Access to Affordable Oral Health Care in Waterloo Region

A report for the Waterloo Region Oral Health Coalition

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The following report was prepared for the Waterloo Region Oral Health Coalition as part of a Master of Public Health Practicum with the Kitchener Downtown Community Health Centre. The Coalition requested a report on the nature and extent of the oral health care access issue in Waterloo Region, including who is primarily affected. The report is intended to assist the Coalition with planning education and advocacy activities to meet its goals.

Highlights

- Oral health is important to overall health. Dental decay and gum disease can: increase the risk for heart disease, diabetes, respiratory disease, pre-term and low-birth weight babies; lead to pain, infection, difficulties eating and talking; and negatively affect one's self-esteem, social connectedness, and employability.

- Oral health is primarily influenced by the social determinants of health; socioeconomic status plays a much bigger role in oral health than health behaviours and oral hygiene habits.

- Medicare/OHIP covers care of the lips, tongue and throat but not the teeth and gums. The oral health care system is almost entirely privately financed with about 50% paid through employer-provided benefits programs and 44% paid out-of-pocket. The remaining portion is publicly-funded by federal, provincial and municipal governments. This system creates inequitable access to oral health care.

- 30-40% of Waterloo Region residents don't have dental insurance. Those with children in the household, single individuals, immigrants, older adults, those with lower educational attainment, and those living in low income are less likely to have dental insurance coverage and can least afford to pay out-of-pocket for dental care.

- About one-third of Waterloo Region residents have not been to a dentist in the past year. 17% of Canadians don't see a dentist because of the cost. 10% of Waterloo Region residents reported that they've turned down or refused necessary dental treatment because they didn't have insurance.

- When people who can't afford dental care have a dental issue, they often go to the ER or their physician. Physicians may prescribe painkillers and/or antibiotics to help manage the issue temporarily, but they are not qualified to treat the underlying dental problem.

- Every nine minutes, a person in Ontario visits an ER for a dental problem. In 2015, there were 61 000 ER visits, costing the health care system $31 million. There were 1295 visits, by 1174 patients, to Waterloo Region's three hospitals at a cost of $664 000; half of these visits were urgent/potentially serious. In 2014, there were 9527 physician visits for dental problems in the WWLHIN area at a cost of $321 000

- Canadians generally enjoy good oral health however there are segments of the population who have limited or no access to affordable oral health care and who consequently experience a disproportionate burden of oral diseases. In Waterloo Region these groups include:
    - Individuals with low income (including children living in low-income families, the working poor, seniors on fixed incomes)
    - Refugees and immigrants

    - Low-German speaking Mennonites from Mexico
    - People who are homeless
    - Long-term care residents

- Some children and youth in low-income households are eligible for preventive and emergency oral health services through Healthy Smiles Ontario. Adults on social assistance are eligible for very limited basic and emergency dental care. If people do not qualify for social assistance but do not have employer-provided benefits, they must pay out-of-pocket for dental care. This creates a considerable financial burden, especially for the working poor and older adults on fixed incomes.

- Based on the number of low-income residents in Waterloo region, the proportion of people who work in jobs with low wages and no benefits, and the proportion of people who report not going to a dentist because of cost, the Waterloo Region Oral Health Coalition conservatively estimates that 60 000 – 90 000 people in the Region may experience difficulties accessing affordable dental care.

- For individuals not receiving social assistance or employer-provided dental benefits, the options for accessing low- or no-cost dental care in the Region are very limited.

Access to affordable oral health care in Waterloo Region

Introduction

The World Health Organization defines oral health as, “a state of being free from chronic mouth and facial pain, oral and throat cancer, oral sores, birth defects such as cleft lip and palate, periodontal (gum) disease, tooth decay and tooth loss, and other diseases and disorders that affect the oral cavity and limit an individual’s capacity in biting, chewing, smiling, speaking, and psychosocial wellbeing” (2012). There are many factors that contribute to oral health including diet, tobacco and alcohol use, oral hygiene habits, and probably most importantly, social determinants (WHO, 2012).

Canadians generally enjoy good oral health however there are segments of the population who have limited or no access to affordable oral health care and who consequently experience a disproportionate burden of oral diseases. Lower income earners, older adults, the uninsured, those with lower education, immigrants, and members of Aboriginal/First Nations communities face significant inequalities when it comes to dental care and oral health. They are less likely to visit a dentist, tend to go to the dentist for emergencies only, are more apt to be without their natural teeth, and are more likely to experience social limitations because of oral health problems (PHO, 2012).

While oral health is essential to maintaining good overall health, the care of teeth and gums is not part of Medicare. OHIP covers some dental surgery when it is done in a hospital but regular dental services performed in a dental office are not covered. Oral health care is almost entirely privately financed through employment-based benefits and out-of-pocket payments. A very small proportion of costs are covered by publicly-funded programs, creating significant barriers to getting care. Canada’s oral health care system is an example of “inverse care law”, i.e. people that need the most care receive the least. Although general medical health care is available to people who need it, regardless of their ability to pay, that is not the case with oral health care (CAHS, 2014).

The Waterloo Region Oral Health Coalition formed in the spring of 2016 with the vision that all Waterloo Region residents have access to affordable oral health services. Coalition members include health, education and social service agencies as well as citizens with lived experience. Members believe that access to oral health care should not be limited to people with private dental insurance or those who can afford to pay out of pocket. The Coalition supports education, advocacy and action locally and provincially to increase access to affordable oral health services for individuals and families. Specifically, the Coalition is calling on the Ontario Government to include oral health as part of primary care transformation initiatives, and to expand public oral health programs with prime consideration for low-income adults and seniors. The purpose of this report is to describe the nature and extent of the oral health care access issue in Waterloo Region using existing national, provincial and local data. Information in the report is meant to assist the Coalition with determining activities it will undertake to meet its goals.

Profile of Waterloo Region

Population and population growth
In 2011 the population of Waterloo Region was 507 096; in 2016 it was 535 154, an increase of 5.5% from the previous Census (Statistics Canada, 2017).

Age breakdown
According to the 2011 Census (the most recent data available) just under one quarter (22.37%) of residents are aged 17 years and younger. Almost two-thirds (65.1%) are between 18 and 64 years of age, and 12.5% are aged 65 and older (Statistics Canada, 2012).

Language
English is the mother tongue for 76% of the population; French for 1.23% of residents. A language other than English or French is the mother tongue for 22.8% of people in Waterloo Region (Statistics Canada 2012).

Education
The National Household Survey provides data on educational attainment and employment. Of Waterloo Region residents aged 15 and over, 20.16% (82 010/406 695) have no certificate, diploma or degree; 27.77% (112 930/406 695) have a high school diploma or equivalent; and 52.06% (211 755/406 695) have a post-secondary certificate, diploma or degree (Statistics Canada, 2013).

Employment
Of residents aged 15 and over, 69.75% (283 680/406 695) are in the labour force; 64.87% are employed; and 4.88% are unemployed. In 2010, 80% (215 935/269 925) of people worked full-time while 20% (53 985/269 925) worked part-time (Statistics Canada, 2013).

Income
In 2015 Region of Waterloo Public Health produced a series of briefs on the low income status of Waterloo Region residents between 2007 and 2012. The information came from Statistics Canada's Taxfiler data and used the Low Income Measure After-Tax (LIM-AT) to identify people living with low income. The data revealed that in 2012, approximately 60,610 residents of Waterloo Region (12.1%) were living with low income, a lower proportion compared to Ontario as a whole. There was little change in the proportion of individuals living with low income in Waterloo Region between 2007 and 2012, however income disparity increased. The median after-tax income of all Waterloo Region residents in 2012 was four times greater than that of residents living with low income ($52,800 versus $12,740). The gap in median after-tax income went from $37,690 in 2007 to $40,060 in 2012 (ROWPH, 2015b).

In 2012, 3,680 couple families without children (6.7%) were living with low income while more than 4,600 couple families with children (6.8%) were living below the Low Income Measure. A greater proportion of families with three or more children were living with low income compared to families with only one or two children. The proportion of families with children living in low income was relatively stable between 2007 and 2012. The median after-tax income of all families with children was more than double that of those living in low income in 2012. There was a disparity in median after-tax income of $66,730 for families with one child; $69,990 for families with two children; and $55,890 for families with three or more children (ROWPH, 2015b).

More than 6,000 lone-parent families (30%) were living below the low income measure in 2012. As with couple families, lone-parent families with three or more children had the highest rate of low income compared to those with one or two children. The median after-tax income of all lone-parent families with children was close to double that of those living in low income. The largest difference was seen in lone-parent families with one child, with those in low income earning 2.5 times less than all lone-parent families with one child ($15,120 versus $38,410). The income gap between all lone-parent families with children and those living with low income rose between 2007 and 2012. In 2012, there was a disparity in median after-tax income of $23,290 for lone-parent families with one child; $20,960 for lone-parent families with two children; and $13,330 for lone-parent families with three or more children (ROWPH, 2015b).

In 2012, the number of children under age 18 whose families were living in low income was approximately 17,880 (15.6%). The proportion of children in families with low income was relatively stable between 2007 and 2012 (ROWPH, 2015b).

An estimated 17,650 individuals, or nearly one-quarter of non-family individuals, were living below the low income measure in 2012. The income gap between all individuals and those living with low income has increased since 2010 in Waterloo Region. The difference between the median after-tax incomes of those living in low income and those who are not was $16,570 in 2012 (ROWPH, 2015b).

About 2,510 Waterloo Region adults aged 65 years and older (3.8%) were living with low income in 2012, slightly lower than Ontario as a whole (5.7%). Following a peak low income rate of 5.4% in 2010, the proportion of older adults living with low income in Waterloo Region has declined (ROWPH, 2015b).

More than one-third (37%) of people who are living with low income in Waterloo Region are employed, and 68% of them are working full-time. However, working full-time at minimum wage does not provide enough income to raise a family above the poverty line. In 2007, 34% of Ontario children who were living in low income lived in a family where at least one parent was working the equivalent of a full time, full year job. Between 2000 and 2005 there was a 24% increase in the rate of working poverty among Ontario's working-age population. Unstable or precarious forms of employment including temporary, part-time and casual forms of work are becoming increasingly common in Ontario. This means that a growing number of people work in low-paying jobs with unpredictable hours, no benefits, and less job security (Region of Waterloo, n.d.).

Immigrant status

From 2006 to 2011, 15 465 people immigrated to Waterloo Region. Immigrants make up 22.3% (111 495/499 610) of the population (Statistics Canada, 2013). A series of fact sheets by Region of Waterloo Public Health provide a profile of immigrants in the Region. The unemployment rates of recent and established immigrants are estimated to be slightly lower than the provincial rates, however twice as many recent immigrants (14%) are unemployed compared to established immigrants and Canadian-born individuals (7%). An equal proportion of recent and established immigrants (62%) participated in the labour force but the proportion was lower than Canadian-born individuals (73%) (ROWPH, 2015c).

Recent immigrants have achieved a higher level of education than established immigrants and Canadian-born individuals. 62% of recent immigrants have a post-secondary certificate, diploma or degree compared to 56% of established immigrants and 51% of Canadian-born individuals.

In 2010, the median employment income of recent immigrants was $23 961, 45% lower than that of Canadian-born individuals ($34 748) and 67% lower than the most prosperous established immigrants (those who immigrated between 1981 and 1990) in the Region ($40 175). Compared to all of Waterloo Region, the median employment income of recent immigrants was 31% lower (ROWPH, 2015c).

Social assistance

The average number of Ontario Works (OW) cases in Waterloo Region in 2016 was 8724, an increase of almost 5% from 2015. The rise in caseload was higher in Waterloo Region compared to the province as a whole. In addition, the local OW caseload has increased substantially over the last eight years. The average in 2008 was 6,292 cases. In December 2016, there were 11,698 Ontario Disability Support Program cases, up 3.8 per cent from a year earlier (Region of Waterloo, 2017).

In Ontario as a whole, the number of OW beneficiaries is approximately 1.77 times the number of cases and the number of ODSP beneficiaries is about 1.37 times the number of cases. A case refers to a single individual or a family unit on social assistance whereas the number of beneficiaries refers to the total number of single individuals and heads of family units on social assistance plus all their dependents (i.e., spouses, dependent children and dependent adults) (MCSS, 2017). If the ratio of beneficiaries to cases in Waterloo Region is comparable to that of the province, there could be over 15 000 OW beneficiaries and 16 000 ODSP beneficiaries. This would mean that over 30 000 residents are eligible for some type of dental care. Dental coverage provided by social assistance is outlined later in this report.

Individuals in receipt of OW, ODSP, and individuals who are working full time at minimum wage are living below the Low Income Cut-Off. After paying market value rent and buying healthy food, a single person on OW would have no money left to cover other basic necessities such as utilities, clothing and transportation, let alone pay for dental care. In fact, they would be overspent by nearly $240 for the month (Region of Waterloo, n.d.).

Region of Waterloo Social Services conducted a review of discretionary benefits in 2012, which included a survey of OW and ODSP participants. Participants identified dental costs for adults as the most important discretionary benefit, ahead of last month's rent. In consultations with community partners and employment and income support staff, dental costs were ranked fourth and fifth respectively. When asked why these benefits were the most important, the common themes were that they support the health, well-being and stabilization of individuals on assistance; maintain or improve quality of life; and other options or resources are limited. Without the benefits, survey respondents felt that ODSP participants would experience negative health, social, educational and emotional impacts (ROW Social Services, 2012).

Determinants of oral health

There are a number of factors, from systemic to individual that influence oral health and oral health disparities. Key determinants include:

- Economic, political and environmental conditions such as socioeconomic status, health and social policy (e.g. government spending on oral health care), access to dental insurance,

food security, access to transportation, inclusion of oral health in the school curriculum, availability of timely, affordable and appropriate oral health care, and the fluoride level in the drinking water;
- Social, cultural, community and family context including norms about oral health knowledge, attitudes, beliefs, values, skills and behaviours, peer groups, cultural identity, social support, self-esteem, and self-efficacy;
- Oral health related literacy and behaviours such as diet, oral hygiene, tobacco, alcohol and drug use, and use of oral health services;
- Individual factors that cannot be controlled such as age, sex, and genetic and biological endowment (Government of Victoria, 2011).

Dental caries and gum disease are largely avoidable by maintaining good oral health habits such as brushing and flossing daily, eating a well-balanced diet, limiting consumption of foods and beverages high in sugar, avoiding tobacco and recreational drug use, and visiting a dental professional regularly (Health Canada, 2009; CDA, 2017; ODA, 2016). However preventive behaviours have much less of an influence on inequalities in oral health and oral health care compared to socioeconomic factors such as poverty and precarious work. Research has found that limited or no access to oral health care accounts for 45% of inequality in dental decay and 38% of inequality in oral pain (CAHS, 2014).

Who is most affected?

There are a number of groups who experience barriers to oral health care and who are therefore at greater risk of poor oral health outcomes. These include: individuals with low income; children, especially those living in low-income families; young adults and others who work but do not have dental insurance; long-term care residents; Aboriginal peoples; refugees and immigrants; people with disabilities; people who are homeless (especially if they have a drug addiction); and people living in rural and remote regions. Furthermore there is increasing evidence that individuals with lower middle incomes are also finding it difficult to access affordable care (CAHS, 2014; Canadian Dental Association, 2017a).

Region of Waterloo Public Health (2012) conducted a situational assessment to determine priority groups, aged 17 and under, who are at risk for poor oral health outcomes. They identified the following:
- Children and youth who are economically disadvantaged;
- Amish;
- Low German-speaking Mennonites from Mexico;
- Immigrants and refugees to Canada;
- Children and youth who do not speak English;
- Pregnant teenagers;
- People who smoke;
- Individuals who misuse substances;
- Children and youth who are street-involved;
- Children and youth with poor nutrition.

They also found that certain characteristics of parents/caregivers could contribute to poor oral health in their children:
- Low level or lack of dental benefits;
- Lack of information regarding program funding and services;

- Single parent household;
- Poor oral health values;
- Caregivers with English as a second language;
- Caregivers with low education.

Many of these characteristics are closely linked to poverty. In short, poor oral health is concentrated in those with low income.

Based on the number of low-income residents, the percent of people working jobs with low wages and no benefits, and the proportion of people not going to the dentist because of cost, there could be 60 000-90 000 or more Waterloo Region residents who experience barriers to accessing affordable dental care.

Impact of poor oral health

Oral health is important to overall health. It contributes to physical, mental and social well-being and enjoyment of life, by allowing one to speak, eat and socialize without pain, discomfort or embarrassment (CDA, 2017b). There is increasing evidence to demonstrate a link between oral health and general health. Poor oral health can not only lead to the loss of teeth but also increase the risk of serious diseases, not to mention its impact on quality of life.

In 5-17 year olds, dental decay is five times as common as asthma (King, 2012). Dental caries in children can lead to toothache, poor school performance and missed school days, and impairments to daily life activities such as eating, smiling, and sleeping (CAHS, 2014). Caries can also impact nutritional status, affect the growth of adult teeth, and negatively affect self-esteem (King, 2012). In adults, dental caries can lead to infection, pain, abscesses, problems chewing and digesting food properly, poor nutritional status, gastrointestinal disorders, missed work or study, and in extreme cases cause severe disability or death (CAHS, 2014; CDA, 2017b; Health Canada, 2010; King, 2012). In addition, decay can negatively affect a person's appearance, dignity, self-respect, employability and social connectedness (CAHS, 2014). No longer having any natural teeth left (edentulism) alters one's appearance and affects food intake and nutrition.

Periodontal (gum) disease is an infectious condition that can result in the destruction of gum tissue and bone. Since the bacteria that cause gum disease may travel through the blood stream, there is an increased risk of respiratory infections (e.g. poor oral hygiene in older adults is a major risk factor for aspiration pneumonia); cardiovascular disease; and premature delivery and/or low birth weight babies (Health Canada, 2009; King, 2012). Gum disease has also been linked to diabetes (people with diabetes are at increased risk of infections such as gum disease; oral infections can increase the severity of diabetes by raising blood glucose levels) and poor nutrition which in turn can lead to weight loss, dehydration, and illness especially in seniors (Health Canada, 2009; King, 2012).

Oral health status

Region of Waterloo Public Health dental staff perform dental screening in schools each year. In 2013-14, they screened 22 317 junior kindergarten, senior kindergarten, and grade two students. Of those, 1699 or 7.6% had unmet urgent treatment needs, which may include one or more large open cavities in the permanent teeth or primary teeth, dental pain, infection, and trauma. 1318 students or 5.9% were found to have unmet non-urgent treatment needs, i.e. conditions that do not require immediate treatment such as chipped fillings, signs of early tooth

decay and mild to moderate levels of gingival bleeding. These findings were consistent with the previous two years (ROWPH, 2015a).

The majority of the data in the remainder of this section come from the Canadian Health Measures Survey, which is considered representative of 97% of the Canadian population 6-79 years of age. Where possible, Waterloo Region-level data is provided and comes from the 2013-14 cycle of the Canadian Community Health Survey (CCHS). The CCHS data is not significantly different from Ontario, nor is there any reason to think Waterloo Region residents are different from Canadians overall when it comes to oral health.

Cavities

Cavities are the number one chronic disease among Canadians although they are mostly preventable. Data reveal that 57% of 6-11 year olds and 59% of 12-19 year olds have, or have had, a cavity. The average number of teeth affected by decay in children aged 6-11 and 12-19 year olds is 2.5. Nearly all adults (96%) have a history of cavities; the average number of decayed, missing or filled teeth is more than 10. One-fifth of Canadians aged 20-79 have an average of nearly three coronal cavities (develops anywhere on the tooth except the root) that need filling. The number of lower income Canadians with cavities that need filling is double the number from the higher income group. About 6% of Canadian adults no longer have any natural teeth, but this is more common in older age; 22% of 60-79 year olds are edentulous (Health Canada, 2010).

Periodontal conditions

21% of adults with teeth have, or have had, a moderate or a severe periodontal (gum) problem. Gingivitis is more common in adults who have not been to a dental professional in the last year. 48% of them have the condition compared to 32% of Canadians aged 20-79. Lower income adults are also more likely to have gingivitis than those with higher incomes (48% vs. 25%) (Health Canada, 2010).

Oral lesions

12% of adults have at least one oral lesion in their mouth (open sores, lumps, bumps, red or white patches) whereas 41% of adults who do not have any teeth have at least one oral lesion in their mouth (Health Canada, 2010).

Self-report oral health

12% of Canadians reported that they avoid certain foods because of problems with their teeth or mouth in the past year. This same number reported that they had ongoing pain in their mouth in the past year (Health Canada, 2010). In a separate survey, 46.8% of respondents from Waterloo Region reported having oral or facial pain in the past month (including toothache, sensitivity to heat or cold, jaw pain, pain in the mouth or face, bleeding gums, dry mouth and bad breath) (PHO, 2016).

Visiting a dental professional

Regularly visiting a dental professional leads to better oral health outcomes including fewer missing and decayed teeth, better oral health-related quality of life, and better self-reported oral health (Thompson, Cooney, Lawrence, Ravaghi & Quinonez, 2014). Almost three-quarters of Canadians have seen a dental professional in the last year but 17% avoided going because of the cost. Furthermore, 16% of Canadians avoided having the full range of recommended treatment due to the cost in the last year (Health Canada, 2010). See Appendix A for a table of typical dental care costs.

In a separate survey, 64.8% of respondents in Waterloo Region reported having visited the dentist in the past year. This varied somewhat with age: 89.4% of 12-19 year olds; 69.5% of 20-44 year olds; 80.8% of 45-64 year olds; and 63.5% of those aged 65 plus visited the dentist. Nearly two-thirds (65.7%) of Waterloo Region respondents reported usually visiting a dentist for a checkup at least once a year. This proportion also varied with age: 90.6% of 12-19 year olds; 71% of 20-44 year olds; 80.1% of 45-64 year olds; 66.3% of those aged 65 plus usually go to the dentist once a year for a check-up (PHO, 2016).

There is good overall availability of oral health care in Canada. The population to dentist ratio has been declining – meaning there are more dentists relative to the population. For every dentist in Canada, there are about 1622 people; the ratio is even better in Ontario – for every dentist there are about 1500 people (CDA, 2017a). Using the 'Find a Dentist' feature on the ODA website and the population of Waterloo Region from the 2016 census, there are about 290 general practitioners in Waterloo region. This equates to a ratio of one dentist for every 1845 people. If specialists are included, the ratio drops to one dentist per 1622 people. Note that the ratio is just an estimate as not all dentists are members of the provincial association.

Preventive behaviours

Two important behaviours for maintaining a healthy mouth are brushing the teeth twice a day and flossing once a day. 73% of Canadians brush twice a day but only 28% reported flossing at least five times a week (Health Canada, 2010). In Waterloo Region, 69.2% of respondents reported brushing their teeth at least twice daily; however the proportion of females who brush is higher than males (78.9% vs. 59.5%) (PHO, 2016).

Sealants can be placed on the chewing surfaces of permanent molars in order to prevent decay. They provide a barrier and prevent food from getting stuck in the grooves and pits of the teeth. One-third of children aged 6-11 have one or more sealants, with an average of 2.88 sealed teeth. Half of adolescents aged 12-19 have one or more sealants; the average number of teeth that were sealed is 3.51 (Health Canada, 2010).

Treatment needs

34% of Canadians aged 6-79 years (who have teeth) had some sort of treatment need identified by the dentists. Dental treatment needs are greater among lower income Canadians compared to those in the higher income group (47% vs. 26%). They are also greater among smokers, with 49% of current smokers having some sort of treatment need identified compared to 30% of those who have never smoked (Health Canada, 2010).

Time lost

Oral health problems may have social and economic impacts, both on an individual's life and for society as a whole. An estimated 2.26 million school-days and 4.15 million working-days are lost annually due to dental visits or dental sick-days (Health Canada, 2010)

Oral health status and sociodemographic characteristics

Researchers at Public Health Ontario examined data from the 2005 CCHS for associations between sociodemographic characteristics of respondents and their self-reported access to dental care and oral health status. They found that Ontarians with higher incomes were more likely to have dental insurance compared to Ontarians with lower incomes. People with higher income and educational attainment were more likely to brush their teeth at least twice a day. Those with lower income, less education, and no insurance were less likely to have visited the dentist in the previous year. While the majority of Ontarians visit a dentist for preventive

purposes, those with lower income, less education, no insurance, and those aged 65 or older, were more likely to go to the dentist only for an emergency. One-fifth of respondents who had not been to a dentist in the past three years gave cost as the reason (PHO, 2012). Access to dental care is especially income sensitive, i.e. the lower a household's income, the more difficult it is to access dental services. Canadians with low income may skip going to the dentist because of competing financial needs such as buying groceries (Barnes, Abban, & Weiss, 2015). Avoiding dental care or forgoing the recommended treatment due to cost may lead to worsening of oral health problems.

Among CCHS respondents aged 65 and older, 36% had dental insurance, 40% visited a dentist only in emergencies, and about 23% did not have any of their own teeth. The rates of edentulism were three times higher among those without dental insurance compared to those with insurance (10.7% vs. 3.5%).

Of respondents who were immigrants, 59.4% reported having dental insurance compared to 71.7% of non-immigrants; 66% had visited a dentist in the past year compared to 73.8% of non-immigrants; and 25.3% reported visiting a dentist only for an emergency compared to 17.2% of non-immigrants.

Finally, 8.5% of those having no to less than $15 000 of income reported social limitation (such as avoiding conversation, laughing or smiling) in the past year due to oral health conditions compared to only 2.5% of those with a household income of $80 000 and higher (PHO, 2012).

Dental insurance

The Canadian Health Measures Survey (2010) showed that 62% of Canadians had private dental insurance (usually employer-paid), 6% had public insurance, and 32% had no dental insurance. Having insurance varied with income and age. While 78% of respondents from the higher income bracket had private insurance coverage, half of those in the lower income bracket did not have any dental insurance. In addition, 53% of adults aged 60-79 did not have any dental insurance (Health Canada, 2010).

In 2015, the Wellesley Institute produced a report on the inequities in health benefits. They found that 64% of employees in Ontario had dental benefit coverage in 2011. More men than women (68% vs. 59%) received dental benefits, which may be because women are more likely to work in part-time jobs that don't offer benefits. There is a substantial discrepancy in benefits based on income. Only 13% of those earning $10 000 or less had dental coverage compared to 94% of those earning more than $100 000 (Barnes, Abban, & Weiss, 2015). Separate research found that the uninsured were almost six times more likely than the insured to avoid the dentist because of cost, even after controlling for other factors (Thompson et al., 2014).

Research has shown that precarious employment is increasing and the number of working poor individuals is on the rise. Many low-wage and precarious jobs do not include dental and other health benefits. People working in these jobs can least afford to pay out of pocket for dental expenses but are typically not eligible for publicly-funded dental benefits (Barnes, Abban, & Weiss, 2015).

Marginalized populations such as women, single parents, racialized groups, new immigrants, temporary foreign workers, Aboriginal persons, persons with disabilities, older adults and youth are more likely to be precariously employed compared to the general population (Barnes,

Abban, & Weiss, 2015). These are the same groups who experience barriers to accessing oral health care.

In 2010, Region of Waterloo Public Health surveyed adults aged 18 and over about dental insurance. The data revealed that 73.3% of respondents had full or partial dental insurance coverage, however significant differences existed by presence of children in the household, marital status, immigration status, age, education level, and household income.

Adults with children in the household were more likely to have dental insurance than adults without children in the household (82.4% vs. 67.9%). Married or common-law adults were more likely to have dental insurance compared to those who were single, separated, divorced or widowed (77.4% vs. 63.3%). Adults who were born in Canada were more likely than those born outside of Canada to have dental insurance (75.7% vs. 64.3%). Almost twice as many adults aged 18 to 64 years (76.5%-81.5%) had dental insurance compared to those aged 65 and over (39.9%).

Individuals who had completed high school and/or some post-secondary education (72.4%) and individuals with a post-secondary certificate (79%) were more likely to have dental insurance than those with less than a high school diploma (45%). Like the Wellesley Institute, Region of Waterloo Public Health also found that adults with a higher household income were more likely to have dental insurance. Three-quarters (75.9%) of those with an annual household income of $40 000-$69 999, 86% of those with an annual household income of $70 000-$99 999, and 87.6% of those with an annual household income of $100 000 or more had insurance compared to 45.5% of adults with a household income less than $40 000.

The majority of adults with dental insurance received coverage through an employer-paid plan (82.9%); 12.2% had private coverage, while 4.9% were covered by government-funded plans such as OW and ODSP. Adults with children in the household were more likely to have dental insurance from an employer-paid plan (89.4%) than adults with no children in the household (78.4%). Married or common-law adults were more likely than single, separated, divorced or widowed adults to have employer-paid dental coverage (87.2% vs. 70.3%). While 11% of single, separated, divorced or widowed adults received dental coverage through government programs, only 2.8% of married or common-law adults did.

88.5% of adults aged 25-44 years had dental coverage through an employer-paid plan compared to 73.2% of adults aged 18 to 24 years, and 51.3% of those aged 65 and older. Adults with a post-secondary degree or diploma were more likely to have employer-paid dental coverage (84.6%) than adults with less than a high school diploma (67.3%).

Of those with a household income less than $40 000, 54.9% had dental insurance through an employer-paid plan while 26.8% had coverage through government support. 93% of adults with a household income of $100 000 or more had employer-paid dental insurance while none had coverage from government support (as they would not qualify). About 10% of respondents aged 18 years and older stated that they had turned down or refused necessary dental treatment such as a filling, root canal or tooth extraction; many said the reason for this was not having insurance (ROWPH, 2011).

Although private dental insurance is an option for people who do not have employer-provided benefits and do not qualify for publicly-funded programs, the cost can be prohibitive. Premiums depend on the insurance provider and services covered in the plan, as well as the age of the beneficiary, whether one is single or a couple, and whether there are children. As an example,

the monthly premium for a basic dental plan from one provider is about $80 for a single adult under age 45 and $112 for a single adult over the age of 90. The cost per child on that plan ranges from $23 to $40 per month. The level of coverage tends to increase with the number of years on the plan, for example the maximum coverage in the first year of the basic plan is $575 whereas in the second year it is $750. The monthly premiums for a more comprehensive health and dental plan range from $191 for a single person under age 45 to $212 for someone over age 65; $350 to almost $400 for couples; and $520 to $560 for families. Plans generally pay a portion of costs, not the full amount, thus there would still be some out of pocket expenses (SBIS, 2017).

ER and physician visits for dental problems

The number of emergency room and physician visits for oral health issues is another indicator of the problem of lack of access to affordable care. Research found that the most people who visit the ER for a dental issue are on social assistance, low income but ineligible for public funding (e.g. the working poor) or seniors (Thompson et al., 2014). Every nine minutes, someone goes to an emergency room in Ontario because of dental pain. In the fiscal year 2015 there were almost 61 000 visits to the ER for oral health problems including abscess, toothache, and disease of the oral cavity, salivary glands and jaw. The numbers do not include dental injury or trauma (Association of Ontario Health Centres, 2017).

There were 2445 ER visits in the geographic area covered by the Waterloo Wellington (WW) LHIN. This included 1295 visits, by 1174 patients, to Waterloo Region's three hospitals – Cambridge Memorial, St. Mary's General, and Grand River. Of these visits, 63 (4.86%) were emergent/potentially life-threatening; 673 (51.97%) were urgent/potentially serious; 508 (39.23%) were less urgent/semi-urgent; and 51 (3.94%) were non-urgent (Association of Ontario Health Centres, 2017).

ER physicians have limited options to help these individuals because they are not trained to deal with diseases affecting the teeth and gums. Although physicians may prescribe painkillers and/or antibiotics to help manage the issue temporarily, they cannot treat the underlying dental problem, thus many people will return to the ER (Association of Ontario Health Centres, 2017).

People also visit physicians' offices for dental problems; about 222 000 such visits occurred in Ontario in 2014, or one every three minutes. In 2014, there were 9527 physician visits for dental problems in the WWLHIN area (Association of Ontario Health Centres, 2017).

Lack of access to preventive and routine dental care, such as cleanings, has financial implications for Ontario's health care system. At about $513 per visit, it is estimated that in 2015 the cost of visits to the ER for dental problems was $31 million. ER visits in WWLHIN area contributed about $1.25 million to this amount. In Waterloo Region alone, the estimated cost was $664 335. For physician visits, the total annual cost in Ontario is estimated to be at least $7.5 million, based on a minimum cost to OHIP of $33.70 per 15-minute visit. The cost of physician visits in the WWLHIN is about $321 000 (Association of Ontario Health Centres, 2017).

The oral health care system

For a variety of reasons, oral health care was not included in Medicare when it was established. This means that the care of a person's lips, tongue and throat is covered, but the teeth and gums are not. In Canada the oral health care system is mainly privately operated with the

majority of dental practices being owned and operated by dental professionals. In 2009, an estimated $12.6 billion was spent on dental care in 2009. 60% of that amount was paid through employment dental insurance plans; less than 6% was publicly-funded, and 35% was paid out of pocket (Health Canada, 2010; King, 2012). Dental services paid through the public system include those covered under the Canada Health Act, by federal government departments (e.g. dental coverage for refugee claimants and First Nations and Inuit) and through provincial/ territorial or municipal dental programs (Health Canada, 2010). See Appendix B for a listing of government-funded dental programs.

Publicly-funded dental care is very limited in Ontario. Compared to other provinces, Ontario has the lowest rate of public funding for dental care at just 1.3% of all dental care expenditures (King, 2012). Per capita public sector spending on dental services is also the lowest in Ontario – $5.67 per person compared to the national average of $19.54. As set out in the Health Insurance Act and Schedule of Benefits for Dental Services under this act, some limited surgical-dental services are covered by OHIP. They must be medically necessary and performed in a public hospital (King, 2012).

OW generally covers emergency dental care while ODSP covers basic dental services, however coverage varies across Ontario. In Waterloo Region, adults on OW are eligible for emergency and essential dental treatment and denture coverage. This coverage is a local discretionary program funded by the Region. ODSP recipients are also eligible for denture coverage in addition to basic services. The ODSP basic coverage is a provincial program administered by Accerta. The denture coverage is a local discretionary program funded by the Region. In addition, Waterloo Region adults aged 18 and older who meet financial eligibility thresholds can access limited emergency dental care for relief of pain through Public Health Emergency Dental Clinics. However, coverage is usually restricted to one visit/one course of treatment. Each year about 200 visits are made by adults to these clinics in Waterloo and Cambridge (R. Hawkins, personal communication, March, 2017). In 2016, about 40% of the Region's discretionary benefits budget, or $1.8 million, was spent on dental services. The over-expenditure for dental services was 50% (Region of Waterloo, 2017). This is an indication of the level of need for dental care among adults.

The Ontario Public Health Standards require boards of health to provide free dental screening to children in kindergarten, grade two and grade eight, and to refer those who may be at risk of poor oral health outcomes. They must also deliver the Healthy Smiles Ontario (HSO) program (MOHLTC, 2016). HSO provides free preventive, routine, and emergency dental services for children and youth 17 years old and under from eligible low-income households. The program includes regular visits to a licensed dental provider and covers the costs of treatment (Government of Ontario, 2017). The Provincial Government expanded income eligibility for HSO as of April 1, 2014 resulting in 70 000 more children and youth being eligible to receive dental services (Government of Ontario, 2016). Region of Waterloo Public Health dental hygienists provide HSO preventive services (e.g. oral hygiene teaching, fluoride varnish applications, dental sealants, cleanings) at their own dental clinics. They also provide these services one day a week at each of the region's three Community Health Centres (CHC) – Kitchener Downtown, Woolwich, and Lang's. Oral health workers at the CHCs assist families to enrol in HSO, book appointments, and find a dentist. In addition they may provide interpretation for those who don't speak English, and accompany families to dental consultations and appointments.

Although publicly-funded programs provide some dental coverage for vulnerable groups, they are inadequate. The eligibility criteria are restrictive and qualifying income thresholds

considered too low. With the exception of HSO, the programs focus on treatment of urgent or emergency dental issues rather than on prevention. The coverage is not comprehensive and is often capped. Finally, the fee schedules fall below the provincial fee guide, sometimes covering less than half of the profession's fees (Optimus SBR, 2014). Dentists can choose whether or not to accept patients with publicly-funded plans. Not being able to find a dentist who will take social assistance clients creates a further barrier for those needing dental care.

Other programs/initiatives

For individuals not receiving social assistance or employer-provided dental benefits, the options for accessing low- or no-cost dental care in the Region are very limited. Dental schools offer low-cost clinics however the only dentistry programs in Ontario are at Western University and the University of Toronto. Western will not accept patients who live more than 45 minutes from London. In addition, waiting lists at the clinics can range from one to three years depending on the services. There are no dental hygiene schools within the Region.

The Working Centre, a social enterprise in downtown Kitchener and member of the Waterloo Region Oral Health Coalition, began operating Community Dental in 2016. The clinic provides free dental care with a focus on individuals who are street-involved, and haven't seen a dental professional for a long time. For a variety of reasons, clients would have difficulty going to a private dental office or even the Region's emergency dental clinic. There is a full-time, paid dental assistant while dentists volunteer their time. An outreach worker from the Working Centre also provides support to patients.

Gift from the Heart is a one-day event held annually in April. It allows registered dental hygienists across Canada to give back to their communities by providing free dental hygiene care to individuals who are under-serviced, neglected, without dental insurance or on a fixed income. According to the website www.giftfromtheheart.ca, four dental hygiene offices in Waterloo Region participated in 2017.

Dentistry from the Heart (www.dentistryfromtheheart.org) although based in the United States, is another initiative in which dental professionals provide free dental care to those in need. Of course, dentists and hygienists can choose, at any time, to offer their services at no cost or for a reduced fee.

Limitations

There are some limitations to the information in this report. First, since the Waterloo Region Oral Health Coalition did not wish at the time to collect nor analyze its own data, the report is based on existing national, provincial and local data. Much of the demographic information comes from the Region of Waterloo's analysis of Census and National Household Survey data.

There is a lack of generally-accepted, consistently-reported indicators to measure access to oral health care in Canada. Furthermore it is difficult to identify underserved populations, or to track trends in use of dental services, oral health outcomes or health status. Oral health data primarily come from the Canadian Community Health Survey (CCHS) and the 2007-2009 version of the Canadian Health Measures Survey (CHMS). A number of the reports that were reviewed involved secondary analysis of the CCHS and CHMS data and therefore errors made in original data analysis cannot be distinguished. In some cases it is difficult to compare data or to try and extrapolate to Waterloo Region due to different survey methodologies; for example the CHMS covers 6-79 year olds whereas the CCHS surveys those aged 12 and over.

There was a direct measurement component to the CHMS, however most surveys collect self-reported data. These surveys are usually phone-based and involve random digit dialling. They are obviously limited to people who have a phone. Responding to the surveys is completely voluntary so people may decline if they are not interested in the topic. Self-reported data is subject to some biases. For example, responses may be influenced by an individual's culture, personal beliefs, age, education, and income. Respondents may not accurately recall the information they are being asked (e.g. whether they visited a dentist in the past year). They may also under- or over-estimate their responses (e.g. how often they experienced dental pain). In addition, respondents may provide socially desirable answers; for example they may state that they brush their teeth the recommended twice per day when in fact they do not brush that frequently. The surveys were cross-sectional in nature, i.e. they collect information at a moment in time. While associations can be determined, causation cannot.

A final limitation of the data is that some of it is nearly 10 years old. Changes may have occurred over that time period that would impact results, for example the introduction of the new Healthy Smiles Ontario program in 2016, an increase in the number of people working low-wage, contract, or part-time jobs, or the number of Syrian refugees coming to Waterloo Region.

Despite the limitations of the data, the report still provides the Waterloo Region Oral Health Coalition with valuable information on which to base decisions about their activities.

Conclusion

Oral health is important to overall health, impacting people physically, mentally and socially. Although oral health problems are generally preventable, behaviours such as toothbrushing, flossing, and avoiding tobacco contribute very little to inequalities in oral health and oral health care. As with overall health, poverty is a key determinant of oral health, i.e. poor oral health is concentrated in those with low income. Interventions that encourage a change in oral health-related behaviours will have limited effect on oral health inequalities compared to interventions that focus on the oral health care delivery system and broad socioeconomic factors (e.g. poverty and precarious work) (CAHS, 2014).

The nature of the oral health care system creates inequities in access to oral health care for two main reasons: first, the care of the lips, tongue and throat is covered by Medicare/OHIP whereas the teeth and gums are not; second, dental care is mostly privately financed through employer-provided benefits or out of pocket payments. People living in low income, who do not have private dental insurance coverage and who do not qualify for publicly funded dental care, face significant cost barriers to accessing care. Consequently, this segment of the population experiences a disproportionate burden of oral disease.

Based on existing national, provincial and local data, there could be tens of thousands of Waterloo Region residents with limited ability to access affordable oral health care. Those most affected include individuals with low income (including the working poor); refugees and immigrants; low-German speaking Mennonites from Mexico; people who are homeless; and long-term care residents. The Waterloo Region Oral Health Coalition hopes to address this issue by supporting education, advocacy and action both locally and provincially. For example, the Coalition is participating in advocacy efforts led by the Association of Ontario Health Centres and Ontario Oral Health Alliance are to have the Ontario government include oral health as part of primary care transformation initiatives, and to expand publicly-funded oral health programs for low-income adults and seniors.

It has been suggested that the oral health of individuals reporting cost barriers to care could be improved if financial barriers were removed. This in turn could lower the burden of oral disease at the population level (Thompson et al., 2014).

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Appendix A: Estimated Cost of Standard Dental Treatments per Person Based on the Ontario Dental Associat

New Patient Visit		Recall Visit		Fillings/Restorations		R
Exam	$133.00	Exam	$33.00	Fees range from $120 to $314 depending on location of tooth and type of filling		Fees v
X-Rays (note: 2 bitewings, panorex, eight periapical radiographs)	$177.00	X-Rays (note: 2 bitewing radiographs)	$34.00	Molar tooth (note: two surface amalgam filling)	$191.00/per tooth	Root c treatm tooth (canals
Scaling (30mins)	$110.00	Scaling (30mins)	$110.00	Front tooth (note: two surface white composite resin filling)	$164.00/per tooth	Crown (note: metal incl. la
Polishing (15mins)	$35.00	Polishing (15mins)	$35.00			Lab fe betwe cost o up/do
Fluoride	$26.00	Fluoride	$26.00			
Total Cost	$481.00	**Total Cost**	$238.00	**Total cost of 2 fillings (molar)**	$382.00	**Total**

*These costs are calculated based on *suggested* fees published by the ODA for 2016 for an individual. Actual fees may vary among providers.

Appendix B: Government Funded Dental Programs

Children and youth (aged 17 years and younger)			
Program	**Who is eligible**	**Coverage**	**How to access**
Healthy Smiles Ontario (HSO) – Core Stream	Children whose family: • Live in Ontario • Are members of a household that meets the income eligibility requirements Children will be automatically enrolled if their family receives: • Ontario Works* • Temporary Care Assistance • Ontario Disability Support Program • Assistance for Children with Severe Disabilities *First nations households on Ontario Works must apply for HSO	HSO card issued. Coverage includes: • Check-ups • Cleaning • Fillings • X-rays • Having a tooth pulled • Relief of pain Services not covered: • Teeth whitening • Braces	Apply by mail o www.ontario.ca/ Call Service On free at 1-844-296-6306 Call Region of W Health at 519-5
HSO – Preventive Services Only Stream	Children whose family: • Live in Ontario • Have a clinical need • Cannot afford to pay for dental care	No HSO card needed. Preventive services are based on individual need and may include: • Fluoride varnish • Sealants • Scaling and/or polishing • Temporary filling to relieve pain	Region of Wate screen children financial need, o the Children's D Call Region of W Health at 519-5
HSO – Emergency and Essential Services Stream	Children whose family: • Live in Ontario • Have a clinical need • Cannot afford to pay for dental care	HSO card issued. Card is valid for 12 months (one year) from the date of enrollment. Coverage includes: • Check-ups • Cleaning • Fillings • X-rays • Having a tooth pulled • Relief of pain Services not covered: • Teeth whitening • Braces	Region of Wate screen children financial need In an emergenc accepts the HS provide direct e complete the ap
Region of Waterloo	Children and youth:	Basic dental care including	Contact Region

Public Health Children's Dental Clinic	• Who live in Waterloo Region • Whose family meets the income eligibility requirements	preventive oral health services	Health 519-575-4400 Ext 3086 for Wa Ext 3088 for Ca

The Ontario Cleft Lip and Palate/Craniofacial Dental Program	Children who:
	• Live in Ontario
	• Have an OHIP card
	• Have a
	  ○ Cleft lip and/or palate
	  ○ Craniofacial anomaly
	  ○ Other severe dental dysfunction
		Up to 75% of the cost not covered by private dental insurance
		Treatment must be pre-approved
		Special dental care directly related to the cleft lip and/or palate
		
		The program will not cover:
		Regular dental check-ups
		Long-term follow-up care
			Screening must
			designated cent
			http://www.healt
			/publications/ch

Adults (aged 18 years and over)			
Program	**Who is eligible**	**Coverage**	**How to access**
Ontario Works (OW)	Adult OW clients and their dependent children aged 18 and over OW dental cards are issued monthly to program clients	Emergency dental care Denture services include new dentures, repairs, relines and adjustments. Pre-approval may be necessary for some procedures	Contact Local OW office Region of Wate 519-575-4400
Ontario Disability Support Program (ODSP)	Adult ODSP clients, their spouses Proof of ODSP coverage is required at each dental visit	Basic dental care Denture services include new dentures, repairs, relines and adjustments.	Contact Local ODSP off
ODSP Dental Special Care Plan	Adults who receive ODSP where the disability, prescribed medications or prescribed treatment affects oral health For example: • Radiation of head/neck • Diuretics • Diabetes • HIV/AIDS • Developmental disabilities	Additional dental services The treatment plan usually lasts for 5 years as long as the client continues to be eligible for the ODSP dental benefit	A dentist or den apply on behalf submitting a pre AccertaClaim S
Region of Waterloo Public Health Adult Emergency Dental Clinic	Adults who: • Live in Waterloo Region • Meet income eligibility requirements	Limited emergency dental care	Application requ Contact Region Health 519-575-4400 Ext 3086 for Wa Ext 3088 for Ca

Ontario Health Insurance Plan (OHIP)	Adults who: • Live in Ontario • Have an OHIP card	Some dental surgery, if done in a hospital	Contact a denti
Veterans Affairs Canada (VAC)	Veterans who receive: • A disability benefit • Services through the Veterans Independence Program • Financial assistance through the Long Term Care program • The War Veterans Allowance	Basic dental care including: • Exams • Polish and fluoride treatments • Scaling • Fillings • Extractions • Standard dentures Some pre-authorized comprehensive dental services	Call 1-866-522- Visit http://www.vete es/health/treatm
First Nations and Inuit			
Program	**Who is eligible**	**Coverage**	**How to access**
Non-Insured Health Benefits (NIHB) Program of Health Canada's First Nations and Inuit Branch	A resident of Canada and any of the following: • a First Nations person who is registered under the *Indian Act* (commonly referred to as a status Indian) • an Inuk recognized by an Inuit land claim organization • an infant less than 1 year old whose parent is a registered First Nations person or a recognized Inuk	• Exams • X-rays • Polishing • Sealants • Fluorides • Scaling • Fillings • Crowns • Braces and retainers • Dentures • Extractions • Root canal	Must have clien Visit a dental pr https://www.can canada/service benefits-first-na services-under- benefits-progra benefits.html#a
Refugees			
Program	**Who is eligible**	**Coverage**	**How to access**
Interim Federal Health Program (IFHP)	People who are not eligible for provincial health insurance: • Protected persons including	Emergency care for conditions involving pain, infection or trauma	Certificate of eli Immigration, Re Citizenship Can

	resettled refugees • Refugee claimants • Certain other groups	Provides temporary coverage; not intended for ongoing regular or routine dental care	Canada Border (CBSA) Apply online at http://www.cic.g ation/applicatio