Canadian
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CANADIAN DENTAL ASSOCIATION

SUBMISSION TO THE

COMMISSION
ON THE FUTURE OF HEALTH CARE IN CANADA

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Preface:

Mission

The Canadian Dental Association is the authoritative national voice of dentistry, dedicated to the representation and advancement of the profession, nationally and internationally, and to the achievement of optimal oral health.

Vision and Key Result Objectives

Leadership in Oral Health Care for Canadians – Ethical and Contemporary, Caring and Responsive

1. Measurable Improvement in Oral Health
2. Recognized Leader in Oral Health
3. Resources and Membership Support
4. Maintenance of a Viable Professional Environment

Definition of Oral Health

Throughout this brief, the term "oral health" is used frequently. In order that all parties are clear on what this objective means, CDA offers the following definition:

> *Oral health is a state of the oral and related tissues and structures that contributes positively to physical, mental and social well-being and the enjoyment of life's possibilities, by allowing the individual to speak, eat and socialize unhindered by pain, discomfort or embarrassment.*

History

The Canadian Dental Association was founded 100 years ago in September of 1902. As CDA enters its centenary year, the words of the founding father, Dr. Eudore Dubeau are as challenging now as they were a century ago: "Every dentist in Canada who can rise above mere local or provincial affairs in our country, and has thought about the immense advantages to be gained by the nationalization of the dental profession, should unhesitatingly give the idea support". And they did: one out of every five dentists in Canada convened in Montreal at McGill University and collectively established the CDA.

In 1962, the Canadian Dental Association made its *Presentation to the Royal Commisison on Health Care*. Ironically, as we will demonstrate in this brief, we are still facing many of the same concerns that CDA identified nearly forty years ago.

While pausing to review its past, and show appreciation for the hard work and foresight of those who served before, CDA is primarily using the occasion of its centenary as an opportunity to look forward and consider what the next 100 years of dentistry in Canada will bring.

Introduction
Oral health is not currently a visible priority of federal or provincial governments in Canada. In spite of research which shows us that oral health is integral to overall health and wellbeing, government funding is decreasing on many fronts. Dental care costs account for approximately 7 % of total health spending in this country, and yet it remains a disproportionately small focus for government programming or financial support.

In order to plan for the future oral health needs of Canadians, we must begin by addressing some of the concerns that exist today: lack of oral health indicators; burden of dental caries carried by the poor; the need to reduce tobacco use; dental human resources issues and escalating tuition fees; and access to care.

This report aims to provide insight into the current situation in this country, and offer direction and suggestions for how to improve on the oral and overall health of future generations of Canadians.

ACTION PLAN FOR ORAL HEALTH:

PREVENTION
Lasting oral health can only be built on a solid foundation of prevention. Prevention in dentistry takes many forms – periodic preventive examinations scheduled according to patient need, public education and promotion about the importance of home dental care, fluoride, reducing tobacco use, and working with government to ensure that the importance of oral health is recognized. Because it is not generally perceived as dramatic or life-threatening the importance of oral health is frequently marginalized outside of the dental community. This will need to change. Increasingly, links are being discovered between oral health status and overall health. It will become even more important to ensure that oral health becomes a demonstrable focus of government.

This section will look at a methodology to produce oral health through prevention, rather than focus on treating disease in order to restore health.

Oral Health Indicators
Government's history of marginalizing oral health is evident in the lack of traditional oral health indicators – such as decayed, missing, filled teeth (DMFT) rates, which are used internationally as indicators of social development much like life expectancy or infant mortality rates. Similarly, there is little in the way of subjective indicators of oral health that may be gathered through direct questionnaires to patients asking about their perception of oral pain, or embarrassment resulting from the condition of their mouth.[i] As a result of this inattention, formal communication is limited between the profession and government, and both parties suffer. Government does not include dentistry in its health care studies where it would have been advantageous to do so, and dentistry suffers from a lack of information with respect to dental health care and emerging needs. Effective overall health planning by government requires comprehensive data that includes those relating to oral health. CDA has written to Statistics Canada requesting to

have oral health indicators included in the regular Canadian Community Health Survey in the hopes that Canada can begin to repair this situation.

The Canadian Dental Association, in its *Presentation to the Royal Commission on Health Services, 1962,* emphasized the fact that more attention needed to be given to including dentistry in federal studies to determine dental needs of Canadians. In the **DENTAL NEEDS** section of that submission, the nature of dental disease is described. Needs are grouped into 5 areas: dental caries, diseases of supporting tissue, malocclusion, congenital defects and lesions requiring surgical treatment. The potential for prevention to reduce needs is emphasized. There is frank acknowledgement of the lack of data on the real prevalence of dental diseases in Canada and in paragraph 30, emphasis on the need for action:

> **Direct surveys of the population are necessary. These have been made only for children of seven to 13 years of age by the Canadian Dental Association's National Dental health Survey.**
>
> **To determine the possible implications of dental needs in terms of manpower requirements and costs, some estimate of treatment needs is necessary…Until such a study can be made, only very hazardous guesses of treatment requirements in terms of chair hours will be available.**

The situation that exists today is essentially the same. Without appropriate information, it is extremely challenging to plan for the needs of future generations, or identify communities at risk, where greater levels of intervention may be required. The oral health care needs of Canadians still must be examined in a systematic and comprehensive fashion.

The Canadian Dental Association recommends that government commit to including national epidemiological surveys on oral health status in their regular Canadian Community Health Survey, or, that at a minimum, government commit to supporting a national questionnaire on subjective oral health indicators. CDA commits, on its part, to use its expertise in support of government in this initiative.

Cavity Prevention

We may be lured into thinking that dental caries (cavities) is yesterday's disease. Regrettably, this is not the reality. Dental caries is often described as a "silent epidemic", and like so many scourges that have come before, it strikes mainly the impoverished and vulnerable members of society. In developed countries, including Canada and the United States, 20% of the population often experience 60% - 80% of dental decay.[ii] For the most part, the 20% are from the poorest segments of the population.

Tooth decay may not have been eradicated, but it is a preventable illness. Fluoride has proven itself to be one of the most effective tools available in the fight against tooth decay. The challenge is to ensure that all communities have adequate access to fluoride to ensure that no-one misses this valuable protection. Water fluoridation was described by the Centers for Disease Control as one of the most effective public health measures of the last century. Yet, only approximately 42% of the Canadian population lives in a community with fluoridated water.

Alternate delivery systems for fluoride include toothpastes, professional fluoride treatments, mouthrinses, and supplements. The key to using fluoride responsibly is to carefully control the dosage so that the minimum required amount is used to achieve caries reduction. Public education is necessary to demonstrate not only the power of fluoride to reduce cavities, but also the care that must be taken to use it responsibly. The Canadian Dental Association has carefully modified its fluoride supplementation guidelines over the years to reflect reduced need for this intervention as other delivery systems, such as toothpaste, took precedence.

Early childhood caries (baby bottle caries) is a particular challenge, because this type of decay usually occurs in pre-school age children – many of whom do not yet regularly use fluoride toothpaste or consume much fluoridated water. Early childhood decay may result from the child having regularly been put to bed with a bottle of milk or juice. This type of decay can destroy many teeth over a very short period. A comprehensive health promotion strategy, which includes public education, is critical to inform parents about this potentially devastating problem and support best infant feeding practises. The Canadian Dental Association has worked together with other dental organizations and government to support public education, and will count on increasing and comprehensive support from government in this area.

Pit and fissure sealants, commonly known as dental sealants, represent another underused tool that has been proven to reduce the formation of new cavities. While many privately funded dental plans include sealants, few public-funded programs exist to provide this service to the most needy, such as children of working poor families. Given the limited discretionary income of this population group, many may not be able to invest today for the long-term preventive value of sealants. As a result the population with, in all likelihood, the greatest need, is missing out on this valuable preventive tool.

The Canadian Dental Association recommends that the federal government undertake a comprehensive health promotion strategy on cavity prevention, particularly in early childhood, and help to ensure that the public has appropriate exposure to fluoride.

The Canadian Dental Association recommends that federal and provincial government sponsored dental plans include dentist-delivered pit and fissure sealants as an important preventive measure.

Tobacco Control

Reduction of use and de-normalization of tobacco will be critical to the future health of Canadians. Dentists regularly see first-hand the devastating effects of tobacco abuse in the course of their work ranging from unsightly tooth staining to severe periodontal disease and oral cancer. Through CDA, dentistry has worked with Health Canada to spread the message of danger loud and clear. CDA's advocacy role led to the introduction of graphic tobacco warning labels, carrying high-impact images including a diseased mouth caused by tobacco use.

The health risks of tobacco smoke, both for smokers and non-smokers, are well established and numerous. Other forms of tobacco, such as chewing or smokeless tobacco are equally harmful to health. Health Canada estimates that, in Canada, the societal costs attributable to tobacco use for 1993 were approximately $11 billion, of which $3 billion was spent on direct health care costs such as hospitalization and physician time. The remaining $8 billion was due to lost productivity, including foregone household income. Labour Canada has estimated that a smoking employee costs $2,308 to $2,613 more a year to employ than a non-smoker as a result of absenteeism, increased health and life insurance premiums and lost productivity. In comparison, it is estimated that in fiscal year 1993/94 federal excise taxes and duties totaled $2.6 billion.[iii] Since eighty-five percent of smokers start smoking before the age of sixteen, virtually their entire lives will be negatively impacted by tobacco.

Regrettably, the addictive power of tobacco products makes it very difficult to persuade those who are hooked to give up the habit. But, because of the ongoing relationship with patients, and the regularity of visits, dentists are in a unique position to help patients quit. CDA recognized this public health opportunity and put significant resources behind a comprehensive approach to tobacco reduction. Through an entirely self-funded effort, CDA provided dentists across the country with educational resources emphasizing the ravages of tobacco on health, accompanied by well-researched documentation to assist them in dialogues with patients about quitting tobacco. Additionally, the message was carried directly to the public through a print ad campaign, which encouraged tobacco users to discuss efforts to quit with their dentist. This approach complements CDA's continuous efforts with government to educate the public about the dangers of tobacco and increase tobacco taxes.

The Canadian Dental Association recommends that the federal government continue to build on its comprehensive strategy for tobacco reduction and de-normalization, particularly with Canada's youth, in order to achieve serious reductions in new smokers, and tobacco related illnesses.

Oral Health and Overall Health

The mouth is sometimes described as the "gateway" to health, not only because we are able to nourish ourselves via a healthy mouth, but also because systemic illness may be revealed as a result of oral manifestations. Researchers are increasingly discovering links

between oral health and systemic health status. In particular, correlations between periodontal disease and conditions including diabetes, heart disease and negative pregnancy outcomes, such as pre-term labour and low birth weight have been demonstrated. At this point, it is not clear whether the relationship is causal or coincidental. More research is required to uncover the true nature of the connection.

In his 2000 report entitled "Oral Health in America", the US Surgeon General devoted a considerable portion of the document to the relationship between oral health and general health and pointed out not only the above mentioned connections, but also more subjective considerations such as the impact of oral health on quality of life – for example a person's ability to smile and laugh without embarrassment.

While the connections between oral and overall health may not ultimately prove as simple as cleaning teeth to prevent heart attack, understanding the impact of the condition of the mouth on the rest of the body will be critical to unlocking some health mysteries. The subject of oral health research is examined in more detail later in this report.

Dentistry and the Environment

Dentists understand that prevention goes a long way outside of dentistry, as well. Great precautions have always been taken to ensure that special dental wastes are dealt with appropriately. Recent new technology has been developed that will permit dentists to be even more responsible with the handling of amalgam waste. Amalgam separators trap much finer particles of waste exiting water systems than previous filters used in dental offices.

Although no health risks are associated with current waste management protocol, dentistry is addressing the issue on a pro-active basis. In order to do its part towards ensuring a clean environment for future generations, the Canadian Dental Association has worked with Environment Canada to facilitate the implementation of the Canadian Council of Ministers of the Environment's Canada-wide standard on Mercury in Dental Amalgam Waste. CDA and Environment Canada are close to signing a memorandum of understanding that would lead to voluntary installation, within a determined time frame, of amalgam separators in every dental office producing amalgam waste. It is important that this process takes place on a nationwide basis and that baselines for reduction are established. Currently, some municipal governments have introduced legislation that differs from city to city. This makes it difficult for manufacturers to ensure standardization of technology, and for dentists to implement.

The Canadian Dental Association recommends that the memorandum of understanding on Canada-wide standards proceeds, and that municipal governments recognize the principles contained within it, rather than establishing their own criteria for amalgam separation.

DENTAL HUMAN RESOURCES AND RESEARCH

A delicate balance exists between the availability of, and the need for, dental personnel. In Canada, with the exception of remote areas, the vast majority of the population will

experience no difficulty in finding a dentist or securing a dental appointment within reasonable time frames. As a result, we may inaccurately conclude that no human resources issues exist, or that we will continue to enjoy a good balance with little or no effort.

This section will look at current human resource challenges facing dentistry, and identify areas where intervention is already required or where vigilant monitoring is warranted, to position Canada to deal with potential problems while still in their infancy.

Human Resources Development Canada Health Sector Studies

The Canadian Dental Association, in conjunction with Human Resources Development Canada has undertaken an in-depth study of human resources in the oral health sector to examine trends related to supply and scope of practice of dentists and allied dental personnel in the context of varying provincial needs and regulations. The goals of the study are to identify areas of concern and to look for solutions to issues such as potentially wasteful overlaps in training and responsibilities.

This study is still in its fact-finding stages. CDA will be pleased to share recommendations that arise from the work of this group with the Commission on the Future of Health Care in Canada, as they become available.

Vulnerable Canadian Faculties of Dentistry

Canadian Faculties of Dentistry are struggling to stay afloat and vulnerable in ways that Faculties of Medicine are not. Dental Education is more costly because of the requirement for universities to operate expensive educational dental clinics – the costs of which are up front and visible to economy-seeking university administrations.

As a consequence, some Canadian universities have undertaken to "integrate" faculties of medicine and dentistry. The *Report of the CDA Task Force on Dental Educatio*n, submitted in 1998, presents some strong concerns to the effect that such integrations may be more concerned with economy than with the improvement of education for dental students. The Task Force points out that dentistry is like a medical specialty. Medical specialties receive specialized training after completing basic medical training. If dental education were fully and equitably integrated, this is the process that would be followed. Instead, dental students may simply follow courses designed for medical students and potentially miss some of the specialized dimensions relating to dentistry. Traditional schools of dentistry combine elements of general medicine with elements of specialized training—a "hybrid" approach which is more economical.

The financial problems of dental education should be of concern to the federal government. Faculties of dentistry provide dental services to a wide range of individuals, including a large number of economically disadvantaged members of the community. University dental specialty clinics –where students learn the dental specialties such as orthodontics, oral surgery, pediatric dentistry, etc.-- also provide services in these dental services to the public. In smaller provinces, the university specialty clinic may be the only source of specialized dental care in the region.

Dental schools are providing dental services and specialized dental services to the public, and the system of provincial funding supporting them does not "subsidize" the service dimension. Instead, it leaves the schools vulnerable to closure or integration with potential to diminish the long term availability of clinically prepared, safe, competent and specialized practitioners.

The Canadian Dental Association recommends that the federal government take action to help financially support the dental schools on the basis of their provision of dental care, which offers affordable services to many low-income individuals and families.

Tuition Fees

The financial problems currently being faced in dental education are reflected in some other current realities. One is the fact that tuition fees for dental students are generally very much higher than tuition fees for any other programs.

High tuition fees, as well as fear of accumulating a high debt load, create socio-economic barriers to application to postsecondary education in professional programs. They may also deter people who traditionally have lower incomes, such as disabled persons and single mothers, from pursuing an education that would lead to a professional career.

Canadians expect a level playing field where students may choose career paths based on their personal aptitude, ambition and inclination, not on their socio-economic ranking.

The Canadian Dental Association recommends that the federal government increase funding of postsecondary institutions to alleviate some of the pressures driving tuition fee increases and that the federal government increase financial support for students, in particular, bursaries and scholarship. This support should be non-coercive; developed at the same time, or in advance, of any tuition increase; in direct proportion to tuition fee increases, and provided at levels that meet the needs of students.

Dental Faculty Recruitment – "No Professors, No Profession"

Canadian faculties of dentistry are already struggling to recruit and maintain faculty complement, and to counterbalance possible negative perceptions about careers in academic fields. Due to the increasing disparity of income between academic pursuits and private practice, there has been a reduction in professionals making the choice to pursue careers in education and research. As a result, funds that should be allocated towards making professional school tuition fees reasonable, and therefore more accessible to a broader range of society, may soon need to be allocated to creating career promotion and special financial support programs in order to attract greater numbers of high-quality dental educators, putting further strains on already tightened budgets.

CDA is concerned about the potential for increased relocations to the United States, of well-qualified professors from Canadian faculties of dentistry. While the faculty

recruitment problem may be partially related to demographic factors, the increasing problems faced by Canadian faculties of dentistry (and doubts about their future sustainability) must be recognized as contributing factors.

On a national basis across the ten Canadian dental schools, as many as one in six funded full-time dental faculty positions stands vacant (49 positions vacant out of a total of 305). The problem is most acute at University of Montréal where 11 of its 43 dental faculty positions are unfilled.

Oral and Craniofacial Research

In order to continuously improve the oral health of the population, dentistry is reliant upon good scientific and clinical research. In Canada, much of this research is conducted within Faculties of Dentistry at Canadian Universities, and most of it requires external funding. A large percentage of funding readily available to independent researchers in this country comes through the umbrella structure of the Canadian Institutes for Health Research (CIHR).

Both the naming of institutes within CIHR and its allocation of funds further illustrate government's tendency to marginalize oral health -- a problem identified earlier in this report. Oral and craniofacial research fall under the auspices of the institute for Muskuloskeletal Health and Arthritis. The absence of oral health from the title creates a perceived negation of the importance of this issue, which is reflected in the negligible funding oral health research receives. In 1999, only 1.6% of CIHR funding was awarded to oral researchers, despite the fact that 7% of overall national health expenditures were for oral care.

When this trend is coupled with the financial constraints facing universities that are making it difficult for them to attract and retain top quality academic dentists and researchers, it is clear that we are on the cusp of a crisis situation.

CDA recommends that the federal government makes oral health a visible priority by allocating more proportionate funding to oral research. A minimum of 3.5% of CIHR funding should be devoted to oral health, given that oral care comprises 7% of national health expenditures.

DELIVERY MODELS AND FUNDING

Funding

The Canadian Dental Association, private dental practitioners and institutional dental services see declining levels of federal and provincial financial support for dental health care services. The problem has been increasingly apparent in the last decade. It can clearly be illustrated using data from the Canadian Institute for Health Information..[iv] Table 1 presents data for the period 1975 to 1981. During this period of time, public funding for dental services gradually increased, every year from 1975 to 1981. In 1975, public funding provided 7.41 of the funding for overall dental services. In 1981, it provided 15.27 percent—an overall increase of almost 100% of the 1975 base:

TABLE 1: Dental Service Expenditures/Financing, 1975-1981 (in thousands)

All of Canada

Sector/Year	1975	1976	1977	1978	1979	1980	1981
Provincial Gov't	46,032	56,281	69,487	88,167	125,308	168,029	246,669
Federal Gov't	4,842	5,676	6,702	7,440	9,235	14,506	17,734
Municipal Gov't	2,501	4,513	4,084	4,366	4,637	7,868	9,121
Social Security Funds	1,447	1,654	1,750	2,142	2,360	2,897	2,777
Total Public	**54,822**	**68,124**	**82,023**	**102,115**	**141,540**	**193,299**	**276,301**
Private Sector	685,272	799,310	950,940	1,087,296	1,230,702	1,397,037	1,533,360
Total Dental Service	**740,094**	**867,434**	**1,032,963**	**1,189,411**	**1,372,242**	**1,590,336**	**1,809,661**
% Covered by Public	7.41	7.85	7.94	8.59	10.31	12.15	15.27

TABLE 2: Dental Service Expenditures/Financing, 1990-1998 (in thousands)

All of Canada

Sector/Year	1990	1991	1992	1993	1994	1995	1996	1997	1998
Provincial Gov't	269,659	283,089	272,091	267,889	270,663	251,416	222,326	217,802	215,810
Federal Gov't	99,770	113,475	130,156	142,838	149,731	155,992	140,718	135,714	133,806
Municipal Gov't	6,619	2,020	7,315	7,467	7,308	8,693	8,195	8,962	7,186
Social Security Funds	6,059	7,069	7,818	6,822	6,702	6,479	6,686	5,662	6,566
Total Public	382,107	405,653	417,379	425,016	434,403	422,580	377,925	368,139	363,368
Private Sector	3,756,788	4,061,811	4,272,816	4,500,853	4,781,245	5,060,246	5,340,714	5,555,050	5,986,792
Total Dental Service	**4,138,895**	**4,467,464**	**4,690,195**	**4,925,869**	**5,215,648**	**5,482,826**	**5,718,639**	**5,923,189**	**6,350,160**
% Covered by Public	9.23	9.08	8.90	8.63	8.33	7.71	6.61	6.22	5.72

By 1998, public funding, as a percentage of dental service expenditure, is actually 1.69 percent less than it was in 1975.

Low Government Priority

As already discussed, dental health care is not a visible priority of the Government of Canada. This is a fact that is demonstrated not only by the data presented above, but also

by day-to-day realities across a wide spectrum of government and health care activities. The vast majority of funding of dental care services comes from third party dental insurance plans. Private dental insurance is a popular employee benefit provided by a majority of Canadian employers, which addresses the needs of approximately 53% of Canadians[v]. Additional dental coverage is also provided by dental plans offered by companies that are not members of the Canadian Life and Health Insurance Association. Patients who do not have access to dental insurance, and who are not captured under existing government-sponsored dental plans (which include First Nations and Inuit, Veterans, RCMP and Social Assistance recipients) pay for dental care directly out-of-pocket. According to Statistics Canada, in 1998 48.5% of households reported direct spending on dental care, which averaged approximately $476.00 per household.[vi]

CDA is not suggesting that dental health care needs to be brought entirely within Medicare, but rather that a safety net be put in place to ensure access for disadvantaged citizens. CDA stands by its position, that some movement in this direction could be achieved, over time, by starting with coverage to address the areas of greatest need – specifically the working poor and their families, and low-income seniors. Dental health care definitely requires and warrants more attention from the federal government.

The Canadian Dental Association recommends a needs-based approach to the creation of a social safety net aimed at providing oral care services to socio-economically disadvantaged Canadians.

Government's preoccupation has traditionally been with medical health care activities, and providers working within Medicare whose focus is saving and extending lives. Evidence is growing, however, that preventive dental health care is a vital component of care that may influence favourable outcomes—for example, potentially improving survival rates for some medically compromised patients undergoing cardiovascular procedures.

There are currently only a handful of federal civil servants with any direct responsibility limited to dentistry compared to thousands working in Medicare and public health. The individuals working with dentistry are primarily linked to the Non Insured Health Benefits program covering Canada's First Nations, which is discussed in greater detail later in this report.

The Canadian Dental Association recommends that the dental focus within the federal government be visibly strengthened. It is time to recognize that oral health care is an essential component of overall health care.

Delivery of Dental Services

The Canadian Dental Association is confident that Canadians currently enjoy dental health care services that are among the best in the world. However, the continuing viability of these services is dependent, not only upon sustaining and improving the research and educational foundations described earlier, but also upon other factors.

The financial foundations supporting provision of dental services require attention. Third party dental pre-payment plans are the largest component of this foundation, and problems are developing and increasing. Insurance companies find dental coverage to be costly and are seeking to reduce costs by limiting coverage. Increasing limitations are being introduced on frequency of treatment or on types of treatment covered. "Capitation" plans are reappearing, under which the dentist assumes the insurance companies risk (by accepting payment on a per capita basis and responsibility for fitting patient needs within the funding provided). While it is reasonable for companies to attempt to limit costs, there are significant dangers associated with capitation plans and with frequency or coverage limitations.

The largest danger is inadequate treatment, whether it arises from patient inability to access care or financial disincentives to practitioners to provide optimal care, in response to inadequate funding under a capitation plan. An associated danger is "dictation of treatment", which arises when a patient's choices are limited so that the least expensive alternative must be chosen to be eligible for third party coverage.

Dental hygienists and other allied dental personnel are seeking independent practice, and the ability to take the low cost, front-end patients away from the dental office. Provincial governments would be mistaken to regard such a development as cost saving for the public. Its inevitable effect would be to make the cost of equipping and maintaining the comprehensive private dental facility prohibitive. Many dentists are accordingly uneasy about current trends and concerned about the long-term viability of dental practice. The federal government should be concerned as well, because it could no longer count on these private, well-equipped facilities, largely outside Medicare, to carry the bulk of dental health care services for Canadians.

The Canadian Dental Association is also concerned about the impact of such division upon directed, coordinated and integrated dental health care for the patient. Dentists are the only professionals with the ability to diagnose, treatment plan and deliver on all required aspects of oral health care. Such statements of principle are often dismissed as simple turf and economic self-protection, however it is the protection of the health of patients that is at stake.

There are other important problems affecting our patients. Access to dental health care continues to be a significant problem for Canadians in remote regions and for socio-econonomically disadvantaged individuals without third party dental health coverage of any kind. Traditionally, the needs of these groups have been met on an ad-hoc basis, with many dentists providing pro-bono work, or setting up individual payment plans to assist patients with their treatment needs. This approach lacks coordination, however, and cannot ensure access to all individuals.

There are many different approaches that can be taken by government to both demonstrate an increased awareness of the importance of oral health, and take action to improve upon it:

- exemption from personal income tax calculation, of costs of third party dental plan coverage/employee benefits. (Certainly, the current status of tax exemption for dental plan premiums, which was later extended to the unincorporated self-employed was a move in the right direction. This approach should be expanded upon, to reach a wider audience)
- encouragement of provincial governments to re-introduce/widen provincial Medicare coverage of dental services for financially disadvantaged individuals.
- change policies that limit dental services covered by Medicare to hospital settings thereby excluding dentists from performing, under coverage by Medicare, the same services in private health care facilities.
- work cooperatively with dentistry to establish inducements to encourage more dentists to settle in municipalities without resident dentists.
- encourage provincial governments to engage full-time traveling dentists to serve areas with populations too scattered to warrant resident dentists.

In taking into consideration the great number of possible avenues touched upon above, as well as new ideas not captured here, it may be difficult to determine which options have the greatest merit. The following recommendation may assist government in determining which approaches to choose by respecting the key principles of good oral care delivery.

The Canadian Dental Association recommends that consideration of new oral health funding or delivery models, or alteration of existing models should respect the following key principles:

- Patients should be free to attend the dentist of their choice
- Long-term relationships between dentists and patients should be encouraged and fostered
- Dentists and patients should be able to make treatment decisions in joint consultation, free from third-party interference based on coverage
- Recognize that dentists are the only oral health care providers who are able to diagnose and make full oral health plans for patients
- That a patient's private health information should be protected both by the dentist providing care and by government institutions providing funding for care.

Institutional Dental Services
Hospital or institutionally based dental departments/dental services are growing in number and importance because they are meeting real and increasing needs. As noted earlier, there is evidence that dental health care of medically compromised patients may be vitally important because of links between oral health and systemic disease which are currently being studied. Such departments are also in demand for student placements to complete dental residency/internship programs or an educational program in one of the dental specialties. In the last few years, dental students have been increasingly interested in gaining some institutional experience prior to establishing a dental practice. There is interest, in the dental education community, in moving dental education towards an internship model along the lines of medical education. Such a new pattern of dental

education might help meet student interest in institutional experience while reducing pressure on educational timetables, increasingly swollen by an ever expanding curriculum. Despite such urgency, hospital dental services are not easy to establish.

Financing of hospital and institutional dental services is the major challenge. Most institutional dental services are expected to fund the greatest part of their operation out of clinic revenue. In some cases, hospital budgets may not fund dental departments or services at all. In addition, oral surgeons serving as staff in such departments generally have to compete with plastic surgeons for hospital beds. Depending on the hospital and the policy of hospital administration, such competition may not take place on equitable terms.

Most institutional dental services recognize a need for oral health care for the broader patient population in extended care/tertiary care centers. However, they lack the resources to provide it. The priorities are to provide preventive treatment and required therapy for medically compromised patients, and to treat outpatients who require specialized care or restorative or other treatment under sedation or general anesthesia.

There may be ways for the federal government, once again playing a defined and limited role, to help offset the challenges faced by hospital and institutional dentistry and to assist in extending the benefits of the associated expertise. CDA would be happy to cooperate in joint discussion on this topic as well.

Oral Health of First Nations and Inuit Peoples

First Nations peoples in Canada are unique in both their need for dental care, and the delivery system available to them to provide for that care. Government readily acknowledges the need for action in order to improve the quality of life of aboriginal peoples in Canada. Decayed, missing, filled teeth (DMFT) rate for 12-year old First Nations Children is 4.4. This is two to three times higher than the DMFT for non-Aboriginal children in Canada where statistics are gathered, and is comparable to the DMFT rate in developing countries such as Costa Rica (4.8), the Ukraine (4.4) Latvia (4.2).

The federal government plays an integral role in the delivery of care to First Nations and Inuit People through the dental program of the First Nations and Inuit Health Branch (FNIHB) of Health Canada. As the caretakers of the oral health of this community, the federal government must recognize its responsibility to ensure that the oral health message of prevention is carried to all communities, and that fiscal concerns are not permitted to interfere with access and delivery of quality care.

Regrettably, while the intention of providing the program is good, its day-to-day administration has some serious faults. The administrative process that must be followed by dentists in order to provide much-needed care to patients is extremely heavy. In many cases, a lengthy pre-determination is required in advance of treatment, which often necessitates costly federal government-funded transportation of the patient back and forth on more than one occasion, since many travel in to the dentist from remote locations.

This "pre-determination" is essentially a second-guessing of the treatment plan by another dentist within the bureaucracy, absent any exam of the patient and represents an inappropriate interference by government into the informed consent process. Additionally, the government is carrying out burdensome on-site audits of providers that have no precedence in the insurance marketplace. While CDA can appreciate government's need to verify that its funds are appropriated correctly, dentistry is gravely concerned about the current audit process, since it appears to contravene existing laws in some provinces. Additionally, dentistry has conveyed to Health Canada serious concerns about the way in which personal health information contained in patient files under audit is handled. A joint proposal, offering sound and practicable alternatives to the on-site audit process, was presented to Health Canada by the Canadian Dental Association, the Ontario Dental Association and the Royal College of Dental Surgeons of Ontario. Unfortunately, it was unequivocally turned down. The future oral health of patients reliant of this program will depend on some serious improvements to the NIHB program, that focus its funds onto patient care, rather than administrative burden.

CDA does support the government's preventive care messaging to First Nations populations through a positive working relationship with Health Canada on education issues. An ongoing joint prevention initiative of CDA, Health Canada and the Assembly of First Nations results in the nation-wide dissemination of oral health care information to First Nations communities. This information is distributed to dental officers and nurses at regional health units in all provinces. CDA maintains a continuous dialogue with Health Canada officials with respect to the administration of the dental insurance program that our members work with when administering care to enrolled First Nations and Inuit peoples.

The Canadian Dental Association recommends that funding be increased to the First Nations and Inuit Health Branch of Health Canada so that additional prevention programs can be created and delivered to First Nations and Inuit people, especially children, and so that dentists can perform necessary treatment in a manner that is consistent with the principles identified in the recommendations for delivery and funding as noted above. The CDA is willing to lend its expertise in any manner that will result in a measurable improvement in the oral health of all Canadians, and recognizes the unique needs of this segment of our population.

Conclusion

To improve on the oral health of all Canadians, we will have to rethink some longstanding views on the priority of oral health, and how we go about achieving it. Access to care cannot be achieved in isolation of funding, or the availability of manpower to deliver required services. Human resources issues cannot be resolved in isolation of problems with tuition fees. What is required is an all-encompassing approach, that considers all of the elements, and builds a system for oral health care that embraces us all.

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[iv] Canadian Institute for Health Information , "National Health Expenditure Trends, 1975-2000", 2000.

[v] Canadian Life and Health Insurance, Website – Special Surveys: Health Insurance Coverage, 2000

[vi] Statistics Canada, "Household Spending on Health Care", Health Reports, Vol. 12