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Non-Insured Health Benefits Program

First Nations and Inuit Health Branch

Annual Report 2011/2012

Canada

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Introduction

SECTION 1

During 2011/12, the Non-Insured Health Benefits (NIHB) Program of the First Nations and Inuit Health Branch (FNIHB) at Health Canada provided 896,624 registered First Nations and Inuit clients with access to a limited range of medically necessary health-related goods and services not otherwise provided through private insurance plans, provincial/territorial health or social programs.

The NIHB Program is administered nationally and covers the following medically necessary benefits:

- Certain prescription and over-the-counter drugs;
- Medical supplies and equipment;
- Dental care;
- Vision care;
- Other health care services such as short-term crisis intervention mental health counselling;
- Medical transportation to access medically required health services not available on reserve or in the community of residence; and
- Provincial health care premiums in British Columbia.

Through the coverage of these benefits, Health Canada supports First Nations and Inuit in reaching an overall health status that is comparable with other Canadians.

The NIHB Program operates according to the following 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.

Now in its eighteenth edition, the 2011/12 NIHB Annual Report provides national and regional data on the NIHB Program client population, expenditures, benefit types and benefit utilization. This Report is published in accordance with the NIHB Program's performance management responsibilities and is intended 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.

Client Population

SECTION 2

Over the last ten years, the NIHB client population has grown at an average rate of 2.3%. As of March 31, 2012, 896,624 First Nations and Inuit clients were registered in the Status Verification System (SVS) and were eligible to receive benefits under the NIHB Program. Of the 896,624 total eligible clients at the end of the 2011/12 fiscal year, 855,009 (95.4%) were First Nations clients while 41,615 (4.6%) were Inuit clients.

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, Bill C-3, and the creation of the new Qalipu Mi'kmaq Band, have and will continue to result 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.

The passage of Bill C-3, the *Gender Equity in Indian Registration Act*, which came into force on January 31, 2011, has given approximately 45,000 eligible grandchildren of women, who lost status as a result of marrying non-Indian men, entitlement to become registered as an Indian in accordance with the *Indian Act*. Once registering under the *Indian Act*, these individuals will be eligible to receive benefits through the NIHB Program. As of March 31, 2012, a total of 12,875 newly registered Indian clients had become eligible to receive benefits through the NIHB Program as a result of this new legislation. Most of these new clients live in the regions of Ontario (3,770), Quebec (2,708) and British Columbia (1,980).

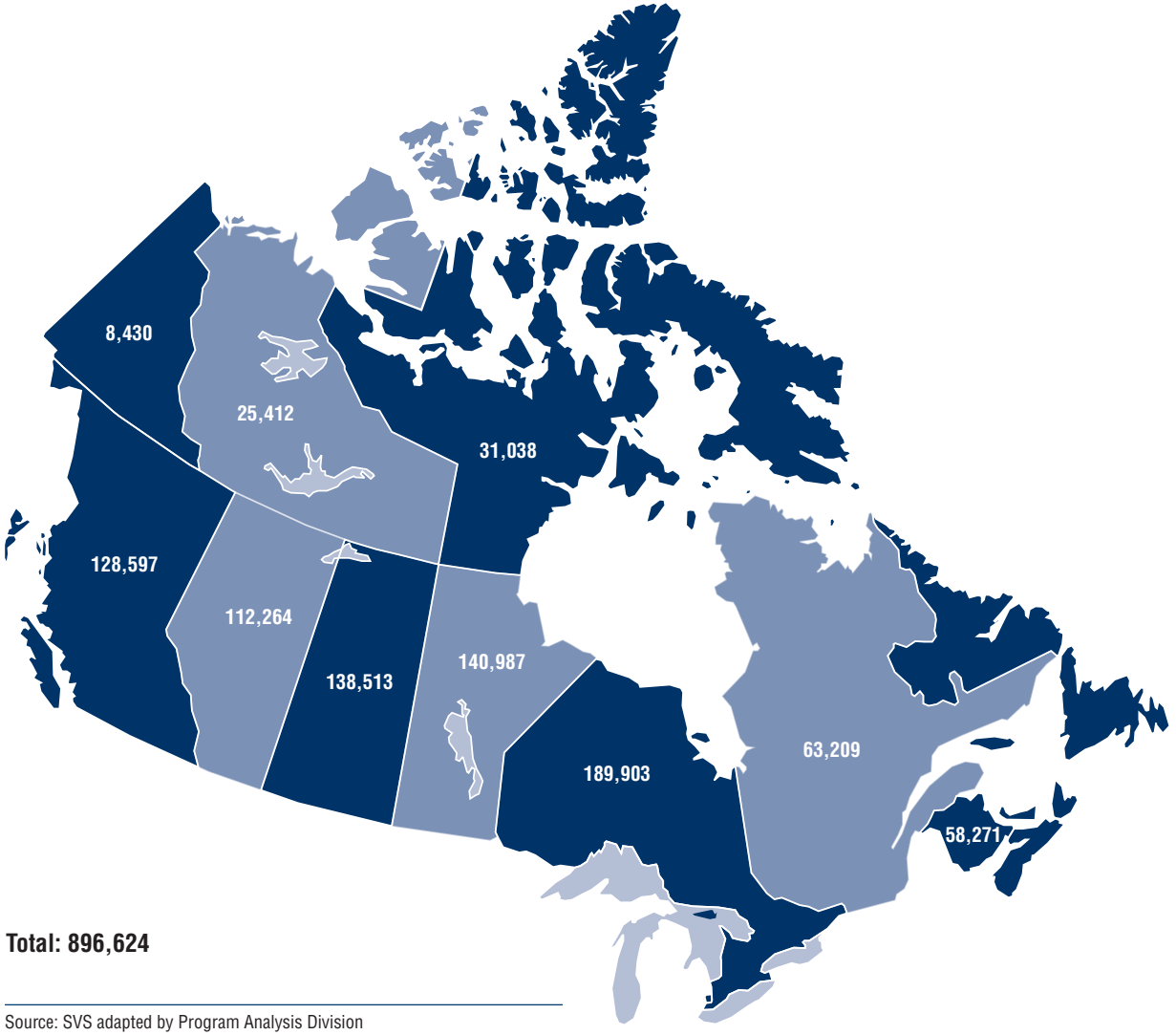
The creation of the new Qalipu Mi'kmaq First Nations band was announced on September 26, 2011, as a result of a settlement agreement that was negotiated between the Government of Canada and the Federation of Newfoundland Indians (FNI). Through the formation of this band, the Qalipu Mi'kmaq became recognized as a band under the *Indian Act*. As of March 31, 2012, a total of 21,419 new Qalipu clients were registered in the Status Verification System (SVS) and were eligible to receive benefits through the NIHB Program.

FIGURE 2.1

Eligible Client Population by Region
March 2012

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 2012 was 896,624, an increase of 6.0% from March 2011. This significant increase in growth can be attributed to the registration of 21,419 new Qalipu Mi'kmaq First Nations clients in the Atlantic Region and 12,875 new Bill C-3 clients as status Indians and who became eligible to receive benefits through the NIHB Program. If these new clients were not included in the overall 2011/12 NIHB client population, the growth rate would have been 1.9%.

The Ontario Region had the largest proportion of eligible population, representing 21.2% of the national total, followed by the Manitoba Region at 15.7% and the Saskatchewan Region at 15.4%.



Total: 896,624

Source: SVS adapted by Program Analysis Division

FIGURE 2.2

Eligible Client Population by Type and Region
March 2011 and March 2012

REGION	First Nations		Inuit		TOTAL		% Change
	March 2011	March 2012	March 2011	March 2012	March 2011	March 2012	2011 to 2012
Atlantic	34,989	57,970	280	301	35,269	58,271	65.2%
Quebec	58,598	62,077	1,061	1,132	59,659	63,209	6.0%
Ontario	182,319	189,309	581	594	182,900	189,903	3.8%
Manitoba	137,055	140,823	157	164	137,212	140,987	2.8%
Saskatchewan	134,581	138,461	52	52	134,633	138,513	2.9%
Alberta	107,357	111,757	482	507	107,839	112,264	4.1%
British Columbia	124,757	128,359	231	238	124,988	128,597	2.9%
Yukon	8,082	8,341	86	89	8,168	8,430	3.2%
N.W.T.	17,585	17,912	7,651	7,500	25,236	25,412	0.7%
Nunavut	0	0	30,120	31,038	30,120	31,038	3.0%
National	**805,323**	**855,009**	**40,701**	**41,615**	**846,024**	**896,624**	**6.0%**

Source: SVS adapted by Program Analysis Division

Of the 896,624 total eligible clients at the end of the 2011/12 fiscal year, 855,009 (95.4%) were First Nations clients while 41,615 (4.6%) were Inuit clients.

As of March 31, 2012, the SVS population statistics reflect a 6.0% growth rate. This is a significant increase compared to the 1.8% growth rate recorded in the previous year. This increase (6.0%) over the previous fiscal year can be attributed to the registration of new Qalipu Mi'kmaq First Nations and Bill C-3 clients as status Indians. In 2011/12, 21,419 new Qalipu and 12,875 new Bill C-3 clients became eligible to receive benefits through the NIHB Program. If these new clients were not included, the overall 2011/12 NIHB client population growth rate would have been 1.9%.

The number of First Nations clients increased by 6.2% while the number of Inuit clients increased by 2.2% over the previous year.

From March 2011 to March 2012, the Atlantic Region had the highest percentage change in total eligible clients with a 65.2% increase. This increase can be attributed to the registration of 21,419 new Qalipu Mi'kmaq First Nations clients. If these clients are excluded from the population in the Atlantic Region, population growth in this region would have been 4.5%. The Quebec and Alberta regions both followed with a 6.0% and 4.1% change respectively.

QUICK FACT

The share of NIHB client population under 20 years of age (35.0%) is high compared to the overall Canadian population (22.7%). There is a much higher percentage of seniors (65 and over) in the Canadian population (14.4%) than in the NIHB client population (6.6%). The average age of NIHB clients is 31, which is well below the Canadian average of 40.

FIGURE 2.3

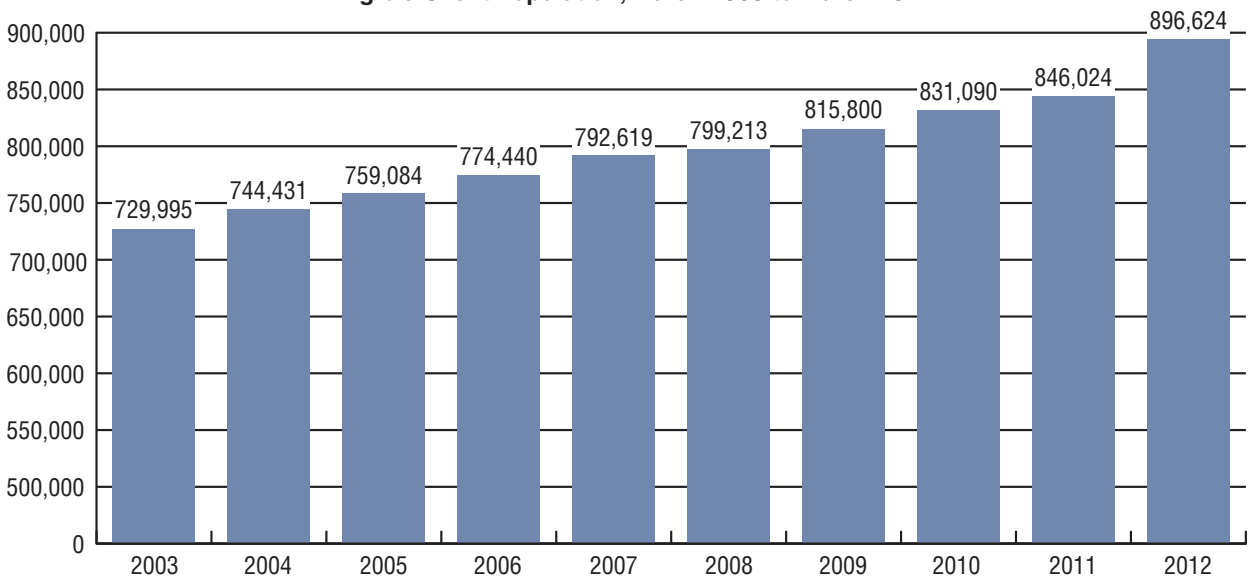
Eligible Client Population

Over the past 10 years, the total number of eligible clients on the SVS increased by 22.8% from 729,995 in March 2003 to 896,624 in March 2012.

The NIHB Program client population is constantly changing. It has been impacted by amendments to the *Indian Act,* such as the passage of Bill C-31, Bill C-3, and the creation of the new Qalipu Mi'kmaq Band, which have and will continue to result in significant increases in the NIHB client population. In contrast, the settlement of First Nations and Inuit self-government agreements, such as those with the Nisga'a Lisims Government and the Nunatsiavut Government, have resulted in decreases in the total NIHB client population as these individuals are no longer eligible to receive benefits through Health Canada's NIHB Program.

Over the past five years, the NIHB Program's total number of eligible clients increased by 12.2% from 799,213 in March 2008 to 896,624 in March 2012. The Atlantic Region had the largest increase in eligible clients over this period, with a growth rate of 74.7%. However, this significant increase can be attributed to the registration of 21,419 new Qalipu Mi'kmaq First Nations clients. If these clients are excluded from the March 2012 population in the Atlantic Region, population growth over the past five years in this region would have been 10.5%. The regions of Alberta, Quebec and Manitoba followed with growth rates of 10.9%, 10.5% and 10.1% respectively.

Eligible Client Population, March 2003 to March 2012



Source: SVS adapted by Program Analysis Division

Eligible Client Population by Region, March 2008 to March 2012

REGION	March 2008	March 2009	March 2010	March 2011	March 2012
Atlantic	33,361	34,141	34,615	35,269	58,271
Quebec	57,228	58,028	58,802	59,659	63,209
Ontario	173,014	176,401	179,641	182,900	189,903
Manitoba	128,010	131,363	134,224	137,212	140,987
Saskatchewan	126,459	129,315	132,141	134,633	138,513
Alberta	101,241	103,716	105,932	107,839	112,264
British Columbia	119,166	121,053	122,989	124,988	128,597
Yukon	7,923	7,999	8,087	8,168	8,430
N.W.T.	24,342	24,644	24,991	25,236	25,412
Nunavut	28,469	29,140	29,668	30,120	31,038
Total	**799,213**	**815,800**	**831,090**	**846,024**	**896,624**
Annual % Change	**0.8%**	**2.1%**	**1.9%**	**1.8%**	**6.0%**

Source: SVS adapted by Program Analysis Division

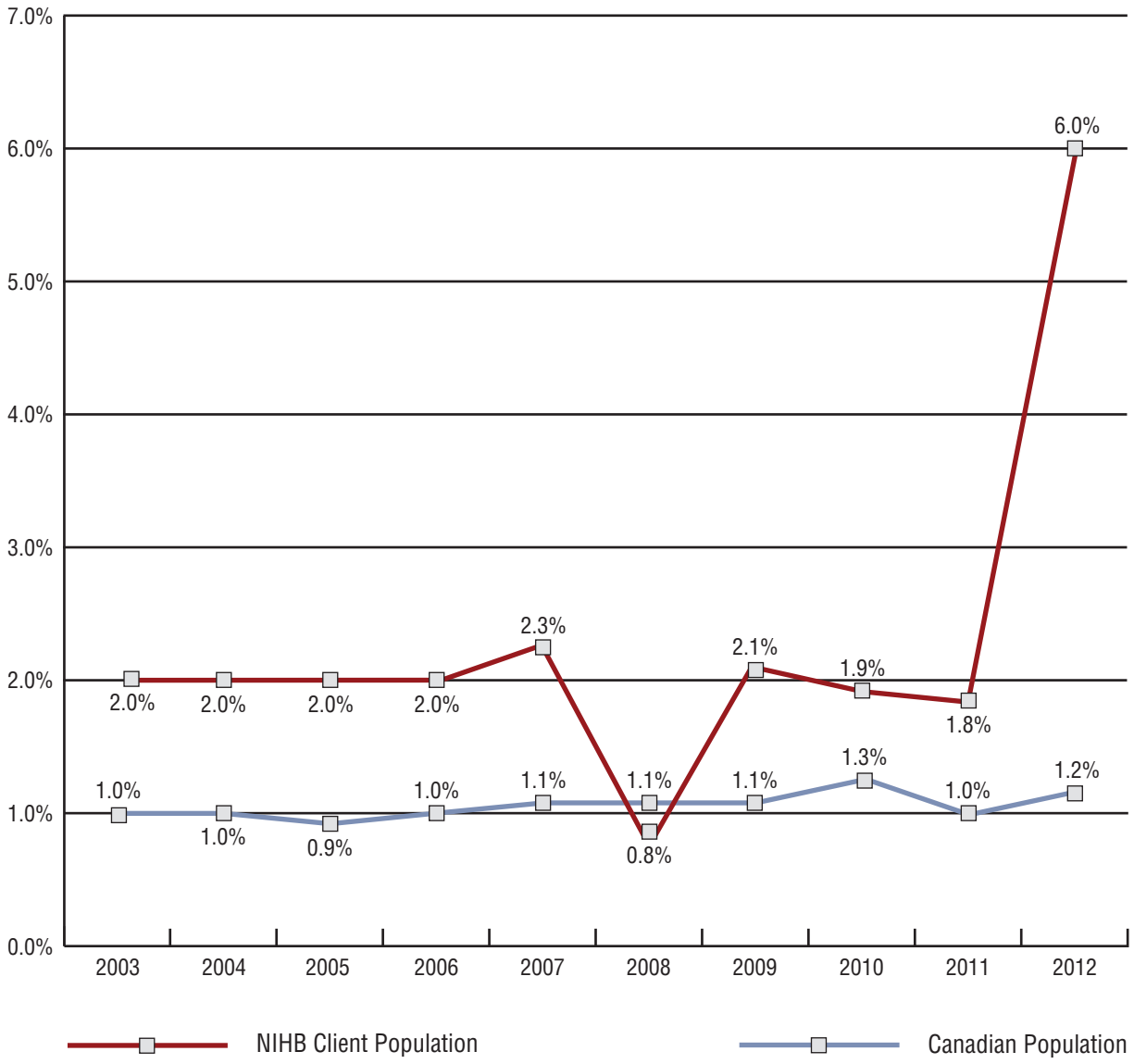
FIGURE 2.4

Annual Population Growth, Canadian Population and Eligible Client Population
2003 to 2012

From 2003 to 2012, the Canadian population increased by 10.1% while the NIHB eligible First Nations and Inuit client population had an increase of 22.8%. Over the same period, the First Nations and Inuit client population grew at an average annual rate of 2.3% compared to 1.1% for the Canadian population. The growth in the eligible NIHB client population will continue to be impacted by the higher birth rate within the First Nations and Inuit populations, and as more Qalipu and Bill C-3 clients register for and obtain their First Nations status.

The significant increase in the NIHB Program client population growth rate to 6.0% in 2011/12 can be attributed to the registration of 21,419 new Qalipu Mi'kmaq First Nations clients in the Atlantic Region and 12,875 new Bill C-3 clients as status Indians. If these new clients were not included in the overall 2011/12 population, the growth rate would have been 1.9%, which is consistent with the population trends of previous years.

The 0.8% annual percentage change in March 2008 is attributed primarily to the decrease in eligible clients in the Atlantic Region resulting from the removal of Nunatsiavut clients who transitioned to self-government.



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

FIGURE 2.5

Eligible Client Population by Age Group, Gender and Region
March 2012

Of the 896,624 NIHB eligible clients on the SVS as of March 31, 2012, 49.1% were male (440,530) and 50.9% were female (456,094).

The average age of the eligible client population was 31 years of age. By region, this average ranged from a low of 26 years of age in Nunavut to a high of 36 years of age in the Quebec Region.

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 a low of 26 years in Nunavut to a high of 34 years in the Quebec and Ontario regions and the Yukon. The average age for females varied from a low of 27 years in Nunavut to a high of 38 years in the Quebec Region.

The NIHB eligible First Nations and Inuit client population is relatively young with two-thirds (66.1%) under the age of 40. Of the total population, over one-third or 35.0% are under the age of 20. Seniors (clients 65 years of age and over) represent 6.6% of the total population.

The seniors' population (clients 65 years of age and over) has been slowly increasing as a proportion of the total NIHB client population. In 2002/03, seniors represented 5.2% of the overall NIHB population. Most recently in 2011/12, seniors accounted for 6.6%. In the coming years, this demographic trend is going to add to cost pressures on the NIHB Program.

REGION	Atlantic			Quebec			Ontario			Manitoba		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	1,684	1,598	3,282	1,746	1,689	3,435	4,983	4,919	9,902	6,624	6,491	13,115
5-9	2,392	2,317	4,709	2,405	2,128	4,533	6,970	6,591	13,561	7,643	7,448	15,091
10-14	2,454	2,415	4,869	2,381	2,313	4,694	7,487	7,211	14,698	7,401	6,958	14,359
15-19	2,719	2,668	5,387	2,775	2,659	5,434	8,470	8,115	16,585	7,590	7,317	14,907
20-24	2,572	2,469	5,041	2,604	2,559	5,163	8,239	7,974	16,213	6,979	6,910	13,889
25-29	2,253	2,221	4,474	2,256	2,272	4,528	7,292	7,064	14,356	5,598	5,384	10,982
30-34	2,106	2,108	4,214	2,110	2,058	4,168	6,675	6,864	13,539	4,854	4,636	9,490
35-39	2,025	2,062	4,087	2,007	2,081	4,088	6,562	6,536	13,098	4,562	4,580	9,142
40-44	2,156	2,184	4,340	2,218	2,287	4,505	6,810	6,970	13,780	4,607	4,802	9,409
45-49	2,084	2,171	4,255	2,250	2,500	4,750	7,086	7,452	14,538	4,232	4,375	8,607
50-54	1,779	2,078	3,857	2,127	2,420	4,547	6,240	6,969	13,209	3,300	3,668	6,968
55-59	1,442	1,774	3,216	1,637	2,058	3,695	4,734	5,801	10,535	2,269	2,690	4,959
60-64	1,077	1,320	2,397	1,226	1,498	2,724	3,496	4,486	7,982	1,639	1,866	3,505
65+	1,772	2,371	4,143	2,691	4,254	6,945	7,147	10,760	17,907	2,792	3,772	6,564
Total	**28,515**	**29,756**	**58,271**	**30,433**	**32,776**	**63,209**	**92,191**	**97,712**	**189,903**	**70,090**	**70,897**	**140,987**
Average Age	**32**	**34**	**33**	**34**	**38**	**36**	**34**	**36**	**35**	**28**	**29**	**28**

Source: SVS adapted by Program Analysis Division

Client Population

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	6,092	5,832	11,924	5,117	4,944	10,061	3,942	3,648	7,590	237	182	419	830	748	1,578	1,665	1,656	3,321	32,920	31,707	64,627
5-9	7,482	7,444	14,926	6,136	5,997	12,133	5,165	5,047	10,212	265	253	518	969	997	1,966	1,919	1,800	3,719	41,346	40,022	81,368
10-14	7,322	7,182	14,504	5,854	5,599	11,453	5,183	4,984	10,167	317	292	609	969	968	1,937	1,785	1,676	3,461	41,153	39,598	80,751
15-19	7,567	7,426	14,993	6,327	5,770	12,097	5,699	5,321	11,020	363	343	706	1,389	1,312	2,701	1,714	1,635	3,349	44,613	42,566	87,179
20-24	7,327	7,087	14,414	5,650	5,546	11,196	6,050	5,601	11,651	359	363	722	1,355	1,373	2,728	1,644	1,577	3,221	42,779	41,459	84,238
25-29	5,893	5,892	11,785	4,847	4,711	9,558	5,377	5,212	10,589	343	327	670	1,122	1,019	2,141	1,264	1,267	2,531	36,245	35,369	71,614
30-34	5,025	4,915	9,940	3,958	4,090	8,048	4,708	4,579	9,287	328	288	616	918	918	1,836	1,033	1,057	2,090	31,715	31,513	63,228
35-39	4,467	4,684	9,151	3,531	3,646	7,177	4,542	4,502	9,044	290	281	571	819	854	1,673	914	923	1,837	29,719	30,149	59,868
40-44	4,420	4,625	9,045	3,468	3,569	7,037	4,563	4,731	9,294	379	312	691	994	1,014	2,008	965	992	1,957	30,580	31,486	62,066
45-49	3,908	4,195	8,103	3,114	3,492	6,606	4,617	5,086	9,703	404	379	783	864	926	1,790	815	840	1,655	29,374	31,416	60,790
50-54	3,069	3,440	6,509	2,479	2,831	5,310	4,202	4,751	8,953	312	344	656	662	794	1,456	573	580	1,153	24,743	27,875	52,618
55-59	2,058	2,412	4,470	1,693	2,132	3,825	3,053	3,707	6,760	189	249	438	438	595	1,033	392	405	797	17,905	21,823	39,728
60-64	1,386	1,737	3,123	1,131	1,555	2,686	2,198	2,607	4,805	126	194	320	385	462	847	361	329	690	13,025	16,054	29,079
65+	2,310	3,316	5,626	2,093	2,984	5,077	3,980	5,542	9,522	285	426	711	756	962	1,718	587	670	1,257	24,413	35,057	59,470
Total	**68,326**	**70,187**	**138,513**	**55,398**	**56,866**	**112,264**	**63,279**	**65,318**	**128,597**	**4,197**	**4,233**	**8,430**	**12,470**	**12,942**	**25,412**	**15,631**	**15,407**	**31,038**	**440,530**	**456,094**	**896,624**
Average Age	**27**	**29**	**28**	**27**	**29**	**28**	**32**	**35**	**33**	**34**	**37**	**35**	**31**	**33**	**32**	**26**	**27**	**26**	**30**	**32**	**31**

FIGURE 2.6

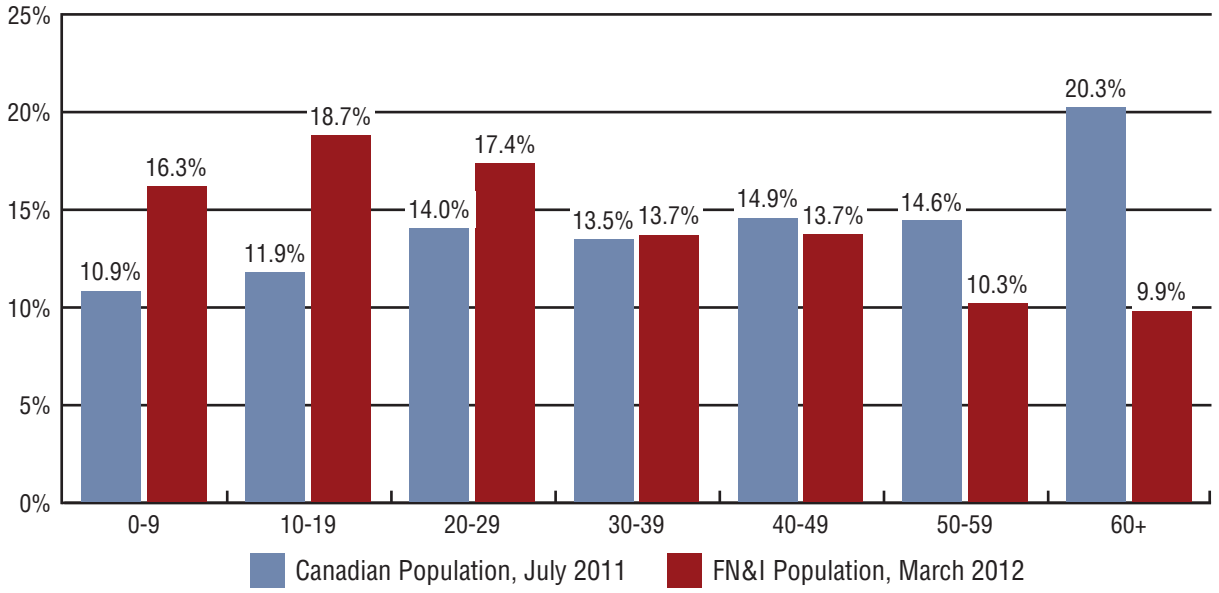
Population Analysis by Age Group

The overall First Nations and Inuit client population is relatively young compared to the general Canadian population. The share of the NIHB client population under 20 years of age was 35.0% compared to 22.7% of the same age group in the Canadian population. The average age of First Nations and Inuit clients is 31 compared to 40 years of age for the Canadian population.

A comparison of March 2008 to March 2012 eligible client population shows an aging population. The client population 40 and above increased by 20.5% from 252,006 in 2008 to 303,751 in 2012. As a proportional share of the overall client population, this group increased from 31.5% in 2008 to 33.9% in 2012.

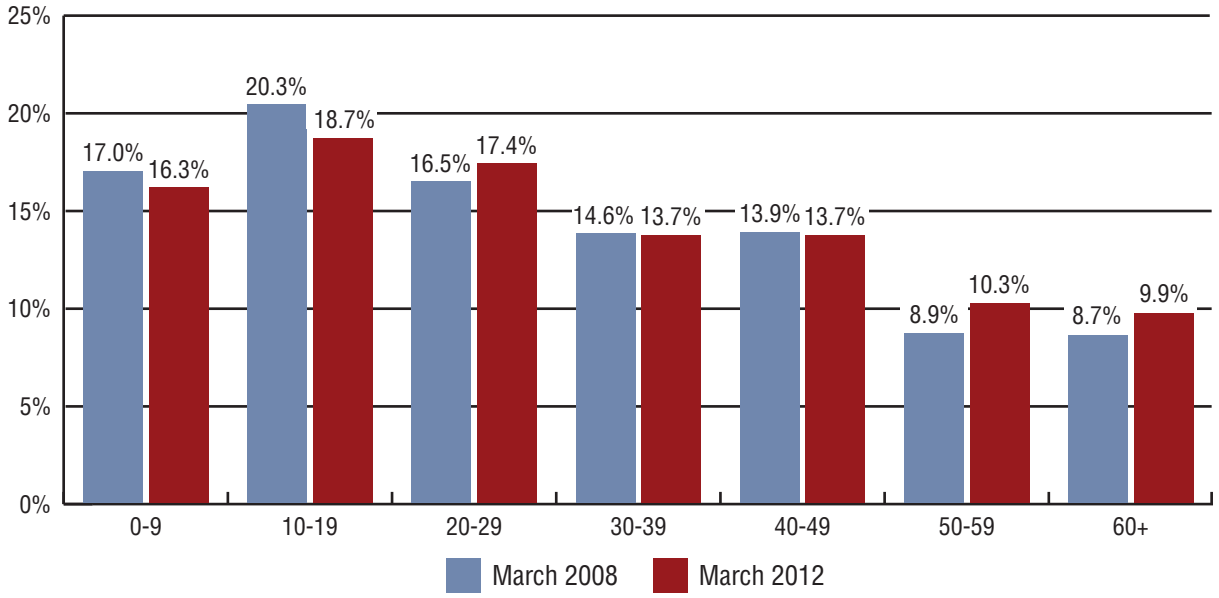
As the First Nations and Inuit client population ages, the costs associated with delivering Non-Insured Health Benefits, particularly pharmacy benefits, to this client population are expected to increase significantly in the coming years.

Proportion of Canadian Population and of 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

Program Expenditures

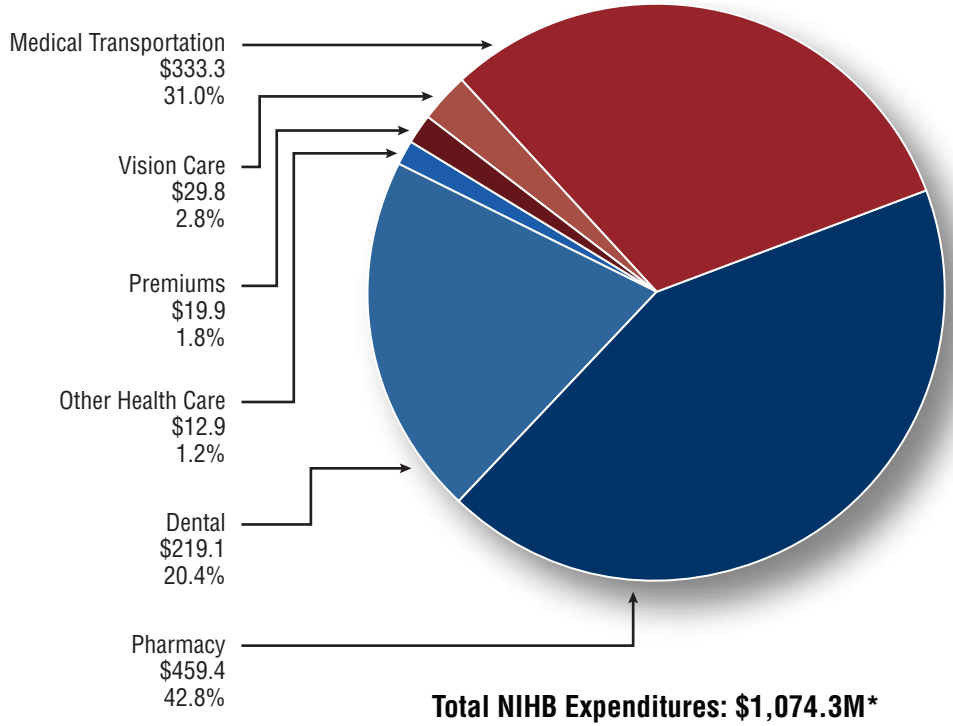
FIGURE 3.1

NIHB Expenditures by Benefit ($ Millions)
2011/12

The Non-Insured Health Benefits (NIHB) Program provides coverage for 896,624 (as of March 31, 2012) registered First Nations and recognized Inuit on a limited range of medically necessary health-related goods and services when they are not otherwise insured to provide support in reaching an overall health status that is comparable with other Canadians.

In 2011/12, total NIHB expenditures were $1,074.3 million. Of this total, NIHB Pharmacy costs (including medical supplies and equipment) represented the largest proportion at $459.4 million (42.8%), followed by NIHB Medical Transportation costs at $333.3 million (31.0%) and NIHB Dental costs at $219.1 million (20.4%).

NIHB Pharmacy, Dental and Medical Transportation benefit expenditures accounted for 94.2% of total NIHB expenditures in 2011/12.



Source: FIRMS adapted by Program Analysis Division

* Not reflected in the $1,074.3 million in NIHB expenditures is approximately $33.8 million in administration costs including Program staff and other headquarters and regional costs. More detail is provided in Figure 11.2.

FIGURE 3.2

NIHB Expenditures and Growth by Benefit
2010/11 and 2011/12

BENEFIT	Total Expenditures ($ 000's) 2010/11	Total Expenditures ($ 000's) 2011/12	% Change From 2010/11
Medical Transportation	$ 311,760	$ 333,304	6.9%
Pharmacy	440,768	459,359	4.2%
Dental	215,796	219,057	1.5%
Other Health Care	12,083	12,936	7.1%
Premiums	18,428	19,868	7.8%
Vision Care	29,219	29,780	1.9%
Total Expenditures	**$ 1,028,053**	**$ 1,074,304**	**4.5%**

Source: FIRMS adapted by Program Analysis Division

Overall NIHB Program expenditures increased 4.5% or $46.3 million from 2010/11 to 2011/12. This growth is slightly higher than the 3.9% annual growth increase recorded in 2010/11.

The highest net growth in expenditures over fiscal year 2010/11 was medical transportation benefits at $21.5 million, followed by pharmacy benefits which increased by $18.6 million.

The NIHB Premiums category had the highest growth rate in 2011/12, recording an increase of 7.8% over the previous year. This is due to new higher premium rates in British Columbia which came into force on January 1, 2010. The NIHB Other Health Care category had the second highest growth rate at 7.1% followed by NIHB Medical Transportation at 6.9%.

NIHB Dental benefit expenditures had the lowest growth rate in 2011/12 at 1.5%. This increase was the lowest annual growth rate recorded for dental benefits over the past 10 years. This low increase can be attributed to a new dental provider compensation model that was implemented in 2011. In addition, in the previous fiscal year (2010/11) a large backlog of manual claims submissions resulting from the transition to a new claims processor were processed, artificially increasing the number of claims and expenditures for that period and resulting in an expenditure growth rate of 10.7%. As a result, the dental growth rate in 2011/12 appears artificially low. A final factor contributing to a low year over year increase in dental benefit expenditures can be attributed to a change in the NIHB Program's financial activity code structure. As of 2011/12, contribution agreement expenditures for the travel of dental professionals are now coded to the NIHB Medical Transportation benefit. Previously, these expenditures were recorded against the NIHB Dental benefit.

NIHB Vision Care benefits had the second lowest growth rate in 2011/12, recording a 1.9% increase over the previous year.

NIHB Pharmacy benefit expenditures increased by 4.2% over the previous year. This growth is higher than the 1.3% annual growth recorded in 2010/11. This can be attributed to an increase in the number of eligible First Nations clients resulting from the passage of Bill C-3 and the creation of the new Qalipu Mi'kmaq Band. As the pharmacy benefit accounts for the largest share of total expenditures, overall Program growth is greatly affected by increases in this benefit area.

FIGURE 3.3

NIHB Expenditures by Benefit and Region ($ 000's)
2011/12

The Manitoba Region accounted for the highest proportion of total expenditures at $219.0 million, or 20.4% of the national total, followed by the Ontario Region at $180.8 million (16.8%), and the Saskatchewan Region at $161.3 million (15.0%).

In comparison, the lowest expenditures were in the Yukon ($11.2 million) and the Northwest Territories ($27.7 million). These totals represented 1.0% and 2.6% respectively of the national total.

The Atlantic Region experienced the highest expenditure growth rate over the last fiscal year at 14.3%. This increase in expenditures can be attributed to the registration of 21,419 new Qalipu Mi'kmaq First Nations clients in the Atlantic Region who became eligible to receive benefits through the NIHB Program.

Headquarters expenditures represent costs paid for claims processing services and account for 1.8% ($19.1 million) of NIHB expenditures. This figure does not include the $11.9 million in Headquarters administrative costs outlined in Figure 11.2

REGION	Medical Transportation	Pharmacy	Dental	Other Health Care	Premiums	Vision Care	TOTAL
Atlantic	$ 5,841	$ 27,571	$ 7,164	$ 254	$ -	$ 2,021	**$ 42,850**
Quebec	21,708	38,827	15,138	875	-	1,404	**77,951**
Ontario	54,725	76,430	41,848	2,349	-	5,425	**180,778**
Manitoba	101,609	80,639	29,861	3,109	-	3,813	**219,031**
Saskatchewan	45,084	73,293	36,941	1,499	-	4,449	**161,265**
Alberta	37,371	61,621	34,543	3,957	-	5,822	**143,313**
British Columbia	26,510	60,890	30,620	889	19,868	3,461	**142,239**
Yukon	4,413	3,878	2,583	4	-	347	**11,225**
N.W.T.	10,157	9,090	7,054	-	-	1,371	**27,672**
Nunavut	25,886	10,894	10,442	-	-	1,668	**48,890**
Headquarters	-	16,227	2,864	-	-	-	**19,090**
Total	**$ 333,304**	**$ 459,359**	**$ 219,057**	**$ 12,936**	**$ 19,868**	**$ 29,780**	**$ 1,074,304**

Source: FIRMS adapted by Program Analysis Division

FIGURE 3.4

Proportion of NIHB Expenditures by Region
2011/12

In 2011/12, the Manitoba Region had the highest proportion of total NIHB expenditures (20.4%) and accounted for 30.5% of total NIHB Medical Transportation expenditures. This can be attributed to the large number of First Nations clients living in remote or fly-in only northern communities in the Manitoba Region.

The Manitoba Region also accounted for the highest proportion of NIHB Pharmacy expenditures at 17.6%, followed by the Ontario Region at 16.6% and the Saskatchewan Region at 16.0%.

The Ontario Region, which accounted for 16.8% of total NIHB expenditures in 2011/12, recorded the highest proportion of total NIHB Dental expenditures at 19.1%. This region also accounted for the highest proportion of the total NIHB population at 21.2%.

The proportion of NIHB Vision Care expenditures ranged from a high of 19.5% in the Alberta Region and 18.2% in the Ontario Region to a low of 1.2% in the Yukon.

The Alberta Region (30.6%) and the Manitoba Region (24.0%) combined accounted for over one half of the total NIHB Other Health Care expenditures in 2011/12.

REGION	Medical Transportation	Pharmacy	Dental	Other Health Care	Premiums	Vision Care	Proportion of NIHB Expenditure	Proportion of NIHB Population
Atlantic	1.8%	6.0%	3.3%	2.0%	0%	6.8%	**4.0%**	**6.5%**
Quebec	6.5%	8.5%	6.9%	6.8%	0%	4.7%	**7.3%**	**7.0%**
Ontario	16.4%	16.6%	19.1%	18.2%	0%	18.2%	**16.8%**	**21.2%**
Manitoba	30.5%	17.6%	13.6%	24.0%	0%	12.8%	**20.4%**	**15.7%**
Saskatchewan	13.5%	16.0%	16.9%	11.6%	0%	14.9%	**15.0%**	**15.4%**
Alberta	11.2%	13.4%	15.8%	30.6%	0%	19.5%	**13.3%**	**12.5%**
British Columbia	8.0%	13.3%	14.0%	6.9%	100%	11.6%	**13.2%**	**14.3%**
Yukon	1.3%	0.8%	1.2%	0%	0%	1.2%	**1.0%**	**0.9%**
N.W.T.	3.0%	2.0%	3.2%	0%	0%	4.6%	**2.6%**	**2.8%**
Nunavut	7.8%	2.4%	4.8%	0%	0%	5.6%	**4.6%**	**3.5%**
Headquarters	0%	3.5%	1.3%	0%	0%	0%	**1.8%**	**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
2011/12

At the national level, approximately three-quarters (73.8%) of total Program expenditures occurred in two benefit areas: pharmacy (42.8%) and medical transportation (31.0%). Dental expenditures accounted for one-fifth (20.4%) of total NIHB expenditures.

NIHB Medical Transportation expenditures accounted for over half (52.9%) of total expenditures in Nunavut compared to 13.6% in the Atlantic Region. However, in the Atlantic Region, 64.3% of total expenditures were spent on pharmacy benefits compared to a low of 22.3% in Nunavut.

The proportion of dental expenditures ranged from 13.6% in the Manitoba Region to 25.5% in the Northwest Territories.

Pharmacy costs represented the highest percentage of total expenditures in all regions except in Nunavut, the Northwest Territories, 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	13.6%	64.3%	16.7%	0.6%	0%	4.7%	100%
Quebec	27.8%	49.8%	19.4%	1.1%	0%	1.8%	100%
Ontario	30.3%	42.3%	23.1%	1.3%	0%	3.0%	100%
Manitoba	46.4%	36.8%	13.6%	1.4%	0%	1.7%	100%
Saskatchewan	28.0%	45.4%	22.9%	0.9%	0%	2.8%	100%
Alberta	26.1%	43.0%	24.1%	2.8%	0%	4.1%	100%
British Columbia	18.6%	42.8%	21.5%	0.6%	14.0%	2.4%	100%
Yukon	39.3%	34.5%	23.0%	0%	0%	3.1%	100%
N.W.T.	36.7%	32.9%	25.5%	0%	0%	5.0%	100%
Nunavut	52.9%	22.3%	21.4%	0%	0%	3.4%	100%
Headquarters	0%	85.0%	15.0%	0%	0%	0%	100%
National	**31.0%**	**42.8%**	**20.4%**	**1.2%**	**1.8%**	**2.8%**	100%

Source: FIRMS adapted by Program Analysis Division

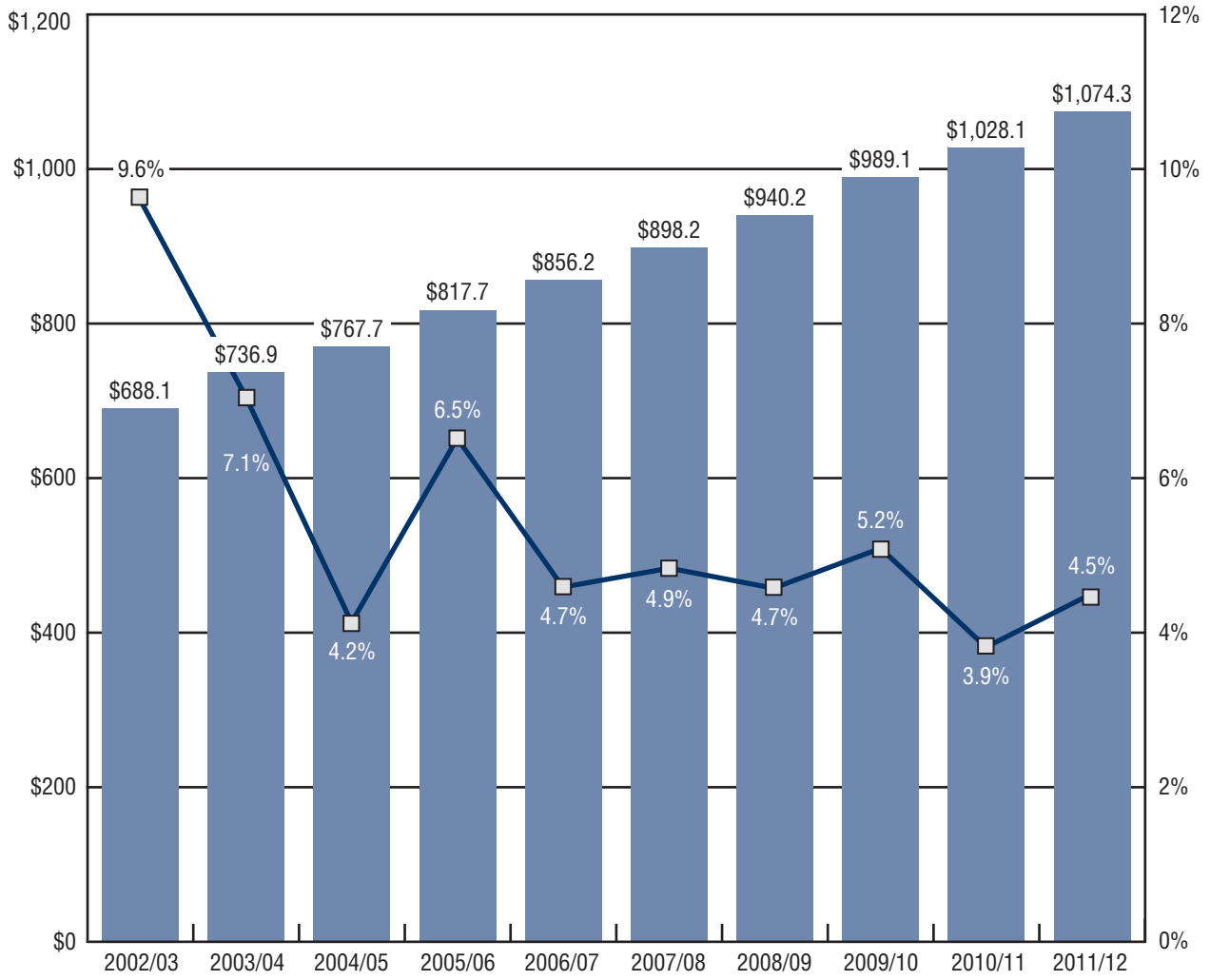
FIGURE 3.6

NIHB Annual Expenditures ($ Millions) and Percentage Change
2002/03 to 2011/12

In 2011/12, NIHB Program expenditures totalled $1,074.3 million, an increase of 4.5% from $1,028.1 million in 2010/11. Since 2002/03, total expenditures have grown by 56.1%. The annualized rate of growth over this period was 5.5%.

There has been wide variation in growth rates between 2002/03 and 2011/12, with a low of 3.9% in 2010/11 to a high of 9.6% in 2002/03.

Fluctuations in NIHB expenditure growth rates are impacted by several factors. For example, policy changes designed to improve access to the Program and those intended to promote Program sustainability affect NIHB expenditure growth rates. In addition, the introduction of new therapies and generic drugs to the market, changes to provincial pricing policies, and economic inflationary pressures have impacted NIHB expenditure growth rates. Variations in the rates of growth are also a result of self-government initiatives and changes in service delivery models within the Program, between the federal government, and between the provinces and territories.



Source: FIRMS adapted by Program Analysis Division

FIGURE 3.7

NIHB Annual Expenditures by Benefit ($ 000's)
2002/03 to 2011/12

In the period from 2002/03 to 2011/12, the expenditures for NIHB Dental and Medical Transportation benefits have grown more than other benefit areas. NIHB Dental expenditures rose by 67.2% from $131.0 million in 2002/03 to $219.1 million in 2011/12. NIHB Medical Transportation expenditures grew by 63.4% from $204.0 million in 2002/03 to $333.3 million in 2011/12.

Over the same period, NIHB Pharmacy expenditures increased by 58.3% and NIHB Vision Care expenditures had an increase of 33.8%.

NIHB Other Health Care expenditures, comprised mainly of short-term crisis intervention mental health counselling, decreased by 23.4% over this same time period from $16.9 million in 2002/03 to $12.9 million in 2011/12. The decrease in growth over this period can be partly attributed to clients accessing mental health services through other service points such as counselling and mental health services through the Indian Residential Schools Resolution Health Support Program.

NIHB Premiums expenditures decreased by 16.9% from $23.9 million in 2002/03 to $19.9 million in 2011/12. This decrease can be attributed to the Government of Alberta eliminating Alberta health care insurance premiums for all Alberta residents on January 1, 2009. Consequently, since 2009/10 the NIHB Program only provides coverage for premiums in the British Columbia Region.

BENEFIT	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Medical Transportation	$ 203,952	$ 205,793	$ 211,527	$ 225,379	$ 241,602	$ 262,294	$ 280,446	$ 301,673	$ 311,760	$ 333,304
Pharmacy	290,112	326,982	343,879	368,398	386,190	403,248	418,968	435,097	440,768	459,359
Dental	131,021	134,504	142,956	153,900	158,584	165,576	176,382	194,918	215,796	219,057
Other Health Care	16,894	16,557	16,904	17,115	16,271	12,289	11,380	12,516	12,083	12,936
Premiums	23,902	28,614	27,830	27,987	28,659	29,211	26,430	17,110	18,428	19,868
Vision Care	22,259	24,420	24,629	24,968	24,894	25,621	26,577	27,779	29,219	29,780
Total	$ 688,140	$ 736,870	$ 767,726	$ 817,748	$ 856,201	$ 898,239	$ 940,182	$ 989,094	$ 1,028,053	$ 1,074,304
Annual % Change	9.6%	7.1%	4.2%	6.5%	4.7%	4.9%	4.7%	5.2%	3.9%	4.5%

Source: FIRMS adapted by Program Analysis Division

FIGURE 3.8

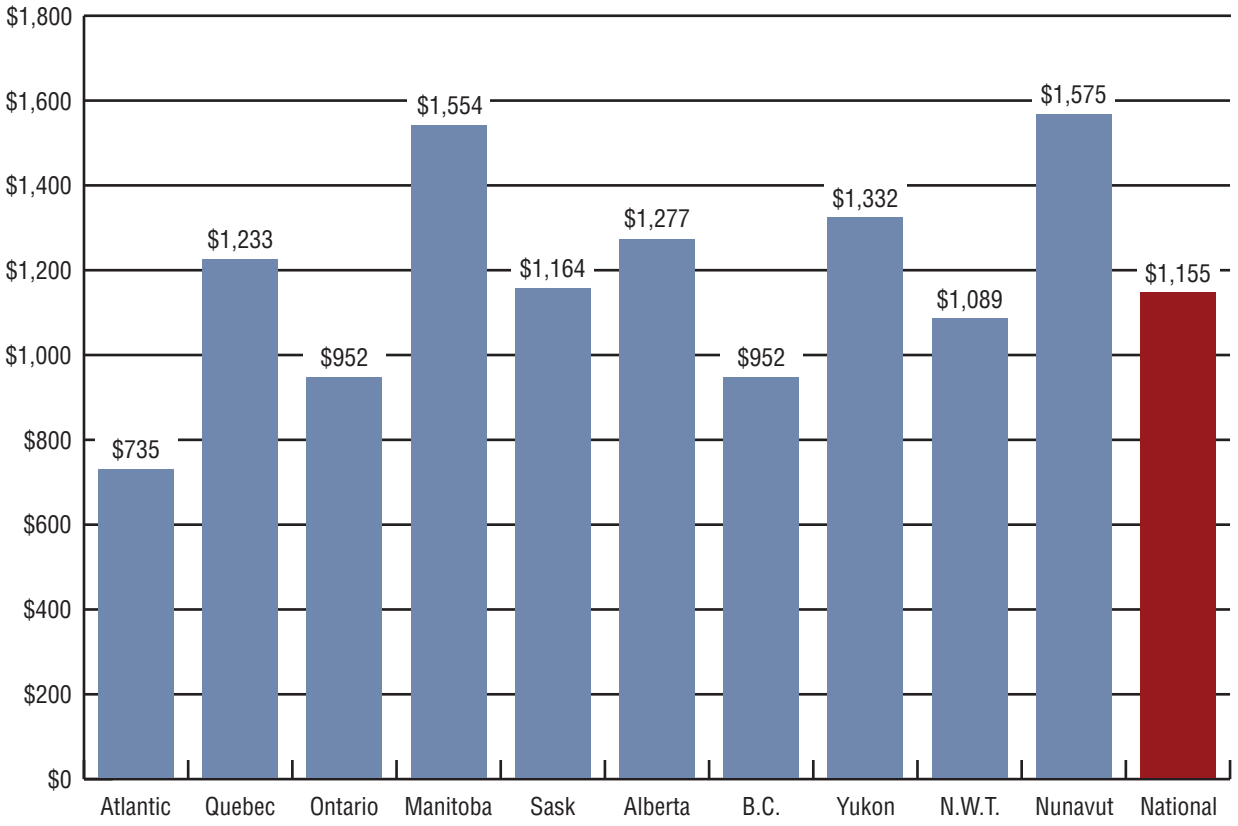
Per Capita NIHB Expenditures by Region (Excluding Premiums)
2011/12

The national per capita expenditure for all benefits in 2011/12 was $1,155. This is a decrease from the 2010/11 national per capita expenditure of $1,173.

Nunavut continued to have the highest per capita cost in 2011/12 at $1,575; however this was lower than the $1,610 per capita cost recorded in 2010/11. The Manitoba Region had the second highest per capita cost at $1,554 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.

In 2011/12, the Atlantic Region had the lowest per capita expenditures at $735. This per capita cost is lower than the $1,063 recorded in 2010/11. The lower per capita cost can be attributed to the significant increase in the eligible client population in this region as a result of the registration of 21,419 new Qalipu Mi'kmaq First Nations clients. These clients became eligible to receive NIHB benefits during the second half of 2011/12 following the creation of the Qalipu Mi'kmaq First Nations Band (September 26, 2011). The lower levels of benefit utilization for these clients in 2011/12 impacted the overall cost per capita for the Atlantic Region as a whole.

If premiums that were paid by the NIHB Program were included in these calculations, per capita costs in the British Columbia Region would be $1,106, with the national total adjusted to $1,177.



Source: FIRMS and SVS adapted by Program Analysis Division

NIHB Pharmacy Expenditure and Utilization Data

SECTION 4

The NIHB Program covers claims for pharmacy benefits not covered by private, public or provincial/territorial health care plans. The NIHB Program covers prescription drugs listed on the NIHB Drug Benefit List (DBL). In addition, a limited but comprehensive range of medical supplies and equipment (MS&E) items are also covered by the Program.

In 2011/12, the NIHB Program paid for pharmacy claims made by a total of 557,731 First Nations and Inuit clients. The total expenditures for these claims was $459.4 million or 42.8% of total NIHB expenditures. Of all the NIHB Program benefits, the pharmacy benefit accounts for the largest share of expenditures and is the benefit most utilized by clients.

The NIHB Program's client population faces many unique health needs requiring medical attention such as a high prevalence of diabetes, cardiovascular disease and tobacco-related illnesses. Through the pharmacy benefit of the NIHB Program, the health needs of approximately 150,000 clients with gastrointestinal problems, 115,000 clients with cardiovascular problems, and 59,000 clients with diabetes were met in 2011/12.

The NIHB Program provides eligible clients with access to pharmacy benefits that will contribute to better health outcomes in a fair, equitable and cost-effective manner, while recognizing the unique health needs of First Nations and Inuit clients. Policies to achieve this objective have and will continue to be adopted by the NIHB Program. For example, NIHB policy is to pay the 'lowest cost alternative drug', and to reimburse only the best price alternative or equivalent product. This policy effectively addresses client health needs while delivering the benefit in a cost-effective manner consistent with Parliamentary appropriations.

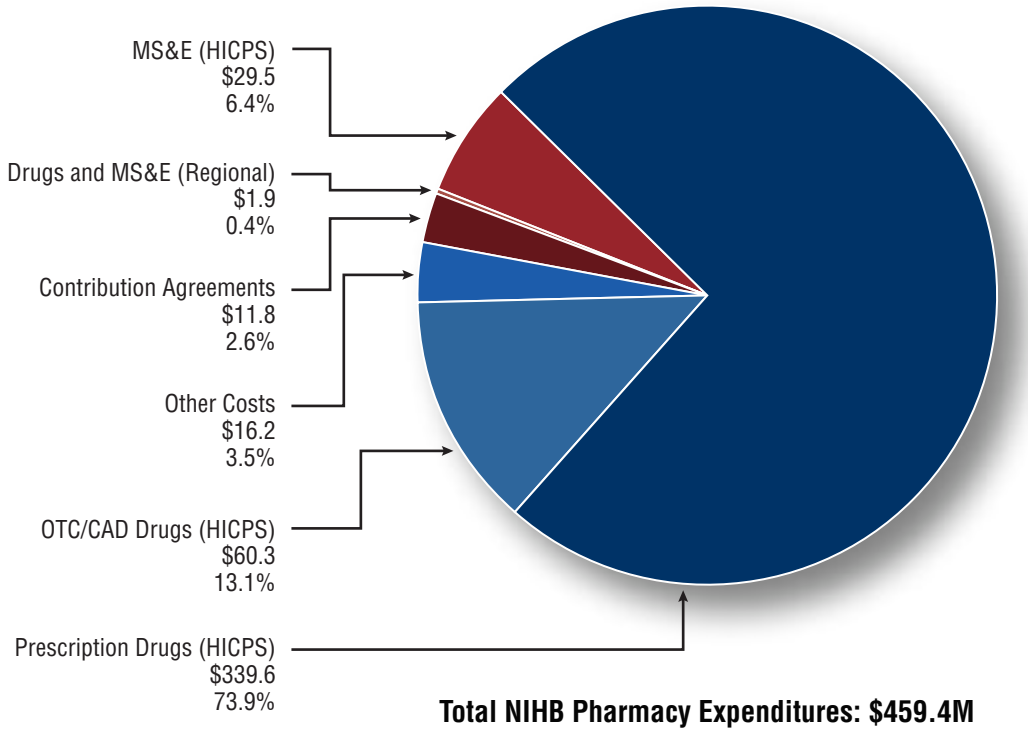
Another objective of the Program is to provide pharmacy benefits and services based on professional judgment, consistent with the current best practices of health services delivery and evidence-based standards of care. To achieve this objective, the addition and removal of pharmacy benefits covered by the NIHB Program follows an evidence-based standard of care approach with a particular emphasis on client safety.

Like prescription and over-the-counter medications, MS&E benefits are covered in accordance with Program policies. Clients must obtain a prescription from a prescriber that is recognized by the NIHB Program for MS&E items, and have the prescription filled at an approved provider. Items covered under the MS&E benefit include:

- Audiology benefits, such as hearing aids and repairs;
- Medical equipment, such as 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)
2011/12



Source: FIRMS adapted by Program Analysis Division

In 2011/12, NIHB Pharmacy benefits totalled $459.4 million or 42.8% of total NIHB expenditures.

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 $339.6 million or 73.9% of all NIHB Pharmacy expenditures, followed by over-the-counter (OTC) drugs and controlled access drugs (CAD) which totalled $60.3 million or 13.1%. Medical supplies and equipment (MS&E) items paid through HICPS was the third largest component in the pharmacy benefit at $29.5 million or 6.4%. In total, the three components managed through automated claims processing accounted for 93.5% of all pharmacy benefit costs.

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

Contribution agreements, which accounted for $11.8 million or 2.6% of total pharmacy benefit 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, which include short-term crisis intervention mental health counselling, totalled $16.2 million or 3.5% in 2011/12. Included in this total are Headquarters expenditures which represent operational costs related to the HICPS system.

FIGURE 4.2

Total NIHB Pharmacy Expenditures by Type and Region ($ 000's)
2011/12

Prescription drug costs paid through the Health Information and Claims Processing Services (HICPS) system represented the largest component of total costs accounting for $339.6 million or 73.9% of all NIHB Pharmacy costs. The Manitoba Region had the largest proportion of these costs at 18.9%, followed by the Ontario Region at 16.6% and the Saskatchewan Region at 16.5%.

The next highest component was over-the-counter (OTC) and controlled access drug (CAD) costs at $60.3 million or 13.1%. The regions of Ontario (21.5%), Manitoba (19.1%) and Saskatchewan (17.6%) had the largest proportions of these costs in 2011/12.

The third highest component was the combined medical supplies and equipment (MS&E) category at $29.5 million (6.4%). The Alberta Region (18.2%) had the highest proportions of MS&E costs in 2011/12. This was followed by the British Columbia Region (17.6%) and the Saskatchewan Region (17.4%).

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	$ 19,150	$ 3,749	$ 6	$ 527	$ 951	$ -	$ 24,383	$ 3,188	$ 27,571
Quebec	31,066	6,562	24	489	676	-	38,817	10	38,827
Ontario	56,311	12,933	21	1,170	2,939	-	73,375	3,056	76,430
Manitoba	64,349	11,539	0	1,557	3,194	-	80,639	0	80,639
Saskatchewan	56,179	10,580	1,344	1,801	3,346	-	73,250	42	73,293
Alberta	44,596	6,577	89	1,667	3,717	-	56,646	4,974	61,621
British Columbia	49,334	5,895	30	1,290	3,900	-	60,450	441	60,890
Yukon	3,221	337	38	80	202	-	3,878	0	3,878
N.W.T.	7,124	934	0	351	565	-	8,974	116	9,090
Nunavut	8,295	1,160	357	403	679	-	10,894	0	10,894
Headquarters	-	-	-	-	-	16,227	16,227	0	16,227
Total	**$ 339,627**	**$ 60,266**	**$ 1,909**	**$ 9,335**	**$ 20,168**	**$ 16,227**	**$ 447,532**	**$ 11,827**	**$ 459,359**

Source: FIRMS adapted by Program Analysis Division

FIGURE 4.3

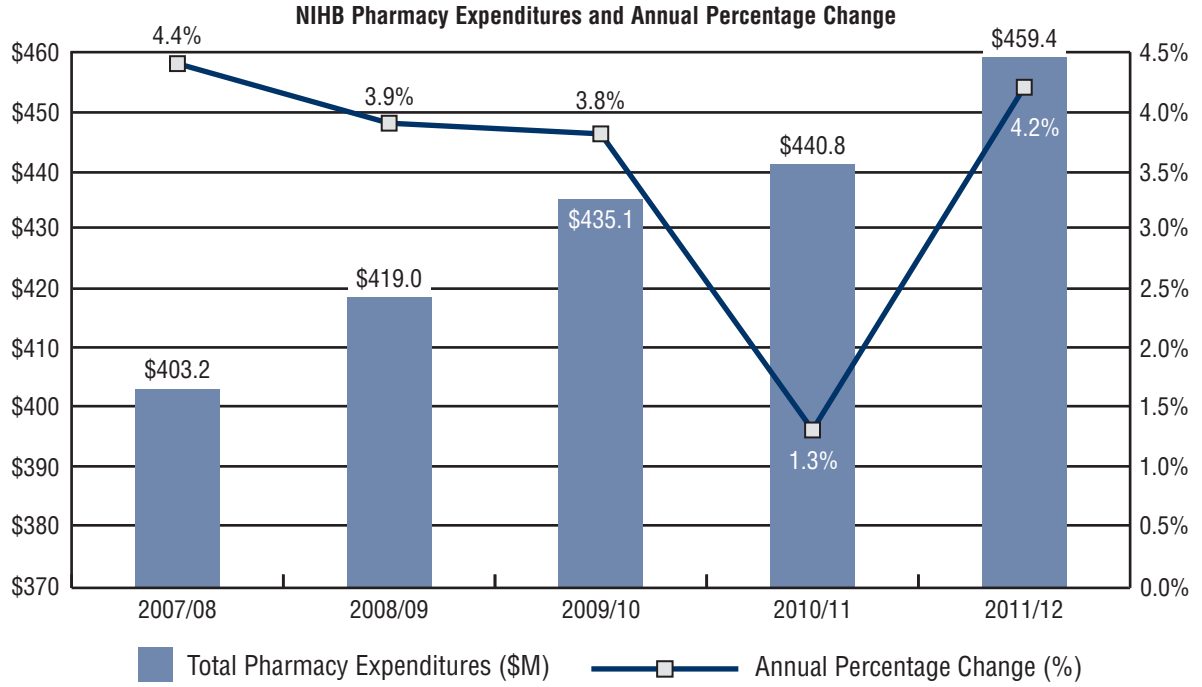
Annual NIHB Pharmacy Expenditures
2007/08 to 2011/12

NIHB Pharmacy expenditures increased by 4.2% during fiscal year 2011/12. This represents a 2.9 percentage point increase over the previous year's growth rate.

Over the past five years, growth in pharmacy expenditures has ranged from a high of 4.4% in 2007/08 to a low of 1.3% in 2010/11. The annualized growth rate over these five years is 3.5%.

Pharmacy expenditure growth has been low and steady over the past five years. Reasons for this stability include the introduction of lower cost generic drugs as they become available on the market, optimizing drug utilization, policy changes designed to promote NIHB Program sustainability, such as the implementation of the NIHB Short-Term Dispensing Policy in 2008/09, and the changes in generic pricing policies in key provinces (Quebec, Ontario, Saskatchewan and British Columbia).

The highest rate of growth in NIHB Pharmacy expenditures in 2011/12 took place in the Atlantic Region, which increased by 16.4% over the previous fiscal year. This increase in pharmacy expenditures can be attributed to the registration of 21,419 new Qalipu Mi'kmaq First Nations clients in the Atlantic Region who became eligible to receive pharmacy benefits through the NIHB Program. The Manitoba Region had the second highest growth rate at 5.4%.



Source: FIRMS adapted by Program Analysis Division

NIHB Pharmacy Expenditures ($ 000's)					
REGION	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**2011/12**
Atlantic	$ 18,984	$ 20,119	$ 21,357	$ 23,689	$ 27,571
Quebec	35,372	36,069	37,358	38,234	38,827
Ontario	77,191	77,244	77,564	73,887	76,430
Manitoba	69,317	71,081	72,789	76,496	80,639
Saskatchewan	60,749	62,809	66,639	70,625	73,293
Alberta	54,353	54,189	56,570	59,738	61,621
British Columbia	54,290	56,104	58,862	60,097	60,890
Yukon	3,802	3,779	3,723	3,792	3,878
N.W.T.	7,863	8,210	8,595	8,999	9,090
Nunavut	6,579	7,084	8,237	10,399	10,894
Headquarters	14,750	22,281	23,403	$14,814	16,227
Total	**$ 403,248**	**$ 418,968**	**$ 435,097**	**$ 440,768**	**$ 459,359**

Source: FIRMS adapted by Program Analysis Division

FIGURE 4.4

Per Capita NIHB Pharmacy Expenditures by Region
2011/12

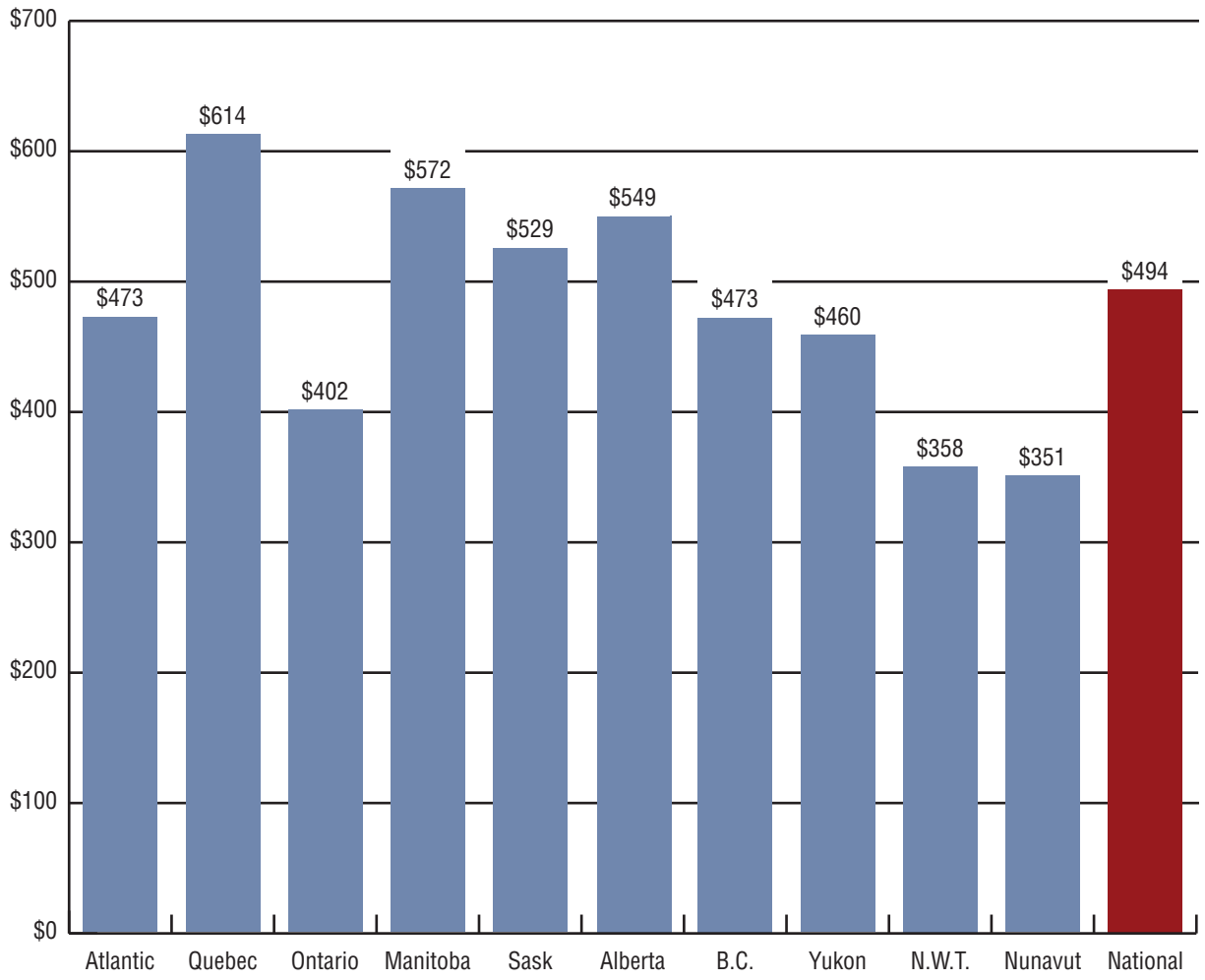
In 2011/12, the national per capita expenditure for NIHB Pharmacy benefits was $494. This was a decrease of 1.8% from the $503 recorded in 2010/11.

The Quebec Region had the highest per capita NIHB Pharmacy expenditure at $614, followed by the Manitoba Region at $572 and the Alberta Region at $549.

Nunavut and the Northwest Territories had the lowest per capita NIHB Pharmacy expenditures at $351 and $358 respectively. A relatively low per capita expenditure in Nunavut and the Northwest Territories is attributed to lower than average utilization rates and also a younger population utilizing lower cost medications. (Refer to Figure 4.6)

The highest net increases in per capita costs were in the Manitoba Region ($15) and Nunavut ($6). However, Nunavut continued to have the lowest per capita expenditure at $351.

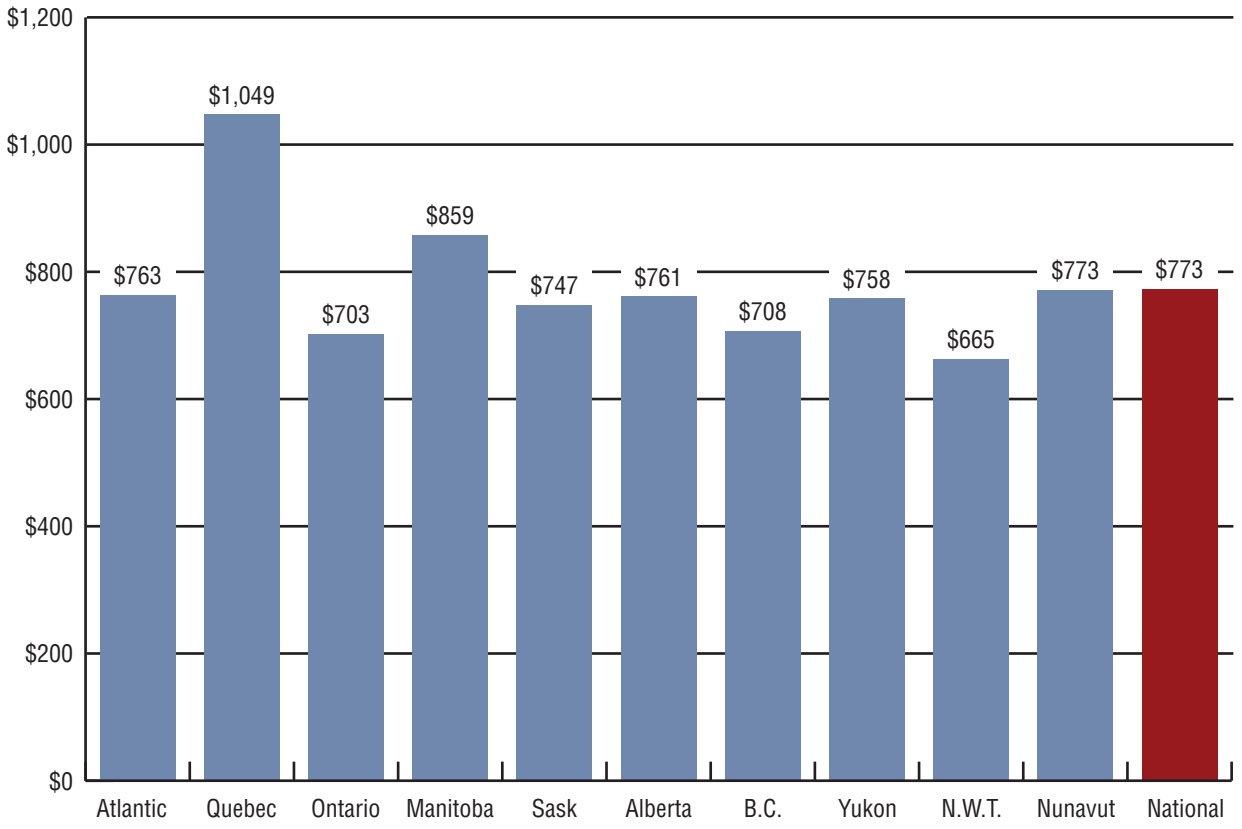
Per capita costs declined significantly in the Atlantic Region by 29.6% ($199) from $672 in 2010/11 to $473 in 2011/12. This decrease in per capita can be attributed to the significant increase in the eligible client population in this region as a result of the registration of 21,419 new Qalipu Mi'kmaq First Nations clients. These clients became eligible to receive NIHB Pharmacy benefits following the creation of the Qalipu Mi'kmaq First Nations Band (September 26, 2011) and were eligible for benefits for less than six months of the fiscal year. The lower level of the pharmacy benefit utilization for these clients in 2011/12 impacted on the pharmacy per capita cost for the Atlantic Region as a whole.



Source: FIRMS and SVS adapted by Program Analysis Division

FIGURE 4.5

NIHB Pharmacy Operating Expenditures per Claimant by Region
2011/12



Source: HICPS and FIRMS adapted by Program Analysis Division

In 2011/12, the national average expenditure per eligible client receiving at least one pharmacy benefit was $773, a slight decrease of 0.3% over the recorded amount of $775 in 2010/11. This decrease can be attributed to savings associated with the introduction of generic versions of high volume drug products (e.g. Lipitor) and the adopting of new generic pricing models in a number of Canadian provinces, including Ontario, Quebec, Saskatchewan and British Columbia.

The Quebec Region had the highest average NIHB Pharmacy expenditure per claimant at $1,049, followed by the Manitoba Region at $859. The Northwest Territories had the lowest expenditure per claimant at $665.

In 2011/12, the rate of growth in NIHB Pharmacy operating expenditures per claimant decreased significantly in the Atlantic Region by 23.8% ($238) from $1,001 in 2010/11 to $763 in 2011/12. As discussed previously in Figure 4.4, this decrease can be attributed to new Qalipu Mi'kmaq clients claiming for approximately half of the fiscal year. This impacted significantly on the cost per claimant totals for the Atlantic Region.

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 2011/12, a claimant between the ages of 0 and 4 years of age accounted for approximately $166 in NIHB expenditures on average, while claimants 65 years of age and older had the highest costs at approximately $2,029 per claimant.

FIGURE 4.6

NIHB Pharmacy Utilization Rates by Region
2007/08 to 2011/12

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 2011/12, the national utilization rate was 62% for NIHB Pharmacy benefits paid through the HICPS system. This is slightly lower compared to the previous four fiscal years.

Pharmacy utilization rates vary across the regions. In 2011/12, regional rates ranged from a low of 45% in Nunavut to 71% 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 or provided completely via third Party plans. For example, if the Bigstone Cree Nation client population were removed from the Alberta Region's population because the HICPS system does not capture any data on services used by this population, the utilization rate for pharmacy benefits in Alberta would have been 71% in 2011/12. Similarly 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 58%. If both the Bigstone and Akwesasne client populations were removed from the overall NIHB population, the national utilization rate for pharmacy benefits would have been 64%.

Pharmacy Utilization					
REGION	2007/08	2008/09	2009/10	2010/11	2011/12
Atlantic	66%	66%	66%	66%	55%
Quebec	59%	60%	59%	59%	59%
Ontario	56%	55%	56%	55%	55%
Manitoba	68%	68%	68%	67%	67%
Saskatchewan	74%	73%	73%	72%	71%
Alberta	68%	67%	67%	67%	66%
British Columbia	68%	68%	68%	68%	66%
Yukon	64%	64%	64%	61%	61%
N.W.T.	53%	53%	54%	53%	53%
Nunavut	41%	44%	46%	44%	45%
National	**64%**	**64%**	**64%**	**64%**	**62%**

Source: HICPS and SVS adapted by Program Analysis Division

The utilization rate recorded in the Atlantic Region in 2011/12 decreased from 66% in 2010/11 to 55% in 2011/12. As mentioned in Figure 4.4, this decrease in utilization can be attributed to the increase in eligible client population in this region as a result of the registration of 21,419 new Qalipu Mi'kmaq First Nations clients. These new clients claimed for approximately half of the fiscal year, impacting the overall utilization rate of this region.

FIGURE 4.7

NIHB Pharmacy Claimants by Age Group, Gender and Region
2011/12

Of the 896,624 clients eligible to receive benefits under the NIHB Program, a total of 557,731 claimants, representing 62% of the NIHB client population, received at least one pharmacy item paid through the Health Information and Claims Processing Services (HICPS) system in 2011/12.

Of this total, 315,206 were female (57%) and 242,525 were male (43%). This compares to the total eligible population where 51% were female and 49% were male.

The average age of pharmacy claimants was 33 years. This is unchanged compared to the previous fiscal year. The average age for female and male claimants was 34 and 33 years of age, respectively. The highest average age of pharmacy claimants was found in the Yukon at 39 years of age, while the lowest was in the regions of Saskatchewan and Alberta both at 30 years of age.

Thirty percent of pharmacy claimants were under 20 years of age. Twenty-eight percent of female claimants were in this age group while males accounted for 32%. Seniors (age 65 and over) represented 7.3% of all pharmacy claimants in 2011/12.

REGION	Atlantic			Quebec			Ontario			Manitoba		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	895	863	1,758	1,011	920	1,931	2,317	2,347	4,664	3,845	3,798	7,643
5-9	1,116	1,157	2,273	1,149	1,102	2,251	3,014	2,978	5,992	4,194	4,252	8,446
10-14	1,022	1,052	2,074	1,010	1,053	2,063	2,959	2,991	5,950	3,576	3,682	7,258
15-19	1,073	1,646	2,719	1,045	1,779	2,824	3,301	4,799	8,100	3,451	4,994	8,445
20-24	991	1,581	2,572	1,028	1,829	2,857	3,257	5,252	8,509	3,480	5,464	8,944
25-29	938	1,410	2,348	938	1,677	2,615	3,163	4,870	8,033	3,059	4,502	7,561
30-34	907	1,295	2,202	979	1,455	2,434	3,212	4,641	7,853	2,904	3,892	6,796
35-39	936	1,272	2,208	1,034	1,476	2,510	3,291	4,421	7,712	2,949	3,796	6,745
40-44	1,084	1,357	2,441	1,199	1,587	2,786	3,529	4,591	8,120	3,129	3,934	7,063
45-49	1,083	1,333	2,416	1,267	1,699	2,966	3,954	5,072	9,026	3,081	3,697	6,778
50-54	1,029	1,338	2,367	1,270	1,696	2,966	3,644	4,690	8,334	2,528	3,169	5,697
55-59	919	1,238	2,157	1,061	1,422	2,483	2,910	3,859	6,769	1,862	2,379	4,241
60-64	747	943	1,690	815	1,114	1,929	2,291	2,980	5,271	1,369	1,669	3,038
65+	1,171	1,556	2,727	1,710	2,693	4,403	3,903	6,087	9,990	2,128	3,041	5,169
Total	13,911	18,041	31,952	15,516	21,502	37,018	44,745	59,578	104,323	41,555	52,269	93,824
Average Age	35	36	36	37	39	38	36	38	37	30	32	31

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	4,162	3,968	8,130	3,142	3,012	6,154	2,452	2,242	4,694	99	72	171	327	285	612	711	701	1,412	18,961	18,208	37,169
5-9	4,658	4,988	9,646	3,407	3,544	6,951	2,890	2,944	5,834	116	100	216	318	393	711	491	504	995	21,353	21,962	43,315
10-14	3,961	4,339	8,300	2,945	3,042	5,987	2,504	2,633	5,137	108	111	219	322	361	683	402	368	770	18,809	19,632	38,441
15-19	3,821	5,490	9,311	3,153	3,993	7,146	2,706	3,875	6,581	151	218	369	416	698	1,114	418	856	1,274	19,535	28,348	47,883
20-24	3,914	5,968	9,882	2,887	4,321	7,208	3,001	4,493	7,494	159	265	424	454	924	1,378	440	1,120	1,560	19,611	31,217	50,828
25-29	3,451	5,094	8,545	2,795	3,821	6,616	2,878	4,202	7,080	168	261	429	392	723	1,115	361	902	1,263	18,143	27,462	45,605
30-34	3,145	4,233	7,378	2,458	3,292	5,750	2,713	3,644	6,357	168	211	379	344	682	1,026	351	711	1,062	17,181	24,056	41,237
35-39	2,972	3,951	6,923	2,252	2,886	5,138	2,730	3,568	6,298	162	217	379	344	633	977	364	624	988	17,034	22,844	39,878
40-44	3,046	3,863	6,909	2,342	2,804	5,146	2,817	3,661	6,478	220	238	458	478	685	1,163	408	646	1,054	18,252	23,366	41,618
45-49	2,836	3,552	6,388	2,236	2,815	5,051	3,064	3,972	7,036	239	277	516	444	667	1,111	378	557	935	18,582	23,641	42,223
50-54	2,343	3,003	5,346	1,801	2,316	4,117	2,831	3,722	6,553	178	266	444	381	602	983	303	427	730	16,308	21,229	37,537
55-59	1,633	2,134	3,767	1,298	1,769	3,067	2,253	2,957	5,210	117	187	304	283	449	732	236	327	563	12,572	16,721	29,293
60-64	1,188	1,559	2,747	907	1,275	2,182	1,683	2,024	3,707	91	152	243	254	352	606	257	256	513	9,602	12,324	21,926
65+	1,958	2,806	4,764	1,611	2,316	3,927	2,914	4,065	6,979	222	346	568	534	741	1,275	431	545	976	16,582	24,196	40,778
Total	43,088	54,948	98,036	33,234	41,206	74,440	37,436	48,002	85,438	2,198	2,921	5,119	5,291	8,195	13,486	5,551	8,544	14,095	242,525	315,206	557,731
Average Age	29	30	30	29	31	30	35	36	35	38	40	39	36	37	36	31	32	32	33	34	33

FIGURE 4.8

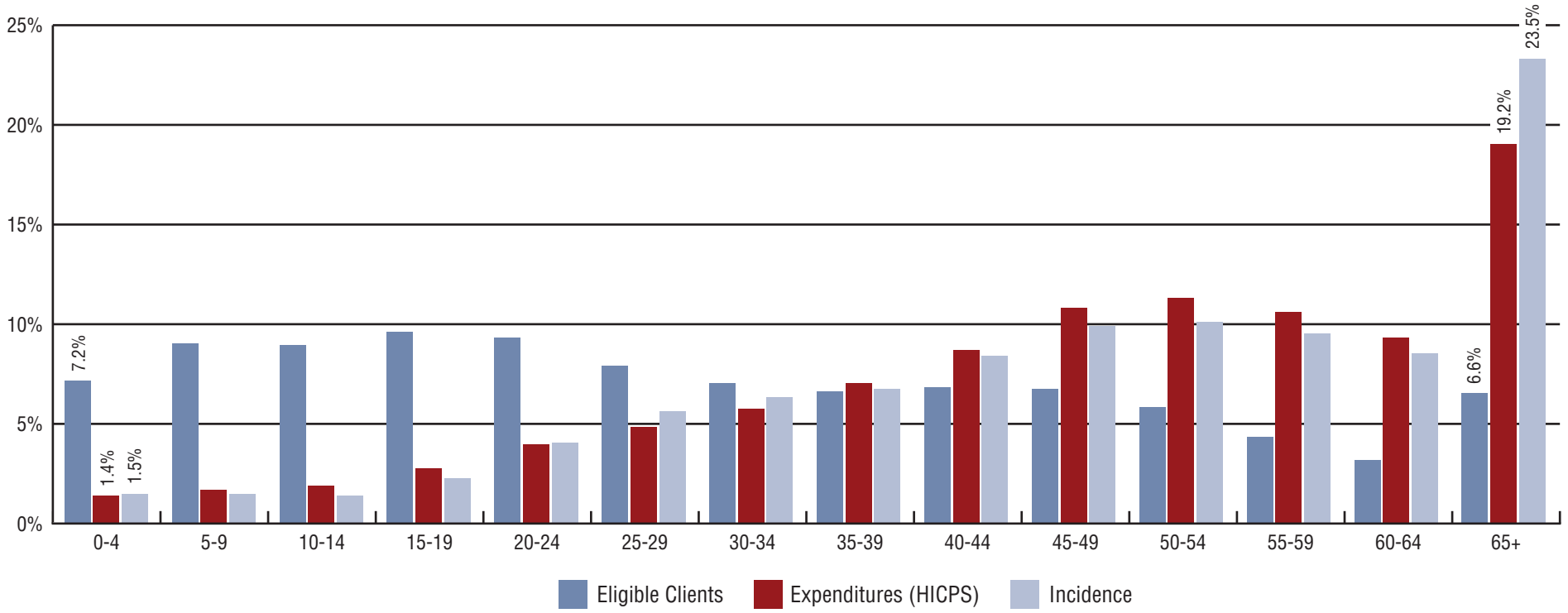
Distribution of Eligible NIHB Population, Pharmacy Expenditures and Pharmacy Incidence by Age Group
2011/12

The main drivers of NIHB Pharmacy expenditures are the cost of medications, the volume of claims* submitted and the professional fees associated with filling these claims. In 2011/12, for example, 7.2% of all clients were in the 0 to 4 age group, but this group accounted for only 1.5% of all pharmacy claims made and only 1.4% of total pharmacy expenditures, a slight decrease over 2010/11. In contrast, 6.6% of all eligible clients were the 65+ age group, but accounted for 23.5% of all pharmacy claims submitted and 19.2% of total pharmacy expenditures, a very minor increase over 2010/11.

During 2011/12, the average claimant aged 65 or more submitted 86 claims compared to 59 claims for their counterpart in the 60 to 64 age group and six claims for the average claimant in the 0 to 4 age group.

QUICK FACT

An examination of pharmacy benefit utilization rates by NIHB claimants indicates that these rates vary according to age. For example, 57.5% 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 age 15. Claimants aged 60 to 64 years had the highest utilization rate at 75.4%.



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 4.9

NIHB Top Ten Therapeutic Classes by Claims Incidence and Expenditure
2011/12

Table 1 ranks the top ten therapeutic classes according to claims incidence. In 2011/12, Opioid Dependence Treatment had the highest claims incidence total at over one million claims (1,116,284). This represents a percentage increase of 21.9% over the 915,855 claims incidence recorded last fiscal year. The significant increase in the number of claims over the previous fiscal year is attributed to an ongoing trend of increased utilization of methadone in the treatment of opioid addiction. Furthermore, methadone is billed daily thereby increasing the overall claims volume.

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) such as Voltaren (Diclofenac) ranked second in claims incidence with 949,422 claims followed by Opioid Agonists and Antidepressants with 928,869 and 789,157 claims respectively.

Table 1: NIHB Top Ten Therapeutic Classes by Claims Incidence

Therapeutic Classification	Claims Incidence	% Change from 2010/11	Examples of Product in the Therapeutic Class
Opioid Dependence Treatment	1,116,284	21.9%	Methadone
Non-Steroidal Anti-Inflammatory Drugs (NSAID)	949,422	4.2%	Voltaren (Diclofenac)
Opioid Agonists	928,869	4.9%	Tylenol no.3 (Acetaminophen w/ codeine)
Antidepressants	789,157	14.0%	Effexor (Venlafaxine)
Angiotensin-Converting Enzyme Inhibitors	549,094	6.2%	Altace (Ramipril)
Anxiolytics, Sedatives and Hypnotics – Benzodiazepines	539,722	9.2%	Ativan (Lorazepam)
HMG-CoA Reductase Inhibitors (Statins)	531,867	10.4%	Lipitor (Atorvastatin)
Proton-Pump Inhibitors	520,275	13.4%	Losec (Omeprazole)
Biguanides	423,348	9.7%	Glucophage (Metformin)
Antipsychotic Agents	391,774	15.0%	Risperdal (Risperidone)

Source: HICPS adapted by Program Analysis Division

Table 2 ranks the top ten therapeutic classes according to expenditure. Opioid Agonists, which ranked third in terms of claims incidence, had the largest expenditure at $20.8 million, an increase of 3.0% over fiscal year 2010/11.

The second largest expenditure class was Antidepressants, at $18.9 million. This is a slight increase of 1.8% over fiscal year 2010/11.

Cholesterol lowering drugs in the HMG-CoA Reductase Inhibitors (Statins) class such as Lipitor (Atorvastatin) had the third largest expenditures at $18.8 million in 2011/12. This significant decrease of 11.2% over fiscal year 2010/11 can be attributed to the introduction of lower cost generic Lipitor in 2010.

Within the top ten therapeutic classes, Antidiabetic Agents such as insulin had the highest percentage increase in expenditures over fiscal year 2010/11 at 30.6%. This increase is primarily driven by the addition of glargine (Lantus) to the NIHB Drug Benefit List. In the past, the NIHB Program covered Lantus on an exception basis, however in 2011/12, this changed to an open benefit resulting in a significant increase in utilization. This growth pattern is expected to stabilize in 2012/13. Disease-modifying Antirheumatic Drugs followed with a percentage increase in expenditures over fiscal year 2010/11 at 16.8%. This can be attributed to costly therapies being transferred to this therapeutic classification.

Table 2: NIHB Top Ten Therapeutic Classes by Expenditure

Therapeutic Classification	Expenditure ($000's)	% Change from 2010/11	Examples of Product in the Therapeutic Class
Opioid Agonists	$ 20,821	3.0%	Tylenol no.3 (Acetaminophen w/codeine)
Antidepressants	18,885	1.8%	Effexor (Venlafaxine)
HMG-CoA Reductase Inhibitors (Statins)	18,786	-11.2%	Lipitor (Atorvastatin)
Proton Pump Inhibitors	18,234	0.8%	Losec (Omeprazole)
Disease-modifying Antirheumatic Drugs	15,620	16.8%	Enbrel (Etanercept)
Antipsychotic Agents	14,624	4.6%	Risperdal (Risperidone)
Angiotensin-Converting Enzyme Inhibitors	14,229	-3.0%	Altace (Ramipril)
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	14,124	3.9%	Voltaren (Diclofenac)
Diabetic Diagnostic Agents	12,695	3.1%	Test Strips
Antidiabetic Agents (Insulin)	12,549	30.6%	Lantus (Insulin)

Source: HICPS adapted by Program Analysis Division

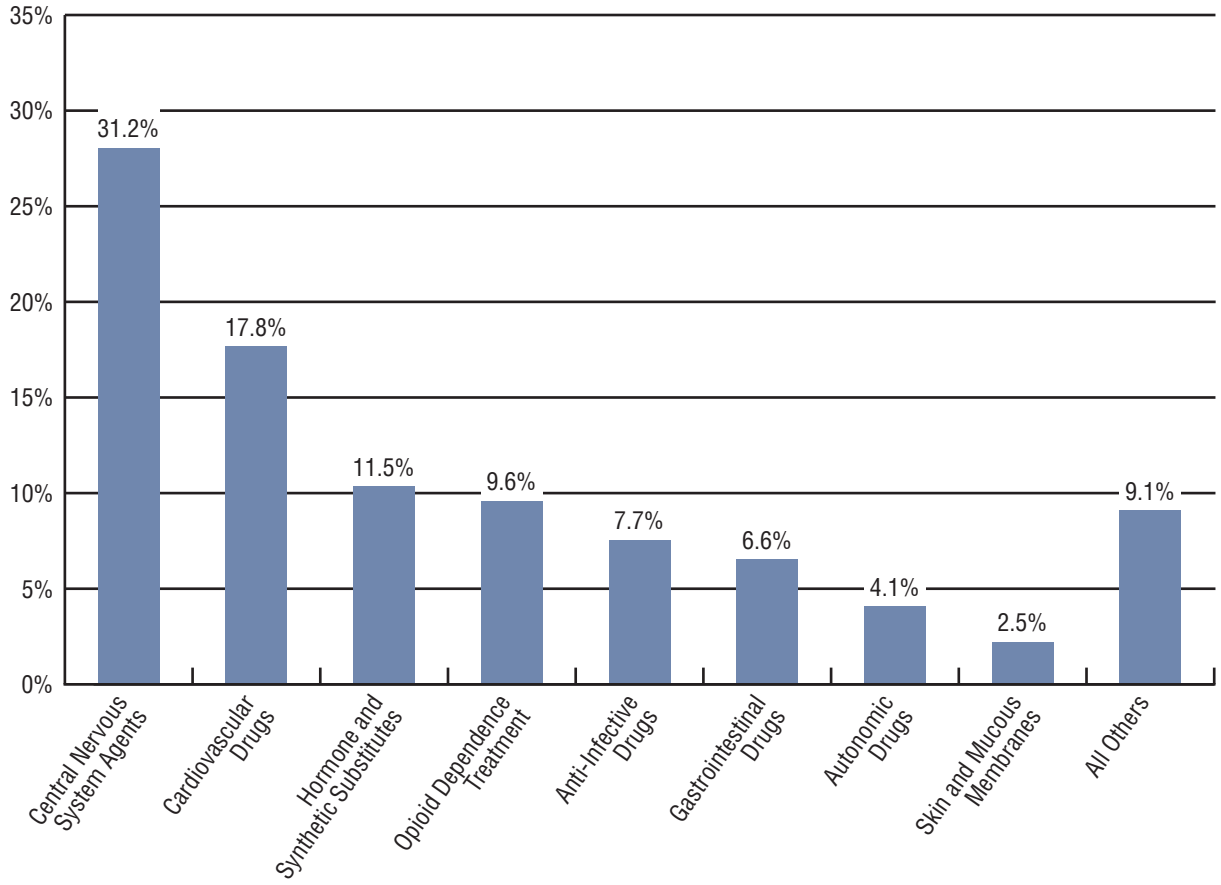
FIGURE 4.10

NIHB Prescription Drug Claims Incidence by Pharmacologic Therapeutic Class
2011/12

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

Central Nervous System Agents, which include drug classes such as analgesics and sedatives, accounted for 31.2% of all prescription drug claims. Central Nervous Systems Agents are used in the treatment of conditions such as arthritis, depression or epilepsy.

Cardiovascular Drugs had the next highest share of prescription drug claims at 17.8% followed by Hormones and Synthetic Substitutes, which consist primarily of oral contraceptives and insulin, at 11.5%. Cardiovascular Drugs are used to treat clients with arrhythmias, hypercholesterolemia or ischemic heart disease. Hormones and Synthetic Substitutes are given to clients to treat conditions such as diabetes or hypothyroidism.



Source: HICPS adapted by Program Analysis Division

FIGURE 4.11

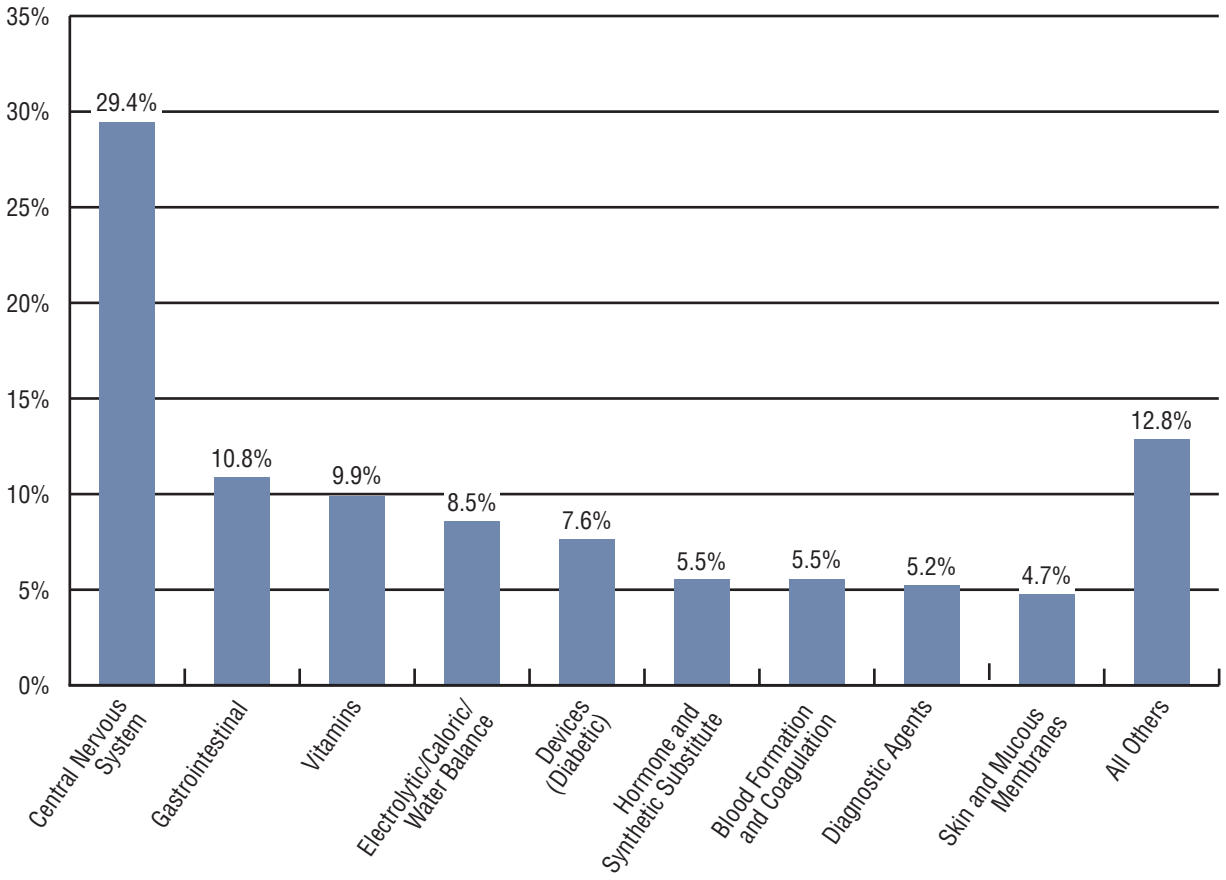
NIHB Over-the-Counter Drugs (Including Controlled Access Drugs – CAD) Claims Incidence by Pharmacologic Therapeutic Class
2011/12

Figure 4.11 demonstrates variation in claims incidence by therapeutic classification for over-the-counter (OTC) drugs. Unlike other health programs or drug plans, the NIHB Program covers the cost of some OTC drugs. To be reimbursed by the NIHB Program, all OTC drugs require a prescription from a recognized health professional who has the authority to prescribe in the province or territory.

Central Nervous System Agents, drugs which are used to manage pain such as headaches (e.g. acetaminophen), accounted for 29.4% of all OTC drug claims.

Gastrointestinal products such as antacids and laxatives, which are used to treat heartburn and constipation, are the next highest category of OTC medication at 10.8%, followed by Vitamins at 9.9%. The Electrolytic/Caloric/Water Balance class such as calcium, which is used in the prevention and treatment of conditions such as osteoporosis, followed at 8.5%.

The largest increase from the last fiscal year (2010/11) in claims volume of OTC drugs by therapeutic class was in Hormones and Synthetic Substitutes which increased by 0.6 percentage points, while the largest decrease was among Central Nervous System Agents which decreased by 0.8 percentage points.



Source: HICPS adapted by Program Analysis Division

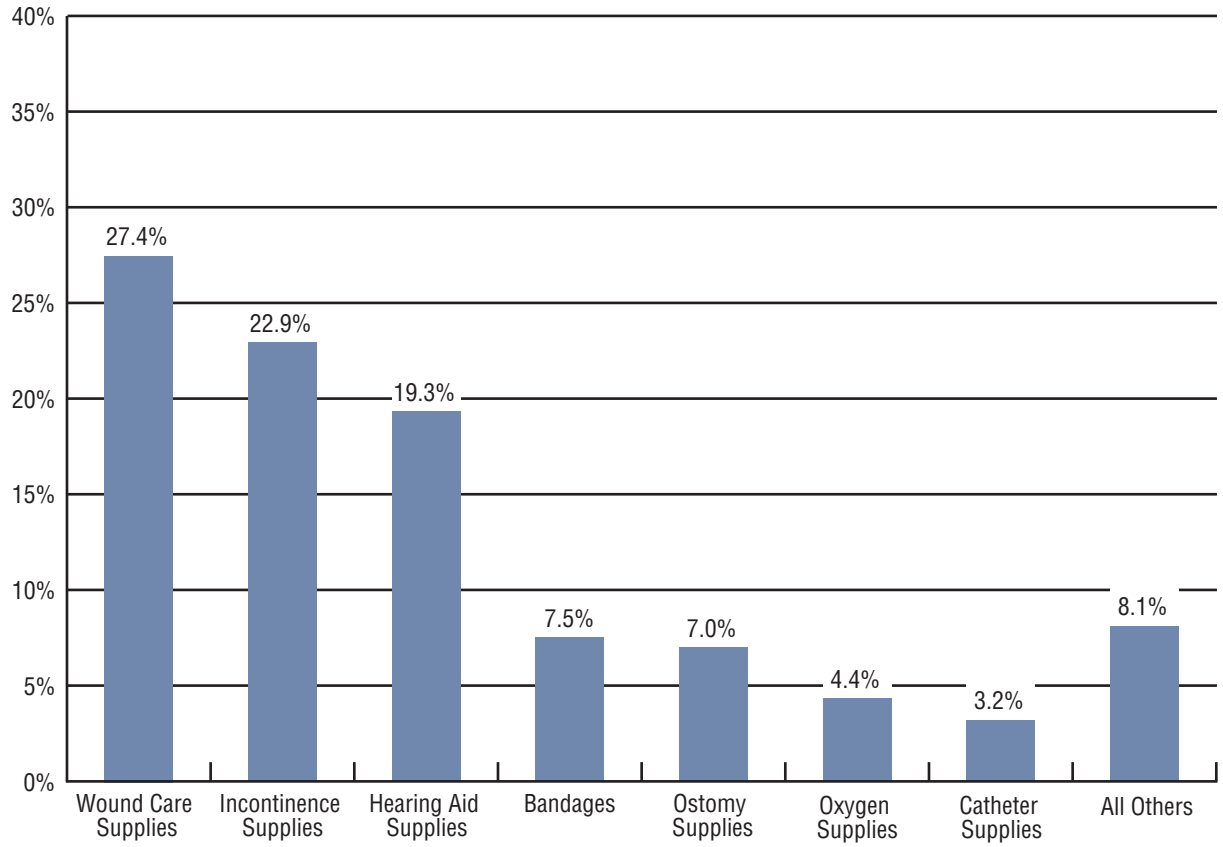
FIGURE 4.12

NIHB Medical Supplies by Category and Claims Incidence
2011/12

Figure 4.12 demonstrates variation in medical supply claims by specific category.

In 2011/12, wound care supplies such as silver dressings, sterile dressings and iodine dressings accounted for 27.4% of all medical supply claims. Incontinence supplies such as liners and pads, represented the second highest category of medical supplies at 22.9%, followed by hearing aid supplies at 19.3%.

The most significant increase in claims for medical supplies over fiscal year 2010/11 was in hearing aid supplies which increased by 2.1 percentage points, while the largest decrease was among wound care supplies which declined by 1.9 percentage points.



Source: HICPS adapted by Program Analysis Division

FIGURE 4.13

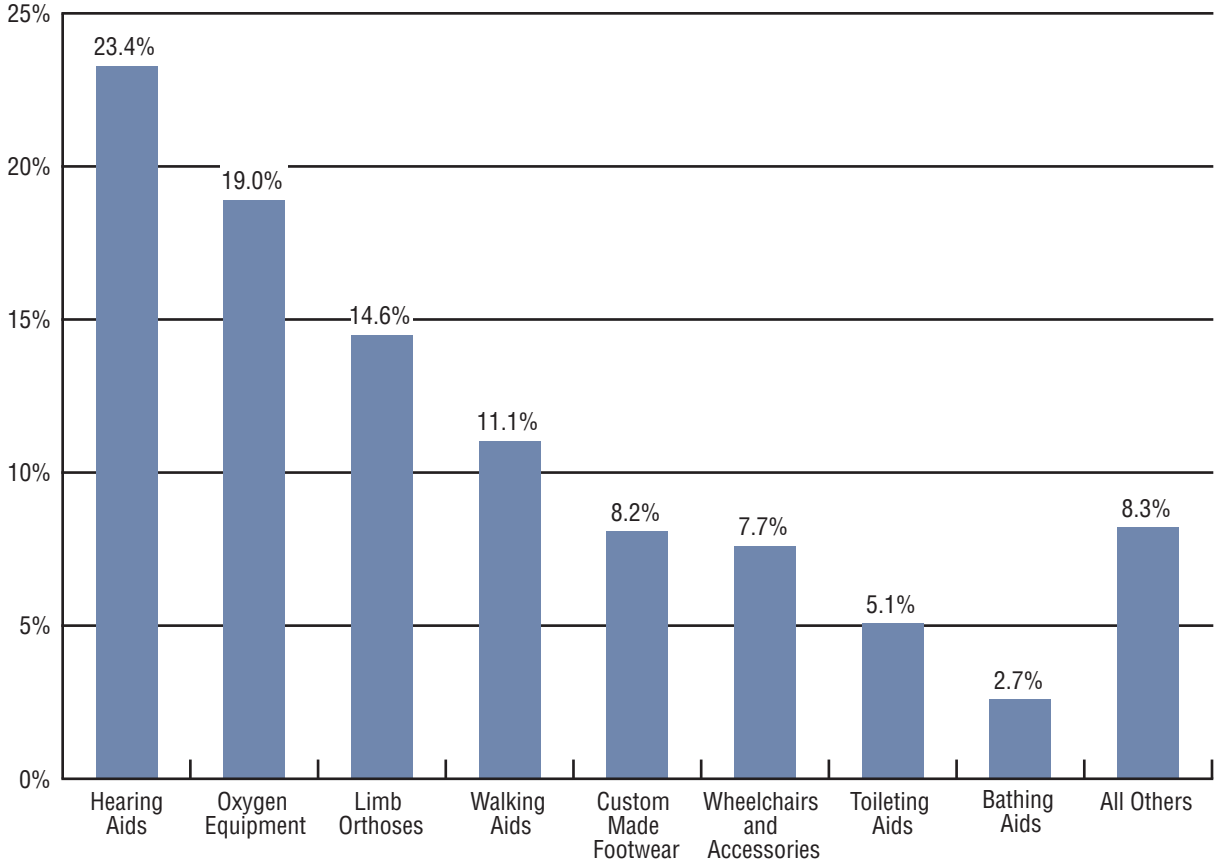
NIHB Medical Equipment by Category and Claims Incidence
2011/12

Figure 4.13 demonstrates variation in medical equipment claims by specific category.

Claims for hearing aids accounted for 23.4% of all medical equipment claims in 2011/12. Oxygen equipment was the next highest at 19.0%, followed by limb orthoses at 14.6% and walking aids at 11.1%.

The most significant increase in the proportion of total medical equipment claims over the fiscal year 2010/11 was in hearing aids which increased by 2.2 percentage points.

The most significant decrease in the proportion of total medical equipment was in oxygen equipment which declined 0.9 percentage points as a share of total claims for medical equipment over the previous fiscal year. Custom made footwear followed closely with a 0.6 percentage point decrease over 2010/11.



Source: HICPS adapted by Program Analysis Division

NIHB Dental Expenditure and Utilization Data

SECTION 5

The NIHB Program recognizes the importance of good oral health in contributing to the overall health of First Nations and Inuit clients, and covers a broad range of dental services in an effort to address the unique oral health needs of this client population.

In 2011/12, the NIHB Program paid for dental claims made by a total of 320,123 First Nations and Inuit clients. The total expenditure for these claims was $219.1 million or 20.4% of total NIHB expenditures. The dental benefit accounts for the third largest Program expenditures.

First Nations and Inuit experience a higher rate of dental disease such as periodontal disease and caries compared to other Canadians. Poor oral health can contribute to a greater incidence and severity of other medical conditions such as diabetes, respiratory illnesses and cardiovascular diseases. The broad range of dental services covered by the NIHB Program provides the opportunity to ensure that proper oral care required for overall good health is available to First Nations and Inuit clients. In 2011/12, through the NIHB Program's Dental Benefit, the oral health needs of approximately 205,000 clients who required intraoral radiograph services, 180,000 clients who received scaling procedures, and 139,000 clients who required restoration treatments were met.

Coverage for NIHB Dental benefits is determined on an individual basis, taking into consideration the client's current oral health status, client history and accumulated scientific research. 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 that determines 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 and the NIHB Dental Benefits Guide which outline 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 and crowns;
- Endodontic services such as root canal treatments;
- Periodontal services such as deep scaling;
- Removable prosthodontic services such as 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 is required for some dental services within these categories.

FIGURE 5.1

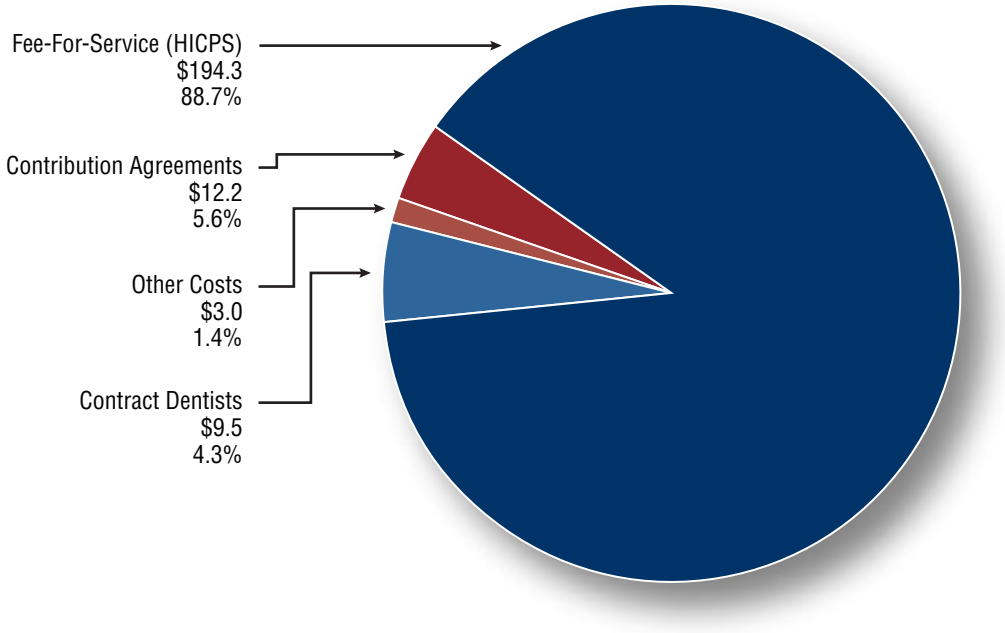
Distribution of NIHB Dental Expenditures ($ Millions)
2011/12

NIHB Dental expenditures totalled $219.1 million in 2011/12. Figure 5.1 illustrates the distinct components of dental expenditures under the NIHB Program. Fee-for-service dental costs paid through the Health Information and Claims Processing Services (HICPS) system represented the largest expenditure component, accounting for $194.3 million or 88.7% of all NIHB Dental costs.

The next highest component was contribution agreements, which accounted for $12.2 million or 5.6% of total dental expenditures. Contribution allocations were used to fund the provision of dental benefits through agreements such as those with 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 $9.5 million or 4.3% of total costs.

Other costs totalled $3.0 million or 1.4% in 2011/12. The majority of these costs are related to claims processing and payment services.



Total NIHB Dental Expenditures: $219.1M

Source: FIRMS adapted by Program Analysis Division

FIGURE 5.2

Total NIHB Dental Expenditures by Type and Region ($ 000's)
2011/12

NIHB Dental expenditures totalled $219.1 million in 2011/12. The regions of Ontario (19.1%), Saskatchewan (16.9%), Alberta (15.8%) and British Columbia (14.0%) had the largest proportion of overall dental costs.

Of the $219.1 million in dental expenditures, $206.8 million (94.4%) were operating expenditures while $12.2 million (5.6%) were contribution expenditures.

Fee-for-service costs paid through the Health Information and Claims Processing Services (HICPS) system represented the largest component of total costs accounting for $194.3 million or 88.7% of all NIHB Dental costs while contract dentists accounted for $9.5 million (4.3%).

REGION	OPERATING			Total Operating Costs	Total Contribution Costs	TOTAL COSTS
	Fee-For-Service	Contract Dentists	Other Costs			
Atlantic	$ 7,020	$ 0	$ 2	$ 7,022	$ 142	**$ 7,164**
Quebec	15,000	0	0	15,000	138	**15,138**
Ontario	33,509	2,573	147	36,229	5,620	**41,848**
Manitoba	24,692	5,071	0	29,763	98	**29,861**
Saskatchewan	33,499	0	4	33,503	3,438	**36,941**
Alberta	32,255	175	6	32,436	2,106	**34,543**
British Columbia	28,737	1,407	0	30,144	476	**30,620**
Yukon	2,287	296	0	2,583	0	**2,583**
N.W.T.	7,028	0	0	7,028	26	**7,054**
Nunavut	10,246	0	0	10,246	196	**10,442**
Headquarters	-	-	2,864	2,864	-	**2,864**
Total	**$ 194,273**	**$ 9,522**	**$ 3,022**	**$ 206,817**	**$ 12,239**	**$ 219,057**

Source: FIRMS adapted by Program Analysis Division

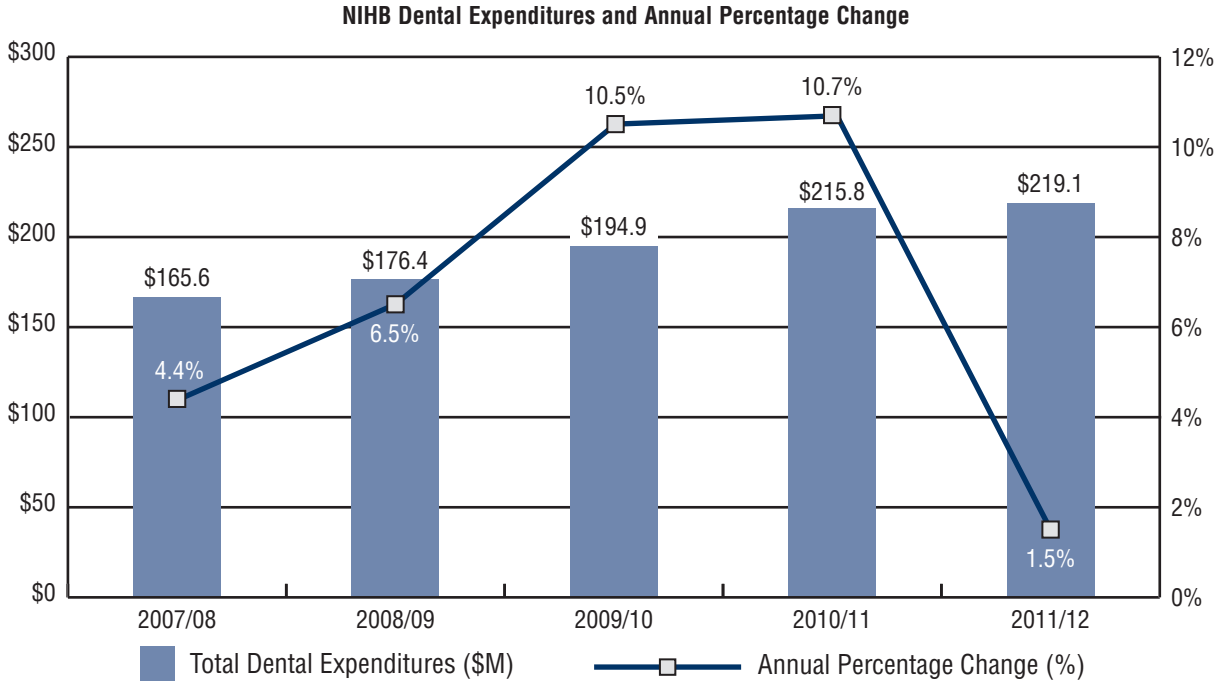
FIGURE 5.3

Annual NIHB Dental Expenditures
2007/08 to 2011/12

Among all the NIHB Program benefits, NIHB Dental expenditures had the lowest growth rate in 2011/12 at 1.5%. This increase was the lowest annual growth rate recorded for dental benefits over the past 10 years. This low increase can be attributed to a new dental provider compensation model that was implemented in 2011. In addition, in the previous fiscal year (2010/11) a large backlog of manual claim submissions resulting from the transition to a new claims processor were processed, artificially increasing the number of claims and expenditures for that period and resulting in an expenditure growth rate of 10.7%. As a result, the dental growth rate in 2011/12 appears artificially low. A final factor contributing to a low year over year increase in dental benefit expenditures can be attributed to a change in the NIHB Program's financial activity code structure. As of 2011/12, contribution agreement expenditures for the travel of dental professionals are now coded to the NIHB Medical Transportation benefit. Previously, these expenditures were recorded against the NIHB Dental benefit.

Over the last five years, annual growth rates for NIHB Dental expenditures have ranged from a high of 10.7% in 2010/11 to a low of 1.5% in 2011/12, with an annualized growth rate of 6.7%. This is the highest rate of annualized growth for all benefit areas over this period.

In 2011/12, the highest rate of growth in NIHB Dental expenditures was in the Atlantic Region, which increased by 10.5% compared to the previous year. This increase in dental expenditures can be attributed to the registration of 21,419 new Qalipu Mi'kmaq



Source: FIRMS adapted by Program Analysis Division

NIHB Dental Expenditures ($ 000's)					
REGION	2007/08	2008/09	2009/10	2010/11	2011/12
Atlantic	$ 5,204	$ 4,945	$ 5,426	$ 6,481	$ 7,164
Quebec	12,141	12,895	14,159	15,245	15,138
Ontario	33,467	35,457	38,047	40,594	41,848
Manitoba	21,696	24,444	26,954	29,399	29,861
Saskatchewan	24,636	28,102	30,777	35,317	36,941
Alberta	22,391	25,016	27,756	33,421	34,543
British Columbia	22,968	24,718	28,042	30,187	30,620
Yukon	1,998	2,246	2,271	2,629	2,583
N.W.T.	5,752	6,279	7,067	7,603	7,054
Nunavut	9,002	8,349	10,289	12,306	10,442
Headquarters	6,321	3,932	4,130	2,614	2,864
Total	**$ 165,576**	**$ 176,382**	**$ 194,918**	**$ 215,796**	**$ 219,057**

Source: FIRMS adapted by Program Analysis Division

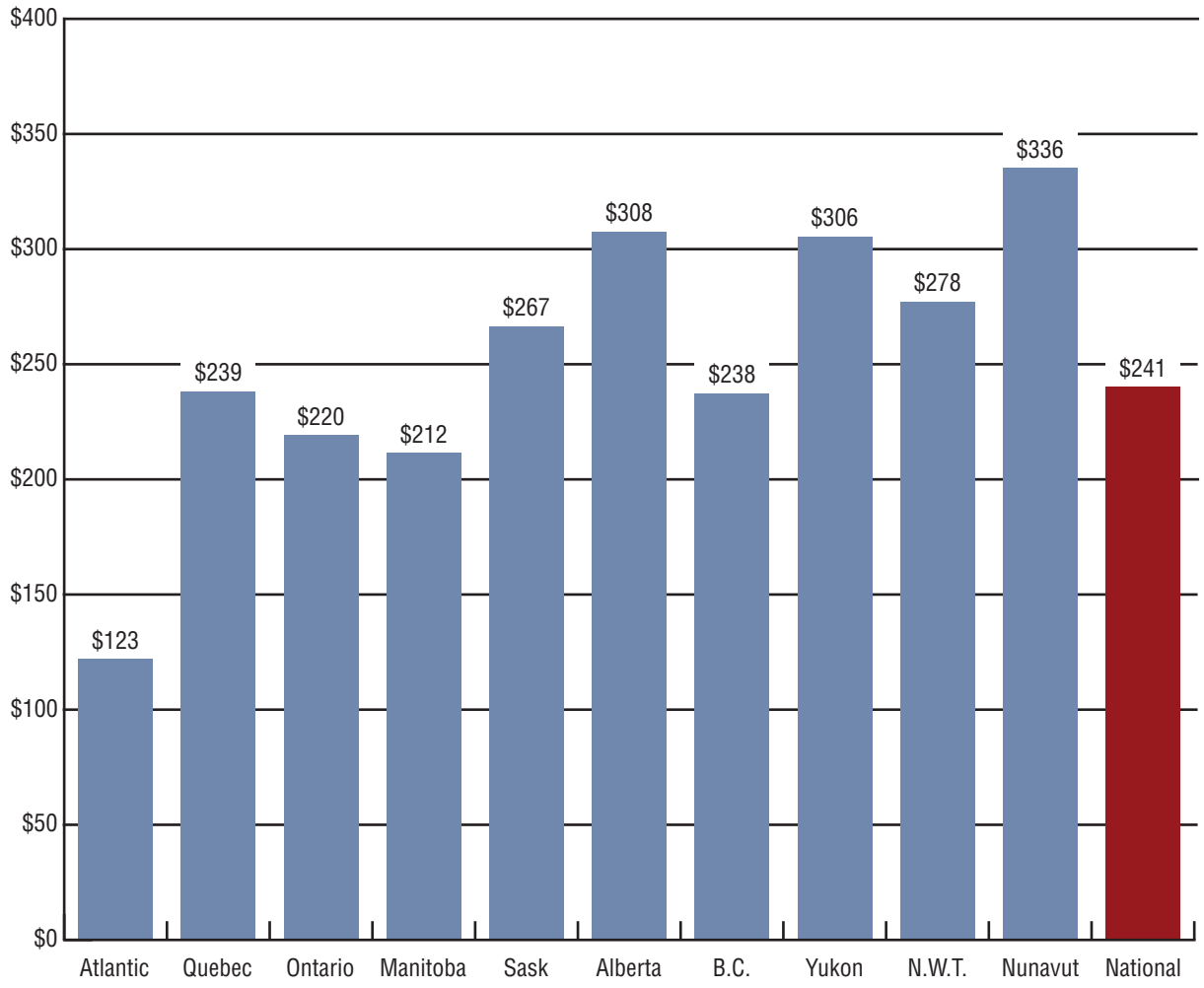
First Nations clients in the Atlantic Region who became eligible to receive dental benefits through the NIHB Program.

In 2011/12, the largest net increase in dental expenditures took place in the Saskatchewan Region where total dental costs grew by $1.6 million. The regions of Ontario and Alberta both followed with a $1.3 million and $1.1 million increase in expenditures respectively over the previous fiscal year.

The Ontario Region had the highest total dental expenditure at $41.8 million and the Yukon had the lowest total dental expenditure at $2.6 million.

FIGURE 5.4

Per Capita NIHB Dental Expenditures by Region
2011/12



Source: SVS and FIRMS adapted by Program Analysis Division

In 2011/12, the national per capita NIHB Dental expenditure was $241, a decrease of 4.4% from the $252 recorded in 2010/11.

Nunavut had the highest per capita dental expenditure at $336. This reflects the comparatively high cost of delivering dental services to clients in Nunavut and is also a product of a high level of utilization of dental benefits in the territory.

The Alberta Region had the second highest dental per capita expenditure at $308, a decrease from $310 in the previous year. This was followed closely by the Yukon at $306, a decrease from the $322 registered in 2010/11.

The Atlantic Region had the lowest per capita dental cost at $123 per eligible client, a decrease from $184 in the previous year. This decrease in per capita cost can be attributed to the significant increase in the eligible client population in this region as a result of the registration of 21,419 new Qalipu Mi'kmaq First Nations clients. These clients became eligible to receive NIHB Dental benefits during the second half of 2011/12 following the creation of the Qalipu Mi'kmaq First Nations Band (September 26, 2011). The lower level of the dental benefit utilization for these clients in 2011/12 impacted on the dental per capita cost for the Atlantic Region as a whole.

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.

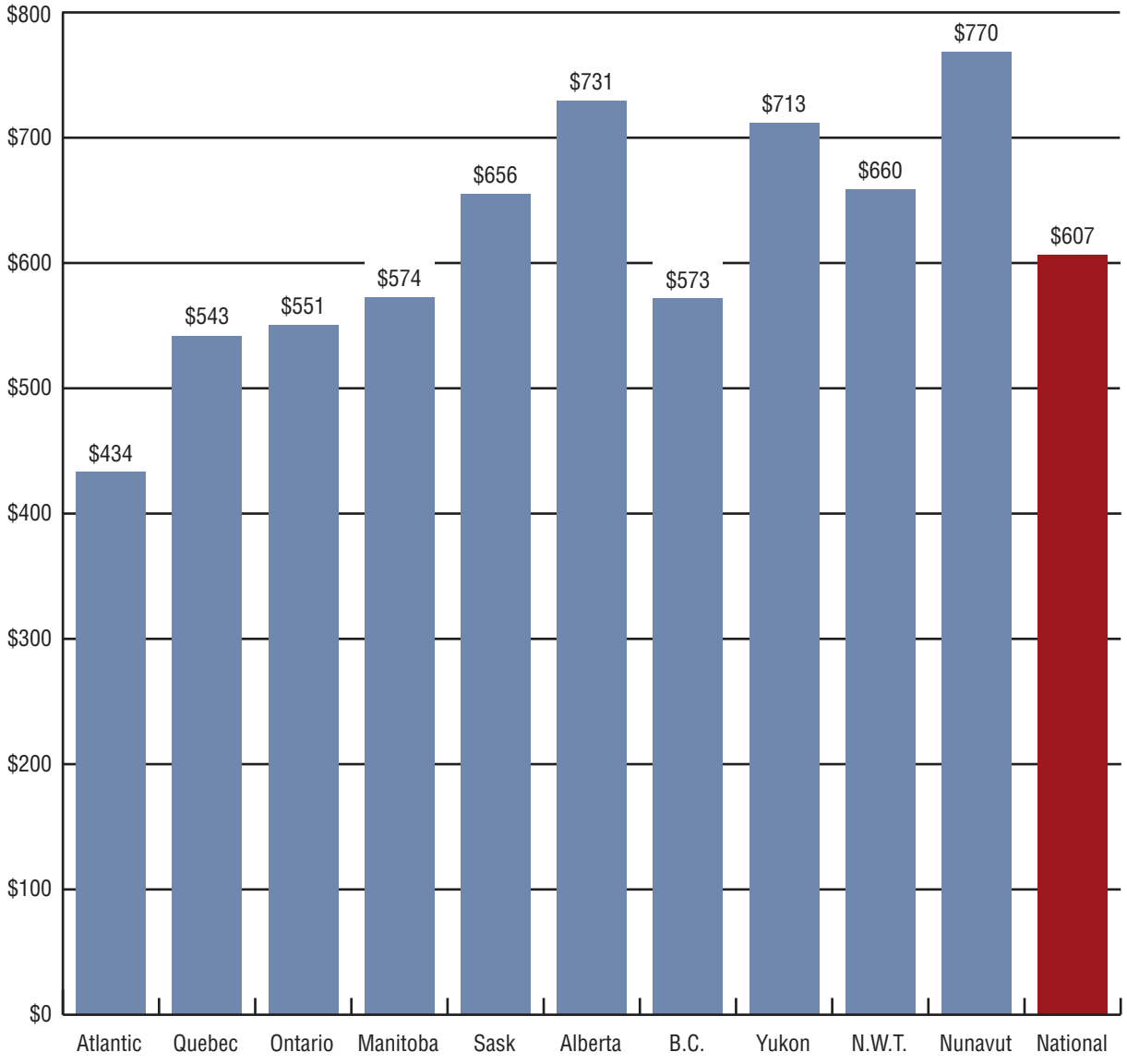
FIGURE 5.5

NIHB Dental Fee-For-Service Expenditures per Claimant by Region
2011/12

In 2011/12, the national NIHB Dental expenditure per eligible client receiving at least one dental benefit was $607. This is a slight increase of 1.0% over the $601 recorded in 2010/11.

Nunavut had the highest dental expenditure per claimant at $770, an increase of 3.6% from the $743 in the previous year. The Alberta Region followed at $731, with an increase of 2.4% from the $714 in 2010/11. The Yukon followed at $713, with a decrease of 2.6% from the $732 recorded the previous year.

The Atlantic Region registered the lowest dental expenditure per claimant at $434, a decrease of 12.7% from the $497 in 2010/11. As discussed previously in Figure 5.4, this decrease can be attributed to new Qalipu Mi'kmaq clients claiming for approximately half of the fiscal year. This impacted significantly on the cost per claimant totals for the Atlantic Region.



Source: FIRMS and HICPS adapted by Program Analysis Division

FIGURE 5.6

NIHB Dental Utilization Rates by Region
2007/08 to 2011/12

Utilization rates reflect those clients during the fiscal year who received at least one dental service paid through the Health Information and Claims Processing Services (HICPS) system 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 2011/12, the national utilization rate for dental benefits paid through the HICPS system was 36%, a decrease of one percentage point compared to the previous fiscal year. National NIHB Dental utilization rates have remained relatively stable over the past five years.

Dental utilization rates vary across the regions with the highest dental utilization rate (44%) found in the Quebec Region and the lowest rate found in the Atlantic Region (28%). The utilization rate in the Atlantic Region in 2011/12 decreased from 36% in 2010/11 to 28% in 2011/12. As mentioned in Figure 5.4, this decrease in utilization can be attributed to the increase in the eligible client population in this region as a result of the registration of 21,419 new Qalipu Mi'kmaq First Nations clients. These new clients became eligible to receive dental benefits half way through the fiscal year. This effectively reduced the overall utilization rate of the Atlantic Region.

It should be noted that the dental utilization rates understate the actual level of service as the data do not include:

- Health Canada dental clinics (except in the Yukon);
- Contract dental services provided in some regions;
- Services provided by Health Canada Dental Therapists or other FNIHB dental programs such as the Children's Oral Health Initiative (COHI); and
- Dental services provided through contribution agreements. For example, if the Bigstone Cree Nation client population were removed 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 2011/12. 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 34%. If both the Bigstone and Akwesasne client populations were removed from the overall NIHB population, the national utilization rate for dental benefits would have been 37%.

Over the two year period between 2010/11 and 2011/12, 436,209 distinct clients received NIHB Dental services resulting in an overall 49% utilization rate over this period.

REGION	Dental Utilization					
	2007/08	2008/09	2009/10	2010/11	2011/12	NIHB Dental Utilization Last Two Years 2010/12
Atlantic	36%	35%	35%	36%	28%	35%
Quebec	44%	44%	45%	46%	44%	56%
Ontario	33%	33%	33%	33%	32%	42%
Manitoba	30%	30%	30%	31%	31%	44%
Saskatchewan	36%	37%	37%	38%	37%	53%
Alberta	37%	38%	39%	40%	39%	55%
British Columbia	39%	39%	39%	40%	39%	53%
Yukon	38%	39%	37%	39%	38%	52%
N.W.T.	42%	42%	41%	42%	42%	57%
Nunavut	43%	41%	43%	45%	43%	61%
National	**36%**	**36%**	**36%**	**37%**	**36%**	**49%**

Source: HICPS and SVS adapted by Program Analysis Division

FIGURE 5.7

NIHB Dental Claimants by Age Group, Gender and Region
2011/12

Of the 896,624 clients eligible to receive dental benefits through the NIHB Program, 320,123 (36%) claimants received at least one dental procedure paid through the Health Information and Claims Processing Services (HICPS) system in 2011/12.

Of this total, 178,911 were female (56%) and 141,212 were male (44%). Compared to the total eligible NIHB population where 51% were female and 49% were male.

The average age of dental claimants was 30 years, indicating clients tend to access dental services at a slightly younger age compared to pharmacy services (33 years of age). The average age for female and male claimants was 31 and 28 years of age respectively. The highest average age of dental claimants was found in the Yukon at 35 years of age, while the lowest was in Nunavut at 25 years of age.

Approximately 39% of all dental claimants were under 20 years of age. Forty-two percent of male claimants were in this age group while females accounted for 36%. Approximately 4% of all claimants were seniors (ages 65 and over) in 2011/12.

REGION	Atlantic			Quebec			Ontario			Manitoba		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	128	140	268	477	435	912	912	974	1,886	1,518	1,523	3,041
5-9	530	545	1,075	1,464	1,366	2,830	2,941	2,909	5,850	2,557	2,757	5,314
10-14	828	834	1,662	1,509	1,583	3,092	3,327	3,392	6,719	2,466	2,657	5,123
15-19	887	1,042	1,929	1,312	1,493	2,805	2,902	3,326	6,228	2,128	2,704	4,832
20-24	631	795	1,426	900	1,296	2,196	2,062	2,795	4,857	1,561	2,412	3,973
25-29	514	718	1,232	798	1,142	1,940	1,779	2,605	4,384	1,345	2,050	3,395
30-34	485	679	1,164	794	1,022	1,816	1,668	2,451	4,119	1,210	1,690	2,900
35-39	500	683	1,183	798	1,098	1,896	1,711	2,360	4,071	1,130	1,574	2,704
40-44	586	723	1,309	887	1,124	2,011	1,791	2,439	4,230	1,182	1,718	2,900
45-49	556	711	1,267	927	1,161	2,088	1,939	2,675	4,614	1,206	1,617	2,823
50-54	436	696	1,132	811	1,095	1,906	1,770	2,407	4,177	920	1,283	2,203
55-59	373	565	938	596	825	1,421	1,321	1,989	3,310	645	903	1,548
60-64	294	410	704	427	568	995	1,039	1,416	2,455	450	588	1,038
65+	384	488	872	671	1,062	1,733	1,427	2,434	3,861	451	767	1,218
Total	7,132	9,029	16,161	12,371	15,270	27,641	26,589	34,172	60,761	18,769	24,243	43,012
Average Age	33	35	34	31	34	32	31	34	33	26	29	28

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	1,408	1,328	2,736	1,408	1,427	2,835	1,282	1,213	2,495	52	42	94	265	220	485	615	660	1,275	8,065	7,962	16,027
5-9	3,233	3,455	6,688	3,065	3,005	6,070	2,746	2,780	5,526	103	97	200	476	514	990	736	762	1,498	17,851	18,190	36,041
10-14	2,971	3,347	6,318	2,827	2,998	5,825	2,687	2,758	5,445	126	117	243	474	539	1,013	662	838	1,500	17,877	19,063	36,940
15-19	2,383	3,139	5,522	2,389	2,852	5,241	2,398	2,692	5,090	137	156	293	497	646	1,143	681	1,004	1,685	15,714	19,054	34,768
20-24	1,983	3,031	5,014	1,528	2,353	3,881	1,783	2,446	4,229	115	182	297	444	674	1,118	709	987	1,696	11,716	16,971	28,687
25-29	1,700	2,590	4,290	1,478	2,069	3,547	1,688	2,313	4,001	127	163	290	380	544	924	502	754	1,256	10,311	14,948	25,259
30-34	1,561	2,231	3,792	1,293	1,797	3,090	1,530	1,980	3,510	106	142	248	316	476	792	388	572	960	9,351	13,040	22,391
35-39	1,467	2,097	3,564	1,140	1,683	2,823	1,511	1,893	3,404	94	129	223	285	432	717	330	475	805	8,966	12,424	21,390
40-44	1,523	2,053	3,576	1,159	1,594	2,753	1,540	1,938	3,478	114	147	261	362	509	871	335	468	803	9,479	12,713	22,192
45-49	1,396	1,804	3,200	1,059	1,526	2,585	1,548	2,091	3,639	149	157	306	336	412	748	285	339	624	9,401	12,493	21,894
50-54	1,044	1,451	2,495	830	1,210	2,040	1,386	1,918	3,304	101	151	252	240	392	632	170	229	399	7,708	10,832	18,540
55-59	670	884	1,554	584	861	1,445	984	1,368	2,352	59	87	146	184	246	430	122	157	279	5,538	7,885	13,423
60-64	417	606	1,023	322	531	853	631	842	1,473	48	73	121	143	185	328	120	113	233	3,891	5,332	9,223
65+	554	747	1,301	475	678	1,153	956	1,275	2,231	93	139	232	205	255	460	128	159	287	5,344	8,004	13,348
Total	22,310	28,763	51,073	19,557	24,584	44,141	22,670	27,507	50,177	1,424	1,782	3,206	4,607	6,044	10,651	5,783	7,517	13,300	141,212	178,911	320,123
Average Age	27	28	27	25	28	27	29	32	31	34	36	35	30	32	31	25	25	25	28	31	30

FIGURE 5.8

NIHB Fee-for-Service Dental Expenditures by Sub-Benefit
2011/12

The NIHB Program recognizes the importance of oral health in contributing to the overall health and well-being of individuals by providing eligible clients with a broad range of dental services to ensure proper oral care.

In 2011/12, expenditures for Restorative Services (crowns, fillings, etc.) were the highest of all dental sub-benefit categories at $87.2 million in 2011/12. This is a 2.7% increase over the previous fiscal year.

Diagnostic Services (examinations, x-rays, etc.) at $22.6 million and Preventive Services (scaling, sealants, etc.) at $22.4 million were the next highest sub-benefit categories, followed by Oral Surgery (extractions, etc.) at $19.0 million and Endodontic Services (root canal treatments, etc.) at $12.6 million.

In 2011/12, Endodontic Services were the fifth highest expenditure for the NIHB Dental Benefit. This is an increase of 25.5% over the previous fiscal year. This increase is primarily a result of the introduction of the NIHB Endodontic Trial Project in April of 2011. This project is intended to assess the merits, feasibility and sustainability of removing the predetermination requirement for standard Root Canal Treatments (RCT) on bicuspids and first molars.

As had been anticipated by the NIHB Program, removing the predetermination requirement on certain endodontic services has increased the number of RCT's across the country thus pushing upward the expenditures. Another factor influencing this growth is the NIHB annual fee increase for these services for fiscal year 2011/2012.

In 2011/12, the three largest dental procedures by expenditure were Composite Restorations ($66.2 million), Scaling ($16.7 million) and Extractions ($13.0 million).

Fee-For-Service Top 5 Dental Sub-Benefits ($ Millions) and Percentage Change		
Dental Sub-Benefit	**2011/12**	**% Change from 2010/11**
Restorative Services	$ 87.2	2.7%
Diagnostic Services	22.6	1.1%
Preventive Services	22.4	7.2%
Oral Surgery	19.0	3.1%
Endodontic Services	12.6	25.5%

Fee-For-Service Top 5 Dental Procedures ($ Millions) and Percentage Change		
Dental Procedure	**2011/12**	**% Change from 2010/11**
Composite Restorations	$ 66.2	4.6%
Scaling	16.7	14.8%
Extractions	13.0	2.8%
Root Canal Therapy	10.4	37.8%
Intraoral Radiographs	7.3	3.5%

Source: HICPS adapted by Program Analysis Division

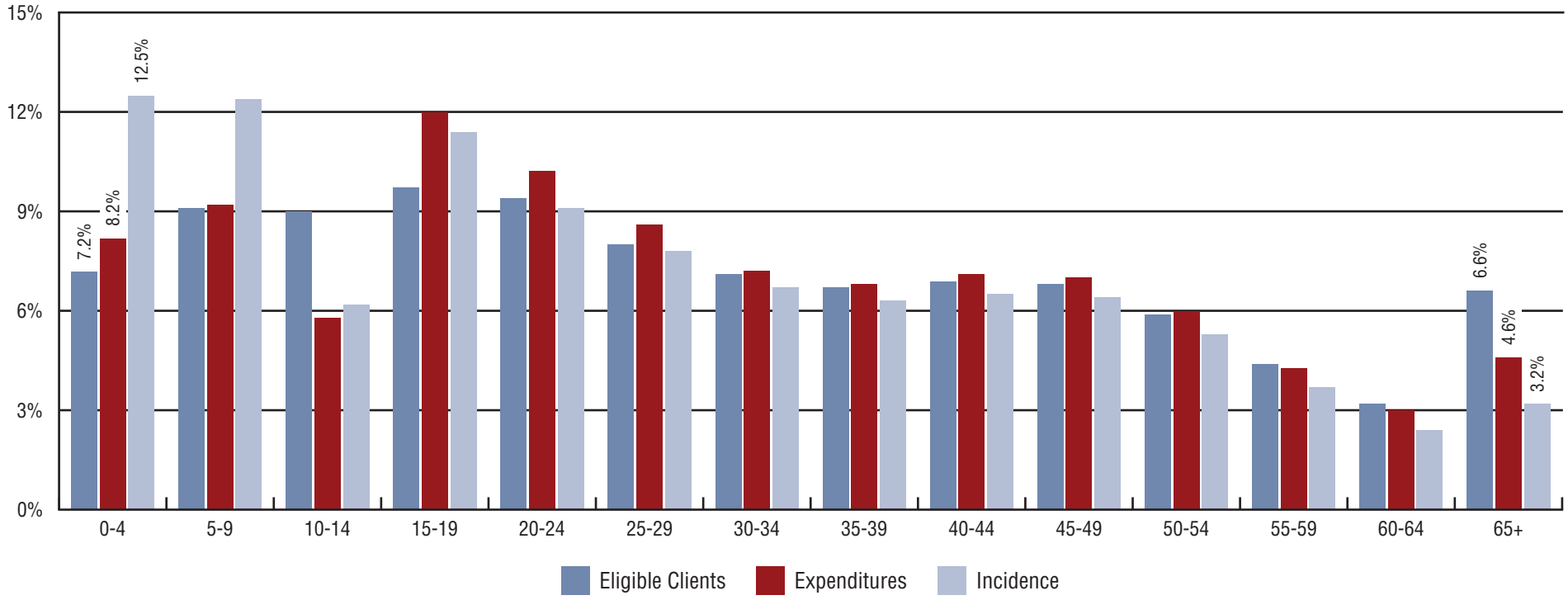
FIGURE 5.9

Distribution of Eligible NIHB Population, Dental Expenditures and Incidence by Age Group
2011/12

The main drivers of NIHB Dental expenditures are increased rates of utilization and increases in the fees charged for services by dental professionals. The type of dental service 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 24.9% to 17.4%.

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 to 14 and clients who are 65 years of age and older. The ratios of eligible clients to expenditures for youth aged 10 to 14 are 9.0% to 5.8% and for clients who are 65 years of age or older they are 6.6% to 4.6% respectively. The ratio of eligible clients to expenditures for those aged 15 to 19 was 9.7% to 12.0%.



Source: HICPS and SVS adapted by Program Analysis Division

NIHB Medical Transportation Expenditure and Utilization Data

SECTION 6

In 2011/12, Non-Insured Health Benefits Medical Transportation expenditures amounted to $333.3 million or 31.0% of total NIHB expenditures. The medical transportation benefit is the second largest Program expenditure.

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 their 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. In 2011/12, a total of 482 contribution agreements were issued for medical transportation.

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; and air ambulance);
- Water Travel (motorized boat; boat taxi; and ferry);
- Living Expenses (meals and accommodations); and
- Transportation costs for health professionals to provide services to isolated communities.

NIHB Medical Transportation benefits may be provided for clients to access the following types of medically required health services:

- Medical services defined as insured services by provincial/territorial health plans (e.g., appointments with physicians, hospital care);
- Diagnostic tests and medical treatments covered by provincial/territorial health plans;
- Alcohol, solvent, drug abuse and detox treatments;
- Traditional healers; and
- Non-Insured Health Benefits (vision, dental, mental health).

NIHB Medical Transportation benefits may also be provided to approved medical escorts for clients travelling to access medically necessary health services.

In addition to facilitating client travel to appointments for these medical services, significant efforts have been made over the past few years to bring health care professionals to the communities of residence of clients living in under-serviced and/or remote and isolated communities. These efforts enhance access to medically necessary services in communities and can be more cost effective than bringing individual clients to the service provider.

FIGURE 6.1

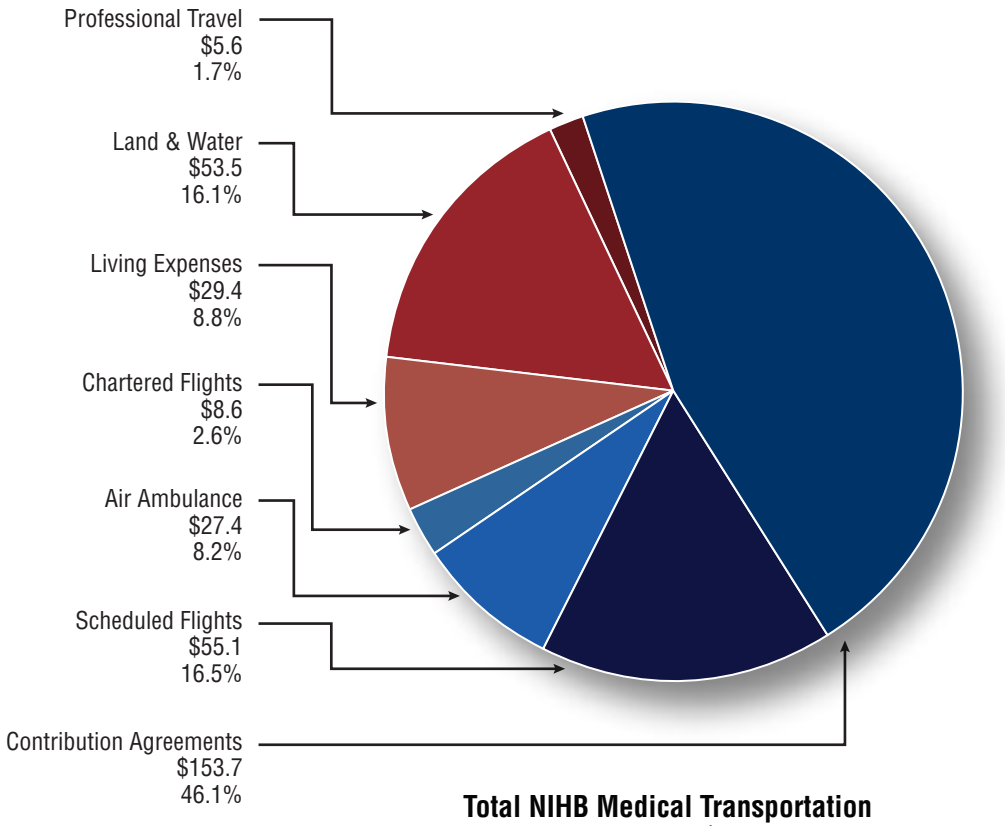
Distribution of NIHB Medical Transportation Expenditures ($ Millions)
2011/12

In 2011/12, NIHB Medical Transportation expenditures totalled $333.3 million or 31.0% of total NIHB expenditures. Figure 6.1 illustrates the components of medical transportation expenditures under the NIHB Program.

Contribution agreements represented the largest component, accounting for $153.7 million, or 46.1% of the total benefit.

Scheduled flights at $55.1 million (16.5%) and land and water transportation at $53.5 million (16.1%) were the largest medical transportation operating expenditures, accounting for one-third of the total benefit.

Costs for living expenses totalled $29.4 million (8.8%) and air ambulance totalled $27.4 million (8.2%). Expenditures for chartered flights totalled $8.6 million (2.6%) and costs for travel associated with bringing professional services to communities (e.g., physician, dentist, mental health professional) totalled $5.6 million (1.7%).



Source: FIRMS adapted by Program Analysis Division

FIGURE 6.2

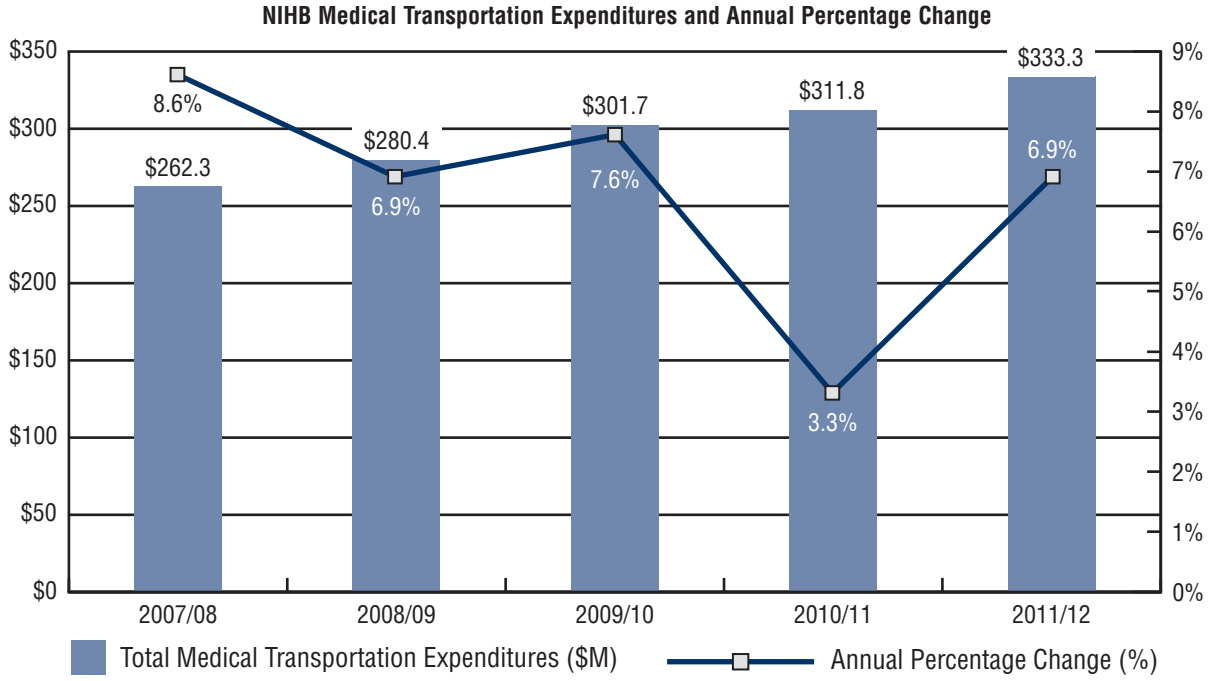
Annual NIHB Medical Transportation Expenditures
2007/08 to 2011/12

NIHB Medical Transportation expenditures increased by 6.9% in 2011/12. 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 3.3% in 2010/11, with a five year annualized growth rate of 6.6%.

Over the past five years, overall medical transportation costs have grown by 27.1% from $262.3 million in 2007/08 to $333.3 million in 2011/12. On a regional basis, the highest growth rates over this period were in Nunavut where expenditures grew by 60.1% from $16.2 million in 2007/08 to $25.9 million in 2011/12.

The largest net increase in expenditures over the past five years took place in the Manitoba Region where total medical transportation costs grew by $25.5 million over this period. Nunavut had the second largest net increase in expenditures over the past five years at $9.7 million followed closely by the Ontario Region at $9.1 million.

The Manitoba Region had the highest total medical transportation expenditure at $101.6 million and the Yukon had the lowest total medical transportation expenditure at $4.4 million.



Source: FIRMS adapted by Program Analysis Division

NIHB Medical Transportation Expenditures ($ 000's)

REGION	2007/08	2008/09	2009/10	2010/11	2011/12
Atlantic	$ 4,585	$ 4,655	$ 5,048	$ 5,314	$ 5,841
Quebec	20,133	20,502	19,918	18,943	21,708
Ontario	45,618	46,848	51,889	52,358	54,725
Manitoba	76,082	83,193	89,078	94,940	101,609
Saskatchewan	36,108	36,239	38,971	41,896	45,084
Alberta	32,107	35,357	36,601	35,877	37,371
British Columbia	21,613	22,711	25,547	25,967	26,510
Yukon	2,935	2,938	3,801	4,097	4,413
N.W.T.	6,943	7,952	8,520	8,498	10,157
Nunavut	16,171	20,053	22,302	23,869	25,886
Total	**$ 262,294**	**$ 280,446**	**$ 301,673**	**$ 311,760**	**$ 333,304**

Source: FIRMS adapted by Program Analysis Division

FIGURE 6.3

NIHB Medical Transportation Expenditures by Type and Region ($ 000's)
2011/12

NIHB Medical Transportation expenditures increased by 6.9% to $333.3 million in 2011/12.

The Northwest Territories had the largest percentage increase in medical transportation expenditures in 2011/12 at 19.5%. This growth is partly attributed to a change in the NIHB Program's financial activity code structure. As of 2011/12, contribution agreement expenditures for the travel of dental professionals are now coded to the NIHB Medical Transportation benefit. Previously, these expenditures were recorded against the NIHB Dental benefit.

The Quebec Region followed with a 14.6% increase in expenditures. This growth rate is higher than normal in 2011/12 due to a freeze that was put on processing some contribution agreement financial commitments in the previous fiscal year (2010/11). As a result, the medical transportation expenditure total and growth rate for the Quebec Region in 2011/12 is higher than normal.

In 2011/12, the Manitoba Region had the highest overall NIHB Medical Transportation expenditure at $101.6 million, primarily as a result of air transportation which totalled $52.4 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.

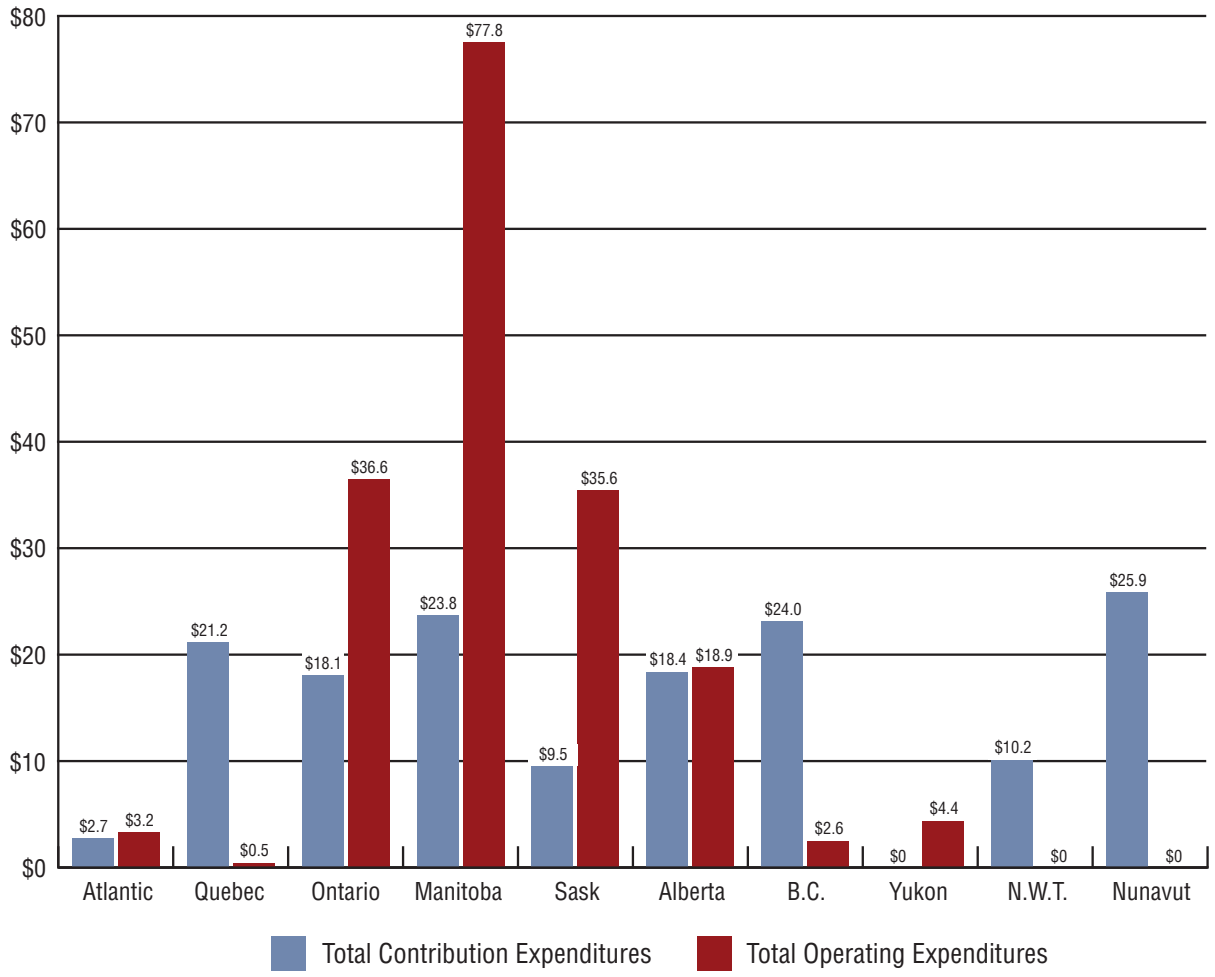
The Ontario Region represented the second highest medical transportation expenditure total in 2011/12 at $54.7 million. The regions of Saskatchewan and Alberta followed at $45.1 million and $37.4 million respectively in medical transportation expenditures.

TYPE	Atlantic	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia	Yukon	N.W.T.	Nunavut	TOTAL
Scheduled Flights	$ 772	$ 266	$ 17,875	$ 27,697	$ 5,401	$ 1,629	$ 402	$ 1,026	$ 0	$ 0	$ 55,069
Air Ambulance	28	19	41	21,684	2,960	1,178	0	1,526	0	0	27,442
Chartered Flights	30	7	3,586	3,005	1,387	601	0	0	0	0	8,612
Living Expenses	557	5	10,315	10,876	3,190	2,921	418	1,069	0	0	29,350
Land & Water	1,764	251	3,902	11,738	21,288	12,173	1,646	770	0	0	53,530
Professional Travel	7	0	885	2,784	1,389	448	89	0	0	0	5,603
Total Operating	**$ 3,158**	**$ 548**	**$ 36,604**	**$ 77,786**	**$ 35,615**	**$ 18,950**	**$ 2,555**	**$ 4,391**	**$ 0**	**$ 0**	**$ 179,607**
Total Contributions	$ 2,683	$ 21,160	$ 18,121	$ 23,823	$ 9,469	$ 18,422	$ 23,955	$ 22	$ 10,157	$ 25,886	$ 153,698
TOTAL	**$ 5,841**	**$ 21,708**	**$ 54,725**	**$ 101,609**	**$ 45,084**	**$ 37,371**	**$ 26,510**	**$ 4,413**	**$ 10,157**	**$ 25,886**	**$ 333,304**
% Change from 2010/11	9.9%	14.6%	4.5%	7.0%	7.6%	4.2%	2.1%	7.7%	19.5%	8.4%	6.9%

Source: FIRMS adapted by Program Analysis Division

FIGURE 6.4

NIHB Medical Transportation Contribution and Operating Expenditures by Region ($ Millions)
2011/12



Source: FIRMS adapted by Program Analysis Division

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.). In 2011/12, a total of 482 contribution agreements were in place for the medical transportation benefit. Direct operating costs are funded to provide medical transportation benefits that are managed by Health Canada's regional offices.

The Manitoba Region had the largest operating expenditure for NIHB Medical Transportation in 2011/12 at $77.8 million. This higher cost in the Manitoba Region is primarily the result of approximately 45,000 clients living in 17 remote or fly-in only communities in the northern areas of the province and the fact that First Nations clients receive their health services primarily in Winnipeg. The Ontario Region was the next largest at $36.6 million, followed closely by the Saskatchewan Region at $35.6 million. Together these three regions accounted for 83.5% of all operating expenditures on medical transportation.

In 2011/12, Nunavut had the largest contribution expenditures for NIHB Medical Transportation at $25.9 million, followed by the regions of British Columbia and Manitoba at $24.0 million and $23.8 million respectively. 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 territorial governments.

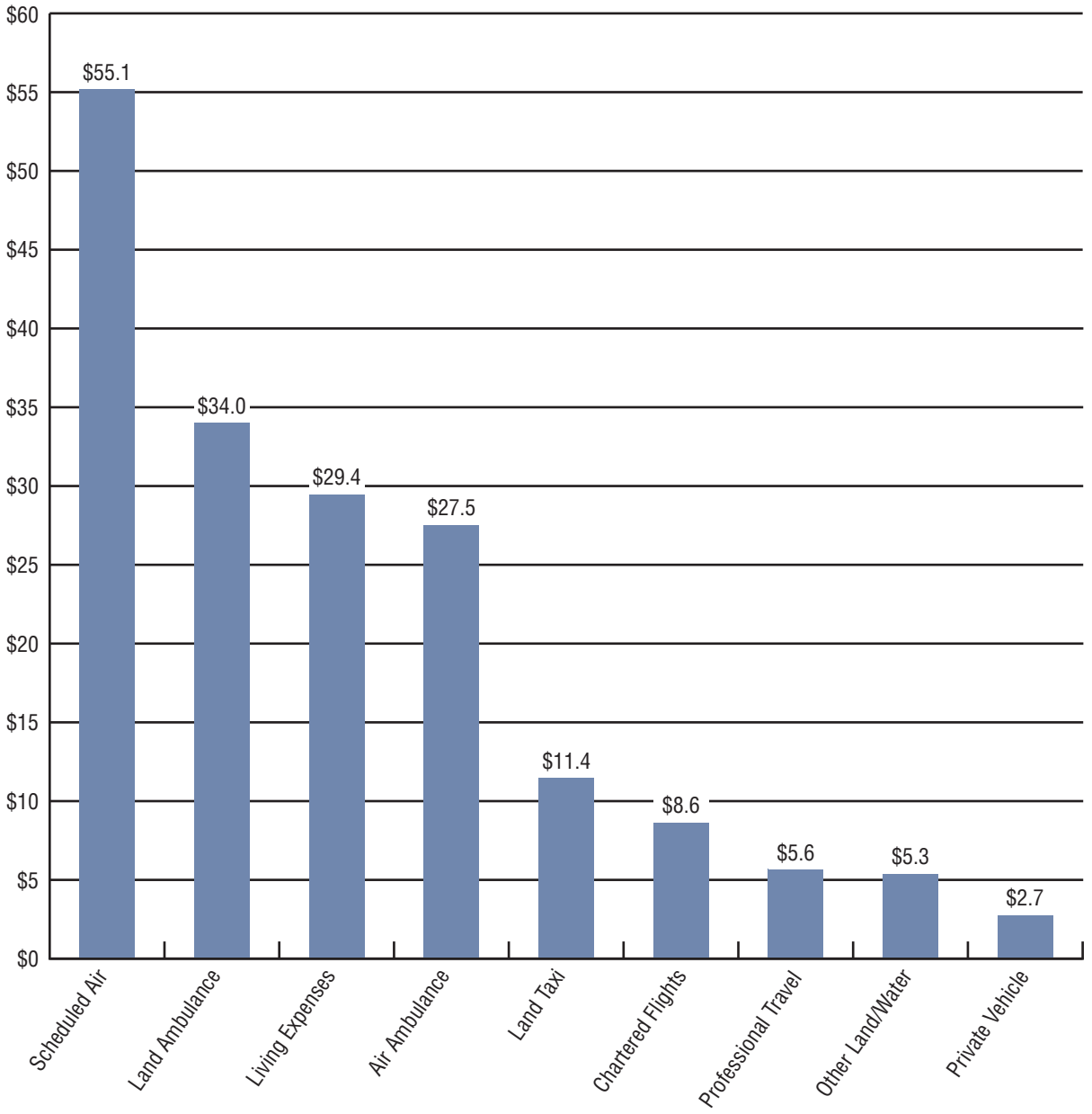
FIGURE 6.5

NIHB Medical Transportation Operating Expenditure by Type ($ Millions)
2011/12

In 2011/12, scheduled flights represented the largest portion of NIHB's Medical Transportation operating expenditures at $55.1 million or 30.7% of the national total. Land ambulance costs were the second highest at $34.0 million representing 18.9% of operating expenditures. Living expenses, which include accommodations and meals, followed at $29.4 million or 16.4%. Air ambulance followed closely at $27.5 million or 15.3% of medical transportation operating costs.

Professional travel expenditures ($5.6 million) consist 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. The NIHB private vehicle kilometric allowance rates are directly linked to the National Joint Council's (NJC) Government Commuting Assistance Directive Lower Kilometric Rates. For the past three fiscal years, NIHB rates have remained consistent with NJC's January 2009 rates because the NJC rates of January 2010 and January 2011 decreased at a time when the costs of private transportation were increasing, and at times were volatile (e.g., the price of gasoline).



Source: FIRMS adapted by Program Analysis Division

FIGURE 6.6

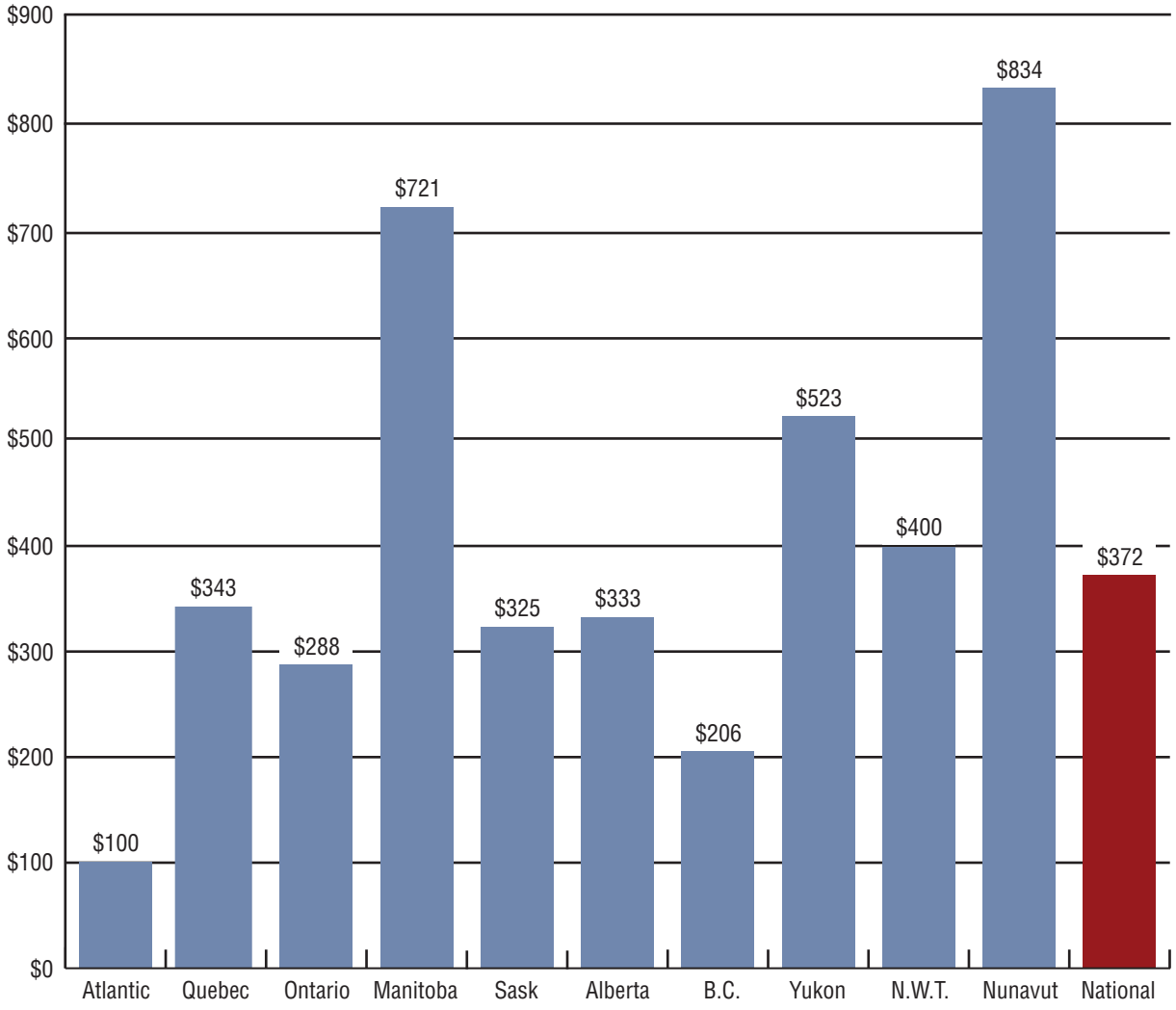
Per Capita NIHB Medical Transportation Expenditures by Region
2011/12

In 2011/12, the national per capita expenditure in NIHB Medical Transportation was $372. This is a 1.1% increase over the 2010/11 per capita expenditure of $368.

Nunavut recorded the highest per capita expenditure in medical transportation at $834, followed by the Manitoba Region at $721. 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 health services covered by the NIHB Program.

In contrast, the Atlantic Region had the lowest per capita expenditure at $100, a decrease from $151 in the previous year. Compared to other regions, this lower per capita cost is reflective of the geography of the region, the relative ease of access to health services, and the lack of dependence on air travel. The decrease in per capita expenditure over the previous fiscal year can be attributed to the significant increase in the eligible client population in this region as a result of the registration of 21,419 new Qalipu Mi'kmaq First Nations clients. These clients became eligible to receive NIHB Medical Transportation benefits following the creation of the Qalipu Mi'kmaq First Nations Band (September 26, 2011). The lower level of the medical transportation benefit utilization for these clients in 2011/12 impacted on the medical transportation per capita cost for the Atlantic Region as a whole.

In 2011/12, the highest rates of growth in NIHB Medical Transportation per capita expenditures was in the Northwest Territories (18.7%).



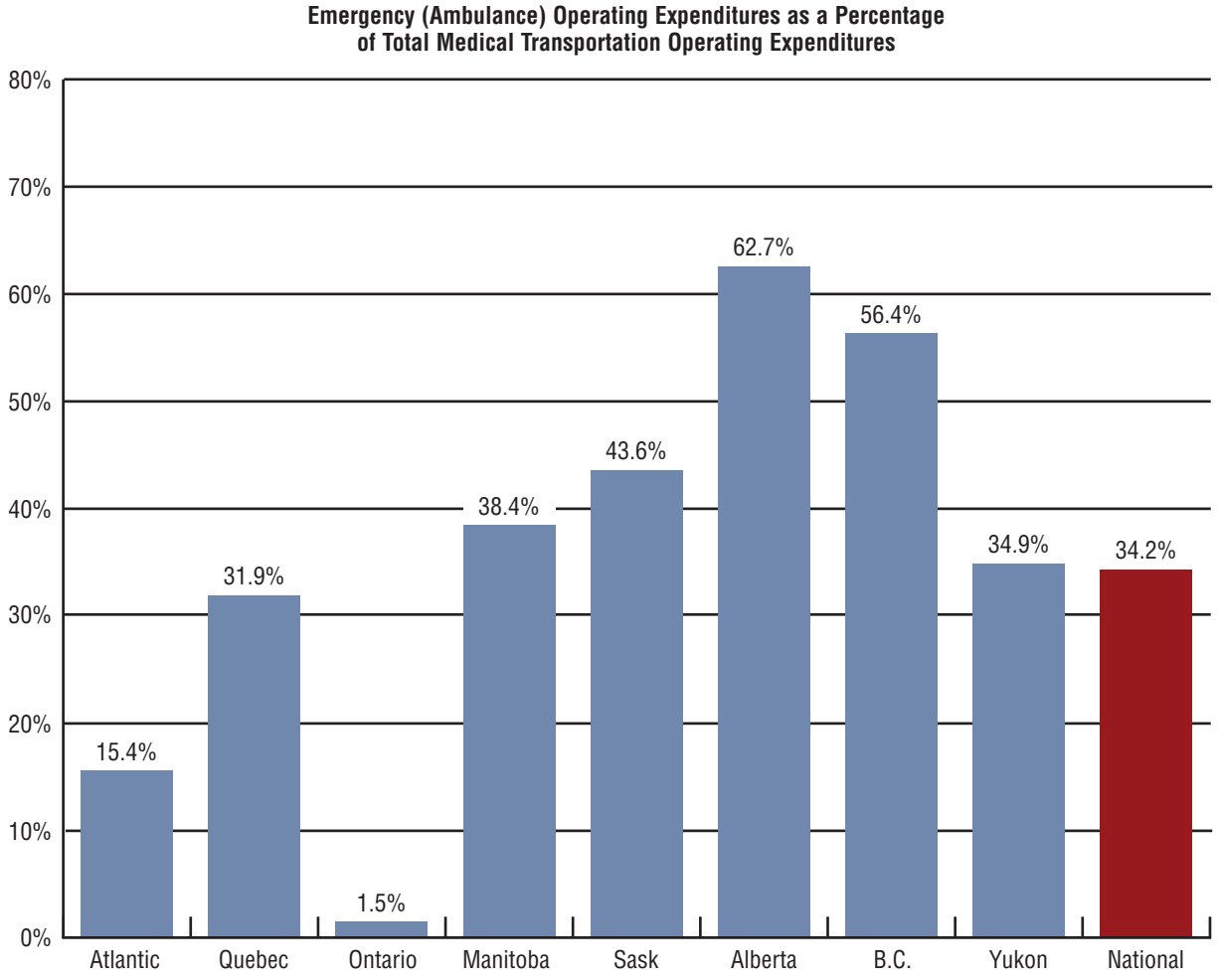
Source: SVS and FIRMS adapted by Program Analysis Division

FIGURE 6.7

NIHB Medical Transportation Emergency (Ambulance) Operating Expenditures by Region
2011/12

In 2011/12, regionally managed NIHB Medical Transportation operating costs totalled $179.6 million. Of this total, $61.5 million or 34.2% 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. For example, in regions such as Manitoba, Saskatchewan, and Alberta, NIHB pays for the full cost of land and air ambulances for NIHB clients. In the Yukon, NIHB pays for the full cost of air ambulances and only pays for ground ambulances when NIHB clients are out of territory. While 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 2011/12, the Manitoba Region recorded the highest emergency (ambulance) operating expenditures at $29.9 million, comprising almost half (48.6%) 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 Saskatchewan Region had the second highest emergency operating expenditures at $15.5 million followed by the Alberta Region at $11.9 million.

The majority of the medical transportation operating expenditures within the Alberta Region consisted of emergency costs (62.7%). These costs included land and air ambulance. The Alberta Region's high proportion of emergency costs is due to the provincial government not paying for any share of these costs on a universal basis (except for seniors and social assistance recipients). Emergency operating costs in the British Columbia Region also represented the majority of total medical transportation operating expenditures at 56.4%.

Almost half (43.6%) of medical transportation operating expenditures in the Saskatchewan Region were for emergency transportation, followed by the Manitoba Region (38.4%), Yukon (34.9%), and the Quebec Region (31.9%).

The Ontario Region had the lowest percentage spent on emergency transportation, accounting for only 1.5% of the Region's total operating expenditures. This is because the Province of Ontario covers emergency medical transportation for all provincial residents including First Nations, whereby the only portion covered by the NIHB Program is the co-pay.

Emergency (Ambulance) Expenditures by Type and Region ($ 000's), 2011/12

TYPE		Atlantic	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia	Yukon	National
Ambulance Operating Costs	Air Ambulance	$ 27.8	$ 19.2	$ 41.0	$ 21,684.3	$ 2,960.5	$ 1,176.4	$ 17.9	$ 1,526.3	$ 27,455.2
	Land Ambulance	457.1	155.7	504.8	8,203.7	12,572.4	10,696.5	1,424.4	5.2	34,019.7
	Total	**484.9**	**174.8**	**545.8**	**29,888.0**	**15,532.9**	**11,874.8**	**1,442.3**	**1,531.4**	**61,474.9**
Share of Ambulance Costs	Air Ambulance	5.7%	11.0%	7.5%	72.6%	19.1%	9.9%	1.2%	99.7%	44.7%
	Land Ambulance	94.3%	89.0%	92.5%	27.4%	80.9%	90.1%	98.8%	0.3%	55.3%
Total Medical Transportation Operating Costs		**$ 3,158.4**	**$ 548.2**	**$ 36,603.8**	**$ 77,785.7**	**$ 35,615.1**	**$ 18,949.7**	**$ 2,555.0**	**$ 4,390.7**	**$ 179,606.5**
Emergency Operating Costs as % of Total Medical Transportation Operating Costs		**15.4%**	**31.9%**	**1.5%**	**38.4%**	**43.6%**	**62.7%**	**56.4%**	**34.9%**	**34.2%**

Source: FIRMS adapted by Program Analysis Division

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

SECTION 7

In 2011/12, total expenditures for NIHB Vision benefits ($29.8 million), Other Health Care benefits ($12.9 million) and Premiums ($19.9 million) amounted to $62.6 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 NIHB Vision Care Policy 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; and
- Other vision care benefits depending on the specific medical needs of the client.

Vision care benefits are provided by an NIHB recognized provider. A vision care provider must be an Optometrist or Optician who is licensed/certified, authorized, and in good standing with the regulatory body of the province/territory in which they practice.

NIHB Other Health Care comprises primarily of short-term crisis intervention mental health counselling benefits to address at-risk situations. This service is provided by a recognized professional mental health therapist when no other service is available to the client. The NIHB Program may cover the following services:

- The initial assessment;
- Development of a treatment plan;
- Mental health treatment by an eligible NIHB Provider as per NIHB Program directives;
- Individual, conjoint (with a couple), family, or group (with unrelated individuals) counselling sessions; 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 2011/12, the NIHB Program funded provincial health premiums for eligible clients in the British Columbia Region.

FIGURE 7.1

NIHB Vision Expenditures and Growth by Region ($ 000's)
2011/12

NIHB Vision expenditures totalled $29.8 million in 2011/12. Regional operating expenditures accounted for $24.5 million or 82.4% of total expenditures while contribution costs accounted for $5.2 million or 17.6%.

The Alberta Region had the highest percentage share in NIHB Vision benefit costs at 19.5%, followed by the Ontario Region at 18.2% and the Saskatchewan Region at 14.9%.

In 2011/12, the highest percentage change in NIHB Vision expenditures was in the Atlantic Region which increased by 14.9%. This high increase is due to an uptake of vision benefits by the new Qalipu Mi'kmaq clients. The Yukon followed with an increase of 11.6%. Nunavut (-12.6%) and the Saskatchewan Region (-4.5%) experienced a decline in expenditure growth over 2010/11.

The largest net increases in expenditures took place in the Atlantic and Ontario regions where total vision care costs grew by $262 thousand and $243 thousand respectively.

In 2011/12, the Alberta and Ontario regions had the highest expenditures in vision care at $5.8 million and $5.4 million respectively.

Region	Operating	Contributions	TOTAL	% CHANGE FROM 2010/11
Atlantic	$ 1,995	$ 26	$ 2,021	14.9%
Quebec	1,339	65	1,404	5.1%
Ontario	4,952	474	5,425	4.7%
Manitoba	3,565	248	3,813	5.6%
Saskatchewan	4,449	0	4,449	-4.5%
Alberta	4,953	869	5,822	0.8%
British Columbia	2,951	510	3,461	3.5%
Yukon	347	0	347	11.6%
N.W.T.	0	1,371	1,371	3.0%
Nunavut	0	1,668	1,668	-12.6%
Total	**$ 24,549**	**$ 5,232**	**$ 29,780**	**1.9%**

Source: FIRMS adapted by Program Analysis Division

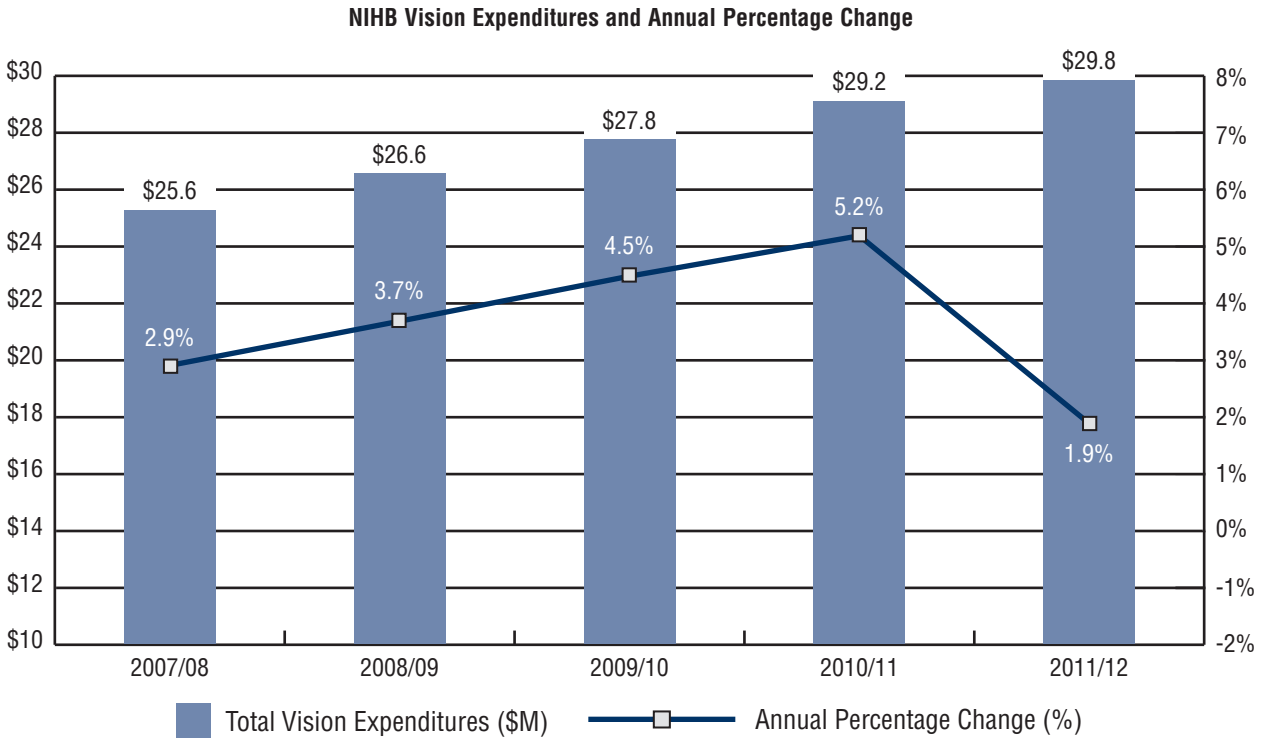
FIGURE 7.2

Annual NIHB Vision Expenditures
2007/08 to 2011/12

In 2011/12, NIHB Vision expenditures increased by 1.9%, compared to the 5.2% increase recorded in 2010/11. Over the past five years, growth in NIHB Vision expenditures has ranged from a high of 5.2% in 2010/11 to a low of 1.9% in 2011/12. The annualized growth rate over these five years was 3.6%.

Over the past five years, overall vision benefit costs have grown by 16.2% from $25.6 million in 2007/08 to $29.8 million in 2011/12. On a regional basis, the highest expenditure growth rate over this five year period was in the Yukon where expenditures grew by 50.9% from $230 thousand in 2007/08 to $347 thousand in 2011/12.

The largest net increases in expenditures over the past five years took place in the Alberta Region where total vision benefit costs grew by $880 thousand over this period, followed closely by the Manitoba Region where costs grew by $877 thousand.



Source: FIRMS adapted by Program Analysis Division

NIHB Vision Expenditures ($ 000's)					
REGION	2007/08	2008/09	2009/10	2010/11	2011/12
Atlantic	$ 1,495	$ 1,596	$ 1,612	$ 1,758	$ 2,021
Quebec	1,257	1,220	1,280	1,336	1,404
Ontario	5,366	5,204	5,343	5,183	5,425
Manitoba	2,936	3,157	3,407	3,612	3,813
Saskatchewan	4,126	4,166	4,222	4,658	4,449
Alberta	4,942	5,225	5,377	5,778	5,822
British Columbia	3,120	3,251	3,253	3,344	3,461
Yukon	230	242	299	311	347
N.W.T.	1,011	1,130	1,340	1,331	1,371
Nunavut	1,139	1,387	1,646	1,908	1,668
Total	**$ 25,621**	**$ 26,577**	**$ 27,779**	**$ 29,219**	**$ 29,780**

Source: FIRMS adapted by Program Analysis Division

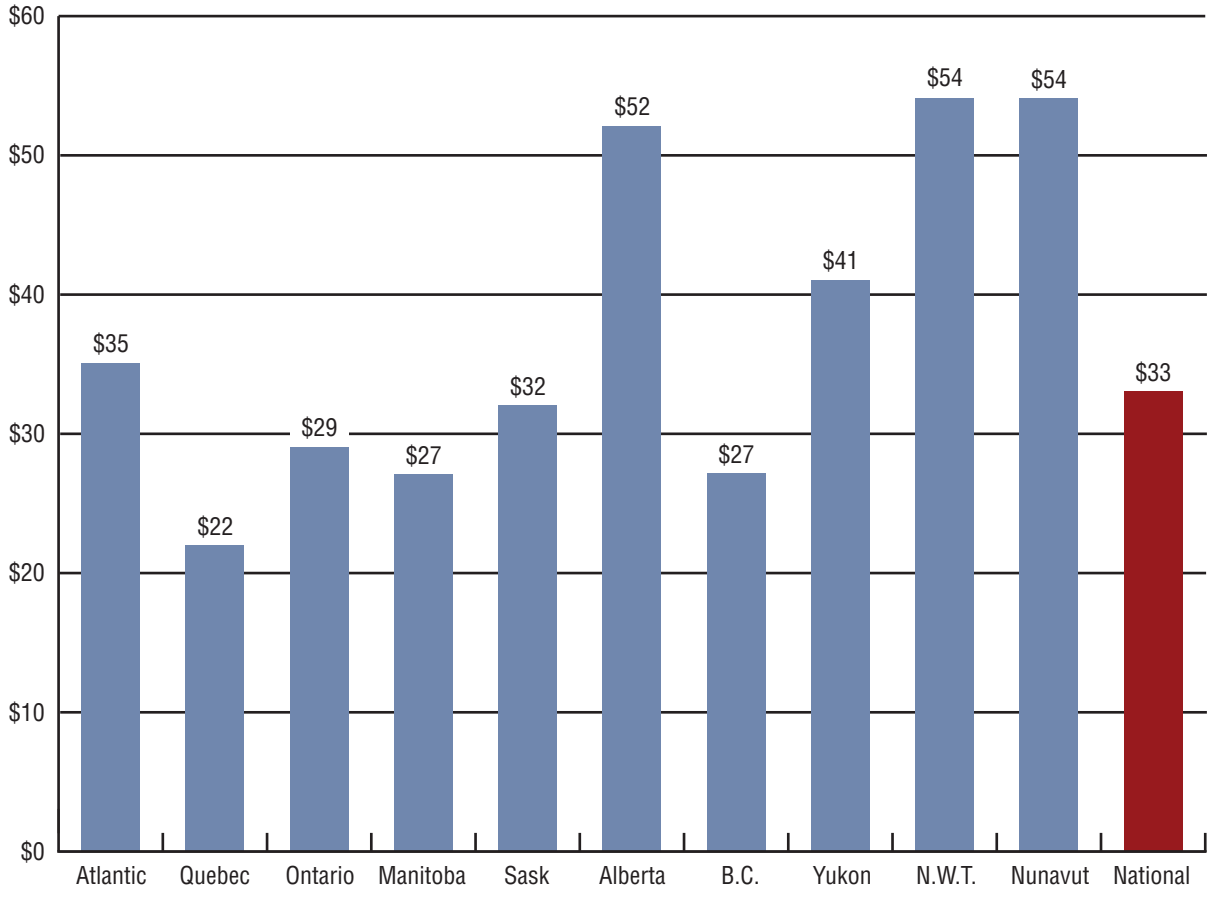
FIGURE 7.3

Per Capita NIHB Vision Expenditures by Region
2011/12

In 2011/12, the national per capita expenditure in NIHB Vision benefits was $33, a decrease from $35 in 2010/11.

Both Nunavut and the Northwest Territories had the highest per capita expenditure at $54. This was followed by the Alberta Region at $52. The Quebec Region registered the lowest per capita expenditure at $22.

While overall vision benefit expenditures in the Atlantic Region increased by 14.9%, the per capita costs in this region declined by 30.0% ($15) from $50 in 2010/11 to $35 in 2011/12. This decrease in per capita expenditures can be attributed to an increase in eligible population in this region as a result of the registration of 21,419 new Qalipu Mi'kmaq First Nations clients.



Source: SVS and FIRMS adapted by Program Analysis Division

FIGURE 7.4

NIHB Other Health Care Expenditures by Region ($ 000's)
2011/12

In 2011/12, NIHB Other Health Care expenditures, which consist primarily of short-term crisis intervention mental health counselling, amounted to $12.9 million. Regional operating expenditures accounted for $9.6 million or 74.4% of total expenditures while contribution costs accounted for $3.3 million or 25.6%.

In 2011/12, the Alberta Region had the highest percentage share of NIHB Other Health Care expenditures at 30.6% followed by the Manitoba and Ontario regions at 24.0% and 18.2% respectively.

The Alberta Region had the highest expenditure in other health care, registering close to $4 million in total expenditures, followed by the regions of Manitoba and Ontario at $3.1 million and $2.3 million respectively.

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

Region	Operating	Contributions	TOTAL
Atlantic	$ 104	$ 150	**$ 254**
Quebec	629	246	**875**
Ontario	2,349	0	**2,349**
Manitoba	2,642	467	**3,109**
Saskatchewan	994	505	**1,499**
Alberta	2,672	1,284	**3,957**
British Columbia	234	655	**889**
Yukon	4	0	**4**
N.W.T.	0	0	**0**
Nunavut	0	0	**0**
Total	**$ 9,628**	**$ 3,308**	**$ 12,936**

Source: FIRMS adapted by Program Analysis Division

FIGURE 7.5

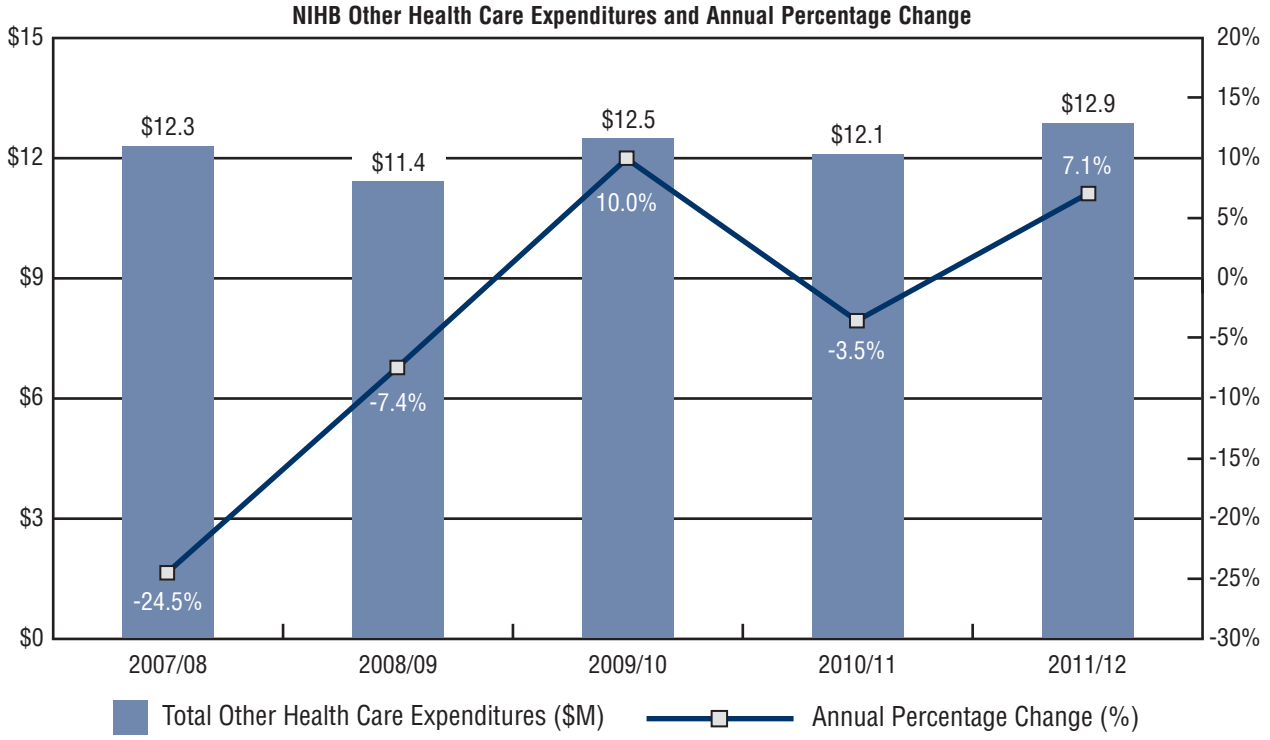
Annual NIHB Other Health Care Expenditures
2007/08 to 2011/12

NIHB Other Health Care expenditures, like other NIHB benefits, are demand-driven and influenced by the number of clients accessing services in a specific year. In 2011/12, expenditures for this benefit area increased by 7.1%, a significant change compared to the decrease of 3.5% recorded in 2010/11.

Over the previous five years, growth in NIHB Other Health Care expenditures has ranged from a high of 10.0% in 2009/10 to a low of -24.5% in 2007/08. The annualized growth rate over these five years was -4.5%.

Fluctuations in expenditures and growth rates since 2007/08 are due primarily to clients accessing mental health benefits through other service points such as counselling and mental health benefits through the Indian Residential Schools Resolution Health Support Program.

The largest net increases in expenditures over the past five years took place in the Saskatchewan Region where total NIHB Other Health Care costs grew by $557 thousand from $942 thousand in 2007/08 to $1.5 million in 2011/12.



Source: FIRMS adapted by Program Analysis Division

NIHB Other Health Care Expenditures ($ 000's)					
REGION	2007/08	2008/09	2009/10	2010/11	2011/12
Atlantic	$ 272	$ 251	$ 213	$ 241	$ 254
Quebec	471	375	459	597	875
Ontario	2,172	2,158	2,603	2,632	2,349
Manitoba	2,964	2,619	3,143	2,930	3,109
Saskatchewan	942	870	812	896	1,499
Alberta	4,343	3,940	4,363	3,903	3,957
British Columbia	1,120	1,165	924	882	889
Yukon	4	1	1	2	4
N.W.T.	0	0	0	0	0
Nunavut	0	0	0	0	0
Total	$ 12,289	$ 11,380	$ 12,516	$ 12,083	$ 12,936

Source: FIRMS adapted by Program Analysis Division

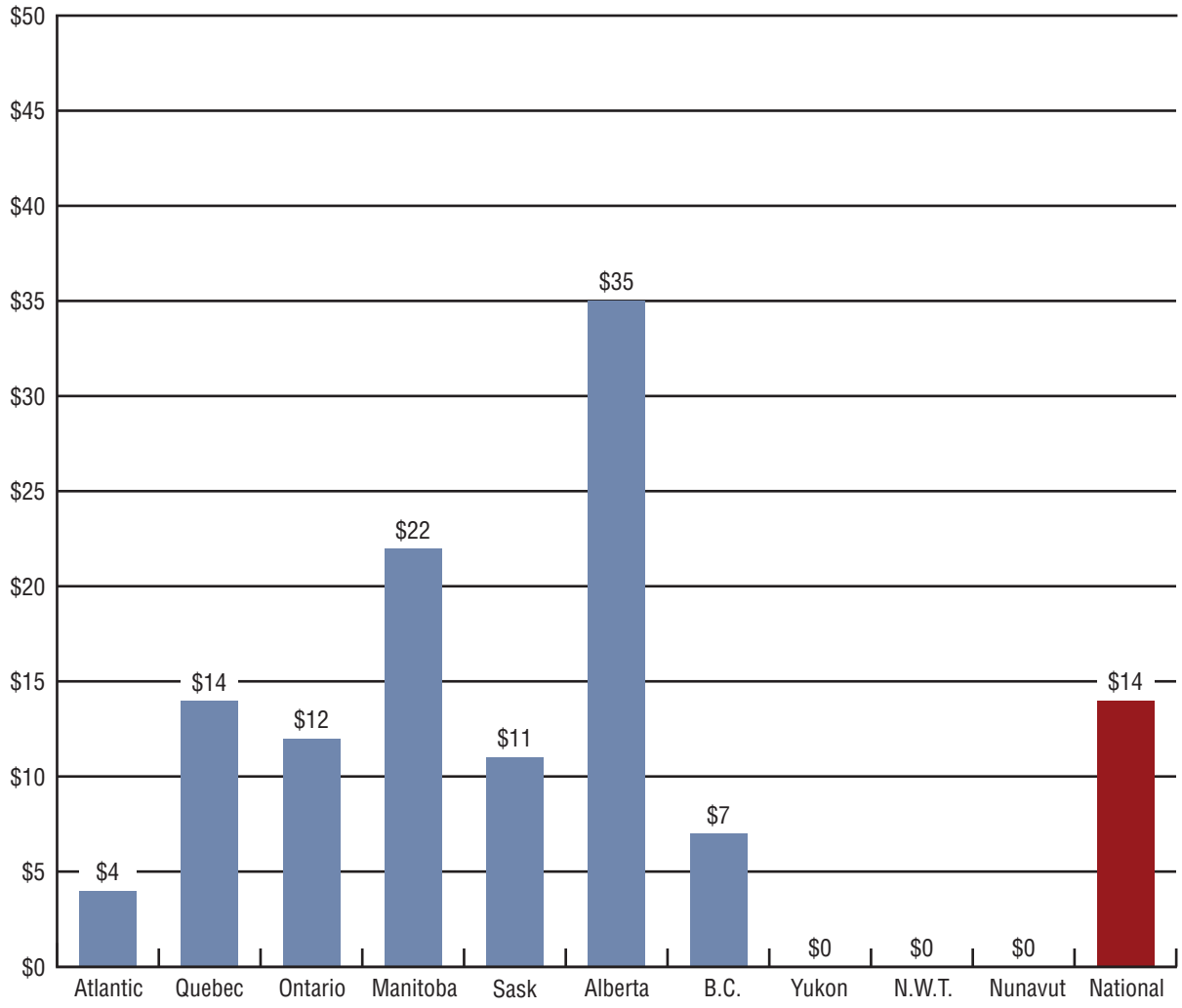
FIGURE 7.6

Per Capita NIHB Other Health Care Expenditures by Region
2011/12

In 2011/12, the national per capita expenditure for NIHB Other Health Care was $14, unchanged from the previous fiscal year.

The Alberta Region had the highest per capita expenditure at $35, followed by the Manitoba Region at $22 per eligible client.

Crisis mental health services in the Yukon, Northwest Territories and Nunavut are delivered by the territorial governments.



Source: SVS and FIRMS adapted by Program Analysis Division

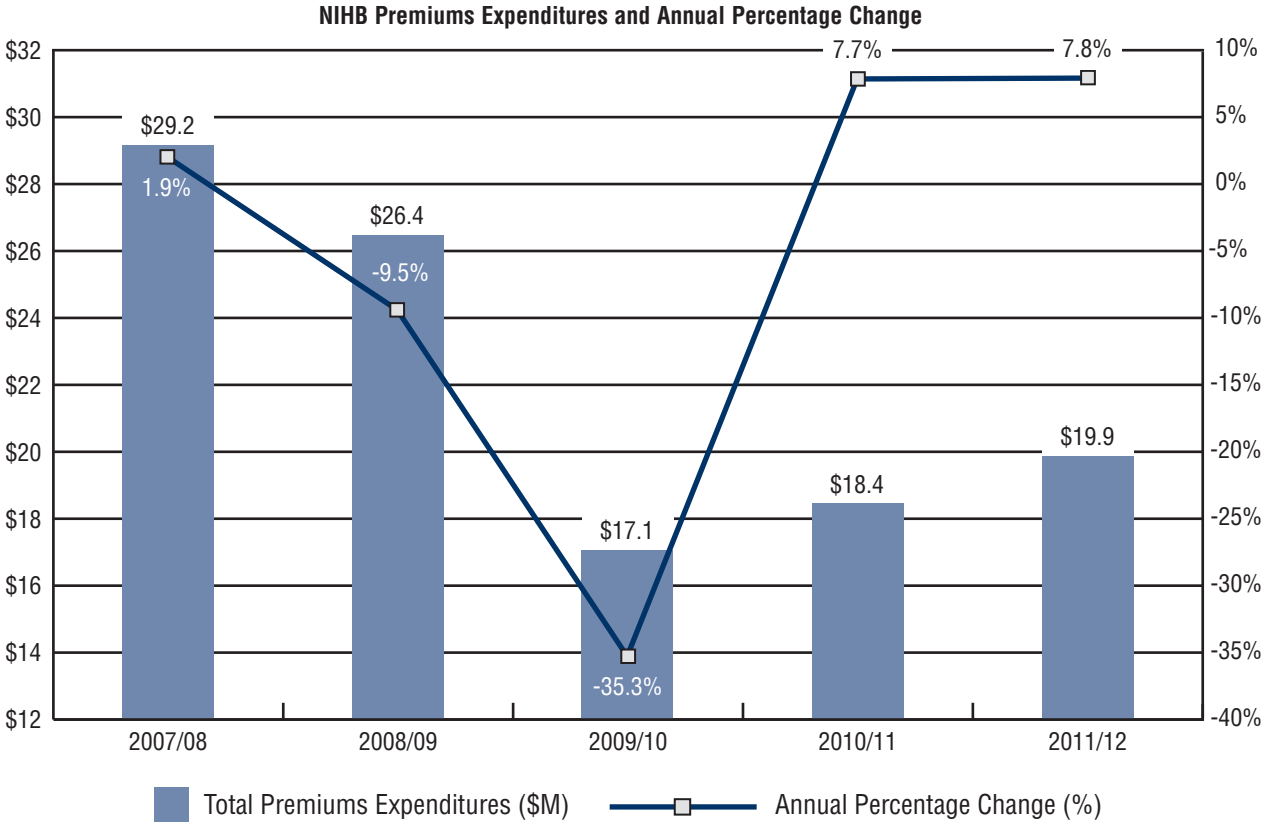
FIGURE 7.7

Annual NIHB Premiums Expenditures
2007/08 to 2011/12

In 2011/12, NIHB Premiums expenditures totalled $19.9 million, an increase of 7.8% over the previous fiscal year. This increase in expenditures can be mainly attributed to new premium rates in British Columbia which came into force on January 1, 2010.

Since January 1, 2009, the NIHB Program has only covered premiums in the British Columbia Region. NIHB Premiums expenditures had a significant decrease of 35.3% ($9.3 million) in 2009/10. 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.

Over the previous five years, the highest growth rate for this benefit area was recorded in 2011/12 at 7.8%. The annualized growth rate for premiums over this five year period is -7.1% and is attributable to the elimination of insurance premiums by the Government of Alberta.



Source: FIRMS adapted by Program Analysis Division

NIHB Premiums Expenditures ($ 000's)					
Region	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**2011/12**
Alberta	$ 12,961	$ 9,920	$ 0	$ 0	$ 0
British Columbia	16,250	16,510	17,110	18,428	19,868
Total	**$ 29,211**	**$ 26,430**	**$ 17,110**	**$ 18,428**	**$ 19,868**

Source: FIRMS adapted by Program Analysis Division

Regional Expenditure Trends 2002/03 to 2011/12

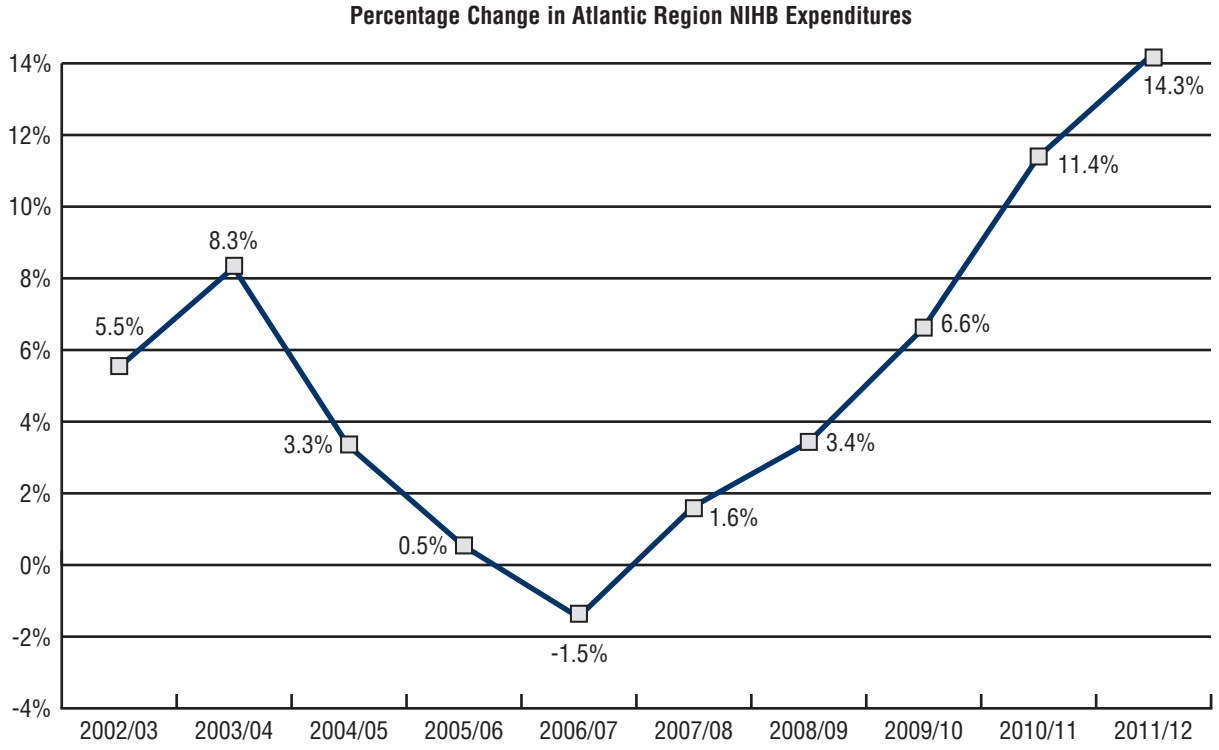
SECTION 8

FIGURE 8.1

Atlantic Region
2002/03 to 2011/12

Annual expenditures in the Atlantic Region for 2011/12 totalled $42.9 million, an increase of 14.3% from the $37.5 million spent in 2010/11. Pharmacy expenditures in 2011/12 increased by 16.4% to $27.6 million, medical transportation costs increased by 9.9% to $5.8 million and dental expenditures increased by 10.5% to $7.2 million. Vision care increased by 14.9%, accounting for the second highest expenditure growth. Other health care expenditures increased by 5.7%.

Pharmacy expenditures accounted for more than half of the Atlantic Region's total expenditures at 64.3%, dental expenditures ranked second at 16.7%, followed by medical transportation at 13.6%. Vision care and other health care accounted for 4.7% and 0.6% of total expenditures respectively.



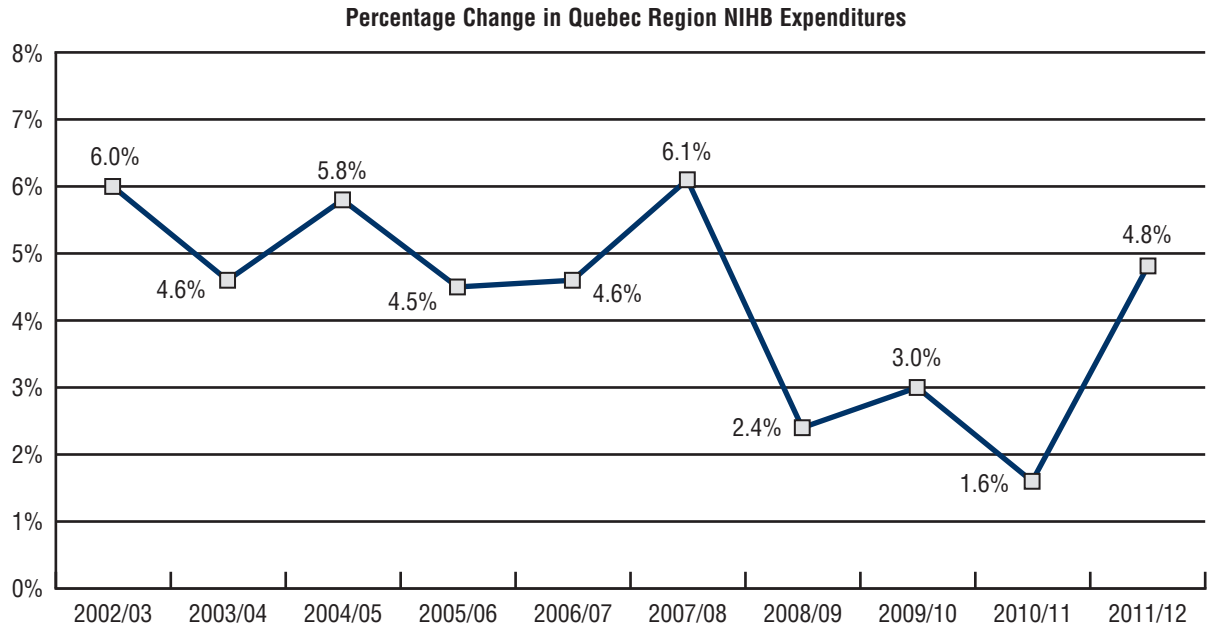
Annual Expenditures by Benefit ($ 000's)										
Atlantic Region	**2002/03**	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**2011/12**
Medical Transportation	$ 6,314	$ 6,498	$ 6,124	$ 5,590	$ 4,401	$ 4,585	$ 4,655	$ 5,048	$ 5,314	$ 5,841
Pharmacy	14,322	16,265	17,533	18,293	18,938	18,984	20,119	21,357	23,689	27,571
Dental	4,691	4,857	4,934	4,831	5,128	5,204	4,945	5,426	6,481	7,164
Other Health Care	198	141	161	201	192	272	251	213	241	254
Vision Care	1,604	1,631	1,619	1,614	1,408	1,495	1,596	1,612	1,758	2,021
Total	**$ 27,128**	**$ 29,391**	**$ 30,371**	**$ 30,529**	**$ 30,067**	**$ 30,539**	**$ 31,567**	**$ 33,656**	**$ 37,482**	**$ 42,850**

Source: FIRMS adapted by Program Analysis Division

On September 26, 2011, the creation of the new Qalipu Mi'kmaq First Nation band was announced. The formation of this band was the result of a settlement agreement that was negotiated between the Government of Canada and the Federation of Newfoundland Indians (FNI). As of March 31, 2012, a total of 21,419 new Qalipu clients were registered in the Status Verification System (SVS) and were eligible to receive benefits through the NIHB Program.

FIGURE 8.2

Quebec Region
2002/03 to 2011/12



Annual expenditures in the Quebec Region for 2011/12 totalled $78.0 million, an increase of 4.8% from the $74.4 million spent in 2010/11. Pharmacy expenditures in 2011/12 increased by 1.6% to $38.8 million. The low growth in pharmacy expenditures can be attributed to the NIHB Program adopting new generic pricing in the Province of Quebec which reduced costs. Medical transportation costs increased by 14.6% to $21.7 million. This increase can be attributed to the processing of some contribution agreement financial commitments that had been frozen at the end of fiscal year 2010/11. Dental expenditures decreased by 0.7% to $15.1 million. Vision care and other health care expenditures increased by 5.1% and 46.4% respectively.

Pharmacy expenditures accounted for half of the Quebec Region's total expenditures at 49.8%, medical transportation expenditures ranked second at 27.8%, followed by dental at 19.4%. Vision care and other health care accounted for 1.8% and 1.1% of total expenditures respectively.

Annual Expenditures by Benefit ($ 000's)

Quebec Region	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Medical Transportation	$ 16,877	$ 16,985	$ 17,291	$ 17,886	$ 18,473	$ 20,133	$ 20,502	$ 19,918	$ 18,943	$ 21,708
Pharmacy	25,005	27,436	29,959	31,771	33,486	35,372	36,069	37,358	38,234	38,827
Dental	10,292	10,277	10,525	10,970	11,603	12,141	12,895	14,159	15,245	15,138
Other Health Care	695	726	697	750	583	471	375	459	597	875
Vision Care	1,173	1,097	1,349	1,135	1,270	1,257	1,220	1,280	1,336	1,404
Total	**$ 54,042**	**$ 56,521**	**$ 59,820**	**$ 62,512**	**$ 65,414**	**$ 69,374**	**$ 71,060**	**$ 73,174**	**$ 74,355**	**$ 77,951**

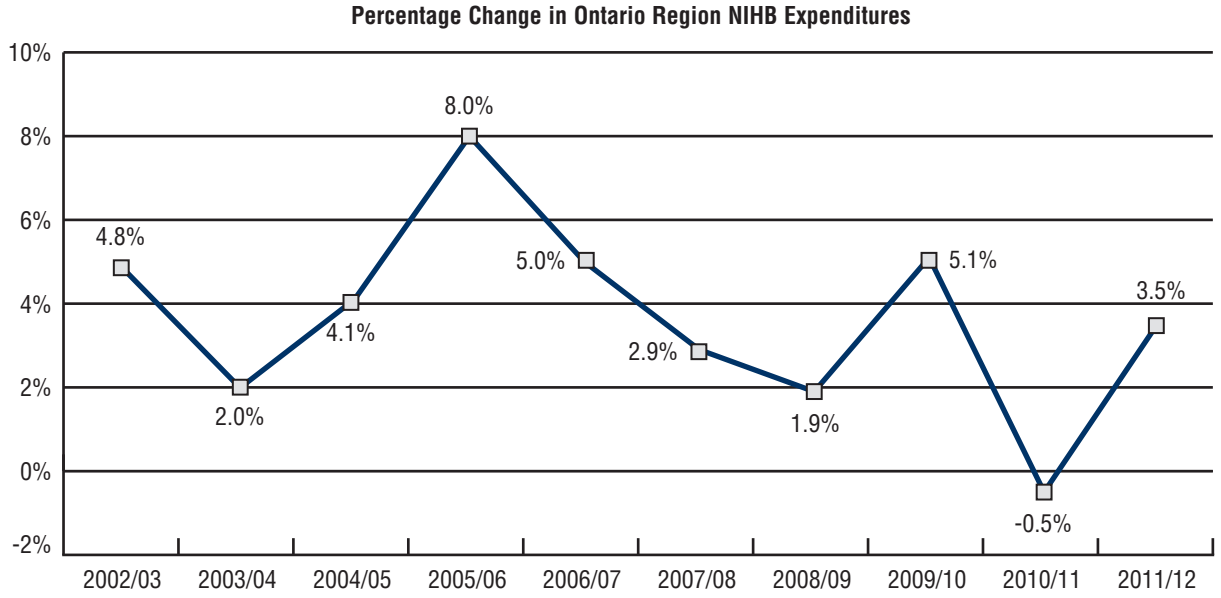
Source: FIRMS adapted by Program Analysis Division

FIGURE 8.3

Ontario Region
2002/03 to 2011/12

Annual expenditures in the Ontario Region for 2011/12 totalled $180.8 million, an increase of 3.5% from the $174.7 million spent in 2010/11. Pharmacy expenditures in 2011/12 increased by 3.4% to $76.4 million, medical transportation costs increased by 4.5% to $54.7 million and dental expenditures increased by 3.1% to $41.8 million. Vision care expenditures increased by 4.7% while other health care expenditures decreased by 10.8%.

Pharmacy expenditures accounted for 42.3% of the Ontario Region's total expenditures, medical transportation costs ranked second at 30.3%, followed by dental at 23.1%. Vision care and other health care accounted for 3.0% and 1.3% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)

Ontario Region	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Medical Transportation	$ 37,493	$ 36,620	$ 35,258	$ 38,553	$ 40,572	$ 45,618	$ 46,848	$ 51,889	$ 52,358	$ 54,725
Pharmacy	57,929	62,953	67,508	73,223	77,788	77,191	77,244	77,564	73,887	76,430
Dental	29,042	27,760	29,655	32,064	32,777	33,467	35,457	38,047	40,594	41,848
Other Health Care	2,548	2,250	2,404	2,213	2,530	2,172	2,158	2,603	2,632	2,349
Vision Care	5,085	5,196	5,428	5,458	5,485	5,366	5,204	5,343	5,183	5,425
Total	**$ 132,097**	**$ 134,779**	**$ 140,253**	**$ 151,510**	**$ 159,152**	**$ 163,814**	**$ 166,910**	**$ 175,447**	**$ 174,653**	**$ 180,778**

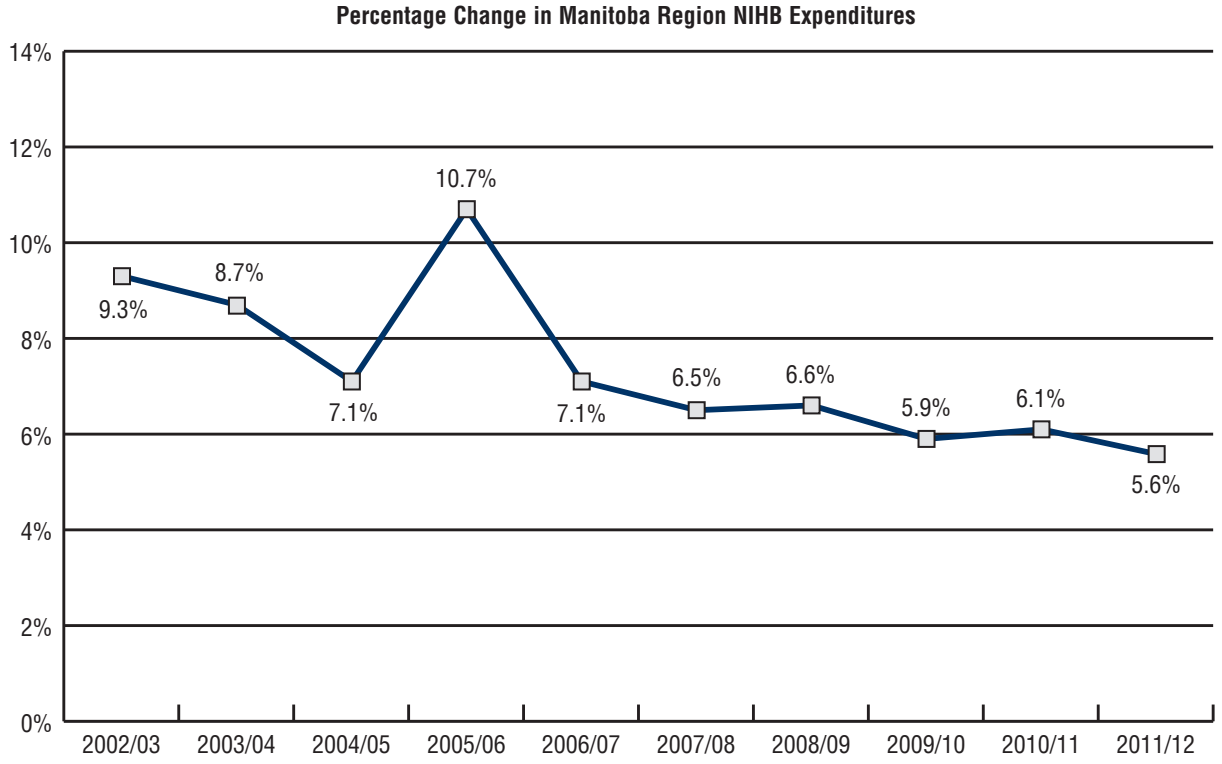
Source: FIRMS adapted by Program Analysis Division

FIGURE 8.4

Manitoba Region
2002/03 to 2011/12

Annual expenditures in the Manitoba Region for 2011/12 totalled $219.0 million, an increase of 5.6% from the $207.4 million spent in 2010/11. Pharmacy expenditures in 2011/12 increased by 5.4% to $80.6 million, medical transportation costs increased by 7.0% to $101.6 million and dental expenditures increased by 1.6% to $29.9 million. Vision care and other health care expenditures increased by 5.6% and 6.1% respectively.

Medical transportation expenditures comprised the largest portion of the Manitoba Region's total expenditures at 46.4%, pharmacy costs ranked second at 36.8%, followed by dental at 13.6%. Vision care and other health care accounted for 1.7% and 1.4% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)

Manitoba Region	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Medical Transportation	$ 51,199	$ 53,533	$ 55,895	$ 63,322	$ 69,047	$ 76,082	$ 83,193	$ 89,078	$ 94,940	$ 101,609
Pharmacy	42,525	48,519	53,998	59,409	64,966	69,317	71,081	72,789	76,496	80,639
Dental	16,600	17,313	18,705	20,326	20,756	21,696	24,444	26,954	29,399	29,861
Other Health Care	4,675	5,621	5,685	5,690	4,786	2,964	2,619	3,143	2,930	3,109
Vision Care	2,640	2,888	2,684	2,864	2,841	2,936	3,157	3,407	3,612	3,813
Total	**$ 117,638**	**$ 127,874**	**$ 136,967**	**$ 151,610**	**$ 162,396**	**$ 172,994**	**$ 184,494**	**$ 195,371**	**$ 207,377**	**$ 219,031**

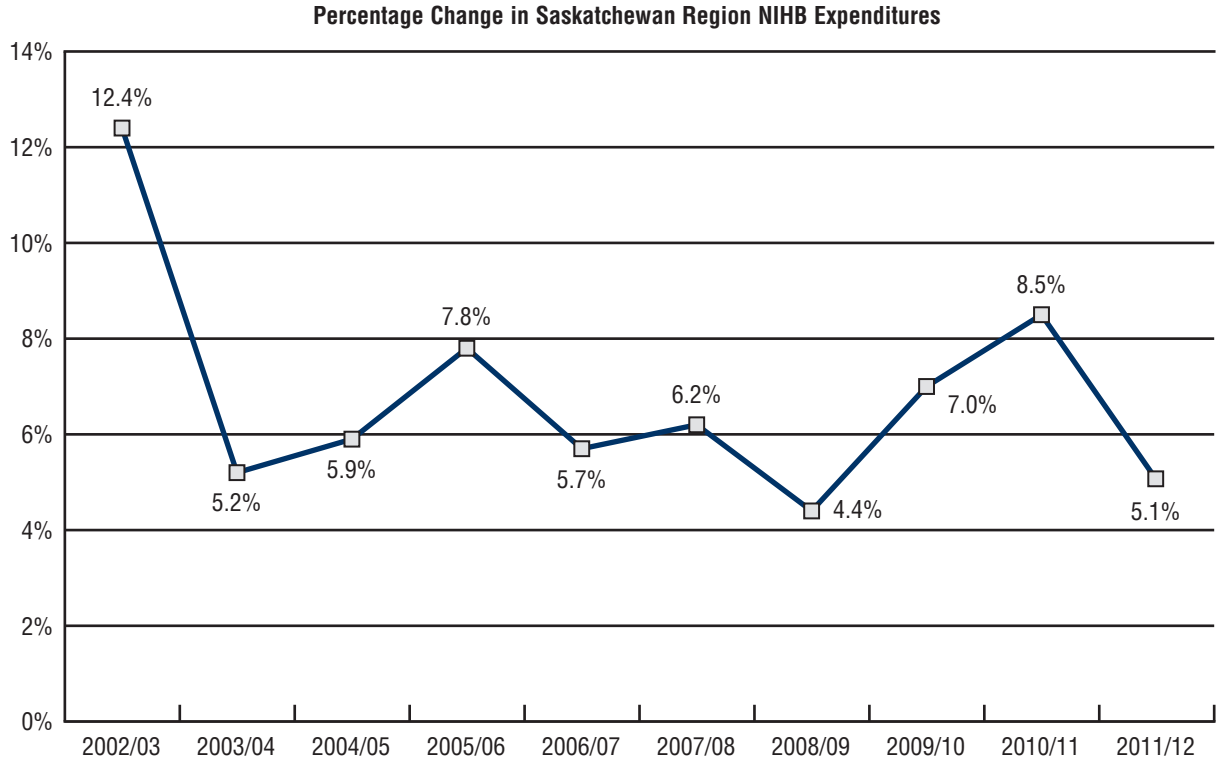
Source: FIRMS adapted by Program Analysis Division

FIGURE 8.5

Saskatchewan Region
2002/03 to 2011/12

Annual expenditures in the Saskatchewan Region for 2011/12 totalled $161.3 million, an increase of 5.1% from the $153.4 million spent in 2010/11. Pharmacy expenditures in 2011/12 increased by 3.8% to $73.3 million, medical transportation costs increased by 7.6% to $45.1 million and dental expenditures increased by 4.6% to $36.9 million. Vision care expenditures decreased by 4.5% while other health care expenditures increased by 67.3%. This significant increase can be attributed to a revision in financial coding practices of professional travel expenditures.

Pharmacy expenditures comprised the largest portion of the Saskatchewan Region's total expenditures at 45.4%, medical transportation costs ranked second at 28.0%, followed by dental at 22.9%. Vision care and other health care accounted for 2.8% and 0.9% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)										
Saskatchewan Region	**2002/03**	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**2011/12**
Medical Transportation	$ 25,853	$ 25,854	$ 26,758	$ 28,786	$ 31,816	$ 36,108	$ 36,239	$ 38,971	$ 41,896	$ 45,084
Pharmacy	44,394	48,952	52,636	55,687	58,083	60,749	62,809	66,639	70,625	73,293
Dental	17,649	18,297	19,530	22,038	23,219	24,636	28,102	30,777	35,317	36,941
Other Health Care	2,671	2,370	2,295	2,237	2,244	942	870	812	896	1,499
Vision Care	3,360	3,375	3,431	4,072	3,835	4,126	4,166	4,222	4,658	4,449
Total	**$ 93,927**	**$ 98,847**	**$ 104,651**	**$ 112,820**	**$ 119,197**	**$ 126,561**	**$ 132,185**	**$ 141,420**	**$ 153,393**	**$ 161,265**

Source: FIRMS adapted by Program Analysis Division

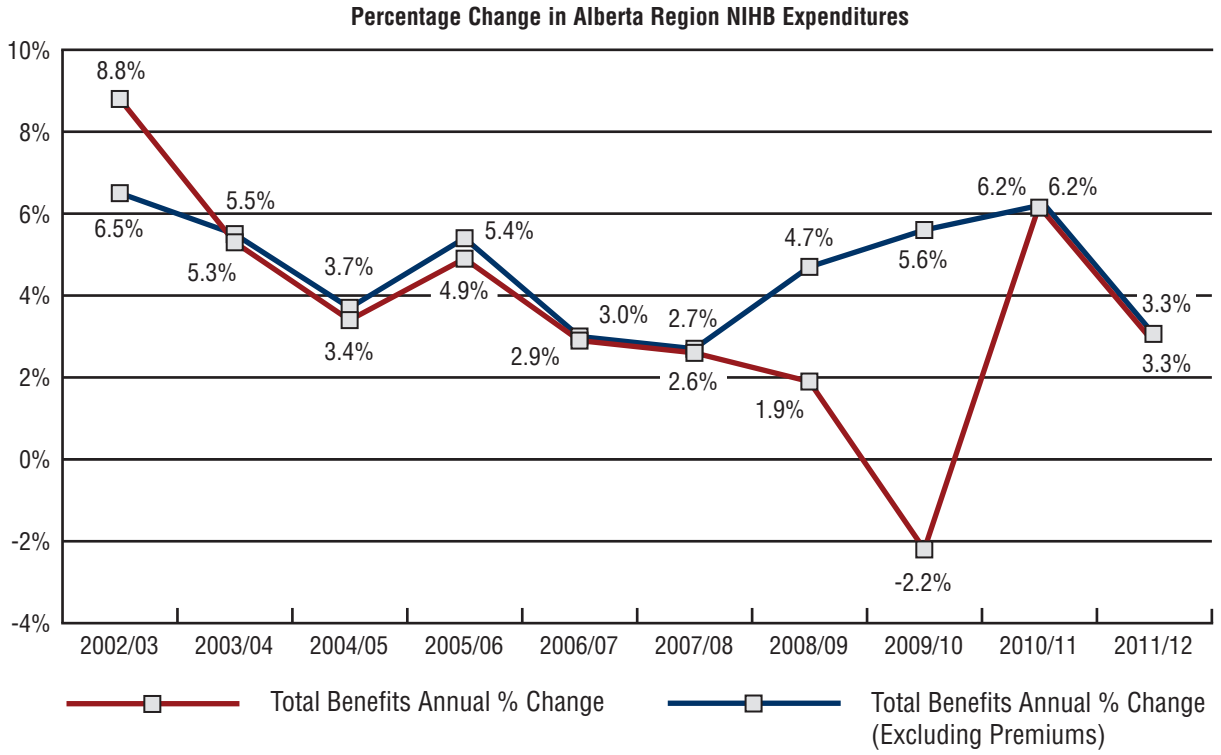
FIGURE 8.6

Alberta Region
2002/03 to 2011/12

Annual expenditures in the Alberta Region for 2011/12 totalled $143.3 million, an increase of 3.3% from the $138.7 million spent in 2010/11. Pharmacy expenditures in 2011/12 increased by 3.2% to $61.6 million, medical transportation costs increased by 4.2% to $37.4 million and dental expenditures increased by 3.4% to $34.5 million. Vision care and other health care expenditures increased by 0.8% and 1.4% respectively.

Pharmacy expenditures accounted for 43.0% of the Alberta Region's total expenditures, medical transportation costs ranked second at 26.1%, followed closely by dental at 24.1%. Vision care and other health care accounted for 4.1% and 2.8% of total expenditures respectively.

The decreased growth rate recorded in 2009/10 is primarily the result of 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.



Annual Expenditures by Benefit ($ 000's)

Alberta Region	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Medical Transportation	$ 28,856	$ 29,030	$ 29,686	$ 30,712	$ 32,204	$ 32,107	$ 35,357	$ 36,601	$ 35,877	$ 37,371
Pharmacy	41,590	45,588	48,207	51,141	52,424	54,353	54,189	56,570	59,738	61,621
Dental	18,375	19,237	19,306	20,594	21,006	22,391	25,016	27,756	33,421	34,543
Other Health Care	3,856	3,794	4,078	4,537	4,736	4,343	3,940	4,363	3,903	3,957
Vision Care	4,239	4,576	4,720	4,762	4,690	4,942	5,225	5,377	5,778	5,822
Sub-Total	**96,916**	**102,224**	**105,996**	**111,746**	**115,060**	**118,135**	**123,726**	**130,666**	**138,717**	**143,313**
Premiums	11,790	12,202	12,377	12,381	12,709	12,961	9,920	0	0	0
Total	**$ 108,706**	**$ 114,426**	**$ 118,373**	**$ 124,127**	**$ 127,769**	**$ 131,096**	**$ 133,646**	**$ 130,666**	**$ 138,717**	**$ 143,313**

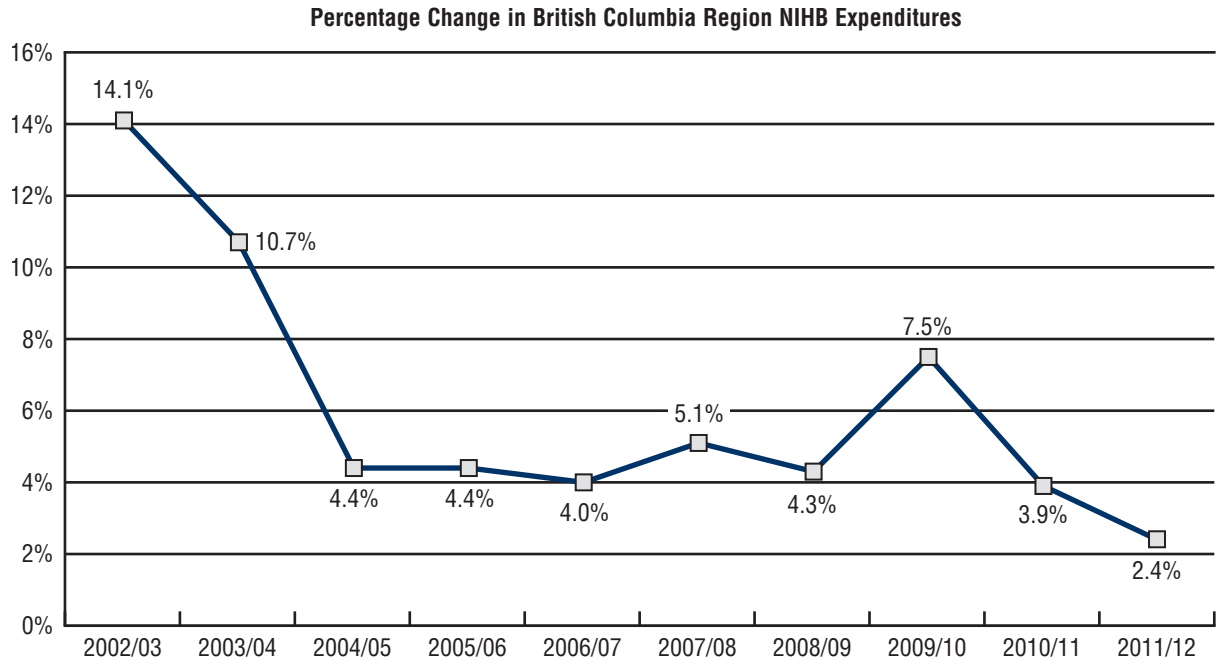
Source: FIRMS adapted by Program Analysis Division

FIGURE 8.7

British Columbia Region
2002/03 to 2011/12

Annual expenditures in the British Columbia Region for 2011/12 totalled $142.2 million, an increase of 2.4% from the $138.9 million spent in 2010/11. Pharmacy expenditures in 2011/12 increased by 1.3% to $60.9 million. The low growth in pharmacy costs can be attributed to the NIHB Program adopting the British Columbia Drug Plan pricing model for generic drugs. Medical transportation costs increased by 2.1% to $26.5 million and dental expenditures increased by 1.4% to $30.6 million. The cost of premiums and vision care increased by 7.8% and 3.5% respectively. Other health care expenditures increased by 0.8%.

Pharmacy expenditures accounted for 42.8% of the British Columbia Region's total expenditures, dental costs ranked second at 21.5%, followed by medical transportation at 18.6%. Premiums, vision care and other health care accounted for 14.0%, 2.4% and 0.6% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)										
British Columbia Region	**2002/03**	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**2011/12**
Medical Transportation	$ 16,410	$ 16,408	$ 17,340	$ 16,944	$ 20,284	$ 21,613	$ 22,711	$ 25,547	$ 25,967	$ 26,510
Pharmacy	38,922	44,141	46,670	49,734	50,387	54,290	56,104	58,862	60,097	60,890
Dental	19,224	18,338	20,357	22,439	22,588	22,968	24,718	28,042	30,187	30,620
Other Health Care	1,240	1,653	1,581	1,486	1,177	1,120	1,165	924	882	889
Vision Care	2,601	3,259	3,249	3,049	3,232	3,120	3,251	3,253	3,344	3,461
Sub-Total	**78,397**	**83,800**	**89,197**	**93,652**	**97,669**	**103,111**	**107,948**	**116,628**	**120,476**	**122,371**
Premiums	12,113	16,411	15,453	15,606	15,951	16,250	16,510	17,110	18,428	19,868
Total	**$ 90,510**	**$ 100,212**	**$ 104,650**	**$ 109,259**	**$ 113,620**	**$ 119,361**	**$ 124,458**	**$ 133,739**	**$ 138,905**	**$ 142,239**

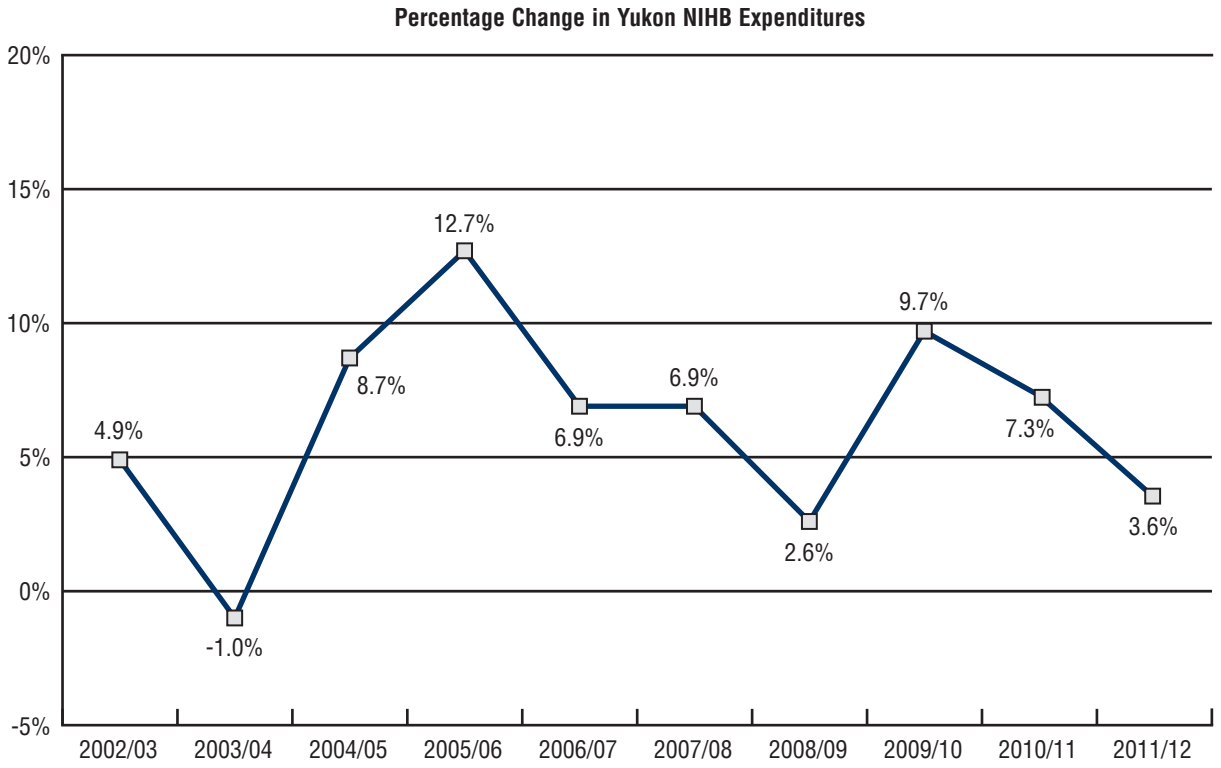
Source: FIRMS adapted by Program Analysis Division

FIGURE 8.8

Yukon
2002/03 to 2011/12

Annual expenditures in the Yukon for 2011/12 totalled $11.2 million, an increase of 3.6% from the $10.8 million spent in 2010/11. Pharmacy expenditures in 2011/12 increased by 2.3% to $3.9 million and medical transportation costs increased by 7.7% to $4.4 million. Dental expenditures decreased by 1.7% to $2.6 million.

Medical transportation expenditures comprised the largest portion of Yukon's total expenditures at 39.3%, pharmacy expenditures ranked second at 34.5%, followed by dental and vision care at 23.0% and 3.1% respectively.



Annual Expenditures by Benefit ($ 000's)

Yukon	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Medical Transportation	$ 1,957	$ 1,600	$ 1,774	$ 2,100	$ 2,421	$ 2,935	$ 2,938	$ 3,801	$ 4,097	$ 4,413
Pharmacy	3,048	3,214	3,476	3,655	3,641	3,802	3,779	3,723	3,792	3,878
Dental	1,236	1,365	1,229	1,863	2,033	1,998	2,246	2,271	2,629	2,583
Other Health Care	11	2	4	1	22	4	1	1	2	4
Vision Care	218	223	480	228	274	230	242	299	311	347
Total	**$ 6,470**	**$ 6,405**	**$ 6,963**	**$ 7,847**	**$ 8,392**	**$ 8,970**	**$ 9,206**	**$ 10,095**	**$ 10,830**	**$ 11,225**

Source: FIRMS adapted by Program Analysis Division

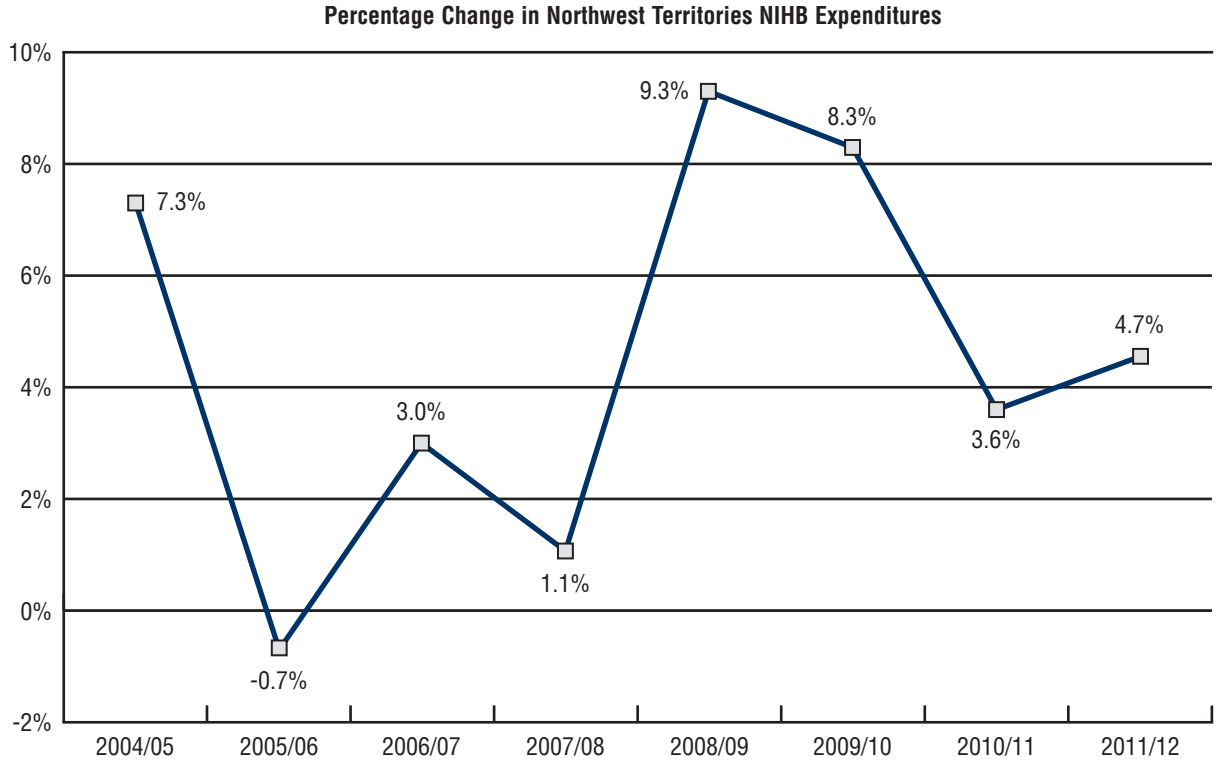
FIGURE 8.9

Northwest Territories
2003/04 to 2011/12

Annual expenditures in the Northwest Territories in 2011/12 totalled $27.7 million, an increase of 4.7% from the $26.4 million spent in 2010/11. Pharmacy expenditures in 2011/12 increased by 1.0% to $9.1 million, medical transportation costs increased by 19.5% to $10.2 million while dental expenditures decreased by 7.2% to $7.1 million. Vision care costs increased by 3.0% to $1.4 million.

Medical transportation comprised the largest portion of the Northwest Territories total expenditures at 36.7%, pharmacy costs ranked second at 32.9%, followed by dental at 25.5%. Vision care made up 5.0% 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**	**2010/11**	**2011/12**
Medical Transportation	$ 6,856	$ 7,428	$ 6,710	$ 7,116	$ 6,943	$ 7,952	$ 8,520	$ 8,498	$ 10,157
Pharmacy	7,161	7,544	8,010	8,151	7,863	8,210	8,595	8,999	9,090
Dental	4,726	5,173	5,249	5,249	5,752	6,279	7,067	7,603	7,054
Other Health Care	0	0	0	0	0	0	0	0	0
Vision Care	700	718	743	819	1,011	1,130	1,340	1,331	1,371
Total	**$ 19,443**	**$ 20,863**	**$ 20,712**	**$ 21,335**	**$ 21,570**	**$ 23,571**	**$ 25,521**	**$ 26,431**	**$ 27,672**

Source: FIRMS adapted by Program Analysis Division

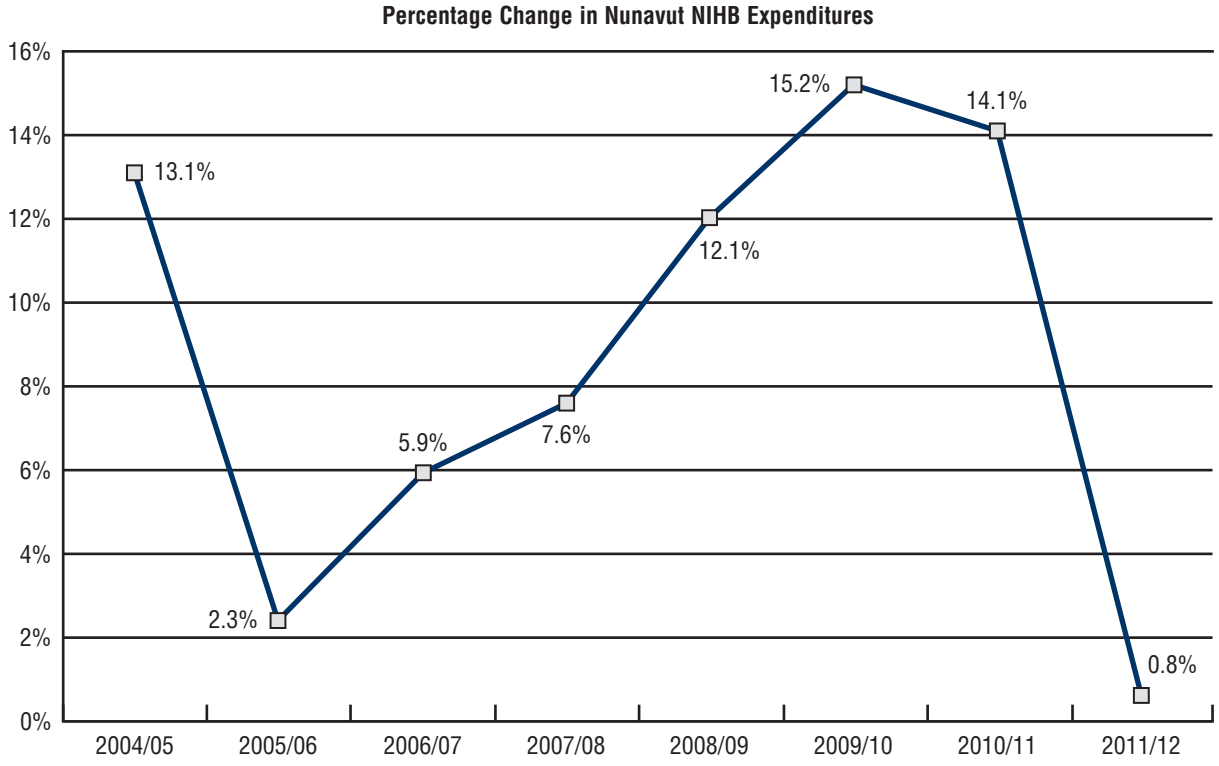
FIGURE 8.10

Nunavut
2003/04 to 2011/12

Annual expenditures in Nunavut for 2011/12 totalled $48.9 million, a slight increase of 0.8% from the $48.5 million spent in 2010/11. Pharmacy expenditures in 2011/12 increased by 4.8% to $10.9 million and medical transportation costs increased by 8.4% to $25.9 million. Dental expenditures decreased by 15.1% to $10.4 million. This decrease can be attributed to a re-alignment of expenditures between 2010/11 and 2011/12. Vision care costs decreased by 12.6% to $1.7 million.

Medical transportation comprised the largest portion of Nunavut's total expenditures at 52.9%, pharmacy expenditures ranked second at 22.3%, followed closely by dental at 21.4%. Vision care made up 3.4% of the 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**	**2010/11**	**2011/12**
Medical Transportation	$ 12,409	$ 13,972	$ 14,776	$ 15,268	$ 16,171	$ 20,053	$ 22,302	$ 23,869	$ 25,886
Pharmacy	4,150	4,734	4,902	5,526	6,579	7,084	8,237	10,399	10,894
Dental	6,932	8,566	8,137	8,740	9,002	8,349	10,289	12,306	10,442
Other Health Care	0	0	0	0	0	0	0	0	0
Vision Care	1,475	951	1,044	1,040	1,139	1,387	1,646	1,908	1,668
Total	**$ 24,965**	**$ 28,223**	**$ 28,860**	**$ 30,574**	**$ 32,890**	**$ 36,873**	**$ 42,474**	**$ 48,482**	**$ 48,890**

Source: FIRMS adapted by Program Analysis Division

Initiatives and Activities

SECTION 9.1

Health Information and Claims Processing Services (HICPS)
2011/12

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 is responsible for developing, maintaining and managing key business processes, systems and services required to deliver eligible non-insured health benefits. 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.

The current HICPS contract is with Express Scripts Canada (formally ESI Canada). This contract came into force on December 1, 2009, following a competitive contracting process led by Public Works and Government Services Canada (PWGSC).

The NIHB Program manages the HICPS contract as the project authority in conjunction with PWGSC, the contract authority.

As of March 31, 2012, 25,408 active providers* were registered with the HICPS claims processor to deliver NIHB Pharmacy, MS&E and Dental benefits. The number of active providers by region and by benefit is outlined in the table below. The number of claims settled through the HICPS system is highlighted in Figure 9.1.1.

Number of NIHB Providers by Region and Benefit, April 2010 to March 2012

REGION	Pharmacy	MS&E	Dental
Newfoundland	167	18	122
Nova Scotia	309	76	458
Prince Edward Island	48	6	50
New Brunswick	214	55	278
Quebec	1,944	161	2,629
Ontario	3,619	639	5,126
Manitoba	361	79	722
Saskatchewan	381	67	438
British Columbia	1,170	354	2,485
Yukon	8	8	45
Northwest Territories	10	5	72
Nunavut	5	2	63
Total	**8,236**	**1,470**	**12,488**

Source: HICPS adapted by Program Analysis Division

* An active provider refers to a provider who has submitted at least one claim in the 24 months prior to March 31, 2012.

FIGURE 9.1.1

Number of Claim Lines Settled Through the Health Information and Claims Processing Services (HICPS) System in 2011/12

Figure 9.1.1 sets out the total number of pharmacy, dental and MS&E claims settled through the HICPS system in fiscal year 2011/12. During this period, 21,442,200 claim lines were processed through HICPS, an increase of 6.2% 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.

REGION	Pharmacy	Dental	MS&E	Total
Atlantic	966,764	115,194	25,349	**1,107,307**
Quebec	2,200,095	202,806	19,150	**2,422,051**
Ontario	4,443,898	527,468	35,006	**5,006,372**
Manitoba	2,911,408	374,084	72,052	**3,357,544**
Saskatchewan	2,692,732	455,830	64,644	**3,213,206**
Alberta	2,087,214	420,951	48,507	**2,556,672**
British Columbia	2,413,541	466,475	40,975	**2,920,991**
Yukon	105,961	26,227	3,146	**135,334**
Northwest Territories	266,859	92,921	8,007	**367,787**
Nunavut	222,716	122,962	9,258	**354,936**
Total Claim Lines	**18,311,188**	**2,804,918**	**326,094**	**21,442,200**

Source: HICPS adapted by Program Analysis Division

SECTION 9.2

Provider Audit Activities
2011/12

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 2011/12, the claims processor Express Scripts 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 Express Scripts Canada;
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 2011/12, 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

Annually, the NIHB Program conducts reviews of providers to identify anomalous billing patterns. Providers with unexplained billings can be put under a restricted billing regime or de-listed as a provider because of financial risk to the Program. In 2011/12, three pharmacy providers and two dental providers were de-listed from the Program due to audit finding results and/or irregular billing patterns detected through provider profiling.

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 2011/12, reviews were conducted on NIHB Vision care benefits in the Saskatchewan Region, NIHB Short-term crisis intervention mental health counselling benefits in the Manitoba Region and on NIHB Medical Transportation in Nunavut.

FIGURE 9.2.1

Audit Recoveries by Benefit and Region
2011/12

Figure 9.2.1 identifies audit recoveries, Next Day Claims Verification (NDCV) and Client Confirmation Program (CCP) savings* from all components of the Express Scripts Canada Provider Audit Program during the 2011/12 fiscal year.

DENTAL				
REGION	Audits Completed	Recoveries	NDCV/CCP Savings	Total Recoveries/ Savings
Atlantic	7	$ 37,603	$ 27,988	$ 65,591
Quebec	6	14,625	33,454	48,079
Ontario	6	7,297	155,682	162,979
Manitoba	8	12,747	55,172	67,919
Saskatchewan	7	384,762	80,898	465,660
Alberta	12	49,134	102,505	151,638
British Columbia	8	37,102	120,927	158,029
Yukon	0	0	5,717	5,717
N.W.T.	1	18,229	15,926	34,155
Nunavut	3	0	21,239	21,239
Total	58	$ 561,500	$ 619,507	$ 1,181,006

PHARMACY				
REGION	Audits Completed	Recoveries	NDCV/CCP Savings	Total Recoveries/ Savings
Atlantic	8	$ 37,624	$ 51,536	$ 89,160
Quebec	3	9,825	61,228	71,053
Ontario	22	141,122	445,862	586,984
Manitoba	21	406,847	169,491	576,338
Saskatchewan	13	103,884	58,521	162,405
Alberta	18	234,935	103,173	338,107
British Columbia	19	146,874	150,350	297,225
Yukon	2	57,882	11,768	69,650
N.W.T.	4	6,361	13,599	19,959
Nunavut	2	8,146	9,358	17,504
Total	112	$ 1,153,498	$ 1,074,887	$ 2,228,385

MS&E				
REGION	Audits Completed	Recoveries	NDCV/CCP Savings	Total Recoveries/ Savings
Atlantic	1	$ 0	$ 6,408	$ 6,408
Quebec	0	0	1,801	1,801
Ontario	3	5,013	25,421	30,434
Manitoba	5	17,162	13,403	30,565
Saskatchewan	2	0	24,948	24,948
Alberta	6	16,983	3,292	20,275
British Columbia	2	63	25,416	25,479
Yukon	0	0	0	0
N.W.T.	1	0	1,742	1,742
Nunavut	0	0	0	0
Total	20	$ 39,221	$ 102,431	$ 141,652

* NDCV savings listed in the recovery charts, per benefit, above do not take into consideration the provider appeals process. All claims that are reversed prior to being paid to providers are deemed savings to the Program. Subsequent appeals to these reversals may lead to claims being paid in full to providers once appropriate billing and supporting documentation has been provided for review.

SECTION 9.3

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 plans. For these drug products, the CDR, through the Canadian Drug Expert Committee (CDEC), 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 plans 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 CDEC 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 NIHB Drugs and Therapeutics Advisory Committee (DTAC). The NIHB Pharmacy and Therapeutic (P&T) Committee and the Drug Use Evaluation Advisory Committee (DUEAC) have been merged to become the NIHB DTAC. The NIHB DTAC is an advisory body of highly qualified health professionals who bring impartial and practical expert medical and pharmaceutical advice to the NIHB Program to promote improvement in the health outcomes of First Nations and Inuit clients through effective use of pharmaceuticals.The membership of this Committee includes practicing physicians and pharmacists from community and hospital settings, and also includes First Nations physicians.

The NIHB DTAC generally meets up to six times per year. Their approach is evidence-based and the advice reflects medical and scientific knowledge, current utilization trends, current clinical practice, health care delivery and specific departmental client healthcare needs. This expert advice is intended to facilitate NIHB program policy development and decisions that will optimize client health benefits within the Program budgetary allocations.

DTAC will be focused on providing recommendations to the NIHB Program in order to maintain a cost effective drug formulary as well as provide necessary expert advice on initiatives that change broad practices, and thus impact health outcomes of the entire client population. A process of continuous quality improvement will guide the Program and a learning organization approach will be nurtured.

SECTION 9.4

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.

SECTION 9.4.1

Drug Exception Centre Special Authorization Process

The Special Authorization Process for pharmacy providers has been in effect since November 2009. This program has accelerated the internal DEC process to extend Limited Use (LU) approvals to approximately 35 additional drugs for chronic conditions. These drugs have been granted extended authorization periods beyond one year, and some will now have an indefinite authorization period, thereby facilitating access for NIHB clients and eliminating unnecessary calls by pharmacists to the DEC.

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

Implementing extended authorization periods for drugs used in certain chronic conditions has significantly reduced the administrative burden on pharmacy providers and enabled the DEC to deal with more complicated reviews. Since this process was implemented, there has been a 30% reduction in prior approvals handled by the DEC. However, the overall amount of requests for 2011/12 has increased from last fiscal year due to the integration of new clients (McIvor and Qalipu) as well as the temporary shortage of generic medications experienced during 2011/12 throughout Canada.

Increased Efficiency of HICPS System to Facilitate Prior Approvals for Specific Drugs

The new HICPS system has the capacity to automatically adjudicate a number of medications to facilitate access for clients and pharmacists and to reduce calls to the DEC. For these specific drugs, the System provides a prompt to pharmacists to continue with the Prior Approval process automatically and if the pharmacists select this prompt, the request is automatically sent to the DEC for review without necessitating a call to the DEC. In this way, the DEC can immediately send a Benefit Evaluation Questionnaire (BEQ) to the physician and thereby reduce the workload of pharmacists. The NIHB Program has seen a three-fold increase of cases approved by the Auto Approval process at the point of sale by pharmacy providers over the last fiscal year.

FIGURE 9.4.2

Total NIHB Drug Exception Centre Requests/ Approvals
2011/12

The DEC is a single call centre that provides 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	Open Benefit	Exceptions	Limited Use	Total
Total Requested	3,663	45,291	82,135	**136,746**
Total Approved	2,788	37,407	62,797	**107,312**

Open 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 9.5

Changes in Medical Supplies and Equipment (MS&E) Prescribing Requirements

Prosthetic and Orthotic Prescribing Requirements

On April 1, 2011, the NIHB Program added general practitioners as valid prescribers of prosthetics and class II/III orthotics to facilitate access to prosthetic and orthotic benefits for First Nations and Inuit clients. The Program also modified its policy on replacement of orthotic and prosthetic items for permanent medical conditions. Also, a prescription is no longer required for replacement requests of prosthetic and orthotic items if certain criteria are met.

Audiologists Recognized as NIHB Prescribers

On January 1, 2012, audiologists were added as recognized prescribers of audiology equipment and supplies under the NIHB Program. To achieve this, the NIHB Program worked collaboratively with the Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA) and the Canadian Academy of Audiology (CAA).

This change acknowledges the scope of practice of audiologists and improves access for First Nations and Inuit clients.

More information concerning these changes can be found in the Provider Guide for Medical Supplies and Equipment on the Health Canada website at: **http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/_medequip/2009-prov-fourn-guide/index-eng.php**

SECTION 9.6

NIHB Vision Care Framework and Benefit List

The NIHB *Vision Care Framework*, last printed in 2005, was updated to ensure that available benefits are more representative of today's standard of health care and to better meet the needs of First Nations and Inuit clients. The 2012 *Vision Care Framework* provides a broad overview of the overarching policies associated with the administration of the vision care benefit under the NIHB Program.

In order to ensure that vision care services and goods covered are updated on a regular basis, the list of vision care benefits covered by the NIHB Program was removed from the *Vision Care Framework* and is now published in a separate document known as the *Vision Care Benefit List*. The *Vision Care Benefit List* contains a comprehensive list of the vision care benefits eligible for coverage under the Program and will be updated on a yearly basis.

The new *Vision Care Framework* and *Vision Care Benefit List* are available on the Health Canada website under the Benefit Information section at: **http://www.health.gc.ca/nihb**

SECTION 9.7

Publication of *Your Health Benefits – A Guide for First Nations to Access Non-Insured Health Benefits*

The NIHB Program collaborated with the Assembly of First Nations (AFN) on the publication of a new handbook entitled, *Your Health Benefits – A Guide for First Nations to Access Non-Insured Health Benefits*. The purpose of the Handbook is to serve as a user-friendly guide to help eligible First Nations understand what benefits are available to them under Health Canada's NIHB Program. It provides detailed information on the benefits covered by the Program, as well as, information regarding the appeals process and key contact telephone numbers and addresses.

The Handbook is available on the Health Canada website at the following address: **http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/yhb-vss/index-eng.php**

SECTION 9.8

Negotiations Secretariat

The NIHB Negotiations Secretariat was created in 2005 to ensure a strategic approach to negotiations with providers which optimizes benefits to clients, reflects value for money, and is sustainable within existing resources. During 2011/12, the Negotiations Secretariat participated in the implementation of the NIHB National Dental Benefit List by providing pricing for new dental procedures being added to the Program. In addition, agreements were concluded with the Pharmacists' Association of Saskatchewan and the Manitoba Society of Pharmacists.

SECTION 9.9

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.

The NIHB Program has also taken measures to protect the privacy of personal information used for claims processing. As the claims processor for NIHB, Express Scripts Canada (ESC) is required to abide by contractual privacy obligations with respect to life cycle management of personal information used for processing and settlement of NIHB claims. During 2011/12, a privacy audit was performed in order to ensure that ESC remains compliant with its privacy obligations and further privacy audits will be conducted on an annual basis to ensure compliance as per the terms outlined in the Health Information and Claims Processing Services (HICPS) system contract.

In August 2009, NIHB and Aboriginal Affairs and Northern Development Canada (AANDC) approved an Information Sharing Agreement (ISA) concerning the exchange of personal information between the Indian Registration System (IRS) at AANDC and the Status Verification System (SVS) at Health Canada. The ISA was amended in December 2010 to add more clarity around the exchange of personal information between the AANDC and Health Canada.

SECTION 9.10

NIHB Newsletters and DBL Updates

Previously, the NIHB Program communicated changes through bulletins, but the Program now provides relevant information and Program changes concerning Dental, Pharmacy and Medical Supplies and Equipment (MS&E) benefits via the NIHB benefit specific Newsletters. These publications are produced on a quarterly basis and are automatically sent to NIHB registered providers. NIHB providers may access the NIHB Newsletters via the Express Scripts Canada website (password required) at: **http://www.provider.express-scripts.ca**

In addition to the Pharmacy Newsletters, the NIHB Program communicates changes to the Drug Benefit List (DBL) through the update to the DBL. The update to the DBL can be found on the Health Canada web site at: **http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/index-eng.php**

Client Safety

SECTION 10

PHARMACY BENEFIT

INTRODUCTION

Prescription drugs have the capacity to heal but also the capacity to do harm if not used correctly. Public drug plans, like the Non-Insured Health Benefits (NIHB) Program, bear a responsibility to those they serve. Timely information to health professionals and analysis of individual situations and broader trend observations are crucial in ensuring that clients are well served.

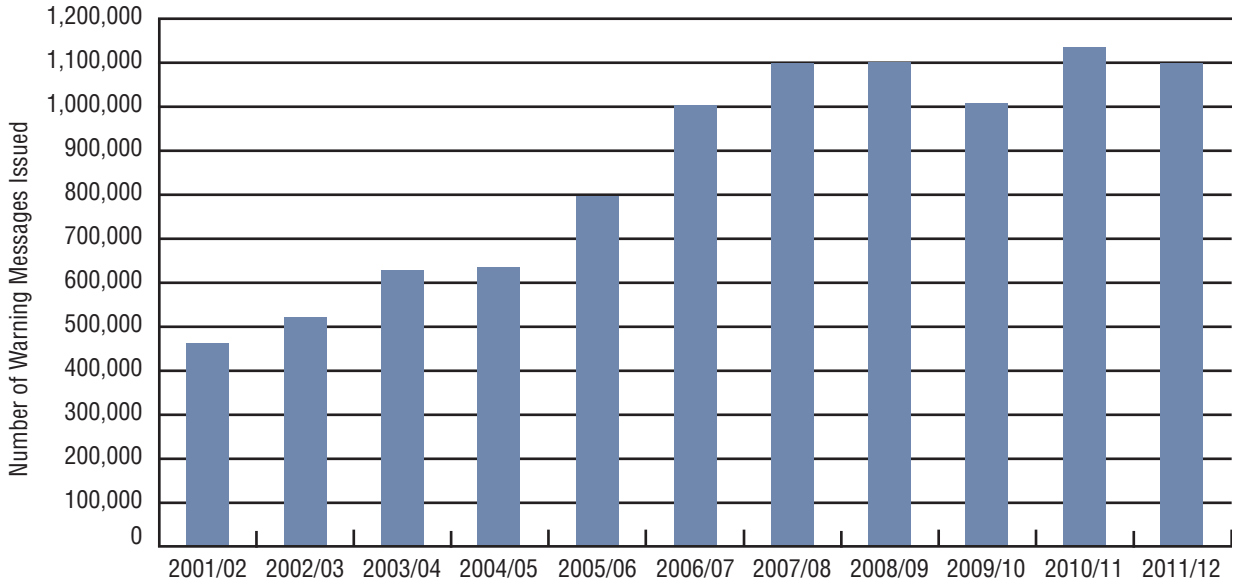
The NIHB Program continues to place a high priority on addressing cases of concern and on enhancing and encouraging the safe use of prescription medications. The NIHB Program has invested considerable time and effort in designing and modernizing its prescription drug benefit program with these responsibilities in mind. The Program has adopted four strategies to improve the safety of our clients.

STRATEGIES TO IMPROVE CLIENT SAFETY

1. Point of Sale (POS) warning and rejection messages;
2. Client and Program level trend analysis of prescription drug use;
3. Evaluations and recommendations from independent experts; and
4. Specific drug safety initiatives.

FIGURE 10.1

NIHB Warning Messages Over Time
2001/02 to 2011/12



Source: HICPS adapted by Benefit Management Division

Strategy #1: Warning and Rejection Messages

Warning Messages

The NIHB Program sends messages electronically in real-time at the POS to warn pharmacy providers about potential client safety issues including drug interactions and repeat prescriptions. Certain warning messages also require the pharmacy providers to report back with specific codes that give the Program information about the actions they have taken related to the warning code received.

Warning messages are important tools that supplement pharmacists' professional judgment at the POS. The NIHB Program actively monitors the number of pharmacy claims that are flagged with warning messages or rejected by this system.

Figure 10.1 shows the number of warning messages sent by the NIHB Program to pharmacies across the country since 2001. The Program issues approximately one million warning messages per year. The information provided via these warning messages

provides additional information to pharmacists and, as a result, enhances their ability to exercise their professional judgment when serving NIHB clients.

Rejection Messages

The NIHB Program also sends rejection messages to pharmacists when a client's claims history indicates potential misuse or overuse of a range of prescription medications. Unlike warning messages, it is not possible for a pharmacy provider to override or to submit electronic response codes. Instead when a rejection message is received, a pharmacy provider must contact NIHB's Drug Exception Centre (DEC), a national toll-free call centre. The DEC will provide more information to the pharmacy provider regarding the reason for coverage rejection and follow up with the prescribing physician before the Program will authorize coverage for the pharmacy benefit in question. The NIHB Program reserves the right to refuse coverage for pharmacy benefits when there is evidence that suggests client safety may be at risk.

An example of a rejection message is when a client exceeds the maximum allowable quantities for acetaminophen and acetaminophen-based opioids. Clients are often unaware of the long-term consequences of commonly available acetaminophen-based products. Negative health effects can result from prolonged use, including serious liver damage if recommended dosages are exceeded. In 2011/12, the Program rejected a total of 1,566 claims for products that contain acetaminophen.

Strategy #2: Client and Program Level Trend Analysis of Prescription Drug Use

Client Level Analysis and Prescription Monitoring Program (PMP)

The NIHB Program has developed the Prescription Monitoring Program (PMP) which focuses on the questionable use of benzodiazepine, opioid and stimulant drugs. The PMP process starts by identifying clients at highest potential risk for misuse of these drugs by reviewing the number of prescribing physicians (which may be an indication of "doctor shopping"), the number of pharmacy providers and the number of opioids, benzodiazepines or stimulants claimed. Enrolment may restrict clients to a specific physician or require clients to have future claims verified and authorized by a pharmacist at NIHB's Drug Exception Centre. If the client or their health care provider cannot provide evidence to support the continuation of the drug therapy in question, the Program reserves the right to refuse coverage for the pharmacy benefit requested.

The NIHB PMP complements existing activities and promotes the optimal use of medications by allowing the Program to enhance its interventions when concerned about how the client is using their medications. The first phase of the NIHB PMP was launched in Alberta in January of 2007. In September 2011, the NIHB PMP was expanded to all regions in Canada, with the exception of Quebec. The NIHB Program plans to extend the PMP to Quebec and to include gabapentin, another drug of concern, during the next fiscal year.

Program Analysis, Identification of Issues and Adjusting Program Requirements

The NIHB Program actively analyzes broad patterns of utilization, prescribing, and dispensing on an on-going basis. This work is conducted by a team of licensed pharmacists and experts in data analysis. Once patterns are identified, the Program intervenes to prevent the recurrence of inappropriate prescription drug use.

For example, during 2011/12, the Program identified a rapid increase in the prescribing of benzodiazepines to First Nations and Inuit clients in certain areas. NIHB is investigating this trend and will take appropriate actions as required.

Evaluating Outcomes

The NIHB Program has a range of interventions (e.g. warning codes, NIHB PMP, etc.) aimed at reducing problematic drug use. One of the main areas of concern has been benzodiazepine use. This class of drugs is meant to be a short-term remedy for individuals coping with anxiety or difficulty sleeping. There is little clinical evidence to support their long-term use.

Based on well-documented concerns, the NIHB Program removed a number of long-acting benzodiazepines from its approved Drug Benefit List (DBL) in September 2007. The use of long-acting benzodiazepines in the elderly is of grave concern because of the link to cognitive impairment and serious injuries as a result of falls.

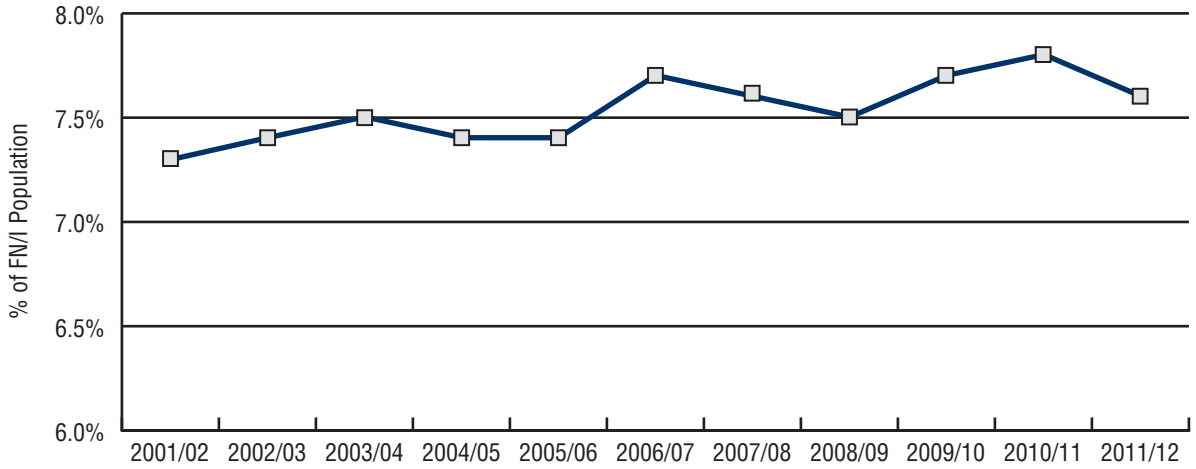
The NIHB Program is continuing its efforts to reduce the use of benzodiazepines, as the percentage of clients accessing this class of drugs continues to rise (Figure 10.2). The number of clients exceeding the maximum recommended daily dose (equivalent to 40 mg per day of diazepam) is shown in Figure 10.3.

In order to reduce the number of clients exceeding the maximum recommended dose of benzodiazepines, the NIHB Program has decreased the Prescription Monitoring Program (PMP) benzodiazepine threshold from 40 mg diazepam equivalent to 30 mg and is also exploring other initiatives to reduce the overall use of this class of drugs.

During 2011/12, the percentage of clients on benzodiazepines decreased but this is likely due to the addition of two large groups of new clients (Bill C-3 Clients and the creation of the Qalipu Mi'kmaq band) rather than the start of a new trend.

FIGURE 10.2

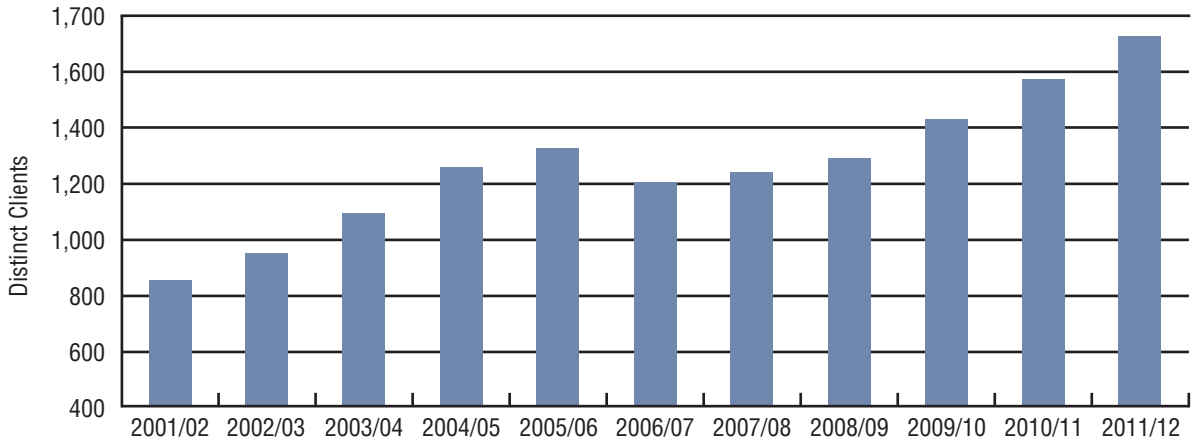
Percentage of Clients Receiving Benzodiazepines
2001/02 to 2011/12



Source: HICPS adapted by Benefit Management Division

FIGURE 10.3

Number of Clients Exceeding the Maximum Recommended Dose of Benzodiazepines (Equivalent to 40 mg of diazepam)
2001/02 to 2011/12



Source: HICPS adapted by Benefit Management Division

To evaluate the impact of the warning message to pharmacists, the NIHB Program has measured the number and percentage of clients who accessed three or more benzodiazepines, three or more opioids, or opioids in conjunction with methadone treatment. Utilization of these medications at these thresholds of concern continued to remain low in 2011/12 (Figure 10.4).

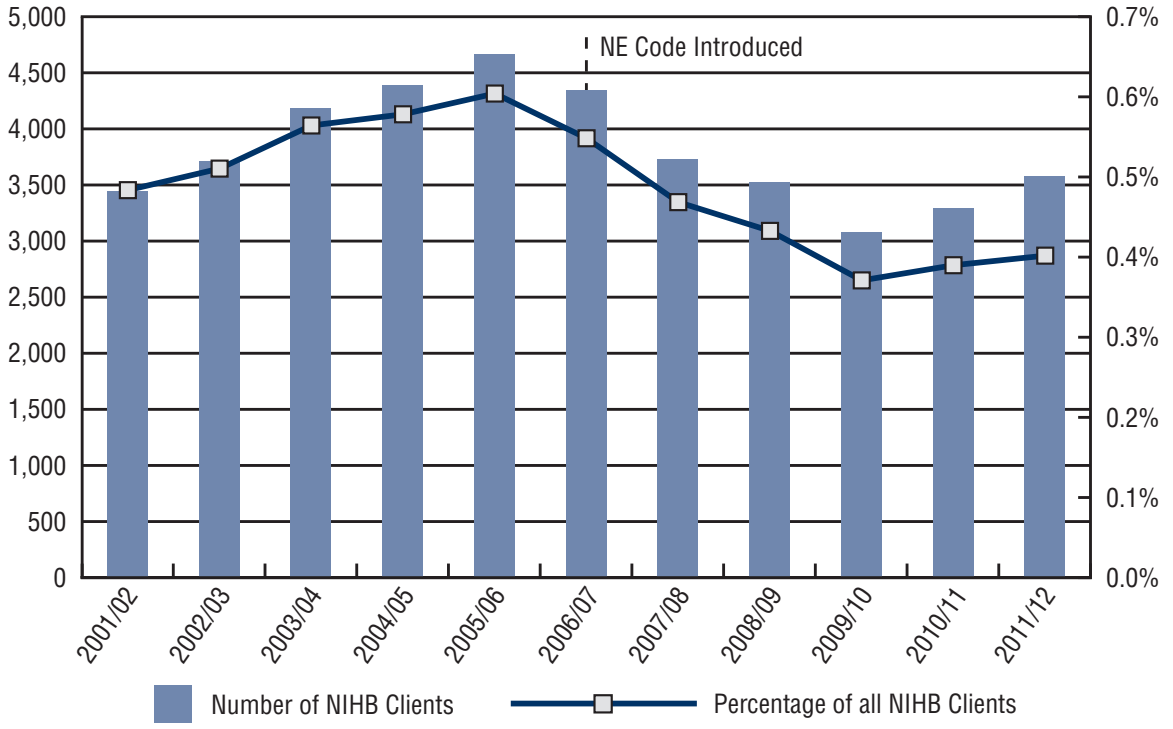
While the percentage of clients who have concurrent claims for opioids, benzodiazepines and methadone is low (less than 1%), there are still 3,500 doing so. NIHB will continue to monitor concurrent use of these pharmacy benefits and explore options to reduce the number of clients on these drugs.

FIGURE 10.4

Measuring the Impact of the NE Code

The number and percentage of clients claiming 3 or more benzodiazepines, 3 or more opioids, or opioids in association with methadone

2001/02 to 2011/12



Source: HICPS adapted by Benefit Management Division

Strategy #3: Evaluations and Recommendations from Independent Experts

For a number of years, the NIHB Program has relied on the advice of two committees: the Drug Use Evaluation Advisory Committee (DUEAC) which was focused on client safety issues; and the Pharmacy and Therapeutics (P&T) Committee which was focused on making drug listings recommendations. These committees have provided the Program with expert advice to help ensure that drugs listed on the Drug Benefit List (DBL) are cost effective, listed in a safe manner, and help improve the health outcomes of the NIHB Program clients.

At the end of 2011, the NIHB Program combined these two separate committees into a single one, the Drugs and Therapeutics Advisory Committee (DTAC). Through this amalgamation, the Program is now provided with recommendations on client safety and listing decisions at the same time. DTAC is comprised of qualified health professionals who share their knowledge and provide recommendations to the NIHB Program in an evidence-based manner that reflects current and relevant medical and clinical practices. The DTAC will continue to strengthen client safety initiatives related to the NIHB Drug Use Evaluation Program (DUEP).

Strategy #4: Specific Drug Safety Initiatives

OxyContin/OxyNeo

In February 2012, the NIHB Program changed the listing status of long acting oxycodone (i.e., OxyContin) from Limited Use (LU) benefit to an exception. A new formulation of long acting oxycodone (i.e., OxyNeo) is available, and it too will be approved on an exception basis. After a careful review of the evidence and safety concerns of all long acting opioids, the NIHB Program de-listed long-acting oxycodone; a first among publically funded drug plans in Canada. Both DUEAC and P&T recommended that NIHB delist all long-acting oxycodone products from the NIHB DBL based on two factors: the patterns of frequent client utilization; and a lack of evidence to demonstrate long acting oxycodone as being more effective than other long acting opioids.

As of July 2012, all other public drug plans in Canada, with the exception of Alberta and Quebec, have followed NIHB and have delisted long acting oxycodone. Alberta Health provides coverage for OxyContin/OxyNeo without restriction. In Québec, the Régie de l'assurance maladie du Québec (RAMQ) has changed coverage status for OxyContin/OxyNeo from open benefit to listed with criteria.

Methadone in Atlantic Canada

Methadone is a synthetic opioid that can be used to treat chronic pain but is predominantly used to treat opioid dependence. The drug has been nationally available to NIHB clients as an open benefit for the treatment of opioid dependence since October 1, 2003. In response to growing concern over methadone use in the Maritimes, the NIHB Program imposed criteria on clients requesting methadone in the Atlantic provinces. Pharmacy benefits other than these can be prescribed by any other licensed practitioner.

Effective August 2011 in New Brunswick, and March 2012 in the rest of the Atlantic Canada, NIHB began approving coverage for methadone provided the client was at least 16 years of age and both the client and their methadone prescriber agree that only that prescriber will be entitled to prescribe methadone, opioids or benzodiazepines to the client. Coverage for other pharmacy benefits will be approved when they are prescribed by another physician.

Suboxone

Suboxone, introduced to Canada in 2007, is a combination drug product (buprenorphine + naloxone) used for the treatment of opioid dependence in adults. Suboxone is considered an alternative to methadone for the treatment of opioid dependency.

In November 2011, the NIHB Program listed Suboxone as a limited use drug for NIHB clients with a contraindication to methadone (i.e. clients with QT prolongation – increased risk of heart arrhythmia). Requests for Suboxone other than for QT prolongation are considered on a case-by-case basis and are subject to specific criteria. Coverage for methadone, opioids, benzodiazepine and stimulants are restricted for clients who receive Suboxone.

CONCLUSION

The NIHB Program is taking an active, evidence-based approach to further develop client safety activities. This approach stresses the appropriate use of medications with a view to achieving the best possible health outcomes for the NIHB Program's First Nations and Inuit clients. Significant interventions are now in place and the NIHB Program is committed to monitoring and measuring the impact of these interventions and working with expert advisors, stakeholders, and other key players to identify further improvements to the NIHB client safety regime.

With the First Nations and Inuit population growing twice as fast as the total Canadian population, and with the addition of the new Qalipu Mi'kmaq First Nations and Bill C-3 clients, the NIHB Program has experienced yearly increases in utilization rates, particularly for prescription medications. The Program has taken steps to confine and reduce the inappropriate use of medications; however, the trend is toward an increase of the use of benzodiazepines drugs. The Program is actively working on strategies to reverse this trend.

The NIHB Program remains committed to ongoing evaluations of its client safety regime and will continue to report on these issues on an annual basis by way of the *Non-Insured Health Benefits Annual Report*.

DENTAL BENEFIT

One of the objectives of the NIHB Program dental benefit is to provide dental services based on evidence-based standards of care and professional judgment, consistent with current best practices of health services delivery.

The *NIHB Sedation and General Anaesthesia Policy* is one example of the Program's commitment to client safety. This service, along with the associated dental services performed under sedation and general anaesthesia requires predetermination, and approval prior to commencement of treatment. Coverage for sedation and general anaesthesia services is provided with a frequency of once in a twelve month period. In extenuating circumstances, additional sessions would be considered for coverage. This policy, while respecting the professional expertise of dental providers, encourages the minimal risk approach to the use of sedation and general anaesthesia in conjunction with associated dental services.

Another measure the NIHB Program has in place to ensure client safety is the enrollment of dental providers. The Program requires that dental providers are licensed and in good standing with their respective provincial or territorial regulatory body and as such, are servicing eligible NIHB clients under the adherence of legal and ethical obligations of those agreements.

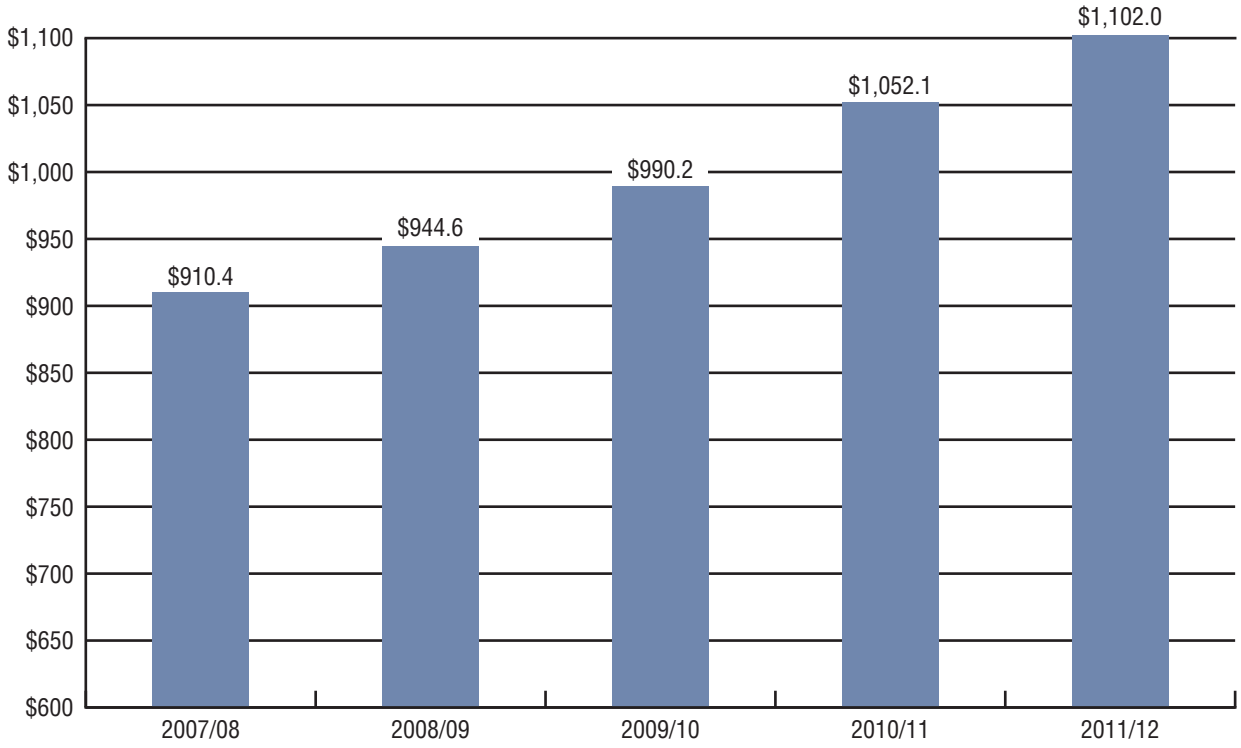
The NIHB Program is taking an active evidence-based approach to further develop client safety within the dental benefit policies. This approach stresses the appropriate use of dental services with a view of achieving the best possible health outcomes for eligible First Nations and Inuit clients. The NIHB Program is committed to monitoring the impact of these policies and working with expert advisors, stakeholders, and other key players to identify further improvements to the NIHB client safety measures.

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 11.1

Non-Insured Health Benefits Program Resources ($ Millions)
2007/08 to 2011/12



Source: Main Estimates

In 2011/12, total resources available to the NIHB Program were $1,102.0 million. This represented a 4.7% increase over the $1,052.1 million in available funds in 2010/11.

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 approximately 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 11.2

Non-Insured Health Benefits Administration Costs ($ 000's)
2011/12

Figure 11.2 provides the Program administration funds expended by each region as well as NIHB headquarters (HQ) in Ottawa. In 2011/12, total NIHB administration costs were $52.9 million representing an increase of $2.1 million or 4.2% over the previous fiscal year.

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 the 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, medical supplies and equipment, dental, vision benefits, and short-term crisis intervention mental health 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	Saskatchewan	Alberta	British Columbia	Northern Region	HQ	Total
Salaries	$ 1,454	$ 1,835	$ 3,153	$ 2,726	$ 1,960	$ 2,730	$ 1,411	$ 1,342	$ 8,482	$ 25,092
Capital	0	0	0	0	0	124	0	0	0	124
EBP	291	367	631	545	392	546	282	268	1,696	5,018
Operating	150	205	524	203	42	354	113	217	1,753	3,561
Sub Total	**$ 1,895**	**$ 2,406**	**$ 4,308**	**$ 3,474**	**$ 2,394**	**$ 3,754**	**$ 1,807**	**$ 1,827**	**$ 11,931**	**$ 33,796**
Claims Processing Contract Costs										**$ 19,090**
Total Administration Costs										**$ 52,886**

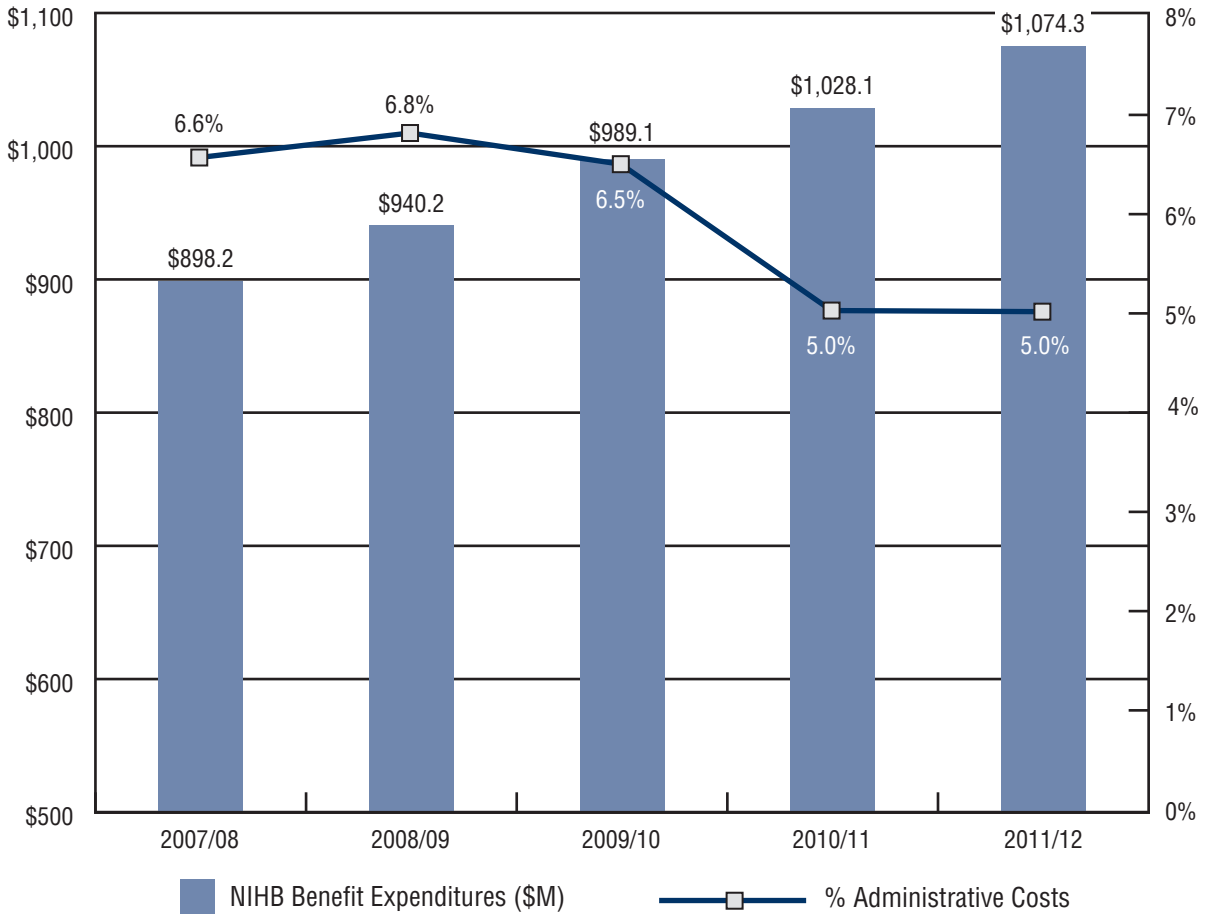
Source: FIRMS adapted by Program Analysis Division

FIGURE 11.3

Non-Insured Health Benefits Administration Costs as a Proportion of Benefit Expenditures ($ Millions)
2007/08 to 2011/12

Figure 11.3 provides the percentage of NIHB Program administrative costs as a proportion of overall NIHB benefit expenditures. In 2011/12, total NIHB expenditures were $1,074.3 million, of which actual benefit expenditures totaled $1,055.2 million and expenditures for claims processing administration amounted to $19.1 million. An additional $33.8 million in expenditures for salaries associated with Program administration are reported separately from total program expenditures. As a result, total NIHB Program administration cost ($52.9 million) as a proportion of actual benefit expenditures ($1,055.2 million) was 5.0% in 2011/12.

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 6.8% in 2008/09 to a low of 5.0% in 2010/11 and 2011/12.



Source: FIRMS adapted by Program Analysis Division

Technical Notes

SECTION 12

Information contained in the 2011/12 NIHB Annual Report has been extracted from several databases. 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. 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.

Population Data

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 Aboriginal Affairs and Northern Development Canada (AANDC). 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.

Pharmacy and Dental Data

Two Health Canada data systems provide information on the expenditures and utilization of the NIHB Pharmacy and Dental benefits. 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 utilization of the pharmacy (including Medical Supplies and Equipment) and dental benefit areas.

Medical Transportation Data

Medical transportation financial data 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. In some communities, MTRS is used to collect contribution agreement data, while other communities report data using spreadsheet templates, in-house data management systems, or through 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) was 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 2011/12, a new initiative was commenced to enhance the data collection and improve the reporting capability of MTDS. In addition, steps are currently underway to improve data collection related to contribution agreements.

Vision Care, Other Health Care and Premiums Data

Financial data on the NIHB vision care, other health care and premiums benefits are provided through the Framework for Integrated Resource Management System (FIRMS).