Non-Insured Health Benefits Program

First Nations and Inuit Health Branch

Annual Report 2012/2013

Cover Artwork: *Moving away from Umanarjuarq* by Joanasie Papatsie

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Introduction

SECTION 1

During 2012/13, the Non-Insured Health Benefits (NIHB) Program of the First Nations and Inuit Health Branch (FNIHB) at Health Canada provided 926,044 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 nineteenth edition, the 2012/13 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.

SECTION 2

Client Population

Over the last ten years, the NIHB client population has grown at an average annual rate of 2.4%. As of March 31, 2013, there were 926,044 First Nations and Inuit clients registered in the Status Verification System (SVS) and were eligible to receive benefits under the NIHB Program. Of the 926,044 total eligible clients at the end of the 2012/13 fiscal year, 883,133 (95.4%) were First Nations clients while 42,911 (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 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, 2013, a total of 26,142 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 (8,008), Quebec (4,952) and British Columbia (3,883).

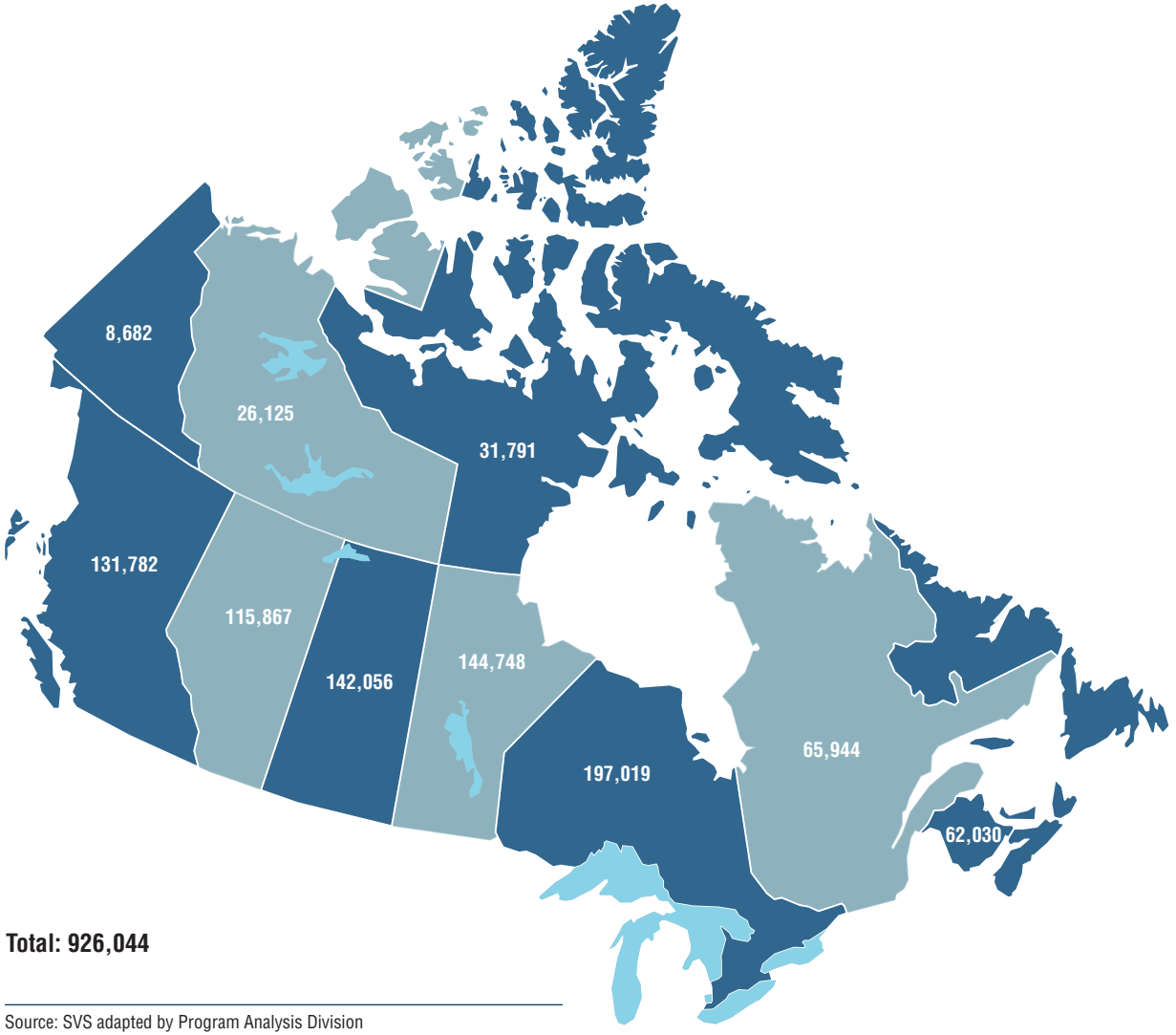
The creation of the new Qalipu Mi'kmaq First Nations band was announced on September 26, 2011, as a result of a settlement agreement that was negotiated between the Government of Canada and the Federation of Newfoundland Indians (FNI). Through the formation of this band, the Qalipu Mi'kmaq became recognized as a band under the *Indian Act*. As of March 31, 2013, a total of 23,856 new Qalipu clients were registered in the SVS and were eligible to receive benefits through the NIHB Program.

FIGURE 2.1

Eligible Client Population by Region
March 2013

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 2013 was 926,044, an increase of 3.3% from March 2012. This significant population growth can be attributed to the increase in registration of Bill C-3 clients from 12,875 in March 2012 to 26,142 in March 2013. This trend is expected to continue through the next fiscal year, as approximately 20,000 new C-3 client registrations remain to be processed. Another significant increase in population is attributable to the new Qalipu Mi'kmaq First Nations who became eligible to receive benefits, representing an increase from 21,419 in March 2012 to 23,856 in March 2013. If these new clients were not included in the overall 2011/12 and 2012/13 NIHB client population, the annual growth rate would have been 1.6%.

The Ontario Region had the largest proportion of eligible population, representing 21.3% of the national total, followed by the Manitoba Region at 15.6% and the Saskatchewan Region at 15.3%.



Total: 926,044

Source: SVS adapted by Program Analysis Division

FIGURE 2.2

Eligible Client Population by Type and Region
March 2012 and March 2013

REGION	First Nations		Inuit		TOTAL		% Change
	March 2012	March 2013	March 2012	March 2013	March 2012	March 2013	2012 to 2013
Atlantic	57,970	61,719	301	311	58,271	62,030	6.5%
Quebec	62,077	64,767	1,132	1,177	63,209	65,944	4.3%
Ontario	189,309	196,406	594	613	189,903	197,019	3.7%
Manitoba	140,823	144,571	164	177	140,987	144,748	2.7%
Saskatchewan	138,461	141,998	52	58	138,513	142,056	2.6%
Alberta	111,757	115,343	507	524	112,264	115,867	3.2%
British Columbia	128,359	131,515	238	267	128,597	131,782	2.5%
Yukon	8,341	8,589	89	93	8,430	8,682	3.0%
N.W.T.	17,912	18,224	7,500	7,901	25,412	26,125	2.8%
Nunavut	0	1	31,038	31,790	31,038	31,791	2.4%
National	**855,009**	**883,133**	**41,615**	**42,911**	**896,624**	**926,044**	**3.3%**

Source: SVS adapted by Program Analysis Division

Of the 926,044 total eligible clients at the end of the 2012/13 fiscal year, 883,133 (95.4%) were First Nations clients while 42,911 (4.6%) were Inuit clients.

As of March 31, 2013, the SVS population statistics reflect a 3.3% growth rate. This growth rate is higher than the 10 year average growth rate of 2.4% but is a decrease in growth compared to the 6.0% recorded in the previous year. This increase (3.3%) over the previous fiscal year can be attributed to the registration of new Bill C-3 clients and the Qalipu Mi'kmaq First Nations as status Indians.

The number of First Nations clients increased by 3.3% while the number of Inuit clients increased by 3.1% over the previous year.

From March 2012 to March 2013, the Atlantic Region had the highest percentage change in total eligible clients with a 6.5% increase. This increase is mainly attributed to the registration of an additional 2,437 new Qalipu Mi'kmaq First Nations clients. If these new clients are excluded from the 2012/13 population in the Atlantic Region, population growth in this region would have been 2.3%. The Quebec and Ontario regions also had high growth rates at 4.3% and 3.7%, respectively.

QUICK FACT

The share of NIHB client population under 20 years of age (34.2%) is high compared to the overall Canadian population (22.4%). There is a much higher percentage of seniors (65 and over) in the Canadian population (14.9%) than in the NIHB client population (6.8%). The average age of NIHB clients is 32, which is well below the Canadian average of 40.

FIGURE 2.3

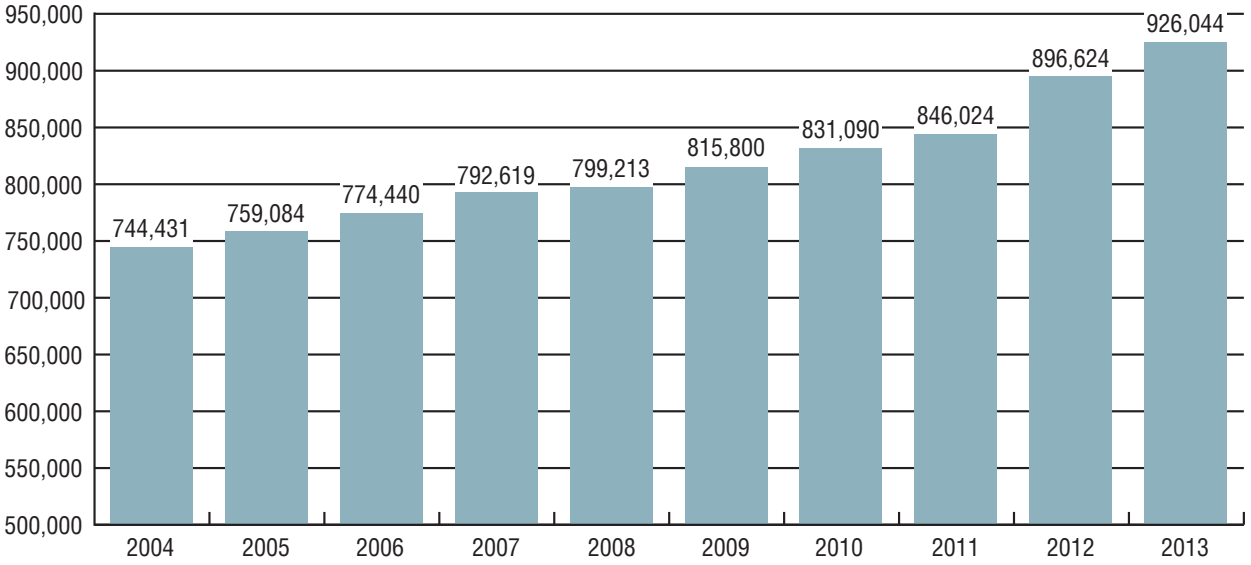
Eligible Client Population

Over the past 10 years, the total number of eligible clients in the SVS has increased by 24.4%, from 744,431 in March 2004 to 926,044 in March 2013.

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 13.5% from 815,800 in March 2009 to 926,044 in March 2013. The Atlantic Region had the largest increase in eligible clients over this period, with a growth rate of 81.7%. However, this significant increase can be attributed to the registration of 23,856 new Qalipu Mi'kmaq First Nations clients during fiscal year 2011/12 and 2012/13. If these clients are excluded from the population in the Atlantic Region, population growth over the past five years in this region would have been 11.8%. The regions of Quebec, Alberta, and Ontario followed with growth rates of 13.6%, 11.7% and 11.7% respectively.

Eligible Client Population, March 2004 to March 2013



Source: SVS adapted by Program Analysis Division

Eligible Client Population by Region, March 2009 to March 2013

REGION	March 2009	March 2010	March 2011	March 2012	March 2013
Atlantic	34,141	34,615	35,269	58,271	62,030
Quebec	58,028	58,802	59,659	63,209	65,944
Ontario	176,401	179,641	182,900	189,903	197,019
Manitoba	131,363	134,224	137,212	140,987	144,748
Saskatchewan	129,315	132,141	134,633	138,513	142,056
Alberta	103,716	105,932	107,839	112,264	115,867
British Columbia	121,053	122,989	124,988	128,597	131,782
Yukon	7,999	8,087	8,168	8,430	8,682
N.W.T.	24,644	24,991	25,236	25,412	26,125
Nunavut	29,140	29,668	30,120	31,038	31,791
Total	**815,800**	**831,090**	**846,024**	**896,624**	**926,044**
Annual % Change	**2.1%**	**1.9%**	**1.8%**	**6.0%**	**3.3%**

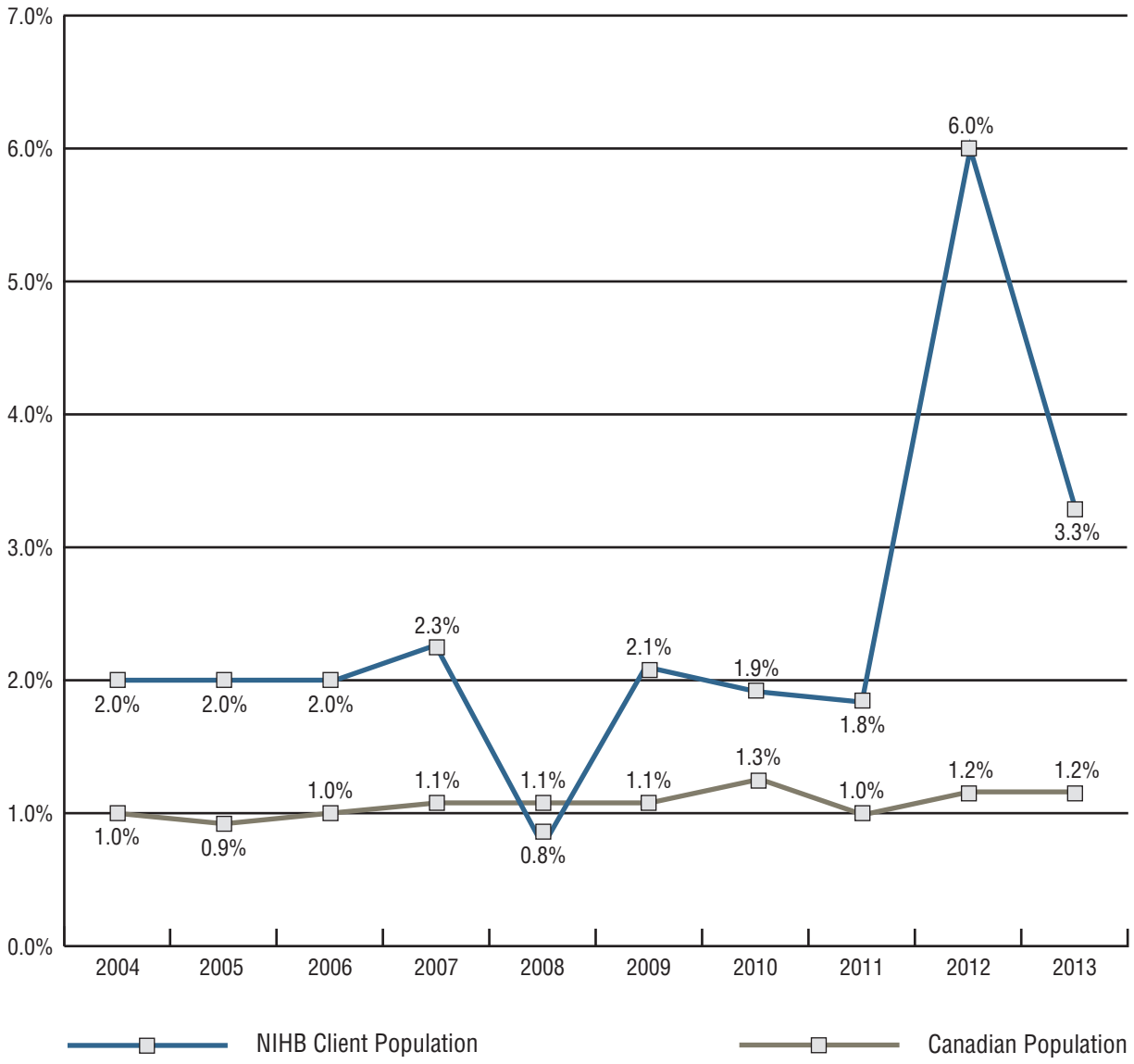
Source: SVS adapted by Program Analysis Division

FIGURE 2.4

Annual Population Growth, Canadian Population and Eligible Client Population
2004 to 2013

From 2004 to 2013, the Canadian population increased by 10.3% while the NIHB eligible First Nations and Inuit client population increased by 24.4%. Over the same period, the First Nations and Inuit client population grew at an average annual rate of 2.4% 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 the registration of new Qalipu and Bill C-3 First Nation clients.

The higher than average NIHB Program client population growth rate of 3.3% in 2012/13 can be attributed to the continued registration of new Bill C-3 clients as status Indians, and to new Qalipu Mi'kmaq First Nations clients in the Atlantic Region. If these clients were not included in the overall 2011/12 and 2012/13 population counts, the growth rate would have been 1.6%, which is lower than the population trends of previous years.



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 2013

Of the 926,044 NIHB eligible clients on the SVS as of March 31, 2013, 49.1% were male (455,078) and 50.9% were female (470,966).

The average age of the eligible client population was 32 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 Yukon and Quebec Region.

The average age of the male and female eligible client population was 31 years and 33 years respectively. The average age for males ranged from a low of 26 years in Nunavut to a high of 35 years in the Quebec Region and the Yukon. The average age for females varied from a low of 26 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 (65.6%) under the age of 40. Of the total population, over one-third (34.2%) are under the age of 20.

The seniors' population (clients 65 years of age and over) has been slowly increasing as a proportion of the total NIHB client population. In 2003/04, seniors represented 5.4% of the overall NIHB population. Most recently in 2012/13, seniors accounted for 6.8%. This demographic trend will contribute 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	1,566	1,522	3,088	1,731	1,651	3,382	5,130	5,009	10,139	6,333	6,121	12,454
5-9	2,607	2,395	5,002	2,523	2,264	4,787	7,263	6,826	14,089	8,021	7,798	15,819
10-14	2,564	2,574	5,138	2,406	2,365	4,771	7,497	7,288	14,785	7,425	7,090	14,515
15-19	2,794	2,761	5,555	2,798	2,695	5,493	8,669	8,300	16,969	7,613	7,261	14,874
20-24	2,847	2,745	5,592	2,834	2,720	5,554	8,676	8,395	17,071	7,264	7,253	14,517
25-29	2,410	2,339	4,749	2,348	2,455	4,803	7,615	7,432	15,047	5,935	5,682	11,617
30-34	2,231	2,277	4,508	2,240	2,150	4,390	6,858	7,157	14,015	4,952	4,789	9,741
35-39	2,118	2,165	4,283	2,095	2,149	4,244	6,706	6,661	13,367	4,658	4,602	9,260
40-44	2,328	2,335	4,663	2,247	2,311	4,558	6,975	7,215	14,190	4,593	4,835	9,428
45-49	2,199	2,288	4,487	2,324	2,620	4,944	7,188	7,364	14,552	4,393	4,545	8,938
50-54	1,936	2,210	4,146	2,310	2,472	4,782	6,561	7,380	13,941	3,551	3,832	7,383
55-59	1,596	1,934	3,530	1,794	2,286	4,080	5,168	6,231	11,399	2,521	2,907	5,428
60-64	1,173	1,467	2,640	1,359	1,628	2,987	3,732	4,656	8,388	1,738	2,013	3,751
65+	1,993	2,656	4,649	2,793	4,376	7,169	7,605	11,462	19,067	2,990	4,033	7,023
Total	**30,362**	**31,668**	**62,030**	**31,802**	**34,142**	**65,944**	**95,643**	**101,376**	**197,019**	**71,987**	**72,761**	**144,748**
Average Age	33	35	34	35	38	36	34	37	35	28	30	29

Source: SVS adapted by Program Analysis Division

REGION	Saskatchewan			Alberta			British Columbia			Yukon			N.W.T.			Nunavut			TOTAL		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	5,607	5,428	11,035	5,099	4,822	9,921	3,574	3,378	6,952	221	185	406	798	736	1,534	1,875	1,849	3,724	31,934	30,701	62,635
5-9	7,855	7,722	15,577	6,374	6,307	12,681	5,412	5,144	10,556	279	252	531	1,025	991	2,016	1,966	1,866	3,832	43,325	41,565	84,890
10-14	7,441	7,214	14,655	6,007	5,639	11,646	5,111	5,114	10,225	314	294	608	970	1,007	1,977	1,805	1,666	3,471	41,540	40,251	81,791
15-19	7,433	7,435	14,868	6,260	5,860	12,120	5,724	5,388	11,112	371	349	720	1,304	1,256	2,560	1,684	1,670	3,354	44,650	42,975	87,625
20-24	7,621	7,348	14,969	5,946	5,773	11,719	6,294	5,718	12,012	369	377	746	1,429	1,410	2,839	1,646	1,546	3,192	44,926	43,285	88,211
25-29	6,270	6,238	12,508	5,000	4,883	9,883	5,576	5,433	11,009	361	342	703	1,187	1,129	2,316	1,291	1,324	2,615	37,993	37,257	75,250
30-34	5,189	5,110	10,299	4,141	4,264	8,405	4,963	4,776	9,739	329	314	643	978	951	1,929	1,075	1,055	2,130	32,956	32,843	65,799
35-39	4,561	4,685	9,246	3,675	3,731	7,406	4,538	4,530	9,068	288	287	575	812	882	1,694	929	928	1,857	30,380	30,620	61,000
40-44	4,534	4,775	9,309	3,516	3,637	7,153	4,641	4,748	9,389	372	306	678	1,021	994	2,015	949	950	1,899	31,176	32,106	63,282
45-49	4,079	4,349	8,428	3,232	3,542	6,774	4,601	5,001	9,602	417	378	795	891	958	1,849	861	886	1,747	30,185	31,931	62,116
50-54	3,275	3,655	6,930	2,662	3,042	5,704	4,465	4,997	9,462	350	360	710	720	855	1,575	584	621	1,205	26,414	29,424	55,838
55-59	2,234	2,643	4,877	1,852	2,283	4,135	3,321	3,960	7,281	219	262	481	462	642	1,104	407	428	835	19,574	23,576	43,150
60-64	1,508	1,861	3,369	1,216	1,645	2,861	2,372	2,798	5,170	133	214	347	397	469	866	355	325	680	13,983	17,076	31,059
65+	2,461	3,525	5,986	2,251	3,208	5,459	4,252	5,953	10,205	293	446	739	818	1,033	1,851	586	664	1,250	26,042	37,356	63,398
Total	**70,068**	**71,988**	**142,056**	**57,231**	**58,636**	**115,867**	**64,844**	**66,938**	**131,782**	**4,316**	**4,366**	**8,682**	**12,812**	**13,313**	**26,125**	**16,013**	**15,778**	**31,791**	**455,078**	**470,966**	**926,044**
Average Age	28	29	28	28	29	29	33	35	34	35	37	36	32	33	33	26	26	26	31	33	32

FIGURE 2.6

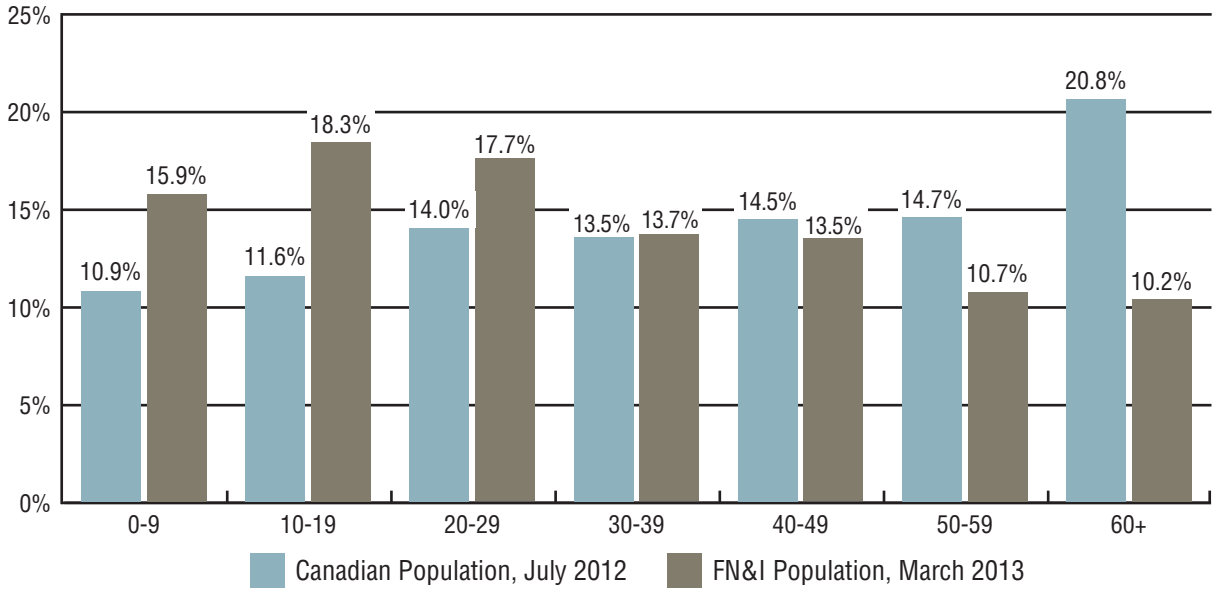
Population Analysis by Age Group

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 34.2% compared to 22.4% of the same age group in the Canadian population. The average age of First Nations and Inuit clients is 32 compared to 40 years of age for the Canadian population.

A comparison of March 2009 to March 2013 eligible client population shows an aging population. The client population 40 and above increased by 21.9% from 261,534 in 2009 to 318,843 in 2013. As a proportional share of the overall client population, this group increased from 32.1% in 2009 to 34.4% in 2013.

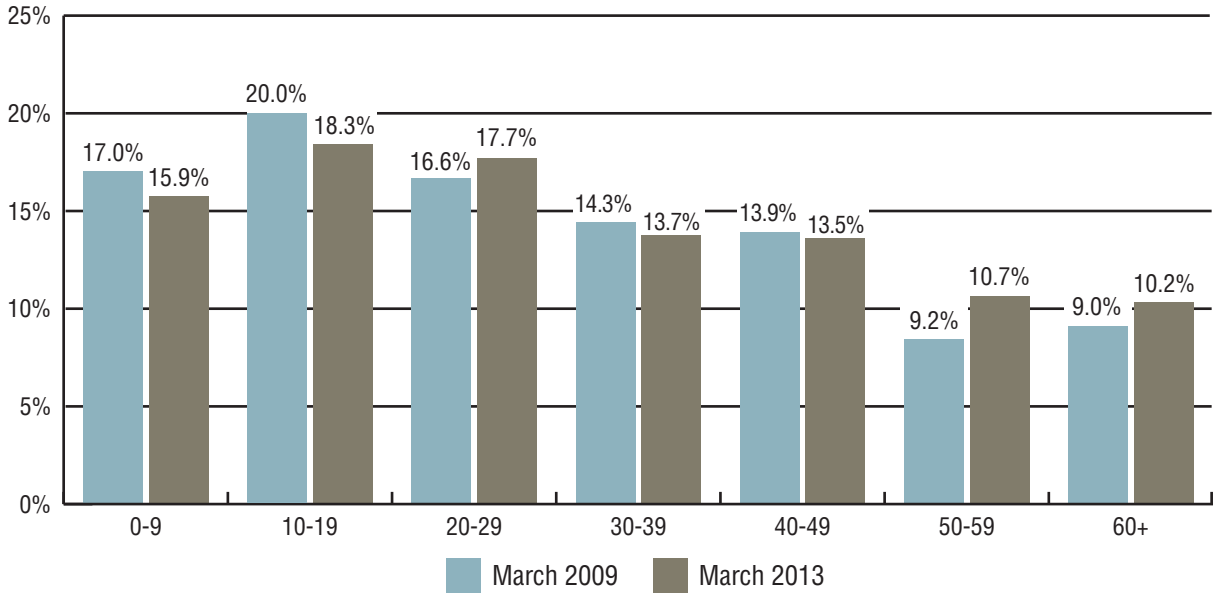
As the First Nations and Inuit client population ages, the costs associated with delivering Non-Insured Health Benefits, particularly pharmacy benefits, to this client population are expected to increase significantly.

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

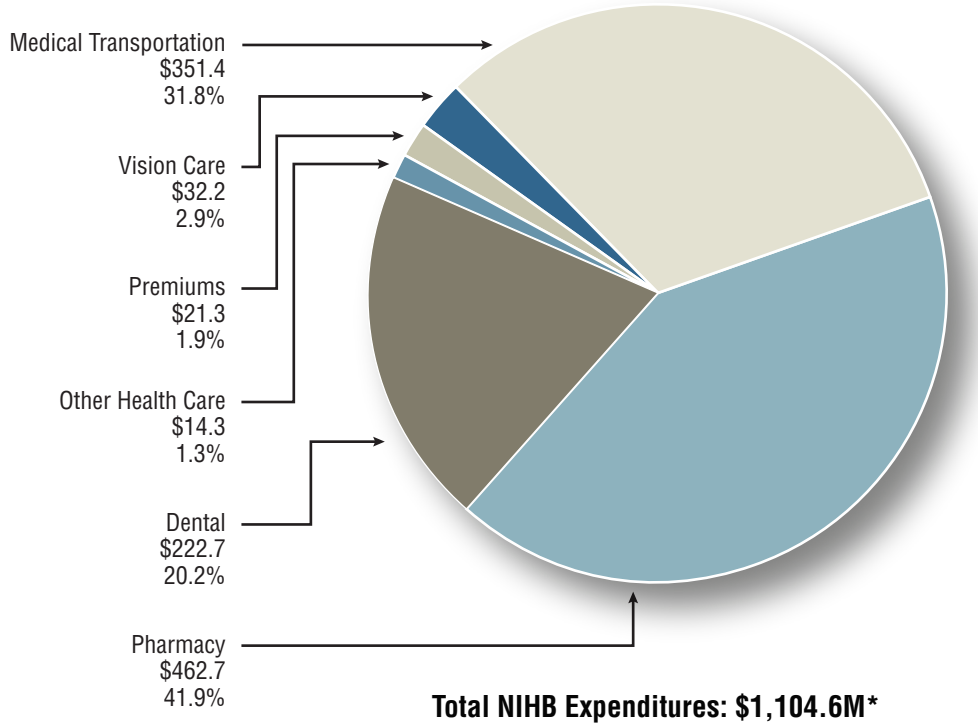
FIGURE 3.1

NIHB Expenditures by Benefit ($ Millions)
2012/13

The Non-Insured Health Benefits (NIHB) Program provides coverage for 926,044 (as of March 31, 2013) 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 that of other Canadians.

In 2012/13, total NIHB expenditures were $1,104.6 million. Of this total, pharmacy costs (including medical supplies and equipment) represented the largest proportion at $462.7 million (41.9%), followed by medical transportation costs at $351.4 million (31.8%) and dental costs at $222.7 million (20.2%).

NIHB Pharmacy, Dental and Medical Transportation benefit expenditures accounted for 93.9% of total NIHB expenditures in 2012/13.



Source: FIRMS adapted by Program Analysis Division

* Not reflected in the $1,104.6 million in NIHB expenditures is approximately $34.5 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
2011/12 and 2012/13

BENEFIT	Total Expenditures ($ 000's) 2011/12	Total Expenditures ($ 000's) 2012/13	% Change From 2011/12
Medical Transportation	$ 333,304	$ 351,424	5.4%
Pharmacy	459,359	462,699	0.7%
Dental	219,057	222,706	1.7%
Other Health Care	12,936	14,337	10.8%
Premiums	19,868	21,257	7.0%
Vision Care	29,780	32,167	8.0%
Total Expenditures	**$ 1,074,304**	**$ 1,104,591**	**2.8%**

Source: FIRMS adapted by Program Analysis Division

Overall NIHB Program expenditures increased 2.8% or $30.3 million from 2011/12 to 2012/13. This growth is lower than the 4.5% annual growth increase recorded in 2011/12.

The highest net growth in expenditures over fiscal year 2011/12 was medical transportation benefits at $18.1 million, followed by dental benefits which increased by $3.6 million.

The NIHB Other Health Care category had the highest growth rate in 2012/13, recording an increase of 10.8% over the previous year. The NIHB Vision Care category had the second highest growth rate at 8.0%, followed by British Columbia Health Care Premiums at 7.0%.

NIHB Pharmacy benefit expenditures had the lowest growth rate in 2012/13 at 0.7%. This increase was the lowest annual growth rate recorded for pharmacy benefits over the past 20 years. This lower growth can be attributed to provincial pricing policies that have resulted in reduced costs for generic drugs, and from the introduction of new generic drugs throughout the year (e.g., Lipitor, Crestor).

NIHB Dental benefit expenditures recorded the second lowest growth rate at 1.7% in 2012/13. The lower than anticipated increase can be attributed, in part, to a backlog in processing of predetermination claims as a result of centralization of services. As part of the Government of Canada's Economic Action Plan 2012, the NIHB Program centralized the processing of dental predetermination (PD) services at NIHB Headquarters in Ottawa. Processing of dental predetermination requests and related services have been transferred from the Health Canada Regional Offices (with the exception of the British Columbia Region) to Ottawa in a phased approach, which began in September 2012 and concluded in September 2013.

FIGURE 3.3

NIHB Expenditures by Benefit and Region ($ 000's)
2012/13

The Manitoba Region accounted for the highest proportion of total expenditures at $228.3 million, or 20.7% of the national total, followed by the Ontario Region at $186.5 million (16.9%), and the Saskatchewan Region at $163.4 million (14.8%).

In comparison, the lowest expenditures were in the Yukon ($10.7 million) and the Northwest Territories ($27.8 million). These totals represented 1.0% and 2.5% respectively of the national total.

The Atlantic Region experienced the highest expenditure growth rate over the last fiscal year at 16.7%. This increase in expenditures can be attributed to the registration of 23,856 Qalipu Mi'kmaq First Nations clients since the creation of the Qalipu Mi'kmaq First Nations band in September 2011. Clients who became eligible with the NIHB Program have steadily increased utilization of eligible NIHB benefits in 2012/13.

Headquarters expenditures represent costs paid for claims processing services and account for 1.7% ($18.5 million) of NIHB expenditures. This figure does not include the $12.5 million in Headquarters administrative costs outlined in Figure 11.2

REGION	Medical Transportation	Pharmacy	Dental	Other Health Care	Premiums	Vision Care	TOTAL
Atlantic	$ 6,875	$ 29,979	$ 9,660	$ 512	$ -	$ 2,969	**$ 49,995**
Quebec	22,578	40,393	15,239	1,135	-	1,570	**80,915**
Ontario	59,251	77,131	42,259	2,490	-	5,412	**186,544**
Manitoba	109,409	80,676	30,734	3,429	-	4,048	**228,295**
Saskatchewan	45,793	74,646	36,219	1,038	-	5,676	**163,372**
Alberta	39,216	60,584	34,501	4,791	-	5,836	**144,928**
British Columbia	26,573	59,858	31,543	940	21,257	3,285	**143,455**
Yukon	3,909	3,994	2,486	4	-	327	**10,719**
N.W.T.	10,157	8,999	7,244	-	-	1,368	**27,769**
Nunavut	27,661	10,690	10,043	-	-	1,675	**50,069**
Headquarters	-	15,749	2,779	-	-	-	**18,529**
Total	**$ 351,424**	**$ 462,699**	**$ 222,706**	**$ 14,337**	**$ 21,257**	**$ 32,167**	**$ 1,104,591**

Source: FIRMS adapted by Program Analysis Division

FIGURE 3.4

Proportion of NIHB Expenditures by Region
2012/13

In 2012/13, the Manitoba Region had the highest proportion of total NIHB expenditures (20.7%) and accounted for 31.1% 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 17.4%, followed by the Ontario Region at 16.7% and the Saskatchewan Region at 16.1%.

The Ontario Region, which accounted for 16.9% of total NIHB expenditures in 2012/13, recorded the highest proportion of total NIHB Dental expenditures at 19.0%. This region also accounted for the highest proportion of the total NIHB population at 21.3%.

The proportion of NIHB Vision Care expenditures ranged from a high of 18.1% in the Alberta Region and 17.6% in the Saskatchewan Region to a low of 1.0% in the Yukon.

The Alberta Region (33.4%) and the Manitoba Region (23.9%) combined accounted for over one half of the total NIHB Other Health Care expenditures in 2012/13.

REGION	Medical Transportation	Pharmacy	Dental	Other Health Care	Premiums	Vision Care	Proportion of NIHB Expenditure	Proportion of NIHB Population
Atlantic	2.0%	6.5%	4.3%	3.6%	0%	9.2%	**4.5%**	**6.7%**
Quebec	6.4%	8.7%	6.8%	7.9%	0%	4.9%	**7.3%**	**7.1%**
Ontario	16.9%	16.7%	19.0%	17.4%	0%	16.8%	**16.9%**	**21.3%**
Manitoba	31.1%	17.4%	13.8%	23.9%	0%	12.6%	**20.7%**	**15.6%**
Saskatchewan	13.0%	16.1%	16.3%	7.2%	0%	17.6%	**14.8%**	**15.3%**
Alberta	11.2%	13.1%	15.5%	33.4%	0%	18.1%	**13.1%**	**12.5%**
British Columbia	7.6%	12.9%	14.2%	6.6%	100%	10.2%	**13.0%**	**14.2%**
Yukon	1.1%	0.9%	1.1%	0%	0%	1.0%	**1.0%**	**0.9%**
N.W.T.	2.9%	1.9%	3.3%	0%	0%	4.3%	**2.5%**	**2.8%**
Nunavut	7.9%	2.3%	4.5%	0%	0%	5.2%	**4.5%**	**3.4%**
Headquarters	0%	3.4%	1.2%	0%	0%	0%	**1.7%**	**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
2012/13

At the national level, approximately three-quarters (73.7%) of total Program expenditures occurred in two benefit areas: pharmacy (41.9%) and medical transportation (31.8%). Dental expenditures accounted for one-fifth (20.2%) of total NIHB expenditures.

NIHB Medical Transportation expenditures accounted for over half (55.2%) of total expenditures in Nunavut compared to 13.8% in the Atlantic Region. However, in the Atlantic Region, 60.0% of total expenditures were spent on pharmacy benefits compared to a low of 21.3% in Nunavut.

The proportion of dental expenditures ranged from 13.5% in the Manitoba Region to 26.1% in the Northwest Territories.

Pharmacy costs represented the highest percentage of total expenditures in all regions except in Nunavut, the Northwest Territories 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	13.8%	60.0%	19.3%	1.0%	0%	5.9%	**100%**
Quebec	27.9%	49.9%	18.8%	1.4%	0%	1.9%	**100%**
Ontario	31.8%	41.3%	22.7%	1.3%	0%	2.9%	**100%**
Manitoba	47.9%	35.3%	13.5%	1.5%	0%	1.8%	**100%**
Saskatchewan	28.0%	45.7%	22.2%	0.6%	0%	3.5%	**100%**
Alberta	27.1%	41.8%	23.8%	3.3%	0%	4.0%	**100%**
British Columbia	18.5%	41.7%	22.0%	0.7%	14.8%	2.3%	**100%**
Yukon	36.5%	37.3%	23.2%	0%	0%	3.0%	**100%**
N.W.T.	36.6%	32.4%	26.1%	0%	0%	4.9%	**100%**
Nunavut	55.2%	21.3%	20.1%	0%	0%	3.3%	**100%**
Headquarters	0%	85.0%	15.0%	0%	0%	0%	**100%**
National	**31.8%**	**41.9%**	**20.2%**	**1.3%**	**1.9%**	**2.9%**	100%

Source: FIRMS adapted by Program Analysis Division

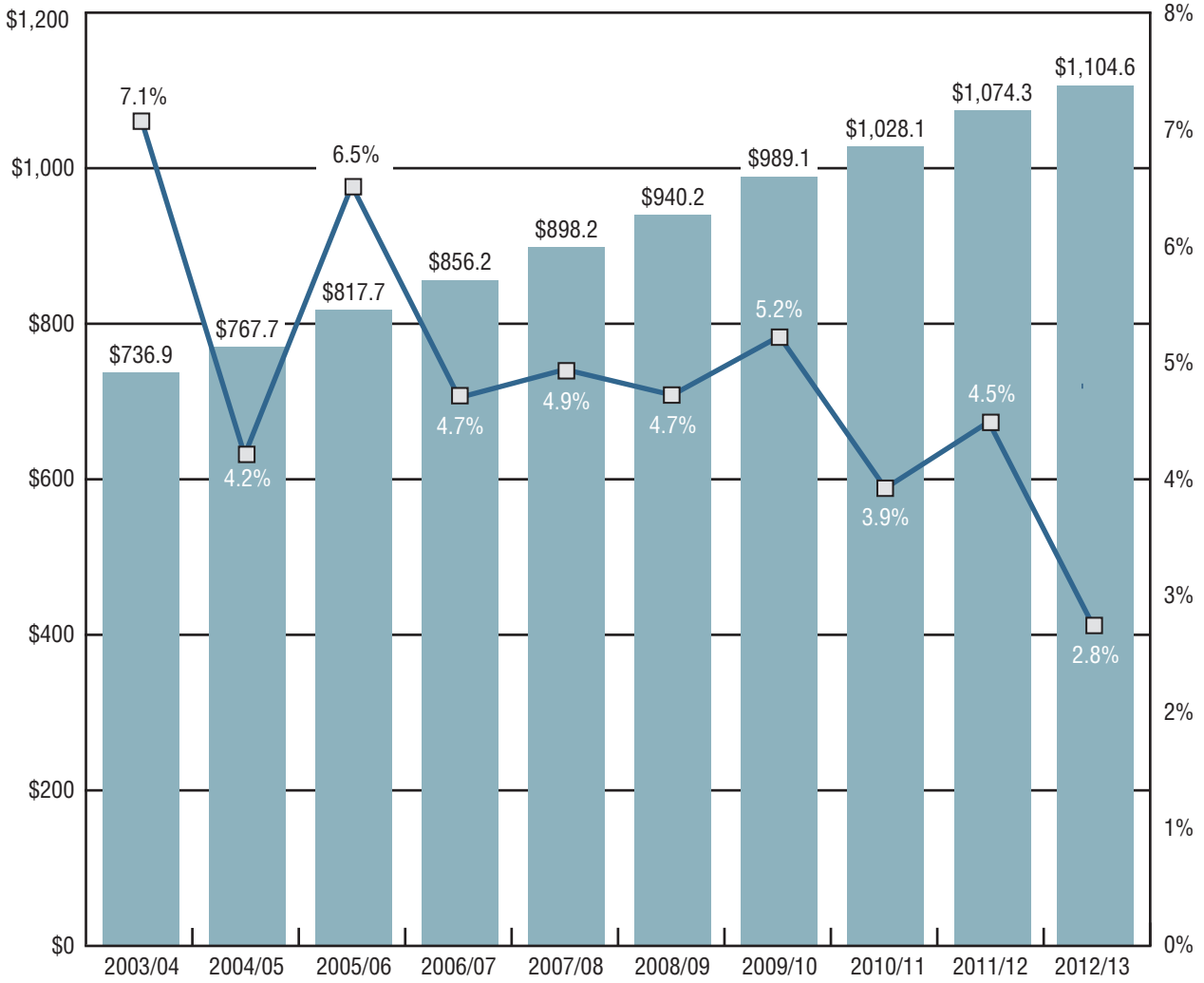
FIGURE 3.6

NIHB Annual Expenditures ($ Millions) and Percentage Change
2003/04 to 2012/13

In 2012/13, NIHB Program expenditures totalled $1,104.6 million, an increase of 2.8% from $1,074.3 million in 2011/12. Since 2003/04, total expenditures have grown by 49.9%. The annualized rate of growth over this period was 4.8%.

There has been wide variation in growth rates between 2003/04 and 2012/13, with a low of 2.8% in 2012/13 to a high of 7.1% in 2003/04.

Fluctuations in NIHB expenditure growth rates are impacted by several factors. Policy changes designed to improve access to the Program and those intended to promote Program sustainability affect NIHB expenditure growth rates. For example, 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. Another factor impacting growth is the centralization of dental benefits. Beginning in September 2012 (and concluding in September 2013), the NIHB Program centralized the processing of dental predetermination (PD) services at NIHB Headquarters in Ottawa. The goal of centralization is to gain efficiencies through consolidation of services and improve consistency in the adjudication of dental benefits. In addition, 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)
2003/04 to 2012/13

In the period from 2003/04 to 2012/13, the expenditures for NIHB Dental and Medical Transportation benefits have grown more than other benefit areas. NIHB Medical Transportation expenditures grew by 70.8% from $205.8 million in 2003/04 to $351.4 million in 2012/13. NIHB Dental expenditures rose by 65.6% from $134.5 million in 2003/04 to $222.7 million in 2012/13.

Over the same period, NIHB Pharmacy expenditures increased by 41.5% and NIHB Vision Care expenditures had an increase of 31.7%.

NIHB Other Health Care expenditures, comprised mainly of short-term crisis intervention mental health counselling, decreased by 13.4% over this same time period from $16.6 million in 2003/04 to $14.3 million in 2012/13. 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.

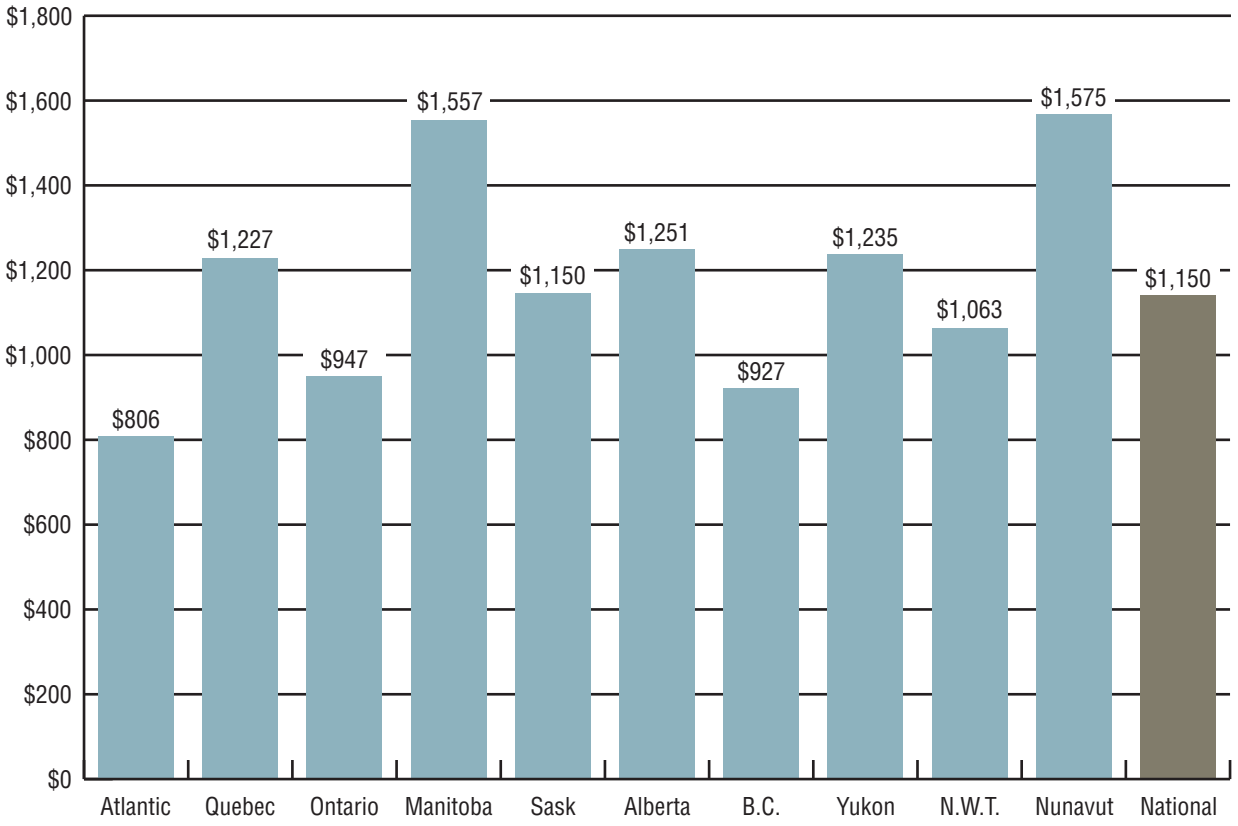
NIHB Premiums expenditures have decreased by 25.7% from $28.6 million in 2003/04 to $21.3 million in 2012/13. This decrease can be attributed to the Government of Alberta eliminating Alberta health care insurance premiums for all Alberta residents on January 1, 2009. Consequently, since 2009/10 the NIHB Program only provides coverage for premiums in the British Columbia Region.

BENEFIT	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Medical Transportation	$ 205,793	$ 211,527	$ 225,379	$ 241,602	$ 262,294	$ 280,446	$ 301,673	$ 311,760	$ 333,304	$ 351,424
Pharmacy	326,982	343,879	368,398	386,190	403,248	418,968	435,097	440,768	459,359	462,699
Dental	134,504	142,956	153,900	158,584	165,576	176,382	194,918	215,796	219,057	222,706
Other Health Care	16,557	16,904	17,115	16,271	12,289	11,380	12,516	12,083	12,936	14,337
Premiums	28,614	27,830	27,987	28,659	29,211	26,430	17,110	18,428	19,868	21,257
Vision Care	24,420	24,629	24,968	24,894	25,621	26,577	27,779	29,219	29,780	32,167
Total	**$ 736,870**	**$ 767,726**	**$ 817,748**	**$ 856,201**	**$ 898,239**	**$ 940,182**	**$ 989,094**	**$ 1,028,053**	**$ 1,074,304**	**$ 1,104,591**
Annual % Change	7.1%	4.2%	6.5%	4.7%	4.9%	4.7%	5.2%	3.9%	4.5%	2.8%

Source: FIRMS adapted by Program Analysis Division

FIGURE 3.8

Per Capita NIHB Expenditures by Region (Excluding Premiums)
2012/13



Source: FIRMS and SVS adapted by Program Analysis Division

The national per capita expenditure for all benefits in 2012/13 was $1,150. This is a decrease from the 2011/12 national per capita expenditure of $1,155.

The Manitoba Region surpassed Nunavut with the highest per capita cost in 2012/13 at $1,577. Nunavut followed closely with the second highest per capita cost at $1,575. The higher than average per capita cost for these regions 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 2012/13, the Atlantic Region had the lowest per capita expenditures at $806. 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 23,856 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 first year of financial impact for these new clients ended in September 2012, impacting the first half of fiscal year 2012/13. 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 $1,089, with the national total adjusted to $1,173.

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 2012/13, the NIHB Program paid for pharmacy claims made by a total of 557,459 First Nations and Inuit clients. The total expenditures for these claims was $462.7 million or 41.9% 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 160,000 clients with gastrointestinal problems, 120,000 clients with cardiovascular problems, and 63,000 clients with diabetes were met in 2012/13.

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.

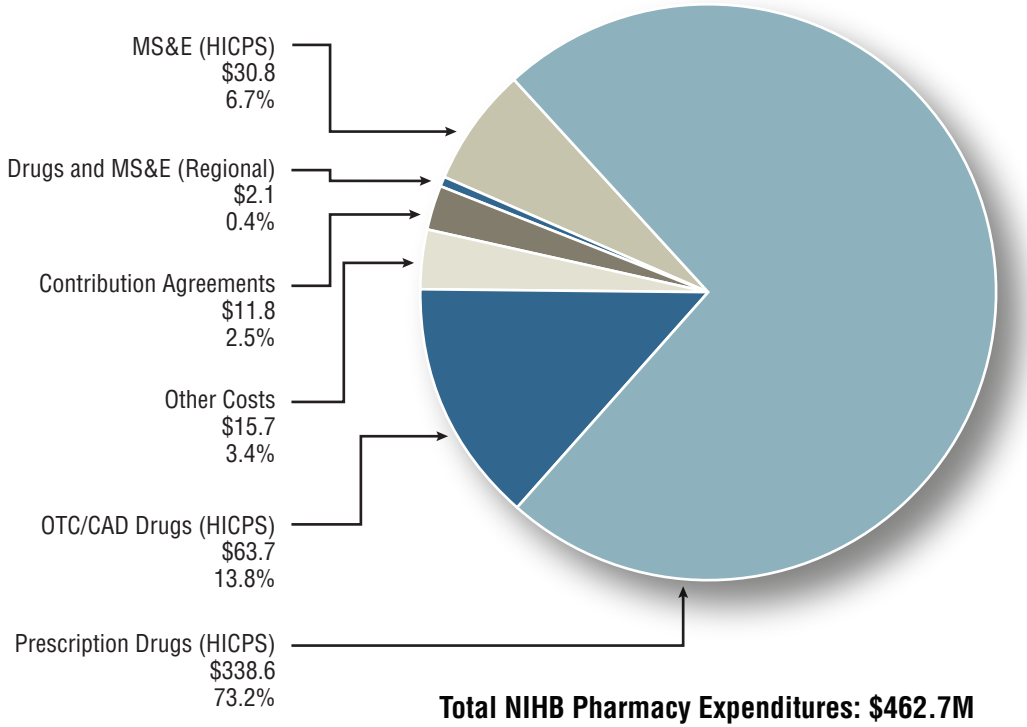
Another objective of the Program is to provide pharmacy benefits and services based on professional judgment, consistent with the current best practices of health services delivery and evidence-based standards of care. To achieve this objective, the addition and removal of pharmacy benefits covered by 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)
2012/13



Source: FIRMS adapted by Program Analysis Division

In 2012/13, NIHB Pharmacy benefits totalled $462.7 million or 41.9% 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 $338.6 million or 73.2% of all NIHB Pharmacy expenditures, followed by over-the-counter (OTC) drugs and controlled access drugs (CAD) which totalled $63.7 million or 13.8%. Medical supplies and equipment (MS&E) items paid through HICPS was the third largest component in the pharmacy benefit at $30.8 million or 6.7%. In total, the three components managed through automated claims processing accounted for 93.6% of all pharmacy benefit costs.

Drugs and MS&E (Regional), at $2.1 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 2.5% 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 totalled $15.7 million or 3.4% in 2012/13. 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)
2012/13

Prescription drug costs paid through the Health Information and Claims Processing Services (HICPS) system represented the largest component of total costs accounting for $338.6 million or 73.2% of all NIHB Pharmacy costs. The Manitoba Region had the largest proportion of these costs at 18.9%, followed by the Saskatchewan Region at 16.7% and the Ontario Region at 16.5%.

The next highest component was over-the-counter (OTC) and controlled access drug (CAD) costs at $63.7 million or 13.8%. The regions of Ontario (21.1%), Manitoba (18.8%) and Saskatchewan (17.4%) had the largest proportions of these costs in 2012/13.

The third highest component was the combined medical supplies and equipment (MS&E) category at $30.8 million (6.7%). The Saskatchewan Region (17.7%) had the highest proportion of MS&E costs in 2012/13. This was followed by the Alberta Region (16.8%) and the British Columbia Region (16.7%).

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	$ 20,744	$ 4,537	$ 11	$ 595	$ 1,547	$ -	$ 27,435	$ 2,545	**$ 29,979**
Quebec	31,954	7,069	12	549	801	-	40,384	9	**40,393**
Ontario	55,966	13,428	25	1,204	3,087	-	73,710	3,422	**77,131**
Manitoba	63,903	11,976	0	1,606	3,191	-	80,676	0	**80,676**
Saskatchewan	56,678	11,053	1,409	1,884	3,579	-	74,604	42	**74,646**
Alberta	43,161	6,734	165	1,731	3,463	-	55,255	5,329	**60,584**
British Columbia	47,849	6,385	36	1,285	3,863	-	59,418	441	**59,858**
Yukon	3,237	354	35	77	291	-	3,994	0	**3,994**
N.W.T.	7,059	1,027	61	339	514	-	8,999	0	**8,999**
Nunavut	8,081	1,089	297	390	833	-	10,690	0	**10,690**
Headquarters	-	-	-	-	-	15,749	15,749	0	**15,749**
Total	**$ 338,632**	**$ 63,651**	**$ 2,050**	**$ 9,659**	**$ 21,170**	**$ 15,749**	**$ 450,912**	**$ 11,788**	**$ 462,699**

Source: FIRMS adapted by Program Analysis Division

FIGURE 4.3

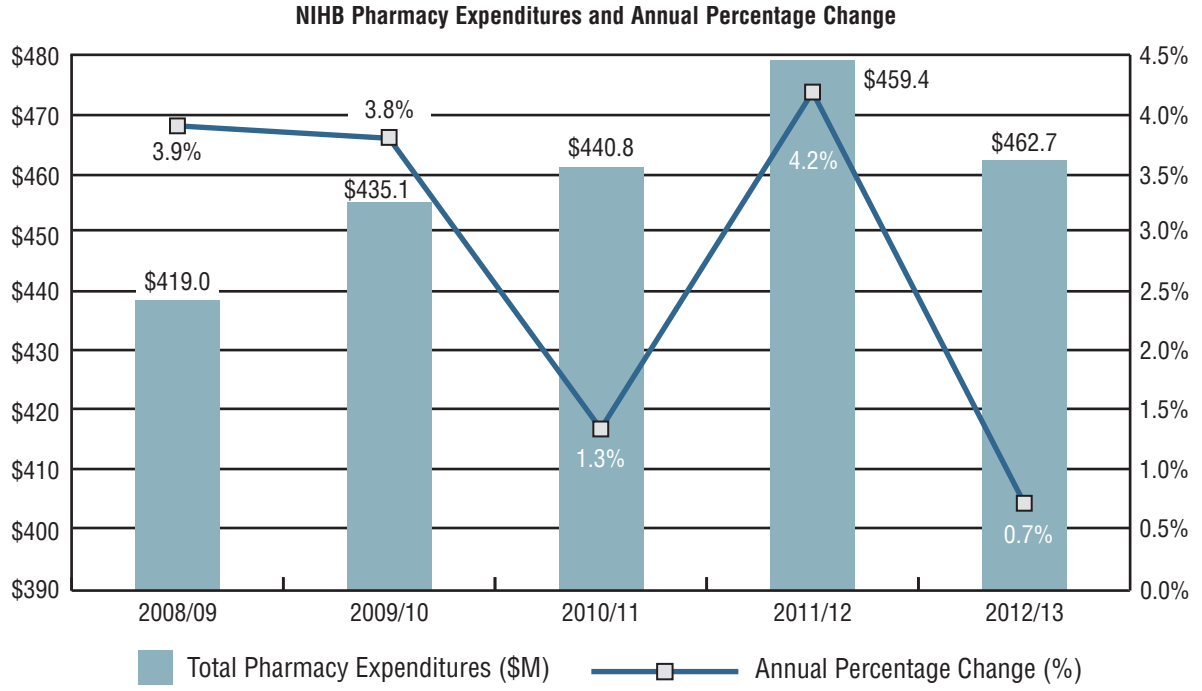
Annual NIHB Pharmacy Expenditures
2008/09 to 2012/13

NIHB Pharmacy expenditures increased by 0.7% during fiscal year 2012/13. This represents a 3.5 percentage point decrease over the previous year's growth rate.

Over the past five years, growth in pharmacy expenditures has ranged from a high of 4.2% in 2011/12 to a low of 0.7% in 2012/13. The annualized growth rate over these five years is 2.8%.

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 2012/13 took place in the Atlantic Region, which increased by 8.7% over the previous fiscal year. This increase in pharmacy expenditures can be attributed to the registration of 23,856 Qalipu Mi'kmaq First Nations clients since the creation of the Qalipu Mi'kmaq First Nations band in September 2011. Clients who became eligible under the NIHB Program have steadily increased utilization of NIHB benefits in 2012/13. The Quebec Region had the second highest growth rate at 4.0%, where the generic savings effect has been less significant in 2012/13 due to later implementation of generic pricing in the Region.



Source: FIRMS adapted by Program Analysis Division

NIHB Pharmacy Expenditures ($ 000's)					
REGION	2008/09	2009/10	2010/11	2011/12	2012/13
Atlantic	$ 20,119	$ 21,357	$ 23,689	$ 27,571	$ 29,979
Quebec	36,069	37,358	38,234	38,827	40,393
Ontario	77,244	77,564	73,887	76,430	77,131
Manitoba	71,081	72,789	76,496	80,639	80,676
Saskatchewan	62,809	66,639	70,625	73,293	74,646
Alberta	54,189	56,570	59,738	61,621	60,584
British Columbia	56,104	58,862	60,097	60,890	59,858
Yukon	3,779	3,723	3,792	3,878	3,994
N.W.T.	8,210	8,595	8,999	9,090	8,999
Nunavut	7,084	8,237	10,399	10,894	10,690
Headquarters	22,281	23,403	14,814	16,227	15,749
Total	**$ 418,968**	**$ 435,097**	**$ 440,768**	**$ 459,359**	**$ 462,699**

Source: FIRMS adapted by Program Analysis Division

FIGURE 4.4

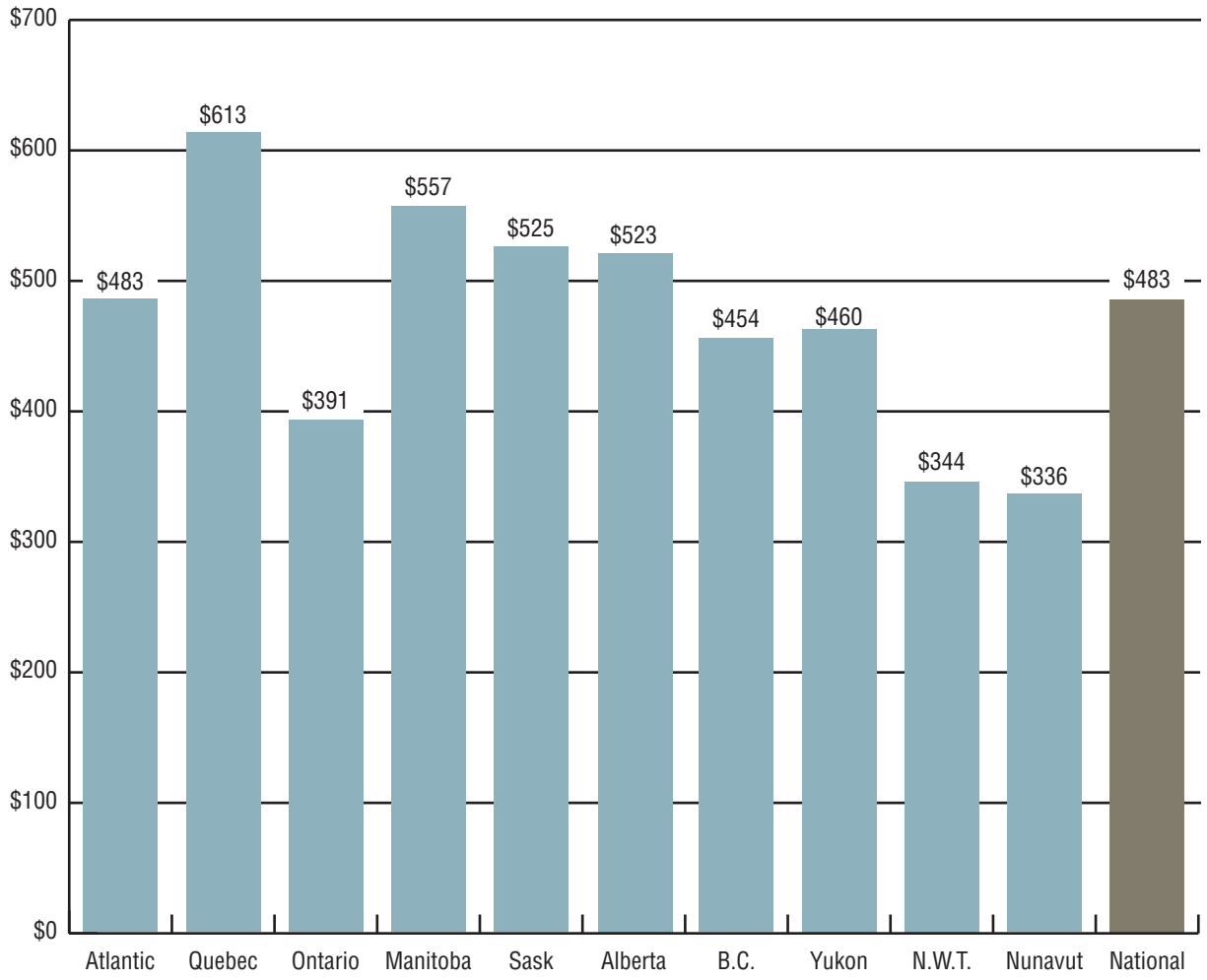
Per Capita NIHB Pharmacy Expenditures by Region
2012/13

In 2012/13, the national per capita expenditure for NIHB Pharmacy benefits was $483. This was a decrease of 2.3% from the $494 recorded in 2011/12.

The Quebec Region had the highest per capita NIHB Pharmacy expenditure at $613, followed by the Manitoba Region at $557 and the Saskatchewan Region at $525.

Nunavut and the Northwest Territories had the lowest per capita NIHB Pharmacy expenditures at $336 and $344 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 only region to have experienced a net increase in per capita cost was the Atlantic Region ($10). The per capita cost in the Atlantic Region in 2010/11 was $672 prior to the creation of the Qalipu Mi'kmaq First Nations band in September 2011. The increase in per capita cost for the Atlantic Region in 2012/13 is indicative of a gradual increase in pharmacy benefit utilization by Qalipu Mi'kmaq clients.



Source: FIRMS and SVS adapted by Program Analysis Division

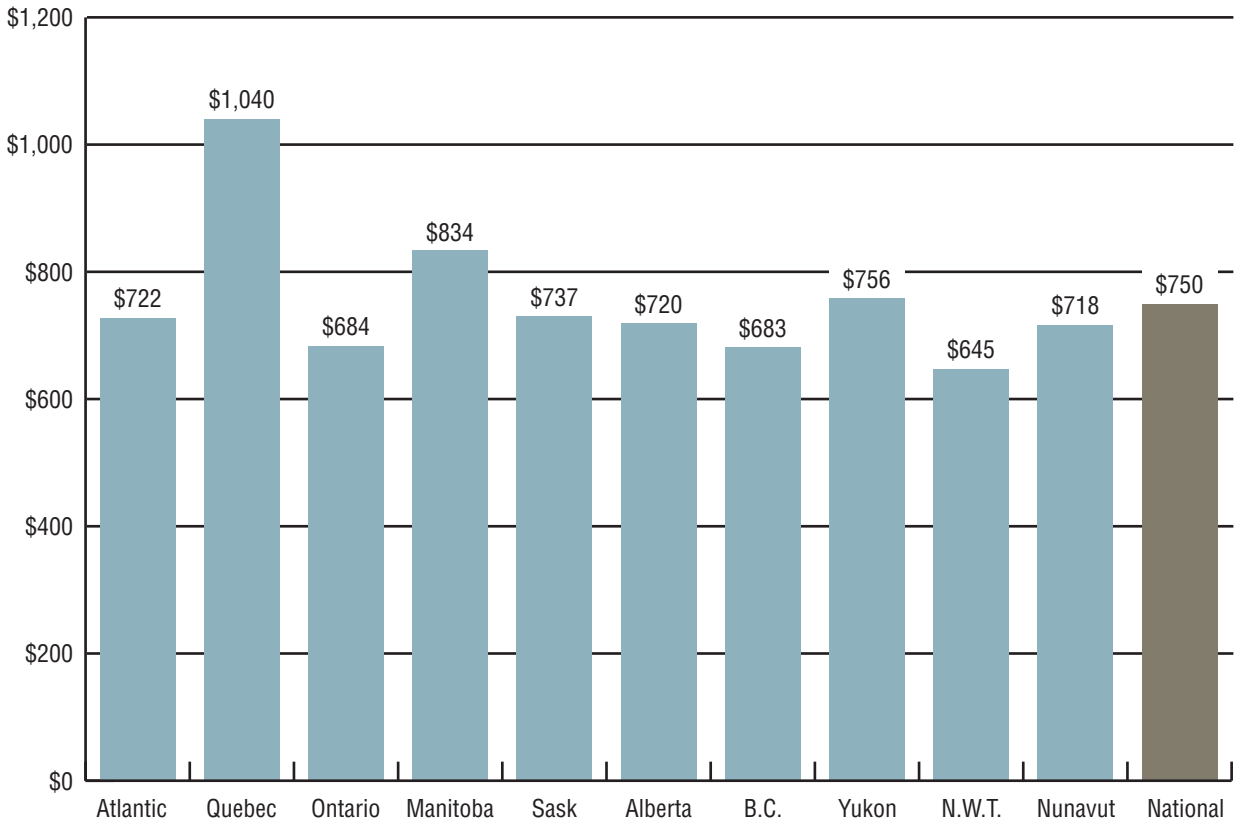
FIGURE 4.5

NIHB Pharmacy Operating Expenditures per Claimant by Region
2012/13

In 2012/13, the national average expenditure per eligible client receiving at least one pharmacy benefit (claimant) was $750, a decrease of 3.0% over the recorded amount of $773 in 2011/12. This decrease can be attributed to savings associated with the introduction of generic versions of high volume drug products (e.g., Lipitor, Crestor) 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 $1,040, followed by the Manitoba Region at $834. The Northwest Territories had the lowest expenditure per claimant at $645.

Overall, all regions recorded lower cost per claimant rates in 2012/13 compared to 2011/12, varying in decreases from a 0.2% in the Yukon to 7.1% in Nunavut.



Source: HICPS and FIRMS adapted by Program Analysis Division

QUICK FACT

An analysis of NIHB Pharmacy expenditures by claimant, based on age, indicates that costs increase with age. In early childhood, these expenditures are quite low but they increase with age and reach a peak in the older age groupings. In 2012/13, a claimant between the ages of 0 and 4 years of age accounted for approximately $165 in NIHB expenditures on average, while claimants 65 years of age and older had the highest costs at approximately $1,905 per claimant.

FIGURE 4.6

NIHB Pharmacy Utilization Rates by Region
2008/09 to 2012/13

	Pharmacy Utilization				
REGION	2008/09	2009/10	2010/11	2011/12	2012/13
Atlantic	66%	66%	66%	55%	61%
Quebec	60%	59%	59%	59%	59%
Ontario	55%	56%	55%	55%	55%
Manitoba	68%	68%	67%	67%	67%
Saskatchewan	73%	73%	72%	71%	70%
Alberta	67%	67%	67%	66%	66%
British Columbia	68%	68%	68%	66%	66%
Yukon	64%	64%	61%	61%	60%
N.W.T.	53%	54%	53%	53%	53%
Nunavut	44%	46%	44%	45%	46%
National	**64%**	**64%**	**64%**	**62%**	**62%**

Source: HICPS and SVS adapted by Program Analysis Division

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

In 2012/13, the national utilization rate was 62% for NIHB Pharmacy benefits paid through the HICPS system. The slightly lower utilization over the last two fiscal years is a result of new C-3 and Qalipu Mi'kmaq First Nations registering with the NIHB Program throughout the fiscal year and therefore not claiming benefits for the entire fiscal year, impacting the overall national utilization rate.

Pharmacy utilization rates vary across the regions. In 2012/13, regional rates ranged from a low of 46% in Nunavut to 70% 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 alternate health coverage. 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 70% in 2012/13. 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%.

The utilization rate recorded in the Atlantic Region in 2012/13 increased from 55% in 2011/12 to 61% in 2012/13. This increase in utilization can be attributed to the 21,419 Qalipu Mi'kmaq First Nation clients registered in 2011/12 which were eligible to receive benefits for all of 2012/13. An additional 2,437 new Qalipu Mi'kmaq First Nations were registered throughout fiscal year 2012/13. These new clients claimed for approximately three quarters of the fiscal year, contributing to a lower overall utilization rate for this region when compared to utilization rates prior to 2011.

FIGURE 4.7

NIHB Pharmacy Claimants by Age Group, Gender and Region
2012/13

Of the 926,044 clients eligible to receive benefits under the NIHB Program, a total of 577,459 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 2012/13.

Of this total, 326,733 were female (57%) and 250,726 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 last two fiscal years. The average age for female and male claimants was 34 and 32 years of age, respectively. The highest average age of pharmacy claimants was for females in the Yukon at 39 years of age, while the lowest was for males in the regions of Saskatchewan and Alberta both at 29 years of age.

Thirty one percent of pharmacy claimants were under 20 years of age. Twenty-nine percent of female claimants were in this age group as were 33% of males. Seniors (age 65 and over) represented 6.9% of all pharmacy claimants in 2012/13.

REGION	Atlantic			Quebec			Ontario			Manitoba		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	1,250	1,197	2,447	1,276	1,242	2,518	3,115	3,064	6,179	4,814	4,751	9,565
5-9	1,339	1,315	2,654	1,141	1,061	2,202	2,965	2,922	5,887	4,097	4,263	8,360
10-14	1,185	1,330	2,515	1,013	1,143	2,156	2,946	3,156	6,102	3,563	3,763	7,326
15-19	1,309	2,044	3,353	1,133	1,940	3,073	3,442	5,286	8,728	3,459	5,346	8,805
20-24	1,213	1,898	3,111	1,051	1,949	3,000	3,372	5,567	8,939	3,503	5,631	9,134
25-29	1,083	1,667	2,750	944	1,714	2,658	3,331	5,053	8,384	3,177	4,575	7,752
30-34	1,061	1,508	2,569	1,006	1,542	2,548	3,244	4,712	7,956	2,966	3,898	6,864
35-39	1,133	1,534	2,667	1,079	1,542	2,621	3,365	4,423	7,788	2,996	3,807	6,803
40-44	1,290	1,598	2,888	1,204	1,627	2,831	3,677	4,682	8,359	3,168	3,979	7,147
45-49	1,286	1,581	2,867	1,357	1,798	3,155	4,030	5,117	9,147	3,120	3,739	6,859
50-54	1,216	1,522	2,738	1,332	1,799	3,131	3,704	4,777	8,481	2,604	3,180	5,784
55-59	1,075	1,411	2,486	1,126	1,504	2,630	2,937	3,915	6,852	1,888	2,390	4,278
60-64	865	1,075	1,940	844	1,153	1,997	2,282	2,988	5,270	1,380	1,659	3,039
65+	1,287	1,697	2,984	1,659	2,622	4,281	3,746	5,861	9,607	2,044	2,926	4,970
Total	16,592	21,377	37,969	16,165	22,636	38,801	46,156	61,523	107,679	42,779	53,907	96,686
Average Age	35	35	35	37	38	37	36	37	37	30	31	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	4,924	4,820	9,744	4,024	3,806	7,830	2,934	2,764	5,698	124	104	228	400	376	776	931	883	1,814	23,792	23,007	46,799
5-9	4,502	4,782	9,284	3,392	3,476	6,868	2,762	2,896	5,658	120	99	219	328	400	728	489	463	952	21,135	21,677	42,812
10-14	3,844	4,361	8,205	2,917	3,106	6,023	2,532	2,839	5,371	124	116	240	314	381	695	414	399	813	18,852	20,594	39,446
15-19	3,794	5,752	9,546	3,214	4,216	7,430	2,751	4,108	6,859	157	240	397	433	751	1,184	410	957	1,367	20,102	30,640	50,742
20-24	3,880	6,020	9,900	2,898	4,362	7,260	3,050	4,576	7,626	158	287	445	465	919	1,384	439	1,088	1,527	20,029	32,297	52,326
25-29	3,421	5,116	8,537	2,787	3,836	6,623	2,842	4,251	7,093	151	271	422	408	741	1,149	378	872	1,250	18,522	28,096	46,618
30-34	3,170	4,218	7,388	2,475	3,310	5,785	2,762	3,645	6,407	165	216	381	369	687	1,056	353	676	1,029	17,571	24,412	41,983
35-39	2,958	3,987	6,945	2,293	2,929	5,222	2,758	3,574	6,332	163	217	380	347	624	971	363	581	944	17,455	23,218	40,673
40-44	3,041	3,906	6,947	2,344	2,784	5,128	2,836	3,694	6,530	211	240	451	490	727	1,217	446	644	1,090	18,707	23,881	42,588
45-49	2,866	3,591	6,457	2,260	2,857	5,117	3,065	4,011	7,076	242	285	527	449	654	1,103	378	577	955	19,053	24,210	43,263
50-54	2,342	3,013	5,355	1,862	2,327	4,189	2,864	3,739	6,603	187	258	445	390	612	1,002	309	422	731	16,810	21,649	38,459
55-59	1,626	2,147	3,773	1,298	1,761	3,059	2,255	2,958	5,213	118	185	303	307	451	758	235	325	560	12,865	17,047	29,912
60-64	1,189	1,540	2,729	891	1,292	2,183	1,689	2,014	3,703	90	156	246	249	346	595	256	254	510	9,735	12,477	22,212
65+	1,863	2,683	4,546	1,549	2,218	3,767	2,813	3,947	6,760	214	338	552	509	723	1,232	414	513	927	16,098	23,528	39,626
Total	**43,420**	**55,936**	**99,356**	**34,204**	**42,280**	**76,484**	**37,913**	**49,016**	**86,929**	**2,224**	**3,012**	**5,236**	**5,458**	**8,392**	**13,850**	**5,815**	**8,654**	**14,469**	**250,726**	**326,733**	**577,459**
Average Age	29	30	29	29	31	30	34	35	35	37	39	38	36	36	36	30	31	31	32	34	33

FIGURE 4.8

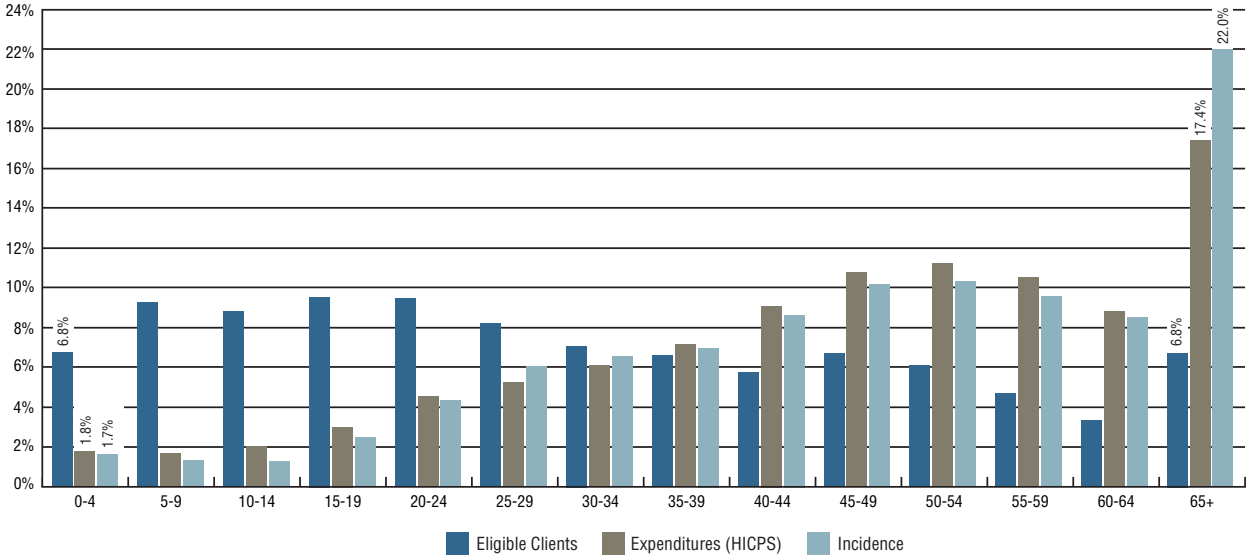
Distribution of Eligible NIHB Population, Pharmacy Expenditures and Pharmacy Incidence by Age Group
2012/13

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 2012/13, for example, 6.8% of all clients were in the 0 to 4 age group, but this group accounted for only 1.7% of all pharmacy claims made and only 1.8% of total pharmacy expenditures. In contrast, 6.8% of all eligible clients were in the 65+ age group, but accounted for 22.0% of all pharmacy claims submitted and 17.4% of total pharmacy expenditures, a decrease over 2011/12.

During 2012/13, the average claimant aged 65 or more submitted 89 claims compared to 61 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 cost per NIHB claimant indicates that these expenditures vary according to age. For example, the average cost per child aged 0 to 4 years was $166 who received pharmaceutical services during fiscal year 2012/13. The cost increased steadily for every age group, with claimants aged 35-39 having an average cost of $779, comparable to the total average claimant cost of $750. Claimants over 65 years of age had the highest cost per claimant with an average of $1,905 for all pharmaceutical services received throughout the fiscal year.



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
2012/13

Table 1 ranks the top ten therapeutic classes according to claims incidence. In 2012/13, opioid dependence treatment had the highest claims incidence total at over one million claims (1,279,805). This represents a percentage increase of 14.5% over the 1,117,971 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 and Suboxone in the treatment of opioid addiction. Methadone is generally billed daily and Suboxone is billed daily for new clients receiving the drug (but moves to a higher frequency in days dispensed after approximately 2 months of drug usage), resulting in an increase in overall claims volume.

Non-steroidal anti-inflammatory drugs (NSAIDs) such as Naprosyn (naproxen) ranked second in claims incidence with 970,572 claims followed by opioid agonists and antidepressants with 935,548 and 878,291 claims respectively.

Table 1: NIHB Top Ten Therapeutic Classes by Claims Incidence

Therapeutic Classification	Claims Incidence	% Change from 2011/12	Examples of Product in the Therapeutic Class
Opioid Dependence Treatment	1,279,805	14.5%	Methadone & Suboxone
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	970,572	2.2%	Naprosyn (naproxen)
Opioid Agonists	935,548	0.7%	Tylenol no.3 (Acetaminophen w/codeine)
Antidepressants	878,291	11.3%	Effexor (Venlafaxine)
Proton-Pump Inhibitors	581,935	11.9%	Losec (Omeprazole)
Angiotensin-Converting Enzyme Inhibitors	579,229	5.5%	Altace (Ramipril)
HMG-CoA Reductase Inhibitors (Statins)	576,321	8.4%	Lipitor (Atorvastatin)
Anxiolytics, Sedatives and Hypnotics - Benzodiazepines	536,479	-0.6%	Ativan (Lorazepam)
Biguanides	455,277	7.5%	Glucophage (Metformin)
Antipsychotic Agents	414,553	5.8%	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 $20.4 million, a decrease of 2.2% over fiscal year 2011/12.

The second largest expenditure class was antidepressants, at $19.1 million. This is a slight increase of 0.9% over fiscal year 2011/12.

Cholesterol lowering drugs in the HMG-CoA reductase inhibitors (statins) class such as Lipitor (atorvastatin) had the largest decrease in expenditures amongst the top ten therapeutic classes at $14.8 million in 2012/13. This significant decrease of 21.5% over fiscal year 2011/12 can be attributed to the introduction of lower cost generic Lipitor and the decrease in generic drug pricing in multiple regions in 2011/12.

Within the top ten therapeutic classes, antidiabetic agents such as insulin had the highest percentage increase in expenditures for the second year in a row, with annual growth of 20.6% over fiscal year 2011/12. This increase continues to be 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. Disease-modifying antirheumatic drugs followed with a percentage increase in expenditures over fiscal year 2011/12 at 12.8%. 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 2011/12	Examples of Product in the Therapeutic Class
Opioid Agonists	$ 20,359	-2.2%	Tylenol no.3 (Acetaminophen w/codeine)
Antidepressants	19,052	0.9%	Effexor (Venlafaxine)
Disease-modifying Antirheumatic Drugs	17,612	12.8%	Enbrel (Etanercept)
Proton Pump Inhibitors	17,017	-6.7%	Losec (Omeprazole)
Antidiabetic Agents (Insulin)	15,139	20.6%	Lantus (Insulin)
Antipsychotic Agents	14,860	1.6%	Risperdal (Risperidone)
HMG-CoA Reductase Inhibitors (Statins)	14,754	-21.5%	Lipitor (Atorvastatin)
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	14,099	-0.2%	Naprosyn (naproxen)
Angiotensin-Converting Enzyme Inhibitors	13,848	-2.7%	Altace (Ramipril)
Diabetic Diagnostic Agents	12,486	-1.6%	Test Strips

Source: HICPS adapted by Program Analysis Division

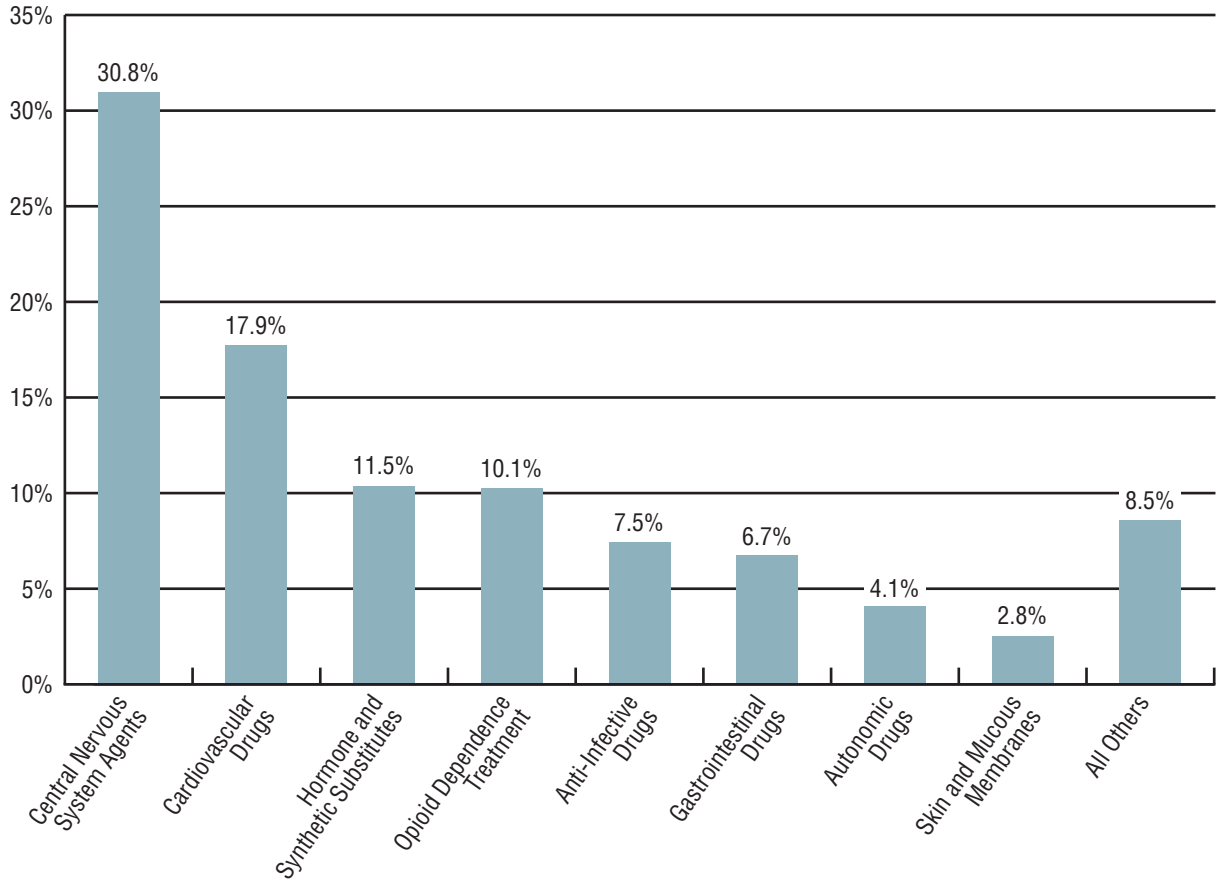
FIGURE 4.10

NIHB Prescription Drug Claims Incidence by Pharmacologic Therapeutic Class
2012/13

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 30.8% of all prescription drug claims. Central nervous system 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 17.9% 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

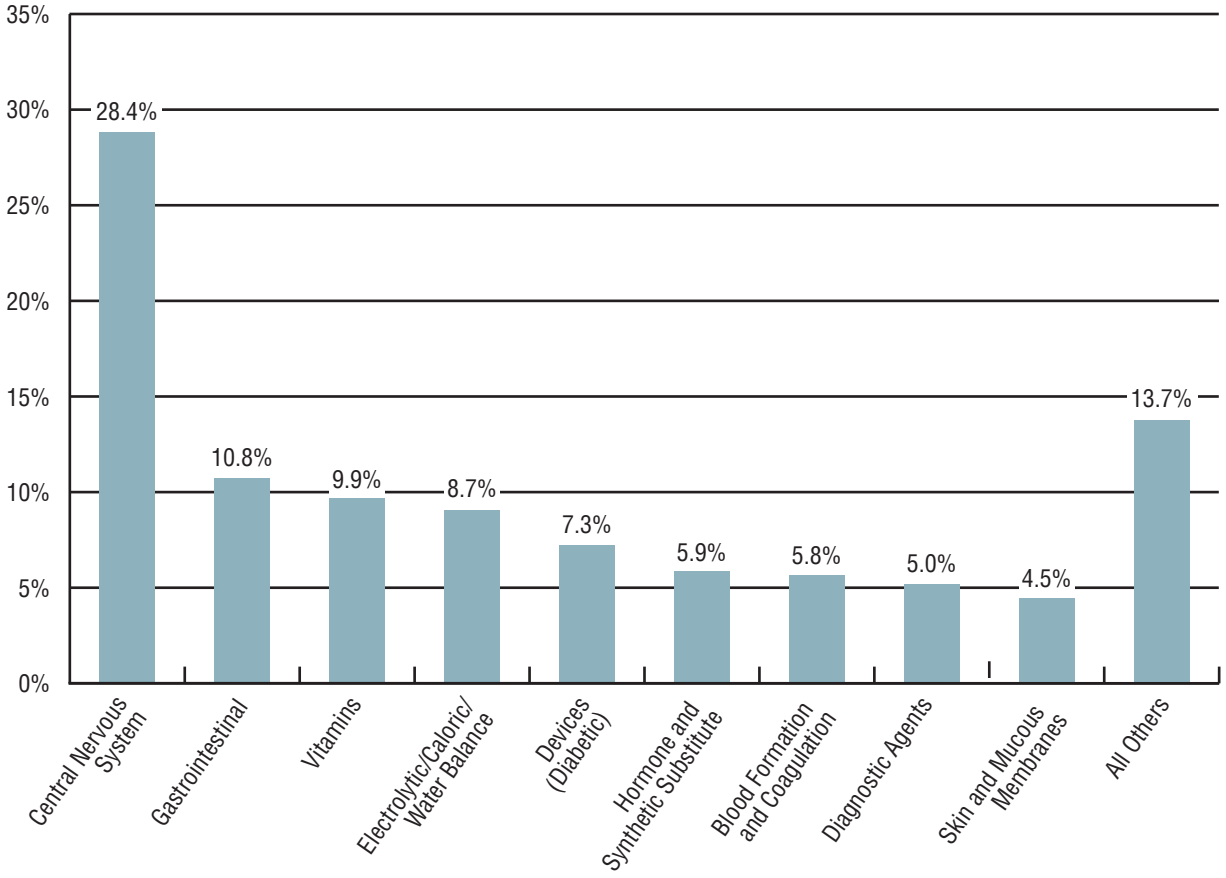
NIHB Over-the-Counter Drugs (Including Controlled Access Drugs – CAD) Claims Incidence by Pharmacologic Therapeutic Class
2012/13

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.

OTC central nervous system agents are drugs used to manage pain, such as headaches (e.g., acetaminophen), accounted for 28.4% 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 8.7%.

The largest increase from the last fiscal year (2011/12) in claims volume of OTC drugs by therapeutic class was in blood formation and coagulation which increased by 0.4 percentage point, while the largest decrease was among central nervous system agents which decreased by 1.0 percentage point.



Source: HICPS adapted by Program Analysis Division

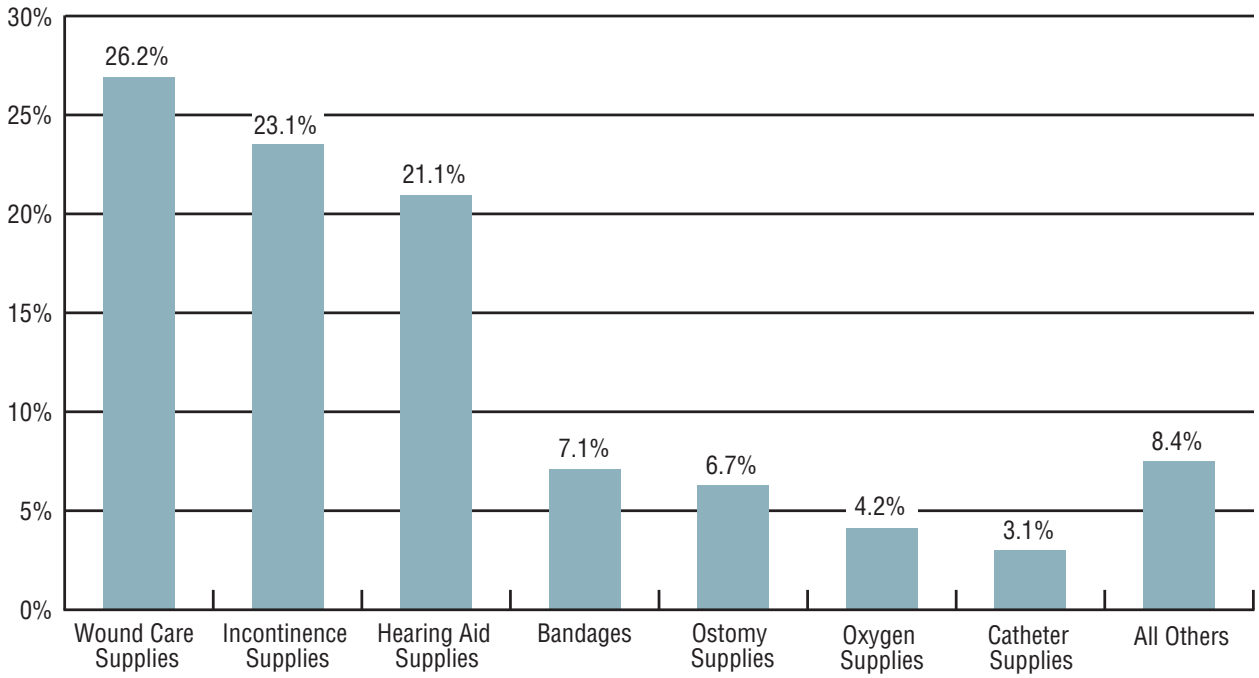
FIGURE 4.12

NIHB Medical Supplies by Category and Claims Incidence
2012/13

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

In 2012/13, wound care supplies such as silver dressings, sterile dressings and iodine dressings accounted for 26.2% of all medical supply claims. Incontinence supplies such as liners and pads, represented the second highest category of medical supplies at 23.1%, followed by hearing aid supplies at 21.1%.

The most significant increase in claims for medical supplies over fiscal year 2011/12 was in hearing aid supplies which increased by 1.8 percentage points, while the largest decrease was among wound care supplies which declined by 1.2 percentage points.



Source: HICPS adapted by Program Analysis Division

FIGURE 4.13

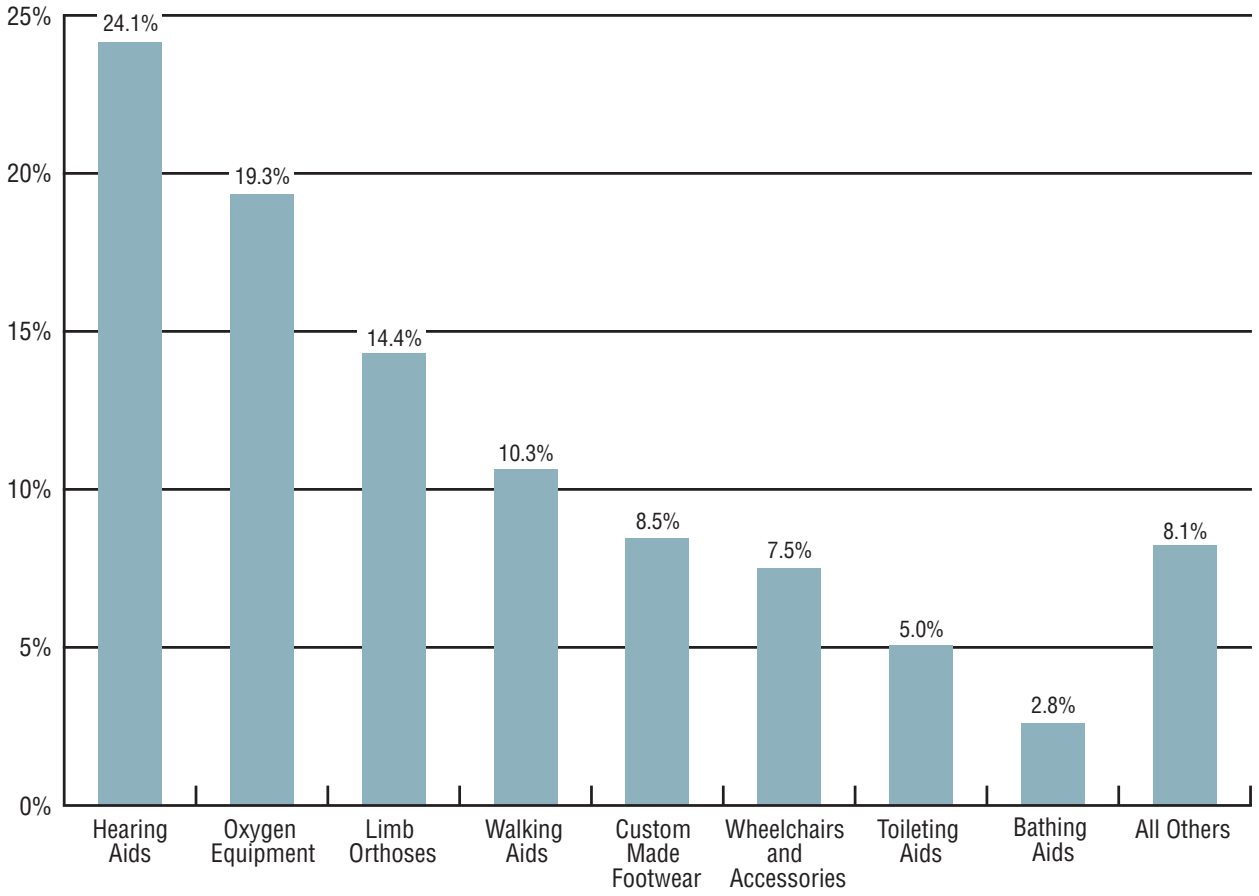
NIHB Medical Equipment by Category and Claims Incidence
2012/13

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

Claims for hearing aids accounted for 24.1% of all medical equipment claims in 2012/13. Oxygen equipment was the next highest at 19.3%, followed by limb orthoses at 14.4% and walking aids at 10.3%.

The most significant increase in the proportion of total medical equipment claims over the fiscal year 2011/12 was in hearing aids which increased by 0.7 percentage point.

The most significant decrease in the proportion of total medical equipment claims was in walking aids which declined 0.8 percentage point as a share of total claims for medical equipment over the previous fiscal year.



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 2012/13, the NIHB Program paid for dental claims made by a total of 331,670 First Nations and Inuit clients. The total expenditure for these claims was $222.7 million or 20.2% of total NIHB expenditures. The dental benefit accounts for the third largest Program expenditure.

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 2012/13, through the NIHB Program's Dental benefit, the oral health needs of approximately 210,000 clients who required intraoral radiograph services, 189,000 clients who received scaling procedures, and 173,000 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 service is 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.

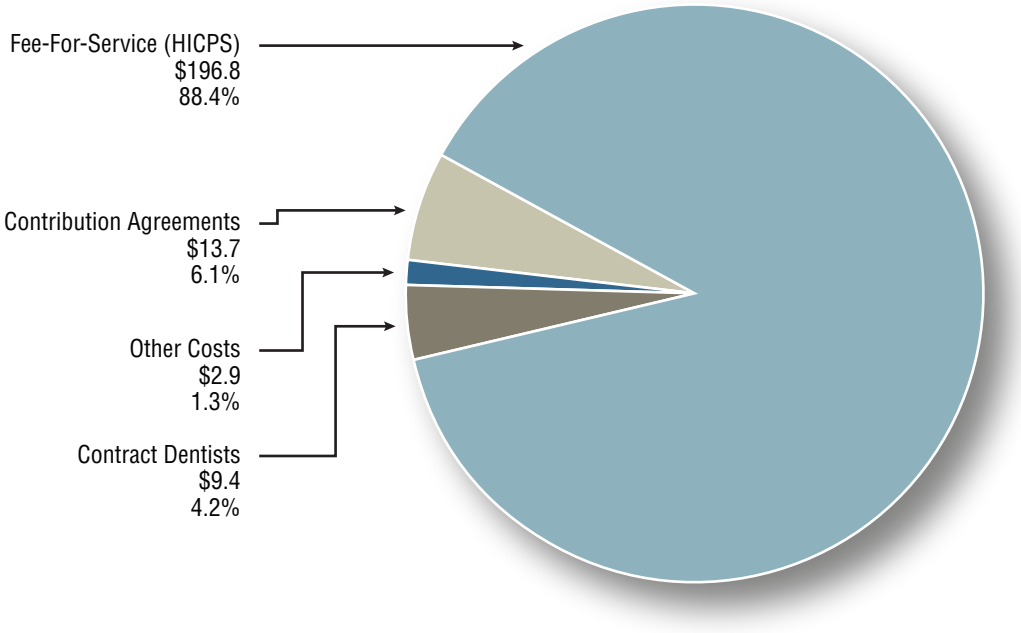
The range of dental services* covered by the NIHB Program, includes:

- 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 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)
2012/13



Total NIHB Dental Expenditures: $222.7M

Source: FIRMS adapted by Program Analysis Division

NIHB Dental expenditures totalled $222.7 million in 2012/13. 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 $196.8 million or 88.4% of all NIHB Dental costs.

The next highest component was contribution agreements, which accounted for $13.7 million or 6.1% 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 $9.4 million or 4.2% of total costs.

Other costs totalled $2.9 million or 1.3% in 2012/13. The majority of these costs are related to claims processing and payment services.

FIGURE 5.2

Total NIHB Dental Expenditures by Type and Region ($ 000's)
2012/13

NIHB Dental expenditures totalled $222.7 million in 2012/13. The regions of Ontario (19.0%), Saskatchewan (16.3%), Alberta (15.5%) and British Columbia (14.2%) had the largest proportion of overall dental costs.

Of the $222.7 million in dental expenditures, $209.0 million (93.9%) were operating expenditures while $13.7 million (6.1%) 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 $196.8 million or 88.4% of all NIHB Dental costs while contract dentists accounted for $9.4 million (4.2%).

REGION	OPERATING			Total Operating Costs	Total Contribution Costs	TOTAL COSTS
	Fee-For-Service	Contract Dentists	Other Costs			
Atlantic	$ 8,604	$ 0	$ 5	$ 8,609	$ 1,051	**$ 9,660**
Quebec	15,194	0	0	15,194	45	**15,239**
Ontario	33,541	2,447	78	36,065	6,194	**42,259**
Manitoba	25,912	4,782	0	30,693	41	**30,734**
Saskatchewan	32,777	0	3	32,781	3,438	**36,219**
Alberta	32,338	175	6	32,519	1,981	**34,501**
British Columbia	29,257	1,639	0	30,896	646	**31,543**
Yukon	2,177	309	0	2,486	0	**2,486**
N.W.T.	7,100	0	0	7,100	145	**7,244**
Nunavut	9,892	0	0	9,892	151	**10,043**
Headquarters	-	-	2,779	2,779	-	**2,779**
Total	**$ 196,791**	**$ 9,352**	**$ 2,871**	**$ 209,014**	**$ 13,692**	**$ 222,706**

Source: FIRMS adapted by Program Analysis Division

FIGURE 5.3

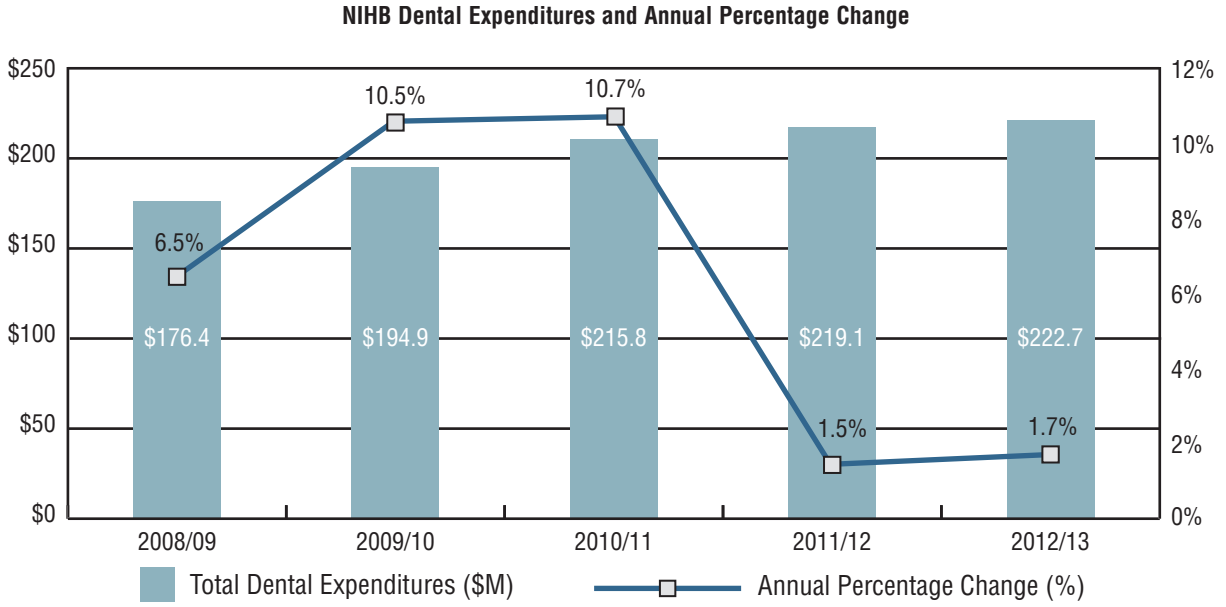
Annual NIHB Dental Expenditures
2008/09 to 2012/13

NIHB Dental expenditures had the second lowest growth rate in 2012/13 at 1.7%. The lower than anticipated increase is mainly attributed to a backlog in processing of predetermination claims as a result of centralization of services to NIHB Headquarters. As part of the Government of Canada's Economic Action Plan 2012, the NIHB Program centralized the processing of dental predetermination (PD) services at NIHB Headquarters in Ottawa. Processing of dental predetermination requests and related services have been transferred from the Health Canada Regional Offices (with the exception of the British Columbia Region) to Ottawa in a phased approach, which began in September 2012 and concludes in September 2013.

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 6.1%.

In 2012/13, the highest rate of growth in NIHB Dental expenditures was in the Atlantic Region, which increased by 34.9% compared to the previous year. This increase in dental expenditures can be attributed to the registration of 23,856 Qalipu Mi'kmaq First Nations clients in the Atlantic Region who became eligible to receive dental benefits through the NIHB Program on September 26, 2011. The Qalipu Mi'kmaq clients have steadily increased utilization of dental benefits in 2012/13, resulting in the high annual growth recorded.

In 2012/13, the largest net increase in dental expenditures was also in the Atlantic Region where total dental costs grew by $2.5 million. The regions of British Columbia



Source: FIRMS adapted by Program Analysis Division

NIHB Dental Expenditures ($ 000's)					
REGION	2008/09	2009/10	2010/11	2011/12	2012/13
Atlantic	$ 4,945	$ 5,426	$ 6,481	$ 7,164	$ 9,660
Quebec	12,895	14,159	15,245	15,138	15,239
Ontario	35,457	38,047	40,594	41,848	42,259
Manitoba	24,444	26,954	29,399	29,861	30,734
Saskatchewan	28,102	30,777	35,317	36,941	36,219
Alberta	25,016	27,756	33,421	34,543	34,501
British Columbia	24,718	28,042	30,187	30,620	31,543
Yukon	2,246	2,271	2,629	2,583	2,486
N.W.T.	6,279	7,067	7,603	7,054	7,244
Nunavut	8,349	10,289	12,306	10,442	10,043
Headquarters	3,932	4,130	2,614	2,864	2,779
Total	**$ 176,382**	**$ 194,918**	**$ 215,796**	**$ 219,057**	**$ 222,706**

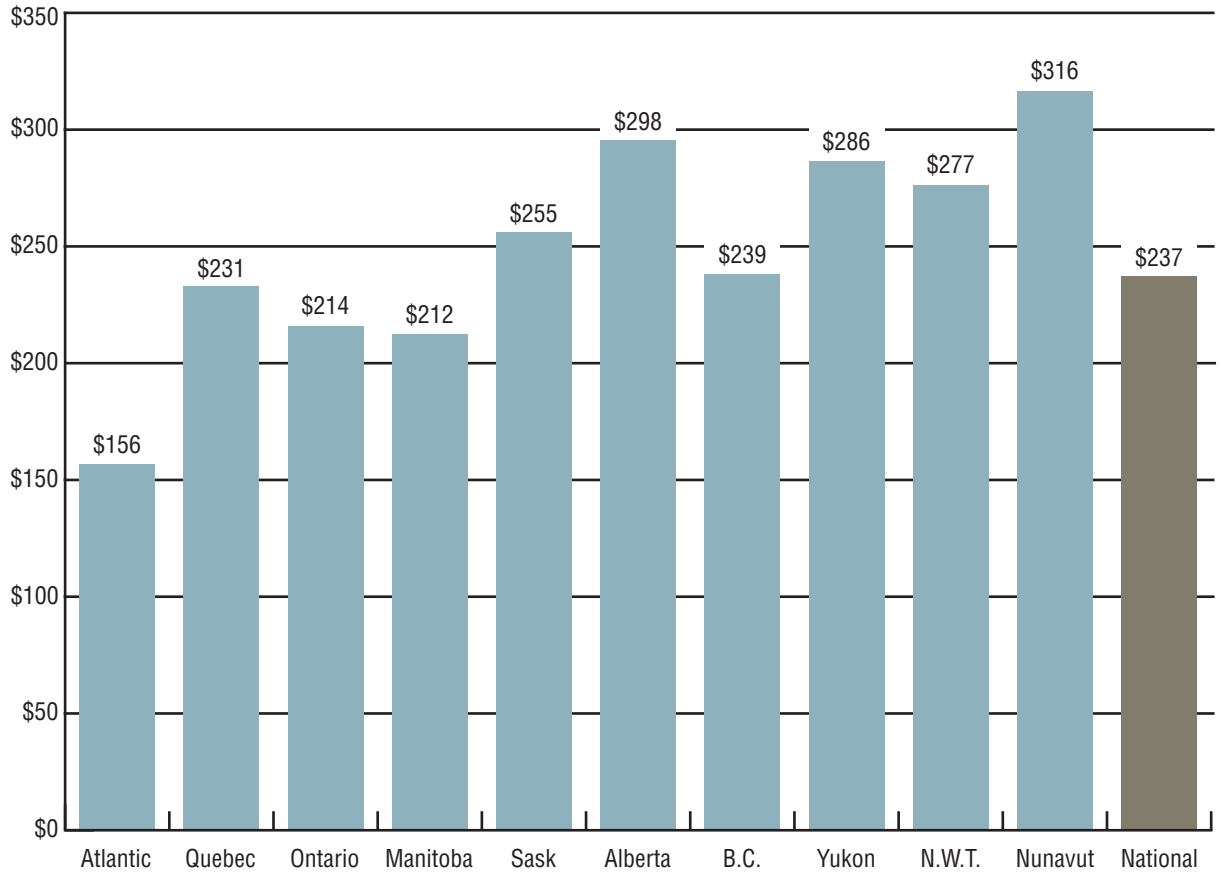
Source: FIRMS adapted by Program Analysis Division

and Manitoba followed with a $923 thousand and $873 thousand increase in expenditures respectively over the previous fiscal year.

The Ontario Region had the highest total dental expenditure at $42.3 million and the Yukon had the lowest total dental expenditure at $2.5 million.

FIGURE 5.4

Per Capita NIHB Dental Expenditures by Region
2012/13



Source: SVS and FIRMS adapted by Program Analysis Division

In 2012/13, the national per capita NIHB Dental expenditure was $237, a decrease of 1.5% from the $241 recorded in 2011/12.

Nunavut had the highest per capita dental expenditure at $316. 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 $298, a decrease from $308 in the previous year. This was followed closely by the Yukon at $286 and the Northwest Territories at $277.

The Atlantic Region had the lowest per capita dental cost at $156 per eligible client. The lower per capita cost in the Atlantic Region is due to an increase in the eligible client population in this region as a result of the registration of 23,856 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 dental benefit utilization for these clients in 2011/12 impacted on the dental per capita cost for the Atlantic Region as a whole. The per capita cost remains lower than levels recorded in 2010/11 ($184), indicating an overall lower dental utilization by the new Qalipu Mi'kmaq compared to the existing Atlantic Region First Nation and Inuit population.

Per capita values reflect total NIHB Dental expenditures as divided by the 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 transfers and other arrangements.

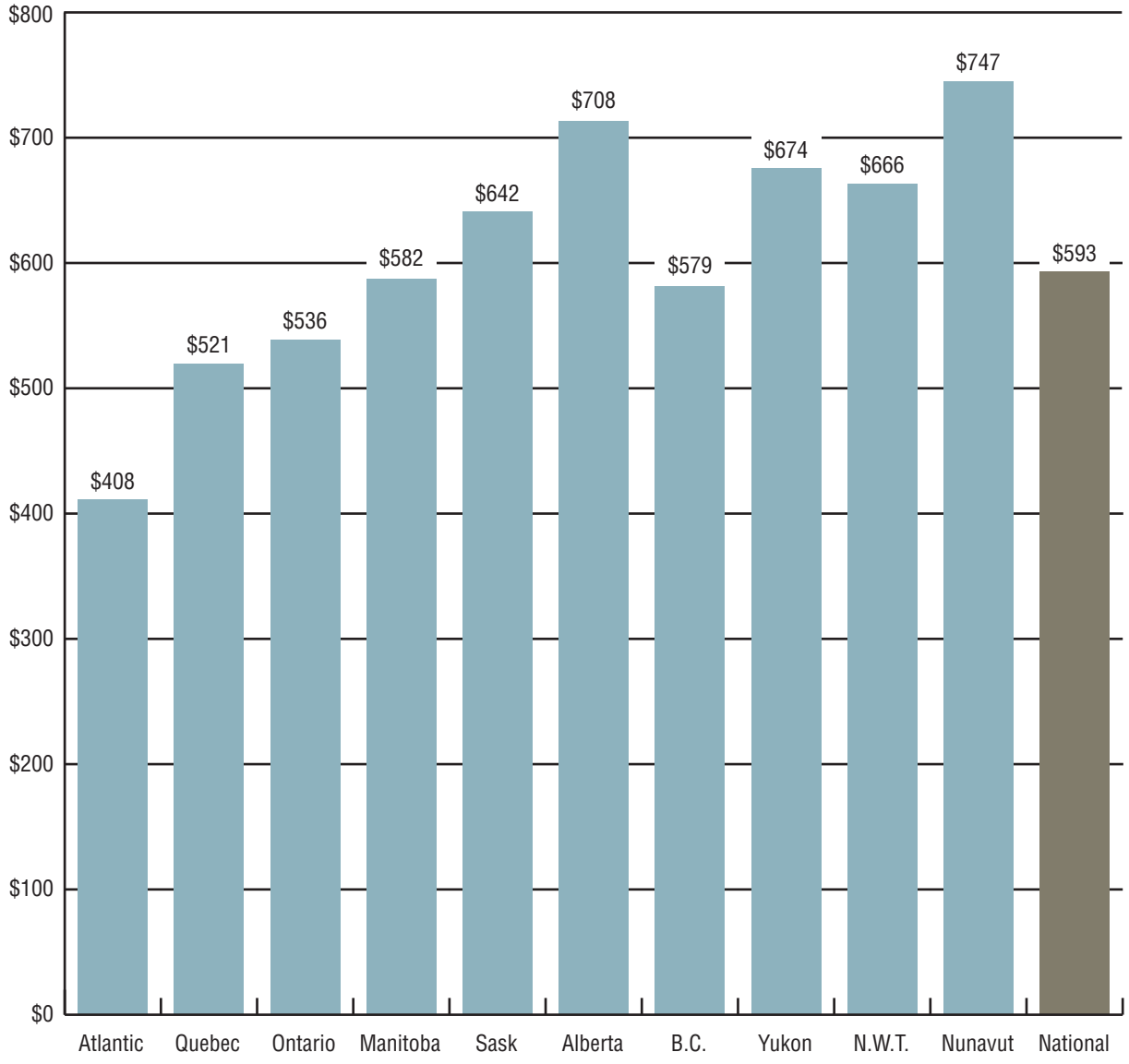
FIGURE 5.5

NIHB Dental Fee-For-Service Expenditures per Claimant by Region
2012/13

In 2012/13, the national NIHB Dental expenditure per eligible client receiving at least one dental benefit was $593. This represents a decrease of 2.2% over the $607 recorded in 2011/12.

Nunavut had the highest dental expenditure per claimant at $747, representing a decrease of 3.0% from the $770 in the previous year. The Alberta Region followed at $708, a decrease of 3.1% from the $731 recorded in 2011/12. The Yukon followed at $674, a decrease of 5.5% from the $713 recorded the previous year.

The Atlantic Region registered the lowest dental expenditure per claimant at $408, a decrease of 6.0% from the $434 in 2011/12.



Source: FIRMS and HICPS adapted by Program Analysis Division

FIGURE 5.6

NIHB Dental Utilization Rates by Region
2008/09 to 2012/13

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 2012/13, the national utilization rate for dental benefits paid through the HICPS system was 36%, constant with 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 Manitoba Region (31%). The highest utilization rate increase was in the Atlantic Region, from 28% in 2011/12 to 34% in 2012/13. As mentioned in Figure 5.4, this increase in utilization can be attributed to the increase in the eligible client population in this region as a result of the registration of 23,856 Qalipu Mi'kmaq First Nations clients in September 2011. These new clients were eligible to receive dental benefits for the full fiscal year in 2012/13, effectively raising the overall utilization rate of the Atlantic Region to a rate comparable to fiscal year 2010/11 and prior.

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 2012/13.

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 2011/12 and 2012/13, 449,422 distinct clients received NIHB Dental services resulting in an overall 49% utilization rate over this period.

REGION	Dental Utilization					
	2008/09	2009/10	2010/11	2011/12	2012/13	NIHB Dental Utilization Last Two Years 2011/13
Atlantic	35%	35%	36%	28%	34%	42%
Quebec	44%	45%	46%	44%	44%	56%
Ontario	33%	33%	33%	32%	32%	41%
Manitoba	30%	30%	31%	31%	31%	43%
Saskatchewan	37%	37%	38%	37%	36%	52%
Alberta	38%	39%	40%	39%	39%	54%
British Columbia	39%	39%	40%	39%	38%	52%
Yukon	39%	37%	39%	38%	37%	52%
N.W.T.	42%	41%	42%	42%	41%	56%
Nunavut	41%	43%	45%	43%	42%	58%
National	**36%**	**36%**	**37%**	**36%**	**36%**	**49%**

Source: HICPS and SVS adapted by Program Analysis Division

FIGURE 5.7

NIHB Dental Claimants by Age Group, Gender and Region
2012/13

Of the 926,044 clients eligible to receive dental benefits through the NIHB Program, 331,670 (36%) claimants received at least one dental procedure paid through the Health Information and Claims Processing Services (HICPS) system in 2012/13.

Of this total, 185,865 were female (56%) and 145,805 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 29 years of age respectively. The highest average age of dental claimants was found in the Yukon and Atlantic Region at 35 years of age, while the lowest was in Nunavut at 26 years of age.

Approximately 38% of all dental claimants were under 20 years of age. Forty-one percent of male claimants were in this age group while females accounted for 35%. Approximately 4% of all claimants were seniors (ages 65 and over) in 2012/13.

REGION	Atlantic			Quebec			Ontario			Manitoba		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	141	150	291	456	398	854	952	1,030	1,982	1,546	1,494	3,040
5-9	642	616	1,258	1,528	1,490	3,018	3,126	2,973	6,099	2,762	2,877	5,639
10-14	954	1,024	1,978	1,496	1,616	3,112	3,259	3,339	6,598	2,558	2,760	5,318
15-19	1,084	1,308	2,392	1,364	1,552	2,916	3,034	3,414	6,448	2,142	2,778	4,920
20-24	839	1,082	1,921	1,027	1,354	2,381	2,099	2,910	5,009	1,581	2,554	4,135
25-29	662	945	1,607	824	1,256	2,080	1,850	2,706	4,556	1,404	2,083	3,487
30-34	607	928	1,535	827	1,088	1,915	1,724	2,569	4,293	1,242	1,706	2,948
35-39	632	883	1,515	836	1,107	1,943	1,745	2,326	4,071	1,182	1,616	2,798
40-44	749	958	1,707	925	1,167	2,092	1,819	2,525	4,344	1,201	1,717	2,918
45-49	692	960	1,652	936	1,253	2,189	1,905	2,507	4,412	1,234	1,599	2,833
50-54	619	923	1,542	861	1,145	2,006	1,790	2,524	4,314	1,028	1,338	2,366
55-59	542	815	1,357	680	958	1,638	1,483	2,161	3,644	682	996	1,678
60-64	408	608	1,016	451	643	1,094	1,056	1,523	2,579	474	631	1,105
65+	572	727	1,299	768	1,130	1,898	1,565	2,666	4,231	503	832	1,335
Total	9,143	11,927	21,070	12,979	16,157	29,136	27,407	35,173	62,580	19,539	24,981	44,520
Average Age	34	36	35	32	34	33	32	34	33	27	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	1,373	1,278	2,651	1,478	1,364	2,842	1,153	1,123	2,276	49	40	89	229	214	443	576	602	1,178	7,953	7,693	15,646
5-9	3,308	3,434	6,742	3,080	3,244	6,324	2,840	2,848	5,688	105	89	194	500	506	1,006	775	793	1,568	18,666	18,870	37,536
10-14	2,921	3,257	6,178	2,874	3,075	5,949	2,583	2,718	5,301	107	110	217	461	527	988	693	788	1,481	17,906	19,214	37,120
15-19	2,237	3,105	5,342	2,374	2,876	5,250	2,292	2,665	4,957	134	160	294	484	600	1,084	651	938	1,589	15,796	19,396	35,192
20-24	1,934	2,952	4,886	1,687	2,472	4,159	1,814	2,442	4,256	122	176	298	451	675	1,126	667	926	1,593	12,221	17,543	29,764
25-29	1,837	2,745	4,582	1,447	2,203	3,650	1,688	2,331	4,019	133	165	298	395	578	973	510	799	1,309	10,750	15,811	26,561
30-34	1,532	2,202	3,734	1,320	1,938	3,258	1,511	2,069	3,580	112	165	277	332	474	806	406	537	943	9,613	13,676	23,289
35-39	1,428	1,979	3,407	1,200	1,659	2,859	1,463	1,925	3,388	100	136	236	284	439	723	311	478	789	9,181	12,548	21,729
40-44	1,467	2,090	3,557	1,153	1,583	2,736	1,516	1,928	3,444	110	140	250	357	445	802	327	473	800	9,624	13,026	22,650
45-49	1,335	1,840	3,175	1,108	1,576	2,684	1,502	2,042	3,544	134	166	300	316	434	750	272	355	627	9,434	12,732	22,166
50-54	1,046	1,530	2,576	900	1,279	2,179	1,479	2,021	3,500	96	146	242	233	414	647	180	270	450	8,232	11,590	19,822
55-59	734	984	1,718	613	934	1,547	1,048	1,491	2,539	80	100	180	181	290	471	120	167	287	6,163	8,896	15,059
60-64	464	642	1,106	370	573	943	740	911	1,651	48	93	141	151	192	343	122	145	267	4,284	5,961	10,245
65+	575	809	1,384	539	774	1,313	979	1,391	2,370	82	131	213	242	253	495	157	196	353	5,982	8,909	14,891
Total	**22,191**	**28,847**	**51,038**	**20,143**	**25,550**	**45,693**	**22,608**	**27,905**	**50,513**	**1,412**	**1,817**	**3,229**	**4,616**	**6,041**	**10,657**	**5,767**	**7,467**	**13,234**	**145,805**	**185,865**	**331,670**
Average Age	27	29	28	26	28	27	30	32	31	34	37	35	31	32	31	25	26	26	29	31	30

FIGURE 5.8

NIHB Fee-for-Service Dental Expenditures by Sub-Benefit
2012/13

Fee-For-Service Top 5 Dental Sub-Benefits ($ Millions) and Percentage Change		
Dental Sub-Benefit	2012/13	% Change from 2011/12
Restorative Services	$ 91.0	4.3%
Preventive Services	23.7	6.0%
Diagnostic Services	23.3	2.9%
Oral Surgery	19.3	1.6%
Endodontic Services	12.0	-4.8%

Fee-For-Service Top 5 Dental Procedures ($ Millions) and Percentage Change		
Dental Procedure	2012/13	% Change from 2011/12
Composite Restorations	$ 70.9	7.0%
Scaling	17.9	7.4%
Extractions	13.3	2.6%
Root Canal Therapy	9.8	-5.5%
Intraoral Radiographs	7.6	4.1%

Source: HICPS adapted by Program Analysis Division

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 2012/13, expenditures for Restorative Services (crowns, fillings, etc.) were the highest of all dental sub-benefit categories at $91.0 million. This is a 4.3% increase over the previous fiscal year.

Preventive Services (scaling, sealants, etc.) at $23.7 million and Diagnostic Services (examinations, x-rays, etc.) at $23.3 million were the next highest sub-benefit categories, followed by Oral Surgery (extractions, etc.) at $19.3 million and Endodontic Services (root canal treatments, etc.) at $12.0 million.

In April 2011, NIHB began an Endodontic Trial Project whose purpose was 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 had initially increased the number of RCTs across the country thus pushing Program expenditures. In 2011/12, Endodontic Services had increased by 25.5% over the previous fiscal year, of which Root Canal Therapy increased by 37.8%. NIHB Program Endodontic services expenditures in 2012/13 decreased slightly by 4.8%, of which Root Canal Therapy decreased by 5.5%.

In 2012/13, the three largest dental procedures by expenditure were Composite Restorations ($70.9 million), Scaling ($17.9 million) and Extractions ($13.3 million).

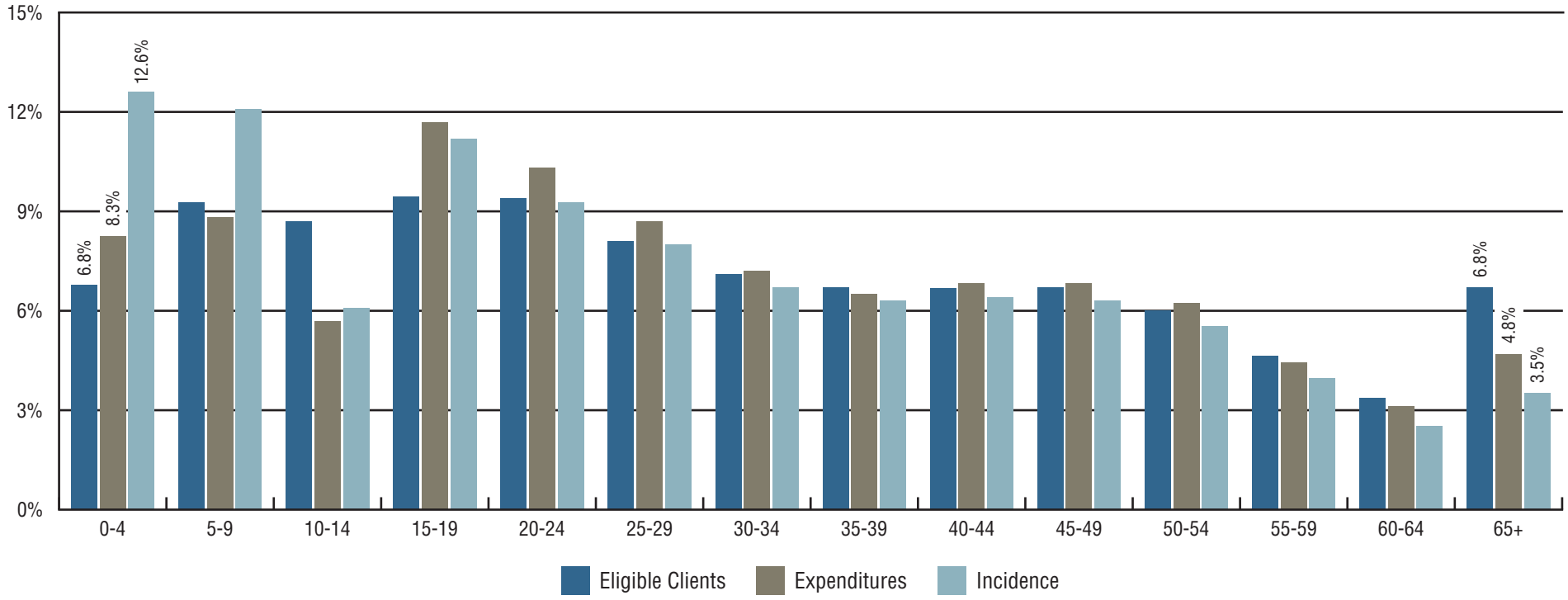
FIGURE 5.9

Distribution of Eligible NIHB Population, Dental Expenditures and Incidence by Age Group
2012/13

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 24.5% to 17.2%.

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 8.8% to 5.7% and for clients who are 65 years of age or older they are 6.8% to 4.8% respectively. The ratio of eligible clients to expenditures for those aged 15 to 19 was 9.5% to 11.7%.



Source: HICPS and SVS adapted by Program Analysis Division

NIHB Medical Transportation Expenditure and Utilization Data

SECTION 6

In 2012/13, Non-Insured Health Benefits Medical Transportation expenditures amounted to $351.4 million or 31.8% 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 2012/13, a total of 490 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

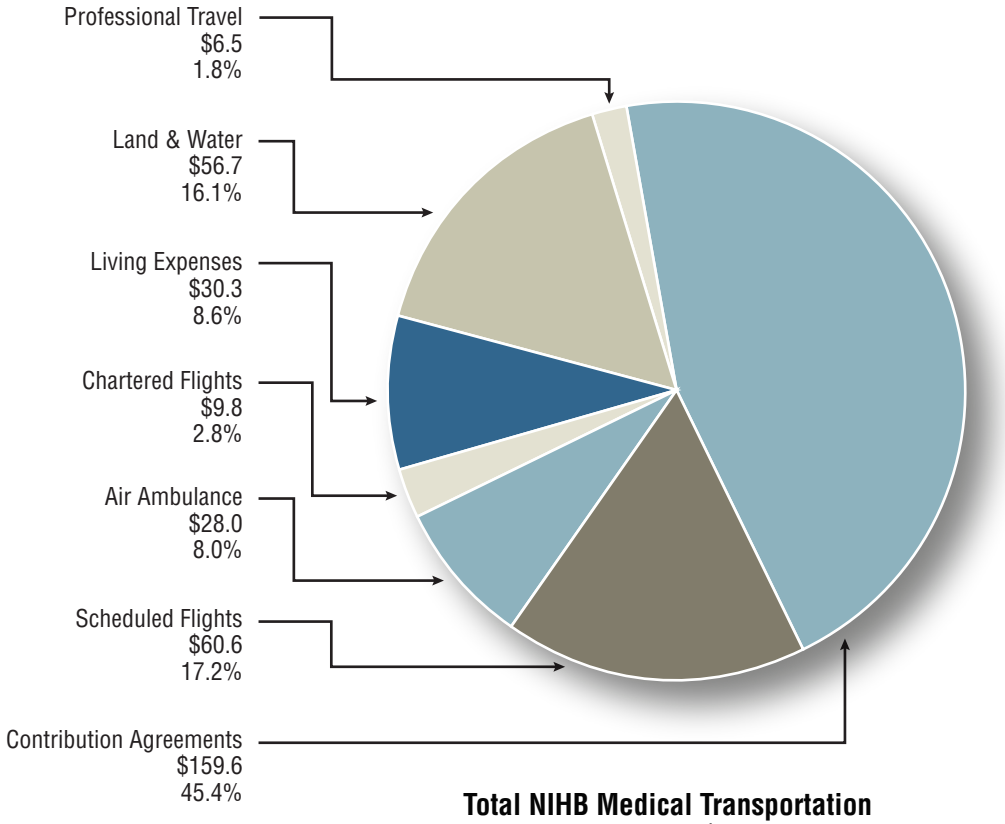
Distribution of NIHB Medical Transportation Expenditures ($ Millions)
2012/13

In 2012/13, NIHB Medical Transportation expenditures totalled $351.4 million or 31.8% 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 $159.6 million, or 45.4% of the total benefit.

Scheduled flights at $60.6 million (17.2%) and land and water transportation at $56.7 million (16.1%) were the largest medical transportation operating expenditures, accounting for one-third of the total benefit.

Costs for living expenses totalled $30.3 million (8.6%) and air ambulance totalled $28.0 million (8.0%). Expenditures for chartered flights totalled $9.8 million (2.8%) and costs for travel associated with bringing professional services to communities (e.g., physician, dentist, mental health professional) totalled $6.5 million (1.8%).



Source: FIRMS adapted by Program Analysis Division

FIGURE 6.2

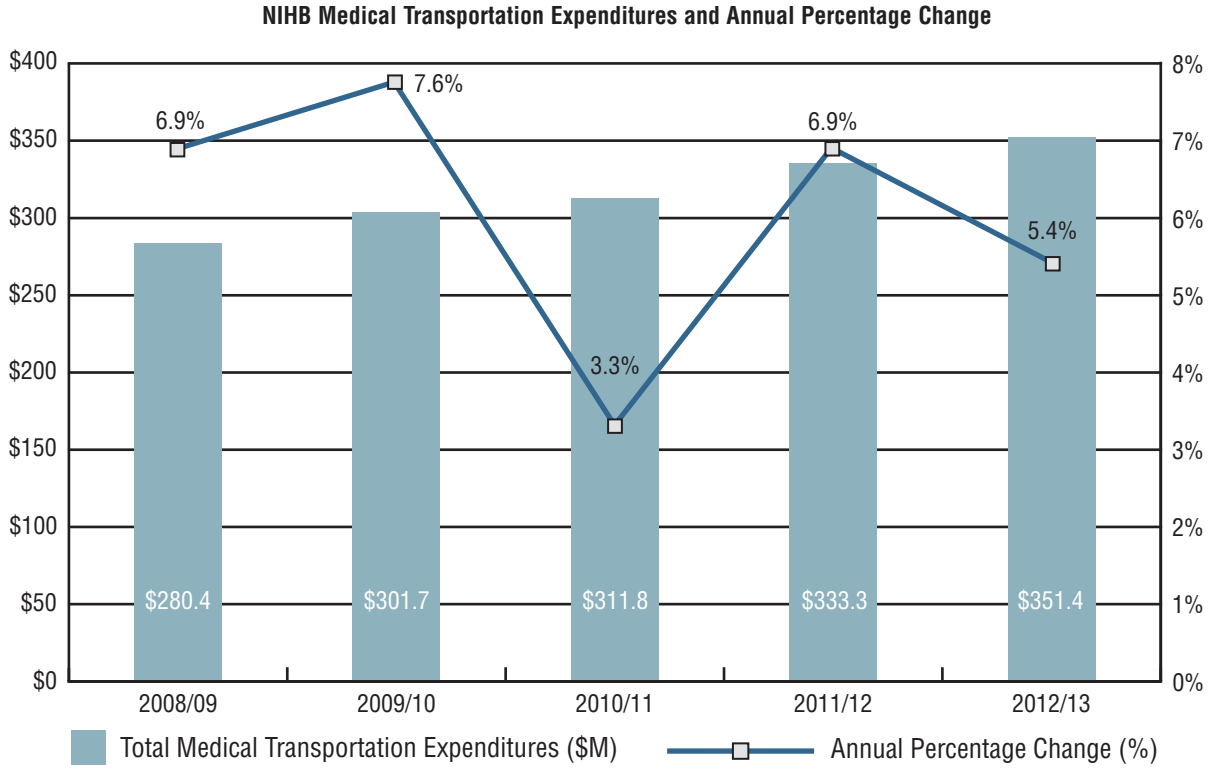
Annual NIHB Medical Transportation Expenditures
2008/09 to 2012/13

NIHB Medical Transportation expenditures increased by 5.4% in 2012/13. Over the last five years, growth in this benefit area has ranged from a high of 7.6% in 2009/10 to a low of 3.3% in 2010/11, with a five year annualized growth rate of 6.0%.

Over the past five years, overall medical transportation costs have grown by 25.3% from $280.4 million in 2008/09 to $351.4 million in 2012/13. On a regional basis, the highest growth rates over this period were in the Atlantic Region where expenditures grew by 47.7% from $4.7 million in 2008/09 to $6.9 million in 2012/13. This high growth is largely attributed to the $543 thousand dollars spent on transportation for the Qalipu Mi'kmaq in 2012/13. Without the new client expenditures, the Atlantic Region five year growth would have been 36.0%, second to Nunavut growth of 37.9%.

The largest net increase in expenditures over the past five years took place in the Manitoba Region where total medical transportation costs grew by $26.2 million over this period. The Ontario Region had the second largest net increase in expenditures over the past five years at $12.4 million followed by the Saskatchewan Region at $9.6 million.

The Manitoba Region had the highest total medical transportation expenditure at $109.4 million and the Yukon had the lowest total medical transportation expenditure at $3.9 million.



Source: FIRMS adapted by Program Analysis Division

NIHB Medical Transportation Expenditures ($ 000's)					
REGION	2008/09	2009/10	2010/11	2011/12	2012/13
Atlantic	$ 4,655	$ 5,048	$ 5,314	$ 5,841	$ 6,875
Quebec	20,502	19,918	18,943	21,708	22,578
Ontario	46,848	51,889	52,358	54,725	59,251
Manitoba	83,193	89,078	94,940	101,609	109,409
Saskatchewan	36,239	38,971	41,896	45,084	45,793
Alberta	35,357	36,601	35,877	37,371	39,216
British Columbia	22,711	25,547	25,967	26,510	26,573
Yukon	2,938	3,801	4,097	4,413	3,909
N.W.T.	7,952	8,520	8,498	10,157	10,157
Nunavut	20,053	22,302	23,869	25,886	27,661
Total	$ 280,446	$ 301,673	$ 311,760	$ 333,304	$ 351,424

Source: FIRMS adapted by Program Analysis Division

FIGURE 6.3

NIHB Medical Transportation Expenditures by Type and Region ($ 000's)
2012/13

NIHB Medical Transportation expenditures increased by 5.4% to $351.4 million in 2012/13.

The Atlantic Region had the largest percentage increase in medical transportation expenditures in 2012/13 at 17.7%. This growth is partly attributed to the uptake of medical transportation services by the Qalipu Mi'kmaq First Nations clients eligible to receive NIHB benefits since September 26, 2011. The Ontario Region followed with an 8.3% increase in expenditures.

In 2012/13, the Manitoba Region had the highest overall NIHB Medical Transportation expenditure at $109.4 million, primarily as a result of air transportation which totalled $55.5 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.

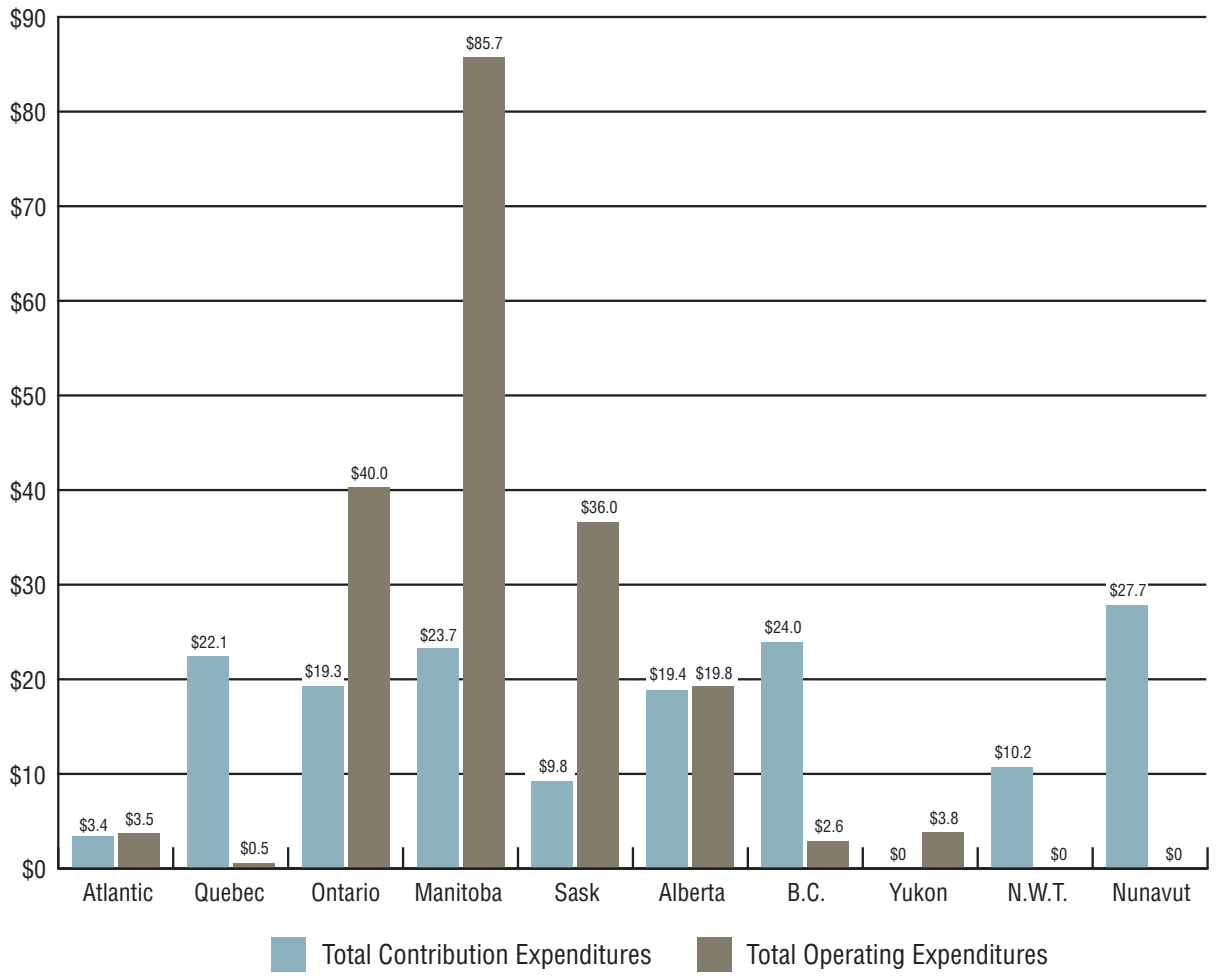
The Ontario Region represented the second highest medical transportation expenditure total in 2012/13 at $59.3 million. The regions of Saskatchewan and Alberta followed at $45.8 million and $39.2 million respectively in medical transportation expenditures.

TYPE	Atlantic	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia	Yukon	N.W.T.	Nunavut	TOTAL
Scheduled Flights	$ 809	$ 292	$ 20,909	$ 31,382	$ 4,930	$ 1,079	$ 389	$ 795	$ 0	$ 0	**$ 60,585**
Air Ambulance	2	6	41	21,550	3,103	1,670	3	1,637	0	0	**28,011**
Chartered Flights	22	0	4,375	2,602	1,537	1,249	0	0	0	0	**9,786**
Living Expenses	797	7	9,971	12,228	3,392	2,620	378	888	0	0	**30,282**
Land & Water	1,823	202	3,974	14,882	20,948	12,684	1,696	497	0	0	**56,705**
Professional Travel	0	0	688	3,049	2,103	541	97	0	0	0	**6,479**
Total Operating	**$ 3,452**	**$ 508**	**$ 39,960**	**$ 85,693**	**$ 36,013**	**$ 19,843**	**$ 2,563**	**$ 3,816**	**$ 0**	**$ 0**	**$ 191,847**
Total Contributions	$ 3,424	$ 22,071	$ 19,291	$ 23,716	$ 9,781	$ 19,373	$ 24,010	$ 93	$ 10,157	$ 27,661	**$ 159,577**
TOTAL	**$ 6,875**	**$ 22,578**	**$ 59,251**	**$ 109,409**	**$ 45,793**	**$ 39,216**	**$ 26,573**	**$ 3,909**	**$ 10,157**	**$ 27,661**	**$ 351,424**
% Change from 2011/12	17.7%	4.0%	8.3%	7.7%	1.6%	4.9%	0.2%	-11.4%	0.0%	6.9%	5.4%

Source: FIRMS adapted by Program Analysis Division

FIGURE 6.4

NIHB Medical Transportation Contribution and Operating Expenditures by Region ($ Millions)
2012/13



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 2012/13, a total of 490 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 2012/13 at $85.7 million. This higher cost in the Manitoba Region is primarily the result of approximately 59,400 clients living in 22 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 $40.0 million, followed closely by the Saskatchewan Region at $36.0 million. Together these three regions accounted for 84.3% of all operating expenditures on medical transportation.

In 2012/13, Nunavut had the largest contribution expenditures for NIHB Medical Transportation at $27.7 million, followed by the regions of British Columbia and Manitoba at $24.0 million and $23.7 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.

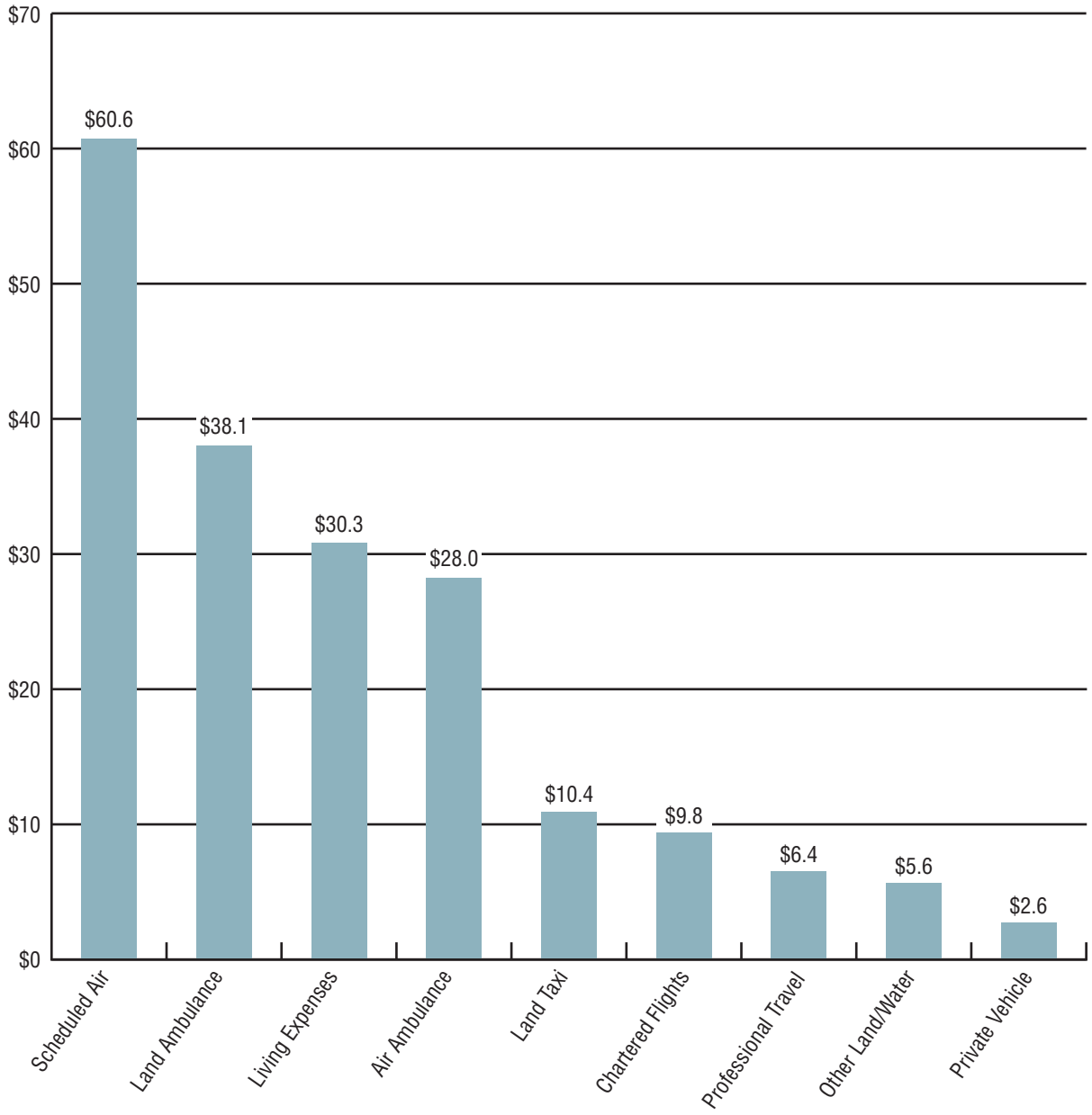
FIGURE 6.5

NIHB Medical Transportation Operating Expenditure by Type ($ Millions)
2012/13

In 2012/13, scheduled flights represented the largest portion of NIHB's Medical Transportation operating expenditures at $60.6 million or 31.6% of the total national operating expenditures. Land ambulance costs were the second highest at $38.1 million representing 19.9% of operating expenditures. Living expenses, which include accommodations and meals, followed at $30.3 million or 15.8%. Air ambulance followed closely at $28.0 million or 14.6% of medical transportation operating costs.

Professional travel expenditures ($6.4 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 ($2.6 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 four 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

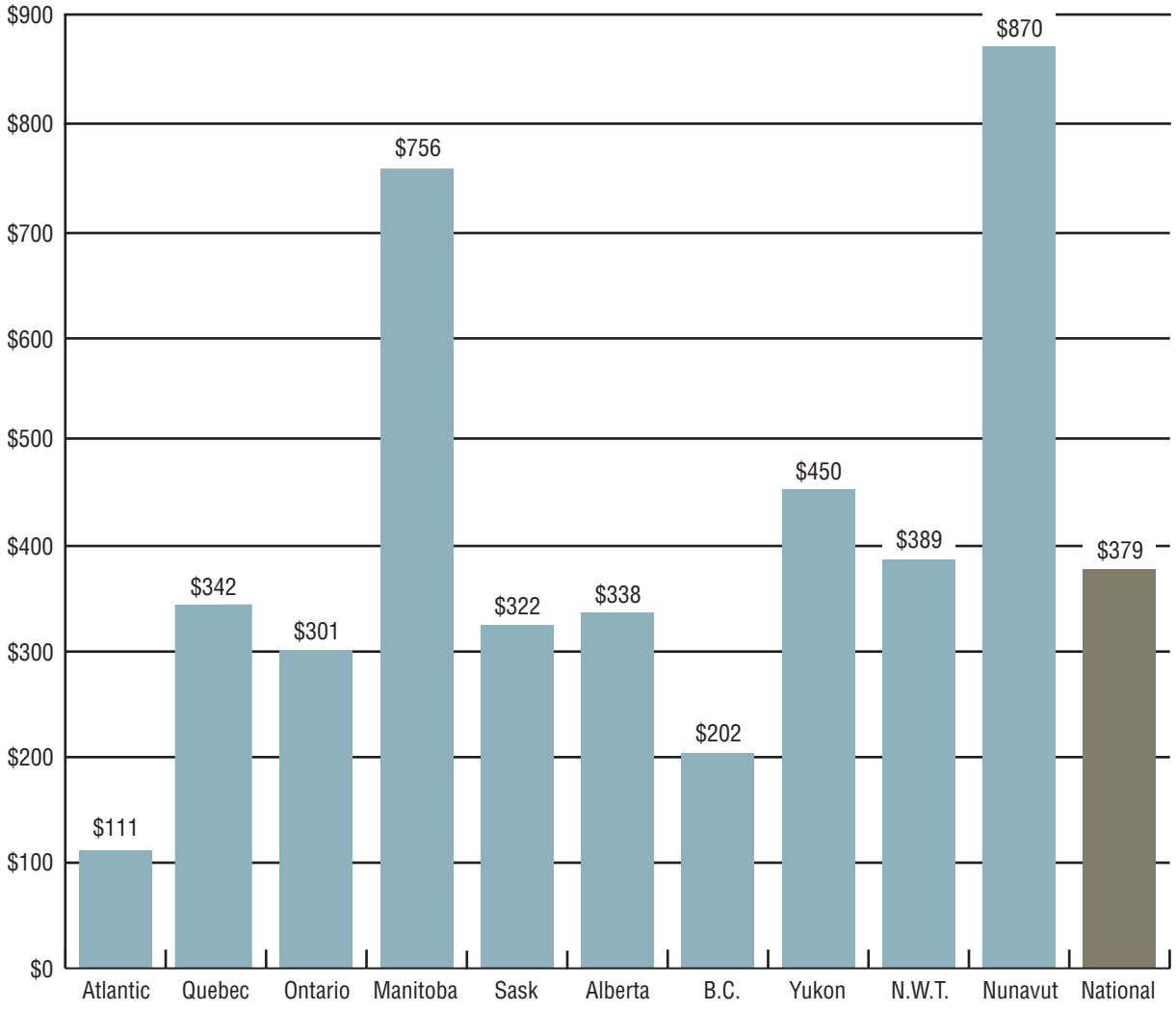
Per Capita NIHB Medical Transportation Expenditures by Region
2012/13

In 2012/13, the national per capita expenditure in NIHB Medical Transportation was $379. This represents an increase of 2.1% over the 2011/12 per capita expenditure of $372.

Nunavut recorded the highest per capita expenditure in medical transportation at $870, followed by the Manitoba Region at $756. 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 $111, an increase from $100 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 lower per capita expenditure can also be attributed to the lower level of the medical transportation benefit utilization for the Qalipu Mi'kmaq clients, which impacts the overall medical transportation per capita cost for the Atlantic Region.

In 2012/13, the highest rates of growth in NIHB Medical Transportation per capita expenditures was in the Atlantic Region (10.6%), followed by the Manitoba Region (4.9%).



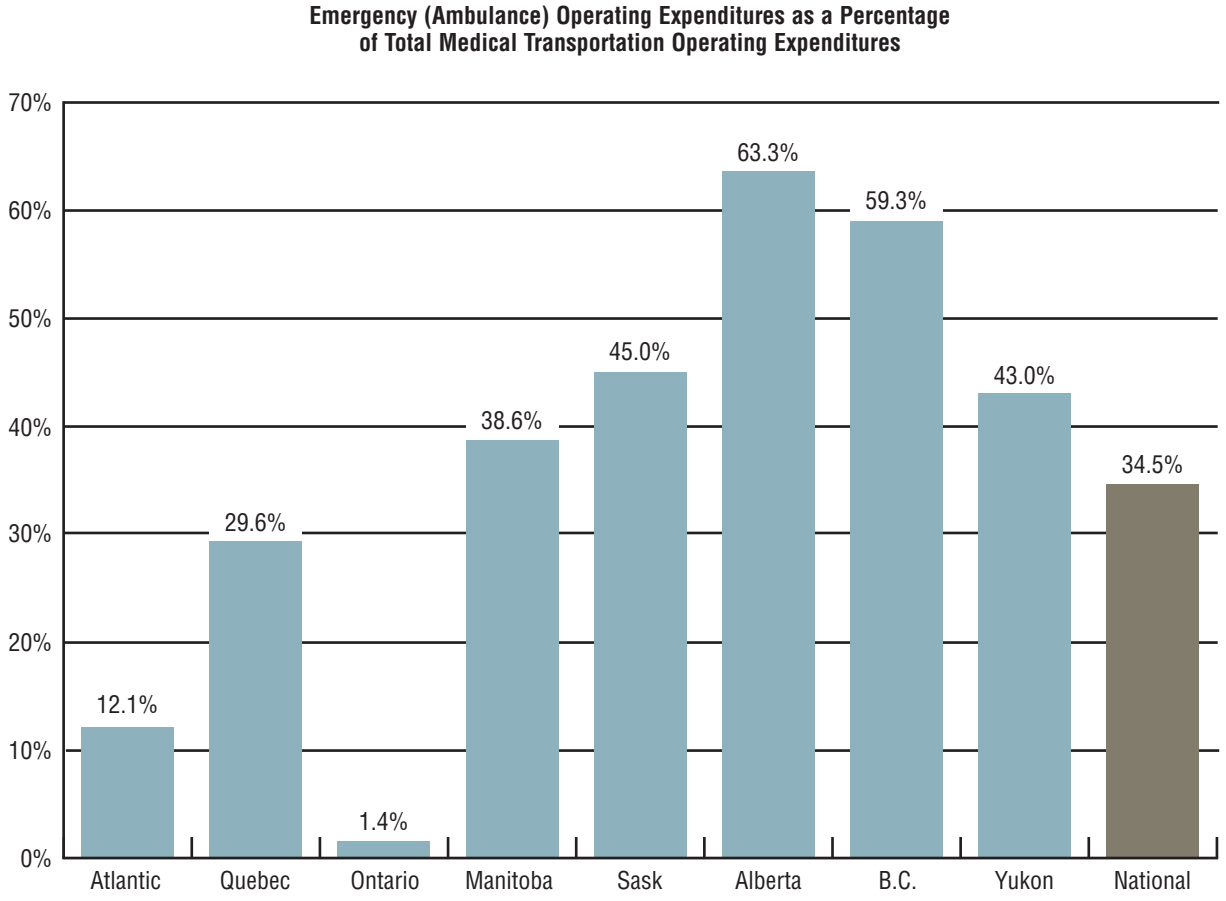
Source: SVS and FIRMS adapted by Program Analysis Division

FIGURE 6.7

NIHB Medical Transportation Emergency (Ambulance) Operating Expenditures by Region
2012/13

In 2012/13, regionally managed NIHB Medical Transportation operating costs totalled $191.8 million. Of this total, $66.1 million or 34.5% 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 2012/13, the Manitoba Region recorded the highest emergency (ambulance) operating expenditures at $33.1 million, comprising half (50.1%) 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 $16.2 million followed by the Alberta Region at $12.6 million.

The majority of the medical transportation operating expenditures within the Alberta Region consisted of emergency costs (63.3%). 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 59.3%.

Almost half (45.0%) of medical transportation operating expenditures in the Saskatchewan Region were for emergency transportation, followed by the Yukon (43.0%), Manitoba Region (38.6%), and the Quebec Region (29.6%).

The Ontario Region had the lowest percentage spent on emergency transportation, accounting for only 1.4% 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), 2012/13

TYPE		Atlantic	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia	Yukon	National
Ambulance Operating Costs	Air Ambulance	$ 1.8	$ 6.1	$ 41.4	$ 21,549.5	$ 3,102.5	$ 1,669.8	$ 3.3	$ 1,636.7	$ 28,011.2
	Land Ambulance	416.8	144.4	502.8	11,557.3	13,093.1	10,895.5	1,515.3	3.8	38,128.9
	Total	**418.6**	**150.4**	**544.2**	**33,106.8**	**16,195.7**	**12,565.3**	**1,518.6**	**1,640.5**	**66,140.0**
Share of Ambulance Costs	Air Ambulance	0.4%	4.0%	7.6%	65.1%	19.2%	13.3%	0.2%	99.8%	42.4%
	Land Ambulance	99.6%	96.0%	92.4%	34.9%	80.8%	86.7%	99.8%	0.2%	57.6%
Total Medical Transportation Operating Costs		**$ 3,451.9**	**$ 507.5**	**$ 39,959.5**	**$ 85,692.9**	**$ 36,012.9**	**$ 19,843.4**	**$ 2,562.8**	**$ 3,815.8**	**$ 191,846.7**
Emergency Operating Costs as % of Total Medical Transportation Operating Costs		**12.1%**	**29.6%**	**1.4%**	**38.6%**	**45.0%**	**63.3%**	**59.3%**	**43.0%**	**34.5%**

Source: FIRMS adapted by Program Analysis Division

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

In 2012/13, total expenditures for NIHB Vision benefits ($32.2 million), Other Health Care benefits ($14.3 million) and Premiums ($21.3 million) amounted to $67.8 million, or 6.1% 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 2012/13, 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)
2012/13

NIHB Vision expenditures totalled $32.2 million in 2012/13. Regional operating expenditures accounted for $26.7 million or 82.9% of total expenditures while contribution costs accounted for $5.5 million or 17.1%.

The Alberta Region had the highest percentage share in NIHB Vision benefit costs at 18.1%, followed by the Saskatchewan Region at 17.6% and the Ontario Region at 16.8%.

In 2012/13, the highest percentage change in NIHB Vision expenditures was in the Atlantic Region which increased by 46.9%. This high increase is due to an uptake of vision benefits by the Qalipu Mi'kmaq clients. The Saskatchewan Region followed with an increase of 27.6%. Four Regions experienced a decrease in growth over 2011/12, the lowest being the Yukon (-5.8%) and the British Columbia Region (-5.1%).

The largest net increases in expenditures took place in the Saskatchewan and Atlantic regions where total vision care costs grew by $1,227 thousand and $948 thousand respectively.

In 2012/13, the Alberta and Saskatchewan regions had the highest expenditures in vision care at $5.8 million and $5.7 million respectively.

Region	Operating	Contributions	TOTAL	% Change from 2011/12
Atlantic	$ 2,778	$ 191	$ 2,969	46.9%
Quebec	1,511	60	1,570	11.9%
Ontario	4,895	517	5,412	-0.2%
Manitoba	3,784	265	4,048	6.2%
Saskatchewan	5,676	0	5,676	27.6%
Alberta	4,934	902	5,836	0.3%
British Columbia	2,774	510	3,285	-5.1%
Yukon	327	0	327	-5.8%
N.W.T.	0	1,368	1,368	-0.3%
Nunavut	0	1,675	1,675	0.4%
Total	**$ 26,679**	**$ 5,487**	**$ 32,167**	**8.0%**

Source: FIRMS adapted by Program Analysis Division

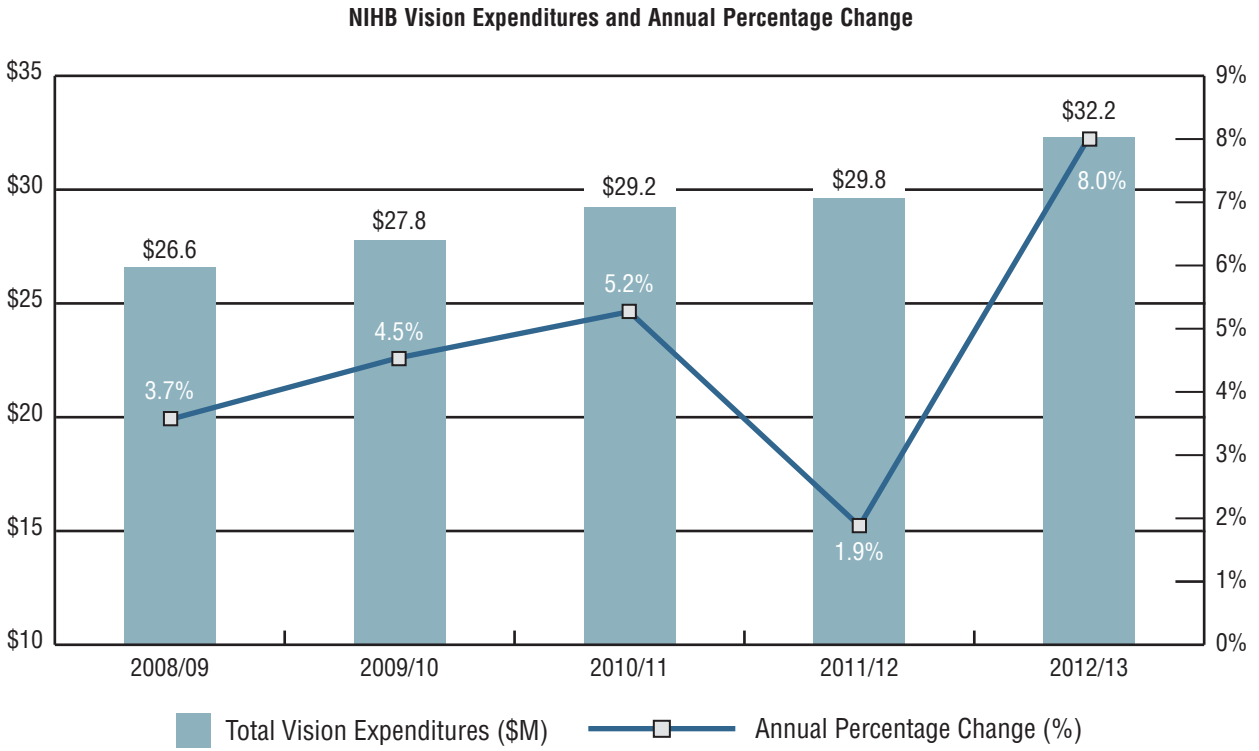
FIGURE 7.2

Annual NIHB Vision Expenditures
2008/09 to 2012/13

In 2012/13, NIHB Vision expenditures increased by 8.0%, compared to the 1.9% increase recorded in 2011/12. Over the past five years, growth in NIHB Vision expenditures has ranged from a high of 8.0% in 2012/13 to a low of 1.9% in 2011/12. The annualized growth rate over these five years was 4.7%.

Over the past five years, overall vision benefit costs have grown by 21.0% from $26.6 million in 2008/09 to $32.2 million in 2012/13. On a regional basis, the highest expenditure growth rate over this five year period was in the Atlantic Region where expenditures grew by 86.0% from $1.6 million in 2008/09 to $3.0 million in 2012/13. This growth is partly attributed to the uptake of vision services by the Qalipu Mi'kmaq First Nations clients eligible to receive NIHB benefits since September 26, 2011. If we exclude the Qalipu clients vision expenditures in 2012/13 of $895.6 thousand, the five year growth would have been 29.9%.

The largest net increases in expenditures over the past five years took place in the Saskatchewan Region where total vision benefit costs grew by $1.5 million over this period, followed closely by the Atlantic Region where costs grew by $1.4 million.



Source: FIRMS adapted by Program Analysis Division

NIHB Vision Expenditures ($ 000's)					
REGION	2008/09	2009/10	2010/11	2011/12	2012/13
Atlantic	$ 1,596	$ 1,612	$ 1,758	$ 2,021	$ 2,969
Quebec	1,220	1,280	1,336	1,404	1,570
Ontario	5,204	5,343	5,183	5,425	5,412
Manitoba	3,157	3,407	3,612	3,813	4,048
Saskatchewan	4,166	4,222	4,658	4,449	5,676
Alberta	5,225	5,377	5,778	5,822	5,836
British Columbia	3,251	3,253	3,344	3,461	3,285
Yukon	242	299	311	347	327
N.W.T.	1,130	1,340	1,331	1,371	1,368
Nunavut	1,387	1,646	1,908	1,668	1,675
Total	**$ 26,577**	**$ 27,779**	**$ 29,219**	**$ 29,780**	**$ 32,167**

Source: FIRMS adapted by Program Analysis Division

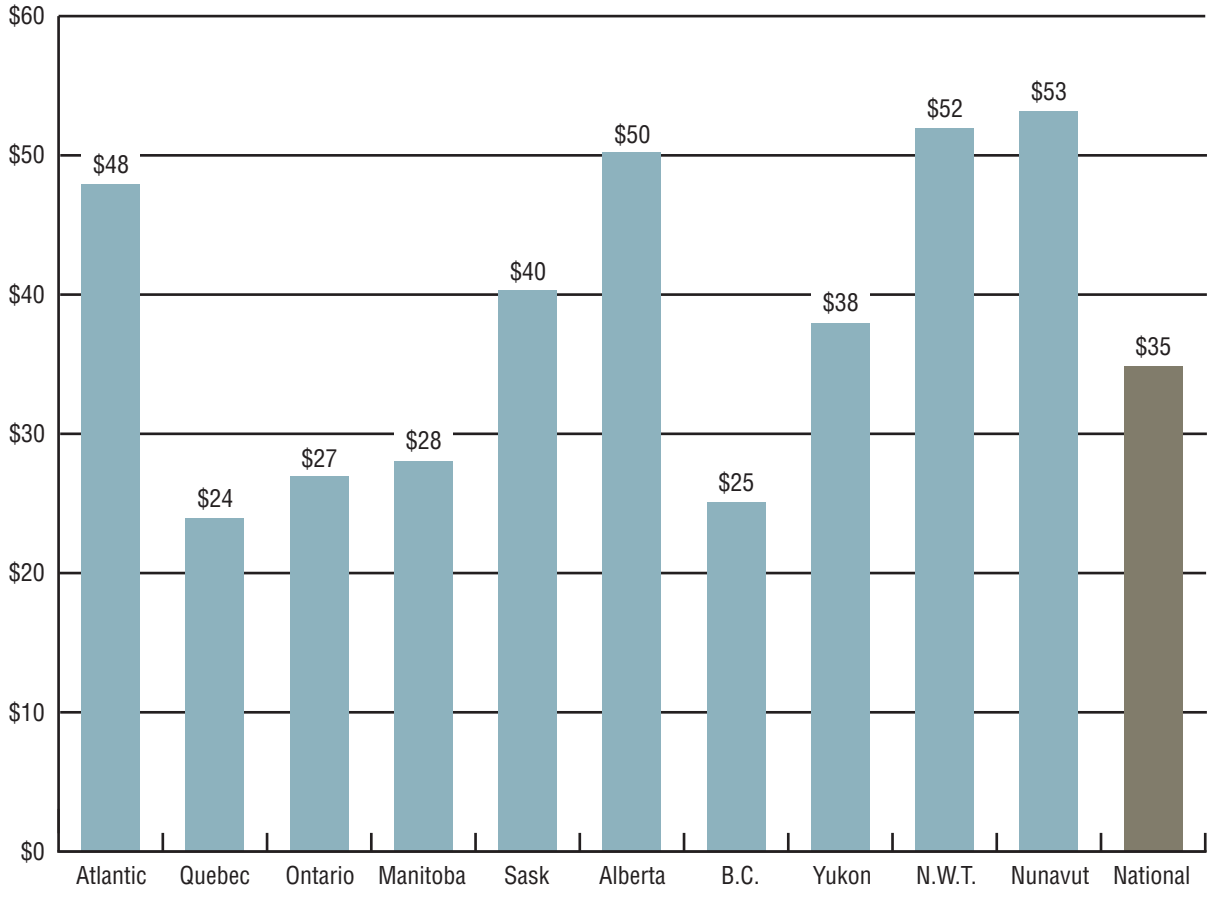
FIGURE 7.3

Per Capita NIHB Vision Expenditures by Region
2012/13

In 2012/13, the national per capita expenditure in NIHB Vision benefits was $35, an increase from $33 in 2011/12.

Nunavut had the highest per capita expenditure at $53, followed by the Northwest Territories at $52. The Quebec Region registered the lowest per capita expenditure at $24.

The Atlantic Region per capita cost increased from $35 in 2011/12 to $48 in 2012/13. This increase in per capita expenditures can be attributed to an increase in vision benefit utilization by the Qalipu Mi'kmaq First Nations clients who were eligible to claim benefits for a full fiscal year 2012/13.



Source: SVS and FIRMS adapted by Program Analysis Division

FIGURE 7.4

NIHB Other Health Care Expenditures by Region ($ 000's)
2012/13

In 2012/13, NIHB Other Health Care expenditures, which consist primarily of short-term crisis intervention mental health counselling, amounted to $14.3 million. Regional operating expenditures accounted for $9.9 million or 68.8% of total expenditures while contribution costs accounted for $4.5 million or 31.2%.

In 2012/13, the Alberta Region had the highest percentage share of NIHB Other Health Care expenditures at 33.4% followed by the Manitoba and Ontario regions at 23.9% and 17.4% respectively.

The Alberta Region had the highest expenditure in other health care, registering close to $4.8 million in total expenditures, followed by the regions of Manitoba and Ontario at $3.4 million and $2.5 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	$ 114	$ 398	**$ 512**
Quebec	958	177	**1,135**
Ontario	2,490	0	**2,490**
Manitoba	2,857	572	**3,429**
Saskatchewan	533	505	**1,038**
Alberta	2,710	2,081	**4,791**
British Columbia	195	745	**940**
Yukon	4	0	**4**
N.W.T.	0	0	**0**
Nunavut	0	0	**0**
Total	**$ 9,860**	**$ 4,477**	**$ 14,337**

Source: FIRMS adapted by Program Analysis Division

FIGURE 7.5

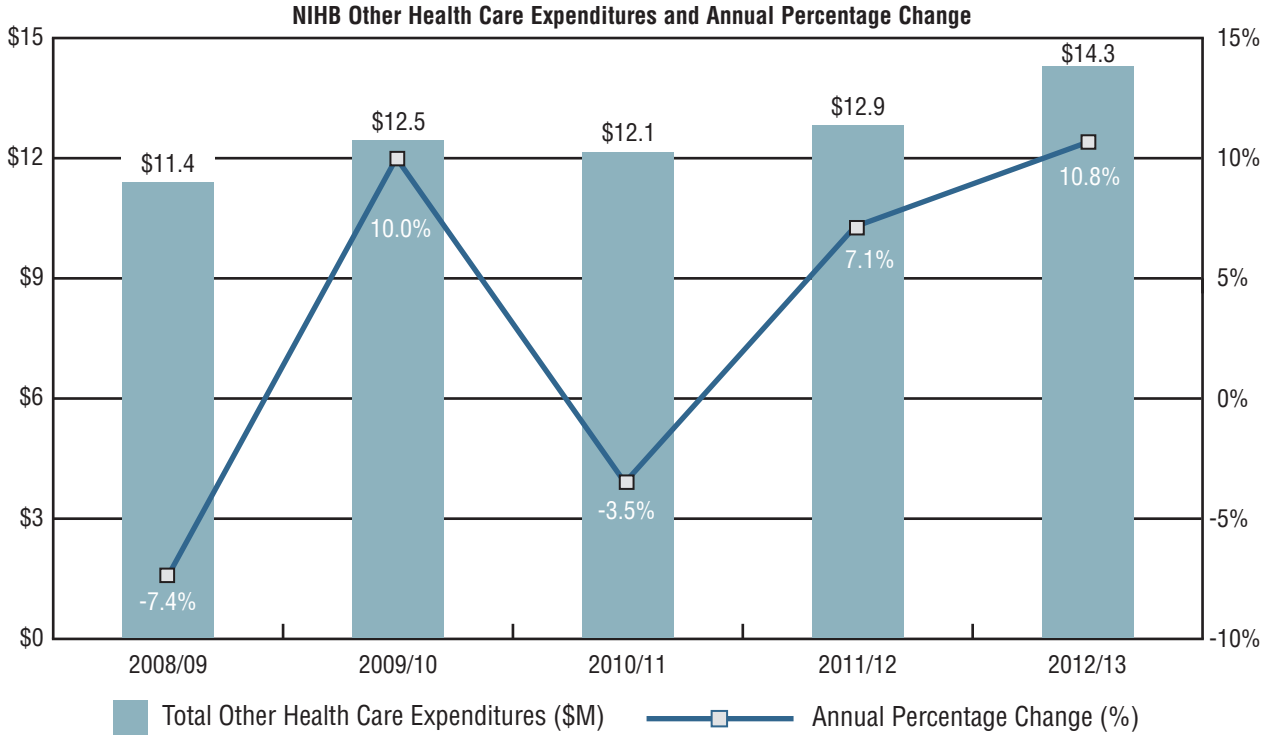
Annual NIHB Other Health Care Expenditures
2008/09 to 2012/13

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 2012/13, expenditures for this benefit area increased by 10.8%, representing a second consecutive year of high growth (7.1% growth recorded in 2011/12).

Over the previous five years, growth in NIHB Other Health Care expenditures has ranged from a high of 10.8% in 2012/13 to a low of -7.4% in 2008/09. The annualized growth rate over these five years was 3.1%.

Fluctuations in expenditures and growth rates since 2008/09 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 Alberta Region where total NIHB Other Health Care costs grew by $851 thousand from $3.9 million in 2008/09 to $4.8 million in 2012/13.



Source: FIRMS adapted by Program Analysis Division

NIHB Other Health Care Expenditures ($ 000's)					
REGION	2008/09	2009/10	2010/11	2011/12	2012/13
Atlantic	$ 251	$ 213	$ 241	$ 254	$ 512
Quebec	375	459	597	875	1,135
Ontario	2,158	2,603	2,632	2,349	2,490
Manitoba	2,619	3,143	2,930	3,109	3,429
Saskatchewan	870	812	$896	1,499	1,038
Alberta	3,940	4,363	3,903	3,957	4,791
British Columbia	1,165	924	882	889	940
Yukon	1	1	2	4	4
N.W.T.	0	0	0	0	0
Nunavut	0	0	0	0	0
Total	**$ 11,380**	**$ 12,516**	**$ 12,083**	**$ 12,936**	**$ 14,337**

Source: FIRMS adapted by Program Analysis Division

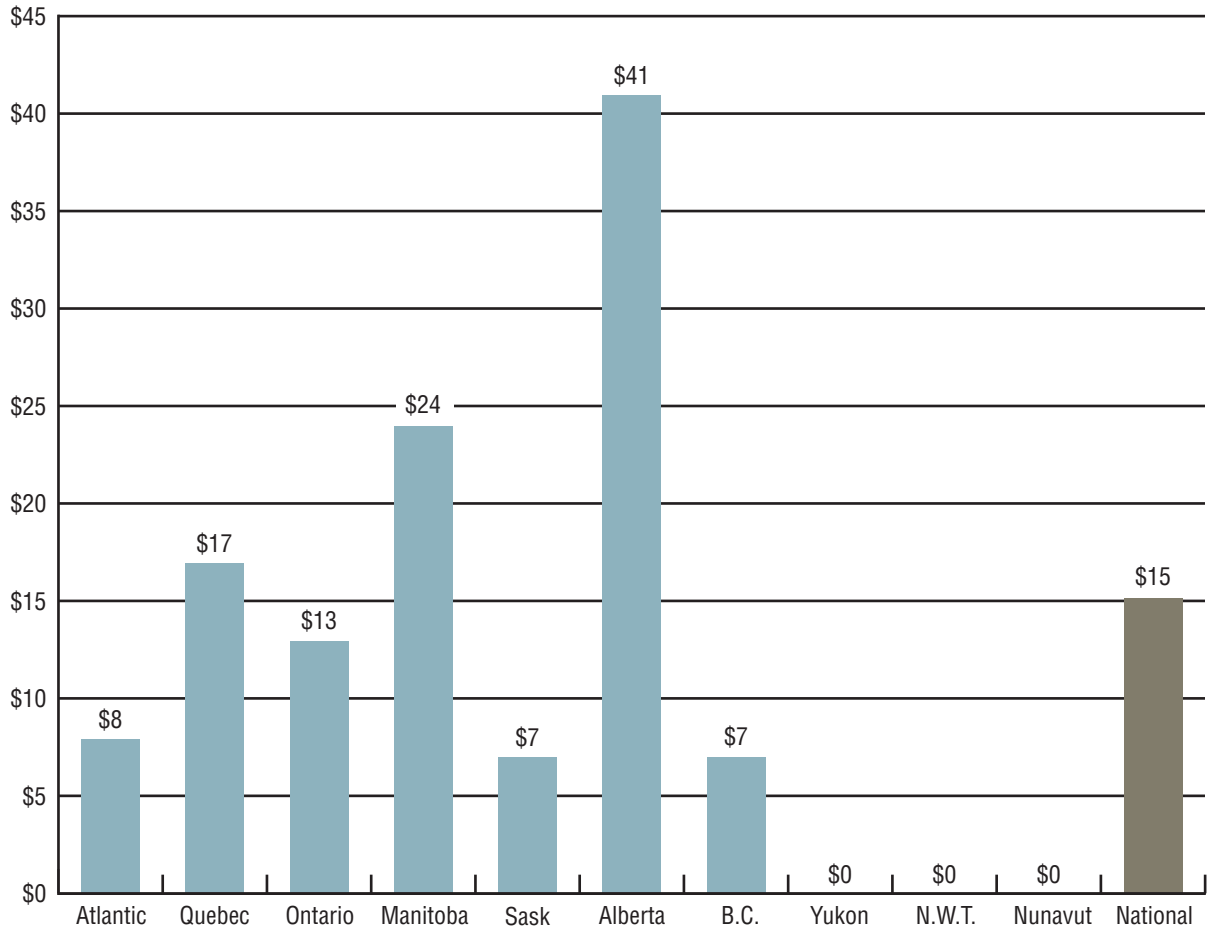
FIGURE 7.6

Per Capita NIHB Other Health Care Expenditures by Region
2012/13

In 2012/13, the national per capita expenditure for NIHB Other Health Care was $15, an increase from the $14 recorded in the previous fiscal year.

The Alberta Region had the highest per capita expenditure at $41, followed by the Manitoba Region at $24 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

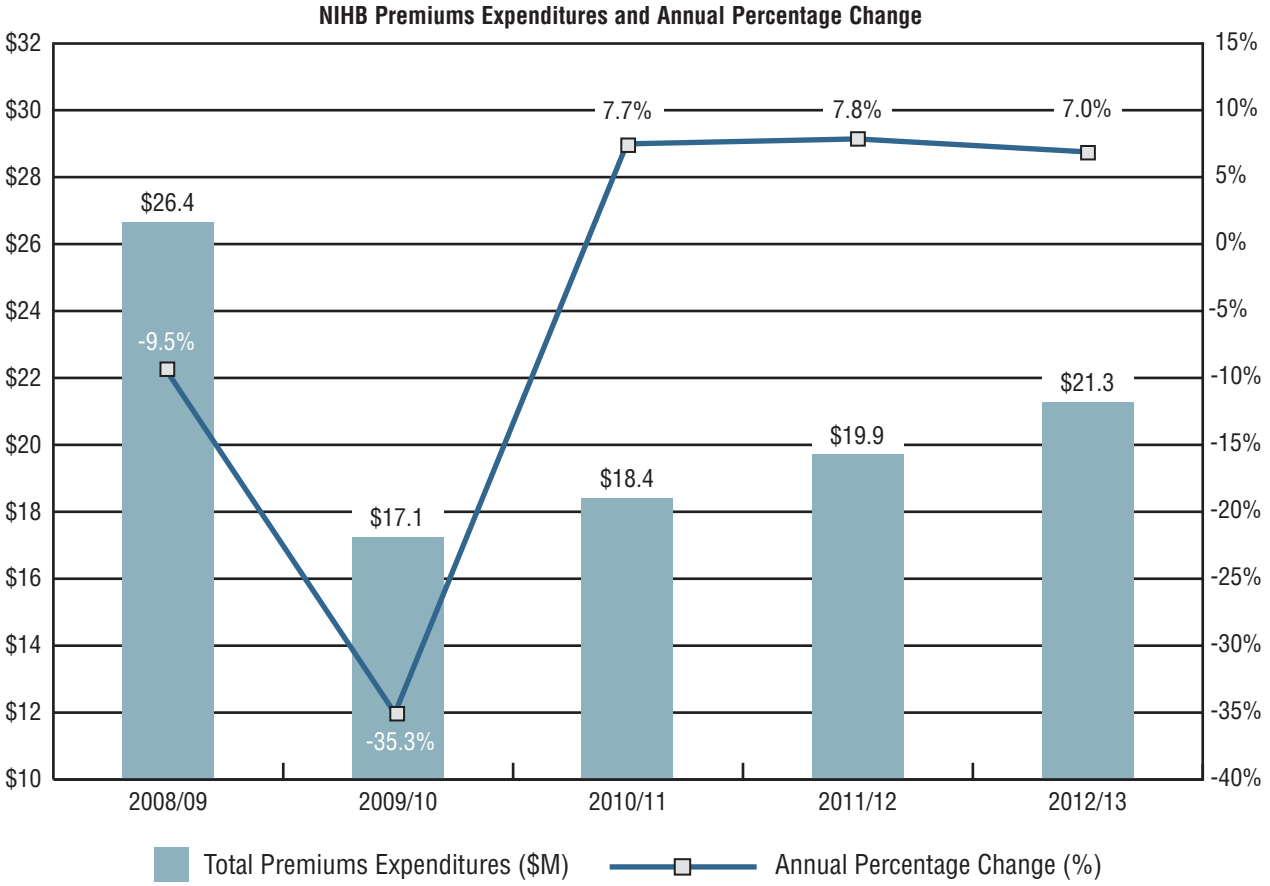
FIGURE 7.7

Annual NIHB Premiums Expenditures
2008/09 to 2012/13

In 2012/13, NIHB Premiums expenditures totalled $21.3 million, an increase of 7.0% over the previous fiscal year. This increase in expenditures can be mainly attributed to new Medical Services Plan premium rates in British Columbia which came into force on January 1, 2012.

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 -6.2% and is attributable to the elimination of insurance premiums by the Government of Alberta. The annualized growth rate for premiums in the British Columbia Region only over this five year period is 5.5%.



Source: FIRMS adapted by Program Analysis Division

NIHB Premiums Expenditures ($ 000's)					
Region	2008/09	2009/10	2010/11	2011/12	2012/13
Alberta	$ 9,920	$ 0	$ 0	$ 0	$ 0
British Columbia	16,510	17,110	18,428	19,868	21,257
Total	**$ 26,430**	**$ 17,110**	**$ 18,428**	**$ 19,868**	**$ 21,257**

Source: FIRMS adapted by Program Analysis Division

Regional Expenditure Trends 2003/04 to 2012/13

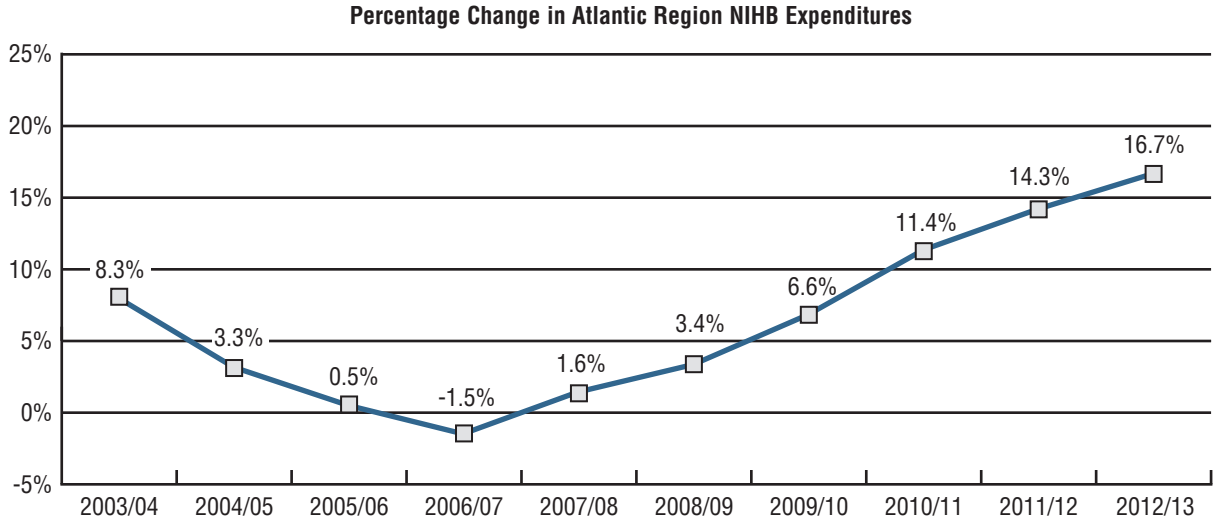
SECTION 8

FIGURE 8.1

Atlantic Region
2003/04 to 2012/13

Annual expenditures in the Atlantic Region for 2012/13 totalled $50.0 million, an increase of 16.7% from the $42.9 million spent in 2011/12. Pharmacy expenditures in 2012/13 increased by 8.7% to $30.0 million, medical transportation costs increased by 17.7% to $6.9 million and dental expenditures increased by 34.9% to $9.7 million. Other health care expenditures increased by 101.3%, accounting for the highest expenditure growth, followed by vision care with an increase of 46.9%.

Pharmacy expenditures accounted for more than half of the Atlantic Region's total expenditures at 60.0%, dental expenditures ranked second at 19.3%, followed by medical transportation at 13.8%. Vision care and other health care accounted for 5.9% and 1.0% of total expenditures respectively.



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, 2013, a total of 23,856 Qalipu clients were registered in the Status Verification System (SVS) and were eligible to receive benefits through the NIHB Program.

Annual Expenditures by Benefit ($ 000's)

Atlantic Region	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Medical Transportation	$ 6,498	$ 6,124	$ 5,590	$ 4,401	$ 4,585	$ 4,655	$ 5,048	$ 5,314	$ 5,841	$ 6,875
Pharmacy	16,265	17,533	18,293	18,938	18,984	20,119	21,357	23,689	27,571	29,979
Dental	4,857	4,934	4,831	5,128	5,204	4,945	5,426	6,481	7,164	9,660
Other Health Care	141	161	201	192	272	251	213	241	254	512
Vision Care	1,631	1,619	1,614	1,408	1,495	1,596	1,612	1,758	2,021	2,969
Total	**$ 29,391**	**$ 30,371**	**$ 30,529**	**$ 30,067**	**$ 30,539**	**$ 31,567**	**$ 33,656**	**$ 37,482**	**$ 42,850**	**$ 49,995**

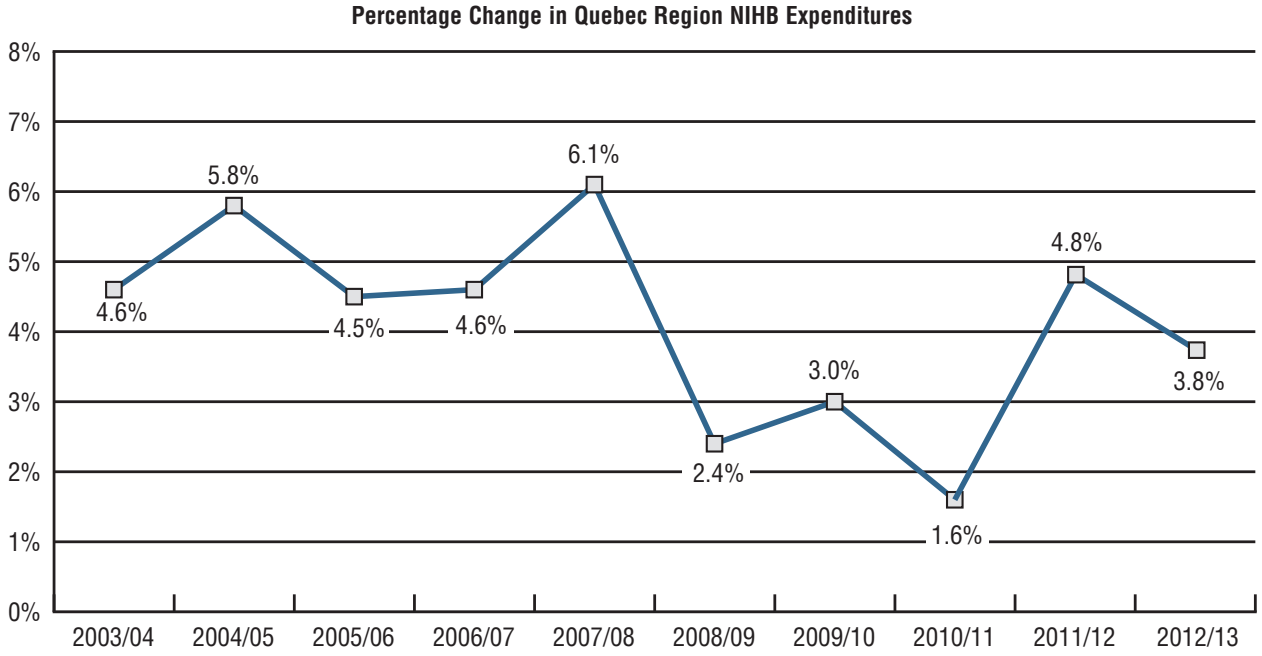
Source: FIRMS adapted by Program Analysis Division

FIGURE 8.2

Quebec Region
2003/04 to 2012/13

Annual expenditures in the Quebec Region for 2012/13 totalled $80.9 million, an increase of 3.8% from the $78.0 million spent in 2011/12. Pharmacy expenditures in 2012/13 increased by 4.0% to $40.4 million, medical transportation costs increased by 4.0% to $22.6 million, and dental benefits recorded the lowest expenditure increase by 0.7% to $15.2 million. Vision care and other health care expenditures increased by 11.9% and 29.7% respectively.

Pharmacy expenditures accounted for half of the Quebec Region's total expenditures at 49.9%, medical transportation expenditures ranked second at 27.9%, followed by dental at 18.8%. Vision care and other health care accounted for 1.9% and 1.4% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)

Quebec Region	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Medical Transportation	$ 16,985	$ 17,291	$ 17,886	$ 18,473	$ 20,133	$ 20,502	$ 19,918	$ 18,943	$ 21,708	$ 22,578
Pharmacy	27,436	29,959	31,771	33,486	35,372	36,069	37,358	38,234	38,827	40,393
Dental	10,277	10,525	10,970	11,603	12,141	12,895	14,159	15,245	15,138	15,239
Other Health Care	726	697	750	583	471	375	459	597	875	1,135
Vision Care	1,097	1,349	1,135	1,270	1,257	1,220	1,280	1,336	1,404	1,570
Total	**$ 56,521**	**$ 59,820**	**$ 62,512**	**$ 65,414**	**$ 69,374**	**$ 71,060**	**$ 73,174**	**$ 74,355**	**$ 77,951**	**$ 80,915**

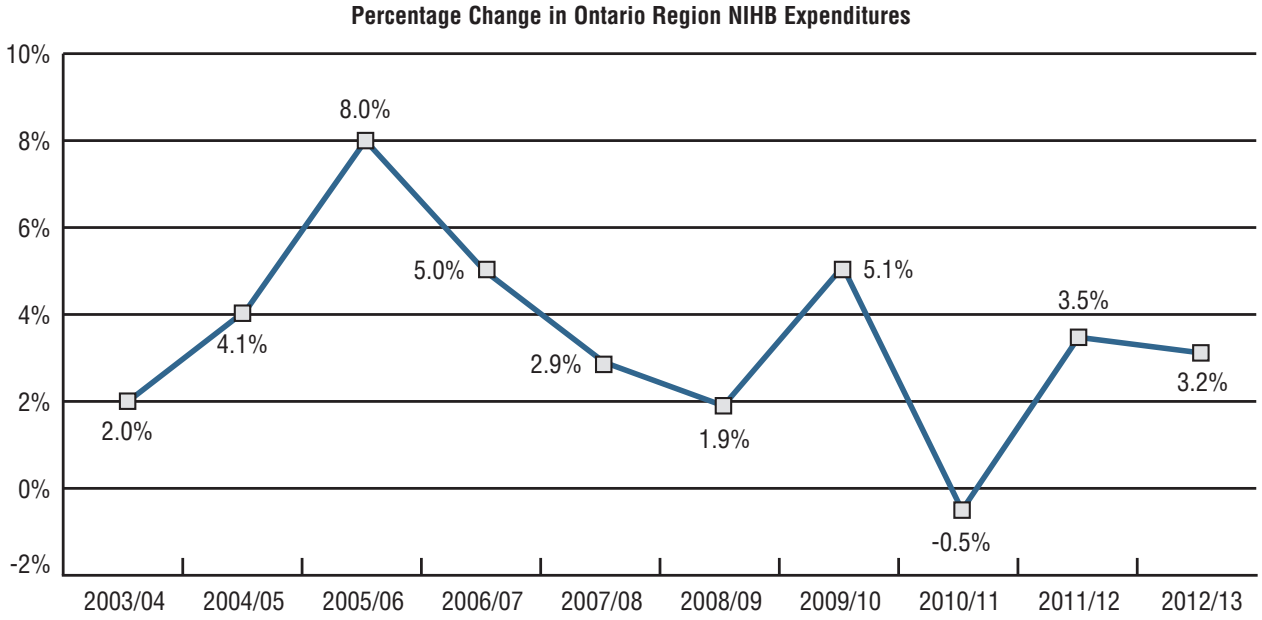
Source: FIRMS adapted by Program Analysis Division

FIGURE 8.3

Ontario Region
2003/04 to 2012/13

Annual expenditures in the Ontario Region for 2012/13 totalled $186.5 million, an increase of 3.2% from the $180.8 million spent in 2011/12. Pharmacy expenditures in 2012/13 increased by 0.9% to $77.1 million, medical transportation costs increased by 8.3% to $59.3 million and dental expenditures increased by 1.0% to $42.3 million. Vision care expenditures decreased by 0.2% while other health care expenditures increased by 6.0%.

Pharmacy expenditures accounted for 41.3% of the Ontario Region's total expenditures, medical transportation costs ranked second at 31.8%, followed by dental at 22.7%. Vision care and other health care accounted for 2.9% and 1.3% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)										
Ontario Region	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Medical Transportation	$ 36,620	$ 35,258	$ 38,553	$ 40,572	$ 45,618	$ 46,848	$ 51,889	$ 52,358	$ 54,725	$ 59,251
Pharmacy	62,953	67,508	73,223	77,788	77,191	77,244	77,564	73,887	76,430	77,131
Dental	27,760	29,655	32,064	32,777	33,467	35,457	38,047	40,594	41,848	42,259
Other Health Care	2,250	2,404	2,213	2,530	2,172	2,158	2,603	2,632	2,349	2,490
Vision Care	5,196	5,428	5,458	5,485	5,366	5,204	5,343	5,183	5,425	5,412
Total	**$ 134,779**	**$ 140,253**	**$ 151,510**	**$ 159,152**	**$ 163,814**	**$ 166,910**	**$ 175,447**	**$ 174,653**	**$ 180,778**	**$ 186,544**

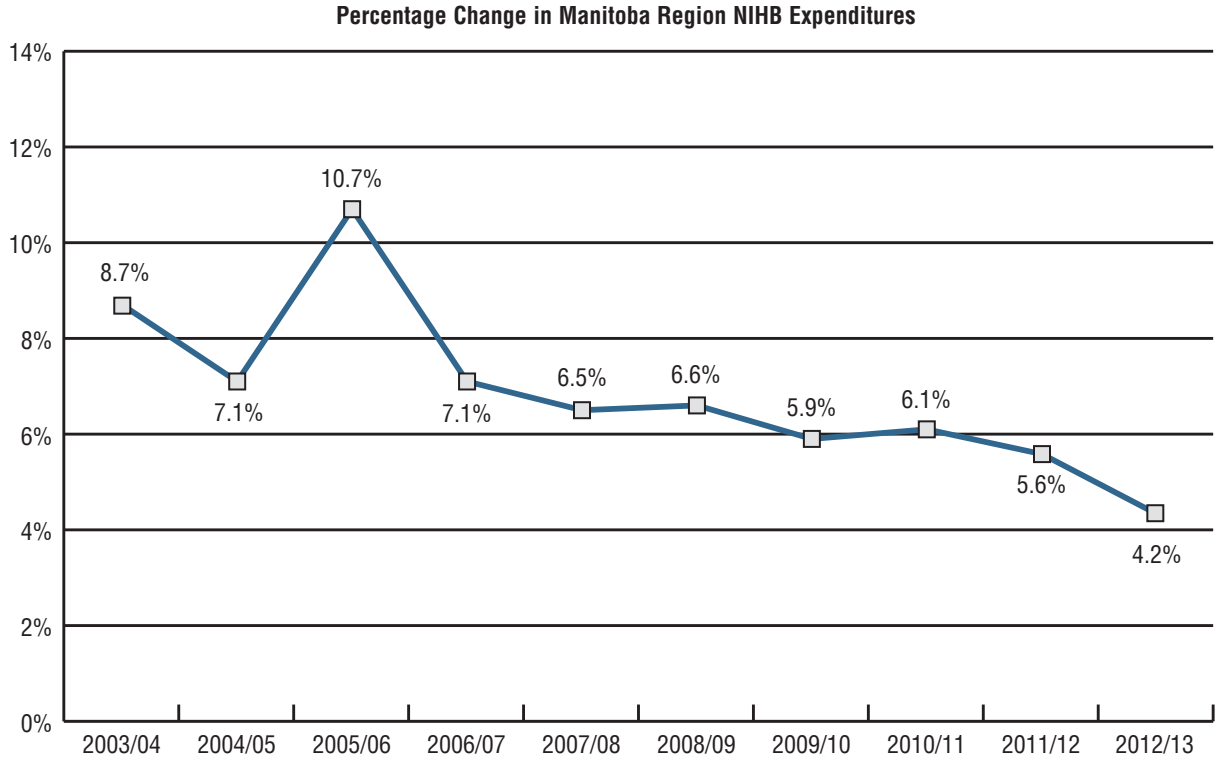
Source: FIRMS adapted by Program Analysis Division

FIGURE 8.4

Manitoba Region
2003/04 to 2012/13

Annual expenditures in the Manitoba Region for 2012/13 totalled $228.3 million, an increase of 4.2% from the $219.0 million spent in 2011/12. Pharmacy expenditures in 2012/13 increased very slightly by $37 thousand dollars to $80.7 million, medical transportation costs increased by 7.7% to $109.4 million and dental expenditures increased by 2.9% to $30.7 million. Vision care and other health care expenditures increased by 6.2% and 10.3% respectively.

Medical transportation expenditures comprised approximately half of the Manitoba Region's total expenditures at 47.9%, pharmacy costs ranked second at 35.3%, followed by dental at 13.5%. Vision care and other health care accounted for 1.8% and 1.5% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)

Manitoba Region	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Medical Transportation	$ 53,533	$ 55,895	$ 63,322	$ 69,047	$ 76,082	$ 83,193	$ 89,078	$ 94,940	$ 101,609	$ 109,409
Pharmacy	48,519	53,998	59,409	64,966	69,317	71,081	72,789	76,496	80,639	80,676
Dental	17,313	18,705	20,326	20,756	21,696	24,444	26,954	29,399	29,861	30,734
Other Health Care	5,621	5,685	5,690	4,786	2,964	2,619	3,143	2,930	3,109	3,429
Vision Care	2,888	2,684	2,864	2,841	2,936	3,157	3,407	3,612	3,813	4,048
Total	**$ 127,874**	**$ 136,967**	**$ 151,610**	**$ 162,396**	**$ 172,994**	**$ 184,494**	**$ 195,371**	**$ 207,377**	**$ 219,031**	**$ 228,295**

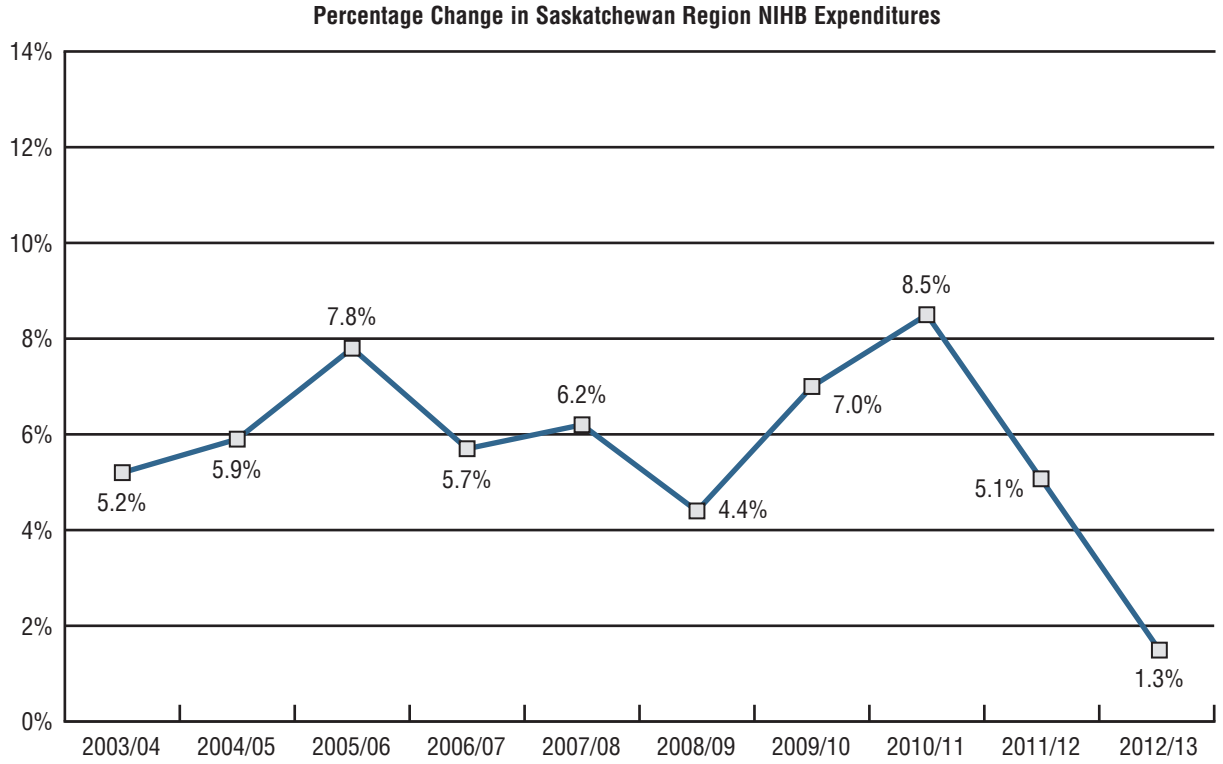
Source: FIRMS adapted by Program Analysis Division

FIGURE 8.5

Saskatchewan Region
2003/04 to 2012/13

Annual expenditures in the Saskatchewan Region for 2012/13 totalled $163.4 million, an increase of 1.3% from the $161.3 million spent in 2011/12. Pharmacy expenditures in 2012/13 increased by 1.8% to $74.6 million, medical transportation costs increased by 1.6% to $45.8 million and dental expenditures decreased by 2.0% to $36.2 million. Vision care expenditures increased by 27.6% while other health care expenditures decreased by 30.8%.

Pharmacy expenditures comprised the largest portion of the Saskatchewan Region's total expenditures at 45.7%, medical transportation costs ranked second at 28.0%, followed by dental at 22.2%. Vision care and other health care accounted for 3.5% and 0.6% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)										
Saskatchewan Region	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Medical Transportation	$ 25,854	$ 26,758	$ 28,786	$ 31,816	$ 36,108	$ 36,239	$ 38,971	$ 41,896	$ 45,084	$ 45,793
Pharmacy	48,952	52,636	55,687	58,083	60,749	62,809	66,639	70,625	73,293	74,646
Dental	18,297	19,530	22,038	23,219	24,636	28,102	30,777	35,317	36,941	36,219
Other Health Care	2,370	2,295	2,237	2,244	942	870	812	896	1,499	1,038
Vision Care	3,375	3,431	4,072	3,835	4,126	4,166	4,222	4,658	4,449	5,676
Total	**$ 98,847**	**$ 104,651**	**$ 112,820**	**$ 119,197**	**$ 126,561**	**$ 132,185**	**$ 141,420**	**$ 153,393**	**$ 161,265**	**$ 163,372**

Source: FIRMS adapted by Program Analysis Division

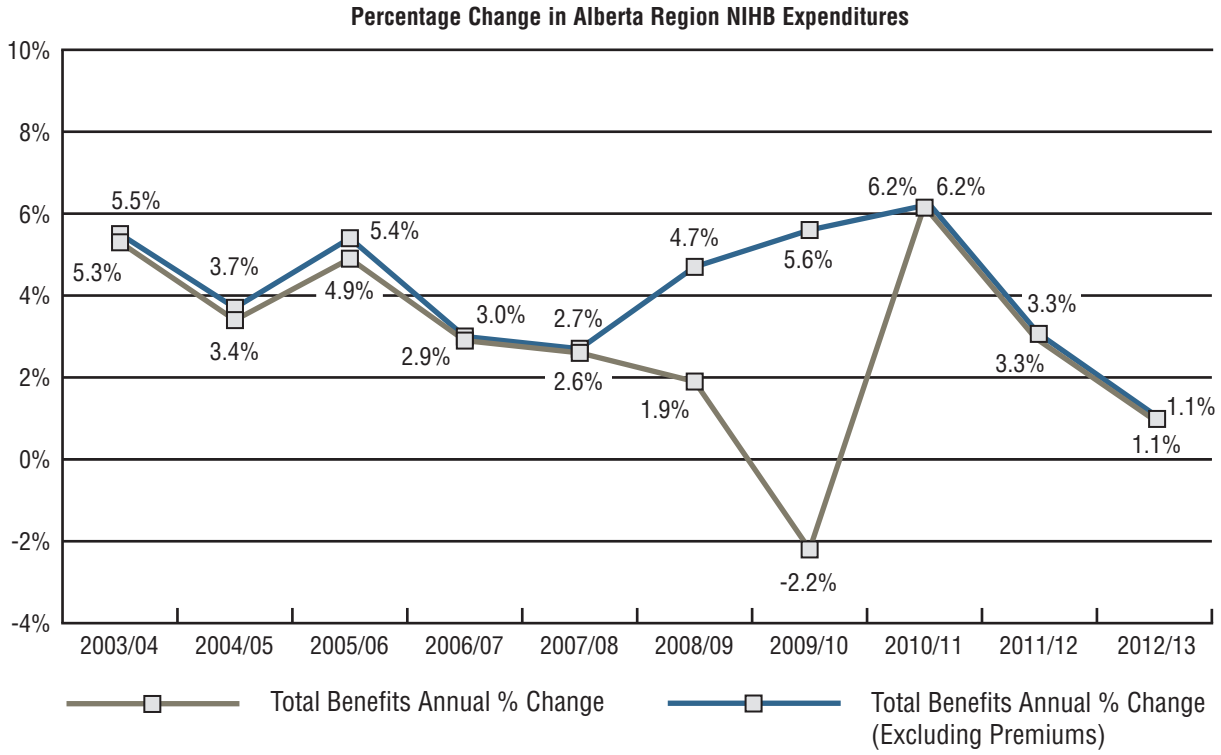
FIGURE 8.6

Alberta Region
2003/04 to 2012/13

Annual expenditures in the Alberta Region for 2012/13 totalled $144.9 million, an increase of 1.1% from the $143.3 million spent in 2011/12. Pharmacy expenditures in 2012/13 decreased by 1.7% to $60.6 million, medical transportation costs increased by 4.9% to $39.2 million and dental expenditures decreased by 0.1% to $34.5 million. Vision care and other health care expenditures increased by 0.3% and 21.1% respectively.

Pharmacy expenditures accounted for 41.8% of the Alberta Region's total expenditures, medical transportation costs ranked second at 27.1%, followed closely by dental at 23.8%. Vision care and other health care accounted for 4.0% and 3.3% 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	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Medical Transportation	$ 29,030	$ 29,686	$ 30,712	$ 32,204	$ 32,107	$ 35,357	$ 36,601	$ 35,877	$ 37,371	$ 39,216
Pharmacy	45,588	48,207	51,141	52,424	54,353	54,189	56,570	59,738	61,621	60,584
Dental	19,237	19,306	20,594	21,006	22,391	25,016	27,756	33,421	34,543	34,501
Other Health Care	3,794	4,078	4,537	4,736	4,343	3,940	4,363	3,903	3,957	4,791
Vision Care	4,576	4,720	4,762	4,690	4,942	5,225	5,377	5,778	5,822	5,836
Sub-Total	**102,224**	**105,996**	**111,746**	**115,060**	**118,135**	**123,726**	**130,666**	**138,717**	**143,313**	**144,928**
Premiums	12,202	12,377	12,381	12,709	12,961	9,920	0	0	0	0
Total	**$ 114,426**	**$ 118,373**	**$ 124,127**	**$ 127,769**	**$ 131,096**	**$ 133,646**	**$ 130,666**	**$ 138,717**	**$ 143,313**	**$ 144,928**

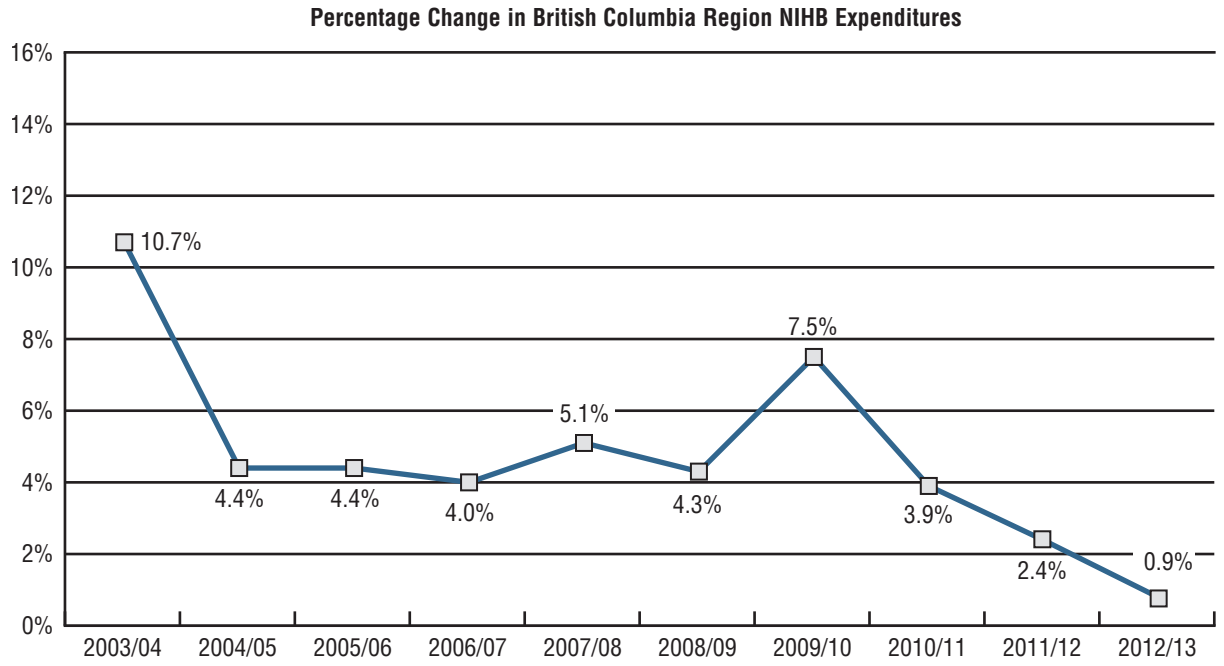
Source: FIRMS adapted by Program Analysis Division

FIGURE 8.7

British Columbia Region
2003/04 to 2012/13

Annual expenditures in the British Columbia Region for 2012/13 totalled $143.5 million, an increase of 0.9% from the $142.2 million spent in 2011/12. Pharmacy expenditures in 2012/13 decreased by 1.7% to $59.9 million. Medical transportation expenditures increased by 0.2% to $26.6 million and dental expenditures increased by 3.0% to $31.5 million. The cost of premiums increased by 7.0% while vision care expenditures decreased by 5.1%. Other health care expenditures increased by 5.7%.

Pharmacy expenditures accounted for 41.7% of the British Columbia Region's total expenditures, dental costs ranked second at 22.0%, followed by medical transportation at 18.5%. Premiums, vision care and other health care accounted for 14.8%, 2.3% and 0.7% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)										
British Columbia Region	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Medical Transportation	$ 16,408	$ 17,340	$ 16,944	$ 20,284	$ 21,613	$ 22,711	$ 25,547	$ 25,967	$ 26,510	$ 26,573
Pharmacy	44,141	46,670	49,734	50,387	54,290	56,104	58,862	60,097	60,890	59,858
Dental	18,338	20,357	22,439	22,588	22,968	24,718	28,042	30,187	30,620	31,543
Other Health Care	1,653	1,581	1,486	1,177	1,120	1,165	924	882	889	940
Vision Care	3,259	3,249	3,049	3,232	3,120	3,251	3,253	3,344	3,461	3,285
Sub-Total	83,800	89,197	93,652	97,669	103,111	107,948	116,628	120,476	122,371	122,198
Premiums	16,411	15,453	15,606	15,951	16,250	16,510	17,110	18,428	19,868	21,257
Total	$ 100,212	$ 104,650	$ 109,259	$ 113,620	$ 119,361	$ 124,458	$ 133,739	$ 138,905	$ 142,239	$ 143,455

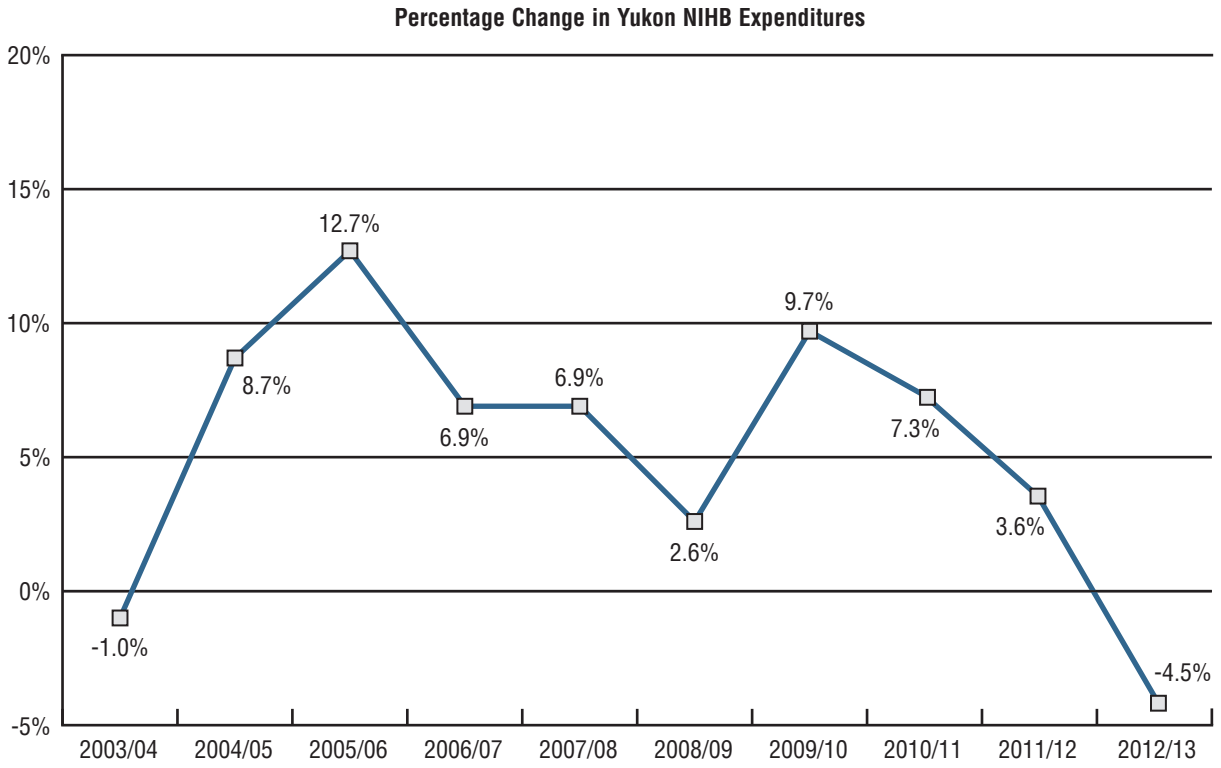
Source: FIRMS adapted by Program Analysis Division

FIGURE 8.8

Yukon
2003/04 to 2012/13

Annual expenditures in the Yukon for 2012/13 totalled $10.7 million, a decrease of 4.5% from the $11.2 million spent in 2011/12. Pharmacy expenditures in 2012/13 increased by 3.0% to $4.0 million while medical transportation costs decreased by 11.4% to $3.9 million. Dental expenditures decreased by 3.8% to $2.5 million.

Pharmacy expenditures comprised the largest portion of the Yukon's total expenditures at 37.3%, medical transportation expenditures ranked second at 36.5%, followed by dental and vision care at 23.2% and 3.0% respectively.



Annual Expenditures by Benefit ($ 000's)

Yukon	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Medical Transportation	$ 1,600	$ 1,774	$ 2,100	$ 2,421	$ 2,935	$ 2,938	$ 3,801	$ 4,097	$ 4,413	$ 3,909
Pharmacy	3,214	3,476	3,655	3,641	3,802	3,779	3,723	3,792	3,878	3,994
Dental	1,365	1,229	1,863	2,033	1,998	2,246	2,271	2,629	2,583	2,486
Other Health Care	2	4	1	22	4	1	1	2	4	4
Vision Care	223	480	228	274	230	242	299	311	347	327
Total	**$ 6,405**	**$ 6,963**	**$ 7,847**	**$ 8,392**	**$ 8,970**	**$ 9,206**	**$ 10,095**	**$ 10,830**	**$ 11,225**	**$ 10,719**

Source: FIRMS adapted by Program Analysis Division

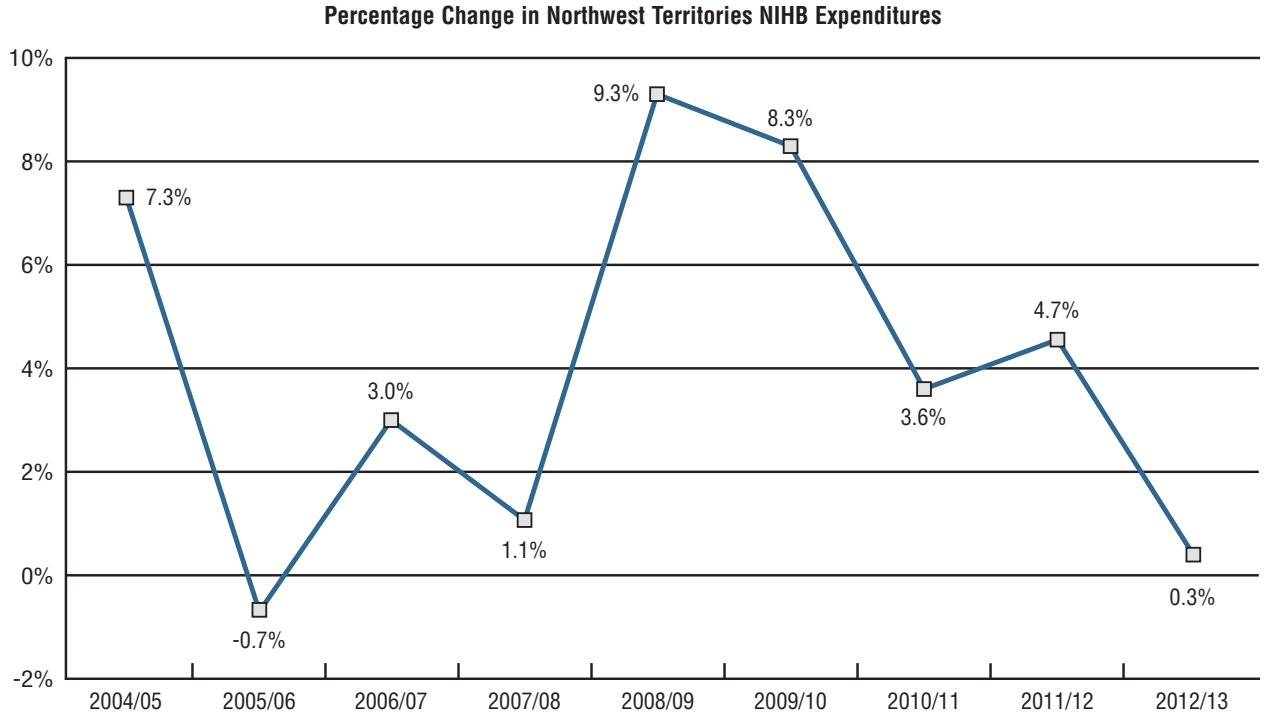
FIGURE 8.9

Northwest Territories
2003/04 to 2012/13

Annual expenditures in the Northwest Territories in 2012/13 totalled $27.8 million, an increase of 0.3% from the $27.7 million spent in 2011/12. Pharmacy expenditures in 2012/13 decreased by 1.0% to $9.0 million, medical transportation costs remained the same at $10.2 million while dental expenditures increased by 2.7% to $7.2 million. Vision care expenditures decreased by 0.3% to $1.4 million.

Medical transportation comprised the largest portion of the Northwest Territories total expenditures at 36.6%, pharmacy costs ranked second at 32.4%, followed by dental at 26.1%. Vision care made up 4.9% of total expenditures.

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



Annual Expenditures by Benefit ($ 000's)

Northwest Territories	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Medical Transportation	$ 6,856	$ 7,428	$ 6,710	$ 7,116	$ 6,943	$ 7,952	$ 8,520	$ 8,498	$ 10,157	$ 10,157
Pharmacy	7,161	7,544	8,010	8,151	7,863	8,210	8,595	8,999	9,090	8,999
Dental	4,726	5,173	5,249	5,249	5,752	6,279	7,067	7,603	7,054	7,244
Other Health Care	0	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	1,368
Total	**$ 19,443**	**$ 20,863**	**$ 20,712**	**$ 21,335**	**$ 21,570**	**$ 23,571**	**$ 25,521**	**$ 26,431**	**$ 27,672**	**$ 27,769**

Source: FIRMS adapted by Program Analysis Division

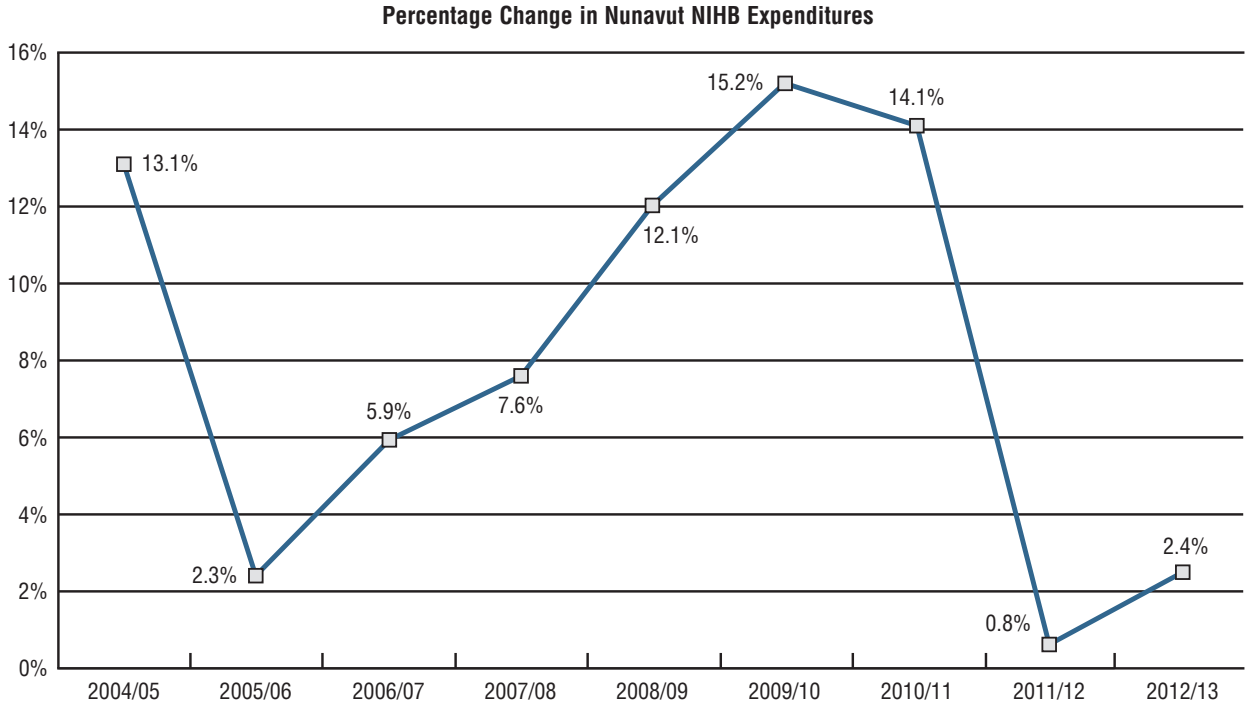
FIGURE 8.10

Nunavut
2003/04 to 2012/13

Annual expenditures in Nunavut for 2012/13 totalled $50.1 million, an increase of 2.4% from the $48.9 million spent in 2011/12. Pharmacy expenditures in 2012/13 decreased by 1.9% to $10.7 million and medical transportation costs increased by 6.9% to $27.7 million. Dental expenditures decreased by 3.8% to $10.0 million and vision care costs increased by 0.4% to $1.7 million.

Medical transportation comprised the largest portion of Nunavut's total expenditures at 55.2%, pharmacy expenditures ranked second at 21.3%, followed by dental at 20.1%. Vision care made up 3.3% 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	2011/12
Medical Transportation	$ 12,409	$ 13,972	$ 14,776	$ 15,268	$ 16,171	$ 20,053	$ 22,302	$ 23,869	$ 25,886	$ 27,661
Pharmacy	4,150	4,734	4,902	5,526	6,579	7,084	8,237	10,399	10,894	10,690
Dental	6,932	8,566	8,137	8,740	9,002	8,349	10,289	12,306	10,442	10,043
Other Health Care	0	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	1,675
Total	**$ 24,965**	**$ 28,223**	**$ 28,860**	**$ 30,574**	**$ 32,890**	**$ 36,873**	**$ 42,474**	**$ 48,482**	**$ 48,890**	**$ 50,069**

Source: FIRMS adapted by Program Analysis Division

Initiatives and Activities

SECTION 9.1

Health Information and Claims Processing Services (HICPS)
2012/13

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, 2013, 25,919 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 2011 to March 2013

REGION	Pharmacy	MS&E	Dental
Newfoundland	191	30	157
Nova Scotia	315	84	488
Prince Edward Island	45	10	50
New Brunswick	221	64	280
Quebec	1,883	146	2,670
Ontario	3,574	673	5,288
Manitoba	388	77	706
Saskatchewan	375	67	469
Alberta	1128	222	2139
British Columbia	1,250	388	2,329
Yukon	9	6	45
Northwest Territories	11	6	69
Nunavut	5	1	60
Total	**9,395**	**1,774**	**14,750**

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, 2013.

FIGURE 9.1.1

Number of Claim Lines Settled Through the Health Information and Claims Processing Services (HICPS) System in 2012/13

Figure 9.1.1 sets out the total number of pharmacy, dental and MS&E claims settled through the HICPS system in fiscal year 2012/13. During this period, 22,705,109 claim lines were processed through HICPS, an increase of 5.9% 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	1,157,766	151,560	29,744	**1,339,070**
Quebec	2,343,458	205,449	21,660	**2,570,567**
Ontario	4,834,119	539,322	38,081	**5,411,522**
Manitoba	3,056,888	385,717	70,227	**3,512,832**
Saskatchewan	2,754,330	449,185	68,985	**3,272,500**
Alberta	2,212,266	431,112	50,504	**2,693,882**
British Columbia	2,524,308	465,625	39,793	**3,029,726**
Yukon	110,045	24,419	2,925	**137,389**
Northwest Territories	279,765	97,470	8,447	**385,682**
Nunavut	221,832	120,895	9,212	**351,939**
Total Claim Lines	**19,494,777**	**2,870,754**	**339,578**	**22,705,109**

Source: HICPS adapted by Program Analysis Division

SECTION 9.2

Provider Audit Activities
2012/13

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 2012/13, 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 2012/13, the primary issues identified as a result of 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 2012/13 eighteen dental providers and one pharmacy provider 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 of these benefits and their associated expenditures. In 2012/13, reviews were conducted on the NIHB Vision Benefit in the Atlantic Region.

FIGURE 9.2.1

Audit Recoveries by Benefit and Region
2012/13

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 2012/13 fiscal year.

DENTAL

REGION	Audits Completed	Recoveries	NDCV/CCP Savings	Total Recoveries/ Savings
Atlantic	8	$ 53,168	$ 58,333	$ 111,501
Quebec	5	19,578	17,410	36,988
Ontario	3	9,807	115,050	124,858
Manitoba	1	12,051	92,554	104,605
Saskatchewan	12	197,034	113,797	310,831
Alberta	3	55,363	183,138	238,501
British Columbia	6	44,713	118,872	163,585
Yukon	0	0	10,322	10,322
N.W.T.	3	47,154	11,342	58,497
Nunavut	3	35,309	15,679	50,988
Total	**44**	**$ 474,177**	**$ 736,497**	**$ 1,210,674**

PHARMACY

REGION	Audits Completed	Recoveries	NDCV/CCP Savings	Total Recoveries/ Savings
Atlantic	8	$ 48,480	$ 65,998	$ 114,478
Quebec	11	14,228	65,123	79,351
Ontario	15	198,748	292,753	491,501
Manitoba	19	245,557	201,630	447,187
Saskatchewan	7	209,805	42,094	251,898
Alberta	18	149,019	103,757	252,776
British Columbia	18	83,979	133,826	217,805
Yukon	0	19,945	4,577	24,522
N.W.T.	2	48,305	4,507	52,812
Nunavut	2	58,804	3,563	62,367
Total	**100**	**$ 1,076,870**	**$ 917,829**	**$ 1,994,699**

MS&E

REGION	Audits Completed	Recoveries	NDCV/CCP Savings	Total Recoveries/ Savings
Atlantic	0	$ 14,579	$ 609	$ 15,188
Quebec	0	0	160	160
Ontario	2	10,949	1,230	12,179
Manitoba	0	7,219	456	7,675
Saskatchewan	3	317	655	972
Alberta	0	29,775	991	30,766
British Columbia	7	4,774	1,012	5,785
Yukon	0	0	0	0
N.W.T.	0	0	0	0
Nunavut	0	0	0	0
Total	**12**	**$ 67,613**	**$ 5,112**	**$ 72,725**

* 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. NDCV savings listed in the recovery charts above, per benefit, take into account the provider appeals process.

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 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 policy development and decisions that will optimize client health benefits within the Program's budgetary allocations.

DTAC is 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.

The Drug Exception Centre supports the implementation of the Prescription Drug Abuse Strategy to address and prevent potential misuse of prescription drugs. The Program has set limits on medications of concern, and developed a structured approach towards client safety which includes the implementation of the Prescription Monitoring Program across the country (not yet implemented in the Quebec Region).

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 medication approvals to approximately 60 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 2012/13 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 2012/13 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
2012/13

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	4,493	45,978	80,131	**135,502**
Total Approved	3,523	37,496	60,190	**104,527**

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

Dental Predetermination Centre (DPC)

As part of the Government of Canada's Economic Action Plan 2012, the NIHB Program centralized the processing of dental predetermination (PD) services at NIHB Headquarters in Ottawa. The goal of centralization is to gain efficiencies through consolidation and improve consistency in the adjudication of dental benefits. Processing of dental predetermination requests and related services have been transferred from the Health Canada regional offices, with the exception of the British Columbia region, to Ottawa in a phased approach, which began in September 2012 and ended in September 2013.

Dental predetermination, dental client reimbursement, and dental appeal requests are now sent to the Dental Predetermination Centre (DPC). All electronic and manual claims not requiring predetermination, as well as inquiries related to client eligibility, frequency, and compliance with NIHB coverage criteria, guidelines and policies, continue to be directed to Health Canada's claims processor, Express Scripts Canada.

The table below provides the effective dates for the transition of each region to the DPC.

Region	Effective Date
Northern Region	September 1, 2012
Saskatchewan	October 1, 2012
Atlantic Region	November 1, 2012
Quebec	February 1, 2013
Ontario	April 1, 2013
Alberta	June 1, 2013
Manitoba	September 1, 2013

SECTION 9.6

Changes in Medical Supplies and Equipment (MS&E)

Prescribers for Custom-Made Shoes

In order to facilitate access to footwear benefits for First Nations and Inuit clients, NIHB added general practitioners and podiatrists as prescribers of custom-made shoes on March 1, 2013.

New Audiology Process

A streamlined prior approval process for hearing aids was implemented on June 1, 2013. The NIHB Program is pleased to have developed this new process in collaboration with the Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA) and the Canadian Academy of Audiologists (CAA).

More information can be found in the Provider Guide for MS&E at: **www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/_medequip/2009-prov-fourn-guide/index-eng.php**

Incontinence Price File

NIHB implemented a national price file to simplify the administration of requests for select incontinence supplies on September 1, 2012. Information concerning the incontinence supplies covered is available on the Program's Medical Supplies and Equipment Benefit List at: **www.healthcanada.gc.ca/nihb**.

SECTION 9.7

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 Program resources. During 2012/13, the Negotiations Secretariat developed compensation models and negotiated and/or liaised with provincial and national professional associations representing providers of pharmacy, dental care, and orthotic and prosthetic services. The Negotiations Secretariat also provided ongoing support for implementation of the NIHB national dental compensation framework.

SECTION 9.8

British Columbia Tripartite Agreement

Over the course of 2012/13, NIHB has been working with the First Nations Health Authority (FNHA) to prepare for the transfer of responsibility for the management and delivery of non-insured health benefits to First Nations in British Columbia. This work is governed by the *2011 BC Tripartite Framework Agreement on First Nation Health Governance*.

As part of this historic undertaking, the FNHA will be taking over responsibility for providing the FNHA Health Benefits Program, which replaces the NIHB Program for First Nations residing in British Columbia, in two phases. Starting on July 2, 2013, the FNHA take responsibility for the

pharmacy, dental, orthodontic and medical supplies and equipment benefits. On October 13, 2013, the FNHA assumed the responsibility for the remaining benefits.

It is important to both parties that service delivery to clients be seamless at this time of transition. To support that shared goal, Health Canada and the FNHA have been working over the past year to establish and implement a short-term arrangement by which Health Canada will provide some technical support services for those benefits processed using the Health Information and Claims Processing Services (HICPS) system. Furthermore, the NIHB Program and the FNHA are establishing ways of working together into the future, in support of ongoing capacity building and as part of the new partnership.

Health Canada is working to establish and implement measures so that Inuit, and First Nations who are in British Columbia temporarily, will continue to have access to the whole suite of existing NIHB benefits.

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. Regular privacy audits are conducted on an annual basis to ensure compliance as per the terms outlined in the Health Information and Claims Processing Services (HICPS) system contract.

SECTION 9.10

NIHB Program Updates

Since September 2012, the NIHB Program has been producing a client-focussed newsletter, which is available on Health Canada's website. *NIHB Program Updates* are written for clients and are intended to inform them about their coverage, as well as updates and changes to NIHB policy and benefit information.

Clients who are interested in reading and sharing this information can find it at: **www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/benefit-prestation/newsletter-bulletin-eng.php**

SECTION 9.11

NIHB Newsletters and DBL Updates

The NIHB Program 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 sent to NIHB registered providers. NIHB providers may access the NIHB Newsletters via the Express Scripts Canada website (password required) at: **www.provider.express-scripts.ca**

In addition to the Pharmacy Newsletters, the NIHB Program communicates changes to the Drug Benefit List (DBL) through the annual update to the DBL at: **www.healthcanada.gc.ca/dbl**

Updates to the DBL can be found on the Health Canada web site at: **www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/index-eng.php**

Client Safety

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.

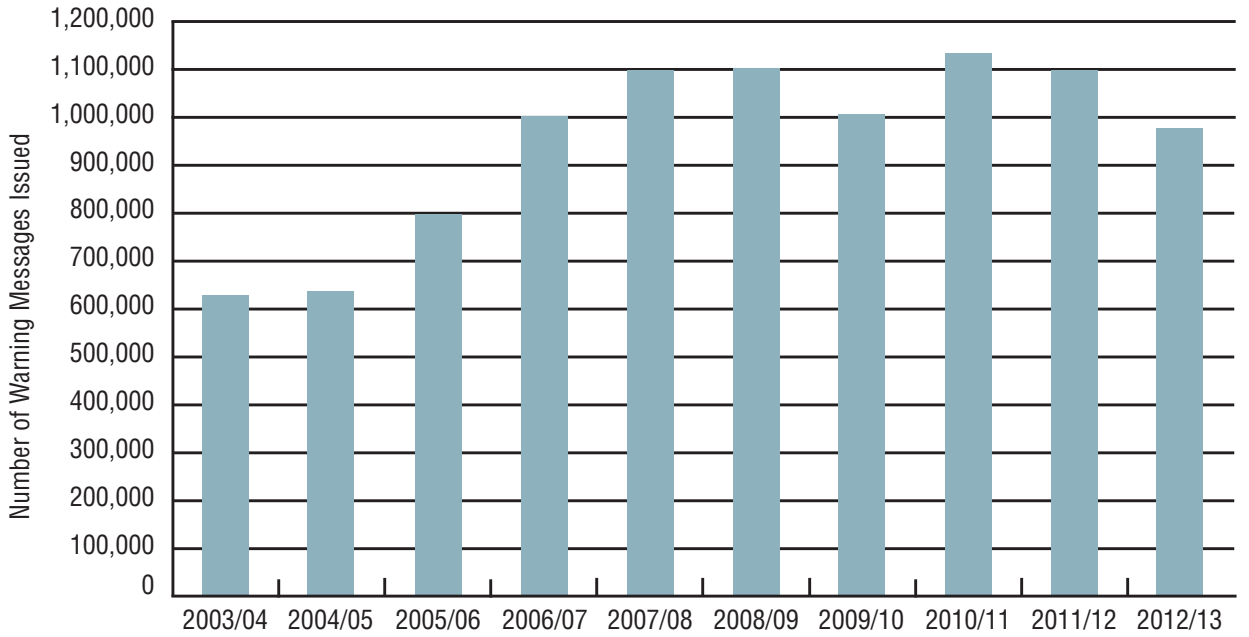
The NIHB Program continues to place a high priority on addressing cases of concern and on enhancing and encouraging the safe use of prescription medications. The NIHB Program has invested considerable time and effort in designing and modernizing its prescription drug benefit with these responsibilities 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
2003/04 to 2012/13



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 2012/13, the Program rejected a total of 1,496 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 potential misuse of benzodiazepine, opioid, gabapentin, 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 or dose of opioids, benzodiazepines, gabapentin 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 anticipates extending the PMP to Quebec during the coming 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, pharmacy technicians 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 alerted the physicians and pharmacists involved and informed them that their prescribing and dispensing of benzodiazepines was much higher than the average. A dose limit on benzodiazepines was also put in place. This resulted in a decrease of benzodiazepine prescribing in these areas.

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 long-term use of benzodiazepines.

Based on safety 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.

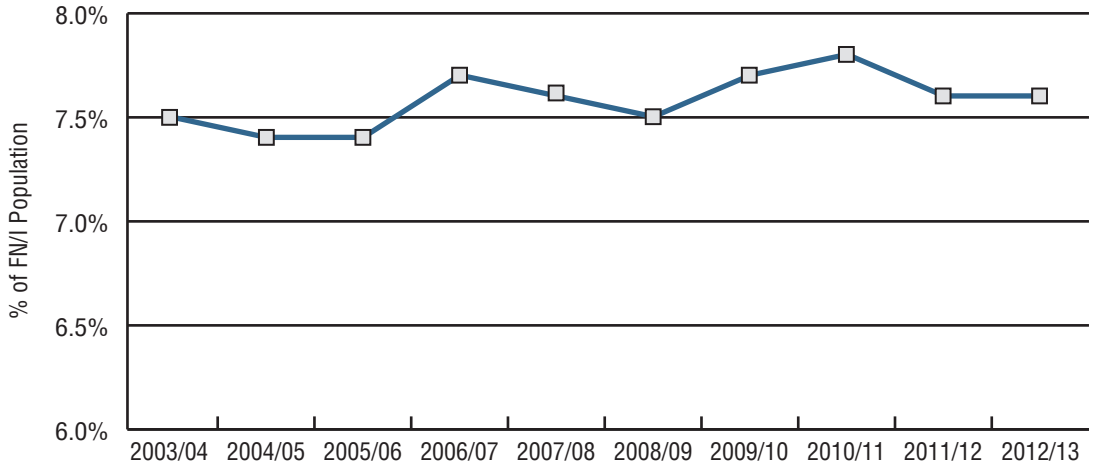
The NIHB Program is continuing its efforts to reduce the use of benzodiazepines, as the percentage of clients accessing this class of drugs has been decreasing since 2010/11 (Figure 10.2). The number of clients exceeding the maximum recommended daily dose (equivalent to 40mg per day of diazepam) is shown in Figure 10.3.

In order to reduce the number of clients exceeding the maximum recommended dose of benzodiazepines, the NIHB Program has doubled the contribution benzodiazepines make to the Prescription Monitoring Program (PMP). The Program is also exploring other initiatives to reduce the overall use of this class of drugs. Effective March 4, 2013, the NIHB Program introduced a dose limit for benzodiazepines of 120mg diazepam equivalent per day for clients. On June 4, 2013, this limit was decreased to 110mg and on September 4, 2013 the limit decreased a second time to 100mg per day. This limit will continue to decrease by 10mg every 3 months until an acceptable level is reached.

As shown in figure 10.2, during 2012/13, the percentage of clients on benzodiazepines decreased by 1.1% over the previous fiscal year, which may be attributable to the addition of two large groups of new eligible NIHB client populations (Bill C-3 clients and the creation of the Qalipu Mi'kmaq band) rather than the start of a new trend in utilization.

FIGURE 10.2

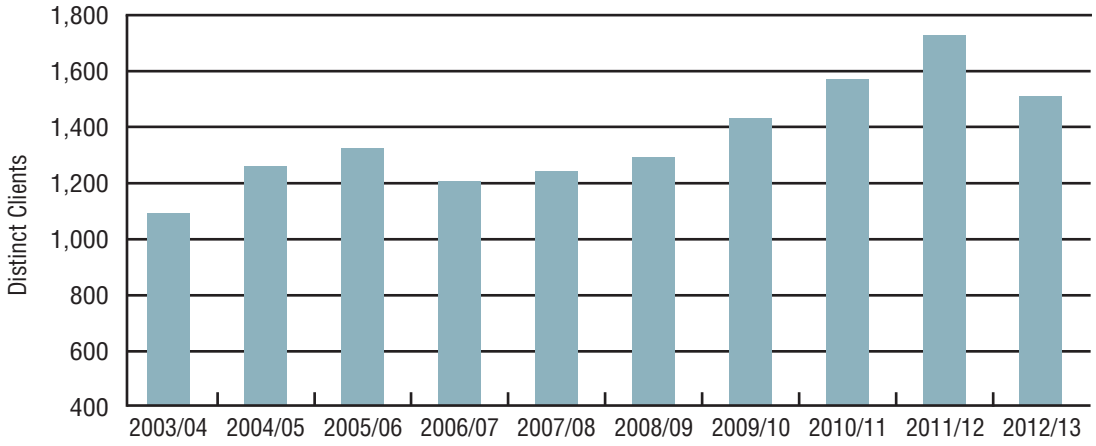
Percentage of Clients Receiving Benzodiazepines
2003/04 to 2012/13



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)
2003/04 to 2012/13



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 2012/13 (Figure 10.4).

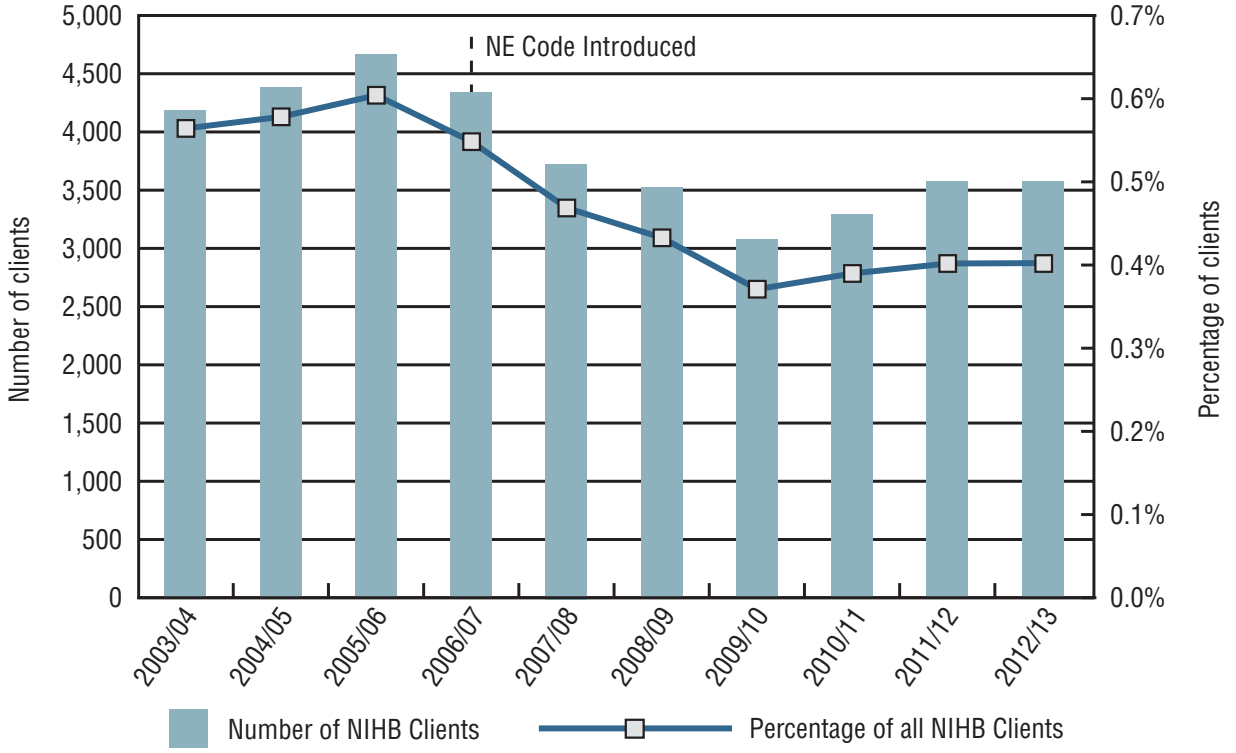
In 2012/13, there were approximately 3,600 clients with concurrent claims for opioids, benzodiazepines and methadone. This represents 0.4% of the total eligible population. NIHB continues to monitor concurrent use of these drug classes.

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

2003/04 to 2012/13



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.

In May 2012, the NIHB Program combined these two separate committees into a single one, called 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 Prescription Drug Abuse Strategy.

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 is reviewed 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.

Methadone for Addiction

Methadone is a synthetic opioid that can be used to treat chronic pain but is predominantly used to treat opioid dependence. Methadone, opioid, benzodiazepine, stimulant and gabapentin therapy require close monitoring by physicians and pharmacists, to maximize safety and effectiveness and minimize the risk of harm, abuse and diversion.

To ensure that prescribers of opioids, benzodiazepines, stimulants and gabapentin are aware that a client is on methadone, NIHB is working toward a national strategy to make methadone maintenance therapy, a limited use (LU) benefit. Clients approved for methadone will be placed in the NIHB Prescription Monitoring Program (NIHB-PMP) which ensures that only one prescriber writes prescriptions for opioids, benzodiazepines stimulants and/or gabapentin.

This policy was implemented in New Brunswick in August 2011, the rest of the Atlantic Provinces in March 2012, Saskatchewan on May 6, 2013 and in Manitoba on September 30, 2013. Currently, the methadone policy in the Atlantic region has placed restrictions on only two of the four classes of drugs mentioned above (i.e. opioids and benzodiazepine drugs) however the expansion of the restriction to the four classes of drugs is currently being planned. This methadone policy will be expanded to other provinces based on Program capabilities.

New Restrictions for Clients on High Doses of Gabapentin and Benzodiazepines

On March 4, 2013, the Program placed a coverage limit on gabapentin of 5000mg/day. This dose limit is initially set higher than the currently recommended maximum daily dose listed in the product monograph (3600mg/day) to allow an interim tolerance period for clients at high doses. The Program will re-evaluate this limit after implementation for potential lowering at a future date.

Also on March 4, 2013, the NIHB Program introduced a dose limit for benzodiazepines, equal to 120mg diazepam equivalent per day. (Note: On June 4, 2013, this limit was decreased to 110mg and on September 4, 2013 the limit decreased a second time to 100mg per day. This limit will continue to decrease by 10 mg every 3 months until an acceptable level is reached.)

Changing the listing status of Ritalin (brand name) products

In January 2013, the NIHB Program no longer provides coverage for Ritalin (brand name) products. The NIHB Drug Benefit List (DBL) lists various other options for the treatment of attention deficit hyperactivity disorder as open benefit, including generic methylphenidate, dexedrine, concerta and vyvanse.

Changing the listing status of Tylenol No. 4 and generic versions

As of January 2013, the NIHB Program no longer provided coverage for opioid containing acetaminophen products containing 60mg of codeine (e.g. Tylenol with codeine No. 4, tablets, Ratio-Lenoltec No. 4, tablets, Acetaminophen codeine 60, tablets). This decision was made following a recommendation by the NIHB Drugs & Therapeutics Advisory Committee (DTAC). Clients receiving maximum daily doses of acetaminophen (4000mg/day) using this

combination product could receive up to 720mg of codeine per day, which is higher than is currently recommended by the National Opioid Guidelines Group. The NIHB DBL lists various other options for the treatment of pain including over the counter (OTC) preparations of acetaminophen, OTC and prescription non-steroidal anti-inflammatory drugs (NSAIDs), opioids (codeine, morphine, hydromorphone or fentanyl patches) and medications for neuropathic pain including pregabalin and duloxetine.

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.

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 is provided in conjunction with eligible dental services and requires predetermination, in other words, approval prior to commencement of treatment. Coverage for sedation and general anaesthesia services is provided with a frequency of once in any 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.

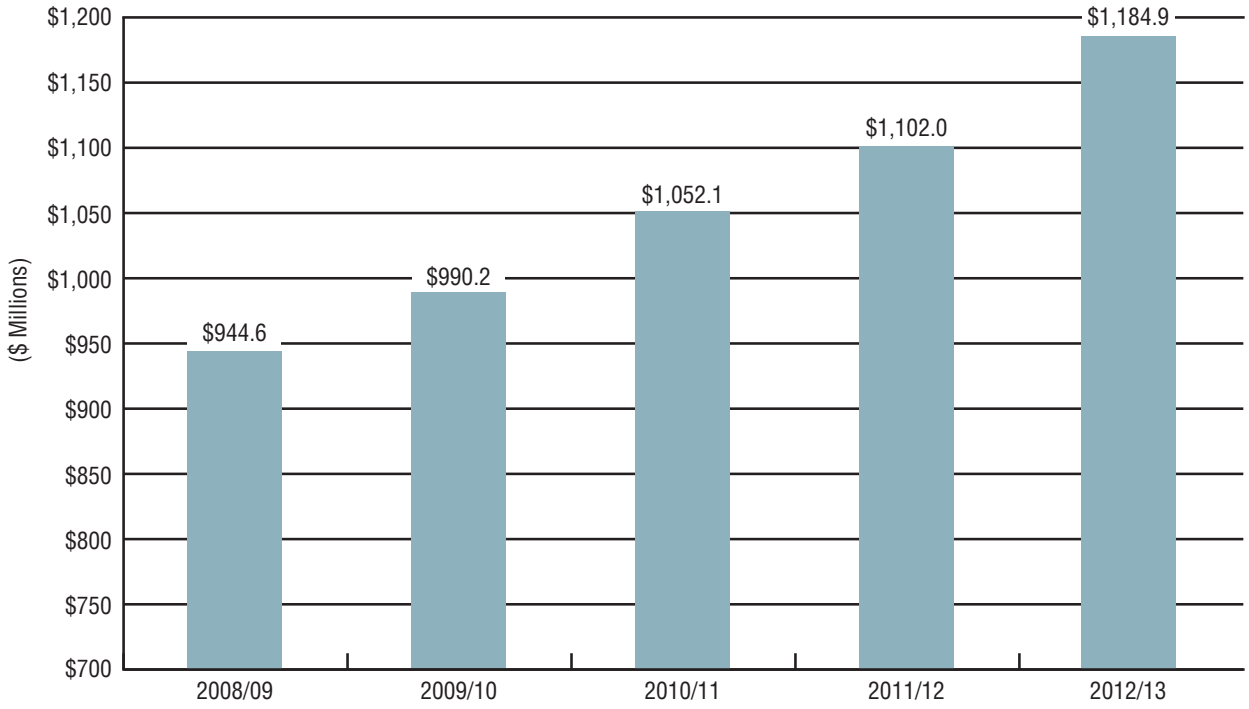
The NIHB Program is taking an active evidence-based approach to further develop client safety within the dental benefit policies. This approach stresses the appropriate use of dental services, within Program coverage, with a view of achieving the best possible health outcomes for eligible First Nations 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)
2008/09 to 2012/13



Source: Main Estimates

In 2012/13, total resources available to the NIHB Program were $1,184.9 million. This represented a 7.5% increase over the $1,102.6 million in available funds in 2011/12. The 2012/13 total resources include additional funding required for the new Qalipu Mi'kmaq and Bill C-3 clients.

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)
2012/13

Figure 11.2 provides the Program administration funds expended by each region as well as NIHB headquarters (HQ) in Ottawa. In 2012/13, total NIHB administration costs were $53.0 million representing an increase of $122 thousand or 0.2% 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	$ 1,524	$ 1,919	$ 3,326	$ 2,877	$ 2,250	$ 2,606	$ 1,446	$ 1,191	$ 9,179	$ 26,319
Capital	0	0	0	0	0	0	0	0	0	0
EBP	305	384	665	575	450	521	289	238	1,836	5,264
Operating	107	102	415	83	159	170	146	192	1,524	2,896
Sub Total	**$ 1,936**	**$ 2,404**	**$ 4,406**	**$ 3,536**	**$ 2,859**	**$ 3,297**	**$ 1,880**	**$ 1,621**	**$ 12,539**	**$ 34,479**
Claims Processing Contract Costs										**$ 18,529**
Total Administration Costs										**$ 53,007**

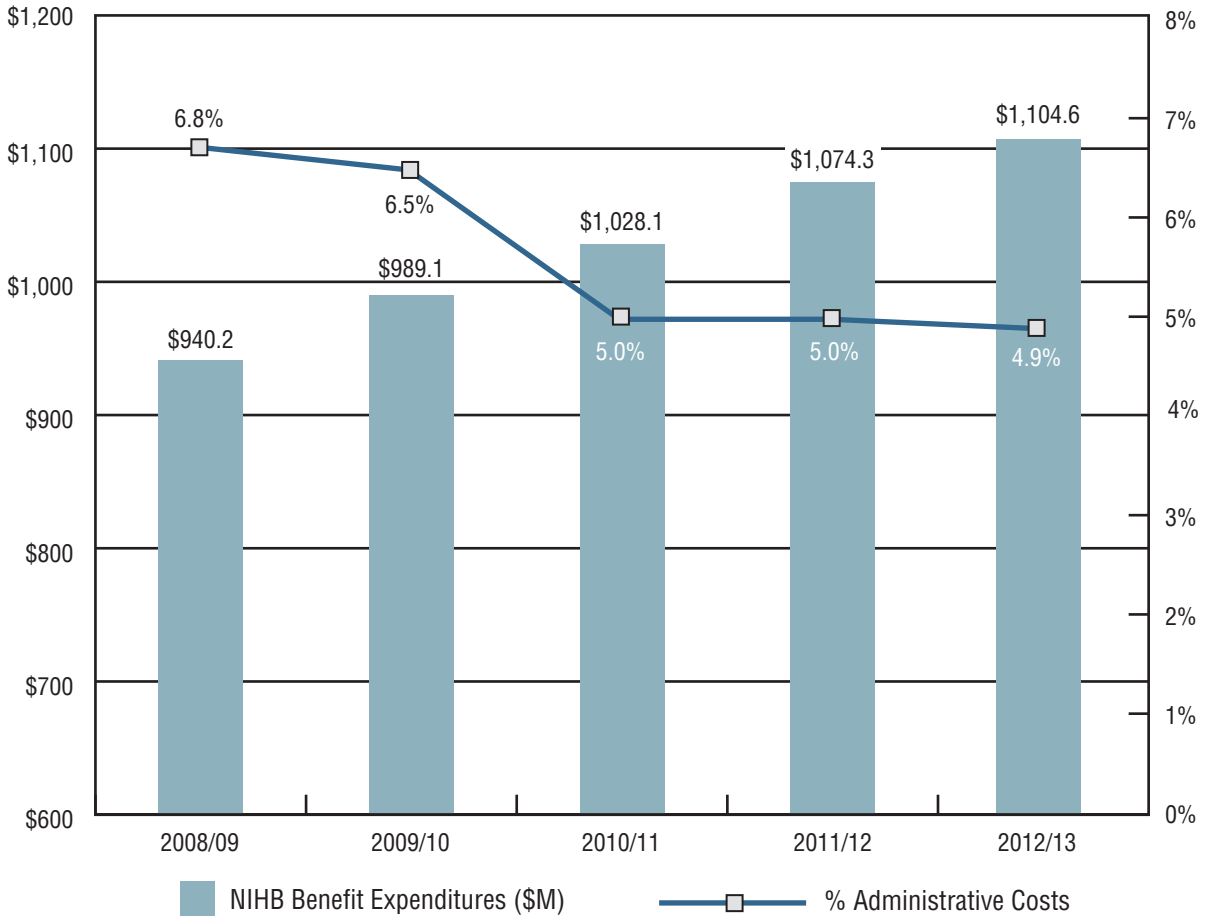
Source: FIRMS adapted by Program Analysis Division

FIGURE 11.3

Non-Insured Health Benefits Administration Costs as a Proportion of Benefit Expenditures ($ Millions)
2008/09 to 2012/13

Figure 11.3 provides the percentage of NIHB Program administrative costs as a proportion of overall NIHB benefit expenditures. In 2012/13, total NIHB expenditures were $1,104.6 million, of which actual benefit expenditures totaled $1,086.1 million and expenditures for claims processing administration amounted to $18.5 million. An additional $34.5 million in expenditures for salaries associated with Program administration are reported separately from total program expenditures. As a result, total NIHB Program administration cost ($53.0 million) as a proportion of actual benefit expenditures ($1,086.1 million) was 4.9% in 2012/13.

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 4.9% in 2012/13.



Source: FIRMS adapted by Program Analysis Division

Technical Notes

Information contained in the 2012/13 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).