Alleviating Disparities in Oral Health: Responding to the Information Needs of Key Decision Makers

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Outline

• Outline the information needs of key decision makers

• Outline our response

• Outline future directions
What information did policymakers need?

- Descriptive information on programming
- General information on disparities
- Individual, health system, and social costs of poor access to care
- Depth of access issue
The Office of the Chief Dental Officer (OCDO) was created in October 2004 to improve the oral health status of Canadians and to increase awareness about the prevention of oral diseases.

The Office works to:

- Provide evidence-based oral health perspectives on a wide range of health policy and program development issues
- Provide expert oral health advice, consultation and information
- Integrate oral health promotion with general health (wellness) initiatives
- Assist in gathering epidemiological information for program planning on federal/provincial/community levels and establish priorities for research
- Develop integrated collaborative approaches to preventing and controlling oral and associated diseases
- Provide a point of contact/liaison with professional associations, provinces, academic institutions, and other non-government organizations on oral health issues

OCDO is involved in the following projects:

- [Oral Health Status Data Collection](#)
- [Federal Provincial Territorial Dental Working Group](#)
- [Federal Dental Care Advisory Committee (FDCAC)](#)
- [Working with First Nations and Inuit Health Branch’s Children’s Oral Health Initiative (COHI)](#)
- [Working with Non-Insured Health Benefits on modifications to improve the dental schedule](#)
- [Updating the report on Dental Care Programs in Canada - Historical Development, Current Status and Future Directions or the “Stamm Report”](#)
- [Dental Public Health Expenditures in Canada, 2007/08](#)
- [Fluoride](#)
- [International Involvement](#)
- [Dental Public Health Human Resources](#)
An Environmental Scan of Public Dental Programs in Canada

In 2005 an environmental scan was conducted of the dental public health programs and services in Canada.

This scan was done under a contract between the Community Dental Health Services Research Unit, University of Toronto, and the Office of the Chief Dental Officer of Canada.
Public Dental Programs

Following are links to information on the various public dental programs in Canada. Policies within the provinces prevail over any information given in this site.

For more information about the programs within a specific jurisdiction, you may wish to visit the website of that jurisdiction, or contact the Department of Health. In some cases, links to the websites or contact addresses are given.

The information provided is about programs at the provincial or territorial level. In many cases, a municipality may provide additional programs to the ones listed.

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Voici, à titre informatif, les principaux programmes de santé dentaire publique au Canada. Les politiques provinciales officielles ont préséance sur toute information donnée ici.

Pour plus de détails sur un programme spécifique, vous pouvez contacter le ministère compétent ou visiter le site web de chaque juridiction. Pour certaines juridictions le lien vers le site web ou une adresse de correspondance est donnée.

Les informations données concernent les programmes provinciaux ou territoriaux. Dans plusieurs cas d'autres programmes peuvent exister à d'autres niveaux (e.g. municipaux)

Alberta  Nova Scotia
British Columbia  Nunavut
Federally Funded Programs  Ontario
Manitoba  Prince Edward Island
New Brunswick  Quebec
Newfoundland and Labrador  Saskatchewan
North West Territories  Yukon
Functional and Psychosocial Impacts of Oral Disorders in Canadian Adults: A National Population Survey

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ABSTRACT

Background: In Canada, national health surveys do not usually include questions pertaining to self-perceived oral health. Those that do use ad hoc sets of questions rather than standardized and validated measures of the functional and psychosocial impacts of oral disorders.

Aims: To collect national data on the impacts of oral disorders from a representative sample of Canadian adults and to compare the results with similar national surveys conducted in the United Kingdom and Australia.

Methods: Data were collected from adults by means of a telephone interview survey based on random-digit dialing. Oral health was measured with the short-form Oral Health Impact Profile (also known as the OHIP-14 questionnaire), which asks about the frequency of 14 functional and psychosocial impacts that people have experienced in the previous year as a result of problems with their teeth, mouth or dentures.

Results: Of 3,033 interviews conducted, data were sufficient for analysis for 3,019 respondents. Just under one-fifth of the 3,019 respondents (19.5%) reported 1 or more of the 14 impacts “fairly often” or “very often” in the previous year. The prevalence was higher among edentulous respondents (30.7%) than among dentate respondents (18.6%), as were the extent and severity scores. The prevalence of impacts was lowest in Atlantic Canada (16.1%) and highest in the Prairies (23.3%), although the difference was not statistically significant. Prevalence rates and extent and severity scores were highest among those who wore dentures, recipients of public dental care and irregular dental visitors. Considerable income disparities were also observed, with 34.9% of those from the lowest-income households reporting impacts. The prevalence of effects and the extent and severity scores in Canada were similar to those reported from the United Kingdom and Australia.

Conclusions: One in 5 Canadian adults experienced adverse impacts from oral disorders. Further work is needed to identify the material and psychological determinants of these impacts.
Disability days in Canada associated with dental problems: a pilot study

Abstract: **Objective:** The aim of this study was to explore disability days, or bed days and cut-down days, associated with dental problems in Canada. **Methods:** Data were collected through a national telephone interview survey of 1005 Canadians aged 18 years and over using random digit dialling. Participants were asked to enumerate the number of disability days associated with dental problems in the previous 2-week period. Descriptive and bivariate logistic regression analyses were undertaken. **Results:** In the previous 2-week period, 33 people, or 3.3% of the sample, reported spending a day in bed because of a dental problem. Of these, 22 people also reported having to cut down on their normal activity because of the dental problem. It appears that younger age groups, those with the lowest incomes, college educations, no dental insurance, oral pain and a history of visiting a hospital emergency room for a dental problem, were all more likely to report a dental disability day. **Conclusions:** These data demonstrate the potential economic impacts of dental problems in Canada, yet they must be interpreted with caution because of the very low prevalence of the main outcome measure, the potential for selection bias and the relative inconsistency with existing historical estimates.

**Key words:** access to dental care; dental insurance; dental problems; disability days; economic impact
Self-reported emergency room visits for dental problems

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Abstract: Objective: To estimate the prevalence of hospital emergency room visits for dental problems not associated with trauma in Canada, and to explore the characteristics that influence such visits. Methods: Data were collected through a cross-sectional and retrospective national telephone interview survey of 1005 Canadians aged 18 years and over using random digit dialling. Participants were asked if they had ever visited a hospital emergency room for a dental problem not associated with trauma. Descriptive and logistic regression analyses were undertaken. Results: A total of 54 people, or 5.4% of the sample reported having to visit an ER in the past for a dental problem not associated with trauma. Income, painful aching in one's mouth in the previous month, and having to spend a day in bed because of a dental problem in the last 2 weeks, appear to be the dominant predictors of this outcome. Conclusions: Access to dental insurance or public care mitigates the use of hospital care for dental problems that are best treated in the dental care setting.

Key words: access to dental care; dental insurance; dental problems; emergency room
Emergency department visits for dental care of nontraumatic origin


Abstract – Objectives: To explore the nature of emergency department (ED) visits for dental problems of nontraumatic origin in Canada’s largest province, Ontario. Methods: The Canadian Institute for Health Information’s National Ambulatory Care Reporting System was used, which contains demographic, diagnostic, procedural and administrative information from hospital-based ambulatory care settings across Ontario. Data of fiscal years 2003/04 to 2005/06 were included for emergency visits that had a main problem coded with an International Classification of Diseases – 10th edition code in the range K00–K14, representing diseases of the oral cavity, salivary glands and jaws. Volumes are presented by a number of different factors in order to describe patient and visit characteristics. Results: During this period, there were a total of 141,365 ED visits for dental problems of nontraumatic origin in Ontario, representing an estimated 116,357 persons. Approximately half of all visits (54%) were made by those 20 to 44 years old, and associated with periapical abscesses and toothaches (56%). The great majority (78%) were triaged as nonurgent, and most (93%) were discharged home. Conclusion: ED visits for dental problems of nontraumatic origin are not insignificant. Over the study period, these visits were greater than for diabetes and hypertensive diseases. Policy efforts are needed to provide alternative options for seeking emergency dental care in Ontario.

Key words: access; dental insurance; health services research

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Day surgery visits for dental problems


Abstract – Objectives: To fill an information gap for dental care policy stakeholders in Canada, this pilot study explored the nature of day surgery (DS) visits for dental problems in Ontario, the country’s largest province.

Methods: The Canadian Institute for Health Information’s National Ambulatory Care Reporting System was used, which contains demographic, diagnostic, procedural and administrative information for ambulatory care settings across Ontario. Fiscal years 2003/2004 to 2005/2006 data were included for DS visits that had a main problem coded with an International Classification of Diseases code in the range K00-K14, representing diseases of the oral cavity, salivary glands and jaws.

Results: During this period, approximately 75,791 persons made 79,133 DS visits for dental problems in Ontario. Proportionally, children under 5 years of age with dental caries represent the majority of DS visits. Restorations and extractions were the most frequently performed DS care procedure.

Conclusions: This is the first study of its kind in Canada, and confirms many of the assumptions held about DS care for dental problems. The study also acts as a baseline for ongoing quality improvement and planning within the province of Ontario.

Key words: day surgery; dental problems; operating room; policy

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Oral health disparities and food insecurity in working poor Canadians


Abstract – Objectives: This study explored oral health disparities associated with food insecurity in working poor Canadians. Methods: We used a cross-sectional stratified study design and telephone survey methodology to obtain data from 1049 working poor persons aged between 18 and 64 years. The survey instrument contained sociodemographic items, self-reported oral health measures, access to dental care indicators (dental visiting behaviour and insurance coverage) and questions about competing financial demands. Food-insecure persons gave ‘often’ or ‘sometimes’ responses to any of the three food insecurity indicators used in the Canadian Community Health Survey (2003) assessing ‘worry’ about not having enough food, not eating enough food and not having the desired quality of food because of insufficient finances in the previous 12 months. Results: Food-insecure working poor persons had poor oral health compared with food-secure working poor persons indicated by a higher percentage of denture wearers (P < 0.001) and a higher prevalence of toothache, pain and functional impacts related to chewing, speaking, sleeping and work difficulties (P < 0.001). Fewer food-insecure persons rated their oral health as good or very good (P < 0.001). Logistic regression analyses showed that oral health disparities between food-insecure and food-secure persons related to denture wearing, having a toothache, reporting poor/very poor self-rated oral health or experiencing an oral health impact persisted after adjusting for sociodemographic factors and access to dental care factors (P < 0.05). Food-insecure working poor persons reported relinquishing goods or services in order to pay for necessary dental care. Conclusions: This study identified oral health disparities within an already marginalized group not alleviated by access to professional dental care. Working poor persons regarded professional dental care as a competing financial demand.
Predictors of dental care utilization among working poor Canadians


Abstract – Objective: This study used the Gelberg-Andersen Behavioral Model for Vulnerable Populations to identify predictors of dental care utilization by working poor Canadians. Methods: A cross-sectional stratified sampling study design and telephone survey methodology was used to collect data from a nationally representative sample of 1049 working poor individuals aged 18 to 64 years. Working poor persons worked ≥20 h a week, were not full-time students and had annual family incomes <$34 300. A pretested questionnaire included sociodemographic items, self-reported oral health measures and two dental care utilization outcomes: time since their last dental visit and the usual reason for dental visits. Results: Hierarchical stepwise logistic analyses identified independent predictors associated with visiting the dentist ≥1 year ago: male gender (OR = 1.63; P = 0.005), aged 25–34 years (OR = 2.05; P = 0.02), paying for dental care with cash or credit (OR = 2.31; P < 0.001), past welfare recipients (OR = 1.65; P = 0.03), <21 teeth (OR = 4.23; P < 0.001) and having a perceived need for dental treatment (OR=2.78; P < 0.001). Sacrificing goods or services to pay for dental treatment was associated with visiting the dentist within the past year. The predictors of visiting the dentist only when in pain/trouble were lone parent status (OR = 4.04; P < 0.001), immigrant status (OR = 1.72; P = 0.006), paying for dental care with cash or credit (OR = 2.71; P < 0.001), a history of an inability to afford dental care (OR = 1.62; P = 0.01), a satisfactory/poor/very poor self-rated oral health (OR = 2.10; P < 0.001), number of teeth <21 (OR = 2.58; P < 0.001) and having a perceived need for dental treatment (OR ≥ 2.99; P < 0.001). Conclusions: This study identified predisposing and enabling vulnerabilities that jeopardize the dental care-seeking practices of working poor persons. Dental care utilization was associated with relinquishing spending on other goods and services, which suggests that dental care utilization is a competing financial demand for economically constrained adults.
Public Opinions on Community Water Fluoridation

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ABSTRACT

Background: Community water fluoridation (CWF) is currently experiencing social resistance in Canada. Petitions have been publicly registered, municipal plebiscites have occurred, and media attention is growing. There is now concern among policy leaders whether the practice is acceptable to Canadians. As a result, this study asks: What are public opinions on CWF?

Methods: Data were collected in April 2008 from 1,005 Canadian adults by means of a national telephone interview survey using random digit dialling and computer-assisted telephone interview technology. Descriptive and bivariate and multivariate logistic regression analyses were undertaken.

Results: Approximately 1 in 2 Canadian adults surveyed knew about CWF. Of these, 80% understood its intended use, approximately 60% believed that it was both safe and effective, and 62% supported the idea of having fluoride added to their local drinking water. Those with greater incomes [OR=1.4; p<0.001] and education [OR=1.6; p<0.001] were more likely to know about CWF. Those with greater incomes [OR=1.3; p<0.03] and those who visited the dentist more frequently [OR=1.8; p<0.002] were more likely to support CWF, and those with children [OR=0.5; p<0.02], those who accessed dental care using public insurance [OR=0.2; p<0.03], and those who avoided fluoride [OR=0.04; p<0.001] were less likely to support CWF.

Conclusion: It appears that Canadians still support CWF. In moving forward, policy leaders will need to attend to two distinct challenges: the influence of anti-fluoride sentiment, and the potential risks created by avoiding fluoride.

Key words: Fluoridation; public opinion; policy

La traduction du résumé se trouve à la fin de l'article.
Public preferences for seeking publicly financed dental care and professional preferences for structuring it


Abstract — Objectives: To test the hypotheses that socially marginalised Canadians are more likely to prefer seeking dental care in a public rather than private setting, and that Canadian dentists are more likely to prefer public dental care plans that approximate private insurance processes. Methods: Data on public opinion were collected through a weekly national omnibus survey based on random digit dialling and telephone interview technology (n = 1005, >18 years). Data on professional opinion were collected through a national mail-out survey of a random selection of Canadian dentists (n = 2219, response rate = 45.8%). Dental and socio-demographic data were collected for the public, as were professional demographic data for dentists. Descriptive and basic regression analyses were undertaken. Results: The majority of Canadians surveyed, 66.4%, prefer to seek dental care in a private setting, 19% in a community clinic, and 7.6% in a dental school; those that are younger and of lowest incomes are most likely to prefer seeking dental care in a public setting. Most Canadian dentists, 80.9%, believe that governments should be involved in dental care, yet only 46% believe this role should include direct delivery. A third of dentists have also reduced the amount of publicly insured patients in their practice. Canadian dentists are more likely to prefer those public plans that most closely reflect private insurance mechanisms. Conclusion: There appears to be a policy disconnect between the preferences of those populations where governmental involvement is most warranted, and the current mechanisms for financing and delivering dental care in Canada. By concentrating almost exclusively on third-party-type financing and indirect delivery, public dental care policy may not be adequately responding to those most in need, especially in an environment where dentists are largely dissatisfied with public plans.

Key words: access; policy; public preferences; provider preferences

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On the Pediatric Oral Health Therapist: Lessons from Canada

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Abstract

**Objectives:** To review the development of dental therapy in Canada. **Methods:** Historical review. **Results:** Over its 35-year history in Canada, this model of service delivery experienced a period of great success, but has since degraded, not fulfilling its potential. **Conclusions:** To ensure the success of the paediatric oral health therapist, US policy leaders will need to mitigate the challenges that degraded the viability of this form of service provision in Canada.

Key Words: dental nurses, dental therapists, dental care delivery, indigenous health services
EXISTING ON A BOUNDARY: THE DELIVERY OF SOCIALLY uninsured HEALTH SERVICES TO ABORIGINAL GROUPS IN CANADA

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**Abstract**

Aboriginal people in Canada suffer persistent health inequalities as a result of individual and structural uncertainty. While in some nations indigenous groups remain uncounted and marginalised, in others, rationing services via an administered identity is an established practice, and can result in negative health outcomes. This paper describes such outcomes, concentrating on the delivery of state-financed commercial social goods to Aboriginal groups in Canada. Two case studies are presented: the first focuses on the pharmaceutical care available to state-recognised and eligible Aboriginal groups; and the second on Aboriginal organisations and their administrative control over programming involving commercial and non-commercial social goods. It is argued that in Canada, health inequalities maintain, in part, due to the socially unclear status of both Aboriginal individuals as citizens with specific rights, and Aboriginal authority as governance with specific decision-making power. As a result, access to health services such as pharmaceutical and dental care can be compromised. In short, individual and structural uncertainty leads to contradictions in jurisdictional oversight and governance, complicating the rights and responsibilities of all parties, hindering service delivery and potential improvements to Aboriginal health.
Where did we succeed?

• Taking policymaker information needs and developing answerable and mutually acceptable research questions

• Improved relations with the private sector

• Participatory Action Research: A good balance between scholarship and politics
Where did we fail?

• Unable to secure private sector data
• Unable to fully move data agenda forward
• Academic collaborations have been slow
Future directions

• Costing of health system impacts
• Examining individual and social impacts of poor oral health and limited access to dental care
• Scientifically and transparently rationing dental care
• Assessing distributional impacts of dental care policy
• Modeling and simulating life transitions on oral health and access to dental care