

FIRST NATIONS AND INUIT ORAL HEALTH

**An oral presentation
to the
House of Commons Standing Committee on Health**

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3:30 to 5:30 p.m.
Room 371, West Block**

First Nations and Inuit Oral Health

Thank you for the opportunity to appear before you today. I am Susan Ziebarth, Executive Director of CDHA and I would like to introduce my CDHA health policy colleague Judy Lux.

The Canadian Dental Hygienists Association is proud to represent the voice of Canada's 14,000 dental hygienists. The association serves the public by developing national positions and standards related to dental hygiene practice, education, research and regulations. CDHA also promotes oral health for the public by working in cooperation with government, health agencies, public interest groups, and other health professions. Furthermore, CDHA provides services to its members, including continuing education, professional development, and representation on various external agencies. Through this work, the association is better able to prepare its members to effectively serve the Canadian public.

Jose Kusagak, president of the Inuit Tapiriit Kanatami emphasized the importance of providing health services in remote areas when he stated: "I believe that...the success of our health care system as a whole will be judged not by the quality of service available in the best of urban facilities, but by the equality of service Canada can provide to its remote and northern communities."ⁱ Canada unfortunately has long struggled with the challenge of providing access

to health services, including oral health services, in its vast, sparsely populated areas and its report card in this area has very low marks.

First Nations and Inuit oral health is in an appalling state. A wide gap exists between the oral health status of this population and non-Aboriginal people; in fact the dental decay rates for First Nations and Inuit people of all ages range from three to five times greater than the non-Aboriginal Canadian population. I must also mention smoking rates, since there is a link between smoking and periodontal disease. The smoking rate for First Nations and Inuit people was over twice as high as the general Canadian population.

The main thrust of my message to you today is to highlight the reasons that the Non-Insured Health Benefits (NIHB) program is failing to provide adequate oral health services to First Nations and Inuit peoples. Program flaws include underfunding, a lack of coordination of services, and difficulties with benefits administration. In addition, limited numbers of professionals work in rural and northern communities so services are sometimes non-existent or require lengthy travel. Most eligible NIHB clients don't get much oral health care; only 38 per cent see a dentist once a year, compared to 75 per cent of the rest of us. In some communities such as Moose Factory, eligible NIHB clients lack access to dental care since there are no oral health care providers in these areas. Northern towns have trouble attracting new dentists and existing dentists are opting out of the NIHB program due to the lengthy administrative requirements and red tape.

For example, in the Inuvialuit region approval for work over \$600 comes from Ottawa and this can be a lengthy wait, since x-rays must be sent by mail to Ottawa.

But human resources and administrative problems are not the only problems plaguing the program. Its mandate and a cost-benefit evaluation also reveal weaknesses. The mandate—to provide restorative treatment and some oral health promotion—does not provide adequate support for long-term preventative oral health. In addition, a cost-benefit analysis shows little value is obtained for the expenditures. A long-term oral health mandate that includes a strong element of oral health prevention can result in program financial savings since children with extensive dental disease have extensive dental disease as adults.

The one redeeming aspect of this program is its use of dental therapists who provide primary oral health care services in the territories and First Nations communities in all provinces but Ontario and Quebec. The use of dental therapists brings effectiveness and efficiencies to the program. Unfortunately, the program does not allow dental hygienists to be on the list of providers with a billing number, and even in the provinces where dental hygienists can legally practice on their own, the program refuses to make use of these independently practicing prevention professionals who can provide cost savings to the program in the long term. A dental hygienist from Sandy Lake Reserve provides a clear example of cost inefficiencies. She sees many children with cellulitis, an

infection of the soft tissue, related to dental caries. These children must take a one hour plane ride to the nearest hospital in Sioux Lookout. A dental hygienists' application of sealants and topical fluoride could prevent this costly activity, and childrens' pain and suffering.

The NIHB program has been at the forefront of government-First Nations and Inuit relations for some time. It is time to stop talking and start acting. In order to address the deficiencies mentioned, **CDHA urges** the federal government to **devote more funding** to the Community Health, NIHB and the Tobacco Control Initiative programs of the First Nations and Inuit Health Branch of Health Canada, so that

- there is an interprofessional approach to health and wellness that involves an oral health component;
- additional oral disease prevention and oral health promotion programs can be created and carried out by dental hygienists, with a billing number, including mobile dental hygienists serving remote areas;
- a comprehensive national preventive initiative can be carried out to address dental disease in young First Nations and Inuit children;
- the NIHB program can be streamlined to reduce administrative requirements;
- adequate basic oral health programs and services can be provided including necessary restoration, maintenance, prevention, and health promotion.

- dental hygienists can conduct anti-tobacco campaigns, as a cost-effective means for preventing cancer and other illnesses associated with smoking.

Concluding Remarks

These are the key policy issues that must be addressed in order to improve access to oral health services for First Nations and Inuit peoples and to narrow the gap in oral health between this population and non-Aboriginal peoples. I look forward to answering any questions that you may have in regards to my presentation.

ⁱ Inuit Tapiriit Kanatami: Verbal presentation to the Commission on the Future of Health Care in Canada, Montreal, Quebec, March 26, 2002