FINANCING AND DELIVERING ORAL HEALTH CARE:

WHAT CAN WE LEARN FROM OTHER JURISDICTIONS?

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Oral health care a low priority in Canada

- Not 'insured' under Medicare
- Absent from Kirby, Romanow reports

Funding and delivery at discretion of provinces

- Eligibility for public funding depends on location, means and other personal circumstances

Federal contributions to Medicare reduced over time

- Reduced capacity of provinces to support non-Medicare programmes

Scope of public programmes

- Funding privately provided services
- Little, if any, management or evaluation

ECONOMIC PROBLEM

Scarcity of resources

- Not enough resources to satisfy all possible uses

Choices

- Must choose how to use available resources (and hence how not to use them)

Opportunity cost

- Highest valued alternative use of resources

ECONOMIC SOLUTION

Does the value of the way we choose to employ resources exceed the opportunity cost?

Would using available resources in different ways generate greater value?

Comparison of benefits produced with benefits forgone

DENTAL CARE:
NEEDS VERSUS DEMANDS

Need: **Epidemiological concept**

Ability to benefit from service

Demand: **Economic concept**

Ability and willingness to pay for service

Individuals with greatest need for services tend to be those with least ability to pay for services

DENTISTS: BASELINE FOR HEALTH POLICY

Relative use of dentist and physician by income among adults in Canada

	Annual family income ($000s)				
1985	***<15***	***15-25***	***25-35***	***35-50***	***>50***
Physician	1.04	0.98	1.04	1.00	1.00
Dentist	0.49	0.63	0.74	0.90	1.00
1998	***<20***	***20-40***		***40-60***	***>60***
Dentist	0.49	0.76		0.70	1.00

General Health Questionnaire 1985
National Population Health Survey 1998-9

DENTISTS AND OTHER NON 'INSURED' SERVICES

No coverage for costs of services by type of service and neighborhood (% adults). **Hamilton 2002**

	drugs	*dental*	*optical*	*hospital*
Neighbourhood:				
Mountain	19.6	25.1	31.4	24.5
Aberdeen	25.5	29.3	32.9	25.4
Industrial	26.6	30.4	34.9	29.4
Downtown	34.5	43.5	45.8	38.3
DIFFERENCES:				
highest – lowest	14.9	18.4	14.4	13.8
highest – next	7.9	13.1	10.9	8.9

Source: Deconstructing the Determinants of Health at the Local Level (see http://www.mcmaster.ca/mieh/research/deconstructing.html).

Public Funding for Dental Care in Ontario

Name	Funding	Type of Care	Age/Special Needs Group
CHIP	MOHLTC	Emergency dental surgery in hospitals (not restorative care) Urgent care (approx 65% of ODA schedule)	All ages
CINST (Children in Need of Treatment)	MOHLTC and municipal	Basic dental and oral health care.	JK to Grade 8
ODSP (Ontario Disability Support Program)	MCFCS		Disabled adults, spouses, depend children(age<65)
ACSD (Assist. for Severely dis. children	MCFCS	Basic dental and oral health care	Disabled children at home (0-18)
Ontario Works	MCFCS and municipal	Basic dental and oral health care	Adults and their dependents
Cleft Lip and Palate Program	MOHLTC	Special treatment (MOHLTC covers 75% cost)	Up to 22 years of age
EHSS (Essential Health and Social Supports)	MCFCS and municipal	Denture/dental services	Seniors and low-income adults on income support
Dept. of Veterans Affairs (DVA)	Federal	Dental care	War veterans
Non-Ins. Health Benefits (NHIB)	Federal	Dental care	Native Canadians
Interim Health Program (IFHP)	Federal	Limited dental care ($400 p.a.)	New refugees

MCFCS = Ministry of Community, Family and Childrens' Services MOHLTC = Ministry of Health and Long-Term Care

Source: Hamilton DHC Review of Oral Health Needs of Special Popns 2002

CANADA: SUMMARY

Services allocated in accordance with willingness and ability to pay

Incidence of having visited dentist in last year positively correlated with household income

Providers rewarded for delivering services not meeting needs

ORAL HEALTH CARE IN AUSTRALIA

(Spencer 2001)

Children and adolescents (0-19)

Salaried school-based dental therapists

State funded

No user fees or co-payments

High coverage but staff shortages and aging workforce

Shift from population based to risk based strategies

Among OECD countries Australia ranks 2 (of 29)

ORAL HEALTH CARE IN AUSTRALIA

Adults

Means tested safety net for low income adults

Community dental clinics, state funded (elderly, disabled, single parents, unemployed)

Commonwealth funded (vets, armed services, indigenous pop, inpatient services, cong mal)

Others: Private dentists, private insurance or out of pocket

Among OECD countries Australia ranks 18th (of 21)

ORAL HEALTH CARE IN AUSTRALIA

Expenditures 1999 (AUS$millions)

Total	**2,583**
Of which(%):	
Public	***15.6 (cf 70% medical care)***
Private Insurance	***22.0***
Out of pocket	***62.4***

ORAL HEALTH CARE IN AUSTRALIA

Private insurance tax rebates:

Encourage private insurance for those who can pay

Focus publicly funded services on who cannot pay

Dental care: public funded care only available for poor

Tax rebate a pure income transfer to non-poor

ORAL HEALTH CARE IN AUSTRALIA

Public expenditures on dental care:

Private insurance tax rebates twice the amount of funds spent on public dental care to eligible adults

Regressive: Subsidy increases with income from $12.27 per capita in lowest income group to $60.29 per capita in highest income group

Funds required to 'fix' problems of access among poor inadvertently distributed to higher income groups

ORAL HEALTH CARE IN NEW ZEALAND

(Leake, Ashton, Cummings)

Children (0-12)

Salaried school-based dental therapists

No user fees or co-payments

Complex needs referred to private dentists under public funding

Coverage: 98% among school age children, about half of preschool children

Staff shortages and aging workforce

ORAL HEALTH CARE IN NEW ZEALAND

Adolescents (13-19)

Register with private dentists under public contracts

Capitation fee for standard package of services

Extra bill Health Boards for additional services

No user fees or co-payments

Access problems (65% registration, willingness of dentists to accept patients under programme)

ORAL HEALTH CARE IN NEW ZEALAND

Adults (including seniors)

Private dentists, fee for service, no public subsidy

Limited private insurance (taxable benefit)

Public hospitals provide emergency treatment for low-income adults

Expenditure

NZ$466m of which 24% public and 70% out of pocket

ORAL HEALTH CARE IN UNITED KINGDOM:
(Driffield and West 2003)

Community Dental Service

Screening of school children (identify needs, encourage registration)

Provision of services to special needs populations and others with problems of access to dental care

Publicly funded – salaried employees

ORAL HEALTH CARE IN UNITED KINGDOM:

General Dental Service

Independent private practitioners

NHS funded services: patient 'registers' with dentist

Attend every 15 months or registration lapses

Patient pays 80% of NHS service fees (Max. 372 UK pounds)

Unemployed, low income and pregnant women exempt from payment

Children exempt from charges, dentist paid through capitation plus service items

ORAL HEALTH CARE IN UNITED KINGDOM

Registration with dentist under GDS:

Children: 60% registered, constant over last decade

Adults: Registration rate fallen from 58% to 45%

Seniors: Registration rate lowest for 75+ (30%)

Dentists: 40% practices not accepting registrations
"Conditions" for registration among other 60%

ORAL HEALTH CARE IN UNITED KINGDOM

Dental Access Centers

Publicly funded salaried dentists to provide access to services in areas with problems accessing GDS

No patient registration, enhance patient choice

Increase competition among providers

ORAL HEALTH CARE IN UNITED KINGDOM

SUMMARY:

NHS 20% subsidy for dental care provided to adults

Use of NHS dental services fallen over the last decade

4 in 10 children and 7 in 10 elderly not registered with dentist

40% dentists not accepting new registrations

NHS responded by introducing Dental Access Centres

Little information available on private dental care

ORAL HEALTH CARE IN EUROPE:

(Driffield and West 2003)

'Beveridge' model: Nordic countries

Funded by general taxation (national, local)

Comprehensive first dollar coverage for children

Adults receive public subsidy for care from public or private dentists – level of subsidy reduced over time

Relatively 'dentist-intensive' service delivery

Objectives aligned with changing incidence:

Population-based improving access to risk-based equating outcomes

Adoption of publicly-funded competition – capitation fees and payment follows patient

Child oral health among best

Adult oral health less impressive

ORAL HEALTH CARE IN EUROPE:

Bismark model: Rest of Europe

Compulsory 'social' insurance schemes

Funded by individuals, employers and governments

Patients reimbursed by social insurance for fees paid to private dentists

Level of coverage varies by type of service

Greater use of hygienists/assistants/therapists

Private insurance as alternative or 'top up'

Child oral health not among best

Adult oral health more impressive

ORAL HEALTH CARE IN USA

(Bailit and Beazoglou 2002)

Access to services determined by willingness and ability to pay

Little public funding and level not increasing substantially

Provision dominated by private providers/private funding

Health care expenditures per capita ($) and source of funds (%)
USA 1960 – 1999

YEAR	HEALTH CARE EXPENDITURES PER CAPITA		SOURCE OF FUNDS (%)					
			Direct		Private Ins.		Public Funds	
	All	Dental	All	Dental	All	Dental	All	Dental
	$		%					
1960	141.50	7.68	48.7	97.2	21.9	1.9	24.5	1.0
1970	340.78	6.68	34.4	90.8	22.4	4.5	37.2	4.7
1980	1051.47	5.57	24.4	66.3	28.2	28.6	42.4	5.1
1990	2687.86	4.70	21.3	48.7	33.3	48.0	40.8	3.3
1999	4355.04	4.62	15.4	45.8	33.1	49.4	45.3	4.6

Source Bailit and Beazoglou 2002

Expenditure on dental care services per capita population $US ppp

Country	1990		1992		2000	
	tot $	pub %	tot $	pub %	tot $	pub %
Australia	66	9.09	81	9.88	142	17.60
Canada	115	9.56	129	8.53	206	5.34
New Zealand						
UK			64	48.43		
USA	126	3.17	144	3.47	230	4.78

Source: OECD Health data 2003

Population Oral Health Status

Mean DMFT per 12 year-old child, selected years

Country	1992	1996	2000
Australia	1.2	0.9	0.8[1]
Canada	3.0[2]		
New Zealand	1.5	1.5	1.6
UK	1.3	1.1	0.9
USA	1.3		

Source: OECD Health Data 2003

1. Data for 1999
2. Data not available in OECD dtat set. Data taken from WHO Oral health country/area profile

Needed care but didn't consult provider due to cost among adults reporting health problems[1], 2002

Country	Physician	Dentist
	%	%
Australia	16	44
Canada	9	35
New Zealand	26	47
U.K.	4	21
U.S.A.	28	40

1. rated health fair or poor, chronic illness, major surgery or hospitalized for reasons other than normal delivery in last 2 years

Source: Blendon et al. 2003.

Needed care but didn't consult provider due to cost among adults reporting health problems[1], 2001

Country	Physician			Dentist		
	Income group			Income group		
	>median	<median		>median	<median	
	%		%		%	%
Australia	10		14		31	38
Canada	3	15		9	42	
New Zealand	18	36		24	40	
U.K.	2	19		4	20	
U.S.A.	15	24		13	51	

Source: Blendon et al. 2002.

MESSAGES:

Expenditures per capita in Canada high by international standards

- Public funding per capita static, low by international standards and falling as proportion of total expenditures
- Public funds an increasing share in other countries
- Trend has greatest impact on utilization of poor
- No systematic data collection to provide evidence on outcomes

MESSAGES:

Universal publicly-funded programmes for children's dental care is common to most countries

- Methods of delivery vary from school-based dental therapist to community based private dentists

Uptake less where based on public funding of private provision.

- Opportunity cost to provider may be too large (e.g., forgone time for private patients) and increase over time
- Providers less willing to take on publicly funded patients

MESSAGES:

Accessibility may require public provision alternative.

- **Dentists locate in areas where greatest demand for their services**
- **Public funding alone does not guarantee access to services**
- **Subsidization of private insurance not the answer**

Compatibility of Item of service remuneration with social goals

- **Income independent of number of clients, needs**
- **Nature of oral health care needs changing**

CONCLUDING QUESTION:

IS IT TIME TO RETHINK HOW WE DEPLOY OUR DENTAL CARE RESOURCES?