FIRST NATIONS ACTION PLAN FOR NON-INSURED HEALTH BENEFITS

Assembly of First Nations
April 25, 2005

VISION

The First Nations Action Plan for Non-Insured Health Benefits (NIHB) is aimed at ensuring that First Nations can access services based on their needs and as per their Treaty and Inherent Rights to Health, and Crown's fiduciary duty. Access must be sustainable and flexible, and must be founded on a community health approach.

Improved access to NIHB is essential to addressing systemic inequities between First Nations and Canadians in health status and access to quality care, at individual, community and Nation levels.

In order to advance this vision, meaningful participation of First Nations is immediately required in all NIHB related activities of the First Nations and Inuit Health Branch, Health Canada.

FIRST NATIONS PERSPECTIVES ON NIHB

The NIHB program presently administered by Health Canada is likely the most visible and frequently accessed program by First Nations clients in need of health care. It represents close to half of Health Canada's total expenditures in First Nations and Inuit health.

NIHB emanate from First Nations' Treaty and Inherent Rights to Health, and result from the federal fiduciary obligation. The Supreme Court of Canada in *Marshall*[1] affirmed that the terms of a treaty are not limited to the text of the Treaty document, but include the actual agreements reached between the parties. Furthermore, the Supreme Court of Canada, beginning with the *Guerin* case and in subsequent cases since, has held that there is a fiduciary duty owed by the Crown to Aboriginal peoples arising from the historical relationship between the two parties.[2] Despite Supreme Court decisions, the Crown has consistently disputed recognition of treaty rights to health or health care,[3] except for certain specific treaties, and the scope and content of the fiduciary duty.

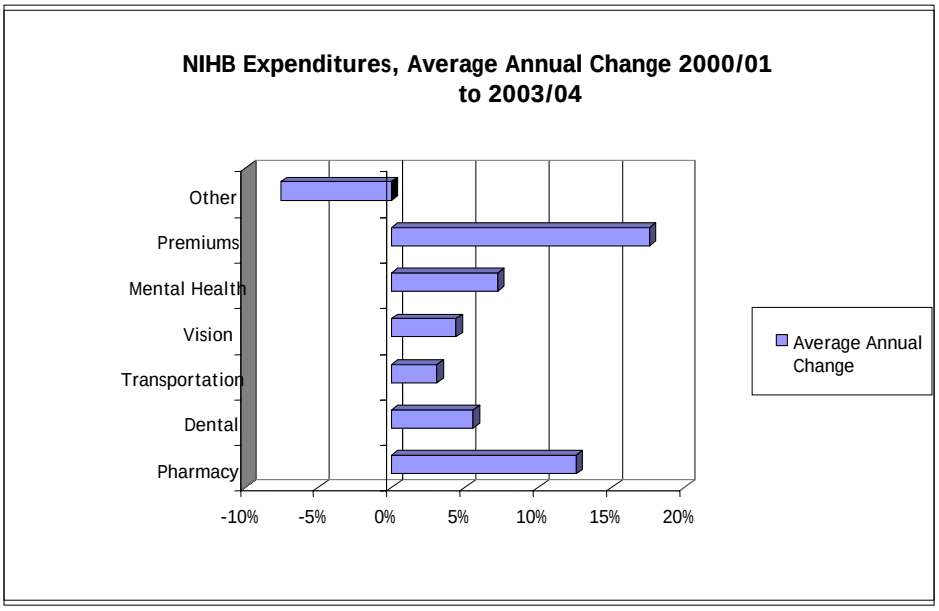
In 2004-05, the Assembly of First Nation (AFN), with advice from the First Nations Caucus on NIHB, completed an independent assessment of the NIHB Program to retrospectively analyze expenditure and utilization trends for the time period 2000/01 to 2003/04, to study the

[1] *R. v. Marshall*, [1999] 3 S.C.R. 533, 1999 CanLII 666 (S.C.C.).
[2] Nadjiwan Law Office Barristers and Solicitors *Impact of Health Transfer Agreements*. March 14, 2005.
[3] Boyer, Y. Discussion Paper Series in Aboriginal Health: Aboriginal Health, No. 2, Native Law Centre, 2004, p. 32.

impact of various cost drivers and to examine policy, service delivery and other administrative issues by conducting informant interviews. **The objective of this independent assessment was to develop recommendations for the June 2005 FNIHB Submission to Cabinet on Sustainability.**

NIHB INDEPENDENT ASSESSMENT: HOW MUCH FUNDING IS NEEDED?

Presently, increases in NIHB Program funding levels are limited to an estimated annual population growth rate, and they do not take into account health needs and cost drivers. Provincial health reforms impact the Program. For instance, hospital closures raise the demand for medical transportation, and shortened lengths of stay in hospitals result in higher utilization of medical supplies and equipment (MS&E) and prescription benefits. In the AFN's retrospective analysis of NIHB expenditures and utilization trends (2000/01-2003/04), the largest component of growth can be attributed to pharmacy benefits which accounts for over a third of the program's expenditures. Pharmacy expenditures increased annually, on average, by 12.6%, including 16.4% growth in over the counter (OTC) medications and 14.7% growth in prescriptions. Premiums (17.6%), mental health (7.3%) and dental (5.6%) benefits also showed healthy gains.



As age and gender-specific expenditure and utilization data are available for dental and pharmacy benefits, sensitivity analyses were conducted to understand major cost drivers: aging, population change, and utilization trends (individual). These have informed cost projections for the NIHB Program over the next five and ten year periods.

The main cost drivers and escalators for NIHB were identified:

- **Aging**

A youthful Fist Nations population is posed to add significantly to the senior population in coming years, and high fertility rates among First Nations have combined with declines in mortality rates to make population aging an important consideration in NIHB expenditure projections. Furthermore, the elderly are high users of health care, in particular non-insured health benefits. Indian and Northern Affairs Canada projections estimate that First Nations persons 65 years and older will increase from 4.25% of the population in 1999 to 8.89% in 2021, a 2.09 times increase.[4] By comparison, the 65+ age group in the general Canadian population will increase by a factor of 1.5.[5]

In the NIHB Program, from 2000/01 to 2003/04, aging had the greatest impact in MS&E[6] expenditure growth (i.e. 29.5% of growth was attributable to aging) and the lowest impact in dental expenditures (7.2%). Prescriptions and OTC benefits were mid range between these two extremes, with 12%-15% of the expenditure growth in the four year period being caused by aging of the population.

When these trends are translated to annual NIHB Program expenditures, aging increased these costs by 2.1% annually for prescription and OTC benefits, 1.4% for MS&E benefits, and 0.3% for dental benefits.

- **Population**

In the NIHB cost driver analysis, the claimant population has been used as an indicator of population growth. In the period 2000/01 to 2003/04, the greatest change of the claimant population was in dental and OTC benefits, where the number of claimants was associated with 30.7% and 22.8% of expenditure growth respectively. A lesser contribution was seen in prescription (11.8%) and MS&E (9.2%) expenditure growth.

In terms of annual change, the average annual growth of prescription claimants (1.6%) was similar to the average annual growth of the eligible population (2.0%), and dental claimant growth was slightly less (1.4%). However, for OTC and MS&E benefits, the rate of average annual growth of claimants is distinctly different from the eligible population, at 3.6% (OTC) and 0.5% (MS&E). **It is possible that this deviation from the eligible population growth rate is due to changes to benefit eligibility or other externally imposed policy changes.**

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[4] Indian and Northern Affairs Canada (INAC). 2002. *Population Projections of Registered Indians 2000-2021*.
[5] Provincial and Territorial Ministers of Health. 2000*. Understanding Canada's Health Care Costs: Interim Report.*
[6] All cost driver analyses involving MS&E and prescription benefits are based on the time period 2001/02 to 2003/04 due to a reorganization of these benefit categories which involved a movement of $10 million in expenditures in 2001/02, and the implementation of new MS&E guidelines that year.

INAC projections of Registered Indian population growth predict that the total population (on and off reserve) will grow by 1.7% in 2005, tapering off to 1.3% in 2015.[7]

It is critical to note that population growth estimates are artificially constrained by the ongoing impacts of Bill C-31. Self-government agreements have enabled First Nations communities to define their membership, and should be seen as the most updated population information.

- **Utilization**

Through a sensitivity analysis, the effect of increased utilization by individuals was separated from the effects of aging and population (claimant growth). This analysis revealed that increased utilization had a greater impact on expenditures than aging in all benefit areas except MS&E. In prescription and OTC benefits, utilization accounted for 35% to 45% of expenditure growth, and in dental benefits was responsible for over 20% of this growth.

On an annual basis, utilization accounted for 1% of dental growth, 4.8% of prescription growth and 7.0% of OTC growth. **Given the continued high health needs of First Nations and lack of improvement in basic health status indicators, it is reasonable to expect this trend to continue.**

MS&E utilization had a slightly negative effect on annual expenditure growth.

- **Inflation**

Statistics Canada price indices from 2000/01 to 2003/04 indicate inflation was most significant in the benefit categories associated with providing services, rather than goods.[8] In dental benefits, 51.7% of the growth in expenditures was attributed to inflation. Inflation was estimated to be responsible for 19.9% of MS&E growth, 10.0% of prescription growth and 4.8% of OTC growth.

- **Health Status and Health Reform**

In order to estimate health status as a cost driver, data is needed to determine if First Nations utilization of health services is increasing, decreasing or staying static. Diabetes is a condition where there are clear indications of increasing disease prevalence and accompanying higher costs. Among First Nations, diabetes is being diagnosed at a younger age resulting in a longer treatment period, the number of diabetics is increasing at a greater rate than population growth, and the number of people with chronic, long term complications is increasing. The NIHB Program saw a two-fold increase in diabetic drugs and

[7] INAC 2002.

[8] Statistics Canada price indices used in this analysis include: Prescribed Medicines, CANSIM, Series P100203, Non-Prescribed Medicines, CANSIM, Series P100203, Health Care Goods, CANSIM, Series P100201 and Health Care Services, CANSIM, Series P100206.

medical supplies in a four year period from 1995/96 to 1999/00. Other areas which were impacted by the larger diabetes prevalence include vision benefits, medical transportation to access specialists and renal dialysis services, dental services and MS&E.[9]

First Nations mortality rates continue to show a declining trend, which has had a positive effect on life expectancy. However, the *Health Canada Statistical Profile on the Health of First Nations in Canada* (2002) concluded that along with increases in life expectancy among First Nations, increases in chronic disease and disability prevalence should be expected, and the resulting pressure on the health care system should be large.[10] In other words, a trend to increased utilization of health services by First Nations should be expected. In the NIHB Program, this will be felt in diverse areas from dressing changes for diabetes clients (covered under MS&E), to increased pharmaceutical expenditures associated with HIV/AIDS and higher demands on medical transportation.

NIHB Program increases due to chronic disease and disability will be exacerbated by provincial health care reform. For instance, in the home care sector, First Nations health systems will be responsible for higher acuity clients who will have need for drugs, supplies and equipment previously covered by provinces. Health care reform has also centralized some hospital services, such as renal dialysis and maternity, which, in turn, will increase medical transportation costs.

Limited trend information on First Nations dental health is available. Surveys of First Nations and Inuit children's oral health in 1990-91[11] and 1996-97[12] showed no improvement in tooth decay rates between the two time periods. Utilization is expected to increase in dental benefits due to the Children's Oral Health Initiative, prevention and promotion programs, as well as emergent care required to address the general poor dental health of the First Nations population.[13]

- **Medical Advances**

The future impact of medical advances cannot be quantified, as there is no acceptable measure of technological change nor can discoveries which drive change be predicted.[14]

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[9] NIHB Sustainability Working Group, Health Canada. 2002. *Non-Insured Health Benefits Sustainability Document.*

[10] Health Canada, FNIHB. 2002. *A Statistical Profile on the Health of First Nations in Canada*. Ottawa: Health Canada.

[11] Leake, J.L. 1992. *Report on the Oral Health Survey of Canada's Aboriginal Children Aged 6 and 12*. Toronto: University of Toronto, Department of Community Dentistry.

[12] Saskatchewan Indian Federated College, National School of Dental Therapy. 2000. *Report on the 1996-1997 Oral Health Survey of First Nations and Inuit Children in Canada.* Ottawa: Minister of Public Works and Government Services Canada.

[13] Health Canada written response to the NIHB Independent Assessment informant survey, March 9, 2005.

[14] Hogan and Hogan, 2002. *How Will Aging of the Population Affect Health Care Needs and Costs in the Foreseeable Future?* Discussion Paper #25, Commission on the Future of Health Care in Canada.

However, recent studies have teased apart pharmaceutical trends in order to quantify drug cost escalators. Even though private drug plans have very different dynamics than publicly available provincial pharmacare plans, in both types of plans, the majority of drug costs increases have been found to be related to the entry of new drugs into formularies and utilization.[15] [16]

The NIHB Program has identified the introduction and uptake of new and more expensive therapies including those for rare conditions, as major cost drivers, both in the time period reviewed and in the future. For example, the NIHB Program projected in 2002 that a new arthritis drug would add $3.5 million or a 2% annual increase to the Program.[17] As well, Avantia was introduced for the treatment of type II diabetes in 2000; its unit price is five times greater than the unit cost of any other drug in its class. More recently, a new insulin product has entered the market, and is three times more expensive than comparable products.[18]

With respect to rarely used drugs, cost can exert a disproportionate effect on the Program. Enbrel is a specialty treatment for rheumatoid arthritis, with an annual cost of $17,000 per client. Although less than 0.03% of the eligible client population claimed for Enbrel in the last year, it is now one of the top five drug products by expenditure for the Program.[19]

Technological change will continue to affect dental benefit expenditures, as more complex services are available to meet needs, such as dental implants. The feasibility of dental implants is being evaluated in a Quebec Region pilot project, particularly for First Nations who have suffered a severe loss of bone density, resulting in the loss of ability to chew with their dentures and accompanying weight loss. Dental impacts are beneficial in securing prosthetics in place.

Policy-Induced Changes

The NIHB Program has been the subject of several cost management measures over the 1990s. These have included: delisting of benefits, changes to eligibility for benefits, reductions in pharmacist service costs (mark ups and dispensing fees), enforcement of low cost pharmaceutical alternatives (generic drugs), prior approval requirements for limited use/special authority drugs, and pre-determination (prior approval) of some dental services. In addition, the Program is affected by reductions in provincial benefits since FNIHB views itself as a payer of last resort. The most recent example of a provincial policy change

[15] Federal/Provincial/Territorial Working Group on Drug Prices and the Patented Medicine Price Review Board. 2000. Cost Driver Analysis of Provincial Drug Plans: Alberta 1993/94 – 1998/99.
[16] Brogan, T. J. Fernely, M. Midena and R. Stewart. 1997. *Factors Affecting the Cost of Private Drug Plans: 1993-1996.* Brogan, Inc.
[17] NIHB Sustainability Working Group, Health Canada. 2002.
[18] Health Canada, March 9, 2005.
[19] Health Canada, March 9, 2005.

affecting the NIHB Program is the Ontario government's delisting of vision benefits as of November 1, 2004.

Experience in First Nations communities suggests that these cost containment measures have had an adverse impact in First Nations communities, for example on decreased quality of service, longer waits, and denial of service if transportation access is not available. Certain categories of service providers – mainly dentists and orthodontists – have moved First Nations individuals to a cash basis due to delays in receiving payment from the NIHB Program. The Canadian Association of Orthodontists sent out an advisory to its membership recommending such action, and the Canadian Association of Pharmacists has suggested doing the same if the NIHB Audit Program is not reformed. Instituting a cash basis for remuneration is an immediate deterrent to care, as individuals requiring service may not have the resources to pay upfront and therefore do not seek treatment.

The main FNIHB policy changes in each benefit area during 2000/01 to 2003/04 were:

- *Pharmacy:* 27 drugs were added to the open list, 25 were deemed limited use, 3 were assigned as exceptions and 22 were classed either as non-benefits or exclusions. From the NIHB Program's perspective, there has been no significant delisting of prescription medications, and the majority of those which have been removed are found in categories of drugs which have been discontinued.
  - Delisted categories of OTC benefits in the NIHB September 2003 bulletin included:
    - cough medications containing codeine;
    - pseudophedrine containing medications (anti-histamines);
    - dental-fluoride supplements;
    - antiacids and absorbents;
    - antipruritics and local anesthetics;
    - sunscreens; and
    - emollients.

- *Dental:* The NIHB guidelines in the June 2002 dental bulletin detailed eight mandatory conditions which must be met for eligibility of orthodontic benefits. Approval of treatment is still considered to be mostly arbitrary by First Nations regional health technicians. The most limiting orthodontic condition is the unclear requirement that the malocclusion be significantly severe and functionally handicapping, not just cosmetically unacceptable. At the same time as the clarification of orthodontic benefits occurred, the benefit list was broadened to add interceptive treatments – wire braces and removable appliances which are of lower cost than braces. From 1999/00 to 2002/03, no uniform trend can be seen in orthodontic benefits nationally, as a 15.1% decrease in per

capita expenditures occurred in 2000/01, followed by an increase of 10.0% the following year, then a 1.3% decrease in 2002/03.[20]

- *Medical Supplies and Equipment:* On April 1, 2001, the recommendations of the January 1999 MS&E review were implemented, and described in four bulletins: audiology benefits, general MS&E benefits, orthotics and prosthetics, and oxygen therapy and respiratory benefits:
  - Audiology: some limits were put on hearing aid benefits. Prior approval is necessary for these benefits.
  - General MS&E: diabetic supplies are only provided by pharmacy providers (as these were found to be less expensive than those from MS&E providers).
  - Orthotics: approved prescribers and providers were identified for limb and body orthotic devices. Previously, there were no regulations on who could provide orthotic devices or limits on costs. Prior approval is necessary for these benefits from specialists – who are often not as accessible to First Nations.
  - Oxygen therapy: controls were placed on oxygen therapy, including provision by an oxygen provider who has the appropriate health care staff with regulatory affiliations, and development of medical guidelines for the use of oxygen therapy. Prior approval is necessary for these benefits.

- *Medical Transportation:* The Interim Medical Transportation Framework took effect on April 1, 2003, defining the terms and conditions for accessing the benefit. FNIHB regions' implementation of these terms and conditions may sometimes restrict access to health providers. One concrete example is the non-eligibility of non-emergent dental services (e.g. fillings, teeth cleaning) for medical transportation benefits in two regions (Ontario and Pacific). Criteria for hospital to hospital transfers – even though no longer covered in some provinces - have been restricted, and there is a general lack of accessibility of subsidized transportation for other community health programs.

- **Benefit Areas Other than Pharmacy and Dental**

Only aggregate expenditure data are available for vision, medical transportation and mental health benefits, as age and gender information are not collected, nor are utilization statistics. As a result, changes in total expenditures over the time period are provided.

Mental health services have averaged 7.3% annual growth from 2000/01 to 2003/04. There is a trend toward contract or salary-based services over fee for service, but it is not known if more clients are receiving services, individual utilization or service costs have increased, or if contract/salaried delivery of services is more cost effective than fee for service.

[20] Orthodontic expenditures were obtained in a letter from Mr. Ian Potter, ADM, Health Canada to the Canadian Dental Association, Assembly of First Nations, Inuit Tapiriit Kanatami and Canadian Association of Orthodontists dated September 15, 2004.

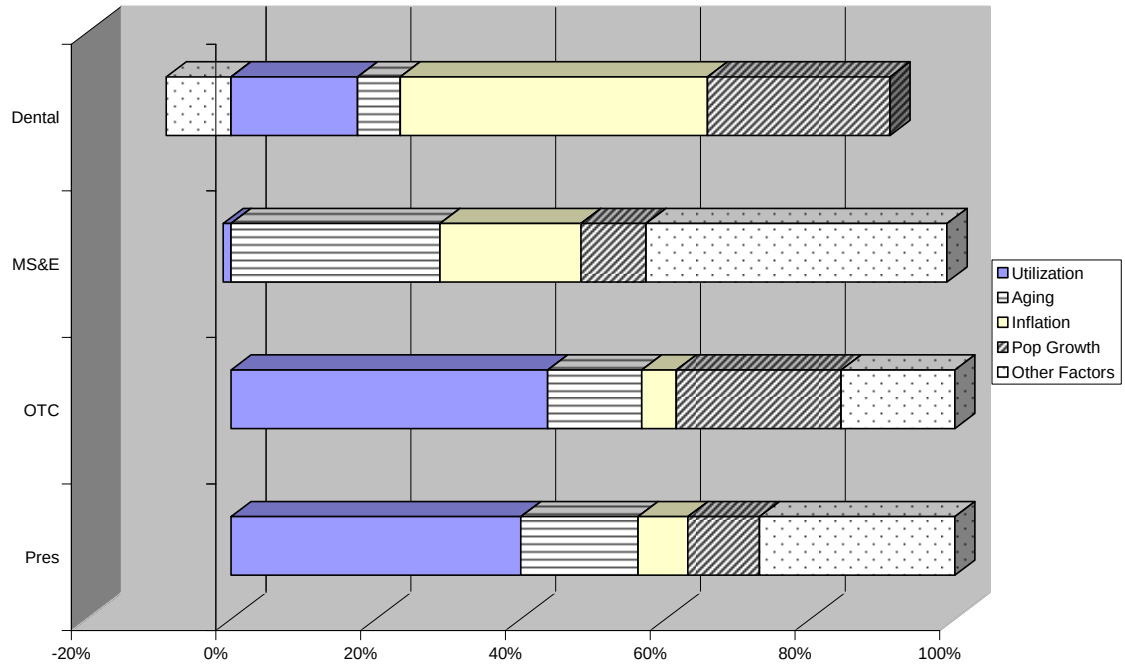
Medical transportation has averaged 3.1% annual growth which is well below what would be expected from population growth and inflation. Cost containment measures in medical transportation benefits have been responsible for its low annual growth. These include: group travel to reduce the number of trips to health providers outside of the community; use of a community van rather than commercial modes of transportation (e.g. taxis); and reductions in eligible benefits (e.g. non-emergent dental-related travel not eligible in two provinces, also restrictions in travel related to mental health services).

Vision benefit expenditures increased an average of 4.4% annually over the time period, and can be attributed to population growth (2.0%) and inflation (2.6%) suggesting that there has been no increased utilization on an individual basis.

Cost Driver Summary

The figure below shows the relative importance of the various cost drivers in the growth of NIHB Program expenditures from 2000/01 to 2003/04.

Figure 1: Cost Drivers by Percentage, 2000/01 to 2003/04



NIHB Program Projections

To determine the best estimates of the budget needed for the NIHB Program in the next five years, AFN reviewed three approaches: 1) historical expenditures; 2) Health Canada projections in 2002, 2004 and 2005; and 3) a scenario using recent Canadian total health expenditure trends (2000-2003) to supplement population growth, aging and inflation projections. The third approach was adopted and the results of an analysis of American Indian and Alaska Native health care was used to estimate greater First Nations health need with a 20% factor.[21]

First Nations NIHB Expenditure Projections Adjusted for First Nations Need

	Aging	Inflation	Pop Growth (INAC)	Other Factors	TOTAL	2003/04 (actual)	2008/09 Projections	2013/14 Projections
	annual average increase					*expenditures*		
Prescriptions	2.1%	1.15%	1.5%	9.3%	14.1%	$239,684,256	$462,504,493	$892,467,488
OTC	2.1%	.88%	1.5%	0.1%	4.6%	$38,348,795	$48,018,672	$60,126,866
MS&E	1.4%	1.5%	1.5%	4.9%	9.3%	$20,230,199	$31,557,382	$49,226,819
Dental	0.3%	2.6%	1.5%	4.0%	8.4%	$120,740,837	$180,717,660	$270,487,379
Med Trans	1.2%	3.1%	1.5%	4.9%	10.7%	$190,377,525	$316,199,682	$525,178,793
Vision	1.2%	2.6%	1.5%	2.4%	7.7%	$22,474,571	$32,566,414	$47,189,834
Mental Health	1.2%	2.6%	1.5%	4.9%	10.2%	$15,950,163	$25,922,274	$42,128,992
Premiums	0%	1.5%	1.5%	4.9%	7.9%	$28,497,901	$41,679,269	$60,957,523
Other	0%	2.6%	1.5%		4.1%	$1,352,360	$1,653,278	$2,021,155
Total						$677,656,607	$1,140,819,122	$1,949,784,849

The projection in the table above is based on INAC population growth projections (1.5% annually), aging as determined through a sensitivity analysis of 2000/01 – 2003/04 data (note: in medical transportation, vision and mental health benefits where age specific data was not available, a blended aging rate of 1.2% annually was used), average inflationary indices from 2000/01 to 2003/04, and an escalator which includes the effects of utilization, medical advances, changes in health status etc. This escalator was extracted from

[21] The AIAN model is based on adjustments to mainstream US health costs for age, health status and rural location of the AIAN population. The risk adjustment method (poorer health status) used data from self-reported health status, presence of specific diseases, disability, child birth, death in three subsequent years and age and sex factors. [I&M Technologies Inc. and Centre for Health Policy Studies. 1999. *Level of Need Funded Cost Model.* Report the Indian Health Service, US Department of Health and Human Services.]

provincial/territorial expenditure trends[22] and has been adjusted upwards by 20% to incorporate the higher health care need of First Nations.

NIHB Independent Assessment: How Can the Quality of Services Be Improved?

As part of the independent assessment, AFN also conducted informant interviews with regional First Nations health technicians and professional service providers.[23] While invited to participate in individual information interviews, FNIHB Headquarters submitted a prepared response as a group to the informant questionnaire. Findings of the interviews are summarized in Appendix 1, and an overview is presented here.

Best Practices

The informants were asked about best practices in NIHB Program service delivery. It was pointed out that a "best practice" should be based on safeguarding and improving First Nations health status; however, informants felt the NIHB Program's definition of a best practice often appears to be cost containment. Many of the best practices offered by informants involved communications, such as:

- professional education seminars between First Nations and health provider organizations;
- community education sessions about the Program in general or about specific issues such as prescription drug abuse;
- regular information bulletins.

In Health Canada's written response to the Independent Assessment survey, FNIHB-NIHB regional managers noted various coordination initiatives, such as coordination of medical transportation in communities, merger of call centre services in a regional office, and linkages with provincial and territorial governments in specific areas.

FNIHB-NIHB regional managers highlighted other examples of best practices in their respective regions. Contracting/provider best practices undertaken by FNIHB regions include negotiating a preferred provider for oxygen concentrators, a three-region oxygen tender process, calls for tender for major items such as wheelchairs where the tender responds to an individual client's requirements, and an online system for prior approvals and tracking

[22] an average of per capita health, prescription, non-prescription, dental and vision expenditures from 2000, 2001, 2002 (forecast) and 2003 (forecast) was obtained from the Canadian Institute of Health Information (www.cihi.ca).

[23] Resource limitations prevented interviews with community informants, but these will be undertaken in April 2005.

(the latter has resulted in shorter wait times and reduced administrative pressure on providers). Two regions spoke of arrangements where NIHB analysts are linked with communities so as to provide continuity services and help alleviate privacy and trust issues.

Mental health was noted by both regional technicians and FNIHB-NIHB regional mangers as an area where innovation is occurring. For example, fee for service counseling is shifting to per diem (visiting) arrangements for patient care and the presence of mental health professionals in communities is facilitating the development of working relationships with community-based health providers.

NIHB Program Administration and Process

The health provider interviews revealed a significant degree of dissatisfaction with the current NIHB Program practices. The NIHB process is very different from other third party requirements, and is seen as ineffective and onerous. The seriousness of these complaints is evident in the increasing number of providers who are choosing to bill clients directly rather than deal with the NIHB Program. Appendix 1 provides a complete listing of provider comments on the NIHB administration and process; however these can be summarized as relating to:

- a high rejection rate for orthodontic services without accompanying rationale for these decisions;
- a slow approval process for prescription drugs;
- unilateral changes to pharmacist fees;
- poor information products (including the web site);
- an overly zealous audit program that is extending into pharmacy regulatory practices; and,
- a predetermination process which cannot be handled during the client visit, thereby necessitating a second visit, and which sometimes overrides a dentist's professional judgment and has far too great a scope given that 80-85% of basic dental care is approved.

The mechanism for reimbursing dental hygienists was identified as a barrier to dental health promotion. In the current system, hygienists must be paid through dentists. This has meant that for remote communities that do not have regular outreach dental services, it is not possible to bring a hygienist into the community to perform basic prevention and health promotion work. Regional technicians observed that there is very little attention paid to preventative oral health strategies. Rather, services are focused after the fact, when dental treatment and restoration are required.

First Nations Regional Health Technicians' Perspectives

First Nations regional health technicians emphasized the Treaty and Inherent Right to health care held by First Nations. They are frustrated with the fact that providers are opting out of the NIHB approval and payment system, leaving First Nations to pay out of their own pockets and then seek reimbursement from the Program or more commonly, not receive any care at all.

The discretionary powers of FNIHB-NIHB regional managers were cited as reason for the many inequities experienced by First Nations in the provision of Program benefits. In addition, benefit guidelines were characterized as difficult to understand and having little written flexibility or leeway in decision making from which to understand regional decisions.

The reporting requirements in the NIHB Program were described as resulting in overdocumentation, particularly in the medical transportation program, without the proper community level supports to address the greater reporting burden.

Inconsistencies in benefits exist across the regions, and in some cases, even within a region. For instance, in Ontario, medical transportation benefits are different in the southern versus northern part of the region. Other inconsistencies noted included: variations in provincial coverage of health services, differences in regulations concerning the dispensing of medications (e.g. requirement for signature, frequency of repeats), variable access to brand name pharmaceutical products, and the ability to be served in the official language of choice (i.e. English in Quebec).

The NIHB Program policy of providing benefits for an unregistered birth for a maximum of one year has resulted in First Nations children being denied benefits in at least one region (Ontario) as the province is now taking up to two years to provide birth certificates.

FNIHB Suggestions for Improvement

Major themes in the FNIHB-NIHB regional managers' suggestions for Program improvement included: coordination with community health programs, and with other federal departments and provincial/territorial jurisdictions, and improved communication strategies (information, feedback, strategic planning).

Suggestions specific to lowering/containing costs were varied: better coordination of medical transportation and use of vans, establishing drug distribution centres, elimination of mark ups on some MS&E items, and a needs-based vision program with changes to eligibility for benefits.

Administrative improvements were recommended to include: on line rules-based procedures and an electronic document management system, a national benefit list and rates for all

benefits in all regions, and community management initiatives where communities have a single NIHB regional contact and/or FNIHB contribution agreement contact.

With respect to individual benefit categories, suggestions for improvement were directed only to dental benefits, and included increased dental health prevention and promotion, a Health Canada operated dental office (in progress), and recruitment of an oral surgeon for the Northwest Territories region.

THE DIRECTION FORWARD

To ensure that the NIHB Program is accountable to First Nations in its business practices, including funding allocation, it is critical for First Nations to be engaged as equal partners at the outset of the development of policies, service delivery agreements and administrative processes. As stated by the Right Honourable Paul Martin during the historic April 19, 2004 Canada-Aboriginal Peoples Roundtable:

> *No longer will we in Ottawa develop policies first and discuss them with you later. This principle of collaboration will be the cornerstone of our new partnership.*

The First Nations Action Plan on NIHB offers several recommendations for improving the functioning and overall management of the NIHB Program under a framework of reciprocal accountability.

FIRST NATIONS ACTION PLAN ON NIHB

The First Nations Action Plan on NIHB provides a comprehensive plan to achieve transformative change in the longer term, as well as immediate support to improving First Nations' access to quality NIHB services.

The Action Plan is premised on three key concepts:

- **Meeting the Health Needs of First Nations through Timely, Quality Care;**
- **Fostering Reciprocal Accountability;**
- **Adopting a Community Health Approach.**

Meeting the Health Needs of First Nations, with more timely and higher quality of care, must be the first and only objective of the NIHB Program. The overriding goal of the NIHB Program, as with all other FNIHB investment areas, must be to enhance the health and well-being of First Nations. With policy changes in recent years, there is a lack of clarity with respect to the mandate of the Program. First Nations are adamant that NIHB emanate from

their Treaty and Inherent Rights to Health, and the Crown's fiduciary duty. Hence, identifying NIHB as supplementary or the "Payer of Last Resort" is not an acceptable policy directive to First Nations. Funding must be matched to health needs on an ongoing cycle to ensure sustainability of the Program. A fixed funding envelope, and resulting Program focus on cost containment, is not amenable to evolving demographic, health status and other trends.

Fostering Reciprocal Accountability is essential to improve overall management of the NIHB Program. FNIHB's approach to responding to Auditor General's criticisms of NIHB management practices, especially in the area of medical transportation, has placed the reporting burden on First Nations communities.

Measurable targets of First Nations health status – as defined in the AFN-led First Nations Health Reporting Framework – must be linked to performance reporting of the NIHB Program. Exchange of data, information and research on public health, overall health status, service utilization and expenditures can be of benefit for planning, surveillance, research and reporting purposes. However, such exchange requires First Nations control, and investment in First Nations infrastructure, capacity and tools, to ensure integrity of the information and ultimate benefit to the population, community and Nation.

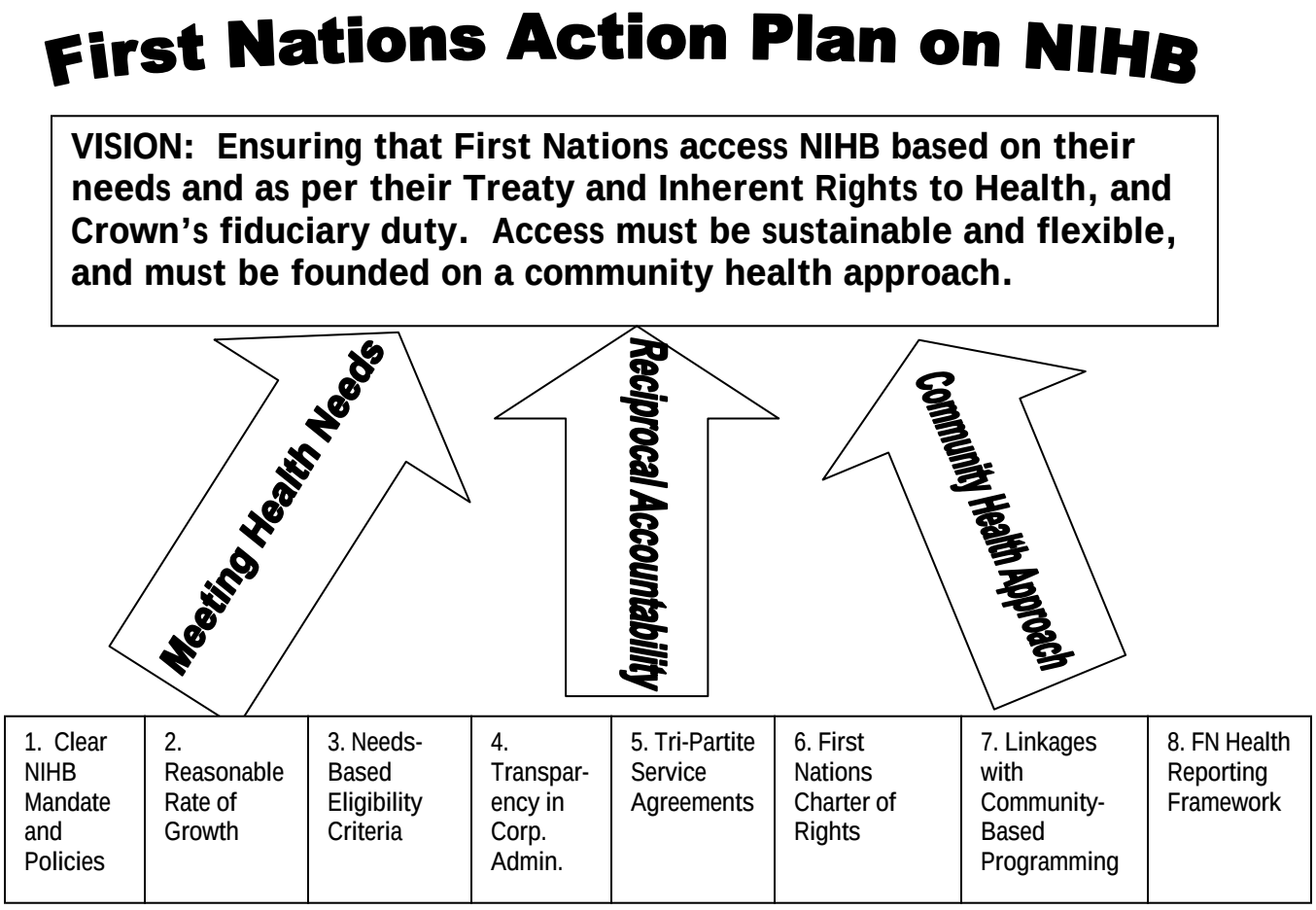
Accountability is also important in joint First Nations – NIHB processes. A regular evaluation is required of these joint activities and the effectiveness of this working relationship in engaging First Nations in policies which respond to First Nations needs and issues in the NIHB Program.

Adopting a Community Health Approach will ensure that the NIHB Program draws linkages with community health programs for the advancement of First Nations health and well-being. The 2003 client consent initiative failed in its attempt to address patient safety because it did not account for community engagement in monitoring and addressing risks associated with prescription drug use.

ELEMENTS OF THE FIRST NATIONS ACTION PLAN FOR NIHB

Based on the 2004-05 AFN Independent Assessment and recommendations from the First Nations Caucus on NIHB, the elements of the First Nations Action Plan for NIHB are:

1. **Clear Mandate and Policies of the NIHB Program**
2. **Reasonable Rate of Annual Growth**
3. **Ensuring Needs-Based Eligibility Criteria**
4. **Transparency in Federal Corporate Administration**
5. **Tri-Partite Service Agreements**
6. **First Nation Charter of Rights and Responsibilities**
7. **Linkages with Community-Based Programming**
8. **First Nations Health Reporting Framework**



1. Clear Mandate and Policies of the NIHB Program

Health Canada describes the NIHB Program as providing a limited range of medically necessary health-related goods and services which are not provided through other private or provincial/territorial health insurance plans, which are complementary to provincial and territorial insured programs and community-based health programs and services funded by Health Canada. The practical consequence of the criterion of complementarity to thirteen different provincial and territorial jurisdictions is inequities in benefit access across the regions. Inequities are due to both differing provincial/territorial services and variability in interpretation of NIHB directives by FNIHB-NIHB regional managers. The discretionary powers of FNIHB-NIHB regional managers in adjudicating benefit requests have been identified as one of the causes of inequities in the NIHB Program. In some instances, this discretionary power results in decisions which could conceivably put an individual at risk, such as a recent situation where a woman close to term was denied medical transportation for a medical appointment, as she had to cancel a previous appointment when child care could not be arranged for her children.

NIHB Program directives have been described in the Independent Assessment as intense, stringent, and difficult to understand. The written directives contain little leeway or guidance for dealing with unusual situations from which to understand FNIHB-NIHB regional managers' decisions on benefit requests. As a result, these decisions are seen as arbitrary and often inequitable, particularly if benefits are denied during an appeals process.

The NIHB Program requires user-friendly policies which are clearly written and address areas of authority which fall under the jurisdiction of the FNIHB-NIHB regional offices, headquarters, and advisory committees. These policies should be applicable across all regions, promote equality of benefits across the regions, and include guidelines for allowable discretionary actions of FNIHB-NIHB regional offices. Their correct interpretation should be ensured by comprehensive training to regional offices, zone clerks and service providers, and a communications strategy based on a policy of transparency, all of which should be developed in equal partnership with First Nations national and regional health technicians.

2. Reasonable Rate of Annual Growth

A long-term strategy for funding premised on realistic expenditure and utilization projections is an integral component to ensuring a sustainable program that meets the needs of First Nations and, consequently, contributes fully to improved First Nations health, at both individual and community levels. At the present time, other health programs are being

affected by the lack of sustainable funding in the NIHB Program. For example, in Ontario Region, children's program funding has been used to offset the region's NIHB Program deficit.

Historical expenditure trends in the NIHB Program have been influenced by cost containment measures in various benefit areas. As these activities do not necessarily have a long-term impact on expenditures and there is no evidence to suggest that First Nations health needs have been fully addressed by the Program, past expenditure patterns are a poor proxy for estimating future NIHB expenditures.

The AFN Independent Assessment has provided a projection based on First Nations population growth and aging projections, inflation trends over the past four years, and an annual escalator attributable to utilization, new treatments, changes in the delivery of health services (e.g. a shift from hospital to community care), and other cost factors. This annual escalator uses Canadian health care expenditure trends which have been adjusted to incorporate the higher health care need of First Nations.

Overall, this First Nations NIHB expenditure projection is estimated at $1.140.8 billion in 2008/09 and $1.949.8 billion in 2013/14. This translates into an increase of 68% in five years, or 10.9% a year. In comparison, recent Health Canada projections have suggested a 56% increase in NIHB expenditures in five years or 9.3% a year.

3. ENSURING NEEDS-BASED ELIGIBILITY CRITERIA

Achieving a balance between protecting the Program against excessive cost increases and meeting First Nations health needs in an equitable manner can be viewed as an imperfect science at best, and a barrier to improved health status as worst. Feedback obtained from provider associations in the Independent Assessment suggest that the current eligibility criteria for dental services have tipped the balance towards delay or denial of needed services. A review of dental eligibility criteria is required to ensure a fair assessment of oral health needs and delivery of services. Areas where a review of eligibility criteria would be beneficial include:

1. *Orthodontic services:* the Canadian Association of Orthodontists has advised its membership to request payment from First Nations clients directly, with these clients then arranging reimbursement from the NIHB Program. This is due primarily to two reasons: NIHB's restrictive eligibility criteria and the high rate of rejection for orthodontic treatment, which has been estimated to reach 80-85%; [24] and the excessive amount of paperwork required to apply for approval to provide services.

[24] This is a non-scientific estimate of the rejection rate for First Nations orthodontics care in Canada provided by the Canadian Association of Orthodontists, which is based on personal feedback from their members nation-wide.

The immediate impact is denial of services, as many First Nations cannot afford to pay up-front for orthodontic care for their children.

2. *Services where predetermination is required:* The current system of predetermination for many routine dental procedures causes a prolongation of illness, lacks in compassion and adds considerable cost to the program, particularly if clients have traveled long distances. As predetermination takes days, a second return trip to the dentist is required, which can cost more than the required treatment. Aside from delays in receiving services, an appreciable number of predeterminations are denied, frustrating dentists who have determined that a certain type of care is required, and leaving First Nations without needed services. Wiliam Descalchuk, a First Nations individual residing in Alberta, graphically illustrates problems with the dental program. In a recent letter to AFN, he stated: "I am not really sure what (FNIHB) is up to with providing medical and dental benefits to First Nations people. It has gone from a bad system to a worse system and this is an issue for many in this region. . . waiting a month for dental approval is ridiculous and having the dentist send approval by mail is even more preposterous. I have personally had a molar in intense pain for the last week and I have had to resort to extracting it myself because (FNIHB) is not authorizing dental care to status people in this area."

   Suggestions to deal with issues in the dental program include:
   - reviewing and/or removing the current $800 threshold for predetermination, and
   - reforming the dental program to include direct service delivery and a reorganized dental services schedule, the latter which categorizes services into those that require prior approval and those which do not. Dental services which do not require prior approval would include diagnostic services, emergency services, preventative services, direct restorative services, surgical services and periodontal services. Further review and discussion would be required on the necessity for prior approval of endodontic services, prosthodontics (removable), and orthodontics.

3. *Medical Supplies and Equipment.* The requirement of prior approval for MS&E benefits such as hearing appliances and oxygen therapy should be reviewed to ensure that conflicts do not exist with needed medical care and approval procedures do not cause delays which prolong illness or disability.
4. *Medical Transportation.* A needs-based review of medical transportation directives is required. Regions have reported unreasonably restrictive medical transportation benefits, for example, denial of an escort to accompany a young child for medical treatment who is developmentally delayed and visually impaired, and limited meal allowances for pregnant women who have been transported out of the community prior to birthing. Ontario Region's policy of not providing medical transportation benefits for dental services is resulting in poorer dental health among the region's First Nations.

5. *Catastrophic Drug Coverage*: First Nations have been left out of the federal/provincial/territorial discussions on catastrophic drug coverage. No policy exists which addresses unforeseen, but life-saving medically necessary treatments for First Nations and a mechanism is needed to ensure needed benefits are received by individuals facing catastrophic situations. An example of the inflexibility of NIHB Program is the current case involving a child with Hurler-Scheie Syndrome who has previously received drug treatments for this condition free of charge during a clinical trial. The province where the child resides has declined to fund these treatments now that the clinical trial is ending. FNIHB-NIHB has not indicated whether these treatments which prevent multiple organ damage will be continued under the NIHB Program. In response to the federal health' minister' statement that the common drug review process must be completed to evaluate the treatment's inclusion in the NIHB formulary despite the urgency of the situation, Alberta regional chief, Jason Goodstriker commented: "Funding and policy should not play a factor when it comes to prolonging the life of a child. . . First Nations citizens are suffering because of jurisdictional confusion relating to First Nations health."
6. *Chiropractic care:* Chiropractic care has proven cost-effectiveness, particularly as a treatment for lower back pain.[25] Despite this, eligibility for chiropractic care funded by the NIHB Program varies across the regions from limited provision of services in two regions to no services in others. Ontario Region will provide services at the discretion of the FNIHB-NIHB regional manager, and Quebec Region does so as a last resort in specific cases. The provincial health systems in British Columbia, Alberta and Saskatchewan[26] do offer limited services, either partially insured under the provincial health plan or up to a maximum number of visits/dollar value. In Yukon, neither the territory nor the NIHB Program covers any level of chiropractic care. Clearly, a standard approach to the provision of chiropractic care is required in order to ensure that all First Nations have access to comparable services.
7. *Ontario OHIP Premiums:* In Ontario Region, the NIHB Program will not cover the Ontario Health Insurance Plan (OHIP) premium for First Nations who reside off reserve and earn over $20,000 per year. This policy is an erosion of the First Nations Treaty Right to health. As well, it puts undue hardship on employed First Nations who in many cases are supporting several family members including the extended family. As with chiropractic care, an inequity across regions also exists - in Alberta and British Columbia (the other provinces which have health premiums), the NIHB Program covers the entire cost of the premium.

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[25] Manga, P., D. Angus, C. Papadopoulos, and W.R. Swan. 2003. *A Study to Examine the Effectiveness and Cost-Effectiveness of Chiropractic Management of Low-Back Pain*. Ottawa: Faculty of Administration, University of Ottawa

[26] In Saskatchewan, the province requires a copayment of $20 for the first chiropractic visit, and $12 for each subsequent visit. As of October 2004, the NIHB Program discontinued its practice of covering these copayments. This was done without consultation with Saskatchewan First Nations.

4. TRANSPARENCY IN FEDERAL CORPORATE ADMINISTRATION EXPENDITURES

Corporate administrative expenditures (operating costs), whether at FNIHB headquarters or regions, are not regularly reported by the NIHB Program and therefore not subject to the same scrutiny as First Nations benefit costs. Recently, FNIHB provided NIHB Program operating cost data for the time period 2000/01 to 2003/04 relating to headquarter, regional office and First Canadian Health expenditures. Total NIHB operating costs were $41.9 million in 2003/04, an increase of 56.1%, or approximately 16% per year, from 2000/01. This is double the average annual rate of growth for First Nations client benefits in the same time period. When combined with First Nations NIHB Program expenditures, operating costs rose from 4.5% of total Program expenditures in 2000/01 to 5.5% in 2003/04.[27]

Headquarters and regional operating expenditures specifically were $23.9 million in 2003/04, or 3.1% of total First Nations NIHB Program expenditures, up from 2.2% in 2000/01. Of this increase, the majority is attributable to headquarters costs. During this four-year time period, operating costs for headquarters increased 2.6 times, or approximately 38% per year. By contrast, the regional expenditure rise was more restrained, at 50.7% over four years or approximately 15% a year.

Clearly, rationale is needed to explain these significant NIHB Program operating expenditure increases, with special emphasis on those attributable to headquarters. This is particularly important in light of the cost containment measures implemented for client benefits and the far lower rate of growth for the Program as a whole. In future**, operating expenditures, including trend analyses should be regularly reported and subject to scrutiny for potential cost efficiencies as are other expenditures in the NIHB Program. These should include costs relating to the NIHB Audit Program (including revenue obtained through claw backs) and development of reporting mechanisms, such as the Medical Transportation Reporting System.**

5. TRI-PARTITE SERVICE AGREEMENTS

The Independent Assessment described a range of administrative issues with service providers which, at the worst, have reduced access by First Nations to benefits, and at the least, contributed to a climate of dissatisfaction with the NIHB Program administration by provider organizations. As noted above, these include:

- a burdensome, onerous and ineffective NIHB process which is different from other third party insurance systems. For example, a high volume of requests

[27] First Nations-specific operating costs were estimated based on the First Nations' percentage of total NIHB eligible population.

must be submitted to the drug exception centre and the process ties up the telephone (faxing is not permitted);
- unilateral cutting of pharmacy fees and removal of drugs from the formulary (Pacific Region);
- lack of ownership within FNIHB with respect to decisions and guidelines with an impact on services provided, combined with poor communications and difficulty accessing information on policies and operational functions of FNIHB;
- audit processes which have resulted in controversial claw backs and have reached beyond investigating fraud to auditing pharmacy practices (Note: these practices may have already met requirements of the College of pharmacists);
- an excessively high percentage of orthodontic treatment denials which are estimated at 80-85%;
- a dental predetermination process which "over administers" incurring unnecessary costs. It does not operate in real time, may overturn dentists' professional judgment, is not cost-effective on an individual basis (as it necessitates a second trip by clients to return to the dentist for treatment), and prolongs pain and suffering by the client; and
- lack of knowledge by the NIHB Program about the differences in pharmacy dispensing guidelines among the various provinces and territories (can cause arbitrary claw backs of pharmacist payments).

A regular communications process should be established which involves the AFN, provider organizations, NIHB Program, and auditors in order to address provider concerns and/or proactively deal with emerging issues related to the administration and delivery of benefits. In addition, a tripartite arrangement which involves First Nations in an advisory, non-signatory capacity in FNIHB's negotiation of service agreements with provider organizations will ensure that First Nations interests (both individual and community) are considered in the development of these agreements, and that administrative processes are workable and will promote the highest quality of care.

First Nations input will be necessary as the Program looks to alternative service delivery models for NIHB benefits, such as professional services by pharmacists in chronic disease management, program medication reviews, diabetic device training and smoking cessation, or more effective mechanisms to deliver oral health promotion via dental hygienist services to communities.

6. First Nations Charter of Rights and Responsibilities

The Independent Assessment has revealed significant issues in the NIHB Program, from a poor understanding by First Nations of eligible benefits and rights including the right to appeal, inequitable provision of services across the regions, and a lack of accessibility to services stemming from restrictive medical transportation directives, opting out of providers from NIHB reimbursement mechanisms, and stringent criteria in dental services. The end result of these issues and concerns is a lack of confidence in the Program by First Nations fueled by a perception that cost containment has been put ahead of meeting health needs and improving health status.

A First Nation Charter of Rights and Responsibilities would serve a number of purposes:

- It would improve First Nation individuals' confidence in the system through principles that address a fair and responsive health system and an appeals system that is understandable, effective and credible.
- It would encourage First Nation individuals to become actively involved in improving their own health status.
- It would establish the rights and responsibilities of all parties in improving First Nations individuals' health.

The First Nation Charter of Rights and Responsibilities would be developed in an equal partnership between First Nations, FNIHB-NIHB, and provider organizations. Suggested areas of First Nation rights and responsibilities to be included in the Charter include:[28]

- The right to receive accurate, easily understood information on the NIHB Program and the provision of assistance when required to explain these benefits. This information to include how to access benefits, the procedures for resolving complaints (appeal process), NIHB processes to ensure quality of services, individuals' right to choose service providers, and responsibilities of service providers.
- The right to provision of eligible benefits in a time frame which does not jeopardize an individual's health status or cause an unnecessary prolongation of illness.
- The right and responsibility to participate fully in all decisions relating to the provision of benefits which are directed to the individual's health care.
- The right to confidentiality of health information involving all communications with service providers, both written and verbal, and the right to review and copy NIHB records involving their benefit history. Allowable uses of personal health information are directly related to care purposes, such as provision of services, payment of

[28] The description of these areas is based, in part, on the Patient's Bill of Rights, adopted by the US Advisory Commission on Consumer Protection and Quality in The Health Care Industry (1998).

services, peer review, disease management, and quality assurance. As much as possible, non-identifiable information is used unless the individual has consented to the disclosure of information which has person-specific identifiers. If person-specific disclosure is required, only that information necessary to achieve the specific purpose of the disclosure should be identified and used.

- The right to a fair and efficient process for resolving disputes involving the denial or substitution of benefits. The appeals process includes (1) a written notification of any decision to deny, reduce or terminate a benefit including an explanation of the reasons for the decisions; (2) resolution of the appeal in a timely manner with expedited consideration for decisions requiring emergency or urgent care (time frame to be determined); and (3) a review process which is conducted by health care professionals which are appropriately credentialed with respect to the treatment involved, and who were not involved in the initial decision.
- The responsibility of individuals to maximize healthy habits, become involved in decisions affecting their health care, be knowledgeable about the NIHB Program benefits and coverage, disclose relevant information to health providers and work collaboratively with health providers to carry out treatments.

7. LINKAGES WITH COMMUNITY-BASED PROGRAMMING

The NIHB Program is an integral component in many areas of the health system. Despite its broad scope, the Program is largely autonomous with little or no direct linkages with other health services in the community other than arranging medical transportation for individuals. In the fixed funding envelope for health services in First Nations communities, it is imperative that all sectors are coordinated to maximize the use of limited resources. For example, if the home care component in the First Ministers' Health Accord is implemented, First Nations communities will be expected to handle home care clients with a higher acuity of care, who essentially have been discharged earlier from hospital. There will be unavoidable demands on the NIHB MS&E benefits as well as the First Nations and Inuit Home and Community Care budget, due to increased need for certain medical supplies and equipment, and new needs related to at home intravenous treatment (IV pump, supplies and medications). Collaborative planning will be necessary to ensure that the financial impact of this additional care is clearly understood and that communities receive the required funding and capacity to support timely service and an optimal quality of care.

Another area where linkages are required between the NIHB Program and community health services is in prescription drug misuse and abuse. Effective solutions to countering this abuse and providing appropriate care to those with addictions and/or mental illness will require collaboration between community primary health providers, pharmacists, NIHB program managers, and mental health and addiction counselors among others.

New strategies for management of chronic diseases may require consideration of alternative service delivery models, such as diabetes management which emphasizes client risk reduction through assessment of patient disease states and include NIHB providers (e.g. pharmacists) as part of the care management team. Similarly, in the area of oral health, preventative strategies require a multi-disciplinary approach with working linkages involving the community health system, schools and the NIHB Program.

8. First Nations Health Reporting Framework

While First Nations recognize the importance of ensuring transparency in public spending and in monitoring quality of care, current methods of reporting devised by the NIHB Program are mainly administrative in nature and do little to inform community-level health planning, or improved linkages with provincial/territorial health services. Furthermore, these reporting mechanisms do not comply with First Nations principles of ownership, control, access and possession of health data.

The Assembly of First Nations, under the oversight of the First Nations Information Governance Committee, is developing a First Nations Health Reporting Framework in response to the 2003 First Minister's Health Accord work on an Aboriginal Health Reporting Framework.

The First Nations Health Reporting Framework will be a practical tool used for community planning that will also allow for reciprocal reporting amongst federal, provincial, territorial and First Nations governments. It will be designed to permit comparison of First Nations data with Canadian data.

Measurable targets of First Nations health status will be linked to performance-based outcomes in the NIHB Program. The data currently available from the NIHB Program will be reviewed for their potential contribution to the framework's list of health indicators. As part of this review, new NIHB data collection and/or analysis may be identified, however, it is clear that any First Nations health data collection must be undertaken in compliance with First Nations principles of ownership, control, access and possession.

This First Nations Action Plan on Non-Insured Health Benefits represents First Nations views and recommendations to improve the functioning and overall management of the NIHB Program and as such, is not a consensus document under joint First Nations and Health Canada NIHB processes.

For more information, please refer to the AFN website: www.afn.ca.

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Appendix 1

Informant Interviews on NIHB Business Practices: Summary of Findings

Question Themes	Summary of Responses
Best Practices: First Nations and health provider respondents	• A *Best Practice* should be based on ensuring the security of the individual's health status, as opposed to cost containment (NIHB approach). • Professional education seminars with First Nations and with the professional service provider associations where the health professionals (pharmacists, physicians and psychologists) are educated on issues with respect to First Nations health in general as well as issues pertaining to specific programs. • Community education sessions aimed at better awareness of prescription drug issues, i.e., abuse, information seminars for elders etc. • Drug Exception Center Improvements: Wait lists are down and the hours of operation have been improved; further, the drug costing with Health Canada is adequately managed. All drugs provided to First Nations are based on the actual acquisition of the drugs by the pharmacy. Communications in this area have improved with government in the last year. • Mental health counseling: shift of focus from fee for service counseling to a per diem system. Social workers and psychologists visit the communities to meet with clients, facilitating a closer professional relationship with NNADAP workers and the Health Director. The program does continue to be under-utilized in some regions.
Best Practices: NIHB Regional Managers	• Multi-sectoral committee to review extraordinary requests • Communications bulletins to First Nations communities • Coordination initiatives: medical transportation coordination, merger of call centre services (medical transportation, vision and pharmacy), integration with provincial children's dental plan, and collaboration with territorial government which administers the NIHB Program. • Contracting: preferred provider for oxygen concentrator including equipment recycling, individual call for tenders for major items (e.g. wheelchairs custom fitted for clients), oxygen tender in three western provinces. • Community visits by providers, e.g. pharmacist, psychologist. • On line system for prior approvals and tracking resulting in shorter wait times and reduced administrative burden on providers. • Linkage of NIHB analyst with communities to provide continuity of services and alleviate privacy/trust concerns.
Administration & Process Grievances	• There is consensus among the service providers that the NIHB program as currently operated is onerous and burdensome to their membership.

	It is the position of the service providers that the current system is too different (from that of other third party insurers) and too ineffective. The result has been that an increasing number of members are backing out of the current process, preferring to deal with their patients directly rather then through FNIHB. • Association members are discontented with the high rejection rates of appeals, FNIHB's failure to provide explanations for rejections and the criteria on which these are based. • Pharmacists feel the approval process for prescription drugs via telephone is slow and, by comparison, other third party insurers accept faxed requests. • FNIHB unilaterally cut some pharmacy dispensing fees. • Responsibility for directions and decisions between FNIHB Headquarters and Regional Offices are unclear. • The website is poorly maintained and lacks transparency. Service providers have expressed difficulty accessing information as to the policies and operational functions of FNIHB, fee schedules, etc. • It is the contention of the pharmacy associations that the manner in which Health Canada has audited the NIHB program has not been administered in a clear and forthright manner. These audits have often led to considerable claw-backs in payments and uncertainty in the field. In British Columbia, auditors have been reportedly looking at issues that are beyond the scope of potential fraud and have turned the process into audits of pharmacy practice. In some cases, the FNIHB auditor requirements have been claimed to be at odds with the requirements of the College of Pharmacists. • The rejection rate of orthodontics cases has been observed to have risen significantly from the past. The Canadian Association of Orthodontists has advised its membership not to treat patients under the current manner, opting instead to treat patients as with all other patients with third party insurance coverage. In other words, the service provider deals directly with the patient; the third party reimburses the patient. • While the dental associations estimated the approval rate for basic dental care to be 80% - 85% (figures were based on an unscientific estimate), their members have experienced a high level of rejection for predeterminations. This has frustrated dentists who have in their professional opinion determined that a certain type of care is required only to have a predetermination denied. • The dental associations contend that the current system whereby patients must wait for a predetermination after their dentists have made their professional assessment before care may be provided, has lacked compassion and added considerable cost to the program, particularly patients who have traveled long distances. In addition to the pain and suffering endured, travel costs have been doubled as the patient must first travel to the dentist for an assessment, only to be returned home to wait for a predetermination and then travel back to the dentist for treatment. Often, one round, long-distance-trip alone has been more then the cost of the actual care provided. • Although there have been a number of dental hygienists who are willing

	to work in remote communities and provide mobile services - the program itself has been structured so that dental hygienists are not paid directly. Currently, they have to be paid through a dentist; and as not all dentists have been willing to undertake remote outreach, hygiene services are also not available. This has left numerous individuals without access to oral health services.
First Nations Regional Health Technicians' Perspectives	• First Nations contend that they hold a treaty and inherent right to health care and that historically, the federal government of Canada has held a fiduciary responsibility to provide health care; yet, FNIHB has expressed that the NIHB program is a supplementary benefit, much like an insurance program. • Service providers are opting out of the NIHB program due to their frustrations with the system and as a result, many First Nations peoples have not been able to access health services such as dental. Most can not afford to pay up front. • There is very little attention paid to prevention of dental. It's all emergency care such as having an abscessed tooth pulled etc. • The Regional Technicians have expressed that there have been to many inequities in the NIHB program. FNIHB managers are allowed too much discretion to do or alter things as they personally see fit. It has not been uncommon for a Regional Technician to discover upon calling headquarters in Ottawa (in relation to a denial to provide service) that a mistake has been made and will be arbitrarily amended. • The reporting requirements of the NIHB program have reached the point where client use has been over documented. Either the over documentation is not viewed (which would mean it was an unnecessary burden) or a considerable amount of funding has been spent by administration analyzing and filing the data. The Regional Technicians feel monies spent on administration has been excessive and would have been better utilized on patient care. Example - medical transportation - Every time a client has used medical transportation, Treasury board has required the community submit the client's band number, birth date etc., destination and the medical reasons for every time medical transportation was used. • The NIHB program directives are intense, stringent and often comprehension is difficult. The guidelines have been difficult to understand due to the fact that there is a considerable amount of documentation to decipher as to what can or cannot be received with no leeway. Example - a child lacking an enzyme has been a participant in a drug testing program for a couple of years. The drug has been approved in the U.S. and is soon to be approved in Canada; however, as of January the child no longer fits the program. The drug company has ceased to provide the necessary medications without payment. The youth is a member of a First Nation community in the Yukon, although currently he resides in the province of Alberta. The Alberta government has refused to pay for him yet they have been paying for two other non-First Nation peoples. The critical question to be asked of the NIHB program is, in the interim, what is going to happen to the child while the federal government responsible for health benefits are refusing to cover the costs for the drug and FNIHB insists that is must go through

	the common drug review process before being included in the NIHB formulary?
Regional Inconsistencies	• The regional technicians reported that inconsistencies exist in the NIHB Program from region to region, and in the case of medical transportation, differences can be seen in different areas within a region. • Provincial coverage varies from region to region. Provincial cutbacks, such as the recent delisiting of vision care formerly covered by OHIP, may result in reduced access by First Nations if the NIHB Program does not cover the portion previously paid by OHIP. • Regulations concerning the dispensing of medications, requirements for a signature and the frequency in which a prescription can be filled vary from province to province. • In Ontario, the medical transportation policy differs from north to south due to high northern transportation costs. • The Quebec region can access pharmaceutical products more easily and at lower cost as many drug companies are located in the province. Generic drugs are used in other regions where access is not equal to Quebec. • In Quebec Regions, a significant number of First Nations communities are English speaking, and have difficulty in obtaining NIHB services in English.
Opportunities to Facilitate Inter-Program Linkages	• There is a need for improved linkages with provincial authorities and provider associations to deal with exceptional cases (severe needs) and jurisdictional issues. • Service delivery models currently in use in Canada need to be modified. For example, professional services offered by pharmacists, such as in diabetes counseling and management, would potentially improve health outcomes of patients.
FNIHB Regional Managers Suggestions for Improvement	• Further cost efficiencies in medical transportation: van based model, better coordination of travel. • Coordination with community health programs, federal and provincial health systems and programs, and physicians. • Improved communications: information and feedback sessions with communities and workshops for providers, other mechanism to inform clients about the Program (e.g. handouts/info sheets). • Drug distribution centres (e.g. home and community care program • Elimination of mark ups on some MS&E such as wheelchairs, incontinence supplies, canes, dressings (redirect savings to other areas) • Dental prevention and promotion. • Needs based vision program and changes to eligibility for benefits • Pilot project: Community management where communities have a single NIHB regional contact. • Single coordinator for the verification of all contribution agreements insuring the uniformity of all FNIHB programs. • Meetings between NIHB region staff and community program managers to brainstorm strategic approaches to service delivery. • On-line rules based procedures and an electronic document management system.

	• Health Canada operated dental office (in progress) to provide access without First Nations paying up front for services. • Recruitment of an oral surgeon for NWT. • National benefit list and rates for all benefits in all regions.