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**The College of Dental Surgeons of Saskatchewan**

**Response to the SDHA Submission (February 2020)**

**Introduction**

The College recognizes The Dental Disciplines Act (1997) has proven to be progressive legislation and will continue to provide the public protection that was intended by the Ministry.

Regulatory authorities act in the public interest to regulate members for the provision of competent oral health care. The College council is aware of its regulatory mandate afforded by the Ministry and is committed to this mandate. The College contends that the SDHA submission is an advocacy document that promotes dental hygienists as key providers to resolve ‘access to care’ by the elimination of Section 25 of The Act. The College’s best guidance regarding the Act is provided by our legal counsel, Reynold Robertson and Sean Sinclair. (Appendix A, B)

The College recognizes that access to oral health care for some segments of the population is not ideal and understand as stated by SDHA “that the issue is multi-faceted and complex; there are no simple one-step solutions”. However, the College believes **the SDHA submission is a ‘one step solution**’ that is an oversimplification of a complex issue. The SDHA submission does not consider the expert comprehensive knowledge of dentists and dental public health specialists with experience in dental public health programs. Dentists and dental specialists have extensive education and experience which includes achievement of master’s degrees in dental public health.

Currently, a variety of delivery models exist in Saskatchewan. Over one hundred clinic facilities provide access to oral health care to vulnerable populations often in conjunction with general healthcare services. Appropriate utilization of all providers (dental public health specialists, dentists, therapists, hygienists, assistants, dental aides and other health care personnel) is always a consideration to address responsible utilization of resources and sustainability of those services.

**Current Legislation**

1. **Delivery Models**
* There are over 100 dental clinics in Saskatchewan that are focused on access to care for vulnerable populations. This is illustrated in the appended documents. (Appendix C, D, E)
* As stated previously, the SDHA submission to eliminate Section 25 of The Act does not recognize the current reality that exists for practicing essentially the way the SDHA proposes, **with no change to The Act**. Various practice models exist under the ‘right touch regulation’ provided by the current legislation. Dental hygienists and dental therapists can be contracted or employed by agencies (Saskatchewan Health Authority, Indigenous Nations, Indigenous Services Canada, the Ministry of Health, school boards, etc.). Practice models exist now where therapists or hygienists own facilities where there is a simple collaborative peer contract relationship with a dentist directly or through an agency. The contract is there for **public confidence** in collaborative consideration of comprehensive authorized practices.
* The SDHA submission suggests that amendment to The Act is necessary to bring Saskatchewan in line with most other Canadian jurisdictions. However, College legal counsel, Sean Sinclair, following a closer review of the legislation across the country suggests “that Saskatchewan is already more progressive than some jurisdictions. For instance, dental therapists are not self-regulated in any other jurisdiction, and dental assistants are not regulated at all in the two largest jurisdictions of Ontario and Quebec.” (Appendix B)
1. **Provider Choice**
* All providers of oral health care are not interchangeable. The current legislation recognizes this and allows oral health providers to practice within their legislated authorized practices. The legislation requires collaboration (via employment, contract or referral-consultative relationships) with other oral health care providers to achieve the same comprehensive standard of care for all Saskatchewan residents.
* Existing delivery models allow for provider of choice within and between dental clinics. No one provider “owns” their patients. Patients always have choice of providers.
1. **Regulatory Barriers**
* The existing delivery models in Saskatchewan demonstrate that the ‘contract’ under Section 25 of The Act is not a barrier to access to care as shown in the appended documents. (Appendix C, D, E)
* The ‘contract’ is with respect to the provision and consideration of comprehensive authorized practices in the public interest and does not necessarily refer to financial arrangements.
1. **Comprehensive Authorized Practice**
* Dentists are the only providers under The Act to have comprehensive authorized practices as set out in Section 23. Therefore, this provides them with the stewardship of comprehensive authorized practices under The Act.
* Our legal counsel states, “Hygiene services such as those offered by the members of the SDHA are but one aspect of comprehensive dental care. If comprehensive dental care becomes segregated or disjointed, as we suggest would be the result of the proposed amendments, public health will be compromised.” (Appendix B)

**Access to Care**

1. **Needs of Vulnerable Populations**
* The appended Statistics Canada 2018 Report on Dental Care states the majority of Canadians are accessing oral health care annually. (Appendix F)
* The College acknowledges there are vulnerable populations that do not have good oral health and have a higher burden of oral disease.
* In Dr. Uswak’ s expert opinion he states, “while pro-independent practice opinion papers suggest that independent practice will increase access to care, there is no evidence in the literature demonstrating that it actually does lower access to care barriers.” (Appendix G)
* The oral health needs of vulnerable populations are more complex than the general population with regular access. Dr. Uswak’ s letter also says “Indigenous Canadians have poorer oral health and require more comprehensive dental care than non-indigenous Canadians. Their access to care barriers are manifold despite having non-insured dental health benefits to cover much of the costs of the care.” (Appendix G)
* Dr. Uswak’ s letter describes current delivery models. “In Saskatchewan, Dental hygienists, dental therapists and dental assistants who work for dental public health agencies and many First Nations practice independently but collaboratively in referral-consultant relationship with a one referral-consultant dentist to channel all patient consults and prescriptions through. The referral-consultant dentist will also do quality assurance assessments of care-provision mandated by the agency.” (Appendix G)
* The majority of oral health needs of vulnerable populations can be met by these delivery models under the current Act through shared leadership and collaboration among all healthcare professionals to predictably achieve the desired outcome.
* Current delivery models for vulnerable populations, in remote locations, through agencies (Saskatchewan Health Authority, Indigenous Nations, Indigenous Services Canada, the Ministry of Health, school boards, etc.) have not demonstrated an urgent need for dental hygienists in primary care. The majority of oral health care for these vulnerable populations, in remote locations, is provided by dental therapists, dental assistants, dental aides, community healthcare workers in a collaborative relationship with a dentist.
1. **Standard of Care - Human Rights**
* It is a fundamental Human Right that there is one standard of care for all. The SDHA submission implies that deleting the requirement for hygienists, therapists and assistants to have a contractual relationship with dentists for consideration of comprehensive authorized practices. We suggest that this illustrates that the SDHA does not understand the complex oral health needs of these vulnerable populations. The SDHA submission is promoting a lower standard of oral care for vulnerable populations. The College can not support this concept.
1. **Cost of Care**
* The experience in other jurisdictions with ‘independent dental hygienists’ (similar to eliminating Section 25 of The Act in Saskatchewan) is **that the dental hygienist fees are the same as dentists with no cost saving to the patient or public program**. Dr. Uswak is of the opinion “Additional providers who charge fee-for-service will not reduce income inequality access to care barriers for these vulnerable populations.” (Appendix G)
* In fact, the appended document from the Canadian Dental Hygienists Association (2012) submitted to the House of Commons Standing Committee on Human Resources was a recommendation to ensure that independent hygienists be recognized as providers in the NIHB (ISC) program and that reimbursement rates for dental hygiene services by an independent hygienist would be the same as that for a dentist and are equal to provincial/territorial market rates. (Appendix H)
* Another unintended consequence of independent hygienists, therapists, or assistants is that if a patient does require a follow-up or a referral to another oral health provider such as a dentist or dental specialist, the patient will be responsible for the additional cost of another examination fee. The frequency restrictions, on examinations within publicly and privately funded programs, will not allow reimbursement for another examination.
* Patients and public programs expect value for services. Patients also want to be informed and have clarity about who is providing care and what level of care they are paying for. There is confusion within the public regarding who is capable of providing various oral health care services.
* For the above reasons the suggestion that there will be cost savings by removing Section 25 of The Act needs further consideration.

**Conclusion**

**The oral health needs of vulnerable populations are more complex than the general population. For this reason, the College supports Section 25 of The Act which requires collaborative involvement of dentists and other health professionals in the delivery of oral health care to vulnerable populations. Shared leadership and collaboration among health care professionals is the most predictable approach to achieve the desired outcome. Hygiene services are but one aspect of comprehensive oral health care.**

**The College believes The Act, when read in its entire context, is progressive. It has enabled the variety of collaborative dental delivery models we have today. The Act allows for these current delivery models to evolve and improve access to care.**

**The College believes there is no need and no urgency to amend The Act as submitted by SDHA.**