Canadian
Dental
Association

L'Association
dentaire
canadienne

Speaking notes for Dr. Tom Breneman
President, Canadian Dental Association
October 31, 2002
Standing Committee on Finance
Pre-Budget Consultations

Good Afternoon.

Thank you for inviting me here to speak to you today. My name is Tom Breneman, and I am the president of the Canadian Dental Association or CDA. In my role as president, it is my job to try to represent to you, the thoughts and priorities of the 17 000 plus dentists that CDA represents as well as our patients, and future dentists.

You will already have received a copy of CDA's brief, which covers, in detail, a number of important issues. Rather than reiterate the contents of that brief, I'd like to give you a bit of insight from my perspective as a dentist into what some of those recommendations look like from where I'm sitting.

I know that Andrew Jones, who is sitting beside me here today has already presented to you as a representative of a group called the National Professional Association Coalition on Tuition, or NPACT, of which CDA is a member. I understand that he covered a range of professions sharing common concerns about how rapid increases in tuition fees are affecting or will affect access to professional programs.

I wanted to add, if I may, to Andrew's presentation just by drawing on some of my own experiences. When I entered the dental program at University of Manitoba in the mid 1960s, I was looking at tuition fees in the neighbourhood of 500 dollars a year. My family was not particularly affluent, and neither were the families of my classmates at the time. A few of them had fathers that were dentists, or doctors, but a lot of them were from working class families. 500 dollars a year was not peanuts, but it was manageable.

I think for many of us, the total debt that we were looking at on graduation would have been under 5000 dollars. For me, it was around 3000. Times were good. When I set up shop, dentists in the city had waiting lists of people who they just couldn't accommodate.

I was able to very quickly establish my own practice with a solid patient base. I don't have my income tax returns from back then – but I think I could count on making something in the region of 30 000 dollars a year. So my total debt load on graduation represented maybe 10 percent of what I could expect to earn in a single year of practise.

Now contrast that with the situation that would face a young person today considering a similar career. To begin with, tuition fees are much higher. Add to that the costs of tools and materials, and the debt that many students are already carrying from an undergraduate degree. On graduation, many students are easily looking at a hundred to a hundred and fifty thousand dollars in debt.

Now it's true that these students will be earning higher than average incomes. But setting up shop today is a different story than it was in the sixties. Establishing an independent practice is a very costly endeavour. Faced with a debt load that represents two or three years income, compared to my 10% of one year, it may be much more attractive to these kids to work as an associate in a large established practise – probably in an urban area. And that's when access becomes a problem. Because it is the smaller, rural areas that are already experiencing shortages, and the expectation is that it will become worse.

We also know that students who come from smaller communities are more likely to return there to practise after graduation. But when the front-end problem of high tuition that is already a hurdle for students from lower-income families is compounded by the high debt demanding repayment at graduation, it can result in a real reduction in professionals providing service to those communities.

Maybe I had it too easy. But there has got to be some middle ground between the 1969 reality and what we've got now. The pendulum has already gone too far, and still seems to be in full swing. At some point, we need to reach out and stop it.

Two other concerns are related to this issue. One because it also deals with university funding, and the other because it speaks to access to care.

The financial constraints that caused universities to make such drastic hikes in tuition fees, also impact on their ability to attract and retain top-quality educators. Fewer dentists are choosing academic careers, and attrition is a real factor. So the tuition question becomes almost a moot point – if there is nobody teaching, it really doesn't matter what the tuition fees are. The bottom line is that universities need more financial support. That may come through the social transfer payments to the provinces, or some other model may be developed.
The point is that the educations of our children and grandchildren are not something that the federal government can afford to ignore.

The second point about access to care is more complex than just simply the availability of an appropriately trained person to deliver that care. There is also the question of how that care is paid for. For the most part, Canadians enjoy high levels of oral health, provided by committed and caring dentists, and paid for through a team approach of employers, insurance companies, and government. But there are some who fall through the cracks. Although we lack detailed statistical information in Canada, we do have a fairly good idea of where the problems are. There is really no system of payment in place to meet the needs of working poor Canadians and their children. In addition, underfunding of welfare programs means that they are able to provide only the most rudimentary services.

Significantly, it is members of the lower-income groups that carry the greatest burden of oral diseases. For example, children from the poorest 20% of families, often experience as many as 80% of the cavities.

Healthcare reform is very much a topic of discussion these days in the context of both the Kirby and Romanow reports. While dentistry is not a focus of either of these, there are some fundamental aspects of delivery of care that are common to both dentistry and general healthcare. Dentists welcome the opportunity to work with government to address the needs of poorer Canadians by designing a system that respects the following key principles:

- Patients should be free to attend the dentist of their choice.
- Long-term relationships between dentists and patients should be encouraged and fostered.
- Dentists and patients should be able to make treatment decisions in joint consultation, free from third-party interference based on coverage.
- Recognize that dentists are the only oral health care providers who are able to diagnose and make full oral health plans for patients.
- That a patient's private health information should be protected both by the dentist providing care and by government institutions providing funding for care.

Our brief covers a number of other issues. I'm pleased to see here at the table our friends from the retirement income coalition. CDA's brief makes a number of recommendations calling for increases in RRSP contribution levels with which I am sure they will concur.

This is an area that has really been overlooked the past few years, and while it is understandable given the competing priorities, we certainly feel that this year is the time to make some positive changes. Other subjects covered in the brief include the need for more Oral Health Research and prevention initiatives, concerns about the oral health of Aboriginal Canadians, and recommendations on Tobacco Control and GST.

Thank you again for giving me this opportunity to bring these important issues to your attention. I welcome your questions and discussion following the remaining reports. With it being Halloween, I'm sure you must have some questions to direct to a dentist!

Tom Breneman, D.M.D.
President, Canadian Dental Association
Président de l'Association dentaire Canadienne