and Inuit communities need to consider being involved with several health-related programs, not just the administration of non-insured health benefits. The approaches taken by the Bigstone Cree Nation, Akwesasne and the Nisga'a are consistent with these interpretations. It may be beneficial for communities which are interested in, or have taken on, transfer of health services to also consider taking on non-insured health benefits, and to consider integrating the two areas to improve overall efficiency and effectiveness.

7.4 Success of the NIHB Pilot Projects

7.4.1 Defining Success

Whether the NIHB pilot projects have been successful or not depends on how one chooses to define "success".

One way to define success is to determine the degree to which the objectives of the NIHB pilot projects have been met. As noted earlier, the objectives of the pilot projects were to:

- test the viability of possible management options;
- test various types of organizational models and structures;
- test the influences of regional diversity on similar pilots;
- provide information from which the efficiency and effectiveness of the pilots could be improved; and
- provide a basis for recommendations for the future management of the NIHB program.

The extent to which the objectives of the NIHB pilot projects have been met is discussed in several sections in this and the following chapter. For example, in Section 6.2 (above), it is suggested that while various types of organizational models and structures were included in the pilot projects, the extent to which regional diversity could be assessed is limited. Nevertheless, as noted in Section 6.4.2 (below), it would appear that valuable lessons can be learned from the previous pilot projects. The next chapter provides a discussion of the ways in which the lessons

from the previous NIHB pilot projects could be used to improve the efficiency and effectiveness of other pilot projects in the future and as a basis for making recommendations regarding the future management of the NIHB Program.

A second way to define success is to determine what intended and unintended impacts the NIHB pilot projects have had. As noted in Section 6.3 above, some of these impacts include improved administration and delivery of non-insured health benefits, increased access to non-insured health benefits, a potential for better integration of non-insured health benefits with other health-related services, and the potential to improve health status overall, at both the individual and community levels.

A third way to define success is determine how well the NIHB pilot projects are currently functioning. Since only 17 out of a possible 30 pilot projects were approved for funding, and since only one of the pilot projects that was funded is still functioning as a pilot site, one might conclude that the NIHB Pilot Projects were not as successful as had been hoped. The fact that the majority of the NIHB pilot projects are no longer operating does not, however, necessarily mean that they were not successful. In fact, several of the pilot projects were successful in terms of demonstrating that First Nations/Inuit can administer at least some of the non-insured health benefits (such as Medical Transportation) quite successfully at the local level; other non-insured health benefits (such as Dental Services or Pharmaceutical Services) may be more difficult for some First Nations/Inuit to administer. Many of the pilot projects found that more people accessed non-insured health benefits when they were administered at the local level. Some of the pilot projects were able to improve cost-effectiveness substantially. Some of the pilot projects were discontinued, not because the First Nations/Inuit organization was unable to administer non-insured health benefits, or were not interested in doing so, but because the organization was concerned about having sufficient funds to administer the non-insured health benefits appropriately.

A considerable number of valuable lessons were learned from the pilot projects which can provide useful information for future pilot projects, for the transfer of non-insured health benefits to First Nations and Inuit control, and/or for the NIHB Program more generally. These lessons are discussed below.

7.4.2 Lessons Learned

7.4.2.1 Opportunities and Challenges of Administering Non-Insured Health Benefits at the Local Level

In general, First Nations and Inuit organizations felt that it was very important that non-insured health benefits be administered and delivered at the local level. Respondents indicated several opportunities to improve service delivery by having First Nations and Inuit administer non-insured health benefits including:

- a better understanding of local issues (e.g., geographical limitations, clients' needs);

- a greater ability to focus on clients' health (as opposed to managing an envelope of money);
- being able to provide some services (e.g., transportation services) more reliably;
- being able to provide services faster (e.g., through faster turnaround times for prior approvals);
- being able to simplify bureaucratic procedures so that individuals are able to better understand what is required;
- having First Nations and Inuit assume responsibility for the health of their people;
- being able to integrate services across several areas (e.g., health, social services, education);
- being able to build capacity at the local level; and
- the opportunity for economic benefits (e.g., local employment).

Respondents also noted that there were challenges to having First Nations and Inuit administer non-insured health benefits. These challenges included:

- having funding that is insufficient to meet demand, both for services and for administrative aspects (e.g., staff training, computers and appropriate computer programs);
- having difficulty obtaining information (e.g., historical data, policy manuals) that is necessary for understanding key issues regarding the administration and delivery of non-insured health benefits;
- having sufficient expertise and capacity at the local level to administer and deliver non-insured health benefits;
- needing to apply policies that may not be appropriate for the local situation;
- having to deny friends and family members non-insured health benefits, particularly when the policies do not seem appropriate; and
- issues related to the potential loss of federal fiduciary responsibility and potential abrogation of existing treaty rights.

7.4.2.2 Success Factors for First Nations and Inuit to Administer Non-Insured Health Benefits

The experiences of some of the NIHB pilot sites, the Bigstone Cree Nation, Akewesasne and the Nisga'a all indicate that First Nations and Inuit are able to administer non-insured health benefits very successfully at the local level. It appears that several factors may be required for success, including:

- support from the management and administrative level of the First Nation/Inuit community;
- support from the membership of the community;
- support from the regional FNIHB office regarding all aspects of the NIHB program;
- support from local providers of non-insured health benefits;
- a willingness to try to improve the efficiency and effectiveness of non-insured health benefits, as well as other health services;
- a willingness to work collaboratively with other areas (e.g., health, social services, education); and
- availability of (or willingness to obtain) necessary resources (e.g., trained staff, computer programs, space).

It may be reasonable to believe that the size of the population being served, as well as its location, may have some impact on the success of the non-insured health benefits program, or at least on which non-insured health benefits can be administered easily, due to availability of providers, economies of scale and similar issues. For the previous pilot sites, size and location did not appear to be particularly problematic as evidenced by the similarity in the issues raised by these sites regarding the administration of non-insured health benefits. It is noted, however, that some respondents commented that it might be easier to administer some benefits rather than others if the population is relatively small. These findings may be a reflection of the (lack of) representativeness of the pilot project sites, rather than a reflection of what may be required if the full range of communities were considered. The experiences of the Bigstone Cree Nation and the Nisga'a illustrate that the population does not have to be extremely large nor does the First Nation need to be located close to a major metropolitan centre to successfully administer non-insured health benefits.

In addition, a First Nation/Inuit community does not need to have transferred general health services in order to administer all of the non-insured health benefits well. It is noted that while both Akwesasne and the Nisga'a manage other health services as well as non-insured health benefits, the Bigstone Cree Nation has not transferred other health services yet (although they are interested in doing so). As noted by some of the pilot project sites, the Bigstone Cree Nation, Akwesasne and the Nisga'a, communities that transfer both general health services and

non-insured health benefits may be able to obtain better integration/coordination of all health-related programs at the local level.

7.4.2.3 Communication Issues

Various NIHB pilot sites, the Bigstone Cree Nation, Akwesasne and the Nisga'a all indicated that they had used a variety of methods to provide members (both inside and outside of the community) with information regarding non-insured health benefits. This was in addition to information provided on Health Canada's website. These methods included: flyers, pamphlets, and brochures; newsletters; presentations at conferences, community forums, public conventions/exhibitions and Annual General Meetings; a community-relevant website; presentations on local radio; identification of an "in-town expert" who provides one-on-one information; and a toll-free telephone information line that was accessible to individuals across Canada. It is noted that communication has been an important component of Akwesasne's NIHB program. Despite the variety and number of communication methods that were used, individuals in many of the pilot sites expressed a desire to have more information regarding the NIHB program, particularly regarding what is covered and what is not.

The majority (90%) of NIHB staff from the pilot sites indicated that they were not provided with sufficient information or data prior to the implementation of the pilot project. Respondents from Akwesasne and the Nisga'a agreed. NIHB staff at the pilot sites (including the Bigstone Cree Nation) and from Akwesasne and the Nisga'a noted that: it took a long time to obtain some critical information (e.g., policy manuals, historical information); information regarding some aspects of the administration of non-insured health benefits was sometimes provided on very short notice (e.g. reporting and record-keeping requirements); and some information (such as policies and procedures) was still being developed at the time the pilot projects started. The researchers understand that pilot projects were provided with a core information package to assist them with their decision making. What was, or is, in the core package is not clear. What is clear, on the basis of the evaluation, is that First Nations and Inuit communities did not feel that they had all the information they needed. In addition, the Bigstone Cree Nation, Akwesasne and the Nisga'a commented that this is still the case and that it is difficult to obtain the necessary information from FNIHB. It would seem appropriate for both FNIHB and First Nations and Inuit communities to review the content of the core information package to ensure that it is still relevant, comprehensive, and so on. It is also important that First Nations and Inuit identify what additional information may be required on an ongoing basis and for FNIHB to provide the requested information (as appropriate) in a timely manner. If FNIHB is unable to provide the requested information, the First Nations and Inuit communities should be informed that this is the case.

Staff in some of the pilot sites indicated that they were satisfied with the support they received from personnel in FNIHB's regional offices. Staff in other pilot sites were dissatisfied with the support they received from personnel in FNIHB's regional offices. Staff in the majority of the pilot sites indicated that they were dissatisfied with the support provided by personnel at the national FNIHB office. Lack of communication was often cited as one of the major reasons for dissatisfaction with personnel in both the regional and national FNIHB offices.

Non-insured health benefits providers for some of the pilot sites expressed a need for more communication, particularly regarding what is covered and what is not under the various benefit areas. Providers (and NIHB staff at the local level) also expressed a desire to be kept informed of changes to the program. It appears that providing information regarding changes to the NIHB Program on Health Canada's website only is insufficient.

FNIHB personnel, at both the regional and national levels, also commented on communication issues. For example, FNIHB personnel noted that at the beginning the pilot project process, communications were inadequate, slow, and involved a lot of people. It was implied that communications may have improved over time.[55]

7.5 Cost-Effectiveness of the NIHB Pilot Projects

7.5.1 Introduction

The term "cost-effectiveness" is often equated with an analysis only of costs, and a method for determining expenditure reductions. However, this is *not* what cost-effectiveness analysis is, or should be, all about. Cost-effectiveness analysis is a means by which funders and service providers can analyze how services are being delivered and if, and how, they can be delivered more effectively. It is *not* only about costs. There is an equal weighting on costs *and* consequences, or outcomes. Thus, outcome indicators such as the satisfaction with care services, as perceived by clients and their informal caregivers, and the quality of life of clients, are as important as the costs of providing such services. The comparative analysis of costs and outcomes may also reveal new information which can be used to change policies, procedures, and clinical practices, in order to provide more efficient and effective services.

7.5.2 Cost-Saving Measures

Many of the pilot projects were able to develop cost-effective ways to manage the administration and delivery of non-insured health benefits. As noted earlier, many of the pilot projects included Medical Transportation. As a result, several of the cost-saving measures relate specifically to this non-insured health benefit and include:

- providing a mix of delivery options for medical transportation;
- negotiating special rates with transportation providers;
- scheduling regular charter flights;
- coordinating travel arrangements for clients with similar needs;
- having providers provide services in the local community rather than having people travel outside the community to obtain the services; and

[55] But one FNIHB representative noted that obtaining reports on time is still an issue.

- hiring or contracting with professionals to provide some services (such as pharmacy and dental services) to the community on an ongoing basis.

Other cost-saving measures included:

- shopping around for the best price and negotiating with providers for lower prices;
- providing goods (such as medical equipment and supplies) within the community;
- recycling equipment, where possible, rather than obtaining new equipment; and
- controlling expenditures by modifying policies, enforcing existing policies and monitoring costs.

Several respondents also indicated that having appropriate computer software may also produce cost-savings in the long run. It is noted that some of these cost-savings measures (e.g., improved management of medical transportation costs in several regions, improved financial and management practices, and the automation of client benefit claims payment processes) have been implemented in the national NIHB Program in an effort to control the costs of the program.

7.5.3 Integration of Non-Insured Health Benefits with Other Services

Several respondents commented on the fact that non-insured health benefits could be integrated with other services. The Bigstone Cree Nation and Akwesasne, in particular, are focusing on integrating non-insured health benefits with other health-related services, social services, and educational programs. The integration of non-insured health benefits with other areas may not only result in improved health on an individual and community level, it may also result in cost-savings for non-insured health benefits. For example, more prevention programs may result in a reduced need for dental services. In addition, the ability to keep surplus funds from the non-insured health benefits program may provide an incentive for a First Nations/Inuit organization to obtain cost-efficiencies in its NIHB program, to apply the surplus(es) gained in one or more years to cost over runs in future years, and to apply the surplus funds to other health programs (e.g., prevention programs).

7.5.4 Outcome Data

7.5.4.1 Client Satisfaction

In previous evaluations of the NIHB pilot projects, it was noted that clients were generally satisfied with the way pilot project staff helped them to obtain non-insured health benefits, although they also expressed a need for more information regarding benefits and services. Clients in several of the study sites commented that project staff needed more training with regard to interpersonal relationships.

In the current evaluation, respondents were generally staff, not clients, and few respondents commented on clients' satisfaction with the administration of non-insured health

benefits. An exception is the in-depth examination of the Bigstone Cree Nation's pilot project which was conducted as part of Phase 3 activities. In this phase of the study, over 60% of clients felt that: they did not have sufficient information regarding benefits and services available under the NIHB program; felt that the administration of non-insured health benefits had stayed the same or improved since the implementation of the pilot project; felt that the transfer of responsibility for non-insured health benefits had been successful; and supported the continued administration of non-insured health benefits by the Bigstone Cree Nation in the future. These findings suggest that clients were satisfied with the administration of non-insured health benefits in this pilot site. It is not known if similar findings would be observed for other First Nations/Inuit organizations that are administering non-insured health benefits.

7.5.4.2 Provider Satisfaction

In previous evaluations of the NIHB pilot projects, providers for many of the pilot sites indicated they: were satisfied with the claims and bill payment services provided by the pilot sites; wanted to have billing time improved; and were willing to continue working with the pilot projects. Although providers for some of the pilot sites indicated that communications had improved, providers for some of the other pilot sites indicated that there was a need for increased communications, particularly regarding changes in the NIHB Program.

In the current evaluation, the input from providers was not generally sought. In addition, the majority of respondents did not comment on providers' satisfaction with the local administration of non-insured health benefits. Again, an exception was the in-depth examination of the Bigstone Cree Nation's pilot project. In this component of the study, over 80% of providers felt that: the administration of non-insured health benefits had stayed the same or improved since the Bigstone Cree Nation had taken on the administration; were very or somewhat satisfied with the claims and bill payment processes; and felt that the transfer of responsibility for the administration of non-insured health benefits to the Bigstone Cree Nation had been very or somewhat successful. Over 66% of providers supported the continued administration of non-insured health benefits by the Bigstone Cree Nation. This finding is similar to what was obtained in an earlier evaluation of this pilot project. It is not known if similar findings would be observed for other First Nations/Inuit organizations that are administering non-insured health benefits.

8. IMPLICATIONS OF THE FINDINGS FOR THE FUTURE

8.1 Introduction

The previous chapter provided a discussion of the evaluation findings with respect to the key research questions. Given the nature of the findings, it is possible to make some evidence-based recommendations regarding future directions for the NIHB Program.[56] In moving forward, senior management from Health Canada and First Nations and Inuit organizations will need to consider a number of key issues. The implications of the evaluation findings for the future of the NIHB Program are discussed under four broad topics. These are:

- The relative appropriateness of transferring non-insured health benefits and services from Health Canada's control to First Nations and Inuit control;
- Possible transfer models which should be considered in the future;
- The steps to be taken before non-insured health benefits and services are transferred (if they are to be transferred in some form); and
- Operational and administrative issues.

8.2 Transferring Non-Insured Health Benefits from Health Canada to First Nations and Inuit

Based on the information collected, there appears to be a desire among (at least some) First Nations and Inuit to have greater ownership and control over the administration and delivery of non-insured health benefits. There also appears to be a desire on Health Canada's part to facilitate a transfer process. ***Thus, it is reasonable to assert that, in principle, Health Canada and First Nations and Inuit should work together to facilitate a NIHB transfer process.*** However, there are a number of important policies and operational issues which need to be addressed before a clear strategic plan for transfer can be initiated.

The current study indicates that there may be many benefits to having First Nations and Inuit administer non-insured health benefits at the local level. However, consideration has to be given to the extent to which all of the First Nations and Inuit communities which are interested in administering non-insured health benefits at the local level are able to administer them in a manner that: is "appropriate to (meet) their unique health needs"; will "maintain health, prevent disease, and assist in detecting and managing illnesses, injuries, or disabilities"; contributes to "the achievement of an overall health status that is comparable to that of the Canadian population as a whole" for all of their members (e.g., both those living on and off reserve); is "sustainable from a fiscal and benefit management perspective"; and is "cost-effective." To the extent that one or more of these objectives are considered difficult to achieve, consideration needs to be given to if, or how, the objectives can be met in new and innovative ways.

[56] Some of the recommendations are identical to those presented in other reports, some are expanded versions of recommendations that appeared in other reports, and some recommendations apply only to this report.

One option could be to transfer some benefits (e.g. Medical Transportation) to existing First Nations and Inuit health services programs. Other benefits (e.g., Pharmaceutical Services, Dental Services) could be administered through a national, or set of regional, insurance providers. A system could be established whereby each First Nation or Inuit community could select from a menu which services it would like to provide at the local level and which services would be provided through a regional or national insurer. A second, but related, option would be to transfer some, or all, of the non-insured health benefits to regional First Nations and Inuit organizations rather than to local First Nations/Inuit communities. A third option would be for larger First Nations and Inuit communities to take on all non-insured health benefits and for smaller First Nations and Inuit communities to obtain the services through a regional or national insurer. It would make sense, in adapting any of the above approaches, to clearly define and document each model and to conduct pilot projects, with evaluations, to see how effective any new structures for delivering NIHB may be.

Whatever solution (or set of solutions) is developed, it should be cost-effective, responsive to local needs, and adaptable to local circumstances and capacities, in order to positively affect the transfer of non-insured health benefits.

Recommendation #1: Steps should be taken at the national, regional and local levels to ensure that the transfer of non-insured health benefits to First Nations and Inuit who wish to take on non-insured health benefits directly is done in an appropriate manner (including at a reasonable time and pace). This may include, but is not limited to: providing the First Nations and Inuit with appropriate support from the FNIHB regional and national offices; ensuring that the First Nations and Inuit have the necessary information to take on transfer (e.g., historical information, policy manuals, and training opportunities); and incentives to ensure that the administration and delivery of non-insured health benefits is cost-effective (e.g., being able to keep surplus funds to off-set cost over runs in future years and/or being able to apply the funds to other health programs).

Recommendation #2: If and when non-insured health benefits are transferred to the local level, appropriate and separate budget envelopes should be developed to cover the costs of implementation, the administration of non-insured health benefits, and the delivery of non-insured health benefits, regardless of which transfer option is implemented.

8.3 Possible Transfer Models

8.3.1 Alternative Approaches

A number of management options have been proposed for the transfer of the NIHB Program.[57] These include:

- ***The status quo*** – The NIHB Program continues to be delivered by FNIHB.

- ***Co-management*** – FNIHB in partnership with First Nations/Inuit manages and administers the NIHB Program. The partnership could be at the national or regional level. The co-management could operate on an on-going or interim basis.

- ***Administration Through Contribution Agreement*** – First Nations or Inuit communities administer the NIHB Program using current FNIHB policies and procedures. Either FNIHB or a third party insurer pay the claims, or the First Nations/Inuit pay the claims for those benefits they administer.

- ***Health Benefit Insurance Plan*** – Either First Nations/Inuit communities or individuals receive funding from FNIHB or negotiate or purchase benefit provision through a private, third party insurer.

- ***Integrated Community-Based Health Services Model*** – First Nations/Inuit assume the management of the NIHB Program as well as any other community health services that the community wishes to manage.

- ***Unconditional Transfer*** – A First Nations/Inuit group[58] assumes full responsibility for providing the NIHB Program, including the description of the benefit list, the identification of eligible recipients, the development of policies and procedures, and so on.

- ***Conditional Transfer*** – A First Nations/Inuit community assumes full responsibility for providing the NIHB Program within some pre-determined parameters (e.g., FNIHB would specify benefit descriptions, eligibility criteria, procedures, and so on).

- ***Self-Government*** – A First Nations or Inuit community has complete authority to allocate health resources to community-based priorities as long as mandatory community health programs are provided.

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[57] Each of these options is discussed in more detail in the 1996 *Report on the Future Management of the Non-Insured Health Benefits Program. Volume 1*, which was written by the Joint AFN/MSB Task Force on the Future Management of the Non-Insured Health Benefits Program.

[58] This could be a First Nations/Inuit community, a First Nations Tribal Council/Inuit Organization, a First Nations/Inuit Provincial/Territorial Organization or a First Nations/Inuit National Organization.

- ***Single Funding Mechanism*** – A First Nations or Inuit community includes funding for the NIHB Program in negotiations for a Single Funding Agreement. These Agreements may include resources from several departments.

- ***Aboriginal For-Profit Corporation*** – An Aboriginal for-profit corporation contracts with both FNIHB and First Nations and Inuit communities to process NIHB claims.

There is a network of First Nations and Inuit organizations across Canada. Each has its own traditions. Many experience geographic, socio-demographic, economic and other challenges that require unique approaches to the delivery of health care. Thus, no one health service model will fit all First Nations and Inuit communities. Rather, in order for First Nations and Inuit health systems to be effective, they will need to be community designed, managed and administered.[59] With regard to the transfer of the NIHB Program, this means that more than one transfer option may need to be considered to maximize the fit between community needs and service responses within the "context" of the community.

Based on the current evaluation, it would seem that different First Nations/Inuit would like to have different transfer options, and that different options are (at least to some extent) feasible from Health Canada's perspective. For example, at this time, the First Nations in Saskatchewan, for a number of reasons, appear to favor the Status Quo. Whether this would remain the case if changes were made to funding and policy issues with regard to the NIHB Program, and to the more general issue of treaty obligations, is unclear. The majority of First Nations and Inuit communities that served as NIHB pilot project sites are operating under Contribution Agreements. For some of these communities, this may be the preferred option. For other communities, a different option may be preferred if funding, policy and other issues regarding the administration of non-insured health benefits are addressed. The Bigstone Cree Nation currently operates under a Co-management-like model, but appears to being moving towards an Integrated Community-Based Health Services model. The Mohawk Council of Akwesasne currently operates under a Contribution Agreement for NIHB, but also appears to be moving towards an Integrated Community-Based Health Services model. The Nisga'a Nation operates under Self-Government.

It is unclear how many different options may be feasible for the administration, management and delivery of non-insured health benefits, given current fiscal and management constraints for Health Canada, and environmental, resource, and support limitations[60] for First Nations and Inuit communities. A key question here is: How realistic is it to set up full NIHB programs in First Nations and Inuit communities irrespective of size, geographic location, etc? Doing so could mean establishing hundreds of NIHB programs, many of which would be for First Nations and Inuit with quite small populations. Taking this approach would mean a major commitment to training and job creation and would involve substantially higher administrative

[59] National Aboriginal Health Organization. (2001). *Making a difference. Submission to the Commission on the Future of Health Care in Canada*. Ottawa: National Aboriginal Health Organization.

[60] Environment limitations may include, but not be limited to, geographic location, population size, and prevalence of chronic diseases at the community level. Resource limitations may include, but not be limited to, personnel, space and financial resources. Support limitations may include, but not be limited to, support from the Chief and Band Council, Band members, health care providers, and regional Health Canada office.

costs for the NIHB Program. The potential disadvantages for Health Canada of having multiple management options for the NIHB Program must be weighed against the advantages of having First Nations and Inuit communities administer non-insured health benefits at the local level (should they wish to do so) at "a time and pace of their choosing".

Recommendation #3: Health Canada, in collaboration with First Nations and Inuit organizations (at the national, regional and local levels), should consider several alternative approaches for the delivery of non-insured health benefits to First Nations and Inuit individuals.

Recommendation #4: If alternative approaches for the delivery of non-insured health benefits to First Nations and Inuit are considered potentially desirable and feasible by both Health Canada and First Nations and Inuit organizations, additional pilot projects should be conducted to assess the practical benefits and challenges of such approach(s).

8.3.2 Additional Pilots

Transfer could take the form of pilot projects that can slowly evolve into transfers or a decision could be made to transfer non-insured health benefits and to have a three to five year initial implementation phase.

There is no clear answer from this study as to whether or not there should be additional pilot projects in the future. One of the reasons for this is that it is not clear how generalizeable the previous pilot projects are to other First Nations and Inuit communities who may be contemplating taking on the transfer of non-insured health benefits. ***The researchers feel that it is not reasonable to replicate the previous pilot process. Unless issues related to overall funding, funding for the pilot process, and issues related to policies are addressed, the outcome of any future pilots may well be similar to the previous pilot projects. Assuming such matters can be addressed, one could consider: continuing with an enhanced and improved pilot process; developing a phased in approach in which the pilots are essentially the initial, implementation phase of the transfer of non-insured health benefits; and/or piloting new approaches to the administration and delivery of non-insured health benefits.***

If additional pilot projects were to be conducted, the pilot projects would need to have: an adequate budget for service delivery; an adequate and separate budget for costs related to the pilot project *per se*; more initial and ongoing training of staff; support and training for information infrastructure; easy access to policies and policy interpretations; a policy framework approach in which adaptations could be made to reflect local circumstances; enhanced communication materials; and adequate time to implement the pilot project so that meaningful evaluations of the pilot project process could be conducted.

It is recognized that some First Nations and Inuit may wish to take on responsibility for all non-insured health benefits directly instead of participating in a pilot project. In such cases, one could simply make the transfer, or one could do a phased in transfer in which the first one to three years would be for implementation. This implementation process could be similar to the

pilot project process but would not be called a pilot. This option could be in addition to, or instead of, a more formal pilot project process. The following recommendations apply to the pilot projects *and* to the implementation phase (which is equivalent to a pilot) for a phased in transfer process.

Recommendation #5: Health Canada, in collaboration with First Nations and Inuit organizations (at the national, regional and local levels) should consider whether additional NIHB pilot projects should be conducted.

Recommendation #6: If additional pilot projects are to be conducted in the future, Health Canada, in collaboration with First Nations and Inuit organizations at the national, regional, and local levels should ensure that realistic goals and expectations for the pilot projects are identified and clearly communicated to all key stakeholders.

Recommendation #7: If additional pilot projects are to be conducted in the future, Health Canada, in collaboration with First Nations and Inuit organizations, should ensure that documentation regarding the development, implementation, and maintenance of the pilot projects exists and is kept up-to-date for the length of time the pilot projects are in operation. This would include, but not be limited to: documentation regarding how to apply for pilot project funding; the expectations of the pilot projects (e.g., reporting and accountability aspects); historical information (e.g., funding and utilization information); core policies that could be adapted to the local situation (e.g., appeals processes); policy and training manuals; and communication materials for key stakeholders.

Recommendation #8: If additional pilot projects are to be conducted in the future, steps should be taken at the national, regional, and local levels to ensure that the pilot projects, as a group, are representative of contextual issues (e.g., size and geographic location), management structures, transfer options, and so on.

Recommendation #9: If additional pilot projects are to be conducted in the future, steps should be taken at the national, regional and local levels to ensure that the projects are developed, implemented and maintained in an appropriate manner. This includes, but is not limited to: having staff at all levels who are specifically assigned to the pilot project process; having FNIHB staff at the national and regional levels who are knowledgeable about the NIHB Program, as well as local circumstances, and who can provide support to the local First Nations/Inuit staff; having sufficient time to develop and implement the pilot project before an evaluation is conducted; ensuring that individuals both inside and outside of the communities are included; and ensuring that all non-insured health benefit areas are piloted.

Recommendation #10: If additional pilot projects are to be conducted in the future, steps should be taken at the national, regional, and local levels to ensure that meaningful evaluations of the pilot projects can be conducted. This would include, but not be limited to, an evaluation of how the pilot projects were implemented as well as evaluations of the short and long term impacts of the pilot projects from the perspectives of key stakeholders (e.g., officials, staff, clients, and providers). The evaluations should focus on the impact of the pilot projects on: the utilization and costs of non-insured health benefits; the utilization of other health services; health status at the individual and community levels; and so on. Planning for the evaluations should occur as part of the development of the pilot projects.

Recommendation #11: If additional pilot projects are to be conducted in the future, appropriate funding envelopes should be developed for the pilot process at all levels. These funding envelopes should include, but not be limited to, resources for: the delivery of non-insured health benefits; the administration of non-insured health benefits (e.g., space, computer systems); and the training of staff.

8.4 Steps to be Taken Before Non-Insured Health Benefits are Transferred

8.4.1 Introduction

There are a number of issues that should be considered in developing and implementing a transfer process regardless of whether transfer occurs directly or through additional pilot projects. The following recommendations relate to the steps that should be taken before non-insured health benefits are transferred.

8.4.2 The NIHB Program and Health Services

As noted earlier, the Transfer of Health Services to First Nations and Inuit control was approved in 1988. However, this decision did not include the transfer of the NIHB Program. The transfer of the NIHB Program to First Nations and Inuit control could follow a process that is similar to that used for community health transfers, and thus lessons learned as part of that process may be applicable here as well.[61] However, there are four major differences between the NIHB Program and Health Services that may present substantial challenges for the transfer of the NIHB Program.[62]

- ***Data*** – The resources required to provide the non-insured health benefits are influenced by utilization rates and market increases. The researchers understand that the national NIHB Program has extensive data regarding the utilization of Pharmaceutical Services, Medical Supplies and Equipment and Dental Services. Other benefit areas are managed regionally, and the availability and quality of relevant data varies.

- ***Responsiveness of Private Sector Providers*** – The provision of non-insured health benefits is dependent on private sector providers. Health care provider choice is limited for most rural or remote communities. Issues such as high turnover and burnout of health care providers, language barriers and a lack of integration of traditional and western health systems may all affect the extent to which private sector providers are willing and able to provide benefits and services under the NIHB Program.[63]

- ***Management Expertise*** – The provision of non-insured health benefits requires knowledge of health benefit management which may not exist at the community level.

- ***Accessibility of Services*** – The provision of non-insured health benefits requires the ability to ensure that all eligible individuals have equal access to benefits regardless of residency (e.g., on-reserve/off-reserve) or income level. However, accessibility may be a major issue for individuals living in Aboriginal communities outside of urban areas because of geography, isolation and small community size.

Given the above differences, the following recommendations are made to facilitate any future NIHB transfer process.

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[61] An evaluation of the Health Transfer Policy has recently been completed. See the document: Lavoie, J.G., O'Neil, J., Sanderson, L., Elias, B., Mignone, J., Bartlett, J., Forget, E., Burton, R., Schmeichel, C., & McNeil, D. (2004). *The evaluation of the First Nations and Inuit Health Transfer Policy*. Winnipeg, MB: Centre for Aboriginal Health Research.

[62] Government Performance Information Consultants (GPIC). (1988). *Evaluation framework: Non-Insured Health Benefits Pilot Projects. Draft*. Orleans, ON: GPIC.

[63] Ibid

Recommendation #12: Utilization and costing data should be collected and analyzed at the local, regional and national levels for a period of several years in order to identify trends that can be used to develop appropriate health programs, allocate funding appropriately and so on.

Recommendation #13: Steps should be taken at the national, regional and local levels to encourage appropriate health care providers to become involved, and to stay involved, with the NIHB program. This may include, but not be limited to: providing incentives for First Nations and Inuit individuals to train and work in various health disciplines (e.g., dentistry, ophthalmology); hiring or contracting with health providers (e.g., opticians, dentists and pharmacists) to provide services in First Nations and Inuit communities on a regular basis; and paying providers using a variety of options (e.g., alternative payment plans rather than fee-for-service).

Recommendation #14: Steps should be taken to ensure that individuals who are responsible for the administration, management, and/or delivery of non-insured health benefits at the local level are provided with appropriate resources to ensure that they have the capacity to carry out the necessary activities. This may include, but not be limited to: receiving training when the individuals first start with the NIHB program; receiving ongoing training on non-insured health benefits on a regular (e.g., annual basis); receiving information regarding what is covered and what is not covered in all non-insured health benefit areas on a regular basis; and being able to access identified resource people at the regional and national FNIHB office (by e-mail, a toll-free telephone information line, and so on) regarding specific issues related to the NIHB program.

Recommendation #15: Steps need to be taken at the national, regional and local levels to ensure that all eligible individuals have access to non-insured health benefits, regardless of residency (e.g., on or off reserve), and regardless of who is administering the non-insured health benefits. This may include, but is not limited to, providing information to all eligible individuals regarding what non-insured health benefits are available and how they can be accessed, and enabling approvals to be obtained 24 hours a day, seven days a week.

8.4.3 Financial Issues

Currently, the NIHB Program appears to be a demand service operating under capped budgets. If the NIHB Program is going to continue to provide all of the current non-insured health benefits to individuals who meet the current eligibility criteria, sufficient funding must be made available to do so. With respect to the broader issue of transferability of the NIHB

Program, many First Nations and Inuit respondents expressed concern about budget caps and their impact on the sustainability of the administration and delivery of non-insured health benefits at the local level. One of the key questions that needs to be addressed is: To what extent is Health Canada prepared to, and financially able to, cover the full costs of non-insured health benefits that have been transferred?

Recommendation #16: Health Canada, in collaboration with First Nations and Inuit, should conduct a review of the current funding and resource allocation methodology for the NIHB Program to ensure that all key factors are included in the funding formula. Examples of key factors would include, but are not limited to: historical age and sex adjusted utilization; a factor for increased utilization resulting from local administration; estimated future age and sex population distributions; an allocation for ongoing administration and training; an inflation factor for key cost drivers; regional cost and utilization patterns; provincial health reforms; and other related factors.

Recommendation #17: Annual budgets for the NIHB Program, at the national, regional and local levels, should include funding increases which reflect the key factors in the funding formula (e.g., increased utilization).

8.4.4 Objectives and Policies

The objectives and policies of the NIHB Program appear to be inconsistent with the provision of non-insured health benefits within a capped budget, particularly since the current funding envelope is designated for other health services in addition to non-insured health benefits. If tight budget caps are used, First Nations and Inuit who are administering non-insured health benefits may need to restrict services, develop needs based eligibility requirements, charge user fees, and/or delist services, in order to remain within their budgets.

Recommendation #18: Health Canada, in collaboration with First Nations and Inuit should review (and revise as necessary) the objectives and policies of the NIHB Program, to be consistent with the way funding for the program is allocated.

The findings from this study suggest that there are a number of policy issues that need to be addressed if the transfer process is to be successful. For example, not all of the current national NIHB policies appear to be relevant at the local level. Some process needs to be developed, with the full involvement of First Nations and Inuit, regarding how NIHB policies are developed, changed and implemented.

Recommendation #19: Health Canada, in collaboration with First Nations and Inuit should conduct ongoing reviews of key policies, and/or develop flexible policies to ensure that policies regarding the administration of non-insured health benefits are relevant for local circumstances.

As noted in the previous chapter, the integration of non-insured health benefits with other areas may not only result in improved health on an individual and community level, it may also result in cost-savings for non-insured health benefits. In order for various programs and services to work efficiently and effectively together, and as a coordinated entity focused on the health of individuals, it is important that staff of the various programs work together. It may also be important that NIHB staff work with staff from other agencies (such as regional health authorities). Policies and procedures need to be in place to both protect the privacy of the client as well as to the meet his/her health needs by ensuring that appropriate health services and programs are in place.[64]

Recommendation #20: Health Canada, in collaboration with First Nations and Inuit, should develop general policies and procedures that both protect the privacy of clients as well as ensure that their health care needs are met.

8.5 Operational and Administrative Issues

8.5.1 Introduction

A number of administrative issues were raised during the course of the evaluation that have an impact on the administration and delivery of non-insured health benefits. The following sections provide commentary on these issues and recommendations for the future.

8.5.2 Documentation

Respondents involved in the current evaluation commented on the need for documentation regarding the NIHB Program in several contexts. For example, clients and providers commented on the desire to have information regarding what is covered and what is not covered under the program. Staff in some of the First Nations and Inuit communities commented on the need to be aware of changes to program, to have policy manuals, and so on. Some of the required documentation may exist but not be considered as complete or as useful as the requestors would like.

Any lack of up-to-date documentation on the NIHB Program makes it difficult for FNIHB staff at the national and regional levels to stay current on what is covered and what is not, to support local First Nations and Inuit and so on. It also makes it difficult for First Nations and Inuit organizations at the local level to administer non-insured health benefits in a consistent manner to all eligible individuals regardless of residency. And, it makes it difficult for evaluations of the NIHB Program, the NIHB pilot process and similar activities to be conducted in a comprehensive manner.

[64] It is noted that Health Canada is governed by the Privacy Act, the Charter of Rights and Freedoms, and the Access to Information Act. It is also noted that Health Canada has developed a NIHB Privacy code, which outlines its practices and responsibilities related to privacy issues.

Recommendation #21: Changes to the NIHB Program should be well documented and the relevant information should be circulated to key stakeholders, through a variety of means, on a regular basis.

Recommendation #22: Documentation regarding the NIHB Program should be kept in an easily accessible location for a minimum of five years.

8.5.3 Communication

There seems to be a need for enhanced communication at several levels. At the senior policy levels, it may be helpful to have senior federal officials meet with senior First Nations and Inuit representatives on a regular basis to discuss issues of policy, funding, and administration with regard to non-insured health benefits. At the working level, there appears to be a need to better document and describe the NIHB Program and how it works to federal officials, First Nations and Inuit organizations, and key stakeholders (including First Nations and Inuit individuals).

Recommendation #23: Representatives from FNIHB (at both the national and regional levels) should meet with representatives from First Nations and Inuit organizations (at the national, regional and local levels) on a regular basis to discuss issues of policy, funding, and administration of non-insured health benefits.

Recommendation #24: Both FNIHB and First Nations/Inuit organizations and communities should develop, as appropriate, enhanced communications plans and materials related to the NIHB program.

Recommendation #25: Health Canada (at the national and regional levels) should ensure that all First Nations and Inuit health staff are directly informed of any changes to the NIHB Program. This could include regular updates on Health Canada's website as well as regular newsletters, e-mail/fax/phone notification, annual workshops, and so on.

Recommendation #26: First Nations and Inuit health staff across Canada should ensure that all relevant individuals (e.g., Band administration, all eligible individuals, providers, and so on) are informed of any changes to the NIHB program.

8.5.4 Training

Many respondents in the current evaluation commented on the need for First Nations and Inuit individuals who are responsible for administering non-insured health benefits at the local level to be adequately trained. This training needs to occur when individuals first start with the NIHB program and should be provided on an ongoing and regular basis after that. Providing First Nations and Inuit individuals who are responsible for the administration, management, and

delivery of non-insured health benefits at the local level with adequate, and ongoing, training may also be one way of reducing staff turnover.

First Nations and Inuit individuals who are responsible for the administration and delivery of non-insured health benefits at the local level rely on FNIHB personnel for information and support. Therefore, it is very important that FNIHB personnel at both the national and regional levels: are knowledgeable about the NIHB Program; have some knowledge about other health programs operated by FNIHB (e.g., community health); have some knowledge about other programs operated by other federal departments that may have an impact on non-insured health benefits (e.g., programs provided by Indian and Northern Affairs Canada); and are aware of regional and local issues that may impact on the provision of non-insured health benefits (e.g., provincial health reforms).

Recommendation #27: Health Canada should ensure that all FNIHB staff, at the national and regional levels, who are directly involved with the administration, management, and delivery of non-insured health benefits receive training on the NIHB program, on other related programs, and on factors that may impact the NIHB Program on an ongoing basis.

Recommendation #28: First Nations and Inuit staff who are directly involved with the administration of non-insured health benefits at the local level should receive both "formal" and "informal" training when they begin working with the NIHB program, and on an ongoing basis. Formal training may involve, but is not limited to working closely with relevant NIHB personnel at the regional Health Canada office and attending seminars on current guidelines, procedures and policies. Informal training may involve, but is not limited to: working closely with relevant NIHB personnel at the regional Health Canada office; attending seminars on current guidelines, procedures and policies; discussions with other First Nations and Inuit organizations; and discussions with staff in other health related areas.

Recommendation #29: Basic provider and staff training manuals should be developed, updated and maintained on a regular basis for all non-insured health benefit areas. These manuals should contain core information that can be adapted for use at the local level.

Recommendation #30: Funding for staff training at all levels should be explicitly included in annual budgets for the NIHB program.

8.5.5 Computer Software

Many respondents in the current evaluation commented on the need to have accessible, up-to-date computer systems and software programs to enable them to administer non-insured

health benefits in a more cost-effective manner. It is also noted that some of the NIHB management initiatives that have been implemented to control the costs of the NIHB Program require computer systems and software. These initiatives include: automation of client benefit claims payment processes; improved financial and management practices; and improved audit and accountability measures. It is recognized that some of the following recommendations may be quite costly to implement. However, it is thought the initial expense will be outweighed by long-term cost-savings.

Recommendation #31: Computer systems and appropriate software should be accessible to staff at all levels (that is, national, regional, and local) who are involved with non-insured health benefits (including those who are responsible for paying invoices). This includes staff of the national and regional FNIHB offices as well as First Nations and Inuit individuals at the local level.

Recommendation #32: An electronic database should be developed or adapted for all non-insured health benefit areas for use by all First Nations and Inuit at the local level, regardless of the transfer option they are operating under. This database should be compatible with systems and programs used by providers across the country, Health Canada (at both the regional and national level) and others.

Recommendation #33: The electronic database should be constructed in such a manner as to enable analyses and summaries to be conducted for accounting and administrative purposes at all levels (i.e., national, regional, and local). The database should also enable First Nations and Inuit organizations to obtain and maintain an up-to-date list of all individuals from their organization who are eligible to receive non-insured health benefits.

Recommendation #34: Written documentation and training manuals should be developed for the database and should be updated on a regular basis. This documentation needs to be provided on a regular basis to individuals at the national, regional and local levels who are directly involved with the administration and management of non-insured health benefits.

Recommendation #35: Funding for updating and improving computer systems and software should be explicitly included in annual budgets for the NIHB program at all levels (i.e., national, regional, and local).

8.5.6 Quality Assurance and Accountability

There is a significant issue, and a potentially significant cost, if hundreds of First Nations and Inuit communities all set up separate, non-insured health benefits programs, particularly if each one adopts a separate information infrastructure. Several respondents in this study

commented on the lack of appropriate information. The researchers were also struck by the lack of basic data regarding NIHB programs. First Nations and Inuit representatives and federal officials should work together to develop standardized software, or standards for data collection and reporting, so that it will be possible to have good data, and comparable data, across all NIHB programs.

Recommendation #36: Representatives from Health Canada and First Nations and Inuit organizations should work together to develop standardized software, and data collection and reporting tools for the non-insured health benefits program. The tools need to be relatively easy to use and appropriate utilization needs to be monitored on a regular basis. In addition, the tools need to provide the information required by Health Canada (at both the national and regional levels) and by First Nations and Inuit organizations (at the national, regional and local levels) to: ensure that non-insured health benefits are being provided in a similar manner to all eligible individuals across the country; that the objectives of the NIHB Program are being met; and that both FNIHB and First Nations and Inuit organizations are accountable for how NIHB funds are being spent.

In order to ensure that the NIHB Program, at the national, regional and local levels, meets the needs of eligible First Nations and Inuit individuals in a manner that is "appropriate to their unique health needs", it is important that the impact of changes be monitored on an ongoing basis. These changes may involve the administration, management and delivery of non-insured health benefits only, changes in other health areas (such as community health) that may impact on the administration, management and delivery of non-insured health benefits, or changes in a combination of areas. Monitoring the impact of such changes could take multiple forms, including, but not limited to: a record of informal feedback received from clients, staff and providers; formal surveys of clients, staff and providers (such as those conducted in the current evaluation); and an examination of management and/or administrative data (such as utilization rates, workload data and cost data).

Recommendation #37: The impact of changes in the NIHB program on various key stakeholders should be monitored on a regular (e.g., annual) basis.

Recommendation #38: The impact of changes in other FNIHB health-related programs on the delivery and administration of non-insured health benefits should be monitored on a regular (e.g., annual) basis.

Respondents from some of the pilot sites as well as from Bigstone, Akwesasne and the Nisga'a commented on the importance of integrating non-insured health benefits with other programs in order to improve overall health at the individual and community levels as well as the efficiency and effectiveness of all programs.

Recommendation #39: Consideration should be given to including some of the current non-insured health benefits in other health-related programs (e.g., Medical Supplies and Equipment into Home and Community Care).

Recommendation #40: First Nations and Inuit organizations which have, or are interested in, taking on the transfer of health services should also consider whether it is feasible to take on the administration of non-insured health benefits.

8.5.7 Broader Federal Issues

From a political and legal perspective, there appears to be a difference of opinion as to whether the provision of non-insured health benefits to First Nations and Inuit individuals constitutes a right or is a matter of policy. The issue of fiduciary responsibilities was beyond the scope of this project, and it is recognized that it cannot be addressed by Health Canada alone. However, the researchers note that this issue may have a substantial impact on the NIHB transfer process.

Recommendation #41: Appropriate government organizations (at both the national and provincial levels) should work with First Nations and Inuit organizations to resolve the issue of the federal government's responsibility to provide non-insured health benefits to First Nations and Inuit individuals.

8.6 Conclusion

The opportunity to improve the delivery of non-insured health benefits to First Nations and Inuit individuals presents great challenges, but also presents great opportunities for providing needed health care services in a more responsive and effective manner. It is the researchers' hope that the knowledge developed through this study can be used to inform the key decisions that will need to be made to enhance the future delivery of non-insured health benefits.