Why do we need an oral health care policy in Canada: past, promises, present, and potential

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Presentation to Access and Care: Towards a National Oral Health Strategy

The Past

- Canadian values
- The Profession's Social Contract

Canadian Social Values

1999 Social Union Framework	2002 Royal Commission of the Future of Health Care
Equality before the law	Equity
Equality of opportunity	Fairness
Respect for diversity	Solidarity
Individual dignity	
Individual responsibility	
Equity	
Fairness	
Mutual aid and responsibilities for one another	

Canadians support collective action to reduce inequities

Social Contract: Gushue, 1998

"…self-regulation is not an entitlement. It has been granted to us by society along with certain responsibilities. Essentially, society has allowed organized dentistry to regulate itself… . In return, society expects organized dentistry to exercise the leadership necessary to ensure that the members of our profession serve and and protect the public…"

Mouradian, 2004

- Social contract extends more widely than individual members' responsibilities
- The profession has promised to act in the public good including the elimination of disparities in oral health, the prevention of oral diseases, and the promotion of oral health
- Without leadership to act in the public good, dentistry risks irrelevancy

The Promises

- Recommendations for improved access
- Previous programs

Robb, Minister of Health of Ontario, 1931

"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."

Minister of Pensions and National Health of the Government of Canada, 1943

Draft national health care legislation including medical, nursing, hospital and dental care "…at least to the extent that existing dental facilities are capable of providing…at the present time (the recommendations for) dental services are restricted to routine fillings and care for children under 16…"

Royal Commission on Health Services, 1964

Recommended "…comprehensive, universal, provincial programs of personal health services…(to) consist of:

- 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
- Home care services

Royal Commission on Health Services, 1964

Commissioners wrote that:

"…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."

Royal Commission on Health Services, 1964

Recommendations for children's plan:

- Incremental program starting with children aged 5 & 6
- Delivered by a school-based, dentist/dental therapist-staffed model
- Federal grants to establish dental facilities in hospitals, public health centres, (and) schools
- Federal matching funds for operating costs

Royal Commission on Health Services, 1964

Dental recommendations comprehensive:

- Public education programs
- Survey of the nation's oral health
- Water fluoridation nation-wide
- Maternal dental health program - to be delivered by private practitioners
- Dental care for recipients of public assistance

National Forum on Health, 1994
Romanow Commission, 2002

Neither discussed the dental health care needs of Canadians nor provided recommendations to address them.

Previous Programs

Saskatchewan 1970s and early 1980s

School-based, dentist/therapist-provided program

- Achieved higher utilization among adolescents (89%-96%) than did the equally "free" private-office based model (ranged from 76%-82%)
- Delivered high quality care

Previous Programs *(cont'd)*

Saskatchewan (and Manitoba) staff terminated by conservative governments prepared to side with the provincial dental associations in their position that only private enterprise should deliver dental care.

Same governments cancelled dental care programs for children when they were not prepared to pay the bills of private practitioners.

The health impact of no universal access to care has reportedly returned the oral health of one in five Saskatchewan children to below that of children "…in the third world."

Previous Programs *(cont'd)*

British Columbia

- Examined its options for children's program
- Implemented the least cost-effective model, then
- Cancelled the program after 20 months when predicted high costs turned out to be accurate

The Present

- Medicare
- Dental care
- Disparities
- Alternate models of care
- Public health capacity

Medicare

A social and cultural icon that defines Canadian society.

Medicare

Delivery system is not socialized:

- Private physicians work in **several models of care delivery**
- Most practice in own office and/or community-owned, not-for-profit hospitals
- Minority in community health centres or other community-based sites

Comparing Dental/Medical Care Delivery

	Medical Care	Dental Care
Financing:	Public, mostly thru' progressive tax system (Alberta has premiums)	52% private insured 42% out-of-pocket 6% public (Romanow p25)
Funding:	Single payer	Many payers
Practitioners:	Private	Private
Payment levels:	Negotiated with governments	Established by provincial dental associations (not Alberta)

	Medical Care	Dental Care
Payments to practitioners:		
	Fee-for-service; but many hospital-based physicians switching to "alternate payment methods"	Fee-for-service
Delivery sites:	Private offices	Private offices
	Hospitals, CLCs	
	Community health centres	
Delivery models and allied providers:		
	Varied, especially in hospital settings	Dentist, staff hygienists, assistants, denturists

Dental Care

- Financing
- Resources allocated
- Oral health disparities
- Access/Utilization
- Programs

Financing Dental Care

Current Policy:

Canadians, including the poor, pay higher taxes to subsidize the "tax-expenditure program" of dental health care for more affluent, insured Canadians.

Employer paid premiums for dental care

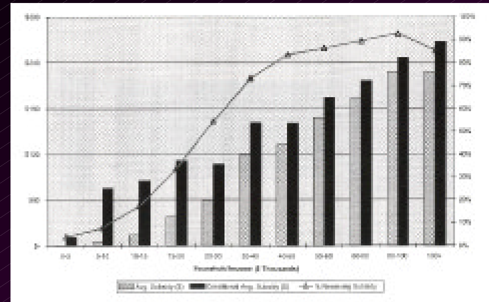
- Part of the total compensation for the employee, but
- Not subject to federal or provincial (except in Quebec) income tax, thus
- Money, otherwise collected, left to subsidize 'tax-free' oral health care
- Auditor General defines this as a "tax-expenditure program" which warrants examination as to the effectiveness and "value for money"

Romanow Commission

"…tax breaks were estimated to be worth… roughly $3 billion (2002) given up by governments in not taxing private insurance premiums…" for drugs, dental and other health benefits.

The tax break favours the more affluent since it is the more affluent who have higher likelihood of employer-paid dental insurance and gain more in absolute dollars because of their higher marginal tax rates.

Figure 1: Tax Subsidization of Employer-provided Health Insurance, by Household Income: Canada, 1994



Tax Subsidy Worth (in 1994)

For all families:
- $0.50 – incomes less than $5000
- $225 – incomes greater than $100,000

Among those with insurance:
- $11 at the bottom income categories
- $265 at the top income categories

Smythe concluded that the subsidy was inferior from (both) an efficiency and equity point of view, and should be revised.

Implications of "Tax-expenditure Program"

- More affluent, insured Canadians receive tax-free dental care
- Uninsured have to pay in after-tax dollars (until they exceed something like 3% of their income)
- All Canadians, including the poor, pay additional tax (e.g., GST/HST, PST, gasoline tax) to make up the taxes on the billions not collected on the dental insurance premiums

Implications of "Tax-expenditure Program" *(cont'd)*

- Through tax-expenditures, we have a publicly funded dental care program for those who are privately insured
- An amount equal to the tax-expenditures could be sufficient to pay for a directed program to address the greater needs of the uninsured Canadians

Dental "Insurance"- Sustainable ?

1. Costs ultimately fall back onto employer firms
2. Costs increasing far faster than rate of inflation and under current models are not subject to management as are other business costs
   - 1992-93 costs rose by 21% (over 2 years) when annual inflation rates were ~ 1.4%
   - 2004 costs set to increase by 9.5% - 11.1%

Dental "Insurance" - Sustainable ? *(cont'd)*

3. No new 'retirees plans' because firms have to account for them as unfunded liabilities
4. Neither McJobs, nor higher-paying contract employment includes dental insurance

Percent of Dental Expenditures Paid Directly from Public Funds by Province, 1960-1999

	Year				
Province	1960	1970	1980	1990	1999
B.C.	1.0	7.6	12	7	6
Saskatchewan	1.3	13.1	25	22	17
Ontario	1.0	5.6	2	2	2
Quebec	1.1	0.4	41	17	10
P.E.I.	0.5	24.8	31	15	12
Total Canada	1.2	5.5	13.7	9.2	5.8

Expenditures on Dental Care, Canada, 1960-1999

Dental Expenditures	1960	1970	1980	1990	1999
Total $ - Millions	110	265	1308	4138	6773
Per capita - $current	6.12	12.43	53.52	149.42	222.03
Per capita - $1960	6.12	9.50	18.89	29.63	37.17
Per user - $1960	19.74	19.00	37.78	55.92	63.00
Utilization - % of Pop	31% (est)	50% (1972)	50% (1979)	53% (1994)	59% (1996)
% Health Expenditures	5.1	4.2	5.8	6.8	7.5
% GDP	0.29	0.31	0.42	0.61	0.69

(Year spans the columns 1960–1999.)

* *Estimated as straight line increment between 1950 (15%) and 1967 (42%) = 1.6% per year for 10 years from the 1950 base.*

Direct Costs of Illness in Canada by Diagnostic Category, 1993, 1998

Disease Category	1993 ($ Mill.)	1998 ($ Mill.)	RANK 1993	RANK 1998
Cardiovascular	7354	6818	1	1
Dental Disorders	4926	6297	3	2
Mental Disorders	5051	4680	2	3
Respiratory Diseases	3787	3461	5	4
Digestive Disorders	3326	3540	4	5
Cancer	3221	2462	7	6
Injuries	3121	3224	6	7

Numbers of Dental Providers and Provider to Population Ratios 1960-1999

Regulation Issues Between Dentistry and Other Provider Groups

Denturists:

- Gained legal status in the 70s despite opposition by many provincial dentist organizations

Dental Therapists:

- Still not allowed to practice in Ontario and Quebec

Regulation Issues Between Dentistry and Other Provider Groups

Canadian Dental Hygienists Association:

- Public should have direct access to dental hygienist services without having to have their care prescribed or "ordered" by dentists

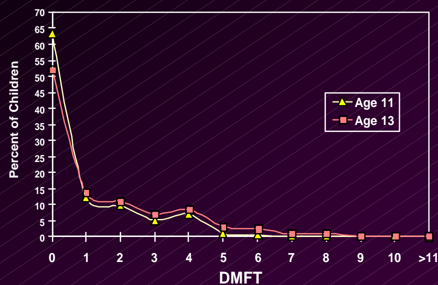
Canadian Dental Association:

- Team approach, led (and controlled) by dentists, provides Canadians with safe and comprehensive care

Improvement in Dental Caries, Toronto 13-year-olds

	1958/59	1999/2000
Have had one or more cavities	89%	39%
Mean number of cavities	5.7	1.1

Percent of Adolescent Children by DMFT Scores, Ontario 1994

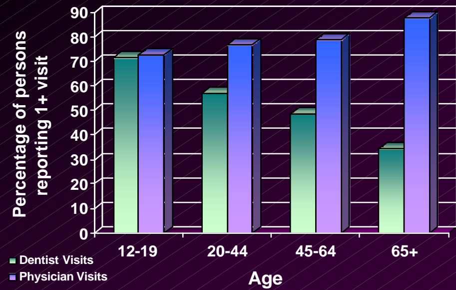


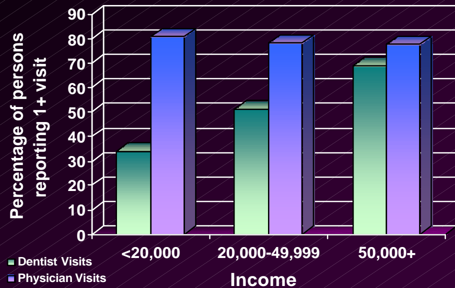
Most recent survey in Toronto shows:

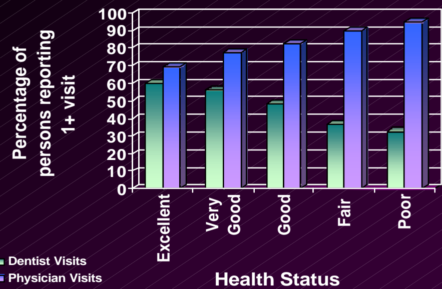
- over 10% of 5-year-olds need two or more teeth treated for cavities
- approximately 7% of both 5 and 7-year-olds need urgent care
- these exceed numbers affected by most other childhood conditions for which medical care is free and access is guaranteed

Dental Caries among Ontario 13-year-olds ca 1991/94

	First Nations	Born outside Canada	Born in Canada
Have had one or more cavities	89%	62%	47%
Mean number of cavities	3.9	2.2	1.4







Percent of Persons Using Dental Services by Income Category from National Health Surveys 1951-1997

Year	Ages	Income Category: All income categories	Lowest	Next to lowest	Next to highest	Highest	Ratio of highest to lowest
1951	<15	-	6.3	12.2	20.0	26.7	4.2:1
1951	All	15	8.4	14.3	18.8	21.8	2.6:1
1978/9	All	50	38.8	45.1	55.1	60.5	1.6:1
1990	≥15 (dentate)	75	64	78	89	97	1.5:1
1994	≥12	53	35.3	44.6	44.6	65.6	1.8:1
1996/7	≥15	59	41	52	65	78	1.9:1

Factors Improving Utilization

Present Programs

Publicly funded

Federal government

Federal Government

Target Group	Indemnity or Service Plan 'Insurance'	Contracts with Providers or Provider Groups	Salaried Staff: Dentists, Dental Hygienists, Dental Therapists, Denturists
First Nations and Inuit	XXX	XXX Private Dentists & w/universities	XXX
Armed Forces/ Veterans		XXX Veteran Hospitals	
RCMP and Federal Employees	XXX		
Corrections Clients		XXX	
Refugees	XXX		

Provincial/Municipal Governments

Target Group	Indemnity or Service Plan 'Insurance'	Contracts with Providers or Provider Groups	Salaried Staff: Dentists, Denturists Hygienists
Community Public Health, Oral Health Promotion Services			A few treatment programs, e.g., Toronto, Vancouver
Income Security Clients	XXX All provinces		X For some municipal programs
Children	XXX Alberta, Ontario, CINOT Quebec, NS, PEI, NF&L		XXX Quebec CLSC for preventive services, PEI
Adults			
Seniors	X Alberta, Territories		X Small municipal program in Toronto

Privately Funded

Source of Payment	Indemnity or Service Plan 'Insurance'	Contract Dentists Provider Groups	Salaried Staff: Denturists, Dental Hygienists
Out-of-pocket	XXX		
Employer paid insurance	XXX		
Union benefit funds		XXX	XXX

Public Health Capacity

United States Institute of Medicine (1988) defined three core public health functions

1. Assessing the health of the community
2. Developing policy by promoting the use of the scientific knowledge base
3. Assuring the provision of (needed) services either by requiring such action through regulation or by providing services directly

Public Health Capacity

1. Canada has not conducted an assessment of oral health to WHO standards since 1974
2. Policy and oral health promotion strategies lacking at national level (other than for FNIHB)
3. Assurance of care not strong.

Canada has little dental public health capacity:

- We have no Chief Dental Officer
- Number of nationally qualified, active, dental public health specialists in Canada = 5 and declining
- Few programs = few career paths (except in Quebec) and as a consequence
- Few (to none) Canadian licensed dentists are being trained (other than in Quebec)

The Potential

- Future models
- Desired change

Future Scenarios

O'Keefe has produced four scenarios for the future. One speaks of funding for low-income Canadians. The premise for all the scenarios is that:

- External forces of demography, technology, and economic power will decide the future
- Providers and the community will take whatever the invisible economic hand shapes

Others feel the profession has already moved to market-driven, technologically-based, provider of expensive elective services to those who can afford them. If so, do the implications include

- Renegotiation of the social contract - dentistry irrelevant; not a component of health care?
- More faculty budget cuts?
- More hospital dental department closings?
- Taxing of dental insurance premiums?
- Reassignment of dental research funds to real health issues?

Organizations other than dentistry are taking the lead to effect desired changes:

- Federal Provincial Territorial Dental Directors
- Nova Scotia Oral Health for Seniors Project
- CAPC/CNCP groups working with poor families in Ontario
- Groups working with the poor in Victoria
- Groups working with First Nations communities in BC
- Faculties and Hospitals
- Clinics serving lower-wage unionized employees

Others not reporting at this meeting include:

- Toronto Oral Health Coalition
- The Children's Youth Action Committee (Toronto)
- Halton Oral Health Outreach Program (Ontario)
- The United Senior Citizens of Ontario
- County Council of Lennox and Addington (Ontario)
- The Kingston Coalition

Toronto Oral Health Coalition

The Coalitions goals are:

1. To advocate for equitable access to dental care for those who traditionally have experienced barriers to receiving good dental care; and
2. To build a strong coalition that can facilitate improved service delivery through education, research, strengthening partnerships, changing policies, and developing funding sources.

The Children's Youth Action Committee (Toronto)

Made up of members of the Toronto Council, school trustees, and community representatives. Its mission is to improve the health and well-being of children and youth in the City of Toronto. The Committee recommended: "…that dental cleaning becomes an integral component of obstetrical care covered by OHIP…"

Halton Oral Health Outreach Program (Ontario)

HOHO operates generally to improve care to seniors; specifically it:

1. Assists community agencies with the implementation of an integrated and coordinated oral health strategy for adults with specials needs;
2. Advocates for solutions which enable individuals to access oral health services; and
3. Influences public policy makers to mandate similar initiatives provincially and nationally.

The United Senior Citizens of Ontario

The voice of over 300,000 older adults in Ontario, at Annual Council Meeting of August, 2003, passed the following resolution unanimously:

"…be it resolved that **seniors have the same benefits (includes dental care) as the socially assisted, disabled persons and new immigrants.**"

County Council of Lennox and Addington (Ontario)

"…be it resolved that the **Province of Ontario be requested to develop a fair and consistent dental care program** to be targeted at lower wage working Ontarians, with eligibility for this program to be based on graduated payments and eligibility determined by commonly used criteria such as the GST Rebate and/or NCB Eligibility and that this supplementary dental program be funded through the Ontario Health Tax."

The Kingston Coalition

A community-based coalition **committed to ensuring everyone has access to dental care regardless of age, circumstance or income.** The Coalition states that inadequate access to dental care is a growing problem and focuses on increasing access to dental care for those living in poverty.

Conclusions

Canada:

- prosperous
- international reputation for its social values, and the translation of those values into high quality education, social and health care delivery systems
- access to health care is seen as a right of citizenship and not something that should be allocated to an entrepreneurial market

Dental care:

- has fallen out of that social construct
- largely provided as a market-driven service despite the public share of funding of dental education and care, and the social contract
- access determined by income, youth and overall good health, the inverse care law

Tax expenditures:

- policy that allows the insured to receive tax-free care and requires all, including the poor, to subsidize that tax-expenditure, is a perversity of social justice; and
- the amount of the subsidy to the more affluent would go a long way to addressing the needs of those with the greater need

Opportunity presented by:

- social values and contract
- national prosperity and example of medicare
- overall good levels of oral health
- extensive provider resources
- funds already allocated to oral health services

frees us to consider what else we might do.

The CDA's call to build "…a system that embraces us all…" can serve as the ultimate goal.

Canadians:

- desire a system that allows access to care in accordance with fairness and need
- are already paying for it
- are building momentum to make it happen