The Saskatchewan Dental Plan: friend or foe?

Definitely not a friend, says Dr. Terry Donovan of Regina. In the following *Viewpoint,* he points to the flaws in the S.D.P. and offers some survival strategies to private practice for avoiding the pitfalls of the Saskatchewan experience.

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The Saskatchewan Dental Plan (S.D.P.) was implemented by the provincial government in 1974 and originally provided dental care to six-year-olds. As of April 1978 it covers children born in the period 1967 to 1973, and eventually will cover children up to age 18.

The plan is modelled basically after New Zealand's dental program, with minor modifications. Dental care is delivered in small clinics established in schools throughout the province, and service is provided by dental nurses (graduates of a two-year course at a technical institute in Regina); dental assistants; and a small group of supervisory dentists.

Dr. Donovan maintains a full-time private practice in Regina, Saskatchewan. A 1967 graduate of the University of Alberta Faculty of Dentistry, he is past president of the Saskatchewan Society of Dentistry for Children and the College of Dental Surgeons of Saskatchewan. Currently he is director of continuing education and chairman of the Auxiliary Services Committee, College of Dental Surgeons of Saskatchewan.

Each child is examined by a dentist *when he or she enters the plan and thereafter whenever the dentist deems necessary.* The result: most care (recall examinations, fillings, primary extractions, stainless steel crowns, pulpotomies, etc.) is given by dental nurses — on a relatively unsupervised basis.

A child can, under specific circumstances, be referred to private practitioners, but this accounts for a negligible portion of the program.

The S.D.P. was established with virtually no consultation with the profession. A board was formed, and it did review submissions from a variety of sources, including the dental profession. But the basic decisions on program design[1] had already been made, and, in fact, almost all the recommendations made by the profession[2] were summarily ignored.

Weaknesses of the S.D.P.

I sincerely believe that the S.D.P.'s delivery system results in several deficiencies that affect the quality of care given to the children. Moreover, I feel that the costs of the plan are unnecessarily high; if a similar plan were implemented in many areas of Canada, severe hardship would result for many private practitioners.

The weaknesses of the plan, as I see them, are as follows:

1) There is a lack of adequate supervision of the dental nurses.

2) Children are only examined once a year, when it is widely recognized that children in the mixed dentition stage should be seen more frequently.

The implications of (1) and (2), with regard to interceptive orthodontics are obvious.

3) Parents are not an integral part of the program. The very design of the plan (school clinics) mitigates against their involvement. This has tremendous implication regarding the potential of prevention — what is accomplished by telling six-year-old Johnny that there is no fluoride in his water and that he must take fluoride supplements?

4) The basic dental care is reduced to the lowest common denominator. Techniques in psychosedation, molar endodontics, etc., are not included in the program.

5) The plan is modelled after New Zealand's concept in which the preventive result has been nil; hence, the long-term benefits are questionable.

6) There is no freedom of choice as to the provider of care. Since den-

tistry is such a personal thing, I believe this is an important deficiency.

Strategies for survival

1) The profession must take a long, hard look at its philosophy of need and demand. As we all know, the *need* for dental services across the population approaches 100%. The *demand*, however, generally averages about 50%.

A number of factors account for this disparity. Politicians may immediately focus on financial barriers, but this is a minor factor, well behind fear, ignorance (or more aptly, "lack of appreciation for the benefits of dentistry"), and perhaps the geographic distribution of dentists.

The dental profession has made some efforts to help translate this need into demand (although I would call it merely "paying lip service"). We have public education programs, dental health week, etc., but the fact remains that organized dentistry seems content to attempt to satisfy the demand and let the "government," through its public health agencies, worry about the need. Perhaps to be fair, this has been merely a function of the fact that only recently we, as a profession, have even begun to satisfy the demand.

2) As a profession, therefore, our first priority should be a solid commitment to finding ways of translating the need into demand. Politicians perceive the present situation simplistically — 50% of the population is not receiving dental care — so their intervention is both political and altruistic. However, when translated into "denticare" of some sort or other, its method of implementation has tremendous implications for private practice.

3) Organized dentistry must *act* rather than *react!* The lesson is there to be learned — both from the British experience[3] and that of Saskatchewan. Provincial dental organizations and the C.D.A. must actively research the problems and approach governments with workable programs for "denticare." This will initiate discussions around *our* game plan. Many would counter this approach with the "let sleeping dogs lie" philosophy, but especially in this age of social awareness I think this is a foolhardy position — *regardless of the political situation* in any given province.

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Economic effects

Fortunately the dentist/population ratio in Saskatchewan has been low (1:4300). Hence, the economic effect of removing children from a practice is minimal. In fact, most dentists have reported increased earnings due to the increased time spent on dentistry for adults, which *can* be more lucrative on a per hour basis. However, for dentists who enjoyed a sizeable paedodontic practice, the implications of the plan are clear.

Worth considering are the effects of a similar plan on centers in Canada where the dentist/population ratio is much higher — Vancouver or Toronto, for example, where many dentists are experiencing difficulty even starting a practice.

I believe the S.D.P.'s delivery system is not the best, and I think most dentists will agree with me on this. Therefore, I offer the following strategies that may help prevent the same situation from developing elsewhere in Canada.

To lie back and wait is to allow the social planners first draft of any program, and unfortunately, they do not think in terms of an optional dental program, but in terms of logistics and administrative efficiency. While important, these should not be the criteria for establishing a dental plan.

In terms of economic cost, a program like the S.D.P. is extremely expensive[4] and many alternative delivery systems, including private practice, can provide care less expensively. Qualitative analysis of various delivery systems would also demonstrate the superiority of private practice in delivering optimum dentistry. However, two fundamental weaknesses must be overcome in the private practice model before we can reasonably expect acceptance of its use in "denticare."

1. Utilization rate. The greatest strength of a school-based dental plan is that it can achieve a very high rate of utilization. At present, the S.D.P. claims a utilization rate of 85%. (The true rate is somewhat controversial, but does lie between 75 and 85%.)

This compares most dramatically with the utilization rate of most private dental insurance plans, which seems to run about 50%. The utilization rate of Quebec's dental plan for children is also, I believe, quite low.

This low rate is one of the great impediments to the use of private practice as the primary delivery system.

It has been demonstrated that those who utilize dentists are above average in educational level. Generally speaking, a high level of education correlates quite closely with a high income. As a general principle, most dental programs will be funded out of general revenue. Thus it can be demonstrated that *the poor will pay for the rich to have their dentistry done.*

This is a negative redistribution of income,[5] which is absolutely unacceptable to most politicians. (Although many economists oppose the principle[6], it is a fact of life that most governmental social programs are designed to help redistribute income from the advantaged to the less advantaged.)

If private practice is to remain in the ball game, ways must be found to overcome the utilization problem. In B.C. the profession has been actively researching this area for some time, and has established a committee along with the major insurance carriers to find ways of improving utilization. Since both parties have a huge stake in the survival of private practice, they should develop some interesting proposals. Obviously, outreach,

with all its ramifications, must be an integral part of any proposed program, and the profession will have to come to grips with the issue of whose responsibility this is.

With a change in government, Manitoba also has a second chance. (Manitoba implemented a dental plan similar to Saskatchewan's under the previous N.D.P. government. The plan began theoretically with "rural" areas, but a conflict exists over what constitutes a rural and an urban area. In any event, many dentists there have felt the economic impact of the plan.) Now, with the change to a Conservative government, private practice has been given a chance to show what it can do. I believe if the Manitoba Dental Association can demonstrate success in percentage utilization and find a way to solve the distribution problem (which is not all that bad in Manitoba), that private practice should show up well there.

2. Geographic distribution. Almost all areas of North America have a problem of geographic distribution of dental services to some extent, since dentists tend to congregate in urban areas and the more rural areas are left without regular service.

It becomes a political problem to offer a service to the people in which some people fail to have equal access to that service. (This also affects utilization, of course.) Therefore, it becomes incumbent upon the profession to ameliorate this situation. There are many potential ways to attack the problem; it is a very real hurdle in our path.

The profession in B.C. has tackled this problem head on and spent a tremendous amount of money establishing and manning modern clinics in remote areas within the province. It takes manpower and dollars to identify needy areas and encourage dentists to locate there; it is a difficult commitment to make, but one that is necessary if private practice is to prevail.

I have used B.C. as an example, not because this is the only province where dentists are concerned, but because I believe they are on the right trail. B.C. has had excellent leadership in recent years, with expert advice from their economic consultant. They are attacking the problems head on with imagination, money and hard work. This, coupled with a change in government, has resulted in an optimistic future for private practice in B.C.

Summary

Organized dentistry must examine its philosophy and efforts in delivering dental care to Canadians. If we wish to be the prime provider of care through private practice, I believe it is essential that we make a determined effort to translate the population's dental need into demand.

It follows then that efforts must be made to design a delivery system that will result in high utilization by the public and improve the geographic distribution of dental manpower.

Dental organizations must therefore initiate discussion and action with appropriate parties so that dentistry can enjoy a preferred future rather than one that is thrust upon us. It may be a high price to pay, but then, what are the alternatives?

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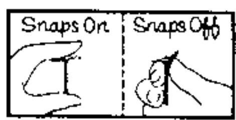

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Observations on the Saskatchewan Dental Plan

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In November 1975 several members of the Ontario Dental Association visited with the staff and students of the Wascana Institute in Regina who direct and deliver dental services to the children of the Province under the Saskatchewan Dental Plan (SDP).

The purpose of the trip was to collect information about the SDP from Dr. Graham Keenan of the Wascana Institute, Dr. Michael Lewis and his staff of the Saskatchewan Dental Plan, together with The College of Dental Surgeons of Saskatchewan. The information gathered, together with the growing experiences of the young SDP, may be useful in any planning for a children's denticare program in Ontario.

The education of the dental nurse in Saskatchewan as an expanded duty auxiliary has been well documented in an article by Keenan (1975); hence, the aims and structure of this program will not be repeated in this brief report.

The SDP began in September, 1974 and covered only the six-year-olds. In 1975-76, ages five, six and seven were to become eligible and by 1978-79 the target group of three- to twelve-year-olds will have been covered.

The basic objective of the Plan is very general — to improve the dental health and care of the children of Saskatchewan. Dental care is provided mainly by the dental nurse (DN)–dental assistant (DA) teams who operate out of school clinics. There is no direct payment by the parent for eligible children, however those parents wishing to take their children to private practicing dentists must pay the total cost of the care provided and they are not reimbursed.

Central administration of the Plan is provided out of Regina. The province is divided into six regions and each region has a dental director (dentist), an administrator (non-dentist), an equipment service man, clerical staff and numerous DN-DA teams.

250 clinics in operation

At the time of our visit there were 14 salaried dentists and 92 DN-DA teams operating some 250 clinics of which three are multi-chair fixed facilities. The school clinics mainly have portable equipment which is moved from school to school by station wagons. Many clinics have no facilities for x-ray equipment, which necessitates transporting children many miles to another clinic. The supervising dentist oversees approximately six DN-DA teams and visits them on an average about every six weeks. At the present time each DN-DA team is expected to care for about 510 children in the clinics which operate mainly during the school day (9:00 a.m. – 3:30 p.m.).

The dentist is responsible for the initial examination and the treatment plan of each new eligible child, as well as the referrals to private practitioners by the DN. The DN does some preventive care including classroom dental health talks, and most of the operative care as well as the deciduous extractions. Most of the recall examinations and treatment plans are also done by the DN. The DA acts as a chairside assistant, applies the rubber dam and does much of the individual preventive procedure.

Diagnostic and preventive services are available on an annual basis. Initial examination and treatment plan by the dentist includes a pair of bite-wing radiographs and one maxillary periapical. Recall examinations and treatment plans for most children are done by the DN. The dentist may examine some children referred to him by the DN but otherwise a child apparently may go through the program without being examined again by a dentist. This is a gross inadequacy in the SDP, for development problems can presumably go unrecognized.

Preventive services include oral hygiene instruction, prophylaxis and topical fluoride application and this seems to be routinely applied on an annual basis.

Restorative care and required extractions are available as required. Specific exclusions are major orthodontics and cosmetic dentistry. Space maintenance has been provided but many cases requiring space maintenance have not been completed. Currently there is no orthodontic care but it is intended to enter into this area when the operation of the initial phase of diagnostic, preventive and restorative care is proceeding satisfactorily.

Referrals of cases from the plan to a private general practitioner or specialist are possible. The principal reasons for referrals are the behaviour problems, patients on special medication, patients with special dental problems and emergencies. There were very few specialty referrals except for some surgery. Since the SDP does not have an emergency service in off-school hours, referrals to private dentists for emergency treatment are necessary.

One main problem in the program is communication with parents. There has been some difficulty getting parents in for consultation at the child'e initial appointment. Also, some parents have complained that treatment wasn't being done quickly enough while others have complained of overtreatment. In addition there has been much concern about dental radiographs, loss of school time and the long distances the children must sometimes travel.

13,000 children at $158 per capita

Total, per capita and breakdown of SDP costs for the first year's operation are available from the Saskatchewan Department of Health. It is known that the cost per enrolled child is $158.29.

More than 14,000 six-year-olds were eligible for care and by actual count 13,140 children were enrolled in the Plan. All but about 10% of those enrolled received complete care under the terms of the Plan. Included in this 10% were children with only space maintenance requirements outstanding. Of the eligible children not enrolling, some continued to get care at their private dentists, others wanted the plan and will enroll, and only a few stated they did not understand or could not fill out the necessary forms.

Restorative work was handled generally very well by the DNs and upon examination, the quality of the restorative work and one-to-one preventive, staining and flossing routines in clinics were impressive. Generally, two restorations would be done per quadrant when indicated. However, the productivity in terms of patients seen — generally four to six patients daily — was low.

These children were not receiving total dental care but some certainly were receiving care they had not received before.

Some concern expressed

A short visit with three representatives of the College of Dental Surgeons of Saskatchewan revealed their concerns about their treatment by government health authorities at the time of the initial development of the SDP and its current operation. These dentists did not feel it had affected their practices greatly. It was suggested that the parents of some of the children using the SDP were now coming in for dental treatment because of a greater dental awareness.

Because of the heavy demands for care in their practices, the dentists feel that they could use DN in their offices, but the government refuses at this time to permit DN to work in private practice.

Some general comments can be made on the Saskatchewan Dental Plan. Of note are the following:

- The costs per patient apparently are very high. Although these costs will be reduced with plan expansion, it is highly unlikely that they will be competitive with private practice.
- The true total costs of the Plan will be difficult to determine as more than one ministry is involved.
- The quality of the restorations observed was excellent.
- Preventive services are presented on a one-to-one basis.
- The distribution of DN-DA teams will eventually be a major administrative problem.
- As the program expands, the increasing complexity of examination, diagnosis and treatment procedures will exceed the present-day capabilities of the Plan.
- There is an extreme lack of radiographic equipment.
- There is a little emphasis on interceptive orthodontics, and there was no consideration for minor orthodontic treatment.
- There is no definite arrangements for re-examination by a dentist.
- These children were not receiving total dental care but some certainly were receiving care that they never received before.

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