Bridges
Community Health Centre
Fort Erie and Port Colborne/Wainfleet

Bridges Community Health Centre
Dental Health Report
June 2014

Prepared by

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Executive Summary

In direct response to the poor dental health conditions experienced by our clients, Bridges Community Health Centre (CHC) developed and administered a dental health survey in order to paint a fuller picture of the dental health inequities that result from a market-based approach. Our intention is to use this information to leverage our advocacy work with local politicians and decision makers in support of the expansion of publicly-funded dental health programs for low-income adults and seniors.

In order to set the stage for our findings and recommendations, the report opens with a synopsis of the physical, psycho-social and economic consequences associated with poor dental health followed by a brief overview of dental health policy.

The survey findings reveal that only 1 in 5 respondents have private dental coverage with the remainder receiving emergency coverage through Ontario Works (OW) (16%), limited coverage through the Ontario Disability Support Program (ODSP) (21%) or no coverage all (38%).

The majority of respondents (70%) cited cost as a barrier to accessing a dentist and approximately 9% experienced difficulty finding or accessing a dentist in their community. Given the low rate of private coverage and the prevalence of cost as a barrier, it is not surprising that 53% of respondents have not seen a dentist in the last year and over half (54%) rated their dental health as poor or fair.

> *"I worked my whole life and my teeth were always nicely kept. I got ill and no longer work so I have no coverage. My teeth are rotting due to meds causing dry mouth besides chronic health concerns now I don't want to smile and my bottom teeth will be falling out. Terrible. It makes me sick."*

With no or limited coverage, and the inability to pay out of pocket for dental care, many people are left dealing with dental issues on a daily basis. Approximately 50% experience dental pain, close to half have missing, loose or broken teeth, 13% have abscesses and 23% have swollen or bleeding gums. No access to preventive and restorative care contributes to infections forcing 19% of respondents to visit urgent care or an emergency room for treatment. Respondents also indicated they dealt with dental emergencies on their own 7% of the time.

Poor dental health is having a direct impact on psychological, social and economic well-being. 40% claim their self-esteem has been negatively affected because of decaying and/or missing teeth. One respondent directly attributed their job loss to dental health issues and many commented on missed days at work and a growing concern over their declining dental health.

We conclude the report with a set of recommendations for action at the municipal, regional and provincial level aimed at increasing awareness and building capacity for upstream public health policies that extend dental health coverage for low income adults and seniors.

Background

According to the World Health Organization (2003), “oral health is an important part of overall health and a determinant of the quality of life.” Unfortunately, teeth and gums are not addressed under the Canada Health Act leaving far too many people without coverage and ultimately, poor oral health. However, this exclusion of teeth and gums from our health care system comes with a hefty cost.

As one of Ontario’s 75 CHC, Bridges offers primary care, health promotion, illness prevention and community development services to clients who are living in poverty on a daily basis either because of inadequate pensions and social assistance rates, or because they are struggling due to precarious employment or a minimum wage that leaves even full-time earners living below the poverty line. Many clients present with poor oral health conditions and our health care providers have no options for addressing their issues other than prescribing antibiotics for infections or helping them with short-term pain relief. To make matters worse, many clients are already living with a chronic illness potentially caused or exacerbated by poor oral health.

> *“I was recently fired because I had to take sick days from my job for dental care and under dentist's orders to stay out of the cold and not raise heart rate in order for my dry socket not to return and require further dental care.”*

In response to our clients' oral health needs, Bridges CHC became involved in the Ontario Oral Health Alliance (OOHA), an umbrella organization uniting the voices of those in Ontario who lobby and advocate for better access to oral health. In 2012, we participated in OOHA’s postcard campaign highlighting gaps in support for adults with severe dental problems by collecting signatures on the postcards and delivering them to Members of Provincial Parliament in Niagara Falls, Welland and St. Catharines.

Moving forward with our advocacy efforts, we recognized the need for more evidence to leverage our work at the local level. The dental health survey marked the next stage of our strategy.

Method

A total of 564 dental health surveys were collected in the communities of Fort Erie, Port Colborne and Wainfleet, between the months of February and April 2014. A purposive sampling method was chosen since we were interested in gathering responses from specific segments of our priority populations: working poor, Ontario Works and Ontario Disability recipients and seniors. The majority of surveys were completed by respondents in hard copy format at Bridges Community Health Centre in Fort Erie and Port Colborne and at our community partner agencies including: Port Cares, Fort Erie Native Friendship Centre, Fort Erie Salvation Army and Community Outreach Program Erie. Participants were also given the option to complete the survey online. Social media and a poster were used to promote the survey and a local newspaper ran an article (http://www.forterietimes.ca/2014/02/25/bridges-looks-at-port-wainfleet-fort-erie-and-concerns-over-lack-of-coverage).

Synopsis of the Physical, Psycho-social and Economic Consequences of Poor Oral Health

There is no shortage of evidence pointing to the link between poor dental health and the impact it has on a person's health and well-being. From a physical health perspective, there is a wealth of scientific evidence that links periodontal disease to a number of ailments, including respiratory infections, cardiovascular disease, diabetes, poor nutrition, low birth weight babies, osteoporosis and rheumatoid arthritis[1] (King, 2012). However, the importance of good oral health goes well beyond physical health.

Untreated oral health conditions contribute to disfiguring tooth loss and decay that can have a profound impact on functional, psychological and social dimensions of a person's health. For example, the mouth is front and centre in social encounters and there is a stigma associated with an "unhealthy" smile. Studies reveal that when people are ashamed of their teeth it affects their self-image and ability to communicate. This contributes to lower self-esteem and confidence and ultimately it can impact on employment opportunities and social relations, including intimacy (Locke, 2009).

> *"I went to a dentist that would cover welfare when I was on welfare at the time and instead of fixing the tooth because I could not pay and welfare would not cover I had to have the tooth removed."*

There is a compelling fiscal argument for investing in oral health services for individuals who are unable to afford it. Limited or no access to dental health services also has indirect costs associated with time loss from work, school and normal activities due to dental problems and treatment. According to a Canadian study conducted by Hayes et al (2013), the average time loss from normal activities due to dental problems and treatment is equal to 40.36 million hours with subsequent potential productivity losses of over 1 billion. Hayes also argues that we need to look at time loss for major restorative and surgical work and time loss for check-up and preventive care independently. She claims these distinct reasons for time loss, defined as "good" and "bad", are currently not on the radar of policy and decision makers. However, from a public policy

[1] **Respiratory Infections** – Many studies have shown that poor oral hygiene in older adults is a major risk factor for aspiration pneumonia. The micro-organisms that cause pneumonia are commonly found in significantly high concentrations in the dental plaque of elderly people with gum disease. **Cardiovascular Disease** - There is also a link between gum disease and cardiovascular disease (CVD). However, there is no evidence to confirm a causal relationship or that treating gum disease will prevent CVD or modify its outcomes. **Diabetes** – The connection between periodontal disease and diabetes is what is described as a two-way relationship. People with diabetes have a higher susceptibility to contracting infections, and so are at greater risk of developing gum disease. Conversely, oral infections can increase the severity of diabetes by increasing blood sugar levels. Harmful periodontal bacteria may mediate increases in insulin resistance, resulting in an increase in blood glucose. **Poor Nutrition** – Poor oral health can have a significant impact on nutritional status. If your mouth is sore and infected, it is hard to eat. For some, particularly seniors, poor oral health can lead to substantial weight loss, dehydration, and infirmity. Low Birth **Weight Babies** – Poor oral health in pregnancy may also have a negative effect. There is evidence that suggests that periodontal disease may contribute to premature delivery and/or low birth weight in the newborn baby. In turn, babies who are pre-term or low birth weight have a higher risk of developmental complications, asthma, ear infections, birth abnormalities, and behavioural difficulties, and are at a higher risk of infant death. Bone-related and inflammatory conditions in seniors linked to oral health status. **Osteoporosis** – This disease is characterized by decreased bone density and weakened bones. Dentists are in a very good position to help identify people with osteoporosis because early signs of the disease can often be seen in the mouth and detected through oral examination and dental x-rays. **Rheumatoid Arthritis** – Rheumatoid arthritis and gum disease are both chronic inflammatory conditions, and researchers have discovered that the management of gum disease with cleanings and antibiotics also has a beneficial effect on the signs and symptoms of rheumatoid arthritis.

programming perspective, this line of argument supports raising the financial eligibility level of current public programs in order to mitigate time loss (Hayes et al, 2013:17).

When assessing the economic consequences associated with a lack of access to preventive care, we also need to consider the costs of emergency room visits related to dental pain and infection. According to data from the Ministry of Health and Long Term Care, there are over 270,000 visits per year to doctors and hospital emergency rooms across Ontario by people with dental pain and infection. In 2012, Niagara alone saw 1900 people visit an emergency room with dental pain and infection costing the health care system approximately 1 million dollars (Ministry of Health & Long Term Care IntelliHEALTH ONTARIO).

The consequences of individuals not having access to oral health services come with serious economic costs and carry a painful human toll. These costs and issues could be seriously curtailed, and many of them avoided altogether, if preventive treatments were made available to low-income adults and seniors.

A Brief Review of Dental Care Policy

Regulated dentistry got its start in Canada in 1867, the first nation in the world to legislate the profession. According to Quienonez (2013:6), “the intent was to protect the public from poorly-trained or self-proclaimed dentists and ensure safe and effective dental treatment.” Since this time, dental care services in Canada have been delivered primarily through the free market. Some consideration was given to including the mouth and teeth in the Canada Health Act, but the dental profession established firm control over the allocation of dollars to avoid government control over the profession (Quinonez, 2013). During these conversations, it was also reasoned that cavities were in decline and fluoride was believed to be an alternative to large-scale treatment. Moreover, the dominant ideology was that teeth were an “individual responsibility not a social one” (Quinonez, 2013:2).

Although dentistry has been largely delivered through the private sector since its inception, there has been some provision of publicly-funded dental health programs supported by a patchwork of federal, provincial and municipal dollars. At its peak, public dental care represented 15% of all dental health in Canada (Yalnizyan et al., 2011). However, the last three decades have seen significant reductions.

The 1980s and 1990s were marked by government cutbacks in many social programs, and dental care came to be seen as a luxury by governments. As of 2010, national public expenditures as a percentage of total dental care costs are 4.9 per cent, the lowest proportion in Canada’s recent history (Yalnizyan and Aslanyan, 2011: 32-33). Public expenditures also vary by province (Moeller, 2012:5). Saskatchewan and Manitoba provide the highest proportions of public expenditure, at 13.8 per cent and 10.8 per cent, respectively, while Ontario provides the lowest at 1.3 per cent annually (Moeller, 2012).

At the same time that public programs have declined, dental health care services per capita have almost tripled since 1975 (Sadeghi, Manson & Quinonez, 2012)**.** Financial incentives for dentists to charge increasingly higher premiums have been reinforced by "anxious patients, the prestige associated with costly technological care while the third party reimbursement system requires annual growth in profit margins for insurers." Meanwhile, public funding for vulnerable individuals has not experienced a similar growth (Sadeghi, Manson & Quinonez, 2012)**.** Given the fact that access to dental health services depends on private insurance or the means to pay out of pocket, our current system does not ensure adequate oral health care for a sizeable portion of the population, including many low-income families, seniors and persons with disabilities. The current model is clearly inequitable and extremely prejudicial to vulnerable populations.

The precariousness of access to dental services, especially for low-income Ontarians, makes little sense since once these same Ontarians develop a serious health condition linked to poor oral health they are able to access treatment and care through the publicly-funded health care system.

"I have used my savings to fix my teeth. Next I will sell my house."

So what are the main issues holding back dental services for low-income adults and seniors? According to Leake (2000), health care policy is narrowly defined as a publicly funded sick-care delivery system. When making policy, we only look at direct costs, not the consequences of dental issues which we know have a significant economic impact. The fact that we do not differentiate between direct costs and costs incurred through the progressive tax system is putting the cost of dental diseases as third highest, behind cardiovascular diseases and mental health (Leake, 2000). This evidence appears to have escaped detection of our policymakers.

There also appears to be a blatant case of prejudicial and discriminatory policies in terms of subsidies for dental health services where higher income Canadians benefit and lower income Canadians subsidize the care of their wealthier counterparts. Case in point, under current tax law, Canadians do not pay federal or provincial tax on health insurance premiums paid by employers. This results in 3 billion annually by not taxing private insurance premiums (Romanow, 2002:5). These are inequitable subsidies where higher income individuals receive more generous relief from governments in Canada than do lower income individuals. A greater proportion of middle and higher income households consistently receive relief from government than their lower income counterparts (Sadeghi, Manson & Quinonez, 2012). Secondly, all Canadians including poor and other economically disadvantaged pay additional taxes (income tax, gas, provincial and

"My teeth are always sore and cause me to have headaches, bother me 24/7."

federal sales tax) in order to make up for the revenue governments forgo in not taxing health insurance premiums (Sadeghi, Manson & Quinonez, 2012).

The dental health survey undertaken by Bridges Community Health Centre offers a fuller picture of the dental health inequities resulting from this market-based approach in our communities.

Bridges CHC Dental Health Survey Findings

Last visit to a dentist (Chart A)

- 53% of respondents have not seen a dentist in the last year
- 15% of respondents have not seen a dentist in 7 years or longer

Self-rated dental health (Chart B)

- 25% of the respondents stated they had poor dental health
- 29% describe their dental health as fair

Dental coverage (Chart C)

- 70% of respondents are unable to afford a dentist
- 21% of respondents indicated they have private insurance
- 16% have limited coverage through Ontario Works
- 21% have limited coverage through the Ontario Disability Support Program
- 38% of respondents indicated they had no dental coverage

Access barriers (Chart D)

- 70% of respondents cited cost as a barrier to seeing a dentist
- 9% indicated they had difficulty finding or accessing a dentist

Prevalence of dental health issues (Chart E & F)

- 50% experience pain while eating
- Nearly 1 in 2 experience dental pain because of missing, loose or broken teeth
- 13% have abscesses and 23% have swollen or bleeding gums
- Close to 40% state their self-esteem has been affected by dental health issues

Dental emergencies (Chart G)

- Nearly 1 in 5 visited urgent care or an emergency room
- 17% did nothing when they experienced a dental emergency
- 7% said handled the emergency on their own

Chart A

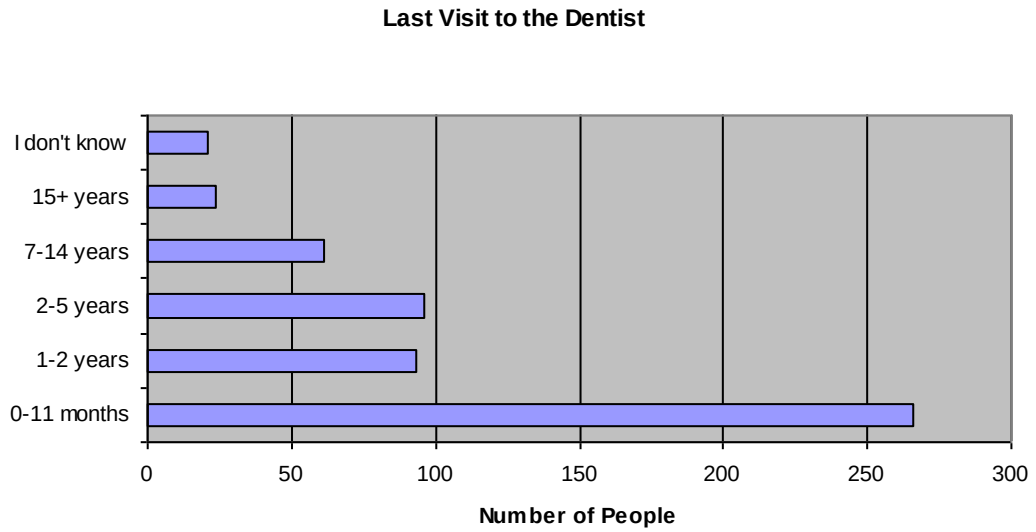


Chart B

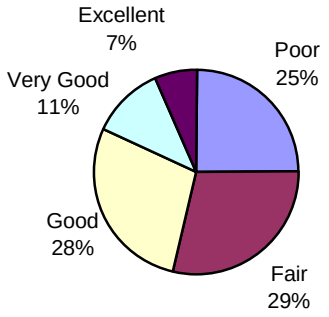


Chart C

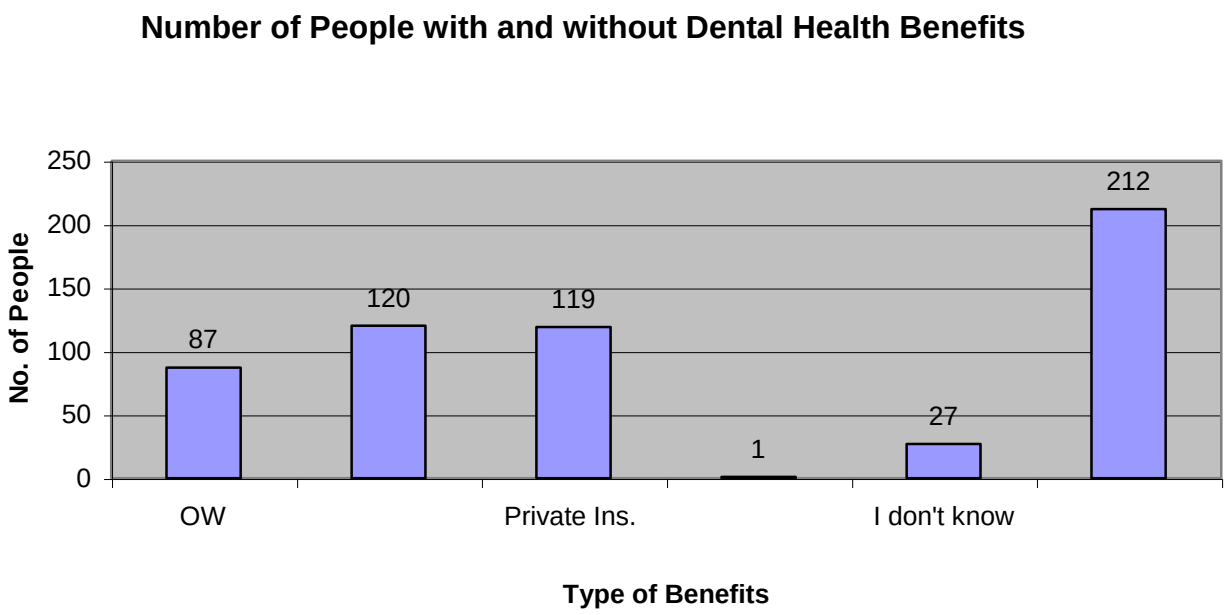


Chart D

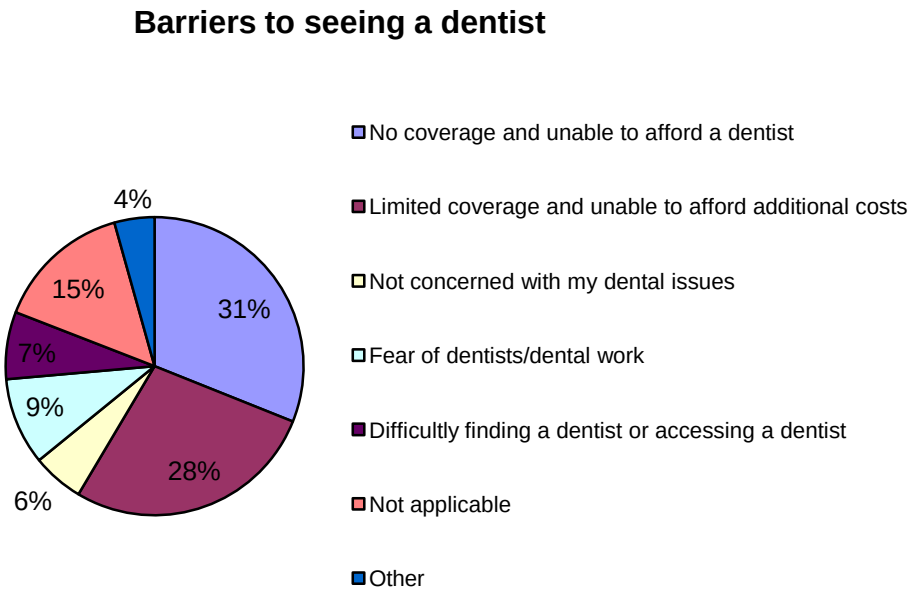


Chart E

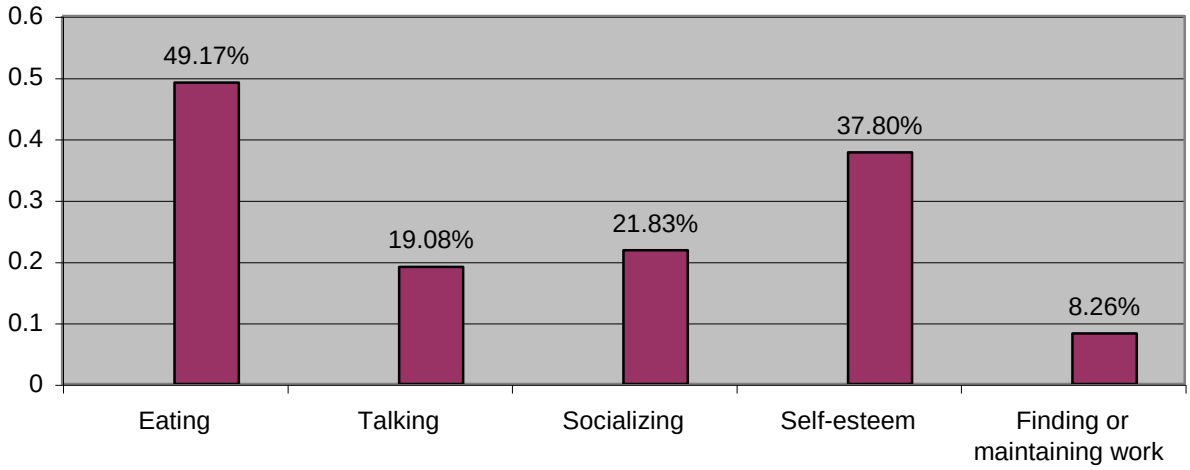
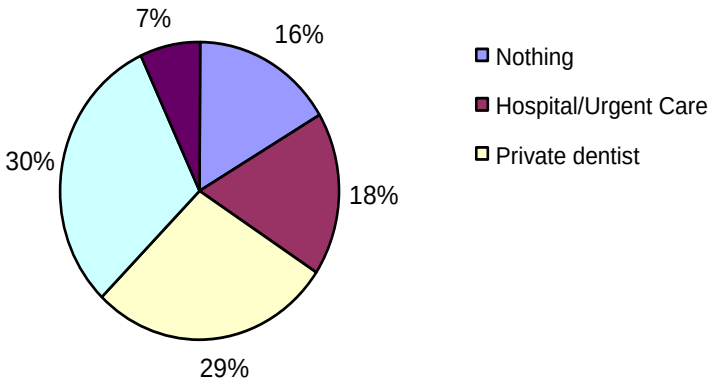


Chart F



Discussion

Only 1 in 5 respondents have private dental benefits with the remainder having limited coverage through Ontario Works (16%) or the Ontario Disability Support Program (21%) and 38% no coverage at all. Given the low rate of private coverage and the prevalence of cost as a barrier (70%), it is not surprising that 53% of respondents have not seen a dentist in the last year and over half (54%) rate their dental health as poor or fair.

With no or limited coverage and an inability to pay out of pocket, many people are living with dental issues on a daily basis and are concerned about their declining dental health. Approximately 50% of respondents experience dental pain, close to half have missing, loose or broken teeth,13% have abscesses and 23% have swollen or bleeding gums. Many respondents also commented on dentures either because they were loose, broken, ill fitting or that they were unable to get dentures because they are cost prohibitive.

In the absence of coverage and no means to pay for preventive and restorative care, oral infection rates can be expected to increase and ultimately result in visits to the urgent care or emergency room. Close to 1 in 5 respondents have gone to an urgent care centre or emergency room in order to treat an oral infection. Respondents also indicated they dealt with dental emergencies independently 7% of the time. Comments included accounts of self-treating their dental emergency by removing their tooth or gluing a tooth back in place in order to protect an exposed nerve. Others used prescribed or over the counter pain medication or home remedies to manage their pain.

"I am ashamed of my appearance."

With limited dental health options, many respondents commented on having no choice but to have their tooth extracted since restorative options are cost restrictive. While extraction is sometimes inevitable, it should not be regarded as an easy option just because it is cost effective. The implications of missing teeth have already been noted. Keeping your teeth requires dental care that goes beyond emergency care, an option often not available to adults with low incomes.

"I was almost crazy with pain. I glued a tooth piece back on exposed nerve."

Poor dental health is having a direct impact on psychological, social and economic well-being. 40% claim their self-esteem has been negatively affected because decaying or missing teeth. Many felt they could no longer smile because of the shame and embarrassment of decaying and/or missing teeth. One respondent remarked on how their dental health issues were contributing to their depression and an overall sense of hopelessness. Multiple respondents indicated they had missed work, one lost their job and many felt an overall sense of hopelessness about their situation.

Earlier concerns around difficulties with OW/ODSP clients accessing a dentist prompted us to contact local dental offices and inquire into whether or not they are accepting social assistance clients. At the time, none of the dentists in Port Colborne, and multiple

dentists in Fort Erie, were not accepting new OW/ODSP clients. Interestingly, dentists are only receiving 47% of recommended Ontario Dental Association payment rates when providing care to OW and ODSP recipients. This matter requires further attention into access issues for social assistance recipients.

> *"I almost overdosed on pain meds (took on own), hospital said they couldn't treat me, said I needed to go and see a dentist."*

Upon reviewing the literature on public funding for dental health programs, we learned there are discrepancies in the allocation of discretionary benefits across the province. In her thesis, McKay (2013) explains how discretionary benefits are cost-shared between a municipality and the Ministry of Community and Social Services and how there tends to be variability depending on regional budgets. Further to this, personal communications with the Ministry of Community and Social Services revealed there is no requirement under the Ontario Works Act for municipalities to provide discretionary funding for dental services. Funding under discretionary benefits is at the sole discretion of the local Ontario Works Administrator and is based on locally established policies around the types of services to be funded and the amounts to be provided. The discretionary nature of these benefits is intended to provide municipalities with the flexibility to address local priorities and needs (Anna Cain, personal communication, May 5, 2014). As a result, there is a great deal of variability of how dental discretionary benefits play out across the province. The following information is an excerpt taken from McKay's thesis:

> *"Adult recipients of OW living in the Durham Region find their benefits limited to emergency dental treatment for no more than two teeth per year (Durham Region, 2011), while those living in the London region can receive restorative care for two teeth and up to four extractions every six months (Middlesex-London Health Unit, 2010). Those in the Middlesex region are limited to services for relief from pain and infection to a maximum of $250 per year (Middlesex-London Health Unit, 2010), while in the Muskoka region the annual maximum is $400 (District of Muskoka, 2012). In some cases municipalities also support local programs for special target populations such as seniors (City of Toronto, 2006; Peel Region, 2011). Here too, regional variation in programming is the norm. For example, seniors in the City of Toronto are eligible for, but limited to, one course of dental treatment and a cost-shared denture program (City of Toronto, 2006), while in the region of Peel, low-income seniors can access a fairly extensive public program (Peel Region, 2011)"*

In Niagara's case, OW recipients are limited to dental work for the relief of pain and suffering only to a maximum of $135 per month, not including laboratory fees.

We feel that since the allocation of public money does not allow any clear, transparent, and evidence-based rationing principles, it raises practical and ethical questions in terms of who benefits from publicly funded dental care, and who is further disadvantaged. McKay (2013) argues that we need a fair process for making decisions

on how and where funds are allocated and suggests that a broad range of stakeholders are needed when making these decisions, including client voices if we want to establish a system that reflects the values of society rather than those of special interest groups.

Conclusion:
When it comes to dental health, our market-based system is resulting in dental health inequities where wealthier segments of the population benefit, and poorer segments not only suffer, but ultimately subsidize coverage for wealthier citizens. Moreover, our current approach carries significant consequences, both financial and human, that are ignored by policy makers. The survey results provide a partial picture of how these consequences play out for individuals in our community.

We feel that in order to correct the health inequities in dental health, we need a system that provides cost-effective oral health promotion and disease prevention. Investments in oral health will reduce costs in the long term since it will prevent the need for costly restoration fees to address dental decay while benefiting the broader health system by mitigating the downstream costs associated with systematic diseases linked to oral disease and chronic disease. Finally, an upstream approach will contribute to a strong economy since good oral health contributes to good physical health and self-esteem needed for secure productive employment.

Recommendations and Next Steps

Knowledge Transfer and Awareness Raising Strategy

- Disseminate the report to professional contacts, networks and Niagara Connects
- Presentations to Fort Erie, Port Colborne and Wainfleet Municipal Councils, Niagara Region Public Health and Social Services Committee and Bridges CHC Primary Care team, HNHB LHIN and four Niagara area Health Links
- Highlight survey findings in Bridges CHC community newsletter
- Share information on Bridges CHC website and via social media i.e. Facebook and Twitter
- Media release to local newspapers and news sources

Provincial

Advocacy/Capacity Building

- Continued support for OOHA and AOHC initiatives advocating for dental services for low-income adults and seniors

- Further research into Ministry of Community and Social Services dental payment rates

Regional/Municipal

Advocacy/Capacity Building

- Bridges CHC to partner with Niagara Region Public Health to provide fluoride varnish clinics for children and youth who have no coverage and are ineligible for Healthy Smiles or whose families are receiving OW/ODSP

- Further research into the evidence determining the allocation of dental discretionary dollars

- Coordinate a professional information event targeting dentists, dental hygienists, local politicians, business community and local health care leaders to present the findings of the report

- Assess the level of interest and support for a Dental Health Coalition

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