**CDSS Government Dossier**

 **(Draft 20191004)**

**I. THE DDA (relative to SDHA questions, same would apply to SDTA, SDAA)**

***i. Autonomy within the DDAs4(3)***

 it is our belief that it is in reference to the regulatory authority(body) itself, not the individuals regulated by the authority. That section states that he SDHA is autonomous to operate without oversight from the CDSS or anyone else other than the Ministry and we agree with that.

*“If the intent of the DDA was to create greater individual autonomy for hygienists, the DDA would have eliminated the supervisory roll of a dentist and allowed a hygienist to operate without any formal ties to dentists. That did not occur.”* (RAR)

***ii. Oversight/supervisory responsibility of dentists DDAs25***

Dentists have unique **comprehensive authorized practices** which enable them and only them to provide oversight/supervision of Comprehensive Patient Centered Care in the public interest! BEW

“The fact that hygienists must practice in an employment relationship with or under a contract with a dentist (DDA s 25) impliedly means that a dentist has supervisory obligations vis-a-vie the **comprehensive authorized practice**. “Under contract” does not imply a lesser standard of care and a dentist still must ensure the quality of the services in a manner consistent with the CDSS regulation of its members. Given that dentists have a supervisory/oversight roll, the CDSS and its members have a duty to ensure that standards of the dental services provided are observed regardless of whether the hygienist is an employee of a dentist or acting under contract with a dentist. Arrangements whereby the dentist is not obligated to ensure that the standards of dental practice are maintained would essentially mean neutering the obligation of dentists by allowing such and this would be contrary to the DDAs25. The DDAs25 limitations on dental hygienists, dental assistants and dental therapists authorized practice is there to address the overall intent of the Act which is regulation of dental services in the public interest” (RAR) and is not about “power and control” as suggested by the SDHA.

 ***iii. Business Models “Hygienist Decisions about their own business endeavors”***

“Business models must be compliant with the Act. As further stated below, in our counsels’ interpretation (italicized), the terms ‘contract’ and ‘employment’ have relative similar meaning within The Act, to provide an element of ‘connection’ to a dentist, for reasons relative to supervision/oversight in the public interest.”

 **iv. CDSS Legal Opinion**

 ***(a) DDA Statutory Requirements (s 25)***

*“Hygienists may only perform the practices they are authorized to perform when employed by or practicing under a contract with:*

*1. An employer that employs or has established a formal referral or consultation process with a dentist; or*

 *2. A dentist.*

 ***It is important to realize that absent compliance with Section 25, hygienists have no***

 ***ability to perform any “authorized practices”.*** *An employer is defined under Section*

 *25(1) in terms of institutions such as governments, Indian Bands, boards of*

 *education, universities, and so on. Dentists are not mentioned, but they employ*

 *hygienists under contracts of employment. These can be differentiated as to hygienists*

 *who receive wages for performing services and are therefore considered to be*

 *“employed”, or hygienists who are under a contract to perform services as*

 *“independent contractors” on a fee for service basis with a dentist or dentists.*

*A possibility exists that the hygienist may hire (employ) a dentist to provide services of a supervisory nature, but that form of contract would be contrary to Bylaw 9.2(iii) of the CDSS.*

*In any event, the issue is not one involving hygienists in institutions or ones working in practices owned by dentists where a dentist is on site most, if not all of the time.* ***Rather, the issue is with those hygienists who wish to practice out of offices with minimal or no dental supervision.***

 ***(b) Statutory Interpretation***

*For dentists, the issue is the extent of their responsibilities under the*

 *Act and CDSS bylaws when it comes to employing hygienists and the*

***degree of supervision*** *required.* ***There must be a reason why the DDA***

 ***places limitations on the ability of a hygienist to practice his or her***

 ***profession and in particular, why it must be under contract with a***

 ***dentist.***

*Acts or bylaws read in isolation may give interpretations which appear ambiguous or contradictory. In a recent Supreme Court of Canada decision, the Court stated:*

*However, it is not sufficient to read the paragraph in isolation. Rather it must be read in its entire context, in its grammatical and ordinary sense harmoniously with the scheme of the Act and the intention of the legislature.*

*Reference re: Broome v. Prince Edward Island, (2010) SCC 11, at para. 58*

*The purpose of the DDA is to regulate the provision of dental services to the public in Saskatchewan. Only those professionals with the requisite training may be licensed by their association to perform certain authorized services. The various associations are charged with the responsibility to license only those who meet and maintain standards of practice, and to discipline those who do not.*

*Dentists have a responsibility to supervise* the comprehensive authorized practice *and to ensure proper records are maintained by themselves and allied staff (Bylaw 9.3). This is a reasonable interpretation of their responsibilities under Section 25 of the DDA.*

*When the Act provides that a hygienist may only perform the practices he or she is authorized to perform where employed by or practicing under a contract with a dentist, then read within the “context of the Act”, “harmoniously with the scheme and the intention of the legislature,” this must mean that the hygienist must practice under the oversight/supervision of a dentist. The degree of supervision may vary depending upon the circumstances, but for the dentist it must be in compliance with CDSS Bylaws, Policies* (standards*) and Guidelines.*

***The responsibility to provide* oversight*/supervision is magnified because the same requirements apply also to dental assistants and dental therapists.***

*If the interpretation were otherwise, then subsections 25(2), 25(3) and 25(4) would be redundant and have no purpose; that cannot be.* ***Every provision in a statute is deemed to have a purpose and must be interpreted meaningfully.*** *Every dentist who allows his or her name to be used in a contract with an allied dental professional and provides limited or no supervision under that contract would be taking a risk. If a complaint was made against the allied professional, the risk is that the complaint would also include the name of the dentist under whom the allied professional was practicing. If an incident results in an injury or inadequate treatment, the dentist also runs the risk of civil liability.” (RAR)*

***Conclusion***

*Public confidence in the CDSS to self-regulate may be undermined if it*

 *gives little or no meaning to Section 25 such that dentists perform little*

 *or no supervisory function over allied personnel with whom they*

 *contract.*

*If allied dental professionals wish to practice with little or no supervision from dentists, then it is up to them to convince the legislators to repeal Section 25. Until then, dentists must exercise their supervisory duties in a meaningful way.*

**v. Legislative Change Process- a 2 year process**

At an October 2019 NIRO seminar the Ministry described the process for changing legislation such as the DDA. Many statutes last for 30 years! The Ministry warned regulators to look at risks of losses when an act is ‘opened’! When an act is open many things can change!

 To get an act on the agenda all involved regulators coming together **may** help! See the proposal process below. Bureaucrats add comments to proposals but the minister burns ‘political capital’ with statute changes so it must be important enough to move it forward! Direct costs to organizations and loss of opportunity costs can be a’ black hole’ so be aware of the costs of ‘pushing uphill’!

1. Proposals (usually by sept oct of a year) are received by Rebecca Baylis (2019) who CDSS staff are familiar with. Capacity limits Ministry activity to 1 or 2 “open Statutes’/ yr

 The criteria used to review proposals include:

 i. How important/necessary

 ii. How does this fit in the Government (of the day) priority?

 iii. How does it mesh with Ministry/Gov Health strategy?

 iv. Are there Barriers(issues) to interprovincial mobility

 v. Has Stakeholder discussion resulted in Unanimity?

 iv Are there Budgetary implications?

2. Input from internal Gov branches is canvassed

3. Administration makes recommendations to Minister

4. Stakeholders are informed of proposal status

5. Jan/Feb of next year a draft summary proposal is prepared

6. Feb/Mar - minister recommends which proposals go forward

7. Apr/June – proposal with all stakeholder consultations to elected

8. More stakeholder consultation may be requested

9. Sept finalize for legislature in Oct

 10. Legislature Readings proceed

 11. Possible royal ascent by spring

**II. Stats Canada, Dental care, Access**

*After several years without comprehensive questions related to dentistry, Statistics Canada’s 2018 Canadian Community Health Survey collected rich, meaningful, and high-quality data about access to dental care. When this new data is compared to Canadian data from 2014, data about access to dental care in other high-income countries, and data about access to other kinds of medical care, an exciting and dynamic picture of the successes of the Canadian dental care system emerges. Even with the current challenges facing dentistry in this country, there’s no doubt that almost all countries around the world would be envious of these numbers and look towards emulating our system. These consultation rates are important indicators, at the highest level, in any health policy debates and discussions regarding the need for major overhaul in the delivery of oral health care in this country, and the utility of “dentacare”.*

 *The new data shows that as many⁠—and even slightly more—people had visited dental professionals (74.7%) than medical doctors (74%) in the last year. Though medical care has public funding and dental care has mixed public-private (largely private) funding, these statistics suggest that both systems are equally accessible for Canadians. These numbers may represent a natural peak—it is rare to find a population with higher rates of regular health care use.*

 *Access has grown significantly. Among Canadians aged 12 and over, 66.5% consulted a dental professional in 2014 and 74.7% did so in 2018. This shift represents 4.8 million people who didn’t access dental care in 2014 but did four years later. Even with a growing number of dentists, an increase of this size in the number of people using dental care is significant. The demographic of people 65 and over has seen impressive increases in access to dental care, from 54.8% to 67.5% in four years. Reasons for these increases are multi-faceted, but one can hypothesize that Baby Boomers have greater resources then previous generations of seniors and spend more on health care; people are having more elective dental treatments; and an increase in the number of dentists may create induced demand—economist-speak for when increasing the supply of a good or service makes people use more of it.*

 *From a* ***health policy perspective****, this data demonstrates that our oral health system provides very high levels of access to dental care for a large population base at a relatively low cost to government and individual citizens. As well, our system provides minimal wait times, a high quality of care and desirable outcome measures amongst the top in the world (as demonstrated by indicators in the Canadian Oral Health Measures survey). Canada’s oral health system is world-class; policy that would dismantle or disrupt it would imperil the oral health of Canadians.*

 *No health care system can achieve 100% annual population access rates for any service. There will always be people who will not visit a dentist or a doctor in a given year. Some people are afraid. Others don’t feel it’s important enough. Yet others find it too much of a commute or an inconvenience in their schedule even if “free”. Access through a universal public health system has its own pitfalls; the 2018 Canadian Community Health Survey shows that 15.3% of Canadians aged 12 and over (roughly 4.7 million people) don’t have a regular health care provider or family doctor.*

*Three out of four people visiting a dental health professional annually seems to be as close to “universal coverage” as any country can get. Germany and Denmark, considered dental care systems to emulate in terms of their access rates, serve about 80% of their population each year. If these latest Canadian numbers included children under 12 years of age in the overall count, Canada may also have an 80% access rate.*

*Canada is a leader among OECD countries in dental care access, even amongst those that have publicly funded dental health care, as these statistics demonstrate:*

*• Australia: 47% visited a dentist or dental professional within the last year (2015).*

*• US: 37% of adults visited a dentist within the last year (2015).*

*• UK: 52% of adults visited a dentist within the last two years (2017).*

*• France: 52% visited a dentist within the last year (2014).*

*The Canadian mixed private-public dental health care system that has been built over many decades is working extremely well. There is opportunity and the obligation to improve access for vulnerable groups, which is an ongoing goal for both government and dental health professionals. But, an attempt to transform the dental health care system into a public universal system would likely have negative consequences for millions of Canadians who are currently well-served with a system, as well as possibly worse outcomes for those who are currently in the vulnerable groups and not served well.* (Costa, CDA)

***III. Expanding Scope of Hygienists***

***In Saskatchewan the DDA would require change or an MOU amongst all of the six regulators under the DDA would be required to present to government to allow such. A third possible route would be that the training provided to hygienist would be recognized by SDTA as equivalent to a therapist, and dual licenses could be provided as they are now to individuals who have both therapy and Hygiene education.***

 ***i. CDA POSITION PAPER (Confidential)***

*The Canadian Dental Hygienists Association (CDHA) developed a position paper this year titled “Filling the Gap in Oral Health Care”. This paper suggested the development of educational pathways for hygienists to assume some of the scope of practice that is currently undertaken by therapists. This issue is framed primarily as an access to care issue, with the underlying rationale being that expanding the abilities of hygienists will inherently address existing gaps in accessing oral health care.*

 ***(a) The CDHA Proposal***

*The CDHA proposal focuses on two initiatives:*

1. *Standardizing Scope of Dental Hygiene Practice: Creating a single, national scope of practice for hygienists.*
2. *Developing Educational Models for Dental Therapy Abilities: Creating a one-year program for dental hygienists to become dually qualified providers, or re-opening three-year dental therapy diploma institutions.*

*An additional Indigenous lens has been applied to both two initiatives, with the goal of providing opportunities for Indigenous people to learn closer to home, with financial and other supports to help them enter the profession.*

***Initiative A****: While much of the initial discussion has focused around initiative B, it is important to recognize that the “nationally-standardized scope of practice” is a critical point to consider. There are provinces in which the scope for hygienists includes some restorative and simple extraction services, as well as the use of a “hygiene diagnosis”.*

*Hygiene, like other health professions, is regulated within the provinces The main benefit of a national scope of practice would be to the hygiene profession itself by selecting all the unique regional elements outside the essential core of their traditional scope.*

*There should be no role for a federal government or agency to intercede in provincial health regulatory frameworks to expand the scope of practice of hygienists.*

***Initiative B****: The underlying logic to the creation of such educational programs is that the closure of the dental therapy school in 2011 has negatively impacted on access to care. However, there is some acknowledgement that the graduates of the dental therapy program in later years were not fulfilling their essential role in addressing the geographic disparities in access to oral health care, as graduates were not filling positions in northern and remote areas.*

*The CDHA was provided with approximately $400,000 to commission further studies on their proposed solutions and develop a pilot curriculum with two dental schools.*

 ***(b) Discussion with the Federal Government***

*CDA staff held a meeting recently with senior officials at the First Nations and Inuit Health Branch (FNIHB) of the Department of Indigenous Services Canada (DISC), including Senior Assistant Deputy Minister Valerie Gideon.*

*The CDA pilot program was one of the items raised. CDA asked how the Department would be evaluating the program, and what success would look like for them. Their response was somewhat non-committal and noted that the question was better directed towards the CDHA.*

*What that response might tell us is that the Department isn’t driving the proposal forward. While they are funding the pilot at a cost of $200,000 for each of the two universities, this does not mean that they have long-term implementation strategy at this stage.*

*A concern of FNIHB, however, is that there are a number of therapists in northern and remote communities who are retiring, and because there are no new graduates, there are few candidates to replace them in these roles. Dental therapy, like dentistry and many other professions, has a “geographical maldistribution” issue.  This is a challenge that the Department believes they need to address, through a renewed therapy program.*

*The CDHA paper does not address ensuring that graduates of any new educational framework be encouraged to practice in areas where dental therapists provide the most vital contribution to the healthcare system.*

*It is also important to note that the belief amongst ADM Gideon and her officials is that the presence of therapists doesn’t undermine or intrude on the business of dentists. Rather, their view is that therapists help to identify oral health needs that can only be fulfilled by dentists.*

 ***(c) Essential Discussion Points for Dentistry***

*The following are some essential discussion points for dentistry on this initiative, or on the use of other providers to enhance access to care.*

 *Initiative A – National Scope of Practice:*

* *Regulation of health professions is done at the provincial level.*
* *Any federal department or agency that would seek to apply regional variations in hygiene’s scope to a national scope of practice would be running counter to the Constitution’s division of powers around healthcare.*
* *Defining scope is currently under provincial authority.*

 ***Initiative B – Developing Educational Models:***

* *Dentists have the most comprehensive training and diagnostic knowledge, and as such, oral health care should be provided to Canadians through dentist-led teams. Any solutions to access to oral health care must include dentists as providers.*
* *Dentist-led also supports the dental team – dentists, assistants, hygienists, therapists (in some locations/provinces), lab technicians. This model is successful in the delivery of dental care for the majority of Canadians.*
* *While the CDA does not support the CDHA’s proposal as-is, we believe that dentistry should be consulted in the development of curricula or changes to the health professions regulatory frameworks that may ensue from this discussion.*
* *Access to oral health care is always – and continues to be – a priority for the CDA, and the dental profession. It is also a significant focus of the Future of the Profession Report.*
* *As a profession, dentistry needs to demonstrate to governments and other stakeholders that we have an open mind about discussing solutions. In the context of those discussions, the profession should be able to offer viable alternative solutions to addressing the access problem in remote areas.*
	+ *Should the profession be developing lists of available dentists ready to be involved in delivering care to remote areas either on site, or by distance, or a combination of these approaches working with a dental team and a remote community?*
	+ *An essential aspect of any model put forward by the dental profession would need to include “continuity of care”. The belief from government officials is that this is the added value that therapists in northern and remote communities may provide. Itinerant dentists who rotate in for short and inconsistent periods would not be seen as a viable substitute for an in-community professional resource.*
* *Given that the most acute needs are in northern and remote areas, any educational model underwritten or substantially subsidized by the federal, provincial or territorial governments for graduating therapists or dual-qualified providers must have* ***an ability to direct these graduates to practice in remote areas after graduation.***

 ***(d) Essential Questions on the CDHA Proposal***

1. *Is the goal of this program to provide candidates to replace vacant or soon-to-be vacant existing therapist’s positions in remote areas?*
2. *Is the program designed to have the therapists work under the supervision of a dentist?*
3. *Will this program be set up in perpetuity, or would the goal be to address existing gaps with therapists’ positions in remote areas?*
4. *Is there any plan for determining where new therapists or dual-qualified providers would be placed once existing positions in remote areas have been filled?*
5. *Who will have regulatory oversight over dually qualified providers (hygienists with therapy skills)? With an expanded scope of practice, is it appropriate for hygiene colleges to undertake this regulation? Should this expanded scope not be overseen by the dental regulatory authorities?*

IV. Demographics of Dentistry in Saskatchewan

V. Charitable Activities of Dentists