INTRODUCTION
The Canadian Dental Association (CDA) represents 18,000 dentists throughout the country. CDA 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.

We trust that our expertise will assist the Committee as it prepares its report to the Minister of Finance. Our brief will address the stated objectives of the Committee: ensuring progress in investing in, and caring for, all members of Canadian society; and ensuring that urban, rural and remote communities are desirable places in which to live and work.

Again this year we have chosen to discuss issues that have a direct impact on both the oral health of Canadians and our member dentists as well as a more global impact on dentistry in general.

HEALTH OF CANADIANS
Oral Health Status – Putting the Mouth back in the Body
Dental disease has been referred to as one of the most common health problems in the world today. The Canadian Dental Association recognizes that oral health can affect the functional, psychological and social dimensions of an individual’s overall health status. Dental problems also lead to a reduction of daily activity that results in a loss of productive work time, which in turn negatively affects the productivity of the Canadian economy. New research is also beginning to demonstrate that oral conditions have complex interactions with whole-body systems, and can affect overall health. For example, diabetes and periodontal diseases often occur in tandem, and each condition exacerbates the disease cycle of the other. Periodontal diseases, such as infections under the gumline, have also been implicated in pre-term low birth weight babies and cardiovascular disease. These conditions have high societal costs, both in terms of their toll on the quality of life of sufferers, and in the direct expenses for care under the public health care system. Dentistry is a profession with a mantra of prevention. Further
research must be conducted to determine whether a causal relationship exists between gum
diseases and other health outcomes, and if so, what preventive dental measures can be taken to
improve overall health.

The good news is that, for the most part, Canadians enjoy a good standard of oral health. Water
fluoridation and the use of fluoride products such as toothpaste are relatively prevalent, resulting
in reduced caries experience in many areas; high access to dental plans results in the majority of
Canadians visiting the dentist at least annually; and Canadian dentists provide leading-edge
standards of care, based on exemplary training and skills.

Before we declare victory over dental disease, however, we must ensure that high levels of oral
health are enjoyed by all Canadians, which is currently not the case. Because oral health
epidemiology is in its infancy in Canada, statistical information is sparse and does not give us a
full picture. But from the information that is available, we are able to reach some basic
conclusions: access to dental insurance has a high correlation with dental visits; dental caries is
most prevalent among lower socio-economic groups; and First Nations and Inuit Canadians
experience significantly poorer oral health than other Canadians. In addition, there appears to be
a trend developing of a higher incidence of cavities among children. The Canadian Dental
Association will monitor this situation closely, as new information is gathered, to determine
whether a true trend exists, and if so, what can be done to reverse it.

Dental Insurance
The CDA supports optimal oral health for all Canadians, provided through a delivery system,
which is open and flexible. Historically in Canada, the quest for affordable and accessible oral
health care has been a partnership of professionals, governments, businesses and labour. This
approach has helped shape a private sector system that creates an incentive for prevention and
oral health maintenance. All the partners have made their individual contributions. In addition
to continuously upgrading skills, and maintaining world-class standards of care, Canadian
dentists have made significant strides in controlling cost increases.
Employers have done their part by financing plans for their employees. Plan providers have designed effective dental plans as their contribution to the partnership. The federal government has provided a tax incentive of deductibility on plan premium costs for employers. While originally, this benefit was restricted and unavailable to the unincorporated self-employed, CDA applauds all the partners who supported the thrust to extend tax deductibility of plan premiums to Canada’s unincorporated self-employed. CDA is particularly grateful to the House of Commons Standing Committee on Finance for making specific recommendations calling for this action\(^1\), and the Minister of Finance for taking action in the 1998 Budget\(^2\).

Dental insurance plans and tax incentives are benefiting the majority of Canadians. But for those not covered through either of these schemes, more attention is required.

**Oral Health of Poor Canadians**

In developed countries, it is typically the case that 20% of the population experiences approximately 80% of cavities. Not surprisingly, that 20% tends to be made up primarily of members of the lower socio-economic groups. While, as previously noted, comprehensive data to fully demonstrate this phenomenon are not currently available in Canada, common sense and anecdotal evidence predict that similar situations exist here. The Canadian Dental Association is working with Statistics Canada and Health Canada to assist in formulating oral health questions to include in future polling, but for the time being, we must rely on current evidence.

The reasons for a higher prevalence of dental caries amongst the poor, and particularly very young poor children, are varied and complex. Solutions to the problem will similarly require a multi-faceted approach. Publicly-funded dental plans to address the needs of poor Canadians are not, in and of themselves, the solution. Governments have historically under-funded these plans – as is now the case with many of the provincial Welfare dental programs. This leads to frustration amongst both the providers and the recipients of care. Additionally, social dental plans are viewed as “fat” when fiscal planners look for areas to cut, and are typically subject to reduced levels of coverage over the lifetime of the plans.
This is not to say that a safety net is unnecessary – certainly there needs to be a formal mechanism in place to address oral health needs of those for whom the inability to pay for services is a barrier to access to care. In designing, implementing and sustaining these programs, however, governments are encouraged to actively consult with stakeholders and care providers to ensure that the goal – in this case to improve the oral health of the population – can reasonably hope to be met within the parameters of the plan.

Even more than the need for dental plans, however, is the need for oral health education. While virtually all Canadians are aware of the need, and heed the advice, to brush their teeth, many are not informed about the oral health needs of young children. Early childhood caries is a devastating disease that can occur as a result of this lack of information and action. While it occurs in every socio-economic group, early childhood caries rates remain high among less-advantaged populations. Early childhood caries, also know as “baby bottle syndrome”, is both preventable, and if detected early, highly treatable. Unfortunately, many children do not see a dentist in their early years. In the preschool aged child, if early childhood caries has been left untreated, it can result in the loss, or serious decay of many or all of the their front teeth. This untreated decay is painful and can prevent children from eating a nutritious diet, from sleeping well, and from concentrating. Governments have already identified the early childhood years as critical to future development of the child – certainly early childhood caries is a developmental barrier that is relatively easy to prevent and correct. By undertaking a broad-based health promotion approach to prevention of early childhood caries, this government could make a tremendous impact on the health of less-advantaged Canadian children.

Oral Health of First Nations and Inuit Peoples
The Non-Insured Health Benefits (NIHB) plan administered by the First Nations and Inuit Health Branch (NIHB) of Health Canada, offers a tangible example of a dental plan not being a total solution. While the plan was undoubtedly conceived with good intentions to provide adequate care for First Nations clients, its poor design and administrative burden direct funds away from patient care.
As many as 72% of First Nations and Inuit children aged two to five suffer from early childhood tooth decay (also known as baby bottle caries) and the decayed, missing, filled teeth (DMFT) rate for 12-year old First Nations Children ranges from 6.9 to 8.7. 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 countries in transition such as the Ukraine (4.4) and Latvia (4.2), as well as developing nations such as Costa Rica (4.8).

This government acknowledged, within its 2002 Speech from the Throne, the need for action in order to improve the quality of life of aboriginal peoples in Canada. In addition, both the House of Commons Standing Committee on Health, in its report: *First Nations and Inuit Dental Health*, acknowledges the need for sweeping changes in order for the NIHB program to better meet the oral health needs of aboriginal Canadians. This issue is especially important in the context of pre-budget consultations because the federal government has an opportunity to deliver on its promises by dedicating resources to a recognized problem and in turn to foster the growth and health of individuals with this community, particularly children.

**The Canadian Dental Association recommends** that government work in conjunction with stakeholders including the Canadian Dental Association and client groups, to raise awareness of oral health issues such as early childhood caries both within government, and to the public through oral health promotion efforts.

**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.

**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

PROFESSIONAL ISSUES

Canadian Faculties of Dentistry
In the current harsh economic climate, Canadian Faculties of Dentistry are struggling to stay afloat. Many concurrent challenges are coming to a head together, exhausting and frustrating dental academics trying to find workable solutions.

In many ways, dental faculties are 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. Such integrations may be more concerned with economy than with the improvement of education for dental and medical students.

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.

The Canadian Dental Association recommends that the federal government encourage greater financial support of dental schools on the basis of their provision of affordable dental care to many low-income individuals and families.

Dental Faculty Recruitment – “No Professors, No Profession”
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. This puts further strain on the already tightened budgets of dental faculties as they look for ways to create career promotion opportunities and special financial support programs that might attract greater numbers of high-quality dental educators.

CDA is also 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.

**Oral and Craniofacial Research**

Individuals who choose to pursue careers in academia are faced not only with reduced remuneration relative to their private-practice counterparts, but also have increasing difficulty securing research funding. Research is not only an essential component of academic life, but is vital in order to continuously improve the oral health of the population. 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).

Canadian oral health researchers are widely recognized as amongst the best in the world, however, in the last year only 0.8% of CIHR funding was awarded to oral researchers, despite the fact that 7% of overall national health expenditures were for oral care. This is a reduction of 50% from 1999, when oral researchers were awarded 1.6%, which was still well below optimal levels.

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.

**The Canadian Dental Association 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.

As a result of the inadequate funding available to them, dental faculties are forced to look to other sources of revenue and savings, which also poses challenges to the continuing viability of the dental profession. Decision-makers feel that they have been painted into a corner in terms of their revenue options, and tuition fees have borne the brunt. Unfortunately, from the vantage point of the profession as a whole, ever-increasing tuition fees are short-term gain for long-term pain.

**Tuition Fees**

Tuition fees for Canadian dental students are already the highest of any of the professional programs. With de-regulation in many provinces, this situation has grown considerably worse. 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. Over the long term, this will undoubtedly lead to a homogenization of the dental profession. While there is currently not an overall shortage of dental practitioners in Canada, rural areas often have difficulty attracting and retaining practitioners. High tuition fees will likely exacerbate this already existing shortage of dentists in rural areas.

As members of the National Professional Association Coalition on Tuition (NPACT), CDA shares a number of other concerns related to rapidly increasing tuition fees:

**Exacerbation of the “Brain Drain” to the United States**

Offers from American recruiters to pay off high debt loads will increasingly attract new professional graduates to the U.S. and elsewhere.
Decreased Access to Professional Services

Access to some professional services is already difficult for many communities. All of the members of NPACT are concerned that high debt loads will generate fewer professionals available or interested in practicing in these areas.

Effects on the Health and Wellbeing of Students

With higher tuition fees, the stress of trying to make ends meet while in university will increase. This will have a negative impact on the health and wellbeing of individuals studying in professional programs.

The Canadian Dental Association recommends that the federal government increase financial support for students, in the form of bursaries and scholarships. 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.

These preceding items have addressed issues that affect the profession of dentistry as a whole. There are a number of issues, however, that speak more to the needs of individual practicing dentists to make their own practices viable, and to ensure their long-term financial independence.

GST Taxation

Dentists have concerns with the Canada Customs and Revenue Agency’s lack of clarity regarding the imposition of GST on certain dental supplies.

Under Schedule V of the Excise Tax Act most dental treatment services, other than cosmetic dental services, are exempt from the application of the GST. Practically this means that dentists do not charge their patients GST on services, unless the service is cosmetic.

Although most dental services are exempt, under Schedule VI Part II of the Excise Tax Act, artificial teeth and orthodontic supplies are defined as zero rated supplies. From a patient perspective the fact that these supplies are zero rated instead of exempt is meaningless, in both cases GST is not charged. However for a dentist the difference is significant because a dentist may claim input tax credits (ITCs) for all GST that was paid on expenses incurred in order to
provide these zero rated supplies. ITCs cannot be claimed for expenses related to exempt services or supplies.

ITCs are a fundamental component of the GST system. Generally a business can claim input tax credits for the GST that was paid on expenses purchased for the purpose of producing a taxable good or service. Practically, the ITC operates such that most businesses collect GST on all of their sales, however they are only required to submit the difference between the total GST collected less the amount of ITC’s that they are eligible for.

A practical example best exemplifies this point. By law a mechanic must charge GST on the full amount that they bill their clients for repairing their automobile (parts plus service). However in order to conduct their business a mechanic would have to purchase a variety of auto parts, tools and perhaps pay rent of their garage. The mechanic would be able to claim an input tax credit for the amount of GST that he/she paid on these expenses.

So if the mechanic charged his/her clients a total of $500,000 the amount of GST collected would be $35,000 (7% of $500,000). But in order to carry on business assume that the mechanic had the following expenses, parts $50,000 tools $20,000 rent $30,000. All of these expenses would be subject to GST and the thus the mechanic would have paid a total of $7,000 in GST on his/her business expenses and therefore eligible for $7,000 in ITCs. As a result the mechanic would only submit $28,000 in GST payable to the Government.

Put in the dental practice context when a dentist performs cosmetic dentistry he/she must charge the patient 7% GST. However the dentist may claim ITCs for any GST that he/she paid on expenses purchased in order to perform that cosmetic surgery.

When a dentist provides orthodontic supplies or artificial teeth to a patient the actual supply is zero rated, meaning that the dentist can claim ITCs for any GST that he/she paid on expenses that they purchased in relation to the supplies. It is important to note that services related to the supply are defined as exempt, not zero rated and thus expenses relative to the service are not eligible for ITCs.
CCRA’s Conflicting Interpretation
The CDA and dentists are concerned with what we see as a new and sometimes conflicting interpretation of the zero rated provisions for artificial teeth. Recently some auditors for the CCRA have begun to disallow ITC claims for expenses relating to the supply of artificial teeth. This revised interpretation has caused the CDA and dentists concern because there does not seem to be any legal basis for a new interpretation to these longstanding provisions of the Act. There have been no changes to the legislation, regulations, schedules or formal policies in relation to this section of the Act, so the CDA cannot see what the basis would be for a change in interpretation. Moreover anecdotal evidence in the field is suggesting that some CCRA auditors are continuing to allow ITC claims in relation to artificial teeth supplies while other auditors are not. This is creating confusion and inconsistency in the interpretation of the law.

The Canadian Dental Association recommends that the Finance Committee requests Canada Customs and Revenue Agency to provide some clarity and consistency to the interpretation law relating to eligibility of ITCs for the supply of artificial teeth. We believe that the Act should continue to be interpreted as it has since its inception. Any change would be unjustified and costly as dentists would have to update their office software and accounting systems for a relatively minor taxation amount.

Personal Finances
Parental Leave
Dentistry is quickly becoming a profession with equal participation of men and women. Graduates of dental school have typically already completed an undergraduate degree, and therefore enter the working world at an age when marriage and family is a not-too-distant goal. As discussed earlier, however, they also enter the profession saddled with mortgage-sized loans to repay, and significant start-up costs if they wish to buy or establish a dental practice. Often, once the practice is established, it evolves into a family business, with the spouse of the dentist managing office affairs. But because Employment Insurance is unfairly structured, neither spouse is eligible to take parental leave, thus adding further financial stress to what could become a thriving family unit. In order to make infant care financially feasible to dentists, staff
and other health care workers, CDA makes two recommendations, which echo some of the innovative ideas brought forward to the Prime Minister’s Task Force on Women Entrepreneurs.

The Canadian Dental Association recommends that the Employment Insurance act be revisited with a view to including opt-in provisions for self-employed entrepreneurs and family members in their employ.

The Canadian Dental Association recommends that dentists, and other self-employed individuals, be afforded the opportunity to withdraw funds without penalty from RRSP savings in order to facilitate maternity leave – provisions for repayment shall be determined according to precedence.

Child Care
As dentistry grows into a profession with equal representation from women, some unique challenges emerge. Since women remain the primary family caregivers in our society, the ability for women dentists to return to, and stay active in their professional careers largely depends on the availability of quality child-care. Many professionals choose home child-care since it offers greater flexibility. However, because of a 1989 legal decision, small business owners are prevented from adding child-care providers to their payrolls. The ability to do so would allow dentists to pay child care workers better wages, thus improving the financial situation for another group of female entrepreneurs. It would also encourage female dentists to employ high quality child-care, and thus return to work more quickly and comfortably.

CONCLUSIONS AND SUMMARY OF RECOMMENDATIONS
The CDA complements the House of Commons Standing Committee on Finance for undertaking extensive pre-budget hearings so that it may create a report to the Minister of Finance that will address the following worthwhile objectives: assuring Canadians greater levels of economic prosperity widely shared by all Canadians; and assuring the highest quality of life for all. We trust that our recommendations will assist the Committee in creating a report to achieve these worthwhile objectives.
The Canadian Dental Association recommends that government work in conjunction with stakeholders including the Canadian Dental Association and client groups, to raise awareness of oral health issues such as early childhood caries both within government, and to the public through oral health promotion efforts.

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.

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- 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

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. This increased funding would also alleviate some of the pressures driving tuition fee increases.

The Canadian Dental Association recommends that the federal government increase financial support for students, in the form of bursaries and scholarships. 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.
The Canadian Dental Association 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.

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ENDNOTES

6 Statistics Canada, The Rising Cost of Education: Average fee increase (2002/03/04) by program: (Online).