Dentistry in Alberta:
Time for a Checkup?

Carlos Quiñonez, DMD, MSc, PhD, FRCDC(C)
This report was published by Parkland Institute
November 2020 © All rights reserved.

Contents

Acknowledgements iii
About the authors iii
About Parkland Institute iii
Executive summary 1

1.0 Introduction 5
  1.1 The problem 5
  1.2 Scope and aim of this report 5
  1.3 Setting the stage 6
  1.4 The stakes are high 7
  1.5 Summary 8

2.0 Dentistry in Alberta 9
  2.1 History of dental care in the province 9
  2.2 Inequality in oral health, dental insurance, and access to dental care 13
  2.3 Alberta in comparative focus 20
  2.4 The question of dental fees 24
  2.5 Potential weaknesses 27
  2.6 Summary 31

3.0 Potential solutions 32
  3.1 Targeted versus universal coverage 32
  3.2 Mandating universal coverage 34
  3.3 Expanding the public and private option 37
  3.4 Expanding and diversifying the workforce 39
  3.5 Integrating oral health into the health-care system 40
  3.6 Rationalizing the primary dental care system and basket of services 42
  3.7 Summary 45

4.0 Conclusions and recommendations 47
  4.1 Recommendations 47
  4.2 Summary 48

References 49

ISBN: 978-1-894949-76-7
Tables
Table 1. Publicly funded dental-care programs in Alberta 10
Table 2. The proportion and likelihood of having dental insurance benefits by income level in Alberta 11
Table 3. Dental care expenditure in Canada, by jurisdiction and source of funds, 2017, current dollars ($000) 11
Table 4. Inequality in oral health-related outcomes in Canada 14
Table 5. Inequality in dental insurance benefits in Alberta 16
Table 6. The proportion having a dental visit in Canada and across its provinces over time 16
Table 7. Income-related inequality in dental visits in Canadian provinces 17
Table 8. The public share for dental care in select OECD nations, 2013 23

Figures
Figure 1. Total, private, and public per capita expenditure for dental care in Alberta, 1975-2017 (constant 1997$) 12
Figure 2. Public per capita expenditure as a share of total per capita expenditure for dental care in Alberta, 1975-2017 13
Figure 3. Slope index of inequality for dental insurance benefits coverage over time, by age group, in Alberta 18
Figure 4. Relative index of inequality for dental insurance benefits coverage over time, by age group, in Alberta 18
Figure 5. Public per capita dental care expenditure in Alberta and Canada, 1975-2017 (constant 1997$) 20
Figure 6. Private per capita dental care expenditure in Alberta and Canada, 1975-2017 (constant 1997$) 21
Figure 7. Public per capita expenditure as a share of total per capita expenditure for dental care in Alberta and Canada, 1975-2017 22
Figure 8. Consumer Price Index (CPI), annual average, Canada, 1914-2019 26
Acknowledgements

Thank you to Dr. Jamie Moeller for his help with the early versions of this report, and thank you to Ms. Julie Farmer and Ms. Nevena Zivkovic for providing data used in this report.

About the Authors

Dr. Quiñonez is a dental public health specialist and an associate professor and program director at the Faculty of Dentistry, University of Toronto. His research centres on the politics and economics of dentistry, with a specific focus on health and social equity.

About Parkland Institute

Parkland Institute is an Alberta research network that examines public policy issues. Based in the Faculty of Arts at the University of Alberta, it includes members from most of Alberta’s academic institutions as well as other organizations involved in public policy research. Parkland Institute was founded in 1996 and its mandate is to:

- conduct research on economic, social, cultural and political issues facing Albertans and Canadians
- publish research and provide informed comment on current policy issues to the media and the public
- sponsor conferences and public forums on issues facing Albertans
- bring together academic and non-academic communities

All Parkland Institute reports are academically peer reviewed to ensure the integrity and accuracy of the research.

For more information, visit www.parklandinstitute.ca
Executive Summary

Alberta's dental care treatment costs are among the highest in Canada, and this means many Albertans cannot access the dental care they need. Poor access to dental care can reduce Albertans' quality of life, inappropriately consume health-care resources, limit the economic productivity of workers and communities, and disproportionately burden vulnerable populations. For some individuals, the impacts of poor access to dental care can even entrap them in a cycle of poverty by affecting academic achievement, the ability to find or maintain long-term employment, and by worsening systemic health conditions.

The issue of access to dental care is increasingly recognized as a significant social challenge in Alberta and Canada. The good news is we can do something about it. If and when we do, the benefits to Albertans and Canadians may be substantial.

This report examines dental care affordability challenges by:

• assessing the merits and drawbacks of expanding public and private dental care
• evaluating targeted and universal approaches to dental care coverage
• analyzing the options of mandating universal dental care coverage through statutory health insurance or through legislation on employer-employee arrangements or both
• examining the possibilities of expanding and diversifying the oral health care workforce, such as by adding dental therapists to the predominant care team of dentists, hygienists and assistants, and by involving physicians and nurses in preventive oral health care interventions
• assessing options of integrating dental care into the broader health-care system to achieve cost savings, provide better care and improve patient outcomes

The private versus public share of total dental-care costs in Alberta

About 90 per cent of dental care services in Alberta are privately funded. Private spending on dental care consists of out-of-pocket costs and costs paid by private insurance benefit plans. It is said that Alberta's private dental care expenditure has grown more than twice the rate of comparable provinces in recent years. Alberta Blue Cross, a major insurer in the province, has stated that, in 2015, 62 per cent of Alberta adults restricted their dental visits and 47 per cent restricted their children's visits due to high costs.

Alberta ($498.90 per capita) is the top private funder of dental care in Canada (the Canadian average is $394.09). This is arguably connected to the
provinces’ heavy emphasis on employer-sponsored dental insurance benefits. Prior to the increased unemployment levels in 2020 due to the COVID-19 pandemic, it was estimated that 73 per cent of employed Albertans had varying levels of employer-sponsored dental benefits.

The latest available data on Albertans’ coverage for dental insurance benefits by income level comes from the 2015-2016 Canadian Community Health Survey. The proportion of Albertans having dental insurance by income quintile is as follows: the poorest 20 per cent of residents (66.9 per cent), second poorest quintile (74.8 per cent), middle quintile (78.7 per cent), second richest quintile (84.7 per cent), and the richest 20 per cent (87.6 per cent).

Alberta’s public share of total dental care costs (or the amount of dental care paid for by government out of all dental care spending) peaked at 19 per cent in 1990. The public share decreased steadily over the last 30 years and is now about 10 per cent, or a bit more than half of what it was in 1990. While Alberta’s 10 per cent public share of total dental care costs puts it ahead of the Canadian average, it also puts it in line with the United States, and well behind most Organization for Economic Co-operation and Development (OECD) nations, where the average public share is about a third.

Among the provinces and on a per capita basis, the Alberta government ($60.35) is second to the Saskatchewan government ($65.18) in the public funding of dental care, but only about nine per cent of Albertans receive government-sponsored dental insurance benefits.

**Dental care pricing and delivery in Alberta**

Similar to Canada’s dental-care system, the pricing of dental-care services in Alberta is mostly set by private markets. There is almost no provincial government involvement in how dental care is priced. An Alberta government report suggests the operating costs of dental offices in Alberta are higher than in other provinces due to higher labour costs. Nevertheless, if one tracks the consumer price index in Canada, one sees that dental care prices have outstripped the growth in prices for all goods and services, including food, shelter, transportation and medicinal and pharmaceutical products.

Almost all dental care in Alberta, whether publicly or privately funded, is delivered in private dental clinics on a fee-for-service basis. Depending too heavily on private markets to provide health care in general or dental care specifically without strategic oversight and intervention can result in increased inequity (or unnecessary and unfair differences between social groups). Fee-for-service payment mechanisms in health care and dental care can also incentivize overtreatment and result in an inefficient use of resources.
Targeted versus universal approaches to dental care

A targeted approach to dental care is what Alberta and Canada already have. This approach results in significant coverage gaps. Over 20 per cent of Albertans do not have any dental insurance. The targeted approach to dental care works to limited effect as well. For example, the dental care needs of low-wage workers without insurance plans may actually be greater than the needs of Albertans and Canadians who currently receive public coverage.

The latest available data on inequality in oral-health-related outcomes in Canada comes from the 2007-2009 Canadian Health Measures Survey. The research shows that:

- 16 per cent of lower income Canadians have persistent mouth pain versus 9.1 per cent of higher income residents
- 10.9 per cent of lower income Canadians have a complete lack of teeth versus 3.2 per cent of higher income residents
- 34.5 per cent of lower income Canadians avoided visiting a dentist in the past year due to cost versus 8.8 per cent of higher income residents
- 29.7 per cent of lower income Canadians declined recommended dental care in the past year due to cost versus 9.9 per cent of higher income residents

In short, the greater one’s needs, the less access to dental care. And if the targeted approach really held true, it would provide coverage for the exact people it is currently excluding (e.g. working poor families).

Provincial and federal governments should invest in making dental care more affordable and accessible to all Canadians based on their dental care needs, not the quality of their jobs or the size of their pocketbooks. Public and private investment in a universal approach that covers the whole population with some type of dental insurance benefit is the most expedient way to address existing coverage gaps and reduce the inequity in access to dental care that currently exists.

A 2020 report by Thomas Lange of the University of Calgary estimated the costs of two options for restructuring the coverage of dental care in Canada: (1) universal first-dollar coverage ("Denticare"), and (2) public dental insurance for adults and seniors without private insurance and for all children under 12 ("Denticaid"). Lange estimated the 2019 total costs for Denticare at $27.5 billion ($737.09 per capita) and for Denticaid at $15.1 billion ($404.49 per capita).

Another recent estimate provided by the federal Parliamentary budget officer suggests that the total costs of a national dental care program for uninsured Canadians with a household income below $90,000 would average out at $2.2
billion per year from fiscal years 2020-2021 to 2024-2025. And depending on the year considered, the per capita estimates range from $251 to $570.

In both of the above analyses, cost estimates decrease when patient contributions are factored in. Both also make different assumptions and cost different dental care service baskets. These analyses represent only two options to restructuring the coverage of dental care in Canada. There are, in fact, many ways to achieve the universal coverage of dental care that involve both the public and private sector, and that give more consideration to the appropriateness and therapeutic benefit of the services included.

Ultimately, though, rather than taking a universal approach to providing dental insurance benefits, the Alberta government has limited its public spending to only targeted populations, leaving over 20 per cent of the population without access to dental insurance benefits and thus having to rely exclusively on out-of-pocket payment. An example of the benefits of government investment in dental care is Alberta's public program for seniors. Delivered by the private sector, expansions to the program's eligibility and funding throughout the 1990s and early 2000s were arguably reflected in a dramatic drop off to inequity in access to dental care among Alberta seniors.

A universal approach to coverage may also lead to cost savings. In an attempt to alleviate pain, those unable to access primary care through a dentist may turn to hospital emergency departments and physician offices, which are most often unable to resolve dental problems beyond prescriptions for antibiotics, painkillers and a referral to a dentist, which can remain unfulfilled. Thus, poor access to dental care can contribute to existing public health challenges associated with antibiotic overprescribing and opioid-related issues, and can tie up valuable health-care resources (hospital rooms, equipment, staff and physicians), with little or nothing to show for it.

A universal approach to coverage means expanding the public and private option, or investing in public and private infrastructure. For example, capital investment in public clinics is arguably necessary given that we know some individuals, often those with the most needs, lowest incomes, and greatest cost-barcers to care, can prefer to access dental care in these settings. At the same time, given that most dental care will ultimately be delivered by the private sector, appropriate funding and payment through public dental care plans is also key. Finally, incentivizing and providing more options for employers to offer dental insurance benefits can also play an important role in achieving universal coverage.

To conclude, expanding the public and private option means a renewed vision for dental care in Alberta and Canada. A vision that brings us more in line with our OECD counterparts, privileges equity and fair equality of opportunity in access to care, and maximizes individual and population health.
1.0 Introduction

1.1 The problem

As in other Canadian provinces, Alberta has been the site of repeated debates about access to dental care. Many recognize that access to dental care can be a challenge for individuals and families faced with a low income or a lack of dental insurance benefits, especially since it is these exact individuals and families who experience the greatest levels of oral disease and thus a need for dental-care services. As a result, access to dental care has recently featured in provincial and federal elections, with many now considering the challenges in this area unnecessary and unfair.

It is important to note that Alberta’s debates on the issue of access to dental care are somewhat unique, as they venture into dentistry’s proverbial sacred cows, including the pricing of dental care, the at-times unsteady and uneasy relationship between dentistry and the insurance industry, and the limits of government in mandating action by the dental profession. In comparison to other Canadian provinces and territories, Alberta is further unique in that it is one of the top public and private funders of dental care in the country and suffers from the boom and bust cycles of a resource-based economy, which make its population particularly vulnerable.

1.2 Scope and aim of this report

There are various aspects to consider when examining the issue of access to dental care, whether it be geographical accessibility or if the needs of user groups align well with the services being offered by oral health care providers. Indeed, Alberta is a large province with geographically isolated areas and is made up of different cultural groups with varying needs. These realities impact access to dental care, yet, in this report, we focus largely on affordability challenges, as cost has historically played the dominant role in the ability to utilize and access dental care in Canada, and is thus the most studied barrier to care.

With this perspective in mind, this report assesses the current challenges in Alberta’s and Canada’s dental-care landscape, and proposes options for how to improve access to dental care for all Albertans and Canadians. The report begins by setting the stage for our discussion and asks what is at stake for Alberta and Canada. It then highlights the history of dental care in Alberta, and what is known about inequality in oral health and access to dental care in the province. It then compares Alberta to other Canadian jurisdictions in terms of the public and private funding of, and access to, dental care. This is followed by a discussion on the nature of dental fees and what that means to Albertans, alongside a consideration of the weaknesses of the dominant approach taken to oral health care by Alberta and Canada. Potential solutions to address historical and current challenges are then offered,
ending with a series of recommendations that can help map the movement toward the universal coverage of dental care in Alberta and Canada.

### 1.3 Setting the stage

It is a paradox in Canadian health policy that our prized single-payer and universal Medicare system protects Canadians against the potentially crippling costs of treating illness by removing financial barriers to accessing appropriate and necessary physician and hospital care, yet our teeth and mouth are essentially left out. Today, like in other provinces, Alberta’s government covers limited dental-care services. Coverage is restricted primarily to children, those with low incomes, those living with a disability, and qualifying seniors. Most people rely primarily on themselves, families, employers and/or private insurers for funding.

Problems with Alberta’s approach – and indeed, with the approach taken by all Canadian jurisdictions – have come under scrutiny in recent years. Multiple news stories highlight the challenges for people to afford the cost of dental care, with one insurance industry report suggesting that Alberta’s treatment costs are “generally considered [some] of the highest in North America.” In fact, it is said that Alberta’s private dental-care expenditure has grown at more than twice the rate of comparable provinces during recent years. Alberta Blue Cross, a major insurer in the province, reported that, in 2015, 62 per cent of Alberta adults restricted their dental visits due to high costs, and 47 per cent restricted their children’s visits for the same reasons.

Critics contend that a primary driver of these trends has been Alberta’s absence of fee structuring during the past two decades, a situation that, according to the current United Conservative Party government, changed in 2018. Provincial dental associations in other provinces publish suggested fee schedules to establish benchmarks for how much to charge patients for different dental procedures, but Alberta’s dual regulator and association, the Alberta Dental Association and College (ADA&C), is said to have eliminated theirs in 1997. Alberta’s previous New Democratic Party (NDP) government mandated that a new fee guide be introduced, which others note occurred in 2017.

The introduction of a fee guide in Alberta is said to have had only a modest impact on treatment costs, with cost continuing to be a concern for patients and funders. Arguably, this will continue to be the case, particularly given that the ability to pay for dental care is exacerbated by economic downturns and given that Alberta relies so heavily on natural resource markets that are vulnerable to boom and bust economic cycles. Finally, the recent COVID-19 pandemic has made all Canadians economically and socially vulnerable, with at-risk groups shouldering the effects of such a radical change to Canada’s economic and social life.
1.4 The stakes are high

It is not difficult to convey the importance of oral health and good teeth to a person’s quality of life. All one needs to do is consider what it would be like to live with few or no teeth and, at worse, what life would be like if one had a brutal and agonizing repeated toothache.\textsuperscript{23,24}

It is largely unknown that the diseases of the mouth are some of the most common non-communicable diseases globally, and rank among those that impose the greatest burdens to societies.\textsuperscript{25,26} The most common of these diseases are dental caries and periodontal disease – referred to as “cavities” and “gum disease” by the general population – which in turn can lead to tooth loss and dental pain. These conditions are not uniformly distributed across the population; like most illnesses, they disproportionately impact those with less income and education, those who are unemployed or have unstable jobs, and those who are marginalized to the fringes of society, such as the homeless and indigent.\textsuperscript{3} Not surprisingly, these groups are the most likely to report barriers to accessing dental care, with cost being paramount,\textsuperscript{27} although affordability challenges appear to be present among higher income groups as well.\textsuperscript{28}

An inability to access timely or necessary dental care can lead to untold suffering from oral pain: missed school days or work absenteeism; an inability to eat well or maintain a healthy diet; an inability to focus on daily activities or sleep well at night; and psychological duress and isolation for others.\textsuperscript{3,29} These impacts can have long-term consequences, entrapping both children and adults in a cycle of poverty by affecting academic achievement, the ability to find or maintain long-term employment and worsening systemic health conditions.\textsuperscript{3,30,31}

This means poor access to dental care has implications for the economy and the population’s overall well-being. For instance, the appearance of teeth can influence employer hiring practices and affect employee earnings.\textsuperscript{32-34} Oral diseases can also worsen the burden of other diseases, such as poor glycemic control, retinopathy, and amputation among diabetics.\textsuperscript{35,36} Importantly, dental treatment can reduce diabetes-related and other health-care costs.\textsuperscript{37}

In addition, in an attempt to alleviate pain and suffering, those unable to access primary care through a dentist may turn to hospital emergency departments and physician offices, which are most often unable to resolve dental problems beyond prescriptions for antibiotics and painkillers and a referral to a dentist that can remain unfulfilled.\textsuperscript{38,39} Thus, poor access to dental care can contribute to existing public health challenges associated with antibiotic overprescribing and opioid-related issues, and can tie up valuable health-care resources (hospital rooms, equipment, staff and physicians), with little or nothing to show for it.
1.5 **Summary**

Poor access to dental care arguably represents an important social issue for Alberta and Canada. From decreasing the quality of life and worsening overall well-being, to inappropriately consuming health-care resources and exacerbating existing public health challenges, poor access to dental care results in inequity and inefficiency. Thus, Alberta and Canada must arguably challenge the status quo and offer changes that benefit individuals, families, the health-care system, governments and society.
2.0 Dentistry in Alberta

2.1 History of dental care in the province

Similar to its provincial counterparts, the public provision of health-care services in Alberta (dentistry included) was largely absent for much of the province's early years in Canadian confederation. The United Farmers of Alberta (UFA) introduced the Alberta Health Insurance Act of 1934, which sought to create a cost-sharing plan (between individuals, employers and the provincial government) for all medical services, pharmaceuticals, hospitalizations, nursing care and limited dental care. However, the legislation was unable to pass before the UFA's defeat in 1935 to the Social Credit Party. The more right-leaning Social Credit Party established a means-tested health insurance plan instead, which subsidized care for the poor but restricted coverage to only those services provided by physicians and hospitals.

The provincial plan was abandoned in the late 1960s, as the federal government responded to mounting public support for a single-payer model of health care by introducing the Medical Care Act of 1966, thus establishing strong financial incentives for the Alberta government to adopt a universally accessible, publicly funded health-care system. For a variety of reasons, including economic scarcity and professional preference, dental care was not included.

2.1.1 Growth in public and private insurance

Given that the demand for dental care and other services remained strong in the absence of public funding, all provincial governments began to establish programs that would cover dental care and other services for those who were deemed unlikely to afford necessary care, or who did not receive private dental insurance benefits through their workplaces. While most provincial governments established either universal or means-tested programs for children in the ensuing years, Alberta focused instead on its elderly population, introducing the largest seniors' dental-care program in North America in 1973. This program provided comprehensive dental benefits to all seniors aged 65 and older and their spouses or dependents and, in 1983, the program was expanded to include widows aged 55 to 64 who met pre-defined income requirements. The program had few limitations and restrictions, and co-payments for services were absent. After several reforms during the late 1990s and early 2000s, the new Dental Assistance for Seniors program replaced the Extended Health Benefits program, today providing up to $5,000 every five years for qualifying seniors and their spouses based on household income (Table 1).
Table 1: Publicly funded dental care programs in Alberta

<table>
<thead>
<tr>
<th>Target population</th>
<th>Program name</th>
<th>General description</th>
<th>Responsible ministry</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All residents</strong></td>
<td>All residents</td>
<td>Provides residents of Alberta specific medically necessary dental and oral surgical health services</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td></td>
<td>Cleft Palate Dental Indemnity Program</td>
<td>Provides residents born with congenital cleft palate some dental services</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td></td>
<td>Oral and Maxillofacial Devices and Services Program</td>
<td>Provides residents with severe oral/facial conditions some dental services</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td></td>
<td>Public Health Dental Clinics Program</td>
<td>Provides families in financial need and without access to dental insurance some dental services</td>
<td>Alberta Health Services</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td>Alberta Child Health Benefit</td>
<td>Provides children of families with limited incomes some dental services</td>
<td>Ministry of Community and Social Services</td>
</tr>
<tr>
<td></td>
<td>Family Support for Children with Disabilities</td>
<td>Provides children living with disability some dental services</td>
<td>Ministry of Community and Social Services</td>
</tr>
<tr>
<td></td>
<td>Preschool Fluoride Varnish Service</td>
<td>Provides young children with fluoride varnish</td>
<td>Alberta Health Services</td>
</tr>
<tr>
<td></td>
<td>School Fluoride Varnish Service</td>
<td>Provides school children with fluoride varnish</td>
<td>Alberta Health Services</td>
</tr>
<tr>
<td></td>
<td>School Dental Sealant Service</td>
<td>Provides school children with sealants</td>
<td>Alberta Health Services</td>
</tr>
<tr>
<td><strong>Adults</strong></td>
<td>Alberta Income Support</td>
<td>Provides those in low income households some dental services</td>
<td>Ministry of Community and Social Services</td>
</tr>
<tr>
<td></td>
<td>Alberta Adult Health Benefit</td>
<td>Provides those in low income households some dental services</td>
<td>Ministry of Community and Social Services</td>
</tr>
<tr>
<td></td>
<td>Assured Income for the Severely Handicapped</td>
<td>Provides adults living with disability some dental services</td>
<td>Ministry of Community and Social Services</td>
</tr>
<tr>
<td><strong>Seniors</strong></td>
<td>Dental Assistance for Seniors</td>
<td>Provides seniors with limited incomes some dental services</td>
<td>Ministry of Seniors and Housing</td>
</tr>
</tbody>
</table>


Over the last four decades, the Alberta government has, similarly to other provinces, introduced relatively comprehensive dental benefits for persons with disabilities (Assured Income for the Severely Handicapped, Family Support for Children with Disabilities) and low-income children (Alberta Child Health Benefit), as well as more restricted benefits for low-income adults through the Alberta Income Support and Alberta Adult Health Benefit program (Table 1).\(^{1,2}\) While these programs have been successful in improving access to care for qualifying individuals, the great majority of Albertans (like residents in other provinces) still rely on private health insurance benefits (primarily through their workplace) and out-of-pocket payments to fund care.

In 2011, the Canadian Centre for Policy Alternatives reported that about 50 per cent of Albertans had privately sponsored dental insurance benefits and 10 per cent received government-sponsored dental insurance benefits.\(^4\) More recently, estimates from the Canadian Community Health Survey 2015-2016 suggest that 68.4 per cent of Albertans had privately sponsored dental insurance benefits and nine per cent received government-sponsored dental insurance benefits (Table 2). In fact, it appears that in Alberta, the overall proportion of the population having some kind of dental insurance benefit has increased over time, as well as across income groups, with about one-fifth (21.4 per cent) of the population relying on out-of-pocket payment (Table 2).
Dentistry in Alberta: Time for a Checkup?

**Table 2:** The proportion and likelihood of having dental insurance benefits by income level in Alberta

<table>
<thead>
<tr>
<th>Income group</th>
<th>Proportion (95% CI)</th>
<th>Odds ratio (95% CI)</th>
<th>Proportion (95% CI)</th>
<th>Odds ratio (95% CI)</th>
<th>Proportion (95% CI)</th>
<th>Odds ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>63.5 (62.4-64.6)</td>
<td>Reference</td>
<td>67.8 (64.7-70.7)</td>
<td>Reference</td>
<td>71.5 (70.1-72.8)</td>
<td>Reference</td>
</tr>
<tr>
<td>Private</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>68.4 (67.1-69.6)</td>
</tr>
<tr>
<td>Public</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>9.0 (8.4-9.7)</td>
<td></td>
</tr>
</tbody>
</table>

Notes: Estimates are age-standardized; Estimates for private and public coverage unavailable for all years except 2015-2016.
Source: Data provided by Ms. Nevena Zivkovic, Dental Public Health, Faculty of Dentistry, University of Toronto.

**2.1.2 Trends in public and private expenditure**

In 2017, Alberta spent a total of $2.4 billion on dental care: $2.2 billion in private expenditure and $256 million in public expenditure (Table 3). The Canadian average was $1.2 billion: $1.1 billion private and $71.4 million public.

**Table 3:** Dental care expenditure in Canada, by jurisdiction and source of funds, 2017, current dollars ($000)

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Public</th>
<th>Per capita</th>
<th>Total</th>
<th>Per capita</th>
<th>Total</th>
<th>Per capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>146,673</td>
<td>29.84</td>
<td>2,103,599</td>
<td>427.37</td>
<td>2,250,472</td>
<td>457.21</td>
</tr>
<tr>
<td>Alberta</td>
<td>256,127</td>
<td>60.35</td>
<td>2,117,328</td>
<td>498.90</td>
<td>2,373,455</td>
<td>539.25</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>75,009</td>
<td>65.18</td>
<td>408,841</td>
<td>355.27</td>
<td>483,850</td>
<td>420.45</td>
</tr>
<tr>
<td>Manitoba</td>
<td>56,845</td>
<td>42.57</td>
<td>429,533</td>
<td>321.65</td>
<td>486,378</td>
<td>364.22</td>
</tr>
<tr>
<td>Ontario</td>
<td>89,253</td>
<td>63.4</td>
<td>627,025</td>
<td>445.60</td>
<td>6,359,478</td>
<td>451.94</td>
</tr>
<tr>
<td>Quebec</td>
<td>221,918</td>
<td>26.74</td>
<td>2,297,881</td>
<td>276.93</td>
<td>2,519,799</td>
<td>303.67</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>12,849</td>
<td>16.76</td>
<td>234,694</td>
<td>306.05</td>
<td>247,543</td>
<td>322.80</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>16,415</td>
<td>17.27</td>
<td>325,304</td>
<td>342.18</td>
<td>341,719</td>
<td>359.45</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>3,154</td>
<td>20.95</td>
<td>44,128</td>
<td>293.08</td>
<td>47,282</td>
<td>314.03</td>
</tr>
<tr>
<td>Newfoundland and Labrador</td>
<td>17,982</td>
<td>34.02</td>
<td>137,502</td>
<td>260.14</td>
<td>155,484</td>
<td>294.16</td>
</tr>
<tr>
<td>Nunavut</td>
<td>11,358</td>
<td>302.46</td>
<td>6,731</td>
<td>179.24</td>
<td>18,089</td>
<td>481.71</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>12,685</td>
<td>282.29</td>
<td>14,457</td>
<td>321.72</td>
<td>27,142</td>
<td>604.01</td>
</tr>
<tr>
<td>Yukon</td>
<td>7,716</td>
<td>194.71</td>
<td>10,087</td>
<td>254.54</td>
<td>17,803</td>
<td>449.25</td>
</tr>
<tr>
<td>Canada</td>
<td>928,184</td>
<td>25.40</td>
<td>14,400,310</td>
<td>394.09</td>
<td>15,328,494</td>
<td>419.50</td>
</tr>
</tbody>
</table>

Source: National Health Expenditure Database, Canadian Institute for Health Information. Data provided by Ms. Julie Farmer, Dental Public Health, Faculty of Dentistry, University of Toronto.
A 2014 study found that in Canada, only British Columbia spent more per capita on dental care than Alberta ($400 versus $389). Although, another 2014 study found Albertans spent the most when compared to all other Canadians. Regardless of the estimates, such a high level of expenditure is consistent with anecdotal news reports in recent years.

It also appears that aside from variability associated with economic recessions – the most pronounced were in the early 1980s and at the end of the first decade of the new millennium (resulting from the 1973 oil crisis and the 1979 energy crisis and The Great Recession, respectively) – Albertans and their government have spent increasing amounts on dental care over time (Figure 1). Alberta’s public share for dental care, or the amount of dental care paid for by governments out of all dental care spending, tends to be high as well. In 2010, for instance, Alberta’s public share was 8.7 per cent, while the Canadian average was 4.3 per cent. At its height, Alberta’s public share was 19 per cent in 1990, when the Canadian average was closer to nine per cent (Figure 2).

Figure 1: Total, private, and public per capita expenditure for dental care in Alberta, 1975-2017 (constant 1997$)

Notes: “f” denotes forecasted estimates.
Source: National Health Expenditure Database, Canadian Institute for Health Information; Data provided by Ms. Julie Farmer, Dental Public Health, Faculty of Dentistry, University of Toronto.
2.1.3 Take-home message

In general terms, Alberta’s dental-care system had a similar trajectory to that of the other Canadian provinces. Dental care became excluded from provincial health insurance plans (except for surgical dental services delivered in hospital), and instead targets specific populations, largely based on a combination of need, income and/or employment status. Alberta, like Canada, has thus come to depend on privately sponsored dental insurance benefits and out-of-pocket payment as the means by which the population is to utilize and access dental care. Year over year, Albertans and their government have also tended to spend increasing amounts on dental care, although the amount spent by government as a percentage of total dental care expenditure has steadily decreased over time.

2.2 Inequality in oral health, dental insurance, and access to dental care

There is precious little epidemiological information on the oral health status of Albertans, a situation that is similar for respective populations across all provinces and territories. This lack of data has been recognized numerous times and places limits on oral-health-related planning for all Canadian jurisdictions, including Alberta.12,46,49 Of the limited data available in Alberta, all of it focuses on subgroups of the population in specific regions, including
schoolchildren (e.g. Indigenous children, immigrant children) and the elderly (e.g. long-term-care residents) in either urban or remote settings.46-56

As a result, we must depend on national estimates, and the story is arguably the same in Alberta as it is across Canada,49 meaning inequality (or differences between social groups) exists in oral diseases and conditions, the utilization of dental care and access to dental care (Table 4). For example, lower income individuals had 3.3 teeth with untreated decay, while higher income individuals had 2.4. Similarly, 6.8 per cent of lower income individuals had severe gum disease, compared to three per cent of higher income individuals. About 10.9 per cent of lower income individuals were edentulous (a complete lack of teeth), compared to 3.2 per cent of higher income individuals. Almost a quarter (24.6 per cent) of lower income individuals reported their oral health status as fair or poor, while 10.9 per cent of higher income individuals did the same. About 16 per cent of lower income individuals reported persistent pain in their mouths, while 9.1 per cent of higher income individuals reported the same experience. About 60 per cent of lower income individuals visited a dentist in the last year, while 83.8 per cent of higher income individuals reported the same. And 34.5 per cent of lower income individuals avoided the dentist due to cost, while 8.8 per cent of higher income individuals did the same. In short, the greater one’s needs, the less the utilization of, and access to, dental care.27

Table 4: Inequality in oral health-related outcomes in Canada

<table>
<thead>
<tr>
<th></th>
<th>Decayed, missing, or filled teeth &gt; 0 (%)</th>
<th>Mean number of untreated teeth with decay</th>
<th>Mean number of filled teeth</th>
<th>Severe periodontal disease, or loss of periodontal attachment of 6 mm or more (%)</th>
<th>Edentulism (%)</th>
<th>Fair or poor oral health (%)</th>
<th>Persistent oral pain (%)</th>
<th>Visited a dentist in the past year (%)</th>
<th>Avoided visiting a dentist in the past year due to cost (%)</th>
<th>Declined recommended dental care within the past year due to cost (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>95.4</td>
<td>3.1</td>
<td>7.3</td>
<td>4.7</td>
<td>6.3</td>
<td>16.8</td>
<td>9.7</td>
<td>73.1</td>
<td>15.5</td>
<td>14.4</td>
</tr>
<tr>
<td>Female</td>
<td>96.5</td>
<td>2.8</td>
<td>8.5</td>
<td>3.5</td>
<td>6.5</td>
<td>14.1</td>
<td>13.5</td>
<td>75.9</td>
<td>19.2</td>
<td>18.6</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower</td>
<td>94.7</td>
<td>3.3</td>
<td>6.5</td>
<td>6.8</td>
<td>10.9</td>
<td>24.6</td>
<td>16.0</td>
<td>60.0</td>
<td>34.5</td>
<td>29.7</td>
</tr>
<tr>
<td>Middle</td>
<td>96.2</td>
<td>3.3</td>
<td>7.5</td>
<td>3.8</td>
<td>8.5</td>
<td>16.5</td>
<td>12.2</td>
<td>69.3</td>
<td>19.5</td>
<td>18.3</td>
</tr>
<tr>
<td>Higher</td>
<td>96.8</td>
<td>2.4</td>
<td>8.9</td>
<td>3.0</td>
<td>3.2</td>
<td>10.9</td>
<td>9.1</td>
<td>83.8</td>
<td>8.8</td>
<td>9.9</td>
</tr>
<tr>
<td>Dental insurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>95.5</td>
<td>2.4</td>
<td>8.3</td>
<td>2.8</td>
<td>3.0</td>
<td>12.9</td>
<td>10.2</td>
<td>82.3</td>
<td>8.6</td>
<td>10.9</td>
</tr>
<tr>
<td>Public</td>
<td>96.9</td>
<td>3.7</td>
<td>8.4</td>
<td>--</td>
<td>13.3</td>
<td>26.3</td>
<td>17.8</td>
<td>70.9</td>
<td>8.9</td>
<td>18.1</td>
</tr>
<tr>
<td>None</td>
<td>96.7</td>
<td>3.5</td>
<td>7.3</td>
<td>7.0</td>
<td>11.4</td>
<td>18.6</td>
<td>13.2</td>
<td>59.3</td>
<td>35.9</td>
<td>27.4</td>
</tr>
<tr>
<td>Place of birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Canada</td>
<td>96.7</td>
<td>3.0</td>
<td>8.1</td>
<td>2.7</td>
<td>6.9</td>
<td>14.7</td>
<td>11.6</td>
<td>74.8</td>
<td>15.8</td>
<td>15.4</td>
</tr>
<tr>
<td>Outside Canada</td>
<td>93.5</td>
<td>3.0</td>
<td>7.4</td>
<td>8.5</td>
<td>4.8</td>
<td>18.3</td>
<td>11.8</td>
<td>73.3</td>
<td>22.8</td>
<td>20.3</td>
</tr>
<tr>
<td>Indigenous status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous</td>
<td>97.7</td>
<td>3.0</td>
<td>9.2</td>
<td>--</td>
<td>--</td>
<td>28.0</td>
<td>26.8</td>
<td>79.1</td>
<td>--</td>
<td>15.8</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>95.9</td>
<td>3.0</td>
<td>7.9</td>
<td>4.2</td>
<td>6.4</td>
<td>15.1</td>
<td>11.1</td>
<td>74.4</td>
<td>17.4</td>
<td>16.5</td>
</tr>
</tbody>
</table>

Notes: Some estimates are not reported due to significant sample variability or small sample sizes.
2.2.1 Dynamics of dental insurance and dental visits in Alberta

Understanding the dynamics of dental insurance benefits and dental visits in Alberta is important. First, the presence or absence of dental insurance benefits is closely tied to income and employment. Second, the presence or absence of dental insurance benefits is strongly associated with the use of, and access to, dental care.3,8,9,27,28,42,46

It appears that a significant proportion of Albertans are covered by some kind of dental insurance benefit (public or private), and this coverage has increased over time across all income groups (Table 2). Yet, inequality persists.

Interestingly, it is also important to note that a recent study on trends in inequality in Canada suggests that differences in yearly dental visits across income groups appears to be decreasing.57 This study argued that, even in the context of increasing dental care prices, stagnating real incomes and chronic affordability challenges in accessing dental care, the demand for dental care is growing at such a pace in lower- and middle-income groups that inequality is diminished.57 This growth in demand could be because of the increased cultural and social importance of oral health (i.e. straight, white teeth) as a status or socioeconomic symbol, an aging population that is keeping their teeth longer, and/or the effects of increases to dental insurance benefits coverage in the Canadian population, meaning with more coverage comes more dental visits.57,58

We can also take a closer look at inequality in dental insurance benefits coverage in Alberta, specifically using the slope index of inequality and relative index of inequality (Table 5). This approach to measuring inequality accounts for changes in the size of the population and the size of the income groups in that population over time; thus, these measures are superior to simply describing the proportion of the population visiting the dentist across income groups. The slope index of inequality measures the absolute difference between the highest and lowest income group (A−B), and the relative index of inequality measures the relative difference between the highest and lowest income group (A÷B). As seen in Table 5, over time, in Alberta, there appears to be decreasing absolute and relative differences in dental insurance benefits coverage. This appears to have translated into increases in dental visits overall, as well as decreases in both absolute and relative inequality in dental visits among Albertans (Table 6 and Table 7),57 all of which can be considered positive.
Table 5: Inequality in dental insurance benefits in Alberta

<table>
<thead>
<tr>
<th></th>
<th>Slope index of inequality (95% CI)</th>
<th>Percent change from previous survey</th>
<th>Relative index of inequality (95% CI)</th>
<th>Percent change from previous survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPHS 1996-1997</td>
<td>0.53 (0.50-0.56)</td>
<td>NA</td>
<td>2.19 (2.07-2.31)</td>
<td>NA</td>
</tr>
<tr>
<td>NPHS 1998-1999</td>
<td>0.50 (0.40-0.60)</td>
<td>-6.18</td>
<td>2.05 (1.76-2.39)</td>
<td>-6.29</td>
</tr>
<tr>
<td>CCHS 2003</td>
<td>0.47 (0.42-0.52)</td>
<td>-5.04</td>
<td>1.95 (1.81-2.10)</td>
<td>-4.98</td>
</tr>
<tr>
<td>CCHS 2015-2016</td>
<td>0.25 (0.22-0.29)</td>
<td>-46.77</td>
<td>1.37 (1.31-1.43)</td>
<td>-29.75</td>
</tr>
</tbody>
</table>

Source: Data provided by Ms. Nevena Zivkovic, Dental Public Health, Faculty of Dentistry, University of Toronto.

Table 6: The proportion having a dental visit in Canada and across its provinces over time

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>61.4</td>
<td>65.5</td>
<td>63.4</td>
<td>64.1</td>
<td>65.8</td>
<td>67.0</td>
<td>69.9</td>
</tr>
<tr>
<td>Alberta</td>
<td>53.7</td>
<td>60.4</td>
<td>59.4</td>
<td>61.5</td>
<td>60.7</td>
<td>59.9</td>
<td>69.0</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>47.2</td>
<td>51.6</td>
<td>54.3</td>
<td>53.3</td>
<td>56.2</td>
<td>57.1</td>
<td>59.5</td>
</tr>
<tr>
<td>Manitoba</td>
<td>56.2</td>
<td>58.5</td>
<td>58.5</td>
<td>59.7</td>
<td>61.1</td>
<td>61.5</td>
<td>66.0</td>
</tr>
<tr>
<td>Ontario</td>
<td>65.1</td>
<td>67.7</td>
<td>68.3</td>
<td>67.7</td>
<td>69.8</td>
<td>70.4</td>
<td>69.7</td>
</tr>
<tr>
<td>Quebec</td>
<td>50.1</td>
<td>54.1</td>
<td>54.8</td>
<td>57.8</td>
<td>59.1</td>
<td>59.8</td>
<td>64.1</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>49.9</td>
<td>50.3</td>
<td>52.4</td>
<td>51.9</td>
<td>57.8</td>
<td>58.2</td>
<td>60.1</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>55.0</td>
<td>58.4</td>
<td>57.4</td>
<td>57.0</td>
<td>63.4</td>
<td>61.2</td>
<td>63.7</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>56.3</td>
<td>61.2</td>
<td>57.5</td>
<td>59.5</td>
<td>65.1</td>
<td>61.0</td>
<td>68.0</td>
</tr>
<tr>
<td>Newfoundland and Labrador</td>
<td>40.6</td>
<td>44.0</td>
<td>45.1</td>
<td>50.4</td>
<td>48.9</td>
<td>53.7</td>
<td>62.0</td>
</tr>
<tr>
<td>Canada</td>
<td>57.8</td>
<td>61.5</td>
<td>61.6</td>
<td>62.5</td>
<td>64.3</td>
<td>64.8</td>
<td>67.4</td>
</tr>
</tbody>
</table>

Notes: Estimates are age-standardized.
Dentistry in Alberta: Time for a Checkup?

Further, if one looks even closer and explores inequality in dental insurance benefits coverage by age (Figure 3 and Figure 4), one can see that absolute and relative inequality appear to have decreased over time for most age groups. What is interesting is that inequality among those above age 65 appears to have increased steadily but then dropped off dramatically. This could be the result of incremental and consistent improvements to Alberta’s public dental benefits program for seniors. Specifically, expansions to eligibility and/or increases in funding occurred throughout the years 2004 to 2014. Arguably, this demonstrates that public investments in dental care can be beneficial in terms of equity, something we will discuss next and in upcoming sections of this report.

**Table 7: Income-related inequality in dental visits in Canadian provinces**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Newfoundland and Labrador</td>
<td>4.42 (4.05, 4.81)</td>
<td>3.53 (3.09, 4.04)</td>
<td>3.63 (2.58, 5.09)</td>
<td>2.94 (2.64, 3.28)</td>
<td>2.57 (2.21, 2.97)</td>
<td>42.0</td>
<td></td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>2.92 (2.90, 2.94)</td>
<td>2.77 (2.77, 2.77)</td>
<td>2.24 (2.24, 2.24)</td>
<td>2.63 (2.63, 2.63)</td>
<td>1.81 (1.81, 1.81)</td>
<td>38.0</td>
<td></td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>2.86 (2.49, 3.28)</td>
<td>2.67 (2.27, 3.13)</td>
<td>2.51 (2.24, 2.81)</td>
<td>2.49 (2.27, 2.73)</td>
<td>2.31 (2.01, 2.66)</td>
<td>19.2</td>
<td></td>
</tr>
<tr>
<td>New Brunswick</td>
<td>2.67 (2.07, 3.45)</td>
<td>3.09 (2.69, 3.57)</td>
<td>2.45 (2.11, 2.84)</td>
<td>2.30 (2.02, 2.62)</td>
<td>2.57 (2.39, 2.76)</td>
<td>3.7</td>
<td></td>
</tr>
<tr>
<td>Quebec</td>
<td>2.25 (2.13, 2.38)</td>
<td>2.18 (2.05, 2.32)</td>
<td>2.34 (2.25, 2.43)</td>
<td>2.27 (2.14, 2.42)</td>
<td>2.01 (1.90, 2.12)</td>
<td>10.7</td>
<td></td>
</tr>
<tr>
<td>Ontario</td>
<td>1.75 (1.66, 1.85)</td>
<td>1.83 (1.76, 1.90)</td>
<td>1.78 (1.67, 1.89)</td>
<td>1.75 (1.68, 1.82)</td>
<td>0.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manitoba</td>
<td>1.96 (1.75, 2.19)</td>
<td>2.01 (1.79, 2.25)</td>
<td>1.81 (1.49, 2.20)</td>
<td>1.95 (1.78, 2.13)</td>
<td>1.76 (1.68, 1.85)</td>
<td>10.2</td>
<td></td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>1.79 (1.72, 1.86)</td>
<td>1.58 (1.47, 1.70)</td>
<td>1.75 (1.58, 1.94)</td>
<td>1.73 (1.52, 1.96)</td>
<td>1.81 (1.66, 1.97)</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>Alberta</td>
<td>1.73 (1.52, 1.96)</td>
<td>1.75 (1.58, 1.94)</td>
<td>1.78 (1.47, 1.70)</td>
<td>1.79 (1.72, 1.86)</td>
<td>1.53 (1.49, 1.58)</td>
<td>11.6</td>
<td></td>
</tr>
<tr>
<td>British Columbia</td>
<td>1.80 (1.71, 1.90)</td>
<td>1.68 (1.54, 1.83)</td>
<td>1.74 (1.57, 1.93)</td>
<td>1.76 (1.63, 1.90)</td>
<td>1.57 (1.48, 1.67)</td>
<td>12.8</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Newfoundland and Labrador</td>
<td>63.1 (53.0, 72.8)</td>
<td>64.1 (58.0, 70.5)</td>
<td>64.1 (57.0, 70.9)</td>
<td>54.9 (52.0, 57.6)</td>
<td>57.4 (55.0, 59.9)</td>
<td>9.0</td>
<td></td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>61.0 (49.0, 73.0)</td>
<td>63.1 (63.0, 63.1)</td>
<td>54.5 (55.0, 54.5)</td>
<td>61.2 (61.0, 61.2)</td>
<td>41.7 (41.7, 41.7)</td>
<td>31.6</td>
<td></td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>61.2 (59.0, 63.1)</td>
<td>58.1 (53.0, 63.4)</td>
<td>60.1 (56.0, 64.2)</td>
<td>57.7 (53.0, 62.4)</td>
<td>53.7 (49.2, 58.2)</td>
<td>12.2</td>
<td></td>
</tr>
<tr>
<td>New Brunswick</td>
<td>52.3 (42.0, 62.4)</td>
<td>57.2 (52.0, 62.7)</td>
<td>53.7 (44.0, 63.4)</td>
<td>47.8 (39.0, 57.0)</td>
<td>58.6 (53.3, 63.9)</td>
<td>12.0</td>
<td></td>
</tr>
<tr>
<td>Quebec</td>
<td>45.0 (42.0, 48.4)</td>
<td>46.4 (43.0, 49.3)</td>
<td>51.9 (50.0, 54.2)</td>
<td>49.2 (46.0, 52.2)</td>
<td>44.8 (41.5, 48.0)</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>Ontario</td>
<td>40.6 (37.0, 44.0)</td>
<td>42.9 (40.0, 45.4)</td>
<td>44.5 (41.0, 48.2)</td>
<td>42.4 (38.0, 46.6)</td>
<td>40.8 (38.6, 43.0)</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>Manitoba</td>
<td>33.4 (32.0, 35.0)</td>
<td>41.0 (35.0, 47.0)</td>
<td>42.4 (38.0, 46.5)</td>
<td>42.4 (37.0, 47.8)</td>
<td>39.1 (36.5, 41.8)</td>
<td>17.1</td>
<td></td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>37.3 (31.0, 43.9)</td>
<td>40.0 (36.0, 44.2)</td>
<td>35.7 (22.0, 49.2)</td>
<td>39.3 (34.0, 44.5)</td>
<td>36.4 (31.6, 41.2)</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>Alberta</td>
<td>36.2 (32.0, 40.3)</td>
<td>29.7 (26.0, 33.0)</td>
<td>36.1 (28.0, 44.1)</td>
<td>32.9 (24.0, 41.4)</td>
<td>29.7 (27.4, 32.0)</td>
<td>17.9</td>
<td></td>
</tr>
<tr>
<td>British Columbia</td>
<td>39.6 (36.0, 43.1)</td>
<td>35.2 (30.0, 40.0)</td>
<td>38.7 (32.0, 45.2)</td>
<td>39.6 (35.0, 44.4)</td>
<td>33.0 (29.0, 37.0)</td>
<td>16.6</td>
<td></td>
</tr>
</tbody>
</table>

Notes: Percentage change in the magnitude of inequality is calculated between the first and last survey; Shaded cells indicate no change or an increase.

Figure 3: Slope index of inequality for dental insurance benefits coverage over time, by age group, in Alberta

![Graph showing slope index of inequality for dental insurance benefits coverage over time, by age group, in Alberta.](image)

Notes: The slope index of inequality measures the absolute difference between the highest and lowest income group (A–B).
Source: Data provided by Ms. Nevena Zivkovic, Dental Public Health, Faculty of Dentistry, University of Toronto.

Figure 4: Relative index of inequality for dental insurance benefits coverage over time, by age group, in Alberta

![Graph showing relative index of inequality for dental insurance benefits coverage over time, by age group, in Alberta.](image)

Notes: The relative index of inequality measures the relative difference between the highest and lowest income group (A÷B).
Source: Data provided by Ms. Nevena Zivkovic, Dental Public Health, Faculty of Dentistry, University of Toronto.
2.2.2 The difference between inequality and inequity and why it matters

In formal terms, inequality is simply a description of a dimensional or mathematical difference in some outcome when comparing social groups. The concept of inequity incorporates an ethical or moral dimension, meaning that the difference between social groups is considered unnecessary, unfair and amenable to policy intervention. This begs the question of whether the differences identified in this report are considered ethically or morally wrong. It seems plausible, given the public, policy and political attention access to dental care receives in Alberta and Canada. At minimum, it seems concerning that some groups should be burdened more than others in terms of disease and illness, and efforts to ameliorate them, especially if something can be done about it. For example, Alberta’s public support for seniors bears out in terms of dental insurance benefits coverage (Figure 3 and Figure 4), and in terms of the utilization of, and access to, dental care. In other words, this means low-income seniors in Alberta, because of government support, have an opportunity to address their dental-care needs and/or improve or maintain their oral health. Put another way, any inequality in the experience of oral disease and access to dental care can arguably be mitigated, thus making this inequality an inequity.

2.2.3 Take-home message

There is precious little epidemiological information on the oral health status of Albertans and other provincial/territorial residents. This lack of information presents challenges to oral-health-related planning in all Canadian jurisdictions, including Alberta. Based on available data, inequality in clinical and self-reported oral health status is readily apparent, as it is in dental care use and access. Surprisingly, although research suggests that cost barriers to dental care may be increasing over time, inequality in dental care use appears to be decreasing in Alberta and other provinces. This demonstrates that the demand for dental care is growing across Canadian jurisdictions, which might be explained by various sociocultural, demographic and market factors (e.g. the growing importance of oral health to individuals, an aging population, and the increased levels of dental insurance benefits over time). Either way, inequality persists, with some arguing that such inequality is unnecessary and unfair, and that something can and should be done about it.
2.3 Alberta in comparative focus

2.3.1 Public and private dental care across the provinces

Alberta has consistently invested more public funds on a per capita basis for dental care than Canada as a whole (Figure 5). When compared to its provincial counterparts, Alberta is among the top public funders of dental care (Table 3). In 2017, the Alberta government ($60.35) was only second to the Saskatchewan government ($65.18) in terms of per capita public investments in dental care. In terms of private investment, again, Alberta consistently spent more private funds on a per capita basis for dental care than Canada as a whole (Figure 6). In 2017, Alberta ($498.90) led private spending for dental care across the country (Table 3). And even as far back as 2009, it is said that Alberta households were spending the most out-of-pocket on dental care across all the provinces. One assumes this level of private investment is due to a heavy emphasis on employer-sponsored dental insurance benefits (estimated to be about 73 per cent in Alberta), yet no cross-provincial data are available on this subject in Canada.

Figure 5: Public per capita dental care expenditure in Alberta and Canada, 1975-2017 (constant 1997$)

Notes: "f" denotes forecasted estimates.
Source: National Health Expenditure Database, Canadian Institute for Health Information; Data provided by Ms. Julie Farmer, Dental Public Health, Faculty of Dentistry, University of Toronto.
2.3.2 The role of public programming and spending

The role of public programming and public spending deserves close attention, as each provides a safety net for those who have the greatest need for care and also the greatest barriers to care, financial or otherwise.\(^1\)\(^2\)\(^3\)\(^7\)\(^6\)\(^0\)

When taking a broad perspective, most Canadian jurisdictions have the same public dental-care programs: medically necessary surgical-dental services delivered in-hospital for all populations, as per the Canada Health Act, and programs aimed at targeted populations, whether based on congenital and/or severe oral/facial conditions, or because of age, income status and/or disability status (Table 1).\(^1\)\(^2\)

Yet while the character of public investments in dental care is generally the same across Canada, variability in coverage and spending does matter.\(^2\)\(^7\)\(^4\)\(^5\)\(^6\)\(^0\)\(^6\)\(^2\)

For example, we know that higher public dental-care expenditure in the provinces is associated with increased dental attendance among those provincial residents reporting poor oral health.\(^2\)\(^7\)\(^6\)\(^0\) This means Alberta's relatively high public funding for dental care is associated with a higher utilization of dental care among Albertans with poor oral health, whereas in provinces where public funding is lower, those with poor oral health report lower levels of utilization.\(^6\)\(^0\) Similarly, in provinces with public dental care programs targeting low-income children and seniors, children and seniors with poor oral health in those provinces are more likely to visit dentists than their counterparts in provinces without these programs.\(^6\)\(^0\)
2.3.3 The public and private share

The above should not be taken to mean that Alberta or Canada have a high public share for dental care, or public expenditure as a percentage of total expenditure, which arguably represents a measure of the robustness of public support for access to care (Figure 2 and 7). In fact, the idea of “state retrenchment,” or reductions in state generosity, can aptly describe Canada as a whole in terms of public investment in dental care over time (Figure 7). While Alberta’s approximately 10 per cent public share puts it ahead of the Canadian average, it also puts it in line with the United States, and well behind most OECD nations, where the average public share is about a third (Table 8).

Figure 7: Public per capita expenditure as a share of total per capita expenditure for dental care in Alberta and Canada, 1975-2017

Notes: “f” denotes forecasted estimates.
Source: National Health Expenditure Database, Canadian Institute for Health Information; Data provided by Ms. Julie Farmer, Dental Public Health, Faculty of Dentistry, University of Toronto.
Table 8: The public share for dental care in select OECD nations, 2013

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage of spending from public sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japan</td>
<td>76.6</td>
</tr>
<tr>
<td>Germany</td>
<td>63.9</td>
</tr>
<tr>
<td>New Zealand</td>
<td>36.5</td>
</tr>
<tr>
<td>Norway</td>
<td>36.5</td>
</tr>
<tr>
<td>Sweden</td>
<td>34.9</td>
</tr>
<tr>
<td>France</td>
<td>33.9</td>
</tr>
<tr>
<td>OECD average</td>
<td>31.5</td>
</tr>
<tr>
<td>Netherlands</td>
<td>27.4</td>
</tr>
<tr>
<td>Australia</td>
<td>22.4</td>
</tr>
<tr>
<td>United States</td>
<td>9.7</td>
</tr>
<tr>
<td>Canada</td>
<td>5.3</td>
</tr>
</tbody>
</table>


2.3.4 A dependence on private markets

Alberta, much like Canada as a whole, arguably depends too heavily on private markets to distribute dental care. For example, almost all dental care, whether publicly or privately funded, is delivered in private dental clinics on a fee-for-service basis. Depending on private markets to distribute health care matters, as it is long known that when structuring the financing and delivery of care in this way, inequity increases. Weaknesses can also appear when depending too heavily (and almost exclusively) on employment contracts to provide dental insurance benefits to the population. Take, for example, what can happen in a boom and bust economy, such as Alberta’s, where employment can be lost quite easily. Further, fee-for-service payment mechanisms are known to incentivize overtreatment and lead to inefficiency and uncontrollable health expenditure. The complete deregulation of dental-care pricing in Alberta, which is addressed next, also has arguably held consequences for the affordability of and access to dental care within the province.

2.3.5 Take-home message

Alberta is one of the top public and private funders of dental care in Canada. While its public spending on dental care outstrips most provinces, as a share of total dental care spending, its public investments have steadily decreased over time. As a result, Alberta, like Canada, now ranks very low among developed nations around the world in terms of public investments in dental care. This is concerning, as public investments provide a safeguard for those in need in terms of accessing much needed dental care. Today, much like elsewhere in Canada, Alberta arguably depends too heavily on private markets to distribute dental care. This dependence matters, as structuring the financing and delivery of dental care solely in this way can increase inequity and inefficiency.
2.4 The question of dental fees

“Dental fees,” or dental-care prices, are foundational, as they influence people's ability to utilize and access dental care and maintain and/or improve oral health. Income and dental insurance benefits are the strongest factors influencing dental care use and access, since they lessen any cost barriers to dental care.68-71 We also know that financial barriers to dental care are the dominant reason why Canadians do not use or receive recommended dental care.68,70 If one cannot access regular dental care, oral health can deteriorate, and if one has a specific dental problem (e.g. cavities, toothache), the problem can worsen and become more acute.71 Thus, the pricing of dental care matters.

2.4.1 Setting dental fees and its implications

The process of pricing dental care is important to understand. In Canada, unlike for medical care where prices are negotiated between medical associations and governments,72 there is almost no government involvement in how dental care is priced.40 Provincial dental associations publish suggested fee schedules based on an assessment of the costs of delivering care and profit considerations. These private fee schedules are not obligatory, as dentists can charge at their discretion. Most insurers set what they are willing to pay based on previous years’ suggested fee schedules. In Alberta, the situation was different, as no suggested fee schedule had been produced since 1997, thus insurers would take some average of prices based on the dental claims they were receiving.61 Starting in 2017, the ADA&C, arguably due to increasing and very public concerns around dental care prices, and at the behest of government, published a suggested fee schedule.73-75

On the public side, things work differently, meaning governments set fee schedules for their public programs, often with no or little input from, and at the consternation of, provincial dental associations and dentists.40,73 This has implications for access to care among those who are publicly insured, as there is long-standing frustration among dentists across Canada given the level of public pricing for dental care (in relation to suggested private fee schedules).40,76,77 For instance, dentists have reported limiting publicly insured populations in their practices for business reasons, chief among them being the fees paid by government plans.76,77

With no provincial fee schedule to guide dentists in how much they might charge for their services, dental care prices in Alberta increased in what some argue was an unsustainable manner.78 This is not surprising, as in such a deregulated environment, one would expect prices to rise to what the market will bear. In this sense, the recent Alberta experience speaks to the moderating role of government in protecting the public interest in terms of
reasonable access to dental care for all populations, not just those who have the means to pay.\textsuperscript{61}

In 2016, the Alberta government reviewed the situation, and its findings are instructive:

“The review found that private market dental fees, based on 49 representative dental procedures, can be as much as 44 per cent higher in Alberta than neighbouring provinces. However, data from Industry Canada indicates that proportionally, business operating costs for dental offices tend to be higher in Alberta than other provinces, primarily due to higher labour costs. When total business operating costs are factored, relative to higher average dental service fees, Alberta dental offices net similar profits to Saskatchewan and higher net profits versus Ontario and British Columbia dental offices. Additional data shows minimal disparities between fees charged by dentists throughout rural and urban areas of the province. […] Overall, the findings provide the Minister with possible options to assist Albertans, ranging from educating the public to become more informed consumers of dental services and their dental plans, to regulating dental fees within the province.”\textsuperscript{61(p3)}

Importantly, concern over the costs of dental care are not Alberta-specific and reflect a situation that is pan-Canadian.\textsuperscript{3,4,40} In fact, if one tracks the consumer price index over time in Canada, one sees that dental care prices have outstripped the growth in prices for all goods and services, including food, shelter, transportation, and medicinal and pharmaceutical products (Figure 8).
2.4.2 An international experiment

A “free market experiment” in The Netherlands in 2012 that allowed dentists to set their own prices is instructive, as it points to the potential outcomes of deregulation or removal of government oversight in such affairs. An analysis of this natural experiment found that:

“The introduction of market mechanisms [was] intended to improve the quality of care and to contribute to cost containment, but increasing health expenditures for citizens have been observed in this context. […] We found substantial increases in prices and patients’ [out-of-pocket] contributions for dental services following the liberalization […] Our results show that price liberalization of dental care came along with increasing service prices and substantial distortions in the composition of dental care demanded. This led to an unintended relative decrease in utilization of check-ups and increased financial burden of seeking oral health care.”


2.4.3 **Take-home message**

The price of dental care influences people's ability to access care, and, in turn, the ability to maintain and/or improve their oral health. The lack of a suggested fee schedule for many years in Alberta may have allowed dental care prices to increase in what some argue was an unsustainable manner. As a result, this may have had a negative effect on the ability of provincial residents to access dental care in terms of affordability. Concern over the costs of dental care is not Alberta-specific and extends throughout Canada and even internationally. In fact, one international experiment in the liberalization of dental-care prices tended to result in increased prices and financial burdens for those seeking care. As the Alberta government found in its review of dental care in 2016, some oversight is arguably necessary to support equity in the dental-care system.

2.5 **Potential weaknesses**

Alberta’s approach to dental care and meeting the oral health needs of its population – much like all Canadian jurisdictions – suffers from some important limitations. Like Canada, Alberta depends heavily on private markets to organize, finance and deliver dental care, focusing on employer-sponsored dental insurance benefits and fee-for-service payment. While this system has tended to work well for the majority of Albertans and Canadians for about half a century now, there are clear indications that it does not work for everyone and there are established and potentially developing weaknesses in the approach.  

2.5.1 **Challenges in meeting need**

By depending so exclusively on the private sector, Alberta engenders the same unavoidable weaknesses as Canada in terms of being able to meet the needs of all segments of the population. Three clear examples of this are, first, access to care challenges associated with the ability to pay, which now involve middle-income populations not just low-income populations. Second, gaps in access for specific populations, such as the working poor who have jobs but cannot access government-sponsored dental insurance benefits, and the jobs are not high quality and lack employer dental benefits. And third, few options beyond traditional private dental clinics for those who experience significant economic and social marginalization (e.g. the homeless and street-involved youth).  

The focus on employer-sponsored dental insurance benefits also holds unique challenges, especially in the context of high dental-care prices. Specifically, underinsurance can be an issue. Although no data are available for this in Alberta or Canada, anecdotal reports suggest that even those with dental insurance benefits can still find it difficult to access care because of
high costs. This is either because of patient cost-sharing that remains prohibitive (i.e. steep co-payments), or simply because the dental insurance benefits covering the individual or family are restricted in scope (i.e. limited services covered).

2.5.2 The taxation-equity trade-off

Another issue that has garnered attention concerning employer-sponsored dental insurance benefits is the way governments approach taxation in this area. Some jurisdictions now impose taxes on premiums paid by the employer and employee, but, for the most part, such benefits still enjoy either no or minimal taxation. While not taxing these benefits results in a significant incentive for their inclusion in employment contracts, this does result in a difficult equity challenge for policymakers. Specifically, those who enjoy the presence of employer-sponsored dental insurance benefits are able to consume dental care using before-tax dollars, while those who do not enjoy such benefits have to consume dental care using after-tax dollars. Thus, in one sense, this represents a regressive form of taxation. What is more, those who have dental insurance benefits are often those without significant oral disease and oral health care needs, while those that do not have these benefits often have the greatest levels of oral disease and dental-care needs. Again, this leaves an open policy question for Albertan and Canadian society in terms of how much inequity they are willing to trade off to facilitate the needs and demands of the majority against the few. Further, provincial and federal governments forego significant tax revenue by maintaining this taxation regime, something not lost on analysts concerned about equity and revenue generation for cash-strapped governments.

2.5.3 A soiled dental-care system

Another challenge is the nature of the dental-care system. For the most part, Alberta's dental-care system, like Canada’s, is siloed, functioning in almost complete isolation from the broader health-care system. This is a problem in terms of the implications oral disease may hold for systemic health conditions, especially when one considers the potential benefits for disease management and care continuity if the dental-care system was more integrated. As well, there remain spillover effects of poor access to dental care on the health-care system in terms of inefficient, ineffective and inappropriate resource use in the primary and tertiary care sectors (e.g. physician and emergency department use for preventable dental problems that are not well-addressed in such settings).
2.5.4 A homogenous dental-care system

The dental-care system itself is also homogenous, meaning it lacks diversity in terms of its organization, financing and delivery. For example, apart from the isolated and rare occurrence of public dental clinics, there really is only one option in terms of accessing dental care in Alberta and Canada, and that is through private dental practices. Importantly, this option is not always ideal for particular segments of the population who either may feel uncomfortable in such settings, or may actually prefer receiving care in public settings. Further, populations with different preferences and needs may not experience reasonable access to care given that dentists themselves may be disincentivized to treat them due to low levels of public reimbursement, especially when coupled with the complexity of treating such populations due to patient compliance issues or the fact that the culture of private dental practice may not always be in step with the needs of marginalized groups.

The lack of diversity in the dental-care system also extends to payment mechanisms. While different forms of paying for dental care and health care more generally result in different incentives and outcomes, the fact remains there is a lack of discussion in this area in dentistry and dental-care policy. In other words, healthy and rational attention must arguably be placed on what other forms of payment may be suitable in specific circumstances, whether in terms of the service setting or population covered.

Similarly, there is little concerted discussion on who else might be able to deliver dental care in Alberta and Canada. The predominant dental-care team as we know it (i.e. dentist, dental hygienist, dental assistant) is necessary and foundational, but it can and should include others. For example, dental therapists, who have long been used in some Canadian jurisdictions, as well as internationally to great effect, can treat at-risk children and in some cases, adults. Diversity in the oral health care team may also include other primary care providers (e.g. physicians and nurses) interested in delivering preventive oral health care interventions (e.g. fluoride varnish applications), which has been shown to result in positive outcomes for individuals and the health-care system in terms of improved child health and reduced need for operating room care for severe early childhood caries. In short, a diverse oral health care system should arguably include different providers and care settings, each targeted and tailored for the needs of specific groups.

There are also potential human capital effects in terms of health and productivity by not having a diverse oral health care system. High levels of oral disease in specific populations and poor access to care can mean reduced quality of life and limited individual and societal productivity (e.g.
school performance, employability and employment, health-care resource burden), which in turn can hold economic implications for Albertan and Canadian society. A more diverse oral health care system could facilitate better access to care and more efficient and effective care.

2.5.5 Value for money

Finally, one must consider whether there is good value for money in the dental care that is currently being delivered to Albertans and Canadians, and for what reason(s) it is being delivered. A surprising issue here is that the evidence on the therapeutic benefit of many dental procedures is weak, uncertain or simply not there. Additionally, little critical attention has been given to what the goals are for delivering dental care to individuals or populations. Is it to improve health? Function? Aesthetics? What about the quality of life? Social and economic productivity? These questions are important, as it would seem clear that dental care has value, but what value? And from whose perspective? Ultimately, these are difficult issues, but they are foundational to any movement forward in terms of policy and/or programmatic approaches to improving the oral health of all Albertans and Canadians, and in establishing equity in oral health, the utilization of, and access to, dental care. Some of these issues will be dealt with in more detail later, but the point is that attention must be given to the reasons why governments, employers and individuals might invest in dental care, and what basket of oral health care services they should pay for specifically, especially if one is interested in establishing the value proposition for public and private investments in dental care.

2.5.6 Take-home message

Much like in other Canadian jurisdictions, Alberta’s approach to dental care and meeting the oral health needs of its population now suffers from some important limitations. Depending too heavily on private markets to organize, finance and deliver dental care, and focusing largely on employer-sponsored dental insurance benefits and fee-for-service payment, has resulted in an inability to efficiently and effectively meet the needs of all segments of the population. Alberta’s and Canada’s dental-care system is now arguably homogenous as well, lacking diversity and creativity in its financing and delivery mechanisms. This state of affairs has resulted in uncomfortable policy trade-offs that appear to privilege those with the least oral health care needs and barriers to care, over those with the greatest needs and barriers to care.
2.6 Summary

This section of the report has presented the history of dental care in Alberta, which reflects a similar trajectory to that of other Canadian jurisdictions. This means Alberta has established a dental-care system that is, for the most part, privately financed and delivered, with public subsidies generally limited to specific at-risk groups. As in the rest of Canada, inequality in oral health and access to dental care in Alberta now arguably constitutes an important social challenge, qualifying as an inequity, in that the situation is unnecessary, unfair and amenable to intervention. As well, while Alberta is one of the top public and private funders of dental care in Canada, like the rest of the country, it arguably depends too heavily on private markets to distribute dental care. This can increase inequity and does not provide options to efficiently and effectively meet the needs of all populations. This state of affairs holds negative impacts on individuals, families, the healthcare system and society, exposing weaknesses in how Alberta and Canada approach dental care. This ultimately begs the question explored next: What might be done to improve the situation?
3.0 Potential solutions

3.1 Targeted versus universal coverage

Over the years, Canadian civil society, health professional groups, and governments have engaged the discussion about whether dental care should be part of our national system of health insurance, Medicare. Most recently, in 2019, the Governor General’s speech from the throne noted that exploring “universal dental care” was a worthwhile idea. In the resulting mandate letter to the federal minister of Health, Canada’s Liberal prime minister asked that work be completed with Parliament “to study and analyze the possibility of national dental care.” Should dental care be added to the existing universal coverage for hospital and physician care? While this question is relevant, it is likely better to first ask: Should our approach to dental care be targeted or universal?

3.1.1 Merits and drawbacks

Given the above question, it is necessary to consider the merits and drawbacks of a targeted versus universal approach to dental-care coverage for Canada and ostensibly Alberta. The targeted approach is what Alberta and Canada currently have, and is based on the notion that public coverage should target socially and economically marginalized groups and private coverage should target the remaining population through tax incentives for employer-sponsored dental insurance benefits. We have already detailed the shortcomings of this general approach, meaning it results in significant coverage gaps for particular segments of the population, both on the public and private side. Also, it should not be lost on us that if the targeted approach really held true, it would provide coverage for the exact people it is currently excluding. Yet, the targeted approach is appealing, as one could argue it would cost less than a universal approach, and movement forward on the policy front might be more politically feasible given Canada’s preference for incrementalism in health care.

The universal approach is also appealing, though, as it would provide some level of coverage for everyone. But what level of coverage? Also, it would seem that the universal approach would cost more than the targeted approach. Notwithstanding the potential costs, a major benefit of the universal approach is that it inheres equity, meaning everyone has some level of coverage and opportunity to reasonably access dental care. There are limitations here, too, especially in terms of the scope of coverage based on actual and perceived needs, let alone geographic challenges in accessing care given Canada’s and Alberta’s geography – debates that are alive and well in Medicare – but, in principle, the idea of equitable access holds.
3.1.2 Canadian culture and policy

The idea of universal dental care might be considered culturally appealing to Canadians, but is it? One of the central reasons for why dental care wasn’t incorporated into Medicare was because, culturally, oral health and accessing dental care were considered individual responsibilities, not social ones, as opposed to other physical health needs and the physician and hospital care needed to treat them.16 This moderating factor in policy is crucial,116-118 as when the public is asked about a universal dental-care plan, while the majority are in favour, the details are not so simple. For example, a 2006 survey found about 83 per cent of Canadians think dental care should be part of Medicare.116 Yet, when asked exactly who should be included, and given the options of “everyone” and groups such as “children,” “seniors,” “social assistance recipients” and “the homeless,” opinions appear to change.116 The idea of universality wanes, with approximately two-thirds (66.3 per cent) now including “everyone,” followed by 17.9 per cent “all children,” 16.1 per cent “seniors,” and 14.5 per cent “anyone without private insurance.”116

3.1.3 Costs and costing

It is only until very recently that estimates have become available for what a more broad-based or universal dental care plan might cost Canadians.119-123 One analysis by Lange122,123 provides estimates for both a national targeted and universal plan and does so with a detailed methodology. He estimated the 2019 costs of Denticare (universal first-dollar coverage) at $27.5 billion ($737.09 per capita), and the 2019 cost of Denticaid (or public insurance for adults and seniors without private insurance and for all children under 12) at $15.1 billion ($404.49 per capita).122,123 Another recent estimate provided by the federal Parliamentary budget officer121 suggests that the total costs of a national dental care program for uninsured Canadians with a household income below $90,000 would average out at $2.2 billion per year from fiscal years 2020-2021 to 2024-2025, and depending on the year considered, the per capita estimates can range from $251 to $570.

It is important to note, though, that in the above two analyses, cost estimates decrease when patient contributions are factored in. More importantly, these analyses only consider direct costs (or costs to government), and do not model other costs (such as time costs to individuals), much less any of the potential benefits of having a national targeted or universal dental-care plan. In other words, these estimates do not shed light on what might be gained in terms of health or what might be saved in terms of avertable costs in other areas (e.g. reductions in inappropriate use of the health-care system for non-traumatic dental conditions). Further, these estimates are relatively uncritical in terms of the dental care services being considered for public
coverage, meaning they include services that could be questioned for their relevance and appropriateness in the context of public coverage, inasmuch as they exclude services that are relevant and appropriate in such a context. Even with these limitations, though, these analyses are timely and welcome given the dearth of costing evidence in this area.

3.1.4 Take-home message

When considering the universal versus targeted debate in dental care, one must recognize both the limitations of a targeted strategy, as well as its political pragmatism. While incrementalism might be appealing, it is arguably still not a reasonable approach in the short- or long-term. Consider how many groups would have to be brought on board or covered incrementally across Canada and in Alberta: low-income seniors in most provinces/territories; low-income adults in most provinces/territories; the homeless in all provinces/territories; working poor families in all provinces/territories; those living with a disability in most provinces/territories; those in long-term care in most provinces/territories; the uninsured and underinsured in all provinces/territories, etc. Thus, while it may be more politically difficult, a universal approach is likely the most expedient way to address existing coverage gaps. This begs the following questions, which will be dealt with next: How might a national and universal dental-care plan materialize? What options do we have to make such a choice more politically expedient?

3.2 Mandating universal coverage

How might Canada and Alberta achieve the universal coverage of dental care? First, it is important to distinguish between Medicare as a publicly financed and privately delivered endeavour versus another vision for the universal coverage of dental care, namely public and private financing and public and private delivery; in other words, a mixed model.

3.2.1 The international experience

Most international oral health care systems – particularly in the European Union – that achieve universal coverage or near universal coverage, are mixed.124,125 They are either funded through general taxation, employer and employee contributions, payroll taxes, out-of-pocket payments, or a combination of these. Delivery occurs through the public and private sector, with some having a robust public dental service that usually targets children, providing care with no cost at point of purchase (meaning they are considered “free” at delivery). Adults can access public clinics as well, although this is usually for groups that are socially and economically marginalized. Most others access the private sector, where dentists either
hold contracts with the state or are paid directly by patients who are then reimbursed by the state. Patient subsidies can vary based on the service (e.g., dental fillings versus orthodontics), or are gradated based on income, meaning cost-sharing arrangements are the norm. Dentists and patients can also engage completely private forms of care, either through voluntary health insurance or by paying out of pocket. Coverage is also variable, meaning service baskets can differ between countries or within countries, often based on need. Finally, negotiated fee scales are the norm.

What is important in these contexts is that, while dentistry is still separate from health care, it enjoys far greater integration with health care in terms of legislation, policy and programmatic approaches. Most importantly, coverage is compulsory, meaning governments legislatively mandate the presence of dental coverage and thus achieve complete or close to complete protection of the population, making these oral health care systems ostensibly universal.

3.2.2 Examples of options for Alberta and Canada

In Alberta and Canada, mandating universal coverage could, in part, mean greater investments in public infrastructure; in other words, it could mean developing new or buttressing existing public programs. From the point of view of funding, the source could be provincial, federal or both. For example, one option is a completely federal plan, covering off those who do not have private dental insurance benefits, as was promoted in the last federal election by the NDP, resulting in direct engagement by Canadians with a federal program. Another option is to develop a program for the uninsured through the traditional fiscal arrangements between federal and provincial authorities (i.e., the Canada Health Transfer), as was promoted in the last federal election by the Green Party.

Interestingly, in terms of the latter, a similar idea was promoted by the Canadian Dental Association, who, in a recent appearance at the House of Commons Standing Committee on Health exploring the COVID-19 pandemic, called for a $3-billion envelope to be added to the Canada Health Transfer for dental care. The Canadian Dental Association also called for basic standards for oral health care in long-term care, a timely proposal given the shortcomings exposed in this sector by the COVID-19 pandemic. This type of approach is important, as the federal government has a central role in establishing national standards for health care (as the Canada Health Act does for Medicare), so why not for oral health care? This would guide the provinces in terms of their use of federal dollars, potentially in terms of population or service coverage, which is a particularly germane issue and something we will return to later in this report.
There are myriad ways for Alberta and Canada to achieve universal coverage. Blomqvist and Woolley\textsuperscript{40} suggest provincial governments establish their own basic dental insurance benefit plans that provincial residents, and even employers, can buy into. These would act as the default public plans, and provincial residents could opt out to seek arrangements elsewhere; one assumes for different or greater coverage. These authors also suggest this is a way to increase competition within insurance markets, which could lead to better pricing for consumers. They term this approach “universal dental insurance with public-private competition,” which in part results in the compulsory or mandatory approach present in other international contexts, as described previously. Importantly, according to these authors, one of the advantages of this approach is that it can be largely cost-neutral to governments and maintains the current tax-financed private system.

3.2.3 Take-home message

At minimum, there are three main points to distill from what has been presented thus far. First, expansions to the public option are arguably necessary, whether to better support at-risk populations or to establish creative ways by which to achieve universal coverage for dental care. Second, the Medicare approach, while potentially aspirational, really only represents one way to organize, finance and deliver dental care. There are other approaches as well, and they can leverage the existing processes and benefits of private markets; in other words, these approaches may be more politically and economically feasible in the short-run. Third, one should never forget that providing universal coverage has potential benefits. For instance, a recent study of the Ontario population looked at the potential effects of providing dental insurance benefits to the entire population; the study found that having insurance benefits can increase the proportion of participants who visit the dentist yearly and who report very good or excellent oral health, and decrease the proportion who visit a dentist only for emergencies.\textsuperscript{128} Moreover, these positive effects are most pronounced in lower-income groups, meaning they achieve an important policy aim: to increase equity by accruing benefits in the worst off.\textsuperscript{128,129}
3.3 Expanding the public and private option

In order to improve the situation in Alberta and Canada, investments in public and private infrastructure are needed. In other words, we need to expand the public and private option. What does this mean?

3.3.1 Public infrastructure and its opportunities

Expanding the public option means investing in capital infrastructure in the form of public clinics. These clinics can be run by local and/or provincial governments, and/or by the non-governmental sector. Why are public clinics important? This type of care delivery is necessary given that we know some individuals, often those with the most needs, lowest incomes and greatest cost-barriers to care, prefer to access dental care in these settings. Some populations are not a good fit for private clinics, whether it be due to a disconnect between these populations and private providers, or the fact that some private providers have decided not to treat them. The latter decision is a difficult one, but when a private provider is paid less through a government program than their privately insured patients, often at rates lower than what it takes to cover overhead costs, business decisions immediately come into tension with professional considerations. The sum of these realities is that access to care is ultimately diminished for at-risk populations and those who need it the most.

Government investment in capital infrastructure provides other opportunities, too. For example, public clinics provide a context to experiment with different remuneration models for providers (e.g. salaried, per diem or session, productivity bonuses). Economies of scale can also be achieved for laboratory and other support services that are common in the delivery of dental care. Finally, expanding the public option also means expanding public plans, whether existing plans or completely new ones such as those proposed by Blomqvist and Woolley.

3.3.2 Private infrastructure and its opportunities

In terms of expanding the private option, there are numerous potential directions here as well. As has been argued, the Alberta government and even the federal government could make dental care coverage mandatory, whether through statutory health insurance or through legislation aimed at employer-employee arrangements, or both. Even with expansions to the public delivery of care, the greatest share of any “universal” care would still be delivered through the private sector, as the supply of private infrastructure would likely always dominate. Thus, legislative changes that support the private option are key.
Governments could engage the private sector in new ways, such as the approach taken by Blomqvist and Woolley, where a default public plan might incentivize changes in private insurance markets that would benefit the consumer. One could also rethink how dental care is paid. The limitations of the fee-for-service model are clear, and mixed payment might offer opportunities to improve access and outcomes. For example, capitation payment, while unpopular with private stakeholders, is one option. Yet, payment approaches have moved beyond simple capitation towards mixed models of payment based on performance and value.

In the context of performance and value-based payment, providers are paid for outcomes, not volume, meaning they are paid (often in the form of bonus payments) for producing health in the patients or populations served (e.g. less disease, better quality of life). Providers are paid for “doing the right thing, at the right time, in the right way, delivered to the right patient.”

One could foresee a day where paying providers includes a mix of the various forms of payment, such as a risk-based fee for managing a patient’s health, a fee per item for services rendered, and a performance or value-based payment for achieving certain outcomes. It is very early days for this type of thinking in dentistry, but the point is that change is arguably needed to achieve value-for-money in dentistry, and to incentivize improvements to individual and population oral health through the delivery of dental care.

3.3.3 Take-home message

In summary, expanding the public and private option means investing in the entire dental care system, and doing so in creative and strategic ways. These ways would create a mixed system that interdigitates and supports each of its components (from infrastructure to payment). Essentially, expanding the public and private option means a renewed vision for dental care in Alberta and Canada. A vision that brings us more in line with our OECD counterparts, privileges equity and fair equality of opportunity in access to care, and maximizes individual and population oral health.
3.4 Expanding and diversifying the workforce

3.4.1 Dental therapy

A renewed vision for dental care in Alberta and Canada also means diversifying the dental-care workforce. Dental therapy is the best and clearest example. Dental therapy was imported into Canada from New Zealand in the early 1970s to meet need in rural and remote communities, with a particular focus on Indigenous populations. Dental therapists are trained to provide preventive and curative care to children, in addition to adults in emergency circumstances. They also play an important role in community oral disease prevention and oral health promotion. Dental therapists had enabling legislation in Saskatchewan and Manitoba, and worked in federal jurisdictions as well. Evaluations of dental therapy practice are available, demonstrating their effectiveness as an alternative model of care provision. The practice flourished into the late 1980s, but has declined from the early 1990s onward due to the eroding of federal and provincial support, the active derogation of dental therapy by dental professional groups and, conversely, the uptake of dental therapists into private dental practice in Saskatchewan and Manitoba. This culminated in the closure of the dental therapy training institution in 2011. There remain consistent attempts to try to renew dental therapy in Canada by various public stakeholders, but unless something is done, the practice may cease to exist, ending what, to this point, can be considered the greatest alternative dental care provision experiment in North America. It should also not be lost on us that dental therapy practice is now gaining ground in the United States. Originating in Alaska, it is now active or has enabling legislation in about a dozen states, all in an effort to meet disparities in provider supply and to meet the needs of socially and economically marginalized populations.

3.4.2 Dental hygiene

Efforts are also underway in Canada to expand the scope of practice of dental hygienists to similar ends. The dually trained “dental hygiene therapist” has been proposed as a means to renew the practice of dental therapy while leveraging existing and new dental hygiene provider supply. The idea has gained some traction at the federal level, and the development of education models and early demonstration projects are underway.

3.4.3 Primary care providers

There is also opportunity for physician and other primary care provider involvement in oral health care. This involves screening for oral disease, the delivery of preventive therapies, and referral to a dental home. Beginning about 20 years ago, this approach is now well established in the United States. For the most part, it involves caries risk assessment during well-baby and
well-child visits, the provision of oral health education to caregivers and fluoride varnish to children, and referral to a dental home. The practice has demonstrated success and is increasingly the standard of care for children in primary care environments. As mentioned previously, this approach can improve child health and reduce the need for operating room care for severe early childhood caries. Unfortunately, the practice has yet to gain any serious traction in Canada.

3.4.4 Take-home message

Diversifying the oral health care workforce is an opportunity to do “the right thing, at the right time, in the right way, delivered to the right patient.” In partnership with dentistry, dental therapy, dental hygiene and primary medical care environments provide Alberta and Canada the capacity to improve access to dental care, as well as the oral health of all individuals and populations.

3.5 Integrating oral health into the health-care system

What does integration of the oral health care system mean? Simply, it means the oral health care system should not be thought of as separate from Canada’s broader health-care system, nor should it function in such isolation.

3.5.1 Integration means shared understanding

At minimum, integration requires that all health-care providers share an understanding of the intrinsic importance of oral health, the importance of oral health to systemic health, and the importance of systemic health to oral health. It has long been known that Canadians suffering from chronic oral conditions (e.g. periodontal disease, caries, tooth loss) can experience significant affects to their quality of life as a result of consistent and sometimes brutal oral pain and infection. Chronic oral conditions can also affect nutritional intake, which in turn can lead to malnutrition and its health effects.

Integration also means understanding that chronic oral infection has implications for other conditions, such as respiratory illnesses like aspiration pneumonia and metabolic disorders like Type 2 diabetes mellitus. In fact, there are a host of other conditions that are potentially made worse by poor oral health, including chronic obstructive pulmonary disease, cardiovascular disease, cerebrovascular disease, dementia, and even some cancers (e.g. lung cancer). On the reverse, we know that some systemic health conditions can be diagnosed through their oral signs and symptoms (e.g. nutritional deficiencies, blood, metabolic, dermatologic, and connective tissue diseases), and that medicines can often hold negative consequences for
the health of the mouth and teeth (e.g. reduced salivation, chronic dry mouth and increased caries risk).160-163

3.5.2 Integration means collaboration

Integration also means collaboration and making use of all providers to their maximum capacity.164-166 In this context, collaborating with a more diversified workforce and skill mix and with the oral-systemic health connection in mind means greater care continuity for individuals with the specific health conditions mentioned above. For instance, the periodontal care provided by oral health care professionals in either a dental or medical context can help mitigate the negative health effects of type 2 diabetes.166 Research also suggests that treating oral inflammation in diabetics may actually save the health-care system and diabetic patients money by reducing health-care resource consumption.37,168

Oral health care professionals can also be involved in screening and providing medical care for chronic diseases, including hypertension, hypercholesterolemia, and HIV and HPV infections.169-173 Here, too, research suggests there are cost-savings for the health-care system if it leverages oral health care professionals and the dental care environment.37,168,173

On the reverse, as we saw in the previous section of this report, primary medical care environments can also be involved in the screening, triaging and referral of patients with oral health conditions.99-101,145-148 One can imagine a situation where strong referral pathways are in place in a universal system, such that oral health related complaints can be dealt with more efficiently and effectively than they are now in primary medical care settings, where currently, no care is provided other than an antibiotic and/or painkiller and advice to go see a dentist.174 This could offset the unnecessary consumption of costly tertiary care for the common toothache, which unfortunately has become far too common in Canada given the lack of timely access to dental care that many experience.38,39,174

3.5.3 Integration means common data

One creative way to promote integration is by incentivizing medical and dental care settings to engage a common core medical/dental data set within electronic health records.175,176 This will involve the will of governments, health professionals and their institutions, as well as public and private software vendors, to make something like this happen. One can argue, though, that by having access to the same information, medical and dental providers can begin the road to better and more effective collaboration.
3.5.4 **Take-home message**

In short, the integration of the oral health care system with the broader health-care system has many potential benefits. It can improve care continuity for patients, improve access to care by cross-referral of more populations, and improve oral and systemic health in individuals and populations. Fundamentally, this will require a conceptual shift in terms of how we think about oral health and oral health care, and how we might organize, finance and deliver care with an eye towards universalism.

3.6 **Rationalizing the primary dental care system and basket of services**

Any movement forward in dental care policy and improving access to dental care in Alberta and Canada will require some important conceptual work. Specifically, it will require rationalizing the goals of primary dental care and the basket of dental care services to be funded.\(^4,40,177\) This is a resource allocation and priority setting exercise, inasmuch as it is a resource allocation ethics exercise. In other words, decisions need to be made as to who ought to receive subsidies for dental care, what services should be subsidized, and for what reasons, or why.\(^177\)

3.6.1 **The targeted approach**

If Alberta and Canada continue to choose a targeted approach to the provision of dental care, then the basis for this approach ought to be made clear. Why fund children? Why seniors? Why not adults? This is a long-standing policy and programmatic question in Canada, and there are some answers. Specifically – albeit without any formal statement in legislation, regulations, or policy – Alberta and Canada choose to fund dental care for specific populations (e.g. low-income children, adults, seniors, those living with a disability, those with craniofacial conditions) on the basis of “personal responsibility.”\(^10\) This goes back to the country’s original discussions around Medicare, and likely well before that in terms of notions of “deserving and undeserving poverty.”\(^10,178\) Here, dentistry is viewed as an individual responsibility, not a social one. This means that public subsidies are made available to those who are perceived to hold no or lessened individual responsibility. This explains why, in the case of Medicare (a system designed on the principle of social responsibility), support is provided in circumstances beyond individual control, such as the surgical-dental services delivered in-hospital for someone who experiences major maxillofacial trauma as a result of an accident, or someone who is born with a craniofacial condition. This also explains why, in comparison to low-income children, very little support is available to low-income adults in many Canadian jurisdictions and, if support is available, it is less comprehensive.
3.6.2 The universal approach

If one were to take a universal perspective, decisions on who should be covered are made clear, meaning it is everyone. This is why, in one sense, a universal program rids us of unnecessarily moralistic policy choices that may create more problems than they solve. Working poverty is a good example of this. Here, individuals are fully responsible given their effort to seek and secure employment but, unfortunately, that employment does not provide for dental insurance benefits, something that is well beyond their control. Yet, the state does not provide any supports in this context, even though we know normative and self-perceived needs may actually be greater for the working poor than those who receive public coverage.

3.6.3 Identifying the basket of services

As to what services should be subsidized, this is likely the most challenging of the issues posed here. This is complicated because the services included in public service schedules may not always be defined by evidence of therapeutic benefit. Public service schedules, like private ones, arguably developed more out of historical custom and the preferences of providers and patients than they did from any effort to ascertain what health and/or other benefits are derived from the services they contain. This is why, historically and into today, governments fund dental-care services where there is no or unclear evidence of therapeutic benefit. In other words, there are inefficiencies in how taxpayer dollars are spent.

A good example of this is the funding of composite (“plastic” or “white”) fillings and amalgam (or “silver”) fillings. The best available evidence “indicates that, compared with composite resin, amalgam restorations appear to be more clinically efficacious and as safe, while also costing less.” This means that, in individuals with higher levels of dental disease (such as those in public programs), amalgam fillings may last longer and need to be replaced less often than composite fillings. Yet, provider and public preference strongly leans towards composite fillings, likely due to their aesthetic advantage. Nevertheless, how does one rationalize a situation where coverage is provided for a potentially less effective therapy? Are we to say that publicly insured populations can only have access to amalgam fillings? On what basis? What if the provider does not offer amalgam fillings? Clearly, there are ethical and operational dimensions here that are not easily navigated.

Some jurisdictions have dealt with this issue by allowing publicly insured patients to pay the difference between the amalgam and composite filling if there is a fee differential (something that used to be common but is less so today). Cost-barriers may once again become an issue here, though.
Importantly, jurisdictions do have the potential to completely sidestep the issue of what services should be funded. They could, for example, not provide a schedule of eligible services at all, and leave those decisions to the patient and provider. Instead, they could define some kind of expenditure limit, such as the $5,000 per five years that the Alberta seniors’ program uses. Either way, the fact remains that some dental care services would be funded whose fitness for purpose is unclear, if not absent.

The above issues speak to “value for money,” and extend beyond public markets in dental care, meaning they have implications for private markets as well. Both public and private funders are increasingly concerned as to what value is derived from the health and dental care services they pay for. This is termed the “value-based agenda,” an issue that was raised earlier when describing potential weaknesses in Alberta’s and Canada’s approach to dental care, and when describing different payment arrangements for dental care (see sections 2.5.5 and 3.3.2).

Finally, how one arrives at what services to cover is important. There are purely technocratic methods that involve evidence reviews and/or that depend on eliciting and quantifying patient and provider preferences. There are methods that depend on consensus among experts. And there are methods that combine all of these approaches. In the end, some attention to arriving at what services to cover in a scientifically and ethically defensible way is needed, if Alberta and Canada are interested in spending efficiently and effectively in a regime for dental care that positions need and value above demand and volume.

3.6.4 Identifying overarching goals

Potentially more important than the issues identified above though, is why. In other words, what is the goal of providing dental care to the population? What should be the objective(s) of primary dental care? While this may seem intuitively obvious, there is a concerning lack of detail about this – if none at all – in dental care legislation, regulations and/or policy, let alone any open and transparent discussion about this in current debate. Why would we fund more dental care, irrespective of whether it is targeted or universal? Is the goal to improve health? The quality of life? What about employability? Is there an equity goal? An economic goal? These questions are asked not because they represent a zero-sum game, but because they are almost never asked in a direct fashion, and they clearly prove germane to any rationalization for why Alberta and Canada should care about this at all. And as for the associated service basket, why would we fund some things and not others? Is it because we want to provide services that relieve pain and infection? Or to prevent disease? What about restoring chewing and/or social function? Again, the answers to this might seem obvious, but it is at
this level of questioning that progress in the future of dental care in Alberta and Canada is arguably made.

3.6.5 The influence of COVID-19

The COVID-19 pandemic may have provided a stark social and policy situation that can move many of the above debates forward, at least conceptually. In a time of crisis, governments, dental regulatory authorities and dental associations around the world have provided guidance on what “emergency and urgent” (or “essential”) dental care services should be available to all new patients and/or patients of record. In some jurisdictions, guidance was general, while in others, it was specific, listing the medical/oral conditions that qualify, as well as the services. In this regard, whether implicitly or explicitly, these agencies were making statements on who should be covered and for what in a time of crisis – everyone ought to have reasonable access to this or that basket of services based on medical need. The value of this, is that as life returns to a “new normal,” the questions posed here now potentially have clearer answers than ever before.

3.6.6 Take-home message

Making progress on the issue of access to dental care in Alberta and Canada will require addressing many of dentistry’s proverbial sacred cows. Chief among these is making decisions about who ought to receive subsidies for dental care, what services should be subsidized, and for what reasons, or why. These are conceptually difficult issues, and they raise many questions concerning dental care that may not always be comfortable for governments or the dental profession. Nonetheless, in order to improve access to dental care, whether in a targeted or universal manner, dealing with these issues will be necessary.

3.7 Summary

At different times throughout the history of Canadian health-care policy, we have engaged discussion about whether dental care should be part of Medicare. This is not a simple issue, and speaks to often misunderstood aspects of Canadian health-care culture, specifically whether incorporating dental care into our national system of health insurance is even a priority for Canadians. At the time of writing this report, there appears to be renewed attention to this issue, given concern over extant challenges in accessing dental care among populations across Canada, including Alberta.

Importantly, including dental care in Medicare (or the public financing and private delivery of dental care) is only one option to facilitating greater access to dental care for all Albertans and Canadians. In fact, as can be seen internationally through mixed systems of financing and delivering dental
care, one can achieve the near universal or universal coverage of dental care in numerous ways. This means Alberta and Canada have the option of thinking creatively and strategically in order to move dental care into the future in a way that meets the needs of more people. This can involve: assessing the merits and drawbacks of targeted versus universal approaches to dental-care coverage; mandating the universal coverage of dental care through statutory health insurance or through legislation aimed at employer-employee arrangements, or both; expanding the public and private options for accessing dental care; expanding and diversifying the oral health care workforce; integrating oral health into the health-care system; and rationalizing the goals of the primary dental-care system and an associated basket of oral health care services.
4.0 Conclusions and recommendations

This report considers the current challenges in Alberta’s and Canada’s dental care landscape, and proposes options for how they can provide better access to dental care for all populations. It describes the history of Alberta’s and Canada’s dental-care system and what is known about inequality in oral health and access to dental care within the province and across the country. It compares Alberta to other Canadian jurisdictions in terms of the public and private funding of, and access to, dental care, and considers the nature of dental fees and what that means to Albertans and Canadians. It describes the weaknesses of the dominant approach taken to oral health care within Alberta and Canada, and offers potential solutions to address historical and current challenges. Now, it will provide four recommendations to map the movement toward universal coverage of dental care in Alberta and for all people living in Canada.

How might one engage positive movement toward the universal coverage of dental care? For some, the recommendations below might seem uninspired, but to this analyst, it is clear that more conceptual work needs to be done for policymakers to fully and truly rationalize why universal coverage for oral health care is needed – irrespective of how that coverage would be organized, financed and delivered. In other words, more policy and political work needs to be done, and, for this work to bear fruit, some basic and foundational steps must be taken.

4.1 Recommendations

4.1.1 Who, what, and why

Alberta and Canada should establish clear goals for primary dental care and the basket of dental care services to be funded. There is a fundamental need to rationalize who ought to receive subsidies for dental care, what services should be subsidized, and for what reasons, or why.

4.1.2 Epidemiological surveys

Alberta and Canada should conduct oral epidemiological surveys of their populations to establish normative need. There is a fundamental need for clinical information on the oral health status of Albertans and Canadians to identify those at risk for poor oral health and access to dental care, and to assess the impacts of poor oral health on other health conditions. This information is critical to health services and human resources planning.
4.1.3 Complete costing

Alberta and Canada should estimate the costs of different targeted and universal dental-care strategies. There is a fundamental need to consider the costs of different policy approaches to achieving broader population coverage for dental care. Such an analysis would incorporate all costs, take the perspective of the individual, family, health-care system, and society, as well as consider mixed public and private coverage schemes and benefits packages.

4.1.4 Coalition and strategy building towards funding

Alberta and Canada should continue to build communities of interest and coalitions around oral health and dental care. There is a fundamental need to establish a common voice around these issues; one that helps to build consensus between civil society groups, professional regulators and associations, and government agencies on problem identification and potential solutions. It is in this way that federal and provincial investments in dental care will materialize.

4.2 Summary

The issue of access to dental care is increasingly recognized as an important social challenge in Alberta and Canada. Poor access to dental care decreases the quality of life, worsens overall well-being, inappropriately consumes health-care resources, exacerbates existing public health challenges, and results in inequity and inefficiency. We can improve access to dental care through strategic intervention, thus providing benefits to individuals, families, the health-care system and society.
Dentistry in Alberta: Time for a Checkup?

References


115. Naylor CD. Health Care in Canada: incrementalism under fiscal duress: fiscal constraints have eroded Canadians' enthusiasm about their single-payer system, but their commitment to universal coverage is holding firm. Health Affairs. 1999 May;18(3):9-26. Available from: https://doi.org/10.1377/hlthaff.18.3.9


Dentistry in Alberta: Time for a Checkup?


Dentistry in Alberta: Time for a Checkup?