Government Response to the 5th Report of the Standing Committee on Health
"First Nations and Inuit Dental Health"
November 2003

## INTRODUCTION

The Government of Canada is pleased to have this opportunity to respond to the fifth Report of the Standing Committee on Health, *First Nations and Inuit Dental Health,* which was tabled in the House of Commons on June 18, 2003. The report, which focuses on the need for increased preventive measures to curtail the negative effects of poor oral health among First Nations and Inuit in Canada and client consent issues from the Non-Insured Health Benefits (NIHB) Program, reflects the testimony from witnesses and the work of committee members. It also demonstrates a commitment from Members of Parliament and the important role that Parliament can play in addressing the needs of First Nations and Inuit across the country.

The government values the work of the standing committee. In particular, the contribution of the report in highlighting many important issues affecting First Nations and Inuit oral health and the identification of potential areas for improvement. Interested stakeholders had the opportunity to voice their perspectives and concerns and their contribution is important to our ongoing efforts to improve client access and health outcomes. Overall, the report is timely and makes a valuable contribution to the national dialogue on how to address the gap in life chances and health status between Aboriginal and non-Aboriginal Canadians.

The challenges facing First Nations and Inuit oral health are documented in the report with references to other contributing factors, including: support for increased food access in remote areas; building capacity among dental health providers; and, greater access to clean potable water with optimal fluoride levels. The government shares the concerns of the standing committee and agrees that improving health among First Nations and Inuit, including their oral health, is important and essential to building strong, healthy First Nations and Inuit communities. The Government of Canada is committed to building strong partnerships with First Nations and Inuit and dental care providers to improve the health system, and to ensure the availability of, and access to, health services for First Nations and Inuit.

The information presented in the report complements, and supports, the current government approach in moving beyond pathology and treatment and placing an increased focus on health promotion and disease prevention activities. The approach is consistent with the *Population Health Approach* which recognizes the health status of a population is a reflection not only of their health but of other factors, including economic, social and physical environments and personal health practices. The report's contents are also consistent with government commitments, particularly recent investments during the formative years of an individual's life, announced in the Speeches from the Throne in January 2001 and September 2002.

The Speeches from the Throne confirmed the government's commitment to close the gap in health status between Aboriginal and non-Aboriginal Canadians and strengthen the delivery of health care services to First Nations and Inuit by championing community-based health promotion and disease prevention programs. This includes investments in: a targeted immunization strategy for First

Nations children; an increase in early childhood development initiatives with an expansion of Aboriginal Head Start (AHS); and, tools to address fetal alcohol syndrome/fetal alcohol effects (FAS/FAE) in Aboriginal communities.

Earlier this year, the government committed $1.3 billion over five years in funding to address program sustainability issues within the First Nations and Inuit health system. This will include funds to address increasing program costs due to cost drivers such as: population increases; rate of disease burden; increased benefit utilization; and, professional fee increases. Complementary initiatives such as the National Health Human Resources Initiative, and the Food Mail Program also contribute to improving the professional capacity and environment which supports and facilitates oral health promotion and disease prevention.

Delivering health care is a shared responsibility between the federal government, the provinces and territories, and First Nations and Inuit. The provinces and territories are responsible for: universal hospital and physician services to all residents, including Aboriginal people; public health and community programs for all residents living off-reserve; supplementary insurance for key populations; long term, nursing homes and community care; and, the regulation of health services and professions. Health Canada operates a major health care delivery system for an estimated 735,000 eligible First Nations and Inuit. This includes: public health and community health programs on all reserves; primary care in remote and isolated communities; some targeted programs for all Aboriginal people; and, health benefits through the NIHB Program to all status Indians and recognized Inuit regardless of residency. Through effective collaboration, service gaps and redundancies will be eliminated which will lead to the provision of higher quality services, including oral health.

## RESPONSE TO THE RECOMMENDATIONS

The report on *First Nations and Inuit Dental Health* makes five overarching recommendations with respect to increasing emphasis on oral health promotion and disease prevention, accessing comprehensive care, accessing dental care providers, collaborating with First Nations and Inuit, and client consent issues under the NIHB Program. Other issues raised as sub-recommendations include: improving public education and awareness; building linkages with complementary initiatives; streamlining NIHB Program administration for dental care providers; and, increasing program effectiveness and accountability.

The government is pleased to have the opportunity to describe its current initiatives aimed at improving the oral health of First Nations and Inuit. Collectively, they represent a multi-faceted approach that combines treatment and restoration with prevention through the NIHB dental program with a steady, increasing emphasis on oral health promotion and disease prevention activities for First Nations and Inuit. This increased focus would initially target children under the age of 7, pregnant women and primary caregivers, to ensure that oral health habits are encouraged during the early years. The Government of Canada is committed to improving the oral health status of First Nations and Inuit based on evidence and working in collaboration with First Nations and Inuit communities to develop effective and culturally appropriate approaches to oral health. Over the long term, the objective is that these efforts will lead to improved oral health among First Nations and

Inuit and a reduction in the overall level of oral disease.

**<u>Recommendation 1: Effective and Accountable Oral Health Strategy</u>**

The committee recommends that Health Canada undertake a new approach to oral health based on a wellness model that gives priority to health prevention and promotion. It also suggests that Health Canada should develop and implement an oral health strategy with measurable goals and results-based incentives to increase positive outcomes through greater monitoring of oral health trends generally, and program performance specifically.

***Oral Health Promotion and Disease Prevention Strategies***

The NIHB Program was designed to supplement other federal, provincial and territorial or third party insurance programs. The benefits include: drugs; medical supplies and equipment; vision care; medical transportation; crisis intervention and short-term mental health counselling; health care premiums; and, dental care. The focus is placed on supplementary coverage that has not already been reimbursed through private coverage or provincial and territorial coverage. NIHB Program benefits are paid on balances after claims have been submitted and reimbursed through other mechanisms. In 2002/03, Health Canada spent $688 million on NIHB Program benefits, including $131 million on dental benefits. An additional $9 million was spent on oral health promotion and disease prevention activities like the National School of Dental Therapy and the First Nations and Inuit Health Careers Program.

Within the NIHB dental program, a broad range of restoration and treatments combined with promotion and prevention activities are provided to First Nations and Inuit clients. Restorative services include root canals, crowns, fillings, and dentures. Diagnostic services include examinations and x-rays. Preventive services include scaling, polishing, dental sealants, and oral hygiene instruction. Of the 735,000 First Nations and Inuit eligible for NIHB dental services, an estimated 36% of the population accessed direct fee-for-service dental care through the program. Additional First Nations and Inuit clients also accessed services through contract dentists, dental therapists and dental hygienists supported by Health Canada through contribution agreements directly with Band Councils and community health facilities.

Health Canada programming has worked to provide equitable access to oral health for First Nations and Inuit clients both on- and off-reserve. It has contributed to closing the oral health gap between First Nations and Inuit relative to other Canadians living in similar circumstances. This includes preventing oral diseases, detecting and managing illnesses, and maintaining and improving their overall oral health. These services have been developed and maintained in consultation with First Nations and Inuit communities and they are specifically designed to address their unique health needs.

Health Canada and its partners have recognized the long-term benefits that result from increased efforts in health promotion and disease prevention. Health Canada has supported a number of regional oral disease prevention and health promotion demonstration pilot projects. The objective of these pilot projects was to test different delivery methods and capacity building concepts in First Nations and Inuit community settings in the Atlantic Region and the provinces of Ontario, Quebec,

Manitoba, Saskatchewan, and Alberta. Some of the key concepts learned or confirmed include: the importance of early access to prenatal women and caregivers of children to influence awareness and the importance of oral health; mechanisms for how to effectively share information on oral hygiene and infectious disease and decay; and, the value of home visits in delivering preventive programs.

Based on the data gathered through these pilot projects and other available information, Health Canada is moving towards an increased focus on oral health promotion and disease prevention activities, with young children as a key target group. This approach would represent a more integrated and coordinated approach to children's oral health and would promote synergies and optimize efforts in areas leading to the greatest impact.

This approach would target four key groups (pregnant women and primary care givers; children 0-5 years of age; 6 year olds; 7 year olds) with combined efforts in health promotion, disease prevention, comprehensive care and restoration measures, specific to their needs. This would also include: oral hygiene instruction; cleanings; sealants; fluoride varnishes; diet counselling and regular follow-ups; and, routine restorative care for children. By putting the focus on children, the goal is that they would receive the best start in life, therefore enabling them to protect and maintain their teeth over a lifetime. Educating parents and primary caregivers would allow them to not only protect and maintain their own teeth, but also support their children in developing oral health skills and behaviour.

Key elements of this approach are already underway under Health Canada's dental therapy program. Currently, proactive prevention services, including classroom/prenatal/well-baby clinics, oral health education/promotion presentations, dental sealants and oral hygiene instruction, the delivery of topical fluoride applications, as well as diet counselling and using xylitol as a sweetener substitute, have been actively underway and delivered by Health Canada in several First Nations and Inuit communities.

Efforts are also being made to integrate oral health information and practices with children's community-based programs. Some community-based projects in the Canada Prenatal Nutrition Program (CPNP) are currently focussing on oral health education by promoting healthy choices to bottle feeding and teaching pregnant women and primary caregivers how to prevent baby bottle tooth decay. Health Canada's First Nations and Inuit Tobacco Control Strategy has developed educational materials on the impact on oral health from smoking and the use of smokeless tobacco. Additional efforts will be made to integrate and enhance complementary components with increased oral health promotion and disease prevention to include: dental screenings; referral services; brushing programs; fluoride treatments; prevention education; and, oral hygiene instruction.

***Monitoring Oral Health Trends***

The NIHB Program collects data as part of an overall management reporting approach which includes information on program expenditures, First Nations and Inuit clients, and benefit utilization across the six benefit categories. Reports are prepared on an annual basis and extracted from databases that are populated by the Governments of the Northwest Territories and Nunavut, and Inuit organizations like the Inuvialuit Regional Corporation, the Nunavut Tunngavik Incorporated, the Labrador Inuit Association, and the Makivik Corporation in Quebec. Health Canada systems

provide information on expenditures and client utilization.

In 1990 and 1996, Health Canada conducted two children's oral health status surveys on First Nations and Inuit children ages 6 and 12. While it is recognized that more work is required to gather information on the overall health and well-being of First Nations and Inuit, it is expected that there will be opportunities to enhance the monitoring of oral health trends over time. As oral health linkages are developed with complementary programs, this would result in related data collection as part of the programs' ongoing performance measurement and monitoring. By increasing oral health promotion and disease prevention activities within these programs, this will enable the Government of Canada to gather more information on First Nations and Inuit health status, including oral health, and thereby contribute to filling the data gaps in this area.

***Results-Based Approaches***

The government is committed to gathering evidence to determine the effectiveness, efficiency and relevancy of its programs and services. The NIHB dental program, the NSDT, the First Nations and Inuit Health Careers Program and other Health Canada programs collect data on program performance in order to measure the reach, utilization and impact of their activities. This includes data from administrative records such as productivity reports on the number of First Nations and Inuit graduates and participants and the total number of oral health services provided, including clients serviced and value of services. Health Canada also gathers data on: oral disease indicator rates by age; participation rates in community-based oral health programs; participation rates in community-based dental clinics, both salaried and contract provided; and, the number of dental therapy positions.

While the NIHB dental program's data collection efforts are primarily based on the demand for services and benefits within the eligible client population as set out in its mandate, the program also collects data to support treatment being sought for pain relief and which clients are using which services. Data collected within the context of these initiatives contribute to a larger goal of building the evidence base on First Nations and Inuit health generally, and oral health specifically.

In addition, many of these programs have already begun developing results-based approaches with measurable goals and benchmarks of success consistent with *Results for Canadians*, the management framework for the Government of Canada. Established in June 2000, this approach requires that all existing and new programs seeking funds create a Results-Based Management and Accountability Framework (RMAF) outlining key goals, objectives, performance measures, and strategies for data collection, analysis, evaluation, reporting on results, and for making the necessary course corrections.

Key goals for Health Canada's dental programs include: a reduction and eventual elimination of extensive dental treatment needs among First Nations and Inuit; an increased number of First Nations and Inuit oral health care professionals; an increased number of community-based oral health promotion initiatives; an increased number of oral health/education resources appropriate to First Nations and Inuit communities; and, more improved access to dental care services at the community level.

The NIHB Program also has accountability and control measures in place to verify billing costs and

other expenditures, and to ensure the appropriate use of the program by clients and providers. The predetermination process establishes a system of prior approval and the submission of a client treatment plan for performing dental services above a prescribed dollar threshold. Since its introduction in 1997, the predetermination process has resulted in substantial savings by re-focussing oral health services on the needs of the client.

A second mechanism is the *Provider Audit Program* which aims to: detect billing irregularities; validate active licensure; ensure the required signatures of claim submissions are valid; ensure that services paid for were received by clients; and, ensure that providers have retained the appropriate documents for each claim. This program has been in existence since the early 1990s. To date it has successfully identified over $8 million for savings and/or recovery within the dental, pharmacy, and medical supplies and equipment benefit areas. Currently, the NIHB Program is in the process of attempting to recover portions of this amount through legal channels or other proceedings.

In some circumstances, cases are identified by the NIHB Program which warrant the attention of the Dental Regulatory Authority within the provincial/territorial jurisdiction. These cases might include concerns identified through: patient complaints, the *Provider Audit Program*, billing irregularities identified by the claims processor, or quality of care issues identified through the predetermination process. When such circumstances arise, the NIHB Program has, in the past, referred concerns about the provider to the respective provincial dental regulatory authority for action as the College deems appropriate.

With these measures in place, the NIHB Program has been able to ensure the appropriate use of funds and thereby direct them towards servicing First Nations and Inuit clients.

## Recommendation 2: Collaboration with First Nations and Inuit Clients

The committee recommends that Health Canada work with First Nations and Inuit to improve public education and communications on the availability of restorative and preventive services for children and adults and to raise awareness on how oral health is linked to overall health and well-being. It suggests working with community-based programs such as Aboriginal Head Start (AHS) and the Canada Prenatal Nutrition Program (CPNP) to build linkages and communicate consistent oral health messaging to First Nations and Inuit clients.

### *Building Oral Health Linkages*

The Government of Canada agrees with the standing committee that there are opportunities to incorporate more oral health promotion and disease prevention activities within current health programs. Further opportunities exist for coordinating these programs horizontally such that community providers could promote and deliver oral health messages. By drawing on the capacity and infrastructure of successful community-based programs, there are opportunities to target children directly in addition to their primary caregivers. Building operational efficiencies between programs, Health Canada will work to significantly improve First Nations and Inuit dental health at stages when they are most receptive to new ideas and knowledge, ultimately affecting health practices and choices.

For example through CPNP, First Nations and Inuit pregnant women facing conditions of risk either on- or off-reserve that threaten their health and the development of their babies are provided information and support. The goal of this community based program is to improve maternal and infant nutritional health by educating pregnant women on components of a healthy diet and helping them access healthy foods through activities such as food vouchers, collective kitchens and community gardens. Collectively, these activities positively impact on oral health. Fruit, vegetables, dairy products and other calcium containing foods combined with traditional Aboriginal foods are promoted in the CPNP as are healthy infant feeding practices which includes the prevention of baby bottle tooth decay. Numerous CPNP projects have already made oral health an overall priority by: partnering with dental therapists; developing reference materials and resources; promoting healthy alternatives to bottle feeding; and, educating caregivers on the prevention of baby bottle tooth decay. The CPNP will continue to be a key component of an integrated approach to oral health promotion for First Nations and Inuit.

Similarly, AHS is an early intervention program that addresses the needs of Aboriginal children living on- and off-reserve, up to six years of age. The objective is to support ECD strategies that are designed and controlled by Aboriginal communities by supporting parents and caregivers as the primary teachers of their children. The AHS Program does not currently include activities which focus on oral health. Nevertheless, Health Canada will build on the program, on a limited basis, to incorporate oral health education, workshops, and consistent oral health messaging, into the health promotion component of the program.

Within the parameters of the National Tobacco Control Program, Health Canada has developed some educational materials that communicate to First Nations and Inuit on the health effects of tobacco usage, including smoking and use of smokeless tobacco, on oral health. Health Canada also manages the First Nations and Inuit Tobacco Control Strategy, a sub-component of the national program, which aims to reduce smoking rates among First Nations and Inuit and develop education and awareness resources to support the prevention of uptake and the appropriate use of tobacco by First Nations and Inuit. Health Canada will build oral health linkages between the two program components in order to support each other's public education activities.

In 1999, Health Canada launched the Aboriginal Diabetes Initiative (ADI) which is aimed at decreasing the incidence of diabetes and its complications among First Nations and Inuit by developing and using holistic, culturally appropriate approaches to health promotion, diabetes prevention, diabetes care and treatment. It has previously worked with the dental health program to develop a fact sheet for distribution among First Nations and Inuit on oral health and disease prevention and its impact on individuals with diabetes. Both programs will continue working together to convey consistent oral health messages through the health promotion components of their programs.

Other linkages include Health Canada's support to the Food Mail Program managed by Indian and Northern Affairs Canada (INAC) which provides funding to Canada Post to subsidize the cost of transportation of nutritious foods to isolated, northern communities, most of which have a predominantly Aboriginal population. This mail transportation subsidy makes a healthy diet more affordable. A healthy diet rich in fruit, vegetables, dairy and other calcium containing foods and combined with traditional Aboriginal foods is critical to oral health. Transporting essential non-

food personal care items including toothpaste, tooth brushes and dental floss are also subsidized. Health Canada, through the First Nations and Inuit Health Branch, also provides advice and guidance to the program and will continue to ensure that priority dental health items are available through the program.

The *Care for a Smile Program* is a successful preventive program delivered by Health Canada's dental therapists in First Nations communities in Alberta. Since 1999, screening exams, fluoride varnish treatments, dental sealants, medicinal fillings, and oral health promotion and education have been provided to infants, preschool, and school-age children through grade six. Early data results have indicated that 23% of participating grade six children had no decay in their teeth. Of greater significance is the fact that in certain locations, 95% of children in the grade three cohort had experienced no decay in their permanent teeth. This program is an example of a successful community-based program delivered by dental therapists and partnered with Health Canada nurses, AHS, CPNP, teachers and community workers.

***Monitoring and Reporting on Oral Health Initiatives***

Within the purview of these activities, the Government of Canada will continue to work with First Nations and Inuit communities to effectively monitor and report on oral health initiatives. It will build on existing surveillance and research activities, including performance measurement strategies to evaluate their success and effectiveness. It will also utilize existing financial and human resources, such as clinical nurse specialists and community-based health providers, in order to coordinate community-directed and results-based incentives for preventive oral health. It will support First Nations and Inuit communities in implementing communal water fluoridation in communities where the appropriate management and safety supports are in place.

***Public Education and Awareness***

The Government of Canada recognizes the dual importance of providing oral health services as well as communicating their availability to First Nations and Inuit clients. The NIHB Program has a variety of communications mechanisms in place such as brochures, pamphlets and other printed materials and community information sessions, all provided in various Aboriginal dialects and languages. The government will work within existing programs to ensure that information and public awareness regarding access and availability to dental health services through the NIHB Program and other related community-based programs continue to support an improved oral health status among First Nations and Inuit. More importantly, efforts to communicate the availability of preventive measures to all eligible First Nations and Inuit clients through the NIHB Program will be reinforced.

**Recommendation 3: Improved Access to Comprehensive Dental Care**

The committee recommends that Health Canada facilitate increased access to oral health care for First Nations and Inuit by creating a prevention plan for individuals under 25 years old involving regular cleanings, fluoride, sealants, instruction, and education sessions. It suggests a number of structural changes to the administration of the NIHB dental program, including increasing the predetermination threshold from $800 to $1000 annually per client, facilitating a more independent

role for dental hygienists, and adhering to similar standards and frequency limitations as established by other dental insurance plans.

***Current Access to Dental Care***

There are approximately 735,000 First Nations and Inuit eligible to receive dental benefits under the NIHB Program. The NIHB Program dental benefit is designed to meet the needs of the client and involve the dental provider submitting a treatment plan for all complex procedures (eg. root canals, dentures, orthodontics, etc.). For basic dental care treatments (eg. regular examinations, cleanings, scaling, polishing, fluoride) clients are already eligible to receive these services, in accordance with demonstrated need, up to a threshold of $800 per year without prior approval. While basic treatments above the $800 threshold require prior approval, all required services within the scope of the NIHB dental program, will be approved for funding because of the consistent focus on client need. This ensures that eligible First Nations and Inuit of all ages have access to basic preventive oral care. Therefore, an increase to the annual predetermination threshold is not necessary given that it is not a limit on services.

***Non-Insured Health Benefits Program Billing Practices***

The NIHB dental program introduced predetermination in 1997 to ensure that individual clients receive the services they need, when they need them. The national threshold was established at $600 in consultation with the CDA, which at the time, was above the industry standard of $500. In 2002, the threshold was increased to $800. This amount represents a reasonable level to ensure access to services, particularly given that this amount is aimed to cover preventive and basic dental care only. Of significance is the fact that over 80% of NIHB claimants currently utilize less than $600 in dental benefits per year. In 2002/03, the average dental expenditure per claimant was $479. The NIHB dental program, in conjunction with the Federal Dental Care Advisory Committee (FDCAC), monitors the predetermination threshold accordingly. It is important to note that the predetermination threshold is not a limit on client care, but rather a threshold above which client treatment plan expenditures must be approved for funding by the NIHB Program as a function of audit and accountability practices. Raising the threshold unnecessarily might, therefore, also increase program risk from client and provider misuse and inappropriate billing practices.
The NIHB predetermination process is also consistent with those used in most public and private dental plans. The difference is that while standard plans provide a limited number of benefits, either up to an allowable frequency, or up to a financial limit, the NIHB dental program does not place limits on client care. The government is committed to providing full access and funding to all First Nations and Inuit clients who require and seek oral treatment. Any reasonable treatment plan, within the scope of the NIHB dental program, will be approved for funding after it is confirmed that it falls within the program's parameters and guidelines. The NIHB dental program has found that an approach that reflects an individual's needs is the most effective way of servicing its clients.

Dental hygienists make an important contribution to oral health promotion and disease prevention activities. In Canada, the provinces and territories are responsible for legislating and regulating dental professionals. The NIHB Program, though nationally funded and administered, operates in accordance with provincial and territorial legislation. The Government of Canada recognizes the important roles and responsibilities of the provinces and territories in governing health care

professionals and is confident that the current practice of dental hygienists billing the NIHB Program through the dentist with whom they practice is appropriate, and is in no way a barrier for NIHB clients in accessing preventive dental services. As a result, it is not necessary to establish an independent billing role for dental hygienists under the NIHB dental program as it would not increase client access to dental services or significantly improve the quality of care. This type of change would also increase program operational and financial requirements, particularly given the variances across the provinces and territories in regulating the profession.

The Government of Canada also recognizes the important role that dental therapists play in delivering oral health promotion and disease prevention services to First Nations and Inuit, particularly in remote northern communities. While dental therapists provide much needed clinical services, they also have an important role to play in community-based oral disease prevention services to meet the needs of communities. Much of their work involves promoting good oral health practices by teaching oral hygiene to their individual patients and providing oral health related support to community-based programs such as prenatal and post-natal classes and school-based prevention programs. Health Canada relies on dental therapists to increase access to comprehensive oral care and treatment, but also to extend oral health services to a wider population.

**Recommendation 4: Improved Access to Dental Care Providers**

The committee recommends that Health Canada work with educational institutions to encourage First Nations and Inuit to enter dental professions. It also suggests that increased access to dental care providers could be achieved through an effective medical transportation policy and by reducing the paperwork for providers when making their claims through the NIHB Program.

***Training and Educational Opportunities***

The government recognizes the need to create and facilitate opportunities for Aboriginal people to enter careers in the health sector. By supporting professional capacity building, the goal is that more First Nations and Inuit will be trained and available to provide oral health services in First Nations and Inuit communities. This would lead to increased access to providers that are cognizant of culturally-based concerns, and more providers living in, and servicing remote areas, which over the long term, would contribute to improved First Nations and Inuit oral health.

The Government of Canada's National School of Dental Therapy (NSDT) and the First Nations and Inuit Health Careers Program provide opportunities to encourage First Nations, Inuit and Métis students to seek careers in health and other health-related sciences. Both are aimed at building a skilled Aboriginal professional workforce so that they can provide increased access to dental care and dental care providers.

The government is committed to the NSDT by continuing to provide adequate funding and support. Dental therapists are trained for a two-year period at the First Nations University of Canada in Prince Albert, Saskatchewan, to provide basic oral health services, such as fillings, extractions, preventive care, and education in oral health. Within their limited scope of practice, they combine the clinical functions of dentists with the health promotion and disease prevention aspects of dental hygienists and they have a key role in administering community-based oral health promotion

programs. Since the school's inception in 1972, there have been an estimated 319 dental therapists trained through the program, of which 42 currently practice on-reserve and an additional 20 dental therapists are employed in the three Territories. The school continues to attract interested students from all walks of life. Each year approximately 15-20 students are accepted into the NSDT. The number of Aboriginal dental therapy students is increasing; half of each year's graduating class is First Nations, Inuit or Métis.

The Government of Canada is committed to building increased capacity among First Nations, Inuit and Métis students in educational opportunities that lead to obtaining professional careers in the health sector. Since its inception in 1984, the First Nations and Inuit Health Careers Program has provided results-based incentives through bursaries and scholarships to assist students who demonstrate adequate need and potential and who are pursuing post-secondary studies in a health or health-related field. In 2002/03, the program provided 137 students with $2.7 million in financial support. Included in these funds are supports for community-based initiatives that encourage student participation in post-secondary health science studies, student summer employment, and culturally appropriate curriculum in post secondary schools. Every year since the program's inception, there have been between two to five individuals enrolled in each of the dentistry, pre-dentistry, dental therapy, and dental hygiene programs.

The Government of Canada will continue to work closely with colleges and universities to increase awareness among Aboriginal students on the availability of the First Nations and Inuit Health Careers Program. It will also support the development of more targeted recruitment strategies to encourage their interest and communicate these available opportunities. Many dental health providers, including dentists, dental hygienists, and dental therapists, have participated in the First Nations and Inuit Health Careers Program. Health Canada is also working with schools to attract students, and to ensure that graduates are encouraged to enter the dental profession, and work in areas of greatest need.

***Non-Insured Health Benefits Program Medical Transportation Policy***

As with any publicly funded program, the NIHB Program administrators are responsible for ensuring the most appropriate use of funds to meet the needs of clients while ensuring program cost-effectiveness and sustainability. In September 2000, a review of the medical transportation benefit area was initiated by a joint working group with representation from AFN, ITK and Health Canada. The review revealed the need for a more consistent national approach and application of the benefit and led to the development of a new records system to collect utilization and expenditure data. On April 1, 2003, the new NIHB Program *Medical Transportation Policy Framework* took effect which includes regional policies and more consistent guidelines to define the terms and conditions under which the NIHB Program will assist eligible clients to access medically required services.

The new framework will streamline and increase the coordination of trips where possible. The goal is to improve the management and administration of the medical transportation benefit in order to ensure clients' continued access to all NIHB benefits, including comprehensive oral care. The Government of Canada is committed to ensuring that the new policy will not negatively affect access to treatment. Travel for all services required to alleviate pain, including emergencies, will continue to be covered.

***Non-Insured Health Benefits Program Administration***

In recent years, the Government of Canada has taken steps to reduce the administrative requirements placed on providers, and to ensure a more consistent application of the NIHB Program across benefit areas. This includes: increasing the predetermination threshold for services from $600 to $800; allowing post approval of selected services; and, establishing audit protocols to meet jurisdictional needs. For all complex dental services and basic dental services exceeding the $800 threshold, providers can also seek a one-time approval for the client treatment plan with no additional approvals required, provided the treatment plan is in accordance with the program guidelines.

The Government of Canada appreciates the amount of administration required by dental providers prior to, and following, the provision of oral health services to NIHB clients. To support these efforts, a *Dental Provider Information Kit (DPIK)* has been developed as a reference tool on benefit coverage and administrative procedures. NIHB officials will undertake to clarify and streamline the DPIK and will invite recommendations from the NIHB/CDA Working Group to support this process. Information is also available through toll free numbers so that dental providers can obtain answers to any questions pertaining to the NIHB dental program, including information on the processing of the required forms.

In addition, the NIHB dental program is in the process of exploring electronic options to reduce administrative requirements. Health Canada is working with the CDA to enable NIHB dental providers to use CDA*net*, the CDA's electronic claims filing system, and has also begun pilot-testing this system in Alberta, with future plans to implement the system nationally.

The government has also put in place feedback mechanisms to obtain advice and guidance on the management and administration of the NIHB dental program. The NIHB/CDA Working Group provides recommendations on how to improve the program with respect to administrative and policy areas. The Federal Dental Care Advisory Committee (FDCAC) considers issues across the six federal departments that provide dental benefits to their clients. FDCAC consists of officials from Health Canada, Veterans Affairs Canada, Royal Canadian Mounted Police, Correctional Services Canada, Citizenship and Immigration, National Defence, along with representatives from the CDA and the CDHA, and with participation from the AFN and ITK. Together, they provide advice and guidance on coordinating federal dental care benefits, reducing duplication, and seeking opportunities to reduce administrative requirements while providing quality oral health care.

**Recommendation 5: Client Consent**

The committee recommends that Health Canada extend the deadline for implementing the new all-inclusive client consent form beyond September 1, 2003. It suggests introducing a separate one-time form for each of the six benefit categories instead of one comprehensive form. Steps to ensure that the consent form is available in a variety of Aboriginal languages and dialects and that both clients and providers are aware that benefit access will not be denied if the consent form is not signed by the deadline should also be widely communicated.

***Extension to the Implementation Deadline***

Following requests from the Assembly of First Nations, the Inuit Tapiriit Kanatami, health care providers, Members of Parliament and First Nations and Inuit across the country, Health Canada has extended the date for First Nations and Inuit clients to sign the NIHB Program client consent form to March 1, 2004. Many First Nations people and Inuit were not well informed of these privacy issues and additional time was needed to adequately inform them. The six-month extension will allow time to work with First Nations and Inuit leaders to address their concerns and move forward with consent in a collaborative way. Clients who have already provided their consent will automatically be grand-fathered. However, should an individual wish to complete a new client consent form, this option will be provided. Any newly completed form would replace an existing form.

Discussions with First Nations and Inuit began in June 2000 when Health Canada and the National Joint Steering Committee struck an advisory committee to provide recommendations on the implementation of the initiative. Meetings were also held with the Office of the Privacy Commissioner in October 2001 and in January 2002. Prior to the launch of the consent campaign in September 2002, consent materials were tested in select communities. The current national consent form which was distributed in September 2002 was the result of a Working Group involving First Nations and Inuit.

The government is collaborating with the AFN and ITK, and engaging regional First Nations and Inuit leaders, to work together to develop a mutually accepted consent form, appropriate protocols to protect patient safety, and clarify key aspects of the consent initiative. This will include issues pertaining to access to information and privacy surrounding how the information will be used, collected, stored, and by whom.

### *Communicating with First Nations and Inuit*

The Government of Canada has put in place active marketing and communications strategies using media, community information sessions, and the distribution of printed materials to be certain that clients understand the initiative and their options so they can make knowledgeable decisions regarding their consent. This includes: information sessions; a toll free information centre; and, translation of the consent form into other dialects. To date, the form has already been translated into Ojibway, Oji-Cree, Cree, with future plans to translate the form into two dialects of Inuktituk. The form will also be available in a format for the visually-impaired.

A key element of the communications plan will involve increasing public awareness in First Nations and Inuit communities that the consent process is a common practice in other dental insurance plans used by other Canadians. Without consent, clients will be asked to pay upfront and seek reimbursement through the NIHB Program and provide one-time consent for each reimbursement request and for their personal information to be shared with the provider and the NIHB Program in order to process the claim.

### *Protecting the Privacy of First Nations and Inuit Clients*

The government is committed to ensuring that data collected through the NIHB Program is used and disclosed appropriately to medical professionals only as required. The new consent form will clearly

identify which parties can access the personal information collected and will affirm that, "...personal information may be disclosed, shared and exchanged with or transferred to and from these parties noted above but only for NIHB Program purposes." The government will abide by this clause and continue to operate in accordance with the *Privacy Act* requiring that NIHB clients be informed of what information is collected, who it will be shared with, and for what purposes it will be disclosed. Health Canada will also protect all personal information collected for NIHB Program purposes.

***Alternative to the Comprehensive Client Consent Initiative***

Prior to selecting a single consent form for all NIHB Program benefit categories, the government had considered collecting separate one-time consent forms for each benefit category. This option was rejected as financially and operationally unfeasible, and would create a potential barrier to clients and providers in accessing and delivering services. More specifically, separate consent forms would not lead to less information being collected, used or disclosed. Secondly, Health Canada does not always have direct contact with clients prior to the receipt of benefits and this would require additional administration by providers to complete forms and then submit them for reimbursement. Thirdly, clients generally would not complete a consent form until they need to access benefits which would result in a delay as the consents would need to be processed prior to processing the claims.

## CONCLUSION

The Government of Canada has put in place a solid foundation that it hopes to build on in the coming years with respect to improving the oral health status of First Nations and Inuit in Canada. This is a balanced approach that combines primary oral health care with an increasing emphasis on health promotion and disease prevention activities in collaboration with First Nations and Inuit communities. The Government of Canada will collect and build on the

available evidence, best practices and lessons learned, and seek operational efficiencies with existing community-based programs, in order to support and focus efforts on innovative solutions that address the unique needs and circumstances of First Nations and Inuit children, their families, and communities.

The Standing Committee on Health has demonstrated the valuable role Members of Parliament can play in supporting and contributing to the national dialogue on First Nations and Inuit oral health and services. The Government of Canada will continue to look to the committee for their expert advice and guidance in meeting our collective goals for improving the oral health status of First Nations and Inuit in Canada. The Government of Canada would like to express its thanks and appreciation to the standing committee for its dedication and hard work on this issue.