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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1615)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): I call meeting number 81 of the Standing Committee on Health to order.

We certainly welcome our guests back. We've had Mr. Ferguson before.

I want to welcome, from the Office of the Auditor General, Michael Ferguson, Auditor General of Canada; Joe Martire, principal; and Casey Thomas, principal. They are going to testify before us today on the oral health programs for first nations and Inuit.

We will ask you to make an opening statement, Mr. Ferguson, of 10 minutes, and then we'll go to questions.

I'm sorry for the delay, but I'm sure you know the reason. Thank you very much.

Mr. Michael Ferguson (Auditor General of Canada, Office of the Auditor General): Thank you.

[*Translation*]

Mr. Chair, thank you for this opportunity to present the results of our audit on oral health programs for first nations and Inuit.

I would like to remind the committee that we have done other reports in the health area—one of them on the access to health services for remote first nations communities which we presented to Parliament in the spring of 2015.

In our audit on oral health programs, we focused on whether Health Canada knew if the programs had a positive effect on the oral health of Inuit and first nations people. These programs are important because they provide access to a range of medically necessary dental services.

We concluded that while Health Canada provided access to these important services, it could not demonstrate how much they helped to maintain and improve the overall oral health of Inuit and first nations people.

Even though the department knew that the oral health of these populations was significantly worse than other Canadians, it did not focus on closing the gap. Also, the department had not finalized a strategic approach to help improve the poor oral health outcomes.

[*English*]

We found that Health Canada did know that its $5-million children's oral health initiative, which is focused on prevention, improved the oral health of some first nations and Inuit children. However, the department's data shows that fewer children are now enrolled and fewer services are provided under the initiative than in previous years. Health Canada does not know why this is the case, which makes it difficult to address the situation.

We also found that there were administrative weaknesses in the department's management of its non-insured health benefits program. The department's service standards for making decisions on pre-approvals and complex appeals were not clear. Also, Health Canada did not always inform its clients and service providers promptly about some of the changes it made to the services it paid for. This matters because delayed or unclear communication about what services are available can affect clients' access to the oral health services they need.

We also found that, in the two regions we examined, Health Canada was slow to take action to address human resource challenges. Without action, these challenges could eventually affect service delivery.

We made six recommendations, including that Health Canada should finalize and implement a strategic approach to improve the oral health of Inuit and first nations people, and that it should develop a concrete plan to determine how much of a difference its programs are making to the oral health of Inuit and first nations people.

Health Canada agreed with our recommendations and committed to take corrective action.

● (1620)

[*Translation*]

Mr. Chair, this concludes my opening remarks.

We would be pleased to answer any questions the committee may have.

Thank you.

[*English*]

The Chair: Thank you very much. I believe those are the shortest opening remarks we've ever had.

Now we'll go to our question period with seven-minute questions.

Mr. Oliver.

Mr. John Oliver (Oakville, Lib.): Thank you very much.

Thank you for coming today to review the report.

I was going through it, and I just wasn't quite sure of the time period that the audit covered. There was mention of 2014 and up to 2016, I think. Was it the 2015-16 year or the 2014-15 year? What was the time period of the study?

Mr. Michael Ferguson: The audit covered the period between September 2013 and December 2016.

Mr. John Oliver: Thank you.

In terms of confirming whether there is now sufficient action on this, you referenced the comments from the department. I read through them. In your mind, in terms of the department's response to your review, are those comments satisfactory? Do you feel there is something more that could be done, or are those sufficient to address the main points in your review?

Mr. Michael Ferguson: The department has agreed with all of our recommendations. I guess we always reserve judgment on how successful what they say they're going to do will be until we come back and do another audit or look at exactly what they've done.

The starting point for us is always that they've agreed with our recommendations. They will be preparing an action plan as part of their normal process for the public accounts committee, which will provide more detail about what they're going to do. These are the first steps toward implementing our recommendations.

Mr. John Oliver: The minister, in terms of her oversight of the department, has highlighted four key ways the government is working with first nations.

“Finalizing a strategy by March 2018 with First Nations and Inuit partners to improve oral health and service delivery”. That was number one. Number two is “Improving data collection...by working with First Nations and Inuit partners to track the needs of community members”. That's on the data collection point that you raised in your audit.

“Utilize programs with First Nations and Inuit partners to attract, educate and retain Indigenous oral health workers in communities”. Again, this is addressing service provision. Finally, “Improving how decisions are documented under NIHB by including more details on approvals and policy changes.” I assume with this is more timely communication to the communities on what the changes are.

Also, in budget 2017 there is an additional investment of $45.4 million for the children's oral health initiative over five years to expand the oral health program in up to 214 additional communities. There is $813 million in the budget, as well—$83.2 million for the children's oral health initiative and also the community-based fetal alcohol spectrum disorder programming, and the maternal and child health programs.

With the ministerial response and the department response, it reads to me as though the ship is turning. I agree with you that it has to be implemented and the plans need to be put in place, but there appears to be a very strong focused agenda now to improve the oral health needs of indigenous people, and there is a fair amount of financial resources being brought to bear to make that happen. Do you agree with that? Do you have a sense that more should be done?

Mr. Michael Ferguson: I would certainly agree that the items you listed were all in the areas where we found there were things that needed to be improved. Those are the topics the department needs to focus on. Again, we'll see what actually happens.

Our overall message in terms of this report was that.... The rate of dental disease, for example, in Inuit and first nations people is about twice that in other populations. With all of these different activities, we need to see that gap starting to close. Yes, there are a number of good activities, perhaps, being announced, but there needs to be a way of making sure those are all going to lead to improving the health outcomes for these populations.

● (1625)

Mr. John Oliver: With the data collection comments I made about the investment that is input there and the department's comments about data collection, it seems as if there will now be tracking mechanisms. Were there reasonably robust indicators that you saw in use that would actually track that improvement? Are those ones that you had to develop to conduct your review, or are those in place within the department so that they can track progress themselves as this goes forward?

Mr. Michael Ferguson: The department has a lot of data. A lot of what it pays for is on, essentially, a fee-for-service basis, so they have a lot of data about the services that are provided under the non-insured health benefits program. They were, in fact, doing quite a bit of analysis of that data, but it was mostly analysis that was helping them manage the payments rather than helping them understand the impacts of their program on the population.

This is a program for which, first of all, we found that they do have quite a bit of data. They just need to use it in other ways, not just to administer payments but also to understand the impact.

On the other hand, there was the other program, the children's oral health initiative, which is not paid for on a fee-for-service basis, so they didn't have the same level of information on that program, although, when they had gone in and reviewed the program, they found it was making a difference in oral health.

We indicated that there were signs of a decrease in enrolment and a decrease in service, which may have, in fact, been just the fact that they weren't tracking that information the way they should have been. I think, on that program, they need to do a better job on the data collection.

Mr. John Oliver: Thank you very much. Those are all my questions.

The Chair: Thanks very much.

Ms. Gladu.

Ms. Marilyn Gladu (Sarnia—Lambton, CPC): Thank you, Chair.

Thank you to the Auditor General and his team for attending. I did attend your briefing, so I had an opportunity to get some of the information.

I wanted to ask a little bit about dental outcome KPIs. I come from an industry focus, where you improve what you measure. I was surprised to not see a very prescriptive comparison. Does this program go across all first nations and Inuit communities, first of all?

Mr. Michael Ferguson: I'll ask Ms. Thomas to reply to that.

Ms. Casey Thomas (Principal, Office of the Auditor General): Thank you very much.

In terms of what we found in the audit, we looked at whether or not they had KPIs and whether or not they were determining what those outcomes would be. We found that the department indicated that because it pays for the services, it is therefore contributing to the overall health outcomes of the populations. It didn't have, with respect to the NIHB or the non-insured health benefits program, those sorts of measures that would allow it to determine whether or not it was actually improving the outcomes.

In COHI, the children's oral heath initiative, for example, it was measuring the DEF, or the decayed, extracted, or filled teeth, and it was using those as measures, as proxies to determine whether or not there were positive or negative outcomes for children. On the children's side, it was measuring and able to demonstrate that when COHI had been in place in communities for eight years, for example, those measures were seeing positive outcomes.

Ms. Marilyn Gladu: One thing I'd like to see then, for sure, are measurements across the country that are the same, so that you could compare different first nations communities to see which ones are in more need or less need, and maybe look at things like not just the number of cavities or the number of procedures, which I think should be tracked, but also the number of prevention interventions with children in the community.

Do you think that's the kind of detail? Did you get any detail from Health Canada about what KPIs they were going to put in place?

Mr. Michael Ferguson: I think that's the type of thing that certainly we felt they should do. Again, the children's oral health initiative is a program that is very much geared towards prevention. If they could start to link the information they have—first of all they need to make sure they're collecting the right data—on that program to the rest of the information they have in their other program, then that would help them link some of those preventative measures to the longer-term outcomes.

Now, the children's oral health initiative—and I think earlier you asked about the coverage—was available in only about half of the first nations, even though that was an initiative that seemed to be leading to better oral health outcomes.

● (1630)

Ms. Marilyn Gladu: When it comes to the programs, then, which ones do you think you should continue and expand? Which ones do you think you need to do more investigation on to find out why the participation rate is dropping, and which ones do you think should be eliminated?

Mr. Michael Ferguson: Our role is to audit the implementation of government policy. Government has to decide, through its policy, what types of things it's going to cover. I think the department will tell you, of course, that all of these are important dental care services.

In terms, though, of the children's oral health initiative, I think fundamentally it's time for them to look at the fact that only half of the first nations were covered, and decide which way they are going to go with that program. They also need to get the information to better understand what's going on with that program, because, again, the data indicated that enrolment had declined and services had declined. But the department told us they thought that was just because they weren't doing a very good job of actually collecting the data about which services were being provided.

For them to really understand whether the program is having an impact, they need to understand what services are provided under it.

Ms. Marilyn Gladu: I noticed in the Health Canada response to your audit that there are actions but there are not specific timelines associated with those actions. Did you get any sense of when these things will be completed?

Mr. Michael Ferguson: When we do an audit and we report our findings and recommendations and we're in the process of preparing the report, we will discuss our recommendations with the department and we will get a response from them. That's what you see in the report.

Then, as part of the regular process with the public accounts committee, the department is asked to put together an action plan that includes those types of timelines. I haven't yet seen the action plan for this report, but of course they haven't been called in front of the public accounts committee yet to discuss the report.

We will, in the not-too-distant future, see an action plan prepared by the department that will include those dates.

Ms. Marilyn Gladu: Okay.

Do you think the split is right in terms of how much is being spent on preventive versus diagnostic? Did you see any evidence of...?

Mr. Michael Ferguson: That's not what the focus of the audit was. Again, in terms of the preventative, we looked at the children's oral health initiative, and then of course we looked at all of the other services, but we didn't look specifically at that split.

Again, I think that's the type of information we'd like to see the department analyze. Which types of services are preventative services, and for the people who get those services, what happens to their longer-term oral health outcomes?

Ms. Marilyn Gladu: This is the engineer in me, so I'll say sorry in advance, but were you able to correlate any of the contributing factors—for example, drinking water? We know that there are more boil water advisories now than there were two years ago. That should have an effect on oral health. Are you able to see anything like that from your audits, or is that not part of the scope?

Mr. Michael Ferguson: We didn't get down to identify the impacts of those things. The department acknowledged, and we acknowledged as well in the context of the report, that there are other things that determine oral health outcomes.

Again, I think those are things that the department needs to take into consideration as it puts together its overall approach for this program to try to close that gap. When these populations have a rate of dental disease that's twice as bad as that of other populations, then all of those factors to try to figure out what could be causing it, how we prevent it, and how we manage it need to be taken into consideration.

Ms. Marilyn Gladu: Yes. They should all be tracked so that you can correlate.

The Chair: You're done.

Ms. Marilyn Gladu: Okay.

The Chair: Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Chair.

According to documents recently released under access to information, the federal government spent more than $110,000 fighting a first nations girl in court to block payments for orthodontic treatment that cost $6,000. Stacey Shiner, the child's mother, sought payment for the braces under the first nations and Inuit health benefit program, but was denied by Health Canada. She appealed three times to no avail. Ultimately, she had to take the case to Federal Court.

Cindy Blackstock, executive director of the First Nations Child and Family Caring Society of Canada and an intervenor in the Shiner case, said the following:

> As a human being, I think it's immoral that Canada would not fund services where two concurring pediatric orthodontists agree that without treatment this girl will experience chronic pain and will have difficulty eating and talking.
>
> As a taxpayer, I'm absolutely floored that Canada would spend $110,000 defending [against] a $6,000 investment to help [an indigenous] child. They could have used that money to buy 18 children in medical need the orthodontic services they needed.

In your view, does this expenditure of $110,000 in legal fees represent good value for money?

● (1635)

Mr. Michael Ferguson: Again, it wasn't the objective of the audit to look at that particular instance or other particular instances. I think the department would have to explain their decision. I mean, certainly when you look at the decision on the basis of those numbers, it's fair, I think, to question the decision, but I think the department would have to explain that.

One thing we did identify was that in the course of their giving a decision on appeals, they had time frames for appeals. The ones where they didn't meet their 30-day service standard on giving a decision on appeals were primarily related to orthodontics. I think there are certainly improvements that the department needs to make on how it's managing appeals for orthodontics.

Mr. Don Davies: Thank you.

During this committee's study of the cannabis act, Bill C-45, we learned that the federal government covers the cost of medicinal cannabis for Canadian veterans but not for first nations and Inuit populations. In your view, how does oral health coverage for registered first nations and recognized Inuit compare with other populations, such as veterans, for which the federal government provides oral health coverage?

Mr. Michael Ferguson: Again, I can't speak to that, because we didn't do that comparison in the audit. I would take the opportunity to remind the committee that we did do an audit on the prescription drug program for veterans that included the medical marijuana, but we didn't do that comparison of this program for oral health with other programs for oral health.

Mr. Don Davies: According to report 4 of the 2017 fall reports of the Auditor General:

> The Department [of Health] had known for many years that Inuit and First Nations people's oral health was poor, and attempted to develop a strategic approach to improving it. We found that the Department drafted strategic approaches to oral health in 2010 and 2015, but did not finalize them.

In your view, why did the department previously fail to finalize its strategic approaches to oral health in 2010 and again in 2015?

Mr. Michael Ferguson: I'll start and then I'll ask Ms. Thomas to add to it.

This is an issue that we see in a number of different places, and it continues to concern us when departments identify the need for a strategy, start a strategy, get a draft strategy in place, but don't finish it.

In this case, they identified it in 2010. They identified it in 2015, but when we were in doing the audit, there still wasn't one developed. Explaining why is something the department would have to do. We don't give departments credit for draft strategies. If they say they need a strategy, then we expect to see a strategy developed and approved so that it can move on to implementation, but in this case, they identified the need in 2010 and 2015, and it still wasn't developed.

I'll ask Ms. Thomas if there are any more details to add.

Ms. Casey Thomas: The only detail I would add is that in 2010 and in 2015, the department's report on plans and priorities also made the commitment to developing a strategic approach, but they still hadn't finalized it in 2016 or 2017. They instead developed regional plans. These regional plans were exactly that. They covered the regions. They looked at the current state of the gaps and possible solutions for those gaps, and we were told that those were being used until the strategic approach could be developed.

● (1640)

Mr. Don Davies: Did you find any evidence that those regional plans had actually been implemented?

Ms. Casey Thomas: We did. The regional plans have been implemented.

Mr. Don Davies: What were those regions?

Ms. Casey Thomas: The seven regions that are covered are Atlantic, Quebec, Ontario, northern, Saskatchewan, Manitoba, and Alberta.

Mr. Don Davies: Did they give you any explanation for why the overall plan has not been implemented yet?

Ms. Casey Thomas: No. They simply told us that they had decided to change direction, to work on the regional plans until they could develop their strategic approach.

Mr. Don Davies: Did they give you a timeline for when the strategic approach might be done?

Ms. Casey Thomas: No, they did not.

Mr. Don Davies: Thank you. Those are my questions.

The Chair: Thanks very much.

We're going now to Dr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you, Mr. Chair.

Thank you all for coming.

I'm reading through this, and I don't know if this was within the scope of your audit, but of course, in any large system, sometimes there are problems with the scope of programs that have to be administered under a given body. In particular, in Indigenous and Northern Affairs, there has recently been a recent change, now that there are basically two ministries and one ministry is dedicated to the provision of services.

Is there an opportunity or likelihood that this may improve the administrative efficiency and perhaps be a step to improving these issues?

Mr. Michael Ferguson: I'm not so much focused on the structure of the delivery. I think what's important is that whoever is responsible is putting the focus on the health outcomes.

We identified in the audit, for example, that Health Canada—the department that was responsible, of course, during the period of the audit—had done some work to determine what the health status of these populations was, but the department doesn't have anything that they use on a regular basis to try to determine whether their day-to-day activities are going to help move the bar in terms of those overall health outcomes.

If they're simply going to come along and measure the health outcomes periodically, say every five or every 10 years, they need some interim measures to actually know whether what they're doing will end up moving those longer-term measures in the direction they need to. Whatever department is responsible for this, what's important is that they have good ways of identifying whether what they are doing is going to contribute to better outcomes.

Mr. Doug Eyolfson: All right. Thank you.

I note that some dental services require pre-approval. Do you have not a comprehensive list but maybe just the categories of the kinds of procedures that require pre-approval and those that don't?

Ms. Casey Thomas: In terms of the types, I can't give you a list, but something like a root canal, orthodontics, or a crown—anything that is more extensive or more complex—would require a pre-approval. Something such as a filling or a scaling, for example, would be the type of service that wouldn't require a pre-approval.

Mr. Doug Eyolfson: Okay. Do you know if the decision on whether or not it was pre-approved was determined on level of complexity, or was there another decision in terms of requiring what would need pre-approval and what would not?

Ms. Casey Thomas: The department has developed a schedule of services that it will provide overall. When you look at the schedule's extensive list, you see that about 40% of the services require pre-approval. The department has predetermined that if a dentist prescribes or requires to give a patient a particular service, then 40% of those services would require pre-approval.

What the department has demonstrated is that in the claims they pay for, only 4% of the claims have actually come back, having received or required a pre-approval.

Mr. Doug Eyolfson: All right. In those requiring pre-approval, does the pre-approval process itself appear to present any difficulties or any barriers?

Ms. Casey Thomas: In the course of our audit, we didn't look at individual cases. The dentists themselves have the patient files, so we wouldn't have had access to those files.

What we did look at is the process that the department went through to determine what should be on the list. I don't think I completely answered your question earlier, in that there are criteria that the department has developed, which I think you alluded to but I didn't speak about. We didn't look at the individual decisions themselves, but we did look at the process the department uses to determine the list and the criteria.

● (1645)

Mr. Michael Ferguson: The other thing in terms of the pre-approval was that they had set a standard of 10 days. If you look at the way they've described the standard, you as an individual would think that you would get an answer back within 10 days on your particular situation, but they weren't measuring it and monitoring it on an individual basis. They were sort of aggregating a whole bunch of decisions and coming up to see whether they were, on average, actually meeting that 10 days.

From the point of view of an individual, if you went to their website, for example, you would expect that you would get a decision within 10 days. You may not actually get the decision within 10 days, even though the department would be saying that they met their service standard because they would be averaging your decision in with other decisions. That could cause some concern and perhaps complaining on the part of people receiving services, who expect that they would be managing that service standard on an individual basis for making a decision within 10 days, when in fact they're measuring it on an averaging basis.

Mr. Doug Eyolfson: Thank you.

There was a document done by the Assembly of First Nations. It's called the “First Nations Health Transformation Agenda”. They talked about the national utilization rate for dental benefits. It was 34% of eligible individuals. This compared to 61% for those who were eligible for pharmacy benefits. The report noted that part of the reason for the low rate of utilization—I'll read this verbatim—was “poor overall communication about the...benefits and, particularly in the case of dental, a hesitation or unwillingness of First Nations clients to try to navigate the onerous NIHB approvals process.”

Would you say that your review supports this conclusion that some of these low utilization rates are in part due to how onerous this approval process was in discouraging people from navigating it?

Mr. Michael Ferguson: Again, that wasn't where we were looking in terms of the audit. There are a number of services they provide that people have access to and, certainly, we did find that in the course of the year about 300,000 people, I think it was, had accessed these services. The population that would be eligible for the services would be significantly higher than that 300,000. That indicates there's work for the department to do to understand who is getting access to the services.

Again, we did find that they made some changes from time to time on the services that were available, and there were some communication issues that we identified. For example, if the department made a decision to change the services they pay for, they didn't communicate that right away. Their reason for this was that when they made this type of change they had to program it into their system, their payment system, and that took a while to do.

In our report, we identified an example where they made a change in 2014. I think it was about the number of X-rays, for example, that they would pay for. They increased it from six to 10, but it took them two years to actually tell people that they had increased it from six to 10. In the meantime, somebody may have heard from their dental service provider that they had already had their six X-rays and couldn't have any more, so then they might have put something off, whereas another dental provider might have said, “Okay, I think you need another X-ray, so I'll ask for approval.” They then would get approval because the department had already increased from six to 10 but hadn't actually communicated it.

In that case, the access to those types of services might have been uneven because either some dental service providers knew about it or some asked for pre-approval, whereas others didn't know about it or didn't ask for the pre-approval.

Mr. Doug Eyolfson: Thank you.

The Chair: Your time is up.

Now we're going to our five-minute rounds, starting with Mr. Webber.

Mr. Len Webber (Calgary Confederation, CPC): Thank you, Mr. Chair, and thank you to our witnesses for being here today.

I'm thinking back to my days back in Alberta in provincial politics when I served as the aboriginal relations minister and dealt a lot with Alberta's dental hygienists association in trying to expand their scope of practice. Initially, for any type of work they did, they required a dentist to be on site, either supervising their work or being on the same site somewhere in case something occurred where a dentist was required. We were able to change that through a lot of work within government to expand their scope of practice so they could provide preventative services, such as scaling, fluoride treatment, or sealants, without the assistance of a dentist or a dentist on site. This enabled them to be mobile and to go out to the communities and do their preventative maintenance work without having a dentist with them.

With regard to Health Canada and their policy, where are they with implementing these health services? Do they require a dentist to be on site? What's their scope for the hygienists out there?

● (1650)

Ms. Casey Thomas: First of all, we didn't look at each of the provincial or territorial requirements, but essentially that's what Health Canada relies on. They are able to use the practitioners in each of the provinces and territories as the provincial jurisdictions regulate them. If a hygienist has the ability to do more in a province, then Health Canada would be able to rely on that service in that province. When you look at it, you see that each of the regions or each of the provinces and territories has a different service delivery mechanism, depending on the provincial or territorial regulations.

Mr. Len Webber: I see. It is a provincial jurisdiction. They decide who has what scope of practice there. Okay. Perhaps Health Canada can put pressure on these jurisdictions that don't have that wide acceptance of dental hygienists and their skills.

Also, in your report, you state, “According to Health Canada's Non-Insured Health Benefits Program 2015-16 annual report, in that fiscal year, fee-for-service expenditures were approximately $87 million for restorative services” and “$24 million each for preventive services and diagnostic services”.

That was back in 2015-16. How is that comparable to the years after that? Has it increased significantly? Is it relatively the same? Is there a comparison from previous years? Do you have those numbers, by chance?

Ms. Casey Thomas: We didn't look back to determine any sort of comparison over the years, but what I can say is that.... There was a question earlier about the weighting between preventive and restorative, and while the department can definitely do work to encourage more preventive services, for example, some of it is reliant on the dentist who is determining what service a client requires. The services themselves seem to remain about the same overall.

Mr. Len Webber: Thank you.

I'm going to pass my last one on to my colleague.

Ms. Marilyn Gladu: Thank you.

I noted that there was sometimes a gap in the human resources needed to execute the services. Can you give us some detail about what resources were missing? Was it hygienists? Dentists? Was it consistent across the country?

Ms. Casey Thomas: Basically what we saw was a lack of service providers that had been identified by the department or the regions themselves. For example, two regions identified the need for contract dentists and had looked to find out if they could get more.

Similarly, as we report, the dental therapist community is declining, and the regional plans that we spoke about earlier have identified the need to fill those spots and to determine how they're going to do that, but as we report as well, they haven't necessarily acted quickly enough on this. They've known since 2009 that the dental therapists' numbers were declining, but they haven't taken enough action yet to fill those spots.

The Chair: Now we'll go to Mr. McKinnon.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): Thank you, Chair.

Mr. Ferguson, your report indicates that first nations and Inuit populations have almost twice as much dental disease and more oral health needs than the general population and cites reasons such as fewer dental visits, lack of affordable and nutritious food, and so forth. Among these on this list, though, are things such as geographic barriers. We know that some of our indigenous communities, particularly in the Far North, are very remote. I would think that this is a very dominant factor in those areas. It would answer for fewer dental visits and all these other things.

I wonder if you were able to correlate your data in relating need with geographic remoteness in any way.

● (1655)

Mr. Michael Ferguson: Again, that's the type of analysis that we would like to see the department do.

I'll start with this. I may ask Mr. Martire to provide some details on other work we've done in terms of access to health services in remote first nations as well, but that's the type of information we would expect the department to be able to do, again, to try to understand.... It's one thing to know that there is a gap, with the rate of dental disease being twice that of other populations in Canada, but then there are all of these different factors that can contribute to that, such as the remoteness and the availability of nutritious food and those types of things. We would like to see the department being able to do some sort of correlation on that.

Certainly, you're right; the remoteness of first nations is a factor. The other audit that I mentioned we did was on access to health services in remote first nations. I'll ask Mr. Martire to perhaps give you a bit of information on that issue.

Mr. Joe Martire (Principal, Office of the Auditor General): Thank you.

The report we're referring to was tabled in the spring of 2015. It focused basically on remote first nation communities. We focused in on Manitoba and northern Ontario, which account for about 65% of all the remote first nations in Canada that are on reserve.

The issue there is that if you think about it, what we were trying to get to was what kind of access they have to clinical and client services. That would include medical transportation. The focal point in these remote communities, as you may be aware, is basically the nursing station. That's their first point of contact. Let's say a dentist comes in. There's an issue around where you put them when they arrive. We found barriers in terms of the accommodation and the state of facilities that were there.

Then there's the actual transportation policy with regard to any health issue, including dental. I think dental covered about 5% of their.... We looked to see how they were actually applying their medical transportation policy. In there we found some significant weaknesses. For example, the first thing that has to happen is that you have to be registered. If your child is not registered, then you may be denied access. We took a sample of about 50 people in the two communities. Half of them were not registered in Manitoba. In Ontario they didn't keep the data, but some of the communities we visited told us us that in one particular community at least 50 individuals weren't registered. Right away that causes complications.

The good news is that if there are medical emergencies, people do get transported to get their needs assessed. The problem is when you're trying to get them back. If you call Health Canada and they're not in the system, then you might have some issues. On the dental specifically, the population.... As I said, it's about 5% of all the transportation benefits, and there are issues with that.

We talked a lot about documentation. That was another area where we found some significant deficiencies. If you look at the medical transportation policy, certain principles guide what that policy is supposed to do. We took a sample of those principles. We tried to look at the compliance rate. In Manitoba we looked at five. For example, we looked at whether the transportation was medically required, 0%. We looked at the attendance confirmation, written confirmation by a health professional that the person actually attended the appointment, 0%. In Ontario it was a little bit better, but they had significant problems with documentation.

There was some discussion earlier about the quality of documentation. In this particular area, it was pretty bad. In Manitoba particularly, they didn't keep documents as they were required to do with the federal government's policy on record-keeping. That's the issue not only for dental but for all health services. For remote locations, the nursing stations are the first point of contact. If people can't be treated there, then the medical transportation policy is designed to bring them to the nearest location to get that service.

● (1700)

Mr. Ron McKinnon: Thank you.

The Chair: Your time is up.

Mr. Van Kesteren.

Mr. Dave Van Kesteren (Chatham-Kent—Leamington, CPC): Thank you, Chair.

Thank you for being here.

I know the question has been asked before, but I want to ask it again, because I want to get your on-the-ground reaction. It was noted that these procedures were supposed to have taken place, and Health Canada had acknowledged that this was the plan.

Mr. Ferguson, when you confronted Health Canada with those facts, what was their reaction? Did they just shrug their shoulders? They must have had some kind of response. I'm a little baffled about that.

Mr. Michael Ferguson: If I understand the question, it's about the fact that they hadn't put the strategy in place. In 2010 they identified they needed a strategy, and again later on. I'll perhaps ask Ms. Thomas to characterize the conversations we had, but what I would say is that unfortunately we come across this not infrequently in departments. They identify the need for a strategy, they start work on the strategy, but then they never totally complete it. It's not unique to this department.

In terms of the conversations we had with them, I'll ask Ms. Thomas to comment.

Mr. Dave Van Kesteren: Can I just interject for a second? Before we get to that, I'm curious; you've said that and I believe that, and I think we've had experience with that before too. Are they just not telling us what the problem is? I'm getting some...from the dialogue we're hearing. Is the task so immense that it is impossible to accomplish?

I'm thinking of Iqaluit, for instance. I've been there. As I'm sure you're aware, there are about 5,000 people there. I don't think they have a dentist. I don't think they do, but if they did, if that's the situation, that they have twice the amount of dental issues you found in the rest of the population, is the task just so daunting that Health Canada has just kind of thrown their hands in the air and said, "Yes, we agreed to do this, and we said we were going to have something in place, but we just don't know how to do it"?

Mr. Michael Ferguson: I certainly wouldn't want to underestimate the complexity of what they're dealing with. Again, some of these people live in very remote locations. Getting access to any types of services on the health front, whether it's dental services or other nursing services, can be complex. Sometimes it requires them to leave their community to travel fairly long distances to get access to those services, so I wouldn't want to underestimate the complexity of the problem.

However, I think it is still incumbent on the department to try to establish what it is they want to accomplish through the program. They already have said that their role is to maintain and improve the oral health of these populations. If that's what they're trying to do, how are they going about doing it? How are they using the data that they have? What measures are they using to know whether they are making progress?

It would be a stretch to expect them to be able to totally close that gap in a short period of time, but you would like to be able to see some indications that at least they're moving in the right direction of reducing that gap, even though, again, they are faced with all of that complexity.

Mr. Dave Van Kesteren: Next, are there any studies that show that the problem is getting worse, or have we planed out?

I have a second part to that question. Again, I've been there. I've witnessed what a lot of people, especially young people, are consuming. It's not healthy stuff. I see an awful lot of pop cans and bottles. Did Health Canada perhaps indicate that, you know, there just isn't any movement towards a healthy diet?

Mr. Martire, you're kind of nodding your head.

I'm trying to look for.... I'm a car dealer. If somebody comes in with a problem, we want to know what their driving habits are, where they have been, and that sort of thing.

● (1705)

Mr. Michael Ferguson: We identified that Health Canada had worked to try to do a couple of surveys of health outcomes. One was on Inuit oral health in 2008-09. One was on first nations health in 2009-10. However, there really haven't been enough of these types of studies over enough of a period of time for them to really know whether what they are doing is having an impact. They need to try to look at their data.

Of course, all we can really expect them to work with is the data they have on the dental services that they are providing or that they are making sure are provided. As soon as you get into things like people's eating habits and that type of thing, a whole different type of data needs to be collected. You get into personal information and all of those types of things.

We would expect them to be able to work with the data that they do collect on the services they're providing to be able to understand whether, for instance, if children are getting the services under the children's oral health initiative by the time they are age seven and as they get older they're coming back for regular dental visits, then there are better health outcomes. We would expect them to be able to look at it from that point of view.

In terms of the other issues, the access to nutritious food and those types of things, those are other activities that they would need to work on, perhaps outside of this program. We did an audit a while back on nutrition north and about how that program is intended to try to get access to that type of food. But that was a different audit. In terms of this particularly, we would expect them to use the data that they do have to try to identify some of that cause and effect.

The Chair: Your time is up.

Ms. Sidhu.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Chair.

Thank you for your hard work in preparing this report. We all know that the first nations and Inuit populations have more dental diseases than other populations and that the barriers can be less access to affordable, nutritious food, or education levels, but in budget 2017 we utilized programs with first nations and Inuit partners to educate indigenous oral health workers. On top of budget 2017, there was an additional investment of $45.4 million for the children's oral health initiative over five years.

Do you think these programs are going to help with those barriers?

Mr. Michael Ferguson: I think that question is exactly the reason why the department needs to have information about what the status is of the oral health outcomes of the Inuit and first nations people and what activities actually will close that gap, because otherwise.... That's the type of information that can be used to make sure that any additional investment is going to be utilized in a way that will close the gap.

Again, I think that's what's important. Additional money is, on the surface, a step towards trying to get to better health outcomes, but there needs to be a way of actually knowing whether or not that's what's going to happen. Money on its own isn't going to necessarily result in better health outcomes. The department needs to know exactly what those health outcomes are, what things affect the health outcomes, and how we know whether they're improving. That would be a way in which they would then be able to demonstrate back to Parliament that any additional money they get for these programs has in fact had an impact on the overall results.

Ms. Sonia Sidhu: There's a nursing station out there, as Mr. Martire said. How can that money be focused to create the greatest benefit? Do you have any ideas? Should we have more school programs to educate them on oral health?

● (1710)

Mr. Michael Ferguson: I think that's sort of the crux of what we were getting at in the audit. The department needs to understand what types of activities actually will lead to better oral health outcomes, whether it's more preventative service or signing up more people for the programs and making sure that people are aware of the programs.

For any of those types of activities, it makes it more difficult for them to figure out what types of services or programs they should put the money into unless they have the information that helps them understand which of those activities actually lead to better results. I think that's really what we were trying to get at. They need to know what activities will affect those outcomes so that they can make those decisions based on that type of evidence.

Ms. Sonia Sidhu: Thank you.

The Chair: Are you all done? Okay.

Now that we've finished that round, we'll go to Mr. Davies for three minutes.

Mr. Don Davies: Thank you.

I'm still stuck on something you said earlier, Mr. Ferguson, which was that it took two years for Health Canada to inform patients of a change in the X-rays from six to 10 years. Is that correct?

Mr. Michael Ferguson: That's correct. The decision was made in 2014, I believe, and made public in 2016.

Mr. Don Davies: There's a fiduciary relationship between the government and indigenous people. One would think that there's an obligation on the government to inform their patients in a timely manner of significant changes to the services they're entitled to. Am I missing something there?

Mr. Michael Ferguson: Certainly, we felt that by not communicating the decision, it could create an inequitable situation. If one dentist applies for a pre-approval for one of their patients and gets approved, then they they know, okay, for other patients, they will apply for that pre-approval. Another dentist may not apply for it, so their patients wouldn't necessarily get access to it. We were certainly concerned that it could have created an inequitable situation, so we felt that the department did have an obligation to try to communicate. I mean, they made the decision in 2014 that they were going to increase the limit, so....

Mr. Don Davies: Did they explain why it took them two years to communicate a change in coverage?

Mr. Michael Ferguson: As I understand it, their reason was that they needed to update their system where they tracked the information and made the payments. I guess that in order for the system to treat those as regular payments that didn't need pre-approval, they needed to make that change in the information system, and it took that long to make the change.

Mr. Don Davies: Do you have any concerns that there may be other changes in coverage, besides that example of the X-rays, that may also not have been communicated in a timely manner?

Ms. Casey Thomas: In the course of our work, we looked at 18 changes, and in three cases the changes were not updated in a timely manner. That would suggest that there could be others that also were not done in a timely manner.

Mr. Don Davies: That's three out of 18. Ten per cent of that is 1.8 so almost 20% of the time the changes are not communicated in a timely fashion. Would that be accurate?

Ms. Casey Thomas: I haven't done the math quickly in my head. I will ask the accountant to my left.

Mr. Don Davies: Don't check my math too carefully.

My other question is that in response to the 2015 AG report, Health Canada pledged to conduct a comparative analysis of access to health services in remote first nations communities and non-indigenous remote communities. Health Canada set itself a deadline of summer 2016, but we learned last spring at main estimates that this report was never, in fact, written.

In your view, would such an analysis help determine the degree to which geography presents a barrier to accessing oral health services, as was raised by Mr. McKinnon?

Mr. Joe Martire: At the time we did the report, we travelled to northern Manitoba and northern Ontario, and there are non-indigenous communities that are not that far from the indigenous communities. The objective of the program is to provide comparable services in a similar geographical area. That's the key phrase.

We asked how they knew whether they were doing this. At the time what we reported was that they didn't have the data, and they didn't have the information to know whether or not they were, in fact, meeting that objective. As you said, they committed to doing that. I'm sad to hear they haven't done it.

Definitely it's an issue we raised back in 2015. It's doable, because there is information there. Of course, that would mean working with indigenous people and the provinces to get that information, and that's what we recommended. The key is to make sure they work together, so they would have information as to whether or not they are trying to do that, because that is the program objective. It's not only for this program but also for many other programs for indigenous communities.

I would say something else, though, about the access issue in the remote communities. Again, we talked about the needs. We asked whether the indigenous people knew what services they could expect from those nursing stations. It wasn't until the end of the audit that the department had actually put together what services people could expect to receive when they visited a nursing station, so that was good progress. The problem was that the department didn't know whether each of those nursing stations had the capacity to deliver on those services. That was the outstanding piece of work. That's still an open question.

● (1715)

Mr. Don Davies: Thank you.

The Chair: That concludes our questions. I want to thank the Auditor General and the staff for coming again.

You give us the most succinct answers we get. I was just thinking you give succinct answers as does the RCMP. I'm not sure if there's a connection there or not, but we get very focused answers from you both. I think probably eventually we will do another study on indigenous health issues, but for now we really appreciate your bringing us up to date on this report and the information you gave us.

Committee members, we are going to go in camera for a few minutes because we're going to do a little committee business. It involves deciding on witnesses for our food guide study, and a budget, and so on.

Thanks very much. We'll suspend for a couple of minutes and then come back.

[*Proceedings continue in camera*]