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Non-Insured Health Benefits Program

First Nations and Inuit Health Branch

Annual Report 2013/2014

Canada

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To obtain additional information, please contact:

Health Canada
Address Locator 0900C2
Ottawa, ON K1A 0K9
Tel.: 613-957-2991
Toll free: 1-866-225-0709
Fax: 613-941-5366
TTY: 1-800-465-7735
E-mail: publications@hc-sc.gc.ca

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Introduction

During 2013/14, the Non-Insured Health Benefits (NIHB) Program of the First Nations and Inuit Health Branch (FNIHB) at Health Canada provided 808,686 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:

- 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

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 twentieth edition, the 2013/14 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.

British Columbia Tripartite Agreement

The *British Columbia Tripartite Framework Agreement on First Nation Health Governance* was signed by Canada, the First Nations Health Council (FNHC) and the British Columbia Ministry of Health on October 13, 2011. A key commitment made in the *Framework Agreement* is the transfer of Federal Health Programs, including Non-Insured Health Benefits (NIHB), from Canada to the First Nations Health Authority (FNHA).

Between July 2nd, 2013 and October 1st, 2013, the FNHA assumed responsibility for the design, planning, management and delivery of the Non-Insured Health Benefits Program to First Nations clients residing in the British Columbia Region. As a transitional measure, Health Canada has continued to provide claims processing and certain adjudication services for the Pharmacy, Dental and MS&E benefits to First Nations clients in British Columbia on behalf of the FNHA. This arrangement will be in place for a term of up to four years.

It is important to both parties that service delivery to clients be seamless during this time of transition. To support that shared goal, Health Canada and the FNHA have been working to facilitate a smooth transfer of responsibilities between the parties and to continue preparing for the full transfer of the NIHB Program in British Columbia following the conclusion of this transition period.

Furthermore, over the course of 2013/14, the NIHB program and the FNHA continued to establish ways of working together into the future, in support of ongoing capacity building and as part of the new partnership.

Health Canada has established and implemented 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.

Client Population

Over the last ten years, the NIHB client population has grown at an average annual rate of 0.8%. As of March 31, 2014, there were 808,686 First Nations and Inuit clients registered in the Status Verification System (SVS) and were eligible to receive benefits under the NIHB Program. The NIHB client population decreased significantly in 2013/14 as a result of the creation of the First Nations Health Authority (FNHA). In a phased approach, between July and October 2013, the FNHA assumed the programs, services, and responsibilities formerly delivered by Health Canada's First Nations and Inuit Health Branch (FNIHB) to First Nation clients residing in British Columbia. If the British Columbia First Nation clients had been eligible to receive benefits from the NIHB Program for all of 2013/14, the ten year average population growth rate would have been 2.4%. Of the 808,686 total eligible clients at the end of the 2013/14 fiscal year, 765,009 (94.6%) were First Nations clients while 43,677 (5.4%) were Inuit clients.

Historically, 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 *An Act to amend the Indian Act* (Bill C-31), the *Gender Equity in Indian Registration Act* (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 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 registered under the *Indian Act*, these individuals will be eligible to receive benefits through the NIHB Program. As of March 31, 2014, a total of 28,751 newly registered Indian clients had become eligible to receive benefits through the NIHB Program as a result of this new legislation.

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, 2014, a total of 23,933 new Qalipu clients were registered in the SVS and were eligible to receive benefits through the NIHB Program.

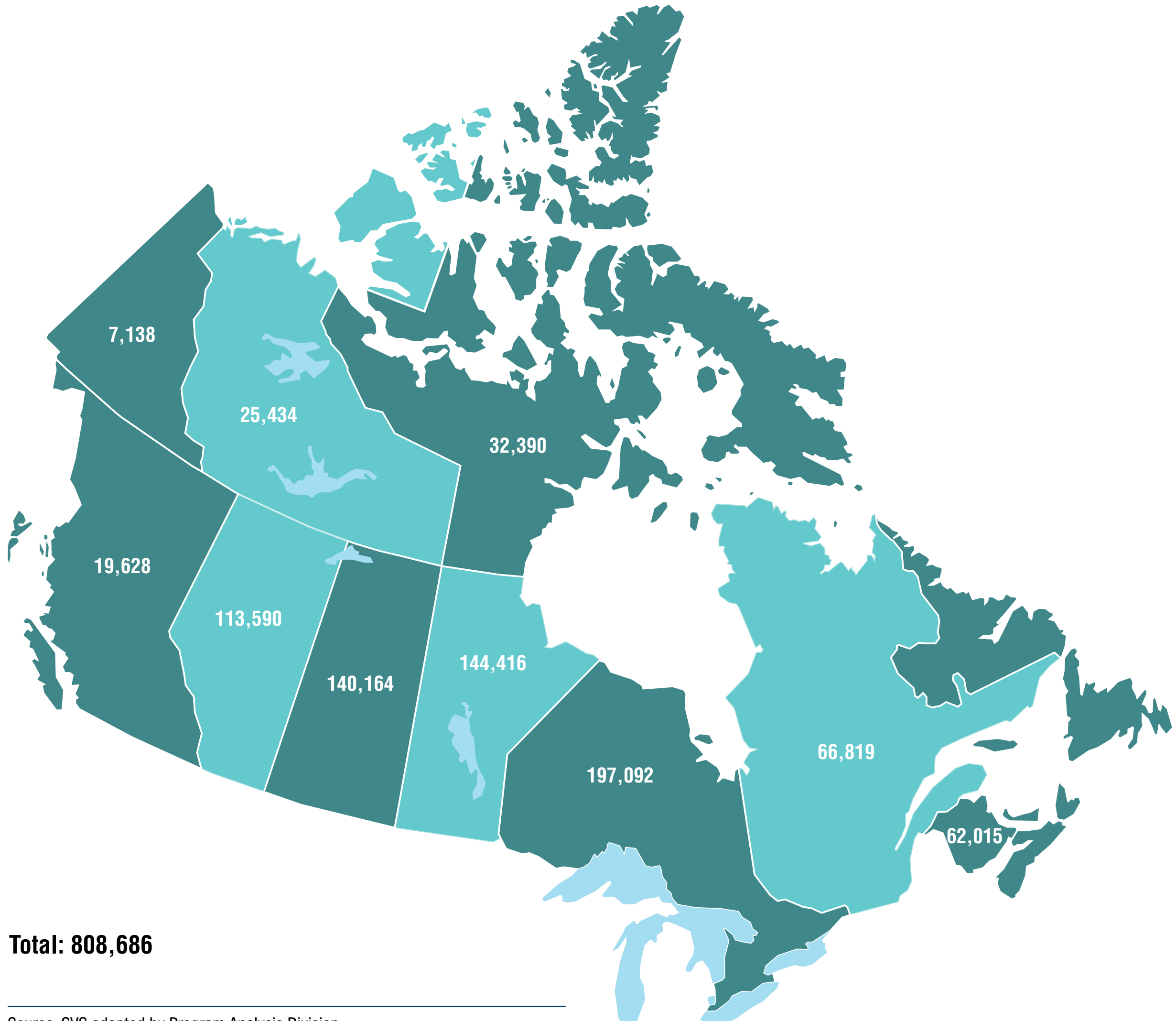
FIGURE 2.1

Eligible Client Population by Region
March 2014

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 2014 was 808,686, a decrease of 12.7% from March 2013. This significant decrease in population can be attributed to the transfer of First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA). If these clients had remained eligible under the NIHB Program, the annual growth rate would have been 1.7%.

The Ontario Region had the largest proportion of eligible population, representing 24.4% of the national total, followed by the Manitoba Region at 17.9% and the Saskatchewan Region at 17.3%.

Note that Figure 2.1 lists population values based on region of band registration, which is not necessarily region of residence.



Total: 808,686

Source: SVS adapted by Program Analysis Division

FIGURE 2.2

Eligible Client Population by Type and Region
March 2013 and March 2014

REGION	First Nations		Inuit		TOTAL		% Change
	March 2013	March 2014	March 2013	March 2014	March 2013	March 2014	2013 to 2014
Atlantic	61,719	61,694	311	321	62,030	62,015	0.0%
Quebec	64,767	65,583	1,177	1,236	65,944	66,819	1.3%
Ontario	196,406	196,444	613	648	197,019	197,092	0.0%
Manitoba	144,571	144,232	177	184	144,748	144,416	-0.2%
Saskatchewan	141,998	140,103	58	61	142,056	140,164	-1.3%
Alberta	115,343	113,046	524	544	115,867	113,590	-2.0%
British Columbia	131,515	19,348	267	280	131,782	19,628	-85.1%
Yukon	8,589	7,042	93	96	8,682	7,138	-17.8%
N.W.T.	18,225	17,517	7,901	7,917	26,126	25,434	-2.6%
Nunavut	0	0	31,790	32,390	31,790	32,390	1.9%
National	883,133	765,009	42,911	43,677	926,044	808,686	-12.7%

Source: SVS adapted by Program Analysis Division

Of the 808,686 total eligible clients at the end of the 2013/14 fiscal year, 765,009 (94.6%) were First Nations clients while 43,677 (5.4%) were Inuit clients.

As of March 31, 2014, the SVS population statistics reflect a 12.7% decrease in growth. This decrease in growth is the result of the transfer of responsibility for the management and delivery of non-insured health benefits for First Nations in the province of British Columbia to the First Nations Health Authority (FNHA).

The number of First Nations clients decreased by 13.4% while the number of Inuit clients increased by 1.8% over the previous year.

From March 2013 to March 2014, Nunavut had the highest percentage change in total eligible clients with a 1.9% increase, followed by the Quebec Region with an increase of 1.3%.

The year over year decrease in population growth witnessed in most Regions can be attributed to First Nation clients living in British Columbia but belonging to bands located in other regions. A First Nation individual with membership to a band in Manitoba (e.g. Cross Lake), and living in permanence in British Columbia, would have been transferred to the FNHA. In the previous fiscal year, the same First Nation would have been counted as an eligible client in Manitoba, not British Columbia. Due to a higher number of migrations into British Columbia, this resulted in a decrease in eligible NIHB clients in most Regions.

QUICK FACT

The share of NIHB client population under 20 years of age (34.7%) is high compared to the overall Canadian population (22.1%). There is a much higher percentage of seniors (65 and over) in the Canadian population (15.7%) than in the NIHB client population (7.0%). The average age of NIHB clients is 32, which is well below the Canadian average of 40.

FIGURE 2.3

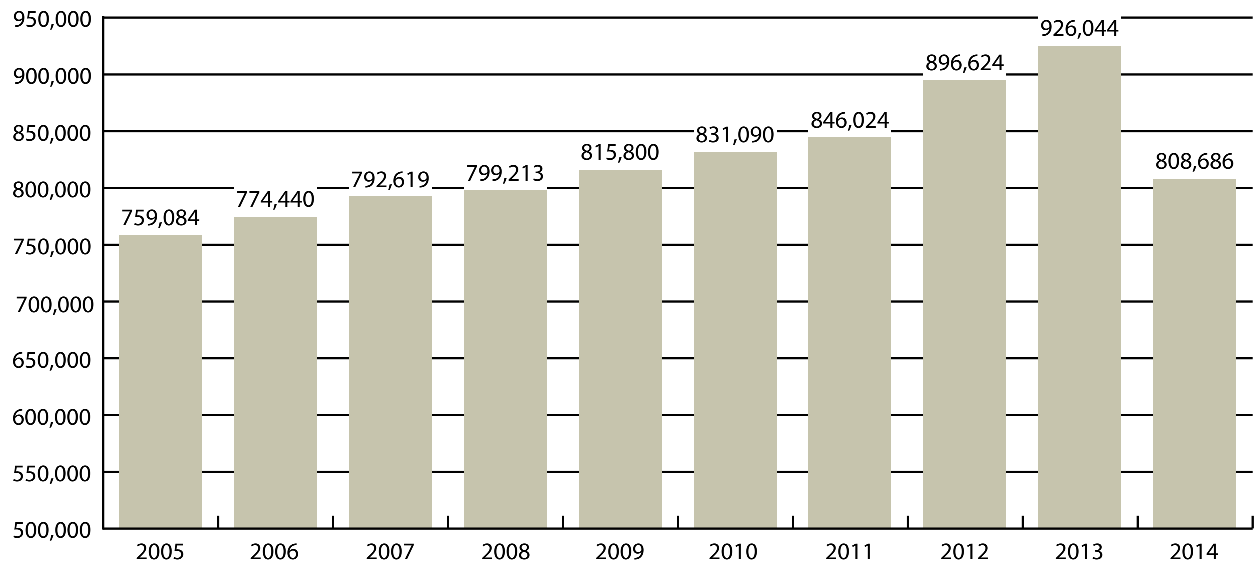
Eligible Client Population

Over the past 10 years, the total number of eligible clients in the SVS has increased by 6.5%, from 759,084 in March 2005 to 808,686 in March 2014.

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 creation of the First Nations Health Authority (FNHA) in British Columbia and 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 decreased by 2.7% from 831,090 in March 2010 to 808,686 in March 2014. The Atlantic Region had the largest increase in eligible clients over this period, with a growth rate of 79.2%. This significant increase can be attributed to the registration of 23,933 new Qalipu Mi'kmaq First Nations clients during fiscal years 2011/12 to 2013/14. 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 10.0%. The regions of Quebec, Ontario, and Nunavut followed with growth rates of 13.6%, 9.7% and 9.2% respectively.

Eligible Client Population, March 2005 to March 2014



Source: SVS adapted by Program Analysis Division

Eligible Client Population by Region, March 2010 to March 2014

REGION	March 2010	March 2011	March 2012	March 2013	March 2014
Atlantic	34,615	35,269	58,271	62,030	62,015
Quebec	58,802	59,659	63,209	65,944	66,819
Ontario	179,641	182,900	189,903	197,019	197,092
Manitoba	134,224	137,212	140,987	144,748	144,416
Saskatchewan	132,141	134,633	138,513	142,056	140,164
Alberta	105,932	107,839	112,264	115,867	113,590
British Columbia	122,989	124,988	128,597	131,782	19,628
Yukon	8,087	8,168	8,430	8,682	7,138
N.W.T.	24,991	25,236	25,412	26,126	25,434
Nunavut	29,668	30,120	31,038	31,790	32,390
Total	**831,090**	**846,024**	**896,624**	**926,044**	**808,686**
Annual % Change	**1.9%**	**1.8%**	**6.0%**	**3.3%**	**-12.7%**

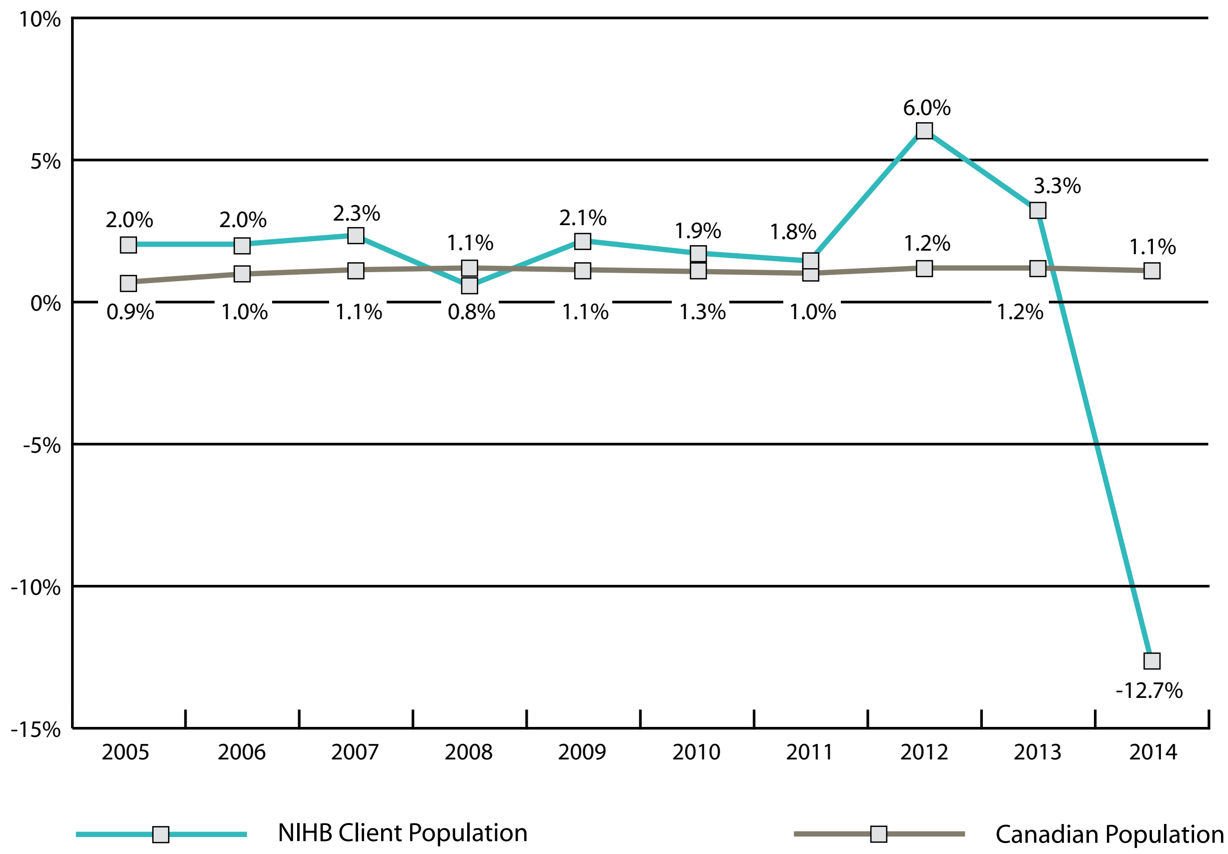
Source: SVS adapted by Program Analysis Division

FIGURE 2.4

Annual Population Growth, Canadian Population and Eligible Client Population
2005 to 2014

From 2005 to 2014, the Canadian population increased by 10.5% while the NIHB eligible First Nations and Inuit client population increased by 6.5%. Over the same period, the First Nations and Inuit client population grew at an average annual rate of 0.8% compared to 1.2% for the Canadian population. Prior to the removal of First Nations Health Authority (FNHA) clients, the NIHB ten year eligible population increase was 24.1%, with an average annual growth of 2.4%. Population growth is expected to return to historical rates in future fiscal years as the transition of residents of British Columbia to the FNHA is completed.

The higher than average NIHB Program client population growth rate of 6.0% in 2011/12 and 3.3% in 2012/13 can be attributed to the registration of new Bill C-3 clients as status Indians, and to new Qalipu Mi'kmaq First Nations clients in the Atlantic Region.



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 2014

Of the 808,686 NIHB eligible clients on the SVS as of March 31, 2014, 49.2% were male (397,595) and 50.8% were female (411,091).

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 37 years of age in the 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. The average age for females varied from a low of 27 years in Nunavut to a high of 38 years in the Quebec Region.

The NIHB eligible First Nations and Inuit client population is relatively young with two-thirds (66.1%) under the age of 40. Of the total population, over one-third (34.7%) 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 2004/05, seniors represented 5.5% of the overall NIHB population. Most recently in 2013/14, seniors accounted for 7.0%. 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	1,296	1,318	2,614	1,619	1,559	3,178	5,056	4,945	10,001	6,097	5,861	11,958
5-9	2,629	2,425	5,054	2,550	2,359	4,909	7,279	6,946	14,225	8,199	8,002	16,201
10-14	2,538	2,514	5,052	2,447	2,363	4,810	7,535	7,262	14,797	7,428	7,114	14,542
15-19	2,811	2,726	5,537	2,704	2,607	5,311	8,469	8,058	16,527	7,423	7,126	14,549
20-24	2,845	2,784	5,629	2,971	2,797	5,768	8,729	8,525	17,254	7,375	7,302	14,677
25-29	2,431	2,358	4,789	2,386	2,530	4,916	7,760	7,481	15,241	6,022	5,787	11,809
30-34	2,234	2,321	4,555	2,281	2,202	4,483	6,860	7,116	13,976	5,060	4,821	9,881
35-39	2,133	2,106	4,239	2,096	2,135	4,231	6,591	6,627	13,218	4,515	4,481	8,996
40-44	2,258	2,218	4,476	2,201	2,291	4,492	6,812	6,929	13,741	4,468	4,694	9,162
45-49	2,175	2,320	4,495	2,305	2,546	4,851	6,909	7,167	14,076	4,287	4,374	8,661
50-54	1,988	2,201	4,189	2,332	2,543	4,875	6,579	7,312	13,891	3,571	3,846	7,417
55-59	1,638	1,953	3,591	1,893	2,376	4,269	5,379	6,369	11,748	2,568	2,911	5,479
60-64	1,218	1,549	2,767	1,466	1,737	3,203	3,838	4,833	8,671	1,769	2,107	3,876
65+	2,159	2,869	5,028	2,943	4,580	7,523	7,894	11,832	19,726	3,097	4,111	7,208
Total	30,353	31,662	62,015	32,194	34,625	66,819	95,690	101,402	197,092	71,879	72,537	144,416
Average Age	34	35	35	35	38	37	34	37	36	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	5,433	5,258	10,691	4,830	4,505	9,335	1,093	1,077	2,170	182	172	354	714	666	1,380	1,818	1,783	3,601	28,138	27,144	55,282
5-9	7,894	7,703	15,597	6,370	6,318	12,688	760	682	1,442	244	220	464	1,027	964	1,991	1,986	1,927	3,913	38,938	37,546	76,484
10-14	7,371	7,236	14,607	6,033	5,670	11,703	704	715	1,419	272	236	508	935	994	1,929	1,865	1,723	3,588	37,128	35,827	72,955
15-19	7,285	7,225	14,510	6,035	5,672	11,707	926	767	1,693	297	297	594	1,182	1,129	2,311	1,679	1,595	3,274	38,811	37,202	76,013
20-24	7,560	7,265	14,825	5,955	5,594	11,549	830	691	1,521	336	305	641	1,412	1,377	2,789	1,656	1,570	3,226	39,669	38,210	77,879
25-29	6,326	6,214	12,540	4,915	4,827	9,742	714	642	1,356	289	274	563	1,169	1,125	2,294	1,393	1,388	2,781	33,405	32,626	66,031
30-34	5,094	5,064	10,158	4,084	4,237	8,321	820	706	1,526	274	260	534	1,001	956	1,957	1,096	1,146	2,242	28,804	28,829	57,633
35-39	4,486	4,536	9,022	3,612	3,589	7,201	643	620	1,263	249	199	448	804	842	1,646	942	957	1,899	26,071	26,092	52,163
40-44	4,306	4,493	8,799	3,295	3,502	6,797	605	601	1,206	271	227	498	919	912	1,831	933	907	1,840	26,068	26,774	52,842
45-49	3,956	4,237	8,193	3,102	3,295	6,397	525	687	1,212	311	263	574	885	934	1,819	873	918	1,791	25,328	26,741	52,069
50-54	3,266	3,552	6,818	2,620	3,017	5,637	540	698	1,238	317	306	623	699	831	1,530	673	689	1,362	22,585	24,995	47,580
55-59	2,300	2,667	4,967	1,844	2,286	4,130	397	556	953	179	228	407	519	665	1,184	408	438	846	17,125	20,449	37,574
60-64	1,533	1,839	3,372	1,253	1,672	2,925	289	428	717	121	172	293	400	463	863	352	350	702	12,239	15,150	27,389
65+	2,528	3,537	6,065	2,260	3,198	5,458	678	1,234	1,912	251	386	637	845	1,065	1,910	631	694	1,325	23,286	33,506	56,792
Total	69,338	70,826	140,164	56,208	57,382	113,590	9,524	10,104	19,628	3,593	3,545	7,138	12,511	12,923	25,434	16,305	16,085	32,390	397,595	411,091	808,686
Average Age	28	29	28	28	30	29	31	35	33	34	37	36	32	34	33	26	27	26	31	33	32

FIGURE 2.6

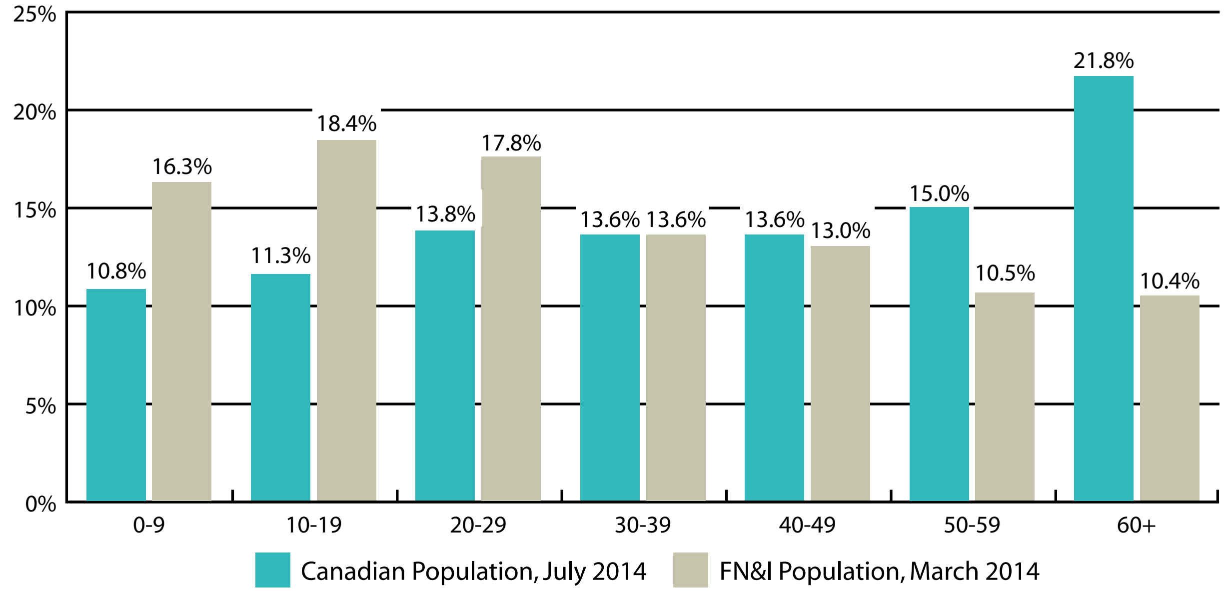
Population Analysis by Age Group

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 34.7% compared to 22.1% 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 2010 to March 2014 eligible client population shows an aging population. The client population 40 and above, as a proportional share of the overall client population, increased from 32.6% in 2010 to 33.9% in 2014.

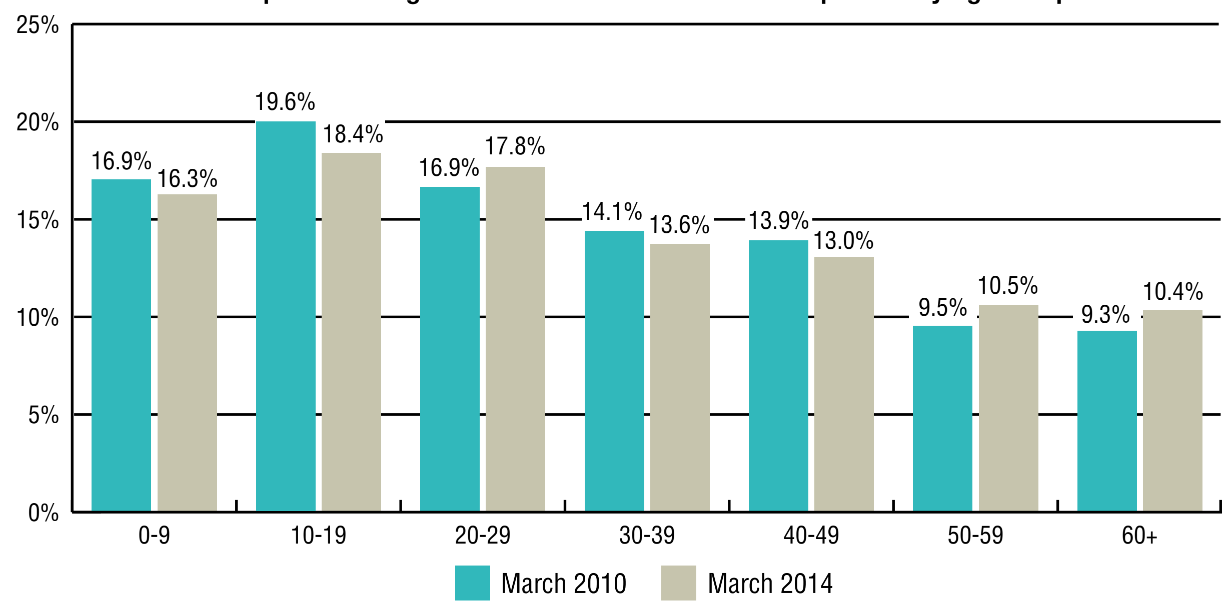
As the First Nations and Inuit client population ages, the costs associated with delivering Non-Insured Health Benefits, particularly pharmacy benefits, to this client population are expected to increase significantly.

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



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

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



Source: SVS adapted by Program Analysis Division

Program Expenditures

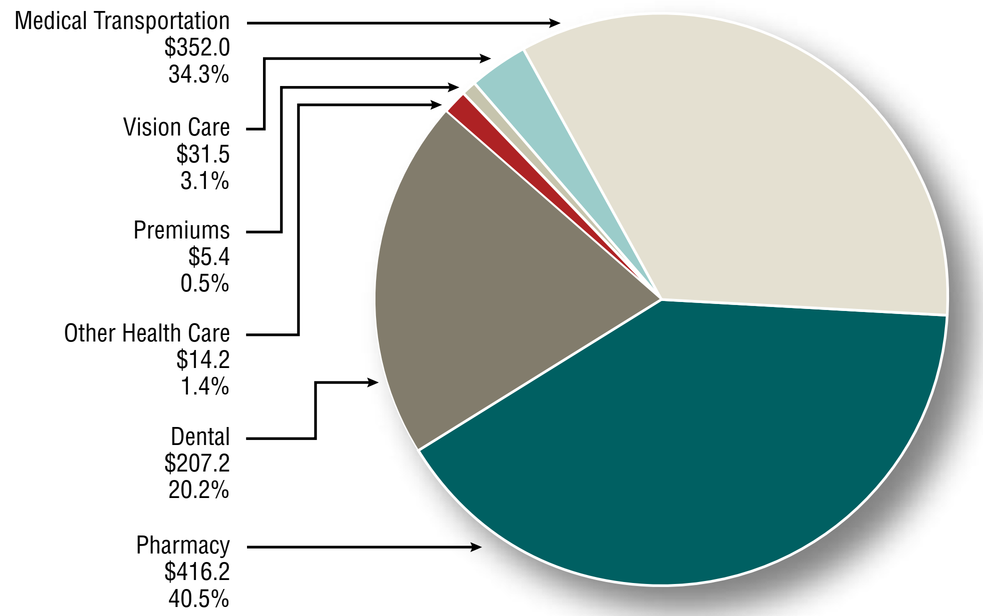
FIGURE 3.1

NIHB Expenditures by Benefit ($ Millions)
2013/14

In 2013/14, total NIHB expenditures were $1,026.4 million. This is a decrease of 7.1% compared to total NIHB expenditures in 2012/13. This decrease can be attributed to the transfer of responsibility for First Nations individuals residing in British Columbia to the First Nations Health Authority (FNHA).

Of this total, Pharmacy costs (including medical supplies and equipment) represented the largest proportion at $416.2 million (40.5%), followed by Medical Transportation costs at $352.0 million (34.3%) and Dental costs at $207.2 million (20.2%).

NIHB Pharmacy, Dental and Medical Transportation benefit expenditures accounted for 95.0% of total NIHB expenditures in 2013/14.



Total NIHB Expenditures: $1,026.4M*

Source: FIRMS adapted by Program Analysis Division

* Not reflected in the $1,026.4 million in NIHB expenditures is approximately $33.3 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
2012/13 and 2013/14

Overall NIHB Program expenditures decreased by 7.1% or $78.2 million from 2012/13 to 2013/14. This decrease in overall expenditures can be attributed to the transfer of First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA). If the expenditures for these FNHA eligible clients are excluded from the 2012/13 and 2013/14 total NIHB expenditures, then the total NIHB expenditure growth rate would have been 2.8%.

With the exception of the NIHB Medical Transportation benefit, all of the other NIHB benefits had a decrease in expenditures over the previous fiscal year. The highest net decrease in expenditures over fiscal year 2012/13 was in the NIHB Pharmacy benefits at $46.5 million, followed by NIHB Premiums with a decrease of $15.9 million and NIHB Dental benefits which decreased by $15.5 million.

NIHB Pharmacy benefit expenditures had the second largest proportional decrease in 2013/14 at 10.1%, followed by NIHB Dental benefits with a decrease of 7.0% over the previous fiscal year. If the expenditures for FNHA eligible clients are excluded from the 2012/13 and 2013/14 expenditures, then the NIHB Pharmacy expenditure growth rate would have been 1.5% and the NIHB Dental expenditure growth rate would have been 3.8%.

BENEFIT	Total Expenditures ($ 000's) 2012/13	Total Expenditures ($ 000's) 2013/14	% Change From 2012/13
Medical Transportation	$ 351,424	$ 352,036	0.2%
Pharmacy	462,699	416,165	-10.1%
Dental	222,706	207,179	-7.0%
Other Health Care	14,337	14,152	-1.3%
Premiums	21,257	5,406	-74.6%
Vision Care	32,167	31,459	-2.2%
Total Expenditures	**$ 1,104,591**	**$ 1,026,397**	**-7.1%**

Source: FIRMS adapted by Program Analysis Division

FIGURE 3.3

NIHB Expenditures by Benefit and Region ($ 000's)
2013/14

The Manitoba Region accounted for the highest proportion of total expenditures at $229.7 million, or 22.4% of the national total, followed by the Ontario Region at $193.9 million (18.9%), and the Saskatchewan Region at $168.8 million (16.4%).

In comparison, the lowest expenditures were in the Yukon ($10.5 million) and the Northwest Territories ($28.1 million). These totals represented 1.0% and 2.7% respectively of the national total.

The British Columbia Region had the largest decrease in expenditures from $143.5 million in 2012/13 to $49.5 million in 2013/14. This is a decrease of 65.5% and can be attributed to the transfer of First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA).

Headquarters expenditures represent costs paid for claims processing services and account for 1.9% ($19.9 million) of NIHB expenditures. This figure does not include the $13.4 million in Headquarters administrative costs outlined in Figure 11.2.

REGION	Medical Transportation	Pharmacy	Dental	Other Health Care	Premiums	Vision Care	TOTAL
Atlantic	$ 6,916	$ 27,517	$ 8,609	$ 235	$ -	$ 2,757	**$ 46,033**
Quebec	21,945	40,825	15,216	1,003	-	1,619	**80,608**
Ontario	62,865	78,510	43,972	2,862	-	5,721	**193,929**
Manitoba	111,016	77,034	33,649	3,622	-	4,348	**229,670**
Saskatchewan	47,180	78,546	36,399	1,017	-	5,611	**168,752**
Alberta	41,451	58,777	34,928	4,959	-	5,936	**146,051**
British Columbia	15,960	14,939	11,013	453	5,406	1,704	**49,475**
Yukon	4,439	3,455	2,210	2	-	377	**10,483**
N.W.T.	10,372	8,677	7,448	-	-	1,582	**28,079**
Nunavut	29,892	11,012	10,757	-	-	1,804	**53,465**
Headquarters	-	16,874	2,978	-	-	-	**19,852**
Total	**$ 352,036**	**$ 416,165**	**$ 207,179**	**$ 14,152**	**$ 5,406**	**$ 31,459**	**$ 1,026,397**

Source: FIRMS adapted by Program Analysis Division

FIGURE 3.4

Proportion of NIHB Expenditures by Region
2013/14

In 2013/14, the Manitoba Region had the highest proportion of total NIHB expenditures (22.4%) and accounted for 31.5% of total NIHB Medical Transportation expenditures. This can be attributed to the large number of First Nations clients living in remote or fly-in only northern communities in the Manitoba Region.

The regions of Ontario and Saskatchewan accounted for the highest proportion of NIHB Pharmacy expenditures both at 18.9%, followed closely by the Manitoba Region at 18.5%.

The Ontario Region, which accounted for 18.9% of total NIHB expenditures in 2013/14, recorded the highest proportion of total NIHB Dental expenditures at 21.2%. This region also accounted for the highest proportion of the total NIHB population at 24.4%.

The proportion of NIHB Vision Care expenditures ranged from a high of 18.9% in the Alberta Region and 18.2% in the Ontario Region to a low of 1.2% in the Yukon.

The Alberta Region (35.0%) and the Manitoba Region (25.6%) combined accounted for over one half of the total NIHB Other Health Care expenditures in 2013/14.

REGION	Medical Transportation	Pharmacy	Dental	Other Health Care	Premiums	Vision Care	Proportion of NIHB Expenditure	Proportion of NIHB Population
Atlantic	2.0%	6.6%	4.2%	1.7%	0.0%	8.8%	**4.5%**	**7.7%**
Quebec	6.2%	9.8%	7.3%	7.1%	0.0%	5.1%	**7.9%**	**8.3%**
Ontario	17.9%	18.9%	21.2%	20.2%	0.0%	18.2%	**18.9%**	**24.4%**
Manitoba	31.5%	18.5%	16.2%	25.6%	0.0%	13.8%	**22.4%**	**17.9%**
Saskatchewan	13.4%	18.9%	17.6%	7.2%	0.0%	17.8%	**16.4%**	**17.3%**
Alberta	11.8%	14.1%	16.9%	35.0%	0.0%	18.9%	**14.2%**	**14.0%**
British Columbia	4.5%	3.6%	5.3%	3.2%	100.0%	5.4%	**4.8%**	**2.4%**
Yukon	1.3%	0.8%	1.1%	0.0%	0.0%	1.2%	**1.0%**	**0.9%**
N.W.T.	2.9%	2.1%	3.6%	0.0%	0.0%	5.0%	**2.7%**	**3.1%**
Nunavut	8.5%	2.6%	5.2%	0.0%	0.0%	5.7%	**5.2%**	**4.0%**
Headquarters	0.0%	4.1%	1.4%	0.0%	0.0%	0.0%	**1.9%**	**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
2013/14

At the national level, approximately three-quarters (74.8%) of total Program expenditures occurred in two benefit areas: pharmacy (40.5%) and medical transportation (34.3%). Dental expenditures accounted for one-fifth (20.2%) of total NIHB expenditures.

NIHB Medical Transportation expenditures accounted for over half (55.9%) of total expenditures in Nunavut compared to 15.0% in the Atlantic Region. However, in the Atlantic Region, 59.8% of total expenditures were spent on pharmacy benefits compared to a low of 20.6% in Nunavut.

The proportion of dental expenditures ranged from 14.7% in the Manitoba Region to 26.5% in the Northwest Territories.

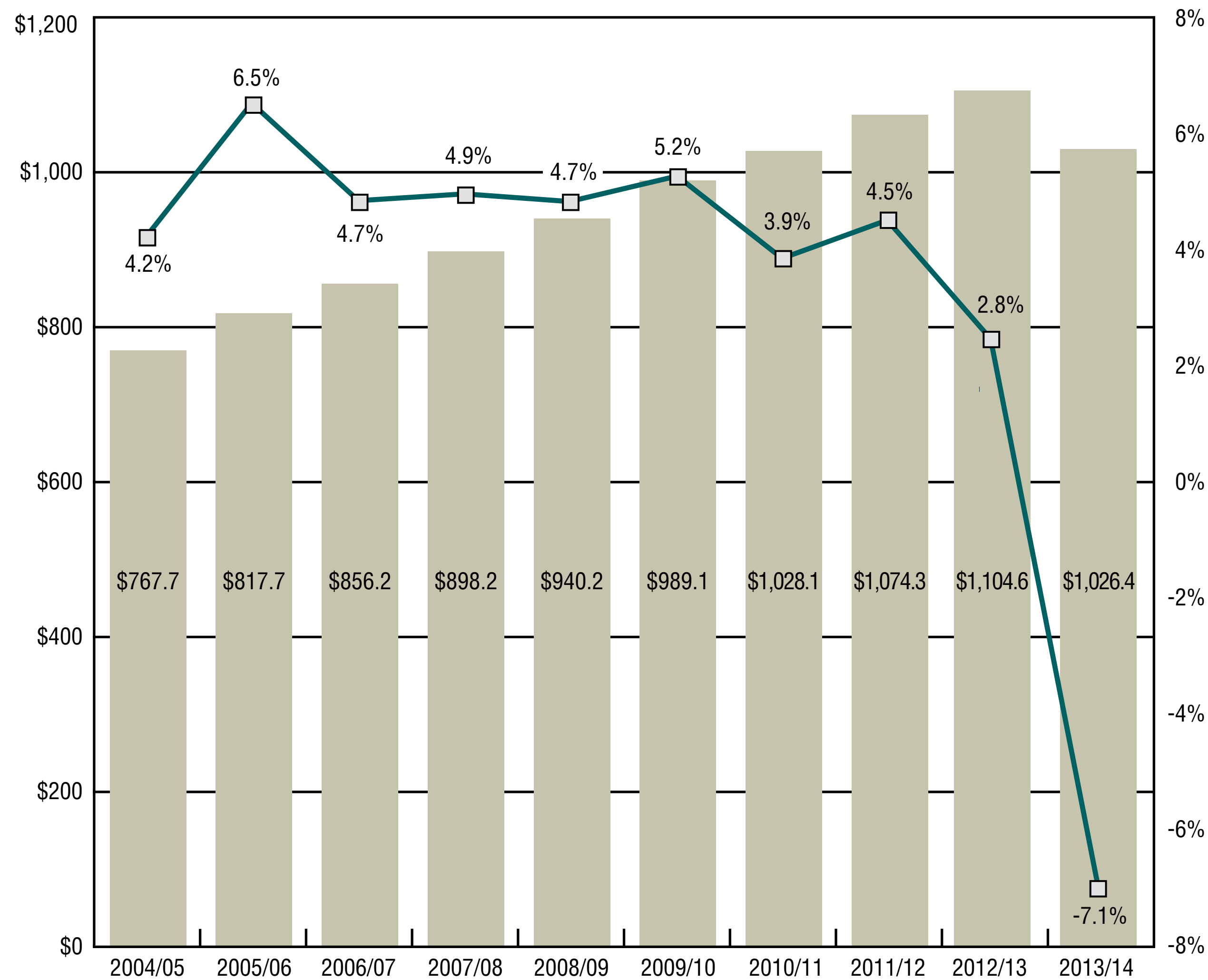
Pharmacy costs represented the highest percentage of total expenditures in all regions except in Nunavut, the Northwest Territories, Yukon and the Manitoba Region, where transportation accounted for the largest share of costs.

REGION	Medical Transportation	Pharmacy	Dental	Other Health Care	Premiums	Vision Care	TOTAL
Atlantic	15.0%	59.8%	18.7%	0.5%	0.0%	6.0%	**100%**
Quebec	27.2%	50.6%	18.9%	1.2%	0.0%	2.0%	**100%**
Ontario	32.4%	40.5%	22.7%	1.5%	0.0%	2.9%	**100%**
Manitoba	48.3%	33.5%	14.7%	1.6%	0.0%	1.9%	**100%**
Saskatchewan	28.0%	46.5%	21.6%	0.6%	0.0%	3.3%	**100%**
Alberta	28.4%	40.2%	23.9%	3.4%	0.0%	4.1%	**100%**
British Columbia	32.3%	30.2%	22.3%	0.9%	10.9%	3.4%	**100%**
Yukon	42.3%	33.0%	21.1%	0.0%	0.0%	3.6%	**100%**
N.W.T.	36.9%	30.9%	26.5%	0.0%	0.0%	5.6%	**100%**
Nunavut	55.9%	20.6%	20.1%	0.0%	0.0%	3.4%	**100%**
Headquarters	0%	85.0%	15.0%	0.0%	0.0%	0.0%	**100%**
National	**34.3%**	**40.5%**	**20.2%**	**1.4%**	**0.5%**	**3.1%**	**100%**

Source: FIRMS adapted by Program Analysis Division

FIGURE 3.6

NIHB Annual Expenditures ($ Millions) and Percentage Change
2004/05 to 2013/14



Source: FIRMS adapted by Program Analysis Division

In 2013/14, NIHB Program expenditures totalled $1,026.4 million, a decrease of 7.1% from $1,104.6 million in 2012/13. This decrease in expenditure growth can be attributed to the transfer of responsibility to the First Nations Health Authority (FNHA) for the management and delivery of non-insured health benefits to First Nation clients in the province of British Columbia. If the expenditures for these FNHA eligible clients are excluded from the 2012/13 and 2013/14 total NIHB expenditures, then the growth rate would have been 2.8%.

Since 2004/05, total expenditures have grown by 33.7%. The annualized rate of growth over this period was 3.4%. There has been wide variation in growth rates between 2004/05 and 2013/14, with a low of -7.1% in 2013/14 to a high of 6.5% in 2005/06.

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 to gain efficiencies through the 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.

FIGURE 3.7

NIHB Annual Expenditures by Benefit ($ 000's)
2004/05 to 2013/14

In the period from 2004/05 to 2013/14, the expenditures for NIHB Medical Transportation and Dental benefits have grown more than other benefit areas. NIHB Medical Transportation expenditures grew by 66.4% from $211.5 million in 2004/05 to $352.0 million in 2013/14. NIHB Dental expenditures rose by 44.9% from $143.0 million in 2004/05 to $207.2 million in 2013/14.

Over the same period, NIHB Vision Care expenditures increased by 27.7% and NIHB Pharmacy expenditures had an increase of 21.0%.

NIHB Other Health Care expenditures, comprised mainly of short-term crisis intervention mental health counselling, decreased by 16.3% over this same time period from $16.9 million in 2004/05 to $14.2 million in 2013/14. 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 significantly by 80.6% from $27.8 million in 2004/05 to $5.4 million in 2013/14. This decrease can be attributed to the Government of Alberta eliminating Alberta health care insurance premiums for all Alberta residents on January 1, 2009 and to the transfer of responsibility for health care insurance premiums for First Nations clients residing in British Columbia to the First Nations Health Authority (FNHA).

BENEFIT	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Medical Transportation	$ 211,527	$ 225,379	$ 241,602	$ 262,294	$ 280,446	$ 301,673	$ 311,760	$ 333,304	$ 351,424	$ 352,036
Pharmacy	343,879	368,398	386,190	403,248	418,968	435,097	440,768	459,359	462,699	416,165
Dental	142,956	153,900	158,584	165,576	176,382	194,918	215,796	219,057	222,706	207,179
Other Health Care	16,904	17,115	16,271	12,289	11,380	12,516	12,083	12,936	14,337	14,152
Premiums	27,830	27,987	28,659	29,211	26,430	17,110	18,428	19,868	21,257	5,406
Vision Care	24,629	24,968	24,894	25,621	26,577	27,779	29,219	29,780	32,167	31,459
Total	**$ 767,726**	**$ 817,748**	**$ 856,201**	**$ 898,239**	**$ 940,182**	**$ 989,094**	**$ 1,028,053**	**$ 1,074,304**	**$ 1,104,591**	**$ 1,026,397**
Annual % Change	**4.2%**	**6.5%**	**4.7%**	**4.9%**	**4.7%**	**5.2%**	**3.9%**	**4.5%**	**2.8%**	**-7.1%**

Source: FIRMS adapted by Program Analysis Division

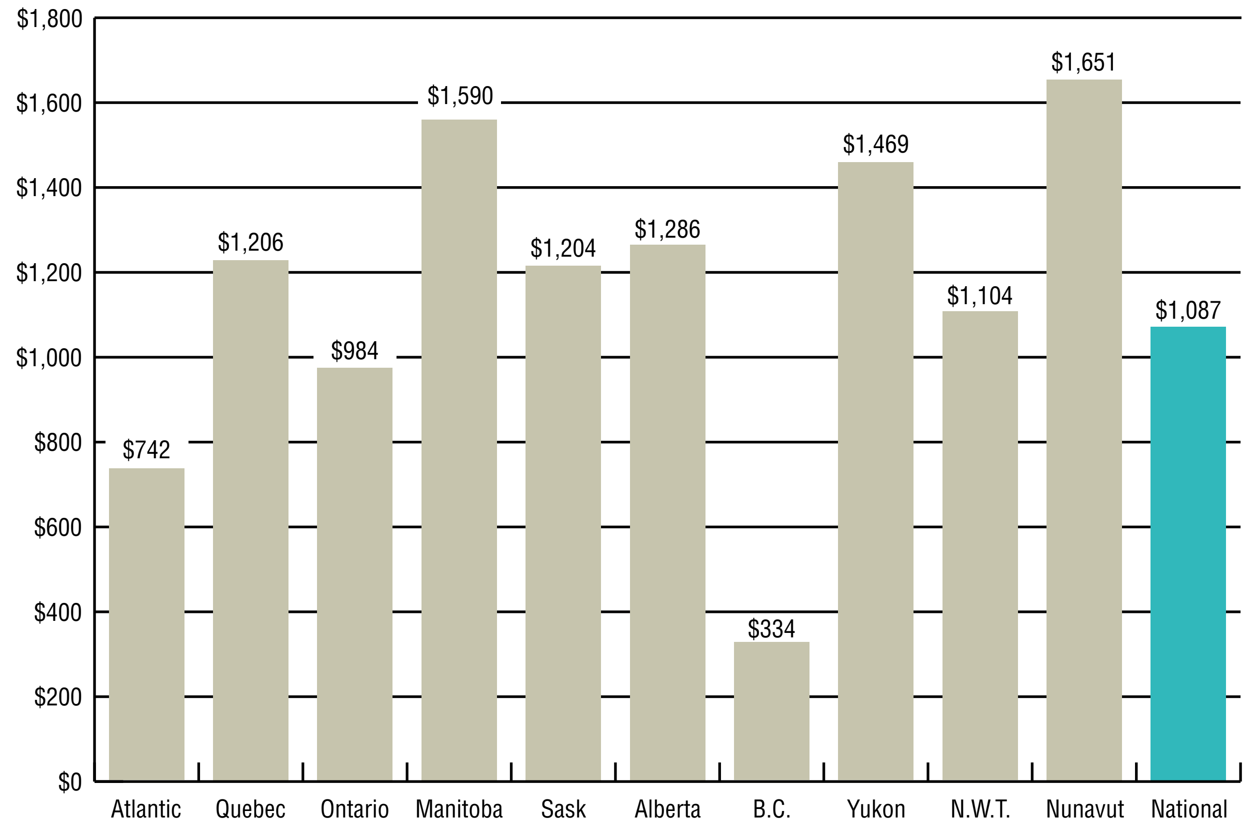
FIGURE 3.8

Per Capita NIHB Expenditures by Region (Excluding Premiums)
2013/14

The national per capita expenditure for all benefits in 2013/14 was $1,087. This is a decrease from the 2012/13 national per capita expenditure of $1,150.

Nunavut had the highest per capita cost in 2013/14 at $1,651. The Manitoba Region followed closely with a per capita cost of $1,590. 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.

The British Columbia Region had the lowest per capita cost in 2013/14 at $334. As a result of the transfer of First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA), only the first three months of claims for FNHA eligible clients are included in the per capita calculation.



Source: FIRMS and SVS adapted by Program Analysis Division

NIHB Pharmacy Expenditure and Utilization Data

The NIHB Program covers claims for pharmacy benefits not covered by private, public or provincial/territorial health care plans. 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 2013/14, the NIHB Program paid for pharmacy claims made by a total of 491,158 First Nations and Inuit clients. The total expenditures for these claims was $416.2 million or 40.5% 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 and cardiovascular disease. Through the pharmacy benefit of the NIHB Program, the health needs of approximately 152,000 clients with gastrointestinal problems, 121,000 clients with cardiovascular problems, and 64,000 clients with diabetes were addressed in 2013/14.

The NIHB Program provides eligible clients with access to pharmacy benefits that are intended to 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.

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

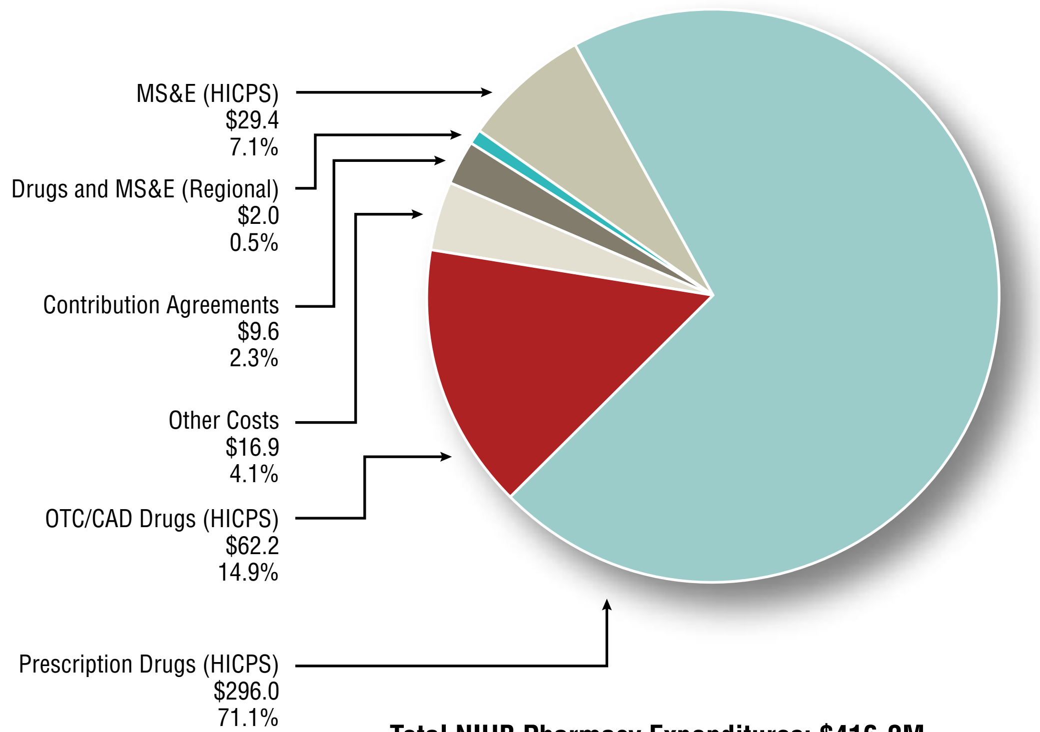
Distribution of NIHB Pharmacy Expenditures ($ Millions)
2013/14

In 2013/14, NIHB Pharmacy benefits totalled $416.2 million or 40.5% 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 $296.0 million or 71.1% of all NIHB Pharmacy expenditures, followed by over-the-counter (OTC) drugs and controlled access drugs (CAD) which totalled $62.2 million or 14.9%. Medical supplies and equipment (MS&E) items paid through HICPS was the third largest component in the pharmacy benefit at $29.4 million or 7.1%. In total, the three components managed through automated claims processing accounted for 93.1% of all pharmacy benefit costs.

Drugs and MS&E (Regional), at $2.0 million or 0.5%, 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 $9.6 million or 2.3% 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.



Total NIHB Pharmacy Expenditures: $416.2M

Source: FIRMS adapted by Program Analysis Division

Other costs totalled $16.9 million or 4.1% in 2013/14. 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)
2013/14

Prescription drug costs paid through the Health Information and Claims Processing Services (HICPS) system represented the largest component of total costs accounting for $296.0 million or 71.1% of all NIHB Pharmacy costs. The Manitoba Region had the largest proportion of these costs at 20.2%, followed closely by the Saskatchewan Region at 19.9% and the Ontario Region at 19.2%.

The next highest component was over-the-counter (OTC) and controlled access drug (CAD) costs at $62.2 million or 14.9%. The regions of Ontario (22.5%), Manitoba (20.1%) and Saskatchewan (18.9%) had the largest proportions of these costs in 2013/14.

The third highest component was the combined medical supplies and equipment (MS&E) category at $29.4 million (7.1%). The Saskatchewan Region (22.2%) had the highest proportion of MS&E costs in 2013/14. This was followed by the Alberta Region (20.8%), the Manitoba Region (16.7%), and the Ontario Region (14.1%).

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	$ 20,500	$ 4,773	$ 4	$ 617	$ 1,445	$ -	$ 27,339	$ 177	**$ 27,517**
Quebec	31,696	7,595	33	569	931	-	40,825	0	**40,825**
Ontario	56,822	14,020	13	1,127	3,024	-	75,005	3,505	**78,510**
Manitoba	59,651	12,475	0	1,581	3,326	-	77,034	0	**77,034**
Saskatchewan	58,836	11,771	1,367	2,079	4,450	-	78,503	42	**78,546**
Alberta	40,108	7,060	23	1,831	4,287	-	53,310	5,467	**58,777**
British Columbia	11,394	1,779	75	317	1,153	-	14,719	220	**14,939**
Yukon	2,688	345	75	78	269	-	3,455	0	**3,455**
N.W.T.	6,379	1,124	70	361	535	-	8,468	209	**8,677**
Nunavut	7,911	1,260	379	393	1,069	-	11,012	0	**11,012**
Headquarters	-	-	-	-	-	16,874	16,874	0	**16,874**
Total	**$ 295,986**	**$ 62,203**	**$ 2,039**	**$ 8,954**	**$ 20,489**	**$ 16,874**	**$ 406,544**	**$ 9,621**	**$ 416,165**

Source: FIRMS adapted by Program Analysis Division

FIGURE 4.3

Annual NIHB Pharmacy Expenditures
2009/10 to 2013/14

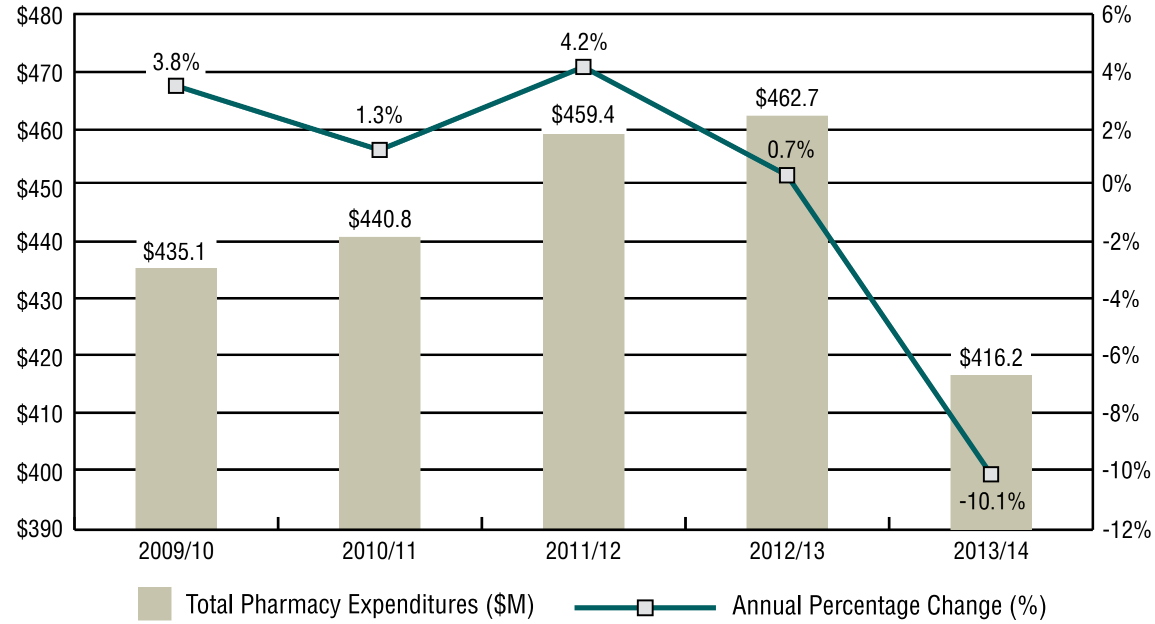
NIHB Pharmacy expenditures decreased by 10.1% during fiscal year 2013/14. This decrease in overall NIHB Pharmacy expenditures can be attributed to the transfer of eligible First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA) along with the transfer of responsibility for the management and delivery of non-insured pharmacy benefits. If the expenditures for these FNHA eligible clients are excluded from the 2012/13 and 2013/14 NIHB Pharmacy expenditures, then the total pharmacy benefit growth rate would have been 1.5%.

Over the past five years, growth in pharmacy expenditures has ranged from a high of 4.2% in 2011/12 to a low of -10.1% in 2013/14. The annualized growth rate over these five years is -0.1%.

If eligible FNHA clients are excluded from the 2012/13 and 2013/14 NIHB client population, NIHB Pharmacy expenditure growth would have 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 changes in generic pricing policies in key provinces (Quebec, Ontario, Saskatchewan and British Columbia).

The highest rate of growth in NIHB Pharmacy expenditures in 2013/14 took place in the Saskatchewan Region, which increased by 5.2% over the previous fiscal year. The regions of Atlantic, Manitoba, Alberta, British Columbia, Yukon and the Northwest Territories had a decrease in pharmacy expenditures.

NIHB Pharmacy Expenditures and Annual Percentage Change



Source: FIRMS adapted by Program Analysis Division

NIHB Pharmacy Expenditures ($ 000's)

REGION	2009/10	2010/11	2011/12	2012/13	2013/14
Atlantic	$ 21,357	$ 23,689	$ 27,571	$ 29,979	$ 27,517
Quebec	37,358	38,234	38,827	40,393	40,825
Ontario	77,564	73,887	76,430	77,131	78,510
Manitoba	72,789	76,496	80,639	80,676	77,034
Saskatchewan	66,639	70,625	73,293	74,646	78,546
Alberta	56,570	59,738	61,621	60,584	58,777
British Columbia	58,862	60,097	60,890	59,858	14,939
Yukon	3,723	3,792	3,878	3,994	3,455
N.W.T.	8,595	8,999	9,090	8,999	8,677
Nunavut	8,237	10,399	10,894	10,690	11,012
Headquarters	23,403	14,814	16,227	15,749	16,874
Total	$ 435,097	$ 440,768	$ 459,359	$ 462,699	$ 416,165

Source: FIRMS adapted by Program Analysis Division

FIGURE 4.4

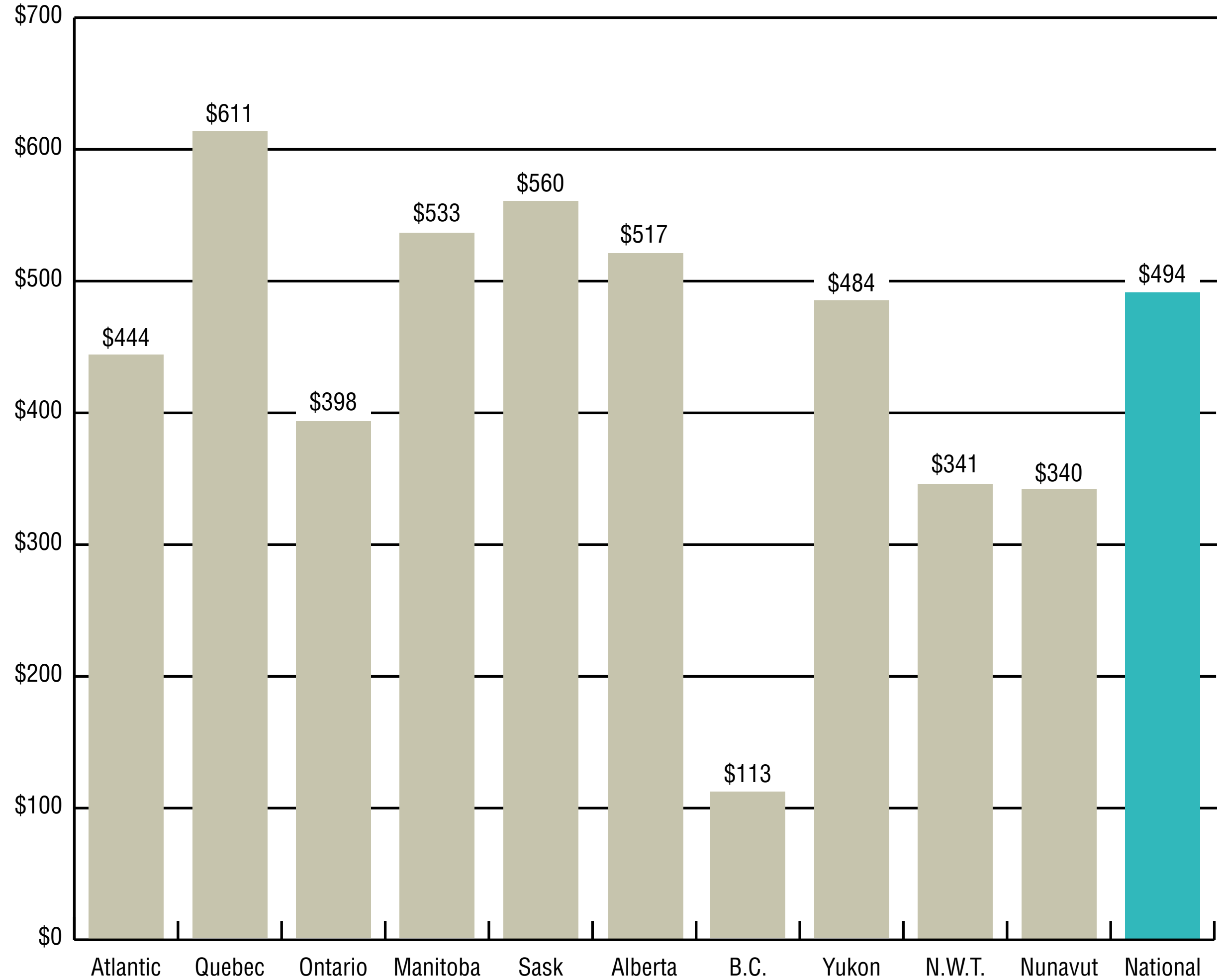
Per Capita NIHB Pharmacy Expenditures by Region
2013/14

In 2013/14, the national per capita expenditure for NIHB Pharmacy benefits was $494. This was an increase of 2.3% from the $483 recorded in 2012/13.

The Quebec Region had the highest per capita NIHB Pharmacy expenditure at $611, followed by the Saskatchewan Region at $560, the Manitoba Region at $533 and the Alberta Region at $517.

The British Columbia Region had the lowest per capita NIHB Pharmacy expenditures at $113. As a result of the transfer of First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA), only the first three months of claims for FNHA eligible clients are included in the per capita calculation. If the FNHA eligible population is excluded from 2013/2014 the per capita cost for British Columbia Region would have been $791.

Nunavut had the second lowest per capita expenditure followed closely by the Northwest Territories at $340 and $341 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)



Source: FIRMS and SVS adapted by Program Analysis Division

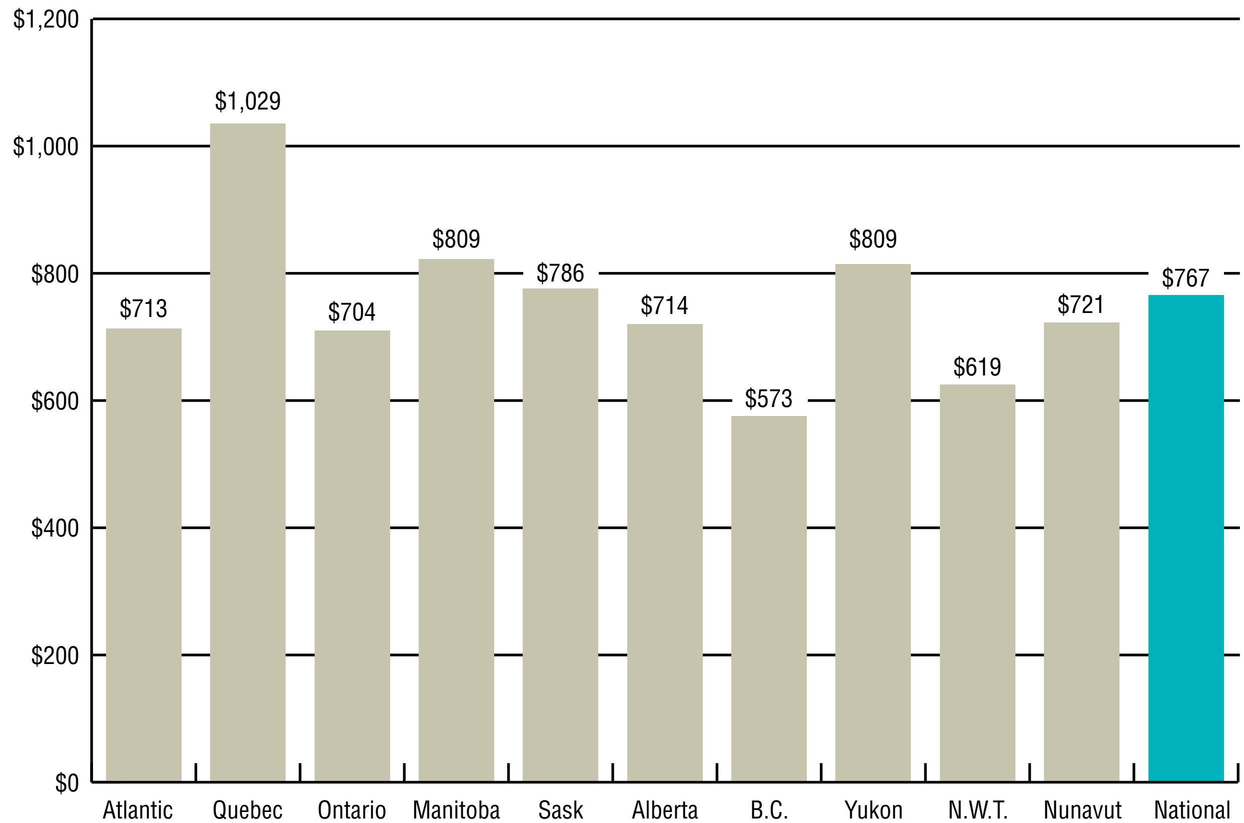
FIGURE 4.5

NIHB Pharmacy Operating Expenditures per Claimant by Region
2013/14

In 2013/14, the national average expenditure per eligible client receiving at least one pharmacy benefit (claimant) was $767, an increase of 2.3% over the recorded amount of $750 in 2012/13.

The Quebec Region had the highest average NIHB Pharmacy operating expenditure per claimant at $1,029, followed by the Manitoba Region and the Yukon both at $809. The British Columbia Region had the lowest expenditure per claimant at $573.

In 2013/14, the rate of growth in NIHB Pharmacy operating expenditures per claimant decreased significantly in the British Columbia Region, by 16.1% from $683 in 2012/13 to $573 in 2013/14. This decrease can be attributed to the transfer of First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA). The regions of Atlantic, Quebec, Manitoba, Alberta and the Northwest Territories also had a decrease in the average operating cost per claimant compared to 2012/13.



Source: HICPS and FIRMS adapted by Program Analysis Division

FIGURE 4.6

NIHB Pharmacy Utilization Rates by Region
2009/10 to 2013/14

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 2013/14, the national utilization rate was 61% for NIHB Pharmacy benefits paid through the HICPS system. The slightly lower utilization over the last three fiscal years is a result of new C-3 and Qalipu Mi'kmaq First Nations being registered with the NIHB Program throughout the fiscal year but not immediately making claims.

Pharmacy utilization rates vary across the regions. In 2013/14, regional rates ranged from a low of 31% in the British Columbia Region to 70% in the Saskatchewan Region. The decrease in utilization in British Columbia Region can be attributed to the transfer of eligible First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA), along with the transfer of responsibility for the management and delivery of non-insured pharmacy benefits.

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.

Pharmacy Utilization					
REGION	2009/10	2010/11	2011/12	2012/13	2013/14
Atlantic	66%	66%	55%	61%	62%
Quebec	59%	59%	59%	59%	59%
Ontario	56%	55%	55%	55%	54%
Manitoba	68%	67%	67%	67%	66%
Saskatchewan	73%	72%	71%	70%	70%
Alberta	67%	67%	66%	66%	66%
British Columbia	68%	68%	66%	66%	31%
Yukon	64%	61%	61%	60%	59%
N.W.T.	54%	53%	53%	53%	53%
Nunavut	46%	44%	45%	46%	46%
National	**64%**	**64%**	**62%**	**62%**	**61%**

Source: HICPS and SVS adapted by Program Analysis Division

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 2013/14. 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 62%.

FIGURE 4.7

NIHB Pharmacy Claimants by Age Group, Gender and Region
2013/14

Of the 808,686 clients eligible to receive benefits under the NIHB Program, a total of 491,158 claimants, representing 61% of the NIHB client population, received at least one pharmacy item paid through the Health Information and Claims Processing Services (HICPS) system in 2013/14.

Of this total, 277,899 were female (57%) and 213,259 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 34 years. The average age for female and male claimants was 34 and 33 years of age, respectively. The highest average age of pharmacy claimants was for females in the Yukon at 40 years of age, while the lowest was for males in the regions of Saskatchewan, Alberta and British Columbia at 30 years of age.

Thirty percent of pharmacy claimants were under 20 years of age. Twenty-eight percent of female claimants were in this age group while males accounted for 32%. Seniors (age 65 and over) represented 7.6% of all pharmacy claimants in 2013/14.

REGION	Atlantic			Quebec			Ontario			Manitoba		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	811	885	1,696	942	912	1,854	2,340	2,292	4,632	3,490	3,345	6,835
5-9	1,354	1,318	2,672	1,211	1,233	2,444	3,056	2,949	6,005	4,373	4,513	8,886
10-14	1,170	1,224	2,394	1,019	1,042	2,061	2,825	2,844	5,669	3,598	3,649	7,247
15-19	1,266	1,896	3,162	1,101	1,804	2,905	3,179	4,663	7,842	3,375	4,811	8,186
20-24	1,280	2,108	3,388	1,146	2,041	3,187	3,322	5,640	8,962	3,487	5,745	9,232
25-29	1,109	1,706	2,815	1,015	1,835	2,850	3,304	5,052	8,356	3,216	4,808	8,024
30-34	1,083	1,637	2,720	1,060	1,586	2,646	3,190	4,802	7,992	3,010	4,058	7,068
35-39	1,111	1,502	2,613	1,061	1,505	2,566	3,268	4,406	7,674	2,823	3,749	6,572
40-44	1,317	1,559	2,876	1,213	1,589	2,802	3,525	4,551	8,076	2,986	3,918	6,904
45-49	1,286	1,620	2,906	1,332	1,779	3,111	3,820	4,836	8,656	3,048	3,607	6,655
50-54	1,225	1,569	2,794	1,410	1,757	3,167	3,800	4,888	8,688	2,758	3,303	6,061
55-59	1,135	1,461	2,596	1,228	1,694	2,922	3,245	4,205	7,450	2,110	2,525	4,635
60-64	916	1,228	2,144	961	1,268	2,229	2,434	3,219	5,653	1,460	1,879	3,339
65+	1,555	2,024	3,579	1,914	2,965	4,879	4,274	6,578	10,852	2,338	3,227	5,565
Total	16,618	21,737	38,355	16,613	23,010	39,623	45,582	60,925	106,507	42,072	53,137	95,209
Average Age	36	37	37	38	39	39	37	38	38	31	32	32

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	3,544	3,470	7,014	2,989	2,768	5,757	393	392	785	69	66	135	298	257	555	785	742	1,527	15,661	15,129	30,790
5-9	4,950	5,190	10,140	3,653	3,678	7,331	211	170	381	89	84	173	375	404	779	578	554	1,132	19,850	20,093	39,943
10-14	4,113	4,291	8,404	2,985	3,020	6,005	146	186	332	95	92	187	312	345	657	443	428	871	16,706	17,121	33,827
15-19	3,589	5,361	8,950	2,975	3,880	6,855	239	322	561	128	183	311	373	622	995	408	847	1,255	16,633	24,389	41,022
20-24	3,899	6,015	9,914	3,040	4,301	7,341	198	349	547	146	212	358	467	876	1,343	430	1,054	1,484	17,415	28,341	45,756
25-29	3,578	5,318	8,896	2,727	3,819	6,546	160	290	450	123	203	326	407	785	1,192	393	944	1,337	16,032	24,760	40,792
30-34	3,156	4,279	7,435	2,488	3,399	5,887	221	277	498	142	188	330	365	704	1,069	359	786	1,145	15,074	21,716	36,790
35-39	2,900	3,800	6,700	2,338	2,864	5,202	171	242	413	137	147	284	322	599	921	349	590	939	14,480	19,404	33,884
40-44	2,964	3,766	6,730	2,192	2,742	4,934	154	229	383	150	162	312	434	662	1,096	396	600	996	15,331	19,778	35,109
45-49	2,804	3,541	6,345	2,173	2,582	4,755	152	268	420	163	179	342	444	651	1,095	420	627	1,047	15,642	19,690	35,332
50-54	2,428	3,065	5,493	1,914	2,419	4,333	142	233	375	190	217	407	393	629	1,022	373	495	868	14,633	18,575	33,208
55-59	1,841	2,352	4,193	1,400	1,865	3,265	108	177	285	117	172	289	342	502	844	232	342	574	11,758	15,295	27,053
60-64	1,280	1,605	2,885	970	1,353	2,323	78	125	203	79	141	220	268	343	611	251	278	529	8,697	11,439	20,136
65+	2,110	2,967	5,077	1,715	2,431	4,146	178	293	471	195	309	504	583	806	1,389	485	569	1,054	15,347	22,169	37,516
Total	43,156	55,020	98,176	33,559	41,121	74,680	2,551	3,553	6,104	1,823	2,355	4,178	5,383	8,185	13,568	5,902	8,856	14,758	213,259	277,899	491,158
Average Age	30	31	30	30	32	31	30	33	32	39	40	40	37	38	37	31	32	32	33	34	34

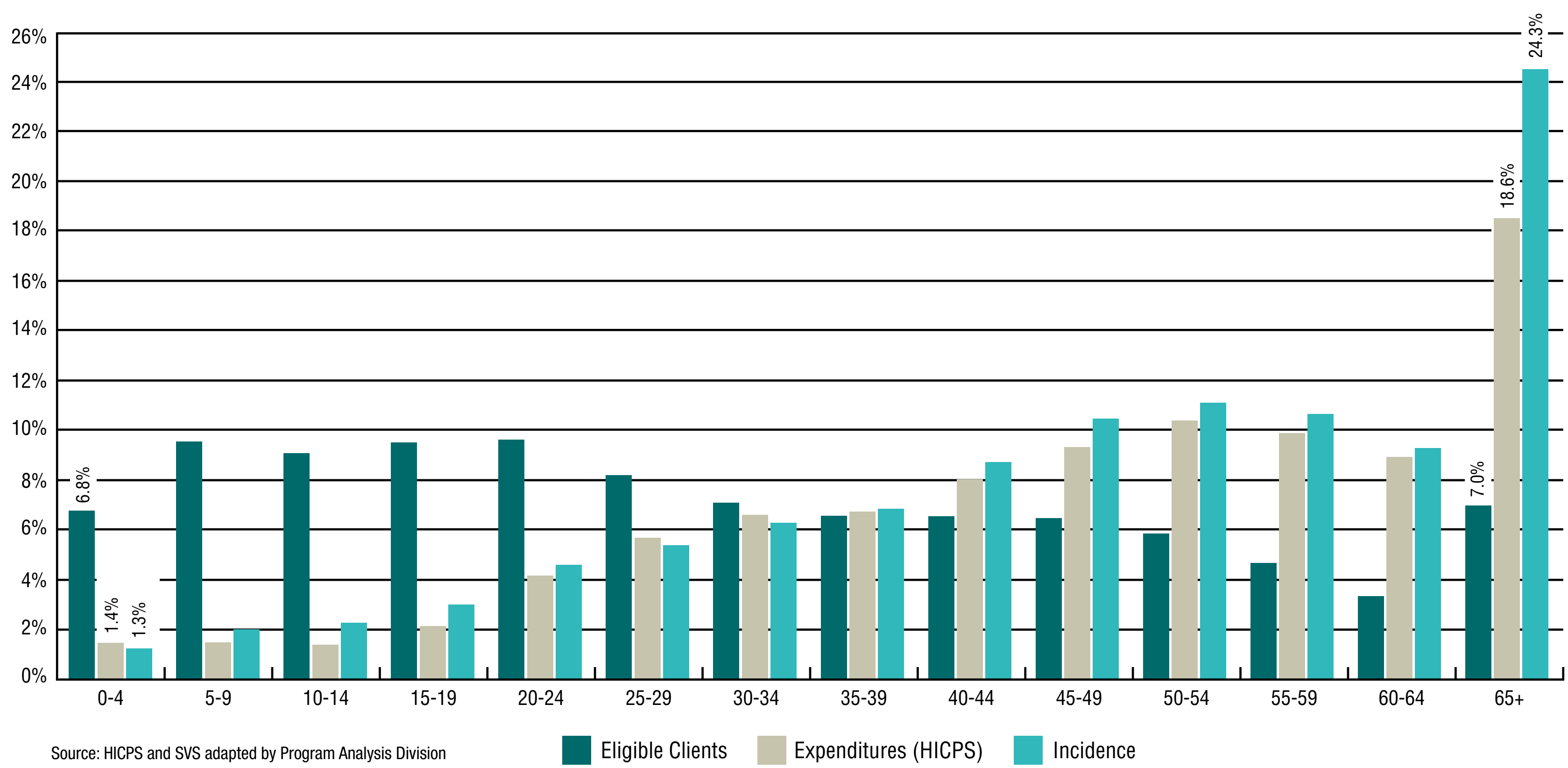
QUICK FACT

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 $175 who received pharmaceutical services during fiscal year 2013/14. The cost increased steadily for every age group, with claimants aged 35-39 having an average cost of $762, comparable to the total average claimant cost of $767. Claimants over 65 years of age had the highest cost per claimant with an average of $1,868 for all pharmaceutical services received throughout the fiscal year.

FIGURE 4.8

Distribution of Eligible NIHB Population, Pharmacy Expenditures and Pharmacy Incidence by Age Group
2013/14

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 2013/14, for example, 6.8% of all clients were in the 0 to 4 age group, but this



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.

group accounted for only 1.3% of all pharmacy claims made and only 1.4% of total pharmacy expenditures. In contrast, 7.0% of all eligible clients were in the 65+ age group, but accounted for 24.3% of all pharmacy claims submitted and 18.6% of total pharmacy expenditures, an increase over 2012/13.

During 2013/14, the average claimant aged 65 or more submitted 92 claims compared to 63 claims for their counterpart in the 60 to 64 age group and 6 claims for the average claimant in the 0 to 4 age group

FIGURE 4.9

NIHB Top Ten Therapeutic Classes by Claims Incidence and Expenditure
2013/14

Table 1 ranks the top ten therapeutic classes according to claims incidence. In 2013/14, Opioid Dependence Treatment had the highest claims incidence total at over one million claims (1,222,720). This represents a decrease of 4.5% over the 1,279,805 claims incidence recorded last fiscal year. This decrease can be attributed to the transfer of First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA). If these FNHA clients are excluded from the 2012/13 and 2013/14 fiscal years, the ongoing trend would be increased utilization of Opioid Dependence Treatment, which is generally dispensed more frequently than drugs in other therapeutic classifications, for reasons of safety and compliance.

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) such as Naprosyn (Naproxen) ranked second in claims incidence with 884,440 claims followed by Opioid Agonists and Antidepressants with 809,430 and 797,233 claims respectively.

Table 1: NIHB Top Ten Therapeutic Classes by Claims Incidence

Therapeutic Classification	Claims Incidence	% Change from 2012/13	% Change if FNHA Removed from 2012/13	Examples of Product in the Therapeutic Class
Opioid Dependence Treatment	1,222,720	-4.5%	9.3%	Methadone & Suboxone
Non-Steroidal Anti-Inflammatory Drugs (NSAID)	884,440	-8.9%	4.1%	Voltaren (Diclofenac)
Opioid Agonists	809,430	-13.5%	9.8%	Tylenol no.3 (Acetaminophen w/codeine)
Antidepressants	797,233	-9.2%	12.7%	Effexor (Venlafaxine)
Angiotensin-Converting Enzyme Inhibitors	565,967	-1.8%	8.0%	Altace (Ramipril)
HMG-CoA Reductase Inhibitors (Statins)	551,311	-5.3%	12.7%	Lipitor (Atorvastatin)
Proton-Pump Inhibitors	549,977	-5.1%	6.7%	Losec (Omeprazole)
Anxiolytics, Sedatives and Hypnotics - Benzodiazepines	469,672	-12.5%	1.0%	Ativan (Lorazepam)
Biguanides	450,049	-1.1%	8.3%	Glucophage (Metformin)
Antipsychotic Agents	363,469	-12.3%	12.0%	Risperdal (Risperidone)

Source: HICPS adapted by Program Analysis Division

Opioid Agonists had the largest decline in claims incidence over the previous fiscal year, decreasing by 13.5% from 935,548 claims in 2012/13 to 809,430 claims in 2013/14.

The decreases in claims incidence observed in all the therapeutic classifications can be attributed to the transfer of eligible First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA) along with the transfer of responsibility for the management and delivery of non-insured pharmacy benefits.

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 $16.9 million, a decrease of 17.1% over fiscal year 2012/13. If the expenditures for FNHA eligible clients are excluded from the 2012/13 and 2013/14 Opioid Agonists expenditures, then the total growth rate for this therapeutic class would have been an increase of 4.1%.

The second largest expenditure class was Disease-Modifying Antirheumatic Drugs, at $16.6 million. This is a decrease of 5.7% over fiscal year 2012/13. However if the expenditures for FNHA eligible clients are excluded from the 2012/13 and 2013/14 expenditures for the Disease-Modifying Antirheumatic Drugs class, then the total growth rate for this therapeutic class would have been an increase of 25.8%.

The Proton Pump Inhibitors class such as Losec (Omeprazole) had the largest decrease in expenditures amongst the top ten therapeutic classes from $17.0 million in 2012/13 to $12.0 million in 2013/14. This significant decrease of 29.4% over fiscal year 2012/13 can be attributed to a reduction in the generic drug pricing of Losec (Omeprazole) and Pariet (Rabeprazole), as well as the transfer of eligible First Nations clients living in British Columbia to the First Nations Health Authority (FNHA). If the expenditures for these FNHA eligible clients are excluded from the 2012/13 and 2013/14 expenditures for the Proton Pump Inhibitor class, then the decrease in expenditures for this class would have been 14.8%.

Table 2: NIHB Top Ten Therapeutic Classes by Expenditure

Therapeutic Classification	Expenditure ($000's)	% Change from 2012/13	% Change if FNHA Removed from 2012/13	Examples of Product in the Therapeutic Class
Opioid Agonists	$ 16,879	-17.1%	4.1%	Tylenol no.3 (Acetaminophen w/codeine)
Disease-Modifying Antirheumatic Drugs	16,604	-5.7%	25.8%	Enbrel (Etanercept)
Antidiabetic Agents (Insulin)	15,848	4.7%	16.8%	Lantus (Insulin)
Antidepressants	15,684	-17.7%	3.0%	Effexor (Venlafaxine)
Antiretrovirals	14,492	22.0%	23.9%	Sustiva (Efavirenz)
Antipsychotic Agents	13,227	-11.0%	1.3%	Risperdal (Risperidone)
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	12,280	-12.9%	0.8%	Voltaren (Diclofenac)
Proton Pump Inhibitors	12,020	-29.4%	-14.8%	Losec (Omeprazole)
Diabetic Diagnostic Agents	11,797	-5.5%	4.9%	Test Strips
Angiotensin-Converting Enzyme Inhibitors	11,507	-16.9%	-5.5%	Altace (Ramipril)

Source: HICPS adapted by Program Analysis Division

Within the top ten therapeutic classes, Antiretrovirals such as Sustiva (Efavirenz) had the highest percentage increase in expenditures at 22.0% over fiscal year 2012/13. This increase can be attributed to an increase in the number of clients accessing drugs within this therapeutic class.

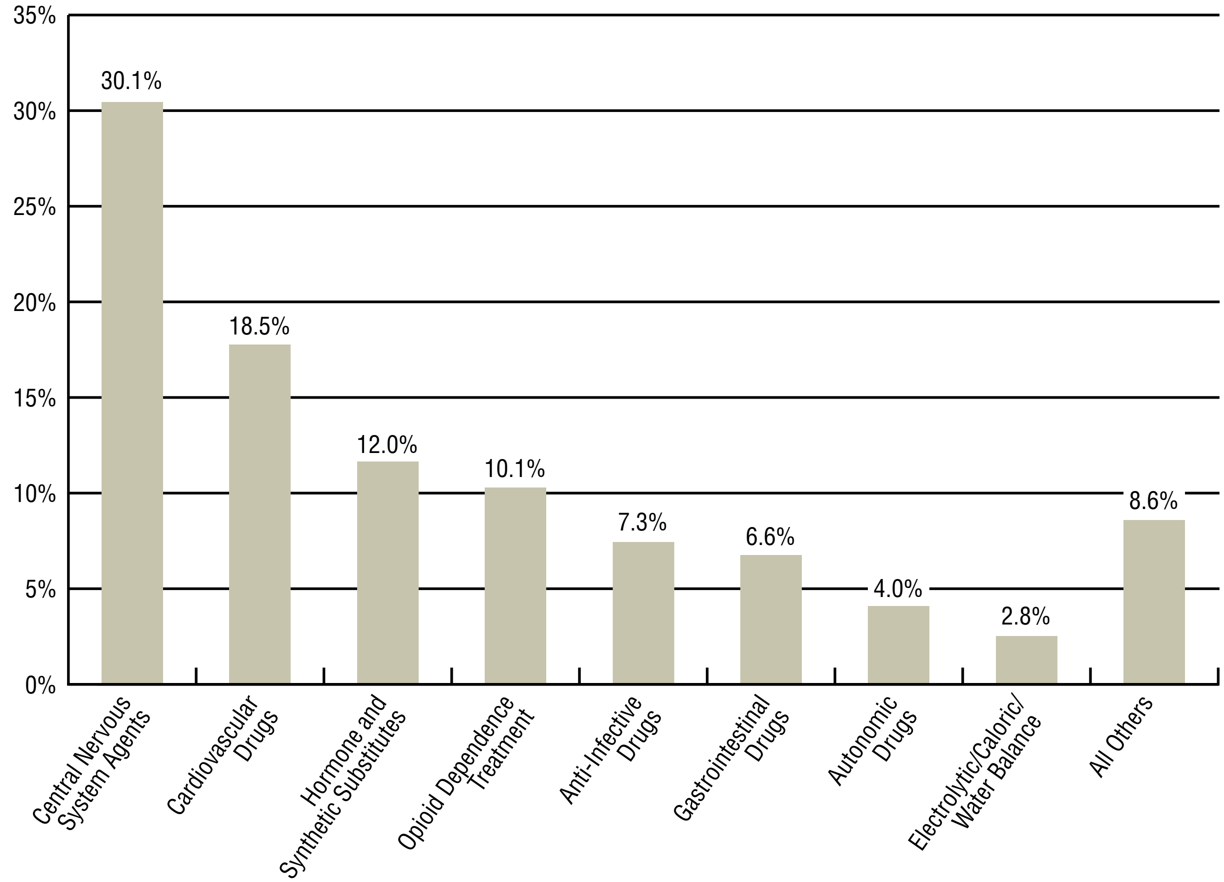
FIGURE 4.10

NIHB Prescription Drug Claims Incidence by Pharmacologic Therapeutic Class
2013/14

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 30.1% of all prescription drug claims. Central nervous systems agents are used in the treatment of conditions such as arthritis, depression or epilepsy.

Cardiovascular drugs had the next highest share of prescription drug claims at 18.5% followed by hormones and synthetic substitutes, which consist primarily of oral contraceptives and insulin, at 12.0%. 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

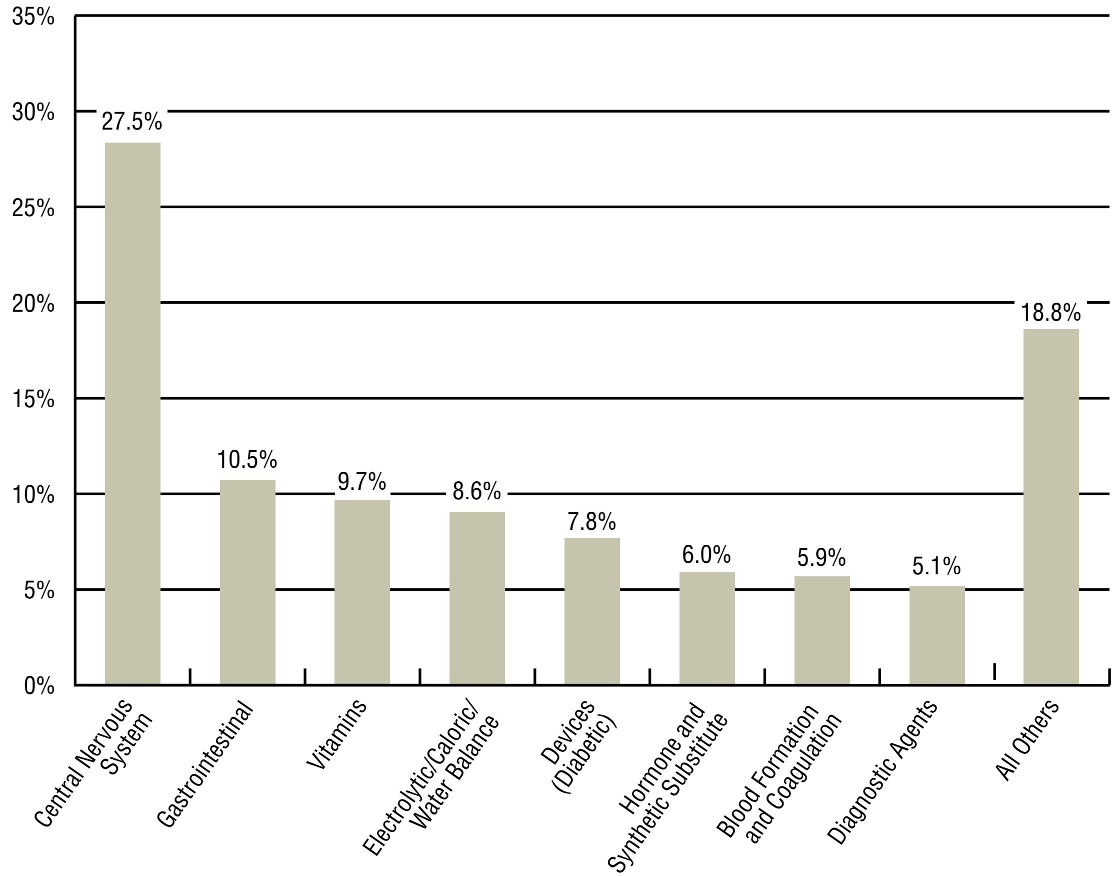
FIGURE 4.11

NIHB Over-the-Counter Drugs (Including Controlled Access Drugs – CAD) Claims Incidence by Pharmacologic Therapeutic Class
2013/14

Figure 4.11 demonstrates variation in claims incidence by therapeutic classification for over-the-counter (OTC) drugs. 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, which are drugs used to manage pain such as headaches (e.g. acetaminophen), accounted for 27.5% 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 10.5%, followed by vitamins at 9.7%. The electrolytic/caloric/water balance class such as calcium, which is used in the prevention and treatment of conditions such as osteoporosis, followed at 8.6%.



Source: HICPS adapted by Program Analysis Division

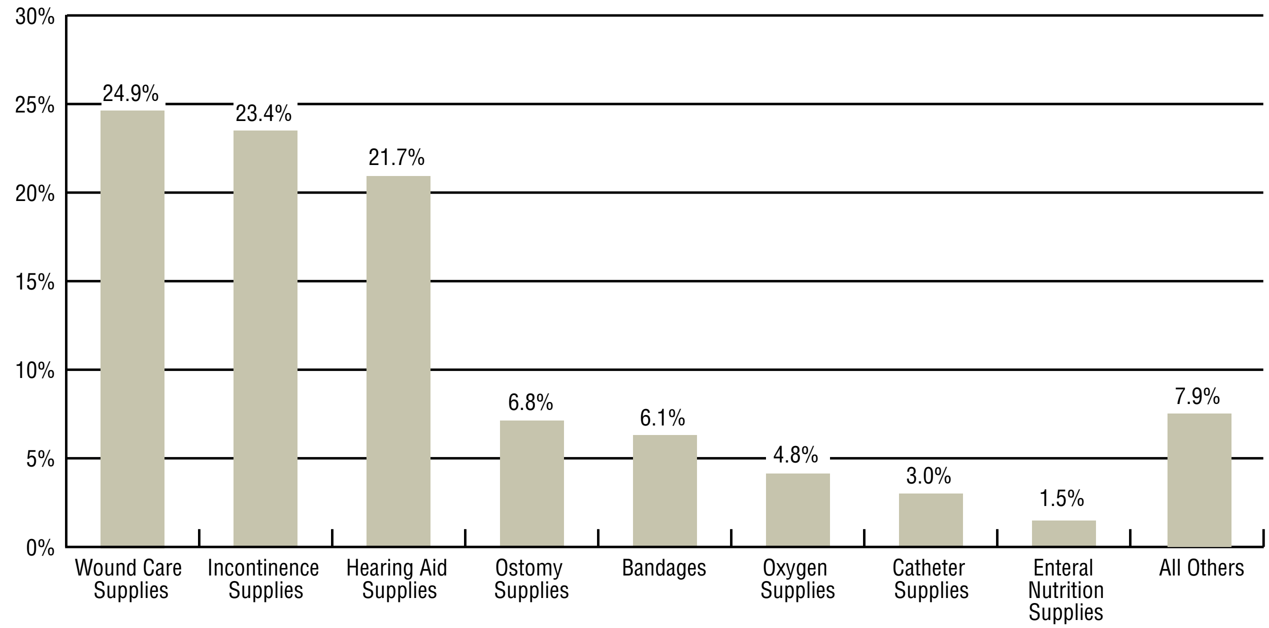
FIGURE 4.12

NIHB Medical Supplies by Category and Claims Incidence
2013/14

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

In 2013/14, wound care supplies such as silver dressings, sterile dressings and iodine dressings accounted for 24.9% of all medical supply claims. Incontinence supplies such as liners and pads, represented the second highest category of medical supplies at 23.4%, followed by hearing aid supplies at 21.7%.

The largest increase in the proportion of claims for medical supplies over fiscal year 2012/13 was in hearing aid supplies and oxygen supplies which both increased by 0.6 percentage points, while the largest decrease was among wound care supplies which declined by 1.3 percentage points.



Source: HICPS adapted by Program Analysis Division

FIGURE 4.13

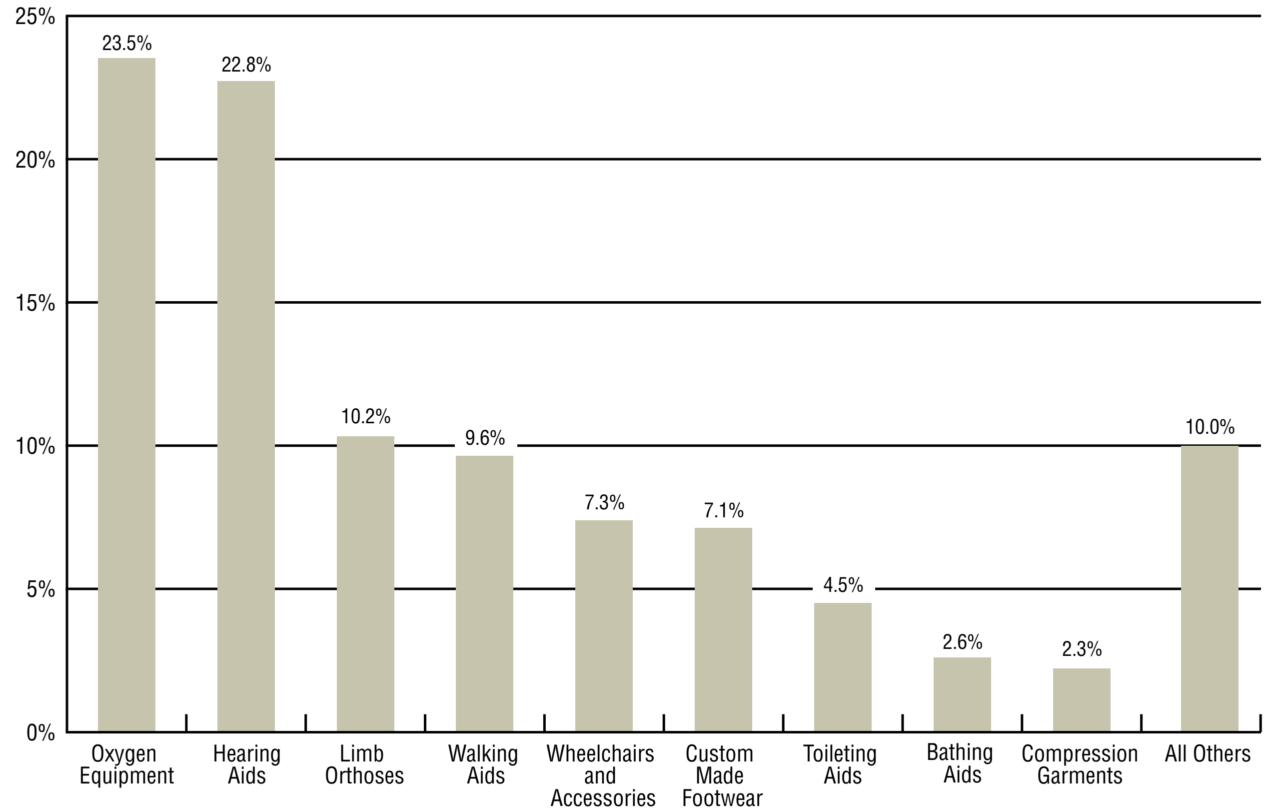
NIHB Medical Equipment by Category and Claims Incidence
2013/14

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

Claims for oxygen equipment accounted for 23.5% of all medical equipment claims in 2013/14. Hearing aids were the next highest at 22.8%, followed by limb orthoses at 10.2% and walking aids at 9.6%.

The most significant increase in the proportion of total medical equipment claims over the fiscal year 2012/13 was in oxygen equipment which increased by 4.2 percentage points.

The most significant decrease in the proportion of total medical equipment claims was in limb orthoses which declined 4.2 percentage points 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

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 2013/14, the NIHB Program paid for dental claims made by a total of 310,877 First Nations and Inuit clients. The total expenditure for these claims was $207.2 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 2013/14, through the NIHB Program's Dental Benefit, the oral health needs of approximately 193,000 clients who required intraoral radiograph services, 178,000 clients who received scaling procedures, and 147,000 clients who required restoration treatments were addressed.

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.

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

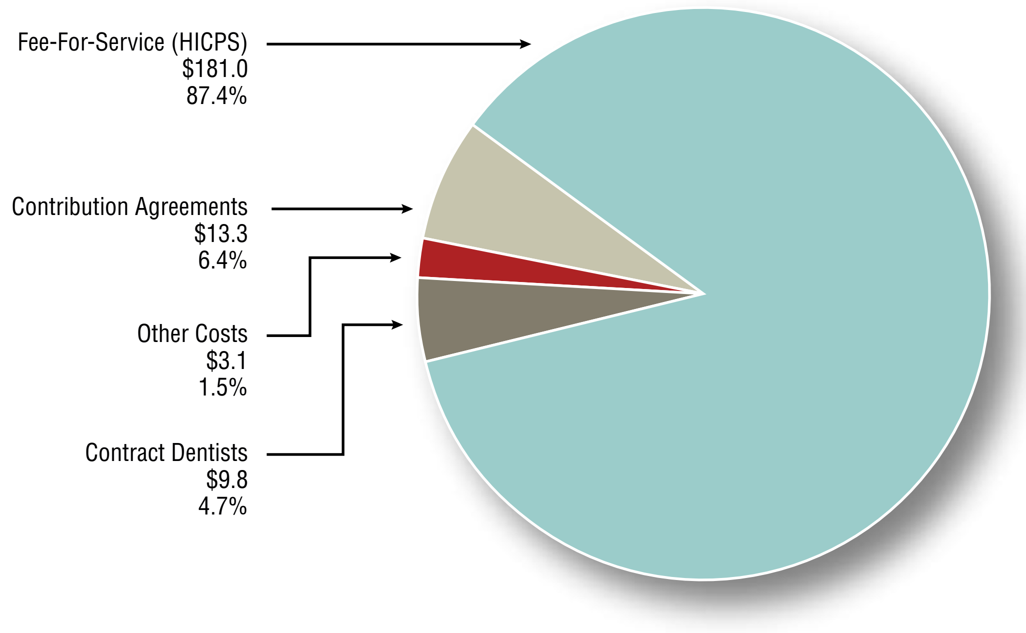
Distribution of NIHB Dental Expenditures ($ Millions)
2013/14

NIHB Dental expenditures totalled $207.2 million in 2013/14. 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 $181.0 million or 87.4% of all NIHB Dental costs.

The next highest component was contribution agreements, which accounted for $13.3 million or 6.4% 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 $9.8 million or 4.7% of total costs.

Other costs totalled $3.1 million or 1.5% in 2013/14. The majority of these costs are related to claims processing and payment services.



Total NIHB Dental Expenditures: $207.2M

Source: FIRMS adapted by Program Analysis Division

FIGURE 5.2

Total NIHB Dental Expenditures by Type and Region ($ 000's)
2013/14

NIHB Dental expenditures totalled $207.2 million in 2013/14. The regions of Ontario (21.2%), Saskatchewan (17.6%), Alberta (16.9%) and Manitoba (16.2%) had the largest proportion of overall dental costs.

Of the $207.2 million in dental expenditures, $193.9 million (93.6%) were operating expenditures while $13.3 million (6.4%) 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 $181.0 million or 87.4% of all NIHB Dental costs while contract dentists accounted for $9.8 million (4.7%).

REGION	OPERATING			Total Operating Costs	Total Contribution Costs	TOTAL COSTS
	Fee-For-Service	Contract Dentists	Other Costs			
Atlantic	$ 8,608	$ 0	$ 1	$ 8,609	$ 0	**$ 8,609**
Quebec	15,135	0	0	15,135	82	**15,216**
Ontario	34,607	2,961	51	37,619	6,353	**43,972**
Manitoba	27,893	5,667	0	33,559	90	**33,649**
Saskatchewan	32,874	0	1	32,875	3,524	**36,399**
Alberta	32,235	37	1	32,273	2,656	**34,928**
British Columbia	9,827	745	71	10,643	369	**11,013**
Yukon	1,851	359	0	2,210	0	**2,210**
N.W.T.	7,411	0	0	7,411	37	**7,448**
Nunavut	10,603	0	0	10,603	154	**10,757**
Headquarters	-	-	2,978	2,978	-	**2,978**
Total	**$ 181,045**	**$ 9,769**	**$ 3,101**	**$ 193,915**	**$ 13,264**	**$ 207,179**

Source: FIRMS adapted by Program Analysis Division

FIGURE 5.3

Annual NIHB Dental Expenditures
2009/10 to 2013/14

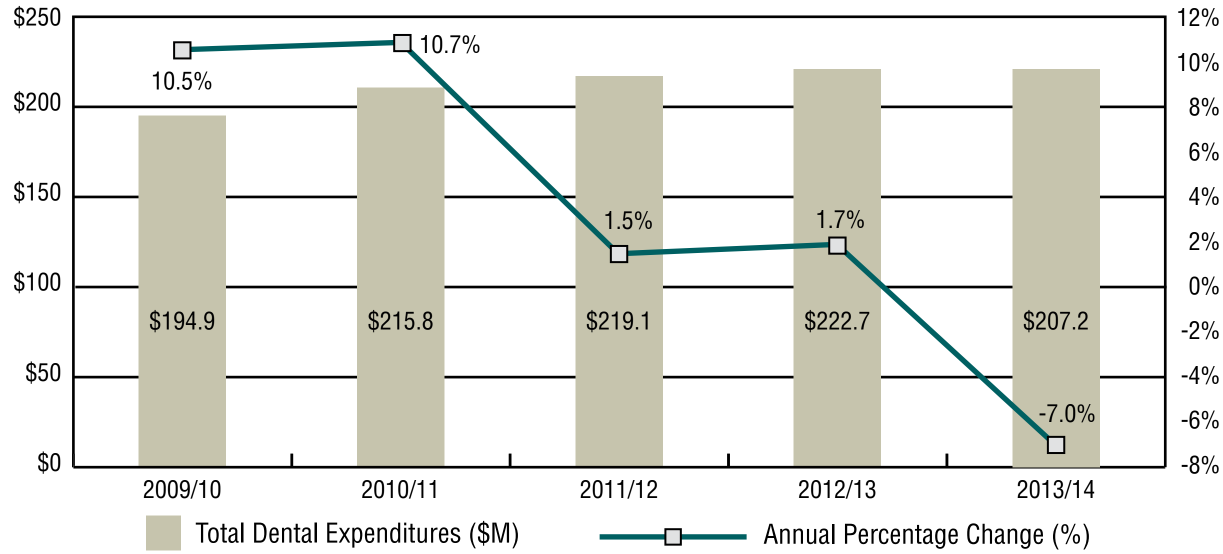
NIHB Dental expenditures decreased by 7.0% during fiscal year 2013/14. This decrease in overall NIHB Dental expenditures can be attributed to the transfer of eligible First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA) along with the transfer of responsibility for the management and delivery of non-insured dental benefits, through a phased approach between July and October 2013. If the expenditures for these FNHA eligible clients are excluded from the 2012/13 and 2013/14 NIHB Dental expenditures, then the total dental benefit growth rate would have been 3.8%.

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 -7.0% in 2013/14, with an annualized growth rate of 3.3%.

In 2013/14, the highest rate of growth in NIHB Dental expenditures was in the Manitoba Region, which increased by 9.5% compared to the previous year. The regions of Atlantic, Quebec and the Yukon had a decrease in dental expenditures, due in part to the centralization of Predeterminations services which occurred in a phased approach by region in FY 2013/14.

The Ontario Region had the highest total dental expenditure at $44.0 million and the Yukon had the lowest total dental expenditure at $2.2 million.

NIHB Dental Expenditures and Annual Percentage Change



Source: FIRMS adapted by Program Analysis Division

NIHB Dental Expenditures ($ 000's)

REGION	2009/10	2010/11	2011/12	2012/13	2013/14
Atlantic	$ 5,426	$ 6,481	$ 7,164	$ 9,660	$ 8,609
Quebec	14,159	15,245	15,138	15,239	15,216
Ontario	38,047	40,594	41,848	42,259	43,972
Manitoba	26,954	29,399	29,861	30,734	33,649
Saskatchewan	30,777	35,317	36,941	36,219	36,399
Alberta	27,756	33,421	34,543	34,501	34,928
British Columbia	28,042	30,187	30,620	31,543	11,013
Yukon	2,271	2,629	2,583	2,486	2,210
N.W.T.	7,067	7,603	7,054	7,244	7,448
Nunavut	10,289	12,306	10,442	10,043	10,757
Headquarters	4,130	2,614	2,864	2,779	2,978
Total	**$ 194,918**	**$ 215,796**	**$ 219,057**	**$ 222,706**	**$ 207,179**

Source: FIRMS adapted by Program Analysis Division

FIGURE 5.4

Per Capita NIHB Dental Expenditures by Region
2013/14

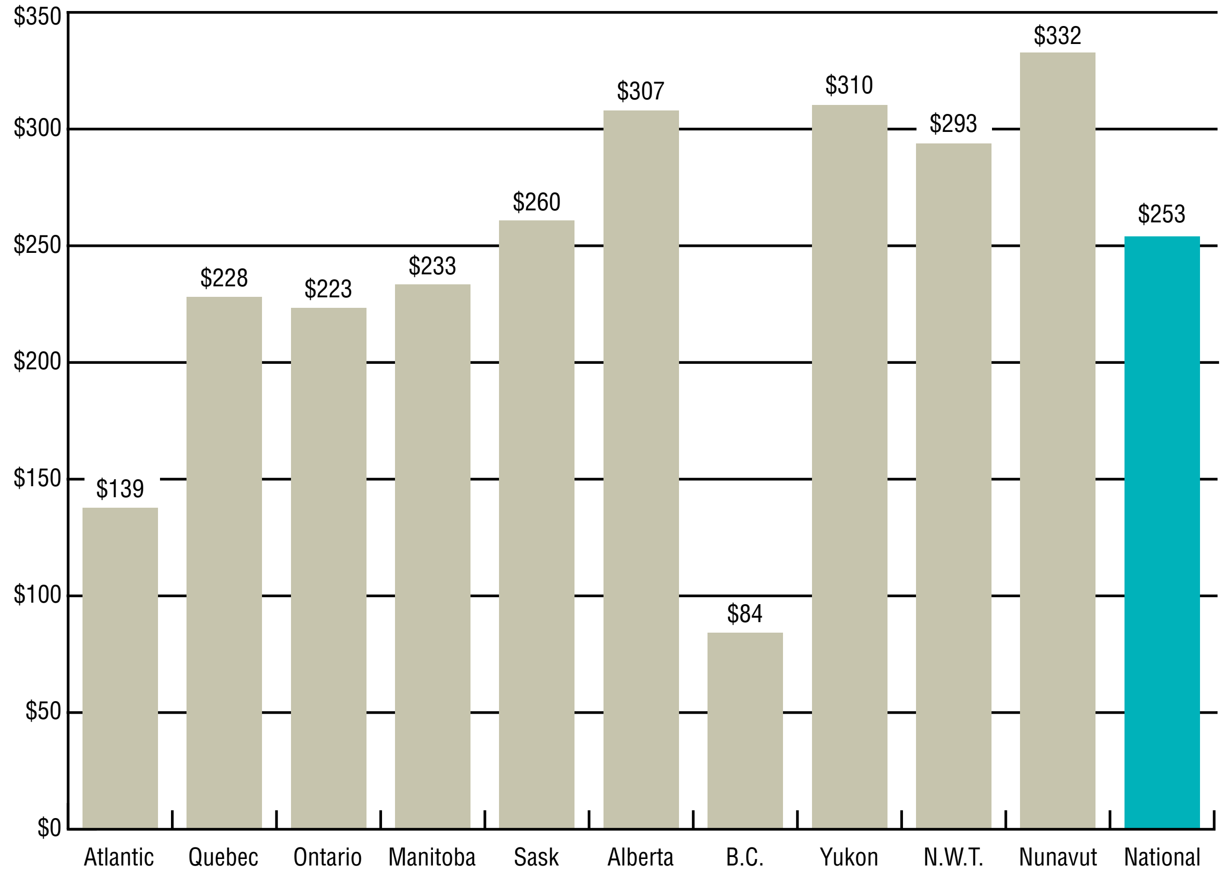
In 2013/14, the national per capita NIHB Dental expenditure was $253, an increase of 6.8% from the $237 recorded in 2012/13.

Nunavut had the highest per capita dental expenditure at $332. 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 Yukon had the second highest dental per capita expenditure at $310, an increase from $286 in the previous year. This was followed closely by the Alberta Region at $307, an increase from $298 in 2012/13.

The British Columbia Region had the lowest per capita NIHB Dental expenditures at $84. As a result of the transfer of First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA), only the first three months of claims for FNHA eligible clients are included in the per capita calculation. If the FNHA eligible population is excluded from 2013/2014 the per capita cost for British Columbia Region would have been $583.

The Atlantic Region had the second lowest per capita dental cost at $139 per eligible client. The lower per capita cost in the Atlantic Region can be attributed to an increase in the eligible client population in this region as a result of the registration of 23,933 Qalipu Mi'kmaq First Nations clients. The lower level of dental benefit utilization for these new clients has impacted on the dental per capita cost for the Atlantic Region as a whole.



Source: SVS and FIRMS adapted by Program Analysis Division

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.

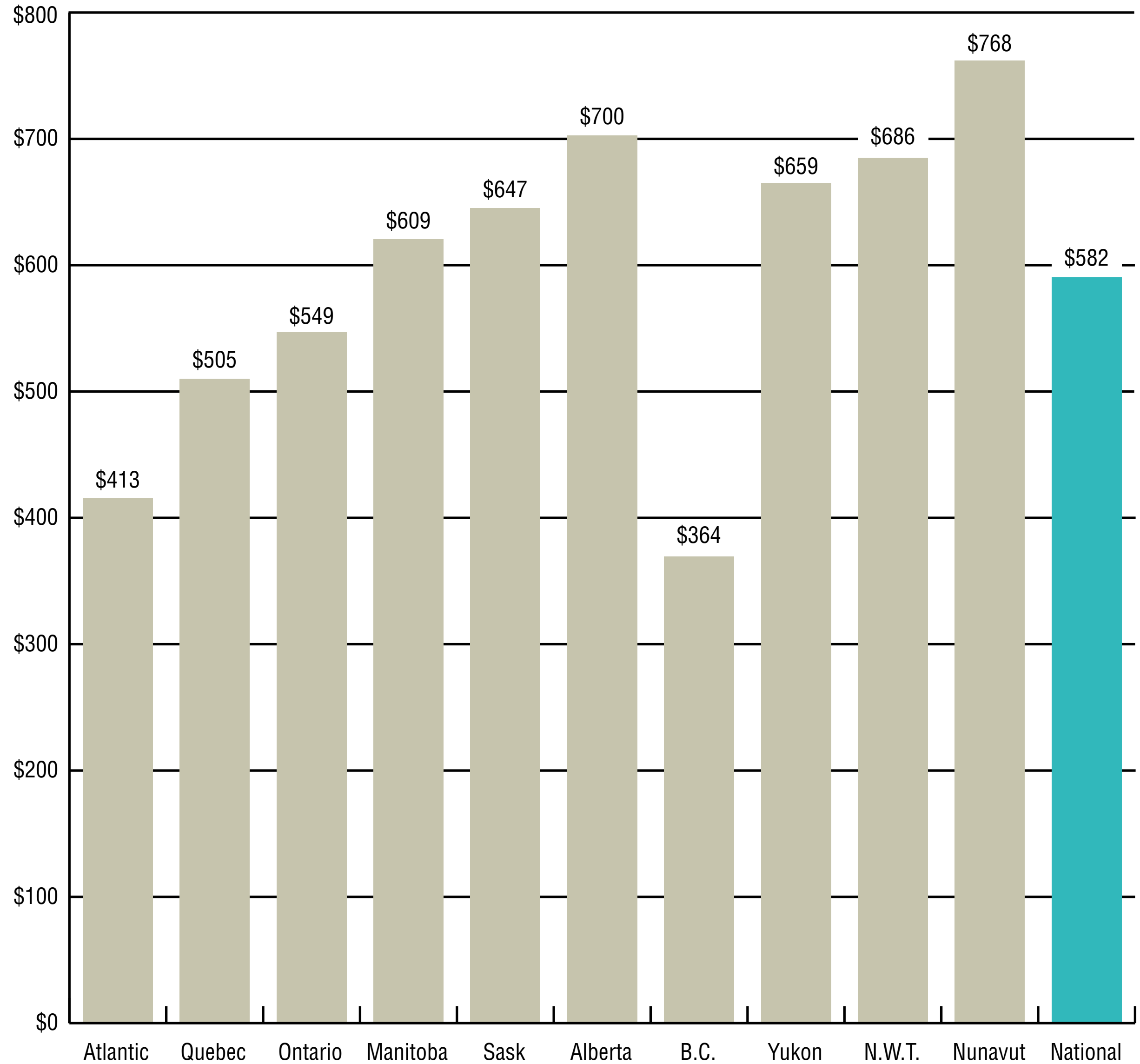
FIGURE 5.5

NIHB Dental Fee-For-Service Expenditures per Claimant by Region
2013/14

In 2013/14, the national NIHB Dental expenditure per eligible client receiving at least one dental benefit was $582. This represents a decrease of 1.9% over the $593 recorded in 2012/13.

Nunavut had the highest dental expenditure per claimant at $768, representing an increase of 2.8% from the $747 in the previous year. The Alberta Region followed at $700, a decrease of 1.1% from the $708 recorded in 2012/13. The Northwest Territories followed at $686, an increase of 3.0% from the $666 recorded the previous year.

The British Columbia Region registered the lowest dental expenditure per claimant at $364, a decrease of 37.1% from the $579 in 2012/13. As a result of the transfer of First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA), only the first three months of claims for FNHA eligible clients are included in the per capita calculation.



Source: FIRMS and HICPS adapted by Program Analysis Division

FIGURE 5.6

NIHB Dental Utilization Rates by Region
2009/10 to 2013/14

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 2013/14, the national utilization rate for dental benefits paid through the HICPS system was 36%, consistent with the previous two fiscal years. 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 found in the Quebec Region (45%). The lowest dental utilization rate was in the British Columbia Region (18%). As a result of the transfer of First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA), only the first three months of claims for FNHA eligible clients are included in the per capita calculation

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 43% in 2013/14. 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 39%.

Over the two year period between 2012/13 and 2013/14, 439,001 distinct clients received NIHB Dental services resulting in an overall 48% utilization rate over this period.

REGION	Dental Utilization					
	2009/10	2010/11	2011/12	2012/13	2013/14	NIHB Dental Utilization Last Two Years 2012/14
Atlantic	35%	36%	28%	34%	34%	44%
Quebec	45%	46%	44%	44%	45%	56%
Ontario	33%	33%	32%	32%	32%	41%
Manitoba	30%	31%	31%	31%	32%	44%
Saskatchewan	37%	38%	37%	36%	36%	51%
Alberta	39%	40%	39%	39%	41%	55%
British Columbia	39%	40%	39%	38%	18%	45%
Yukon	37%	39%	38%	37%	39%	50%
N.W.T.	41%	42%	42%	41%	43%	56%
Nunavut	43%	45%	43%	42%	43%	60%
National	**36%**	**37%**	**36%**	**36%**	**36%**	**48%**

Source: HICPS and SVS adapted by Program Analysis Division

FIGURE 5.7

NIHB Dental Claimants by Age Group, Gender and Region
2013/14

Of the 808,686 clients eligible to receive dental benefits through the NIHB Program, 310,877 (36%) claimants received at least one dental procedure paid through the Health Information and Claims Processing Services (HICPS) system in 2013/14.

Of this total, 174,519 were female (56%) and 136,358 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 (34 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 Atlantic Region and the Yukon at 36 years of age, while the lowest was in Nunavut at 25 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 5% of all claimants were seniors (ages 65 and over) in 2013/14.

REGION	Atlantic			Quebec			Ontario			Manitoba		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	114	129	243	428	383	811	939	980	1,919	1,453	1,450	2,903
5-9	653	670	1,323	1,581	1,493	3,074	3,158	3,053	6,211	2,949	2,967	5,916
10-14	858	885	1,743	1,566	1,605	3,171	3,297	3,329	6,626	2,484	2,830	5,314
15-19	1,045	1,257	2,302	1,286	1,463	2,749	2,969	3,275	6,244	2,175	2,836	5,011
20-24	859	1,060	1,919	1,082	1,445	2,527	2,143	3,019	5,162	1,721	2,694	4,415
25-29	695	929	1,624	924	1,327	2,251	1,912	2,765	4,677	1,497	2,243	3,740
30-34	628	914	1,542	831	1,128	1,959	1,770	2,556	4,326	1,314	1,832	3,146
35-39	624	836	1,460	854	1,102	1,956	1,695	2,338	4,033	1,229	1,576	2,805
40-44	718	879	1,597	908	1,163	2,071	1,764	2,391	4,155	1,189	1,741	2,930
45-49	697	946	1,643	956	1,270	2,226	1,905	2,584	4,489	1,194	1,573	2,767
50-54	618	885	1,503	945	1,170	2,115	1,801	2,573	4,374	1,068	1,387	2,455
55-59	589	825	1,414	758	1,065	1,823	1,535	2,215	3,750	752	1,004	1,756
60-64	423	681	1,104	512	712	1,224	1,078	1,651	2,729	481	705	1,186
65+	618	796	1,414	788	1,203	1,991	1,607	2,775	4,382	553	873	1,426
Total	9,139	11,692	20,831	13,419	16,529	29,948	27,573	35,504	63,077	20,059	25,711	45,770
Average Age	35	36	36	32	34	33	32	35	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	1,196	1,176	2,372	1,494	1,381	2,875	540	495	1,035	31	35	66	206	191	397	730	706	1,436	7,131	6,926	14,057
5-9	3,216	3,448	6,664	3,189	3,358	6,547	1,543	1,568	3,111	88	79	167	525	516	1,041	941	990	1,931	17,843	18,142	35,985
10-14	2,938	3,310	6,248	2,897	3,060	5,957	1,408	1,546	2,954	92	95	187	458	565	1,023	680	835	1,515	16,678	18,060	34,738
15-19	2,229	3,002	5,231	2,327	2,832	5,159	1,275	1,467	2,742	115	141	256	454	604	1,058	624	911	1,535	14,499	17,788	32,287
20-24	1,988	2,993	4,981	1,683	2,408	4,091	901	1,325	2,226	125	157	282	464	682	1,146	631	959	1,590	11,597	16,742	28,339
25-29	1,829	2,748	4,577	1,471	2,183	3,654	824	1,237	2,061	108	144	252	406	594	1,000	526	817	1,343	10,192	14,987	25,179
30-34	1,535	2,280	3,815	1,310	1,930	3,240	762	1,093	1,855	116	150	266	321	511	832	414	603	1,017	9,001	12,997	21,998
35-39	1,395	1,967	3,362	1,183	1,691	2,874	728	1,025	1,753	83	96	179	288	415	703	330	449	779	8,409	11,495	19,904
40-44	1,446	1,988	3,434	1,110	1,611	2,721	773	980	1,753	94	107	201	329	451	780	321	412	733	8,652	11,723	20,375
45-49	1,375	1,869	3,244	1,133	1,446	2,579	749	1,107	1,856	110	108	218	322	435	757	260	346	606	8,701	11,684	20,385
50-54	1,088	1,545	2,633	926	1,413	2,339	834	1,114	1,948	113	137	250	259	387	646	210	242	452	7,862	10,853	18,715
55-59	742	1,029	1,771	657	946	1,603	596	828	1,424	64	86	150	213	289	502	119	160	279	6,025	8,447	14,472
60-64	444	615	1,059	397	657	1,054	403	557	960	42	84	126	157	208	365	125	132	257	4,062	6,002	10,064
65+	566	855	1,421	539	797	1,336	553	750	1,303	82	128	210	258	303	561	142	193	335	5,706	8,673	14,379
Total	21,987	28,825	50,812	20,316	25,713	46,029	11,889	15,092	26,981	1,263	1,547	2,810	4,660	6,151	10,811	6,053	7,755	13,808	136,358	174,519	310,877
Average Age	27	29	28	26	28	27	30	32	31	35	37	36	31	32	32	24	25	25	29	31	30

FIGURE 5.8

NIHB Fee-for-Service Dental Expenditures by Sub-Benefit
2013/14

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 2013/14, expenditures for Restorative Services (crowns, fillings, etc.) were the highest of all dental sub-benefit categories at $82.6 million. Preventative Services (scaling, sealants, etc.) at $22.8 million and Diagnostic Services (examinations, x-rays, etc.) at $22.2 million were the next highest sub-benefit categories, followed by Oral Surgery (extractions, etc.) at $18.6 million and Endodontic Services (root canal treatments, etc.) at $10.7 million.

Expenditures for all of these dental sub-benefits decreased over the previous fiscal year. If the dental expenditures for FNHA eligible clients are removed from the 2012/13 and 2013/14 expenditures for these dental sub-benefits, then Oral Surgery would have had the largest increase in expenditures (5.5%).

In 2013/14, the three largest dental procedures by expenditure were Composite Restorations ($66.7 million), Scaling ($17.3 million) and Extractions ($12.6 million). The overall decrease in expenditures for these dental procedures can again be attributed to the decrease of the eligible client population due to the transfer of First Nations clients residing in British Columbia to the FNHA.

Fee-For-Service Top 5 Dental Sub-Benefits ($ Millions) and Percentage Change

Dental Sub-Benefit	2013/14	% Change from 2012/13	% Change with Exclusion of FNHA Clients in 2013/14 and 2012/13
Restorative Services	$ 82.6	-9.2%	3.8%
Preventive Services	22.8	-3.9%	4.2%
Diagnostic Services	22.2	-4.4%	4.4%
Oral Surgery	18.6	-3.8%	5.5%
Endodontic Services	10.7	-10.8%	0.8%

Fee-For-Service Top 5 Dental Procedures ($ Millions) and Percentage Change

Dental Procedure	2013/14	% Change from 2012/13	% Change with Exclusion of FNHA Clients in 2013/14 and 2012/13
Composite Restorations	$ 66.7	-5.9%	8.9%
Scaling	17.3	-3.3%	4.5%
Extractions	12.6	-5.2%	4.4%
Root Canal Therapy	8.8	-10.6%	0.6%
Intraoral Radiographs	7.4	-2.6%	6.8%

Source: HICPS adapted by Program Analysis Division

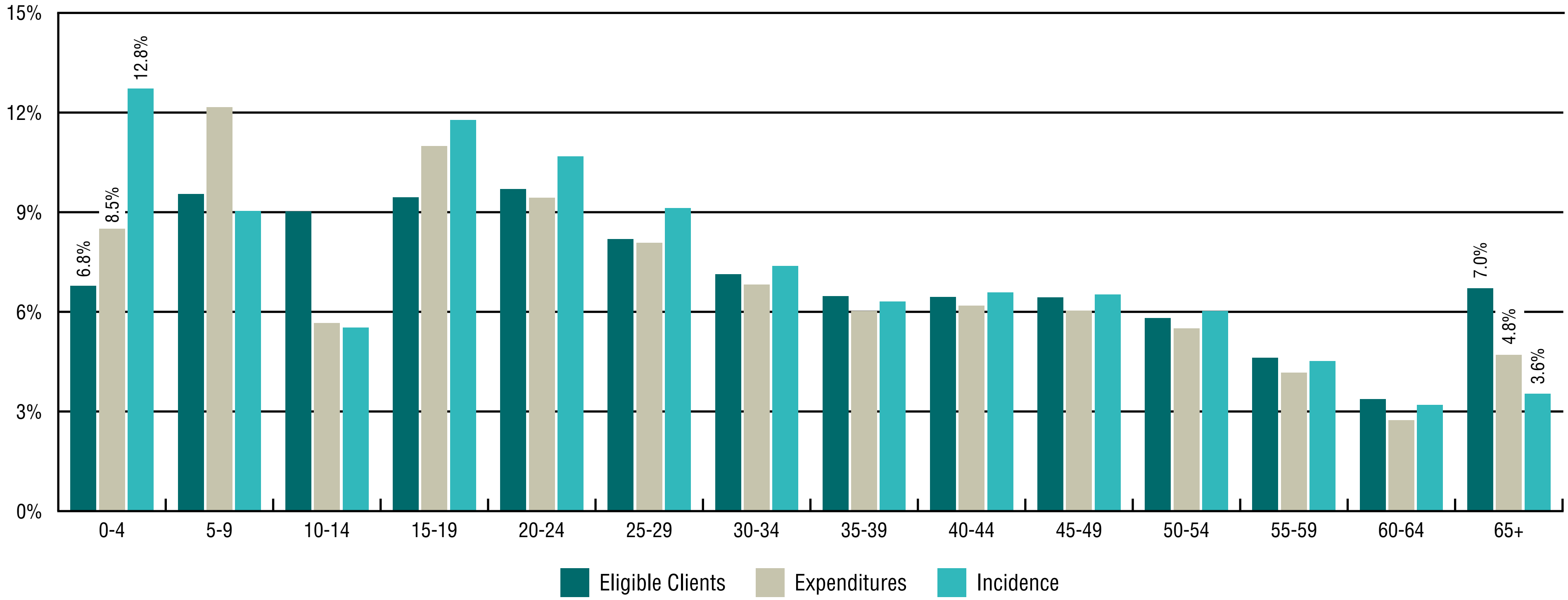
FIGURE 5.9

Distribution of Eligible NIHB Population, Dental Expenditures and Incidence by Age Group
2013/14

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 24.8% to 17.5%.

With respect to the ratio of eligible clients to expenditures, a relatively stable relationship exists across most age groups. The notable exceptions to this pattern are youth aged 10 to 14 and clients who are 65 years of age and older. The ratios of eligible clients to expenditures for youth aged 10 to 14 are 9.0% to 5.7% and for clients who are 65 years of age or older they are 7.0% to 4.8% respectively. The ratio of eligible clients to expenditures for those aged 15 to 19 was 9.4% to 11.7%.



Source: HICPS and SVS adapted by Program Analysis Division

NIHB Medical Transportation Expenditure and Utilization Data

In 2013/14, Non-Insured Health Benefits Medical Transportation expenditures amounted to $352.0 million or 34.3% 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 2013/14, a total of 486 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 and non-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

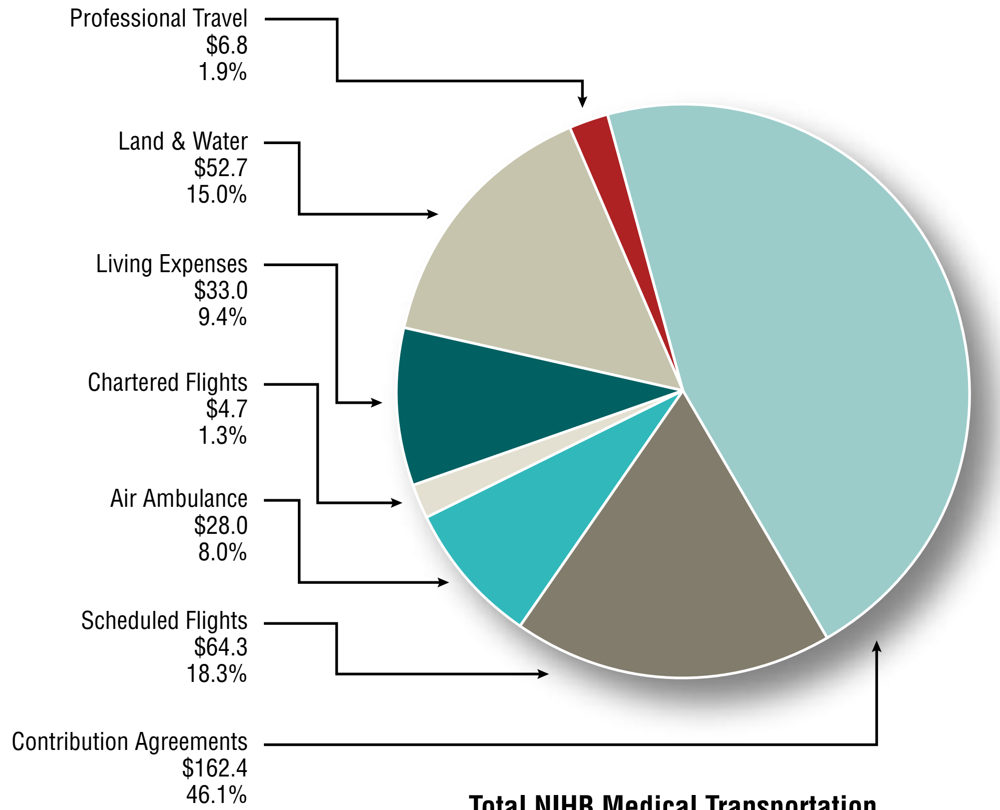
Distribution of NIHB Medical Transportation Expenditures ($ Millions)
2013/14

In 2013/14, NIHB Medical Transportation expenditures totalled $352.0 million or 34.3% 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 $162.4 million, or 46.1% of the total benefit.

Scheduled flights at $64.3 million (18.3%) and land and water transportation at $52.7 million (15.0%) were the largest medical transportation operating expenditures, accounting for one-third of the total benefit.

Costs for living expenses totalled $33.0 million (9.4%) and air ambulance totalled $28.0 million (8.0%). Expenditures for chartered flights totalled $4.7 million (1.3%) and costs for travel associated with bringing professional services to communities (e.g., physician, dentist, mental health professional) totalled $6.8 million (1.9%).



Total NIHB Medical Transportation Expenditures: $352.0M

Source: FIRMS adapted by Program Analysis Division

FIGURE 6.2

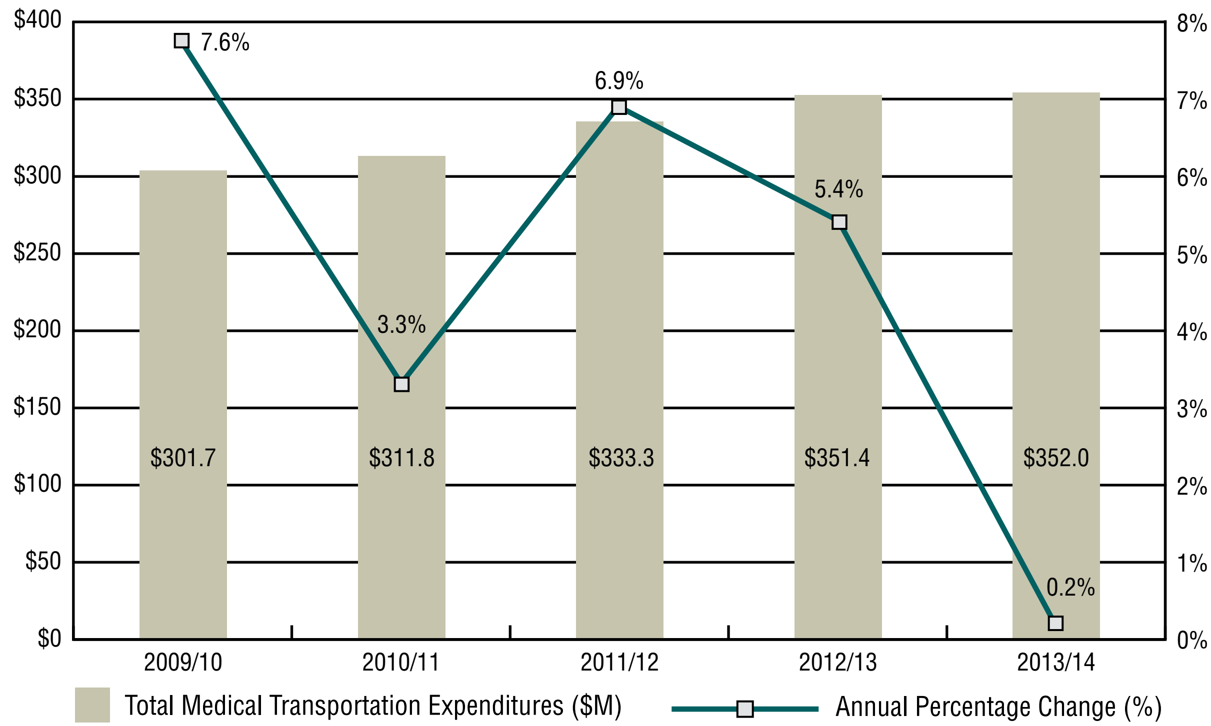
Annual NIHB Medical Transportation Expenditures
2009/10 to 2013/14

NIHB Medical Transportation expenditures increased by 0.2% in 2013/14. This low increase in overall NIHB Medical Transportation expenditures can be attributed to the transfer of eligible First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA) along with the transfer of responsibility for the management and delivery of non-insured medical transportation benefits. If the expenditures for these FNHA eligible clients are excluded from the 2012/13 and 2013/14 NIHB Medical Transportation expenditures, then the total medical transportation benefit growth rate would have been 3.6%.

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 0.2% in 2013/14, with a five year annualized growth rate of 4.7%.

Over the past five years, overall medical transportation costs have grown by 16.7% from $301.7 million in 2009/10 to $352.0 million in 2013/14. On a regional basis, the highest growth rates over this period were in the Atlantic Region where expenditures grew by 37.0% from $5.0 million in 2009/10 to $6.9 million in 2013/14. This high growth is largely 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. This was followed by Nunavut with an increase of 34.0% from $22.3 million in 2009/10 to $29.9 million in 2013/14.

NIHB Medical Transportation Expenditures and Annual Percentage Change



Source: FIRMS adapted by Program Analysis Division

NIHB Medical Transportation Expenditures ($ 000's)

REGION	2009/10	2010/11	2011/12	2012/13	2013/14
Atlantic	$ 5,048	$ 5,314	$ 5,841	$ 6,875	$ 6,916
Quebec	19,918	18,943	21,708	22,578	21,945
Ontario	51,889	52,358	54,725	59,251	62,865
Manitoba	89,078	94,940	101,609	109,409	111,016
Saskatchewan	38,971	41,896	45,084	45,793	47,180
Alberta	36,601	35,877	37,371	39,216	41,451
British Columbia	25,547	25,967	26,510	26,573	15,960
Yukon	3,801	4,097	4,413	3,909	4,439
N.W.T.	8,520	8,498	10,157	10,157	10,372
Nunavut	22,302	23,869	25,886	27,661	29,892
Total	$ 301,673	$ 311,760	$ 333,304	$ 351,424	$ 352,036

Source: FIRMS adapted by Program Analysis Division

The largest net increase in expenditures over the past five years took place in the Manitoba Region where total medical transportation costs grew by $21.9 million over this period. The Ontario Region had the second largest net increase in expenditures over the past five years at $11.0 million followed by the Saskatchewan Region at $8.2 million.

The Manitoba Region had the highest total medical transportation expenditure at $111.0 million and the Yukon had the lowest total medical transportation expenditure at $4.4 million.

NIHB Medical Transportation expenditures increased by 0.2% to $352.0 million in 2013/14.

The Yukon had the largest percentage increase in medical transportation expenditures in 2013/14 at 13.5%. Nunavut followed with an 8.1% increase in expenditures and was followed closely by the Ontario Region at an increase of 6.1%.

The British Columbia Region had the largest decrease in medical transportation expenditures at -39.9% from $26.6 million in 2012/13 to $16.0 million in 2013/14. This can be attributed to the significant decrease in the eligible client population in this region as a result of the transfer of responsibility for First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA).

In 2013/14, the Manitoba Region had the highest overall NIHB Medical Transportation expenditure at $111.0 million, primarily as a result of air transportation which totalled $55.9 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 2013/14 at $62.9 million. The regions of Saskatchewan and Alberta followed at $47.2 million and $41.5 million respectively in medical transportation expenditures.

FIGURE 6.3

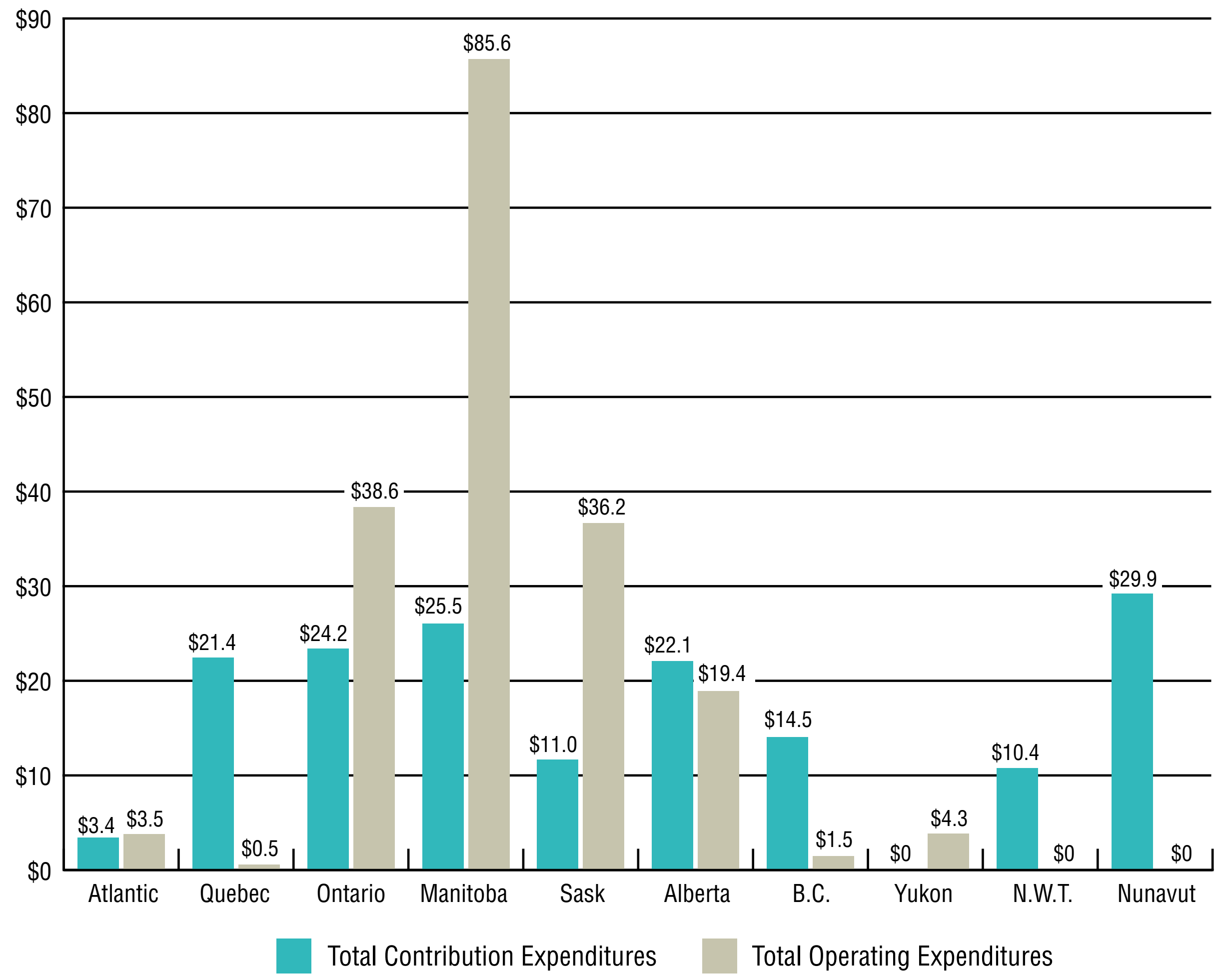
NIHB Medical Transportation Expenditures by Type and Region ($ 000's)
2013/14

TYPE	Atlantic	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia	Yukon	N.W.T.	Nunavut	TOTAL
Scheduled Flights	$ 716	$ 221	$ 22,363	$ 32,529	$ 6,420	$ 882	$ 202	$ 1,015	$ 0	$ 0	$ 64,348
Air Ambulance	7	29	43	20,654	3,831	1,621	23	1,810	0	0	28,017
Chartered Flights	0	1	493	2,689	244	1,298	0	0	0	0	4,726
Living Expenses	874	15	10,950	13,498	3,463	2,995	221	956	0	0	32,971
Land & Water	1,946	247	3,930	13,137	19,745	12,131	1,009	548	0	0	52,693
Professional Travel	0	0	865	3,056	2,449	429	33	0	0	0	6,832
Total Operating	$ 3,543	$ 512	$ 38,644	$ 85,562	$ 36,153	$ 19,356	$ 1,487	$ 4,330	$ 0	$ 0	$ 189,586
Total Contributions	$ 3,373	$ 21,433	$ 24,221	$ 25,454	$ 11,027	$ 22,095	$ 14,474	$ 109	$ 10,372	$ 29,892	$ 162,449
TOTAL	$ 6,916	$ 21,945	$ 62,865	$ 111,016	$ 47,180	$ 41,451	$ 15,960	$ 4,439	$ 10,372	$ 29,892	$ 352,036
% Change from 2012/13	0.6%	-2.8%	6.1%	1.5%	3.0%	5.7%	-39.9%	13.5%	2.1%	8.1%	0.2%

Source: FIRMS adapted by Program Analysis Division

FIGURE 6.4

NIHB Medical Transportation Contribution and Operating Expenditures by Region ($ Millions)
2013/14



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 2013/14, a total of 486 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 2013/14 at $85.6 million. This higher cost in the Manitoba Region is primarily the result of approximately 59,600 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 $38.6 million, followed closely by the Saskatchewan Region at $36.2 million. Together these three regions accounted for 84.6% of all operating expenditures on medical transportation.

In 2013/14, Nunavut had the largest contribution expenditures for NIHB Medical Transportation at $29.9 million, followed by the regions of Manitoba and Ontario at $25.5 million and $24.2 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.

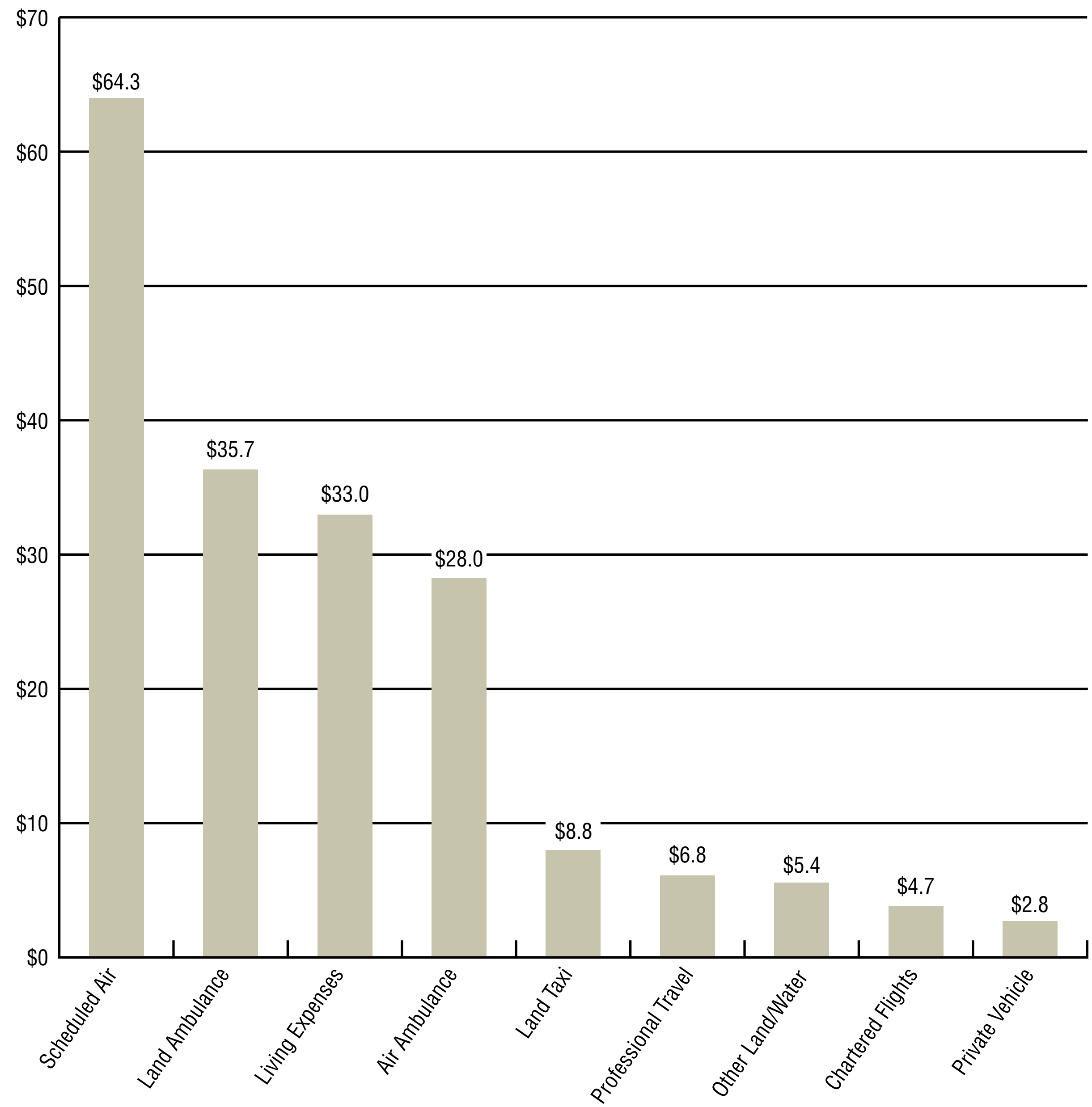
FIGURE 6.5

NIHB Medical Transportation Operating Expenditure by Type ($ Millions)
2013/14

In 2013/14, scheduled flights represented the largest portion of NIHB's Medical Transportation operating expenditures at $64.3 million or 33.9% of the total national operating expenditures. Land ambulance costs were the second highest at $35.7 million representing 18.8% of operating expenditures. Living expenses, which include accommodations and meals, followed at $33.0 million or 17.4%. Air ambulance followed closely at $28.0 million or 14.8% of medical transportation operating costs.

Professional travel expenditures ($6.8 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 ($2.8 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 five fiscal years, NIHB rates have remained consistent with NJC's January 2009 rates because the subsequent NJC rates decreased at a time when the costs of private transportation were increasing, and at times were volatile (e.g., the price of gasoline). However in 2013/14, NIHB's per-kilometre allowance was increased in three provinces (New Brunswick, Nova Scotia and Quebec) to correspond with the NJC's rate increases posted on January 1, 2013.



Source: FIRMS adapted by Program Analysis Division

FIGURE 6.6

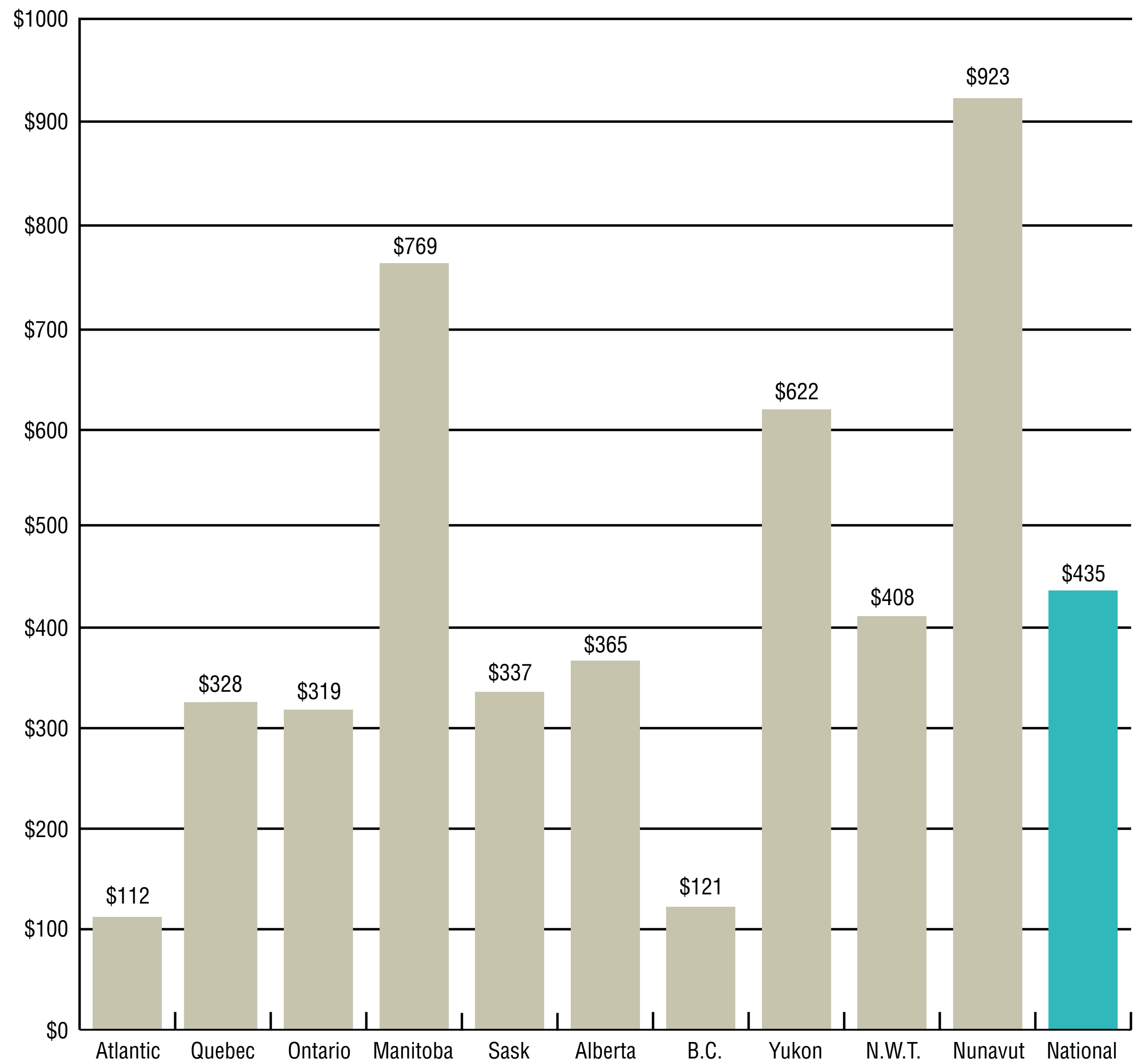
Per Capita NIHB Medical Transportation Expenditures by Region
2013/14

In 2013/14, the national per capita expenditure in NIHB Medical Transportation was $435. This represents an increase of 14.8% over the 2012/13 per capita expenditure of $379.

Nunavut recorded the highest per capita expenditure in medical transportation at $923, followed by the Manitoba Region at $769. 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 $112, a very slight increase from $111 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 2013/14, the highest growth in NIHB Medical Transportation per capita expenditures was in the Yukon which increased from $450 in 2012/13 to $622 in 2013/14.



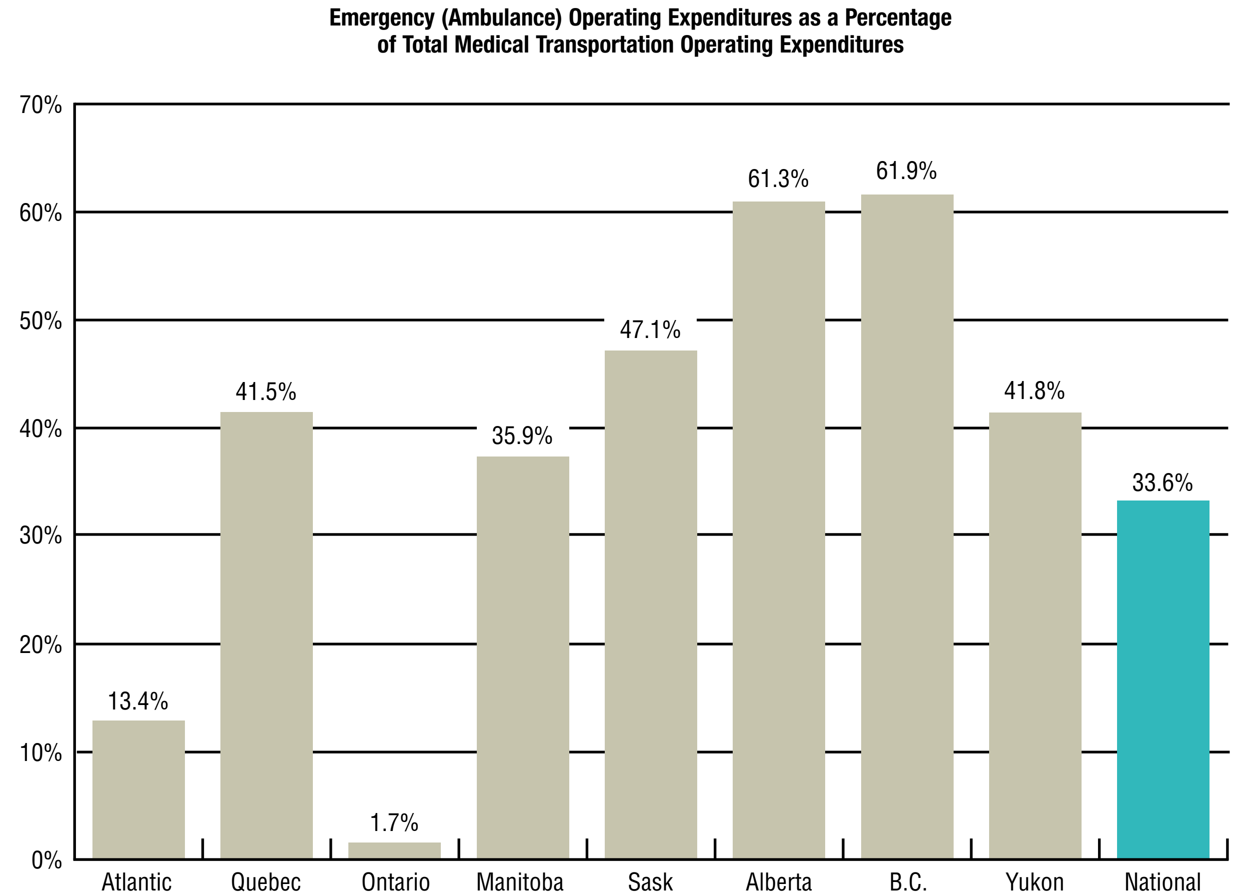
Source: SVS and FIRMS adapted by Program Analysis Division

FIGURE 6.7

NIHB Medical Transportation Emergency (Ambulance) Operating Expenditures by Region
2013/14

In 2013/14, regionally managed NIHB Medical Transportation operating costs totalled $189.6 million. Of this total, $63.7 million or 33.6% 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 2013/14, the Manitoba Region recorded the highest emergency (ambulance) operating expenditures at $30.7 million, comprising almost half (48.2%) 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 $17.0 million followed by the Alberta Region at $11.9 million.

The majority of the medical transportation operating expenditures within the British Columbia Region (61.9%) consisted of emergency costs. These costs included land and air ambulance. Emergency operating costs in the Alberta Region also represented the majority of total medical transportation operating expenditures at 61.3%. 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).

Almost half (47.1%) of medical transportation operating expenditures in the Saskatchewan Region were for emergency transportation, followed by the Yukon (41.8%), Quebec Region (41.5%) and the Manitoba Region (35.9%).

The Ontario Region had the lowest percentage spent on emergency transportation, accounting for only 1.7% 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), 2013/14

TYPE		Atlantic	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia	Yukon	National
Ambulance Operating Costs	Air Ambulance	$ 6.5	$ 28.6	$ 42.8	$ 20,653.6	$ 3,831.0	$ 1,620.6	$ 23.1	$ 1,810.5	$ 28,016.6
	Land Ambulance	469.9	183.9	602.7	10,050.2	13,204.4	10,251.9	897.4	0.3	35,660.7
	Total	**476.4**	**212.5**	**645.5**	**30,703.8**	**17,035.4**	**11,872.6**	**920.5**	**1,810.7**	**63,677.3**
Share of Ambulance Costs	Air Ambulance	1.4%	13.5%	6.6%	67.3%	22.5%	13.7%	2.5%	100.0%	44.0%
	Land Ambulance	98.6%	86.5%	93.4%	32.7%	77.5%	86.3%	97.5%	0.0%	56.0%
Total Medical Transportation Operating Costs		**$ 3,542.8**	**$ 512.5**	**$ 38,643.7**	**$ 85,561.9**	**$ 36,153.4**	**$ 19,355.6**	**$ 1,486.6**	**$ 4,329.9**	**$ 189,586.5**
Emergency Operating Costs as % of Total Medical Transportation Operating Costs		**13.4%**	**41.5%**	**1.7%**	**35.9%**	**47.1%**	**61.3%**	**61.9%**	**41.8%**	**33.6%**

Source: FIRMS adapted by Program Analysis Division

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

In 2013/14, total expenditures for NIHB Vision benefits ($31.5 million), Other Health Care benefits ($14.2 million) and Premiums ($5.4 million) amounted to $51.0 million, or 5.0% 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 2013/14, 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)
2013/14

Region	Operating	Contributions	TOTAL	% Change from 2012/13
Atlantic	$ 2,757	$ 0	$ 2,757	-7.1%
Quebec	1,619	0	1,619	3.1%
Ontario	5,182	538	5,721	5.7%
Manitoba	4,084	265	4,348	7.4%
Saskatchewan	5,611	0	5,611	-1.1%
Alberta	4,799	1,136	5,936	1.7%
British Columbia	1,449	255	1,704	-48.1%
Yukon	377	0	377	15.4%
N.W.T.	0	1,582	1,582	15.7%
Nunavut	0	1,804	1,804	7.7%
Total	$ 25,879	$ 5,580	$ 31,459	-2.2%

Source: FIRMS adapted by Program Analysis Division

NIHB Vision expenditures totalled $31.5 million in 2013/14. Regional operating expenditures accounted for $25.9 million or 82.3% of total expenditures while contribution costs accounted for $5.6 million or 17.7%.

The Alberta Region had the highest percentage share in NIHB Vision benefit costs at 18.9%, followed closely by the Ontario Region at 18.2% and the Saskatchewan Region at 17.8%.

In 2013/14, the highest percentage change in NIHB Vision expenditures was in the Northwest Territories and the Yukon with an increase of 15.7% and 15.4% respectively.

The British Columbia Region experienced a significant decrease in expenditures over 2012/13 at -48.1%. This can be attributed to the significant decrease in the eligible client population in this region as a result of the transfer of First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA).

The largest net increases in expenditures took place in the Ontario and Manitoba Regions where total vision care costs grew by $309 thousand and $300 thousand respectively.

In 2013/14, the Alberta Region had the highest expenditures in vision care at $5.9 million. This was followed by the Ontario and Saskatchewan regions at $5.7 and $5.6 million respectively.

FIGURE 7.2

Annual NIHB Vision Expenditures
2009/10 to 2013/14

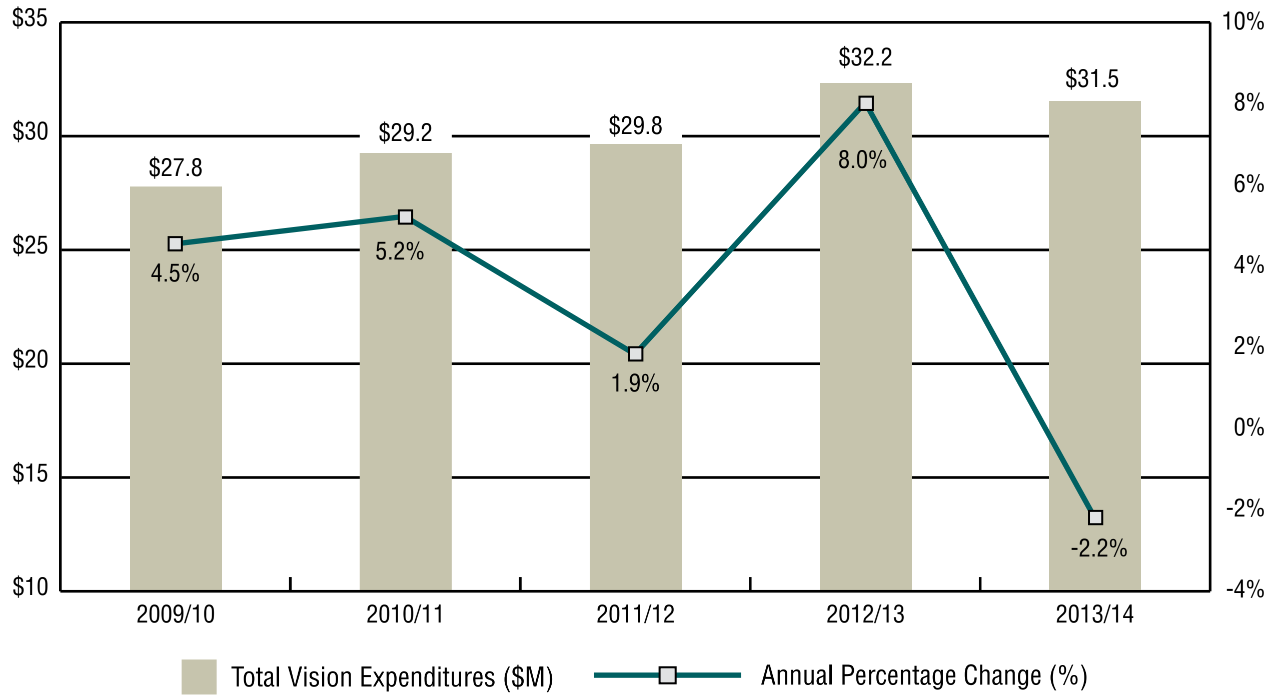
In 2013/14, NIHB Vision expenditures decreased by 2.2%, compared to the 8.0% increase recorded in 2012/13. This decrease in overall NIHB Vision expenditures can be attributed to the transfer of eligible First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA) along with the transfer of responsibility for the management and delivery of non-insured vision benefits. If the expenditures for these FNHA eligible clients are excluded from the 2012/13 and 2013/14 NIHB Vision expenditures, then the total vision benefit growth rate would have been 3.0%.

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 -2.2% in 2013/14. The annualized growth rate over these five years was 3.4%.

Over the past five years, overall vision benefit costs have grown by 13.3% from $27.8 million in 2009/10 to $31.5 million in 2013/14. On a regional basis, the highest expenditure growth rate over this five year period was in the Atlantic Region where expenditures grew by 71.0% from $1.6 million in 2009/10 to $2.8 million in 2013/14. 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.

The largest net increases in expenditures over the past five years took place in the Saskatchewan Region where total vision benefit costs grew by $1.4 million over this period, followed closely by the Atlantic Region where costs grew by $1.1 million.

NIHB Vision Expenditures and Annual Percentage Change



Source: FIRMS adapted by Program Analysis Division

NIHB Vision Expenditures ($ 000's)

REGION	2009/10	2010/11	2011/12	2012/13	2013/14
Atlantic	$ 1,612	$ 1,758	$ 2,021	$ 2,969	$ 2,757
Quebec	1,280	1,336	1,404	1,570	1,619
Ontario	5,343	5,183	5,425	5,412	5,721
Manitoba	3,407	3,612	3,813	4,048	4,348
Saskatchewan	4,222	4,658	4,449	5,676	5,611
Alberta	5,377	5,778	5,822	5,836	5,936
British Columbia	3,253	3,344	3,461	3,285	1,704
Yukon	299	311	347	327	377
N.W.T.	1,340	1,331	1,371	1,368	1,582
Nunavut	1,646	1,908	1,668	1,675	1,804
Total	**$ 27,779**	**$ 29,219**	**$ 29,780**	**$ 32,167**	**$ 31,459**

Source: FIRMS adapted by Program Analysis Division

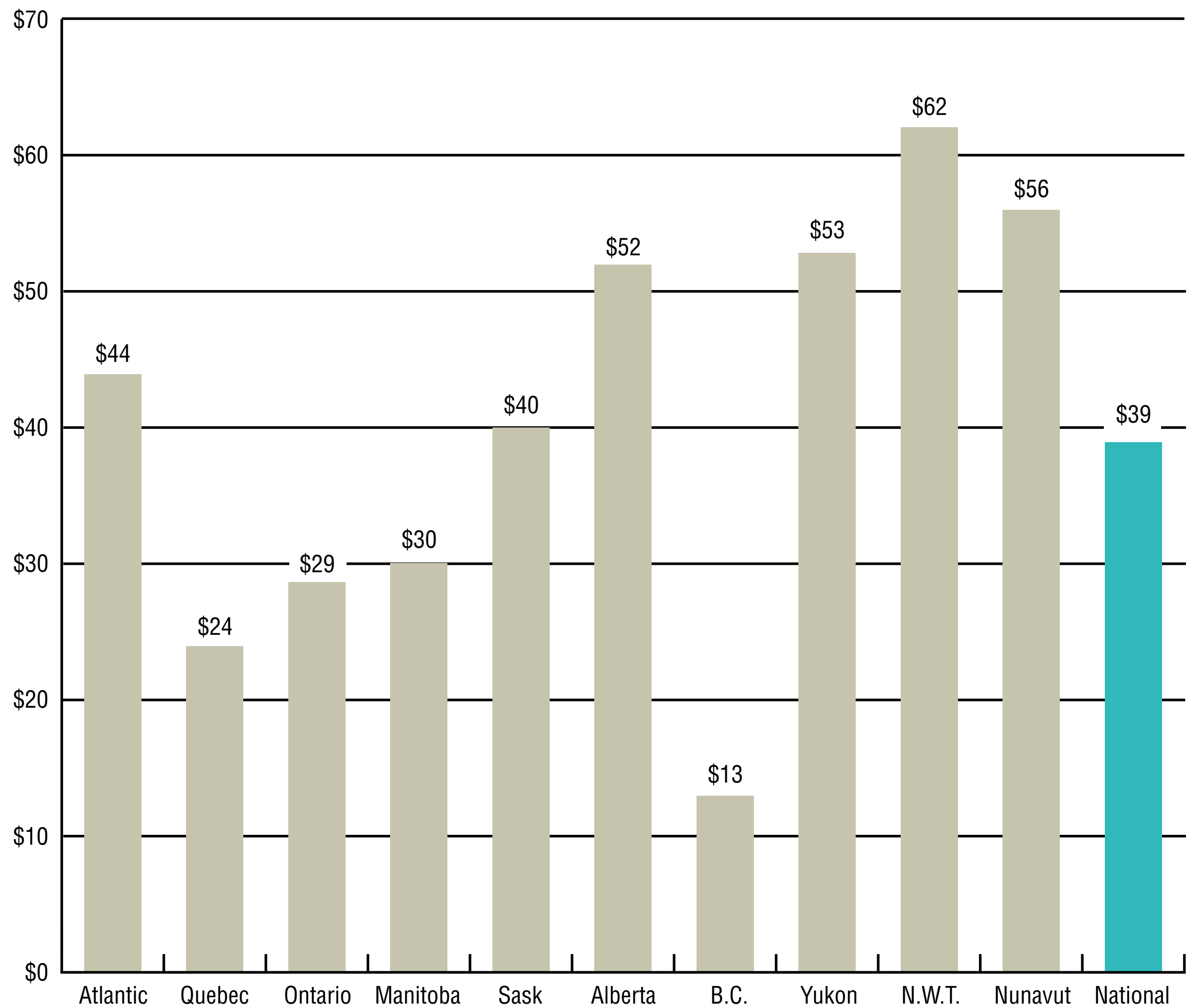
FIGURE 7.3

Per Capita NIHB Vision Expenditures by Region
2013/14

In 2013/14, the national per capita expenditure in NIHB Vision benefits was $39, an increase from $35 in 2012/13.

The Northwest Territories had the highest per capita expenditure at $62, followed by Nunavut at $56. The Yukon and Alberta Region followed closely at $53 and $52 respectively.

The British Columbia Region had the lowest per capita NIHB Vision expenditure at $13, a decrease from $25 in the previous year. This can be attributed to the significant decrease in the eligible client population in this region as a result of the transfer of First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA).



Source: SVS and FIRMS adapted by Program Analysis Division

FIGURE 7.4

NIHB Other Health Care Expenditures by Region ($ 000's)
2013/14

In 2013/14, NIHB Other Health Care expenditures, which consist primarily of short-term crisis intervention mental health counselling, amounted to $14.2 million. Regional operating expenditures accounted for $9.9 million or 70.1% of total expenditures while contribution costs accounted for $4.2 million or 29.9%.

In 2013/14, the Alberta Region had the highest percentage share of NIHB Other Health Care expenditures at 35.0% followed by the Manitoba and Ontario regions at 25.6% and 20.2% respectively.

The Alberta Region had the highest expenditure in other health care, registering close to $5.0 million in total expenditures, followed by the regions of Manitoba and Ontario at $3.6 million and $2.9 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	$ 133	$ 102	$ 235
Quebec	843	160	1,003
Ontario	2,862	0	2,862
Manitoba	2,940	682	3,622
Saskatchewan	464	553	1,017
Alberta	2,561	2,398	4,959
British Columbia	121	332	453
Yukon	2	0	2
N.W.T.	0	0	0
Nunavut	0	0	0
Total	$ 9,926	$ 4,226	$ 14,152

Source: FIRMS adapted by Program Analysis Division

FIGURE 7.5

Annual NIHB Other Health Care Expenditures
2009/10 to 2013/14

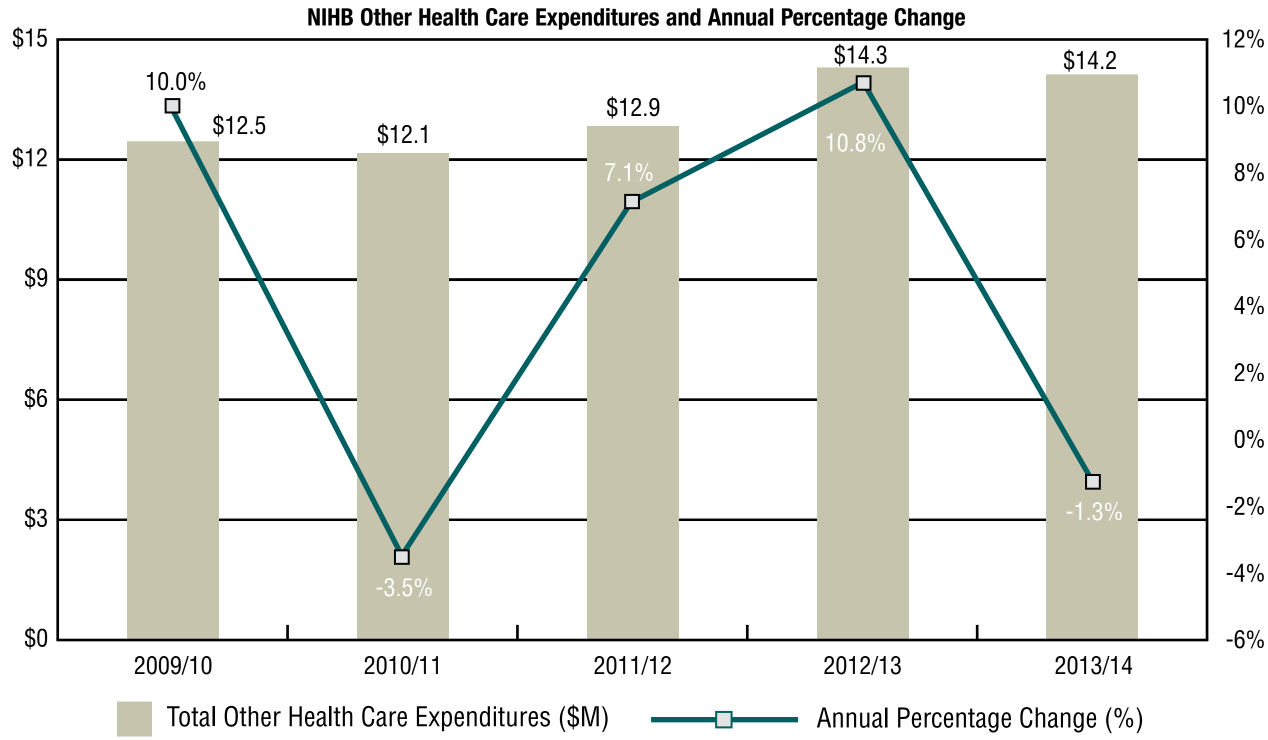
NIHB Other Health Care expenditures, like other NIHB benefits, are demand-driven and influenced by the number of clients accessing services in a specific year.

In 2013/14, expenditures for this benefit area decreased by 1.3%, a significant change compared to the 10.8% increase in 2012/13. This decrease in NIHB Other Health Care expenditures can be attributed to the transfer of eligible First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA) along with the transfer of responsibility for the management and delivery of non-insured other health care benefits, through a phased approach between July and October 2013. If the expenditures for these FNHA eligible clients are excluded from the 2012/13 and 2013/14 NIHB Other Health Care expenditures, then the overall growth rate for this benefit would have been 2.2%.

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 -3.5% in 2010/11. The annualized growth rate over these five years was 4.5%.

Fluctuations in expenditures and growth rates since 2009/10 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 $596 thousand from $4.4 million in 2009/10 to $5.0 million in 2013/14.



Source: FIRMS adapted by Program Analysis Division

NIHB Other Health Care Expenditures ($ 000's)					
REGION	2009/10	2010/11	2011/12	2012/13	2013/14
Atlantic	$ 213	$ 241	$ 254	$ 512	$ 235
Quebec	459	597	875	1,135	1,003
Ontario	2,603	2,632	2,349	2,490	2,862
Manitoba	3,143	2,930	3,109	3,429	3,622
Saskatchewan	812	$896	1,499	1,038	1,017
Alberta	4,363	3,903	3,957	4,791	4,959
British Columbia	924	882	889	940	453
Yukon	1	2	4	4	2
N.W.T.	0	0	0	0	0
Nunavut	0	0	0	0	0
Total	**$ 12,516**	**$ 12,083**	**$ 12,936**	**$ 14,337**	**$ 14,152**

Source: FIRMS adapted by Program Analysis Division

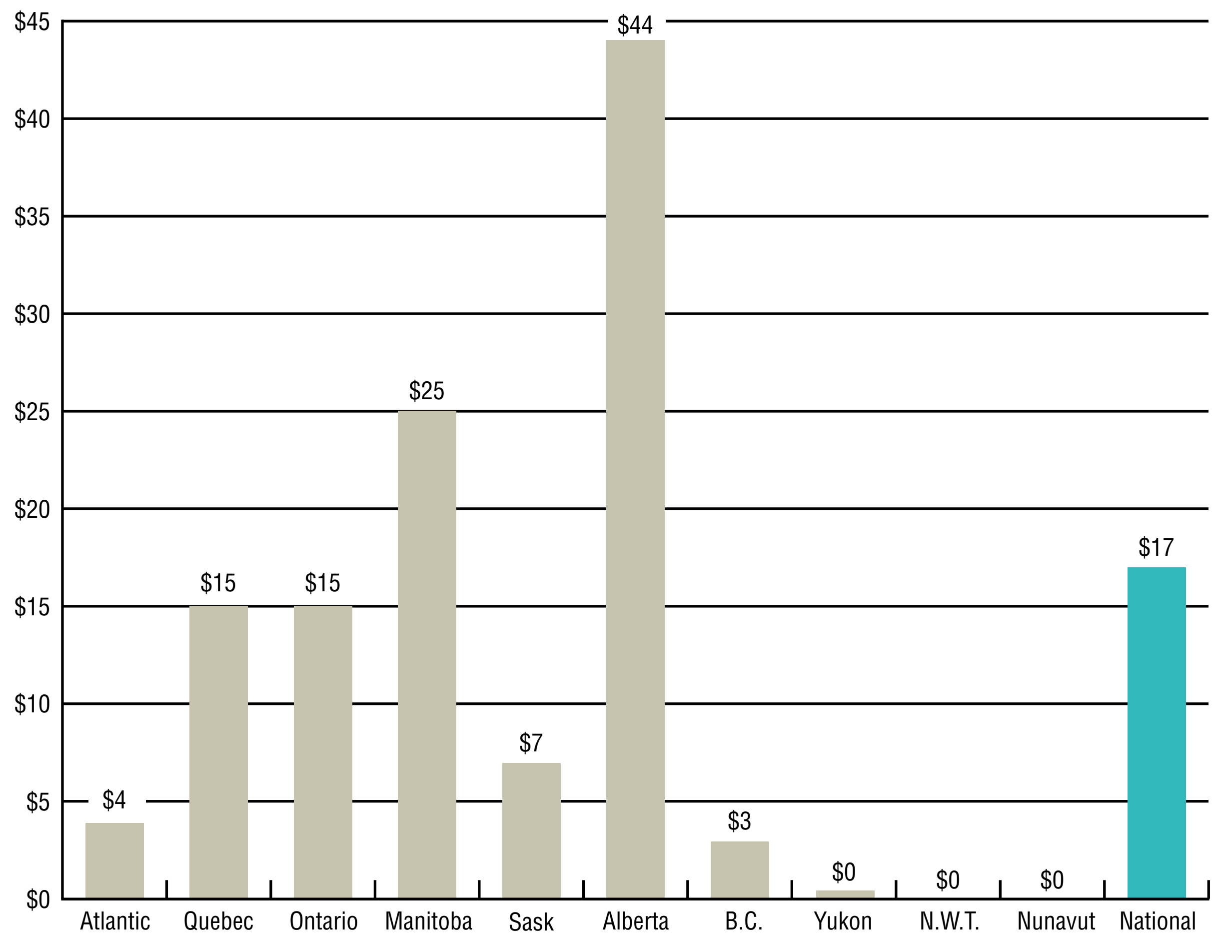
FIGURE 7.6

Per Capita NIHB Other Health Care Expenditures by Region
2013/14

In 2013/14, the national per capita expenditure for NIHB Other Health Care was $17, an increase from the $15 recorded in the previous fiscal year.

The Alberta Region had the highest per capita expenditure at $44, followed by the Manitoba Region at $25 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

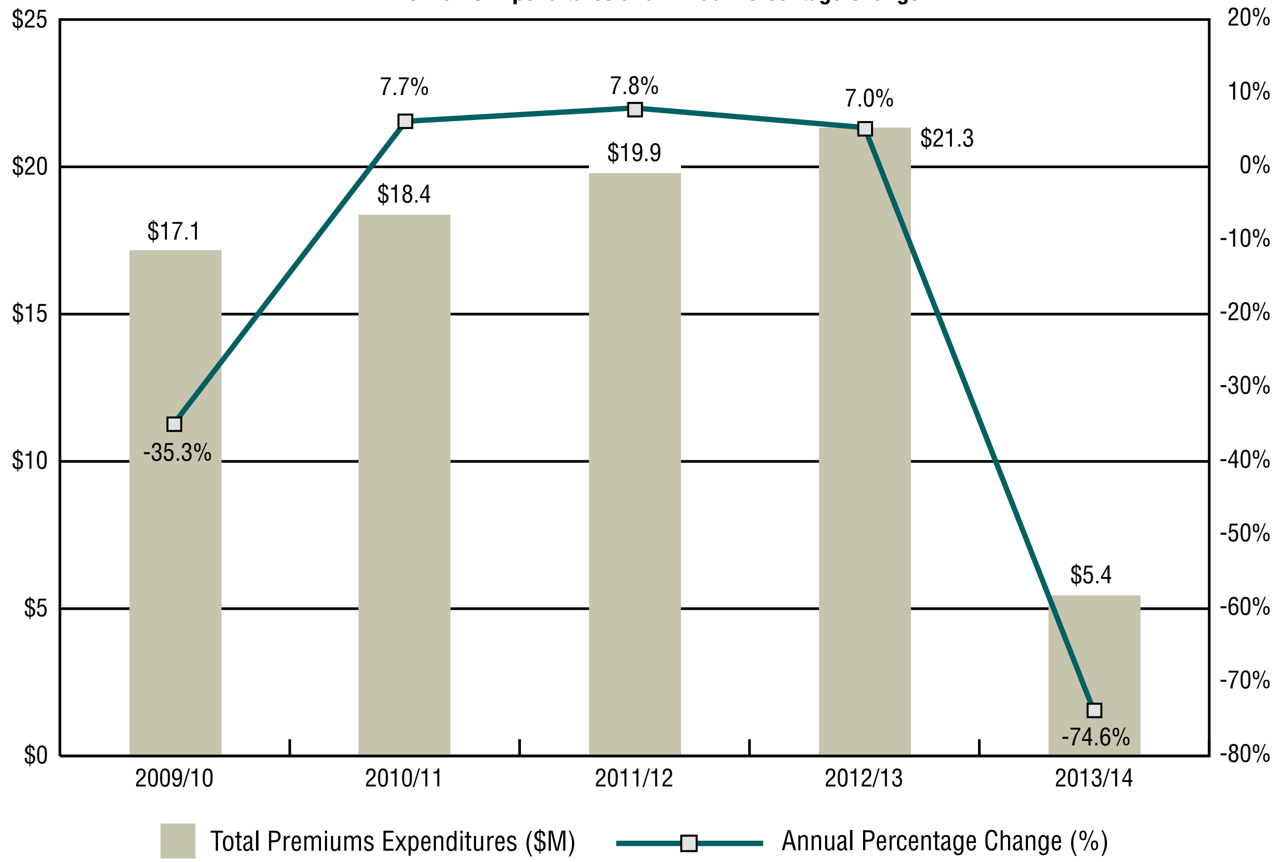
Annual NIHB Premiums Expenditures
2009/10 to 2013/14

In 2013/14, NIHB Premiums expenditures totalled $5.4 million, a significant decrease of 74.6% over the previous fiscal year. Since January 1, 2009, the NIHB Program has only covered premiums in the British Columbia Region. This significant decrease in NIHB Premiums expenditures can be attributed to the transfer of First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA) along with the programs, services, and responsibilities formerly delivered by Health Canada's First Nations and Inuit Health Branch (FNIHB) to First Nation clients residing in British Columbia, including coverage for premiums.

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 -27.2% and is attributable to the elimination of insurance premiums by the Government of Alberta and the transfer of premiums coverage for First Nations individuals residing in British Columbia to the FNHA. The annualized growth rate for premiums in the British Columbia Region only over this five year period is -20.0%.

NIHB Premiums Expenditures and Annual Percentage Change



Source: FIRMS adapted by Program Analysis Division

NIHB Premiums Expenditures ($ 000's)					
Region	2009/10	2010/11	2011/12	2012/13	2013/14
British Columbia	17,110	18,428	19,868	21,257	5,406
Total	**$ 17,110**	**$ 18,428**	**$ 19,868**	**$ 21,257**	**$ 5,406**

Source: FIRMS adapted by Program Analysis Division

Regional Expenditure Trends 2004/05 to 2013/14

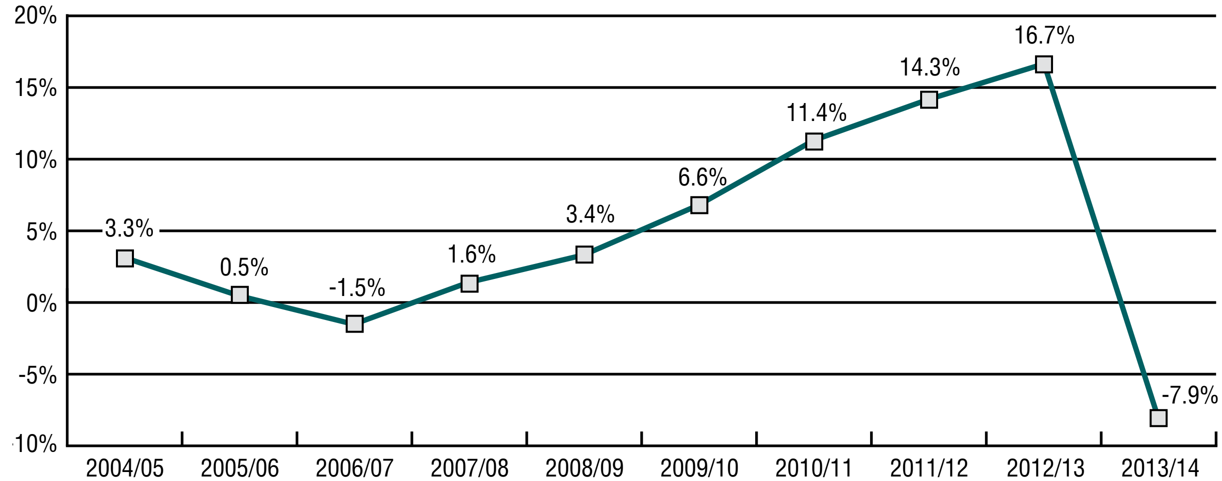
FIGURE 8.1

Atlantic Region
2004/05 to 2013/14

Annual expenditures in the Atlantic Region for 2013/14 totalled $46.0 million, a decrease of 7.9% from the $50.0 million spent in 2012/13. 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). The addition of these new clients resulted in a 2 year surge in Atlantic Regional expenditures, which has now leveled off, resulting in a small decrease in expenditures for 2013/2014.

As of March 31, 2014, a total of 23,933 Qalipu clients were registered in the Status Verification System (SVS) and were eligible to receive benefits through the NIHB Program.

Percentage Change in Atlantic Region NIHB Expenditures



Pharmacy expenditures in 2013/14 decreased by 8.2% to $27.5 million, medical transportation costs increased by 0.6% to $6.9 million and dental expenditures decreased by 10.9% to $8.6 million. Other health care expenditures decreased by 54.1% and vision care expenditures decreased by 7.1%.

Pharmacy expenditures accounted for more than half of the Atlantic Region's total expenditures at 59.8%, dental expenditures ranked second at 18.7%, followed by medical transportation at 15.0%. Vision care and other health care accounted for 6.0% and 0.5% of total expenditures respectively.

Annual Expenditures by Benefit ($ 000's)

Atlantic Region	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Medical Transportation	$ 6,124	$ 5,590	$ 4,401	$ 4,585	$ 4,655	$ 5,048	$ 5,314	$ 5,841	$ 6,875	$ 6,916
Pharmacy	17,533	18,293	18,938	18,984	20,119	21,357	23,689	27,571	29,979	27,517
Dental	4,934	4,831	5,128	5,204	4,945	5,426	6,481	7,164	9,660	8,609
Other Health Care	161	201	192	272	251	213	241	254	512	235
Vision Care	1,619	1,614	1,408	1,495	1,596	1,612	1,758	2,021	2,969	2,757
Total	$ 30,371	$ 30,529	$ 30,067	$ 30,539	$ 31,567	$ 33,656	$ 37,482	$ 42,850	$ 49,995	$ 46,033

Source: FIRMS adapted by Program Analysis Division

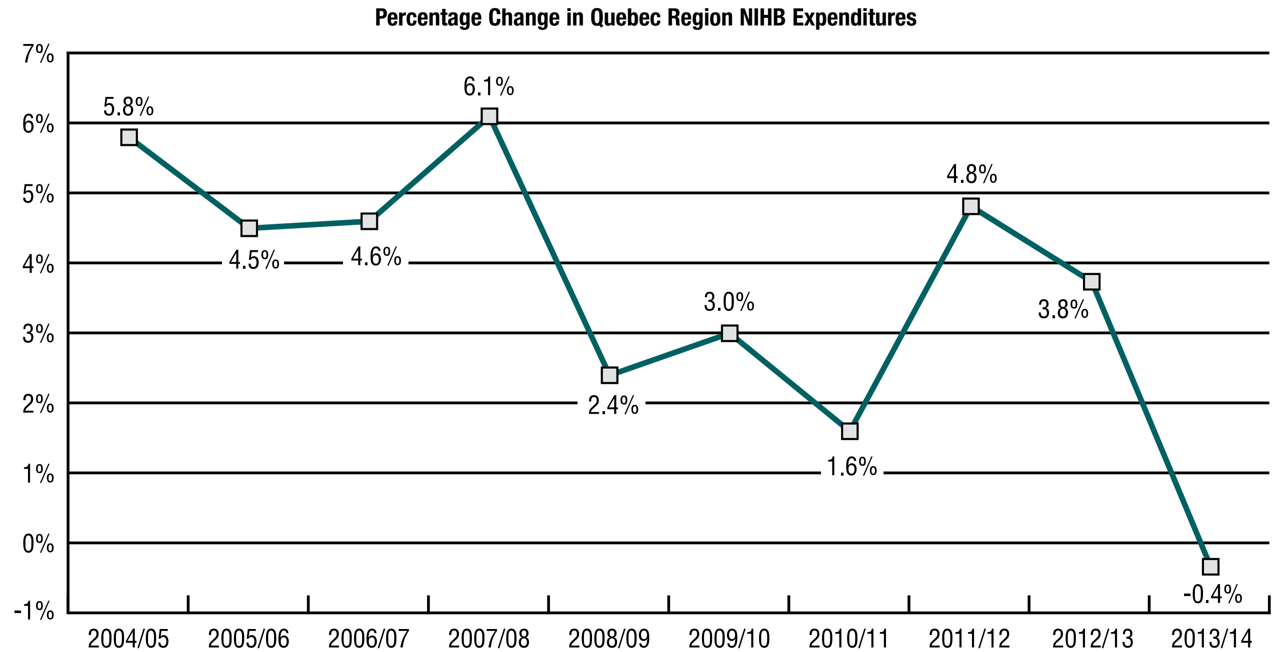
FIGURE 8.2

Quebec Region
2004/05 to 2013/14

Annual expenditures in the Quebec Region for 2013/14 totalled $80.6 million, a slight decrease of 0.4% from the $80.9 million spent in 2012/13.

Pharmacy expenditures in 2013/14 increased by 1.1% to $40.8 million, while medical transportation costs decreased by 2.8% to $21.9 million, and dental expenditures decreased slightly by 0.1% to $15.2 million. Vision care expenditures increased by 3.1% while other health care expenditures decreased 11.6%.

Pharmacy expenditures accounted for half of the Quebec Region's total expenditures at 50.6%, medical transportation expenditures ranked second at 27.2%, followed by dental at 18.9%. Vision care and other health care accounted for 2.0% and 1.2% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)

Quebec Region	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Medical Transportation	$ 17,291	$ 17,886	$ 18,473	$ 20,133	$ 20,502	$ 19,918	$ 18,943	$ 21,708	$ 22,578	$ 21,945
Pharmacy	29,959	31,771	33,486	35,372	36,069	37,358	38,234	38,827	40,393	40,825
Dental	10,525	10,970	11,603	12,141	12,895	14,159	15,245	15,138	15,239	15,216
Other Health Care	697	750	583	471	375	459	597	875	1,135	1,003
Vision Care	1,349	1,135	1,270	1,257	1,220	1,280	1,336	1,404	1,570	1,619
Total	$ 59,820	$ 62,512	$ 65,414	$ 69,374	$ 71,060	$ 73,174	$ 74,355	$ 77,951	$ 80,915	$ 80,608

Source: FIRMS adapted by Program Analysis Division

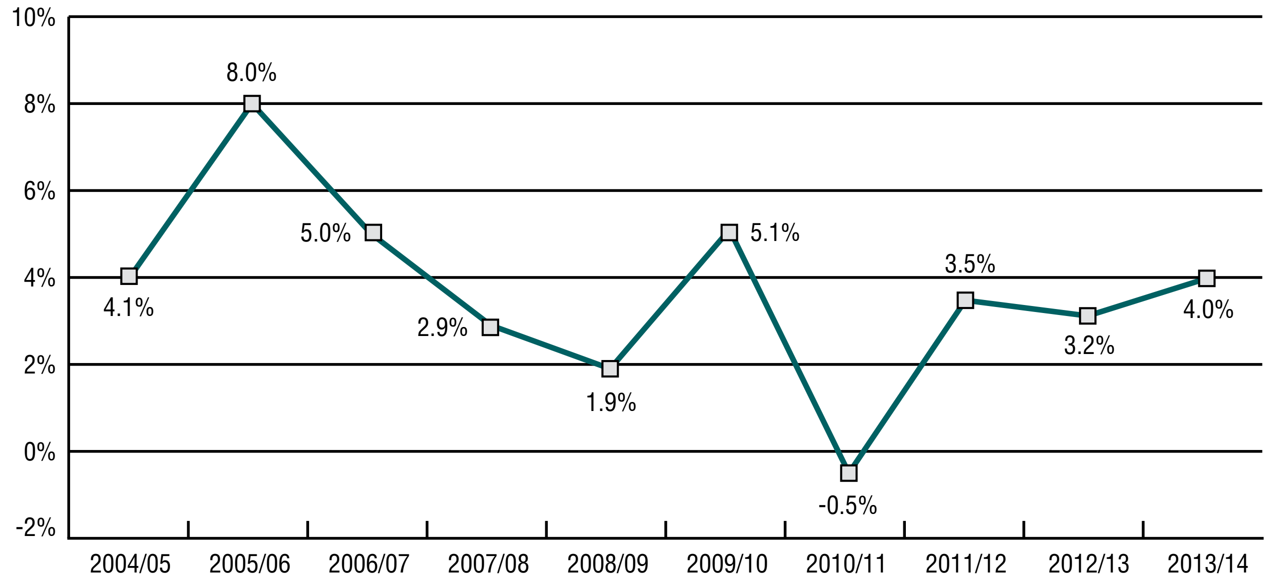
FIGURE 8.3

Ontario Region
2004/05 to 2013/14

Annual expenditures in the Ontario Region for 2013/14 totalled $193.9 million, an increase of 4.0% from the $186.5 million spent in 2012/13. Pharmacy expenditures in 2013/14 increased by 1.8% to $78.5 million, medical transportation costs increased by 6.1% to $62.9 million and dental expenditures increased by 4.1% to $44.0 million. Vision care and other health care expenditures increased by 5.7% and 14.9% respectively.

Pharmacy expenditures accounted for 40.5% of the Ontario Region's total expenditures, medical transportation costs ranked second at 32.4%, followed by dental at 22.7%. Vision care and other health care accounted for 2.9% and 1.5% of total expenditures respectively.

Percentage Change in Ontario Region NIHB Expenditures



Annual Expenditures by Benefit ($ 000's)

Ontario Region	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Medical Transportation	$ 35,258	$ 38,553	$ 40,572	$ 45,618	$ 46,848	$ 51,889	$ 52,358	$ 54,725	$ 59,251	$ 62,865
Pharmacy	67,508	73,223	77,788	77,191	77,244	77,564	73,887	76,430	77,131	78,510
Dental	29,655	32,064	32,777	33,467	35,457	38,047	40,594	41,848	42,259	43,972
Other Health Care	2,404	2,213	2,530	2,172	2,158	2,603	2,632	2,349	2,490	2,862
Vision Care	5,428	5,458	5,485	5,366	5,204	5,343	5,183	5,425	5,412	5,721
Total	$ 140,253	$ 151,510	$ 159,152	$ 163,814	$ 166,910	$ 175,447	$ 174,653	$ 180,778	$ 186,544	$ 139,929

Source: FIRMS adapted by Program Analysis Division

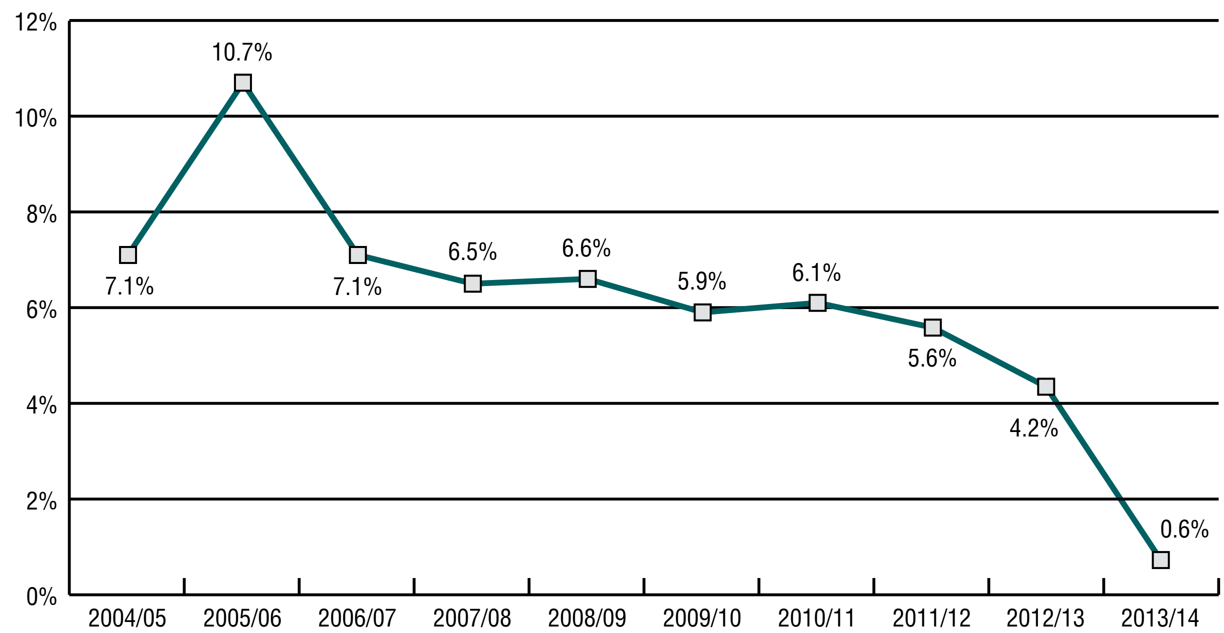
FIGURE 8.4

Manitoba Region
2004/05 to 2013/14

Annual expenditures in the Manitoba Region for 2013/14 totalled $229.7 million, a slight increase of 0.6% from the $228.3 million spent in 2012/13. Pharmacy expenditures in 2013/14 decreased by 4.5% to $77.0 million, while medical transportation costs increased by 1.5% to $111.0 million and dental expenditures increased by 9.5% to $33.6 million. Vision care and other health care expenditures increased by 7.4% and 3.6% respectively.

Medical transportation expenditures comprised almost half of the Manitoba Region's total expenditures at 48.3%, pharmacy costs ranked second at 33.5%, followed by dental at 14.7%. Vision care and other health care accounted for 1.9% and 1.6% of total expenditures respectively.

Percentage Change in Manitoba Region NIHB Expenditures



Annual Expenditures by Benefit ($ 000's)

Manitoba Region	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Medical Transportation	$ 55,895	$ 63,322	$ 69,047	$ 76,082	$ 83,193	$ 89,078	$ 94,940	$ 101,609	$ 109,409	$ 111,016
Pharmacy	53,998	59,409	64,966	69,317	71,081	72,789	76,496	80,639	80,676	77,034
Dental	18,705	20,326	20,756	21,696	24,444	26,954	29,399	29,861	30,734	33,649
Other Health Care	5,685	5,690	4,786	2,964	2,619	3,143	2,930	3,109	3,429	3,622
Vision Care	2,684	2,864	2,841	2,936	3,157	3,407	3,612	3,813	4,048	4,348
Total	**$ 136,967**	**$ 151,610**	**$ 162,396**	**$ 172,994**	**$ 184,494**	**$ 195,371**	**$ 207,377**	**$ 219,031**	**$ 228,295**	**$ 229,670**

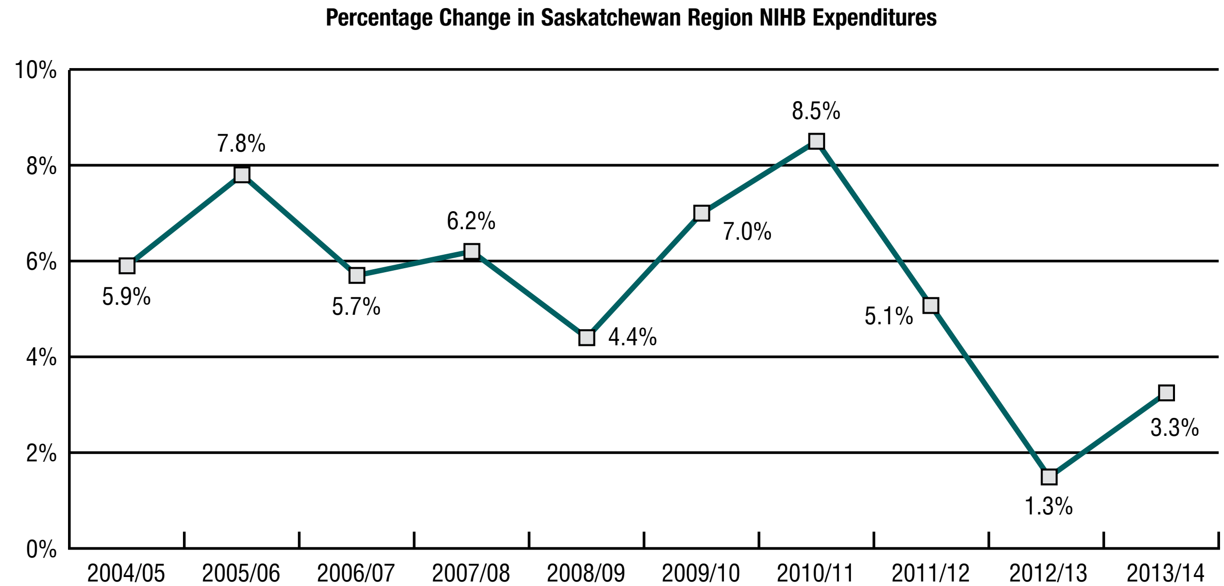
Source: FIRMS adapted by Program Analysis Division

FIGURE 8.5

Saskatchewan Region
2004/05 to 2013/14

Annual expenditures in the Saskatchewan Region for 2013/14 totalled $168.8 million, an increase of 3.3% from the $163.4 million spent in 2012/13. Pharmacy expenditures in 2013/14 increased by 5.2% to $78.5 million, medical transportation costs increased by 3.0% to $47.2 million and dental expenditures increased by 0.5% to $36.4 million. Vision care and other health care expenditures decreased by 1.1% and 2.0% respectively.

Pharmacy expenditures comprised the largest portion of the Saskatchewan Region's total expenditures at 46.5%, medical transportation costs ranked second at 28.0%, followed by dental at 21.6%. Vision care and other health care accounted for 3.3% and 0.6% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)										
Saskatchewan Region	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Medical Transportation	$ 26,758	$ 28,786	$ 31,816	$ 36,108	$ 36,239	$ 38,971	$ 41,896	$ 45,084	$ 45,793	$ 47,180
Pharmacy	52,636	55,687	58,083	60,749	62,809	66,639	70,625	73,293	74,646	78,546
Dental	19,530	22,038	23,219	24,636	28,102	30,777	35,317	36,941	36,219	36,399
Other Health Care	2,295	2,237	2,244	942	870	812	896	1,499	1,038	1,017
Vision Care	3,431	4,072	3,835	4,126	4,166	4,222	4,658	4,449	5,676	5,611
Total	**$ 104,651**	**$ 112,820**	**$ 119,197**	**$ 126,561**	**$ 132,185**	**$ 141,420**	**$ 153,393**	**$ 161,265**	**$ 163,372**	**$ 168,752**

Source: FIRMS adapted by Program Analysis Division

FIGURE 8.6

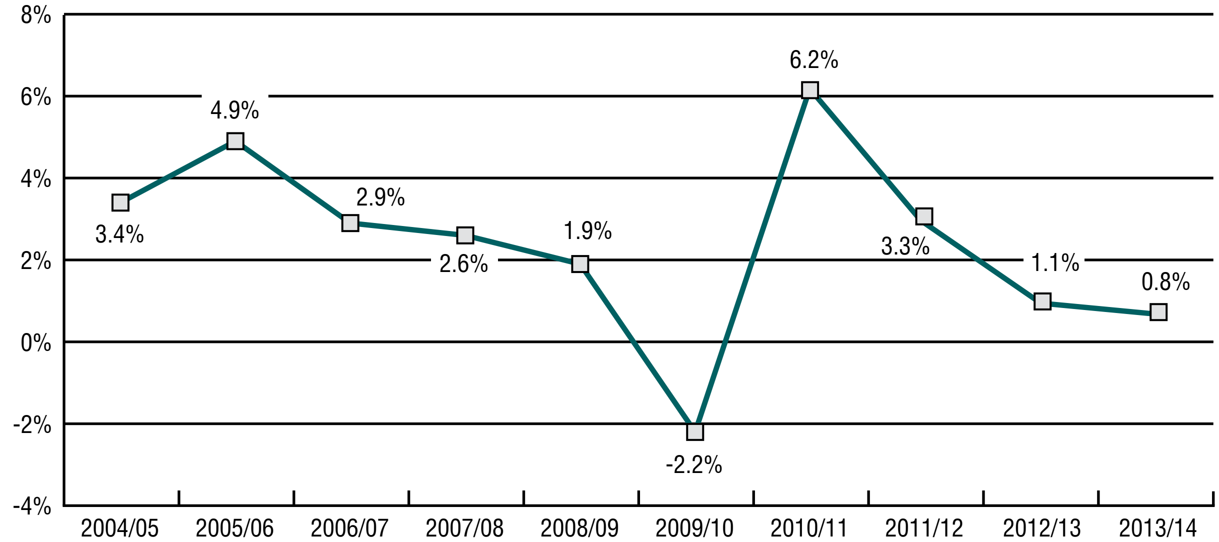
Alberta Region
2004/05 to 2013/14

Annual expenditures in the Alberta Region for 2013/14 totalled $146.1 million, an increase of 0.8% from the $144.9 million spent in 2012/13. Pharmacy expenditures in 2013/14 decreased by 3.0% to $58.8 million, while medical transportation costs increased by 5.7% to $41.5 million and dental expenditures increased by 1.2% to $34.9 million. Vision care and other health care expenditures increased by 1.7% and 3.5% respectively.

Pharmacy expenditures accounted for 40.2% of the Alberta Region's total expenditures, medical transportation costs ranked second at 28.4%, followed closely by dental at 23.9%. Vision care and other health care accounted for 4.1% and 3.4% 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.

Percentage Change in Alberta Region NIHB Expenditures



Total Benefits Annual % Change

Annual Expenditures by Benefit ($ 000's)

Alberta Region	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Medical Transportation	$ 29,686	$ 30,712	$ 32,204	$ 32,107	$ 35,357	$ 36,601	$ 35,877	$ 37,371	$ 39,216	$ 41,451
Pharmacy	48,207	51,141	52,424	54,353	54,189	56,570	59,738	61,621	60,584	58,777
Dental	19,306	20,594	21,006	22,391	25,016	27,756	33,421	34,543	34,501	34,928
Other Health Care	4,078	4,537	4,736	4,343	3,940	4,363	3,903	3,957	4,791	4,959
Vision Care	4,720	4,762	4,690	4,942	5,225	5,377	5,778	5,822	5,836	5,936
Premiums	12,377	12,381	12,709	12,961	9,920	0	0	0	0	0
Total	**$ 118,373**	**$ 124,127**	**$ 127,769**	**$ 131,096**	**$ 133,646**	**$ 130,666**	**$ 138,717**	**$ 143,313**	**$ 144,928**	**$ 146,051**

Source: FIRMS adapted by Program Analysis Division

FIGURE 8.7

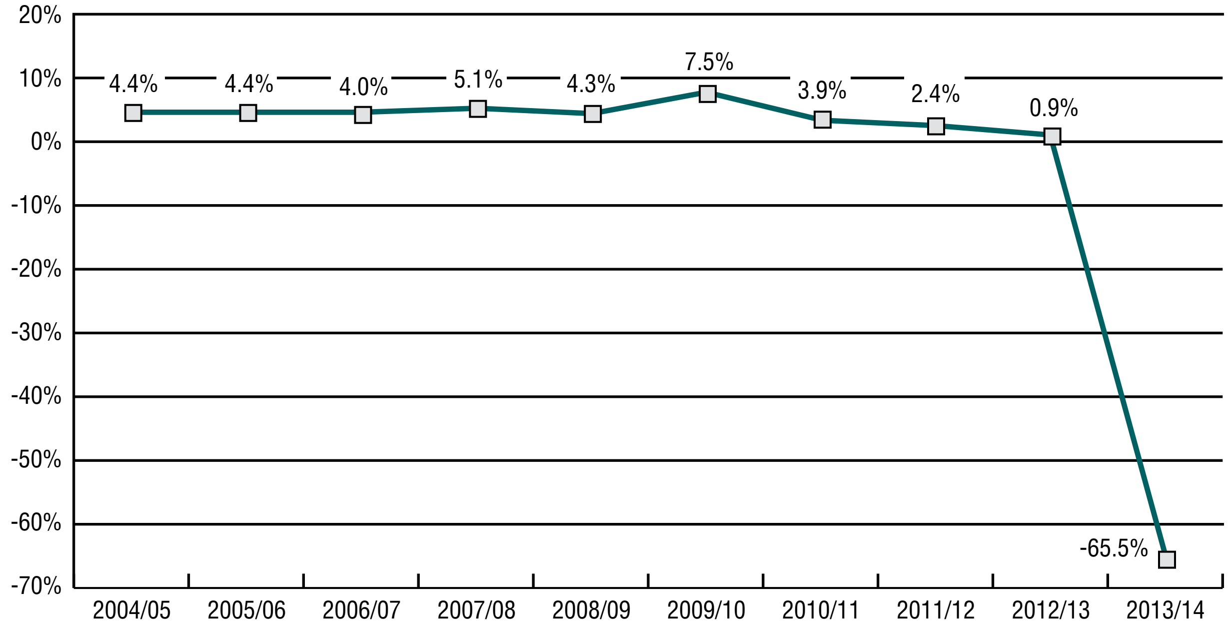
British Columbia Region
2004/05 to 2013/14

Annual expenditures in the British Columbia Region for 2013/14 totalled $49.5 million, a significant decrease of 65.5% from the $143.5 million spent in 2012/13. This decrease in overall expenditures in this region can be attributed to the transfer of First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA). The FNHA assumed the programs, services, and responsibilities formerly delivered by Health Canada's First Nations Inuit Health Branch (FNIHB) to First Nation clients residing in British Columbia.

In 2013/14, all of the NIHB benefit areas had a decrease in expenditures as eligible First Nations clients in this region began to receive non-insured health benefits through the FNHA. Pharmacy expenditures decreased by 75.0% to $14.9 million. Medical transportation expenditures decreased by 39.9% to $16.0 million and dental expenditures decreased by 65.1% to $11.0 million. The cost of premiums decreased by 74.6%, vision care expenditures decreased by 48.1% and other health care expenditures decreased by 51.8%.

Medical Transportation expenditures accounted for 32.3% of the British Columbia Region's total expenditures, pharmacy costs ranked second at 30.2%, followed by dental at 22.3%. Premiums, vision care and other health care accounted for 10.9%, 3.4% and 0.9% of total expenditures respectively.

Percentage Change in British Columbia Region NIHB Expenditures



Annual Expenditures by Benefit ($ 000's)

British Columbia Region	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Medical Transportation	$ 17,340	$ 16,944	$ 20,284	$ 21,613	$ 22,711	$ 25,547	$ 25,967	$ 26,510	$ 26,573	$ 15,960
Pharmacy	46,670	49,734	50,387	54,290	56,104	58,862	60,097	60,890	59,858	14,939
Dental	20,357	22,439	22,588	22,968	24,718	28,042	30,187	30,620	31,543	11,013
Other Health Care	1,581	1,486	1,177	1,120	1,165	924	882	889	940	453
Vision Care	3,249	3,049	3,232	3,120	3,251	3,253	3,344	3,461	3,285	1,704
Sub-Total	89,197	93,652	97,669	103,111	107,948	116,628	120,476	122,371	122,198	44,069
Premiums	15,453	15,606	15,951	16,250	16,510	17,110	18,428	19,868	21,257	5,406
Total	$ 104,650	$ 109,259	$ 113,620	$ 119,361	$ 124,458	$ 133,739	$ 138,905	$ 142,239	$ 143,455	$ 49,475

Source: FIRMS adapted by Program Analysis Division

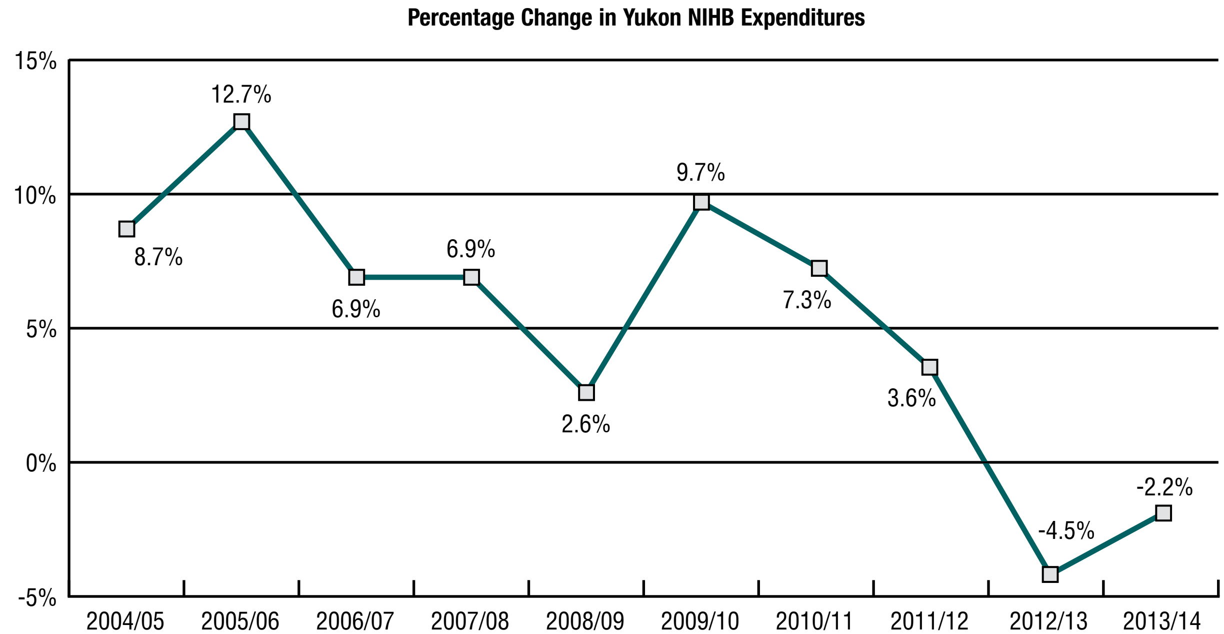
FIGURE 8.8

Yukon
2004/05 to 2013/14

Annual expenditures in the Yukon for 2013/14 totalled $10.5 million, a decrease of 2.2% from the $10.7 million spent in 2012/13. This year over year decrease in expenditure growth can be attributed to the transfer of First Nation clients from this region but who are living in permanence in the British Columbia region to the First Nations Health Authority (FNHA) and who are now eligible for and receive non-insured health benefits under the FNHA.

Pharmacy expenditures in 2013/14 decreased by 13.5% to $3.5 million while medical transportation costs increased by 13.5% to $4.4 million. Dental expenditures decreased by 11.1% to $2.2 million.

Medical Transportation expenditures comprised the largest portion of the Yukon's total expenditures at 42.3%, pharmacy expenditures ranked second at 33.0%, followed by dental and vision care at 21.1% and 3.6% respectively.



Annual Expenditures by Benefit ($ 000's)

Yukon	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Medical Transportation	$ 1,774	$ 2,100	$ 2,421	$ 2,935	$ 2,938	$ 3,801	$ 4,097	$ 4,413	$ 3,909	$ 4,439
Pharmacy	3,476	3,655	3,641	3,802	3,779	3,723	3,792	3,878	3,994	3,455
Dental	1,229	1,863	2,033	1,998	2,246	2,271	2,629	2,583	2,486	2,210
Other Health Care	4	1	22	4	1	1	2	4	4	2
Vision Care	480	228	274	230	242	299	311	347	327	377
Total	**$ 6,963**	**$ 7,847**	**$ 8,392**	**$ 8,970**	**$ 9,206**	**$ 10,095**	**$ 10,830**	**$ 11,225**	**$ 10,719**	**$ 10,483**

Source: FIRMS adapted by Program Analysis Division

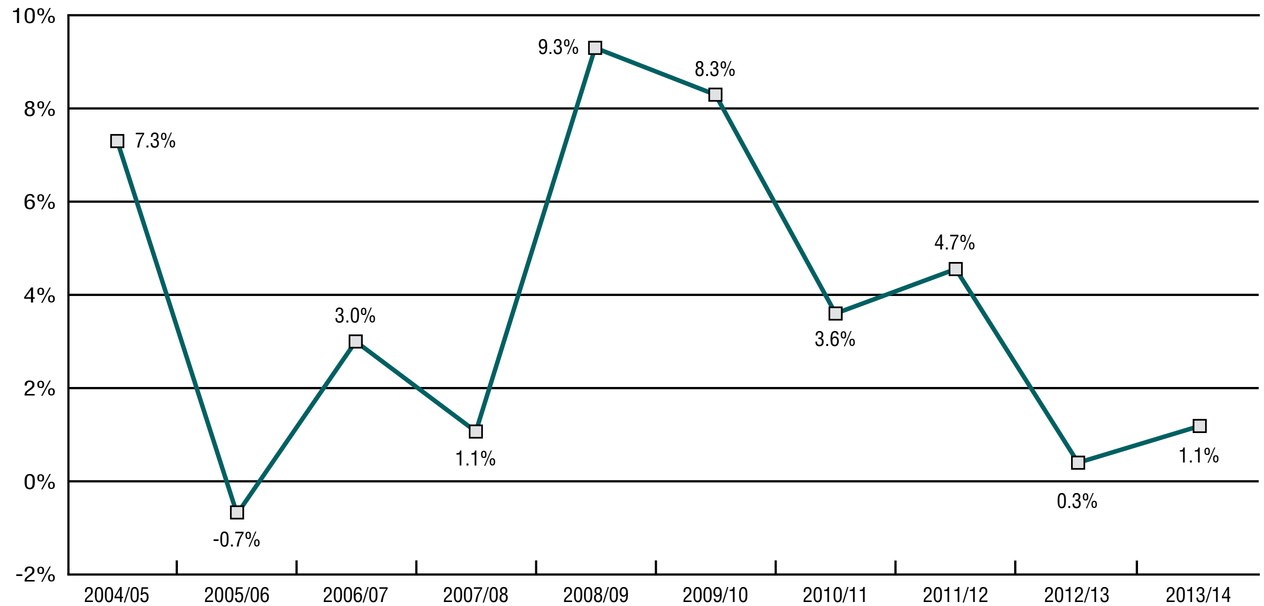
FIGURE 8.9

Northwest Territories
2004/05 to 2013/14

Annual expenditures in the Northwest Territories in 2013/14 totalled $28.1 million, an increase of 1.1% from the $27.8 million spent in 2012/13. Pharmacy expenditures in 2013/14 decreased by 3.6% to $8.7 million, medical transportation costs increased by 2.1% to $10.4 million and dental expenditures increased by 2.8% to $7.4 million. Vision care expenditures increased by 15.7% to $1.6 million.

Medical transportation comprised the largest portion of the Northwest Territories total expenditures at 36.9%, pharmacy costs ranked second at 30.9%, followed by dental at 26.5%. Vision care made up 5.6% of total expenditures.

Percentage Change in Northwest Territories NIHB Expenditures



Annual Expenditures by Benefit ($ 000's)

Northwest Territories	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Medical Transportation	$ 7,428	$ 6,710	$ 7,116	$ 6,943	$ 7,952	$ 8,520	$ 8,498	$ 10,157	$ 10,157	$ 10,372
Pharmacy	7,544	8,010	8,151	7,863	8,210	8,595	8,999	9,090	8,999	8,677
Dental	5,173	5,249	5,249	5,752	6,279	7,067	7,603	7,054	7,244	7,448
Other Health Care	0	0	0	0	0	0	0	0	0	0
Vision Care	718	743	819	1,011	1,130	1,340	1,331	1,371	1,368	1,582
Total	$ 20,863	$ 20,712	$ 21,335	$ 21,570	$ 23,571	$ 25,521	$ 26,431	$ 27,672	$ 27,769	$ 28,079

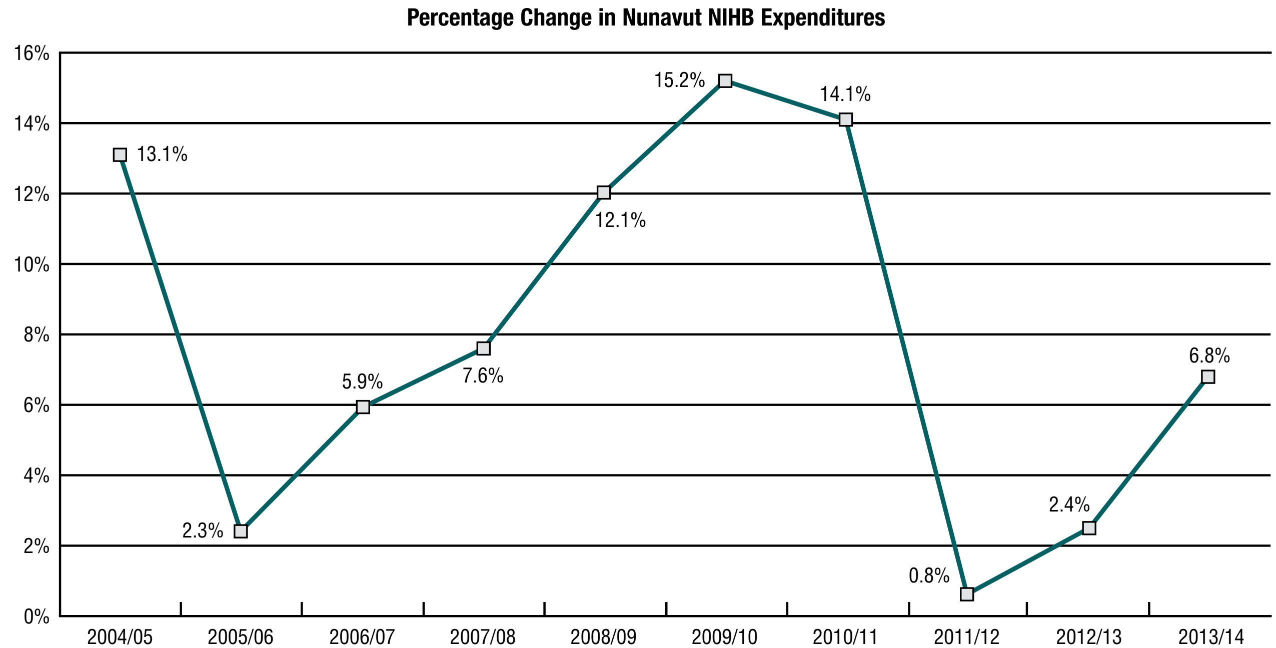
Source: FIRMS adapted by Program Analysis Division

FIGURE 8.10

Nunavut
2004/05 to 2013/14

Annual expenditures in Nunavut for 2013/14 totalled $53.5 million, an increase of 6.8% from the $50.1 million spent in 2012/13. Pharmacy expenditures in 2013/14 increased by 3.0% to $11.0 million and medical transportation costs increased by 8.1% to $29.9 million. Dental expenditures increased by 7.1% to $10.8 million and vision care costs increased by 7.7% to $1.8 million.

Medical transportation comprised the largest portion of Nunavut's total expenditures at 55.9%, pharmacy expenditures ranked second at 20.6%, followed by dental at 20.1%. Vision care made up 3.4% of the total expenditures.



Annual Expenditures by Benefit ($ 000's)

Nunavut	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Medical Transportation	$ 13,972	$ 14,776	$ 15,268	$ 16,171	$ 20,053	$ 22,302	$ 23,869	$ 25,886	$ 27,661	$ 29,892
Pharmacy	4,734	4,902	5,526	6,579	7,084	8,237	10,399	10,894	10,690	11,012
Dental	8,566	8,137	8,740	9,002	8,349	10,289	12,306	10,442	10,043	10,757
Other Health Care	0	0	0	0	0	0	0	0	0	0
Vision Care	951	1,044	1,040	1,139	1,387	1,646	1,908	1,668	1,675	1,804
Total	$ 28,223	$ 28,860	$ 30,574	$ 32,890	$ 36,873	$ 42,474	$ 48,482	$ 48,890	$ 50,069	$ 53,465

Source: FIRMS adapted by Program Analysis Division

Initiatives and Activities

SECTION 9.1

Health Information and Claims Processing Services (HICPS)
2013/14

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 6, 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, 2014, there were 26,961 active providers* 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 2012 to March 2014

REGION	Pharmacy	MS&E	Dental
Atlantic	778	196	1,008
Quebec	1,909	165	2,761
Ontario	3,649	694	5,420
Manitoba	433	83	722
Saskatchewan	410	68	481
Alberta	1,279	237	2,198
British Columbia	1,379	422	2,426
Yukon	8	8	46
Northwest Territories	11	7	65
Nunavut	5	2	81
Total	9,871	1,882	15,208

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, 2014.

FIGURE 9.1.1

Number of Claim Lines Settled Through the Health Information and Claims Processing Services (HICPS) System in 2013/14

REGION	Pharmacy	Dental	MS&E	Total
Atlantic	1,183,308	150,588	29,870	**1,363,766**
Quebec	2,423,084	208,842	24,300	**2,656,226**
Ontario	5,044,027	553,822	38,171	**5,636,020**
Manitoba	3,142,977	403,093	69,706	**3,615,776**
Saskatchewan	2,806,783	445,377	75,604	**3,327,764**
Alberta	2,257,803	437,862	52,318	**2,747,983**
British Columbia	751,607	186,524	12,560	**950,691**
Yukon	91,911	19,873	2,839	**114,623**
Northwest Territories	280,325	94,433	8,172	**382,930**
Nunavut	239,718	122,612	11,215	**373,545**
Total Claim Lines	**18,221,543**	**2,623,026**	**324,755**	**21,169,324**

Source: HICPS adapted by Program Analysis Division

Figure 9.1.1 sets out the total number of pharmacy, dental and MS&E claims settled through the HICPS system in fiscal year 2013/14. During this period, a total of 21,169,324 claim lines were processed through HICPS, a decrease of 6.8% over the previous fiscal year. In addition, during 2013/14, a total of 950,691 claim lines were processed through HICPS in the British Columbia Region, a decrease of 68.6% over the previous fiscal year. This decrease in the number of claim lines settled through HICPS can be attributed to the transfer of First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA). The FNHA assumed the programs, services, and responsibilities formerly delivered by Health Canada's First Nations and Inuit Health Branch (FNIHB) for First Nation clients residing in British Columbia.

Claim Lines vs. Prescriptions

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

SECTION 9.2

Provider Audit Activities
2013/14

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 2013/14, the claims processor Express Scripts Canada (ESC) 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 2013/14, 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 2013/14, two dental providers were de-listed from the Program due to audit finding results and/or irregular billing patterns detected through provider profiling.

Benefit Audit Frameworks

As part of meeting its management accountability responsibilities, NIHB has developed additional audit frameworks for NIHB Medical Transportation, Vision Care and Mental Health Care benefits. These frameworks provide effective mechanisms to conduct reviews of these benefits and their associated expenditures. In 2013/14, one review was conducted on the NIHB Crisis Mental Health Benefit in the Alberta Region.

FIGURE 9.2.1

Audit Recoveries by Benefit and Region
2013/14

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 2013/14 fiscal year.

PHARMACY				
REGION	Audits Completed	Recoveries	NDCV/CCP Savings	Total Recoveries/ Savings
Atlantic	3	$ 24,304	$ 48,466	**$ 72,770**
Quebec	12	66,976	44,490	**111,466**
Ontario	13	184,201	365,607	**549,807**
Manitoba	17	218,658	134,996	**353,654**
Saskatchewan	15	96,411	47,561	**143,972**
Alberta	14	310,337	115,288	**425,625**
British Columbia	15	269,603	126,230	**395,833**
Yukon	1	876	434	**1,309**
N.W.T.	0	46,317	3,357	**49,674**
Nunavut	0	31,075	403	**31,478**
Total	**90**	**$ 1,248,757**	**$ 886,831**	**$ 2,135,588**

Note 1: Legal settlement recoveries via the Department of Justice Canada on behalf of Health Canada received during the fiscal year 2013/14 amounted to approximately $1.9 million.

Note 2: Pharmacy recoveries in the regions of Manitoba and British Columbia exclude FNHA recoveries.

DENTAL				
REGION	Audits Completed	Recoveries	NDCV/CCP Savings	Total Recoveries/ Savings
Atlantic	0	$ 4,030	$ 45,843	**$ 49,873**
Quebec	4	19,594	32,967	**52,561**
Ontario	5	6,885	140,685	**147,570**
Manitoba	7	1,691	106,636	**108,327**
Saskatchewan	9	76,047	59,142	**135,189**
Alberta	9	22,081	135,717	**157,798**
British Columbia	6	7,150	139,527	**146,677**
Yukon	1	0	3,705	**3,705**
N.W.T.	4	17,186	12,565	**29,751**
Nunavut	5	27,672	4,238	**31,910**
Total	**50**	**$ 182,336**	**$ 681,025**	**$ 863,361**

MEDICAL SUPPLIES AND EQUIPMENT				
REGION	Audits Completed	Recoveries	NDCV/CCP Savings	Total Recoveries/ Savings
Atlantic	0	$ 0	$ 563	**$ 563**
Quebec	0	0	729	**729**
Ontario	3	6,062	2,730	**8,792**
Manitoba	1	0	130	**130**
Saskatchewan	2	0	3,895	**3,895**
Alberta	0	1,730	1,255	**2,984**
British Columbia	0	7,067	330	**7,397**
Yukon	0	0	0	**0**
N.W.T.	0	0	0	**0**
Nunavut	0	0	0	**0**
Total	**6**	**$ 14,859**	**$ 9,632**	**$ 24,492**

* 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 DEC 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.

FIGURE 9.4.1

Total NIHB Drug Exception Centre Requests/Approvals

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 (LU) drugs, for prescriptions on which prescribers have indicated "No Substitution", and for claims that exceed $999.99.

Open Benefit (unrestricted): 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.

Open Benefit (restricted): Drugs included on the NIHB Drug Benefit List which have been restricted due to safety concerns. These drugs are part of the Prescription Drug Abuse Strategy, such as opioids, benzodiazepines, stimulants and gabapentin.

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.

Status	Open Benefit (unrestricted)	Open Benefit (restricted)	Exceptions	Limited Use	Total
Total Requested	4,440	4,604	50,688	75,864	**135,596**
Total Approved	3,188	4,523	41,830	58,092	**107,633**

Open Benefit (unrestricted): 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.

Open Benefit (restricted): Drugs included on the NIHB Drug Benefit List which have been restricted due to safety concerns. These drugs are part of the Prescription Drug Abuse Strategy, such as opioids, benzodiazepines, stimulants and gabapentin.

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 9.4.2

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 Limited Use (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, such as supporting the implementation of Prescription Drug Abuse Strategy.

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

The Health Information and Claims Processing System (HICPS) now 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.

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 was 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 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.

Please refer to the table below for 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 selected incontinence supplies On September 1, 2012. Information concerning the incontinence supplies covered by the Program is available on the Program's Medical Supplies and Equipment Benefit List (please visit the Health Canada website 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 2013/14, the Negotiations Secretariat negotiated a new pharmacy agreement with the Association québécoise des pharmaciens propriétaires and completed compensation adjustments for pharmacy providers in New Brunswick, Alberta and Saskatchewan. The Negotiations Secretariat also continued work on the NIHB national dental compensation framework including fee adjustments.

SECTION 9.8

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 9.9

Client and Provider Communications

The Non-Insured Health Benefits (NIHB) Program is continually seeking ways to improve communications with clients, providers and stakeholders regarding benefit coverage and administration.

The NIHB Program regularly produces newsletters and updates to inform clients and providers about any changes to NIHB policy and benefit coverage information. For example, NIHB registered providers for Dental, Pharmacy and Medical Supplies and Equipment receive policy updates and relevant information regarding benefits through both quarterly Provider newsletters and fax broadcasts.

The Provider newsletters are distributed by Health Canada's claims processing contractor, Express Scripts Canada (ESC), to registered providers and are available via the ESC website (password required) at: http://www.provider.express-scripts.ca

The NIHB website is a key venue for disseminating Program information. NIHB Program updates provide information for clients regarding updates to coverage that have taken place each month. They can be found on the Health Canada website at: http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/benefit-prestation/newsletter-bulletin-eng.php

In 2013/14, the NIHB Program produced a joint publication in collaboration with the Inuit Tapiriit Kanatami (ITK) for Inuit clients entitled, Your Health Benefits – A Guide for Inuit to Access Non-Insured Health Benefits, which contains essential information about all the non-insured health benefit programs available to Inuit: Health Canada's NIHB Program, the Nunatsiavut Non-Insured Health Benefits (NIHB) Program (administered by the Nunatsiavut Government), and Nunavik's Insured/Non-Insured Health Benefits (INIHB) Program (administered by the Nunavik Board of Health and Social Services). The Guide provides an overview of these three programs and explains eligibility, what is covered, and access to benefits. This Guide complements a similar publication produced jointly with the Assembly of First Nations (AFN) for First Nations clients in 2012-2013. The Guide is available on the Health Canada website at: http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/yhb-vss-inuit/index-eng.php

Client Safety

SECTION 10

PHARMACY BENEFIT

INTRODUCTION

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

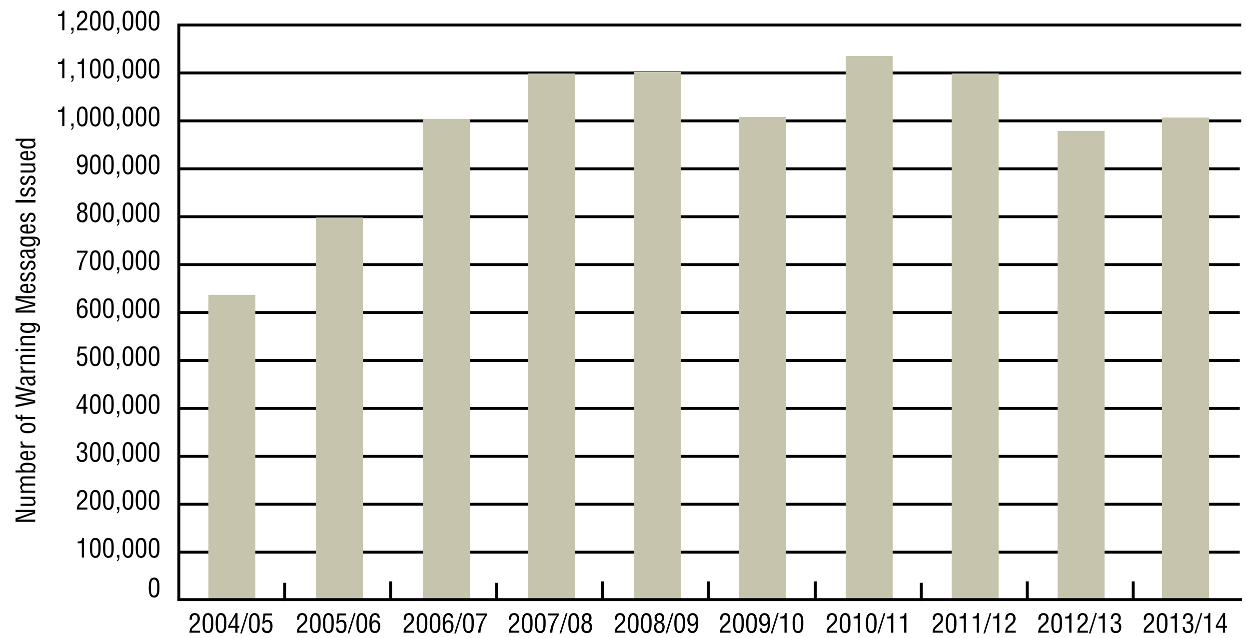
The NIHB Program continues to place a high priority on addressing cases of concern and on enhancing and encouraging the safe use of prescription medications. The NIHB Program has invested considerable time and effort in designing and modernizing its prescription drug benefit with these responsibilities 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
2004/05 to 2013/14



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 2013/14, the Program rejected a total of 1,602 claims for products that contain acetaminophen, as compared to 1,496 in 2012/13. The increase in rejected claims was driven by an NIHB policy change in October 2013 which decreased the maximum allowable dose of acetaminophen, from 4000mg daily to 3600mg daily.

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.

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.

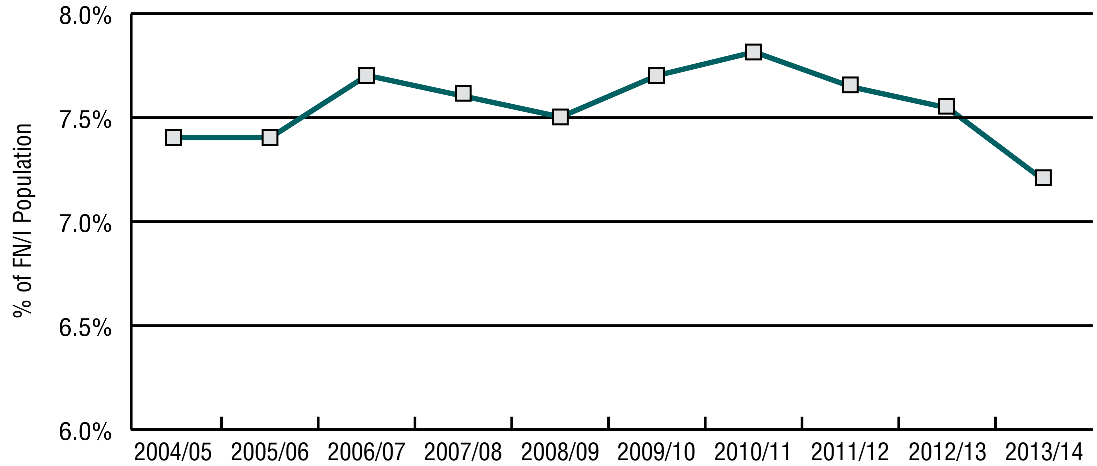
The NIHB Program is continuing its efforts to reduce the use of benzodiazepines. The percentage of clients accessing this class of drugs has been decreasing since 2010/11 (Figure 10.2). The number of clients exceeding the maximum recommended daily dose (equivalent to 40mg per day of diazepam) is shown 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) risk score calculation. 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 on a schedule until an acceptable level is reached.

As shown in figure 10.2, during 2013/14, the percentage of clients on benzodiazepines decreased by 4.7% over the previous fiscal year. If eligible FNHA clients are excluded from the 2012/13 and 2013/14 NIHB claims and client population the percentage of clients on benzodiazepines would have increased 0.1%.

FIGURE 10.2

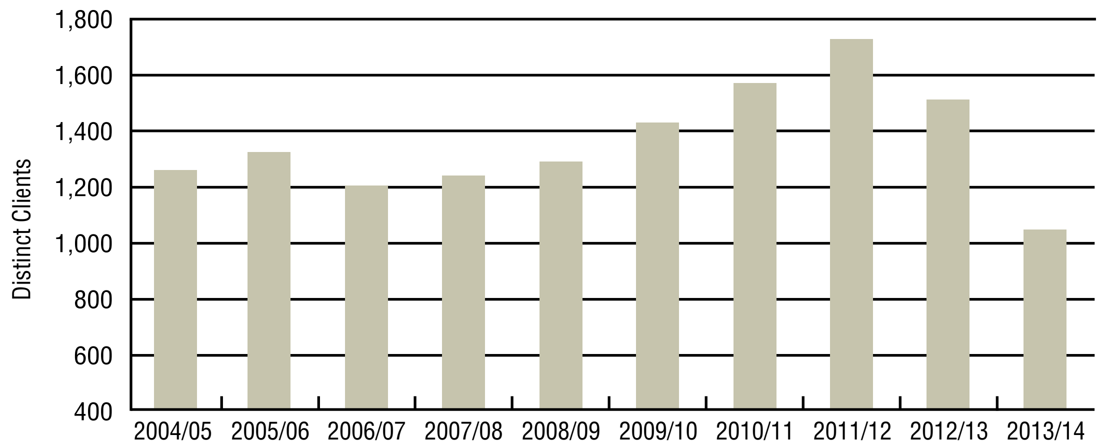
Percentage of Clients Receiving Benzodiazepines
2004/05 to 2013/14



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)
2004/05 to 2013/14



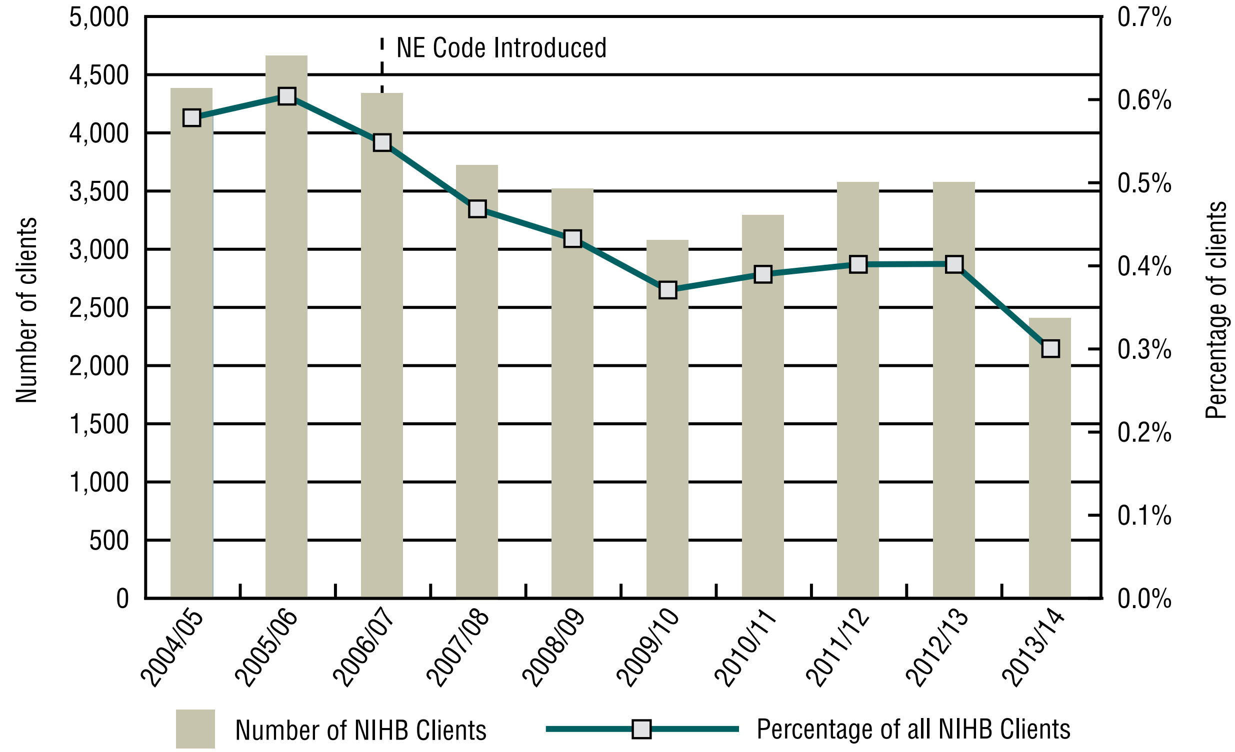
Source: HICPS adapted by Benefit Management Division

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 2013/14 (Figure 10.4).

In 2013/14, there were approximately 2,500 clients with concurrent claims for opioids, benzodiazepines and methadone. This represents 0.3% 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
2004/05 to 2013/14



Source: HICPS adapted by Benefit Management Division

Strategy #3: Evaluations and Recommendations from Independent Experts

The NIHB Program receives recommendations on client safety and drug listing decisions from the Drug and Therapeutic Advisory Committee (DTAC). The 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

Methadone for Addiction

Methadone is an opioid that can be used to treat chronic pain but is predominantly used to treat opioid dependence. The concurrent use of methadone and /or opioids and benzodiazepines should be avoided.

The NIHB Program worked on a national strategy to make methadone maintenance therapy (MMT) a limited use (LU) benefit. When a client is receiving methadone maintenance therapy, the client is placed in the NIHB Prescription Monitoring Program (NIHB-PMP) for the duration of MMT treatment, which ensures that only one prescriber writes prescriptions for opioids, benzodiazepines, stimulants and/or gabapentin in order to maximize safety and effectiveness and minimize the risk of harm, abuse and diversion.

This policy was implemented in New Brunswick in August 2011, the rest of the Atlantic Provinces in March 2012, Saskatchewan in May 2013, Manitoba in September 2013 and Alberta in March 2014. Other regions will be added in the future.

Changing the listing status of Ritalin (brand name) products

As of January 2013, the NIHB Program no longer provides reimbursement for brand name Ritalin and Ritalin SR, short and long acting methylphenidate products. The brand name Ritalin products have a higher potential for abuse and misuse than generic versions. The NIHB Drug Benefit List (DBL) lists various other options for the treatment of attention deficit hyperactivity disorder as open benefits, including generic short and long acting methylphenidate products, Dexedrine, Concerta and Vyvanse.

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

The maximum recommended daily dose of codeine can be exceeded when the maximum daily quantity of Tylenol #4 is used. As of January 2013, the NIHB Program no longer provides coverage for acetaminophen products containing 60mg of codeine (e.g. Tylenol with codeine No. 4). 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

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. On February 3, 2014, the NIHB Program decreased the limit to 4000mg /day.

Also on March 4, 2013, the NIHB Program introduced a dose limit for benzodiazepines, equal to 120mg diazepam equivalent per day. This limit will continue to gradually decrease until an acceptable level of 40 mg is reached. The NIHB Program is concerned when a client's dose of gabapentin or benzodiazepines exceeds the recommended dose limits.

Reduction in the Opioid Dose Limit

To ensure appropriate opioid use amongst NIHB clients, on September 30, 2013, the NIHB Program implemented an opioid dose limit of 600 mg morphine equivalents per day for clients with chronic non-cancer/non-palliative pain. This limit is calculated based on the total daily dose of all opioids a client is receiving covered through the Program. Many NIHB clients were seen with doses beyond the recommended limits, which can be harmful. According to the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain, "chronic non-cancer pain can be managed effectively in most patients with dosages at or below 200 mg/day of morphine or equivalent.

Consideration of a higher dosage requires careful reassessment of the pain and of risk for misuse, and frequent monitoring with evidence of improved patient outcomes."

Delisting of Talwin (pentazocine)

As of October 15, 2013, the NIHB Program no longer provides coverage for Talwin 50 mg tablets, and Talwin 30 mg/ml injectable. These products became exclusions to the NIHB Program. The delisting was based on the lack of evidence of clinical benefit, and an increased risk of adverse effects associated with the drug.

__Acetaminophen Dose Limit Change__

The dose limit for acetaminophen was modified by the NIHB Program on October 15, 2013. The limit is now calculated based on the total milligrams of acetaminophen dispensed to a client, and set at 3600 mg/day, or 360 g over a 100-day period. The limit continues to apply to all plain acetaminophen and opioid containing acetaminophen products and equals approximately 11 tablets/day of acetaminophen 325 mg, 12 tablets/day of acetaminophen 300 mg with codeine, or seven tablets/day of acetaminophen 500 mg. The previous limit was 12 tablets/day (or 1200 tablets per 100-day period) regardless of strength. Liver toxicity is associated with the use of both acute and chronic high doses of acetaminophen.

__Changing Opioids dispensing Frequency__

On February 25, 2014, the NIHB Program instituted a 30-day maximum dispense policy for all opioids. Previously the maximum dispense policy for all opioids was 100 days. The policy applies to all open benefit and limited use opioids covered under the Program, as well as to other opioids that are not listed, but are covered on a case-by-case basis. For safety reasons, the dispensing of smaller quantities of opioid will help to reduce harm and prevent diversion. Presently, 99% of all opioid claims to NIHB are for 30 days or less. Only the remaining 1% of opioid claims will be impacted by this policy.

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.

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. Anaesthesia services are provided in conjunction with eligible dental services and require 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.

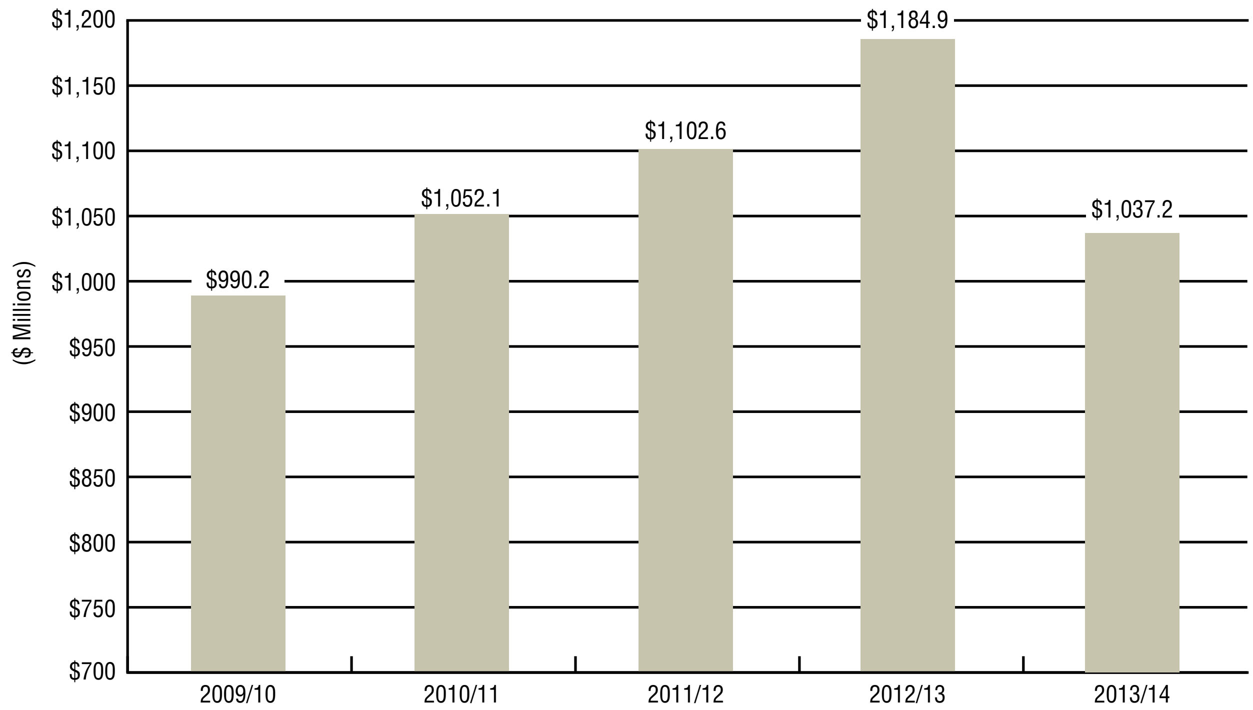
The NIHB Program is taking an active evidence-based approach to further develop client safety within the dental benefit policies. This approach stresses the appropriate use of dental services, within Program coverage, with a view of achieving the best possible health outcomes for eligible First Nations 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)
2009/10 to 2013/14



Source: Main Estimates

In 2013/14, total resources available to the NIHB Program were $1,037.2 million. This represented a 12.5% decrease over the $1,184.9 million in available funds in 2012/13. This decrease in NIHB Program resource expenditures can be attributed to the transfer of First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA) along with related expenditures for program resources.

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 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)
2013/14

Figure 11.2 provides the Program administration funds expended by each region as well as NIHB headquarters (HQ) in Ottawa. In 2013/14, total NIHB administration costs were $53.2 million representing an increase of $184 thousand or 0.3% over the previous fiscal year.

NIHB administrative costs in the British Columbia Region decreased by 48.1% from $1.9 million in 2012/13 to $975 thousand in 2013/14. This decrease is attributed to the transfer of salary funds to the First Nations Health Authority (FNHA) which became responsible for the programs and services formerly delivered by Health Canada's First Nations and Inuit Health Branch (FNIHB) for First Nation clients residing in British Columbia.

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:

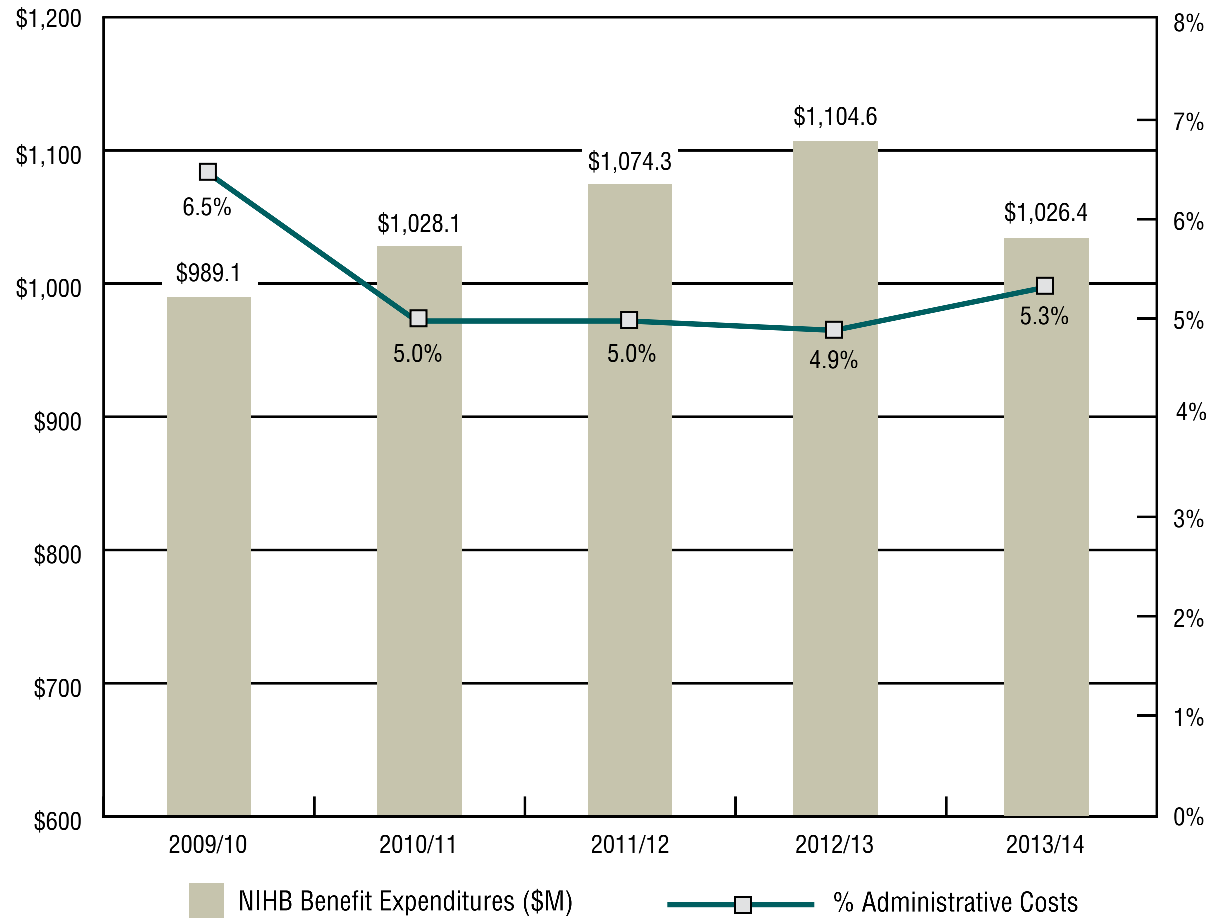
- Adjudicating benefit requests for medical transportation, medical supplies and equipment, dental, vision benefits, and short-term crisis intervention mental health counselling;
- Working with NIHB headquarters on policy development, provider negotiations and audits; and
- Maintaining productive relationships 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	$ 1,385	$ 1,695	$ 3,063	$ 2,682	$ 2,800	$ 2,676	$ 744	$ 750	$ 10,311	$ 26,105
Capital	0	0	0	0	0	0	0	0	0	0
EBP	277	339	613	536	560	535	149	150	2,062	5,221
Operating	83	84	388	66	63	167	83	14	1,065	2,013
Sub Total	**$ 1,744**	**$ 2,118**	**$ 4,063**	**$ 3,284**	**$ 3,423**	**$ 3,379**	**$ 975**	**$ 913**	**$ 13,438**	**$ 33,339**
Claims Processing Contract Costs										**$ 19,852**
Total Administration Costs										**$ 53,191**

Source: FIRMS adapted by Program Analysis Division

FIGURE 11.3

Non-Insured Health Benefits Administration Costs as a Proportion of Benefit Expenditures ($ Millions)
2009/10 to 2013/14



Source: FIRMS adapted by Program Analysis Division

Figure 11.3 provides the percentage of NIHB Program administrative costs as a proportion of overall NIHB benefit expenditures. In 2013/14, total NIHB expenditures were $1,026.4 million, of which actual benefit expenditures totaled $1,006.5 million and expenditures for claims processing administration amounted to $19.9 million. An additional $33.3 million in expenditures for salaries associated with Program administration are reported separately from total program expenditures. As a result, total NIHB Program administration cost ($53.2 million) as a proportion of actual benefit expenditures ($1,006.5 million) was 5.3% in 2013/14.

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 6.5% in 2009/10 to a low of 4.9% in 2012/13.

In 2013/14, the percentage of NIHB administrative costs as a proportion of total benefit expenditures increased compared to the previous fiscal year. This increase can be attributed to the transfer of benefit expenditures for First Nation clients residing in the British Columbia region to the First Nations Health Authority (FNHA) which caused the proportion of administrative costs to increase.

Technical Notes

Information contained in the 2013/14 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.

In 2013/14, a new version of the MTDS was released to enhance the data collection method and improve the reporting capability of the data store. These enhancements ensure that the MTDS responds reliably to NIHB's analytical needs, and allows accurate analysis of Medical Transportation (MT) cost drivers in order to manage the efficiency and effectiveness of the MT benefit. 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).