HOUSE OF COMMONS
CANADA

FIRST NATIONS AND INUIT DENTAL HEALTH

REPORT OF THE STANDING COMMITTEE ON HEALTH

Bonnie Brown, M.P.
Chair

June 2003

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Available from Communication Canada — Publishing, Ottawa, Canada K1A 0S9

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THE STANDING COMMITTEE ON HEALTH

has the honour to present its

FIFTH REPORT

In accordance with its mandate under Standing Order 108(2), your committee has conducted a study on First Nations and Inuit dental health and reports its findings and recommendations.

CHAIR'S FOREWORD

The Standing Committee on Health is concerned about the dental health of First Nations and Inuit people in Canada. While the dental health of average Canadians has improved greatly in the last 30 years, this is unfortunately not the case for the Aboriginal population of this country. Indeed, socio-economic conditions and the remote locations of First Nations and Inuit communities often make it difficult to ensure that these populations receive timely dental care and effective preventive measures. In addition, clients were clearly apprehensive about the potential uses of a comprehensive client consent form proposed by Health Canada for implementation in September 2003.

The Committee wants to ensure that these Canadians receive the same quality of care as that available to the general population. To accomplish this, the emphasis must be on increased and appropriate funding for preventive measures to curtail the negative effects of poor dental health in these communities. The Committee also concurs with witnesses who suggested that the amount available for dental benefits without pre-approval needs to be increased. In addition, it calls for better coordination on the part of Health Canada and dental care practitioners as well as wider education by and of community members to improve the general dental health of First Nations and Inuit. Furthermore, the Committee feels that the traditional single-procedure client consent forms for dental care must remain an option until the Department of Health has gained the confidence of the clients for the use of the comprehensive consent form.

On behalf of the members of the Committee, I would like to thank the witnesses for their time and expertise. The Committee members are grateful for the professional guidance provided by the researchers from the Library of Parliament, Nancy Miller Chenier and Sonya Norris, and the clerk of the Committee, José Cadorette. In addition, we thank the editors, interpreters, console operators and others for their hard work and team effort to make this report possible.

I would also like to thank the individual members of the Committee who participated in this study for their time and concern for this issue.

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THE COMMITTEE FOCUS

When the Standing Committee on Health became aware of concerns about dental care provided through Health Canada's Non-Insured Health Benefits (NIHB) program, it decided to undertake a short study. Initially, this undertaking was to examine access by First Nations and Inuit individuals to preventive and restorative services. However, during the proceedings, the Committee also heard related problems surrounding client consent.

To gain clearer knowledge about the multiple issues, the Committee arranged one meeting with Health Canada and various organizations representing the involved interests. The meeting included witnesses from the Assembly of First Nations (AFN), Inuit Tapiriit Kanatami (ITK), Canadian Dental Association (CDA), and Canadian Dental Hygienists Association (CDHA).

THE NON-INSURED HEALTH BENEFITS DENTAL PROGRAM

A. Overview of the Dental Program

Health Canada told the Committee that, through the Non-Insured Health Benefits (NIHB) program, it provides specified dental services to approximately 720,000 registered First Nations, Inuit and Innu individuals. In general, coverage for dental services is based on individual need and includes:

- Diagnostic (examinations, x-rays)
- Preventive (cleanings)
- Restorative (fillings)
- Endodontic (root canal treatments)
- Periodontic (treatment of gums)
- Prosthodontics (removable dentures and fixed bridges)
- Oral surgery (removing teeth)
- Orthodontics (straightening teeth)
- Adjunctive services (additional like sedation).

> "Given the diverse group of providers and services covered, the program recognizes that opportunities exist to improve the program."
>
> – Peter Cooney, Health Canada

In 2002/2003, the NIHB dental program funded an estimated 365,000 First Nations and Inuit clients at a cost of approximately $130 million. This represented an expenditure increase of 5% from the previous year. Dental expenditures accounted for about one-fifth of the total costs of the NIHB.

B. Previous Concerns about the Dental Program

Without providing details, Health Canada referred several times to public calls for audits and increased accountability for the public funds dispensed through this program. The Committee understood that these references pointed to various concerns highlighted in reports of the Auditor General of Canada. In 1993, 1997 and 2000, the Auditor General made recommendations for improved program management and delivery in the Non-Insured Health Benefits program.

Specifically, on the dental program, the reports included the following observations:

- 1993 — The claims processing systems and departmental procedures are inadequate for monitoring and controlling some benefit claim payments.[1]
- 1997 — Dental care providers provide services up to the established frequencies and limits rather than based on needs, resulting in over-servicing of some clients. Audits of providers and a system of predetermining dental benefits has the potential to achieve savings while implementing a needs-based approach to ensure receipt of required dental care.[2]
- 2000 — Concerns about over-servicing by dental care providers led to a predetermination process whereby prior approval and a treatment plan for performing dental services above a prescribed dollar threshold was required. This move to predetermination was implemented nationally in late 1997 as a needs-based approach to providing dental care. Predetermination, combined with changes to the benefit schedule, reduced dental costs and program costs.[3]

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1 Auditor General of Canada, *Chapter 19 — Department of National Health and Welfare, Non-Insured Health Benefits*, Ottawa: 1993, paragraphs 19.29 to19.33.

2 Auditor General of Canada, *Chapter 13 — Health Canada — First Nations Health*, Ottawa: 1997, paragraphs 13.124 to 13.140.

3 Auditor General of Canada, *Chapter 15 — Health Canada — First Nations Health: Follow-up*, Ottawa: 2000, paragraphs 15.90 and 15.91.

C. Current Dental Plan Conditions

Health Canada indicated that it now assesses individual client needs through a predetermination process under which the dental practitioner completes a treatment plan for the recipient and submits it to the program for funding approval. The department maintains that the needs-based approach to the provision of dental benefits ensures that the client receives required services. A dental benefit grid that sets out frequency limitations for various services is also a component of the dental benefit plan.

Under the NIHB dental plan, the First Nations or Inuit client does not pay the provider directly and then seek reimbursement from the NIHB program. Instead, the provider is responsible for billing the plan in order to receive payment. Health Canada reported that the plan is moving toward electronic transfer of claims statements directly from the dental office to the claims processor. Alberta is expected to be online in the spring of 2003 and it will be followed soon after by national access for providers in all provinces and territories.

Currently, each registered client is entitled to receive dental work up to a pre-established amount of $800 every 12 months without any prior approval. This pre-determination level was increased from $600 as recently as October 2002. Health Canada indicated that the average patient receives about $420 worth of care annually.

For payment on other work beyond the pre-established amount of $800, the dentist is required to provide particular documentation. While specific emergency procedures above this amount do not require predetermination, plan administrators expect predetermination for certain procedures such as root canals, crowns and dentures. However, post approvals are considered for certain basic and emergency services when the intervention is deemed necessary. Thus, post-approval of services that are appropriate and required can take place and be reimbursed through the NIHB plan.

> "[trans] The predetermination level should be raised to $1,000, as with most standard programs on the market."
>
> – Dr. Louis Dubé, CDA

D. Current Providers and Care

Information from Health Canada pointed out that dentists in private practice are the primary providers of dental care under the NIHB dental program. Fee-for-service dental costs represented 84.9% of all NIHB dental costs in 2001/2002. Health Canada also utilized contract dentists who accounted for 4.2% of total costs.[4]

[4] Health Canada, *Non-insured Health Benefits Program 2001/2002 Annual Report*, Ottawa: 2003.

Health Canada noted that dental hygienists provide care to clients within dental practices but not independently. The department also employs First Nations and Inuit dental therapists who are trained over two years at the National School of Dental Therapy in Prince Albert, Saskatchewan. After training, these dental therapists generally return to live and work in their communities.

Expenditure data for 2001/2002 reveals that recall examinations were performed most often and porcelain/ceramic fused metal crowns were the most costly dental procedure. Utilization data indicates that 36% of eligible clients received at least one dental procedure. Of these, 55% were female and 45% male. The average age of the dental claimants was 27 years.

ISSUES

A. Promotion and Prevention

The Committee heard that, although dental and oral diseases are largely preventable, First Nations and Inuit people have dental decay rates from two to five times greater than the non-Aboriginal population in Canada. This is a particular concern for young people with indications that the average 12-year old First Nations or Inuit child may have between seven to nine teeth missing, filled or decayed compared to one in other Canadian children the same age. Much of this problem starts with early childhood tooth decay, experienced by an estimated 72% of First Nations and Inuit children aged two to five years. An additional worry is the link of gum diseases with cardiovascular diseases and with adverse pregnancy outcomes such as low birth weight babies and pre-term deliveries.

> "Aboriginal children aged 6 to 12 have two to five times the dental decay rates of non-aboriginal children."
>
> – Wendell Nicholas, AFN

Witnesses emphasized the importance of good oral health to self-esteem as well as for the routine functions of daily living such as eating, communications and socializing. They noted that poor dental health among First Nations and Inuit children leads to significantly increased costs for medical travel and treatment involving surgery under general anaesthetic. If left untreated, oral disease can lead to infection, pain, inability to concentrate in school, trouble sleeping, difficulties with digestion, behavioural and social problems.

The Committee learned about numerous factors that may lead to poor oral health and dental decay. Witnesses pointed out the link to dietary changes and called for support for traditional dietary practices and for improved food access in remote areas. They noted the lack of access to clean potable water with fluoridation in many communities and mentioned the link between smoking and periodontal disease. Finally,

witnesses indicated that there are numerous impediments to accessing oral health prevention and treatment services ranging from a lack of providers to culturally based client concerns.

The Committee is cognizant of Health Canada's ongoing efforts to improve the dental health of First Nations and Inuit clients. It supports the effort to develop and implement a comprehensive and coordinated oral health initiative. However, it feels that the current approach focusing on pathologies and treatments must be transformed more quickly to one focusing on wellness and prevention.

The Committee took particular note of the numerous references to the need to achieve and maintain oral health. It agreed that there must be a clear definition of the desired oral health standard with specific objectives and targets. It supports oral health programs that will produce measurable and positive results. In particular, it wants an increase in the number of First Nations and Inuit clients accessing preventive care and a decrease in the amount of tooth decay among children. To accomplish such outcomes, it calls on Health Canada to establish an effective and accountable oral health strategy in collaboration with First Nations and Inuit clients.

RECOMMENDATION 1: EFFECTIVE AND ACCOUNTABLE ORAL HEALTH STRATEGY

The Committee recommends that Health Canada:

(a) Undertake a new approach to oral health based on a wellness model that gives priority to promotion and prevention strategies;

(b) Develop and implement an oral health strategy with measurable goals that will investigate alternative delivery systems aimed at improving oral health and access to services;

(c) Initiate results-based incentives for all participants, clients and providers, to increase access to and positive outcomes from prevention measures; and,

(d) Increase the ability to monitor oral health trends to ascertain if the resource allocations are effective and the program is accountable.

RECOMMENDATION 2: COLLABORATION WITH FIRST NATIONS AND INUIT CLIENTS

The Committee recommends that Health Canada work with First Nations and Inuit clients to:

(a) Improve public education and awareness of oral health as a key element of overall well-being;

(b) Build oral health links into existing programs with a health education and promotion focus such as the First Nations Headstart On-reserve and the Canada Prenatal Nutrition Program;

(c) Assist communities in monitoring and reporting on oral health initiatives;

(d) Initiate community-directed and results-based incentives for preventive oral health, including such elements as community recognition campaigns and dental hygiene or dentistry scholarships;

(e) Communicate the availability of necessary preventive (and restorative) measures for every child and adult; and,

(f) Develop more creative and culturally appropriate models for delivering preventive (and restorative) care.

B. Dental Care

The Committee was told that only about 36 to 38% of NIHB clients see a dentist once a year compared to 75% for other Canadians. They also pointed to data indicating that women and young adults were more likely to seek care. Of the almost half of respondents who needed dental care, most needed restoration such as fillings and crowns, maintenance such as check-ups and cleaning, prosthetic work such as dentures.

> "Oral health is essential for the routine functions of daily living such as eating, communications and socializing, but is also necessary to self-esteem."
>
> – Larry Gordon, ITK

Witnesses suggested several reasons for limited client access to dental care. For example, they noted that many clients live in geographically remote areas where there is no dentist in residence. Many northern towns have trouble attracting and retaining new dentists on a permanent basis. In addition, clients may not have access to the preventive and treatment services offered by dental hygienists. The NIHB program does not allow dental hygienists to be on the list of

providers with a billing number even in provinces where dental hygienists can practise independently from dentists. Others indicated that the current medical transportation policy might, in some regions, lead to a reduction in client access to dental treatment.

From the provider perspective, witnesses indicated that existing dentists are opting out of the NIHB program due to heavy administrative requirements for predeterminations and for minor revisions to treatment plans. They noted the lengthy waits for approval when X-rays are sent to Ottawa by mail. They called for the ability to send pre-approvals or other information electronically. Dentists pointed particularly to additional requirements and differences from standard plans that required specially trained staff to deal with the extra paperwork. They worried about assuming a financial risk if Health Canada denies payment after the procedure has been done.

The Committee acknowledges that Health Canada recently increased to $800 the client entitlement for dental work every 12 months without any prior approval. It feels however that this pre-established amount could limit the ability to undertake appropriate and necessary preventive and restorative work. It also noted that providers and clients appeared unaware of the fact that dentists are covered for the performance of work done without prior approval if it is deemed essential. In addition, it is supportive of the preventive efforts of dental hygienists and would like to see an expanded role for them under the NIHB dental program.

The Committee is particularly anxious to remove impediments that currently limit the movement to improved oral health and to appropriate access to dental care. While it supports the efforts to train dental therapists for First Nations and Inuit communities, it also wants to ensure that First Nations and Inuit individuals can enter established fields of dentistry. In addition, it seeks reassurance that Health Canada will address the administrative problems and concerns about medical transportation.

> "Northern towns have trouble attracting new dentists and existing dentists are opting out of the NIHB program due to lengthy administrative requirements and red tape."
>
> – Susan Ziebarth, CDHA

RECOMMENDATION 3: IMPROVED ACCESS TO COMPREHENSIVE DENTAL CARE

The Committee recommends that Health Canada:

(a) Outside of the pre-established amount for services provided without prior approval, establish and promote a regular prevention plan for every First Nation and Inuit client under 25 years of age to allow on a routine annual basis a prescribed number of preventive interventions such as dental cleanings and sealants, fluoridation; instruction and education sessions, etc.;

(b) Increase the pre-established amount for services provided without prior approval to $1,000 while continuing to monitor for appropriateness of services provided;

(c) Permit and facilitate a more independent role for dental hygienists; for example, allow them to bill directly up to a predetermined amount of $200 per client annually; and,

(d) Adhere to the same standards and frequency limitations as those established with dental insurance plans for other Canadians and inform clients that the approach and limitations are applicable to other populations.

RECOMMENDATION 4: IMPROVED ACCESS TO DENTAL CARE PROVIDERS

The Committee recommends that Health Canada:

(a) Work closely with relevant universities and colleges on appropriate measures, including directed scholarships, aimed at increasing the number of First Nations and Inuit dentists and dental hygienists;

(b) Ensure that the medical transportation policy facilitates and enables access to dental treatment; and,

(c) Reduce the administrative burden for providers while ensuring accountability.

C. Client Consent

When the Committee became aware of concerns about the NIHB dental health program, it did not know about the problems associated with the consent forms that must be completed by First Nations and Inuit clients. After hearing the frequency and intensity of witness testimony on this matter, it was convinced that the requirement for consent as a condition of dental benefit coverage must be addressed as part of this oral health study.

"We have always worked, in the past, with implicit consent from our clients, but based on advice from the Department of Justice, we began working on a plan to begin to collect the [written] consent from our clients."

– Leslie MacLean, Health Canada

The Committee learned that the NIHB program has now developed a single consent form to cover all the non-insured health benefits, namely: drugs, medical transportation, dental, medical supplies and equipment, vision, crisis intervention counselling and provincial health care premiums. Health Canada explained that this 'blanket consent' is intended to reduce the paper burden and the bureaucracy while reducing misuse of the program. Health Canada emphasized that the consent initiative respects the privacy rights of the clients and indicated that benefits will not be denied to clients should they refuse to sign the new consent form. The Committee was told that clients still retain the right to apply for reimbursement on a per-use basis by submitting a 'NIHB Client Reimbursement Request Form'.

However, other witnesses suggested that a 'blanket consent' covering all benefit areas is inappropriate and culturally insensitive. Witnesses testified that the consent is too broad and leaves the impression with clients that other departments, organizations or individuals will have unrestricted use of their personal information. In particular, they noted a previous breach of trust by the First Nations and Inuit Health Branch that resulted in the violation of access and privacy surrounding the collection, use and disclosure of personal health information of First Nations and Inuit peoples. The Committee heard from some providers that the consent might also conflict with existing provincial privacy laws.

The Committee appreciates Health Canada's attempts to improve the NIHB program while balancing fair and complete benefits to First Nations and Inuit peoples with accountability to the Canadian public. It understands the need to make the administration and delivery of the program more efficient and accountable. It acknowledges that the new single NIHB client consent approach appears to be more efficient.

"The disrespectful and thoughtless way that this consent initiative has been handled has turned an empowering process, which is informed consent, into a shameful and frightening experience for First Nations."

– Dr. Mary Jane McCallum, AFN

However, the Committee is sympathetic to the arguments forwarded by First Nations and Inuit clients as well as the providers. It agrees that the new consent was not introduced in the most effective or accommodating manner. Witnesses suggested that, if the new consent is introduced over a period of just one year, many clients who do not access the NIHB program in that period may be overlooked. In order to better accommodate the cultural diversity, witnesses felt that the consent should have been introduced more gradually but more actively and directly in specific communities. Some suggested that the introduction of the consent initiative should include the direct involvement of program employees, with appropriate translators, to explain the new consent and provide an opportunity for questions. This explanation must include a clarification of who would have access to client information and who would not.

RECOMMENDATION 5: CLIENT CONSENT

The Committee recommends that Health Canada:

(a) Introduce another option of a one-time client consent for <u>each</u> of the separate benefits categories;

(b) Restrict and clarify the permission for use of information acquired with consent; specify who will have access to client information and clearly state that no one else will;

(c) Adhere to the same standards as dental insurance consent forms for other Canadians and ensure that clients are aware that the approach is applied to other populations;

(d) Extend the deadline for introducing the new consent beyond 1 September 2003;

(e) Indicate clearly to clients and providers that access to program benefits is still available even if the blanket consent form is not signed;

(f) Invest in appropriate promotion of the consent initiative through improved communication with First Nations and Inuit people on a community-by-community basis about the rationale for and uses of any client consent form; and,

(g) Ensure that the client consent form is available in all necessary languages and dialects.

LIST OF RECOMMENDATIONS

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(g) Ensure that the client consent form is available in all necessary languages and dialects.

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the Committee requests that the government table a comprehensive response to this report.

A copy of the relevant Minutes of Proceedings (*Meeting Nos. 32, 35, 39 and 42, including this report*) is tabled.

Respectfully submitted,

Bonnie Brown, M.P.
Chair

MINUTES OF PROCEEDINGS

Wednesday, June 4, 2003
(*Meeting No. 39*)

The Standing Committee on Health met *in camera* at 3:48 p.m. this day, in Room 269, West Block, the Chair, Bonnie Brown, presiding.

Members of the Committee present: Bonnie Brown, Jeannot Castonguay, Raymonde Folco, Betty Hinton, Hélène Scherrer, Carol Skelton and Yolande Thibeault.

Acting Members present: Dominic LeBlanc for Brenda Chamberlain, Alan Tonks for Stan Dromisky and Gérard Binet for the Hon. Hedy Fry.

In attendance: *From the Library of Parliament*: Nancy Miller Chenier and Sonya Norris, research officers.

Pursuant to Standing Order 108(2), the Committee resumed its study on First Nations and Inuit Dental Health.

The Committee resumed consideration of a draft report.

It was agreed, — That, the Committee adopt the English version of the draft report, as amended, and that the French version be redone; and that the Chair designate some members of the Committee to approve the revised French translation.

It was agreed, — That, pursuant to Standing Order 109, the Committee request that the government table a comprehensive response to this report.

It was agreed, — That the Chair be authorized to make such typographical and editorial changes as may be necessary without changing the substance of the report.

It was agreed, — That the Committee meet with members of a delegation from the United Kingdom on June 10, 2003 at 9:00 a.m.

It was agreed, — That the Committee meet with members of a delegation from Germany on June 12, 2003 at 9:30 a.m.

Pursuant to Standing Order 108(2), the Committee resumed its study on issues concerning synthetic insulin.

The Committee resumed consideration of a draft report.

It was agreed, — That, the Committee adopt the draft report, as amended, as the fourth report of the Committee to the House.

It was agreed, — That, pursuant to Standing Order 109, the Committee request that the government table a comprehensive response to this report.

It was agreed, — That the Chair be authorized to make such typographical and editorial changes as may be necessary without changing the substance of the report.

It was agreed, — That, pursuant to Standing Order 108(1)(*a*), the Committee authorize the printing of brief dissenting and/or supplementary opinions as appendices to this report, immediately after the signature of the Chair, and that the opinions be sent to the Clerk of the Committee in electronic form in both official languages on or before 3:00 p.m. on Monday, June 9, 2003.

It was agreed, — That the Chair, or her designate, be authorized to present the report to the House.

At 4:48 p.m., the Committee adjourned to the call of the Chair.

Wednesday, June 11, 2003
(*Meeting No. 42*)

The Standing Committee on Health met *in camera* at 3:23 p.m. this day, in Room 308, West Block, the Chair, Bonnie Brown, presiding.

Members of the Committee present: Bonnie Brown, Jeannot Castonguay, Brenda Chamberlain, Stan Dromisky, Raymonde Folco, Hon. Hedy Fry, Betty Hinton, Réal Ménard, Svend Robinson, Carol Skelton and Yolande Thibeault.

Acting Member present: Robert Bertrand for Hélène Scherrer.

In attendance: *From the Library of Parliament*: Nancy Miller Chenier and Sonya Norris, research officers.

Pursuant to Standing Order 108(2), the Committee resumed consideration of its study on prescription drugs.

It was agreed, — That, pursuant to Standing Order 108(2), the Committee undertake a study on prescription drugs under the following terms of reference:

1. To gather evidence on the health aspects of the following issues relative to prescription drugs (patented and generic) in Canada:

   (a) Rising costs;

   (b) Mechanisms for reviewing and controlling prices of all prescription drugs;

   (c) Mechanisms for approving new drugs and introducing them onto the market, with respect to their therapeutic value, their side effects, their interactions with other drugs, etc., as well as a focus on clinical trials;

   (d) Monitoring of adverse effects and prescribing practices;

   (e) Marketing to and lobbying of prescribers and dispensers;

   (f) Direct-to-consumer advertising;

   (g) Consumer and health professional access to drugs, including but not limited to access to new drugs for new diseases and old drugs for old diseases (excluding commentary on provincial formularies);

   (h) Misuse, abuse and addiction within the general population; and,

   (i) International comparisons.

2. To examine the evidence gathered with respect to these issues;

3. To discuss the implications of the evidence for Canadians;

4. To make recommendations for future actions.

It was agreed, — That the Clerk of the Committee, in consultation with the Chair, issue a news release to announce the Committee's study on prescription drugs and to invite the public to submit briefs and requests to appear in relation to the study.

Pursuant to Standing Order 108(2), the Committee resumed consideration of its study on First Nations and Inuit dental health.

It was agreed, — That, pursuant to Standing Order 108(1)(*a*), the Committee authorize the printing of brief dissenting and/or supplementary opinions as appendices to this report, immediately after the signature of the Chair, and that the opinions be sent to the Clerk of the Committee in electronic form in both official languages on or before noon, Thursday, June 12, 2003.

It was agreed, — That the Chair, or her designate, be authorized to present the report to the House.

At 3:52 p.m., the Committee adjourned to the call of the Chair.

José Cadorette
Clerk of the Committee