THE CANADIAN DENTAL HYGIENISTS ASSOCIATION

CDHA ACHD

L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES

Oral Health:

A call to action

A submission to the

House of Commons Standing Committee on Finance,

Pre-budget consultations

12 August 2011

EXECUTIVE SUMMARY

The Canadian Dental Hygienists Association (CDHA) is a national non-profit association, representing the collective voice of over 16,500 dental hygienists. CDHA advocates on key oral health issues, including a greater strategic role for the federal government in oral health, to achieve the world's best oral health. Oral health is essential for overall wellness and it is an integral part of physical, social, and mental wellbeing. Poor oral health can interfere with an individual's ability to be productive and to contribute to a growing economy as well as to Canada's economic recovery. We call on the federal government to implement the following two recommendations.

RECOMMENDATIONS

1. FNIHB increase the investment in oral health promotion and disease prevention through the following three program modifications:
   - Expand provider status to dental hygienists across Canada.
   - Implement equitable reimbursement rates for dental hygiene services.
   - Expand oral health promotion and disease prevention through the Children's Oral Health Initiative and the NIHB program.

2. Federal government continue its leadership to enhance federal, provincial and territorial cooperation for a strong, equitable pan Canadian public health system that meets the oral health needs of Canadians, and to support this end, designate a transfer of $10 million to the provinces each year for public health dental hygiene human resources.

INTRODUCTION

Oral health is essential for overall wellness and it is an integral part of physical, social, and mental wellbeing. Poor oral health can cause pain and diminish quality of life and contribute to diabetes, cardiovascular disease, and lung disease. For example, if you have two co-existing medical conditions, periodontal disease and diabetes, it is harder for you to control your blood sugar than it is for someone who does not have periodontal disease. Poor oral health can interfere with an individual's ability to find employment, be productive in employment, and to contribute to Canada's economic recovery. As members of the public health team, dental hygienists focus on a wellness approach, using health promotion and disease prevention. Some examples of dental hygiene public health programs include prenatal, preschool and school age caries prevention programs, oral disease screening, and dental sealant programs.

In comparison to the three other countries of the Organization for Economic Cooperation and Development (OECD), Canada falls far behind in terms of government investments in oral health. While Canada provides no consistent Canada wide oral health services, some of the largest OECD countries have national oral health services, including France; Germany, and Japan.[1] In addition, a number of provincial public oral health programs have implemented changes that result in less support for oral health. Some provincial oral health

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programs have been reduced—they have client participation fees, oral health professionals can balance bill and many do not emphasize prevention.

Canada's poor record in providing equitable oral healthcare is documented in a 2010 Commonwealth Fund report.[2] Canada's health system ranked a shocking fifth of seven countries on equity issues, particularly on equitable access to dental care. The report[2] also notes that low income Canadians more frequently forego oral health services because of cost barriers, in comparison to higher income Canadians. In 2007, 33% of individuals with below average incomes and 13% of those with above average incomes, needed oral healthcare, but did not see an oral health provider in the past year because of cost.

The facts about oral healthcare expenses are not common knowledge. Canada spends $12.6 billion annually on oral healthcare, which is costly relative to other conditions covered by Medicare. In terms of costs associated with disease categories, oral healthcare follows cardiovascular disease, and exceeds costs for respiratory disease, and cancer.[3] In 2009, dental care paralleled prescription drugs as the greatest component of total private health spending.[4] However, it is not the government that is supporting good oral health, as the largest portion of spending (94%) came from private sources (out of pocket spending and private dental plans). Public funding is only 6% ($756 million) of all dental expenditures. Out of this 6%, the federal government contributes 40% ($302 million) of the total and the provinces 60% ($454 million).[5,6]

CDHA recommends curbing these expenses, which are primarily addressing oral disease after it arises. This can be accomplished by refocusing on oral health promotion and disease prevention. The high cost of dental care, the lack of access for the neediest, and the existing lack of investment in oral health by federal and provincial governments point to the need to create better oral health policies. Federal investment in oral health must refocus ineffective, costly oral health services which treat disease after it arises, to a more cost effective oral health system with an oral disease prevention and oral health promotion emphasis. There are sufficient numbers of qualified dental hygienists in Canada to fulfill this role.

RECOMMENDATIONS

1. First Nations and Inuit Access to Oral Health Care

There is a large gap between Inuit[7] and First Nations[8] oral health status and the oral health status in the remainder of Canada.[9]

	% WITH DENTAL CARIES		MEAN COUNT OF TEETH	
CHILD'S AGE	INUIT	OTHER	INUIT	OTHER
Pre-school	85.3	Not available	8.22	Not available
School aged (6 – 11)	93.4	56.8	7.08	2.48
Adolescents (12–17)	96.7	58.8	9.49	2.49
Adults (18 +)			15.1	6.85

In addition, more oral disease in the Inuit adult population is treated by extracting teeth; Inuit population had 58.7 teeth extracted for every 100 they had restored compared to 6.9 teeth extracted in the rest of Canada.

The new Assembly of First Nation's *Teeth for Life: First Nations Oral Health Strategy* provides valuable information on oral health status and an analysis of costs for First Nations Inuit Health (FNIH) Branch programs and services.

This strategy indicates that dental decay rates for First Nations communities are three to five times greater than the remainder of the population in Canada. Children have the heaviest burden of oral diseases, with an incidence that does not meet the World Health Organization's goal of having 50% of children entering school caries free. In isolated communities, 57% reported not having seen an oral health professional in the last year, compared to 25% in the general population.

These statistics from Inuit and First Nations populations point to a pressing need for an increase in financial and program support for the First Nations Inuit Health Branch (FNIHB), Non-Insured Health Benefits (NIHB) program and public oral health programs. The focus of this support should be on oral health promotion and disease prevention, since there is a high cost associated with the treatment of early childhood caries (ECC). In 2008/2009 the total cost for NIHB to treat ECC was $16.5 million, or $2,479 per child, which includes general anaesthesia costs of $8.5 million and hospital costs of $8 million. And this does not include transportation costs from remote communities. In contrast, the FNIHB, Children's Oral Health Initiative costs only $110 per child to deliver, and it includes education, oral health assessments, fluoride varnishes, sealants, and dental hygiene services. This demonstrates the enormous cost savings that can be realized from an effective oral health promotion and disease prevention strategy.

CDHA congratulates the federal government on the new NIHB dental hygiene pilot project in Alberta to enable FNIHB eligible clients to directly access dental hygiene services. This project now recognizes dental hygienists as a provider group with NIHB, and will reimburse them directly for their services. CDHA joins the Assembly of First Nations and the Inuit Tapariit Kanatami in supporting this project which will increase access to care, since clients in communities where there are presently no dentists will now be able to receive dental hygiene services. In addition, the federal/provincial/territorial dental directors confirm support for the principles in this pilot, with their recommendation to "…promote alternative forms of service delivery for underserved areas…" and "…facilitate the provision of dental hygiene services in isolated areas…".[10] We are very pleased with the preliminary results from this pilot project, indicating 12 dental hygienists are serving 142 clients.[11] The success of this pilot project warrants the modification of the NIHB program to assign dental hygienists with provider status across Canada, and not only in Alberta.

The pilot project has much to celebrate as it has the potential to provide dental hygienists with enhanced business opportunities, thereby stimulating the Canadian economy and improving access to care. CDHA supports equitable reimbursement rates for dental hygienists who are currently reimbursed for services at much lower rates (more than 35% lower) than dental hygienists employed in traditional dental practices. The current low reimbursement rates for dental hygienists makes the viability of these businesses difficult, thus reducing access to care. The twenty-six private dental plans across Canada have equitable reimbursement schedules. CDHA encourages the federal government to match private industry by implementing equitable reimbursement rates for these much needed services.

CDHA applauds the government for including in Canada's Economic Action Plan, Budget 2009, an investment of $305 million over two years to strengthen current health programs (Non-Insured Health Benefits – NIHB and Primary Care services), 19% of which will be allocated to improve oral health outcomes for First Nations and Inuit individuals.[12] Although this is a welcome investment, the inequality between federal dental program spending for federal employees and NIHB clients suggests that the NIHB dental program warrants further investment. In 2004-2005 the federal government spent $228 million for its 800,000 NIHB clients, but more than five times that amount, $271 million, for its 172,000 employees and retired workers.[13] These numbers and the high dental caries incidence in First Nations and Inuit populations suggest that there is a pressing need for an

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increase in financial and program support specifically for FNIHB oral health services and oral public health programs.

CDHA recommends that the FNIHB increase the investment in oral health promotion and disease prevention through the following three program modifications:

- **Expand provider status to dental hygienists across Canada**
- **Implement equitable reimbursement rates for dental hygiene services.**
- **Expand oral health promotion and disease prevention through the Children's Oral Health Initiative and the NIHB program.**

2. Expanding Public Health Human Resources

There is a pressing need for a comprehensive plan to provide consistent Canada wide public health programs that focus on oral health promotion and disease prevention. This focus for public health will be less costly than treating chronic oral disease after it arises. CDHA joins a call for the creation of a pan Canadian public health system with expanded public health human resources identified in the Pan-Canadian Framework for Public Health Human Resources,[14] and in the Canadian Public Health Association finance brief 2011.[15] As the Naylor report states, "No attempt to improve public health will succeed that does not recognize the fundamental importance of providing and maintaining in every local health agency across Canada an adequate staff of highly skilled and motivated health professionals."[16] In order to implement a framework that will result in a pan Canadian public health system, there is a need for federal government coordination and leadership.

At the present time, there are 42,633 oral healthcare providers in Canada; however, there are only 718 in public health, including 453 dental hygienists. This is a ratio of 45,961 Canadians to one public oral health professional.[17] This small number of public oral health providers does not provide adequate support for the high need, low income populations. Income is a strong contributor to oral health, as Canadians from lower income families have almost two times worse outcomes compared to higher income Canadians.[18] The utilization of oral healthcare is inconsistent with the needs of the population and those with the highest need—the low income group—are not receiving the oral care they require through fee for service. Increased emphasis on population health approaches used in public health can help address the inadequate oral care experienced by low income groups.

There is a need to support the recruitment and retention of public health dental hygienists to meet the high need population health groups in Canada, and to reduce disparities in oral health across Canada. A modest starting point is to support a 50 per cent increase in the present number of dental hygiene professionals. This will require an investment of $10 million each year in public health dental hygiene human resources, to create 226 new dental hygiene positions. The federal, provincial, territorial dental directors indicate that "oral health promotion will be most successful if it is an integral component of general health promotion."[19] Dental hygienists can promote the integration of federal, provincial and local strategies, and serve as the linking agent for public–private collaborations.

A health system that focuses on health promotion and disease prevention is also a priority for national health organizations, health coalitions, parliamentary committees, the Council of the Federation, and policy think tanks.[20,21,22,23,24] An investment in public health dental hygienists who focus on oral health promotion and disease

prevention will contribute to sustained economic recovery, since individuals with good oral health lead healthier more productive lives. Oral diseases and conditions are often chronic, painful, and disfiguring; together, they represent a huge economic and social burden of illness in Canada. While rarely fatal, the costs of these oral diseases and conditions have a large economic impact costing Canadians the chance to contribute to society through work and volunteerism. An estimated total of 40.36 million hours are spent each year on check-ups or problems with teeth. [25] Some of the consequences of dental decay are acute and involve chronic pain, interference with eating, sleeping and proper growth, tooth loss, and compromised general health.

Investing in public health dental hygienists who focus on oral disease prevention and oral health promotion will also decrease the need for costly oral disease treatment. It will build capacity within the public health system to improve oral health and not simply treating oral disease after it arises. It will engage Canadians in optimizing their health, and will be a less expensive way of addressing oral health issues in the long term, as treatment costs are greater than prevention costs. Public health dental hygiene programs require a small investment with potentially large dividends. A Canada wide school based program would cost an estimated $564 million — about 4.5% of the $12.6 billion being spent on dental care today and 0.3% of total health spending.[26]

Furthermore, oral disease is the most common chronic disease in children and adolescents in North America, and is one of the main reasons that children receive a general anaesthetic.[27] This is a costly procedure that takes place in a hospital setting and prevention will lower these health system costs by keeping more children out of the operating room. New research shows that children with poor oral health status are more likely to experience dental pain, miss school and perform poorly in school.[28] Children need to stay healthy and have good oral health in order to succeed in school and become productive citizens and contribute to a growing economy. Many of the services that dental hygienists provide can prevent future oral diseases, for example applying fluoride varnish on new teeth can reduce the amount of dental caries.[29] Dental disease is preventable and improving children and adults' oral health is a vehicle to ensure their success in school, work and play.

Good oral health for life is more effectively promoted the earlier the preventive care is provided.[30] That is why it is important as a first step to focus on new parents, young children and pre-teens. There is also a need to integrate oral health programs into existing health and social programs, to make the best use of interprofessional collaboration. For example dental hygienists can be integrated into new mothers' visiting programs, and into school based health programs.

CDHA recommends that the Federal government continue its leadership to enhance federal, provincial and territorial cooperation for a strong, consistent pan Canadian public health system that that meets the oral health needs of Canadians; and as a starting point, designate a transfer of $10 million to the provinces each year for public health dental hygiene human resources.

CLOSING REMARKS

We need to create a continuum of care in the Medicare system, an oral health system for First Nations and Inuit populations, and a public health system that is responsive to the needs of individuals and helps them to maintain their own oral health. We can do this with an oral health promotion and disease prevention approach. Maintaining Canadians' oral health is the key to a prosperous and productive society and economy and will contribute to sustained economic recovery.

REFERENCES

1. Organization for Economic Cooperation and Development. *Overcoming challenges in health-care reform*. OECD. September 2010 <http://www.keepeek.com/Digital-Asset-Management/oecd/economics/oecd-economic-surveys-canada-2010_eco_surveys-can-2010-en>

2. Davis K, Schoen C and Stremikis K. *How the Performance of the U.S. Health Care System Compares Internationally 2010 Update*. The Commonwealth Fund. June 2010. Available from: <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Jun/Mirror-Mirror-Update.aspx>

3. Canadian Centre for Policy Alternatives. *Putting Our Money Where Our Mouth Is: The Future of Dental Care in Canada*. CCPA. April 2011. Available from: http://www.policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2011/04/Putting%20our%20money%20where%20our%20mouth%20is.pdf

4. Canadian Institutes of Health Information. *National Health Expenditure Trends 1975 to 2009*. CIHI. 2010. Available from: <http://secure.cihi.ca/cihiweb/products/National_health_expenditure_trends_1975_to_2009_en.pdf >

5. Organization for Economic Cooperation and Development .*OECD Health at a Glance 2009: key findings for Canada*. OECD. 2009. Available from: <http://www.oecd.org/document/11/0,3343,en_2649_33929_16502667_1_1_1_37407,00.html>

6. Organization for Economic Cooperation and Development. *Health Data 2007*. OECD. 2007. Available from: <http://www.healthinnovationforum.org/2008/may/31/how-does-canada-measure-against-other-countries/>

7. Health Canada, Nunavut Tunngavik Incorporated, Nunatsiavut Government, Inuvialuit Regional Corporation, Inuit Tapiriit Kanatami. *Inuit Oral Health Survey Report 2008 – 2009*. Government of Canada. March 2011. Available from: http://www.cdha.ca/AM/Template.cfm?Section=News_Releases&CONTENTID=9931&TEMPLATE=/CM/ContentDisplay.cfm

8. Assembly of First Nations: *Teeth for Life: The First Nations Oral Health Strategy*. AFN. October 2010.

9. Health Canada. *Report on the Findings of the Oral Health Component of the Canadian Health Measures Survey 2007 – 2009*. Government of Canada. 2010. Available from: <http://www.fptdwg.ca/assets/PDF/CHMS/CHMS-E-tech.pdf>

10. Federal/provincial/territorial dental directors: *Canadian Oral Health Strategy*, FPT Dental Directors, 2005 http://www.fptdwg.ca/assets/PDF/Canadian%20Oral%20Health%20Strategy%20-%20Final.pdf

11. Verbal report from Lynda McKeown from report presented to the Federal Dental Care Advisory Committee meeting. Ottawa, June 2011.

12. Health Canada. *Audit and Accountability Bureau, Audit of Economic Action Plan (Budget 2009): Expenditure Controls 2009*. Health Canada. Available from: <http://www.hc-sc.gc.ca/ahc-asc/alt_formats/pdf/pubs/audit-verif/2009-27/2009-27-eng.pdf>

13. Health Canada. *Report on the findings of the Oral Health Component of the Canadian Health Measures Survey 2007-2009*. Government of Canada. <http://www.fptdwg.ca/assets/PDF/CHMS/CHMS-E-tech.pdf. http://www.fptdwg.ca/assets/PDF/CHMS/CHMS-E-tech.pdf>

14. Health Canada, Joint Task Group on Public Health Human Resources: Advisory Committee on Health Delivery and Human Resources, and the Advisory Committee on Population Health and Health Security. *Building the Public Health Workforce for the 21st Century: A Pan-Canadian Framework for Public Health Human Resources Planning*. Government of Canada. October 2005. Available from:. < http://www.phac-aspc.gc.ca/php-psp/pdf/building_the_public_health_workforce_fo_%20the-21stc_e.pdf >

15. Canadian Public Health Association. *Enhancing the Public Health Human Resource Infrastructure in Canada*. 11May. 2010. Available from: <http://www.cpha.ca/uploads/policy/enhance_ph_e.pdf >

16. Government of Canada. *Learning from Sars: Renewal of Public Health in Canada – A report of the national Advisory Committee on SARS and Public Health*. October 2003. Available from: http://www.phac-aspc.gc.ca/publicat/sars-sras/naylor/

17. Federal/provincial/territorial Dental Directors. *Canadian Oral Health Strategy*. FPTDD. 2005. Available from: http://www.fptdwg.ca/assets/PDF/Canadian%20Oral%20Health%20Strategy%20-%20Final.pdf

18. Health Action Lobby. *People, Place and Technology: Laying the Foundations for Health System Modernization*. 13 August 2010. Available from: <http://www.cpa.ca/docs/file/Practice/HEAL_Prebudget2011Brief_FINALAug13.pdf >

19. Senate Sub-Committee on Population Health. *A Healthy, Productive Canada: A Determinant of Health Approach*. October 2009. Available from: < http://www.phn-rsp.ca/pubs/ssphfr-rfscssp/pdf/ssphfr-rfscssp-2009-10-eng.pdf>

20. Canadian Medical Association, Canadian Nursing Association. *Principles to Guide Health Care Transformation in Canada*. July 2011. Available from: < http://www.cma.ca/advocacy/hctprinciples>

21. Council of the Federation. *Premiers Focus on Families*. (News release.) July 2011. Available from: http://www.councilofthefederation.ca/pdfs/Communique_and_Backgrounder_Families_July21.pdf

22. Caledon Institute of Social Policy. *Health Care in a Renewed Federalism*. April 2011. Available from: http://www.caledoninst.org/Publications/PDF/932ENG.pdf

23. Canadian Centre for Policy Alternatives. *Putting Our Money Where Our Mouth Is: The Future of Dental Care in Canada*, CCPA, April 2011. Available from: http://www.policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2011/04/Putting%20our%20money%20where%20our%20mouth%20is.pdf

24. Office of the Chief Dental Officer, Health Canada. *Oral Health Care in Canada*.(Power point presentation by the OCDO, Health Canada, October 2009.)

25. Jackson SL, Vann WF Jr, Kotch JB, Pahel BT, Lee JY. Impact of Poor Oral Health on Children's School Attendance and Performance. *Am J Public Health*. 17 Feb. 2011. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/21330579

26. Pahel BT, Rozier G, Stearns SC, Quinonez RB. Effectiveness of Preventive Dental Treatments by Physicians for Young Medicaid Enrollees. *Pediatrics*. 2011;127; e682-e689.

27. Caledon Institute of Social Policy. *Health Care in a Renewed Federalism*. April 2011. Available from: http://www.caledoninst.org/Publications/PDF/932ENG.pdf