

# Why Do We Need an Oral Health Care Policy in Canada?

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## ABSTRACT

Although health care is a right of citizenship, severe inequities in oral health and access to care persist. This paper provides information on the financing, organization and delivery of oral health services in Canada. It concludes that dental care has largely fallen out of consideration as health care. The increasing costs of dental insurance and disparities in oral health and access to care threaten the system's sustainability. The legislation that allows the insured to receive tax-free care and requires all taxpayers to subsidize that expenditure is socially unjust. Unless an alternative direction is taken, dentistry will lose its relevance as a profession working for the public good and this will be followed by further erosion of public support for dental education and research. However, never before have we had the opportunity presented by high levels of oral health, the extensive resources already allocated to oral health care, plus the support of other organizations to allow us to consider what else we might do. One of the first steps would be to establish new models for the delivery of preventive measures and care that reach out to those who do not now enjoy access.

**MeSH Key Words:** Canada; dental health services/utilization; health services accessibility

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Severe disparities in oral health and inequities in access to oral health care continue and may even be increasing among Canadians. These inequities are inconsistent with the values of Canadians, the social contract the profession holds and the current resources allocated to oral health care. This paper provides information on the financing, organization and delivery of oral health services in Canada and contrasts the current situation with past promises and the potential demonstrated by medicare and alternative models of dental care delivery. It thereby provides the context in which to consider the need to revise oral health policy.

### Values of Canadian Society and the Profession's Social Contract

The 2002 Royal Commission on the Future of Health Care in Canada,<sup>1</sup> described Canadian

values as equity, fairness and solidarity. This and other reports<sup>2</sup> point out that Canadians strongly support collective action to achieve equity in health services and access to care.

The understanding that the professions have a contract to serve society has been recognized by the Canadian Dental Association (CDA). The president has written:

Essentially, society has allowed organized dentistry to regulate itself and govern the practice of our profession. In return, society expects organized dentistry to exercise the leadership necessary to ensure that the members of our profession serve and protect the public.<sup>3</sup>

More recently, Mouradian<sup>4</sup> pointed out that the contract extends to dentistry, which, as a group, has promised to act in the public good. She claims that acting in the public good

**Table 1** Proportion (%) of dental expenditures paid from public funds by province, 1960–1999<sup>7-9</sup>

Province	1960	1970	1980	1990	1999
British Columbia	1.0	7.6	12	7	6
Alberta	1.2	1.7	12	19	8
Saskatchewan	1.3	13.1	25	22	17
Manitoba	2.0	8.7	15	12	11
Ontario	1.0	5.6	2	2	2
Quebec	1.1	0.4	41	17	10
New Brunswick	1.2	16.6	6	9	6
Nova Scotia	4.0	8.8	25	17	9
Prince Edward Island	0.5	24.8	31	15	12
Newfoundland and Labrador	12.6	25.3	47	22	11
Yukon Territory	100.0	21.9	56	55	44
Northwest Territories	—	—	—	48	57
Nunavut	—	—	—	—	65
<b>Canada</b>	<b>1.2</b>	<b>5.5</b>	<b>13.7</b>	<b>9.2</b>	<b>5.8</b>

includes the elimination of disparities in oral health, the prevention of oral diseases and the promotion of oral health and, without such action, dentistry risks becoming irrelevant.

### Canada’s Health Care System

Canada’s public health care system is a social and cultural icon that in some ways defines Canadian society. Canada’s medical and hospital care system is not socialized; most care is provided by private physicians in their own offices or community-owned, not-for-profit hospitals, although a significant minority of physicians work in community health centres or other community-based sites. However, the funding and financing of the delivery system for medical and hospital care is socialized. Funds are raised through taxes or premiums, collected by governments who then distribute them to finance payments to physicians and hospitals. The collection of these funds, through the progressive tax system, is deemed equitable, and distribution of them through a “single-payer” has achieved relative efficiencies in administration<sup>5</sup> and in the allocation of expensive technologies.

### Dental Care Delivery

As with medical services, dental care is delivered by private, for-profit practitioners. However, there are 3 major differences between the delivery of most dental care and the delivery of medical care in Canada:

- Private financing, either as out-of-pocket payments or as private insurance, dominates dental care; in contrast, over 98% of payments to physicians are publicly funded.<sup>6</sup>

- Funds to pay for dental care come from individuals or are administered by several private insurers; thus we have many payers compared with the single payer in medicare.
- Dentistry is largely provided through a single model of care delivery (fee-for-service, private practitioners in private offices), compared with several models and sites in medical care.

### Public–Private Mix of Financing Dental Care

Data on the economic factors in dental care in Canada are taken from 3 reviews.<sup>7-9</sup> They date back to 1960, the end of the period on which the first Royal Commission on Health Services<sup>10</sup> had to base its recommendations. **Table 1** shows the proportion of dental care expenditures paid out of public funds over the 4 decades ending in 1999 for each province and territory. Public funding rose to a peak at the beginning of the 1980s (15.3% in 1981)<sup>11</sup> and since then, has fallen to 5.8%.

The public share rose then fell as provinces started then cut back on dental care programs. For example, in or about 1950, Newfoundland and Labrador introduced the first province-wide dental care program in Canada and the funds expended on that program are reflected in their 1960 position relative to the other provinces. In the 1970s and 80s, provincial programs for children were introduced in British Columbia, Saskatchewan, Manitoba, Quebec, Nova Scotia and Prince Edward Island and for seniors in Alberta and the Northwest Territories. The diminishing share of public funding for dental care services, seen in 1990 and continuing to 1999, is attributable to the cancellation of provincial dental programs for children in British Columbia, Saskatchewan and Manitoba, and

**Table 2** Indicators of expenditures on dental care in Canada, 1960–1999<sup>7-9</sup>

Indicator	1960	1970	1980	1990	1999
Total dental expenditures (\$ millions)	110	265	1308	4138	6773
Per capita dental expenditures					
Current \$	6.12	12.43	53.51	149.42	222.03
1960 \$	6.12	9.50	18.89	29.63	37.17
1960 \$ per user	19.74	19.00	37.78	55.91	63.00
Dental expenditures as % of health expenditures	5.1	4.2	5.8	6.8	7.5
Dental expenditures as % of GDP	0.29	0.31	0.42	0.61	0.69
Utilization (%)	31 <sup>a</sup>	50 (1972)	50 (1979)	53 (1994)	59 (1996)

<sup>a</sup>Estimate based on a straight-line increment between 1950 (15%) and 1967 (42%), i.e., 1.6% a year for 10 years from the 1950 base.

**Table 3** Direct costs of illness in Canada by diagnostic category, 1993 and 1998<sup>9</sup>

Disease category	1993		1998	
	Cost (\$ billions)	Rank	Cost (\$ billions)	Rank
Cardiovascular disorders	7.35	1	6.82	1
Dental disorders	4.93	3	6.30	2
Mental disorders	5.05	2	4.68	3
Digestive disorders	3.79	4	3.54	4
Respiratory diseases	3.33	5	3.46	5
Injuries	3.22	6	3.22	6
Cancer	3.12	7	2.46	7

reductions in proportionate funding in Newfoundland and Labrador’s children’s program and in Alberta’s seniors program.

As of 1999, 5.8% of funding for dental care was derived from public sources. That national average is pulled down by government’s 2% share in the most populous province, Ontario.

### Economic Trends in Oral Health Care

By the end of the 1990s, the resources consumed by the dental care system were at an all-time high and were continuing to increase. Table 2 shows that over the 40-year period from 1960 to 1999, dental expenditures increased, in current dollars, from \$110 million to \$6.77 billion or from \$6.12 to \$222.03 per capita. Controlling for inflation by converting the per capita expenditures to 1960 dollars results in a 1999 estimate of \$37.17 per capita — a more than 6-fold increase over this period.

Total expenditures are made up of both the cost per person and the number of people using the services. Table 2 also shows the “best estimate” of the proportion of the population visiting for dental care one or more times in that year. These are somewhat imprecise estimates, as the years for which utilization survey data were derived

do not correspond exactly to the start of each decade for which we have taken the economic estimates. Nonetheless, the estimates demonstrate a relatively rapid increase in utilization from 31% to 50% during the 1960s, followed by a constant rate, then a rise sometime in the late 1980s, which continued into the 1990s. By 1996, 59% of those over 15 years of age were estimated to have made a visit. Nonetheless, the 1996 expenditures per person, adjusted for inflation and the increase in utilization, still represent a 3-fold increase over the 1960 amount. This is mirrored by a 2.4-fold increase in dentistry’s share of the gross domestic product (GDP) and an absolute increase of 47% in dentistry’s share of the nation’s expenditures on health care.

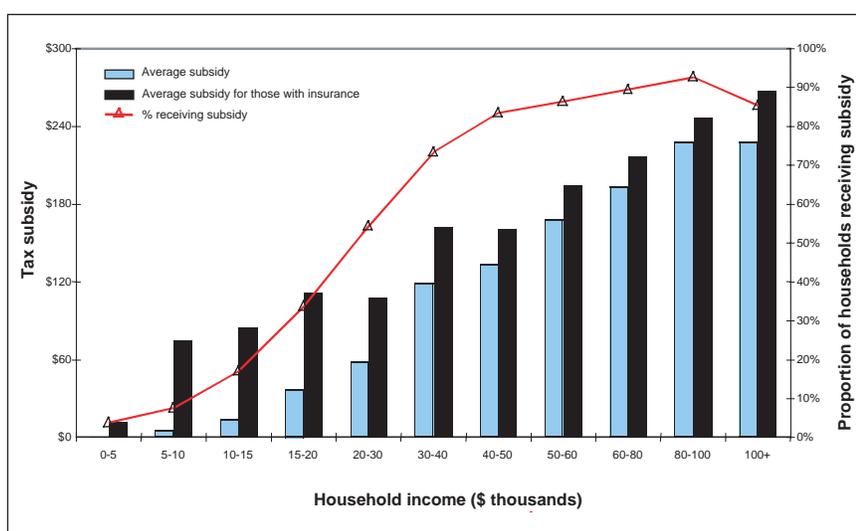
The data in Table 3 show that the level of expenditures on dental diseases made the cost of diagnosing and treating them one of most costly disease categories during the 1990s.

### Human Resources

Consistent with these increasing expenditures were the rapidly increasing human resources allocated to dental health services (Table 4). Although the number of dentists more than tripled, the most dramatic increases occurred

**Table 4** Numbers of dental providers and population-to-provider ratios, 1960–1999<sup>7-9</sup>

Dental human resources	1960	1970	1980	1990	1999
Dentists	5,780	7,413	11,095	14,341	16,899
Dental hygienists	74 (1961)	746	3,862	8,832	14,525
Denturists	–	–	1,526	1,925 (1989)	2,075
Dental therapists	0	0	244	365	240
Total	5,854	8,159	16,727	25,463	33,739
Population (rounded) <sup>12</sup>	17,870,000	21,297,100	24,516,300	27,700,900	30,509,300
Population per					
Dentist	3,092	2,873	2,210	1,932	1,805
Dental care provider	3,052	2,610	1,466	1,088	904



**Figure 1:** Tax subsidization of employer-provided health insurance by household income, Canada<sup>16</sup> 1994

in the number of dental hygienists — from 74 to over 14,500, and the number of denturists, from (officially) 0 to over 2,000, following changes in legislation in all provinces that allowed denturists to practise. By the end of the 1990s, there were an estimated 33,740 oral health care providers in Canada, up from 5,854 in 1960.

Increases in all the major provider groups exceeded the rate of population growth. For example, the population per dentist fell from nearly 3,100:1 to 1,800:1 over the 40 years. However, with the addition of the dental hygienists and denturists, the actual population-to-licensed provider ratio in 1999 was 904:1.

### Regulation Issues for Dentistry, Dental Hygiene and Dental Therapy

Dentistry has continuously opposed the provision of care by dental therapists.<sup>13</sup> A more recent concern is the relation of dental hygiene to dentistry. Through the Canadian Dental Hygienists Association and provincial

organizations, dental hygienists have argued that the public should have direct access to their services without having their care prescribed or “ordered” by dentists.<sup>14</sup> The CDA president responded that the team approach, led by dentists, provides Canadians with safe and comprehensive care.<sup>15</sup>

### Inequities in Financing Dental Care

Under current tax law, Canadians do not pay federal income tax nor provincial income tax (except in Quebec) on health care insurance premiums paid by employers. The Romanow Commission<sup>1</sup> contracted a study that showed that these tax breaks (plus deductions for expenses over and above 3% of income) “were

estimated to be worth... roughly \$3 billion (2002) given up by governments in not taxing private insurance premiums.” The study<sup>16</sup> found that for 1994, the tax subsidy amounted to \$0.50 for families with incomes less than \$5,000 and \$225 for households with incomes greater than \$100,000, a 450-fold difference (Fig. 1). Among those with insurance, the subsidy was \$11 and \$265 for those in the bottom and top income categories, respectively (a 24-fold difference).

The tax expenditure program has 3 implications that must be understood when considering a national oral health policy:

- first, more affluent, insured Canadians receive tax-free dental care, whereas the uninsured have to pay in after-tax dollars (until they exceed something like 3% of their income);
- second, all Canadians, including the poor, pay additional tax (GST/HST, provincial sales taxes, gasoline taxes, income taxes) to make up for taxes not collected on the health insurance premiums;

**Table 5** Percent of people using dental services by income category from national health surveys, 1951–1996

Year	Ages	Income category					Ratio of highest to lowest
		All income categories	Lowest	Next to lowest	Next to highest	Highest	
1951 <sup>24</sup>	Under 15	—	6.3	12.2	20.0	26.7	4.2:1
1951 <sup>24</sup>	All ages	15	8.4	14.3	18.8	21.8	2.6:1
1978–79 <sup>25</sup>	All ages	50	38.8	45.1	55.1	60.5	1.6:1
1990 <sup>26</sup>	15 and older (dentate only)	75	64.0	78.0	89.0	97.0	1.5:1
1994 <sup>27</sup>	12 and older	53	35.3	44.6	—	65.6	1.8:1
1996–97 <sup>28</sup>	15 and older	59	41.0	52.0	65.0	78.0	1.9:1

- third, as our tax system becomes less progressive, lower-income, non-insured people contribute more and more to finance care for the insured.

Essentially, we need to recognize that we have an oral health care program that requires all Canadians, including the poor, to pay higher taxes to subsidize the tax-free dental health care (and other extended health benefits such as prescription drugs) for more affluent, insured Canadians.

### Sustainability of Employer-Paid Dental “Insurance”

Dental insurance, in its present format, is not sustainable due to increasing costs. The cost of insured care ultimately falls back onto employers and these costs have continued to rise at well beyond the rate of inflation. For example, between 1992 and 1993 some employers experienced cost increases in the order of 21%, a period when the annual rate of inflation was 1.4%.<sup>17</sup> In 2001, the Employer Committee on Health Care — Ontario (ECHCO),<sup>18</sup> a confederation of large employers, pointed out to the Ontario Dental Association that “a 3% increase in the fee guide typically yields a 6–7% overall increase [in costs],” and Dudley<sup>19</sup> reported that costs of dental plans were targeted to increase 9.5% to 11.1% in 2004.

The way the insured part of the dental care system in Canada functions is similar to that of the insured health care system in the United States in the era before managed care. There, Enthoven<sup>20</sup> attributed the increasing costs, which were also well above inflation, to the incentives for physicians to provide “more and more costly services... and third party reimbursement [which] leaves the consumer with, at most, a weak financial incentive to question the need for, or value of, services.” Many people who attend dentists regularly are provided services, especially diagnostic and preventive services, for which the cost effectiveness “must be questioned.”<sup>21</sup>

ECHCO<sup>18</sup> has written that it intends to “pursue new models for the delivery of dental care to employees.... [The] new models could include reimbursement schedules developed by insurers and/or employers, as well as capitation plans” and Graham<sup>22</sup> states that 11% of employers in Ontario are considering cutting back or eliminating dental insurance coverage. Further, dental insurance is most commonly available to permanent full-time employees and thus the number of people covered by dental insurance will fall “with the continued trends to more ‘non-standard employment’ — part-time, temporary and self-employment.”<sup>23</sup> Finally, insurance for retirees is more likely to contract rather than expand as changes in accounting practices require firms to list such plans as unfunded liabilities.<sup>19</sup>

### Disparities in Access to Oral Health Care

Table 5 shows national dental care utilization rates for selected years from 1951 to 1999. The studies vary in terms of target populations and income categories, which decreases the precision with which they can be compared. Nonetheless, over the 50 years, utilization rose from 15% to nearly 60% and, among the dentate, 75% made a visit in 1990. The surveys consistently show that lower proportions of low-income Canadians visit the dentist compared with their more affluent compatriots. In 1951, those in the richest category visited 2.6 times as often as those in the poorest. That ratio improved to 1.5:1 by 1990 but worsened — to 1.9:1 — by 1999. Thus, the data since 1990 are consistent with both increasing rates of visiting over the period and increasing inequality in access for the poorest levels.

Particularly revealing is the comparison of factors influencing utilization of dental care and medical care in Sabbah’s 1994 study<sup>27</sup> (Table 6). In Canada, education and income are accepted as important measures of socioeconomic status. Sabbah found that both factors strongly predicted the rate of visiting a dentist, with lower levels of

**Table 6** Comparison of effect of factors determining utilization of dental and medical care in Canada, 1994<sup>27</sup>

Factors	% of Canadians making one or more visits to	
	Dentist	Physician
<b>Education</b>		
Less than high school	40.9	77.5
Completed high school	54.1	78.6
More than high school	64.7	80.1
<b>Annual income</b>		
< \$20 000	34.0	80.7
\$20 000–49 999	51.2	78.1
> \$50 000	68.8	77.6
<b>Age</b>		
12–19 years	71.4	72.6
20–44 years	57.0	76.6
45–64 years	48.8	78.6
65+ years	34.3	87.5
<b>General health</b>		
Poor	32.7	94.7
Fair	36.7	90.1
Good	48.3	82.7
Very good	56.0	77.5
Excellent	60.2	69.2

each predicting lower rates of attendance. In contrast, neither factor had an effect on physician visits. He further showed that increasing age predicted higher utilization of physicians but lower utilization of dentists, and that poor general health predicted greatest use of physicians but lowest use of dentists.

We would expect both dental and medical care needs to be greatest among lower socioeconomic level, older Canadians with poorer self-reported health. Drawing on a review by Locker and Matear<sup>29</sup> and on Health Canada data,<sup>30</sup> it is revealing that for medical care, the socioeconomic gradient had no effect and utilization was consistent with expected needs among older and sicker people. In contrast, the socioeconomic factors determined dental care utilization to such an extent that they invert the need factors — the more the (expected) need, the less use. Hart<sup>31</sup> has termed this the “inverse care law.”

Some of the unequal access to care might be laid at the feet of our single model of delivery. Clients are expected to come to the dentist, which leaves some, such as many nursing home residents, out of the system.<sup>32</sup> Also, the poor have encountered discrimination from providers. For example, in a Toronto Oral Health Coalition study<sup>33</sup> among the “under-housed” and poor in Toronto, several interviewees reported being made to feel inferior and

**Table 7** Dental caries among Toronto children, 1958–59<sup>38</sup> and 1999–2000<sup>39</sup>

Age	% of children with 1 or more teeth affected (mean number of teeth decayed, missing or filled)	
	1958–59	1999–2000
<b>7 years</b>		
Deciduous teeth	79 (5.3)	38 (1.5)
Permanent teeth	43 (1.0)	6.9 (0.1)
<b>13 years</b>		
Deciduous teeth	3 (0.1)	4.1 (0.6)
Permanent teeth	89 (5.7)	39 (1.1)

blamed for their oral disease and care needs. Similarly, Bedos and others<sup>34</sup> found that welfare clients in Montreal felt that comments by the dentist or the receptionist were “hurtful and stigmatized them” and that, in general, dentists were “not very sensitive to their problems.”

In contrast, the universal, apparently adequately funded, Nova Scotia children’s dental plan allowed 94% of 6- and 7-year-old children in one study to visit a dentist at least once a year.<sup>35</sup> This high use of dental services made access to care more equitable and compensated, in part, for the deficits in health associated with other determinants. In absolute terms, children of less-educated parents received more than twice as many fillings as children of well-educated parents (5.7 vs. 2.6 fillings), demonstrating that once the economic barrier was reduced for all, children of less-educated parents were able to obtain care more proportionate to their needs.

### Disparities in Oral Health

In Canada, no agency is required to report on inequities in oral health — the last complete survey was the 1974 Nutrition Canada study. Provincial and local studies have shown that although the prevalence of caries has fallen and periodontal health among older adults in Ontario is somewhat better than in the United States,<sup>36</sup> caries remains more prevalent and more severe among children born outside Canada and among First Nations and Inuit children.<sup>37</sup>

Table 7 compares oral health status reported by the original Royal Commission on Health Services<sup>38</sup> with 1999–2000 data.<sup>39</sup> Among 13 year olds, 89% in 1958–59 vs. 39% 40 years later had a cavity of any kind, and the mean number of decayed missing and filled teeth fell from 5.7 to 1.1. Although this is wonderful news, that same recent Toronto survey showed that large numbers of children do not enjoy a healthy state. Over 10% of 5 year olds needed 2 or more teeth treated for cavities and about 7% of both 5 and 7 year olds needed urgent care. The number of children with urgent dental needs exceeded the number

affected by most other childhood conditions for which medical care is free and access is guaranteed.

The Locker and Matear review<sup>29</sup> found that “within provinces, poor oral health is concentrated within low income and other disadvantaged groups such as new immigrants and those without dental insurance coverage.” In Canada, oral health status has been best documented in Quebec children,<sup>40</sup> adolescents<sup>41</sup> and adults.<sup>42</sup>

### Previous Promises

Although there are probably similar promises from other provinces, those in Ontario remain among the most unfulfilled. In 1931, Dr. John Robb,<sup>43</sup> then minister of health, addressed “a dental public health rally” stating:

It is recognized by all that dental care is an absolute necessity in the life of every child. Many parents unfortunately cannot pay for this attention, and it is the duty of the municipality and the state to come to their assistance. School clinics are needed in all parts of Ontario and in order to encourage municipalities to undertake this responsibility, the Government is paying grants ranging from seven and one-half to thirty-five per cent of the costs of the service.

In early 1943, the federal minister of pensions and national health<sup>44</sup> submitted to the Parliamentary Committee on Social Security and Pensions draft legislation for “a broad [national] scheme of sickness prevention and complete medical and hospital care” and dental care “at least to the extent that existing dental facilities are capable of providing... at the present time dental services are restricted to routine fillings and care for children under 16. It [the plan] offers traveling dental clinics for rural areas.” During that summer, the promise of a provincial dental care system by the Ontario Conservative party helped them defeat the ruling Liberals and began 42 years of Conservative governments that never fulfilled that promise.<sup>45</sup>

The 1964 Royal Commission on Health Services<sup>10</sup> chaired by Justice Emmett Hall again called for the inclusion of dental care services in the universal health programs proposed for Canadians. The commissioner’s very first recommendation called on governments to

introduce and operate comprehensive, universal, provincial programs of personal health services, with similar arrangements for the Yukon and the Northwest Territories. The programmes should consist of the following services, with the provinces exercising the right to determine the order of priority of each service and the timing of its introduction: medical services; dental services for children, expectant mothers, and public assistance recipients; prescription drug services; optical services for children and public assistance recipients; prosthetic services; and home care services.

On dental services, the commissioners wrote:

The shortage of dentists in Canada is so acute that, however desirable and necessary it may be, it is impossible to think at the present time of a program of dental services for the entire population.... Nevertheless, we believe it imperative to make a beginning and that beginning should start with the new generation.

Accordingly they recommended

- incremental implementation of the program, starting with children aged 5 and 6 years
- grants to build dental facilities in hospitals, public health centres and schools
- provision of matching funds by the federal government to employ staff (dental auxiliaries and dentists) to provide the care
- public education programs
- a survey of the nation’s oral health
- special consideration of the dental requirements of children suffering from physical or mental handicap
- water fluoridation nation-wide
- a maternal dental health program to be delivered by private practitioners
- attracting dentists to rural areas
- introduction and funding of dental care for recipients of public assistance
- expansion of the capacity of the 5 existing dental schools
- 5 new dental schools
- training grants for dental students, and especially teachers and specialists in pediatric dentistry and dental public health
- funding and training of dental auxiliaries (therapists) to staff the public clinics providing dental care to children.

All reviews to that point stated explicitly that oral health was a part of health, recognized that oral health needs had to be addressed, and included recommendations to address them as part of health policy. More recently, neither the 1994 National Forum on Health<sup>46</sup> nor the 2002 Romanow Commission<sup>1</sup> included a discussion of the dental health care needs of Canadians or recommendations to address them.

For more detail in this area, readers should consult the Canadian Association of Public Health Dentistry’s brief to the Romanow Commission.<sup>47</sup>

### Alternative Privately Funded Models of Oral Health Care

A few alternative models of private dental care delivery can be found. For example, in Toronto and Hamilton, the United Steelworkers have developed clinics to provide care to their members using staff dentists — the equivalent of a closed-panel health maintenance organization in the United States. Also in Toronto, the Hotel Employees and

Restaurant Employees union clinics provide comprehensive services to these lower-paid unionized workers by contracting all care on a global budget to one dentist who then employs other dentists and hygienists. Staff are paid per-diem rates and the cost to the employers is reportedly about half that of the equivalent plan offered to the University of Toronto employees across the road.<sup>48</sup>

Golden Care and Direct Dental, 2 private-for-profit firms, provide in-home dental care for residents of homes for the aged who can afford the somewhat higher fees. Other examples may be available in other provinces, but I am unaware of them.

### Alternative Publicly Funded Program Models

Federally funded programs for the Armed Forces, First Nations and Inuit people and the Royal Canadian Mounted Police meet the standards of the Canada Health Act. Other publicly funded dental programs across Canada are neither comprehensive nor universal. For example, in all provinces and territories, people receiving income assistance are eligible for dental services. However, in some of these jurisdictions, dental care, especially adult care, is severely restricted allowing treatment for only one emergency condition, i.e., pick your worst toothache.

Some jurisdictions offer province-wide dental care programs for identified age groups. In some, coverage is universal, e.g., for all children in Newfoundland and Labrador, Nova Scotia, Prince Edward Island and Quebec. But in Ontario, care is offered only to those children who have urgent needs that are causing pain and infection. Where these programs operate, especially in Newfoundland and Labrador, they appear to be well supported by the dental profession. Although more information on current public programs is available from the Canadian Association of Public Health Dentistry website,<sup>49</sup> more research is needed to evaluate them.

In the early 1970s, Saskatchewan and Manitoba developed children's dental programs using dental therapists, as recommended by the 1964 Royal Commission. Despite continuous and strident opposition by the dental profession,<sup>13</sup> the school-based therapist program achieved higher utilization rates among rural adolescents (89% to 96%) than did the equally "free" private-office model (76% to 82%)<sup>50</sup> and delivered high-quality care.<sup>51</sup> This degree of success is unique, especially in rural areas. However, in both provinces, the programs were ultimately terminated by newly elected conservative governments prepared to side with the provincial dental associations in their position that "private enterprise" should deliver dental care. These governments, along with that of British Columbia, by and large cancelled the programs as they were not prepared to pay the bills when private practitioners provided the care.<sup>52</sup> The cutbacks in funding dental care has meant that, by 1999, children's oral health

failed to meet WHO targets for the year 2000 in 24 of 29 Saskatchewan health districts.<sup>53</sup>

Dental therapists continue to provide primary dental care, under dentists' supervision, in the territories and in First Nations communities in all provinces but Ontario, Quebec and Prince Edward Island. Therapists are trained at the National School for Dental Therapy in Prince Albert, Saskatchewan. However, the number of licensed dental therapists is declining<sup>9</sup> and programs staffed by dental therapists may be threatened.

Some municipal public health departments in Ontario and elsewhere have historically provided dental care to children, often in school-based clinics. Those in Vancouver, Edmonton and Winnipeg have been reduced or closed. In 1999, the Toronto Public Health program was criticized by some private dentists who opposed it on the basis of its alleged inefficiency and their desire to preserve the private fee-for-service system.<sup>54</sup> The Toronto program continues largely because families served by the program appeared before the committees of council to state that, without the service, they would have no access to dental care. In Ottawa and London, the public health department provides care for those on income assistance. However, there is no recent inventory of the current capacity or additional role of these or similar municipal programs.

Readers are encouraged to consult the Canadian Association of Public Health Dentistry's website, [www.caphd-acsdp.org](http://www.caphd-acsdp.org), "Public Programs," for more detail.

### Dental Public Health Capacity in Canada

A 1988 report by the United States Institute of Medicine (IOM)<sup>55</sup> succinctly defined the mission of public health "as fulfilling society's interest in assuring conditions in which people can be healthy." The IOM stated that governmental public health agencies have the unique function to see that the vital elements are in place and the mission is adequately addressed. According to the IOM, governmental public health functions are

- to assess the health of the community, including compiling statistics on health status, community health needs and epidemiology and conducting other studies of health problems
- to develop policy by promoting the use of the scientific knowledge base
- to assure the provision of (needed) services either by requiring such action through regulation or by providing services directly.

How does Canada measure up to this simple mandate? For more than 25 years, the public health system has not been able to assess the oral health of Canadians consistent with the international standards of, for example, the World Health Organization/National Institutes of Health's International Collaborative Study or the National Health and Nutrition Examination Surveys in the United States,

or even the standards set out by CDA in the late 1960s. In the meantime, information from self-report surveys such as the National Population Health Survey alert us to inequities in oral health and in access to oral health care. Canadians lack an ongoing surveillance system to measure current oral health status and trends.

Similarly, the capacity to develop dental health policy based on evidence and best practices is limited. Indeed, in at least 3 provinces, there is no senior dentist of any kind providing oral health policy advice. Although applauding the quality of the work of those who have specialist status awarded by a provincial dental regulatory authority in many provinces, and especially those in Quebec, as of May 2004, there is no nationally certified dental public health specialist employed in the policy development area in any province or even at the federal level. The low and falling number of nationally qualified active dental public health specialists represents a severely compromised capacity.

Whether as a cause or a consequence of the above, we have to recognize the decreased commitment of governments to assure oral health care — the third mandate of public health. Thus, as programs providing primary oral health care universally or to disadvantaged groups are reduced or eliminated, we have fewer specialists and few programs.

As a ray of hope, the federal government<sup>56</sup> has created the Canadian Public Health Agency. Clearly, as set out in the United States Surgeon General's report on oral health,<sup>57</sup> the importance of oral health in and of itself, the allocation of resources used to diagnose and treat oral diseases, the potential for poor oral health to influence other health conditions and the potential to use oral health measures as screening tools for other conditions make oral health an important area to include in the new Canadian Public Health Agency.

### The Future of Oral Health Care Delivery in Canada

In a recent lecture to staff and students at the University of Toronto, O'Keefe<sup>58</sup> pointed to the trends in demography, economic conditions, knowledge and technology, social values and government policy that are likely to shape the profession. He envisaged 4 paths that the profession might take between now and 2020 and he sketched the implications of each from the perspective of the profession. Although O'Keefe's scenarios are thought-provoking, his underlying premise seems to be that the external forces of demography, technology and economic power will decide the future, and providers and the community will take whatever the "invisible economic hand" shapes for them.

Alternatively, the professions can move along a track that some feel they are now wrongly taking, namely toward the market-driven, technology-based provider of expensive elective services to those who can afford them. If this occurred, it would surely prompt a renegotiation of the social contract, potentially opening the market by per-

mitting others to provide traditional oral health care services now reserved for licensed dentists. Indeed, in a foretaste of that future, Alberta legislation no longer restricts the communication of a diagnosis exclusively to dentists.<sup>58</sup>

If dentists were to become providers of discretionary services for those who can pay, it would have severe implications for the public funding of dental training and research. If dentistry was no longer seen as a component of health care (assuming it is now), then there would be justification for further faculty budget cuts, further closings of hospital dental departments, taxing of dental insurance premiums and reassignment of dental research funds to "real" health issues.

### Response of Others

The issue of oral health and oral health care for Canadians, especially those who are disadvantaged, is attracting the attention of others. In May 2003, the *Ontario Health Promotion E-Bulletin* reported on the actions of both the Toronto Oral Health Coalition and a similar group in Hamilton.<sup>59</sup>

The Toronto Oral Health Coalition is a group representing social service providers, dental education programs, dental professionals and individuals who are committed to advocating and making changes to ensure that dental care is accessible to all, particularly those most in need of it. The coalition has produced the report mentioned above<sup>33</sup> and a brief to the Romanow Commission; collected 7,000 signatures on a petition seeking to make dental care a part of the Ontario medicare plan; and supported renewal funding for Regent Park's Community Health Centre's dental program serving the homeless. It continues to support the Scarborough Dental Workgroup, which is seeking to establish a clinic to serve the homeless and refugees in that part of Toronto.

Other Ontario groups that work toward or have passed resolutions that call for new policies include

- The Children and Youth Action Committee, Toronto<sup>60</sup>
- Halton Oral Health Outreach Program<sup>61</sup>
- The United Senior Citizens of Ontario<sup>62</sup>
- County Council of Lennox and Addington<sup>63</sup>
- The Kingston Coalition for Dental Care<sup>64</sup>

The Canadian Dental Hygienists Association supports the development of public programs<sup>65</sup> to meet the needs of Canadians. Similarly, CDA's<sup>11</sup> brief to the Romanow Commission concluded with these words:

What is required is an all-encompassing approach that considers all of the elements, and builds a system for oral health care that embraces us all.

CDA's call to build such a system can serve as the ultimate goal. However, one of the first steps has to be the establishment of revised models of prevention and care delivery that reach out to those who do not now enjoy oral health and access to oral health care.

## Conclusions

Canada, a country ranked consistently at the top of the list of desirable countries in which to live, has earned an international reputation for its social values and the translation of those values into high-quality education and social and health care delivery systems. In this country, access to health care is seen as a right of citizenship, not something that should be allocated by an entrepreneurial market.

In this context, the answer to the question posed in the title of this paper — why do we need an oral health policy in Canada? — would seem to include the following:

- the dental care delivery system has, in many ways, ceased to be considered health care and, in spite of Canadian values and the profession's social contract, appears to be continuing toward a market-driven service available to those who can afford it;
- the increasing costs of dental insurance and the disparities in oral health and access to care threaten the sustainability of the current system;
- the legislation that allows the more affluent insured to receive tax-free care and requires all, including the poor, to subsidize that tax expenditure is socially unjust;
- unless an alternative course is set, dentistry will lose its relevancy as a profession working for the public good, and this will be followed by further erosion of public support for dental education and research and ever widening gaps in oral health;
- however, never in our history have we had the opportunity presented by the overall high levels of oral health, the vast human resources, national affluence and funds already allocated to oral health services to allow us to consider what else we might do.

New models of care delivery may vary according to local needs and circumstances, but they must be efficient and sustainable through support from the community they serve. Additional models to improve the current system need to be considered by the professions along with those they serve. Canadians need improved oral health and access to oral health care; they already have the resources, and the momentum to make it happen is growing. ❖

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