Sorry Doctor, I Can't Afford the Root Canal, I Have a Job: Canadian Dental Care Policy and the Working Poor

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ABSTRACT

Background: In Canada, most dental care is privately financed through employment-based insurance, with only a small amount of care supported by governments for groups deemed in social need. Recently, this low level of public financing has been linked to problems in accessing dental care, and one group that has received major attention are the working poor (WP), or those who maintain regular employment but remain in relative poverty. The WP highlight a significant gap in Canadian dental care policy, as they are generally not eligible for either public or private insurance.

Methods: This is a mixed methods study, comprised of an historical review of Canadian dental care policy and a telephone interview survey of WP Canadian adults.

Results: By its very definitions, Canadian dental care policy recognizes the WP as persons with employment, yet incorrectly assumes that they will have ready access to employment-based insurance. In addition, through historically developed biases, it also fails to recognize them as persons in social need. Our telephone survey suggests that this policy approach has important impacts in that oral health and dental care outcomes are significantly mitigated by the presence of dental insurance.

Discussion: Canadian dental care policy should be reassessed in terms of how it determines need in order to close a gap that holds negative consequences for many Canadian families.

Key words: Dental care; public policy; insurance; working poverty

La traduction du résumé se trouve à la fin de l'article.

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Canada's national system of health insurance does not include dental care. Governments pay for only 4-6% of all dental care expenditures.¹ Dental care is delivered in the private sector, financed by out-of-pocket expenditures (43%) and by employment-based insurance (53%).¹ This method of structuring dental care has developed in relation to social need and employment status, meaning governments finance care for groups receiving social transfers (e.g., welfare), while employment-based insurance plays the dominant role in the private sector.

This level of public financing has led to a social discourse on access to dental care, and increased attention is being paid to the challenges experienced by low-income Canadians, in particular the working poor (WP).²⁻⁴ The WP, or individuals who maintain regular employment but remain in relative poverty,⁵ do not qualify for welfare insurance that covers some dental care, yet they rarely enjoy employment-based dental benefits. In 2001, approximately 75% of Canadians living in non-poor families reported having access to dental insurance, whereas only 26% of the WP reported such access.⁵ That same year, there were 650,000 WP persons in Canada, and including dependants this totalled 1.5 million Canadians, approximately 4-5% of the national population.⁵

From the point of view of dental care policy, social concerns are not unfounded. National population estimates demonstrate that those with no income report more dental visits than those making \$15-30,000 a year, pointing to the role of public insurance and the importance of insurance generally.⁶ The WP highlight a gap in how

dental care has become structured in Canada, as the country's dental care policy has defined itself along moralized lines, meaning that the basis upon which social need is assessed turns on personal responsibility, and employment is an exemplar of this social standing. So by its very definitions, Canadian policy recognizes the WP as persons with employment, yet through historically developed biases, fails to recognize them as persons in social need.

Through a mixed methods approach, this research aims to explore the development of Canadian dental care policy and the place of the WP within it. This paper describes this development, and presents findings from a 2007 national survey of WP adults concerning their oral health and dental care experiences within the context of such policy. Ultimately, the aim of this research is to inform debates on access to dental care and the working poor.

METHODS

Historical review

The development of Canadian dental care policy was detailed through a series of document reviews. All current volumes of the *Journal of the Canadian Dental Association* (1935-2008) were searched

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Table 1. Sample Characteristics, Comparing With Other Population Samples

		Sample Percentage*			
		WP Survey, 2007 (n=1049)	HRSDC Survey, 2001 (n=40,200)	CCHS, 2005 (n=132,221)	Public Opinion Survey, 2006 (n=1006)
Sex	Male	49.4	56.5	49.3	48.5
	Female	34.8	43.5	50.7	51.5
Age (years)	18-24	14.4	11.9	11.3	7.6
	25-34	19.4	24.8	15.4	21.6
	35-44	22.0	31.7	18.8	18.8
	45-54	22.3	21.9	17.6	22.4
	55-64	20.2	9.7	13.1	14.8
Education	High School or less	45.9	45.5	43.9	39.1
	College/University	48.5	41.5	56.1	58.9
Income	Less than \$15,000	20.2	—	5.6	6.8
	\$15,000-\$30,000	77.7	—	12.8	12.8
	\$30,000 or more	2.1	—	81.6	62.1
Income from self-employment	Yes	17.8	40.7	16.9	—
	No	82.2	59.3	83.1†	—
Previous history of social assistance	Yes	15.2	18.2	—	—
	No	84.8	81.8	—	—
Born outside of Canada	Yes	30.4	11.5	20.9	—
	No	69.2	77.8	79.1	—
Married	Yes	74.5	54.4	50.3	—
	No	25.5	45.6	30.4	—
Dental insurance status	Insurance	50.5	25.6	62.4	62.3
	No insurance	49.5	74.4	37.6	35.3
Oral health status	Poor/Very poor	11.2	—	14.4	13.9
	Good/Excellent	88.9	—	85.6	85.4
Last dental visit	Less than 3 years	89.3	—	80.4	84.6
	3 or more years	9.5	—	18.6	13.5
	Never	1.2	—	1.0	1.4
Visiting behaviour	Regular check ups	76.3	—	75.0	84.5
	Only in emergencies	23.5	—	25.0	15.5
Had toothache in previous month	Yes	11.9	—	9.8	—
	No	72.3	—	90.2	—
Reported inability to afford dental care	Yes	29.3	—	—	25.8
	No	69.1	—	—	73.3

* Percentages may not equal 100 due to missing cases and/or categories.

† From CCHS, 2003 (n=134,072).

for pertinent issues (e.g., dental insurance). Federal, provincial and municipal websites were searched for documentation that defined the broad and specific bases of dental care policy (e.g., legislation, policy directives). Other primary sources included reports from major public commissions on health and social policy in Canada (1938 Royal Commission on Dominion Provincial Relations, 1964 Royal Commission on Health Services, 2002 Royal Commission on the Future of Health Care in Canada), and submissions to these commissions by the Canadian Dental Association (CDA).

Telephone interview survey

A national telephone interview survey of WP Canadians was conducted from March to September of 2007. A private firm was contracted to collect the data via computer-assisted telephone interview technology. A provincially stratified sample of 1,067 people was considered representative (for a sample with a maximum variance and standard confidence interval of $95\% \pm 3\%$, then $n = ((P)(1-P))/((C/Z)^2) = ((1.96)(0.5)/(0.03))^2$). The WP are defined as individuals aged 18 to 64 who have worked for pay a minimum of 910 hours (part-time) in the reference year, are not full-time students, and have a low family income according to the Market Basket Measure (MBM).⁵ The MBM defines a low-income person as someone whose disposable income falls below the cost of the goods and services (e.g., food, clothing, shelter) in the market basket in their community. The MBM ranges from \$22,017 to \$29,343 across Canada. With this knowledge, the private firm purchased a telephone listing of households making less than \$35,000 per year, compiled by a major retailer and containing approximately 10,000 numbers. A regionally stratified quota was set by province, and

numbers were called until the quota was satisfied. On average, 1.25 numbers were called for every person who qualified. This resulted in a final sample of 1,049 WP adults.

The telephone interview began with eligibility questions (i.e., 18 to 64 years, worked a minimum of part-time hours, not a full-time student, a family income below the MBM). Questions were asked regarding oral health and dental care (e.g., self-reported oral health status, dental insurance status) and socio-demographic characteristics (e.g., age, sex, income). Table 1 describes these variables, all of which are recognized in the literature as outcomes of dental care policy (e.g., dental insurance status, visiting behaviour), are correlates of dental care access (e.g., last dental visit, toothache in previous month), or are deemed relevant when discussing working poverty (e.g., income from self-employment, history of social assistance). Where possible, our findings were compared with Statistic Canada's 2005 Canadian Community Health Survey (CCHS), a Human Resources and Social Development Canada (HRSDC) report⁵ outlining a WP subsample from Statistic Canada's 2001 Survey of Labour and Income Dynamics, and a national public opinion survey on dental care that we conducted in 2006. Simple descriptive analyses were undertaken, and multivariate logistic regression odds ratios were calculated for variables that again are recognized as outcomes of dental care policy, are related to dental care access, or are relevant to working poverty. Table 2 describes these variables along two axes, dental insurance status and history of social assistance, both of which are considered fundamental when discussing access to dental care (i.e., insurance is the dominant predictor of dental care utilization, and social assistance provides such insurance).

Table 2. Age- and Sex-adjusted Odds Ratios for Various Outcomes, by Insurance Status, and by Reported History of Social Assistance

	WP With No Dental Insurance OR (95% CI)	WP With No History of Social Assistance OR (95% CI)
Reported oral health as poor or very poor	1.81 (1.36, 2.41)	0.45 (0.31, 0.67)
Only visits for emergencies	3.80 (2.62, 5.51)	0.53 (0.35, 0.79)
Had visited dentist within the previous year	0.29 (0.17, 0.49)	2.27 (1.31, 3.94)
Impaired dental functioning (less than 21 teeth)	1.81 (1.05, 3.11)	0.31 (0.17, 0.55)
Perceived a need for dental treatment	2.28 (1.69, 3.07)	0.41 (0.28, 0.62)
Reported inability to afford dental care	2.19 (1.60, 3.00)	0.49 (0.27, 0.59)
Gave something up to pay for dental care	2.00 (1.29, 3.10)	0.56 (0.34, 0.94)
Reported self-employment income	2.97 (2.00, 4.40)	1.30 (0.77, 2.19)
High school education or less	1.45 (1.09, 1.93)	0.54 (0.37, 0.79)

RESULTS

The development of Canadian dental care policy

In the 1870s, the Canadian father of 'public health dentistry', John Adams, opened a free dental hospital for poor children and published mass health education material.⁷ This reference contains much of what concerns dentistry in its response to social need, namely public support for the treatment of marginalized groups, in particular children, with a heavy emphasis on prevention. By 1902, the CDA was calling for the legislated coverage of children's dental examinations and the inclusion of education materials in public settings.⁷ By the Roaring Twenties, the average Canadian was spending \$25 a year on dental care.⁸ The 1920s boom gave way to the Great Depression, and with the widespread social suffering, the idea that the state should have a role in the delivery of health services gained prominence.⁹ This growth in social thinking, or social responsibility, led to the 1938 Royal Commission on Dominion Provincial Relations, which considered a potential system of national health insurance that included dentistry. In its brief, the CDA characterized dental care in terms of: "Those able to provide adequate dental services for themselves [...]. Those only able to provide partial and inadequate dental services for themselves [and] [t]hose unable to provide any dental services for themselves".¹⁰ Note the strong emphasis on individual responsibility. The profession continued to advocate for a preventive approach that focussed on children, and with this, dental care policy in Canada was essentially defined: a strong bias towards children, prevention and personal responsibility.

World War II played a strong role in establishing dentistry as a social priority, as 1 in 5 recruits were reported as unfit for enlistment due to dental disease.¹¹ Dental care gained new prominence and dental departments were incorporated into health ministries across the country.⁷ This was linked to the major social investments made after the war, which for health involved federal grants that promoted investments in government-delivered dental care.¹² Canada began adopting community water fluoridation at this time as well, and by the 1950s, had nationalized the delivery of hospital care, which included some dental care.^{13,14} Based on the plans of the 1964 Royal Commission on Health Services, the country had nationalized payment for physician services by 1968, giving rise to Medicare. Dentistry was not included, as the Commission defined dental care as a personal responsibility, and for the most part only supported dental care for children and for those receiving welfare assistance.¹⁵ Canada thus guaranteed a social minimum, but one based on age, employment and a particular conception of social need.

Concurrently, private, employment-based dental insurance was taking hold through government tax incentives for both employ-

Figure 1. Total, private, public per capita dental care expenditures, Canada, 1960-2005 (2005 dollars)

Source: National Health Expenditure Database, Canadian Institute for Health Information; National population estimates, Statistics Canada; Historical inflation rates, Bank of Canada.

Figure 2. Top two reasons for not seeking dental care by those who do not regularly visit a dentist, WP sample compared to CCHS

er and employee. The growth in the private sector was significant (Figure 1), as across many industries, employer contributions for health benefit plans increased substantially.⁸ Public investments also grew, as almost all provinces established children's and welfare programming during this period. By the 1980s, public investments had slowed, and with the impacts of two economic recessions and subsequent governmental cutbacks, public financing for dental care began a steady decline.

The experiences of the working poor

The entire sample met HRSDC criteria for WP. The majority were male, aged 35 years and over, had postsecondary educations, pre-tax incomes between \$15-30,000, were married and born in Canada (Table 1). Similar to HRSDC findings, approximately 15% of the sample had previously received social assistance, but significantly fewer reported self-employment income. Of those who reported a

history of social assistance, approximately half had accessed dental care at such time. Our sample reported significantly lower dental insurance coverage when compared to the general populations that make up the CCHS and the public opinion survey (Table 1). Yet the HRSDC sample reported much less insurance coverage. In terms of self-reported oral health status, our sample was equivalent to the general population. In terms of dental visits, our sample reported visiting more frequently when compared to the general population. Yet for those who did not visit regularly, our sample reported cost as the main barrier to accessing care, compared to not thinking the visit necessary as reported by the general population (Figure 2). Our sample also sought regular preventive care, reported a slightly higher level of toothache in the previous month, and a greater inability to afford dental care.

Logistic regression analyses demonstrate that WP persons with no dental insurance coverage were more likely to report poorer outcomes, such as worse oral health, visiting a dentist only in emergencies, having a functionally impaired dentition, and/or being unable to afford dental care (Table 2). The uninsured were also more likely to have reported self-employment income. Those with no history of social assistance also appeared to be better off, reporting a lesser likelihood of poor oral health, visiting only in emergencies, having a functionally impaired dentition, and/or being unable to afford dental care.

DISCUSSION

Canadian dental care policy has historically placed emphasis on children, social assistance recipients and the employed. In this sense, a bias has developed towards age, employment status and personal responsibility. This has resulted in a dental care system that finances care in both public and private ways. Yet with this policy approach, a significant contradiction has appeared: by using age, employment status and personal responsibility as proxies for social need, Canada recognizes that unemployment and limited incomes generally define a greater likelihood of disease and barriers to accessing dental care, and that children in particular cannot be held responsible in any regard. Nevertheless, Canadian dental care policy does not adequately assess need by its very own standards, as it does not merit those who are conceived as being responsible (because they are employed) and whose families may experience barriers to care because of limited incomes or a lack of dental insurance (public or private).

The importance of dental insurance is key. In this sample of WP Canadians, a lack of insurance was consistently associated with the worse oral health and dental care outcomes. These data also suggested that there is a strong social gradient to inequalities in oral health, meaning that those WP individuals who had never been on social assistance were consistently better off than those who had received social support.

These findings are supported by several Canadian and American studies. Guendelman et al.^{16,17} have demonstrated that for health services, the largest disparities between WP and non-poor American families concerned access to dental care. They also noted that WP families reported significantly more unmet dental care needs. In Canada, analyses by Williamson and Fast^{18,19} demonstrated that a lack of insurance had important implications for the achievement of overall health, and that participants living in WP families are generally healthier than participants living in families that have

received social assistance. These authors also argue that Canadian public policy compromises accessibility to health services for WP families.

What are the policy implications of this study's findings? Initially, it is evident that need exists in WP families. It is also clear that Canadian dental care policy needs to be reassessed on the basis of how it determines need in order to close a gap that holds important consequences for many families. Policy-makers may consider broadening the eligibility for public insurance on the basis of a more accurate understanding of the variety of employment conditions present in the country (e.g., low paid work, self-employment, increases in part-time employment with few fringe benefits), and may also consider legislation designed to improve entitlements to employee benefits.²⁰

It is important to consider the limitations of the study's findings. For example, compared to the HRSDC survey, our WP sample appears to have under-represented adults aged 25 and 44, and over-represented those between 55 and 64. The sample also under-represents women, is biased towards those who are married, and over-represents those with postsecondary educations. In effect, as a result of sampling phone numbers to collect data, we have likely captured a particular segment of Canada's WP population, namely those who have land lines. Recent Statistics Canada data demonstrate that those with the lowest incomes are more likely to opt for cellular phones.²¹ Our sample has thus likely under-represented the lower income segment of Canada's WP population. This can explain why this study observed a significantly greater level of insurance coverage when compared to the HRSDC report, and why this sample appears to be on par with the general population in terms of oral health status and dental care visiting patterns. Nonetheless, this simply implies that the situation may actually be worse than what is presented here.

In closing, this paper has informed an understanding of why Canada has certain gaps in its dental care policy. It suggests that our policy approach to dental care has important impacts on WP Canadians, in that oral health and dental care outcomes can be significantly mitigated by the presence of dental insurance. It is hoped that these data can be used to inform future discussion on investments aimed at improving access to dental care for the working poor.

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RÉSUMÉ

Contexte : Au Canada, la plupart des soins dentaires sont financés par les régimes d'assurance des employeurs; seule une petite partie de ces

soins est subventionnée par l'État pour les groupes ayant besoin d'une aide sociale. Récemment, ce faible niveau de financement public a été lié à des problèmes d'accès aux soins dentaires; l'un des groupes les plus en vue à cet égard est celui des petits salariés, qui demeurent relativement pauvres malgré leur emploi. Le cas des petits salariés fait ressortir une lacune importante dans la politique canadienne de soins dentaires, car ces personnes ne sont généralement admissibles ni à l'assurance privée, ni à celle de l'État.

Méthode : Cette étude fait appel à plusieurs méthodes, dont un rappel historique de la politique canadienne de soins dentaires et une enquête téléphonique auprès de petits salariés canadiens d'âge adulte.

Résultats : Dans ses définitions mêmes, la politique canadienne de soins dentaires reconnaît que les petits salariés ont un emploi, mais présume à tort qu'ils ont facilement accès aux régimes d'assurance fournis par les employeurs. En outre, en raison de biais historiques, cette politique ne les reconnaît pas comme des personnes ayant besoin d'une aide sociale. Selon notre enquête téléphonique, ces orientations stratégiques ont d'importantes répercussions, car la santé bucco-dentaire et les résultats des soins dentaires sont significativement mitigés en l'absence d'une assurance dentaire.

Discussion : Il faudrait revoir la détermination des besoins dans la politique canadienne de soins dentaires, afin de combler une lacune qui a des conséquences négatives pour de nombreuses familles canadiennes.

Mots clés : soins dentaires; politique publique; assurance; petits salariés

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