



Canada's Oral Health Report Card: A call to action

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EXECUTIVE SUMMARY

The newly released *Report on the Findings of the Oral Health Component of the Canadian Health Measures Survey 2007–2009* serves as an oral health report card (OHRC) which gives a snapshot of the oral health status of Canadians. It is a call to action to invest in oral health. Good oral health is not experienced evenly across all segments of the population, since there is a lack of equitable access to oral health professionals, for a specific portion of the population. Canada's health system was ranked a shocking fifth of seven countries on equity issues, particularly equitable access to prescriptions and dental care. Those with the poorest oral health; the lowest education, and the lowest income have less access to an oral health provider. Between 17 and 33 per cent of low income individuals do not visit dental professionals due to the cost. Income is a strong contributor to oral health, as Canadians from lower income families have almost two times worse outcomes compared to higher income Canadians.

In Canada, dental care is costly relative to other conditions covered by Medicare. Dental care paralleled prescription drugs as the greatest component of total private health spending. In terms of costs associated with disease categories, dental care follows cardiovascular disease, and exceeds costs for respiratory disease, and cancer. Federal investment in oral health must change an ineffective, costly oral health system which treats disease after it arises, to a more cost effective system with a prevention emphasis.

RECOMMENDATIONS:

The federal government collaborates with the provinces and territories to revise the *Canadian Oral Health Strategy* (COHS), based upon the new data in the *Report on the Findings of the Oral Health Component of the Canadian Health Measures Survey 2007 – 2009*. An integral aspect of the COHS will be a federal or provincial implementation plan, which includes, but is not limited to the following activities:

Public health human resources

- Federal government collaborates with the provincial or territorial governments to develop a comprehensive plan to provide oral health promotion and disease prevention for all Canadians, as part of the continuum of care in the *Canada Health Act*.
- Federal government invests 10 million dollars each year, for a designated fund to enable the provinces to bolster public health dental hygiene human resources.

Data collection

- Incorporate an oral health component into the Canadian Health Measure Survey, every five years.
- In 2011, provide funding for a Canada oral health survey on infants, young children, and seniors.

First Nations and Inuit Oral Health

- The federal government works collaboratively with stakeholders, including First Nations and Inuit organizations to develop a comprehensive long term plan with secure and stable funding to address the oral health issues identified in the pending First Nations and Inuit oral health report.

ORAL HEALTH STATUS IN CANADA

The newly released *Report on the Findings of the Oral Health Component of the Canadian Health Measures Survey 2007 - 2009*¹ serves as an oral health report card (OHRC) which gives a snapshot of the oral health status of Canadians. Following a 30-year gap in gathering comparable data, oral health has finally registered on the radar at Health Canada. This data collection is critical for informing health policy and informing the public about oral health issues in Canada. This new OHRC demonstrates that overall, Canadians have good oral health; three out of every four Canadians annually visit a dental professional.

However, there are several caveats to this positive outcome. Good oral health is not experienced evenly across all segments of the population. The survey report did not include First Nations and Inuit health data, which will be released at a later date, and is expected to reveal very poor oral health status. Nor did the survey include data on young children, infants and seniors—populations with known high rates of oral diseases. Oral diseases and conditions are often chronic, painful, and disfiguring; together, they represent a huge economic and social burden of illness in Canada. While rarely fatal, the costs of these diseases and conditions have a large economic impact costing Canadians the chance to contribute to society through work and volunteerism. An estimated total of 40.36 million hours were lost from normal activities, school or work in the previous 12 months due to check-ups or problems with teeth.¹ Some of the consequences of dental decay are acute and involve chronic pain, interference with eating, sleeping and proper growth, tooth loss, and compromised general health. In addition, there is a connection between oral diseases and other diseases, such as diabetes, lung and heart diseases. For example, if you have two co-existing conditions, periodontal disease and diabetes, it is harder for you to control your blood sugar than it is for someone who does not have periodontal disease. Furthermore, oral disease is the most common chronic disease in children and adolescents in North America, and is one of the main reasons that children receive a general anesthetic.²

One further caveat is the lack of equitable access to oral health professionals, for a specific portion of the population. The survey report concludes that those with the poorest oral health; the lowest education, and the lowest income have less access to an oral health provider.¹ Having no insurance is two and a half times more common in the low income families (49.8%) compared to the higher income families (19.8%).¹ Having no insurance is a significant factor in making decisions to seek care and to follow up on recommendations for treatment. The report indicates that 17% of Canadians did not make an appointment to see a dental professional due to the cost and 16% stated that they avoided getting all their recommended treatment due to the cost. In addition, 47% of lower income Canadians needed one or more types of treatment, compared to 26% of those with higher incomes.¹ Highest rates of avoiding visiting because of costs occur among young adults aged 20 to 39 with no insurance (50%) and low incomes. The highest proportion of those with oral pain is found among young adults with lower incomes (19.8%) and among adults aged 40–50 years who are in the lower income category (20.3%). Income is a strong contributor to oral health, as Canadians from lower income families have almost two times worse outcomes compared to higher income Canadians.

Further evidence for Canada's poor record in providing equitable oral health care comes from a 2010 Commonwealth Fund report.³ Canada's health system ranked a shocking fifth of seven countries, on equity issues, particularly on equitable access to prescriptions and dental care.³ The report also notes that low income Canadians often forgo medical treatment because of cost barriers. In 2007, 33% of individuals with below average incomes and 13% of those with above average incomes, needed dental care, but did not see a dentist because of cost in the past year.³ Compared with the Netherlands and

several other European countries, where the universal health system includes prescription drugs and dental care, Canada's health system is inequitable.

WHO PAYS FOR ORAL HEALTH CARE IN CANADA?

Oral diseases are linked with general health issues, such as diabetes, respiratory and cardiovascular diseases. However, the facts about oral health care expenses are not common knowledge. Canada spends 10 billion dollars annually on oral health care; and in terms of costs associated with disease categories, it follows cardiovascular disease, and exceeds costs for respiratory disease, and cancer.⁴ In 2009, dental care paralleled prescription drugs as the greatest component of total private health spending.⁴ In 2009, 6.3 billion dollars was spent on dental care in Canada.⁵ The largest portion of spending (94%) came from private sources (out of pocket spending and private dental plans). Dental care in Canada is costly relative to other conditions covered by Medicare. From 1960 to 2008, per capita expenditures on dental care increased from \$6.16 to \$361.62.

There may be a misperception in Canada that health care is predominantly publicly funded. However, in 2009 in Canada, public funding covered only 70 per cent of health spending, less than the average of 73 per cent for OECD countries.⁶ This rating places Canada among the lowest in its coverage of total health care costs. The UK, Sweden, Japan, France, and Germany have higher public share of total spending than Canada.⁷ When it comes to dental care, many European nations include dental care as part of national health plans; however, in Canada public funding is a paltry 6 per cent of all dental expenditures. Out of this 6 per cent, the federal government contributes 40 per cent of the total and the provinces 60 per cent. The high cost of dental care, the lack of access for the neediest, and the existing lack of investment in oral health by federal and provincial governments point to the need to create better oral health policies. Federal investment in oral health must refocus an ineffective, costly oral health system which treats disease after it arises, to a more cost effective system with a prevention emphasis.

POLICY SOLUTIONS: A CALL TO ACTION ON ORAL HEALTH

The *Canadian Oral Health Strategy* (COHS) was developed in 2005, through a wide consultation process involving oral health professionals, health organizations, and provincial or territorial governments. The positive aspects of the COHS include its identification of measurable, specific goals and objectives for the year 2010. The limitations of COHS include the absence of an implementation plan.

The OHRC is a call to action to invest in oral health and the *Canadian Oral Health Strategy* must be revised to reflect the OHRC. A new strategy must be accompanied by an implementation plan for federal and provincial governments. There are a number of areas where the federal government can make an important contribution to the oral health of Canadians. This brief focuses on three main areas:

- Public health human resources
- Data collection and research
- First Nations and Inuit oral health

Public health human resources

Despite the large and increasing resources expended on dental care, of which public programs remain a very small part, utilization of dental care is inconsistent with the needs of the population. Those with the highest need—the low income group—are not receiving the care they require. The federal government must address the relationship between poor oral health and socioeconomic status, and address the populations with high need.

CDHA calls on the federal government to work collaboratively with the provincial and territorial governments to develop a comprehensive plan to provide public health programs that focus on oral health promotion and disease prevention. The timing is right, as we have started to witness a growing lobby from community groups to expand oral health coverage, and the physician community has become more interested in oral health based on the tie-in with systemic health.⁸ The father of Medicare, Tommy Douglas, recommended that Medicare be implemented in two stages; the first was public payment based on treating illness in hospitals, and the second stage was a new system, designed as much as possible to keep people healthy.⁹

Improving Canadians oral health requires an investment in the right kind of services and programs. Oral health services in Canada presently focus on treating disease after it arises, but this is a costly alternative, and there is a pressing need to decrease the growth rate of oral health services to support economic recovery. A public health prevention model is less costly than treating chronic oral diseases after they develop. The federal government must work with the provinces to ensure secure and stable funding for public oral health.

In order to make a shift from a treatment model to a prevention model, we need to examine health human resources. At the present time, there are 42,633 oral health care providers in Canada; however, there are only 718 in public health (453 dental hygienists) creating a ratio of 45,961 Canadians to one oral public health professional.¹ To support a 50 per cent increase in the present number of dental hygiene professionals, there is a need to invest 10 million dollars each year in public health dental hygiene human resources. As members of the public health team, dental hygienists focus on a wellness approach, using health promotion and disease prevention. Some examples of dental hygiene public health programs include prenatal, preschool and school age caries prevention programs, oral disease screening and dental sealant programs. Dental hygienists can promote the integration of federal, provincial and local strategies, and serve as the linking agent for public–private collaborations.

Data collection

Until this year, Canada had not collected oral health data for thirty years. Such data are critical to adequately develop oral health policies and programs. To avoid a future gap in data collection, the federal government must make a commitment to invest in oral health data collection on a regular basis. An oral health component must be incorporated in the *Canadian Health Measures Survey* on a 5-year cycle. Since there are significant population gaps in the survey released this year, data collection next year must include a Canada wide survey of infants, young children under the age of 6 years, and seniors. It is important to survey infants and young children, as the Canadian Association of Paediatric Health Centres declares early childhood caries (ECC = tooth decay) as the most common chronic childhood disease, which they label a pandemic in North America.¹⁰ It is also important to survey seniors, as a larger number of seniors are keeping their teeth as they age; however, physical and mental health complications, medication, and decreased dexterity significantly compromise their oral health.

First Nations and Inuit oral health

First Nations and Inuit peoples' oral health was surveyed recently, and the two reports reflecting this data will be released in the Fall. The 2010 report by the Standing Committee on Health draws attention to the pressing needs of these communities with their recommendation for secure and stable funding for aboriginal health human resources in the North.¹¹ CDHA calls on the federal government to collaborate with stakeholders, including First Nations and Inuit organizations to develop a comprehensive long term plan to address the oral health issues which will be identified in the pending First Nations and Inuit oral health reports.

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