THE CANADIAN DENTAL HYGIENISTS ASSOCIATION

L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES

ACCESS ANGST:

A CDHA POSITION PAPER ON

ACCESS TO ORAL HEALTH SERVICES

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BACKGROUND

This position paper has two purposes: first, to gather comprehensive background information on issues related to access to oral health care, issues that are of concern to the Canadian Dental Hygienists Association (CDHA), its members, oral health practitioners, educators, researchers, and policy-makers; and second, to examine the literature on the topic in order to explain issues in some detail and to permit CDHA to base its positions on in-depth analysis. This position paper also provides an avenue for receiving input and developing consensus among CDHA members on the advocacy positions that the Association should take on the issue. To this end, CDHA posted a draft of this paper on its web site and received input from 22 members.

CDHA position statements or recommendations—brief statements of CDHA's official positions on critical issues relating to access to oral health care—are listed at the end of this document. These statements will be distributed as needed to policy-makers and the media in order to communicate and advocate for CDHA's positions. Oral health advocates can also look to these position statements for direction in dealing with important issues affecting the oral health of Canadians. These statements are supported by research and are based on CDHA's policy goals.

CDHA has considered access to dental hygiene care an important issue for a number of years. In 1992, CDHA developed the following guiding principle that focused on access issues: "Every Canadian is entitled to access comprehensive oral health care. The dental hygiene profession promotes access to affordable oral health care through alternative practice arrangements and non-traditional work settings.… CDHA is committed to the attainment of these goals by working in cooperation with government, health agencies, public interest groups and other health professions."[1] More recently, CDHA developed an end policy, or goal, that focuses on access issues: "There are no financial or other barriers to public access to dental hygiene services."[2] Access is important not only at the national association level but also in all provincial associations.[3]

Important in the past, access to oral health is now considered a critical issue with increased evidence that oral and general health are linked. These links include a correlation between periodontal disease and low-birth-weight babies and some indications of a bi-directional relationship between periodontal disease and cardiovascular disease, respiratory disease, and diabetes.

Recently there has been a heightened interest in health issues in Canada with the discussion centering on funding, accountability, and access. Several important reports have helped to frame this discussion and emphasize that Canadians want greater access to health care: the report of the Commission on the Future of Health Care in Canada (Commissioner Roy Romanow);[4] the report of the Standing Senate Committee on Social Affairs, Science and Technology (chaired by Senator Michael Kirby);[5] and the report of the Canadian Institute for Health Information.[6] In response to the issues raised in these reports, CDHA developed two briefs that incorporated issues regarding access to oral health care issues.[7,8]

In 2002, a third brief—which also included access issues—was submitted to the House of Commons Standing Committee on Finance.[9]

Although statistics and epidemiological information on the oral health of Canadians are limited compared with the information available in the United States, a number of important studies indicate oral health access issues need to be addressed. Statistics Canada's Canadian Community Health Survey indicates that approximately 62 per cent of Canadians aged 12 or older consulted a dentist/orthodontist at least once in 1999–2000. However, the survey also indicates a lack of accessibility for very sizable subgroups within the population.[10] These subgroups with higher oral disease rates include individuals with low socio-economic status, seniors, immigrants, persons with disabilities, and Aboriginal peoples.

A number of factors limit access to care. One of the most obvious is not being able to afford services. But some of the lesser known access issues include systemic barriers such as restrictive dental hygiene legislation and a lack of coverage by private and public dental care plans. Dental offices exist in most towns and cities across Canada. Access to dental hygiene services, however, is restricted for many individuals due to the cost, difficulties with transportation to private offices, a lack of services in rural and remote geographical areas, and fear of obtaining services.

With an access problem so complex, there is no single solution. This paper groups solutions into three sections: population subgroups, public programs, and system issues. Although some of the same issues are discussed in more than one section, solutions are listed only in the section where the issue is discussed in the greatest detail.

BARRIERS TO ACCESS AND PROPOSED RECOMMENDATIONS

1. Population subgroups

Low-income Canadians

Numerous studies have documented that individuals with low socio-economic status (LSS) have inferior dental health compared with those in wealthier groups.[11,12,13,14] This may be due to financial barriers, or the inability to pay for services not covered by government programs or by private insurance plans. The U.S. Surgeon General's report in 2000, *Oral Health in America: A Report of the Surgeon General*, points out a significant disparity in oral health between racial and socio-economic groups and the general population.[15] In 2002, a five-country study of the inequities in health care showed that in Canada, Australia, and the United States, between 20 per cent and 51 per cent of citizens with incomes below the national median reported they needed dental care but did not get it because of cost.[16] A 1999 Statistics Canada survey reports a similar finding.[17] When Canadians were asked why they did not seek needed dental care, 20 per cent of the lowest income group mentioned cost compared with just 10 per cent of the highest income group.

Children from LSS families are particularly susceptible to oral health problems and severe tooth decay.[18,19,20] The following statistics emphasize the serious unmet needs in children's oral health:[21]

- LSS children suffer from twice as many dental caries as their more affluent peers;[22]
- more than 51 million school hours are lost each year to dental-related illness;
- LSS children have nearly 12 times the number of restricted-activity days as do children from higher-income families;
- 25 per cent of LSS children never visit a dentist before entering kindergarten.

Children from LSS families are not only more susceptible to poor oral health, their general health is also compromised since healthy teeth contribute in a number of ways to a child's health, growth, and development. Children's teeth are involved in nutritional intake, development of proper speech, and normal jaw development. They also guide the permanent teeth into proper position and contribute to a child's appearance and healthy self-esteem. In addition, severe dental decay undermines the quality of life of young children through pain and sleeping, eating, and behavioural problems and can be a contributing factor in "failure to thrive."[23]

Many policies to increase access and address disparities in oral health status between low and high socio-economic groups are based on the assumption that providing free services will result in better oral health status. A recent legislative initiative in the United States, such as the Children's Health Insurance Program for low-income children, was based on this premise. Findings from the Rand Corporation Health Insurance Experiment, which compared oral health status of those receiving a free service and those enrolled in plans with co-payments, also supported the assumption.[24]

However, a study by Ismail and Sohn on a universal, publicly financed dental care program in Nova Scotia challenges this premise. The study shows that disparities in oral health status between children from families with low educational levels and those with high educational levels cannot be reduced or eliminated solely by providing universal access to oral health care.[25] The researchers point out that access alone cannot eliminate dental caries and that efforts should also focus on understanding the determinants of oral health—socio-economic, behavioural, family, and community. They conclude that inequalities in oral health should be addressed not only with professional dental care programs but also by a combination of programs including community-based preventive services, general oral health promotion programs (such as school-based education), and mass media promotion of the appearance of a person's teeth and smile.

CDHA recommends that

- provincial governments provide basic oral health programs and services, including necessary restoration, maintenance, prevention, and health promotion services, for LSS individuals and their families including the working poor; these programs and services should take into account the determinants of oral health and include clinical service, community-based oral health promotion and disease prevention programs, and be based on a comprehensive plan that includes school programs and programs for new mothers and immigrants.

Seniors

A proliferation of oral health care statistics shows tooth decay and periodontal disease[26] increase with age. These statistics support the need for increased access to preventive primary oral hygiene care for the elderly. Some Canadian and United States statistics follow:

- The root caries rate was more than three times greater for seniors over the age of 65 than for those under age 45.[27]
- For people aged 65 to 74, 31 per cent had tooth surfaces decayed or filled, compared with 10 per cent of people aged 18 to 24.[28]
- Cancers of the lip, tongue, mouth, gum, pharynx, and salivary glands increase with age.[29]
- Over half of adults aged 55 or more have periodontitis.[30,31]
- Although 43 per cent of Caucasians aged 75 were missing all their teeth, the percentage was higher in other multicultural groups, such as African Americans with 53 per cent and Mexican Americans with 44 per cent.[32]
- Of homebound seniors, 60 per cent to 90 per cent reported a need for dental services but only 26 per cent reported visiting a dentist at least once every two years; 12 per cent to 16 per cent had not visited a dentist in over five years.[33,34,35]
- For seniors in institutions, 9 per cent to 25 per cent see a dentist once a year; 30 per cent to 78 per cent have not visited a dentist in over five years.[36,37,38]
- Although older adults have some of the highest rates of oral disease, they continue to be the lowest users of oral health care.[39]

- A summary of six studies indicates a high degree of dental disease and unacceptable levels of oral health in residents of nursing homes and long-term care facilities.[40,41,42]
- There are significant unmet dental needs in long-term care facilities: dental prostheses in poor condition, poor oral hygiene, and a high prevalence of disease including denture stomatitis,[43] periodontal diseases, and caries.[44,45]

Despite this established need, seniors—particularly those in long-term care facilities (LTCFs)—have trouble accessing services for a number of reasons: poverty, restricted mobility, transportation difficulties, poor overall health, and long-term care facilities with a limited capacity to deliver oral health services. In addition, retirement often means losing private dental insurance. In fact, Canada has a startling rate of 75 per cent of senior men and 83 per cent of senior women who do not have dental insurance.[46] This lack of coverage for women, who account for up to three-quarters of the institutionalized elderly,[47] indicates that the provision of oral health care services in LTCFs is an important women's issue.

Access for seniors can also be restricted by issues related to oral health service providers. Some dentists are reluctant to treat seniors due to a perception that seniors have insufficient patience, endurance, or finances to undergo treatment; that they require more chair time; and that treatment is more difficult.[48,49] The caregivers in LTCFs providing daily oral hygiene report that it is accorded a low priority for a number of reasons. The caregivers see oral care as invading an individual's privacy; they view oral care as the most undesirable task over changing diapers, feeding, and hair washing; they have difficult and uncooperative patients.[50]

Perry also identifies several other barriers to providing access to oral health care in LTCFs.[51] She notes that it is sometimes difficult to obtain consent and payment for treatment when a third party has power of attorney. When there is disagreement about the need for oral health services, the dental hygienist can help resolve the issue. The dental hygienist can act as an advocate and educate the third party about the value of oral health as an integral part of overall health. Perry also highlights the challenge of working with a LTCF's administration to provide education on the role of the dental hygienist, the importance of oral health, and the need for the dental hygienist to view a client's health records prior to providing service.

Access for seniors in LTCFs can also be limited by the lack of education of the daily caregivers. A Winnipeg LTCF pilot project shows the success of having dental hygienists provide education to nurses, nursing assistants, and speech language pathologists. The pilot project report suggests that education should focus on oral health and its connections with overall health; the causes and prevention of oral disease; and how to perform mouth care.[52] Matear also argues for the need to create preventive oral health care programs for the institutionalized elderly that consist not only of examinations and preventive care but also of an educational component for the allied health care professionals and members of the patient's family.[53]

LTCF regulation changes can also increase access and provide increased protection for vulnerable seniors. An example is in British Columbia where the Adult Care Regulations

(1980) of the Community Care Facility Act now require the licensee of the long-term care facility to "encourage a resident to obtain an examination by a dental health care professional at least once every year" and ensure "that staff develop and implement an individualized [oral health] care plan."[54] The dental health care profession is defined in this regulation as a dental hygienist, denturist, or dentist. Other legislative advances in British Columbia include the establishment of the Residential Care Registration (RCR) category for registrants with the College of Dental Hygienists of British Columbia. Clients of RCR dental hygienists are exempt from the requirement for an annual examination by a dentist and these dental hygienists are very active in long-term care facilities.

Supervision requirements for dental hygienists, which vary from one province or territory to another, and the 365-day rule in British Columbia also have a negative impact on seniors' access to oral health services. These provincial requirements are discussed in more detail in Section 3. The following example from Ontario shows how provincial supervision requirements affect the ability of dental hygienists to provide care in LTCFs.

In Ontario, there is a legal obligation for LTCFs to provide clients with access to yearly oral assessments.[55] An unnecessary barrier, however, complicates this provision of care because dental hygienists require an order from a dentist prior to performing the act of scaling. A standing order may be given for individuals with a clear medical history, who are not taking medications, and where no pre-medication is required to perform scaling. However, as Perry points out, few elderly persons living in LTCFs have a clear medical history. They must therefore visit a dentist for an examination and review of their medical history prior to scaling.[56]

Dental hygienists across Canada have considerable interest in serving the senior population in LTCFs but provincial legislative barriers limit their ability to do so. Internationally, there is also an interest in expanding the role of dental auxiliaries with particular emphasis on the provision of services to clients with special needs due to illness or disability.[57] For example, South Australia passed legislation to allow dental hygienists to provide preventive oral health care services to patients in nursing homes and places of long-term residential care.[58]

CDHA recommends that

- provincial governments
  - provide funding for oral health services in long-term care facilities (LTCFs);
  - revise legislation to allow dental hygienists to provide dental hygiene services in LTCFs;
  - implement LTCF legislation requiring the development and implementation of oral health care plans for residents that include a daily oral care strategy;
- long-term care facilities
  - provide educational oral health sessions for staff and clients' families;
  - establish oral health care policies and protocols;
  - ensure that health care/nurses aides provide daily basic oral hygiene care to residents who are unable to manage their own care.

Rural, northern, and Aboriginal Communities

The president of the Inuit Tapiriit Kanatami emphasized the importance of providing health services in remote areas when he stated: "I believe that…the success of our health care system as a whole will be judged not by the quality of service available in the best of urban facilities, but by the equality of service Canada can provide to its remote and northern communities."[59] Canada unfortunately has long struggled with the challenge of providing access to health services, including oral health services, in its vast, sparsely populated areas and its report card in this area has very low marks.

Aboriginal peoples' oral health is in an appalling state. A wide gap exists between the oral health status of Aboriginal children and non-Aboriginal children. In 1999, the decayed/missing/filled teeth (DMFT) rate for 12-year-old Canadian First Nations children was 4.4, two to three times higher than the DMFT rate for non-Aboriginal children in Canada.[60] A more recent statistic from 1999–2000 indicates the dental decay rates for First Nations and Inuit people of all ages range from three to five times greater than the non-Aboriginal Canadian population.[61]

Although the Non-Insured Health Benefits (NIHB) program provides oral health services to Aboriginal peoples, this program is failing Aboriginal peoples for a number of reasons. Program flaws include underfunding, a lack of coordination of services, and difficulties with benefits administration. In addition, limited numbers of professionals work in rural and northern communities so services are either non-existent or require lengthy travel.

An oral health professional working with the NIHB program reports: "Most First Nations people don't get much dental care; only 38 per cent see a dentist once a year, compared to 75 per cent of the rest of us."[62] This is confirmed in a report indicating the program reaches only 38 per cent of the eligible population, since oral health providers are not located in all of the areas where Aboriginal peoples live.[63,64] In some communities such as Moose Factory, eligible NIHB clients lack access to dental care since there are no oral health care providers in these areas.[65] Northern towns are unable to attract new dentists because "the red tape scares them away...even $15 procedures must be pre-approved."[66] Even the dentists who are providing services in Aboriginal communities are opting out of the NIHB program because of the lengthy administrative requirements.[67,68,69] A First Nations and Inuit Health Branch report of June 17, 2002 on a new Oral Health Plan also shows that providers and clients find program coverage and services confusing with substantial administrative requirements.[70]

But human resources and administrative problems are not the only problems plaguing the program. Its mandate and an external cost-benefit evaluation of the program also reveal weaknesses. The mandate—to provide restorative treatment—does not provide adequate support for long-term preventative oral health[71] and a cost-benefit analysis shows little value is obtained for the expenditures.[72] A long-term oral health mandate that includes oral health prevention can result in program financial savings since "children with extensive dental disease have extensive dental disease as adults."[73]

The one redeeming aspect of this program is its use of dental therapists who provide primary oral health care services in the territories and First Nations communities in all provinces but Ontario and Quebec. The Canadian Association of Public Health Dentistry reports using dental therapists brings effectiveness and efficiencies to the program.[74]

Commissioner Romanow's 2002 report, *Building on Values: The Future of Health Care in Canada,* attempts to address some of these access issues. It describes a method for financing, organizing, and delivering health care to Aboriginal peoples that involves creating Aboriginal Health Partnerships.[75] These partnerships will have the following features:

- consolidated funds provided by the federal, provincial, and territorial governments and Aboriginal organizations with framework agreements negotiated on a provincial or territorial basis;
- health care services restructured around prevention;
- services adapted to the social and cultural realities of different Aboriginal communities.

CDHA recommends that

- the federal government implement Commissioner Romanow's recommendation for an Aboriginal Health Partnership;
- the federal government increase funding for both the Community Health and NIHB programs of the First Nations and Inuit Health Branch of Health Canada, so that
  - there is an interprofessional approach to health and wellness that involves an oral health component;
  - additional oral disease prevention and oral health promotion programs can be created and carried out by dental hygienists, including mobile dental hygienists serving remote areas;
  - a comprehensive national preventive initiative can be carried out to address dental disease in young Aboriginal children;
  - the NIHB program can be streamlined to reduce administrative requirements;
  - adequate basic oral health programs and services can be provided including necessary restoration, maintenance, prevention, and health promotion.

Persons with physical, developmental, and psychiatric disabilities

The oral health of individuals with special health care needs may be affected negatively by required medications, therapies, or special diets; or by their difficulty with cleaning teeth thoroughly on a daily basis. For example, children and adolescents with developmental disabilities are at high risk for enamel irregularities, gum infections, delays in tooth eruption, moderate-to-severe malocclusion, and oral infection.[76] Individuals with Down syndrome also have increased oral health problems. Pilcher confirms this in a study with children and adolescents with Down syndrome, indicating they have a high incidence of periodontal disease, xerostomia, fissuring of the tongue and lips, and malocclusion.[77] Finally, children and adolescents with cleft lip/palate are at increased risk for dental caries, gingivitis,[78] cross bite, and crowding.[79]

Although persons with disabilities may have higher oral health needs than the general population, results of the 1994–1995 United States National Health Interview Survey (NHIS) indicate that oral health care is the most prevalent unmet health need for children with disabilities.[80] A survey of 774 case managers serving 18,333 developmentally disabled clients indicates the following reasons for clients' inability to obtain oral health care:[81]

- 47 per cent were refused treatment in the last 12 months;
- 72 per cent indicated that there were not enough dentists in the community who were willing to treat people with disabilities.

Other studies in the United States report similar oral health access problems for persons with developmental disabilities. Some of the issues include[82]

- dentists' unwillingness to treat disabled persons because of inadequate training, time involvement, and increased malpractice liability if sedation is used;
- a lack of dentists who accept Medicaid reimbursement;
- behavioural problems;
- families' transportation problems.

In addition, the California Dental Access Project report points out the negative impact that private practice has on access for persons with developmental disabilities. Most dentists practise in private settings. This results in a lack of connection to general or specialty medical expertise and support, as well as a lack of connection with community organizations and services for people with disabilities.[83] Improved connections between health professionals and community organizations may make it easier for oral health care professionals to provide appropriate services for persons with developmental disabilities.

Persons with physical and developmental disabilities[84] encounter physical barriers that prevent their obtaining oral health services at private clinics or offices: inaccessible offices, an inability to travel, or difficulty obtaining public transportation. Persons with psychiatric disabilities likely find many of the same access problems as persons with developmental or physical disabilities.

Since most dental hygiene services are portable and can be delivered on-site, non-traditional delivery models such as mobile dental hygiene services can address the access issue for many people with disabilities. A program in the United States has devised a way to bring basic dental care to people with disabilities in the community. In Missouri Elks, a 30-year-old mobile oral health program for children with special health care needs is based on a public/private partnership involving a trust, a department of health, and a medical centre.[85] Basic dental care is free to medically and financially eligible clients and is provided in three vans that drive to designated locations. In Canada, the York Region Dental Hygienists' Society in Toronto presented another solution. Since 1999, volunteers have made domiciliary visits to provide oral health services for clients with amyotrophic lateral sclerosis (ALS).

The literature reviewed for this paper shows a predominance of information from the United States and suggests that there may be a need for increased Canadian oral health and disability research.

CDHA recommends that

- provincial governments provide
  - funding for oral health services for persons with disabilities with LSS, including basic oral health programs and services, including necessary restoration, maintenance, prevention, and health promotion;
  - public oral health care services in collaboration with other health services.

Multicultural issues

Ethnicity influences oral health and access to oral health care. In Ontario, Aboriginal children and children born outside of Canada have fewer healthy teeth, higher decayed/missing/filled teeth (DMFT) scores, and more untreated decay than other children.[86] Statistics in Vancouver indicate that 64 per cent of Vietnamese children over the age of 18 months had nursing bottle decay, compared with only 5 per cent in the general population.[87]

Two important health care reports from 2002 highlight the importance of multicultural issues in health care. In Commissioner Romanow's report, Recommendation 29 states: "Governments, regional health authorities, and health care providers should continue their efforts to develop programs and services that recognize the different health care needs of men and women, visible minorities, people with disabilities, and new Canadians.[88] Senator Kirby's final report also recommends strategies for increasing the supply of health care professionals from under-represented multicultural groups, such as Canada's Aboriginal peoples, and in underserviced regions, particularly the rural and remote areas of the country. [89]

The importance of multicultural representation within health care professions is underscored by a study showing that minority oral health professionals, including dentists and physicians, are more likely to serve multicultural communities than non-minority health professionals.[90,91] The under-representation of multicultural health care providers is substantiated by a study in the United States showing that the racial and ethnic diversity of dental professionals is not consistent with the general population.[92] The researchers argue that this restricts access to care for many citizens who would feel more comfortable receiving service from providers with a similar cultural background. The supply of dental hygienists and dentists from multicultural backgrounds is determined by the number of multicultural individuals graduating from educational institutions; therefore, there may be a role to play for educational institutions in this issue.

In Aboriginal communities in northern Canada, there is not only a lack of cultural representation within health care providers; non-Aboriginal health care providers also lack an understanding of cultural issues. Commissioner Romanow proposes a solution to this

issue in his final report when he identifies a need to recruit new Aboriginal health care providers and increase training in cultural issues for non-Aboriginal health care providers.[93]

CDHA recommends that

- governments and health care providers continue their efforts to develop programs and services that recognize the different health care needs of seniors, Aboriginal communities, persons with disabilities, low-income citizens, and multicultural communities;
- dental hygiene education institutions
  - develop admission policies that take into account an awareness of demographic patterns and cultural needs of various communities;
  - include more educational components that raise awareness of linguistic, cultural, and social differences.

2. Public programs

This section deals with oral health financing through the federal, provincial, and territorial governments. Although some municipal governments also provide public oral health programs, no comprehensive review of these programs is available.

Federal programs

The federal government provides funding for oral health programs in areas that include Health Canada's Non-Insured Health Benefits (NIHB) program for Aboriginal peoples, Citizenship and Immigration Canada, Correctional Service Canada, Royal Canadian Mounted Police, Veterans Affairs Canada, and Canadian Forces.

Provincial and territorial programs

Provincial and territorial public oral health programs are listed on the web site of the Canadian Association of Public Health Dentistry (CAPHD) at <www.caphd-acsdp.org/programs.html>.[94] This list shows that public oral health care coverage at the provincial/territorial level varies greatly and is neither comprehensive nor universal. All 10 provinces and the Northwest Territories provide some form of oral health coverage for social assistance recipients; Nunavut and the Yukon do not. It should be noted, however, that the majority of the population in Nunavut and the Yukon is eligible for oral health services through the Non-Insured Health Benefits program for First Nations and Inuit peoples. Across Canada, limitations on services for social assistance recipients vary. Some areas provide emergency coverage (relief of pain or infection); others, basic coverage (restorative and preventive); and a limited few, comprehensive coverage (restorative, preventive, and prosthetic). All provinces and territories with the exception of British Columbia, Manitoba, and New Brunswick have special programs for children. Only Alberta, British Columbia, New Brunswick, and Ontario have programs specifically for persons with disabilities. Alberta and the Northwest Territories offer programs for seniors

(with a maximum income requirement). Prince Edward Island is the only province or territory with a long-term care facility program. Finally, school-based programs are provided in the Northwest Territories, Nova Scotia, Nunavut, Ontario, Prince Edward Island, Quebec, and northern Saskatchewan with most of the programs offered only in targeted, high-risk schools.

The CAPHD list of provincial and territorial oral health programs is an important first step in identifying the differences between provinces. But these differences highlight the need for additional research to compare and evaluate programs across Canada.[95] The research should also show the oral health status of citizens of each province or territory and indicate how the public programs address the different needs in the provinces or territories. These differing needs are highlighted in a Saskatchewan study showing that one in five Saskatchewan children has an oral health status below the level found in the Third World.[96] Canadians need to know how their province/territorial government is addressing health issues. In addition, there is a need to document the history and current status of municipal programs since there are signs that municipal public health departments across Canada are divesting themselves of oral health programs.

At a time when there is increased evidence of a link between oral health and overall health, it seems inconsistent to reduce public funding for oral health programs. Part of the problem is caused by the increased pressures for health care dollars in all areas of health that have had a particularly negative impact on public oral health programs. For example, in May 2002, Nova Scotia changed its universal program for children to a payor-of-last-resort program.[97] Ontario also made a similar move. Prior to 1992, social service recipients in Ontario were entitled to basic dental care that consisted of regular checkups and preventive services as well as emergency care. Now the modified program covers only emergency services, defined as "an immediate circumstance where the patient appears in immediate suffering, requires care and immediate appropriate treatment is instituted to correct the problem."[98] Another limitation of this program is that root canal treatment is not covered, only the alternative treatment of pulling the tooth.[99] The decreased funding for public oral health programs may have had an impact on the deployment of dental hygienists. In the CDHA report *Dental Hygiene Practice in Canada 2001*, which compares data over the last 24 years, the proportion of dental hygienists working in public health decreased threefold, from 13 per cent in 1977 to 3.8 per cent in 2001.[100]

The health care debate in Canada is polarized: there are those who assert that the federal budget cannot sustain an increase in funding for the health care system, and those who call for increased funding. According to a survey in 2000 of 1,200 Canadians and 800 health care providers and managers, Canadians are troubled by the range of care covered under the public system and the funding of the system.[101] A close examination of the range of care provided by the public system shows there is limited funding for oral health services. In fact, oral health care statistics show that the burden of oral health care expenses falls on individual Canadians. Governments are responsible for only 15.27 per cent of these expenses[102] and in fact, government contributions have decreased by 1.7 per cent from 1975 to 1998.[103] This shows we *do* have reason to be concerned that the government is not taking adequate responsibility for oral health expenses and access to oral health services.

There are concerns with public oral health not only at the macro level, but also at the micro level. Individual Canadians are having difficulty obtaining services at private offices where the majority of public oral health money is spent. The Ontario Dental Association confirms that dentists are discouraged from providing services to clients who have public coverage, due to the time-consuming administrative requirements and low reimbursement levels.[104] These problems were confirmed in a 1994 study at the West Central Community Health Centres in Toronto that showed that 23 per cent of family benefits clients and 20 per cent of general welfare clients were refused dental treatment by a dentist.[105]

CDHA recommends that

- federal/provincial/territorial governments conduct surveillance research on
  - Canadians' oral health status, which allows a comparison based on geographical area, gender, age, income, and multicultural status;
  - public oral health programs and their ability to meet the need and demand for preventive oral health care;
- federal/provincial/territorial governments
  - use the above research when prioritizing funding and developing effective, relevant oral health care programs;
  - expand public health promotion and disease prevention programs in schools, community health centres, and LTCFs;
  - streamline the administrative requirements in public programs to ensure easy filing of claims and better align the fee payment for oral health services with market rates.

3. System Issues

Legislation, health human resources planning, and an alternative oral health care delivery system

Human resources have become a significant concern for health care managers and policy-makers. Some say it is their biggest challenge over the next few years; others label it a crisis.[106] Since approximately three-quarters of health care expenditures are for wages, salaries, and fees, the efficient use of health personnel is important to ensure a cost-effective delivery system. Some health economists in Canada suggest that human resource substitution, which can lead to cost efficiencies, is a fundamental aspect of health human resource planning.[107] However, except for a limited use of nurse practitioners, the introduction of midwives, and the substitution of dentists by denturists, human resource substitution has not been seriously attempted despite considerable evidence of its cost-saving potential.[108]

Senator Kirby's 2001 report on health care recommends a spectrum approach to human resources, an approach similar to human resource substitution. This spectrum approach rejects a hierarchical approach to human resources and is based on the idea of valuing the particular strengths of each profession. This report points out that "Canadians have been

led to believe that they must see a doctor, when they could well consult a nurse or a nurse practitioner.…"[109] In a similar vein, Senator Wilbert Keon—chief executive officer of the University of Ottawa Heart Institute—once said that we have too many doctors doing what nurses should be doing; we have too many nurses doing what nursing assistants should be doing; we have too many technicians doing what clerks and administrators should be doing.[110]

Wilbert Keon's statement, exemplifying the spectrum or human resource substitution model, can also be applied to the field of oral health. CDHA maintains that Canadians have been led to believe that they must see a dentist when they could consult a dental hygienist. As a result, too many dentists are doing what dental hygienists should be doing. In 2000, the ratio of dental hygienists to dentists per 100,000 population was 48:56.[111] If the ratio of dental hygienists to dentists increased, the access to preventive oral health care would improve. Manga in the *Political Economy of Dental Hygiene in Canada* also calls for an increase in the ratio of dental hygienists to dentists in order to improve access and efficiency in the oral health system. He calls for an optimal allied-dental-personnel-to-dentist of 5:1 to 10:1.[112]

The Employer Committee on Health Care – Ontario (ECHCO) is also interested in new models for the delivery of dental care to employees. Due to cost increases in the order of 21 per cent between 1992 and 1993, ECHCO sent a letter to the Ontario Dental Association indicating that ECHCO intended to pursue new models for the delivery of dental care to employees.[113] ECHCO suggests that these new models may include reimbursement schedules determined by insurers and/or employers as well as capitation plans. Dentists paid under a capitation plan would receive a set amount depending on the number of clients they serve. On the one hand, capitation plans may encourage dental offices to emphasize preventive oral health since payment is not based on the number or type of services rendered. However, some capitation plans incorporate elements that prevent users from accessing the provider of their choice.

Unnecessary, restrictive provincial dental hygiene legislation that requires supervision, an order, authorization, or directions from dentists makes it more difficult to bring about change or to reduce barriers to oral health care delivery. For example, the British Columbia legislation makes it mandatory that a dentist must have examined the client prior to or during the client's initial appointment with a dental hygienist; and at the time of any subsequent appointment, the client must have been examined by a dentist within the previous 365 days. The Saskatchewan legislation requires dental hygienists to be employed by or to practise under contract with (a) an employer who employs or has established a formal referral or consultation process with a dentist or (b) a dentist. In Ontario, dental hygienists must have an order from a dentist to perform a controlled act of scaling and root planing, including curettage of the surrounding tissue.

These unwarranted limitations mean the majority of dental hygienists must work alongside dentists in dental clinics or offices. Many dentists argue that this mode of service delivery should not change since patient safety is compromised in unsupervised settings. However, Manga documents numerous studies showing this is not the case.[114] Although existing

dental hygiene education is comprehensive and sufficient to allow dental hygienists to provide dental hygiene care safely and competently in alternative practice settings, in some areas dental hygienists are forced to maintain traditional delivery systems and are unable to practise their profession in communities without a dentist.

Support in principle for removal of restrictive provincial dental hygiene legislation is found in a report by the Commission on the Future of Health Care in Canada. This report recommends that governments and health care employers take a role in changing legislation and employment agreements to better match health care practitioners' jobs to their training.[115] The recommendation argues that allowing more people to perform a wider range of services will improve access to health care; help solve staff shortages, especially in underserved areas; and also increase the system's cost-effectiveness. Manga also supports this concept when he emphasizes that changing legislation to allow for direct access to dental hygiene care is "unquestionably the single best reform of the oral health care system throughout Canada."[116]

Provincial and territorial dental directors also agree in principle with this type of legislative change. They indicate that the provincial/territorial legislation pertaining to dental hygienists is written with only the traditional dental practice setting in mind.[117] This leads to difficulties in implementing dental hygiene programs and services in non-traditional practice settings, such as long-term care facilities, community health centres, schools, community clinics, and public health settings. Although legislation is a provincial/territorial responsibility, the dental directors call for leadership from the federal government to ensure that the legislation is reviewed, especially as it pertains to improving access to care through alternative, non-traditional delivery systems.

The removal of restrictive legislation will have a number of positive impacts. The oral health care delivery system could be re-organized to allow the public to consult the most appropriate oral health care professional, be it a dentist, dental hygienist, or denturist. It would also allow the public to access dental hygienists directly without first having to see a dentist. The public could then obtain dental hygienists' services in non-traditional locations outside of dentists' offices or a clinic. It would allow a larger number of people to obtain access to services in a larger number of settings—increased choice for consumers and service in convenient locations. One of the most significant advantages would be increased opportunities for mobile dental hygiene services in remote and rural areas and in residential facilities. Mobile oral health services appear to be well established in California. There, the majority of staff of mobile oral health programs rely on combination funding, including grants or contracts with government agencies, private foundations, and service clubs as well as donations from individuals, alumni of dental schools, and larger institutions such as dental schools.[118]

Another significant advantage to removing restrictive legislation is that dental hygiene services could be integrated into general health services. This integration is currently limited as about 85 per cent of dental hygienists work in traditional dentists' private practices, with another 8 per cent to 10 per cent in public health, and about 3 per cent in

teaching and administration.[119] A number of public health experts advocate this integration since it facilitates a comprehensive approach to health.[120]

One of the strongest arguments for integrating oral health services into general health services is recent research that indicates a link between oral health and general health and that suggests gains could be made in the health delivery system by integrating these two areas. Substantial evidence for this link is found in the Surgeon General's report[121] and a number of other studies also support this link. A 1996 study[122] showed that if a pregnant woman has gingivitis, she is seven times more likely to have a premature, low-birth-weight baby (PLBW). Another study in 1998[123] showed a correlation between maternal periodontal diseased sites and low-birth-weight babies. Lopez et al. also conducted randomized controlled clinical trials and found that periodontal therapy significantly reduces the rate of PLBW babies.[124] There is also a possible link between periodontal disease and major health problems including cardiovascular disease, infective endocarditis, stroke,[125] respiratory diseases (such as aspiration pneumonia),[126,127] osteoporosis, and diabetes.[128] In addition, dental plaque is a possible reservoir for *Helicobacter pylori*, a causative micro-organism of chronic type B gastritis and peptic ulcer disease.[129]

The delivery of oral health in the existing private practice model has other drawbacks as well. It relies on the individual patient to have resources, transportation, initiative, and an understanding of the importance of oral health. Unfortunately, many individuals from the hard-to-serve population do not have this combination of factors that allows them to maintain their own and their family's oral health properly.[130] A more efficient system would bring the oral health service to the high-need population or would involve a population-based strategy, rather than focusing on service delivery to individuals. The integration of oral health services into general health services may be considered a population-based strategy that will provide important solutions to the access problem for the underserved.

Some population-based strategies that would benefit the hard-to-serve include offering oral health services in primary health care settings, community health centres, outreach clinics, mobile oral health units, home care, and LTCFs. Other examples include dental hygienists providing a provincial dental sealant program in schools and hospital-based oral health clinics. An illustration of the latter program is the Children's Hospital of Eastern Ontario dental clinic for hard-to-serve and medically compromised children, including those who have developmental disabilities or cancer. Dental hygiene programs can also be incorporated into existing community health centres, similar to the program offered at the West Central Community Health Centres in Toronto.[131] These options would alleviate the unmet oral health needs of various socio-economic and demographic population groups in Canada, including isolated individuals, the frail elderly, persons with disabilities, the difficult to serve, and those with special needs.

Commissioner Romanow in his final 2002 report makes three recommendations[132] that could facilitate the integration of oral health promotion and disease prevention services into general health services. First, he recommends that the Canadian Population Health Initiative, currently managed by the Canadian Institute for Health Information, help to

assess health promotion initiatives and measure the benefits of integrating prevention with primary health care. Second, he calls for a new Centre for Health Innovation that would focus on health promotion. Third, he recommends a Primary Health Care Transfer that would fast-track primary health care reform; it would be used in part to expand health promotion and prevention programs.

Educational institutions also have a role to play in facilitating the integration of oral health services into general health services. Commissioner Romanow notes that one of the best ways of ensuring that health care providers work effectively in integrated settings is to begin with their education and training.[133] There is at present a growing literature on interprofessional learning and health care delivery for health professionals and educational institutions are moving to explore this area. For example, at Dalhousie University, there is a Tri-Faculty Inter-Professional Academic Advisory Committee that has undertaken a major initiative in interprofessional learning among three faculties including medicine, dentistry, and health professions.[134] This type of initiative can raise awareness about the link between oral health and general health and can enhance students' abilities to work in interprofessional teams.

CDHA recommends that

- the federal government establish a nationwide oral health care human resources strategy that
  - provides guidance for the provinces/territories and ensures that they eliminate legislation that prohibits or inhibits the direct access to dental hygienists by the public and ensures that they allow access to care through alternative, non-traditional delivery systems;
  - addresses the need for alternative practice settings, equal distribution of oral health care professionals across the country, and a workforce that is representative of different ethnic populations and native languages;
- the federal government establish a plan for integrating oral health into general health that
  - ensures the Canadian Institute for Health Information (CIHI), through the Canadian Population Health Initiative, assesses oral health promotion initiatives and measures the benefits of integrating oral health prevention with primary health care;
  - creates a new Centre for Health Innovation focusing on health promotion (including oral health promotion);
  - ensures the provinces use the Health Transition Fund for Primary Care in part for expanding oral health promotion and disease prevention programs;
- provincial/territorial governments eliminate legislation that prohibits or inhibits direct access to dental hygienists by the public;
- federal/provincial/territorial governments
  - incorporate dental hygiene services into primary health care settings and general health services and programs;
  - develop population-based strategies to address the oral health needs of the underserved population;

  - provide increased public education on the importance of oral health and its positive effects on general health;
  - build capacity at the community level in order to allow the public to contribute to their well-being and oral health;
- dental hygiene education institutions develop more opportunities for dental hygiene students to gain knowledge of and experience with interdisciplinary teams;
- health professional educational institutions integrate oral health promotion and disease prevention into the curriculum for all health professions.

Private insurance coverage

The following is a collection of data on private insurance coverage from various sources:

Statistics Canada[135]

- 54 per cent of those aged 15 to 24, 64 per cent of those aged 35 to 44, and 21 per cent of those 65-or-older had dental insurance.
- While 22 per cent of the non-insured population cited cost as a factor for not seeing a dentist, just 6 per cent of the insured group gave cost as the reason.
- 60 per cent of those working had dental insurance compared with 41 per cent of those not working.
- 70 per cent of those with the highest income and 23 per cent of those with the lowest income had dental insurance.
- Those with higher levels of education had higher rates of dental insurance coverage.
- The lowest rates for dental care utilization were found among low-income persons without insurance.

Canadian Institute of Health Information[136]

- Among the lowest 40 per cent of the income groups, only 25 per cent had any kind of dental insurance and only 45 per cent visited a dentist in 1996–1997. In the high-income group, 73 per cent had dental insurance coverage and 81 per cent reported visiting a dentist in that year.

The Political Economy of Dental Hygiene in Canada (Manga 2002)[137]

- In Quebec, 40 per cent of the population has dental coverage; in Ontario, 63 per cent has coverage.

U.S. 1989 NHIS[138] and *the Medical Expenditure Panel Survey (MEPS)*[139,140]

- 70 per cent of people with dental insurance had at least one dental visit during 1989; only 50 per cent of those without dental insurance reported at least one visit during the same period.
- Private insurance payments accounted for 43 per cent of all dental expenditures ($18 billion).
- Non-Caucasians with LSS and the elderly were less likely to have dental coverage.

- Those with dental coverage had a mean total expenditure that was almost double those without coverage (US$417.20 versus US$298.70, respectively).
- People at a low-income level made fewer visits to the dentist than did people at a higher income level, regardless of insurance coverage.

These data indicate that private dental insurance and income level have a profound effect on oral health care use and support a call for employers to adopt health insurance plans. This issue is of particular importance to women as they are less likely than men to have supplementary health benefits.[141] Also, a lack of insurance coverage has a greater negative impact on women than men because women generally have lower incomes than men.[142] An increase in employer health plans may be limited by the fact that most of the larger unions are already covered.[143] A further limitation results from a trend toward increased part-time, temporary, and self-employment, which could also threaten existing coverage.[144]

The data also show that income, employment, education, and middle age are associated with private dental insurance. Canadians access private dental insurance primarily through employment-based plans. Individuals without private dental insurance are generally those employed with small businesses, part-time workers, the unemployed, and retired seniors. For those without coverage through employment, the options are limited since there are few plans, charging high premiums and providing limited benefits.[145] These data support the need for public oral health coverage for the working poor and private employer-based dental plans for retired employees.

The fact that people with low-income levels did not access oral health care even when they had insurance coverage suggests that, for LSS individuals and families, there are other significant factors involved in the decision whether or not to obtain oral health services. More research is needed to determine these factors. It is possible that LSS individuals are deterred from obtaining oral health services due to unaffordable co-payments or there could be other determinants of health issues that are at play here.

Finally, there is a dearth of Canadian oral health data compared with data in the United States. This situation highlights the need for the federal, provincial, and territorial governments to be more involved in surveillance research.

CDHA recommends that

- employers recognize the value of providing oral health insurance coverage for employees and retired employees;
- large employers consider the feasibility of providing on-site dental hygiene clinics for disease prevention, health promotion, screening, and referral to other health professionals as needed.

Internal policies of employers, insurance companies, and government programs

Access to care is also limited by internal policies of employers and insurance companies that prevent direct payment to dental hygienists for their services. Over the past several years, CDHA has worked on two projects that will have a positive impact on this issue including work with the Canadian Life and Health Insurance Association (CLHIA) to develop a National Dental Hygiene Care Claim Form and a CDHA National List of Dental Hygiene Services and System of Service Coding. The CDHA has also developed positive relationships with several insurance companies, which recognize that some provincial legislation now allows dental hygienists to practise in alternative settings. As a result, these companies have adjusted their plans to allow payment for services performed by a dental hygienist.

Although there has been some progress, the majority of insurance companies still do not provide direct reimbursement to dental hygienists. As a result, even in British Columbia where dental hygienists legally practise unsupervised and in their own practice, insurance companies still require the signature and billing number of a dentist before any payment is made. This is also required by many government-sponsored programs and for government employee programs. Therefore, CDHA's work in this area continues.

On the one hand, dental hygienists in alternative practice settings are willing and keen to provide services to social assistance recipients who have difficulty finding a dentist to treat them. On the other hand, publicly sponsored programs and government employee benefits programs will not recognize dental hygienists in alternative practice settings. In order to increase public access, dental hygienists must be able to receive payment directly for their services regardless of the employment arrangement—a dental hygienist working under contract, employed by a dentist, or working in his or her private business.

CDHA recommends that

- the federal government take a leadership role by directing the federal government employee benefits plans to reimburse dental hygienists directly for their services;
- the federal, provincial, and territorial governments change public oral health program internal policies in order to allow reimbursement of dental hygienists in alternative practice settings;
- private health insurance plans update dental plans to allow payment directly to dental hygienist for their services.

CONCLUSIONS

Oral health is an important part of overall health status and it is therefore critical that all Canadians have adequate access to oral health services. The solutions presented in this paper recognize that improving access involves more than piecemeal improvements in one or two areas. There is a need to move beyond this to create a public oral health system that includes a comprehensive plan for human resources, legislation, research, and employers' health plans. This oral health system must address the unequal access of individuals in marginalized subgroups in society. The oral health system must be recognized as an integral component of the general health system. This vision is based on the needs of the public, supports the recommendations in the significant health reports of Commissioner Romanow and Senator Kirby, and will allow more effective use of resources and better outcomes.

Dental hygienists—through work in their individual practices and with other health care professionals and through their professional organizations—have a vital role to play in spearheading initiatives that will create a comprehensive system that resolves national oral health access issues. CDHA is committed to promoting integrated action by governments, the education system, professional dental hygiene organizations, dental hygiene regulatory authorities, and the public to move toward the creation of an oral health care system that improves access to oral health.

CDHA POSITION STATEMENTS

The Canadian Dental Hygienists Association's (CDHA) Board of Directors approved the following position statements on March 22, 2003.

It is the position of the CDHA that oral health care—a significant component of overall health—is the right of all Canadians. Lack of access to oral health care is a critical issue and dental hygienists are vital in order to solve this problem and ensure high quality, accessible oral health care for all Canadians. CDHA promotes access to affordable oral health care through alternative practice settings and by working in cooperation with governments, health agencies, public interest groups, and other health professions.

LOW-INCOME CANADIANS

CDHA recommends that

- provincial governments provide across Canada basic oral health programs and services, including necessary restoration, maintenance, prevention and health promotion services, for LSS individuals and their families including the working poor; these programs and services should take into account the determinants of oral health and include clinical service, community-based oral health promotion and disease prevention programs, and be based on a comprehensive plan that includes programs in schools and for new moms and immigrants.

SENIORS

CDHA recommends that

- provincial governments
  - provide funding for oral health services in long term care facilities (LTCFs);
  - revise legislation to allow dental hygienists to provide dental hygiene services in LTCFs;
  - implement LTCF legislation requiring the development and implementation of oral health care plans for residents that include a daily oral care strategy;
- long-term care facilities
  - provide educational oral health sessions for staff and clients' families;
  - establish oral health care policies and protocols;
  - ensure that health care/nurses aides provide daily basic oral hygiene care to residents who are unable to manage their own care.

RURAL, NORTHERN, AND ABORIGINAL COMMUNITIES

CDHA recommends that

- the federal government implement Commissioner Romanow's recommendation for an Aboriginal Health Partnership;

- the federal government increase funding for both the Community Health and NIHB programs of the First Nations and Inuit Health Branch of Health Canada, so that
  - there is an interprofessional approach to health and wellness that involves an oral health component;
  - additional oral disease prevention and oral health promotion programs can be created and carried out by dental hygienists, including mobile dental hygienists serving remote areas;
  - a comprehensive national preventive initiative can be carried out to address dental disease in young Aboriginal children;
  - the NIHB program can be streamlined to reduce administrative requirements;
  - adequate basic oral health programs and services can be provided including necessary restoration, maintenance, prevention, and health promotion.

PERSONS WITH PHYSICAL, DEVELOPMENTAL, AND PSYCHIATRIC DISABILITIES

CDHA recommends that

- provincial governments provide
  - funding for oral health services for persons with disabilities with LSS, including basic oral health programs and services, including necessary restoration, maintenance, prevention, and health promotion;
  - public oral health care services in collaboration with other health services.

MULTICULTURAL ISSUES

CDHA recommends that

- governments and health care providers continue their efforts to develop programs and services that recognize the different health care needs of seniors, Aboriginal communities, persons with disabilities, low-income citizens, and multicultural communities;
- dental hygiene education institutions
  - develop admission policies that take into account an awareness of demographic patterns and cultural needs of various communities;
  - include more educational components that raise awareness of linguistic, cultural, and social differences.

PUBLIC PROGRAMS

CDHA recommends that

- federal/provincial/territorial governments conduct surveillance research on
  - Canadians' oral health status, which allows a comparison based on geographical area, gender, age, income, and multicultural status;

  - public oral health programs and their ability to meet the need and demand for preventive oral health care;
- federal/provincial/territorial governments
  - use the above research when prioritizing funding and developing effective, relevant oral health care programs;
  - expand public health promotion and disease prevention programs in schools, community health centres, and LTCFs;
  - streamline the administrative requirements in public programs to ensure easy filing of claims and better align the fee payment for oral health services with market rates.

LEGISLATION, HEALTH HUMAN RESOURCES PLANNING, AND AN ALTERNATIVE ORAL HEALTH CARE DELIVERY SYSTEM

CDHA recommends that

- the federal government establish a nationwide oral health care human resources strategy that
  - provides guidance for the provinces/territories and ensures that they eliminate legislation that prohibits or inhibits the direct access to dental hygienists by the public and ensures that they allow access to care through alternative, non-traditional delivery systems;
  - addresses the need for alternative practice settings, equal distribution of oral health care professionals across the country, and a workforce that is representative of different ethnic populations and native languages;
- the federal government establish a plan for integrating oral health into general health that
  - ensures the Canadian Institute for Health Information (CIHI), through the Canadian Population Health Initiative, assesses oral health promotion initiatives and measures the benefits of integrating oral health prevention with primary health care;
  - creates a new Centre for Health Innovation focusing on health promotion (including oral health promotion);
  - ensures the provinces use the Health Transition Fund for Primary Care in part for expanding oral health promotion and disease prevention programs;
- provincial/territorial governments eliminate legislation that prohibits or inhibits direct access to dental hygienists by the public;
- federal/provincial/territorial governments
  - incorporate dental hygiene services into primary health care settings and general health services and programs;
  - develop population-based strategies to address the oral health needs of the underserved population;
  - provide increased public education on the importance of oral health and its positive effects on general health;

  - build capacity at the community level in order to allow the public to contribute to their well-being and oral health;
- dental hygiene education institutions develop more opportunities for dental hygiene students to gain knowledge of and experience with interdisciplinary teams;
- health professional educational institutions integrate oral health promotion and disease prevention into the curriculum for all health professions.

PRIVATE INSURANCE COVERAGE

CDHA recommends that

- employers recognize the value of providing oral health insurance coverage for employees and retired employees;
- large employers consider the feasibility of providing on-site dental hygiene clinics for disease prevention, health promotion, screening, and referral to other health professionals as needed.

INTERNAL POLICIES OF EMPLOYERS, INSURANCE COMPANIES, AND GOVERNMENT PROGRAMS

CDHA recommends that

- the federal government take a leadership role by directing the federal government employee benefits plans to reimburse dental hygienists directly for their services;
- the federal, provincial, and territorial governments change public oral health program internal policies in order to allow reimbursement of dental hygienists in alternative practice settings;
- private health insurance plans update dental plans to allow payment directly to dental hygienists for their services.

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