Health Canada Santé Canada

Your health and safety... our priority. *Votre santé et votre sécurité... notre priorité.*

Non-Insured Health Benefits Program

First Nations and Inuit Health Branch

Annual Report 2009/2010

Canada

Cover Artwork: Sharing of the Sweetgrass, by Daphne Odjig

HEALTH CANADA
FIRST NATIONS AND INUIT HEALTH BRANCH
NON-INSURED HEALTH BENEFITS DIRECTORATE

Manulife Place
55 Metcalfe St.
Postal Locator 4006A
Ottawa, Ontario
K1A 0K9

Telephone: 613-952-7385

http://www.hc-sc.gc.ca/fnih-spni/pubs/nihb-ssna_e.html

Artwork supplied courtesy of Indian and Northern Affairs Canada
Artwork Photographer: Lawrence Cook

Cat. No.: H33-1/2-2010E-PDF
ISBN: 978-1-100-16048-1
Publication Number: 100272

Table of Contents

Shaman's World by Lyle Wilson

Introduction and Background

Introduction

This is the sixteenth annual report prepared by the First Nations and Inuit Health Branch (FNIHB) of Health Canada on the Non-Insured Health Benefits (NIHB) Program.

As part of performance management, the report provides national and regional NIHB data, including information on NIHB Program clients, expenditures, benefit types and benefit utilization, for the following target audiences:

- First Nations and Inuit organizations and governments at community, regional and national levels;
- Regional and Headquarters managers and staff of Health Canada; and
- Others in government and in non-government organizations with an interest in the provision of health services to First Nations and Inuit communities.

Background

The Non-Insured Health Benefits (NIHB) Program provides coverage for 831,090 (as of March 31, 2010) registered First Nations and recognized Inuit on a limited range of medically necessary health-related goods and services when they are not otherwise insured.

Provinces and territories are responsible for delivering health care services, guided by the provisions of the *Canada Health Act*. These services include insured hospital care and primary health care and the services of physicians and other health professionals. Like all Canadian residents, First Nations and Inuit access these insured services through provincial and territorial governments. There are, however, a number of health-related goods and services that are not insured by provinces and territories or private insurance plans.

To support First Nations and Inuit in reaching an overall health status that is comparable with other Canadians, the NIHB Program covers a specified range of medically necessary benefits. These include:

- Pharmacy benefits (including prescription and over-the-counter drugs as well as medical supplies and equipment);
- Dental services;
- Transportation to access medically necessary services;
- Eye and vision care services;
- Health care premiums in British Columbia; and
- Other health care services including short-term crisis intervention mental health counselling.

The NIHB Program operates according to a number of guiding principles:

- All registered First Nations and recognized Inuit normally resident of Canada, and not otherwise covered under a separate agreement with federal or provincial governments or through a separate self-government agreement, 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 judgment, consistent with the best practices of health services delivery and evidence-based standards of care;
- There will be national consistency with respect to 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 jointly agreed to with First Nations and Inuit organizations; and
- When an NIHB-eligible client is also covered by another public or private health care plan, claims must be submitted to the client's other health care/benefits plan first. NIHB will then coordinate payment with the other payor on eligible benefits.

Legend Story by Henry Beaudry

Client Population

The NIHB client population has been growing steadily at an average rate of 2.0% over the last ten years. As of March 31, 2010, 831,090 First Nations and Inuit clients were registered in the Status Verification System (SVS) and were eligible to receive benefits under the NIHB Program.

The First Nations and Inuit population has a higher growth rate than the Canadian population as a whole. This is primarily because First Nations and Inuit have a higher birth rate compared to the overall Canadian population. In addition, amendments to the *Indian Act*, such as the passage of Bill C-31, have resulted in greater numbers of individuals being able to claim or restore their status as Registered Indians.

To become eligible under the Program, an individual must be a resident of Canada and have the following status:

- A registered Indian according to the *Indian Act*; or
- 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 client; and
- Currently registered or eligible for registration, under a provincial or territorial health insurance plan; and
- Is not otherwise covered under a separate agreement (e.g., a self-government agreement) with federal, provincial or territorial governments.

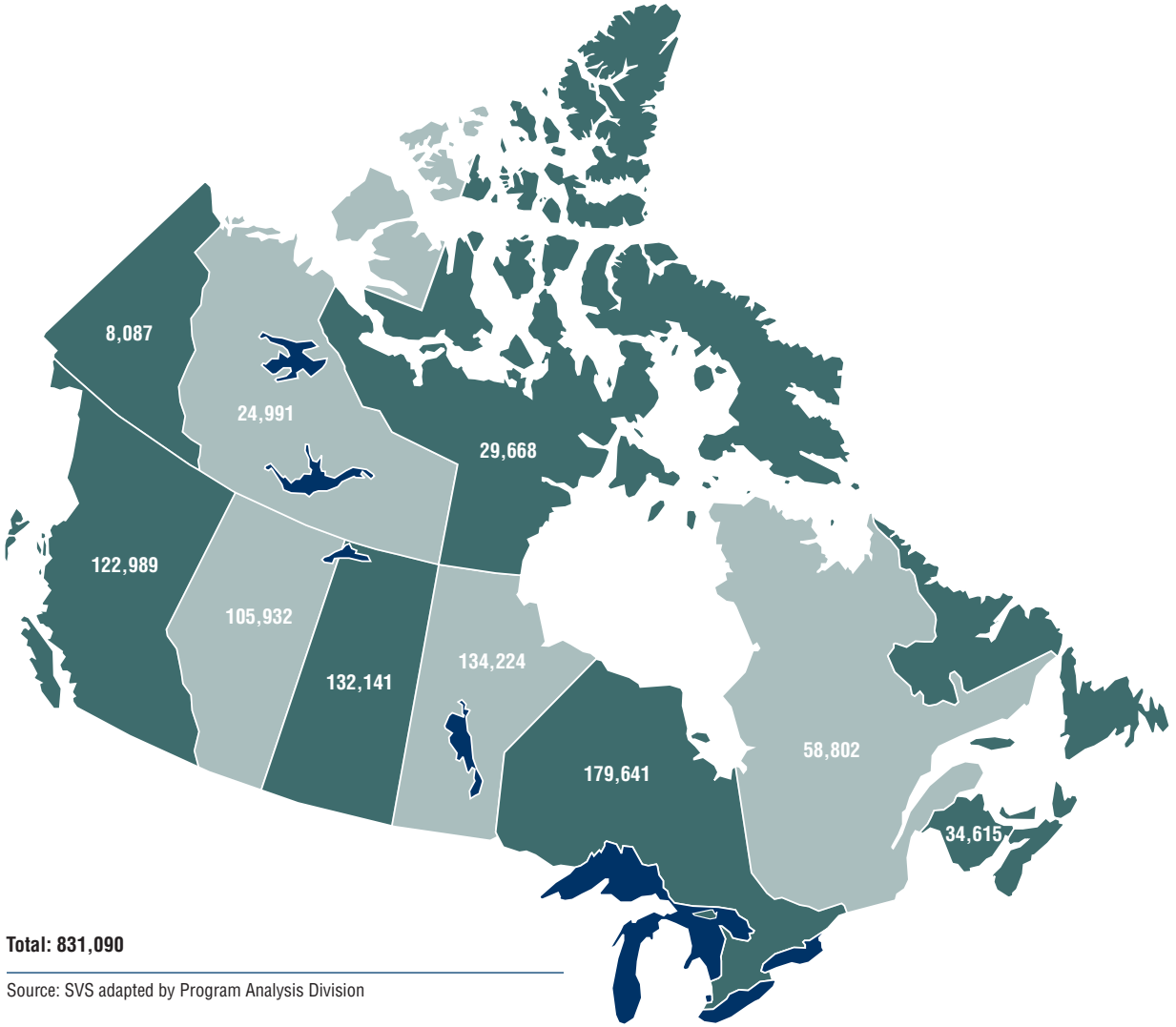
When clients are eligible for benefits under a private health care plan or a public health or social program, claims must be submitted to those plans and programs first before submitting them to the NIHB Program.

FIGURE 2.1

Eligible Client Population by Region
March 2010

NIHB Program client eligibility information is provided by the Status Verification System (SVS). The total number of eligible clients on the SVS at the end of March 2010 was 831,090, an increase of 1.9% from March 2009.

The Ontario Region had the largest eligible population representing 21.6% of the national total, followed by the Manitoba Region at 16.2% and the Saskatchewan Region at 15.9%.



Total: 831,090

Source: SVS adapted by Program Analysis Division

FIGURE 2.2

Eligible Client Population by Type and Region
March 2009 and March 2010

Of the 831,090 total eligible clients at the end of the 2009/10 fiscal year, 791,053 (95.2%) were First Nations clients while 40,037 (4.8%) were Inuit clients.

As of March 31, 2010 the SVS population statistics reflect a 1.9% growth rate. This is a slight decrease compared to the 2.1% growth rate recorded in the previous year and is comparable to historical growth rates. The number of First Nations eligible clients increased by 1.9% while the number of Inuit clients increased by 1.6% over the previous year.

The lower growth rate among Inuit clients is attributed to a joint effort with Inuit organizations and Territorial governments to improve the accuracy of eligible client population through the removal of records of deceased Inuit clients from the SVS. Efforts to improve the quality of data in SVS are ongoing, specifically in the North, and will be reflected in future reports.

From March 2009 to March 2010, both the Manitoba and Saskatchewan regions had the highest percentage change in total eligible clients with a 2.2% increase. The Alberta Region followed closely with a 2.1% change.

REGION	First Nations		Inuit		TOTAL		% Change
	March/09	March/10	March/09	March/10	March/09	March/10	2009 to 2010
Atlantic	33,738	34,339	403	276	34,141	34,615	1.4%
Quebec	57,147	57,870	881	932	58,028	58,802	1.3%
Ontario	175,867	179,090	534	551	176,401	179,641	1.8%
Manitoba	131,222	134,076	141	148	131,363	134,224	2.2%
Saskatchewan	129,273	132,094	42	47	129,315	132,141	2.2%
Alberta	103,299	105,479	417	453	103,716	105,932	2.1%
British Columbia	120,833	122,766	220	223	121,053	122,989	1.6%
Yukon	7,918	8,002	81	85	7,999	8,087	1.1%
N.W.T.	17,095	17,337	7,549	7,654	24,644	24,991	1.4%
Nunavut	0	0	29,140	29,668	29,140	29,668	1.8%
National	**776,392**	**791,053**	**39,408**	**40,037**	**815,800**	**831,090**	**1.9%**

Source: SVS adapted by Program Analysis Division

QUICK FACT

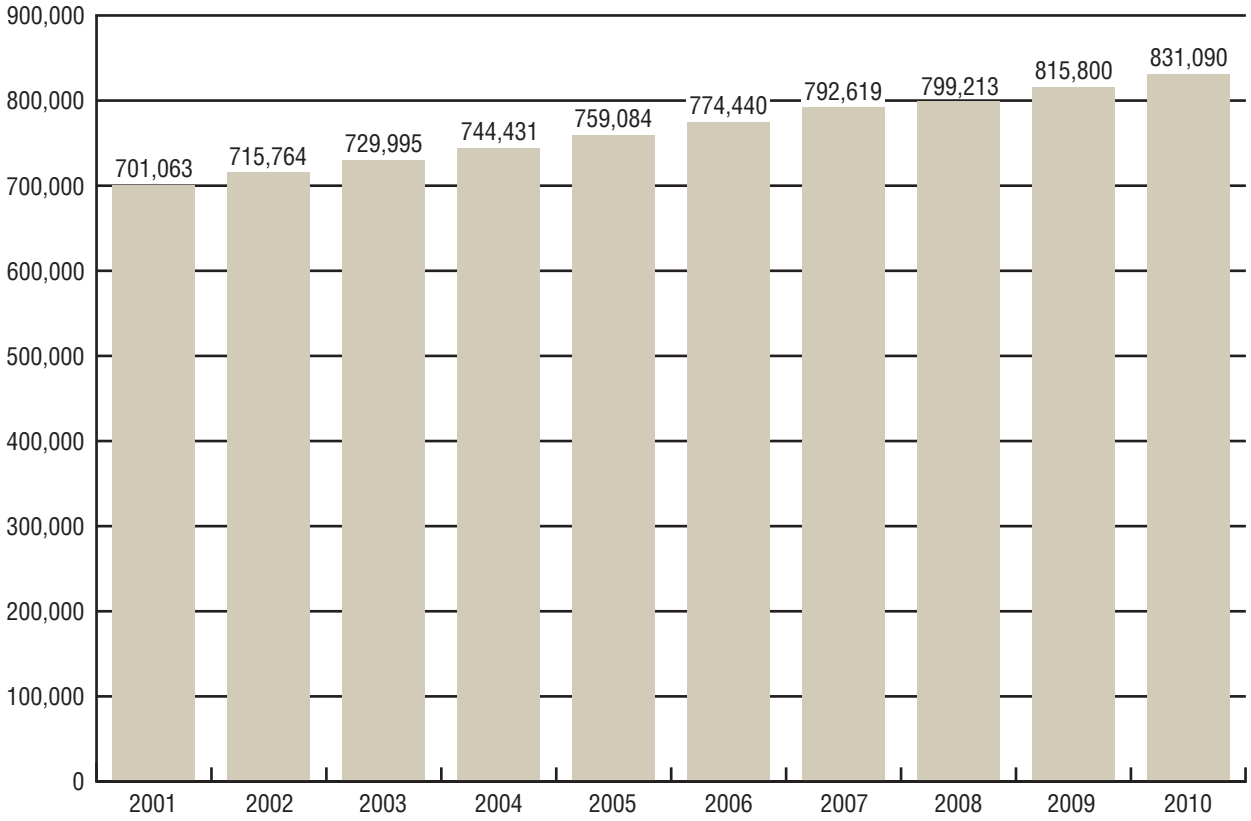
The share of NIHB client population under 20 years of age (36.5%) is high compared to the overall Canadian population (23.3%). There is a much higher percentage of seniors (65 and over) in the Canadian population (13.9%) than in the NIHB client population (6.2%). The average age of NIHB clients is 31, which is well below the Canadian average of 39.

FIGURE 2.3

Eligible Client Population
March 2001 to March 2010

The total number of eligible clients on the SVS increased from 701,063 at the end of fiscal year 2000/01 to 831,090 in March 2010, an increase of 18.5% over this period.

The NIHB Program client population is characterized as a constantly changing population. Amendments to the *Indian Act*, such as the passage of Bill C-31, have resulted in significant increases in the NIHB population. In contrast, the conclusion of First Nations and Inuit self-government agreements has resulted in decreases in total client population. For example, under the terms of self-government agreements and associated funding arrangements with the Department of Indian and Northern Affairs Canada, the Nisga'a Lisims Government and Nunatsiavut Government have assumed responsibility for the delivery of non-insured health benefits. Clients covered under these agreements are no longer eligible to receive benefits through Health Canada's NIHB Program.



Source: SVS adapted by Program Analysis Division

FIGURE 2.4

Eligible Client Population by Region
March 2006 to March 2010

The NIHB Program's total number of eligible clients increased by 7.3% from 774,440 in March 2006, to 831,090 in March 2010.

Nunavut had the largest increase in eligible clients over this period, with a growth rate of 10.4%, followed by the Manitoba Region at 9.9%, the Saskatchewan Region at 9.5%, and the Alberta Region at 9.2%.

The 0.8% annual percentage change in March 2008 is primarily attributed to the decrease in eligible clients in the Atlantic Region resulting from the removal of Nunatsiavut clients who transitioned to self-government. These individuals were no longer eligible for the NIHB Program and were therefore removed from the NIHB Program client population along with the resources allocated to Nunatsiavut clients under the self-government agreement.

REGION	March/06	March/07	March/08	March/09	March/10
Atlantic	37,867	39,191	33,361	34,141	34,615
Quebec	55,436	56,518	57,228	58,028	58,802
Ontario	167,271	170,296	173,014	176,401	179,641
Manitoba	122,166	125,449	128,010	131,363	134,224
Saskatchewan	120,639	124,111	126,459	129,315	132,141
Alberta	97,001	99,553	101,241	103,716	105,932
British Columbia	115,574	117,721	119,166	121,053	122,989
Yukon	7,788	7,877	7,923	7,999	8,087
N.W.T.	23,836	23,984	24,342	24,644	24,991
Nunavut	26,862	27,919	28,469	29,140	29,668
Total	**774,440**	**792,619**	**799,213**	**815,800**	**831,090**
Annual % Change	**2.0%**	**2.3%**	**0.8%**	**2.1%**	**1.9%**

Source: SVS adapted by Program Analysis Division

FIGURE 2.5

Eligible Client Population by Age Group, Gender and Region
March 2010

Of the 831,090 eligible clients on the SVS as of March 31, 2010, 50.9% were female (423,074) and 49.1% were male (408,016).

The average age of the eligible client population was 31 years of age. By region, this average ranged from a high of 35 years of age in the regions of Quebec, Ontario and the Yukon to a low of 26 years of age in Nunavut.

The average age of the male and female eligible client population was 30 years and 32 years respectively. The average age for males ranged from 25 years in Nunavut to 33 years in the regions of Quebec, Ontario and the Yukon. The average age for females varied from 26 years in Nunavut to 37 years in the Quebec Region.

The NIHB eligible First Nations and Inuit client population is relatively young with over two-thirds (67.4%) under the age of 40. Of the total population, over one-third or 36.5% are under the age of 20. Seniors (clients 65 years of age and over) represent 6.2% of the total population.

REGION	Atlantic			Quebec			Ontario			Manitoba		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	1,252	1,162	2,414	1,805	1,613	3,418	4,605	4,453	9,058	6,645	6,537	13,182
5-9	1,554	1,424	2,978	2,254	2,103	4,357	6,676	6,399	13,075	7,353	6,968	14,321
10-14	1,612	1,606	3,218	2,375	2,281	4,656	7,593	7,190	14,783	7,306	7,008	14,314
15-19	1,674	1,609	3,283	2,630	2,510	5,140	8,126	7,814	15,940	7,511	7,319	14,830
20-24	1,503	1,453	2,956	2,263	2,281	4,544	7,569	7,204	14,773	6,243	6,074	12,317
25-29	1,317	1,337	2,654	2,061	2,001	4,062	6,742	6,786	13,528	5,258	4,999	10,257
30-34	1,219	1,209	2,428	1,956	1,925	3,881	6,494	6,431	12,925	4,627	4,528	9,155
35-39	1,287	1,228	2,515	1,977	2,063	4,040	6,507	6,589	13,096	4,568	4,672	9,240
40-44	1,311	1,365	2,676	2,086	2,257	4,343	6,802	6,907	13,709	4,450	4,551	9,001
45-49	1,138	1,311	2,449	2,110	2,292	4,402	6,696	7,245	13,941	3,889	4,223	8,112
50-54	938	1,145	2,083	1,811	2,252	4,063	5,651	6,489	12,140	2,877	3,145	6,022
55-59	658	896	1,554	1,444	1,684	3,128	4,132	5,187	9,319	1,993	2,356	4,349
60-64	489	675	1,164	1,076	1,419	2,495	3,175	4,087	7,262	1,480	1,727	3,207
65+	868	1,375	2,243	2,411	3,862	6,273	6,384	9,708	16,092	2,516	3,401	5,917
Total	**16,820**	**17,795**	**34,615**	**28,259**	**30,543**	**58,802**	**87,152**	**92,489**	**179,641**	**66,716**	**67,508**	**134,224**
Average Age	**30**	**33**	**32**	**33**	**37**	**35**	**33**	**36**	**35**	**27**	**29**	**28**

Source: SVS adapted by Program Analysis Division

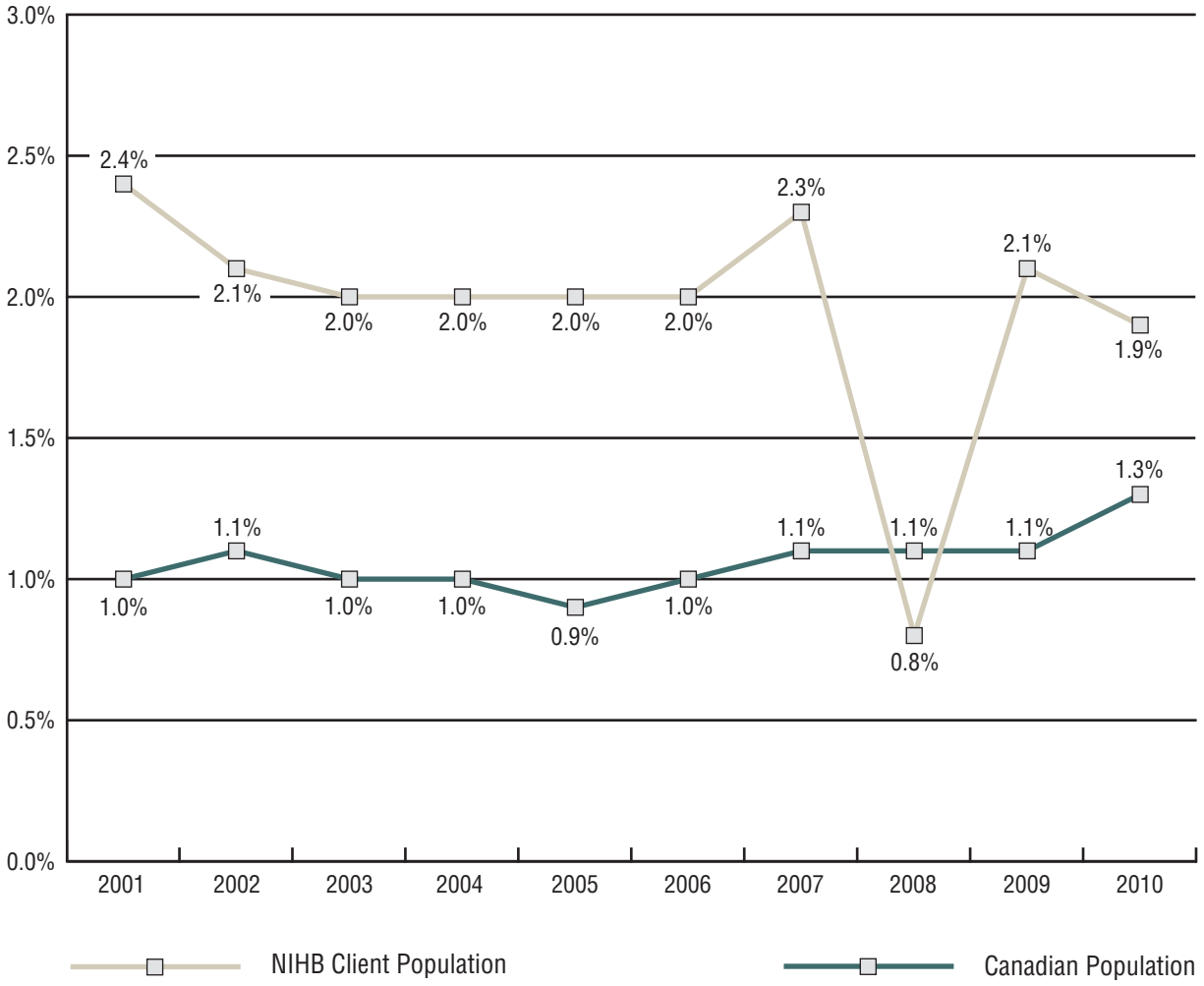
REGION	Saskatchewan			Alberta			British Columbia			Yukon			N.W.T.			Nunavut			TOTAL		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	6,316	6,118	12,434	4,917	4,801	9,718	4,029	3,810	7,839	203	164	367	864	813	1,677	1,849	1,829	3,678	32,485	31,300	63,785
5-9	7,272	7,161	14,433	5,854	5,612	11,466	4,987	4,831	9,818	286	265	551	955	996	1,951	1,867	1,697	3,564	39,058	37,456	76,514
10-14	7,179	7,064	14,243	5,965	5,579	11,544	5,173	4,910	10,083	314	297	611	1,118	1,092	2,210	1,711	1,623	3,334	40,346	38,650	78,996
15-19	7,592	7,425	15,017	6,057	5,666	11,723	5,727	5,381	11,108	368	338	706	1,447	1,411	2,858	1,667	1,616	3,283	42,799	41,089	83,888
20-24	6,780	6,526	13,306	5,236	5,157	10,393	5,709	5,255	10,964	325	327	652	1,241	1,195	2,436	1,490	1,453	2,943	38,359	36,925	75,284
25-29	5,465	5,359	10,824	4,360	4,417	8,777	4,998	4,836	9,834	338	324	662	1,088	992	2,080	1,159	1,141	2,300	32,786	32,192	64,978
30-34	4,664	4,716	9,380	3,749	3,796	7,545	4,406	4,412	8,818	308	250	558	847	908	1,755	965	1,022	1,987	29,235	29,197	58,432
35-39	4,422	4,653	9,075	3,457	3,604	7,061	4,544	4,508	9,052	331	309	640	912	912	1,824	927	899	1,826	28,932	29,437	58,369
40-44	4,255	4,495	8,750	3,328	3,471	6,799	4,484	4,698	9,182	376	316	692	943	963	1,906	927	928	1,855	28,962	29,951	58,913
45-49	3,584	3,869	7,453	2,887	3,239	6,126	4,621	5,127	9,748	375	393	768	798	939	1,737	736	745	1,481	26,834	29,383	56,217
50-54	2,594	3,024	5,618	2,111	2,508	4,619	3,675	4,288	7,963	250	292	542	566	719	1,285	462	474	936	20,935	24,336	45,271
55-59	1,759	2,084	3,843	1,444	1,892	3,336	2,688	3,210	5,898	156	233	389	442	518	960	384	381	765	15,100	18,441	33,541
60-64	1,199	1,593	2,792	1,004	1,374	2,378	1,946	2,346	4,292	120	174	294	341	429	770	329	298	627	11,159	14,122	25,281
65+	2,062	2,911	4,973	1,847	2,600	4,447	3,478	4,912	8,390	267	388	655	685	857	1,542	508	581	1,089	21,026	30,595	51,621
Total	**65,143**	**66,998**	**132,141**	**52,216**	**53,716**	**105,932**	**60,465**	**62,524**	**122,989**	**4,017**	**4,070**	**8,087**	**12,247**	**12,744**	**24,991**	**14,981**	**14,687**	**29,668**	**408,016**	**423,074**	**831,090**
Average Age	**26**	**28**	**27**	**27**	**29**	**28**	**32**	**34**	**33**	**33**	**36**	**35**	**30**	**32**	**31**	**25**	**26**	**26**	**30**	**32**	**31**

FIGURE 2.6

Annual Population Growth, Canadian Population and Eligible Client Population
2001 to 2010

From 2001 to 2010, the Canadian population increased by 10.0% while the NIHB eligible First Nations and Inuit client population had an increase of 18.5%. Over the same period, the First Nations and Inuit client population grew at an average annual rate of 2.0% compared to 1.1% for the Canadian population. These trends in population growth are expected to continue, primarily as a result of the higher birth rate within First Nations and Inuit populations.

As mentioned in Figure 2.4, the decrease in NIHB Program client population growth in 2007/08 was mainly attributed to the removal of the Labrador Inuit Association (LIA) population in the Atlantic Region who now receive non-insured health benefits through the Nunatsiavut Government. These individuals were no longer eligible for the NIHB Program and were therefore removed from the NIHB Program client population along with the resources allocated to Nunatsiavut clients under the self-government agreement.



Source: SVS and Statistics Canada Catalogue No. 91-002-XWE, Quarterly Demographic Statistics

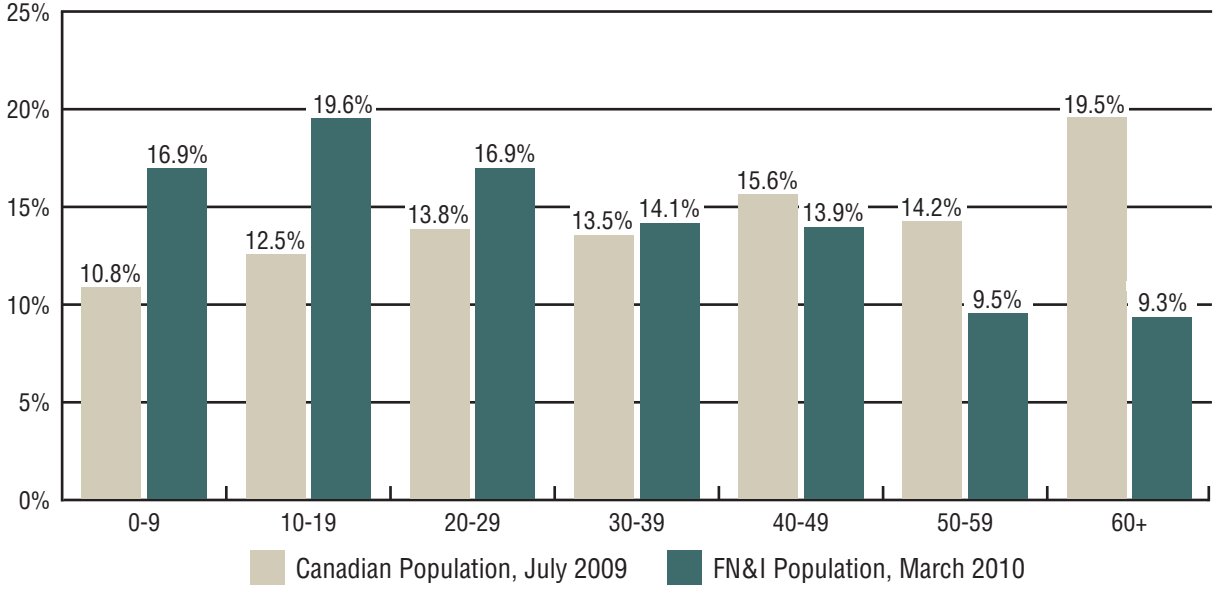
FIGURE 2.7

Population Analysis by Age Group

The overall First Nations and Inuit population is relatively young compared to the general Canadian population. However, due to the aging of this population, it is anticipated that the costs associated with delivering non-insured health benefits, particularly pharmacy benefits, to this client population will increase significantly in the coming years.

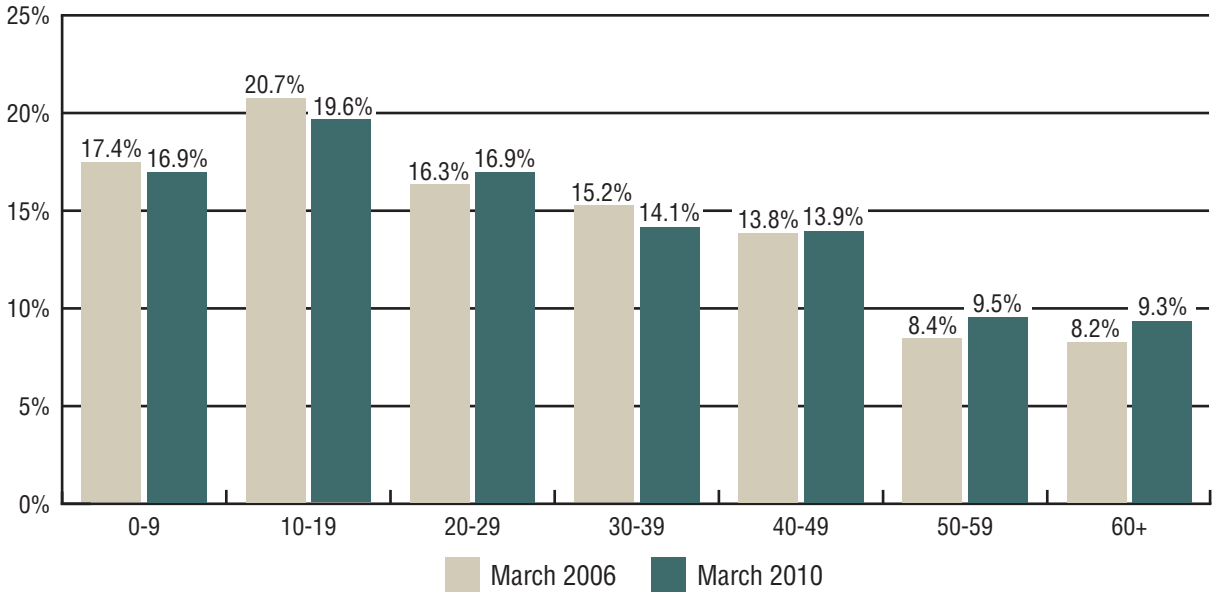
A comparison of March 2006 to March 2010 eligible client population shows an aging population. The client population 40 and above increased by 14.5% from 236,629 in 2006 to 270,844 in 2010. As a proportional share of the overall client population, this group increased from 30.3% in 2006 to 32.6% in 2010.

Proportion of Canadian Population and of the First Nations and Inuit (FN&I) Client Population by Age Group



Source: SVS adapted by Program Analysis Division and Statistics Canada CANSIM table 051-0001, Population by Age and Sex Group

Proportion of Eligible First Nations and Inuit Client Population by Age Group



Source: SVS adapted by Program Analysis Division

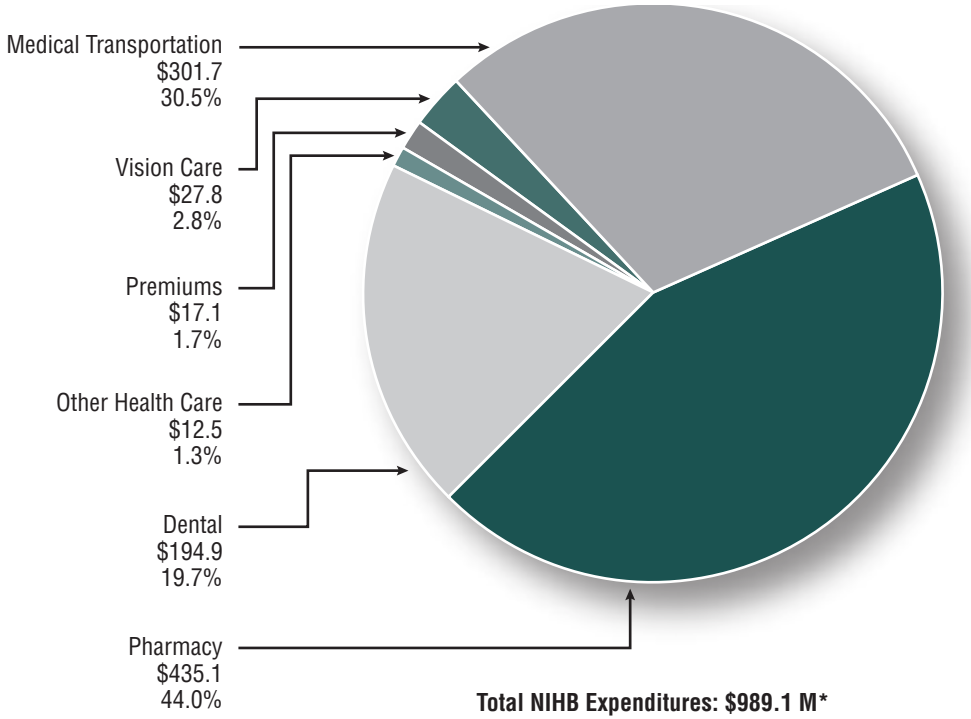
Will Someone Help Me by Shirley Cheechoo

Program Expenditures

FIGURE 3.1

NIHB Expenditures by Benefit ($ Millions)
2009/10

Total Non-Insured Health Benefits expenditures in 2009/10 were $989.1 million. Of this total, NIHB Pharmacy costs (including medical supplies and equipment) represented the largest proportion at $435.1 million (44.0%), followed by NIHB Medical Transportation costs at $301.7 million (30.5%) and NIHB Dental costs at $194.9 million (19.7%).



Source: FIRMS adapted by Program Analysis Division

* *Not reflected in the $989.1 million in NIHB expenditures is approximately $34.9 million in administration costs including Program staff and other headquarters and regional costs. More detail is provided in Figure 10.2.*

FIGURE 3.2

NIHB Expenditures and Growth by Benefit
2008/09 and 2009/10

BENEFIT	Total Expenditures ($ 000's) 2008/09	Total Expenditures ($ 000's) 2009/10	% Change From 2008/09
Medical Transportation	$ 280,446*	$ 301,673	7.6%
Pharmacy	418,968	435,097	3.8%
Dental	176,382*	194,918	10.5%
Other Health Care	11,380*	12,516	10.0%
Premiums	26,430	17,110	-35.3%
Vision Care	26,577*	27,779	4.5%
Total Expenditures	**$ 940,182***	**$ 989,094**	**5.2%**

Source: FIRMS adapted by Program Analysis Division

NIHB expenditures increased 5.2% or $48.9 million from 2008/09 to 2009/10. This increase (5.2%) was slightly higher compared to the 4.7% annual growth increase recorded in 2008/09.

The highest net growth in expenditures over fiscal year 2008/09 was medical transportation benefits at $21.2 million followed by dental benefits which increased by $18.5 million and pharmacy benefits by $16.1 million.

Dental benefits had the highest growth rate in 2009/10, recording a 10.5% increase over the previous year. This is mainly attributed to increases in compensation paid to dental care professionals, improved accessibility to dental benefits and increases in utilization in the North. Other health care benefits, comprised mainly of short-term crisis intervention mental health counselling, followed closely at 10.0%. In 2007/08 and 2008/09, this benefit had a decrease in growth which was partly attributed to funding arrangements allocated for short-term crisis intervention mental health counselling services through the Indian Residential Schools Resolution Health Support Program.

The NIHB Premiums benefit category showed a significant decrease over the previous year at -35.3% ($9.3 million). This decrease is mainly attributed to the NIHB Program no longer covering provincial health premiums in the Alberta Region. The Government of Alberta eliminated Alberta Health Care insurance premiums for all Albertans on January 1, 2009. When costs paid in 2008/09 for the Alberta Region premiums are not taken into consideration, the growth rate for premiums in the British Columbia Region in 2009/10 would have been 3.6%.

* Number from 2008/09 NIHB Annual Report restated here and in subsequent sections. For further information see technical notes in Section 11.

FIGURE 3.3

NIHB Expenditures by Benefit and Region ($ 000's)
2009/10

The Manitoba Region accounted for the highest proportion of total expenditures with $195.4 million, or 19.8% of the national total, followed by the Ontario Region at $175.4 million (17.7%), and the Saskatchewan Region at $141.4 million (14.3%).

By contrast, the lowest expenditures were in the Yukon ($10.1 million) and Northwest Territories ($25.5 million). These totals represented 1.0% and 2.6% respectively of the national total.

Headquarters expenditures in the table represent costs paid for health information and claims processing services and account for 2.8% of NIHB expenditures. Included in these costs is an approximate one time $6.4 million charge in contract costs associated with the development phase of the new claims processor Express Scripts Inc. (ESI) Canada.

REGION	Medical Transportation	Pharmacy	Dental	Other Health Care	Premiums	Vision Care	TOTAL
Atlantic	$ 5,048	$ 21,357	$ 5,426	$ 213	$ –	$ 1,612	**$ 33,656**
Quebec	19,918	37,358	14,159	459	–	1,280	**73,174**
Ontario	51,889	77,564	38,047	2,603	–	5,343	**175,447**
Manitoba	89,078	72,789	26,954	3,143	–	3,407	**195,371**
Saskatchewan	38,971	66,639	30,777	812	–	4,222	**141,420**
Alberta	36,601	56,570	27,756	4,363	–	5,377	**130,666**
British Columbia	25,547	58,862	28,042	924	17,110	3,253	**133,739**
Yukon	3,801	3,723	2,271	1	–	299	**10,095**
N.W.T.	8,520	8,595	7,067	–	–	1,340	**25,521**
Nunavut	22,302	8,237	10,289	–	–	1,646	**42,474**
Headquarters	–	23,403	$4,130	–	–	–	**27,533**
Total	**$ 301,673**	**$ 435,097**	**$ 194,918**	**$ 12,516**	**$ 17,110**	**$ 27,779**	**$ 989,094**

Source: FIRMS adapted by Program Analysis Division

FIGURE 3.4

Proportion of NIHB Expenditures by Region
2009/10

In 2009/10, the Manitoba Region had the highest proportion of total NIHB expenditures (19.8%) and accounted for over one-quarter (29.5%) of total NIHB Medical Transportation expenditures. This reflects the large number of First Nations clients living in remote or fly-in only northern communities in the Manitoba Region.

The Ontario Region, which accounted for 17.7% of total NIHB expenditures in 2009/10, recorded 19.5% of total NIHB Dental expenditures and 17.8% of total NIHB Pharmacy expenditures.

The proportion of NIHB Vision Care expenditures ranged from a high of 19.4% in the Alberta Region and 19.2% in the Ontario Region to a low of 1.1% in the Yukon.

The Alberta Region (34.9%) and the Manitoba Region (25.1%) combined accounted for over one half of the total NIHB Other Health Care expenditures in 2009/10.

On January 1, 2009, the Government of Alberta eliminated Alberta Health Care insurance premiums for all Albertans. Consequently, in 2009/10 the NIHB Program no longer covered health premiums in the Alberta Region.

REGION	Medical Transportation	Pharmacy	Dental	Other Health Care	Premiums	Vision Care	Proportion of NIHB Expenditure	Proportion of NIHB Population
Atlantic	1.7%	4.9%	2.8%	1.7%	0%	5.8%	**3.4%**	**4.2%**
Quebec	6.6%	8.6%	7.3%	3.7%	0%	4.6%	**7.4%**	**7.1%**
Ontario	17.2%	17.8%	19.5%	20.8%	0%	19.2%	**17.7%**	**21.6%**
Manitoba	29.5%	16.7%	13.8%	25.1%	0%	12.3%	**19.8%**	**16.2%**
Saskatchewan	12.9%	15.3%	15.8%	6.5%	0%	15.2%	**14.3%**	**15.9%**
Alberta	12.1%	13.0%	14.2%	34.9%	0%	19.4%	**13.2%**	**12.7%**
British Columbia	8.5%	13.5%	14.4%	7.4%	100%	11.7%	**13.5%**	**14.8%**
Yukon	1.3%	0.9%	1.2%	0%	0%	1.1%	**1.0%**	**1.0%**
N.W.T.	2.8%	2.0%	3.6%	0%	0%	4.8%	**2.6%**	**3.0%**
Nunavut	7.4%	1.9%	5.3%	0%	0%	5.9%	**4.3%**	**3.6%**
Headquarters	0%	5.4%	2.1%	0%	0%	0%	**2.8%**	**N/A**
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: FIRMS and SVS adapted by Program Analysis Division

FIGURE 3.5

Proportion of NIHB Regional Expenditures by Benefit
2009/10

At the national level, almost three-quarters of total Program expenditures occurred in two benefit areas: pharmacy (44.0%) and medical transportation (30.5%). Dental expenditures accounted for one-fifth (19.7%) of total NIHB expenditures.

NIHB Medical Transportation expenditures accounted for 52.5% of total expenditures in Nunavut compared to 15.0% in the Atlantic Region. In the Atlantic Region, 63.5% of total expenditures were spent on pharmacy benefits compared to a low of 19.4% in Nunavut.

The proportion of dental expenditures ranged from 13.8% in the Manitoba Region to 27.7% in the Northwest Territories.

Pharmacy costs represented the highest percentage of total expenditures in all regions except in Nunavut, Yukon and the Manitoba Region, where transportation accounted for the largest share of costs.

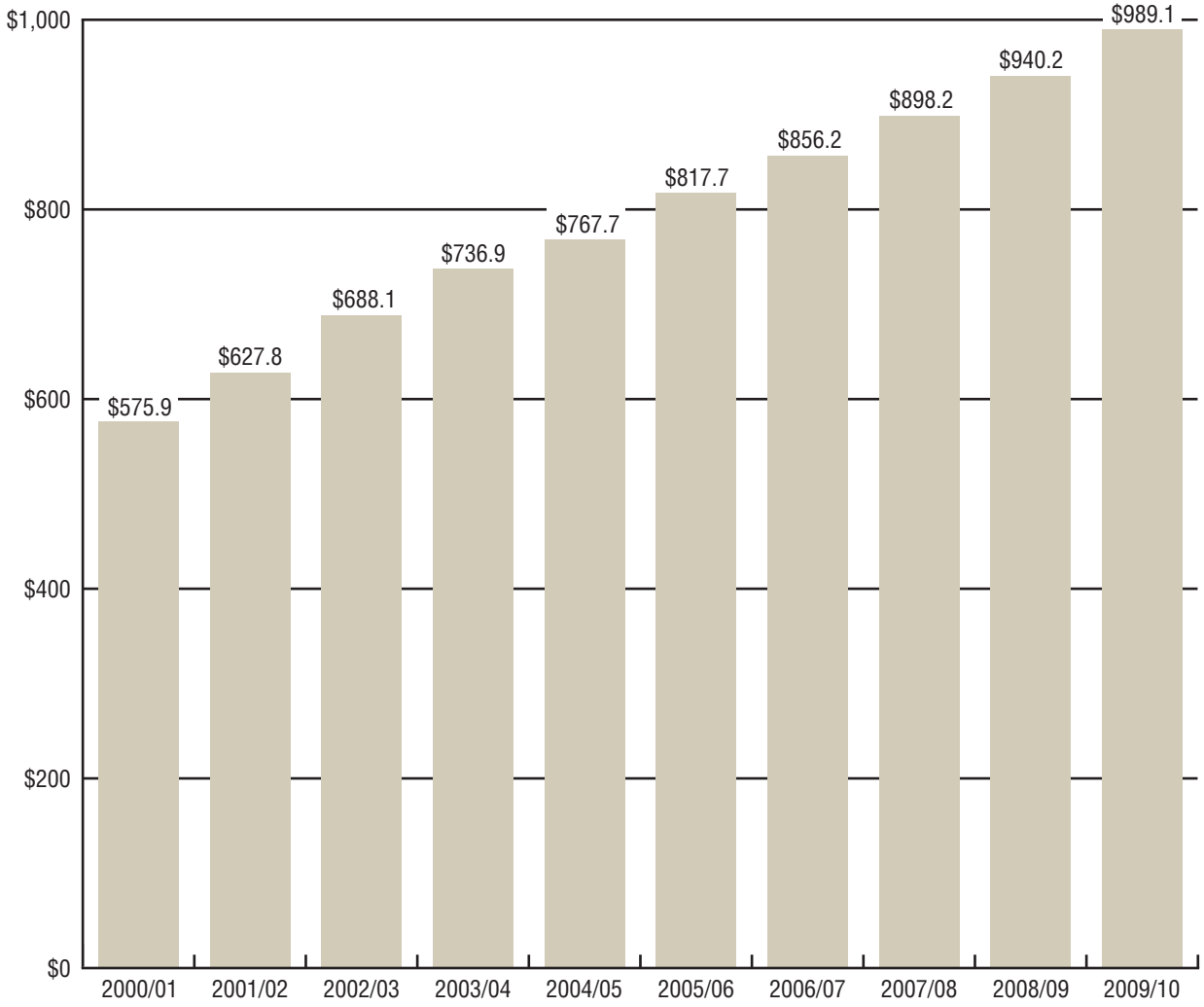
REGION	Medical Transportation	Pharmacy	Dental	Other Health Care	Premiums	Vision Care	TOTAL
Atlantic	15.0%	63.5%	16.1%	0.6%	0%	4.8%	**100%**
Quebec	27.2%	51.1%	19.3%	0.6%	0%	1.7%	**100%**
Ontario	29.6%	44.2%	21.7%	1.5%	0%	3.0%	**100%**
Manitoba	45.6%	37.3%	13.8%	1.6%	0%	1.7%	**100%**
Saskatchewan	27.6%	47.1%	21.8%	0.6%	0%	3.0%	**100%**
Alberta	28.0%	43.3%	21.2%	3.3%	0%	4.1%	**100%**
British Columbia	19.1%	44.0%	21.0%	0.7%	12.8%	2.4%	**100%**
Yukon	37.7%	36.9%	22.5%	0%	0%	3.0%	**100%**
N.W.T.	33.4%	33.7%	27.7%	0%	0%	5.3%	**100%**
Nunavut	52.5%	19.4%	24.2%	0%	0%	3.9%	**100%**
Headquarters	0%	85.0%	15.0%	0%	0%	0%	**100%**
National	**30.5%**	**44.0%**	**19.7%**	**1.3%**	**1.7%**	**2.8%**	**100%**

Source: FIRMS adapted by Program Analysis Division

FIGURE 3.6

NIHB Annual Expenditures ($ Millions)
2000/01 to 2009/10

In 2009/10, NIHB Program expenditures were $989.1 million, up 5.2% from $940.2 million in 2008/09. Since 2000/01, total expenditures have grown by 71.8%. The average annualized growth over this period was 6.1%.



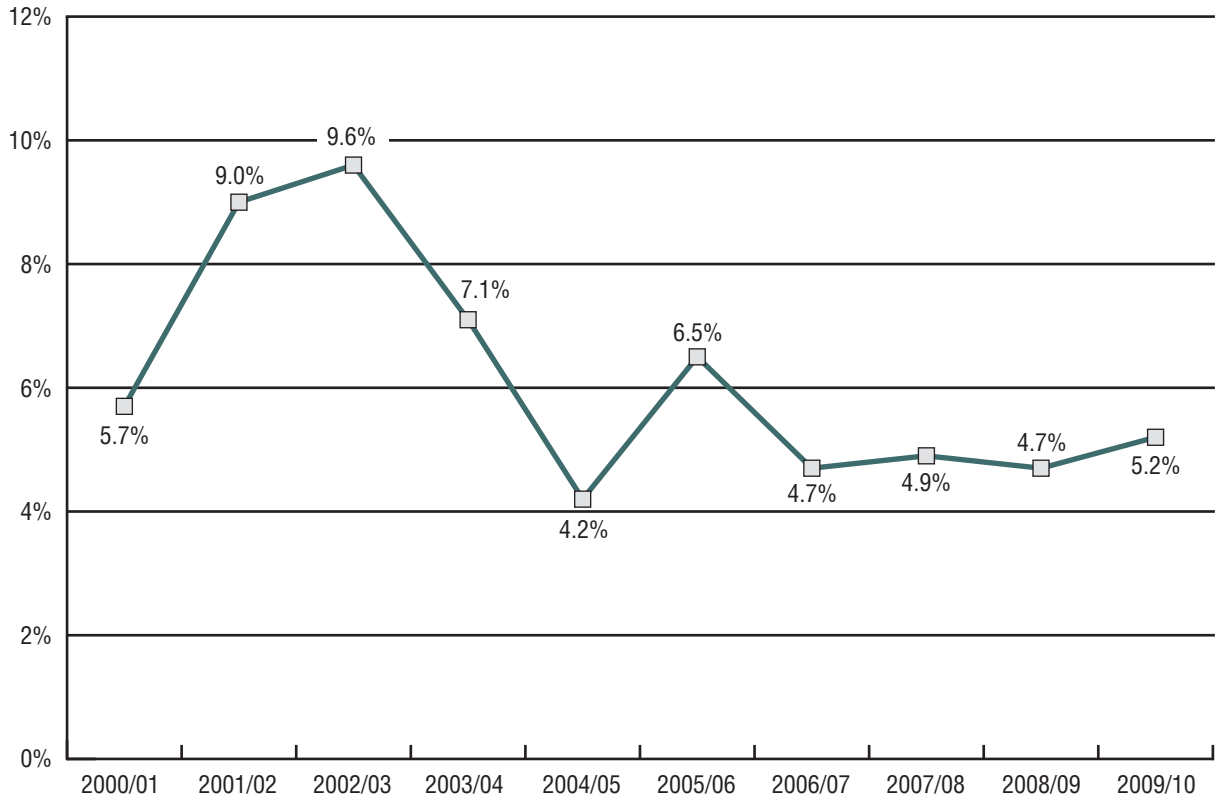
Source: FIRMS adapted by Program Analysis Division

FIGURE 3.7

Percentage Change in NIHB Annual Expenditures
2000/01 to 2009/10

The expenditures for the Non-Insured Health Benefits Program increased by 5.2% to $989.1 million in 2009/10. There has been wide variation in growth rates between 2000/01 and 2009/10, with a low of 4.2% in 2004/05 to a high of 9.6% in 2002/03. However, growth rates have remained relatively stable since 2006/07. The average annualized growth over this period was 6.1%.

There are several factors that contribute to fluctuations in NIHB expenditure growth rates. These include policy changes designed to improve access to the Program and those intended to promote Program sustainability. In addition, the introduction of new therapies and generic drugs to the market, changes to provincial pricing policies, and economic inflationary pressures have also had an impact on the fluctuations of NIHB expenditure growth rates. Variations in the rates of growth have also resulted from self-government initiatives and changes in service delivery models within the Program and between the federal government and the provinces and territories.



Source: FIRMS adapted by Program Analysis Division

FIGURE 3.8

NIHB Annual Expenditures by Benefit ($ 000's)
2000/01 to 2009/10

The expenditures for NIHB Pharmacy benefits have grown more than other benefit areas in the period from 2000/01 to 2009/10. Pharmacy expenditures rose by 90.1% from $228.9 million in 2000/01 to $435.1 million in 2009/10. Over the same period, NIHB Dental expenditures grew by 77.4% and NIHB Medical Transportation expenditures increased by 65.0%. NIHB Vision Care expenditures had an increase of 40.7% over this period.

NIHB Other Health Care expenditures, comprised mainly of short-term crisis intervention mental health counselling, decreased by 25.4% over this same time period from $16.8 million in 2000/01 to $12.5 million in 2009/10. A 10.0% growth rate was recorded in 2009/10. In previous years, this benefit had a decrease in growth which was partly attributed to clients accessing the mental health component of the Indian Residential Schools Resolution Health Support Program.

NIHB Premiums expenditures decreased by 3.8% from $17.8 million in 2000/01 to $17.1 million in 2009/10. On January 1, 2009, the Government of Alberta eliminated Alberta Health Care insurance premiums for all Albertans. Consequently, in 2009/10 the NIHB Program no longer covered health premiums in the Alberta Region. As such, the NIHB Premiums benefit category showed a significant decrease over 2008/09 at -35.3% ($9.3 million).

BENEFIT	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Medical Transportation	$ 182,851	$ 195,719	$ 203,952	$ 205,793	$ 211,527	$ 225,379	$ 241,602	$ 262,294	$ 280,446	$ 301,673
Pharmacy	228,861	252,846	290,112	326,982	343,879	368,398	386,190	403,248	418,968	435,097
Dental	109,852	124,468	131,021	134,504	142,956	153,900	158,584	165,576	176,382	194,918
Other Health Care	16,775	14,135	16,894	16,557	16,904	17,115	16,271	12,289	11,380	12,516
Premiums	17,779	18,596	23,902	28,614	27,830	27,987	28,659	29,211	26,430	17,110
Vision Care	19,748	22,020	22,259	24,420	24,629	24,968	24,894	25,621	26,577	27,779
Total	**$ 575,866**	**$ 627,784**	**$ 688,140**	**$ 736,870**	**$ 767,726**	**$ 817,748**	**$ 856,201**	**$ 898,239**	**$ 940,182**	**$ 989,094**
Annual % Change	**5.7%**	**9.0%**	**9.6%**	**7.1%**	**4.2%**	**6.5%**	**4.7%**	**4.9%**	**4.7%**	**5.2%**

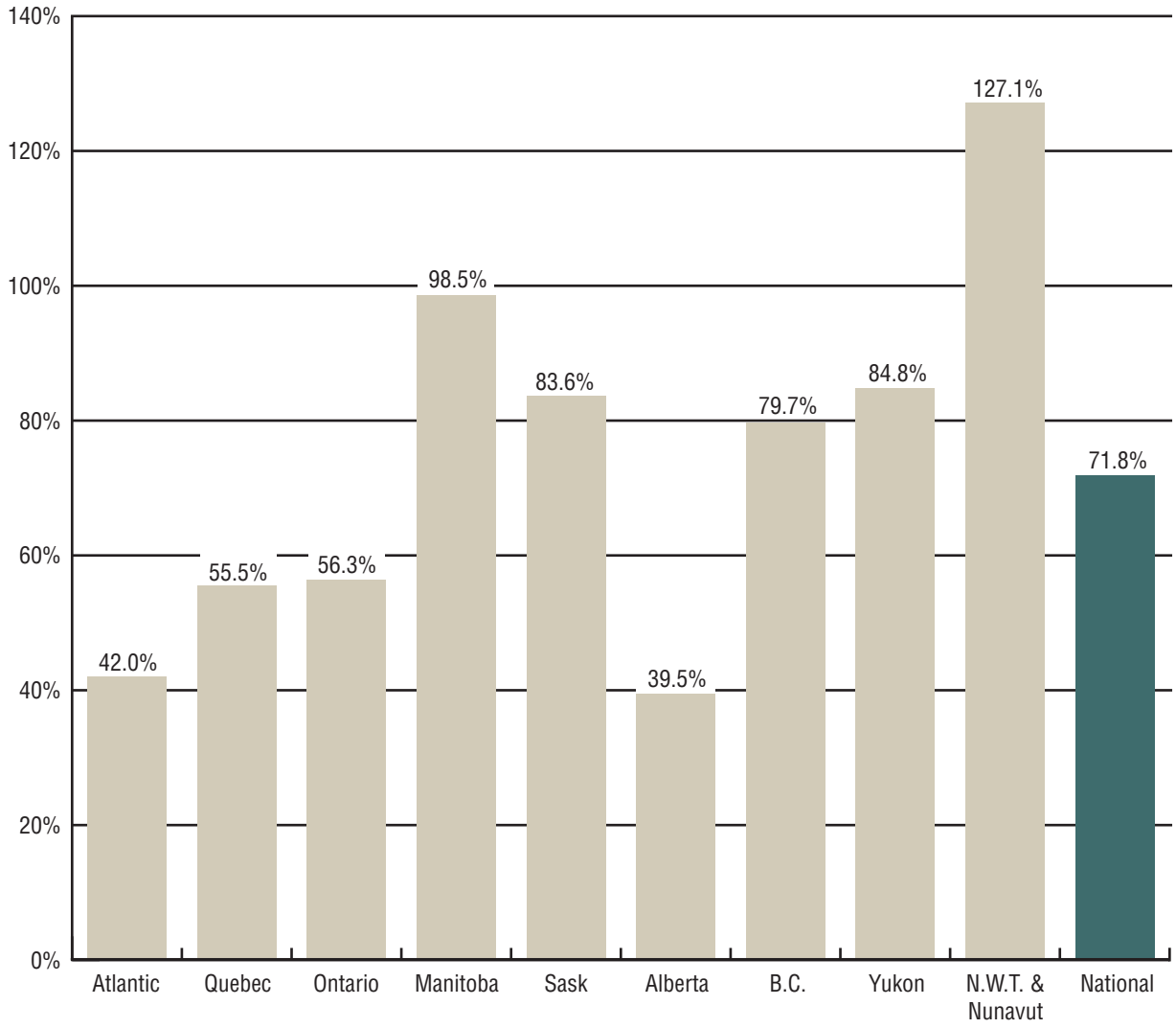
Source: FIRMS adapted by Program Analysis Division

FIGURE 3.9

Percentage Growth in NIHB Expenditures by Region
2000/01 to 2009/10

From 2000/01 to 2009/10, total NIHB expenditures in the combined Northwest Territories and Nunavut increased the most (127.1%) followed by the Manitoba Region with a rate of growth of 98.5%. The Yukon (84.8%) and the Saskatchewan Region (83.6%) showed the next highest rates of growth over this period.

The Alberta Region had the lowest increase at 39.5%. This is mainly attributed to the NIHB Program no longer covering for health premiums in the Alberta Region as of January 1, 2009. The growth rate for this region over this period excluding premiums is 53.7%. The Atlantic Region followed with a rate of growth of 42.0% over this period. This low rate of growth can be attributed primarily to the movement towards self-government for Nunatsiavut Inuit that commenced in December of 2005. This transition process has resulted in a transfer of funding previously identified for Atlantic Region clients to the Nunatsiavut Government.



Source: FIRMS adapted by Program Analysis Division

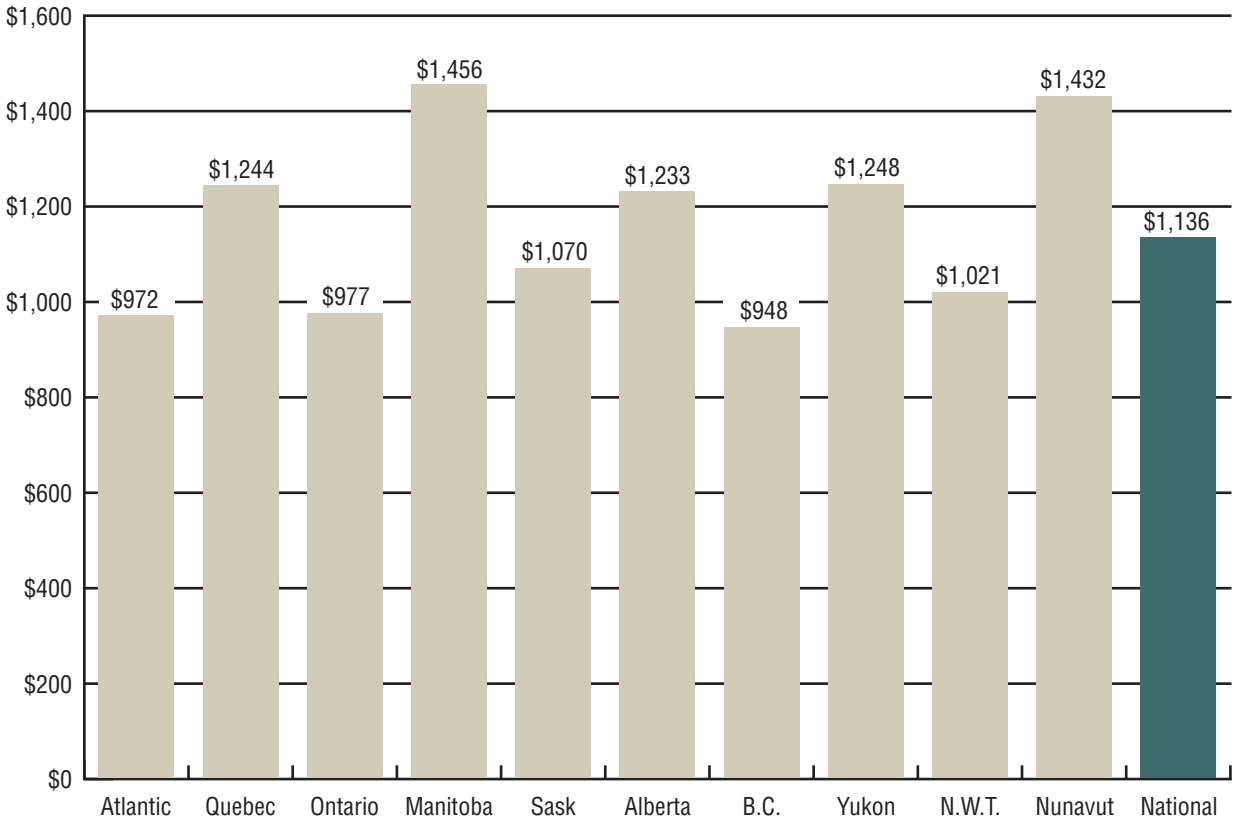
FIGURE 3.10

Per Capita NIHB Expenditures by Region (Excluding Premiums)
2009/10

The national per capita expenditure for all benefits in 2009/10 was $1,136. This is a slight increase from the 2008/09 national per capita expenditure of $1,088*.

The Manitoba Region had the highest per capita cost at $1,456 in 2009/10 which is partly attributable to high medical transportation costs because of the large number of First Nations clients living in remote or fly-in only northern communities. Nunavut ranks second in per capita expenditures at $1,432 followed by the Yukon at $1,248 and the Quebec Region at $1,244.

If premiums that were paid by the Program were included in these calculations, per capita costs in the British Columbia Region would be $1,087, with the national total adjusted to $1,157.



Source: FIRMS and SVS adapted by Program Analysis Division

* The national per capita expenditure from the 2008/09 NIHB Annual Report has been adjusted to account for the restated 2008/09 overall total expenditure. For further information see technical notes in Section 11.

Girl Hoop Dancer by Daphne Odjig

NIHB Pharmacy Expenditure and Utilization Data

The NIHB Program covers claims for pharmacy benefits not covered by private, public or provincial/territorial health care plans. In fiscal year 2009/10, NIHB Pharmacy benefits totalled $435.1 million or 44.0% of total NIHB expenditures.

The objective of the drug benefit program is to provide eligible clients with access to pharmacy services that will:

- Contribute to optimal health outcomes in a fair, equitable and cost-effective manner, recognizing the unique health needs of First Nations and Inuit clients; and
- Provide drug benefits and services based on professional judgment, consistent with the current best practices of health services delivery and evidence-based standards of care.

The NIHB Program covers prescription drugs listed on the Non-Insured Health Benefits Drug Benefit List and approved over-the-counter medications. NIHB policy is to pay the 'lowest cost alternative drug', and to reimburse only the best price alternative or equivalent product in a group of interchangeable drug products.

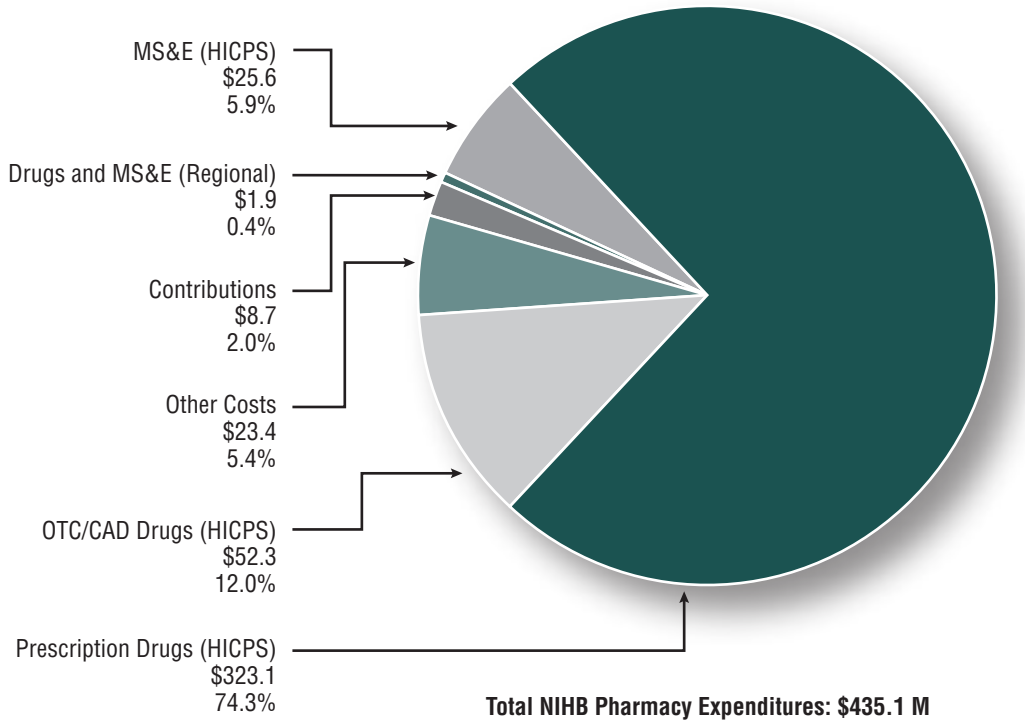
In addition, the Program monitors professional fees closely to find the right balance between providing reasonable compensation to providers and maximizing the funding available for client benefits. Consequently, in 2008/09 the NIHB Program introduced the new Short-Term Dispensing Policy. This policy establishes compensation criteria for short-term refills of chronic use medications, and was implemented to address the significant increases in the frequency of the short-term dispensing of chronic medications that the Program has experienced in recent years. It is estimated that the implementation of this policy has resulted in an estimated saving of approximately $5 million for the Program in 2009/10 and will account for continued cost avoidance in the future.

Like prescription and over-the-counter medications, medical supplies and equipment benefits are covered in accordance with Program policies. Recipients must obtain a prescription from a physician or nurse practitioner for medical supplies and equipment items, and have the prescription filled at an approved provider. Items covered in this category of benefit include:

- Audiology items, such as hearing aids;
- Medical equipment including wheelchairs and walkers;
- Medical supplies, such as bandages and dressings;
- Orthotics and custom footwear;
- Pressure garments;
- Prosthetics;
- Oxygen supplies and equipment; and
- Respiratory supplies and equipment.

FIGURE 4.1

Distribution of NIHB Pharmacy Expenditures ($ Millions)
2009/10



Source: FIRMS adapted by Program Analysis Division

In fiscal year 2009/10, NIHB Pharmacy benefits totalled $435.1 million. Figure 4.1 illustrates the components of pharmacy expenditures under the NIHB Program. The cost of prescription drugs paid through the Health Information and Claims Processing Services (HICPS) system was the largest component, accounting for $323.1 million or 74.3% of all NIHB Pharmacy expenditures, followed by over-the-counter (OTC) drugs and controlled access drugs (CAD) (paid through HICPS) which totalled $52.3 million or 12.0%. Medical supplies and equipment items (MS&E) paid through HICPS was the third largest component in the pharmacy benefit at $25.6 million or 5.9%. In total, the three components managed through automated claims processing accounted for 92.2% of all pharmacy costs.

Drugs and MS&E (Regional), at $1.9 million or 0.4%, refers to regionally managed prescription drugs and OTC medication. This category also includes medical supplies and equipment items paid through Health Canada regional offices.

Contributions, which accounted for $8.7 million or 2.0% of total pharmacy costs, are used to fund the provision of pharmacy benefits through agreements such as those with the Mohawk Council of Akwesasne in Ontario and the Bigstone Cree Nation in Alberta.

Other costs totalled $23.4 million or 5.4% in 2009/10. Included in this total are Headquarters expenditures which represent costs related to automated claims payment.

FIGURE 4.2

Total NIHB Pharmacy Expenditures by Type and Region ($ 000's)
2009/10

Prescription drug costs claimed electronically and paid through the Health Information and Claims Processing Services (HICPS) system represented the largest component of total costs accounting for $323.1 million or 74.3% of all NIHB Pharmacy costs. The Ontario Region (18.6%) and the Manitoba Region (18.1%) had the largest proportions of these costs in 2009/10.

The next highest component was over-the-counter and controlled access drug costs at $52.3 million or 12.0%. The Ontario Region (21.2%), Manitoba Region (19.3%) and the Saskatchewan Region (18.2%) had the largest proportions of these costs in 2009/10.

The third highest component was the combined medical supplies and equipment (MS&E) category at $25.6 million (5.9%). The Saskatchewan Region (18.0%) and the Alberta Region (17.9%) had the highest proportions of MS&E costs in 2009/10.

REGION	OPERATING						Total Operating Costs	Total Contribution Costs	TOTAL COSTS
	Prescription Drugs	OTC/CAD Drugs	Drugs/ MS&E Regional	Medical Supplies	Medical Equipment	Other Costs			
Atlantic	$ 16,660	$ 2,927	$ 27	$ 466	$ 848	$ –	$ 20,928	$ 429	**$ 21,357**
Quebec	30,919	5,410	23	363	632	–	37,348	10	**37,358**
Ontario	60,095	11,070	41	964	2,758	–	74,928	2,637	**77,564**
Manitoba	58,345	10,074	2	1,487	2,882	–	72,789	0	**72,789**
Saskatchewan	51,274	9,521	1,195	1,667	2,942	–	66,599	40	**66,639**
Alberta	40,865	5,846	174	1,551	3,034	–	51,469	5,100	**56,570**
British Columbia	48,709	5,405	56	1,063	3,189	–	58,422	441	**58,862**
Yukon	3,058	320	29	81	234	–	3,723	0	**3,723**
N.W.T.	6,756	856	52	354	510	–	8,528	67	**8,595**
Nunavut	6,454	873	304	293	313	–	8,237	0	**8,237**
Headquarters	–	–	–	–	–	23,403	23,403	–	**23,403**
Total	**$ 323,135**	**$ 52,301**	**$ 1,903**	**$ 8,289**	**$ 17,342**	**$ 23,403**	**$ 426,374**	**$ 8,723**	**$ 435,097**

Source: FIRMS adapted by Program Analysis Division

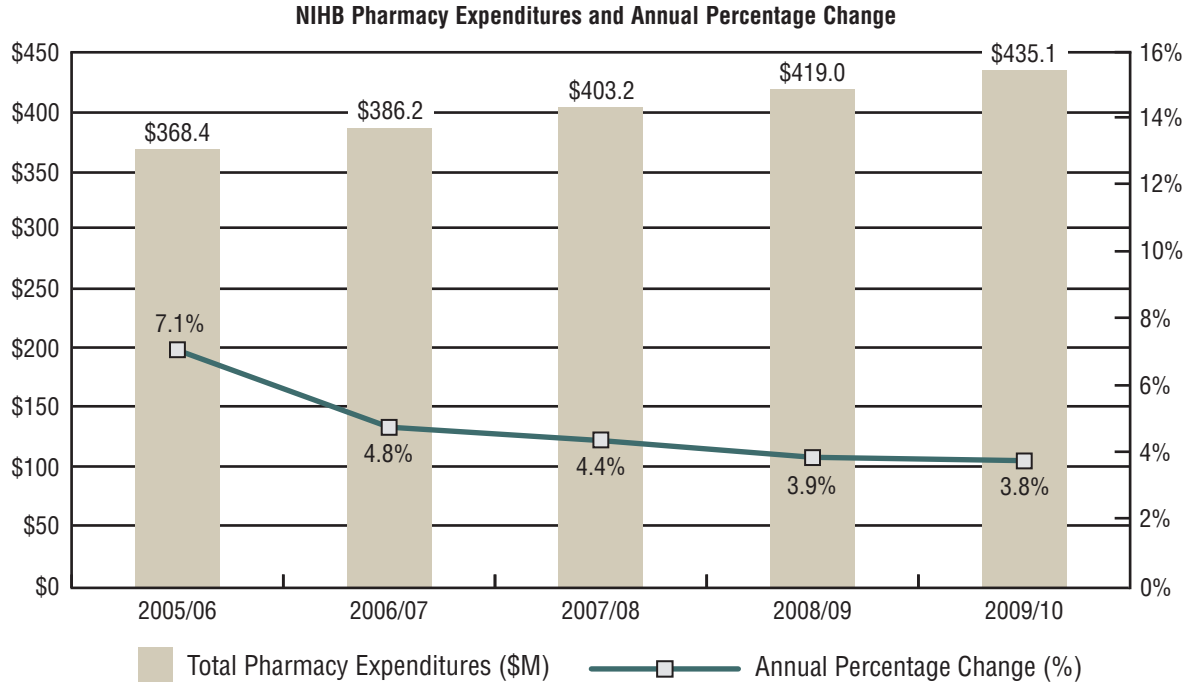
FIGURE 4.3

Annual NIHB Pharmacy Expenditures
2005/06 to 2009/10

NIHB Pharmacy expenditures increased by 3.8% during fiscal year 2009/10. This represents a 0.1 percentage point decrease over the previous year's growth rate. Over the past five years, growth in pharmacy expenditures has ranged from a high of 7.1% in 2005/06 to a low of 3.8% in 2009/10. The annualized growth rate over these five years is 4.8%.

Over the past five years there has been movement towards increased stability in NIHB Pharmacy expenditures. Reasons for this trend include the introduction of lower cost generic drugs as they become available on the market, optimizing drug utilization, and policy changes designed to promote NIHB Program sustainability such as the implementation of the Short-Term Dispensing Policy in 2008/09.

The highest rate of growth in NIHB Pharmacy expenditures in 2009/10 took place in Nunavut, which increased by 16.3% over the previous fiscal year. The Atlantic Region had the second highest growth rate at 6.2%, followed closely by the Saskatchewan Region at 6.1%.



Source: FIRMS adapted by Program Analysis Division

NIHB Pharmacy Expenditures ($ 000's)					
REGION	2005/06	2006/07	2007/08	2008/09	2009/10
Atlantic	$ 18,293	$ 18,938	$ 18,984	$ 20,119	$ 21,357
Quebec	31,771	33,486	35,372	36,069	37,358
Ontario	73,223	77,788	77,191	77,244	77,564
Manitoba	59,409	64,966	69,317	71,081	72,789
Saskatchewan	55,687	58,083	60,749	62,809	66,639
Alberta	51,141	52,424	54,353	54,189	56,570
British Columbia	49,734	50,387	54,290	56,104	58,862
Yukon	3,655	3,641	3,802	3,779	3,723
N.W.T.	8,010	8,151	7,863	8,210	8,595
Nunavut	4,902	5,526	6,579	7,084	8,237
Headquarters	12,574	12,800	14,750	22,281	23,403
Total	**$ 368,398**	**$ 386,190**	**$ 403,248**	**$ 418,968**	**$ 435,097**

Source: FIRMS adapted by Program Analysis Division

FIGURE 4.4

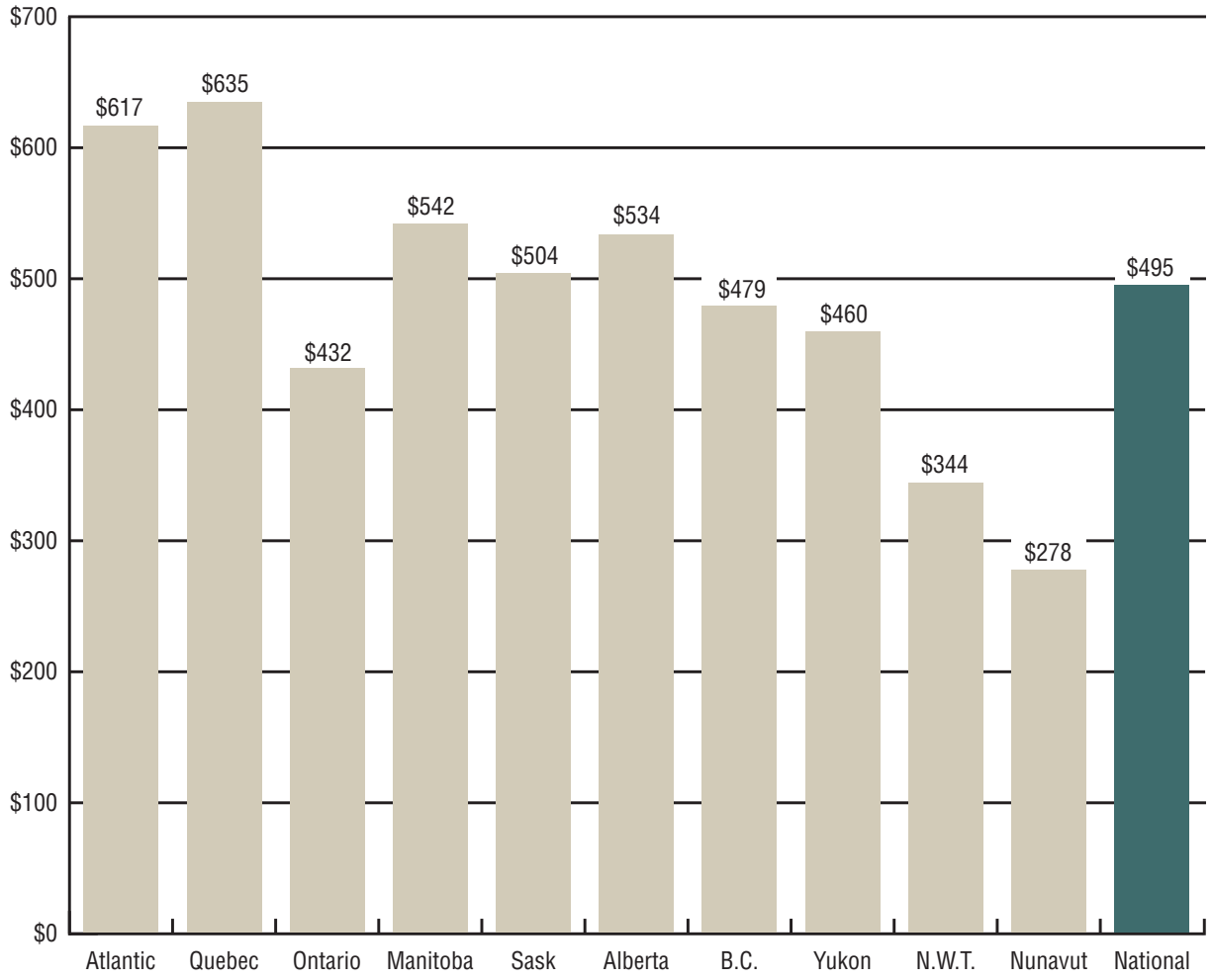
Per Capita NIHB Pharmacy Expenditures by Region
2009/10

In 2009/10, the national per capita expenditure for NIHB Pharmacy benefits was $495. This was an increase of 1.9% from the $486 recorded in 2008/09.

The Quebec Region had the highest per capita NIHB Pharmacy expenditure at $635, followed by the Atlantic Region at $617 and the Manitoba Region at $542.

The highest increases in per capita costs were in Nunavut ($35) and the Atlantic Region ($28). However, Nunavut continued to have the lowest per capita expenditure at $278.

A relatively low per capita expenditure in the Northwest Territories and Nunavut is attributed to lower than average utilization rates and also a younger population utilizing lower cost medications. (Refer to Figure 4.6)



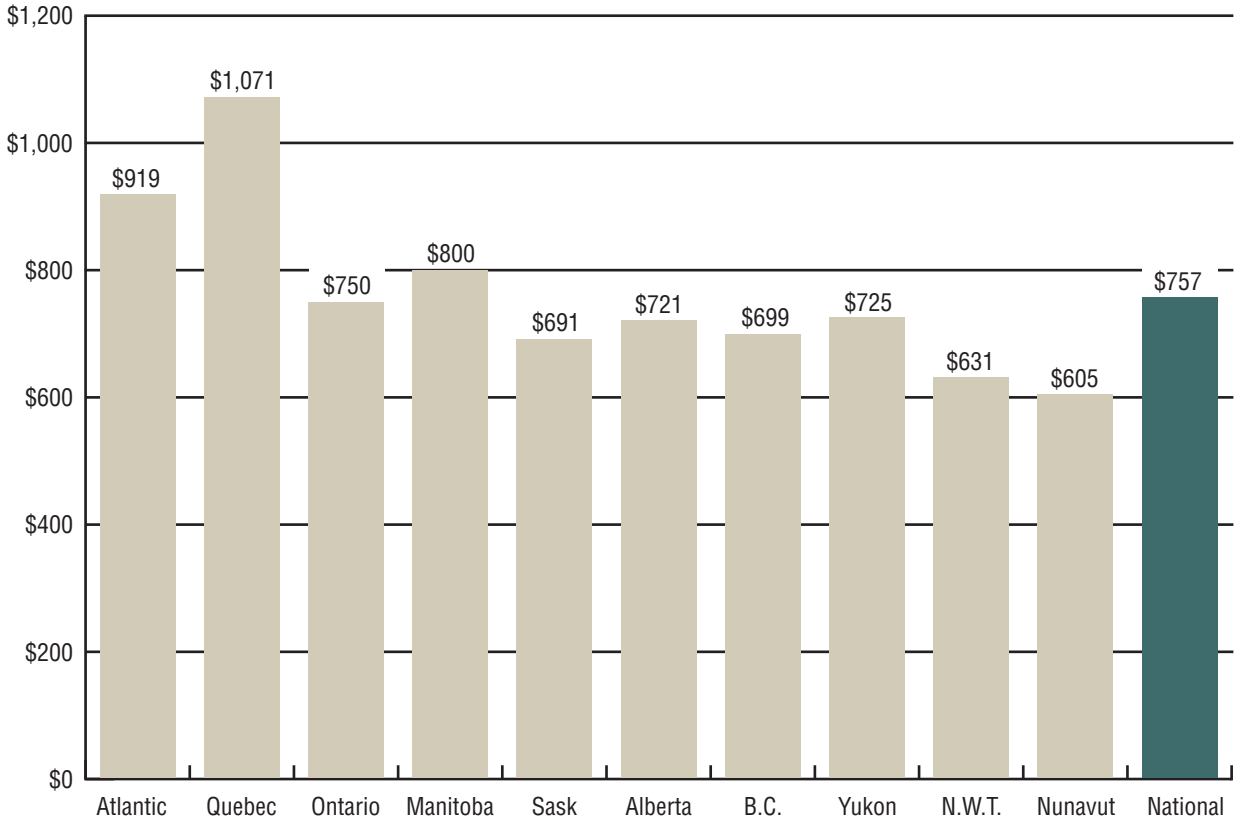
Source: FIRMS and SVS adapted by Program Analysis Division

FIGURE 4.5

NIHB Pharmacy Operating Expenditures per Claimant by Region
2009/10

In 2009/10, the national average expenditure per eligible client receiving at least one pharmacy benefit was $757, an increase of 1.6% over the recorded amount of $745 in 2008/09.

The Quebec Region had the highest average NIHB Pharmacy expenditure per claimant at $1,071, followed by the Atlantic Region at $919 and the Manitoba Region at $800. Nunavut had the lowest expenditure per claimant at $605, followed by the Northwest Territories at $631.



Source: HICPS and FIRMS adapted by Program Analysis Division

QUICK FACT

An analysis of NIHB Pharmacy expenditures by claimant, based on age, indicates that costs increase with age. In early childhood, these expenditures are quite low but they increase with age and reach a peak in the older age groupings. In 2009/10, a claimant between the ages of 0 and 4 years of age incurred approximately $161 in expenditures on average, while claimants 65 years of age and older had the highest costs at approximately $2,094 per claimant. The highest costs were observed among claimants aged 60-64 years with average expenditures of $2,117.

FIGURE 4.6

NIHB Pharmacy Utilization Rates by Region
2005/06 to 2009/10

	Pharmacy Utilization				
REGION	2005/06	2006/07	2007/08	2008/09	2009/10
Atlantic	59%	58%	66%	66%	66%
Quebec	60%	60%	59%	60%	59%
Ontario	56%	56%	56%	55%	56%
Manitoba	69%	69%	68%	68%	68%
Saskatchewan	76%	74%	74%	73%	73%
Alberta	70%	68%	68%	67%	67%
British Columbia	70%	69%	68%	68%	68%
Yukon	65%	65%	64%	64%	64%
N.W.T.	52%	53%	53%	53%	54%
Nunavut	42%	43%	41%	44%	46%
National	**65%**	**64%**	**64%**	**64%**	**64%**

Source: HICPS and SVS adapted by Program Analysis Division

Utilization rates represent those clients who received at least one pharmacy benefit paid through the Health Information and Claims Processing Services (HICPS) system in the fiscal year as a proportion of the total number of clients eligible to receive benefits as registered on the Status Verification System (SVS) in that year.

In 2009/10, the national utilization rate was 64% for NIHB Pharmacy benefits paid through the HICPS system. National NIHB Pharmacy utilization rates have remained stable over the past five years.

Pharmacy utilization rates vary across the regions. In 2009/10, regional rates ranged from 46% in Nunavut to 73% in the Saskatchewan Region.

The rates understate the actual level of service as the data do not include pharmacy services provided through contribution agreements and benefits provided through community health facilities. For example, if the Bigstone Cree Nation client population were excluded from the Alberta Region's population because the HICPS data do not capture any services used by this population, the utilization rate for pharmacy benefits in Alberta would have been 72% in 2009/10. The same scenario would apply for the Ontario Region. If the Akwesasne client population were removed from the Ontario Region's population, the utilization rate for pharmacy benefits would have been 59%. If both the Bigstone and Akwesasne client population were removed from the overall NIHB population, the national utilization rate for pharmacy benefits would have been 65%.

The increased utilization rate recorded in the Atlantic Region after 2006/07 can be attributed to the removal of the Nunatsiavut clients who transitioned to self-government and were no longer eligible to receive coverage for pharmacy benefits under the NIHB Program.

FIGURE 4.7

NIHB Pharmacy Claimants by Age Group, Gender and Region
2009/10

Of the 831,090 clients eligible to receive benefits under the NIHB Program, 532,097 (64%) claimants received at least one pharmacy item paid through the Health Information and Claims Processing Services (HICPS) system in 2009/10.

Of this total, 299,140 were female (56%) and 232,957 were male (44%). This compares to the total eligible population where 51% were female and 49% were male.

The average age of pharmacy claimants was 32 years. The average age for male and female claimants was 31 and 33 years of age, respectively. The highest average age of pharmacy claimants was found in the Yukon (37 years of age), while the lowest was in the Saskatchewan Region (28 years of age).

Approximately one-third of pharmacy claimants were under 20 years of age. Thirty-six percent of male claimants were in this age group while females accounted for 31%. Seniors (age 65 and over) represented approximately 6% of all pharmacy claimants in 2009/10.

REGION	Atlantic			Quebec			Ontario			Manitoba		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	966	929	1,895	1,236	1,096	2,332	2,822	2,627	5,449	5,039	4,896	9,935
5-9	906	913	1,819	1,012	930	1,942	3,038	2,915	5,953	4,076	4,145	8,221
10-14	877	981	1,858	983	1,113	2,096	3,061	3,289	6,350	3,643	3,926	7,569
15-19	891	1,214	2,105	1,060	1,793	2,853	3,293	4,921	8,214	3,483	5,284	8,767
20-24	735	1,083	1,818	926	1,678	2,604	3,127	4,837	7,964	3,175	4,683	7,858
25-29	712	1,060	1,772	928	1,479	2,407	3,024	4,776	7,800	2,924	4,066	6,990
30-34	707	937	1,644	944	1,441	2,385	3,056	4,398	7,454	2,795	3,788	6,583
35-39	832	954	1,786	1,080	1,511	2,591	3,436	4,447	7,883	2,997	3,967	6,964
40-44	768	997	1,765	1,160	1,614	2,774	3,677	4,741	8,418	3,044	3,709	6,753
45-49	716	902	1,618	1,230	1,602	2,832	3,688	4,793	8,481	2,763	3,402	6,165
50-54	629	837	1,466	1,073	1,539	2,612	3,221	4,209	7,430	2,117	2,634	4,751
55-59	469	655	1,124	864	1,168	2,032	2,493	3,266	5,759	1,543	1,995	3,538
60-64	335	466	801	740	1,023	1,763	1,940	2,620	4,560	1,193	1,480	2,673
65+	494	799	1,293	1,394	2,267	3,661	3,175	5,042	8,217	1,740	2,485	4,225
Total	**10,037**	**12,727**	**22,764**	**14,630**	**20,254**	**34,884**	**43,051**	**56,881**	**99,932**	**40,532**	**50,460**	**90,992**
Average Age	**31**	**33**	**32**	**35**	**38**	**36**	**35**	**37**	**36**	**29**	**30**	**29**

Source: HICPS adapted by Program Analysis Division

REGION	Saskatchewan			Alberta			British Columbia			Yukon			N.W.T.			Nunavut			TOTAL		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	5,360	5,283	10,643	3,733	3,658	7,391	3,114	2,981	6,095	99	97	196	424	388	812	748	682	1,430	23,541	22,637	46,178
5-9	4,696	4,888	9,584	3,369	3,314	6,683	2,793	2,812	5,605	132	123	255	358	392	750	491	447	938	20,871	20,879	41,750
10-14	4,099	4,705	8,804	3,125	3,213	6,338	2,640	2,857	5,497	126	140	266	392	435	827	422	457	879	19,368	21,116	40,484
15-19	4,166	5,836	10,002	3,081	4,130	7,211	3,057	4,260	7,317	173	247	420	499	812	1,311	461	939	1,400	20,164	29,436	49,600
20-24	3,680	5,509	9,189	2,725	3,945	6,670	2,918	4,283	7,201	145	264	409	434	803	1,237	447	1,037	1,484	18,312	28,122	46,434
25-29	3,258	4,515	7,773	2,538	3,544	6,082	2,830	3,847	6,677	171	265	436	386	765	1,151	374	829	1,203	17,145	25,146	42,291
30-34	2,981	4,054	7,035	2,370	2,960	5,330	2,653	3,587	6,240	166	206	372	357	643	1,000	362	668	1,030	16,391	22,682	39,073
35-39	3,053	3,982	7,035	2,266	2,905	5,171	2,802	3,613	6,415	226	233	459	448	677	1,125	401	609	1,010	17,541	22,898	40,439
40-44	2,953	3,772	6,725	2,233	2,692	4,925	2,944	3,758	6,702	212	252	464	464	679	1,143	397	634	1,031	17,852	22,848	40,700
45-49	2,547	3,245	5,792	1,979	2,578	4,557	3,063	4,016	7,079	221	292	513	392	658	1,050	341	491	832	16,940	21,979	38,919
50-54	1,911	2,475	4,386	1,466	1,986	3,452	2,457	3,207	5,664	136	202	338	331	511	842	238	360	598	13,579	17,960	31,539
55-59	1,350	1,761	3,111	1,048	1,452	2,500	1,877	2,373	4,250	98	192	290	284	361	645	234	268	502	10,260	13,491	23,751
60-64	994	1,307	2,301	763	1,074	1,837	1,390	1,780	3,170	92	144	236	230	302	532	218	246	464	7,895	10,442	18,337
65+	1,617	2,324	3,941	1,335	1,858	3,193	2,320	3,349	5,669	190	292	482	462	634	1,096	371	454	825	13,098	19,504	32,602
Total	**42,665**	**53,656**	**96,321**	**32,031**	**39,309**	**71,340**	**36,858**	**46,723**	**83,581**	**2,187**	**2,949**	**5,136**	**5,461**	**8,060**	**13,521**	**5,505**	**8,121**	**13,626**	**232,957**	**299,140**	**532,097**
Average Age	**27**	**29**	**28**	**28**	**30**	**29**	**33**	**34**	**34**	**36**	**38**	**37**	**34**	**35**	**34**	**30**	**31**	**30**	**31**	**33**	**32**

FIGURE 4.8

NIHB Pharmacy Claimants and Non-Claimants by Age Group and Gender
2009/10

Sixty-four percent of all eligible clients received at least one pharmacy benefit paid through the Health Information and Claims Processing Services (HICPS) system in 2009/10. Thirty-six percent of eligible clients did not access the Program through the HICPS system for any pharmacy benefits.

The use of pharmaceutical services and the associated costs varied according to age. More than 50% of eligible clients in each age group received pharmaceutical services or products in 2009/10. The highest utilization rate was observed among eligible clients aged 60 to 64 years, where 73% of eligible clients were claimants. The age group where pharmacy utilization was lowest in 2009/10 was the 10 to 14 age group, where 51% of clients received at least one pharmacy benefit.

Of the 298,993 non-claimants in 2009/10, 175,059 were male (59%) while 123,934 were female (41%). Forty-two percent of all non-claimants were under 20 years of age, while 72% were under 40 years of age.

Age Group	Claimants			Non-Claimants			TOTAL		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	23,541	22,637	46,178	8,944	8,663	17,607	32,485	31,300	**63,785**
	72%	72%	72%	28%	28%	28%	100%	100%	**100%**
5-9	20,871	20,879	41,750	18,187	16,577	34,764	39,058	37,456	**76,514**
	53%	56%	55%	47%	44%	45%	100%	100%	**100%**
10-14	19,368	21,116	40,484	20,978	17,534	38,512	40,346	38,650	**78,996**
	48%	55%	51%	52%	45%	49%	100%	100%	**100%**
15-19	20,164	29,436	49,600	22,635	11,653	34,288	42,799	41,089	**83,888**
	47%	72%	59%	53%	28%	41%	100%	100%	**100%**
20-24	18,312	28,122	46,434	20,047	8,803	28,850	38,359	36,925	**75,284**
	48%	76%	62%	52%	24%	38%	100%	100%	**100%**
25-29	17,145	25,146	42,291	15,641	7,046	22,687	32,786	32,192	**64,978**
	52%	78%	65%	48%	22%	35%	100%	100%	**100%**
30-34	16,391	22,682	39,073	12,844	6,515	19,359	29,235	29,197	**58,432**
	56%	78%	67%	44%	22%	33%	100%	100%	**100%**
35-39	17,541	22,898	40,439	11,391	6,539	17,930	28,932	29,437	**58,369**
	61%	78%	69%	39%	22%	31%	100%	100%	**100%**
40-44	17,852	22,848	40,700	11,110	7,103	18,213	28,962	29,951	**58,913**
	62%	76%	69%	38%	24%	31%	100%	100%	**100%**
45-49	16,940	21,979	38,919	9,894	7,404	17,298	26,834	29,383	**56,217**
	63%	75%	69%	37%	25%	31%	100%	100%	**100%**
50-54	13,579	17,960	31,539	7,356	6,376	13,732	20,935	24,336	**45,271**
	65%	74%	70%	35%	26%	30%	100%	100%	**100%**
55-59	10,260	13,491	23,751	4,840	4,950	9,790	15,100	18,441	**33,541**
	68%	73%	71%	32%	27%	29%	100%	100%	**100%**
60-64	7,895	10,442	18,337	3,264	3,680	6,944	11,159	14,122	**25,281**
	71%	74%	73%	29%	26%	27%	100%	100%	**100%**
65+	13,098	19,504	32,602	7,928	11,091	19,019	21,026	30,595	**51,621**
	62%	64%	63%	38%	36%	37%	100%	100%	**100%**
Total	**232,957**	**299,140**	**532,097**	**175,059**	**123,934**	**298,993**	**408,016**	**423,074**	**831,090**
	57%	**71%**	**64%**	**43%**	**29%**	**36%**	**100%**	**100%**	**100%**

Source: HICPS and SVS adapted by Program Analysis Division

FIGURE 4.9

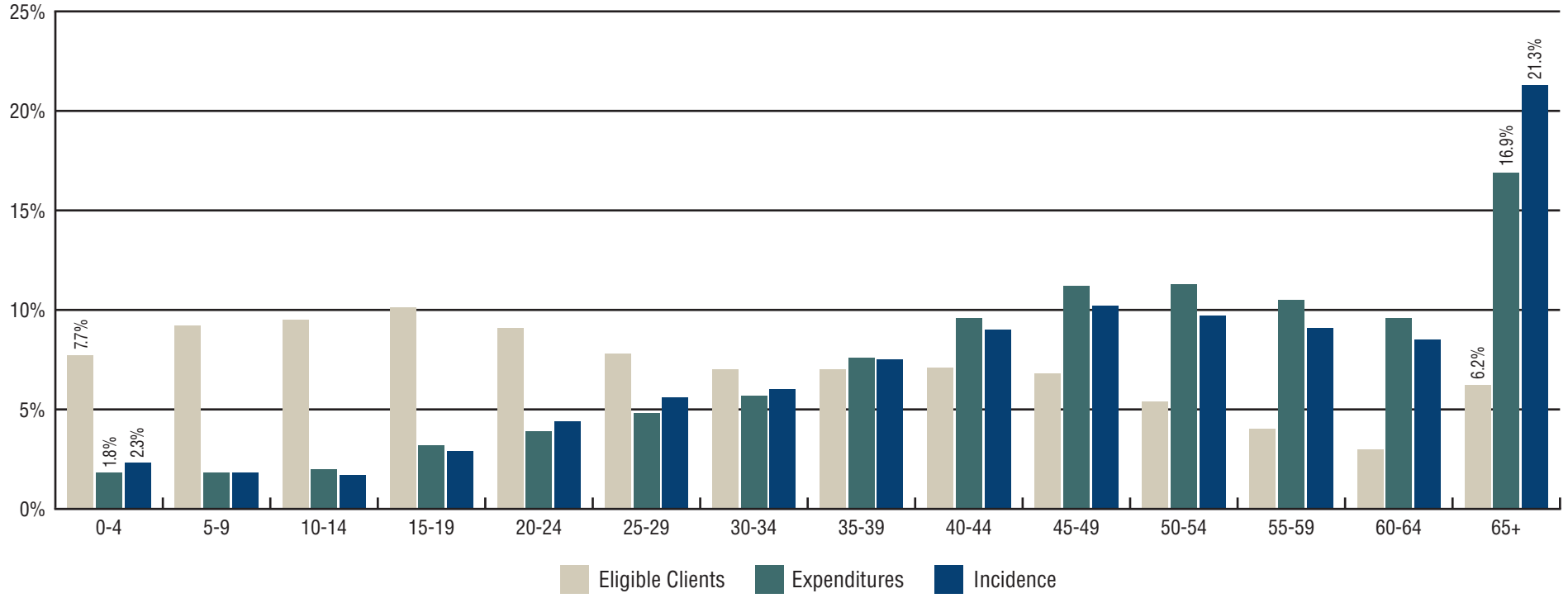
Distribution of Eligible NIHB Population, Pharmacy Expenditures and Pharmacy Incidence by Age Group
2009/10

The utilization rate of NIHB Pharmacy benefits within a given age group is not the primary determinant of expenditures. Rather, it is the frequency of claims* submitted and the cost of medications that act as the principal drivers of NIHB Pharmacy expenditures. In 2009/10, for example, 7.7% of all clients were in the 0 to 4 age group, but this group accounted for only 2.3% of all pharmacy claims made and only 1.8% of total pharmacy expenditures, a slight increase over 2008/09. In contrast, the 65+ age group represented 6.2% of all eligible clients, but accounted for 21.3% of all pharmacy claims submitted and 16.9% of total pharmacy expenditures, a slight decrease over 2008/09.

During fiscal year 2009/10, the average claimant aged 65 or more submitted 84 claims versus 59 claims for their counterpart in the 60 to 64 age group and 6 claims for the average claimant in the 0 to 4 age group.

QUICK FACT

An examination of pharmacy services utilization rates by NIHB claimants indicates that these rates vary according to age. Pharmacy benefit use is highest in early childhood and among those 60 to 64 years of age. In 2009/10, 72.4% of children aged 0 to 4 years received pharmaceutical services. A reduction occurs between the ages of 5 and 14 with an upward trend resuming around the age of 15. Claimants aged 60 to 64 years also had the highest utilization rate at 72.5%.



Source: HICPS and SVS adapted by Program Analysis Division

* Claims are not equal to prescriptions as a prescription can comprise a number of claim lines. For further clarification see section 9.1.1.

FIGURE 4.10

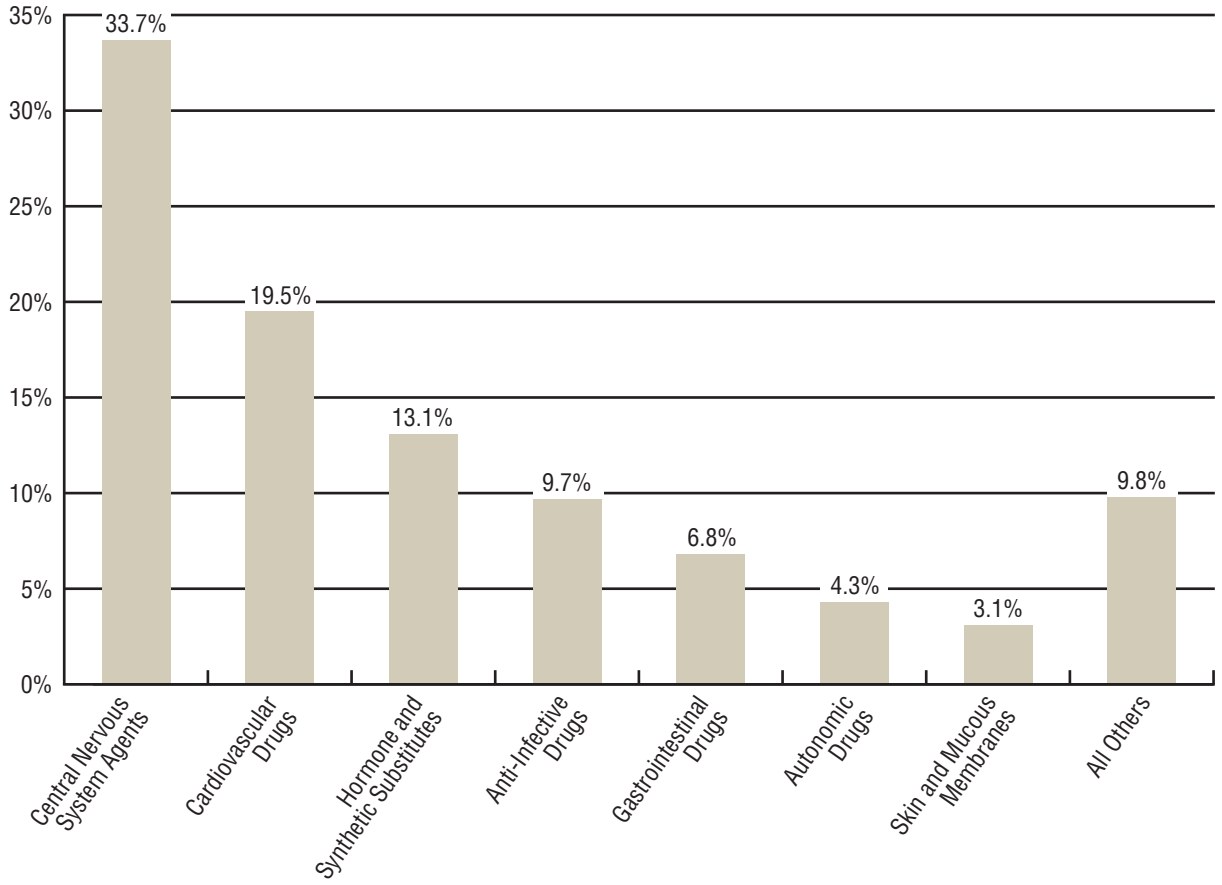
NIHB Prescription Drug Utilization by Pharmacologic Therapeutic Class and Incidence
2009/10

Figure 4.10 demonstrates variation in utilization by therapeutic classification for prescription drugs.

Central Nervous System Agents, which include drug classes such as analgesics and sedatives, accounted for approximately one third (33.7%) of all prescription drug claims. This therapeutic class had an increase of 0.8 percentage points from the 32.9% recorded in 2008/09.

Cardiovascular Drugs had the next highest share of prescription drug claims at 19.5% followed by Hormones, which consist primarily of oral contraceptives and insulin, at 13.1%.

Variation in the utilization of these therapeutic classes was minimal compared to 2008/09.



Source: HICPS adapted by Program Analysis Division

FIGURE 4.11

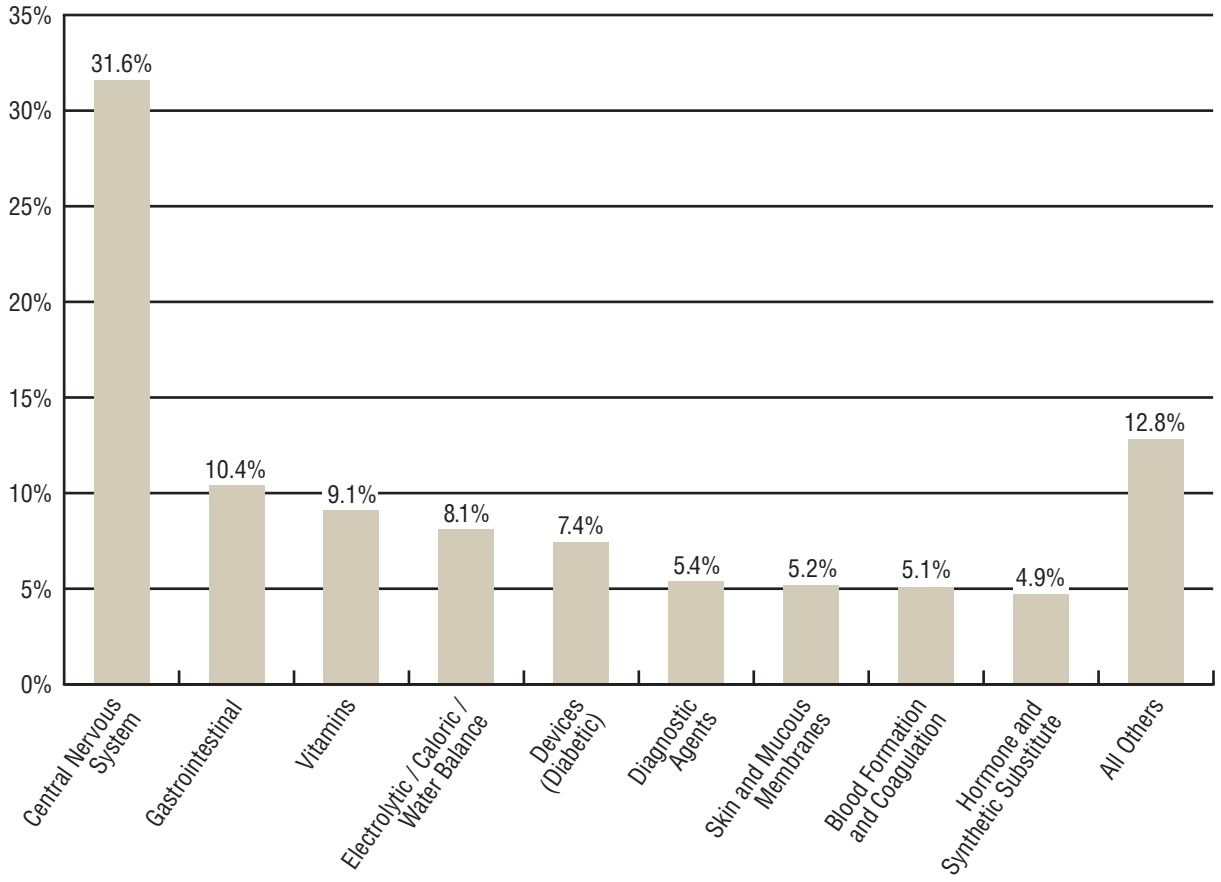
NIHB Over-the-Counter Drugs (Including Controlled Access Drugs – CAD) by Pharmacologic Therapeutic Class and Claims Incidence
2009/10

Figure 4.11 demonstrates variation in utilization by therapeutic classification for over-the-counter (OTC) drugs.

Central Nervous System Agents, which include drugs such as acetaminophen, was the highest ranking therapeutic class, accounting for 31.6% of all OTC drug claims.

Gastrointestinal products such as antacids and laxatives are the next highest category of OTC medication at 10.4%, followed by Vitamins at 9.1% and the Electrolytic/Caloric/Water Balance class such as calcium at 8.1%.

The largest increase from the last fiscal year (2008/09) in utilization of OTCs by therapeutic class was among Vitamins which increased by 0.8 percentage points, while the largest decrease was among the Skin and Mucous Membrane class which decreased by 0.9 percentage points.



Source: HICPS adapted by Program Analysis Division

FIGURE 4.12

NIHB Top Ten Therapeutic Classes by Claims Incidence
2009/10

Figure 4.12 ranks the top ten therapeutic classes according to claims incidence. In 2009/10, Non-Steroidal Anti-Inflammatory Agents (NSAIDs) had the highest claims incidence total at 869,998. Voltaren (Diclofenac) is an example of a drug product in this therapeutic class.

Opiate Agonists such as Tylenol no.3 (Acetaminophen w/codeine) ranked second in claims incidence with 850,450 claims followed by the Pharmaceutical Aids class* and Antidepressants with 747,794 and 627,135 claims respectively.

Within the top ten therapeutic classes, the Pharmaceutical Aids class had the largest percentage increase (12.5%) over the last fiscal year. The Opiate Agonists class followed with a 7.2% increase in claims incidence over 2008/09. The Anxiolytics, Sedatives and Hypnotics – Benzodiazepines and HMG-CoA Reductase Inhibitors (Statins) classes had a 6.4% and 6.0% change in claims incidence over the last fiscal year respectively.

The Angiotensin-Converting Enzyme Inhibitors class had a decrease of 1.3% over 2008/09. Altace (Ramipril) is an example of a drug product in this therapeutic class.

Therapeutic Classification	Claims Incidence	% Change from 2008/09	Examples of Drug Product in the Therapeutic Class
Non-Steroidal Anti-Inflammatory Agents (NSAID)	869,998	2.1%	Voltaren (Diclofenac)
Opiate Agonists	850,450	7.2%	Tylenol no.3 (Acetaminophen w/codeine)
Pharmaceutical Aids	747,794	12.5%	Methadone
Antidepressants	627,135	4.6%	Effexor (Venlafaxine)
Angiotensin-Converting Enzyme Inhibitors	493,606	-1.3%	Altace (Ramipril)
Anxiolytics, Sedatives and Hypnotics – Benzodiazepines	461,852	6.4%	Ativan (Lorazepam)
HMG-CoA Reductase Inhibitors (Statins)	433,283	6.0%	Lipitor (Atorvastatin)
Proton-Pump Inhibitors	404,572	4.1%	Losec (Omeprazole)
Biguanides	353,881	3.2%	Glucophage (Metformin)
Miscellaneous Analgesics and Antipyretics	316,413	2.4%	Tylenol (Acetaminophen)

Source: HICPS adapted by Program Analysis Division

* The Pharmaceutical Aids class is a broad category which contains a wide variety of drug and medical products that do not belong to any other class. The largest component of this class is Methadone. Nutritional supplements are also another example of this class.

FIGURE 4.13

NIHB Top Ten Therapeutic Classes by Expenditure
2009/10

Figure 4.13 ranks the top ten therapeutic classes according to expenditure. Cholesterol lowering drugs in the HMG-CoA Reductase Inhibitors (Statins) class such as Lipitor (Atorvastatin) had expenditures of $26.2 million in 2009/10. This is an increase of 9.0% over fiscal year 2008/09. While ranking first in terms of expenditures, HMG-CoA Reductase Inhibitors (Statins) ranked seventh in terms of claims incidence.

Opiate Agonists, which ranked second in terms of claims incidence, was the second largest therapeutic class by expenditure at $19.5 million, an increase of 7.7% over fiscal year 2008/09. Tylenol no.3 (Acetaminophen w/codeine) is an example of a drug product listed in this therapeutic classification.

The third largest expenditure class was Antidepressants, at $18.1 million. This is an increase of 5.5% over fiscal year 2008/09.

Within the top ten therapeutic classes, the therapeutic class with the highest percentage increase in expenditure over fiscal year 2008/09 was the Miscellaneous Anticonvulsants class (21.0%), followed by the HMG-CoA Reductase Inhibitors (Statins) class (9.0%), and by the Opiate Agonists class (7.7%).

Antipsychotic Agents decreased by 3.2% in expenditures over fiscal year 2008/09 to $14.5 million.

Therapeutic Classification	Expenditure ($ 000's)	% Change from 2008/09	Examples of Product in the Therapeutic Class
HMG-CoA Reductase Inhibitors (Statins)	$ 26,243	9.0%	Lipitor (Atorvastatin)
Opiate Agonists	19,506	7.7%	Tylenol no.3 (Acetaminophen w/codeine)
Antidepressants	18,088	5.5%	Effexor (Venlafaxine)
Proton Pump Inhibitors	17,332	1.6%	Losec (Omeprazole)
Angiotensin-Converting Enzyme Inhibitors	14,816	0.2%	Altace (Ramipril)
Antipsychotic Agents	14,465	-3.2%	Risperdal (Risperidone)
Non-Steroidal Anti-Inflammatory Agents (NSAIDs)	13,106	0.0%	Voltaren (Diclofenac)
Diabetic Diagnostic Agents	12,151	2.9%	Test Strips
Beta Adrenergic Agonist	9,425	7.4%	Ventolin (Salbutamol)
Miscellaneous Anticonvulsants	$ 8,979	21.0%	Neurontin (Gabapentin)

Source: HICPS adapted by Program Analysis Division

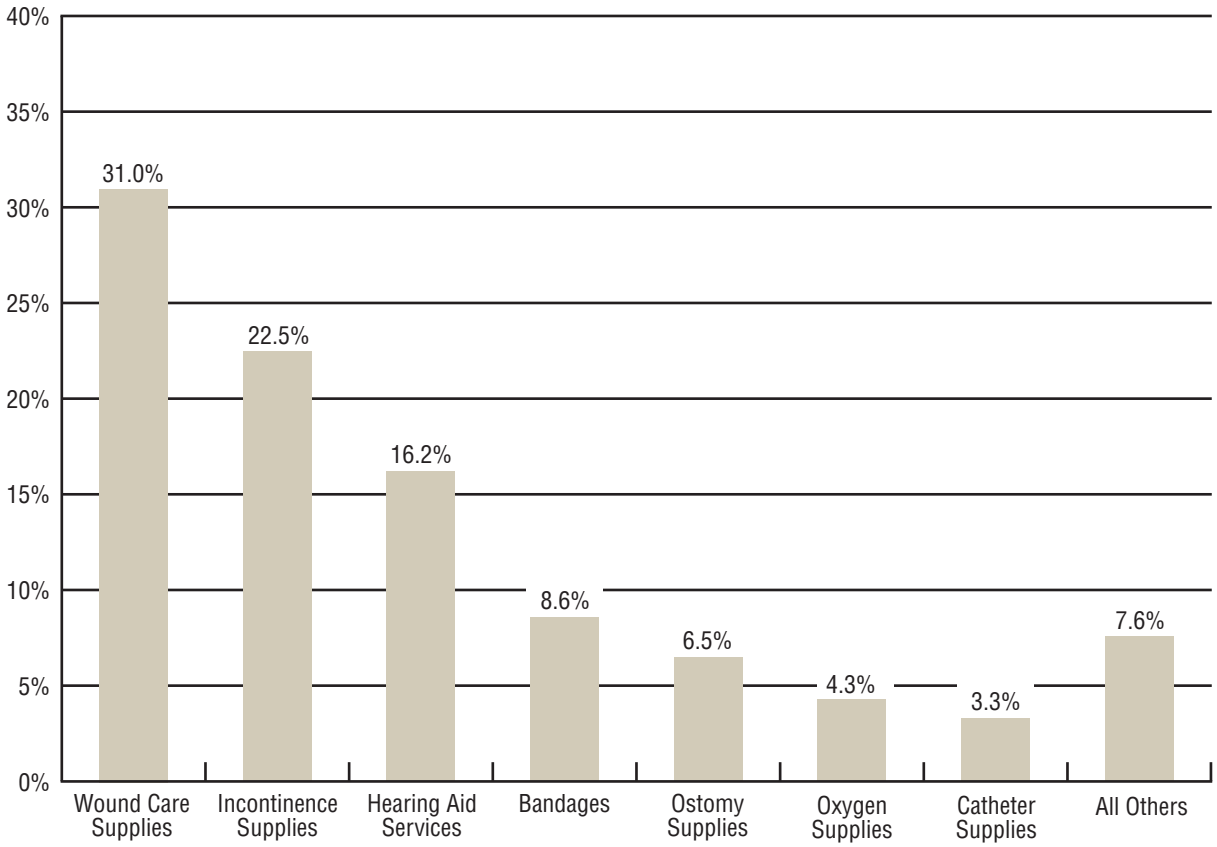
FIGURE 4.14

NIHB Medical Supplies by Category and Claims Incidence
2009/10

Figure 4.14 demonstrates variation in medical supply claims by specific category.

Wound care supplies accounted for 31.0% of all medical supply claims in 2009/10. Incontinence supplies represented the second highest category of medical supplies at 22.5% followed by hearing aid services at 16.2%.

The most significant change in claims for medical supplies over fiscal year 2008/09 was in hearing aid services which increased 3.6 percentage points, while wound care supplies and bandages decreased by 3.1 and 1.1 percentage points respectively.



Source: HICPS adapted by Program Analysis Division

FIGURE 4.15

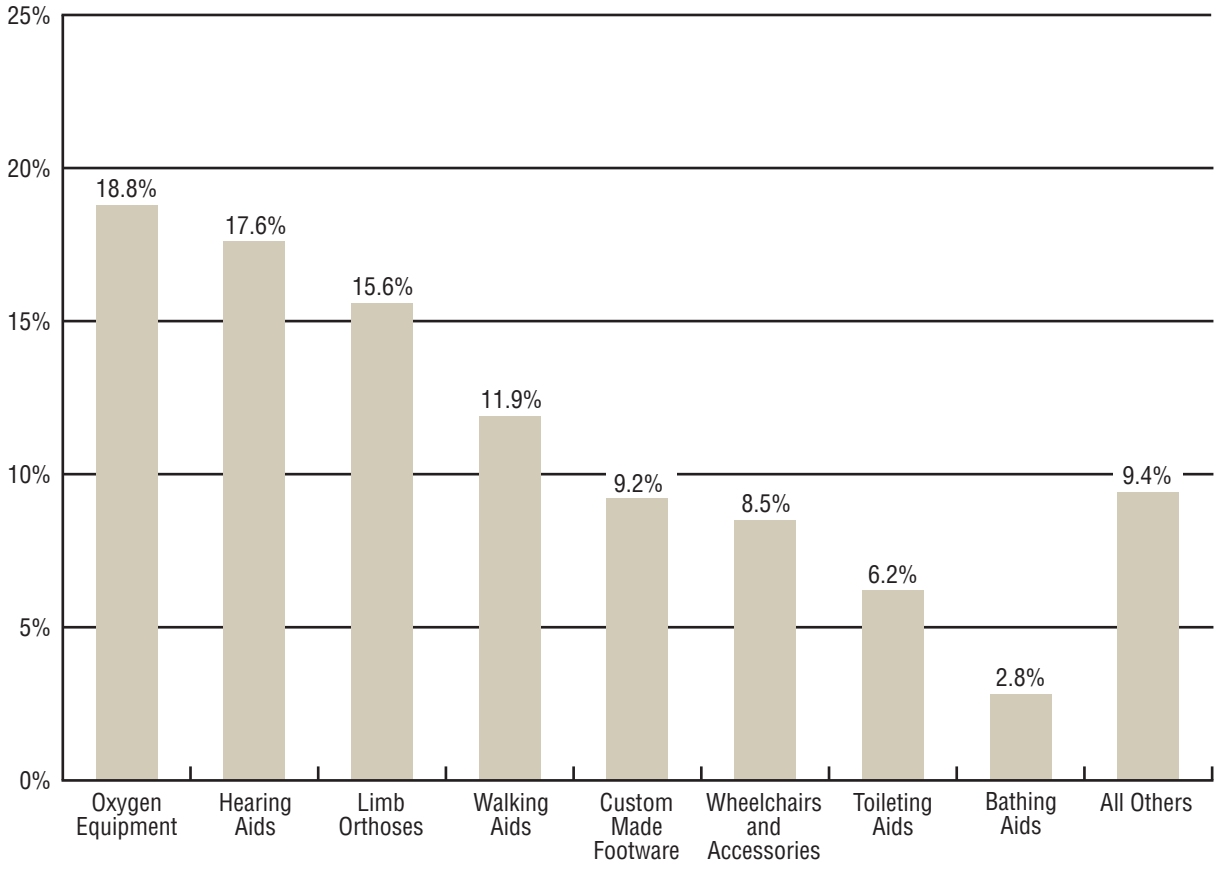
NIHB Medical Equipment by Category and Claims Incidence
2009/10

Figure 4.15 demonstrates variation in medical equipment claims by category.

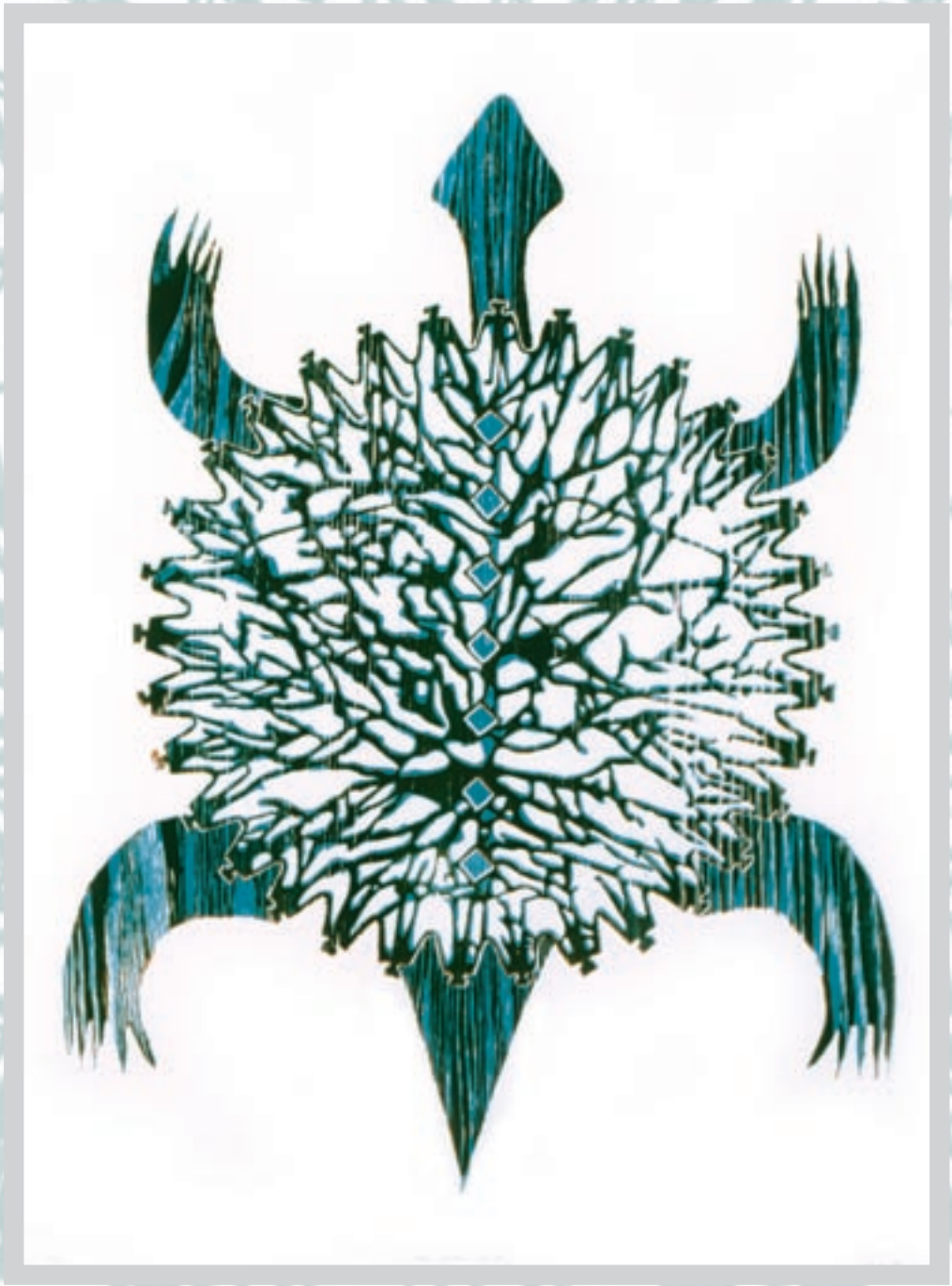
Claims for oxygen equipment accounted for 18.8% of all medical equipment claims in 2009/10. Hearing aids were the next highest at 17.6% followed by limb orthoses at 15.6% and walking aids at 11.9%.

The most significant shift in the proportion of total medical equipment claims over the fiscal year 2008/09 was in hearing aids which increased by 4.2 percentage points.

The most significant decrease in the proportion of total medical equipment was in limb orthoses which declined 3.1 percentage points as a share of total claims for medical equipment over the previous fiscal year.



Source: HICPS adapted by Program Analysis Division



La Danse Ronde by Mireille Sioui

NIHB Dental Expenditure and Utilization Data

In 2009/10, NIHB Dental expenditures amounted to $194.9 million, accounting for 19.7% of total NIHB expenditures.

Coverage for NIHB Dental services is determined on an individual basis, taking into consideration current oral health status, recipient history, accumulated scientific research, and availability of treatment alternatives. Dental services must be provided by a licensed dental professional, such as a dentist, dental specialist, or denturist, who has agreed to provide services to First Nations and Inuit clients through the NIHB Program.

NIHB dental services are determined on individual assessment and are based on current Program policies. Some dental services require predetermination prior to the initiation of treatment. Predetermination is a review to determine if the proposed dental services are covered under the Program's criteria, guidelines and policies. During the predetermination process, the NIHB Program reviews the dental services submitted against its established Dental Policy Framework which outlines clear definitions of the types of benefits available to clients.

The range of dental services* covered by the NIHB Program, includes:

- Diagnostic services such as examinations and radiographs;
- Preventive services such as scaling, polishing, fluorides and sealants;
- Restorative services such as fillings;
- Endodontic services such as root canal treatments;
- Periodontal services such as deep scaling;
- Prosthodontic services such as removable dentures;
- Oral surgery services such as simple extractions;
- Orthodontic services to correct significant irregularities in teeth and jaws; and
- Adjunctive services such as general anaesthesia and sedation.

* Predetermination applies for some dental services within these categories.

FIGURE 5.1

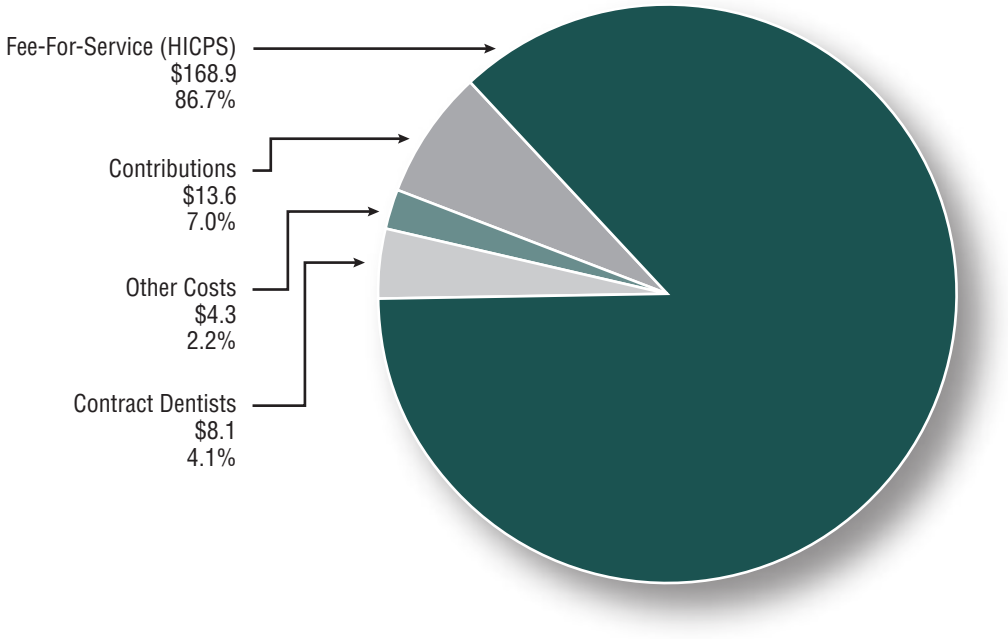
Distribution of NIHB Dental Expenditures ($ Millions)
2009/10

NIHB Dental expenditures totalled $194.9 million in 2009/10. Fee-for-service dental costs paid through the Health Information and Claims Processing Services (HICPS) system represented the largest expenditure component, accounting for $168.9 million or 86.7% of all NIHB Dental costs.

Contributions, which accounted for $13.6 million or 7.0% of total dental expenditures, were the next highest component. Contribution costs were used to fund the provision of dental benefits through agreements such as those with the Governments of the Northwest Territories and Nunavut, the Mohawk Council of Akwesasne in Ontario and the Bigstone Cree Nation in Alberta.

Expenditures for contract dentists providing services to clients in remote communities totalled $8.1 million or 4.1% of total costs.

Other costs totalled $4.3 million or 2.2% in 2009/10. The majority of these costs are related to claims processing and payment services.



Total NIHB Dental Expenditures: $194.9 M

Source: FIRMS adapted by Program Analysis Division

FIGURE 5.2

Total NIHB Dental Expenditures by Type and Region ($ 000's)
2009/10

Dental expenditures totalled $194.9 million in 2009/10. The regions of Ontario (19.5%), Saskatchewan (15.8%), British Columbia (14.4%) and Alberta (14.2%) had the largest proportion of overall dental costs.

Of the $194.9 million, $181.3 million (93.0%) were operating expenditures while $13.6 million (7.0%) were contribution expenditures.

REGION	OPERATING			Total Operating Costs	Total Contribution Costs	TOTAL COSTS
	Fee-For-Service	Contract Dentists	Other Costs			
Atlantic	$ 5,292	$ 0	$ 1	$ 5,293	$ 133	**$ 5,426**
Quebec	14,159	0	0	14,159	0	**14,159**
Ontario	31,233	1,763	175	33,170	4,877	**38,047**
Manitoba	22,019	4,936	0	26,954	0	**26,954**
Saskatchewan	27,410	33	4	27,447	3,331	**30,777**
Alberta	25,549	294	12	25,854	1,902	**27,756**
British Columbia	26,836	742	0	27,578	464	**28,042**
Yukon	1,977	293	1	2,271	0	**2,271**
N.W.T.	6,408	0	0	6,408	659	**7,067**
Nunavut	8,066	0	0	8,066	2,223	**10,289**
Headquarters	–	–	4,130	4,130	–	**4,130**
Total	**$ 168,948**	**$ 8,061**	**$ 4,321**	**$ 181,330**	**$ 13,589**	**$ 194,918**

Source: FIRMS adapted by Program Analysis Division

FIGURE 5.3

Annual NIHB Dental Expenditures
2005/06 to 2009/10

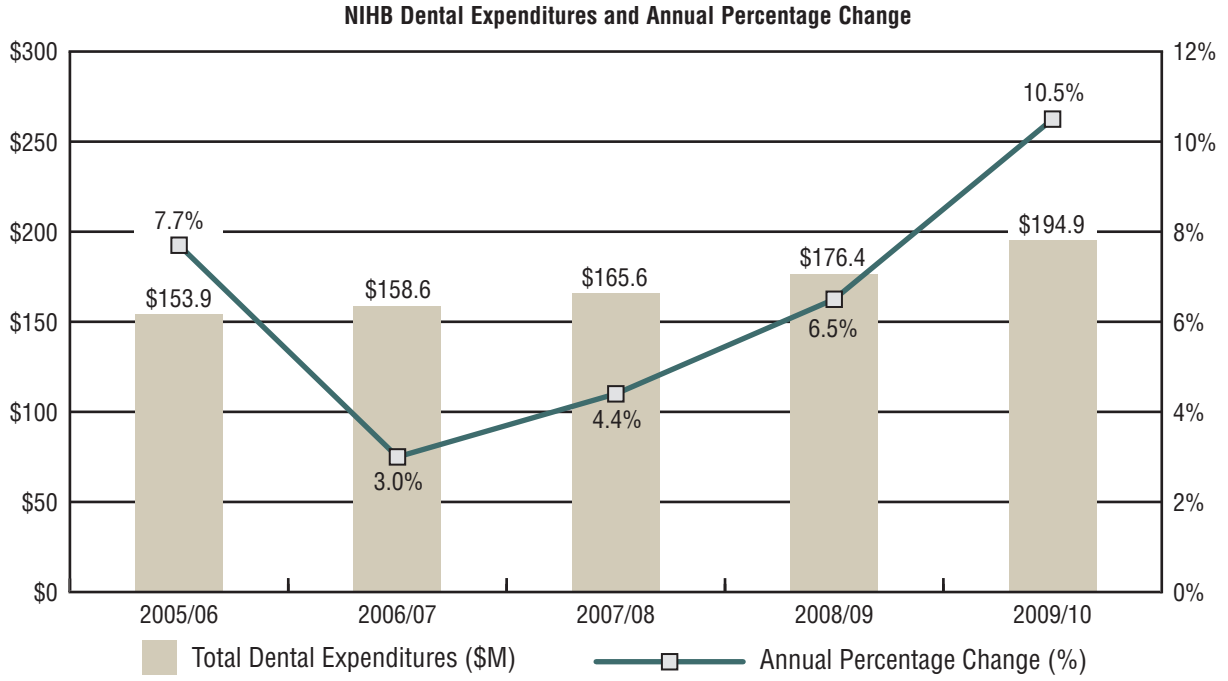
NIHB Dental expenditures increased by 10.5% in fiscal year 2009/10, which was the highest rate of growth of all benefits. This growth is significantly higher than the previous year with an increase of 4.0 percentage points over the previous fiscal year's growth. Approximately 50% of this growth can be attributed to increases in compensation paid to dental care professionals. Additional factors include improved client accessibility to dental benefits and increases in utilization in the North.

In the last five years, annual growth rates for NIHB Dental expenditures have ranged from a high of 10.5% in 2009/10 to a low of 3.0% in 2006/07, with the average annualized growth rate being 6.4%.

In 2009/10, the highest rate of growth in NIHB Dental expenditures was in Nunavut, which increased by 23.2% compared to the previous year. This increase can be attributed to improved accessibility and utilization of dental procedures in the North.

The largest net increase in expenditures took place in the British Columbia Region where total dental costs grew by $3.3 million. The Alberta and Saskatchewan regions followed where total dental expenditures grew by $2.7 million in each region.

The Ontario Region had the highest total dental expenditure at $38.0 million and the Yukon had the lowest total dental expenditure at $2.3 million.



Source: FIRMS adapted by Program Analysis Division

NIHB Dental Expenditures ($000's)					
REGION	2005/06	2006/07	2007/08	2008/09	2009/10
Atlantic	$ 4,831	$ 5,128	$ 5,204	$ 4,945	$ 5,426
Quebec	10,970	11,603	12,141	12,895	14,159
Ontario	32,064	32,777	33,467	35,457	38,047
Manitoba	20,326	20,756	21,696	24,444	26,954
Saskatchewan	22,038	23,219	24,636	28,102	30,777
Alberta	20,594	21,006	22,391	25,016	27,756
British Columbia	22,439	22,588	22,968	24,718	28,042
Yukon	1,863	2,033	1,998	2,246	2,271
N.W.T.	5,249	5,249	5,752	6,279	7,067
Nunavut	8,137	8,740	9,002	8,349	10,289
Headquarters	5,389	5,486	6,321	3,932	4,130
Total	**$ 153,900**	**$ 158,584**	**$ 165,576**	**$ 176,382**	**$ 194,918**

Source: FIRMS adapted by Program Analysis Division

FIGURE 5.4

Per Capita NIHB Dental Expenditures by Region
2009/10

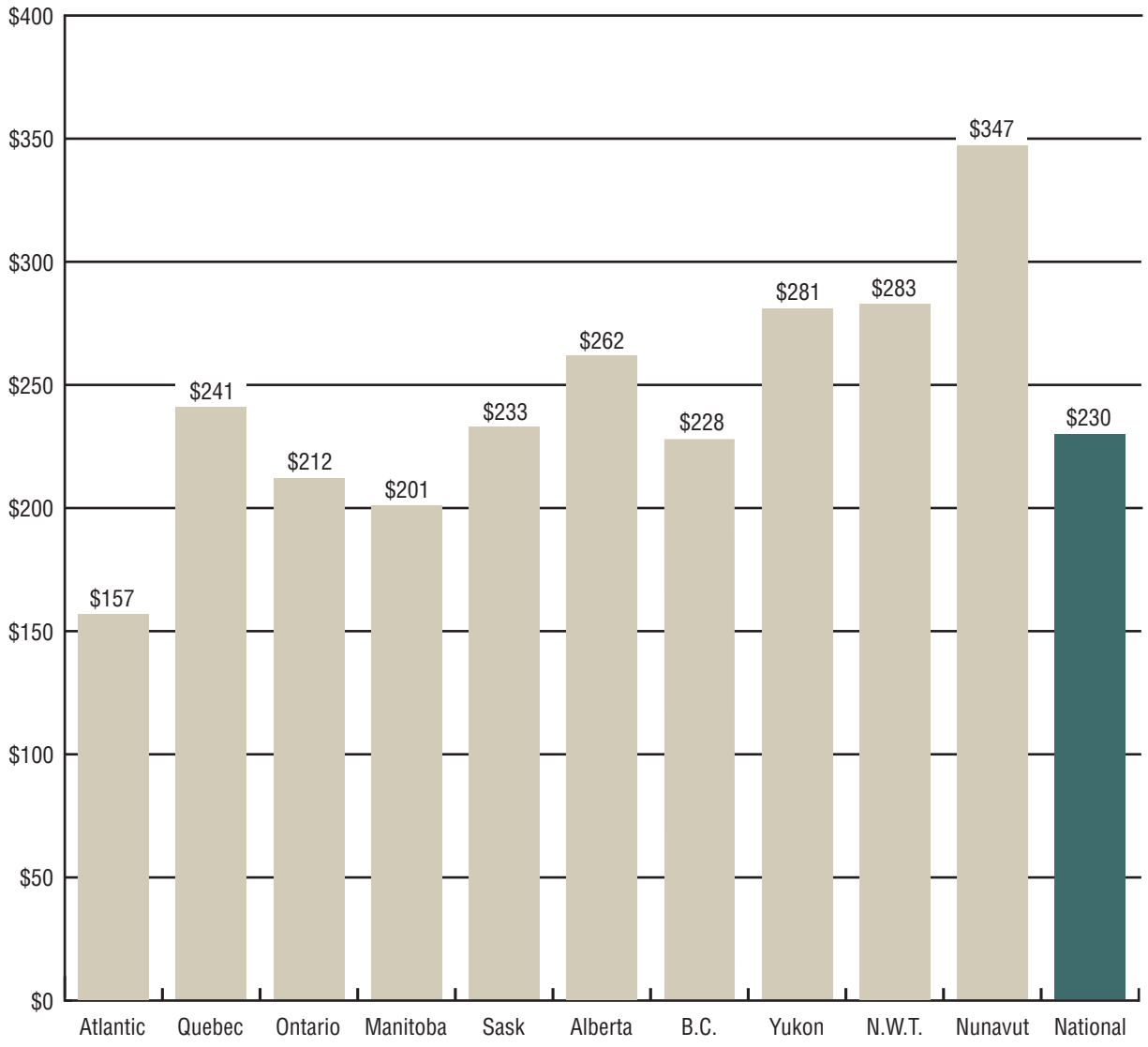
In 2009/10, the national per capita NIHB Dental expenditure was $230, an increase of 9.0% from the $211 recorded in 2008/09.

Nunavut had the highest per capita dental expenditure at $347, an increase from $287 in the previous year. This increase is partly attributed to ongoing efforts to improve the quality of data in SVS in the North. In previous years, per capita expenditures had been under-estimated due to the presence of non-eligible or deceased clients in the SVS database.

The Northwest Territories had the second highest per capita dental expenditure at $283, an increase from $255 in the previous year. This was followed by the Yukon at $281, unchanged from 2008/09.

The Atlantic Region had the lowest per capita dental cost at $157 per eligible client, an increase from the $145 registered in 2008/09.

Per capita values reflect total NIHB Dental expenditures as divided by total eligible NIHB client population. These values do not include additional financial resources provided to First Nations and Inuit populations through other Health Canada programs or through transfer and other arrangements.



Source: SVS and FIRMS adapted by Program Analysis Division

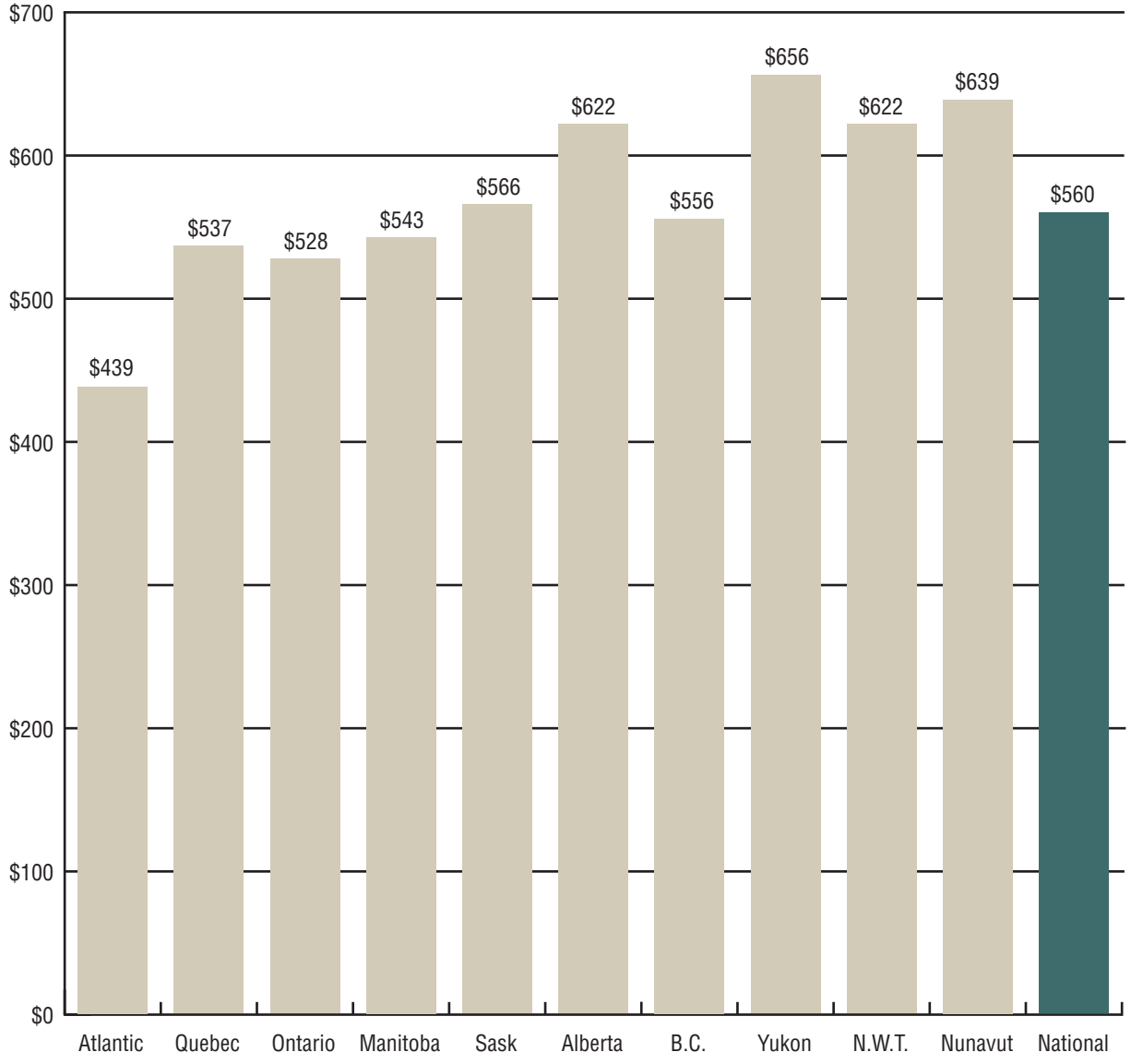
FIGURE 5.5

NIHB Dental Fee-For-Service Expenditures per Claimant by Region
2009/10

In 2009/10, the national NIHB Dental expenditure per eligible client receiving at least one dental benefit was $560. This is an increase of 9.4% over the $512 recorded in 2008/09.

Yukon had the highest dental expenditure per claimant at $656, a decrease of 8.1% from the $714 in the previous year. Nunavut followed at $639, with a significant increase of 34.2% from the $476 in 2008/09. This increase can be attributed to improved accessibility and utilization of dental procedures in the North. The Alberta Region and the Northwest Territories both followed at $622. This is an increase of 8.2% in the Alberta Region and 10.5% in the Northwest Territories from the previous year.

The Atlantic Region registered the lowest dental expenditure per claimant at $439, an increase of 12.0% from the $392 in 2008/09.



Source: HICPS adapted by Program Analysis Division

FIGURE 5.6

NIHB Dental Utilization Rates by Region
2005/06 to 2009/10

Utilization rates reflect those clients who received at least one dental service paid through the Health Information and Claims Processing Services (HICPS) system during the fiscal year as a proportion of the total number of clients eligible to receive benefits as registered on the Status Verification System (SVS) in that year.

The national utilization rate in 2009/10 for dental benefits paid through the HICPS system was 36%. National NIHB Dental utilization rates have remained stable over the past five years. Dental utilization rates vary across the regions with the highest dental utilization rate (45%) found in the Quebec Region. The lowest rate was recorded in the Manitoba Region (30%). It should also be noted, however, that the Manitoba Region had the largest expenditure in 2009/10 for contract dental services at $4.9 million, accounting for 18.3% of total expenditures in this region. If these clients had received services on a fee-for-service arrangement basis, the Manitoba Region utilization rate would have been significantly higher.

In addition to the impact of contract dental services, the utilization rates understate the actual level of service as the data do not include:

- Health Canada dental clinics (except in the Yukon);
- Services provided by Health Canada Dental Therapists or other FNIHB dental programs such as Children's Oral Health Initiative (COHI); and
- Dental services provided through contribution agreements. For example, if the Bigstone Cree Nation client population were excluded from the Alberta Region's population, because the HICPS data do not capture any services utilized by this population, the utilization rate for dental benefits for Alberta would have been 42% in 2009/10. The same scenario would apply for the Ontario Region. If the Akwesasne client population in Ontario were to be removed, the utilization rate for dental benefits in Ontario would have been 35%. If both the Bigstone and Akwesasne client population were removed from the overall NIHB population, the national utilization rate for dental benefits would have been 37%.

Over the two year period between 2008/09 and 2009/10, 409,535 distinct clients received NIHB Dental services resulting in an overall 49% utilization rate over this period.

REGION	Dental Utilization					
	2005/06	2006/07	2007/08	2008/09	2009/10	NIHB Dental Utilization Last Two Years 2008/10
Atlantic	36%	34%	36%	35%	35%	46%
Quebec	46%	44%	44%	44%	45%	56%
Ontario	34%	33%	33%	33%	33%	43%
Manitoba	30%	29%	30%	30%	30%	43%
Saskatchewan	38%	36%	36%	37%	37%	52%
Alberta	39%	37%	37%	38%	39%	53%
British Columbia	40%	39%	39%	39%	39%	53%
Yukon	34%	36%	38%	39%	37%	53%
N.W.T.	44%	41%	42%	42%	41%	57%
Nunavut	45%	40%	43%	41%	43%	58%
National	**37%**	**36%**	**36%**	**36%**	**36%**	**49%**

Source: HICPS and SVS adapted by Program Analysis Division

FIGURE 5.7

NIHB Dental Claimants by Age Group, Gender and Region
2009/10

Of the 831,090 clients eligible to receive dental benefits through the NIHB Program, 301,851 (36%) claimants received at least one dental procedure paid through the Health Information and Claims Processing Services (HICPS) system in 2009/10.

A higher proportion of female clients (56%) accessed dental services compared to male clients (44%). This compares to the total eligible population where 51% are female and 49% are male.

The average age of dental claimants was 28 years, indicating clients tend to access dental services at a younger age compared to pharmacy services (32 years of age). The highest average age of dental claimants was found in the Yukon (34 years of age) while the lowest was in Nunavut at 24 years of age.

Approximately 42% of all dental claimants were under 20 years of age. Forty-five percent of male claimants were in this age group while females accounted for 39%. Approximately 3% of all claimants were seniors (age 65 and over) in 2009/10.

REGION	Atlantic			Quebec			Ontario			Manitoba		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	196	191	387	631	592	1,223	1,373	1,351	2,724	2,043	1,955	3,998
5-9	505	489	994	1,468	1,455	2,923	3,187	3,117	6,304	2,518	2,607	5,125
10-14	738	851	1,589	1,608	1,662	3,270	3,385	3,584	6,969	2,327	2,675	5,002
15-19	667	733	1,400	1,190	1,402	2,592	2,761	3,175	5,936	1,916	2,581	4,497
20-24	432	587	1,019	746	1,160	1,906	1,879	2,568	4,447	1,397	2,018	3,415
25-29	405	586	991	762	995	1,757	1,743	2,600	4,343	1,282	1,829	3,111
30-34	358	523	881	794	1,039	1,833	1,666	2,318	3,984	1,160	1,645	2,805
35-39	445	515	960	842	1,131	1,973	1,842	2,372	4,214	1,165	1,672	2,837
40-44	403	587	990	897	1,163	2,060	1,856	2,547	4,403	1,248	1,547	2,795
45-49	344	506	850	841	1,068	1,909	1,882	2,622	4,504	1,069	1,390	2,459
50-54	294	435	729	697	929	1,626	1,544	2,145	3,689	735	994	1,729
55-59	192	316	508	486	624	1,110	1,114	1,621	2,735	460	712	1,172
60-64	144	213	357	349	489	838	765	1,194	1,959	310	437	747
65+	147	265	412	510	838	1,348	1,079	1,869	2,948	317	561	878
Total	**5,270**	**6,797**	**12,067**	**11,821**	**14,547**	**26,368**	**26,076**	**33,083**	**59,159**	**17,947**	**22,623**	**40,570**
Average Age	**29**	**32**	**31**	**29**	**32**	**31**	**29**	**32**	**31**	**25**	**27**	**26**

Source: HICPS adapted by Program Analysis Division

REGION	Saskatchewan			Alberta			British Columbia			Yukon			N.W.T.			Nunavut			TOTAL		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	1,879	1,955	3,834	1,835	1,857	3,692	1,704	1,694	3,398	52	45	97	314	312	626	716	685	1,401	10,743	10,637	21,380
5-9	3,338	3,332	6,670	2,918	2,871	5,789	2,761	2,648	5,409	101	92	193	456	516	972	784	787	1,571	18,036	17,914	35,950
10-14	2,843	3,300	6,143	2,639	2,851	5,490	2,726	2,767	5,493	107	121	228	507	569	1,076	679	889	1,568	17,559	19,269	36,828
15-19	2,177	2,932	5,109	1,984	2,533	4,517	2,300	2,610	4,910	118	173	291	495	670	1,165	674	983	1,657	14,282	17,792	32,074
20-24	1,757	2,752	4,509	1,410	2,101	3,511	1,658	2,320	3,978	109	169	278	444	589	1,033	584	863	1,447	10,416	15,127	25,543
25-29	1,554	2,311	3,865	1,323	1,979	3,302	1,563	2,141	3,704	118	168	286	362	535	897	450	679	1,129	9,562	13,823	23,385
30-34	1,447	2,032	3,479	1,244	1,642	2,886	1,470	1,969	3,439	102	122	224	281	461	742	385	518	903	8,907	12,269	21,176
35-39	1,526	2,111	3,637	1,125	1,638	2,763	1,521	1,930	3,451	123	150	273	342	486	828	361	454	815	9,292	12,459	21,751
40-44	1,461	1,990	3,451	1,124	1,505	2,629	1,494	2,012	3,506	138	144	282	336	462	798	331	397	728	9,288	12,354	21,642
45-49	1,167	1,643	2,810	936	1,309	2,245	1,528	2,097	3,625	117	148	265	274	432	706	218	259	477	8,376	11,474	19,850
50-54	817	1,157	1,974	677	970	1,647	1,154	1,539	2,693	79	91	170	201	307	508	108	185	293	6,306	8,752	15,058
55-59	479	680	1,159	454	662	1,116	770	1,009	1,779	52	98	150	146	194	340	109	126	235	4,262	6,042	10,304
60-64	320	479	799	272	410	682	508	675	1,183	53	56	109	110	145	255	87	94	181	2,918	4,192	7,110
65+	394	552	946	349	480	829	738	952	1,690	67	102	169	159	202	361	90	129	219	3,850	5,950	9,800
Total	**21,159**	**27,226**	**48,385**	**18,290**	**22,808**	**41,098**	**21,895**	**26,363**	**48,258**	**1,336**	**1,679**	**3,015**	**4,427**	**5,880**	**10,307**	**5,576**	**7,048**	**12,624**	**133,797**	**168,054**	**301,851**
Average Age	**25**	**27**	**26**	**24**	**26**	**25**	**28**	**30**	**29**	**33**	**35**	**34**	**28**	**30**	**29**	**23**	**24**	**24**	**27**	**29**	**28**

FIGURE 5.8

NIHB Dental Claimants and Non-Claimants by Age Group and Gender
2009/10

Thirty-six percent of all eligible clients received at least one dental procedure paid through the Health Information and Claims Processing Services (HICPS) system in 2009/10. Sixty-four percent of eligible clients did not access the Program through HICPS for any dental benefits.

Of the 529,239 non-claimants in 2009/10, 274,219 were male (52%), while 255,020 were female (48%). One-third (33%) of all non-claimants were under 20 years of age, while 65% were under 40 years of age.

Claimants under the age of 20 accounted for 42% of all NIHB eligible clients who received dental benefits through the HICPS system, while claimants 65 years and older accounted for approximately 3%.

Age Group	Claimants			Non-Claimants			TOTAL		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	10,743	10,637	21,380	21,742	20,663	42,405	32,485	31,300	**63,785**
	33%	34%	34%	67%	66%	66%	100%	100%	**100%**
5-9	18,036	17,914	35,950	21,022	19,542	40,564	39,058	37,456	**76,514**
	46%	48%	47%	54%	52%	53%	100%	100%	**100%**
10-14	17,559	19,269	36,828	22,787	19,381	42,168	40,346	38,650	**78,996**
	44%	50%	47%	56%	50%	53%	100%	100%	**100%**
15-19	14,282	17,792	32,074	28,517	23,297	51,814	42,799	41,089	**83,888**
	33%	43%	38%	67%	57%	62%	100%	100%	**100%**
20-24	10,416	15,127	25,543	27,943	21,798	49,741	38,359	36,925	**75,284**
	27%	41%	34%	73%	59%	66%	100%	100%	**100%**
25-29	9,562	13,823	23,385	23,224	18,369	41,593	32,786	32,192	**64,978**
	29%	43%	36%	71%	57%	64%	100%	100%	**100%**
30-34	8,907	12,269	21,176	20,328	16,928	37,256	29,235	29,197	**58,432**
	30%	42%	36%	70%	58%	64%	100%	100%	**100%**
35-39	9,292	12,459	21,751	19,640	16,978	36,618	28,932	29,437	**58,369**
	32%	42%	37%	68%	58%	63%	100%	100%	**100%**
40-44	9,288	12,354	21,642	19,674	17,597	37,271	28,962	29,951	**58,913**
	32%	41%	37%	68%	59%	63%	100%	100%	**100%**
45-49	8,376	11,474	19,850	18,458	17,909	36,367	26,834	29,383	**56,217**
	31%	39%	35%	69%	61%	65%	100%	100%	**100%**
50-54	6,306	8,752	15,058	14,629	15,584	30,213	20,935	24,336	**45,271**
	30%	36%	33%	70%	64%	67%	100%	100%	**100%**
55-59	4,262	6,042	10,304	10,838	12,399	23,237	15,100	18,441	**33,541**
	28%	33%	31%	72%	67%	69%	100%	100%	**100%**
60-64	2,918	4,192	7,110	8,241	9,930	18,171	11,159	14,122	**25,281**
	26%	30%	28%	74%	70%	72%	100%	100%	**100%**
65+	3,850	5,950	9,800	17,176	24,645	41,821	21,026	30,595	**51,621**
	18%	19%	19%	82%	81%	81%	100%	100%	**100%**
Total	**133,797**	**168,054**	**301,851**	**274,219**	**255,020**	**529,239**	**408,016**	**423,074**	**831,090**
	33%	**40%**	**36%**	**67%**	**60%**	**64%**	**100%**	**100%**	**100%**

Source: HICPS and SVS adapted by Program Analysis Division

FIGURE 5.9

NIHB Fee-for-Service Dental Expenditures by Sub-Benefit
2009/10

Expenditures for Restorative Services (crowns, fillings, etc.) were the highest of all dental sub-benefit categories at $77.2 million in 2009/10. This is a 12.6% increase over the previous fiscal year.

Diagnostic Services (examinations, x-rays, etc.) at $20.1 million and Preventive Services (scaling, sealants, etc.) at $19.1 million were the next highest sub-benefit categories, followed by Oral Surgery (extractions, etc.) at $15.9 million and Removable Prosthodontics (dentures, etc.) at $9.7 million.

In 2009/10, the three largest dental procedures by expenditure were Composite Restorations ($57.1 million), Scaling ($13.1 million) and Extractions ($11.1 million).

Fee-For-Service Top 5 Dental Sub-Benefits ($ Millions) and Percentage Change		
Dental Sub-Benefit	2009/10	% Change from 2008/09
Restorative Services	$ 77.2	12.6%
Diagnostic Services	$ 20.1	9.4%
Preventive Services	$ 19.1	11.5%
Oral Surgery	$ 15.9	9.1%
Removable Prosthodontics	$ 9.7	1.3%

Fee-For-Service Top 5 Dental Procedures ($ Millions) and Percentage Change		
Dental Procedure	2009/10	% Change from 2008/09
Composite Restorations	$ 57.1	15.7%
Scaling	$ 13.1	12.7%
Extractions	$ 11.1	9.2%
Root Canal Therapy	$ 7.1	9.1%
Amalgam Restorations	$ 6.6	-3.3%

Source: HICPS adapted by Program Analysis Division

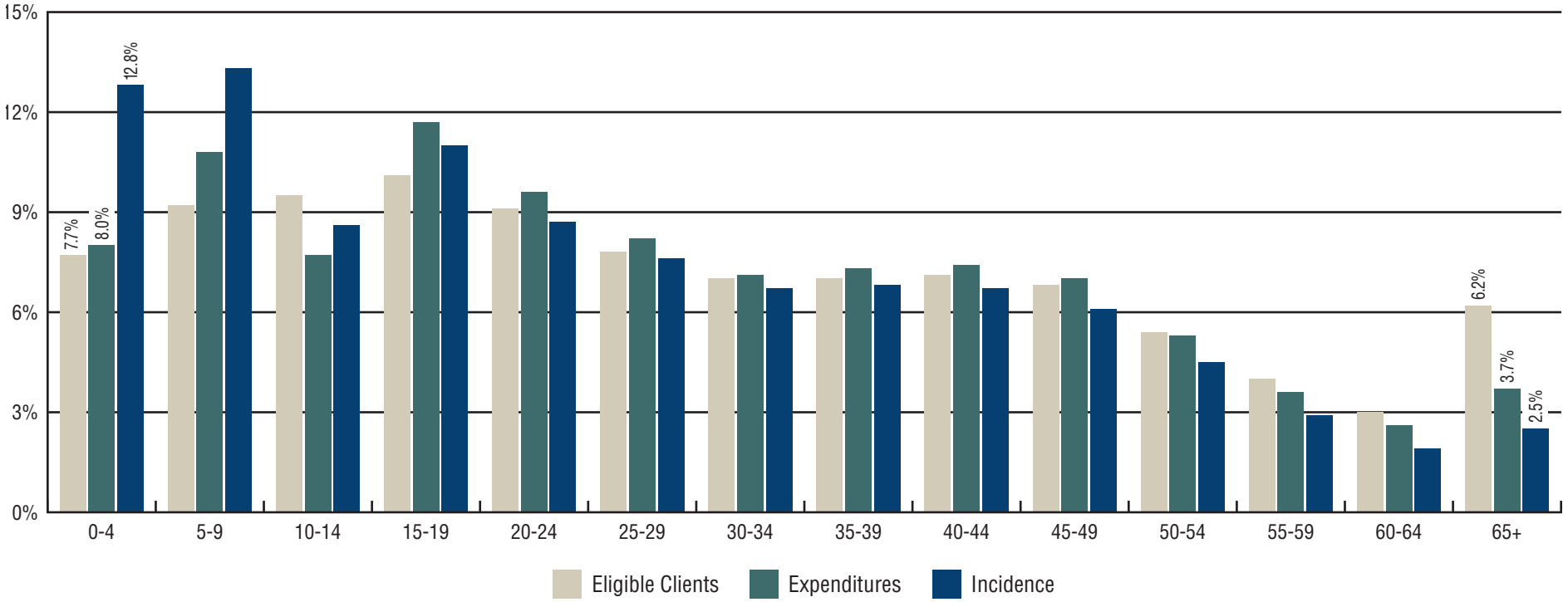
FIGURE 5.10

Distribution of Eligible NIHB Population, Dental Expenditures and Incidence by Age Group
2009/10

The main drivers of NIHB Dental expenditures are increases in utilization rates and increases in the fees charged for services by dental professionals. The type of dental services provided also has an impact on expenditures.

The ratio of incidence to expenditures is relatively consistent across most age groupings; however, there are notable exceptions. For children aged 0 to 9, a larger number of low-cost procedures (e.g., low-cost restorative procedures such as fillings) are provided. The result was a ratio of incidence to expenditures of 26.1% to 18.9%.

With respect to the ratio of eligible clients to expenditures, a relatively stable relationship exists across most age groups. The notable exceptions to this pattern are youth aged 10 to14 and clients who are 65 years of age and older. The ratios of eligible clients to expenditures for these two groups are 9.5% to 7.7% and 6.2% to 3.7% respectively.



Source: HICPS and SVS adapted by Program Analysis Division

Jigging on Thin Ice by Pitaloosie Saila
Reproduced with the permission of the Dorset Fine Arts

NIHB Medical Transportation Expenditure and Utilization Data

In 2009/10, Non-Insured Health Benefits Medical Transportation expenditures amounted to $301.7 million or 30.5% of total NIHB expenditures.

NIHB Medical Transportation benefits are needs driven and funded in accordance with the policies set out in the NIHB Medical Transportation Policy Framework to assist eligible clients to access medically necessary health services that cannot be obtained on reserve or in the community of residence.

NIHB Medical Transportation benefits are operationally managed by regional offices. These benefits are also managed by First Nations or Inuit Health Authorities, organizations or territorial governments who, under a contribution agreement, have assumed responsibility for the administration and coverage of medical transportation benefits to eligible clients.

NIHB Medical Transportation benefits include:

- Ground Travel (private vehicle; commercial taxi; fee-for-service driver and vehicle; band vehicle; bus; train; snowmobile taxi; and ground ambulance);
- Air Travel (scheduled flights; chartered flights; helicopter; air ambulance);
- Water Travel (motorized boat; boat taxi; and ferry);
- Living Expenses (accommodations and meals); and
- Transportation costs for health professionals to provide services to isolated communities.

Medical transportation financial data for the NIHB Annual Report are provided through the Framework for Integrated Resource Management System (FIRMS). Medical transportation data are also collected regionally through other electronic systems. Operational data at the regional level are tracked through the Medical Transportation Reporting System (MTRS) for most regions, while the Alberta and Ontario regions use their own systems. Contribution agreement data are also collected, but in a limited manner. Some communities report on spreadsheet templates, others by paper reports. In some regions, other information such as ambulance data is collected separately.

In 2005, an initiative was launched to collect medical transportation data on a national basis. The Medical Transportation Data Store (MTDS) has been created to act as a centralized system for cross regional data. The MTDS serves as a repository for selected operational data, as well as the data collected from medical transportation contribution agreements, and ambulance data systems. The objective of the MTDS is to enable aggregate reporting on medical transportation at a national level in order to further strengthen Program management, provide enhanced data analysis and reporting and aid in decision making.

The MTDS has been maintaining data since 2006/07 and significant improvements in data collection and populating MTDS have been made. Most regions have successfully submitted operating data, although some issues still remain to be resolved before all operating expenditures will be available through MTDS. In addition, steps are underway to improve data collection related to contribution agreements.

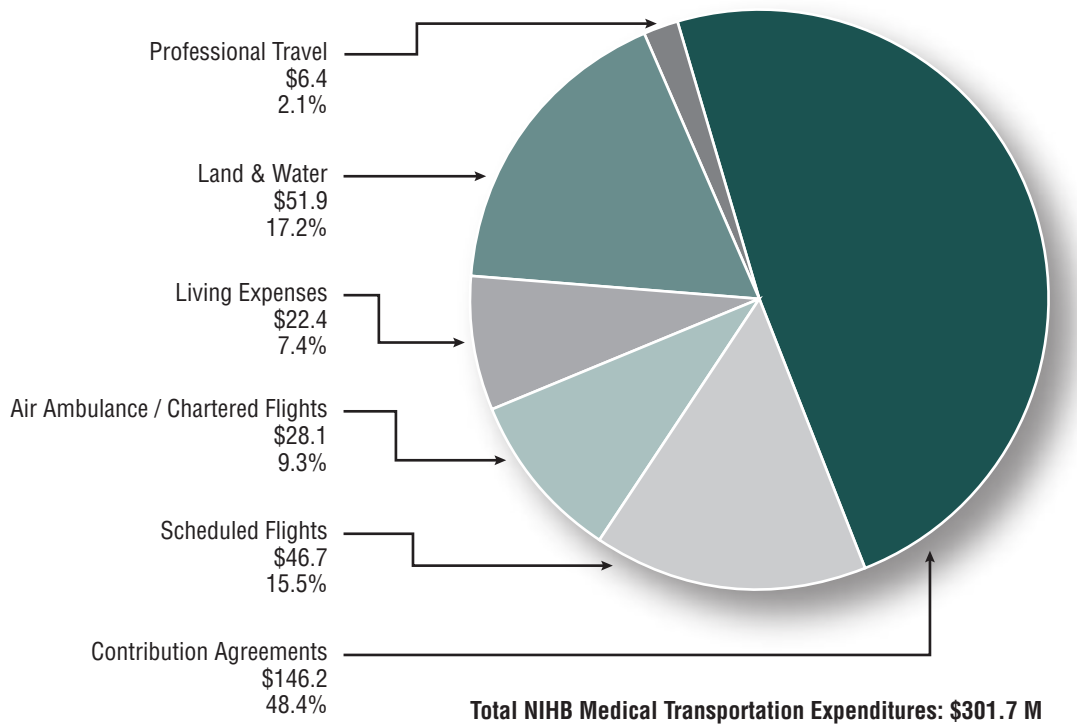
FIGURE 6.1

Distribution of NIHB Medical Transportation Expenditures ($ Millions)
2009/10

NIHB Medical Transportation expenditures totalled $301.7 million in 2009/10. Contribution agreements represented $146.2 million, or 48.4% of the total benefit.

Land and water transportation at $51.9 million (17.2%) and scheduled flights at $46.7 million (15.5%) were the largest medical transportation operating expenditures, accounting for one-third of the total benefit.

Air ambulance/chartered flights costs totalled $28.1 million (9.3%) and living expenses totalled $22.4 million (7.4%). Expenditures for travel associated with professional services (e.g., physician, dentist, mental health professional) totalled $6.4 million (2.1%).



Total NIHB Medical Transportation Expenditures: $301.7 M

Source: FIRMS adapted by Program Analysis Division

FIGURE 6.2

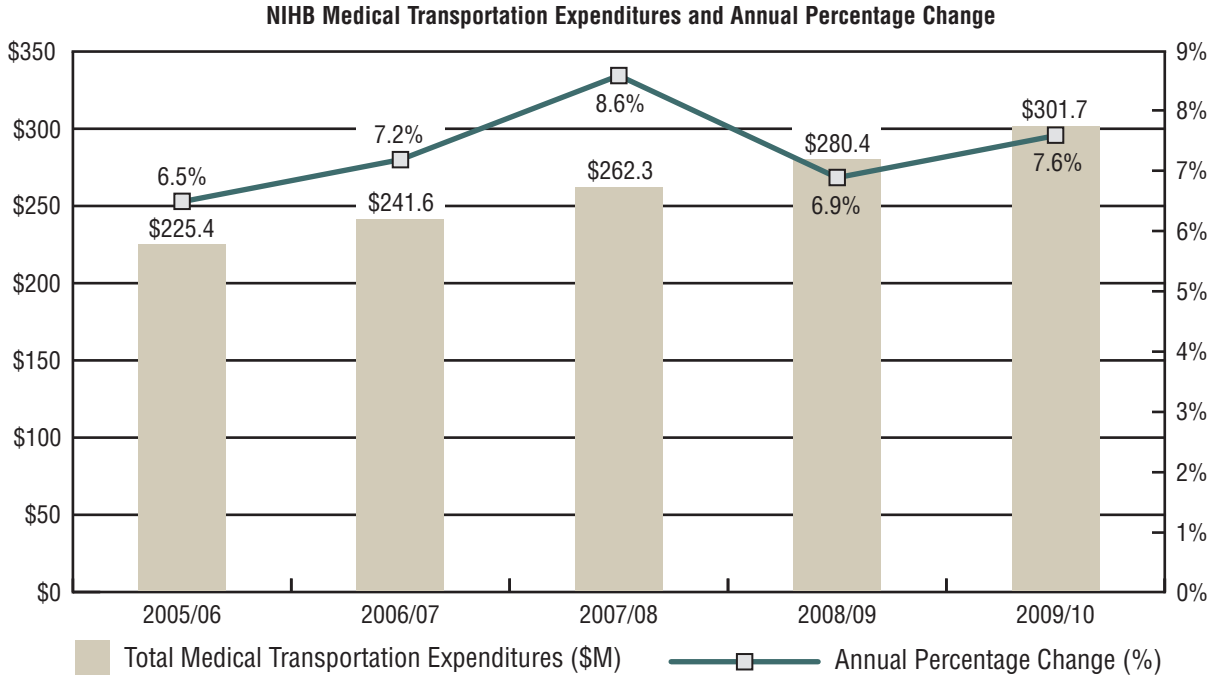
Annual NIHB Medical Transportation Expenditures
2005/06 to 2009/10

NIHB Medical Transportation expenditures increased by 7.6% in 2009/10. Over the last five years, growth in this benefit area has ranged from a high of 8.6% in 2007/08 to a low of 6.5% in 2005/06, with a five year annualized growth rate of 7.4%, the highest for all benefit areas over this period.

In 2008/09, there was a one time budget allocation in medical transportation of $5.5 million. These resources were allocated to the regions of Ontario ($1.8 million), Manitoba ($839 thousand), Saskatchewan ($467 thousand) and Nunavut ($2.4 million). Without this investment, the growth rate of medical transportation in 2009/10 would have been 9.7% rather than 7.6%.

Over the past five years, overall medical transportation costs have grown by 33.9% from $225.4 million in 2005/06 to $301.7 million in 2009/10. On a regional basis, the highest growth rates over this period were in the Yukon where expenditures grew by 81.0% from $2.1 million in 2005/06 to $3.8 million in 2009/10.

The largest net increases in expenditures over the past five years took place in the Manitoba Region where total medical transportation costs grew by $25.8 million over this period. The Ontario and Saskatchewan regions followed with net increases of $13.3 million and $10.2 million respectively.



Source: FIRMS adapted by Program Analysis Division

NIHB Medical Transportation Expenditures ($ 000's)					
REGION	2005/06	2006/07	2007/08	2008/09	2009/10
Atlantic	$ 5,590	$ 4,401	$ 4,585	$ 4,655	$ 5,048
Quebec	17,886	18,473	20,133	20,502	19,918
Ontario	38,553	40,572	45,618	46,848	51,889
Manitoba	63,322	69,047	76,082	83,193	89,078
Saskatchewan	28,786	31,816	36,108	36,239	38,971
Alberta	30,712	32,204	32,107	35,357	36,601
British Columbia	16,944	20,284	21,613	22,711	25,547
Yukon	2,100	2,421	2,935	2,938	3,801
N.W.T.	6,710	7,116	6,943	7,952	8,520
Nunavut	14,776	15,268	16,171	20,053	22,302
Total	**$ 225,379**	**$ 241,602**	**$ 262,294**	**$ 280,446**	**$ 301,673**

Source: FIRMS adapted by Program Analysis Division

FIGURE 6.3

NIHB Expenditures on Medical Transportation by Type and Region ($ 000's)
2009/10

NIHB Medical Transportation expenditures increased by 7.6% to $301.7 million in 2009/10. In 2008/09, there was a one time budget allocation in medical transportation of $5.5 million. Without this investment, the growth rate of medical transportation in 2009/10 would have been 9.7% rather than 7.6%.

The regions of Ontario (10.8%), Manitoba (7.1%), Saskatchewan (7.5%) and Nunavut (11.2%) had positive growth rates in 2009/10. It should be noted that in 2008/09 these regions received one time budget allocations in medical transportation. Without these investments, the growth rates in 2009/10 would have been more significant at 15.1% in Ontario, 8.2% in Manitoba, 8.9% in Saskatchewan and 26.3% in Nunavut.

In 2009/10, the Yukon had the largest percentage increase in medical transportation expenditures at 29.4%. This is attributed to increases in the utilization of scheduled flights, air ambulance and chartered flights. The British Columbia Region followed with a 12.5% increase and Nunavut with an 11.2% increase in expenditures.

The Manitoba Region had the highest overall NIHB Medical Transportation expenditure at $89.1 million, primarily as a result of air transportation which totalled $45.4 million. High medical transportation costs in the region reflect in part the large number of First Nations clients living in remote or fly-in only northern communities.

The Ontario Region registered $51.9 million and represented the second highest medical transportation expenditure totals in 2009/10. The Saskatchewan and Alberta regions followed at $39.0 million and $36.6 million respectively in medical transportation expenditures.

TYPE	Atlantic	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia	Yukon	N.W.T.	Nunavut	TOTAL
Scheduled Flights	$ 646	$ 205	$ 16,430	$ 23,237	$ 4,052	$ 807	$ 410	$ 881	$ 0	$ 0	**$ 46,668**
Air Ambulance / Chartered Flights	23	6	589	22,145	2,922	1,058	0	1,391	0	0	**28,134**
Living Expenses	451	16	6,507	9,338	2,660	1,834	627	940	0	0	**22,374**
Land & Water	1,535	232	3,884	11,403	19,308	13,691	1,280	589	0	0	**51,922**
Professional Travel	10	14	677	2,713	1,853	613	546	0	0	0	**6,426**
Total Operating	**$ 2,666**	**$ 472**	**$ 28,087**	**$ 68,836**	**$ 30,795**	**$ 18,003**	**$ 2,863**	**$ 3,801**	**$ 0**	**$ 0**	**$ 155,523**
Total Contributions	$ 2,383	$ 19,446	$ 23,803	$ 20,242	$ 8,176	$ 18,598	$ 22,683	$ 0	$ 8,520	$ 22,302	**$ 146,150**
TOTAL	**$ 5,048**	**$ 19,918**	**$ 51,889**	**$ 89,078**	**$ 38,971**	**$ 36,601**	**$ 25,547**	**$ 3,801**	**$ 8,520**	**$ 22,302**	**$ 301,673**
% Change from 2008/09	8.4%	-2.8%	10.8%	7.1%	7.5%	3.5%	12.5%	29.4%	7.1%	11.2%	7.6%

Source: FIRMS adapted by Program Analysis Division

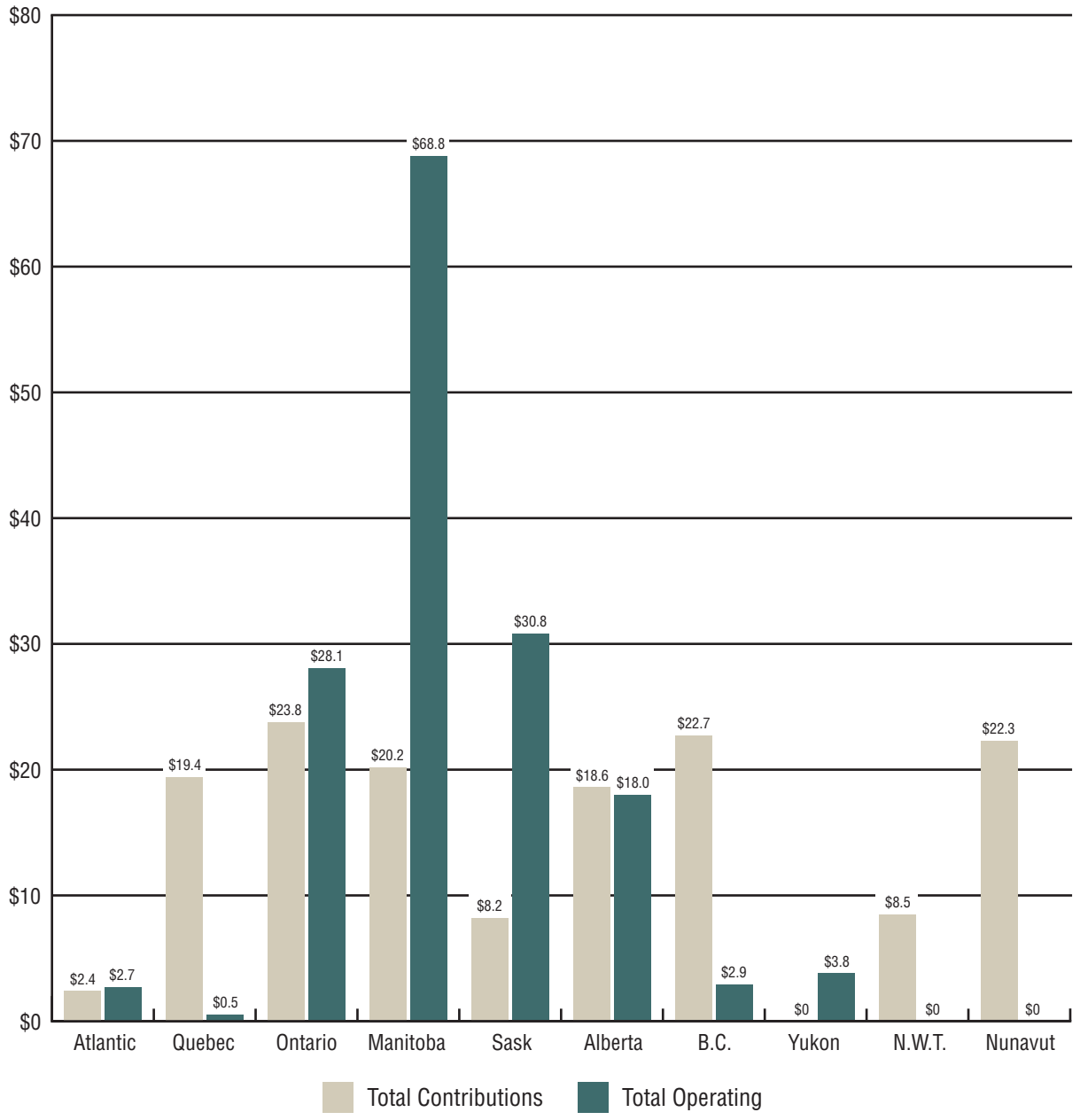
FIGURE 6.4

NIHB Medical Transportation Contribution and Operating Expenditures by Region ($ Millions)
2009/10

Figure 6.4 compares contribution funding to direct operating costs in NIHB Medical Transportation. Contribution funds are provided to First Nations bands, Territorial governments and other organizations to manage elements of the medical transportation benefit (e.g., coordinating accommodations, managing ground transportation, etc.).

The Manitoba Region had the largest operating expenditure for NIHB Medical Transportation in 2009/10 at $68.8 million. The Saskatchewan Region was the next largest at $30.8 million, followed by the Ontario Region at $28.1 million. Together these three regions accounted for 82.1% of all operating expenditures on medical transportation.

The largest contribution expenditures for NIHB Medical Transportation were registered as follows: the Ontario Region ($23.8 million), British Columbia Region ($22.7 million), Nunavut ($22.3 million), Manitoba Region ($20.2 million), and Quebec Region ($19.4 million). Almost all NIHB Medical Transportation services were delivered via contribution agreements in Quebec and British Columbia, while in the Northwest Territories and Nunavut, all medical transportation services were delivered via contribution agreements with the Territories.



Source: FIRMS adapted by Program Analysis Division

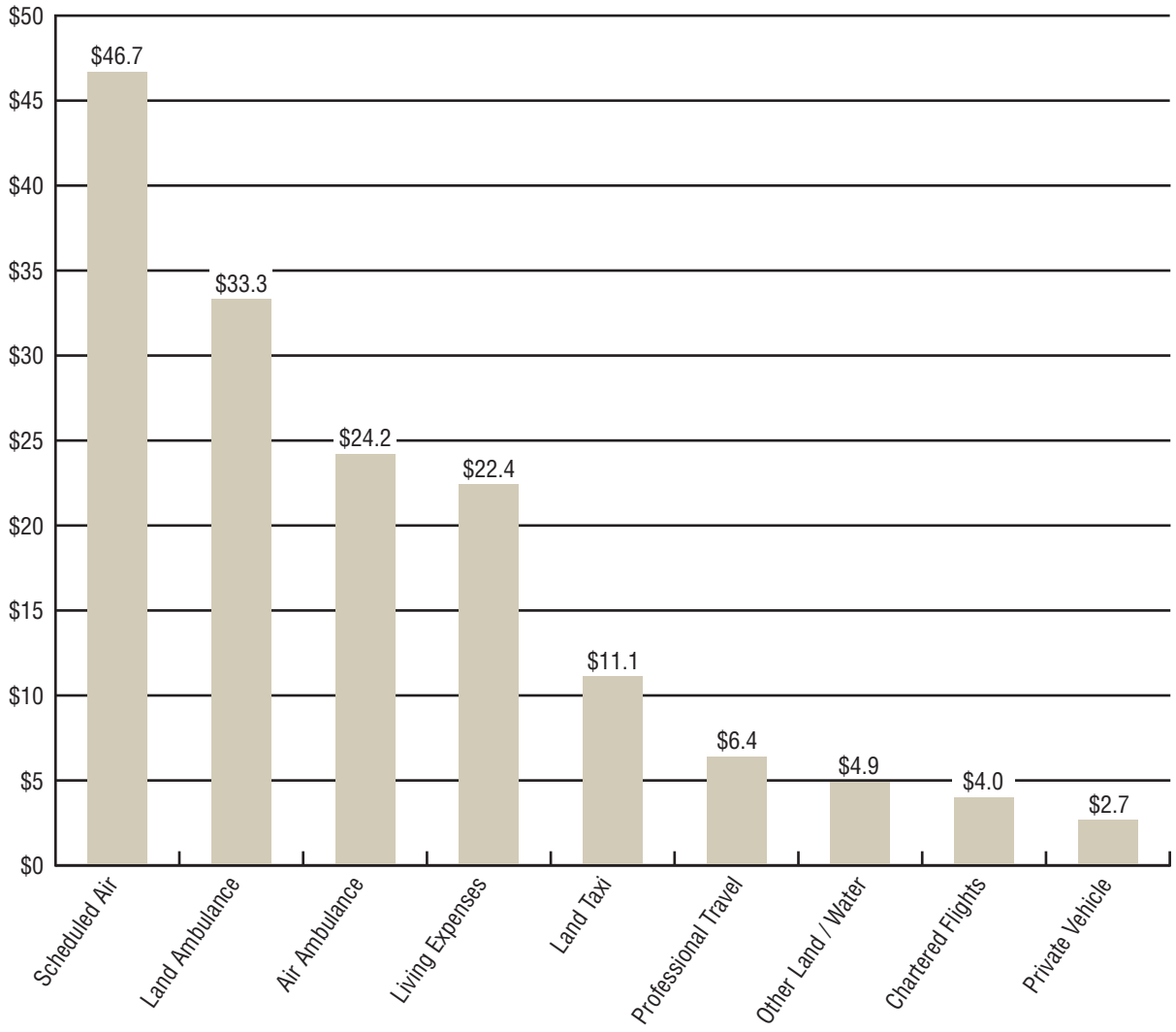
FIGURE 6.5

NIHB Medical Transportation Operating Expenditure by Type ($ Millions)
2009/10

The largest portion of NIHB Medical Transportation operating expenditures fell under scheduled flights ($46.7 million) representing 30.0%. Ambulance costs follow closely with land ambulance ($33.3 million) representing 21.4%, and air ambulance ($24.2 million) at 15.5%. Living expenses ($22.4 million), which include accommodations and meals, comprised 14.4% of all operating medical transportation costs.

Professional travel expenditures ($6.4 million) consists of the costs related to bringing health professionals to under serviced or remote/isolated communities in order to enhance access to clients, provide services in a more cost-effective manner and contribute to better health outcomes.

Private vehicle expenditures ($2.7 million) consist of the costs reimbursed through a per-kilometre allowance for private vehicle use by a client to access medically necessary eligible health services. In 2008, the NIHB base private mileage rates were directly linked to the National Joint Council (NJC) Government Commuting Rates. The NIHB rates are updated on April 1st of each year according to the NJC rates in effect as of January 1st of that year.



Source: FIRMS adapted by Program Analysis Division

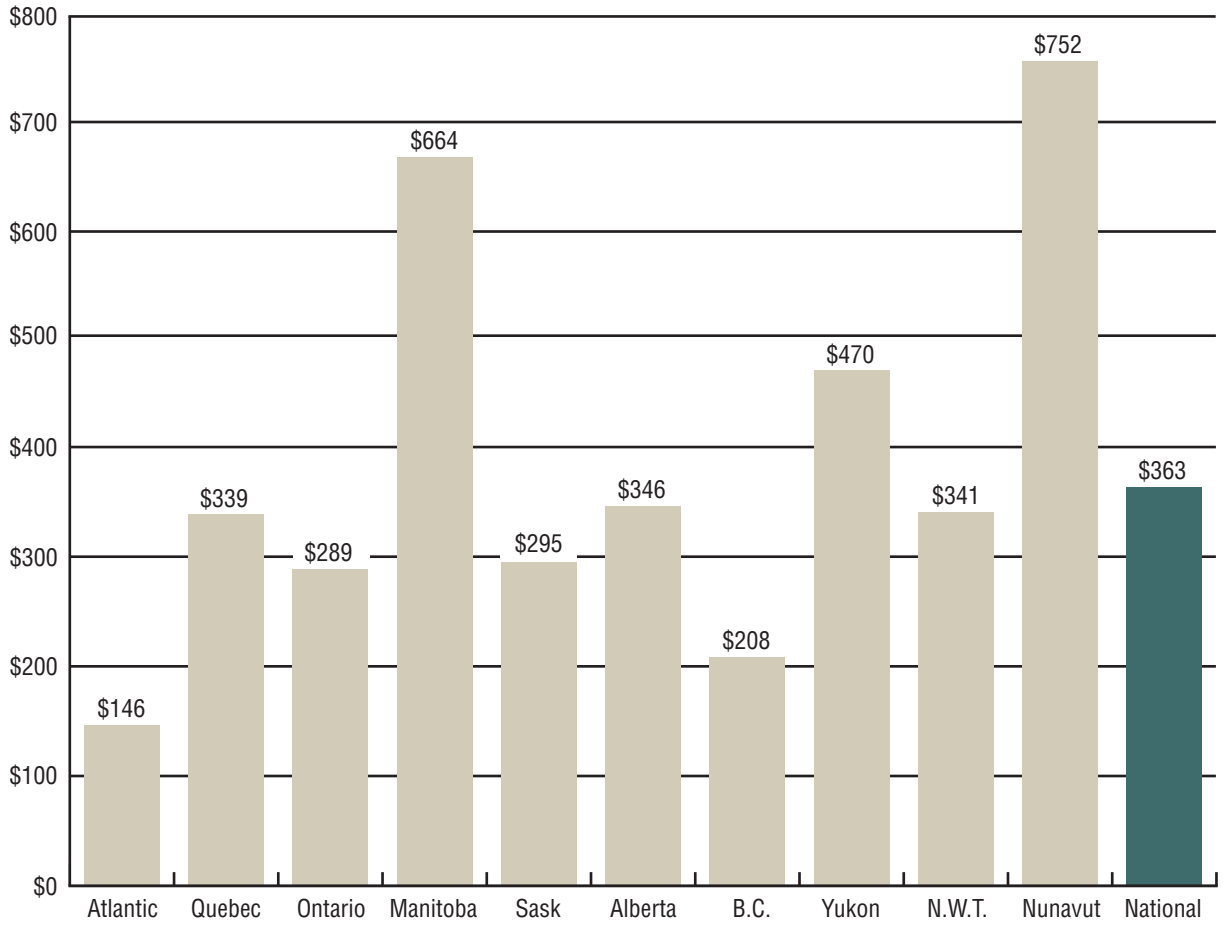
FIGURE 6.6

Per Capita NIHB Medical Transportation Expenditures by Region
2009/10

In 2009/10, the national per capita expenditure in NIHB Medical Transportation was $363. This is a 5.5% increase over the 2008/09 per capita expenditure of $344*.

Nunavut recorded the highest per capita expenditure in transportation at $752, followed by the Manitoba Region at $664. These expenditures reflect the large number of First Nations and Inuit clients living in remote or fly-in only northern communities that need to be sent south for medical and dental services.

In contrast, the Atlantic Region recorded the lowest per capita expenditure at $146.



Source: SVS and FIRMS adapted by Program Analysis Division

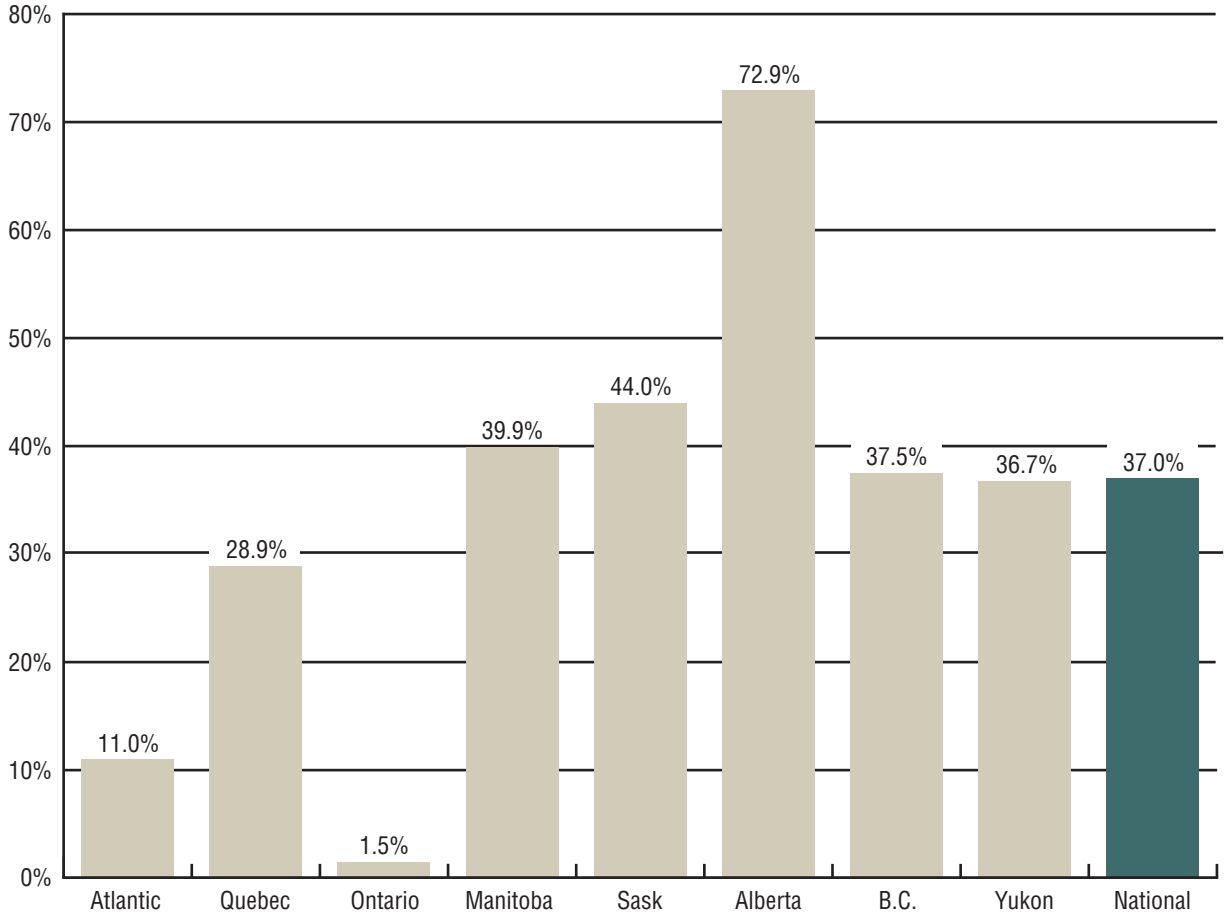
* The medical transportation per capita expenditure from the 2008/09 NIHB Annual Report has been adjusted to account for the restated 2008/09 medical transportation expenditure. For further information see technical notes in Section 11.

FIGURE 6.7

NIHB Medical Transportation Emergency (Ambulance) Operating Expenditures by Region
2009/10

In 2009/10, regionally managed NIHB Medical Transportation operating costs totalled $155.5 million. Of this total, $57.5 million or 37.0% were emergency operating expenditures. Emergency operating costs (defined as "ambulance") include all ambulance costs for both land and air ambulance service.

Emergency costs varied considerably from region to region, largely as a result of different provincial/territorial government coverage for emergency transportation. In regions such as Manitoba, Saskatchewan and Yukon, NIHB pays for the entire cost of land and air ambulances for NIHB clients. In the remaining regions, NIHB covers certain user fees or flat rates depending on the coverage provided by the provincial/territorial governments.



Source: FIRMS adapted by Program Analysis Division

In 2009/10, Manitoba Region ambulance expenditures were $27.5 million dollars, comprising nearly half of the total ambulance expenditures for this year. The high cost was primarily due to the size of the client population in the Manitoba Region living in remote or fly-in only communities.

The majority of the medical transportation operating expenditures within the Alberta Region consisted of emergency costs (72.9%). These costs included land and air ambulance. Alberta Region's high proportion of emergency costs is due to the provincial system not paying for any share of these costs on a universal basis (except for seniors and social assistance recipients). Nearly half (44.0%) of transportation operating expenditures in the Saskatchewan Region were for emergency transportation, followed by the regions of Manitoba (39.9%), British Columbia (37.5%) and the Yukon (36.7%).

The Ontario Region had the lowest percentage spent on emergency transportation, accounting for only 1.5% of the Region's total operating expenditures.

In terms of net expenditures, the Manitoba Region recorded the highest emergency operating expenditures in 2009/10 at $27.5 million, followed by the Saskatchewan Region at $13.6 million and the Alberta Region at $13.1 million.

Emergency (Ambulance) Expenditures by Type and Region ($ 000's), 2009/10

TYPE		Atlantic	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia	Yukon	National
Ambulance Operating Costs	Air Ambulance	$ 5.2	$ 0.0	$ 18.1	$ 19,486.8	$ 2,203.7	$ 1,058.1	$ 0.0	$ 1,390.9	$ 24,162.8
	Land Ambulance	288.3	136.5	389.2	7,991.5	11,357.5	12,071.6	1,073.7	3.2	33,311.5
	Total	**293.5**	**136.5**	**407.3**	**27,478.3**	**13,561.2**	**13,129.7**	**1,073.7**	**1,394.1**	**57,474.3**
Share of Ambulance Costs	Air Ambulance	1.8%	0.0%	4.4%	70.9%	16.3%	8.1%	0.0%	99.8%	42.0%
	Land Ambulance	98.2%	100.0%	95.6%	29.1%	83.7%	91.9%	100.0%	0.2%	58.0%
Total Operating Costs		**$ 2,665.5**	**$ 472.0**	**$ 28,086.7**	**$ 68,836.3**	**$ 30,795.2**	**$ 18,003.1**	**$ 2,863.4**	**$ 3,800.8**	**$ 155,523.0**
Emergency Operating Costs as % of Total Operating		**11.0%**	**28.9%**	**1.5%**	**39.9%**	**44.0%**	**72.9%**	**37.5%**	**36.7%**	**37.0%**

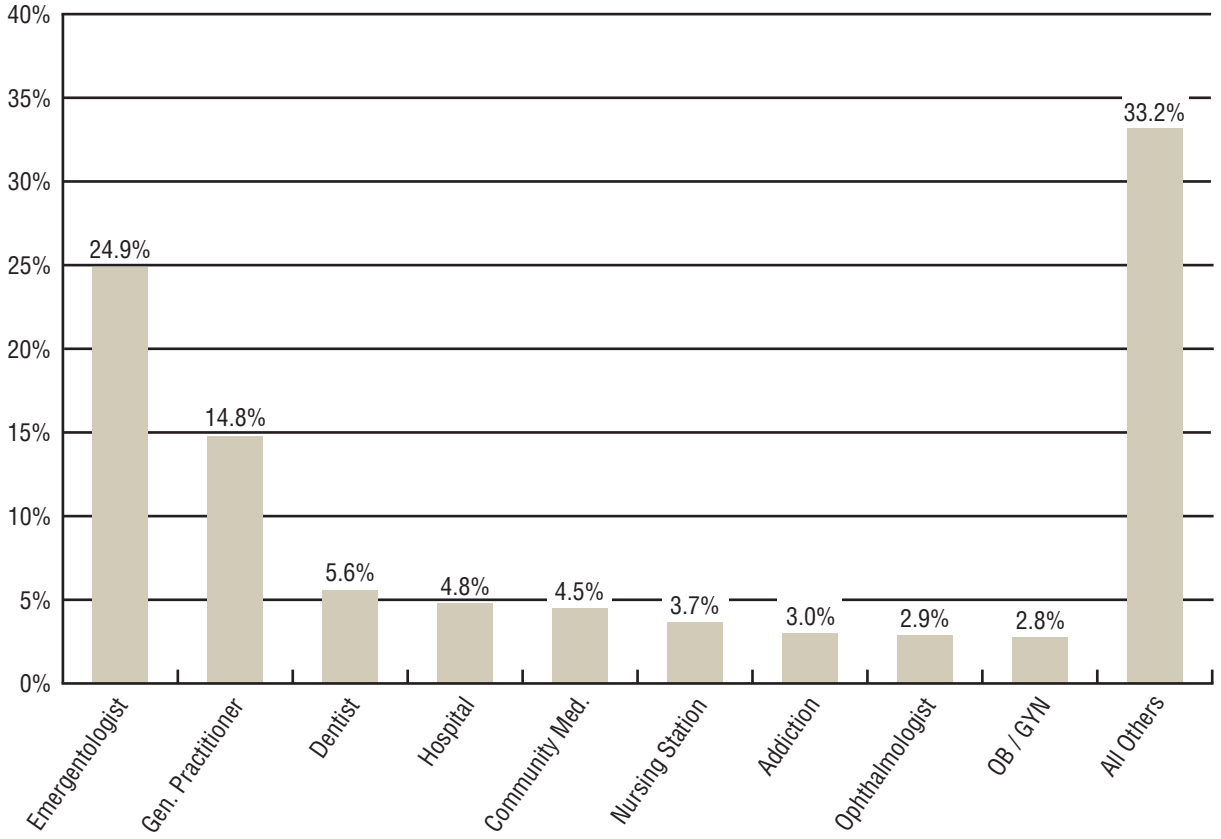
Source: FIRMS adapted by Program Analysis Division

FIGURE 6.8

Distribution of Client Appointments by Health Specialty
2009/10

According to the Medical Transportation Data Store (MTDS), in 2009/10, one-quarter of all appointments were with Emergentologists (emergency room specialists). Approximately 15% of appointments requiring some form of medical transportation were with General Practitioners and 5.6% were with Dentists.

Figure 6.8 shows the top ten most visited health care practitioners. The remaining 33.2% of all appointments include other practitioners such as Pediatricians and Neurosurgeons. There are over 80 types of health care practitioners identified in the MTDS.



Source: Medical Transportation Data Store (MTDS) adapted by Program Analysis Division

The Kitchen Floor is All Beat Up by Ken Swan

NIHB Vision Benefits, Other Health Care Benefits and Premiums Expenditure Data

In 2009/10, total expenditures for NIHB Vision benefits ($27.8 million), Other Health Care benefits ($12.5 million) and Premiums ($17.1 million) amounted to $57.4 million, or 5.8% of total NIHB expenditures for the fiscal year.

Vision care benefits are covered in accordance with the policies set out in the Non-Insured Health Benefits Vision Care Framework. The NIHB Program covers:

- Eye examinations, when they are not insured by the province/territory;
- Eyeglasses that are prescribed by a vision care professional;
- Eyeglass repairs;
- Eye prosthesis (an artificial eye); and
- Other vision care benefits depending on the specific medical needs of the client.

Other Health Care comprises primarily short-term crisis intervention mental health counselling. This service is provided by a recognized professional mental health therapist when no other service is available to the client. The NIHB Program covers:

- The initial assessment;
- Development of a treatment plan; and
- Fees and associated travel costs for the professional mental health therapist when it is deemed cost-effective to provide such services in a community.

In 2009/10, the NIHB Program continued to fund provincial health premiums for eligible clients in the British Columbia Region. The NIHB Program no longer covers provincial health premiums in the Alberta Region because the Government of Alberta eliminated Alberta Health Care insurance premiums for all Albertans as of January 1, 2009.

FIGURE 7.1

NIHB Vision Expenditures by Region ($ 000's)
2009/10

In 2009/10, NIHB Vision expenditures amounted to $27.8 million. Regional operating expenditures accounted for 81.8% of total expenditures with contribution costs accounting for the remaining 18.2%.

The Alberta and Ontario regions had the highest percentage shares in NIHB Vision benefit costs at 19.4% and 19.2% respectively, followed by the Saskatchewan Region at 15.2%.

REGION	Operating	Contributions	TOTAL
Atlantic	$ 1,587	$ 25	$ 1,612
Quebec	1,230	50	1,280
Ontario	4,895	448	5,343
Manitoba	3,184	223	3,407
Saskatchewan	4,207	14	4,222
Alberta	4,566	811	5,377
British Columbia	2,743	510	3,253
Yukon	299	0	299
N.W.T.	0	1,340	1,340
Nunavut	0	1,646	1,646
Total	**$ 22,712**	**$ 5,067**	**$ 27,779**

Source: FIRMS adapted by Program Analysis Division

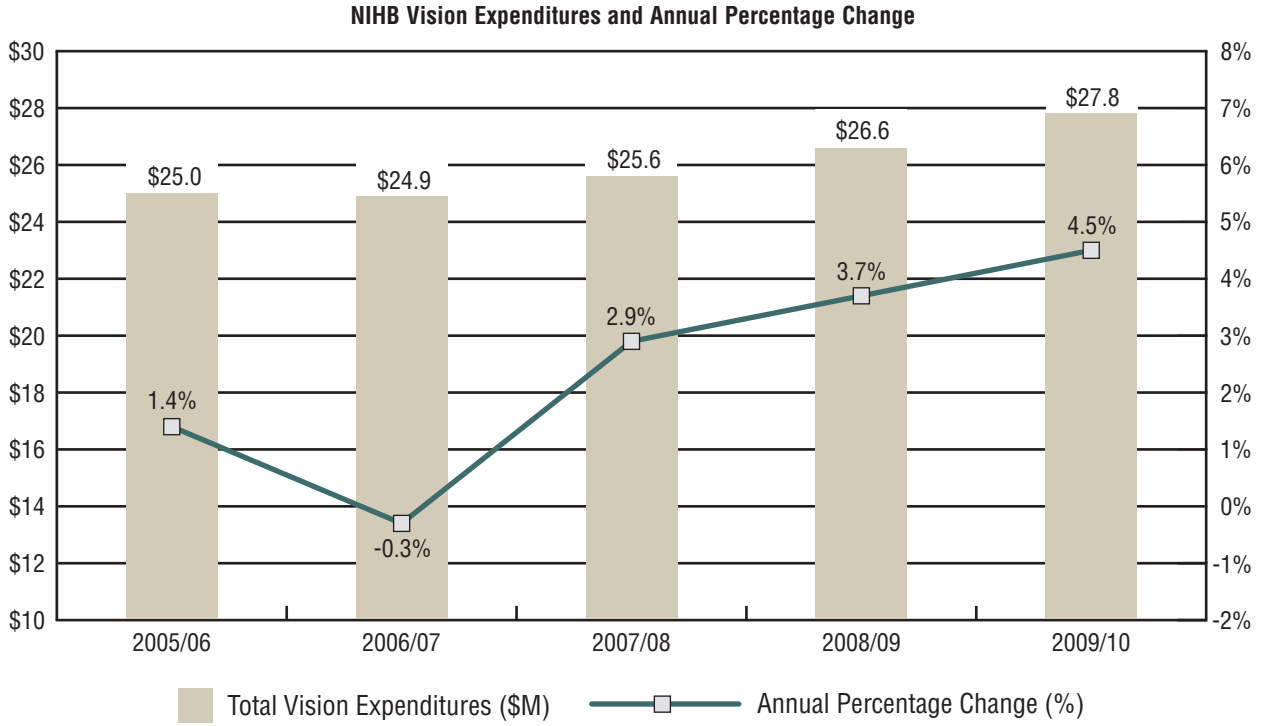
FIGURE 7.2

Annual NIHB Vision Expenditures
2005/06 to 2009/10

In 2009/10, NIHB Vision expenditures increased by 4.5%, compared to the 3.7% increase recorded in 2008/09. Over the previous five fiscal years the highest growth rate was recorded in 2009/10 at 4.5% and the lowest was in 2006/07 at -0.3%, with the annualized growth rate in this benefit area over the last five years being 2.4%.

In 2009/10, the highest percentage change in NIHB Vision expenditures was in the Yukon which increased by 23.5%, followed by Nunavut and the Northwest Territories which increased by 18.7% and 18.6% respectively. This reflects increases in compensation paid to vision care professionals in the North over the past few years. The largest net increases in expenditures took place in the regions of Nunavut and Manitoba where total vision care costs grew by $259 thousand and $250 thousand respectively.

In 2009/10, the Alberta and Ontario regions had the highest expenditures in vision care at $5.4 million and $5.3 million respectively.



Source: FIRMS adapted by Program Analysis Division

NIHB Vision Expenditures ($ 000's)					
REGION	2005/06	2006/07	2007/08	2008/09	2009/10
Atlantic	$ 1,614	$ 1,408	$ 1,495	$ 1,596	$ 1,612
Quebec	1,135	1,270	1,257	1,220	1,280
Ontario	5,458	5,485	5,366	5,204	5,343
Manitoba	2,864	2,841	2,936	3,157	3,407
Saskatchewan	4,072	3,835	4,126	4,166	4,222
Alberta	4,762	4,690	4,942	5,225	5,377
British Columbia	3,049	3,232	3,120	3,251	3,253
Yukon	228	274	230	242	299
N.W.T.	743	819	1,011	1,130	1,340
Nunavut	1,044	1,040	1,139	1,387	1,646
Total	**$ 24,968**	**$ 24,894**	**$ 25,621**	**$ 26,577**	**$ 27,779**

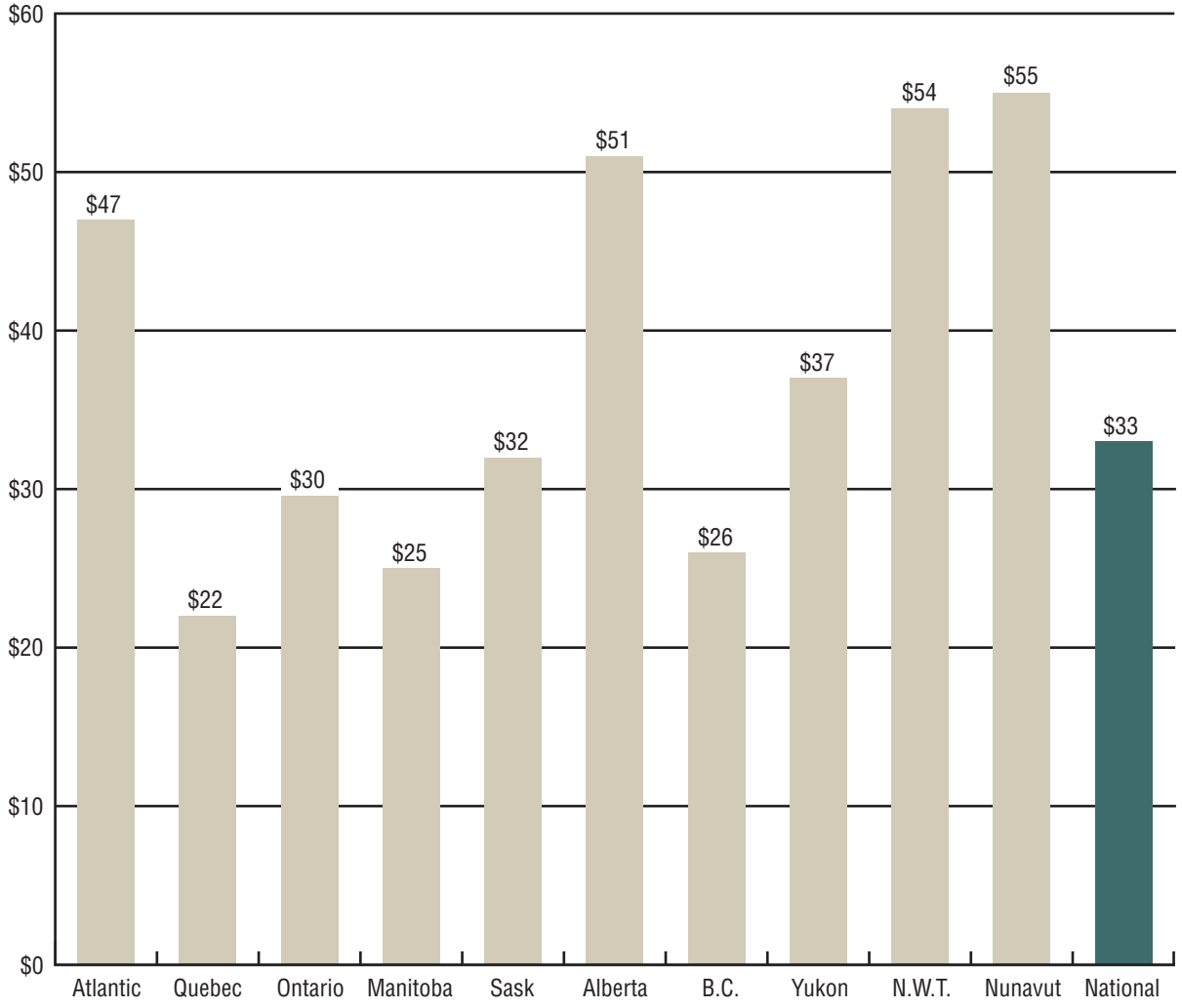
Source: FIRMS adapted by Program Analysis Division

FIGURE 7.3

Per Capita NIHB Vision Expenditures by Region
2009/10

In 2009/10, the national per capita expenditure in NIHB Vision Care was $33. This is unchanged from 2008/09*.

Nunavut had the highest per capita expenditure at $55, followed by the Northwest Territories at $54, the Alberta Region at $51 and the Atlantic Region at $47. The Quebec Region registered the lowest per capita expenditure at $22.



Source: SVS and FIRMS adapted by Program Analysis Division

* The vision care per capita expenditure from the 2008/09 NIHB Annual Report has been adjusted to account for the restated 2008/09 vision care expenditure. For further information see technical notes in Section 11.

FIGURE 7.4

NIHB Other Health Care Expenditures by Region ($ 000's)
2009/10

In 2009/10, NIHB Other Health Care expenditures, which includes short-term crisis intervention mental health counselling, amounted to $12.5 million. Regional operating expenditures accounted for 73.1% of total expenditures with contribution costs accounting for the remaining 26.9%.

The Alberta Region had the highest percentage share of NIHB Other Health Care costs at 34.9% followed by the Manitoba and Ontario regions at 25.1% and 20.8% respectively.

In the Northwest Territories and Nunavut, the NIHB Program does not provide short-term crisis intervention mental health counselling services, the largest component of other health care costs, as this is the responsibility of the territorial governments.

REGION	Operating	Contributions	TOTAL
Atlantic	$ 86	$ 127	$ 213
Quebec	459	0	459
Ontario	2,603	0	2,603
Manitoba	2,407	735	3,143
Saskatchewan	407	405	812
Alberta	2,894	1,468	4,363
British Columbia	296	628	924
Yukon	1	0	1
N.W.T.	0	0	0
Nunavut	0	0	0
Total	**$ 9,154**	**$ 3,363**	**$ 12,516**

Source: FIRMS adapted by Program Analysis Division

FIGURE 7.5

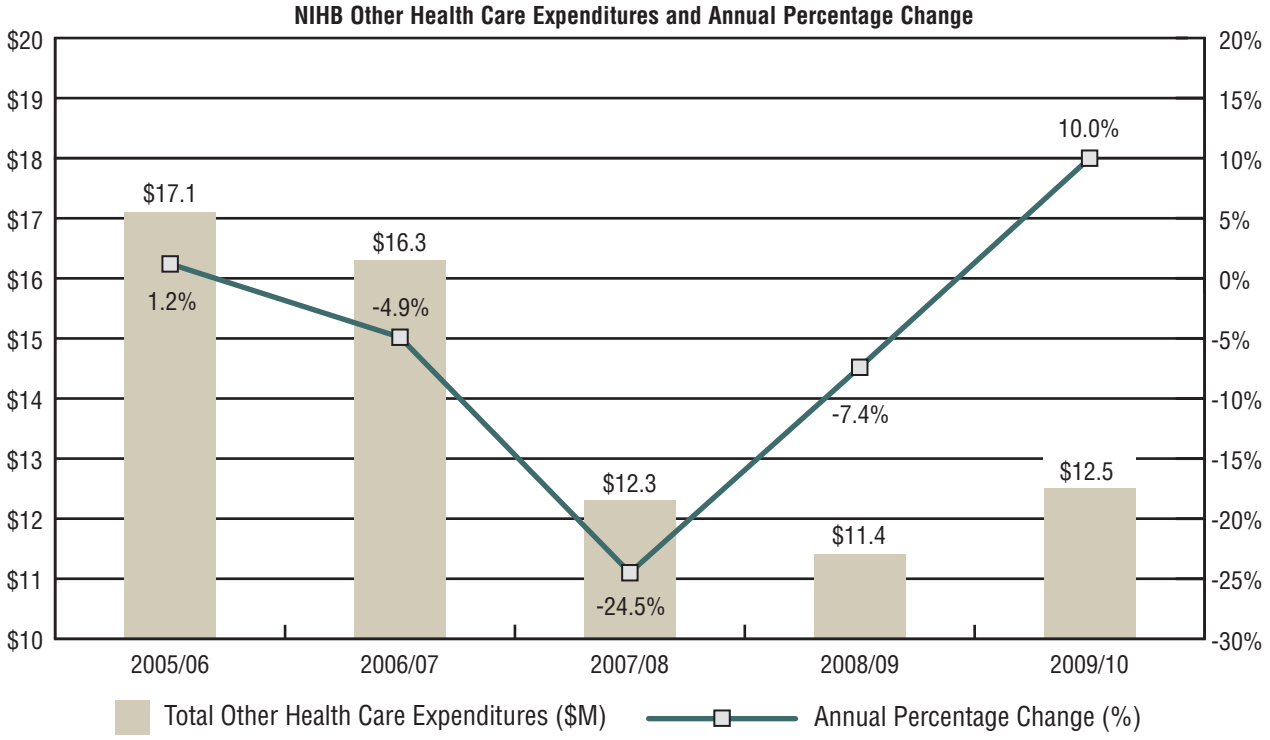
Annual NIHB Other Health Care Expenditures
2005/06 to 2009/10

In 2009/10, NIHB Other Health Care expenditures increased by 10.0%, a significant change compared to the decrease of 7.4% in 2008/09. Over the previous five fiscal years the annualized growth rate in this benefit area was -5.8%.

The highest expenditures for NIHB Other Health Care benefits were recorded in the Alberta Region at $4.4 million followed by the Manitoba Region at $3.1 million.

Expenditures under other health care comprise primarily short-term crisis intervention mental health counselling. Like other NIHB benefits, these services are demand-driven. The decline in expenditures experienced over the past several years is a result of clients accessing services through other service points such as counselling and mental health services through the Indian Residential Schools Resolution Health Support Program.

The decreased growth rate in 2007/08 is attributed primarily to an accounting methodology change which affected the other health care and medical transportation benefit categories. In previous fiscal years, physician travel to communities was reported under other health care in approximately half of the regions.



Source: FIRMS adapted by Program Analysis Division

NIHB Other Health Care Expenditures ($ 000's)					
REGION	2005/06	2006/07	2007/08	2008/09	2009/10
Atlantic	$ 201	$ 192	$ 272	$ 251	$ 213
Quebec	750	583	471	375	459
Ontario	2,213	2,530	2,172	2,158	2,603
Manitoba	5,690	4,786	2,964	2,619	3,143
Saskatchewan	2,237	2,244	942	870	812
Alberta	4,537	4,736	4,343	3,940	4,363
British Columbia	1,486	1,177	1,120	1,165	924
Yukon	1	22	4	1	1
N.W.T.	0	0	0	0	0
Nunavut	0	0	0	0	0
Total	**$ 17,115**	**$ 16,271**	**$ 12,289**	**$ 11,380**	**$ 12,516**

Source: FIRMS adapted by Program Analysis Division

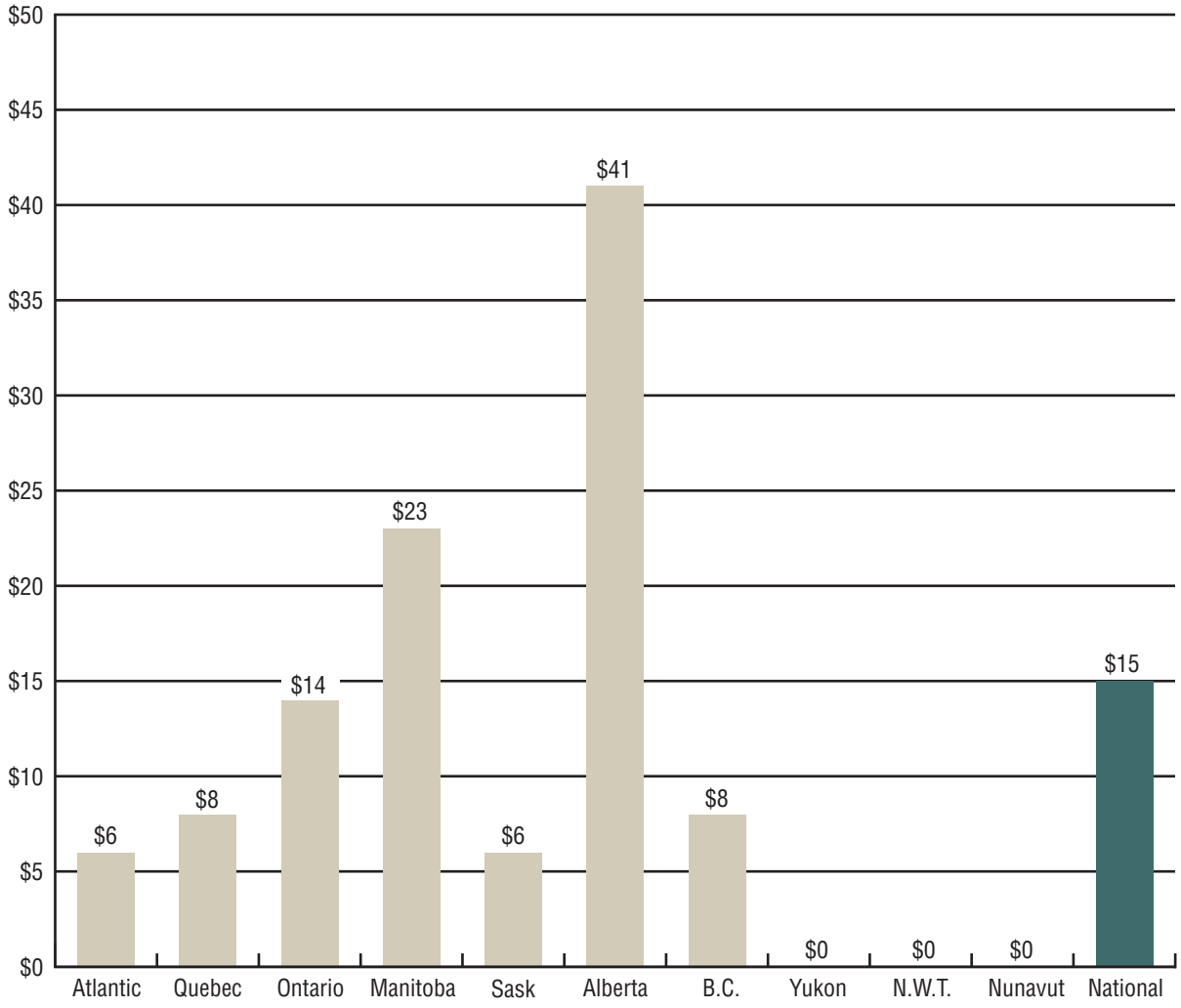
FIGURE 7.6

Per Capita NIHB Other Health Care Expenditures by Region
2009/10

In 2009/10, the national per capita expenditure for NIHB Other Health Care was $15, an increase from $14 in 2008/09.

The Alberta Region had the highest per capita expenditures at $41, an increase from $38 in the previous year. The high per capita expenditures in the Alberta Region is attributable primarily to some expenditures for the Indian Residential Schools Health Support Program being coded to the NIHB Program expenditures. This coding methodology has since been addressed.

The Manitoba Region followed with a total of $23 per eligible client, an increase from $20 in the previous year.



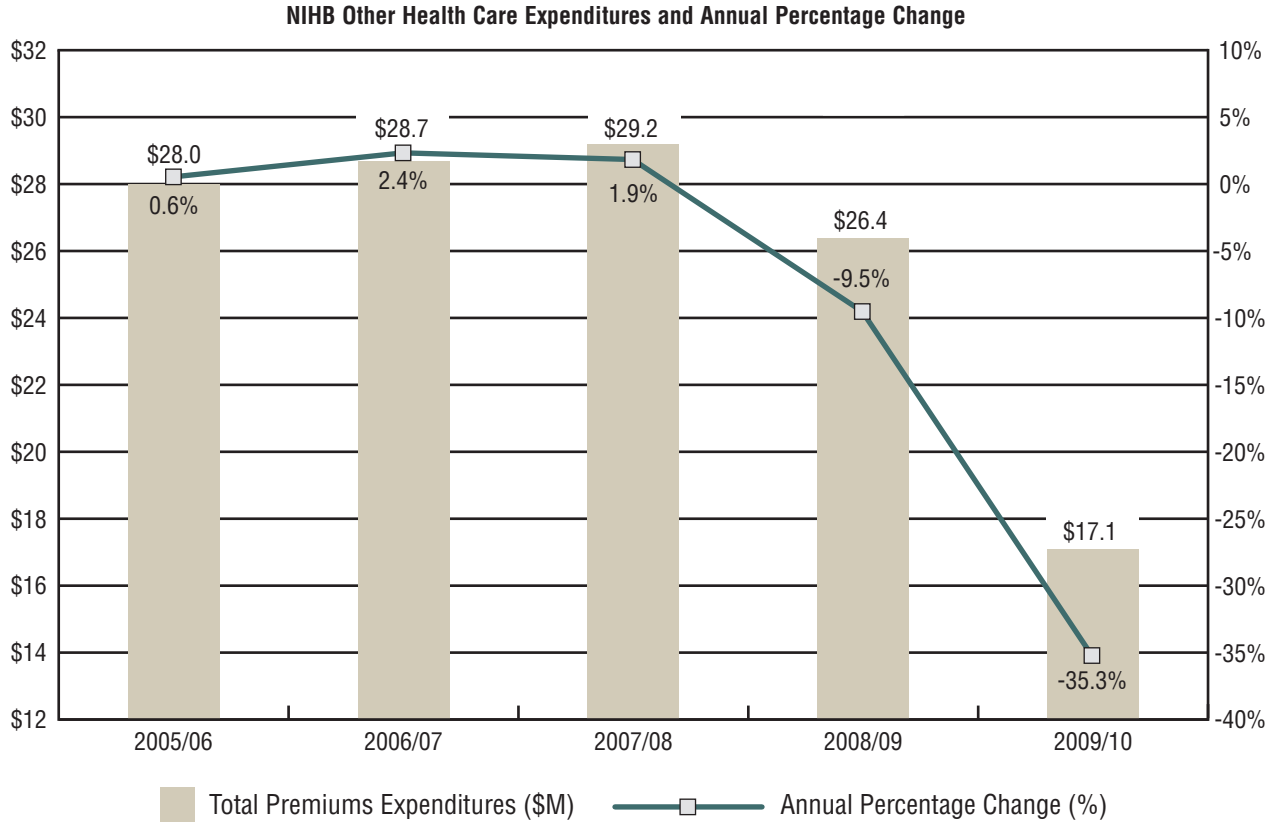
Source: SVS and FIRMS adapted by Program Analysis Division

FIGURE 7.7

Annual NIHB Premiums Expenditures
2005/06 to 2009/10

In 2009/10, NIHB Premiums expenditures totalled $17.1 million. Since January 1, 2009, the NIHB Program only covers premiums in the British Columbia Region. NIHB Premiums expenditures had a significant decrease over the previous year at -35.3% ($9.3 million). This decrease is mainly attributed to the NIHB Program no longer covering provincial health premiums in the Alberta Region. The Government of Alberta eliminated Alberta Health Care insurance premiums for all Albertans on January 1, 2009.

If only the British Columbia Region expenditures are taken into consideration in 2008/09, the growth rate for premiums in the British Columbia Region in 2009/10 would have been 3.6%. Over the previous five fiscal years the highest growth rate was recorded in 2006/07 at 2.4%, with the annualized growth rate for this benefit area being -9.3%. The annualized growth rate for the British Columbia Region is 2.1%.



Source: FIRMS adapted by Program Analysis Division

NIHB Premiums Expenditures ($ 000's)					
REGION	2005/06	2006/07	2007/08	2008/09	2009/10
Alberta	$ 12,381	$ 12,709	$ 12,961	$ 9,920	$ 0
British Columbia	15,606	15,951	16,250	16,510	17,110
Total	**$ 27,987**	**$ 28,659**	**$ 29,211**	**$ 26,430**	**$ 17,110**

Source: FIRMS adapted by Program Analysis Division

Elizabeth Lawrey by Judith P. Morgan

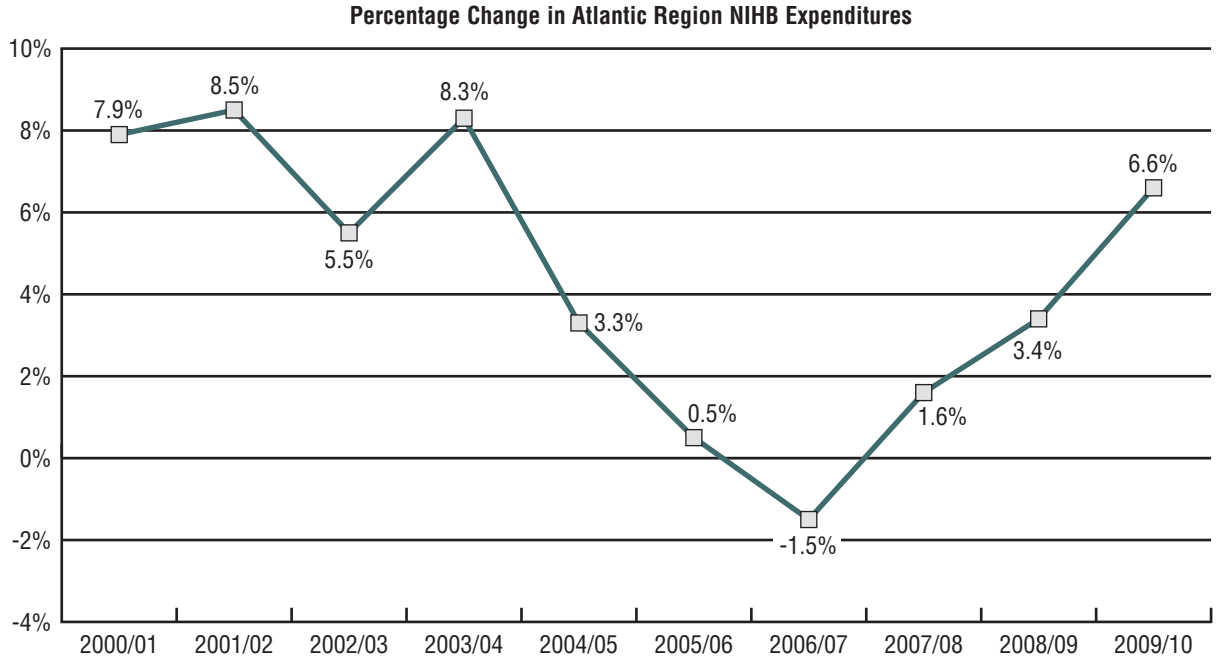
Regional Expenditure Trends 2000/01 to 2009/10

FIGURE 8.1

Atlantic Region
2000/01 to 2009/10

Annual expenditures in the Atlantic Region for 2009/10 totalled $33.7 million, an increase of 6.6% from the $31.6 million spent in 2008/09. Pharmacy expenditures in 2009/10 increased by 6.2% to $21.4 million, medical transportation costs increased by 8.4% to $5.0 million and dental expenditures increased by 9.7% to $5.4 million. Vision care expenditures increased by 1.0% while other health care costs decreased by 15.4%.

Pharmacy expenditures accounted for more than half of the Atlantic Region's total expenditures at 63.5%, dental expenditures ranked second at 16.1%, followed by medical transportation at 15.0%. Vision care and other health care accounted for 4.8% and 0.6% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)										
Atlantic Region	**2000/01**	**2001/02**	**2002/03**	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**
Medical Transportation	$ 6,098	$ 6,235	$ 6,314	$ 6,498	$ 6,124	$ 5,590	$ 4,401	$ 4,585	$ 4,655	$ 5,048
Pharmacy	11,371	12,667	14,322	16,265	17,533	18,293	18,938	18,984	20,119	21,357
Dental	4,511	5,196	4,691	4,857	4,934	4,831	5,128	5,204	4,945	5,426
Other Health Care	138	173	198	141	161	201	192	272	251	213
Vision Care	1,583	1,433	1,604	1,631	1,619	1,614	1,408	1,495	1,596	1,612
Total	**$ 23,701**	**$ 25,704**	**$ 27,128**	**$ 29,391**	**$ 30,371**	**$ 30,529**	**$ 30,067**	**$ 30,539**	**$ 31,567**	**$ 33,656**

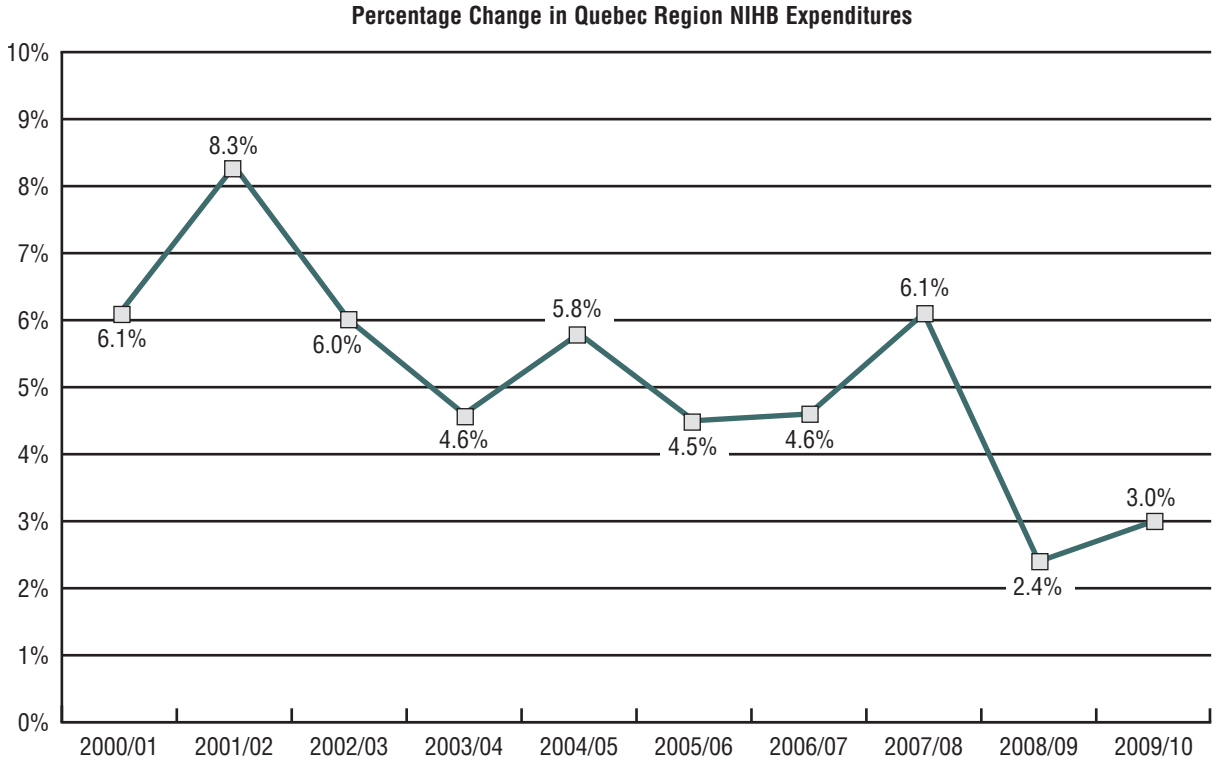
Source: FIRMS adapted by Program Analysis Division

FIGURE 8.2

Quebec Region
2000/01 to 2009/10

Annual expenditures in the Quebec Region for 2009/10 totalled $73.2 million, an increase of 3.0% from the $71.1 million spent in 2008/09. Pharmacy expenditures in 2009/10 increased by 3.6% to $37.4 million, medical transportation costs decreased by 2.8% to $19.9 million and dental expenditures increased by 9.8% to $14.2 million. Vision care and other health care expenditures increased by 5.0% and 22.4% respectively.

Pharmacy costs accounted for half of the Quebec Region's total expenditures at 51.1%, medical transportation expenditures ranked second at 27.2%, followed by dental at 19.3%. Vision care and other health care accounted for 1.7% and 0.6% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)										
Quebec Region	**2000/01**	**2001/02**	**2002/03**	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**
Medical Transportation	$ 15,475	$ 16,589	$ 16,877	$ 16,985	$ 17,291	$ 17,886	$ 18,473	$ 20,133	$ 20,502	$ 19,918
Pharmacy	19,680	22,209	25,005	27,436	29,959	31,771	33,486	35,372	36,069	37,358
Dental	9,574	10,505	10,292	10,277	10,525	10,970	11,603	12,141	12,895	14,159
Other Health Care	1,355	544	695	726	697	750	583	471	375	459
Vision Care	984	1,119	1,173	1,097	1,349	1,135	1,270	1,257	1,220	1,280
Total	**$ 47,068**	**$ 50,966**	**$ 54,042**	**$ 56,521**	**$ 59,820**	**$ 62,512**	**$ 65,414**	**$ 69,374**	**$ 71,060**	**$ 73,174**

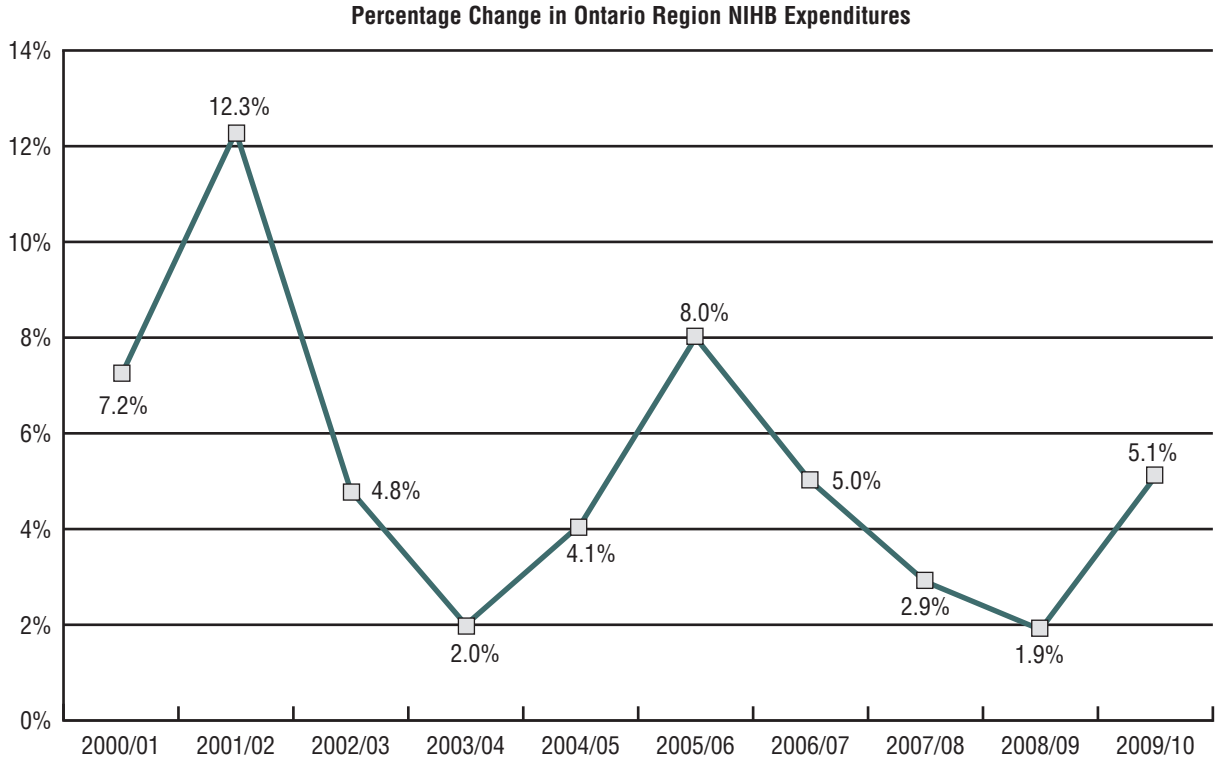
Source: FIRMS adapted by Program Analysis Division

FIGURE 8.3

Ontario Region
2000/01 to 2009/10

Annual expenditures in the Ontario Region for 2009/10 totalled $175.4 million, an increase of 5.1% from the $166.9 million spent in 2008/09. Pharmacy expenditures in 2009/10 increased slightly by 0.4% to $77.6 million while medical transportation costs increased by 10.8% to $51.9 million. However, in 2008/09 the Ontario Region had a one time budget allocation in medical transportation of $1.8 million. Without this one time investment, the growth rate of medical transportation expenditures in 2009/10 would have been 15.1% rather than 10.8%. Dental expenditures increased by 7.3% to $38.0 million. Vision care and other health care expenditures increased by 2.7% and 20.6% respectively.

Pharmacy expenditures accounted for 44.2% of the Ontario Region's total expenditures, medical transportation costs ranked second at 29.6%, followed by dental at 21.7%. Vision care and other health care accounted for 3.0% and 1.5% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)

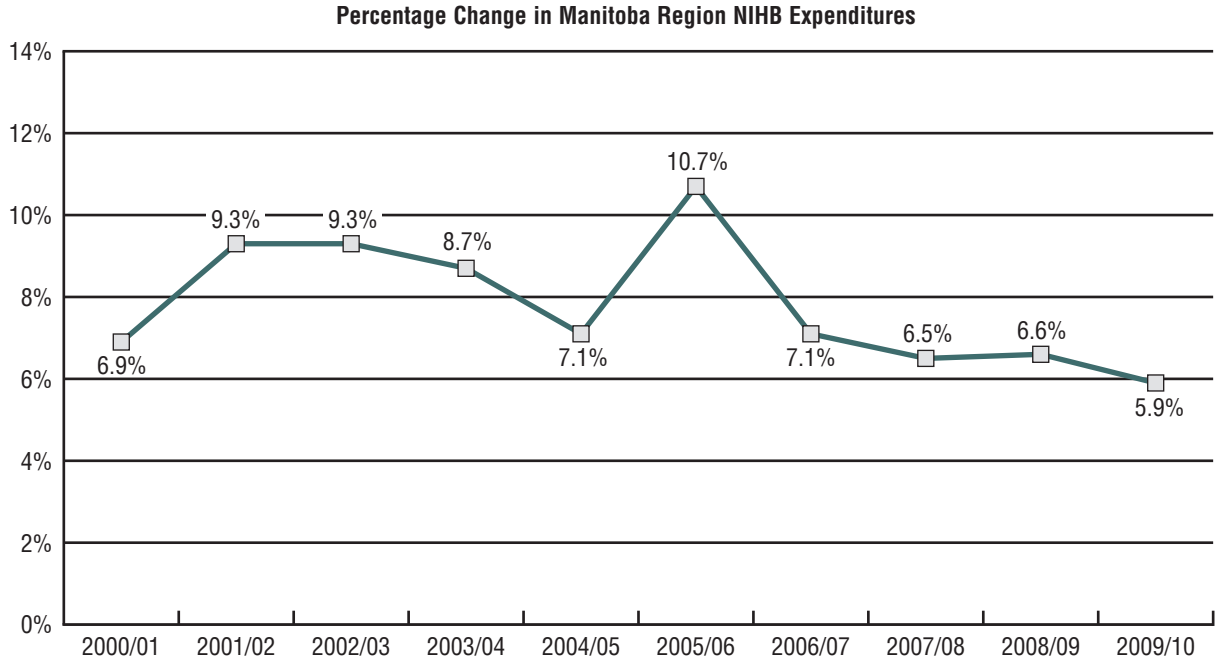
Ontario Region	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Medical Transportation	$ 35,072	$ 40,264	$ 37,493	$ 36,620	$ 35,258	$ 38,553	$ 40,572	$ 45,618	$ 46,848	$ 51,889
Pharmacy	45,244	51,167	57,929	62,953	67,508	73,223	77,788	77,191	77,244	77,564
Dental	23,255	27,568	29,042	27,760	29,655	32,064	32,777	33,467	35,457	38,047
Other Health Care	3,899	2,183	2,548	2,250	2,404	2,213	2,530	2,172	2,158	2,603
Vision Care	4,792	4,886	5,085	5,196	5,428	5,458	5,485	5,366	5,204	5,343
Total	**$ 112,262**	**$ 126,068**	**$ 132,097**	**$ 134,779**	**$ 140,253**	**$ 151,510**	**$ 159,152**	**$ 163,814**	**$ 166,910**	**$ 175,447**

Source: FIRMS adapted by Program Analysis Division

FIGURE 8.4

Manitoba Region
2000/01 to 2009/10

Annual expenditures in the Manitoba Region for 2009/10 totalled $195.4 million, an increase of 5.9% from the $184.5 million spent in 2008/09. Pharmacy expenditures in 2009/10 increased by 2.4% to $72.8 million and medical transportation costs increased by 7.1% to $89.1 million. Dental expenditures increased by 10.3% to $27.0 million. Vision care and other health care expenditures increased by 7.9% and 20.0% respectively. However, in 2008/09 the Manitoba Region had a one time budget allocation of $839 thousand in medical transportation, $86.6 thousand in vision care, $13.6 thousand in other health care, and $9.7 thousand in dental. Without these one time investments, the growth rate of these benefits in 2009/10 would have been 8.2% rather than 7.1% for medical transportation, 11.0% rather than 7.9% for vision care, 20.6% rather than 20.0% for other health care, and unchanged for dental at 10.3%.



Medical transportation expenditures comprised the largest portion of Manitoba Region's total expenditures at 45.6%, pharmacy costs ranked second at 37.3%, followed by dental at 13.8%. Vision care and other health care accounted for 1.7% and 1.6% of total expenditures respectively.

Annual Expenditures by Benefit ($ 000's)

Manitoba Region	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Medical Transportation	$ 46,089	$ 48,320	$ 51,199	$ 53,533	$ 55,895	$ 63,322	$ 69,047	$ 76,082	$ 83,193	$ 89,078
Pharmacy	35,533	36,078	42,525	48,519	53,998	59,409	64,966	69,317	71,081	72,789
Dental	11,832	16,319	16,600	17,313	18,705	20,326	20,756	21,696	24,444	26,954
Other Health Care	3,218	4,023	4,675	5,621	5,685	5,690	4,786	2,964	2,619	3,143
Vision Care	1,748	2,860	2,640	2,888	2,684	2,864	2,841	2,936	3,157	3,407
Total	**$ 98,420**	**$ 107,600**	**$ 117,638**	**$ 127,874**	**$ 136,967**	**$ 151,610**	**$ 162,396**	**$ 172,994**	**$ 184,494**	**$ 195,371**

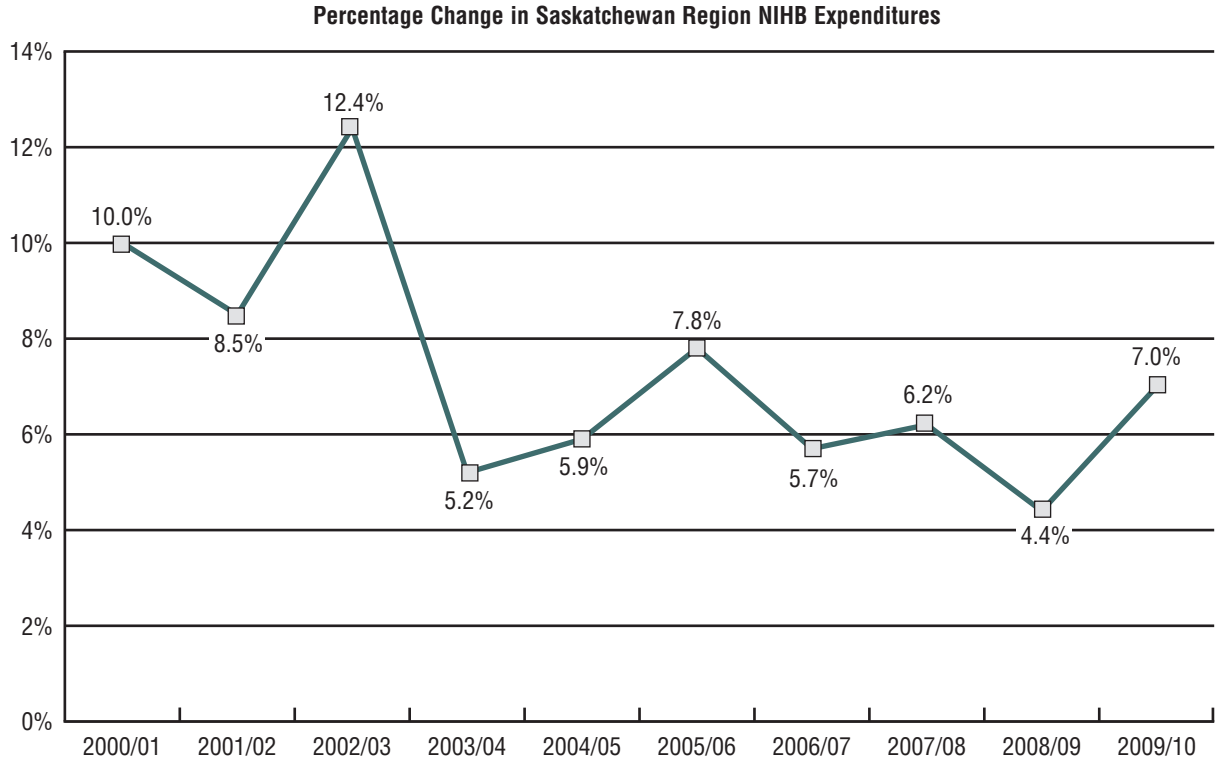
Source: FIRMS adapted by Program Analysis Division

FIGURE 8.5

Saskatchewan Region
2000/01 to 2009/10

Annual expenditures in the Saskatchewan Region for 2009/10 totalled $141.4 million, an increase of 7.0% from the $132.2 million spent in 2008/09. Pharmacy expenditures in 2009/10 increased by 6.1% to $66.6 million and medical transportation costs increased by 7.5% to $39.0 million. However, in 2008/09 the Saskatchewan Region had a one time budget allocation in medical transportation of $467 thousand. Without this one time investment, the growth rate of medical transportation expenditures in 2009/10 would have been 8.9% rather than 7.5%. Dental expenditures increased by 9.5% to $30.8 million. Vision care costs increased by 1.3% while other health care expenditures decreased by 6.7%.

Pharmacy expenditures accounted for almost half of the Saskatchewan Region's total expenditures at 47.1%, medical transportation costs ranked second at 27.6%, followed by dental at 21.8%. Vision care and other health care accounted for 3.0% and 0.6% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)

Saskatchewan Region	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Medical Transportation	$ 24,438	$ 23,862	$ 25,853	$ 25,854	$ 26,758	$ 28,786	$ 31,816	$ 36,108	$ 36,239	$ 38,971
Pharmacy	34,926	38,240	44,394	48,952	52,636	55,687	58,083	60,749	62,809	66,639
Dental	12,731	15,708	17,649	18,297	19,530	22,038	23,219	24,636	28,102	30,777
Other Health Care	2,032	2,663	2,671	2,370	2,295	2,237	2,244	942	870	812
Vision Care	2,890	3,113	3,360	3,375	3,431	4,072	3,835	4,126	4,166	4,222
Total	**$ 77,017**	**$ 83,586**	**$ 93,927**	**$ 98,847**	**$ 104,651**	**$ 112,820**	**$ 119,197**	**$ 126,561**	**$ 132,185**	**$ 141,420**

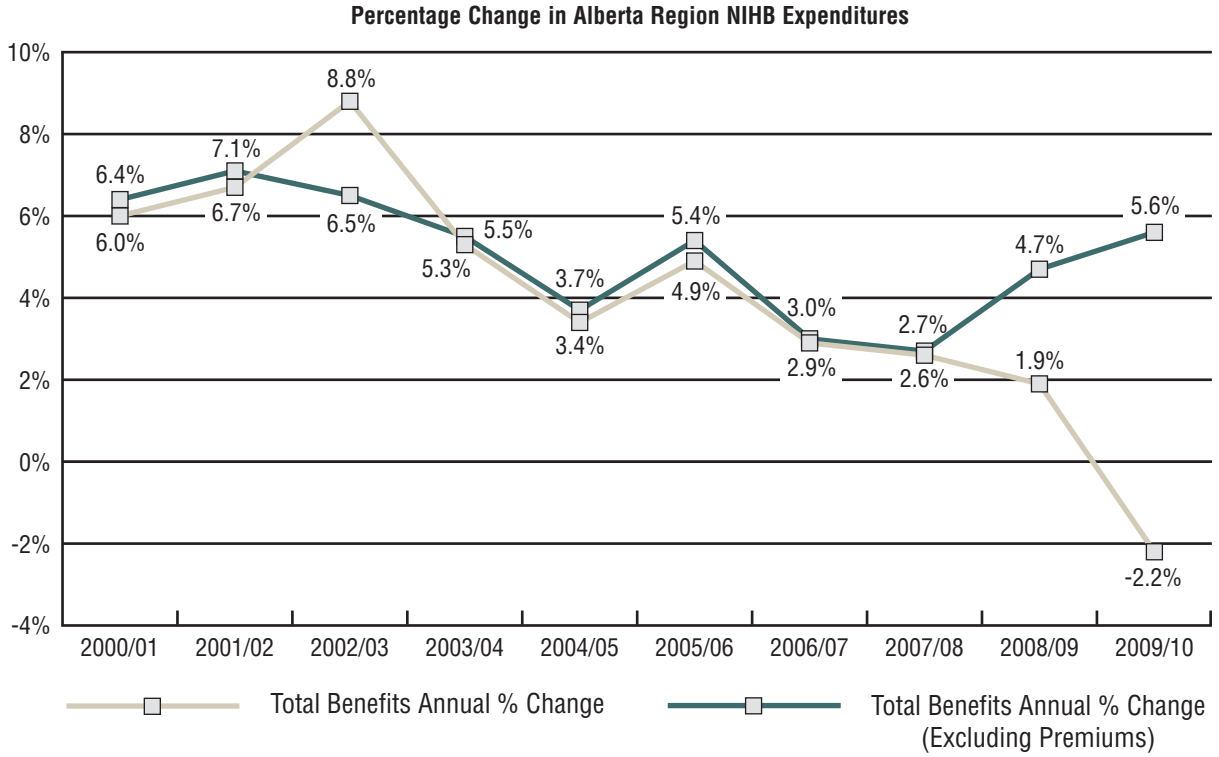
Source: FIRMS adapted by Program Analysis Division

FIGURE 8.6

Alberta Region
2000/01 to 2009/10

Annual expenditures in the Alberta Region for 2009/10 totalled $130.7 million, a decrease of 2.2% from the $133.6 million spent in 2008/09. The decreased growth rate is mainly attributed to the NIHB Program no longer covering provincial health premiums in the Alberta Region because the Government of Alberta eliminated Alberta Health Care insurance premiums for all Albertans as of January 1, 2009. Consequently, in 2009/10 the NIHB Program no longer covered health premiums in the Alberta Region. The overall adjusted growth rate excluding premiums for this region over 2008/09 is 5.6% or a net growth of $6.9 million.

Pharmacy expenditures in 2009/10 increased by 4.4% to $56.6 million, medical transportation costs increased by 3.5% to $36.6 million and dental expenditures increased by 11.0% to $27.8 million. Vision care and other health care expenditures increased by 2.9% and 10.7% respectively.



Pharmacy expenditures accounted for 43.3% of the Alberta Region's total expenditures, medical transportation costs ranked second at 28.0%, followed by dental at 21.2%. Vision care and other health care accounted for 4.1% and 3.3% of total expenditures respectively.

Annual Expenditures by Benefit ($ 000's)

Alberta Region	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Medical Transportation	$ 28,116	$ 29,796	$ 28,856	$ 29,030	$ 29,686	$ 30,712	$ 32,204	$ 32,107	$ 35,357	$ 36,601
Pharmacy	33,365	36,781	41,590	45,588	48,207	51,141	$52,424	54,353	54,189	56,570
Dental	15,527	16,680	18,375	19,237	19,306	20,594	$21,006	22,391	25,016	27,756
Other Health Care	4,285	3,371	3,856	3,794	4,078	4,537	$4,736	4,343	3,940	4,363
Vision Care	3,696	4,397	4,239	4,576	4,720	4,762	$4,690	4,942	5,225	5,377
Sub-Total	**84,989**	**91,025**	**96,916**	**102,224**	**105,996**	**111,746**	**$115,060**	**118,135**	**123,726**	**130,666**
Premiums	8,689	8,914	11,790	12,202	12,377	12,381	$12,709	12,961	9,920	0
Total	**$ 93,678**	**$ 99,939**	**$ 108,706**	**$ 114,426**	**$ 118,373**	**$ 124,127**	**$ 127,769**	**$ 131,096**	**$ 133,646**	**$ 130,666**

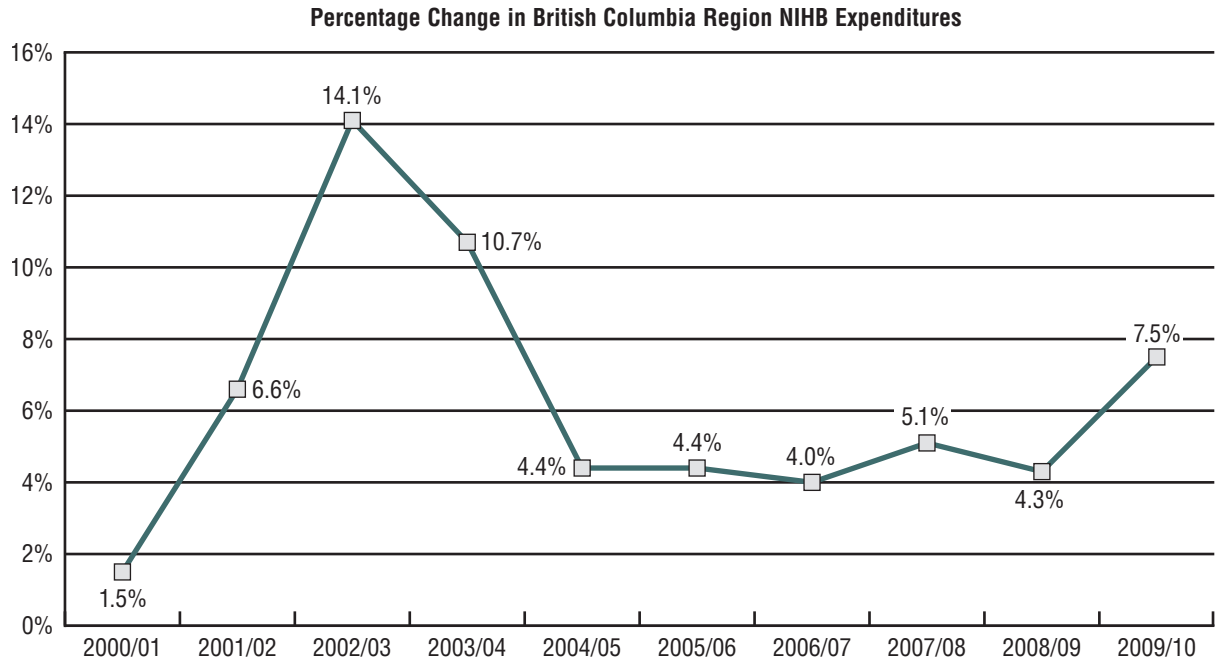
Source: FIRMS adapted by Program Analysis Division

FIGURE 8.7

British Columbia Region
2000/01 to 2009/10

Annual expenditures in the British Columbia Region for 2009/10 totalled $133.7 million, an increase of 7.5% from the $124.5 million spent in 2008/09. Pharmacy expenditures in 2009/10 increased by 4.9% to $58.9 million, medical transportation costs increased by 12.5% to $25.5 million and dental expenditures increased by 13.5% to $28.0 million. The cost of premiums and vision care increased by 3.6% and 0.1% respectively while other health care decreased by 20.7%.

Pharmacy expenditures accounted for 44.0% of the British Columbia Region's total expenditures, dental costs ranked second at 21.0%, followed by medical transportation at 19.1%. Premiums, vision care and other health care accounted for 12.8%, 2.4% and 0.7% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)										
British Columbia Region	**2000/01**	**2001/02**	**2002/03**	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**
Medical Transportation	$ 12,718	$ 14,039	$ 16,410	$ 16,408	$ 17,340	$ 16,944	$ 20,284	$ 21,613	$ 22,711	$ 25,547
Pharmacy	30,185	33,592	38,922	44,141	46,670	49,734	50,387	54,290	56,104	58,862
Dental	18,078	18,230	19,224	18,338	20,357	22,439	22,588	22,968	24,718	28,042
Other Health Care	1,831	1,165	1,240	1,653	1,581	1,486	1,177	1,120	1,165	924
Vision Care	2,518	2,622	2,601	3,259	3,249	3,049	3,232	3,120	3,251	3,253
Sub-Total	**65,330**	**69,648**	**78,397**	**83,800**	**89,197**	**93,652**	**97,669**	**103,111**	**107,948**	**116,628**
Premiums	9,091	9,682	12,113	16,411	15,453	15,606	15,951	16,250	16,510	17,110
Total	**$ 74,421**	**$ 79,330**	**$ 90,510**	**$ 100,212**	**$ 104,650**	**$ 109,259**	**$ 113,620**	**$ 119,361**	**$ 124,458**	**$ 133,739**

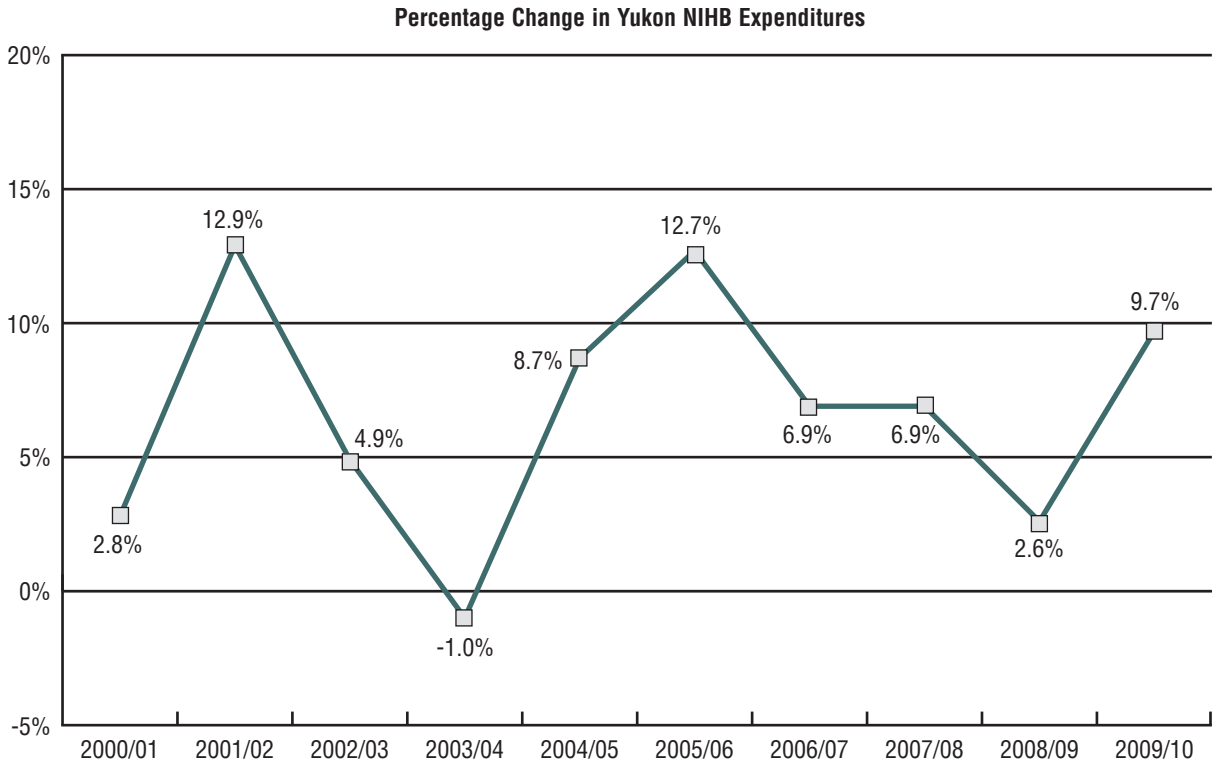
Source: FIRMS adapted by Program Analysis Division

FIGURE 8.8

Yukon
2000/01 to 2009/10

Annual expenditures in the Yukon for 2009/10 totalled $10.1 million, an increase of 9.7% from the $9.2 million spent in 2008/09. Pharmacy expenditures in 2009/10 decreased by 1.5% to $3.7 million while medical transportation costs increased by 29.4% to $3.8 million. Dental expenditures increased by 1.1% to $2.3 million.

Medical transportation expenditures accounted for 37.7% of Yukon's total expenditures, pharmacy expenditures ranked second at 36.9%, followed by dental and vision care at 22.5% and 3.0% respectively.



Annual Expenditures by Benefit ($ 000's)										
Yukon	**2000/01**	**2001/02**	**2002/03**	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**
Medical Transportation	$ 1,852	$ 2,020	$ 1,957	$ 1,600	$ 1,774	$ 2,100	$ 2,421	$ 2,935	$ 2,938	$ 3,801
Pharmacy	2,393	2,649	3,048	3,214	3,476	3,655	3,641	3,802	3,779	3,723
Dental	994	1,284	1,236	1,365	1,229	1,863	2,033	1,998	2,246	2,271
Other Health Care	16	13	11	2	4	1	22	4	1	1
Vision Care	208	199	218	223	480	228	274	230	242	299
Total	**$ 5,463**	**$ 6,165**	**$ 6,470**	**$ 6,405**	**$ 6,963**	**$ 7,847**	**$ 8,392**	**$ 8,970**	**$ 9,206**	**$ 10,095**

Source: FIRMS adapted by Program Analysis Division

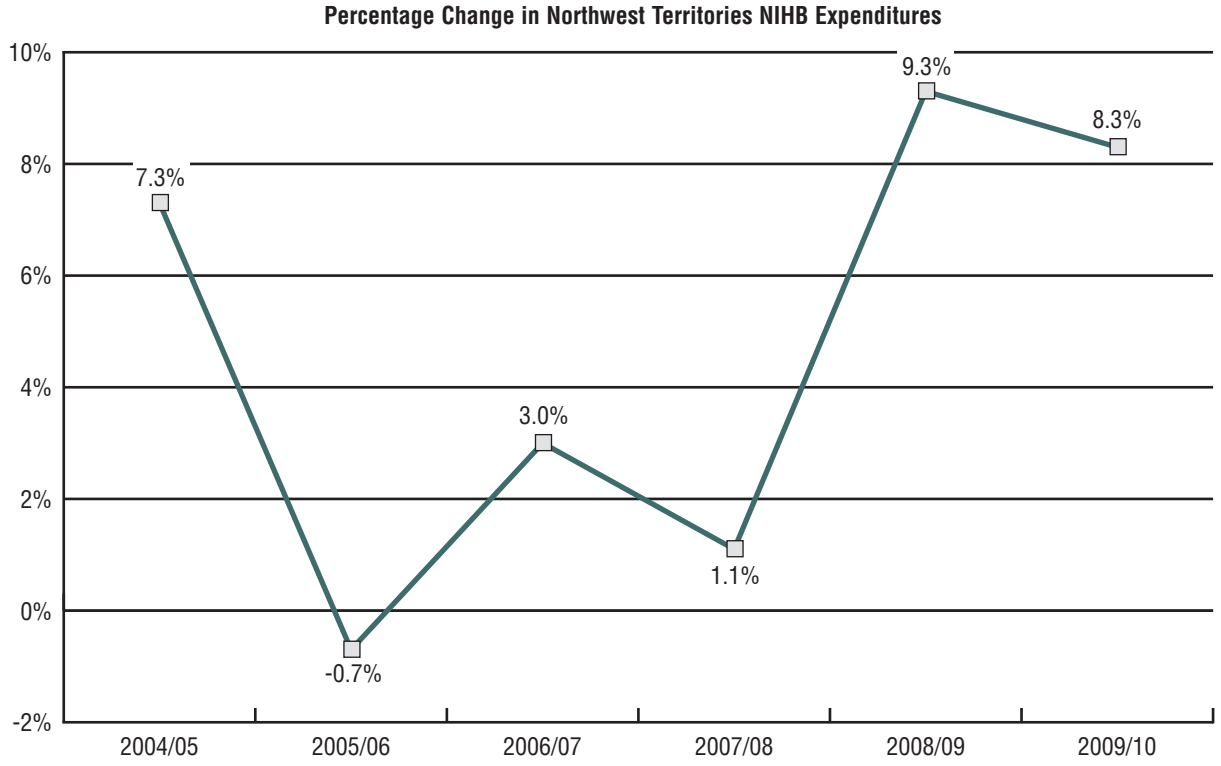
FIGURE 8.9

Northwest Territories
2003/04 to 2009/10

Annual expenditures in the Northwest Territories in 2009/10 totalled $25.5 million, an increase of 8.3% from the $23.6 million spent in 2008/09. Pharmacy expenditures in 2009/10 increased by 4.7% to $8.6 million, medical transportation costs increased by 7.1% to $8.5 million and dental expenditures increased by 12.5% to $7.1 million. Vision care costs increased by 18.6% to $1.3 million.

Pharmacy costs accounted for 33.7% of the total expenditures of the Northwest Territories, medical transportation expenditures ranked second at 33.4%, followed by dental at 27.7%. Vision care made up 5.3% of total expenditures.

Separate data for the Northwest Territories and Nunavut cannot be reported on for the period prior to 2003/04.



Annual Expenditures by Benefit ($ 000's)							
Northwest Territories	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**
Medical Transportation	$ 6,856	$ 7,428	$ 6,710	$ 7,116	$ 6,943	$ 7,952	$ 8,520
Pharmacy	7,161	7,544	8,010	8,151	7,863	8,210	8,595
Dental	4,726	5,173	5,249	5,249	5,752	6,279	7,067
Other Health Care	0	0	0	0	0	0	0
Vision Care	700	718	743	819	1,011	1,130	1,340
Total	**$ 19,443**	**$ 20,863**	**$ 20,712**	**$ 21,335**	**$ 21,570**	**$ 23,571**	**$ 25,521**

Source: FIRMS adapted by Program Analysis Division

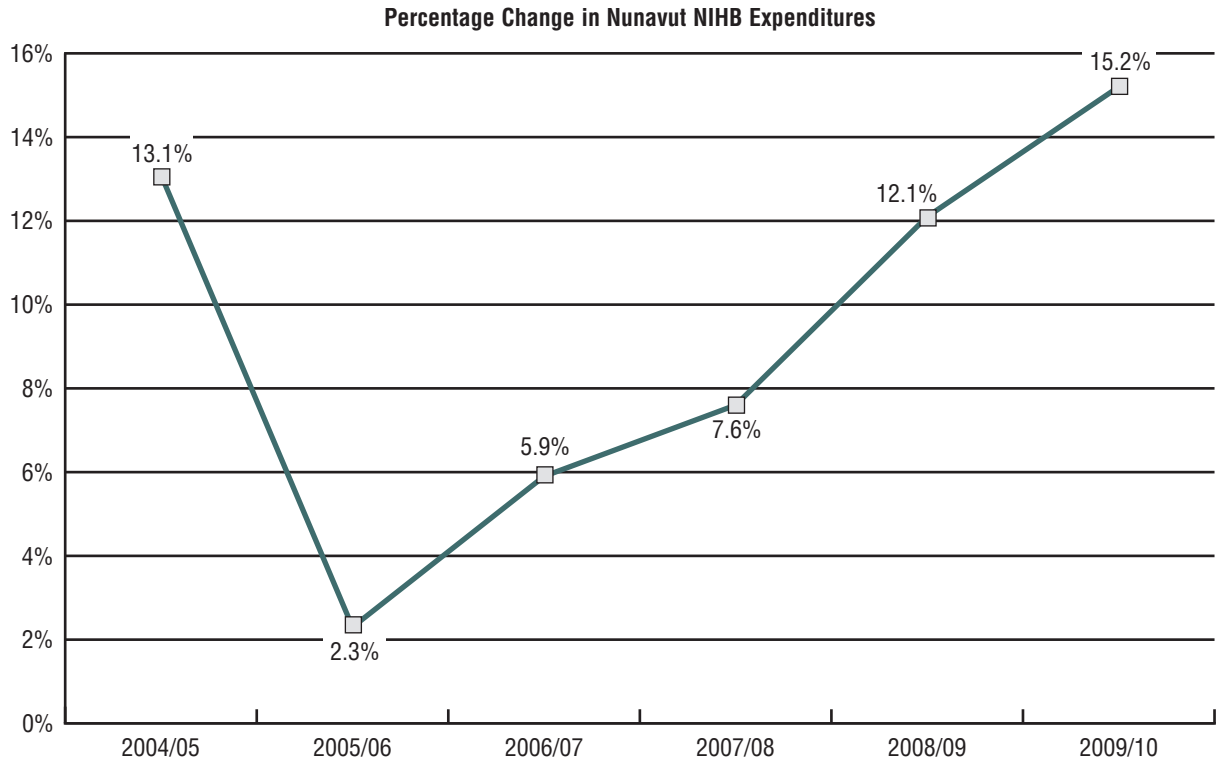
FIGURE 8.10

Nunavut
2003/04 to 2009/10

Annual expenditures in Nunavut for 2009/10 totalled $42.5 million, an increase of 15.2% from the $36.9 million spent in 2008/09. Pharmacy expenditures in 2009/10 increased by 16.3% to $8.2 million and medical transportation costs increased by 11.2% to $22.3 million. However, in 2008/09 Nunavut had a one time budget allocation in medical transportation of $2.4 million. Without this one time investment, the growth rate of medical transportation expenditures in 2009/10 would have been 26.3% rather than 11.2%. Dental expenditures increased by 23.2% to $10.3 million and vision care costs increased by 18.7% to $1.6 million.

Medical transportation costs accounted for 52.5% of the total expenditures of Nunavut, dental expenditures ranked second at 24.2%, followed by pharmacy at 19.4%. Vision care made up 3.9% of total expenditures.

Separate data for the Northwest Territories and Nunavut cannot be reported on for the period prior to 2003/04.



Annual Expenditures by Benefit ($ 000's)							
Nunavut	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**
Medical Transportation	$ 12,409	$ 13,972	$ 14,776	$ 15,268	$ 16,171	$ 20,053	$ 22,302
Pharmacy	4,150	4,734	4,902	5,526	6,579	7,084	8,237
Dental	6,932	8,566	8,137	8,740	9,002	8,349	10,289
Other Health Care	0	0	0	0	0	0	0
Vision Care	1,475	951	1,044	1,040	1,139	1,387	1,646
Total	**$ 24,965**	**$ 28,223**	**$ 28,860**	**$ 30,574**	**$ 32,890**	**$ 36,873**	**$ 42,474**

Source: FIRMS adapted by Program Analysis Division

Divinity of Light by Leonard A. George Jr.

Initiatives and Activities

SECTION 9.1

Health Information and Claims Processing Services (HICPS)
2009/10

Claims for the Non-Insured Health Benefits (NIHB) Program pharmacy, dental and medical supplies and equipment (MS&E) benefits provided to eligible First Nations and Inuit clients are processed via the Health Information and Claims Processing Services (HICPS) system. HICPS includes administrative services and programs, technical support and automated information management systems used to process and pay claims in accordance with NIHB Program client/benefit eligibility and pricing policies.

The NIHB Program manages the HICPS contract as the project authority in conjunction with Public Works and Government Services Canada (PWGSC), the contract authority.

The NIHB Program is responsible for developing, maintaining and managing key business processes, systems and services required to deliver HICPS. Since 1990, the NIHB Program has retained the services of a private sector contractor to administer the following core claims processing services on its behalf:

- Claim processing and payment operations;
- Claim adjudication and reporting systems development and maintenance;
- Provider registration and communications;
- Systems in support of pharmacy and MS&E benefits prior approval and dental predetermination processes;
- Provider audit programs and audit recoveries; and
- Standard and ad hoc reporting.

As a result of a competitive contracting process led by PWGSC, Express Scripts Inc. (ESI) Canada commenced operations as the new claims processor for the NIHB Program on December 1, 2009. ESI Canada and Health Canada worked jointly with the previous claims processor, First Canadian Health Management Corporation (FCH), to facilitate the transition for clients and providers between the two claims processors. Prior to the transition, ESI Canada had undertaken the re-enrolment of providers previously enrolled with FCH.

As of March 31, 2010, 25,520 active providers* were registered with the HICPS claims processor to deliver NIHB pharmacy, MS&E and dental benefits. The number of claims settled through the HICPS system is highlighted in Figure 9.1.1.

* An active provider has participated in the NIHB Program at least once over the past 24 months.

FIGURE 9.1.1

Number of Claim Lines Settled Through the Health Information and Claims Processing Services System in 2009/10

REGION	Pharmacy	Dental	MS&E	Total
Atlantic	768,995	90,561	22,362	**881,918**
Quebec	1,780,354	171,334	15,571	**1,967,259**
Ontario	3,617,710	518,819	31,796	**4,168,325**
Manitoba	2,553,437	351,519	70,143	**2,975,099**
Saskatchewan	2,117,530	325,820	58,359	**2,501,709**
Alberta	2,223,599	494,879	56,999	**2,775,477**
British Columbia	2,449,762	488,239	39,701	**2,977,702**
Yukon	87,990	22,056	2,895	**112,941**
Northwest Territories	170,478	72,100	6,610	**249,188**
Nunavut	154,916	98,035	5,006	**257,957**
Total Claim Lines	**15,924,771**	**2,633,362**	**309,442**	**18,867,575**

Source: HICPS adapted by Program Analysis Division

Figure 9.1.1 sets out the total number of pharmacy, dental and MS&E claims settled through the HICPS system in fiscal year 2009/10. During this time, 18,867,575 claim lines were processed through HICPS, an increase of 4.1% over the previous fiscal year.

Claim Lines vs. Prescriptions

It is important to note that the Program reports annually on claim lines. This is an administrative unit of measure as opposed to a health care unit of measure. A claim line represents a transaction in the claims processing system and is not equivalent to a prescription. Prescriptions can contain a number of different drugs with each one represented by a separate claim line. Prescriptions for a number of drugs may be repeated and refilled many times throughout the year. In the case of repeating prescriptions, each time a prescription is refilled, the system will log another transaction (claim line). Therefore, it is possible for an individual who has a prescription that repeats multiple times in a year to have numerous related claim lines associated with the single prescription. Some prescriptions (e.g. methadone) are dispensed daily and will increase the per capita number of claim lines.

SECTION 9.2

Provider Audit Activities
2009/10

The NIHB Program is a publicly-funded program that must account for the expenditure of those public funds. The Provider Audit Program contributes to the fulfillment of this overall requirement. As part of the Health Information and Claims Processing Services (HICPS) system financial controls, Health Canada has mandated the claims processor to maintain a set of pre-payment as well as post-payment verification processes including a provider audit program. During 2009/10, the previous claims processor, First Canadian Health Management Corporation (FCH), and the new claims processor, Express Scripts Inc. (ESI) Canada, carried out audit activities as directed by the NIHB Program. The audit activities address the need of the NIHB Program both to comply with accountability requirements for the use of public funds and to ensure provider compliance with the terms and conditions of the Program as outlined in the NIHB Provider Claims Submission Kit, Provider Agreement and other relevant documents. The objectives of the audit program are to detect billing irregularities, to validate active licensure of providers, to ensure that any required signatures on claim submissions are valid, to ensure that services paid for were received by eligible NIHB clients and to ensure that providers retained appropriate documentation in support of each claim. Claims not meeting the billing requirements of the NIHB Program are subject to audit recovery.

There are five components of the Provider Audit Program for the pharmacy, medical supplies and equipment and dental benefit areas. These are:

1) Next Day Claims Verification (NDCV) Program which consists of a review of a defined sample of claims submitted by providers the day following receipt by FCH/ESI;
2) Client Confirmation Program (CCP) which consists of a monthly mail-out to a randomly selected sample of NIHB clients to confirm the receipt of the benefit that has been billed on their behalf;
3) Provider Profiling Program which consists of a review of the billings of all providers against selected criteria and the determination of the most appropriate follow-up activity if concerns are identified;
4) On-Site Audit Program which consists of the selection of a sample of claims for administrative validation with a provider's records through an on-site visit; and
5) Desk Audit Program which consists of the selection of a sample of claims for administrative validation with a provider's records. Unlike on-site audits, a desk audit serves to validate records through the use of fax or mail. Generally, a smaller number of claims are reviewed during a desk audit.

During 2009/10, the primary issues identified in on-site audits were as follows:

- Documentation to support paid claims was either not available for audit review or did not meet the NIHB Program requirements;
- Paid claims did not match the item/service provided to the client;
- Items/services were claimed prior to client(s) receiving the services/items;
- Professional fee submitted was higher than the NIHB approved rate; and
- Overcharging of drugs/items and/or associated fees/markup.

Completion of the audit process often spans more than one fiscal year. Although the complete audit recovery for any audit may overlap into another fiscal year, recoveries from on-site audits are recorded in the fiscal year in which they are received.

Annual Provider Review

Since 2007, NIHB has conducted an annual review of providers to identify anomalous billing patterns. Providers with unexplained anomalies can be put under a restricted billing regime or de-listed as a provider because of financial risk to the NIHB Program. Since 2007, ten pharmacy and two dental providers have been de-listed. In 2009/10, no additional pharmacy or dental providers were de-listed.

Benefit Audit Frameworks

As part of meeting its management accountability responsibilities, NIHB has developed additional audit frameworks for NIHB Medical Transportation, Vision Care and Mental Health Care benefits. These frameworks provide effective mechanisms to conduct reviews on the utilization of these benefits and their associated expenditures. In 2009/10, reviews were conducted on the NIHB Vision Care benefit in the Ontario Region and on Crisis Mental Health benefits in the Atlantic Region.

FIGURE 9.2.1

Audit Recoveries by Benefit and Region
2009/10

Figure 9.2.1 identifies audit recoveries, Next Day Claims Verification (NDCV) and Client Confirmation Program (CCP) savings from all components of the FCH/ESI Provider Audit Program during the 2009/10 fiscal year.

DENTAL				
REGION	Audits Completed	Recoveries	NDCV/CCP Savings	Total Recoveries/ Savings
Atlantic	3	$ 291	$ 9,047	$ 9,338
Quebec	0	6,925	14,859	21,784
Ontario	1	533	86,550	87,083
Manitoba	8	5,277	30,446	35,723
Saskatchewan	8	92,717	32,101	124,818
Alberta	6	86,017	78,162	164,179
British Columbia	3	60,186	79,831	140,017
Yukon	2	12,823	3,233	16,056
N.W.T.	2	2,410	7,646	10,056
Nunavut	3	0	11,562	11,562
Total	36	$ 267,178	$ 353,437	$ 620,615

PHARMACY				
REGION	Audits Completed	Recoveries	NDCV/CCP Savings	Total Recoveries/ Savings
Atlantic	3	$ 24,282	$ 41,503	$ 65,785
Quebec	9	25,968	53,796	79,764
Ontario	13	530,345	267,269	797,614
Manitoba	27	219,742	198,528	418,271
Saskatchewan	9	69,825	70,374	140,199
Alberta	14	343,014	97,112	440,126
British Columbia	9	162,958	59,956	222,914
Yukon	0	0	7,134	7,134
N.W.T.	0	0	19,027	19,027
Nunavut	0	0	31,374	31,374
Total	84	$ 1,376,135	$ 846,074	$ 2,222,209

MS&E				
REGION	Audits Completed	Recoveries	NDCV/CCP Savings	Total Recoveries/ Savings
Atlantic	2	$ 0	$ 29,104	$ 29,104
Quebec	0	0	10,524	10,524
Ontario	2	6,603	40,311	46,914
Manitoba	5	1,561	25,894	27,455
Saskatchewan	1	4,761	23,051	27,811
Alberta	3	85	36,183	36,268
British Columbia	0	53	54,601	54,654
Yukon	0	0	168	168
N.W.T.	0	0	15,711	15,711
Nunavut	0	0	144	144
Total	13	$ 13,063	$ 235,691	$ 248,754

Note: The data for the period April 1, 2009 to November 30, 2009 is provided by FCH and the data for the period December 1, 2009 to March 31, 2010 is provided by ESI Canada.

SECTION 9.3

Federal Dental Care Advisory Committee (FDCAC)

The Federal Dental Care Advisory Committee (FDCAC) is an advisory body of oral health professionals established to provide advice on dental matters as requested by federal departments.

Participating federal departments include: Health Canada, Veterans Affairs Canada, Royal Canadian Mounted Police, Correctional Services Canada, Citizenship and Immigration Canada and National Defence. Observers are included at FDCAC meetings at the discretion of the Chair in consultation with the federal departments. The total number of observers shall not exceed three. The suggested composition is two observers from the Assembly of First Nations (AFN) and one from the Inuit Tapiriit Kanatami (ITK).

The mandate of the FDCAC is to advise the Chief Dental Officer at Health Canada and each of the federal departments on oral health policy, on best practices and evidence based oral health as well as on specific clinical issues, including current issues, new technologies, procedures as well as complementary issues that will impact on the oral and dental health and needs of their clients.

The approach is evidence-based. The professional advice reflects dental and scientific knowledge, current best practice in all aspects of clinical practice as well as health and health care delivery appropriate to specific client health needs. The expert dental health professional advice assures federal clients of a dental program which considers their health and oral health needs, facilitates decision-making within resource allocation and fosters communication with dental health professionals providing services on behalf of federal programs.

The Committee may have up to four scheduled meetings each year, and may be required to meet for an additional meeting depending upon the needs of the federal departments. The appointment of members is carried out by the Chair in consultation with the federal departments and the FDCAC Secretariat to determine the expertise required. A normal term of appointment for members is three years renewable. Rotation of members is gradual to ensure continuity of membership on the FDCAC.

The responsibility for the FDCAC Secretariat was assumed by the Office of the Chief Dental Officer as of April 1, 2006. The NIHB Program remains an active participant on the FDCAC.

SECTION 9.4

NIHB Pharmacy and Medical Supplies and Equipment Benefit Policy Framework

The NIHB Pharmacy and Medical Supplies and Equipment Benefit Policy Framework was published in March 2010. The purpose of this document is to explain the overarching policies that guide the administration of the pharmacy and medical supplies and equipment benefits.

This policy framework is intended to provide stakeholders, providers and clients with a broad overview of the parameters of the NIHB Program policies as they relate specifically to the pharmacy and medical supplies and equipment (MS&E) benefit area.

This policy framework can be found on the internet at: **http://www.healthcanada.gc.ca/nihb-publications**

SECTION 9.5

The Drug Review Process

The NIHB Program is a member of the Federal/Provincial/Territorial (F/P/T) Common Drug Review (CDR) process, whereby drugs that are new chemical entities, new combination drug products, or existing drug products with new indications on the Canadian market are reviewed on behalf of all participating F/P/T public drug programs. For these drug products, the CDR, through the Canadian Expert Drug Advisory Committee (CEDAC), helps support and inform public drug plan listing decisions about new drugs based on rigorous evidence-based reviews of relevant clinical and cost effectiveness data. The CDR was set up by F/P/T public drug programs to reduce duplication of effort in reviewing drug submissions, to maximize the use of limited resources and expertise, and to enhance the consistency and quality of drug reviews, thereby contributing to the quality and sustainability of Canadian public drug plans. The NIHB Program and other drug plans make listing decisions based on CEDAC recommendations and other specific relevant factors, such as the particular circumstances of NIHB clients.

The Canadian Agency for Drugs and Technologies in Health (CADTH) provides a list of requirements for manufacturers' submissions and a summary of procedures for the Common Drug Review Process. Inquiries about the CDR process should be directed to:

Common Drug Review (CDR)
Canadian Agency for Drugs
and Technologies in Health
865 Carling Avenue, Suite 600
Ottawa, Ontario K1S 5S8
Telephone: 613-226-2553
Website: **www.cadth.ca**

Line extensions of existing drug products on the Drug Benefit List, drug class reviews and reviews of existing listing criteria are subject to a separate process which involves referral to the Federal Pharmacy and Therapeutics (FP&T) Committee. The FP&T Committee is an advisory body of health professionals established by federal drug programs to provide evidence-based advice to participating federal departments, which include: Health Canada, Veterans Affairs Canada, the Royal Canadian Mounted Police, Correctional Services Canada, Citizenship and Immigration Canada and the Department of National Defence.

The FP&T Committee generally meets three to four times a year. Individual members are selected based on their specific areas of expertise and experience, with consideration being given to providing a balance between scientific knowledge and practical community experience. As a result, the membership of this Committee includes practicing physicians and pharmacists from community and hospital settings. The Committee also includes First Nations physicians. In its review of drugs, the Committee follows an evidence-based approach and considers current medical and scientific knowledge, current clinical practice, health care delivery and specific client health needs. The NIHB Program and other federal drug plans make their formulary listing decisions based on the recommendations of the FP&T Committee and other specific relevant factors, such as the particular circumstances of their clients. It is the goal of the NIHB Program to maintain a comprehensive list of cost-effective drugs which will allow practitioners to prescribe an appropriate course of therapy for NIHB clients.

Generic drug products are reviewed internally and considered for inclusion on the NIHB formulary based on cost, provincial interchangeability and other relevant factors.

SECTION 9.6

Drug Use Evaluation (DUE)

The use of prescription drugs in ways that are not supported by clinical evidence affects the health of many Canadians. In order to effectively address the issue for NIHB clients, the problem of sub-optimal prescription drug use must be understood in the context of health status and health program issues impacting First Nations and Inuit.

Optimal drug use means providing the right drug to the right client in the right dose at the right time. The First Nations and Inuit Health Branch (FNIHB) of Health Canada recognizes that, in order to address medication issues and improve health outcomes, the Branch must work with First Nations and Inuit communities, organizations and stakeholders to develop and implement strategies around awareness, promotion, prevention and treatment. This includes:

- Reviewing aggregate FNIHB information to identify trends and issues;
- Engaging First Nations and Inuit communities, organizations and stakeholders in working together on approaches and materials; and
- Working with prescribers, pharmacists and clients to address specific instances of at-risk clients.

In the context of FNIHB community-based mental health and substance abuse programs, the Non-Insured Health Benefits Program recognizes the value of drug use evaluation as a tool to support these activities. Programs and strategies based on DUE can work to improve the quality of client care, enhance therapeutic outcomes and thereby improve health outcomes.

To assist the NIHB Program, a Drug Use Evaluation Advisory Committee (DUEAC) has been established. The DUEAC is an advisory body of licensed health

care professionals – experts in drug use evaluation, Aboriginal health issues and drug utilization. The membership of the Committee includes First Nations health care professionals.

The DUEAC provides advice and recommendations to the NIHB Program to promote safe, therapeutically effective and efficient use of drug therapy and contribute to positive health outcomes for eligible First Nations and Inuit clients.

The objectives of the Committee include:

- Providing recommendations that lead to improved prescribing, dispensing and use of drugs among First Nations and Inuit clients;
- Where appropriate, facilitating partnerships with First Nations and Inuit communities and FNIHB regional offices in order to recommend culturally appropriate educational interventions and strategies as well as tools for their implementation; and
- Evaluating the effectiveness of the intervention strategies, as required.

NIHB has undertaken many DUE activities since the inception of the Committee in December of 2003. All DUE activities conducted by NIHB are done in a manner respecting existing privacy legislation and guidelines. For further information please see Drug Use Evaluation Bulletins at: **http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/index-eng.php#drug-med**

FNIHB has also established the Drug Utilization and Prevention and Promotion Working Group (DUPP). The purpose of the DUPP working group is to ensure a coordinated and consistent approach to the implementation of all DUE client and population level initiatives across the Program to promote improvement in health outcomes of First Nations and Inuit clients through effective use of pharmaceuticals.

Drug Utilization Reviews

A drug utilization review, which is part of the point-of-service or online adjudication system, provides an analysis of both previous and current pharmacy claims data to identify potential drug-related problems.

Messages are sent electronically in real time to pharmacists to alert them of potential problems. These messages are intended to enhance pharmacy practice with additional information. For a listing of these messages, please refer to: **http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/2009_secur_rpt/index-eng.php#a7**

NIHB Prescription Monitoring Program (NIHB PMP)

The NIHB PMP was established in 2007 by the NIHB Program consistent with the continuing focus on protecting client safety and improving health outcomes. The NIHB PMP allows the NIHB Program to make effective interventions with individual clients and prescribers/providers of potential misuse/abuse of benzodiazepine and opioid drug products at the point-of-sale in pharmacies. The pharmacy provider must call the Drug Exception Centre (DEC) for a client in the NIHB PMP when a point-of-sale message indicates to do so. Both the prescribers' and providers' collaboration are a critical aspect of the PMP process. The NIHB PMP was implemented initially in the Alberta Region. The NIHB PMP has expanded to Nova Scotia in September 2009, to New Brunswick in 2010, and will be expanded to other regions in the future.

More information on these initiatives is provided in the *Report on Client Safety* on the Health Canada web site: **http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/2009_secur_rpt/index-eng.php**

SECTION 9.7

Drug Exception Centre (DEC)

The NIHB Drug Exception Centre (DEC) was established in December 1997 to process and expedite pharmacists' requests for drug benefits that require prior approval, to help ensure consistent application of the NIHB drug benefit policy across the country, and to ensure an evidence-based approach to funding drug benefits. The DEC handles requests for prior approval from pharmacy providers across Canada.

FIGURE 9.7.1

Drug Exception Centre Special Authorization Process

A Special Bulletin from the Non-Insured Health Benefits (NIHB) Program for pharmacy providers was sent in November 2009 to announce the acceleration of an internal Drug Exception Centre (DEC) process to extend Limited Use (LU) approvals to approximately 34 additional drugs for chronic conditions as shown in table below. These drugs have been granted extended authorization periods beyond one year, and some will now have an indefinite authorization period, thereby eliminating unnecessary calls by pharmacists to DEC.

For LU medications with an indefinite authorization, it is only necessary for the pharmacy provider to confirm that the patient meets the clinical criteria once by obtaining a prior approval and then the patient will be set up on indefinite approval.

For other drugs that continue to have a defined authorization period (i.e.: 2, 3 or 5 years), a new approval must be completed according to the authorization period provided in the list below.

Implementing extended authorization periods for drugs used in certain chronic conditions will significantly reduce the administrative burden on pharmacy providers and enable DEC to deal with more complicated reviews. Between November 2009 and the end of the 2009/10 fiscal year, there was an estimated 20% reduction in prior approvals handled by DEC which helped smooth the transfer to the new HICPS claims processing system.

Use of HICPS System to Facilitate Prior Approvals for Specific Drugs

The new HICPS system also has the capacity to automatically adjudicate a number of medications to reduce the calls to DEC. For the following drugs, the systems will provide a prompt to pharmacists to continue with the Prior Approval process automatically and if the pharmacists select this prompt, the request will automatically be sent to DEC for review without necessitating a call to the DEC. In this way DEC can immediately send a review questionnaire (BEQ) to the physician and thereby reduce the workload of pharmacists in calling DEC.

Use of the Automated Call Distribution System Linkage to the HICPS System to Streamline DEC Call Times

As part of the overall HICPS System change, the ACD System used by DEC has been used to introduce Integrated Communications Technology to permit pharmacists to key in certain information when making a call to DEC which automatically pulls up the appropriate screens when the call is answered, to immediately begin discussions on the reason for the call, thereby reducing the wait time for pharmacists.

LIMITED USE EXTENDED EXPIRY DATES BY DURATION
Indefinite
Advair Diskus®
Advair Inhaler®
Aggrenox®
Ezetrol®
Magic Bullet®
Spiriva®
Symbicort®
5 years
Actonel®
Alphagan P® and generics
Avodart®
Detrol®
Detrol LA®
Evista® and generics
Fosamax® and generics
Fosavance®
Miacalcin® and generics
Proscar®
Trosec®
3 years
Foradil®
Oxeze®
Serevent®
2 years
Accolate®
Actos® and generics
Avandia®
Arava® and generics
Celebrex®
Minocycline
Nuvaring
Panto® and generics
Prevacid®
Singulair®
Wellbutrin SR® and generics
Wellbutrin XL®
Zanaflex® and generics

FIGURE 9.7.2

Total NIHB Drug Exception Centre Requests/Approvals
2009/10

The DEC is a single call centre to provide efficient responses to all requests for drugs that are not on the NIHB Drug Benefit List or require prior approval, for extemporaneous mixtures containing exception or limited use drugs, for prescriptions on which prescribers have indicated "No Substitution", and for claims that exceed $999.99.

Status	Benefit	Exceptions	Limited Use	Total
Total Requested	4,556	39,856	101,837	**146,249**
Total Approved	3,421	27,991	80,995	**112,407**

Benefit: Drugs included on the NIHB Drug Benefit List for which the total dollar value exceeds Point of Sale limit or for which more than a three-month supply is requested.

Exceptions: Drugs not included on the NIHB Drug Benefit List, as well as requests for drugs for which the physician has indicated "No Substitution".

Limited Use: Drugs covered only if they are prescribed for conditions which meet specific criteria for Program coverage.

SECTION 9.8

Short-Term Dispensing Policy

On September 9, 2008, the Non-Insured Health Benefits (NIHB) Program implemented the Short-Term Dispensing Policy which establishes compensation criteria for short-term refills of chronic use medications. This policy was implemented to address the problem associated with significant increases in the frequency of short-term dispensing of chronic medications that the Program has experienced in recent years by establishing compensation criteria for short-term refills of medications used to treat chronic conditions.

Prior to the implementation of this policy, in certain situations, the same drug prescriptions were being billed as often as every day. However, with the new Short-Term Dispensing Policy, pharmacists can either bill the NIHB Program once every 28 days for their dispensing fee, or they can bill the Program every day but would only be paid 1/28th of the dispensing fee.

The Short-Term Dispensing Policy drug list is a full list of medications included under this policy and can be found at: **http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/pharma-prod/short-term-court-eng.php**

The cost-saving effect of the implementation of the Short-Term Dispensing Policy was evident over the past two years. NIHB Pharmacy expenditures increased by 3.9% in 2008/09 and 3.8% in 2009/10.

SECTION 9.9

Federal Healthcare Partnership

The Federal Healthcare Partnership (FHP) was created under the leadership of Veterans Affairs Canada. The initiative involves the following federal departments and agencies: Health Canada, Royal Canadian Mounted Police, Correctional Services Canada, National Defence, Citizenship and Immigration Canada, Veterans Affairs Canada and the Public Health Agency of Canada.

The federal government provides a wide variety of health care services and products through its programs. The purpose of the FHP is to share information and experience, thereby limiting duplication of effort, and to identify potential savings through the combined purchasing power of the member departments and through the coordination of health care benefits.

The FHP undertakes the following activities:

- Coordinates mechanisms for information sharing, collective decision making and policy development (e.g., the interdepartmental committee on Pharmacy Audit which is chaired by Health Canada);
- Collectively negotiates agreements, contracts and standing offers with provider associations, suppliers and retailers for the provision of health care services and products which enhance competition and cost savings while maintaining or improving the quality of care for federal clients; and
- Represents or coordinates representation of the federal departments in federal, provincial and territorial task groups.

Through the FHP, NIHB has successfully reached a number of pharmacy and vision agreements with provincial pharmacy and optometrist associations. In addition, a joint agreement with the Canadian Audiology Manufacturers Association is in place. Other opportunities for joint negotiation continue to be explored in all regions.

SECTION 9.10

Negotiations Secretariat

The Negotiations Secretariat was created in 2005 in order to facilitate information sharing and to ensure a strategic approach to NIHB negotiations which optimizes benefits to clients, reflects value for money, and is sustainable within existing resources. During 2009/10, the Negotiations Secretariat was primarily involved in negotiations with the Association québécoise des pharmaciens propriétaires. As of the end of 2009/10, these negotiations were still ongoing.

During the same year, the Negotiations Secretariat was also involved in the implementation of a number of pilot projects. In New Brunswick, a pilot allowing pharmacists to submit claims to the NIHB Program for over-the-counter products that are prescribed under their scope of practice was implemented in order to evaluate the impact on client accessibility. A second pilot was negotiated with the College of Registered Dental Hygienists of Alberta allowing hygienists to register with NIHB as independent providers.

SECTION 9.11

Privacy

The NIHB Program recognizes an individual's right to privacy and is committed to protecting this right and to safeguarding the personal information in its possession. When a request for benefits is received, the NIHB Program collects, uses, discloses and retains an individual's personal information according to the applicable privacy legislation.

As a Program of the federal government, NIHB must comply with the *Privacy Act*, the *Charter of Rights and Freedoms*, the *Access to Information Act*, as well as Treasury Board of Canada privacy and data protection policies including the Privacy Impact Assessment (PIA) Policy. The latter requires all federal government programs to conduct PIAs on their processes, services and systems involved with the collection, use, disclosure and retention of personal information in order to identify any privacy-related risks and to mitigate or eliminate them.

During 2009/10, NIHB updated its PIA on the Health Information and Claims Processing Services System (HICPS) in preparation for submission to the Office of the Privacy Commissioner of Canada. Consistent with its ongoing commitment to privacy, NIHB will undertake PIAs on its other systems and processes as appropriate.

In June 2007, NIHB began working with Indian and Northern Affairs Canada (INAC) on an Information Sharing Agreement (ISA) concerning the exchange of personal information between the Indian Registration System at INAC and the Status Verification System at Health Canada. The ISA was approved as of August 2009 and outlines the authority and the roles and responsibilities of each party when handling personal information.

SECTION 9.12

NIHB Drug Bulletins/DBL Updates and Dental Bulletins

The NIHB Drug Bulletin was launched in June 1997 as a vehicle for providing timely information about NIHB drug benefits to prescribers, providers, client groups and other stakeholders. The Drug Benefit List (DBL) Update was subsequently introduced in 2005 to announce changes to the NIHB Drug Benefit List. The objectives of these publications are to provide relevant drug information and to announce management or Program changes. Drug Bulletins / DBL Updates can be found on the Internet at: **http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/index-eng.php**

The NIHB Dental Bulletin, first released in September 1999, provides information about NIHB dental benefits to providers. The purpose of this publication is to provide relevant information on benefit and Program changes. Dental Bulletins can be found on the Internet at: **http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/index-eng.php#dent**

Registered NIHB providers may also access the NIHB Newsletter via the ESI website (password required) as the main source of information for relevant changes to benefits or policies related to Dental, Pharmacy, and Medical Supplies and Equipment (MS&E) services. This can be found on the Internet at: **http://www.provider.esicanada.ca**

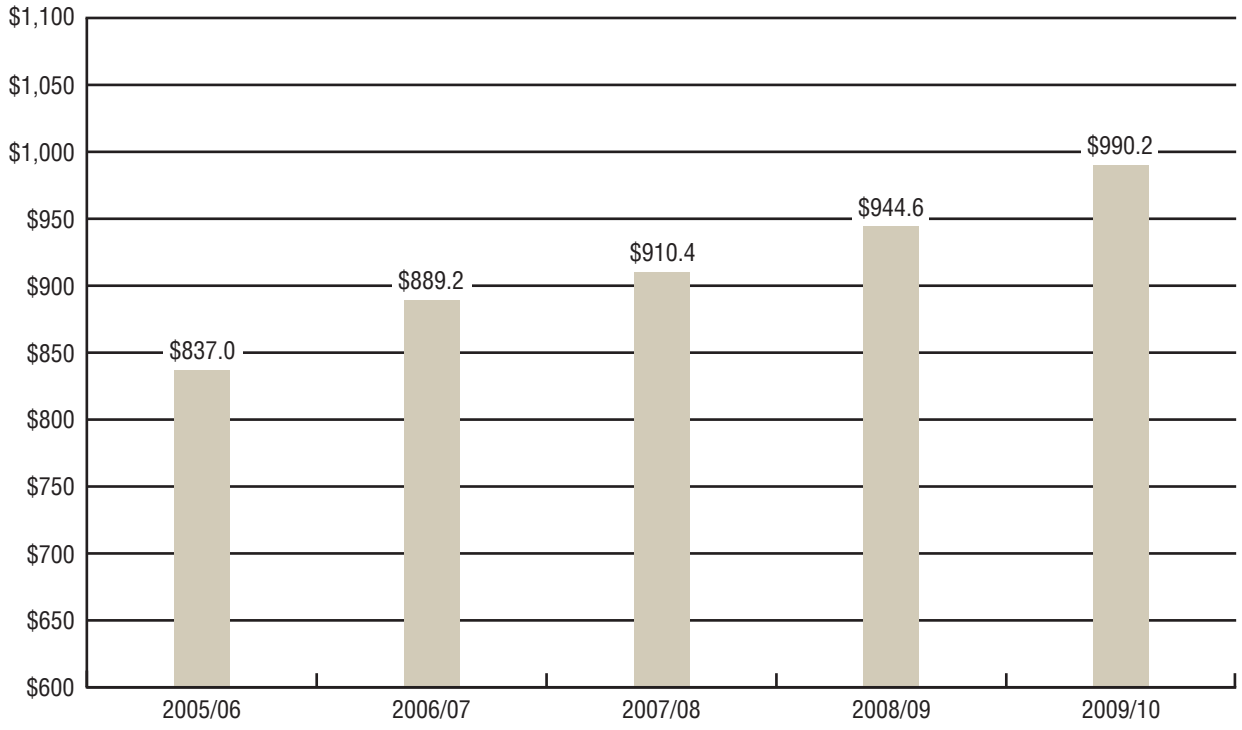
The Homecoming by Annie Pootoogook
Reproduced with the permission of the Dorset Fine Arts

Financial Resources

The Non-Insured Health Benefits (NIHB) Program operates within the fiscal environment of the First Nations and Inuit Health Branch (FNIHB). Available NIHB financial resources include funds in the FNIHB reference levels for the Program, as well as any supplementary funding approved by Parliament through the course of the fiscal year.

FIGURE 10.1

Non-Insured Health Benefits Program Resources ($ Millions)
2005/06 to 2009/10



Source: Main Estimates

In 2009/10, total resources available to the NIHB Program were $990.2 million. This represented a 4.8% increase over the $944.6 million in available funds in 2008/09. The available resources identified for the NIHB Program Benefits for 2010/11, both operating and contribution, amount to $1.052 billion.

NIHB Program Sustainability

Cost and service pressures on the Canadian health system have been linked to factors such as an aging population and the increased demand for and utilization of health goods, particularly pharmaceuticals, and services. In providing its benefits to First Nations and Inuit clients, the NIHB Program faces additional challenges linked to growth in its client base, which is growing at two times the Canadian population growth rate, as well as challenges associated with assisting clients in small and remote communities to access medical services.

The NIHB Program constantly strives to address these pressures by implementing measures such as promoting the use of generic drug products to ensure that it delivers its benefits within its Parliamentary allocations, while maintaining high quality and timely services to its clients.

FIGURE 10.2

Non-Insured Health Benefits Administration Costs ($ 000's)
2009/10

Figure 10.2 sets out the funds allocated for each region as well as NIHB headquarters (HQ) in Ottawa for Program administration.

The roles of NIHB headquarters include:

- Program policy development and determination of eligible benefits;
- Development and maintenance of the HICPS system and other national systems such as Medical Transportation Reporting System (MTRS);
- Audits and provider negotiations;
- Adjudicating benefit requests through the NIHB Drug Exception Centre and Orthodontic Review Centre; and
- Maintaining productive relationships with stakeholders at the national level as well as with other federal departments and agencies.

The roles of the NIHB regions include:

- Adjudicating benefit requests for medical transportation, MS&E, dental and vision benefits and short-term crisis intervention mental health crisis counselling;
- Working with NIHB headquarters on policy development, provider negotiations and audits; and
- Maintaining productive relationships with stakeholders at the provincial/territorial level as well as with provincial/territorial officials.

CATEGORIES	Atlantic	Quebec	Ontario	Manitoba	Sask.	Alberta	British Columbia	Northern Region	HQ	Total
Salaries	$ 1,317	$ 1,697	$ 3,761	$ 2,561	$ 1,906	$ 2,757	$ 1,524	$ 1,197	$ 8,907	$ 25,626
Capital	0	0	0	0	0	0	0	0	0	0
EBP	263	339	752	512	381	551	305	239	1,781	5,125
Operating	83	178	474	245	155	259	173	130	2,456	4,152
Sub Total	**$ 1,663**	**$ 2,214**	**$ 4,987**	**$ 3,319**	**$ 2,442**	**$ 3,567**	**$ 2,002**	**$ 1,566**	**$ 13,144**	**$ 34,903**
Claims Processing Contract Costs										**$ 27,533***
Total Administration Costs										**$ 62,436**

Source: FIRMS adapted by Program Analysis Division

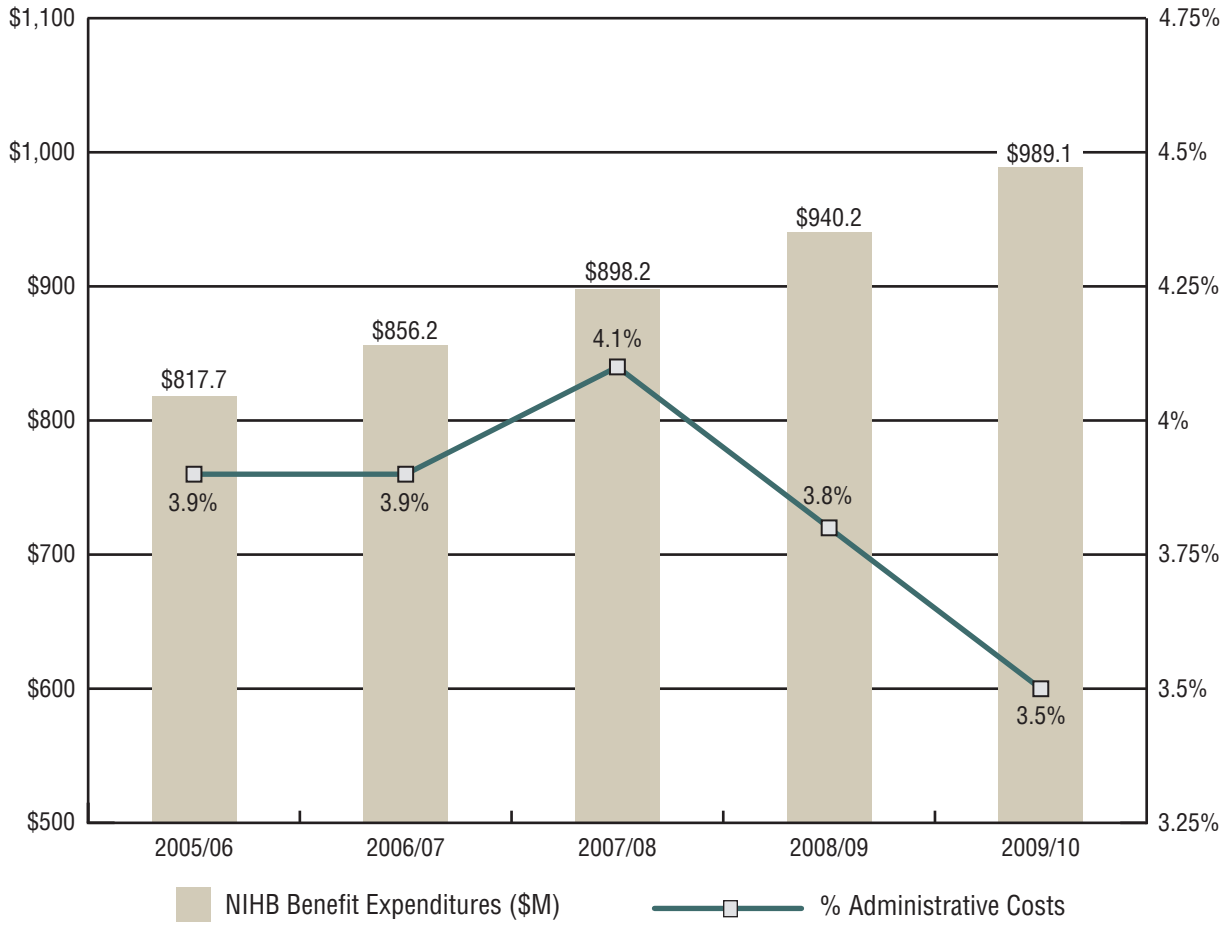
* Note: Included in the $27.5 million cost for processing claims is a one time contract cost of approximately $6.4 million, associated with the development phase of the new claims processor Express Scripts Inc. (ESI) Canada.

FIGURE 10.3

Non-Insured Health Benefits Administration Costs as a Proportion of Benefit Expenditures ($ Millions)
2005/06 to 2009/10

Figure 10.3 provides the percentage of NIHB Program administrative costs as a proportion of overall NIHB benefit expenditures. In 2009/10, NIHB Program administrative costs were 3.5% of total benefit expenditures. Over the past five fiscal years, the percentage of NIHB Program administrative costs as a proportion of total benefit expenditures has ranged from a high of 4.1% in 2007/08 to a low of 3.5% in 2009/10.

A recent evaluation of the NIHB Program found that administrative costs compared favorably to privately funded plans.



Source: FIRMS adapted by Program Analysis Division

Brother in Spirit by Vernon Brown

Technical Notes

Databases

Information contained in the report is extracted from several databases. First Nations and Inuit population data are drawn from the Status Verification System (SVS) which is operated by FNIHB. SVS data on First Nations clients are based on information provided by Indian and Northern Affairs Canada. SVS data on Inuit clients are based on information provided by the Governments of the Northwest Territories and Nunavut, and Inuit organizations including the Inuvialuit Regional Corporation, Nunavut Tunngavik Incorporated and the Makivik Corporation.

Two Health Canada data systems provide information on expenditures and selected benefit utilization. The Framework for Integrated Resource Management System (FIRMS) is the source of most of the expenditure data, while the Health Information and Claims Processing Services (HICPS) system provides detailed information on the pharmacy (including Medical Supplies and Equipment) and dental benefit areas. All tables and charts are footnoted with the appropriate data sources. These data sources are considered to be of very high quality but, as in any administrative data set, some data may be subject to coding errors or other anomalies. When such values are identified, values are restated so as to reflect actual benefit expenditure totals at both the regional and national levels. For this reason, users of the data should always refer to the most current edition of the NIHB Annual Report. Please note that some table totals may not add due to rounding procedures.

Restatement of 2008/09 Expenditure Totals

Some expenditure totals have been restated from those published in the 2008/09 NIHB Annual Report as a result of the restatement of figures in the medical transportation, dental, vision and other health care benefits to reflect one time budget allocations in the regions of Ontario, Manitoba, Saskatchewan and Nunavut. These changes have resulted in the restatement of 2008/09 figures in sections 3.2, 3.6, 3.7, 3.8, 3.10, 5.3, 6.2, 6.6, 7.2, 7.3, 7.5, 8.3, 8.4, 8.5 and 8.10.

Overall total NIHB expenditures for 2008/09 have been restated by $5.6 million from $934.6 million to $940.2 million. More specifically, the 2008/09 medical transportation expenditure total has been restated to account for a one time budget allocation of $5.5 million that was made to the regions of Ontario ($1.8 million), Manitoba ($839 thousand), Saskatchewan ($467 thousand) and Nunavut ($2.4 million). In addition, in the Manitoba Region, a one time budget allocation of $86.6 thousand was made to the vision care benefit, $13.6 thousand to the other health care benefit and $9.7 thousand to the dental benefit.