Summary of Findings and Opportunities to Improve Access to Oral Health Services in Ontario

Review of Oral Health Services in Ontario

FINAL SUMMARY REPORT

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OPTIMUS | SBR

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1.0 INTRODUCTION

Oral health consists of much more than healthy teeth and gums. 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."
>
> (Petersen, 2003)

Oral health also relates to quality of life factors such as appearance and the ability to speak and socialize. The most common aspects of oral health care are the prevention, diagnosis and treatment of dental decay (i.e., caries), periodontal disease and other oral diseases.

The majority of oral conditions are preventable; they often occur when people do not take preventive action themselves or are unable to get adequate support from oral health professionals. Preventive measures to maintain oral health include brushing at least two times a day and flossing every day, the use of dental products with fluoride (e.g., toothpaste), regular checkups with an oral health professional, and community water fluoridation.

1.1 Impetus for this Review

The Regulated Health Professions Act, 1991 (RHPA), and associated health profession Acts, set out the governing framework for the regulated health professions in Ontario. The Health Professions Procedural Code, which is Schedule 2 to the RHPA, sets out the practical rules for the colleges regarding member issues, quality assurance, and serving and protecting the public interest (Government of Ontario, 2013).

The College of Dental Hygienists of Ontario (CDHO) has increased its focus on this particular duty for a number of reasons:

- The public face of health care tends to be dominated by the mainstream health care sector (i.e., physicians, nurses and hospitals) and does not tend to highlight issues in predominantly privately delivered and funded services such as oral health care.

- While there is scientific evidence in dentistry that helps inform public policy decisions for oral health care, there is considerably less evidence for other oral health professions (e.g., dental hygiene, dental technology and denture therapy), resulting in relatively less focus on these roles in public policy decisions.
- Dental hygiene is characterized as a preventive health profession, which has always been the "poor cousin" to diagnostic and treatment services.

The CDHO is also aware of reports that certain segments of Ontario's population have poor access to oral health services. These reports suggested to the CDHO that it was not fulfilling its obligation to ensure access to oral health services for these populations. The CDHO felt that a public report, in addition to other publications (such as the *Canadian Oral Health Strategy* and the *Oral Health: More than Just Cavities* report (Federal, Provincial, Territorial Dental Directors, 2005; King, 2012)), describing the current state of access to and delivery of oral health services, identifying strengths and weaknesses, would provide a foundation for stakeholders (e.g., government, regulators, educators, associations) to engage in active discussions about policy, investments and activities regarding oral health services.

1.2 The Review

In 2013, the CDHO engaged Barry Monaghan, working in collaboration with OPTIMUS | SBR and Dr. Barry Maze as clinical advisor (collectively the "Review Team"), to identify existing and emerging themes relating to access to and quality of oral health services as well as barriers and enablers to improve access to services.

The purpose of the review was to:

- Raise the awareness and interest of those consulted during the review in contemplating the state of oral health services in Ontario.
- Develop a public document for use by interested stakeholders and decision makers as a basis for policy discussions to inform the future of oral health services delivery in Ontario.
- Identify specific gaps in and barriers to access to the delivery of oral health services.
- Identify potential opportunities and strategies to address the identified gaps and barriers.

The CDHO provided funding for the review and engaged the Review Team, and encouraged the team to work independently from the CDHO. The CDHO was consulted in the development of the work plan and in the interpretation of issues that were raised during the conduct of the review.

2.0 METHODS

The Review Team made every effort to identify evidence-informed information regarding the state of oral health services in Ontario and focused most intensely on published literature and input from expert and public stakeholders. Specifically, the Review Team conducted research through a variety of methods:

- A review of published and grey literature;
- A review of the organization of oral health services in Ontario and other jurisdictions;
- Thirty-six key informant interviews involving 46 individuals; and
- Focus groups with representatives of the public (12 participants in total).

The Review Team prepared a full report documenting the detailed methodology and findings of its work in a report submitted to the CDHO. This summary document represents key findings from the literature as well as our assessment of stakeholders' input. Detailed findings are documented in the full report. Given that some key sector stakeholders declined to participate in the key informant interviews, this report does not represent all views held in the Ontario oral health sector.

3.0 THE POLICY ENVIRONMENT

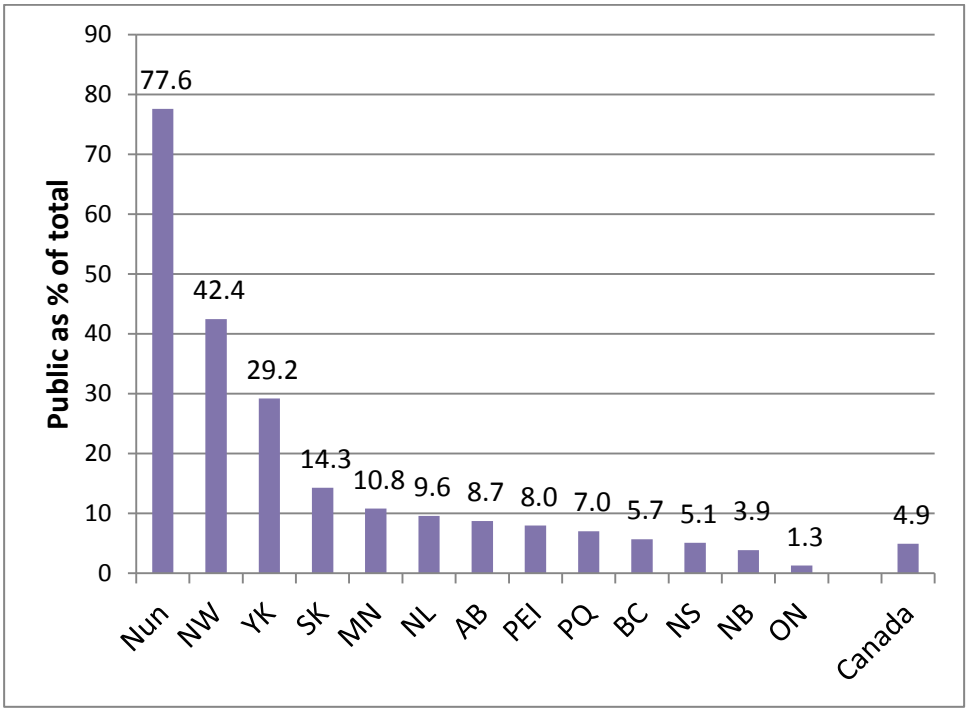
For the past several years, policy makers and funders have been concerned about the growing costs of health care in the context of constrained fiscal resources to meet these needs. Until the recent financial crisis, health care costs had historically outpaced economic growth in most industrial democracies over the past few decades. As a consequence, the last few years have seen a strengthening of Ontario's resolve to undertake health system reform to ensure population needs are met within a sustainable health system. Oral health services have not figured prominently in this agenda or the health policy discussions it has created; this is expected, because the majority of oral health services are not publicly funded and do not significantly factor into the budgets.

Until the 2014 provincial election ushered in a new majority government, Ontario had been operating under a minority government since 2011, which has made long-term planning for provincial services that fall outside of the government's core transformation agenda more challenging. In this environment, neither the government nor opposition parties were likely to spend significant political capital on issues that are not prominent in the minds of either policymakers or broad segments of the public as a whole. While the Ontario government has consolidated some oral health programs, there is no transformation agenda underway for oral health services comparable to the one for the overall health system.

In Ontario in 2010, the publicly funded share of total expenditures for dental services was only 1.3% - the lowest in the country and far below the national average of 4.9% (See Figure 1).

Although many stakeholders expressed a wish for a fully publicly funded oral health system, most acknowledge that this is not realistic in the current fiscal environment, especially given that some populations (i.e., the well insured) do have good access to services. However, there is an increasing awareness of the challenges of some vulnerable populations in accessing oral health services and of the relationship between good oral health and overall health, population health and the utilization of the overall health system.

Figure 1: Per Capita Public Spending on Oral Health in Canada, by Province, 2010[1]



- *Source: (Canadian Centre for Policy Alternatives, 2011); Data Source: Canadian Institute for Health Information (CI HI), National Health Expenditure Database 2010 (NHEX); from 2010*

4.0 SUMMARY FINDINGS AND OPPORTUNITIES

When Medicare was introduced in Canada through the passing of the Hospital Insurance and Diagnostic Act in 1957 providing universal access to health care, oral health services were not included in the scope of publicly funded services. Since then, a growing body of research has provided evidence of an important link between oral health and overall health, and the importance of promotion and prevention at an early age to create a sound basis for life-long oral

[1] Note that per capita spending for the territories and some provinces may not be comparable to the Ontario data due to high proportion of the population eligible for the federally funded Non-insured Health Benefits (NIHB) Program.

health. However, given the current fiscal environment in Ontario, stakeholders acknowledged that it is highly unlikely that these services will be brought into a comprehensive publicly funded insurance program.

4.1 Access to Oral Health Services

The Review Team was asked to examine access to oral health services in Ontario. This task was frustrated by the lack of any generally-accepted and consistently reported indicators to measure access, in addition to a lack of timely, comprehensive and meaningful data to calculate these indicators.

One utilization measure that is relatively broadly available is the proportion of the population that has visited a dentist in the past 12 months. Although this is not necessarily an appropriate measure of good access, it was used as a proxy for lack of a better measure. According to the Canadian Health Measures Survey, 76.7% of Canadian adults (40-59 years) had visited a dentist in the past 12 months in 2007 to 2009 (Health Canada, 2010). Reliable data was not available for people younger than 40 or older than 59. Despite the lack of a comprehensive publicly funded program, approximately three out of four adult Ontarians have access to oral health services.

Stated another way, approximately 23% of adult Ontarians (approximately 1 in 4 adults) have not seen a dentist in the past 12 months, or even longer. For the population as a whole, underserved populations include:

- The unemployed, contract and part-time workers and retired seniors who do not have insurance benefits and cannot afford the services.
- Children of low-income families. A recent study reported that many Toronto children included in a survey had never seen a dentist, and that children from low-income families were most likely not to have seen a dentist (Darmawikarta et al., 2014).
- Those living in small, rural and remote communities that do not have a sufficiently large population to support a dental practice or have not been able to attract oral health professionals.
- Vulnerable populations where the social determinants of health are likely to contribute to poor overall population health (e.g., First Nations[2], Inuit and Métis, the homeless, new immigrants, refugees). Amongst Ontario First Nations children (3 to 11 years of age) living on-reserve, 23% had baby bottle tooth decay, of which 77% were treated, and 51% of these treatments were in hospital (Chiefs of Ontario, 2013).

[2] Throughout this report, Canada's native population is referred to as "First Nations, Inuit and Métis" except where the source publication used a different term.

- Residents of institutions (e.g., long-term care homes) and those with complex needs (e.g., with mental health and addiction issues, medically complex patients).

Poor access to oral health services for these populations coincides with poor oral health status. For example, adults aged 40 to 59 years are more likely to have seen a dentist in the past 12 months, are more likely to have insurance and are more likely to have teeth than seniors aged 60 to 79 years and low-income adults, as shown in Table 1.

Table 1: Comparison of Oral Health Indicators by Age and Income, (%), Canada, 2007-2009

	Adults (40-59 years)	Seniors (60-79 years)	Low Income adults
Visited dentist in past 12 months	76.7	68.4	58.9
Have no insurance	28.6	53.2	49.8
Are edentulous (have no teeth)	4.4	21.7	10.9
Proportion of total Canadian Population	33.4%	16.9%	15.4%

Source: Report on the Findings of the Oral Health Component of the Canadian Health Measures Survey (2007-2009), Health Canada (Health Canada, 2010).

Programs funded by municipal, provincial and federal governments are available for some of these vulnerable populations, including First Nations, Inuit and Métis, children and low-income adults. However, many of these programs were criticized by stakeholders as inadequate due to:

- Restrictive eligibility criteria (e.g., income thresholds to qualify for benefits are too low),
- A focus on services and treatment rather than outcomes and prevention (e.g., paying for the treatment of cavities but not for regular preventive services),
- Non-comprehensive coverage,
- Approvals being denied for services recommended by oral health professionals,
- Fee schedules below the profession's provincial fee guides and onerous administrative processes (e.g., for pre-approvals and payments) that have led to some oral health professionals not accepting patients who are insured by these programs or asking for upfront payment from the patient (a practice that is allowed by the federal Non-insured Health Benefits (NIHB) program, but not provincial programs in Ontario).

Not all vulnerable populations are eligible for publicly funded programs (e.g., residents of long-term care homes, retired seniors and the working poor). Stakeholders noted that these populations are becoming an increasingly larger part of our population:

- Ontario is experiencing a trend towards "precarious employment," which is characterized by part-time or contract employment that does not provide health insurance benefits as part of the employment contract.

- Even for those with insurance, many companies are moving away from comprehensive benefit plans (e.g., reducing the provided coverage) or allowing employees to select the level of coverage they would like. When choosing which benefits to purchase, many employees will assign a lower priority to dental benefits than to other health benefits and may choose less comprehensive coverage in an attempt to reduce their monthly costs.
- The aging of Ontario's population is well documented, and this segment of the population is expected to continue to grow significantly. Many of Ontario's seniors have enjoyed oral health insurance through most of their working lives and have a higher rate of dentation than ever before; however, this insurance usually stops at retirement, leaving them to cover their own expenses out of their retirement income. Seniors must then carry the cost of repairing cracked teeth and old fillings that break down. Maintaining the dental work they had during their working years may also present a financial burden, and neglecting these ongoing maintenance expenses can have consequences for their oral and overall health.

4.2 Significant Trends in the Delivery of Services

4.2.1 Establishing Good Oral Health Practices Early in Life

Along with the growing awareness of the importance of oral health, public health authorities are also recognizing the importance of oral health promotion as early in life as possible. Representatives of First Nations, Inuit and Métis communities spoke of the need for education and promotion strategies for pregnant women and newborns, to ensure that children have the best start possible.

In the US, many programs sponsored by public health authorities and volunteer organizations target pregnant women and newborns, to ensure that the new mothers understand the importance of oral health and can adopt best practices (e.g., limiting juice intake, not allowing a baby to sleep with a bottle). In Ontario, the importance of an early start is recognized through the publicly funded oral health programs for children of low-income adults and school age children and in-school programs. However, there is no formal or province-wide strategy for reaching pregnant women and newborns and preschoolers other than for low-income families.

4.2.2 Local Activism Against Community Water Fluoridation

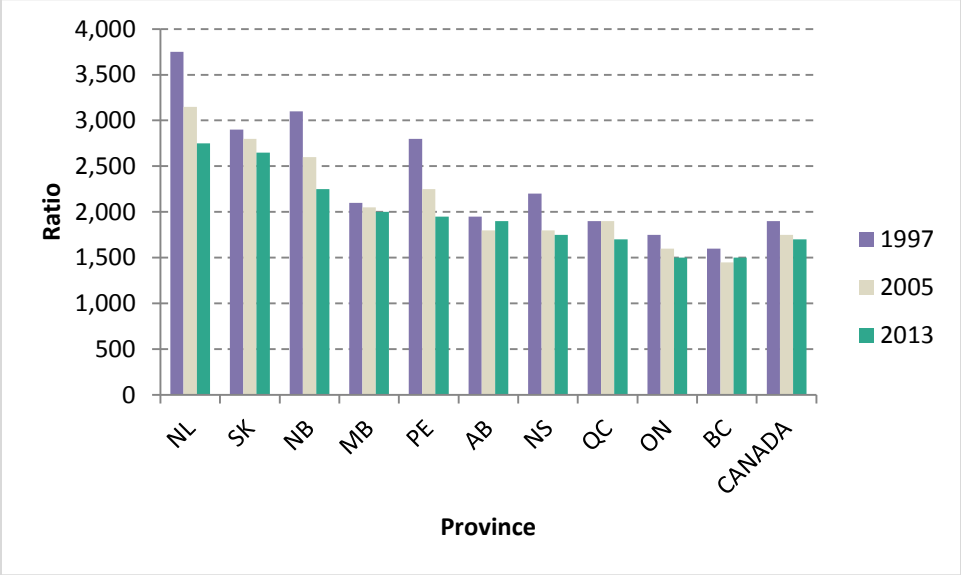
Water fluoridation has been demonstrated to be an important and effective preventive oral health treatment that has been used in Ontario communities for decades. With life-long exposure to water fluoridation, adults experience a 20 to 40% reduction in tooth decay (American Dental Association, 2005). As of 2008, 45.1% of all Canadians and 75.9% of Ontarians have access to fluoridated water (Government of Canada, 2011).

Despite good evidence on the value of community water fluoridation programs, Ontario has experienced growing opposition to this practice. Many stakeholders believe that this movement will continue to grow and to threaten community water fluoridation programs across the province unless the provincial government chooses to consider the issue on behalf of all provincial jurisdictions (Stakeholder Interviews, 2014). Experience in the US suggests that the discussion of fluoridation has moved away from a discussion of the evidence-based and scientific arguments as community activists mobilize to reduce municipal costs.

4.2.3 Increasing Supply of Oral Health Professionals in Ontario

The supply of dentists has been increasing (See Figure 2) at the same time as the demand for services is decreasing (due to fewer people having dental coverage and/or reduced benefits within their dental plans). It is unclear how the changing relationship between supply, demand and price for dental services will play out.

Figure 2: Population to Dentist Ratios, Canadian Provinces, 1997, 2005 and 2013



Source: (Canadian Dental Association, 2013)

Stakeholders also described an oversupply of dental hygienists, particularly in urban areas. Similar to the situation with dentists, this oversupply does not yet appear to have increased access to services in small and remote communities.

4.2.4 Changes in Scope of Practice

The oral health sector is beginning to experience the redefinition of scope of practice for some of its professionals similar to recent developments in medical care, where the nursing scope of

practice has been expanded to allow nurse practitioners to take on an enhanced role in the delivery of primary medical care. When first introduced, this role was not well received among many physicians; however, nurse practitioners now play an important and valued role in primary care – especially in small and remote communities that cannot attract a physician – and in acute care.

In the oral health services sector, the equivalent progression has begun with dental hygienists. As of 2007, dental hygienists in Ontario may "self-initiate" care, which means they may provide select dental hygiene services (e.g., scaling teeth and root planing, including curetting[3] surrounding tissue) without an order from a dentist, in independent clinics or in the community, including clients' homes, offices, and long-term care homes.

While there are no hard data on how many dental hygienists have started their own practices under the new legislation; key informant estimates suggest that about 300 to 500 work independently in Ontario. Similarly, there are no data yet on whether or how much this independence has improved access to some services. A pilot program for the Non-insured Health Benefits (NIHB) program allowing dental hygienists to bill the program for some services has been well accepted by the First Nations' communities that hygienists can now serve more fully. Other benefits cited by key informants included the expanded provision of dental hygiene services in long-term care homes and a lower-cost option for clients (i.e., the fee schedule for some services can be significantly lower than the ODA fee schedule).

In 2005, the CDHO began the process of applying for an amendment to the Dental Hygiene Act that would allow trained dental hygienists to administer local anesthetics for clients who experience pain or anxiety during dental hygiene treatment. Some patients have sensitive teeth, and if the dental hygienist cannot apply a local anesthetic, services cannot be provided because of the patient's discomfort. The ability to apply a local anesthetic would be particularly valuable in northern and remote communities where dental hygienists provide on-site independent clinics. However, without the removal of the requirement for a dentist's order, self-initiating local anaesthetics did not make sense until that was removed.

Another potential resource for providing services to clients in remote locations is the dental therapist. Dental therapy was initiated through the University of Toronto for the Medical Services Branch of the Government of Canada with the concept of training students from remote First Nations, Métis and Inuit communities in basic preventive, restorative and surgical treatments who would then practice in rural and remote communities. Approximately 300 dental therapists are licensed to work for First Nations people on crown lands in several provinces (i.e., British Columbia, Alberta, Saskatchewan, Manitoba, Nova Scotia, New Brunswick,

[3] Curetting of surrounding tissue involves the use of a curette, a scoop-like tool, to remove diseased tissue.

Newfoundland and Labrador), and are licensed in three states in the US, and are being considered in at least four others. However, the profession has not evolved in Ontario.

5.0 OBSERVATIONS ON ACCESS TO ORAL HEALTH SERVICES IN ONTARIO

5.1 Strengths of Ontario's Oral Health System

Overall, many positive statements can be made about the delivery of oral health services in Ontario. For example:

- Despite the fact that, unlike medical services, oral health services are not covered by the Ontario Health Insurance Plan (OHIP) or other sources of public funding available to the majority of Ontarians, the majority of Ontario's population has access to services (predominantly through employment-related dental insurance) and enjoys relatively good oral health status.
- No issues were identified in the literature or raised in the interviews and focus groups about the quality of services provided by oral health professionals in Ontario.
- Programs delivered through Public Health for school-age children provide screening and some preventive services for this population. Publicly funded mobile oral health clinics have been a welcome service for some small and remote communities in Ontario.
- The Government of Ontario recognizes the importance of good oral health through its programs for low-income families and school-age children. The Ministry of Health and Long-Term Care is currently amalgamating six programs into a single program to improve access and is examining the overall program at the same time to ensure that it is evidence based and provides the most appropriate services to deliver the desired outcomes. It is acknowledged that this process will take time.
- Access to oral health services in Ontario compares favourably to most provinces in Canada and reasonably well to many jurisdictions outside of Canada. For example, Ontario has the highest rate of water fluoridation among the Canadian provinces (Wolfe, Ishaque, & Aung, 2013).

5.2 Barriers to Access to Oral Health Services

The Review Team identified three primary barriers to access to oral health services in Ontario; often, underserved populations faced more than one of these barriers:

- **Financial Barriers.** In Ontario, 98.7% of expenditures for oral health services are privately funded through third-party insurance or paid out-of-pocket, and only 1.3% are publicly

funded, the lowest provincial rate in Canada (Public Health Ontario, 2012) (see Figure 1 on page 6). Accordingly, the cost of oral health services was cited by almost all stakeholders as the largest barrier to access in Ontario. Even when a person has insurance, the cost of the deductible and costs above what the insurance will cover can be prohibitive or a strong disincentive for those with low or fixed incomes to seek care.

- **Geographic Barriers.** For First Nations, Inuit and Métis communities in the north (and some in the south), residents can only access services by leaving the community (often by air and at some cost to the individual) or if they are lucky enough to have a mobile clinic serving their community. Residents of small and rural communities in Southern Ontario may also have challenges in accessing local services, since many oral health professionals prefer to live and practice in larger urban centres. Similarly, residents of long-term care homes and individuals who find it difficult to leave their home (e.g., frail seniors) may not be able to access services.
- **Lack of Awareness of the Importance of Oral Health.** Since oral health services are not covered under Medicare, an individual must value the services sufficiently to allocate limited financial resources to oral health services, in light of competing needs. For the unemployed and low- and middle-income earners, oral health is not always perceived as a priority within the family's budget. Citizens may take cues about an activity's importance from the extent to which a government communicates, invests, delivers services, oversees or simply registers certain events – consider vaccination, anti-smoking campaigns, and major life milestones such as marriage or birth. As one stakeholder noted: "*If it were important, the government would pay for it*." Health promotion campaigns to address smoking and obesity are well established in Ontario; many stakeholders suggested that the next wave of health promotion campaigns should be on oral health.

6.0 OPPORTUNITIES TO IMPROVE ACCESS TO ORAL HEALTH SERVICES IN ONTARIO

Although many Ontarians enjoy good access to oral health care, relatively sparse data suggest that as many as 2 to 3 million Ontarians have not seen a dentist in the past 12 months. These findings are consistent with the findings of the Canadian Oral Health Framework (COHF) 2013-18, produced by the Federal, Provincial and Territorial Dental Working Group (Federal, Provincial, Territorial Dental Directors, 2012). The Review Team identified a number of opportunities to enhance the planning and delivery of oral health services that can contribute to improved access for these underserved populations, as discussed below, which are also consistent with many of the strategies outlined in the COHF.

6.1 Need for an Oral Health System

> "We don't have an oral health system; we have an oral treatment system.
> In the acute care sector, there are dozens of groups that purport to be leading the system. The MOH, the OMA, the RNAO, the OHA. But there's no de facto leader in oral health. Groups are providing care, but there is no sense of a system or sense of a need for a system."
>
> - Stakeholder Interview, 2014

Our Review Team agrees that there is a need for an oral health system in Ontario; delivery of services is currently fragmented, with no overall provincial strategy for the delivery of timely, quality, accessible and cost-effective oral health services. This sector lacks a common vision and direction, and leadership is diffuse; the various provider groups do not have a history of collaborating well together on moving towards an effective oral health system.

Although there is a National Oral Health Framework 2013-18 (which replaced the previous National Oral Health Strategy), and some regional municipalities have strategic plans for oral health services in their regions (e.g., through Public Health), there is no oral health strategy for the province to:

- Undertake coordinated promotional programs to raise the awareness of the importance of good oral health among health professionals and the public.
- Collect sufficient data on utilization and outcomes to conduct surveillance of the oral health status of its population.
- Identify underserved populations and emerging trends that affect access so that effective and targeted programs can be developed to support these vulnerable populations.
- Use the existing health human resources to their full scope of practice as cost-effectively as possible.
- Ensure that publicly funded programs are evidence based and cost effective.
- Address potential shortages and/or maldistribution of oral health professionals in Ontario.
- Provide accountability to the system for the expenditures made.

Stakeholders identified many vulnerable and marginalized populations that require an investment in services to improve access to care. Without a coordinated provincial strategy,

these populations will continue to experience a standard of care well below what other residents of Ontario enjoy.

> "We have very poor oral health data … there is no survey to tell us what dental health status is. We have general information for some populations, but no hard cold data to take to the government to define the oral health needs for children, adults and seniors. We need money to do surveillance to get some hard core local data. If we had data to show the need, the politicians would have to pay attention."
>
> - Stakeholder Interview, 2014

Most oral health services are delivered by private-sector providers, who do not have the same requirements to collect and report utilization and outcome data as in the public sector. Accordingly, there is very little data on oral health at the individual or provincial level other than one-off surveys of utilization and health status. The lack of data makes it difficult to identify underserved populations; track trends in utilization, outcomes or health status; or otherwise plan programs to ensure that quality, timely and cost-effective services are available to those who need them. Similarly, when plans and programs are developed, it is difficult to evaluate them due to the lack of baseline or ongoing data.

Opportunity 1: For representatives of public health, oral health professionals and primary care practitioners to come together to build a consensus on strategic priorities for oral health services in Ontario and provide advice to the Ministry of Health and Long-Term Care, Local Health Integration Networks and Health Quality Ontario on those priorities and supporting policies. These priorities should include the identification of data requirements to support the planning and delivery of services as well as quality metrics.

The forum for the development of a provincial strategy for oral health could take any number of forms, including, for example:

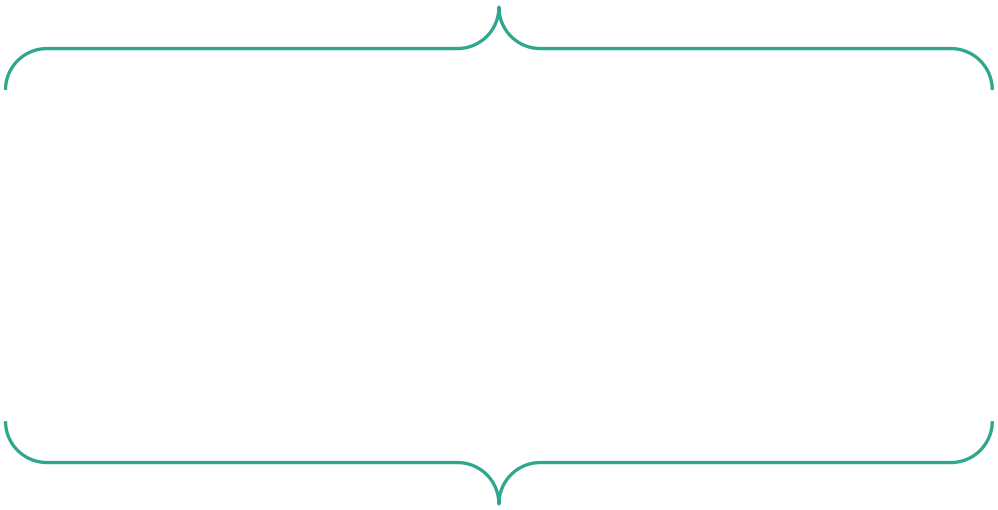
- A provincial commission similar to the federal Commission on the Future of Health Care in Canada (commonly referred to as the Romanow Commission) in 2002.

- A provincially appointed expert to lead the development of a provincial strategy, similar to the appointment of Dr. Samir Sinha for the recently completed Seniors' Care Strategy for Ontario, or Dr. Charles Pascal for early childhood education in Ontario.
- An expert or consensus panel, with representatives of oral health, primary care and public health professionals, health policy makers, funders, and the public with a mandate to develop a provincial strategy.
- The development of a white paper that examines options for the delivery models and publicly funded programs to meet the needs of underserved populations.

At a minimum, a provincial oral health strategic plan should identify priorities that emerge from sector-wide responses for:

- Identifying the most cost-effective means and policy tools to significantly improve access to care for First Nations, Inuit and Métis populations living on or off reserve, in consultation with the Non-Insured Health Benefits program.
- Determining whether a promotional campaign to educate health service professionals and targeted members of the public about the importance of good oral health is effective and actually contributes to improved outcomes.
- Determining how best the province and its municipalities can communicate their commitment to community water fluoridation, both in terms of existing regulations and responding to future movements against it.
- Creating evidence-based provincial programs to improve access to oral health services for underserved or vulnerable populations (e.g., low income adults and their children, pregnant women and newborns, pre-school and school-age children, seniors) that address financial, geographic and socio-economic barriers to access.
- Identifying oral health system surveillance measures and outcomes that will indicate whether the strategic plan is achieving its objectives.

6.2 Additional Research on Oral Health



In addition to frustrating attempts to plan or evaluate services, the lack of data makes research into the oral health system very difficult. The lack of data, combined with the lack of focus on health system or outcomes research in the oral health sector, also contributes to the lack of quality data on relationships between oral health and overall health. The oral health services sector in Ontario needs more and better research into the relationships between clinical practice, utilization and outcomes, as well as interrelationships between oral health, overall health and the health system. Research is also needed to better understand the current oral health services sector and to develop a foundation to monitor system performance.

Opportunity 2: For representatives of public health, oral health professionals, primary care practitioners and relevant specialist physicians to create a forum for discussion about oral health research priorities (both clinical and oral health system) and strategies to support this research.

6.3 Better Integration Between Oral Health and the Health System

> "One of the biggest things is the separation of oral health from your overall health. You have a chief medical officer and a chief dental office, and they are separate. I wonder if they shouldn't be under the same umbrella … so the oral cavity is included in overall health care."
>
> - Stakeholder Interview, 2014

Although the literature has identified several linkages between oral health and overall health, the oral cavity is still very much separate from the rest of the body in medical practice. More work needs to be done to ensure that health professionals outside of the traditional oral health professions have a clear understanding of the impact of poor oral health on overall health – for an individual and for a population. Increased collaboration and referral systems would help to ensure that patients receive a complete suite of services to maximize health status.

In Ontario, integration at the planning level could be facilitated through Local Health Integration Networks (LHINs). LHINs have a mandate to plan health services. Although oral health services are not explicitly included in their mandate, the most forward-thinking LHINs already recognize that overall health status cannot be maintained without addressing oral health needs. If every LHIN were to include oral health services in its Integrated Health Service Plan (IHSP), such a requirement would go a long way to raising the profile of the importance of good oral health among the public and health service providers, and bringing oral health into health system planning.

Opportunity 3: For Local Health Integration Networks to recognize oral health services as an important component of the overall health system and to facilitate planning for oral health services in their regions.

6.4 Better Integration of Oral Health and Health Care Delivery

Integration of services at the delivery level could be facilitated through a number of avenues:

- Community health centres (CHCs) are one promising link between primary care and oral health care. CHCs, which have a mandate to advance health equity, are typically in low-income, rural or remote areas, where people have challenges accessing health care, and serve vulnerable populations such as First Nations, the homeless, new immigrants and refugees. CHCs focus on addressing the social determinants of health and provide programs and services for health promotion, disease prevention and community development based on the needs of the local community and provide culturally competent services to these difficult to serve populations. In some parts of the province, CHCs have included some oral health services as part of their overall basket of services (including the operation of dental suites within the centres). CHCs could be an excellent venue for providing oral health services to underserved and at-risk individuals.
- Similarly, Aboriginal Health Access Centres (AHACs) deliver culturally-oriented, inter-generational programs and services that enhance the well-being of the First Nations, Métis and Inuit clients they serve. Similar to the CHCs, some AHACs have developed innovative programs for the delivery of oral health services in addition to overall health services.
- Family Health Teams (FHTs) and Community Care Access Centres (CCACs) could also be encouraged to incorporate an oral health assessment and appropriate referrals for services into their initial intake and subsequent visits.

Opportunity 4: For Local Health Integration Networks to support Community Health Centres, Aboriginal Health Access Centres, Family Health Teams, and Community Care Access Centres in the development and implementation of strategies to incorporate oral health assessments, referrals and services to better integrate oral health services into the health system.

6.5 Health Promotion and Prevention for Life-long Oral Health

As noted earlier, the majority of oral conditions are preventable; they often occur when people do not take preventive action themselves or are unable to get adequate support from oral health professionals. It was also noted earlier that one barrier to access to oral health services is a lack of awareness of the importance of good oral health for good overall health.

Access to oral health services could be improved through a variety of initiatives to raise awareness, including, for example:

- A broad-based promotion campaign (perhaps similar to the successful smoking cessation strategy embraced by Ontario in prior years).

- A program to educate pregnant women and provide well-baby visits, particularly for at-risk populations (e.g., low-income; First Nations, Inuit and Métis, low-income families).

The value of improving oral health habits early in life has been demonstrated in other jurisdictions, most notably in Denmark where providing comprehensive and free oral health services for all children under 18 years of age contributed to the oral health status of Danish children moving from among the poorest in Europe 40 years ago to one of the best (Patel, 2012). Ontario could do more to ensure that all residents develop an appreciation of the importance of oral health and an understanding of good oral health habits early in life.

Ontario's Public Health Units already offer services for children and are well positioned to manage the delivery of these programs.

Opportunity 5: For increased awareness of the importance of good oral health through strategies to promote oral health across all populations and targeted programs to educate at-risk populations through social programming, visits with primary care practitioners, public health nurses and dental hygienists and school-based programs in at-risk neighbourhoods.

6.6 Building Stronger Interprofessional Teams

There is an opportunity in Ontario to strengthen collaboration among oral health providers so that they can work in closer partnership to identify key priorities for oral health to improve access to care for those marginalized and vulnerable populations who have poor access to services and correspondingly poor oral health status.

Stakeholders told the Review Team of many innovative approaches to providing oral health services through interprofessional teams within Ontario (with particular mention of the teaching clinics at George Brown College). The Review Team is also aware of many innovative interprofessional models of care being adopted in the US to deliver oral health services for vulnerable populations. These initiatives provide a convenient one-stop service location for clients, where the health professionals work collaboratively to meet all health needs – including oral health needs – of their clientele.

The Review Team believes that changing the culture and behaviour of health professionals to work more collaboratively begins in the education sector. Interprofessional activities should not be restricted to oral health providers, but should also involve health services providers for a truly integrated approach to the delivery of services.

Opportunity 6: For representatives of public health, oral health professionals, health service providers and educators to continually look for and nurture opportunities for developing strong and sustainable models for interprofessional care in the delivery of oral health services.

REFERENCES

American Dental Association. (2005). *Fluoridation Facts*. Retrieved from http://www.ada.org/sections/newsAndEvents/pdfs/fluoridation_facts.pdf

Canadian Centre for Policy Alternatives. (2011). *Putting our money where our mouth is the future of dental care in Canada.* Ottawa, ON: Canadian Centre for Policy Alternatives.

Canadian Dental Association. (2013). Licensed Dentists in Canada By Province - 2013. Retrieved from http://cda-adc.ca/en/services/fact_sheets/dentistincanada.asp

Chiefs of Ontario. (2013). *Ontario First Nations Oral Health Survey: Summary Report*.

Darmawikarta, D., Chen, Y., Carsley, S., Birken, C. S., Parkin, P. C., Schroth, R. J., & Maguire, J. L. (2014). Factors Associated With Dental Care Utilization in Early Childhood. *Pediatrics*, peds.2013–3725. doi:10.1542/peds.2013-3725

Federal, Provincial, Territorial Dental Directors. (2005). *Canadian Oral Health Strategy*. Retrieved from http://www.fptdwg.ca/assets/PDF/Canadian%20Oral%20Health%20Strategy%20-%20Final.pdf

Federal, Provincial, Territorial Dental Directors. (2012). *Reducing Dental Disease: A Federal, Provincial and Territorial Framework for Action to Improve Oral Health*.

Government of Canada, H. C. (2011). Office of the Chief Dental Officer Projects - First Nations and Inuit Health Branch - Health Canada [organizational description]. Retrieved December 16, 2013, from http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/ocdo-bdc/project-eng.php#t2

Government of Ontario. (2013). Regulated Health Professions Act 1991. Retrieved from http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91d25_e.htm

Health Canada. (2010). *Report on the findings of the oral health component of the Canadian health measures survey, 2007-2009*. [Ottawa, Ont.]: Health Canada. Retrieved from http://site.ebrary.com/id/10410801

King, A. (2012). Oral Health-More Than Just Cavities.

Patel, R. (2012). *The State of Oral Health in Europe*. Platform for Better Oral Health in Europe.

Public Health Ontario. (2012). Report on Access to Dental Care and Oral Health Inequalities in Ontario. Toronto: Queen's Printer for Ontario.

Wolfe, J., Ishaque, S., & Aung, Y. N. (2013). The State of Dental Health in Alberta A Brief Report. Retrieved from http://www.health.alberta.ca/documents/CMOH-Dental-Health-Alberta-2012.pdf