Oral Health Care in Canada — A View from the Trenches

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ABSTRACT

Purpose: Concern is increasing over the effect of lack of access to oral health care on the oral health, and hence general health, of disadvantaged groups. In preparation for a national symposium on this issue, key informants across Canada were canvassed for their perceptions of oral health services and their recommendations for improving oral health care delivery. This paper reports the results of that survey.

Method: A questionnaire was constructed to address problems facing agencies with responsibility for meeting the oral health care needs of people receiving government assistance, the underhoused and the working poor. The survey was sent to 200 agencies, government and professional organizations. Data from the returned questionnaires were entered into a Statistical Package for the Social Sciences database and analyzed. Responses from Ontario were compared with those from the rest of Canada, those from government organizations were compared with others and results were examined by cultural nature of clients and by type of organization.

Results: In assessing the positive aspects of oral health care, 84% of respondents agreed that public programs were useful and 81% felt that dentists offer good care. However, 77% disagreed that preventive care is accessible and that access to dentists and dental specialists is easy. More Ontarians than others thought that there are few alternative settings for care delivery (95% vs. 83%) and that the poor feel unwelcome in dental offices (83% vs. 70%). The issues most commonly identified were the need for alternative delivery sites, such as community health centres where service delivery could be affordable, accountable and sustainable; the need for oral health to be recognized as part of general health; regulatory issues (e.g., expanding practice opportunities for non-dentist oral health care providers and removing restrictions on other dental health professionals in providing basic care to the financially challenged); and training.

Discussion: The survey helped to identify access and care issues across the country. There was considerable agreement that lack of access to dental care services is an important detriment to the oral and general health of many Canadians. Respondents believe that dental health is isolated from general health.

MeSH Key Words: Canada; dental health services; health services accessibility/trends; vulnerable populations

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Throughout Canada, social service agencies, emergency room staff and others are reportedly often frustrated in their attempts to obtain access to oral health care for their clients.[1] In 1984, the Canada Health Act (CHA) defined the insured health benefits that provinces must provide. Although oral health is part of general health, it was not defined as an insured benefit. Thus, there is no obligation to meet the 5 tenets of the CHA[2] (public

Table 1 Responses by province and employer

	% of responses
Province	
Ontario	53.2
Nova Scotia	11.4
British Columbia	7.6
Quebec	5.1
Manitoba	5.1
Prince Edward Island	3.8
Saskatchewan	3.8
Newfoundland and Labrador	3.8
Northwest Territories	2.5
Alberta	2.5
Yukon	1.3
Nunavut	0
New Brunswick	0
Employer	
Government	55.1
Nongovernment	44.9
Health care delivery	34.9
Education	21.7
Health or social service, policy analysis or formation	10.8
Social service	9.6
Provider association	4.8
Other	18.1

administration, universality, portability, accessibility and comprehensiveness), and Canadians must use their own resources, third-party programs or government programs for oral health care. Although most provinces have limited programs for welfare clients and some have dental care programs for children, such programs do not meet the 5 tenets of the CHA. As a result, the working poor and those living in poverty have restricted access to dental care[3] and much untreated disease.

The decrease in publicly funded dental care, from 9.2% in 1990 to 5.8% in 1999,[4] has affected access to oral health care. This follows a pattern of the last 20 years in which dental programs for children and seniors in the western provinces have been cut[5] and a more recent spate of hospital department closures has affected both the delivery of care and the training of undergraduates and some specialists. Operating room time has been lost and hospital dental outpatient services — many of which were often the sole source of emergency care for some — have been closed.

These cuts to publicly funded dental care are occurring in spite of increasing evidence that poor oral health has an effect on general health, specifically diabetes, cardiovascular disease and pre-term deliveries.[6,7] Thus, concern is increasing that lack of access to oral health care is affecting the general health of disadvantaged groups, which in turn impedes their ability to participate fully in society.[8]

In May 2004, the Toronto Oral Health Coalition, the faculty of dentistry at the University of Toronto and the Dental Hygiene program at George Brown College, with the support of Health Canada and other sponsors, held a national symposium to raise awareness of the need to improve access to care and oral health services. As part of the preparation for the symposium and integral to the identification of issues, key informants across Canada were canvassed for their perceptions of oral health services and their recommendations for improving oral health care delivery. This paper reports the information obtained from those key informants.

Methods

Ethical Review

Approval was obtained from the Ethics Review Board at the University of Toronto.

Target Group

The survey was intended to reach agencies mandated to meet the oral health care needs of those receiving government assistance (welfare), the underhoused and the working poor and to reveal the issues around provision of dental care facing these agencies. A questionnaire was designed to seek answers from key informants on behalf of these clients. Thus the responses were sought from those at a senior management position.

Sampling Frame

As no complete list of such agencies exists, we compiled a list that we believe included both those who might work on behalf of such clients (social and health care agencies) and those who might be providing or organizing the provision of care to these clients (dental, dental hygiene and denturist professional organizations).

The mailing list was constructed to include social service agencies listed with the Toronto Oral Health Coalition; all faculties or schools of dentistry, dental hygiene, denture and dental therapy across the country; all ministries of health and social or community services for the provinces and Health Canada; all regulatory authorities for dentistry and dental hygiene; Canada-wide professional organizations for dentists, dental hygienists, denturists and dental therapists; dental insurance companies; and all local health authorities across Canada. The latter were obtained from a database maintained by the Canadian Public Health Association. Members of the Canadian Association of Public Health Dentistry were invited to identify key agencies in their regions. Despite these efforts, there is no independent way of verifying the completeness of the mailing list.

Table 2 From your agency's or clients' perspective, what are the positive aspects of oral (dental) health care delivery in Canada? (*n* = 91)

	Agree (%)	Disagree (%)	No opinion (%)
Some children have access to free dental care	84.3	9.0	6.7
Some public programs provide treatment for special groups	84.1	11.4	4.5
Providers offer good dental care	81.1	7.8	11.1
Dental care is a benefit for many employees and their dependents	76.4	20.2	3.4
Most patients can choose their dental care provider	73.9	23.9	2.3
There is easy access to dentists	42.7	55.1	2.2
There is easy access to dental specialists	31.5	58.4	10.1
Many recently graduated dentists are sensitive to other cultures and speak languages other than French and English	26.1	38.6	35.2
There is good access to preventive services	20.0	76.7	3.3

Agencies were selected using a random number start and a frequency based on the number for each category on the list. Thus surveys were mailed to 1 in 10 local health authorities, 1 in 3 social service agencies and all of the others. After 6 weeks, surveys were re-mailed to those who had not responded.

Questionnaire

Questions were developed by the authors with input from the planning group for the symposium. Once the questions had been selected and reviewed against other similar questionnaires for validity, the survey was sent out to the key informants. Those surveyed were asked to provide information in the following areas: their opinion of the positive and negative aspects of oral health care delivery in Canada; local developments in the past 5 years that have made the system more effective in providing access and care; innovative projects that provide dental health care training or delivery; changes that have occurred over the last 10 years to make the system less effective in providing access and care; and suggestions about what should be done to improve access to dental care. In addition, we collected information on the nature of the surveyed organizations and their clients. Respondents were asked to indicate whether they were in a government agency; whether they delivered health care, social services or education; and whether their organization was a health or social service policy developer or a provider. They were asked to identify the income, sex, cultural and health status of their clients and the province in which they operate. Responses were to be anonymous, although participants could volunteer their names and email addresses if they wished to receive feedback from the survey or the symposium.

The data from the returned questionnaires were entered into a Statistical Package for the Social Sciences (SPSS) database (SSPS Inc., Chicago, Ill.) and analyzed. Initially, frequencies were carried out to help determine further direction for analyses. Because of the modal nature of the data when collated using "province or territory" as a descriptor of the survey participants, the data were reanalyzed using Ontario or Not Ontario as the dichotomous variables. Comparisons were made between Ontario and the rest of Canada; between government organizations and others; by cultural background of clients (First Nations or not); and by type of organization.

The responses were used to inform the conference of experiences with access and dental care delivery across Canada.

Results

Of the 225 surveys that were mailed out, 91 were completed and returned (40% response rate). **Table 1** shows the percentage of responses for each province and by employer and employment category.

Most respondents reported that their organization serves people from all cultures, but almost 15% serve only First Nations and Inuit people.

Because the sample size was small, the results cannot be considered significant, although there are some interesting differences between Ontario and the rest of Canada.

Responses were sought first about the positive aspects of oral health care (**Table 2**). Most respondents found the public programs for children and adults positive, most agreed that dentists offer good care and three quarters said that dental insurance and choosing a dentist are positive. On the other hand, nearly 77% disagreed with the statement that preventive care is accessible and over 55% disagreed with the statements that access to dentists and dental specialists is easy. Key informants from Ontario agreed less frequently (79%) than the rest of Canada (91%) with the statement that children have good access and much less frequently with the statements on access to preventive care (9% vs. 31%) and ease of access to dentists (38% vs. 50%).

Table 3 From your agency's or clients' perspective, what are the negative aspects in dental health care delivery? (n = 91)

	Agree (%)	Disagree (%)	No opinion (%)
High cost of dental care makes much of dental care inaccessible to people without insurance coverage	97.8	2.2	0
Insurance unavailable to unemployed, self-employed, low-income people	94.4	2.2	3.4
Those who need care the most may be least likely to receive it	93.3	4.5	2.2
Few alternative settings of dental care exist outside of the traditional dental office	91.1	6.7	2.2
Dental health is isolated from general health	91.1	5.6	3.3
Governments generally resist including dental care in health programs	86.5	7.9	5.6
People with special needs have problems in accessing care	86.5	11.2	2.2
Some insurance plans are inadequate	84.1	5.7	10.2
Poor and disadvantaged groups often feel unwelcome at the dental office	75.0	13.6	11.4
Dentists tend to practise in more affluent and urban areas, leaving some parts of the country underserviced	73.0	14.6	12.4

In responses to the questions on negative aspects of dental health care delivery (**Table 3**), most respondents agreed that

- high cost makes care inaccessible without insurance (97.8%)
- insurance is unavailable to low-income people (94.4%)
- those with the greatest need get the least care (93.3%)
- oral health is isolated from general health (91.1%)
- governments resist including dental care in health programs (86.5%)
- people with special needs have problems accessing care (86.5%)
- some insurance plans are inadequate (84.1%).

Specifically, comparing the experiences in Ontario with those in the rest of Canada, more Ontarians thought there were few alternative settings (95% vs. 83%) and that the poor feel unwelcome at the dental office (83% vs. 70%).

Although the numbers are small, limiting accurate interpretation, the perspectives of the different agencies varied. Fewer informants from government agencies (62% vs. 90% of the others) felt that patients' ability to choose their dentist was a positive attribute of the system. Respondents from First Nations and Inuit agencies disagreed that their clients have good access to dentists (9 of 10) and specialists (8 of 10), and all 10 reported that their clients with special needs had problems obtaining access to care. **Table 4** compares responses to some of the questions in **Tables 1** and **2** by type of organization. More respondents from policy development agencies thought that access to good prevention (60%) and easy access to dentists (80%) were attributes of the system, in contrast with the mean responses of 20% and 42%, respectively. Social service providers were less likely to agree that dental care was a benefit of employment (56% compared with the mean of 76%).

Respondents' concurrence on developments that appear to have made the system less effective is shown in **Table 5**. Strongest agreement was found with the statement that the provinces are turning away from responsibility for delivery of oral health care (81%) and over 76% agreed that unemployment or loss or reduction of dental (insurance) benefits was contributing. Again, Ontario respondents differed from those in the rest of the country on several issues:

- Municipal cutbacks make it difficult to fund local dental programs (88% of respondents in Ontario agreed vs. 46% in the rest of the country).
- In regional health authorities, dental care has been reduced further (44% vs. 67% in Ontario), perhaps reflecting that Ontario has had no experience with regionalization, since some 56% of respondents had no opinion.
- More people cannot afford dental care due to unemployment (81% vs. 63%).

Table 6 shows responses to the question about how to improve access to dental care. Overall, 93% of respondents thought that basic dental care should be provided under

Table 4 Selected responses (% agreeing) highlighting differences by type of agency

	Social services *n* = 9	Health delivery *n* = 31	Educators *n* = 19	Professional associations *n* = 4	Health/social services policy analysis and development *n* = 10	All responses *n* = 88
Question 1: From your agency's or clients' perspective, what are the positive aspects of oral (dental) health care delivery in Canada?						
Many recently graduated dentists are sensitive to other cultures and speak languages other than French and English	0	23	53	33	0	26
There is good access to preventive services	22	16	13	50	60	20
Dental care is a benefit for many employees and their dependents	56	81	74	100	80	76
There is easy access to dentists	33	32	42	25	80	42
Question 2: From your agency's or clients' perspective, what are the negative aspects in dental health care delivery?						
People with special needs have problems in accessing care	78	87	100	75	60	86
Poor and disadvantaged groups often feel unwelcome at the dental office	75	65	95	50	60	74

Table 5 What changes have occurred over the last 10 years to make the system less effective in providing access and care?

	Agree (%)	Disagree (%)	No opinion (%)
Provinces turning away from responsibility for dental health care delivery	81.8	4.5	13.6
More people cannot afford dental care due to unemployment or loss/reduction of dental benefits	76.1	9.1	14.8
Cutbacks to municipalities make it difficult to fund local dental programs	69.3	6.8	23.9
Hospital underfunding has led to cutbacks in dental services for medically compromised patients	66.3	10.1	23.6
In regional health authorities, dental care has been reduced further	50.6	11.5	37.9
University dental clinics have raised their fees and reduced access	42.0	5.7	52.3
Hospital closures have reduced training opportunities	38.6	18.2	43.2

provincial medical plans for high-need groups and over 86% thought that community clinics should be funded and greater use made of other dental health care professionals. There was strong (78%) agreement that basic dental care should be included in the provincial health care plans for all citizens. Again, there was a difference between Ontario (91%) and the rest of Canada (71%) in favouring the provision of training of dentists in community and hospital settings.

Respondents were also asked to identify other issues related to oral and dental care delivery. Most commonly cited were the need for alternative delivery sites, such as community health centres where service delivery could be affordable, accountable and sustainable; the need for recognition of oral health as a component of general health; regulatory issues (e.g., increasing practice opportunities for non-dentist oral health care providers and removing restrictions on other dental health professionals to provide basic care to the financially challenged); and training issues (e.g., providing oral care for medically compromised people in dental departments of teaching hospitals, asking departments of health to provide grants to clinics in faculties of dentistry and increasing training in the community).

Table 6 What should be done to improve access to dental care?

	Agree (%)	Disagree (%)	No opinion (%)
Provide basic dental care under medical plans for high-need groups	93.0	4.7	2.3
Fund dental clinics within community and hospital settings	86.7	7.8	5.6
Make greater use of other dental professionals, i.e., dental hygienists, dental therapists and denturists	86.4	9.1	4.5
Provide for training of dentists in community and hospital settings	81.8	5.7	12.5
Include basic dental care (preventive care, checkups, fillings) under provincial medical plans for all citizens	78.4	17.0	4.5

Respondents were asked for suggestions to improve the system and for examples of local developments that had occurred over the past 5 years to make the system more effective. The responses ranged from suggestions for changes in delivery models to development of grassroots coalitions and provision of preventive care. Examples of local developments included partnering with public health authorities to provide care including transportation to dental clinics for identified children and opening dental clinics on Nangis First Nation reserves with the federal government's assistance. However, many respondents volunteered the converse: that, in fact, there had been developments that have lessened the effectiveness of such provisions.

Respondents reported some creative programs, such as communities paying for low-income children (British Columbia); the Oral Health of Seniors project (Nova Scotia); the development of a long-term care fee guide (London, Ontario); new programs, such as Save A Smile (Alberta) and geriatric programs; provision of dental care for high-need children from low-income families by dental therapists (Saskatchewan); and a long-term care facility that has been able to set up an in-house dental clinic with limited visits, usually monthly by a local dentist (Bruce County, Ontario).

They also reported that coalitions to improve access and oral health care have formed in Toronto, Kingston and Peterborough, Ontario, and that there is some activity among seniors to lobby for better access. In relation to prevention, respondents noted that more small communities have fluoridation; that dental health promotion programs are partnering with existing programs and building community capacity to identify preventable conditions; and that organized dentistry is involved in prevention.

Discussion

Although our 40% response rate is not high,[9] it is generally considered acceptable for a mail-out survey. Higher response rates could have been achieved with repeat mailings and by offering an incentive.[9] The rate of response from grassroots social service agencies was particularly low, making the overall results biased toward those who work in government. Among the respondents who identified themselves, 2 were from denturist regulatory bodies; none were dental hygienists or from dentist regulatory agencies.

The survey helped to identify access and care issues across the country. It highlighted the fact that not all issues are common across all provinces. For example, more Ontario respondents felt that they had fewer services now than 10 years ago, perhaps because Ontario had been well supplied with dental care options but has seen programs for social service recipients and within-hospital training programs eroded. Other provinces may have had less in the past and were reflecting little change; however, they also identified the need for programs and better access to care. There was considerable agreement that lack of access to dental care services is an important detriment to the health of many Canadians.

Respondents working in government agencies did not think that access to prevention or to dental services including specialists was good, but they did not think that hospital closures or funding had reduced training for dental professionals nor that these events had reduced access for medically compromised patients.

Respondents generally thought that dental health was isolated from general health. They did not think there was good preventive care or ease of access to dentists or specialists. The impact on various agencies and their understanding of local changes, such as regionalization, municipal cutbacks and hospital underfunding or closures varied. Those most likely to be aware of these changes were concerned about their impact on access, patient care and the training of professionals.

All issues and comments were provided to the conference attendees and helped guide specific discussions during the workshop component. They were compared with access and care issues identified through other current initiatives: Canadian Oral Health Strategy devel-

oped by the Federal Provincial and Territorial Dental Directors; the Nova Scotia Seniors Access and Care Project; the Family Oral Health Project (an Ontario Coalition of Community Action program for Children/Canada Prenatal Nutrition Project in Kitchener, Ontario); the Canadian Dental Association's response to the Romanow Commission; and access and care issues identified by the Conference Planning Committee. There was considerable agreement and overlap among these initiatives in terms of the oral health issues facing Canadians, particularly the poor and disadvantaged. The data will continue to aid discussion within the new coalition that was created at the conference.

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