

**Non-Insured Health Benefits:
How BC First Nations Can Control Their
Health Services**

by

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Abstract

The Non-Insured Health Benefits (NIHB) program is frequently criticized for its poor service delivery and weak effectiveness at addressing health issues facing Aboriginal communities in Canada. This research examines the veracity of these claims within British Columbia and determines that cost reduction measures implemented by Health Canada have reduced the accessibility of the program, particularly with regard to dental coverage.

The NIHB program is being transferred to the First Nations Health Authority (FNHA). Prospects for the FNHA to improve the program and resolve its long-standing issues are investigated. Within the context of this transfer, an analysis of the policy alternatives available to BC First Nations community leaders and band governments to improve their Members' access to secondary health services is conducted. This analysis concludes that programs which assist Members with utilizing their NIHB coverage, as well as provide more general health education and promotion, would be most effective.

Keywords: NIHB; First Nations Health; FNHC; FHNA

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List of Acronyms

Term	Definition
BC	British Columbia
FNHA	First Nations Health Authority
FNHC	First Nations Health Council
HC	Health Canada
NIHB	Non-Insured Health Benefits
TCA: FNHP	the Transformative Change Accord: First Nations Health Plan

Executive Summary

When comparing First Nations individuals in British Columbia with their non-First Nations counterparts, the evidence overwhelmingly points to an imbalance in health conditions and outcomes. First Nations citizens in BC, both those living on-reserve and off-reserve, have lower life expectancies at birth, poorer dental health, and higher rates of depression, suicide, obesity, diabetes, and heart disease. These health problems have their roots in historical developments. While much was done in the second half of the twentieth century in Canada to move toward parity of health conditions, much more needs to be done to understand why a gap still exists and how it can further be eliminated.

The research done in this paper investigates the current state of access to secondary (or supplemental) health care among First Nations individuals in BC. This type of care is typically made available to British Columbians through private insurance (e.g. from an employer health plan). Health Canada's Non-Insured Health Benefits (NIHB) program delivers a minimum level of secondary health coverage to Canadians with Indian Status. The NIHB program is arguably the most important factor influencing access to secondary health care by BC First Nations.

A critical characteristic of NIHB is that it functions as a "payer of last resort," meaning that it does not coordinate benefits with other health plans, instead only paying for a particular benefit if the individual has no other coverage plan that would otherwise pay for it. Since the mid-1990's, NIHB has steadily adopted reforms which resemble features commonly found in private insurance schemes. For example, it has instituted systems of prior approvals for most of its benefits, and it has outsourced its claims adjudication and eligibility verification processes to a third party. Most significant for the program's future, authority over NIHB (along with other Aboriginal health programs) is currently being transferred from Health Canada to the First Nations Health Authority (FNHA) in BC. Resulting from a series of tripartite negotiations between representatives from BC, Canada, and BC First Nations, the FNHA has been established as *the* governing body to provide health programs and services to First Nations communities province-wide, with the key distinction that it is politically responsible to those

communities. Given this major shift in jurisdiction and authority, as well as the recent trends and changes within the NIHB program, a number of important questions should be posed by First Nations leaders regarding the future of secondary health care access in their communities.

First, this paper answers the question on what problems truly exist with NIHB. This program has been in operation for decades, and during that time period, particularly since the 1990's, the gap in health outcomes has not closed. If NIHB's primary objective is to elevate health outcomes in the Aboriginal population to the level of the rest of Canadians, it has not been particularly successful. More specifically, the NIHB program often fails to improve access due to its administrative barriers. Its dental coverage frequently requires predetermination requests, which are complex, difficult to complete, and typically involve lengthy processing times. Reimbursements for dental costs that patients incur at the point of service also involve excessively long processing times. NIHB's pharmaceutical benefits are frequently criticized for having an inflexible formulary and an overemphasis on generic drugs. Its medical transportation benefits are seen as being underfunded and poorly managed. Together, these three benefit categories account for nearly 95% of all of NIHB's annual expenditures (Health Canada, 2011b). In general, the barriers to utilizing NIHB deter many eligible individuals from using the program and ensure that the program's coverage obligations stay at a minimum. These characteristics all stem from the emphasis Health Canada places on cost containment, which ultimately comes from pressure applied by federal government leaders.

The research question that guides this paper asks what actions BC First Nations leaders can take to improve the usage of secondary health services and products within their respective communities. In order to answer this question, three major issues need to be explored:

- How the NIHB program will evolve under the FNHA's new authority;
- What portion of the remaining gap in health outcomes will individual First Nations be left to address, after any health improvements resulting from new actions by the FNHA; and
- What role engagement will have in the development of the FNHA's policies.

The methodology used to gather these answers involves two components: a literature review, and a series of qualitative interviews. The literature review examines audit reports on the NIHB program, both from the Auditor General of Canada and from Health Canada, and government and academic studies related to the program specifically and/or to Aboriginal health more generally. Of the six interviews conducted, four involve health professionals located in areas with sizeable First Nations populations, and two involve representatives from the First Nations Health Council.

This research produces the following main findings. First, that the FNHA will have a preliminary period of two to four years in which it will not make significant changes to the NIHB program, but will instead focus on gaining the experience to operate the program independent of Health Canada. After this preliminary period, the FNHA will work to improve the program by seeking to coordinate benefits with private plans, as well as by emphasizing the needs of low-income individuals and families. A key component to its strategy is to promote health literacy through educating citizens on the best ways to traverse Canada's health system, and the best ways to improve individual health and wellness.

Second, the health gap will continue to exist even with NIHB under the FNHA's control. The remaining causes of poorer health conditions within First Nations communities are associated with differences in behavioral and lifestyle choices and conditions. These primarily include poorer dietary and exercise habits, higher rates of tobacco use and alcohol and drug abuse, and lack of employment opportunities.

Last, engagement with communities and community leaders forms one of the main pillars of the FNHA's approach to policy development. Engagement played a central role in the consolidation of First Nations groups and the advancement of a common interest during the tripartite negotiations. A mutual understanding exists between the FNHA and First Nations leaders that the FNHA will engage with chiefs and health directors once a more detailed plan for the transformation of the NIHB program is designed. Engagement will involve the development of a consensus between the FNHA and leaders on what overall approach should be taken to improve NIHB.

Considering these researching findings, three policy alternatives emerge for a First Nations leader to consider. First, a First Nation may attempt to negotiate the further transfer of NIHB from the FNHA to their local-level government. Second, a First Nation may create a supplementary coverage program, which would use the Nation's own resources to provide additional coverage to its Members, above NIHB's coverage. Third, a First Nation may implement a program which assists Members in utilizing benefits through NIHB, as well as educates Members on the best practices they should adopt to improve their individual health and wellness. This paper's analysis considers the following criteria during its evaluation of these options: short-term effectiveness, long-term effectiveness, implementation and operational costs, and political feasibility.

Based on the results of its policy evaluation, this paper recommends the third option, that First Nations develop programs which assist Members in using NIHB and educate them on health-related best practices. This option has the advantage of being moderately effective both in the short- and long-term, and it has limited financial costs. The second option, to develop a supplementary program, could be more seriously considered by First Nations with both the necessary experience and resources to do so, but the additional increase in health coverage would certainly come at a substantial financial and political cost. The first option, to attempt to take over administration of the program, cannot be recommended under any foreseeable circumstance. This option would have little real benefit in terms of improving access to secondary health services, and the political barriers to successfully implementing this option are nearly insurmountable.

Perhaps the most valuable conclusion arrived at from this research is that the FNHA is truly the organization most capable of improving secondary health care access for BC First Nations. It is capable both in a narrow sense through its approach to transforming NIHB, and in a broader sense through its more comprehensive approach to addressing health needs province-wide. Over the next several years, the FNHA will have the knowledge, experience, and economy of scale to address BC First Nations' health concerns most effectively. This leaves individual First Nations leaders to take smaller actions that complement the larger actions taken by the FNHA.

1. Introduction

1.1. Foreword

For many First Nations communities in BC, few options exist for receiving adequate health services. Under the *Canada Health Act* (Medicare), health care delivery falls under provincial jurisdiction, and in British Columbia, primary health services are provided by the Ministry of Health, in partnership with the five regional health authorities. First Nations Members receive Medicare, as do all Canadians, but many communities are located in remote or sparsely populated areas, making access to covered services difficult. When it comes to obtaining secondary health coverage, which includes services such as dental care, vision care, and pharmaceuticals, many First Nations Members do not have private insurance that covers these services. Health Canada operates the Non-Insured Health Benefits (NIHB) program for Canadians with Indian Status. This program covers a selection of eligible secondary health services, and is directly funded by the federal government. It may seem, since such a program provides services which go beyond those offered to most non-Aboriginal Canadians by the federal and provincial governments, that First Nations would derive a higher level of care. Unfortunately, the reality is far removed from this presumption. While it is true that the NIHB program has not directly caused poor health conditions among First Nations communities, many have come to depend exclusively on the program for secondary health services. Because of this, the potential to improve First Nations health in the future is inextricably tied to the future of the NIHB program.

Stemming from tripartite negotiations between the federal and British Columbian governments and BC First Nations, the NIHB program, along with other Aboriginal health programs provided by Health Canada, is being transferred to the First Nations Health Authority (FNHA). The FNHA has been established, alongside the First Nations Health Council (FNHC -- the political body representing First Nations health in BC) so that federal aboriginal health services can be transferred to First Nations control. The

impetus for this transfer comes from all three parties involved in the negotiation process. The federal government has, for the past several years, sought to devolve the responsibility for First Nations health to the provinces and to First Nations governments. First Nations groups have been seeking the opportunity to gain direct control over health programs in their communities, and, more generally, to redefine their relationship with the federal government in a manner that transcends what they perceive to have traditionally been a paternalistic relationship in which First Nations are viewed as wards of the state. The BC government, having jurisdiction over health issues in the province, has committed to better integrating Aboriginal programs into its service delivery. The FNHA intends to complete the transfer of the NIHB program by November 2013. At that point, the FNHA will go through a transition in which it purchases the provision of NIHB services from the federal government, as it prepares to independently operate the program. Following this transitional stage, which could continue to 2015 or 2017, the FNHA will examine the policy opportunities it has available to reform the program into a more effective First Nations Health Benefits program.

1.2. Policy Problem

The NIHB program does not deliver adequate coverage to improve the health outcomes of First Nations Members in BC. The overall health conditions of the BC First Nations population are, on average, noticeably worse than those of other British Columbians. Many First Nations Members have no way to access secondary health benefits, aside from the NIHB program, due to low levels of income and/or an absence of private insurance.

In light of the ongoing transfer of the NIHB program to the FNHA, new opportunities are emerging for BC First Nations to take actions that help fill the gap in secondary coverage. This gap exists between what the NIHB program has traditionally provided and what First Nations communities require. While the FNHA opens the way for the program to be re-designed and improved upon, many difficulties and challenges are expected to arise throughout the re-design process. A major question regarding the future status of NIHB under the FNHA is whether sufficient resources will be available to

the FNHA, and whether those resources will be used efficiently to meet the health demands of First Nations communities.

The FNHA places a strong emphasis on engaging with First Nations communities at a grassroots level to involve them in the transformative process. This means that many First Nations Members across BC concerned about the future of the NIHB program have the expectation that their voices and perspectives will influence changes to the program, and, to some extent, result in higher-quality coverage and easier access to services. While reasonable, these expectations could become problematic if they conflict with each other, across various communities and interests. Improvements to the NIHB program will only occur if the FNHA's engagement process results in a consensus among BC First Nations on a unified direction for the program. This is why First Nations communities must understand the dynamics at play regarding the program if they are to fully participate in the NIHB decision-making process and contribute meaningfully to the dialogue over the program. These communities must also be made aware of the choices they have available to them and the actions they can directly take to fulfil the health needs that NIHB currently does not. It is under these presumptions that this research is being conducted. This research attempts to discover the best strategies for BC First Nations to adopt, considering the diversity of needs, priorities, abilities, and experience among this population.

2. Background

2.1. History

2.1.1. *Health Conditions Among First Nations*

Studies (Adelson, 2005; BC PHO, 2007; Wilson & Cardwell, 2012) that compare the overall health of individuals from First Nations populations to individuals from the rest of the Canadian population invariably conclude that First Nations populations are noticeably less healthy and receive lower quality care. Where secondary health services are concerned, First Nations populations tend to have poorer dental health, receive less frequent dental exams and cleanings, are more likely to avoid receiving major dental procedures, more likely to be overweight or obese, have diabetes, and develop associated chronic conditions such as heart disease (Quiñonez & Lavoie, 2009). First Nations populations also see higher rates of teen depression and suicide, and alcohol and drug abuse. These populations do not receive the same level of preventative care as other Canadians. This particularly affects children, whose lack of appropriate preventative dental care in their early years has lasting and far-reaching consequences throughout their adulthood.

In 2012, the BC Office of the Provincial Health Officer (BC PHO) published a report entitled, “The Health and Well-being of the Aboriginal Population.” This report provides an update to previous reports by the PHO on Aboriginal health in Canada. It states that, between the years 2006 and 2010, the average life expectancy at birth for Status Indians was 74.7, while for other BC residents it was 81.1. For the same time period, the age-standardized mortality rate, per 10,000 people, was 76.3 for Status Indians and 45.5 for other residents. The youth suicide rate was 3.0 per 10,000 people for Status Indians and 0.7 for other residents. The infant mortality rate, per 1,000 live births, was 7.2 for Status Indians and 3.5 for other residents. The rate of diabetes, per 100 people, was 8.0 for Status Indians and 5.8 for other residents.

While the 2012 PHO report did not discuss dental health, the preceding 2007 PHO report did. That report demonstrated that, in 2006/2007. For children aged 0-4 years, there were 37.4 dental surgeries per 1,000 children among Status Indians, while there were 10.5 per 1,000 children among other BC residents. Similarly, for children aged 5-9 years, 21.8 dental surgeries occurred among Status Indians, and 7.2 among other residents. The incidence of dental surgeries is a somewhat problematic measure, since a high incidence can be interpreted to mean either that a population has poor dental health and thus is in need of more services, or it simply has better access to dental services and thus likely has better dental health. A more usable statistic would be decayed, missing, or filled teeth (DMFT), but data containing this statistic which differentiates between Aboriginal and non-Aboriginal Canadians has been scarce in recent years. Lawrence and Leake (2001) compare the dental health of Ontario Aboriginal and non-Aboriginal children aged 5 and 13 from 1990 to 1994. Their work most notably shows that only 15% of Aboriginal children aged 5 had no DMFT, while 69% all Canadian (born in Canada) children aged 5 had no DMFT (p. 588). The average number of DMFT for all Canadian children aged 5 was 1.2, while the average for Aboriginal children was 6.5 (p. 588). A final salient point from Lawrence and Leake (2001) is that 9% of all Canadian children aged 13 had untreated decayed teeth, while 31% of Aboriginal children aged 13 had untreated tooth decay (p. 588). These statistics suggest that Aboriginal children do indeed have much poorer dental health than their non-Aboriginal counterparts. Based on the evidence provided by these indicators, the existence of a gap in health status between the two populations is obvious.

Further evidence points out that some substantial convergence had occurred between the mid-1970's and early 1990's of Aboriginal and non-Aboriginal health conditions, but since the 1990's additional progress toward convergence has slowed. Richards (2006) notes that in 1975 the life expectancy for Status Indians was eleven years shorter than for the larger Canadian population, and by 1990 that gap had been reduced to roughly seven years. Fifteen years later, in 2005, the gap had only reduced to six years. A relatively dated "potential years of life lost" (PYLL) survey conducted by Health Canada (1999b, via Richards, 2006) illustrates the significance of injury-related deaths (including suicide) in explaining why a gap has continued to prevail since 1990. The survey results show that injury-related deaths are not only by far the largest source

of PYLL for Status Indians living on-reserve, but account for the largest difference between that population and the entire Canadian population: 3,638 PYLL (per 1,000 population) (Richards, 2006, p. 37). This suggests that the remaining health conditions gap is at least in part due to living and working conditions, and behavioral and lifestyle choices.

The conclusions reached by the Romanow Commission (Health Canada, 2002) substantiate the points raised by Richards. The Commission states that the health conditions of Aboriginal Canadians have improved markedly since the first half of the twentieth century, largely as a result of improvements to living conditions, disease prevention, and public health services (2002, p. 218). The health concerns Aboriginal individuals are faced with today, however, differ from those that were faced decades ago. Importantly, the report mentions alcohol and drug abuse, mental health issues, diabetes, heart problems, and HIV as important concerns, which substantiates the assertion that much of the remaining health gap comes from differences in living conditions and behavioral/lifestyle choices.

The Romanow Commission further explains that access to health services for Aboriginal individuals has improved significantly in recent years, but that further improvements to access must be made if additional convergence of the health gap is to occur (2002, p. 220). The primary culprits it identifies as responsible for current inaccessibility are the “confusing and unsatisfactory” (p. 217) nature of current Aboriginal health funding, and the lack of integration between government services for Aboriginal and non-Aboriginal populations. In order to increase access to health services, the Commission recommends consolidating funding for Aboriginal health services at the provincial level, and establishing “Aboriginal Health Partnerships” (p. 223) to work toward integrating social services and adapting them to the local circumstances of individual communities.

2.1.2. *The NIHB Program*

In 1979, the Canadian government adopted its Indian Health Policy. This document outlined the direction that the government would take in the administration of its Aboriginal health programs, and it standardized the approach to delivering secondary

health benefits through the NIHB program. Prior to this policy, the federal government delivered such services based on perceived need, and it did not have a systematic method of determining which services would be covered or how much assistance would be provided. The impetus for this policy was a growing opposition within several First Nations communities to the government's desire to gain additional control over its expenses related to Aboriginal non-insured benefits, and to formalize the delivery of these benefits. The perspective of some First Nations groups was that these benefits were entitled to them as Treaty rights. The federal government did not share this viewpoint, but it attempted to reconcile this difference by expanding the scope of the NIHB program to include all Status Indians and Inuit, regardless of the individual's ability to pay, and regardless of whether or not he or she resided on-reserve.

A Renewed Mandate was created for the NIHB program in April 1997. This new mandate added clarity to the program by stating that its purpose is: "to provide non-insured health benefits to First Nations and Inuit people in a manner that:

- is appropriate to their unique health needs;
- contributes to the achievement of an overall health status for First Nations and Inuit people that is comparable with that of the Canadian population as a whole;
- is sustainable from a fiscal and benefit management perspective; and
- *facilitates First Nations/Inuit control at a time and pace of their choosing.*"
(OAG, 1997)

In the years since this mandate was developed, the NIHB program has followed a trend of growing administrative and cost-saving controls to minimize the fiscal impact of the program. The NIHB program currently lacks (and has lacked throughout its history) enabling legislation to establish it as a formal service of the federal government and define the level of service that the government is obligated to deliver.

In 1989, the federal government adopted a new approach to the delivery of Aboriginal health programs: the Indian Health Transfer Policy (Health Canada, 1999a). This policy involves the devolution of responsibility and control to willing First Nations governments over a range of services traditionally provided by Health Canada. According to Health Canada, the three pillars of this policy include community development, trust between Aboriginal people and the federal government, and

interrelation with the Canadian health system. Services eligible for transfer initially included community health programs, administration of hospital services, and non-medical residential treatment programs, but notably excluded the NIHB program. Health Canada stated that it desired to eventually transfer all Aboriginal programs and services currently under its control. It describes several challenges that it anticipated in the process of implementing transfers. These challenges include population growth, fiscal sustainability, accountability, the transition to self-government, conflicts with treaty land entitlements, and integration of services.

2.1.3. *Official Reports – The Auditor General and Health Canada*

In 1993, the Auditor General of Canada produced its first report on the NIHB program. The Auditor General found that the procedures administering the program, specifically the claims processing system, were ineffective at properly controlling billing and payment. A significant contributor to this was the inability to determine whether users were abiding by the principle of last resort. The Auditor General estimated that \$45 million annually could be saved if this trend was reversed. The report made three key recommendations to address this problem: to clarify responsibility and accountability for financial practices, to pursue cost savings through the principle of last resort, and to strengthen the claims processing system.

The Auditor General's second report on NIHB was published several months after the Renewed Mandate was revealed, in October 1997. This report updated the areas of concern for the program that had developed since the earlier report. The program had become vulnerable to several types of misuse, which included overuse and prescription drug abuse by clients, overprescription by physicians, and overservicing and overbilling by providers. The potential for this misuse was blamed on the large number of claims that were submitted and the trait of being gratis for beneficiaries. As with the first report, the Auditor General recommended more rigorous financial controls, specifically the adoption of a predetermination process.

A third report was developed in October 2000 by the Auditor General. This report had overall positive observations. The NIHB program had successfully adopted the

predetermination process, resulting in reduced costs for the program. For example, the program reduced its dental costs by 15% in 1997, despite the recommendation from the Auditor General only having been made that same year. Predetermination continued to reduce program costs in subsequent years.

Most recently, the Auditor General released an NIHB report in May 2006. The program had continued to implement controls on claims processing and service delivery. Adequate improvements were continually being made that reinforced the program's financial sustainability. The Auditor General also observed that Health Canada had improved its process for creating Community Health Plans and Transfer Agreements with Aboriginal communities, and had initiated several pilot projects in order to evaluate transfers of administration of NIHB.

The Auditor General in June 2011 produced a report that, while not mentioning NIHB specifically, examined the status of health programs for First Nations on reserves. Most relevant to this discussion is its following observation:

The federal government has often developed programs to support First Nations communities without establishing a legislative or regulatory framework for them... As a result, the services delivered under these programs are not always well defined and there is confusion about federal responsibility for funding them adequately. (OAG, 2011)

This illustrates a critical dilemma within the NIHB program: ambiguity surrounding the responsibility the federal government has toward supporting this program. This ambiguity leads to a program which, although heavily relied upon by Aboriginal communities, only partially receives the necessary resources to meet its primary objectives. The exact definition of its primary objectives also remains elusive. Underlying objectives of the program, specifically financial sustainability, then become the focal point of the program's management.

Internal audits specifically related to the NIHB program have been conducted by Health Canada. These audits evaluated each individual benefit category according to the policy framework established for it (Health Canada, 2009a, 2010a, 2011a). In general, these audits focused on the cost-efficiency of each benefit category, and the controls put in to administer the coverage. Little examination was given to the effectiveness of the

program at improving or elevating the health status of Aboriginal people. In addition, neither the Health Canada audits nor the Auditor General audits give any indication that information was sought directly from Aboriginal people using the program. This means that information from Health Canada and the Auditor General does not provide an adequate basis for measuring the impact of the program on Aboriginal health.

2.1.4. History of NIHB Expenditures

The spending trends for the NIHB program provide more concrete information on the evolution of the program in recent years. Figures 6-8 (see Appendix C) respectively display NIHB's annual expenditures according to benefit, annual per capita expenditures (excluding premium expenditures) by region, and estimated per capita expenditures (premiums included) by region. Examining the data on NIHB's spending by benefit reveals that in 1992 the three largest benefit categories, pharmaceuticals, medical transportation, and dental, were relatively equal in size, with pharmaceutical and medical transportation spending weighing in at roughly \$100 each, and dental spending a little over \$84 million. Over the next two decades pharmaceutical spending grew at the most rapid pace, costing roughly \$440 million in 2011. This trend is unsurprising and is consistent with the general aging of the Canadian population and the growing costs of pharmaceutical products. Medical transportation and dental spending grew at a slightly slower rate, but still manage to increase significantly over the nearly 20-year period described, with transportation costing nearly \$312 million in 2011, and dental nearly \$215 million.

Figures 7 and 8 both attempt to describe per capita expenditures. Figure 7 uses Health Canada's own calculations for this statistic, which excludes any coverage of provincial Medicare premiums (since not all regions provide this coverage), as provided in Health Canada's annual NIHB reports. Figure 8 uses other data provided in the annual reports to estimate this statistic, namely data on eligible number of clients in each region for each year, and the total annual spending for each region. This data thus includes premium coverage for those regions that provide it. Figure 8 also presents an additional four years of data for this statistic.

In general, both figures show the same trends. The regions of Nunavut, Manitoba, Yukon, Alberta, and Quebec have shown both the highest and highest-growing per capita spending over the past decade, while Ontario and the Northwest Territories have seen their per capita spending stay relatively constant. BC's data differs significantly between the two figures. Since BC is one of the regions which cover Medicare premiums, its per capita spending in Figure 8 has shown noticeable growth and sits somewhere near the middle of the regions by 2011. Excluding premiums, however, it appears that BC is nearly tied with Ontario in being the lowest-spending region (per capita). In essence, this shows that for all comparable areas of spending, BC and Ontario are the most prudent regions.

3. Literature Review

3.1. The FNHC, FNHA, and Tripartite Agreements

The Transformative Change Accord (TCA) (BC ARR, 2005), signed in November 2005, signaled a new commitment to cooperation between the Canadian government, the British Columbian government, and First Nations (then represented by the BC Assembly of First Nations, the First Nations Summit, and the Union of BC Indian Chiefs). The TCA established goals to close gaps in socio-economic conditions that exist between First Nations peoples and other British Columbians, reconcile Aboriginal rights and title, and create a new relationship between First Nations, BC, and Canada “based on mutual respect and recognition” (BC ARR, 2005). The Accord specified four areas where socio-economic gaps should be addressed: education, housing and infrastructure, health, and economic opportunities. The signatories agreed to develop a ten-year plan, which would detail the initiatives and reforms to be put in place to meet the Accord’s goals.

In 2006, the Transformative Change Accord: First Nations Health Plan (TCA: FNHP) (BC Health, 2006a) developed a vision for how improvements to First Nations health can be achieved. It outlined four objectives to improving health outcomes. The first involves creating mental health programs that target youth suicide and substance abuse. The second involves integrating the approach to preventable diseases, especially diabetes, with the ActNow BC initiative. Thirdly, tripartite pilot programs should be established in the Northern Health Authority, and the Lytton Health Centre should be built. Lastly, the number of First Nations health professionals should be increased. Shortly after the TCA: FNHP was signed, a First Nations Health Plan Memorandum of Understanding (BC Health, 2006b) was developed that further elaborated on the Health Plan. The Memorandum desired to put in place a framework from which a tripartite First Nations health plan could be agreed to. It also reiterated the points that the signatories must improve the programs that currently exist if the health gaps are to be closed, and

that such improvements should come from a collaborative partnership between the three parties. In 2007 the Tripartite First Nations Health Plan (TFNHP) (BC Health, 2007) was signed. The TFNHP outlined the requirements for a ten-year health plan, and described the short and medium-term actions needed to implement the plan. Most significantly, it defined the principles that would be applied to develop a new governance system for First Nations health. These principles included the creation of governing bodies that would later become the FNHC, the FNHA, and the First Nations Health Directors Association (FNHDA).

In October 2011, a Framework Agreement (FNHC, 2011a) was signed which established the conditions for transferring Health Canada's Aboriginal programs in BC to the First Nations Health Authority (FNHA). Most of these programs are delivered on-reserve, although the NIHB program is delivered to all registered Indians, regardless of whether they live on-reserve or off-reserve. Among the programs described in the Agreement are: children and youth programs, chronic disease programs, communicable disease control programs, mental health and addictions programs, primary care programs, and the NIHB program. The FNHA administers and delivers these health programs, and although it is operationally distinct from the FNHC, it also provides administrative services to the FNHC. The transfer of the NIHB program is currently in preparation and is expected to be completed by October 2013. Once it assumes control over the program, the FNHA will have the autonomy not only to administer the program, but to modify its policies and design. The FNHA anticipates that the transition stage, which encompasses the period after the transfer when the FNHA will focus on ensuring that its delivery of the program functions as expected, will continue for at least two years, reaching its end between 2015 and 2017. This is also known as the NIHB "buy-back" period, since the FNHA will purchase back the servicing of NIHB benefits from Health Canada. After it is confident that it can properly and independently deliver the program, the FNHA will enter its transformative stage, when it will begin discussions on altering the program's design as part of its engagement processes with BC First Nations communities.

In 2011, the FNHC released a document entitled, "Consensus Paper: British Columbia First Nations Perspectives on a New Health Governance Arrangement." This Consensus Paper assembles the feedback provided by First Nations through the

FNHC's engagement process related to establishing a new governance arrangement for First Nations health. This document explicitly mentions the NIHB program twice. First, when describing the directives the FNHC has received toward improving services, it elaborates that it has been directed to "improve and revitalize" the NIHB program. Second, when discussing the priorities of the FNHA, the document states that the FNHA must renovate and improve the NIHB, with an emphasis on medical transportation. A second consensus paper was released by the FNHC in 2012, which functioned as an update to the 2011 paper. The 2012 mentions the NIHB program a single time, and simply repeats the wording from the first document by stating that NIHB should be improved and revitalized.

More detailed compilations of community feedback to the FNHC can be found in the Regional Reports (FNHC, 2011c, 2011d, 2011e, 2011f, 2011g) produced for each of the FNHC's five regional caucuses. These documents summarize the responses provided by community members during meetings in which FNHC governance and direction were discussed. The NIHB program was mentioned in each Regional Report, and the responses from each region share multiple similarities. These responses can be grouped into two general themes. The first theme concentrates on the need for the FNHC to review, evaluate, and address the deficiencies of the program. The second theme involves the lack of funding provided to the program. More specifically, the Fraser, Interior, and Northern regions discussed concerns over the quality of medical transportation provided by the program. These regions stated that NIHB medical transportation is inefficient and poorly funded, and that it does not address the lack of access that isolated communities have to physicians. While not discussed within the context of NIHB, concerns related to dental health and diabetes were also mentioned during some regional meetings.

3.2. The Academic Discussion on NIHB

Brown, Forget, and Lavoie (2010) discuss the general shift within Health Canada toward an emphasis on providing more autonomy to First Nations communities over the management of certain health programs. They point out that, while such an attitude may appear to empower First Nations by equipping them with jurisdictional authority over

their own health affairs, such health transfers more importantly transfer the costs of these programs from the federal government to First Nations communities. This is readily observed from the limited funding that the federal government commits to. In fact, they state that Health Canada's goal, in the long term, is to discontinue its direct delivery of health services to First Nations. A primary motivation for doing so is to contain costs. By having First Nations deliver these health programs themselves, within a budget determined by Health Canada, Health Canada is able to ensure that their expenditures do not exceed the budget, without being responsible for devising changes to the programs. Put more simply, Health Canada's strategy is to provide First Nations with a set amount of funds, and then task them with deciding how to deliver the programs with those funds.

Jacklin and Warry (2004) contribute to Brown et al.'s interpretation of the Health Transfer Policy. According to their work, Aboriginal communities involved in health transfers commonly view the federal government's actions with suspicion and dissatisfaction, citing specifically the government's focus on cost containment. Jacklin and Warry approach this topic from a so-called medical anthropology perspective. In essence, the historical approach taken by the federal government has been to assimilate Aboriginal communities. They note that, despite these assimilationist efforts, the health conditions of Aboriginal people have not been equalized with the rest of the Canadian population. A shift in the government's approach occurred in the 1970's and 1980's with a new commitment to realizing Aboriginal self-determination, with the aim to develop and improve communities. As argued by Brown et al., this change in political position was not met with an equal change in financial commitment. While the federal government could argue that it was seeking to foster growth in Aboriginal health by giving communities more administrative control, the higher-level, structural limitations set in place hampered real potential for change.

Regarding concerns with the NIHB program in particular, Quiñonez (2004) provides a synopsis of complaints from dental providers. He states that frequent areas of criticism include billing and claims processing irregularities, problems with reimbursements, burdensome prior approval requirements, problematic professional audits, and a disinterest in offering preventative coverage. He further examines the program's interaction with providers, stating that Health Canada has resisted the option

of hiring providers internally to administer care. He suggests that a great deal of mistrust between the NIHB head office and health professionals is responsible for the poor quality of interaction between the two sides. In a later study (2006), Quiñonez describes the relationship between dental care, insurance coverage, and income. He states that high-income Canadians are seven times more likely to be covered by private health insurance than low-income Canadians, and that insured Canadians are over twice as likely to visit a dentist over the course of a year as uninsured Canadians. Within the context of this information, he further discusses the impact of NIHB on Aboriginal communities in northern Canada. He describes broad dissatisfaction of the program due to poor administration and limited provisions of care. As with the studies mentioned above, he attributes the root cause of these problems to Health Canada's cost-containment priority.

Quiñonez and Lavoie (2009) succinctly review the health issues of most concern to NIHB's coverage. They first discuss the prevalence of diabetes in Aboriginal populations. Diabetes occurs at earlier ages, has greater severity once diagnosed, and results in more associated risk factors within Aboriginal populations than in the non-Aboriginal population. Dental health, particularly in children, is a second health area which is perhaps as significant as diabetes for Aboriginal health. Dental decay rates can be twice as high, and sometimes even five times as high, in Aboriginal children than in non-Aboriginal children. Dental health in Aboriginal children is closely related to poor nutrition and compounds additional negative effects; for example, children with frequent decay and toothaches suffer from severe cognitive stress, which interferes with learning and development. Evidence also suggests that oral disease can have longer-term implications like diabetes, heart disease, and pregnancy complications (Quiñonez & Lavoie).

Their review (Quiñonez & Lavoie, 2009) goes on to analyze the NIHB program and its effectiveness at improving health outcomes. They conclude that the NIHB program, under Health Canada, resembles an insurance scheme rather than a typical government health program. In their view, health programs have primary objectives clearly related to improvements in health, while insurance provides coverage as required, up to established limits. Significantly, NIHB differs from normal insurance plans by the absence of premiums, deductibles, and copayments. They argue that while an

insurance company can accommodate increases in usage or expenditures by increasing premiums, the NIHB program must do so by requesting additional funds from the federal government. Because of these qualities, the program is not economically sustainable (assuming that insurance schemes must be justifiable in economic terms) since it has no internal mechanisms for adjustment, aside from cost containment. Most government health programs, on the other hand, view spending as an investment which yields surplus gains. These gains can take the form of higher overall health, reduced health disorders (and thus reduced long-term health expenses), or higher labor productivity resulting from a healthier labor force. Viewed in this way, health expenses do not need to be internally sustainable, since purely financial returns are not expected.

The conclusions drawn by the academic sources described above can be summarized into three broad statements. First, the health conditions of the Aboriginal population in Canada have remained notably worse than the health conditions of the rest of the Canadian population over the time period in which Health Canada has operated the NIHB program. Second, criticisms of the program concentrate on the poor administration of dental benefits, particularly for predeterminations and reimbursements, as well as pharmaceuticals (which can occasionally involve complex pre-approval processes) and medical transportation (which typically is under-funded and poorly delivered). Lastly, the fundamental characteristic which has held back the NIHB program, as well as other health programs transferred to First Nations, is the emphasis on cost containment by Health Canada.

4. Research

4.1. Methodology

4.1.1. Goal

The task at hand is to present the facts regarding the current situation, as well as the most realistic near future situation, as fully as possible to BC First Nations. Accurate facts are needed so that First Nations are able to best decide what actions they should take over the next several years to address the shortcomings of the NIHB program. In order to do this, several broad categories of information must be gathered. First, the distance between the current end results of the NIHB program and the desired results (in other words, the NIHB “care gap”) must be ascertained. This requires that not only the specifics surrounding the final service outcomes of NIHB be gathered, but also that the desired level and quality of health care outcomes be clearly defined. Meeting the first requirement can be accomplished by examining Health Canada’s data on NIHB’s expenditure trends, as well as by contacting health professionals that interact regularly with the program and can offer an informed perspective on the relative inadequacies of the program. Meeting the second requirement appears to be a more difficult task, as idealistic goals must be tempered by realistic expectations, and, most importantly, a consensus among BC First Nations on their collective goals must at least be attempted. Ideally, such information would be gathered directly from First Nations Members who are representative of both their communities and their larger geographic regions throughout BC.

A second broad category of needed information is the future evolution of the NIHB program, specifically under the control of the FNHA. BC First Nations must be aware of which aspects of the program will change, when or over what period of time these changes will occur, and what the likelihood is of these changes successfully being implemented. As with any inquiry into events occurring in the future, the NIHB program’s

evolution is a matter of probability. An element of subjectivity is involved in any evaluation of the NIHB's future potential, as First Nations may vary in how much risk they consider acceptable for their community. Put simply, First Nations communities must judge for themselves whether the potential improvements to the program, taking into consideration the likelihood of them occurring, are worth depending on the NIHB program in lieu of other actions or options. For the purposes of gathering relevant information, this means that accurate and concrete answers to questions on NIHB's future are essential.

Finally, a third broad area for consideration is the opportunity for First Nations in BC to interact and coordinate both with the FNHA through its engagement processes, and with one another on an ad hoc basis, outside of the FNHA's processes. Understanding the dynamics of the public engagement process around NIHB means having as much information as possible on when engagement processes will occur, when they will focus on specific changes to the program, and how the various First Nations in BC differ in their views on, and goals for, the NIHB program. Engagement adds a further level of uncertainty to the NIHB's future, since it will have an influence over the final decisions to change the program. . Necessary information on engagement includes the content of engagement activities, the link between these activities' outputs and the FNHA's policy decisions, and the characteristics of the people participating in the processes. Specifically, it is important to know the level of technical detail that will be discussed and debated, the level of influence the products of the processes have over decision-makers, and the level of contention that could arise between different communities and interests.

A related area of interest is potential for First Nations in BC to take collective action outside of the FNHA's operations. This could mean, for example, that tribal councils or community hubs develop supplementary health programs to narrow the NIHB care gap. In order to assess the viability of such options, information must be gathered on the relative dispositions of the First Nations in BC to coordinate such a venture, as well as the likelihood that such a venture would be practical, from an administrative viewpoint.

4.1.2. Process

Initially, this research intended to approach three different groups of people to gather information from: health professionals, representatives from the FNHC, and First Nations Members. Health professionals who provide services to First Nations Members were interviewed to gain an understanding of the interactions between health professionals and the NIHB program under Health Canada. The interviews were semi-structured and concentrated on the topics of previous experiences with the program and perceived limitations of the program. This involved comparing NIHB to similar government programs, as well as private insurance plans. In total, four individuals were interviewed. Three of them work in health centers in First Nations communities located in various regions of BC. The fourth individual works in a private dental clinic that does not primarily serve First Nations Members, but does receive First Nations patients regularly.

Interviews were conducted with representatives from the FNHC knowledgeable about the NIHB transfer, the future plans for NIHB, and the overall strategic-level objectives of the FNHC and FNHA. The Chair of the FNHC was interviewed in-depth concerning both the present status and future trajectory of the NIHB program, as well as the administrative realities of the FNHA. A second representative from the FNHC was interviewed on the specific topic of engagement activities, both regarding the past activities of the Health Council and the future activities that will concentrate on the NIHB program.

At the outset of this research, First Nations Members themselves were identified as a group that could contribute greatly to an accurate understanding of the issues at hand. Unfortunately, there were no available communications vehicles with which to contact suitable individuals within the timeframe of this research project. The frequency with which the FNHC's regional caucuses meet does not allow for participants to be approached and contacted for interviews until the summer of 2013. While it is regrettable that the input of First Nations Members could not be gathered for this project, their perspectives can be alternatively explored through the responses provided in the interview with the FNHC Chair. They can be further explored through the secondary source documents, specifically the Regional Reports, discussed in the earlier literature review. Since the majority of health professionals interviewed work in First Nations

communities, it is reasonable that their responses, specifically regarding the most commonly used benefits and the most problematic aspects of the program, would also closely match the responses that might have been gathered directly from Members. Regarding the research questions on what expectations exist for FNHC engagement on NIHB, and on what possibilities exist for cooperation between communities, there is no reason to suspect that the information provided by the two FNHC representatives inaccurately presents the perspectives held by First Nations Members.

Table 3 provides the list of prompting questions used for the four interviews with health professionals. In brief, the first question was designed to allow the participants to give a general impression of the program and its level of use in the community, while the second question asked for more detail on the demographics of the typical NIHB user. The third question allowed for far-reaching responses that, in general, touched on the inadequacies of the program. The fourth and fifth questions then allowed the participants to offer ideas and possible solutions for addressing those inadequacies, based on their professional experience, with a specific prompt inquiring about interactions with dental providers. Taken together, the responses from these questions allow for an accurate portrayal of the current state of NIHB services from reliable sources and within the wider context of the private secondary insurance system. By interviewing health professionals, the exposure to personal bias is reduced, but it is important to note that three of the interviewees worked within First Nations communities. Potential exists for bias in favor of First Nations communities from those interviewees, and bias may also exist from the fourth interviewee, in the form of her particular familiarity with private insurers. Tables 4 and 5 provide the lists of questions used during the interviews with the Chair of the FNHC and the second FNHC representative, respectively. . The prompts used in these interviewees were designed to allow the respondents freedom to elaborate as they saw fit, while also eliciting specific answers required by this research. These two respondents were interviewed as expert informants. Their responses show no evidence of being biased, unprofessional, or factually inaccurate.

4.2. Findings

4.2.1. Interviewee #1

This participant states that medications and prescriptions are the primary benefits she perceives community members accessing. Additionally, the use of breast pumps for first-time mothers is a regular occurrence, as are the use of other medical supplies and the access of vision care and dental care. Dental care access in the community is a combination of both basic dental and major dental procedures, but she notes that more young children need access to a specialist due to the high level of complications in the dental procedures. On the topic of which types of individuals use NIHB, she mentions that nearly every member of the community is low-income or below the poverty line. Young mothers, young families, and children use NIHB benefits more than older individuals, except in the case of chronic issues. Men seem to be more resistant to seeking assistance, and are more likely to not seek benefits that they are entitled to, while women seem more comfortable asking for support. She also names contraceptives as an important NIHB benefit that women frequently access.

Without the support of her health center, NIHB access would be difficult for Members, for all benefit categories. Communication with NIHB staff is arduous, specifically over the phone. The phone line contains multiple confusing automated messages, is usually busy, and involves long wait times. Members are often unclear of which department they should be asking to speak with. Speaking with NIHB personnel is challenging, since they often seem disinterested in assisting with Members' problems.

She states that virtually no one in the community has private coverage through an employer. Members who work for the band have access to the band's health plan, but they make up only a small fraction of the population. Of the Members that do not work for the band, she estimates that less than 5% have access to any other form of health coverage.

She describes the difficulty for Members seeking Indian Status to receive NIHB coverage. For example, in situations where children with Indian Status are entered into foster care by the Ministry of Children and Family Development and then subsequently

returned to their parents, a gap in time exists from when the child receives secondary health benefits from the provincial program and when he or she receives benefits through NIHB. Since NIHB is tied to Status, the difficulties in applying or reapplying for Status are worsened if the individual does not have access to any other source of secondary health coverage.

She states that the overall health coverage afforded to First Nations Members is nominally higher than for other Canadians, since all Canadians are entitled to primary coverage through the government, but only those with Indian Status (or other individuals receiving social assistance) are entitled to secondary coverage through a government program. The issue is that while most other Canadians have access to private secondary insurance either through their employer or because they purchase it themselves, First Nations Members are typically too impoverished or underemployed to have that access, so they are forced to rely on NIHB.

The coverage that NIHB offers is relatively good, when compared to private insurance plans, but it does not have the full set of benefits normally found in private plans. NIHB covers a large percentage of medications, but it also has many exclusions. Members must visit a physician who is willing to adjust the prescription to ensure that NIHB will cover it all. According to her, this differs from private plans, because if the medication is not covered at all, a low-income First Nations Member will likely not purchase it themselves, because they cannot afford it. Coverage is ostensibly available, but Members are uninformed about how to apply for and receive it. Doing so requires someone to be familiar with the NIHB bureaucracy to go through the process. This difficulty is so great that most Members decide not to go through the process at all.

The administrative process for NIHB is more complex than for private plans. When an individual with private insurance uses benefits, the process is simple: he or she provides the insurance number, and then the process occurs without any further action on his or her part. Additionally, private insurance normally covers a percentage of drug costs, while NIHB will either fully cover a drug, or not cover a drug at all. The process is also lengthy in terms of time, taking several months.

She states that a billing number is required for health professionals to support First Nations Members in accessing NIHB. The process for professionals to receive a billing number is arduous. Professionals must write a letter, prove credentials, and justify why their service or practice is needed by First Nations Members in the area. According to her, NIHB only issues a certain number of billing numbers. NIHB has criteria for how many professionals can get a billing number within a given geographical area. She provides an example of a health specialist who waited for over six months after submitting his application for a billing number, without hearing anything from the NIHB. There does not seem to be a process for a particular NIHB worker to be paired to applicants and see the process all the way through to completion. She expresses the sentiment that professionals are already trying to run a business, and it is cumbersome to learn this billing and approval system, since it is notably different from all other insurance and coverage systems. Without a billing number, a patient must get approval from NIHB before visiting the professional, get a quote from the professional on the cost of the procedure, and then apply for a reimbursement after the procedure.

On the topic of the interaction between dental professionals and the NIHB department, she recommends that NIHB allow all interested providers to participate, and offer training to them on accessing NIHB. She suggests that professionals be trained on how to manage the various aspects of the paperwork requirements and bureaucratic process. She expresses that it should not be difficult for professionals to participate in the program, since they are, in essence, advocating for the community by providing their services. In light of these difficulties, NIHB stops being a resource and actually becomes a burden on health, since it consumes much time and energy from Members and professionals, and often compels Members to avoid seeking any health care. Professionals have become intimidated by NIHB's processes. She provides an example of a pharmacy on reserve land that does not accept NIHB, even though the local area has a high First Nations population. Professionals who endure the processes and manage to successfully interact with the program often do so simply because of their commitment to the community's health, despite the negative impact it has on their businesses.

Further recommendations that she describes involve more training for NIHB staff on communication and cultural training. The experience using the program will improve from having a culturally respectful person on the phone. She explains that it once took

her three weeks to get to the right person to speak with on the phone. She further explains that once she found the right person, he provided the necessary answers immediately, and was exceptional and responsive in his communication. All the people she was required to speak with over the phone before then, however, were rude, disrespectful and belittling. Her last recommendations are for more transparency for Members and professionals as to how the benefits work, how to access, and what the process involves. Finally, she suggests that more supports be given to Members who are in the process of acquiring their Indian Status, so that they can easily begin accessing benefits.

4.2.2. Interviewee #2:

According to this participant, a major benefit from NIHB that is used in her community is medical transportation. While this benefit only provides minimal coverage, the support that NIHB provides alleviates some of the costs that Members incur from having to visit large urban centers, like Vancouver, for medical treatment. She states that Members rarely use NIHB for dental services, because of the difficulty in accessing coverage. She finds the coverage offered for dental services to be lacking. Few dentists accept NIHB coverage, because it pays less than their usual fee-for-service, and so dentists do not get commensurate payment. Additionally, NIHB can take up to a year to reimburse dentists who take Status clients. Dental coverage is always the most complained-about issue that Members have with NIHB. Orthodontic coverage is also difficult for Members. It requires a fee to submit an application, and requests are almost always rejected. For pharmaceutical coverage, generic options must be used if available, and only drugs from NIHB's approved list can be used. She also states that NIHB differs from private insurance in that it doesn't offer to cover percentages of all (or nearly all) drugs. Instead, it covers all drugs on its list, up to the cost listed in NIHB's fee guide, while paying nothing for excluded drugs. NIHB, specifically on transportation, has poor communication and customer service, and it requires extensive efforts at communicating with the NIHB office. She states that, in general, NIHB rules and guidelines for eligibility and pre-approval are too rigid, and the time required for reimbursements to be approved and disbursed is too long. When compared to private insurance plans, NIHB has stricter requirements and more red tape. NIHB has a policy

of payer-of-last-resort, and so Members must exhaust their other health coverage before being able to use NIHB.

She states that low-income families and families with children use NIHB most often. Members who use NIHB essentially consist of all Members who do not have any other option for coverage. Any Member that has alternate coverage or can afford to not go through NIHB chooses to do so whenever possible. According to her, NIHB purposely restricts quality care for Members and restricts adequate payment to providers. She states that the program is not really a benefit, despite its name, for anyone. Its process of access is too difficult. After Members attempt to initially get benefits, they quickly give up after realizing the futility of the process. NIHB staff are not personable or easy to work with, and are indifferent to the needs of Members. She recommends that the NIHB program improve its customer service. Also, she describes the stigma of having Indian status and the perceived favoured treatment that is afforded to First Nations Members, despite the fact that there is little benefit provided by the program.

4.2.3. Interviewee #3:

The third participant works in a dental office within a First Nations community. She notes that the most commonly accessed NIHB program benefits in her community are restorations and fillings. In addition, preventative services like cleanings and check-ups, as well as pain-relief services like extractions, are frequently accessed through NIHB. According to her, little crown or bridge work is done using NIHB, because the program does not readily cover them. She states that few Elders receive dental care through NIHB, because they already have dentures. Elders typically receive dentures at a relatively early age, as a result of NIHB's policies, which more readily cover dentures over root canals, crowns, or other preventative work. She further expresses her impression that her office sees as many male patients as they do female patients.

Regarding NIHB's coverage, the program is, in some ways, relatively good, considering that there is no financial limit placed on Members. The services which the program states it covers are covered at 100% of their fee guide, while private plans typically cover 50% of costs. NIHB, however, uses an outdated fee guide compared to the fee guides used by private plans. She expresses the sentiment that NIHB coverage

is superior to the analogous provincial program offered for low-income individuals. Despite this, NIHB has less coverage for preventative services than do private plans. Private plans more readily cover crowns and root canals, while NIHB has more restrictions on eligibility for these services. Furthermore, services from specialists are particularly difficult to receive coverage for, since most providers do not accept NIHB at par, and will bill the patient the difference. In terms of NIHB's billing practices, providers can bill the program through its electronic claims submission process. Non-electronic submissions do not require patient signatures, as opposed to private plans. Because of this, she believes that direct billing is actually easier with NIHB than with private plans.

She states that NIHB's pre-determination process is a "nightmare." Nearly every procedure a dental provider does with a patient must receive pre-authorization from NIHB. The process to receive this pre-authorization requires a lot of paperwork that is sent back and forth between the provider and the NIHB office. Importantly, NIHB does not accept electronic pre-determinations, which makes the process more cumbersome and time-consuming, almost requiring a full-time person to be devoted exclusively to that work in the provider's office. Those providers who primarily serve First Nations communities have already adapted to NIHB's requirements. Because of this, improvements to the interaction with providers would only significantly affect providers who primarily serve non-First Nations communities.

She recommends that the NIHB program begin accepting and processing pre-determination requests electronically, and that it focus more of its communications on providers, specifically concerning the release of fee guides. She also recommends that the program remove some eligibility requirements, so that providers do not have to call the NIHB office to approve every procedure. One way of doing so would be to adopt more of a blanket policy for all procedures, instead of having a detailed policy for each procedure. She also suggests that NIHB could develop a method for providers to electronically look up NIHB coverage and policy rules and requirements.

In general, she proposes that the NIHB program adopt more of a focus on preventative dentistry practice like cleanings, and remove its focus on extractions and dentures. Additionally, she recommends more of a focus on children through emphasizing good dental care and maintenance. Lastly, she suggests that NIHB could

expand its coverage to include hospital privileges by covering certain fees, such as sedation fees, that aren't covered by Medicare. As a final note on NIHB's relations with dental providers, she observes a trend in the dental care industry toward providers directly billing patients instead of accepting coverage from insurance plans. This is simply a result of dental providers attempting to run a business, moving toward the system used by eye care and optometrists. While NIHB has several characteristics that make it more difficult for providers to deal with than private plans, many dentists are deciding to eschew direct billing in favor of asking patients to pay at the point of service.

4.2.4. Interviewee #4:

This participant works in a dental clinic that is not located within a First Nation community, but is in close proximity to several communities and serves a moderate number of First Nations patients regularly. She states that those patients who use NIHB mostly access basic dental procedures, not major dental work, through it. According to her, NIHB does not cover major dental work the majority of the time. The program contains quite a few stipulations regarding which procedures are covered, and under which conditions those services will be eligible for coverage. For example, NIHB has many requirements on what makes a given tooth eligible. Most of the time, Members will only seek basic care with NIHB, because coverage of major dental work is too time consuming to pursue, and the process usually ends in the procedure being denied.

She states that NIHB's pre-approval process is "horrible." While simple procedures, such as fillings and basic hygiene work, do not require approval, crowns and other major procedures require documentation such as x-rays, charts of missing teeth, and proof that the patient does not simply need a more basic procedure. For example, the NIHB program will only cover a crown if the tooth is broken, but not if there is a crack line. NIHB will never cover a crown on a back tooth unless there is a missing tooth in front of it and there is contact with a bottom tooth during biting. She elaborates by stating that NIHB is quite different from private insurance in that Members do not pay into the plan, so there is no emphasis on the part of the insurer for pre-emptive measures and preventative work. NIHB only covers one dental exam in every 12-month period, which is half as often as most private plans. Private plans will cover orthodontics at 50% percent of costs, up to a lifetime maximum for each individual. NIHB, however,

only covers orthodontics for severe malformation or malocclusion. The program will not cover patients who simply have crooked teeth, and will not cover patients with even a 100% overbite if it does not meet NIHB's malformation definition. By contrast, most private plans cover all patients with crooked teeth, if the plan includes an orthodontic component. Additionally, she mentions that NIHB does not pay providers on a current fee guide, instead using a fee guide that is at least a year or more behind. For their part, most dental providers follow the currently released fee guide from the British Columbia Dental Association (BCDA) when setting their service fees.

She conveys her impression that low-income individuals do not often visit the dental office, when covered by NIHB. In addition, children do not regularly visit her office using NIHB coverage, since most low-income families utilize the province's Healthy Kids program, and so that coverage is used prior to accessing NIHB. She states her understanding that, in general, women tend to go to the dentist more often than do men.

On the issue of lack of information, she believes that the NIHB program is not notably less transparent or more complex than private plans. All plans include members who do not have enough knowledge about how the plan works. In terms of policy, NIHB offers relatively basic coverage which is on par with other plans, but these policies require a large amount of reading and are written in technical language that most members will not understand. Members have a misunderstanding that all dental offices know all the terms of each dental plan and can thus answer all questions that patient may have regarding what coverage they're entitled to.

Most insurance companies will respond to pre-determination requests in 4 or 5 weeks, while NIHB takes around 2 months. She states that this makes accepting NIHB coverage less appealing for providers than private plans, but that complications with direct billing and pre-determination requests cause many providers to ask all patients to pay upfront for services. In situations when a patient wishes to have a treatment done soon and chooses to have it completed before it gains approval, but NIHB (or the private insurer) subsequently rejects the coverage, the dental office must track down the patient and receive the payment from him or her. This requires a large amount of time from the dental office to send out statements and contact the patient, which can become costly.

This participant recommends that the NIHB program focus on making the experience of accessing benefits easier for the patient. The program should make it easier to get information from the NIHB office. Communication with the NIHB department, over the phone, is typically characterized as being rude, short, and unhelpful. She also describes a misperception among First Nations Members that NIHB entitles them to all benefits, and that this misperception frustrates them when they find out that NIHB does not cover a procedure they need. Some Members gets frustrated with the dental office, because they do not understand the dental office cannot influence what is covered. For many Members, NIHB tops up a private plan. This participant suggests that NIHB should be used to pay for fractions of total health costs, and should be viewed as being better than nothing.

4.2.5. Interviewee #5:

This participant is currently the Chair of the FNHC. Regarding the top priorities for the FNHC regarding NIHB in both the short term and long term, he states that there are opportunities for transformation of NIHB, and that the strategy is to first undertake a buy-back arrangement with Health Canada for two or three years. During the course of that period, the FNHA will be learning details about the program, how it operates, and how it is structured and managed. For example, the FNHA will learn more about the relationship that exists between the Government of Canada, as a funding agency, and the relevant health service providers in BC. Health Canada currently has relationships with various professional associations, such as the BCDA, and the FNHA must get to know those associations, particularly in terms of what their interests are.

The FNHA acknowledges that there are a number of issues with the NIHB program, such as policy issues, access issues, delivery issues, and funding and cost issues. In the short term, the FNHA wants to be able to address service delivery issues. Dental care is clearly a priority for First Nations citizens. The Government of Canada has attempted over time to contain the costs of the program. For example, the fee schedules for dentists have not kept pace with the fee schedules used by private plans. Some dentists have begun asking patients to either pay the difference between total service costs and the amount NIHB pays, and this causes some poorer Members to have to choose between dental service and other essential expenses. In addition, some dentists

ask patients to pay the entire bill and seek reimbursement from the program, which is even more difficult for poorer Members. The FNHA wants to revisit the relationship between the NIHB program and dentists, in order to make sure of the quality of the service and experience. The FNHA's approach is to clarify which dentists are interested in participating in the program, which dentists are not, and why. Once it is clear which dentists are willing to work with the program, the FNHA can begin to work with them to make sure patients get the care they need. The FNHA is aware that a growing number of First Nations citizens are being turned away by their dentists, or are having dentists refuse to deal with NIHB. The FNHA will work with the BCDA to reach a meeting of the minds, so that First Nations citizens can know what to expect from dentists, and dentists can know what to expect from their interaction with the FNHA, as part of an ongoing partnership.

On the topic of improving health outcomes, he describes a need to eradicate health illiteracy. Citizens do not fully understand how to navigate the health system to get the best care possible. He asserts that individuals must accept personal responsibility for their own health and wellbeing, and have a better appreciation for making healthy choices. This includes decisions on how people eat, how active they are, how communities manage substance use and abuse, and how individuals look after and interact with their families. He states that this requires an attitude adjustment. Furthermore, obesity is an epidemic. This illustrates a need to educate Members in order for them to make informed choices. Doing so means beginning to promote preventative care and health education through increasing investments in education and prevention.

Regarding the question of parallel systems of care, he states that the NIHB program should focus on coordination of benefits with private plans. Health Canada's current policy is to not permit coordination of benefits¹. He describes this as "penny wise and pound foolish." Coordination allows the splitting of costs between multiple plans through cost sharing. This can making better use of the resources that NIHB already has. Focusing on coordination of benefits, he states, allows Members to get more care of higher quality for the same dollar amount. This produces a better bottom line without

¹ Note: here he is likely alluding to NIHB's current policy of being the payer-of-last-resort.

increasing expenditures. With this policy, neither dentists nor the FNHA lose anything, and citizens benefit significantly. This practice is already done in the industry today, and so it would only require a change of stance in the NIHB program to allow coordination to occur.

On the issue of how NIHB could be transformed to better help those Members most in need, he emphasizes that statistics show that the health status of First Nations Members is not on par with other Canadians or British Columbians. The FNHA will focus on finding ways to support the provision of much-needed health services, as a means to bring the health status up to the level of other Canadians. Health Canada's policies of trying to contain costs have made it difficult for those citizens most in need to access services. The FNHA is looking at different strategies which are currently not permitted with the national program. Because the FNHA is taking over the program, it is going to be able to make changes in policies that ensure that those people who need NIHB's services, and qualify for it, will receive those services. He reiterates that those people who already have other supports available to them will coordinate benefits so that each dollar will go further. He states that those who need the most will get what they need, as will those who need only a little bit of help.

He confirms that the buy-back period will last a minimum of 2 years and a maximum of 4 years. Administrative services to make the program better can be made first, in the short term. In the long term, the program is going to be transformed. The FNHA is currently investigating whether it would be more effective to employ dentists and have them work in certain communities. This requires more research, and the FNHA must look at a number of considerations before any decisions can be made. Over time, information will be gathered, the FNHA will develop discussion papers on the transformation of NIHB, and these discussion papers will be provided to First Nations through regional engagement. The FNHA has made the commitment to chiefs and leaders across BC that it will not transform programs without their direction. The FNHA and BC First Nations must engage in a dialogue, get approval from chiefs, and come to a consensus on the nature of the transformative change. He mentions the Gathering Wisdom forum as a key component of that engagement process. According to the Chair, BC chiefs have already given their approval for the FNHA to make administrative changes as necessary, in the short term, to improve the program as much as possible.

In the long term, chiefs understand that the FNHA will return to the topic of NIHB transformation in its engagement, propose changes, and explore and refine ideas. In accordance with its established due process, only once the proposal gains approval from the chiefs can it be implemented.

On the discussion of the BC government's role, he states that before the tripartite negotiation, Health Canada would deliver services to Members living on reserve, as well as those living off reserve. The BC government, through its Ministry of Health and its regional health authorities, offered a different set of services to Members. The staff members responsible for delivering those sets of services did not interact with one another, even though they served the same group of people. With the current agreement, this situation changes. The FNHA is looking at integrating some of its services with provincial services. The objective is to make sure that chiefs and health directors are more actively involved and participate in decision-making related to care provided to their citizens. This means that the FNHA has partnered with each of the regional health authorities, and has signed partnership protocols with the First Nations leadership in each region. With these partnerships, the health authorities and First Nations leaders agreed to work together on planning, setting priorities, developing budgets, and evaluating programs and services. As a result, First Nations are going to have greater influence on health-related decisions. Additionally, the province is actively engaged in the partnership, and work on integrating services is now underway. The province will not be specifically involved in the NIHB program, but the kinds of care they provide will be influenced by First Nations, and that will help improve the overall quality of care.

According to him, there are a number of areas to work with the province on. For example, many First Nations Members do not have a family physician. Instead, some visit drop-in clinics, but for Members who live in remote areas, that is not possible. Some drop in to emergency rooms, which is the most expensive type of care. The FNHA can help the province reduce costs by helping First Nations Members get family doctors. One method for doing this is to have physicians visit remote communities. At the moment, this line of thinking does not extend to dental care, but the FNHA will be looking for opportunities to partner with the province to spend money smarter, instead of spending more money.

Regarding collaboration between various First Nations communities, he states that economy of scale is a critical issue, particularly for administration and service delivery. In essence, the size of a population dictates whether it is viable for a certain program or service to be operated by that population. This has been a challenge for most small First Nations communities. There has already been a fair bit of collaboration between communities to develop a better economy of scale and produce the necessary critical mass for certain health programs to be developed and delivered by those communities. Previous efforts at doing so have been focused on gaining eligibility for Government of Canada funds specifically for those purposes. Types of programs that have been the focus of such efforts include community health nurses, environmental health services, and water monitoring programs. The NIHB program, however, is a riskier program to transfer to First Nations communities. The smaller a population delivering such a program, the higher the risks become, in terms of managing expenditures. With one program for all First Nations Members in BC, the money is centralized. This means that the risk can be managed on a provincial level in ways that cannot be done on smaller levels. By maintaining one central program, the FNHA can strategize about how best to manage the risk. According to the Chair, there is not a way to run NIHB from a more local level. The FNHA is not going to have multiple points of managing the program; there is simply not a feasible way to make it work. Instead, the FNHA will work together with communities that wish to collaborate in other ways, such as employing a dentist. The FNHA is looking at the possibility of creating such opportunities by identifying communities that are close with each other and wish to work together on health-related initiatives.

On the topic of whether any First Nations have expressed interest in taking over the management and delivery of NIHB for their community, he affirms that there is a lot of interest in NIHB, but primarily around improving the program and making sure those that need a service receive it. There is a broad base of interest in this area of discussion. It is unclear, however, that people have enough information about what the Nisga'a Nation and others are doing with NIHB in their communities. He states that there is work to be done to inform First Nations chiefs and health directors of what is within the realm of the possible, and that the FNHA is beginning to do that now. It is important to note that no decisions on this topic have been made yet. After transfer is complete, the FNHA

will begin in earnest to learn about the program, how it is being run, and what the challenges are.

The possible improvements to administrative delivery that could be made during the buy-back will involve working with dentists. The Chair asserts that those dentists who are participating in the program need to promise to not ask NIHB patients to pay upfront or pay the difference in cost. Regarding pharmacy, the FNHA must find out how to work with pharmacists to ensure that the needs of First Nations citizens are being met. Additionally, he states that issues with patient transportation could be addressed. Currently, Members must go out of their communities to larger urban centers to receive care not provided locally, and there are costs incurred with that. The FNHA is considering addressing this by bringing physicians into remote communities.

Regarding the topic of the FNHA's funding for NIHB, he describes his attempt to negotiate increases above the amount provided to Health Canada. He states that, when the envelope system was implemented by Health Canada (that is, each region is told how much money they can spend, and directed not to spend over that limit), the Pacific region had astute managers who were committed to managing within their envelope. As a result, the Pacific region rarely overspent its budget. Other regions, however, did not have that kind of management, and overspent every year. Those regions were not admonished or disciplined for this. Instead, NIHB headquarters increased the annual budgets for those regions. In effect, well-managed regions, like the Pacific region, were punished, because they did not receive any funding increases. The Pacific region began to fall behind in the allocation of national resources. The Chair explains that he made the case to Health Canada that it would take an additional \$18 million each year to provide the region with a more average service delivery level. This dollar amount would not increase spending to the same level as the most overspent provinces, but would create a more mid-level spending amount. Health Canada did not agree with this conclusion, but did agree to increase the overall budget for NIHB by \$11 million, with an additional 5.5% annual increase.

On the question of what local First Nations communities could do on their own, he reiterated that a major focus should be on eradicating health illiteracy. This requires chiefs and health directors to learn how the health system works and how to get the best

care out of it for their citizens. Also, it is important for individual citizens to learn how to take care of their own health. This can be done through an emphasis on wellness, prevention, and health promotion.

4.2.6. Interviewee #6:

According to this participant, the FNHC defines their engagement process in three ways: communication, collaboration, and planning. The FNHC's approach to engagement has been comprehensive, including activities that engage chiefs and health directors, that provide information resources to communities, that involve aspects of collaboration through the Community Engagement Hubs, as well as direct communications with First Nations Members on FNHC planning. She notes that the FNHC's community-driven approach empowers communities to use its mechanisms to conduct engagement activities themselves. This allows communities to target their engagement to their specific needs and communicate back and forth with the FNHC.

She suggests that, on the question of which topics will be open to discussion during the engagement process, the FNHC is open to engaging on both broad, end-user kinds of issues, as well as more specific, technical aspects of the program. The most significant statement, however, appears to be that the FNHC is not currently in a position to provide detailed descriptions of the engagement process on NIHB, as it has not been designed yet. Rather, the FNHC currently focuses its efforts on overseeing the finalization of the transfer process, and once that is complete, it will focus on delivering the program, independent of Health Canada. The FNHC is still at least a few years away from being able to transform the NIHB program into a First Nations health program, so the approach it will take in the future regarding engagement is unclear at this point. The FNHC acknowledges that a variety of individuals, from chiefs to health directors to concerned community members, may ask different questions on NIHB and its transformation. The engagement process will be designed once a clearer picture is gained on the extent of engagement that communities expect and the extent of feedback that the organization would need to proceed with the transformation. Regardless of what the exact details of future NIHB engagement are, it is apparent that the outcomes will influence the decision-making process.

Finally, while it is difficult to predict now what the conversation topics on NIHB will be, it is reasonable to expect that much of it will focus on the resources available to the FNHC to deliver its services, and how those resources can best be allocated. There may be issues that generate some level of disagreement among participants, but the FNHC's process is based on working towards and generating consensus. Because of this, it is sensible to anticipate that no major impasse will occur during engagement that significantly stalls or prevents the transformation of the NIHB program.

4.3. Common Elements

4.3.1. *The Care Gap*

Based on the interview responses, dental care represents the largest gap between the secondary care received by First Nations citizens through NIHB and the care received by other British Columbians. The barriers to qualifying for dental procedures under NIHB and the difficulty of receiving coverage are largely responsible for this gap. These barriers do not manifest in the *de jure* policy framework of the program, but rather in the practice of attempting to receive benefits ostensibly provided by the program. The burdensome paperwork, long response times, and strict approval requirements impede First Nations citizens who seek secondary care.

In addition to dental care, the two other major areas of NIHB coverage, medical transportation and pharmaceuticals, have become problematic to use. Medical transportation significantly impacts the accessibility of care for remote communities, and NIHB has historically had difficulty with adequately funding and accommodating Members using this benefit. Critiques of NIHB's pharmaceutical benefits revolve around Health Canada's inflexibility. While NIHB covers a wide range of drugs, its refusal to cover certain drugs even partially, or cover name-brand drugs when generics are available, irritates and frustrates users.

These barriers are complicated by the fact that, in some cases, the primary users of the program in a community are low-income families. These families do not have the capacity to absorb the financial obligations of waiting for a reimbursement cheque to arrive, or of paying the share of a bill not covered by NIHB. In addition, many individuals

cannot bear the lengthy processing time of a predetermination request, and so opt for a tooth extraction instead of a preventative procedure. These factors combine to create an experience that most Members decide against enduring, and those who do choose to endure do so as a last resort.

4.3.2. Program Transition

The future of the NIHB program, at least for the next four to five years, is clearly outlined in the FNHC Chair's responses. The buy-back arrangement with Health Canada will continue for two to four years, after which the FNHA will begin engaging First Nations leaders and community members on the possibilities for NIHB transformation. A key aspect of the FNHA's strategy for improving NIHB, and the health of BC First Nations citizens generally, involves what the Chair terms "health literacy." By this he means educating citizens and community leaders on how the NIHB program works, specifically in conjunction with the wider secondary health industry, and thus how to achieve the highest quality of care from it. Health literacy also signifies educating citizens on how to make the best personal lifestyle choices to improve their individual health. It can be expected that a new approach to NIHB will emphasize these qualities, but little else is known on what specific tactics the FNHA might use to influence or incentivize changes in personal behavior.

Another important component of the FNHA's strategy, as described by the FNHC Chair, is the coordination of benefits between NIHB and private insurance plans. In effect, this means removing the payer-of-last-resort policy established by Health Canada. The question remains on whether doing so will truly result in more efficient spending. From the perspective of Health Canada, the payer-of-last-resort policy is the most effective method to contain the costs of the program. The FNHA's perspective, however, seems to be the opposite. It is unknown how effective Health Canada's enforcement mechanism is for this policy. It may likely be the case that Members who have a private plan are incentivized to withhold the existence of this plan from NIHB, because NIHB would then likely not cover any costs. Additionally, for Members who do not have another plan, or who have exhausted the benefits from that plan, NIHB becomes responsible for all costs thereafter that the Members are entitled to. In light of

these assumptions, it may indeed be more cost-efficient for the FNHA to adopt a policy focused on coordination of benefits.

4.3.3. *Engagement*

Most of the feedback and discussion generated on NIHB through the FNHC's engagement process has been focused on calling attention to its problems and pressing for positive changes, as opposed to suggesting and advocating for specific solutions or policy directions. This suggests First Nations communities trust the FNHA to conduct a rigorous review of the options it has at its disposal for improving the program. Future engagement on NIHB will likely not involve community Members or leaders competing with each other to influence particular policy decision outcomes. The exception to this would be if certain policy directions visibly and overwhelmingly favored certain communities or geographical regions over others. It is more likely, however, that discussions will concentrate on how quickly improvements are being made. If there is a significant amount of discontent surrounding a lack of immediate fixes, the discussion could concentrate on the restraints, which are principally financial in nature, that prevent or slow down potential fixes.

Since the FNHA will conduct its own internal policy analysis and then seek approval from First Nations communities through engagement, communities do not need to develop specific policy options on their own. Considering that the next several years will involve the FNHA transitioning into a fully capable and independent service deliverer, communities will have ample opportunity to ensure that exhaustive consideration of all viable options is ongoing. They can also ensure that the FNHA provides the necessary informational resources to support any discussions that may arise at the Regional Caucus level.

Discussions over shifting the emphasis on some benefits over others will only play a minor role in the overall discussion on NIHB's future. There could potentially be discussions over how to save money in each benefit category, specifically with medical transportation, since the FNHA is considering ways of bringing health professionals to remote communities. The discussion will more likely focus on redefining the scope and purpose of the program. Currently, a dichotomy exists within the program between its

role in providing essentially a coverage “top-up” for Members that already have private coverage, and its role in providing a base level of care for Members without any other source of coverage. The current expected level of funding does not allow for both of these roles to be performed well.

One of the most fundamental reasons that the NIHB program under Health Canada experienced problems with service delivery was the lack of enabling legislation. Rather than receiving its mandate directly from the Canadian Parliament, the program has evolved extemporaneously from the relationship between the Canadian government and First Nations, specifically around meeting the immediate health needs of First Nations communities. Because of this, no long-term vision for elevating the quality of health conditions in First Nations communities to the same level as the rest of Canada was developed. No meaningful measures for appraising the effectiveness of this program with regard to improving Aboriginal health were likewise developed.

In light of its transfer to the FNHA, the program appears to be gaining a firmer mandate. While not legislative in nature, the series of multilateral agreements that have led to the transfer provide a more solid representation of the program’s primary purpose. Perhaps more importantly, the program will now be politically responsible to First Nations, through the FNHC and FNHA. Regardless of which measures are implemented to assess the program’s success, there is little doubt that First Nations community members will be vocal about which aspects of the program they approve and disapprove of.

5. The Need for Engagement

5.1. Introduction

The research results above provide positive but realistic expectations that the FNHA will succeed in adopting effective solutions to the problems that afflict the NIHB program today. In order for these solutions to come about, however, the FNHA must have a fruitful engagement process with BC First Nations on this topic. This must be done both so that the FNHA adheres to the engagement precedent established during the tripartite negotiations, and so that it receives the necessary feedback to decide on its actions. This section reviews current academic theory on engagement practices, and applies that theory to the FNHA's engagement approach. It then briefly recommends some best practices based on this approach.

5.2. Theory on Engagement

5.2.1. *Arnstein*

An early voice in the discussion of engagement and participation in decision-making is Arnstein (1969), who provides the useful metaphor of the ladder when critically viewing citizen participation activities. Her ladder, and its eight rungs, has been reproduced in Table 1 in Appendix A. Most notably, Arnstein begins her analysis under the premise that government fails to appropriately consider citizens when making decisions. As such, her analysis essentially provides advice on how engagement can transfer power from the government to citizens.

The rung of manipulation involves activities by the government that merely serve to provide the public with information, without seeking any input in exchange. This is usually done through the construction of citizen bodies, usually termed "advisory

councils,” or “advisory groups,” which ostensibly offer an opportunity for the government to receive input from citizens, but in reality are limited in that functionality.

Therapy functions in a similar manner to manipulation, in that the real goal is to transmit information to citizens. It differs in that it focuses on issues of mental illness, pathology, or some other kind of socially undesired misbehaviour. This means that the purpose of the information is to compel certain individuals to adjust their behavior, whereas manipulation simply intends to pacify the public by presenting the government’s policies in a favorable light.

Informing activities are similar to the previous two, but typically manifest through one-way communication tools like posters and pamphlets. The type of information conveyed in this manner may involve simple explanation of the government’s planned course of action, and may even involve explaining ways in which citizens could provide the government with input or feedback.

Consultation activities seek the direct input of citizens, but typically lack a clearly defined mechanism for that input to influence decision outcomes. Common consultation events include surveys and public hearings. Arnstein describes the purpose of these activities as helping governments and politicians meet their obligations for involving the public in policy discussions, and likewise helping citizens who only desire participation for the inherent value of its exercise.

Placation involves allowing citizens to have some limited control or influence over the decision-making process. Some citizens may be appointed to sit on a certain board or council, or allowed to operate in an advisory role. The crucial aspect that defines placation is the inability to alter final results or re-direct the decision process.

When the decision-making process involves partnership, the traditional decision-makers share power with participating citizens so that all actors have roughly equal influence. Citizens may hold a near-majority of seats on a board or council, or may organize a parallel council which has the power to block or veto certain decisions.

The final two rungs, delegated power and citizen control, differ from each other only slightly. They both involve citizens holding more decision-making power than

traditional politicians. While delegated power still has a functional role for politicians, perhaps by holding a minority of seats on a council, citizen control altogether removes politicians from the process. Useful examples of citizen control would be referendums and New England-style town meetings.

5.2.2. *Fung's Democracy Cube*

Fung (2006) provides a critique of Arnstein's ladder and offers another model for considering public participation. He believes that Arnstein's model has value in terms of advocating a thoughtful inquiry into which participation methods are most suitable for the variety of engagement needs. Arnstein's model, nevertheless, fails to provide the suitable analytical utility. The model that Fung devises progresses from Arnstein's one dimensional approach by using three different and independent measures: participant selection method, mode of communication and decision, and extent of authority and power. Each measure includes a scale of possible positions. The various positions on each scale are provided in Table 2 (see Appendix A). Together, these three measures form Fung's "Democracy Cube."

When imagined as a cube, with each measure's scale representing one edge, the analysis of any given participatory process will involve finding three independent values and then constructing a rectangular box to represent the overall level of participation. The volume of the box can then be considered as a quantified depiction of an engagement activity's true participatory nature, but the most valuable consequence of this model is how it exposes the relativity of participation. One type of engagement may have a high value for one measure and a low value for another, while a second type may have the reverse. This demonstrates that public participation and engagement does not lend itself to absolute values, or simple judgements of activities as being "good at participation" or "bad at participation." Furthermore, Fung argues that the real value of a given activity or engagement mechanism relies heavily on the context of its use. For example, some decision-making processes would benefit more from an engagement mechanism that's extent of power involves advising and consulting than if it involved direct authority. This contrasts with Arnstein's evaluation that consultation is simply a form of tokenism, and that citizen control would yield more effective outcomes.

Most importantly, Fung proposes that certain democratic values, namely justice, legitimacy, and the effectiveness of public action, are at the heart why participation is sought by the public. Participatory processes typically focus on one or more of these democratic values, and the three dimensions of the democracy cube may be combined in any number of ways to meet that end. In essence, this method of viewing public participation suggests that the process should be designed beforehand by considering who wishes to be involved, how they want to contribute, and what they expect to be produced.

5.2.3. *Creighton*

The process of selecting appropriate tools with which to engage the public can benefit significantly from Creighton's (2005) analysis. Creighton advises that any scenario in which public participation is being considered can be broken down according to several characteristic categories.

First, regarding the characteristics of the public issue being discussed, the duration of the decision-making process should be discerned. For processes that are relatively brief, perhaps taking a few months, participation may be fairly straightforward and would not require a complicated engagement plan. Processes that continue for an extended period of time, perhaps several years, would demand a more thoughtful approach that focuses on maintaining a minimum level of public interest in the topic.

The level of technical complexity of the issue also heavily influences the structure of participation activities. An issue that requires a high amount of technical understanding likewise requires that either the public engagement activities focus heavily on successfully conveying complex, or that the activities be limited to only the non-technical aspects of the issue.

Public participation relies on a public that is interested in the issue. Because of this, the existing level of interest from the public prior to the engagement process strongly dictates how that engagement should proceed. This characteristic closely relates to the needs of the government in extracting information from the public. If the public has a high level of interest in the issue, but the government struggles to find

avenues for public input, an engagement process should be carefully constructed that satisfies the public's interest without portraying a sense of placation, appeasement, or insincerity. Conversely, if the public expresses little interest in an issue, but the government requires a significant amount of engagement, efforts at engagement must generate new interest in order for the decision-making process to be successful.

Creighton's final issue characteristic involves the importance of the issue to various stakeholder groups. Some groups may find little importance in a particular issue, while others may see the issue as vital to their future continuation, business success, or political survival. Single-issue advocacy groups could devote the entirety of their resources on a single decision-making process, since doing so serves the very purpose they were established to pursue. There may be situations in which no modification to the engagement process can satisfy all stakeholder groups. Furthermore, some stakeholder groups may attempt to influence how the engagement process proceeds so that it works to their advantage.

Characteristics of the public itself also serve an important role in Creighton's model. First, how informed members of the public are about the issue or decision being considered can help shape the ways in which information is presented. If the issue is relatively new or obscure, members of the public may not even know enough to contribute any commentary or perspective. Conversely, if an issue has been a part of public political conversation for an extended period of time, members of the public may be inundated with information, to the point that they have separated into polarized or partisan camps.

Creighton draws a distinction between publics that are hostile and those that are apathetic (considering also that there is variance between these two extremes, and that most publics will fall somewhere between them, on a spectrum). The more hostile a public is, the more opportunities should be provided for members to "vent," or to express their anger or disapproval. Until this impulse toward venting is satisfied, the effectiveness of attempts to solve the problem or reach consensus will be limited.

The level of division among members of the public significantly impacts the complexity of engagement. For members that are relatively united in their perspectives

and approaches to the issue, the process can simply serve as a way to further solidify and articulate the public's viewpoint. For members that disagree vehemently, however, the primary purpose of engagement may be to mediate the conflict and slowly work toward resolving it. It is important that the process assure members that some positive outcome will be achieved. If members perceive the division to be so wide that only unproductive quarreling can occur, the process would likely be avoided altogether.

A closely related characteristic that Creighton describes is the timing or maturity of the issue. If two sides to an issue do not trust the sincerity of the other side in seeking a resolution, little hope exists for a compromise to be found. Only once both sides come to the realization that continued conflict and disagreement cannot result in a more preferable solution, does compromise, through engaged dialogue, become the most viable course of action.

The physical geography that relates to the issue involved can also play an important role in how engagement is pursued. An issue that impacts a geographically compact area may only require a small engagement program, while an issue that impacts a large area or an area in which impacted residents are highly dispersed may require a more intense effort at involving everyone.

The final two characteristics that Creighton outlines are the presence of outside interests, and the presence of existing institutions. Outside interests could include any individuals or groups which are not directly affected by the issue, but still seek an active role in its decision process. They may do so either because the issue has significance for a given region, or is significant for moral, political, or possibly economic reasons. The mechanisms to engage outside interests do not need to be identical to those used with more relevant participants. Outside interests should, however, be engaged to the extent that they contribute to the resolution of the issue.

Existing institutions, which would include various types of organizations and associations that represent relevant stakeholders, may offer their own mechanisms or vehicles for engagement. Using tools which already exist would contribute to the ease of facilitation, and it also would likely add an additional element of legitimacy and trust, from the point of view of the stakeholders.

5.3. Recommended Approach

Based on the information provided by the FNHC Chair, the FNHC plans to engage both with First Nations leaders (chiefs and health directors) and concerned First Nations citizens. Arnstein's style of analysis would suggest that the FNHC has partnership-level engagement with leaders, and consultation-level engagement with citizens. However, this style, which envisions a clash of interests between the government and the citizens, seems less useful for the FNHC than Fung's and Creighton's perspectives, since the FNHC is not a traditional government institution and has actively sought to engage citizens. It is also helpful to note that citizens have elected representatives who participate in the FNHC's and the FNHA's decision-making processes, both as chiefs and as FNHC members.

Using Fung's classifications, the FNHC engages citizens as self-selected participants who express their preferences and have communicative influence. First Nations leaders are engaged as elected representatives who deliberate and negotiate, and whose extent of power can be described as co-governance. These are clearly two distinct approaches to engagement, as they have been designed to produce distinct engagement experiences with the respective participants.

Applying the classification used by Creighton reveals that the NIHB decision process has a relatively long duration, a high level of technical complexity, a high level of public interest, and a moderate level of importance to stakeholders such as advocacy groups. Regarding the characteristics of the public, citizens are relatively uninformed about the topic, more hostile than apathetic to the issue, have a low level of division, have a generally matured view on the program, and are geographically dispersed. There do not appear to be any significant outside interests. Existing institutions are present, both in the form of previous engagement processes the FNHC has conducted, and engagement done within communities.

This assessment leads to the conclusion that citizens should be engaged differently from leaders. Citizens who are drawn to participate in discussions on NIHB will likely desire to express their own dissatisfaction with the program. It is important that they be given the opportunity to do so. Many of these citizens are uninterested in

contributing to the development of policy actions, and simply seek to convey the information that they are concerned decision-makers may not be aware of yet. Citizens from geographically isolated areas may worry that their unique experiences and preferences have not been incorporated into deliberations. In essence, citizens will engage because they want to confirm that their voices are heard and that decision-makers are being held accountable.

Engagement with leaders will be more complex. Leaders will desire to be more informed and to actively participate in developments related to NIHB decision-making. Since leaders are elected representatives and lack sufficient expertise to make technical evaluations, technical experts must be present to support the deliberative process. Since the FNHA plans to conduct some policy analysis on its own prior to engaging with leaders, it must be ready to thoroughly explain and justify its analysis. Furthermore, it must be ready to accept a consensus from leaders that advocates for any of several different policy directions. Leaders have previous experience with deliberating, and they likely have relationships with each other, so gridlock and impasses in the process, if they occur, would not be serious enough to prevent decisions from being agreed to. . The process should, nevertheless, allocate enough time and facilitation resources to ensure that interests and priorities become balanced.

Citizen participants should avoid strategies that focus on second-guessing the FNHA's specific, technical-level policy evaluations and recommendations, as well as avoid strategies that focus on merely reiterating the current problems with the program and stressing the need to do something about it. Instead, participants should find a strategic middle ground by focusing discussions on higher-level approaches and longer-term design goals. This means ensuring that all viable options are rigorously evaluated, that the limitations, particularly financial limitations, on the program are understood, that all concerns are expressed, and that consensus is developed around what the overall vision of the program should be. Most important, for both citizens and the FNHC, is the acknowledgment of the FNHC's and the FNHA's legitimacy and authority. The administration of health programs and services province-wide under the FNHA is a centralized approach. If the FNHA is to be effective at delivering and improving the NIHB program, decision-making must stay at this higher level. This means that the FNHA must

allow citizens to contribute as much of their input as they deem necessary, and citizens, in return, must allow the FNHA to have the final say.

6. Policy Analysis

6.1. Introduction

The discussion now turns to how an individual First Nations community can fill the care gap left by the NIHB program's current shortcomings. The information provided through this analysis may be most helpful to a First Nations chief, health director, or other community leader concerned with how the community interacts with NIHB or, more fundamentally, how the quality of its overall health can grow. The problem being addressed by this analysis consists of two components: the short-term measures that can be taken to increase the usage of secondary health services, and the longer-term strategies that can be adopted regarding the FNHA's approach to the NIHB program. Put more simply, this analysis asks, from the point of view of First Nations leaders, how much of the care gap is going to be filled by the FNHA's improvements, how much of the gap will be left for individual First Nations to fill, and how best can First Nations fill it. This section first discusses and describes the alternatives that First Nations have to choose from. The various criteria with which to assess the alternatives are then outlined, as are the specific measures and benchmarks for each criterion. Lastly, the alternatives are assessed and a recommendation is provided.

6.2. Alternatives

The policy alternatives available to BC First Nations communities and band governments in this analysis come from both the background information and literature available on the NIHB program, and the research findings described earlier. First Nations leaders can pursue three broad courses of action: acquiring responsibility from the FNHA over the management and delivery of the program in their community, implementing and funding a health program to supplement NIHB's coverage, or

organizing and implementing a program for health education, promotion, and NIHB assistance.

Gaining responsibility over the program stems from previous NIHB transfers to the Nisga'a Nation, Mohawk Council of Akwesasne, and First Nations involved in a Health Canada NIHB transfer pilot project (Health Canada, 2006a). These experiments in NIHB transfer attempt to improve secondary health benefits by giving the First Nation more influence over the quality of the experience Members have with NIHB staff. The idea to supplement the NIHB program comes from interview responses (from Section 4.2) that state a major drawback of the program is its limited coverage. A supplementary program offers the most straightforward solution: improving secondary health benefits simply by providing more coverage. An education, promotion, and assistance program derives from interview responses, both from health professionals and the FNHC chair, that suggest that improvements in these areas would increase the use of the NIHB program (or other sources of secondary benefits) and increase the adoption of healthy lifestyle choices. This type of program attempts to improve secondary health benefits by increasing the likelihood that Members successfully seek out and receive services.

Taken together, these options embody the full range of potential action First Nations have. Each of these three options encompasses a wide variety of possible customizations and design details which can be altered by a community. This gives communities the freedom to adapt this analysis and design a custom policy to best meet their needs. The possible configurations for each policy option are described below, and this analysis considers which configurations might be most applicable to certain kinds of communities. This analysis does not, however, evaluate these specific configurations in the same manner that it evaluates the broader options. A standard set of criteria have been devised for these broader options, and each option is measured using the same benchmarks. These criteria and measures are described in further detail after the policy options are elaborated on.

6.2.1. NIHB Takeover

All First Nations governments in BC could potentially negotiate to manage and deliver the NIHB program to their respective communities. It is useful to discuss the examples of the Nisga'a Nation, Mohawk Council of Akwesasne, and NIHB transfer pilot projects. These transfers stipulate that the First Nation or Inuit government would be given responsibility for managing and delivering the program to its citizens. The federal government finances the program through recurring contribution funds. The First Nation or Inuit government has the freedom to improve communications and customer service, while being responsible for the administrative duties of the program. It does not have the power, however, to alter the policy regulations and frameworks devised by Health Canada. This means that the First Nations government cannot, for example, alter the NIHB pharmaceutical formulary, or modify the requirements for a dental crown pre-determination approval. The government is limited to conducting the same work that would have been conducted by NIHB staff at the Health Canada regional office. (Health Canada, 2006a)

If a First Nations government were to attempt to negotiate a similar agreement with the FNHA, the stipulations would likely resemble those of previous transfer arrangements. It is unlikely that the FNHA would be willing to grant a First Nation any authority beyond managing and delivering NIHB, given the statements made by the Chair of the FNHA regarding economy of scale. Another important potential limitation around a negotiated transfer would be whether the First Nation in question has completed a treaty or self-government agreement which acknowledges the Nation's self-governing authority. In the absence of this, the federal government may take issue with a First Nation exercising such authority, despite the fact that it has relinquished control over NIHB to the FNHA. This ambiguity may or may not pose a barrier to the negotiation of such a transfer between a First Nation and the FNHA, but it would no doubt have to be addressed and clarified during the negotiation process.

In addition to an individual First Nation having the potential to negotiate such an agreement, a group of several First Nations could collaborate for the program to be transferred to them collectively. This could take the form of a tribal council, Community Engagement Hub, or ad hoc association pursuing a negotiation together with the FNHA.

While doing so would increase the economy of scale available to the managers of the program, such an arrangement has never been completed before in Canada, and so the FNHA could have some additional reservations about agreeing to a transfer.

Regardless of who pursues this option, some common characteristics can be expected. A local office would be established to administer the program, and new staff would be hired to oversee its delivery. This aspect was seen as an advantage by First Nations participating in NIHB pilot projects, since it produced economic benefits (employment) to the community. Instead of communicating with the FNHA for predetermination requests and reimbursements, for example, Members would communicate directly with their local office. The benefits that Members are entitled to would stay the same as they are for others receiving NIHB coverage through the FNHA. Additionally, it is likely that Members would no longer be able to participate in, or contribute to, the FNHA's engagement process. Members would engage solely with the local authority responsible for delivering the program to them. Communities that participated in a pilot project note that funding from Health Canada was insufficient (Health Canada, 2006a). Health Canada provided no additional funding beyond what was required to provide the benefits themselves. The absence of additional funding may or may not reoccur under negotiations with the FNHA.

Supplementary Coverage

Rather than attempt to improve Members' experience with NIHB by taking over the program, a First Nation could develop an internal program to provide coverage that supplements NIHB's services. In this context, supplementing means providing a mechanism through which Members can benefit from additional coverage above and beyond the coverage provided through NIHB. This mechanism would be funded directly by the First Nation government itself. Such additional coverage could include services, procedures, or products excluded from NIHB coverage, or could include coverage that overlaps or "tops up" NIHB coverage. The various benefit categories that compose such supplementary coverage would be decided by the First Nation, but, based on the previous discussions of areas of concern for NIHB, a supplement would likely be most effective if it concentrated on major dental, medical transportation, and possibly expanded pharmaceutical coverage. It is important to note that, just as with the previous

option, a group of First Nations could collaborate to establish a collective program. A First Nations government is not necessarily limited to taking action in isolation.

A supplementary program would involve either purchasing private insurance, establishing a self-insured plan, or creating a more targeted delivery of health services. Private insurance companies offer plans to individuals that cover many secondary benefits, and also offer the ability for groups (typically employees) to buy plans together, functioning as an insurance pool. Private plans typically require a monthly premium to be paid by all members, and may also have further requirements, such as deductibles or copayments. These plans normally cover between 50% and 100% of certain services and products, up to a yearly maximum dollar amount for each member (see Appendix D). The First Nations government would be responsible for deciding how much of the costs of the private plan(s) the government itself would pay for, and how much individual Members would be responsible for. In other words, the government could subsidize, at various levels, the price of the plan(s) for all or some of its Membership.

The distinction presented here between individual and groups plans conveys the reality that some, if not all, private insurers may not be willing to arrange a group plan for a First Nations community. A single group plan would be more cost-efficient and provide more comprehensive coverage than multiple individual plans. Without a willing insurer, however, a community may have no choice but to purchase individual plans, if it wants to purchase private insurance.

Establishing a self-insured plan involves the First Nation directly funding the coverage itself, instead of purchasing coverage from a private insurer. This would likely still involve hiring a private insurance company to handle claims adjudication and eligibility verification. Self-insurance involves the First Nation paying for all eligible expenses from Members accessing benefits, either through the creation of an initial dedicated fund which is continually replenished, or through making payments directly from the government's budget. The First Nation would have the flexibility to decide which services and products are covered through a self-insured program, although an increase in coverage would increase costs for the government.

A more targeted program would be similar in some respects to a self-insured program, because it also requires the First Nations government to directly finance health care expenses. Instead of pay health bills for visits to a dentist or pharmacist, however, this type of program would involve possibly hiring a community dentist, or establishing a community health clinic, staffed by health professionals. Doing so would allow the First Nations government the most flexibility in tailoring the program to the community's specific needs. Such a program would also likely not require any services, such as claims adjudication, to be outsourced to a private company.

Under either arrangement, the government should seek supplementation specifically for health priorities. This means the program gains coverage for major dental procedures (e.g. root canals, crowns, bridges, orthodontics), medical transportation (including ambulance services, long-distance travel, accommodations, etc.), and drugs and medical supplies that NIHB either excludes or does not cover the full costs for. Again, priorities may change between communities. The priorities described here consider both areas where First Nations health is particularly deficient and where NIHB is particularly problematic.

6.2.2. *NIHB Assistance, Health Education, and Preventative Care Promotion*

A First Nation could adopt a program that assists Members with using the NIHB program, improves overall health education, and promotes preventative health care. As with the previous two broad options, this option could be realized through collaboration between multiple First Nations communities, rather than by a single community. When the promotion and education of best health practices are combined with assistance in accessing the care offered through NIHB, Members who typically avoid receiving such care, or observing such best practices, are more likely to do so. Implementation of this program involves either hiring new staff in the First Nation government's health department, or expanding the roles of current staff and re-training them. Qualifications for new staff roles include a knowledge of the NIHB program's internal processes, knowledge of the community's health needs, and experience with designing and carrying out informational and educational campaigns and regular community communications.

This program assists Members by helping them fulfill and submit requests and documentation to the FNHA's NIHB office. Such documentation includes reimbursement and predetermination requests, which are the most common documents NIHB clients must submit, and are two of the most challenging components of the program. Members are further assisted through providing information on which local health care providers, especially dentists, accept NIHB coverage. This includes compiling an up-to-date list of providers within the community's local vicinity that Members should visit, as well as helping Members schedule appointments with these providers. The program also helps Members determine whether they are eligible for certain procedures or products. The complexity and uncertainty that defines NIHB's requirements for dental procedures, prescription drugs, and medical supplies and equipment often intimidates Members into avoiding applying for them altogether. A First Nation government's staff would not be able to conclusively confirm to a Member whether or not the NIHB program would approve a given request before that request is submitted. An informed staff would, nevertheless, be able to confidently advise Members on whether approval should be sought. This requires that staff both gain specific information on the Member's health conditions, and be familiar with NIHB's procedures and approval prerequisites.

Health education can be improved through a public information campaign that focuses on informing citizens both of which benefits they are entitled to through NIHB, and which lifestyle choices would best improve their overall health. This component involves, for example, informing the community of changes to NIHB's drug formulary, providing information on what NIHB's transportation benefits cover, and suggesting ideas for healthy meals and fun ways to exercise. Promotion of preventative health care also involves an information campaign that advises citizens on which services they should seek in order to help prevent future health disorders. This includes promoting basic dental practices, such as regular exams and cleanings, especially for children. This program also involves informing citizens of other government programs that they may be eligible for, specifically the BC government's Health Kids program and PharmaCare program, and assisting them with enrolling in these programs. These programs offer secondary health benefits to individuals and families in need, such as low-income families, that resemble NIHB. First Nations governments should research

these options themselves and determine whether seeking assistance through these programs would be more beneficial to the community than NIHB.

6.3. Assessment of Alternatives

6.3.1. *Criteria and Measures*

This analysis considers the options in terms of the various types of communities that would implement them. Each community would, no doubt, design a more sophisticated program or policy than can be described here, and which would take into account the nuanced needs unique to the community. The options' effects should not be construed as effects on an individual level, nor on a provincial level, but rather a community level. Furthermore, the choice ultimately lies with a community to determine which parts of its population to concentrate on, and which specific health areas to target. This means that the analysis of policy options here must necessarily be generalized.

Short-Term Effectiveness

Perhaps the most pertinent criterion for First Nations communities is how effectively an option addresses health concerns in the short-term. A useful definition of "short-term" for this discussion would be the period of time before the FNHA's transitional stage ends, which could be anytime between 2015 and 2017. While the concept of entering the "transformational stage" may seem somewhat nebulous, it would be most prudent to consider the point in time at which the FNHA's buy-back agreement with Health Canada expires. It is currently unknown how gradually or abruptly the buy-back period will be phased out, but it can be assumed that the FNHA will begin making some preparations and changes to NIHB in anticipation of the end of the buy-back.

For the purposes of this discussion, the health concerns used in this evaluation will be limited to dental services (particularly preventative care and major procedures for children), pharmaceuticals, medical supplies and equipment (particularly those related to obesity, diabetes, and heart disease), and medical transportation. These health concerns have been identified through the literature review and the six interviews as the highest priority areas of NIHB coverage.

The 2006 Transformative Change Accord: First Nations Health Plan (TCA: FNHP) (BC Health, 2006a) provides seven indicators that the FNHC plans to use to evaluate the progress toward meeting the Health Plan's goals. Those indicators are: life expectancy at birth, mortality rates, infant mortality rates, youth suicide rates, diabetes rates, childhood obesity, and the number of practising, certified First Nations health care professionals. Of these, the indicators that are particularly relevant to evaluating NIHB and the overall access to secondary health services are diabetes rates and life expectancy at birth. Diabetes is a disease commonly treated with prescription drugs and medical supplies provided through NIHB. Life expectancy provides a general measure of healthiness for all age groups. As discussed in section 2.1.1, the gap in dental health would best be measured by data on decayed, missing, or filled teeth (DMFT), but can also be measured by the number of dental surgeries per 1,000 children. Appendix C provides four graphs which compare the rates of dental surgeries in children, life expectancies, and rates of diabetes between Aboriginal British Columbians and other BC residents. The datasets for the latter two measures also include predicted trends and the TCA's goal targets, for comparison.

While these statistics provide an ideal perspective from which to evaluate effectiveness, the options analyzed here are too hypothetical to apply these indicators as measures. For example, it is impossible to know how many dental surgeries a supplementary program would prevent. Instead, it should be considered how well each option provides community members with access to secondary health services equivalent to that typically received by other British Columbians. This means evaluating the options according to: whether more members access major dental procedures, such as crowns and bridges, when dentists recommend doing so; whether more members visit their dentist regularly (the Canadian Dental Association recommends every six months for most people²); whether more members are able to travel to a physician; whether more members receive prescription medications and medical supplies for chronic illnesses (like diabetes); and whether less members are diagnosed with preventable conditions, like obesity, diabetes, and heart disease.

² As stated on Canadian Dental Association's webpage, "Dental Care FAQs". Source: http://www.cda-adc.ca/en/oral_health/faqs_resources/faqs/dental_care_faqs.asp

Measures:

Low: the gains in community access to secondary care, or gains in health, over the next three to five years are either nonexistent or negligible when compared to the community's overall health as it exists currently.

Moderate: the gains in community access to secondary care, or gains in health, over the next three to five years are significant, but a substantial gap still exists between the health conditions of community members and the larger Canadian population.

High: the gains in community access to secondary care, or gains in health, over the next three to five years either erase the gap in health conditions between community members and the larger Canadian population, or reduce it to a negligible size.

Long-Term Effectiveness

The concept of long-term effectiveness remains the same as the short-term effectiveness criterion, but the time period being considered shifts to after the FNHA ends its buy-back period, and continues on for an unspecified number of years. While some options can effectively address a community's health concerns before the FNHA's transformational stage begins, others may require a significantly longer amount of time before its effects materialize.

Measures:

Low: the gains in community access to secondary care, or gains in health, after the buy-back period ends are either nonexistent or negligible when compared to the community's expected overall health at the point in time when the buy-back period ends.

Moderate: the gains in community access to secondary care, or gains in health, after the buy-back period ends are significant, but a substantial gap still exists between the health conditions of community members and the larger Canadian population.

High: the gains in community access to secondary care, or gains in health, after the buy-back period ends either erase the gap in health conditions between community members and the larger Canadian population, or reduce it to a negligible size.

Costs – Capital and Operational

The total cost of adopting a given policy or program typically consists of two categories of cost: capital and operational. Capital costs are the financial requirements for implementing and initiating a program or policy. Operational costs are the continuous or regular financial expenses necessary to maintain the program or policy over time, once it is implemented. For many policy options, accurate and comprehensive cost estimates cannot be constructed, and so reducing the question of cost down to a single dollar figure becomes impractical. It may be more useful to provide a range of probable cost figures, or discussing cost in qualitative terms, as the potential impact on the government's budget.

An important facet to consider when assessing options according to this criterion is the ease of implementation. This means that not only are financial expenses for material goods (supplies) and outsourced services (contract work, health expenditures) considered, but so too are less tangible costs, such as time costs. Time costs essentially consist of the incremental burden placed on government workers. This would ideally be measured by the additional number of hours of work required to accomplish the necessary implementation and operational tasks, as well as the competitive wage rates for the appropriate job positions. If new staff members are required, the further cost of hiring new staff must be taken into account as well.

Measures:

Method 1: Anticipated implementation and operational expenditures, in Canadian Dollars. Costs are also measured as dollars per person, or dollars per unit of time (months, years, etc.). Alternatively, expenditures are expressed as a range of dollar values.

Method 2:

Low³: Costs significantly impact the government's budget, requiring sizable reductions in other areas of government spending, sizable increases in revenue, or both.

Moderate: Costs have a moderate impact on the budget, requiring some spending reductions or revenue increases.

High: Costs have little to no impact on the budget, requiring only minor spending reductions or revenue increases.

Political Feasibility

Policies and programs can have political barriers that must be overcome before they can be adopted, aside from financial costs. First Nations in BC operate within a multitude of different governing frameworks. Some First Nations have finalized modern treaties with the Government of Canada and operate with self-determination. Others have had limited exposure to negotiating with the federal government and little experience with, or authority to, manage programs on their own. First Nations governments also could have to gain public approval within their communities before taking substantial action to adopt a new policy direction. Lastly, certain policies or programs may require a First Nation to negotiate or collaborate with other governments, including other First Nations and other levels of government. The ease of such collaboration may be simple or complex, depending on the attitudes and interests of the other governments involved.

The political feasibility of an option, then, depends on the amount of time and resources a First Nations government must commit to securing the approval, cooperation, or collaboration of other governments, or of its citizenry. Feasibility also involves an element of risk. It considers the presence of barriers or levels of resistance to a given policy direction from important stakeholders and political actors. In some instances, a successful negotiation outcome is not possible, if other actors are sufficiently unwilling to agree to compromises. These various components of feasibility

³ Note: a low value here means that cost has a negative impact on the option's evaluation. It does not mean that costs themselves are low.

can be consolidated into a single term: political activity. Within this analysis, political activity involves actions, such as stakeholder engagement, public consultation, and negotiation sessions with other governments, that must be completed in order to gain suitable approval from the public, from stakeholders, and from other political actors for the option to go forward.

Measures:

Low: The option requires substantial political activity before it can be adopted.

Moderate: The option requires moderate political activity before it can be adopted.

High: The option requires little to no political activity before it can be adopted.

6.3.2. Evaluations and Trade-Offs

NIHB Takeover

Short-Term Effectiveness

There is little possibility that the FNHA will devolve the control and management of the NIHB program to an individual community during the buy-back period. There are multiple reasons for this. The negotiation process itself would require a substantial amount of time. The FNHA has expressed its preference to remain the sole manager and deliverer of NIHB to BC First Nations. The FNHA will also devote its resources nearly exclusively to overseeing the administration of the buy-back arrangement, while at the same time developing its proficiency at delivering the program independent of Health Canada. This leaves few resources to be devoted to a new negotiation process, particularly one whose outcome the organization is averse to. For the purpose of comparison, Health Canada's process for completing NIHB pilot project transfer agreements was protracted. It involved initial discussions, the development of a clear mandate from the community, the preparation of a preliminary proposal, the assessment and approval of that proposal by a Joint Regional Review Committee, the preparation of a subsequent business plan, and the assessment and approval of that proposal (Health Canada, 2006a).

In addition to the length of time that would be required to organize and negotiate such an arrangement, there would no doubt be other time-intensive requirements once the arrangement is implemented and the program is transferred to a given community. The community would have to go through the same process the FNHA must go through to better understand the program and identify areas of improvement. This means there would likely be no tangible improvements to the way a community experiences NIHB once a transfer is completed for at least a few years, which is the amount of time the FNHA estimates it needs to be able to produce improvements. In effect, the community would be duplicating the FNHA's own efforts, and possibly even slowing down the FNHA's progress with improving the program province-wide. The short-term effectiveness of this option is therefore **low**.

Long-Term Effectiveness

Over a wider time range, a community would be able to generate a modest amount of improvements to the program. These improvements, however, would be limited by the community's necessarily small economy of scale. This aspect explains why, under Health Canada, only First Nations communities with large populations were selected for its NIHB transfer pilot projects (Health Canada, 2006a). The long-term effectiveness of this option, then, depends on the size of the community receiving the program. The possible improvements, however, would not be able to exceed the improvements that the FNHA could make province-wide, and would be further constrained by the inability to alter the actual policy framework and design, since the FNHA will likely reserve that ability for itself. This last point cannot be confirmed, as the FNHA has not stated what its approach to this would be, and there is a chance that the FNHA would want to distance itself from the confining approach taken by Health Canada by allowing more freedom to communities.

In its evaluation of the pilot projects (2006), Health Canada concludes that transfers result in improvements to administration, but that those improvements have not been shown to positively affect health status. It acknowledges that local governments provide certain services "faster and more reliably" (p. x) than does Health Canada. Neither the relatively short-term pilot projects nor the Nisga'a Nation, which has the longest-running NIHB transfer, have been able to demonstrate real changes in health

status. Despite this, communities participating in pilot projects state that the transfer has caused improvements in collaboration with health providers and in local empowerment that could more subtly improve health statuses. Based on these limitations, this option's long-term effectiveness would be **moderate**.

Costs

Such an arrangement, if agreed to by the FNHA, would include built-in funding contributions. This means that the community would not have to use any of its own revenue to fund its operations related to the program. The exception to this would be if the community had expenses related to the initial transfer and implementation of the program, such as staff training. The evaluation of NIHB pilot projects (Health Canada, 2006a) notes that Health Canada did not provide resources or funding for capital resources, such as computer software and office equipment. Furthermore, many project participants remark that funding for staff training was inadequate. The community could decide to contribute some of its own funds to the program, in addition to the FNHA's contributions, and doing so would have a positive impact on the effectiveness of the program. Such contributions would be completely voluntary, and would be at the discretion of the First Nations government. Given these circumstances, the cost criterion of this option is scored **high**, meaning that it has a positive impact on this option's evaluation.

Political Feasibility

Pursuing this option would be an enormous undertaking. If a community desires to negotiate an agreement with the FNHA, the FNHA would desire to engage in extensive dialogue and consultation before arriving at a decision. The FNHA would likely endeavor to convince the community to reconsider this option, as it visibly conflicts with their strategy and goals. More importantly, the mere act of suggesting that one's community would be better served by acting alone than by staying under the FNHA's management signals a lack of faith in the organization's capacity and implies a failure of its engagement process. This option undermines the FNHA's reputation and its perceived legitimacy among BC First Nations. Because of this, the FNHA would no doubt initially seek to rectify the community's grievances, rather than discuss the terms of the transfer. In the face of requests for negotiating a transfer, the FNHA's primary goal

would be to prevent the spread of such doubt to other communities. If the FNHA completed an agreement for such a transfer, it would be an admission of its own ineptitude. Logically, this means that such an option would only be politically feasible if the FNHA felt that it had no other choice.

Achieving a consensus among the community's population presents another challenge to this option's political feasibility. Given the serious nature of this option, there would likely be disagreement among the community's citizens on the need for taking such action. The considerable dedication the FNHA has made towards engaging with all BC First Nations communities and its commitment to achieving consensus provides reason to assume that a sizeable proportion of most communities hold a favorable view of the FNHA. A community's population would not come to a consensus on abandoning the FNHA's management unless there was already widespread agreement that the FNHA could not follow through with its promises of improvement. With this context, this option's political feasibility is **low**.

Supplementary Coverage

Short-Term Effectiveness

Designing and implementing a supplementary program would require a substantial amount of time. The exact time commitment would vary depending on the specific details of the program, as a program that attempts to develop a private group insurance plan would require a long period of discussion and negotiation with private insurance companies that a targeted coverage program would not need. Any incarnation of this option, however, would exhibit a high level of complexity and organization, since the government would regularly interact with (again, depending on the specific design) a host of fee-for-service health professionals, internally-employed health professionals, and private insurance companies. Such a program would require an array of decisions to be made, which partially include: what coverage is offered, whether personal maximums and other limitations will be applied, which Members will be eligible, how eligibility will be verified, and whether a dedicated fund will be established. In addition to the complexities involved in designing such a program, the question of how the community will pay for the program further adds to the length of the design process. Since the program would have a significant impact on the government's budget, a long period of time would be

necessary before an adequate source of funding could be secured. The level of detail that must be decided upon before such a program could even become operational means that this option would **not be effective** in the short term.

Long-Term Effectiveness

Once a supplementary program is designed and implemented, the potential to significantly improve the community's health is considerable. This is due to the freedom and flexibility afforded to the government to direct the program at its particular priorities. A longer timeframe allows the government to achieve the health benefits that may accumulate more slowly, and also provides the opportunity to reflect on the program's successfulness post-implementation. Assuming that the government succeeds in identifying the most suitable program design, and in acquiring the necessary funding, the resulting program would make the largest possible strides toward elevating the community's health to the same level as the rest of British Columbia. Each of the four health professionals interviewed confirm that, while the NIHB program appears to offer coverage that is on par with private plans, the actual delivery of the program reduces the actual coverage provided to a much less adequate level. A supplementary program resolves this by circumventing the NIHB program entirely for high priority benefits. The long-term effectiveness of this option is therefore **high**.

Costs

A supplementary program would be expensive, both in terms of implementation costs and operational costs. It is already clear that such a program would require a large time commitment in order to be implemented, and this time commitment involves a corresponding funding commitment. Specifically, implementation requires staff to be paid for the additional work they do to design the program and negotiate with health professionals and insurance companies. Other implementation costs might include staff training, construction (or renovation) and furnishing of health facilities, additional communications with citizens to inform them of the new program, and the establishment of an initial dedicated fund with which to operate the program from.

Operational costs would include additional salaries and wages for staff, the maintenance of new facilities, ongoing communication with citizens, and, perhaps most

significantly, expenses directly related to the new health coverage. Importantly, there is little chance that a First Nations community would receive contributions from either the federal government, the Provincial government, or the FNHA to fund this program. These governments have already committed to supporting the NIHB program under the FNHA, and so unless responsibility over NIHB is devolved to a community (as with the first option), a community would have difficulty justifying its need for contributions to fund its program. In light of these considerations, this option's cost score is **low**, meaning that it has a negative impact on the option's overall evaluation.

The most appropriate way to look at exact costs for an option that involves purchasing private insurance is to look at the cost per person, presented as a range of possible coverage levels. Insurance companies adapt plans primarily by adjusting premiums to reflect the riskiness of the individual and the quality of the coverage. Appendix D provides a description of the private insurance plans that were examined in order to gain the following conclusions. Depending on how a group plan is negotiated, it can be expected that **50%** to **100%** of basic dental costs would be covered up to an annual maximum between **\$500** and **\$1,500**, per beneficiary. Major dental costs would likely be covered at **50%**, up to an annual maximum between **\$500** and **\$1,000**. Orthodontic expenses, if included, would be covered at **50%**, up to a lifetime maximum of around **\$2,000**.

Individual plans would probably offer less coverage collectively for the same price as a group plan. For example, it would likely cover between **60%** and **80%** of basic dental costs, up to an annual maximum of between **\$500** and **\$750**. Major dental costs would be covered at **50%**, up to a maximum of around **\$500**. Such a plan may or may not cover orthodontics, but this component would likely be the same as with a group plan. As mentioned earlier, some communities may not have the option of developing a group plan with an insurer, and so the cost of private insurance (in the form of purchasing multiple individual plans) would be higher than it otherwise would be with a group plan.

While it is difficult to predict what premiums an insurance company would set, it is reasonable to assume, based on the premium levels described in Appendix D, that they would range between **\$50** and **\$150** each month, per person. For individual plans,

premiums would partially be determined by age. For group plans, premiums would be influenced by the number of participants, as premiums typically decrease as the insurance pool increases.

The costs of a self-insured program can be estimated based on the numbers provided above for private insurance. For example, basic dental would cost **\$1,000** per person each year, considering that many private insurance plans cover basic dental at 50%, up to a maximum of \$500. This assumes that such a program does not require copayments. Alternatively, if the program does not require premiums, the cost of the program would be, at most, between **\$50** and **\$150** per person, per month. It would likely be less than that, since private companies build some component of profit into the premiums, above overhead costs.

The cost of a more targeted plan cannot be as accurately estimated, but it may be useful to consider the wages and salaries for health professionals, if a First Nations government is to hire any. The annual salary of a dentist in BC is between **\$31,735** and **\$172,213** (BC JTI, 2012a). The annual salary of a pharmacist in BC is between **\$43,770** and **\$111,234** (BC JTI, 2012b). The most frequent hourly wage for a registered nurse is **\$36.59** (BC Stats, 2013). The costs of constructing, renovating, and/or furnishing a health facility are too variable to provide useful dollar estimates for, but First Nations government should be aware that such a project would no doubt consume a large portion of their budget. The table below consolidates the cost figures discussed above. These costs will increase or decrease as the government adjusts its desired coverage level. Further costs should be anticipated above those explicitly outlined in this table, such as renovation and furnishing costs, and staff hiring costs.

Summary of Supplementary Program Costs

Private Insurance	\$50-150 per person per month, based on demographics
Self-Insured Plan	\$50-150 per person per month
Targeted Plan	Dentist: \$31,735-172,213, annually Pharmacist: \$43,770-111,234, annually Registered Nurse: \$36.59 per hour

Political Feasibility

As stated earlier, designing and implementing a supplementary program requires negotiating with insurance companies and/or health professionals. This means that the government must devote some of its time and energy into confirming that it has the necessary partners to bring the program into reality. As such a program will, ostensibly, also benefit partners, it would be reasonable to assume that the government would not have difficulty identifying willing partners. The difficulty resides in consolidating the needs of all parties involved so that the terms of the agreement are indeed agreeable. As with the first option, an important component of the program's design involves gaining consensus within the community. Concerned members of the community will desire to be engaged in the decision-making process, and will want to ensure that their priorities are being met. Because of this, the option should be considered politically feasible, but only **moderately** so, since it requires some effort to gain the approval of all participants, including the community's citizens themselves.

Assistance, Education, and Promotion

Short-Term Effectiveness

Two of the four health professionals interviewed, as well as the FNHC Chair, suggest that providing support directly to Members can greatly improve experiences with NIHB, as well as overall health. Similarities exist between this option and the transfer option, since both attempt to overcome NIHB administrative obstacles. This leads to some scepticism that an assistance program would have substantive positive impacts on health statuses, since the NIHB transfer pilot projects were not able to show such

impacts resulting from administrative improvements. A review of studies on the effectiveness of worksite wellness programs (Chan, 2012), which are similar (but not identical) to this proposed program, concludes that most studies have found positive outcomes resulting from these types of programs. However, this review states that the empirical evidence is mixed in support of these positive outcomes, specifically for impacts on health-related behaviors, substance use, physiologic markers, and healthcare cost (Chan, 2012). The mixed nature of the evidence is largely a result of poor methods of evaluation applied to these programs.

This program would not directly provide additional health coverage to citizens; rather, it does so indirectly by reducing the obstacles associated with using NIHB, as well as with using other government programs, such as Healthy Kids BC and BC PharmaCare. The maximum extent that community health could increase by is limited to the maximum coverage that can be gained through NIHB, plus the coverage from other government programs, as well as the incremental increase in care accessed through private means as a result of the educational and promotional components of this program. A program which provides NIHB assistance, as well as health education and promotion, can be implemented relatively quickly. Compared with the previous two options, this option does not require substantial negotiation or complex design. Implementation consists of training staff to be fluent in the NIHB's processes, developing informational material that will be most effective within the community, and designing appropriate communication channels, as necessary. Given these considerations, this program would not have as high an effectiveness as a supplementary program, but would still be **moderately** effective.

Long-Term Effectiveness

Once this program is implemented, it can continue its assistance, education, and promotion activities for an extended period of time. The assistance component will continue to be effective until the FNHA remedies all obstacles that currently deter citizens from receiving care. It also provides a mechanism to respond to new obstacles that may arise, which increases this program's effectiveness in the long term. While there may be a point at which the educational and promotional components reach a maximum level of saturation and marginal effectiveness thus declines, the cumulative

effects are durable. The increased level of community health as a result of education and promotion will be maintained in the long term (WELCOA, 2007). This option's long-term effectiveness, then, is **moderate**.

Costs

Since this program can be adapted to suit the unique characteristics of a community, it would not be useful to estimate the costs of specific activities. Of more value would be the average costs of programs of this type, in terms of costs per person. A study that examines employer-based wellness programs states that, of the programs it investigated, the average cost per employee per year was **\$144**, while producing **\$358** in savings per person per year (Baicker, Cutler, & Song, 2010). It has also been estimated that, for every dollar spent on wellness promotion, employers saw a reduction in health care expenses by two to four dollars (Loeppke et al., 2009). Additionally, Dr. Ron Goetzel recommends that employers spend between **\$200** and **\$500** per employee per year (WELCOA, 2012). While there are obvious differences between a program targeted toward a company's employees and a program targeted toward a First Nations community, the basic underlying principles regarding wellness promotion stay the same.

Regarding the costs of providing assistance to citizens when interacting with the NIHB program, the most significant expense would be the additional wages provided to staff to acquire the necessary knowledge and spend the additional time assisting citizens. The most frequent hourly wage in BC for positions in the category "other assisting occupations in support of health services" (excluding registered nurses, nurse aides, orderlies and patient service associates) is **\$22.24** (BC Stats, 2013). Individual First Nations governments must determine for themselves how many additional hours of staff time would be necessary to serve their community. Given the cost estimates provided above, the score for the cost of this program is **high**, meaning that cost is low and thus has a positive impact on this option's evaluation.

Political Feasibility

An assistance, education, and promotion program would not require extensive collaboration with an outside party. A First Nations government may choose to briefly consult with a company experienced in designing such programs, but this would not

require any political negotiation. The government, as with the previous two options, would have to gain approval from its citizens before implementing this program. Since this program does not have severe impacts on the government's other functions or on its relations with other levels of government or other First Nations, there would be little controversy or concern from citizens. In light of these observations, the political feasibility of this program is **high**.

Summary of Analysis Results

<i>Options</i>	<i>Criteria</i>			
	Short-Term Effectiveness	Long-Term Effectiveness	Costs	Political Feasibility
Program Acquisition	Low	Moderate	High	Low
Supplementary Coverage Program	Low	High	Low	Moderate
Education, Promotion, and Assistance Program	Moderate	Moderate	High	High

6.4. Recommendation

Based on the results of this analysis, it is recommended that most First Nations communities and band governments consider implementing the third option. An assistance, education, and promotion program allows a community to realize noticeable

improvements in the health of its citizens relatively quickly, and at low financial and political cost. This is not to say that a First Nations community should disregard the option of a supplementary program altogether. A supplementary program could be considered by communities who desire health improvements far above what can be done by improvements to the NIHB program, or by the third option. Communities should be cautioned, however, to only seriously pursue this option if they have the available revenue and necessary experience to organize such a program. Furthermore, communities should only pursue this option after the FNHA's buy-back period has ended, and the organization has made clear which changes it will make to the NIHB program. The first option, acquiring control of the program from the FNHA, should only be considered as a last resort solution, in the event that the FNHA has demonstrated an inability to make satisfactory improvements to the program.

The third option is recommended above the first two in part due to its suitability for a wide range of communities. Even small communities with little experience managing programs transferred from Health Canada can successfully implement this option, although it might be more beneficial for them to collaborate with neighboring communities. Most importantly, this option does not commit a community to a course of action that responds poorly to future developments surrounding NIHB. This research demonstrates that the FNHA, at this point in time, is the organization best suited to make improvements to the NIHB program in the long term. While it is still too early to predict what the exact improvements will be, there is no evidence to suggest that the FNHA cannot or will not make improvements which could or would be made by any other First Nations government or organization in BC. Because of this, First Nations communities interested in improving their citizens' access to secondary health services in the short term would be best served by an assistance, education, and promotion program.

6.5. Unresolved Issues

Arguably the most significant issue that needs to be resolved concerning the NIHB program is its duality as both an insurance-like program that supplements individuals who already have private insurance, and a needs-based program that provides coverage to those who have no other coverage sources. For the 2010/2011

Fiscal Year (FY), Health Canada spent almost \$139 million on NIHB in BC (Health Canada, 2011b). This means that the additional \$11 million provided as a result of the FNHA's negotiations increases the NIHB budget by roughly 7.9%. As seen in Figure 5, the percentage change in NIHB spending in BC between FY 1992/1993 and FY 2010/2011 was, on average, 5%, which means that the 5.5% annual increase in spending provided to the FNHA for NIHB will stay roughly on par with the previous decade's spending increases. Based on these facts, it is logical to assume that the more comprehensive the change that the FNHA pursues with NIHB, the more bold a distinction it has to draw around which of its two roles it focuses on. This may lead to questions such as whether the FNHA should create two distinct programs, whether it should implement premiums into the NIHB program, and whether it should adopt an income test or needs assessment component to the program. Implementing premiums would reform the program into a fundamentally insurance-based service. It would allow the program to be internally sustainable, from a financial viewpoint, and allow it to expand its coverage, but would also exclude the poorest citizens from participating. Adopting an income test or needs assessment would exclude citizens who are not most in-need, but would allow the program to expand coverage for citizens who are eligible.

The effect that improved administration has on utilization rates for the NIHB program also deserves serious attention. If the program sees a significant increase in claims under the FNHA, the limited funding provided to the FNHA may be strained. Lastly, the socio-economic factors that contribute to poor health among First Nations populations remain an important concern for both First Nations leaders and higher levels of government. Factors such as unemployment, underemployment, hazardous working conditions, low high school graduation rates, poor housing, and food insecurity are well-known contributors to low health statuses (BC PHO, 2007). These are just some of the issues which should be critically examined in the future. Such policy discussions require an abundance of information about the NIHB program and secondary health services in BC, and this research aimed to lay the initial groundwork for the accrual of this information. Hopefully this research can serve to assist First Nations leaders in making decisions for their communities, and to provide other researchers with a foundation on which to continue building.

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Appendices

Appendix A.

Table 1. Arnstein's Ladder of Citizen Participation

8	Citizen Control	Citizen Power
7	Delegated Power	
6	Partnership	
5	Placation	Tokenism
4	Consultation	
3	Informing	
2	Therapy	Non-Participation
1	Manipulation	
Source: Arnstein, 1969		

Table 2. Fung's Measures of Participation

Participant Selection Method	Mode of Communication and Decision	Extent of Authority and Power
Expert administrators	Listen as spectator	Personal benefits
Elected representatives	Express preferences	Communicative influence
Professional stakeholders	Develop preferences	Advise and consult
Lay stakeholders	Aggregate and bargain	Co-governance
Random selection	Deliberate and negotiate	Direct authority
Open, targeted recruiting	Deploy technique and expertise	
Open, self-selection		
Diffuse public sphere		

Appendix B.

Table 3. Questions for Health Professionals
1. Which NIHB benefits do you perceive to be most commonly used by members of your community?
2. Which categories of people are most likely to seek benefits (children, young adults, elderly, men, women, low-income, etc.)?
3. How does the program compare to private insurance and other public health programs? Coverage categories? Billing practices? Pre-approval processes?
4. Some dental professionals choose to not participate in the program or to bill the program, and instead ask patients to pay directly for services, and then seek reimbursement from the program themselves. What qualities of the NIHB program would need to be improved for providers to be willing to participate in it?
5. Do you have any suggestions for how the program could be improved, generally?

Table 4. Questions for FNHC Chair
1. What are the top-priority improvements that you hope to see made to the program, both long and short term?
2. What is the vision of First Nations health that a transformed First Nations Health Benefits program would strive for? In other words, what are the overall health outcomes or end results that a transformed NIHB program would aim to achieve? (Children's health, Elder health, dental, chronic illnesses, etc.) How much of this vision has come from community feedback?
3. Will the BC Government have a larger or more involved role in assisting with the delivery of NIHB under the FNHA?
4. What opportunities do you see for collaboration between various First Nations in BC to improve Members' health services related to NIHB, such as developing economies of scale, coordinating programs, etc.?
5. How much interest exists currently among First Nations in BC to develop an arrangement similar to the Nisga'a Nation's NIHB management?
6. Given the extensive amount of engagement that has already been achieved by the FNHC, what kind of engagement do you anticipate will occur specifically around the transformation of NIHB into a First Nations Health Benefits program?
7. What is the current timeline of NIHB's future under the FNHA? How long will the buy-back period last? (2015- 2017?)
8. What improvements to NIHB, in terms of administration and delivery, does the FNHA expect it will make over the course of the buy-back period?

Table 4. Questions for FNHC Chair

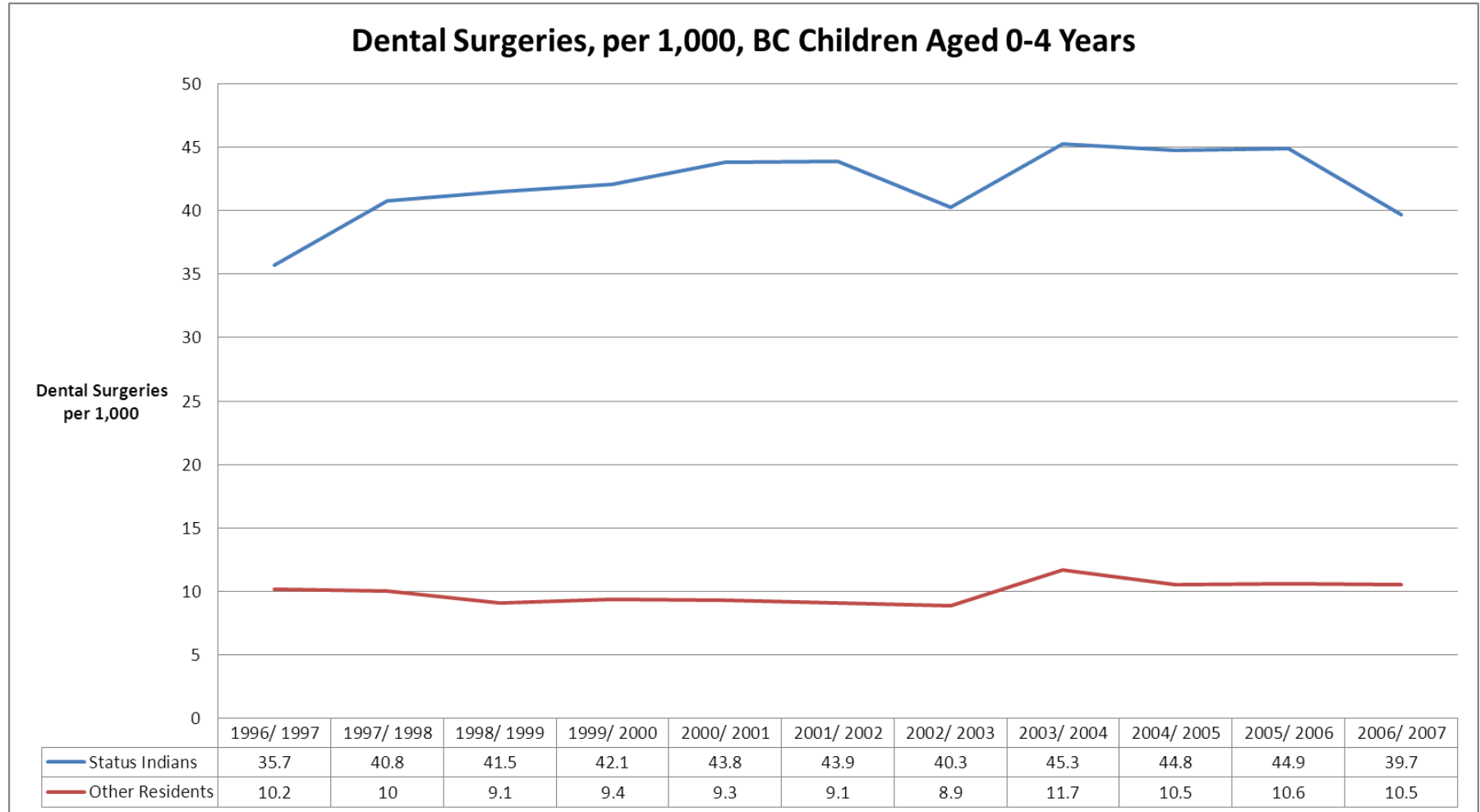
- | |
|---|
| 9. What does the funding aspect of the NIHB transfer look like? How might the current agreement, including any escalators for population growth and/or rise in health costs, affect the amount of funding available, per capita, in the coming years, for spending on NIHB? |
| 10. What improvements to NIHB can the FNHA make, either during the buy-back period or after, that could increase the quality or quantity of health services received by BC First Nations (specifically, regarding dental provider enrollment with Express Scripts Canada, and the pre-determination process for major dental procedures)? |
| 11. What things can be done at a local level by individual First Nations communities to help improve the experience that Members have while interacting with and using the program? |

Table 5. Questions for FNHC on Engagement

- | |
|---|
| 1. At this point, what predictions can be made about the makeup of the participants in the NIHB transformation engagement process (once that process begins)? <ol style="list-style-type: none">How many people would wish to participate?What roles or positions will be most represented (chiefs, health directors, lay persons, etc.)?How informed will participants be of the NIHB program and its inner workings prior to engagement? How much learning “on-the-job” will be required of participants over the course of engagement? |
| 2. Are any particular regions or communities interested in engaging on NIHB specifically, compared to others? |
| 3. Do you predict or anticipate any contentious issues or competing interests surrounding NIHB that could arise during engagement on NIHB? |

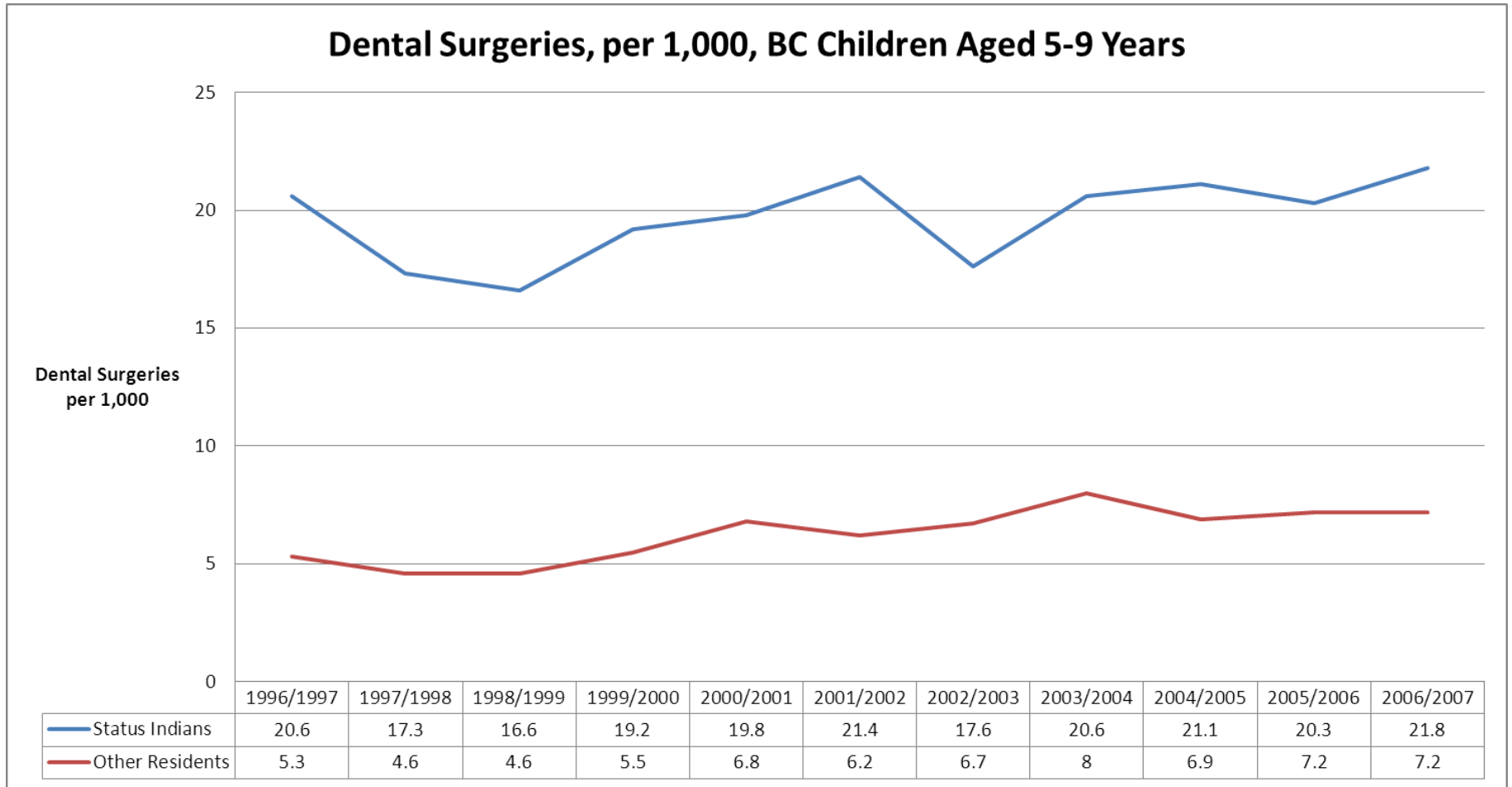
Appendix C.

Figure 1. Dental Surgeries, per 1,000, BC Children Aged 0-4 Years



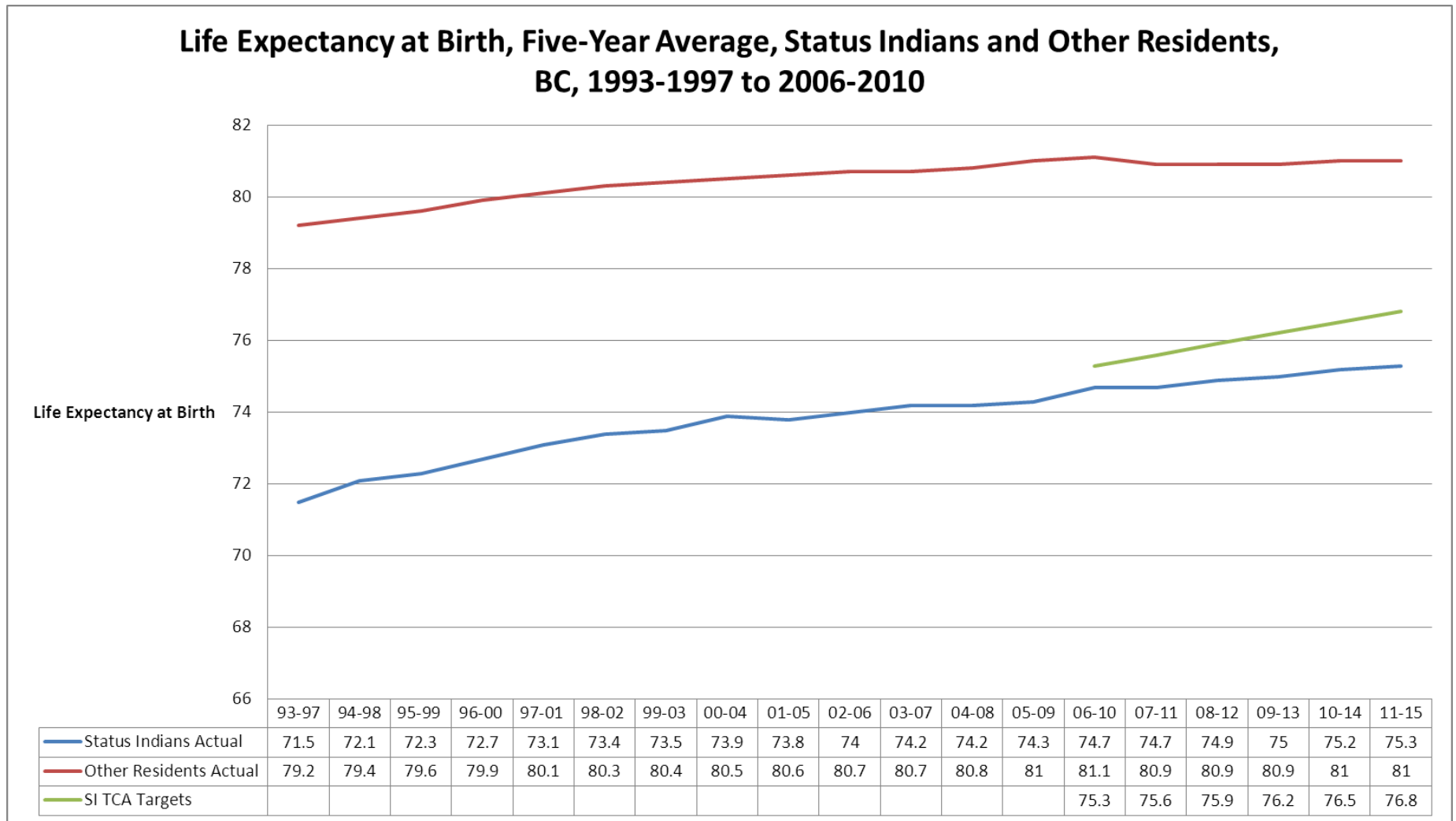
Source: BC PHO, 2007

Figure 2. Dental Surgeries, per 1,000, BC Children Aged 5-9 Years



Source: BC PHO, 2007

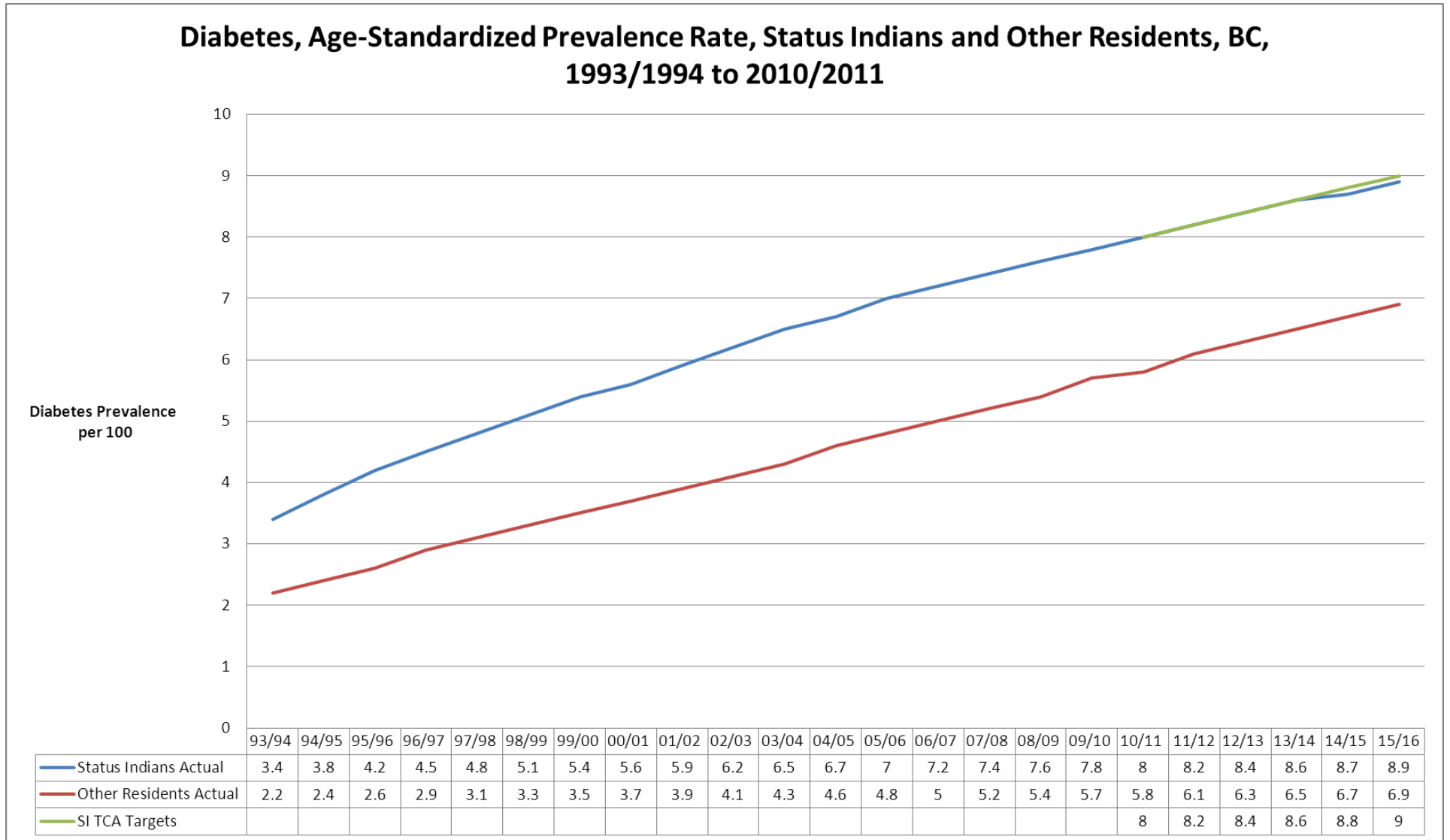
Figure 3. Life Expectancy at Birth, Five-Year Average, Status Indians and Other Residents, BC, 1993-1997 to 2006-2010



NOTE: Projected figures after 10/11

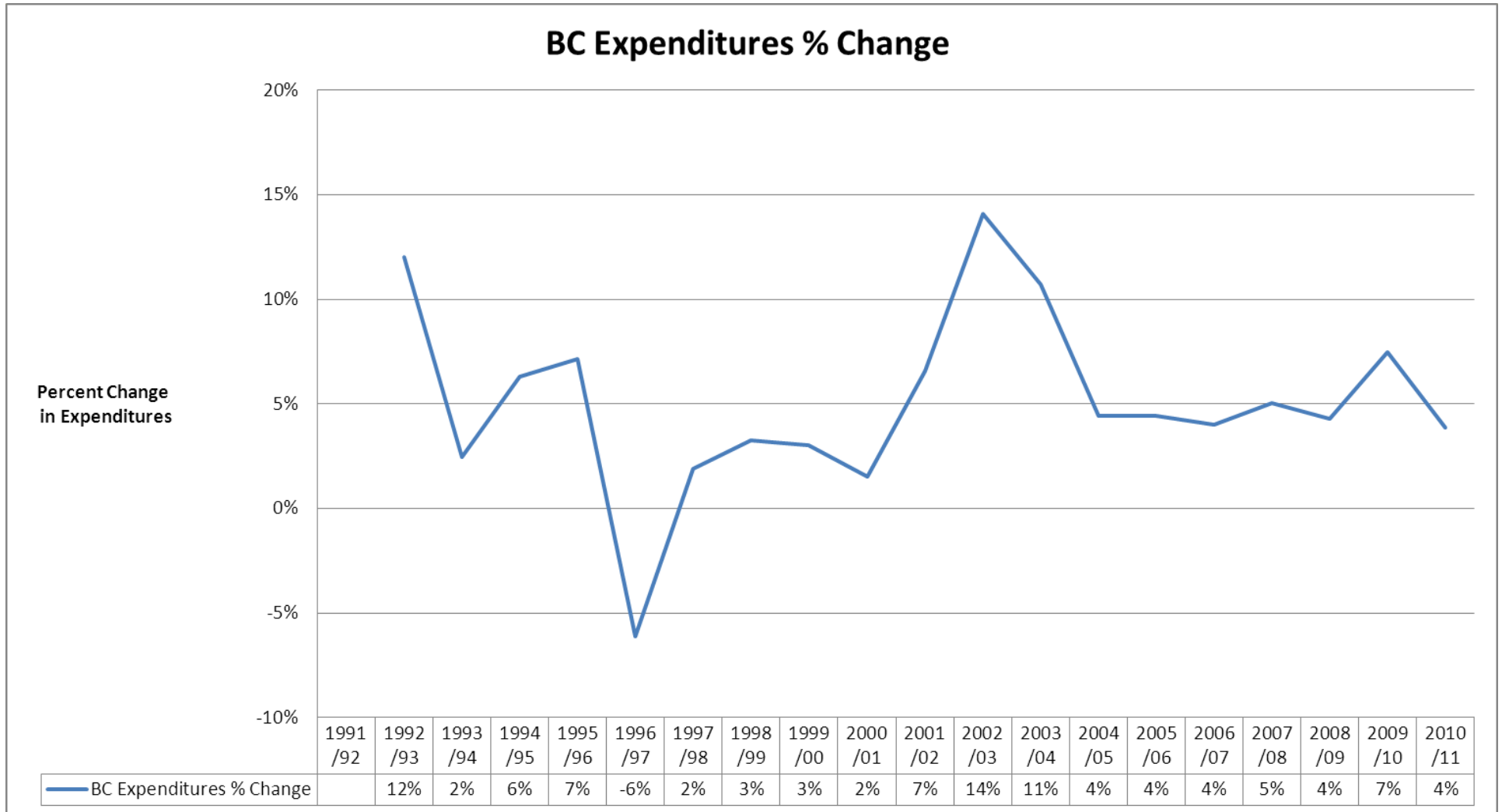
Source: BC PHO, 2012

Figure 4. Diabetes, Age-Standardized Prevalence Rate, Status Indians and Other Residents, BC, 1993/1994 to 2010/2011



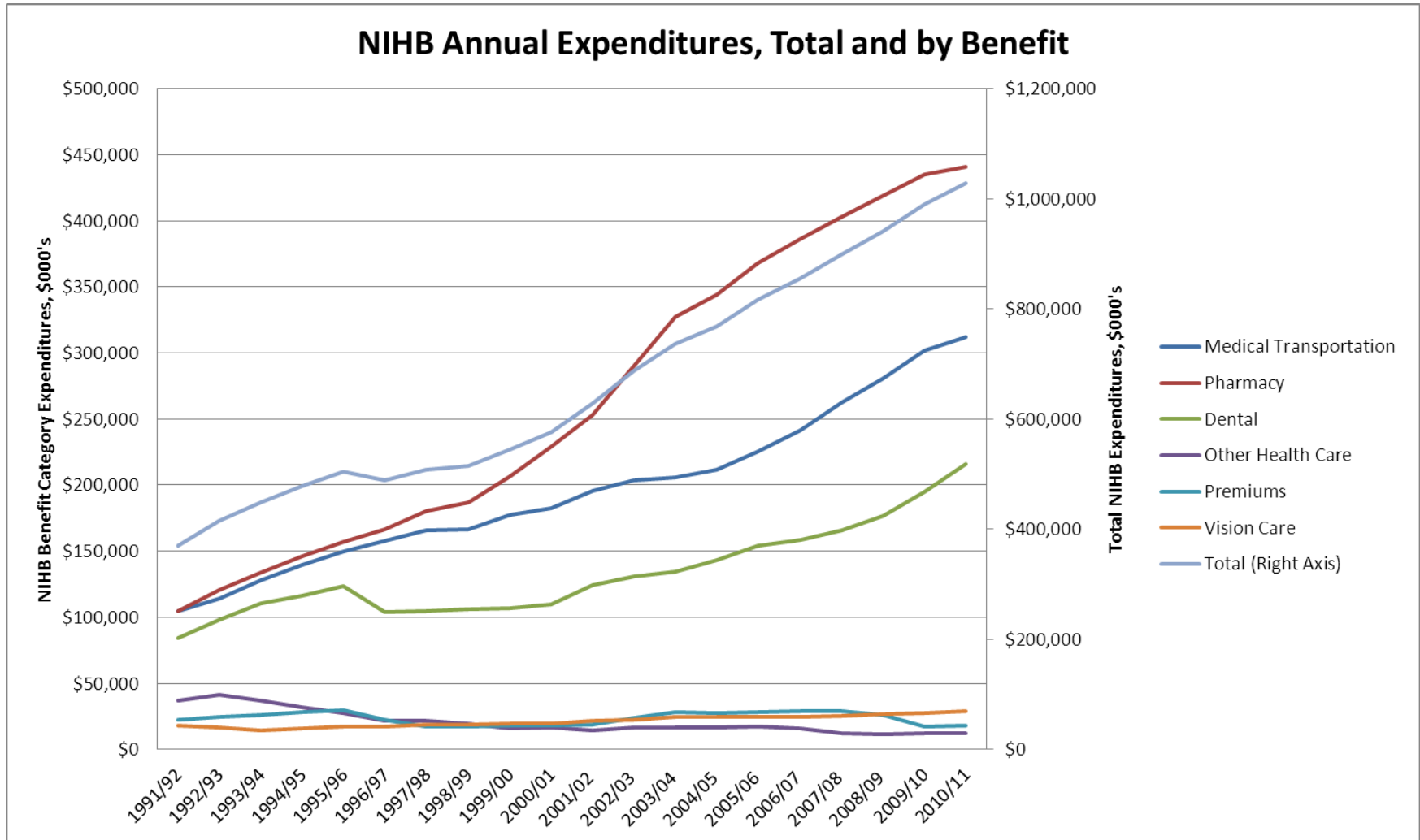
NOTE: Projected figures after 10/11
Source: BC PHO, 2012

Figure 5. Percent Change in Annual NIHB Expenditures, BC



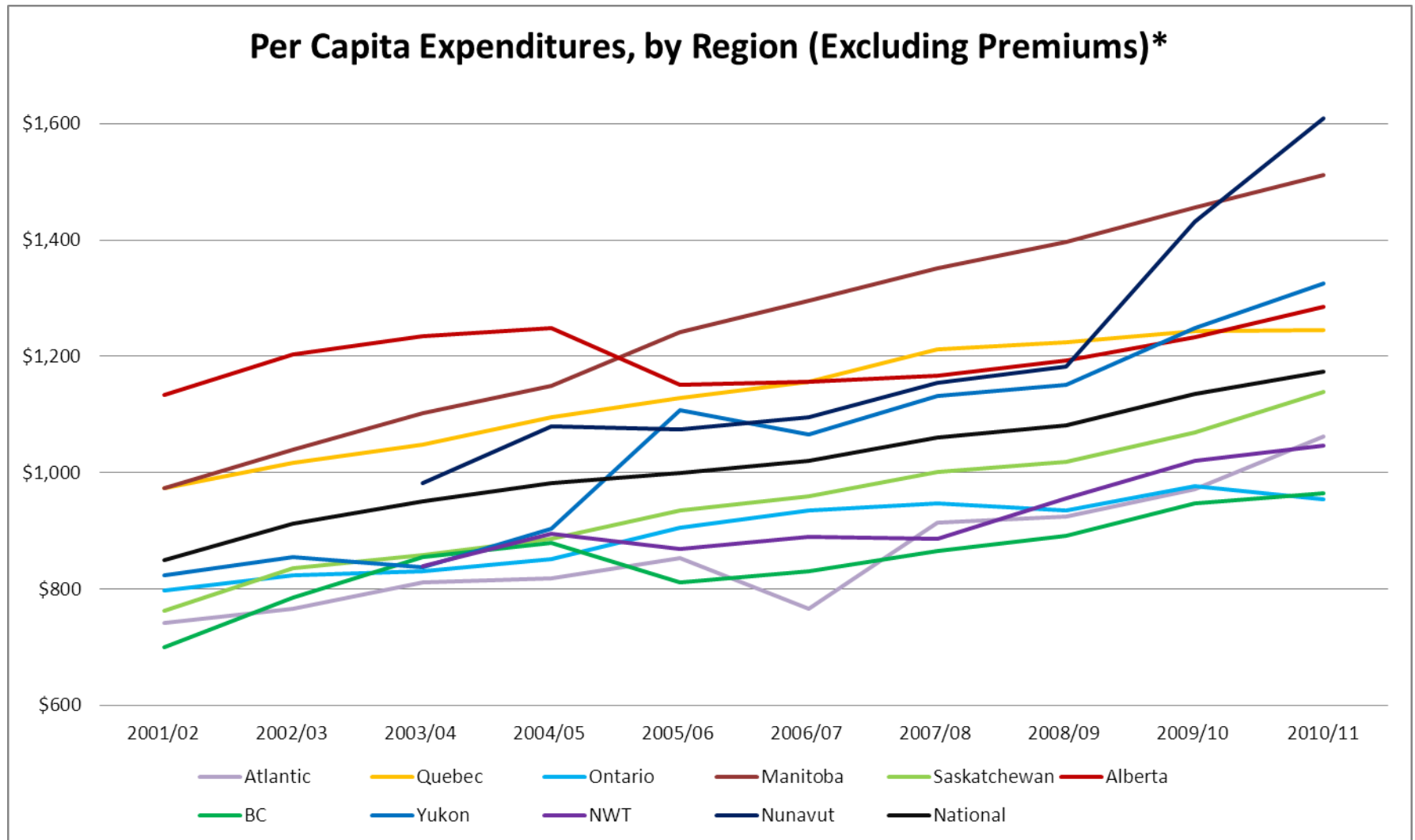
Sources: Health Canada, 2003, 2004, 2005, 2006b, 2007, 2008, 2009b, 2010b, 2011b.

Figure 6. NIHB Annual Expenditures



Sources: Health Canada, 2003, 2004, 2005, 2006b, 2007, 2008, 2009b, 2010b, 2011b.

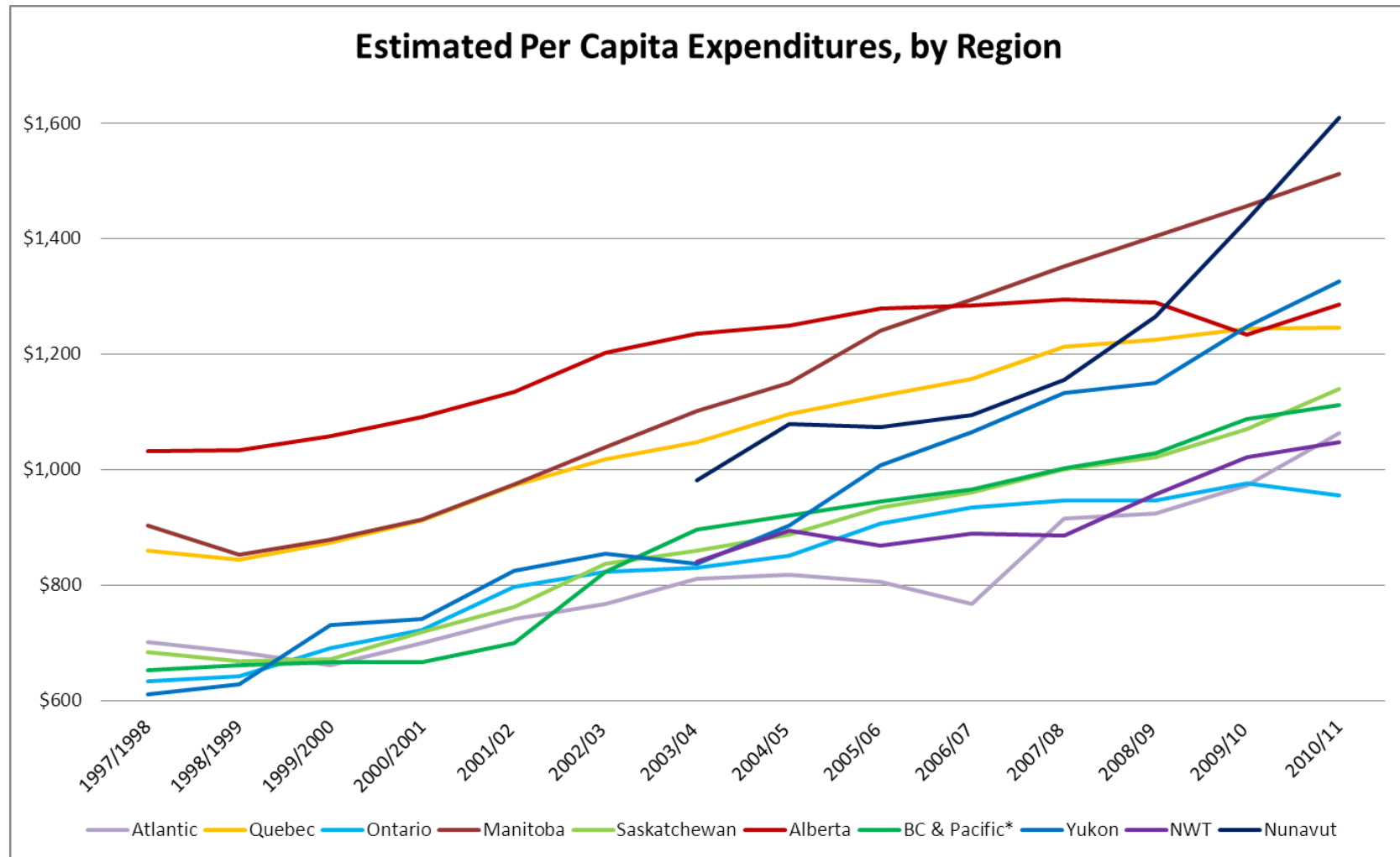
Figure 7. Per Capita Expenditures (from Health Canada)



* As published by Health Canada. Medicare premiums have been removed from this dataset, since not all regions provide coverage for them.

Sources: Health Canada, 2003, 2004, 2005, 2006b, 2007, 2008, 2009b, 2010b, 2011b.

Figure 8. Estimated Per Capita Expenditures



* The Pacific region was replaced in 2003 by the British Columbia region. All data used for this graph were estimated using data released by Health Canada on the number of eligible clients, and total expenditures by region.

Sources: Health Canada, 2003, 2004, 2005, 2006b, 2007, 2008, 2009b, 2010b, 2011b.

Appendix D.

Information on private secondary insurance plans has been gathered from three separate insurers: Great-West Life Assurance Company, Pacific Blue Cross, and Sun Life Financial. Each of these companies offers a range of insurance products and services, none of which exactly coincide with the coverage offered by the NIHB program. In light of this, the various options from each company are described below. Both the level of coverage and the estimated premiums are provided. It is important to note that the options below are for individual plans, not group plans. The premiums for group plans are generally not decided until the insurer has evaluated the health and demographic qualities of the group.

Pacific Blue Cross offers its basic plan, Primary Blue¹, with premiums that range from \$47.00 to \$112.00, depending on the age of the individual. This plan covers 80% of eligible expenses, up to a maximum of \$500 each year for pharmaceuticals, and \$400 each year for dental. This plan does not cover major dental. Pacific Blue Cross also offers a more flexible design called Blue Choice². For a single 18-year-old, premiums would be \$62 each month, and the plan would cover 50% of costs up to \$500 each year, including major dental procedures.

Sun Life offers personal health insurance through several plans³. The basic plan has premiums of \$57.66 for individuals under 30. This provides 60% coverage for pharmaceuticals and preventative dental, with yearly maximums of \$750 and \$500, respectively. The enhanced option reimburses at 80%, and also provides 50% major dental coverage with a \$500 yearly maximum. The monthly premiums for the enhanced option would be \$132.22 for individuals under 30.

1 Source: Pacific Blue Cross. Primary Blue. Retrieved from <http://www.pac.bluecross.ca/Corp/individual/primaryblue.aspx>

2 Source: Pacific Blue Cross. Blue Choice. Retrieved from <http://www.pac.bluecross.ca/Corp/individual/bluechoice.aspx>

3 Source: Sun Life Financial. Personal health insurance. Retrieved from http://www.sunlife.ca/Canada/sunlifeCA/Health/Personal+health+insurance?vgnLocale=en_CA

Great-West Life offers its *Sonata* individual health plan at five different scales⁴. This plan is eligible for individuals 60 and younger. Scales 1, 2, and 3 are most relevant when comparing to NIHB. The table summarizes the characteristics of each scale.

Summary of Sonata Plan Designs

Scale	Premiums	Pharmaceutical Benefits	Dental
1	<ul style="list-style-type: none"> • \$53.87 to \$70.08 	<ul style="list-style-type: none"> • 70% for both generic and brand name prescriptions • \$750 max. per person each calendar year • \$5 max. dispensing fee per prescription • No Hearing Aids 	<ul style="list-style-type: none"> • 70% for selected routine services • \$350 max. per person each calendar year • No major dental
2	<ul style="list-style-type: none"> • \$77.75 to \$108.90 	<ul style="list-style-type: none"> • 75% for both generic and brand name prescriptions • \$10,000 max. per person each calendar year • \$5 max. dispensing fee per prescription • Hearing Aids: 100% to a max. of \$400 per person every 5 years 	<ul style="list-style-type: none"> • 50% for endodontic, periodontal and oral surgery services • 75% for other covered routine services • \$500 max. per person each calendar year • No major dental
3	<ul style="list-style-type: none"> • \$117.46 to \$178.55 	<ul style="list-style-type: none"> • 90% for both generic and brand name prescriptions • \$10,000 max. per person each calendar year • \$7 max. dispensing fee per prescription • Hearing Aids: 100% to a max. of \$500 per person every 5 years 	<ul style="list-style-type: none"> • 60% for endodontic, periodontal and oral surgery services • 80% for other covered routine services • \$750 max. per person each calendar year • Major dental: 50%, \$500 max. per person each calendar year

⁴ Source: Great-West Life. (2013). Plan Designs. Retrieved from http://www.greatwestlife.com/001/Home/Individual_Products/Insurance/Health___Dental_Insurance/For_Individuals___Families_-_Sonata_Health/Plan_Designs/index.htm