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Chair

The Honourable Kevin Sorenson

Standing Committee on Public Accounts

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● (1530)

[*English*]

The Chair (Hon. Kevin Sorenson (Battle River—Crowfoot, CPC)): Good afternoon, colleagues.

This is meeting 90 of the Standing Committee on Public Accounts for Thursday, March 22, 2018.

Today we are here to consider "Report 4: Oral Health Programs for First Nations and Inuit—Health Canada" of the fall 2017 reports of the Auditor General of Canada.

I would remind all of our guests as well as members of our committee and those in the audience today that we are televised.

I welcome our witnesses today. We have the Auditor General of Canada, Mr. Michael Ferguson. Welcome back. As well, from the Office of the Auditor General, we have Jo Ann Schwartz, Principal. Welcome to you.

From the Department of Indian Affairs and Northern Development, we have Jean-François Tremblay, Deputy Minister; Sony Perron, Associate Deputy Minister; David Peckham, Chief Audit and Evaluation Executive, Audit and Evaluation Sector; as well as Marc Plante, Manager, Dental Policy, First Nations and Inuit health Branch.

Colleagues, I would like to point out that when this audit was undertaken by the Office of the Auditor General, the authority and responsibility for first nation and Inuit oral health programs fell under the purview of the first nations and Inuit health branch within Health Canada. Due to an order in council dated November 30, 2017, it is now under the purview of the Department of Indigenous Services Canada, and thus the reason we have officials from the Department of Indian and Northern Development here as opposed to from Health Canada.

We welcome our guests today. I open the floor and turn it to Mr. Ferguson, our Auditor General.

Welcome.

[*Translation*]

Mr. Michael Ferguson (Auditor General of Canada, Office of the Auditor General): Mr. Chair, thank you for this opportunity to present the results of our audit on oral health programs for First Nations and Inuit.

In our audit of Health Canada's oral health programs, we focused on whether the department knew if its programs, the non-insured health benefits program and the children's oral health initiative, 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 the services contributed to their objective 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 that of 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 in the populations it served.

● (1535)

[*English*]

We found that Health Canada knew 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 showed that fewer children were enrolled and fewer services were provided under the initiative than in previous years. Health Canada didn't know why this was the case, making it difficult to address the situation.

We also found 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 weren't clear. Also, Health Canada didn't 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. If unaddressed, 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, an effort it began in 2010. We also recommended that it should develop a concrete plan to determine how much difference its programs are making to the oral health of Inuit and first nations people.

[*Translation*]

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

Now that these oral health programs are the responsibility of Indigenous Services Canada, we understand that it intends to fulfill the commitment made by Health Canada.

[*English*]

Mr. Chair, this concludes my opening remarks. I would be pleased to answer any questions the committee may have.

The Chair: Thank you very much, Mr. Ferguson.

We'll now turn to you, Mr. Tremblay. We look forward to your comments.

[*Translation*]

Mr. Jean-François Tremblay (Deputy Minister, Department of Indian Affairs and Northern Development): I would like to thank the committee chair and the rest of the members of the public accounts committee for the invitation to speak here today. I would also like to acknowledge at the outset that we are meeting on the traditional territory of the Algonquin Nation.

I am accompanied today by Sony Perron, Associate Deputy Minister, Dr. Plante, Dental Policy Manager, and David Peckham, Chief Audit and Evaluation Executive.

I want to assure committee members that officials from Indigenous Services Canada welcome the recommendations of the Auditor General of Canada's oral health report and are fully committed to their implementation with First Nations and Inuit partners.

Oral health services for First Nations and Inuit funded by Indigenous Services Canada reach a significant number of people. Last year, more than 300,000 First Nations people and Inuit received dental benefit services through the non-insured health benefits program, while the children's oral health initiative provided oral health services to 237 First Nations and Inuit communities.

It is important to note, however, that these numbers do not include First Nations service by the First Nations Health Authority in British Columbia, which began to administer all federally funded First Nations health programs in 2013.

In all other provinces and territories, Indigenous Services Canada relies on an interdisciplinary team or oral health professionals to both advise and manage the suite of oral health programs and services to ensure that they reflect the current evidence base.

[*English*]

The children's oral health initiative provides direct clinical preventive oral health services for children, including screening, application of fluoride varnish to prevent decay, placement of sealants on teeth to help prevent tooth decay, sterilization therapy to stop the progression of cavities, and the provisions of oral health information sessions at the community level.

In 2016, through the children's oral health initiatives, 16,000 children received dental screening and 10,677 children received at least two fluoride treatment applications. According to the recent published national report, the “First Nations Regional Health Survey”, access to oral health care for first nations children aged zero to 11 living on reserve and in northern communities has increased from 69.1% in phase one of the RHS to 71.4% in 2015-16.

Based on the strength of existing programs, new funding was received in budget 2017 to support the increased utilization of non-insured health benefits and to invest $45.5 million over five years to expand the children's oral health initiatives. Following regional engagements with first nation and Inuit partners, the department has developed detailed implementation plans for these investments, which will result in greater first nations and Inuit access to oral health and at the community level.

● (1540)

[*Translation*]

As recommended by the Auditor General, the department is also completing a comprehensive plan to improve measurement of the impacts of First Nations and Inuit oral health programs, including data collection, analysis and reporting.

The plan will help to ensure that data collected in the course of the delivery of services under the children's oral health initiative and dental therapy programs are accurate and rich enough to contribute to the department's overall management and quality assurance of these services.

[*English*]

To ensure that population-level oral health data are also available, the department is working with the Public Health Agency of Canada's Office of the Chief Dental Officer, Statistics Canada, and first nation and Inuit partners to explore the feasibility of conducting new first nations and Inuit oral health surveys. This could dovetail with an oral health component of the Canadian Health Measures Survey cycle in 2022 and 2023.

The department has also sought the advice of the non-insured health benefit program oral health advisory committees on ways to improve its oral health data collection and analysis. The committee is composed of highly qualified, independent oral health professionals and academic specialists. It provides the department with impartial expert advice on a variety of topics, including current and evolving best practices, evidence-based oral health prevention and treatment, non-insured health benefits oral health policy, and clinical technologies and procedures. We have recently received feedback from the committee, which we are incorporating into our oral health data plan.

In addition, there is research funded by the Canadian Institutes of Health Research that aims to evaluate the impact of the children's oral health initiative in first nations and Inuit communities across the country. The department intends to review the findings of this research to identify further service improvements.

Regarding the integrated oral health approach,

[*Translation*]

The Auditor General recommends that the department finalize and implement a more strategic approach to First Nations and Inuit oral health and actively monitor its implementation. The approach would be accompanied by a detailed action plan to be delivered by June 2018.

In an effort to reduce the oral health disparities experienced by First Nations and Inuit, the department is leveraging the opportunity under this new integrated oral health approach to set evidence-based targets in discussions with First Nations and Inuit partners that will measure progress in reducing these disparities.

Getting these targets will require the department to better mine the data captured across its programs to create a more robust and holistic profile of First Nations and Inuit oral health needs and outcomes.

[*English*]

The strategic approach takes culture, context, and the social determinants of health into consideration.

The integrated oral health approach is in its final stages of development and will be presented for approval in June 2018 to the first nations and Inuit health branch's senior management committee. Members of the committee include the Assembly of First Nations and Inuit Tapiriit Kanatami.

On service standards, decision-making and communications, the Auditor General also calls on the department to better document when and how decisions are made by the non-insured health benefits program to change the coverage of health benefits. In particular, the Auditor General specifies that both service providers and clients need to be advised quickly of these changes.

We accept this recommendation.

[*Translation*]

An evergreen decision-making process map and governance documents were revised in 2017 that solidify management processes with respect to policy coverage.

To improve program management, the Auditor General recommends that the department clarify its service standard for pre-approvals, clarify the service standard for complex appeals, and improve data entry, so that it has accurate and reliable information in its appeals database.

Mr. Chair, we also accept this recommendation.

● (1545)

[*English*]

Evergreen client and provider communication process maps are under development and will be finalized in April 2018. Information for clients and providers will be provided in a clearer and more timely manner.

The department further revised the appeals section on its website, including clearly stated service standards for appeals. Quality assurance processes are currently being developed and implemented to ensure improved data entry in the appeals database. The department is also in the process of revising its service standard for dental predeterminations.

Now, I'll turn to responding to human resources challenges.

Lastly, the Auditor General recommends that the department implement strategies to ensure there is adequate human resources capacity to deliver first nations and Inuit oral health programs over the long term.

We, of course, accept this recommendation. To respond to it, regional service delivery plans are under way. These include regional-specific strategies to identify and address human resource needs. In addition, the department is supporting the Canadian Dental Hygienists Association to advance their work on curriculum development for an expanded scope of practice for oral health practitioners.

The department encourages all non-insured health benefits providers to enrol with its automated claim processing system, allowing claims to be processed in real time and payments to be directly deposited. This greatly simplifies administration and timeliness of payment to providers.

[*Translation*]

In closing, the department is committed to continuing to expand access to oral health services that contribute to the overall well-being of First Nations and Inuit.

As the Auditor General's review makes clear, we recognize that there is room for further improvement and are taking concrete steps to improve service delivery.

[*English*]

We will continue to work closely with our indigenous partners to support better access to effective, sustainable, culturally appropriate health services, and to expand their roles in the design, management, and delivery of oral health services.

We would be pleased to answer questions. Thank you.

[*Translation*]

The Chair: Thank you, Mr. Tremblay.

Mr. Massé, you have the floor for seven minutes.

Mr. Rémi Massé (Avignon—La Mitis—Matane—Matapédia, Lib.): Thank you, Mr. Chair.

I would like to thank the witnesses for being with us to answer our questions, and I thank the Auditor General for his excellent report.

My first question is for Mr. Tremblay.

Mr. Tremblay, in your opening remarks, you mentioned that by bringing health services together with education, child and family services, and infrastructure under the responsibility of one federal department, Indigenous Services Canada, you will be able to better support the needs and priorities of Indigenous communities.

Could you explain how bringing these services together will enable you to concretely help with the delivery of services to Canada's indigenous communities?

Mr. Jean-François Tremblay: What we think it important is the ability to work on the social determinants of health. When working in health, such as on TB, issues related to home construction and housing can't be ignored. If you are working on the issue of oral hygiene, you also have to look at other things, such as those affecting food security, for instance.

There are many things to consider when trying to treat health properly and effectively.

[*English*]

In some ways, the creation of this department is offering us capacity. One example that is quite easy to understand is mental health. Mental health touches many areas in health, not only one place, so you have different ways of approaching it. Working with child and family services, for example, what you do with income assistance, what you do with health, what you do in other areas gives you a chance to have a more holistic approach and develop an approach that, over time, will better respond to the needs of the community and also to the way they want to shape their programs and respond to the challenges they are facing. For us, it's actually a very good opportunity.

In many respects, this reiterate the points made by the Auditor General about the need for better data. If you want to do that, you will need to have better information about what exactly impacts what, how you can have an impact on that information, how you can have more success, and how you can improve the situations over time. We will look forward to developing that. That's a challenge for us, of course, that we will be addressing with our partners over the next few years.

● (1550)

[*Translation*]

Mr. Rémi Massé: Thank you.

At point 4.28 of his report, on page 8 of the English version, the Auditor General raised something important. The paragraph reads as follows:

> 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.

Obviously, it's the last sentence that is important. I'd like your comments on this. The sentence is:

> At the time of our audit, the Department had not finalized a strategic approach.

I would like you to explain to us why, at the time of the report, this strategy hadn't yet been developed and implemented. I know that officials from Indigenous and Northern Affairs Canada are very qualified and engaged, and I know you are, too. In fact, I want to recognize the officials from your department because I know a lot of work has been done to prepare you for this testimony.

Please explain why there was no concrete strategy at the time to address these pressing needs and issues.

Mr. Jean-François Tremblay: An approach had been developed, but it was more a regional approach. We work a lot at the regional level because, as you know, the health systems come under the provincial government and the rules differ from region to region. Some work had been done.

[*English*]

I think Parliament had neither the means nor the ambition at the time. With the funding we received in budget 2017, we decided that it was an opportunity to step up. With the report of the Auditor General helping, we are now moving towards what is now more of a national strategy, where we would exchange information from region to region in looking at the trends, at where we're going, and at what we think are the needs, and we would also exchange information about best practices from one place to another. For example, on human resources, the services are not necessarily shaped the same way from one province to another or from one region to another, especially on the COHI side, the oral health initiative side.

I think it was Parliament's intention to develop that. I will let my colleagues to say more about that.

I think the first thing was to address the regional aspects, but there was not necessarily the second level, if you like, which is more about a real national strategy. With this report and the engagement they're undertaking now, I think we're basically putting the system at the maturity level that we would like to have and that I think we need to have for the country.

[*Translation*]

Mr. Rémi Massé: A national strategy is an important aspect of this approach, and it should be implemented quickly.

I would like to point out that two Indigenous communities in my riding expect the government to support them in a practical way.

When do you think this national strategy will be developed? What is your plan of action, and what schedule will you adopt to develop that strategy?

Mr. Jean-François Tremblay: I will ask Dr. Plante to speak to the next steps and the schedule we will follow.

[*English*]

The Chair: Very quickly, please. You have under a minute.

[*Translation*]

Dr. Marc C. Plante (Manager Dental Policy, First Nations and Inuit Health Branch, Department of Indian Affairs and Northern Development): In terms of strategy, we are now at the senior management stage. It should be understood that these are separate programs, which concern both the Office of the Auditor General of Canada and the First Nations and Inuit Health Branch.

In terms of oral health, everyone will try to go in the same direction. Our branch is in the process of identifying priorities. Goals will be established. Some targets will be more specific: we will have an action plan for the next 10 years.

[*English*]

The Chair: Thank you very much, Mr. Massé.

Monsieur Deltell.

● (1555)

[*Translation*]

Mr. Gérard Deltell (Louis-Saint-Laurent, CPC): Thank you very much, Mr. Chair.

Ms. Schwartz, gentlemen, welcome to your Parliament.

Mr. Ferguson, it is very nice to see you again. Congratulations on the quality of your French and your bilingualism.

I am always very proud to say that I represent an indigenous community, the Huron-Wendat Nation, which is located near Quebec City, on the Wendake Reserve. It is at the heart of my riding. The people on that reserve have been my neighbours since I was born. I know them very well, and they are very close friends.

We all know that there are communities in Canada that live in urban or semi-urban areas, and others that live in less densely populated areas. We also know that it is sometimes urgent to be seen by a dentist—everyone has suffered a toothache—that it is always difficult to find one on Saturdays or Sundays, although it's possible. This happened to me seven years ago. That said, in your report, you mention 300,000 First Nations and Inuit, and 237 communities.

For the moment, my question is for the officials from Indigenous and Northern Affairs Canada.

Is there a noticeable difference between access to dental care for First Nations and Inuit in urban areas and that for First Nations and Inuit in non-urban areas?

Mr. Jean-François Tremblay: I think my colleagues, particularly Dr. Plante, are better positioned to answer your question.

Mr. Sony Perron (Associate Deputy Minister, Department of Indian Affairs and Northern Development): Thank you for the question.

You've put your finger on the problem: the geographic distribution of clients and service providers. The programs make it possible to reach these clients differently, which is why a strategy is needed. The non-insured health benefits program is actually a benefits program where the expenses incurred by the client are reimbursed directly to the dentist. It works extremely well in urban or suburban settings, where people have access to dentists.

We usually use more programs like the children's oral health initiative to provide services in communities where we would not otherwise find them.

However, even in peri-urban areas, these programs can be useful for prevention in schools and to ensure that parents bring their children to specialists first, and to dentists, second. It's a combination of services, so it's important to have the strategy that we talked about earlier. Efforts should be combined when it comes to these programs. In remote areas, we have to face more difficulties.

The non-insured health benefits program, for example, will sometimes make it possible to contract work to dentists rather than having them present themselves as independent service providers. In fact, we are awarding contracts in certain regions to get dentists to practise in communities, which is more efficient and less expensive. This also provides support and a clientele to service providers who come to work in a remote community. The approaches to services are therefore very different depending on the regions and geographic distribution of customers and service providers.

Mr. Tremblay spoke earlier about our strategy and regional access plans that take into account this dynamic and the type of tool we need to bring clients closer to service providers or, conversely, to bring clients closer to service providers in communities.

Mr. Gérard Deltell: In fact, when we say “bring service providers”, we understand that they are dentists, their assistants and the necessary equipment. We also understand that dentists don't walk around with their equipment in a small suitcase, as Dr. Welby did—it would be a bit heavy.

Does the majority of the fees apply directly to care or to being able to provide care, that is, bringing the physician or dentist with the necessary equipment to the communities living in the North? In other words, is the budget spent primarily on logistics rather than patient care?

Mr. Sony Perron: That’s a very good question. Let me reassure you in this regard.

Part of our program spending goes to the transportation of medical personnel and equipment, and it is calculated differently. The figures presented in the auditor’s report relate to services and medical procedures.

According to our infrastructure program, when renovating or building facilities for nursing stations in remote communities, for example, a room is often set up for oral care, and there is a dentist's chair.

Some funding will be provided to have local workers, for example, who will be responsible for scheduling appointments, ensuring that clients keep their appointments, and providing local support. There is a little bit of that in the programs, and it's extremely useful.

In fact, one of the truly positive things about the children's oral health initiative is local support. Irregular visits to a professional service outlet have an impact on oral health. We think it is extremely important to have a person from the community there at all times. The person ensures that clients are registered, calls them to confirm their appointments and ensures follow-up at the school, to obtain parental consent for services, for example. In this sense, we do not have many requests for service. We should really ensure a local dynamic, especially in remote communities.

● (1600)

Mr. Gérard Deltell: Mr. Auditor General, in the report, you mentioned that indigenous people experience twice as much difficulty as non-indigenous people in terms of services and dental care.

Is this true from coast to coast to coast? Is there a difference between urban and non-urban indigenous people?

Are the statistics for urban indigenous peoples similar to those for non-indigenous people? Is there a major difference between those who live in the north and those who live in urban areas?

Mr. Michael Ferguson: We have not specifically analyzed this issue, but we mentioned in paragraph 4.2 that more precarious oral health is related to factors such as geographical barriers.

Clearly, it is more difficult to provide those services to more remote communities. So this is a challenge. However, I think it is one more reason why it is important to have a national strategy to determine how to serve those populations.

Mr. Gérard Deltell: Perhaps I could ask the people experiencing this reality on a daily basis.

Mr. Tremblay, what do you think?

Mr. Jean-François Tremblay: There is information, but it would probably be difficult to obtain very recent information. We can provide the committee with a survey on oral health from 2007, I believe. It probably shows regional disparities between what happens in northern and southern Canada or in small and large urban centres.

[*English*]

The Chair: Thank you, Mr. Deltell.

Mr. Christopherson, please. You have seven minutes.

Mr. David Christopherson (Hamilton Centre, NDP): Very good. Thank you, Chair.

Thank you all for your attendance today.

Again, it won't come as a surprise to anyone that when it comes to services for indigenous peoples, Canada does an abysmal job, especially when compared with our reputation in so many other areas. This report is not the worst I've seen—I've seen some nightmares come through here—but it's still not good. My colleagues have already addressed some of the most obvious questions. I'd like to drill down just a little, if I might.

Auditor General, at the beginning of the year, or certainly near the beginning of the term, you presented us with the fact that you consider data collection, data analysis, and accuracy of data to be key components. You were concerned, and you addressed our committee about the fact that it needed to change, that after all these years, we're great at getting bunches of data—my word—but in using them effectively, analyzing them effectively, and getting the best benefit, it hasn't been so good; again, my word.

I want to focus on that. In your report, on page 10, paragraph 4.45, you say, “However, Department officials informed us that the apparent decline in enrolment might reflect poor quality in data collection and recording...”. On the very next page, your recommendation is that Health Canada “should improve” its analysis of data.

Deputy, in your remarks, I found at least three occasions where you mentioned it. On page 4 you talked about data collection, analysis, and reporting. On page 5 you mentioned that your plan will ensure that data collected in the course of the delivery of services will be accurate and rich enough to contribute to overall improved management. On page 6 you talked again talked about the importance. In fact, we find that it's a focus of the action plan, which is a critical component of the work we do. In there, referring to the recommendations coming from paragraph 4.47, the key interim milestones, you make a reference to the data improvement strategy working group.

I would like you to talk to me about that group. Is that new? Is it a result of the initiatives of the AG? Is it something you've always had? Can you talk to me about that, please, before I go any further? Again, it's the data improvement strategy working group.

● (1605)

The Chair: Mr. Perron.

Mr. Sony Perron: I could start, and maybe Dr. Plante could complement it further.

There are a number of programs and different ways to collect information. For example, the children's oral health initiative depends on the work that is done in each of the 200 communities, in day-to-day services, to record the service provided, the oral health of the child, and a measurement of the progression in terms of the quality of the oral health. This requires collaboration to make sure that the data collected in northern Manitoba will be consistent with the data collected in northern Quebec.

Mr. David Christopherson: When did all of this start?

Mr. Sony Perron: We have been doing it all the time in order to try to improve, but there is a challenge to get this data and analyze it at a national level. This is what the Auditor General revealed in the report, that it's not something that's conclusive. There's more work to be done there.

Second, we have many programs, and we need to be able to link this data together. The working group is made up of people from the various programs. It's to try to harmonize the way they collect the data and organize the data. It's to provide training and also to use external experts to advise us. In the introductory remarks, we talked a little about the expert group, which is independent. They give us guidance on how we can make this happen. This working group is charged with implementing these measures.

Mr. David Christopherson: Okay. Thank you.

Deputy or Auditor General, does every department have one of these, or is it unique to you to have a data improvement strategy working group—in other words, a group that is actually struck for the sole purpose of dealing with the issue of poor data management and analysis?

Mr. Jean-François Tremblay: I cannot talk for all of the departments. I'm not sure of this. I think all departments have a data strategy for sure.

Mr. David Christopherson: You're not sure. Okay that's fine.

Auditor General, do you know, sir?

Mr. Michael Ferguson: No, I don't know whether all departments have it. Obviously, we've seen issues in a number of departments with data quality. I suspect it's not all departments, but I don't know that for sure.

Mr. David Christopherson: Okay.

On my other question, what I'd like is the actual from you, Deputy, and then, AG, on whether that meets what you think should be happening.

We don't talk a lot about internal audit committees, and yet I think they play a bigger role than we're acknowledging. Would they be responsible for the issue of data management, Deputy?

Mr. Jean-François Tremblay: No. The internal audit committee works with us and advises the deputy minister on the quality of the audit that we produce, on the risk management of our audits, and which audits we do. They will advise us on the quality of those audits, on what we should identify as risks, where we should go, and what we should address, but they will not necessarily be part of the working groups.

Mr. David Christopherson: Okay.

What surprises me, and it happens over and over in AG reports, and it's in here again—I can dig it out if you want—is that there's analysis saying that the planning wasn't done. They weren't following up on these things, strategic analysis, and it seems to me that the in-house audit committee ought to be doing some of that.

If we have an in-house audit committee and they're doing their job, how is it that we can get through them and still have so many problems that the national Auditor General then finds?

Mr. Jean-François Tremblay: The department has to do its job. The audit committee cannot do the job of the department, so we have to do it ourselves. We also have to do it with our partners. We have to find efficient and sustainable ways of collecting and analyzing that data. This is our responsibility. We recognize it, and as we have said, we're developing plans and hope that we will be able to—

Mr. David Christopherson: No. Very quickly, maybe I'll give the Auditor General a chance to comment. I'll come back to this again when I get another round of questions, but that was a bit cursory for me. I'm looking for a little more, Deputy, in the next round.

Auditor General.

Mr. Michael Ferguson: I think there is a role for internal audit committees to play in this. As the deputy said, dealing with and fixing these issues is obviously the responsibility of the departments, but I think there would be a role for audit committees to look at, for example, the different audits that we've done.

As the question indicated, in a number of our audits we have talked about the problems with data quality in departments. I think audit committees should be aware of those types of systemic issues that we bring up, and they should ask the departments they're involved in how we know whether the data in the department is being managed in a way that is of sufficient quality so that the department doesn't end up with data quality issues showing up in an Auditor General's report.

It is definitely the responsibility of the department to fix the issues, but I think there is an oversight and challenge role for internal audit committees to make sure that departments are paying attention to these types of issues.

● (1610)

Mr. David Christopherson: Thank you, Auditor General.

Thank you, Chair.

The Chair: Thank you, Mr. Ferguson and Mr. Christopherson.

We'll now move to Mr. Chen please.

Mr. Shaun Chen (Scarborough North, Lib.): Thank you very much, Mr. Chair.

Oral health is so important. We all know that. I know that. I recently had a filling that went bad, and it was not good. It was painful, but I won't get into the details of that.

I'm lucky that I have access to any number of dentists in Ottawa and Toronto. I have a good insurance plan. But we know, and it is especially important, that there are many communities and many individuals in this country who are disadvantaged and marginalized and do not have access to proper services. That is why it's so important for us to ensure that indigenous children, in particular, have proper oral health.

It's no secret that the oral health of Inuit and first nation children is especially poor. I heard the Auditor General say very clearly in his earlier remarks on the work of the department that it was not focusing on closing the gap. What we need to do is very much remember that there is a gap, and it is our responsibility to close that gap, because there are children who do not have access to these services.

Oral health is so important, because it's linked to general health outcomes. It's linked to their ability to receive a proper education. It's linked to their personal sense of well-being and confidence. When there is poor oral health, there are poor outcomes for children.

In the Auditor General's report on page 3, paragraph 4.9, it states that $5.4 million was allocated by the federal government in 2014-15 for the children's oral health initiative, but in 2016, Health Canada found that only 238 out of 452 eligible communities received services.

Of course, I'm going to go to the negative and ask, why didn't 214 communities receive any services? Why was that the case?

Mr. Jean-François Tremblay: We go with the resources we have. With the funding we have received under budget 2017, we expect to increase the number of communities with access to COHI by more than 100. That's something that would help oral health.

However, don't forget that all of those communities still have access to NIHB services. If they want to have access to a dentist, if they need access to an oral health specialist, they do have that access. It's not that communities are not covered by any kinds of oral health services; that's not necessarily the case. This is more for the community approach that we described before, where we helped to actually do some prevention work in terms of oral health in communities. That's something that we were doing with the $5 million, as you mentioned, but with the budgetary increase that we received, we hope to be able to expand this. We would expand it in terms of numbers of communities who have access to it, and potentially also the age of the people who would have access to the service.

Mr. Shaun Chen: Are you saying that with the budget increases that were passed, there will be an increase in the number of communities that are served?

Mr. Jean-François Tremblay: Yes, in 2017.

Mr. Shaun Chen: As well, what is the age range for children currently?

Mr. Jean-François Tremblay: I think it's zero to seven.

Mr. Shaun Chen: What is the department looking at in terms of increasing the age range of children who are—

Mr. Jean-François Tremblay: It's zero to 11. It may vary from place to place, but it is something that we're looking at.

Mr. Shaun Chen: Can you talk about the importance of that? When we are dealing with indigenous communities, it's very important for us to ensure that the communities are involved—

Mr. Jean-François Tremblay: Yes.

Mr. Shaun Chen: —in the delivery of service. There needs to be a sense of cultural appropriateness and to ensure that indigenous ways of knowing are incorporated in the services provided to members of that community. Can you talk about the importance of that, and how that thinking has been incorporated in your goal, ultimately, of ensuring that more first nations and Inuit children are provided with these services?

Mr. Jean-François Tremblay: Do you want to maybe elaborate a bit on COHI?

Mr. Sony Perron: First, budget 2017 provides an additional investment of $45 million, over five years, for this program. Right after the announcement, we engaged with first nations and Inuit partners across the country to determine how this funding would be allocated. This year, for the first time, we have increased the budget of all 237 communities that were receiving the program. We did so because they had been receiving the same amount for a number of years. This budget allowed an increase in the capacity of existing sites. Then we are starting to create new sites in new communities, so at the end of the year there will probably be 140 new locations where this program is available. We did that with the input of our first nations and Inuit partners in each and every region.

In the non-insured health benefits program, which is more a fee-for-service model, we are also paying attention and working with the Assembly of First Nations, for example, to make sure that the providers understand that the client groups are culturally sensitive. Fortunately in both programs we have providers who are indigenous themselves and who understand this, but we have to partner with others to train and provide the information. A lot of the workers that we already have in the department are indigenous. Therefore, there are many fronts by which we will ensure cultural safety around this program.

As I mentioned before in another response, what is really important is also to find a way to have local staff tasked with managing these programs at the local level and to make these work in their context, by creating the trust with the parents and the child that these services will be good for them. I think we would all agree that going to a dentist is not your first choice in the day, so we need local workers to make them feel comfortable that this is good for them, that it's useful, and that it will help over time to prevent problems.

We have to do it in partnership; we cannot do it from outside. This is why these programs have to be grounded in the community. We need to stabilize which provider goes into the community to make sure they develop a relationship and a continuity of services with the family and the child. It's very important.

● (1615)

Mr. Shaun Chen: Absolutely.

The Auditor General said with respect to the $5-million investment in the children's oral health initiative that the department's data showed that fewer children were enrolled and fewer services were provided. I think it's great that you are looking forward to the additional investment, that you're looking to reach out to more communities, and that you're working with indigenous communities to ensure that these services are culturally relevant and that they are involved in the process. As you say, you have providers who are indeed indigenous themselves. However, why should I be convinced that with more money and with what you're doing, you are going to have better outcomes? As the Auditor General pointed out today, there are fewer children enrolled and fewer services were provided with that $5-million investment.

The Chair: Thank you. Unfortunately we're going to have to get the answer a little later because we're way over the time.

We'll go to Monsieur Deltell.

Mr. Gérard Deltell: I want to get back to the point that I addressed a few minutes ago about the difference between indigenous communities near downtown or urban centres and those up north. I thank you for your suggested “concrete plan” and “strategic approach”. Those were the words you used in your introductory remarks. I think you should focus on that difference and put the emphasis up north. Those people are far away from having access to dental necessities. If there is going to be a new approach, it should be concentrated and focused on those communities. This is my personal observation. I'm sure you will make good of that.

[*Translation*]

I would like to talk about the broader vision for First Nations health care and dental care.

Mr. Tremblay, earlier, you said that, when you talk about asthma problems, you have to talk about housing, and if you talk about dental problems, you have to talk about nutrition.

My question is for you first, Mr. Ferguson.

At the time of your analysis, and to the extent possible, did you consider the overall picture of First Nations communities in terms of diet compared to non-indigenous people? As we all know, a poor diet, which leaves too much room for sugar, leads to bad teeth.

Mr. Michael Ferguson: Thank you for the question.

This is another indication, just like the geographical barriers. We have identified five factors, including limited access to nutritious and affordable food. Of course, there are geographical barriers, but there are other factors, such as the high smoking rate and the level of education. A number of factors can affect the health of those populations, and access to nutrients is one of those factors.

● (1620)

Mr. Gérard Deltell: That brings us to a very sensitive issue. We can encourage people to eat in ways that are consistent with healthy living, but we cannot force them to do so. Besides, we do not have to do it either.

My question is for Mr. Tremblay.

When food containers are sent from the south to the north, are their contents inspected?

Mr. Jean-François Tremblay: Not to my knowledge.

Mr. Gérard Deltell: In your opinion, should we do that? I ask the question very openly. According to our party's principles, we must let people make their own choices; it's not up to the government to tell them what to do. At the same time, we should perhaps encourage them to have healthy lifestyle habits.

Could this view be considered, improved and even become an objective?

Mr. Jean-François Tremblay: I think prevention work is still the best thing to do. We must focus on education and prevention. As you know, Minister Bennett's department has nutrition programs for northern communities to ensure that healthy, nutritious food is distributed in the north. The associated costs are also a major issue.

As for deciding what should be sent to these communities—

Mr. Gérard Deltell: That's fine. Honestly, I share your point of view. The government's role is not to tell people what to do or to force them to do anything, but it can still give them information.

Mr. Jean-François Tremblay: That reinforces what we were saying earlier. It's really important to work with the communities. That's what they have to realize. There is also the fact that indigenous people have had access to traditional food for years, which is no longer as accessible today.

Mr. Gérard Deltell: Exactly, let's talk about that.

Have you studied the traditional food in those communities? If so, were the results positive or negative in terms of dental problems?

Mr. Jean-François Tremblay: I have not done any studies on that, and I don't think the department has done any either. However, university research groups, including from the University of Montreal and Laval University, in Quebec, have looked at those issues.

Mr. Gérard Deltell: In my opinion, giving First Nations more opportunities to preserve, maintain, develop and promote their traditional diet might be something to think about. The feeling of belonging would then be 10 times higher.

Mr. Jean-François Tremblay: Yes.

Mr. Gérard Deltell: As you said so well, it's not up to us in the south to tell those people what to do. Since time immemorial, those communities have been much better placed than us to know what is good for them and what is not.

Mr. Jean-François Tremblay: Yes, absolutely.

[*English*]

The Chair: Thank you, Mr. Deltell.

We'll now move to Mr. Arya, please, for five minutes. We're into our second round.

Mr. Chandra Arya (Nepean, Lib.): Mr. Tremblay, I would like to continue the questions that were asked by my colleague Shaun. The Auditor General's report mentioned that with the $5-million initiative, fewer children were enrolled and fewer services were provided compared to the previous years. Budget 2017 has now increased the amount available, but what is the point of increasing the amount when you can't use the existing money that was already provided?

Mr. Sony Perron: I think the children's oral health initiative was introduced in 2005, with $5 million. We were in 2017-18 when the Office of the Auditor General made the audit, and the budget was the same. Over time, the capacity of communities to deliver the service —this funding is going toward the communities mainly—with the same budget is limited. Somehow the impetus for increasing the resources available is coming from the fact that 15 years at the same level is not—

Mr. Chandra Arya: Sorry, I don't understand. Yes, the budget was at the same level, but the data shows that fewer children were accessing it.

Mr. Jean-François Tremblay: No, but that's the point. If you look at it over 10 years, you see, of course, that the costs have increased, but not the budget. One of the hypotheses, and that's why we're going to need to have more information about this, is that if you provide the same amount of money for the program, you basically have cut the services, because you don't necessarily follow the CPI.

Mr. Chandra Arya: So, you don't know the reason that fewer children are accessing it, but you're happy with having a larger budget for it.

● (1625)

Mr. Jean-François Tremblay: Our understanding of this is that you keep the budget as it was 10 years ago, it's difficult to get the same result that you had a few years ago. We're quite confident that with this new amount of money, we'll be able to reach out more—

Mr. Chandra Arya: Because of the budget—you say it's low, that funding was kept at the same level since 2005—have you ever turned away a child who came for the services?

Mr. Jean-François Tremblay: If we have been looking for...? Sorry?

Mr. Chandra Arya: With the same budget, have you ever had a child who can't access the services you provide because there's no budget?

Mr. Jean-François Tremblay: No. What we've been doing is transferring the dollars to the communities, the same ones that had these programs. With the same amount of money, they were trying to continue the same services and to do what they could, but the costs, for example, of hiring people, the therapist and so on, increased over time, so we—

Mr. Chandra Arya: Okay.

I have a question for the Auditor General. I know you looked at these two programs. But in looking at this program in isolation, I don't know if it is of benefit to us. This is just one program related to health. There are other health factors, for example, the increase in diabetes among indigenous people. There are things related to safe foster care. There are other issues like mental health services. Is it possible to look at the whole big picture that affects the children?

Mr. Michael Ferguson: Certainly, as you say, there are many different factors that we can look at. When we do a particular audit, we have to scope it down to what we can do within a particular time frame. That's why we picked this and focused on it, so we could get a report on one subject. Certainly, all of those other subjects could be the subject of audits in the future.

Mr. Chandra Arya: The same question goes to the deputy minister. Do you look at this program in isolation? How are you fitting that with the mental health services that you provide, or the increase in diabetes, or the issues with foster care?

Mr. Jean-François Tremblay: Our objective over the long term is not to go program by program with first nations, Inuit, and Métis communities, but to go with the fiscal relationship and their community plans so we can address holistically the different elements, sectors, and issues they face, rather than going case by case. To answer your question, it's something that we're working on. We end up with a lot of programs. Programs are not necessarily as flexible as they should be. As you said, sometimes they are just one part of the story and don't necessarily give you a full picture—

Mr. Chandra Arya: I have limited time, I'm sorry. I apologize.

On the contract dentists, I know there's an issue there. How do you think you're going to address it?

Mr. Jean-François Tremblay: What do you mean?

Mr. Chandra Arya: I believe you have difficulty having enough dentists on contract.

Mr. Jean-François Tremblay: We have almost 16,000 or 17,000 dentists across the country. The real difficulty is more with the therapists.

Mr. Chandra Arya: Okay.

Mr. Jean-François Tremblay: There are some provinces where therapists will not continue to work, and we were using, in some regions, for example, the Atlantic and Manitoba, the COHI programs that used a lot—

Mr. Chandra Arya: The reason I asked that was our Auditor General found in one of the two regions that there were not enough contract dentists available to provide services in the communities they served.

The Chair: Thank you. Your time is up, Mr. Arya.

We'll now go back to Monsieur Deltell.

Mr. Deltell.

[*Translation*]

Mr. Gérard Deltell: Thank you again, Mr. Chair.

Let's continue our conversation about general care for First Nations, but starting with the example provided to us by the precise analysis and the commitments made by officials from the Department of Health.

I have a general question. When we talk about First Nations health, we know that there are a lot of issues, whether related to social services, substance abuse or dental care.

In your opinion, is dental care the health priority for First Nations?

Mr. Jean-François Tremblay: I would let the First Nations speak on that.

First Nations priorities are different across the country. We think oral health is a priority, for sure. When you look at the number of people who have access to those services and who want to have access to dentists, it shows that there is a need, that people want better oral health. Clearly, health is a priority, but it includes various aspects, as you mentioned, including mental health and various health issues, such as diabetes.

I could not speak for indigenous people and say what their priority is in that respect.

● (1630)

Mr. Sony Perron: I would invite you to look at the plan presented by the Assembly of First Nations in 2017, which lists health priorities.

In our partnership approach, the points of view raised by our partners are taken into account in order to drive action. You will see that, in that plan, the approach is multi-sectoral, and the priorities that have been identified include mental health, primary care, preventive care and oral care. The approach proposed is holistic.

Mr. Gérard Deltell: Clearly, it's always difficult to make judgments. Let's be honest, those communities were there before us. I never thought that we had to tell people what to do. It should be up to them to tell us what they want. This is true for First Nations, as it is true for any area of public activity. It should be up to the people experiencing the problems to submit their comments so that we can assess that in a general way. At the end of the day, it is not up to us in the south to tell people in the north what is good for them. That's our vision.

Mr. Tremblay, my question was not about how First Nations see this. To your knowledge, as a senior official and administrator in the department, as well as deputy minister of Indian Affairs and Northern Development, must budgets for dental care be a priority?

Mr. Jean-François Tremblay: In terms of basic health services, I think it's important not to make choices as such. Basic health services should be provided to indigenous people as they are to all Canadian citizens. Access to health services is important, whether it is access to mental health services, primary care or hospitals. We do not consider the priorities related to these services in comparison to each other. We see them as basic services to which a citizen is entitled and to which they will have effective and easy access.

Mr. Gérard Deltell: I will end my remarks with a general comment.

I think the sooner we deal with the problems, the more we avoid creating problems later. It's very easy to say, of course, but it's not easy to do. However, the more prevention is done and the more information is circulated, the more children are allowed to access quality care—whether dental, psychological, or basic care. This can help prevent unfortunate and regrettable incidents that can strike anyone in society. This is even more true for people who live in the regions and are at greater risk of experiencing such tragedies.

I think that, if we want to take a cognitive approach to health care, we must first focus on the care for young people.

[*English*]

The Chair: Thank you very much, Mr. Deltell.

We'll now move to Ms. Yip, please.

Ms. Jean Yip (Scarborough—Agincourt, Lib.): It was found that indigenous services did not promptly inform clients and service providers about the changes it made to certain services. I would like to know how they are going to inform clients more promptly when they make service changes. Especially when you're dealing with kids, it's tough juggling schedules when you're relying on something as important as these appointments.

Mr. Jean-François Tremblay: Yes, and the difficulty with clients is this. Let's say you're a client, for example, for a filling. It's not something that on a day-to-day basis you wake up and ask, “What exactly is the new policy and what should I or do I have access to?” We need to find a way to make sure they know this and have access to it, especially when they need to know it. It's hard, because access to dental care is not something that people think about on a daily basis.

We're working with first nations and Inuit communities and organizations in trying to find ways to ensure that we actually reach out to and communicate to our partners and the clients. We're talking about a potential 853,000 clients at the moment, dispersed across the country, on and off reserve, so it's a vast population. For us, it means that we've been working with communities, the primary health care centres that exist in the communities, and the health professionals, and also, of course, potentially working with social media to make sure that clients have access to the most information perspectives possible. We also have newsletters that inform people about what we're doing, and that's something that we are looking at improving.

I don't know, Dr. Plante, if you want to add something on this.

● (1635)

Dr. Marc C. Plante: Yes. We're looking at a strategy and also working with our partners. They know better than we do how to get to the people who need the information.

We are looking into a plan in the next few months to do a better job about communicating. We've already made improvements. Clients now can subscribe on our website to have all the client newsletters. For the information on the program itself, they have the same information as the dentists. The issue with that information is that sometimes it's very technical, so that's why we're trying to find new ways of explaining the services that they have the right to have, basically. This is all work that's being done.

We're also working with the Canadian Dental Association. Whenever we make changes now, they also publish them, sometimes on their website, and there are the other associations also, such as the Denturist Association of Canada and the Canadian Dental Hygienists. They're helping us by trying to spread the word throughout the providers, but also on the client side, because they also see the clients in their offices. There's a lot of work to be done, for sure.

Ms. Jean Yip: Thank you.

The Chair: Thank you, Ms. Yip. Before we go to the next round, because we do have another minute or two on your round, I would like to ask a question.

I'm looking at the Auditor General's paragraph 4.44, where he says, “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...”.

I guess where I'm going with this is that when you have general health care among first nations or Inuit on or off reserve, typically off reserve, we know that it's not simply a doctor who can deliver that type of health care; it can be a nurse, a nurse practitioner, or a whole large group of people who can deliver some health care. On dental care, it's a little different. You have a dentist and a dental hygienist. I'm not sure if there are any groups other than those two who can do typical dental work.

However, the Auditor General said in his report that when it came to prevention.... I understand that there are things you can educate people about, such as the importance of brushing and hygiene, but there were “about 20 percent fewer fluoride applications in 2016” than in 2014. That struck me. We know that fluoride applications can help prevent cavities and help with dental health and health, certainly in remote areas where fluoride is not in the water supply. Why, then, would there be such a drastic drop in fluoride applications over two years, from 2014 to 2016?

Mr. Jean-François Tremblay: Dr. Plante, do you want to try that one?

Dr. Marc C. Plante: The fluoride program is a voluntary program. Parents can enrol or not enrol their kids. Also, fluoride is only part of the big team, basically, because fluoride can be provided by provincial programs and by NIHB, through private means—

The Chair: Is that the case? Did it drop here because the province had increased...?

Dr. Marc C. Plante: We cannot say that. We can only—

The Chair: Then how do you take this data of a 20% drop in fluoride treatment and respond to it if you don't know? It might be covered by the province, and it might be covered by other groups.

Dr. Marc C. Plante: That's why we need to look a bit more closely, as we said before, at why we are seeing this happen. We're just putting a hypothesis out there. We have to look really closely at what is happening there. In terms of putting the data together, that's one of the reasons: we'll also have a better sense of where the clients are going. The only data that we will not have for sure is the data from the provincial governments, but at least throughout our programs, if we are able to put the data together, we'll have a better story for each client individually.

The Chair: Thank you.

Mr. Christopherson.

● (1640)

Mr. David Christopherson: I had indicated, Deputy, I would be looking to you for a further answer, but you're in luck. The answers the AG gave did give me what I wanted, but I do hope you'll reflect on that answer. It wasn't very good.

I do want to say that hope springs eternal, and a lot of emphasis in the response from the government is placed in the new restructuring, in that it should allow the synergies of the various components to work together to give us more service delivery. Whatever, I'll take anything, but somebody just show up and fix what's going on in terms of services for our first nations people.

We shall see, but just remember, every time you make a promise that gets you out of today, that promise has to be accounted for someday down the road.

I have two very brief questions. My last one will be on the macro data and how we're doing, Mr. Ferguson.

Deputy, I want to read one paragraph, and I'd like your response, because this just blows me away. On page 6 at paragraph 4.28, it states:

> 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.

What the heck is going on with this? Why is it so difficult to come up with a strategic plan? Why are there promises and then a failure to honour those promises? All we have today is another promise. Give me some reason to believe, Deputy, that this time you folks are actually serious about keeping the promise, as opposed to your track record.

The Chair: Mr. Tremblay.

Mr. Jean-François Tremblay: First of all, I would say that there were regional plans. We were working on this. We knew that the oral health situation of first nations and Inuit was poor. We have programs that were developed for this. We made our decisions on an evidence base. We worked with experts in developing those programs, and we put them in place.

Now we're going to a more mature level in our programs where, yes, we will try to finally have a national approach where we can compare the data between and among our programs, as well as among regions, and try to make sure that we have the resources we need for the kinds of demands that we meet for the population we serve.

Mr. David Christopherson: I hear you going forward, and again, it's more promises, but talk to me about the failure along the way. How can this be? It's something that's so important, but there are all these fits and starts and we're still not there. This is about accountability. It's not just about what's going forward. We want to know what the heck happened in the past. This is a disaster, and I haven't heard you give me one good reason why it happened—it's not even acknowledged—so, Deputy, please.

Mr. Jean-François Tremblay: We acknowledge there is progress to be made. The national strategy is not necessarily everything that will fix everything here. As was mentioned, those issues are broader than just a strategy at the national level on how we will collect the data among those programs. It's an important step, and we will take that step. That's the way we see it.

Mr. David Christopherson: I have to tell you, I don't like that answer at all, and that's consistent with the other answers you're giving. I'm sorry, but I don't get the feeling you're listening and addressing what we're dealing with. You want to talk about what you want to talk about, and we're insisting you talk about what we want to talk about.

I'll leave that. I don't have a lot of time. This round is very brief. However, I'm sorry, but that answer was not sufficient, Deputy. It didn't address how the heck so many mistakes were made in the past and deal with why we should listen to this promise when you've made promises before and you didn't keep them.

I have a last question—a macro question.

Auditor General, I had raised the issue of data. I raised the fact that you'd come to us with a report asking us to make it as much of a priority as we can. We've tried to do that. We could always do a better job, like everybody and everything, but are we making a difference? Are we starting to turn the corner at all, or do we need to ramp up our efforts because we're still not getting the message through?

Can you give me your thoughts, sir?

● (1645)

Mr. Michael Ferguson: In general when we're doing audits, we still see many problems with how departments are collecting and managing data. I think, though, that the committee has been successful in starting to shed some light on this, and departments are starting to take it more seriously. However, I don't think it is yet showing up in our audits.

In this particular audit, I would like to point out that there were some places where we saw that the department was doing some good things with data, and then some places where they needed to improve in data.

The department has a lot of data about individual payments for individual services. When dentists are providing individual services and those services are being paid for through the department's program, they have a lot of data on that. They have done a lot of analysis on that data to make sure dentists are only claiming what they should and people are only getting paid what they should. They've been collecting a lot of data. That data is accurate, and they've been using that data to make sure that payments are appropriate. They haven't been using the data sufficiently to manage the outcomes, to manage what this data can tell us about dental health outcomes and how we can use that data to improve that.

Similarly, on something like the children's oral health initiative, they don't have the information about individual services because the department doesn't pay for each individual service. It pays for a hygienist, perhaps to go into an area in some of these programs. The hygienist gets paid, but not necessarily on an individual service, so they don't have as much information. That's why when we talk about the children's oral health program and there appears to be some data quality issues, it's because they don't collect the same level of data.

They're doing a good job on some of it, where they have the individual transactions. They need to use that information to get more insight out of that information. Then, in some of these other places, they just need to do a better job on collecting information in general.

Mr. David Christopherson: Excellent, that's very helpful. Thank you so much.

Thank you, Chair.

The Chair: Thank you, Mr. Christopherson.

I will now move to Mr. Tabbara.

Mr. Tabbara, welcome to our committee.

Mr. Marwan Tabbara (Kitchener South—Hespeler, Lib.): Thank you.

The Chair: The times is yours.

Mr. Marwan Tabbara: Do I have five minutes?

The Chair: You have five minutes.

Because you're new, we can give you up to five and a half, maybe six minutes.

Mr. Marwan Tabbara: Thank you very much, Mr. Chair.

Thank you for testifying before us today.

When I was travelling to Ottawa one time, I was speaking to a nurse who was working in an indigenous community up north, and she continues to work in indigenous communities. She was telling me about a lot of the services that they provide. When individuals would come in, she would do regular checkups, but she would notice that their oral health, to say the least, wasn't very good.

I'm new to the committee, so I'm sorry if I ask repetitive questions, but how will the significant funds given in 2017 help you take a national approach?

Mr. Jean-François Tremblay: It will help on the prevention side, which is the dimension you were talking about, in how we will be able to reach out to more communities to work with them in developing prevention, and making sure that good habits are there from the oral health perspective. That's, in part, what it will do.

We will also build on this to develop the national strategy that, as we said, will be presented in the next few months.

Mr. Marwan Tabbara: This question is for anyone: how do we do that in the most remote communities? How do we ensure that their oral health is—

Mr. Jean-François Tremblay: We have to work with the communities. We have to have professionals going there, working with the communities, reaching the families and the children, and actually working with them in training and showing them the benefits of good oral health. Doing this with the partners is the key element for us, the key point.

It's the same thing even for the national strategy. We have to sit down with our partners, first nations and Inuit. If we want to have targets over the long term, they are targets that they need to embrace, of course, as we will embrace them in the end. It's about the different working groups that we have and the different ways we have to actually reach out and work with our partners.

● (1650)

Mr. Sony Perron: You were talking about the patient journey and their going to see a nurse. I think this is a prime example.

In the north, where there is a nurse, a patient will see the nurse, and if there is a problem with oral health, the nurse will do a couple of things. First, the nurse will say that there is a dentist visiting the community in two or three weeks and they will put them on the list, but this is more for prevention and convincing the patient to take care of this. If it's urgent, the nurse will arrange with our services to get the patient out. Sometimes there is pain and there is a need. If there is no dentist coming soon, the patient's care is a priority, and she will help to arrange it so that the patient can get out and get services from a dentist somewhere if it's an emergency.

If there is no visiting dentist, we sometimes organize flights out to see a dental provider, but that's why earlier today I was talking about these regional plans, because each community deserves a different action. Sometimes there are already dentists who are visiting communities and there are already dental therapists residing in communities. In each case, we are trying to organize the service.

What really matters is that in all of the stages of health care provided, whether it's the nurse doing prevention work, the dental therapist seeing the patient, or the dentist outside of the community, we try to integrate all of that work to make sure it is patient-centric. We sometimes have a problem with the data and being able to see the patient's journey, but the staff and our partners have all the same information about what program can be leveraged to get the client to the service provider as soon as possible when there is a need.

Mr. Marwan Tabbara: Just as a follow-up question, to give you an example, let's say a dentist were visiting the community and performed surgery or conducted something with the patient. Is there any follow-up? Maybe the dentist leaves again, but as you know, if you're extracting teeth you have to check if the patient is healing properly. Is there any follow-up? Or do nurses do that?

Mr. Sony Perron: Yes, this is part of the treatment and the process of serving the patient. There is a responsibility for the local nurse, for the treating dentist, and for the dental therapist.

What we have to work on is the stabilization of the service provider community in order to make sure that the same dentist or the same dental therapist visits the community. When there is a disruption, there might be difficulty in following up with the client. It's about investing in local workers as well and doing it with the community, so that there is someone locally who is in charge of doing the follow-up and calling back the clients to make sure they show up when the dentist comes. If it's only two days a month, there is that window, so we need local workers to organize that and to be very efficient. Again, that's why we need plans in each region to organize the service in the most efficient way. Ultimately, however, if there is an urgent need, we get the patient out to see a dentist outside the community, for sure.

The Chair: Thank you, Mr. Tabbara.

Now we will go to Mr. Nuttall, please, for five minutes.

Mr. Alexander Nuttall (Barrie—Springwater—Oro-Medonte, CPC): Thank you, Mr. Chair, and thanks to all of you for the presentation as well as the answering of questions today.

The Auditor General highlighted both the successes of and the need for improvement surrounding data. I want to pick up on where Mr. Christopherson was. It sounds like the data is being used effectively when looking at the focus on dollars spent.

Where it sounds like the data is not being used effectively is that it's supposed to focus on people and the actual person who's being helped, or taken from the person who has been helped and used within national statistics. At this point within your department, would you have data you could pull that would say "we're seeing this many issues in relation to oral health at this age with our young people" in first nation communities or even in the city?

Mr. Jean-François Tremblay: We have a lot of data on access to this service and what kind of surgery and services people receive. It's there. The issue is going to level 2, if you want. As you said, it's to use that data to try to prevent...to look at what the trends are and what other kinds of services we should offer in the future. Where do we see progress? Where do we see gaps? We actually have a lot of that data.

Mr. Alexander Nuttall: So, the funding that's put into this program, is it funding the analysis of this data as well, or would there be separate individuals who do that work?

Mr. Jean-François Tremblay: It is something that we're doing in the department.

Mr. Alexander Nuttall: It's within the department, so you have direct control over that.

Mr. Jean-François Tremblay: For the non-insured health benefits program, we have the information, yes.

● (1655)

Mr. Alexander Nuttall: So, you would be able to, then, turn this information around pretty quickly.

Mr. Sony Perron: Actually, we are using this. We are using the data we have to look at trends, the type of utilization, and prevention versus treatment. We do all of this. What we cannot do, and where I think our partners from the OAG are driving us, is to be able to say how much these services—because they are evidence-based—are improving overall oral health. The data doesn't tell us this, so we need more. We need to bring other data together with this data to be able to say whether, overall, as a result of scaling, the exams that are done, and fluoridation that oral health is improving.

We know that the services we are funding and supporting are increasing the demand, the utilization. These are all good indicators, but in the end, is all this leading to a better oral health outcome? We need a population-level survey, for example, to help us on that front, and we are working on this as well.

Mr. Jean-François Tremblay: We have a lot of information on—

Mr. Alexander Nuttall: But at the same time, the access is not increasing, right?

The data is there and the funding is there. You may ask for more funding, but the funding is there. However, the access is actually going down. To me, that's a management issue.

The reason I call it a management issue is this. We have the data to use to determine the path that we need to go to attain the results we're looking for. We have the funding in place as well, even if the funding remains the same and does not increase. Also, you're right, the CPI and all of these things are contributing factors. The idea is that we're finding efficiencies, at the same time, in every department in this government, not just yours. If we're finding efficiencies, if the CPI and funding remain the same, but access is going down, plus we have data that we're not using, then that's straight up a management issue. That's something I would like to see addressed in the future once we go through this report at committee. This is something I want to see reported back on because if that data is truly there, it should not take very long to be able to provide examples to this committee as to what changes are going to be taking place.

In fact, I can tell you—because we happen to be in politics and data is incredibly important to us—that if I go to a group with zero information and say, "I need a poll on these 10 subjects in these cities, and I need you to bring the information to me", we can analyze it and turn it around from front to back in two to three weeks. If you have the data already, I assume you should be able to do a similar thing.

Mr. Jean-François Tremblay: I will just give you specific points on this.

We have a significant level of data on the access to the non-insured health benefits, which means going to the dentist and getting surgery, for example. On that usual access to the system, we have a lot of information. The area where we have seen a decline, and that we have to better explain in the future, is prevention. This program, as it was mentioned, is the $5 million per year. It's not our major program. It's actually a small program in comparison with the rest. That's where we need to have more information.

As the Auditor General mentioned, we don't necessarily have the same relationship with each of the individuals who participate in those events. That's the part that we need to actually work on.

The Chair: I think Mr. Nuttall's frustration about this, without putting words in our Auditor General's mouth but paraphrasing him when he tabled these reports in the House of Commons, is that too many federal government programs do not seem to measure success in terms of how they affect Canadians. He said this not just about this department, but about other departments in government as well.

What Mr. Nuttall has said is that we do the data analysis, we pinpoint the money and where it's going, the issues, and all of that, but really, what it boils right down to is the effect on Canadians. That's where we have to take data. We have to improve it on the people side.

All right, Monsieur Massé, I think you may have the final say today. Go ahead. You have five minutes.

[*Translation*]

Mr. Rémi Massé: Mr. Tremblay and Mr. Perron, you have a number of years of experience in this organization. You have obviously consulted with First Nations communities for a number of years.

The oral health of indigenous people does not seem to be improving at the desired rate. Moreover, significant challenges remain in terms of data collection, service delivery and administrative mechanisms. Of course, we would not be here today if there were no problems. Clearly, there are some. Given your expertise and experience, here is my question for you.

If all means were at your disposal, which three priorities would you like to see addressed? Which three things do you think should be put in place to solve this significant challenge for our First Nations in the coming years?

● (1700)

Mr. Jean-François Tremblay: Is your question focused on oral health?

Mr. Rémi Massé: Exactly.

Mr. Jean-François Tremblay: Our main concern is still the need for information and, above all, results. So we really need surveys in order to find out the direct impact of the programs.

Mr. Rémi Massé: What is preventing you from having that type of information?

Mr. Jean-François Tremblay: We are preparing to work with the public health sector, with Statistics Canada, as well as with First Nations and Inuit. As you have already heard, a national health survey is planned for 2021 or 2022. In collaboration with the First Nations and Inuit, our objective is certainly to develop a component for them, so that we can study the results of the programs. For us, that is an essential factor.

Mr. Rémi Massé: Okay. That was your first factor. What would be the second?

Mr. Jean-François Tremblay: It would be to continue to work in partnership with the indigenous peoples. Changes in health cannot be imposed on anyone; they must come from people. So the changes must be planned in partnership with indigenous people. In the long run, these changes should ideally be developed by indigenous authorities.

The third factor—

Mr. Rémi Massé: Forgive my curiosity, Mr. Tremblay, but what feedback or recommendations are you receiving from First Nations and Inuit regarding oral health? What are the basic aspects?

Mr. Jean-François Tremblay: I'm going to let Dr. Plante or Mr. Perron answer you, since they were the ones who led the consultations.

Mr. Sony Perron: The first aspect would be cultural safety, that is, serving the clients in an appropriate way with people who understand the culture.

The second aspect would be the control of the services. The approach cannot be the same in the Quebec City region as it is in northern Quebec, nor in northern Ontario compared to the Toronto area. Therefore, we have to work with indigenous partners to give them control of these programs so that they can organize and manage them according to their particular context. We already do this to a certain extent with our regional teams, but the best approach is for services to be managed by the communities themselves.

We mentioned earlier that the data did not include British Columbia because the responsibility for services was transferred to the First Nations Health Authority in 2013. So an indigenous organization, not the federal government, manages all health services for First Nations in British Columbia. Since the transfer, the indigenous people have slightly modified the services to improve and tailor them to their provincial context and to the needs of the regions of British Columbia.

We need to really move forward on this whole issue of the federal government transferring the management of services to people who are closer to the front lines and who can organize programs more effectively.

Mr. Rémi Massé: That is interesting, Mr. Perron. Could you explain how those transfers are done and how it works today? If I understand correctly, we are talking about an agreement that has been negotiated between your department and the Government of British Columbia.

Mr. Jean-François Tremblay: It is a tripartite agreement with the indigenous peoples and it was negotiated over a number of years.

Mr. Rémi Massé: Do you consider it as a model?

Mr. Jean-François Tremblay: We do. The recent budget allocated funds to support our negotiations on reworking health services. So we have to see how we can make sure that the services will not only be provided by the indigenous peoples, but also ultimately developed by them to meet their own needs.

Mr. Rémi Massé: Does that model influence your strategic planning nationally? We are hoping that it will all be worked out quite quickly so that we can all become familiar with your action plan. Would you like to extend the model to other provinces in the coming years?

Mr. Jean-François Tremblay: Yes, but it is more than that. Actually, the third point that I wanted to bring up is about the holistic approach. We cannot proceed program by program alone. What we have to do, clearly, is give indigenous organizations the means to provide a body of services. In our view, that approach goes beyond oral health care and services, which make up one part of the overall health care and social services.

We are also making efforts in education, as you were able to see with the negotiations that took place in northern Ontario. We mentioned the British Columbia situation, but we could also have mentioned the governmental autonomy in education in the Atlantic provinces., where the gap between indigenous and non-indigenous populations has been practically eliminated over the last 21 years.

That is the kind of approach we are looking at. We do not have one single approach because we do not want to impose one. The department's objective is certainly to move to that model across the country as quickly as possible.

● (1705)

Mr. Rémi Massé: Thank you, Mr. Tremblay.

Mr. Chair, if I may, I would like to ask Mr. Ferguson a question.

Mr. Ferguson, we have talked about strategic planning, about collecting and analyzing data, about administrative process, and about projects that seem to have produced results.

Have we missed anything as we studied your report, anything to which we should pay particular attention? Are there matters that you would like to see us address by the end of our study?

We have a few minutes left.

Mr. Michael Ferguson: In general, I believe that we have touched on the main points.

We first have to understand the impact of the services and the gap that exists between the two populations. We must also ask ourselves whether it is possible to narrow that gap. That is what I see as the most important.

In my opinion, there is one topic that we have not really dealt with, which is to fully understand all the obstacles that exist. We have discussed diet and geographic distribution, for example, but not the problems caused for the people doing the work.

There might be issues with facilities, with buildings, with housing, and with the way to get into those communities. Obstacles, in fact, that come from the very remoteness of the communities. Can the people who go to work in those communities have the equipment, the machinery and the housing they need in the communities? That is another aspect that we have not discussed today.

Mr. Rémi Massé: Thank you, Mr. Auditor General. I am very grateful for your comments.

Your reports are clearly important. I was a public servant for a number of years. Sometimes, we focus on programs and service delivery, but we also tend to look at them in isolation. You allow officials and departments to sort of take a step back to determine whether the service delivery should be looked at again. We do it from time to time, but I must highlight once again the remarkable work you and your team do to help parliamentarians and public servants to provide decent services all across Canada to Canadians, to the First Nations and to the Inuit.

[*English*]

The Chair: Thank you, Mr. Massé, and thank you to all of our guests here today.

Typically at the end of a meeting I remind those who have attended that the Auditor General issued his report on this. I think he had five or six recommendations. We also will be issuing a report on today's study. As you leave here, you may contemplate some of the questions that were asked of you. If you're like me and are on your way home and think that you could have added something to your answers or should have said something more, we encourage you to please submit to our analysts and our committee any further information you have that might be of benefit to us as we try to build a report around this.

We wish you all the best in the strategy you're building and as you deliver for our Inuit and first nations people.

I thank the committee for its good questions today and, as always, the Auditor General for a job well done on the audit.

We are now adjourned.