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Perceptions of Oral Health Care in Canada –

A view from the trenches

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Abstract

Purpose
Most provinces have limited programs for welfare clients and for children. There is increasing concern that the lack of access to oral health care is limiting the potential of disadvantaged groups' general health.

Method
The survey addressed the aspects of care facing agencies with responsibility for meeting the oral health care needs of those receiving government assistance (welfare), the under-housed, and the working poor. The data from the returned questionnaires were entered into an SPSS database and analyzed. Following review of the frequencies, cross-tabulations were carried out for Ontario compared to the rest of Canada; by government organization or other; by cultural nature of clients and by type of organization.

Results
For positive aspects of oral health care, 84% found public programs were positive and 81% felt that dentists offered good care. However, 77% disagreed that preventive care is accessible and that access to dentists and dental specialists is easy. More Ontarians thought there were few alternative settings, (95% versus 83%) and that the poor feel unwelcome, (83% versus 70%). The most commonly identified other issues were the need for alternate delivery sites such as in community health centres where alternate delivery can be affordable, accountable and sustainable.

Discussion and Conclusion
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 health of a great many Canadians. Respondents generally thought that dental health was isolated from general health.

Background, Purpose, Objectives

Throughout Ontario and other provinces, social service agencies, emergency room staff and others are often reportedly frustrated in their attempts to access oral health care for their clients [1]. While most provinces have limited programs for welfare clients and some provinces have dental care programs for children, dental care programs do not meet the criteria of the Canada Health Act[2]. As a result, the working poor and those living in poverty have restricted access to dental care[3] and much untreated disease. At the same time access to care has been further constrained, at least in Toronto, where hospitals have had to close their dental outpatient services that often were the sole source of emergency care for some of the members of these groups.

This follows a pattern of the last 20 years where dental programs for children and seniors in the four western provinces have been cut completely[4] and a more recent spate of hospital department closures that affect both the delivery of care and the training of undergraduates and some specialties.

These events are occurring in spite of increasing evidence that poor oral health is a risk for general health outcomes. Diabetes, cardiovascular disease, and pre-term deliveries have been associated with oral disease markers[5, 6]. Thus, there is increasing concern that the lack of access to oral health care is limiting the potential of disadvantaged groups general health which in turn impedes their ability to participate fully in society[7].

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 in May 2004 to raise awareness of the need to improve access and care for oral health services. As part of the preparation for the symposium, and integral to the identification of issues, we canvassed key informants across Canada for their perceptions of oral health services and their recommendations for improving oral health care delivery.

Methods

Ethical Review

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

Target group

The survey was intended to capture the aspects of care facing agencies that might have responsibility for meeting the oral health care needs of: those receiving government assistance (welfare), the under-housed, and the working poor. The questionnaire was designed to seek answers of key informants on behalf of these clients and so it was sought the responses from those at a senior management position in such organizations.

Sampling frame

No complete list of such agencies is available. Accordingly we compiled a list that we felt from our experience would include both those who might work on behalf of such clients (social and health care agencies) and those who might be providing or organizing to provide care to these clients such as dental, dental hygiene, and denturist professional organizations.

We constructed the mailing list 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 ministers 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 from a database maintained by the Canadian Public Health Association. We also invited members of the Canadian Association of Public Health Dentistry to identify key agencies in their areas/region. Despite these efforts, we have no independent way of verifying the completeness of our mailing list for such a purpose.

We mailed surveys to one in 10 local health authorities, to one in three of the social services and all of the others. After six weeks, we re-mailed the surveys to those who had not responded.

Questionnaire

Questions were developed by the authors with the input of the group planning the symposium. Key informants were asked to provide information on: their opinions of the positive and negative aspects of oral (dental) health care delivery in Canada; local developments in the past five 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 organizations and their clients. The respondents were asked to indicate if they were a government agency, whether their delivered health care, social services, or education, and whether it was a health or social service policy development or provider association. They were asked to identify the income, sex, cultural, health status of their clients and province where they operate. Responses were to be anonymous, although they could volunteer their names and e-mail addresses if they wished to receive feed-back from the survey or the symposium.

The data from the returned questionnaires were entered into an SPSS database and analyzed. Initially frequencies were determined. Following review of the frequencies, cross-tabulations were carried out for Ontario and the rest of Canada; by government organization or other; by cultural nature of clients (First Nations or not) and finally by type of organization.

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

Results

Some 225 surveys were mailed out of which 90 completed surveys were returned (response rate of approximately 40%).

The responses were mostly received from agencies in Ontario (53%), followed by Nova Scotia (11%) and British Columbia (8%). Most of the respondents were employed by governments (55%) with 32% employed in health agencies and 23% in education organizations. Responses were received from health care delivery organizations (n= 30), educational facilities (n= 19), professional associations or policy makers (n = 14) and social service agencies (n=9) and other (n=18). The agencies served adult populations predominantly, and people from all levels of income, although some 43% served people with low or no income. Predominantly the people served were from all cultures, but almost 15% served only First Nations and Inuit populations.

We asked first about the positive aspects of oral health care. Table 1 shows that about 84% found the public programs for children and adults were positive, 81% felt that dentists offered good care, and about 75% said that dental insurance and choosing a dentist were positive. On the other hand, nearly 77% disagreed with the statement that preventive care is accessible and over 55% disagreed with statements that access to dentists and dental specialists is easy. Key informants from Ontario agreed less frequently with the statement that children have good access (79% Ont versus 91% in rest) and much less frequently with the statements on access to preventive care (9% Ont versus 31% rest) and ease of access to dentists (38% Ont versus 50% rest).

For the responses to the questions on negative aspects of dental health care delivery, the overall results were as follows: (Table 2)

- High cost makes care inaccessible without insurance (97%)
- Insurance unavailable to low income people (95%);
- Those with the greatest needs get the least care (94%);
- Governments resist including dental care in health (89%);
- People with special needs have problems in accessing care (87%);
- Insurance plans are inadequate (85%) and
- Oral health is isolated from general health (84%).

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

Although the numbers are small and the percentages may not, therefore, be stable perspectives of the different agencies varied. Fewer (62% vs. 90% of the others) informants from Government agencies felt that patients' ability to choosing their dentist was a positive attribute of the system. Nine of 10 responses and eight out of ten responses from First Nations and Inuit agencies disagreed that their clients have good access to dentists and specialists respectively, and all 10 reported that their clients with special needs had problems accessing care. Table 3 compares some additional responses to questions in Tables 1 and 2, by type of organization. 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 to the means of 20% and 42% respectively. Social service providers thought that dental care was less likely to be a benefit of employment (56% compared to a mean of 76%).

Respondents' concurrence with several developments that appear to have made the system less effective is shown in Table 4. Strongest agreement was found with the statement that the provinces are turning away from responsibility for oral health care (81%) and over 76% agreed that unemployment or loss or reduction of dental (insurance) benefits were contributing. Again there were differences in agreement with

the reasons reported by Ontario respondents compared to those in the rest of the country including:

- Municipal cutbacks make it difficult to fund local dental programs: (46% versus 88% in Ontario);
- Regionalized health authorities: (44% versus 67% in Ontario), perhaps reflecting that Ontario has had no experience with regionalization, since some 56% had no opinion
- Increased number of people cannot afford dental care due to unemployment: (81% versus 63% in Ontario).

Table 5 shows the responses to the questions about the means to improve access to dental care. Overall 93% of respondents thought that basic dental care should be provided under 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 and the rest of Canada with 91% of Ontarians compared with 71% in the rest favouring the provision of training of dentists in community/ hospital settings.

We also asked respondents to identify other issues related to oral and dental care delivery. The most commonly identified were: the need for alternate delivery sites such as in community health centres where alternate forms of service delivery can be affordable, accountable and sustainable; the need for recognition of oral health in

general health; the need to deal with regulatory issues; (as an example, expanding practice opportunities for non-dentist healthcare providers and removing restrictions on other dental health professionals to provide basic care to the financially challenged); and the need to deal with training issues; (e.g. providing oral care for medically compromised and asking departments of health to provide grants to clinics in Faculties of Dentistry and increasing training in the community).

We asked respondents to provide suggestions to improve the system and for examples of local developments that had occurred over the past five years to make the system more effective in providing access and care. The responses ranged from suggestions for changes in delivery models, development of grass roots coalitions, and provision of prevention. Examples of local developments included partnering with Public Health to provide care including transportation for identified children to the dental clinics, and opening dental clinics with the Federal government's assistance for Nangis First Nation reserves. However many respondents volunteered the converse, that in fact there had been developments that have lessened the effectiveness of such provisions.

Respondents did report on some pockets of creative programs such as: communities paying for low-income children in British Columbia; special projects such as the Oral Health of Seniors project in Nova Scotia; the development of long-term care fee guide (London, Ontario); new programs such as Save A Smile (Alberta) and geriatric programs; provision of dental care for high dental needs children from low income families by dental therapists in 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 advocate for better access. In relation to prevention, respondents noted that more of the smaller communities have fluoridation and that dental health promotion programs are partnering with other existing programs and building community capacity to identify preventable conditions' as well as organized dentistry's involvement in prevention.

Discussion and Conclusion

While our response rate at 40% is not very high[8], it is generally considered an acceptable response rate for a mail-out survey. There was a very low rate of response from social service agencies, making the overall results biased towards respondents who worked in government. Of those surveys where the respondent was identified two were from denturist regulatory bodies and none were identified as a dental hygienist or dentist regulatory agency.

The survey helped to identify access and care issues across the country. It highlighted 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. This is perhaps

related to the fact that Ontario was well supplied with dental care options and has had these eroded in the public health system, for social assistance recipients and within hospital and training programs. Other provinces may have had less in the past and were reflecting little change; however they were also identifying the need for programs and access to care. There was considerable agreement that lack of access to dental care services is an important detriment to the health of a great many Canadians.

Respondents working in government agencies did not think that there was good access to prevention, to dental services including specialists, 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 access to prevention ease of access to dentist or specialists. The impacts and understanding of local changes, such as regionalization, municipal cutbacks and hospital underfunding or closures varied by the agencies. Those most likely to be aware were concerned about these impacts on access, patient care and on the training of professionals.

All of the issues and comments were provided to the conference attendees and helped to identify and elaborate on specific discussions at the workshop component. These issues were compared with the access and care issues identified through other current initiatives; Canadian Oral Health Strategy developed by the Federal Provincial and

Territorial Dental Directors (FPTDD); 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 amongst all of these initiatives in terms of the oral health issues facing Canadians particularly the poor and disadvantaged. The data will continue to aid discussion in the new coalition that was created at the conference.

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Table 1: 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

Table 2: 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 practice in more affluent and urban areas, leaving some parts of the country under-serviced	73.0	14.6	12.4

Table 3: Selected Responses from Types of Agencies compared to Total Responses

Type of Agency	Social Services n=9	Health Delivery n=31	Educators n=19	Professional Associations n=4	Health/ Social Services Policy Analysis and Formation n=10	Total n=88
Question 1: From your agency's or clients' perspective, what are the positive aspects of oral (dental) health care delivery in Canada? (percent agreeing)						
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? (percent agreeing)						
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 4: 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 makes it difficult to fund local dental programs	69.3	6.8	23.9
Hospital underfunding has lead to cutbacks in dental services for medically compromised patients	66.3	10.1	23.6
In regionalized 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

Table 5: 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 to all citizens	78.4	17.0	4.5