



Canadian Academy of Health Sciences  
Académie canadienne des sciences de la santé

# **IMPROVING ACCESS TO ORAL HEALTH CARE FOR VULNERABLE PEOPLE LIVING IN CANADA**

**A Canadian Academy of Health Sciences Report**

**EXECUTIVE SUMMARY AND RECOMMENDATIONS**

## **The Canadian Academy of Health Sciences**

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## EXECUTIVE SUMMARY AND RECOMMENDATIONS

This report concludes a three-year evaluation by a multi-disciplinary Canadian Academy of Health Sciences (CAHS) panel (from here on referred to as “the Panel”) into the issue of access to oral health care among vulnerable groups in Canada. It presents an innovative analysis of data from the recent Canadian Health Measures Survey (CHMS), which for the first time in approximately 40 years has provided nationally representative, clinical information on the oral health status of Canadians. In addition, targeted literature reviews were completed, with all resulting information reviewed, discussed, and integrated into the report by the Panel.

The following major issues have emerged from the CAHS investigation in relation to oral health and oral health care in Canada:

- Many low income, and even middle income, Canadians suffer from pain, discomfort, disability, and loss of opportunity because of poor oral health.
- Approximately six million Canadians avoid visiting the dentist every year because of the cost.
- There are significant income-related inequalities in oral health and inequity in access to oral health care.
- Those with the highest levels of oral health problems are also those with the greatest difficulty accessing oral health care.
- Income-related inequalities in oral health are greater than income-related inequalities in general health indicators.
- Income-related inequalities in oral health are greater in women than men.
- Inequalities in access to dental care are contributing to inequalities in oral health.
- Oral health is part of general health, with the same social, economic, and behavioural determinants, and with direct links between poor oral and poor general health.
- The vast majority of dental care is provided in the private sector, with only approximately six per cent of expenditure on dental care in the public sector.
- Private sector dentistry is providing good quality oral health care for a majority of people living in Canada, but it is not a good model of health care provision for the vulnerable groups who suffer the highest levels of oral health problems.
- There is no consensus on standards of oral health care provision among federal, provincial, territorial, and municipal governments in Canada. The small proportion of publically-funded oral health care services provided across the country varies enormously between jurisdictions.
- There is no consensus among federal, provincial, territorial, and municipal governments across Canada on the use of a range of dental and other health care professionals that might improve access to oral health care services, particularly for groups suffering the greatest burden of oral diseases.

- In Canada, tax legislation helps reduce the financial burden of dental care for those with private dental insurance. Those without such insurance do not have this benefit, yet these are the groups with the highest levels of disease and the greatest difficulty accessing dental care.

In summary, analysis of the CHMS data illustrates major inequalities in oral health and access to oral health care across social groups in Canada. *Compared to the rest of the population, vulnerable groups in Canada are i) less likely to have dental insurance; ii) more likely to avoid the dentist due to cost; iii) more likely to consult dentists only in emergencies; iv) more likely to have untreated dental decay, gum diseases, missing teeth, and dental pain; and v) more likely to avoid eating healthy foods such as fruits and vegetables due to oral health problems.* The CAHS investigation also found that the differences in ability to access and use oral health care makes a major contribution to inequalities in oral health status. In a wealthy country with explicit policy goals of reasonable access to health care as part of the *Canada Health Act*, these inequalities and the resulting inequity should be a matter of national concern.

This situation goes against Canadian principles of the Canada Health Act, which is “to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.” Some agreed upon standard of preventive and restorative oral health care should be provided for people in Canada who need it, irrespective of their physical or geographical ability to access services, or their capacity to pay. There are important challenges in being able to utilize oral health care services, namely: **affordability** (Do the provider’s charges relate to the client’s ability to pay for services?); **availability** (Does the provider have the requisite resources, such as personnel and technology, to meet the needs of the client?); **accessibility** (How easily can the client physically reach the provider’s location?); **accommodation** (Is the provider’s operation organized in ways that meet the constraints and needs of the client?); and **acceptability** (Is the client comfortable with the characteristics of the provider, and vice versa?).

Oral health care in Canada is overwhelmingly privately financed and delivered. Payment is predominantly made through employment-based or individually purchased insurance or directly “out-of-pocket” by users. Canada contributes one of the lowest proportions of public funds among Organisation for Economic Co-operation and Development (OECD) countries. For example, Canada’s public share of expenditure on dental care is approximately six per cent, compared to 7.9 per cent in the U.S. (another country with a low public share) and 79 per cent in Finland (a country with among the highest public contributions to the cost of dental care).

While this system of private finance and private provision may provide access to good quality care for many in Canada, the evidence is that this system also creates substantial barriers to care for many others. These other people are Canada’s most vulnerable groups, including:

- those with low incomes;
- young children living in low income families;
- young adults and others working without dental insurance;
- elderly people living in institutions or with low incomes;



- aboriginal peoples;
- refugees and immigrants;
- those with disabilities; and
- people living in rural and remote regions.

Furthermore, there is increasing evidence that with the current economically difficult times, lower middle income families in Canada are also struggling to access affordable oral health care.

Although the affordability of oral health care is certainly an important barrier, it is not the only one. The CAHS investigation found evidence for other problems, including:

- The lack of integration of dental professionals into public institutions delivering other health and social services, with a lack of options and versatility in the workforce;
- The organization of dental and other health care professions, including their scope of practice, does not facilitate equitable access to oral health care; and
- The lack of national oral health care standards to ensure reasonable access to an agreed quality of oral health care for all people living in Canada, regardless of their situation.

Given these important and well-substantiated observations, the Panel has developed a vision for oral health care in Canada and makes recommendations aimed at advising a variety of stakeholders on how to move towards achieving this vision. The stakeholders targeted by this report include:

- Federal, provincial, territorial, and municipal governments and governmental agencies;
- The dental professions, including dental professional regulatory bodies, professional associations, dental education and research institutions, and other forms of “organized dentistry;”
- Physicians, nurses, and other health care professionals that regularly care for vulnerable groups; and
- The organizations or advocacy groups representing vulnerable groups in Canada.

## A Vision for Oral Health Care in Canada

The Panel envisages equity<sup>1</sup> in access to oral health care for all people living in Canada.

<sup>1</sup> By equity in access, the Panel means reasonable access, based on need for care, to agreed-upon standards of preventive and restorative oral health care

## The Core Problems Identified in this Report

This report identifies a number of issues, as outlined in the aforementioned list. These can be distilled to the following core problems:

- Vulnerable groups living in Canada have both the highest level of oral health problems and the most difficulty accessing oral health care; and

- The public and private oral health care systems in Canada are not effective in providing reasonable access to oral health care for all vulnerable people living in Canada.

## Recommendations to Address the Core Problems and Achieve the Vision

The recommendations designed to address the core problems identified in the report are grouped into a framework that provides a logical order of priority, proceeding as follows:

- A. Communicate with relevant stakeholders concerning the core problems raised in the report.
- B. Establish appropriate standards of preventive and restorative oral health care to which all people living in Canada should have reasonable access.
- C. Identify the health care delivery systems and the personnel necessary to provide these standards of oral health care.
- D. Identify how provision of these standards of preventive and restorative oral health care will be financed.
- E. Identify the research and evaluation systems that monitor the effects of putting these recommendations into place.

As an aid to making progress, the Panel also identified groups that should be acting on the recommendations, either within the wording of the recommendations or identified at the end of each one. The recommendations are therefore expanded as follows:

- A. Communicate with relevant stakeholders concerning the core problems, to enable mutual understanding of the report's findings and initiate discussions to address the recommendations.**
  - i. Communicate the findings of this report with representatives of relevant vulnerable groups and obtain their input to contextualize them.
  - ii. Communicate the findings of this report with relevant dental and other health care professional groups and obtain their input to contextualize them.
  - iii. Communicate the findings of this report with relevant federal, provincial, territorial, and municipal government agencies and obtain their input to contextualize them.
  - iv. Communicate the findings of this report with relevant private sector stakeholders (e.g., health insurance companies) and obtain their input to contextualise them.
- B. Engage with relevant decision-making, professional, and client/patient groups to develop evidence-based standards of preventive and restorative oral health care to which all people living in Canada have reasonable access.**
  - i. Engage vulnerable groups and their representation as partners in order to identify their needs for standards of oral health care.
  - ii. Engage with the dental professions to identify their views on what evidence-based standards of oral health care should be.

- iii. Engage with federal, provincial, territorial, and municipal government and other public agencies to identify their views on what agreed-upon standards of oral health care should be.

**C. Plan the personnel and delivery systems required to provide these standards of oral health care to diverse groups, in a variety of settings, with particular attention to vulnerable groups.**

- i. Create or enhance public options for oral health care in alternative service settings, such as community health centres, institutions for elderly people who are non- and semi-autonomous, long-term care settings for those with handicaps, etc. *(Targets: community health centres; centres for the elderly and those with handicaps.)*
- ii. Deliver simple, preventive oral health care for children in non-dental settings and dental offices so that children get a good start in life. *(Targets: pediatric dentists, physicians, nurses and other pediatric health professionals; dental hygienists; preschool institutions; primary schools.)*
- iii. Develop domiciliary and other “outreach” oral health care for those with difficulties accessing private dental offices or community services, for example, on-site services for the institutionalized elderly. *(Targets: geriatricians, dentists and other health professionals caring for the elderly; dental hygienists; institutions for the elderly and handicapped.)*
- iv. Renew the role of dental therapy, review the use of dental hygienists, and explore the use of alternative providers of oral health care to ensure that cost-effective care is provided in settings not currently served by dental professionals. *(Target: provincial governments; dental regulatory bodies; dental therapists; dental hygienists.)*
- v. Provide explicit training for oral health care professionals in versatile approaches to oral health care delivery for a variety of vulnerable groups. *(Targets: Association of Canadian Faculties of Dentistry [ACFD]; dental schools; dental hygiene colleges; Commission on Dental Accreditation of Canada.)*
- vi. Promote and deliver continuing education that equips practicing professionals with the knowledge and skills to understand and treat the oral health care needs of vulnerable groups. *(Targets: dental schools; dental hygiene colleges; Canadian Dental Regulatory Authorities Federation; provincial dental regulatory bodies.)*
- vii. Promote the inclusion of relevant oral health and oral health care training in non-dental training programs, such as medicine and nursing. *(Targets: Canadian Association of Schools of Nursing; Association of Faculties of Medicine of Canada.)*

**D. Review and provide the financing of necessary personnel and systems and create mechanisms to ensure the availability and prioritization of funds for the provision of agreed-upon standards of oral health care.**

- i. Establish more equity in the financing of oral health care by developing policy to promote dental insurance that promotes evidence-based practice among all

- employers, employees, and self-employed people, including those working in non-traditional work arrangements. *(Targets: federal, provincial, and territorial governments; insurance companies; employers' associations; workers' associations; unions.)*
- ii. Review the legislation concerning tax treatment for employment-based dental insurance to address the lack of tax benefits for those without insurance. *(Targets: federal, provincial, and territorial governments; employers' associations; workers' associations; unions)*
  - iii. Review the fees paid for oral health care to ensure that they are fair for both provider and patient, and incentivize the provision of care based on evidence. *(Targets: federal, provincial, and territorial governments; dental profession.)*
  - iv. Prioritize the financing of interventions where there is strong evidence of therapeutic effect and social gain (e.g., community water fluoridation and fluoride varnish), with disinvestment from interventions where there is weak or no evidence of effectiveness (e.g., routine teeth scaling in healthy individuals) or evidence of more effective and efficient alternatives. *(Targets: federal, provincial, and territorial governments; dental profession; ACFD; dental schools.)*

**E. Monitor and evaluate publically funded oral health care systems that are designed to improve access to agreed-upon standards of care for all people living in Canada.**

- i. Create effective data collection and information systems for use in answering policy-relevant questions, using appropriate outcome indicators. *(Targets: federal, provincial, and territorial governments; Canadian Institutes of Health Research [CIHR]; ACFD; dental schools; dental profession.)*
- ii. Develop a more integrated approach to generating and translating knowledge into evidence to provide more effective oral health care for vulnerable groups. Government agencies, health care professionals, researchers, educators, and those representing the client groups and organizations involved in care need to create networks to enable the development, implementation and evaluation of standards of care. *(Targets: federal, provincial, and territorial governments; CIHR; ACFD; dental professions; client group representatives; insurance companies)*