Specialty Feature

Indian and Inuit Dental Care in Canada: The Past, The Present, and The Future

W.R. Bedford, DDS, DDPH
Ottawa
K.W. Davey, DDS, M.Sc.D., FRCD(C)
Nanaimo, B.C.

Summary of Legislative History

The legal mandate for the provision of health services to Canada's native people has never been definitively established by legislation. In fact, the wording of many of the key acts is ambiguous and sometimes appears contradictory. It is often unclear which act or clause takes precedence over others. As a result, native organizations and the federal government have very different perceptions of Canada's responsibilities in this area. The provinces have tended to stay out of the debate, which in itself is instructive.

Arguments about the legal mandate for the provision of native health services usually refer to one or more of the following:

1. The Royal Proclamation of 1763
2. The BNA Act of 1867 (now known as the Constitution Act)
3. The Indian Act of 1874 and its amendments
4. Treaty No. 6 of 1876 (and perhaps later Treaties)
5. The Charter of Rights and Freedoms of 1982, enshrined in the Constitution of Canada
6. The Canada Health Act of 1984

Treaty Number 6 (1876)

Signed by Canada and the Cree of central Alberta and Saskatchewan, this treaty contains the "medicine chest" clause that forms the nucleus of Indian claims to health care as a right. It states that: "A medicine chest shall be kept at the house of each Indian agent for the use and benefit of the Indians at the direction of such agent."

This is the only written treaty that defines the responsibilities of the federal government with regard to native health care services, but oral equivalents are believed to exist in Treaties 8, 10, and 11.

Canada Health Act (1984)

Section 10 of the Canada Health Act states that: "The health care insurance plan of a province must entitle 100 per cent of the insured persons of the province to the insured health service provided for by the plan on uniform terms and conditions." The accepted interpretation of this section is that Indians are entitled to insured hospital and medical services on the same basis as all other residents.

The Canada Health Act, however, insures diagnostic and treatment services only. In effect, the federal government provides a uniform per capita block grant for insured services. The provinces, at their discretion, then provide other services to some or all residents.

The Federal Government Position

The 1979 Indian Health Policy (IHP) is the basis for the current design and direction of Canada's Indian Health Services (IHS) program. Major sections of this policy include statements that:

"The federal Indian health policy is based on the special relationship of the Indian people to the federal government, a relationship which both the Indian people and the government are committed to preserving...

"The 1979 policy rests on "three pillars"... The first, and most significant, is community development, both socio-economic development and cultural and spiritual development, to remove the conditions of poverty and apathy which prevent the members of the community from achieving a state of physical, mental, and social well-being.

"The second pillar is the traditional relationship of the Indian people to the federal government, in which the federal government serves as advocate of the interests of Indian communities to the larger Canadian society and its institutions, and promotes the capacity of Indian communities to achieve their aspirations...by encouraging their greater involvement in the planning, budgeting and delivery of health programs.

"The third pillar is the Canadian health system. This system is one of specialized and interrelated elements which may be the responsibility of federal, provincial or municipal governments, Indian bands, or the private sector. But these divisions are superficial in light of the health system as a whole. The most significant federal roles in this interdependent system are in public health activities on reserves, health promotion, and the detection and mitigation of hazards to health in the environment. The most significant provincial and private roles are in the diagnosis and treatment of acute and chronic disease, and in the rehabilitation of the sick. Indian communities have a significant role to play in health promotion, and in the adaptation of health services delivery to the specific needs of their community...The federal government is committed to maintaining an active role in the Canadian health system as it affects Indians. It is committed to encouraging provinces to maintain their role and to filling gaps in necessary diagnostic, treatment, and rehabilitative services."

The Indian Position

The position of Canada's Indian people has always been clear, consistent and unequivocal: The right to health care services is a treaty right, and the federal government has a responsibility to provide health care to Indians.

Although no written mention of health services appears in any of the treaties other than Treaty No. 6, the Indian people claim that health services were similarly negotiated in the discus-

sions leading up to other treaties. From their perspective, the federal government pledged its word, even though there is no written record that this occurred. The Indian position is that:

1. The federal government is responsible for Indian Health services, with "responsibility" defined in the strongest possible terms.
2. Indian people wish to deal with one government in negotiating health services – the federal government.
3. Indian people regard Treaty No. 6 and the other treaties that followed as fundamental and binding.
4. Indian people consider the federal government's failure to recognize the full meaning and scope of the treaties, together with its unwillingness or inability to resolve jurisdictional disputes with the provinces, as instrumental in the failure to improve Indian health status to an acceptable level.

The Federal Health Delivery System

The National Health and Welfare Act was passed in 1944. The next year, Indian Health Services was finally severed from the Indian Affairs Branch and transferred to the reorganized federal Health Department.

Indian Health Services was administered by one of several directorates in the Health Department through a network of regions and zones. There were initially five regions: Eastern, Central, Saskatchewan, Foothills, and Pacific. During the 1950s, the number of field facilities grew rapidly, and by 1960 there were 22 hospitals with a total of 2,172 beds, as well as 30 clinics, 37 nursing stations, and 83 health centres. Over $23 million, or about 10 per cent of the total Health and Welfare departmental budget, was spent on these services.

A major reorganization of the Health Department took place in 1962. Indian Health Services was discontinued as a separate administrative entity, and a new branch called Medical Services was created by amalgamating seven former independent field services: Civil Aviation, Civil Service Health, Indian Health, Northern Health, Quarantine, Immigration, and Sick Mariner services. This new directorate was given the task of providing direct services to various categories of Canadians whose health care fell outside provincial jurisdiction. The Indian health program remained a major activity within Medical Services, and the region and zone structure was maintained and applied to the entire Medical Services spectrum of activities.

In the century since the "medicine chest" was first mentioned in Treaty No. 6, health services for Indians had developed into a vast network of facilities and personnel, offering a wide array of programs. While the role of the federal government appeared to have peaked, the debate about who should be responsible for health care services for Indian people, and how these services should be delivered, has never ended.

Dental Services

No official policy exists to describe the responsibilities of the Medical Services Branch (MSB) in the area of native dental care. As a result, the dental program has been allowed to evolve as needs arose, and to respond to client demands as well as departmental fiscal restraints.

As little as 20 years ago, there were virtually no formal dental delivery services in place in remote locations. It was not uncommon for nurses, and sometimes priests, to extract teeth. Children were often flown into larger centres such as Frobisher Bay (now Iqaluit), where they would be given a general anesthetic, have their decayed teeth extracted and their mouths packed with gauze, and be sent back home.

There was little or no equipment available to provide restorative care in remote communities, and government salaries were too low to attract good personnel. As well, dentists were far too busy in their private practices to have any interest in providing more than emergency care to Indian patients, particularly since the approval and payment systems operated by MSB were very slow and cumbersome.

To respond to some of these shortcomings, Health and Welfare Medical Services Branch contracted with the University of Toronto in 1971 to develop and operate what is now called The National School of Dental Therapy (NSDT).

The school's dental therapy program embraces a teaching component and a service component designed to meet the dental needs of Medical Services Branch. In addition to its training responsibilities, the school is responsible for:

1. Standardization of procedures, equipment and techniques.
2. Quality control with regard to the work performance of graduates.
3. Placement, orientation and refresher courses for graduates.

As the dental therapy program grew and expanded to provide consistent levels of care in remote locations, the dental situation for private practitioners was also changing. The profession began to experience a surplus of dentists, and many dentists found that they were becoming less busy. As a result, the dental community became more interested in treating native people.

This new-found interest put a great deal of pressure on the existing, and somewhat antiquated, manual processing system used to handle prior approvals for treatment and payment for services rendered. As a result, MSB dental officers became mired in volumes of paper.

In 1979, a slow, painful process was begun to develop a schedule of dental services that would be acceptable to MSB management and the basis for a National Dental Claims Processing System (DCPS). This became a reality in 1987.

Unfortunately, the new system still demanded a great deal of prior approval for care, which, combined with a less-than-acceptable client identification system, created an even greater paper load for regional dental officers (RDOs) and their staff. Obviously, if MSB was ever to ease the administrative load of its RDOs, and provide time to begin good preventive programming, it would have to reduce the requirement for prior approvals. This proved to be easy, as prior approval was generally not necessary. In actual fact, cases were seldom turned down except for financial reasons.

A revised schedule of dental services was developed in cooperation with the Canadian Dental Association, with a view to minimizing the requirement for prior approval. As part of this process, consideration was given to removing prior approval requirements for all services that:

1. RDOs could not reasonably refuse without personally examining the patient.
2. An individual who was maintaining reasonable oral hygiene could reasonably be expected to require.

Reducing the requirement for prior

approvals and relieving RDOs of the responsibility for verifying patient status would, MSB believed, give the branch's field staff more time to develop good preventive care programs. This approach was seen as the best way for MSB to bring about improved oral health in the native population, but it would require the branch to reach people on reserves or in schools.

Today, the new system is refined to the point where dental care is being made available on a regular basis to most native people who want it. Even the most remote settlements are now visited by dental care teams for varying periods of time.

The Dental Therapy Program

In the summer of 1972, the Department of National Health and Welfare embarked on a new participatory concept for dental care in Canada's Northern communities. This involved training residents of the Northwest and Yukon territories as dental therapists, who would then be capable of meeting the primary dental care needs (fillings, extractions, and preventive services) of Canadians living in the Arctic and Subarctic.

The concept embraced two essential components: developing a school and a two-year dental therapy program; and ensuring that the quality and delivery of dental care remained in the control of certified graduates in the field. Three primary objectives were established for the program:

1. To train residents of Canada's north to administer high quality primary dental care under the supervision of a dentist.
2. To make dental care available to everyone, particularly inhabitants of small settlements, by establishing dental clinics manned by a resident dental therapist.
3. To establish a program of dental health education and preventive dentistry in each community.

To accomplish these objectives, three basic principles were formulated:

1. Equipment and procedures throughout the service would have to be standardized.
2. The quality of the work provided by the therapists and supervising dentists in the field would have to be controlled and monitored.
3. The clinics established under the program would have to be portable.

The dental therapist concept adopted by Medical Services Branch owes its strength to standardization and its focus on simplicity and consistency. Uniformity is established during training. It is maintained after graduation through a mechanism of regular field evaluations and consultations by NSDT staff.

Recently, the dental therapist concept has caught the attention of several developing nations. These countries tend to have very limited resources, and view the concept as an ideal solution to many of their dental needs.

As a result, NSDT has incorporated an international component. This has resulted in training opportunities being made available to students from countries such as Cameroon, Zimbabwe, Zaire, Nepal, Dominica, Grenada, Anguilla, Jamaica, and the Philippines.

Since its inception in 1972, the school has graduated 116 non-native students and 63 Indian, Inuit and/or Metis students, for a total of 179. The school has also graduated nine foreign students and others are still in training. In addition, from 1985 to 1988, a special one-year training program was conducted for 17 Mozambicans.

Status of Current Dental Care Program

a) Strengths

The present dental care system provides prompt service to those MSB clients who can access private practitioners, as well as to those in remote or isolated areas, where treatment is provided by resident dental therapists.

Blue Cross is providing efficient payment mechanisms (by mail or direct bank deposit) to private practitioner providers, who highly appreciate this service.

Equally important, for the first time in MSB history, the national claims processing system is capturing national data as well as individual client histories and provider profiles.

b) Weaknesses

Unfortunately, the program still lacks total standardization, and it will continue to do so until all prior approval requirements are eliminated as individual dental officers view treatment requests and special circumstances differently.

In addition, the program lacks an effective denture delivery system in remote areas, as witnessed by the 55 per cent denture failure rate reported in two separate studies in the Northwest Territories.

There is presently no preventive programming thrust, except for the oral health education provided by the dental therapists themselves. Furthermore, the dental program lacks the support of regional senior managers. This was borne out recently by the decision to delete dental person years in several regions, and restrict the number of dental therapist positions.

Finance and Administration

There are approximately 450,000 Indian and Inuit people in Canada who are deemed eligible to receive services under the Non-Insured Health Benefits Program. These benefits include drugs, eye glasses, prosthetic appliances, dental care and transportation services.

The cost of providing dental services to Canada's native people is in excess of $60 million per year, with the bulk of this money going to private practice dentists. These dentists are paid through a computerized National Dental Claims Processing System operated for Medical Services Branch by Blue Cross of Canada.

Yearly negotiations between MSB's regional offices and Canada's provincial dental associations establish appropriate fee schedules for the services provided to native patients. These negotiated or established rates, usually a percentage of each provincial dental association's fee schedule, are provided to Blue Cross to be used for automatic cheque processing.

Nationally, CDA was involved in the development and revision of the Schedule of Dental Services for native people. The community dentistry section at the University of Toronto, along with the National School of Dental Therapy, played a key role in a recent survey to assess the dental needs of native people, as well as in expanding the Management Information System (MIS) for dental therapists. They were also involved in a joint project with the Commonwealth of Dominica in the Caribbean to train dental therapists, and to reinforce and upgrade the dental therapist program.

Involvement of Native People

In some parts of the north, local people are frequently employed by visiting dental staff. This has proven to be advantageous, given that these individuals, when trained, can act as dental assistants and, importantly, as interpreters.

Some locally-trained people have developed a keen interest in dentistry. A

few have subsequently been encouraged to pursue formal training at NSDT and have graduated as dental therapists. Some of these graduates have continued their academic careers, and have graduated as dentists via an access program at the University of Manitoba. The access program upgrades the students' knowledge of basic sciences to facilitate their entrance into the dental faculty. Given their experience and skill in dental therapy, dental hygiene is also a viable option for NSDT graduates, and this is being explored in some parts of the country.

All of the MSB dental therapists, many of whom are Canadian Indians, participated in the data collections process for the recently completed survey of Indian and Inuit dental needs.

The federal government is committed to transferring control of Northern health services to Indian and Inuit organizations, as well as to the governments of the Northwest and Yukon territories. Several transfers have already taken place, although only a few of these have included dental services. One of the earliest such transfers took place in 1976, when the Manitoba-based Swampy Cree Tribal Council took over control of their band's dental program. The program has had some difficult periods since then, but it has survived. Current plans call for the program to be expanded by using dental therapists to service six communities under the council's jurisdiction.

The Future

As in all other sectors, the dental program will have to make do with fewer resources for the foreseeable future. Spending and staffing cutbacks could adversely affect the program. It will therefore become increasingly important to involve native leaders in the decision-making process, as they can best assess the type of service and delivery modes needed to meet the oral health needs of their communities.

Significant improvement in the oral health status of MSB clients can only be brought about through effective dental preventive programs. These programs have already resulted in a dramatic reduction in dental caries among the general Canadian population. To accomplish similar results in the Indian and Inuit population will require a greater commitment on the part of Medical Services Branch.

There is no doubt that dentistry has the knowledge and materials to vastly reduce or even eliminate dental decay. New and more effective products to prevent both dental caries and periodontal disease are constantly coming on the market. And dental therapists are now trained and working in remote and underserviced small communities, on a full-time basis, as additional members of the dental health teams.

The MSB dental program has now been refined to the point where it should be able to begin programs that will result in significant improvement in the oral health of Canada's Indian and Inuit people. ■

Bibliography

1. Policy of the Federal Government Concerning Indian Health Services, Ottawa, Health and Welfare Canada, 1974.
2. Indian Health Policy, Ottawa, Health and Welfare Canada, 1979.
3. Indian Health Discussion Paper, Ottawa, Health and Welfare Canada, 1980.
4. Evaluation of Indian Health Services, Ottawa, Health and Welfare Canada, 1990.
5. Young, T.K. *Health Care and Cultural Change*, Toronto, University of Toronto Press, 1988.
6. Gershman, D.M. *Northern Dental Program – Manitoba Region and Northwest Territories*, Winnipeg, University of Manitoba Press, 1983.
7. Davey, K.W. Dental Therapists in the Canadian North. J Canad Dent Assoc 40:287-291, 1974.

Tantum™ Oral rinse
(Benzydamine HCl Solution)

Prescription relief of oral pain and inflammation.

Summary of prescribing information

THERAPEUTIC CLASSIFICATION
Topical Analgesic — Anti-Inflammatory

Action
Animal studies using the parenteral route have shown that "Tantum" Oral Rinse possesses properties of an analgesic—anti-inflammatory agent. This effect is not mediated through the pituitary-adrenal axis. Studies using the topical route have demonstrated the local anesthetic properties of benzydamine hydrochloride. In controlled studies in humans with oro-pharyngeal mucosity due to radiation therapy, "Tantum" Oral Rinse provides relief through reduction of pain and edema. Similar studies in patients with acute sore throat demonstrated relief from pain.

Indications
"Tantum" Oral Rinse is indicated for relief of pain in acute sore throat and for the symptomatic relief of oro-pharyngeal mucositis caused by radiation therapy.

Contraindications
"Tantum" Oral Rinse is contraindicated in subjects with a history of hypersensitivity to any of its components.

Precautions
The use of undiluted "Tantum" Oral Rinse may produce local irritation manifested by burning sensation in patients with mucosal defects. If necessary, it may be diluted (1:1) with lukewarm water. Since "Tantum" Oral Rinse is absorbed from the oral mucosa and excreted mostly unchanged in the urine, a possibility of its systemic action has to be considered in patients with renal impairment.

Use In Pregnancy
The safety of benzydamine HCl has not been established in pregnant patients. Risk to benefit ratio should be established if "Tantum" is to be used in these patients.

Use in Children
Safety and dose directions have not been established for children five years of age and younger.

Adverse Reactions
The most frequent adverse reactions reported are: local numbness (9.7%), local burning or stinging sensation (8.2%), nausea and/or vomiting (2.1%). The least frequent were reports of throat irritation, cough, dryness of the mouth associated with thirst, drowsiness and headache.

Treatment of Overdosage
There are no known cases of overdosage with benzydamine HCl gargle. Since no specific antidote for benzydamine is available, cases of excessive ingestion of the liquid should receive supportive symptomatic treatment aimed at rapid elimination of the drug.

Dosage and Administration
Acute sore throat: Gargle with 15 mL every 1 1/2 to 3 hours keeping in contact with the inflamed mucosa for at least 30 seconds. Expel from the mouth after use.

Radiation Mucositis: Use 15 mL as a gargle or rinse repeated 3-4 times a day, keeping in contact with the inflamed mucosa for at least 30 seconds and then expel from the mouth. Begin "Tantum" Oral Rinse the day prior to initial radiation therapy; continue daily during the treatment and after cessation of radiation until the desired improvement is obtained.

Availability
Tantum Oral Rinse is available in 100 and 250 mL bottles. "Tantum" Oral Rinse is a clear yellow-green liquid containing 0.15% benzydamine hydrochloride in a pleasant-tasting aqueous vehicle with 10% ethanol.

Product monograph is available on request.

References:
1. Simard-Savoie S and Forest D. *Curr Ther Res* 1978; 23(6):734-45.
2. Whiteside MW. *Curr Med Res Opin* 1982;8:188-9.
3. Wethington JF. *Clin Ther* 1985;7(5):641-6.
4. Product monograph.
5. Yankell SL. Evaluation of benzydamine HCl in patients with aphthous ulcers. *The Compendium of Continuing Education* 1981; II(1).
6. Epstein JB. *Int J Radiation Oncology Biol Phys* 1989; 16(6):1571-5.

PAAB CCPP

3M Pharmaceuticals
3M Canada Inc.
Post Office Box 5757
London, Ontario N6A 4T1

3M