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Standing Committee on Human Resources

Chairperson
Mr. Doug Martindale
Constituency of Burrows

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MANITOBA LEGISLATIVE ASSEMBLY
Thirty-Eighth Legislature

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LEGISLATIVE ASSEMBLY OF MANITOBA

THE STANDING COMMITTEE ON HUMAN RESOURCES

Monday, November 28, 2005

TIME – 9 a.m.

LOCATION – Winnipeg, Manitoba

CHAIRPERSON – Mr. Doug Martindale (Burrows)

VICE-CHAIRPERSON – Ms. Marilyn Brick (St. Norbert)

ATTENDANCE – 11 QUORUM – 6

Members of the Committee present:

Hon. Mr. Sale

Mr. Aglugub, Ms. Brick, Messrs. Dyck, Eichler, Jennissen, Ms. Korzeniowski, Messrs. Martindale, Rocan, Mrs. Stefanson, Mr. Swan

SUBSTITUTIONS:

Mr. Martindale for Ms. Brick

APPEARING:

Mr. Kevin Lamoureux, MLA for Inkster

WITNESSES:

Bill 5–The Dental Hygienists Act

Ms. Shelly Irvine-Day, Manitoba Speech and Hearing Association
Ms. Sheelagh Smith, Private Citizen
Ms. Mickey Emmons Wener, Chairperson, Manitoba Dental Hygienists Association
Ms. Mary Scott, Provincial Council of Women of Manitoba
Ms. Joanna Asadoorian, Private Citizen
Mr. Rafi Mohammed, Membership Services Director, Manitoba Dental Association
Ms. Salme Lavigne, Director, School of Dental Hygiene, University of Manitoba

Bill 6–The Dental Association Amendment Act

Mr. Rafi Mohammed, Membership Services Director, Manitoba Dental Association

MATTERS UNDER CONSIDERATION:

Bill 5–The Dental Hygienists Act

Bill 6–The Dental Association Amendment Act.

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Ms. Marilyn Brick (Chairperson of the Standing Committee on Human Resources): Good morning. Will the Standing Committee on Human Resources please come to order.

I would like to inform the committee that I am, at this point in time, resigning my position as Chair, although I am staying on the committee.

Clerk Assistant (Mr. Rick Yarish): Your first item of business, then, is the election of a Chairperson. Are there nominations for Chair?

Ms. Bonnie Korzeniowski (St. James): I would nominate Mr. Martindale.

Clerk Assistant: Mr. Martindale has been nominated. Are there any other nominations?

Seeing no other nominations, Mr. Martindale, would you please take the chair.

Mr. Chairperson: The next item of business is the election of a Vice-Chairperson. Are there any nominations?

Ms. Korzeniowski: I nominate Ms. Brick.

Mr. Chairperson: Ms. Brick has been nominated. Are there any further nominations?

Hearing none, Ms. Brick is Vice-Chair of this committee.

This meeting has been called to consider the following bills: Bill 5, The Dental Hygienists Act and Bill 6, The Dental Association Amendment Act.

We have presenters registered to speak this morning as noted on the lists before you. Before we proceed with these presentations, though, we do have a number of other important points of information to consider. First of all, how long does the committee wish to sit this morning?

Floor comment: Oh, until midnight.

Mr. Chairperson: Do we have any suggestions from people sitting at their microphone?

Ms. Marilyn Brick (St. Norbert): I suggest we sit until noon and then reconsider at that point.

Mr. Chairperson: It has been suggested we sit until noon and then reconsider at twelve o'clock. Is that agreed? *[Agreed]*

Second, if there is anyone else in the audience who would like to make a–*[interjection]*

Order. Ladies and gentlemen, the next announcement is important to the audience.

If there is anyone else in the audience who would like to make a presentation this morning, please register with staff at the entrance of the room. Also, for the information of all presenters, while written versions of presentations are not required, if you are going to accompany your presentation with written materials, we ask that you provide 20 copies. If you need help with photocopying, please speak with our staff.

As well, I would like to inform presenters that, in accordance with our rules, the time limit of 10 minutes has been allotted for presentations, with another five minutes allowed for questions from committee members. Also, in accordance with our rules, if a presenter is not in attendance when their name is called, they will be dropped to the bottom of the list. If the presenter is not in attendance when their name is called a second time, they will be removed from the presenters' list.

On the topic of determining the order of presentations, I will note that we do have out-of-town presenters in attendance. As well, we have had some requests from the presenters regarding the speaking order. Presenter No. 6 for Bill 5 has asked to present last.

With these considerations in mind, then, in what order does the committee wish to hear the presentations? I have heard the suggestion that we have out-of-town presenters first. Is that agreed? *[Agreed]*

Have you agreed that presenter No. 6, at her request, drops to the bottom of list? Is that agreed? *[Agreed]*

With these considerations in mind, then, in what order does the committee wish to hear the presentations? We did that. I am sorry.

Prior to proceeding with public presentations, I would like to advise members of the public regarding the process for speaking in committee. The proceedings of our meetings are recorded in order to provide a verbatim transcript. Each time someone wishes to speak, whether it be an MLA or a presenter, I have to first say the person's name. This is the signal for the Hansard recorder to turn the mikes on and off.

Thank you for your patience. We will now proceed with public presentations.

Bill 5–The Dental Hygienists Act

Mr. Chairperson: We are going to start with out-of-town presenters. Shelly Irvine-Day, Manitoba Speech and Hearing Association, on Bill 5.

Please come forward, Shelly. Do you have a written presentation for committee members?

Ms. Shelly Irvine-Day (Manitoba Speech and Hearing Association): Yes, I do.

Mr. Chairperson: We will distribute it. Please proceed when you are ready.

Ms. Irvine-Day: Honourable members of the standing committee of the House. I am pleased to have been asked to represent my professional association, the Manitoba Speech and Hearing Association, in supporting the bill to allow self-regulation for the profession of dental hygiene. As a speech-language pathologist who specializes in the area of swallowing disorders or dysphagia, I am well aware of the importance of a healthy dentition and good oral hygiene for the long-term care population. Oral disease is very common in long-term care, and can have very serious health consequences. Oral disease and poor oral hygiene can contribute to the development of aspiration pneumonia and infections in the elderly which, in serious situations, can lead to death.

As a speech-language pathologist, I regularly assess the structure of the oral cavity, including the presence/absence of dentition, as well as the muscle function of the lips, tongue and other oro-pharyngeal and laryngeal musculature. Through this clinical assessment process, I have been long aware of the need for better attention to the oral care of the dependent elderly.

Several years ago, after participating in a workshop series on oral health delivered by dental hygienists affiliated with Deer Lodge Centre, my colleagues and I contacted them for assistance in

learning more about oral hygiene and to develop some educational material for our patients and their caregivers. My experience collaborating with my dental hygiene colleagues has been overwhelmingly positive. We have shared clinical expertise that has mutually impacted and improved our clinical practice in our respective professions. I feel that the knowledge and skill that dental hygienists can bring to long-term care is extremely important to the overall health of my patients. Many caregivers are unaware of the importance of daily mouth care and oral health for their patients and loved ones as a preventative component for reducing the incidence of serious health problems and, also, as an important aspect in their socialization and the general feeling of well-being. The dental hygienists affiliated with Deer Lodge Centre have helped to develop excellent evidence-based educational programs and resources to promote better oral care for our patients, including fact sheets for health care professionals and families, the latter at our request.

We definitely view dental hygienists as a profession in and of themselves, with a wealth of knowledge, experience and expertise that is vital in long-term care in Manitoba. At my place of employment, Deer Lodge, we are very fortunate to have access to clinical dental and dental hygiene care in the Deer Lodge Dental Clinic. Ours is, though, one of only a few dental clinics in Manitoba located in a long-term care facility. Our department also provides swallowing assessment services in 38 of the 39 personal care homes within the Winnipeg Regional Health Authority. Therefore, we are acutely aware of how fortunate Deer Lodge is to have such ready access to the dental clinic in comparison to the services that are available at other long-term care facilities for this aspect of the residents' health.

***** (09:10)

Until last year, dental hygienists were unable to work in long-term care unless a dentist was on site. I understand now that dentists can apply for permission from the Manitoba Dental Association for a partnering dental hygienist to see resident patients who have been seen by a dentist within the last six months. Although this is an improvement, direct access to care would allow a tremendous amount of clinical preventative work to be done in long-term care in the area of oral hygiene.

A seminal article entitled "Predictors of Aspiration Pneumonia: How Important is Dysphagia," published in the *Dysphagia Journal*, in 1998, by Judith Langmore, et al., identified the significant contribution of poor oral hygiene in the development of aspiration pneumonia in the elderly. Another important article in '99 was published in the *Lancet*. In this article, researchers Yoneyama, Yoshida, Matsuyi, Sakaki, et al. from Japan concluded that, "Oral care lowered the risk of pneumonia in the institutionalized elderly. This finding underscores the necessity for the monitoring of specific oral hygiene courses for nurses and caregivers."

Oral care continues to be essential throughout the continuum of care also, as evidenced by its importance in palliation for the terminally ill.

On behalf of the Manitoba Speech and Hearing Association, which is the regulating body for the profession of speech language pathologists and audiologists in the province, I strongly recommend that the profession of dental hygiene receive self-regulating status and be enabled to access long-term care residents directly to expand on the valuable work that they are already involved with in our growing geriatric population.

Dental hygiene deserves the respect and recognition that comes from being self-regulated. I am aware that this is certainly not precedent setting as Manitoba, along with the Atlantic provinces, are the only locations in Canada where dental hygiene is not already self-regulated.

Thank you very much for your time and attention to this important bill.

Mr. Chairperson: Are there any questions from committee members? Seeing none, thank you for your presentation.

The next presenter is Ms. Sheelagh Smith, private citizen. Sheelagh Smith, please proceed when you are ready.

Ms. Sheelagh Smith (Private Citizen): As a community dietitian, I see first-hand the damage caused by tooth decay and the tremendous benefit when a dental hygienist can join a health promotion team in the community. Thank you for hearing me this morning.

In babies and children, when Health Action Centre dental hygienists first started working with us in the community, I realized that dental health was a much bigger problem than I originally thought. Then the Manitoba Dental Hygienists Association served as our primary contact for our *Poverty Barometer*

newsletter on dental health for the Social Planning Council's campaign 2000 committee against child poverty. This document is one of a series to identify and describe the issues of poverty, and I learned a lot more.

Some of the facts: Children of mothers with poor diets during pregnancy, or who were born prematurely, are more likely to have weak or pitted teeth, putting them at risk for early-childhood tooth decay, ECTD. If parents have unhealthy mouths, they put their infants and toddlers at risk of transferring their cavity-causing bacteria to their children. Parents and children need to remove bacterial plaque daily and have regular dental care. This is often not the case for families with limited access to dental services, financial challenges, or negative past dental experiences.

High-risk foods, including the hidden sugars in fruit juices, formula and milk interact with mouth bacteria producing acid, which can cause teeth to weaken and decay. ECTD risk increases when children frequently nibble and sip on sugar-containing drinks and snacks throughout the day or when sleeping. We see these behaviours all too often in the community that I serve.

Proper nutrition is important to prevent ECTD and other diseases. However, nutritious foods that are rich in tooth-building calcium and vitamin D, such as milk, vegetables, among others, are often not within the limited budget of low-income families. Often, parents are not aware of the importance of oral health and preventive behaviour and care. For example, pregnant women need to understand the importance of daily mouth care for mom and baby, healthy feeding practices and a dental visit by age one.

New research has established a link between untreated pregnancy gum disease and an increased risk of three to eight times of having a pre-term, low-birth-weight baby, a baby that will likely have huge health challenges in the first years of life. Sadly, for some, ECTD has become a normal, expected childhood occurrence. It is not unusual for several children in one family to need treatment for ECTD, some returning more than once. Families who are struggling with poverty often wait to go for dental care until there is a problem. This makes it difficult to identify and treat ECTD at an early stage, but, more importantly, to receive guidance and support in order to prevent the problem in the first place.

In adults, when the dental hygienist comes to community programs for adults, for example, job search programs, the adults start thinking and talking about their teeth and their need for dental care. Dental care and gum health are critical to diabetes prevention and care, and can even have an impact on securing a job.

For seniors, when the dental hygienist comes to programs for seniors, like Health Action Centre's Health Services for the Elderly, seniors learn that, if they have teeth, dental care can be the key to overall health. For those without their own teeth, daily tissue and dental care, yearly exams to check denture fit and check the mouth for oral cancer can make a difference to staying healthy. Dentures that fit well help people choose appealing food with texture instead of soft, gummable food that all tastes the same. Well-fitting dentures make a huge difference to physical appearance and enhance the willingness to get out and have a social life, so critical to well-being and prevention of malnutrition.

One of the biggest barriers for all these groups is poverty. The *Poverty Barometer* indicates, as professional dental services are not included in Canada's Medicare program, Canadians must rely on private, third-party insurance, government programs, or pay out of their own pocket for dental care. Families with low income often have the greatest difficulty because of this. Low income earners are more likely to have no or limited dental benefits, as many make only minimum or near-minimum wage, and part-time jobs often do not extend health and dental benefits to their employees.

So who is the most at risk? Families with low income, lower levels of educational attainment, immigrant status, visible minority status, Aboriginal, headed by a single parent, limited access to dental care or no dental insurance are more likely to experience ECTD.

By working in the community, dental hygienists can inform and guide people to clinics that can provide reduced-fee services. This role of prevention through oral health promotion can provide huge benefits by reducing the severity of illness and related costs of care. Even people who have had painful experiences in the dentist's office will listen to a dental hygienist in the community about brushing and flossing your teeth, both their own and their children's.

In summary, dietitians are concerned with health and nutrition and have a strong link with dental

hygienists. We recognize that oral health is a critical part of being healthy for all. Painful teeth or tooth loss affects what people eat and could put individuals at risk for malnutrition and morbidity.

Professionally, we have a lot in common. For example, the connections between periodontal disease during pregnancy and pre-term, low-birth-weight babies, early childhood tooth decay, failure-to-thrive issues for children and limited food choices for older adults, especially those who have lost their teeth and enjoyment of eating, with malnutrition.

Dental hygienists are professionals who collaborate well in interdisciplinary settings and are knowledgeable team players. They have an important role to play in overall health and wellness. I view them as a profession in and of themselves. With a strong commitment to oral health and prevention, dental hygienists have played an important role in Health Action Centre community programs as clinicians, as key players in promoting and advocating for health and dental care for individuals and communities in the inner city.

In Health Action Centre pre- and post-natal programs, I have observed a huge unmet dental need and low oral health awareness of parents. It has become very evident that dental hygienists have significant expertise in the community and to share with others to prevent oral disease.

***** (09:20)

Many of our clients are Aboriginal. The fastest growing population in Manitoba are newcomers to Canada. Both groups have substantial, unmet dental needs and truly benefit from their interactions with dental hygienists. I have witnessed first-hand new immigrants gratefully receiving a toothbrush and then learning, through a translator, how to brush and position an active toddler for daily mouth care.

My experience with dental hygiene certainly supports that they are, indeed, a profession with an important, unique body of knowledge to share with the public. Along with the Social Planning Council of Winnipeg, I fully support their quest to become self-regulated and thus be recognized as a profession that will serve the best interests of the public.

The *Poverty Barometer* states that every day 500 Manitoba children could be crying with a toothache; yet, tooth decay is 100-percent preventable. Passing The Dental Hygienists Act would be a step towards ending their pain. Thank you.

Mr. Chairperson: Are there any questions for the presenter? Thank you for your presentation.

Ms. Smith: You are welcome.

Mr. Chairperson: The next presenter is Mickey Emmons Wener from the Manitoba Dental Hygienists Association.

Ms. Mickey Emmons Wener (Chairperson, Manitoba Dental Hygienists Association): Wener. *[interjection]* I do not like being a wiener.

Mr. Chairperson: I stand corrected. Please proceed when you are ready.

Ms. Wener: Okay, Honourable Minister Sale, Chairperson Doug Martindale, standing committee and all those in attendance today, as chairperson of the Manitoba Dental Hygienists Association legislation committee, I would like to sincerely thank the Government of Manitoba for this long-awaited opportunity to speak on behalf of a bill that would establish the college of dental hygienists of Manitoba. I would like to extend a special thank you to Health Minister, the Honourable Tim Sale, former Health Minister David Chomiak, and to the Health policy and legislative unit staff for their major contribution and guidance in the development of this act.

Dental hygiene is Canada's fastest growing health profession, demonstrating a 42 percent growth rate between 1991 and 2000. Dental hygiene services constitute one of the major reasons people seek oral health care. In 1990, 96 percent of Canadians who went for dental care did so for a checkup and periodontal therapy, or what is commonly known as a cleaning. Dental hygienists are the only health care professionals whose primary concern is the prevention of oral disease and promotion of health. Prevention is always preferable to treatment, something recognized by this government, and is more cost-effective. It has been estimated that spending a dollar on prevention of oral disease saves $8 to $50 in restorative and emergency treatment.

In Manitoba, following a rigorous three-year program at the University of Manitoba, dental hygienists are licensed to provide oral disease prevention and health promotion services. We are key educators and providers in the treatment of gum disease, prevention of tooth decay and screening for oral cancer. Although traditional views of medically necessary health care have ignored the oral cavity, and you have heard some of these things already from the previous speakers, research is increasingly

reconnecting the mouth to the body as it links poor oral health to respiratory disease; pre-term, low-birth-weight babies; diabetes control and cardiovascular disease. Dental hygiene care reaches far beyond cosmetic care. It is, in fact, infection control.

During the past decade, dental hygiene has emerged across Canada as a profession in its own right. Across the country, dental hygienists practise as clinicians, promoters of health, educators, researchers, administrators and change agents. We have a strong and effective national association and leadership, established standards of practice, a code of ethics and a National Dental Hygiene Certification Board examination. Currently, 92 percent of Canadian dental hygienists are self-regulated, with this trend beginning as early as 1975 in Québec; Alberta, '90; Ontario, '93; British Columbia, '95 and Saskatchewan, '97. As was mentioned earlier, Manitoba and the Atlantic provinces are the only remaining jurisdictions where dental hygienists are not self-regulated.

In the attached handout detailing the chronology of MDHA's 30-year quest for self-regulation, note that we have progressed during the last decade due to the impetus provided by the dental professions act working group initiated by the Filmon administration and continued by the Doer administration under the guidance of receptive ministers of Health.

Currently, dental hygienists in Manitoba are regulated by the Manitoba Dental Association who currently requires, for annual licensure and practice, graduation from an accredited program, working under the direct supervision of a dentist and fee payment. Our goals are reflected in our message: Now is the time to increase Manitobans' access to oral health care by self-regulated dental hygienists. Without self-regulation, dental hygiene in Manitoba will remain unable to realize either our oral health goals for the public or professional autonomy. We currently serve alternating two-year terms with dental assisting on the MDA's board, and thus have limited voice or legitimacy.

Dental hygienists in Manitoba are in a situation no other health professional group is in, as we are regulated by another health profession, dentistry, who is also our primary, if not sole, employer. This situation has been recognized in other jurisdictions as constituting a conflict of interest. In fact, Manitoba's 1994 Law Reform Commission strongly stated that this is not in the public's best interest as it creates a situation or climate where self-interest can supersede those of providing the best standard of care to patients.

The membership of the Manitoba Dental Hygienists Association advocates moving Manitoba forward from a traditional to a more modern regulatory approach, an approach where dental hygienists can contribute more significantly to oral health care delivery decisions. MDHA believes that public access to quality care is paramount, as it facilitates a climate where innovative, evidence-based alternatives regarding the provision of effective and efficient care can be considered and applied.

Specifically, the goals we strive to achieve through self-regulation are to be accountable to the public as a profession, to ensure high-quality care, to act as client advocates and to establish our legitimacy in Manitoba's oral and health care community through responsible self-regulation.

Dental hygienists are ready to take this important step. In a survey done collaboratively with Manitoba Health in the spring of 2004, 75 percent of the 554 dental hygienists licensed to practise in Manitoba responded to the survey; 78 percent were in favour of self-regulation. We have received significant support from the public, including Aboriginal Health and Wellness, Assembly of Manitoba Chiefs, the town of Churchill, many long-term care facilities, other health care professions, the Provincial Council of Women and the Winnipeg Social Planning Council, to name a few. The MDHA appreciates the confidence these groups have placed in our membership, and we come before you today prepared to assume the responsibility that self-regulation entails. In preparation, MDHA has networked and drawn upon the expertise of dental hygiene registrars across the country, become part of the Manitoba health registrars association and developed a working relationship with other well-established health professions.

Regarding our plans for the management of our profession's college, we have sought advice regarding a potential administrative structure and have developed a preliminary administrative plan, which is also included in your handout today.

In summary, our initial plan indicates that we would have sufficient revenue and human resources to support the activities of a newly established college of dental hygienists of Manitoba. Through careful planning and fiscal responsibility, we will

strive to provide a college that will serve the public and the professionals it represents.

It is well-established that access to quality care, specifically to health care professionals, is integral to overall health and well-being. In our role as client advocate, it is our goal to increase the public's access to preventive oral health services by moving toward a more modern collaborative model, rather than the current traditional model of clinical care, where the client is expected to attend a traditional dental clinic. There are many Manitobans with unmet oral health needs, those living in rural or northern areas, the urban poor, the institutionalized, the homebound and, our most vulnerable, our very old and our very young. With legislative change, we would explore innovative, cost-effective delivery systems and strategies to help promote health and prevent disease in at-risk populations, while providing increased points of entry and more freedom of choice for Manitobans.

***** (09:30)

Our goals are strongly supported by Manitoba's 2002 Primary Health Care policy, whose major tenets include community involvement, access to care for everyone, collaboration and cost-effectiveness. The importance of these principles is further supported at the federal level by the First Ministers' 2004 Accord.

Currently, in almost all circumstances, a dental hygienist in Manitoba cannot assess an individual's mouth with anything but a mirror, cannot apply fluoride to a child's teeth, or provide care for someone who is homebound without the physical presence of a supervising dentist, all of which adds significantly to the cost and accessibility of delivering care. The college of dental hygienists of Manitoba would support increasing access to care in a cost-effective manner, in accordance with Manitoba's primary health care vision. Dental hygienists look forward to helping to ensure public safety and promote oral health by establishing regulatory mechanisms focussed on best practice, including evidence of adequate educational preparation for practice, a quality assurance program, disciplines and complaints protocols, public representation on the board, client advocacy, including access to care.

The Manitoba Dental Hygienists Association believes, and we hope that you do too, that now is the time to increase Manitobans' access to oral health care services through self-regulated dental hygienists.

Thank you so much for having this opportunity today. I would welcome any questions that you might have.

Mr. Chairperson: Thank you for your presentation, Ms. Wener.

Hon. Tim Sale (Minister of Health): I just wanted to thank you on our behalf for, I think it is about three years or four years now of work together off and on to get to this stage today. You have been patient and professional and sometimes frustrated, and so have we from time-to-time, but I want to thank you for the work in getting us to this stage today. I am delighted that this is a day off school, apparently, and the students and faculty have joined us for this day. So congratulations on the work of your association.

Floor comment: Well, thank you so much. It is a real–

Mr. Chairperson: Excuse me, sorry, I need to recognize you first.

Ms. Wener: Oh, I did not know about that protocol. Sorry.

Thank you so very much. We are really very, very excited to be here today, and, as you can see, it has been a long quest, even longer than the three or four years of your involvement. We are hoping that this will be a very historic moment today, and as the bill makes its way through all the final stages that it has to go through. We are proud to be here and very much pleased that you are so receptive to hearing our issues. Thank you very much.

Mr. Chairperson: Any other questions? Please stay there.

Mr. Kevin Lamoureux (Inkster): I wonder if you could just give an indication today for, you mentioned an oral hygienist, if they want to do any sort of oral work, a dentist would have to oversee it.

Floor comment: Yes, according to the–

Mr. Chairperson: Ms. Wener.

Ms. Wener: Sorry, I do not know. I do not think I would make a very good politician. I cannot wait my turn.

Yes, according to the current legislation right now, a dental hygienist cannot provide any of their oral health care services unless a dentist is physically

present. I know that Shelly Irvine-Day did mention the fact that there has been a recent by-law where, in special circumstances, a dentist can apply to the Manitoba Dental Association to examine a patient in a long-term care institute, and then the dental hygienist can provide care without the dentist actually physically being there. But there still has to be that preliminary examination by the dentist.

Mr. Lamoureux: Finally, how would you interpret that this, then, would change that? Was this enabling legislation that now will allow hygienists to do it without the supervision of the dentist?

Floor comment: This particular–

Mr. Chairperson: Ms. Wener.

Ms. Wener: Sorry, I am a slow learner.

This particular legislation would establish the college of dental hygienists of Manitoba. Within this legislation, we become able to license or regulate or register our members. We would look at what particulars were involved for them to practise any kind of continuing competency requirements. It, in fact, at this point, does not enable us to provide care without supervision. That would be something that, during the transitional council phase, will be discussed as part of the regulations. We just want to be very up front with all of you, though, that that is our vision, that we do want to be able to work, as I think was referred to in the Hansards, as front-line health workers that can provide our full scope of practice to the public.

Mr. Chairperson: Any further questions? Thank you very much.

Ms. Wener: Thank you.

Mr. Chairperson: The next presenter is Mary Scott, Provincial Council of Women of Manitoba.

Welcome. Please proceed.

Ms. Mary Scott (Provincial Council of Women of Manitoba): Good morning, Mr. Martindale, Mr. Sale, ministers and MLAs. My name is Mary Scott, and I am the president of the Provincial Council of Women of Manitoba. I am here to speak in support of The Dental Hygienists Act. I would also like to acknowledge the presence of Arlene Draffin Jones, our immediate past-president, who worked very hard on the policy that we do have as part of our resolutions.

You know quite a bit. I think we have appeared before some of you with our brief. You do know a little bit about the Provincial Council and how we are structured. I did also include some pamphlets which listed our federate members, and you will see here that one of our federates is a dental hygienist. So the Manitoba Dental Hygienists Association is a federate member, along with 25 other organizations, as well as individual members of the Provincial Council of Women.

With that background, and also just to let you know that a very recent federate which has just joined is the Autism Society of Manitoba. It is not listed there, but it is a new federate which has just recently joined, just last week.

I am going to be brief this morning because I think you have heard excellent presentations and excellent rationale for the support of the bill before you. We, the Provincial Council of Women of Manitoba, passed a resolution in 1992 on the self-regulation of Manitoba dental hygienists, so this is not a new issue for us. It was back in '92 that we first heard about the structure of the Manitoba situation. Currently, as you have heard, they are regulated by the Manitoba Dental Association and, in fact, the Manitoba Law Reform Commission has observed that regulation of one profession by another does not serve to protect the public and, in fact, perpetuates monopolies over services. So that is something to keep in mind.

Also, to keep in mind is that 92 percent of dental hygienists in Canada practise in provinces where they are self-regulated, Manitoba being the only province west of New Brunswick that is regulated by dentistry. The Manitoba Dental Hygienists Association supports the removal of restrictive supervision to allow increased public access to dental hygiene services. Manitobans can currently, as we have heard, only access dental hygiene preventative and therapeutic services when a dentist is physically present. Manitoba dental hygienists support the removal of restrictive supervision to allow increased public access to dental hygiene services.

The dental hygienist's role in the prevention of oral disease, particularly gum disease, is no small matter. In addition to the more commonly known effects of dental disease, oral infections are increasingly being linked to heart disease, upper respiratory infections and low-birth-weight, pre-term babies. The dental hygienists are licensed oral health professionals, who serve the public in oral disease prevention, intervention and health promotion. Their scope of practice includes the provision of

preventative, educational and therapeutic services for both individuals and the community.

Currently, for dental hygienists, there are minimal quality assurance provisions, and the registrants are not required to successfully complete the National Dental Hygiene Certification Examination. The government of the province of Manitoba in the past 13 years has, we feel, failed to address our original resolution, and so we are very pleased to see that this is before you today. We feel that the Manitoba dental hygienists are ready to take on this important responsibility, and strongly endorse the concept of the self-regulation bill that is being considered by the Manitoba Legislature. We are pleased to see the work that has gone into this.

Questions?

***** (09:40)

Mr. Chairperson: Are there any questions? Seeing none, thank you for your presentation.

Ms. Scott: Thank you very much. Best wishes.

Mr. Chairperson: The next presenter is Phillip Reynolds, private citizen. Phillip Reynolds. That name is dropped to the bottom of the list.

The next presenter is Joanna Asadoorian, private citizen. I hope I got that name right.

Ms. Joanna Asadoorian (Private Citizen): You do. Honourable members of the standing committee of the House, good morning, and thank you for the opportunity to address the standing committee in my support of the bill to permit the self-regulation of Manitoba dental hygienists.

One of the main goals of health profession regulation is to ensure the provision of safe and proficient delivery of care, and it is the responsibility of each specific regulatory body to ensure that this does occur. As a PhD student with an ongoing research focus in quality assurance and continuing competency of health care professionals, and, also, as a practising dental hygienist, I have been working with the Manitoba Dental Hygienist Association and the legislation committee in envisioning the future of delivering quality dental hygiene care for the Manitoba public.

It is now well-recognized that simply monitoring individuals coming into the profession, also known as inputs monitoring–I can refer you to Model 1 on the second page, such as entry to practise requirements–is insufficient to ensure the continued competence and the improvement of health care providers. More contemporary ideals utilize mechanisms that monitor outputs, which are commonly included in continuing competency and quality assurance programs, and include continuing education programs or, I am sorry, include continuing education programs, practice audits and self-assessment, to name a few.

Research has demonstrated that, in health care professions, almost 25 percent of practitioners display either minor or major deficiencies. This indicates that ongoing examination of continuing competence and quality assurance programming is warranted. The MDHA views the proposed changes in legislation as an opportunity to implement quality assurance programming based on current knowledge, in order to ensure the ongoing competence of Manitoba dental hygienists and ensure quality delivery of care to the public.

Various mechanisms exist for achieving the goal of continuing competence of practitioners and quality assurance in practice settings. Outputs monitoring is designed to set the standards of competence for professionals, ensure that compliance with those standards is met and deal with those who do not meet the standards in appropriate ways. More traditional methods place a heavy reliance on triggers such as patient and peer complaints. This means that practitioners or practices that do not set off monitoring processes are not assessed periodically and/or rigorously.

The Manitoba Law Reform Commission asserts that relying on patient complaints is inappropriate as an isolated method for detecting defects. In their 1994 report, the MLRC recommended that each self-governing body should develop preventative measures which attempt to ensure that practitioners remain competent. They stated that self-governing bodies should not rely solely on consumer complaints to identify breaches of practice standards. They should actively supplement consumer complaints with other forms of detection.

The MLRC recommended that full advantage should be taken of all available methods to prevent improper delivery of care. Recognizing that the U.S. health care work force required substantial regulatory reform to ensure public health and safety in the mid-1990s, the Pew Health Professions Commission assembled a task force on health care work force regulation. The task force highlighted the limitations of currently, widely used continuing

competency methods, and recommended an emphasis on direct measures such as methods that assess practice structure like equipment and personnel, process, for example, patient care procedures and outcomes, such as measures of improved oral health status.

In a later report, the Pew task force recognized and supported Ontario models of quality assurance programming implemented under the Regulated Health Professions Act that utilized self-assessment and also professional portfolios. Recent recommendations have also supported an increase in non-professional representation on QA and continuing competency committees, with one-third to one-half public representation becoming an acceptable norm in new legislation. However, it is still essential that the professions themselves have an input in designing and carrying out their quality assurance programs because they often impose more demanding standards than those that are externally implemented. They are in a good position for the delineation of standards. Finally, the members themselves are more confident in a system that they have had a role in developing.

Of course, it needs to be recognized that no program will ever prevent 100 percent of improper conduct, and so disciplinary systems are also necessary.

It is becoming well accepted that outputs monitoring programs should have an increasing emphasis on application, rather than just on the acquisition of new knowledge and skills. Currently, self-regulated Canadian dental hygienists employ a full range of general outputs-monitoring systems, from the traditional, such as continuing education time requirements, to more contemporary and innovative methods, like mandatory self-assessment. Therefore, Manitoba dental hygienists have the advantage of accessing the collective expertise and various jurisdictional experiences for the development of their own continuing competency and quality assurance programs.

A full review of quality assurance and continuing competency programs for Canadian self-regulated dental hygienists has been previously published, and the emphasis of these programs is as follows: in British Columbia, they currently have a mandatory continuing education credit hours program, and, in Alberta, there is a mandatory continuing education program. However, both of these are currently under review. In Saskatchewan, there is mandatory continuing education credit-hour requirements. In Ontario, they have a mandatory professional portfolio with a heavy emphasis on self-assessment and self-directed learning. In Québec, they have a recommended, but not mandatory, continuing education program.

Other health professions in Canada have similar range in their general outputs-monitoring program, and can be similarly used as potential models for dental hygiene in Manitoba. Some of these program highlights include: the Manitoba nurses have a mandatory self-assessment and self-directed learning program; Ontario nurses have a mandatory reflective practice with self-assessment tool; the Ontario physicians use a mandatory peer review; and, in B.C., physicians have an optional peer-assessment program.

It makes sense for dental hygiene in Manitoba to draw on contemporary general outputs monitoring systems that have incorporated current research findings and are reflective of recently recommended reforms, while keeping in mind the distinct demographics of and resources available to dental hygiene in Manitoba. Some recommendations that have emerged from the recent literature include the use of a more proactive approach; for example, using mandatory methods for demonstrating competence, and moving to direct methods rather than those that are indirect, such as a departure from mandatory continuing education; and, also, beginning to implement non-triggered practice visits. Also, continuing to maintain professional input and increasing the public input in quality assurance and continuing competency programs with, what I mentioned, a minimum of one-third representation independently appointed from the profession. Also, increasing professional accountability.

I can state with confidence that the MDHA is acutely aware of the need to assure the continuing competence of dental hygienists to the public as part of its responsibility as a health profession, and that quality assurance and continuing competency program can also facilitate an opportunity for improving the overall standard of care provided.

As such, the MDHA is committed to pursuing evidence-based recommendations as part of their commitment to ensuring safely delivered and quality care to the public of Manitoba. Thank you.

Mr. Chairperson: Thank you. Any questions? Seeing none, thank you for your presentation.

Ms. Asadoorian: Thank you.

Mr. Chairperson: The next presenter is Rafi Mohammed, representing the Manitoba Dental Association. Please proceed when you are ready.

Mr. Rafi Mohammed (Membership Services Director, Manitoba Dental Association): Thank you. Good day. My name is Rafi Mohammed, and I am the Membership Services Director of the Manitoba Dental Association.

I have been asked by our president, Dr. Lee McFadden, to make this presentation to you on his behalf. I appreciate the opportunity to present our point of view about a bill that is before you, The Dental Hygienists Act.

***** (09:50)

As mentioned in the copy of a letter sent on March 4, 2005, we want you to know that we do not understand the need for the Legislature to proceed with the development of a dental hygienists act at this time. The Minister of Health (Mr. Sale), in his introduction of this bill, indicated that dental hygienists have a very broad scope of practice. The duties he mentions, administer oral anesthetic, orthodontic and restorative procedures, can only be provided to a patient while a dental hygienist is under the supervision of a dentist.

Dental hygienists have the technical capabilities to do some part of each of the mentioned services. They do not have the background or training to respond to emergency situations regarding needle injections or anesthetic. They can place in orthodontic appliances that are planned by dentists or orthodontists, and they can place a filling material into a tooth that has had the tooth cut to accept the filling material. Dental hygienists cannot cut into the teeth with a drill. The bill before you does not allow a dental hygienist to work unsupervised.

The minister went on to say that dental hygienists would have the capacity to treat people who live in rural or remote communities. Experience has shown in two jurisdictions where this is allowed, British Columbia and the state of Colorado, that dental hygienists do not locate in rural and remote areas, but remain in populated urban centres.

Under a by-law of the Dental Association, dental hygienists have had the opportunity to work in personal care homes without a dentist's supervision. To date, only a few dental hygienists have availed themselves of the opportunity, and they are mostly in the city of Winnipeg working for the Faculty of Dentistry outreach program. It is our understanding that the bill as drafted would establish dental hygienists as their own regulatory body, and establish a mechanism to investigate complaints about dental hygienists' services.

Other features outlined by the minister are not included in this legislation. Dental hygienists are currently regulated within The Dental Association Act and have been for 48 years. This alternative regulatory mechanism is well-established and working, and should be considered when it is determined whether or not dental hygienists should be self-regulating.

It is our belief that it is not possible to provide examples of any threat to the public under the current system. In 1994, the Manitoba Law Reform Commission report No. 84, *Regulating Professions and Occupations*, outlines tests that must be met before a group could be considered for self-governing legislation. In our reading of the report, dental hygiene would not meet the test described.

Recommendation No. 8 in chapter 2 of the report says, "If more than one form of regulation will adequately protect the public from the threat posed by the improper performance of the service, the least costly form should be selected." Currently, the annual licence fee for dental hygienists, administered by the Manitoba Dental Association, is $40.

Also, The Dental Professions Act working group, which was meeting at the request of the government, was considering the appropriate way to regulate all professions involved in oral health care: dentists, dental hygienists, dental assistants, dental therapists, dental technologists and denturists. The working group has presented a report to the government and awaits further instruction to continue its deliberations.

To single out dental hygiene for special consideration and development of an act will cause great concern for other members of the working group. Given that we do not see the need or the societal value to a dental hygiene act, here are some of our comments about the draft:

The draft is far too broad and lacks a definition of important principles such as scope of practice and changes to it, supervision, qualifications for registration and continuing competence. It is all well and good to say that these will be the subject of developing regulations, but they are so fundamental

to the establishment of a dental hygiene act that they must be known at the outset and widely debated.

Also, we would need to know at this time what stakeholder consultation is contemplated for review and discussion of developing regulations. Regulations that might describe how dental hygiene would be practised should not be produced without significant dentist involvement.

Should a dental hygiene act be passed by the Legislature, we would need significant clarification on the section dealing with entry to premises and inspections of records. For the most part, dental hygienists are employees in dental offices. Records would be the property of the dentist. How entry and inspection would be conducted must be developed with the full understanding and approval of the Manitoba Dental Association.

The legislative role of the Manitoba Dental Association is the protection of the public. Since 1883, the Manitoba Dental Association has been the regulating authority for dentists, and, since 1957, for dental hygienists as well. In our view, a separate and distinct act to regulate dental hygienists is unnecessary. Members of the Legislature will be required to spend valuable time debating this proposed bill and any update, amendment or regulation that will eventually be brought forward should such an act come into effect.

It is interesting to us that, at this time at the same sitting of the Legislature, you are considering amendments to the dental act to certify dental assistants. This procedure is appropriate from our point of view and should be considered as a model to follow for the regulation of dental hygienists.

If you have any questions, I would be happy to respond to them now. Thank you.

Mr. Chairperson: Any questions?

Mr. Denis Rocan (Carman): Mr. Mohammed, you make reference, I believe, on your first page, you say other features outlined by the minister are not included in this legislation. Would you want to elaborate a little bit on these other features?

Mr. Mohammed: Such as inspection of records in dental offices. Right now, the health records are the property of the dentist. Under the description within certain parts of the discussion paper, it was alluded to that dental hygienists would have access to those health records. Some appropriate way must be put in place to ensure that the health status of individuals is kept private, and that the dentist is the primary provider of any health care provided by patients within that dental office.

Mr. Lamoureux: Seems to me that Manitoba stands alone, west of New Brunswick, where we have not recognized this. Because you expressed concern in regards to scope of practice, are you familiar with the scope of practices in Saskatchewan and Ontario, and could you just give a comment if you are, on those?

Mr. Mohammed: Certainly, I think the scope of practice in the western provinces is probably similar to dental hygienists here in Manitoba. I think as a self-regulating situation in Saskatchewan, Alberta and B.C., dental hygienists in those provinces can work unsupervised within a period of time that the patient must be examined by a dentist. Certainly, that exists in those three provinces. It is a similar situation in Ontario, except, I believe, in Ontario dental hygienists are debating that issue, whether a patient needs to be examined by a dentist prior to being seen by a dental hygienist. The scope of practices is very similar in those various provinces. The issue is supervision requirements of dental hygienists, whether the dentist has to see the patient within a set period of time before being seen by the dentist, or whether there is a need for the patient to be examined by a dentist prior to being seen by a dental hygienist, and those are the major issues.

Mr. Chairperson: Any other questions? Thank you for your presentation.

The next presenter is Salme Lavigne, School of Dental Hygiene, University of Manitoba. Please proceed.

Ms. Salme Lavigne (Director, School of Dental Hygiene, University of Manitoba): Honourable Minister Sale, Mr. Martindale and members of the standing committee.

One of the hallmarks of a profession is the possession of specialized knowledge. As the director of the School of Dental Hygiene at the University of Manitoba, I can attest with confidence that dental hygienists are well prepared to assume roles as self-regulated health professionals.

The dental hygiene profession was founded in the early 20th century in Bridgeport, Connecticut, and was introduced in Canada in 1951. The intended role of the dental hygienist at that time was to educate the public about dental health and to serve in a health promotion, disease-prevention role in both private dental offices and in public schools. The

community health focus of the profession has continued to be one of the primary areas of dental hygiene specialization, along with the prevention and assessment of tooth decay and gum disease, including the treatment of periodontal or gum disease.

***** (10:00)

Over the years, the community health role spread to public health agencies throughout the country, where dental hygienists were able to work unsupervised as part of an oral health team that included dentists, dental hygienists and dental assistants. In those settings, they provided preventive education and therapeutic services to school children, the elderly, as well as those confined to institutions. However, a shift occurred in the latter half of the 20th century when state support of public health agencies began to wane. Additionally, the requirement of direct supervision of dental hygienists by dentists occurred throughout the country, preventing the majority the option of acquiring community-based employment unless a dentist was also employed by the agency. This led to the great majority of dental hygienists being employed by dentists in private dental practices.

The School of Dental Hygiene at the University of Manitoba was founded in 1963 within the Faculty of Dentistry, and graduated its first class in 1965. Although originally a two-year program with direct entry from high school, in 1991 a pre-professional year of university prerequisite course work was added, converting the total education to three years of university studies, totalling 99 credit hours.

First-year prerequisite courses are comprised of basic sciences similar to those required for other health professionals. The professional portion of the program is comprised of course work in oral health sciences, behavioural sciences, biomedical sciences and dental hygiene theory and practice. Several of these courses are combined courses with dentistry students.

Dental hygienists are distinct from dentists in that health promotion and disease prevention form the foundation of dental hygiene care. As such, dental hygiene is founded on a care-based model similar to nursing, rather than a cure-based model that is the primary focus of dentistry and medicine. Despite overlapping clinical scopes of practice in the area of periodontal therapy, dental hygienists are more specialized or focussed than general dentists in the provision of periodontal therapy and, in particular, health promotion and prevention, which dental students have little preparation in. Dental hygienists have more than 600 hours of clinical practice in periodontal therapy, compared to less than 150 hours of similar preparation in dentistry. In fact, dental hygienists are involved in the teaching of periodontal skills to dental students at the Faculty of Dentistry, which is not unique to Manitoba.

Dental hygiene graduates are well-prepared to practise as autonomous health professionals who will collaborate with other health professionals, including dentists, when encountering situations beyond their competence or scope of practice. This occurs in other provinces in Canada, thus permitting increased access to preventive oral health care services for those members of the public unable to attend traditional dental offices. For example, if you have attended a dental practice for the past 40 years, and suddenly become incapacitated and are not able to go to that practice, dental hygiene services are portable to any setting.

The University of Manitoba offers the only dental hygiene program in the province. It is fully accredited by the Commission on Dental Accreditation of Canada, and has maintained that status since its inception. Graduates of the University of Manitoba School of Dental Hygiene have made significant contributions to the health of not only the Manitoba public, but have assumed leadership roles both nationally and internationally.

One of the requirements of maintaining accreditation is the incorporation of evidence-based decision making throughout the curriculum. Graduates of the School of Dental Hygiene are educated to search and rank the most current literature and to incorporate the best evidence into their daily practices. Dental hygienists transfer this important knowledge to their practice through their assessment of the client's overall oral health and well-being. They assess not only the gums and the teeth, but also perform cancer screenings by assessing the oral soft tissues and the head and neck regions. They identify the presence of risk factors for oral diseases, as well as deficiencies in the client's oral hygiene practices. The development of well-rounded, evidence-based care plans to address all deficiencies through appropriate counselling, clinical interventions and referrals is an integral part of the dental hygiene process of care model.

Some examples of what might be included in a dental hygiene care plan are tobacco cessation

counselling, working closely with patients undergoing chemotherapy and radiation and advising new patients regarding the prevention of early childhood tooth decay.

Through extensive externship placements throughout the community and the province, dental hygiene students gain experience in a variety of community health settings, including long-term care facilities, personal care homes and First Nations' communities, to name just a few.

Clinical interventions addressing periodontal disease progression include invasive procedures such as scaling, root planing and soft tissue curettage, accompanied by the administration of local anaesthetic agents. Additionally, the application of periodontal medicaments to treat gum disease and the application of anticariogenic agents for the prevention of tooth decay require specialized knowledge.

A high level of clinic competence is necessary to safely perform these procedures, all of which have the potential to create harm. As such, it is important that the practice of dental hygiene continues to be regulated in order to protect the public, and, based on the recommendations of the Manitoba Law Reform Commission, regulation should not be employer-based.

In summary, dental hygienists are respected health professionals who possess specialized knowledge grounded in good science, are educationally prepared to deliver their scope of practice, abide by a national code of ethics, interact with other health professionals in their client advocacy role and serve in a primary capacity as oral health promotion experts and clinicians, whose main focus is on the health and well-being of the public. Dental hygienists are well-prepared to become responsible, self-regulated health professions.

Thank you for the opportunity to deliver this presentation. However, I would like to ask permission of the Chair to address a couple of items that Mr. Mohammed alluded to in his presentation.

Mr. Chairperson: Yes, you have two minutes left.

Ms. Lavigne: Thank you. The first one that I would like to address is the comment that Mr. Mohammed made about dental hygienists not being prepared or educated to respond to emergency situations, particularly during the administration of local anesthesia. That statement is not correct. They are very well-educated to respond to any emergency situation, and, in addition, they are also required to have currency in CPR, cardiopulmonary resuscitation.

The other issue is the matter of dental records. It is my understanding, and we have been advised by Manitoba Health, that, in the interest of public safety, the issue of being able to access dental records pertaining to an issue of patient safety or of clinician safety, and, in this instance, if it would be an issue addressing dental hygiene safety of practice, that there should not be a problem with that accessibility in the interest of public safety. This has occurred in other provinces as well who are self-regulated, that they are able to access records. It would not be the dental hygienist; it would be obviously a representative of the college of dental hygienists in the best interest of public safety. Thank you very much.

Mr. Chairperson: Any questions? Thank you for your presentation.

Bill 6–The Dental Association Amendment Act

Mr. Chairperson: With the agreement of the committee, we are going to hear the one presenter on Bill 6, The Dental Association Amendment Act.

So I call on Mr. Rafi Mohammed, Manitoba Dental Association. Please proceed when you are ready.

Mr. Rafi Mohammed (Membership Services Director, Manitoba Dental Association): Thank you. I am here to present support for the bill that is before you, Bill 6, The Dental Association Amendment Act. The proposed amendments before you will do a number of things to adjust the role of the Manitoba Dental Association and allow it to better protect the public. Until these amendments are enforced, there is no system in place to register and govern dental assistants who have trained to work in the mouth of a patient while under the supervision of a dentist.

Both the Manitoba Dental Association and the Manitoba Dental Assistants Association support these amendments. As well, the amendments would allow for an increase in the number of public representatives that serve on the MDA board. At least one third of the members of the board must be public representatives. To date, there is one public

representative on the board. With the amendment, there will be three. We welcome this increase and openness and transparency in the activities of the MDA board. Thank you.

Mr. Chairperson: Any questions? Thank you for your presentation.

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Mr. Chairperson: We are now going to go back to Bill 5 and call for the second and last time for Mr. Phillip Reynolds, private citizen. Mr. Phillip Reynolds. His name is now dropped from the list of presenters.

That concludes the list of presenters I have before me. Are there any other persons in attendance who wish to make a presentation? Seeing none, that concludes public presentations.

***** (10:10)

In what order does the committee wish to proceed with clause-by-clause consideration of the bills?

An Honourable Member: Five and six.

Mr. Chairperson: It has been suggested five and then six. Agreed? *[Agreed]*

During the consideration of a bill, the table of contents, the enacting clauses and the title are postponed until all other clauses have been considered in their proper order. Also, if there is agreement from the committee, I will call clauses in blocks that conform to pages, with the understanding that we will stop at any particular clause or clauses where members may have comments, questions or amendments to propose. Is that agreed? *[Agreed]*

We will now proceed to clause-by-clause consideration of the bills.

Bill 5–The Dental Hygienists Act

Mr. Chairperson: Does the Minister responsible for Bill 5 have an opening statement?

Mr. Sale: Very briefly, Mr. Chairperson. First of all, I want to, again, welcome the presenters and thank them for the work that they have done, not just to bring this bill forward, but to present, I think, very interesting briefs. It is somewhat unusual in a bill to have as much helpful and substantive content in terms of the profession being spoken of or the issue being addressed as we had this morning. I want to thank the various associations who spoke about collaborative practice and about the particular critical role that oral hygiene plays in overall health of the young, us middle-agers and the elderly.

The only other comment I wish to make, and I am going to be fairly blunt in this regard. The reason that we think this is a very important bill is not only the capacity and competency of the association to regulate itself appropriately and safely for the public, but to try and support the notion that collaborative practice and, particularly, the availability of services that focus on prevention and oral hygiene and, particularly, prevention in children will become more widely available. I think that there is a bit of a chicken-and-egg situation here, and that is that, until now, for the most part, the only jobs available have been directly in a dental practice. However, in the provinces where the profession has been regulated, there has not been a significant move to the profession finding ways to work effectively outside of the traditional model.

So I am very hopeful that the college and that the university and that our staff and department will quickly, and I underline quickly, get the regulations done because I think we sometimes take too long doing that. We have got models in other provinces, and we should move promptly in getting the regulations done.

Then, I think, we should be strategically addressing the availability of these services. We have serious challenges in Manitoba with our rural and remote communities. My understanding, I hope I am not incorrect in saying this, is that most dental hygienists do not practise, are not available outside of our larger practices in our larger centres. I am hopeful that that is because there have not been jobs.

I am also hopeful that we will strategically address the recruiting into professional training so that more students from rural and remote communities are deliberately recruited into our faculties, because the evidence is overwhelming that, when students come from home communities that are outside the city, there is a higher likelihood, not a certainty, but a higher likelihood that they will return and serve those communities and be comfortable in those communities. We have seen it in medicine; we have seen it in social work and teaching, in nursing. I trust that the same will be seen in this profession.

It is, I think, a stain on all of us that we have the level of child tooth decay and periodontal disease, particularly in our more remote communities. While I recognize that we do not need to have a dental hygienist to prevent that, that there is good public health education that is easily done by what we might call paraprofessionals or health educators, nevertheless, the availability of these services in our remote communities would do a great deal, I think, to promote oral health and thereby promote overall nutrition and health standards.

So I really welcome the bill. It is lovely that the students are all here because, often, we do not have this kind of attendance for a bill like this, but I do want to challenge you to think about how we then make the promise of the bill through the regulations and the availability of your services to a wider community a reality for us in the not-too-distant future. Thank you.

Mr. Chairperson: We thank the minister.

Does the critic from the official opposition have an opening statement?

Mrs. Heather Stefanson (Tuxedo): Well, I just briefly want to thank all the presenters who were here today for presenting what were very informative presentations, and just thank each and every one of you for taking the time out of your day to be here.

Also, to the students there, as well, to thank you for coming and being a part of this legislative process. I really do not have anything else to add to that but, again, just thank you so much for being here and being a part of this process.

Mr. Chairperson: We thank the members for their statements.

Shall clause 1 pass?

Mr. Lamoureux: Mr. Chairperson, I am going to also use this opportunity to express our appreciation of seeing the presenters come forward and express their thoughts on what is a very important bill. In fact, it is, as my colleague in opposition has indicated, very rewarding to see young people, which is going to be the future of the profession, take such an interest in the procedures in bringing this bill forward.

Having said that, I think that it is also important to note that this is legislation. We are the last west of New Brunswick to bring forward this legislation. It is, in fact, a substantial piece that could have been dealt with previously. We do support the legislation and would like to be able to see this legislation be given third reading. But I think it attempts to address a very important issue of decay in which we have raised in second reading, and we hope that the government would take a more proactive approach at dealing with the problem. But, for now, we just want to express our appreciation for those that had taken the time to come before the committee and make presentations. Thank you.

Mr. Chairperson: Clause 1–pass; clause 2 and 3–pass; clauses 4 and 5–pass; clause 6–pass; clause 7–pass; clauses 8 and 9–pass; clause 10–pass; clauses 11 and 12–pass; clauses 13 and 14–pass; clauses 15 and 16–pass; clause 17–pass; clauses 18 through 20–pass; clauses 21 through 23–pass; clause 24–pass; clauses 25 and 26–pass; clauses 27 and 28–pass; clause 29–pass; clauses 30 through 33–pass; clauses 34 through 36–pass; clauses 37 and 38–pass; clauses 39 and 40–pass; clauses 41 and 42–pass; clauses 43 and 44–pass; clause 45–pass; clause 46–pass; clause 47–pass; clauses 48 and 49–pass; clauses 50 through 52–pass; clause 53–pass; clause 54–pass; clause 55–pass; clauses 56 and 57–pass; clause 58–pass; clauses 59 through 61–pass; clause 62–pass; clauses 63 through 65–pass; clause 66–pass.

***** (10:20)

Clauses 67 through 69–pass; clause 70–pass; clause 71–pass; clauses 72 through 74–pass; table of contents–pass; enacting clause–pass; title–pass. Bill be reported.

Sorry. Excuse me. Ladies and gentlemen, I understand your enthusiasm, but you are not allowed to participate in the proceedings of the committee in any way.

Bill 6–The Dental Association Amendment Act

Mr. Chairperson: Does the minister responsible for Bill 6 have an opening statement?

Mr. Sale: No, Mr. Chairman.

Mr. Chairperson: We thank the minister.

Does the critic for the official opposition have an opening statement? Thank you.

Clauses 1 and 2–pass; clause 3–pass; clauses 4 and 5–pass; clause 6–pass; clause 7–pass; clauses 8

through 11–pass; clauses 12 through 14–pass; clauses 15 through 17–pass; clause 18–pass; clauses 19 and 20–pass; clauses 21 and 22–pass; clauses 23 through 25–pass; clauses 26 and 27–pass; clauses 28 and 29–pass; clauses 30 through 35–pass; clauses 36 through 43–pass; clauses 44 and 45–pass; clauses 46 through 49–pass; enacting clause–pass; title–pass. Bill be reported.

The hour being 10:23, what is the will of the committee?

Some Honourable Members: Committee rise.

Mr. Chairperson: Committee rise. We are adjourned.

COMMITTEE ROSE AT: 10:23 a.m.