Staying ahead of the curve:

A unified public oral health program for Ontario?

UNIVERSITY OF TORONTO FACULTY OF DENTISTRY

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Staying ahead of the curve: A unified public oral health program for Ontario?

About this report

This report was compiled by a group of individuals who care about the health of Ontarians. They discuss the current status of, and various policy options for, publicly funded oral health care programs with the aim of maximizing efforts to maintain and improve the health of Ontarians. This report contains the collective and individual views of the group and does not necessarily represent the decisions or the stated policy of the organizations they represent.

Acknowledgements

The group is grateful to the organizers of the Ontario Public Health Convention in 2012 for bringing the theme of this report to its participants through a panel debate. The group thanks Brant County Health Unit and the OAPHD for sharing the overview information on publicly funded oral health care programs in Ontario. The group is thankful for the financial support provided by the Discipline of Dental Public Health, Faculty of Dentistry, University of Toronto, which helped convene the experts and print the report. We are grateful to Tracy Craig for doing the graphics layout of the report.

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Foreword

By Vivek Goel

The Ontario Public Health Convention (TOPHC) developed out of a desire to create a forum for public health professionals to interact and share best practices, enhance knowledge and skills, and advance the practice of public health. Public Health Ontario is proud to have sponsored TOPHC along with partners at the Association of Local Public Health Agencies (alPHa) and the Ontario Public Health Association (OPHA). It is gratifying that a report such as this has come out of a panel discussion at the second convention in 2012.

This report brings together views from different disciplines and sectors on a critical topic: oral health. The Chief Medical Officer of Health's recent special report (announced at TOPHC), Oral Health: More Than Just Cavities, highlights the importance of oral health and access to oral health services. The report notes that oral health is linked to serious conditions that include cardiovascular disease, diabetes, low birth weight babies, respiratory infections, osteoporosis and rheumatoid arthritis. The report makes recommendations regarding access to fluoridated drinking water, stewardship of publicly funded oral health programs, integration and alignment of low-income oral-health services, and improvement of services for First Nations peoples.

To achieve good oral health status, a combination of population-based preventive interventions, such as fluoridation and access to individual services, is needed. While significant achievements in both realms have been made in Ontario, we continue to see debates regarding the role of fluoridation. And unfortunately, too many individuals, particularly children, are unable to obtain access to adequate oral health services.

The papers that follow provide perspective on why a review of how publicly funded oral health programs are monitored and evaluated, as called for in Dr. King's report, is necessary. They present cogent arguments that better integration and alignment of oral health services would be beneficial to the people of Ontario. Given the very challenging economic circumstances that the province faces, it is particularly relevant that the authors are not simply calling for more resources. They are pointing out that we could do better with what we have if we coordinated diverse activities across ministries and organizations into a unified program. This is how we can gain efficiencies and improve health outcomes for all Ontarians.

Dr. Vivek Goel is the President and CEO of Public Health Ontario and Professor at the Dalla Lana School of Public Health and the Institute of Health Policy, Management, and Evaluation at the University of Toronto

Introduction and overview

By Garry Aslanyan

Nothing matters more, individually or collectively, than our health. Canadians, regardless of political allegiances, are nearly unanimous that a universal health system is a good thing. Yet in Canada, oral health care is not part of universal health care. Nonetheless, with the exception of a few countries, most Western nations have to some degree included oral health care in their universal health systems. We Canadians also like to stress that our health care system is better than that of the Americans. The reality though is that the United States spends more public (government) funds per person on oral health care than Canada[1]. Oral health remains a hole in our celebrated Canadian health care model and gets marginal interest at the national level and inconsistent interest at the provincial levels of health policy discourse. This is confirmed by the fact that the average publicly funded share of dental care expenditure has decreased from approximately 20 per cent in the early 1980s to approximately 6 per cent today[2]. The current economic challenges and reductions in public spending mean that this trend will likely continue. The discontinuation or limiting of certain funding streams such as the federal refugee health program and provincial social assistance schemes will put additional strain on provincial and local oral health care programs. What is even more disappointing is that when public money is used to fill the dental hole in our health system, it is targeted to a patchwork of policies and programs that have no unified or consistent approach to the issue of access to dental care.

In Ontario in recent years, there have been some welcome signs of change: Oral health gets discussed more often and there have been slight increases in public funding. Anecdotally, people who work in public health comment that there is enough money to cover everybody and have a unified single public oral health care program in Ontario – because money is not the problem. They say anyone can see that how we have run publicly funded dental care programs in Ontario is chaotic (see table in Appendix A).

Oral health is no longer a concern only for dental health professionals. Many non-dental professionals working in public health or social policy sectors, recognizing the needs and lack of coherence, have stepped up advocacy efforts. Medical Officers of Health, public health nurses, nutritionists and dietitians are engaged more than ever. This is a welcome development as public health solutions for oral disease are arguably more effective when they are integrated with public health programs[3]. In addition, the Canadian Centre for Policy Alternatives (CCPA), known as a strong social, fiscal and equity policy think tank, published a report in 2011 outlining options for national-level denticare or dentiaid solutions[4].

1 Organization for Economic Co-operation and Development (OECD). OECD.Stat available from http://www.oecd-ilibrary.org/statistics
2 Quiñonez C, Locker D, Sherret L, Grootendorst P, Azarpazhooh A, Figueiredo R; Community Dental Health Services Research Unit. An environmental scan of publicly financed dental care in Canada. Toronto, ON: University of Toronto; 2007. Available from: http://www.fptdwg.ca/assets/PDF/Environmental_Scan.pdf
3 Petersen PE (2008) WHO global policy for improvement of oral health. International Dental Journal 58(3): 115-121.
4 Canadian Centre for Policy Alternatives (CCPA). Putting Our Money Where Our Mouth Is: The Future of Dental Care in Canada Toronto, Canada: CCPA; 2011.

As we write this report, the Canadian Academy of Health Sciences (CAHS) is working on its own report critically examining the systematic inequalities in access to oral health care that affect the health and social functioning of vulnerable populations in Canada, and what we can do about it.

In 2012, a group of committed individuals formed a panel to debate what exactly is wrong with the patchwork of programs in Ontario and why and how we need to fix it. The Ontario Public Health Convention offered an intriguing theme – staying ahead of the curve. The goal of this panel debate was to consider policy options for a unified public oral health care program in Ontario, taking advantage of the diversity of the convention's audience. As a result of that panel, this report was produced. It focuses on the question of why, even with additional funding available for oral health care in Ontario, inequalities in access to care still exist and access-limited populations continue to carry a higher burden of oral disease. At the same convention, the Ontario Chief Medical Officer of Health (CMOH), Dr. Arlene King, made an announcement of an upcoming report on oral health that was subsequently released at the end of April 2012, drawing attention to the importance of oral health and calling for a review of the effectiveness and efficiency of current publicly funded programs in Ontario[5].

The strength of our report is in the views of its contributors on what needs to be done. They all agree that this is a complex issue requiring a wise solution. While it may be perceived as a collection of broad-ranging opinions, make no mistake: All authors agree that the current model of funding of oral health care programs through various provincial ministries and local/regional governments in Ontario is no longer acceptable. The papers confirm that the diversity of service delivery models in the province is not rational, and leaves many behind. Many authors underline the lack of consistently collected information on oral health needs and services, making it difficult to track changes, evaluate and improve programs and identify determinants of good oral health. This makes evidence-based decision-making difficult and hampers cost containment in publicly funded oral health care programs. The authors fully endorse the recommendations made in the CMOH's report on oral health and call on the provincial government to review and potentially replace the current patchwork with a unified oral health program for all Ontarians.

The following papers offer ideas from public health and primary health care settings, dental professionals and dental public health experts, to help fuel this discussion. They show that there are many different ways to make Ontario's publicly funded dental care more efficient, effective, and ultimately better for all Ontarians.

Dr. Garry Aslanyan is a Canadian public health expert currently working as a Policy Manager with the World Health Organization in Geneva, Switzerland

5 Ontario Ministry of Health and Long-Term Care (OMHLTC): Report by Ontario's Chief Medical Officer of Health. Oral Health – More Than Just Cavities Toronto, Canada: MOHLTC; 2012.

Report Recommendations

The panel debate at the Ontario Public Health Convention and the papers in this report have led to the formulation of three overall recommendations:

Recommendation 1

Combine the current patchwork of public oral health care programs in Ontario.

Recommendation 2

Design a unified public oral health care program in Ontario to be managed by a central government agency/ministry with a diversity of delivery models that address unique regional needs.

Recommendation 3

Implement all recommendations made by the Ontario Chief Medical Officer of Health (CMOH) in the 2012 Report “Oral Health – More Than Just Cavities.”

Oral health inequalities, unified centralized programming, evaluation and sustainability

By Carlos R. Quiñonez

We have long been aware of significant oral health inequalities in Ontario. Socially and economically marginalized groups have more cavities and gum disease, and report more toothache and loss of time from work or school because of dental problems. They also experience the greatest barriers to dental care, as their incomes are low, and care can prove too costly in the face of other needs, such as eating a nutritious diet or paying the rent. They also have some of the lowest levels of employment-based dental insurance, and this is important, as these dental benefits are the main avenue by which people use and access dental care.

Yet oral health inequalities are becoming subtler. Over the last decade, we have become aware of the challenges of the working poor. These are individuals who have jobs, thus they cannot benefit from public programs that target unemployed families, yet their jobs do not provide dental benefits. In fact, people in the lowest income brackets now report better use of and access to dental care than working poor families.

In addition, the economic downturn and changes in the labour market have placed middle-income families at risk. These families have some of the lowest rates of employment-based dental insurance among all income groups. The recent Canadian Health Measures Survey (CHMS) demonstrated that middle-income families have more severe oral disease than do those on social assistance and with low education[6]. An analysis of Ontario data from the Canadian Community Health Survey (CCHS) confirms the challenges of access to dental care and oral health inequalities that exist in the province[7].

In addition, it appears that middle-income seniors are the most at risk, specifically because they tend to lose their dental benefits upon retirement. An aging population increasingly dependent on institutional care is a major factor that we cannot ignore. What this means is that inequality is no longer a simple distinction between rich and poor, or child and adult. Rather, inequality crosscuts income and age in complex ways. We must pay attention to this if we are to adequately respond with our policy efforts.

Yet what would a unified program look like? What could we expect? What services could we include? How would they be delivered? To design a program, a target population must be defined, but this task is complicated by some of the challenges described above in terms of adequately envisioning inequalities in Ontario. A program that is based in prevention is also ideal – particularly one that employs community water fluoridation and clinical preventive modalities such as fluoride varnish – yet we know that many people will require treatment. Regardless of preventive or curative care though, any program must include

6 Health Canada: Summary Report on the Findings of the Oral Health Component of the Canadian Health Measures Survey 2007-2009. Ottawa, Canada: Health Canada; 2010.

7 Public Health Ontario: Report on Access to Dental Care and Oral Health Inequalities in Ontario. Toronto, Ontario: Public Health Ontario; 2012

services that are grounded in the best possible evidence. Right now, we spend a lot of public dollars on treatments where the evidence of therapeutic benefit is poor (e.g. asymptomatic third molar extraction), or where the evidence is strong in suggesting that we should rethink why we fund certain treatments over others (e.g. plastic fillings vs. silver fillings).

We also need to consider the issue of centralization. Currently, with so many programs, all with different eligibility criteria, funding models and administrative structures, a strong argument can be made to move their organization and management to a central government ministry. While always respecting and allowing flexibility for unique regional needs, a central ministry would provide the added benefit of standardizing and streamlining solutions to many of the challenges that have been identified by others in this report (e.g. eligibility criteria that fail in terms of logic and need, cumbersome administration, lack of strong leadership in dental public health within the provincial government, and lack of useful data for evaluation).

In situations where such unified and centralized programs have been introduced, it appears that people tend to use a lot of care once it becomes available, but this eventually trails off. Undoubtedly though, access to dental care is improved, as are levels of oral health through reductions in oral disease and associated illness. As to how the services can be delivered, the role of dentists is invaluable, yet we need to be creative. Research has shown that the lower one's income, the more of a preference one has to access dental care in a public clinic, a service environment that is largely unavailable in Ontario. We also need to think about involving non-dental settings and providers, particularly in rural areas where dentists are often not available. For example, American programs have demonstrated the tremendous benefits of dovetailing oral health care programming to other health and social services, supported by the work of physicians and nurses and their allied staff [8,9,10]. So in the end, a mixed and creative model has the most potential.

Ultimately, any program must be evaluated and monitored to ensure sustainability. To some extent, this is also our lowest-hanging fruit, as it really is the first step in getting our system in order. Right now in Ontario, we do a really poor job of collecting the right type of data from the right people, and packaging that data in ways that are useful to planners and researchers. Our oral health data info-structure is incredibly weak. Yes, we have a lot of data on the treatments we provide; yet we have little data on levels of oral disease, so we really have no idea whether the money we spend is improving anyone's health.

Our info-structure is also poorly managed. As researchers trying to access data, we are often met with poor bureaucratic excuses for why data cannot be released. Yet without proper monitoring and evaluation, we are lost, with no hope of arguing for the benefits of our programs, which in the end has severe implications for the sustainability of programs that are critical to the public's health.

Dr. Carlos R. Quiñonez is Assistant Professor and Program Director of the Dental Public Health Specialty Training Program at the Faculty of Dentistry, University of Toronto

8 Lee JY, Rozier RG, Norton EC, Kotch JB, Vann WF (2004) The effects of the Women, Infants, and Children's Supplemental Food Program on dentally related Medicaid expenditures. Journal of Public Health Dentistry 64(2): 76-81.
9 Lee JY, Rozier RG, Norton EC, Kotch JB, Vann WF (2004) Effects of WIC participation on children's use of oral health services. American Journal of Public Health 94(5): 772-7.
10 Rozier RG, Stearns SC, Bhavna TP, Quiñonez RB (2007) Research brief: Evaluation of the Into the Mouths of Babies Program. School of Public Health, Department of Health Policy and Administration, University of North Carolina.

Beyond Band-Aid solutions: A unified oral health program for Ontario

By Adrianna Tetley

It is hard to believe that in a country as rich as ours about one in six Canadians avoids going to the dentist because he or she cannot afford it.

Throughout Ontario, our Association's member centres see the urgency of the problem every day: people with decaying, broken and abscessed teeth as well as people with no teeth at all. They cannot afford to visit a dentist and take preventive measures to maintain and/or improve their oral health. As a result, their physical and emotional well-being suffers, as well as their ability to get work. We believe that to truly eliminate barriers to health our long-term goal should be to ensure that oral health care is covered under the Ontario Health Insurance Plan (OHIP) so that everyone, at every income level, has access to quality dental care.

In 2010, the provincial government took a step in the right direction when it introduced the Healthy Smiles Ontario (HSO) program, which provides preventive and early treatment dental services to children under 18. Children are eligible if their adjusted family net income is under $20,000 and the family does not have access to any form of dental insurance coverage. One third of Ontario's 73 Community Health Centres (CHCs) now participates in HSO.

But HSO is still a Band-Aid approach added to a patchwork of government programs. The program is also experiencing teething problems:

- The income eligibility criteria are too low leaving far too many low-income children without access;
- There is lengthy paperwork to be completed;
- Most CHCs did not receive operational funding for program delivery so some are experiencing financial difficulties;
- The program does not address oral health needs for the rest of the family.

An obvious solution is to unify the province's five fragmented oral health programs. The first logical step is to combine HSO and the Children in Need of Treatment (CINOT) program into one program for low-income children, with a common income eligibility level higher than $20,000 that would allow more low-income children to get the oral health services they need.

The Ministry then needs to extend publicly funded emergency dental services to low-income adults. There is a huge need among this population, which is already burdened with illness. A recent survey of our members found that 90% of their oral health clients present with chronic diseases, including diabetes, cardiovascular disease and mental health and addictions issues. The need is especially high for Aboriginal people, new immigrants, people with disabilities, people with mental health problems, and people without insurance.

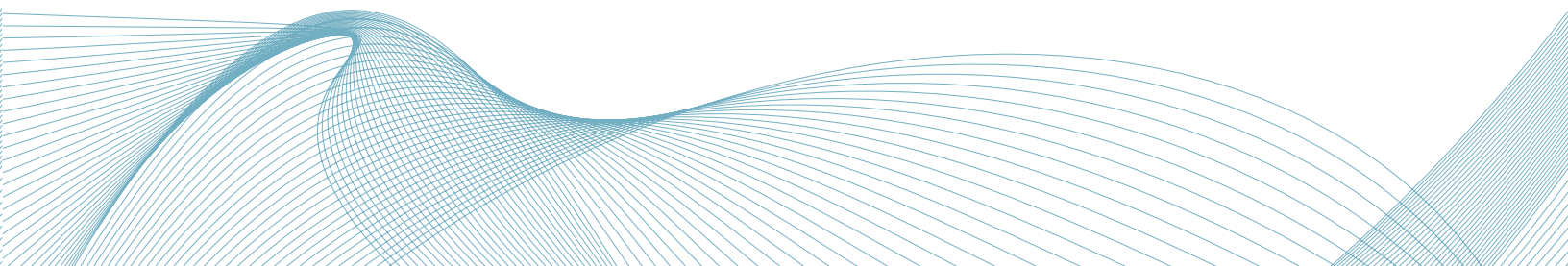
Ontario's 83 CHCs and Aboriginal Health Access Centres (AHACs) are in a good position to play a strengthened role in delivering a more cohesive oral health program for people in need. Many of those we serve tell us they do not feel welcome in mainstream dental offices. Dentists are not always accustomed to working with homeless people or people who cannot pay their dental bills upfront. But CHCs and AHACs specialize in working with vulnerable people. Low-income individuals and families can get their teeth checked, while also being referred to appropriate services within our centres, such as diabetes prevention and management programs, the mental health team, nutrition programs and primary health care providers. The AOHC has started collecting data that are expected to show that by treating both oral health and related diseases, the community health care model will help save health care dollars.

Much more could be done to leverage the potential of CHCs and AHACs in delivering oral health services to low-income people. Some of our member-centre dental suites are open only two or three days per week due to funding constraints. They are not being used to their full capacity.

In short, we need the government to make public investments that recognize oral health as essential to overall health and well-being. The AOHC members are keen to play a leadership role and will continue to advocate for an affordable, accessible oral health care program for all.

The AOHC is the voice of community-governed primary health care in Ontario. Its members include 73 Community Health Centres and 10 Aboriginal Health Access Centres that provide primary health care and a range of other health promotion and community development services under one roof. A third of the Association's membership offers oral health services to low-income people living in Ontario.

Ms. Adrianna Tetley is the Executive Director of the Association of Ontario Health Centres (AOHC) in Toronto, Ontario



Time for change: Reshaping public oral health care in Ontario

By Paul Sharma and Robert Hawkins

Each day Public Health receives phone calls from the public asking for financial assistance for dental care. More and more people need help to pay for dental treatment during these difficult economic times. In Ontario, multiple publicly funded dental programs for children and youth exist with different eligibility requirements, fee schedules and program administrators. However, few programs are available for even the emergency dental needs of adults. The current oral health care system in Ontario is best described as fragmented, difficult to navigate, and missing large segments of the population.

Recently, the government has made progress in expanding dental care for children and youth. As a part of its 2007 election platform, the provincial government introduced Ontario's Poverty Reduction Strategy, which aimed to reduce the number of children living in poverty by 25 per cent over five years. Funding of $135 million over three years was committed to providing dental services for low-income families. It was believed this new funding could provide dental care to both children and adults living in poverty.

On January 1, 2009, the first phase of this commitment was launched by allocating $10 million per year to expanding the Children in Need of Treatment (CINOT) program to include children until their 18th birthday and to provide out-of-hospital anesthesia coverage for children aged 5 to 17. In October 2010, the Healthy Smiles Ontario (HSO) program was implemented throughout the province to provide preventive and early treatment services to eligible children and youth up to age 17. Eligibility criteria include an adjusted family net income of less than $20,000, residency in Ontario, and having no other form of dental insurance.

The Ontario Association of Public Health Dentistry (OAPHD) was disappointed that adult oral health care was not part of the new investment into oral health. OAPHD is an association of dental professionals whose prime interest is the oral health of the general public. Our members work in local public health departments and provide oral health information and services for communities. The OAPHD promotes oral health and advocates for improved access to dental care for all Ontarians.

In Ontario, oral health is excluded from the publicly funded medical system. For those individuals who are not eligible for provincially or locally funded dental programs, the burden to finance oral health care falls on the individual either through employer-paid benefits ("dental insurance") or paying out-of-pocket. Private dental coverage or insurance facilitates access to care, however, obstacles remain if dental coverage is limited or has restrictions (e.g. the deductibles may not be affordable). The inability to pay for dental care is a major barrier for adults, especially adults with low incomes.

Why is the mouth so important? Teeth are important for eating, speaking, appearance, and holding space for the developing adult teeth. They are crucial to one's overall growth, development, and well-being. Oral health is not only important to one's appearance and sense of well-being, but also to overall health. Cavities and gum disease may worsen or lead to many serious conditions, such as diabetes or respiratory diseases.

The importance of oral health to the overall well-being of children and adults is well known. To enhance and promote the health of Ontarians, a review of the current Ontario dental infrastructure and programs is necessary. This review would identify where gaps and efficiencies exist, and whether there are resources available to help priority populations such as low-income adults and seniors. The private practice dental model is unable to meet the dental care needs of everyone. In some areas of the province, public health units and Community Health Centres have established community dental clinics to serve priority populations. They are trying to address local needs and are able to spend the time to help clients not only with their oral health needs but with their overall health needs.

Simply put, the role of public health is to protect and promote the health and well-being of the public. As public health professionals, we have expertise and experience dealing with vulnerable populations experiencing barriers in accessing services and needing guidance in navigating the health care system. Leaders working in dental public health can help guide the review of oral health care in Ontario and make evidence-informed recommendations for future decisions.

The bottom line is that the current model of care in Ontario is not working and needs to be tailored to the present climate. A review of the current dental infrastructure is necessary with the participation of all key stakeholders to improve dental access for the entire population. The government has made some advances but needs to develop an overall oral health strategy to serve the Ontario population.

Mr. Paul Sharma is the past-President of OAPHD and Manager, Chronic Disease and Injury Prevention, Peel Public Health in Ontario

Dr. Robert Hawkins is a member-at-large with the OAPHD and dental consultant with Ontario regional units of Halton Region Health Department, Region of Waterloo Public Health and Wellington-Dufferin-Guelph Public Health

Dental care in Ontario: A view from the public health field

By Andrea Feller

In 2010, Dr. Arlene King's Chief Medical Officer of Health of Ontario report Health, not Health Care made it clear that inequities and the social determinants of health need to be addressed, and be front and centre in our priorities[11]. It is no different for oral health, as dental disease disproportionately affects many, or those without the means to access dental care on a regular basis.

Currently, Ontario has several programs for those in need: Children in Need of Treatment (CINOT), Healthy Smiles Ontario (HSO), Ontario Works (OW)-Child, OW-Adult, Ontario Disability Support Program (ODSP), as well as Assistance for Children with Severe Disabilities (ACSD) and the Ontario Cleft Lip and Palate/ Craniofacial Dental Program. In addition, there are several federal and local programs that provide dental benefits with different inclusion criteria and coverage levels. This patchwork results in administrative burden, inefficiency and data systems that do not communicate with each other, making data not readily available or comparable. Clearly, despite recent laudable additional investments in dental care for children, Ontario is facing challenges in efficiently organizing an equitable dental care system.

A Public Health field survey of Medical Officers of Health (MOH) conducted in 2010 showed that the majority of respondents feel that dental care needs to be universally covered, that dental care is becoming cost-prohibitive for their populations, and that more research, data and surveillance are needed in Ontario[12]. MOHs expressed concerns over people's ability to pay for care as well as the need to support water fluoridation across the province. They noted the many groups left out of the provincial dental care programs, with inadequate or no dental coverage. Also, they expressed interest in more research around the links between oral health and general, overall health.

It is time for a review of oral health coverage in Ontario. The patchwork of current programs needs to be reviewed to improve access, efficiency, effectiveness, and health equity. A review could potentially find the means to improve and expand coverage, even with current fiscal restraints. The evidence is mounting that oral health clearly affects overall health. Could the Ontario Health Insurance Program (OHIP) someday cover preventive services such as fluoride varnish, sealants and basic exams, in the same way vaccinations are covered? In the more realistic near future, can other health care professionals (e.g. physicians, nurse practitioners, nurses, home visitors) be reimbursed for providing fluoride varnish, to minimize "missed opportunities"?

11 Ontario Ministry of Health and Long-Term Care (OMHLTC): 2010 Annual Report of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario. Health, Not Health Care - Changing the Conversation Toronto, Canada: MOHLTC; 2011.
12 Ontario Agency for Health Protection and Promotion – Public Health Ontario (2010) Unpublished raw data from the Ontario Oral Public Health Survey.

Is there a way to support water fluoridation as the most cost-effective means of prevention for those who are particularly vulnerable?

The 2010 survey mentioned above clearly showed that the needs of children and their parents, the working poor, and seniors are not being met. While HSO is an improvement, it still leaves adults out. At the very least, in terms of prevention, we would do better to treat parents and children together as we know there are links between parental oral health and children's oral health. Ontario's provision of dental care needs to be reviewed. Access to prevention and care needs to be as simple as possible, with streamlined entry and exits, robust data for analysis and evaluation, and improvements using a health equity lens.

Dr. Andrea Feller is an Associate Medical Officer of Health at Niagara Region Public Health in Ontario and represented the Association of Local Public Health Agencies (alPHa)

Appendix A – Publicly funded oral health programs in Ontario

Program	Who Is Eligible	Plan coverage	How to Access
CINOT (Children in Need of Treatment)	Ontario children from birth, up to and including age 17 and if the child's family has no dental insurance and the cost of dental treatment would result in financial hardship.	Essential Dental Care, as defined in CINOT Schedule of Dental Services and Fees.	Must be screened by Health Unit Staff to establish both a dental and financial need. A CINOT claim form will be issued following the screening, or achild with an emergency condition (as defined in CINOT fee guide) may see a dentist immediately as long as the Health Unit is contacted on the next business day to arrange for an emergency coverage.
Healthy Smiles Ontario	Children 17 and under may be eligible if: They are residents of Ontario; They are members of a household with an Adjusted Family Net Income of $20,000 per year or below; and They do not have access to any form of dental coverage (including other government-funded programs)	Regular visits to a licensed dental care provider, such as a dentist or dental hygienist, to establish and maintain good oral health. It covers a full range of preventive and early treatment dental services including check-ups, cleaning, fillings, x-rays, scaling and more.	Public health unit assists with the application process, which involves completing a form and showing required documentation: Annual Goods and Services Tax Credit Entitlement Notice OR Annual Canada Child Tax Benefit and Ontario Child Benefit Notice (most recent tax year). Government-issued identification (valid Ontario Health Card, Passport, Certificate of Canadian Citizenship, Permanent Resident Card, Canadian Immigration Identification Card OR valid Ontario's Driver's Licence). Child's valid Ontario Health Card
ODSP (Ontario Disability Support Program)	ODSP participants, their spouses and dependent children up to 18 years of age. Eligible dependants 18 and over other than recipient's spouse at discretion of municipality.	Basic Dental Care as defined in MCSS (Ministry of Community and Social Services) Schedule of Dental Services and Fees.	ODSP and ACSD dental card issued monthly will indicate the program name, eligibility for "basic" dental care and valid benefit month. Family needs to provide proof of coverage each month to the dental office
ACSD Assistance for Children with Severe Disabilities	Children whose parents receive Assistance for Children with Severe Disabilities (ACSD).	All services under Dental Special Care Plan require predetermination, as indicated in the MCSS Schedule of Dental Services and Fees.	
OW Child (Ontario Works)	Dependent children from birth up to 18 years of age, whose parents are OW participants. Children whose guardian is receiving Temporary Care Assistance.	Basic Dental Care as defined in the MCSS Schedule of Dental Services and Fees.	Family needs to provide proof of OW coverage each month to dental office. Documents required vary by municipality.
OW Adult (Ontario Works)	Dental care for adult OW participants may be provided, at the discretion of their municipality.	At discretion of municipality.	
The Ontario Cleft Lip and Palate/ Craniofacial Dental Program	A resident of Ontario in possession of a valid OHIP number Diagnosed as having a cleft lip and /or palate, a craniofacial anomaly or other severe dental dysfunction Registered in the program before their 18th birthday.	Up to 75% of pre-approved dental specialist treatment costs not covered by private dental insurance will NOT cover the cost of routine dentistry and long-term follow-up care	An individual must contact or be referred to one of the designated centres for a screening assessment. Eligibility is determined by the Paediatric Dental Director and the assessment team at each designated clinic.

Local colleges and universities may also offer reduced-fee dental care

A group photo after the panel discussion at the Ontario Public Health Convention, April 2, 2012, Toronto, Ontario. From left to right: *Garry Aslanyan*, Policy Manager, World Health Organization, *Carlos Quiñonez*, Assistant Professor and Discipline Head, Dental Public Health, Faculty of Dentistry, University of Toronto; *Andrea Feller*, Associate Medical Officer of Health, Niagara Regional Public Health Department; *Stephen Abrams*, Chair, Dental Benefits Committee, Ontario Dental Association (ODA), *Adrianna Tetley*, Executive Director, Association of Ontario Health Centres (AOHC) and Member, Ontario Oral Health Coalition; *Paul Sharma*, President, Ontario Association of Public Heath Dentistry (OAPHD) and Manger, Peel Public Health Department.

"A powerful call for government action to help those who cannot afford dental care: This report clearly states the physical and social harm created by a health system that excludes dental care for society's most vulnerable citizens."

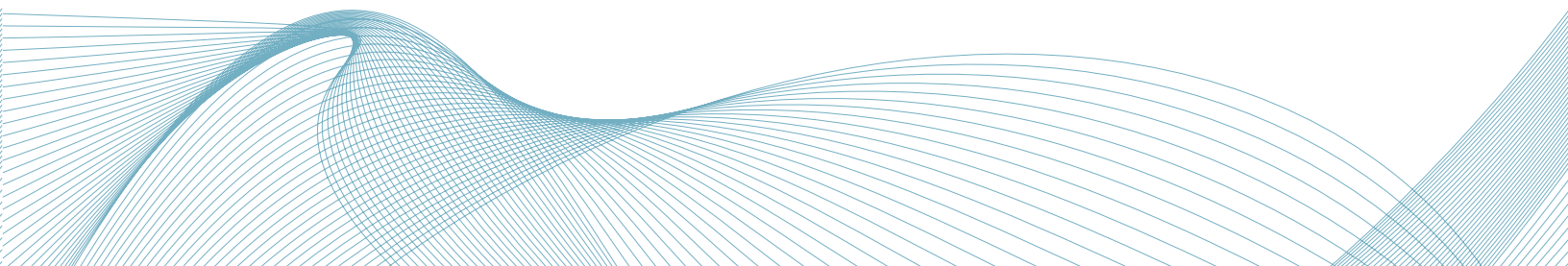
Moira Welsh
Reporter, the Toronto Star

"One cannot talk about oral health without stressing its important impact on overall wellness across the life course. Social determinants of health such as low socioeconomic status, not only foster chronic illness, but paradoxically limit access to oral health care for those who most need it. Now is the time to start our path towards a unified public health oral program for Ontario. Despite current fiscal realities, with an upstream mindset, expansion of eligibility criteria and removal of administrative obstacles are achievable. This approach is the conceptual key towards a health care system focusing on prevention and health promotion across all ages."

Dr. Paul Roumeliotis
President, Association of Local Public Health Agencies (alPHa)
Medical Officer of Health and CEO, Eastern Ontario Heath Unit

"It is time to put the mouth back into the body. The Ontario Oral Health Alliance endorses the recommendations made in this report…these are necessary steps forward to help build a system that allows for equitable access to dental care for all Ontarians."

Anna Rusak
Chairperson, Ontario Oral Health Alliance



"Can a government save money and improve health? Yes, say this group of experts, with focused leadership. This report shows the Government of Ontario how to advance its considerable leadership in health care, by unifying its patchwork approach to oral health, bringing care to the community and emphasizing prevention. If the future of health care relies on bending the cost curve while reducing health inequities, this is the path to the future."

Armine Yalnizyan
Economist, Canadian Centre for Policy Alternatives

"As the collective voice representing public health professionals within Ontario, OPHA fully supports the position and the recommendations detailed in this report. We agree with the need for a unified, publicly funded oral health care program within the province. This will enhance equitable access to consistent and quality oral health services for Ontarians. OPHA commends the authors for their leadership on this issue."

Sue Makin
President, Ontario Public Health Association

"The time to act is now. The marginalization of oral health from the rest of the health care system and the patchwork of government funded programs targeting the same age cohort has disenfranchised a significant portion of Ontario residents and resulted in poor social, economic and health outcomes for these people. The importance of good oral health to general health is undeniable. The current Ontario government should make good on its promise in the 2008 budget "to provide dental services to low income persons" a reality."

Dr. Hazel Stewart
Director of Oral and Dental Services, Toronto Public Health and Chair, Toronto Oral Health Coalition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