JOHNSON SHOYAMA GRADUATE SCHOOL OF PUBLIC POLICY

FIRST NATIONS AND THE HEALTH SERVICE DIVIDE BEYOND MEDICARE

Provincial and Federal Coverage for the Diagnosis and Treatment of Sleep Apnea

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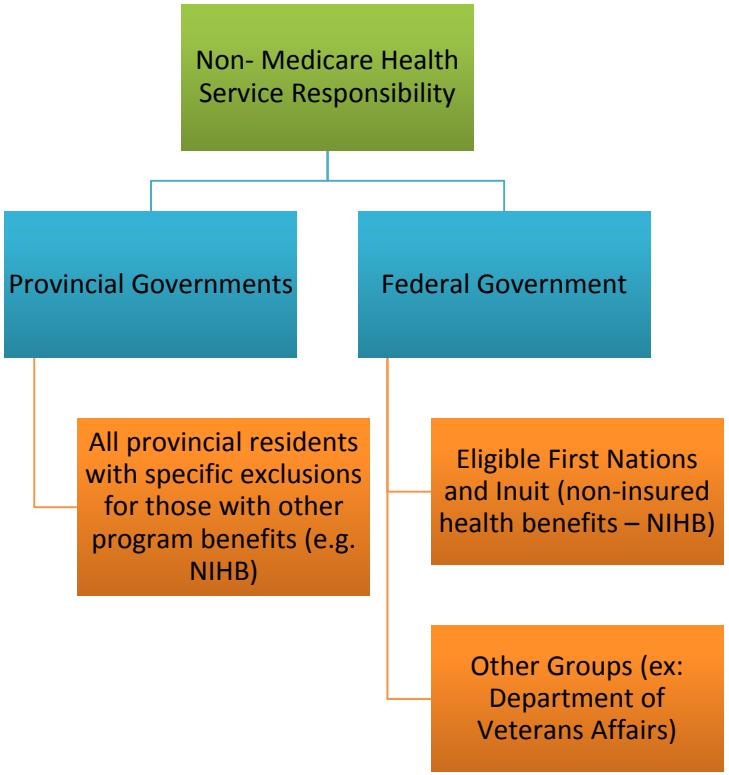
WHAT HAS POLICY TO DO WITH SERVICE DELIVERY?

- Service delivery access, diagnostic protocols and treatment options shaped by policy regime
- In Canada, we have a health services divide for constitutional and historic reasons
- This occurs at two levels
  1. Medicare ("insured services" under Canada Health Act)
     - Applies equally to all residents, including all Aboriginal residents of provinces and territories
  2. Non-Medicare services
     - Does not apply equally to all residents
     - Federal government is responsible for funding, administrating and delivering (depending on self-government agreements) non=Medicare services for "eligible" First Nation and Inuit
     - Provincial governments responsible for all other residents
     - Creates two systems of benefits with accompanying service implications
     - Sleep Apnea as case study of these differences

The Double World of Jane Doe

BACKGROUND: HEALTH SERVICE STRUCTURE FOR NON-MEDICARE SERVICES



Saskatchewan Medical Care Insurance Act (1978)

Section 15

"**uninsured services** for the purposes of this Act...

(d) services received by a beneficiary pursuant to an Act of the Parliament of Canada;

Saskatchewan Medical Care Insurance Beneficiary and Administration Regulations (1988):

Section 10:
"the following services are **uninsured services...**
(d) services that a person is eligible to receive from, or for which he is entitled to be reimbursed by:
(ii) ***the Government of Canada****;*

RATIONALE

- Where did these policies come from?
  - Distinction between Medicare and non-Medicare
  - Inclusion of all Aboriginal residents as provincial residents during federal-provincial negotiations, 1955-57 (universal hospital coverage)
  - Provincial programs for non-Medicare services beginning in 1970s
  - Introduction of NIHB by federal government in latter half of 1970
  - Federal policy (1979) stated that NIHB benefits would rely upon "professional medical and dental judgment"
- What is the underlying basis for these policies? Current relevance?
- What views are held about these parallel programs?
  - By federal and provincial program and policy administrators?
  - By providers?
  - By patients and their families?

RESEARCH DESIGN

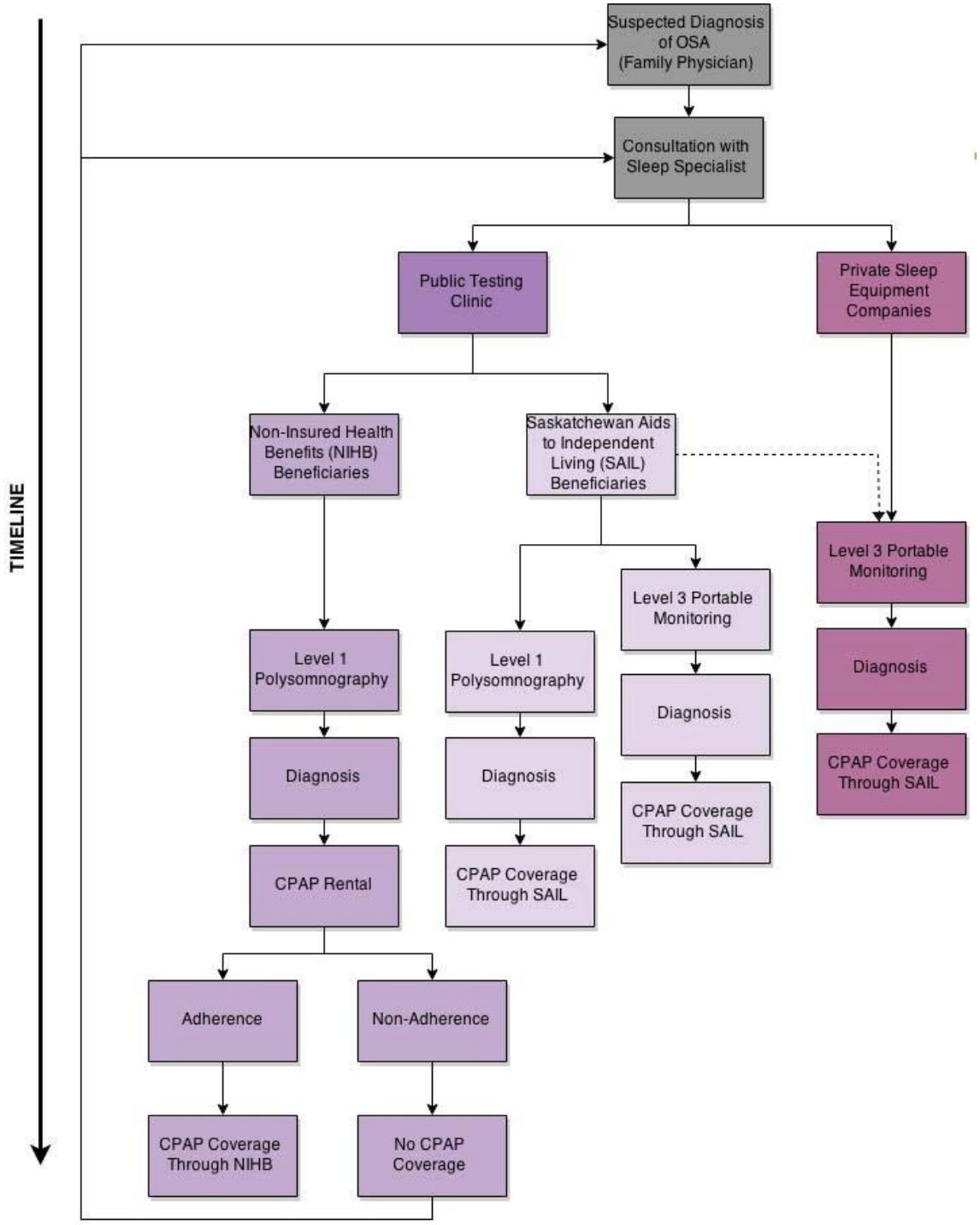
- Literature review
- Interviews on three main levels:
  - Providers,
  - Governments (federal and provincial)
  - Patients and Indigenous community members*
- Snowball recruitment style
- Semi-structured in nature, paralleled approach
- Trust-building as central consideration
- Options for withdrawal

IMPACT OF HEALTH SERVICES DIVIDE:

CASE STUDY OF SLEEP APNEA

- Both programs ultimately cover the gold-standard treatment for sleep apnea (CPAP machine).
- However, pathway for Registered Indian patients can result in a significantly longer timeline to access CPAP coverage.

- Key differences:
  - Level 1 (gold standard) test required for all Registered Indian patients despite long wait-times and greater availability of lower level testing in the province.
  - Proof of adherence required prior to full CPAP coverage for Registered Indian patients



PROVIDER INTERVIEWS

SLEEP MEDICINE SPECIALISTS PRACTICING IN SASKATCHEWAN

Provider key issue #1: *procedural differences are a barrier to care for NIHB eligible patients*

"I know they won't get funded for a CPAP machine if I send them for Level 3 testing, regardless who's providing it, right? So I actually preferentially send people with a Treaty [registration] number for Level 1 polysomnography because I know that it's going to be an administrative mess for them to try and get a CPAP machine if I don't do that. It's just a way of facilitating care for them"

Sleep Medicine Specialist

PROVIDER INTERVIEWS

SLEEP MEDICINE SPECIALISTS PRACTICING IN SASKATCHEWAN

Provider key issue #2: *modifications to existing coverage requirements to create better access for Registered Indian patients*

- Given existing wait-times and the high public cost of Level 1 testing, Level 3 testing is a reasonable alternative that could improve timeliness of care.
- While there is good reason to require proof of adherence, patient adherence to guidelines could be better supported through means other than the threat of refusing treatment.
- Policy solutions proposed: single-pipe delivery with payment responsibility determined behind-the-scenes.

INTERVIEWS WITH GOVERNMENT OFFICIALS

Administrator key issue #1: *"primary covering agency" vs. "payer of last resort"*

"[Regarding a specific benefit] the [provincial] program might say 'well we do provide this but because they're [Status] First Nations, we think you should be providing this through NIHB' and NIHB will say 'But it's excluded. This piece of equipment we don't even provide' ... So the clients end up getting stuck in the middle of that, right, so sometimes it's not so much based on benefits, it's based on Status"

Federal Program Administrator

INTERVIEWS WITH GOVERNMENT OFFICIALS

Administrator key issue #2: *lack of comprehensive knowledge of program gaps, coupled with limited collaboration on these issues*

- Aware of some gaps and differences in coverage, but no comprehensive knowledge thereof.
- Benefits of collaboration recognized by both provincial and federal policymakers however has occurred in certain areas to a greater extent than others (often re-active rather than pro-active).
- Few policy solutions offered, perhaps due to perceived complexity of federal-provincial relations on Indigenous health policy.

BIG PICTURE POLICY SPECULATION ON HOW TO ADDRESS

- Option 1: Comprehensive re-alignment of NIHB services to match provincial program
  - Complex task given variability of provincial programs and available benefits
- Option 2: Utilize provincial infrastructure with federal government as payer for eligible NIHB clients
  - Possible disparities between provinces can create inequities among NIHB clients
- Option 3: Formal classification respiratory health as core Medicare service
  - Provincial governments absorb First Nations populations into existing system
  - High cost, little incentive for provinces – more off-loading of federal responsibility
  - Favorable for federal government
  - Does not deal with other non-Medicare conditions where similar issues exist

LIMITATIONS AND NEXT STEPS IN RESEARCH

- To our knowledge, this study is the first of kind on extended health benefits
  - examining differential coverage as medical determinant of health and health inequities
- However, it remains a small window into the world of extended health benefits and the resulting health service divide for “status Indians” and “recognized Inuit”
- For this reason, this research can serve only as an initial, hypothesis generating study for which further research will need to be undertaken
  - First Nation patients
  - Other extended health benefit services and programs
  - Other provinces and territories

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