

Policy Paper

Canadian Dental Association | Ottawa, ON

Federal Investments in Dental Care

DRAFT – FOR FEEDBACK

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# Background

## History of Publicly Funded Dental Care in Canada

Dentistry is one of the oldest professions in the world and can be cited as far back as 7000 B.C. with the Indus Valley Civilization. In Canada, it really started taking its modern form during the mid-19th century. During this time, professional organizations were starting to form, as well as professional legislation in some parts of the country. As well, professional education was formalizing, and some scientific dental literature was starting to be produced.

At this time, much like today, most dentists practiced in private settings and would run their own private, fee-for-service dental practices. During this time, dental care was not accessible for many Canadians, as there was no public infrastructure for it. Due to this, in the late 19th and early 20th centuries many organizations, including the Canadian Dental Association (formed in 1902), Ontario Dental Association (ODA) and Nova Scotia Dental Association (NSDA), started calling for legislation that included periodic dental examinations for children, and the inclusion of health education in schools and military camps.

Regarded as a huge milestone for oral health, in the early 1930s Dr. H. Trendley Dean, of the U.S. National Institutes of Health, discovered a link between fluoride and the reduction of dental caries. Following this research, in 1945 Brantford, Ontario became the first city in Canada to intentionally add fluoride to its water. To fully understand the benefits of added fluoride in water, a study was done comparing the prevalence of dental caries in individuals living in Brantford with those living in the neighbouring city Sarnia. Over an 11-year period, Brantford children had a 63% reduction in the severity of caries and a 35% reduction in the prevalence of caries. This study prompted many other municipalities in Canada to adopt community water fluoridation. That said, as of 2017 only 38.7% of Canadians had access to fluoridated water, lagging significantly behind the United States at 73%. This remains one of the single biggest advancements in Canadian public health of the 20th century.

Following new advancements to healthcare and health services in Canada, the Canadian government appointed a Royal Commission on Health Services. The purpose of the Royal Commission was to inquire into and report upon the existing facilities and the future need for health services for the people of Canada and the resources to provide such services, and to recommend such measures, consistent with the constitutional division of legislative powers in Canada, as the Commissioners believe will ensure that the best possible health care is available to all Canadians. The Commission held 67 days of public hearings in all provinces and in the Yukon, visited and studied health care systems in several other countries, received submissions, heard individuals and delegates from 406 organizations (including CDA, NSDA, as well as the dental associations in Alberta, British Columbia, Manitoba, and Prince Edward), and commissioned 26 research studies.

The first volume of the commission’s report was released in June 1964 and recommended that the federal government enter into agreements with the provinces to “introduce and operate comprehensive, universal, provincial programmes of personal health services”. The Commission ultimately did not recommend including dental care as part of the set of publicly financed services.

When Canada’s medicare system was established via the Medical Care Act of 1966, which offered to reimburse, or cost share, one-half of provincial and territorial costs for medical services provided by a doctor outside hospitals, dentistry was left out. There are a few reasons as to why this happened, but the recommendation from the 1964 Royal Commission is a leading factor. Other factors include the increase of community water fluoridization leading to a decline in dental caries, as well as concerns regarding oral health human resources, namely, a lack of dentists in Canada. Nevertheless, around this time, many provinces began to set up publicly-funded dental care initiatives to promote and improve oral health – particularly among children. Notably, in the early 1970s, Saskatchewan set up a school-based program to provide basic dental care to all children. Although this program, and many others, showed positive results, many were later cancelled or scaled back due to shifting government priorities. Given the ad-hoc nature in which these programs had been launched – outside of a broader national approach to healthcare – oral health became an easy target for cost-cutting initiatives.

Today, in Canada, publicly funded dental care continues to be mostly privately provided through dental clinics usually owned and operated by dentists. While there is some public dental coverage in Canada, it varies drastically between provinces/territories. There are major differences between programs, eligibility criteria, and what is covered in each jurisdiction. As healthcare is mostly a provincial and territorial responsibility (with a few exceptions), many provinces continue to put most of their healthcare funds into social assistance programs and public health programs, while leaving public dental programs consistently underfunded.

## The Existing Dental Care Ecosystem – A Blended Model

The private health benefits sector, particularly employer-provided dental benefits, has been and continues to be the backbone of dental care financing in Canada. Unlike medical care, which is almost exclusively publicly financed in Canada, dental care services in Canada generally fall outside the scope of provincial/territorial universal health insurance plans and are paid for through private insurance or out-of-pocket payments. About 95% of all dental care services are financed through private sources, and over 55% of all dental services in Canada are financed by private dental insurance. In fact, Canada is at the top of OECD countries in terms of private health insurance being the largest component of the source of funding for dental services for the population. The bulk of private insurance is comprised of employer-provided benefits, approximately half of Canadians have access to employer-provided dental insurance.

In 2021, the health insurance sector paid a record $30.4 billion in supplementary health for 27 million Canadians, in claims for health, drugs and dental care. Of that it is estimated that $9.5 billion (32%) was for dental services. Canadians highly value their workplace dental benefits, the majority of employees consider basic dental services to be a most valued benefit, and for many employees not having an employer benefit plan they are satisfied with would result in them looking for another job. Canadians with benefits also enjoy the flexibility in choice of dentists, minimal wait times and high-quality dental care with few limitations. Studies have also demonstrated that there is an association between having dental insurance and the utilization of dental care, an important component of improved oral health outcomes. Policy instruments that could potentially impact workplace dental benefits to any extent must be carefully considered as they risk having significant and consequential impacts throughout the employment sector.

A recent poll of Canadians has indicated that the majority (78%) support the federal investments in dental care, however support falls in half to (39%) when the idea that it might impact existing employer benefits is introduced. Also, most (70%) Canadians with employer benefits would be unable to afford dental care or not easily afford if they lost their employer dental benefits.

There has been some loss of dental benefits through the pandemic, where up to ten percent of Canadians have worse dental benefits coverage now than before the pandemic. The fact that three quarters of Canadians have been consulting dental professionals on an annual basis, amongst the highest annual utilization rates in the world, is largely linked to the unique, high functioning and efficient private dental insurance sector that has served the majority of working Canadians very well for decades.

Clearly, many Canadians without private dental insurance face barriers to dental care, as a recent Canadian Community Health Survey found (one-in-five Canadians avoided going to a dentist because of cost). Another challenge is the growing demographic of Canadians aged 65 and over, a much lower proportion who have private dental insurance after retirement. According to Statistics Canada projections, by 2030 close to one-quarter of the population could be aged 65 and older, a large increase from 19 percent in 2022 and 14 percent in 2010, and according to the latest census figures, Canada's working-age population is also older than it has ever been, with more than one in five working adults now nearing retirement, and this group now makes up a larger share of the Canadian population than those aged 15 to 24. In the context of the current challenges of the public health care system, a good oral health care delivery system in Canada is a blended one that has a good balance between a modernized, efficient and effective private insurance sector as the backbone for the majority of Canadians in combination with a properly designed and adequately financed public sector component for those without private coverage. Even when the federal investments in dental care are fully implemented in 2027, the public share of dental expenditures in Canada will still be far below the private sector expenditures which will continue to account for the majority of financing.

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## State of Oral Health in Canada

Although data on the oral health status of Canadians is scarce, the last national survey with clinical data

on oral health outcomes was carried out in 2007-2008 through the Canadian Health Measures

Survey (CHMS) and it was quite comprehensive. Health Canada published a report on the dental health of Canadians in 2010, based on the findings of the CHMS. The results showed that 75% of Canadians visited a dental clinic annually and 86% did so at least once every 2 years. This is a significant improvement from the early 1970s, when barely half of the population consulted a dentist on an annual basis.

Collectively, with the current oral health care delivery system that has been in place for decades, Canadians have experienced significant decreases in levels of dental decay over the past 40 years. According to Health Canada's Report on the Findings of the Oral Health Component of the CHMS, the percentage of the population that consulted a dentist per year increased from 49.5% to 74.5%, the percentage of children with at least one decayed tooth decreased from 74% to 23.6%, the percentage of adolescents with at least one decayed tooth decreased from 96.6% to 58.8%, the average number of decayed, missing or filled teeth (per child) decreased from 6 to 2.5, and the percentage of adults with no natural teeth decreased from 23.6% to 6.4%, and 34% of Canadians 6-79 years of age and who have teeth had some sort of treatment need identified. That same study found that approximately 2 out of 3 Canadians with natural teeth did not need non-preventive dental treatment, and of the one-third of Canadians who did need treatment only 1 out of 6 said they could not address this need because of financial reasons. Overall, Canadians from lower-income families were found to have outcomes twice as worse as those in higher income families in many measures, and 47% of lower-income Canadians had a need identified, compared to 26% of the higher-income group. For example, twice as many lower income Canadians had cavities that needed a filling compared to Canadians from the higher income group, and 48% of Canadian adults from the lower income group had gingivitis compared to 25% of Canadians with higher incomes.

The Inuit Oral Health Survey (IOHS), conducted in 2008-2009, found that compared to non-Indigenous Canadians, more Inuit reported poor oral health and higher frequency of food avoidance and oral pain. Fewer than half made a visit for dental care, even though very few reported that costs were a factor in avoiding a visit or accepting recommended treatment. The prevalence of dental decay was also very high among young children, with more than 85% of preschoolers having cavities, impacting a mean of 8 baby teeth per child. Counts of decayed, missing or filled permanent teeth increased at every age, and the prevalence and mean DMFT counts exceeded similar counts for non-Indigenous Canadians by a significant margin.

The prevalence of coronal caries was very high among Inuit. More than 85% of preschoolers had dental caries and by adolescence, 98% had been affected and among the oldest adults, the disease had affected the entire population.  Among Inuit adolescents, there were 20.3 extractions per 100 teeth filled, much higher than findings for non-Indigenous adolescents, who had only one tooth extracted per 100 filled.

There are also significant indirect costs associated with the economic burden of oral health disease. The percentage of Canadians who have experienced time-lost from normal activities for oral health reasons is 39.1%, and over 2 million school days are lost annually due to dental visits or dental sick-days. It is estimated that over 4 million working-days for adults are lost annually due to dental visits or dental sick-days.

One key oral health measure for comparative purposes is the decayed, missing and filled teeth (DMFT) index measure. There are not many other well-established and universally accepted measures of oral health particularly for the adult population. The DMFT is usually measured in 12-year-olds and compared internationally. The mean DMFT was 1.02. This measure is better than the OECD average, which was 1.6 in 2006. It also compares favourably with other DMFT scores for 12-year-olds from most OECD countries. In addition to favorable DFMT scores, Canada also ranks favourably in terms of prevalence of severe chronic gum disease (less than 10% of the population aged 15 and over), and incidence of oral and lip cancer (2.5-4.9 per 100,000 people).

## Canada in a Global Context

Bar chart

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Canada has one of the best oral health care delivery systems in the world with care primarily delivered through privately owned and operated dental clinics, but not all Canadians can access dental offices. Alternative models of care or funding in other countries could provide some insight into how to alleviate such inequities.

The organization of oral health care delivery systems and coverage of dental care varies across OECD countries; however the one common element is access to care barriers. Many dental services require substantial cost-sharing in most countries, leading to high out-of-pocket spending. Socioeconomic status is a main determinant for access to dental care, but other factors such as geography, age and comorbidities can also inhibit access and affect outcomes. Coverage in most oral health systems is targeted at treatment and less at preventative oral health care.

At 75% annual population utilization rates, Canada is a leader amongst OECD countries in this metric, even compared to countries with higher levels of publicly funded dental care: Australia (48%), the United States (66% of adults), the United Kingdom (51% of adults in the National Health Service (NHS) within a two-year period) and France (64%). Although Canada’s annual utilization is relatively high, access to dental care by the most vulnerable groups is a major challenge. Outlined below are some features of the oral health care delivery systems of countries, which are based on a wide range of financing models, and strongly influenced by the organization of the health care system.

In Sweden, there are both public and private oral health-care providers. The public dental service (PDS) is operated by all 21 county councils/regions. Public provision is the most pronounced in Sweden where less than half of dentists work in private practices. Most dentists work in public dental clinics or municipal health centres that have a focus on dental care provision for children and adolescents. Approximately 60% of adult patients visit private dental care providers, while 40% visit the PDS. Dental care is free up to the age of 23 and all others receive an annual general dental care allowance to encourage dental check-ups and preventive care. People with certain illness or conditions receive a special dental care subsidy and in addition, most dental care in Sweden is subject to a high-cost protection scheme, which aims to protect patients from very high dental care costs. Even though private out-of-pocket makes up over 60 percent of all sources of financing for dental care, only two percent of the population in the country reports unmet dental care needs. Nonetheless, dental care is not included in the basic benefits package, and it is subject to higher co-payments for adults above the age of 24. A recent government report recommended major reform to the dental care system in 2026 to tackle inequalities in access.

Germany has a statutory health insurance system, predominantly based on social health insurance as a source of financing for over eighty percent of health care and half of dental care. Almost 90% of Germans belong to not-for-profit ‘sick funds’, which must provide a legally sanctioned package of health care. This is based on a cut-off income for employed people, there is a requirement to get this social insurance. Premiums for membership of these funds are shared between employees and employers. The sick funds are “not for profit” organisations, and membership in a sick fund entitles the member to a package of free basic dental care, with advanced treatment options sometimes requiring significant patient copayments. One of the challenges in Germany is that the number of state funds keep decreasing and amalgamating and there is a reduction of services to contain costs. There is also a burden of administration and delays in treatment, people often must wait a year to get care for some procedures. Taking everything into account, it has been reported that Germany’s safety net is resulting in an excessively high cost of Germany’s oral health system, and that further potential for improving both efficacy and efficiency in German dental care persists.

Japan has a universal health and dental system, where all providers are a part of the system and charge on a fee-for-service basis- patients generally pay 30% of co-payment for dental services. There are exceptions for those who are not able to afford it, however generally patients need to pay a significant part of the fee. There is also a variation across Japan of oral health indicators, although in general they have improved over the last decades.  Japan also has a unique and good system with regards to the delivery of oral health care to its rapidly growing senior population, mostly because of its integrated medical/dental approach.

The United Kingdom has a national public dental service that finances over forty percent of dental care, however there is a private sector as well that accounts for about half of all financing for dental care. A recent government report has found there are marked inequalities in oral health in England across all stages of the life course and over different clinical indicators such as dental decay and related quality of life measures. The relative inequalities in the prevalence of dental caries in 5-year-old children in England has increased. There are also inequalities in the availability and utilisation of dental services across ages, gender, geographies, and different social groups.  As well, a growing number of dentists do little or no NHS-funded work, citing problems with the dental contract.

Brazil is the only country in the world with a universal health care system with the aim of guaranteeing delivery of all levels of health care, free of charge, to a population of over 200 million inhabitants by means of a unified health system. As part of this initiative, Brazil implemented a country-wide National Oral Health Policy in 2004 which in effect made the delivery of oral health care universal. Recent findings demonstrate that although there was a reduction in the percentage of individuals who never had access to a dentist appointment, despite the policy implementation, the maintenance of high levels of relative inequality in access to dental consultation continue to be observed. Decreasing cost barriers alone have not resulted in better access to dental care and more comprehensive policies for addressing the wider determinants of inequality are needed.

In the United States, a 2021 National Institutes of Health report reviewed the state of the US oral health care system, achievements made since 2000, and remaining challenges. The percentage of Americans with an annual oral health care visit increased from 2000 through 2018, particularly among children younger than 18 years. Annual visit rates among older adults increased to 66% in 2018, but rates did not change among adults. Differences also persist across race or ethnicity and income groups for all adults older than 18 years: in 2018, less than half of older adults living below 200% of a federal poverty guideline had a dental visit. Access to comprehensive oral health care continues to be one of the biggest challenges within the oral health care system and a key driver of oral health care inequity, as many cannot afford the high deductibles and co-payments of private dental insurance programs. Public insurance coverage has increased since 2000 but remains limited for many low-income, minority, and older adult populations.

In Australia, government does not cover the costs of most dental services in the way it does with other health services. Less than one-fifth of dental care is financed through the government, one-fifth through private insurance and over sixty percent is out of pocket, therefore most dental costs are paid for by patients. However, Medicare does pay for some essential dental services for some children and adults who are eligible. The main aim is to provide dental coverage for children between the age of two and seventeen and is income-testing based. Eligible children are provided with up to $1000 in benefits for basic and preventive dental services. Around one tenth of people who saw a dental professional received public dental care, and one-third who needed to see a dental professional delayed seeing or did not see one- and around 1 in 7 reported that cost was a reason.

# The Treatment Plan - Our Recommendations

## Overview

On March 22, 2022, Prime Minister Justin Trudeau announced the signing of a Confidence and Supply Agreement between the Liberal Party of Canada and the New Democratic Party (NDP), led by Jagmeet Singh. As part of this agreement, “Delivering for Canadians Now,” the federal government committed to, for the first time, broad-based federal action to enhance access to dental care.

Launching a new dental care program for low-income Canadians. Would start with under 12-year-olds in 2022, then expand to under 18-year-olds, seniors and persons living with a disability in 2023, then full implementation by 2025. Program would be restricted to families with an income of less than $90,000 annually, with no co-pays for anyone under $70,000 annually in income.

Dental care in Canada, delivered largely by the network of 16,000 private dental offices and almost exclusively through private funding, enables Canada to have comparatively good oral health outcomes. However, there are still gaps in dental coverage and barriers in accessing care for many Canadians, particularly those from more vulnerable populations including seniors, children, low-income families, Indigenous Peoples, racialized individuals, and persons living with disabilities. While every province and territory have a set of dental care initiatives, these vary greatly from jurisdiction to jurisdiction, and many have significant shortcomings. Some only cover children or those from low-income households; others do not even cover the cost of dental services provided; many are chronically underfunded. Therefore CDA – alongside provincial and territorial dental associations across the country and other key oral health stakeholders – had long been advocating for the federal government to invest in dental care programming. This would enhance access to dental care for Canadians and help them achieve and maintain optimal oral health. CDA appreciates that, after many years of advocacy, the federal government has responded with a strong commitment to supporting the oral health of Canadians.

Several weeks later, Deputy Prime Minister and Minister of Finance Chrystia Freeland unveiled the 2022 federal budget, entitled “A Plan to Grow Our Economy and Make Life More Affordable.” This contained a historic commitment of $5.3 billion over the next five years towards the government’s dental care commitment, with $1.7 billion annually thereafter.

Budget 2022 proposes to provide funding of $5.3 billion over five years, starting in 2022-23, and $1.7 billion ongoing, to Health Canada to provide dental care for Canadians. This will start with under 12-year-olds in 2022, and then expand to under 18-year-olds, seniors, and persons living with a disability in 2023, with full implementation by 2025. The program would be restricted to families with an income of less than $90,000 annually, with no co-pays for those under $70,000 annually in income.

While a landmark moment for federal spending on oral health, CDA does have concerns around the scope of the budgetary envelope provided. Previous estimates by the Parliamentary Budget Officer (PBO) in September 2019 and October 2020, based on a policy design provided by the NDP, found that providing dental coverage of this nature could easily cost $9.6 to $9.9 billion over the fist five years, more than double the proposed amount. Adjusting for inflation, this would be $10.5 billion in 2022 dollars. A subsequent Legislative Costing Note, released June 2022 and based on the phased roll-out to different demographic cohorts, still pegged the cost at $9.0 billion over five years.

Even these numbers are likely underestimates, as there are several significant flaws in the PBO costing assumptions. Among other things, these include:

* The assumption that there will be no scaling back of existing publicly funded dental coverage programs at the provincial or territorial level;
* The assumption that there will be no withdrawal of existing employee dental benefits plans by employers;
* A sliding co-payment scale for those living in families with annual incomes between $70,000 and $90,000 that would see some families required to make co-payments for upwards of 95% of the treatment provided;
* A model that would assume no treatment beyond routine preventative care is needed except for the first year an eligible individual is covered by the program and subsequently at ages 6, 12, 20, 40, and 60; and
* A reliance on the use amalgam restorations that may not respect current trends in provider recommendations around restorative materials.

In all cases, the PBO also projects a different financial profile for the costs of such a program, with a significant up-front investment required when the program is launched or expanded to a new demographic cohort, compared to the step wise increases in Budget 2022. This raises concerns about whether such a program would be sufficiently funded to cover the cost of providing comprehensive dental care to the patients it covers, and whether it will be sustainable in the long run. For this reason, CDA feels that the federal government must release a full, detailed costing before settling on any long-term approach.

Over the past several months, CDA has called on the federal government to proceed slowly and carefully in developing proposals to implement its commitment on dental care. This would allow time to consult broadly with all relevant stakeholders, including dentists, as well as to collaborate with other levels of government that are active in this policy space. The government has heeded CDA’s advice by announcing a phased approach, starting with an interim Canada Dental Benefit for eligible children under 12. That said, given broad-based oral health programming is a relatively new area of activity for the federal government, it will be important for the government to factor in opportunities to review and revise its approach, adjusting as needed. CDA urges the federal government to commit to a five-year program review of its approach to dental care, with a full report being made public upon completion. Five-year legislative reviews should also be built into any legislation introduced to implement these proposals to ensure they are fulfilling their purpose. This could be done either by existing parliamentary committees – such as the House of Commons Standing Committee on Health and the Standing Senate Committee on Social Affairs, Science and Technology. Alternatively, a purpose-built committee or committees could be created for the occasion to avoid delays due to busy parliamentary agendas.

Additionally, as is outlined below, CDA believes that the federal government should use this occasion to develop a broader strategy to improve oral health outcomes across Canada. While a lack of dental coverage does pose a significant financial barrier for many Canadians, there are also an array of other financial barriers that can make it challenging for Canadians to access the dental care they need and to achieve and maintain optimal oral health. Contributing factors can include socioeconomic facto, geography – particularly in rural, remote, and rural regions, availability of dental office staff such as dental assistants, lack of community-wide preventative health measures, and even access quality data and research. Action on these fronts should not be neglected and will likely require additional federal investments in the coming years.

## Designing a Model

As outlined above, Canada already has a system of publicly funded oral health and dental care programs in provinces and territories across the country. These range from systems of universal coverage for children under a certain age in Newfoundland and Labrador, Nova Scotia, and Yukon, to seniors’ programs in Alberta and Ontario, to those targeted exclusively at those in receipt of social assistance payments in Saskatchewan or Manitoba. Though some programs have been well received by dentists – notably the recently renewed children’s’ programs in Prince Edward Island and Newfoundland – others face challenges. Beyond restricted eligibility, these can include underfunded budget envelopes, limited services being covered, or payment rates that don’t cover the costs associated with the treatment provided. In addition to these programs, the federal government also has a limited set of dental care programs for First Nations and Inuit, veterans, and refugees. It also provides coverage for individuals in the federal correctional system, and, as an employer, it provides dental benefits for federal public servants as well as members of the Royal Canadian Mounted Police and the Canadian Armed Forces.

While federal, provincial, and territorial governments all have responsibility for delivering dental care programming, the administration of healthcare has traditionally been the domain of provinces and territories. In contrast, the federal government’s role has focused more on public health promotion, emergency response, and providing significant funding for public healthcare systems administered by provinces and territories through the Canada Health Transfer. Regardless of the model chosen by the federal government for its long-term approach to dental care, coordination between all levels of government will be crucial towards its success in the long run. Because of this, the federal government should consult and collaborate with provincial and territorial governments in designing and delivering initiatives to enhance access to dental care for Canadians. Where possible, they should seek to leverage existing expertise, infrastructure, or programs. Attention should also be paid to resolving many of the challenges presented by existing provincial and territorial programs to ensure coverage is equitable across the full breadth of publicly funded dental care in Canada. For example, situations should be avoided where individuals are limited to inferior coverage by existing publicly funded programs and cannot benefit from new federal investments.

This cooperation between levels of government also needs to happen in the short-term at the political level. Federal, provincial, and territorial governments should be encouraged to seek consensus on the best way to administer federally funded dental care initiatives within Canada’s constitutional framework. While there has been recent success in building a publicly funded early learning and childcare system, it has been many decades since the last time there was a major expansion of publicly funded healthcare programming and the creation of new social policy programs providing direct federal payments to individuals. This took place in the mid-20th century, starting with the creation of a federal Employment Insurance program via constitutional amendment in 1940, followed by seniors’ pensions in 1952, disability pensions in 1964, and the introduction of the Medical Care Act in 1966. It will be vital to avoid political or legal disputes between levels of government that could delay or disrupt access to dental care for Canadians eligible for publicly funded programs. Federal funding for enhancing access to dental care must also be designed as incremental investments on top of existing funding levels of other federal, provincial, and territorial programs; this should not lead to existing oral health funding to be redirected to other purposes, or for programs already in place to be scaled back or cancelled.

No matter the resulting delivery model for these federal investments, this should nevertheless be an opportunity to create minimum criteria with respect to publicly funded oral health programming across Canada. A set of common national standards should be established with respect to publicly funded dental coverage to ensure that Canadians receive the quality dental care they need to achieve and maintain optimal oral health. As part of this process, efforts should be made to improve existing programs. Should the funds be used to support a model – now or in the future – that involves administration via provincial or territorial programs rather than directly by the federal government, these standards should be used to establish a clear accountability on the part of provinces and territories for how these funds are used. It will also be important to include provincial and territorial dental associations in these discussions, as well as other relevant regional stakeholders to make sure that these programs make sense based on different on-the-ground regional realities. This will help ensure that longer-term proposals are ultimately well suited to the realities of both patients and providers, no matter where in Canada they live.

## Key Principles

CDA supports the *FDI World Dental Federation* definition of oral health and has worked with provincial and territorial dental associations to adapt a public-facing Canadian definition. Just like other diseases, prevention, early detection, and treatment of oral diseases is important to stop any negative effects on the rest of a person’s body. An unhealthy buildup of plaque and tartar can make your gums prone to bleeding. Unhealthy oral bacteria and the inflammation associated with gum disease may enter the bloodstream, which can increase the risk of other health problems. Oral disease can affect other aspect of day-to-day life, including personal relationships and self-confidence. It can lead to pain, anxiety, disfigurement, and acute/chronic infections. It can also disrupt sleep and affect eating— all of which can impact the overall quality of a person’s life. While some risk factors can be reduced or eliminated through healthy lifestyle choices or changing certain habits, others – such as aging – are unavoidable. It is therefore essential that any federally funded dental care program or oral health initiative be designed in a way that is compatible with this approach to oral health.

Oral health is part of your overall health. With a healthy mouth you can eat, speak and smile in comfort, which helps you feel physically, socially and mentally well. A healthy mouth helps you enjoy life.

Policy design should also be done in a way that promotes the concept of patient-centred care. Patients should be active participants in their own oral healthcare, and have timely and local access to education, preventative care, and any necessary treatment. The patient-provider relationship should be built on mutual respect and decisions should ultimately be agreed upon by both parties. By putting patients at the centre of the oral health journey, this also allows individual needs, preferences, and experiences to be reflected.

Beyond these two central concepts, **federally funded initiatives should focus on the management of a patient’s oral health throughout their lifetime**, in the same way other parts of the health manage chronic conditions and disease on an ongoing, long-term basis. Because oral health conditions and needs are so unique, varying from patient to patient based on a variety of factors, dental care programs need to be more than just a pre-defined list of services. Ensuring there is flexibility to allow patient and provider to agree on a customized oral care routine and treatment plan is a must. Such a program should also be designed in a way that prioritizes and promotes preventative care, absent in many existing programs. As opposed to only providing downstream therapeutic intervention - which is costlier, less beneficial for the patient, and can create a strain on healthcare providers – a better approach entails ensuring access to up front care such as regular exams and hygiene services.

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| Possible Considerations for Federally Funded Dental Coverage   * Recall examinations with diagnostic radiographs should be covered at the appropriate frequency, based on the recommendation of the dental care provider (e.g. every 4 months, 6 months, 9 months, etc.), as should routine, preventative dental hygiene services (e.g. scaling, prophylaxis, fluoride). * Emergency exams, radiographs, and diagnosis should also be covered as needed. * Extractions should be covered as well as other common procedures to manage pain and infection. * Therapeutic treatments covered should not be limited to those necessary to address the existential threat of pain and infection, but should also include those which promote broader health and wellbeing. * Basic restorative treatment should be covered, as well as root canal treatment for teeth that can be simply restored. Providers should not be restricted in recommending the most appropriate restorative material to the patient. * There should be a mechanism to permit the delivery of more advanced care to patients based on their unique needs (e.g. more frequent examinations, additional preventative care, etc.) * Anaesthesia and any private facility fees should be covered where regulations permit, and providers recommend it as a tool to effectively manage a patient’s treatment (e.g., for children or persons with disabilities). |

As oral health conditions and needs vary greatly from one patient to the other, it can also be difficult to estimate the annual cost of treatment. While someone with good oral health may only need periodic recall examinations and the associated diagnostic radiographs, along with hygiene services, others may need significant restorative work, prosthodontics, or even oral surgery. It is therefore important that patients covered by any federally funded dental care program not face arbitrary annual limits on the cost of dental treatment covered. While, for budgeting and accountability purposes, it may be prudent to notionally set a soft annual cap, this should not be a barrier to patients receiving the treatment they require.

In implementing a long-term approach to providing access to dental care for all Canadians, there is a huge opportunity to leverage the existing network of 16,000 private dental offices across Canada, most of which are small businesses focused on serving the needs of their communities**.** Federally-funded initiatives should promote the delivery of care primarily through this existing system, supplemented as needed by public clinics (i.e. dental schools, remote and northern communities, etc.). It is also crucial that the program utilize the skills and expertise of all oral health professionals – for example, dental hygienists, dental assistants, denturists, dental therapists, and dental technologists. That said, the advantages of providing care by dentist-led teams, where a broad spectrum of care can be provided in an integrated fashion, should be clearly recognized.

There may also be occasions where, based on the unique needs of certain demographics or regions, alternative approaches may be needed in addition to dental care delivered via private clinics. In provinces like Prince Edward Island and in northern Canada, for example, school-based programs play an important role in supporting children’s oral health. Other public health programs may also play a role in raising public awareness of the importance of oral health or providing patient education. There may even be the need for some publicly funded, community-led initiatives to make dental care accessible in rural, remote, and northern communities where private delivery of dental care is not economically viable. In partnership with other levels of government, innovative approaches to responding to these scenarios should be encouraged, as a supplement to privately delivered care.

## Program Delivery and Administration

While there is a need to fill the gaps in access to dental care that many Canadians face, it is also important that the foundational building blocks of Canada’s dental care delivery system remain in place. These include the network of private dental offices across the country, a robust system of employer-provided dental benefits, and a common set of tools used by both the dental care and the benefits sectors.

First and foremost, it’s essential that any federally funded dental care plan fully cover the cost of treatment provided to patients. Canadian dental offices are complex facilities – miniature outpatient hospitals, in effect. Beyond routine dental treatment, they can also serve as a venue for oral surgery, the provision of varying levels of anaesthesia, and the treatment of medically compromised patients. This has been underlined by Canadian dentistry’s successful response to the COVID-19 pandemic where, thanks to an existing commitment to stringent infection protection and control procedures as well as heightened protocols, there have been no known cases of COVID-19 transmission between patients and providers. The provision of such safe, quality treatment comes at a cost, however. These include but are not limited to the facility and associated infrastructure, clinical materials and equipment, dental personnel, and administration. Given the current inflationary environment and the tight labour market, most if not all of these are rising. Dentists must also account for longer-term factors like infrastructure and technological maintenance and upgrades, continuing education, and even planning for personal items like maternity and paternity leaves or eventual retirement. One tool provincial and territorial dental associations provide to their member dentists is to objectively calculate a set of recommended fees each year that serves as a benchmark as to the cost of providing any number of dental services. Any federally funded dental care program should use the most up to date version of fee guides as the basis to determine the cost of treatment. If necessary, to maintain the financial viability of their practice, dentists should be able to bill the balance between any amount covered by a federally funded program and the recommended level in the current fee guide.

It is also crucial that any new federally funded initiatives do not create additional administrative burdens for dental offices. Attention should be paid to ensuring that administrative procedures do not impact or delay the provision of care to patients. The focus for dentists and dental office staff should remain on providing safe, quality treatment – with the need to spend time on paperwork and communications with dental benefits providers or government programs kept to a minimum. This is particularly important given the staffing shortages facing dental offices, and the broader healthcare sector. One way to streamline program administration would be to make use of several tools developed by CDA and widely adopted across Canada. These include:

* The Uniform System of Coding and List of Services (USC&LS), which is updated regularly and allows dentists to record services and prepare and transmit claim forms to dental benefits providers in a consistent manner;
* CDAnet and the ITRANS Claim Service, which both facilitates the seamless and secure electronic submission of claims to dental benefits providers and informs dental office staff and patients of the coverage provided; and
* The Standard Dental Claim Form, developed by CDA and the Canadian Life and Health Insurance Association, which serves as a template for any paper-based claims.

Another way to ease the administration burden on dental offices and ensure that patients receive timely care is to limit the requirement for submission of pre-determinations prior to dental treatment being covered. The current approach to the *Canada Dental Benefit* – where decisions as to what treatment is necessary are left between patients and providers – sets a good example to follow. For patients in rural, remote, and northern areas that must travel greater distances to receive dental care, there is a significant advantage to being able to proceed with necessary treatment at a single appointment, rather than forcing the patient to make a return visit. This can also be beneficial for other demographics where there are barriers to accessing care – for example seniors, children, persons with disabilities, medically-compromised patients, shift-workers with irregular hours, and even those with dental fear and anxiety. While understandable in the case of complex treatment plans, pre-determination requirements should not be used as a cost-control mechanism, especially when it impedes the provision of routine dental care.

There is also a need to ensure any federally funded dental care does not disrupt access for the many Canadians who already have access to employer-provided benefits. Public dental care programs should remain a payor-of-last resort, after any privately funded coverage. This can be done by either restricting eligibility for federally funded dental care programs to only those without employer-provided dental benefits, or by requiring that all privately funded dental benefits be exhausted before public dental coverage kicks in. The federal government should also, in collaboration with other levels of government, as well as industry stakeholders, explore ways to put in place a system that preserves and promotes further employed-provided dental coverage.

This latter point is essential to the long-term success of any federally funded dental care program. A situation where there is widespread uploading of the responsibility for dental coverage from employers to the public sector must be avoided, as the displacement of any significant amount of private sector investment in dental care would significantly overwhelm government budgetary envelopes. Though there is already some incentive built into both the corporate and income tax systems for employers to provide health and dental benefits, the federal government should explore other models that would retain or increase private sector investment in the provision of dental benefits. Beyond legislative solutions – which may prove tricky given more than 90% of the private sector workforce in Canada falls under provincial and territorial jurisdiction – the government could look beyond our borders for inspiration. For example, the United States and Germany are two examples of advanced economies with federal systems of government that could provide models to follow. Resolving this challenge needs to be a top priority for the federal government to address in any future dental care proposals.

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| United States   * Affordable Care and Patient Protection Act (2010) * Employers with 50 or more FTEs must offer health benefits to full time employees (30+ hours) aged 26 and older and their dependents. * Employers not meeting the requirement can be subject to Employer Shared Responsibility Payment calculated based on the number of employees not provided coverage. * Amounts ranged from $2,750 - $4,120 per employee and are collected by the Internal Revenue Service (IRS). | Germany   * Compulsory social health insurance system originated in the 19th century. * Private-sector employers must enroll most employees in one of over 200, not-for-profit “sick funds.” * High-income earners are not required to enroll, but can opt-in or can purchase private insurance. * Premiums are split between employer and employee contributions, with the latter being collected via wages. |

## A Broader Approach

Overall, the federal government’s commitment to enhance access to dental care for Canadians is a historic milestone for dentistry in Canada. That said, the reduction – or even elimination - of financial barriers to dental care is not a silver bullet for ensuring all Canadians can achieve and maintain optimal oral health. There remain substantial non-financial barriers to accessing necessary dental care and achieving oral health, particularly for vulnerable or underserved populations. For this reason, the federal government must develop and unveil a comprehensive federal oral health strategy that addresses a broader set of challenges facing Canadians in achieving optimal oral health. Given the federal government plans are set to be fully implemented by 2025 – and with a federal election slated to take place that year as well – we urge the government to have such a strategy in place by April 1, 2025. It should be developed as a result of engagement with a broad set of stakeholders, including CDA, provincial and territorial dental associations, other organizations representing health professionals at the federal, provincial, and territorial level, as well as other key groups representing children, seniors, persons with disabilities, Indigenous communities, racialized Canadians, and similar underserved demographics. Such a strategy should focus on delivering results – both for patients’ oral health, and for the long-term sustainability of Canada’s dental care delivery system. While the full scope of such a strategy should be designed in concert with the many partners outlined above, it should include action on the following issues.

### Indigenous Oral Health

One of the biggest federal interventions into dental care is via the Non-Insured Health Benefits (NIHB) program for eligible First Nations and Inuit – slightly less than a million people from coast to coast to coast. Despite NIHB coverage comparing favourably to many other publicly funded programs on a variety of levels (i.e. breadth of coverage, covering the cost of treatment provided), it still results in Indigenous oral health outcomes lagging significantly behind those of the general population. As the federal government prepares to invest billions of dollars in the coming years in enhancing access to dental care and improving the oral health of Canadians, ensuring that this also leads to improved Indigenous oral health outcomes needs to be a priority. This can be done both by improving the accessibility and administration of the NIHB program – as was recently studied by the House of Commons Standing Committee on Indigenous and Northern Affairs – as well as by making investments in Indigenous oral health above and beyond the provision of NIHB coverage

CDA has long worked with officials at Health Canada – and now Indigenous Services Canada – on providing feedback on the administration of the dental component of the NIHB program. For example, in the past CDA has advocated to ensure the program follows industry standards with respect to allowing restorative care for second molars, rather than prematurely resorting to extractions. More recently, CDA has urged the federal government to improve or remove pre-determination requirements for partial dentures, which adds unnecessary delays to patient care – particularly for those living in remote regions who must travel great distances to see their dentist. There is work to do to ensure that NIHB protocols align with the best practices of other major benefits programs, particularly around things such as partial dentures, crowns, and night guards, a key for preventative treatment for teeth grinding.

Outside of the NIHB program, investments could be made in several areas, including but not limited to education and awareness campaigns, public health programs providing preventative care, access to clean drinking water and community water fluoridation, as well as better access to surgical facilities or those requiring dental treatment under general anaesthesia. The latter issue is particularly pressing, as wait times for access to hospital operating rooms have greatly increased over the past several years because of the strain on the healthcare system caused by the COVID-19 pandemic. Many high-needs patients, particularly Indigenous children living in rural, remote, and northern communities without access to dental treatment, end up with rampant dental decay that cannot be treated conventionally in a dental office and requires sedation and a surgical facility. To address this, the federal government could look to revise its policies to better leverage existing privately-run surgical facilities. Alternatively, the possibility of funding the construction of dedicated, Indigenous-run surgical facilities in regional centres could be explored.

### Better Oral Health Data and Research

While oral health is an essential component of overall health, it is rarely included in any largescale health-related survey conducted by the federal government. An oral health component has not been part of the Canada Health Measures Survey (CHMS) since 2010, nor has oral health been regularly included in the Canadian Community Health Survey (CCHS). It is incredibly difficult to monitor and track progress on Canadians’ oral health outcomes without regular, reliable data on oral health trends. The ability to collect oral health data in future CHMS and CCHS cycles will be critical to evaluating the impact of these initiatives, and identifying any adaptations needed to ensure they are contributing to a long-term improvement in Canadians’ oral health. The federal government should commit to long-term, ongoing funding to ensure that oral health components are routinely included as part of both the CHMS and the CCHS. The oral health indicators to be included, as well as the roles of both household questionnaires and physical examinations, should be determined in consultation with oral health experts, including dentists. CDA has also encouraged the new House of Commons Standing Committee on Science and Research to undertake a dedicated study of oral health research and data collection in Canada and provide further recommendations to the government.

### Funding for Oral Health Organizations

Navigating an influx into dental offices of up to 9 million new patients with federally funded dental coverage over the next several years will require oral health organizations across Canada to significantly step up their activities relating to oral health promotion and professional support for their members. In the coming months and years, they will need to pivot and adapt their activities to support both patients and providers alike. This could include promoting awareness of new federal dental care initiatives, public education campaigns on the importance of oral health to overall health, responding to questions from individual oral health professionals, and continuing to provide expert advice and feedback to the federal government on developing and delivering future oral health proposals. To address this, and as part of a broader oral health strategy, the federal government should provide financial support to oral health organizations to offset the costs of these new activities. Such support could begin as early as Budget 2023.

### Addressing Dental Workforce Challenges

Canada’s healthcare system is experiencing a human resources crisis, and the oral health sector is far from immune. Long before the pandemic, dentists were raising concerns about their ability to recruit and retain dental office staff, particularly Certified Dental Assistants, who are the backbone of any dental office. In the decade preceding the pandemic, the ratio of new dental assistants to new dentists fell roughly in half. By 2019, a third of dental offices had vacant dental assistant positions. Since then, the situation has further deteriorated, accentuated by the broader labour market challenges resulting from the COVID-19 pandemic.

With an expected increase in demand for appointments as a result of federally funded dental coverage, ensuring the dental workforce has the capacity to respond is critical. This workforce is already stretched thin. Recent public opinion research conducted for CDA has also indicated that there is an increasing rate of dental appointment cancelations due to dental office staffing issues. CDA recommends that the federal government specifically address these human resource challenges and staffing shortages in the oral health sector. This will help ensure that patients do not face increasing wait times to see dental care providers. This is more complex than simply recruiting and retaining more dental assistants and other staff. It can include, for example:

* providing mental health and wellness training to all dental office staff,
* improving human resources management skills dental office staff,
* leveraging new digital technologies to expand access to Certified Dental Assistant training programs,
* improving labour mobility between jurisdictions, and
* harnessing the workforce potential of Canada’s increasing immigration levels.

Furthermore, while there is a sufficient and growing number of dentists in Canada, efforts must nevertheless be made to ensure that dentist-led teams can meet the needs of patients from all demographics in all parts of Canada. The federal government has already made good progress by committing to expand eligibility for the Canada Student Loan Forgiveness program. Given the cost of attending dental school exceeds that faced by every comparable health professional in Canada – including physicians – providing loan forgiveness as an incentive for newly-graduated dentists to service rural, remote, and northern areas could help address geographic challenges to the provision of dental care in Canada. Efforts are also required to ensure that the dental workforce across Canada has the knowledge and expertise needed to provide all patients with the care they need – particularly those from high-needs demographics (i.e. children, seniors, persons with disabilities, etc) who will benefit from federally funded coverage. In this, the federal government could look to collaborate with the Association of Canadian Faculties of Dentistry as well as their member dental schools on activities such as curriculum development or continuing education modules on treating these populations.

# Annexes

## Annex A – About CDA

#### About **CDA**

Founded in 1902, and representing the dental profession across Canada, the Canadian Dental Association (CDA) is a trusted brand and source of information for and about the dental profession, on national and international issues. CDA is a separately incorporated national association whose members are 10 corporate-member provincial and territorial dental associations (PDAs) representing nine provinces and three territories. Quebec-based dentists can also access CDA programs and benefits, as CDA Affiliate Members.

#### Mission

The CDA is the national voice for dentistry dedicated to the promotion of optimal oral health, an essential component of general health, and to the advancement and leadership of a unified profession.

#### Vision

* A Healthy Public
* A Strong Profession
* A United Community

#### Prioritizing Goals of Canadian Dentists

Provincial and territorial dental associations, faculties of dentistry, dental regulatory authorities and specialty groups each have their own goals to achieve. CDA connects all stakeholders across the dental profession, prioritizing the goals of CDA’s Corporate Members and through these organizations Canadian practising dentists.

Corporate Members, dentists and dental and health care stakeholder groups benefit from CDA every day. CDA works with Corporate Members and stakeholder groups to discuss professional issues at the national level and to identify potential solutions for a range of issues impacting dentistry, oral health, small business relations, and more.

#### CDA Primary Areas of Focus

CDA’s three primary areas of focus include Advocacy, Knowledgeand Practice Support Services. CDA also offers a range of programs, such as the Dental Aptitude Test (DAT) and the CDA Seal Program, and other services to support the dental profession in meaningful ways.

#### Advocacy

CDA lobbies the federal government on issues facing the dental profession in Canada and the oral health of Canadians. CDA’s primary advocacy tools include government relations, media relations, and public education.

#### Knowledge

CDA captures, organizes and disseminates information about oral health and the dental profession to Corporate Members and their member dentists and to key stakeholders.

#### Practice Support Services

CDA provides a range of practice support services and programs, which help ensure that dentists are efficient, secure and compliant with applicable regulations when sending e-claims, e-referrals and patient records electronically.

## Annex B – About Dentistry in Canada

## With over 25,000 licensed dentists working out of over 16,000 offices – most of them small businesses – dentistry represents a significant portion of Canada’s healthcare sector. In 2019, $16.4 billion was spent on addressing Canadians’ dental care needs.

CDA maintains strong relationships with all dental stakeholders in Canada and internationally by ensuring ongoing dialogue with the leadership of the various national dental groups, including the Canadian Dental Specialties Association (CDSA) and the national dental specialty organizations, the Canadian Dental Regulatory Authorities Federation (CDRAF), the Association of Canadian Faculties of Dentistry (ACFD), the Canadian Association for Dental Research (CADR), the National Dental Examining Board of Canada (NDEB), the Royal College of Dentists of Canada, the Royal Canadian Dental Corps (RCDC), the Canadian Association of Hospital Dentists (CAHD), the Commission on Dental Accreditation of Canada (CDAC) and the Federation of the Canadian Dentistry Student Associations (FCDSA), the FDI World Dental Federation (FDI), the American Dental Association (ADA), and Canadian Dental Service Plans Inc. (CDSPI).

CDA has ongoing communications with other organizations that impact the delivery of oral health care, such as the Dental Industry Association of Canada (DIAC) and the Canadian Life and Health Insurance Association (CLHIA) and remains in regular contact with the Canadian Dental Hygienists Association (CDHA) and the Canadian Dental Assistants Association (CDAA).

## Annex C – What We Heard (Executive Summary)

In early 2022, the Canadian federal government announced that they are going to be investing over $5 billion into access to dental care for Canadians. Dentists, while excited, want to know what this means for them and their offices. After an already stressful past few years, dentists are once again frustrated that they are being left out of decisions that involve them.

The CDA reached out to dentists across Canada to get their thoughts on the new federal funding. Below is a high-level summary of their feedback.

1. *Ensure appropriate reimbursement of dental services and compensation of dentists in line with provincial/territorial fee guides***.**

We have heard that this is one of the most significant factors impacting dentists’ participation in a publicly funded dental program, and hence improving access for Canadians to oral health care. Increasing the ratio of remuneration levels in relation to provincial fee guide levels will help ensure patients who need treatment continue to be seen, while also ensuring that dentists can afford to keep their practices going, based on regionality.

1. *Provincial/territorial public plans already exist and there is infrastructure in place.*

Dentists feel that keeping already established provincial programs in place will avoid conflict over jurisdiction and in many provinces would allow for efficient implementation of the under 12 children’s program by the end of 2022. Keeping existing and well-known programs in place will ensure ease of administration and ensure that programs that are currently working well for patients will continue to provide the same or even enhanced services. Provincial/territorial programs can be amended and enhanced to include more eligibility and a better basket of services for the program.

1. *Income eligibility criteria need to be administered efficiently by governments, either federal and/or provincial/territorial.*

Dentists hope that determining income eligibility will be an easy process so that they can avoid making mistakes as well as avoid additional administrative burden. They also hope this process also includes the critical step of ensuring that in the case of private dental insurance availability, the government plan is the payor of last resort, to ensure effective and efficient service provision in dental offices and help prevent employers from dropping existing coverage.

1. *Provincial/territorial fee guides and claims processing systems currently exist and should continue to exist.*

Dentists know that the provincial fee guides are reviewed yearly by experts and incorporate the procedure, time required, materials used, manpower requirements, cost of living and other factors. Keeping the existing system would ensure that the fee guides remain up to date and would make administration easier on dental staff who have been using the fee guide and coding system for years.

1. *Ensure that the private employer-based insurance system, which has worked well for decades, remains intact.*

Mechanisms should be in place prior to the rolling out of the federal public dental program to avoid major decreases in private dental insurance coverage which will result in significant impacts on the viability of dental practices. Private insurance must be the primary payor, and government plans should only be used as a last resort. Dentists feel that the ability to balance-bill should be an element of the plans. Dentists feel the private insurance model has been working well up until now and hope that public programs are used as a way to fill in the gaps for patients who do not currently have access to private insurance.

## Annex D - Overview of Existing Public Dental Programs in Canada

## Alberta:

### Children and youth:

Alberta Children’s Dental Benefit covers basic and preventative services like fillings, x-rays, examinations and teeth cleaning for children from low -income families. Eligibility for this program is based on income, marital status, and number of children. Once approved, they will receive a dental card to present to dental provider.

Alberta’s Children’s Oral Health Initiative is an early childhood tooth decay prevention program aimed at children aged 0 to 7, their caregivers and pregnant women living on-reserve or accessing on-reserve resources. Services include fluoride varnish, sealants, fillings and teaching about tooth brushing and flossing.

### Seniors:

The Dental and Optical Assistance for Seniors Program is government program that can help low-income seniors cover the cost of basic dental services. There is a tiered system that determines the amount of coverage a senior is eligible for, based on income. This program provides basic dental coverage that includes diagnostic services (examinations and x-rays); preventive services (polishing and scaling); restorative services (fillings, trauma, pain control); extractions (simple and complicated); root canals (endodontics); procedures relating to gum disease (periodontics, root planing); and dentures (removable prosthodontics, full and partial basic dentures).

### Persons with Disabilities:

The Assured Income for the Severely Handicapped program is a government program that provides financial and health benefits for eligible Albertans with a permanent medical condition that prevents them being able to work. This program provides basic dental coverage as well as coverage for dentures if needed.

### Adults in Financial Need:

The Alberta Adult Health Benefit program covers health benefits for Albertans in low-income households who are pregnant or have high ongoing prescription drug needs. This health plan includes children who are 18 or 19 years old if they are living at home and attending high school. Eligibility for this program is based on income, marital status, and number of children. . Once approved, they will receive a dental card to present to dental provider. Basic services like extractions, fillings and dentures and preventative care like x-rays, examinations and teeth cleaning are all covered under the program.

## British Columbia:

### Children and Youth:

The Healthy Kids program is a government program that provides coverage for basic dental treatment assistance to children in low-income families, who are not in receipt of income assistance, disability assistance or hardship assistance. To provide dental care to children on this program, providers must first contact the ministry to confirm eligibility.

### Other Programs:

The Income Assistance Program is a government program that provides residents who receive income or disability assistance with basic dental cost coverage. Everyone who receives assistance can access emergency dental services to relieve pain.

Adults on this program can receive up to $1,000 over two calendar years, beginning on January 1 of every odd-numbered year for basic dental services, such as restorations, extractions and preventative services, partial dentures, replacement dentures or reline/re-base of dentures and crowns, bridges, and dentures under certain circumstances.

Children under 19 in families on this program can receive up to $2,000 over two calendar years, beginning on January 1 of every odd-numbered year towards basic dental coverage and an additional $1,000 per year to cover the cost of dental treatment in a hospital under a general anaesthetic.

## Manitoba

### Employment and Income Assistance

The Employment and Income Assistance Program (EIA) provides financial help to Manitobans who have no other way to support themselves or their families. Manitoba residents may be eligible for assistance if the total cost of their family’s monthly basic needs and housing costs are more than the applicant’s total financial resources. This program provides benefits (money) to help with the costs of basic dental services.

## New Brunswick:

### Children and Youth:

Healthy Smiles, Clear Vision is New Brunswick’s dental and vision plan for children of low-income families with no insurance plans. If a child’s family meets the income threshold the program will cover basic dental treatment such as regular exams, X-rays, and extractions, with some focus on preventative treatments such as sealants and fluoride treatments.

### Adults in Financial Need:

The Health Services Dental Program provides some dental coverage to adults who have special health needs and no insurance plans. This program covers examinations, x-rays, dentures and repairs, and some fillings. Those on this program are eligible for a maximum of $1000 per year, excluding emergency and prosthetic services.

## Newfoundland and Labrador:

### Children and Youth:

The Children’s Dental Health Program provides universal access to eligible dental services for children aged 12 years and under. This program covers basic dental treatments such as: examinations at six-month intervals; cleanings at 12-month intervals; fluoride applications for children aged six to twelve years at 12 month intervals (except where the School Rinse Program is in place); routine fillings and extractions; and sealants.

The Income Support Program and Low Income (Access Program) provide basic dental services for youths aged 13 – 17 years, whose family is in receipt of Income Support or is enrolled in the Access Plan of the Newfoundland and Labrador Prescription Drug Program. These programs cover examinations at two-year intervals and routine fillings and extractions.

### Adults in Financial Need:

The Adult Dental Program provides basic dental services to adults enrolled under the Foundation Plan of the Newfoundland and Labrador Prescription Drug Program. This program covers an examination and two x-rays every three years, routine fillings on a three-year cycle, extractions, and there is a denture component allowing the delivery of standard dentures once every eight years.

## Northwest Territories:

### Children and Youth:

The school-based Oral Health Program is available in five communities throughout the Northwest Territories. Each of these communities has either a dental hygienist or dental therapist located in the community, and these hygienists and therapists also travel to the surrounding communities in their regions to provide services. The school-based program provides preventative oral health care to children in schools, including oral health education, fluoride varnish application, oral examinations, specialized oral health preventive and therapeutic treatments, and referrals to dentists.

### Seniors:

The Extended Health Benefits for Seniors Program provides residents of the Northwest Territories who are 60 years of age and over, and have no insurance plan, access to a range of benefits not covered by hospital and medical care insurance. This program covers 100 percent coverage of the cost of eligible dental services, as defined by Indigenous Services Canada’s NIHB Schedule of Dental Benefits and subject to plan limitations and exclusions.

## Nova Scotia:

### Children and youth:

Through the Children’s Other Health Program, the Government of Nova Scotia covers universal basic dental coverage for all children under age 14. Children are required to use their private insurance first (if applicable) before supplement coverage can be used through the program. Per year, the program covers one routine dental examination, two routine x-rays, and one preventative service (i.e. brushing and flossing instruction, cleaning, filling, extraction etc.).

### Adults in Financial Need:

Nova Scotia’s Employment Support and Income Assistance (ESIA) program may help some low-income individuals with dental treatments. Eligible individuals may receive emergency dental care based on the Dental Fee Guide in the ESIA policy manual.

### Individuals with Special Needs:

This program provides coverage for the basic dental needs of Nova Scotia residents who have been diagnosed to have an intellectual disability that makes it necessary for their dental care to take place in a hospital setting under a general anesthetic or acceptable alternative.

Services covered by this program are for basic elective/routine preventive, diagnostic and restorative needs. Eligible individuals must register for this program and are not automatically enrolled. Program provides 100% coverage for eligible services and is designated as payer of last resort; private insurance must first be used before the program will provide coverage.

## Nunavut:

### Children and Youth:

The Nunavut Children’s Oral Health Project provides preventative and basic dental treatments for children in the community. This program is administered at schools in the community and covers sealants, temporary fillings, extractions, fluoride varnish and referrals for additional treatments are made available.

## Ontario:

### Children and youth:

Healthy Smiles Ontario (HSO) is a government-funded dental program that provides preventive, routine, and emergency dental services for children and youth 17 years old and under from low-income households. This program covers check-ups, cleanings, fillings, x-rays, scaling, tooth extraction, urgent or emergency dental care (including treatment of a child’s toothache or tooth pain).

### Seniors:

Ontario Seniors Dental Care Program is a government-funded dental care program, providing free, routine dental services for low-income seniors who are 65 years of age or older. To be eligible, seniors have to be below the income threshold and have no other dental coverage, either through private insurance, or public programs Once approved, they will receive a dental card to present to dental provider.

Services covered under this program include check-ups, including scaling, fluoride and polishing, repairing broken teeth and cavities, x-rays, removing teeth or abnormal tissue (oral surgery), anesthesia, treating infection and pain (endodontic services), treating gum conditions and diseases (periodontal services). Care can be accessed though Public Health Units, Partner Community Health Centres, Partner Aboriginal Health Access Centres. The program cannot be accessed through private dental clinics, so eligible seniors need to switch from their existing providers to public clinics.

### Persons with Disabilities:

Ontario Disability Support Program (ODSP) is a government program that provides basic dental coverage. To be eligible for this program, an individual, 18 years or older, needs to be in financial need, as well as they need to meet the definition of a disability under the Ontario Disability Support Program Act, or be a member of a prescribed class that is exempt from the disability adjudication process.

In addition to basic dental services, recipients and eligible spouses may receive services under the Dental Special Care Plan. The Dental Special Care Plan provides additional dental services for those whose disability, prescribed medications or prescribed medical treatment affects their oral health.

### Adults in Financial Need:

Ontario Works is a government program that helps people who are in financial need. To be eligible, a person needs to be 16 years or older and be in financial need based on their income and assets, living expenses, family size and make-up and shelter costs. Services covered by this program include basic services such as fillings and extractions, as well as treatment for dental problems that are considered an emergency.

## Prince Edward Island:

### Children and Youth:

The School Oral Health Preventative Program provides preventative services to all children until age 17, including an annual oral health risk assessment, and cleaning and polishing of teeth.

### Adults in Financial Need:

The Provincial Dental Care Program enables Islanders, including seniors, who earn a low income to receive subsidized basic dental treatment services. The level of subsidy is determined using family income and family size. This program provides coverage for: examinations and diagnosis; preventative services; appliances, mouth guards/TMJ; restorations/endodontics; oral surgery; prosthetics; and adjunctive services.

## Quebec:

### Children and Youth:

Régie de l’assurance maladie (RAMQ) is a Quebec’s public health insurance plan and it provides universal dental coverage to all children in the province under age 10. This program covers basic and dental care including annual and emergency examinations, x-rays, local or general anaesthesia, fillings, extractions, endodontics, pulpotomy and pulpectomy, prefabricated crowns, and oral surgery services.

### Adults in Financial Need:

Through RAMQ, adults in financial need can receive dental coverage if they are recipients of last-resort financial assistance. Covered services vary depending on how long an individual has been a recipient of last-resort financial assistance. Those who have only been a recipient for under 12 months will have emergency dental coverage. Those who have been a recipient for at least 12 months will have dental coverage that includes annual and emergency examinations, x-rays, local or general anaesthesia, scaling, fillings, extractions, endodontics, pulpotomy and pulpectomy, prefabricated crowns, and oral surgery services. Dependent children of those who have been a recipient for at least 12 months will have access to fluoride application, cleanings, scaling, and root canals. Those who have been a recipient for at least 24 months will have dental coverage that they received previously, as well as coverage for acrylic dental prostheses services.

## **Saskatchewan:**

In Saskatchewan, there are no dental public health programs directly targeting children, seniors or persons living with a disability. The main public program is a low-income based program that provides basic dental services for those eligible, including children.

### Supplementary Health Benefits

In Saskatchewan, qualified individuals are eligible for several health services and products in addition to the universal health benefits. Some qualified individuals include, government wards, inmates are provincial correctional institutions, residents at special care facilities, and those enrolled in provincial income support programs.

Those who are above 18 years and able to work only have emergency dental coverage for the first 6 months, and then become eligible for full benefits, whereas children are automatically eligible for full benefits. Coverage includes a range of basic dental services (preventive, restorative, exodontic and prosthetic) required to maintain good dental health.

## Yukon:

### Children and Youth:

The Yukon Children's Dental Program is a universal school-based public dental health program that provides diagnostic, preventative and restorative dental services to Yukon children. Kindergarten children up to grade 8 with a resident dentist, and Kindergarten children up to grade 12 without a resident dentist. Eligible dental services may include fillings, stainless steel crowns, pulpotomies, extractions and emergency dental services. Additionally, on an annual basis, every child is eligible to receive dental examination, diagnostic x-ray films, oral hygiene instruction, cleaning and scaling of teeth, fluoride application and sealants.

## Federal Programs:

### Non-Insured Health Benefits (NIHB):

The NIHB program provides eligible First Nations and Inuit with coverage for a range of medically necessary health benefits when these benefits are not otherwise covered by private health insurance plans, provincial/territorial health insurance plans, or social programs.

The NIHB program's dental benefit covers services that include, diagnostic, preventive, restorative, endodontic, periodontal, removable prosthodontic, oral surgery, orthodontic and adjunctive.

### Veterans Affairs Canada:

This program provides basic coverage of dental services, and some pre-authorized comprehensive dental services to eligible veterans in Canada. This program covers annual basic treatments up to $1500, and well as some more comprehensive treatments with pre-authorization.

### Interim Federal Health Program:

This program provides emergency dental coverage to refugees in Canada. The program covers emergency oral exams; x-rays; caries, trauma, and pain control; writing or dispensing an emergency prescription; simple tooth extractions; denture relines; and denture repairs. More comprehensive treatments may also be covered with pre-authorization.