2017 Fall Reports of the Auditor General of Canada to the Parliament of Canada

Independent Auditor's Report

Report 4—Oral Health Programs for First Nations and Inuit—Health Canada

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Introduction

Background

Health Canada's oral health programs for Inuit and First Nations people

4.1 Health Canada supports the oral health of First Nations and Inuit populations through various programs. The largest of these is the Non-Insured Health Benefits Program, which reimburses claims for medically necessary health services, including oral health services. Another program, the Children's Oral Health Initiative, promotes oral health care and offers preventive oral health services for young children in about half of the eligible communities. These programs support the Department's mandate to ensure access to health services for First Nations and Inuit populations.

4.2 Oral health surveys have found that First Nations and Inuit populations had nearly twice as much dental disease and more unmet oral health needs compared with other Canadians. This poorer oral health is linked to factors such as

- fewer regular dental visits,
- less access to affordable and nutritious food,
- higher rates of smoking,
- geographic barriers, and
- education level.

Between the 2011–12 and the 2015–16 fiscal years, the Department spent more than $200 million per year to provide services through these two programs to help First Nations and Inuit individuals improve their oral health.

4.3 **Non-Insured Health Benefits Program.** According to Health Canada's Dental Benefit Policy Framework: Non-Insured Health Benefits Program, this national program "provides coverage to registered First Nations and recognized Inuit for a limited range of medically necessary health-related goods and services not otherwise provided through private insurance plans, provincial/territorial health or social programs." The Department reimburses claims by these eligible individuals for oral health services through this program.

4.4 Health Canada and the Assembly of First Nations began a joint review of the Non-Insured Health Benefits Program in 2014 to respond to concerns raised by First Nations. The objective of the review, which is currently under way, is to identify and implement actions that

- enhance client access to benefits,
- identify and address gaps in benefits,
- streamline service delivery to be more responsive to client needs, and
- increase program efficiencies.

4.5 According to Health Canada's policy framework, the objective of the Non-Insured Health Benefits Program's dental benefit is

> to provide eligible clients with access to oral health services in a fair, equitable, and cost-effective manner that will: address oral health needs and contribute to improving the oral health status of eligible First Nations and Inuit clients; and provide coverage for a range of oral health services based on professional judgment and the client's oral health status/condition, consistent with current best practices of health services delivery, and evidence-based services and standards of care.

Health Canada's Non-Insured Health Benefits Program annual reports show that the program paid claims made by approximately 300,000 eligible Inuit and First Nations people annually.

4.6 Some dental professionals provide oral health services on a fee-for-service basis to clients covered under the program. In some regions, Health Canada also contracts dentists directly to deliver services in First Nations and Inuit communities. The Department also uses contribution agreements to fund the delivery of oral health services to eligible First Nations and Inuit clients.

4.7 According to Health Canada's Non-Insured Health Benefits Program annual reports, oral health services covered by the program include

- diagnostic services, such as exams and x-rays;
- preventive services, such as scaling, fluoride treatments, and sealants;
- restorative services, such as fillings and crowns;
- endodontic services, such as root canal treatments;
- periodontal services, such as deep scaling;
- services for removable prosthodontics, such as dentures;
- oral surgery services, such as extractions;
- orthodontic services "to correct significant irregularities in teeth and jaws"; and
- adjunctive services, such as general anesthesia and sedation.

4.8 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,
- $24 million each for preventive services and diagnostic services,
- $23 million for oral surgery services, and
- $11 million for endodontic services.

According to Health Canada, 40 percent of the oral health services covered under the Non-Insured Health Benefits Program required dental professionals to obtain the Department's approval through a predetermination process (referred to as "pre-approval" in this report) before they could provide the service. However, only 4 percent of the claims in 2015–16 required pre-approval.

4.9 **Children's Oral Health Initiative.** According to Health Canada's First Nations and Inuit Health Program Compendium 2011–2012, the objectives of the Children's Oral Health Initiative are to "reduce and prevent oral disease through prevention, education and oral health promotion" and "increase access to oral health care." The preventive services include sealants and fluoride treatments for children seven years old or younger. Oral health education is provided to children, their parents and caregivers, and pregnant women. The initiative relies on voluntary participation; it cost approximately $5.4 million in the 2014–15 fiscal year. According to Health Canada, in 2016, the initiative was provided in 238 of 452 eligible First Nations and Inuit communities. A variety of dental workers, including contract dentists, dental therapists, dental hygienists, and Children's Oral Health Initiative community workers, delivered services.

Focus of the audit

4.10 This audit focused on whether Health Canada had reasonable assurance that its oral health programs for eligible Inuit and First Nations people had a positive effect on their oral health.

4.11 This audit is important because poor oral health can have a negative effect on overall health. Therefore, it is important for Health Canada to know if its oral health programs have a positive effect.

4.12 We did not examine oral health programs and benefits delivered by other federal departments or agencies, by provincial and territorial governments, or by First Nations and Inuit communities under transfer agreements or self-governing agreements. We also did not examine decisions made by dental professionals or the quality of the oral health services and benefits provided. Nor did we examine the use of medical transportation to access oral health care or how the Department determined eligibility for dental benefits.

4.13 More details about the audit objective, scope, approach, and criteria are in **About the Audit** at the end of this report.

Findings, Recommendations, and Responses

Effect of oral health programs on Inuit and First Nations people

Overall message

4.14 Overall, we found that Health Canada monitored and analyzed the dental benefits paid for by the Non-Insured Health Benefits Program. However, the Department did not know how much of a difference it was making to Inuit and First Nations people's oral health. Despite knowing for many years about the poor oral health of Inuit and First Nations people, the Department had never finalized a strategic approach to help improve it.

4.15 The Department delivered the Children's Oral Health Initiative, which focused on prevention and helped some First Nations and Inuit children improve their oral health. However, departmental data indicated that both enrolment in the initiative and the number of services it delivered had declined. The Department did not know why.

4.16 These findings matter because Inuit and First Nations people have more unmet oral health needs than the rest of Canadians do. The Department spends more than $200 million per year on oral health services for these populations; a strategy would provide Health Canada with direction on how to meet their needs and help them to improve their oral health. Knowing what difference the programs are making would also help the Department find opportunities to improve the programs' effect on oral health.

Context

4.17 Dental disease is a preventable condition that is influenced by other determinants of health, such as smoking and access to nutritious food and clean drinking water. The goal of the Department's First Nations and Inuit Health Branch is that Inuit and First Nations communities and individuals receive health services and benefits that respond to their needs and improve their health status.

4.18 Health Canada provides access to dental services for Inuit and First Nations clients. It collects information about its oral health services and benefits in various national and regional databases—including information on Non-Insured Health Benefits Program dental claims, Children's Oral Health Initiative services, dental therapy services, and contract dentists.

Health Canada did not determine how much its dental benefit program was improving oral health

What we found

4.19 We found that Health Canada had known for many years that the oral health of First Nations and Inuit populations was much poorer than that of other Canadians. However, the Department had not finalized a strategic approach to help reduce those differences.

4.20 We also found that, while Health Canada monitored the dental benefits paid for through the Non-Insured Health Benefits Program, the Department did not determine how much of a difference the program was making to the oral health of Inuit and First Nations at the population level. Health Canada's view was that, by providing Inuit and First Nations people with coverage for evidence-based dental services, the Department was contributing to the improvement of oral health in First Nations and Inuit populations.

4.21 Our analysis supporting this finding presents what we examined and discusses the following topics:

- Oral health strategic approach
- Oral health information

Why this finding matters

4.22 This finding matters because Health Canada's oral health programs provide access to oral health services that contribute to the general overall health of Inuit and First Nations people. Furthermore, knowing the effect of these services on oral health could help the Department revise its programs to better meet its clients' needs.

Recommendations

4.23 Our recommendations in this area of examination appear at paragraphs 4.30 and 4.37.

Analysis to support this finding

4.24 **What we examined.** We examined whether Health Canada had assessed the oral health needs of its First Nations and Inuit clients and developed a strategic approach to respond to those needs. We also examined whether Health Canada monitored the available information to determine whether it provided its clients with prompt and efficient access to oral health services. Finally, we examined whether Health Canada had assessed whether its oral health programs and related services met First Nations and Inuit individuals' needs and helped them to improve their oral health.

4.25 **Oral health strategic approach.** We found that Health Canada had information in its dental claims database that it used to understand the oral health needs of Inuit and First Nations people. It also funded surveys that gathered information about First Nations and Inuit oral health.

4.26 Additionally, the Office of the Chief Dental Officer, in collaboration with the Inuit Tapiriit Kanatami, the Nunatsiavut Government, Nunavut Tunngavik Incorporated, and the Inuvialuit Regional Corporation, conducted a survey of Inuit oral health in the 2008–09 fiscal year. In 2009–10, the Office of the Chief Dental Officer also contributed its dental expertise to the First Nations Information Governance Centre's survey of First Nations oral health. Both surveys consisted of interviews and oral health examinations.

4.27 The surveys provided Health Canada with valuable data on oral health, showing that the oral health needs of Inuit and First Nations people were greater than those of the rest of the Canadian population. Notably, more than 90 percent of First Nations and Inuit adolescents had one or more teeth affected by cavities, compared with 58 percent of adolescents who were not Inuit or First Nations. Both Inuit and First Nations people were also more likely to have untreated dental issues, and fewer of them visited oral health professionals in a year.

4.28 The Department 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. The Department committed to the implementation of an oral health strategy and action plan in 2015 in its Report on Plans and Priorities. Department officials developed regional plans for oral health service delivery. They also continued to discuss a strategic approach to oral health, and in 2016, the Department hired a contractor to develop one. At the time of our audit, the Department had not finalized a strategic approach.

4.29 In our opinion, a strategic approach would provide direction for making decisions and allocating resources. This is especially important when more than one program is working toward a common goal.

4.30 **Recommendation.** Health Canada should finalize and implement a strategic approach to oral health for Inuit and First Nations people, along with a detailed action plan with specific timelines, and monitor implementation.

The Department's response. Agreed. Health Canada has already developed oral health service delivery plans to guide the delivery of oral health programs in each region. The expansion of the Children's Oral Health Initiative, announced in Budget 2017, is currently the subject of planning discussions with First Nations and Inuit partners in all regions. This work will lead to the finalization of the Oral Health Integrated Approach in the coming months.

4.31 **Oral health information.** We found that the Department monitored and analyzed the dental benefits paid for by the Non-Insured Health Benefits Program. For example, once a month, the Department tracked how many clients made claims, the number of claims made, and the related costs for each category of service (for example, preventive or restorative). We also found that the Department used the program's dental benefit information to support audits of service providers, to develop policies, and to respond to inquiries from senior management and from the Non-Insured Health Benefits Oral Health Advisory Committee, an independent advisory body of oral health professionals that provides advice and recommendations to the program.

4.32 Monitoring the use of benefits provided the Department with valuable information on clients' access to oral health services; however, in our opinion, this information would not allow the Department to determine whether the services helped to improve the oral health of Inuit and First Nations people.

4.33 The Treasury Board's Policy on Results states an expectation that departments be clear on what they are trying to achieve and how they will assess success. Moreover, an objective of the Non-Insured Health Benefits Program is to contribute to maintaining and improving First Nations and Inuit health. Working to determine whether there were any improvements in Inuit and First Nations people's oral health could help the Department meet these objectives.

4.34 We found that the Department did not have a concrete plan to determine how much of a difference the Non-Insured Health Benefits Program's dental benefit was making. This plan could include determining the information the Department needs to assess the impact of the services, how often it should be collected, and how this information could be used to adjust the dental benefits or other programs to achieve better outcomes. According to the Department, because the program covered evidence-based dental services, it is having a positive effect on its clients' oral health. Furthermore, Department officials explained that they depend on the oral health surveys that are carried out periodically (discussed in paragraphs 4.25 to 4.27) to provide the Department with information on Inuit and First Nations people's oral health.

4.35 Although Health Canada collected information in various databases on Non-Insured Health Benefits Program claims, Children's Oral Health Initiative services, dental therapy services, and contract dentists, the Department did not regularly analyze this data together to determine whether its programs and benefits improved oral health. In our opinion, conducting analyses that use information from all relevant sources would enhance the overall picture the Department has about whether its services are helping to improve oral health.

4.36 Analyzing this information could also assist with managing the oral health programs. For example, the Department had information on the services that First Nations and Inuit clients received from contract dentists in one of the regions we examined. However, according to Department officials, the region had not analyzed this information to compare the costs associated with using different types of service providers.

4.37 **Recommendation.** Health Canada should develop a concrete plan to determine how much of a difference its oral health services are making on the oral health of Inuit and First Nations people. This plan should use all the relevant information the Department collects, and should include a collaboration among all of Health Canada's programs involved in oral health.

The Department's response. Agreed. Health Canada agrees that understanding the impact of these programs on the oral health of First Nations and Inuit is important, and will continue to work with its partner organizations towards the goal of completing the population-level oral health surveys. Health Canada has well-established processes and methodologies in place to monitor the data it collects, and will engage the Non-Insured Health Benefits Oral Health Advisory Committee to provide advice on the First Nations and Inuit Health Branch's approach to analyzing all the relevant information it collects. Annually, over 300,000 clients access the evidence-based oral health services covered by the Non-Insured Health Benefits Program. Over the five-year period ending in the 2015–16 fiscal year, approximately 551,000 clients accessed the program's dental benefit (64 percent of clients overall).

The Non-Insured Health Benefits Oral Health Advisory Committee is an independent body composed of clinical and academic experts, including First Nations and Inuit dental professionals. Its mandate is to provide Health Canada with impartial, expert, professional advice on a variety of topics identified by the Non-Insured Health Benefits Program (that is, current and evolving best practices, evidence-based oral health disease prevention and treatment, and the program's oral health policy).

Health Canada will continue to refine its approach to analyzing all the relevant information it collects for the Children's Oral Health Initiative to determine the extent to which Health Canada's oral health services contribute to maintaining and improving the oral health of its First Nations and Inuit clients.

The Children's Oral Health Initiative helped some First Nations and Inuit children maintain and improve their oral health

What we found

4.38 The Children's Oral Health Initiative provides access to important preventive services that help children maintain and improve their oral health. We found that Health Canada analyzed data from the initiative and determined that it had had a positive effect on the oral health outcomes of participating children in the communities where it was offered. However, departmental data also showed that the number of children enrolled in the initiative had declined over the past three years along with the numbers of services provided. We found that the Department was not sure why this had occurred.

4.39 Our analysis supporting this finding presents what we examined and discusses the following topics:

- Children's oral health
- Targets for participation and service delivery

Why this finding matters

4.40 This finding matters because the Children's Oral Health Initiative delivers preventive services that are vital to children's oral health. Assessing this initiative and the effect of its services is necessary for Health Canada to determine how the program could be improved. Declining enrolments might indicate problems that Health Canada is unaware of in the management of the initiative or in the Department's communication with eligible communities.

Recommendation

4.41 Our recommendation in this area of examination appears at paragraph 4.47.

Analysis to support this finding

4.42 **What we examined.** We examined whether Health Canada, through the Children's Oral Health Initiative, met First Nations and Inuit children's needs and helped them to maintain and improve their oral health. We also examined whether the Department met the initiative's targets for service delivery.

4.43 **Children's oral health.** We found that Health Canada monitored the oral health of children participating in the Children's Oral Health Initiative. The Department had determined that children living in communities where the initiative had been in place for eight years had fewer decayed teeth and more teeth that had been treated (for example, with fillings and extractions), which it considered indications that the children's general oral health was better. Furthermore, a Health Canada analysis found that children living in communities where the initiative was in place needed fewer restorative procedures (such as fillings) and dental surgeries than other First Nations and Inuit children.

4.44 **Targets for participation and service delivery.** Health Canada's data for the school years ending in 2014, 2015, and 2016 showed that the Children's Oral Health Initiative had not met its enrolment targets, but that it had met most of its targets for the delivery of preventive services (Exhibit 4.1). In the 2015–16 fiscal year, the initiative enrolled 38 percent of eligible children who were four years old and younger and 40 percent of children aged five, six, and seven—short of its targets of 40 percent and 70 percent, respectively, for these age groups. For preventive services in that same year, the initiative exceeded its targets for screenings for enrolled children in both age groups and for fluoride varnishes for the older group. However, it provided fluoride to 55 percent of enrolled children four years old and younger, falling short of its target of 70 percent. Furthermore, the number of children enrolled in the Children's Oral Health Initiative had declined by almost 30 percent since 2014, and the number of preventive services delivered through the initiative declined during these years. For example, the initiative delivered about 20 percent fewer fluoride applications in 2016 than it did in 2014.

Exhibit 4.1—Health Canada met only some of its Children's Oral Health Initiative targets for participation and for delivery of services

Objective of Children's Oral Health Initiative	Age group (years)	Children's Oral Health Initiative target	Performance against target (national)
Enrolment: Signed authorization forms and up-to-date medical histories	0 to 4	40% of eligible children	Not met
	5 to 7	70% of eligible children	Not met
Preventive services: Oral health screening completed	0 to 4	90% of authorized children	Met
	5 to 7	90% of authorized children	Met
Preventive services: All required fluoride varnish applications completed	0 to 4	70% of screened children	Not met
	5 to 7	70% of screened children	Met

Source: Based on Health Canada information

4.45 We found that the Department had not analyzed its information to determine why the numbers for enrolment and services provided had decreased. However, Department officials informed us that the apparent decline in enrolment might reflect poor quality in data collection and recording, such as not properly entering authorization forms into the dental database. Nonetheless, they did not know why this might have occurred.

4.46 In 2017, the Department drafted a strategy to address its data collection issues, but the strategy has yet to be finalized. The Department has recognized that the current dental database requires fundamental changes before it can be used for proper data collection, analysis, and reporting. This would be an even greater challenge if the Children's Oral Health Initiative were expanded.

4.47 **Recommendation.** Health Canada should improve its analysis of data, including the information that is collected and recorded in its dental database, so that its information on the Children's Oral Health Initiative is accurate and comprehensive enough to contribute to the Department's overall management of its oral health programs.

The Department's response. Agreed. Health Canada will continue to improve its data analysis by implementing the Strategies to Improve Oral Health Data Collection, Analysis, and Reporting for First Nations and Inuit Health Branch's dental programs to inform program management decision making in alignment with the Oral Health Integrated Approach.

Program management

Overall message

4.48 Overall, we found that there were administrative weaknesses in Health Canada's management of its Non-Insured Health Benefits Program. Health Canada's service standards for making decisions on pre-approvals and complex appeals were not clear. We found that the Department was meeting its service standard for appeals 80 percent of the time, but we were unable to rely on the Department's appeal database to determine this. We also found that Health Canada did not always inform clients and service providers promptly about some of the changes it made to its services.

4.49 Furthermore, despite a long-standing awareness of upcoming shortages in dental therapists in two regions, Health Canada has been slow in taking action to address this issue.

4.50 These findings matter because delayed or unclear communication can affect clients' expectations about what oral health services are available to them and how long they must wait for decisions. Furthermore, without action on human resource challenges, delivery of oral health services could be affected.

Context

4.51 According to Health Canada, the Non-Insured Health Benefits Program dental benefit covers evidence-based services that are medically necessary, and not cosmetic services. Health Canada employs dental professionals to carry out a variety of tasks, including reviewing appeals and pre-approvals, analyzing data, and providing advice to senior management. The Department has governance documents that contain the guidelines, policies, and criteria for the program's dental benefits. These documents include controls for some of the oral health services covered by the program, such as frequency limits or requirements that dentists obtain pre-approval from the Department before providing the service. When the program denies a request for pre-approval of an oral health service, the client can appeal the decision. It also has service standards for pre-approvals and appeals.

4.52 Both the Non-Insured Health Benefits Program and the Children's Oral Health Initiative rely on a mix of service providers, only some of whom are employed by the Department, to deliver oral health services.

Health Canada's framework for decision making did not include which elements should be considered when making changes to its list of dental benefits

What we found

4.53 We found that Health Canada's framework for decision making did not include all the elements that the Department should consider when making changes to its list of oral health services covered by the Non-Insured Health Benefits Program. Nor did the Department specify how to document decisions or who would be responsible for their final approval, in some cases. In a few cases, we also found lengthy delays between a decision to change a benefit—for example, frequency limits or criteria—and the implementation of the change.

4.54 Our analysis supporting this finding presents what we examined and discusses the following topic:

- Decisions to make changes to the list of oral health services

Why this finding matters

4.55 This finding matters because decisions to make changes to the list of oral health services covered by the Non-Insured Health Benefits Program affect which services are available to clients. It is important to have a documented process, based on clear criteria, so that the Department can make such decisions about its list of dental services consistently. Furthermore, delayed or unclear communication can affect clients' expectations about what oral health services are available to them.

Recommendation

4.56 Our recommendation in this area of examination appears at paragraph 4.63.

Analysis to support this finding

4.57 **What we examined.** We examined whether Health Canada had a formal process to make decisions about changes to the list of oral health services covered by the Non-Insured Health Benefits Program. We also examined whether Health Canada considered elements such as cost-effectiveness in its decisions, and whether these were documented. We reviewed the changes the Department made to oral health services from 2014 to 2016, including changes to frequency limitations and pre-approval requirements. We did not examine decisions on individual clients' requests for services.

4.58 **Decisions to make changes to the list of oral health services.** Health Canada had a list of oral health services covered by the Non-Insured Health Benefits Program. Some of the eligible services included specific criteria to define when the service was necessary. For example, to qualify for a crown or a root canal, an individual would have to meet detailed medical criteria that set out which teeth were eligible and under what conditions. Some services were also subject to controls, such as frequency limits or a requirement for pre-approval. The list of eligible services, their criteria, and their controls were published on the Department's website.

4.59 We found that the Department had documented the process it used to decide whether to make changes to the list of eligible oral health services covered by the Non-Insured Health Benefits Program. However, this process did not identify what Department officials should consider when deciding whether to make such changes. For example, although the process indicated that in-depth analysis should be conducted, it did not explain what this analysis should involve. Nor did the process clearly indicate how decisions should be documented or who should approve them, in some cases. For example, the process indicated that decisions that could create major financial or political risks should be approved by Health Canada's First Nations and Inuit Health Branch Senior Management Committee. However, it did not set a threshold for what constituted a "major" risk.

4.60 From 2014 to 2016, the Department made decisions to change some of the oral health services it covered. These decisions were largely about changing controls. For example, some decisions we looked at increased the limits on how frequently a service could be covered, while others removed the pre-approval requirement for certain services. Department officials told us that these changes were made to improve client access to services.

4.61 We found inconsistencies in how the Department documented the 13 decisions it made in that period: While 8 had signed records of decision, 5 did not, meaning that we could not determine when or by whom those decisions were made. Furthermore, the documentation of the factors that were considered varied; for example, the documentation for only some of the changes clearly showed the expected effects of the proposed changes on costs.

4.62 We also found that Health Canada did not promptly inform clients and service providers about three of the changes it made to its services in that period. For example, in 2014, the Department increased the number of a type of radiograph it would cover from 6 to 10 per year, but did not make the change public until 2016. The Department explained that, after a change to a service, it could take a long time to update the related claim database. In these cases, the Department did not always announce the changes while it waited for the database to be updated. Department officials told us that service providers who asked for pre-approvals within the new frequency limits would be approved, and that providers had the option to ask for pre-approval for services that did not meet the published criteria. In our opinion, this delay in communicating updated criteria or frequency limits created a risk that providers did not have up-to-date information on the oral health services available to clients.

4.63 **Recommendation.** Health Canada's process for making changes to its list of oral health services covered by the Non-Insured Health Benefits Program should

- include which elements should be considered,
- include requirements to document when and how decisions are made,
- specify who has final approval for all such decisions, and
- include quickly updating providers and clients on changes.

The Department's response. Agreed. Health Canada has detailed documentation in place, such as its Dental Benefits Policy Framework: Non-Insured Health Benefits Program and evidence-based guidelines, to govern decision making related to dental benefits. One of these documents—the Policy Review and Development Process for Dental Benefits—has been revised in light of the findings of this audit to be more specific about the elements that must be considered when making policy changes. Additionally, the Non-Insured Health Benefits Program will adapt the process for updating clients and service providers of changes in a timely manner.

Health Canada's service standards for pre-approvals and complex appeals were unclear, but it met its service standard for appeals most of the time

What we found

4.64 We found that Health Canada's service standards for pre-approvals and complex appeals were unclear. We also found that the Department's appeal database could not be relied on for accurate information to calculate processing timelines. Our review of a sample of appeal files found that the Department met its service standards for appeals 80 percent of the time.

4.65 Our analysis supporting this finding presents what we examined and discusses the following topics:

- Pre-approvals
- Appeals

Why this finding matters

4.66 This finding matters because, without clear service standards and accurate information on processing timelines in its database, the Department cannot be sure that it is meeting those service standards, or that clients and providers understand them.

Recommendation

4.67 Our recommendation in this area of examination appears at paragraph 4.72.

Analysis to support this finding

4.68 **What we examined.** We examined whether Health Canada processed requests for pre-approvals and appeals of decisions under the Non-Insured Health Benefits Program dental benefit within its service standards.

4.69 **Pre-approvals.** According to Health Canada, in the 2015–16 fiscal year, 4 percent of the oral health services the Non-Insured Health Benefits Program paid for required pre-approval. Health Canada had a published service standard specifying that the program would make pre-approval decisions within 10 business days from the date of receipt of complete information. In our opinion, Health Canada's clients could interpret this service standard as a commitment to provide each client with a decision within 10 business days. In fact, Health Canada does not measure its service standard by individual client. Health Canada indicated that information on turnaround times for individual cases was readily available and could be provided to clients if they contacted the Department directly.

4.70 **Appeals.** Health Canada published a service standard of 30 business days to make a decision about an appeal. Health Canada has stated that complex appeals can take longer to process, but did not clearly explain what constitutes a complex appeal. Without this explanation, clients cannot know whether their appeals are "complex," and therefore, how long they should expect to wait for a response.

4.71 According to the Department's statistics, there were 3,599 appeals from 2014 to 2016. We used representative sampling to compare the original paper files of 85 appeal cases with their corresponding database entries to determine whether we could rely on the Department's database. We found that we could not, because the database contained many administrative errors; notably, on average, 30 percent of the dates had been entered incorrectly. We therefore used our sample to calculate whether the Department had met its service standard for appeals. We found that Health Canada had processed 68 of 85 appeals (80 percent) within 30 business days. Of the 17 appeals that did not meet the service standard, 15 were for orthodontics.

4.72 **Recommendation.** To improve its program management for the Non-Insured Health Benefits Program dental benefit, Health Canada should

- clarify what its service standard for pre-approvals is measuring;
- clarify the service standard for complex appeals; and
- improve its data entry, so that it has accurate and reliable information in its appeal database.

The Department's response. Agreed. Health Canada will review its program management processes and will develop communications for clients, partners, and providers regarding its timelines for reviewing predeterminations and appeals. Furthermore, the Department will continue to improve data entry accuracy pertaining to its administrative appeals database. The procurement process for the new Health Information and Claims Processing Services system is looking to integrate the appeals process within this system.

Health Canada was slow to take action on human resource challenges in two of its regions

What we found

4.73 We found that, in the two regions we examined, Health Canada was slow to take action to address human resource challenges.

4.74 Our analysis supporting this finding presents what we examined and discusses the following topics:

- Contract dentists
- Dental therapists

Why this finding matters

4.75 This finding matters because, although they are small in number compared with other groups of oral health professionals, contract dentists and dental therapists are important to Health Canada's delivery of oral health services. Contract dentists and dental therapists facilitate access to oral health care in First Nations and Inuit communities. Dental therapists are community-based professionals who can provide more services than some oral health professionals, such as dental hygienists. Without action to address difficulties in recruiting contract dentists—and with an impending shortage of dental therapists to deliver oral health services, including the Children's Oral Health Initiative—eligible First Nations and Inuit children and their communities might not receive the services they need to reduce and prevent oral disease.

Recommendation

4.76 Our recommendation in this area of examination appears at paragraph 4.85.

Analysis to support this finding

4.77 **What we examined.** We examined whether Health Canada had developed human resource plans that identified how current and future oral health services would be delivered. We also examined whether Health Canada had implemented any of the strategies outlined in such plans.

4.78 **Contract dentists.** Health Canada uses various types of service providers across seven of its regions. The Department relies primarily on dentists to provide services, but it cannot require them to participate in the Non-Insured Health Benefits Program; nor can it plan for the number of providers who register with the program.

4.79 Health Canada may provide oral health services through contract dentists who travel to communities. Clients may also travel to locations outside their communities to receive oral health care. In the two regions we looked at, Health Canada tried to address the lack of local dental providers by using contract dentists. For example, one of these regions used 28 contract dentists to provide services in 27 communities.

4.80 We found that one of the two regions we examined had determined that not enough contract dentists were available to provide services in the communities it served.

4.81 The regional office indicated that recruiting more contract dentists would allow it to expand dental services in communities. While it had developed some short- and long-term strategies, such as better accommodations for dental professionals, it had not implemented these strategies. Without such implementation, individuals living in communities that do not have local service providers must travel to access oral health services. We also found that, according to Department officials, the region had not analyzed the costs and benefits of using contract dentists relative to other types of service providers.

4.82 **Dental therapists.** Health Canada also used dental therapists to provide services in communities in four of seven of its regions. Dental therapists in these communities focus primarily on the needs of children, but can also provide services to adults. According to the Department, as of the end of 2016, Health Canada relied on 82 community-based dental therapists, employed by either the Department or the communities, to deliver Children's Oral Health Initiative services in collaboration with the initiative's community workers. The Northern region used dental therapists, but they were not Health Canada employees or funded through a contribution agreement. The two remaining regions used a mix of dental professionals to deliver services to children through the initiative.

4.83 The Department stopped funding the National School of Dental Therapy, the only dental therapy school in the country, on the grounds that direct funding of post-secondary education was outside of Health Canada's mandate. The school closed in 2011. The Department has estimated that about 25 percent of its dental therapists would be eligible to retire by 2020.

4.84 Health Canada had known about the impending high rate of retirements of dental therapists for several years and started to develop strategies to address this in 2009. We found that one region had recently requested funds for some of these strategies. For the other region, this was not the case, despite the fact that several dental therapist positions were already vacant. Department officials told us that Health Canada continues to pursue discussions and strategies to address this issue.

4.85 **Recommendation.** Health Canada should implement strategies to ensure that it has the human resources it needs to deliver oral health programs and related services to First Nations and Inuit populations over the long term. These strategies could incorporate the use of a variety of professionals and adopt practices from other regions, where applicable.

The Department's response. Agreed. Health Canada relies on a variety of oral health professionals (such as dentists, dental hygienists, and dental therapists) to provide access to oral health services for its clients and continues to work with partners and stakeholders to increase oral health provider enrolment. Additionally, Health Canada has participated in discussions with partners regarding opportunities to ensure and improve access to oral health care services in First Nations and Inuit communities over the long term.

Health Canada will ensure that foreseeable shortages are addressed through contingency plans developed by regions facing such a challenge.

Conclusion

4.86 We concluded that while Health Canada provided Inuit and First Nations people with access to important oral health services, the Department did not demonstrate how much its oral health programs helped maintain and improve the overall oral health of Inuit and First Nations at the population level.

About the Audit

This independent assurance report was prepared by the Office of the Auditor General of Canada on Health Canada's dental benefit under the Non-Insured Health Benefits Program and on its Children's Oral Health Initiative. Our responsibility was to provide objective information, advice, and assurance to assist Parliament in its scrutiny of the government's management of resources and programs, and to conclude on whether the Department's provision of access to oral health services complied in all significant respects with the applicable criteria.

All work in this audit was performed to a reasonable level of assurance in accordance with the Canadian Standard for Assurance Engagements (CSAE) 3001—Direct Engagements set out by the Chartered Professional Accountants of Canada (CPA Canada) in the CPA Canada Handbook—Assurance.

The Office applies Canadian Standard on Quality Control 1 and, accordingly, maintains a comprehensive system of quality control, including documented policies and procedures regarding compliance with ethical requirements, professional standards, and applicable legal and regulatory requirements.

In conducting the audit work, we have complied with the independence and other ethical requirements of the Rules of Professional Conduct of Chartered Professional Accountants of Ontario and the Code of Values, Ethics and Professional Conduct of the Office of the Auditor General of Canada. Both the Rules of Professional Conduct and the Code are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality, and professional behaviour.

In accordance with our regular audit process, we obtained the following from management:

- confirmation of management's responsibility for the subject under audit;
- acknowledgement of the suitability of the criteria used in the audit;
- confirmation that all known information that has been requested, or that could affect the findings or audit conclusion, has been provided; and
- confirmation that the audit report is factually accurate.

Audit objective

The objective of this audit was to determine whether Health Canada had reasonable assurance that it delivered oral health programs to eligible Inuit and First Nations people that helped to maintain and improve their oral health.

Scope and approach

The audit focused on Health Canada's Non-Insured Health Benefits Program dental benefit and Children's Oral Health Initiative. The audit focused on two key aspects of these programs: program management, including human resource planning, and the design of the programs.

To assess whether Health Canada had reasonable assurance that its oral health programs for eligible First Nations and Inuit populations were designed to help them maintain and improve their oral health, we examined Health Canada's assessment of Inuit and First Nations people's oral health needs as well as Health Canada's strategy to address these needs. We also examined the Department's processes for deciding which services to include in the programs. This included an examination of what was considered when the Department made decisions about its dental benefits in 2014, 2015, and 2016.

To assess whether Health Canada had reasonable assurance that it provided First Nations and Inuit individuals with access to efficient and timely oral health programs and related services that responded to their oral health needs and helped them to maintain and improve their oral health, we also examined how Health Canada monitored Non-Insured Health Benefits Program dental benefit claims and conducted our own analyses of claim data and other oral health information. We examined whether Health Canada met service standards for pre-approvals and appeals within the Non-Insured Health Benefits Program's dental benefit and, similarly, whether it met its goals for providing preventive oral health care to young children through the Children's Oral Health Initiative. We also examined whether the Department measured the outcomes of its program delivery and used that information to make necessary quality improvements.

Where representative sampling was used, samples were sufficient in size to conclude on the sampled population with a confidence level of at least 90 percent and a margin of error of no more than ± 10 percent.

To assess whether Health Canada had a plan to acquire and maintain adequate human resources to deliver oral health programs and related services that would meet the needs of eligible Inuit and First Nations people and help them to maintain and improve their oral health, we examined human resource plans for oral health programs as well the implementation of any strategies outlined in these plans. We focused on two of Health Canada's regional offices for this work.

The audit included three First Nations community visits and discussions with representatives from First Nations, Inuit, and dental professional organizations.

The audit involved reviewing and analyzing key documents and interviewing Department officials at headquarters and in the Manitoba and Atlantic regional offices. It also included testing samples of appeal files and analyzing information in the Department's oral health databases.

The audit scope did not include examinations of

- oral health programs and benefits delivered by other federal departments and agencies, by provincial and territorial governments, or by First Nations and Inuit communities under transfer agreements or self-governing agreements;
- decisions made by dental professionals or the quality of oral health services and benefits provided;
- the use of medical transportation to access oral health care;
- how the Department determined eligibility for dental benefits;
- Health Canada's award or management of a contract with Express Scripts Canada to administer the claim processing system for the Non-Insured Health Benefits Program;
- public health education; or
- social determinants of health.

Criteria

To determine whether Health Canada had reasonable assurance that it delivered oral health programs to eligible Inuit and First Nations people that helped to maintain and improve their oral health, we used the following criteria:

Criteria	Sources

Criteria	Sources
Health Canada has reasonable assurance that oral health programs and related services for eligible Inuit and First Nations people are designed to respond to their needs and help them to maintain and improve their oral health.	• First Nations and Inuit Health Strategic Plan, Health Canada • Dental Benefit Policy Framework: Non-Insured Health Benefits Program, Health Canada, 2014 • First Nations and Inuit Health Program Compendium 2011–2012, Health Canada
Health Canada has developed a plan to acquire and maintain adequate human resources to deliver oral health programs and related services that meet the needs of its First Nations and Inuit clients and help them maintain and improve their oral health.	• Integrated Planning Handbook for Deputy Ministers and Senior Managers, Treasury Board of Canada Secretariat • First Nations and Inuit Health Strategic Plan, Health Canada • 2013–2016 Health Canada Human Resources Strategic Plan • Dental Benefit Policy Framework: Non-Insured Health Benefits Program, Health Canada, 2014
Health Canada has reasonable assurance that it provides access to efficient and timely oral health programs and related services to First Nations and Inuit individuals that respond to their oral health needs and help them to maintain and improve their oral health.	• First Nations and Inuit Health Strategic Plan, Health Canada • First Nations and Inuit Health Program Compendium 2011–2012, Health Canada

Period covered by the audit

The audit covered the period between September 2013 and December 2016. This is the period to which the audit conclusion applies. However, to gain a more complete understanding of the subject matter of the audit, we also examined certain matters that preceded the starting date of the audit and considered program-related decisions that occurred after 2016.

Date of the report

We obtained sufficient and appropriate audit evidence on which to base our conclusion on 26 September 2017, in Ottawa, Ontario.

Audit team

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List of Recommendations

The following table lists the recommendations and responses found in this report. The paragraph number preceding the recommendation indicates the location of the recommendation in the report, and the numbers in parentheses indicate the location of the related discussion.

Effect of oral health programs on Inuit and First Nations people

Recommendation	Response
4.30 Health Canada should finalize and implement a strategic approach to oral health for Inuit and First Nations people, along with a detailed action plan with specific timelines, and monitor implementation. **(4.19–4.29)**	**The Department's response.** Agreed. Health Canada has already developed oral health service delivery plans to guide the delivery of oral health programs in each region. The expansion of the Children's Oral Health Initiative, announced in Budget 2017, is currently the subject of planning discussions with First Nations and Inuit partners in all regions. This work will lead to the finalization of the Oral Health Integrated Approach in the coming months.
4.37 Health Canada should develop a concrete plan to determine how much of a difference its oral health services are making on the oral health of Inuit and First Nations people. This plan should use all the relevant information the Department collects, and should include a collaboration among all of Health Canada's programs involved in oral health. **(4.31–4.36)**	**The Department's response.** Agreed. Health Canada agrees that understanding the impact of these programs on the oral health of First Nations and Inuit is important, and will continue to work with its partner organizations towards the goal of completing the population-level oral health surveys. Health Canada has well-established processes and methodologies in place to monitor the data it collects, and will engage the Non-Insured Health Benefits Oral Health Advisory Committee to provide advice on the First Nations and Inuit Health Branch's approach to analyzing all the relevant information it collects. Annually, over 300,000 clients access the evidence-based oral health services covered by the Non-Insured Health Benefits Program. Over the five-year period ending in the 2015–16 fiscal year, approximately 551,000 clients accessed the program's dental benefit (64 percent of clients overall). The Non-Insured Health Benefits Oral Health Advisory Committee is an independent body composed of clinical and academic experts, including First Nations and Inuit dental professionals. Its mandate is to provide Health Canada with impartial, expert, professional advice on a variety of topics identified by the Non-Insured Health Benefits Program (that is, current and evolving best practices, evidence-based oral health disease prevention and treatment, and the program's oral health policy). Health Canada will continue to refine its approach to analyzing all the relevant information it collects for the Children's Oral Health Initiative to determine the extent to which Health Canada's oral health services contribute to maintaining and improving the oral health of its First Nations and Inuit clients.
4.47 Health Canada should improve its analysis of data, including the information that is collected and recorded in its dental database, so that its information on the Children's Oral Health Initiative is accurate and comprehensive enough to contribute to the Department's overall management of its oral health programs. **(4.38–4.46)**	**The Department's response.** Agreed. Health Canada will continue to improve its data analysis by implementing the Strategies to Improve Oral Health Data Collection, Analysis, and Reporting for First Nations and Inuit Health Branch's dental programs to inform program management decision making in alignment with the Oral Health Integrated Approach.

Program management

Recommendation	Response

Recommendation	Response
4.63 Health Canada's process for making changes to its list of oral health services covered by the Non-Insured Health Benefits Program should • include which elements should be considered, • include requirements to document when and how decisions are made, • specify who has final approval for all such decisions, and • include quickly updating providers and clients on changes. **(4.53–4.62)**	**The Department's response.** Agreed. Health Canada has detailed documentation in place, such as its Dental Benefits Policy Framework: Non-Insured Health Benefits Program and evidence-based guidelines, to govern decision making related to dental benefits. One of these documents—the Policy Review and Development Process for Dental Benefits—has been revised in light of the findings of this audit to be more specific about the elements that must be considered when making policy changes. Additionally, the Non-Insured Health Benefits Program will adapt the process for updating clients and service providers of changes in a timely manner.
4.72 To improve its program management for the Non-Insured Health Benefits Program dental benefit, Health Canada should • clarify what its service standard for pre-approvals is measuring; • clarify the service standard for complex appeals; and • improve its data entry, so that it has accurate and reliable information in its appeal database. **(4.64–4.71)**	**The Department's response.** Agreed. Health Canada will review its program management processes and will develop communications for clients, partners, and providers regarding its timelines for reviewing predeterminations and appeals. Furthermore, the Department will continue to improve data entry accuracy pertaining to its administrative appeals database. The procurement process for the new Health Information and Claims Processing Services system is looking to integrate the appeals process within this system.
4.85 Health Canada should implement strategies to ensure that it has the human resources it needs to deliver oral health programs and related services to First Nations and Inuit populations over the long term. These strategies could incorporate the use of a variety of professionals and adopt practices from other regions, where applicable. **(4.73–4.84)**	**The Department's response.** Agreed. Health Canada relies on a variety of oral health professionals (such as dentists, dental hygienists, and dental therapists) to provide access to oral health services for its clients, and continues to work with partners and stakeholders to increase oral health provider enrolment. Additionally, Health Canada has participated in discussions with partners regarding opportunities to ensure and improve access to oral health care services in First Nations and Inuit communities over the long term. Health Canada will ensure that foreseeable shortages are addressed through contingency plans developed by regions facing such a challenge.