HANSARD

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STANDING COMMITTEE

ON

HEALTH

Tuesday, January 14, 2020

LEGISLATIVE CHAMBER

Children's Oral Health

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STANDING COMMITTEE ON HEALTH

Hon. Gordon Wilson (Chair)
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Barbara Adams
Colton LeBlanc
Susan Leblanc
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[Hon. Margaret Miller replaced Hon. Gordon Wilson]
[Bill Horne replaced Keith Irving]
[Claudia Chender replaced Tammy Martin]

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

College of Dental Hygienists of Nova Scotia

Stacy Bryan - RDH, Registrar

Patricia Grant - RDH, Former Registrar

Shauna Hachey - RDH, Assistant Professor,
School of Dental Hygiene, Dalhousie University

Dianna Major - RDH, Dental Hygiene Practice Owner

Department of Health and Wellness

Jeannine Lagassé - Acting Deputy Minister

Angela Purcell - Executive Director,
Pharmaceutical Services and Extended Health Benefits

Dr. Ferne Kraglund - Dental Consultant

House of Assembly
Nova Scotia

HALIFAX, TUESDAY, JANUARY 14, 2020

STANDING COMMITTEE ON HEALTH

1:00 P.M.

CHAIR
Hon. Gordon Wilson

VICE-CHAIR
Suzanne Lohnes-Croft

SUZANNE LOHNES-CROFT (The Chair): Order. This is the Standing Committee on Health. My name is Suzanne Lohnes-Croft. I am the MLA for Lunenburg and also the vice-chair of this committee.

Today we will hear from the College of Dental Hygienists and the Department of Health and Wellness regarding children's oral health.

A reminder for everyone to turn your phones off or put them on vibrate. In case of emergency, please exit through the back door and walk down the hill to Hollis Street and gather in the courtyard of the Nova Scotia Art Gallery.

I will ask committee members to introduce themselves.

[The committee members and witnesses introduced themselves.]

THE CHAIR: I welcome our witnesses today. We will start with opening remarks. Ms. Lagassé.

JEANNINE LAGASSÉ: Good afternoon. I would like to start by thanking the committee for the invitation to appear here today.

We are pleased to be here with the representatives of the College of Dental Hygienists of Nova Scotia, one of many partners in improving the oral health of Nova Scotians. Our other partners include the Provincial Dental Board, the Nova Scotia Dental Association, the IWK Health Centre, the Nova Scotia Health Authority, and universities and colleges.

Along with dentists, dental hygienists play a vital role in preventing dental disease and helping to maintain good oral health. Many factors impact a person's oral health, including things like access to dental services, eating a well-balanced diet, access to fluoridated water, and good oral hygiene practices.

We are here today to speak specifically about children's oral health. We know that dental care and good oral health habits need to start at a young age to achieve the best results. The department develops, implements, and monitors programs that support oral care for our children.

Our largest program, the Children's Oral Health Program, provides funding for basic dental care for all children 14 years of age and under. The provincial government also funds six other dental programs, each of which meets specific needs of our citizens.

Government has been supporting children's oral health services since 1974. The Children's Oral Health Program was created in 1997, replacing the Children's Dental Plan, and has evolved over the years.

Recent changes to the Children's Oral Health Program were informed by the collaborative work of the Oral Health Advisory Group. This group had broad engagement with professional and community representatives, including the College of Dental Hygienists, the Nova Scotia Dental Association, Dalhousie Faculty of Dentistry, and department representatives.

In January 2019, the Children's Oral Health Program was expanded to include molar sealants and annual fluoride treatment, preventive measures that we know lead to improved outcomes.

We would also like to highlight the following areas that support our children's oral health. Dr. Ferne Kraglund, who is with us today, is the department's part-time dental consultant who provides advice on oral health to government and offers significant clinical expertise.

A fluoride program is offered in 139 schools in communities most at risk for poorer oral health outcomes. Fourteen dental hygienists work in schools through NSHA's Public Health program, delivering the fluoride program and working on a variety of matters that affect oral health outcomes, such as school food policy, healthy food environment, and poverty reduction.

New agreements between the Department of Health and Wellness and dentists are in place for publicly funded services, including the expanded preventive services. Fluoridated drinking water continues to be provided in most of our major municipalities.

While progress has been made, we know there is still more work to do. We will continue to look for opportunities to collaborate with our dental community partners as we consider further changes that will benefit the oral health of children in Nova Scotia.

We greatly appreciate the college's work, including the development of its White Paper, published in October 2014. Since that time, the paper's recommendations have helped to inform our work and changes made to focus more on prevention as a key part of improving oral health.

In closing, I would again like to acknowledge the work of the many partners in the dental community that promote the importance of oral health and dental care for our children, in particular the college, the Provincial Dental Board, the Nova Scotia Dental Association, the IWK, and the NSHA. Thank you.

THE CHAIR: I'll call on Ms. Bryan for her opening statements.

STACY BRYAN: Good afternoon. We thank you for inviting us here today to continue the conversation about improving children's oral health in Nova Scotia. We are pleased to have here with us today one of our partners, the Department of Health and Wellness, as the second group that will be presenting to you today.

The CDHNS and the profession of dental hygiene in general are committed to improving the oral health and overall health of Nova Scotians. We are committed to ensuring equitable access to oral health for all people in this province. We want to be active partners in creating and delivering the solution. We support promoting health and preventing disease by integrating dental hygienists at their full scope into Nova Scotia's primary health care system. We strongly believe in "preventing more to treat less."

It's wonderful that a Children's Oral Health Program exists in Nova Scotia. It is a testament to this government and all governments in the past that recognize the importance of providing a program that focuses on children's oral health. However, despite the fact we've had a Children's Oral Health Program or MSI as part of the medical insurance program in Nova Scotia since the 1970s, we know that there is significant room for improvement.

We are here today to provide some insights into potential approaches that complement the existing initiatives, to ensure that future children's oral health initiatives will be more effective for all children in this province.

We recognize that there are many competing needs for the limited resources in this province. It is critical that we spend our resources in a thoughtful manner to achieve a long-lasting return on investment.

While the majority of oral health care services are excluded from our health care system, the impact of oral disease is not. Early childhood caries - cavities or tooth decay - is a crisis in Canada, and the same is true in Nova Scotia. Tooth decay, a preventable disease, is the most common chronic disease among children, and treatment of tooth decay is the most common day surgery for children in Canada.

Poor oral health in children affects nutrition, growth, sleep, learning, behaviour, socialization and self-esteem, communication, and ultimately can cause failure to thrive during some of the most critical years of child development. There is an increasing body of evidence suggesting linkages between oral disease - both cavities and gum disease - and systemic conditions, including diabetes and cardiovascular disease, which could potentially have lifelong impacts.

While the number of beneficiaries through MSI has increased since the age of eligibility increased in 2013, the rate at which the program is being accessed has declined. The 39 per cent who accessed services in 2018-19 is 3 per cent less than those who were accessing MSI when the CDHNS prepared the White Paper in 2014. Why is this so?

Of the 61 per cent who are not accessing the program, it is likely the majority belong to the populations most at risk for oral disease, including children who are living in families with lower socio-economic status, from Indigenous populations, those living in rural communities, or those newly immigrated to Canada.

Every child has a right to live without the burden of oral disease and all its negative impacts. Our White Paper envisioned a healthier future and included 13 recommendations which made up the basis for a multi-pronged approach to solving this crisis. We still support them all. Some of these recommendations were broad and all-encompassing, while others were specific and directed to certain at-risk population groups, such as children and seniors.

Some high-level recommendations included appointing a chief oral health officer, integrating oral health care into overall health, and developing and implementing an oral health strategy that complements the provincial overall health plan. Some more specific recommendations included investing in workforce innovations that integrate dental hygienists into non-dental community-based settings, such as immunization clinics and mandatory oral health care screenings for children as early as possible.

The time was right in 2014, and the time is right now to act on these recommendations.

THE CHAIR: We will start our questions beginning with the PC caucus for 20 minutes. Ms. Adams.

BARBARA ADAMS: I really appreciate the comments that you both prepared and gave us copies of. I'm going to reference them to start with. I would like to start with Jeannine Lagassé. In your statement, you mentioned that Dr. Kraglund is the department's part-time dental consultant, who provides advice on oral health to government and offers significant clinical expertise. Then Stacy Bryan mentioned the need for a chief dental officer.

Both the NDP and the PC Party in the last year introduced legislation to have a chief dental officer. I would like to ask Jeannine: How do you feel about this province having a chief dental officer for the Province of Nova Scotia, and how important might that be?

JEANNINE LAGASSÉ: As you drew from my opening statement, Dr. Kraglund started with us earlier in 2019 as the dental consultant. It was determined that that was the first step that we would be taking along this path as we look toward preparation of a more comprehensive oral health strategy. Dr. Kraglund is currently on contract with us until the end of March, and we are going to be issuing a request for proposals for a longer term dental consultant once that term is up.

BARBARA ADAMS: Is there consideration to expanding that from part time to full time?

JEANNINE LAGASSÉ: At this time, the consideration is that it would remain part time.

BARBARA ADAMS: Is the Department of Health and Wellness considering implementing a chief dental officer for the province?

[1:15 p.m.]

JEANNINE LAGASSÉ: At this time, the department will be continuing with the dental consultant as we move forward with preparations for an oral health strategy.

BARBARA ADAMS: We don't have representation from the department of dentistry or the Dental Association, so does the Dental Association itself also support the recommendation for a chief dental officer?

ANGELA PURCELL: I think you'd probably have to speak to the Nova Scotia Dental Association to confirm. I know they were pleased that we hired a part-time dental consultant as a step in the right direction. That's about all I can say on their behalf, given our past conversations.

BARBARA ADAMS: Okay, so we don't know how the dentists in the province feel about a chief dental officer, but I would assume they would likely be in favour of it. I think it would be good to know what their position is on it. I'd be interested in knowing why it wouldn't be a good step, why we wouldn't move towards that, given the magnitude of the expense of dental care in the province.

I'm wondering if the Department of Health and Wellness can tell me - we know what the cost for pediatric dental care is in the province, according to the stats we were given; it was $6.1 million in 2018-19. What's the total budget for dental care in the province?

ANGELA PURCELL: Last fiscal year, I think it was just a little bit over $10 million that we spent on all of our dental programs. I'll just put a reminder out that we have what we spend on those dental programs; we don't have a figure for what private dental coverage is and what that expense is. It provides the government cost for this, but not the private share of that cost.

BARBARA ADAMS: When we look at the statistics that we were given about children's dental services in Nova Scotia from 2008 to 2019, in 2015-16, it shows that the number of services rendered was 273,147, and then it drops considerably the next year. In 2018-19, the last year we have numbers for, it's 173,825. That's a dramatic drop of almost 98,000 services rendered, almost a third fewer services rendered.

Can somebody explain to me why we have a third fewer services rendered as was mentioned during Stacy Bryan's comment that the number of services has gone down in the province?

JEANNINE LAGASSÉ: We don't know with certainty, but because the program is payer of last resort, a number of people do access dental services through their private insurance. The drop may be that people are accessing dental services, but it's being paid for by private insurance.

BARBARA ADAMS: I guess what I'd also like to understand is: Can you describe to me what the wait time is like for children to go to the IWK for a consult with a specialist and then the wait time for actual surgery if the child needs surgery?

JEANNINE LAGASSÉ: I'm sorry we don't have that wait time with us, but we can provide that to you, though. We can consult with the IWK to get that.

BARBARA ADAMS: On the website for the Nova Scotia Government, I have the wait times themselves and right at the moment, the consult for children is 293 days just for a consult. For an actual surgery, it's another 378 days for a total of an average of 563 days from the time you're referred to the time you actually have your surgery - I see the dental hygienists nodding; they know - so that's a year and a half exactly. For adults, it's 464 days, so it's actually 100 days shorter for adults.

If we assume that the number of services got cut by almost 100,000 and maybe people are getting it through private, why do we have a year and a half wait time for children to go to the IWK for specialized services?

ANGELA PURCELL: I can speak a little bit to the dental academic funding plan and the program we provide at the IWK. I think it is recognized by all partners that there have been wait times for surgeries and for specialized care for children. A couple of years ago, government invested in another dental specialist for that AFP, as well as anaesthesiology support to help deliver those services. It took a while to recruit that provider, as you can appreciate.

Since that provider has come on board, they have also made great efforts at trying to address some of those issues. They recognized that perhaps the wait times are longer than they would ideally hope for and they have started to look at some process improvements to make sure that the referrals that are coming in from community-based dentists are actually - specialized care is needed at the IWK for instances where that care could be provided by a community dentist. They are also transitioning those back to a community dentist.

Work is under way. I appreciate that probably the volume and the wait time is not where we want to be, but I think collaboratively with the partners, efforts are being made to try to address that.

BARBARA ADAMS: According to another stat that we were given, over 500 children are currently waiting to get into the IWK - sorry, I'm not sure if that's the exact number now. Can you tell me if the number of kids waiting and the wait time has improved or declined over the last five years?

ANGELA PURCELL: I'd be happy to reach out to confirm. I believe it stayed about stable. Up until now, it has neither increased nor decreased significantly, but I would like to highlight that additional resources took some time to hire, and there have also been some additional circumstances in terms of access to anaesthesiology across the province. That has resulted in more care being centralized in Halifax, so there's a shift happening across the province at the same time that could impact that.

BARBARA ADAMS: If you look at the wait times for dental extraction and restoration consult and surgery, though, Halifax has the highest wait times: 370 days for a consult to 441 days for surgery, for a total of 811. Whereas somewhere in Amherst: 112 days for a consult and 50 days for surgery. I'm assuming it's because the IWK is a specialized area that the wait time is there.

The dentists that we've spoken to suggest that the wait times are actually getting longer. One of the things that we also got in those statistics is that the number between 2008 to 2019 - the number of services per insured person went from two insured services per person in 2008, to 1.8 during the NDP Government, to 1.7 at the beginning of the Liberal reign, which is now at its lowest point: 1.3. Yet, the amount of money we're spending for dental care for children - when we were offering 273,000 services in 2015, it cost us $6.8 million. We dropped almost 100,000 services, and it cost us $6.1 million.

I'm wondering from the Department of Health and Wellness: How have we offered almost 100,000 less services, but the amount of money we've paid out has only dropped $700,000? I have the numbers here, if that's helpful.

ANGELA PURCELL: I'll try to respond to that. I may not have all the answers and I think one of the challenges, just to go back to it, is we have a piece of the information, so we know what's happening in the programs that we fund. What we don't know is what's happening when you align this with private drug coverage.

I have the same information that you have in front of you. I think when the age increased - I believe it was at the initial period of 2013-14 - it isn't uncommon when there's a change in a program that the following year there has been some communication about that, so sometimes you will see an increase in utilization that will then historically kind of taper out. That could be one reason. Private coverage could be another reason.

All things combined, I think what I would like to emphasize is that the program is available to all children. It's not a capped budget. It's not something that we say has a fixed dollar amount. It is based on utilization. Utilization fluctuates from year to year across many of our programs, and the factors that play into that are numerous.

BARBARA ADAMS: I'm a little confused, because the trend that I referenced has been going on for several years. It's not a one-year change in the drop. Although I know it's not a capped program, the end result is that there are fewer services being offered per person or being utilized per person now compared to 10 years ago, yet the budget amount did not drop significantly.

One of the things I'm aware of is that in Nova Scotia, there's legislation that blocks dentists from extra billing when the fee code that MSI puts in place doesn't match what the dental association's recommendation is for that particular service. Some of the dentists have indicated that when this government changed who was covered, they did it without

consulting the dentists. They found out about it at the same time everybody else did or a couple of days sooner.

What is happening is that there are some procedures that dentists are doing at a loss of income. They're actually losing money by providing some of those services. Their reaction, as they have told me, is that there are some who are making the decision that it's not cost-effective now to provide pediatric dental care. I'm wondering if you're also hearing that and if it's a concern to you, because it is for me.

ANGELA PURCELL: Appreciating the change that happened in 2013-14 was perhaps not well-known to the dental community before it was announced, as you might be aware, government then initiated a review of the Children's Oral Health Program. That put the changes to that age at a stop while the program was reviewed. I am aware that the dental community was not happy with that. Other partners were not either. A review was done, and the results of that review said to keep the age at 14, which it has stayed at.

We have worked closely with them since that time to review all of the programs and to implement a new contract. We have a new agreement with the NSDA that's about a year old. It has some new preventive services to help address the recommendations from a number of partners that have helped to inform the work forward. Are we where we need to be? Maybe not, but through our discussions with the NSDA and the Dental Association, I certainly feel we are better than where we were.

BARBARA ADAMS: I'm assuming that might be over the past year perhaps. I know in 2013, when the contract was signed, the dentists said that they were not consulted. In 2017, when the changes were made again, they got very brief notice before those changes were made in terms of the fee codes. I know when there was an announcement made about cutting out scaling and cleanings, the dentists were not aware of that. They're not feeling consulted, at least the ones that I'm speaking with.

It goes back to having a chief dental officer rather than a chief medical officer as the one responsible for this. We're going to continue to encourage the Department of Health and Wellness to consider implementing a chief dental officer, who would have a better understanding of all of the players in this game, and not just one certain part over another.

I want to go back to the surgery wait times. Where the statistics are showing that there were fewer services rendered by the public system, does the Department of Health and Wellness make any attempt to find out how many of those services are being offered by private providers? If you're going to look at implementing other programs, like a school dental program or any other program, you would need to have some idea as to how many people are actually getting dental care before you assume what kind of strategy might actually improve dental care. If fewer people are going to the dentist, that's one thing, but if more people are going to the dentist and therefore are getting fewer services, that's a different strategy.

[1:30 p.m.]

Has the Department of Health and Wellness or any of the associations reached out to the private insurers to get statistics from them as to how much private dental coverage there is in the province?

JEANNINE LAGASSÉ: At present, we have not reached out for that information, but I would expect that as we move forward in preparation of an oral health strategy, that that's the type of information that we would be looking to gather.

BARBARA ADAMS: Does the Department of Health and Wellness have feedback from the Dental Association on the 13 recommendations that the dental hygienists have made? Have they given a formal written response to what their feelings are about all of those 13 recommendations?

JEANNINE LAGASSÉ: We're not aware of a formal written response. However, the Dental Association was a partner with us and others in the Oral Health Advisory Group, so they would have been aware of all of the information that was before us at that time.

BARBARA ADAMS: I appreciate them being aware of the information and the recommendations that may have come out of it, but I think it would be useful to consult with them in a formal way to say, these are recommendations made by another allied health professional in the same industry: How does your association feel about that? I think that's important because they're the ones who are ultimately responsible, they're the family dentists, so I think it's important that they have feedback on this.

I think it would have been good for us to have had them here so that they could give their feedback on why those wait times have gone up. I have four children, and if any one of them had had to wait a year and a half to have a dental extraction, that would have been a miserable year and a half. I think it's really important that we have them involved in what we're looking for.

I would like to speak to the dental hygienists themselves. In terms of the recommendations for actions, which of them would you say would be the most important for government to look at and implement?

STACY BRYAN: One thing I'd like to comment on is that when I'm hearing the conversation, I think one thing we're really missing is we have a whole health care provider sector that's being missed: the dental hygienists. We have over 745. We can actually own and operate independent dental hygiene practices, and we would like to be part of the conversation which we appreciate today. We'd also like to be part of the solution.

There are many areas where we . . .

THE CHAIR: Order. Time has elapsed for the PC caucus. We will move to the NDP for 20 minutes. Ms. Leblanc.

SUSAN LEBLANC: Thank you very much for your opening comments. I come to this meeting as one who went seven years without seeing a dentist at one time, because I never had dental coverage in my professional life. That's a long time. Thank God I didn't have any cavities when I went back, but that was because I had excellent care when I was young. There was a dental hygienist who came to my elementary school every single year and worked on every kids' teeth. That set the stage for my oral health.

I also come as a mother of a child who went through a terrible 2018, rife with dental extractions at the IWK, so I feel really passionately about this subject and I'm excited to talk about it.

I just want to direct my first comments to the department. According to the WHO, oral health care is an integral component of universal, accessible primary health care. There was a study published this year in the *Journal of Family Medicine and Primary Care* which, in the author's words, found the integration of oral health into primary care as "the key" to affordable and accessible oral health care.

We know, as has been mentioned already today, that oral health care is directly connected with overall health care. Gum disease is linked to heart disease, diabetes, respiratory disease, osteoporosis, rheumatoid arthritis, and on top of the physical issues, poor oral health care is also predictive of poor mental health care. People who suffer from severe mental illnesses are nearly three times as likely as the average person to lose all of their teeth.

Given all of that information that we all know in this room, I'm wondering if someone from the department can take a crack at this question. Given that oral health care is so important to overall health care, how come we don't treat it like that in Nova Scotia?

DR. FERNE KRAGLUND: You're right, it isn't seen as part of overall health, and that has been a struggle of our profession for a long time to be included as overall health. It's part of a topic that's greater than a provincial or territorial sort of thing. I've been working with a working group at the Canadian Dental Association that is talking about this. It's a bigger issue than a provincial-territorial thing. It has been left to the provinces and territories to find out solutions, but really, it's a national issue that we need to figure out.

There is a push at the national level, and it is coming - specifically, I can't speak for you guys - from the Canadian Dental Association. There is a huge push to start putting at least some backup plans, to be able to provide some care for people who have infections and such, because it is impacting so many other systemic conditions that they have, so it is a really important part.

I think as we move forward, we'll start seeing this kind of draw out into more of national debate that will then kind of infiltrate more into a provincial and territorial sort of thing.

SUSAN LEBLANC: Just a B part to that question. In my office, I see an awful lot of people who are connected with the Department of Community Services. I've had folks come in many times who need dental care. There's the Green Shield insurance, and the department covers a certain amount of money, but very often it doesn't cover enough of the cost of dental care for folks.

I'm wondering if the Department of Health and Wellness works with the Department of Community Services on those metrics. Ms. Lagassé, you mentioned a new agreement with public service providers. I don't know if that's what you were talking about, but if anyone could talk a little bit about if there are any changes to make oral health care more accessible for folks on Community Services or connected with Community Services. Is that something that you folks work with - that department - or is it totally separate?

JEANNINE LAGASSÉ: The programs are currently administered separately; the Children's Oral Health Program and the other ones that we have, and then the DCS one is administered separately.

SUSAN LEBLANC: We know that dental extractions account for 33 per cent of all pediatric day surgeries at the IWK. We know that proportion could be reduced if we were investing more heavily in prevention, obviously. In 2009, amendments were made to the Dental Hygienists Act that allowed dental hygienists to work without requiring patients to be examined by a dentist first. This change was made in order to increase access to preventive oral health care, but that work is incomplete because dental hygienists are not approved health providers that can bill the province unless they're working directly under the supervision of a dentist.

Given the fact that we know dental hygienists can be such an important part of the preventive side of dental health care and oral health care, why hasn't the department taken the steps to expand the profession under the Health Services and Insurance Act? It seems to me that hygienists right now are an underutilized resource.

JEANNINE LAGASSÉ: As we spoke about a bit earlier, the Oral Health Advisory Group has completed two phases to date. Phase 1 was the review of the Children's Oral Health Program and the changes that were ultimately implemented in 2019 from that review. Phase 2 of the Oral Health Advisory Group was a review of all of our programs that we administered through the Department of Health and Wellness.

As we move forward from that, the next step is for us to work with Dr. Kraglund as our dental consultant on a timeline for the preparation of an overall oral health strategy. We have not done any work to date in relation to any health professionals that would have an input into oral health care. That review would take place as part of the preparation of a strategy.

SUSAN LEBLANC: What is the timeline for that strategy? You've brought Dr. Kraglund in. When do you expect to be able to table a new strategy?

JEANNINE LAGASSÉ: We don't have a timeline for tabling; we're just doing early work with Dr. Kraglund. She started with us earlier this year and we're just working on a timeline for preparation of the strategy. We're in the very early stages of it.

SUSAN LEBLANC: I just want to be clear about this. Right now, we're in kind of a holding pattern, status quo, and the people of Nova Scotia will not see any changes until a strategy is developed and then completed and then implemented. We could be talking about several years.

JEANNINE LAGASSÉ: Our current plan is to move towards the implementation of a strategy.

SUSAN LEBLANC: I guess I'm going to direct that same question about the billing situation to the dental hygienists, as well. Feel free to address that in your answer to my question, which is: What changes do you feel are needed in order for dental hygienists to provide the full scope of oral health care in Nova Scotia?

PATRICIA GRANT: I think the overall answer to that would be probably still more prevention and less treatment. If I think back to five years ago when the White Paper was written, we could have an oral health strategy here today with us. We need to move both at the higher level - some of our recommendations were very much at the high level, and many of them were very direct and specific about where dental hygienists could be used to their full scope.

I feel like the sooner we begin Phase 3 of the Oral Health Advisory Group work, which was to develop that oral strategy, the better. I think in all due respect to our friends at the Department of Health and Wellness, we really need to consider that a part-time person working in that position - it's a big job to develop a provincial oral health strategy. I'm not sure that it can be done in any kind of timeline with someone who is working at it

part time. We really need to make sure that we include all of the appropriate people at the table as we move forward with that. I'm hoping it will be sooner rather than later.

I'm sorry, was there another part?

SUSAN LEBLANC: It was about the fact that dental hygienists right now can't bill the province for professional services unless they're working under the direct supervision of a dentist, if you want to speak to that.

PATRICIA GRANT: I can't speak to that directly. I do not own an independent dental hygiene practice, but we have seen the numbers in the college who register as an independent practitioner rise over the last 10 years since it's been a possibility after our legislation was passed. We had five or six who worked in long-term care, and now we have 18 who register as being independent practitioners.

Each of them over my nine or 10 years at the college submitted to me many, many circumstances where because they cannot bill MSI, they cannot treat children who are in need. I don't think that's correct for the patient in a situation. They're not being able to choose the provider, and I don't think it's correct for a health care provider who provides the same service in another setting where they would be paid or acknowledged for their work, that they aren't acknowledged in a setting that's legal to them.

We have an independent practitioner here with us today who can provide you with some of those specific stories, and it's probably better to maybe look at that. But there are many circumstances where hygienists could provide care where there just is not another oral health provider available who's able to, or can, in those circumstances.

SUSAN LEBLANC: If you would like to chime in, please feel free.

DIANNA MAJOR: We have a dental hygienist right now who is working within the North End Community Health Centre. This is a dental clinic that has employed this hygienist to help reduce the burden of disease within their catchment area. This organization has a very innovative structure that includes provision of care to this community through their employed dental hygienist, volunteer dentists, and students.

[1:45 p.m.]

The North End Community Health Centre is facing barriers with regard to provision of care for individuals in need and potential reimbursement for services that could readily be provided by the dental hygienist. For example, according to MSI, professional services provided to a client may be claimed by a dentist only when the dentist personally renders or supervises the service. If the dental hygienist does not have a volunteer dentist on site that day, the dental hygienist is unable to bill for treatment for provision of care to children who would qualify under the COHP program.

This causes difficult challenges for the North End Community Health Centre as they seek to ensure that they are a sustainable dental clinic. Parents are not fully aware of the MSI program and what it covers and have heard stories of other families that went to a clinic thinking services would be fully covered, only to find out that they had to pay at the end of the appointment for something that MSI doesn't cover.

Often, they are embarrassed to decline the six-month dental hygiene visit that was recommended and won't be covered by MSI. They book the appointment, but don't bring their child to it, and subsequently aren't contacted to rebook at the one-year interval, which MSI does cover.

Who is this hygienist seeing? It's this simple - she sees kids who are in pain. She sees 5- and 6-year-olds who have been sent to the IWK for sedation for extractions or a full set of stainless steel crowns. She can see 12- and 15-year-olds who need permanent teeth extracted, forever impacting their nutrition, their self-esteem, and their well-being.

SUSAN LEBLANC: I just want to jump on something you said there quickly, and that is the surprise at the end of the visit where something you think is covered is not covered. In my great year of guiding my daughter through her several extractions, I came to understand that MSI, as the payer of last resort, covers the extractions for children, but does not cover the sedation for children. When I think about that - I did have coverage, and obviously I was lucky enough to be able to afford $100 a shot for sedation, but many people aren't. I can't imagine, as a parent with not a lot of income, having to make the decision to have my children's teeth extracted without sedation.

Why is that not covered? It seems like they have to be part and parcel, those two things. Can someone from the department talk about that?

ANGELA PURCELL: There are a large number of B codes in the dentist guide. I'm happy to take that away and look at it a little bit more closely because I don't know that I have an answer for that today. I think it's a great question. I think sometimes because of the way health care has been set up we tend to cover things. As you know, the Canada Health Act covers things that are hospital based, so if that procedure is done in the hospital, it would typically be covered under the Canada Health Act and under our programs there.

I'm not sure if the same transpires into an office setting so it may depend on where that takes place, but it's certainly something I'm happy to take away and find out some detail on and have some further conversation.

SUSAN LEBLANC: That would be great because I do think about the folks who would be faced with that decision, and it doesn't make any sense to me.

Going back to the dental hygienists, you spoke a little bit about the roles of hygienists, but could you talk a little bit about how you see the role of a dental hygienist in non-dental community settings? The North End clinic is a health care setting at least, but talk about places like long-term care facilities or schools.

PATRICIA GRANT: I'd be happy to. In the White Paper, we recognized that there are many examples, both in the U.S. and a few in Canadian provinces, where dental hygienists were working in community settings that we really needed to be in here. Along came the idea of the first dental visit by the first birthday, or six months after the eruption of the first tooth, but we were thinking about where we would find those children that young. They're not bringing them to the dental office. When they do, we know there is a history of dental offices not being ready to receive them. That's for a few reasons, I believe.

We thought dental hygienists, or someone, should be meeting them out in the community where they are. Where would they be? They might be in daycare centres that have government subsidy positions in them. They certainly will be in the pre-Primary programs. The College of Dental Hygienists had a proposal put forth and a pilot project which we were willing to fund and had received some funding from the Sparkle Fund, which is administered here in Halifax by the Children's Aid Society. We had some, but the rapid changes that happened in the pre-Primary programs where they were setting new programs up very quickly over that Summer, we didn't get to go there. We hope that perhaps something could be set up in the future for that.

There are lots of places for hygienists to be working. We have the Primary programs; pre-Primary; diabetic education clinics, both for adults and for children - there's a higher rate of diabetes among our young people now; cancer care and rehab centres; registered daycares; early childhood education centres; and schools.

The Chief Dental Officer of Canada recognized quite a number of years ago that the best place to present blanket coverage is in schools. You have a captive audience. The children are there, and permission forms go back and forth all of the time. If you want to do fluoride mouth rinse programs, fluoride varnish, and sealant programs, the plan is carefully laid out for those three things. Water fluoridation is the other issue, and it was mentioned earlier by our colleagues here.

I think those are the areas - certainly seniors and long-term care facilities. There is a great need there, and hygienists can work there. Many hygienists do. They either do it independently, or they're doing it as an adjunct of their dental office work. But again, not all seniors have coverage. You will find many of us, when we leave our jobs, even if we had coverage for a good number of years, we do not in retirement. That is an issue for those people as well.

STACY BRYAN: I just wanted to add one thing to that. As we're talking about children, whether it's Primary and on, one of the things we have come to really emphasize, and Pat alluded to this, is that it's important that we need to do it even sooner. By the time we are seeing them at four and five, it is often too late for those areas. Some of the other things that she mentioned - the immunization clinics, maybe some of those other potential new ways that we can work with collaborative care . . .

THE CHAIR: Order. Time has elapsed for the NDP. We'll move on to the Liberal caucus for 20 minutes. Ms. DiCostanzo.

RAFAH DICOSTANZO: Thank you for the information that I have heard so far. It's amazing. I really wanted to start by saying that I was hoping somebody from the IWK would be here today, because I worked with them for many years as a medical interpreter. It was one of my favourite departments to work with, the IWK dental department. Unfortunately, they're in the basement in a little hole, but I think you guys have one of the best teams in the world. They are the most caring, hard-working team. I would go in with a lot of the refugees who have not had any dental care for three years, some of them none whatsoever, and the amount of care they received and the treatment and education - they would allow me to educate them about eating and flossing and using a toothbrush, which they had never used. All this could be done, I guess, at the doctor's.

A lot of times, what's used at the IWK can be done somewhere else. I also know that a lot of the cases arrived at the IWK because a lot of dentists didn't want to do the work, or they felt uncomfortable maybe with the pediatric and dealing with children. Dealing with children is very difficult - to even open their mouth. Sometimes it takes 20 minutes to get the child to open their mouth and listen to the doctor. I think maybe sometimes that is too time-consuming for the dentists. If there's an issue, if there's an abscess or this, then let's just send it to the IWK. They know how to deal with it.

Really what my question is here that I heard today - 61 per cent are not using it, our children. That, to me, is a high number when it's free. I know that also when I worked with newborns, I would be amazed that they will teach them to use a wet cloth to wipe; at birth, we're cleaning teeth. This is amazing how good we are with cleaning teeth in Canada. Compared to other countries, we care about teeth and we do very well.

I've lived in England. I've lived in the Middle East. I've lived in Italy. No one looks after teeth as well as Canadians do. We are very good with hygiene and education, and we should continue with that. I'm sure there are always gaps, but we have to give credit where credit is due: Canadians do very well with hygiene, in general. If I'm wrong, please correct me.

My question is to the doctor. When the mothers go home, we tell them to come back for the immunization at three months, see a doctor at so many months. Why don't we allow them to say the best time for children to start going to see a dentist or hygienist, and why don't we start it at birth? Tell the mother that at this month or six months or a year, they should be seen.

A lot of mothers don't know it's available and that it's free of charge. I did not know until my dentist told me to bring my daughter, she was three years old, and she should have been seen. I had no clue that it was included and covered. If you could maybe speak to how we are promoting it, as well.

FERNE KRAGLUND: I can speak to that. I do work full time at the Faculty of Dentistry, so I don't work at the pediatric department. I teach public health and prevention, so I do work with them a lot.

The dental students are taught - I can say at our faculty, anyway - that you should start speaking to the parents before the baby is even born, so it's even before birth. I teach my students as soon as you know that you have a patient that's pregnant - and you should know that because we check medical history - then that's when the conversation starts. We find that moms are really receptive to that sort of information, particularly if it's a new mom because they're receptive to any sort of information at that point in time.

It's getting used to having people communicate that regularly. I find newer dentists might do that a little bit easier than dentists who have been practising for decades and that may not have been the habit or the training that they've been doing. Sometimes it may be difficult to get changes of habits when they go into practice, so it might be the policy of the office that they get into that if they don't see you by a certain age, but they certainly are trained to be able to see them from beginning age, as I said. Within six months of eruption of the first tooth, no later than one year of age is what we train.

Whether it gets done is another thing completely; there is a problem with trying to get that information out. It's definitely something we can work on more and communicate not only to our dental community, but also to the parents.

RAFAH DICOSTANZO: Do you have any statistics of how many kids are going? Right now at school is probably the first point if their family dentist didn't warn the mother to bring them. The first point is happening when - at age four, at age five, as my colleague mentioned? What is happening in the schools?

FERNE KRAGLUND: I can only speak anecdotally. It does depend on the office. You do hear of some offices that say 3 years old, and it tends to be because of co-operation, but you do have other offices - I worked at the faculty and even when I worked in New Brunswick where, as I said, I would have that conversation right from the get-go. There are some dentists' offices that the hygienist and the dentist are speaking to moms and dads long before the baby is even born.

It's dependent on what the office protocol and policy is, or how they're trained. I would say that overall the uptake's not there as well as it should be. It should definitely be more of a policy protocol - that that's just what's done. It might take some time to get switched over just because this is a newer sort of thing we've seen in the last decade or so, that this is the training that's been provided to the students that that's what they should be doing.

RAFAH DICOSTANZO: Maybe you can enlighten us to know how many of the dentists, in general, how many we have and how many actually practise pediatrics. Do they need to have pediatric specialty to practise on children in the private sector? How does it work? Can any dentist do children and know how to work with children?

[2:00 p.m.]

FERNE KRAGLUND: Everybody gets training in all disciplines, so pediatrics is one of the specialties that we train upon. Anyone can see general cases, and part of having a normal general dentistry practice is that you rely on seeing patients across the whole family, including children.

It's when the cases become a little bit more difficult and it wouldn't be suitable to treat the child in office because you feel that there might be some harm to the child, either mentally or physically, just because it could be harmful to them. You rely on specialists to be able to provide that expanded care to them so it can be done in a safe way. We rely on all specialists when we have cases that are a little bit more challenging or difficult.

RAFAH DICOSTANZO: Just on the same line, what do they have for anesthesia in offices? It's one thing to give an adult a needle, but trying to give a needle to a child, it doesn't happen. What other methods of anesthesia can they use for children in regular private offices?

FERNE KRAGLUND: Some of it is behavioural training; sometimes just talking with the child and trying to get the trust relationship built. I can only speak for myself, but you could get a lot of work done with some children and you could provide any spectrum of care that you would provide to an adult. What you could achieve depended on the child and their relationship with the dentist and hygienist. Sometimes it depended on medically compromised children and you wouldn't feel comfortable doing that, or sometimes behaviourally you would just want to send that to a specialist.

A lot of cases could be done just with local anesthesia, what you would normally expect to have when you get a filling or extraction. If it became a little bit more challenging, then mainly nitrous oxide would be another thing that we would tend to offer. People do expanded training beyond dental school to be able to do that sort of training and provide it to their clients; sometimes people will do oral sedation as well. It's a variety of different things that they need to expand their skill set in order to provide that service.

RAFAH DICOSTANZO: Am I understanding that we don't have a specialty of pediatric dentists? Is everybody trained in pediatrics or do we have referrals to pediatric? I'm trying to think how many - what's the percentage of private dental offices that take children? That's where I'm trying to head.

FERNE KRAGLUND: Every dental student going through would be trained to do pediatrics. It doesn't necessarily mean that they'd be trained to do specialized cases, so we do have the specialty on top of having general dentists. Just like any specialty where we might have people who would do certain kinds of extractions for adults - some extractions might be too difficult, so you'd want to send that to a surgeon.

It's the same thing with pediatrics: they would do a certain scope where they would feel comfortable practising with that, and then cases beyond that scope of comfortability, they would want to send that off to a private practice that's specialized in pediatrics. How many cases get sent there? I couldn't tell you. I have no idea.

RAFAH DICOSTANZO: I also wanted to know: Where are we as a province compared to the rest of Canada? How well are we doing? I know our numbers have come down. I know that some of the information I received - the percentage of children with at least one decayed tooth decreased from 74 per cent to 24 per cent between the 1970s and 2009, which is amazing. That's a large number. If you can speak to what we have done to reach those numbers.

FERNE KRAGLUND: I have to say, honestly, our data for oral health status in Canada is poor. We had one cycle that was done with the Canadian Health Measures Survey, and it was a cycle done back in 2007 to 2009. We're still using that data as kind of current data, unfortunately.

I'm happy to say that we will be participating in Cycle 7, which will be coming up next year, so we'll have updated data. That data provided some information to tell us that overall, the oral health of all Canadians - pediatric population included with that - has improved significantly over the last 40 years.

What is not included in that is that there are certain marginalized populations that experience a burden of illness. While overall population is improving, there are certain populations experiencing more disease prevalence.

RAFAH DICOSTANZO: I assume you're referring to rural areas, the Indigenous, and newcomers when you say "certain populations." What are you doing to reach them? How are you communicating, for example, with the newcomers and others about hygiene? If you can expand on that, as well.

FERNE KRAGLUND: I think that's what we've been referring to with an oral health strategy. Oral diseases are very much multifactorial, so one type of approach is not going to work. We do rely on a variety of different factors and a lot of different treatment modalities that we need to apply. I don't just mean providing treatment in the mouth. There are a lot of preventive things that we need to do such as water fluoridation advocacy; providing fluoride month programs in schools and that sort of thing; and working with partners to have policies in place that we can provide care at earlier stages, healthy food policies and food security.

When we can see all of that, we can reach those populations that are not achieving care. Part of that, as well, is being able to provide the access to care so that they can get services when they require them, so even when the prevention side doesn't work, we can still provide the provision of care when they have acute problems.

Looking at that, the overall strategy is where we're going to be able to come up with those ideas of finding out what populations are not achieving optimal oral health and how we can achieve better optimal oral health for those populations through different strategies that aren't currently working.

RAFAH DICOSTANZO: That are not working right now, is that what you said? Do we have people working on that to improve it?

FERNE KRAGLUND: That would be part of what the overall oral health strategy would be. It's looking at what resources we have. We're also looking at redundancies in services; meaning, we're all kind of working in silos. We need to collaborate and pool resources a little bit better to be able to provide better services and to provide better information so that we can get better health outcomes, essentially.

RAFAH DICOSTANZO: I'll pass it on to my colleague for the next few minutes.

THE CHAIR: Mr. Jessome.

BEN JESSOME: Ms. Purcell, you received a line of questioning related to subscription of the program and indicated that there was no cap pertaining to the program. I'm wondering: How does advertisement, communication, maximizing subscription to the program factor into the greater strategy that's being planned out? To the best of your ability - either you or Dr. Kraglund could jump in here - what type of activity do you see taking place to maximize that subscription if there's a gap there?

ANGELA PURCELL: I think across any of our programs, we can always do a better job of making sure we communicate and have the right strategies to reach all the populations that we serve and all the citizens of Nova Scotia. Can we do a better job? Of course, we can always do a better job. I think, as Dr. Kraglund has said, working towards a strategy will help us enable not just how we might target those communities, but how we communicate to the groups that we really know we need to serve.

Right now, what we do is work with our partners to make sure they have the information on our current programs. They're the ones who are having those conversations with parents and providers. We also work closely with the Health Authority so that they have updated information on our programs, and their public health team can also provide that additional communication in the schools and in the populations that they have outreach to. They would be our main mechanisms for communication right now.

BEN JESSOME: What specific role does the Department of Education and Early Childhood Development play as a community partner?

ANGELA PURCELL: I'm not sure, from a direct kind of relationship with our team, I haven't had that outreach right now.

BEN JESSOME: I'm going to change gears here. Specific to the White Paper, Recommendation 10 suggests mandatory health screening prior to reaching Primary. Perhaps both parties could offer some comments: How significant is that, and do we have any data related to how many children would be subscribing to that type of screening, presently, prior to entering the school system?

PATRICIA GRANT: Dr. Kraglund is quite correct. Our collection of data on oral health in Canada is not a great record, and in Nova Scotia, we would follow that.

If you look at public health dental hygienists in Nova Scotia, some regions will say that they are still doing some Primary screening. There's only one required screening for Primary students in Nova Scotia, and that's vision exams. It's very easy for a dental hygienist to take a flashlight, a mouth mirror, or some wooden sticks and have a look in the mouth to find out whether the child has already received dental care, whether they need dental care, and give them some information on the Children's Oral Health Program. That happened quite regularly at many points.

What I understand now is that it's not done consistently, and the few hygienists who do still work in public health are not necessarily invited to those screenings or to do that screening. They're employed in other areas of oral health and other areas of health, I guess. Preschool screening might tell us, if we kept good records, how many people are not accessing the oral health care that MSI would provide, for example.

I believe in 2015, the Cape Breton district school board did a screening of all Grade 1s or Primaries. What they found is that a slightly higher percentage than the national average in Canada of those children already had cavities, and some of them had been to the dentist. It was slightly higher than average for the number of children who had decay in their mouth. That's in a very big district in Cape Breton.

Again, we're looking at pockets . . .

THE CHAIR: Order. Time has elapsed. We will turn it over to the PC caucus for 12 minutes. Mr. LeBlanc.

COLTON LEBLANC: Thank you all for joining us this afternoon. It's certainly a topic of great discussion that seems to be much bigger, as was stated, than just at a provincial level but goes beyond to a national level. It sounds like some changes need to be reflected in the Canada Health Act.

I would like to start by stating to the dental hygienists that I can certainly empathize with your profession. You can see the role or the possible growth of scope of practice, similar to mine. I can see that as you can see the desire to see your scope expand for the benefit of Nova Scotians.

A question for Ms. Lagassé: The last oral health strategy was which year?

JEANNINE LAGASSÉ: The province has never had an oral health strategy.

COLTON LEBLANC: In 2014, the College of Dental Hygienists of Nova Scotia presented this document. When was Dr. Kraglund hired to begin her work on eventually implementing an oral health strategy?

JEANNINE LAGASSÉ: Dr. Kraglund joined the department part time in March 2019.

COLTON LEBLANC: Ms. Grant said earlier that a strategy is certainly a big job, and Dr. Kraglund said some organizations are working in silos. For Ms. Grant, is the job of developing an oral health strategy for Nova Scotia too big of a job for part time? Would that be too big of a job for a chief medical officer to oversee for Nova Scotia?

[2:15 p.m.]

PATRICIA GRANT: Having never developed an oral health strategy for the Province of Nova Scotia, it would be difficult for me to say. I feel that if they had the right support and services behind them - if they approached it, truly, with all the players onside - it's possible that the person could be part time and oversee it. I would say that it would move along much more quickly if there was someone - whether we call them the chief dental officer in Nova Scotia or another name, it would have to have a designation, someone who actually worked in the area of oral health.

Oral health has been left out of overall health for so long that it's difficult to find the right people to marry them back together sometimes. I think that's one of the things that would possibly be an aim of an oral health strategy. It might be too big for a part-time person, at least someone who should be working on it full time for six months. It is a big job.

COLTON LEBLANC: Can somebody explain to what magnitude oral health is an issue for children in Nova Scotia? In broad context. We've learned of some of the issues being from early childhood caries and things like that, but to the longer terms of chronic conditions or systemic conditions, how could that negatively impact their lives and go on to cause them further health problems later in life?

SHAUNA HACHEY: Unfortunately, I think as has been referred to a few times, one of the challenges in Nova Scotia is lack of data. Our last published data set across the province is from 1995-96 that has been published. What we have is subsets of data, as Pat referred to, in terms of the oral health of children in Cape Breton. We also know that Indigenous children in Cape Breton have the highest rate of using emergency rooms for oral pain. Outside of that is as described: failure to thrive. If you're in pain and potentially have a challenge, if you're at an age where that's difficult to communicate, that affects a whole host of concerns in terms of development, growth, and thriving.

While we don't know what that looks like in terms of across the entire province, the subsets we know in terms of use at the IWK, which from a small study that I was involved in, looked to see that the social determinants of health are still very much impacting that population. From the study that I was involved in, the people that we looked at who were using the IWK specifically for oral-related disease, not necessarily behavioural problems or medical problems, the majority of those people were from rural areas, low socio- economic backgrounds, and Indigenous populations.

As we know from the Canadian data, on top of those are also new immigrants. While I haven't had experience working with children, we can say that from the experience that we have of the Dalhousie externships that yes, of course, they come to Canada with huge challenges, oral health being one of them, and that needs to be addressed.

COLTON LEBLANC: In your comprehensive report that you presented back in 2014, the question was posed earlier regarding which recommendation would be a priority. I'll ask that in part of my question, but it seems that many of the recommendations would fall under the purview of a chief dental or chief oral health officer in the province.

I'll give you the opportunity to answer the question: Which recommendations would you see as a priority to be implemented in Nova Scotia?

STACY BRYAN: I think you're right that a chief oral health officer would help to develop the oral health strategy that many of us have alluded to. It does make it very difficult when such a multi-pronged approach is required and it's a very multi-faceted issue. Without that comprehensive oral health strategy, it's difficult to make all of those changes. To ask us to pick one out of 13 is always very difficult.

In terms of increasing the impact and the ability for dental hygienists to be able to provide care to a larger diverse number of Nova Scotians, one of the things we had alluded to earlier is the fact that they cannot be reimbursed under the MSI program, particularly the Children's Oral Health Program. That's one barrier that is preventing dental hygienists from improving the oral health for a subset of that population.

PATRICIA GRANT: I would have to say that trying to meet the needs of the underserved populations in a place where we can actually access them - the people who are not accessing the Children's Oral Health Program now are not necessarily going to access it by putting more leaflets out at the public health centre. They need to be met in the communities where they are. I think that has been demonstrated in many other jurisdictions and programs.

We did a screening, and the college supported it, where we hired a dental hygienist to run oral health screenings for children with an immunization clinic. This was for the Syrian refugee children when we received a large number of Syrian refugees in this province. It was one of the most successful because we were asked to do it by the medical officer who looked after the Syrian refugee people. I really believe we need to meet some people in the community where they are.

COLTON LEBLANC: I think some of these potential solutions could be implemented before an oral health strategy for our province. However, some changes have to come from the federal level.

I assume that other provinces have strategies, and I guess the federal government has had a strategy. Canada has had its chief dental officer since 2004, which helps promote and educate best practices for oral health. Does it seem that the province without an oral health strategy is turning to the federal government for guidance or to seek aspects of their oral health strategy?

ANGELA PURCELL: I don't know that I'd capture it as turning to the federal government for that strategy. I think they're also a welcome partner in this; they have some great information online. Any source of information that's evidence-based and can be an opportunity to educate citizens across the country is terrific. I wouldn't see it as stepping away from our role at all.

The premise when we started the review of our program - it started with Children's Oral Health Program and a review of that. It started with that because it is our largest program. We always knew we needed to have that baseline information of our current programs, that and our other programs, before we moved through the work of a strategy.

It was meant that this would be the foundation of informing a strategy, and part of the work of a strategy was making sure we had resources in house at the Department of Health and Wellness through a dental consultant to help build, develop, and advise that strategy. I would echo the comments made; it wouldn't be work done only by a dental consultant.

THE CHAIR: Order. The time has elapsed for the PC caucus. We'll turn it over to the NDP caucus for 12 minutes. Ms. Chender.

CLAUDIA CHENDER: Thank you all for being here today. I want to turn back to the brief conversation we had about billing codes. My colleague asked about sedation; I've also had this same issue with my child. It's a little bit surprising to me that it's not something that's on the department's radar. I think it's a huge issue, because we're talking about barriers to access.

Notwithstanding the fact that we've heard we don't have a strategy - we have a strategy. We cover oral health for children up to 14 years of age; we cover some things and we don't cover other things. Clearly there are challenges in that. We hear challenges from both sides, so we hear challenges obviously from an access perspective because it's not a universal program, because we're not meeting people where they're at. We hear challenges around getting children to access that program and the fear that some services will be covered and others won't, so parents stay away.

We also hear issues from dentists who say not all of the services that a child who presents to them needs will be covered, which puts them in a difficult situation in terms of how to treat that child. Then when they bill MSI, it's a huge administrative burden vis-à-vis working with private insurers.

I would be surprised, actually, if dentists were telling every pregnant mother to bring their child in. That was not my experience in my pregnancies with my three children. I know they're being told that; I don't know if it's accurate that they're doing that, though. I guess I wonder: Can we see a change in that, or do we have to wait five years until this strategy is implemented? Is there an ongoing review of how those services, which are covered for children under 14, are actually covered and how effective they are?

ANGELA PURCELL: We haven't waited for work to continue. We definitely did want to have a review done of our current programs to help inform the direction moving forward. We negotiated a new agreement with the Nova Scotia Dental Association; part of that was the joint proposal to invest in preventive services. Those kinds of conversations continue, and we meet with them on a regular basis.

Part of our new contract is to make sure that we have a touch point and continue to move forward on priority issues. I'd say that work will continue - and it need to continue - on our existing programs while we do the work to invest in the development and planning of a longer term strategy. One is not going to happen without the other.

CLAUDIA CHENDER: To that end, in terms of ongoing work, we've heard a lot about the lack of data, so I think it's shocking that 1995 is the last complete data set. I wonder, especially given that we're at the outset of the development of a robust strategy: Are steps being taken now to collect that data so that it can properly inform that strategy, that it's based on more than best practices and ideas but the actual needs of the population?

ANGELA PURCELL: Building on Dr. Kraglund and her conversation about an upcoming survey - I don't know what the timing of that is going to be like. We can rely right now on the information that we have, and we can analyze that any number of ways.

I think what we're going to have to do in the planning is seeing what other pieces of information we need to bring into that, be it conversations with private insurance and how we have those conversations to see what information we can get from them to get a more fulsome picture of what's happening in Nova Scotia, which will be part of the building of the background work we need to inform that strategy and the pieces we need. As well, having those conversations with our partners - and they're numerous - to see what other pieces of information we can get at the community-based level and through other sources to help inform that direction.

CLAUDIA CHENDER: Maybe just to continue on that line, I think another thing we've heard, and something that we strongly advocate for, would be meeting people where they are. We just heard this example of working with the chief medical officer to provide a large program to arriving refugees. Presumably, the more that these services can be provided in community to broad swaths of people, the more data that can be collected and the more preventive care that's being taken. Are there moves to be expanding that kind of access now?

[2:30 p.m.]

ANGELA PURCELL: I don't know that there is a specific move, although I don't know that we would ever be close to a conversation about that. I was engaged in the North End clinic for a long time. I think it is a great example of a community-based health care organization and how you service a community in the best way that meets their needs. I think that is a great example, and we should be looking for more opportunities on how we can do that through a strategy. A strategy will help to inform where we can go to meet people. It doesn't mean the conversation stops until we get to that point or that we aren't open to those conversations.

CLAUDIA CHENDER: I can't miss the opportunity to just register that when we hear the North End Community Health Clinic as an example, it's both inspiring and deeply frustrating because that type of clinic is not and will not be funded anywhere else in the province. While they do incredible work, we cannot replicate their work anywhere else, as far as we understand. When you talk about working with partners, that's one partner, and that's amazing for that community.

In terms of that kind of access in places like schools, would your partner be the Department of Education and Early Childhood Development? When you say you're open to those conversations, I guess my question is, would you ever initiate those conversations? If not, then who are the partners that are going to approach you about that?

FERNE KRAGLUND: I think that's really what the role of the strategy is. There's a lot of good work happening all over the province by so many different organizations, so many different groups, that it really requires some coordination. I think we need to get people together so we can figure out what's happening and what we can do better. A coordination by the professional societies and organizations is part of that and getting the institutions meeting, like the Faculty of Dentistry and all the training institutions. I'll pump us up a little bit. A reason why the North End clinic works so well is that they partnered with the Faculty of Dentistry. A lot of partnerships are developed like that.

I think that's maybe what's lacking a lot in the province, that there's this lack of coordination of getting all the parts together to talk to see what can be developed moving forward. There's some capacity here, and there's some capacity there, but the momentum is lacking. I think they need that one sort of group to be able to move all that forward, so I think that's what's required. Education and Early Childhood Development needs to be in there. Public health needs to be in there. The public health hygienists who are working, we need to be able to maximize what they're doing for oral health. I don't think that's really being done optimally at the moment, and I think this is the moment when we can get them to optimize to do that to really be able to do a coordinated effort as a group.

CLAUDIA CHENDER: Stepping back a little bit - I guess this is probably a question for the acting deputy - fluoridation was mentioned in the opening statement. My understanding is that 46 per cent of Nova Scotians have access to water fluoridation. In terms of prevention, the data seems to show this is prevention.

I think the province certainly has a role to play in terms of flowing through to the municipalities to enable water utilities to provide fluoridation. Is that on the radar of the Department of Health and Wellness? Is that a conversation that's happening?

JEANNINE LAGASSÉ: I'm going to ask Dr. Kraglund to speak to that, actually.

FERNE KRAGLUND: While I'm employed with the Department of Health and Wellness, I have had lots of conversations with others in government. I have been talking with those in public health. There are talks many places to be able to mobilize people from all across the province to be able to lend support on it. I'm in a working group as part of the faculty to make sure that we are getting the information out proactively instead of waiting for information to come up after and trying to defend our stance on water fluoridation, which is really difficult to do.

Right now, Amherst is one of those communities that's looking at fluoridating; they have something happening next week. They're providing some community information sessions so that they can get the support there to have a proper conversation. I know NSHA is supporting that, even though it's a municipal sort of momentum that's going there.

CLAUDIA CHENDER: I'll just follow up on that. That's good to hear, but I guess I'm talking more about real dollars for implementation because municipalities, of course, are a creature of the province, so that's why I directed my question to the deputy. I acknowledge that's an important role and I'm glad to see the department playing that role, but if a community decides that they are ready to do that and have the social licence to do that, is the department actively thinking about allocating funds that would be necessary for municipalities to be able to do that?

JEANNINE LAGASSÉ: Not specifically within the department, but we'd certainly be open to having discussions with our partner departments within government, to have those conversations.

CLAUDIA CHENDER: I guess in my last minute, this would probably be directed to Dr. Kraglund in terms of access again. We had a CCPA report come out today that shows that as opposed to the one in five statistic we used last year, we now know that one in four children in Nova Scotia are living in poverty, and one in three children in Cape Breton are living in poverty. These are the kids whose parents are not taking them to the dentist. How are you addressing that in developing this policy and reducing those barriers to access?

FERNE KRAGLUND: I think that's where it comes in with the oral health strategy - it's not just about a treatment, it's also about prevention. It's about the social determinants of health. It's having those broader conversations with other partners that if we can have some influence by even just having the conversation for them to realize the impact of oral health and poor oral health on them, that maybe we can have some policies developed or at least have some say in policy development that will have some impact overall - things about food security, for example.

THE CHAIR: That's good timing. We'll turn it over to the Liberal caucus for 12 minutes. Ms. Miller.

HON. MARGARET MILLER: I have to say that I think I'm the exception. My children and even my grandchildren have never had to go beyond our family dentist and have always had great success. I wonder if I can attribute that a little bit - and possibly you would too - to the attitude of dentists.

My kids used to fight to go to the dentist like it was a competition to see who didn't have any cavities and who had the best teeth. They couldn't wait to go and come back and say, I didn't have any, I'm good. They were really excited about it. I just wonder if a little bit of that - is it fear? I don't know why children are going to the dentist and that they're terrified. Why are they terrified? Where are they getting that? Is it coming from parents? Is it coming from media? Possibly our dental hygienist could speak to that.

DIANNA MAJOR: I think a lot can come from parental fear. If a parent has any sort of past experiences that were not positive, that can translate onto their children sometimes. Kids talk to their friends at school about what their friends' experiences have been, and those aren't always positive either.

Also, it's a lack of control. Fear comes from a lack of control. It doesn't matter what the situation is, be it in the dental office or going in for a different type of surgery or just going to a medical appointment for an injection. It's all about loss of control.

MARGARET MILLER: I think I would have to agree with that. Can you tell me a little bit more about what's going on in the Children's Oral Health Program? Can you tell me about the program, how it works and what is covered?

ANGELA PURCELL: I'm going to try my best not to forget anything. It is a program that's universally accessible, so it's available to any child from zero to 14 in the province with a health card number for Nova Scotia. It actually goes to the last day of the month of their 15th birthday, to be precise. It covers one exam a year, two X-rays, fluoride treatments, molar sealants, non-routine extractions, fillings, and a preventive service.

MARGARET MILLER: I notice that you said until 14. How was that age arrived at? Was there ever a time that it was more than 14? What's the thought process of stopping it at 14 when we recognize children are children until they are a little older than that?

ANGELA PURCELL: Since the program has been in place in the early 1970s, the age has actually fluctuated a little bit over the years. It has gone from zero to nine. At one time it was up from zero to 15. It has kind of been back and forth - 12, 13, I think as well, and we're at 14 right now.

It varies across the country. If you look at what's happening across the country, there are different ages as well. When the Oral Health Advisory Group, Phase 1, looked at it, there was no evidence that increasing age actually increased the number of beneficiaries that accessed the program. So they recommended - and the government supported it - that

the expansion be stopped at that time and that it be part of the work of the development of a strategy to look at the evidence of what that age of eligibility should be.

MARGARET MILLER: Apparently there has been a change in the last year, the strategy was expanded in January 2019. Can you tell me what those changes were?

ANGELA PURCELL: In the new agreement with the Nova Scotia Dental Association, we expanded the availability of fluoride and sealants. They were available previous to this, but for a child to access fluoride treatment they already had to have caries, and to be able to access sealants for their molars they had to have evidence of deep grooves in their teeth. That has been removed. That access since January of last year has expanded.

MARGARET MILLER: Just to move on now, what kind of work do the public health dental hygienists who work for the Nova Scotia Health Authority do? I'd like to know what their areas of focus are and where in the province they work.

PATRICIA GRANT: I actually think that's a question for the province, perhaps.

ANGELA PURCELL: I'm not going to be familiar with all the details of what these approximately 14 hygienists do on a day-to-day basis. I know they do provide the dental sealant program; it was a mouth rinse program. It is transitioning the next school year to a fluoride varnish program. That outreach includes approximately 139 schools that they go into to oversee this. As well, they work with schools, daycares, and child care institutions to implement those good nutrition eating habits. I believe there's also some outreach to other communities depending on the need. As I think I also heard, the actual work may vary a little bit from zone to zone, but those are the highlights.

MARGARET MILLER: Can you tell me what has happened or what has been done by the department over the last five years, what advances have been made?

ANGELA PURCELL: I'm going to do some math. I think that brings us down to the first oral health review - Oral Health Advisory Group, Phase 1, which was a review of the Children's Oral Health Program. It has completed a review of all the other oral health programs. We've hired a dental consultant part time. We have reached agreement with the Nova Scotia Dental Association, and specifically expanded preventive services. We are in the very early stages of developing the plan for an oral health strategy.

If I can add one other thing, we've added a pediatric dentist to the IWK, as well, as part of their academic funding plan.

THE CHAIR: We'll turn it over to Ms. DiCostanzo.

RAFAH DICOSTANZO: I just wonder if you can highlight for me something that confuses me. For example, they charge $120 for a filling, and the insurance covers $80. These are just figures that cover it. Where do we come up with these figures, and what's

the standard in Canada? Why is the insurance paying $80 when the dentist is charging $120? Can you give us an outline of those figures? Who comes up with them? How does the government deal with that, if you don't mind?

[2:45 p.m.]

FERNE KRAGLUND: Each province or territory comes up with their own fee guide. Fee guides differ from province to province, so Alberta may be very much different than what you see in Ontario, which might be different than what's in Nova Scotia. It is a fee guide. Most dentists will choose to charge whatever it is in the current fee guide, and it changes for year per year. It doesn't go up by a percentage across the board on every single code, essentially. It might go up by slightly different percentages on different codes.

This is where the problem is. Each insurance plan that comes through the door, and we as a dental office could deal with hundreds of different insurance plans, are negotiated with the employer and the companies. For example, when I worked in Saint John, Irving was a huge company, and they could have dozens of different plans even within the same company. It might not even be the current fee guide that they go on. It could be an older fee guide depending on when negotiations happened.

They will negotiate how much of a percentage they'll cover for certain procedures. If something is a basic procedure, for example, something that would be like an extraction or a filling, they might cover 75 per cent or 80 per cent of that. If it's something that's larger and more expensive like a crown or a denture, they might do it at less of a percentage at which they would cover that. From there, the co-pay would then be the responsibility of the patient to pay to the dental office for the remainder of what would be owed.

RAFAH DICOSTANZO: I believe a couple of the dentists complained to me at one point - is it Green Shield for people who are covered through government? If the insurance pays the 80 per cent, then there's no coverage for them after that, so the dentist is out. Is that correct, or is that not correct?

ANGELA PURCELL: I'll just separate them out. If I'm only covered through private insurance, so it's for me personally, and my private insurance covers 80 per cent, then I would be responsible to pay the 20 per cent. For programs like the Children's Oral Health Program, which are in legislation and regulations, we will pay up to the tariff that is set in those regulations. In some of those cases, it isn't the dental fee that is recommended by the NSDA in Nova Scotia, their guide. We have a fee and tariff that might be a bit lower than that, so the dentist is not permitted to bill in addition. They're not allowed to bill up to what their guide suggests. They have to bill what's in the tariff.

RAFAH DICOSTANZO: There is a standard that the government uses for the children, and that's how much it should be. Certain doctors charge more than others, is that correct? Is that why there's a difference that they will end up with?

ANGELA PURCELL: The dentists who are billing for people who are eligible for our programs, for the Children's Oral Health Program, should not be billing above what it is we will pay.

RAFAH DICOSTANZO: Just another one: For referrals between doctors, how do you deal with that as well? When a doctor refers to another doctor, do they get paid as well for exams, or do they not? If they go see one dentist, their exam is with them, and then they move to the other who also has to do an exam, does the second dentist get paid as well or not? How does it work?

FERNE KRAGLUND: Yes, they do, particularly when it's a specialist, and they have to do a separate examination. The government will pay for both examinations.

THE CHAIR: Order. Time has elapsed. That wraps up our questioning time. I'll ask if there are any closing remarks from our witnesses. Ms. Lagassé.

JEANNINE LAGASSÉ: I would just like to thank the members for having us here today to talk about this important program and thank my colleagues, Ms. Purcell and Dr. Kraglund, and our partners at the College of Dental Hygienists for being here today. We hope that we have provided the members with some valuable information. If you do have any follow-up questions, I would be happy to speak with any of the members and provide them with further information.

THE CHAIR: Thank you. Any others? No.

You may go on your merry way. I'm sure there will be questions by the media when you leave the Chamber. We'll give you a minute or two to leave, and we'll get on with the business part of our meeting.

[2:49 p.m. The committee recessed.]

[2:50 p.m. The committee reconvened.]

THE CHAIR: We would love to have your closing remarks, Ms. Bryan.

STACY BRYAN: My apologies. I said I didn't have written ones in advance. I was going to do it based on the feedback that we heard today, so that's probably where the confusion was.

I just want to start off by thanking you very much for inviting us here today to continue with this dialogue. We appreciate the opportunity to provide our feedback to your very insightful questions. I think it is apparent to all of us that all of you are very passionate about improving oral health care for all Nova Scotians.

For many Nova Scotians, we will say that the oral health system appears to be working well as the rate of oral disease continues to decline across Canada, but a more intentional approach is needed to reduce the inequalities that we've outlined today regarding the populations of children who are experiencing that heavier burden of oral disease.

We feel that it's time to put the mouth back into the body and help decrease the burden of oral disease on both the individual and the already over-taxed health system. Prevention at the right time with the right resources will help to reduce this burden. This includes implementing direct delivery services via school and community-based programs, offering integrated approaches for the earliest intervention possible, using oral health care providers to their full scope of practice, and implementing regulations that allow for financial reimbursement of dental hygienists as providers.

All of the discussions that we have had today, none of these options or innovative solutions that we're offering are an expansion of scope. They are merely using dental hygienists to their full scope of practice, what is already in existence. We would encourage all of you to access some of your most important resources to assist with these solutions - the oral health care providers in your communities, including dental hygienists.

I would encourage you to seek feedback from those providers in all settings - those in public health, private dental and dental hygiene practice, as well as others who are providing services in other community settings. These individuals have their ears to the ground, and they know the specific needs for these communities as well as potential solutions.

The CDHNS will continue to work closely with stakeholders, including government, Nova Scotia's professional education and health care sectors to address the challenges that we've identified and further the integration of oral health and dental hygienists into the primary health care system into Nova Scotia. I believe that working together we can implement more innovative solutions to help resolve these issues in Nova Scotia. Thank you again for your time.

THE CHAIR: Thank you, Ms. Bryan. You may leave the Chamber. We're just going to have a very short business meeting.

We will turn to the business portion of our meeting today. We have from the Department of Health and Wellness updated organizational charts. You would have received them by email. They are very long, so I directed the clerk not to print them off for everybody. If anyone would like them, I suggest that you print them off yourself or use your electronic devices to peruse them.

You have a printed copy in front of you from Deputy Lagassé, which includes a request:

> "In order to ensure we are providing useful information to the Committee, DHW would like to propose that going forward, information on our organizational structure and staffing be provided for the executive leadership team and staff down to the director level. Please let us know if this will satisfy the interests of the Committee or whether more information is required."

I think that's because of the number of pages it requires. We're asking for suggestions. Are we in agreement with that or is that an issue? Ms. Adams.

BARBARA ADAMS: I was the one who suggested that we get this update. I'm not quite sure I understand why we wouldn't continue to get the update for all the departments, because I assume that they are keeping those charts up to date. I'm not sure I understand why we would want to exclude them. I certainly find them all helpful, so I don't know how big a deal it is to update them all the way down the list.

My recommendation is that we keep it as is, which is to request that they update all of the hierarchy charts that they have been doing so far.

THE CHAIR: On a quarterly basis. Are there any other comments?

Are we in agreement to continue with this practice?

It is agreed.

If you can pass that along. Thank you to our clerk, who I did not introduce for our meeting. Judy Kavanagh and our Legislative Counsel, Mr. Hebb. I left you out of our introductions at the beginning of the meeting. My apologies for that.

Also, the Nova Scotia Health Authority updated their organizational chart. It's on the back; it's a one-sheeter. The clerk printed it off because it was one sheet only.

Our next meeting is Tuesday, February 11, 2020. Our topic will be the Youth Mental Health Outreach Program (CaperBase), and the witness will be Samantha Hodder, Senior Director, Mental Health & Addictions in the Nova Scotia Health Authority.

If there's no further business, I adjourn this meeting.

[The committee adjourned at 2:57 p.m.]