


Help! Teeth Hurt



Government's Obligation to Provide Timely Access
to Dental Treatment to B.C. Adults Who Have
Developmental Disabilities:
A Legal Analysis

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BARRISTER & SOLICITOR

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For Graeme

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EXECUTIVE SUMMARY

Adults with developmental disabilities (DDs) in British Columbia face enormous barriers in accessing necessary dental treatment in a reasonable time. Those who have such fragile medical health that they require hospitalization for dental treatment are placed on wait-lists that are often longer than two years. Other adults with DDs who potentially could be treated in community dental clinics also are unable to access care because the provincial dental plan that insures them is so low that many dentists are unwilling to accept these adults as patients. In addition, many dentists feel unqualified to treat the complex dental needs of adults with DDs.

Chapter 1 of this report explains the background to this problem and describes the barriers to treatment. Chapter 2 analyzes the legal rights of adults with DDs to receive necessary dental treatment in a reasonable time and concludes that government's failure to ensure that adults with DDs receive timely access to necessary dental treatment is a breach of their *Charter* rights and human rights and is a breach of government's duty of care. Chapter 3 examines the history of provincial responsibility to care for adults with DDs under statute and through policy. Based upon this history, it argues that government owes a private law duty of care to these adults. In fact, this report finds that government potentially owes a fiduciary obligation to adults with DDs to ensure their health and well-being, including providing timely access to necessary dental treatment.

Chapter 4 describes the dental plan insuring B.C. adults with DDs and compares similar dental plans offered by other Canadian jurisdictions. This comparison highlights improvements that B.C. could make to its plan based on practices adopted in other provinces. Chapter 5 describes the legal remedies available to adults with DDs who have suffered because of government's failure to ensure timely access to necessary dental treatment. It also recommends steps government might follow to address and resolve this problem.

Government is also responsible to ensure that the College of Dental Surgeons of B.C. meets its duty to serve and protect the public. The college fails in this duty if dentists are not qualified to treat all members of the community, including adults with DDs.

Background information for this report was provided by dentists and dental specialists, dental hygienists and dental organization administrators, hospital administrators, families and care providers for adults with DDs. The historical research included information from the records of the B.C. legislative assemblies, *Journals* and *Hansard* as well as current legislation and case law. The conclusions reached and opinions offered are solely those of the author.

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Joan L. Rush, LL.M.

Visiting Scholar, UBC Faculty of Law, 2012

CHAPTER 1

The Issue

“HELP TEETH HURT.”¹ These were the first words painstakingly typed out with one finger by Carly Fleischmann when she learned to use a computer at the age of 10. Carly is a young woman with severe autism who cannot speak or write by hand. Carly’s first words were not to express her love for her family or her wish to talk, although both are deep. Her first words were a desperate plea for dental treatment. Carly’s recent communication breakthrough mesmerized the disability community, but her first words also highlight a serious problem.

Framing the Problem

Like Carly, many B.C. adults with developmental disabilities (DDs)² suffer with pain from tooth decay, but it is extremely difficult for most of them to receive necessary dental treatment. The serious implications of tooth decay (medically known as “dental caries”) are well documented. According to a report from Ontario’s chief medical officer of health, “Apart from structurally weakening teeth, dental caries can lead to infection, pain, abscesses, chewing problems, poor nutritional status and gastrointestinal disorders.”³ A position paper from the Canadian Dental Association reported, “Patients with physical and developmental disabilities ... are particularly prone to dental caries and periodontitis that can have a catastrophic impact on their survival and ability to thrive.”⁴

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1. Arthur Fleischmann, “A new voice for autism,” *Chatelaine* (16 March 2012), online: Chatelaine <<http://www.chatelaine.com>>.
 2. Generally meaning significantly impaired intellectual functioning: see definition later in this chapter.
 3. Ontario, Ministry of Health and Long-Term Care, *Oral Health—More Than Just Cavities: A Report by Ontario’s Chief Medical Officer of Health* (Queen’s Printer for Ontario, 2012) at 6 (Chief Medical Officer: Arlene King) [*Oral Health*].
 4. Canadian Dental Association, *Position Paper on Access to Oral Health Care for Canadians* (Ottawa: CDA, 2010) at 5, online: CDA <http://www.cda-adc.ca/_files/position_statements/CDA_Position_Paper_Access_to_Oral_Health_Care_for_Canadians.pdf> [*CDA Position Paper*]. See also MA Jaber, “Dental Caries Experience, Oral Health Status and Treatment Needs of Dental Patients with Autism” (2011) 19 *J Appl Oral Sci* 212 (children with autism had significantly higher rates of filled, missing or decayed teeth compared to the control group).

The most seriously challenged adults with DDs in B.C. face enormous barriers in accessing dental treatment. They are placed on wait-lists of two to three years⁵ to access care in the few B.C. hospitals that provide dental treatment to adults under general anaesthetic (GA). While waiting, they may receive regular heavy doses of pain relief, such as ibuprofen, which can lead to other medical complications. Like Carly, many of these people cannot speak and do not read or write. Since they have no other way to communicate what they are feeling, they sometimes beat their heads or bite their arms from pain.

The cases of self-abuse because of dental pain are heartbreaking. The provincial nursing consultant for Community Living B.C., the B.C. Crown agency that supports adults with DDs, recalls a case of a man beating his head so fiercely from dental pain that his retina detached, rendering him partly blind. Care providers describe cases of clients who have broken bones in their faces from beating their heads because of dental pain. The care providers regularly medicate clients suffering from dental pain, often with heavy doses of pain relief or with tranquilizers.

One young autistic man, who, like Carly, cannot speak, beat his ear so severely because of a dental infection that it is permanently deformed; the side of his head has a permanent swelling. His arms are scarred from biting them because of dental pain. He was given massive amounts of ibuprofen, Tylenol and codeine while waiting to access dental treatment, but his dental pain did not abate until he was finally treated in hospital. By that time, five of his teeth needed root canal treatment.⁶

Many dentists and care providers in B.C. have confirmed that lack of access to dental treatment for B.C. adults with DDs is not simply common: it is an epidemic.

Lack of access is not restricted to people placed on hospital wait-lists. B.C. adults with DDs who do not require hospitalization also do not receive timely access to necessary dental treatment. Adults with DDs in B.C. are insured under a government dental plan that pays approximately 60% of the fee guide recommended by the BC Dental Association (BCDA).⁷ Some dentists are not willing to accept the lower payment, particularly for clients who may require more time to treat. In addition, many dentists in dental clinics do not feel professionally competent to treat this population and instead direct them to the hospital. These adults join the more medically fragile or behaviourally challenged patients with DDs waiting to be seen in hospital operating rooms. And there is no (operating) room at the inn.

5. Typical wait times for dental surgery confirmed by staff at Vancouver General Hospital Dental Clinic are 24 to 27 months, as at October 2012.

6. Case of GR, VGH Dental Clinic patient, documented 2008.

7. Based on a comparison of the rates set out in the British Columbia Dental Association, *Fee Guide for Dental Treatment Services Provided by General Practitioners and to Geriatric Patients Requiring Out of Office Care* (Vancouver, BC: British Columbia Dental Association, 2012); with British Columbia, Ministry of Social Development, *Dental Supplement: Dentist* (1 April 2010) at 1-23, online: Province of British Columbia <<http://www.eia.gov.bc.ca/publicat/pdf/dentistschedule.pdf>>; published pursuant to the *Employment and Assistance for Persons with Disabilities Act*, SBC 2002, c 41 (government rates have remained constant since the schedule was published on January 1, 2007).

B.C. adults with DDs have enjoyed a relatively short history of being included in community.⁸ Until the early 1990s, many of these people were housed in government-run institutions such as Woodlands Hospital (Woodlands) in New Westminster, originally known as the Provincial Hospital for the Insane (PHI).⁹ Woodlands played many roles; it was a residence, a school and a hospital. It housed an operating theatre and employed a dentist for the residents.

Starting in the early 1970s, the concept of Community Living was expanding in B.C. as a way of caring for people with DDs. Progressively, community and government agreed that keeping adults with DDs in a locked institution was in breach of their human rights. The hospital-like wards of Woodlands did not provide a healthy social or educational environment. However, the institutions did provide timely access to health and dental treatment.¹⁰ When Woodlands closed in 1996, many government officials and families assumed that former residents would access treatment in community, just like all other members of society.

However, some of these adults have such complex medical and/or behavioural conditions that they can only receive dental treatment under GA in hospital. For example, some adults with Down syndrome have misshapen jaws holding too many or too few teeth, so that they require specialized treatment. Some adults with cerebral palsy may be unable to hold their mouths open for a complete dental examination. Some adults with autism may become anxious to the point of violence in the dental clinic.

The B.C. Ministry of Health was aware of this problem. In a joint proposal to government regarding transition to community, the Ministries of Social Services and Health explained that a “Specialized Medical Clinic” and “Other Health Services” would be provided by the Ministry of Health.¹¹ Sadly, no such clinic was ever built. Despite “25 years of planning”¹² for the transition to community, the provincial health care system did not create a replacement special-needs health clinic, dental clinic or special operating theatre where people with DDs could be treated under GA. The institutions had provided dental treatment for these adults. On gaining their freedom, adults with DDs entered a community that offered little access to dental treatment in community and a health care system unresponsive to the need for many of them to be treated in hospital.

8. A detailed history of the institutionalization of people with DDs in B.C. is set out in Chapter 3.

9. Other B.C. institutions for people with DDs included Tranquille in Kamloops and Glendale in Victoria.

10. Dulcie McCallum, *The Need to Know: Administrative Review of Woodlands School* (Victoria, BC: Ministry of Children and Family Development, 2001), online: B.C. Association for Community Living <http://www.bcacl.org/sites/default/files/The_Need_to_Know.pdf> [*Need to Know*] (Ms McCallum, the former Provincial Ombudsperson, found that many residents of Woodlands suffered abuse).

11. British Columbia, Ministry of Health & Ministry of Social Services and Housing, *Planning for the Future: A Proposal for Services for People with Mental Handicaps* (Victoria, BC: Ministry of Health, Ministry of Social Services and Housing, 1991) at 3 (see chart titled: *Network of Services to Support Adults with a Mental Handicap [By 1994]*).

12. *Choices: Downsizing of Woodlands and Glendale*, VHS: (Victoria, BC: Ministry of Social Services and Housing, 1989) (available at the Ministry of Health—Health and Human Services Library) [*Downsizing*].

A report prepared for the Ministry of Social Services and Housing in 1988 stated that government needed to develop options to get other agencies and community resources involved, such as mental health clinicians, doctors and dentists. However, the report did not set out a detailed plan to accomplish this goal apart from recommending that a list of such resources be created to provide to agencies.¹³

Government actively encouraged families to move their children or family member to the new community settings,¹⁴ and families facing the transition were told that government funds directed to new community services would equal the costs of maintaining the institutions.¹⁵ In view of the current wait-lists for dental treatment and lack of available treatment in community, it would appear that promise was not kept by government.

Instead of funding a dental clinic, the Ministry of Health created a dental hygiene program under which part-time dental hygienists throughout the province, whose total hours would equal five full-time equivalent workers, would train care providers at the newly created group homes in proper dental hygiene for adults with DDs. These dental hygienists are employed by the provincial Health Authorities to provide care to various groups, and not only adults with DDs served under the Health Services for Community Living (HSCL) program. Their job is made difficult due to the ongoing turnover of staff at the group homes and the fact that they can often dedicate only a small portion of their working hours to the Dental Hygiene HSCL program.

Dr. Malcolm Williamson, the senior dental consultant for B.C.,¹⁶ advised that although the HSCL dental hygienists provide a highly regarded service, they are understaffed to meet the needs of this client group. In addition, he is aware that they despair the lack of access to necessary dental treatment for their clients, particularly those adults with DDs who must be seen in hospital. In essence, the Province agreed to fund, to a limited extent, expert training for caregivers on how to brush and floss the teeth of adults with DDs but failed to provide sufficient funding to ensure that caries or infected teeth could be treated. Some adults in group homes have now lost all their teeth and must eat finely chopped food, which detrimentally affects their digestion.

Dr. Williamson confirmed that there is no formal responsibility and “nothing in place” in the Ministry of Health regarding dental treatment under GA for adults with DDs. He advised that a new position is required to deal with this issue. He explained that hospitals have no documents or protocols concerning

13. British Columbia, Ministry of Social Services and Housing, *The Review, Services for Individuals with Mental Handicaps: The Downsizing of Woodlands* (Victoria, BC: Ministry of Social Services and Housing, 1988) at 19-32.

14. *Going Home: Life Outside Woodlands*, VHS: (Woodlands, 1987) (available at the Ministry of Health—Health and Human Services Library).

15. *Downsizing*, *supra* note 12.

16. Interview of Dr Malcolm Williamson, Senior Dental Consultant, BC Ministry of Health (19 June 2012) [*Williamson*] (he is sometimes described as the Senior Dental Advisor in Ministry of Health correspondence).

the dental support needs for adults with DDs. He believes that the Province should have an “overall policy” on the matter. However, neither he nor any other member of the Ministry of Health has yet prepared such a policy.

Dental treatment is an odd duck floating on the sea of Canadian health care. Dentists and medical doctors agree that dental decay leads to other medical complications. Dental literature has linked dental infection to heart disease and diabetes, among other serious medical conditions.¹⁷ However, the federal and provincial Poseidons who rule the sea of Canadian health care have determined that dental treatment generally does not belong in the water. Consequently, many low-income Canadians who cannot afford private dental treatment, including indigenous peoples, the aged and the disabled, suffer from lack of access to affordable dental care.¹⁸

Yet the people who unfairly and wrongly suffer the most from lack of timely access to necessary dental treatment are adults with DDs who require treatment in hospital. Both the *Canada Health Act*¹⁹ and the *B.C. Medicare Protection Act*²⁰ include “surgical-dental services” or “dental and orthodontic services”²¹ as a covered benefit where treatment is required in hospital. These adults cannot be seen in community, but the hospitals do not provide them timely access for necessary dental treatment because it is not typically insured under our health care system. They have no voice to demand timely treatment and so they go untreated, sometimes for years.

Since the 1990s, as more children with DDs living in community have become adults, the problem of access to necessary dental treatment has worsened. And now it is a crisis.

About This Report

This report argues that the B.C. government is obligated to ensure that B.C. adults with DDs can access necessary dental treatment in a timely fashion. There is not only a moral and ethical obligation for government to ensure that adults with DDs do not live with dental pain and progressive dental caries, there is also a clear legal obligation.

For adults with DDs who require treatment in hospital, the failure to provide timely access to dental-surgical treatment necessary to alleviate pain, progressive dental decay or extreme anxiety is a breach of their *Canadian Charter*²² rights to life, liberty and security of the person and is a breach of their human

17. *Oral Health*, *supra* note 3 (“There is also a growing body of scientific research suggesting that a relationship exists between periodontal disease and a number of serious health conditions” at 6).

18. *CDA Position Paper*, *supra* note 4.

19. RSC 1985, c C-6 [CHA].

20. RSBC 1996, c 286; *Medical and Health Care Services Regulation*, 426-97 [MHC Reg].

21. *CHA*, *supra* note 19, s 2; *MHC Reg*, *supra* note 20, s 19.

22. *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982 (UK)*, 1982, c 11 [Charter].

rights under the B.C. *Human Rights Code* [HRC].²³ The Province of B.C., and in particular the Ministry of Health, is in breach of these legal rights owed to adults with DDs by failing to ensure reasonable access to necessary dental treatment.²⁴

In addition, those adults with DDs who can tolerate dental treatment in community must also receive timely access to necessary treatment. This report sets out research on the scope of government's obligation to ensure timely access to necessary dental treatment for all B.C. adults with DDs. Based on this research, government has a duty of care to ensure such access, a duty that is not being met.

The obligation owed by government is not merely a public law duty, but a private law duty of care to adults with DDs. In fact, the historical and legal relationship between government and adults with DDs in B.C. potentially results in government owing a fiduciary obligation towards adults with DDs to ensure the health and well-being of these adults, including ensuring access to necessary dental treatment.

This report also examines government's obligation to ensure that the dental profession meets its mandate to provide treatment to all members of society. There is little question that the dental profession has failed to address the needs of Canadian adults with DDs. Most Canadian dental faculties provide little or no education to undergraduate dentists on how to treat this group, and dental students are not required to demonstrate competence in treating special-needs patients. This report recommends that dentists receive suitable education and training in treating people with disabilities, including adults with DDs, to carry out the mandate of the profession.

Similarly, the College of Dental Surgeons of B.C. (CDSBC), the self-regulatory body governing dentists in the province, does not require applicants for registration as dentists to have any proficiency in treating patients with special needs, including adults with DDs. Yet the CDSBC is designated a college under the *Health Professions Act*²⁵ and is charged with a duty "to serve and protect the public."²⁶

Government has an oversight responsibility to ensure that the CDSBC fulfills its mandate. This report argues that government fails to require the CDSBC to ensure that dentists registered in B.C. are able to treat all members of the community. If the dental health care needs of adults with DDs in B.C. are not being met, and cannot be met, by B.C. dentists, then the CDSBC is failing to serve and protect all members of the public. Furthermore, the government is allowing the CDSBC to perpetuate a dental registration practice that discriminates against adults with DDs.

23. RSBC 1996, c 210.

24. See legal analysis in Chapter 2 of this report.

25. RSBC 1996, c 183.

26. *Ibid*, s 16(1)(a).

Definition of Developmental Disability (DD)

This report uses the definition of “developmental disability” set out in the B.C. *Community Living Authority Act*,²⁷ which reads as follows:

- “developmental disability”** means significantly impaired intellectual functioning that
- (a) manifests before the age of 18 years,
 - (b) exists concurrently with impaired adaptive functioning, and
 - (c) meets other prescribed criteria.

Physical or medical conditions commonly associated with a diagnosis of DD include autism, Down syndrome, cerebral palsy, spina bifida and Fragile X syndrome.

Under the *Community Living Authority Regulation*,²⁸ Community Living B.C. adopted the definition of “impaired adaptive functioning” set out in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, Text Revision, published by the American Psychiatric Association in 2000 (DSM-IV-TR). An excerpt from the regulation²⁹ is set out below:

2. In the Act:

“adaptive functioning” has the same meaning as used in the description of “mental retardation” as set out in the DSM-IV-TR;

“impaired adaptive functioning” means adaptive functioning that, when evaluated by a qualifying practitioner, is determined to be a contributing factor as required in making a diagnosis of “mental retardation” within the meaning of the DSM-IV-TR;

Developmental disability

2.1 For the purposes of the definition of “developmental disability” in section 1 of the *Act*, intellectual functioning that, when tested according to one or more standardized intelligence tests by a qualifying practitioner, attains a score of 70 or less is a prescribed criterion.

27. SBC 2004, c 60.

28. BC Reg 231/2005, as amended by BC Reg 228/2008.

29. *Ibid*, s 2.

Barriers to Access

Three major barriers prevent adults with DDs from being able to gain timely access to necessary dental treatment: insufficient access to hospital operating rooms, insufficient funding for dental coverage, and insufficient education of dentists in treating adults with disabilities. All three of these barriers are discussed in more detail below.

Insufficient Access to Hospital Operating Rooms

Nearly every dental expert consulted in connection with this report, including the registrar of the Royal College of Dentists of Canada,³⁰ the senior dental consultant to the B.C. Ministry of Health³¹ and the Dean of Dentistry at UBC,³² emphasized the need for more operating-room time to address the problem of lack of timely access to dental treatment for adults with DDs. Dr. Charles Shuler, Dean of Dentistry, noted “the very pronounced barriers that exist with respect to OR time and GA support that exist both for [the] post-graduate program and for dentists in the community.” Limited hospital operating-room time has led to severe wait-lists for dental treatment under GA, typically between two and three years. Adult patients with DDs considered “urgent” wait as long as eight months for treatment.³³ The long wait times increase the overall cost of treatment.

The Vancouver Coastal Health dental clinic at Vancouver General Hospital (VGH)—the primary provincial resource for this service, according to Dr. Chris Zed, clinical director of the VGH Dental Clinic—is granted 22 days per year of OR time to perform dental work, drawing from a total caseload of more than 7,000 patients. The VGH clinic is currently unable, for safety, cost and zoning reasons, to offer deep sedation as a means to provide diagnostic procedures, including X-rays, to adults with fragile medical health. Therefore, the hospital dentists frequently rely on a visual examination to determine whether dental decay is present in adults with DDs. Consequently, patients with DDs may not be effectively triaged according to degree of dental decay. By the time these patients are seen, dental treatment costs are often very high, with specialty requirements increasing costs well above the average. The cost of OR time and staff is extra.³⁴

Dr. Williamson, the senior dental consultant for B.C., explained that the former institutions, such as Woodlands and Glendale, were guaranteed operating-room time. These institutions kept a number of

30. Interview of Dr Patricia Main, Registrar, Royal College of Dentists of Canada (10 April 2012) (Dr Main retired as Registrar in September 2012) [*Main*].

31. *Williamson, supra* note 16.

32. E-mail from Dr Charles Shuler, Dean, Faculty of Dentistry, UBC, to JL Rush (14 May 2012).

33. There are little or no waits at BC Children’s Hospital, which, under the direction of Dr DH Johnston, Chief of Dentistry, instituted a wait-time protocol consistent with the National Pediatric Surgical Wait Times Strategy.

34. Interview of Dr C Zed, Director, VGH Dental Clinic (June 2012).

community dentists on retainer to treat adults with DDs in the facilities.³⁵ When the institutions were closed, the operating-room time was not replaced by the Ministry of Health. Conversion of health administration into regional Health Authorities and closure of a number of hospitals as a measure to help contain health care costs have made the problem worse.

For example, when Woodlands was closed, many former residents were directed to St. Mary's Hospital in New Westminster for dental treatment. St. Mary's Hospital was subsequently closed in 2004 as part of the rationalization of the Fraser Health Authority service plan. Former patients of St. Mary's Hospital were directed to Eagle Ridge Hospital in Port Moody, where wait-lists for dental treatment under GA are now similar to those at VGH, or approximately two years or more.³⁶

Dental treatment under GA is not performed at all hospitals; only a few hospitals in B.C. provide access to operating-room time for dental treatment. Therefore, patients with complex DDs often have to travel considerable distances to access treatment. Adults with severely compromised medical conditions are frequently directed to VGH in Vancouver, because their local hospitals are not sufficiently equipped to meet their needs.

A recent example of this is the case of "Amy" (not her real name), who was directed to VGH for dental treatment by her Squamish dentist. On learning that the wait time for dental treatment would be more than two years, the dentist arranged to have Amy admitted to the Squamish hospital, but the local anesthetist deemed her condition too complex for her to be treated there. The Squamish hospital administrator arranged to have her admitted to UBC Hospital, but close to the date of treatment she was again deemed too complex to be seen in that OR and was redirected to VGH. Her dentist insisted her case was urgent and that she could not wait two years for treatment. Finally, after many months of waiting and enormous administrative work, Amy was treated at VGH.

A review of the surgical wait-list data posted on the Ministry of Health website³⁷ reveals that wait times for dental surgery are longer than for nearly every other medical procedure completed in B.C., and much longer than wait-lists for most surgeries. However, the posted wait times may not give an accurate reflection of the number of people waiting for treatment. The true lists are larger than the published lists. According to hospital administrators at VGH and Eagle Ridge Hospital, many people are placed on internal wait-lists, and their names are not added to the published surgical wait-times list for up to two years.

35. See discussion regarding the treatment of adults with DDs in institutions in Chapter 3.

36. Interview of Dr Dana Herberts, Eagle Ridge Hospital (4 June 2012). A similar wait-list of two years was reported at Kamloops Royal Inland Hospital early in 2012.

37. British Columbia, Ministry of Health, *Surgical Wait Times: Summary Totals for Each Procedure*, online: Province of British Columbia <<http://www.health.gov.bc.ca/swt/faces/ProcedureFacility.jsp>>.

The internal wait-lists are maintained because the consent documentation required for operations under GA will stale-date after one year. Since most patients are not seen for two to three years, frequently the formal paperwork for their case is not generated until closer to the time of their dental surgery, to ensure it will not stale-date. The dental clinics do not send the relevant information to the Ministry of Health to add the patient to the published surgical wait-times list until after the formal consent documentation has been completed.

The dentists, dental specialists and dental hygienists consulted for this report all agreed that greater access to preventive dental treatment, such as frequent professional cleaning by dental hygienists, application of topical sealants and filling of small or incipient cavities, would reduce the need for more costly treatments and improve the health and quality of life of adults with DDs.

Insufficient Funding for Dental Coverage

Some adults with DDs are sufficiently capable and healthy to receive dental treatment in community, but they have great difficulty accessing dental care at community dental clinics. B.C. adults with DDs qualify for dental insurance under a provincially funded dental plan for Persons with Disability (PWD)³⁸ but, as previously explained, it pays only 60% of the rate recommended by the BCDA.³⁹ In addition, adults with DDs often require extra time for treatment owing to the nature of their disability. Therefore, many dentists prefer not to accept these patients because they will receive a lower payment for an appointment that might take longer than usual.

Adults with DDs are typically poor.⁴⁰ On closure of the institutions, the primary responsibility for care of adults with DDs shifted from the Department of Health to Social Services (now called Ministry of Social Development [MSD]). Under MSD policy these adults are now on “employment assistance” programs. Although many adults with DDs are extremely challenged to find gainful employment, and some may never do so, they are provided with exceptionally little income to meet their needs, including the cost of necessary dental treatment.⁴¹

The PWD dental plan funded by MSD is limited both by monetary cap and by frequency: basically \$1,000 in every two-year period (plus \$500 where GA is required), with most services limited to once in every two-year period.⁴² This funding is not cumulative, so if the two-year period expires before the

38. BC Reg 67/2010, as amended by BC Reg 114/2010 (administered under the *Employment and Assistance for Persons with Disabilities Act*, SBC 2002, c 41).

39. *Supra* note 7.

40. Human Resources and Skills Development Canada, *2010 Federal Disability Report: The Government of Canada's Annual Report in Disability Issues* (Gatineau, QC: HRSDC) at ch 1, online: HRSDC <http://www.hrsdc.gc.ca/eng/disability_issues/reports/fdr/2010/page07.shtml> [*Federal Disability Report*].

41. B.C. adults with DDs are currently entitled to a provincial monthly allowance of \$906 to cover all costs of food, clothing, shelter and other necessities.

42. See Chapter 4 for a detailed description of the PWD dental plan.

adult with DDs can access dental treatment, the funding for that period is no longer available. Adults with DDs waiting more than two years for hospital treatment simply lose access to funds they are entitled to receive under the plan. The hospital dentists will only be entitled to claim up to the \$1,000 in dental coverage although the patient will effectively be treated once in a four-year period. There is an obvious savings to government in this outcome, since government directly funds the dental costs.

The PWD plan is funded by the B.C. government but administered by Pacific Blue Cross (PBC) under an administrative services only contract. Dr. Williamson, the senior dental consultant for the Ministry of Health, also sits on the board of PBC as vice-chairman. Dr. Williamson acknowledges that the coverage provided by the PWD plan is far too low and advised that he had “advocated for improvements for years.” He noted that U.K. dentists are entitled to bill extra time when they treat adults with DDs and recommended that a similar “uplift” be approved under the PWD plan. He explained that he had no ability to influence decisions on the plan, however, as it is entirely the responsibility of MSD to make enhancements.

According to Dr. Zed, who in addition to being clinical director of the VGH Dental Clinic is head of postgraduate and hospital programs at the UBC Faculty of Dentistry, the provincial coverage under the PWD plan is so low that it “does not meet Canadian standards for dental treatment.” The provincial government is aware that better coverage is necessary, since PBC also administers the excellent dental plan that insures members of the legislative assembly and senior civil servants and the slightly less comprehensive dental plan for provincial civil servants who are covered by the benefits program of the B.C. Government Service and Employees’ Union (BCGEU). These plans offer coverage at rates and frequency that provide as much as four times⁴³ the coverage allowed to adults with DDs.

All three plans are funded by government, but the PWD plan offers significantly lower dental coverage to adults with DDs than the plans covering government workers and elected officials. The assistant deputy minister of MSD responded to correspondence to the minister on this issue with the following comments: “I note your concerns about dental fees and limits and access to treatment under general anaesthetic.... I understand your concerns. However, the ministry is not in a position to consider an increase to dental fees or limits at this time.”⁴⁴ There is some irony to the fact that the government officials who administer the underfunded PWD plan are themselves recipients of a significantly better dental plan that is also funded by government.

The biennial funding cap limits the ability of adults with DDs to access regular preventive hygiene, especially as the insurance coverage is insufficient to meet the typical dental treatment needs of this

43. Flexible Benefits Program for Excluded Members in the BC Public Service and BCGEU members’ dental plan, both administered by PBC.

44. E-mail from M Harrington, Assistant Deputy Minister, Ministry of Social Development, to JL Rush (10 August 2012).

group. The limited coverage often leads to adults with DDs having teeth extracted rather than restored because there are insufficient funds to cover the cost of restoration. This is particularly the case if expensive treatment, such as root canal treatment, is required.

Family members and dentists complain that the PBC and government administrators of the PWD plan frequently refuse coverage for root canal treatment even for the front teeth of adults with DDs. The following quote is an example of this problem:

I petitioned the Ministry of Housing and Social Development and Health Services for support for Linda as she was living with infection in her mouth and at risk of losing her three front teeth. I was told unequivocally—*NO*—they had no further support for her; they adamantly told me to *listen*, that they were not responsible for any additional funding for her dental health; the dentist could extract her teeth if she was in pain.⁴⁵

The low funding under the PWD dental plan also impedes better access at hospitals, because the hospital-based clinics bill the provincial insurance plan for treatments. The cost of the OR is covered by the Medical Services Plan, but the dental treatment is billed to the provincial PWD dental plan. The coverage is too low to allow the hospitals to fully recover their costs, especially when treatment is delivered in the OR. Therefore, the hospitals limit treatment because of the budgetary impact. According to Jocelyn Johnston, executive director of the BC Dental Association (BCDA), most dental experts in B.C. agree that an improved plan is necessary.⁴⁶

Low funding for publicly financed dental treatment is consistent across Canada, although some provinces provide more coverage than others.⁴⁷ Over the past 30 years the trend has been a dramatic decrease in public funding for dental care. A major Canadian survey found that while total Canadian dental care expenditures increased from \$1.3 billion in 1980 to \$12.6 billion in 2011, the total publicly funded share of dental care expenditures decreased from 20% in the early 1980s to approximately 6% in 2011.⁴⁸

45. Case provided by D Madsen, via e-mail (18 January 2012).

46. Interview of Jocelyn Johnston, Executive Director, BC Dental Association (20 June 2012).

47. A comparison of provincial dental insurance programs for adults with DDs is included in Chapter 4 of this report.

48. Carlos Quiñonez et al, Community Dental Health Services Research Unit, *An Environmental Scan of Publicly Financed Dental Care in Canada* (Toronto: University of Toronto, 2007), online: Federal, Provincial and Territorial Dental Working Group <http://www.fptdwg.ca/assets/PDF/Environmental_Scan.pdf> [Quiñonez]; see also Canadian Centre for Policy Alternatives, *Putting Our Money Where Our Mouth Is: The Future of Dental Care in Canada* (Ottawa: CCPA, 2011), online: CCPA <<http://www.policyalternatives.ca/publications/reports/putting-our-money-where-our-mouth>>.

A 2009 federal disability report surveyed access to health care for the disabled, but did not specifically mention access to dental care. However, of the people with disabilities who reported lack of access to necessary health care (which presumably includes dental care), 47% reported that cost was the most common reason why their needs were unmet.⁴⁹

Many dentists and dental organizations believe that the ability of adults with DDs to access necessary dental treatment will not improve until fee schedules under publicly funded dental plans are increased. For example, the Canadian Dental Association (CDA) states in its 2010 *Position Paper on Access to Oral Health Care for Canadians* that it supports “enhanced tax-based (income tested) dental coverage that recognizes the medically complex needs of patients with special needs.”⁵⁰ The CDA position paper also encourages a broad collaboration among groups who “have the capacity to contribute to this challenge”⁵¹ to find solutions to the problem of limited access and recommends the development of a national action plan to reduce the barriers to access to dental care. The CDA committee that drafted the position paper suggested that a proposed national action plan include as one of its goals: “A collaborative approach ... among oral health care providers, medical and other health care providers, along with provincial and federal health departments and educators.”⁵²

However, when the CDA was approached this year to consider working with the Canadian Life and Health Insurance Association (CLHIA) and both levels of government on developing a potential pan-Canadian dental plan for adults with DDs, the CDA declined to participate. The CDA executive advised officials with the CLHIA that the problem of access to treatment was very broad and the CDA believed other members of society to be equally disadvantaged.⁵³

Perhaps the CDA executive declined to pursue any collaboration because they preferred to consider the larger societal problem of access to dental treatment. However, there is no indication that the CDA has taken any steps to further the objective of collaborating with other groups who “have the capacity to contribute to this challenge” since the issue of its position paper in 2010.

49. Human Resources and Skills Development Canada, *2009 Federal Disability Report: Advancing the Inclusion of People with Disabilities* (Gatineau, QC: HRSDC, 2009) at 48, online: HRSDC <http://www.hrsdc.gc.ca/eng/disability_issues/reports/fdr/2009/fdr_2009.pdf>.

50. *CDA Position Paper*, *supra* note 4 at 6.

51. *Ibid* at 8.

52. *Ibid*.

53. E-mail from Stephen Frank, Vice President, Policy Development and Health, CLHIA, to JL Rush (9 October 2012).

Insufficient Education of Dentists in Treating Adults with Disabilities

Most dentists have little, if any, training to treat adults with special needs. Canadian faculties of dentistry do not require undergraduate dental students to acquire competency to treat patients with DDs.⁵⁴ The faculties are not required to ensure their undergraduate students gain such competency in order to be accredited.⁵⁵ And Canadian dental colleges, including the College of Dental Surgeons of B.C., do not require applicants to be competent to treat dental patients with DDs in order to be licensed.

Dr. Shuler, the current chair of the Deans Committee of the Association of Canadian Faculties of Dentistry, proposed that the issue of education to treat adults with special needs be dealt with by continuing education (CE) courses rather than enhanced undergraduate training.⁵⁶ However, a review of the CE courses offered by the Pacific Dental Association, the BCDA and the UBC Faculty of Dentistry revealed that no courses were offered on this topic during 2011 or 2012.

Jocelyn Johnston, executive director of the BCDA, does not agree that this complex topic should be taught through CE courses. In her view, and that of many dentists consulted for this report, education on treating special-needs patients should be incorporated into the undergraduate dental programs.

Since community dentists have little or no training in how to treat adults with DDs, many feel unqualified to serve this population. As a result, they direct patients with DDs to hospitals for dental surgery. There they are placed on wait-lists, although it is possible that some of these adults could be seen in typical dental clinics.

A number of specialists consulted for this report speculated that many Canadian dentists may consider their undergraduate dental education as insufficient training for treating adults with DDs. The issue of training to treat adults with disabilities has been researched in the United States. A study completed at the University of Michigan showed that only 41% of dental students felt their education was training them to meet the needs of people with disabilities, and only 35% of alumni agreed that their dental education had prepared them to treat this population. Both students and alumni confirmed that they were least likely to feel comfortable treating people with disabilities compared to any other marginalized population. Significantly, only 47% of dental students planned to treat adults with disabilities in their future practices.⁵⁷

54. Interview of Susan Matheson, Director, Commission on Dental Accreditation of Canada (14 June 2012).

55. Commission on Dental Accreditation of Canada, *Accreditation Requirements for Qualifying Programs for Graduates of Non-Accredited Educational Programs of Dentistry*, online: CDA <http://www.cda-adc.ca/_files/cda/cdac/accreditation/qualifying_programs_2006_en.pdf>.

56. *Supra* note 32.

57. Carlos S Smith et al, "Dental Education and Care for Underserved Patients: An Analysis of Students' Intentions and Alumni Behavior" (April 2006) 70(4) J Dent Educ 398 at 402.

A second Michigan study confirmed that a large majority of dentists in that state did not feel they had received sufficient training to treat adults with disabilities. The study also confirmed that those dentists who felt they had been properly trained to treat this group were also much more willing to include adults with disabilities among their clients. We can conclude from this study that teaching dentists to treat adults with DDs significantly improves the likelihood of dentists including such patients in their practices.⁵⁸

This research should be considered and appropriate curriculum enhancements implemented by Canadian dental faculties, including the UBC Faculty of Dentistry. If general dentists were willing to treat healthy adults with DDs in their dental clinics, it is likely that these adults would have much greater access to beneficial dental hygiene so that serious dental decay might be limited or avoided.

One solution to training dental students is to bring disabled patients to the university. A dental clinic located at the University of Washington has used this approach. In 1974, the University of Washington School of Dentistry established the DECOD dental clinic (Dental Education in the Care of Persons with Disabilities) on-site as a way to ensure that dental students could learn to treat adults with disabilities.⁵⁹ The clinic also provides an enormous service to people with disabilities living in Washington. The DECOD website states:

Through its clients, DECOD provides more than 4,500 dental visits per year to persons with disabilities. It is a major resource for Washington citizens who are severely disabled due to developmental disorders, medical illness, trauma, [and] degenerative conditions.⁶⁰

Several Canadian dentists recommended the oral surgery clinic at Mount Sinai Hospital in Ontario as the standard that should be followed in B.C. The Mount Sinai Hospital operates a special clinic providing dental treatment to mentally and physically challenged adults in collaboration with other medical departments. The clinic works in association with the University of Toronto Faculty of Dentistry; its dental team includes both undergraduate and graduate dental students.

58. Doan P Lao et al, "General Dentists and Special Needs Patients: Does Education Matter?" (October 2005) 69(10) J Dent Educ 1107.

59. University of Washington School of Dentistry, *Patient Services*, online: School of Dentistry <<http://dental.washington.edu/departments/oral-medicine/patient-services.html>>.

60. *Ibid.*

Dr. Michael Sigal, dentist-in-chief, states on the clinic website:

There is a significant lack of access for these patients. The first question I ask a new patient is, “Have you looked for a dentist in your community?” And they say, “Yes, I’ve tried, but I can’t find one...”⁶¹

According to Dr. Sigal, graduates of the program are now seeing patients in their own practices. It would be possible to create a similar clinic at UBC Hospital dedicated to special-needs dentistry where dental students and other medical students could be taught to treat the dental and health care needs of adults with disabilities.

To further exacerbate the problem of insufficient training, Canada does not recognize a dental specialization in Special Needs Dentistry, such as exists in the U.K., Australia and New Zealand. While children with special needs are seen by pediatric dentists, there is no comparable specialization for special-needs adults. Consequently, when children with special needs grow too large to be seen by pediatric dentists at BC Children’s Hospital, they frequently fall into an abyss. They are directed to hospital-based dentists who may not be able to take X-rays, except under GA. They are placed on wait-lists of two to three years for both diagnosis and treatment. The dental health benefits of regular access to dental examinations and care that these people enjoyed as children are quickly lost.⁶²

Perhaps as a result of the lack of undergraduate education and any recognition of a specialization in treating adults with special needs, the dental profession fails to address the needs of many groups. Geriatric patients, low-income and marginalized communities, and adults with DDs all struggle to access necessary dental treatment. A 2008 study of this issue in B.C. found that inaccessibility was reported in every area of the province. The report states:

In British Columbia there are significant disparities in oral health, with low-income and socially disadvantaged groups having a disproportionately high level of dental problems. These health disparities are linked to inequalities in access to oral health care. In BC, oral health care for adults is typically delivered by dental professionals in private practice, with services delivered on a fee-for-service basis. This service structure creates financial and other barriers for many low-income adults.⁶³

61. Oral Health Total Health, *Dentistry Clinic*, online: Oral Health Total Health <<http://ohth.ca/about-us/dentistry-clinic>>.

62. *Main*, *supra* note 30.

63. See generally, Bruce Wallace, *Improving Access to Dental Services for Low Income Adults in BC* (Victoria, BC: Victoria Cool Aid Society, 2008), online: Victoria Cool Aid Society <http://www.coolaid.org/publications/dental_services_research_2008.pdf>; and see generally, *CDA Position Paper*, *supra* note 4.

Some dentists in community, and many dental specialists, particularly pediatric dentists, have tried to address these needs, often working for little or no money to serve the needs of adults with DDs and people of other marginalized communities.

The profession as a whole, however, has been relatively indifferent to the plight of the poor, the aged and the disabled, while pursuing practices that emphasize profitable cosmetic dentistry. A great number of dental CE courses focus on cosmetic dentistry, including courses on botox treatment and teeth whitening. In a 2008 audio interview with the *Journal of the Canadian Dental Association*,⁶⁴ the Chief Dental Officer for Canada, Dr. Peter Cooney, expressed his hope that the focus of the profession would turn to coordinating dentistry with other branches of medicine and away from cosmetic dentistry. Dr. Cooney recommended that dentists expand their role as primary health care providers and not be seen by the public as primarily “cosmeticians” or people who make a “pretty smile”. He also recommended that the faculties of dentistry offer suitable training to achieve this end.⁶⁵

There is evidence that the general public has lost trust in the dental profession, in part because of this emphasis on offering cosmetic dentistry. In his final letter to the CDA members in 2012, former president Dr. Robert MacGregor expressed concern about this issue, as follows:

The Ipsos research findings indicate that the public does not view esthetic services as health care. Excessive promotion of such procedures can generate or reinforce distrust in dentistry, especially if a dentist recommends procedures that are unnecessary. Indeed, the research revealed that public trust in the profession is waning, with only 9% of patients surveyed “completely agreeing” that they trust dentists. The public’s faith in dentists must be elevated if the social contract between the profession and the public is to be sustained.⁶⁶

The profession must take steps to ensure that the most vulnerable members of society, including adults with DDs, do not go without necessary dental treatment if dentists wish to regain the confidence of the Canadian public.

64. Interview of Dr Peter Cooney, Canada’s Chief Dental Officer, by JCDA (15 September 2008) in The JCDA Interview, online: CDA <<http://www.cda-adc.ca/jcda/vol-75/issue-1/29.html>> (note that the above comments are only on the audio file of this interview and are not included in the J Can Dent Assoc written transcript published in JCDA 75.1, Feb:2009).

65. *Ibid.*

66. Dr Robert MacGregor, “Professionalism: We Can All Do Our Part,” Canadian Dentistry News (29 March 2012), online: CDA <http://www.cda-adc.ca/en/cda/canadian_dentistry_news/articles/2012/032912.asp>.

Scope of the Research

The Canadian courts confirm that the scope of governmental obligation to a particular party or group rests on the mandate set out in applicable legislation together with an analysis of the relationship of proximity between government and that party or group over time. To establish the scope of government's obligation to ensure timely access to dental treatment to adults with DDs, this report includes the following research:

1. Government's obligations under relevant common law and legislation, regarding:
 - a. timely access to necessary dental treatment for adults with DDs
 - b. oversight of the regulation of the dental profession in B.C.

2. History of government's care for adults with DDs dating from the establishment of B.C. as a province, including:
 - a. the legislative history
 - b. selected reports of the Medical Superintendent to government, including reports on dental treatment provided to patients, recorded in *Sessional Papers* of the legislative assembly
 - c. selected *Hansard* reports
 - d. records of government expenditures on dental treatment in the public institutions

3. Analysis of the public dental plan for B.C. adults with DDs, including:
 - a. a detailed description of the dental insurance plan that provides limited coverage for adults with DDs
 - b. a description of all provincial public dental plans in Canada and comparison with that of B.C.

4. Conclusions and recommendations, including:
 - a. an analysis of the legal rights and remedies of adults with DDs who cannot access necessary dental treatment in a reasonable time
 - b. recommendations for actions government can take to meet its legal obligation to ensure that B.C. adults with DDs receive necessary dental treatment in a timely fashion

CHAPTER 2

Legal Analysis

Under Canadian law, adults with DDs who require hospitalization for dental treatment are entitled to access that treatment in hospital in as timely a fashion as the hospitals provide any other treatment defined as a covered benefit. Section 2 of the *Canada Health Act* includes “surgical-dental services” as a covered benefit for the purposes of federal contribution to health care costs incurred by the provinces. Section 19(2)(a) of the *Medical and Health Care Services Regulation* under the B.C. *Medicare Protection Act* includes “dental and orthodontic services” as a covered benefit if the beneficiary (the patient) has been admitted to hospital or is a patient under the Day Care Services Program where hospitalization is required for the safe and proper performance of the surgery.⁶⁷ Yet adults with DDs face unreasonably long wait times for necessary dental treatment in hospital, frequently longer than two years, despite referrals from dentists who have diagnosed their need for treatment.

The failure of the B.C. government to ensure that adults with DDs who require dental treatment in hospital can access necessary treatment within a reasonable time is a breach of government’s legal obligation to these patients under the *Canadian Charter of Rights and Freedoms* [*Charter*]⁶⁸ and is a breach of their human rights under the B.C. *Human Rights Code* [*HRC*].⁶⁹

Government also owes a duty of care to adults with DDs based upon its historical responsibility to ensure the health and well-being of these people. Canadian courts have examined situations where the relationship of government to a particular individual or group creates a private law duty of care that government must meet. For more than a century the B.C. government increasingly ensured that people with DDs received necessary dental treatment, to the extent of providing specialized clinics and operating theatres in the institutions. Government effectively abdicated this responsibility upon closure of the institutions.

67. Relevant excerpts from the *Canada Health Act*, *Medicare Protection Act*, *Medical and Health Care Services Regulation*, *Hospital Act and Regulations*, and related legislation and regulation governing hospitals are set out in an appendix to this report.

68. *Charter*, *supra* note 22.

69. RSBC 1996, c 210.

The minimal coverage provided under the current Persons with Disability (PWD) dental insurance plan is insufficient to meet the duty of care owed by government to adults with DDs and falls far below the insurance coverage provided under other dental plans paid for by government, such as the dental plan for MLAs and senior managers of government ministries. The failure of government to provide timely access to hospital ORs for treatment under general anaesthetic (GA), specialized dental clinics for adults with DDs, and sufficient insurance coverage to meet the dental treatment needs of this group constitutes a breach of government's duty of care to adults with DDs.

Potentially, government's duty of care to ensure the health and well-being of adults with DDs in B.C. extends to a fiduciary duty, based upon the long history of government care for this group. That history is described in Chapter 3 of this report.

Government also has an oversight obligation under the *Health Professions Act* [HPA] to confirm that the College of Dental Surgeons of B.C. (CDSBC) registers and regulates the dental profession in the province under guidelines that ensure that dentists can meet the needs of all members of society. If dentists in the province are not, on the whole, competent to treat adults with DDs, then government has an obligation to use its powers under the *HPA* to require the CDSBC to amend its bylaws to rectify this deficiency.

This chapter describes government's legal obligation to adults with DDs under the *Charter*, under the *HRC*, and under its historical duty of care. It also describes the scope of government's legislative duty to require the dental profession to meet its legal obligations towards all members of the public.

Charter Rights under Section 7

*Access to a waiting list is not access to health care.*⁷⁰

—Beverley McLachlin, Chief Justice of Canada

Section 7 of the *Charter* provides a guarantee that “[e]veryone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.” The Section 7 *Charter* rights of Canadians to timely access to necessary health care have been confirmed by the Supreme Court of Canada (SCC) in the two landmark decisions of *Morgentaler*⁷¹ and *Chaouilli*.⁷²

In the *Morgentaler* decision, Chief Justice Brian Dickson held for the majority that a delay in abortion treatment that increased the risk of complications and mortality and created severe anxiety for the patient constituted a breach of her Section 7 rights to security of the person. The hospital wait-lists for necessary dental treatment facing adults with DDs meet the test established in *Morgentaler*: dentists and care providers agree that long delays in accessing necessary dental treatment cause adults with DDs to experience extreme anxiety. Delays cause these adults to suffer further dental decay and potential dental infections, and they often leave them in agony.

The *Chaouilli* decision considered a *Charter* challenge to the provincial prohibition of private health insurance for services typically covered under the public health insurance scheme where the public health care was not being provided in a timely fashion. Justice Marie Deschamps stated regarding medical delays that create harm to the patient, “Canadian jurisprudence shows support for interpreting the right to security of the person generously in relation to delays.”⁷³ She held that it was not up to the appellants to find a solution to resolve the problem of wait-lists: that was a function for the state. The patients’ “only burden was to prove that their right to life and to personal inviolability had been infringed.”⁷⁴

In her concurring judgement in *Chaouilli*, the Chief Justice agreed that a wait for necessary hospital treatment that risked the life or health of the patient was a breach of their Section 7 security rights under the *Charter*. That breach was not saved by the existence of a hospital wait-list that failed to ensure timely access to treatment. The Chief Justice stated: “The *Charter* does not confer a freestanding constitutional right to health care. However, where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*.”⁷⁵

70. *Chaouilli v Quebec (Attorney General)*, [2005] 1 SCR 791, 2005 SCC 35, per McLachlin, CJ, at para 123 [*Chaouilli*].

71. *R v Morgentaler* [1988] 1 SCR 30.

72. *Chaouilli*, *supra* note 70.

73. *Ibid* at para 43.

74. *Ibid* at para 100.

75. *Chaouilli*, *supra* note 70, per McLachlin, CJ, at para 104.

In *Chaouilli*, the court considered whether there was some aspect of fundamental justice that could uphold the wait-lists in the public health system and restrict the use of private insurance to allow patients to access health treatment faster. The majority of the SCC concluded that the health care system must provide reasonable access to health services and that imposing the wait-lists on patients for financial and other practical reasons did not fall within the principle of fundamental justice. Therefore, the breach of the patients' rights to security of the person caused by the wait-lists could not be justified under Section 7 as a principle of fundamental justice.

The extensive wait-lists for dental treatment in B.C. hospitals are caused, to some extent, by the hospitals' reliance on reimbursement from the underfunded provincial dental insurance that covers adults with DDs. The low reimbursement negatively affects the hospital budget; therefore, the hospital rations access to the OR for this group of patients. The effect is to arbitrarily create extensive wait-lists that predominantly affect adults with DDs and limit their equitable access to necessary health care. This administrative policy of the health care system fails to meet the test of fundamental justice based upon the SCC's analysis in *Chaouilli*. The B.C. government "plan" for dental treatment in hospital fails to ensure reasonable access for cost containment reasons.

An ironic difference between the facts of the *Chaouilli* case and the prolonged wait-lists for adults with DDs who require dental treatment in hospital is that Dr. Chaouilli and his patient argued for the right to use private insurance to avoid the wait-list for treatment in the public health care system. Adults with DDs on hospital wait-lists for dental surgery can't access treatment using private insurance even though there is no prohibition to doing so; their compromised medical conditions mandate their treatment in hospital. So while the majority of Canadians pay for dental treatment using private insurance, those adults with DDs who must be treated in hospital have no choice but to wait for care in the public system.

In fact, as described in the case of "Amy" in Chapter 1, some patients have such compromised medical health that they cannot be treated in smaller regional hospitals, but must be admitted to large hospitals, such as VGH, which have sophisticated intensive care units. This restriction is imposed by the hospitals to protect the life and health of patients with compromised medical health conditions, but it serves as an additional barrier to timely treatment for some of the most medically complex patients. This requirement also forces these medically frail patients to travel to larger hospitals, frequently at their own cost. Since adults with DDs are more likely than most to be poor or live with a poor family,⁷⁶ or are supported by agencies with limited funds, they are further restricted from accessing treatment.

The limited insurance coverage paid under the provincial PWD dental plan also restricts the ability of adults with DDs who do not require hospitalization for dental surgery to access necessary dental treatment. Many adults with DDs struggle to find dentists willing to accept the low funding, but they

76. Gwen Brodsky, Shelagh Day & Yvonne Peters, *Accommodation in the 21st Century* (March 2012) at 2, online: Canadian Human Rights Commission <http://www.chrc-ccdp.gc.ca/pdf/accommodation_eng.pdf>; and see also *Federal Disability Report*, *supra* note 40.

are also restricted by the type and frequency of treatment allowed under the plan. As shown in the case of Linda in Chapter 1, the Ministry of Social Development (MSD) sometimes refuses coverage for treatment that is essential to the health and well-being of any person, such as treatment to heal and restore their front teeth.

One young woman with Down syndrome and her caregivers recently lost their battle with MSD for insurance coverage to save her front teeth. She is not adjusting well to the prosthetic bridge she was given when her front teeth were removed, owing to the misalignment of her jaws. She now hesitates to smile and has lost much of her joy in socializing.⁷⁷

Adults with DDs have little or no money to pay for necessary dental care that is not covered by the provincial PWD dental plan. If the cost of treating their dental decay exceeds the provincial limits, then family or caregivers are called upon to pay the difference. If the adult with DDs has no family, or the family or caregivers have no money to pay the difference, then the adult with DDs will either go without care or have their teeth extracted.

Government's failure to ensure that adults with DDs can access necessary dental treatment in community is also a breach of their Section 7 rights to security of the person. Government cannot argue that the limited coverage is justified by principles of fundamental justice. When these adults were institutionalized, their dentists had access to a specialized dental clinic⁷⁸ and dedicated OR hours in the hospital surgery. The Ministries of Health and Social Services assured families that government would provide specialized health and dental care upon closure of the institutions; however, adults with DDs now have minimal access to necessary dental treatment. Even if these adults find a dentist in community who is able to provide treatment, the provincial insurance coverage is too low to maintain healthy teeth.

77. Case provided by the foster parent of a young woman with Down syndrome.

78. See Chapter 3 for a history of the care of adults with DDs in B.C.

Human Rights

*Here's the really important point: Budget concerns alone, straight up, cannot justify human rights denial.*⁷⁹

—Margot Young, Associate Professor, UBC Faculty of Law

In the 2012 decision of *Moore v British Columbia (Education)* [Moore],⁸⁰ which concerned access to special education necessary to accommodate the needs of Jeffrey Moore, formerly a B.C. elementary school student with dyslexia, the SCC confirmed unanimously that the North Vancouver School District's decision not to fund his special education for budgetary reasons was a breach of Moore's human rights.

The *Vancouver Sun* published a strongly worded objection to the SCC decision in the *Moore* case.⁸¹ In his antiquated opinion, the author included the following statement: “At all times, he had access to exactly the same educational services available to every other public school student in his region of B.C.” Twice the author mentions the potential “unlimited financial liability” arising from the *Moore* decision that could burden B.C. taxpayers.

This opinion is similar to saying that everyone is equally entitled to ascend the same set of steps to a building, regardless of whether they can use their legs, because it will cost taxpayers too much to build a ramp. The Canadian public has long rejected the view that we need not make special arrangements to accommodate people with special needs.

The lower courts that considered Jeffrey Moore's case failed to appreciate that students with special needs must be accommodated or else they remain at the bottom of the steps, denied access to the school. Justice Rosalie Abella used this same metaphor of a ramp to a building in her opinion: “For those with severe learning disabilities, [adequate special education] is the ramp that provides access to the statutory commitment to education made to *all* children in British Columbia.”⁸²

Canadian law does not accept the utilitarian argument that the cost of ensuring individual human rights is too high if it detrimentally affects the economic interests of the majority. As the eloquent legal philosopher John Rawls stated, “Each member of society is thought to have an inviolability founded on

79. Tamsyn Burgmann, “Jeffrey Moore, Dyslexic Student, Discriminated Against by North Vancouver School District: SCC,” *Canadian Press* (9 November 2012), online: Huffpost British Columbia <<http://www.huffingtonpost.ca>>.

80. *Moore v British Columbia (Education)*, 2012 SCC 61 [Moore].

81. Derek James, “Supreme Court's ruling rejects one equality in favour of another,” *The Vancouver Sun* (16 November 2012), online: The Vancouver Sun <<http://www.vancouversun.com>>.

82. *Moore*, *supra* note 12, at para 5.

justice or, as some say, on natural right, which even the welfare of everyone else cannot override.”⁸³ This philosophy is adopted in cases like *Chaouilli* and *Moore*.

The SCC in the *Moore* decision did not insist that students with special needs perform at any particular level in the school system; the justices only insisted that students with special needs be (metaphorically) entitled to access the school. This same issue faces adults with DDs regarding access to necessary dental treatment. On leaving the institutions, adults with DDs were given access to the same dental treatment available to adults who do not have physical or intellectual special needs.

The failure of the government to accommodate the special needs of adults with DDs leaves them standing (or sitting in a wheelchair) in front of hospitals and dental clinics, unable to access necessary dental treatment. They remain on unreasonably long wait-lists for hospital treatment or unable to pay in community for their complex dental treatment needs, which are expensive owing to the greater complexity of their physical and intellectual conditions. The *Moore* decision confirms that this failure to accommodate their special needs is a breach of their human rights that cannot be justified on the basis of budgetary pressures. The SCC made it very clear that limited funds will not be accepted as a lawful justification for a breach of the human rights of adults with special needs under the *HRC*, especially if there has been no reasonable attempt to achieve accommodation. As stated by Justice Abella:

As the Tribunal properly recognized, to demonstrate *prima facie* discrimination, complainants are required to show that they have a characteristic protected from discrimination under the *Code*; that they experienced an adverse impact with respect to the service; and that the protected characteristic was a factor in the adverse impact. Once a *prima facie* case has been established, the burden shifts to the respondent to justify the conduct or practice, within the framework of the exemptions available under human rights statutes. If it cannot be justified, discrimination will be found to occur.⁸⁴

The SCC in *Moore* also considered whether it is appropriate to compare accommodation of special-needs groups only with other groups who also have special needs and rejected this limitation as creating a “separate but equal” category. This issue is relevant because the MSD publishes in its annual report a comparison of its services with other provinces. In the 2011 MSD annual report, the minister notes that services to persons with disabilities are “the fourth highest in Canada.”⁸⁵ (A summary comparison of all the Canadian provincial dental programs covering adults with DDs is included in Chapter 4 of this report.)

83. John Rawls, *A Theory of Justice*, rev ed (Oxford: Oxford University Press, 1999) at 24.

84. *Moore*, *supra* note 12, per Abella, J, at para 33.

85. British Columbia, Ministry for Social Development & Ministry Responsible for Multiculturalism, *Annual Service Plan Report* (2010/11) at 3.

Using only this comparison means that B.C. need never consider improving access to dental treatment for adults with DDs so long as it offers coverage relatively similar to the amount provided by other provinces. However, evidence provided by the CDA,⁸⁶ among other Canadian dental experts, including the Chief Dental Officer, is that adults with DDs across the country suffer from a lack of access to necessary dental treatment. And if all other provinces chose to eliminate dental benefits for this group entirely, but B.C. offered \$1 per year of insurance coverage, it would immediately offer the best program in Canada. Comparing a bad administrative program with equally bad administrative programs does not justify a failure to accommodate special needs and provide necessary service. The SCC stated in *Battlefords and District Co-operative Ltd. v Gibbs* that “in order to find discrimination on the basis of disability, it is not necessary that all disabled persons be mistreated equally.”⁸⁷

The analysis in *Moore* confirms that the appropriate comparator groups for adults with DDs who are being denied timely access to necessary dental treatment are those adults without special needs, or with different special needs, who are able to access necessary dental treatment. B.C. hospitals provide dental treatment to many people in a timely fashion. For example, the B.C. Cancer Agency (BCCA) employs dentists and dental specialists who treat the complex dental care needs of adults who have experienced cancer and cancer treatment.⁸⁸ BCCA patients are able to access necessary dental treatment at specialized clinics operated at four of the six provincial BCCA centres. However, the same level of access is not provided to adults with DDs, despite their special needs. Based upon the *Moore* decision, this failure to recognize and accommodate the special needs of adults with DDs constitutes a breach of their human rights under the *HRC*.

The government must accommodate the special needs of adults with DDs to allow them to access treatment. An obvious way to do this is to create specialized clinics, just as the BCCA has done, and fund access to operating rooms in suitable hospitals where adults with DDs can receive necessary dental treatment within a reasonable time. The BC Medical Association recommended the use of specialized clinics as one approach to resolving the issue of wait-lists for all health care in its 2006 report on reducing wait times for necessary health treatment.⁸⁹

Government might argue that not all people in B.C. have dental insurance and that adults with DDs have been provided a special benefit. However, adults in B.C. who do not have special needs are typically financially able to pay for dental treatment directly or are physically able to access a variety of lower-cost or free walk-in clinics in community. Adults with DDs cannot take advantage of these programs if their special needs are sufficiently complex that community dentists will not treat them. If they are

86. *CDA Position Paper*, *supra* note 4.

87. [1996] 3 SCR 566 at para 27.

88. Interview of Dr Allan Hovan, Provincial Professional Practice Leader for Oral Oncology, BCCA (May 2012).

89. British Columbia Medical Association, *Waiting Too Long: Reducing and Better Managing Wait Times in BC* (Vancouver, BC: BCMA, June 2006) at 62, online: BCMA <https://www.bcma.org/files/waiting_too_long.pdf>.

directed to hospitals, they face unreasonable delays for treatment, and their actual dental treatment needs might not be covered under the government-administered insurance plan. Therefore, while adults with DDs have insurance coverage that not all adults in society possess, they are still prevented from accessing necessary treatment because the program does not accommodate their special needs.

The kind of discrimination that occurs when society fails to take into account the special needs of individuals with disabilities was described by Justice John Sopinka of the SCC as follows:

Exclusion from the mainstream of society results from the construction of a society based solely on “mainstream” attributes to which disabled persons will never be able to gain access. Whether it is the impossibility of success at a written test for a blind person, or the need for ramp access to a library, the discrimination does not lie in the attribution of untrue characteristics to the disabled individual. The blind person cannot see and the person in a wheelchair needs a ramp. Rather, it is the failure to make reasonable accommodation, to fine-tune society so that its structures and assumptions do not result in the relegation and banishment of disabled persons from participation, which results in discrimination against them.⁹⁰

Government might also argue that the *HRC* entitles it to fund lower insurance premiums for the PWD dental plan covering adults with DDs because of the exemption set out in Section 8(2)(b) of the *HRC*. This section states that a person does not contravene Section 8 (the prohibition against discrimination) “if the discrimination relates to the determination of premiums or benefits under contracts of life or health insurance.” Section 8(2)(b) does not provide the government with the ability to underfund coverage on the ground that the recipients of the health insurance (under which the dental insurance supplement is issued) are disabled. Section 8(2)(b) was added to the *HRC* (and similar codes across the country) to enable private life insurance companies to underwrite premiums appropriately. It was not enacted to enable governments to administer insurance programs that deny effective access to the insurance protection.

The B.C. government dental insurance plan fails to consider and accommodate the special needs of adults with DDs. These adults should not be required to access treatment like the “mainstream,” since they have special needs that must be accommodated. The barriers to treatment they face constitute a form of discrimination that breaches their human rights.

It is not a sufficient argument to say that the costs of accommodating their needs should not be imposed on the community, but should be absorbed by the patients or their families or caregivers. Chief Justice

90. *Eaton v Brant County Board of Education*, [1997] 1 SCR 241 [*Eaton SCC*] per Sopinka, J, at para 67.

Beverley McLachlin stated in the SCC case of *Krangle (Guardian ad litem of) v Brisco*, “When a disabled person becomes an adult, the burden of his or her care shifts from the parents to society as a whole, and it is accepted as fair and just that the continued burden of care of disabled adults should be spread over society generally.”⁹¹

In view of the multiple decisions of the SCC confirming that government has an obligation to accommodate the needs of adults with DDs, despite the financial implications of doing so, it is mandatory that the B.C. government take steps to ensure timely access to necessary dental treatment for adults with DDs.

Duty of Care

*[P]arallel with public law duties there may coexist those duties which persons—private or public—are under at common law to avoid causing damage to others in sufficient proximity to them.*⁹²

—Lord Wilberforce, *Anns v Merton London Borough Council*

Canadian courts have adopted the two-part test set out by the English House of Lords in the famous *Anns* decision to determine whether government owes a duty of care to avoid harming a particular person or group. The first stage of the test is to determine whether a relationship of sufficient proximity exists between the parties to find a *prima facie* duty of care based upon the concept of foreseeability (with *prima facie* meaning “on the face of it” or “apparent”).

The concept of foreseeability was recently defined by the SCC in *R v Imperial Tobacco Canada Ltd. [Imperial]*⁹³ as follows: “At the first stage of this test, the question is whether the facts disclose a relationship of proximity in which failure to take reasonable care might foreseeably cause loss or harm to the plaintiff.”⁹⁴

If a *prima facie* duty is found, the second stage of the test examines whether there are overriding policy considerations that will negate the duty of care. The Canadian courts will not find government liable for its “core policy decisions”: typically those decisions “that are based on public policy considerations, such as economic, social and political factors, provided they are neither irrational nor taken in bad faith.”⁹⁵

91. [2002] 1 SCR 205, 2002 SCC 9, at 19.

92. [1978] AC 728 at 6.

93. 2011 SCC 42, [2011] 3 SCR 45 [*Imperial*].

94. *Ibid* at para 39.

95. *Ibid* at para 74.

However, the courts have imposed liability on government in cases where government actors have failed to act in accordance with established government policy. The courts also accept that liability may be imposed on government where a history of interactions with a particular person or group, with or without accompanying statutory responsibility, creates a *prima facie* duty of care that government fails to meet. The B.C. government is liable to adults with DDs for failing to meet its duty of care to ensure timely access to necessary dental treatment under both of these legal analyses.

Negligent Failure to Act in Accordance with Government Policy

The SCC case of *Just v British Columbia*⁹⁶ confirms an established category of the duty of care that may be imposed on government, stating that government may be liable for negligent implementation of a government policy, or negligent operational decisions made while carrying out the policy, even if government cannot be found liable for making the policy decision.

The plaintiff in *Just* brought an action in negligence against the B.C. government after a huge boulder fell on his car from the cliff beside the road as he was driving to Whistler, injuring him and killing his daughter. The lower courts held that no duty of care could be established because construction and maintenance of highways is a matter of core provincial policy that is implemented for the benefit of all citizens of the province and is therefore exempt from civil actions.

The SCC did not agree with the lower courts and held that a duty of care could be imposed. The court explained that it was necessary to examine how the policy of road maintenance was carried out to determine whether any negligence existed. The court found that there was sufficient proximity between the plaintiff and government to establish a *prima facie* case because it was foreseeable that any driver on the road could suffer from government's failure to properly administer the policy of undertaking road maintenance. The SCC distinguished between policy and operational decisions of government in maintaining the roads.

Consistent with the *Anns* decision, the court held that government policy decisions, which typically fall within the realm of social, political or economic matters, are exempt from the traditional tort law duty of care. However, "operational" decisions, or the way that government implements its policy decisions, may be subject to claims in tort. The SCC acknowledged that it may be difficult to differentiate between policy decisions and operational decisions, but determined it was necessary to do so since the negligent delivery of government services can subject government to ordinary claims in negligence.

96. [1989] 2 SCR 1228.

A 2011 B.C. Ministry of Health Policy, entitled the Provincial Health Services Management Policy, includes the following statements:

Health Authorities are required to use the following values as the foundation for planning, monitoring and managing health services;

- Citizen and patient focus which respects the needs and diversity of all British Columbians.
- Equity of access and in the quality of services delivered by government.
- Access for all to quality health services.⁹⁷

These statements are merely words on paper if government makes no attempt to ensure the Health Authorities implement them with respect to access to necessary dental treatment in hospital for adults with DDs. More importantly, based upon the analysis in the *Just* decision, failure to implement the policy because of deficient operational methods used by the hospitals that do not ensure reasonable access to adults with DDs is a breach of government's duty of care.

The B.C. Ministry of Health published an earlier policy directive requiring Health Authorities (HAs) to deliver surgical access in a timely fashion. In a 2009 Ministry of Health memo, the deputy minister sent to the CEOs of the B.C. HAs a Surgical Waitlist Management Policy, which contains the following preamble:

British Columbia's health authorities (HAs) are responsible and accountable for the delivery of quality, appropriate, and timely access to surgical services for patients within their respective geographic region. To ensure timely access to surgical services, accurate and reliable wait time information that facilitates informed decision making by health care providers and HA administrators is required. Standard, comprehensive provincial policies that support active management of waitlists will improve the accuracy of provincial wait time data, ensuring only those patients who are ready, willing and able to have surgery are placed on a waitlist.⁹⁸

Unfortunately, virtually all of the points in the deputy minister's policy communiqué describe methods to eliminate names from the wait-list rather than to enhance access to treatment. Patients to be flagged for temporary or permanent removal from the wait-list include patients who have been on the wait-list

97. British Columbia, Ministry of Health Services, *Health Services Management Policy for Health Authorities* (Victoria, BC: Ministry of Health Services, May 2002).

98. British Columbia Ministry of Health, Policy Communiqué, CLIFF No 790507, "Surgical Waitlist Management Policy" (July 2009) (John Dyble, Deputy Minister).

for longer than one year. That group would include nearly every adult with DDs placed on the VGH dental clinic wait-list for dental treatment in hospital, since these patients typically wait longer than two years for access to treatment. Hopefully, the more recent 2011 statement of policy overrides the deputy's 2009 memo to the Health Authorities.

The B.C. government is conscious of the need for specialized health and dental care for adults with DDs, and its obligation to provide specialized services. In furtherance of its commitment to meet the special medical needs of this group, the government published in January 2010 a set of *Guidelines for Collaborative Service Delivery for Adults with Developmental Disabilities*⁹⁹ (*Guidelines*) agreed between Community Living B.C. (CLBC), regional and provincial HAs, the Ministry of Health Services, and the Ministry of Housing and Social Development (now MSD). The “Background” section of the *Guidelines* states at page 3:

The Government of British Columbia is committed to a comprehensive system of care and support for individuals with developmental disabilities to assist them to live a full life in their family home and/or in the community. This commitment was confirmed with the establishment of a focused Community Living Program, and service delivery system managed by the Ministry of Children and Family Development. This commitment also included funding to the Ministry of Health Services to provide specialized health and mental health services for those individuals with co-existing developmental disabilities.

Appendix 4 to the *Guidelines* is entitled “Dental Health Services for Persons with a Developmental Disability” and states as follows at page 11:

This program was developed to facilitate access to community based dental services. The focus of this service is on individuals with developmental disabilities who are unable to access generic dental health services in their community. *The objective of these services is to maintain optimum levels of oral health.* [emphasis added]

Appendix 4 lists various services to be provided and includes the following section:

5. Program direction, policies and standards will be provided by the Senior Dental Health Consultant in the Ministry of Health Services.

99. British Columbia Ministry of Health, *Guidelines for Collaborative Service Delivery for Adults with Developmental Disabilities between Community Living B.C., Regional and Provincial Health Authorities, Ministry of Health Services and Ministry of Housing and Social Development* (January 2010), online: Province of British Columbia <<http://www.health.gov.bc.ca/library/publications/year/2010/Guidelines-collaborative-service-delivery-adults.pdf>> [*Guidelines*].

Multiple requests were made to Dr. Williamson, the senior dental health consultant in the Ministry of Health Services, and to CLBC, MSD (formerly MHSD) and the Minister of Health for a copy of the “Program direction, policies and standards” created under Appendix 4, but nothing was provided. Dr. Williamson advised in a telephone interview that there was “nothing in place” in the Ministry of Health, notwithstanding the obligation set out in Appendix 4, Section 5, of the *Guidelines*. Many sources in CLBC and in the Ministry of Health advised that they were unaware that the *Guidelines* existed, including dental hygienists with the Dental Health Services for Community Living (DHSCL) program who assist adults with DDs. Government’s commitment may be real, but operationally and administratively it is ignored by the departments charged with carrying out government policy.

The legal position of government relative to adults with DDs who cannot access dental treatment fits within the established category of a breach of duty of care as described in the *Just* decision. The B.C. government has made a policy decision to provide necessary dental treatment to adults with DDs, a policy with an objective “to maintain optimum levels of oral health.”¹⁰⁰ Government’s commitment arises through Ministry of Health policies made under applicable health legislation, its historical policy of providing care to this group, its current underwriting of the PWD dental insurance plan and through inter-ministerial agreements such as the *Guidelines*. It is reasonably foreseeable (and medically predictable) that failure to provide timely access to necessary dental treatment will cause physical harm to adults with DDs. Government’s clear duty of care is not being met because its administrative and operational methods do not accommodate the special needs of adults with DDs, in violation of government’s commitment set out in ministerial policy.

The reasoning of the SCC in *Just* was followed by the Ontario Court of Appeal in *Heaslip Estate v Ontario [Heaslip]*,¹⁰¹ which considered the issue of provincial government liability for failure to follow an established government policy. The action against the Ontario government was brought by the parents of the deceased, who claimed that the Ontario air ambulance service failed to give priority to their son, in violation of a provincial policy. Ontario had made a policy decision to direct air ambulances to give priority to those whose life was more endangered. The parents argued that the decision to give air ambulance priority to a less endangered person than their son was an operational decision. Following the reasoning in *Just* regarding an established category of duty of care, the Ontario Court of Appeal held that the operational decision made by the air ambulance managers failed to follow the provincial policy. By characterizing this decision as an operational rather than a policy decision, the court held that Ontario owed the plaintiffs a duty of care and was liable for a breach of that duty.

The Ontario court described the decision in *Just* as “the established category of a public authority’s negligent failure to act in accordance with an established policy where it is reasonably foreseeable that

100. *Guidelines*, *supra* note 99 at 11.

101. 2009 ONCA 594, 96 OR (3d) 401.

failure to do so will cause physical harm to the plaintiff.”¹⁰² The court held that “Ontario failed to follow its own policy,”¹⁰³ and thus the decision was operational in nature and not a policy decision, leaving the government liable to a negligence claim.

The analysis in *Just* and *Heaslip* applies equally to the situation facing adults with DDs in British Columbia. Provincial published policy affirms that hospitals must provide timely and equitable access to necessary treatment to all patients. The HAs indicate a desire to ensure equity among diverse populations. For example, the first goal in the current Service Plan¹⁰⁴ for Vancouver Coastal Health Authority (VCH) reads, in part, on page 6:

VCH is committed to helping residents who do not enjoy good health or who are at risk of diminished health, along with supporting residents who enjoy positive health status. VCH will focus on reducing health inequities in the populations we serve.... There will be emphasis on key populations, including Aboriginal peoples, young children, people with mental illness and/or problematic substance use, people of low socio-economic status, and people with chronic conditions.

This is a laudable goal, but it will not be met with regard to the dental health needs of adults with DDs unless VCH significantly enhances access to necessary dental treatment for those adults who require treatment in hospital.

The government also made a policy decision to close the institutions and support adults with DDs to live inclusively in community. Recognizing that specialized medical and dental services are needed to accommodate the special needs of this group, government made a policy decision to provide a dental plan for adults with developmental disabilities and to coordinate services of relevant ministries to ensure adults with DDs can receive optimal oral care. The policy must be implemented in good faith. It is not sufficient to offer the dental plan if government takes no steps to ensure that adults with DDs can access treatment. The policies speak to the government’s commitment to the health and well-being of adults with DDs. If operational or administrative decisions made by government agents fail to follow those policies, the courts will impose liability on government for a breach of its duty of care.

102. *Ibid* at 21.

103. *Ibid* at 28.

104. Vancouver Coastal Health, *2012/13–2014/15 Service Plan* (August 2012), online: VCH <http://www.vch.ca/media/Service-Plan-2012-2012_Vancouver-Coastal-Health.pdf>. Provisions of the *Hospital Act* and *Hospital Act Regulations* regarding requirements for Hospital Board Bylaws are apparently no longer followed, despite provisions such as Section 5 of the regulations, which mandates certain information that must be included in the bylaws. Instead, the HAs follow the mandate of the *Health Authorities Act*, which requires development of a Service Plan.

It would be unreasonable and unlawful for government to argue that the lack of access to treatment faced by adults with DDs exists because of a policy decision to delay treating this group. That argument would be evidence of discrimination against adults with DDs in breach of their human rights and in breach of government's duty of care. The delays that face adults with DDs in accessing dental treatment in hospital are *operational* in nature. The delays that face adults with DDs in accessing dental treatment in community are *administrative* in nature, since government could make the administrative decision to establish specialized clinics or improve funding for treatment by community dentists.

The Government of B.C. has an established duty of care to ensure that dental treatment in hospital and in community is reasonably accessible to adults with DDs. Failure to meet that duty will impose liability on government.

Duty of Care Arising from a History of Interactions

The use of the *Anns* test to establish liability against a government regulator was carefully considered by the SCC in the 2001 case of *Cooper v Hobart* [*Cooper*].¹⁰⁵ Unlike the *Just* decision, the case did not concern an established category of liability for government, such as operationally failing to follow established policy. In *Cooper*, the court considered whether it was appropriate to establish a new category of liability, based on a claim of pure economic loss, caused by the provincial regulator of mortgage brokers failing to take prompt action against a registrant.

The SCC examined how the proximity test in *Anns* should be applied and determined that the test required more than mere foreseeability of harm. While acknowledging that it is not always straightforward to determine how proximity is established, the SCC offered these thoughts:

Defining the relationship may involve looking at expectations, representations, reliance, and the property or other interests involved. Essentially, these are factors that allow us to evaluate the closeness of the relationship between the plaintiff and the defendant and to determine whether it is just and fair having regard to that relationship to impose a duty of care in law upon the defendant.¹⁰⁶

In the *Cooper* case, the court held that it was not sufficient that the regulator's careless acts could foreseeably harm investors for them to establish a *prima facie* duty of care; it was necessary to show that there was proximity between the investors and the regulator. The court decided that the investors, who were arguably limitless in number, could not demonstrate the required degree of proximity. In addition, the court decided that the potential duty of care owed to the general investing public would expose government to an unlimited liability. Finally, the court in *Cooper* determined that where a regulator's powers are strictly defined by statute, any duty of care must be found within the statute.

105. [2001] 3 SCR 537, 2001 SCC 79.

106. *Ibid*, McLachlin, CJ, and Major, J, at para 34.

The issue of proximity between the parties was examined again in the 2011 *Imperial*¹⁰⁷ decision of the SCC. In *Imperial*, certain tobacco companies sought to add the federal government as a third party to a lawsuit being brought against them by the Province of B.C. for health care costs allegedly caused by the effects of cigarette smoking. The tobacco companies argued that they had entered into a relationship of proximity with the federal government in connection with the promotion of low-tar cigarettes and had relied on government's negligent misrepresentations. On examination of the history of interactions between government and the tobacco companies, the SCC agreed that a special relationship of proximity had been established between the parties.

The SCC did not alter the two-stage *Anns* test as the appropriate method of analysis; however, the court elaborated on the circumstances under which a situation of proximity may arise between the government and claimants. The court distinguished cases where the *prima facie* duty of care arises directly from statute, such as in *Cooper*, from cases where proximity between government and the claimant(s) arises from a history of interactions between the parties.

In *Imperial* the court held that government can “through its conduct, [enter] into a special relationship ... sufficient to establish the necessary proximity for a duty of care.”¹⁰⁸ The SCC held that a relationship of sufficient proximity existed between Canada and the tobacco companies to establish a *prima facie* case. However, the court also confirmed that if the duty to the public found in the underlying statute would conflict with a private law duty of care, then this might negate a finding of proximity.

Having established that a special relationship of proximity existed between government and the tobacco companies, the court turned to the second stage of the *Anns* test. The SCC followed its earlier decision in *Just* regarding the immunity of government from liability for core policy decisions. The SCC held that the actions of government in *Imperial* were based upon core public policy considerations and were immune from a finding of liability. The Chief Justice offered the additional opinion, however, that “the prospect of indeterminate liability is fatal to the tobacco companies’ claims of negligent misrepresentation.”¹⁰⁹ The *Imperial* decision stands for the proposition that a finding of proximity may be based on the history of interactions between government and the claimant(s), but liability for breach of duty may not be imposed if it would conflict with a public law duty, if government’s action was based on core government policy, or if it would expose government to unlimited liability.

The relationship between adults with DDs and government gives rise to a duty of care based upon the SCC analyses of proximity in both *Cooper* and *Imperial*. As described in Chapter 3, the close relationship between government and adults with DDs has existed since B.C. became a province, both under statute and through a century of interactions. The Province took responsibility for the care and

107. *Imperial*, *supra* note 93.

108. *Ibid*, per McLachlan, CJ, at para 45.

109. *Ibid* at para 99.

well-being of adults with DDs from its inception pursuant to statute, government policies, and day-to-day management of the institutions in which these adults lived, worked, and received medical care and dental treatment. The province continues to oversee protection of adults with DDs through various statutes and multiple policies applicable to Community Living B.C. and the agencies and individuals who contract with CLBC to provide care and services for these adults.

Adults with DDs must rely on government to ensure that their best interests are protected. Where government fails to ensure the protection of adults with DDs, it is reasonably foreseeable that this group will suffer. The B.C. courts confirmed that government's failure to ensure that residents of the institutions were not abused gave rise to a class action against government.¹¹⁰ The first stage of the *Anns* test for proximity is met in the special relationship of proximity between government and adults with DDs.

Government's legislative obligations to adults with DDs began in the 1800s and have continued ever since. Government's failure to adhere to its obligations towards adults with DDs regarding access to dental treatment is relatively recent, commencing with the closure of the institutions. The failure to ensure access to necessary dental treatment either in hospitals or in community cannot be saved as representing a core public policy. To the contrary, the failure to ensure access is a violation of government's statutory obligations and private law duty of care.

Government would not be exposed to unlimited liability through a finding that it breached its duty of care to ensure adults with DDs receive timely access to necessary dental treatment. Less than 5% of the population falls within the definition of DD. The government already provides some financial assistance to this group for dental treatment, so its exposure would only increase by the amount needed to ensure optimal oral health necessary to meet the *Charter* rights and human rights of adults with DDs. Also, pursuant to Section 26(4)(c) of the *Employment and Assistance for Persons with Disabilities Act [EAPDA]*, under which the dental supplements are provided, the government is entitled to make specific regulations that differentiate between groups and is not required to offer identical benefits to everyone who qualifies for assistance under the legislation.

110. *Richard v HMTQ and WW and DW by Litigation Guardian, the PG&T of BC v HMTQ*, 2003 BCSC 976. The class action was subsequently settled by the parties under an agreement by the Province to make adjudicated payments to adults with DDs who had suffered abuse. No payments under the settlement agreement have been made by the Province as at December 2012. See discussion under "Civil Actions" in Chapter 5.

The section reads as follows:

(4) In making regulations under this Act, the Lieutenant Governor in Council may do one or more of the following:

...

(c) make different regulations for different groups or categories of persons or family units.

In light of *EAPDA* Section 26(4)(c), the government could enhance dental benefits solely for adults with DDs and is not exposed to unlimited liability to all groups in community who require governmental assistance for dental treatment.

As this analysis demonstrates, no plausible policy considerations exist to negate government's duty of care to ensure that adults with DDs receive timely access to necessary dental treatment.

Fiduciary Duty

[T]he special characteristics of governmental responsibilities and functions mean that governments will owe fiduciary duties only in limited and special circumstances.... [However, a] fiduciary duty can exist toward a class—for example, adults in need of a guardian or trustee...¹¹¹

—Beverley McLachlin, Chief Justice of Canada,

Alberta v Elder Advocates of Alberta Society

In the 2011 decision of *Alberta v Elder Advocates of Alberta Society* [*Elder*],¹¹² the SCC again confirmed that the two-stage *Anns* test is appropriate to decide claims against government for breach of a duty of care. However, the court also definitively pronounced on when and whether a claim for breach of fiduciary duty may be brought against government. The SCC confirmed that government will rarely be found to have a fiduciary obligation towards a person or group, and it set out the circumstances for deciding when a fiduciary duty might exist. The court also confirmed that a claim for breach of fiduciary duty should be brought only in those few cases where it is likely to have some chance of success.

Arguably, adults with DDs represent one of the rare cases where government holds a fiduciary obligation towards a class of people. Chief Justice McLachlin mentions the role of government as a guardian on several occasions throughout the *Elder* decision, highlighting the case where there is a “fundamental human or personal interest that is implicated when the state assumes guardianship of a child or incompetent person”¹¹³ as a sufficient interest to impose a fiduciary duty on government.

111. *Alberta v Elder Advocates of Alberta Society*, 2011, SCC 24, [2011] 2 SCR 261, at paras 37 and 50 [*Elder*].

112. *Ibid.*

113. *Ibid* at para 51.

The court confirmed that the general principle that a fiduciary must act in the best interests of the beneficiary, before all others, works against the concept of government holding a fiduciary obligation to individuals or special groups within society, since government must act on behalf of everyone. Nevertheless, the federal government has been held to owe a fiduciary obligation to Aboriginal peoples with respect to administration of their lands.¹¹⁴ The court examined the basis for government's fiduciary duty in the management of Aboriginal lands and found that it was grounded in a form of private law duty arising out of a historic relationship between government and the Aboriginal peoples of Canada. Chief Justice McLachlin highlighted the *Royal Proclamation* that provided the original commitment of the Crown:

The necessary undertaking is met with respect to Aboriginal peoples by clear government commitments from the *Royal Proclamation* of 1763 (reproduced in R.S.C. 1985, App. II, No. 1) to the *Constitution Act, 1982* and considerations akin to those found in the private sphere. It may also be met where the relationship is akin to one where a fiduciary duty has been recognized on private actors.¹¹⁵

This same historical commitment is found in the case of government's relationship with adults with DDs. The Crown's responsibility for adults with DDs in England was established under the 1324 Statute cited as *17 Edward II*.¹¹⁶ The Crown's responsibility was incorporated into the English *Lunacy Act*, which became the basis for the earliest B.C. *Lunacy Act*, enacted in 1897. An unbroken chain of legislation setting out government's duty of care towards adults with DDs has existed since that date. (This history is described in detail in Chapter 3.)

Similar to the undertaking in the *Constitution Act, 1867*, 91(24) confirming the federal government's responsibility over "Indians, and Lands reserved for the Indians," so does Section 92(7) of the *Constitution Act* provide exclusive powers over "The Establishment, Maintenance, and Management of ... Asylums" to the provinces. And similar to the relationship between the government and Aboriginal peoples, the relationship between government and adults with DDs is also *sui generis* (or "of its own kind"), and should be defined in the light of the history of government's responsibility to ensure the welfare of adults with DDs.

The fiduciary duty owed to the Aboriginal peoples of Canada is unique, but so too is the nature of the fiduciary obligation owed to adults with DDs. Just as the relationship between government and Aboriginal peoples is trust-like, at least with respect to their lands, so too is the relationship between government and adults with DDs, particularly as the latter are, by definition, in need of guardian-like assistance.

114. *Guerin v The Queen*, [1984] 2 SCR 335.

115. *Elder*, supra note 111, per McLachlin, CJ, at para 48.

116. The legislative history of governmental responsibility for adults with DDs is set out in Chapter 3.

This trust obligation is statutorily imposed under the *Public Guardian and Trustee Act*,¹¹⁷ the *Patients Property Act*,¹¹⁸ and related provincial legislation (see Chapter 3). This trust obligation is also shown in the *parens patrie* (or “parent of the country”) power of the courts to act on behalf of an adult with DDs to make decisions in the best interests of that adult.

The nature of the *parens patrie* power of the court was explained by Justice Gérard La Forest in the case of *E. (Mrs.) v Eve*,¹¹⁹ which concerned an application by a mother to have her developmentally disabled daughter sterilized. In refusing the mother’s request, Justice La Forest explained that the *parens patrie* power of the court can only be used for the best interests of the adult with DDs, and not for the benefit of anyone else, even a concerned mother. He stated:

The *parens patriae* jurisdiction is, as I have said, founded on necessity, namely the need to act for the protection of those who cannot care for themselves. The courts have frequently stated that it is to be exercised in the “best interest” of the protected person, or again, for his or her “benefit” or “welfare.”

The Crown’s *parens patriae* jurisdiction exists for the benefit of those who cannot help themselves, not to relieve those who may have the burden of caring for them.¹²⁰

The fiduciary obligation owed to adults with DDs is to ensure their health and well-being. This obligation does not flow solely from the statutory requirement to fund benefits under the *EAPDA*. The court in *Elder* confirmed that government does not attract a fiduciary duty simply because it offers a benefit scheme, since entitlements to benefits are a creation of public law. The PWD dental plan is simply one means by which government’s fiduciary obligation may be met. Government must ensure that dental treatment is actually accessible and received so that adults with DDs remain in good health.

Most adults with DDs are unable to independently access medical and dental treatment; in fact, many adults with DDs require assistance with every aspect of daily living. Government acknowledges that these individuals require special assistance and has enacted detailed legislation and regulations that establish minimum standards of care applicable to caregivers and agencies. For example, Section 7 of the *Community Care and Assisted Living Act*¹²¹ and *Residential Care Regulation* Section 54 (see Appendix 2) set out detailed obligations for caregivers, including the obligation to assist people in care to obtain professional dental services.

117. RSBC 1996, c 383.

118. RSBC 1996, c 349.

119. [1986] 2 SCR 388.

120. *Ibid* at paras 73 and 92.

121. SBC 2002, c 75.

Residential Care Regulation Section 54(3)(b)(ii) is an example of government’s attempt to meet its fiduciary obligation to adults with DDs. This section states:

- 54 (3) A licensee must . . .
- (b) assist persons in care to . . .
- (ii) obtain professional dental services as required

The fact that caregivers are unable to obtain professional dental services for adults with DDs is an example of government’s failure to meet its fiduciary obligation.

Adults with DDs are, by definition, vulnerable people. However, the *Elder* decision confirmed that vulnerability alone is not sufficient to impose a fiduciary obligation on government. Many people become vulnerable as they age and many groups in society are vulnerable. The situation of adults with DDs differs from the elderly patients in the *Elder* case not because they are highly vulnerable, but because adults with DDs have never been competent to care for themselves or make arrangements for their future care, as most adults can. The SCC noted in the *Elder* case that most of the class members were still competent to manage their own affairs or had appointed their own guardians and trustees. Adults with DDs are people who legally have never been able to manage their own affairs.

As described in Chapter 3, throughout the history of the province, government frequently acknowledged its responsibility towards adults with DDs. In 1987, Honourable Claude Richmond, then minister of Social Services and Housing, stated in connection with government’s decision to close the institutions:

Deinstitutionalizing people generally does not save dollars. It generally costs more to integrate them into the community than to leave them in institutions. I think that dollars are secondary in this case. *It’s what’s best for these people that we’re interested in...*¹²² [emphasis added]

Government committed to the families of adults with DDs, and to the community generally, that systems would be put in place to do “what’s best for these people” when the institutions were closed. The Province fails to meet that commitment respecting access to dental treatment. No steps have been taken to enhance access, no specialized clinics built or special-purpose OR suites created. The *Guidelines* purport to offer inter-ministerial collaboration to enhance access, but no “policies, directions or standards” have been drafted for hospitals or dentists. No strategies have been developed to speed access to dental treatment in hospital or to enhance access in community.

122. British Columbia, Legislative Assembly, *Official Report of Debates (Hansard)*, 34th Parl, 1st Sess (31 March 1987) at 368 (Claude Richmond).

Government has failed to meet its historical obligation to care for adults with DDs, an obligation that might be construed as a fiduciary duty. By failing to ensure the health and well-being of adults with DDs through providing timely access to necessary dental treatment, government breaches its historical obligation and commitment to this group, and is therefore liable for dereliction of its duty.

Government Oversight of Dentists

The practice of dentistry is designated as a “health profession” under the *Health Professions Act (HPA)*.¹²³

A health profession is defined as follows in Section 1:

a profession in which a person exercises skill or judgment or provides a service related to

- (a) the preservation or improvement of the health of individuals, or
- (b) the treatment or care of individuals who are injured, sick, disabled or infirm

The *HPA* sets out the primary duty and the objects of every college designated as a health profession under the act. The primary duty of a college is as follows:

- (a) to serve and protect the public, and
- (b) to exercise its powers and discharge its responsibilities under all enactments in the public interest.

When the *HPA* was enacted, it recognized and continued the College of Dental Surgeons of B.C. CDSBC is mandated under *HPA* Section 16(2) to superintend the practice of dentistry in the province and to govern registrants in accordance with the *HPA*, the *HPA* regulations and CDSBC bylaws. The CDSBC must set standards for practice, administer registration of dentists in general practice or in approved specialties of dentistry, and discipline dentists who fail to meet the required standards of professional practice. The CDSBC must also establish standards of professional ethics and standards for continuing competency.

Under the *HPA*, the CDSBC is given power to establish the competencies required for registration as a dentist under its bylaws. Part 6 of the college bylaws entitles the CDSBC to establish rules for registration. However, where the Minister of Health considers it in the public interest to do so, he may request the board of a college, pursuant to *HPA* Section 19(5), to amend or repeal a bylaw if the minister is satisfied that it is necessary or advisable to do so.

123. RSBC 1996, c 183.

The CDSBC does not require dentists or applicants for registration as a dentist to be competent to treat adults with DDs. The CDSBC therefore fails to meet its *HPA* Section 16(1) duty to serve and protect the public. Adults with DDs are members of the public, and the dental profession must be qualified to meet their needs. The minister has the power to amend the CDSBC bylaws to require dentists to be competent to treat adults with DDs as a professional standard for registration.

As explained in Chapter 1, undergraduate dentists in B.C. receive little or no training to treat adults with DDs. Training dental students in the ability to treat adults with DDs under general anaesthetic (GA) requires access to hospital OR time. Training them to treat physically disabled adults with DDs in community (or outside of hospital) may require access to clinics with specialized equipment, such as lifts to move a patient from a wheelchair into a dental chair, and other specialized tools. Training dental students to treat adults with functional deficits and challenging behaviours may require classroom time to learn from behavioural consultants how to communicate with adults with DDs who do not speak, read or write, and who may become anxious or aggressive. Dentists require education on receiving informed consent from substitute decision-makers.

Teaching these competencies requires the UBC Faculty of Dentistry to spend time and money. Students would be required to dedicate some portion of their education to learning how to treat adults with DDs, although the undergraduate curriculum is already extremely demanding. Training students to treat adults with DDs under GA in hospital requires access to ORs under clinical/academic oversight. The Ministry of Health, the university and the dental faculty have not worked together to create the necessary access to hospital ORs or in specialized dental clinics to provide this training. Because of the cost and time involved, the governmental and academic response to this need has been to ignore the ethical requirement to ensure that dental students are trained to treat all members of the community.

The Canadian colleges of dentistry, including the CDSBC, have accepted that omission and do not require Canadian faculties of dentistry to ensure that students are competent to treat adults with DDs as a requirement to be registered to practise. The faculties of dentistry are accredited by the Commission on Dental Accreditation of Canada without being required to confirm that students achieve a level of competency in treating adults with DDs. Students can and do graduate without knowledge of how to treat these members of the community.

The B.C. Minister of Health has the power to ask the CDSBC to amend its bylaws to require that dental registrants hold sufficient competency to treat all members of the community, including adults with DDs. The minister must do so to ensure that adults with DDs have equal access to appropriate professional dental care as all other members of society.

Dentists are recognized as health care practitioners under the *Medicare Protection Act* and the Regulations to the *Hospital Act*, as well as under the *HPA* and the *Canada Health Act*. The dental profession provides treatment to people in the public health care system. It is unethical for the profession not to ensure that dentists are trained to meet the needs of all people, including adults with DDs. This lack of competence in the dental profession creates inequity in services typically available under publicly funded health care.

One object of a college under *HPA* Section 16(2)(k)(i) is:

(k) in the course of performing its duties and exercising its powers under this Act or other enactments, to promote and enhance the following:

(i) collaborative relations with other colleges established under this Act, regional health boards designated under the *Health Authorities Act* and other entities in the Provincial health system, post-secondary education institutions and the government.

Government is responsible to demand that the CDSBC meet the terms of the *HPA*. Therefore, government must require the CDSBC to collaborate with HAs and the UBC Faculty of Dentistry to ensure dental students become competent to meet the needs of adults with DDs.

CHAPTER 3

History of Government Responsibility

B.C. legislative history concerning the care and treatment of adults with DDs confirms that from the time the province joined Confederation, provincial legislators considered government to be responsible for the care of these people. This chapter examines the origin and development of these laws; it highlights reports and information corroborating how government accepted responsibility for the health and dental care of adults with DDs throughout the history of the province.

Contemporary B.C. legislation concerning governmental responsibility for the care and treatment of persons with DDs or mental illness can be traced back to early English law. The earliest reference to the Crown's responsibility for "idiots" in English law dates to the 1324 English statute cited as *17 Edward II*. This declared that the King "shall have ward of the lands of natural fools, taking the profits without waste or destruction, and shall find them their necessaries; and after the death of such idiots he shall render the estate to the heirs; in order to prevent such idiots from aliening their lands, and their heirs from being disinherited."¹²⁴ Sir William Blackstone explained the English law pertaining to "lunacy" and the estates of mentally incompetent persons at that time in his *Commentaries on the Laws of England* as follows:

And therefore it is declared by the statute 17 Edw. II. c. 10 that the king shall provide for the custody and sustentation¹²⁵ of lunatics, and preserve their lands and the profits of them, for their use, when they come to their right mind: and the king shall take nothing to his own use; and if the parties die in such estate, the residue shall be distributed for their souls by the advice of the ordinary, and of

124. Statute Prerogative Regis, *17 Edward II* (AD 1324), c 9.

125. Old Middle English word meaning "something that sustains; a support."

course (by the subsequent amendments of the law of administrations) shall now go to their executors or administrators.¹²⁶

The two dominant legislative issues in the early law were “Lunacy” and “Asylums for the Insane.” Legislation addressing lunacy generally concerns the maintenance of the property of persons deemed incapable of maintaining their affairs. Legislation relating to insane asylums concerned the commitment, hospitalization and care of insane persons. The development of each branch of legislation in B.C. is described below.

The Lunacy Acts

The quote from Blackstone’s *Commentaries* confirms the responsibility of the King and Crown to preserve and protect the estates of persons deemed “lunatic” for the benefit of their descendants and to provide necessary support to “lunatics.” These concepts were consolidated in the English *Lunacy Act*¹²⁷ of 1890, which defined a “lunatic” as “any person-idiot lunatic or of unsound mind and incapable of managing himself or his affairs whether found lunatic by inquisition or not.”¹²⁸

In 1866, various British colonies in what is now B.C. amalgamated to form the Colony of British Columbia. The colony was deemed by common law to have imported British Law,¹²⁹ so the British imperial laws were applicable in the new colony. B.C. joined Canadian confederation in 1871. The following year the provincial government took responsibility for the welfare of people with mental disabilities. Previously the colony had taken expedient measures such as exiling the mentally ill back to their home countries, sending them to California or placing them in prisons in Victoria and New Westminster.¹³⁰

In 1872, B.C. opened the Victoria Lunatic Asylum. It was a former pest house, located “on expropriated Songhees First Nations lands.”¹³¹ In 1897, the B.C. legislature enacted *An Act Respecting the Care and Commitment of the Persons and Estates of Lunatics*,¹³² to be cited as the *Lunacy Act*. This legislation essentially duplicated the British statute of 1890, altering it slightly to refer to local courts and registries. The definition of lunatic under the B.C. *Lunacy Act* included a person who is “through mental infirmity

126. Sir William Blackstone, *Commentaries on the Laws of England*, 9th ed (London: Cavendish, 2001) v 1, ch 8 at 303.

127. 53 Vict c 31.

128. *Ibid*, s 1 (Imp) c 5.

129. WHP Clement, *The Law of the Canadian Constitution*, 3d ed (Toronto: Carswell, 1916) at 271.

130. Val Adolph, *In the Context of Its Time: A History of Woodlands* (Richmond, BC: Government of British Columbia, Ministry of Social Services, 1996) at 1-3 [*A History of Woodlands*].

131. Robert Menzies & Chris Atchison, *Archive on the History of Madness in British Columbia* (2009), online: History of Madness in Canada <http://historyofmadness.ca/index.php?option=com_content&view=article&id=52&Itemid=42> at introduction.

132. 61 Vict c 126.

arising from disease or age or otherwise, incapable of managing his affairs.”¹³³ The *Lunacy Act* provided a scheme for determining lunacy and described the powers of the judiciary over the property and estates of a lunatic, including the administrative powers of a judge to maintain and dispose of the lunatic’s property, financial assets and estates in general. At this time “causes of insanity” were thought to include masturbation, living alone, money troubles, religious excitement and intemperance.¹³⁴

This legislation existed essentially intact until the 1900s. In 1911, the act was revised to empower the attorney general to act as the committee for persons who had no property.¹³⁵ Committee was the term given to the person or persons responsible for the affairs of an incapable adult, functioning similarly to an executor of the lunatic’s estate. Various amendments were made between 1912 and 1936 dealing with administrative issues, the committee scheme, and the power of the attorney general to distribute the personal effects of a deceased lunatic to their remaining family members. Amendments in the 1940s and 1950s updated the language to reflect contemporary terminology and medical developments, such as medical psychology clinics.

In 1962, the B.C. *Lunacy Act* was replaced by *An Act Respecting the Estates of Mentally Incompetent Persons*,¹³⁶ known as the *Patients Estates Act [PEA]*. (For a list of this changing legislation, see Table 1.) To a large degree the *PEA* performed the same functions as its predecessor and applied to persons deemed incapable of managing their affairs, but it was modernized. For example, the *PEA* used the word “patient” rather than “lunatic,” and the act deleted any reference to lunacy. The *PEA* again confirmed the powers of B.C. judges and the attorney general to maintain or dispose of property of a person committed to a provincial hospital or clinic of psychological medicine. The section of the *PEA* describing the appointment and powers of a committee is more sophisticated than the prior legislation, and it includes the possibility of the patient nominating a person or persons to serve as his or her committee.¹³⁷ In 1973, the term “superintendent” was changed to “director” throughout the act. In 1979, the *PEA* was renamed the *Patients Property Act [PPA]*.¹³⁸

Few substantive changes were made until the 1990s, when the four acts that collectively comprise contemporary adult guardianship legislation were passed, including the *Representation Agreement Act [RAA]*,¹³⁹ the *Health Care (Consent) and Care Facility (Admission) Act [HCFA]*,¹⁴⁰ the *Public Guardian and Trustee Act [PGTA]*¹⁴¹ and the *Adult Guardianship Act [AGA]*.¹⁴² Though enacted in 1993, this

133. *Ibid*, s 2.

134. *A History of Woodlands*, *supra* note 130 at 40.

135. *Lunacy Act*, RSBC 1911, c 148, s 47.

136. SBC 1962, c 44.

137. *Ibid*, s 10.

138. RSBC 1979, c 313.

139. RSBC 1996, c 405.

140. *Ibid*, c 181.

141. *Ibid*, c 383.

142. *Ibid*, c 6.

legislation was not brought into force until 2000, and then only in part. The legislation, especially the *RAA* proposal to replace the power of attorney, was contentious and ultimately this provision of the *RAA* was abandoned.

Section 7 of the *RAA* enables adults with DDs to make limited representation agreements permitting their representative to assist them with certain health and routine financial matters. The *HCFA* establishes the protocol for appointing substitute health care decision-makers and for obtaining informed consent, including for adults with DDs. The *PGTA* defines the powers of the Public Guardian and Trustee (PGT) regarding health care decisions, financial oversight and personal planning for adults with limited capacity. Most of the *AGA* has not been brought into force, and so many provisions of the *PPA* continue to operate in B.C. at the time of writing.

The current legislation maintains the historical government oversight for adults with DDs that existed in B.C. at the time that it joined Canadian confederation. There has been an unbroken link in the legislation recognizing the need for government to ensure the well-being of adults with DDs and to safeguard their financial assets. The role of the PGT as a fiduciary for adults with DDs (among others) descends directly from the obligation of the Crown and the earliest legislation concerning “lunatics” to assure the protection of this vulnerable group. Similarly, the historical role of the court in making orders in the best interests of an individual who is deemed incapable is adopted in the current *PPA*.

Table 1: B.C. Legislation Governing Maintenance and Estate Administration

Title	Year	Citations	Amendments	Repealed
<i>Lunacy Act</i>	1890	53 Vict, c 31	Adopted in B.C. in 1897	1962 Replaced by <i>Patients Estates Act</i>
	1897	RSBC 1897, c 126	—	
	1911	RSBC 1911, c 148	<ul style="list-style-type: none"> • 1912, c 22 • 1916, c 39 • 1918, c 52 • 1923, c 42 	
	1924	RSBC 1924, c 149	<ul style="list-style-type: none"> • 1926/27, c 40 • 1929, c 38 • 1933, c 37 	
	1936	RSBC 1936, c 162	<ul style="list-style-type: none"> • 1943, c 35 	
	1948	RSBC 1948, c 194	<ul style="list-style-type: none"> • 1951, c 57 • 1953, c 24 • 1955, c 45 	
	1960	RSBC 1960, c 226	—	
<i>An Act Respecting the Estates of Mentally Incompetent Persons</i> Known as <i>Patients Estates Act</i>	1962	SBC 1962, c 44	<ul style="list-style-type: none"> • 1964, c 36 • 1965, c 32 • 1968, c 36 • 1973(2), c 127 • 1976, c 33 	1993 Replaced by quartet of adult guardianship legislation (see below). Some provisions still in force.
	1979	RSBC 1979, c 313 Renamed <i>Patients Property Act</i>	<ul style="list-style-type: none"> • 1980, c 50 • 1982, c 7 • 1984, c 27 • 1985, c 51 • 1993, c 64 	
<i>Public Trustee Act</i>	1963	SBC 1963, c 38	<ul style="list-style-type: none"> • 1968, c 53 • 1969, c 35 • 1975, c 64 • 1977, c 31 • 1981, c 15 • 1987, c 11 • 1989, c 11 	1993 Replaced by <i>Public Guardian and Trustee Act</i> Repeal effective: February 28, 2000
<i>Adult Guardianship Act</i>	1996	RSBC 1996, c 6	—	—
<i>Health Care (Consent) and Care Facility (Admission) Act</i>	1996	RSBC 1996, c 181	—	—
<i>Public Guardian and Trustee Act</i>	1996	RSBC 1996, c 383	—	—
<i>Representation Agreement Act</i>	1996	RSBC 1996, c 405	—	—

The Asylum Acts

Under the Canadian division of powers, responsibility for hospitals and asylums is a provincial matter.¹⁴³ At the time that B.C. joined Confederation in 1871, only the Victoria Royal Hospital treated people deemed mentally ill or insane. The institution was eventually governed by the second legislative scheme pertaining to lunacy and insanity, entitled *An Act Respecting Asylums for the Insane*,¹⁴⁴ enacted by the B.C. legislature in 1873. This act established provincial authority over asylums for the care and treatment of insane persons and outlined the powers and responsibilities of the Medical Superintendent.

The Medical Superintendent was required to direct the “medical and moral” treatment of the patients, supervise the internal management of the institution, and report to government monthly and annually on events at the facility.¹⁴⁵ In 1878, the Medical Superintendent supervised the opening of the Provincial Asylum for the Insane (PHI) at New Westminster, which was subsequently named Woodlands. Early reports express concern about the lack of necessary medical facilities for the patients, although the PHI possessed an “up-to-date” operating room at this time.¹⁴⁶ The reports provide detailed information on the treatments given to the patients and even describe the exact diets provided to residents.¹⁴⁷

In 1897, the legislature repealed the 1873 act and replaced it with *An Act to Amend and Consolidate the Law Relating to Lunatic Asylums and the Care and Custody of the Insane*.¹⁴⁸ Consistent with the *Lunacy Act*, this legislation defined lunatic as “any insane person, whether found so by inquisition or not, or any idiot, or imbecile, or person of unsound mind.”¹⁴⁹ A Public Hospital for the Insane was defined as a “[h]ospital established or acquired under any grant from the Legislature of this Province, for the custody and treatment of Lunatics, of which all the property and effects, real and personal, belonging thereto shall be vested in the Crown.”¹⁵⁰ Very little changed in the period between 1897 and 1912, when the act was renamed the *Mental Hospitals Act* [MHA], no doubt reflecting changing social attitudes towards mental illness. (For a summary list of this legislation, see Table 2.)

In 1940, the majority of provisions concerning insanity or lunacy in the MHA were reworded to describe “mental illness,” apart from references to the still operational *Lunacy Act*. A “mentally ill” person was defined as “suffering from such a disorder of the mind as to require care, supervision, and control for his own protection or welfare or for the protection of others, and includes any idiot, imbecile or other person of unsound mind; also any person who is a lunatic within the meaning of the *Lunacy Act*.”¹⁵¹

143. *Constitution Act, 1867* (UK), 30 & 31 Vict, c 3, reprinted in RSC 1985, App II, No 5, s 92(7).

144. *Insane Asylums Act*, 36 Vict 28, amended 1893.

145. *Ibid*, s 4.

146. British Columbia, “Report of the Medical Superintendent” in *Sessional Papers* (1902).

147. *Ibid*, and see generally the reports of the Medical Superintendent in the early *Sessional Papers*, 1887–1920.

148. *Hospitals for the Insane Act*, 61 Vict, c 101.

149. *Ibid*, s 2.

150. *Ibid*.

151. *Mental Hospitals Act*, SBC 1940, c 27.

In 1948, the legislature enacted the *Clinics of Psychological Medicine Act*,¹⁵² which closely mirrored the *MHA* but enabled establishment of specialized clinics adjacent to existing hospitals. Pursuant to this legislation, the province built Crease Clinic next to Essondale Hospital (subsequently renamed Riverview Hospital).

An amendment to the *MHA* in 1953 removed the antiquated references to imbeciles and idiots, reflecting the modernization of laws to accord with developments in the mental health profession, although it continued to refer to lunatics. The amendment defined a “mentally ill” person as “any person suffering from such a disorder of the mind as to require care, supervision, and control for his own protection or welfare or for the protection of others, and includes any person of unsound mind; also any person who is a lunatic within the meaning of the *Lunacy Act*.”¹⁵³

In 1953, the legislature passed the *Schools for Mental Defectives Act*.¹⁵⁴ The act defined a “mental defective” as a “person in whom there is a condition of arrested or incomplete development of the mind, whether arising from inherent causes, or induced by disease or injury, and who requires care, supervision, and control for his own protection or welfare or for the protection of others...”¹⁵⁵ This act governed Woodlands School, which was situated at the repurposed PHI in New Westminster.

Consistent with previous legislation, the act set out the responsibility of the Medical Superintendent to supervise the staff and patient care and to report to government. Section 5 required that monthly reports be submitted to the Director of Mental Health Services, who in turn reported to the Deputy Provincial Secretary. The superintendent’s annual reports to the Director of Mental Health Services were incorporated into the annual report submitted to the provincial legislature.

In 1964, B.C. repealed the *MHA*, the *Clinics of Psychological Medicine Act* and the *Schools for Mental Defectives Act* and passed *An Act Relating to Mental Health (Mental Health Act)*,¹⁵⁶ which revised the provincial mental health policies. The definitions in the *Mental Health Act* originally distinguished between a mentally disordered person, a mentally ill person and a mentally retarded person. Mental retardation was distinguished from mental illness on the basis that the person’s condition was one of arrested development of the mind.

152. RSBC 1948, c 52.

153. *Mental Hospitals Amendment Act*, SBC 1950, c 27, s 2.

154. SBC 1953, c 26.

155. *Ibid.*

156. SBC 1964, c 29.

The *Mental Health Act*, though amended since its initial passing, continues in force as a direct descendant of the earliest B.C. legislation governing asylums. The purpose of the current legislation is “the treatment of the mentally disordered who need protection and care...”¹⁵⁷ It is no longer applicable to adults with DDs unless they have a dual diagnosis of DD and mental illness.

Beginning in the 1970s, B.C. began closing institutions for people with DDs, such as Tranquille in Kamloops, and the last of the institutions were closed in the 1990s. The daily life of adults with DDs is no longer governed by mental health legislation. Adults with DDs are now eligible for “community living support” services funded by the Ministry of Social Development under the *Community Living Authority Act*.¹⁵⁸ Support services offered must include “a range of funding and planning options that promote choice, flexibility and self-determination, for example, individualized funding, independent planning support and the involvement of community resources.”¹⁵⁹ Government continues to have clear responsibility for the needs and well-being of adults with DDs, although these adults are finally able to choose the life they want to lead.

157. *McCorkell v Director of Riverview Hospital Review Panel* (1993), 104 DLR (4th) 391 (BCSC).

158. SBC 2004, c 60.

159. *Ibid*, s 12(1).

Table 2: Asylums for the Insane (Mental Health) Acts

Title	Year	Citations	Amendments	Repealed
<i>An Act Respecting Asylums for the Insane</i> Known as <i>Insane Asylums Act</i>	1873	36 Vict 28	<ul style="list-style-type: none"> • 1888, c 61 • 1893, c 18 	1897 Replaced by <i>Hospitals for the Insane Act</i>
<i>Hospitals for the Insane Act</i>	1897	61 Vict, c 101	—	1940 Replaced by revised <i>Mental Hospitals Act</i>
<i>Insane Asylums Act</i> Renamed <i>Mental Hospitals Act</i> in 1912	1911	RSBC 1911, c 111	<ul style="list-style-type: none"> • 1912, c 13 • 1920, c 56 	
	1924	RSBC 1924, c 58	—	
	1936	RSBC 1936, c 172	<ul style="list-style-type: none"> • 1937, c 44 	
<i>Mental Hospitals Act</i>	1940	SBC 1940, c 27	<ul style="list-style-type: none"> • 1941, c 19 • 1945, c 49 	1964 Replaced by <i>An Act Relating to Mental Health</i>
	1948	RSBC 1948, c 207	<ul style="list-style-type: none"> • 1950, c 48 • 1953, c 27 • 1958, c 29 	
	1960	RSBC 1960, c 241	<ul style="list-style-type: none"> • 1961, c 38 • 1961, c 59 	
<i>Clinics of Psychological Medicine Act</i>	1948	RSBC 1948, c 52	<ul style="list-style-type: none"> • 1950, c 8 • 1953, c 8 	
	1960	RSBC 1960, c 58	<ul style="list-style-type: none"> • 1961, c 59 	
<i>Schools for Mental Defectives Act</i>	1953	SBC 1953, c 26	<ul style="list-style-type: none"> • 1955, c 47 • 1958, c 28 • 1961, c 59 	
<i>An Act Relating to Mental Health</i> Known as <i>Mental Health Act</i>	1964	SBC 1964, c 29	<ul style="list-style-type: none"> • 1968, c 27 • 1969, c 17 • 1971, c 33 • 1973(2), c 127 • 1974, c 106 • 1976, c 33 	In force
	1979	RSBC 1979, c 256	<ul style="list-style-type: none"> • 1981, c 21 • 1983, c 10 • 1985, c 12 • 1987, c 42 • 1993, c 35 	
	1996	RSBC 1996, c 288	—	

Disability Benefits Legislation

In the post-war era, a dramatic expansion in social welfare programming took place throughout Canada. In 1945, the B.C. legislature enacted the *Social Assistance Act* [SAA],¹⁶⁰ which provided social assistance to individuals or families “who through mental or physical illness or other exigency are unable to provide in whole or in part by their own efforts ... necessities essential to maintain or assist in maintaining a reasonably normal and healthy existence.”¹⁶¹ In 1954, the *Disabled Persons Allowance Act* [DPAA] was introduced, which consisted of a federal-provincial cost-sharing program to provide a monthly benefit to disabled persons who were unable to work because of a disability that impaired their ability to perform daily activities. The eligibility criteria centred on the person’s medical condition, and not necessarily their capacity for employment. Regulations to the SAA defined eligible persons to include people receiving an allowance under the DPAA and who were in need.¹⁶² Under the 1966 *Canada Assistance Plan* (CAP), the federal government agreed to fund 50% of provincial government expenditures on provincial assistance and welfare services.¹⁶³

In 1972, B.C. passed the *Handicapped Persons’ Income Assistance Act* [HPIA].¹⁶⁴ People receiving benefits under the SAA and DPAA were transferred to benefit administration under the HPIA. The eligibility criteria were connected to potential employability, and benefits were restricted to those unable to work due to physical or mental disability. (For a summary list of this changing legislation, see Table 3.)

In 1975, replacement SAA regulations¹⁶⁵ were introduced that defined a “handicapped person” as a person “18 or older who in the opinion of the Director, with the advice of a medical practitioner and/or other trained specialist is unable and will likely continue to be unable to engage in any type of employment necessary for financial independence.”¹⁶⁶ The new regulations also provided coverage for dental care¹⁶⁷ pursuant to an agreement between the College of Dental Surgeons of British Columbia and the government. It stated that “basic dental care may be authorized by the administering authority and special or extensive work may be authorized by the Director.”¹⁶⁸ These SAA regulations were made regulations under the HPIA.¹⁶⁹

160. SBC 1945, c 62.

161. *Ibid*, s 3.

162. SBC 1954, c 7. also BC Reg 444/59. In 1971, these regulations were replaced by BC Reg 145/71, although little changed apart from the appeals procedure.

163. *Canada Assistance Plan*, SC 1966–67, c 45.

164. SBC 1972, c 4.

165. BC Reg 259/75.

166. *Ibid*, s 2(9).

167. *Ibid*, Schedule F, s 6.

168. *Ibid*.

169. BC Reg 382/75.

In 1976, the *HPIA* was repealed and a new income assistance program was established under the *Guaranteed Available Income for Need Act* [*GAIN*].¹⁷⁰ Eligibility depended on a combination of medical and social factors, including whether disability was “permanent.” The *GAIN* regulations defined a handicapped person as an

individual age 18 years or older who, at the discretion of the Director, has been designated as handicapped due to the individual being mentally ill or mentally retarded as defined in section 2 of the Provincial *Mental Health Act*, 1964... Such designation shall be made only after a qualified medical practitioner has confirmed that the disability is apparently permanent and that there is no remedial therapy available for the individual to significantly lessen the disability, and provided the disability is sufficiently severe that (a) the individual requires extensive assistance or supervision to manage normal daily functioning, or (b) as a direct result of the disability the individual requires unusual and continuous monthly expenditures for transportation, or for special diets or for other unusual but essential and continuous needs.¹⁷¹

Section 29 Schedule F permitted the administering authority to pay for health care services, including basic dental care and specialized care with the director’s authorization.

In 1995, CAP was abolished by the federal government and replaced with the Canadian Health and Social Transfer (CHST) legislation.¹⁷² The following year, B.C. introduced the *Disability Benefits Program Act* [*DBPA*].¹⁷³ The preamble to the *DBPA* emphasized the role of disability support programs in promoting the inclusion and integration of persons with disabilities into society and the importance of treating persons with disabilities with fairness, dignity and sensitivity. The *DBPA* contained two levels of benefits: Level I for clients who were required to periodically requalify and Level II for those persons whose disability was permanent.

In 2002, the B.C. legislature replaced the *DBPA* with the *Employment and Assistance for Persons with Disabilities Act* [*EAPDA*],¹⁷⁴ which remains in effect. Notably absent from the *EAPDA* is a preamble confirming government’s responsibility to treat disabled people with fairness and respect. In 2004, in response to the tightened eligibility criteria under the *EAPDA*, the auditor general of B.C. issued a report noting the high number of individuals who were forced to have their disability reassessed to determine whether they continued to be eligible under the new legislative scheme.¹⁷⁵

170. SBC 1976, c 19.

171. BC Reg 479/76, s 2(12).

172. *Federal-Provincial Fiscal Arrangements Act*, RSC 1985, c F-8.

173. RSBC 1996, c 97.

174. SBC 2002, c 41.

175. British Columbia, Legislative Assembly, Auditor General Report No. 6, 2003/04, *Audit of the Government’s Review of Eligibility for Disability Assistance* (Victoria, BC: Office of the Auditor General, 2005), online: <<http://www.leg.bc.ca/cmt/37thparl/session-5/pac/reports/Rpt-PAC-37-5-Report.htm#disability>>.

In 2004, the Canada Social Transfer (CST) was created when the federal CHST was split into two transfers: one for social assistance and services, post-secondary education, and services for children, and a second transfer for health services. Subsequent changes to the calculation of the CST in 2007 and 2008 reduced B.C.'s entitlement to CST dollars from the federal government.¹⁷⁶ B.C.'s entitlement to federal transfers under the CST has declined by almost 5% relative to the calculation used before the revisions.¹⁷⁷

The reduction in federal CST entitlement may be one reason why B.C. has not increased benefits and instead decreased the basic dental coverage provided to adults with DDs in 2009. As explained earlier in this report, the level of coverage provided to these adults under the *EAPDA* regulations is so poor, especially in light of their frequently compromised medical health, that it does not meet current Canadian standards for dental care.

As the institutions were closed during the 20 years from the 1970s through 1996, adults with DDs became eligible for coverage under the *EAPDA*. Although the program defines eligibility for coverage to include adults with DDs, it does not differentiate between the treatment needs of adults with complex medical or behavioural challenges and the needs of typical adults who are entitled to coverage because of low income. The dental treatment insured under the *EAPDA* is essentially the most basic dental coverage possible. The benefit scheme does not consider that many of these adults are so physically and behaviourally challenged that they must be treated in hospital or, at least, that they require more time and attention by a dentist to complete their treatment than is typical.

Although all adults with DDs should be supported to live in an inclusive community setting, they are also entitled to access necessary dental treatment. It appears that when the government and the community jointly embraced the concept of community living, the provincial government simply abandoned the prior commitment to proper dental care for adults with DDs that had been an accepted obligation of government over the many decades that the institutions operated.

The solution of insuring adults with DDs under a dental insurance plan intended to support typical people who require financial and other social assistance is untenable. The current dental coverage does not properly recognize the medical and behavioural needs of adults with DDs. Consequently, many dentists are unwilling to accept this client group and hospitals are badly equipped to meet their needs. The resulting hospital wait-lists of two to three years for necessary dental treatment for adults with DDs are a direct result of the failure of government to provide necessary access through specialized clinics and appropriate dental insurance.

176. James Gauthier & Shahrzad Mobasher Fard, "The Canada Social Transfer," Library of Parliament Research Publications PRB 08-57-E (23 July 2009), online: Parliament of Canada <<http://www.parl.gc.ca/content/LOP/ResearchPublications/prb0857-e.htm>>.

177. *Ibid.*

The B.C. government recognized its obligation to provide necessary medical and dental treatment to adults with DDs for all the years that the institutions operated. The government must find a way to ensure that the complex dental treatment needs of this group are met now that adults with DDs live in community.

Table 3: Disability Benefits Legislation

Title	Year	Citations	Amendments	Repealed
<i>Social Assistance Act</i>	1945	SBC 1945, c 62	—	1976 Replaced by <i>Guaranteed Available Income for Need Act</i>
	1948	RSBC 1948, c 309	—	
	1960	RSBC 1960, c 360	<ul style="list-style-type: none"> • 1961, c 59 • 1973, c 81 	
<i>Disabled Persons Allowance Act</i>	1954	SBC 1954 c 7	<ul style="list-style-type: none"> • 1955, c 18 	1980
	1960	RSBC 1960, c 113	<ul style="list-style-type: none"> • 1961, c 59 • 1977, c 75 	
<i>Handicapped Persons' Income Assistance Act</i>	1972	1972(2), c 4	—	1976 Replaced by <i>Guaranteed Available Income for Need Act</i>
<i>Guaranteed Available Income for Need Act</i>	1976	SBC 1976, c 19	—	1996 Replaced by <i>Disability Benefits Program Act</i>
	1979	RSBC 1979, c 158	<ul style="list-style-type: none"> • 1981, c 25 • 1982, c 8 • 1983, c 10 • 1984, c 25 • 1985, c 13 • 1988, c 4 • 1990, c 58 • 1995, c 25 	
<i>Disability Benefits Program Act</i>	1996	RSBC 1996, c 97	<ul style="list-style-type: none"> • 1997, c 15 	2002 Replaced by <i>Employment and Assistance for Persons with Disabilities Act</i>
<i>Employment and Assistance for Persons with Disabilities Act</i>	2002	SBC 2002, c 41	—	In force

B.C. Sessional Papers, 1873 to 1975: Reports of the Medical Superintendent

Beginning in 1873, the government-appointed Medical Superintendent began reporting annually to the B.C. legislature on the health and well-being of asylum patients, including the treatments provided to patients and events at the institutions during the year. The superintendent often included recommendations for changes to the facilities and to the type of treatment offered the patients, and also commented on beneficial developments. Summaries of the superintendent's annual reports to government are set out below (see also Table 4).

The superintendent's reports progressively indicate concern over the physical well-being of the patients. In 1916, the superintendent placed a dentist on the staff of the Provincial Hospital for the Insane (PHI) to work one day per week. In his 1917 report, the superintendent confirmed for government that the work of the dentist was of "inestimable value to the welfare of the patients," and he recommended routine examinations be carried out on all cases "both from a prophylactic and curative standpoint."¹⁷⁸ By 1921, the Medical Superintendent recommended to government that a resident dentist be hired who could devote "his entire time" to the dental needs of the patients. A full-time dentist was hired at the PHI in 1937.

A review of the dental treatments provided to patients in the following tables shows that the number and variety of treatments grew over the years, reflecting developments in the practice of dentistry. Initially, the dental work at the institutions was primarily comprised of extractions, but over time more fillings and other treatments were completed. By 1939, the reports refer to treatments completed under general anaesthetic, and by 1951 the reports confirm that Woodlands (the former PHI) provided all forms of medical and dental treatment to patients.

By 1973, the reports show that Woodlands housed a Dental Department for patients. All of this progress in ensuring access to dental care for adults with DDs was effectively abandoned when the institutions were shuttered. When Woodlands closed in 1996, the government made no attempt to replace the Dental Department with a specialized clinic or clinics in community.

During the 1980s, community programs and typical health services provided by government were found to be inadequate to meet the needs of some of the more medically compromised and severely challenged former residents of Woodlands who required many of the health care support services they had received in the institutions. In 1990, the Ministry of Social Services and Housing agreed to fund the Ministry of Health to provide specialized community-based nursing and rehabilitation services and preventative dental health services.¹⁷⁹ This program, called Health Services for Community Living (HSCL), began operating in 1993.

178. See years 1916 and 1917 in Table 4.

179. Louise Le Cavalier, "Health Services to Adults with Intellectual and Developmental Disabilities in British Columbia: Building Partnerships in our Communities" (2005) 2(1) *Int J Nurs Intellect Dev Disabil*, online: <<http://journal.ddna.org/volumes/volume-2-issue-1/articles/24-health-services-to-adults-with-intellectual-and-developmental-disabilities-inbritish-columbia-building-partnerships-in-our-communities>>.

A 1994 Ministry of Social Services and Housing report confirms that the government committed to funding the salary equivalent of five dental hygienists who would work throughout B.C. under a Dental Health Services for Community Living (DHSCCL) program together with a specialized dental team that would be available for training and consultation. At that time, the government budgeted approximately \$345,000 per year for these services.¹⁸⁰ Dr. Ernest Baja, who had been Woodlands' dentist for many years and continued to treat some former Woodlands residents, and Dr. Williamson, who became the senior dental consultant for B.C., recruited the dental hygienists for DHSCCL who would train group home care providers regarding dental hygiene practices for adults with DDs.¹⁸¹

There is no longer a specialized dental team available for consultation to DHSCCL. The original funding for five dental hygienists has not been increased.¹⁸² According to Dr. Williamson, the dental hygienists who work with DHSCCL express despair over the limited access to dental surgery in hospital for exceptionally challenged adults with DDs. Today there is no special dental clinic or hospital program. Instead adults with DDs face limited access to community dentists and cruel wait times for treatment in hospital. The government funds expert advice on cleaning teeth but provides minimal access to treatment for decayed teeth.

180. Norman Jacobsen & John Jansen, *Planning for the Future: A Proposal for Services for People with Mental Handicaps* (Victoria BC: Ministry of Social Services and Housing, 1991).

181. *A History of Woodlands*, *supra* note 130 at 135.

182. Today, approximately 20 hygienists around the province share the funding, each allocating a portion of their work time to this activity.

Table 4: Reports on Mental Health Institutions (Asylums) from B.C. *Sessional Papers*

Title	Year	Description
Report, Provincial Lunatic Asylum (Victoria) ¹⁸³	1873	“The existing accommodation for the insane of the Province is wretched and insufficient, and considering the consequent disabilities we labour under in treatment, the results are very satisfactory.”
Report, Provincial Lunatic Asylum	1874	“The responsibility of the care of the Insane rests with the Government and it can scarcely be well assumed without provision of suitable accommodation; should four or five additional applications for admission be made, there would not be house room for the increased number, and under existing circumstances it is impossible to bestow good treatment and comfort upon any.”—L.W. Powell (Medical Superintendent)
Report on the Royal Hospital	1877	Note: The Royal Hospital was the first facility to house the insane in B.C., prior to being relocated to the New Westminster facility when it opened in the late 1870s.
Report on the Royal Hospital and the Lunatic Asylum	1878	Details of the patients, 32 men and 2 women. General suggestions on improvement.
Report Asylum for the Insane at New Westminster (RAINW)	1885	Report mentions that no “paying patients” were admitted that year, indicating the government paid for all patients.
RAINW	1891	Discussion of further expenditures the government should provide.
RAINW	1892	Detailed statistical charts regarding the profile of the patients.
RAINW	1896	Detailed statistical tables outlining the profiles of patients and institutional expenditures.
RAINW	1897	Discussions of expansion of the facilities.
RAINW	1898	Detailed reports on the infrastructure of the facilities, expansion of the buildings.
RAINW	1900	“When it is remembered that this is the only place in the province for the reception of lunatics ... of any kind under the direct control of the Provincial government,” report recommends that inspectors be sent as an intermediary between province and facility. Also lists a number of required updates that have been left unattended.
RAINW	1902	The institution lacks “many facilities, even primary ones, for carrying on the most modern and scientific treatment of the insane, and narrowly escapes ranking as a mere house of detention.”
Report on Public Hospital for the Insane (RPHI)	1905	Addition of a new ward, including a surgical capacity for patients requiring surgical treatment. Discussion of the extremely poor condition of the facilities and the urgent need for repairs.
RPHI	1906	Extensive discussion of the need to expand, detailing the acquisition of land in Coquitlam for a new facility.

183. Note: Reports for some years are not included where there was nothing of relevance to mention.

Title	Year	Description
RPHI	1907	“All patients are regarded and treated as persons who are sick, and our treatment suited to the individual cases, according to their several needs, in an earnest effort to restore each to his normal condition.” Further discussion of the requirements of the institution.
RPHI	1909	<p>“The burden upon the taxpayer of caring for the constantly increasing numbers of the insane has occasionally given rise to a division of sentiment, when the question of appropriations for their care has been under discussion; but I can assure you that those members of the Legislature who oppose a liberal and enlightened policy do so under a mistaken idea of economy.”</p> <p>Note: Interesting pictures in the report.</p>
RPHI	1911	Discussion of the opening of a new facility in Coquitlam.
RPHI	1916	<p>First reference to dental care. A dentist, Dr. Smith, is placed on the staff of the facility at New Westminster and devotes one day per week to his work.</p>
RPHI	1917	<p>“The work of Dr. Smith has been proven of inestimable value to the welfare of the patients, as a great percentage of our admissions have neglected their teeth and many are in a deplorable condition, which has a most detrimental effect upon their digestive system. A regular routine examination is made of all wards and cases are treated as required, both from a prophylactic and curative standpoint.”</p> <p>Report: 522 extractions, 78 cleanings, 10 abscesses treated</p>
RPHI	1918	Dental Report: 494 extractions, 4 “root fillings,” 5 abscesses treated
RPHI	1920	Dental Report: 839 extractions, 4 “root fillings,” 111 scaling/cleaning, 167 “Various operations”
Annual Report of the Mental Hospitals of British Columbia	1921	<p>Dental care was provided by a visiting dentist.</p> <p>“This serves to care for the acute and urgent cases, but the limited time allotted only permits a very limited attention to prophylactic work, which is a very important feature indeed among a population many of whom have not yet been accustomed to more than cursory care of the mouth before mental illness attacked them. It is important indeed that our patients should have clean hands, faces, and bodies, but is it not even more important that they should have clean healthy mouths to eliminate one of the most common sources of focal infection from which so many serious bodily ills arise? I do not suggest that the elimination of unhealthy mouths will cure mental disease, but it will certainly do much to improve physical health and by so doing greatly supplement mental improvement. I feel, therefore, that our dental service should be extended very materially, and that the time is rapidly approaching for the appointment of a resident dentist who will devote his entire time to the dental needs of our ever-increasing population.”</p> <p>Dental report from visiting dentist: 1,279 extractions, 181 scaling/cleaning, 5 abscesses treated</p>

Table 4 continued on next page

Table 4: Reports on Mental Health Institutions *continued*

Title	Year	Description
Annual Report of the Mental Hospitals of British Columbia	1923	“Dental Work has been carried on, as in the past, by a visiting dentist, who devotes time each month to the patients’ dental requirements. The appended table shows the work accomplished. The Hospital Population has now become so large that it would be in the best interests of the patients to have a dentist continually employed in prophylactic work. There are many patients who will not take care of their mouths even when given every opportunity and encouragement, and these cases must be frequently attended by the dentist.” Dental Report: 453 extractions, 76 scaling and cleaning...
Report of the Mental Hospitals of British Columbia	1924	General overview on the condition at Colquitz, Essondale, Woodlands, etc. Dental Report includes 408 extractions, 81 polishing/cleanings, 16 dentures, etc. Report also includes a chart that outlines the hierarchy of responsibility.
Report, Mental Hospitals of British Columbia	1925	Dental Report: 453 extractions, 46 amalgam fillings, 24 cement fillings, 76 scaling/cleaning and 1 “general anaesthetics” (GA)
Report, Mental Hospitals of British Columbia	1929	Dental Report: 1 abscess treated, 514 extractions, 30 scaling/cleaning and 1 X-ray exam
Dental Report, Tranquille Sanitorium	1929/ 30	“The principal aims of the Clinic have remained the same as in preceding years—namely to remove all foci for infection, to restore the mouth to a healthy condition, and to maintain it as such as long as the patient is in the institution.” 661 fillings, 251 extractions, 16 root fillings, 76 prophylaxis and 4 “special cases”
Dental Report, Provincial Mental Hospital at Essondale	1929/ 30	410 extractions, 20 scaling/cleaning, 48 fillings and 20 “other treatments.” 37 pyorrhea treatment
Dental Report—Provincial Hospital for the Insane at New Westminster & Essondale	1934	Essondale: Patients treated = 435, 421 “patients had hopelessly diseased teeth extracted,” 219 local anaesthetic, 9 pyorrhea treatment... New Westminster: 211 treated, 131 diseased teeth extracted, 91 local anaesthetic, 7 special emergency calls...
Mental Hospitals Report	1939	“1,117 Examinations conducted in addition to the actual work required. The treatment in this service has done much to alleviate suffering.” Essondale: 1,117 examinations, 935 extractions, 103 periodontal treatments, 16 GA New Westminster: 314 examinations, 190 diseased teeth extracted, 90 local, 9 GA, 8 special emergency calls
Mental Hospitals Report	1947/ 48	Essondale: 777 examinations, 517 extractions, 272 fillings, 3 GA New Westminster: 185 examinations, 218 extractions, 27 GA, 49 fillings inserted and 27 gingivitis/pyorrhea treatments

Title	Year	Description
Mental Hospitals Report	1951	<p>“It is perhaps not generally realized that our mental hospitals furnish medical, surgical, psychiatric, psychological, radiological, pathological, neurological, and social services for our patients, and, in addition, provide food, fuel, clothing, shelter, drugs and medicines, occupational therapy, recreational therapy, spiritual and funeral services, and rehabilitation, besides concomitant services, such as dental, eye, ear, nose, and throat, hydrotherapy, cardiograph, optical, etc.”</p> <p>Essondale: 943 examinations, 2,470 extractions, 457 fillings, 191 prophylaxis, 41 GA...</p> <p>Woodlands School: 257 extractions, 124 examinations, 57 cleanings, 67 fillings</p> <p>Note: In 1950 the PHI is renamed Woodlands and repurposed as a residential facility and school for the developmentally disabled.</p>
Mental Hospitals Report	1961	<p>A program of examinations of patients was being conducted.</p> <p>Woodlands School: 3,929 dental procedures completed. 1,674 patients, 623 examinations, 1,221 fillings, 937 extractions, 93 X-rays</p>
Mental Hospitals Report	1963	<p>Woodlands School Dental Report: 1,539 patients, 517 examinations, 266 prophylaxis, 1,170 fillings, 534 extractions and 46 X-rays</p>
Mental Health Branch Report	1973	<p>Report on Woodlands School: Detailed reports of all the programs and activities undertaken at Woodlands.</p> <p>“The Dental Department, in addition to increasing the amount of restorative work and oral rehabilitation, improved in-service education of nursing personnel with regard to mouth care.”</p>
Mental Health Branch Report	1975	<p>Dental Health Services: Discussion of the decision to create a preventative and curative dental care program for children.</p> <p>Mentions three dental health surveys conducted in 1958/60, '61-67 and '68-74. Discussion of the system of aid to the handicapped consultants.</p>

Excerpts from *Hansard*

Where the *Journals* and *Sessional Papers* of the legislative assembly of the Province are edited versions of what occurred in the B.C. legislature, *Hansard* provides verbatim transcripts. However, B.C. did not begin publishing *Hansard* until 1970. The *Hansard* materials starting from 1970 record the legislature's frequent recognition of government responsibility for the well-being of people with DDs.

Table 5 sets out comments made by various ministers in the B.C. legislature confirming this recognition. For example, in 1987, Honourable Claude Richmond, then minister of Social Services, explained to the members of the legislative assembly that “[d]einstitutionalizing people generally does not save dollars. It generally costs more to integrate them into the community than to leave them in institutions. I think that dollars are secondary in this case. It’s what’s best for these people that we’re interested in.” In June 1993, Honourable Joan Smallwood, then minister of Social Services, stated: “The responsibility of this Ministry is to people with mental handicaps.” And on May 22, 1997, only one year after the closure of the last provincial institution housing people with DDs, Honourable Joy MacPhail, then minister of Health, stated: “We provide the health services to people who used to live in institutions such as Woodlands or Glendale and who have now been moved into the community.”

Governmental acknowledgement of its responsibility to meet the dental health care needs of adults with DDs has all but disappeared during the fifteen years that have passed since the date of Health Minister MacPhail’s statement. The Ministries of Health and Social Development both advise that they are aware of, and appreciate, the problem facing adults with DDs who cannot access necessary dental treatment, including those who require treatment in hospital, but regret their inability to take action because of budget pressures. The legislative history above, and the comments of previous members of the legislative assembly recorded in *Hansard* and set out in Table 5, confirm that the current response of the Ministries of Health and Social Development is an abdication of a responsibility formerly assumed by the Government of B.C.

Table 5: Excerpts from *Hansard*

Speaker	Date	Transcript
Mr. Lecours	February 3, 1970	<p>“I want to compliment the Minister of Health for his efforts with respect to the retarded children, Mr. Speaker. He gave a promise some months ago that he would eliminate the backlog of retarded children waiting for entry into Woodlands by the end of the year. Now he didn’t quite make it, because there was some unavoidable delay, but he’s made a valiant effort and I’m sure the people of this Province all appreciate his fine effort in that regard, and I think that within a few days now the backlog will be caught up with, and this is very commendable. I have been concerned over the years about the retarded and all handicapped children, and I was quite critical in the past of some of the Ministers of Health for their inaction, and it’s a nice change to see the Minister applying himself so assiduously.”</p>
Mr. Cocke	February 12, 1970	<p>“Let’s deal for a second with another aspect of the mental health situation of this Province. You know the waiting list at Woodlands has been a subject of conversation for so long I can hardly remember. You know I live in New Westminster, thank goodness, and in Woodlands it’s certainly the subject, and I’m sure that some of it gets over to this area from time to time. But in any event, it’s shameful that this situation has not been resolved. I had a case brought to my attention of a 19-year-old girl, whose parents first made application for Woodlands in 1957. Now she’s still waiting to get on the list. 1957 to now is 13 years, virtually. She’s still waiting to get on the list, despite the fact that her parents cannot handle this situation. Twelve years, or going on 13. Now this is not simply a case of retardation, it involves a person unable to control her limbs properly. I don’t suggest that expanding the facilities of Woodlands is the answer, the answer should be to provide the service on a mainly decentralized basis again, but in any event, we have to provide facilities....</p> <p>“[T]he Budget does not say too much with regard to radical changes in carrying out the Government’s responsibility to the mentally ill. The tragedy of mental illness and mental retardation is compounded by this Government not applying itself to the problem. There was a time in British Columbia when we were considered way ahead of our time. We are no longer in that position.”</p>
Mr. Wallace	March 17, 1977	<p>“Mr. Chairman, we’ve spent a great deal of time on this debate castigating the minister and I would like to at least finish up the debate by commending the minister for including an increase of \$2 million to Woodlands School. The situation that society so often adopts towards the retarded is: ‘out of sight, out of mind.’ Despite the fact that there has been a tremendous amount of recurring publicity about the problems at Woodlands, I think that we can have some optimism that the minister recognizes the very inadequate facilities at Woodlands and the lack of staff.”</p>

Table 5 continued on next page

Table 5: Excerpts from *Hansard* continued

Hon. Mr. Vander Zalm	April 12, 1978	<p>“You know, when I became Minister of Human Resources, I found, naturally, that Woodlands School was one of MY responsibilities. Only a month after taking office, I visited Woodlands School. I found, despite what has been said by some opposition members, that this building had received little attention. The beds were six to eight inches apart, little steel cots; the hallways had maybe received a coat of paint, but the play rooms were small, the facilities were limited.</p> <p>“If that situation had existed in any normal hospital providing for any of us here, we would have been screaming all the way from here to Come-by-Chance, Newfoundland. We would not have stood for it. We would have seen protests.</p> <p>“This ministry immediately set out to say: ‘Hey, those people also deserve a break.’ They deserve some of the opportunities provided us. They must share in the resources and wealth that we’re creating in this province. Let’s give them a chance to live in the community as near a normal a life as possible. Let’s make some changes to allow those that can provide for themselves with our assistance that opportunity. Project LIFE will do that very thing. We are providing the resources through Project LIFE to make this happen, to make it possible. Give us some time and the progress will be seen. I know that all members here will speak well of it. Project LIFE holds a tremendous future for people who deserve our every attention.”</p>
Hon. Mr. Vander Zalm	May 10, 1978	<p>“We recently announced a \$20 increase for handicapped people to take effect July 1, 1978. Last week we received a letter from the Liberal federal government in Ottawa—of which this member on the other side for North Vancouver–Capilano is so proud—which said: ‘Hey, the handicapped people in British Columbia are already getting enough. They are already getting more than all other handicapped people anywhere else in the country, so we are not going to give it [the 50 per cent that the federal government should pay for]. If you want to give an increase, you do so at provincial cost. But despite our cost sharing with all other provinces, we will not cost-share in that province.’ I say shame on the federal government for that particular decision, and I would suggest the member for North Vancouver–Capilano (Mr. Gibson), who stands up for those Liberals in Ottawa, should view this realistically and, along with this government, petition those members in Ottawa who represent this province and say, ‘Why treat British Columbia differently?’ and ‘Why not provide for the handicapped as the Minister of Human Resources, the Premier of the province, and all members of this government are wanting to do?’ ...</p> <p>“So contrary to what the member for North Vancouver–Capilano has said, this province is moving ahead to provide for handicapped people, moving ahead of all other provinces in Canada. As a matter of fact, we’re moving far ahead of the federal government to the point where they’re deciding not to share. Shame, I say. Shame.”</p>
Mr. Gibson	May 10, 1978	“I stand up for the handicapped.”
Hon. Mrs. McCarthy	July 19, 1979	“I want to address myself to the so-called cuts in the camp budget for Woodlands. You make light of the commitment that this side of the House, or any member of this House, has to the retarded children in this province. Let me say once again that we have the best program and services for retarded children anywhere in Canada. There isn’t any place that gives better.”

Mr. Hall	June 2, 1981	<p>“I want to say that I was horrified to realize that the grand promise made by my colleague the first member for Surrey (Hon. Mr. Vander Zalm) has not been fulfilled, and that what he said two years ago, that the institutions of B.C. were in effect a thing of the past, has not been carried out. We have, indeed, seen no real reduction in our institutionalizing habits; we’re still warehousing our mentally disturbed people; we’re not responding to that grandiose plan announced with a lot of public-relations hype by the then Human Resources minister. In 1977 the then Human Resources minister identified 200 persons as being ready for immediate release from Woodlands into the community. In 1977 the resident population of Woodlands was 906; in 1980 the population was 842—a reduction that is hardly in keeping with the tone of the release in 1977. At that rate, Mr. Chairman, it’s going to be way past the year 2000 before our institutions are depopulated.</p> <p>“The questions one has are, of course, these. Why has the government not come through with its promise and commitment? Where are the examples of expansion of community-based services? How many group homes for mentally handicapped persons will the ministry fund this year? I know that the minister has sent a letter to the association and that they sent an open letter back to the minister. When I attended this meeting and saw the brief that was presented to the social services committee of cabinet, I wondered why on earth we still are in the business of warehousing people the way we are in our institutions, and why we allowed that public-relations statement to take place, as we did way back in 1977 when my colleague the first member for Surrey introduced the LIFE program—Living Independently for Equality. I see, for instance, that now in 1981 a <i>Times</i> lead editorial pointed out that that project was an empty promise. I think many of you have seen that lead editorial—how the B.C. Association for the Mentally Retarded released a devastating report on the status of the mentally disabled in the province. The scathing indictment charges that government policy forces hundreds of mentally handicapped citizens to remain in institutions against their wishes and the wishes of their families. Particularly disheartening is the report’s underscoring of the failure of the ministry to provide promised improvements, specifically those outlined by my colleague away back in 1977—<i>Living Independent {sic} for Equality</i>. That report promised that the Human Resources ministry would be launching a major effort to de-institutionalize services, ‘The day of the massive institution is over.’ was proudly proclaimed...</p> <p>“Thousands of dollars are being spent both federally and provincially trying to tell the public there are all sorts of things taking place for the disabled people in our province. Here’s one of our first duties and first responsibilities—to simply make sure that those people who shouldn’t be in institutions are returned to the community...</p> <p>“I was horrified and shocked to the very core of my being when I first went into Coquitlam and New Westminster and saw those institutions. I remember travelling with the then member for Vancouver-Burrard, Dr. Parkinson, and with the member for Burnaby North (Mrs. Dailly). I’ve never forgotten that day and what a criminal waste—I use the word in a clinical sense—we saw of a chance for people to take part in solving their own problems and creating their own freedom, in the sense of breaking loose from some of the disabling features that we are forcing on them by institutionalizing them.”</p>
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Table 5: Excerpts from *Hansard* continued

Mrs. McCarthy	June 2, 1981	<p>“I’m going to say immediately to the member that I have also been at Woodlands. There are some residents who can never come out of that institution. There are residents in the Tranquille facility in Kamloops and in Glendale¹⁸⁴ on lower Vancouver Island who will never be able to move out of the residence. But in those institutions where we have those who can move out, it is the commitment of this government. It has been fulfilled, not totally, but partially. Remember, it can’t be fulfilled totally until we can ease those young people into the community, so when they get into the community there are resources, support and public and community understanding for them. Let’s remember that...”</p>
Mr. Cocke	June 2, 1981	<p>“[W]hen we took over government in 1972, we found the medical model at Woodlands, Tranquille, etc., for the care of those people in our community who are called—dubbed, named or whatever, retarded. We felt that the best thing possible would be to transfer it to a more appropriate ministry. The medical model wasn’t working and wouldn’t work, in our view, so it was transferred to the Ministry of Human Resources. I believe that, unfortunately, the solution has not come out of that transfer, because the model has not changed.</p> <p>“I suggest to you very strongly that we believe the people in those institutions are human beings entitled to all the human rights available to anybody in this chamber, anybody walking the streets or anybody out there in our province. Traditionally this has not been available, and particularly it’s unavailable when one is institutionalized...”</p> <p>“I notice the minister suggesting that there are a number of people that cannot be removed and cannot leave that institution. There isn’t one person in there that can’t. Those institutions are something of the past. I suggest that even for those people who are bedridden there are more appropriate facilities than what we find in Woodlands, Tranquille, etc. Those are massive institutions that dehumanize people. The cases we have studied and followed that have been put into the community have been a success.</p> <p>“You don’t have a person with an IQ of something under 70 or whatever able to cope in the same way as someone with an IQ of over 100, 120 or 140, but there is a place for them in our community... We should not be hiding those who are less fortunate through a disability of any sort. We should be moving heaven and earth to put before them as appropriate and free a life imbued with human rights as we possibly can, and we’re not...”</p> <p>“It’s time we regarded those less fortunate and those disabled in this Year of the Disabled as people, not charges—people not the least bit less important than anyone here or anyone else in the province.”</p>
Hon. Mr. Richmond	March 31, 1987	<p>“Deinstitutionalizing people generally does not save dollars. It generally costs more to integrate them into the community than to leave them in institutions. I think that dollars are secondary in this case. It’s what’s best for these people that we’re interested in...”</p>
Hon. Mr. Richmond	April 21, 1987	<p>“Mr. Speaker, let me assure the member and this House that moving people from these institutions is not done for the purposes of saving money. It is done for the good of the people in the institutions, and the progress that they make is absolutely incredible. In fact, if anything it costs more to keep those people outside the institutions than inside.”</p>
Hon. J. Smallwood	June 22, 1993	<p>“The responsibility of this Ministry is to people with mental handicaps.”</p>
Hon. J. MacPhail	May 22, 1997	<p>“We provide the health services to people who used to live in institutions such as Woodlands or Glendale and who have now been moved into the community.”</p>

184. Although there were initial concerns such as those expressed by Minister McCarthy regarding the residents of Glendale institution being unable to live in the community due to their higher medical needs, the government did close Glendale in 1996. See B.C. Association for Community Living, *The 1990s*, online: British Columbia Association for Community Living <<http://www.BCacl.org/about-us/history/1990s>>.

Government Expenditures on Dental Care in Institutions

The B.C. government published information on the costs of maintaining the institutions, including detailed information on dental expenses, in annual reports for many of the years that the institutions operated. Information from these reports is set out in Tables 6 through 9, regarding total expenses of the institutions and itemized costs for dental expenses.

Table 6: Annual Government Expenditures for Residential Institutions

Year	Woodlands (\$)	Tranquille (\$)	Glendale (\$)
1975	15,900,000	7,800,000	6,200,000
1976	16,938,113	7,604,316	6,402,674
1977	19,598,096	8,615,521	8,306,394
1978	22,730,220	9,327,128	8,579,857
1979	23,620,917	10,414,001	8,975,568
1980	27,546,171	11,529,979	10,105,353
1981	31,671,677	12,914,335	10,456,257
1982	33,510,695	13,716,821	10,926,086
1983	32,656,605	14,252,524	12,992,920
1984	34,000,226	10,785,599	12,590,839
1985	33,616,087		13,662,748
1986	32,409,359		13,862,748
1987	33,331,813		
1988	28,932,026		
1989	26,957,489		15,300,000
1990	34,701,363		15,400,000
1991	32,696,001		14,400,000
1992	27,900,000		12,400,000
1993	27,800,000		13,100,000

Dental costs paid by the Medical Services Division, and subsequently the Ministry of Health, regarding patients in the institutions were recorded in annual reports to government. These costs are listed in Tables 6 and 7. Dental expenses for patients in the provincial institutions were itemized according to procedure for the report years 1955/56 through 1971/72 and are listed in Tables 8 and 9. The reports on expenditures provide detailed evidence of specific dental treatments provided to adults with DDs when they were institutionalized. Beginning in the late 1980s, the reports discuss the downsizing of Woodlands and transition into community homes. From 1993 onwards, there is no further discussion concerning the institutions.

Table 7: Dental Costs Paid by Government for Patients in Institutions, 1946–81 and 1993–95

Year	Dental Costs (\$)	Year	Dental Costs (\$)
1946/47	6,457	1971/72	2,403,257
1947/48	13,008	1972/73	2,429,538
1948/49	19,290	1973/74	2,655,573
1949/50	24,764	1974/75	2,560,068
1950/51	30,915	1975/76	3,218,006
1951/52	50,044	1976/77	5,296,651
1952/53	73,010	1977/78	6,152,356
1953/54	86,717	1978/79	7,905,683
1954/55	112,719	1979/80	8,784,379
1955/56	119,512	1980/81	7,532,995
1956/57	129,267	1981/82	701,285*
1957/58	148,223	1982/83	N/A
1958/59	168,051	1983/84	N/A
1959/60	279,550	1984/85	N/A
1960/61	508,392	1985/86	N/A
1961/62	548,973	1986/87	N/A
1962/63	513,761	1987/88	N/A
1963/64	534,820	1988/89	N/A
1964/65	588,500	1989/90	N/A
1965/66	590,074	1990/91	N/A
1966/67	670,580	1991/92	N/A
1967/68	773,979	1992/93	N/A
1968/69	792,475	1993/94	30,200,000**
1969/70	1,611,115	1994/95	36,300,000**

* In 1981–82, the ministry’s dental care services were administered and financed by the Ministry of Health’s Denticare program introduced January 1, 1981. The program covered children, the elderly and people with low income. The program was ended in 1982, after only 20 months in operation, as a result of higher than anticipated costs experienced during a recession. The Minister of Health, Honourable James Neilsen, explained that the Province would restart the program once the economic situation improved,¹⁸⁵ but Denticare was never reinstated. People receiving dental benefits through the Ministry of Human Resources (including people in the institutions) were not affected by the termination of the program. Records of the dental expenditures during the period of Denticare and in the following years were not available in the ministry reports until the 1993/94 report. The dental expense reports ended after 1995.

** It is not clear whether these are total government expenses in connection with dental service.

185. “BC Denticare plan killed by recession,” *Leader-Post* (20 August 1982) at C13.

Table 8: Dental Expenses for Patients in Institutions Itemized by Procedure, 1955/56–1964/65

Year	Prophylaxis (\$)	Extractions (\$)	Dentures (\$)	Totals (\$)
1955/56	15,385.80	8,570.90	95,556.04	119,512.74
1956/57	24,996.66	7,596.04	96,674.86	129,267.56
1957/58	28,430.52	9,589.80	110,203.40	148,223.72
1958/59	34,115.73	12,138.92	121,796.41	168,051.06
1959/60	76,740.07	26,115.00	176,695.01	279,550.08
1960/61	199,686.63	65,078.39	243,627.23	508,392.25
1961/62	227,033.02	74,339.50	247,601.22	548,973.74
1962/63	229,099.47	64,316.50	220,345.60	513,761.57
1963/64	264,976.86	64,120.08	205,723.53	534,820.47
1964/65	310,009.00	61,700.00	216,791.00	588,500.00

Table 9: Dental Expenses for Patients in Institutions Itemized by Procedure, 1965/66–1971/72

Year	Examinations, Prophylaxis, Miscellaneous (\$)	Surgery (\$)	Restorations (\$)	Dentures and Repairs (\$)	Totals (\$)
1965/66	64,209	49,652	237,004	239,209	590,074
1966/67	80,893	73,568	312,686	203,433	670,580
1967/68	101,391	89,782	378,476	204,330	773,979
1969/70	301,279	212,667	621,890	475,279	1,611,115
1970/71	510,776	323,906	976,703	680,204	2,491,589
1971/72	528,717	288,391	1,033,400	552,749	2,403,257

CHAPTER 4

Government Dental Programs

In Canada, government-insured health services are provided by the provinces and territories. These jurisdictions receive federal funding in respect of a portion of their health care costs, subject to their medical insurance plans meeting the conditions of the federal *Canada Health Act* [*CHA*].¹⁸⁶ The provincial and territorial health insurance schemes and the *CHA* do not insure general oral health care, although “insured health services” is defined under the *CHA* to include the provision of “surgical-dental services.”¹⁸⁷ However, the definition of surgical-dental services is limited to those “medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures.”¹⁸⁸

While inclusion of “surgical-dental services” establishes government coverage under provincial plans for medically necessary oral surgical procedures, it excludes the preventive and curative dental treatments that most people need regularly. Therefore, a majority of Canadians visit private dental clinics and pay for treatment through private insurance or as an out-of-pocket expense. The 2007–09 Canadian Health Measures Survey (CHMS) found that 62% of Canadians have private dental insurance, 32% have no dental insurance, and the remaining 6% receive some form of public dental insurance.¹⁸⁹ Many of the public insurance plans provide minimal dental coverage despite research showing that adults with DDs typically have a higher incidence of untreated dental disease and a greater number of extracted teeth as compared to the general population.¹⁹⁰

186. RSC 1985, c C-6 [*CHA*].

187. *Ibid*, s 1.

188. *Ibid*.

189. Health Canada, *Oral Health Statistics 2007–2009—Canadian Health Measures Survey (CHMS)*, online: Health Canada <<http://www.hc-sc.gc.ca/hl-vs/pubs/oral-bucco/fact-fiche-oral-bucco-stat-eng.php>>.

190. Anjani Koneru & Michael J Sigal, “Access to Dental Care for Persons with Developmental Disabilities in Ontario” (2009) 75(2) *J Can Dent Assoc* 121 at 121a.

In common with other health services, the creation and administration of the public dental insurance programs falls under provincial jurisdiction. There is no Canada-wide dental insurance plan or provincial agreement on oral health requirements for adults with DDs. The provinces negotiate independently with the provincial dental associations on fee schedules covering the provincial dental plans. This leads to discrepancies between provinces in the approved fees for dental services and the range of dental treatments provided under the provincial insurance plans that cover adults with DDs.

Research has not been done to compare success rates of these plans, and nearly every jurisdiction reports significant unmet need. However, a cross-comparison of the provincial programs shows that some provinces provide more comprehensive strategies to address the needs of adults with DDs. B.C. should implement aspects of the more comprehensive provincial plans, such as those in Ontario, Quebec and Alberta, to improve the current program of dental care offered to B.C. adults with DDs. B.C. should strive to meet the highest standards of care that are adopted in Canada to ensure that B.C. adults with DDs do not suffer with unnecessary and unacceptable dental decay. The provincial MSD and health administrators should work with the BC Dental Association to improve the provincial coverage to meet dental recommendations and Canadian best standards of practice.

Set out below is a description of the dental insurance legislation covering adults with DDs in B.C. (see also Table 10), followed by a provincial dental program chart (Table 11) that briefly describes the coverage in all the provinces. Following Table 11 is a short description of the legislative schemes in the other jurisdictions that provide for dental insurance to adults with DDs and an analysis of the comparison to B.C.

British Columbia

Dental insurance covering adults with DDs in B.C. is administered by the Ministry of Social Development under the *Employment and Assistance for Persons with Disabilities Act [EAPDA]*,¹⁹¹ which enables the minister to provide disability assistance and supplements to eligible persons. Pursuant to Section 63 of the *EAPDA Regulation*,¹⁹² the minister may provide the dental supplements set out in Section 4 of Schedule C to the regulations.¹⁹³ Section 4 lists the dental supplements (treatments) that may be paid under Section 63 to eligible persons. Coverage for adults with DDs is restricted to a \$1,000 maximum over each two calendar years, commencing with odd-numbered years. The coverage is not cumulative, but expires at the end of each two-year period.

191. SBC 2002, c 41.

192. British Columbia, Ministry of Housing and Social Development, *Employment and Assistance for Persons with Disabilities Regulation* (Victoria, BC: MHSD, 2012) s 63, online: Province of British Columbia <<http://www.eia.gov.bc.ca/publicat/vol1/pdf/3-5pol.pdf>>.

193. *Ibid*, Schedule C, s 4-5.

Certain exemptions apply to this limit, such as where a person requires dentures to relieve pain following extraction.¹⁹⁴ In addition, crown and bridgework may be covered where the Minister of Social Development is satisfied that the recipient has a dental condition that cannot be corrected through the provision of “basic dental care.”¹⁹⁵ This exemption applies where the recipient is unsuitable for the use of a removable prosthetic, due to impossibility, allergy, physical impairment or compromised capacity rendering the person unable to assume responsibility for the prosthetic.¹⁹⁶ This coverage is further limited by Section 4.1(4), which provides that this supplement is only available every 60 calendar months for a given tooth.

Eligible persons qualify for emergency dental service, where necessary, which is defined as a “dental service necessary for the immediate relief of pain” under Schedule C S.1. A dentist completing this emergency dental service may only charge the rate approved by MSD (Schedule of Fee Allowances, April 1, 2010), which pays approximately 60% of the fee rates approved by the BCDA. Consequently, “emergency dental service” usually constitutes extraction of the tooth, since extraction is typically a more cost-effective treatment than restoration.

The exact coverage under the *EAPDA Regulation* is itemized below:

Table 10: Dental Supplements Provided under Schedule C Section 4 to the *EAPDA Regulation*

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- 4 (1) In this section, “period” means
- (a) in respect of a dependent child, a 2 year period beginning on January 1, 2009, and on each subsequent January 1 in an odd numbered year, and
 - (b) in respect of a person not referred to in paragraph (a), a 2 year period beginning on January 1, 2003 and on each subsequent January 1 in an odd numbered year. (B.C. Reg. 65/2010)
- (1.1) The health supplements that may be paid under section 63 [dental supplements] of this regulation are basic dental services to a maximum of
- (a) \$1400 each period, if provided to a dependent child, (B.C. Reg. 65/2010)
 - (b) \$1000 each period, if provided to a person not referred to in paragraph (a), (B.C. Reg. 163/2005)
 - (c) Repealed (B.C. Reg. 163/2005)
- (2) Dentures may be provided as a basic dental service only to a person
- (a) who has never worn dentures, or
 - (b) whose dentures are more than 5 years old.

194. *Ibid*, Schedule C, s 4(3).

195. *Ibid*, Schedule C, s 4.1(2).

196. *Ibid*, Schedule C, s 4.1(2)(b).

Table 10: Dental Supplements *continued*

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- (3) The limits under subsection (1.1) may be exceeded by an amount necessary to provide dentures, taking into account the amount remaining to the person under those limits at the time the dentures are to be provided, if
- (a) a person requires a full upper denture, a full lower denture or both because of extractions made in the previous 6 months to relieve pain,
 - (b) a person requires a partial denture to replace at least 3 contiguous missing teeth on the same arch, at least one of which was extracted in the previous 6 months to relieve pain, or
 - (c) a person who has been a recipient of disability assistance or income assistance for at least 2 years or a dependant of that person requires replacement dentures. (B.C. Reg. 94/2005)
- (4) Subsection (2) (b) does not apply with respect to a person described in subsection (3) (a) who has previously had a partial denture.
- (5) The dental supplements that may be provided to a person described in subsection (3) (b), or to a person described in subsection (3) (c) who requires a partial denture, are limited to services under
- (a) fee numbers 52101 to 52402 in the Schedule of Fee Allowances—Dentist referred to in paragraph (a) of the definition “basic dental service” in section 1 of this Schedule, or (B.C. Reg. 94/2005)
 - (b) fee numbers 41610, 41612, 41620 and 41622 in the Schedule of Fee Allowances—Denturist referred to in paragraph (b) of the definition “basic dental service” in section 1 of this Schedule. (B.C. Reg. 94/2005)
- (6) The dental supplements that may be provided to a person described in subsection (3) (c) who requires the replacement of a full upper, a full lower denture or both are limited to services under
- (a) fee numbers 51101 to 51102 in the Schedule of Fee Allowances—Dentist referred to in paragraph (a) of the definition “basic dental service” in section 1 of this Schedule, or (B.C. Reg. 94/2005)
 - (b) fee numbers 31310, 31320 or 31330 in the Schedule of Fee Allowances—Denturist referred to in paragraph (b) of the definition “basic dental service” in section 1 of this Schedule. (B.C. Reg. 94/2005)
- (7) A reline or a rebase of dentures may be provided as a basic dental service only to a person who has not had a reline or rebase of dentures for at least 2 years.

Crown and bridgework supplement

- 4.1 (1) In this section, “crown and bridgework” means a dental service
- (a) that is provided by a dentist, (B.C. Reg. 94/2005)
 - (b) that is set out in the Schedule of Fee Allowances—Crown and Bridgework, that is effective April 1, 2010 and is on file with the deputy minister, (B.C. Reg. 315/2006) (B.C. Reg. 65/2010)
 - (c) that is provided at the rate set out for the service in that Schedule, and
 - (d) for which a person has received the pre-authorization of the minister.
- (2) A health supplement may be paid under section 63.1 of this regulation for crown and bridgework but only if the minister is of the opinion that the person has a dental condition that cannot be corrected through the provision of basic dental services because
- (a) the dental condition precludes the provision of the restorative services set out under the Restorative Services section of the Schedule of Fee Allowances—Dentist, and (B.C. Reg. 94/2005)
 - (b) one of the following circumstances exists:
 - (i) the dental condition precludes the use of a removable prosthetic;
 - (ii) the person has a physical impairment that makes it impossible for him or her to place a removable prosthetic;
 - (iii) the person has an allergic reaction or other intolerance to the composition or materials used in a removable prosthetic.
 - (iv) the person has a mental condition that makes it impossible for him or her to assume responsibility for a removable prosthetic.
- (3) The minister must also be satisfied that a health supplement for crown and bridgework will be adequate to correct the dental condition.
- (4) A health supplement for crown and bridgework may not be provided in respect of the same tooth more than once in any period of 60 calendar months. (B.C. Reg. 430/2003)

Emergency dental supplements

5 The health supplements that may be paid for under section 64 [*emergency dental and denture supplements*] of this regulation are emergency dental services.

Table 11: Public Dental Insurance for Adults with DDs, All Provinces and Territories

Province	Ministry	Eligibility	Services Covered	Limits
British Columbia	<ul style="list-style-type: none"> Ministry of Social Development Adjudication and payment functions performed through Pacific Blue Cross 	<ul style="list-style-type: none"> Recipients of the Persons with Disability benefit and their dependants 	<ul style="list-style-type: none"> Basic dental service, including diagnostic, preventative, prosthodontics, and oral surgery services Emergency dental services, where necessary to alleviate immediate pain Crown and bridgework (in some cases) 	<ul style="list-style-type: none"> \$1,000 maximum for every two-year period (excluding emergencies) Crown and bridgework is only available where the minister is satisfied the dental condition cannot be corrected through basic dental.
Alberta	<ul style="list-style-type: none"> Ministry of Human Services Previously: Ministry of Seniors and Community Supports Centrally administered by Alberta Blue Cross 	<ul style="list-style-type: none"> Adults 18–64 years with a disability that must be “permanent and substantially limit the person’s ability to earn a living” 	<ul style="list-style-type: none"> Basic dental, including recall and emergency examinations, teeth cleaning, X-rays, fillings, extractions, dentures and other dental services¹⁹⁷ Emergency medically necessary dental and maxillofacial surgical services are covered under the Alberta Health Care Insurance Plan. 	<ul style="list-style-type: none"> There are annual limits, but they are dependent on the level of coverage of each individual recipient. Specific limits are unknown, but the annual limits are governed by fee agreements between the Province and the Alberta Dental Association.

197. Alberta Human Services, *Assured Income for the Severely Handicapped (AISH) Online Policy Manual*, online: Government of Alberta <http://www.seniors.alberta.ca/aish/PolicyManual/AISH_Online_Policy_Manual.htm> [Alberta Human Services].

Province	Ministry	Eligibility	Services Covered	Limits
Saskatchewan	<ul style="list-style-type: none"> • Saskatchewan Ministry of Social Services • Saskatchewan Health • Administered by Saskatchewan Health, Drug Plan and Extended Benefits Branch 	<ul style="list-style-type: none"> • Saskatchewan Assured Income for Disability (SAID) is available for persons aged 18 years or older who lack the financial resources to meet their basic needs and have a significant and enduring disability that is likely to be permanent and substantially impacts daily living. • The Ministry of Social Services determines eligibility for the Supplementary Health Program, but virtually all SAID program participants qualify. 	<ul style="list-style-type: none"> • If approved for full benefits the recipient is entitled to a range of basic dental services “required to maintain good dental health,” including diagnostic, preventative and restorative services. • Supplementary Health Program (SHP) coverage for emergency services is limited to relieving pain and controlling infections. • Residual emergency coverage is available under the Medical Services Plan. 	<ul style="list-style-type: none"> • Limited to those services “which are essential for the maintenance of health” • The payment is governed by an agreement between the minister and the College of Dental Surgeons of Saskatchewan.
Manitoba	<ul style="list-style-type: none"> • Manitoba Family Services and Labour 	<ul style="list-style-type: none"> • An adult who by reason of physical or mental illness is unable to earn an income sufficient to support themselves and meet their basic needs 	<ul style="list-style-type: none"> • Basic diagnostic, preventative, restorative and other “essential” services • Emergency dental services where necessary to alleviate pain 	<ul style="list-style-type: none"> • Limited to “essential care” as decided in agreement between the Province, Manitoba Dental Association and Denturist Association of Manitoba

Table 11 continued on next page

Table 11: Public Dental Insurance for Adults with DDs *continued*

Province	Ministry	Eligibility	Services Covered	Limits
Ontario	<ul style="list-style-type: none"> Ministry of Community and Social Services 	<ul style="list-style-type: none"> An adult who has a substantial physical or mental impairment that is continuous ... and is expected to last one year or more 	<ul style="list-style-type: none"> Ontario Disability Support Program (ODSP) beneficiaries receive coverage for basic dental services, including basic diagnostic, preventative, restorative and oral surgery services. Dental Special Care Plan (DSCP) recipients are entitled to the same benefits as the ODSP, but receive additional coverage annually for diagnostic, preventative, restorative and endodontic services. 	<ul style="list-style-type: none"> The ODSP is limited to basic dental care in accordance with a fee agreement between the Province and the Ontario Dental Association. DSCP recipients are entitled to four examinations in any 12-month period.¹⁹⁸
Quebec	<ul style="list-style-type: none"> Ministère de la Santé et des Services sociaux 	<ul style="list-style-type: none"> Eligible for the Social Solidarity Program if an adult with a significant physical or mental condition, which is likely to be permanent, severely limits their capacity for employment 	<ul style="list-style-type: none"> Emergency diagnostic, endodontic and oral surgery services are covered for all residents through Régie de l'assurance maladie du québec (RAMQ). Recipients of the Social Solidarity Program, for persons whose capacity for employment is severely impaired, are covered for a range of basic and emergency diagnostic, preventative and restorative dental care. 	<ul style="list-style-type: none"> One examination per year, with emergency examinations if necessary¹⁹⁹ Dental benefits are governed according to a fee agreement between the Province, relevant dental organizations and RAMQ. Only some dentists in Quebec participate, and they are reimbursed through RAMQ.

198. Note: Information current as of 2009.

199. Régie de l'assurance maladie québec (RAMQ), *Dental Services*, online: Government of Quebec <<http://www.ramq.gouv.qc.ca/en/citizens/health-insurance/healthcare/Pages/dental-services.aspx>>.

Province	Ministry	Eligibility	Services Covered	Limits
New Brunswick	<ul style="list-style-type: none"> Department of Social Development 	<ul style="list-style-type: none"> Persons certified disabled by the Medical Advisory Board; adults who are considered to be indefinitely impaired in their capacity to conduct activities pertaining to normal living 	<ul style="list-style-type: none"> The range of services eligible depends on which class assistance category a recipient falls within. Health Services Dental Program (HSDP) basic diagnostic and treatment services, including exams, X-rays, fillings and dentures The Enhanced Dental Program (EDP) covers the above in addition to complete oral exams, cleanings and root canals in certain specific scenarios. Emergency services 	<ul style="list-style-type: none"> HSDP recipients are limited to a maximum of \$800 per year and are subject to a 30% participation fee. EDP recipients are limited to a maximum of \$1,000 per year. The above limits exclude emergency services. The fee and service arrangements are negotiated between the Province and the New Brunswick Dental Society
Nova Scotia	<ul style="list-style-type: none"> Department of Health Department of Community Services 	<ul style="list-style-type: none"> Employment Support and Income Assistance Dental Plan (ESIADP) recipients must demonstrate financial need. Recipients of the Mentally Challenged Program (MCP) must be certified by a medical authority as “mentally challenged.” 	<ul style="list-style-type: none"> ESIADP recipients are covered for emergency dental care, some diagnostic, preventative, and restorative depending on the predetermination of their need. MCP covers diagnostic, preventative and treatment services. Medically necessary emergency treatment is covered. 	<ul style="list-style-type: none"> MCP recipients are subject to a 10% premium when care is delivered in a private practice and a 30% premium where delivered in hospital. MCP recipients are entitled to one examination every 335 days.²⁰⁰ ESIADP recipients are limited to \$300 per item as per contracted services, in accordance with the Dental Fee Guide.²⁰¹

200. NS Reg 87/2001, online: <http://www.gov.ns.ca/just/regulations/regs/HSIdental.htm#TOC1_8> [HSIdental].

201. Nova Scotia, Department of Community Services, *Employment Support and Income Assistance (ESIA) Policy Manual*, at ch 6, s 3(1), online: Government of Nova Scotia <<http://novascotia.ca/coms/employment/>>

Table 11: Public Dental Insurance for Adults with DDs *continued*

Province	Ministry	Eligibility	Services Covered	Limits
Newfoundland and Labrador	<ul style="list-style-type: none"> Department of Health and Community Services 	<ul style="list-style-type: none"> Adults who are assessed to be in financial need 	<ul style="list-style-type: none"> Medically necessary emergency services 	<ul style="list-style-type: none"> Only available for emergencies as a result of pain, infection or trauma, and extractions
Prince Edward Island	<ul style="list-style-type: none"> Department of Community Services and Seniors 	<ul style="list-style-type: none"> Adults who are unable to seek employment because of their disability and demonstrate financial need 	<ul style="list-style-type: none"> Limited diagnostic, emergency, prosthetic, preventative and restorative services 	<ul style="list-style-type: none"> Oral exams are limited to teeth affected by pain or infection.
The Territories	<ul style="list-style-type: none"> Department of Health and Social Services 	<ul style="list-style-type: none"> NWT: Eligible for the Indigent Health Benefits if an adult demonstrates financial need NVT: Unknown 	<ul style="list-style-type: none"> Basic dental and emergency diagnostic, restorative and oral surgery services 	<ul style="list-style-type: none"> Unknown Unknown

Other Provinces and Territories

Alberta

Alberta's coverage for persons with disabilities falls under the *Assured Income for the Severely Handicapped Act [AISHA]*.²⁰² Section 1 of *AISHA*, which establishes eligibility, defines “severe handicap” as an “impairment of mental or physical functioning or both that, in a director’s opinion after considering any relevant medical or psychological reports, causes substantial limitation in the person’s ability to earn a livelihood and is likely to continue to affect that person permanently because no remedial therapy is available that would materially improve the person’s ability to earn a livelihood.”²⁰³

The *AISHA* regulations permit the provision of health benefits, including dental care, to an eligible person.²⁰⁴ Pre-authorization for all dental procedures is required from the Alberta Dental Service Corporation (ADSC), and covered procedures include recall and emergency examinations, teeth cleaning, X-rays, restorations (fillings) and dentures.²⁰⁵ These covered services “are provided according to fee schedules in a memorandum of understanding with the Alberta Dental Association and College, and in agreements with the College of Alberta Denturists and the College of Registered Dental Hygienists of Alberta.”²⁰⁶

Saskatchewan

The Saskatchewan Assured Income for Disability (SAID) program provides income support for persons with a “significant and enduring disability.” Recipients of the SAID program are eligible to receive health benefits through the Supplementary Health Program (SHP), which provides health services to citizens of Saskatchewan who require additional assistance.²⁰⁷ Recent amendments altered the designated beneficiary criteria for the SHP to include “a person who is receiving benefits pursuant to *The Saskatchewan Assured Income for Disability Regulations*.”²⁰⁸ SHP includes emergency dental care where necessary to relieve pain and control infection as well as a benefit package, which includes basic dental care. Denture services are only partially covered, and the recipient may be required to pay additional costs to the dentist.

202. SA 2006, C A-45.1.

203. *Ibid*, s 1(f).

204. Alta Reg 91/2007, s 7(1).

205. *Alberta Human Services*, *supra* note 197.

206. *Ibid*.

207. Sask Reg 65/66 ss 9.

208. Sask Reg 34/2012.

Manitoba

The Manitoba Family Services and Labour division is responsible for overseeing income assistance to disabled persons, which includes provisions for dental care. To qualify for this program a person must be one who “by reason of a physical or mental illness, incapacity or disorder that is likely to continue for more than 90 days, are unable to earn sufficient income to provide the basic necessities for themselves and their dependents” or is unable to care for him or herself and requires the care of another at home or in an institution.²⁰⁹ Eligible persons are entitled to certain health benefits, including “such essential dental care, including dentures, as may be agreed upon from time to time between the minister and the Manitoba Dental Association.”²¹⁰ Dental benefits for persons with disabilities are subject to a three-month waiting period after initial enrolment. However, this waiting period is waived in dental emergencies where a particular procedure is necessary to alleviate pain.

Ontario

The Ontario Disability Support Program (ODSP) includes a range of income support and health services for disabled residents of the province.²¹¹ For the purposes of the ODSP, a person with a disability is one who has a substantial “physical or mental impairment that is continuous ... and is expected to last one year or more,”²¹² rendering the person unable to properly attend to their personal care. Each recipient under this plan is entitled to dental benefits.²¹³ Certain persons are eligible to receive a higher level of dental support through the Dental Special Care Plan (DSCP). This service covers adults who have dental needs that stem from their disability, including diabetics, HIV-positive persons and persons with developmental disabilities. Services under this program must be pre-approved, and coverage is limited in accordance with agreements between the ministry and the relevant dental associations. Upon approval, the DSCP is valid for a maximum of five years. According to a 2009 fee schedule available online, the ODSP allows for two annual examinations. However, recipients of the DSCP are entitled to an additional two examinations, totalling four per 12-month period. Similarly, the coverage for polishing, scaling, periodontal appliances and other restorative and endodontic services are more expansive for DSCP recipients than their ODSP counterparts, reflecting the recognition of the importance of dental care for specific vulnerable groups.

Quebec

Quebec is regarded within Canada as a national leader in the provision of public access to dental care, reflecting the province’s commitment to social programming.²¹⁴ Within the province certain

209. *The Employment and Income Assistance Act*, CCSM C E98, s 5(1)(a).

210. Man Reg 404/88, s 7(1).

211. *Ontario Disability Support Program Act*, SO 1997 c 25, Schedule B.

212. *Ibid*, s 4(1).

213. Ontario Reg 222/98, as am., under the *Ontario Disability Support Program Act*, 1997.

214. *Quiñonez*, *supra* note 48 at 59.

services provided by dental professionals are covered for everyone by the Régie de l'assurance maladie du Québec (RAMQ), which falls under the authority of the Minister of Health and Social Services. Recipients of employment assistance benefits for 12 consecutive months or more are entitled to dental care coverage through RAMQ. Dental coverage for disabled persons is covered through the Social Solidarity Program and includes annual preventive, endodontic and specific restorative treatments. This program, governed by the *Individual and Family Assistance Act*,²¹⁵ and its associated regulation exist to grant last resort financial assistance to people with “severely limited capacity for employment.”

New Brunswick

New Brunswick's Health Services Dental Program provides basic dental care to individuals who qualify in accordance with criteria set out in the *Family Income Security Act*.²¹⁶ Section 1 of the corresponding regulations holds that “‘disabled’ means, with reference to a person, suffering from a major physiological, anatomical or psychological impairment, as verified by the Medical Advisory Board under Ss. 4(5), that is likely to continue indefinitely without substantial improvement and that causes the person to be severely limited in activities pertaining to normal living.”²¹⁷ New Brunswick offers two public dental programs, the Health Services Dental Program (HSDP) and the Enhanced Dental Program (EDP). Under the first plan, clients are eligible for a maximum of \$800 per year for procedures such as exams, X-rays, specific fillings and dentures. Clients covered under the EDP are entitled to oral exams, cleanings, restorative treatment including root canals in certain situations, up to a maximum of \$1,000 per year. Participants are charged a 30% fee for services covered under this program.

Nova Scotia

Residents of Nova Scotia whose dental needs may necessitate hospitalization and who are deemed mentally challenged by a medical authority are eligible to receive public dental benefits through the Mentally Challenged Program (MCP). Persons with disabilities who fall within the scope of the MCP are eligible for some dental care through the provincial Employment Support and Income Assistance Dental Plan if they satisfy the requisite criteria and demonstrate financial need. The *Employment Support and Income Assistance Act*, SNS 2000, c 27, allows for the provision of “special needs,” including approved dental care for eligible recipients.²¹⁸ The MCP covers basic diagnostic, preventative and restorative services in accordance with a fee schedule negotiated between the Province and the provincial dental association. MCP recipients are subject to a 10% premium where care is administered in a private facility and a 30% premium where they are treated in a hospital setting, including dental care administered under GA. Additionally, a Dental-Surgical (In Hospital) Program exists for all residents of Nova Scotia who require medically necessary dental procedures in hospital.

215. RSQ c A-13.1.1.

216. RSNB 2011, c 154.

217. NB Reg 95-61.

218. NS Reg 25/2001.

Newfoundland and Labrador

Newfoundland and Labrador's Department of Community Services is responsible for administering social assistance to eligible residents of the province. Eligibility is determined in accordance with *The Income and Employment Support Act*, SNL 2002, c I-0.1 and *Regulations*. Adult recipients of income support are eligible for dental coverage only for emergency examinations as a result of pain, infection or trauma and extractions. Persons designated to have special assistance requirements for dentures are eligible to receive them, in accordance with the *Regulations*.²¹⁹

Prince Edward Island

Prince Edward Island provides coverage to all residents whose medical conditions require in-hospital dental care. Additional coverage is provided for residents of long-term care facilities and recipients of Social Assistance. Disabled recipients of Social Assistance are entitled to a limited range of diagnostic, emergency, prosthetic, preventative and restorative services. Persons with “ongoing intellectual, mental or physical impairments” can apply for coverage through Social Assistance. Services through this program to persons with disabilities may be performed in hospital if treatment in a dental office is not possible.

The Territories

In the Northwest Territories persons receiving government income support, including disabled persons, are entitled to basic dental care. Indigent Health Benefits recipients are eligible for emergency diagnostic, restorative and oral surgery services.

Nunavut's Department of Health and Social Services provides an Extended Health Benefits Plan which applies to persons suffering from a list of specific conditions. This list does not include disability, but there is a residual category for a “special approved case” that could apply to a disabled applicant. The extent of dental coverage, if any, is unclear under the policy.

Provincial Comparison

Much of the general information about the provincial dental insurance programs is available online. However, unlike B.C., many of the provinces do not publish the maximum limits for dental coverage annually or biannually. Efforts to uncover this information were extensive, but ultimately fruitless.

For example, Alberta managers with the Assured Income for the Severely Handicapped (AISH) program could not confirm the specific financial or treatment limits under the plan. Representatives of the Alberta Dental Service Corporation, the organization responsible for approving claims under AISH, explained that limits do exist, but they were unable to release that information. The Alberta

219. NL Reg 144/04.

Dental Association and College also confirmed that there were coverage limits under the plan, but said that permissible coverage was assessed patient by patient. They were unable to provide the fee schedule.

Representatives of the Saskatchewan disability affairs office were unaware that there was an annual financial limit under the plan. Similar to Alberta, efforts to uncover the specific monetary limits proved unsuccessful. Manitoba's online information is complex and spread over a number of different websites, none of which include information on annual limits under the dental plan.

Ontario publishes annual limits for ODSP and DSCP online, but the site is dated 2009 and may be outdated. An online policy manual for the Ministry of Community and Social Services states:

The MCSS Schedule of Dental Services and Fees and the MCSS Schedule of Dental Hygienist Services and Fees are available to ODSP staff, participating dentists, municipal Ontario Works Administrators, Regional Directors and the Provincial Dental Plan Administrator. AccertaClaim Servcorp Inc. administers the dental program on behalf of MCSS. AccertaClaim adjudicates decisions, makes payments and determinations regarding dental benefit claims.

Ontario officials could not provide further information.

Nova Scotia publishes a variety of documents online, including policy manuals²²⁰ and regulations, which outline the fee agreements for general practitioners and specialists.²²¹ Nova Scotia also published an *Oral Health Review* in 2008 that was reviewed by Dr. Peter Cooney, Chief Dental Officer for Canada.²²² The *Oral Health Review* recommends, among other things, significantly greater collaboration between the dental profession and governments.

Although it is relatively easy to learn the basic structure of each provincial public insurance scheme, it is difficult to discern specifics, such as annual financial limits under a plan. Many provincial plan administrators were uncertain of the specific benefits provided under their plan. Typically, the provincial fee guides, which might indicate the maximum coverage, are not available to the public. Many dental associations contacted were unwilling to provide copies of the fee guides.

The lack of transparency regarding the fees and limits under the provincial dental insurance plans for adults with DDs means the public often does not know what the entitlements are. It also suggests that claims adjudicators may not know the scope of coverage. Consequently, some decisions on coverage are potentially made arbitrarily.

220. *ESIA*, *supra* note 201.

221. *HSidental*, *supra* note 200.

222. Dr Ferne Kraglund & Dr Peter Cooney, *Nova Scotia Oral Health Review* (Nova Scotia: Department of Health Promotion and Protection, 2008), online: Government of Nova Scotia <http://www.gov.ns.ca/hpp/publications/08-35069-Oral_Health_Review.pdf>.

Required Actions

As the above comparison makes clear, B.C. falls short in terms of the coverage that it offers to adults with DDs under its provincial plan. B.C. should adopt the more comprehensive coverage offered in other provinces, such as under the Ontario Disability Support Program.

The ODSP offers additional coverage under the Dental Special Care Plan for persons whose dental needs stem from their disability. Coverage under this plan provides for an increased number of cleanings, fillings and exams annually, all of which are especially important for persons with compromised capacity. Adopting this program is a relatively simple change that could significantly improve oral health outcomes for B.C. adults with DDs.

B.C. should also follow the precedents of the programs offered by Quebec and Alberta, both of which provide a wider scope of coverage than the limited B.C. plan, particularly in terms of preventive treatment.

It is not appropriate for the provinces to offer disparate dental insurance coverage for treatment that is crucial to the health and well-being of adults with DDs. The Chief Dental Officer for Canada, the provincial dental colleges and associations, and the responsible provincial ministries should work together to establish necessary levels of dental treatment for adults with DDs. The federal government should enhance its commitment to the Canada Social Transfer and Canada Health Transfer funding to share this cost with the provinces. A standard level of care should be implemented and funded across the country to ensure that all Canadian adults with DDs receive necessary dental treatment in a timely fashion.

CHAPTER 5

Remedies and Recommendations

This chapter examines three categories of remedies for B.C. adults with DDs who cannot access necessary dental treatment in a reasonable time: patient care quality complaints, complaints under the B.C. *Human Rights Code*, and civil actions. The report concludes with six recommendations for actions government can take to meet its legal obligation to ensure that B.C. adults with DDs receive necessary dental treatment in a timely fashion.

Patient Care Quality Complaints

Since 2008, patients of B.C. hospitals and health care facilities have been able to file a formal complaint under the *Patient Care Quality Review Board Act [PCQRBA]*²²³ with a Patient Care Quality Office if they are dissatisfied with the health care treatment they received in a hospital or other health facility regulated under the Ministry of Health (see Appendix 2). Health care is broadly defined to include therapeutic, preventive, palliative, diagnostic or other health-related purpose, as well as other prescribed services.

Under the *PCQRBA*, Patient Care Quality Offices are established in each Health Authority (HA). A care quality complaint can be made regarding the delivery of, or the failure to deliver, health care. If a patient is not satisfied with the response of the Patient Care Quality Office, they are entitled to appeal to the Patient Care Quality Review Board. The board must investigate the complaint and report back to the patient regarding actions taken to resolve the complaint, if any. The board must report all complaints to the minister.

Adult persons in care in a community care facility subject to the *Community Care and Assisted Living Act* are similarly entitled to protection and promotion of their health, safety and dignity, including the right to be protected from abuse and neglect. The rights of persons in care are reproduced as the

223. SBC 2008, c 35.

Resident's Bill of Rights pursuant to the *PCQRBA*. A person in care or someone acting on behalf of the person in care may submit a complaint.²²⁴

Families and caregivers of adults with DDs are entitled to file complaints with the Patient Care Quality Office regarding lack of timely access to necessary dental treatment. Where the office cannot resolve the problem quickly, the family or caregiver is entitled to file a complaint with the Patient Care Quality Review Board. The board is required to file a report to the minister and may attach recommendations to improve service delivery. If multiple complaints were made to the Patient Care Quality Offices and appeals brought before the board relating to the lack of access to necessary dental treatment, then the board might choose to recommend changes to the service delivery system to enhance access.

Complaints under the B.C. *Human Rights Code*

Any person or group of persons alleging a complaint of discrimination on the basis of, among other things, physical or mental disability may file a complaint with the B.C. Human Rights Tribunal under the *Human Rights Code* [*HRC*] if they have been denied a service customarily available to the public. Hospitals are a provincial matter and health care delivery is a service customarily available to the public. Therefore, a complaint that the hospitals have denied equitable access to health care can be made under the *HRC* by a single adult with DDs or a group of adults with DDs (or by their legal representatives). Complaints must be filed within six months of the alleged contravention of the *HRC*, but the tribunal members have discretion to accept complaints that are filed later than this date where they consider it in the public interest to do so.

Two of the purposes of the *HRC* set out in Section 3 are:

- (d) to identify and eliminate persistent patterns of inequality associated with discrimination prohibited by this Code; and
- (e) to provide a means of redress for those persons who are discriminated against contrary to this Code.

The tribunal must, where it finds that discrimination has occurred, order the person who contravened the *HRC* to end the discrimination. The tribunal may allow one or more persons to intervene in a hearing, even if they will not personally be affected by the order. Therefore, organizations such as the B.C. Association for Community Living could apply to intervene in the hearing to argue that the inequitable lack of access to necessary dental treatment is a provincial phenomenon and is not restricted to a single Health Authority, such as Vancouver Coastal Health.

224. *Residential Care Regulation*, BC Reg 10/2010.

Civil Actions

This report argues that government owes a duty of care to adults with DDs. In fact, this report argues that government may be held to owe a fiduciary duty to ensure the health and well-being of adults with DDs. Where government fails to act in a reasonable manner to prevent injury to a person where it would be reasonably foreseeable that failure to act would cause the injury, and where government owes a duty of care towards the injured person, the injured person will have a legal cause of action against the government for failure to meet its duty of care. There are two alternative ways by which adults with DDs may bring an action against government for injuries suffered as a result of government's failure to ensure timely access to necessary dental treatment: individual personal injury claims and class action claims. In both cases, adults with DDs must be represented by a *guardian ad litem*, or a special guardian appointed by the court, to bring the action on their behalf.

Personal Injury Claims

Adults with DDs may file a legal action against a Health Authority and the government for compensation for injury, pain and suffering related to the failure of the HA to ensure timely access to necessary dental treatment in hospital. The legal decisions of *Morgentaler* and *Chaouilli* confirm that the HA and government will be found to have violated the *Charter* rights of the adult with DDs if they have suffered physical harm, pain or extreme anxiety because of an unreasonably long wait for treatment. The *Limitation Act*²²⁵ does not apply in the case of adults with DDs.

An individual legal action against the B.C. government for injury, pain and suffering may include a claim for government's failure to meet its duty of care to provide timely access to necessary treatment both in hospital and in community, if the adult with DDs can prove injury owing to the delay. Government owes adults with DDs a private law duty of care to ensure timely access to necessary dental treatment and potentially owes adults with DDs a fiduciary duty to ensure their health and well-being, including ensuring their dental health.

Class Action Lawsuits Against Government

Adults with DDs could bring a class action against government arguing that they qualify as a class by their inclusion within the definition of "Developmentally Disabled" under the *Community Living Authority Act*.²²⁶ Adults with DDs can show that they are unfairly over-represented on wait-lists for dental treatment in hospitals. They can provide evidence of injury, pain and suffering experienced during their waits for treatment and show evidence of exacerbated dental decay because they could not be treated within a reasonable time. Adults with DDs can prove that their dental health care needs are more complex, and accordingly more expensive, than those of the general population and show that they receive insufficient funding under the provincial PWD dental insurance plan to enable them to maintain healthy teeth.

225. RSBC 1996, c 266, s 7(1) and (2).

226. SBC 2004, c 60.

However, the experience of adults with DDs in receiving timely justice through the class action process suggests it is doubtful that a class action lawsuit will achieve a successful outcome, even if the case has merit. After an external review by former ombudsperson Dulcie McCallum found that residents of Woodlands had suffered physical and sexual abuse in the institution,²²⁷ representatives for former residents brought a class action against the Province of B.C. for breach of fiduciary duty. The action was first certified as a class proceeding by Justice Nancy Morrison in March 2005.²²⁸ The parties settled before trial and an agreed methodology for adjudicating claims was agreed between them, subject to approval of the individual settlements by members of the judiciary.

On October 3, 2012, a full seven years after the class action was first certified, Chief Justice Robert Bauman of the B.C. Supreme Court issued a judgement confirming an extension of the time to settle claims under the class action by another year, to September 19, 2013.²²⁹ Chief Justice Bauman noted in his judgement that the Province (the Defendant) had vigorously disputed every claim to be adjudicated under the settlement, in each case stating that the appropriate amount to fund the claim is \$0. Chief Justice Bauman also noted that the Province had virtually swamped counsel for the Claimants in a tidal wave of paper. He stated as follows:

In none of its responses filed to date has the Defendant suggested any amount of money owing to any class members. They have fully disputed each claim, stating that the amount payable in each claim was \$0. The Defendant has fully litigated each claim, and appears to have significantly outspent Claimants Counsel on the claims litigated to date. The raw data on the seven claims tells the tale. The number of pages of material submitted on this initial batch of claims varied from 1,418 pages (WCA-002) to 4,263 pages (WCA-004). The total volume of material submitted on these seven claims was 19,046 pages. This included 20 affidavits and 23 expert reports submitted by the Claimants, and 22 affidavits and 43 expert reports submitted by the Defendant. It also included 361 pages of written argument by the Claimants and 675 pages of written argument by the Defendant.

This strident defence against claims brought by adults with profound disabilities who were found to have been abused as children during the years they lived at Woodlands indicates that the Province may have little remorse about the suffering experienced by these people. Therefore, the B.C. government may not willingly recognize its legal obligations towards adults with DDs to ensure timely access to dental treatment and may make a class action litigation process as tortuous as possible.

227. *Need to Know*, *supra* note 10.

228. 2005 BCSC 372.

229. *Richard v British Columbia*, 2012 BCSC 1464.

Part of the complexity in litigating the class action claims for the abuse that took place at Woodlands is the difficulty for counsel to take instruction from adults who are not legally competent. Chief Justice Bauman noted that some clients have difficulty communicating and some suffer significant anxiety and stress when recalling their experience at Woodlands. The challenges of communication and high anxiety might exist in any class action brought on behalf of this group.

For these reasons, although a class action may be a viable course of legal action against the Province, it will likely be more cost-effective and efficient to pursue the other remedies described above.

Six Recommendations

The Province of B.C. should take the following steps to enable adults with developmental disabilities (DDs) to access necessary dental treatment in a reasonable time:

1. Build specialized dental clinics

- at UBC to allow dental students to be trained in treating adults with DDs,
- at or near all major hospitals in the province,
- and hire staff/faculty dentists and dental experts to work in the clinics, in similar fashion to the staff/faculty dentists at the BC Cancer Agency dental clinics. These staff dentists could oversee dental residency programs for hospital-based dentistry.

2. Create special-purpose dental OR suites for dentistry

- at UBC to allow dental students and medical students an opportunity to be trained in treating adults who require dental treatment under general anaesthetic (GA) and so that dental and medical treatment can be coordinated under a single GA session,
- at VGH and other major hospitals that have sufficiently sophisticated intensive-care equipment available to enable them to treat exceptionally medically fragile adults with DDs, and
- in the short term, create sufficient access to operating rooms in existing hospitals, perhaps using weekend or other under-utilized time, to allow the dental surgery wait-lists to be reduced or eliminated.

3. Implement proven strategies to reduce wait times for dental surgery in hospital

- such as the Pediatric Surgical Wait Times Strategy to reduce or eliminate wait times,
- similar to the cancer care, cardiac care, hip and knee replacement and cataract surgery strategies to reduce or eliminate wait times.

4. Implement best practices

- Collaborate and seek advice from other jurisdictions, dental organizations, life and health insurance organizations, dentists, dental hygienists and other dental experts to determine appropriate services and funding levels for provincially funded dental treatment and dental hygiene for adults with DDs.
- Collaborate with the above groups to establish suitable policies, procedures and standards for treating adults with DDs in hospital and in community and implement practices and strategies to ensure the policies are followed throughout the province.
- Based on the above information, provide necessary funding for a suitable dental insurance plan for adults with DDs that will ensure optimal oral health.

5. Mandate the College of Dental Surgeons of B.C. (CDSBC)

- to require dental registrants to have or acquire competency to treat adults with DDs, and
- to require new graduates from the UBC Faculty of Dentistry be able to demonstrate competency to treat adults with DDs as a condition of registration.

6. Encourage the following actions:

- the College of Dental Surgeons of B.C. to actively collaborate with other Canadian colleges of dental surgeons to promote recognition of a specialization in Special Needs Dentistry, and
- all provincial and federal governments to collaborate with the Canadian Dental Association, Canadian dental colleges and the Canadian Life and Health Insurance Association to develop a pan-Canadian dental plan for adults with DDs (see Appendix 1).

APPENDIX 1

E-mail to CDA Proposing a Pan-Canadian Dental Plan

From: Joan Rush <joanrush@telus.net>
Sent: August 20, 2012 3:40 PM
To: Robert Sutherland <president@cda-adc.ca>
Subject: Access to Dental Treatment for Developmentally Disabled Adults

Dr. Robert Sutherland
President, Canadian Dental Association

Dear Dr. Sutherland,

Re: Access to Dental Treatment for Developmentally Disabled Adults

Congratulations on your appointment as the President of the CDA for the 2012–2013 term. I was pleased to read that access to care will be one of your primary concerns during your term as President. I agree that it is important for your profession to consider the needs of children and seniors. I am writing to ask if you will also advocate for greater access to care for adults with developmental disabilities during your mandate. These adults face enormous barriers to dental treatment and have some of the worst rates of caries of any group in society.

Some adults with disabilities, who are unable to speak, read or write, and who cannot communicate their pain, may hit their heads or bite their arms from dental pain. Many live on massive doses of pain relief while waiting years for dental treatment. They are probably more challenged than any other group of Canadians to access needed dental treatment.

In his online address to the profession at the end of his term as President earlier this year, Dr. Robert MacGregor wrote an excellent column entitled “Professionalism: We Can All Do Our Part.” Dr. McGregor quoted a 2004 article by Dr. Welie defining professionalism in connection with dentistry in terms of commitment to “give priority to the existential needs and interests of the public they serve above their own...”

Dr. MacGregor explains that “To this end, CDA is currently working with the Association of Canadian Faculties of Dentistry to re-examine the selection process for dental school applicants. The goal is to identify students who exhibit traits of ethical and professional behaviour and to encourage this behaviour prior to graduation.”

I think it is worthwhile to quote more fully the comments made in Dr. Welie's JCDA article, as I think they are particularly relevant to the issue of access to dental treatment for adults with developmental disabilities. Dr. Welie states as follows:

We can ourselves arrange for clothing to protect against the elements, but if a toothache strikes or we break a limb, we have to rely on expert dental and medical care, trusting that our health care providers will not abuse their power in their own interests. This trust is warranted by the profession, i.e., the public promise by the service provider always to give priority to the interests of those served over self-interest. We can thus define a profession as a collective of expert service providers who have jointly and publicly committed to always give priority to the existential needs and interests of the public they serve above their own and who in turn are trusted by the public to do so.¹

... the social contract between profession and society is dynamic. It continuously changes, grows, matures and adjusts to the circumstances of time and location.²

However, it is important to remember that, in final analysis, the ethical foundation of a profession is the profession, the voluntary promise to care for those fellow humans who are vulnerable and in need. No dentist was forced to embark on a dental education. No dental graduate was forced to profess his or her commitment to the public. Each chose to do so voluntarily.³

While I think it is highly beneficial to choose applicants to the faculties of dentistry carefully, I assume that most dental students, past and present, look to the practice as a way to promote oral health, relieve suffering and generally do good work for their community. I doubt that the problem with dentists failing to meet the needs of all members of the community is the prevailing lack of any spirit of human kindness. I do think, however, that dentists will continue to be unable to offer treatment to vulnerable people in community, who have the greatest need for dental care, if dental students receive no training in treating clients with special needs.

Faculties of dentistry must ensure that their curriculum offers training to treat adults with special needs, including adults with developmental disabilities. Research and anecdotal evidence indicates that many dentists do not feel they can treat adults with developmental disabilities because they have no training to do so. They direct these adults to hospital programs which have extraordinarily limited access to operating-room time, so that the disabled adults stay on wait-lists that may be two or three years long. Often dental decay progresses to the point where the only option for the dentist is extraction. Some adults with disabilities have lost so many teeth that their food must be strained, leading to further medical complication.

1. JV Welie, "Is Dentistry a Profession? Part 1. Professionalism Defined" (2004) 70(8) J Can Dent Assoc 529-32 at 531.

2. *Ibid.*

3. *Ibid* at 532.

Thirty years ago, these adults were typically institutionalized. As a more enlightened society we now recognize how wrong and terrible it was to effectively imprison adults with developmental disabilities. However, one small benefit of the medical model of treatment for the disabled was that adults who resided in hospitals had access to health and dental care, since the institutions typically housed dental clinics and operating theatres.

Inclusion of adults with developmental disabilities is an example of a change in society that mandates evolution of the social contract between the dental profession and community. Many adults with developmental disabilities can be seen while awake, or sedated in some fashion other than GA. Treatment for these adults may be somewhat more complicated and more time-consuming for the dentist, but it is possible. However, dentists must have the necessary training to enable them to feel comfortable treating such adults. The profession, and the educators who teach the professionals, must recognize that the needs of the community they serve have altered and they must be prepared to properly meet these new obligations.

Another significant barrier to treatment, however, is the fact that the provincial plans that cover treatment for adults with developmental disabilities typically do not pay dentists enough to cover the necessary time required to treat these adults. In B.C., for example, the plan offered by the Ministry of Social Development and administered by Pacific Blue Cross pays only 60% of the fees set out in the fee guide published by the BCDA. In addition to the limited funding, many services cannot be provided more than once in every two-year period. Various preventive treatments, which would ultimately save the cost of more extensive treatment, are often restricted under the MSD plan. For that reason, I have approached the Chief Dental Officer for Canada, Dr. Cooney, and the Canadian Life and Health Insurance Association, as well as the CDA, to propose a more suitable insurance program that would be shared among the federal, provincial and territorial governments, and assisted by philanthropy from the industry. I understand that the CDA has agreed to discuss this plan at the President's meeting to be held in September. I am extremely pleased to know that the association is considering the benefit of establishing a suitable plan that would properly reimburse dentists for the additional time required to treat adults with developmental disabilities and ensure timely access to those adults who can be seen in community. However, I am writing to ask if your organization could take additional steps in connection with this plan.

I understand that the Dentistry Charitable Foundation that was established in 1994 is no longer in existence. Dr. Smith, the former Chair of the DCF, wrote about the wonderful impression that charitable giving by the dental profession would have on the general public.⁴ When the directors decided to terminate the fund in 2009, it appears that no other charitable fund or other charitable endeavour was established by the CDA to take the place of the DCF. I suggest that helping to fund a dental program for Canadian adults with developmental disabilities, or sharing the cost of extraordinarily high-cost cases with the CLHIA, would be one way for the CDA to restore some portion of its former philanthropic activity. If the profession wants to improve the poor public perception of dentists' ethics, offering to assist with this project could work towards achieving that goal.

4. D Smith, "Why the Success of Dentistry's Charitable Foundation Should Matter to You" (2001) 67 J Can Dent Assoc 79-80.

As a second request, I am asking if the CDA would publicly advocate for greater access to necessary oral surgery under GA for adults with developmental disabilities, similar to the recent publication of your support for restoration of health and dental benefits to refugees. I have spoken with dentists in several provinces who treat adults in hospital under GA. They express grave concern about the lack of access to OR time for those adults who must be seen in hospital. I hope that the CDA will ask the federal and provincial Ministries of Health to enhance access to OR time for treatment of these vulnerable adults.

As explained, I have approached the CLHIA regarding my request that they consider making the pan-Canadian dental program for adults with developmental disabilities one of their philanthropic projects, particularly regarding assisting with catastrophic cases. Accordingly, I have copied Mr. Stephen Frank, Vice President, Policy Development and Health, CLHIA, in light of his responsibility and interest in this issue, to let him know that I have approached you and your colleagues at CDA with the above requests. Similarly, in light of his interest in this issue, I have copied Dr. Cooney.

I have also copied Dr. Jeff Myers and Dean Charles Shuler in their roles as President and Chair of the Dean's Committee for the Association of Canadian Faculties of Dentistry, in view of my comments regarding dentist education.

Again, I congratulate you on your appointment as President of the CDA. I look forward to learning the outcome of your discussions regarding the potential pan-Canadian dental plan after your September meeting. Please do not hesitate to contact me if I can offer any further information or assistance regarding the proposed dental plan.

Sincerely,

JOAN L. RUSH

B.Comm., LL.B., LL.M.
Barrister & Solicitor

Addendum: Dr. Sutherland did not respond to this letter. He also did not write to advise that the CDA had decided not to participate in discussions regarding a pan-Canadian dental plan.

APPENDIX 2

Excerpts from Relevant Statutes, Regulations and Bylaws

Bylaws of the College of Dental Surgeons of B.C.	/ 110
<i>Canada Health Act</i>	/ 110
<i>Community Care and Assisted Living Act</i>	/ 110
<i>Dentist Regulation 2009</i>	/ 111
<i>Employment and Assistance for Persons with Disabilities Act</i>	/ 111
<i>Health Professions Act</i>	/ 112
<i>Health Professions General Regulation</i>	/ 114
<i>Hospital Act</i>	/ 115
<i>Hospital Act Regulation</i>	/ 116
<i>Hospital Insurance Act</i>	/ 117
<i>Hospital Insurance Act Regulations</i>	/ 117
<i>Human Rights Code</i>	/ 118
<i>Limitation Act</i>	/ 119
<i>Medicare Protection Act</i>	/ 119
<i>Medical and Health Care Services Regulation</i>	/ 120
<i>Patient Care Quality Review Board Act</i>	/ 120
<i>Residential Care Regulation</i>	/ 121

BYLAWS OF THE COLLEGE OF DENTAL SURGEONS OF B.C.

The Bylaws of the CDSBC¹ set out the duties and responsibilities of the board and registrar and the qualifications for registration. Part 6 of the bylaws entitles the college to establish rules for registration of an applicant as a “dentist” or a “certified specialist.”

CANADA HEALTH ACT [RSC 1985] CHAPTER C-6

[Excerpts from Preamble and Interpretation sections]

AND WHEREAS the Parliament of Canada wishes to encourage the development of health services throughout Canada by assisting the provinces in meeting the costs thereof;

2. In this Act

“dentist” means a person lawfully entitled to practise dentistry in the place in which the practice is carried on by that person;

“insured health services” means hospital services, physician services and surgical-dental services provided to insured persons;

“surgical-dental services” means any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures;

COMMUNITY CARE AND ASSISTED LIVING ACT [SBC 2002] CHAPTER 75

Standards to be maintained

7 (1) A licensee must do all of the following:

- (b) operate the community care facility in a manner that will promote
 - (i) the health, safety and dignity of persons in care, and
 - (ii) in the case of adult persons in care, the rights of those persons in care;

1. CDSBC Bylaws, online: <http://www.cdsbc.org/~ASSETS/DOCUMENT/CDSBC_Bylaws_April_3_2009.pdf>.

Schedule

(Section 7)

Rights to health, safety, and dignity

1. 2. An adult person in care has the right to the protection and promotion of his or her health, safety and dignity, including a right to all of the following:

(b) to be protected from abuse and neglect;

Complaints that rights have been violated

2 (1) In addition to any complaint that may be made under this Act, if a person in care believes that his or her rights have been violated, the person in care or a person acting on his or her behalf may submit a complaint under the *Patient Care Quality Review Board Act*.

(2) A complaint submitted under subsection (1) is a care quality complaint for the purposes of the *Patient Care Quality Review Board Act*.

[Note: The rights of Persons in Care are reproduced as the *Resident's Bill of Rights* under the *Patient Care Quality Review Board Act*.]

DENTIST REGULATION 2009

Pursuant to the Dentist Regulation² “dentistry” is defined as follows:

“Dentistry” means the health profession in which a person provides the services of assessment, management, treatment and prevention of diseases, disorders and conditions of the orofacial complex and associated anatomical structures;”

EMPLOYMENT AND ASSISTANCE FOR PERSONS WITH DISABILITIES ACT

[SBC 2002] CHAPTER 41, SECTION 26

Power to make regulations

(4) In making regulations under this Act, the Lieutenant Governor in Council may do one or more of the following:

...

(c) make different regulations for different groups or categories of persons or family units.

2. Dentist Regulation made under the *Health Professions Act* s 12(2) pursuant to Ministerial Order 308 effective April 3, 2009, R1226/2008/48.

HEALTH PROFESSIONS ACT [RSBC 1996] CHAPTER 183

Definitions

1 In this Act:

“**college**” means, in relation to a designated health profession, its college established under section 15 (1);

“**health profession**” means a profession in which a person exercises skill or judgment or provides a service related to

- (a) the preservation or improvement of the health of individuals, or
- (b) the treatment or care of individuals who are injured, sick, disabled or infirm;

Designation of a health profession

12 (1) The Lieutenant Governor in Council may, by regulation, designate a health profession for the purposes of this Act.

Colleges continued

15.1

(2) The College of Dental Surgeons of British Columbia continued under the Dentists Act is continued as a college under this Act.

Duty and objects of a college

16 (1) It is the duty of a college at all times

- (a) to serve and protect the public, and
- (b) to exercise its powers and discharge its responsibilities under all enactments in the public interest.

(2) A college has the following objects:

- (a) to superintend the practice of the profession;
- (b) to govern its registrants according to this Act, the regulations and the bylaws of the college;
- (c) to establish the conditions or requirements for registration of a person as a member of the college;
- (d) to establish, monitor and enforce standards of practice to enhance the quality of practice and reduce incompetent, impaired or unethical practice amongst registrants;
- (e) to establish and maintain a continuing competency program to promote high practice standards amongst registrants;
- (f) to establish, for a college designated under section 12 (2) (h), a patient relations program to seek to prevent professional misconduct of a sexual nature;

- (g) to establish, monitor and enforce standards of professional ethics amongst registrants;
- (h) to require registrants to provide to an individual access to the individual's health care records in appropriate circumstances;
- (i) to inform individuals of their rights under this Act and the *Freedom of Information and Protection of Privacy Act*;
- (i.1) to establish and employ registration, inquiry and discipline procedures that are transparent, objective, impartial and fair;
- (j) to administer the affairs of the college and perform its duties and exercise its powers under this Act or other enactments;
- (k) in the course of performing its duties and exercising its powers under this Act or other enactments, to promote and enhance the following:
 - (i) collaborative relations with other colleges established under this Act, regional health boards designated under the *Health Authorities Act* and other entities in the Provincial health system, post-secondary education institutions and the government;
 - (ii) interprofessional collaborative practice between its registrants and persons practising another health profession;
 - (iii) the ability of its registrants to respond and adapt to changes in practice environments, advances in technology and other emerging issues.

Inquiry

18.1 (1) If the minister considers it necessary in the public interest, the minister may appoint a person to inquire into

- (b) the state of practice of a health profession in
 - (i) British Columbia,

(2) Subsection (1) includes inquiry into an exercise of a power or a performance of a duty, or the failure to exercise a power or perform a duty, under this Act.

Bylaws for college

19 (1) A board may make bylaws, consistent with the duties and objects of a college under section 16, that it considers necessary or advisable, including bylaws to do the following: (*inter alia*)

- (m) establish conditions or requirements for the registration of a person as a member of the college, including the following:
 - (i) standards of academic or technical achievement;
 - (ii) competencies or other qualifications;

(5) The minister may request a board to amend or repeal an existing bylaw for its college or to make a new bylaw for its college if the minister is satisfied that this is necessary or advisable.

(6) If a board does not comply with a request under subsection (5) within 60 days after the date of the request, the minister may, by order, amend or repeal the existing bylaw for the college or make the new bylaw for the college in accordance with the request.

HEALTH PROFESSIONS GENERAL REGULATION

[includes amendments up to BC Reg 212/2010, June 29, 2010]

Notice to be given

2 For the purposes of section 12 (3), 19 (6.2) and (7), 50 (3), 50.3 (4) and 55 (3) of the Act, notice must be given to each of the following:

- (b) College of Dental Surgeons of British Columbia;

Oath of office

4 The oath of office set out in Schedule 1 is prescribed for the purpose of section 17.11 of the Act.

Schedule 1 Oath of Office

I do swear or solemnly affirm that:

- I will abide by the *Health Professions Act* and I will faithfully discharge the duties of the position, according to the best of my ability;
- I will act in accordance with the law and the public trust placed in me;
- I will act in the interests of the College as a whole;
- I will uphold the objects of the College and ensure that I am guided by the public interest in the performance of my duties;
- I have a duty to act honestly;
- I will declare any private interests relating to my public duties and take steps to resolve any conflicts arising in a way that protects the public interest;
- I will ensure that other memberships, directorships, voluntary or paid positions or affiliations remain distinct from work undertaken in the course of performing my duty as a board member;
- So help me God. *[omit this phrase in an affirmation]*

HOSPITAL ACT

[RSBC 1996] CHAPTER 200

Duties of a hospital

4 (1) A hospital must not refuse to admit a person on account of the person's indigent circumstances.

5 (1) . . .

“**patient**” means a person, including a mentally disordered person as defined in the *Mental Health Act*, who is under observation, treatment or care for illness, disease or injury, or who is receiving nursing care and attention, or a person who needs that care or treatment, but does not include a person who, in the opinion of the inspector, only needs or is receiving personal care or occasional skilled care, or both;

Facilities for university medical students

45 (1) A hospital that provides primarily acute care must provide reasonable facilities in or near the hospital for giving clinical instruction to the medical students of The University of British Columbia by designated staff of the hospital and by professors and members of the teaching staff of the medical faculty of The University of British Columbia.

(2) If the authorities of the hospital and of the university are unable to agree as to the nature and extent of the facilities to be granted, or the rules under which they are to be made use of, they must be determined by the Lieutenant Governor in Council.

Power to withhold amounts payable to hospitals

47 The Lieutenant Governor in Council may withhold the amounts payable under this or any other Act to a hospital including a hospital under Part 2.1, if its board of management refuses or neglects to comply with this Act or the regulations, or fails to administer the hospital in a manner satisfactory to the minister.

Power to make regulations

56 (1) The Lieutenant Governor in Council may make any regulations deemed necessary for the carrying out of the provisions of this Act to meet any contingency not expressly provided for in it, and providing for the returns to be rendered by the secretary or other executive officer of a hospital.

(3) The power to make regulations under this section extends to prescribing, for any hospital as defined under any of the provisions of this Act, any of the following: . . .

(b) the number or proportion of persons

(i) to or for whom income assistance is provided under the Employment and Assistance Act or disability assistance is provided under the Employment and Assistance for Persons with Disabilities Act, and

(ii) who are to be provided with the necessary care and accommodation;

(b.1) the rates payable for the persons referred to in paragraph (b);

(g) the rules or standards regarding the care and treatment of patients;

- (4) If regulations are made,
- (a) a hospital to which the regulations apply must observe them, and
 - (b) the person in charge of admissions to a hospital to which regulations made under subsection (3)(b) apply must, if the number or proportion of the persons to whom that paragraph refers accommodated in that hospital is less than the number or proportion prescribed, give preference of admission to those persons.

Schedule

[section 24.1] (*inter alia*)

- 7 Eagle Ridge Hospital and Health Care Centre
- 30 U.B.C. Health Sciences Centre Hospital
- 31 Vancouver General Hospital

HOSPITAL ACT REGULATION

[includes amendments up to BC Reg 423/2008, June 1, 2009]

Prescribed health professions

2 For the purpose of the definition of “**practitioner**” in section 1 of the Act, the following are prescribed health professions:

- (a) dentistry

Bylaws respecting health care responsibilities

5 A hospital’s board must provide in the bylaws of its medical staff a procedure under which . . .

- (c) the responsibility for dental care of a patient
 - (i) is assumed, throughout the patient’s stay in the hospital, by an attending dentist on the medical staff, and
 - (ii) may be transferred from one dentist on the medical staff to another.

Attending and treating patients in hospital

7 (1) A practitioner is not entitled to attend or treat patients in a hospital or in any way make use of the hospital’s facilities for his or her practice unless the practitioner

- (a) is a person who is authorized to practise a profession regulated by one or more of the following:
 - (i) the College of Dental Surgeons of British Columbia;
- (2) A permit issued under subsection (1) (b) does not entitle a practitioner to patient admitting and discharging privileges in the hospital unless the practitioner to whom the permit is issued
 - (a) is a medical practitioner, or
 - (b) for the purpose of midwifery, is a midwife.
- (7) (c) the responsibility for the dental care of a patient while in the hospital rests with the dentist on the hospital’s medical staff who is attending the patient.

HOSPITAL INSURANCE ACT **[RSBC 1996] CHAPTER 204**

Definitions

1 In this Act:

“benefits” means the general hospital services authorized under this Act;

Benefits

5 (1) . . . , the general hospital services provided under this Act are the following: . . .

(c) for beneficiaries requiring treatment or diagnostic services as out patients, the out patient treatment or diagnostic services prescribed by regulation.

(3) For the purposes of subsection (1) (c), the regulations may authorize the minister to define categories of out patient care and specify the treatment or diagnostic services to be provided for those categories.

Hospitals to provide services for beneficiaries

8 Every hospital must provide for beneficiaries those public ward facilities, including necessary operating and case room facilities, X-ray and laboratory diagnostic and therapeutic procedures, anesthetics, and other services, dressings and drugs the Lieutenant Governor in Council requires or provides for under regulations.

HOSPITAL INSURANCE ACT REGULATIONS

[includes amendments up to BC Reg 231/2011, February 1, 2012]

Day care surgical services

5.6 Where a beneficiary has not been admitted to hospital as an in-patient but has been rendered day care surgical services therein, there shall be paid to the hospital a sum determined by the minister. The amount shall be paid by the government in the manner prescribed by the minister. The minister shall define day care surgical services and shall specify the benefits which are to be made available under this section.

HUMAN RIGHTS CODE
[RSBC 1996] CHAPTER 210

Discrimination in accommodation, service and facility

- 8** (1) A person must not, without a bona fide and reasonable justification,
- (a) deny to a person or class of persons any accommodation, service or facility customarily available to the public, or
 - (b) discriminate against a person or class of persons regarding any accommodation, service or facility customarily available to the public because of the race, colour, ancestry, place of origin, religion, marital status, family status, physical or mental disability, sex, sexual orientation or age of that person or class of persons.
- (2) A person does not contravene this section by discriminating
- (a) on the basis of sex, if the discrimination relates to the maintenance of public decency or to the determination of premiums or benefits under contracts of life or health insurance, or
 - (b) on the basis of physical or mental disability or age, if the discrimination relates to the determination of premiums or benefits under contracts of life or health insurance.

Complaints

- 21** (1) Any person or group of persons that alleges that a person has contravened this Code may file a complaint with the tribunal in a form satisfactory to the tribunal.

...

- (4) Subject to subsection (5), a complaint under subsection (1) may be filed on behalf of
- (a) another person, or
 - (b) a group or class of persons whether or not the person filing the complaint is a member of that group or class.
- (5) A member or panel may refuse to accept, for filing under subsection (1), a complaint made on behalf of another person or a group or class of persons if that member or panel is satisfied that
- (a) the person alleged to have been discriminated against does not wish to proceed with the complaint, or
 - (b) proceeding with the complaint is not in the interest of the group or class on behalf of which the complaint is made.
- (6) A member or panel may proceed with 2 or more complaints together if a member or panel is satisfied that it is fair and reasonable in the circumstances to do so.

LIMITATION ACT
[RSBC 1996] CHAPTER 266

If a person is a minor or incapable

7 (1) For the purposes of this section,

(a) a person is under a disability while the person

(i) is a minor, or

(ii) is in fact incapable of or substantially impeded in managing his or her affairs

(2) If, at the time the right to bring an action arises, a person is under a disability, the running of time with respect to a limitation period set by this Act is postponed so long as that person is under a disability.

MEDICARE PROTECTION ACT
[RSBC 1996] CHAPTER 286

[Excerpts from Preamble and Interpretation sections]

AND WHEREAS the people and government of British Columbia believe it to be fundamental that an individual's access to necessary medical care be solely based on need and not on the individual's ability to pay.

Definitions

1. In this Act:

“**benefits**” means . . .

(b) required services prescribed as benefits under section 51 and rendered by a health care practitioner who is enrolled under section 13, or

“**health care practitioner**” means a person entitled to practise as

(a) . . . a dentist, . . .

Power to make regulations

51 (1) The Lieutenant Governor in Council may make regulations . . .

(a) specifying the services rendered by an enrolled health care practitioner that are benefits under this Act;

MEDICAL AND HEALTH CARE SERVICES REGULATION

[includes amendments up to BC Reg 179/2011, January 1, 2012]

Dental and orthodontic services

- 19 (1) Subject to section 27, a dental or orthodontic service is a benefit if the service is
- (a) related to the remedying of a disorder of the oral cavity or a functional component of mastication,
 - (b) listed in a payment schedule for dentists and described in subsection (2),
 - (c) rendered by an enrolled dentist, and
 - (d) described in an adequate clinical record.
- (2) The following are services for the purpose of subsection (1) (a) or (b):
- (a) an oral surgical procedure rendered to a beneficiary who
 - (i) has been properly admitted to a hospital, or
 - (ii) is a patient under the Day Care Services Programand for whom hospitalization is medically required for the safe and proper performance of the surgery;

PATIENT CARE QUALITY REVIEW BOARD ACT

[SBC 2008] CHAPTER 35

Definitions

1. In this Act

“care quality complaint” means a complaint

- (a) respecting one or more of the following:
 - (i) the delivery of, or the failure to deliver, health care;
 - (ii) the quality of health care delivered;
 - (iii) the delivery of, or the failure to deliver, a service relating to health care;
 - (iv) the quality of any service relating to health care, and
- (b) made by or on behalf of the individual to whom the health care or service was delivered or not delivered;

“complainant” means

- (a) the individual referred to in paragraph (b) of the definition of “care quality complaint”, or
- (b) if a person has been authorized under the common law or an enactment to make health care decisions in respect of that individual, the person having that authority;

“**health care**” means anything that is provided to an individual for a therapeutic, preventive, palliative, diagnostic or other health related purpose, and includes

- (a) a course of health care, and
 - (b) other prescribed services relating to individuals’ health or well-being;
-

RESIDENTIAL CARE REGULATION

[includes amendments up to BC Reg 10/2010, January 15, 2010]

General health and hygiene

54 (1) A licensee must establish a program to instruct, if necessary, and assist persons in care in maintaining health and hygiene.

(2) A licensee must

- (a) assist persons in care to obtain health services as required, ...

(3) A licensee must

(a) encourage persons in care to be examined by a dental health care professional at least once every year, and

(b) assist persons in care to

- (i) maintain daily oral health,
- (ii) obtain professional dental services as required, and
- (iii) follow a recommendation or order for dental treatment made by a dental health care professional.

(4) For the purposes of subsection (3), “**dental health care professional**” means a person who is a member of

- (a) the College of Dental Surgeons of British Columbia,
- (b) the College of Dental Hygienists of British Columbia, or
- (c) the College of Denturists of British Columbia.

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