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Non-Insured Health Benefits Program

First Nations and Inuit Health Branch

Annual Report 2015/2016

Canada

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Introduction

SECTION 1

During 2015/16, the Non-Insured Health Benefits (NIHB) Program of the First Nations and Inuit Health Branch (FNIHB) at Health Canada provided 839,129 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;
- Short-term crisis intervention mental health counselling; and
- Medical transportation to access medically required health services not available on reserve or in the community of residence.

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 twenty-second edition, the 2015/16 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 2015/16, 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.

SECTION 2

Client Population

As of March 31, 2016, there were 839,129 First Nations and Inuit clients registered in the Status Verification System (SVS) who 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. Of the 839,129 total eligible clients at the end of the 2015/16 fiscal year, 793,187 (94.5%) were First Nations clients while 45,942 (5.5%) 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, 2016, a total of 35,288 clients had become eligible to receive benefits through the NIHB Program as a result of this 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, members of the Qalipu Mi'kmaq became recognized under the *Indian Act* and eligible for registration. As of March 31, 2016, a total of 24,327 Qalipu clients were registered in the SVS and were eligible to receive benefits through the NIHB Program.

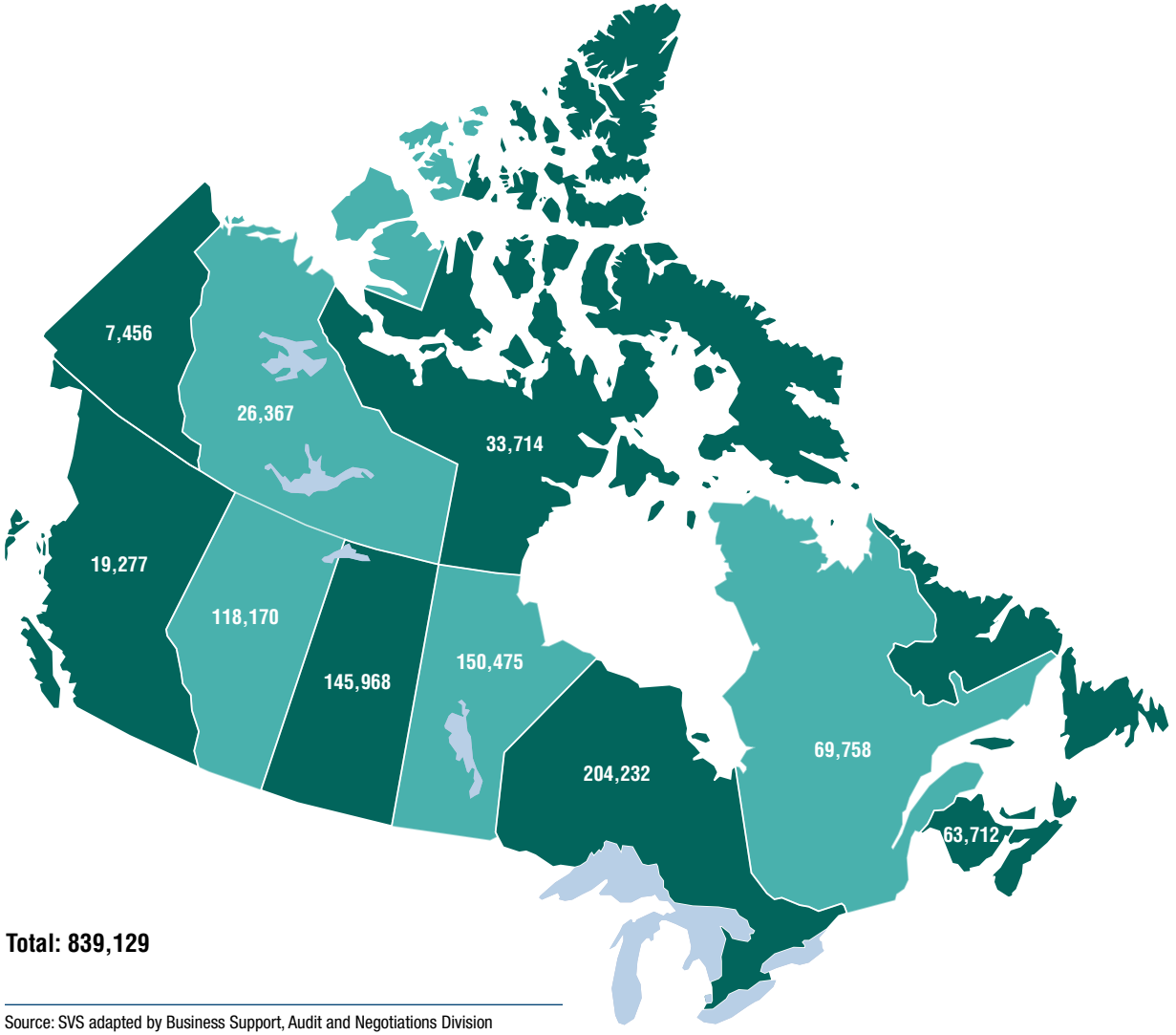
FIGURE 2.1

Eligible Client Population by Region
March 2016

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 2016 was 839,129, an increase of 1.8% from March 2015.

The Ontario Region had the largest proportion of eligible population, representing 24.3% of the national total, followed by the Manitoba Region at 17.9% and the Saskatchewan Region at 17.4%.

Note that Figure 2.1 lists population values based on region of band registration, which is not necessarily region of residence. The majority of B.C. clients previously covered by the NIHB Program are currently covered by the B.C. First Nation Health Authority (FNHA) and are not represented in this chart. The remaining B.C. population are Inuit clients or clients associated with B.C. bands, but residing in other provinces and territories of Canada.



Total: 839,129

Source: SVS adapted by Business Support, Audit and Negotiations Division

FIGURE 2.2

Eligible Client Population by Type and Region
March 2015 and March 2016

Of the 839,129 total eligible clients at the end of the 2015/16 fiscal year, 793,187 (94.5%) were First Nations clients while 45,942 (5.5%) were Inuit clients. The number of First Nations clients increased by 1.8% and the number of Inuit clients increased by 2.7%.

From March 2015 to March 2016, Northwest Territories had the highest percentage change in total eligible clients with a 3.0% increase, followed by Quebec and Alberta with an increase of 2.2% and 2.0% respectively.

REGION	First Nations		Inuit		TOTAL		% Change
	March 2015	March 2016	March 2015	March 2016	March 2015	March 2016	2015 to 2016
Atlantic	62,418	63,362	338	350	62,756	63,712	1.5%
Quebec	66,965	68,384	1,309	1,374	68,274	69,758	2.2%
Ontario	199,837	203,517	681	715	200,518	204,232	1.9%
Manitoba	147,739	150,277	193	198	147,932	150,475	1.7%
Saskatchewan	143,163	145,899	65	69	143,228	145,968	1.9%
Alberta	115,299	117,561	587	609	115,886	118,170	2.0%
British Columbia	18,964	18,938	319	339	19,283	19,277	0.0%
Yukon	7,303	7,350	99	106	7,402	7,456	0.7%
N.W.T.	17,612	17,899	7,975	8,468	25,587	26,367	3.0%
Nunavut	0	0	33,167	33,714	33,167	33,714	1.6%
National	**779,300**	**793,187**	**44,733**	**45,942**	**824,033**	**839,129**	**1.8%**

Source: SVS adapted by Business Support, Audit and Negotiations Division

FIGURE 2.3

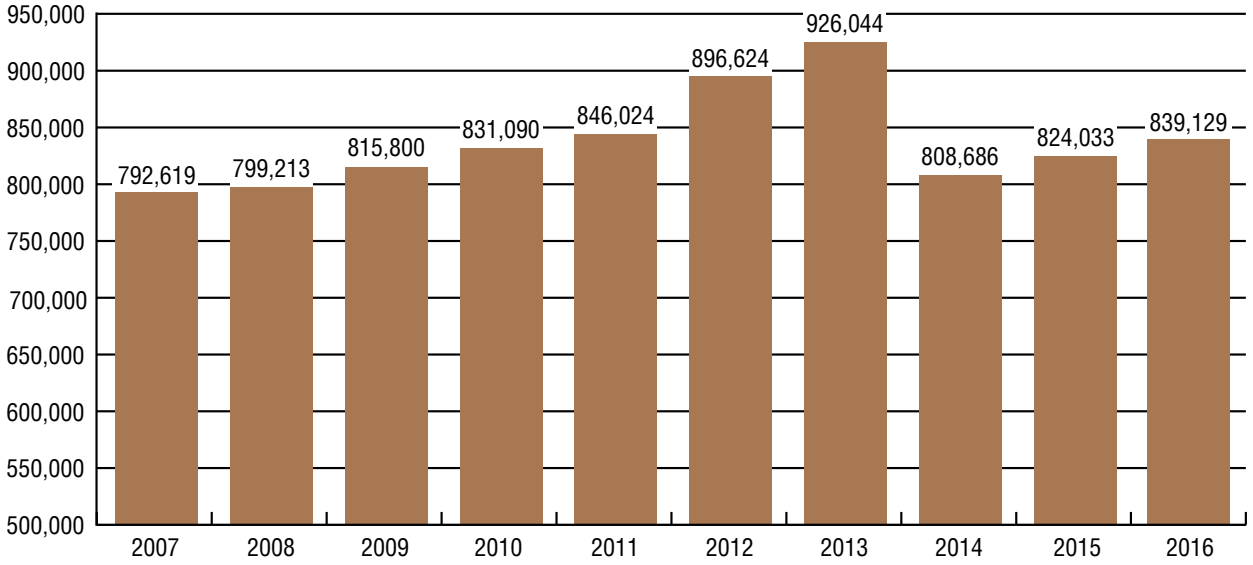
Eligible Client Population

Over the past 10 years, the total number of eligible clients in the SVS has increased by 5.9%, from 792,619 in March 2007 to 839,129 in March 2016.

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 6.4% from 896,624 in March 2012 to 839,129 in March 2016. The Quebec Region had the largest increase in eligible clients over this period, with a growth rate of 10.4%. The regions of Atlantic, Nunavut, and Ontario followed with growth rates of 9.3%, 8.6% and 7.5% respectively.

Eligible Client Population, March 2007 to March 2016



Source: SVS adapted by Business Support, Audit and Negotiations Division

Eligible Client Population by Region, March 2012 to March 2016

REGION	March 2012	March 2013	March 2014	March 2015	March 2016
Atlantic	58,271	62,030	62,015	62,756	63,712
Quebec	63,209	65,944	66,819	68,274	69,758
Ontario	189,903	197,019	197,092	200,518	204,232
Manitoba	140,987	144,748	144,416	147,932	150,475
Saskatchewan	138,513	142,056	140,164	143,228	145,968
Alberta	112,264	115,867	113,590	115,886	118,170
British Columbia	128,597	131,782	19,628	19,283	19,277
Yukon	8,430	8,682	7,138	7,402	7,456
N.W.T.	25,412	26,125	25,434	25,587	26,367
Nunavut	31,038	31,791	32,390	33,167	33,714
Total	**896,624**	**926,044**	**808,686**	**824,033**	**839,129**
Annual % Change	**6.0%**	**3.3%**	**-12.7%**	**1.9%**	**1.8%**

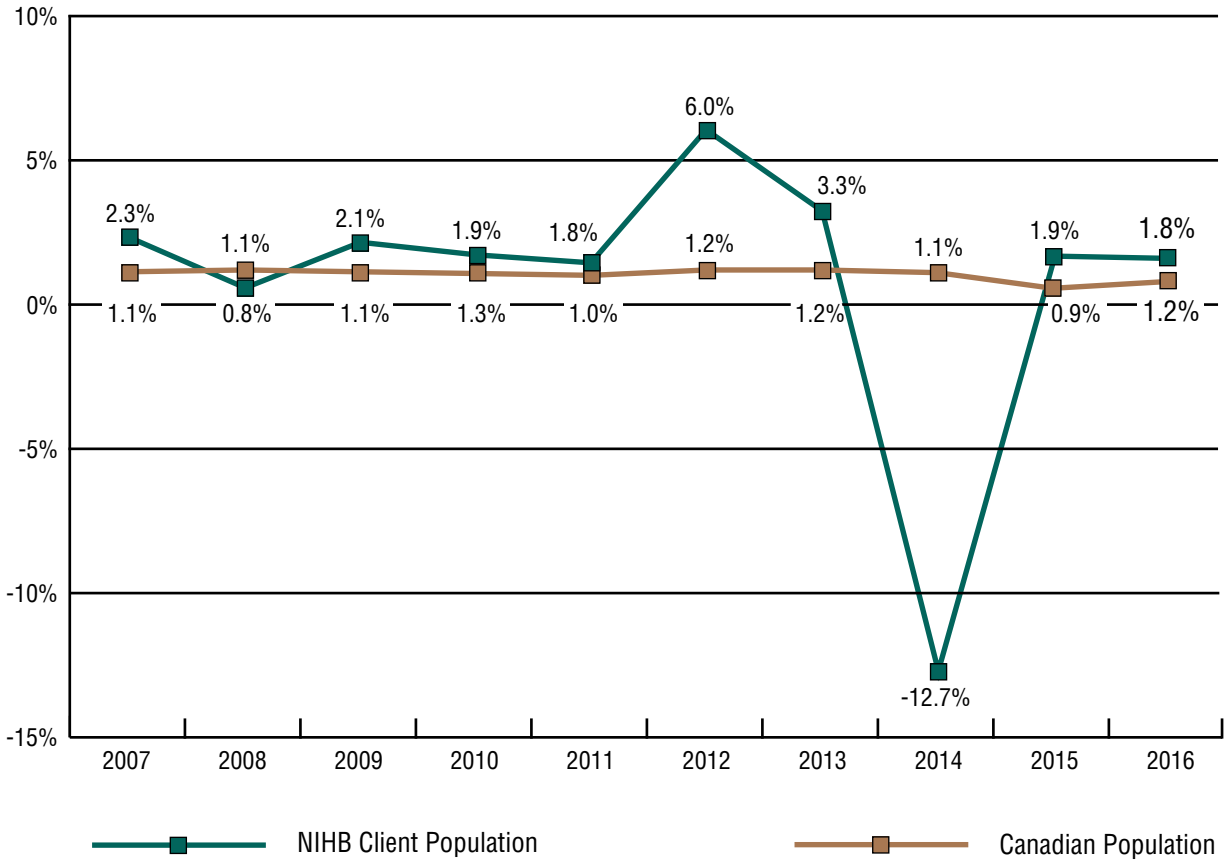
Source: SVS adapted by Business Support, Audit and Negotiations Division

FIGURE 2.4

Annual Population Growth, Canadian Population and Eligible Client Population
2007 to 2016

From 2007 to 2016, the Canadian population increased by 10.5% while the NIHB eligible First Nations and Inuit client population increased by 5.9%. 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, adapted by Business Support, Audit and Negotiations Division

FIGURE 2.5

Eligible Client Population by Age Group, Gender and Region
March 2016

Of the 839,129 NIHB eligible clients on the SVS as of March 31, 2016, 49.2% were male (412,878) and 50.8% were female (426,251).

The average age of the eligible client population was 32 years of age. By region, this average ranged from a low of 27 years of age in Nunavut to a high of 37 years of age in the Quebec and Yukon Regions.

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

The NIHB eligible First Nations and Inuit client population is relatively young with nearly two-thirds (65.2%) under the age of 40. Of the total population, over one-third (33.5%) are under the age of 20.

The senior population (clients 65 years of age and over) has been slowly increasing as a proportion of the total NIHB client population. In 2005/06, seniors represented 5.6% of the overall NIHB population. Most recently in 2015/16, seniors accounted for 7.5%. 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	1,409	1,394	2,803	1,739	1,665	3,404	4,925	4,836	9,761	5,895	5,613	11,508
5–9	2,392	2,258	4,650	2,715	2,531	5,246	7,496	7,213	14,709	8,482	8,307	16,789
10–14	2,587	2,509	5,096	2,537	2,347	4,884	7,684	7,204	14,888	7,602	7,311	14,913
15–19	2,682	2,636	5,318	2,647	2,532	5,179	8,171	7,980	16,151	7,445	7,079	14,524
20–24	2,906	2,846	5,752	2,984	2,878	5,862	9,033	8,761	17,794	7,645	7,462	15,107
25–29	2,625	2,548	5,173	2,678	2,688	5,366	8,320	8,173	16,493	6,621	6,480	13,101
30–34	2,344	2,333	4,677	2,356	2,347	4,703	7,286	7,268	14,554	5,395	5,174	10,569
35–39	2,122	2,156	4,278	2,191	2,174	4,365	6,727	6,916	13,643	4,645	4,529	9,174
40–44	2,196	2,168	4,364	2,149	2,292	4,441	6,726	6,755	13,481	4,497	4,573	9,070
45–49	2,231	2,322	4,553	2,299	2,441	4,740	6,828	7,134	13,962	4,419	4,550	8,969
50–54	2,093	2,258	4,351	2,423	2,679	5,102	7,007	7,488	14,495	3,855	4,183	8,038
55–59	1,740	2,079	3,819	2,137	2,552	4,689	5,956	6,867	12,823	3,018	3,250	6,268
60–64	1,375	1,689	3,064	1,617	1,972	3,589	4,305	5,475	9,780	1,998	2,410	4,408
65+	2,498	3,316	5,814	3,247	4,941	8,188	8,780	12,918	21,698	3,447	4,590	8,037
Total	**31,200**	**32,512**	**63,712**	**33,719**	**36,039**	**69,758**	**99,244**	**104,988**	**204,232**	**74,964**	**75,511**	**150,475**
Average Age	34	36	35	35	38	37	35	37	36	29	30	30

Source: SVS adapted by Business Support, Audit and Negotiations Division

REGION	Saskatchewan			Alberta			British Columbia			Yukon			N.W.T.			Nunavut			TOTAL		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0–4	4,930	4,891	9,821	4,320	4,005	8,325	1,167	1,159	2,326	159	146	305	693	674	1,367	1,907	1,826	3,733	27,144	26,209	53,353
5–9	8,276	7,855	16,131	6,793	6,573	13,366	680	634	1,314	259	215	474	1,047	979	2,026	2,104	2,040	4,144	40,244	38,605	78,849
10–14	7,456	7,481	14,937	6,115	5,918	12,033	594	606	1,200	242	243	485	958	1,001	1,959	1,853	1,757	3,610	37,628	36,377	74,005
15–19	7,395	7,222	14,617	5,989	5,640	11,629	713	607	1,320	304	253	557	1,044	1,015	2,059	1,726	1,625	3,351	38,116	36,589	74,705
20–24	7,584	7,412	14,996	6,107	5,733	11,840	782	650	1,432	309	305	614	1,444	1,354	2,798	1,604	1,596	3,200	40,398	38,997	79,395
25–29	6,925	6,810	13,735	5,364	5,266	10,630	784	676	1,460	320	303	623	1,310	1,317	2,627	1,557	1,468	3,025	36,504	35,729	72,233
30–34	5,587	5,553	11,140	4,541	4,488	9,029	737	723	1,460	306	286	592	1,053	983	2,036	1,171	1,163	2,334	30,776	30,318	61,094
35–39	4,750	4,618	9,368	3,710	3,773	7,483	665	661	1,326	259	221	480	882	903	1,785	976	1,013	1,989	26,927	26,964	53,891
40–44	4,243	4,517	8,760	3,416	3,527	6,943	603	570	1,173	260	234	494	826	864	1,690	860	886	1,746	25,776	26,386	52,162
45–49	4,246	4,377	8,623	3,215	3,448	6,663	594	670	1,264	305	242	547	939	967	1,906	931	910	1,841	26,007	27,061	53,068
50–54	3,527	3,892	7,419	2,873	3,163	6,036	532	711	1,243	346	354	700	812	925	1,737	725	777	1,502	24,193	26,430	50,623
55–59	2,681	3,072	5,753	2,120	2,549	4,669	448	652	1,100	227	278	505	591	735	1,326	509	506	1,015	19,427	22,540	41,967
60–64	1,774	2,059	3,833	1,460	1,897	3,357	291	465	756	154	203	357	412	525	937	350	371	721	13,736	17,066	30,802
65+	2,845	3,990	6,835	2,535	3,632	6,167	695	1,208	1,903	281	442	723	952	1,162	2,114	722	781	1,503	26,002	36,980	62,982
Total	**72,219**	**73,749**	**145,968**	**58,558**	**59,612**	**118,170**	**9,285**	**9,992**	**19,277**	**3,731**	**3,725**	**7,456**	**12,963**	**13,404**	**26,367**	**16,995**	**16,719**	**33,714**	**412,878**	**426,251**	**839,129**
Average Age	28	30	29	28	30	29	31	36	34	36	38	37	33	35	34	26	27	27	31	33	32

FIGURE 2.6

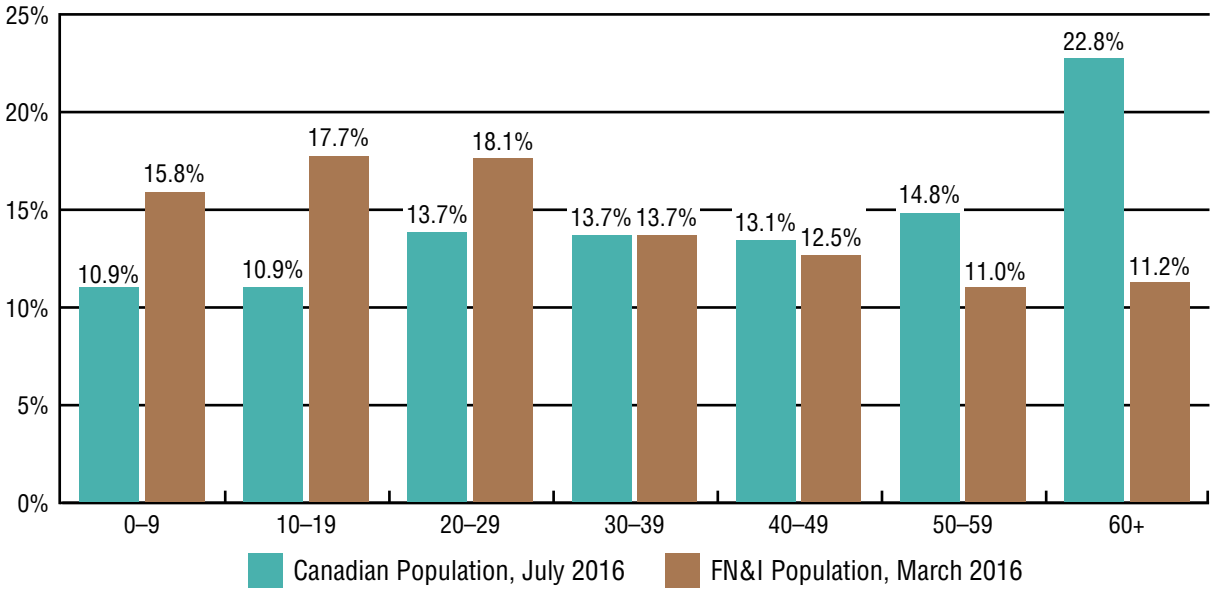
Population Analysis by Age Group

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 33.5% compared to 21.8% of the same age group in the Canadian population. The average age of First Nations and Inuit clients is 32 compared to 41 years of age for the Canadian population.

A comparison of March 2012 to March 2016 eligible client population shows an aging population. The client population 40 and above, as a proportional share of the overall client population, increased from 33.9% in 2012 to 34.8% in 2016.

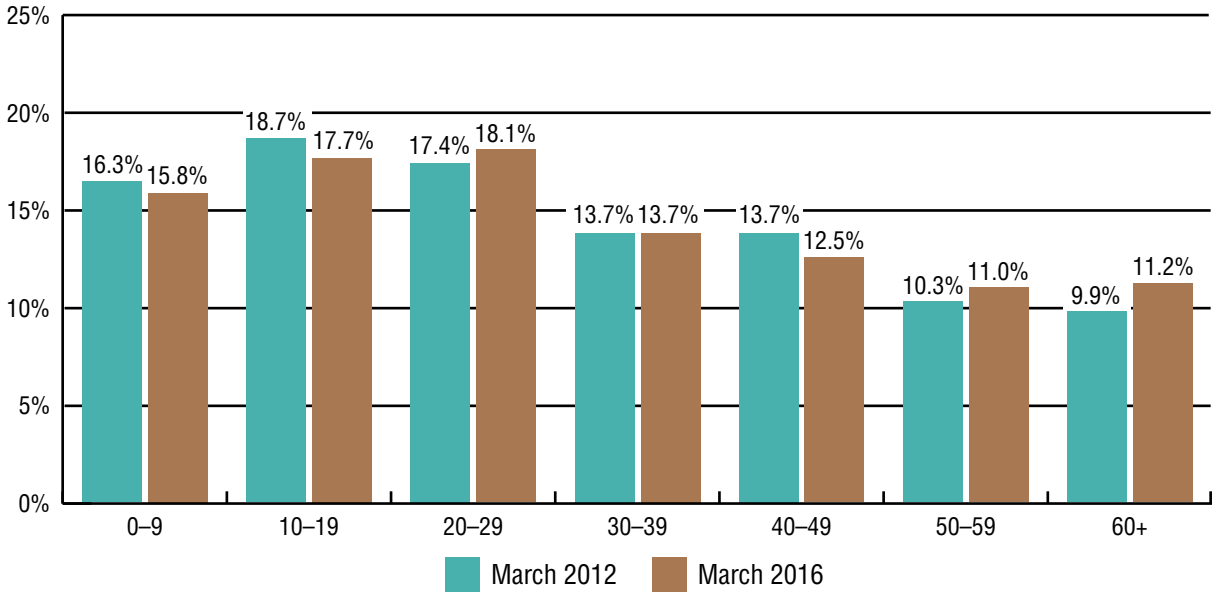
As the First Nations and Inuit client population ages, the costs associated with delivering Non-Insured Health Benefits, particularly pharmacy benefits, to this client population are expected to increase significantly.

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



Source: SVS and Statistics Canada CANSIM table 051-0001, Population by Age and Sex Group, adapted by Business Support, Audit and Negotiations Division

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



Source: SVS adapted by Business Support, Audit and Negotiations Division

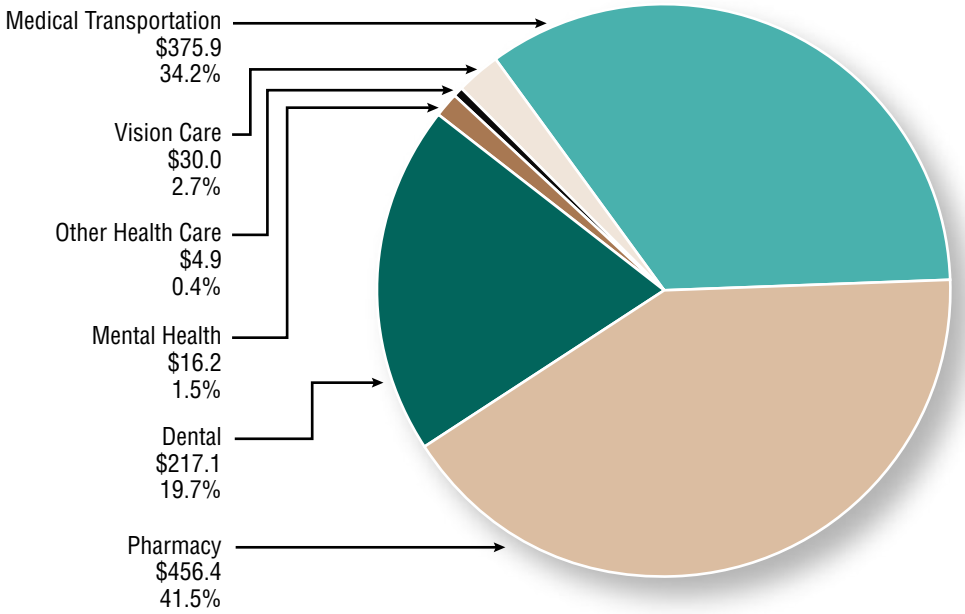
NIHB Program Expenditures

FIGURE 3.1

NIHB Expenditures by Benefit ($ Millions)
2015/16

In 2015/16, total NIHB expenditures were $1,100.5 million. This represents an increase of 6.7% over total NIHB expenditures of $1,031.5 million in 2014/15. Of the 2015/16 total, Pharmacy costs (including medical supplies and equipment) represented the largest proportion at $456.4 million (41.5%), followed by Medical Transportation costs at $375.9 million (34.2%) and Dental costs at $217.1 million (19.7%).

NIHB Pharmacy, Dental and Medical Transportation benefit expenditures accounted for 95.4% of total NIHB expenditures in 2015/16.



Total NIHB Expenditures: $1,100.5M*

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

* Not reflected in the $1,100.5 million in NIHB expenditures is approximately $34.5 million in administration costs including Program staff and other headquarters and regional costs. More detail is provided in Figure 11.1.

FIGURE 3.2

NIHB Expenditures and Growth by Benefit
2015/16

NIHB Program expenditures increased by 6.7%, or $69.0 million overall from 2014/15. All NIHB benefit areas had an increase in expenditures over the previous fiscal year. The highest net increase in expenditures over fiscal year 2014/15 was in the NIHB Pharmacy benefits at $34.1 million, followed by NIHB Medical Transportation benefits with an increase of $17.9 million and NIHB Dental benefits which increased by $15.2 million.

BENEFIT	Total Expenditures ($ 000's) 2014/15*	Total Expenditures ($ 000's) 2015/16	% Change From 2014/15
Medical Transportation	$ 357,963	$ 375,904	5.0%
Pharmacy	422,350	456,430	8.1%
Dental	201,886	217,109	7.5%
Vision Care	29,704	30,017	1.1%
Mental Health	15,581	16,193	3.9%
Other	4,005	4,858	21.3%
Total Expenditures	$ 1,031,488	$ 1,100,512	6.7%

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

* Values differ from 2014/15 NIHB Annual Report as specific benefit expenditures were restated in Alberta.

FIGURE 3.3

NIHB Expenditures by Benefit and Region ($ 000's)
2015/16

The Manitoba Region accounted for the highest proportion of total expenditures at $258.1 million, or 23.5% of the national total, followed by the Ontario Region at $215.7 million (19.6%), and the Saskatchewan Region at $193.5 million (17.6%). In comparison, the lowest expenditure was in the Atlantic Region at $50.8 million (4.6%).

Headquarters expenditures represent costs paid for claims processing services, as well as various contribution agreements including funding arrangements with the FNHA for Bill C-3 and Qalipu clients and for payment of Inuit premiums in British Columbia. Other expenditures in this category include partner contribution agreements related to Program oversight. Total Headquarters expenditures account for 2.2% ($24.0 million) of NIHB expenditures. This figure does not include the $15.0 million in Headquarters administrative costs outlined in Figure 11.1.

REGION	Medical Transportation	Pharmacy	Dental	Vision Care	Mental Health	Other Health Care	TOTAL
Atlantic	$ 8,380	$ 30,064	$ 8,846	$ 3,021	$ 419	$ 44	**$ 50,773**
Quebec	23,687	44,206	16,641	1,749	1,148	258	**87,690**
Ontario	67,772	88,872	49,903	6,160	3,021	11	**215,738**
Manitoba	125,308	87,997	36,764	4,212	3,780	17	**258,077**
Saskatchewan	53,566	91,170	41,028	6,104	1,631	4	**193,502**
Alberta	46,252	69,992	39,753	6,207	6,003	3	**168,211**
North	50,940	27,408	20,936	2,564	191	1	**102,040**
Headquarters	0	16,546	2,920	0	0	4,521	**23,987**
Total	$ $375,904	$ 456,430	$ 217,109	$ 30,017	$ 16,193	$ 4,858	$ 1,100,512

Source: FIRMS adapted by by Business Support, Audit and Negotiations Division

FIGURE 3.4

Proportion of NIHB Expenditures by Region
2015/16

In 2015/16, the Manitoba Region had the highest proportion of total NIHB expenditures (23.5%) and accounted for 33.3% 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 Saskatchewan Region accounted for the highest proportion of NIHB Pharmacy expenditures at 20.0%, followed closely by both Ontario and Manitoba at 19.5% and 19.3% respectively.

The Ontario Region, which accounted for 19.6% of total NIHB expenditures in 2015/16, recorded the highest proportion of total NIHB Dental expenditures at 23.0%. This region also accounted for the highest proportion of the total NIHB population at 24.3%.

The proportion of NIHB Vision Care expenditures ranged from a high of 20.7% in the Alberta Region, 20.5% in the Ontario Region and 20.3% in the Saskatchewan Region to a low of 5.8 % in Quebec.

The Alberta Region (37.1%) and the Manitoba Region (23.3%) combined accounted for over one half of total NIHB Mental Health expenditures in 2015/16.

REGION	Medical Transportation	Pharmacy	Dental	Vision Care	Mental Health	Other Health Care	Proportion of NIHB Expenditure	Proportion of NIHB Population
Atlantic	2.2%	6.6%	4.1%	10.1%	2.6%	0.9%	**4.6%**	**7.6%**
Quebec	6.3%	9.7%	7.7%	5.8%	7.1%	5.3%	**8.0%**	**8.3%**
Ontario	18.0%	19.5%	23.0%	20.5%	18.7%	0.2%	**19.6%**	**24.3%**
Manitoba	33.3%	19.3%	16.9%	14.0%	23.3%	0.3%	**23.5%**	**17.9%**
Saskatchewan	14.2%	20.0%	18.9%	20.3%	10.1%	0.1%	**17.6%**	**17.4%**
Alberta	12.3%	15.3%	18.3%	20.7%	37.1%	0.1%	**15.3%**	**14.1%**
North	13.6%	6.0%	9.6%	8.5%	1.2%	0.0%	**9.3%**	**8.0%**
Headquarters	0.0%	3.6%	1.3%	0.0%	0.0%	93.1%	**2.2%**	**0.0%**
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: FIRMS and SVS adapted by Business Support, Audit and Negotiations Division

FIGURE 3.5

Proportion of NIHB Regional Expenditures by Benefit
2015/16

At the national level, approximately three-quarters (75.6%) of total Program expenditures occurred in two benefit areas: pharmacy (41.5%) and medical transportation (34.2%). Dental expenditures accounted for one-fifth (19.7%) of total NIHB expenditures.

NIHB Medical Transportation expenditures accounted for nearly half (49.9%) of total expenditures in the Northern Region. In the Atlantic Region, 59.2% of total expenditures were spent on pharmacy benefits.

The proportion of dental expenditures ranged from 14.2% in the Manitoba Region to 23.6% and 23.1% in Alberta and Ontario respectively.

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

REGION	Medical Transportation	Pharmacy	Dental	Vision Care	Mental Health	Other Health Care	TOTAL
Atlantic	16.5%	59.2%	17.4%	5.9%	0.8%	0.1%	**100%**
Quebec	27.0%	50.4%	19.0%	2.0%	1.3%	0.3%	**100%**
Ontario	31.4%	41.2%	23.1%	2.9%	1.4%	0.0%	**100%**
Manitoba	48.6%	34.1%	14.2%	1.6%	1.5%	0.0%	**100%**
Saskatchewan	27.7%	47.1%	21.2%	3.2%	0.8%	0.0%	**100%**
Alberta	27.5%	41.6%	23.6%	3.7%	3.6%	0.0%	**100%**
North	49.9%	26.9%	20.5%	2.5%	0.2%	0.0%	**100%**
Headquarters	0.0%	69.0%	12.2%	0.0%	0.0%	18.8%	**100%**
National	**34.2%**	**41.5%**	**19.7%**	**2.7%**	**1.5%**	**0.4%**	**100%**

Source: FIRMS and SVS adapted by Business Support, Audit and Negotiations Division

FIGURE 3.6

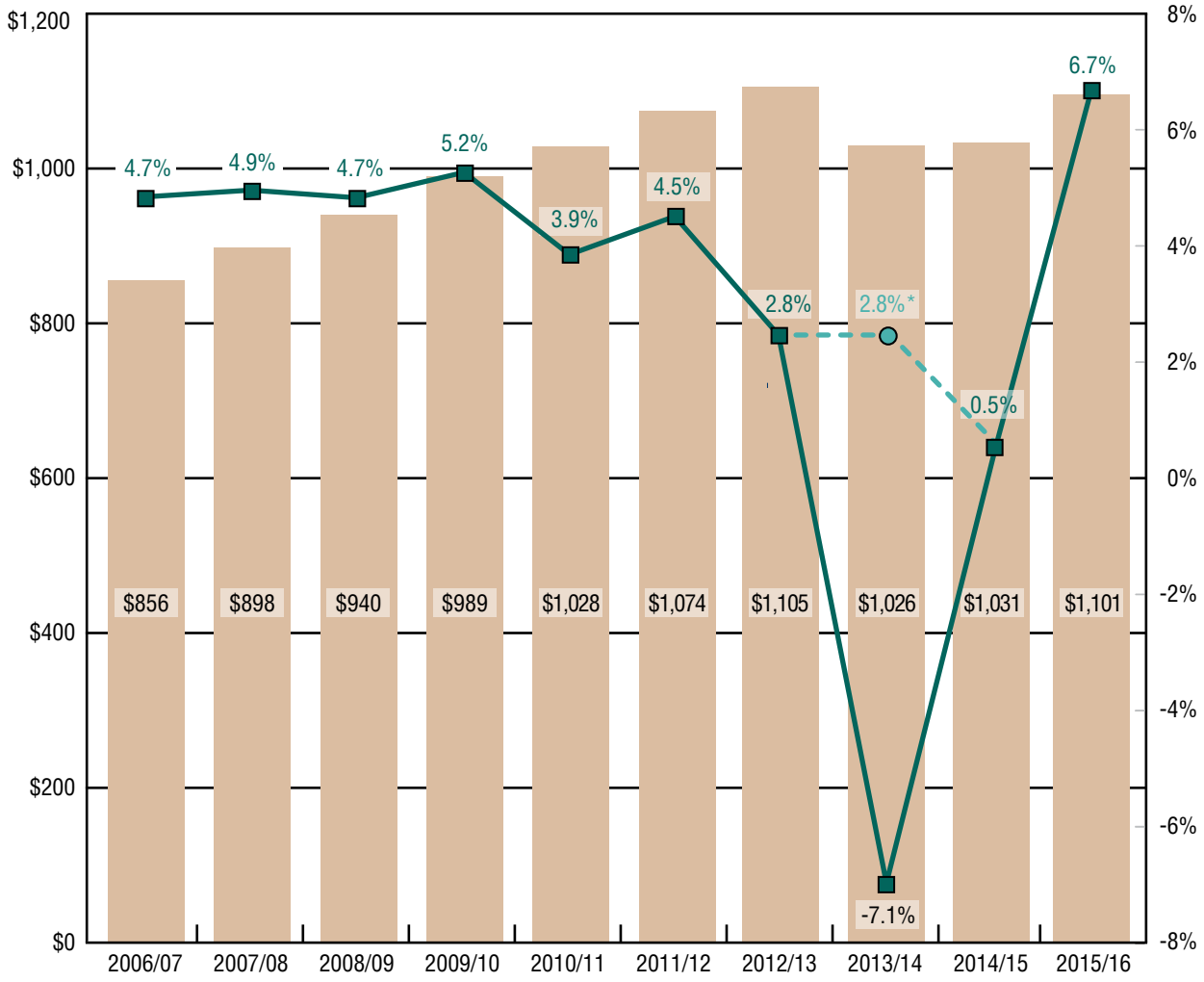
NIHB Annual Expenditures ($ Millions) and Percentage Change
2006/07 to 2015/16

In 2015/16, NIHB Program expenditures totalled $1,100.5 million, an increase of 6.7% from $1,031.5 million in 2014/15. Since 2006/07, total expenditures have grown by 28.5%. The annualized rate of growth over this period was 3.0%. There has been wide variation in growth rates between 2006/07 and 2015/16, with a low of -7.1% in 2013/14 to a high of 6.7 % in 2015/16.

Fluctuations in NIHB expenditure growth rates are impacted by a number of 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.

Other factors which affect growth include Program changes such as the centralization of dental benefits in 2012/13, the transfer of responsibility for First Nations clients residing in BC to the FNHA in 2013/14, and court decisions resulting in new eligible client populations such as the creation of the Qalipu Mi'kmaq Band. 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.

*If expenditures for FNHA eligible clients are excluded from 2012/13 and 2013/14 total NIHB expenditures, then the growth rate for 2013/14 would have been 2.8%.



Source: FIRMS and SVS adapted by by Business Support, Audit and Negotiations Division

FIGURE 3.7

NIHB Annual Expenditures by Benefit ($ 000's)
2006/07 to 2015/16

In the period from 2006/07 to 2015/16, the expenditures for NIHB Medical Transportation and Dental benefits have grown more than other benefit areas. NIHB Medical Transportation expenditures grew by 55.6% from $241.6 million in 2006/07 to $375.9 million in 2015/16. NIHB Dental expenditures rose by 36.9% from $158.6 million in 2006/07 to $217.1 million in 2015/16.

Over the same period, NIHB Pharmacy expenditures increased by 18.2% and NIHB Vision expenditures had an increase of 20.6%.

NIHB Mental Health expenditures decreased by 0.5% over this same time period from $16.3 million in 2006/07 to $16.2 million in 2015/16. 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.

The decrease in NIHB Premiums expenditures 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). Other expenditures in 2014/15 include various contribution agreements including funding arrangements with the FNHA for Bill C-3 and Qalipu clients and for payment of health premiums for Inuit clients in British Columbia. Additional expenditures in this category include partner contribution agreements related to Program oversight.

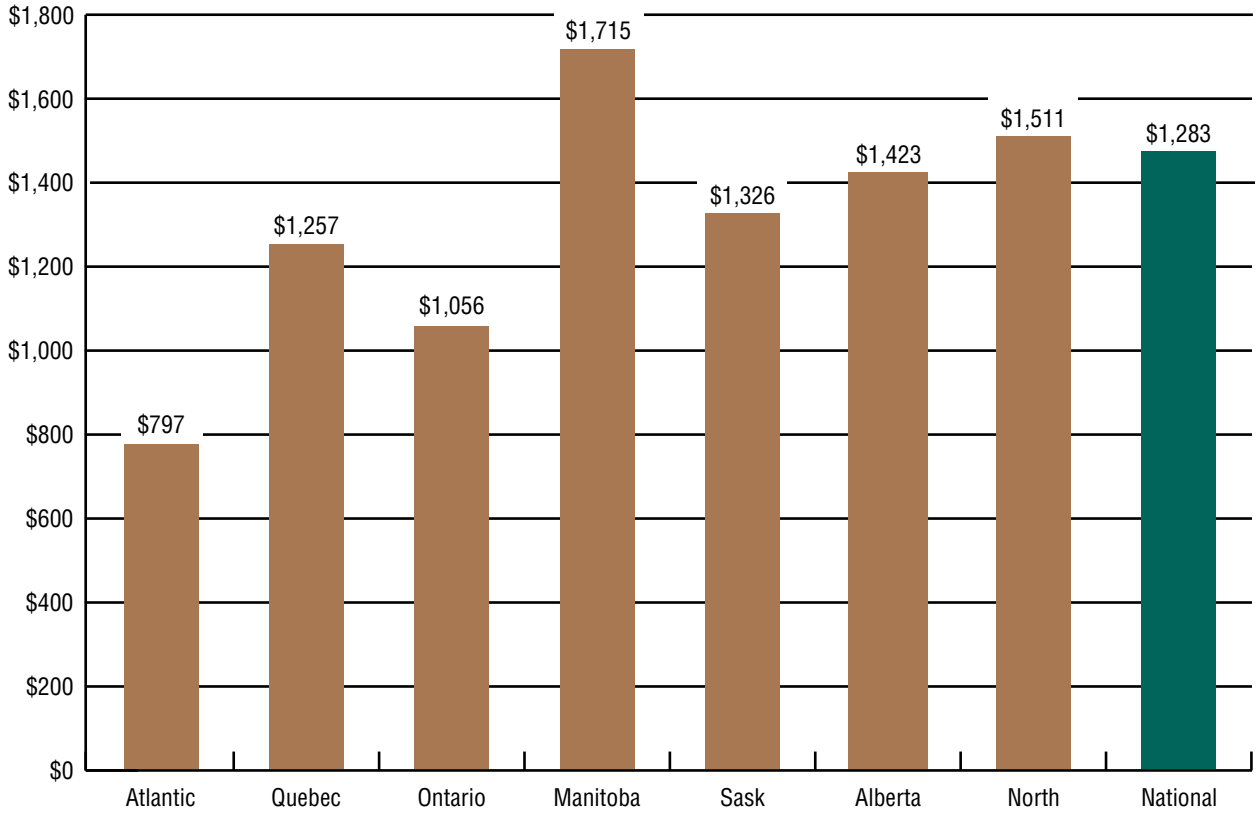
BENEFIT	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Medical Transportation	$ 241,602	$ 262,294	$ 280,446	$ 301,673	$ 311,760	$333,304	$ 351,424	$ 352,036	$ 357,963	$ 375,904
Pharmacy	386,190	403,248	418,968	435,097	440,768	459,359	462,699	416,165	422,350	456,430
Dental	158,584	165,576	176,382	194,918	215,796	219,057	222,706	207,179	201,886	217,109
Vision Care	24,894	25,621	26,577	27,779	29,219	29,780	32,167	31,459	29,704	30,017
Mental Health	16,271	12,289	11,380	12,516	12,083	12,936	14,337	14,152	15,581	16,193
Other	28,659	29,211	26,430	17,110	18,428	19,868	21,257	5,406	4,005	4,858
Total	$ 856,201	$ 898,239	$ 940,182	$ 989,094	$ 1,028,053	$ 1,074,304	$ 1,104,591	$ 1,026,397	$ 1,031,488	$ 1,100,512
Annual % Change	4.7%	4.9%	4.7%	5.2%	3.9%	4.5%	2.8%	-7.1%	0.5%	6.7%

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 3.8

Per Capita NIHB Expenditures by Region
2015/16

The national per capita expenditure for all benefits in 2015/16 was $1,283. Manitoba had the highest per capita cost in 2015/16 at $1,715. The Northern Region followed with a per capita cost of $1,511. The higher than average per capita cost for these regions is partly attributable to high medical transportation costs due to the large number of First Nations clients living in remote or fly-in only northern communities. In contrast, the Atlantic Region had the lowest per capita cost of $797, due to the comparatively low medical transportation expenditures in the region.



Source: FIRMS and SVS adapted by Business Support, Audit and Negotiations Division

NIHB Pharmacy Expenditure and Utilization Data

SECTION 4

The NIHB Program provides eligible clients with coverage for pharmacy benefits not insured by private, public or provincial/territorial health care plans. The NIHB Program covers a range of prescription drugs and over-the-counter medications 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. This is 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.

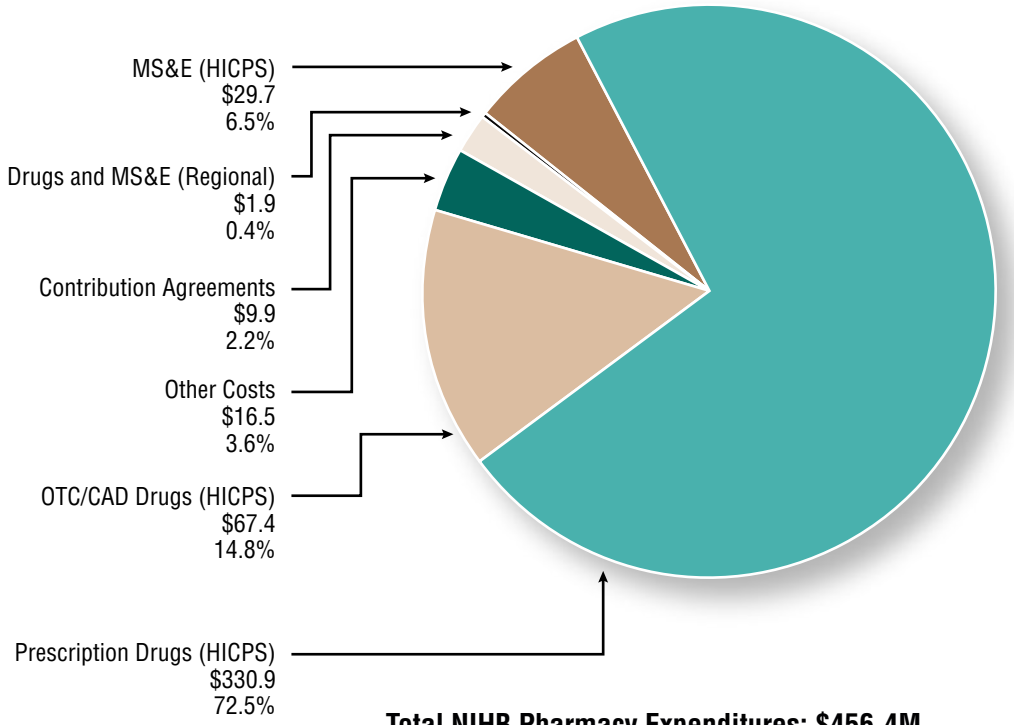
Like prescription and over-the-counter medications, MS&E benefits are covered in accordance with Program policies. Clients must obtain a prescription from a prescriber that is recognized by the NIHB Program for MS&E items, and have the prescription filled at an approved provider. Items covered under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

In 2015/16, the NIHB Program paid for pharmacy claims made by a total of 513,621 First Nations and Inuit clients. The total expenditures for these claims was $456.4 million or 41.5% 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.

FIGURE 4.1

Distribution of NIHB Pharmacy Expenditures ($ Millions)
2015/16



Total NIHB Pharmacy Expenditures: $456.4M

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

In 2015/16, NIHB Pharmacy benefits totalled $456.4 million or 41.5% 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 $330.9 million or 72.5% of all NIHB Pharmacy expenditures, followed by over-the-counter (OTC) drugs and controlled access drugs (CAD) which totalled $67.4 million or 14.8%. Medical supplies and equipment (MS&E) items paid through HICPS was the third largest component in the pharmacy benefit at $29.7 million or 6.5%.

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

Contribution agreements, which accounted for $9.9 million or 2.2% of total pharmacy benefit costs, are used to fund the provision of pharmacy benefits through agreements such as those with the Mohawk Council of Akwesasne in Ontario and the Bigstone Cree Nation in Alberta.

Other costs totalled $16.5 million or 3.6% in 2015/16. Included in this total are Headquarters contract and claims processing expenditures related to the HICPS system.

FIGURE 4.2

Total NIHB Pharmacy Expenditures by Type and Region ($ 000's)
2015/16

Prescription drug costs paid through the Health Information and Claims Processing Services (HICPS) system represented the largest component of total costs accounting for $330.9 million or 72.5% of all NIHB Pharmacy costs. The Saskatchewan Region had the largest proportion of these costs at 21.0%, followed by Manitoba at 20.6% and the Ontario Region at 20.0%.

The next highest component was over-the-counter (OTC) and controlled access drug (CAD) costs at $67.4 million or 14.8%. The regions of Ontario (21.9%), Manitoba (21.4%) and Saskatchewan (19.6%) had the largest proportions of these costs in 2015/16.

The third highest component was the combined medical supplies and equipment (MS&E) category at $29.7 million (6.5%). The Saskatchewan Region (23.4%) had the highest proportion of MS&E costs in 2015/16. This was followed by the Alberta Region (19.9%), the Manitoba Region (17.8%), and the Ontario Region (14.8%).

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	$ 22,186	$ 5,255	$ 11	$ 722	$ 1,722	$ 0	$ 29,896	$ 167	**$ 30,064**
Quebec	34,309	8,133	14	673	1,078	0	44,206	0	**44,206**
Ontario	66,044	14,732	18	1,114	3,290	0	85,198	3,673	**88,872**
Manitoba	68,301	14,400	0	1,717	3,579	0	87,997	0	**87,997**
Saskatchewan	69,582	13,172	1,418	2,134	4,821	0	91,127	42	**91,170**
Alberta	49,686	8,504	49	2,022	3,890	0	64,152	5,840	**69,992**
B.C.	113	62	0	0	0	0	175	0	**175**
Yukon	4,057	373	53	120	279	0	4,883	0	**4,883**
N.W.T.	7,523	1,279	0	545	644	0	9,991	213	**10,204**
Nunavut	9,147	1,464	368	438	904	0	12,321	0	**12,321**
North	20,727	3,116	421	1,103	1,828	0	27,195	213	**27,408**
Headquarters	0	0	0	0	0	16,546	16,546	0	**16,546**
Total	**$ 330,949**	**$ 67,373**	**$ 1,932**	**$ 9,486**	**$ 20,208**	**$ 16,546**	**$ 446,494**	**$ 9,936**	**$ 456,430**

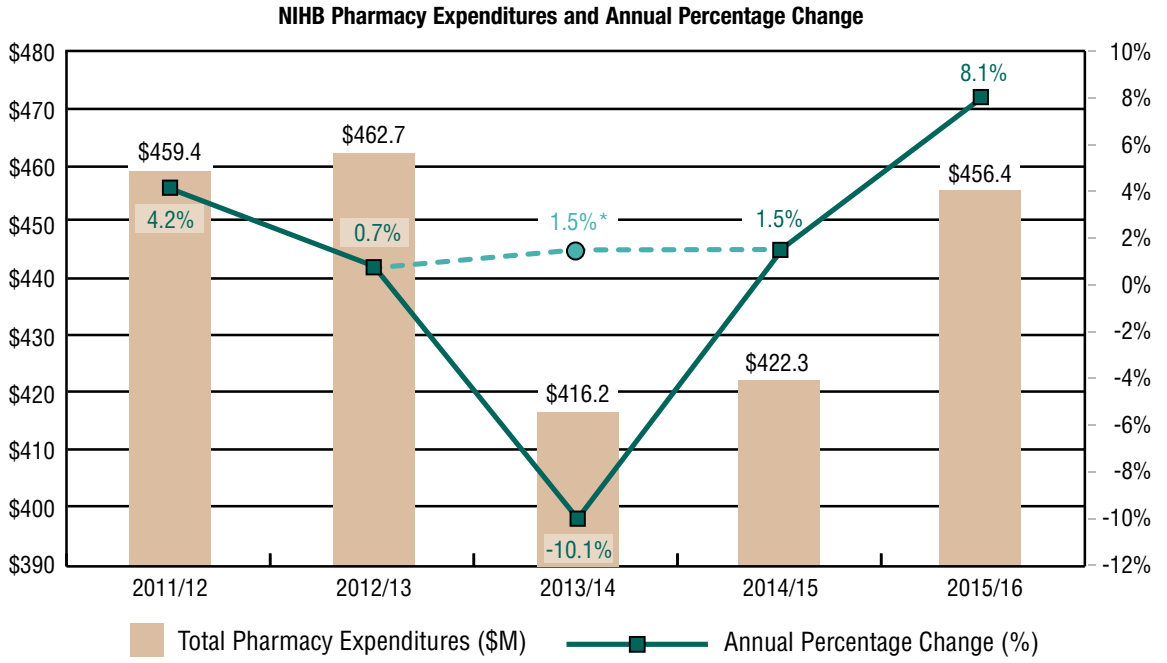
Source: FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 4.3

Annual NIHB Pharmacy Expenditures
2011/12 to 2015/16

NIHB Pharmacy expenditures increased by 8.1% during fiscal year 2015/16. Over the past five years, growth in pharmacy expenditures has ranged from a high of 8.1% in 2015/16 to a low of -10.1% in 2013/14. Growth has been strongly impacted by the transfer of eligible First Nations clients living in British Columbia to the responsibility of the First Nations Health Authority in 2014. *If expenditures for FNHA eligible clients are excluded from 2012/13 and 2013/14 total NIHB expenditures, then the growth rate for 2013/14 would have been 1.5%.

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



Source: FIRMS adapted by Business Support, Audit and Negotiations Division

NIHB Pharmacy Expenditures ($ 000's)					
REGION	2011/12	2012/13	2013/14	2014/15	2015/16
Atlantic	$ 27,571	$ 29,979	$ 27,517	$ 28,398	$ 30,064
Quebec	38,827	40,393	40,825	42,581	44,206
Ontario	76,430	77,131	78,510	81,982	88,872
Manitoba	80,639	80,676	77,034	81,059	87,997
Saskatchewan	73,293	74,646	78,546	83,361	91,170
Alberta	61,621	60,584	58,777	64,087	69,992
North	23,863	23,682	23,144	23,941	27,408
Headquarters	16,227	15,749	16,874	16,678	16,546
Total	$ 459,359	$ 462,699	$ 416,165	$ 422,350	$ 456,430

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

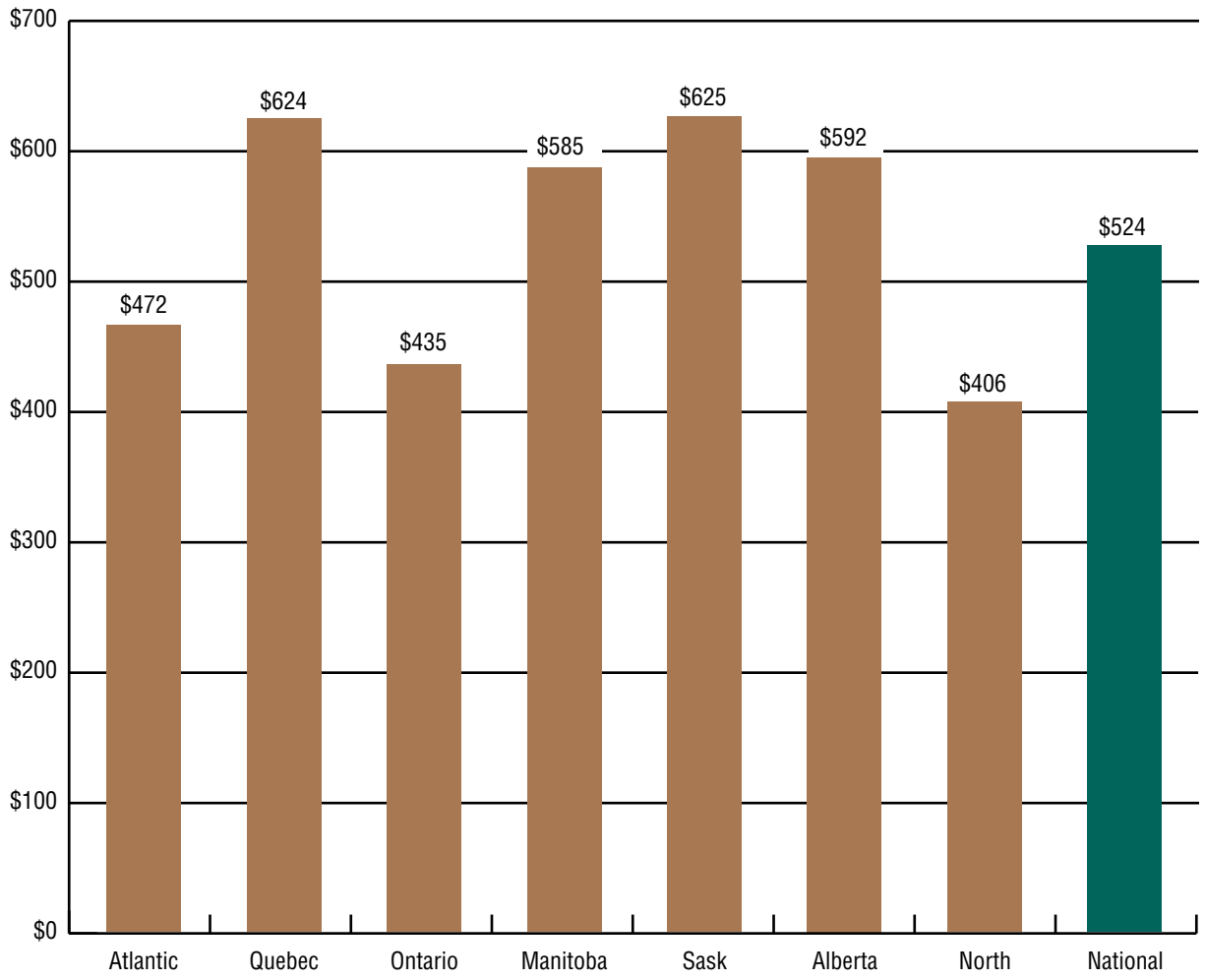
FIGURE 4.4

Per Capita NIHB Pharmacy Expenditures by Region
2015/16

In 2015/16, the national per capita expenditure for NIHB Pharmacy benefits was $524. This was an increase of 6.5% from the $492 recorded in 2014/15.

The Quebec Region had the highest per capita NIHB Pharmacy expenditure at $634, followed by the Saskatchewan Region at $625.

The Northern Region had the lowest per capita expenditure at $406 followed by the Ontario Region at $435. A relatively low per capita expenditure in the North 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 Business Support, Audit and Negotiations Division

FIGURE 4.5

NIHB Pharmacy Operating Expenditures per Claimant by Region
2015/16

In 2015/16, the national average expenditure per eligible client receiving at least one pharmacy benefit (claimant) was $833, an increase of 6.8% over 2014/15.

The Quebec Region had the highest average NIHB Pharmacy operating expenditure per claimant at $1,054, followed by Saskatchewan at $882.

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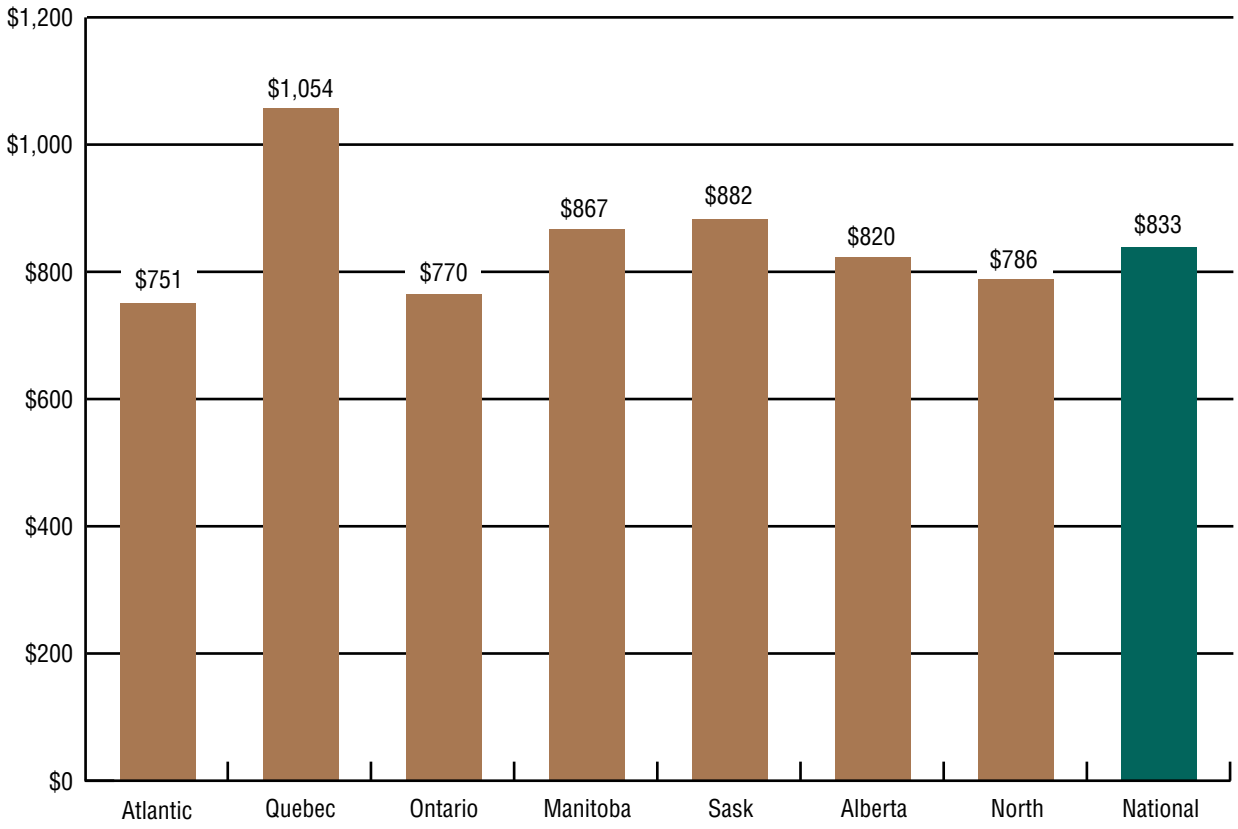


Source: HICPS and SVS adapted by Business Support, Audit and Negotiations Division

FIGURE 4.6

NIHB Pharmacy Utilization Rates by Region
2011/12 to 2015/16

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 2015/16, the national utilization rate was 61% for NIHB Pharmacy benefits paid through the HICPS system. The slightly lower utilization over the last five 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.

The rates understate the actual level of service as the data do not include pharmacy services provided through contribution agreements and benefits provided through community health facilities or provided completely via alternate health coverage. For example, if the Bigstone Cree Nation client population were removed from the Alberta Region's population because the HICPS system does not capture any data on services used by this population, the utilization rate for pharmacy benefits in Alberta would have been 71% in 2015/16. 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 63%.

Pharmacy Utilization					
REGION	2011/12	2012/13	2013/14	2014/15	2015/16
Atlantic	55%	61%	62%	62%	62%
Quebec	59%	59%	59%	60%	60%
Ontario	55%	55%	54%	54%	54%
Manitoba	67%	67%	66%	66%	67%
Saskatchewan	71%	70%	70%	70%	70%
Alberta	66%	66%	66%	66%	66%
Yukon	61%	60%	59%	60%	60%
N.W.T.	53%	53%	53%	54%	54%
Nunavut	45%	46%	46%	47%	46%
National	**62%**	**62%**	**61%**	**61%**	**61%**

Source: HICPS and SVS adapted by Business Support, Audit and Negotiations Division

FIGURE 4.7

NIHB Pharmacy Claimants by Age Group, Gender and Region
2015/16

Of the 839,129 clients eligible to receive benefits under the NIHB Program, a total of 513,621 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 2015/16. Of this total, 290,167 were female (56%) and 223,454 were male (44%). This compares to the total eligible population where 51% were female and 49% were male.

The average age of pharmacy claimants was 34 years. The average age for female and male claimants was 35 and 34 years of age, respectively.

REGION	Atlantic			Quebec			Ontario			Manitoba		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0–4	814	818	1,632	985	973	1,958	2,204	2,112	4,316	3,590	3,354	6,944
5–9	1,284	1,245	2,529	1,329	1,354	2,683	3,133	3,124	6,257	4,616	4,753	9,369
10–14	1,194	1,246	2,440	1,113	1,187	2,300	2,847	2,804	5,651	3,840	3,951	7,791
15–19	1,270	1,815	3,085	1,095	1,721	2,816	3,145	4,564	7,709	3,556	4,995	8,551
20–24	1,361	2,215	3,576	1,209	2,094	3,303	3,511	5,790	9,301	3,784	5,874	9,658
25–29	1,259	1,886	3,145	1,140	1,975	3,115	3,529	5,551	9,080	3,628	5,375	9,003
30–34	1,125	1,674	2,799	1,068	1,683	2,751	3,374	4,949	8,323	3,256	4,407	7,663
35–39	1,097	1,497	2,594	1,109	1,534	2,643	3,323	4,568	7,891	2,984	3,844	6,828
40–44	1,233	1,548	2,781	1,191	1,623	2,814	3,491	4,503	7,994	3,105	3,809	6,914
45–49	1,331	1,648	2,979	1,317	1,701	3,018	3,791	4,696	8,487	3,142	3,832	6,974
50–54	1,322	1,635	2,957	1,474	1,863	3,337	4,059	5,083	9,142	2,942	3,591	6,533
55–59	1,189	1,548	2,737	1,387	1,837	3,224	3,609	4,552	8,161	2,452	2,832	5,284
60–64	1,027	1,332	2,359	1,101	1,416	2,517	2,736	3,608	6,344	1,680	2,127	3,807
65+	1,801	2,376	4,177	2,164	3,276	5,440	4,774	7,230	12,004	2,597	3,589	6,186
Total	**17,307**	**22,483**	**39,790**	**17,682**	**24,237**	**41,919**	**47,526**	**63,134**	**110,660**	**45,172**	**56,333**	**101,505**
Average Age	37	38	37	38	39	39	38	39	38	32	33	32

Source: HICPS and SVS adapted by Business Support, Audit and Negotiations Division

REGION	Saskatchewan			Alberta			North			TOTAL		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0–4	3,102	3,108	6,210	2,643	2,506	5,149	1,152	1,073	2,225	14,988	14,401	29,389
5–9	4,954	5,125	10,079	3,903	3,987	7,890	1,083	1,042	2,125	20,458	20,785	41,243
10–14	4,072	4,485	8,557	3,108	3,286	6,394	872	888	1,760	17,176	17,985	35,161
15–19	3,755	5,269	9,024	2,925	3,931	6,856	892	1,608	2,500	16,789	24,129	40,918
20–24	3,846	6,059	9,905	3,065	4,360	7,425	1,009	2,161	3,170	17,977	28,853	46,830
25–29	3,889	5,809	9,698	2,967	4,129	7,096	1,094	2,144	3,238	17,707	27,221	44,928
30–34	3,409	4,759	8,168	2,753	3,596	6,349	919	1,727	2,646	16,098	23,077	39,175
35–39	3,075	3,859	6,934	2,391	3,015	5,406	846	1,474	2,320	14,986	20,056	35,042
40–44	2,912	3,822	6,734	2,273	2,800	5,073	935	1,356	2,291	15,317	19,675	34,992
45–49	3,013	3,687	6,700	2,232	2,697	4,929	1,086	1,473	2,559	16,082	20,007	36,089
50–54	2,670	3,350	6,020	2,093	2,542	4,635	1,036	1,506	2,542	15,737	19,843	35,580
55–59	2,125	2,673	4,798	1,590	2,097	3,687	814	1,160	1,974	13,272	16,884	30,156
60–64	1,460	1,797	3,257	1,128	1,539	2,667	635	844	1,479	9,822	12,791	22,613
65+	2,351	3,281	5,632	1,871	2,706	4,577	1,400	1,824	3,224	17,045	24,460	41,505
Total	44,633	57,083	101,716	34,942	43,191	78,133	13,773	20,280	34,053	223,454	290,167	513,621
Average Age	31	32	31	30	32	31	35	36	36	34	35	34

Source: HICPS and SVS adapted by Business Support, Audit and Negotiations Division

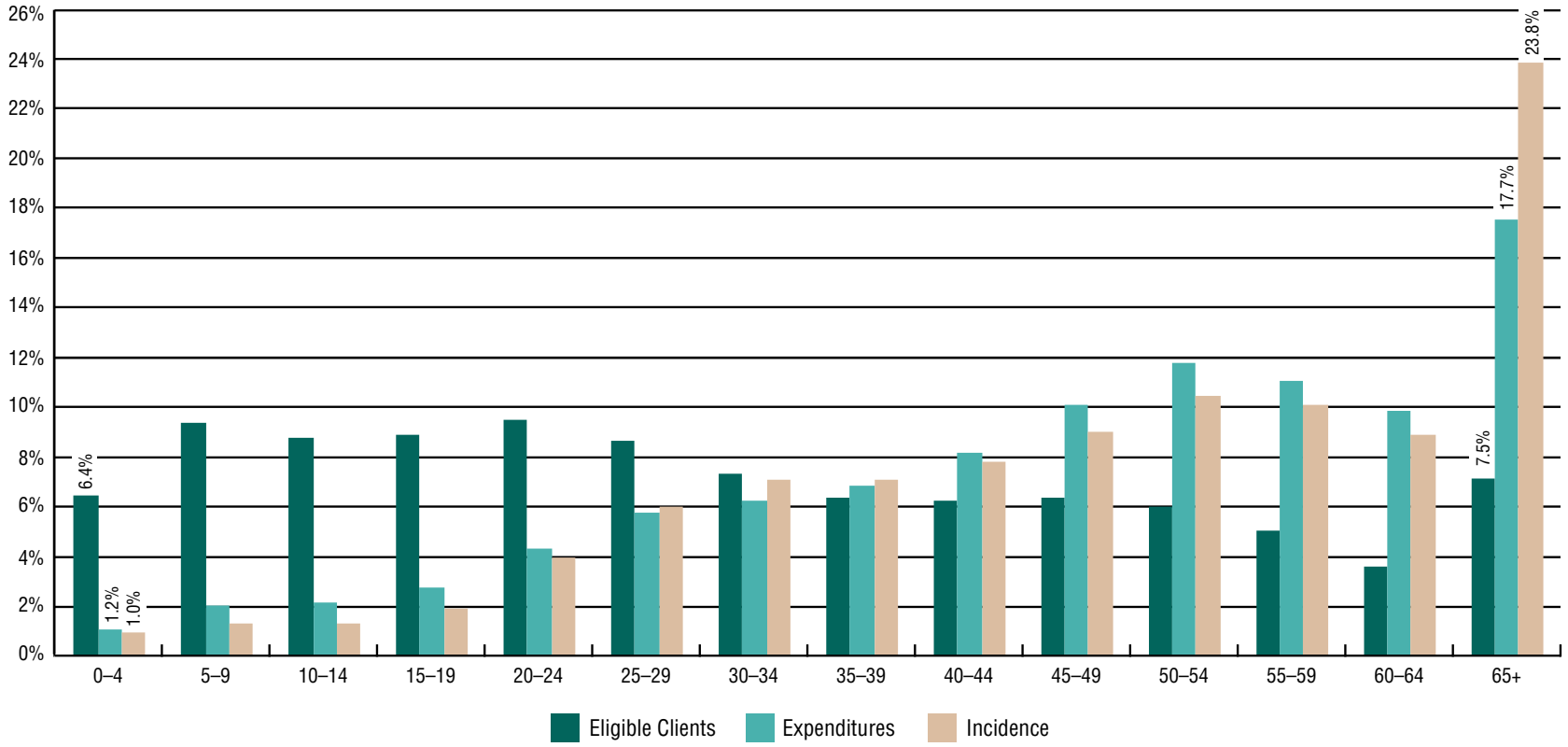
FIGURE 4.8

Distribution of Eligible NIHB Population, Pharmacy Expenditures and Pharmacy Incidence by Age Group
2015/16

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 2015/16, 6.4% of all clients were in the 0 to 4 age group, but this group accounted for only 1.0% of all pharmacy claims made and only 1.2% of total pharmacy expenditures. In contrast, 7.5% of all eligible clients were in the 65+ age group, but accounted for 23.8 % of all pharmacy claims submitted and 17.2 % of total pharmacy expenditures.

During 2015/16, the average claimant aged 65 or more submitted 94 claims compared to 64 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.

An examination of pharmacy benefit cost per NIHB claimant indicates that these expenditures vary according to age. For example, in 2015/16 the average cost per child aged 0 to 4 years was $169. The cost increased steadily for every age group, with claimants aged 35-39 having an average cost of $842, comparable to the total average claimant cost of $833. Claimants over 65 years of age had the highest cost per claimant with an average of $1,822 for all pharmaceutical services received throughout the fiscal year.



Source: HICPS and SVS adapted by Business Support, Audit and Negotiations Division

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

FIGURE 4.9

NIHB Top Ten Therapeutic Classes by Number of Claimants
2015/16

Figure 4.9 ranks the top ten therapeutic classes according to number of claimants. In 2015/16, Non-Steroidal Anti-Inflammatory Drugs (NSAID) had the highest number of distinct claimants at 198 thousand, an increase of 1.7% over 2014/15. Penicillins such as Amoxil (Amoxicillin) ranked second in number of claimants with 160 thousand followed by Opioid Agonists with 119 thousand claimants.

Therapeutic Classification	Claimants	% Change from 2014/15	Examples of Product in the Therapeutic Class
Non-Steroidal Anti-Inflammatory Drugs (NSAID)	197,717	1.7%	Voltaren (Diclofenac)
Penicillins	159,879	0.4%	Amoxil (Amoxicillin)
Opioid Agonists	119,284	1.4%	Statex (Morphine Sulphate)
Miscellaneous Analgesics and Antipyretics	112,736	0.0%	Tylenol (Acetaminophen)
Proton-Pump Inhibitors	85,731	6.0%	Losec (Omeprazole)
Beta-Adrenergic Agonists	84,770	0.5%	Ventolin (Salbutamol)
Antidepressants	84,284	6.4%	Effexor (Venlafaxine)
SMMA–Anti-inflammatory Agents	77,035	2.5%	Cortate Cream (Hydrocortisone)
Cephalosporins	73,827	2.0%	Keflex (Cephalexin)
Adrenals	70,004	1.4%	Flovent (Fluticasone Propionate)

Source: HICPS adapted by Business Support, Audit and Negotiations Division

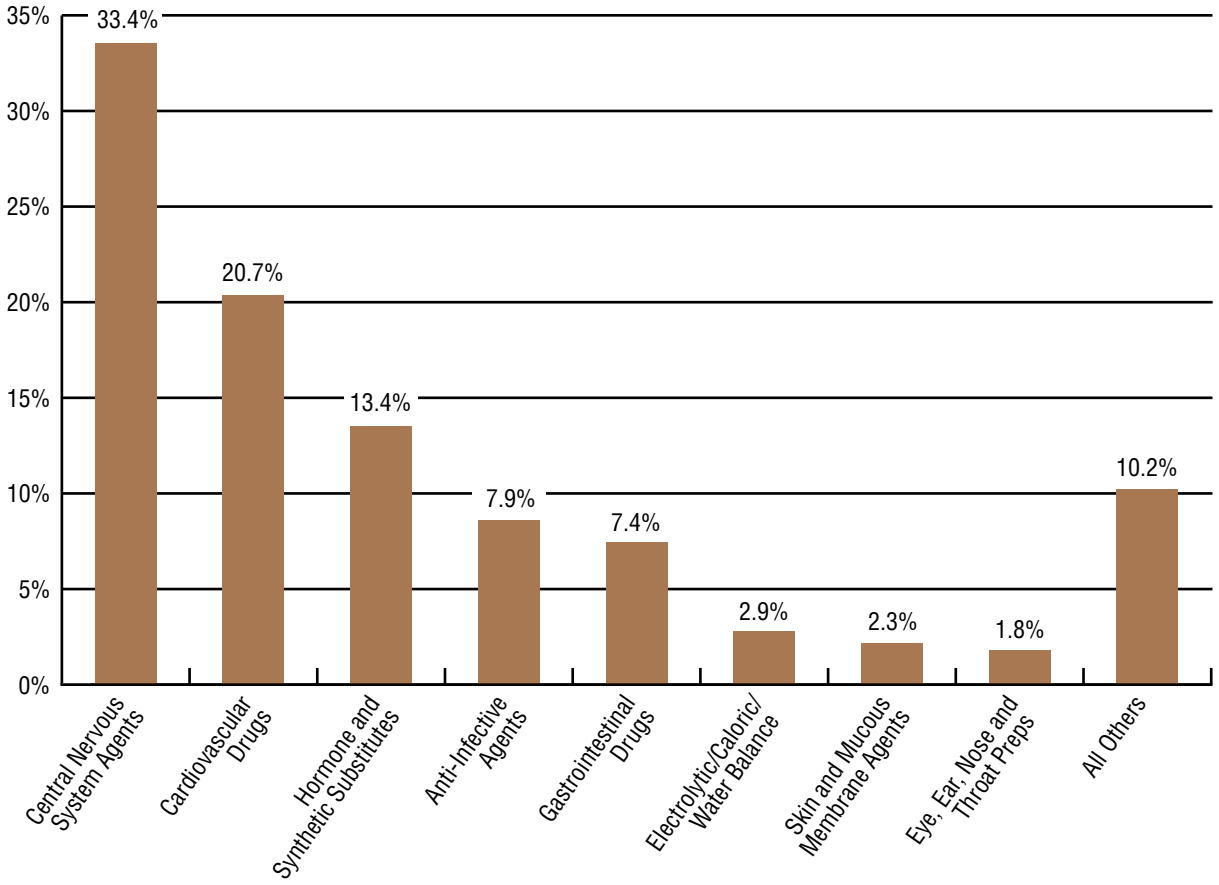
FIGURE 4.10

NIHB Prescription Drug Claims Incidence by Pharmacologic Therapeutic Class
2015/16

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 33.4% of all prescription drug claims in 2015/16. 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 20.7% followed by hormones and synthetic substitutes, which consist primarily of oral contraceptives and insulin, at 13.4%. 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 Business Support, Audit and Negotiations Division

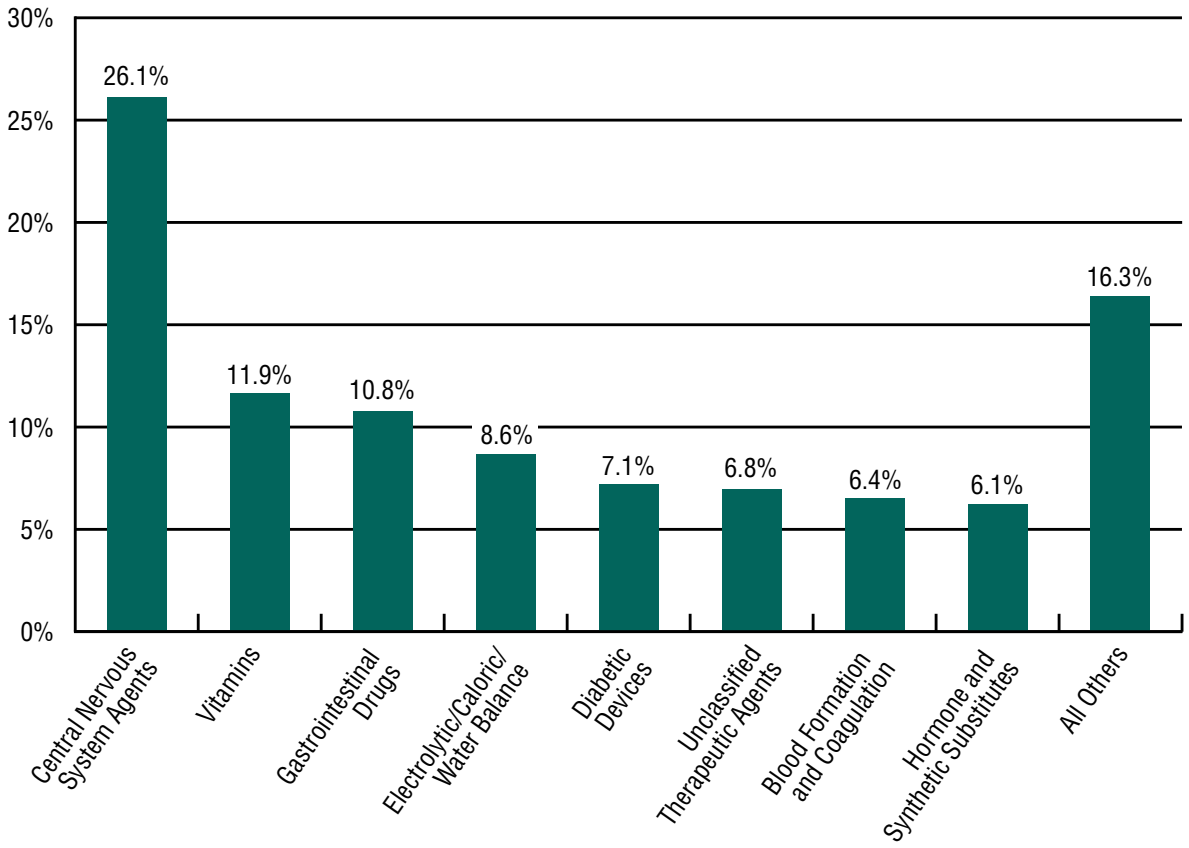
FIGURE 4.11

NIHB Over-the-Counter Drugs (Including Controlled Access Drugs—CAD) Claims Incidence by Pharmacologic Therapeutic Class
2015/16

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 their province or territory of practice.

OTC central nervous system agents, which are drugs used to manage pain such as headaches (e.g. acetaminophen), accounted for 26.1% of all OTC drug claims.

Vitamins are the next highest category of OTC medication at 11.9%, followed by gastrointestinal products such as antacids and laxatives, which are used to treat heartburn and constipation, at 10.8%. 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%.



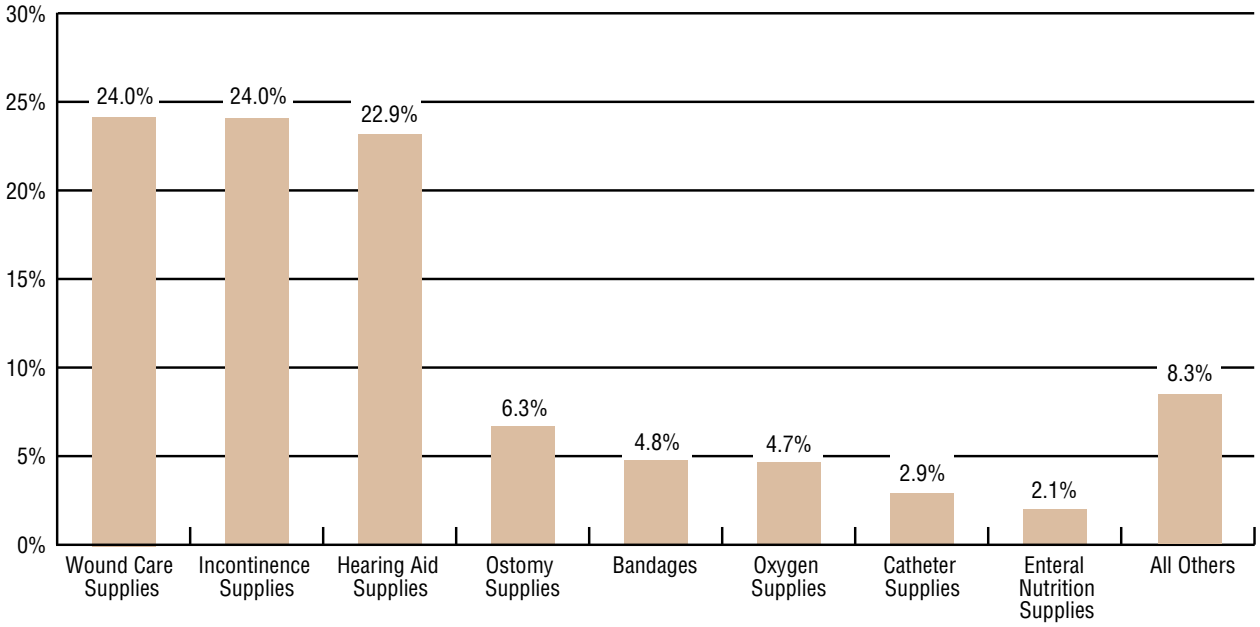
Source: HICPS adapted by Business Support, Audit and Negotiations Division

FIGURE 4.12

NIHB Medical Supplies by Category and Claims Incidence
2015/16

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

In 2015/16, wound care supplies such as silver dressings, sterile dressings and iodine dressings accounted for 24.0% of all medical supply claims. Incontinence supplies such as liners and pads, also represented 24.0%, of all medical supply claims, followed by hearing aid supplies at 22.9%.



Source: HICPS adapted by Business Support, Audit and Negotiations Division

FIGURE 4.13

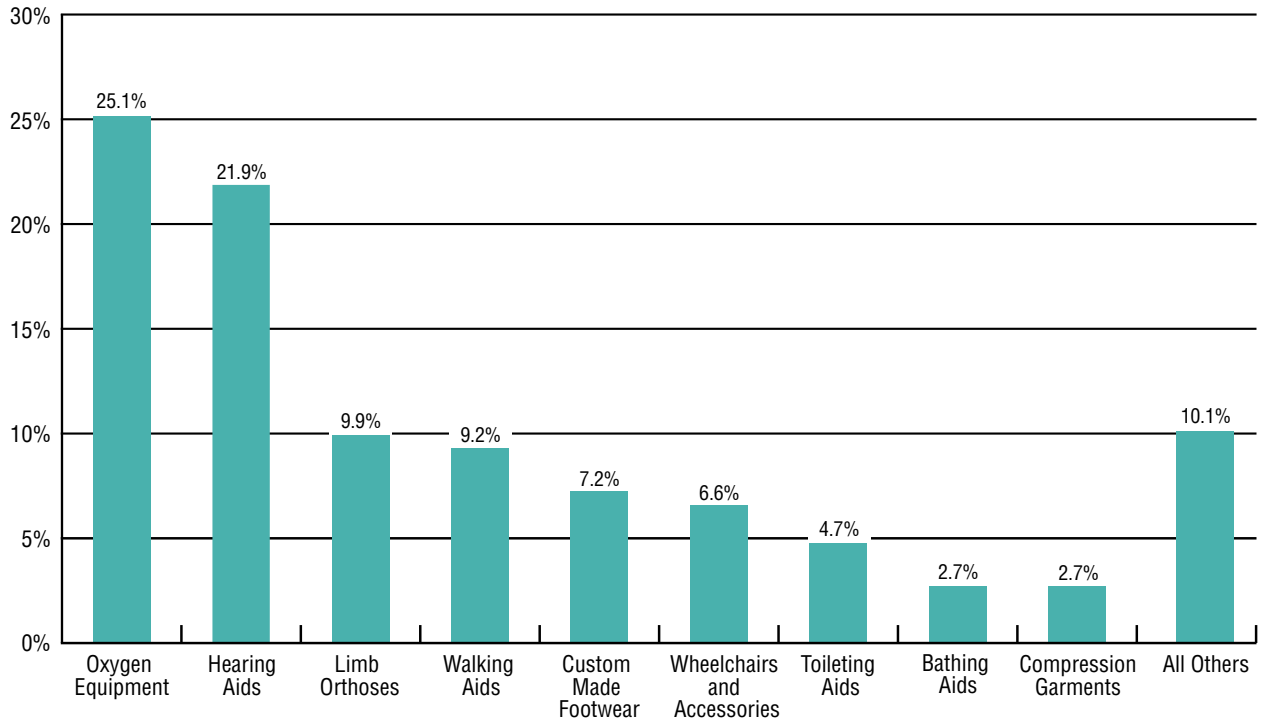
NIHB Medical Equipment by Category and Claims Incidence
2014/15

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

Claims for oxygen equipment accounted for 25.1% of all medical equipment claims in 2015/16. Hearing aids were the next highest at 21.9%, followed by limb orthoses at 9.9% and walking aids at 9.2%.

The most significant increase in the proportion of total medical equipment claims over the fiscal year 2014/15 was in hearing aids which increased by 1.2 percentage points.

The most significant decrease in the proportion of total medical equipment claims was in walking aids and limb orthoses which declined 0.7 percentage points each as a share of total claims for medical equipment over the previous fiscal year.



Source: HICPS adapted by Business Support, Audit and Negotiations Division

NIHB Dental Expenditure and Utilization Data

SECTION 5

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

In 2015/16, the NIHB Program paid for dental claims made by a total of 297,636 First Nations and Inuit clients. The total expenditure for these claims was $217.1 million or 19.7% 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 2015/16, through the NIHB Program's Dental Benefit, the oral health needs of approximately 190,000 clients who required intraoral radiograph services, 180,000 clients who received scaling procedures, and 135,000 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.

FIGURE 5.1

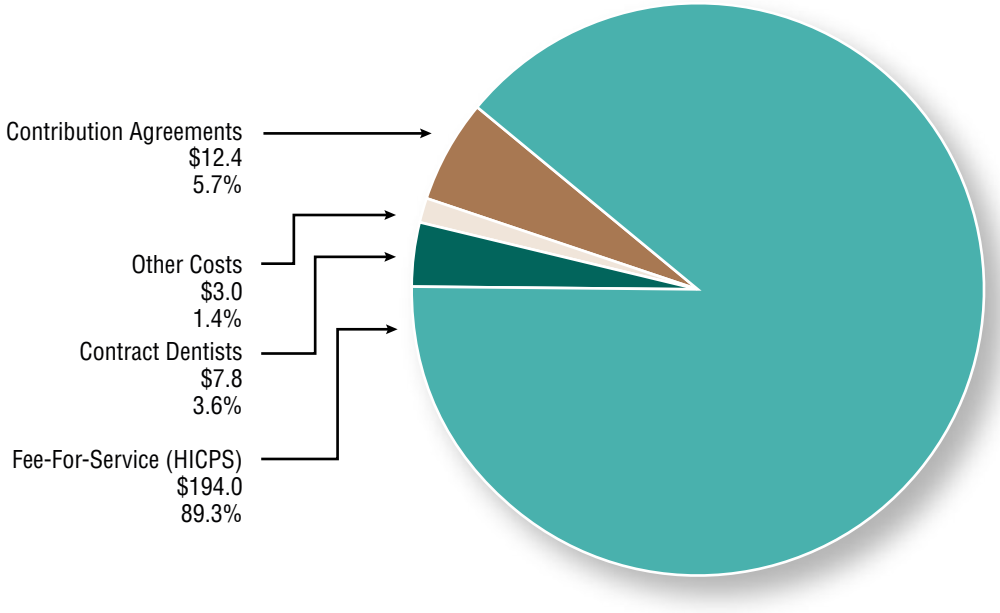
Distribution of NIHB Dental Expenditures ($ Millions)
2015/16

NIHB Dental expenditures totalled $217.1 million in 2015/16. Figure 5.1 illustrates the distinct components of dental expenditures under the NIHB Program. Fee-for-service dental costs paid through the Health Information and Claims Processing Services (HICPS) system represented the largest expenditure component, accounting for $194.0 million or 89.3% of all NIHB Dental costs.

The next highest component was contribution agreements, which accounted for $12.4 million or 5.7% 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 $7.8 million or 3.6% of total costs.

Other costs totalled $3.0 million or 1.4% in 2015/16. The majority of these costs are related to claims processing and payment services.



Total NIHB Dental Expenditures: $217.1M

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 5.2

Total NIHB Dental Expenditures by Type and Region ($ 000's)
2015/16

NIHB Dental expenditures totalled $217.1 million in 2015/16. The regions of Ontario (23.0%), Saskatchewan (18.9%), Alberta (18.3%) and Manitoba (16.9%) had the largest proportion of overall dental costs.

REGION	OPERATING			Total Operating Costs	Total Contribution Costs	TOTAL COSTS
	Fee-For-Service	Contract Dentists	Other Costs			
Atlantic	$ 8,846	$ 0	$ 0	$ 8,846	$ -	**$ 8,846**
Quebec	16,627	0	0	16,627	15	**16,641**
Ontario	40,880	2,612	61	43,552	6,350	**49,903**
Manitoba	31,954	4,757	0	36,711	53	**36,764**
Saskatchewan	37,504	0	0	37,504	3,524	**41,028**
Alberta	37,411	41	0	37,451	2,302	**39,753**
North	20,422	348	0	20,770	166	**20,936**
Headquarters	-	-	2,920	2,920	-	**2,920**
Total	**$ 193,962**	**$ 7,758**	**$ 2,981**	**$ 204,701**	**$ 12,408**	**$ 217,109**

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

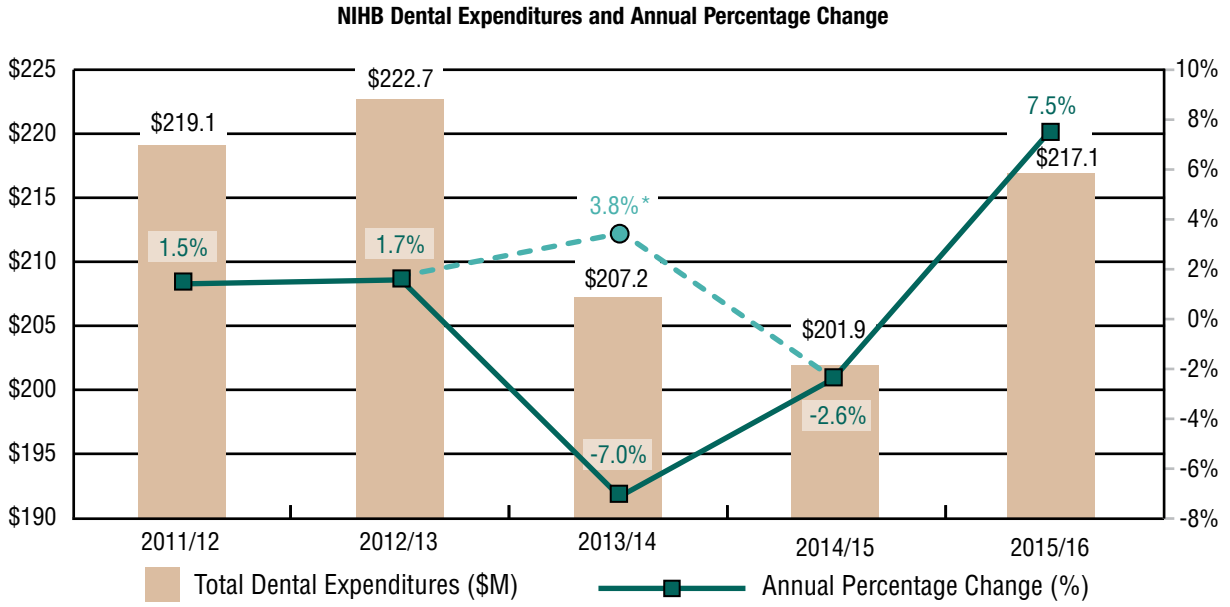
FIGURE 5.3

Annual NIHB Dental Expenditures
2011/12 to 2015/16

NIHB Dental expenditures increased by 7.5% during fiscal year 2015/16. The decrease in overall NIHB Dental expenditures recorded in fiscal years 2012/13 and 2013/14 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 expenditures for FNHA eligible clients are excluded from 2012/13 and 2013/14 total NIHB expenditures, then the growth rate for 2013/14 would have been 3.8%.

Over the last five years, annual growth rates for NIHB Dental expenditures have ranged from a high of 7.5% in 2015/16 to a low of -7.0% in 2013/14.

The Ontario Region had the highest total dental expenditure at $49.9 million and the Atlantic Region had the lowest total dental expenditure at $8.8 million.



Source: FIRMS adapted by Business Support, Audit and Negotiations Division

NIHB Dental Expenditures ($ 000's)					
REGION	2011/12	2012/13	2013/14	2014/15	2015/16
Atlantic	$ 7,164	$ 9,660	$ 8,609	$ 8,238	$ 8,846
Quebec	15,138	15,239	15,216	15,799	16,641
Ontario	41,848	42,259	43,972	46,759	49,903
Manitoba	29,861	30,734	33,649	33,527	36,764
Saskatchewan	36,941	36,219	36,399	37,679	41,028
Alberta	34,543	34,501	34,928	35,974	39,753
North	20,079	19,773	20,415	20,413	20,936
Headquarters	2,864	2,779	2,978	2,943	2,920
Total	$ 219,057	$ 222,706	$ 207,179	$ 201,886	$ 217,109

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

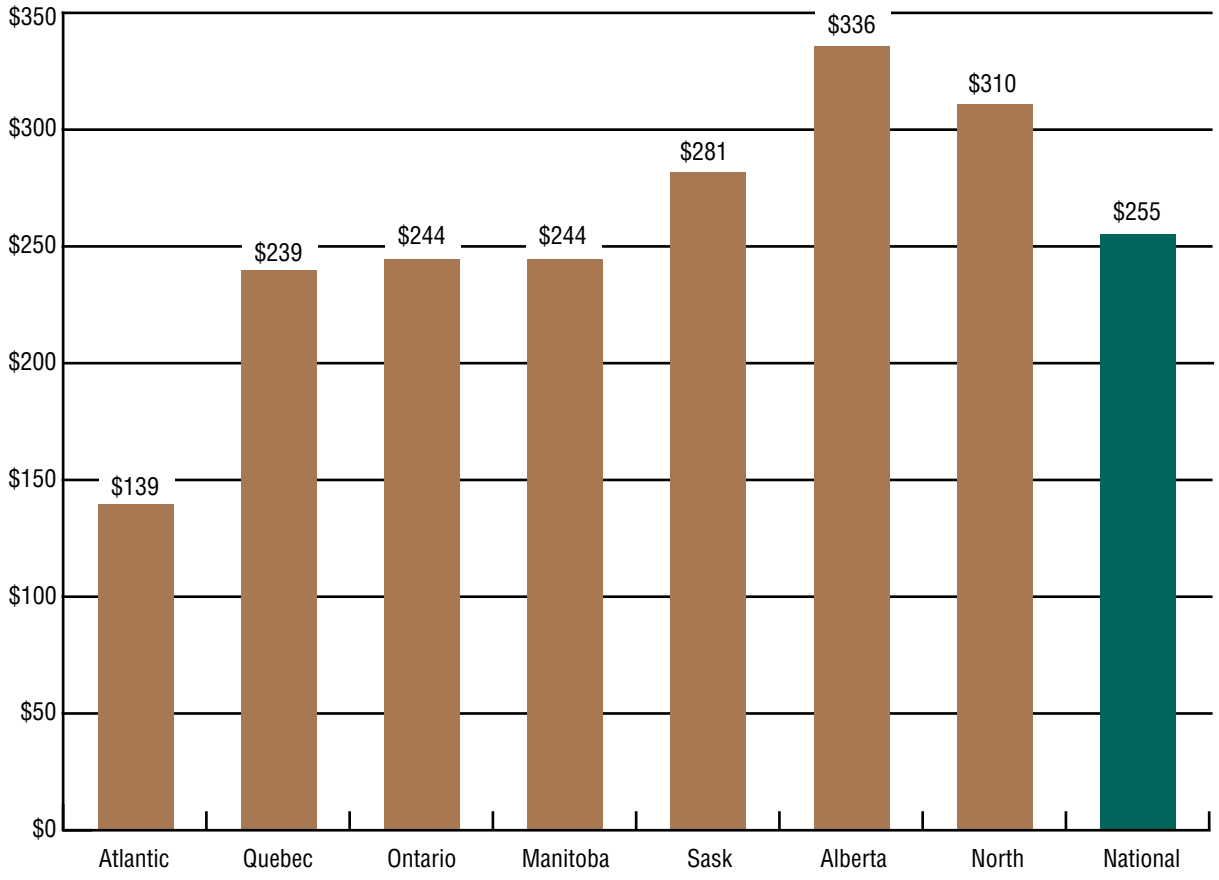
FIGURE 5.4

Per Capita NIHB Dental Expenditures by Region
2015/16

In 2015/16, the national per capita NIHB Dental expenditure was $255, an increase of 5.7% from the $241 recorded in 2014/15.

The Alberta Region had the highest per capita dental expenditure at $336, followed closely by the Northern Region at $310. The Atlantic Region had the lowest per capita dental cost at $139 per eligible client. The lower per capita cost in the Atlantic Region can be partly attributed to an increase in the eligible client population in this region as a result of the registration of 24,327 Qalipu Mi'kmaq First Nations clients. A large number of these clients have alternative dental coverage. The lower level of dental benefit utilization for these new clients has impacted the dental per capita cost for the Atlantic Region as a whole.

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.



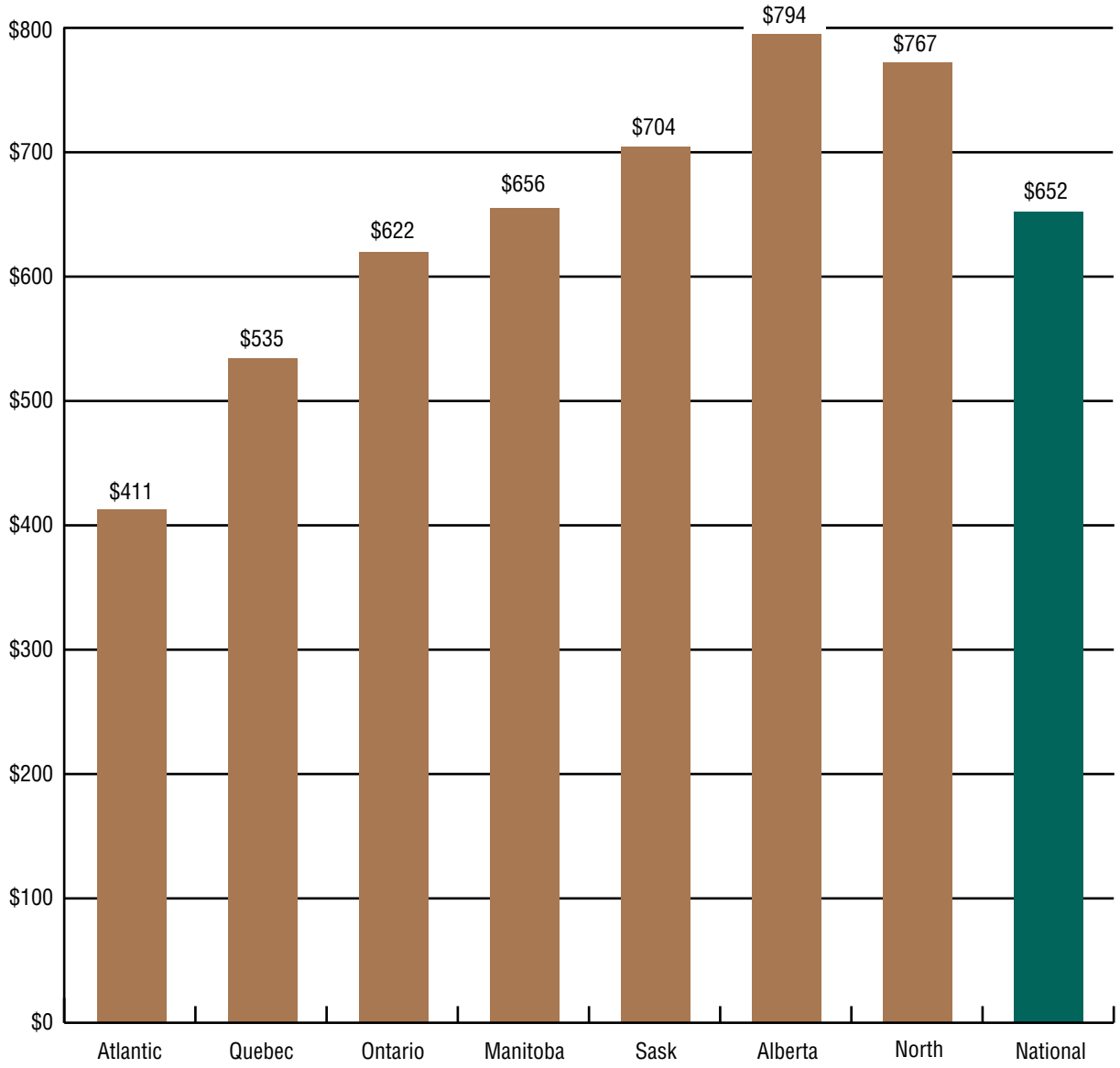
Source: SVS and FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 5.5

NIHB Dental Fee-For-Service Expenditures per Claimant by Region
2015/16

In 2015/16, the national NIHB Dental expenditure per eligible client receiving at least one dental benefit was $652. This represents an increase of 6.0% over the $615 recorded in 2014/15.

The Alberta Region had the highest dental expenditure per claimant at $794 followed by the Northern Region at $767, an increase of 4.2% from the $736 recorded in the previous year.



Source: FIRMS and HICPS adapted by Business Support, Audit and Negotiations Division

FIGURE 5.6

NIHB Dental Utilization Rates by Region
2011/12 to 2015/16

Utilization rates reflect those clients who, during the fiscal year, 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 2015/16, the national utilization rate for dental benefits paid through the HICPS system was 35%, consistent with the previous four fiscal years. National NIHB Dental utilization rates have remained stable over the past five years.

Dental utilization rates vary across the regions with the highest dental utilization rate found in the Quebec Region (45%). The lowest dental utilization rate was in the Manitoba and Ontario Regions (32%). It should be noted that the dental utilization rates understate the actual level of service as data does 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, HICPS data does not capture any services utilized by the Bigstone Cree Nation. If this client population was removed from the Alberta Region's population, the utilization rate for dental benefits for Alberta would have been 43% in 2015/16. 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 36%.

Over the two year period between 2014/15 and 2015/16, 402,711 distinct clients received NIHB Dental services resulting in an overall 48% utilization rate over this period.

REGION	Dental Utilization					
	2011/12	2012/13	2013/14	2014/15	2015/16	NIHB Dental Utilization Last Two Years 2013/15
Atlantic	28%	34%	34%	33%	34%	44%
Quebec	44%	44%	45%	45%	45%	56%
Ontario	32%	32%	32%	32%	32%	41%
Manitoba	31%	31%	32%	32%	32%	45%
Saskatchewan	37%	36%	36%	36%	36%	52%
Alberta	39%	39%	41%	39%	40%	55%
Yukon	38%	37%	39%	37%	36%	52%
N.W.T.	42%	41%	43%	41%	40%	55%
Nunavut	43%	42%	43%	42%	40%	57%
National	36%	36%	36%	35%	35%	48%

Source: HICPS and SVS adapted by Business Support, Audit and Negotiations Division

FIGURE 5.7

NIHB Dental Claimants by Age Group, Gender and Region
2015/16

Of the 839,129 clients eligible to receive dental benefits through the NIHB Program, 297,636 (35%) claimants received at least one dental procedure paid through the Health Information and Claims Processing Services (HICPS) system in 2015/16.

Of this total, 166,677 were female (56%) and 130,959 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 31 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 32 and 29 years of age respectively.

Approximately 37% of all dental claimants were under 20 years of age. Forty-one percent of male claimants were in this age group compared to 35% of female claimants. Approximately 5% of all claimants were seniors (ages 65 and over) in 2015/16.

REGION	Atlantic			Quebec			Ontario			Manitoba		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0–4	136	130	266	350	392	742	974	1,014	1,988	1,453	1,351	2,804
5–9	625	656	1,281	1,669	1,606	3,275	3,377	3,347	6,724	3,114	3,215	6,329
10–14	796	891	1,687	1,559	1,582	3,141	3,367	3,306	6,673	2,735	3,009	5,744
15–19	1,044	1,199	2,243	1,228	1,422	2,650	2,917	3,195	6,112	2,299	2,895	5,194
20–24	871	1,146	2,017	1,132	1,487	2,619	2,313	3,167	5,480	1,891	2,683	4,574
25–29	801	1,059	1,860	1,036	1,367	2,403	2,094	3,023	5,117	1,702	2,493	4,195
30–34	699	936	1,635	883	1,162	2,045	1,821	2,622	4,443	1,432	1,946	3,378
35–39	613	853	1,466	854	1,104	1,958	1,669	2,409	4,078	1,207	1,699	2,906
40–44	653	884	1,537	860	1,178	2,038	1,736	2,336	4,072	1,243	1,727	2,970
45–49	715	897	1,612	953	1,202	2,155	1,808	2,512	4,320	1,229	1,663	2,892
50–54	684	918	1,602	990	1,259	2,249	1,914	2,620	4,534	1,159	1,461	2,620
55–59	589	890	1,479	840	1,156	1,996	1,679	2,384	4,063	871	1,119	1,990
60–64	489	728	1,217	593	812	1,405	1,217	1,886	3,103	601	815	1,416
65+	700	912	1,612	954	1,428	2,382	1,921	3,144	5,065	644	1,050	1,694
Total	**9,415**	**12,099**	**21,514**	**13,901**	**17,157**	**31,058**	**28,807**	**36,965**	**65,772**	**21,580**	**27,126**	**48,706**
Average Age	35	37	36	33	35	34	32	35	34	27	29	28

Source: HICPS adapted by Program Analysis Division

REGION	Saskatchewan			Alberta			North			TOTAL		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0–4	1,296	1,354	2,650	1,364	1,352	2,716	822	818	1,640	6,515	6,561	13,076
5–9	3,649	3,706	7,355	3,523	3,570	7,093	1,286	1,413	2,699	17,453	17,695	35,148
10–14	2,967	3,453	6,420	2,955	3,157	6,112	1,183	1,496	2,679	15,718	17,072	32,790
15–19	2,348	2,979	5,327	2,315	2,717	5,032	1,177	1,602	2,779	13,488	16,193	29,681
20–24	2,003	2,922	4,925	1,681	2,387	4,068	1,130	1,658	2,788	11,169	15,616	26,785
25–29	1,948	2,971	4,919	1,583	2,239	3,822	1,127	1,647	2,774	10,406	14,998	25,404
30–34	1,619	2,386	4,005	1,438	1,998	3,436	843	1,243	2,086	8,864	12,464	21,328
35–39	1,423	1,960	3,383	1,273	1,711	2,984	691	1,012	1,703	7,822	10,879	18,701
40–44	1,390	1,949	3,339	1,112	1,523	2,635	651	901	1,552	7,743	10,621	18,364
45–49	1,390	1,903	3,293	1,112	1,488	2,600	695	937	1,632	8,010	10,756	18,766
50–54	1,155	1,570	2,725	970	1,343	2,313	618	816	1,434	7,551	10,143	17,694
55–59	889	1,169	2,058	684	1,078	1,762	421	578	999	6,033	8,471	14,504
60–64	541	735	1,276	447	713	1,160	298	424	722	4,211	6,178	10,389
65+	641	949	1,590	570	836	1,406	511	636	1,147	5,976	9,030	15,006
Total	23,259	30,006	53,265	21,027	26,112	47,139	11,453	15,181	26,634	130,959	166,677	297,636
Average Age	27	29	28	26	28	27	29	30	29	29	32	31

FIGURE 5.8

NIHB Fee-for-Service Dental Expenditures by Sub-Benefit
2015/16

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 2015/16, expenditures for Restorative Services (crowns, fillings, etc.) were the highest of all dental sub-benefit categories at $87.0 million. Preventative Services (scaling, sealants, etc.) at $24.5 million and Diagnostic Services (examinations, x-rays, etc.) at $24.2 million were the next highest sub-benefit categories. Rounding out the top 5 was Oral Surgery (extractions, etc.) at $22.6 million and Endodontic Services (root canal treatments, etc.) at $11.3 million.

In 2015/16, the three largest dental procedures by expenditure were Composite Restorations ($72.6 million), Scaling ($18.8 million) and Extractions ($16.0 million).

Fee-For-Service Top 5 Dental Sub-Benefits ($ Millions) and Percentage Change			
Dental Sub-Benefit	2014/15	2015/16	% Change from 2014/15 (FNHA Clients Excluded)
Restorative Services	$ 79.3	$ 87.0	9.7%
Preventive Services	22.9	24.5	7.0%
Diagnostic Services	22.5	24.4	8.4%
Oral Surgery	19.1	22.6	18.4%
Endodontic Services	10.5	11.3	7.2%

Fee-For-Service Top 5 Dental Procedures ($ Millions) and Percentage Change			
Dental Procedure	2014/15	2015/16	% Change from 2013/14 (FNHA Clients Excluded)
Composite Restorations	$ 65.7	$ 72.6	10.5%
Scaling	17.5	18.8	7.3%
Extractions	12.9	16.0	24.4%
Root Canal Therapy	8.7	9.3	7.0%
Intraoral Radiographs	7.5	8.2	9.6%

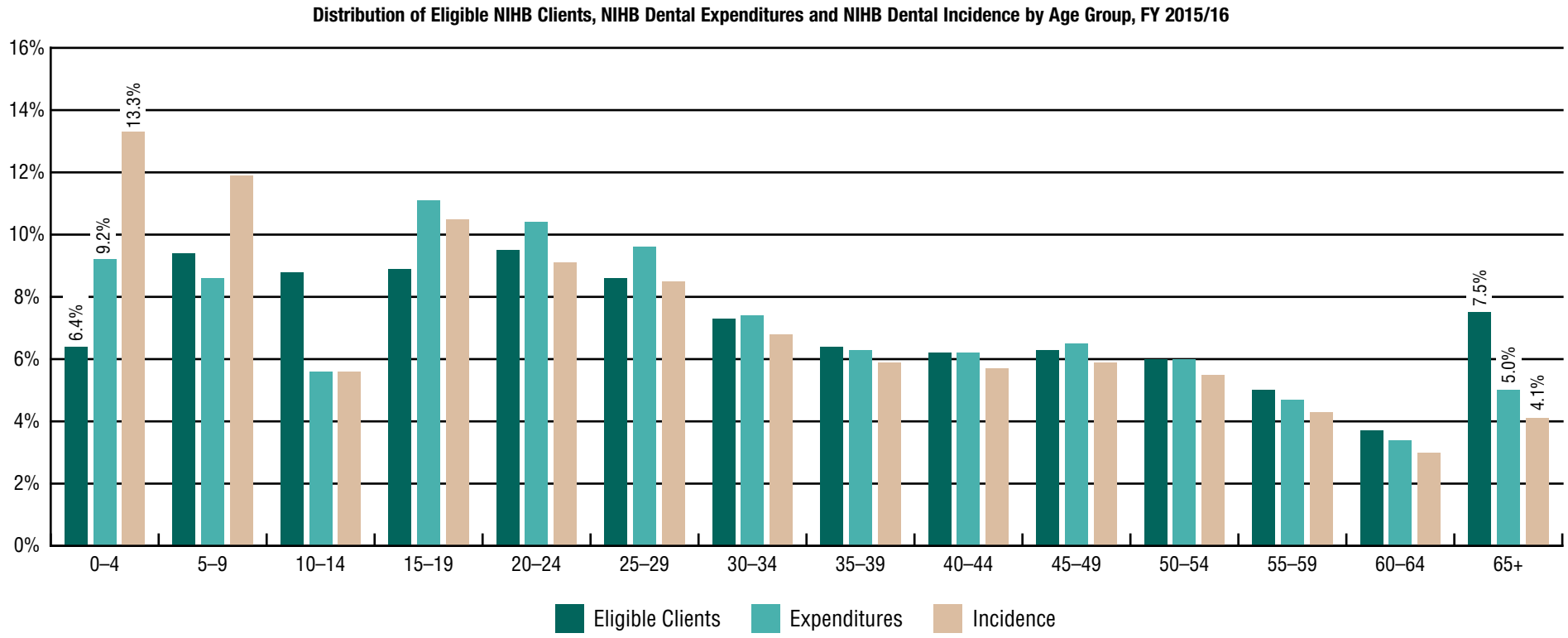
Source: HICPS adapted by Business Support, Audit and Negotiations Division

FIGURE 5.9

Distribution of Eligible NIHB Population, Dental Expenditures and Incidence by Age Group
2015/16

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 25.2% to 17.8%.



Source: HICPS and SVS adapted by Business Support, Audit and Negotiations Division

NIHB Medical Transportation Expenditure and Utilization Data

SECTION 6

In 2015/16, Non-Insured Health Benefits Medical Transportation expenditures amounted to $375.9 million or 34.2% 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.

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).

NHB 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

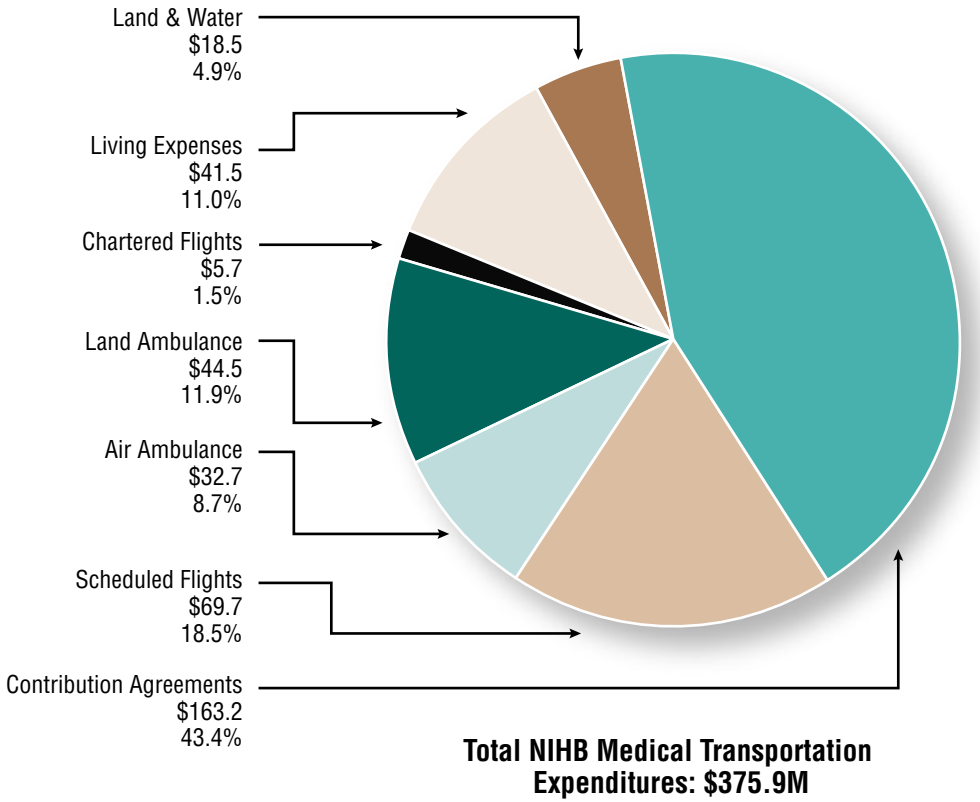
Distribution of NIHB Medical Transportation Expenditures ($ Millions)
2015/16

In 2015/16, NIHB Medical Transportation expenditures totalled $375.9 million. Figure 6.1 illustrates the components of medical transportation expenditures under the NIHB Program.

Contribution agreements represented the largest component, accounting for $163.2 million, or 43.4% of the total benefit.

Scheduled flights at $69.7 million (18.5%), land ambulance at $44.5 million (11.9%) and living expenses at $41.5 million (11.0%) were the largest medical transportation operating expenditures, accounting for over 40% of the total benefit.

Rounding out medical transportation expenditures are costs for air ambulance at $32.7 million (8.7%), land and water at $18.5 million (4.9%) and chartered flights at $5.7 million (1.5%).



Source: FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 6.2

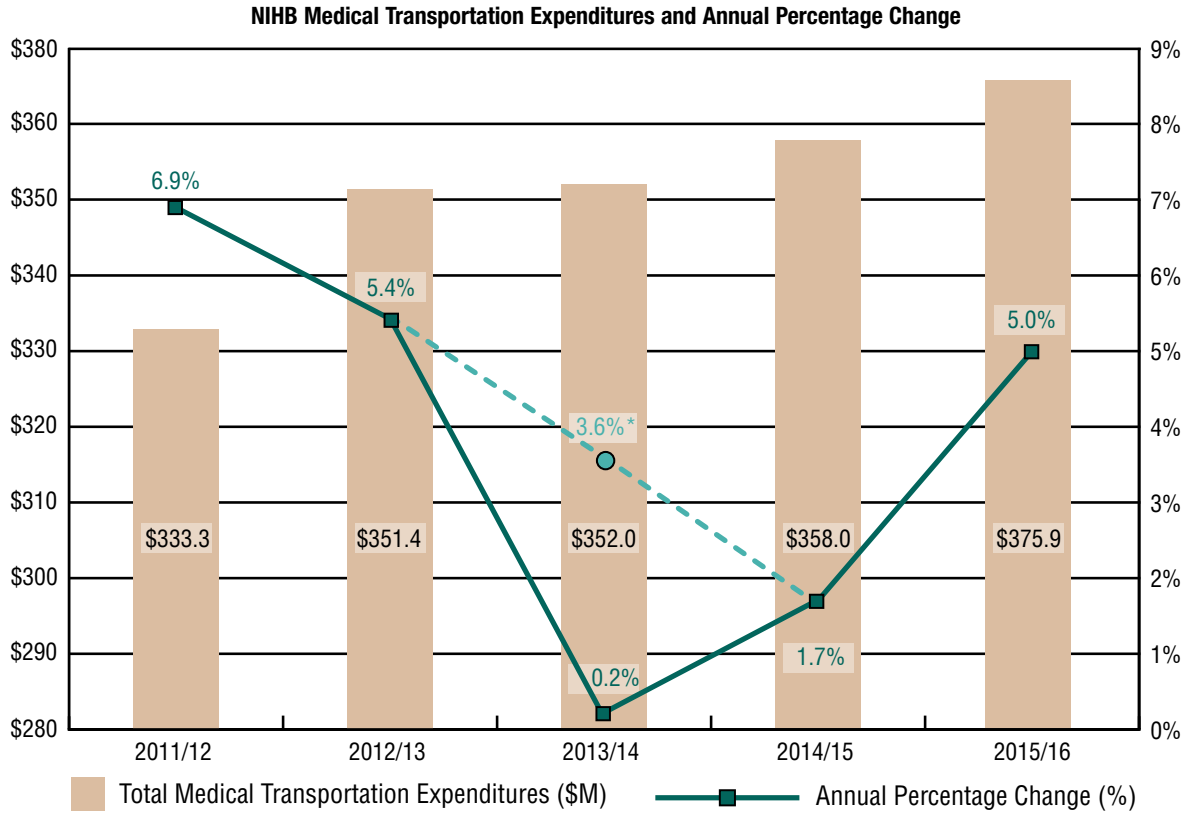
Annual NIHB Medical Transportation Expenditures
2011/12 to 2015/16

NIHB Medical Transportation expenditures increased by 5.0% in 2015/16.

Over the past five years, overall medical transportation costs have grown by 12.8% from $333.3 million in 2011/12 to $375.9 million in 2015/16. On a regional basis, the highest growth rates over this period were in the Atlantic Region where expenditures grew by 43.5% from $5.8 million in 2011/12 to $8.4 million in 2015/16. 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 the Northern Region with an increase of 25.9% from $40.5 million in 2011/12 to $50.9 million in 2015/16.

The Manitoba Region had the highest total medical transportation expenditure at $125.3 million and had the largest net increase in expenditures over the past five years as medical transportation costs grew by $23.7 million over this period. The Ontario Region had the second largest net increase in expenditures over the past five years at $13.0 million followed by the Alberta Region at $8.9 million.

*If expenditures for FNHA eligible clients are excluded from 2012/13 and 2013/14 total NIHB expenditures, then the growth rate for 2013/14 would have been 3.6%.



Source: FIRMS adapted by Business Support, Audit and Negotiations Division

NIHB Medical Transportation Expenditures ($ 000's)					
REGION	2011/12	2012/13	2013/14	2014/15	2015/16
Atlantic	$ 5,841	$ 6,875	$ 6,916	$ 7,419	$ 8,380
Quebec	21,708	22,578	21,945	23,506	23,687
Ontario	54,725	59,251	62,865	65,781	67,772
Manitoba	101,609	109,409	111,016	115,705	125,308
Saskatchewan	45,084	45,793	47,180	51,543	53,566
Alberta	37,371	39,216	41,451	45,756	46,252
North	40,455	41,727	44,703	48,246	50,940
Total	$ 333,304	$ 351,424	$ 352,036	$ 357,963	$ 375,904

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 6.3

NIHB Medical Transportation Expenditures by Type and Region ($ 000's)
2015/16

NIHB Medical Transportation expenditures increased by 5.0% to $375.9 million in 2015/16.

The Atlantic Region had the largest percentage increase in medical transportation expenditures in 2015/16 at 13.0%. The Manitoba Region followed with an 8.3% increase in expenditures.

In 2015/16, the Manitoba Region had the highest overall NIHB Medical Transportation expenditure at $125.3 million, primarily as a result of air transportation which totalled $63.1 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 2015/16 at $67.8 million. The regions of Saskatchewan and the North followed at $53.6 million and $50.9 million, respectively.

TYPE	Atlantic	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	North	TOTAL
Scheduled Flights	$ 1,231	$ 236	$ 24,132	$ 34,944	$ 7,088	$ 1,078	$ 958	**$ 69,666**
Air Ambulance	16	81	27	25,339	4,120	1,651	1,514	**32,747**
Chartered Flights	0	1	301	2,813	1,374	1,215	0	**5,704**
Land Ambulance	517	180	646	14,268	15,475	13,461	0	**44,547**
Land & Water	1,615	122	3,088	3,947	6,849	2,120	740	**18,480**
Living Expenses	819	23	13,923	16,416	4,839	4,440	1,077	**41,537**
Total Operating	**$ 4,198**	**$ 643**	**$ 42,117**	**$ 97,727**	**$ 39,745**	**$ 23,964**	**$ 4,288**	**$ 212,681**
Total Contributions	$ 4,182	$ 23,045	$ 25,655	$ 27,581	$ 13,821	$ 22,288	$ 46,651	**$ 163,223**
TOTAL	**$ 8,380**	**$ 23,687**	**$ 67,772**	**$ 125,308**	**$ 53,566**	**$ 46,252**	**$ 50,940**	**$ 375,904**
% Change from 2014/15	**13.0%**	**0.8%**	**3.0%**	**8.3%**	**3.9%**	**1.1%**	**5.6%**	**5.0%**

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

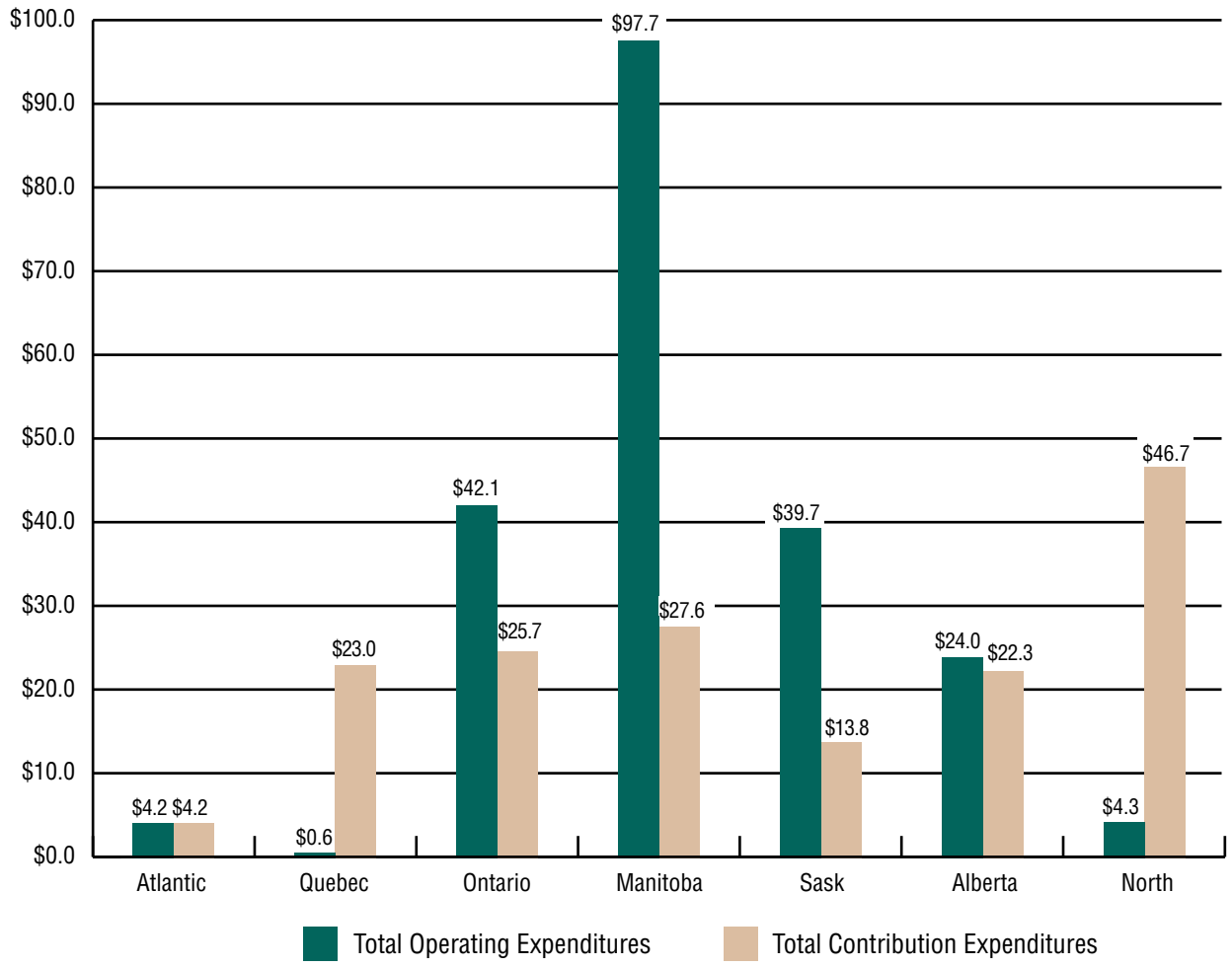
FIGURE 6.4

NIHB Medical Transportation Contribution and Operating Expenditures by Region ($ Millions)
2015/16

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.). Direct operating costs are funded to provide medical transportation benefits that are managed by Health Canada's regional offices.

Manitoba Region had the largest operating expenditure for NIHB Medical Transportation in 2015/16 at $97.7 million. This higher cost in the Manitoba Region is due in part to a high number of clients living in 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 $42.1 million, followed closely by the Saskatchewan Region at $39.7 million. Together these three regions accounted for 84.4% of all operating expenditures on medical transportation.

In 2015/16, the Northern Region had the largest contribution expenditures for NIHB Medical Transportation at $46.7 million, followed by the regions of Manitoba and Ontario at $27.6 million and $25.7 million, respectively. Almost all NIHB Medical Transportation services were delivered via contribution agreements in Quebec.



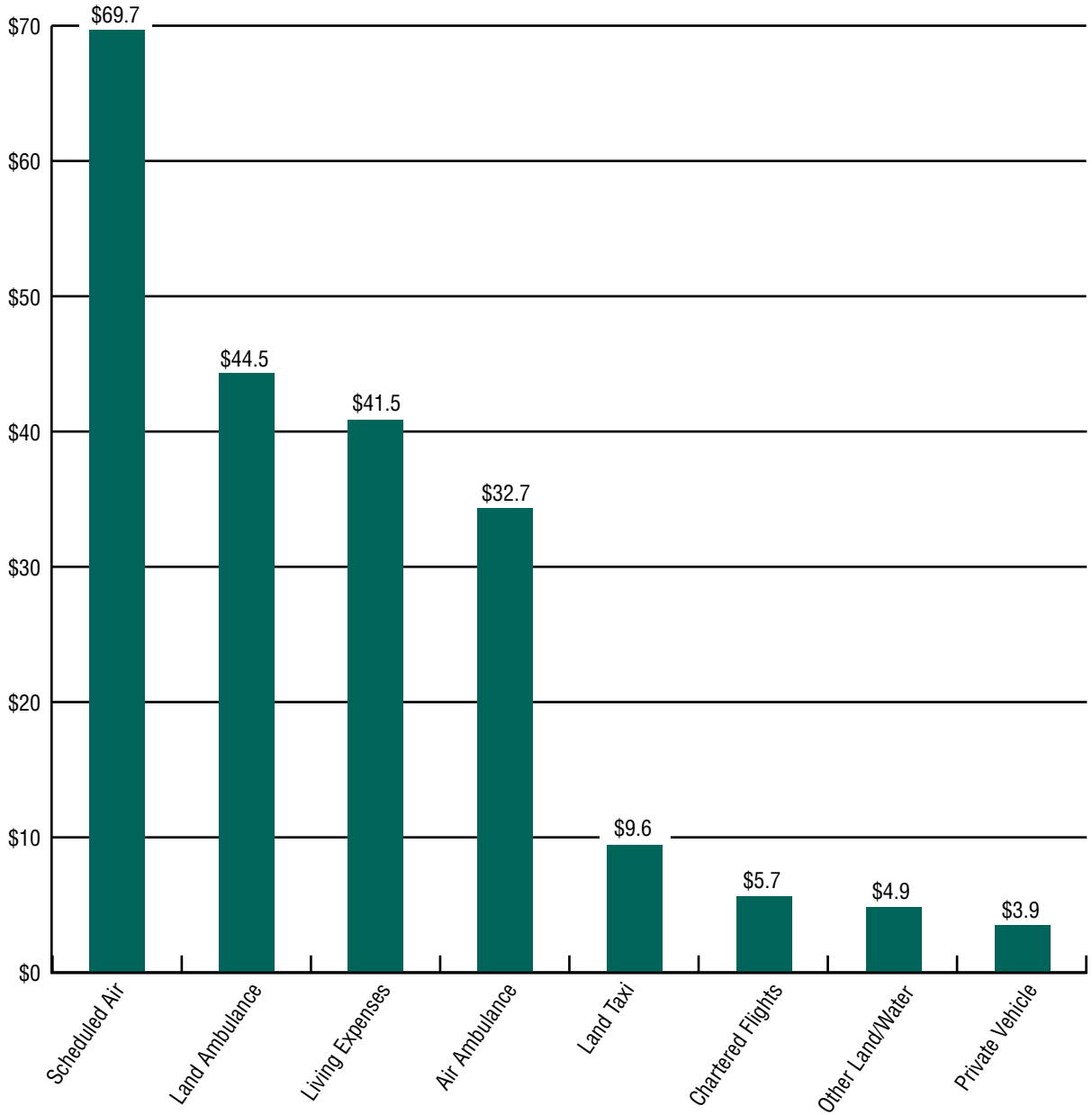
Source: FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 6.5

NIHB Medical Transportation Operating Expenditure by Type ($ Millions)
2015/16

In 2015/16, scheduled flights represented the largest portion of NIHB's Medical Transportation operating expenditures at $69.7 million or 32.8% of the total national operating expenditures. Land ambulance was the second highest at $44.5 million representing 20.9% of operating expenditures. Living expenses, which include accommodations and meals, followed at $41.5 million or 19.5%, and air ambulance costs comprised $32.7 million or 15.4% of medical transportation operating costs.

Private vehicle expenditures ($3.9 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.



Source: FIRMS adapted by Business Support, Audit and Negotiations Division

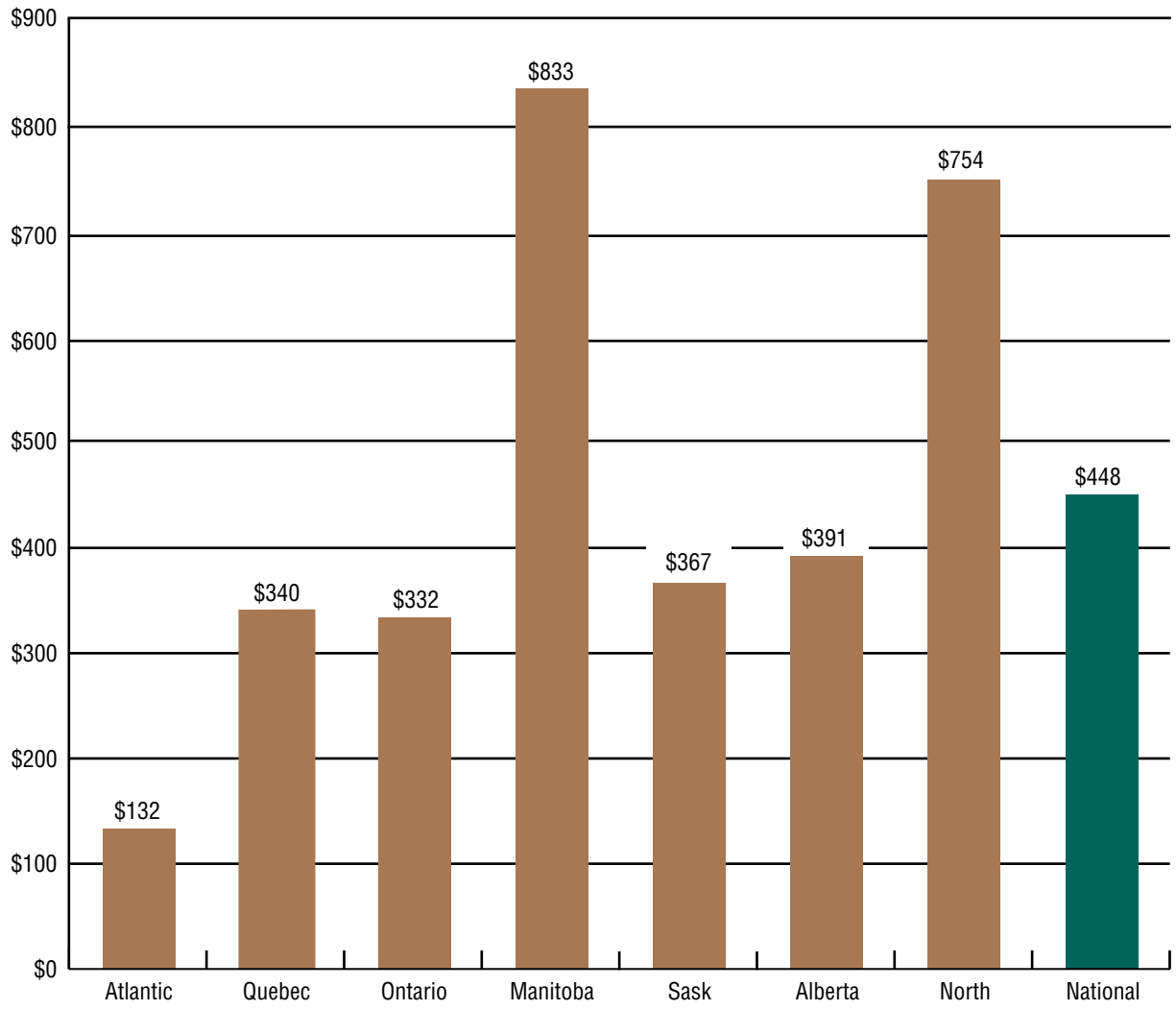
FIGURE 6.6

Per Capita NIHB Medical Transportation Expenditures by Region
2015/16

In 2015/16, the national per capita expenditure for NIHB Medical Transportation benefits was $448.

Manitoba recorded the highest per capita expenditure in medical transportation at $833, followed by the Northern Region at $754. 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 $132, a slight increase from $118 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.



Source: SVS and FIRMS adapted by Business Support, Audit and Negotiations Division

NIHB Vision Benefits, Mental Health Counselling Benefits and Other Health Care Benefits Data

SECTION 7

In 2015/16, total expenditures for NIHB Vision benefits ($30.0 million), Mental Health Counselling benefits ($16.2 million) and Other Health Care benefits ($4.9 million) amounted to $51.1 million, or 4.6% 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 licensed/certified, authorized, and in good standing with the regulatory body of the province/territory in which they practice.

NIHB Mental Health Counselling is primarily 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.

NIHB Other Health Care includes expenditures related to funding arrangements with the FNHA for Bill C-3 and Qalipu clients, and for payment of health premiums for Inuit clients in British Columbia. Other expenditures also include funding for Program oversight and partner contribution agreements.

FIGURE 7.1

NIHB Vision Expenditures and Growth by Region ($ 000's)
2015/16

NIHB Vision expenditures totalled $30.0 million in 2015/16. Regional operating expenditures accounted for $25.8 million or 85.9% of total expenditures while contribution costs accounted for $4.2 million or 14.1%.

In 2015/16, the Alberta Region had the highest expenditures in NIHB Vision benefits at $6.2 million, a percentage share of 20.7%, followed by the Ontario Region at $6.2 million (20.5%) and the Saskatchewan Region at $6.1 million (20.3%).

In 2015/16, the largest net increase in expenditures took place in the Northern Region, where total vision care costs grew by $822 thousand. The highest percentage change in NIHB Vision expenditures was also in the Northern Region, with an increase of 47.1%.

REGION	Operating	Contributions	TOTAL
Atlantic	$ 3,021	$ 0	$ 3,021
Quebec	1,749	0	1,749
Ontario	5,617	543	6,160
Manitoba	3,910	302	4,212
Saskatchewan	6,104	0	6,104
Alberta	5,063	1,144	6,207
North	336	2,229	2,564
Total	**$ 25,799**	**$ 4,218**	**$ 30,017**

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 7.2

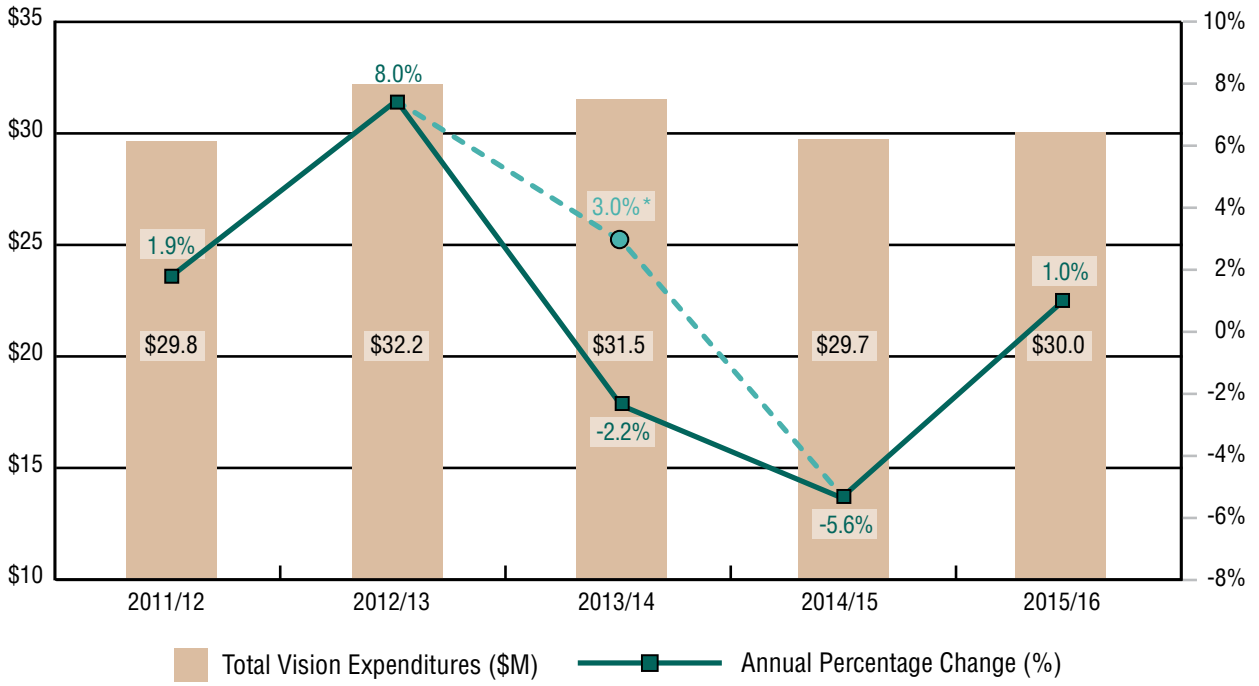
Annual NIHB Vision Expenditures
2011/12 to 2015/16

In 2015/16, NIHB Vision expenditures increased by 1.1%. Over the past five years, overall vision benefit costs have remained steady, the total value unchanged from $29.8 million in 2011/12 to $30.0 million in 2015/16. On a regional basis, the highest expenditure growth rate over this five year period was in the Atlantic Region where expenditures grew by 49.5% from $2.0 million in 2011/12 to $3.0 million in 2015/16. This growth is primarily 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 2014/15 decrease in overall NIHB Vision expenditures can be partially 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.

The largest net increases in expenditures over the past five years took place in the Saskatchewan Region where total vision benefit costs grew by $1.7 million over this period, followed closely by the Atlantic Region where costs grew by $1.0 million. The significant drop in Northern Region vision expenditures in fiscal year 2014/15 is due to a change in financial coding for specific Vision benefit contribution agreements in Nunavut and the Northwest Territories.

*If expenditures for FNHA eligible clients are excluded from 2012/13 and 2013/14 total NIHB expenditures, then the growth rate for 2013/14 would have been 3.0%.

NIHB Vision Expenditures and Annual Percentage Change



Source: FIRMS adapted by Program Analysis Division

NIHB Vision Expenditures ($ 000's)					
REGION	2011/12	2012/13	2013/14	2014/15	2015/16
Atlantic	$ 2,020.7	$ 2,968.7	$ 2,756.8	$ 2,665.9	$ 3,020.7
Quebec	1,403.5	1,570.4	1,619.1	1,621.7	1,749.2
Ontario	5,425.3	5,412.0	5,720.9	5,716.9	6,159.7
Manitoba	3,812.8	4,048.4	4,348.4	4,799.9	4,211.9
Saskatchewan	4,448.8	5,676.0	5,611.1	6,066.2	6,104.3
Alberta	5,821.6	5,836.4	5,935.7	7,083.9	6,207.2
North	3,386.7	3,370.0	3,763.1	1,742.7	2,564.3
Total	$ 29,780.5	$ 32,166.7	$ 31,459.4	$ 29,703.7	$ 30,017.2

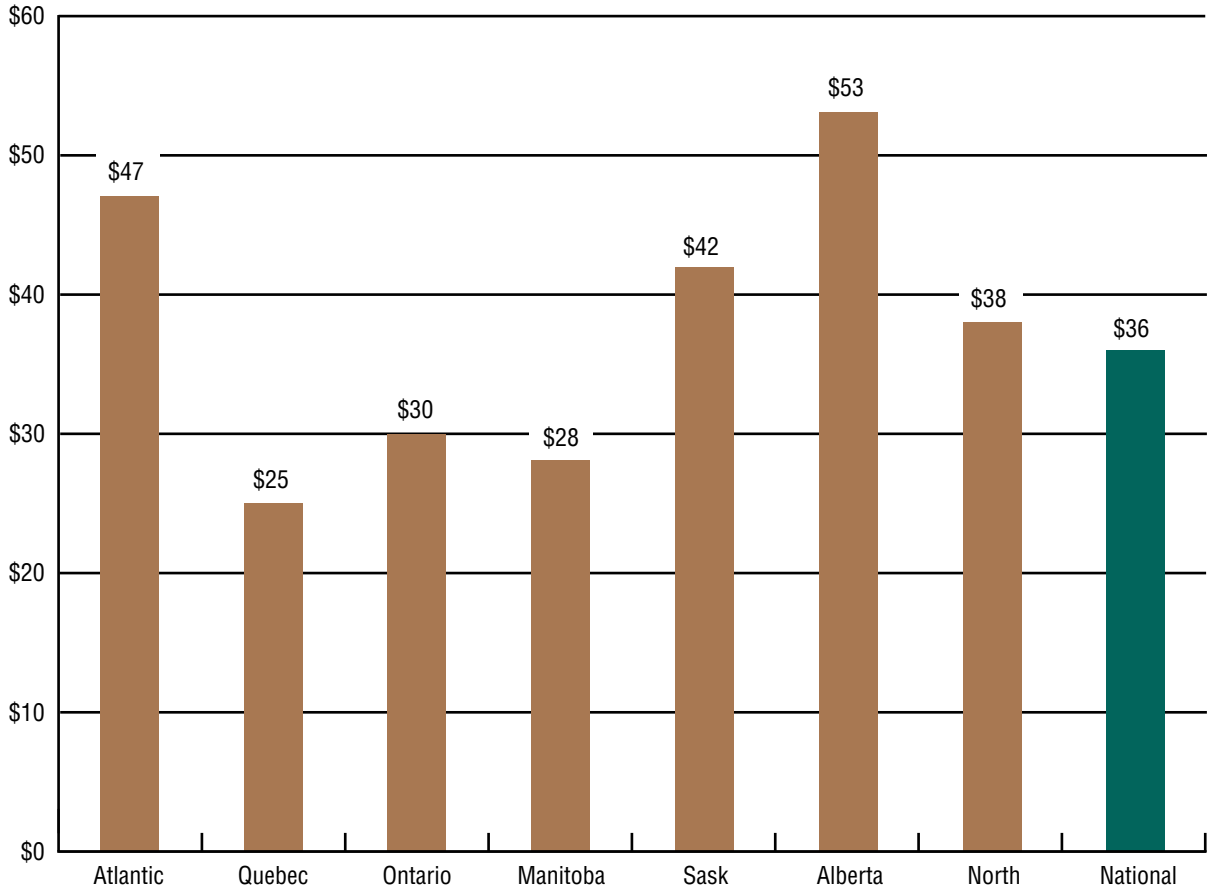
Source: FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 7.3

Per Capita NIHB Vision Expenditures by Region
2015/16

In 2015/16, the national per capita expenditure in NIHB Vision benefits was $36.

Alberta had the highest per capita expenditure at $53, followed by the Atlantic Region and Saskatchewan Region at $47 and $42 respectively. The lowest per capita NIHB Vision benefit expenditure was in the Quebec Region at $25.



Source: SVS and FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 7.4

NIHB Mental Health Counselling Expenditures by Region ($ 000's)
2015/16

Prior to 2014/15, NIHB Mental Health Counselling expenditures were reported under Other Health Care. In this edition of the NIHB Annual Report, and going forward, expenditures associated with the provision of mental health counselling services to NIHB clients will be reported separately from other Program expenditures classified under Other Health Care.

In 2015/16, NIHB Mental Health Counselling expenditures amounted to $16.2 million. Regional operating expenditures accounted for $10.4 million or 64.0% of total expenditures while contribution costs accounted for $5.8 million or 36.0%.

In 2015/16, the Alberta Region had the highest percentage share of NIHB Mental Health Counselling expenditures at 37.1% followed by the Manitoba and Ontario regions at 23.3% and 18.7% respectively.

REGION	Operating	Contributions	TOTAL
Atlantic	$ 185	$ 234	**$ 419**
Quebec	933	215	**1,148**
Ontario	2,909	113	**3,021**
Manitoba	2,943	837	**3,780**
Saskatchewan	473	1,158	**1,631**
Alberta	2,913	3,090	**6,003**
North	4	187	**191**
Total	$ 10,360	$ 5,833	$ 16,193

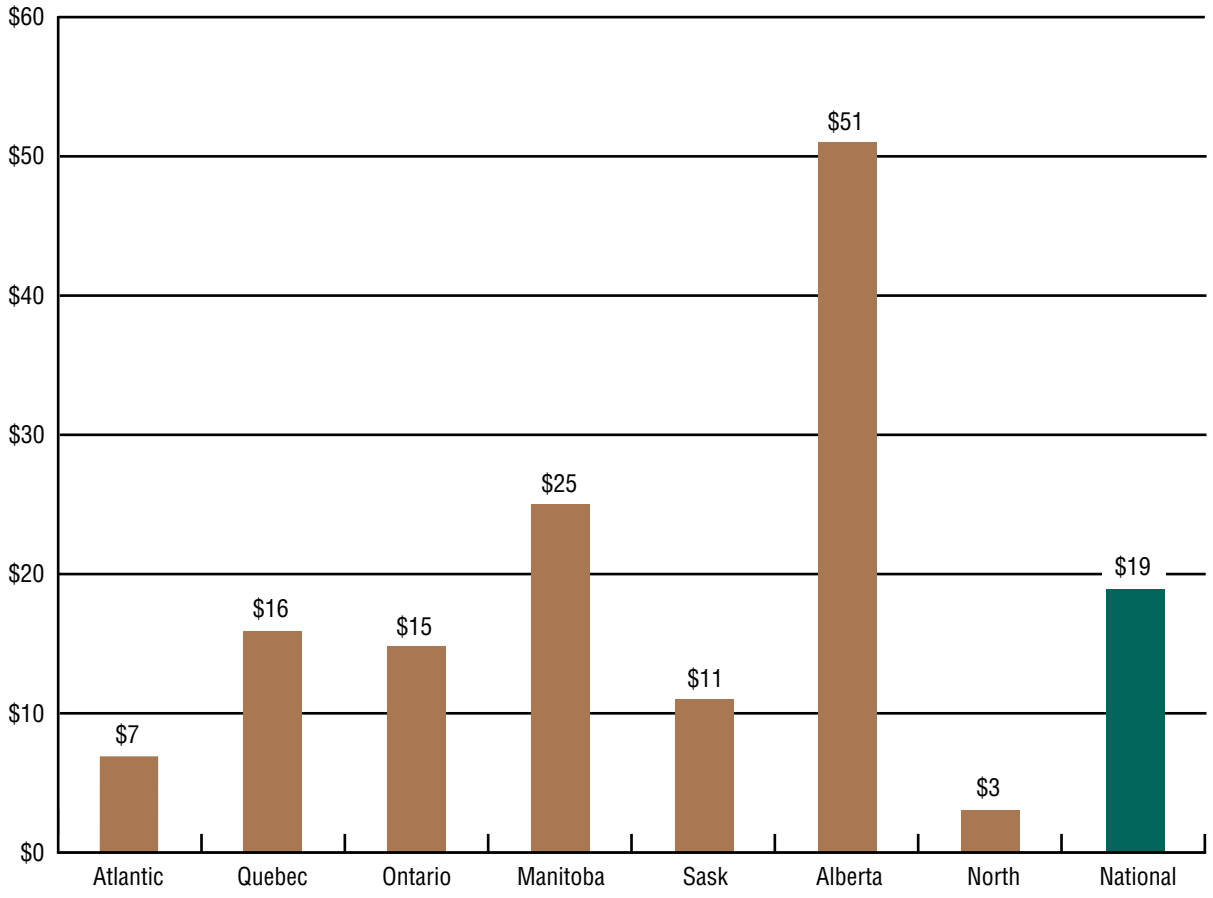
Source: FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 7.5

Per Capita NIHB Mental Health Counselling Expenditures by Region ($ 000's)
2015/16

In 2015/16, the national per capita expenditure for NIHB Mental Health Counselling was $19.

The Alberta Region had the highest per capita expenditure at $51, followed by the Manitoba Region at $25 per eligible client.



Source: SVS and FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 7.6

NIHB Other Health Care Expenditures by Region ($ 000's)
2015/16

In 2015/16, NIHB Other Health Care expenditures totalled $4.9 million. The majority of these expenditures are related to contribution agreements including funding arrangements with the FNHA for Bill C-3 and Qalipu clients, and for payment of health premiums for Inuit clients in British Columbia. Other expenditures in this category include partner contribution agreements related to Program oversight.

REGION	Operating	Contributions	TOTAL
Atlantic	$ 14	$ 30	**$ 44**
Quebec	2	256	**258**
Ontario	11	0	**11**
Manitoba	17	0	**17**
Saskatchewan	4	0	**4**
Alberta	3	0	**3**
North	1	0	**1**
Headquarters	56	4,465	**4,521**
Total	**$ 107**	**$ 4,751**	**$ 4,858**

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

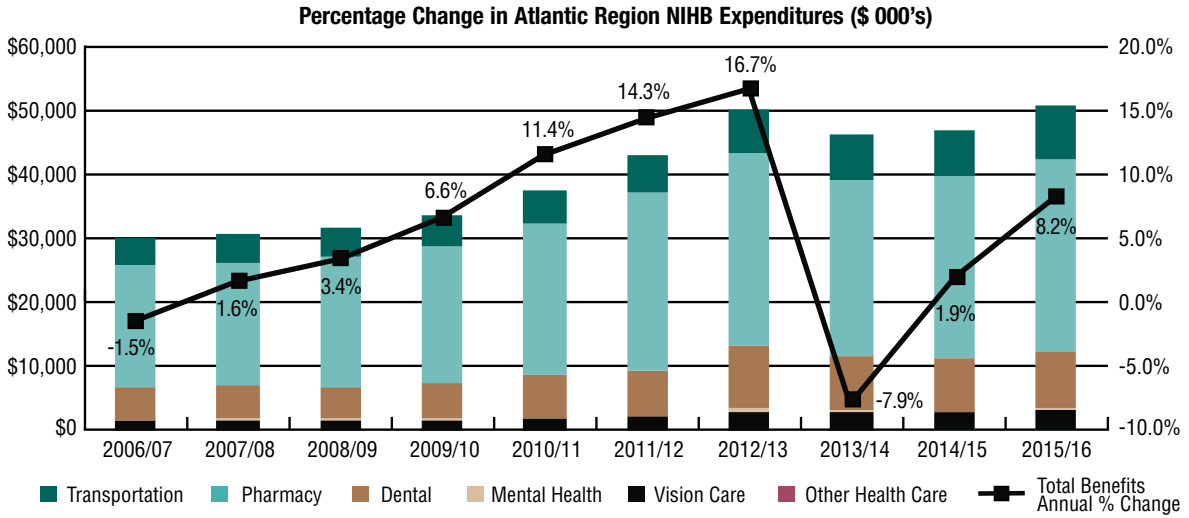
Regional Expenditure Trends 2006/07 to 2015/16

SECTION 8

FIGURE 8.1

Atlantic Region
2006/07 to 2015/16

Annual expenditures in the Atlantic Region for 2015/16 totalled $50.8 million, an increase of 8.2% over the $46.9 million spent in 2014/15. 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. The decrease in expenditures in 2013/14 can be attributed to the transfer of authority to the First Nations Health Authority for clients registered to Atlantic First Nations residing in British Columbia. As of March 31, 2016, a total of 24,327 Qalipu clients were registered in the Status Verification System (SVS) and were eligible to receive benefits through the NIHB Program.



Pharmacy expenditures in 2015/16 increased by 5.9% to $30.1 million, medical transportation costs increased by 13.0% to $8.4 million and dental expenditures increased by 7.4% to $8.8 million. Mental health expenditures increased by 147.5% and vision care expenditures increased by 13.3%.

Pharmacy expenditures accounted for more than half of the Atlantic Region's total expenditures at 59.2%. Dental expenditures ranked second at 17.4%, followed by medical transportation at 16.5%. Vision care and mental health expenditures accounted for 5.9% and 0.8% of total expenditures respectively.

Annual Expenditures by Benefit ($ 000's)

Atlantic Region	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Transportation	$ 4,401	$ 4,585	$ 4,655	$ 5,048	$ 5,314	$ 5,841	$ 6,875	$ 6,916	$ 7,419	$ 8,380
Pharmacy	18,938	18,984	20,119	21,357	23,689	27,571	29,979	27,517	28,398	30,064
Dental	5,128	5,204	4,945	5,426	6,481	7,164	9,660	8,609	8,238	8,846
Mental Health	192	272	251	213	241	254	512	235	169	419
Vision Care	1,408	1,495	1,596	1,612	1,758	2,021	2,969	2,757	2,666	3,021
Other Health Care	0	0	0	0	0	0	0	0	21	44
Total	$ 30,067	$ 30,539	$ 31,567	$ 33,656	$ 37,482	$ 42,850	$ 49,995	$ 46,033	$ 46,912	$ 50,773

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

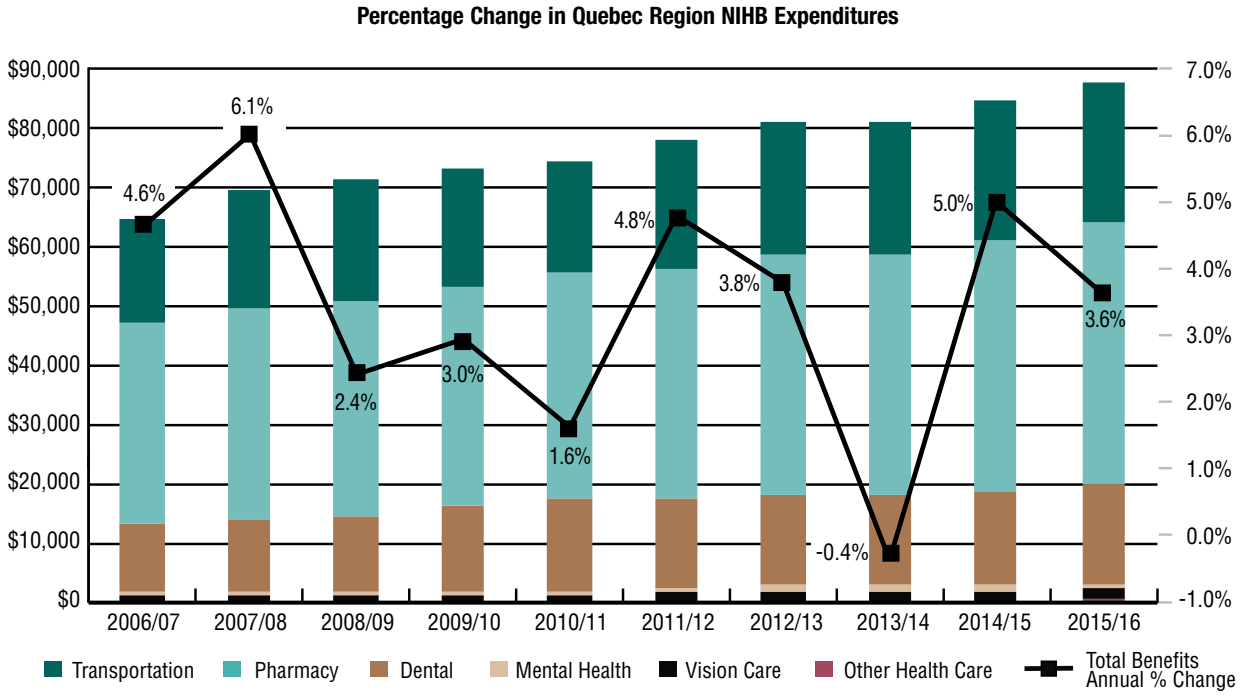
FIGURE 8.2

Quebec Region
2006/07 to 2015/16

Annual expenditures in the Quebec Region for 2015/16 totalled $87.7 million, an increase of 3.6% from the $84.7 million spent in 2014/15.

Pharmacy expenditures increased by 3.8% to $44.2 million and dental expenditures increased by 5.3% to $16.6 million, while medical transportation costs in 2015/16 increased slightly by 0.8% to $23.7 million. Mental health expenditures did not see an increase or decrease and vision care expenditures increased by 7.9%.

Pharmacy expenditures accounted for half of the Quebec Region's total expenditures at 50.4%. Medical transportation expenditures ranked second at 27.0%, followed by dental at 19.0%. Vision care and mental health expenditures accounted for 2.0% and 1.3% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)

Quebec Region	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Transportation	$ 18,473	$ 20,133	$ 20,502	$ 19,918	$ 18,943	$ 21,708	$ 22,578	$ 21,945	$ 23,506	$ 23,687
Pharmacy	33,486	35,372	36,069	37,358	38,234	38,827	40,393	40,825	42,581	44,206
Dental	11,603	12,141	12,895	14,159	15,245	15,138	15,239	15,216	15,799	16,641
Mental Health	583	471	375	459	597	875	1,135	1,003	1,148	1,148
Vision Care	1,270	1,257	1,220	1,280	1,336	1,404	1,570	1,619	1,622	1,749
Other Health Care	0	0	0	0	0	0	0	0	10	258
Total	$ 65,414	$ 69,374	$ 71,060	$ 73,174	$ 74,355	$ 77,951	$ 80,915	$ 80,608	$ 84,666	$ 87,690

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

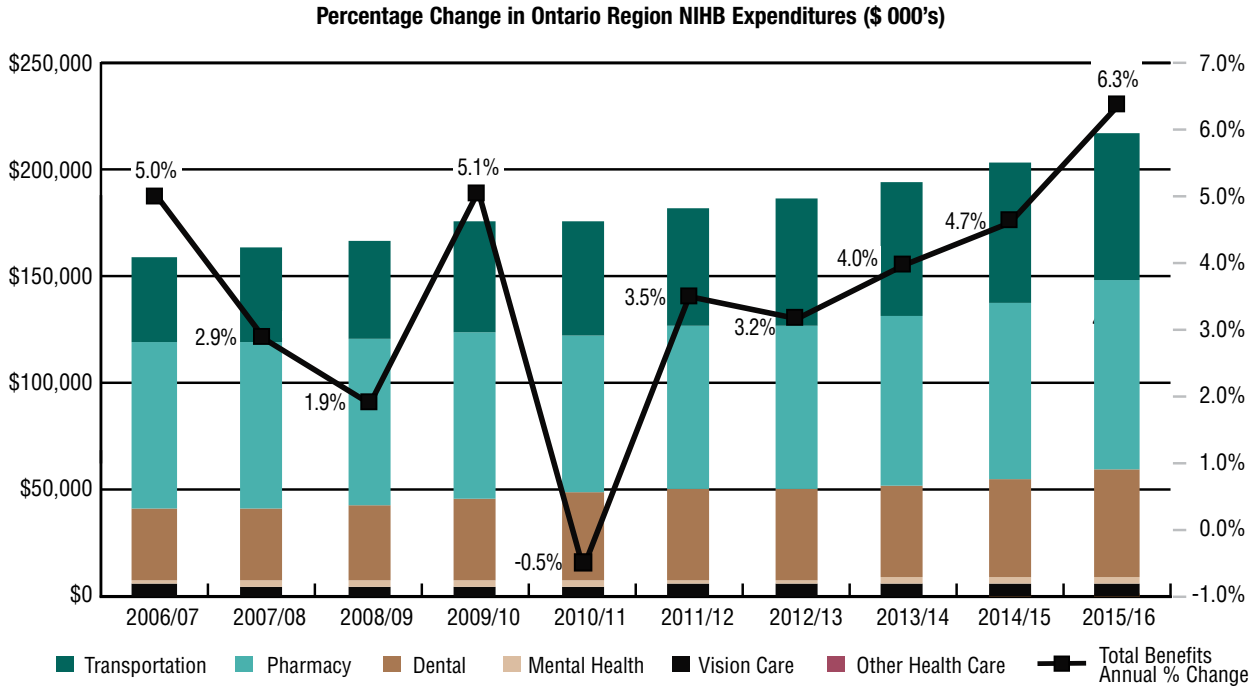
FIGURE 8.3

Ontario Region
2006/07 to 2015/16

Annual expenditures in the Ontario Region for 2015/16 totalled $215.7 million, an increase of 6.3% from the $203.0 million spent in 2014/15.

Ontario had the highest expenditures in dental care, followed by Saskatchewan and Alberta. In Ontario, pharmacy expenditures in 2015/16 increased by 8.4% to $88.9 million, while medical transportation costs increased by 3.0% to $67.8 million and dental expenditures increased by 6.7% to $49.9 million. Vision care and mental health expenditures increased by 7.7% and 7.8% respectively.

Pharmacy expenditures accounted for 41.2% of the Ontario Region's total expenditures. Medical transportation costs ranked second at 31.4%, followed by dental at 23.1%. Vision care and mental health expenditures accounted for 2.9% and 1.4% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)

Ontario Region	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Transportation	$ 40,572	$ 45,618	$ 46,848	$ 51,889	$ 52,358	$ 54,725	$ 59,251	$ 62,865	$ 65,781	$ 67,772
Pharmacy	77,788	77,191	77,244	77,564	73,887	76,430	77,131	78,510	81,982	88,872
Dental	32,777	33,467	35,457	38,047	40,594	41,848	42,259	43,972	46,759	49,903
Mental Health	2,530	2,172	2,158	2,603	2,632	2,349	2,490	2,862	2,803	3,021
Vision Care	5,485	5,366	5,204	5,343	5,183	5,425	5,412	5,721	5,717	6,160
Other Health Care	0	0	0	0	0	0	0	0	2	11
Total	$ 159,152	$ 163,814	$ 166,910	$ 175,447	$ 174,653	$ 180,778	$ 186,544	$ 193,929	$ 203,043	$ 215,738

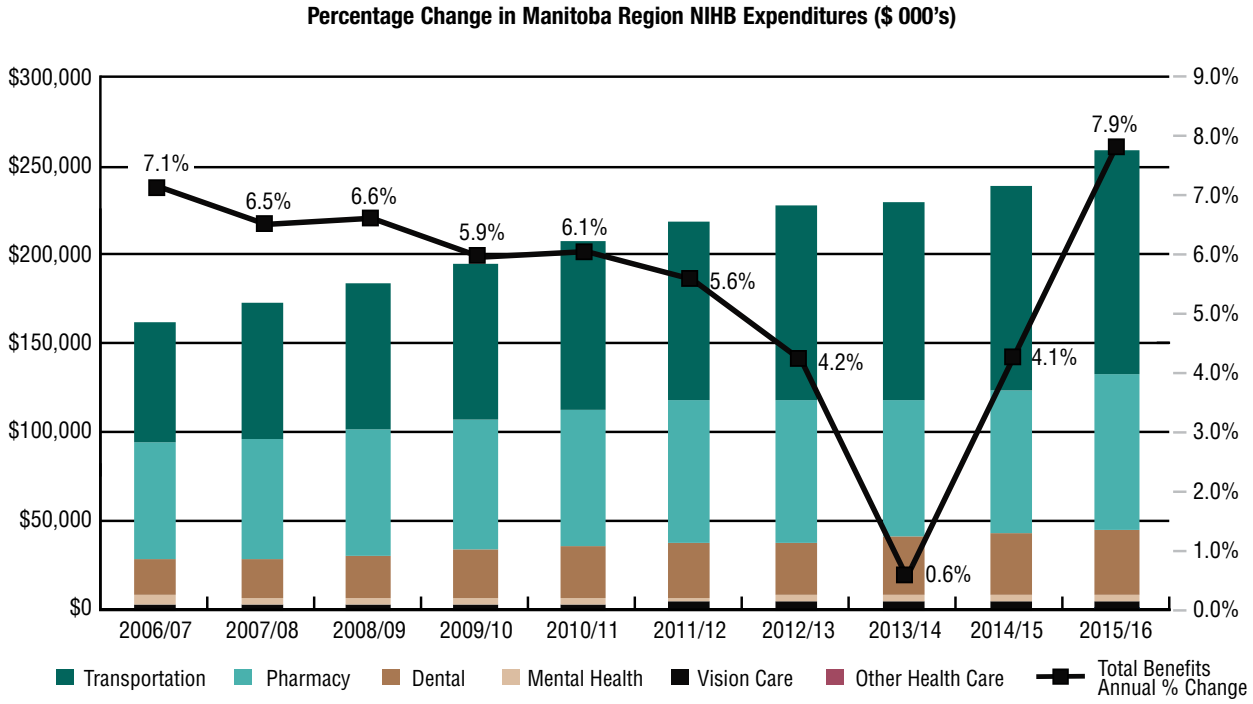
Source: FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 8.4

Manitoba Region
2006/07 to 2015/16

Annual expenditures in the Manitoba Region for 2015/16 totalled $258.1 million, an increase of 7.9% from the $239.2 million spent in 2014/15. Pharmacy expenditures in 2015/16 increased by 8.6% to $88.0 million, while medical transportation costs increased by 8.3% to $125.3 million. Dental expenditures increased by 9.7% to $36.8 million. Vision care and mental health expenditures decreased by 12.3% and 7.8% respectively.

Unlike most other regions, pharmacy expenditures in Manitoba do not represent the largest proportion of total expenditures. Due to the higher proportion of clients living in northern or remote communities in Manitoba, medical transportation expenditures comprised almost half of the Manitoba Region's total expenditures at 48.6%. Pharmacy costs ranked second at 34.1%, followed by dental at 14.2%. Vision care and mental health expenditures accounted for 1.6% and 1.5% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)

Manitoba Region	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Transportation	$ 69,047	$ 76,082	$ 83,193	$ 89,078	$ 94,940	$ 101,609	$ 109,409	$ 111,016	$ 115,705	$ 125,308
Pharmacy	64,966	69,317	71,081	72,789	76,496	80,639	80,676	77,034	81,059	87,997
Dental	20,756	21,696	24,444	26,954	29,399	29,861	30,734	33,649	33,527	36,764
Mental Health	4,786	2,964	2,619	3,143	2,930	3,109	3,429	3,622	4,099	3,780
Vision Care	2,841	2,936	3,157	3,407	3,612	3,813	4,048	4,348	4,800	4,212
Other Health Care	0	0	0	0	0	0	0	0	0	17
Total	$ 162,396	$ 172,994	$ 184,494	$ 195,371	$ 207,377	$ 219,031	$ 228,295	$ 229,670	$ 239,190	$ 258,077

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

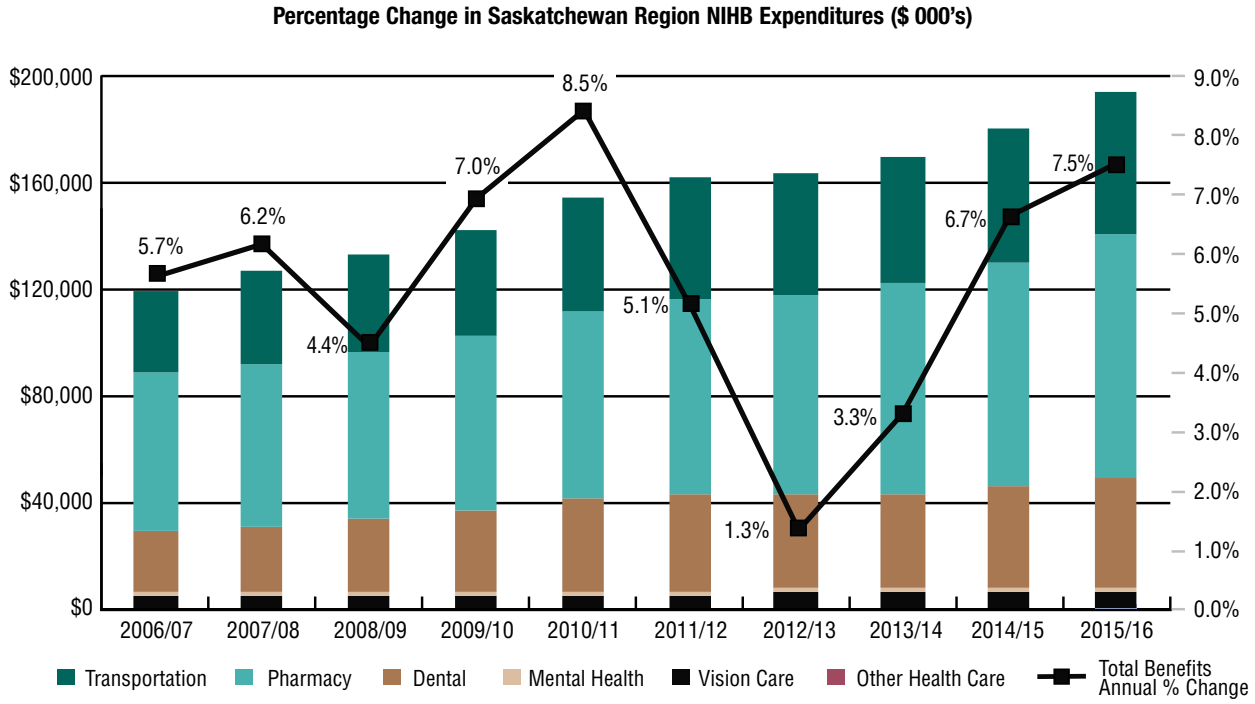
FIGURE 8.5

Saskatchewan Region
2006/07 to 2015/16

Annual expenditures in the Saskatchewan Region for 2015/16 totalled $193.5 million, an increase of 7.5% from the $180.0 million spent in 2014/15.

Saskatchewan had the highest expenditures in pharmacy, followed closely by Manitoba and Ontario. In Saskatchewan, pharmacy expenditures in 2015/16 increased by 9.4% to $91.2 million, while medical transportation costs increased by 3.9% to $53.6 million and dental expenditures increased by 8.9% to $41.0 million. Vision care and mental health expenditures increased by 0.6% and 20.7% respectively.

Pharmacy expenditures comprised the largest portion of the Saskatchewan Region's total expenditures at 47.1%, medical transportation costs ranked second at 27.7%, followed by dental at 21.2%. Vision care and mental health expenditures accounted for 3.2% and 0.8% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)

Saskatchewan Region	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Transportation	$ 31,816	$ 36,108	$ 36,239	$ 38,971	$ 41,896	$ 45,084	$ 45,793	$ 47,180	$ 51,543	$ 53,566
Pharmacy	58,083	60,749	62,809	66,639	70,625	73,293	74,646	78,546	83,361	91,170
Dental	23,219	24,636	28,102	30,777	35,317	36,941	36,219	36,399	37,679	41,028
Mental Health	2,244	942	870	812	896	1,499	1,038	1,017	1,351	1,631
Vision Care	3,835	4,126	4,166	4,222	4,658	4,449	5,676	5,611	6,066	6,104
Other Health Care	0	0	0	0	0	0	0	0	0	4
Total	$ 119,197	$ 126,561	$ 132,185	$ 141,420	$ 153,393	$ 161,265	$ 163,372	$ 168,752	$ 180,000	$ 193,502

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

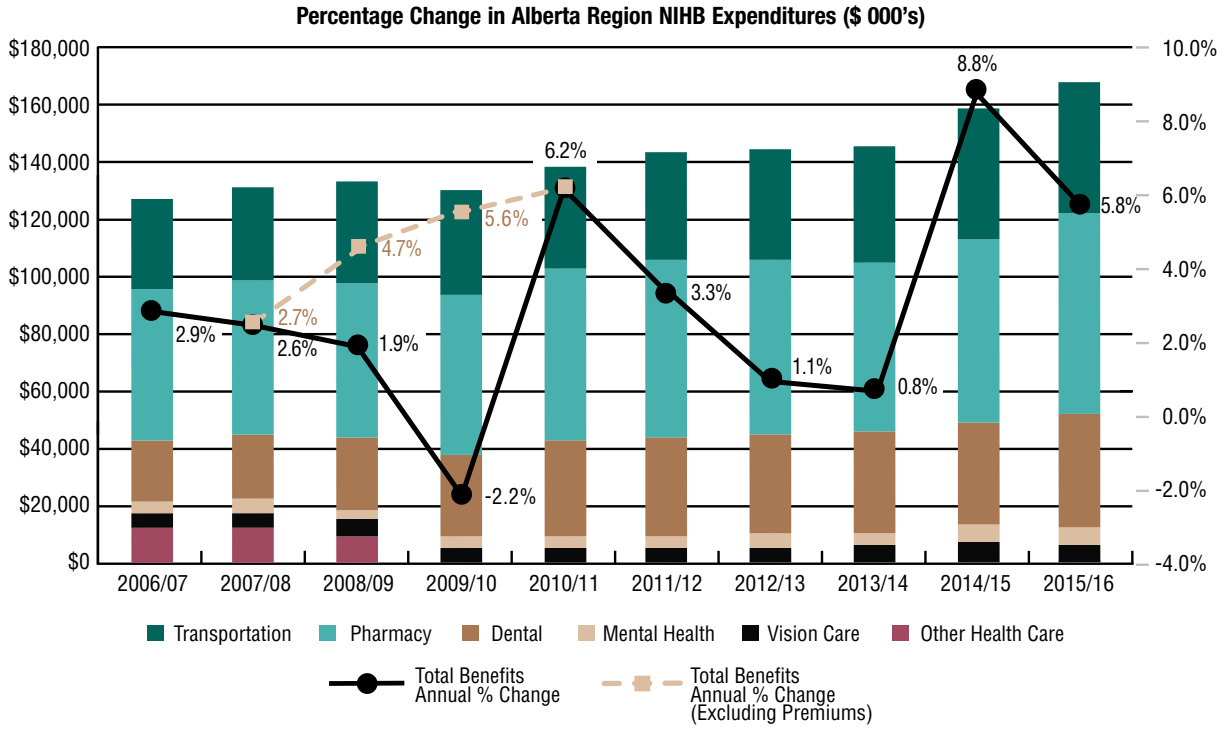
FIGURE 8.6

Alberta Region
2006/07 to 2015/16

Annual expenditures in the Alberta Region for 2015/16 totalled $168.2 million, an increase of 5.8% from the $159.0 million spent in 2014/15. Pharmacy expenditures in 2015/16 increased by 9.2% to $70.0 million, while medical transportation costs increased by 1.1% to $46.3 million and dental expenditures increased by10.5% to $39.8 million. Vision care and mental health expenditures decreased by 12.4% and 0.1% respectively.

Pharmacy expenditures accounted for 41.6% of the Alberta Region's total expenditures. Medical transportation costs ranked second at 27.5 %, followed closely by dental at 23.6%. Vision care and mental health expenditures accounted for 3.7% and 3.6% 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.



Fiscal year 2014/15 expenditures totals for Alberta Medical Transportation, Vision and MSE benefits have been restated and differ from the expenditures totals that appeared in the 2014/15 edition of the NIHB Annual Report.

Annual Expenditures by Benefit ($ 000's)

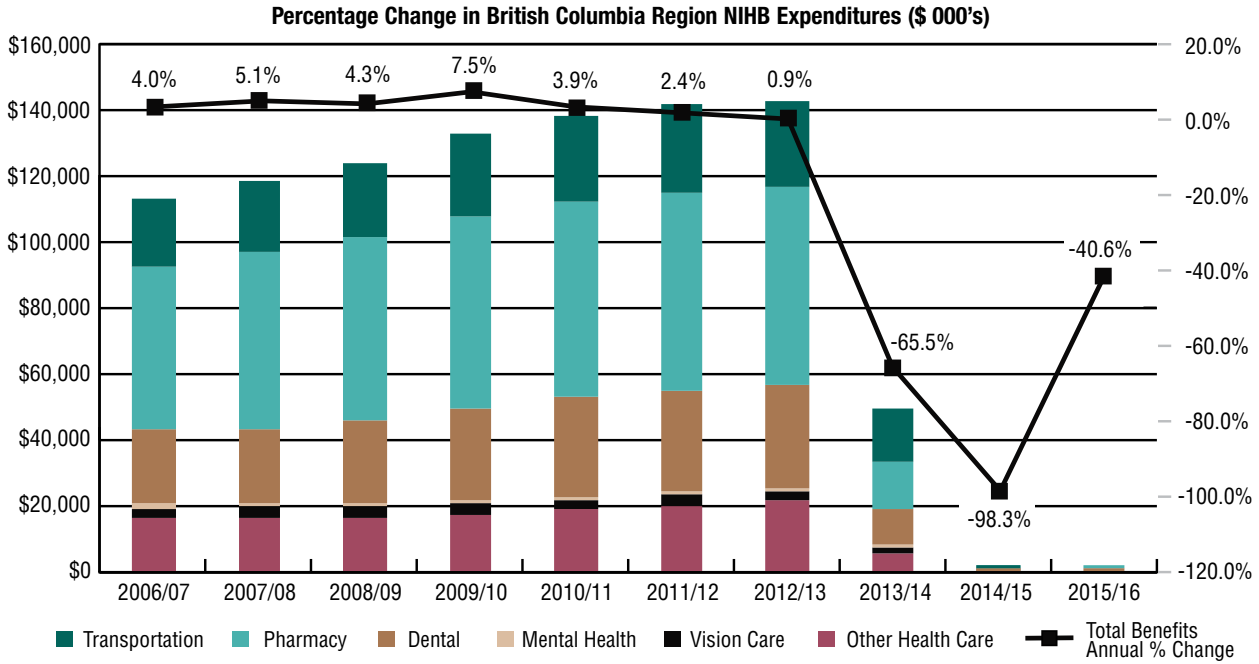
Alberta Region	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Transportation	$ 32,204	$ 32,107	$ 35,357	$ 36,601	$ 35,877	$ 37,371	$ 39,216	$ 41,451	$ 45,756	$ 46,252
Pharmacy	52,424	54,353	54,189	56,570	59,738	61,621	60,584	58,777	64,087	69,992
Dental	21,006	22,391	25,016	27,756	33,421	34,543	34,501	34,928	35,974	39,753
Mental Health	4,736	4,343	3,940	4,363	3,903	3,957	4,791	4,959	6,010	6,003
Vision Care	4,690	4,942	5,225	5,377	5,778	5,822	5,836	5,936	7,084	6,207
Other Health Care	12,709	12,961	9,920	0	0	0	0	0	0	3
Sub-Total (Excluding Premiums)	115,060	118,135	123,726	130,666	138,717	143,313	144,928	146,051	158,911	168,208
Total	$ 127,769	$ 131,096	$ 133,646	$ 130,666	$ 138,717	$ 143,313	$ 144,928	$ 146,051	$ 158,911	$ 168,211

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 8.7

British Columbia Region
2006/07 to 2015/16

Annual expenditures in the British Columbia Region for 2015/16 totalled $0.5 million. 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 has 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.



Annual Expenditures by Benefit ($ 000's)

British Columbia Region	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Transportation	$ 20,284	$ 21,613	$ 22,711	$ 25,547	$ 25,967	$ 26,510	$ 26,573	$ 15,960	$ 7	$ 0
Pharmacy	50,387	54,290	56,104	58,862	60,097	60,890	59,858	14,939	263	175
Dental	22,588	22,968	24,718	28,042	30,187	30,620	31,543	11,013	554	318
Mental Health	1,177	1,120	1,165	924	882	889	940	453	1	0
Vision Care	3,232	3,120	3,251	3,253	3,344	3,461	3,285	1,704	7	0
Other Health Care	15,951	16,250	16,510	17,110	18,428	19,868	21,257	5,406	0	0
Total	$ 113,620	$ 119,361	$ 124,458	$ 133,739	$ 138,905	$ 142,239	$ 143,455	$ 49,475	$ 831	$ 493

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

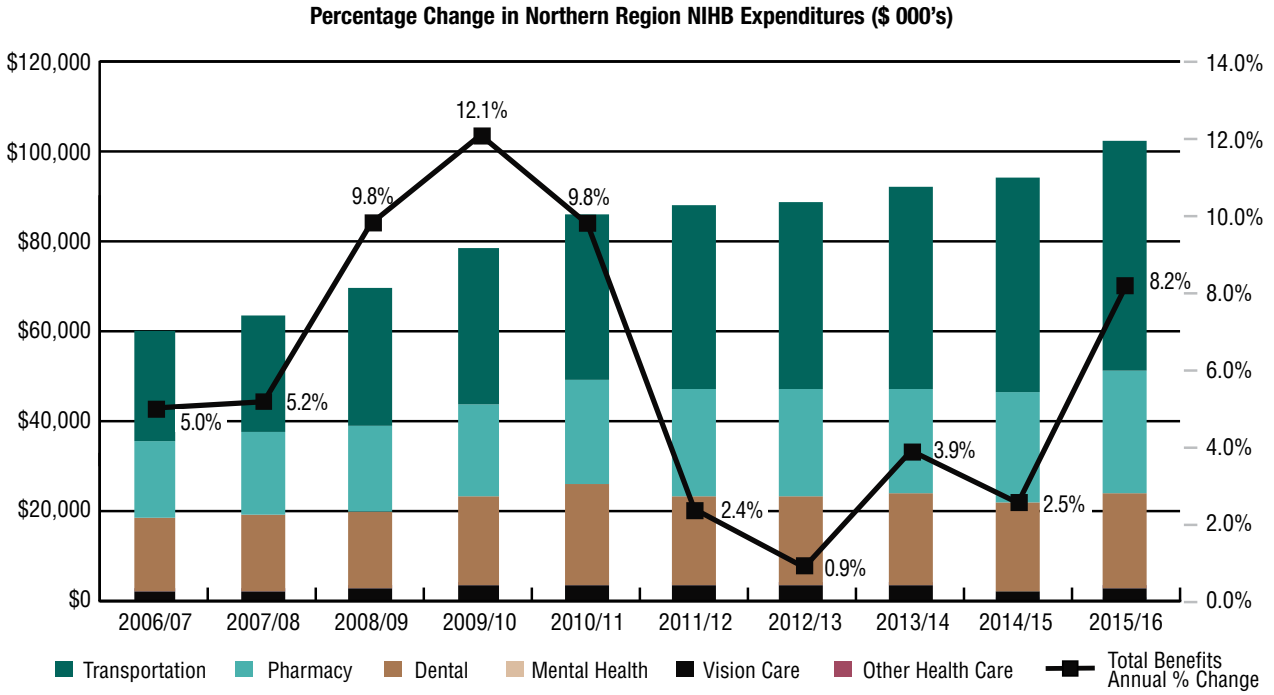
FIGURE 8.8

Northern Region
2006/07 to 2015/16

Annual expenditures in the Northern Region for 2015/16 totalled $102.0 million, an increase of 8.2% from the $94.3 million spent in 2014/15.

Medical Transportation expenditures in 2015/16 increased by 5.6% to $50.9 million while Pharmacy costs increased by 14.5% to $27.4 million. Dental expenditures increased by 2.6% to $20.9 million.

Similar to Manitoba, Medical Transportation expenditures comprised the largest portion of the Northern Region's total expenditures at 49.9%.



Annual Expenditures by Benefit ($ 000's)

Northern Region	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Transportation	$ 24,805	$ 26,049	$ 30,942	$ 34,622	$ 36,464	$ 40,455	$ 41,727	$ 44,703	$ 48,246	$ 50,940
Pharmacy	17,318	18,243	19,073	20,555	23,190	23,863	23,682	23,144	23,941	27,408
Dental	16,022	16,752	16,874	19,627	22,537	20,079	19,773	20,415	20,413	20,936
Mental Health	22	4	1	1	2	4	4	2	0	191
Vision Care	2,133	2,380	2,759	3,284	3,550	3,387	3,370	3,763	1,743	2,564
Other Health Care	0	0	0	0	0	0	0	0	1	1
Total	$ 60,301	$ 63,430	$ 69,649	$ 78,089	$ 85,744	$ 87,787	$ 88,557	$ 92,027	$ 94,343	$ 102,040

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

Initiatives and Activities

FIGURE 9.1

Health Information and Claims Processing Services (HICPS)
2015/16

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, 2016, there were 27,903 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 9.2.

Number of NIHB Providers by Region and Benefit, April 2014 to March 2016

REGION	Pharmacy	MS&E	Dental
Atlantic	795	221	1000
Quebec	1,914	195	2,843
Ontario	3,901	694	5,630
Manitoba	431	84	737
Saskatchewan	417	75	506
Alberta	1,267	258	2,367
British Columbia	1,369	436	2,542
Yukon	9	8	45
Northwest Territories	10	7	53
Nunavut	6	2	81
Total	**10,119**	**1,980**	**15,804**

Source: HICPS adapted by Business Support, Audit and Negotiations Division

* An active provider refers to a provider who has submitted at least one claim in the 24 months prior to March 31, 2016.

FIGURE 9.2

Number of Claim Lines Settled Through the Health Information and Claims Processing Services (HICPS) System in 2015/16

REGION	Pharmacy	Dental	MS&E	Total
Atlantic	1,323,512	155,245	35,286	**1,514,043**
Quebec	2,725,413	222,115	29,821	**2,977,349**
Ontario	5,826,187	597,643	42,709	**6,466,539**
Manitoba	3,649,672	442,854	79,000	**4,171,526**
Saskatchewan	3,184,272	486,113	77,318	**3,747,703**
Alberta	2,635,651	469,907	56,757	**3,162,315**
British Columbia	129,415	31,260	1,655	**162,330**
Yukon	100,870	19,337	3,033	**123,240**
Northwest Territories	321,426	89,726	9,425	**420,577**
Nunavut	271,375	125,596	13,826	**410,797**
Total Claim Lines	**20,167,793**	**2,639,796**	**348,830**	**23,156,419**

Source: HICPS adapted by Business Support, Audit and Negotiations Division

Figure 9.2 sets out the total number of pharmacy, dental and MS&E claims settled through the HICPS system in fiscal year 2015/16. During this period, a total of 23,156,419 claim lines were processed through HICPS, an increase of 7.8% over the previous fiscal year. Ontario had the highest volume of total claims processed at 6.5 million, followed by Manitoba at 4.2 million and Saskatchewan at 3.7 million.

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 9.3

Provider Audit Activities
2015/16

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 program's risk management activities, Health Canada has mandated its claims processor to maintain a set of pre-payment and post-payment verification processes, including a provider audit program.

During 2015/16, the claims processor 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 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 2015/16, 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; and
- Items/services were claimed prior to client(s) receiving the services/items;

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.

FIGURE 9.3.1

Audit Recoveries by Benefit and Region
2015/16

Figure 9.3.1 identifies audit recoveries, Next Day Claims Verification (NDCV) and Client Confirmation Program (CCP) savings* from all components of the Provider Audit Program during the 2015/16 fiscal year.

PHARMACY				
REGION	Audits Completed	Recoveries	NDCV/CCP Savings	Total Recoveries/ Savings
Atlantic	7	$ 47,087	$ 63,947	$ 111,034
Quebec	4	140,784	127,436	268,220
Ontario	6	142,657	520,984	663,641
Manitoba	15	373,389	303,017	676,406
Saskatchewan	6	35,461	53,328	88,788
Alberta	21	244,683	81,502	326,185
British Columbia	18	15,122	231,794	246,916
Yukon	0	0	0	0
N.W.T.	3	42,103	84	42,187
Nunavut	3	23,111	96	23,208
Total	83	$ 1,064,397	$ 1,382,188	$ 2,446,585

DENTAL				
REGION	Audits Completed	Recoveries	NDCV/CCP Savings	Total Recoveries/ Savings
Atlantic	5	$ 4,897	$ 48,491	$ 53,388
Quebec	2	10,831	41,315	52,146
Ontario	0	0	210,730	210,730
Manitoba	5	13,757	116,038	129,795
Saskatchewan	6	65,570	114,722	180,292
Alberta	7	7,863	197,652	205,515
British Columbia	9	4,367	303,653	308,020
Yukon	4	5,623	11,773	17,396
N.W.T.	2	26,462	21,083	47,545
Nunavut	3	42,824	14,003	56,827
Total	43	$ 182,193	$ 1,079,460	$ 1,261,653

MEDICAL SUPPLIES AND EQUIPMENT				
REGION	Audits Completed	Recoveries	NDCV/CCP Savings	Total Recoveries/ Savings
Atlantic	0	$ 0	$ 930	$ 930
Quebec	0	0	216	216
Ontario	3	30,762	3,619	34,381
Manitoba	9	90,460	815	91,275
Saskatchewan	1	200	2,678	2,878
Alberta	0	7,144	1,363	8,507
British Columbia	2	24,231	931	25,161
Total	15	$ 152,797	$ 10,552	$ 163,348

* 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.

FIGURE 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.

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 $1,999.99.

Status	Open Benefit (unrestricted)	Open Benefit (restricted)	Exceptions	Limited Use	Total
Total Requested	20,667	10,228	20,655	77,921	**129,471**
Total Approved	20,093	10,054	17,790	69,197	**117,134**

Open Benefit (unrestricted): Drugs included on the NIHB Drug Benefit List for which the total dollar value exceeds Point of Sale limit, the pre-determined frequency limit has been reached 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.

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) 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

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 9.6

Mental Health Counselling

In support of its role as a part of the Mental Wellness Continuum that supports cultural competency and includes other FNIHB, community based, and provincial/territorial programming, the NIHB Program collaborated with the Indian Residential Schools Resolution Health Support Program (IRS RHSP) to develop and implement a joint Guide to Mental Health Counselling Services on April 1, 2015.

The purpose of this publication is to provide information to clients and providers on what mental health counselling services are eligible under each Program, and how these services or benefits can be accessed. It also establishes a nationally consistent process for prior approval and streamlines the administration of the mental health benefit through the implementation of a new claim submission process.

The Guide is available on the Health Canada website at: **www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/benefit-prestation/crisis-urgence/guide-eng.php**

SECTION 9.7

New Provider Enrolment Process for Vision Care and Mental Health Providers

Beginning in February 2015, Health Canada initiated a nationally consistent process to enroll vision care and mental health counselling providers. This process is intended to ensure that all the applicable terms and conditions are clearly outlined for all providers and to support national consistency of administration.

For both benefit areas, only providers who have enrolled will be able to obtain prior approval for services and bill Health Canada directly.

The process for mental health providers is administered jointly with the Indian Residential Schools Resolution Health Support Program (IRS RHSP) to support linkages between the NIHB Program and the IRS RHSP.

SECTION 9.8

Negotiations Secretariat

The NIHB Negotiations Secretariat was created in 2005 to ensure a strategic approach to negotiations with providers which optimizes benefits to clients, reflects value for money, and is sustainable within existing Program resources. During 2015/16, the Negotiations Secretariat completed compensation adjustments for pharmacy providers in Quebec, Ontario, Manitoba, Saskatchewan, Alberta and Northern Region. The Negotiations Secretariat also reviewed the NIHB national dental compensation framework and determined new compensation rates.

SECTION 9.9

Privacy

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

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

The NIHB Program has also taken measures to protect the privacy of personal information used for claims processing. As the claims processor for NIHB, Express Scripts Canada (ESC) is required to abide by contractual privacy obligations with respect to life cycle management of personal information used for processing and settlement of NIHB claims. Regular privacy audits are conducted on an annual basis to ensure compliance as per the terms outlined in the Health Information and Claims Processing Services (HICPS) system contract.

SECTION 9.10

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: **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: **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: **www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/yhb-vss-inuit/index-eng.php**

SECTION 9.11

Collaboration with First Nations and Inuit Partners

In 2014, the Minister of Health agreed to undertake a multi-year Joint Review of the NIHB Program in partnership with the Assembly of First Nations. The overall objective of the review is to identify and implement actions that enhance client access to benefits, identify gaps in benefits, streamline service delivery to be more responsive to client needs, and increase Program efficiencies. The Joint Review is guided by a Steering Committee comprised of First Nations and FNIHB representatives. An implementation plan for changes and improvements to the NIHB mental health counselling benefit was approved by the Joint Review Steering Committee and presented to AFN leadership in 2015. Reviews of other benefits are underway, and the Steering Committee is examining broader issues of Program policy and management.

Health Canada continues to work with Inuit representatives through the Inuit NIHB Senior Bilateral Committee (INSBC) to identify and address areas of concern and recommendations to improve the quality, access, and delivery of NIHB benefits to Inuit clients. Joint terms of reference have been developed to guide the work of the INSBC, and a two-year work plan focuses on priority issues that were identified by the National Inuit Committee on Health (NICoH) through a survey of Inuit regions.

Client Safety

SECTION 10

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.

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

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*.

SECTION 10.1

Point of Sale (POS) Warning and Rejection Messages

2015/16

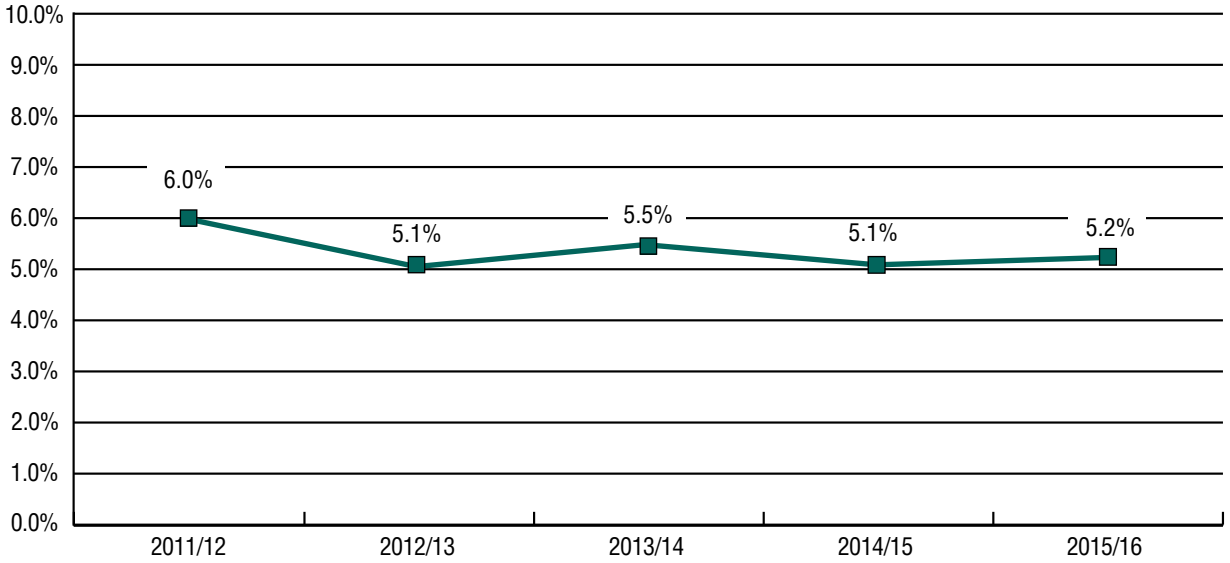
The NIHB Program sends messages electronically in real-time at the POS to warn pharmacy providers about potential client safety issues including drug interactions and repeat prescriptions. Certain warning messages also require the pharmacy providers to report back with specific codes that give the Program 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 10.1.1 shows percentage of claims affected by warning messages sent by the NIHB Program to pharmacies across the country since 2010/11. 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.

FIGURE 10.1.1

Percentage of Pharmacy Claim Line with a Warning Message
2011/12 to 2015/16



Source: HICPS adapted by Business Support, Audit and Negotiations Division

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. In 2015/16, the Program rejected a total of 2,291 claims for products that contain acetaminophen, as compared to 2,775 in 2014/15.

Another example of a rejection message is the NE code, created in 2006 to address the health risks associated with the misuse of specific drugs of concern. These drugs include opioids (such as morphine, codeine, and oxycodone which are used to relieve pain), benzodiazepines (so-called "minor" tranquilizers, sleep aids and anti-anxiety medications) and methadone (a long-acting synthetic opioid used to treat opioid addiction or pain). In designing this warning message, it was important to recognize that all of these drugs have clinically valid applications. Therefore, the warning message was designed to focus attention on cases where there were concerns about potential misuse, and where continued utilization was difficult to justify.

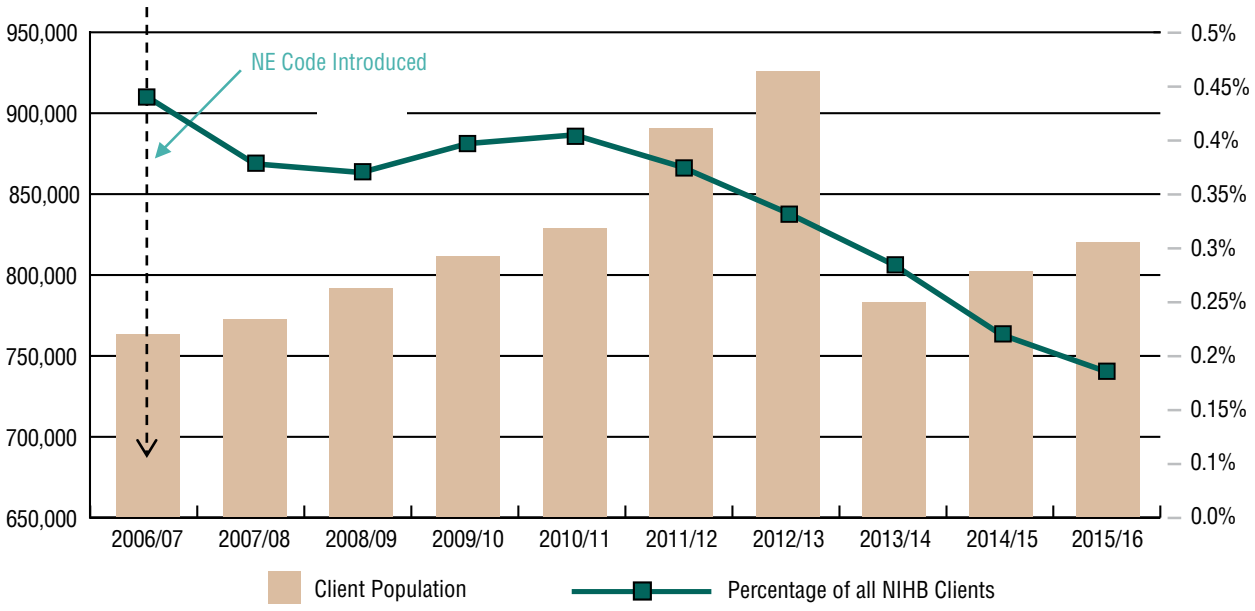
This intervention addresses situations where clients access:

- 3 or more active prescriptions for benzodiazepines
- 3 or more opioids
- 3 or more benzodiazepines and 3 or more opioids
- a prescription for methadone in association with opioid-based drugs

A message is provided to pharmacists indicating that potential misuse of prescription drugs should be explored. It is one more tool to supplement their professional judgment and to protect client safety. 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. In 2015/16, there were 1,174 clients with concurrent claims for opioids, benzodiazepines and methadone. This represents 0.1% of the total eligible population. NIHB continues to monitor concurrent use of these drug classes.

FIGURE 10.1.2

The number and percentage of clients claiming 3 or more benzodiazepines, 3 or more opioids, or opioids in association with methadone
2006/07 to 2015/16



Source: HICPS adapted by Business Support, Audit and Negotiations Division

SECTION 10.2

Client and Program Level Trend Analysis of Prescription Drug Use
2015/16

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.

Client Level Analysis

In January of 2007, NIHB launched the Prescription Monitoring Program (PMP) which focuses on the potential misuse of benzodiazepine, opioid, gabapentin, and stimulant drugs. The NIHB 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 interventions when there are concerns about how a client is using their medications. The NIHB PMP operates in all regions of Canada, with the exception of Quebec, and monitored nearly 15,000 clients in 2015/16.

Program Level Analysis

NIHB's Prescription Drug Abuse Surveillance Strategy tracks how drugs like methadone, opioids, benzodiazepines and stimulants are prescribed and dispensed. NIHB has an electronic system that closely monitors claims for these drugs and lets health providers know if there is a concern. The goal of these measures is to protect client safety.

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.

SECTION 10.3

Evaluations and Recommendations from Independent Experts
2015/16

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.

SECTION 10.4

Specific Drug Safety Initiatives
2015/16

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 begins 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 is in now effect in all regions except Quebec.

Improved Access to Suboxone™ for Addiction

Suboxone is a medication used to treat opioid dependence.

Previously, the NIHB Program provided coverage for Suboxone in special circumstances. This included coverage for those unable to take methadone, whether due to lack of access or serious reactions to the medication.

As of September 15, 2014, the NIHB Program has changed how it covers Suboxone to ensure that it is more readily available as a treatment option for clients. Health care providers now have the choice of prescribing Suboxone or methadone. Clients receiving Suboxone will be placed in the NIHB Prescription Monitoring Program (NIHB-PMP) for the duration of 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.

Changing the Listing Status of Kadian™ (a type of opioid)

As of November 17, 2014, the NIHB Program changed the way it covers Kadian, a medication used to treat chronic pain as well as drug addiction. Prescribers now need to provide the NIHB Program with additional information when requesting coverage. When Kadian is prescribed for drug addiction, the client is placed in the NIHB-PMP.

This 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. These changes ensure clients have safe and appropriate access to drugs like Kadian.

Introduction of a Dose Limit for Stimulants

Stimulants (for example, Dexedrine or Concerta) are medications used to treat attention disorders in children or adults. On February 25th, 2015 the NIHB Program set a new dose limit for stimulants to help ensure that clients are using these drugs safely. Dose limits are the maximum quantity of these drugs that a client can receive per day.

NIHB has contacted doctors whose clients exceed this dose limit to inform them of the change. If the doctor has provided NIHB with justification, some clients may continue to receive the higher dose.

Reduction in the Benzodiazepine Dose Limit

In March 2013, the NIHB Program introduced a dose limit for benzodiazepines, equal to 120mg diazepam equivalent per day. This limit was gradually decreased to 40 mg diazepam equivalence in 2015.

Reduction in the Opioid Dose Limit

To ensure appropriate opioid use amongst NIHB clients, beginning in September 2013, the NIHB Program implemented an opioid dose limit 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. This limit, which was 450mg of morphine equivalence per day in FY 2015/16, will continue to gradually decrease until an acceptable level is reached. 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."

SECTION 10.5

Dental Benefit Client Safety

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

NIHB Program Administration

FIGURE 11.1

Non-Insured Health Benefits Administration Costs ($ 000's)
2015/16

Figure 11.1 provides the Program administration funds expended by each region as well as NIHB headquarters (HQ) in Ottawa. In 2015/16, total NIHB administration costs were $54.0 million representing a decrease of $128 thousand over the previous fiscal year.

The roles of NIHB headquarters include:

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

The roles of the NIHB regions include:

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

CATEGORIES	Atlantic	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	Northern Region	HQ	Total
Salaries	$ 1,346	$ 1,739	$ 3,309	$ 2,810	$ 2,692	$ 2,578	$ 1,083	$ 11,107	$ 26,664
EBP	269	348	662	562	538	516	217	2,221	5,333
Operating	79	51	404	34	56	187	32	1,685	2,528
Sub Total	$ 1,694	$ 2,137	$ 4,375	$ 3,406	$ 3,287	$ 3,280	$ 1,331	$ 15,014	$ 34,525
Claims Processing Contract Costs									$ 19,466
Total Administration Costs									$ 53,991

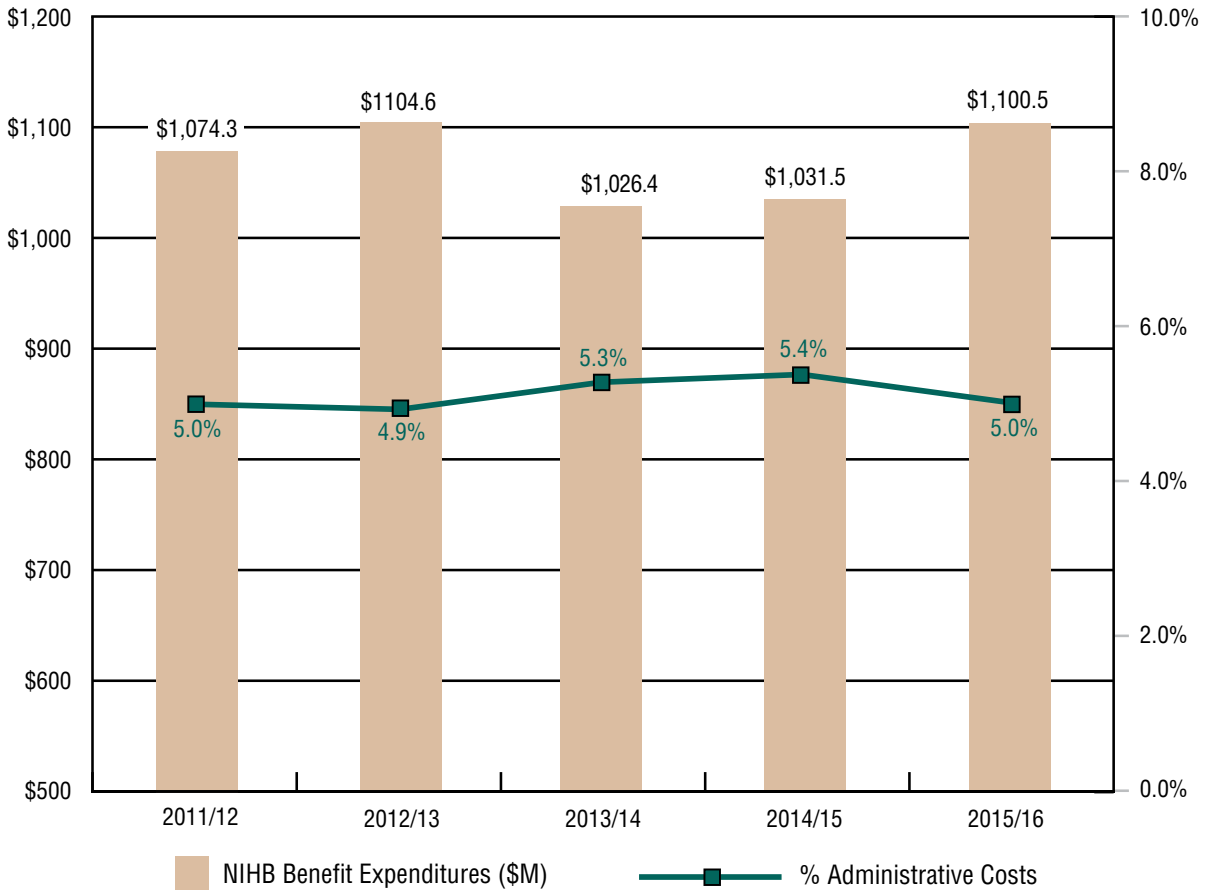
Source: FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 11.2

Non-Insured Health Benefits Administration Costs as a Proportion of Benefit Expenditures ($ Millions)
2011/12 to 2015/16

Figure 11.2 provides the percentage of NIHB Program administrative costs as a proportion of overall NIHB benefit expenditures. In 2015/16, total NIHB expenditures were $1,100.5 million, of which actual benefit expenditures totaled $1,081.0 million and expenditures for claims processing administration amounted to $19.5 million. An additional $34.5 million in expenditures for salaries and operating associated with Program administration are reported separately from total program expenditures. As a result, total NIHB Program administration cost ($54.0 million) as a proportion of actual benefit expenditures ($1,081.0 million), was 5.0% in 2015/16.

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 5.4% in 2014/15 to a low of 4.9% in 2012/13.



Source: FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 11.3

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.

Requests for NIHB coverage are driven by the number of eligible clients and their medical needs. The cost of claims is driven by external factors over which the Program has no control.

Client Base	Market Forces	Clinical Evidence
• Changing demographics, including high population growth, an aging population, and uncertainty about the registration of new or existing clients • Health status, including high prevalence of chronic and infectious diseases • Geographic location impacting clients' ability to access health benefits or services	• Introduction and price of new therapies and procedures by the private sector • Provincial/Territorial decisions and insurance industry dynamics • Shift from hospital treatments (insured) to non-insured coverage • Economic factors, including inflation, volatility in the price of gas and oil, and employment status • Lack of healthcare in communities, requiring medical transportation • Changes in scope of practice • Relationships with health professional associations	• Prescribing and treatment decisions of regulated health professionals • Evolving evidence on treatment options • Preventive intervention versus restorative oral treatment

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.

Technical Notes

SECTION 12

Information contained in the 2015/16 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.

To address reporting challenges related to in-year transfer of responsibility for First Nations individuals residing in British Columbia to the First Nations Health Authority (FNHA) in 2013/14, select financial and utilization data relating to the British Columbia Region have been suppressed. National totals, however, include these values.

Fiscal year 2014/15 expenditures totals for Alberta Medical Transportation, Vision and MSE benefits have been restated and differ from the expenditures totals that appeared in the 2014/15 edition of the NIHB Annual Report.

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, Emergency Mental Health 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).