



Brief to the House of Commons Standing Committee on Finance
2001 Pre-Budget Consultations

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INTRODUCTION

The Canadian Dental Hygienists Association (CDHA), formed in 1964, is a national organization representing over 14,000 dental hygienists across Canada. The CDHA consists of nine constituent members—the nine provincial dental hygienists' associations—a representative of the Quebec members, plus representatives from the Federation of Dental Hygiene Regulatory Authorities and the Dental Hygiene Educators of Canada. The mission of the CDHA is as follows:

The Canadian Dental Hygienists Association, as the collective voice of dental hygiene in Canada, is dedicated to advancing the profession in support of our members and contributing to the health and well-being of the public.

One of the association's main responsibilities is to help develop national positions and standards related to dental hygiene practice, education, research, and regulation. Through this work, the association is able to serve both its members and the Canadian public more effectively.

We would like to thank the committee for the opportunity to appear before it and take part in this year's pre-budget consultations. We believe that good oral health care can contribute much to the achievement of the committee's objectives: ensuring Canada's role as a major player in the new economy; providing Canadians with equal opportunity to succeed; and creating an economic and social environment where Canadians can enjoy the best quality of life and standard of living. **Good oral health is key to the social and economic well-being of Canadians.**

Dental hygienists are often the first point of contact in the oral health system so they can assess, plan, and implement preventive care. With our experience, we can point to *serious gaps* in the Canadian health care system, for example:

- socio-economic inequities
- limited access due to physical disability, illness, or distance from services
- lack of or restrictive dental insurance
- lack of public awareness and understanding of the importance of oral health
- lack of access to care for a significant number of Canadians

All Canadians are entitled to comprehensive, quality oral health care and we believe they should have access to the preventive services provided by dental hygienists. Our association is committed to attaining this goal and will work in tandem with government, health agencies, public interest groups, and other health professions to achieve it.

1. ENSURING CANADA'S ROLE AS A MAJOR PLAYER

1.1 Oral Health Care: The Silent Epidemic

Health care is a provincial responsibility. But the CDHA believes that **modernizing Medicare is a priority for all Canadians**. We therefore expect our national government to play a key role in ensuring a universal, financially sustainable Medicare system in Canada.

When it comes to oral health care, Medicare is anything *but* universal. An unacceptable number of Canadians still do not have access to oral care. In 1999, Statistics Canada reported the following:¹

In 1996/97, 53% of the population aged 15 or older reported having dental care insurance. . . . (p.55) The overall rate in Canada was 53%, and rates ranged from a high of 60% in Ontario to a low of 39% in Québec and Newfoundland. . . . (p.60)

. . . 59% [of the population aged 15 or older] said they had visited a dentist in the past year. . . (p.55)

. . . dental insurance was an important factor influencing dental visits. About three-quarters (73%) of individuals with insurance had visited a dentist in the past year, compared with 45% of the non-insured. . . . (pp.59-60)

But even when they had insurance, individuals with low incomes and low educational attainment had much lower odds of visiting a dentist than those with higher incomes or more education. (p.55)

So 40 per cent of all Canadians do not go to the dentist and 45 per cent do not have coverage. Most of those *not* going are not covered and are part of the population that is less educated and less fortunate.

Reduced transfer payments and lack of accountability have contributed to the erosion of provincial dental programs and to a drastic reduction in oral health services available to the public. The recent federal and provincial agreement on transfer payments is certainly welcome after years of cutbacks. However, money is only part of the solution. Governments and health care professionals still face the same challenges in delivering health care that meets the actual health needs of the population. These challenges will not be solved with money alone.

Medical research has clearly shown the link between oral and general health. However, government policy-makers have failed to act on the mounting medical evidence that oral disease directly affects the health of the body.

Unless our health care services and the way we deliver them are refocused on *preventing* illness rather than just *treating* it, the Canadian people and their governments will be stuck in a spiral of increasing public expenditures with no real solution to our health needs. Government policy-makers, together with health care professionals and the public, must ensure that money is invested appropriately—where it can improve the delivery and quality of health care—and focused on prevention. Good oral health care is an effective illness-prevention strategy.

¹ WJ Millar, D Locker, "Dental insurance and use of dental services," *Health Reports* 11(1): 55–67. (Statistics Canada Cat. No. 82-003-XIE)

1.2 The Link: Oral Health and General Health

In May 2000, the Surgeon General of the United States released a groundbreaking report on oral health, *Oral Health in America: A Report of the Surgeon General*.² This report aims at alerting “Americans to the full meaning of oral health and its importance in relation to general health and well-being.” This warning is equally important for Canadians and their governments.

While oral health care is not taken completely for granted, its significance to our general health is grossly underestimated. Government policy-makers seem to overlook the fact that the mouth is connected to the rest of the body. This point is expressed forcefully in the Surgeon General’s report:

The word *oral*, both in its Latin root and in common usage, refers to the mouth. The mouth includes not only the teeth and the gums (gingiva) and their supporting connective tissues, ligaments, and bone, but also the hard and soft palate, the soft mucosal tissue lining of the mouth and throat, the tongue, the lips, the salivary glands, the chewing muscles, and the upper and lower jaws, which are connected to the skull by the temporomandibular joints. Equally important are the branches of the nervous, immune, and vascular systems that animate, protect, and nourish the oral tissues, as well as provide the connections to the brain and the rest of the body. The genetic patterning of development in utero further reveals the intimate relationship of the oral tissues to the developing brain and to the tissues of the face and head that surround the mouth, structures whose location is captured in the word *craniofacial*. . . .

These are tissues whose functions we often take for granted, yet they represent the very essence of our humanity. They allow us to speak and smile; sigh and kiss; smell, taste, touch, chew, and swallow; cry out in pain; and convey a world of feelings and emotions through facial expressions. They also provide protection against microbial infections and environmental insults. (p.17)

Most people agree that a sore mouth has an impact on their well-being. Oral health problems can be very uncomfortable indeed but in general do not threaten our lives directly. But their non-life-threatening nature can lull us into underestimating their true impact on our health. The mouth harbours a wide variety of microbes that have a direct route to the rest of the body. Poor oral health is often the source of significant illnesses and fatalities. In addition, the condition of the mouth can help diagnose major ailments of the body. Medical research has shown us how oral health influences and affects general health, and this evidence should be a wake-up call for government policy-makers.

1.2.1 Pregnancy

Poor oral health has been directly linked to low-birth-weight babies and also affects the quality of a woman’s pregnancy. A healthy mother is more likely to deliver a healthy baby, reducing the chances of problems for the child later in life. Small size and thinness of a baby at birth are associated with coronary heart disease, hypertension, and diabetes in later life.³

² United States, Surgeon General, U.S. Public Health Service, *Oral Health in America: A Report of the Surgeon General* (Washington DC: U.S. Government Printing Office, May 2000).

³ Ontario Children’s Secretariat, *The Early Years Study: Reversing the Real Brain Drain*, Report from the Early Years Study, by Dr. JF Mustard and the Hon. MN McCain (Toronto: The Secretariat, 1999), p.42.

A 1996 study reported in the *Journal of Periodontology*⁴ showed that if a pregnant woman has gingivitis (gum disease), she is seven times more likely to have a premature, low-birth-weight baby. This impact is greater than if she smoked during pregnancy, a danger that has been highly publicized.

Toxins or other products generated by periodontal bacteria in the mother may reach the general circulation, cross the placenta, and harm the fetus. In addition, the response of the maternal immune system to the infection elicits the continued release of inflammatory mediators, growth factors, and other potent cytokines, which may directly or indirectly interfere with fetal growth and delivery.⁵

Poor oral hygiene and diseases of the mouth directly affect the quality of nutrition for children, both before and after birth. Nutrition, along with sensory stimulation, is essential for brain development.⁶ Performance at all educational levels and at work depends on the quality of nutrition in the early years.

It is a significant challenge to increase the chances of a healthy pregnancy. Many young and single mothers-to-be are unprepared for, and unaware of, the special health needs during pregnancy. Their situation is made worse by socio-economic realities:⁷ many young women who leave school do so because of pregnancy; and almost 50 per cent of single-parent, mother-led families are in low-income situations.

Preventive oral health care is important for a healthy pregnancy but we also have to understand and respond to the challenges faced by pregnant women and their unborn children.

1.2.2 Systemic Disease

Periodontal diseases are linked to major health problems including heart disease, stroke, respiratory diseases—such as aspiration pneumonia⁸—osteoporosis and diabetes.⁹ An American Heart Association study reveals that having minor chronic infections, such as an impacted tooth, can more than double the risk of having a stroke.¹⁰

While medical research tells us *why* oral health care should be a regular and normal part of the health care system, government funding, taxation policies, and regulations continue to separate oral health care from general concept of health care and well-being.

1.2.3 Children

⁴ S Offenbacher *et al.*, "Periodontal Infection as a Possible Risk Factor for Preterm Low Birth Weight," *Journal of Periodontology* 67 (10): 1103–1113.

⁵ Surgeon General's Report, p.120.

⁶ *Early Years Study*, p.42.

⁷ Health Canada, Statistics Canada, Canadian Institute for Health Information, University of Toronto; Report of the Federal, Provincial and Territorial Advisory Committee on Population Health, *Toward a Healthy Future: Second Report on the Health of Canadians* (Ottawa: Queen's Printer, September 1999), p.41.

⁸ D Matear, "The importance of oral health in the elderly," *Mature Medicine Can* 1(5) (Sept/Oct 1998): 34–37.

⁹ Surgeon General's Report, p.95.

¹⁰ J Armin *et al.*, "Association between Acute Cerebrovascular Ischemia and Chronic and Recurrent Infection," *Stroke* 28: 1724–1729.

After a wave of progress in oral health education and screening programs for children, we are now seeing funding cuts. Prevention programs have been eliminated. Repercussions from these cuts were predicted for our children's health—and research is proving these fears justified. One example: The World Health Organization's Year 2000 goal was for 50 per cent of 6-year-old children to be cavity free. Results of the 1998–1999 Dental Screening Program in Saskatchewan are in, and 24 of 29 Health Districts failed to meet this goal.¹¹

The Canadian Dental Hygienists Association recommends that, regardless of jurisdictional issues, the federal government work toward bringing preventive oral care into comprehensive health care in Canada under Medicare. At present, under the Canada Health Act, services provided by a dentist in a hospital setting are covered under provincial hospital insurance plans. All oral care services, whether provided in a hospital setting, a dental office, or “in-home” by a dental hygienist, should be covered under our publicly funded health care system.

The Canadian Dental Hygienists Association recommends that the federal government make any increments in health care funding dependent on regulatory reform, including for oral health care, that focuses on illness prevention; furthermore, that the \$2.2 billion earmarked for early childhood development include preventive oral health care measures.

2. PROVIDING CANADIANS WITH EQUAL OPPORTUNITY TO SUCCEED

2.1 The Lack of Equity: A National Shame

Despite numerous surveys showing that a significant portion of the population does not have access to preventive oral care services,¹² effective steps have still not been taken by policy-makers.

Those who can benefit the most from the oral health care services are the ones least likely to have access. And if problems are not caught in the early stages, then costly treatment will be needed later on. This not only raises costs for oral care but can—and most likely will—lead to serious medical conditions beyond the mouth. The CDHA recognizes the importance of preventive care and of the needs of those with no insured benefits. These Canadians include those in long-term care, those requiring home care, children in low-income families, the homeless, people with disabilities, and Aboriginal communities. We are committed to making oral hygiene care more available through regulatory reform and will work with both federal and provincial governments to achieve the necessary legislative changes. It should be noted that in 1988, the federal government identified “**dental hygienists as the only health professionals whose primary concern is the prevention of oral disease.**”¹³

¹¹ “Spotlight on Oral Health,” *Health Educators Association Newsletter* 3(1) (Spring 2000).

¹² Statistics Canada, National Population Health Survey, 1996-97; College of Dental Hygienists of Ontario. Gallup Poll of Ontarians, 1997.

¹³ Health Canada, *Practice of Dental Hygiene in Canada*, Report of the Working Group on the Practice of Dental Hygiene in Canada (Ottawa: Health Canada, 1988).

2.1.1 *The Disabled*

Disabled persons face barriers when they try to obtain proper oral health care services delivered in the traditional model. Those with physical and mental disabilities have a higher rate of oral disease than do other groups in the population. This is due to medical problems, side effects of medications, or the disability itself. Proper oral hygiene, including the normally simple tasks of brushing and flossing on a regular basis, is challenging for many. In addition, many dental offices are ill prepared, or unwilling, to manage the complex medical and behavioural problems associated with these individuals—assuming that a disabled person can even get to the dental office in the first place.

2.1.2 *The Homeless*

A study done in 1996¹⁴ on the oral health of street youth in the former City of Toronto found that 41.4 per cent had dental decay and 49.4 per cent reported they had had dental and oral pain in the past month. This is higher than would be expected for teenagers and young adults in the general population. Fifty-seven percent of street youth said lack of money is the main reason for not seeing a dentist. A minority of street youth are on welfare and thus have access to at least emergency treatment. The remainder lack even this level of access to service.

2.1.3 *The Elderly*

Aging brings not only changes in health; it often reduces mobility and access to services required by these new health care needs, including oral health care.

Many individuals lose their dental insurance when they retire. Combine this with increased mobility problems, and seniors face significant deterrents to securing proper oral health care. This happens at the same time as the immune system begins slowing down, making seniors vulnerable to systemic diseases and to side effects of medications—an example is dry mouth. Even if an individual can secure care in a home for the aged, long-term care facilities have a limited capacity at best to deliver oral health services.

Medical research supports the need for preventive primary oral health care for the elderly. Care provided by dental hygienists is vital to the overall health of seniors. The *Journal of Periodontology* in January 1999 reported that over half of adults aged 55 or more have periodontitis.¹⁵

Older adults can also lose their teeth and have problems chewing. This can lead to other problems such as malnutrition and a reduced ability to socialize, which can itself lead to further health problems. The Ontario Health Survey¹⁶ carried out in 1993 showed that 15.3 per cent of adults aged 50 to 64, and 35.1 per cent of those aged 65 and older, had no natural teeth.

An unhealthy mouth often is a major reason for nutrition problems, such as weight loss. However, the prescribed treatment often deals with only the nutritional deficits—for example, weight loss is often managed with a high-calorie diet that may in fact aggravate the oral condition. It's a Catch 22 situation:

¹⁴ S Gaetz, J Lee, *Harmonization of Dental and Oral Health Services*, Report to the City of Toronto (Toronto: [n.p.], 1996).

¹⁵ JM Albandar, JA Brunelle, A Kingman, "Destructive Periodontal Disease in Adults 30 Years of Age and Older in the United States, 1988–1994," *Journal of Periodontology* 70(1) (1999): 13–29.

¹⁶ D Locker, B Payne, *Ontario Health Survey*, Report 1 (Toronto: Ontario government, 1993).

good oral health is influenced by diet, but the elderly need healthy teeth and gums to eat the variety of foods that ensure proper nutrition.

The lack of effective care is partly because dental hygienists' services are not an integrated part of health care services in homes for the aged or residences for senior citizens. The British Columbia government, however, is showing leadership in this regard. In that province, all homes for the aged have to make sure that residents see an oral health care professional—and the definition includes dental hygienists—at least once every 12 months.¹⁷

A healthy mouth protects against systemic diseases toward which the elderly may have less immunity. With our population aging, the need and demand for oral care for seniors will continue to increase.

2.1.4 Aboriginal People

In 1997, dental visits by Aboriginal people were fewer than the national average, despite First Nation and Inuit people having oral care coverage as a non-insured health benefit. According to the First Nations and Inuit Regional Health Survey, only 51 per cent of the Aboriginal population on reserve reported visiting a dentist during the previous year.¹⁸ Seventy-five per cent of Aboriginal children surveyed had received oral care in the preceding year; still, 91 per cent of these children suffered from tooth decay. Even of those who have access to fluoridated water, 25 per cent regularly suffered from toothache or bleeding gums. Only half the children could be said to have healthy gums.

The incidence of diabetes in the Aboriginal population is three times that of the non-Aboriginal population. The link between periodontal disease and diabetes is a significant concern in the Aboriginal community.

Health services need to catch up with the higher incidence of systemic disease in Aboriginal communities. This is perhaps most clearly evident in the case of oral health, an area where problems have escalated rapidly due to changes in Aboriginal people's diet after contact with the non-Aboriginal community.¹⁹ Many provincial programs that provided dental hygiene services in the past have been severely reduced. Some of the previous issues of providing dental services outside of public health programs have been addressed by changing provincial legislation that provides for direct dental hygiene care and costs and payment for such care.

We applaud the federal government for its recent award of a contract for a dental therapy program. We recommend that, in addition to restorative therapy, improved access to preventive oral care services be provided within Aboriginal communities. Having dental hygienists work with dental therapists could provide increased service.

2.1.5 Lower-income Canadians

Income level and dental insurance are powerful determinants of oral care: lower-income Canadians are the least likely to have dental insurance or to have visited a dentist during the past year.

¹⁷ "BC Government Passes New Adult Care Regulations," *Probe* 32(2) (March/April 1998): 49.

¹⁸ F Weins, L McIntyre, "Health and Dental Services for Aboriginal People," First Nations and Inuit Regional Health Survey (Ottawa: Statistics Canada, 1999.) As reported in *Probe* 34(1)(January/February 2000): 25.

¹⁹ Weins and McIntyre, p. 28.

Among Canadians in the low middle income group, only 25% had dental insurance and only 45% visited a dentist during 1996–97. By contrast, 73% of high-income Canadians had dental insurance.²⁰

As discussed earlier, income level has an impact on the health outcomes associated with pregnancy and early childhood development.

The CDHA's commitment to treat those who fall through the cracks is unfortunately most often met with resistance, plus a denial of the links between oral health care, general health care, and lack of access.

The Canadian Dental Hygienists Association recommends that the federal government work with provincial governments to support programs and policies that will equalize access to affordable oral health care. The current medical/dental tax credit is inadequate and has such a high deductible that it is useful only for major medical conditions and does not encourage illness prevention.

²⁰ *Toward a Healthy Future*, p.148.

3. CREATING AN ECONOMIC AND SOCIAL ENVIRONMENT FOR AN IMPROVED QUALITY OF LIFE AND STANDARD OF LIVING

3.1 The Economic Cost

Canada could enhance its competitive economic position through better health care. The spring 1998 issue of Statistics Canada's *Perspectives on Labour and Income*²¹ indicated a serious lack of productivity in the Canadian workforce due to absenteeism. Most of this absenteeism is due to poor health; individuals are either ill themselves or have to care for a child with health problems. Missing and unfilled teeth mean pain, loss of sleep, poor performance, low self-esteem, and cause difficulties in both getting and keeping a job. Periodontal disease is the most prevalent chronic disease so the state of the population's oral health affects workplace productivity. Prevention could result in great savings.

A healthy workforce is productive and competitive. Our public health care system is a advantage when attracting investment and jobs to Canada. However, its costs have become a national concern. Despite this concern, affordable preventive measures are ignored.

3.2 Improving Health Care Delivery

There is a critical need to develop new ways of delivering *integrated* health care. Unfortunately, oral care is often forgotten in discussions of such delivery models, even though oral health remains a major indicator of overall health. The "gatekeeper" role played by medicine in the delivery of health care must be changed so that Canadians can get better care.

Similarly, the effective utilization of dental hygienists is hampered by an outdated dentist-centred model that restricts access and service delivery. As health professionals, dental hygienists need to be permitted to work in a variety of roles and environments, together with other health care professionals, to make health care available to all Canadians.

3.2.1 The Role of Dental Hygienists

Canada's dental hygienists have been providing accessible, affordable oral health care for 50 years. They originally began working in Canada because provinces saw them as a cost-effective way to provide basic oral health care services. An informal survey of all dental services by the CDHA and an associated insurance company found that 50 per cent of the services currently being billed to existing dental plans *are, or can be, provided by dental hygienists.*

In addition to the traditional workplaces—public health offices, dental offices, public health programs, schools—dental hygienists have increasingly been working in outreach programs that serve the homebound and institutionalized. Examples include long-term care facilities, community health clinics, home care programs, and other outreach programs.

²¹ Statistics Canada, *Perspectives on Labour and Income* (Spring 1998, Catalogue No.75-001-XPE).

A policy to permit the independent practice of dental hygiene was recommended at least 20 years ago.²² This policy is consistent with the major objectives of health care reform because dental hygiene

- is a cost-efficient alternative to full oral health care
- promotes efficiency by improving the quantity and mix of preventive oral health care services
- emphasizes disease prevention, health promotion, protection, and education
- promotes equity by providing preventive oral care services to underserved populations

Change in the delivery of oral health care is inevitable. Dental hygienists are an essential component of a more integrated approach to delivery of care because

- demographic, epidemiologic, economic, and social influences will increase the demand for dental hygiene care
- awareness of the importance of oral disease prevention will continue to grow
- dental hygienists will continue to adapt to an ever-changing environment and health care system
- dental hygienists will be recognized as providers of choice in preventive oral health care and oral promotion
- dental hygienists enable clients to achieve optimal oral health
- dental hygiene practice is founded on a growing body of knowledge from research in dental hygiene, biological sciences, dental sciences, social sciences, and technology
- dental hygienists value and actively pursue new scientific and clinical knowledge and skills

3.2.2 Regulatory Change

It is ironic that, on one hand, there are underserved areas with shortages of traditional health care professionals, such as doctors, nurses, dentists; while on the other hand, we have dental hygienists who are restricted in their attempts to meet these needs.

Governments need to assist dental hygienists achieve their goal of serving the oral health care needs of the public.

The Canadian population is a step ahead of existing legislation and is looking for changes to permit greater accessibility to care. For instance, in the winter of 1998, the Population Research Laboratory at the University of Alberta polled Albertans on their beliefs and opinions about dental hygiene services and their willingness to visit dental hygiene clinics.²³ Results clearly indicate that Albertans would be prepared to visit independent dental hygienists and believe that going to dental hygienists is important for a healthy mouth. A clear majority also wanted the freedom to visit the oral health practitioner of their choice. An overwhelming number (92.4 per cent) believed that some form of dental insurance plan should cover direct access to dental hygienists; 56.3 per cent believed that direct access to a dental hygienist would save them money.

The population understands the importance of oral care. They want simple, effective, and affordable options. Public policy-makers must catch up to the needs and wants of Canadians.

²² Ontario Economic Council, *Health: Issues and Alternatives* (Toronto: OEC, 1976); R Evans, M Williams, *Extending Canadian Health Insurance Options for Pharmacare and Denticare* (Toronto: Univ. of Toronto Press, 1978). As mentioned in: P Manga, "The Independent Practice of Dental Hygiene: Political Economy, Professionalism and Policy," *Probe* 31(1) (January/February 1997): 16.

²³ Alberta Dental Hygienists' Association, *Support for Dental Hygiene in Alberta. Public Opinion Tracking Study* (Edmonton: ADHA, 1999), pp.3-4. This study was one element of the 1998 Alberta Survey conducted by the Population Research Laboratory, University of Alberta (University of Alberta, 1999).

In some provinces—British Columbia, Saskatchewan, and Ontario—health legislation is slowly evolving to give Canadians greater direct access to dental hygienists’ services. However, **legislation has not evolved far enough**. Many provinces’ regulatory structure still restricts access to care in favour of an outdated hierarchical model. As well, insurance coverage does not recognize the independence and importance of dental hygienists in the delivery of oral health care services within their scope of practice.

As shown by recent meetings of federal and provincial health ministries and of the provincial First Ministers, the health care debate has been taken over by discussions on transfer payments and spending. More money is not the only answer. Are provinces using the dollars they have efficiently? The answer is clearly “No.” The debate should revolve around better use of dollars and how we can prevent disease in *all segments* of the population. The federal government should insist that provinces adopt prevention-oriented regulatory reforms in exchange for federal dollars.

The Canadian Dental Hygienists Association recommends that the federal government encourage its provincial and territorial partners to remove restrictive regulations, where they exist, that deny Canadians direct access to dental hygienists’ services. This proactive reform of service delivery will improve access to professional care and reduce health care costs both in service delivery and through reduction of future incidence of illness and treatment.

The Canadian Dental Hygienists Association recommends that the tax system be modified to allow greater tax incentives for health care practitioners such as dental hygienists who are willing to work with underserved populations.

3.2.3 *The Federal Public Service Dental Care Plan*

The federal government can lead by example and acknowledge dental hygienists as full partners in the multidisciplinary health care continuum. Dental hygienists in Canada provide care in a variety of practice settings, including direct service delivery in provinces where provincial legislation allows. Revenue Canada recognizes dental hygienists’ services as “medical practices” for income tax remittance and there is an increase in the number of dental hygienists across Canada providing services as independent contractors.

The CDHA has worked with the Canadian Health and Life Insurance Association (CHLIA) over the past few years to develop a National Dental Hygiene Care Claim Form and a CDHA National List of Dental Hygiene Services and System of Service Coding©. Many insurance companies (for example, Sunlife, Manulife) recognize that provincial legislation has changed with regard to dental hygienists’ services and have adjusted their plans accordingly. **Sun Life recognizes dental hygiene claims for all employers whose plans they administer, with one exception—the federal government plan. Great West Life, the other major insurance carrier for the federal government, has informed the CDHA that, while the wording in their plan does not meet current provincial legislation, change must be directed by the employer—in other words, the federal government.**

The Public Service Dental Care Plan, Appendix B – Eligible Dental Services, currently states:

Eligible dental services mean services listed hereafter, when rendered by a dentist of dental specialist, or rendered by a dental hygienist under the direct supervision of a dentist of dental specialist, or rendered by a dental mechanic (also referred to as a denturist or denturologist) who is licensed to provide services in the province or territory in which the service was received, and who is permitted by law to deal directly with public.

Dental hygienists in British Columbia, Alberta, Saskatchewan, and Ontario do not provide care under direct supervision. In fact, to do so is contrary to provincial legislation. However, current claims originating in these provinces are accepted; thus the wording does not address the issue, “Who submits the bill?” Currently, this clause restricts the practice of dental hygiene in Canada and is contrary to the federal government’s position on increased trade and access to care. It is inappropriate under provincial legislation and needs to be deleted immediately. In addition, restricting direct billing by dental hygienists would seem contrary to increasing trade and access to care.

The Canadian Dental Hygienists Association recommends that the federal government instruct Great West Life and Sun Life to delete the words “under direct supervision of a dentist” from the Public Service Dental Care Plan and the Pensioner’s Dental Services Plan.

SUMMARY

The Canadian Dental Hygienists Association's overall purpose in presenting this submission to the House of Commons Standing Committee on Finance is two-fold.

First, we seek to inform and educate the committee's members about the importance of oral hygiene. Medical research has shown us that good oral hygiene gives us much more than a beautiful smile. In fact, *it is the gateway to good overall health.*

We now know, for example, that women who practise good oral hygiene have healthier babies. This is good not only for the children and their families, but also for Canada as a nation competing in the global marketplace. We also know that people who suffer from periodontal disease are more likely to suffer from heart disease and stroke, respiratory disease, osteoporosis, and diabetes.

The link between good oral health and the general health of our nation—both physically and economically—is, quite simply, undeniable.

Second, we seek to ensure that oral health care gets the recognition—from both a funding and a policy-development perspective—that it rightfully deserves. This means that money must be spent where it will have the greatest impact: on prevention. And it means that access to oral health care should be universal.

In 1988, the federal government identified dental hygienists as the only professionals whose primary concern is the prevention of oral disease. As it stands, those who would derive the most benefits from the services provided by dental hygienists are those who are least likely to have access: the disabled, the homeless, the elderly, Aboriginal peoples, and low-income Canadians.

This must change if Canada wants to ensure a national competitive advantage. A healthy workforce is productive and competitive—and one that practises good oral hygiene.

We know that our goal of contributing to the well-being of *all* Canadians is one that is shared by members of the House of Commons Standing Committee on Finance. We would like to conclude by thanking you for allowing us to submit our comments on behalf of the Canadian Dental Hygienists Association.

LIST OF RECOMMENDATIONS

Whereas good oral health is central to achieving the objectives of the House of Commons Standing Committee on Finance, and good oral health is a key component in meeting the social and economic needs of Canadians, the **Canadian Dental Hygienists Association recommends that:**

- regardless of jurisdictional issues, the federal government work toward bringing preventive oral care into comprehensive health care in Canada under Medicare. At present, under the Canada Health Act, services provided by a dentist in a hospital setting are covered under provincial hospital insurance plans. All oral care services, whether provided in a hospital setting, a dental office, or “in-home” by a dental hygienist, should be covered under our publicly funded health care system;
- the federal government make any increments in health care funding dependent on regulatory reform, including for oral health care, that focuses on illness prevention; furthermore, that the \$2.2 billion earmarked for early childhood development include preventive oral health care measures;
- the federal government work with provincial governments to support programs and policies that will equalize access to affordable oral health care. The current medical/dental tax credit is inadequate and has such a high deductible that it is useful only for major medical conditions and does not encourage illness prevention;
- the federal government encourage its provincial and territorial partners to remove restrictive regulations, where they exist, that deny Canadians direct access to dental hygienists’ services. This proactive reform of service delivery will improve access to professional care and reduce health care costs both in service delivery and through reduction of future incidence of illness and treatment;
- the tax system be modified to allow greater tax incentives for health care practitioners such as dental hygienists who are willing to work with underserved populations;
- the federal government instruct Great West Life and Sun Life to delete the words “under direct supervision of a dentist” from the Public Service Dental Care Plan and the Pensioner’s Dental Services Plan.