Health Coverage for Registered First Nations and Inuit in Canada
A Patchwork of Plans and Policies

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Our research and presentation takes a deeper look into the Canadian experience. Using NIHB as our point of reference and comparing with the provinces and territories, we’re interested in the gaps and overlaps that exist in coverage for registered First Nations and recognized Inuit. Due to time and resource constraints, we chose to perform our research on two particular benefits areas: drugs and pharmacy products, and assistance with medical transportation to access medically necessary services.

Truth and reconciliation commission’s calls to action include a call upon
One of the largest plans in Canada: provides eligible registered First Nations and recognized Inuit with a limited range of medically necessary health-related goods and services not provided through private or provincial/territorial health insurance plans. These benefits complement provincial and territorial health care programs, such as physician and hospital care, as well as other First Nations and Inuit community-based programs and services.

Main Objective: 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.

NEW: Pharmaceutical plus medical transportation account for over 70% of NIHB’s overall expenditures.

If we look at this breakdown of benefits expenditure from 2014-2015 we see that drugs and pharmacy products accounted for $421.9 million dollars, which was 41% of the total expenditure.

Medical transportation accounted for $356.6 million, or 34.7% of total expenditure. Because of the substantial costs associated with these two benefits, they were the focus of our research and analysis and are the focus of our presentation.
Drugs and Pharmacy Products
Map sets out # of clients serviced by NIHB

One way of looking at drug coverage programs offered by provincial and territorial governments is to consider them as falling into one or more of three main categories.

The first category consists of plans for individuals in the general population who have no other form of coverage and who are experiencing high drug costs relative to their income. These are known as catastrophic drug coverage plans.

There are currently 7 provinces offering this type of program. They have varying benefit payment structures (premiums, deductibles, co-payments) and caps depending on the province. As we can see, BC, Manitoba, Saskatchewan, Nova Scotia, Ontario, Newfoundland and PEI offer catastrophic programs to their residents.

(For example, a person whose annual household income is $14,000 per year and whose drug costs to treat her hypothyroidism and hyperlipidemia total $807 annually would pay $490 a year under Saskatchewan’s Special Support Program, but only $375 under Ontario’s Trillium Drug Program.)
The second category is **targeted drug coverage programs**. These plans are targeted to certain individuals (i.e. on social assistance and seniors) or children in care. Most provinces and territories offer these programs in addition to, or as a supplement to, other drug coverage programs.

The third category consists of **universal public pharmaceutical coverage programs**. These programs aren't universal in the sense that all drugs are covered for everyone. They are, rather, universal in the sense that they're for individuals who have no other type of drug coverage. Essentially, there are government-sponsored insurance plans. Plan members need not necessarily be experiencing high drug costs, nor fall into a specific “targeted” group. These programs generally have premiums, deductibles and co-pays).

Four provinces offer programs that fall under this option: Quebec, with its Public prescription drug insurance plan, Alberta, through its Non-Group coverage benefit program, New Brunswick, through its New Brunswick drug plan, and BC’s fair pharma plan.

*(If asked: Quebec has a mandated program which required residents to have insurance - whether is be private or public. This program also protects individuals from catastrophic drug costs by providing an upper payment limit (currently $1,029). Alberta's program caps out-of-pocket drug expenses at $25 per prescription. Those enrolled in these programs pay a premium, which may be subsidized depending on the income level of the individual or family)*

*New Brunswick's program is a bit different. It provides coverage for individuals who either lack insurance entirely or have insufficient private insurance through their employer to cover the costs of their medications. So under this program, individuals pay a premium which is based upon their income level, as well as a co-payment on each prescription with a maximum cap -once again income-based- for each prescription. This plan doesn't have an overall limit on out-of-pocket costs).*

-- What does this tell us? This shows us that the type of coverage you can “opt into” or in some cases are “entitled to” varies. Some provinces have quite extensive programs in place, such as BC, and others are quite limited (Ontario). One thing that is quite consistent across the provinces, even those with premiums, co-pays and deductibles, is that seniors, social assistance recipients and, for the most part, children, have access to provincial drug plans – usually at very minimal or no cost to the resident.

For our analysis, in the instances where targeted drugs plans used different formularies,
we chose the formulary that appeared to be open to the greatest number of residents in that province (ie. Not disease specific programs).
As discussed, Canadian health care is a patchwork of provincial and territorial systems further disaggregated by the existence of sub-regional, health care agreements between First Nations and federal, provincial, territorial counterparts. In order to understand the jurisdictional divides and associated cost implications within this fractured landscape, we began our research by looking into the provincial and territorial health care systems. We did not include tri-partite agreements in our analysis, such as the FNHA or Big Stone Health Commission in Alberta, as to our knowledge most tri-partite agreements adopt the NIHB formulary and related services.

We decided at the outset that we would use drug identification numbers as the main variable to compare drug coverage between these jurisdictions. The reason being that DINs are unique to every drug, dosage and form. Also, every province and territory (so we thought) includes DINs in their formularies. Unfortunately, one motivating factor was that we found the BC formulary early on, in excel format with nearly every drug ever offered. It turned out that this was more of the exception not the rule, as many jurisdictions provided pdf versions, and in the case of Manitoba the only available list of drugs in their formulary that we were able to obtain was listed by drug name. We address this further in our discussion of limitations. Due to the vast differences in available drugs and eligibility for different plans we also had to ensure that we knew who was available for each provincial and territorial plan and what that plan covered.

We then used Stata data analysis and statistical software to compare NIHBs list of available drugs to the formularies we retrieved for the provinces and territories. In line with the study objectives we used NIHB as our comparison group, creating a table in
Stata of NIHBs DINs to which we added: the drug category corresponding with each DIN, FNIHB’s supply and cost of each drug for a one year period from 2014 to 2015.

For each province and territory we the DINs offered per province and the population of registered First Nations and Inuit in each province and territory.

We then ran comparisons in Stata to determine the extent of overlap between drugs offered by NIHB and those offered in each jurisdiction under the plans included in the formularies that we used.

Based on FNIHB’s data of supply and cost over a one year period for each drug that requested from their formulary we were able to calculate the total value of all the drugs offered by both NIHB and each province or territory, in our analysis, according to the distribution of the First Nations and Inuit population across Canada.
Unable to retrieve all formularies: Despite concerted efforts we were unable to retrieve a Manitoba formulary with the DINs. It was the only jurisdiction that couldn’t provide a list of DINs, and only had a list of drug names. In addition, the list of drug names is a 134 page column which we were unable to read in given time constraints, therefore we dropped Manitoba from our study. There were too many gaps between the Yukon formulary and NIHB (only about 15% matched/overlapped), and despite repeated efforts to re-run the data we did not trust the data or results of the matching, therefore the Yukon was dropped. The health programs in Nunavut and NWT are mostly limited to hospital based care, with the exception of non-indigenous seniors in NWT. First nations and Inuit residents are encouraged to seek coverage under NIHB.

Based on these factors of data corruption, and health care in the North, and the population demographics in the NWT and Nunavut (majority First nations and Inuit), the territories were excluded from this study.

Formulary does not…: Formulary and therefore our analysis does not cover all provincial drug plans. While the specific plan name and eligibility is discussed below in findings, it is important to note that drugs for cancer and HIV/AIDS are excluded in the formularies we used.

Implications of this research are limited to the specific plans within each P/T.

DINs identify drug not use of the drug: “A rose by any other name would smell as sweet“ In Shakespeare as in drugs treatments. There can be many different names for drugs that do essentially the same thing. Formularies are not perfectly comparable because they only list the drugs available in each province but not the substitutions (i.e. other brand and/or generic). Therefore by comparing DINs we may miss drugs that treat the same symptoms, but for some reason are covered by one plan but not another. Some but not all formularies list equivalent drugs. The
formularies only list the drugs available through provincial plan, but not equivalent

- Duplicates: as shortcoming of using STATA for this analysis is that we were only able to match information to a single record, in other words, where certain drugs are used in multiple categories we saved the first occurrence of the DIN and deleted subsequent occurrences. In total we removed approximately 1,300 duplicates and 350 triplicates.
- Because the data we received from NIHB is aggregated by DIN and not by region we do not know demand/cost disaggregated by province and territory and therefore used the population of first nations and Inuit in each province and territory as a proxy.
- The final limitation is that our calculations do not include a growth factor and are therefore relevant only to the study timeframe, 2014-2015.
- Source for NWT exclusion: http://www.hss.gov.nt.ca/en/services/r%C3%A9gimes-d%E2%80%99assurance-maladie-compl%C3%A9mentaires/extended-health-benefits-seniors%E2%80%99-program
- Source for Nunavut: http://gov.nu.ca/health/information/health-insurance-extended-health-benefits
Eligibility: selected the broadest formularies available per province to capture the most drugs offered in each jurisdiction. As indicated on the map, most of the formularies include basic plans for which eligibility is determined by residency and income, as well as targeted drug plans covering a range of conditions and circumstances. Common among the targeted plans are those for which eligibility is defined by income, age (senior), specific condition(s) and stage of life, i.e. palliative care.

Provincial residents may also be eligible for specific plans that target treatments for conditions like cystic fibrosis and HIV/AIDS, and/or targeted groups such as children, seniors, people with disabilities.

Some provinces exclude individuals who have private or other health insurance. Two provinces specifically exclude First Nations and Inuit.

**British Columbia Pharmacare:** Formulary includes, for example, drugs available through Fair Pharmacare which is available to most residents, plus 6 other targeted plans such as for palliative and children. Eligibility is based on income, age, and specific conditions.

Formulary Source: http://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/what-we-cover/drug-coverage
Drug Plans Source: http://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/who-we-cover

**Alberta Supplementary health benefit plans:** Formulary includes, for example, premium free plans for those over 65, premium based plans for those under 65, and a range of targeted plans, for example palliative, diabetes, cancer, high drug costs, disease control and prevention, acid reflux, and children. It is unclear if registered First Nations and Inuit are eligible for Alberta’s supplementary health benefit plan, as their website specifically notes that some people in Alberta “have coverage through publicly-funded plans offered by the provincial or federal governments.”

Interactive Drug Benefit List (iDBL) (Formulary) Source: https://www.ab.bluecross.ca/dbl/publications.html
Eligibility Source: http://www.health.alberta.ca/services/benefits-supplementary.html
Possible Non-Eligibility Source: http://www.health.alberta.ca/services/drug-coverage-services.html

**Saskatchewan Extended Benefits and Drug Plan:** Formulary includes, for example, drug plans for children, seniors, exception drugs, palliative, insulin pumps. Specifically does not include, “insulin, blood-testing agents, urine-testing agents, syringes, needles, lancets and swabs used by diabetic patients.” Eligibility is determined, for example by income, age and specific condition, with the caveat that “[r]esidents whose health services are covered under existing federal programs through First Nations and Inuit Health, Health Canada, Department of Veteran Affairs, Worker's Compensation and federal penitentiaries are not eligible for Drug Plan benefits from Saskatchewan Health.”

Formulary Source: http://formulary.drugplan.health.gov.sk.ca/

**Manitoba Pharmacare Program:** Formulary includes drugs for seniors and those listed as having Exception Drug Status. Eligibility is determined by income alone. Specifically, “Pharmacare is a drug benefit program for eligible Manitobans, regardless of disease or age, whose income is seriously affected by high prescription drug costs. Pharmacare coverage is based on both your total family income and the amount you
pay for eligible prescription drugs. The total family income is adjusted to include a spouse and the number of dependents, if applicable.” The Manitoba Pharmacare Program provides the least amount of detail on the type of conditions that are covered by the Manitoba Pharmacare Program. Manitoba Pharmacare excludes people whose prescriptions are covered by “other provincial or federal programs,” i.e. NIHB.

Formulary Source: http://web22.gov.mb.ca/eFormulary/

**Ontario Drug Benefit Program:** Formulary includes a limited number of drugs for a range of conditions and circumstances including, for example, palliative care, HIV/AIDS, and diabetes. Eligibility is automatic for people over 65 years old, or for people under 65 who live in a long-term care home, or are enrolled in one of four provincial programs: Home Care, Ontario Works, Ontario Disability Support Program, or Trillium Drug Program for which eligibility is based on income and family size.

Eligibility Source: https://www.ontario.ca/page/get-coverage-prescription-drugs#section-1

**Quebec Public Prescription Drug Insurance Plan:** Formula covers a very broad range of drugs including those deemed Exceptional Drugs. Eligibility is determined based on not being eligible for private health insurance (including their children), for people 65 years old and over, and for recipients of “last resort” financial assistance. Quebec law excludes registered First Nations from the Public Prescription Drug Insurance Plan, as stated in “An Act respecting prescription drug insurance (CQRL, chapter A-29.01), r. 4 - Regulation respecting the basic prescription drug insurance plan:

DIVISION I

**COVERAGE EQUIVALENT TO THE BASIC PRESCRIPTION DRUG INSURANCE PLAN COVERAGE**

1. The following classes of persons are entitled to coverage equivalent to the coverage of the basic plan established by the Act respecting prescription drug insurance (chapter A-29.01) under another Act of Québec or under a program administered by a government or by a government department or body but are not covered by this plan:

   (1) beneficiaries of the “Agreement” within the meaning of the Act approving the Agreement concerning James Bay and Northern Québec (chapter C-67) and the Act approving the Northeastern Québec Agreement (chapter C-67.1);
(2) users or beneficiaries sheltered in a facility maintained by a public or private institution under agreement operating a residential and long-term care centre governed by the Act respecting health services and social services (chapter S-4.2) or by the Act respecting health services and social services for Cree Native persons (chapter S-5);

(3) Indians registered with the Department of Indian Affairs and Northern Development of the Government of Canada in accordance with the Indian Act (R.S.C. 1985, c. I-5) and Inuit recognized by that department.


Exclusion Act Source: http://legisquebec.gouv.qc.ca/en/ShowDoc/cr/A-29.01%2c%20r.%204

New Brunswick Drug Plan and New Brunswick Prescription Drug Plan: Formulary includes all drugs available under both plans, including special authorization drugs. Conditions include cystic fibrosis, multiple sclerosis, and HIV/AIDS. Eligibility is determined by income, age (65 years or older), and specific conditions and circumstances, and individuals are specifically excluded if they “have existing drug coverage (through a private plan or a government program)” under certain plans if covered in part or in-whole by “any other drug plan,” which we presume to include NIHB.


Coverage and Eligibility Source: http://www2.gnb.ca/content/gnb/en/departments/health/MedicarePrescriptionDrugPlan/TheNewBrunswickPrescriptionDrugProgram/BeneficiaryGroups.html

Other Plan Exclusion Source: http://www2.gnb.ca/content/gnb/en/departments/health/MedicarePrescriptionDrugPlan/NBDrugPlan.html

Nova Scotia Pharmacare: Formulary lists all of the drugs available under Nova Scotia’s five drug plans, Nova Scotia Seniors' Pharmacare Program, Family Pharmacare Program, Diabetes Assistance Program, Community Services Pharmacare Programs and Drug Assistance for Cancer Patients, and includes exception and special authorization drugs. Eligibility is determined by income, age (65 years and older), and specific conditions.
Prince Edward Island (PEI) Pharmacare Formulary: Formulary lists all of the drugs available under PEI’s many drug plans, which includes special authorization drugs. The specific drug plans includes drugs for HIV/AIDS, diabetes, hepatitis, tuberculosis and meningitis. Eligibility is determined by income, age (65 years and older), and specific conditions.


Drug Plans Source: https://www.princeedwardisland.ca/en/information/health-pei/drug-programs

Newfoundland and Labrador Prescription Drug Program (NLPDP): The five main plans under the Newfoundland and Labrador Prescription Drug Program (NLPDP) and special authorization drugs are covered under the formulary. Drugs for specific conditions include cystic fibrosis, growth hormone deficiency, severe acute rheumatoid arthritis, and HIV/AIDS. These plans are: The Foundation Plan, The 65Plus Plan, The Access Plan, The Assurance Plan and The Select Needs Plan. Eligibility is determined by income, age (65 years and older), and specific conditions.


Eligibility Source: http://www.health.gov.nl.ca/health/prescription/nlpdp_plan_overview.html

Nunavut Extended Health Benefits (EHB): Formulary is based on NIHB’s formulary, as such it covers the same conditions. Specifically, “EHB will pay the full cost of approved prescription drugs listed in the NIHB formulary.” Eligibility is determined by having one of those conditions, or for individuals who are 65 years and older who are not covered by third-party plans including NIHB. The EHB plan does however including additional support for travel when third party sources have been exhausted, as will be discussed further on.

Formulary Source: see NIHB’s formulary

EHB Coverage Source: http://gov.nu.ca/health/information/ehb-full-coverage-plan
EHB Eligibility Source: http://gov.nu.ca/health/information/health-insurance-extended-health-benefits

North West Territories (NWT) Extended Health Benefits (EHB): Formulary covers drugs available through the EHB and is based on NIHB’s formulary. Eligibility is determined by specific medical conditions and/or for individuals who are 65 years and older. Registered First Nations, Inuit and Metis are specifically excluded from this plan. Note that NWT Government has a Metis Health Benefits program that provide 100% of the benefits under NIHB, and is managed by Alberta Blue Cross.


Yukon Insured Services: Targeted drug plans cover children, chronic diseases (including HIV/AIDS, diabetes, adrenal disease), palliative care, and seniors. Restrictions apply to those if client has third party or private insurance, specifically, “[i]f you receive health insurance benefits through your employer or a third party insurance agency, claims must be submitted to these insurers first. The Pharmacare program is the insurer of last resort.” Eligibility is determined by income, age (65 years and older), and for individuals with chronic diseases or a serious functional impairment.

Eligibility by Program Source: http://www.hss.gov.yk.ca/insuredservices.php
Total number of DINs: 89,461
Total number of unique DINs: 16,097
NIHB unique DINs: 8,562
Top Categories for overlap: Cardiovascular Drugs and Central Nervous System Drugs
Zero match: contraceptives
Highest Matches: Quebec, Nova Scotia, Newfoundland, Saskatchewan
Lowest Matches: Ontario, BC,
DIN duplicates and triplicates removed so final categories do not reflect full drug availability
Based on population the biggest potential offsets could come from Saskatchewan, Alberta, and Quebec. As we noted earlier, Saskatchewan and Quebec specifically exclude First Nations and Inuit from their health care plans, hence this is a real offset.

NOTE on BC: Since 2013 NIHB transferred most of its BC clients to the FNHA. Currently NIHB still provides health care for approximately 19,283 (2.3%) first nations who are registered to reservations in BC, but not resident in the province which they would require to receive care.

NIHB distribution of demand is equal to the proportion of registered FN and Inuit per province. 

overage under FNHA.
(2015) Quebec has a population of 8,259,500 people. According to our data 68,274 (8.2%) of the population are either Status First Nations of Inuit. This represents 8.3% of the status First Nation and Inuit population in Canada.

are not on NIHB’s list (gap)

co-pay is $0-660

Depending on income premiums, deductibles and co-pay varies.

Paying co-pays, premiums and deductibles could present a substantial cost savings to FNIB depending on the income of most of the clients residing in Quebec
While the overlaps tells us potential cost savings, the gaps tell us a different story – they show us what the exclusionary policies are making those covered by NIHB miss out on.

Because Saskatchewan excludes, they’re offsetting almost 60 million dollars in costs to the federal government.
Medical Transportation
Just to restate: Medical transportation accounted for $356.6 million, or 34.7% of total expenditure.

The Non-Insured Health Benefit (NIHB) Program provides assistance so beneficiaries can access eligible, medically necessary health services that cannot be obtained in the community of residence.

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 physician, hospital care);
- diagnostic tests and medical treatments covered provincially;
- alcohol, solvent, drug abuse and detox treatment;
- traditional healers; and
- Non-Insured Health Benefits (vision, dental, mental health).
Ground Ambulance costs vary across provinces, although they all have co-pay arrangements. Ontario has the lowest co-pay for residents ($45); Manitoba currently has the highest ambulance costs – though Manitoba’s new government has mandated a standardization, and gradual reduction of fees beginning with a maximum fee of $475 effective January 2017, and reducing to $250 by January of 2020. As it stands, even within the province, it varies from region to region.

Inter-facility transfers that are deemed “medically necessary” are generally covered provincially, as air “air lifts”. Manitoba is a special case in that it explicitly excludes registered First Nations and recognized Inuit from such coverage.

Some provinces (such as Quebec) pay ambulance costs for seniors; others (Newfoundland) cover the costs for social assistance recipients.
British Columbia: BC- Travel Assistance Program
http://www2.gov.bc.ca/gov/content/health/accessing-health-care/tap-bc/travel-assistance-program-tap-bc

Alberta: N/A

The Rural Health Services Review Final Report March 2015, highlights the challenges posed to rural Albertans who lack access to transportation in order to access health care services. Section 3 (P.31) of the report presents the recommendations based on the findings and includes two specific to transportation: under the heading of Specialized Services, “Provide transportation via non-ambulance transfer to specialized services when no other option or opportunity exists to provide services remotely or via technology;” and under the heading of
Transportation and Telehealth, “Examine various models in use for publicly accessible transportation and consider support for regional or community-based public transportation systems.”

Source:

**Saskatchewan:** Specialized Transportation Services
https://www.saskatchewan.ca/residents/health/emergency-medical-services/ambulance-services#assistance-programs

**Manitoba:** Manitoba Northern Patient Transportation Program
http://www.gov.mb.ca/health/ems/nptp.html

**Ontario:** Ontario Health Insurance Plan

Northern Health Travel Grants (NHTG)

**Quebec:** Expenses for Medical Services Not Available in Your Area (Quebec)
Newfoundland: Medical Transportation Assistance Program
(Newfoundland and Labrador)
http://www.health.gov.nl.ca/health/mcp/travelassistance.html

New Brunswick: N/A

Nova Scotia: N/A

Prince Edward Island: Out of Province Travel Support Program
http://www.gov.pe.ca/photos/original/hpei_oop_ms_e.pdf?_ga=1.129466639.24680279.1480567885

Nunavut: Medical Travel
http://gov.nu.ca/health/information/medical-travel

All Nunavut residents who have exhausted their third-party insurance or have no medical travel benefits, including Health Canada’s Non-Insured Health Benefits (NIHB) may be eligible for the Extended Health Benefits (EHB) for Medical Travel Support.

EHB Medical Travel Support may provide coverage for client and client escort expenses such as:

- Flight co-payment specified under the Medical Travel Policy
- Taxi fare or ground transportation between person’s accommodation, health facilities and the airport
- Ambulatory charges for transferring the client from one facility
to another
Stay in private or commercial accommodations
Meals for stay in private accommodations
Long-term care plan, indicated prior to or after start of medical trip

Source:
http://gov.nu.ca/health/information/medical-travel-extended-health-benefits
(The link also includes a full table of coverage amounts)

**North West Territories:** Medical Travel
http://www.hss.gov.nt.ca/en/services/r%C3%A9gimes-d%E2%80%99assurance-maladie-compl%C3%A9mentaires/extended-health-benefits-seniors%E2%80%99-program

**Yukon:** Medical travel benefits

**Northern Health Travel Grants (Ontario)**
Land, accommodation

**Medical Transportation Assistance Program (Newfoundland and Labrador)**
Airfare, private vehicle usage,
accommodations, buses, ferries

The Northern Patient Transportation Program (Manitoba)

Land, air (may be), meals and accommodations (only if there is an essential escort)

Extended Health Benefits Medical Travel Support (Nunavut)

Land, air, accommodations, meals

*Others (Quebec) have tax credits for medical travel in place
Conclusions

Pharmaceutical
- Not all provincial plans extend coverage to registered First Nations and Inuit peoples
- Provincial drug coverage is severely fragmented and inconsistent throughout the country
- There are significant differences in provincial drug formulary sizes, and overlaps with NIHB

Medical Transportation
- Ambulance costs are lowest in Ontario, and highest in Manitoba
- Manitoba excludes registered First Nations and recognized Inuit from some provincial coverage (inter-facility)
- Few provinces assist with medical transportation costs