Introductory Remarks

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The House of Commons' Standing Committee on Indigenous and Northern Affairs

Administration and accessibility of Indigenous Peoples to the Non-Insured Health Benefits (NIHB) Program

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Thank you, Mr. Chair.

Bon après-midi à tous les membres du comité.

I am speaking to you from Toronto on the traditional territory of the Huron-Wendat, Haudenosaunee and the Anishinabek (*ah-nish-NAH-bek*) Nations, and the Mississaugas of the Credit First Nation. I am happy to be joined by Dr. Philip Poon, who leads our sub-committee on the Non-Insured Health Benefits (NIHB)program and has extensive experience on this subject. He joins us today from Winnipeg—located on Treaty One territory and the homeland of the Métis people.

At the Canadian Dental Association (CDA) we know that oral health is an essential component of overall health, and we believe that Canadians have a right to good oral health. That is why we are fully supportive of efforts by all levels of government to improve Canadians' oral health and to increase their access to dental care, especially for Canadians who need it most. CDA has long advocated for investments in Indigenous oral health and access to dental care. We have been collaborating for over a decade with officials who manage the dental component of the NIHB program and provide technical advice on its administration.

Today, we would like to offer three recommendations in the context of your current study. First, **we are calling for better access to facilities where dental treatment can be performed under general anaesthesia.** Many high needs patients—particularly children—require dental procedures performed under sedation, specifically under general anaesthesia, and this requires a surgical facility. This is often the case for Indigenous children who live in remote communities without access to regular dental care. These children often have severely decayed teeth, which can be difficult to treat in a conventional dental office setting.

Although the treatment is covered by the NIHB program, it is often a challenge to access the surgical facilities in which to provide treatment. In many cases, hospital operating rooms are used. Even prior to the pandemic, it could be challenging to find the necessary OR space or staff. Treatment was often delayed for months. This has been worsened by the toll COVID-19 has taken on the healthcare system. The resulting surgical backlog means that this issue will likely persist for some time.

One option is to make better use of private surgical facilities, which exist in many larger cities. However, these clinics often charge rates significantly higher than the N-I-H-B program's reimbursement levels or impose fees which are outside standardized system of dental treatment codes, which are not reimbursed at all. Another option could be to construct dedicated, Indigenous-run, surgical facilities in communities that serve a high number of patients that qualify for the N-I-H-B program.

Secondly, although the NIHB program compares favourably to other publicly funded provincial or territorial dental programs, some patients continue to face significant barriers in accessing care due to the program's burdensome administration. Many common treatments, such as partial dentures, require pre-authorization despite the exceptionally low rejection rates. The pre-authorization process for other treatments, such as crowns, can also be more complex under the NIHB program compared to other dental programs. This includes the federal government's Public Service Dental Care Plan (PSDCP).

Furthermore, other common services, such as night guards for bruxism (tooth grinding) are included as a service under most dental plans, such as the PSDCP, but are not covered by the NIHB program. The program has already made significant improvements in the past, such as removing the pre-authorization requirement for root canal treatment. Given that Indigenous oral health outcomes have lagged behind those of the non-Indigenous population, the NIHB program should aim to facilitate quick, efficient access to care, rather than focusing on cost-containment. **We recommend that the program conduct a comprehensive review of the administration of dental coverage to ensure that any pre-authorization requirements are in line with best practices of other dental programs, both private and public.**

Finally, CDA applauds the historic investment in Budget 2022. However, at a time when the federal government has committed to investing over $5 billion dollars in dental care for Canadians, Indigenous oral health must not be overlooked. As it currently stands, none of this funding targets the nearly one million First Nations and Inuit in Canada eligible for the NIHB program. This may actually increase the significant oral health inequities between this group, and the broader Canadian population. **The federal government should, in partnership with Indigenous governments and other relevant stakeholders, develop an oral health investment strategy to improve the oral health of Indigenous communities.** Beyond the concerns outlined earlier, this could also include investments in education and awareness campaigns, public health programs providing preventative care, as well as access to clean drinking water and community water fluoridation, to highlight a few.

Thank you for the opportunity to participate in a study of this important federal initiative. Dr. Poon and I would now be happy to answer any questions you may have.