A political economy of oral health services in Nunavut

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ABSTRACT

Objectives. We wanted to consider what factors influence oral health care services and carried out an Ethnographic Case Study in Nunavut. Methods. Participant observation, document review, stakeholder interviews. Results. This study argues that four general factors influence oral health care in Nunavut. Conclusion. These factors delimit oral health and care in Nunavut by influencing people’s oral health, their experiences with health and disease, and ultimately the positions and practices of individuals within this system of care. Thus these factors contribute to (or take away from) the ability for positive change in the oral health of Nunavut residents. It is in settling debates within the latter two factors that an appreciable difference can be made in the oral health and care of Nunavut residents.

Keywords: Aboriginal Health, Oral Health, Dental Care, Political Economy, Nunavut.

INTRODUCTION

The oral health of Nunavut residents lies well below that of the general Canadian population. Epidemiological evidence, governmental and non-governmental discourse, countless newspaper accounts and simple observance confirm that oral disease remains at unacceptably high levels (1-6). These levels have proven to negatively impact the quality of life of individuals (7-12).

This reality is one part of the historical outcome of the subsumption of Indigenous populations into the Canadian State. In response to the inequities of the past, policy has seen Indigenous groups adopt ideological, bureaucratic, administrative, business, and budgetary control over the processes that govern their lives. In this regard, the devolution of responsibility for health services (e.g. dental services) from Federal to First Nations and Inuit governments continues, generating one of the largest experiments in health care reform in Canadian history (13).

For First Nations and Inuit communities alike, control over services is contextualised in social, political and economic development, as well as perceived to improve health status (14-16). In devolving power, the consensus has been that this is one part of Aboriginal self-determination and social development (14-16). Therefore, self-governance has implications for the administration of health services, as well as for the general well-being of the Inuit population.

MATERIAL AND METHODS

This study asked: "What factors currently influence oral health care services in Nunavut?" To answer this question, an ethnographic case study methodology was employed, using data collected through participant observation, document reviews, and stakeholder interviews. With a political economic approach (17), the factors that shape dental services were addressed. These factors are described as those that impact the provision of health services, and by extension, impact health through such action as decreasing quality, diminishing access, and creating less than optimum conditions for health promoting behaviours (18, 19).
RESULTS
The factors influencing the development of dental care in Nunavut are: 1. Geography and Disease Burden; 2. Indigenous Self-Determination; 3. State/Indigenous Relations; and 4. Dental Practice and Philosophy. In delimiting this system, these factors shape people’s oral health, their experiences with health and disease, and ultimately the positions and practices of individuals within this system of care.

1. Geography and Disease Burden
Dental care in Nunavut is complicated by the realities of isolation and overwhelming disease. Isolation means only a handful of dental trips each year (itinerant care of two- to three-week periods), with difficulties experienced in the shipping of equipment and supplies and in the maintenance of clinics. It means long periods of travel and long clinical days (with little or no professional support), resulting in high professional turnover and a limited number of providers. In short, it means increased costs and generalised difficulty.

Such disease burden means that whatever care is available only relieves pain, and is not capable of addressing comprehensive needs. It means that curative services and not preventative ones consume system funds. In short, it means an overburdened system that has difficulty responding to global needs.

Isolation will remain a reality, but one that can be addressed. Stakeholders suggest the complete stocking of clinics so nothing needs to be shipped. Also suggested are improved recruitment and retention strategies so professionals ‘come and stay,’ and ‘dental’ educational opportunities for Nunavut residents so as to decrease the dependence on southern expertise.

Disease burden is harder to address as it involves changing peoples’ behaviours in an environment where prevention is poorly funded (e.g. individual and community education, individual and community health promotion). However, stakeholders do recognise that prevention is necessary for improvements in oral health and are now moving in that regard. Nevertheless, prevention alone cannot address such disease presence. Significant intervention is also observed through social legislation that, while difficult to enact as per current political economic realities, can result in improved levels of health (e.g. policies aimed at removing the barriers of a cost-prohibitive diet and those that address base level determinants of health)

2. Indigenous Self-Determination
Inuit self-determination and the ethnonationalist movement of Canada (whereby Indigenous groups began to change the relations of power between them and the State), also impacts the development of dental care. As a governing entity, Nunavut is a public government, but insofar as it stems from a land claims agreement, it is also a form of Indigenous self-government (20). As a model for ‘self-government through public government,’ Nunavut without exception acclaims a people’s right to prosperity and cultural recognition.

As part of this, one axis of Inuit self-determination revolves around the control of health services. Thus social and economic development policy reflects the need to employ and train local individuals, as well as support local, territorial and Inuit business interests. In turn, local business interests (chiefly non-Inuit owned dental corporations run by dentists) have found support in gaining and maintaining contracts for dental services. In this sense, it is business and personal residence (and at times ethnicity) that constitutes substantive issues in this economy (21, 22). In short, the ability for Inuit stakeholders to produce their own proposals and/or improve non-Inuit proposals is fundamental in the development of services.

3. State/Indigenous Relations
For Indigenous groups, control over the structure and delivery of services (e.g. dental care) is tethered to relations with the Canadian State. These historical relations surround the health programs delivered to Aboriginal populations by the First
Nations and Inuit Health Branch (FNIHB) of Health Canada (23). For dental care, these relations are constituted in debates surrounding the Non-Insured Health Benefits (NIHBs) (24).

The NIHBs are a hotly debated issue. While federal administrators respond to repeated criticisms by the Auditor General of Canada, and from parliamentary and civil leadership concerned about the rise in costs (25-29), Aboriginal groups insist that services are lacking, poorly developed and funded, and in fact are a fiduciary right associated with their status as Indigenous Canadians (30). In turn, federal authorities answer that the NIHBs are not part of a fiduciary right, but are delivered out of policy, out of need (i.e. a needs-based approach as opposed to a rights-based one).

The devolution of responsibility for the administration and delivery of NIHBs and other FNIHB programs is another substantive issue in governance relations between both groups. These debates include the relevance and realities of current devolution policies, of the adequacy of funding associated with transferred programs, and with the possibility that Indigenous Canadians are being ‘set up’ so as to ‘administer their own misery.’ The NIHBs thus represent debates surrounding the questions of ‘What exactly are the rights of Indigenous Canadians relative to their particular relationship with the State?’ and ‘What exactly are the responsibilities of the State to Indigenous populations as per this relationship?’ Fundamental disagreements still exist, leading to problems on the service delivery front. Consider that not having clarity as to the true nature of the NIHB program confuses such things as the rights of the Aboriginal health consumer, the reimbursement of dentists, and does not allow for proper long-term planning of dental programs as funding remains a contentious issue.

4. Dental Practice and Philosophy
Dentists and their organised representation have routinely raised and addressed complaints with the NIHB dental care system, and importantly, with the levels of oral health experienced by those it is meant to insure. Organised dentistry and its members comment on irregularities in billing, on irregularities with processing claims, with reimbursement, with the cumbersome approval needed prior to the delivery of treatments, with the problematised auditing of professionals, and with the clear lack of prevention programs and services available to Aboriginal clients. Less obviously, dentists and the organised dental profession have also played a role in establishing these realities.

Since the NIHB dental program is couched within a greater Canadian system of care, this system plays a definitive role in establishing how dentistry is practiced and thought about in Nunavut. Stakeholders note that this greater system ‘does not work’ in a northern context. What may ‘not work’ is a system that concentrates on curatively based forms of care, and while recognising the need to employ dental public health interventions, often does not. Surely, in an environment of much disease and need, it makes no sense to wait for problems to arise (as they will); it makes better sense to prevent disease.

What may also ‘not work’ is the way dental care has come to be structured in Nunavut. This structure has developed piecemeal over time, region to region, based on the greater structure and practice of dentistry in Canada. This greater system is characterised by a series of predominantly private (private practice dentists - PPDMs), and to a much lesser extent public providers (public health dentists - PHDMs, and dental therapists - DTs); through a continuum of predominantly private care (private practice dentistry - PPD), and to a much lesser extent public care (public health dentistry - PHD). In this sense, dental interactions in Canada occur in relation to care delivered in private dental offices by PPDMs, and to a much lesser extent in relation to public services delivered by PHDMs and DTs within publicly funded clinics.

Dental transactions have also overwhelmingly occurred relative to a private system of re-
muneration, as payment, whether by individuals or by third party indemnity (i.e. dental insurance), involves the flow of capital through market transactions and involves no governmental mediation. Thus dental insurance constitutes through private market carriers, or through employee-employer contracts that provide for dental insurance. Significantly, this system does not include the global coverage of dental care to all Canadian citizens. As a result, in this mostly private system of care, sub-forms of public care are constituted through quasi-public transactions, whereby public insurance pays for non-insured private care in private dental settings (e.g. the dental NIHB, Social Assistance, Refugee Coverage, amongst others).

Continuing towards the public side of the Canadian dental spectrum are those public institutions (i.e. academic and/or non-governmental organisations) that deliver services to marginalised populations (again using public forms of insurance or out of pocket contributions). In terms of truly public forms of care (i.e. state employees, public clinics, public funding), some exists in relation to services delivered by salaried PHDMDs and DTs delivering care in public clinics.

In short, these structural and transactional realities come to fund Nunavut’s privately based, predominantly fee-for-service system. Importantly, public forms of care are represented through academic institutions, and through DTs delivering care as employees of the Nunavut Government. Nevertheless, as mentioned, this system of practice ‘may not work’ in a population with high levels of disease and need.

The ‘public’ option (i.e. salaried professionals delivering basic care at little or no cost with emphasis on prevention) is often resisted by the dominant structure (and its supporters). Less obviously then, it is through historical practices that the NIHB program is problematised. To be sure, this program is described as ‘wrought with mistrust’ between practitioner and insurer, between organised dental representation and federal administrators, and between practitioner and health consumer (31-35). Thus dental care in Nunavut is also tied into the political economy surrounding the maintenance of current Canadian dental practice and professional ideology.

**DISCUSSION**

In sum, it is in the latter two factorial domains (i.e. State/Indigenous Relations and Dental Practice and Philosophy) that substantial answers lie in relation to any improvements in oral health and disease, and in any improvements in the system meant to deal with these entities. As long as these debates remain open, the dental NIHB will remain entrenched in ideological struggles that ultimately become represented through problematised care to Aboriginal patients/clients. Thus it is in the reconciliation of these higher-level debates that change is found.

| Table I. Dentistry ‘Private to Public’ spectrum of care, payment and treatment. |
|-----------------------------------------------|-----------------------------------------------|
| **Private**                                   | **Public Health**                             |
| Service delivered                             | DMD                                           |
|                                              | DMD and dental therapies                      |
| Location                                     | Dental office                                 |
|                                              | Public dental clinics                         |
| Treatment                                    | Curative, Individual prevention, Cosmetic     |
|                                              | Curative, Public health services, Medical necessary |
| Mode of payment                               | ‘Out of pocket’, Insurance, Employment         |
|                                              | Public, Social assistance, Federal, NIHB, Refugees, military |
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23. FNIBH is the administrative structure of the Canadian State that coordinates and manages health care services delivered to certain Canadian Aboriginal populations (i.e. First Nations, Inuit, Innu). In contrast to all other Canadian health services, which are administered and delivered by the Provinces, FNIBH directly (or indirectly through contractors) delivers all health services to these Aboriginal populations as per its historical relationship with these groups.

24. NIHBI provides for some non-insured health services to some Aboriginal populations (First Nations, Inuit, Innu). These services lie beyond those insured for the general Canadian population as per the 1984 Canada Health Act (i.e. physician and hospital services) and are thus considered 'non-insured.' They are normally accessed in the market and have come to be defined by FNIBH as "pharmacy (including prescription and over-the-counter drugs and medical supplies/equipment), dental service, glasses and other vision care aids and services, transportation to access medically required services, health care premiums (in two Canadian provinces), and other health care services including crisis intervention, mental health counselling and selected other health services.”

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