An environmental scan of publicly financed dental care in Canada

Carlos Quiñonez, DMD, MSc
David Locker, BDS, PhD, DSc, FCAHS
Laurel Sherret, LLB
Paul Grootendorst, PhD
Amir Azarpazhooh, DDS, MSc
Rafael Figueiredo, DDS

CDHSRU
COMMUNITY DENTAL HEALTH SERVICES RESEARCH UNIT

A report prepared on contract for the Office of the Chief Dental Officer, Health Canada

This is a report to a federal government agency and does not represent a policy statement by the federal government

Acknowledgments

This report was made possible by the efforts and cooperation of many people. Below is a listing of those that we would like to thank, and apologise in advance for anyone that was missed.

Federally

Peter Cooney, Harry Ames, Marc Plante, Laurel White, Chantal Rochon, Amanda Gillis, Lyne Chartrand, Kyle Glabb, Jocelyne Abi-Nahed, Costa Popadopoulos, Judy Lux, Brenda Leggett, Marc Noel, Patricia Main, and James Leake

British Columbia

Malcolm Williamson, Colleen Wilkins, Mano Sandhu, Jocelyn Johnston, Dorthy Rosenberg

Alberta

Steve Patterson, Lynda Cantell, Luke Schwart, Andrea Blakie, Marianne Howell, Gordon Thompson

Saskatchewan

Janet Gray, Leslie Topola, Gerry Uswak, Elsie Waddington, Brenda Taylor

Manitoba

Bernadette Mellon, Ronda Pfeiffer, Patti Moore, Robert Schroth, Carol Yakiwchuk, Ross McIntyre, Marcel Van Woensel, Joan Dawkins, Jo-Anne Kilgour

Ontario

Sandra Bennett, Geoff Kettel, Ivan Gottlieb, Hazel Stewart, Joel Rosenbloom, Aaron Burry, Joyce Sinton, Dan Otchere, Robert Hawkins, Robert Bowes, William Ryding, Dick Ito, Neil Farrel, Peter Wiebe, David Wiebe, Nancy Kennedy, Heather Murray, Dawn Sauve, Beth McIntosh, Wayne McKay, Victoria Leck, Kayla Glynn, Trina Merkel, Terry Hicks, Susan Yuskow, Marilee Koenderink, Liz McLaren, Lisa Taylor, Laurie Boston, David Klooz, Kim Casier, Charlene Plexman, Julie Lahti, Bonnie Jeffrey, Jan Herbison, Mary Helen Garsch, Sharat Doshi, Donna Clark, Donna Bowes, Anna Read, Ann Keys, Marg Bray-Holzinger, Brent Dalgleish

Québec

Bernard Laporte, Gérard Bouger, Lilianne Bertrand, Marie-Claude Giguère

New Brunswick

Suzanne Clair, Shauna Miller, Dianna Arnold, Barb Wishart

Nova Scotia

Carl Canning, Don Pamenter, Donna Samson

Prince Edward Island

Barry Maze, Brian Barrett

Newfoundland and Labrador

Bruce Bowden, Peter Hornett

Nunavut

Raouf Hammoud

The Northwest Territories

Joyce Bourne, Rick Trimp, Jim Tennant, Donna Manuel

Yukon Territory

Robert Drapeau, Paula Pasquali, Ronald Kelly, Tim Brady

Table of contents

List of Abbreviations

OCDO	Office of the Chief Dental Officer, Health Canada
FPTDD	Federal, Provincial, and Territorial Dental Directors and Consultants Working Group
HIDSA	Hospital Insurance and Diagnostic Services Act of 1957
CAP	Canada Assistance Plan of 1966
LGIC	Lieutenant Governor in Council
COPA	Canadian Oral Prophylactic Association
CHST	The Canada Health and Social Transfer Regulations of the Federal-Provincial Fiscal Arrangement Act of 1995
SUFA	Social Union Framework Agreement
NCB	National Child Health Benefit
EHB	Extended Health Benefits
AISH	Assured Income for the Severely Handicapped
ACHB	Alberta Child Health Benefit
APHA	Alberta Public Health Association
SHP	Supplementary Health Program
SHDP	Saskatchewan Health Dental Plan
CDP	Children's Dental Plan
DHEP	Dental Health Education Program
FHB	Family Health Benefits Program
SAHS	Social Allowance Health Services Program
MCDP	Manitoba Children's Dental Program
CINOT	Children In Need Of Treatment Program
DIS	Dental Indices Survey
OHS	Oral Health Screening
OW	Ontario Works
ODSP	Ontario Disability Support Program
GWA	General Welfare Assistance
MCSS	Ministry of Community and Social Services FBA – Family Benefits Allowance
RAMQ	La Régie de l'assurance maladie du Québec
MSI	Nova Scotia Medical Services Insurance Program
PEI	Prince Edward Island
CDCP	Children's Dental Care Program
NCDP	Newfoundland Children's Dental Program
CDP	Children's Dental Program
NWT	The Northwest Territories
MSB	Medical Services Branch of Health and Welfare Canada

List of Tables

List of Figures

An environmental scan of publicly financed dental care in Canada

Executive summary

- Publicly financed dental care in Canada is in a time of renewal. For example, since 2004, the federal government and five provinces have announced targeted investments in public dental care.

- This is change in the context of twenty years of decreasing expenditures and in the context of a general waning in public health dentistry nationally (e.g., the public share for dental care in Canada decreased from approximately 20% in the early 1980s to approximately 6% today; in 1990, every province and territory had a dental director or consultant, by 2006, only seven had such a position).

- This decline has been defined by the impacts of economic recession, inter-professional challenges, legislative changes, and health regionalization.

- Nonetheless, with a renewed focus, the future of publicly financed dental care appears positive in Canada. For example, over the long-term, in order to safeguard governmental interest and expertise in oral health, and in order maintain and/or expand existing programs, public health dentistry must make efforts to strengthen leadership, to develop standards for the rationing of services, and to promote its evidence base.

- A centralised vision and/or goals should be centralised and promoted by existing dental public health leadership. This should involve a primary focus on evidence in order to create a strong policy base for the public and private organisation and rationing of services.

- In this regard, efforts in surveillance, program evaluation, and analyses of administrative data will be crucial for the successful development of publicly financed dental care in Canada.

- Stakeholders should promote the inclusion of dental public health within the larger health care sector, specifically in terms of a common risk factor approach that ties dental public health to varied health and social services settings.

- Canadian society, including governments, dental professionals, and the public, must move towards a commitment that dental care is an essential service in many regards. It must also enter into a social discussion aimed at defining a social minimum in access to dental care.

Introduction

Canada is entering a time of public dental health care renewal. The establishment of the Office of the Chief Dental Officer (OCDO) at the federal level, and the financing initiatives currently coming on-line in select provinces, speak to a renewed governmental willingness to consider the question of oral health (1-5). This state of affairs extends from the now consistent, professional, public health, and social welfare calls for governmental intervention, in an environment of worsening disparities in oral health and access to dental care (6-10).

In Canada, publicly financed dental care does not often receive close public attention. For example, it held no mention in the recent Royal Commission on the Future of Health Care in Canada, although it was, in the same time period, the sole focus of a United States Surgeon General's report (11). Yet dentistry's social importance is hard to deny, as public and private expenditures for dental care compete with the top four most costly diseases in Canadian society (i.e., cardiovascular diseases, digestive and respiratory conditions, mental illness) (12, 13).

The Canadian Institute for Health Information estimates that publicly financed dental care amounts to 4.6% of total dental expenditures, down from 5.8% in 1999, decreasing steadily from an apex of roughly 20% in the early 1980s. Whereas total dental expenditures continue their increase, up from $1.3B in 1980, to $6.7B in 1999, now reaching an estimated $9B (14, 15) (see Figures 1 and 2). Decreases in the public financing of dental care are not positive for Canadian society, especially with mounting evidence linking oral disease to resource intensive and acute care based illnesses such as cardiovascular disease, diabetes, and adverse pregnancy outcomes (16-19), much less the fact that oral ill health acts as a significant burden to those socially marginalised groups that invariably suffer most of the disease and barriers to access (20).

More tangible gains are achievable as well. On the issue of wait times for example, paediatric surgeries for rampant tooth decay could potentially be avoided and cleared from busy operating room schedules. Other cost-savings are also conceivable, for example, those who cannot regularly afford dental care could be routed to treatment options that do not involve a hospital emergency room setting, a costly and inefficient endeavour for Canada's ambulatory care system. It is issues like these that require consideration as we move forward in this time of renewal. In turn, this will require an accurate understanding of what public dental health care system is in place today.

In 2003/04, such a discussion led the Federal, Provincial, and Territorial Dental Directors and Consultants Working Group (FPTDD) to call for an updating of knowledge on Canada's public dental health care programming; namely, to update 'the Stamm Report' (21). It is this task that we have undertaken.

Stamm et al. produced their report at the end of Canada's last major national social discussion on publicly financed dental care. As these authors' note:

"Canada experienced a remarkable growth in dental care programs during the 1970s. This expansion proceeded at a much greater rate than could have been foreseen in the 1960s. A number of expected problems accompanied the rapid growth, including vague goal-setting, hurried planning, uncertainty about probable expenditures, and inadequate record-keeping. These problems, combined with the diversity of dental care programs, have resulted in confusion about the present status of the programs. More succinctly, […] as dental care program growth began to abate in the early 1980s, it seems timely to take stock of what now exists in the field" (21, p. 1).

Since Stamm et al.'s time, public dental care programs have continued to abate (see Figure 2), and it is now once again time to take stock of what exists. So by way of introduction to the Stamm Report, and to the details of theirs and our efforts, we now very briefly review the social epidemiology of dental disease in Canada, and the public system that has developed in response.

The social epidemiology of dental disease and its treatment in Canada

Stamm et al. began their efforts in 1983, just past the height of public financing for dental care (see Figure 2). From such a vantage point, the broad acceptance of municipal water fluoridation, and then population estimates of dental care utilisation reaching 50%, only supported the idea that historical decreases in dental caries (the major and most document of dental diseases) would continue. For example, historical data demonstrates that the number of caries free children in Toronto had considerably increased up to the time of the Stamm Report (22, 23) (see Figure 3), trends that to some extent continue into today (23, 24).

Yet such a dynamic was, and is, not evenly distributed in Canadian society (20, 25). Today, it is evident that dental disease concentrates at the social margin, and that disparity in accessing care persists (26, 27) (see Figures 4 and 5). It is this social epidemiology that contextualised Stamm et al.'s descriptions of programming.

Stamm et al. described a public system that had developed to provide prevention and treatment services to those most at most risk and/or those with no regular access to dental care. Early on, in terms of public financing, both the National Health Grants program of 1948 and the Hospital Insurance and Diagnostic Services Act (HIDSA) of 1957 had promoted the universal coverage of dental services delivered in-hospital, something that was not in common practice until the 1970s (21, 28). Yet the Medical Care Insurance Act of 1967, the legislation that essentially structured Canada's health care system, did not capture dentistry. Such services were instead socially insured in a targeted fashion through the Canada Assistance Plan (CAP) of 1966 (21), which made funds available to provinces for the financing of supplementary health benefits to social assistance recipients. The provinces themselves had actually been developing their own specific financing and delivery mechanisms for at risk groups (in particular children) since the 1950s, some even as early as the 1920s (28), but all made their most significant gains in

response to recommendations made by the Royal Commission on Health Services, 1961-1964.

So for dentistry, the individual became publicly insured (in some cases) if care was received in-hospital, or if belonging to a particular institutionalised and/or at risk group (e.g., children, those holding a state-recognised indigenous status, the Military, inmates, social assistance recipients and their dependents, refugees, some seniors and/or those with developmental disabilities) (21) (see Tables 1 and 2). Care itself can be received in public spaces (i.e., institutional and community clinics with salaried providers), but is predominantly delivered in private spaces (i.e., private dental practices using a form of public third-party financing). Canada's public dental health care system is a complex one, intersected by different jurisdictional, professional, and social interests, yet all now agree that this system has suffered since the time of Stamm et al.'s report.

The Stamm Report noted that changes in government held particular impacts for public programming, specifically as the former responded to private professional challenges against public care and to the larger economic insecurities of the time (21, p. 1, 30, 35, 60, 68). Fully in agreement with Stamm et al., we will note how inter-professional challenges and larger economic insecurity continued their effects, and will additionally document how the movement towards health regionalisation in Canada played a role in degrading the public dental health care system.

In this regard, this report will describe the historical development of Canada's public dental health care system, focussing on the events of the last twenty years. This is done as a national 'environmental scan,' describing provincial and territorial programming, legislation, public financing trends, and changes to what a low-income household has had to spend on dental care over time. Ideally, this report is a step in the building of renewed interest in public health dentistry, and in providing an early knowledge base for any potential reform. Ultimately, we aim to improve the care delivered to socially marginalised groups.

Methods

The Stamm Report produced a consideration of: 1. Federal direct and indirect service delivery activities; 2. Provincial and territorial surgical-dental programming delivered under authority of the Medical Care Insurance Act (now the Canada Health Act) and provincial and territorial medical care legislation; 3. Provincial and territorial public programming, variously legislated and largely aimed at children; 4. Provincial and territorial public programming for social assistance recipients as per CAP and provincial and territorial social assistance legislation; and 5. Group dental plans within the private sector.

Relative to FPTDD information needs, our environmental scan will only consider provincial and territorial programming, excluding federal and private sector efforts. Further, like Stamm et al., we largely exclude any detailed consideration of municipalities and individual health region/unit efforts, as well as the work of provincial and territorial correctional facilities. Within these broad limits, every Provincial and Territorial Health Minister, and every member of the FPTDD were formally informed of our efforts (see Appendix 1).

After a brief review of previously collected documentation on public dental programming in Canada, a survey instrument was created. It was reviewed by the OCDO, then translated into French, and sent to FPTDD members as a form-fillable .pdf document (see Appendix 2). We received 7 out of the 13 sent, but have acquired the majority of the information queried through contact with numerous provincial and territorial stakeholders.

To further determine public dental program components and expenditures, a review of electronically available governmental and non-governmental documentation was conducted (i.e., legislation, regulations, policy directives, ministry and departmental annual reports, budgetary papers, public accounts, program brochures, news releases, Hansards, scholarly publications, professional and non-professional institutional reports, journalistic accounts). A census of the complete series of the Canadian Society for Public Health Dentistry Journal, and its successor, the Canadian Journal of Community Dentistry, was also conducted.

Due to the complexity of the public dental health care environment, alternate routes of accessing information were also attempted. For example, persons listed in government directories that would arguably be connected to dental public health programming were contacted, and this led to a moderate level of success in tracking and collecting data.

Programming tables

Using the data collected through the process described above, public dental programming tables were created for each province and territory. Importantly, since “provincial and territorial dental care programs are difficult to describe in a concise and systematic

fashion [and represent] an extremely difficult area of study" (21, p. i), we decided to continue Stamm et al.'s typology for describing such programming. This allows for a certain level of systematisation and comparability. Thus programming is described in terms of program eligibility, the types of services covered, utilisation, service environments, administration, and expenditures (see Tables 7 as an example).

Moreover, due to the scant historical information available, we decided to abstract, in a tabular format (again using Stamm et al.'s typology), programming information from two of the three interim attempts to update knowledge in this regard (29-32). In this sense, we build a cross-sectional narrative of the development of public programming over the last twenty years.

Expenditure trends

Using the Canadian Institute for Health Information data on health expenditures, and historical population estimates from Statistics Canada, we plotted per capita publicly financed dental care expenditures from 1975-2005 (constant dollars). To extend this timeline backwards into the 1960s, we used estimates available within the dental literature (15).

Describing expenditure trends is a useful but dubious analytical task, as they can give us a sense of the social events of the time (specifically as they are represented in governmental outlays for public dental care), yet cannot provide the bases for strong conclusions. For example, there is no way to disaggregate purely preventive expenditures from treatment ones, much less tease out which level of government is making the expenditure, to whom, and in whose regard. The Canadian Institute for Health Information explains that their expenditure data consists of 'health care spending by governments and governmental agencies, sub-divided into four levels: 1. Provincial government sector, including health spending from provincial/territorial government funds, federal health transfers to the provinces/territories, and provincial government health transfers to municipal governments; 2. Federal direct sector, referring to direct health care spending by the federal government in relation to health care services for special groups such as Aboriginal peoples, the Armed Forces and Veterans, as well as expenditures for health research, health promotion and health protection, excluding federal health transfers to the provinces; 3. Municipal government sector, including health care spending by municipal governments for institutional services, public health, capital construction and equipment, and dental services provided by municipalities in the provinces of Nova Scotia, Manitoba and British Columbia, and excluding funds transferred by provincial governments to the municipal sector; and 4. Social security funds, meaning social insurance programs controlled by government authority, involving compulsory contributions by employees and employers for the purposes of workers' compensation boards' (14).

While this means that trends are non-specific, capturing a wide range of public dental health care expenditures (some of which we do not consider), they arguably still represent

a material outcome of the social events impacting such care over time. So again, while somewhat unspecific, these expenditures provide the most direct analytical access to the events of the last twenty years.

Engel curves

We are not only interested in what governments have spent, but also in what impacts programming changes have had on users of the public dental health care system. In this regard, using Statistics Canada's Survey of Family Expenditures (1969-1997) and its successor the Survey of Household Spending (1997-2003), we have undertaken the semi-parametric estimation of the household budgetary share for dental care from 1969 to 2003 (i.e., Engel curves). These curves plot the amount of money that a family has had to take out of its pocket to pay for dental care over time. While the econometric details are not relevant here, it is important to note that these curves relate the dental share of the household budget to the size of such a budget (standardised to 1992 dollars), holding constant the influence of household size and household head age, sex and marital status.

So for different income categories, changes in the household budgetary share for dental care can be seen as an approximation of both the impacts of financing, whether private or public, and of changes in user preferences. Here, we argue that changes to the household budgetary share for dental care in low-income families is highly driven by what services are being publicly financed at any given time, once again providing another descriptive and analytical window into the events of the last 20 years.

Legislative tables

In an effort to provide as much valuable information as possible, we describe the essential provisions in provincial and territorial legislation relating to the public financing of dental care. The material presented is the result of extensive searching of provincial and territorial legislation. Both the provincial and territorial legislative databases were utilised, as well as the comprehensive Canadian Legal Information Institute service (available online at www.canlii.org).

The legislative sources referenced are those that have incorporated the most recent amendments available. The result is that cited sources are not 'official' but rather are the 'unofficial' versions. These versions are the most readily available and understandable for members of the public and thus, for the purposes of this report, the most preferential. They are not to be cited for the purposes of interpretation and application of the law; for this, one should consult the bound sessional and annual volumes, as well as the regulations published in governmental Gazettes. Further, only legislation currently in force is included, with any repealed or prospective acts being excluded for the sake of clarity.

For those unfamiliar with legislative structure, a brief explanation follows. The first column (see Table 13 as an example) lists statutes first, recognised by the word 'Act,' followed by their associated regulations. Statutes begin as bills and are ultimately passed by the legislative assembly of the province or territory, usually coming into force on proclamation in the provinces by the Lieutenant Governor in Council (LGIC) or commissioner in the territories. Regulations on the other hand are a form of subordinate legislation, enacted by bodies to which legislative powers have been delegated by legislatures. They carry the same legal weight as statutes. Their enactment is done pursuant to an enabling clause found in the 'parent' statute. Procedures vary between the provinces and territories, but typically jurisdictions will have some variation of a Regulations Act, which specifies the appropriate method for enacting regulations. Regulations can be contrasted with directives, which include such items as policy manuals, guidelines, circulars and the like. These are non-legislative administrative documents and guide the activities and practices of civil servants (a point that will become key when providing analyses of the reviewed legislation for public dental care programming).

These tables, like the programming tables, are organised by province and territory. Again, in the first column, one finds the relevant statutes and regulations. Statutes are listed first and any associated regulations follow immediately below. The statutes and regulations are grouped according to the minister whose jurisdiction they fall under (noted in the fourth column). The second column, outlining intended beneficiaries, notes the populations targeted by the legislation, either explicitly or by implication. In some cases, the statute fully defines the intended beneficiaries, but for the most part, the regulations contain the detailed specifications of eligibility and related criteria.

The third column lists relevant provisions of the statutes and regulations. For many statutes, the only relevant provision will be the enabling clause as the legislature relies on the delegated authority to flesh out the substance of the legislation in the regulation(s). This is not uncommon, as legislatures will often defer to ministries (where the substance of most regulations are developed). The relevant provisions typically include definitions, describing the benefits conferred, and their availability and limitations. Some regulations refer to cost tariffs and agreements established by the appropriate ministerial authorities, which may appear as schedules in the regulations themselves or as separate documents.

The fourth and final column lists the minister responsible for the legislation and any provincial or territorial programs associated with the legislation. A caveat to be noted here is that not all programs administered by the provinces or territories derive their mandates from specific legislation. Programs may be entirely policy-based, relying on the non-legislative directives referred to above. Moreover, even when programs do derive their mandates from legislation, the detail and implementation of such programs is rarely spelled out in the legislation.

The limits of the study

This study faced significant limits in regards to collecting and analysing public dental care program data. Stamm et al. report a similar experience:

"The first [limitation] involves the question of accuracy. […] Programs that were more prevention-oriented […] were not able to provide the same high quality data as were the treatment oriented programs. [...] The second data limitation is a lack of completeness. Some programs simply do not collect or make available data that are necessary for either descriptive or analytical purposes. […] Aggregation of data presents a third limitation" (21, p. 3).

We encountered these challenges, and considering the general agreement among stakeholders of a diminished and fractionated public dental health care system, we would argue that such challenges have only exacerbated. For example, in his attempt to update knowledge on programming in the 1990s, O'Keefe states:

"A number of difficulties prevented the completion of this project within a reasonable period of time. Some provinces no longer have a dental consultant. The position is either vacant or the incumbent is not an oral health care professional. Public sector organisations all across Canada are undergoing change and shrinkage at present. Dental consultants at ministry level have larger workloads and tend to have less support staff than in former years" (30, p. 16).

In effect, there now appears difficulty in reporting efforts, especially preventive ones, as they are often captured in larger more general public heath expenditures and descriptions (especially with the general introduction of global budgeting across Canada). This means that they do not readily appear in ministry and departmental annual reports, budgetary papers, or public accounts.

Then there are those systems in which a private third-party administers claims processing for publicly financed treatment, necessitating another layer of process and negotiation to access data. Early on, we did attempt to negotiate access to any available dental health services data, whether held by governments or a third-party. Yet in the two instances where it was received, it was of such little detail, that it did not add anything substantive to this presentation.

Here too, there must be a consideration of what 'public'' and 'private' actually mean. As described, public services can either exist in public or private places, meaning public clinics with salaried dental and allied dental health providers delivering prevention and treatment services, or private practices using different forms of public third-party financing. There also exist situations in which private practitioners use public infrastructure to deliver services either through contract (i.e., per diems) or billing fee-for-service, or where public institutions such as dental faculties access public third-party financing, either in public clinics or in association with non-governmental organisations and their infrastructure.

Importantly then, public dental health care in Canada now includes a growing not-for-profit sector, here represented in the work of dental faculties and non-governmental service organisations. Again, due to resource constraints, we were not able to include a thorough consideration of such organisations and their increasing importance in the dental public health environment.

Noteworthy as well is that in each jurisdiction, from province to territory to municipality, there is a different way of discussing the services provided through programming. This extends to the categorisation practices used to define beneficiaries, and to the way services are described. As such, in many instances, it is each jurisdiction's descriptive language that is used in programming tables, unless a general descriptive statement is more efficient. From a methodological point of view, this is an inevitable outcome of abstracting information from numerous documents and compiling them into the clearest presentation possible. Further, when reproducing data from the Stamm Report, the last year reported is noted, that being 1981/82 or 1982/83, with costs being nominal (see expenditure trends to gauge a relative value).

To reiterate, this report does not constitute a review of federal efforts, nor of any one provincial or territorial dental public health care system. It does not include a consideration of any community water fluoridation effort, another important segment of provincial and territorial systems, nor do we consider those services provided by provincial and territorial correctional services, academic institutions, or non-governmental organisations. Moreover, to provide a complete analysis of public services (in addition to the former institutions), an examination of policy manuals and public fee guides is required, and that of any dental health services data available; something that again lies well beyond an environmental scan.

Ultimately, all numbers reported (other than those referenced) should be considered estimates. There are also instances when data is incomplete, and these are noted. It is really no surprise then, that twenty years ago, Stamm et al.'s second central recommendation was to develop "data gathering systems that meet at least a limited set of minimal information criteria" (21, p. 125).

Canada

The father of public health dentistry in Canada is John C.G. Adams of Toronto (33, 34). Adams was one of four brothers, all dentists, and founded a "free dental hospital for poor children, naming it Christ's Dental Education Institute" (33, p. 95). He published 'School Children's Teeth: Their Universally Unhealthy and Neglected Condition' and mass health education material. He kept his hospital running for upwards of 20 years, and became an advocate of "preclud[ing] the need for artificial dentures by preventing diseases of the teeth among children" (33, p. 94-95). The relevance of this detail is that it contains much, if not all, of what concerns dentistry in its response to social need into today. This being, public support for the treatment of marginalised groups, in particular children, with a heavy emphasis on prevention, and a public context for hospital care.

Several key things can also be said about Canadian dentistry by the mid 19th century. Most if not all dentists practiced as they do today for example, namely as a health practitioner in a private setting, running a sole-proprietorship fee-for-service private practice, with costs to be paid directly by the patient or a third party (33, 34). Individual freedoms are generally observed as holding primacy, with little or no expectation for governmental involvement (35). Nonetheless, leaders such as John Adams made matters of health education and personal health behaviours an explicit concern, arguably more so than any other health profession of the time (33-37).

In this regard, dentistry was part of the burgeoning social idea that the state had responsibilities over an individual's health, and involved itself in the large public health movements of the late 19th and early 20th century. These movements concentrated on children, on hygiene, and on partnerships between 'friendly societies' and the profession (38). At the 1906 Canadian Dental Association meeting for example, resolutions were adopted calling for the legislation of periodic dental examinations for children, and the inclusion of educational materials at schools and military camps (33). On the east coast, the Halifax Visiting Dispensary Society, a reduced cost and/or free care clinic, was supported by philanthropy and a grant from the provincial government. The Dispensary represents the earliest Canadian example of a state supported dental service through a non-governmental organisation (33, 39). Further, the then active Canadian Oral Prophylactic Association (COPA), another non-profit organisation created by dentists to conduct research on "an acceptable dentifrice and toothbrush which dentists could recommend with impunity" (33, p. 131), presents clear evidence that public health links to the social and leadership core of the profession (34).

The inter-war years were important for public health dentistry. The activities of COPA led to the Canadian Dental Hygiene Council for example, another non-profit organised "[t]o prevent, reduce or assist in the control of dental disease, thus establishing a higher standard of public health" (33, p. 175). The Council led large public education campaigns, successfully promoting partnerships between provincial governments and the Red Cross and other lay organisations. In some areas, these campaigns led to travelling clinics that serviced rural areas; in Ontario for example, railway cars were used, and by Stamm et al.'s time, mobile homes were in operation.

Major efforts were also underway in the US. The American profession and allied groups specifically targeted child nutrition and oral heath, undertaking a successful lobby for school dental education programs, and for the infrastructure to clinically treat children in the school setting (37). It is reported that the Halifax Visiting Dispensing Society was itself replaced by school dental clinics in this time (33). Archival evidence also demonstrates collaboration between dentists and the Junior League in Montreal, another friendly society whose focus was to improve child health, nutrition and literacy (40). In fact, most urban Canadian centres had some form of government provision for children by the 1940s (28, 33, 41).

The rise of the Canadian welfare state marks the beginning of major investments in publicly financed dental care across the country. For example, the federal National Health Grants program of 1948 promoted hospital and community dental care (28), and by 1959, all ten provincial health ministries had dental divisions (33) (see Table 3). In 1957, HIDSA then insured some dental care in hospital (33, 41). While hospital accredited programs were only available in select provinces at this time (28, 33, 41), they would be established across the country by the mid 1970s (21).

Another significant step occurred in 1964 with the Royal Commission on Health Services. This commission established the modern face of Canadian health care, and through the Medical Care Insurance Act of 1967, added physician services to already insured hospital care. The dental profession made a total of 23 recommendations to the Commission, calling for the mandatory fluoridation of water supplies, increases to public education, dental education and research, and the funding of treatment benefits for beneficiaries of public assistance programs (28). The latter is particularly relevant as governments did follow over time, using the CAP of 1966 to expand dentistry's initial public mandate from children to include adults at the social margin. In the end, the Commission's recommendations largely reflected professional advice, and did not define dentistry as a universally essential service. Yet the Commission did extend beyond the profession by promoting the use of clinically trained dental auxiliary to treat children. This materialised into the dental nurse of Manitoba and the dental therapist of Saskatchewan and federal authority.

Also extending from the Commission was strong support for the training and advancement of dental public health as a specialty (28, 33). Such social activity is well represented in articles published mid decade in the Canadian Journal of Public Health (42-47). In turn, the federal government and Canadian Dental Association commissioned three studies to gauge the development of dental public health across the country (41, 48, 49). The second of the series, 'A survey of dental public health within the dental profession and within public health agencies including those of government,' gives a sense of public health dentistry at the time:

"Dental Public Health as an organized activity has experienced [an] irregular growth [...]. [I]t would be fair to describe the general attitude of the profession [and] that of most

official[s] [...] as one of almost apathy. Dental public health needs able recruits and attracts few" (41 p. ii).

Yet concurrently, the first in the series, 'What is the nature of dental public health – its objective?' states this:

"Dentistry by 1950 was well regarded as a therapeutic profession, concerned chiefly with individual patients in a limited socio-economic bracket. Almost suddenly [...] it had become a public health profession with responsibilities extending beyond the individual to the community [...]. By the early 1960s, a growing number of dentists, including those at the administrative level of the profession, were becoming aware of a need for defined public health policies" (48, p. iv).

Whatever the case, these reports confirm that all provincial professional organisations had pubic health committees before 1950, some as early as 1906. Many professional associations noted involvement in organising care for isolated areas. All government dental divisions were named differently, placed in different institutional contexts and created through numerous mechanisms, everything from Orders in Council to establishment in budgets and public health acts. Few if any dental hygienists were employed when departments started, just clinical dentists, administrators, dental assistants and clerk-type staff, but became hired and given bursaries for training as public infrastructure developed. In short, there existed then, as now, much variation in the activities of governments regarding dental public health.

Publicly financed dental care then came to full fruition in the 1970s. Apart from Newfoundland's Children Dental Program, which began in 1950 (21), most provinces established a firm level of programming for children and for social assistance recipients at this time, directly hiring practitioners on salary, and/or financing delivery in private practice. To be sure, expenditures would increase by a factor of 129 times (see Figure 2).

Some provinces, such as Quebec and British Columbia, concentrated almost entirely on public third party financing (21). While Saskatchewan and Manitoba, for example, established expansive direct delivery dental therapy and dental nursing programs respectively. The federal government also invested in dental therapy, and in relation to such activity, formalised a strong role for dental education in service delivery to marginalised groups. Across the country, dental faculties began working more closely and regularly with federal authority, specifically in relation to under-serviced indigenous areas. To be sure, if the 1950s are considered the Golden Age of Dentistry (21, 35), the 1970s represent the Golden Age of Public Health Dentistry. Yet things would rapidly change (see Figure 2).

It is here where Stamm et al. took their snapshot of provincial and territorial public dental care programs. As these authors note:

"[L]ike most developed countries, Canada has undergone a period of economic difficulty in recent years. As a result, governments […] began to look for areas where greater

economic restraint could be exercised. Considerable pressures have been placed on health care programs because they represent relatively large expenditures […]. Dental care programs have not gone unscathed, and the outlook for them in the future appears uncertain" (21, p. 1).

So in the context of economic recession, across the country, restraint became the order of the day (see Figure 2). Many further note that when coupled to strong professional challenges, public dental care programming became an easy target:

"According to [the] Executive Director of the […] Dental Health Plan, 'Just because you're paranoid, doesn't mean they're not out to get you.' [He] is right. They are out to get us. Dental public health programs are luxuries to politicians and nuisances to fee-for-service dentists. Our programs are the last to expand when the budgets rise and the first to be cut when they fall" (50, p. 3).

The situation did not improve either, as another recession in the early 1990s continued to promote government restraint. Strong centralised measures were often taken, and cuts were made to the major social funding connecting federal, provincial/territorial, and municipal governments (see Figures 6-9). The impacts on public expenditures are evident (see Figure 2). More specifically, the changes in the mid 1990's link to the establishment of a new federal transfer initiative, the Canada Health and Social Transfer Regulations of the Federal-Provincial Fiscal Arrangement Act of 1995 (CHST). This legislation replaced the CAP, and its impacts will be evident in every province and territory described in this report.

More recently, federal authority has responded with the injection of targeted funding in relation to the Social Union Framework Agreement (SUFA). Other than Quebec, SUFA was signed in 1999 partly in response to the cuts associated with CHST. This has led to the National Child Health Benefit (NCB) for example, which has been used in several provinces to finance children's dental care. Nonetheless, compared to Stamm et al.'s time, Canada's public dental health care system is now much reduced.

This is evident when considering the significant drop in dental public health human resources. In early 1987 for example, we conservatively estimate that there were 1500 public dental health care staff across the country. Today, there are approximately 1100 (51) (see Table 4). The dental public health specialist to population ratio is also indicative. It stood at 1 per 491,971 in 1988. Today, it is an estimated 1 per 1,200,000. To be sure, in 1990, all 13 provinces and territories employed a dental director or consultant. Today, only 7 have such positions (see Figure 10).

In this regard, it is the general opinion that centralised dental public health leadership is required for a strong public dental health care system. It is no surprise then to hear stakeholders speak of de-centralisation, or the movement towards health regionalisation in Canada, as important in the decline of public health dentistry. While there is no consensus definition on what regionalisation means, it is generally characterised by four things: 1. Recognising a region as a health service delivery unit; 2. Devolving centralised

authority to such regions; 3. Regionally consolidating authority previously distributed among programs and communities; and 4. Regions are responsible for a considerable range of health services (52). Table 3 documents when regionalisation began for each province, when restructuring has occurred since its inception, and when centralised public dental care planning appears to have been reduced or removed from provincial activity. It is important to note that Ontario has not implemented regional health authorities. Nonetheless, it is involved in devolving power and restructuring the organisation of service delivery, and still part of common provincial responses to current health care challenges. Ultimately, across Canada, it is argued that regionalisation allowed provincial governments the ability to offload costs through the devolvement of authority, while regional consolidation allowed newly formed regions the ability to make cut backs in an effort to survive the centralised retrenchment. Consequently, provincial and municipal dental directors and consultant positions could be reduced, and the programs that they led cut back.

Another oft-discussed issue in the decline of public health dentistry is the notion of inter-professional challenges. The Stamm Report notes it in several instances (21, p. 30, 35, 60, 68), and most would agree that early on, major investments in public programming were not met with enthusiasm by the dental profession. Most would also agree that such challenges continued well after the Stamm Report. In British Columbia, Alberta, Ontario and Quebec for example, provincial dental associations led strong efforts to limit the use of dental therapists, essentially isolating the practice within federal jurisdiction (53, 54). Most also recall Saskatchewan and Manitoba's charged interactions, which ultimately led to the closing of what remain as North America's largest efforts in the direct public delivery of dental care.

More recently, unanticipated inter-professional challenges have also developed. For example, in Saskatchewan, the derogation of dental therapy is now partially replaced with an understanding of the benefits of the allied dental health care provider. Once the province's dental therapy program closed, dental therapists sought opportunities within the private sector, and in time, private practitioners hired them, coming to appreciate their skills with children. While this is a positive development for the professions of dentistry and dental therapy, it nevertheless points to the newer challenges faced by governmental stakeholders when considering how to address issues of access.

Another unanticipated development is the recent role of organised dentistry in promoting a public focus on dental care. For instance, the national profession have enhanced their lobby in the nation's capital and have been instrumental in promoting the importance of oral health in Canada's health care system. They also played a key role in the establishment of the OCDO. Moreover, in some provinces, dental organisations have been successful in promoting the expansion of publicly financed services and their funding envelopes (2-5).

In this regard, it is also necessary to consider the professional advance of dental hygiene (55). Dental hygiene numbers have increased substantially over time: in 1961, there were a total of 74 hygienists in the country (compared to 5,780 dentists), and by 1999, the

number had risen to 14,525 (compared to 16,899 dentists) (13, 15). Such growth has resulted in expanding training opportunities, some specifically focussed on the public dental health care environment. For example, In British Columbia there is special certification for residential care; in Saskatchewan, Alberta, and Yukon Territory, there is special certification to deliver local anaesthesia; and in Newfoundland and Labrador, Nova Scotia, Ontario, and Saskatchewan, dental hygienists can deliver some restorative care (56). As a result, this allied dental health provider has risen in the public dental health care environment, and many dental hygienists now act as managers and dental public health leaders (51). Dental hygiene has also organised on a national and provincial bases, in turn creating a very focused lobby. So in addition to dental professional efforts, dental hygiene is now another key player in promoting publicly financed dental care on the national agenda, and they too were instrumental in the establishment of the OCDO. More recently, Ontario, Alberta, and Nova Scotia have changed legislation to allow dental hygienists the ability to provide their services independently. This has in turn added another dimension to the debates concerning how to best improve access to dental care in Canada.

Before turning to each individual province and territory, it is a good idea to compare jurisdictional efforts in public financing (see Figure 11). While each of these expenditure trends will be dealt with individually, it is important to note their general volatility. Again, all will respond in some regard to the aforementioned themes: the recessions of the 1980s and 1990s, regionalisation, the CHST, the NCB, and inter-professional challenges.

A very brief comparison with federal efforts is warranted here as well. For example, federal authority predominantly concentrates on indigenous care, with such investments constituting 77% of all federally financed dental health care expenditures, a figure which itself is close to a third of all publicly financed dental health care expenditures in Canada (see Tables 5 and 6). These efforts substantially interlock with territorial activity (see Figure 12), and in some instances with provincial activity, inasmuch as a large percentage of Canada's indigenous populations reside in the provinces. In this way, debates surrounding federal care have formed a strong basis for debates concerning Canada's public dental health care system (7, 10). To be sure, when adding the other areas of federal activity, the latter constitute close to 40% of all publicly financed dental health care expenditures in Canada (see Table 5 and 6).

Ultimately, it is important to assess the impacts of public health dentistry's decline on the users of Canada's public dental health care system. So in terms of the household budgetary share for dental care, or what a low-income family has had to take out of its pocket to pay for dental care, Figure 13 demonstrates how low-income users have responded to changes in public financing. From 1969 to 1982 for example, a considerable drop is evident in the household budgetary share for dental care in low-income households. This is arguably due to the significant injections of public funds within the period (see Figure 2). Yet from 1982 to 2003, the budgetary share has increased steadily, again likely in response to the general trend downwards in public financing. This suggests that for low-income Canadians, accessing dental care has become more difficult

over the last twenty years, corroborating recent social discussion on the issue. In the end, it is this concern that has promoted renewal in public health dentistry, and it is to the development of this renewal that we now turn.

British Columbia

British Columbia began a provincial dental division in 1949 (33) (see Table 3). Stamm et al. report that as far back as 1958, the division was preparing plans for a children's dental treatment program (21, p. 30). By this time, similar to most provincial jurisdictions, hospital and community based services were established in large municipal centres, with children's services composing the largest portion of programming. Rapid increases in expenditures soon followed, again largely due to CAP investments and as per targeted children's programming. In British Columbia, increases extend to 1975 then level off, followed by tremendous gains and falls at the turn of the decade (see Figure 14).

Stamm et al. report that British Columbia's dental programming was a major tipping point in two provincial elections, with early programming cancelled in 1975, yet reinstated by the end of the decade (21, p. 30-32) (see Table 7). In this regard, the province's dental program is the shortest-lived provincial-level dental treatment program, running for approximately 20 months in 1981/82. It brought together human resource clients, recipients of premium assistance (in British Columbia, premiums are paid for the province's health insurance plan, the Medical Services Plan), senior citizens, and children up to 14 years of age. The program was legislated under the Medical Services Act, and administered by the Medical Services Commission, who also administered the Medical Services Plan (see Table 13). Once disbanded, programming returned to what had been in place previously, meaning services for human resource clients and recipients of premium assistance. Whatever the case, governmental investments from 1969 to 1982 were positive in terms of what a low-income family had to take out of its pocket to pay for dental care (see Figure 15).

Post Stamm et al.'s description, the Canadian Society for Public Health Dentistry Journal and its successor the Canadian Journal of Community Dentistry report a variety of programming components:

- School program, with dental hygiene and assistants conducting screening and referral, with treatment clinics in the province's two major urban centres, Vancouver and Victoria
- Perinatal program in specific areas
- Dental education, identified through screening and referral
- Dental extern (reduced from 13 to 3 in 1982)
- Cleft palate program
- University of British Columbia summer dental clinic funded through the children's Ministry;
- Five hospital residents
- Funding of equipment in two small hospitals, linked to a private practitioner, and to a hospital partnered with the United Church who provided funding for three dentists
- Private professional investments in mass dental education and in the form of a committee for institutionalised care and for an adult dental health survey conducted in private offices

The recession at the turn 1990s then impacted programming across Canada, and in British Columbia, financing for social services and public dental care reached historical lows (see Figures 14 and 16). Here too, there was an impact on low-income households, with the budgetary share for dental care increasing to historical heights by 1992 (see Figure 15). Public outlays then began to climb, with a reported increase in dental treatment expenditures from $24.2M in 1991 to $36.3M by 1995 (57). Yet by this time, while programming looked similar to previous descriptions, it had arguably lessened (29, 31, 32) (see Tables 8 and 9).

Cuts in federal transfers were also beginning to play their role, as the CHST led to new funding lows by 1999 (see Figures 14 and 16). In 1996 however, the province introduced the Healthy Kids program, attempting to make more services available to low income children, with responsibilities falling under the Ministry of Families and Children (57). Importantly, the low-income budgetary share for dental care was actually down by 1998, arguably reflecting the introduction of this program (see Figure 15). Healthy Kids also captured the rebounds in financing observed at the turn of the 21st century (see Figure 14), and was largely infused with new funding dollars made available under SUFA and the NCB.

As described, in 1999, the First Ministers (except the Premier of Québec) signed SUFA in an effort to renew Canadian social policy. In this regard, SUFA promoted British Columbia to implement policy for such things as public health nursing, nutrition and dental services (58). By 2001 for example, on top of the treatment services delivered in private practice through Health Kids, 45,000 preventive dental health services were being delivered to children 0 to 6 years through the province's regional network of dental hygienists (58) (see Table 10).

In 2002 however, according to the Ministry of Children and Family Development, the percentage of kindergarteners never experiencing dental caries was decreasing, from 66.8% in 1995, to 61.2% in 2000, falling short of the ministry's goal of 70% (59). In this regard, in terms of oral health outcome and service data, detailing programs is difficult, as very little information was made available to the researchers. Yet some data has been reported for the Medical Services Plan, essentially covering those services delivered in-hospital (see Table 11) (60).

Table 11 demonstrates a one-time lump sum retroactive payment to the dental specialties for 2001/02, largely for oral surgery (60). This is an outcome of debates concerning whether facility fees should be paid for dental surgeries requiring general anaesthesia when conducted in private clinics. The pressure to pay for such fees has increased in the face of evidence for Status Indian children, which demonstrates a rate of hospitalisation for dental procedures 4 times that of other British Columbia children (61) (see Figure 17). As an area of mutual concern for municipal, provincial, federal, and indigenous authority, these debates link publicly financed dental care to issues of operating room wait-times, the organisation of treatment services in-hospital and in the community, and the need for prevention. It also stresses the need for an appropriate public response to professional calls for parity between public and private remuneration and payment processes. Such are

the tensions in the face of declining public funds since 2001 (see Figure 14), and a low-income household budgetary share for dental care that had increased by 2003 (see Figure 15).

At present, the province's regional network of dental hygienist and assistant delivered preventive public dental services cost approximately $3.5M per year (see Table 10). This includes early childhood caries prevention, and identification of high-risk individuals for referral and treatment, in daycares, schools, long-term care facilities, and some state-run facilities (62-64). There are 59.7 full time equivalent (FTE) positions in dental public health across the province, 58.1 FTEs allotted to dental hygienists and assistants. British Columbia has one certified dental public health specialist working as the provincial Dental Consultant under the Medical Services Branch, Medical Services Division, of the Ministry of Health. There is also a clinical dentist (at 0.6 FTE) working for the Vancouver Coastal Health Authority in the Vancouver municipality (See Table 4).

More recently, British Columbia has experienced some positive renewal in public dental care programming. The provincial government recently announced new clinical and preventive dollars, and plans to invest over $47M in three years to improve access to care (2, 65). Apart from its bulk, which constitutes increases in fees for private practitioners, dollars will flow to the University of British Columbia for their outreach efforts and to hospital care for particular child populations. There will also be $1.5M over three years for a public education campaign run in partnership with the British Columbia Dental Association, $3M over three years to enhance community dental public health services by increasing dental hygienists and assistant positions, and $4M over three years to enhance coordination and technical support for such services.

British Columbia also presents the important and increasingly valued role of non-governmental organisations in the delivery of care to populations of public health concern. For example, the University of British Columbia's dental faculty has recently expanded its outreach programming, servicing at-risk children, adult, and elderly populations, in partnership with such organisations as the Tzu Chi Buddhist Compassion Relief Foundation, the St. Vincent's Foundation, the Portland Hotel Society, and the Skidegate Band Council (66, 67). A treatment clinic has also been funded in part through The Vancouver Agreement, a tri-partite agreement between the City of Vancouver and the provincial and federal governments (68).

These endeavours give a sense of what is possible in the strategic targeting of health and social services resources. Ultimately, renewal is arguably underway in the province. To be sure, a recent strategic report has promoted changes to legislation, to the organisation of human resource capacity, and to public and private remuneration practices, all in an effort to improve the oral health of British Columbians (69) (see Tables 12 and 13).

Alberta

Alberta established a dental division in 1959, but had health units that included 'dental hygiene' since 1931 (33, 70) (see Table 3). By 1965, it is reported that 18 of its 24 health units had a dental program (70). Alberta is unique in that rather than focussing on children, its major initial public dental care program was for seniors. The Extended Health Benefits (EHB) was introduced in 1973 as part of the Alberta Health Care Insurance Plan, and included coverage for those over 65, their spouses and dependents (21) (see Tables 14 and 18).

In 1974, 3 mobile dental clinics became available for private practitioners to travel to isolated regions, growing to 10 by 1982 (70, 71). Three of these clinics eventually became staffed and operated by the University of Alberta's dental faculty (21, 72). In 1978, the Assured Income for the Severely Handicapped (AISH) program was established through the Assured Income for the Severely Handicapped Act, the first social assistance program of its kind in Canada (21) (see Tables 14 and 18).

By that year as well, the Community Health Dental Services Division provided or supported local health authority dental programs, dental services for under-serviced areas, a cleft palate/lip program, and a handicapped children's dental program (21, 72) (see Table 14). By 1983, all 27 local health authorities provided health promotion and disease prevention activities (3 had treatment programs), using 16 part time and 7 full time dentists, 102 dental hygienists, 80 dental assistants, for an estimated total budget of $4.8M (compare to Table 4) (21, 70) (see Table 14). Increases in public dental care financing follow from these investments (see Figure 18), as does the household budgetary share for dental care in low-income families, which in the Prairie region, fell from 1969 to 1982, thus maintaining trends observed in British Columbia and across Canada (see Figures 13**,** 15, and 19).

By 1984, in corroborating Stamm et al., others report a 'restraint program [relative to] hard economic times' (73, p. 26) (see Figure 20). Two years later, Alberta's dental public heath infrastructure was described as consisting of:

- Dental inspection and referral as identified through screening
- Fluoride treatments in schools
- Special programs for denture needs in geriatric facilities
- Cleft lip and palate program, expending $660,000 per year, with a relatively constant $160/claim
- Visiting Dentists Program and Mobile Dental Clinic Program
- University of Alberta Dental Outreach in northern communities
- Social Assistance Programs
- Extended Health Benefits (72) (see Table 14)

Public financing did drop that year, yet it rose to historical highs by 1991, but once again dropped by 1997 (see Figure 18).

As elsewhere, such volatility was associated with economic recession, and with Alberta's first round of health regionalisation in 1995 (see Table 3). It is reported that the latter specifically resulted in a loss of positions in dental public health and the eventual loss of three regional programs (70, 74). Concurrently, the Department of Health also "divested responsibility for its Dental Outreach Program to the […] University of Alberta" (75, p. 39), and reduced funding for the EHB from $25M to $17M (31). Patterson (70) links these program changes to the recession of the early 1990s and to the CHST. The evidence is clear when observing the provinces social funding stream (see Figure 20). All of this is also apparent in the then current and lessened descriptions of dental programming (29) (see Table 15), and in a low-income household's budgetary share for dental care that had reached historical highs by 1992 (see Figure 19).

As in British Columbia, SUFA and the NCB then resulted in children-specific investments. Alberta introduced the Alberta Child Health Benefit (ACHB), a means-tested program for low-income families that provided 100% coverage for children's dental services, prescription drugs, optical services, ambulance services and essential diabetic supplies (76). By the 1999/00 fiscal year, the ACHB was spending $7.5M on dental care (31, 32) (see Table 16), resulting in increases to public financing and to decreases in the low-income household budgetary share for dental care (see Figures 18 and 19).

Increases to public financing were also associated with the addition of 16 paediatric oral surgery contracts for private facilities (77). Becoming a forum for popular concerns about privatisation and wait times, the Minister of Health and Wellness confirmed that the contracts "meet the requirements [and] principles of the Canada Health Act, and identify a benefit to the public" (77, p.1). He also stated that "the contracts free[d] needed hospital space for other, hospital-based procedures [and noted that] the contracts offer a saving to the health authorit[ies] [and that] [r]epatriating these procedures […] will put pressure on public facilities, and will increase wait times for other procedures" (77, p.2).

In this regard, Alberta is an example of the importance of costing out hospital visits for dental care in order to make evidence-based decisions concerning such things as private versus public delivery and resource needs and allocation. Alberta has produced consistent costing data since the late 1990s (78). For example, in 1998/99, average in-patient costs (with no co-morbidities) for dental and oral diseases excluding extractions and restorations were $1801/case with an average length of stay of 2 days. If co-morbidities are taken into account, this cost rises to $4195/case with an average stay of 6 days. For dental extractions and restorations, costs and length of stay without co-morbidities were $1296/case, 1 day, and with co-morbidities $1709/case, 2 days. For ambulatory care, costs for dental interventions were $589/case. By 2005, amongst diseases and disorders of the ear, nose, mouth and throat, dental extractions and restorations were the fifth most costly in terms of in-patient surgical activity, and the most costly in terms of ambulatory care visits. So whether in public or private markets, it is clear that the economic importance of dentistry cannot be denied. More fundamentally, such costs point to the importance of investing in prevention.

By 2003, public financing was down again, likely due to the elimination of the EHB (see Figure 18 and Table 17). Nonetheless, the low-income household budgetary share for dental care was at historical lows (see Figure 19). The latter could be due to:

"[The] Special Needs Assistance for Seniors program [formerly EHB] experienced a 106 per cent increase in applications compared with the 2001-02 fiscal year [as per] improved publicity [and] increased assistance for seniors' dental and optical expenses" (79, p.24).

To be sure, seniors' services continued as an important part of Alberta's response to public dental care need. For example, a new Ministry of Seniors and Community Supports "develop[ed] a landmark agreement with the University of Alberta Department of Dentistry and Dental Hygiene [to] provide funding to the university department for the provision of dental services to low-income seniors" (79, p.40). By 2004, "536 seniors [had] received $184,807 worth of dental services, with an additional $264,000 in services committed" (80, p.46).

A second round of regionalisation then occurred in 2003 (see Table 3). Patterson (70) reports that of the three regions that had discontinued dental programs in 1995, two were re-established at this time, and that all new health authorities had some level of public dental service (see Table 17). Clearly, there is recognition that public dental services are important to Albertans.

In a recent survey of ACHB recipients for example, dental exams and cleanings were the services most valued by clients, with the primary reason for enrolment being 'in case children needed health services in the future' (34%), followed by 'dental services' (20%) (81). As will be described throughout this report, counteracting public health dentistry's decline are social movements that stress the need for public dental care programs and/or financing. The Alberta Public Health Association (APHA) itself recently adopted a resolution entitled 'Improving the Oral Health of Albertans: Access to Dental Public Health Services,' and has been advocating on behalf of public care since the early 1990s (82); again, similar positions have been taken by other local (83), regional (84), and national groups (85).

The APHA specifically notes that:

"Alberta does not have a Provincial Dental Director. There is no provincial direction on oral health or dental programs designed to improve health, address inequities in accessing dental care and provide preventive services. […] Alberta has no official voice participating in National Oral Health Strategies. Regionalization of health services in Alberta has amalgamated budgets of hospitals and health units with subsequent reductions and eliminations of dental public health programs in parts of the province. Public Health programs, including existing dental programs continue to face reductions, and must function on an ever-decreasing proportion of the regional health authority budget" (82).

Such statements immediately confront the province's challenges in meeting need:

"The Government of Alberta continues to emphasize making government more effective and efficient while ensuring the sustainability of its programs and services. Program sustainability […] continues to be a major issue for the Department. In some programs, such as [AISH] and Supports for Independence [see Table 17], increasing medical costs are placing growing financial pressure on [the Department]. […] In addition, growth in caseloads and higher per-client costs bring concerns about the Department's ability to pay for the additional costs. Higher per-client costs are partially due to increased long-term care accommodation charges, utility costs, and increased medical and dental costs" (86, p.137).

Alberta, like British Columbia, has in turn found creative ways to maintain publicly accessible services. Recall that in the mid 1990s, the province transferred the administration of the Dental Outreach Program to the University of Alberta. As a result, the University accepts requests from communities with a dentist to population ratio of 4000-5000 people (87). To qualify, the community must show that it has attempted to recruit a dentist, and/or still has a ratio in excess of that recommended. Once accepted, the community is assessed as to which strategy is the most appropriate for service delivery. Mobile dental clinics are one option, composed of portable equipment, staffed with practitioners on fee for service that "are responsible for providing staff, supplies, and laboratory fees, etc" (87) (4 communities currently have this service). Community health centres are another option, where facilities and the maintenance of equipment are provided in settings such as a hospital, medical clinic, or health unit building, staffed by practitioners who again are responsible for staff and supplies (2 communities currently have this service). Finally, a visiting dentist program can be established, where a practitioner provides staff and supplies and visits a community with equipment performing care "in an existing building such as a school or commercial site" (87) (2 communities currently have this service). Three other satellite dental clinics for under-serviced and marginalized groups are also used, and these as specifically used for educational purposes (88).

Another important non-governmental organisation in Alberta is Michener Services (89). Michener (a community for those with developmental disabilities) operates under the governance of the Persons with Developmental Disabilities Central Alberta Community Board, and within the overall mandate and direction of the Provincial Persons with Developmental Disabilities Board. Alberta Seniors and Community Supports allocates Michener's resources, through which it operates a fully equipped dental clinic and operating room that provides care to 371 individuals who live at Michener or elsewhere. No one living at Michener receives AISH, although some of those living externally get a modified AISH. The average age of people living at Michener is 54.

Finally, renewal is clearly underway in Alberta. The province has recently introduced new financing, and reports that "spending on social services will increase by 8.3%, or $205 million in 2005-06 [and will include] [a]n additional $42 million for enhanced dental and optical assistance for seniors, with a nearly 20% increase in AISH funding in

2005-06 for an increase [in] program enhancements and higher caseloads and health benefit costs" (90, p.2).

Saskatchewan

According to Gullet (33), in 1928, Saskatchewan was the first province to introduce a large-scale mouth health campaign. The Departments of Health and Education alongside the Red Cross and other lay organisations, dental organisations, and the Canadian Life Insurance Officers Association, promoted health education materials developed by the Canadian Oral Prophylactic Association (the then national, professional arms-length public health organisation). Part of the campaign included dentists that travelled into rural areas to examine school children.

Known as a leader in health and social services, in 1945, Saskatchewan was also the first to provide a comprehensive health service program for those receiving social assistance, namely the Social Assistance Medical Care Plan (21, 33). In 1966, this approach was formalised under the Supplementary Health Program (SHP) and legislated under The Saskatchewan Assistance Plan, the corollary to the federal CAP (see Table 23). The SHP exists into today (29, 31, 32) (see Tables 19, 20, 21, and 22).

In 1974, Saskatchewan then introduced the Saskatchewan Health Dental Plan (SHDP), the much-lauded universal children's dental program that used dental therapists as the primary provider (21) (see Table 19). Developed on New Zealand's dental nurse model (an allied dental health professional trained over two years to deliver preventive and curative care specifically to children), the SHDP delivered care in school clinics distributed across the province's then six administrative regions. Beginning with the delivery of services to 6-yr olds, the program added additional age cohorts such that by 1983, all children aged 5 to 16 years were eligible (21). By this time, the SHDP employed 26 dentists, and spent $13.4M on the program, up from $2.1M in its first year (21, 91) (see Table 19). Such investments are well reflected in public financing and in the household budgetary share for dental care (see Figures 21 and 19).

Aside from Saskatchewan, dental therapists were also part of federal attempts to meet demand in indigenous communities. In this regard, it is important to note that Stamm et al. did not report on provincial services for children in northern Saskatchewan (a largely indigenous population), which at the time operated through the Northern Services Branch, Department of Health, with consultation from SHDP and federal administration. Such consultation continues into today (see Table 22).

With the economic uncertainty at the turn of the 1980s, and with a change in government that facilitated a strong professional lobby against the SHDP, the wholly public program was reshaped to incorporate the private sector (21, 92). In 1981, major participation by general practitioners began, resulting in the closure of 11 high school clinics (21). By 1983, changes in policy mandated private sector responsibility for adolescent dental care in specific regions, with 4-yr old children no longer covered, and a potential to cut of those that were born in 1966, or those 17-yrs old (21).

Alongside economic uncertainty, a change in government, and professional pressure, the provincial position of slowing the growth of the SHDP was also strengthened by changes

to population oral health. From 1974 to 1980 for example, the SHDP was credited for controlling dental caries amongst the province's youth by reducing its incidence approximately 25% (93, p. 63). Changing the structure of the SHDP was also strengthened by then national professional dental care policy that was critical of school-based programs (92). Yet it is noteworthy that in the early to mid 20th century, it was the profession that heavily promoted the organisation and establishment of such clinics across Canada (33, 34, 38).

The promotion of private delivery continued, and in 1985, a "bridging program for young people [was] developed in co-operation with the College of Dental Surgeons […] to encourage […] the transition from receiving care in school clinics to private dental practice" (94, p. 33). This again resulted in a loss of public infrastructure, with the SHDP reducing its compliment of 26 dentists to 18 (94). At this time, the province's social assistance program, the SHP, also incorporated a 6-month waiting period for dental benefits, with only emergency care available during this period, something that exists into today (see Table 22). These decreases in public financing are apparent in Figures 21 and 22.

As in many places in Canada, Saskatchewan was also challenged by a continued shortage of dentists in rural areas (95). In order to motivate dental students into rural practice, a dental externship program was in place at this time (94). This program linked senior dental students and rural practitioners on a 50:50 cost-share basis, meaning that the province paid students $800 a month, to be matched by the dental practitioner. Nine students were involved in 1986.

In 1987, the privatisation of services was complete, with 400 SHDP staff dismissed and 578 dental clinics closed (96, 97). The SHDP became the Children's Dental Plan (CDP), covering 5-12 yr olds in private dental offices. Saskatchewan Health, Community Services Branch ultimately retained 18 senior dental therapists, re-branding them as dental health educators, and created the Dental Health Education Program (DHEP). Importantly, school-based dental therapy services were maintained in the province's northern regions and in Saskatoon and Prince Albert (97).

These events were not taken lightly, and dozens of communities petitioned to keep the SHDP (98). Legislative debate was fierce and carried on for two years:

"[T]his is a very sad day for Saskatchewan families, because it marks the official end of the best children's dental plan in North America and a replacement of that plan with the government's privatized inferior version. […] Mr. Minister, isn't it a fact that you're in a real hurry to sell off [dental] equipment because you want to make it more difficult for the next Government of Saskatchewan to reintroduce a school-based dental program?" (99).

"[T]he Provincial Auditor's report […] refers to dental equipment [and] illustrates that there's over $2 million worth of dental equipment that cannot be accounted for. […] What happened [is] it in the warehouse? Has it been sold? […] The Provincial Auditor

indicates that the money [is] to be put in the Consolidated Fund, in the general fund for general revenues of the government. […] So here we have a government that privatized the school-based children's dental plan and fired 400 dental workers in this province, put the dental equipment in a warehouse, and sold some of it, and is refusing to account to the public for how that dental equipment is being sold" (100).

So as had occurred in British Columbia in the early 1980s, a children's dental care plan became a hot issue in governmental debate. This period actually shows a subsequent rise in public expenditures (see Figure 21), arguably representing the potentially increased costs of financing private delivery on a fee for service basis, as opposed to a direct delivery system with salaried providers. By 1993, the critical opposition quoted above was now in power, and they quickly eliminated the CDP (96, 97). This resulted in decreases to public financing (see Figure 21), yet the new government did not re-introduce the SHDP.

In 1995, following the trend towards regionalisation, the DHEP was transferred to Saskatchewan's health districts. This continued the provision of health education and preventive services to children across the province, as well as school-based clinical programs in the aforementioned regions (see Table 22). Today, this program employs a total of 19 dental health educators, and approximately 10 dental therapists (see Table 4).

As observed in British Columbia and Alberta, the 1995 CHST led to further drops in public financing (see Figures 21 and 22), and to the introduction of a children-specific program in response to SUFA and the NCB. Beginning in 1998, the Family Health Benefits Program (FHB) was structured as an extension of the SHP, and assisted recipients of the new Saskatchewan Child Benefit and/or the Saskatchewan Employment Supplement with the dental care costs of children less than 18 years (see Table 22). In time, this has led to modest increases in the public financing of dental care, but the same cannot be said for the larger social service sector (see Figures 21 and 22).

In terms of service data, little is available, yet similar to British Columbia, Saskatchewan reports on the services provided in-hospital through its Medical Services Plan (101-104) (see Tables 22 and 24). Again similar to British Columbia, Saskatchewan also negotiated retroactive payments to dentists that deliver care in-hospital relative to professional pressure that fees were too low:

"The current dental agreement between the College of Dental Surgeons and Saskatchewan Health covers 10 years, [from 1995 to 2005]. No adjustments in payments were made for the first six years. A retroactive payment of 2% was made on claims billed between [2001 and 2002] plus an additional 3% for claims billed between April 1, 2002 and December 31, 2002. A new Payment Schedule was effective January 1, 2003. The agreement provided for 3% increases April 1, 2003 and April 1, 2004" (104, p. 4).

Amendments to payment regulations in 2002 provided the authority for the retroactive payments on the basis of the new fee schedule. These payments are not included in Table 24, and are estimated at $1.3M (103, p. 7).

At this time, another amendment that is of interest took place within the Saskatchewan Assistance Plan Supplementary Health Benefits Regulations (see Table 23). This change allowed:

"[FHB and SHP] beneficiaries flexibility in order that they may 'upgrade' two specific dental services, namely tooth coloured fillings in posterior teeth and cast metal partial dentures, from the basic services covered under the program [and] permitted dentists to 'extra bill' [FHB] families for the difference between their customary fees and the fees paid by this benefit program" (103, p. 7)

Change and renewal are established themes by now, so as in British Columbia and Alberta, Saskatchewan has identified dental health as an important component of its present and future public health planning. In 2001, Saskatchewan Health reviewed its public and population health services, and identified dental health as routine public health practice, alongside such things as healthy birth outcomes, healthy child development, and food security (105). Its focus on dental health was also broad and inter-professional, linking it with health promotion activities such as breastfeeding and the social isolation of seniors, and to providers such as public health nurses, public health nutritionists, teachers, and school counsellors. Saskatchewan Health specifically identified the goal of reducing the incidence of dental disease, but did not report by how much and in what timeframe. It also reported the seriousness and potentially population impacts if no action on current needs is taken (e.g., pain and discomfort, acute and chronic infections, school absenteeism, compromised general health, nutrition, and self-esteem). It is not surprising then that the Canadian Union of Public Employees concurrently recommended the "reinstatement of the children's school-based dental program [as] a valuable investment in the long-term health of [Saskatchewan's] children" (106).

In this regard, in 2004, Saskatchewan's Market Supplement Review Committee (107) considered the status of the dental therapist. Three health regions reported to the Committee, two northern and one southern. They described experiencing service delivery issues in their school-based programs due to vacancies and budgetary constraints. One region in fact had changed their focus to more preventive and urgent care approaches due to the insufficient number of budgeted positions.

As in British Columbia and Alberta, wait times for dental surgery have also become a focus in Saskatchewan (108). With a degraded dental therapy workforce, dental stakeholders point to the increasing numbers of children on waiting lists as a negative outcome of not promoting this type of care (see Table 25). This is a specific problem for northern regions, where human resource issues are most acute. As such, in 2003, Saskatchewan Health began working towards the implementation of a 'Northern Health Strategy' that included a 'Dental Health Strategy' for both children and adults (103). The plan is to develop proposals to access funding from the 'Federal Primary Health Care Transition Fund.'

Indeed, as will also be seen in Manitoba (the only other province that used the dental therapy model in the 1970s and 1980s), there appears an increasing focus on dental surgery wait-times as a foil for renewed action on oral health and access to care. Importantly, support is now also gathered from physicians, who increasingly require that their patients dental care needs be met prior to surgery relative to an increased awareness of how dental disease impacts systemic responses, such as those impacting a patient's pre- and post-surgical constitution. To be sure, Saskatchewan's Medical Services Plan offers the "[e]xtraction of teeth [as is] medically required for the provision of: heart surgery, services for chronic renal disease, or services for total joint replacement by prosthesis where the beneficiary was referred to a dentist by a specialist in the appropriate surgical field and where prior approval of the MSP is received" (104, p. 10). Stakeholders across Canada suggest that such medical requirements constitute an increasing number of requests to hospital insurance programs.

Saskatchewan is also a further example of the increasing role of dental education in public dental health programming. Historically involved with provincial and federal authority in meeting the need of under-serviced groups, as British Columbia and Alberta, Saskatchewan's dental faculty has experienced a recent influx of provincial funds. For example, Saskatchewan's dental residency programs, which remained steady at approximately $75,000 from 1999 to 2003, gained significantly in 2003 to reach nearly $190,000 per year (101-104). By now, it is clear that across western Canada, there appears some appetite to address issues surrounding public dental care and its programming.

Manitoba

Gullet (33) reports that in 1946, the province of Manitoba established a dental division (see Table 3). Stamm et al. (21) reports that a 'variety of services' were available for children in the 1950s, and that by the 1960s, the Manitoba government ran education, prevention and treatment programs. As Saskatchewan had done, it also focussed on recruiting dentists into rural areas. A 'Dental Public Health Service' operated mobile dental units, offering free care to children, and charging fees to adults. This was jointly financed between the Department of Health and participating municipalities and/or other local agencies, such as social welfare groups or school districts. The provincial department and the Manitoba Dental Association further developed an incentive program for rural practice.

Importantly, at some level, all of these activities (i.e., preventive and clinical services organised and delivered alongside non-governmental and professional organisations) were also occurring in most other Canadian provinces (28, 41). This is a relevant historical point, as despite the variability in public programming in terms of organisation and legislation, there is nonetheless some sense of a general structure and direction in what constitutes a public dental health care system in Canada (see Table 1).

In this regard, Manitoba began financing dental care for low-income families in the 1960s through its Social Allowances Medicare Program. As a result of CAP, this program was re-structured as the Social Allowance Health Services Program (SAHS), running under the Department of Community Services and Corrections (see Table 26). As in British Columbia and Saskatchewan, Manitoba also began a Children's Dental Program (MCDP) in 1976 **(**see Table 26). The province established a Dental Health Workers Board, defining the practices of a dental nurse, hygienist, assistant, and technician. The dental nurse was closely modelled after Saskatchewan's dental therapist, and alongside salaried dentists, the MCDP delivered care to approximately a third of Manitoba children in rural and remote school-based clinics. These investments are well reflected in public financing (see Figure 23).

Similar to British Columbia and Saskatchewan as well, changes in government interacted heavily with the development of children's programming. Stamm et al. (21) report that in 1978, due to professional pressures, a new Progressive Conservative party established a parallel, dental association-run, public program for schoolchildren in specified areas. By 1982, these areas included enough urban centres to capture "over half of the child population 6-12 years [resulting in no] cover[age] under the [MCDP]" (109, p. 26). Expenditures would slow by this time, and peak by 1984 (see Figure 23).

That year, the government that had created the MCDP was back in power. They had recognised the "importance of the need for an adequate dental treatment delivery system […] during the recent election" (109, p. 26), and expanded programming to include all children born in 1978, or those 6 years old, repatriating certain school divisions and a major urban centre back to the MCDP (110). It was predicted that by 1987, all children 6-14 yrs of age would be included in the program (110). Expenditures also declined at this

time (see Figure 23), potentially reflecting the decreased costs of financing salaried providers instead of a fee for service system.

By 1988, the MCDP was being clawed back again, in a "political environment [that was] slightly unstable with a newly elected minority government in power" (111, p. 40). Now covering children 6-14 yrs of age, new exceptions included two urban centres, where coverage was limited to children 6-10 yrs of age (111). Children in the province's two major urban centres, Winnipeg and Brandon, were also now completely excluded. As a response, public stakeholders promoted a newly described 'Children's Dental Preventive Program,' consisting of bi-annual classroom education, weekly fluoride rinses in schools, pre/post natal education, and 3-5 year old preventive services. It operated throughout the whole province except Winnipeg.

Further, to safeguard the MCDP's 80 staff members from potential cutbacks (including dentists, dental nurses, dental assistants, equipment technicians, administrators, secretaries, clerks and a fluoridation officer), public managers "hoped that [the] diversification of services to increasing numbers of recipients [i.e., the private sector] [would] help prevent the enucleation of the Children Dental Treatment Program component such as occurred to the Saskatchewan Children's Dental Plan" (111, p. 39). It was even necessary to provide "[a]dditional responsibilities to the workload of the eight program dentists [in order to] maintain busyness during school holiday periods" (111, p. 39). In this regard, it became important to document comparisons between public and private delivery (111) (see Table 27).

Expenditures in Manitoba became quite volatile after this period (see Figure 23), as the general environment in Canada spoke to a slowing of public programming:

"Health care costs will continue to escalate until new methods of supplying services in a more cost effective manner are identified. Dental public health should be looking in this direction. If we don't, then programs will be progressively cut to curtail these costs. Program cuts will of course lead to lost jobs for public health dentistry" (112, p. 16).

To be sure, by 1993, Manitoba cancelled the treatment component of the MCDP, downsizing from 70 to 4 staff, and finally down to 2 part-time staff by 1995 (113). The program's $4.5M budget was cut to $1.5M and again to $0.5M respectively (114). The only public dental care activities left were a regional weekly fluoride mouth rinse program (that would close within the year) and a program for the centralised support of community water fluoridation (114). Importantly, the City of Winnipeg maintained a municipally financed 'welfare' treatment program in a small number of public clinics, but most would close by 1997 (29, 31, 32) (see Tables 28 and 29).

By now, the CHST was having its impacts on Manitoba's health and social services sector (see Figures 23 and 24). Manitoba was also beginning health regionalisation (see Table 3), and in 1997, "[i]n the process of decentralizing decision-making for health" (115, p. 2), the province reviewed its core services. Recognising oral health under the domain of prevention and community health services, the goal was:

"To promote dental and oral health and reduce dental and oral disease and oro-facial injuries among all segments of the population. Goals are achieved through pre/postnatal, school health, community education and promotion programs, and consultation with health-care providers. Programs include instruction in personal oral hygiene, nutrition and feeding, injury prevention, tobacco-use reduction and maximizing the benefits of fluoride use. Dental and oral disease and injuries are almost all preventable if education and promotion programs are provided and access to care services is readily available" (115, p. 13).

Such programming was described as a requirement for every new health region, yet by 2000, no programs were in place (see Table 29). Provincially, public programming now came under the External Programs and Operations Division of Manitoba Health, and was the responsibility of the Environmental Health unit in the Public Health and Epidemiology branch (116). The goal of this 'Dental/Oral Health Unit' was:

"To promote policies and community-based programs aimed at optimizing […] oral health [by] facilitat[ing] and consult[ing] with the Regional Health Authorities […]. Partnerships with private associations and academic facilities help to guarantee evidence-based policy development [and will] facilitate the development of a Provincial Oral Health Strategy. The Community Water Fluoridation Program is funded and facilitated by Department staff. Four communities were awarded grants to upgrade [their] systems. During this fiscal year, an Agency grant was awarded to St. Amant Centre [an assisted living centre for the developmentally challenged] for a resident dental care program. Monitoring continued on the St. Theresa Point Nursing Caries Project [a northern community]. Activities were initiated to develop a needs assessment survey tool." (116, p. 48).

As in Saskatchewan, the province focussed on a 'Northern Development Strategy' that recognised 'Dental Health' (117). This strategy hinged on two issues, early childhood caries among indigenous and low-income children, and the paediatric dental surgery waiting lists that present as a result. In 2002:

"The Circle of Smiles Early Childhood Caries Pilot Project was awarded $260,000.00 of funding from various partners and began operation in November with the appointment of a Co-ordinator. It is running in [three northern communities and central Winnipeg]. It is a multi sectoral effort to address the problem of early childhood tooth decay and has a research component, a prevention, promotion and educational component as well as a community based approach and is linked to other programs that are establishing repatriation surgical treatment options" (118, p. 45).

Now called the 'Healthy Smile - Happy Child Early Childhood Tooth Decay Prevention Project' (see Table 30), the multi-sectoral collaboration involves in-kind support and financial contributions ($225,000 in 2005) from Healthy Child Manitoba, the Manitoba Dental Association, the Winnipeg, Burntwood, and South Eastman Regional Health Authorities, the University of Manitoba, Health Canada, the Winnipeg Foundation, and

the Children's Hospital Research Foundation (3, 118). Nationally recognised and awarded, the prevention program recently received another $1.2M over two years from the province, and is an example of the creative ways that can be found to fund targeted public dental services (3, 119). For example, these funds stem from the Federal Wait List initiative, and represent the view that in the long run, prevention can diminish the use of costly treatment services. Further, while the money will flow from Manitoba Health, it has been given to the partnership to run, meaning 1 full-time project coordinator (housed within the University of Manitoba), 5 full-time community facilitators (housed within regional health authorities), and 1 part-time administrative assistant (118). The program is also unique in that it takes a community development approach, concerned with networking among young families and with local programs already working with pregnant women and preschool children. The program's main researcher is very clear in stating that it is not a service oriented project, but more so advocacy for dental prevention, with an aim of establishing links with dental professionals who are willing to treat high-risk children (120).

In terms of treatment services, the province also committed $400,000 over three years to reduce waiting times, expanding access by approximately 850 more surgeries per year (3, 121). This increase is observable in recent hospital expenditures for dental services (see Table 31). Hospital costing detail is also available, as Manitoba is another Canadian leader in health care costing (122). Similar to Alberta then, Manitoba's average in-patient costs (with no co-morbidities) for dental and oral diseases excluding extractions and restorations were $1592/case, with an average length of stay of 2.8 days. If co-morbidities are taken into account, this cost can rise to $3438/case with an average stay of 3.3 days. For dental extractions and restorations, costs and length of stay without co-morbidities were $1166/case, 1.3 days, and with co-morbidities $2249/case, 1 days. For ambulatory care, costs for dental interventions were $620/case.

Service detail is also available for social assistance programming, or the Health Service Program of the Department of Family Services and Housing (see Tables 30 and 32). Table 32 demonstrates the introduction of a Services for Persons with Disabilities Division in 2001, de-aggregating previous reporting into income assistance recipients and into persons with disabilities (123). In this regard, the province also provides funding for two assisted living centres, which receive services from the University of Manitoba. The Winnipeg Regional Health Authority's financial statements also demonstrate a contribution of $13,000 per year for such services (124).

The Winnipeg Regional Health Authority further provides targeted services through a recently created program called SMILEplus. An acronym for Saving Mouths in a Limited Income Environment, this is a children's dental clinic in a core area school that employs a dentist 4 days a week on contract (currently trying to hire for 5 days), 2 clinical dental assistants, and 2 dental assistants conducting screening and education in core area schools. There are also 2 dental hygienists who concentrate on special projects (e.g., home visits for fluoride varnish and a pre-term low birth weight initiative project at the region's major hospital). This program is reportedly spending approximately $600,000 to $700,000 per year (125) (see Table 30).

Importantly, in the Winnipeg region, one also finds public dental care programming associated with specific health centres, organised and managed in relation to the University of Manitoba and other non-governmental organisations. Detail is available for Mount Carmel Clinic, a core area health centre with a dental program. It is partnered with the University of Manitoba, and receives funding from the United Way and the provincial government, and "recognises that it is difficult for some individuals and families to afford private practice dental fees, therefore, dental services [are] provided at a minimal cost to individuals who meet […] financial guidelines" (126). The service fee is based on a sliding scale, and determined on the basis of net family income and the number of people living in the home. No person is refused service because of an inability to pay, and the program provides a broad range of clinical and preventive services. Currently, the program is managed by a dental therapist and employs 12 staff, costing the clinic approximately $355,000 per year. To be sure, the public share for dental care in Canada would be increased if the activities of dental schools and other non-governmental organisations were taken into account.

In this regard, the budgetary and human resource details of academic programming are unknown, yet as argued in the introduction and throughout this report, the public non-governmental sector now constitutes a recognisable and important part of Canada's oral health care system. For example, the University of Manitoba's dental faculty has a strong history in governmental contracting and outreach services (53, 54). The same can be said for dental faculties across the country. In this regard, there appears a general discussion within dental education to promote the direct funding of dental schools by federal and/or provincial authority in order to meet current public dental health care demand. Dental faculties are interested relative to their social contract with Canadians, the production of more socially aware practitioners, and due to the potential opportunities for offsetting the high-costs of dental education.

Finally, as in the three provinces already reviewed, it is clear that public dental care in Manitoba is experiencing some level of renewal. Yet as in these provinces as well, programming and associated financing are negligible compared to their historical place in such public health care systems. What makes Manitoba unique is that it is still one of few places in Canada where public dental care has an exclusive legislative basis for its activity, whether enacted or not; the others are Saskatchewan, Ontario and Quebec (see Table 33). Such legislation is important as it recognises the importance of governments in the delivery of dental care, and provides the legislative bases for any potential renewal in the direct public delivery of dental care in Canada.

Ontario

In 1925, Ontario became the first province to establish a dental division within its health department (33) (see Table 3). The home of John Adams, the founder of dental public health in Canada, Ontario was also the first province where a municipality financed the direct delivery of treatment services, and the first with academic training in the discipline of dental public health (33, 34, 127). Today, Ontario is a robust dental public health environment, maintaining the largest number of specialists in Canada, and when considering its demography, some of the most populated and geographically concentrated dental public health activities across the country.

Throughout the 1950s and 1960s, in response to the National Health Grants program and HIDSA, Ontario insured some hospital dental care, and joined British Columbia, Manitoba, and Québec as the only provinces with accredited hospital dental programs (28, 41). As in most provinces, it also introduced large-scale social assistance programming in response to CAP (21, 28) (see Table 34). Ontario also follows the common rise in public financing and subsequent decline to the low-income household budgetary share for dental care (see Figures 25 and 26).

Yet unlike the provinces already reviewed, Ontario did not operate any form of universal programming in the 1970s, a time when most were active in this regard. Instead, 10 out of the province's then 43 health units had direct treatment programs, with eligibility largely confined to school age children, and with services delivered in schools, health units, and mobile clinics (21) (see Table 34). It is also reported that "[a]ll 43 health units have preventive dental programs but these are not standardised" (128, p. 24) (see Table 34).

The idea of standardisation is something that has held historical currency in Ontario. Throughout the early 1980s for example, efforts at standardisation were present through health unit accreditation and through activities in legislation. For example:

"A new Health Protection Act [was] scheduled to replace the existing Public Health Act [with] [c]ore programs now being outlined [to] set minimum standards" (128, p. 24).

Two years later:

"Guidelines are being written [for] the Preventive Dental Core Programs [with] [t]he Ontario Council on Community Health Accreditation […] encouraging all local [public health] Agencies to attain peer-set operational standards" (129, p. 23-24).

Even to this day, standardisation of public dental care programming is something identified as necessary by provincial stakeholder groups (130, 131).

In 1984, the Health Protection and Promotion Act was proclaimed, mandating "the 43 Ontario Boards of Health [to] include [a] fluoride program, dental health education - oral hygiene instruction, screening and referral, topical fluoride and geriatric programs" (132, p. 7). Importantly, there is no other Canadian jurisdiction that defines legislative

responsibilities over preventive dental care in terms of health protection. Stakeholders view this as significant, arguing that legislation provides stability for the viability of public programming. In effect, this legislation, with its mandatory program components, recognises that certain dental services must be socially protected and/or guaranteed. Nevertheless, public expenditures for dental care begin to decline at this time (see Figure 25). Historically, the province has in fact maintained the lowest per capita share across the country (see Figure 11).

Today, the Health Protection and Promotion Act defines a different set of programs. These include the Children In Need Of Treatment (CINOT) program, the Dental Indices Survey (DIS), oral health screening (OHS), dental education and health promotion, clinical preventive services, and the monitoring of water fluoridation. All of these are in turn associated with Mandatory Health Programs and Services Guidelines (see Tables 37 and 38).

This new core programming structure began in 1987 with the introduction of CINOT. Stemming from the Report of the Advisory Committee on Dental Care for Ontario Children, CINOT was a response to new interpretations of the Child Welfare Act of 1978, where dental neglect became considered a form of child abuse (133). Parental follow-up by Children's Aid Societies often noted "a lack of money to pay for the required care" (133, p. 40), thus CINOT aimed to remove financial barriers to accessing basic and emergency dental care. It financed care in private practices or through health unit clinics and/or some hospitals (134). Initially funded at 100% by the Ministry of Health, it was estimated that "the first full year of the program [would] cost between $9,000,000 and $10,000,000" (133, p. 42). This is reflected in public expenditures that rose from that year onward, peaking in the mid 1990s (see Figure 25). Yet interestingly, unlike in most other provinces, an influx of public financing is not reflected in the low-income household budgetary share for dental care, which had increased by 1992 (see Figure 26).

In terms of the DIS, the survey was initiated by the Ministry of Health in 1971, and conducted biennially until 1990 when a four-year cycle began (131). Although health units are required by Mandatory Health Programs and Services Guidelines to conduct the DIS for all school entrants, many do not have sufficient resources and instead only sample a subset of children. Each health unit now uses a different methodology depending on local resources, so the DIS is not comparable across regions. On the other hand, the OHS is conducted yearly to identify children with gross dental health problems and to determine eligibility for CINOT and clinical preventive services. Again, similar to the DIS, screening methodologies vary, with some health units not completing the required screening due to insufficient resources.

As the reader will note, originally proposed Mandatory Health Programs and Services Guidelines included geriatric programs. This original approach stemmed from activities of the 1974 Task Force on Community Dental Services (135), and from a 1980 report by the Ontario Advisory Council on Senior Citizens, which "recommended that public health units conduct dental health promotion programs for seniors, carry out screening

and referral, and provide follow-up activities in the community and institutions," (135, p. 316). By 1982, 23 of 43 health units offered community-based seniors' programs, but by 1987, only 16 reported such services (135). An Advisory Committee on Dental Care for Seniors in Need was then struck in 1988, and a year later recommended a community-based health promotion program and a targeted treatment program (136, 137). Nonetheless, the most recent revisions of the mandatory service guidelines, released in 1989 and 1997, exclude seniors' services (136, 137).

The addition of new programming may not have even proven feasible though, as by the early 1990s, there began growing fiscal and human resources concerns in Ontario's public dental health care system:

"[In 1992] [t]he Council of [a] Regional Municipality […] Reports [on a] Proposed Provincial Dental Program for Seniors and Long Term Care Clients […] Whereas this is a period of financial constraint; And whereas at this time there are unresolved [CINOT] funding concerns; Therefore be it resolved that the [Region] not support the proposal of the Ontario Society of Public Health Dentists for Dental Health for Ontario Seniors and Long Term Care Clients at this time. Carried" (138).

"Non-mandatory activities such as the local management of [CINOT] and anticipated initiatives in the area of seniors dental health programming (treatment) reinforces the need for qualified public health dentists in each health unit. A shortage of qualified Dental Directors [and] a perceived lack of commitment by some boards of health [has] necessitated the sharing of dental directors by two or more health units [now approximately 15]. […] No other discipline (directors of nursing and inspection, nutrition, health promotion personnel) shares its personnel to the same extent [as] public health dentistry. […] The Ontario Society for Public Health Dentists has raised its concerns about the manpower issues over the past several years and has asked the Ministry to address the problem" (137, p. 12).

The situation was then only exacerbated by Ontario's response to the CHST (see Figures 25 and 27). So while advocating for funding was arguably moot, human resource concerns were addressed repeatedly: in 1990 by the Report of the Advisory Committee on the Training, Recruitment and Distribution of Public Health Dentists in Ontario; in 2000 by the Report of the Working Group on the Availability and Distribution of Public Health Dentists in Ontario; and in 2005 by the Report of the Joint Working Group on Dental Public Health-Human Resources (139).

Interestingly, the early 1990s were also a time when activity pointed to the potential expansion of public programming. In 1991 for example, the province's Social Assistance Review Committee proposed that "[o]ne comprehensive dental care program should be developed and made available to all low-income children and adults, whether or not they are social assistance recipients" (140, p. 8). The Ontario Society for Public Health Dentistry in turn promoted the aforementioned proposal for seniors and long term care clients (141), and a more encompassing "cost-neutral dental assistance plan to extend access to dental treatment to secondary school students, seniors and low-income

Ontarians" (142, p. 49). The latter in particular "had been gaining momentum in government committees, but progress [was] stalled [and] it is unlikely that it will advance any further until after the 1995 provincial election" (140, p. 8). In the end, the proposal was never implemented, and similarly to the provinces already reviewed, public programming in Ontario was now in clear decline (see Table 35 and Figures 25 and 27).

During this period, inter-professional dynamics would also play their role in Ontario, but this time, such activity related to the profession of dental hygiene:

"The College of Dental Hygienists of Ontario has proposed an amendment to the Dental Hygiene Act, 1991 that would allow dental hygienists to self-initiate [treatment]. This would eliminate the need for an 'order' from a dentist for dental hygienists to perform certain authorized acts. Hygienists are suggesting that public health dentistry would be adversely affected if they cannot self-initiate these procedures" (140, p. 9).

In this regard, in the City of Toronto in 1999, "concerns [existed] about the need for dentists to manage the City's dental programs" (143), and one problem included the need for dentists to supervise the activities of approximately 19 dental hygienists and their '8,410 dental hygienist assessments, 167,541 screenings, 17,675 oral hygiene instructions, 11,355 topical fluorides, 10,882 sealants, 13,607 cleaning of teeth, 2,312 denture cleaning and 10,720 scaling of teeth' (143). Significantly, in 2007, Ontario joined British Columbia and Alberta by amending its Dental Hygiene Act, permitting dental hygienists to self-initiate treatment.

The debate surrounding independent hygiene practice lies well beyond this analysis, yet it is an important issue, especially in a human resource environment where dental public health specialist numbers are decreasing, and where the importance of dental hygiene in public health dentistry is increasing. Nonetheless, while Alberta, Québec, British Columbia, and Ontario have the greatest percentage of dental hygienists in the public sector, the limiting of dental public health environments over the last 20 years has also reduced their involvement in community practice, from 13.3% in 1977, to 9% in 1987, to 3.8% by 2001 (144). Yet as intimated, one can also observe changes in the provider mix within Canadian dental public health environments, as evidenced by a rise in hygiene administrator/manager positions, from 10.9% in 1987, to as high as 16.7% by 2001 (144). In Ontario, approximately 17 dental public health specialists currently work as administrators/managers, down from 22 in 1988, while 9 dental hygienists now act in similar leadership roles (51).

By 1997, new Mandatory Health Programs and Services Guidelines revised the goals and expectations of Boards of Health and their associated health units. Oral health requirements now came under the Family Health Program, Child Health Section (CINOT, DIS, clinical preventive services and education), and the Chronic Disease Program (tobacco cessation and prevention) (145) (see Table 36). Fissure sealants were also added to the list of mandated services in the 1997 revision.

These new guidelines were linked to legislative and structural changes within Ontario's larger municipal governance and health and social services sectors. For example, Ontario's original 43 health units became 36 with the merger of two northern health units and with the amalgamation of seven municipalities into the new City of Toronto. The Social Assistance Reform Act of 1997 also began a process whereby existing social assistance legislation, the General Welfare Assistance Act (GWA) and the Family Benefits Act (see Table 34), were changed to the Ontario Works Act (OW) and Ontario Disability Support Program Act (ODSP) (see Tables 36, 37, and 38).

A salient way to describe the situation is by presenting the impact on the province's largest municipality, the City of Toronto:

"The current municipal dental program, which was developed under the terms of the [GWA], is a limited emergency program primarily geared to adult social assistance recipients. Under [GWA] dental services were a discretionary benefit […]. Municipalities could choose whether to provide such a program, and had substantial flexibility regarding its design and delivery. The program was cost shared on a 50/50 per cent provincial/municipal basis. The program is currently administered by a third party (The Great-West Life Assurance Company). Under the new Ontario Works Act […] dental programs for adults in receipt of [OW] will continue to be provided at the discretion of municipalities. Program cost sharing has changed to 80/20 provincial/municipal. […] Under the Provincial Family Benefits Program […] adults have historically had access to dental services through an extended emergency dental program administered by a third party (the Ontario Dental Association). […] Historically, there has been no municipal cost sharing of this program. [In] 1997, the Province announced that it was fundamentally reforming the social assistance system. […] As a result of the introduction of [OW and ODSP], and due to decisions implemented by the Province which download new responsibilities onto municipalities, there will be substantial changes to the cost sharing and delivery of dental programs to social assistance recipients. As a result of the assumption of financial responsibility for the provincial [ODSP], the municipality will pay 20 per cent of the cost of dental services provided to adults with disabilities who receive benefits [...]. As noted earlier, the municipality will now be responsible for sharing 20 per cent of the cost of dental services for adults in receipt of [OW]" (146).

In effect, by 1998, municipalities were required to fund 100% of all public health programs (147). This was met with clear resistance, and by March of 1999, the province announced that retroactive to the start of that year, it would cost-share ministry approved budgets for boards of health, changing from a budgeted cost per program to a global contribution for all public health activities. Importantly, this structure of global contributions is largely present throughout Canada, and as mentioned in our methodology, this has made it difficult to collect clear and specific public dental care expenditures, particularly for preventive programming. Practically, this funding structure has had impacts on the management of public dental programs as well, especially in situations where dental public health managers are not part of senior level budgetary decisions. In Ontario, stakeholders are clear that global budgeting and the restructuring of the late 1990s continued the degradation of central and local dental public health

leadership. It is said that as dental programs came under general public health programs, dental administrators became increasingly marginalised from decision-making authority.

It helps to consider a provincial description of events in order to get a sense of the complexity of the restructuring involved:

"Up until 1998, there was a direct link between the CINOT program and children eligible for social assistance. The [Ministry of Health and Long-Term Care] received reimbursement for the associated treatment costs from the Ministry of Community and Social Services (MCSS) for children eligible for [GWA] who received treatment through [CINOT]. The same arrangement existed for children from families receiving Family Benefits Allowance (FBA) who received additional services through CINOT that were not covered under their social assistance basic dental benefits. In the spring of 1998, the MCSS introduced a new structure for social assistance that included two new programs [OW and ODSP]. The programs also redefined eligibility requirements. All eligible GWA clients and sole support parents, who were previously part of FBA, were transferred to the OW program. Disabled individuals, their spouses and dependant children, were automatically transferred to ODSP. Under [OW and ODSP], all children are eligible for the same basic dental benefits so there is no longer a need for children from families receiving social assistance to access the CINOT program" (147, p. 105).

Changes in this period can be partly illustrated in service data (119, 143) (see Tables 39-41 and Figures 29-31). For example, several health units predicted that caseloads and expenditures for CINOT would increase with the 1998 introduction of OW and ODSP, given that more low-income families would be ineligible for social assistance (see Table 39 and Figures 29 and 30). They also predicted changes in relation to the Ministry of Community and Social Services and CINOT Schedule of Dental Services and Fees, which were modified to pay 75% of the 1998 Ontario Dental Association Suggested Fee Guide for General Practitioners (147). This was expected to increase fees by approximately three to five percent (134, 147), as arguably observed in a higher average cost per course of treatment for 1999 (see Table 39). Most significant were changes to the fees paid for restorative services, particularly composite fillings, now reimbursed at a higher rate than amalgam fillings. Health units again predicted that this would increase their expenditures given the higher reimbursement and public perception of safety with these materials (see Figures 30 and 31).

As in the provinces already reviewed, the issue of paediatric dental surgeries also becomes important in Ontario at this time. In 1997 for example, "there was increased difficulty in obtaining operating room time for dental procedures" (147, p. 106). In line with Alberta, Manitoba, and British Columbia, "this led to the transfer of some of these services to the private sector" (147, p. 106). This shifted funding from the Ontario Health Insurance Plan to CINOT, and too had impacts on service volumes, as expressed in the rising use of eight units of general anaesthetic (the largest amount of general anaesthetic covered by CINOT) as an adjunctive service (147) (see Figures 30 and 31).

Overall, changes to Ontario's health and social services sector were perceived as another example of Canadian welfare state retrenchment. For example, the number of individuals eligible for social assistance had decreased by 32% between 1998 and 2000 (147). In response, provincial advocacy efforts for public dental care programming were significant and well organised. At the local level, oral health coalitions became active, including but not exclusive to the cities of Toronto, Peterborough, Kingston, and Ottawa, and to the counties of Northumberland, Hastings and Prince Edward. Their activity has linked into and promoted municipal resolutions across Ontario, on such things as homeless dental care (148), a national oral health strategy (149), and access to dental care for the working poor (150). At the provincial level, the Association of Ontario Health Centres (151), the Association of Local Public Health Agencies (152), and the Ontario Public Health Association (153) have all adopted resolutions or made recommendations on issues of access to dental care and the importance of public dental programming. Yet surprisingly, by 1998 and most recently by 2003, the low-income household budgetary share for dental care actually dropped below 1982 levels, suggesting that public programming in Ontario may have responded better than most assess (see Figure 26).

Nevertheless, the degradation of Ontario's public dental care system is clear, especially so in relation to the DIS, OHS, and the preventive services mandated by the province's service guidelines. As mentioned, many health units no longer have sufficient resources to carry out the DIS and OHS (131), such that the most recent provincial data extends from 1994 (154) (see Figures 32 and 33). Preventive services are also now delivered on a diminished basis (134, 155) (see Tables 42 and 43).

As in other provinces, the government of Ontario has responded to some degree. In its northern communities for example, capital funding was provided to 38 health facilities, 20 of which included funds for dental equipment and facility repairs (156). Other one-time payments have also been made specifically for dental infrastructure (157, 158). The province's Northern Health Grants Program, which provides travel subsidies to access specialist services, was also infused with new funding (159). While more recently, through the Primary Health Care Transition Fund, operational funding was provided to the Ottawa area for the development of an interdisciplinary medical and dental preventive clinic for inner city youth (160).

As elsewhere, creative funding opportunities have also been found in order to re-invest in public dental infrastructure. The Ottawa Hospital Dental Clinic, for example, was able to raise over one million dollars from the private sector, including contributions from national professional dental organisations, dental equipment and supply manufacturers, and professional and community donors, in order to modernise the facility (161). Enough money was raised that an endowment fund is now present to maintain ongoing operations.

Today, "Public Health Dentistry [in Ontario] is functioning in the midst of rapidly changing environments at both the local and provincial levels [where] [s]trategic assessment and planning initiatives, such as The Local Public Health Capacity Review, are in the process of identifying future directions for public health" (130, p. 4). This

Capacity Review is still underway, and an interim report was produced in 2005 (162). Not surprisingly, equitable access to programming, standardisation, human resources, and sustainable funding continue as important issues for Ontario's public dental health care system (130).

Québec

In the mid-1920s, Québec did what no other Canadian government has ever done: it held a formal commission on dental hygiene (33, 163). The commission emphasised that the average dentist was generally not concerned with public education, and was willing to relegate the responsibility to state and professional institutions (33). In this regard, Gullet (33) reports the opening of a provincial dental division in 1946 (see Table 3).

Similar to other provinces, Québec began making large investments in public dental care in the 1970s, and also experienced the relative declines of the 1980s (see Figure 34). As in all other provinces as well, Québec's public programming largely became composed of surgical-dental services provided in hospital, services for social assistance recipients and their dependents, and targeted clinical and preventive services for children. In this regard, by the early 1980s, the province had one of the most robust children's dental treatment programs in Canada, and the most extensive school-based caries prevention program nationally, the Preventive Dental Services Public Program (see Table 44).

Provincial surgical-dental services were actually in place in 1961 as per federal financing and local custom, but became recognised more formally in 1970 under the creation of La Régie de l'assurance maladie du Québec (RAMQ) (21, 164-166) (see Table 44). RAMQ was established by law in 1969, and tasked with the administration of the province's health insurance plan in response to the new federal Medicare regime (21, 164, 166).

In turn, the Children's Dental Care Program was written into the Health Insurance Act in 1971 and also administered by RAMQ (166) (see Tables 44 and 47). Predominantly a third-party payment program delivered in private practice, protracted negotiations with the dental profession pushed the program's introduction back to 1974 (21). The program began by insuring those younger than 8 years, and by 1982, had steadily climbed to include all children younger than 15 years (21, 165). The program also paid salaries and sessional fees for dentists employed in hospitals, departments of community health, in local community service centres, and in provincial prisons (21) (see Table 44).

In 1976, RAMQ began administering the Ministry of Social Affairs' social assistance program, which had been running as per CAP since 1966 (166). It assumed coverage for those not insured through the children's program, or at that time, those greater than 10 years (21, 164, 165) (see Table 44). Additionally, in 1979, a program specifically aimed at administering prosthetic denture services was introduced (165) (see Table 46).

As everywhere in Canada, investments in public dental care decreased the low-income household budgetary share for dental care (see Figure 35). Québec also similarly entered into welfare state retrenchment, and in 1982, limited eligibility within its children's program; 13-15 year olds were no longer eligible for treatment services, and children less than 11 years ceased to be eligible for preventive care in private dental offices (21, 164, 166). In 1982 as well, social assistance recipients seeking prosthetic care would have to wait 6 months before they could access services; two years later, this waiting period applied to all services with the exception of emergency care (166).

Limiting access to private preventive care was strategic:

"The Minister of Social Affairs [distributed] a far reaching working document on the government's intention of intervening in the delivery of dental services in Quebec. The document has been circulated to interested parties other than the dental profession for comments. [If] implemented, the program will have a significant impact on the present mode of dental practice in Quebec, in that the bulk of preventive dentistry services will be non subsidized in the private practice setting and will be transferred to Public Service hygienists, and the government will become a provider of dental services to many segments of the population. [The] program aims [to] provide comprehensive care [where] existing services are inadequate" (167, p. 11).

At the time, Dussault (168) claimed that Québec's dental care system had actually failed on two counts: "the geographical maldistribution of dental manpower and the lack of development of preventive services." To him, the then recent recognition of hygienists and denturists through legislated practice, and the transfer of services from private to public sector, were responses to such failures, and would in turn reduce costs and increase accessibility:

"Under Denticare, between 1974 and 1982, more than $350,000,000 (Can.) were spent on services provided in private surgeries. It is estimated that, at the present growth rate, the total cost of the scheme will double every 3 years. Approximately 10% of these sums were devoted to preventive services, namely teaching dental hygiene basics, cleaning the teeth and topic application of fluorides. Arguing financial constraints, the Ministry [has] now reviewed its policy of subsidising preventive services to individuals in private surgeries [and] estimates that a school and hospital based preventive service employing hygienists working under the supervision of dentists would cost less than the present system […]. Such a scheme would supply preventive services right from the start to 95% of school-children, to 80% of preschool-children, to pregnant women and to chronically-ill persons in long-stay institutions, whereas under the present system only 70% of school children and 25% of pre-school children receive such services" (168, p. 254)

So in 1982, Québec launched the Preventive Dental Services Public Program (164) (see Tables 44, 45, and 46). The program was to employ 32 dentists and 387 hygienists, at an estimated cost of $13,717,877 (167). Stamm et al. (21) do not report on expenditures, but described 20 full-time equivalent dentists and approximately 200-250 dental hygienists (see Table 44). Today, throughout the province's 18 regions and 95 health centres, the program employs approximately 23 dentists and 230 dental hygienists, at a human resource cost of $12.4M per year (169). Hygienists are led by dentistes-conseils located in the 18 regions, and have reporting relationships with both the region's director of public health, and the dentistes-conseils at the Ministère Santé et Services sociaux (170).

By the late 1980s, Québec was in the process of health regionalisation (see Table 3), and would soon reach a low in public financing for social assistance programming, including public dental care (see Figures 34 and 36). Yet unlike most other provinces, the low-

income household budgetary share for dental care was at historical lows by 1992 (see Figure 35).

That year, the children's dental program was again clawed back, limiting coverage to children under 10 years and excluding those 10 to 15 years from both treatment and private preventive care (165) (see Tables 45 and 46). Similarly, in 1996, in response to the CHST, three new rules for social assistance recipients were established: the waiting period to access care increased from 6 to 12 months consecutive; a new waiting period of 24 months consecutive for periodontal services; an increase from 5 to 8 years for replacing prostheses (165, 166). In 1997, the government further restricted children's programming by reducing the yearly frequency of allowable dental exams in private offices from two to one (165). The impacts of these limitations are well represented in public expenditures and in the low-income household budgetary share for dental care (see Figures 34, 35, and 36).

As a province, Québec is generally considered progressive in its social programming. For example, in 1989, approximately ten years before 'food' became an important issue in national health policy circles, the province implemented a school food policy, aiming to shape healthy eating habits through education, and by promoting change in the school food services industry (171). In 2001, Québec also began supplementing existing federal refugee/newcomer health coverage by insuring select newcomers during the 3-month waiting period prior to eligibility for provincial health and social services coverage (165, 172) (see Figure 34). Services became available to victims of domestic violence or sexual abuse, those requiring care for pregnancy or its termination, and for individuals with an infectious disease deemed a public health risk (172).

Québec has also been at the forefront of provincial support for population oral health research and surveillance (173-178). This support is linked to the research activities of both, the Institut National de Santé Publique du Québec, a provincial organisation that conducts and disseminates applied public health research, and Le Réseau de recherche en santé buccodentaire et osseuse, a provincially funded network of academics involved in oral health research. This level of organisation is also well reflected in Québec's reporting of dental health services data (165) (see Tables 48-59).

By 2003, the low-income household's budgetary share for dental care was now reaching historical highs (see Figure 35). In turn, as elsewhere in Canada, the province increased its attention on issues of access, and in 2004, it commissioned a study to explore ways by which to address the challenge (179). Québec is also the only Canadian jurisdiction where a global plan of action has been drafted in order to address population oral health (180). The plan is commendable for its clear and measurable objectives, and for its support of evidence-based clinical and policy practice. To be sure, Québec is now a national leader in the planning and delivery of public oral health care services.

New Brunswick

New Brunswick established a provincial dental department in 1948 (33) (see Table 3). During the next thirty years, as occurred nationally in response to a developing welfare state and legislation such as CAP, the province introduced social assistance programming and began financing some in-hospital dental care (see Tables 60 and 64). More specifically, in 1972, the Department of Health introduced a school-based preventive dental health services program, and three years later, added treatment services to targeted groups of children (21). By 1979, a province-wide weekly fluoride mouth rinse program was also in place for grades 1 through 6 (181).

As Stamm et al. (21) note, the province's programming developed almost exclusively of private sector involvement, and by 1983, delivered preventive care with 13 full-time and 2 part-time hygienists, and treatment services through 5 salaried dentists in three regional clinics. Sessional positions were also available for a mobile component, which focussed on under-serviced areas (see Table 60). These investments are reflected in the province's financing of public care, and in Atlantic Canada's low-income household budgetary share for dental care (see Figures 37 and 38).

By the mid 1980s, as elsewhere, services were in decline, leaving the province with only a school-based fluoride mouth rinse program, and only 1 dentist and 4 hygienists in government (182). In turn, by the early 1990s, the government's dental department had been eliminated, and in 1995, the remaining 2 hygienists at central office followed, replaced by a dental health education resource for schools named Smile New Brunswick (182). It is reported that this resource is not currently in common use (182). Such declines are observable in public financing, and follow the common provincial impacts of regionalisation and the CHST (see Tables 3 and 61, and Figures 37 and 39).

Aside from social assistance programming, the fluoride mouth rinse program is the only program that continues today, at an estimated cost of $50,000 per year (see Table 62). Available to children aged 1 to 6, it is delivered by teachers and community volunteers, and managed by a registered dietician centrally (182). Nonetheless, the program is under review due to a steady decline in participation (182) (see Table 63).

Nova Scotia

Nova Scotia is the first Canadian jurisdiction where a non-governmental organisation took on the role of dental service provider. While not formally an non-governmental organisation as they are known today, the Halifax Visiting Dispensary Society was the mid 19thC equivalent, supported by philanthropy and by a provincial grant. Services were free of charge, delivered at specified hours daily, with a small fee assessed if patients could contribute (33).

Dental services are reported to have stopped at the dispensary in the early 1920s, "replaced by school dental clinics" (33, p.175). Yet the Society is also reported to have moved into the Dalhousie University Public Health Clinic in 1924, having a Board of Directors and producing annual reports until 1966 (183). This is a pertinent detail, as it provides historical roots to university dental faculty involvement in public dental health care delivery.

Nova Scotia established a provincial dental division in 1948 (33) (see Table 3), and in the 1950s and 1960s, operated "an active dental public health service" (21, p.46). The latter provided care mainly to children in rural areas, and continued into the 1980s (21) (see Table 65). Interestingly, as compared to most provincial response to CAP, Nova Scotia did not introduce a province-wide social assistance program in the 1960s (21). It instead administered an income support program for disabled persons and single mothers, and through cost sharing, authorised the province's then 66 municipalities to provide financial assistance under a General Welfare Assistance Act to anyone with a 'special need' (see Table 65 and 69).

In 1974, as Saskatchewan and Québec had done that same year, the province then introduced a universal children's dental care plan (21) (see Table 65):

"Nova Scotia's program consisted of a publicly-funded, third-party reimbursement scheme along the line of those operated by Newfoundland and Quebec, rather than a direct service program such as was implemented in Prince Edward Island and Saskatchewan" (21, p.45)

It is important to note that across Canada, administering service claims has either been done by governments directly, or by a third party, whether for-profit or non-profit, including the profession. In Nova Scotia, the task of administering claims was given to the Maritime Medical Care Inc., a private, non-profit pre-payment insurance plan established in 1948 (21). In 1967, the non-profit was contracted to administer all provincial health service claims through the Nova Scotia Medical Services Insurance program (MSI). It is MSI that acts as the legislative and institutional bases for remuneration (see Table 69). Fee schedules were negotiated between the Health Services and Insurance Commission and the province's dental association as they are today.

By 1980, alongside this form of third party financing, it is reported that there were also 9 dentists and 28 dental hygienists working in the Department of Health's Dental Division

delivering care in rural schools (184). Three new programs had also been established by this time: the broadening of eligibility for students registered at the Sir Frederick Fraser School for the Blind in 1976; an in-hospital dental program for the severely developmentally disabled in 1977; and that same year, an extension of dental coverage for cleft palate cases registered with the Cleft Palate Unit at Izaak Walton Killam Hospital for Children (see Table 65). All of these programs exist into today (see Table 68).

These investments reflect in public financing and the low-income household budgetary share for dental care (see Figures 38 and 40). Yet difficult economic times were then reported in 1983:

"1. With respect to the Children's Dental Program sponsored under [MSI], most noteworthy is the cut-off age for children insured under the government program [no cut-off had ever been established]. As of November [1982] eligibility will cease on the last month in which the child turns sixteen yeas of age. […] 2. There will be minimal funding under the Dental Incentive Grant Program to secure dentists for underserviced areas. […] 3. All financial assistance under the Dental Hygiene Bursary Program has been cancelled. […] 4. There is no funding under the Fluoridation Grant Program to assist [communities] in installing fluoridation equipment in their water systems" (185, p. 24).

Interestingly, unlike anywhere else in Canada, the 1984 Canada Health Act had impacts on Nova Scotia's public dental care system. Prior to the act:

"[Dentists] could charge fees in excess of the scheduled amount provided that the patient was notified in advance in writing and agreed to the extra charge, and provided that MSI was notified of the extra charge when the claim was submitted. Consequent to [the Act] which required the federal government to reduce financial contributions to provinces allowing extra-billing […] the Nova Scotia Health Services and Insurance Act was amended to eliminate the practice" (21, p.47).

Financing for public care peaked around the same time, and as the Canadian average, has been in steady decline ever since (see Figure 40). Similarly, cuts were significant by 1996 as per the CHST and regionalisation, yet had recovered somewhat by the year 2000 (see Tables 3, 65 and 66, and Figures 40 and 41).

By this time as well, the universal children's program had undergone a series of eligibility and service limitations, and public programming no longer included dentists (31, 32). Public programming was in general undergoing change, as reflected in the standardisation of the province's fluoride mouth rinse program (186, 187):

"The school-based fluoride mouthrinse program was mandated by Ministerial announcement in 1998. Over time, the recommended provincial protocol was adapted to regional and local preferences. A review initiated by an Ad Hoc Committee of the Public Health Enhancement Core Working Group in July 2001 was intended to determine the protocol variations, and then to provide a revised standardized protocol to be used across

the province. […] Recommendations from a consensus conference included the investigation and development of a model of eligibility based on population health indicators, specifically those related to socioeconomic status. […] By arrangement with the Statistics Division of the Nova Scotia Department of Finance, a new model was created. […] The application of the census indicators to school catchment areas resulted in a ranked list of elementary schools in Nova Scotia. […] Nearly 40 percent of all elementary schools were included with 71 schools continuing in the program, 70 new schools added, and 34 schools retiring from the program. Further validation of the population indicators and model of eligibility can be undertaken by comparison of the school populations selected using those indicators with dental caries risk assessed by intraoral screening at program baseline" (187, p. 4)

This strong population health approach also reflects the province's reporting approach to public dental care (see Tables 70-77). In this regard, the province has also become a national leader on equity and policy issues concerning oral health in long-term care and seniors' populations (188, 189).

Prince Edward Island

Prince Edward Island (PEI) established a provincial dental division in 1950 (33) (see Table 3). Similar to Nova Scotia, it did not adopt a province-wide social assistance program in response to CAP. Instead, it too provided care on an as needed basis (21) (see Table 82). Yet as other jurisdictions, PEI began its Children's Dental Care Program (CDCP) in 1971, enrolling all 6-year old children (21) (see Table 78). For the first six years, salaried personnel in fixed and mobile clinics delivered most care, and did so in a way that was new to Canada, namely through expanded-duty dental hygienists and assistants. The former were trained at Dalhousie University's Faculty of Dentistry, and could place amalgam fillings in teeth prepared by dentists. The latter were trained at the community college level, and could clean, polish, and apply topical fluoride to teeth. The feasibility of providing care in this way was established through a demonstration project funded by the federal government conducted in PEI from 1969-1972. Interestingly, in 1975, the CDCP came to include an interceptive orthodontic clinic, something that was novel in Canada as well.

"It was hoped from the outset that dental care under the plan would be rendered jointly by the private and public sectors, but concerns about fee levels, cost control, and quality assurance delayed this goal [until] 1977" (21, p. 55). Such inter-professional challenges have been described in other jurisdictions, and as elsewhere, similarly resulted in the decline of public programming. By 1983, the province's novel approach to delivering care was essentially gone, and while the practice of using dental assistants continued, the use of expanded duty dental hygienists was stopped. That year also observed the first major cuts to the program, removing children aged 13-16 years, and limiting services to those aged 4-12 years (190). Such a slow down is well observed in public expenditures (see Figure 42).

Unlike other Canadian jurisdictions, PEI observed some early rebounds and even growth in the context of government retrenchment. For example, reductions in CDCP eligibility were actually restored in 1986 and 3 year-olds were also added to the roster. Additionally, and again demonstrating the importance of dental education in public dental health care systems, "[w]ith the assistance [of] Dalhousie University a dental program for institutionalized seniors in government nursing homes [was] developed" (191, p. 31). This program was formally introduced in 1990, and other new programs such as school-based preventive programming and cleft palate orthodontic treatment funding were introduced by 1995 (see Tables 80 and 81). This growth is also well observed in provincial expenditures for dental care (see Figure 42). Nonetheless, PEI did not escape the impacts of the 1995 CHST as is also well observed (see Figures 42 and 43). In fact, "[d]ental public health programs [were then] currently under a program review, and future changes to [programming] are possible" (192).

Importantly, PEI demonstrates the valuable role of a strong centralised dental public health leadership. From 1968 to 1994 for example, the province had a single dental public health specialty trained director (193), and continued this trend with a community dentist in the position into today. This has arguably buffered programming from the funding

shortfalls of the period (see Figure 43), and from regionalisation (see Table 3). To be sure, the province's strategic plan for its health and social services system from 2001-2005 described dental health as part of a regionalised and integrated system that nonetheless faced fiscal uncertainty and human resource shortages (194).

New services were even introduced, first in 1998 in the form of early childhood initiatives (screening and risk assessment), and then in 2001 as a paediatric specialist services dental program (see Table 81). The former was coupled to public health immunisation clinics, demonstrating the importance of interdisciplinary approaches to public health intervention, and the latter was a response to a shortage in the supply of paediatric care.

More recently, in 2004, the CDCP introduced a means-tested 20% co-pay on treatment services (restorations and extractions). This resulted from the common concern for cost control, and discussion among the province's leaders highlights this and other themes now common across Canada:

"[Legislative Member #1]: I just want to make sure that [the CDCP] program is staying the exact same this year. There are no changes to that program? […] [Legislative Member #2]: It's going to be maintained, yes. […] Right now we are under negotiations with the Dental Association of PEI. Their contract is up this year and we are bargaining with them, and we're getting along, and we hopefully will be able to fairly soon announce if there are any changes to the program. […] [Legislative Member #1]: Just a fear I always have. I [also] have a question in regards to seniors. […] A couple of seniors mentioned there is no support for them in terms of dental [care]. […] [Legislative Member #2]: The last time there was a cut to this program was done by your [government] and we reinstated it […]" (195).

Today, the province is facing the retirement of its dental director, bringing to attention the need for succession planning in public dental health care leadership. Programming appears to be stable (see Table 83) (196), with the province maintaining the third highest per capita share for public dental care across the country (see Figure 11).

Newfoundland and Labrador

Newfoundland established a dental division in 1952 (33) (see Table 3), yet in 1950, by order-in-council, the province was the first in Canada to establish a publicly financed children's dental treatment program, the Newfoundland Children's Dental Program (NCDP) (21). Initially, the program was limited to 5-year olds and conditional on residence and the availability of a participating dentist. Since its inception, almost all dentists have participated in the NCDP, early on working for an hourly rate, but by 1965, functioning in a fee for service system. In 1975, the program had become universal, covering all children under ten, with residence no longer limiting eligibility. Three years later, coverage was expanded to include all children under twelve (see Table 84).

Similar to Nova Scotia and Prince Edward Island, the province did not introduce formal social assistance programming in this time, and only financed limited services for those receiving public transfers. Yet as these provinces also did, it extended NCDP coverage to children of families receiving such assistance (see Table 84). Ultimately, the growth of the NCDP resulted in the fastest growing per capita expenditures for public dental care across the country (see Figures 11 and 44).

Historically, dental care in northern Newfoundland and Labrador is important to mention, as it is associated with a distinct aspect in the development of dental care in Canada. This history involves the development of northern, largely indigenous areas, predominantly serviced by federal authority, and linking to the nature of State/Indigenous relations. This history will be developed in the forthcoming description of the territories, but essentially applies to the northern regions of this and most other provinces. At the very least, it applies to those indigenous persons in Canada who access or have accessed dental care financed by federal authority, whether in an urban centre or in a northern community.

In brevity:

"It is possible to break [this history, in a very general sense,] into four main periods. The first was the pre 1940 era when most dental care was carried out [traditionally], or [by] dental volunteers during the summer. [In northern Newfoundland and Labrador] dentists came from the United States with the Harvard Dental School being particularly prominent. In the winter months the Moravian Missionaries, doctors, nurses and the occasional volunteer dentist provided such care as was possible, mainly emergency extractions. [In some cases, the natural resource industry and the military acted as service providers.] The second period from 1940-1960 saw the establishment of permanent dentists located strategically [and] travel[ing] to the surrounding communities. The third phase […] occupied most of the [1960s and 1970s]. Dental services were expanded and improved to provide better cover throughout the [the north, using contract and salaried dentists and/or Canadian dental faculties]. The fourth phase began in the late 1970's and early 1980's when comprehensive dental care became available throughout the area and preventive and educational programmes began to be implemented region wide [in partnership with federal and indigenous authority]" (197, p. 45).

By this time, services in northern Newfoundland and Labrador had become the responsibility of the International Grenfell Association, then "often still referred to incorrectly as 'the mission'" (197, p. 45). The health service delivery organisation employed salaried dentists, and had a specific dental division, staffed by a Chief of Dental Services and two other clinicians (197). In 1981, the Association turned its entire medical care assets (nursing stations, hospitals, equipment) over to the provincial government. This coincided with what is reported to be the province's first round of regionalisation (198), which in the north, created the Grenfell Regional Health Services and the Health Labrador Corporation.

The establishment of regional health units also reorganised the province's "Dental Services Program by separating the public health aspects of dental services from the Children's Dental Program [CDP]" (198, p. 26). By 1985, a Division of Community Dentistry had been created (199), while the Newfoundland Medical Care Commission, established in 1968 to administer the provinces Medical Care Plan, took responsibility of payment aspects of the 'Dental Health Plan' (200) (see Table 87).

As elsewhere in Canada, by the late 1980s, public dental care financing in Newfoundland was in significant decline (see Figure 44). It is reported that in 1992, a $7.2M budget was reduced to $5.2M (201), and that all dental fees were frozen (201, 202). In turn, another round of regionalisation and the CHST also had their effects (see Table 3 and Figures 44 and 45). By 2000, the CDP had introduced a five dollar co-pay (see Table 85), and it was now common practice for dentists to 'balance bill' to the current professional fee guide (201, 202). Importantly, some service detail is available for this time (see Table 88).

By 2005, CDP payments were approximately 40% of the suggested fee guide, and it is reported that 'this imposed an economic barrier to access for individuals with limited financial resources, resulting in particularly adverse impacts for working poor and rural populations' (202). CDP expenditures had also now been reduced to an estimated $4.0M from $5.2M (201, 202) (see Table 86 and Figure 44). As a result, public health stakeholders began to argue for renewed investments in public dental care, and chose to concentrate on the significant resource demands associated with preventable paediatric operating room surgeries for early childhood caries (202, 203).

Oft quoted is a report conducted by the Newfoundland and Labrador Centre for Health Information on day surgery utilisation (203). The report found that in 1997, dental surgeries represented 6.2% of all surgical day cases, and that in terms of the principal diagnoses for all such cases, dental caries ranked third in the province, and first for the Grenfell Regional Health Services and Health Labrador Corporation. By 1999, there were 2272 dental day surgery cases in the province, most involved extractions and/or restorative dentistry, and 61.5% of them were associated with children less than 15 years of age (203) (see Table 89). It is also estimated that the non-dental, general anaesthetic costs for such services can reach $7M per year (202).

Ultimately, public stakeholders have asked: Why is this volume of children being subjected to the risks associated with general anaesthetic care? What are the true societal

costs associated with these cases of preventable disease? Is Newfoundland and Labrador's current Dental Health Plan effective in treating and preventing dental disease? (203) As in other Canadian jurisdictions, steady pressure has resulted in renewed investments, and in 2006:

"[The] government announced a $4.1 million investment to improve the effectiveness of the children's dental health program. As outlined in the agreement signed by the minister and the Newfoundland and Labrador Dental Association, government will significantly increase the fees under the MCP Payment Schedule, bringing them more in line with the levels in the [Association's] own fee guides. This will eliminate the need for 'balance billing,' which was a significant financial barrier to children visiting their dentist" (5).

By now, it is clear that across Canada, public dental health care renewal is the order of the day.

Nunavut

Nunavut was created in 1999. Immediately before this, its geographic area represented the three most eastern Arctic health regions of the former Northwest Territories (NWT). These were the Kivalliq, Keewatin, and Baffin Regional Health Boards.

As described for Newfoundland and Labrador, apart from traditional healing methods, the development of dental care in Canada's northern regions is historically linked to church, military, industry, federal, and academic activity. Prior to 1940 for example, C.H.M. Williams, R.W. Leigh, and C.S. McEuen all ventured north on federal supply ships through their involvement with the military and/or academic dentistry (33, 204, 205). Over the next thirty years, a minimal level of federal activity predominated (206), but by 1970, as public dental care programming was beginning its tremendous expansion across the country, federal investments took their early shape.

Federal efforts initially focussed on salaried providers, on contracting the services of private practitioners and Canadian dental faculties, and most importantly, on the training and disbursement of a dental therapy workforce. As Saskatchewan and Manitoba, the Medical Services Branch of Health and Welfare Canada (MSB) opened a training facility and hired graduates for service provision in rural and northern indigenous regions. These investments are well represented in the per capita financing of dental care within the former NWT, which follow the trends of the period, namely rapid growth up until the early 1980s, followed by periods of decline (see Figure 12).

By the mid 1980s, private practices were more commonplace in major northern centres, and they too were contracted to deliver care to neighbouring communities. Also in place were federally supported, territorial government based, public health treatment programs, generally involving the partnered coordination of dental and dental therapy services (see Table 93). These programs were created as territorial governments grew and developed their own capacity in health services administration and delivery. In time, they came to absorb federal programming through the processes of territorial devolution and health regionalisation (53, 54).

Devolution refers to the efforts, by territorial and indigenous governments, to establish independent decision-making power for territorial governments. Health regionalisation refers to the creation of Regional Health Boards in the former NWT. The Baffin Regional Health Board was the first in 1986, and two years later, health boards were present across the territory. Again, with that came the gradual transfer of public dental care programming to the territorial government, and to the regions where federal and territorial dental staff were present.

This transfer of control was also associated with increases in operational funding, so as opposed to the provinces, which were experiencing declines in the public financing of dental care, expenditures in the former NWT demonstrated significant growth at this time (see Figure 48). Moreover, with a young and rapidly expanding indigenous population,

and with changes to federal legislation that made many in the territory eligible for federally financed care, such growth is also largely attributed to utilisation (207).

Importantly, devolution and the creation of health boards were tightly linked to indigenous political efforts. In the former NWT, regions were defined as much by cultural boundaries as they were by administrative ones, and the social push to create self-governing territories was strong. By the early 1990s, dental care in the three pre-Nunavut regions became tied to such a dynamic.

With efforts at self-determination, territorial and indigenous political and corporate organisations pushed for the formation of policy that favoured northern and indigenous business interests in the contracting of services, and dental care was such a service. As southern dental markets became saturated, interest in the service contracts offered by territorial and federal authority grew, creating a small but viable economy based on a competitive contracting process (53, 54, 206). This involved historical contractors, namely dental faculties, northern private practices, and itinerant private practitioners.

In the pre-Nunavut regions, those dentists that owned northern private practices and that lived in northern communities took advantage of policy that awarded points to businesses whose central offices were in the north, and whose owners were resident. By the mid 1990s, these contractors controlled most of the dental care delivered in the pre-Nunavut regions, displacing other long-term contractors. The economic realities of the time were key, as the slowing of federal fiscal transfers for health and social services promoted any effort at cost saving (see Figure 49). In short, it was easier to fly in dentists one community away than it was from tens of thousands of miles away.

Funding shortfalls also promoted the idea of 'P3 planning,' or 'public private partnerships' in the former NWT, and dental care became a test case for such an approach. The P3 plan involved contracting the administration and delivery of all dental care, including dental therapy, to the existing contractor. More territorial cost savings were perceived in the contracting of the dental therapy program, as the contractor would bill dental therapy services directly to federal authority, removing the need for a large component of territorial administration.

Dental therapists and the communities that they worked in did not respond positively to the P3 plan, as it was unknown if the contractor would rehire dental therapists, or whether dentists would take over the provision of all care. Federal authority was not supportive either, as this was viewed as a form of cost shifting. Some indigenous organisations also viewed the P3 plan as a step backwards in their efforts at devolution. With so much countermovement, the contractor and territorial government stepped away from the P3 plan, and returned to previous activity. New contracts were then tendered, and historical arrangements were re-established with dental faculties and other itinerant contractors.

With the creation of Nunavut in 1999, health boards were disbanded, yet services remained coordinated on a regional basis, but now connected to a central administrative authority within a single Department of Health and Social Services (see Table 90). The

new territory continued the approach to service provision that began with the former NWT, one that stressed dental therapy, contracted services, and financing for seniors not eligible for federal programming (see Tables 94 and 95). The new territory also continued the financing of in-hospital care. In this regard, Nunavut simply turned over existing NWT legislation and made it their own (see Tables 91).

Contracts for dental service were re-tendered in 2001. As was the custom, the Nunavut Land Claims Agreement directed the new territory to engage in "preferential contracting policies, procedures and approaches intended to maximise local, regional and northern employment and business opportunities, and implement measures that will increase participation of Inuit firms in business opportunities" (208). As a result, historical non-resident contractors began to build dental offices in major territorial centres, and/or partnered with indigenous professionals.

In this competitive environment, contractors claimed that they would aid or take over the territorial administration and delivery of dental public health services. They also promoted plans to offer such services as a specific contract service, an option that was not taken by the territorial government, but one that afforded academic providers legitimacy, as they represented the seat of this knowledge. In turn, contractors formed further strategic partnerships that incorporated academic stakeholders, creating larger, more expertise-rich corporations. These details are important in that dental service corporations may become more important in the context of a waning dental therapy workforce (51). Ultimately, by 2003, contracts were awarded to new and historical providers.

More recently, there has been a renewed focus on public health activities in Nunavut, such as emphasising the role of nurse practitioners and community health representatives in maternal and infant oral health interventions (209). Additionally, the territory plans to use existing telehealth technology to train a new cadre of local dental health/nutrition educators. Such public health renewal is linked to two factors.

Firstly, as mentioned, there now exists a chronic shortage of dental therapists across Canada. As of 2005, only 7 of 17 positions were filled in Nunavut (209). This makes primary health care interventions using non-dental personnel that much more relevant and necessary. Secondly, there has been an effort of trying to devolve some responsibility back to federal authority. Nunavut officials simply claim that they do not receive enough federal financing for the services provided every year within the territory (see Figure 47).

Federal authority has partly accommodated this through the creation of the Northern Secretariat, a "new 'single window' approach in facilitating optimum delivery of federal health programs and services in the territories in partnership with territorial governments, First Nations, Inuit and other territorial stakeholders" (210). In this regard, both are now jointly working on the implementation of the federally developed Children's Oral Health Initiative in two pilot communities (209). Ultimately, per capita financing for dental care within the territory appears to be growing (see Figure 46).

The Northwest Territories

As in most northern parts of Canada, dental care in the western Arctic is characterised by traditional, church, military, industry, federal, and academic activity. According to Gullet (33), the first recorded dentist in the western Arctic was W.P. Millar, who in 1922, spent six months in the far northwest on behalf of the Hudson's Bay Company. Archival evidence also places dentists in the western Arctic in and around the 1930s (211, 212). Between 1948 and 1956, British dentist Terrence Hunt photographically documented much of his experience while working for the Department of National Health and Welfare (213).

By late 1960s, when nursing stations were delivering a fuller complement of services, the infrastructure for dental care was still minimal. "[G]overnment salaries were too low to attract good personnel [and] dentists were far too busy in their private practices to have any interest in providing more than emergency care to Indian patients" (206, p. 127). As mentioned, apart from few salaried providers, federal authority turned to the contracting of services and to the dental therapy model as methods for meeting need (206, 214)

Compared to the pre-Nunavut regions, the western Arctic observed more economic activity, so as it's regional centres became larger places of social activity, economies of scale promoted the establishment of dental practices. In 1973, the Hay River Dental Clinic became the first private practice in the former NWT, with others eventually seeking similar opportunity (215). As resident providers, these practitioners were quickly contracted to deliver services to outlying communities.

By the mid 1980s, dental therapy and contracting were now the norm (see Table 92). As elsewhere, financing did slow, yet unlike most provinces, growth extended into the 1990s (see Figure 48). Again, this was associated with increases in operational funding for territorial programs (as per devolution and health transfer) but arguably more so relative to a growing indigenous population and changes to federal legislation that expanded eligibility for federal services (207).

The role of indigenous self-determination is equally important here as well. The western Arctic is not as culturally homogenous as the pre-Nunavut regions, so in this sense, devolution and the transfer of health programs involved a number of groups, each with their own claims and interests. The importance to dental programming appears when considering territorial health regionalisation.

The creation of regional health boards in the western Arctic resulted in nine boards, some defined by municipal catchments, but most by cultural boundaries. Over time, as global funding shortages developed, such a high level of regionalisation was considered negative to resource allocation:

"One of the key underlying issues which gives rise to [internal competition] is the dispersal of resources which an overlay of nine boards requires. That is, each CEO and Board, in an understandable effort to provide 'their' residents with the best service

possible, and in response to the pressures from their respective Boards, tries to offer a full range of services. While this may sound commendable, this effort simply serves to stretch already thin resources close to or beyond the breaking point" (216, p. 12).

As everywhere in Canada, the CHST had produced strain, and for dental care, the challenges of 'thin resources' were relatively immediate, meaning that the territory was by now experiencing funding shortfalls and dental therapy shortages (see Figure 48) (214).

This state of affairs was also coupled to the social tenuity of the time; namely, many wondered whether funding levels would maintain with the creation of Nunavut. Some even wondered whether the territory would keep its name. The transition to Nunavut did in fact have impacts, as is evident in the sudden drop to financing circa 1999 (see Figures 12, 48 and 49). With the end result of administrative separation known, an opportunity was taken to consider the new NWT's governance structure, service delivery organisation, and current needs (216).

In this regard, the NWT produced a report on the territory's health status, aiming to set priorities and directions (217). The report described dental problems as an important concern. In 1997 for example, approximately 13% of territorial hospitalisations were due to problems of the digestive tract, of which dental problems were described as a key contributor. The significant level of dental disease among children was also targeted for immediate public health action.

The territory also commissioned a comprehensive review of the health and social services system (216), which recommended the streamlined administration of services through one Department, supporting the activities of three new Health and Social Services Authorities. In the end, the NWT restructured into one Department and eight Authorities, and in terms of dental services, chose to administer claims processing functions centrally, while supporting and collaborating in the dental therapy and public health activities of its new regions (see Table 93 and 94). Legislatively, the territory rolled over its existing Acts (see Table 95).

More recently, as in Nunavut, dental therapy shortages have promoted a renewed focus on prevention. For example, in 2003, the territory reported using its Health Promotion Strategy Fund to support numerous community-based oral health projects. Aimed at 'improving the health of prenatal women, infants, children and youth,' these projects include:

"[A]n NWT-wide dental health program that targeted dental decay and baby bottle tooth decay in young children. A training program was implemented for health care professionals to learn the application of fluoride varnish. […] [One] Health and Social Services Board incorporated a healthy breakfast and dental program in its school. […] [Another] set up a program with the local school to have a daily brushing program and a weekly fluoride rinse" (218, p. 15-16).

Funding shortfalls have also promoted the idea of devolving some administration back to federal authority. Again, this was partly accommodated through the newly created Northern Secretariat. In this restructuring of balance, challenges have appeared, specifically relating to what the original transfers of programming actually meant in the former NWT, and how this would influence the rationing of care:

"The federal-territorial health transfer agreements have limited the eligibility of First Nations for certain federal programs, for example, […] preventative dental care. […] Existing treatment and dental prevention services were included in the federal health transfer agreements with the [Yukon] and the [NWT] […]. The federal policy is to prevent duplication of funding in areas which have been transferred to territorial jurisdiction. At the time of the federal health transfer to the territories, federal programs were often minimal. […] Preventative dental services were school-based. However, the federal government's position is that the school services were representative of a dental prevention program which was transferred and therefore any further expansion in this area is the responsibility of the territorial government, and not [federal authority]. The [NWT] maintains that they received only a school-based program and have no commitment to a larger dental prevention program to First Nations. That this federal decision on non-eligibility could be counter productive to [the] financial bottom line given the significantly poor dental health of children in the north was only considered after advocacy by the Northern Secretariat […]. Eligibility for […] first year pilot funding [of a children's oral health initiative] was extended late to Inuit in Nunavut – a population where $2 million in federal funds was recently spent on hospital-based extractions to children […]. First Nations in the territories who also have high emergency extraction rates in children are currently non-eligible for [this initiative]; however, a broader eligibility in the territories which will include First Nations is now being considered" (219, p. ii-iii).

In terms of financing, the NWT did experience some renewal post-Nunavut, but as stated, investments have declined sharply since 2002 (see Figure 48). Whatever the case, dental therapy shortages appears to be the most pressing issue for northern dental care planners:

"Dental Therapist (3 Positions) Description: The Inuvik Regional Health & Social Services Authority serves eight communities in the Inuvik Region via community Health Centres and the Regional Hospital in Inuvik as well as providing regional services to five Sahtu communities. The Dental Therapy Program offers regional dental services in Inuvik and to four surrounding aboriginal communities with visiting services/programs provided to the remaining communities. Dental Therapists work with health centers, schools and a variety of community resources to provide basic dental care, dental health promotion and education to primarily school-aged children. […] Salary range of $34.71 to $39.38 per hour ($67,684.50 – $76,791.00 per annum) plus a Northern Allowance of $$8,552 in Inuvik; $10,651 in Aklavik; and $11,381 in Tuktoyaktuk per annum. Close Date: Open" (220).

The Yukon Territory

The Yukon follows the same historical trends as the other territories, yet it defined the operation of two public dental care programs much earlier on:

"The Yukon Children's Dental Program was implemented in 1963. [This] program is administered by [MSB], while program expenses are shared between the [Territory] and the federal government. The dental program for the elderly is included in the Yukon Extended Health Care Benefits (EHB) program implemented in 1982 in response to concerns for the welfare of senior citizens in the Territory. The EHB is administered by the Yukon Health Care Insurance Plan [and] is similar to [programs] in Alberta [and the NWT]" (21, p. 76)

The structure of children's programming at this time also reflected territorial norms:

"Under the Children's Dental Program, diagnosis, treatment planning and consultation are provided by [contracted and salaried] dentists. The bulk of the remaining treatment services are provided by dental therapists in school clinics. […] The dental therapists are employed by [MSB]. However, all other costs for this program are shared between the federal (30 per cent) and Yukon (70 per cent) governments. One dentist and one clerk, employed by [MSB], provide the administrative support for the [program]" (21, p. 76) (see Table 96).

Expenditures in the Yukon further follow from established territorial trends: significant growth from 1975 onwards with declines in the early 1980s (federal expansion and economic recession); growth into the 1990s (increased operational funding for territorial programs, growth of indigenous populations, changes to federal eligibility criteria); volatility into today (the impacts of the CHST and State/Indigenous relations) (see Figures 50 and 51). Although uniquely among the territories, the Yukon's financing of seniors' dental care has a legislative basis (see Table 99).

The transfer of health programming from federal to territorial authority occurred in 1997 in the Yukon, and this included the Children's Dental Program. As a result, today's Department of Health and Social Services administers claims associated with the delivery of care in private practice, and the Community Health division organises dental therapy and contracted care centrally, supporting the activities of 13 rural communities (221) (see Tables 97, 98, and 100). Importantly, dental therapy shortages are also present in the territory (222). Finally, similar to the other territories as well, the transfer of health programming and the influence of indigenous self-government have combined to create challenges in the rationing of dental care:

"Yukon First Nations assert that they do not receive comparable funding from the Yukon Government for the delivery of programs and services otherwise meant to be provided through federal enhancements, nor do they receive territorial services in their communities which are comparable" (219, p. ii).

Conclusions and Recommendations

It is clear that publicly financed dental care is in a time of renewal. From the start of this report's data collection in early 2005 for example, four provinces have announced targeted investments in public dental care (2, 3, 5, 223). This is change in the context of twenty years of decreasing expenditures, and in the context of a general waning in public health dentistry nationally (e.g., in 1990, every province and territory had a dental director or consultant, by 2006, only seven had such a position). This report has descriptively outlined the nature of this decline, demonstrating impacts in relation to economic recession, inter-professional challenges, legislative changes, and health regionalization.

As Stamm et al. (21), this report has also documented the historical development and current status of public dental care programs in Canada. The goals were so similar that the Stamm Report's words can almost be reproduced:

"Canada experienced a remarkable [decline] in dental care programs during the [1980s and 1990s] […] A number of expected problems accompanied the rapid [decline], including vague goal-setting, [reduced] planning, uncertainty about […] expenditures, and inadequate record-keeping. These problems, combined with the diversity of dental care programs, have resulted in confusion about the present status of the programs. More succinctly, […] as dental care program[s] began to abate [eventually becoming fractionated and in some jurisdictions completely stopped] it seems timely to take stock of what exists in the field" (21, p. 1).

With this task complete, we must now make statements on future directions.

The future of publicly financed dental care appears positive in Canada. Yet over the long-term, in order to safeguard governmental interest and expertise in oral health, and in order maintain and/or expand existing programs, public health dentistry must make efforts to strengthen leadership, to develop standards for the rationing of services, and to promote its evidence base.

To make this case, and as another corollary to the Stamm Report, this final chapter will be structured into several parts. First, we will provide a summary overview of publicly financed dental care in Canada. Second, we will consider the dental care policy questions that result from this analysis. Third, we will make recommendations based on the idea that leadership, rationing standards, and evidence hold the greatest potential for the success of publicly financed dental care in Canada.

An overview of publicly financed dental care in Canada

Since policy and programs are derived from legislation, we will focus this summary review on the varied legislative provisions associated with public dental care in Canada. This will provide the global perspective that would be expected from an environmental

scan such as this, and will set the discussion concerning policy.

To say there is variance between provinces and territories in terms of the legislative provisions dealing with dental public health is perhaps unsurprising. Each Canadian health jurisdiction has uniquely established, by local custom, different ways to ration dental care. So apart from legislatively mandating spending under provincial and territorial medical care insurance plans, as required by the Canada Health Act, provinces, territories, and their administrative regions exercise a wide degree of discretion on dental public health related matters. Yet they do have commonality, in that all jurisdictions recognise some dental care as medically necessary, and all set a social minimum, meaning that every province and territory targets dental health care resources to marginalised groups using varied health and social services provisions.

Recipients of surgical-dental services

All provinces and territories provide for coverage of surgical-dental services delivered in hospital and/or for those associated with congenital abnormalities under their Medical and Hospital Insurance statutes. All of these statutes exclude services for those covered under financial arrangements with the federal government (e.g., veterans, refugees, those with a state-recognised indigenous status). Most jurisdictions have specific cleft palate programmes in relation to this legislation. Some jurisdictions have a listing of services that are insured. Manitoba is among the jurisdictions using this approach. At the other end is the approach of employing some version of "medical necessity," relying on the treating practitioner to determine whether the services properly fall under the in- and out-patient services insured by the jurisdiction. The Yukon adopts this approach. Most jurisdictions fall somewhere in between, listing broad categories of services for which some element of discretion is retained.

Social assistance recipients

Social assistance recipients and their dependents form a large part of the subpopulation for which jurisdictions finance dental care, albeit to varying degrees. Coverage within and between jurisdictions varies with the application of specific criteria set by the various social assistance-related schemes. Most jurisdictions disaggregate their social assistance recipient populations into categories that are based on their perceived ability to become self-sufficient, and then distribute funding for services accordingly. An example of this approach is Alberta, which employs the use of the following categories: Not Expected to Work, Expected to Work, and Learners. Recipients and their dependents in the first category are entitled to supplementary care whereas those in the latter categories receive coverage only for relief of dental pain and infection. This categorization is directly drawn from the legislation. Other jurisdictions, such as Quebec, draw no broad distinction between social assistance recipients in terms of their eligibility for receiving benefits. Still others do not deal directly with dental services in their social assistance legislation. Newfoundland and Labrador's legislation on general social assistance does not explicitly mention dental services with the exception of defining dentures as a "special need" which may be available for applicants or recipients. Overall, discretion is the major defining factor in the financing of care for social assistance recipients.

Adults with disabilities

In some instances, persons with disabilities are subsumed into general social assistance legislation and then provisions are adjusted accordingly. Prince Edward Island draws the distinction between short- and long-term assistance, and persons with disabilities belong to the latter category. Under the social assistance program, recipients with disabilities are then entitled to diagnostic, emergency, prosthetic, preventive and restorative services whereas recipients of short-term assistance are limited to emergency dental benefits only. In contrast, some jurisdictions have separate legislation treating adults and children with disabilities. The Ontario Disability Support Program Act for example has a Dental Special Care Plan that covers costs for approved services and items for members of a benefit unit (i.e., family). Overall, in Canada, adults with disabilities and their dependents are invariably entitled to a broad range of services, from the preventive to the prosthetic.

Children

As a broad category of beneficiaries, children are entitled to the most dental health-related benefits under provincial and territorial legislation. Children living in low-income families, whether the families are in receipt of financial assistance or not, are typically entitled to some level of support for accessing dental services. For instance, in British Columbia, children of low-income families are entitled to health supplements and dependent children of social assistance-recipients are additionally entitled to orthodontic supplements. The Alberta Child Health Benefit, with its Supplementary Dental Coverage Program, derives its mandate broadly from the province's social assistance legislation. The only beneficiaries of Manitoba's dental health-specific legislation are children, a similar situation to Saskatchewan. Specific children's services are also legislated. Examples include Ontario's Children in Need of Treatment and related programmes and Newfoundland and Labrador's Dental Health Plan.

In addition to the provision of services for children in low-income families, there are often further targeted provisions in legislation dealing with children with disabilities, children in care, and children who are being adopted. Some jurisdictions specifically deal with the provision of financial assistance to families of children with disabilities or special needs. For instance, Ontario provides that dental benefits be provided when considered necessary for the welfare of the child. Similarly, Alberta provides that the costs of dental and orthodontic treatment be covered provided they are directly related to the child's disability. Children in the care of a province or territory may also be entitled to dental care paid for by the province or territory. Some of the jurisdictions legislatively adopting this approach include Ontario, New Brunswick, and Nova Scotia. Lastly, persons adopting children may be entitled to financial assistance for the dental care of those adopted. Jurisdictions with explicit legislative provisions in this regard include the Northwest Territories, Quebec, and British Columbia. Overall, with respect to access to dental health-related services, it is clear that children are privileged relative to the wider population.

Seniors, long-term care, and miscellaneous categories

In addition to the categories enumerated above, there are a number of other populations for which provisions of varying sorts are made legislatively. Seniors' services are specifically legislated in Alberta and the Yukon for example, and in other provinces, such as British Columbia and Saskatchewan, targeted financing is policy and program based. The lack of provisions for persons in long-term care does not mean that they are entirely neglected either, as they often fall under the provisions of social assistance or disability-related legislation or both. Prince Edward Island is also the only province with a specific funding provision for health care services (which include dental services) for residents of long-term care facilities that are not persons in need under social assistance. Another set of legislation that has dental provisions is that for victims of crime. Various provinces employ legislative measures to deal with either the reimbursement for services rendered or for their direct payment. Examples include British Columbia, Alberta, and New Brunswick.

A note on the direct public delivery of oral health care services

The only provinces to legislate the direct public delivery of oral health care services are Saskatchewan, Manitoba, Ontario and Quebec. Saskatchewan and Manitoba ensure access to these services relative to the dental service acts associated with historical dental therapy programs. These acts were amended to reflect the significant limitations imposed on programming from the mid 1980s onwards and do not offer a strong legislative basis for publicly delivered care. Yet Ontario and Quebec represent the other end of the spectrum. The former legislates these services in its Health Protection and Promotion Act, while the latter through its Health and Social Services Act. These two acts represent a strong and robust legislative bases for the direct public delivery of oral health care services in Canada.

Dental care policy questions stemming from the study

The policy questions associated with publicly financed dental care are numerous, and we will only consider some them in a global way. For example, while the details of human resources management, public pricing, targeting care, and program evaluation in provincial and territorial dental care programs are paramount, we will only address these issues from the point of view of leadership, the rationing of services, and the exigencies of evidence.

What can public health dentistry do without leadership?

Dental care is a 'public heath service' when considering the salary- and community health-based preventive and treatment services delivered to Canadian populations. Dental care is also a 'social service' in that it ties directly into the financing of health benefits under social assistance legislation. This makes up most of the public dental care services

in Canada, and the vast majority of these services are in turn delivered by the private sector. Finally, dental care, at its most basic, is a 'health service' as well.

In a society that views access to health care as a right, publicly financed dental care arguably meets a social minimum, meaning that access to an unessential service is granted in specific cases of need, wherein it becomes essential, or in the extreme, necessary on a case-by-case basis. Surely, this describes the bases of current legislation. These details are important, as by these very definitions, publicly financed dental care sits on a margin. A margin defined by public and private conditions, and one that is associated with a firm but discretionary commitment to public rationing under specific circumstances.

It is arguable that as a result of decline, this albeit conceptual margin has blurred: as programming became fractionated, the three lines of responsibility associated with public health dentistry drifted (i.e., public health service, social service, and health service). While not a universal statement, this study invariably observed regional dental public health activities that were either distant from health and social services ministries, or in very little contact. In some circumstances, dental public health activities have become defined exclusively in terms of claims processing, dealing little or in any significant regard with the broader health and social services arena.

In Stamm et al.'s time, the Dental Director managed these three lines of government business. Again, with the loss of these positions, and especially with the creation of more autonomous regions, centrally at least, governmentally based dental care (i.e., public health dentistry) became weakened in its respective spheres of influence (i.e., public health service, social service, and health service). Regional consolidation and/or the cancellation of programming meant that a similar effect was also observed regionally.

It then follows that with a lack of central leadership, those regions that maintained responded to fiscal struggle by developing their own unique solutions to the challenges that faced them. While this is commendable, it has challenged activities where uniformity is needed. For example, routine surveillance of oral disease is the exception in Canada. One need only consider that we have not had nationally representative estimates of the two most prevalent oral diseases, dental caries and periodontal disease, since the Nutrition Canada Survey of the early 1970s. Provincially, outside of Quebec, the same can be said from the early 1990s onwards.

A lack of central organization also challenges the notion of service standards. It is not uncommon for regions to offer differential access to certain dental services. It is also not uncommon for regions to offer access to services where evidence suggests that treatment outcomes are unfavorable. More will be said on these two issues shortly. Finally, at the very least, a lack of central leadership and organization challenges any effort aimed at maintaining a national, provincial and territorial focus on dental care.

It is thus arguable that by making efforts at centralization, publicly financed dental care can take fuller advantage of its current renewal. In this regard, efforts must be made to

promote provinces and territories to create or expand existing dental public health portfolios in relevant ministries. Similar efforts must also be made at the regional and municipal level.

Human resources will be key here, specifically in terms of dentists and dental hygienists. Both offer a wealth of opportunity for leadership, management, and service delivery, and both represent an opportunity to have graduate- and specialty-level trained dental public health care providers. To be sure, by promoting specialty and public health graduate education among senior providers, such a workforce will also be sensitive to the need for evidence in advancing policy arguments, and for the need to better integrate into the broader public health care system. In terms of evidence, such a workforce could, through rigorous program evaluation, demonstrate the benefits, or need for reconsideration, in Canada's public dental health care programming. In terms of integration with the broader health care system, there is much opportunity to do this, especially by dovetailing into areas of recognised need (e.g., preparing for major surgeries, pre-natal and infant care, diabetic and heart care, long-term care, social work, food security programs). It is in this way that public health dentistry will engender itself within Canada's health care system.

How should we ration dental care?

Publicly financed dental care is truly at a margin. As an activity, over three quarters of all public expenditures for dental care in Canada are associated with persons seeking treatment in a private dental office, where public insurance is billed as a third-party payer. Yet approximately only 30% of dentists deal with public insurance in any significant regard, the remaining having public insurance rates of 10% or less (224). This method of delivery has led to several challenges, especially in relation to issues of ideology, control over care, public pricing, and quality control. Saskatchewan's dental therapy and Manitoba's dental nursing programs are robust historical examples of such challenges, although the debates are evident across the country today.

For example, in a recent national survey of Canadian dentists (224), the majority of those who had twenty-five percent or more of their patients covered by public insurance gave unsatisfactory ratings to public dental programs across the domains: level of coverage, fees, and administration and management. When asked what specifically bothered them about publicly financed care, aside from level of coverage and fees, most reported broken appointments, patient non-compliance, and complicated paperwork. Approximately a quarter of these dentists had also made a business decision to reduce the amount of public insurance in their practice.

Two points deserve attention here. First, 71% of these dentists, and 67% of all dentists, reported that they would still be willing to accept new publicly insured patients, with the general majority also willing to consider alternative modes of financing and delivery (i.e., tax incentives, the involvement of dental faculties). Second, a recent national survey of Canadians (225) demonstrates that when given the choice to seek care in a public or private setting, both the large majority of the general population, and the large majority of those that are publicly insured, report a desire to seek care in a private dental office. So

barring a major shift in governmental policy concerning the delivery of publicly financed dental care, private practice will remain the preferred method of service delivery.

Yet this does not mean that other avenues should not be explored. With fee guides and public mechanisms that are often unattractive to dentists, and with public insurance utilisation rates of thirty to forty percent, it behoves policy stakeholders to consider alternative means by which to deliver care to specific groups. The Association of Ontario Health Centres (151), for example, notes their expertise in dealing with severe poverty, and links this to arguments for why community health centres with dental clinics are crucial for specific segments of the population. Dental faculties have also expressed interest in meeting current public demand, and have partnered with the community-health sector, rejuvenating historical activities or establishing new clinics and/or programs.

The need for such activity becomes more apparent when considering the aforementioned national survey of Canadian adults: multivariate modelling demonstrates that amongst age, gender, education, self-ratings of oral health, dental visiting patterns, and insurance coverage, income remains as the only significant predictor of the preference to visit a community clinic versus a private dental office. This suggests that there is an aspect of social marginalisation that biases individuals towards care in community and primary health care settings.

Targeting care becomes even more relevant when coupled to competing resource demands. While low-income and high-risk children remain the dominant focus of programming across the country, new populations have begun to garner social attention. For example, with the recent high profile coverage of employed persons suffering medically and socially due to cost-prohibitive dental care needs (226-229), the working poor have entered this discussion, and are to be the recipient of significant investments in Ontario. Other groups that have received strong attention include seniors and those in long-term care. The former due to the loss of employment-based insurance upon retirement, which is then further compounded by a newly limited income, and the latter due to the general severe under-servicing of such populations and a recognition that oral health often declines in such circumstances. The homeless, the under-housed and food bank populations have also received attention, as have indigenous populations, particularly aboriginal children with severe early childhood caries. With this diversity, it is certain that in particular situations, delivery would be best met in a private dental setting, while in others, a public setting would be ideal.

In this regard, human resources are once again essential. Over the last twenty years, dental public health human resources have been degraded. Dental therapy is likely the single most significant example, yet the closure of school and community-based clinics using salaried dentists and dental hygienists is also noteworthy. While it would take significant social movement to fully renew such activity, more funding for existing public clinics is not unreasonable. The context is also lending itself to this situation if one considers changes to the gender ratio within the dental profession. In 1961 for example, this ratio stood at approximately 65:1 (28), whereas today, it is approximately 3:1 (230). With known gender differences in practice careers (231-233), female dentists represent a

potential source of supply for any renewed interest in governmental and non-governmental community health practice. Similarly, the growth of dental hygiene numbers and the notion of independent dental hygiene practice further present new avenues by which to target services to specific populations (i.e., long-term care, home care).

Another important consideration in the rationing of dental care has to do with the care that is actually financed. Stamm et al. (21) dealt with this issue in relation to the public financing of dental prophylaxis, topical fluoride application, dental health education, nutrition counselling, and radiographs, calling it "The Dilemma of Fee-For-Service Prevention." The argument is this: apart from topical fluoride application, research confirms that the traditional chair-side cadre of preventive services are not associated with any appreciable improvements in primary oral health outcomes (i.e., a reduction in caries); moreover, all of these services cannot apply universally simply as a result of disease risk (i.e., those with no previous caries history do not generally need fluoride applications nor regular radiographs). In Stamm et al's time, 28 to 45% of program expenditures were being consumed by preventive services, and with economic recession, cost-effectiveness became the primary consideration. Since then, limitations have been placed on these and other services in relation to evidence on effectiveness or prognosis (e.g., complete and recall examinations, pit and fissure sealants, immediate dentures).

In the spirit of Stamm et al., the dilemma in today's dental public health environment concerns the financing of composite resins. As observed in Ontario, restorative services can drive expenditures (see Figures 30 and 31), arguably in relation to a dental material that is increasingly sought by patients, and one that appeals to practitioners as the fees paid are generally greater than those of traditional amalgam. Further, in a high caries and periodontal disease environment, such a material has been proven to be more technique sensitive, fails more often, and necessitates re-treatment more regularly, in turn exacerbating costs. With these considerations, could there then be an opportunity to truly scrutinise public fee guides? Could we place limits on those services that have a poorer prognosis, and reimburse closer to private fee guides for those services that are clinically and cost effective? Could we begin to develop the scientific bases for rationing public dental care in Canada?

At the very least, the dental community should begin a discussion on what a social minimum actually means in public dental care. The variability among programming, even within provinces, is now generally recognised as problematic, and most recognise that standards are a good direction forward. In harkening back to our overview summary on legislative provisions, could we promote legislation that includes some statement on a social minimum? In moments where centralisation is arguably needed, could a focus on standards and legislation be a basis for an integrated approach to thinking about publicly financed dental care nationally?

What about data?

Having evidence on the effectiveness of interventions and treatments is paramount. In today's environment, arguing for why we need access to dental care at any given social minimum demands evidence. Nonetheless, apart from analyses concerning dental therapy practice (234-236), and more recent work on the effectiveness of dental hygiene programming in Quebec and Nova Scotia (237-238) and fluoride applications in northern Ontario (239), data that proves or disproves the beneficence of public provision in Canada are scant. Moreover, while using public claims data for quality control purposes has developed since Stamm et al.'s time (e.g., provider profiling), such data remain considerably underutilised for administrative and research purposes. Surely, would it not be important to know what the longevity of treatments are, who and how many receive repeat care, and whether public programs actually result in decreases in disease?

In this regard, not only has this research observed the decline of dental public health leadership and programming, it has also observed a relative lack of development in its knowledge base. For example, similar to Stamm et al., this research met with a general paucity of readily accessible and organised data. Once again, the latter's words are almost reproducible:

"A recurrent problem encountered during many phases of this study was the extraordinary difficulty in obtaining data about the operation of various dental programs. In virtually no case was this due to a lack of cooperation […], rather the basic data being sought was often not available or not present in the form required to permit even basic statements about program operation or the most rudimentary comparisons of program performance" (21, p. 122).

Stamm et al. considered this so important that their recommendations were aimed at two goals: to promote dental programs that resulted in a higher oral health status, and to promote programs that have "better information systems in order that [they] be conducted on a more rational, efficient and goal-oriented basis" (21, p.125).

Twenty years later, it appears that with the exception of Quebec, and perhaps Ontario, public dental care information systems remain poorly developed. As stated, minimal disease surveillance and program evaluation occurs, and neither is there regular use of claims data to their full benefit. Issues of training are once again important here, as is the need to actually log what data exists. Concerning the latter, this environmental scan has observed isolated data holdings across ministries, regions, and departments. From the point of view of Stamm et al.'s vision, this arguably reconfirms the need for some level of centralisation and organisation.

The implications are clear. Without organised and comparable data at any level, we cannot conduct programming 'on a rational, efficient and goal-oriented basis.' We cannot argue for renewal and expect consistent return over the mid- to long-term. To thrive, dental public health must practice evidence-based policy and programming. We must prove the beneficence of publicly financed dental care in Canada. There is capacity

across the country, and the development of a national management information system and/or program of evaluation as initial suggestions may prove useful. At the very least, it behoves anyone that is introducing new programming to establish some level of evaluation. We in effect argue that by developing a central focus on evidence, issues in human resources management, public pricing, targeting care, and program evaluation could be met directly and with purpose. To use a colloquialism, with this focus, 'all would potentially fall into place.'

In closing, consider what success may look like: In the State of North Carolina, two innovative models of financing oral health care services have demonstrated significant returns. First, food security programming has introduced oral health education and dental referrals for low-income families and their children. Importantly, when compared to those children that do not receive the services, those that do go to a dentist more often and end up consuming less costly dental care over time (240). The intervention also reduced the amount of children's general anaesthesia care (241). The second program involves the financing of oral health education, screening and referral, and fluoride varnish applications by physician- and nurses-aids in public and private practice. A strong evaluation program has demonstrated similar results, confirming impacts on dental care utilisation and consumption over time (242). Such evidence is undeniable. Whether there is an appetite for approaches like these in Canada is unknown, yet ultimately, if we are to responsibly meet public need in what appears to be a situation of worsening disparity, it is time to think creatively.

Recommendations

Leadership

1. A vision and/or goals should be centralised and promoted by existing leadership.
2. Efforts should be made to promote governments to create or expand existing dental public health portfolios.
3. Dentists and dental hygienists should be promoted to seek out dental public health specialty and graduate-level public health training.
4. Leadership should promote a primary focus on evidence in order to create a strong policy base for the rationing of services.
5. Leadership should promote efforts in surveillance, program evaluation, and analyses of administrative data.
6. Leadership should promote the inclusion of dental public health within the larger health care sector, specifically in terms of a common risk factor approach that ties dental public health to varied health and social services settings.
7. Leadership should promote standards for rationing.
8. Leadership should promote legislative provisions for publicly financed dental care.

Rationing care

1. Public health dentistry should explore new ways with the private sector to ration dental care.
2. Public health dentistry should explore new ways with the public sector to ration dental care.
3. Public health dentistry should promote the idea of culturally relevant and targeted care.
4. Public health dentistry should promote a social and professional discussion on what it means to meet a social minimum in dental care.
5. Public health dentistry should promote evidence-based care.
6. Public health dentistry should promote the scientific development of rationing standards.
7. Public health dentistry should promote a social and professional discussion on expanding the public dental health care envelope to include other groups.

Data

1. Public health dentistry should promote efforts in surveillance.
2. Public health dentistry should promote efforts in program evaluation.
3. Public health dentistry should promote the analyses of existing administrative data.
4. Public health dentistry should promote discussion on what administrative data is held and by whom.
5. Public health dentistry should organise collaboration between jurisdictions that have administrative data.
6. Public health dentistry should promote a national public dental care management information system.
7. Public health dentistry should promote a national program of evaluation.
8. The introduction of any new program should, if at all possible, include some level of program evaluation.

Closing Remarks

This environmental scan has attempted to document and analyse publicly financed dental care in Canada. On the basis of this analysis, a series of recommendations have been proposed. These recommendations are aimed at one central goal: to safeguard the vitality of public health dentistry across the country. Indeed, if we are to reverse the trend of decline that has defined public dental care over the last twenty years, we will have to move beyond historical debates. We will have to move towards a commitment that dental care is an essential service in many regards, and that the public financing of such services can be conducted in a way that meets the needs of all involved.

Table 1. Canada's public dental health care system

	Public delivery		Types of care	
	Direct	Indirect	Preventive	Clinical
Federal Government finance care for:				
- Military personnel - Those with state recognised indigenous status - Veterans - Federal prisons - Refugees	Yes	Yes	Yes	Yes
	No		No	
Provinces/Territories finance care for:				
- Surgical-dental services requiring hospitalisation or associated with a congenital anomaly or medical need	Yes	Yes	NA	Yes
- Social assistance recipients and their dependents - Targeted child and adult populations (e.g., low-income families)	No		Yes	
- Targeted disabled and institutionalised populations (e.g., those in long-term care) - Provincial prisons	Yes			
			No	
Health Regions/Municipalities/Units finance care for:				
- Social assistance recipients and their dependents - Targeted child and adult populations (e.g., low-income families) - Targeted disabled and institutionalised populations (e.g., those in long-term care)	Yes	Yes	Yes	Yes
Non Governmental Organisations				
- Universities and social welfare groups deliver care to a variety of marginalised populations through their clinics, either with state financing or through the billing of state associated dental plans	Yes	N/A	Yes	Yes

Table 2. Dental public health service populations

	Total population[a]	Children <5 years[a]	Children 5-14 years[a]	Young adults 15-19 years[a]	Adults >65 years[a]	Persons covered by social assistance 1995[b]	Persons covered by social assistance 2003[b]	Children <19 living in poverty[c]	Institutionalised elderly[d]	Persons with severe to very severe developmental disabilities[e]	
										0-4 years	>15 years
BC	3,907,740	205,650	500,420	270,280	533,085	374,300	180,700	182,577	[f]	[f]	[f]
AB	2,974,805	186,435	431,155	222,965	308,410	113,200	57,800	132,806			
SK	978,935	60,940	84,615	78,315	147,560	82,200	53,200	53,110			
MB	1,119,585	70,670	163,045	80,425	156,415	85,200	59,900	67,540			
ON	11,410,050	671,250	1,561,500	769,420	1,472,180	1,344,600	673,900	594,428			
QC	7,237,480	375,765	915,820	462,070	959,810	802,200	544,200	366,512			
NB	729,500	37,690	92,410	50,665	126,210	67,400	49,300	36,515			
NS	908,005	47,455	117,565	61,750	126,565	104,000	58,300	48,076			
PEI	135,290	7,550	19,080	10,230	18,580	12,400	7,000	5,346			
NF/LA	512,930	24,820	63,950	39,455	166,055	71,300	51,200	29,875			
NU	26,745	3,355	3,575	2,520	610	12,000	7,100	[f]			
NWT	37,360	3,005	7,105	2,955	1,635		1,900				
YK	28,675	1,695	4,345	2,290	1,725	2,100	1,100				
Canada	30,007,095	1,696,280	4,029,255	2,053,325	3,888,550	3,070,900	1,745,600	1,524,657	371,100	11,130	66,030

[a] Statistics Canada, 2001 Census of Canada. Catalogue number 95F0300XCB2001006, 2002.
[b] Statistics Canada, Canadian Economic Observer, Catalogue no 11-010, 2004.
[c] National Council on Welfare, Child poverty profile, 1998, Minister of Public Works and Government Services Canada, ISBN 0-662-30954-5, 2001.
[d] Statistics Canada. Health Reports, 1995; 7(3); number 82-003.
[e] Statistics Canada, Profile of Disability in Canada, Catalogue number 89-557-XIE, 2001.
[f] Not reported

Table 3. The establishment and regionalisation of dental public health infrastructure in Canadian provinces

Province	Health Department	Dental Division	Centralised Planning dissolved or reduced	Regionalisation established	Regionalisation restructured
BC	1946	1949	1983	1997	2001
AB	1919	1959	1992	1994	2002 and 2003
SK	1923	1948	1987	1992	2002
MB	1928	1946	1993	1997-1998	2002
ON	1923	1925	1994	N/A	N/A
QC	1926	1943	N/A	1989-1992	2001 and 2003-04
NB	1918	1948	1991	1992	2002
NS	1930	1948	1988	1996	2001
PEI	1931	1950	N/A	1993-1994	2002
NFLD	1950	1952	1992	1994	-

Table 4. Dental public health human resources in Canada, full-time equivalents, 2005

	Dental public health specialist	Dentists in community practice	Allied dental public health human resources			
			Dental therapist	Dental hygienist	Dental assistant	Other
BC	1	0.6		35.2	23.9	
AB	0.63	4.8		35.21	40.46	12.73
SK		0.31	70.4		9.5	
MB		1.8		2	6	
ON	13.69	45.1		116.7	140.47	122.39
QC	29			229.7		
NB						
NS		0.3		18.6		
PEI		3.2		5.4	13.4	1
NF/LA	0.4	6.4		1	7.32	2
NU			8			3
NWT			11.5			
YK			8			2
Federal	2	6	60	8		4
Total	50.72	68.51	157.9	451.81	241.05	147.12

Table 5. Dental public health expenditures in Canada

	Targeted dental public health expenditures ($000)	Targeted treatment expenditures for the socially marginalised ($000)	Canada Health Act expenditures ($000)	Total publicly financed dental care expenditures ($000)
BC	3,500	40,270	9,000[a]	52,770
AB	6,100[a]	40,000[a]	2,404	48,504
SK	2,468	7,088	1,499	11,055
MB	1,800[a]	4,300	750	6,850
ON	33,000[a]	65,500[a]	9,200	107,700
QC	45,529	47,710	5,966	99,205
NB	50	2,980	189	3,219
NS	7,655	4,000[a]	1,707	13,362
PEI	2,600	250	91	2,941
NF/LA	4,700		419	5,119
NU	1,400			1,400
NWT	1,067	348[a]		1,415
YK	375	221[a]	25	621
Subtotal	110,244	212,667	31,250	354,161
Federal	225,000			225,000
Total				579,161

[a] Estimate

Table 6. Federal public dental health care expenditures in Canada

Federal organisation	Current expenditures ($000)
Department of National Defence	19,400
Veterans Affairs Canada	19,300
Royal Canadian Mounted Police	9,100
Correctional Services Canada	2,800
Citizenship and Immigration Canada	1,000
Health Canada	173,400
Total Federal	225,000

Table 7. Public dental programming in British Columbia, 1983

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Medical Services Commission						
Dental Care Plan of British Columbia (1981-1982)	- Ministry of Human Resources clients - Recipients of premium assistance - Persons >65yrs - Children <14yrs	$700/yr in basic services, including: - Emergency, diagnostic, preventive, restorative, endodontic, periodontic, removable prosthetics - Higher income children and seniors held 50% coverage for all care (except 100% coverage for children's preventive care)	Approx. 1,113,304 eligible $42.60/person	Private practice	Administered by Medical Services Commission under authority of Medical Services Act	$47,376 over 8mo period
Medical Care Program	Surgical-dental services requiring hospitalisation	Various oral surgical, oral medicine and pathology, dental technical, and orthodontic procedures	$675/1,000 population	Hospitals	[a]	$1,853
Ministry of Human Resources						
Income Assistance	- Persons who are unemployable or unable to find work - Persons temporarily unable to work due to poor health or disability - Working persons who cannot support themselves or family - Single parents with dependent children - The handicapped - Children in care	$700/yr in basic services, including: - As for Provincial Dental Plan (see above) - Some orthodontic care	120,251/159,954	Private practice	Administered by the Health Care Services Division under authority of Guaranteed Available Income Act (GAIN)	$14,843 $14,245 Provincial Dental Plan (see above)

[a] Not reported

Table 8. Public dental programming in British Columbia, 1995

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
[a]						
Social Assistance Programs	Children, adults, and seniors	From emergency to basic care, depending on level of assistance	[a]	[a]	[a]	[a]
Ministry of Health						
Health Passport	All children <3yrs	Free dental check-up	[a]	Dentists/ private practice	Ministry of Health / BC College of Dental Surgeons	[a]
Screening Program	Entry-level school children 5-6yrs	Oral health assessment		Dental assistant/ schools	[a]	
Urgent Treatment Program	Screened children with decay in all quadrants and/or pain and/or infection	One-time course of treatment with extensive preventive follow-up	30,000 eligible 500 in need of urgent treatment	Dentists/ private practice	[a]	[a]
School Program	20% of schools whose children have the poorest levels of oral health	Education and oral hygiene instruction up to grade 7	[a]	[a]		
Non-Institutionally Handicapped Program	Those in group homes	[a]	1000/5000			
Cleft Lip and Palate Program	Those with craniofacial anomalies	Surgery services from extractions to major oral surgical procedures	[a]			

[a] Not reported

Table 9. Public dental programming in British Columbia, 2000

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Ministry of Social Services						
Social Services Dental Coverage	Social assistance recipients - Adults 19-64yrs, 100% basic, $250 annual limit - Persons >65yrs, 100% basic, $500 annual limit - Persons with disabilities, 100% basic, $500 annual limit - Dependents, 100% basic, $700 annual limit Children covered by Healthy Kids program - Children 0-18yrs, 100% basic, $500 annual limit	Basic diagnostic, preventive, restorative, endodontic, periodontic, prosthodontic, and oral surgery	[a]	Dentists/ private practice	[a]	[a]
Emergency Dental	Social assistance recipients that do not have dental coverage under social services programming	Emergency care to relieve pain				
Orthodontic Program	Social assistance children in receipt of enhanced medical coverage	Interceptive and comprehensive care				
[a]						
Health Passport, Screening, Education, and Oral Hygiene Program	Infants and toddlers (health passport) Children 5-6yrs (screening)	Free check-up before age 3yrs Prevention in select area schools	[a]	[a]	[a]	[a]

[a] Not reported

Table 10. Public dental programming in British Columbia, 2005

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Ministry of Human Resources (MHR)						
Dental Supplements (Employment and Assistance Regulations define a general dental supplement, crown and bridgework supplement, denture supplements, emergency dental and denture supplements, and orthodontic supplement)	All MHR clients entitled to emergency dental services MHR clients entitled to basic dental services: - Persons with Disabilities (PWD) $1000/2yrs - Persons with Persistent Multiple Barriers (PPMB) $500/2yrs - Person >65yrs who have retained income assistance eligibility $500/2yrs - Spouses of PWD $500/2yrs - Children <19yrs who are dependent on client of income or disability assistance $700/yr	Different levels of coverage provided depending on income assistance designation - Emergency diagnostic, restorative, endodontic, periodontal, prosthodontic, oral surgery services - Basic diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral surgery services - Orthodontic services	64,385/180,095	Dentist and denturist/private practices Pays for some GA care in-hospital Instances of balance billing	Centrally administered, adjudication and payment functions the responsibility of Pacific Blue Cross	22,750
Healthy Kids	- Children whose families are in receipt of premium assistance through MSP $700/yr	As above, except orthodontic services	63,953/161,706			15,020
Ministry of Children and Family Development						
Medical Benefits Program, Dental Benefits Program for Children in Foster Care and Youth Agreements	- Children in foster care $700/yr - Children in the home of a relative $700/yr	As above, orthodontic benefits available to children in foster care	Approx. 10,000 eligible	As above	As above	2,500

Table 10 cont'd

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Ministry of Health Services						
Medical Services Plan (MSP)	MSP covers specified dental services when: - Hospitalisation is medically required - Services are rendered by a specialist in oral medicine to a beneficiary with a severe systemic disease Orthodontic services are provided to: - To those 20 years of age or younger, when service arises as part of or following plastic surgical repair in the treatment of severe congenital facial abnormalities	Various oral surgical, oral medicine and pathology, dental technical, and orthodontic procedures	[a]	Specialists and generalists/hospitals, private anaesthesia clinics, private practices	Centrally administered	9,000[b,c]
Preventive Dental Health Services	Children, their parents or caregivers, seniors in residential care, and persons with disabilities in group homes	Preventive services such as screening and education	[d]	Dental hygienists and assistants/ regional health units, schools, residential facilities	Regionally administered	3,500

[a] Not reported
[b] 5,400 is MSP budget proper, with 2,600 available for anaesthesia related to surgical-dental services, and 1,000 transferred to Provincial Health Services Authority for private anaesthesia clinic fees related to MHR covered children
[c] Estimate
[d] 45,000 preventive dental health services were delivered as per Ministry for Children and Families (2001) *Annual Report*. Government of British Columbia, ISSN 1488-4798.

Table 11. Medical Services Plan dental health services data, 1999/00 - 2003/04

Specialty	Year	Practitioners	Services	Expenditures (current dollars)
Oral Surgery	1999/00	34	32165	$3,923,390
	2000/01	38	33363	$4,202,482
	2001/02	37	24228	$3,299,923
	2002/03	41	20414	$3,339,445
	2003/04	32	19385	$3,047,439
Dental Surgery	1999/00	154	20555	$1,441,829
	2000/01	162	20549	$1,544,584
	2001/02	154	17475	$1,344,060
	2002/03	126	14428	$1,135,285
	2003/04	131	15654	$1,201,900
Oral Medicine	1999/00	3	545	$26,387
	2000/01	4	343	$30,096
	2001/02	4	278	$25,934
	2002/03	3	365	$33,554
	2003/04	3	327	$42,446
Orthodontia	1999/00	81	1373	$492,214
	2000/01	79	1388	$544,702
	2001/02	80	1524	$731,773
	2002/03	79	1473	$871,166
	2003/04	77	1443	$872,463

	Total (current dollars)
1999/00	$5,893,820
2000/01	$6,321,864
2001/02	$5,401,691
2002/03	$5,379,450
2003/04	$5,164,249

Table 12. Strategies to improve the oral health of British Columbians

Legislative	- Tax specific confectionary goods and beverages to support programs directed at the adverse impact of excessive sugar consumption on health - Require manufacturers of confectionary, soft drinks and other snacks to label their products with health warnings - Amend the "Adult Care Regulations, B.C. 1997" to specify that a resident of a long-term facility must be examined by a dentist within six months prior to, or within three months after, entering the facility and at least once a year thereafter - Legislate preventive health practices to insure that prevention of disease is an integral part of oral health-care in the province
Health Promotion and Disease Prevention	- Develop consumer educational programs that equip individuals of all ages and cultures to assess the validity of nutritional information in advertisements of foods, snacks and beverages - Expand awareness of mouth-guards, helmets, car seats and other protective devices to reduce the incidence and severity of orofacial trauma - Enhance the awareness and availability of resources about oral health promotion to all health-care workers, social workers and teachers
Targeted	- Enhance the current initiatives in the Health Regions that identify and follow-up infants and young children at high risk to early childhood caries - Implement school-based pilot projects to assess the benefits of agents - such as fluoride rinses, fissure sealants, and xylitol chewing gum - for controlling caries in elementary and high schools where the risk of caries is high - Integrate oral health-related educational programs with other preventive or health promotional activities at Child Health Clinics, school nursing programs, community centres, regional health clinics, Seniors' centres, long-term care facilities and traditional community gatherings - Facilitate access to dental services for all Aboriginal people by encouraging care-providers, consumers, insurance carriers to solve the difficulties Aboriginal people experience when seeking services to which they are entitled
Structural and Organisational	- Explore with the Ministry of Advanced Education, Training and Technology, the College of Dental Surgeons of B.C. and the Association of Certified Dental Assistants in B.C. the possibility of expanding the educational base of certified dental assistants in preparation for a coordinating role in preventing oral health-related problems within long-term care facilities - Promote the use of fair methods of remunerating dentists, dental hygienists, denturists and certified dental assistants within long-term care facilities - Encourage the College of Dental Surgeons and the Association of Certified Dental Assistants in B.C. to develop a coordinating role for certified dental assistants in preventing oral health-related problems within long-term care facilities without the direct supervision of a dentist - Encourage the Ministry of Social Development and Economic Security to permit direct billings of their dental plan from dental hygienists for services they provide directly to persons in residential care - Encourage Health Regions to support in each region the infrastructure and staff for at least one public dental clinic suitable for low-income groups, and ask local professional associations to seek volunteers willing to provide treatment at reduced fees - Resume negotiations between the Ministry of Social Development and Economic Security and the dentists, dental hygienists and denturists in the province to establish fair reimbursement for treatment provided to recipients of dental benefits
Educational	- Encourage research granting agencies to support public dental health research - Provide government funds to assist in the development and maintenance of an "internship" year for new dentists to encourage the expansion of oral health services to remote localities

Table 13. Public dental care associated legislation in British Columbia

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Medicare Protection Act, R.S.B.C 1996, c. 286	Broadly based on residence (s.1), enrolled in accordance with the provisions of the Act (s.7) and related regulations	Types of benefits defined broadly (s.1), essence is medical necessity Provides for the continuation of the Medical Services Plan (s.3) The LGIC may make regulations respecting aspects of the Act and its operation (s.51), including (s.51(2)(i)) "… the provision of dental care services and benefits (s.51(2)(i))	Minister of Health Medical Services Plan
Medicare Protection Act – Medical and Health Care Services Regulation, B.C. Reg. 426/97; O.C. 1436/97	As above; further expands eligibility requirements (s.11) and who is not otherwise ineligible (ss.27 and 28)	Dental and orthodontic services are benefits, and thus insured, provided they are medically required (s.19); these include: oral surgical procedures where hospitalization is medically required (s.19(2)(a), (b) and (e)); services that are medically required to benefit a severe systemic disease (s.19(2)(c)); orthodontic services restricted to beneficiaries under the age of 20 when part of or following plastic surgical repair to correct severe congenital facial abnormalities (s.19(2)(d))	Minister of Health
Hospital Insurance Act, R.S.B.C. 1996, c. 204	Beneficiary as defined in *Medicare Protection Act* (s.1)	Benefits are general hospital services (s.1) that include treatments for acute illness or injury (s.5(1)(a)) or chronic illness or disability (s.5(1)(b)) and/or those described in the regulations The LGIC may make regulations with respect to the operation of the Act (s.29)	Minister of Health
Hospital Insurance Act Regulations, B.C. Reg. 25/61; O.C. 315/61	As above	Does not include any services performed by a dentist; only those performed by an attending physician or midwife (s.5.1)	Minister of Health
Community Care and Assisted Living Act, S.B.C. 2002, c.75	Applies to adults and children in licensed "Community Care Facilities" (determined under Part 2) or "Assisted Living Residences" (determined under Part 3)	The LGIC may make regulations regarding the operation of the act (s.34)	Minister of Health
Adult Care Regulations, B.C. Reg. 536/80; O.C. 2539/80	Applies to persons in care over 19 years of age	Licensees must encourage persons in care to obtain annual examinations by a dental health professional (s.9.2)	Minister of Health No provisions with respect to funding Possibly used for Preventive Dental Health Services Program
Employment and Assistance Act, S.B.C.	Recipients of income assistance, hardship assistance or a	Does not included persons with disabilities (s.3)	Minister of Employment and Income Assistance

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
2002, c.40	supplement provided under the Act, including their spouses and dependants (s.1)	Applicants must meet eligibility requirements (Part 2 and regulations) The LGIC may make regulations with respect to the operation of the Act (s.35)	Dental Supplements provided under the BC Employment and Assistance Program
Employment and Assistance Regulation, B.C. Reg. 263/2002; O.C. 873/2002	Identifies persons who have persistent multiple barriers (s.2) Further eligibility criteria (Parts 2 and 3)	Dental supplements (s.4 of Schedule C) are provided to or for a person in the family unit if they fall into one of the specified categories (s.68) Crown and bridgework may be provided to recipients or members of their family unit with persistent multiple barriers to employment and who do not receive a federal spouse's allowance or guaranteed income supplement benefits (s.68.1) Denture supplements (s.5 of Schedule C) are provided to recipients who are not eligible under s.68 [general dental supplements] but who have had tooth extractions in the previous 6 months and require a full upper or lower denture or both (s.69) Emergency dental supplements (s.6 of Schedule C) are available to MHR clients who do not meet other categories of eligibility (s.70) Orthodontic supplements are limited to dependant children or children in the home of a relative (s.71(1)) and are subject to limitations (s.71(2)) Health supplements for children (s.7 of Schedule C) may be provided to dependent children of people who were receiving premium assistance under the *Medicare Protection Act* and who do not qualify for general health supplements under s.67(1) (s.72)	Minister of Employment and Income Assistance
Employment and Assistance for Persons with Disabilities Act, S.B.C. 2002, c. 41	Persons with disabilities (s.2) Applicants must be persons with disabilities and meet further eligibility requirements (Part 2)	The LGIC may make regulations with respect to the operation of the Act (s.26)	Minister of Employment and Income Assistance Dental Supplements provided under the Disability Assistance Program
Employment and Assistance for Persons with Disabilities Regulation B.C. Reg. 265/2002, O.C. 874/2002	Persons meeting the eligibility requirements (Parts 2 and 3)	General dental supplements (s.4 of Schedule C) are provided to or for a family health unit who meets the general health supplements requirements under s.62(1)(a) to (d) (s.63) Crown and bridgework supplements (s.4.1 of Schedule C) are	Minister of Employment and Income Assistance

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
		provided to those recipients of disability assistance (63.1(1)(a)) or a person with disabilities who is under 65 years and who is not receiving disability assistance because of employment or pension income (63.1(b)) Emergency supplements (s.5 of Schedule C) are available to recipients who meet the general health supplements criteria under s.62(1) (s.64) Orthodontic services are available on a limited basis to persons with disabilities or their dependant children (s.65)	
Child, Family and Community Service Act, R.S.B.C. 1996, c. 46	Children (persons under 19 years of age) who are in the custody, care of guardianship or a director or the director of adoption (s.1)	Children in care have the rights to receive medical and dental care when required (s.70(1)(g)) The LGIC may make regulations with respect to the operation of the Act (s.103)	Minister of Children and Family Development Nothing in the *Child, Family and Community Service Regulation*, B.C. Reg. 527/95; O.C. 1589/95 speaks to the provision of care referred to in s.70(1)(g)
Adoption Act, R.S.B.C. 1996, c.5	Persons proposing to adopt or adopting children	Financial assistance may be provided to a person who proposes to adopt or adopts a child placed for adoption by the director (s.80(a)) The LGIC may make regulations with respect to the operation of the Act (s.91)	Minister of Children and Family Development
Adoption Act; Financial Administration Act – Adoption Regulation, B.C. Reg. 291/96; O.C. 1226/96	Persons who propose to or who do adopt a "designated child" (defined in s.26) (s.27)	Financial assistance may be provided for orthodontic and corrective dental treatment where the service relates to the special needs of the designated child (s.28(1)(b)) Assistance is provided only as a last resort (s.28)	Minister of Children and Family Development
Correction Act, S.B.C. 2004, c.46	Persons in correctional centres under provincial jurisdiction (s.1)	The LGIC may make regulations with respect to the operation of the Act (s.33)	Minister of Public Safety and Solicitor General
Correction Act Regulation, B.C. Reg. 58/2005; O.C. 161/2005	As above	Inmates must be given access to health care (s.2(1)(h))	Minister of Public Safety and Solicitor General Nothing specific on dental care, although dentists are listed as a "health care professional" (s.1)
Crime Victim Assistance Act, S.B.C. 2002, c.38	Persons who are victims of prescribed offences or events	Benefits may be awarded for medical or dental services or	Minister of Public Safety and Solicitor General

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
	referred to in s.3(1)(a)(ii) (s.1)	expenses (s.4(1)(a)) The LGIC may make regulations with respect to the operation of the Act (s.26)	Funds provided out of the Crime Victim Assistance Program
Crime Victim Assistance (General) Regulation, B.C. Reg. 161/2002; O.C. 519/2002	As above	Benefits for dental services or expenses are limited to those specified in Part 2 (s.8)	Minister of Public Safety and Solicitor General

Table 14. Public dental programming in Alberta, 1983

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Department of Social Services and Community Health						
Alberta Community Health Dental Services Division					Centrally and regionally administered	
Local Health Authority Dental Programs	Local populations[a]	Range of preventive and/or dental health promotion activities	[a]	Dentists, dental hygienists and assistants		$4,879
Dental Services for Under-serviced Areas		Comprehensive basic dental services		Dentists/mobile dental clinics and portable equipment		[a]
Cleft Palate/Lip Program	Those with congenital defect	Comprehensive range of services	2,266 claims	Dentists and dental mechanics/private practices		$359
Handicapped Children's Dental Program	Non-institutionalised children <17yrs – guardian subject to $75 fee		869 claims			$106
Income Security and Assured Income plans	- Persons receiving assistance from Alberta Social Allowance Program - Those assisted by AISH - Children <18yrs who are wards of the Division of Social Services	Comprehensive basic dental services including: - Fillings, extractions, orthodontia, dentures, denture repair		Dentists and dental mechanics/private practices	Administered by Alberta Dental Association, including claims payment and preauthorisation	$6,967
Department of Hospitals and Medical Care						
Extended Health Benefits Program	- Persons >65yrs registered under the Alberta Health Care Insurance Plan, spouses, and dependents - $1200 max per two yrs - Allowed extra-billing	Comprehensive basic dental services	66,609/209,059 367,284 services delivered $271.78/user $86.36/eligible	Dentists and dental mechanics/private practices	Centrally and regionally administered	$18,103
Medical Care Program	Surgical-dental services requiring hospitalisation	Various oral surgical, oral medicine and pathology, dental technical, and orthodontic procedures	$98.6/1,000 population	Hospitals	[a]	$221

[a] Not reported

Table 15. Public dental programming in Alberta, 1995

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
[a]						
Social Assistance Programs	Children, adults, and seniors	From emergency to basic care, depending on level of assistance	[a]	[a]	[a]	[a]
Seniors Extended Health Benefits	Persons >65yrs	Surgical procedures				
Alberta's Health Care Benefits Regulations	All citizens, no means test	Diagnostic, restorative, periodontic, removable prosthodontic, oral surgery				
Cleft Lip and Palate Program	Those with craniofacial anomalies	[a]				
Dental Program for the Handicapped	Handicapped persons	[a]			Family and Social Services Board	

[a] Not reported

Table 16. Public dental programming in Alberta, 2000

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
[a]						
Alberta Child Health Benefit (ACHB)	Dependents of social assistance aged <18yrs	Most basic dental services	49,00 enrolled Approx. 10% used dental benefit	Dentists/ private practice	[a]	$7,500
Ministry of Health						
Extended Health Benefits	Persons >65yrs	Basic care	44% of eligible seniors	Dentists/ private practice	[a]	$17,000

[a] Not reported

Table 17. Public dental programming in Alberta, 2005

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Ministry of Human Resources and Employment						
Alberta Works Income Supports	Income Supports helps people who do not have the resources to meet basic needs; the level of assistance depends on each individual's situation including financial resources, ability to work and the number of children in the family People in three general situations qualify: - Not Expected-to-Work (NETW), those who have difficulty working because of a chronic mental or physical health problem or because of multiple barriers to employment - Expected-to-Work (ETW), those who are looking for work, working or unable to work in the short-term - Learners, people who need academic upgrading or training so they can get a job	Standard Dental Coverage is primarily limited to relief from dental pain and oral infection; coverage can include some diagnostic, restorative, and prosthodontic care Supplementary Dental Coverage includes Standard benefits with some diagnostic, restorative, endodontic, periodontal, prosthodontic, and oral surgery services - NETW, Supplementary - ETW, Standard - Learner, Standard	51,030 cases per month eligible[a]	Dentist and denturist/private practices	Centrally administered, adjudication and payment functions the responsibility of Alberta Blue Cross	[b]

Table 17 cont'd

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Alberta Child Health Benefit (ACHB)	ACHB is a premium-free health benefit plan for children <18yrs living in low-income families	Supplementary Dental Coverage	65,640 cases per month eligible[a] $17.78 per case per month[e]	As above	As above	[b]
Alberta Adult Health Benefit (AAHB)	AAHB provides continuing premium-free health benefits to NETW and ETW clients and their children who leave Income Supports for work, and to AISH recipients who leave the program due to employment income or Canada Pension Plan Disability benefits	Standard Dental Coverage	1,050 cases per month eligible[a]			
Minister of Seniors and Community Supports						
Dental Assistance for Seniors Program (formerly EHB)	Those >65yrs meeting income thresholds; up to a program maximum of $5,000 per person every five years	Depending on income, partial or maximum coverage; some diagnostic, restorative, endodontic, periodontal, prosthodontic, and oral surgery services	Dentists $101.92/patient Denturists $221.79/patient[f]	As above	As above	[b]
Assured Income for the Severely Handicapped (AISH)	AISH provides health benefits for adults 18-64yrs with a permanent disability that that severely impairs their ability to earn a living; level of benefits depends on income and assets	As above	31,250 cases per month eligible[a]			
Family Support for Children with Disabilities	Services for families with disabled children not covered under any other plan; must be directly related to the child's disability; pays for the portion of costs exceeding those covered by the guardian's dental insurance or benefit plan, or if the guardian does not have such insurance, the costs exceeding $250 annually	As above, some orthodontic treatment	6,695 cases per month eligible[a]			

Table 17 cont'd

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Ministry of Health and Wellness						
Alberta Health Care Insurance Plan Cleft Palate Dental Indemnity Program Oral and Maxillofacial Devises and Services Program	Alberta insures a number of medically necessary oral surgical and dental procedures; a dentist may perform a small number of these procedures, but the majority of the procedures can be billed to the Plan only when performed by an oral or maxillofacial surgeon	Various oral surgical, oral medicine and pathology, dental technical, and orthodontic procedures	8,788 procedures completed in 6,014 visits $219.09 average costs per patient[c]	Specialists and generalists/hospitals, private anaesthesia clinics, private practices	Centrally administered	2,404[c]
Regional Dental Public Health Services	Targeted preschoolers, school-age children, adults, and elderly	Includes education, screenings/fluoride applications, dental sealants, dental cleanings, denture cleanings, and smoking cessation, amongst others	[b]	Dental hygienists and assistants/regional health units, schools, residential facilities; includes clinical dental services in Capital and Calgary health regions	Regionally Administered	6,000[d]

[a] Ministry of Human Resources and Employment (2004) *Annual Report*. Government of Alberta, ISSN 1497-0473.
[b] Not reported
[c] Government of Canada (2004) *Canada Health Act Annual Report*. Canada Health Act Division, Health Canada.
[d] Estimate
[e] Personal communication, Government of Alberta.
[f] Ministry of Health and Wellness (2001) Alberta Health Care Insurance Plan Statistical Supplement 2000/2001. Government of Alberta.

Table 18. Public dental care associated legislation in Alberta

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Alberta Health Care Insurance Act, R.S.A. 2000, c.A-20	Broadly based on residence (s.3), enrolled in accordance with the provisions of the Act (s.4) and regulations	Basic health services are provided to all residents (s.3(1)) and extended health services are provided to residents who are 65 years of age or older or who are receiving a widow's pension (s.3(2)(a) and (b)) Basic health services include insured services and services provided by a dentist in the field of oral and maxillofacial surgery and are specified in the regulations but are not within the definition of insured services (s.1(b)(ii)) Insured services include those services that are provided by a dentist in the field of oral and maxillofacial surgery and are specified in the regulations (s.1(n)(ii)) The LGIC may declare any basic health services in s.1(b)(ii), (iii), (v) or (vi) to be insured services for the purposes of the Plan (s.2) The LGIC may make regulations respecting aspects of the Act and its operation (ss.16, 30, 33) The Minister may make regulations in limited areas (ss.17, 32) The LGIC may establish a financial assistance program for residents who are faced with expenses not reasonably foreseen (s.43(1))	Minister of Health and Wellness Alberta Health Care Insurance Plan
Alta. Reg. 76/2006, *Alberta Health Care Insurance Regulation*	As above	Those services that are provided by a dentist in the field of oral and maxillofacial surgery for which benefits are payable under the *Oral and Maxillofacial Surgery Benefits Regulation* are hereby specified as insured services for the purposes of section 1(n)(ii) of the Act. (s.2) Extended health services benefits include goods and services provided by a dentist or denturist listed in the *Extended Health Services Benefits Regulation* (s.10(a)) Excludes services for which residents are eligible for under other provincial and federal statutes (s.12)	Minister of Health and Wellness
Alta. Reg. 86/2006, *Alberta*	As above	Benefits for oral and maxillofacial surgery services provided	Minister of Health and Wellness

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Health Care Insurance Act - Oral and Maxillofacial Surgery Benefits Regulation		to a resident are those listed in the Schedule of Oral and Maxillofacial Surgery Benefits (s.3(1); Schedule attached to Regulation)	Oral and Maxillofacial Devices and Services Program
Alta. Reg. 83/2006, *Extended Health Services Benefits Regulation*	Persons identified in s.3(2) of the *Alberta Health Care Insurance Act* [i.e. residents who are 65 years of age or older or who are receiving a widow's pension]	Benefits are provided in accordance with Schedule attached to the Regulation (s.1(a) and (b)) Provision of dentures subject to time-limitations (s.3) List of dentist goods and services provided in the Schedule	Minister of Health and Wellness Dental Assistance for Seniors – administered by Minister of Seniors and Community Supports
Hospitals Act, R.S.A. 2000, c.H-12	Persons receiving insured services under Part 3 (s.36(d))	Hospitalization benefits plan described (Part 3) Insured services are the hospital services the operating costs of which will be provided for under Part 3 (s.36(h)) and include those furnished by an approved hospital of the patient's choice, by any other institutions or persons that are prescribed in the regulations (s.37(1)) and include. They include standard ward hospitalization in an approved hospital, and any other goods and services that are prescribed in the regulations (37(2)) The LGIC may make regulations with respect to the operation of this act (s.43)	Minister of Health and Wellness Authorizes the hospital insurance plan
Alta. Reg.244/90, *Hospitals Act – Hospitalization Benefits Regulation*	As above	Insured services do not include any services a resident is eligible to receive under a statute of any other province or the Parliament of Canada (s.4(2)(b)) and those that a resident is entitled to receive under the *Alberta Health Care Insurance Act,* unless approved by the Minister (s.4(2)(c))	Minister of Health and Wellness
Income and Employment Supports Act, S.A. 2003, c.I-0.5	Children and adults who meet the eligibility requirements for health benefits (s.7)	Eligibility for health benefits based primarily on residency and financial eligibility (s.8) The LGIC may make regulations with respect to the operation of this Act (s.18)	Minister of Human Resources and Employment Alberta Works Income Supports Alberta Child Health Benefit Program
Alta. Reg. 60/2004, *Income and Employment Supports Act – Income Supports, Health and Training Benefits Regulation*	As above	Health benefits includes "dental needs" (s.20(b)(iii)) Health benefits provided for dental needs can be provided only in accordance with the terms of agreements struck between the Minister and the Alberta Dental Association and College and the Minister and the College of Alberta Denturists (s.21(1)(c)) or those approved by the Health Benefits Review Committee (s.21(2))	Minister of Human Resources and Employment Agreements listed under s.21(1)(c) are not considered public documents by the Alberta Government

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
		Financial eligibility for adult health benefits is determined relative to a recipient's category under the regulations (s.22) Financial eligibility for children's health benefits is satisfied so long as s/he is a dependent child of an adult eligible under s.22 (s.23) or where there is no other health benefit coverage reasonably available to cover the cost of ongoing health needs and the household unit meets the income levels in s.23(3) Persons may be eligible for health benefits even if they are not eligible for income support and benefits, provided they meet criteria in Part 5 of the Act (s.27(1))	
Assured Income for the Severely Handicapped Act, S.A. 2006, c.A-45.1 (awaiting proclamation)	Persons who satisfy the definition of "severe handicap" (s.1(i)) and otherwise meet the eligibility criteria	Health benefits (the Alberta Adult Health Benefit) are provided to AISH recipients and their dependants or partners (s.3(1)(b)) where they are not ineligible for any reason (s.3(3) and (4)) The LGIC may make regulations in respect of this Act (s.12)	Minister of Seniors and Community Supports but the AAHB offered through AISH is administered under by the Ministry of Human Resources and Employment Dental services under AISH are provided under agreement between the Minister and the Alberta Dental Association and College and College of Alberta Denturists. These agreements are not considered public documents.
Alta. Reg. 209/1999, *Facilities, Institutions, Health Benefits Regulation*	AISH applicants and recipients and their dependents and partners (s.1(1))	Health benefits include dental services pursuant to pursuant to health benefits cards issued by the Director, or in accordance with agreements between the Minister and the Alberta Dental Association, the Alberta Denturists Society (s.1(2)(a) and (b))	Minister of Human Resources and Employment Minister of Seniors and Community Supports
Family Support for Children with Disabilities Act, S.A. 2003, c.F-5.3	Children (under the age of 18 years) (s.1(d)) who have disabilities (s.(1)(c)) and who are not excluded by reasons of ineligibility (s.4.1)	The Minister may make regulations regarding the operation of this Act (s.10)	Minister of Children's Services
Family Support for Children with Disabilities Regulation, Alta. Reg. 140/2004	As above	The costs of dental and orthodontic treatment may be covered if it is recommended by the dental review committee established by the Alberta Dental Service Corporation (s.4(1)(i)) and are directly related to the child's disability	Minister of Children's Services Family Support for Children with Disabilities

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
		(s.4(1)(j)) Financial assistance is restricted to either the portion of costs exceeding the costs covered by the guardian's dental insurance or benefit plan, or, if the guardian does not have dental insurance or a benefit plan for dental care, the costs exceeding $250 annually (s.4(1)(j)(A) and (B))	
Child, Youth and Family Enhancement Act, R.S.A. 2000, c. C-12	Children who have been apprehended pursuant to the operation of Part 1, Division 3 Persons seeking to adopt under Part 2	A director may authorize the provision of any recommended health treatment, including dental care, for a child who has been apprehended (s.22.1) A director may provide financial assistance in accordance with the regulations to a person who adopts a child who was, at the time of the adoption order, the subject of a permanent guardianship agreement or order if the director is satisfied that (a) the adoption of the child by that person is desirable, and (b) the adoption would place an undue burden on the financial resources of that person (s.81(1)). If the guardian of a child is unable or unwilling to care for the child and the child is, in the opinion of a director, being cared for by another adult person, financial assistance may be provided in accordance with the regulations to that adult person on behalf of the child. (s.105.8)	Minister of Children's Services Alta. Reg. 187/2004, *The Adoption Regulation,* enumerates financial assistance for dental care in adoption processes
Alta. Reg. 160/2004, *Child, Youth and Family Enhancement Regulation*	Children	A director may provide health benefits in respect of a child pursuant to a Child Health Benefit Program card issued in accordance with an agreement between officials on behalf of the Department of Children's Services and the Department of Human Resources and Employment, if the child is not covered in respect of such benefits under an insurance plan of the caregiver or the child's parent or guardian (s.22)	Minister of Children's Services In accordance with s.105.8 of the Act
Victims of Crime Act, R.S.A. 2000, c.V-3	Victims of crime who have been injured (s.12(1)(a)) and meet the criteria in the regulations	The Lieutenant Governor in Council may make regulations for the operation of this Act (s.17)	Solicitor General and Public Security
Alta. Reg. 63/2004, *Victims of Crime Regulation*	Victims of "eligible offences" (s.2) who have been injured	Awards are determined with reference to an Injury Schedule (s.3)	Solicitor General and Public Security

Table 19. Public dental programming in Saskatchewan, 1983

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Saskatchewan Health						
Saskatchewan Health Dental Plan (SHDP)	All children 3-16yrs	Broad range of diagnostic, preventive and therapeutic dental services	149,743/177,631 $86.29 per enrolled child	Dental therapists/school clinics (salaried) Dentists/private practice (fee for service)	Centrally and regionally administered As above with College of Dental Surgeons of Saskatchewan coordinating and paying for adolescent care	$13,416
Saskatchewan Social Services						
Supplementary Health Plan (SHP)	- Saskatchewan Assistance Plan beneficiaries - Government wards - Inmates of correctional institutions - Persons >65yrs in certain special care homes or long-term care facilities	Comprehensive range of services including preventive, restorative, oral surgical, orthodontic, and prosthetic dentistry	44,863 avg. monthly enrolment $27.28 per person enrolled 47,166 services	Dentists/private practice	Administered by Medical Services Division	$1,224
Medical Care Program	Surgical-dental services requiring hospitalisation	Various oral surgical, oral medicine and pathology, dental technical, and orthodontic procedures	$523.7/1,000 population	Hospitals	[a]	$507

[a] Not reported

Table 20. Public dental programming in Saskatchewan, 1995

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
[a]						
Social Assistance Programs	Children, adults, and seniors	From emergency to basic care, depending on level of assistance	[a]	[a]	[a]	[a]
Ministry of Health						
[a]	School age children 2 pilot schools in Prince Albert and 6 in Saskatoon for treatment services	Prevention and treatment services in select area schools	[a]	Dentists, dental therapists and dental health educators	[a]	[a]

[a] Not reported

Table 21. Public dental programming in Saskatchewan, 2000

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
[a]						
Family Health Benefits Program	Children <18yrs whose parents are recipients of Family Income Plan	Basic care	[a]	Dentists, denturists/ private practice	[a]	[a]
Supplementary Health Benefits	Low income adults	Limited care				
Assistance Plan	Adults	Emergency benefits only				

[a] Not reported

Table 22. Public dental programming in Saskatchewan, 2005

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Saskatchewan Health						
Supplementary Health Program (SHP)	Provides dental services for: - Saskatchewan Assistance Plan (SAP) recipients nominated by Saskatchewan Community Resources and Employment - Wards of the state - Those in correctional institutions - Nominated persons >65yrs who are in special care homes or hospitals and whose income meets SAP levels	Employable adults and spouses are eligible for emergency benefits for 6-months from the time of being nominated; then one becomes eligible for full benefits Children automatically qualify for full benefits Includes diagnostic, preventive, restorative, oral surgery, removable prosthodontics, limited endodontic, and orthodontic on a case by case basis	42,808 eligible	Dentists, dental therapists/private practice	Saskatchewan Health, Drug Plan and Extended Benefits Branch	4,636
Family Health Benefits (FHB)	- An extension of SHP, assists recipients of Saskatchewan Child Benefit and/or the Saskatchewan Employment Supplement with dental care costs of children <18yrs	Includes diagnostic, preventive, restorative, oral surgery Coverage is largely aimed at children, special cases for adults	59,679 eligible	Dentists, dental therapists/private practice If covered by SHP, provider can balance bill FHB for the difference between SHP fee guide and the lesser of the usual and/or customary fee or professional fee guide		2,452

Table 22 cont'd

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Medical Services Plan	Insured surgical-dental services are those that are medically necessary and must be carried out in a hospital	Services include: oral surgery required in hospital as a result of trauma; treatment for infants with cleft palate; hospital-based dental care to support medical/surgical care (e.g., extractions when medically necessary); and surgical treatment for temporomandibular joint dysfunction.	18,300 services 18 services/1000 beneficiaries $1,336/1000 beneficiaries[a]	Specialists and generalists/hospitals, private practices	Saskatchewan Heath, Medical Services Branch	1,499[a]
Dental Health Education Program Saskatoon and Prince Albert School-Based Children's Dental Program	General population, focus on preschoolers, children, youth, seniors Children 4-13yrs in Saskatoon and Prince Albert	Prevention and health promotion, targeted screening, fluoride mouth rinse and varnish Basic diagnostic, preventive, restorative, oral surgery	Approx. 30,000 eligible	Dental therapists, hygienists/primary health centres, schools, preschools, daycares	Regionally administered	1,553
Northern Health Regions' Children Dental Programs Keewatin Yatthé, Mamawetan, Athabasca Health Regions	General population, focus on preschoolers, children, youth, seniors Any child <16yrs		Approx. 10,500 eligible	Dental therapists, assistants/primary health centres, schools, preschools, daycares	Regionally administered, federal consultation	915

[a] Government of Saskatchewan (2005) *Annual Statistical Report 2004-05*. Saskatchewan Health, Medical Services Branch.

Table 23. Public dental care associated legislation in Saskatchewan

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	
The Saskatchewan Medical Care Insurance Act, c. S-29, R.R.S. 1978	Residents who are beneficiaries in accordance with the Act (s.12)	Medically required services provided by a dentist are included in insured services (s.14(2)(b)) Services which are covered under other provincial or federal acts are not insured services (s.15) The LGIC may make regulations for the operation of this Act, including the establishment of a medical care insurance plan (s.48)	Saskatchewan Health Medical Services Plan
The Medical Care Insurance Beneficiary and Administration Regulations, R.R.S. c. S-29, S. Reg. 13	As above; further defined (ss.3, 5, and 6)	Eligible dental services include those in s.13(d) [oral radiology-related] and oral surgery; orthodontic services to correct a cleft palate; and those related to specified chronic disease (s.15)	Saskatchewan Health
Dental Care Act, S.S. 1982-83, c. D-4	Beneficiary as defined within *The Saskatchewan Medical Care Insurance Act* (s.2(a)) and who is a member of the class of persons designated by the LGIC	Minister of Health is empowered to make provisions for certain preventive and treatment dental services for beneficiaries (s.3) The LGIC may make regulations for the operation of this Act (s.8)	Saskatchewan Health Allows for the subsidy program for children receiving dental care
Dental Care Beneficiary Regulations, 1987, R.R.S. c. D-4, S. Reg. 3	Further circumscribes the category of beneficiaries	A beneficiary is any person who is 16 years of age or less and who resides in the Northern Saskatchewan Administration District, subject to subsection (4) (s.2(1))	Saskatchewan Health
The Saskatchewan Assistance Act, R.S.S. 1978, c.S-8	Persons in need (s.2(f))	Assistance includes health coverage (s.2(a)(iii)) The LGIC may make regulations for the operation of this Act (s.14)	Community Resources
The Saskatchewan Assistance Regulations, S.Reg. 78/66	As above, provided they meet the eligibility criteria set (s.6)	Applicants may apply only for health services (s.4(2)) Supplementary health benefits may be provided to recipients in accordance with the *Saskatchewan Assistance Plan Supplementary Health Benefits Regulations*	Community Resources
The Saskatchewan Assistance Plan Supplementary Health Benefits Regulations, S.Reg. 65/66	Beneficiaries list is detailed and includes persons and their dependants receiving assistance by way of the *Saskatchewan Assistance Regulations* as well as many others in other programs, mainly means-tested (s.3(1))	Dental services which will be paid for include those which are essential for the maintenance of health; those designated by the minister; dentures or partial dentures [subject to limits in s.14] (s.9(1)) Those deemed “fully employable persons” and their dependants are only eligible after a six-month waiting period (s.9B(1)) except for emergency services (s.9B(3))	Community Resources Supplementary Health Program
The Adoption Act, 1998, S.S.	Those adopting Crown wards	The minister may provide financial assistance to	Community Resources

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	
1998, c.A-5.2		persons adopting Crown wards owing to the special needs of the ward of circumstances of the adoption (s.9) The LGIC may make regulations for the operation of this Act (s.43)	
Adoption Regulations, 2003, R.R.S. c. A-5.2 S. Reg. 1	As above	Financial assistance can include payments for orthodontic or corrective dental treatment provided the treatment relates to the child's special needs (s.49(b)(ii)) Adoptive family must meet eligibility criteria for financial assistance (ss.50 and 51)	Community Resources

Table 24. Medical Services Plan dental health services data, 1997/98-2003/04

	Number of services (000's)	Number of services per 1,000 beneficiaries	Dollar payments ($000's)	Dollar payments per 1,000 beneficiaries	Average payment per service ($)
1997/98	18.5	18	1272	1232	68.60
1999/00	18.1	17	1309	1257	72.40
2000/01	19.9	19	1405	1375	70.69
2001/02	18.9	18	1275	1245	67.66
2002/03	18.5	18	1264	1234	68.39
2003/04	18.3	18	1346	1336	73.43

Table 25. Distribution of operating room wait times for dental surgery in Saskatchewan

	Patients completed	Within 3 weeks	4-6 weeks	7 weeks - 3 months	4-12 months	13-18 months	More than 18 month	Patients waiting
2004/05	985	32%	14%	16%	26%	4%	7%	1263
2005/06	1605	29%	8%	14%	33%	10%	6%	2801

Table 26. Public dental programming in Manitoba, 1983

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Department of Health						
Manitoba Children's Dental Program (MCDP)	All children 6-12yrs	A full range of essential diagnostic and preventive services, including oral hygiene instruction, nutritional and parental counselling, restorative, endodontic, periodontic, oral surgery, removable prosthodontic	29,480/36,882	Dental nurse/school clinics and/or portable equipment (salaried) Dentists/private practice (fee for service)	Centrally and regionally administered As above with Manitoba Dental Association coordinating and paying for specific regions' care	$3,997
Medical Care Program	Surgical-dental services requiring hospitalisation	Various oral surgical, oral medicine and pathology, dental technical, and orthodontic procedures	$723.2/1,000 population	Hospitals	[a]	$742
Department of Community Services and Corrections						
Social Allowance Health Services (SAHS)	- Sole-support mothers - The aged - Persons unemployable due to physical or mental disability - Students - Children whose parents are dead or unable to support them - Persons with dependents in need of special care - Unemployed persons where municipal assistance is not available	Basic diagnostic, preventive, restorative, endodontic, periodontic, prosthodontic, oral surgery, some orthodontic	15,841/32,203 $106.80 per user	Dentists and denturists/private practice	Centrally administered	$1,826

[a] Not reported

Table 27. Comparison between public and private delivery in the Manitoba Children's Dental Care Program, 1988

	Public	Private
Treatment utilisation	85.54%	79.08%
Per capita costs		
Direct	$76.79	$69.64
Indirect[a]	[b]	$22.92
Total	$76.79	$92.56

[a] Includes parent time loss and travel costs
[b] Not reported

Table 28. Public dental programming in Manitoba, 1995

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
[a]						
Social Assistance Programs	Children <18yrs - $500 max per yr Adults and seniors - $300 max per yr	From emergency to basic care, depending on level of assistance	[a]	[a]	[a]	[a]
Department of Health						
Provincial Dental Programs						
Cleft Lip and Palate	Those with craniofacial anomalies	[a]	[a]	[a]	[a]	$500
Oral Surgery for Medically Compromised	The medically-compromised					$500
Fluoride rinse	[a]	Fluoride rinse				[a]
Municipal Program in Winnipeg	Children, adults, and seniors - Limited to $75 of work	Emergency care	[a]	[a]	[a]	[a]

[a] Not reported

Table 29. Public dental programming in Manitoba, 2000

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Manitoba Health						
Sponsored Dental Programs						
Regional Health Authorities	General population	Prevention and promotion is focus of activities	[a]	[a]	Regionally administered	[a]
Family Services	Social assistance recipients	Basic dental treatment		Dentists/ private practice	Centrally and regionally administered	
City of Winnipeg	Those who qualify for municipal social assistance			As above with school-based clinics	Administered by Winnipeg Regional Health Authority	

[a] Not reported

Table 30. Public dental programming in Manitoba, 2005

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Department of Family Services and Housing						
Health Services Dental Program	Those receiving: - Employment Income Assistance (EIA) - Mother's and Father's Allowance - General Assistance - Disabled - Child wards of the state <18yrs $500/yr >18yrs $400/yr	Basic diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral surgery services	Approx. 55,000 eligible	Dentists and denturists/private practices, hospitals	Department of Family Services and Housing, Health Services	4,300
Manitoba Health						
Medical Program	Services performed by oral and maxillofacial surgeons or licensed dentists when hospitalisation is required; provides orthodontic benefits in cases of cleft lip and palate for persons registered by 18yrs, when provided by an orthodontist	Various oral surgical, oral medicine and pathology, dental technical, and orthodontic procedures	3,498 services provided $214 per service[a]	Specialists and generalists/hospitals, private practices	Manitoba Health, Medical Program	750[a]
Healthy Smile - Happy Child Winnipeg Regional Health Authority SMILEplus	At risk child populations	Preventive and basic treatment services	[b]	Dentists, dental hygienists and educators/primary health centres, public clinics, hospitals	Regionally administered	1,800[c]

[a] Government of Canada (2004) *Canada Health Act Annual Report*. Canada Health Act Division, Health Canada.
[b] Not reported
[c] Estimate based on $1.2M contribution by the provincial government for regional programming on Healthy Smile – Happy Child program, plus roughly $700,000 for the Winnipeg Regional Health Authority's SMILEplus program

Table 31. Manitoba Medical Program, average and median payments, oral, dental, and periodontal surgery, 1996/97 - 2005/06

	Number of practitioners	Average Payment ($)	Median Payment ($)
1996/97	3	89,780	78,100
1997/98	4	78,837	71,119
1998/99	5	73,409	63,989
2001/02	4	99,825	85,171
2002/03	5	89,040	76,652
2003/04	4	109,839	80,081
2004/05	5	119,772	64,897
2005/06	5	126,780	101,952

Table 32. Department of Family Services and Housing Health Service Program expenditures, 1999/00 - 2004/05

	Year	Expenditures ($000)	Caseload per month
Total	1999/00	3,512.9	37,314
	2000/01	3,553.1	34,949
	2001/02	4,056.8	33,576
	2002/03	4,286.3	32,588
	2003/04	4,539.2	33,758
	2004/05	4,948.8	32,889
De-aggregated for disability services			
Employment and Income Assistance	2001/02	2,199.4	19,065
	2002/03	2,282.1	17,729
	2003/04	2,361.3	17,062
	2004/05	2,514.4	17,627
Persons with disabilities	2001/02	1,857.4	15,538
	2002/03	2,004.2	16,198
	2003/04	2,177.9	16,696
	2004/05	2,343.4	15,262

Table 33. Public dental care associated legislation in Manitoba

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
The Health Services Insurance Act, C.C.S.M. c. H35	Residents entitled to receive benefits under the Act (s.2(1), "insured persons"; s. 33 and the regulations)	Continues the Manitoba Health Services Insurance Fund (s.28) Insured persons are entitled to in- and out-patient services in a hospital or surgical facility (s.46(1)) Exclusions for insured persons include benefits to which a person is entitled under other provincial or federal statutes (s.47) The LGIC may provide that this Act applies to other health services, including services provided by oral and maxillofacial surgeons or services provided by dentists in hospitals (s.71)	Manitoba Health Manitoba Health Services Insurance Fund
Hospital Services Insurance and Administration Regulation, Man. Reg. 48/93	As above	"in patient services" that are not excluded are set out in Schedule A; "out-patient services" that are not excluded are set out in Schedule B (s.1(1)) Insured persons admitted to hospitals are entitled to receive non-excluded in- and out-patient services (s.(2)) This applies to dental services described in section 3 when provided by a person described in Schedule C (s.2.1) Insured dental services are described in Schedule C and all are available only when, in the opinion of the oral and maxillofacial surgeon or dentist, hospitalization is required Hospitalization requirements are determined on the basis of medical necessity, the medical status of the patient, or both Part 1 and its 5 divisions describe the procedures that may qualify as insured dental services	Manitoba Health
Excluded Services Regulation, Man. Reg. 46/93	As above	Dental care is generally an excluded service except as provided for in regulations made under the Act (s.22) Anaesthetic services are only insured services if provided in a hospital in connection with a dentist's services that are insured services unless the services are provided to a child under the age of six or under the age of 16 where there is a serious pre-existing medical condition (s.32)	Manitoba Health
The Dental Health Services Act, C.C.S.M., c.	Those designated as beneficiaries by the LGIC (s.1)	The Minister may make arrangements for the provision or preventive and treatment dental services to a beneficiary (s.2(1);	Manitoba Health

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
D33		listed services (a) – (i)) Ministerial powers include the establishment of clinics for the provision of dental services to beneficiaries (s.3) The LGIC may make regulations in accordance with this Act (s.9(1))	
Dental Health Services Regulation, Man. Reg. 449/88R	Persons who are eligible to receive dental services within the age and geographic categories established in this regulation (s.1(1))	Beneficiaries are entitled to all services listed under s.2(1) of the Act as well as crowns and endodontic treatment of both deciduous and permanent teeth (s.2) Parents or guardians may enrol beneficiaries in a dental services program in accordance with the provisions of this regulation (s.3) Beneficiaries are eligible if they are enrolled in the schools (or doing home study) in the districts specified in Schedule B (s.5(1)) and meet the age limits set out in Schedule C (s.5(2)); all beneficiaries must also be registered under the *Health Services Insurance Act* (s.5(3))	Manitoba Health
Employment and Income Assistance Act, C.C.S.M. c. E98	Persons in need of financial assistance and who meet the criteria established in the Act (s.5) and its regulations	The LGIC may make regulations in respect of the operation of this Act (s.19(1))	Manitoba Family Services and Housing
Employment and Income Assistance Regulation, Man. Reg. 404/88 R	As above	Eligibility is determined in accordance with the regulations (ss. 4 and 5) Essential dental care services, including dentures, may be provided in accordance with the agreements between the minister and The Manitoba Dental Association and The Denturists Association (s.7(1))	Manitoba Family Services and Housing Health Services Dental Program General assistance recipients are limited to emergency dental benefits; some other applicants are eligible only for Health Services Recipients in listed residential facilities may receive services on an item-by-item basis
The Child and Family Services Act, C.C.S.M. c. C80	Children apprehended under the Act	An agency may authorize provision of medical or dental treatment for the child (s.25(1)(c))	Manitoba Family Services and Housing

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Adoption Act, C.C.S.M. c. A2	Persons adopting children	The director authorized under the act may allow for financial assistance to a person adopting a child where the child has a physical or mental condition that will make care more expensive than that usually provided to a child (s.34(a)) The LGIC may make regulations with respect to the operation of the Act (s.127)	Manitoba Family Services and Housing Neither the *Adoption Regulation,* Man. Reg. 19/99 nor the *Financial Assistance for Adoption of Permanent Wards Regulation*, Man. Reg. 21/99 provide any specifics on health or dental services and financial assistance

Table 34. Public dental programming in Ontario, 1983

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Ministry of Health						
43 Local Health Unit Programs	10 health units operated treatment programs - School-children - 2 units cover persons all ages - Means-tested to residency-only requirements 43 health units - Dental prevention activities - 3,979 schools targeted (kindergarten to grade 8) - Nurseries, day cares, pre-school groups, centres for handicapped, geriatric population	- Full range of diagnostic and basic restorative, endodontic care, emergency and minor oral surgery as necessary - Some orthodontic care - Screenings and traditional preventive services	75,000 people requested dental treatment from the 10 health units with treatment programs; 66,022 received treatment 1,153,262 preventive clients	Dentists/school, health unit office, and mobile clinics (salaried) Dental hygiene and health education staff/various medical and/or public settings	Centrally and regionally administered Cost-shared between province and municipalities	$9,558 (total) $4,216 (10 health units)
Programming for Under-Serviced Areas						
Dental Coach Program	A fleet of 10, 18m mobile homes equipped with clinic and accommodations	Provides full range of preventive and treatment services	500-600 children per year	Dentists/mobile clinics	Centrally administered	$730
Dentist Placement Program	Incentive grants to encourage dentists into rural areas		[a]	Dentists/private practice		$228
Undergraduate Dental Bursaries	Bursaries in return for their practice in designated areas					$25
Special Grants	Health units grants for specific treatment program needs			Dentists/ school, health unit office, and mobile clinics		$160
Homes for Special Care	Adults discharged from psychiatric hospitals living under state care		7,000 eligible	Dentists/private practice		$250
Mobile Dental Clinic for Disabled Children	[a]	[a]	[a]	[a]		$44

Table 34 cont'd

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Medical Care Program	Surgical-dental services requiring hospitalisation	Various oral surgical, oral medicine and pathology, dental technical, and orthodontic procedures	$635.8/1,000 population	Hospitals	[a]	$5,255
Government of Ontario						
Dental Services in Correctional Institutions Psychiatric Hospitals Retardation Facilities	Such groups in institutional care	[a]	[a]	Dentists/ institutional clinics	Centrally administered	$2,610
Ministry of Community and Social Services						
Family Benefits Program	Parents and dependent children who are recipients of social allowance - Primarily sole-support mothers and disabled parents with children <18yrs	Basic diagnostic, preventive, restorative, endodontic, periodontic, prosthodontic, oral surgery	[a]	[a]	161,365 eligible	$6,700
General Welfare Assistance Program Supplementary Aid	Covers services not provided by Family Benefits	Discretionary services	[a]	[a]	[a]	[a]
Special Assistance	Covers services for those with low incomes not receiving social allowance					

[a] Not reported

Table 35. Public dental programming in Ontario, 1995

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
[a]						
Social Assistance Programs	Children, adults, and seniors	From emergency to basic care, depending on local or regional policies	[a]	[a]	[a]	[a]
Ministry of Health						
Public Health Programs						
Screening Program Urgent Treatment Program School Programs Services for Children in Daycares Children in Need of Treatment (CINOT)	Children 0-9yrs, 10-19yrs, and seniors in collective living centres	Prevention and treatment services in select areas and schools	[a]	[a]	[a]	[a]
Services for Seniors	Persons >65yrs	From prevention to limited treatment in some areas				
Hospital and Cleft Lip and Palate Programs	Those with craniofacial anomalies	Major oral surgery		Dentists/private practice	Regionally administered by local health units	$11,342

[a] Not reported

Table 36. Public dental programming in Ontario, 2000

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Ministry of Health						
Public Health Programs Child Health Program Delivered by 37 Public Health Units	Children and schools must meet risk criteria	Elementary school screening; Dental Indices Survey (DIS); clinical preventive and treatment services; monitoring municipal water fluoridation; provision of education resources for teachers	a	A mix of public health staff Dentists/ private practice	Centrally and regionally administered 50:50 cost shared by provincial and municipal government	a
Children in Need of Treatment (CINOT)	- Children <14yrs or to grade 8 - Require emergency or essential care as per specified criteria - Parents have no dental insurance and the cost of care would result in financial hardship	Basic dental care	Approx. 10% of schoolchildren require emergency or essential care 33,000 received services $291 avg. course of treatment	Dentists/ private practice Some public health treatment clinics		$7,600
Ontario Disability Support Program (ODSP)	Disabled clients receiving benefits, spouses and dependents	a	a	Dentists/ private practice	Centrally and regionally administered 80:20 cost shared by provincial and municipal government for treatment and 50:50 for administration	a

Table 36 cont'd

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Cleft Lip and Palate Program	Those <27yrs diagnosed with cleft lip and/or palate or other sever congenital or acquired dental dysfunction	Prosthetics, orthodontics, dental orthopaedics, dental consultations, preventive dentistry Ministry of Health reimburses a maximum of 75%; parent responsible for 25%	Approx. 9,000 registered	5 designated hospitals and 3 Children's Treatment Centres	[a]	$4,400
Ontario Health Insurance Plan (OHIP)	Valid Ontario health card	Surgical-dental services delivered in hospital	[a]	Dental and surgical staff with OHIP billing numbers and hospital admitting privileges	[a]	[a]
[a]						
Ontario Works (OW)	Those receiving social assistance	Basic dental care for children, discretionary care for adults (as determined by municipality)	Approx. 30%	Dentists/ private practice	Centrally and regionally administered 80:20 cost shared by provincial and municipal government for treatment and 50:50 for administration	$11,700

[a] Not reported

Table 37. Public dental programming in Ontario, 2005

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Ministry of Community and Social Services						
Ontario Works	Based on an assessment of financial need; determined according to family size, income, assets, and shelter costs	Mandatory basic coverage for <18yrs, discretionary services for adults Municipality determine service levels Basic diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral surgery services	Approx. 30% 382,961 eligible[a]	Dentists/private practices, hospitals	Centrally and regionally Funded 80:20 (province/municipality) for treatment, 50:50 for administration	65,500
Ontario Disability Support Program (Dental Special Care Plan)	Basic coverage for disabled recipient, spouse and dependent children; determined according to family size, income, assets, shelter costs, and individual circumstances of the benefit Special care available to eligible recipients whose dental needs result from their disability		294,354 eligible[a]		As above Adjudication and payment functions the responsibility of the Ontario Dental Association	
Assistance for Severely Disabled Children (ASDC)	- Must be <18yrs living at home with a parent/legal guardian - Family income is evaluated to qualify - Child must have a severe disability - Extraordinary costs must be present which are incurred due to disability	Basic diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral surgery services	24,338 eligible[a]		[b]	[b]

Table 37 cont'd

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Ministry of Health Promotion						
Public Health Programs Child Health Program:						
Dental Indices Survey	Systematic sample of children 5, 7, 9, 13yrs; two age groups per year	Evidence based planning and decision making	NA	NA	Centrally and regionally administered	[b]
Elementary school screening	Grades 2, 4, 6, 8 in high risk schools; 2 and 8 in medium risk schools	Streamlines children into publicly financed care	[b]	Schools	Regionally administered	
Clinical Preventive Services	Grades 2 and 8 targeted for clinical preventive services	Topical fluoride and fissure sealants	8,685/35,599[c]	Community clinics		
Educational resources	High risk schools, English as a Second Language teachers	In-services, literature, technical support	[b]	Schools		
Children in need of Treatment (CINOT)	Children <14yrs or end of grade 8 yr, whichever comes later; requires emergency or essential care; parents have no dental insurance and the cost of care would result in financial hardship	Includes diagnostic, preventive, restorative, prosthodontics, endodontic, oral surgery, and pays for adjunctive services such as general anaesthesia and conscious sedation	Approx. 30,800 children treated $333 average costs per treatment	Dentists, dental hygienists, denturists/ private practice, community clinics, hospitals	Centrally and regionally administered Cost-shared between province and municipalities	10,559

Table 37 cont'd

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Ministry of Health and Long-Term Care (MOHLTC)						
Ontario Health Insurance Plan (OHIP) Cleft Lip/Palate Craniofacial Program	Insured surgical-dental services are prescribed under the Health Insurance Act MOHLTC reimburses max 75% of costs for cleft lip/palate program	Includes repair of traumatic injuries, surgical incisions, excision of tumours and cysts, treatment of fractures, homeografts, implants, plastic reconstructions, and other specified dental procedures	72,900 services provided[d] >10,000 registered for cleft lip/palate program	Specialists and generalists/ hospitals	Centrally and regionally administered	9,200[d] (6,200 for cleft lip/palate program)

[a] Government of Ontario (2005) *Ontario Social Assistance Quarterly Statistical Report*. Ministry of Community and Social Services, Social Policy Development Division, Statistical and Analysis Unit.
[b] Not reported
[c] Public Health and Epidemiology Reports (2001) "Dental Preventive Services Annual Reports." 12(10): 322-5.
[d] Government of Canada (2004) *Canada Health Act Annual Report*. Canada Health Act Division, Health Canada.

Table 38. Public dental care associated legislation in Ontario

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Health Insurance Act, R.S.O. 1990, c. H.6	Every person who is a resident of Ontario who establishes his or her entitlement (s.11)	Continues the Ontario Health Insurance Plan (s.10) Insured services are those provided to insured persons and include prescribed services of hospitals and health facilities as well as health care services rendered by prescribed practitioners under the regulations (s.11.2) The LGIC may make regulations for the operation of this Act (s.45)	Minister of Health and Long-Term Care Ontario Health Insurance Plan
GENERAL, R.R.O. 1990, Reg. 552	As above	Insured services, both in- and out-patient, are enumerated (ss.7-11) Services rendered by dental surgeons that are insured services are set out in Column 1 of Parts I, II, and III of the schedule of dental benefits (s.16); services under Part II must be rendered in conjunction with one or more of the insured services in Parts I or III (s.16(3)), where services performed under Part III must be rendered where hospitalization is a medical necessity and there is prior approval by the General Manager (s.16(4))	Minister of Health and Long-Term Care
Health Protection and Promotion Act, R.S.O. 1990, c. H.7	School Pupils	Establishes and continues regional and municipal boards of health in the province (s.1(1)) Boards of health are responsible for superintending, providing and ensuring the provision of programs and services in multiple areas, including preschool and health services, including dental services (s.5(4)(iv)) Furthermore, every board of health is required to provide such of the health programs and services as are prescribed by the regulations for the purposes of this section to the pupils attending schools within the health unit served by the board of health (s.6(1))	Minister of Health and Long-Term Care

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
		Regulations may be made by the Minister or LGIC in accordance with the Act (Part VIII, ss.96-99)	
School Health Services and Programs, R.R.O. 1990, Reg. 570	Elementary school children	Prescribes that elementary school children are entitled to the Children in Need of Treatment (CINOT), oral health screening, the dental indices survey, dental education and health promotion, clinical preventive services and monitoring of water fluoridation in accordance with the *Mandatory Health Programs and Services Guidelines*. (s.1)	Minister of Health and Long-Term Care Child Health Programs
Nursing Homes Act, R.S.O. 1990, c. N.7	Residents of nursing homes licensed under the Act (s.1)	The LGIC may make such regulations as considered necessary for carrying out the purposes of the Act (s.38(1))	Minister of Health and Long-Term Care The *GENERAL*, R.R.O. 1990, Reg. 832, provides administrators of homes shall arrange for residents to receive, at their own expense, the services of a dentist when in need of her or his services (s.62)
Ontario Works Act, 1997, S.O. 1997, c. 25, Sch. A	Applicants and their dependants who meet the criteria for specified categories	Establishes basic financial assistance, which includes benefits (s.5) Basic criteria to receive income assistance (s.7) and benefits are established (s.8) and both include persons who receive income support under the *Ontario Disability Support Program Act, 1997* The LGIC may make such regulations as considered necessary for carrying out the purposes of the Act (s.74)	Minister of Community and Social Services Ontario Works
GENERAL, O. Reg. 134/98	As above; further defined (Part I)	Applicants must meet the expanded eligibility criteria as well as apply in the prescribed manner (Part II) For recipients of income assistance and their benefit unit, dental services may be paid for dependent children if those services, items, and costs have been approved by the Minister (s.55(1)(1)(ii)) Recipients of income assistance may or may not receive benefits that include the cost of dental	Minister of Community and Social Services Health-related benefits may be issued at the discretion of the Administrator so as to allow for "decisions to be made on an individual basis" (Ontario Works Policy Directives, http://www.mcss.gov.on.ca/mcss/english/pillars/social/ow-directives/ow_policy_directives.htm)

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
		services, as these are classified as discretionary benefits (s.59(2)(1)) If a recipient is no longer eligible for income assistance by reason of an increase in employment income, his or her dependent children may be eligible to continue receiving services under s.55(1) if the benefit unit still meets the eligibility requirements otherwise specified (s.57.2(2)); other members of the benefit unit may be able to receive discretionary benefits which may include the cost of dental services for members other than dependent children (s.57.2(4)(1))	
Ontario Disability Support Program Act, 1997, S.O. 1997, c. 25, Sch. B	Eligible persons with disabilities and his or her dependants (s.3)	The person must satisfy the eligibility requirements (s.5 and regulations) The LGIC and Minister may make regulations for the operation of this Act (s.55(1) and (2))	Minister of Community and Social Services The does not provide for specific health benefits for children
GENERAL, O. Reg. 222/98	As above	If the cost, services, and items have been approved by the Minister, then the cost for members of the benefit unit (other than dependent adults) shall be paid for dental services (s.44(1)(1)(ii)(A))	Minister of Community and Social Services Ontario Disability Support Program, Dental Special Care Plan
Assistance for children with severe disabilities, O. Reg. 224/98	Children (under the age of 18) and their parents	If financial assistance is paid on behalf of a child, then most of the benefits, including dental, are to be paid if the Director considers them necessary for the welfare of the child (s.7)	Minister of Community and Social Services Assistance for Severely Disabled Children plan
Child and Family Services Act, R.S.O. 1990, c. C.11	Children in care (s.99)	Children in care have a right to receive medical and dental care at regular intervals and whenever required, in a community setting whenever possible (s.105(2)(d))	Minister of Children and Youth Services
GENERAL, R.R.O. 1990, Reg. 70	As above	Every licensee must ensure that there are arrangements for a dentist to advise them on an ongoing basis about dental care required by residents (s.91(1)(b)) and that there is at least an annual assessment for the dental condition of	Minister of Children and Youth Services

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
		residents (s.91(1)(c))	
Ministry of Correctional Services Act, R.S.O. 1990, c. M.22	Young persons in custody (s.54(1))	A young person in custody has the right to receive necessary medical and dental care (s.54(7)(d))	Minister of Community Safety and Correctional Services No equivalent provisions for adults in custody

Table 39. CINOT expenditures, Ministry of Health and Long-Term Care, non-welfare children, 1990-2006

	Number of Courses of Treatment[a]	Total Expenditure (Provincial + Municipal) ($)	Average Cost/Course of Treatment ($)
1990	12,648	3,359,075	266
1991	20,934	5,727,601	274
1992	19,644	5,513,113	281
1993	20,373	5,890,591	289
1994	22,396	6,337,592	283
1995	22,916	6,338,275	277
1996[1]	21,982	6,202,116	282
1997	21,309	5,798,256	272
1998[2]	19,529	5,661,643	290
1999[3]	22,039	6,792,904	308
2000	20,207	7,602,277	376
2001	25,437	8,136,854	320
2002	27,820	8,891,718	320
2003	28,004	9,337,027	333
2004	30,803	10,262,125	333
2005	30,914	10,559,102	342
2006[4]	30,852	11,247,162	365

[a]Software changes in 1995 tied all claims for a course of treatment to one child, meaning that the number of claims is equal to the number of courses of treatment, approximating the number of children receiving services

[1]New fee schedule with added restrictions and removal of some items

[2]Social assistance changes in late 1990s with 1998 program being 100% municipally funded

[3]New fee schedule with approximately 5% increase in fees

[4]New fee schedules released with 4% increase and other changes

Table 40. CINOT expenditures, Ministry of Community and Social Services, General Welfare Assistance, 1994-1998

	Number of courses of treatment[a]	Amount paid ($)	Average cost/course of treatment ($)
1994	14,260	4,251,282	298
1995	14,692	4,151,124	283
1996	13,295	3,839,449	289
1997	12,433	2,447,404	277
1998	8,208	2,414,642	294

[a]Software changes in 1995 tied all claims for a course of treatment to one child, meaning that the number of claims is equal to the number of courses of treatment, approximating the number of children receiving services

Table 41. CINOT expenditures, Ministry of Community and Social Services, Family Benefits Allowance, 1994-1998

	Number of courses of treatment[a]	Amount Paid	Average cost/course of treatment
1994	1,562	427,426	274
1995	1,771	445,580	252
1996	1,354	323,729	239
1997	1,023	255,447	250
1998	773	201,299	260

[a]Software changes in 1995 tied all claims for a course of treatment to one child, meaning that the number of claims is equal to the number of courses of treatment, approximating the number of children receiving services

Table 42. Dental preventive services annual report, topical fluoride, 1998/99-2005/06

	Health units reporting[a]	Children who met criteria[b]	Children offered the service	Children who consented	Children who received the service	Percent who met criteria and received the service
1998-99	25	24,394	20,072	5,836	12,418	51%
1999-00	16	13,697	14,101	4,959	4,447	32%
2000-01	28	35,599	32,880	14,803	8,585	24%
2001-02	33	63,654	53,156	33,054	27,539	43%
2002-03	35	64,953	58,432	33,966	27,624	43%
2003-04	35	57,724	45,019	18,391	17,729	31%
2004-05[c]						
2005-06	36	74,356	61,910	16,788	18,760	25%

[a]Some health unit reports were incomplete for some categories
[b]The 1997 Mandatory Health Programs and Services Guidelines use evidence-based eligibility criteria for clinical preventive services
[c]Not reported

Table 43. Dental preventive services annual report, fissure sealants, 1998/99-2005/06

	Health units reporting[a]	Children who met criteria[b]	Children offered the service	Children who consented	Children who received the service	Percent who met criteria and received the service
1998-99	23	16,078	14,507	2,499	5,614	35%
1999-00	13	16,177	16,736	3,338	2,869	18%
2000-01	29	27,702	24,365	11,154	4,452	16%
2001-02	32	33,503	29,600	10,798	10,541	31%
2002-03	36	30,896	25,512	10,995	10,007	32%
2003-04	32	29,984	22,931	8,213	7,704	26%
2004-05[c]						
2005-06	36	30,031	19,630	6,983	8,907	30%

[a]Some health unit reports were incomplete for some categories
[b]The 1997 Mandatory Health Programs and Services Guidelines use evidence-based eligibility criteria for clinical preventive services
[c]Not reported

Table 44. Public dental programming in Québec, 1983

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Ministry of Social Affairs						
Children's Dental Care Program	All children 0-15yrs	Age specific, basic diagnostic, preventive, restorative, endodontic, and oral surgery	877,082/1,487,377 $88.08 per user	Dentists/private practices (fee for service) Dentists/hospitals, Département de santé communautaire (DSC), Centre local de service communautaire (CLSC), and provincial prisons (salaried)	La Régie de l'assurance maladie du Québec (RAMQ)	$77,255
Social Assistance Recipients	Social assistance recipients	As above, excluding topical fluoride and endodontics, plus periodontic and prosthodontic	138,394/806,872 $165.72 per user 978,932 services provided 7.1 services per user $23.43 avg. cost per user	Dentists/private practices, hospitals, university teaching centres		$22,935
Medical Care Program	Surgical-dental services requiring hospitalisation	Various oral surgical, oral medicine and pathology, dental technical, and orthodontic procedures	$606.9/1,000 population	Hospitals		$3,784
Preventive Dental Services Public Program	School children	Preventive services	[a]	Dentists/dental hygienists in schools and in the 32 DSCs, various CLSCs	[a]	[a]

[a]Not reported

Table 45. Public dental programming in Québec, 2000

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Ministère Santé et Services sociaux						
Public Preventive Dental Services Program	Children <12yrs meeting screening criteria	Individualised preventive follow-up and referral twice per year	Approx. 25% of kindergarten children meet criteria	Dental hygienist/school based clinics, Local Community Service Centres	Centrally coordinated by 1 dental consultant Regionally coordinated by 32 dental consultants	$10,000
Remedial Dental Care	Children <10yrs	Basic diagnostic, preventive, restorative, endodontic, oral surgical, removable prosthodontic	[a]	[a]	[a]	$39,743
	Income security recipients					$41,003
Oral Surgery Program	- Provincial resident - Oral surgery performed in hospital or university setting	Basic diagnostic, anaesthesia, endodontic, and major oral surgery		Generalists and specialists/hospitals and university clinics		$4,023

[a] Not reported

Table 46. Public dental programming in Québec, 2005

Program	Eligibility	Services Covered	Utilisation[a]	Service Environments	Administration	Expenditures $(000)[a]
Ministère Santé et Services sociaux						
Chirurgie buccale	Everyone	Emergency diagnostic, endodontic, oral surgery services; includes repair of traumatic injuries, and various other specified dental procedures oral maxillofacial procedures	0.5% participation 1.8 services per participant $166 per participant	Generalists and specialists/ hospitals and universities	Santé Publique La Régie de l'assurance maladie du Québec (RAMQ) Agence (18) de la Santé et des Services sociaux (ASSS)	5,966
Services dentaires pour les enfants	<10yrs	Basic diagnostic, preventive, restorative, endodontic, periodontal, oral surgery services	49.1% participation 2.7 services per participant $106 per participant	Dentists, dental hygienists, denturists/private practices, public clinics (CSSS)	Santé Publique RAMQ ASSS Centres (95) de santé et des services sociaux Santé Publique (CSSS)	45,529
Services dentaires pour les prestataires de l'assistance-emploi (PAE)	>10yrs	As above	39.3% participation 6.3 services per participant $282 per participant			47,710
	>12yrs	Oral hygiene instruction, cleanings				
	<13yrs	Root canal treatment on a permanent tooth				
	12-15yrs	Topical fluoride application				
	>16yrs	Scaling				
Prosthesis dentaires acryliques pour les PAE[b]	>10yrs	Select removable prosthodontics				
Preventive Dental Services Public Program	Children and high risk adults	Select preventive services	[b]	Dentists, dental hygienists/public clinics (CSSS), educational settings and long-term care centres	Santé Publique ASSS CSSS	13,558

[a] Gouvernement du Québec (2005) *Statistiques annuelles 2004 de la Régie de l'assurance maladie du Québec*. RAMQ, ISSN 1712-4204.
[b] Not reported

Table 47. Relevant public dental programming legislation in Québec

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Health Insurance Act, R.S.Q. c.A-29	Insured persons, or those residents duly registered under this Act and its regulations (s.1(g.1))	Insured services are those specified in section 3 (s.1(a)) Insured services for which the cost will be assumed by the Board include services of oral surgery determined by regulation and required by dentistry, rendered by a dentist in accordance with the Act (s.3(b)) The cost of services required by dentistry and rendered by dentists are assumed by the Board on behalf of every insured person according to whether or not he holds a valid claim booklet issued pursuant to section 71.1 (s.3) The Government may make regulations in accordance with this act and its regulations (s.69) Provisions for claim booklets to be issued by Minister of Employment and Social Solidarity to persons at least 60 years of age and less than 65 years of age (s.71) Claim booklets shall also be issued by Minister of Employment and Social Solidarity to those families or persons prescribed as under a last resort financial assistance program (s.71.1)	Ministère Santé et Services sociaux Health Insurance Plan
Application of the Health Insurance Act, Regulation respecting the, R.Q. c. A-29, r.1	As above	Lists a number of services which are not considered insured services including: those rendered more than once during a 12-month period by a dentist; surgical extractions by a physician subject to limitations; beneficiaries under 10 years of age; recipients holding valid claims booklets under section 71.1 of the Act (s.22) Oral surgery services considered as insured services are listed in detail under Division X of these regulations Dental services that are considered insured services for beneficiaries under the age of 10 years are listed in detail in Division XIII of these regulations; these services are considered insured only if the beneficiary has held a valid claim booklet for 12 consecutive months (subject to limitations, s.36.1)	Ministère Santé et Services sociaux

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Hospital Insurance Act, R.S.Q., c.A-28	Residents of Quebec and other such persons determined by regulation (s.2)	Insured services mean hospital services as defined in the regulations (s.1(c)) The Government may make regulations in conformity with the provisions of this Act (s.8)	Ministère Santé et Services sociaux
Application of the Hospital Insurance Act, Regulation respecting the, R.Q. c. A-28, r.1	As above Beneficiaries are every person benefiting from the services of a hospital centre (s.1(a))	Insured services are provided free of charge during the period in which such services are medically required (s.2) Insured services include the services listed which are required from a medical or dental standpoint, the latter being to the extent that they are insured services for the purposes of subparagraph b of the first paragraph of section 3 of the *Health Insurance Act* or for the purposes of the second paragraph of section 3 of the Act (s.3)	Ministère Santé et Services sociaux
Health services and social services, An Act respecting, R.S.Q. c. S-4.2	Residents of Quebec	Overview of health and social services provided in Quebec Among other provisions, the Act establishes the *Centre local de services communautaires* (CLSC – Local Community Service Centre) where health and social services of a preventive or curative nature are provided, including public health activities (s.80) Section 303 provides the basis for a classification of services offered by intermediate resources based on the degree of support or assistance required by users Ministerial functions are outlined in Chapter I of Title II; Regulations in Chapter VII	Ministère Santé et Services sociaux Primarily deals with administration
Classification of services offered by family-type resources and the rates of compensation applicable to each type of service, R.Q. c. S-4.2, r.0.001	Residents in need of services offered by family-type resources	Foster families are entitled to reimbursement of costs for dental care that is justified by the foster child's condition (s.25(2)) and/or orthodontic services so long as the child has been in foster care for at least one year and a professional can attest to the medical or psychological need for such services (s.25(3))	Ministère Santé et Services sociaux
Youth Protection Act, R.S.Q. c. P-34.1	Children	Children are entitled to receive adequate health, social and educational services according to his or her personal requirements (s.8)	Ministère Santé et Services sociaux Nothing specific on dental
Financial assistance to facilitate the adoption of a child, Regulation respecting, R.Q. c. P-34.1, r.0.1.1	Children	Financial assistance may be granted to a person who has lodged a child for at least one year in his or her home in the capacity of a foster family (s.1)	Ministère Santé et Services sociaux Establishes comparable rates of coverage for adopting families as

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
		The amount is the rate to which a foster family would be entitled under ss.303 and 314 of the Act respecting health services and social services (s.6)	foster families
Health services and social services for Cree Native persons, An Act respecting, R.S.Q. c. S-5	Refers to persons in the territory of the Conseil de la santé et des services sociaux de la Baie-James. (s.1.1)	Regulations powers of Government (Division IX)	Ministère Santé et Services sociaux
Public Health Act, R.S.Q. c. S-2.2	Residents of Quebec	Provides for the fluoridation of drinking water (Division II)	Ministère Santé et Services sociaux The *Optimum fluoride concentration to prevent tooth decay, Regulation prescribing the*, R.Q. c. S-2.2, r.3 provides for the optimal level of fluoride concentration (s.1)
Income support, employment assistance and social solidarity, An Act respecting, R.S.Q. c. S-32.001	Independent adults or families whose resources fall short of the amount needed to provide for their needs (s.14)	Eligibility for assistance is determined in accordance with s.14 and Division IV and who is not ineligible by operation of s.15	Emploi et Solidarité sociale Employment Assistance Program Persons must be in receipt of employment-assistance for at least 12 consecutive months
Income support, Regulation respecting, R.Q. c. S-32.001, r.1	As above	Those who no longer qualify for income support may continue to receive dental care referred to in ss. 70 and 71.1 of the *Health Insurance Act* provided they meet the eligibility requirements in the regulation (s.12) Dental services referred to in ss.70 and 71.1 of the *Health Insurance Act* and in Schedule I to these regulations (acrylic dental prostheses) are granted as special benefits but are not subject to the same restrictions (see s.45) as other special benefits (s.50) Transitional provisions relevant to recipients of financial assistance under previous statutes (s.196 and 212)	Emploi et Solidarité sociale

Table 48. Costs of programs administered by RAMQ, 1999-2003

	$(000)				
	1999	2000	2001	2002	2003
Dental Services	99,723	100,800	102,627	102,336	103,961
In Quebec	93,321	93,803	95,057	94,701	95,698
Chirurgie buccale	4,154	4,550	4,814	5,107	5,534
Services dentaires pour les enfants	41,517	40,056	38,796	37,159	41,631
Services dentaires pour les prestataires de l'assistance-emploi (PAE)	37,329	34,771	33,227	32,136	42,688
Flat rate contracts	10,244	14,360	18,185	20,257	5,798
Out of Quebec	77	66	35	42	47
Wages and vacation, includes flat rate contracts	6,402	6,997	7,570	7,635	8,263

Table 49. Costs of programs administered by RAMQ, 1999-2003

Year	Chirurgie buccale				Services dentaires pour les enfants				PAE	
	PAE	Others	Total	Δ%	PAE	Others	Total	Δ%	$	Δ%
1999	466,683	3,694,796	4,161,479	2	6,969,224	39,90,705	46,878,929	-1.8	42,203,950	-6.3
2000	474,606	4,104,700	4,579,306	10	6,516,263	41,099,210	47,615,473	1.6	41,542,338	-1.6
2001	492,602	4,442,785	4,935,387	7.8	6,190,283	41,801,172	47,991,455	0.8	42,095,692	1.3
2002	513,309	4,747,184	5,260,493	6.6	5,804,441	41,426,542	47,230,983	-1.6	42,167,968	0.2
2003	496,009	5,371,101	5,867,110	11.5	5,480,251	38,690,380	44,170,631	-6.5	45,613,298	8.2

Table 50. Evolution of the services dentaires pour les enfants, Québec 1999-2003

Services											Provider		Persons Eligible		Participants		Percentage participation	
Year	Number	Δ%	Total cost	Δ%	Average cost	Δ%	Per participant	Δ%	Per provider	Δ%	N	Δ%	N	Δ%	N	Δ%	%	Δ%
1999	1,312,583	-1.7	41,516,774	-1.8	31.36	-0.1	2.8	-1.9	401	-3.7	3,273	2.1	940,086	-1.2	470,934	0.2	50.1	1.4
2000	1,268,207	-3.4	40 055 947	-3.5	31.58	-0.1	2.8	-0.8	389	-2.9	3,258	-0.5	894,639	-4.8	458,705	-2.6	51.3	2.4
2001	1,227,336	-3.2	38 796 108	-3.1	31.61	0.1	2.7	-0.6	373	-4.2	3,290	1	871,346	-2.6	446,418	-2.7	51.2	-0.1
2002	1,173,965	-4.3	37 159 451	-4.2	31.65	0.1	2.7	-0.6	356	-4.6	3,298	0.2	851.273	-2.3	429,493	-3.8	50.5	-1.5
2003	1,124,221	-4.2	41 630 984	12	37.03	17	2.7	-0.8	339	-4.7	3,313	0.5	832,947	-2.2	414,532	-3.5	49.8	-1.4

Table 51. Evolution of dental services for PAE children, Québec 1999-2003

Services											Persons eligible		Participants		Participation	
Year	Number	Δ%	Total cost	Δ%	Average cost	Δ%	Number per participant	Δ%	Cost per participant	Δ%	N	Δ%	N	Δ%	%	Δ%
1999	190,910	-13	6,172,063	-12.9	32.33	0.2	3.7	-2.2	120.19	-2	118,577	-13.9	51,353	-11.1	43.3	3.2
2000	170,140	-10.9	5,481,728	-11.2	32.22	-0.3	3.7	0.8	120.75	0.5	106,179	-10.5	45,397	-11.6	42.8	-1.3
2001	154,876	-9	5,004,201	-8.7	32.31	0.3	3.8	1.1	122.47	1.4	95,847	-9.7	40,860	-10	42.6	-0.3
2002	141,907	-8.4	4,566,703	-8.7	32.18	-0.4	3.7	-1.2	120.57	-1.6	89,929	-6.2	37,875	-7.3	42.1	-1.2
2003	134,546	-5.2	5,165,157	13.1	38.39	19.3	3.8	2.1	146.86	21.8	84,457	-6.1	35,171	-7.1	41.6	-1.1

Table 52. Evolution of services for other eligible children, Québec 1999-2003

	Services									Persons eligible		Participants		Participation	
Year	Number	Δ%	Total cost	Δ%	Average cost	Δ%	Number per participant	Δ%	Cost per participant	Δ%	N	Δ%	N	Δ%	%	Δ%
1999	1,121,673	0.5	35,344,711	0.5	31.51	0	2.7	-1.1	83.66	-1.2	821 509	0.9	422 462	1.7	51.4	0.8
2000	1,098,067	-2.1	34,574,219	-2.2	31.49	-0.1	2.6	-0.6	83.11	-0.7	788 460	-4	416 020	-1.5	52.8	2.6
2001	1,072,460	-2.3	33,791,907	-2.3	31.51	0.1	2.6	-0.4	82.81	-0.4	775 499	-1.6	408 067	-1.9	52.6	-0.3
2002	1,032,058	-3.8	32,592,748	-3.5	31.58	0.2	2.6	-0.3	82.74	-0.1	761 344	-1.8	393 936	-3.5	51.7	-1.7
2003	989,675	-4.1	36,465,827	11.9	36.85	16.7	2.6	-1	95.57	15.5	748 490	-1.7	381 546	-3.1	51	-1.5

Table 53. Evolution of PAE services, Québec, 1999-2003

Services										Provider		Persons eligible		Participants		Participation	
Year	Number	Δ%	Total cost	Δ%	Average cost	Δ%	Per participant	Δ%	Per provider	Δ%	N	Δ%	N	Δ%	N	Δ%	%	Δ%
1999	1,251,019	-7.1	37,328,701	-6.3	29.84	0.9	6.2	-0.4	309	-8.1	4,055	1.1	512,342	-5.9	200,647	-6.7	39.2	0.9
2000	1,149,754	-8.1	34,771,209	-6.9	30.24	1.4	6.1	-1.5	285	-7.6	4,035	-0.5	482,937	-5.7	187,251	-6.7	38.8	-1
2001	1,087,325	-5.4	33,227,075	-4.4	30.56	1	6.1	-0.7	269	-5.7	4,045	0.2	458,622	-5	178,265	-4.8	38.9	0.2
2002	1,050,535	-3.4	32,135,748	-3.3	30.59	0.1	6.1	0.3	260	-3.4	4,046	0	446,564	-2.6	171,736	-3.7	38.4	-1.1
2003	1,043,307	-0.7	42,687,955	32.8	40.92	33.8	6.2	1.8	256	-1.5	4,081	0.9	436,651	-2.2	167,480	-2.5	38.4	-0.2

Table 54. Evolution of the chirurgie buccale, Québec, 1999-2003

	Services										Providers		Persons eligible		Participants		Participation	
Year	Number	Δ%	Total cost	Δ%	Average cost	Δ%	Per participant	Δ%	Per provider	Δ%	N	Δ%	N	Δ%	N	Δ%	%	Δ%
1999	49,596	3.1	4,116,920	2	83.01	-1	1.6	2.3	166	9	298	-5.4	7,227,269	0.3	30,978	0.8	0.4	0.5
2000	50,243	1.3	4,407,031	7	87.71	5.7	1.6	2	169	1.6	297	-0.3	7,137,525	-1.2	30,770	-0.7	0.4	0.6
2001	51,280	2.1	4,571,872	3.7	89.16	1.6	1.6	-3	169	0	303	2	7,174,018	0.5	32,384	5.2	0.5	4.7
2002	50,626	-1.3	5,106,758	11.7	100.87	13.1	1.5	-2.9	176	4.2	287	-5.3	7,208,160	0.5	32,917	1.6	0.5	1.2
2003	55,306	9.2	5,534,244	8.4	100.07	-0.8	1.6	6.3	197	11.6	281	-2.1	7,246,114	0.5	33,831	2.8	0.5	2.2

Table 55. Evolution of chirurgie buccale for PAE, Québec, 1999-2003

	Services										Persons eligible		Participants		Participation	
Year	Number of services	Δ %	Total cost	Δ%	Average cost	Δ%	Number per participant	Δ %	Cost per participant	Δ %	N	Δ%	N	Δ%	%	Δ%
1999	7,432	-9.9	461,686	-13.2	62.12	-3.7	1.4	-9.4	88.56	-12.7	630,919	-7.5	5,213	-0.6	0.8	7.5
2000	7,140	-3.9	456,751	-1.1	63.97	3	1.5	3.5	94.39	6.6	589,116	-6.6	4,839	-7.2	0.8	-0.6
2001	7,118	-0.3	456,319	-0.1	64.11	0.2	1.4	-1.9	92.75	-1.7	554,469	-5.9	4,920	1.7	0.9	8
2002	6,860	-3.6	498,308	9.2	72.64	13.3	1.4	-2.6	102.41	10.4	536,583	-3.2	4,866	-1.1	0.9	2.2
2003	6,966	1.5	467,868	-6.1	67.16	-7.5	1.5	5.6	99.97	-2.4	521,107	-2.9	4,680	-3.8	0.9	-1

Table 56. Evolution of chirurgie buccale for other eligible persons, Québec, 1999-2003

	Services										Persons Eligible		Participants		Participation	
Year	Number	Δ%	Total cost	Δ%	Average cost	Δ%	Number per participant	Δ%	Cost per participant	Δ%	N	Δ%	N	Δ%	%	Δ%
1999	42,164	5.8	3,655,234	3.3	86.69	-2.4	1.6	4.6	141.52	2.1	6,596,350	1.1	25,828	1.2	0.4	0.1
2000	43,103	2.2	3,950,280	8.1	91.65	5.7	1.7	1.5	151.92	7.3	6,548,409	-0.7	26,002	0.7	0.4	1.4
2001	44,162	2.5	4,115,553	4.2	93.19	1.7	1.6	-3.2	149.54	-1.6	6,619,549	1.1	27,522	5.8	0.4	4.7
2002	43,766	-0.9	4,608,450	12	105.3	13	1.6	-2.9	163.98	9.7	6,671,577	0.8	28,104	2.1	0.4	1.3
2003	48,340	10.5	5,066,376	9.9	104.81	-0.5	1.7	6.3	173.42	5.8	6,725,007	0.8	29,214	3.9	0.4	3.1

Table 57. Number and cost of dental services by socio-health district, provider and program, Québec, 2003

	Chirurgie buccale						Services dentaires pour les enfants						PAE		All programs	
	PAE		Others		Total		PAE		Others		Total		Total		Total	
Socio-health district	N	$	N	$	N	$	N	$	N	$	N	$	N	$	N	$
Bas Saint-Laurent	177	18,883	1,628	138,466	1,805	157,349	3,171	116,515	27,927	1,005,918	31,098	1,122,433	32,153	1,372,655	65,056	2,652,436
Saguenay-Lac Saint-Jean	236	29,854	1,576	267,039	1,812	296,893	5,592	213,572	47,698	1,718,270	53,290	1,931,842	49,675	2,147,812	104,777	4,376,547
Capitale – Nationale	1,098	78,300	9,224	1,068,302	10,322	1,146,602	6,974	263,172	74,477	2,704,987	81,451	2,968,159	87,489	3,702,953	179,262	7,817,714
Mauricie et Centre-du-Quebec	365	50,269	1,363	298,111	1,728	348,380	8,386	317,794	66,032	2,460,536	74,418	2,778,330	83,059	3,482,644	159,205	6,609,354
Estrie	64	8,001	846	189,057	910	197,059	5,218	203,233	39,065	1,430,216	44,283	1,633,449	41,880	1,694,132	87,073	3,524,639
Montreal	4,191	209,522	23,943	1,593,534	28,134	1,803,057	56,560	2,186,700	245,941	9,118,094	302,501	11,304,794	384,859	15,194,469	715,494	28,302,319
Outaouais	100	9,482	1,169	229,868	1,269	239,349	5,369	202,867	36,475	1,332,186	41,844	1,535,052	34,557	1,398,676	77,670	3,173,077
Abitibi-Temiscamingue	193	15,883	1,925	196,055	2,118	211,938	2,794	104,002	25,113	932,140	27,907	1,036,142	19,875	856,951	49,900	2,105,030
Cote-Nord	8	290	23	805	31	1,095	1,834	69,648	16,307	602,087	18,141	671,735	10,559	443,441	28,731	1,116,272
Nord-du-Quebec, Nunavik et Terres-Cries-de-la-Baie-James							228	8,530	3,285	116,002	3,513	124,532	1,296	51,727	4,809	176,259
Gaspesie-Iles-de-la-Madeleine	12	757	23	793	35	1,550	2,158	73,885	10,434	373,998	12,592	447,883	15,125	661,122	27,752	1,110,555
Chaudiere-Appalaches	224	19,851	3,532	347,325	3,756	367,175	3,092	116,300	59,898	2,210,099	62,990	2,326,399	35,697	1,532,767	102,443	4 226 341
Laval	9	710	341	72,006	350	72,716	3,280	129,930	42,505	1,559,369	45,785	1,689,298	25,765	1,006,454	71,900	2,768,469
Lanaudiere	90	10,477	1,795	450,885	1,885	461,362	5,768	218,875	56,468	2,100,154	62,236	2,319,029	42,876	1,791,760	106,997	4,572,151
Laurentides	31	3,831	198	33,691	229	37,522	5,910	225,961	61,393	2,249,825	67,303	2,475,785	48,871	2,040,825	116,403	4,554,132
Monteregie	168	11,760	754	180,438	922	192,198	18,212	714,174	176,657	6,551,947	194,869	7,266,121	129,571	5,309,567	352,362	12,767,885
All Quebec	6,966	467,868	48,340	5,066,376	55,306	5,534,244	134,546	5,165,157	989,675	36,465,827	1,124,221	41,630,984	1,043,307	42,687,955	2,222,834	89,853,182

Table 58. Participation, number, and cost of dental services by socio-health district and program, Québec, 2003

	Chirurgie buccale			Services dentaires pour les enfants			PAE		
Socio-health district	Percentage participation	Number per participant	Cost per participant	Percentage participation	Number per participant	Cost per participant	Percentage participation	Number per participant	Cost per participant
Bas Saint-Laurent	0.8	1.3	126.37	57.1	2.8	100.24	39.6	5.9	253.52
Saguenay-Lac Saint-Jean	0.3	2.2	357.67	57.9	3.1	114.03	42.6	6.4	275.11
Capitale -Nationale	0.8	1.7	170.96	52.8	2.3	84.69	39.6	6.3	266.23
Mauricie et Centre-du-Quebec	0.3	1.9	336.74	53.7	2.9	107.01	39.9	6.1	257.53
Estrie	0.1	2	358.2	50.5	2.8	104.35	39.3	6.2	249.67
Montreal	0.8	1.4	82.20	44.1	3	112.38	39	6.5	254.87
Outaouais	0.2	2.4	434.01	42.3	2.6	95.06	33.6	5.7	229.22
Abitibi-Temiscamingue	0.8	1.4	145.27	55.2	2.8	105.30	37	5.8	252.54
Cote-Nord	0.3	1.6	228.03	49.2	3.5	128.37	33.5	6.1	261.74
Nord-du-Quebec, Nunavik et Terres-Cries-de-la-Baie-James	0.4	1.8	219.42	14.2	3.4	124.69	9.5	6.2	274.96
Gaspesie-Iles-de-la-Madeleine	0.2	1.6	188.46	48.1	2.9	105.15	33.2	5.2	229.55
Chaudiere-Appalaches	0.7	1.9	194.15	55.7	2.7	99.29	38.4	6.1	265.98
Laval	0.3	1.7	174.80	48.9	2.5	90.35	38.5	6.3	248.61
Lanaudiere	0.2	1.9	270.13	53.4	2.6	97.18	36.1	6.2	258.17
Laurentides	0.2	1.8	252.41	52.4	2.5	91.56	36.6	6	254.12
Monteregie	0.2	1.9	263.66	51.4	2.5	94.18	38.3	6	248.87
All Quebec	0.5	1.6	163.58	49.8	2.7	100.43	38.4	6.2	254.88

Table 59. Participation, number, and cost of dental services by gender, age, and program, Québec, 2003

	Chirurgie buccale			Services dentaires pour les enfants			PAE		
Sex and age group	Percentage participation	Number per participant	Cost per participant	Percentage participation	Number per participant	Cost per participant	Percentage participation	Number per participant	Cost per participant
Male									
Less than 4yrs	0.4	1.2	36.57	18.8	1.9	68.64	-	-	-
4 to 9	0.7	1.2	42.72	68.8	2.9	109.38	0	2.7	106.60
10 – 14	0.4	1.3	98.52	28.7	2.5	89.53	44.4	4.7	139.93
15 – 19	0.6	2.2	374.53	-	-	-	32.9	6.3	204.78
20 – 24	0.5	2.1	306.47	-	-	-	32.5	7	253.53
25 – 29	0.4	1.8	216.15	-	-	-	35.9	7.3	261.86
30 – 34	0.4	1.8	218.27	-	-	-	36.4	7.3	263.23
35 – 39	0.4	1.8	186.85	-	-	-	39.2	7.2	265.71
40 – 44	0.3	1.7	198.37	-	-	-	39.2	6.8	263.79
45 – 49	0.3	1.8	177.97	-	-	-	36.4	6.6	279.25
50 – 54	0.4	1.7	140.22	-	-	-	31.7	6.3	292.56
55 – 59	0.4	1.7	135.39	-	-	-	28	6	314.61
60 – 64	0.4	1.5	103.88	-	-	-	26.4	5.6	369.28
65 – 69	0.5	1.5	98.11	-	-	-	37.9	5.5	340.03
70 – 74	0.5	1.6	105.87	-	-	-	35.8	7.3	376.07
75 – 79	0.5	1.5	80.51	-	-	-	37.1	6.3	323.11
80 – 84	0.6	1.3	72.70	-	-	-	26.2	6.8	493.08
85 yrs or more	0.7	1.3	64.07	-	-	-	22.7	5	285.17
Total	0.4	1.7	164.11	49.2	2.8	103.33	35	6.5	263.41
Female									
Less than 4 yrs	0.4	1.2	38.87	19.4	1.8	64.92	-	-	-
4 to 9	0.6	1.1	43.05	70.1	2.8	103.36	*	2.5	105.23
10 – 14	0.4	1.3	105.05	29.4	2.4	79.67	49.1	4.8	139.97
15 – 19	0.8	2	358.17	-	-	-	41.1	6.4	212.63
20 – 24	0.7	1.8	233.15	-	-	-	44.5	6.9	244.64
25 – 29	0.5	1.8	242.59	-	-	-	46.5	6.8	239.07
30 – 34	0.5	1.8	223.65	-	-	-	47.6	6.7	237.09
35 – 39	0.4	1.8	229.74	-	-	-	46.5	6.4	235.08
40 – 44	0.4	1.7	170.04	-	-	-	44.4	6.1	240.52
45 – 49	0.4	1.7	157.73	-	-	-	40.2	6	258.93
50 – 54	0.4	1.6	133.86	-	-	-	36.6	5.6	279.66
55 – 59	0.4	1.6	116.87	-	-	-	33.3	5.3	306.33
60 – 64	0.5	1.6	98.14	-	-	-	29.9	4.9	342.10
65 – 69	0.5	1.5	88.47	-	-	-	39.7	4.9	324.18

Table 59 cont'd

	Chirurgie buccale			Services dentaires pour les enfants			PAE		
Sex and age group	Percentage participation	Number per participant	Cost per participant	Percentage participation	Number per participant	Cost per participant	Percentage participation	Number per participant	Cost per participant
70 – 74	0.5	1.4	69.04	-	-	-	28.2	6	350.52
75 – 79	0.5	1.5	78.71	-	-	-	29.2	4.9	338.94
80 – 84	0.4	1.4	70.31	-	-	-	30.3	4.5	378.59
85 yrs or more	0.4	1.3	67.37	-	-	-	22.3	2.5	166.28
Total	0.5	1.6	163.13	50.4	2.7	97.48	41.4	6	248.19
Male and female total	0.5	1.6	163.58	49.8	2.7	100.43	38.4	6.2	254.88

Table 60. Public dental programming in New Brunswick, 1983

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Department of Health						
Dental Health Services Program	- All school-children in grades 1 to 6 offered various preventive services - In districts with no local dentists, all children in grades 1 to 3 offered basic treatment services - Children in grades 1 to 12 whose families are classified as underprivileged offered basic treatment services	Includes a broad range of diagnostic, preventive, restorative, endodontic, and oral surgical services	72,459/66,784 (for preventive services) 4268 users (treatment services) 21,898 services provided	Dentists and dental hygienists/regional clinics (salaried) Dentists/private practice and mobile clinics (sessional and fee for service)	Personal Health Services Division, Dental Health Services Branch	$927
Medical Care Program	Surgical-dental services requiring hospitalisation	Various oral surgical, oral medicine and pathology, dental technical, and orthodontic procedures	$71.3/1,000 population	Hospitals	[a]	$50
Department of Social Services						
Social Assistance Program	- Families and individuals in need of financial assistance - Persons in institutional care because of age and disability who cannot meet cost of care	Age specific, limited diagnostic, restorative, endodontic, periodontic, prosthetic, oral surgical, orthodontic - Patients >18yrs pay 25% 'participation fee' for dentures if asked by treating practitioner	68,595 eligible 75,500 services provided $21.19 avg. cost per service	Dentists/private practice	Department of Social Services	$1,600

[a] Not reported

Table 61. Public dental programming in New Brunswick, 2000

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
[a]						
Surgical Dental Procedures	Surgical care delivered in hospital	Major oral surgery	[a]	Generalists and specialists/ Hospitals	[a]	[a]

[a] Not reported

Table 62. Public dental programming in New Brunswick, 2005

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Family and Community Services (FCS)						
Health Services Dental Program	Based on an assessment of financial need, household number, and determination of employability Different service levels are defined, from Dental, Full Basic, to Enhanced Dental, with criteria recognised for those <19 yrs, Children in Care <25yrs, and adults certified by FCS as disabled	Assistance categories determine service levels, and includes some diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, surgical, and additional services Enhanced Dental benefits are subject to a 30% client participation fee	[a]	Dentists and denturists/private practices	Centrally administered	2,980

Table 62 cont'd

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Department of Health and Wellness						
Cleft Palate Program	Provides financial assistance with the cost of authorised orthodontic work for children 0-19 years who have a cleft of the hard palate; eligibility is income based	Orthodontic care	[a]	Specialists and generalists/private practices	Administered by Atlanta Blue Cross	[a]
Insured Surgical-Dental Services	Insured surgical-dental services are prescribed under the Medical Services Payment Act	Various oral and maxillofacial procedures	1,232 services provided[b]	Specialists and generalists/hospitals	Centrally administered	189[b]
Fluoride Mouth Rinse Program	School age children, grade 1-6	Fluoride mouth rinse	58% participation Approx. 60,000 eligible	Teachers and volunteers/participating schools		50

[a] Not reported
[b] Government of Canada (2004) *Canada Health Act Annual Report*. Canada Health Act Division, Health Canada.

Table 63. Participation rates in New Brunswick's fluoride mouth rinse program

School year	Percentage participation
1995-96	88.1%
1996-97	87.9%
1997-98	82.4%
1998-99	79.5%
1999-00	71.2%
2000-01	72.4%
2001-02	60.6%
2002-03	58%

Table 64. Public dental care associated legislation in New Brunswick

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Medical Services Payment Act, R.S.N.B. 1973, c.M-7	As defined in the regulations (s.1)	"Entitled services" include medically required services rendered by oral and maxillofacial surgeons (s.1(a)) Provides for the establishment of a medical services plan for residents of the province (s.2) Services by an oral and maxillofacial surgeon must be provided to a patient as an in-patient or out-patient in a hospital facility (s.2.01(c)) The LGIC may make regulations under this Act (s.12)	Minister of Health and Wellness Medical Services Plan
General Regulation - Medical Services Payment Act, N.B. Reg. 84-20	Beneficiaries are those residents meeting the requirements specified in the regulations (ss.2 and 3, subject to s.4)	Services rendered in hospital facilities by dental practitioners for which beneficiaries are covered include those listed in Schedule 4 (s.22(1)), subject to the exclusions in Schedule 2 (s.10)	Minister of Health and Wellness Services listed in Schedule 4 are limited to surgical dental procedures
Hospital Services Act, R.S.N.B. 1973, c.H-9	Residents as defined in the regulations (s.1)	Entitled services include the insured hospital and diagnostic services outlined in the regulations (s.1) The LGIC may make regulations for the operation of this Act, including the establishment of a hospital services plan (s.9)	Minister of Health and Wellness
General Regulation - Hospital Services Act, N.B. Reg. 84-167	Entitled persons, or residents entitled to receive entitled services (ss.2 and 4) and not subject to the ineligibility provisions (s.6)	Entitled services include in-patient and out-patient services rendered in accordance with the regulations, and include those involving an oral and maxillofacial surgeon (s.9)	Minister of Health and Wellness
Regional Health Authorities Act, S.N.B. 2002, c. R-5.05		Deals with the provision of community health services and their description and implementation by regional health authorities The LGIC may make regulations regarding the operation of this Act (s.72)	Minister of Health and Wellness In the *Community Health Centres Regulation - Regional Health Authorities Act,* N.B. Reg. 2002-87, dental services are not included in the definition of "community health services" (s.3)
Family Income Security Act, S.N.B. 1994, c. F-2.01	Persons in need (s.1), or those deemed likely to become persons in need (s.3)	Assistance (defined in s.1) shall be given in accordance with the Act and regulations (s.3) The LGIC may make regulations regarding the	Minister of Family and Community Services

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
		operation of this Act (s.20)	
General Regulation - Family Income Security Act, N.B. Reg. 95-61	Recipients of assistance, including their dependents, as well as those meeting the definitions of blind, deaf and disabled (s.1)	Detailed eligibility provisions (s.4) Items of special need include the purchase of health and medical supplies and services that are not covered under the *Health Services Act* and its regulations (s.19(2)) The Minister may grant assistance by way or providing a Health Services Card under the *Health Services Act* (s.23) Coverage for social assistance recipients is adjusted to full coverage for adults after 3 months; in some cases, health cards are issued to those not eligible for social assistance (s.4(4))	Minister of Family and Community Services
Health Services Act, R.S.N.B. 1973, c. H-3	As defined in the regulations (s.1)	The Minister shall establish a health services plan to provide entitled services for persons in need (s.3) The LGIC may make regulations regarding the operation of this Act, including the establishment of a health services plan (s.11)	Minister of Family and Community Services Health Services Dental Program
General Regulation - Health Services Act, N.B. Reg. 84-115	Holders of valid health services cards issued under: the *Family Income Security Act* (other than dependants of beneficiaries); the *Family Services Act* to children in care; the *Family Income Security Act* to persons who are blind or disabled; or to residents of licensed nursing homes (s.2)	Schedule II lists goods and services that are considered "entitled services" (s.2) Every beneficiary is eligible to receive entitled services listed in Schedule II (s.3(1)) Dental services for social assistance beneficiaries and their dependants over 18 years and who are not in receipt of social assistance benefits as a blind or disabled person under the *Family Income Security Act* or are not children in care under the *Family Services Act* are limited to diagnostic, emergency and prosthetic services (s.4) Benefits are not available to persons imprisoned (s.7) The Dental Advisory Committee (established by s.9) may approve additional benefits (s.5) and is required	Minister of Family and Community Services Dental benefits for those not falling under s.4 include the following services: Diagnostic; Preventive; Restorative; Endodontic; Periodontal; Prosthetic; Surgical; and Additional.

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
		to give pre-approval in specified instances (s.5.1) Excluded services include orthodontic treatment unless performed by an orthodontist, cosmetic goods and services, and self-curing relines to dentures (Schedule I)	
Family Services Act, S.N.B. 1980, c. F-2.2	Children in care (s.1)	The LGIC may make regulations for the operation of this Act (s.143)	Minister of Family and Community Services
Children in Care Services Regulation - Family Services Act, N.B. Reg. 91-170	As above	The Minister shall provide each child in care with a health services card (s.12)	Minister of Family and Community Services
Custody and Detention of Young Persons Act, S.N.B. 1985, c.C-40	Young persons admitted to youth custodial facilities	Medical treatment includes dental treatment (s.1) The LGIC may make regulations for the operation of this Act (s.15)	Minister of Public Safety
General Regulation - Custody and Detention of Young Persons Act, N.B. Reg. 92-71	Young persons admitted to youth custodial facilities (s.4)	The facility supervisor shall arrange for dental examinations and treatment as necessary upon a young person's admission (s.4(c)) Supervisors may also establish and provide for the operation of medical and dental treatment programs (s.22(f))	Minister of Public Safety
Victims Services Act, S.N.B. 1987, c. V-2.1	Victims of specified crimes	Establishes a victim services fund (s.17) out of which victims of crime may receive financial compensation The LGIC may make regulations for the operation of this Act (s.26)	Minister of Public Safety
Compensation for Victims of Crime Regulation - Victims Services Act, N.B. Reg. 96-81	As above	Eligible expenses for financial compensation for dental expenses are limited to $1,000 (s.5(b))	Minister of Public Safety
Corrections Act, R.S.N.B. 1973, c. C-26	Inmates of provincial correctional facilities	Nothing in the *General Regulation - Corrections Act,* N.B. Reg. 84-257 or this Act with respect to dental services	Minister of Public Safety

Table 65. Public dental care programming in Nova Scotia, 1983

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Department of Health						
Children's Dental Care Plan	All children 0-15yrs	Full range of basic dental services including diagnostic, preventive, restorative, endodontic, oral surgery	101,408/194,900 $82.17 per user	Dentists/private practice	Maritime Medical Care Inc. as Medical Services Insurance (MSI)	$8,333
Sir Frederick Fraser School for the Blind	School children	As above	[a]	[a]	[a]	$0.678
Dental Program for the Severely Mentally Retarded	Such populations registered with Health Services Insurance Commission	[a]	[a]	[a]	[a]	$12
Dental Coverage for Cleft Palate Cases	Registered with Cleft Palate Unit at IWK Hospital for Children	[a]	[a]	[a]	[a]	$125
Dental Public Health Service	Rural, under-serviced areas (particularly children)	As above	[a]	Dentists and dental hygienists/regional clinics (salaried)	Dental Division	$850
Medical Care Program	Surgical-dental services requiring hospitalisation	Various oral surgical, oral medicine and pathology, dental technical, and orthodontic procedures	$1,546/1,000 population	Hospitals	[a]	$1,309
Department of Social Services						
General Assistance Program Income Supports Program	Disabled persons and single mothers with children Those considered "special needs"	Municipally varied and limited basic care	8,180 avg. monthly caseload 1,648 claims $84.44 avg. cost per claim	Dentists/private practice	Family Benefits Division Centrally and regionally administered	$139

[a] Not reported

Table 66. Public dental care programming in Nova Scotia, 1995

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
[a]						
Social Assistance Programs	Children, adults, and seniors	From emergency to basic care, depending on level of assistance	[a]	[a]	[a]	[a]
Department of Health						
Screening Program Prevention, Education, and Treatment Program	School age children up to grade 8	Prevention and treatment services in select area schools	[a]	[a]	[a]	$7,000

[a] Not reported

Table 67. Public dental programming in Nova Scotia, 2000

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
[a]						
Children's Oral Health Program	Children 0-10yrs	Limited diagnostic, preventive, restorative	[a]	Dentists/ private practice	[a]	$6,809
Dental Surgical Program	Surgical care requiring hospitalisation	Major oral surgery		Oral surgeons/ hospitals		$1,658
Cleft Palate/Craniofacial Program	Registered as cleft palate/craniofacial patient					$248
Mentally Challenged Program	Those deemed by medical authority to be severely medically challenged and whose need must be met in a hospital setting	Basic dental care		[a]		$90
Maxillofacial Prosthodontics Program	Those deemed eligible because of a functional problem as a result of congenital disorder, cancer, surgery, trauma, and neurological deficits	[a]		Specialists/hospitals and private practice		$325
Atlantic Provinces Special Education Authority Dental Program, Sir Frederick Fraser School	Blind and deaf residents	Limited diagnostic, preventive, restorative		[a]		$0
Adult Special Consideration	[a]	[a]				$42
Public Health Dental Hygiene Program	Select schools	Education, health promotion, fluoride rinse	106,708 received education 14,561 screenings 14,000 children in 89 schools received fluoride rinses	Dental hygienists/ schools	[a]	[a]

[a] Not reported

Table 68. Public dental programming in Nova Scotia, 2005

Program	Eligibility	Services Covered	Utilisation[a]	Service Environments	Administration	Expenditures $(000)[a]
Department of Community Services						
Employment Support and Income Assistance Dental Program	Based on an assessment of financial need, household number, and determination of employability Eligible clients and dependents	Emergency dental care, some diagnostic, preventive, restorative, prosthodontic, endodontic, and oral surgical services Assistance pays 80%, 20% patient, can be means tested	Approx. 32,262 eligible	Dentists and denturists/private practices	Centrally administered	[b]
Department of Health						
Children's Oral Health Program (COHP)	<10yrs; children are required to access private coverage first, program pays balance	Diagnostic, preventive, and treatment services Community-based prevention	38,747/101,853 165,397 services rendered 4.3 services and $104 per beneficiary	Dentists and dental hygienists/private practices and community clinics, schools	Medical Services Insurance (MSI) administers the diagnostic, preventive and treatment component, with adjudication and payment the responsibility of Quickcard Solutions Inc. (QSI) Public Health Services Division administers community-based prevention	7,109

Table 68 cont'd

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Cleft Palate/Craniofacial Program	Cleft Palate/Craniofacial Team registered, but does not guarantee eligibility Those craniofacial anomalies that directly influence growth and development of dentoalveolar and craniofacial structures	Various oral surgical and dental procedures beyond the eligibility under COHP	185 beneficiaries 1,029 services rendered 5.6 services and $725 per beneficiary	Specialists and generalists/hospitals and private practices	MSI/QSI	134
Maxillofacial Prosthodontics Program	Those whose maxillofacial prosthodontic needs result from congenital facial disorders, cancer, trauma, and neurological deficit	Various oral surgical and prosthodontic services	531 beneficiaries 1,681 services rendered 3.2 services and $999 per beneficiary			531
Mentally Challenged Program	Anyone deemed mentally challenged by a medical authority, and whose dental needs may necessitate hospitalisation	Various oral surgical and dental procedures beyond he eligibility under COHP Subject to a 10% premium when delivered in private practice, and 30% premium when in-hospital	216 beneficiaries 1,647 services rendered 7.6 services and $497 per beneficiary			107

Table 68 cont'd

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Dental Surgical (In-Hospital) Program	Anyone whose dental needs may necessitate hospitalisation	Various oral surgical and dental procedures	1,706 beneficiaries 4,363 services rendered 2.6 services and $548 per beneficiary	Specialists and generalists/hospitals	As above	935
Atlantic Provinces Special Education Authority (APSEA) Dental Program Sir Fredrick Fraser School	Those who are blind, visually impaired, deaf or hard of hearing, and resident at APSEA facility	Diagnostic, preventive, and treatment services	999 beneficiaries 5,081 services rendered 5.1 services and $546 per beneficiary	Dentists/private practices		546

[a] Government of Nova Scotia (2004) *Medical Services Insurance Annual Statistical Tables 12 Months Ending March 31, 2003*. Information Management, Nova Scotia Department of Health.
[b] Not reported

Table 69. Public dental care associated legislation in Nova Scotia

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Health Services and Insurance Act, R.S.N.S. 1989, c. 197	Residents of the province meeting the terms and conditions of the act and regulations (s.3)	Insured hospital services are the in-patient and out-patient services (s.2(f)) Insured professional services are those to which a resident is entitled under this Act and regulations (s.2(ha)) All residents entitled to receive insured hospital services and insured professional services to the extent of the established tariffs (s.3) The Governor in Council may make regulations under this Act, including for the Hospital Insurance Plan and the M.S.I. Plan (s.17)	Minister of Health
Hospital Insurance Regulations, N.S. Reg. 11/58	As above	Outlines in-patient services (s.1(h)) and out-patient services, which include limited dental-surgical procedures (s.1(j)) Residents are entitled to receive in-patient and out-patient services provided they are medically required (s.2)	Minister of Health
M.S.I. Regulations, N.S. Reg. 41/69	As above	Insured services include only those dental services referred to in Section 10 (s.1(e)(x)) Dentists are deemed physicians if rendering insured dental services outlined in the *Insured Dental Services Tariff Regulations* (s.10(1)) Intro-oral or extra-oral prostheses may be insured services (s.12(c))	Minister of Health
Health Authorities Act, S.N.S. 2000, c. 6		Neither "community-based health services" not "health services" include reference to dental public health measures (s.2(g) and (k))	Minister of Health
Employment Support and Income Assistance Act, S.N.S. 2000, c. 27	Persons in need (s.3(g))	Assistance may include money, goods or services for basic needs, special needs, or employment services (s.3(a)) The Governor in Council may make regulations for the operation of this Act (s.21(1))	Minister of Community Services
Employment Support and Income Assistance Regulations, N.S. Reg. 25/2001	As above	Special needs include dental care (s.2(ab)(i)(A)) Applicants or recipients may request assistance for items of special need and must provide the information required to support the request (s.24(1)) If the special need item is for the health or medical requirements of the applicant or recipient or his or her spouse or dependent child, a caseworker may request advice as to the item's appropriateness,	Minister of Community Services

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
		necessity and effectiveness (s.25) Items of special need are disbursed in accordance with Appendix A, however if there is documentation that determines the item is necessary but its cost exceeds the maximum, a supervisor may provide the higher documented amount (s.27)	
Children and Family Services Act, S.N.S. 1990, c. 5	Children in care (s.3(1)(f)) or children with special needs (ss.18 and 19)	Parents or guardians who are unable to provide the services required for a child with special needs may receive assistance from an agency or the Minister to meet the special needs of the child, as specified in a written agreement (s.18) The Governor in Council may make regulations for the operation of this Act (s.99)	Minister of Community Services
Children and Family Services Regulations, N.S. Reg. 183/91	As above	Children in care shall have their costs covered by the Minister, including those for dental care (s.50(1)(a))	Minister of Community Services
Corrections Act, R.S.N.S. 1989, c. 103	Inmates of provincial correctional institutions	The Governor in Council may make regulations under this act, including for the medical attendance on inmates (s.22)	The *Correctional Facilities Regulations*, N.S. Reg. 248/88 contain no mention of dental services

Table 70. Dental programs, payment summary, Nova Scotia, 1997/98 to 2002/03[1]

Payment Summary	1997/98	1998/99[2]	1999/00[2]	2000/01[2,3]	2001/02[3]	2002/03[3]	Percent Change 1998/1999	1999/2000	2000/2001	2001/2002	2002/2003
Children's Oral Health Program	6,100,705	7,109,061	6,963,583	6,563,854	6,883,315	3,994,233[4]	16.5	-2	-5.7	4.9	-42
Dental Surgical Program	1,514,346	1,725,024	1,929,519	1,008,10[5]	903,100	934,502	13.9	11.9	-47.8	-10.4	3.5
Out-of-province	965	1,622	819	0	0	0	68.1	-49.5	-100	n/a	n/a
IWK Dental Alternate Funded Program[6]		217,073	468,363	495,271	458,873	546,090	n/a	115.8	5.7	-7.3	19
Subtotal Dental Programs	7,616,016	9,052,780	9,362,284	8,067,225	8,245,288	5,474,825	18.9	3.4	-13.8	2.2	-33.6
Special Dental Programs[7]											
Maxillofacial Prosthodontics	264,129	321,207	311,835	429,674	436,537	530,671	21.6	-2.9	37.8	1.6	21.6
Cleft Palate	226,249	243,794	236,850	116,867	103,608	134,058	7.8	-2.8	-50.7	-11.3	29.4
Mentally Challenged	63,998	89,766	86,985	93,370	101,671	107,353	40.3	-3.1	7.3	8.9	5.6
Sir Frederick Fraser School	409	2	2	0	0	0	-99.5	0	-100	n/a	n/a
Special Considerations - Adult	36,573	41,131	40,231	14,443	21,984	16,418	12.5	-2.2	-64.1	52.2	-25.3
Subtotal Special Dental Programs	591,358	695,899	675,903	654,353	663,800	788,500	17.7	-2.9	-3.2	1.4	18.8
Total Dental Payments	8,207,374	9,748,680	10,038,187	8,721,579	8,909,087	6,263,326	18.8	3	-13.1	2.1	-29.7

[1] Data provided for 1997/98 and 1998/99 are "date of payment". Data beginning in 1999/00 are "date of service."
[2] Totals include dental retroactive payments.
[3] Totals include accounting adjustments.
[4] In 2002/03 the Department of Health became "insurer of last resort."
[5] A reduction in 2000/01 was due to some services being deinsured.
[6] IWK Dental Alternate Funding Program began January 1, 1999.
[7] Special Dental Programs procedures are also provided under the IWK Dental Alternate Funded Program. Amount paid excludes the block funded paid amount for these procedures.

Table 71. Children Oral Health Program, utilization summary, 1997/98-2002/03

Utilization Summary[1,2]	1997/98	1998/99[3]	1999/00[3]	2000/01[4]	2001/02[4]	2002/03[4]	Percent Change 1998/99	1999/00	2000/01	2001/02	2002/03
Services Rendered	263,845	298,557	283,978	266,392	260,387	165,397[5]	13.2	-4.9	-6.2	-2.3	-36.5
Amount Paid	6,100,705	7,109,061	6,963,583	6,563,854	6,883,315	3,994,233[5]	16.5	-2	-5.7	4.9	-42
Persons Insured[6]	117,400	115,300	111,800	108,500	105,100	101,853	-1.8	-3	-3	-3.1	-3.1
Beneficiaries[7]	64,017	65,459	64,375	61,301	59,868	38,747	2.3	-1.7	-4.8	-2.3	-35.3
Services Per Insured Person	2.2	2.6	2.5	2.5	2.5	1.6	15.2	-1.9	-3.3	0.9	-34.5
Paid Per Insured Person	51.97	61.66	62.29	60.5	65.49	39.22	18.7	1	-2.9	8.3	-40.1
Services Per Beneficiary	4.1	4.6	4.4	4.3	4.3	4.3	10.7	-3.3	-1.5	0.1	-1.9
Paid Per Beneficiary	95.3	108.6	108.17	107.08	114.97	103.08	14	-0.4	-1	7.4	-10.3

[1] Data provided for 1997/98 and 1998/99 are "date of payment". Data beginning in 1999/00 are "date of service".
[2] Excludes services from the IWK Dental Alternate Funded Program. See Table 5.4 for the IWK Dental Alternate Funded Program services.
[3] Totals include Dental Retroactive payments.
[4] Totals include accounting adjustment.
[5] In 2002/03 the Department of Health became "insurer of last resort".
[6] Insured population from Statistics Canada new estimates as of July 1st of each year.
[7] Persons receiving insured services.

Table 72. Dental Surgical Program, utilization summary, 1997/98-2002/03

Utilization Summary[1,2]	1997/98	1998/99[3]	1999/00[3]	2000/01[4]	2001/02[4]	2002/03	Percent Change 1998/99	1999/00	2000/01	2001/02	2002/03
Services Rendered	15,549	16,909	19,422	6,952	4,407	4,363	8.7	14.9	-64.2	-36.6	-1
Amount Paid	1,514,346	1,725,024	1,929,519	1,008,100	903,100	934,502	13.9	11.9	-47.8	-10.4	3.5
Persons Insured[5]	934,800	934,600	939,800	941,000	942,700	944,800	0	0.6	0.1	0.2	0.2
Beneficiaries[6]	8,655	9,224	9,664	3,456	1,501	1,706	6.6	4.8	-64.2	-56.6	13.7
Services Per Insured Person	0.02	0.02	0.02	0.01	<0.01	0	8.8	14.2	-64.3	-36.7	15.7
Paid Per Insured Person	1.62	1.85	2.05	1.07	0.96	0.99	13.9	11.2	-47.8	-10.6	3.2
Services Per Beneficiary	1.8	1.8	2	2	2.9	2.6	2	9.6	0.1	46	-12.9
Paid Per Beneficiary	174.97	187.01	199 66	291.7	601.67	547.77	6.9	6.8	46.1	106.3	-9

[1] Data provided for 1997/98 and 1998/99 are "date of payment." Data beginning in 1999/00 are "date of service."
[2] Excludes services from the IWK Dental Alternate Funded Program. See Table 5.4 for the IWK Dental Alternate Funded Program services.
[3] Totals include dental retroactive payments.
[4] Reduction due to some services being deinsured in August 2000 and further program change in 2001/02.
[5] Insured population from Statistics Canada new estimates as of July 1st of each year, include Armed Forces and RCMP personnel.
[6] Persons receiving insured services.

Table 73. IWK Dental Alternate Funded Program, utilization summary, 1997/98-2002/03

Utilization Summary[1,2]	2000/01	2001/02	2002/03	Percent Change 2001/02	Percent Change 2002/03
Services Rendered	5,960	6,391	5,081	7.2	-20.5
Amount Paid	495,271	458,873	546,090	-7.3	19
Beneficiaries[3]	914	1,133	999	24	-11.8
Services Per Beneficiary	6.5	5.6	5.1	-13.2	-9.8
Paid Per Beneficiary	541.87	405.01	546.64	-25.3	35
Services by Program					
Children's Oral Health	5,035	5,307	4,329	5.4	-18.4
Cleft Palate	525	653	431	24.4	-34
Mentally Challenged	338	329	240	-2.7	-27.1
Dental Surgery	22	90	78	309.1	-13.3
Special Considerations	40	12	3	-70	-75

[1] Data provided are "date of service."
[2] Includes services from the IWK Dental Alternate Funded Program only.
[3] Persons receiving insured services.

Table 74. Special Dental Program-Maxillofacial Prosthodontics, utilization summary, 1997/98-2002/03

Utilization Summary[1,2]	1997/98	1998/99[3]	1999/00[3]	2000/01[4]	2001/02[4]	2002/03[4]	Percent Change 1998/99	Percent Change 1999/00	Percent Change 2000/01	Percent Change 2001/02	Percent Change 2002/03
Services Rendered	1,366	1,549	1,622	1,626	1,987	1,681	13.4	4.7	0.2	22.2	-15.4
Amount Paid	264,129	321,207	368,316	429,674	436,537	530,671	21.6	14.7	16.7	1.6	21.6
Beneficiaries[3]	425	634	583	484	597	531	49.2	-8	-17	23.3	-11.1
Services Per Beneficiary	3.2	2.4	2.8	3.4	3.3	3.2	-24	13.9	20.8	-0.9	-4.9
Paid Per Beneficiary	621.48	506.64	631.76	887.76	731.22	999.38	-18.5	24.7	40.5	-17.6	36.7

[1] Data provided for 1997/98 and 1998/99 are "date of payment." Data beginning in 1999/00 are 'date of service."
[2] Excludes services from the IWK Dental Alternate Funded Program. See Table 5.4 for the IWK Dental Alternate Funded Program services.
[3] Totals include Dental Retroactive payments.
[4] Totals include accounting adjustments.
[5] Persons receiving insured services.

Table 75. Special Dental Program-Cleft palate, utilization summary, 1997/98-2002/03

Utilization Summary[1,2]	1997/98	1998/99[3]	1999/00[3]	2000/01[4]	2001/02[4]	2002/03[4]	Percent Change 1998/99	1999/00	2000/01	2001/02	2002/03
Services Rendered	3,029	3,019	2,146	840	1,007	1,029	-0.3	-28.9	-60.9	19.9	2.2
Amount Paid	226,249	243,794	236,850	116,867[5]	103,608	134,058	7.8	-2.8	-50.7	-11.3	29.4
Beneficiaries[6]	404	393	443	183	196	185	-2.7	12.7	-58.7	7.1	-5.6
Services Per Beneficiary	7.5	7.7	4.8	4.6	5.1	5.6	2.5	-36.9	-5.2	11.9	8.3
Paid Per Beneficiary	560.02	620.34	534.65	638.62	528.61	724.64	10.8	-13.8	19.4	-17.2	37.1

[1] Data provided for 1997/98 and 1998/99 are "date of payment." Data beginning in 1999/00 are 'date of service."
[2] Excludes services from the IWK Dental Alternate Funded Program. See Table 5.4 for the IWK Dental Alternate Funded Program services.
[3] Totals include Dental Retroactive payments.
[4] Totals include accounting adjustments.
[5] Decrease due to many procedures now being provided under the IWK Dental Alternate Funded Program.
[6] Persons receiving insured services.

Table 76. Special Dental Program-Mentally challenged, utilization summary, 1997/98-2002/03

Utilization Summary[1]	1997/98	1998/99[3]	1999/00[3]	2000/01[4]	2001/02[4]	2002/03[4]	Percent Change 1998/99	1999/00	2000/01	2001/02	2002/03
Services Rendered	1,368	1,564	1,469	1,419	1,578	1,647	14.3	-6.1	-3.4	11.2	4.4
Amount Paid	63,998	89,766	85,341	93,370	101,671	107,353	40.3	-4.9	9.4	8.9	5.6
Beneficiaries[5]	192	196	210	200	202	216	2.1	7.1	-4.8	1	6.9
Services Per Beneficiary	7.1	8	7	7.1	7.8	7.6	12	-12.3	1.4	10.1	-2.4
Paid Per Beneficiary	333.32	457.99	406.39	466.85	503.32	497	37.4	-11.3	14.9	7.8	-1.3

[1] Data provided for 1997/98 and 1998/99 are "date of payment". Data beginning in 1999/00 are 'date of service".
[2] Excludes services from the IWK Dental Alternate Funded Program. See Table 5.4 for the IWK Dental Alternate Funded Program services.
[3] Totals include Dental Retroactive payments.
[4] Totals include accounting adjustments.
[5] Persons receiving insured services.

Table 77. Special Dental Program - Special Considerations-Adult, utilization summary, 1997/98-2002/03

Utilization Summary[1,2]	1997/98	1998/99[3]	1999/00[3]	2000/01[4]	2001/02[4]	2002/03[4]	Percent Change 1998/99	1999/00	2000/01	2001/02	2002/03
Services Rendered	222	260	204	77	155	97	17.1	-21.5	-62.3	101.3	-37.4
Amount Paid	36,573	41,131	54,217	14,443[5]	21,984	16,418	12.5	31.8	-73.4	52.2	-25.3
Beneficiaries[6]	27	31	38	21	27	19	14.8	22.6	-44.7	28.6	-29.6
Services Per Beneficiary	8.2	8.4	5.4	3.7	5.7	5.1	2	-36	-31.7	56.6	-11.1
Paid Per Beneficiary	1,354.56	1,326.81	1,426.76	687.77	814.2	864.13	-2	7.5	-51.8	18.4	6.1

[1] Data provided for 1997/98 and 1998/99 are "date of payment". Data beginning in 1999/00 are 'date of service".
[2] Excludes services from the IWK Dental Alternate Funded Program. See Table 5.4 for the IWK Dental Alternate Funded Program services.
[3] Totals include Dental Retroactive payments.
[4] Totals include accounting adjustments.
[5] Decrease due to many procedures now provided under the IWK Dental Alternate Funded Program.
[6] Persons receiving insured services.

Table 78. Public dental care programming in Prince Edward Island, 1983

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Department of Health						
Children's Dental Care Program (CDCP)	All children 4-16yrs	Wide range of preventive, diagnostic, emergency, restorative, oral surgical, endodontic, oral pathology, and preventive orthodontic care	26,500 eligible 77.6% utilisation $75.60 per user	Dentists and dental hygienists/mobile and stationary public health clinics (salaried) Dentists/private practice (fee for service)	Centrally and regionally administered	$1,555
Medical Care Program	Surgical-dental services requiring hospitalisation	Various oral surgical, oral medicine and pathology, dental technical, and orthodontic procedures	$336.3/1,000 population	Hospitals	[a]	$41
Department of Social Services						
General Welfare Assistance	[a]	Confined to emergency treatment and dentures	11,300 eligible	[a]	[a]	$100

[a] Not reported

Table 80. Public dental care programming in Prince Edward Island, 1995

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
[a]						
Children's Dental Care Program (CDCP)	Children 3-16yrs $15 annual registration fee; max $35 per family	Most basic dental services, with preventive and orthodontic care only provided in public clinics	Approx. 85% 301 children receiving orthodontic care	Dentists/private practice (fee for service) Dentists/public health clinics (salaried)	Centrally administered at Queen's Regional Authority	$2,100
Cleft Palate Orthodontic Treatment Funding Program	Children who require orthodontic treatment as a result of cleft palate Treatment must commence before age 17yrs Cost shared 50:50 with parents; may be eligible for 75-100% coverage, depending on income	Obturators, arch expansion, basic orthodontic	Approx. 20 registered	Specialists/private practice (fee for service)	[a]	
Long Term Care Program	Residents of provincial and some private long-term care facilities	Screenings and prevention	[a]	Public health dentists and dental hygienists/on-site		$8 (captured by above)
Welfare Assistance Dental Services	Adult welfare recipients	Emergency and limited prosthodontic Broader mix of services for mentally handicapped adults		Dentists/private practice		$150
Hospital Surgical Services	Those requiring hospitalisation	[a]	[a]	Dentists/ private practice		[a]

[a] Not reported

Table 81. Public dental programming in Prince Edward Island, 2005

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Department of Social Services and Seniors						
Social Assistance Dental Services	Adult recipients Those deemed physically or mentally disabled	Emergency and removable prosthodontic care; 20% premium for the latter Diagnostic, preventive, and treatment services	[a]	Dentists/private practices	Centrally administered by Child and Family and Services division	250
Children Dental Care Program						
Diagnostic and Treatment Services	Children 3-16yrs Annual registration fee of $15 per child to a maximum of $35 per family	Diagnostic and treatment services; 20% premium for treatment services; if net income <$30,000, can apply for exemption	90% estimated participation 24,500 eligible	Dentists/private practices, dental public health clinics	Centrally administered by Pharmacy and Dental Services division	2,600
Preventive Services	Children 3-16yrs	Oral health education, screening, selective polishing, scaling, topical fluoride, sealants	75% schools participation 70-100% estimated participation 24,500 eligible	Dental public health staff/ schools, dental public health clinics		
Orthodontic Clinic	As above, geared towards lower income families	Minor preventive, interceptive and orthodontic services; parents responsible for laboratory costs of any appliance used	Approx. 300-400 patients registered	Specialist/private practices		
Early Childhood Dental Initiatives	15 and 18 month-old infants at immunisation clinics	Screening, risk-assessment, moderate- and high-risk follow-up and referral	Approx. 400-600 children per year Approx. 2,600 eligible	Dental hygienist/public health clinics		

Table 81 cont'd

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Long Term Care Facilities Dental Program	Residents of high needs private and provincial long term care facilities	Annual screenings and referral of residents in long term care Preventive services such as denture labelling and cleaning, scaling, fluoride varnish, in-service education sessions	Approx. 1000 residents of 18 facilities	Dentists/private practices Dentists and dental hygienists/long term care facilities	As above	Part of Children's Dental Program expenditures
Paediatric Specialist Services Dental Program	Children in medical and financial need Annual registration fee of $15 per child	Diagnostic, treatment, some preventive services	[a]	Specialst/private practices		
Cleft Palate Orthodontic Treatment Funding Program	Assists those with hard tissue cleft palate or equivalent congenital disorder	Orthodontics; treatment must commence <17yrs 50% of costs covered; depending on family income, funding can be 75-100%	Approx. 4-8 cases being funded			
Department of Health						
In-Hospital Surgical-Dental Services	Dental services are not insured in the Health Care Insurance Plan Only covered when the patient's medical condition requires that they be done in hospital or in an office with prior approval	Various oral surgical and dental procedures	393 services provided Approx. 135,000 eligible	Specialst and generalists/in-hospital, private practices	Centrally administered by Hospital Services Commission	91

[a] Not reported

Table 82. Public dental care associated legislation in Prince Edward Island

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Health Services Act, R.S.P.E.I. 1988, c. H-1.5	Province's residents	The Minister shall provide essential health services in the province and promote and maintain the good health of the province's residents (s.2) Health services include hospital, health and other such services as the LGIC may determine (s.1(e))	Minister of Health and Social Services
Health Services Payment Act, R.S.P.E.I. 1988, c. H-3	Entitled persons who are residents entitled to basic health services (s.1(e))	Basic health services are those medically required (s.1(d)) Authorizes the minister to develop and operate a health services plan (s.2(a) and Part II) The LGIC may make regulations for the operation of this Act (s.5)	Minister of Health and Social Services Medical Services Plan
General Regulations, P.E.I. Reg. EC453/96	As above	Basic health services include procedures performed by a dentist as listed in Schedule A and by a prosthodontist as listed in Schedule B (s.1(d)) Schedule A lists eligible dental procedures (primarily surgical and associated services) Schedule B lists eligible prosthodontic services	Minister of Health and Social Services
Hospitals Act, R.S.P.E.I. 1988, c. H-10.1	Users of provincial hospitals	Deals with the provision of insured services in hospitals Insured services are basic health services under the Health Services Payment Act of the insured services under the Hospital and Diagnostic Services Insurance Act (s.4)	Minister of Health and Social Services
Hospital and Diagnostic Services Insurance Act, R.S.P.E.I. 1988, c. H-8	Residents of PEI who meet eligibility requirements (s.9)	Insured services are the hospital and diagnostic services to which a person is entitled under this Act and regulations (s.1(e)) Authorizes establishment of a plan of hospital care insurance and for the LGIC to make regulations under this Act (s.11(1))	Minister of Health and Social Services
General Regulations, P.E.I. Reg. EC539/63	Entitled persons (s.1(f))	Outlines eligible in-patient and out-patient hospital services which are insured (s.1(l)) and for which	Minister of Health and Social Services

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
		the Minister shall ensure all entitled persons receive (s.21) Services must be medically necessary (ss. 13 and 14)	
Long-Term Care Subsidization Act, R.S.P.E.I. 1988, c.L-16.1	Persons in need and her or his dependents (s.1)	Health care services include dental services (s.1(e)) The Minister shall provide financial assistance to those persons in need as determined in accordance with this Act and regulations and may provide financial assistance to applicants who are not persons in need(s.2) The LGIC may establish categories and rates of assistance under this Act (s.5(1)) The LGIC may make regulations for the operation of this Act (s.12)	Minister of Health and Social Services Long-term Care Facilities Dental Program
Social Assistance Act, R.S.P.E.I. 1988, c.S-4.3	Persons in need and her or his dependents (s.1)	The Minister shall provide social assistance, in accordance with the regulations, to persons in need (s.2) Social assistance includes financial assistance and social services (s.1) The LGIC may make regulations for the operation of this Act (s.7)	Minister of Health and Social Services Social Assistance Dental Services
General Regulations, P.E.I. Reg. EC396/03	Persons in receipt of social assistance ("applicant", s.1)	Social assistance provides "items of basic need (s.1(1)(m)) and may include "items of special need" (s.1(1)(n)) Persons with disabilities are covered under this act (s.1) Persons must meet criteria under either short-term assistance or long-term assistance, the latter covering persons with disabilities (s.7(2)) Persons not in need made be granted assistance if	Minister of Health and Social Services All applicants are eligible for a range of emergency dental benefits for the relief of pain and infection only; persons with disabilities are entitled to diagnostic, emergency, prosthetic, preventive, and restorative services (PEI Social Assistance Program Manual, http://www.gov.pe.ca/infopei/onelisting.php3?number=20587 All eligible children receive basic dental services, including

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
		he or she is likely to become a person in need if the services are not provided (s.11) Items of special need may be granted at the Director's discretion (s.19) Financial assistance for dental services may be granted if the Director determines it "essential for the health and welfare of the applicant" (s.19(18)(a))	some preventive orthodontic services, under the Children's Dental Care Program
Rehabilitation of Disabled Persons Act, R.S.P.E.I. 1988, c. R-12	Disabled persons (s.1(b))	The Minister may provide such goods and services as may be considered for the rehabilitation of any disabled person, including by way of grant, loan or otherwise, dental and orthodontic treatment and care and prosthetic supplies (s.2(c) and (d))	Minister of Health and Social Services Social Assistance Dental Services

Table 83. Public dental programming in Prince Edward Island, select program performance

Program performance	2001-02	2002-03	2003-04
Children's Dental care Program			
Children receiving services	18,115	18,069	17,540
Utilisation rate, children 3-17	72.50%	72.30%	71.60%
Average decayed, missing or filled teeth, grade 6-7	0.8	0.7	0.7
No decay on permanent teeth, children 12-13	69.10%	68%	70%
Average decayed, missing or filled teeth, adolescents graduating from CDCP	2.2	2	1.7
No decay on permanent teeth, adolescents	46%	43%	47%
Children receiving preventive dental services	15,984	15,919	14,767
Preventive Orthodontic Clinic			
Children registered	497	455	411
Orthodontic appliances, children treated	232	220	235
Early Childhood Dental Program			
Children screened	544	492	321
Cleft Palate Orthodontic Treatment Funding			
Parents receiving funding	6	5	5
Long-Term Care Facilities Dental Program			
Clients screened	886	1,067	922

Table 84. Public dental programming in Newfoundland/Labrador, 1983

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Department of Health						
Newfoundland Children's Dental Program (NCDP)	All children 0-12yrs	Basic diagnostic, restorative, oral surgical, fixed and removable prosthodontic, endodontic, minor orthodontic	72,697/142,700 $76.65 per user	Dentists/private practice (fee for service) Dentists/International Grenfell Association clinics (salaried)	Division of dental services	$5,733
Medical Care Program	Surgical-dental services requiring hospitalisation	Various oral surgical, oral medicine and pathology, dental technical, and orthodontic procedures	$839.6/1,000 population	Hospitals	[a]	$477
Department of Social Services						
[a]	- Persons >18rs receiving assistance - Extends NCDP coverage to 18yrs for dependents, and to 21yrs for wards of the state	- Persons >18yrs limited to surgical removal of teeth and dentures when medically necessary	48,500 eligible	Dentists/private practice	[a]	[a]

[a] Not reported

Table 85. Public dental programming in Newfoundland/Labrador, 2000

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
[a]						
Children's Dental Plan (CDP)	Children 0-17yrs $5 co-pay per service	Most basic dental services with some limitations; basic diagnostic, prevention, and emergency care exempt from co-pay	Approx. 50%	Dentists/ private practice	Medical Care Plan	$5,600
Social Assistance Component of CDP	Children 13-17yrs and adults on social assistance No co-pay	As above for children with extractions only for adults	[a]			[a]
Surgical Dental Program	Surgical-dental treatment for medical reasons when hospitalisation is required	Limited oral surgery	[a]	Specialists and generalists/ Hospitals		$397

[a] Not reported

Table 86. Public dental programming in Newfoundland/Labrador, 2005

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Department of Health and Community Services						
Dental Health Plan						
Children's component	Children <12yrs	Diagnostic, preventive, periodontal, restorative, oral surgical services, and other specific procedures $5 co-pay per service	[a]	Dentists/private practices Intances of balance billing	Centrally administered, Medical Care Plan	4,700
Social assistance component	13-17yrs for social assistance recipients Social assistance recipients	Some diagnostic, restorative, oral surgical services Emergency examination and extractions only				
Insured Surgical-Dental Services	Anyone whose dental needs may necessitate hospitalisation	Various oral and maxillofacial procedures	11,000 services provided[b]	Dentists/hospitals		419[b]

[a] Not reported
[b] Government of Canada (2004) *Canada Health Act Annual Report*. Canada Health Act Division, Health Canada.

Table 87. Public dental care associated legislation in Newfoundland/Labrador

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Medical Care Insurance Act, 1999, S.N.L. 1999, c. M-5.1	Persons defined under the regulations, including their dependents (s.2(a))	Insured services are those listed in the regulations (s.2(d)) The minister shall administer a plan of medical care insurance for the residents of the province (s.4(1)) and where a dental program is established, the minister shall be responsible for its supervision, direction and control (s.4(2)) Regulations on specific areas under the Act may be made by the LGIC (s.20) or the Minister (s.21)	Minister of Health and Community Services Medical Care Plan, Dental Health Plan
Medical Care Insurance Beneficiaries and Inquiries Regulations, C.N.L.R. 20/96	Those residents who have applied for registration under the Act and produced proof of eligibility (s.3)	Eligibility set out for beneficiaries (ss.4 and 5)	Minister of Health and Community Services
Medical Care Insurance Insured Services Regulations, C.N.L.R. 21/96	As above	Beneficiaries are eligible for insured services which include surgical-dental treatment provided in a hospital by a dentist (s.3(b)) Eligible surgical-dental services are listed in the Schedule to the *Medical Care Insurance Physicians and Fees Regulations* Routine dental extractions and fluoride dental treatment for children under 4 years of age are not insured, even if performed in hospital (s.4)	Minister of Health and Community Services
Hospital Insurance Agreement Act, R.S.N.L. 1990, c. H-7	Residents using the provinces hospitals	The minister may make regulations for the operation of this Act (s.4)	Minister of Health and Community Services
Hospital Insurance Regulations, C.N.L.R. 742/96	"Insured persons", or residents deemed eligible and entitled to insured services (s.2(e))	Insured services are those in-patient and out-patient services set out in the Schedule to these regulations (s.2(f)) Insured persons are entitled to receive insured services in a hospital free of charge (s.3)	Minister of Health and Community Services
Child, Youth and Family Services Act, S.N.L. 1998, c.C-12.1	Children in the director's care (s.27)	Health care can be provided to children in care (s.32)	Minister of Health and Community Services
Income and Employment	Persons who meet the	Various types of assistance are provided including	Minister of Human Resources and Employment

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Support Act, S.N.L. 2002, c.I-0.1	eligibility requirements in the Act (s.17)	financial assistance to meet basic needs, supplementary assistance to persons and families, support to victims of violence (s.3(2)) The LGIC may make regulations for the operation of this act (s.52)	
Income and Employment Support Regulations, N.L.R. 144/04	As above	Outlines residency requirements (s.4), criteria for assessment (s.6), additional eligibility requirements (s.9) Items of special need may be available for applicants or recipients (s.19) Special needs include dentures (s.24)	Minister of Human Resources and Employment Nothing specific to provision of dental services in the regulations Adult recipients of social assistance are eligible for emergency examination for relieve and pain and infection only and a $5 co-payment fee is paid by the Dental Health Plan under the social assistance component (Dental Health Plan, Medical Care Plan)
Prisons Act, R.S.N.L. 1990, c. P-21	Persons in penitentiaries (s.2) as defined in the Act (s.5)	The LGIC may make regulations under this act (s.9(1))	Minister of Justice
Prisons Regulations, C.N.L.R. 993/96	As above	Confined prisoners shall be given or provided with adequate medical and dental treatment or advice (s.20(d))	Minister of Justice

Table 88. Newfoundland's Dental Health Plan, summary of payments, by age group, 1999/00 ($000)

Age	Exam	Fluoride	Prophylaxis	Fillings & Crowns	Extractions	Appliances	Radiographs	Pulpotomy	Other	Totals	Co-pay
< 1	-	-	-	-	-	-	-	-	-	-	-
1	-	-	-	-	-	2	-	-	2	4	-
2	6	-	-	1	1	1	-	-	1	10	-
3	26	-	5	14	3	-	-	1	-	50	1
4	61	-	21	55	8	-	1	5	1	155	3
5	86	-	43	110	11	-	2	11	1	269	5
6	104	2	59	158	15	-	5	15	-	364	6
7	109	22	73	178	19	-	9	13	-	429	6
8	123	30	84	207	26	-	13	14	1	505	7
9	126	33	89	210	30	1	16	11	1	524	7
10	133	35	96	201	34	-	17	7	1	530	6
11	123	33	90	163	28	2	17	3	3	466	4
12	120	33	89	164	30	1	16	1	1	459	4
13	112	31	84	207	33	4	18	-	4	497	4
14	31	7	20	90	12	4	6	-	5	179	4
15	5	-	-	35	4	4	2	-	1	54	3
16	5	-	-	30	4	4	2	-	5	53	3
17	5	-	-	31	6	3	2	-	1	51	3
18	4	-	-	24	4	-	1	-	1	37	3
19	2	-	-	9	4	-	1	-	30	47	1
20-29	26	-	-	-	112	6	7	-	9	160	-
30-39	26	-	1	1	152	-	7	-	7	195	1
40-49	17	-	1	1	126	4	5	-	2	157	1
50-59	8	-	-	-	77	-	2	-	4	91	-
60+	2	-	-	-	24	-	1	-	6	33	-
Totals	1,260	226	755	1,889	763	36	150	81	87	5,319	72
Cost/Service	74	24	31	45	24	-	12	3		213	

Table 89. Dental cases involving general anaesthesia, Newfoundland and Labrador, 1998/1999

Age	Number of Cases	Cumulative Incidence
0-4	556	0.23
5-9	660	0.51
10-14	182	0.58
15-19	206	0.68
20-24	178	0.75
25-34	227	0.85
35-44	177	0.92
45-54	99	0.96
55-64	50	0.98
64-75	29	0.99
75-84	10	0.99
85+	2	1.00

Table 90. Public dental programming in Nunavut, 2005

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Department of Health and Social Services						
Contracted Dental Services	Registered First Nations and Inuit	Emergency, diagnostic, restorative, endodontic, periodontal, prosthodontic, oral surgery, orthodontic services	[a]	Dentists, denturists/community clinics and private practices	Centrally and regionally administered, adjudication and payment functions the responsibility of First Canadian Health	1,400
Dental Therapy Program	Children and emergencies in adults	Emergency, preventive, restorative, periodontal, and oral surgery services; community health interventions		Dental therapists/community clinics	Centrally and regionally administered	
Prevention Programs	Everyone	Some oral health education, fluoride rinses, screening and referral		Dental therapists, nurses, community health representatives, teachers, volunteers/community clinics, shools		
Seniors Extended Health Benefits	>60yrs and not eligible other private or public coverage; $1000 annual max	Emergency, diagnostic, restorative, endodontic, periodontal, prosthodontic, oral surgery services	16/130	Dentists, denturists/community clinics and private practices		
In-Hospital Surgical-Dental Services	Services requiring the unique capabilities of a hospital for their performance	Various oral surgical and dental procedures; oral surgeons are brought to Nunavut on a regular basis, but for medically complicated situations, patients are flown south	[a]	Specialst and generalists/hospitals		

[a] Not reported

Table 91. Public dental care associated legislation in Nunavut

Statutes and Regulations[a]	Intended Beneficiaries	Relevant Provisions	Notes
Consolidation of Medical Care Act, R.S.N.W.T. 1988, c.M-8	Residents of the province who are eligible (s.3)	Insured services includes those which are medically required and for which persons are not entitled to under other statutes (s.1) Authorizes the establishment of a Medical Care Plan by the Commission on recommendation of the Minister (s.30) Other regulations may be made by the Commissioner on the recommendation of the Minister (s.30)	Minister of Health and Social Services
Consolidation of Medical Care Regulations, R.R.N.W.T. 1990, c.M-4	As above	Dental-related benefits are provided in accordance with the provisions in section 24 and the listed services in Section C Limited to oral surgery services (s.36(1)(i))	Minister of Health and Social Services
Consolidation of Hospital Insurance and Health and Social Services Administration Act, R.S.N.W.T. 1988, c. T-3	Residents of the province who are eligible are insured persons (s.2)	Insured services are those in-patient and out-patient services to which insured persons are entitled under this Act and regulations (s.1) The Minister may establish a hospital insurance plan (s.5) The Commissioner, on the recommendation of the Minister, may make regulations for the operation of this Act (s.28)	Minister of Health and Social Services
Consolidation of Territorial Hospital Insurance Services Regulations, R.R.N.W.T 1990, c. T-12	As above	Dentists with hospital privileges are "members of the medical or professional staff" (s.1) and are entitled to admit insured persons for in-patient insured services (s.9)	Minister of Health and Social Services
Consolidation of Adoption Act, R.S.N.W.T. 1998, c.9	Child's adoptive parent (s.41)	Specific provision dealing with the financial or other assistance available to parents of adopted children when the child has a physical or mental condition that is congenital in nature and that was not reasonably apparent prior to the adoption of the child; and the care, treatment or assistance required by the child because of that condition would place an undue burden on the financial resources of the adoptive parent. (s.41(1))	Minister of Health and Social Services The *Consolidation of Adoption Regulations*, R-141-98 do not make any specific provisions for dental services although they do allow for medical aids and special needs assistance (s.19)

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Consolidation of Social Assistance Act, R.S.N.W.T. 1988, c.S-10	Persons in need (s.1)	Director shall make provision for assistance to any person in need (s.5) The Commissioner, on the recommendation of the Minister, may make regulations for the operation of this Act (s.16)	Administered by the Department of Education Income Support Program
Consolidation of Social Assistance Regulations, R.R.N.W.T. 1990, c.S-16	As above; Persons in need further defined (s.1.1)	Nothing specifying entitlements to dental or health services	

[a] *The Nunavut Act*, S.C. 1993, c.28 as amended brought Nunavut into being 1 April 1999 and section 29 of the Act provided that the ordinances of the Northwest Territories and "the laws made under them effective March 31, 1999 will be duplicated for Nunavut. The adopted legislation appears as "Consolidated" and for the purposes of this presentation of information, there has been no new source law (i.e., post-1999) on topic.

Table 92. Public dental programming in the Northwest Territories, 1983

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Department of Health and Department of National Health and Welfare, Medical Services Branch (MSB), Northwest Territories Region						
Uninsured Medical and Dental Benefits	- Indians and Inuit in the territory - MSB ensured access to dental care for all of the population as well - Territory's Department of Health delivered care for those in regional centres	Basic range of services, including diagnostic, preventive, restorative, prosthodontic, periodontic, endodontic, and oral surgery	24,000 Indians and Inuit	MSB employed and/or contracted dentists and dental therapists/fixed and temporary clinics using portable equipment (salaried and fee for service) Dentists/private practice (fee for service)	Department of Health in regional centres and MSB in smaller communities	$1,450
Medical Care Program	Surgical-dental services requiring hospitalisation	Various oral surgical, oral medicine and pathology, dental technical, and orthodontic procedures	NIL	Hospitals	[a]	NIL

[a] Not reported

Table 93. Public dental programming in the Northwest Territories, 2000

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Department of Health						
Seniors' Dental Program	- Registered with territorial Health Care Plan - Permanent resident - Non-Native or Metis >60yrs - Registered with Department of Health - $1000 annual limit	Basic care	24% of eligible males and 25% of eligible females	Dentists/ private practice	Administered by Blue Cross	$182

[a] Not reported

Table 94. Public dental programming in the Northwest Territories, 2005

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Department of Health and Social Services						
Non Insured Health Benefits (NIHB)	Registered First Nations and Inuit	Emergency, diagnostic, restorative, endodontic, periodontal, prosthodontic, oral surgery, orthodontic services	[a]	Dentists, denturists/ private practices, community clinics	Centrally administered by Health Services Administration, adjudication and payment functions the responsibility of First Canadian Health	[a]
Métis Health Benefits (MHB)	Descendent of particular cultural groups; and resided in the Mackenzie Basin on or before 1921, or is a Community Acceptance Member, or was adopted as a minor				Centrally administered by Health Services Administration, adjudication and payment functions the responsibility of Alberta Blue Cross	
Extended Health Benefits (EHB) Seniors Dental Plan	>60yrs and non-Native or Métis; $1000 annual max	Emergency, diagnostic, restorative, endodontic, periodontal, prosthodontic, oral surgery services				287
Indigent Health Benefits (IHB)	Those receiving income support payments from Education, Culture, and Employment and not covered under the NIHB program	Short-term income support clients are eligible for emergency benefits only Long-term clients eligible for NIHB coverage levels			Centrally administered by Health Services Administration	61
EHB for Cleft Lip and Palate	Services requiring a hospital for their performance	Various oral surgical and dental procedures		Specialists and generalists/in-hospital		[a]
Dental Therapy Program	Children and emergencies in adults	Emergency, preventive, restorative, periodontal, and oral surgery services; community health interventions	[a]	Dental therapists/community clinics, shools	Regionally administered by Health Authorities	1,067

[a] Not reported

Table 95. Public dental care associated legislation in the Northwest Territories

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Medical Care Act, R.S.N.W.T. 1988, c.M-8	Residents of the province who are eligible (s.3)	Insured services includes those which are medically required and for which persons are not entitled to under other statutes (s.1) Authorizes the establishment of a Medical Care Plan by the Commission on recommendation of the Minister (s.30) Other regulations may be made by the Commissioner on the recommendation of the Minister (s.30)	Minister of Health and Social Services Health Care Plan
Medical Care Regulations, R-038-2006	As above	Uses a tariff system whereby insured services are those for which a tariff has been approved under section 3.1 of the Act (s.1)	Minister of Health and Social Services
Hospital Insurance and Health and Social Services Administration Act, R.S.N.W.T. 1988, c.T-3	Residents of the province who are eligible are insured persons (s.2)	Insured services are those in-patient and out-patient services to which insured persons are entitled under this Act and regulations (s.1) The Minister may establish a hospital insurance plan (s.5) The Commissioner, on the recommendation of the Minister, may make regulations for the operation of this Act (s.28)	Minister of Health and Social Services
Hospital Insurance Services Regulations, R.R.N.W.T 1990, c. T-12	As above	Dentists with hospital privileges are "members of the medical or professional staff" (s.1) and are entitled to admit insured persons for in-patient insured services (s.9)	Minister of Health and Social Services
Adoption Act, R.S.N.W.T. 1998, c.9	Child's adoptive parent (s.41)	Specific provision dealing with the financial or other assistance available to parents of adopted children when the child has a physical or mental condition that is congenital in nature and that was not reasonably apparent prior to the adoption of the child; and the care, treatment or assistance required by the child because of that condition would place an undue burden on the financial resources of the adoptive parent. (s.41(1))	Minister of Health and Social Services The *Adoption Regulations*, R-141-98 do not make any specific provisions for dental services although they do allow for medical aids and special needs assistance (s.19)
Social Assistance Act, R.S.N.W.T. 1988, c. S-10	Persons in need (s.1)	Director shall make provision for assistance to any person in need (s.5) The Commissioner, on the recommendation of the Minister, may make regulations for the operation of this Act (s.16)	Minister of Education, Culture and Employment
Social Assistance Regulations, R.R.N.W.T. 1990, c. S-16	As above; Persons in need further defined (s.1.1)	Nothing specifying entitlements to dental or health services	Minister of Education, Culture and Employment

Table 96. Public dental programming in the Yukon Territory, 1983

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Yukon Health Care Insurance Plan / Department of National Health and Welfare, Medical Services Branch (MSB)						
Children's Dental Program	All children from pre-school to grade 8	Basic range of services, including diagnostic, preventive, restorative, prosthodontic, periodontic, endodontic, and oral surgery	3,500 enrolled $124 per child	MSB employed dentists and dental therapists/fixed and temporary clinics using portable equipment (salaried)	MSB/ Yukon Health Care Insurance Plan	$434
Extended Health Care Benefits (EHB)	Persons >65yrs		1,273 eligible $47 per eligible person	Dentists/private practice (fee for service)		$60
Medical Care Program	Surgical-dental services requiring hospitalisation	Various oral surgical, oral medicine and pathology, dental technical, and orthodontic procedures	$391.3/1,000 population	Hospitals	[a]	$9

[a] Not reported

Table 97. Public dental programming in the Yukon Territory, 2000

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
[a]						
Yukon Children's Dental Program	Children up to and including grade 8	Most basic dental services	Approx. 3,600 eligible	Dentists and dental therapists/ School-based clinics	[a]	$952

[a] Not reported

Table 98. Public dental programming in the Yukon Territory, 2005

Program	Eligibility	Services Covered	Utilisation	Service Environments	Administration	Expenditures $(000)
Health and Social Services						
Social Assistance	Recipients of social assistance	Emphasis on the Immediate treatment of acute conditions or the removal of pain and discomfort Recipients may also qualify for supplemental health benefits, diagnostic, restorative, endodontic, periodontal, prosthodontic, oral surgery services	[a]	Dentists/private practices	Centrally administered	221
Pharmacare and Extended Health Care Benefits	Resident and >65yrs, or >60yrs and married to a resident who is >65yrs; $1400 per two-yr period	Diagnostic, restorative, endodontic, periodontal, prosthodontic, oral surgery services	[a]			[a]
Children's Dental Health Program	All school-aged children from kindergarten to Grade 8 in communities with a resident dentist, and through to Grade 12 in communities without a dentist	Emergency, preventive, restorative, periodontal, and oral surgery services; community health interventions	3,276 children enrolled	Dental therapists/school and community clinics	Centrally administered by Community Health, Dental Health	375
Insured Surgical-Dental Services	Anyone whose dental needs may necessitate hospitalisation	Various oral and maxillofacial procedures	104 services provided	Dentists/hospitals	Centrally administered	25[b]

[a] Not reported
[b] Government of Canada (2004) *Canada Health Act Annual Report*. Canada Health Act Division, Health Canada.

Table 99. Public dental care associated legislation in the Yukon Territory

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Health Care Insurance Plan Act, R.S.Y. 2002, c. 107	Residents who are entitled to insured health services (s.2)	Insured health services include surgical-dental services that are provided to insured persons but does not include services to which persons are entitled under other provincial or federal laws (s.1) Surgical-dental services are any medically or dentally required surgical-dental service that is performed by a dentist in a hospital if a hospital is required for the proper performance of the procedure (s.1) Regulations may be made by the Commissioner in Executive Council, including the establishment of a Health Care Insurance Plan (s.8)	Minister of Health and Social Services Health Care Insurance Plan
Health Act, R.S.Y. 2002, c. 106		Established the Department of Health and Social Services (s.3(1)) and authorized the Minister to be responsible for the implementation and administration of a number of acts (s.4(1)) Regulations may be made by the Commissioner in Executive Council (s.46)	Minister of Health and Social Services
Extended Health Care Benefits Regulation, Y. O.I.C. 1994/169	Persons who are at least 65 years of age or at least 60 years of age and whose spouse is a Yukon resident who is at least 65 years old (s.2(1))	Provides that the cost of dental care, including dental restorations, dentures and preventive services, upon approval by the director, shall be payable as a benefit subject to specified limitations (s.4)	Minister of Health and Social Services Seniors Dental Program
Hospital Insurance Services Act, R.S.Y. 2002, c. 112	Residents who are eligible are entitled to insured services (s.2)	Insured services are the in-patient and out-patient services to which eligible persons are entitled under this Act and its regulations (s.2) Authorizes for the establishment of a hospital insurance plan (s.9(a)) Other regulations may be made by the Commissioner in Executive Council (s.9)	Minister of Health and Social Services Hospital Insurance Plan
Yukon Hospital Insurance Services Regulations, Y.C.O. 1960/035	As above; further defined (s.4 and ff)	Dental services that are covered are those that could properly be classified as in-patient and out-patient services and satisfy the need of medical necessity (s.10)	Minister of Health and Social Services
Social Assistance Act, R.S.Y. 2002, c. 205	Persons in need as defined in the regulations (s.1)	The director is to grant assistance to any person in need (s.7(1)) Regulations may be made by the Commissioner in Executive Council (s.8)	Minister of Health and Social Services Adult Community Services

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Social Assistance Regulations, Y.C.O. 1972/228	Persons in need who meet the eligibility criteria specified (s.5)	Health care services include dental services and prosthetic appliances but do not include insured services or benefits provided under the Health Care Insurance Plan Act, the Hospital Insurance Services Act, the Travel for Medical Treatment Act, the Chronic Disease and Disability Benefits Regulation, the Extended Health Care Benefits Regulation or the Pharmacare Plan Regulation (s.2) Persons who leave general assistance due to employment are entitled to transitional assistance for health care services for up to six months (s.17.1) Rates for eligible health care services are set by the director (Schedule A, Part Q)	Minister of Health and Social Services

Table 100. The Yukon Children's Dental Program

	2005-06 Forecast	2004-05 Actual	2003-04 Actual
Whitehorse Dental Enrollment	2,250	2,003	1,985
Rural Dental Enrollment	868	755	911
Preschool/Homeschool Program Number of Children Number of Clinics	 150 12	 121 10	 152 11
Road Trips to Rural Communities Dental Therapists Dentists	 35 22	 42 8	 35 11
Daycare/Homecare Dental Visits	15	15	15
Pre or Postnatal Visits	17	17	17

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

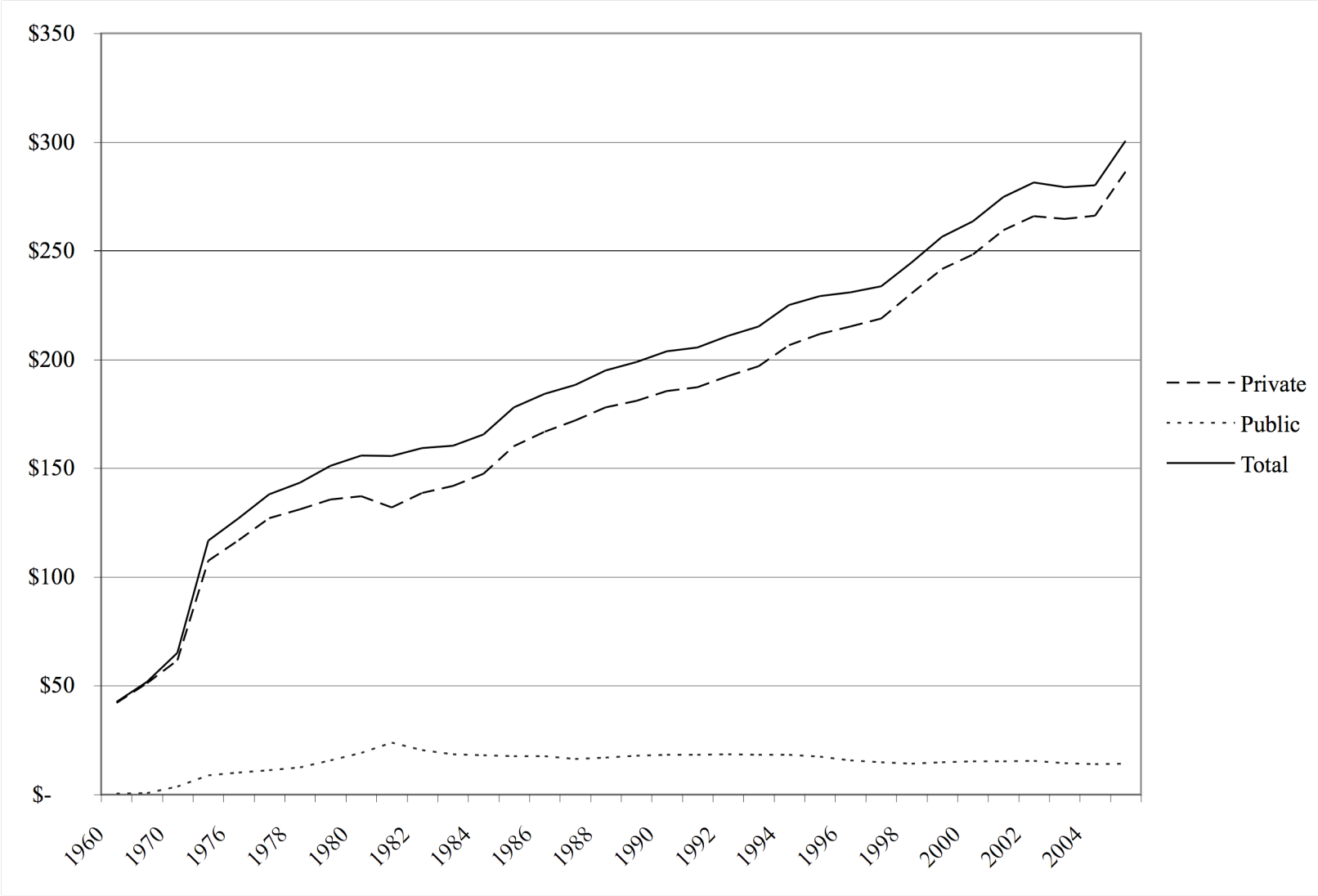


Figure 2. Public per capita dental care expenditures, Canada, 1960-2005 (constant dollars)

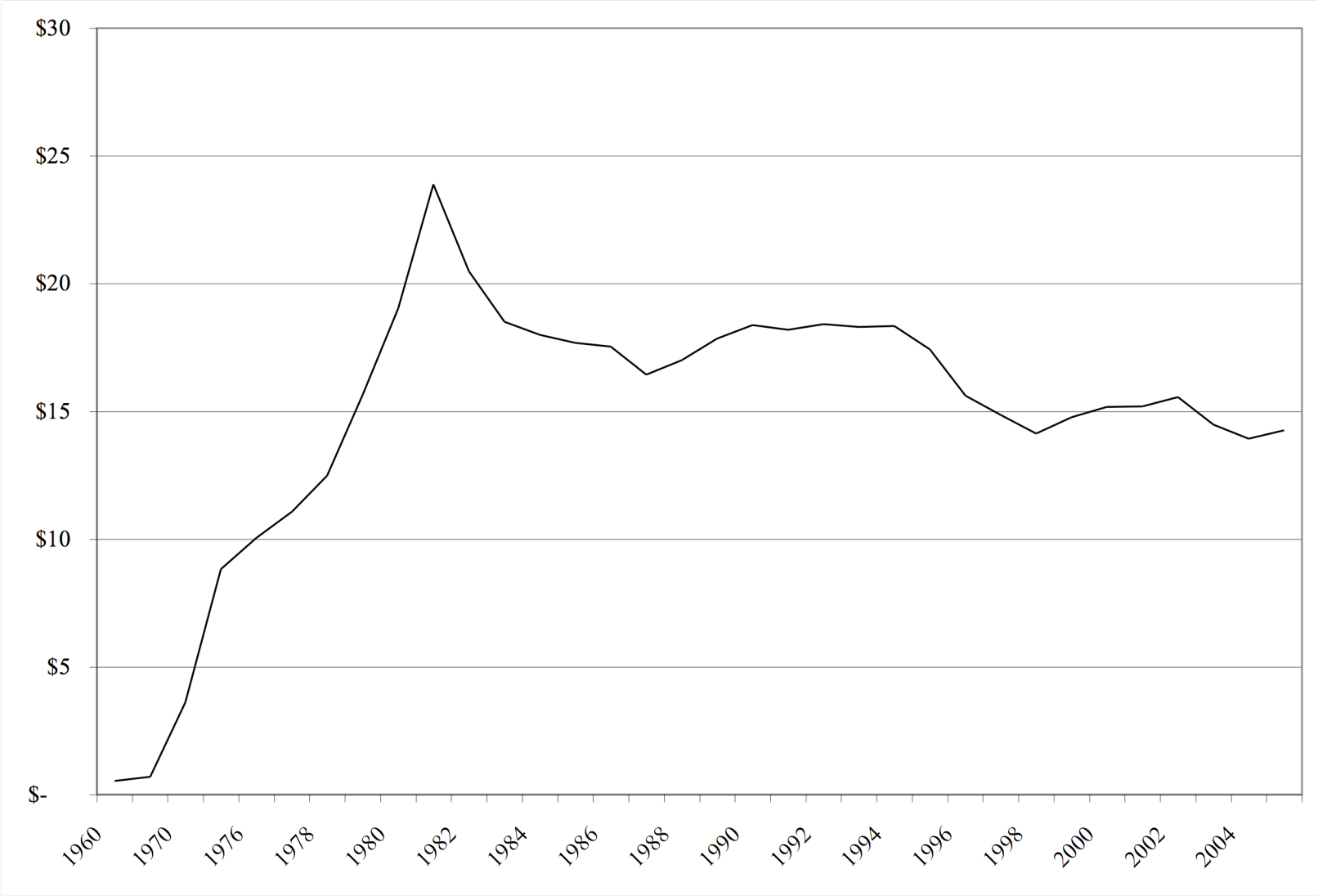


Figure 3. Caries free children, age 5 and 13 years, Toronto, Canada, 1955-2000

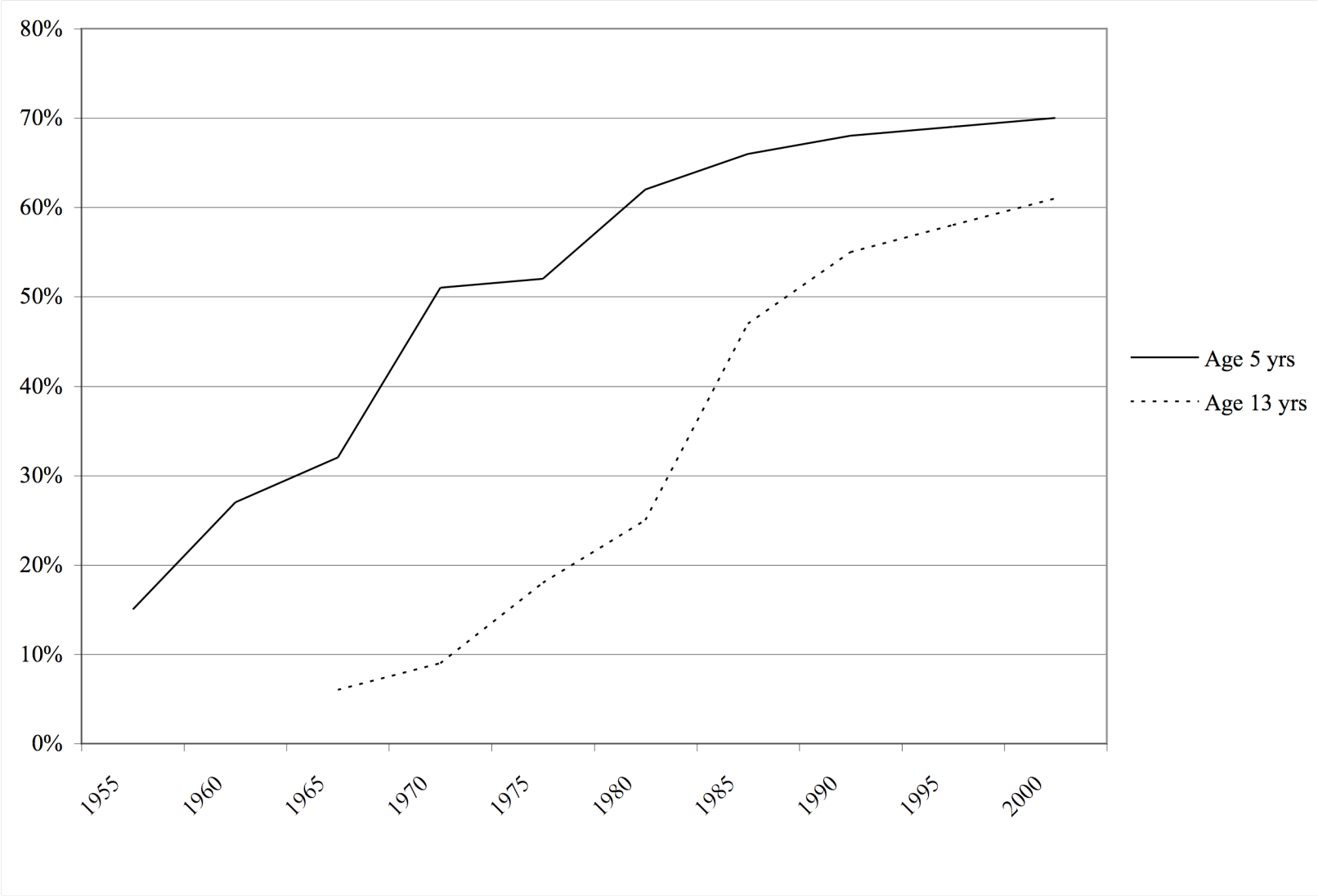


Figure 4. Percent children caries free in Ontario, by social group, 1990 to 1994

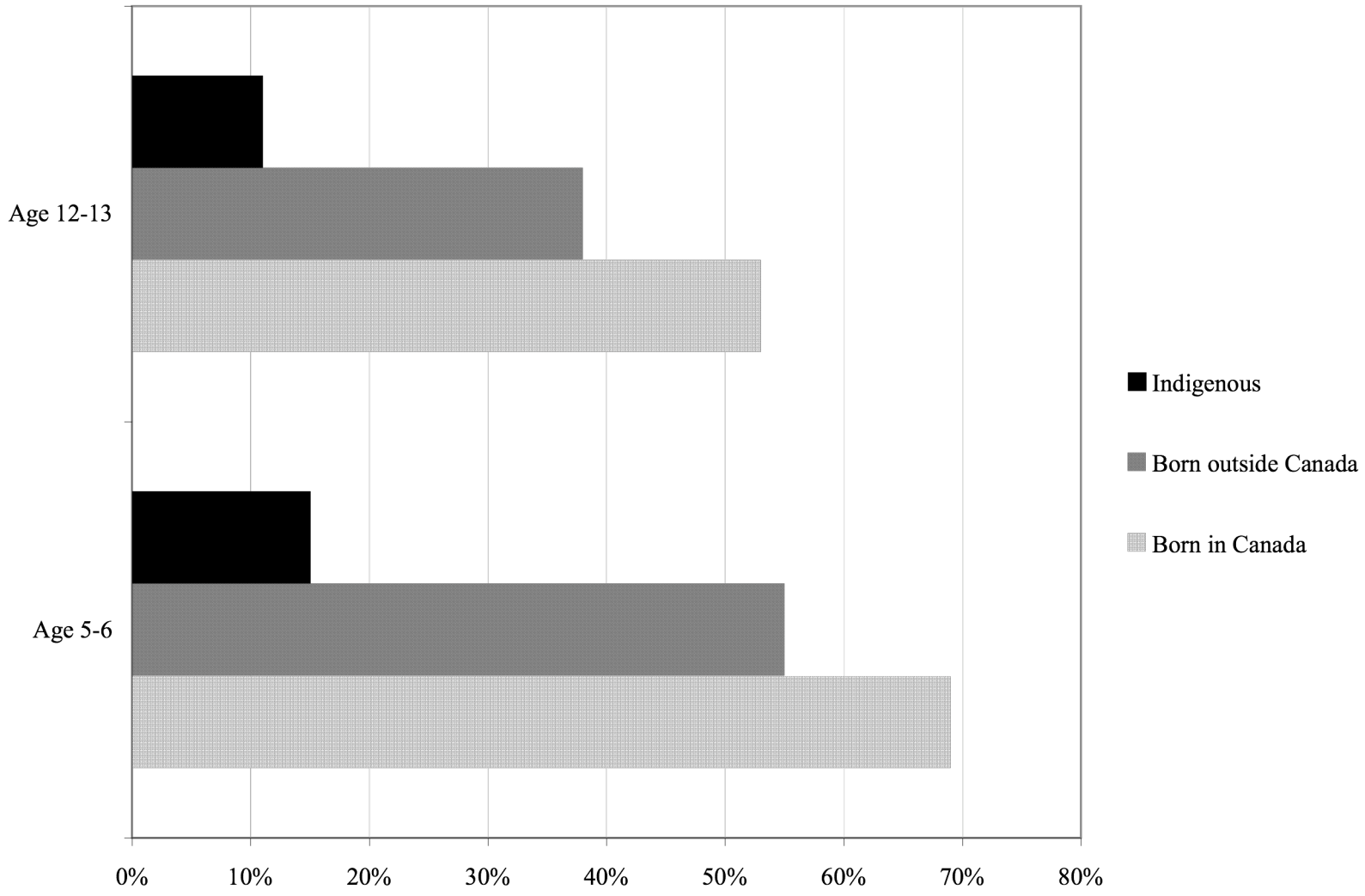


Figure 5. Dental care utilisation by income group, Canada, 1950 and 2001

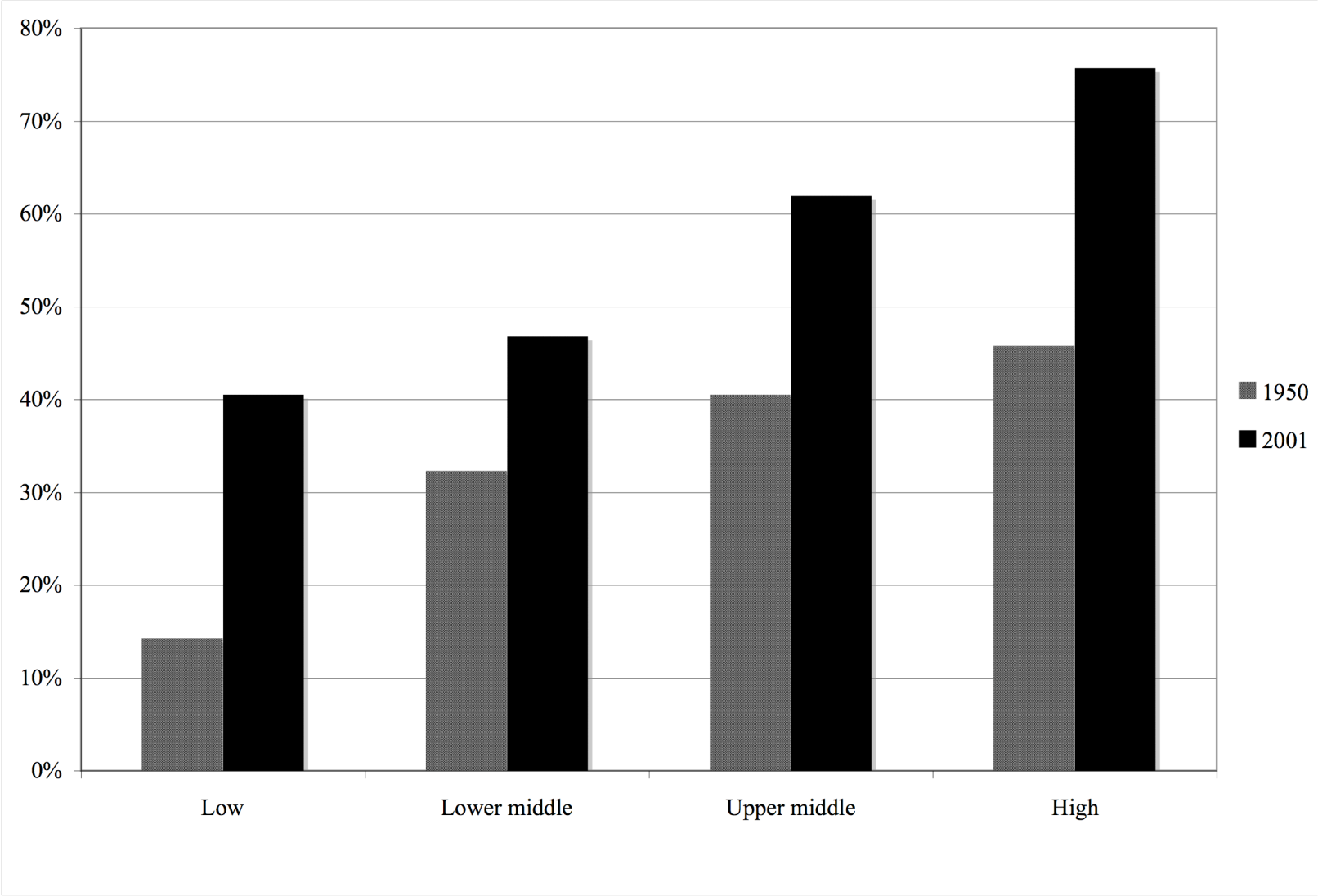


Figure 6. Total federal payments, Canada Assistance Plan, 1978-1995 (current dollars, '000,000,000)

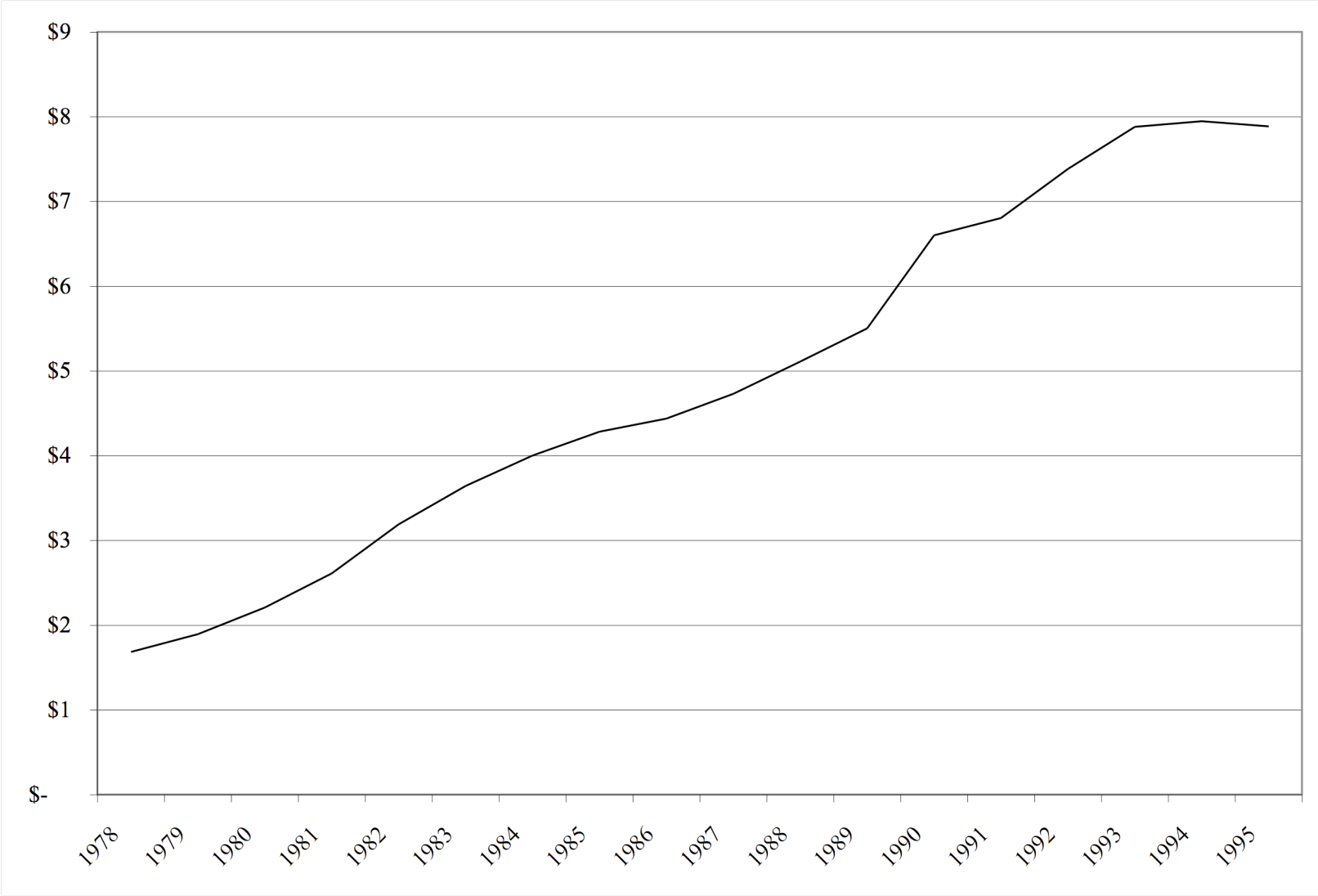


Figure 7. Total federal payments, Canada Health and Social Transfer, 1996-2002 (current dollars, '000,000,000)

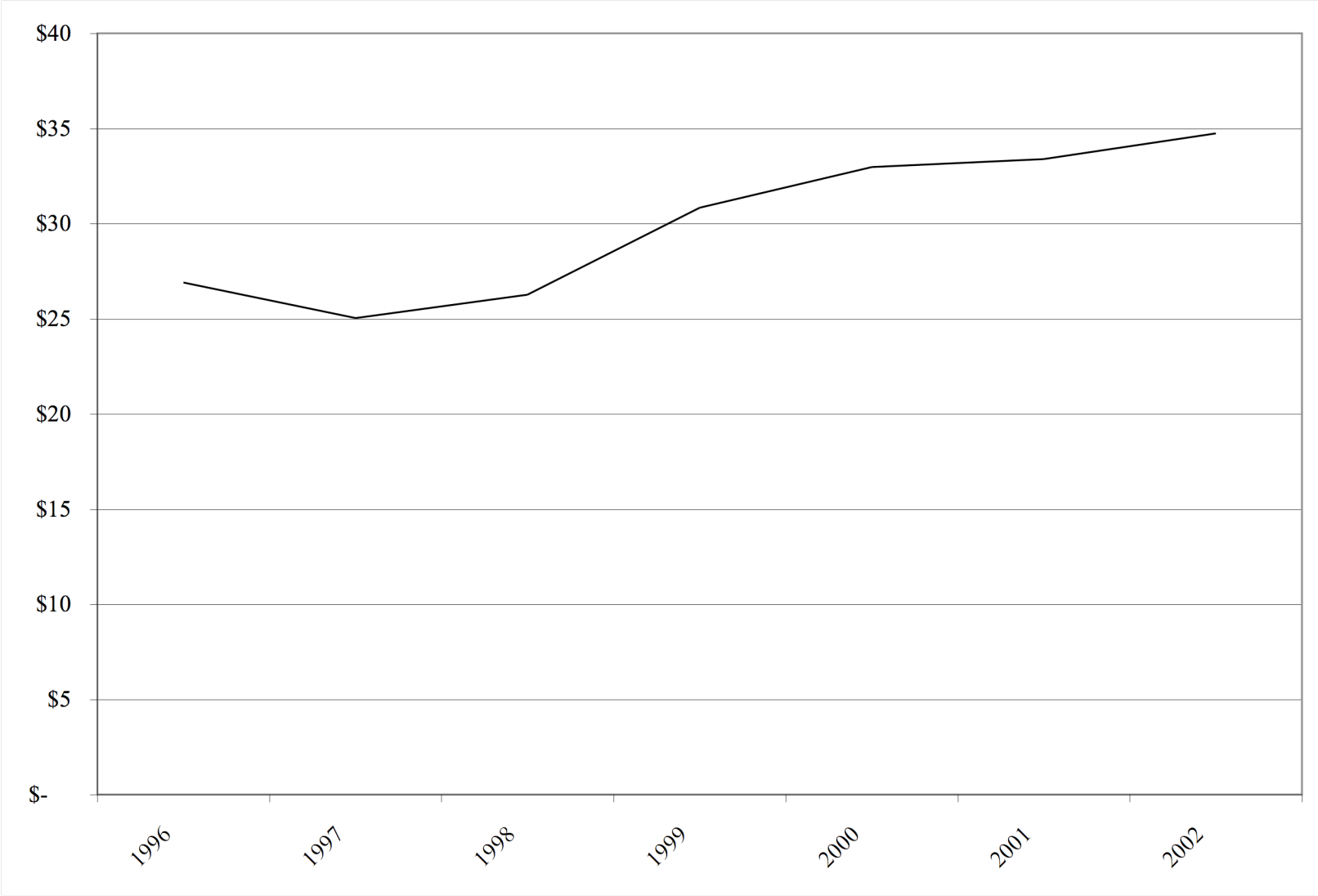


Figure 8. Provincial/territorial health expenditures in Canada, 1977-2005 (constant dollars, '000,000)

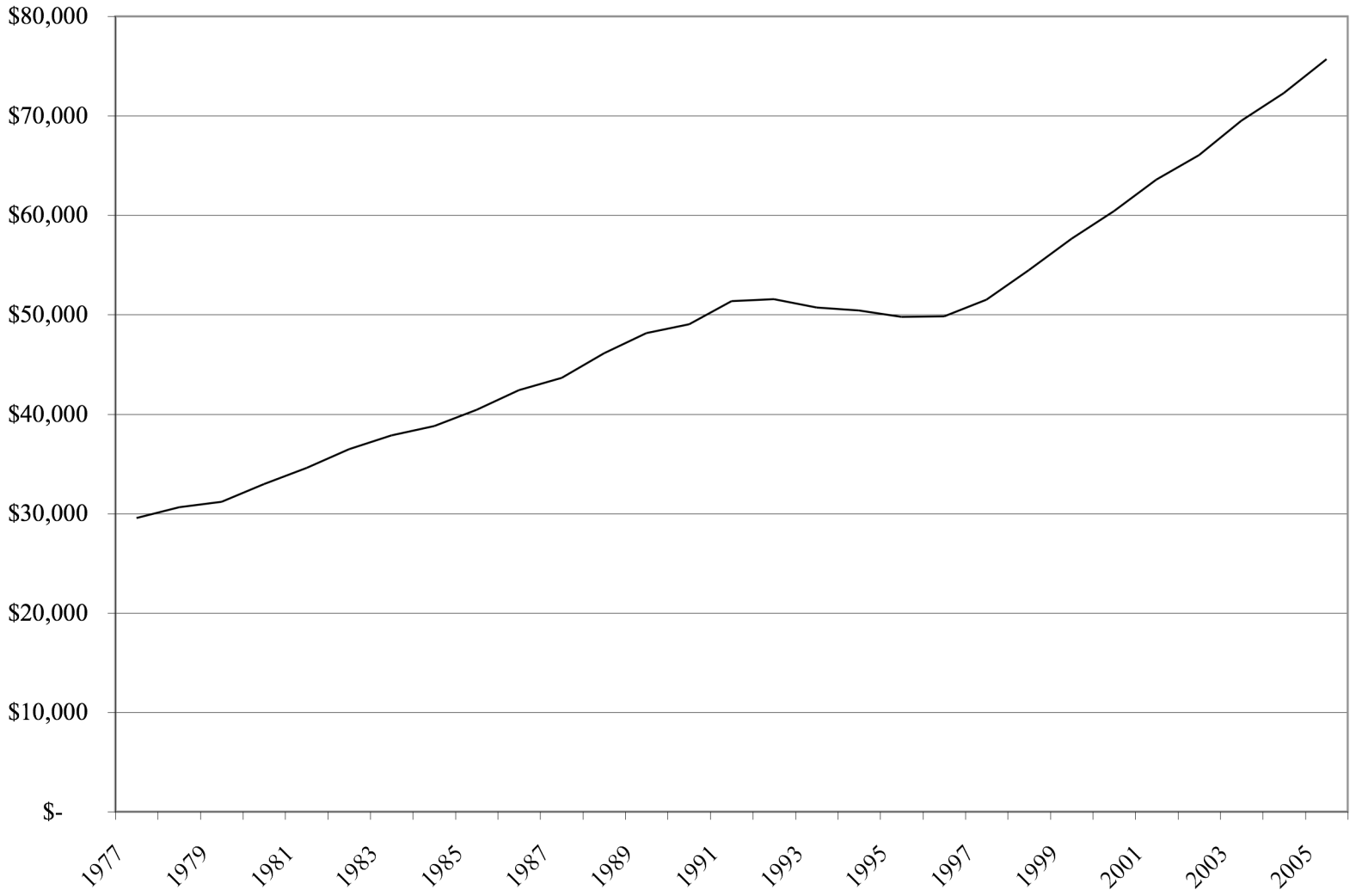


Figure 9. Total provincial and municipal social assistance expenditures, Canada, 1980-2002 (constant dollars, '000,000,000)

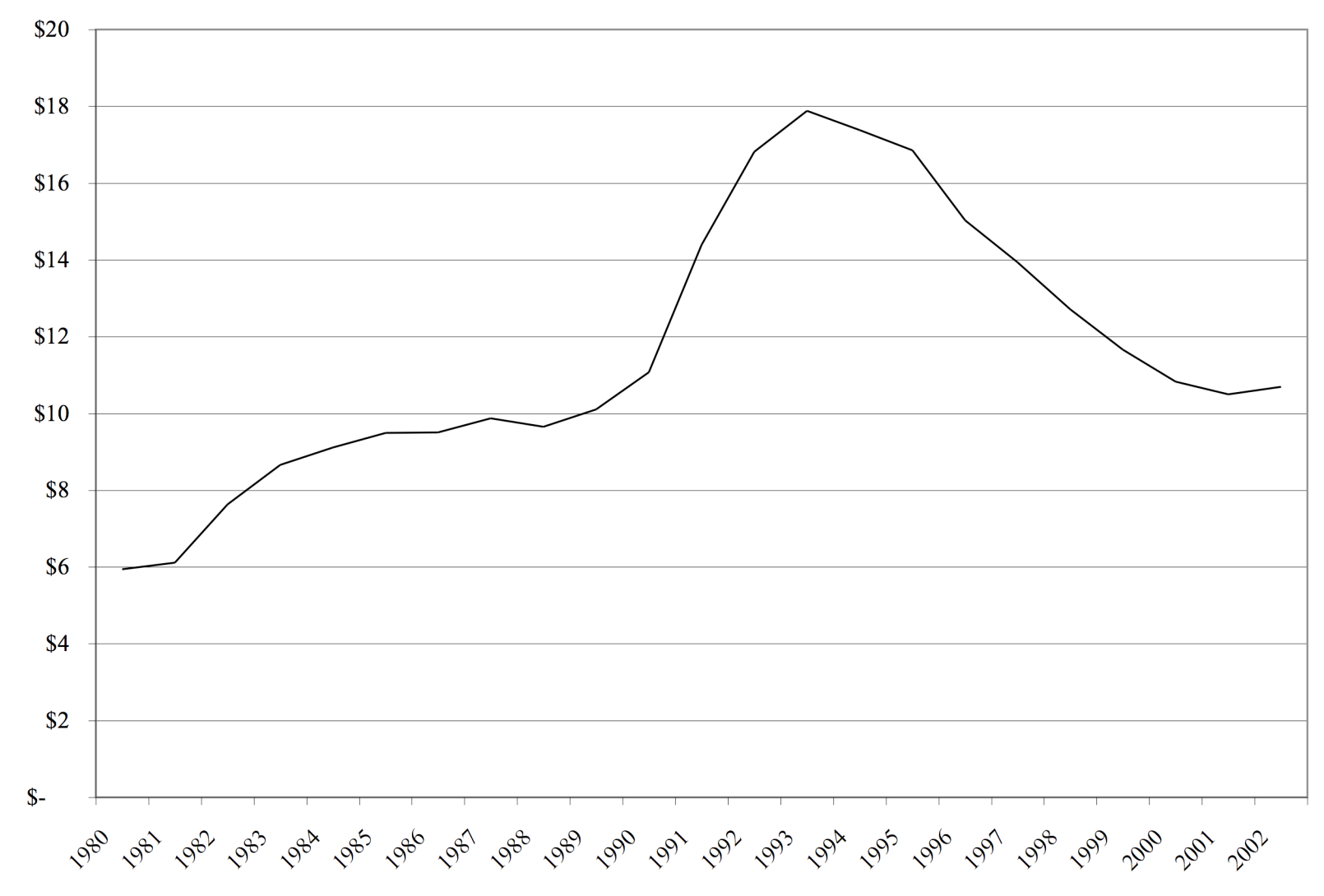


Figure 10. The provincial and territorial dental public health environment, 2005

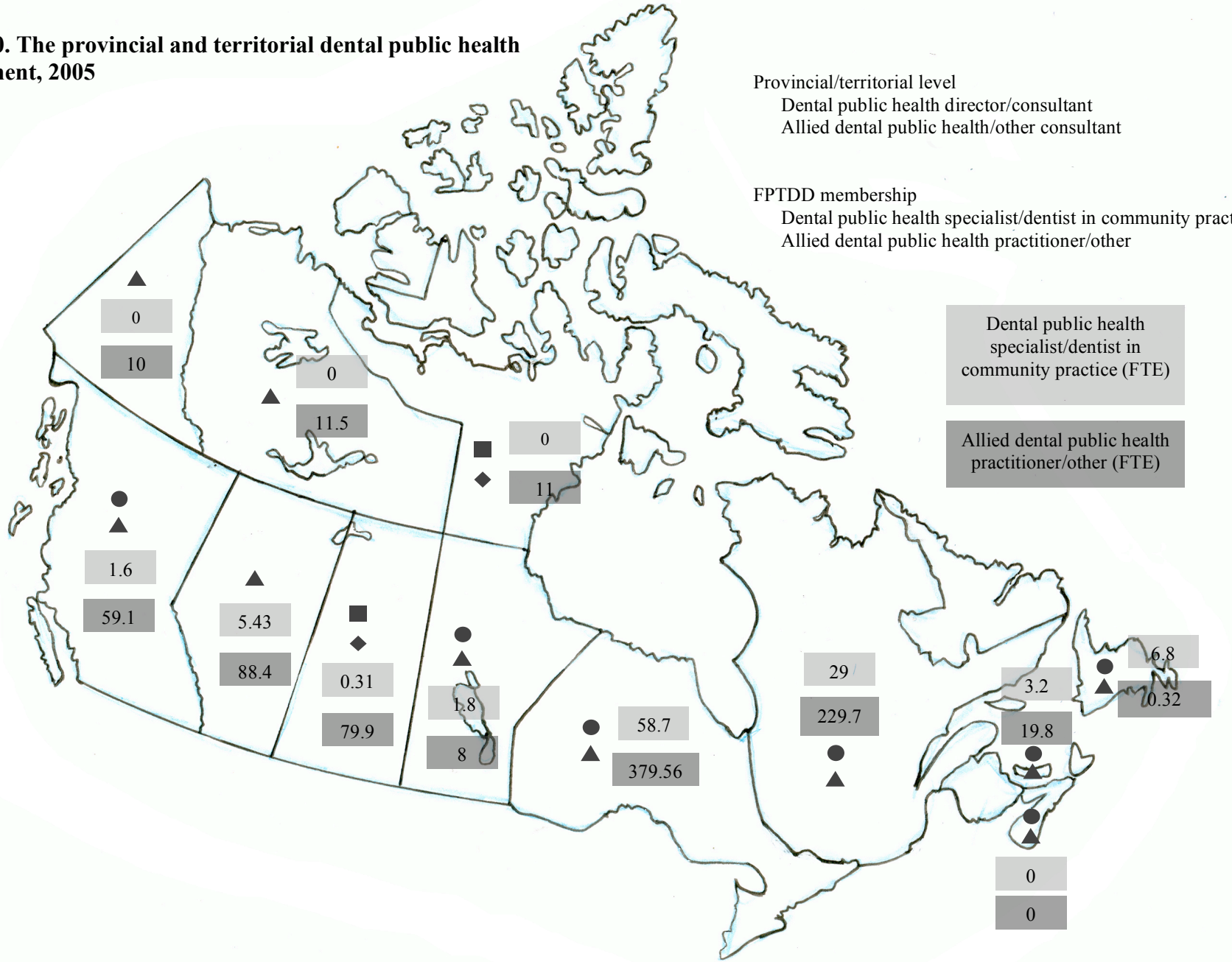


Figure 11. Per capita public dental care expenditures, Canada, by province, 1960-2005 (constant dollars)

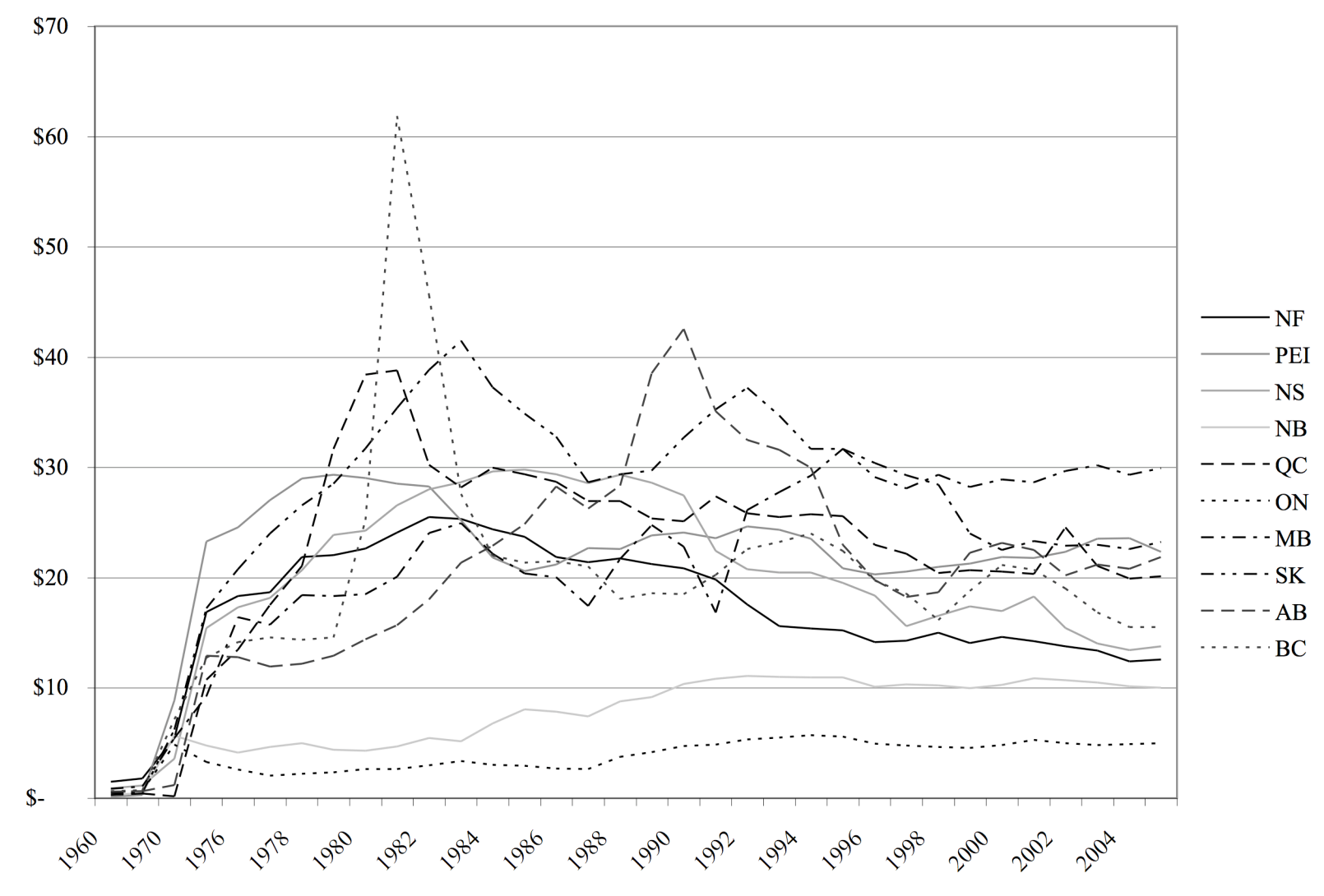


Figure 12. Per capita public dental expenditures, Canada, by territory, 1975-2005 (constant dollars)

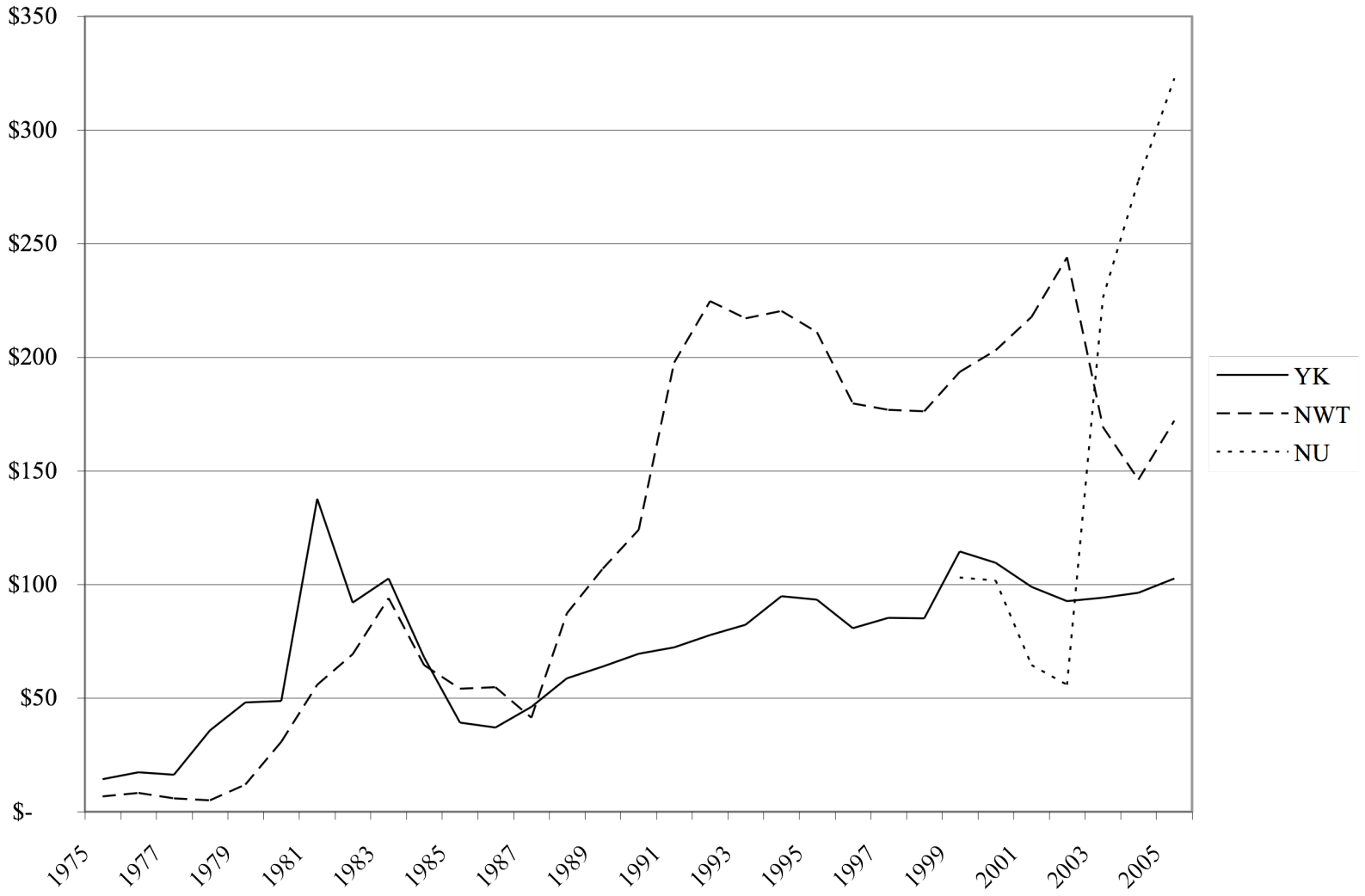


Figure 13. Household budgetary shares for dental care, Canada, 1969-2003 (constant dollars)

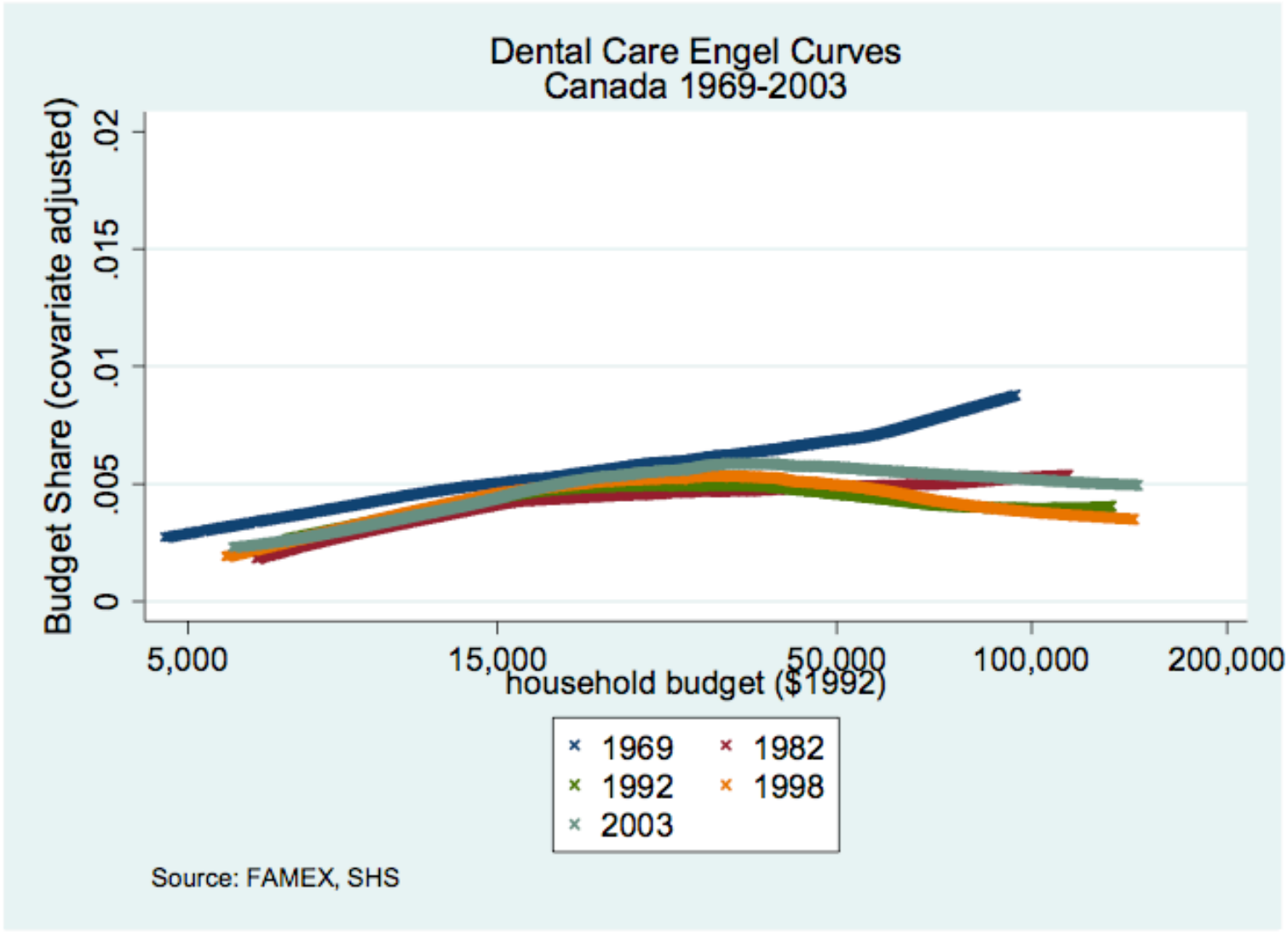


Figure 14. Public per capita dental expenditures in British Columbia, 1960/65/70, 1975-2005 (constant dollars)

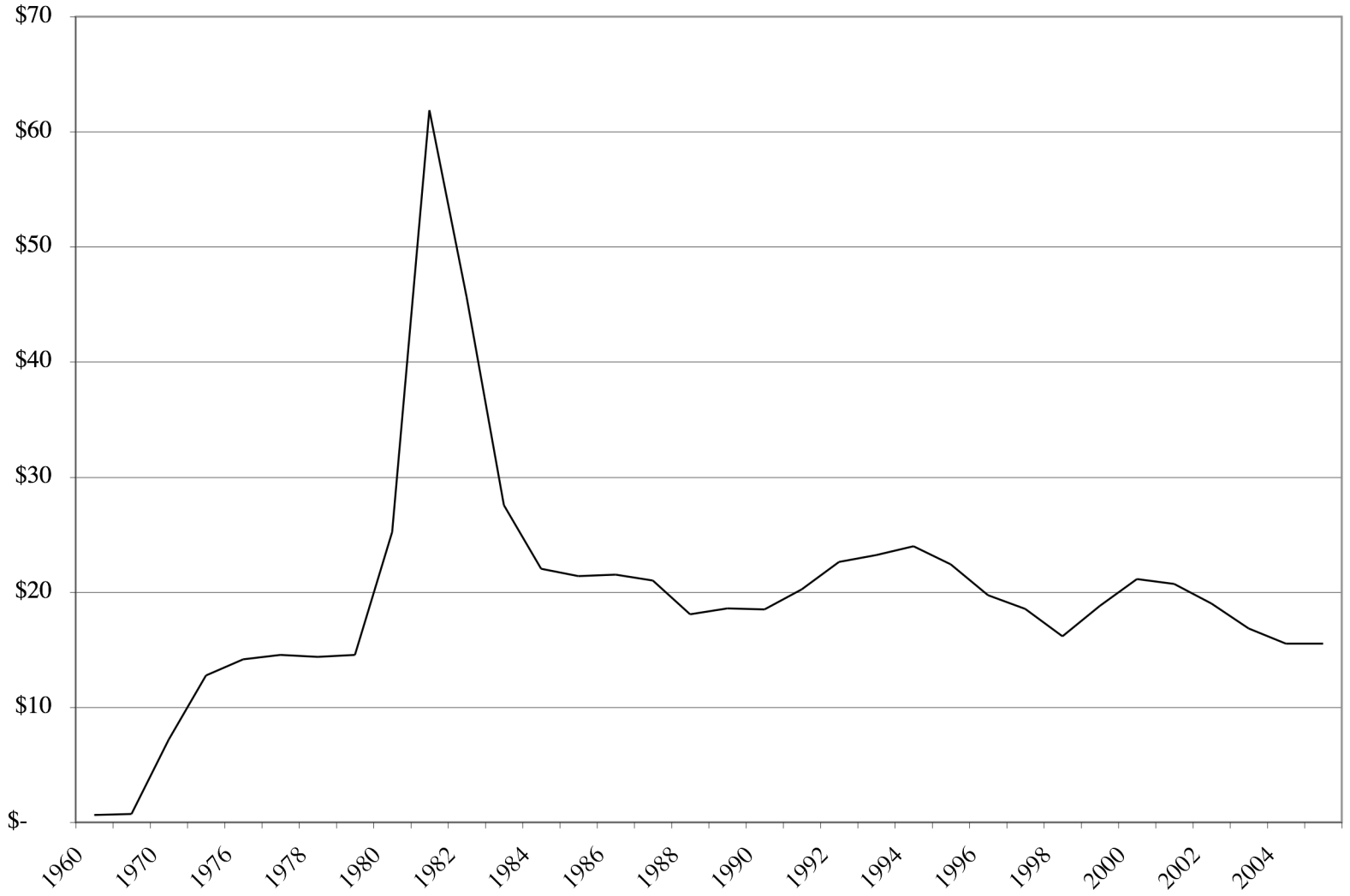


Figure 15. Household budgetary shares for dental care, British Columbia, 1969-2003 (constant dollars)

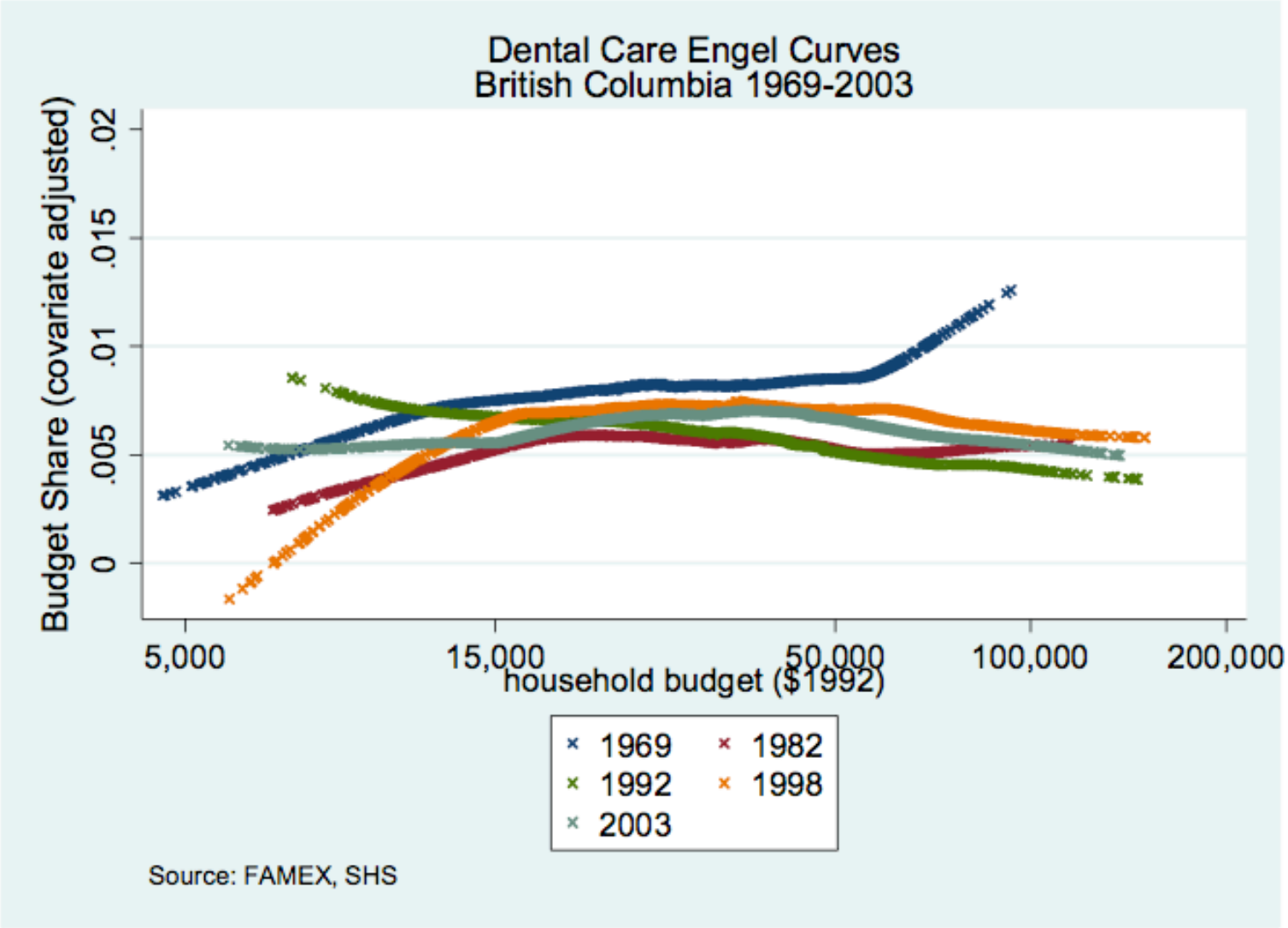


Figure 16. Social assistance expenditures in British Columbia, 1980/81-2002/03 (constant dollars, '000)

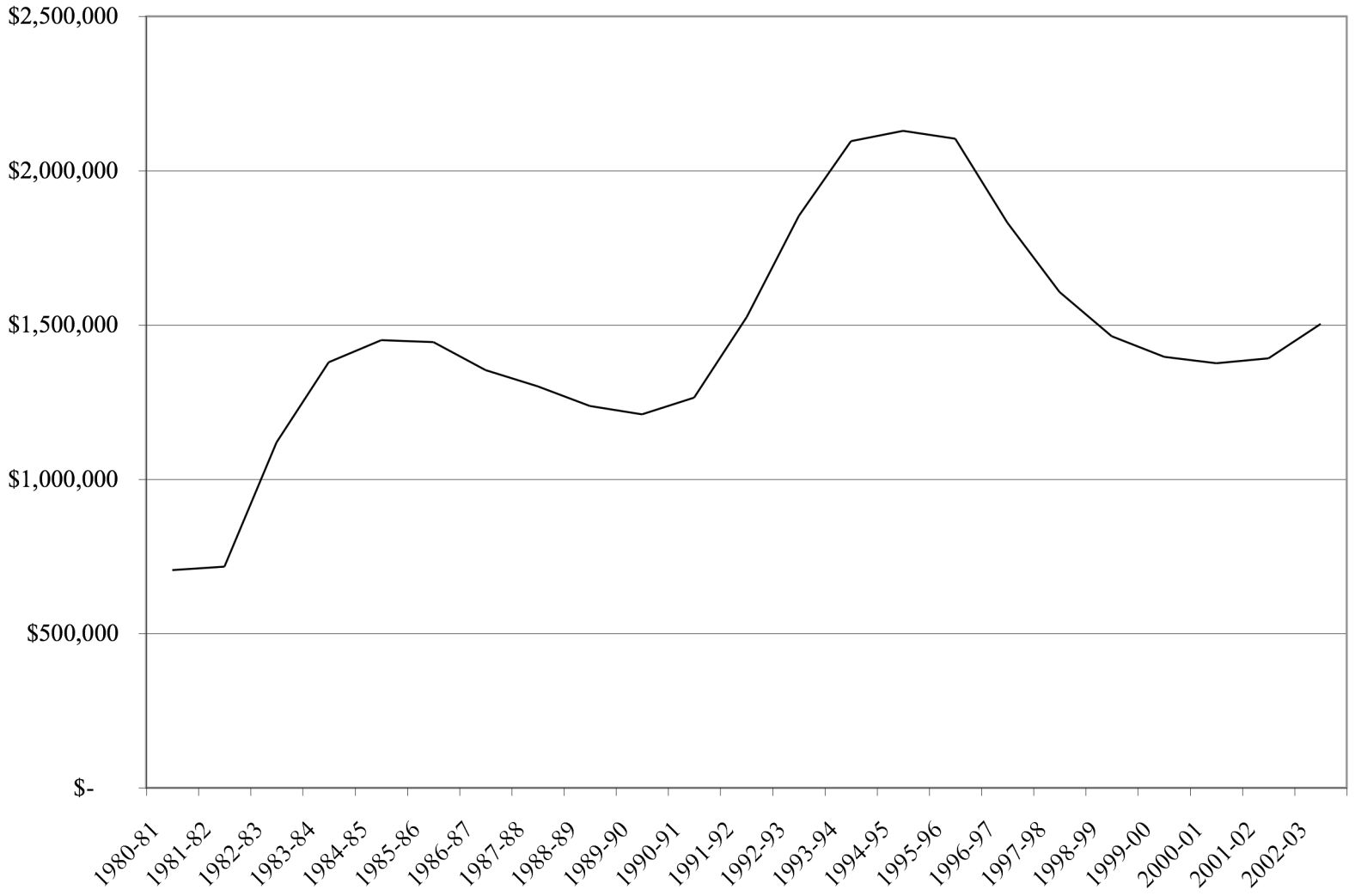


Figure 17. Hospitalisations for dental procedures, children age 0-14, British Columbia, 1997-2001

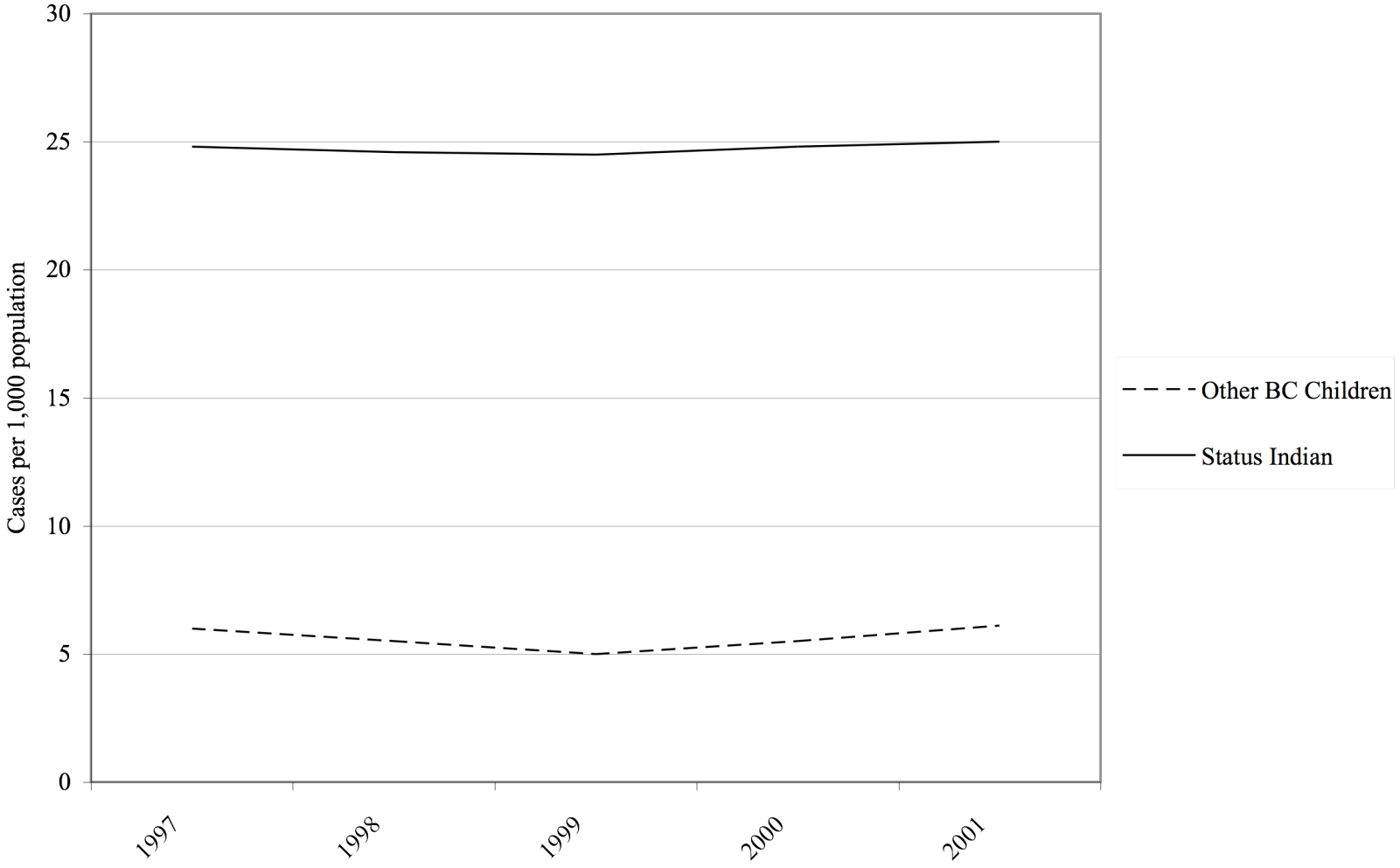


Figure 18. Public per capita dental expenditures in Alberta, 1960/65/70, 1975-2005 (constant dollars)

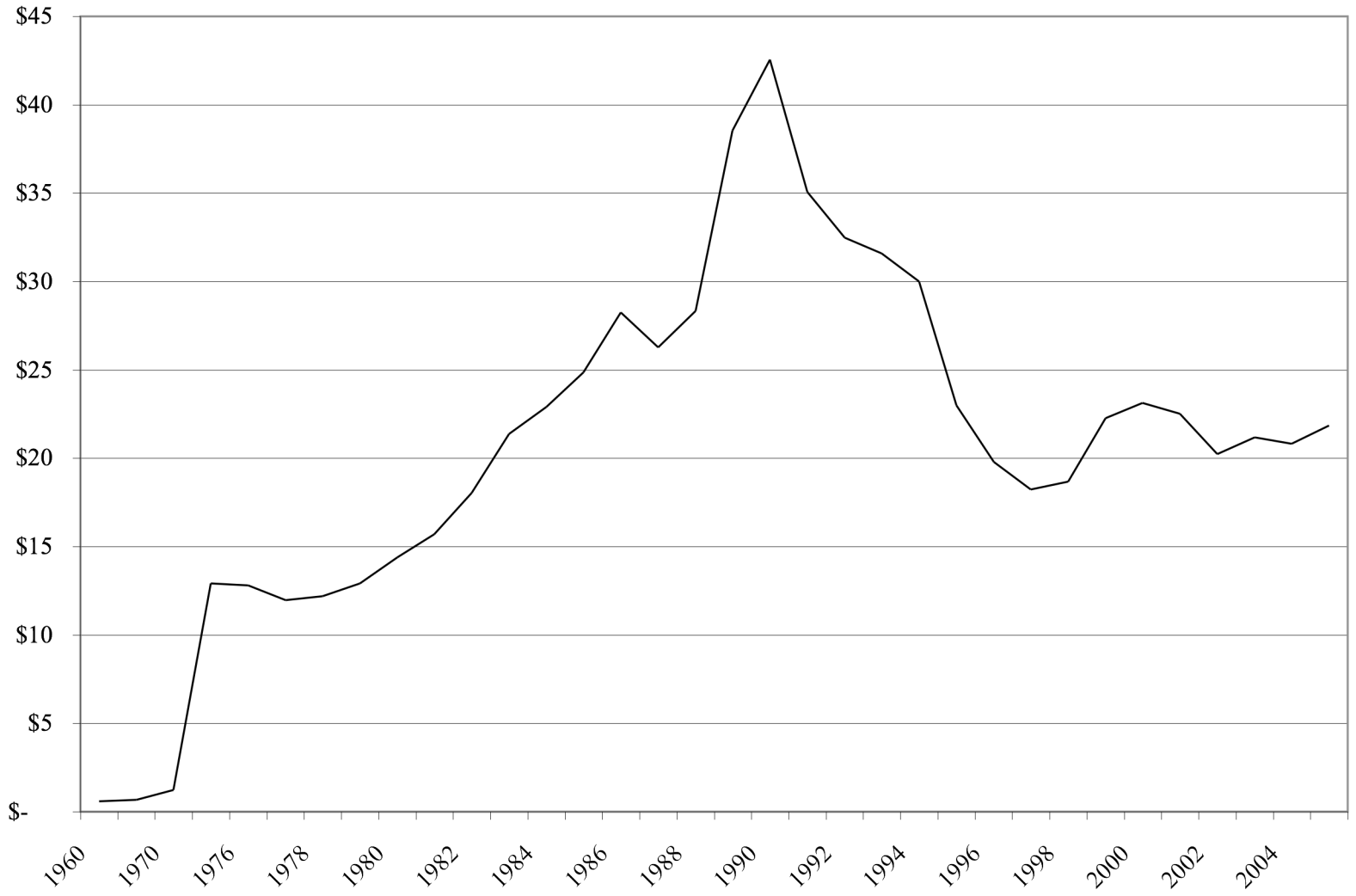


Figure 19. Household budgetary shares for dental care, the Prairies, 1969-2003 (constant dollars)

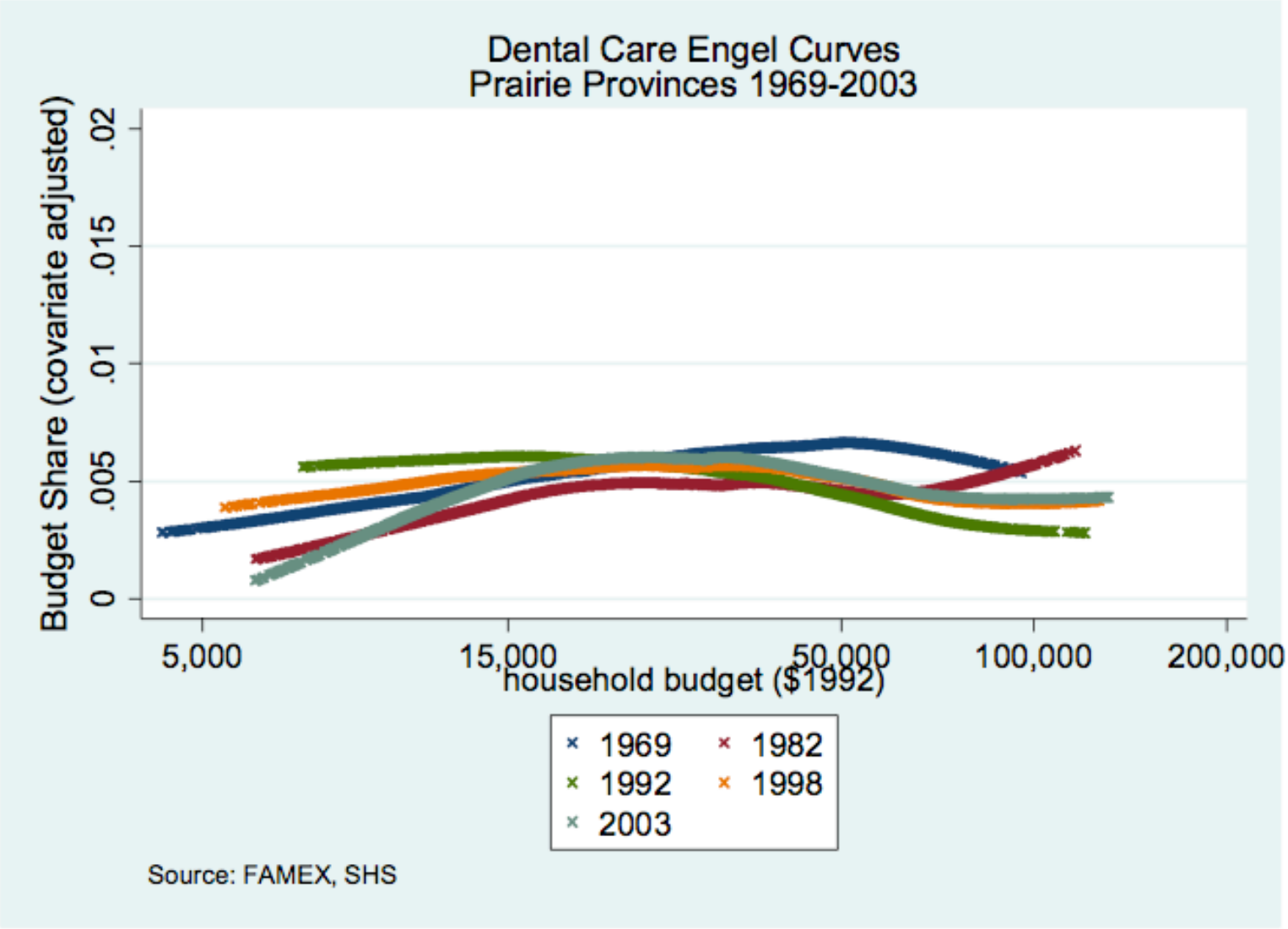


Figure 20. Social assistance expenditures in Alberta, 1980/81-2002/03 (constant dollars, '000)

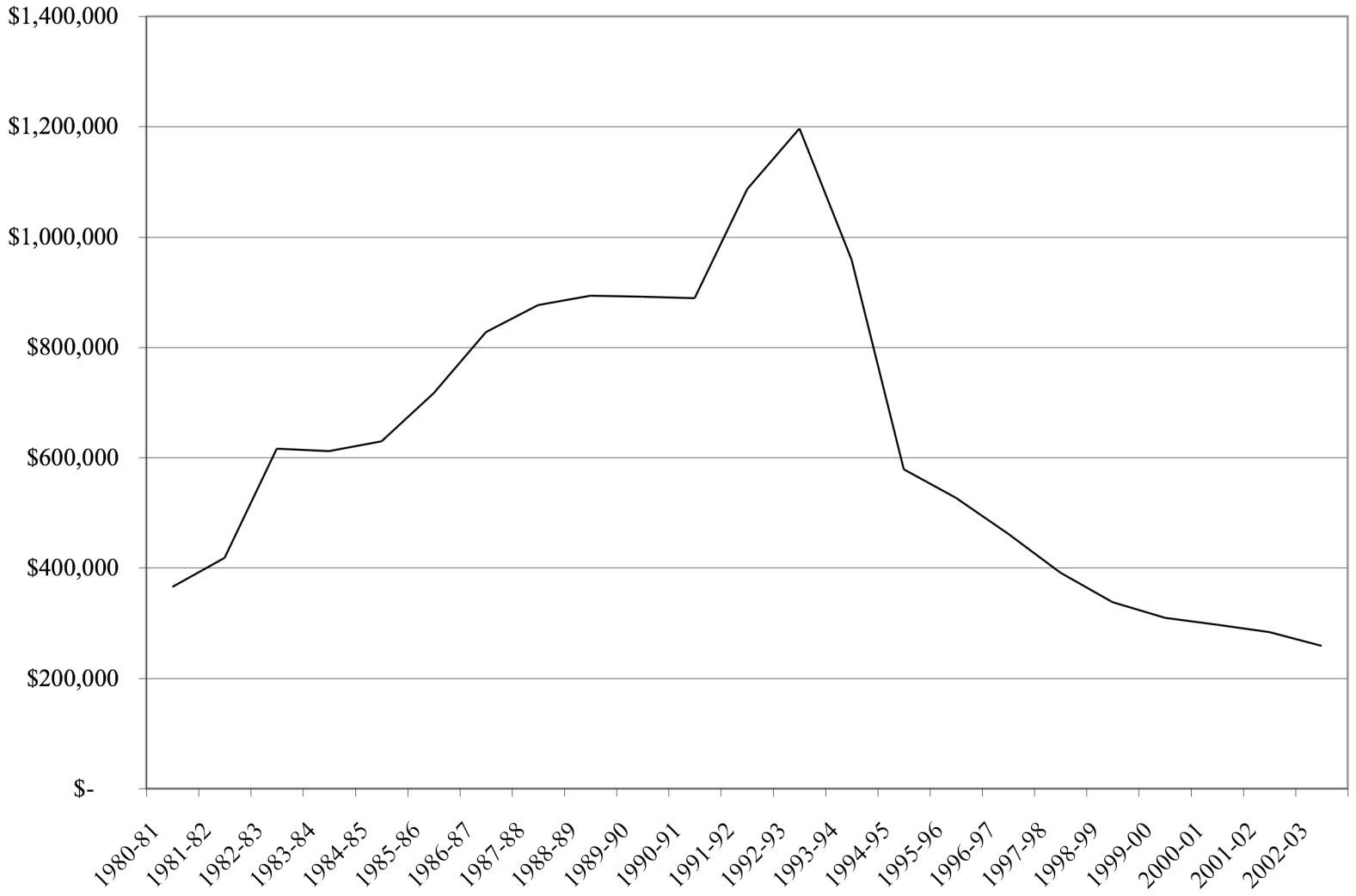


Figure 21. Public per capita dental expenditures in Saskatchewan, 1960/65/70, 1975-2005 (constant dollars)

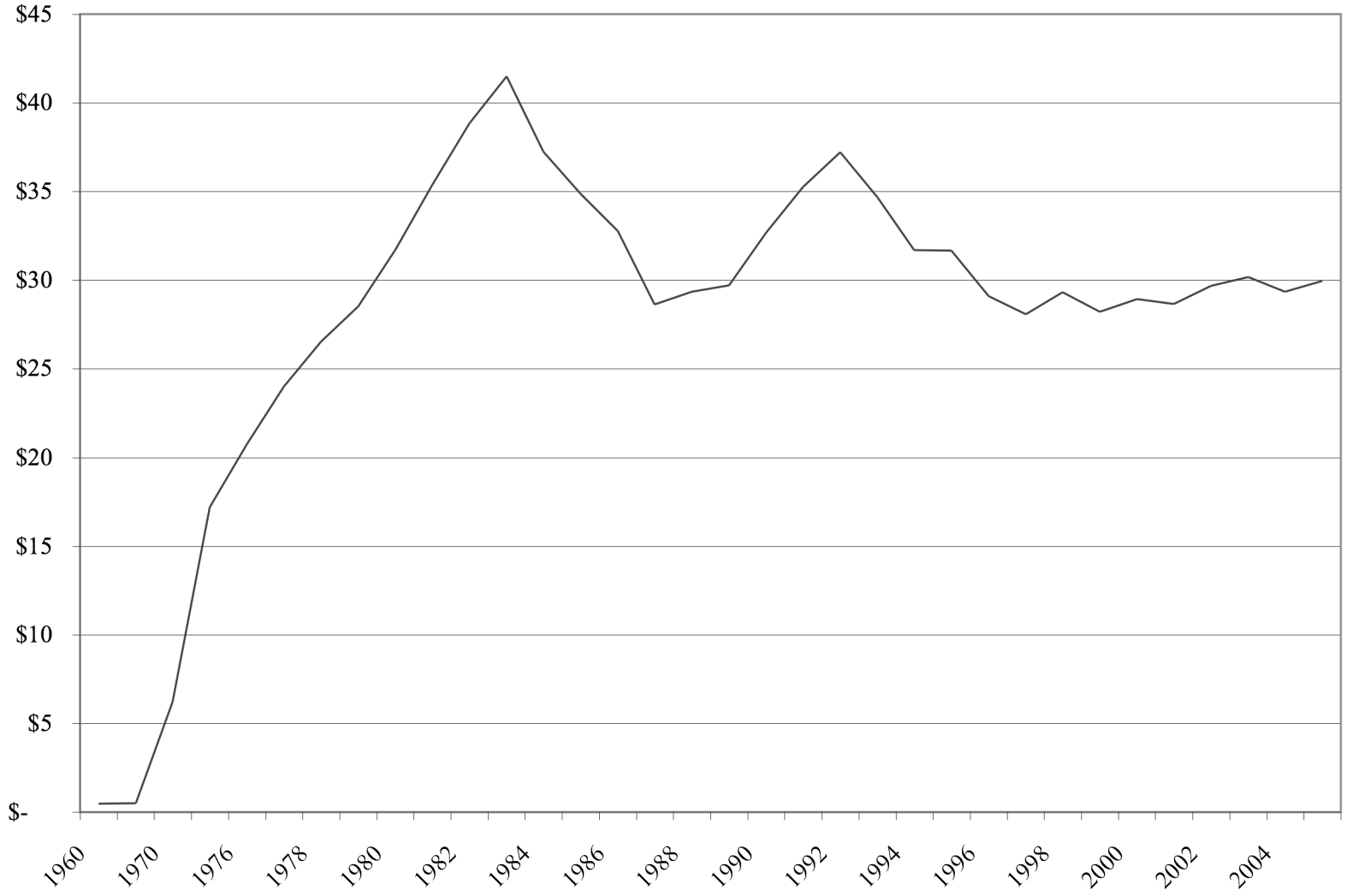


Figure 22. Social assistance expenditures in Saskatchewan, 1980/81-2002/03 (constant dollars, '000)

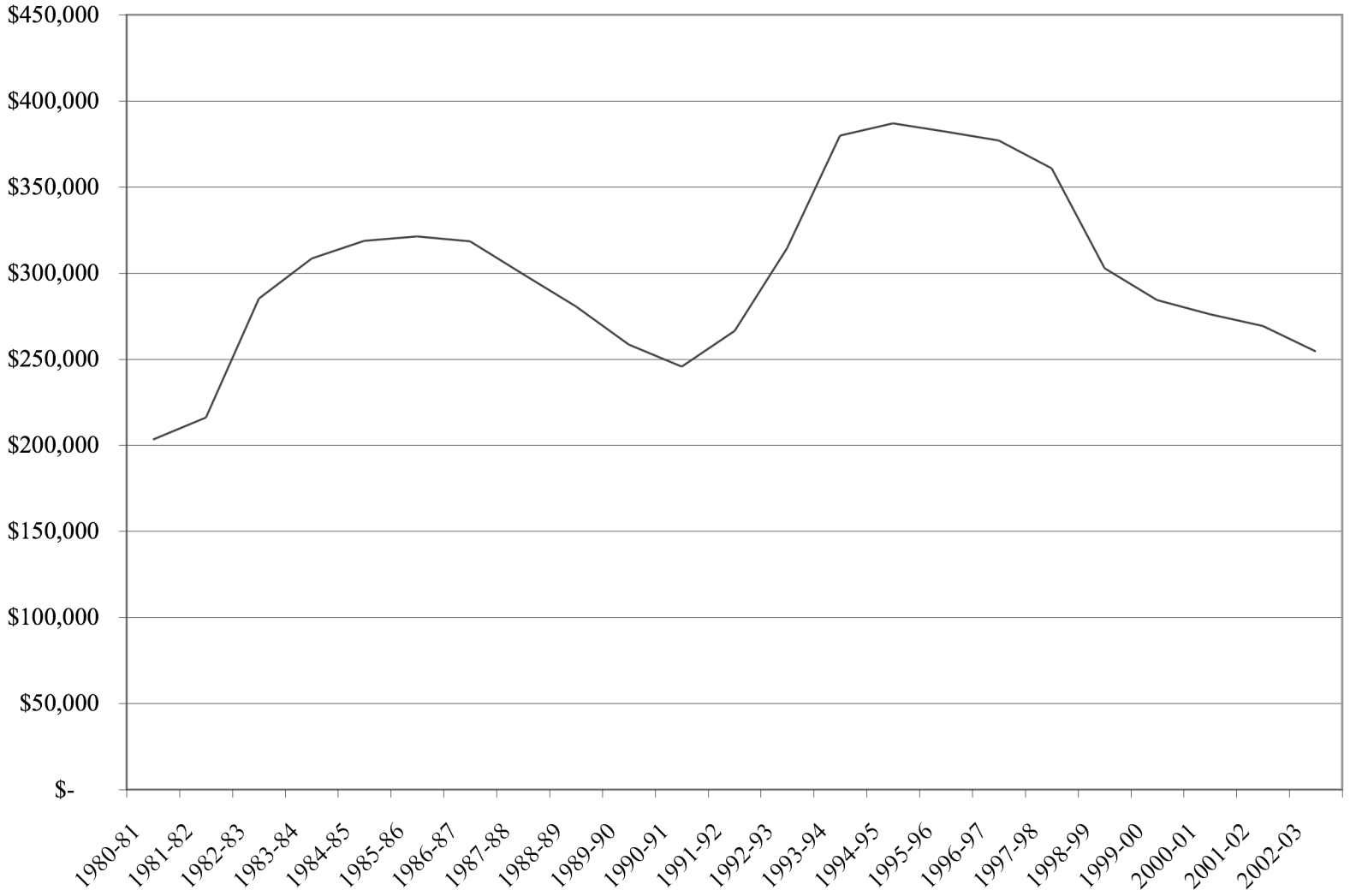


Figure 23. Public per capita dental expenditures in Manitoba, 1960/65/70, 1975-2005 (constant dollars)

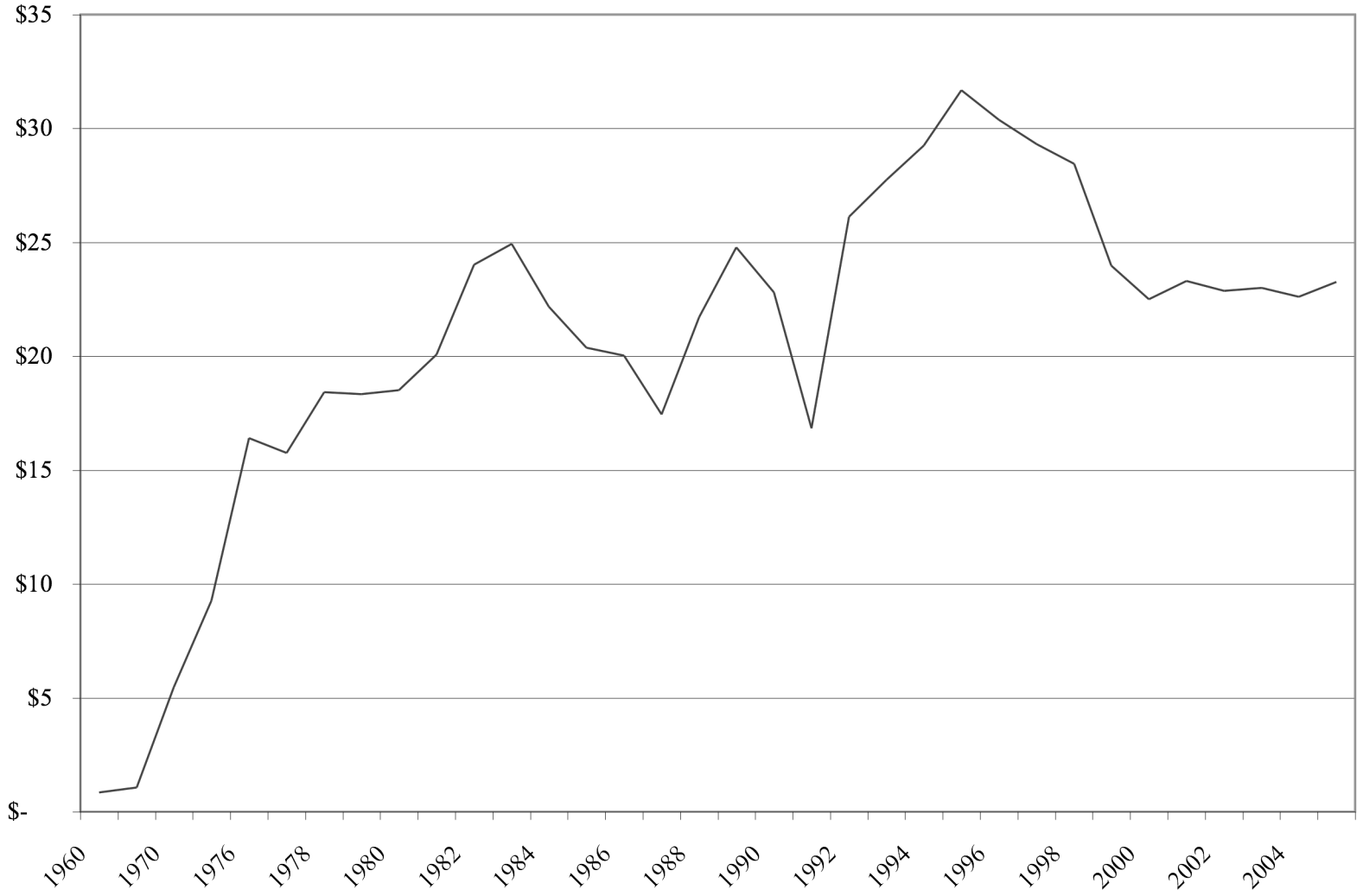


Figure 24. Social assistance expenditures in Manitoba, 1980/81-2002/03 (constant dollars, '000)

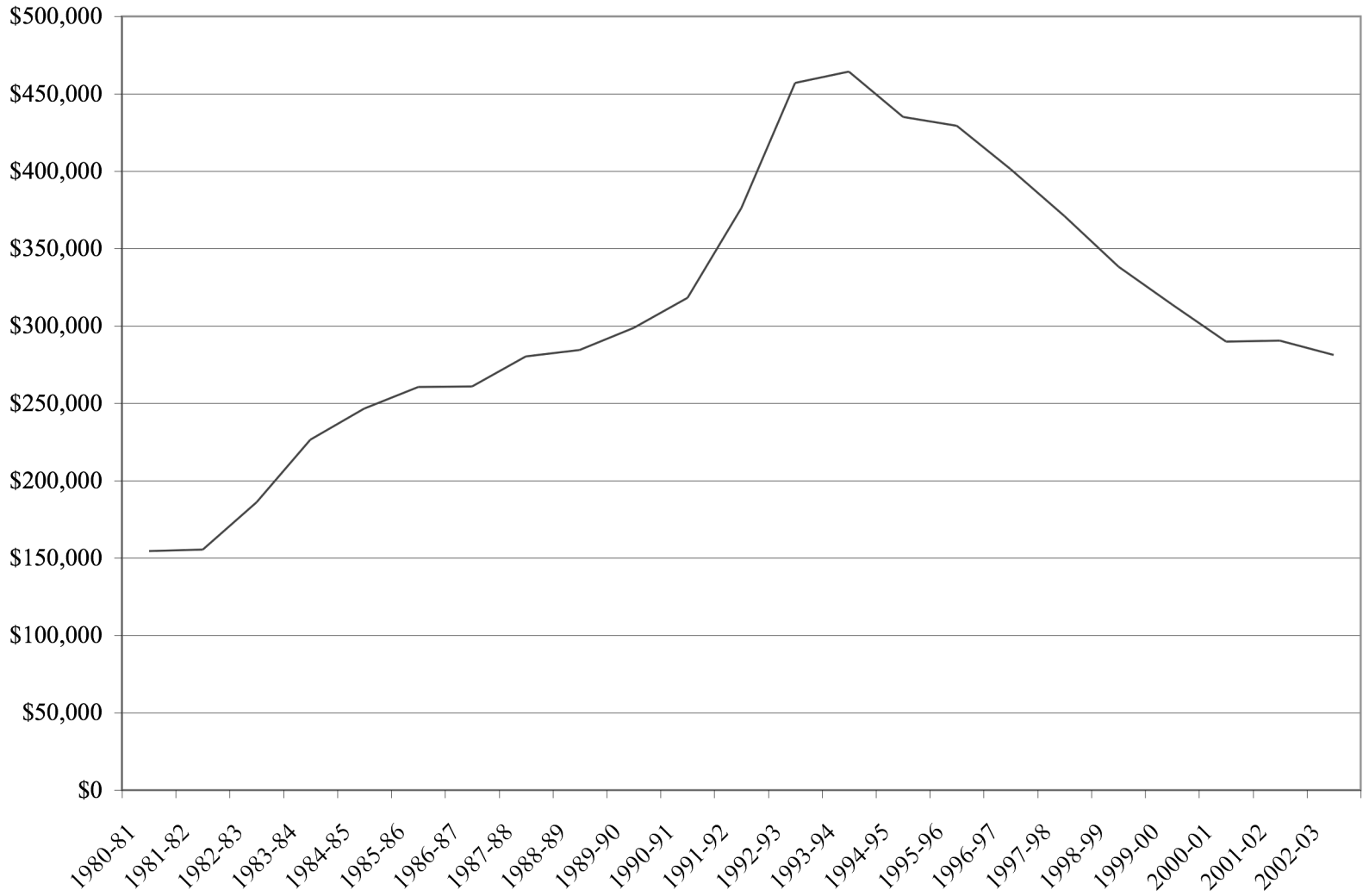


Figure 25. Public per capita dental expenditures in Ontario, 1960/65/70, 1975-2005 (constant dollars)

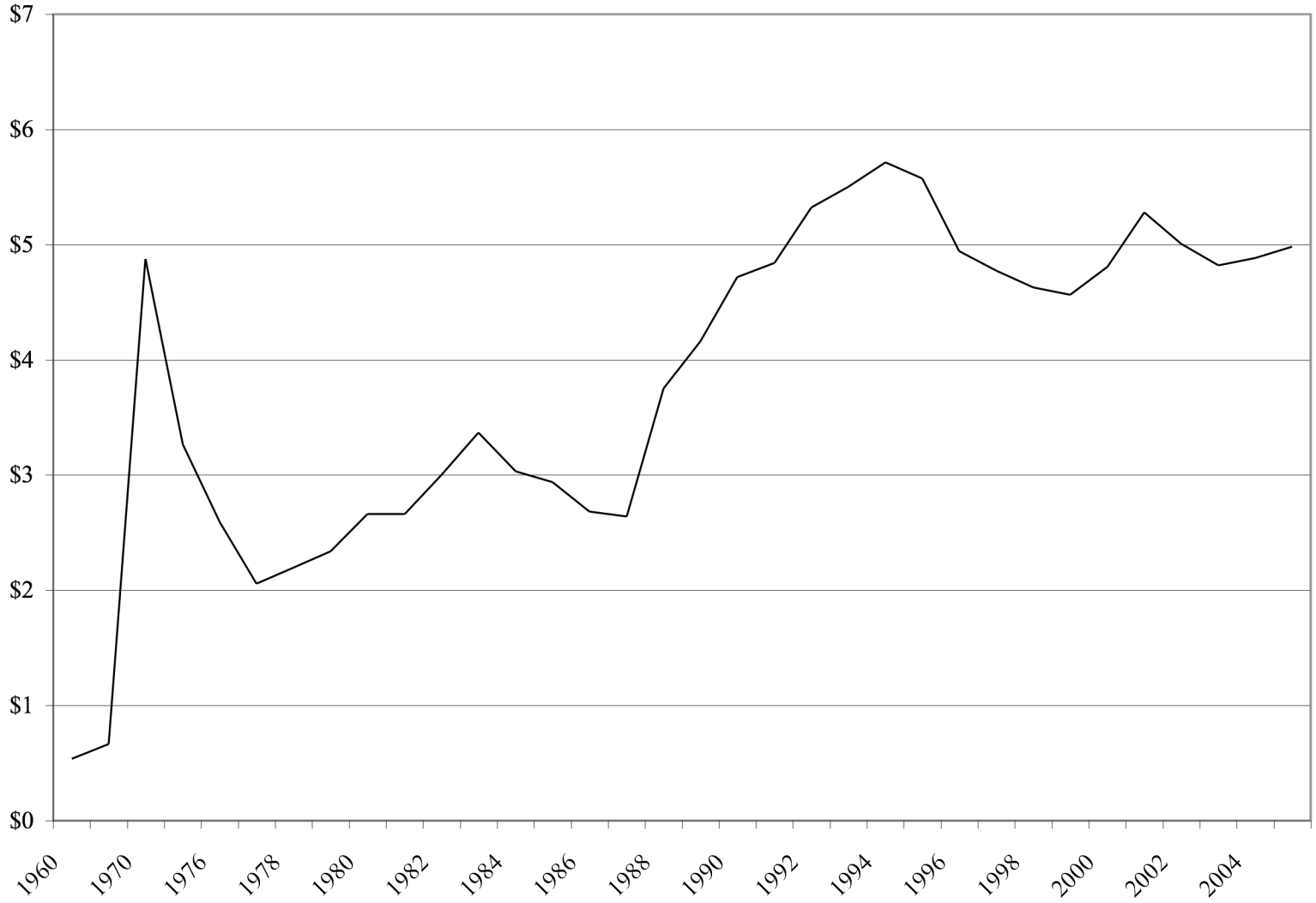


Figure 26. Household budgetary shares for dental care, Ontario, 1969-2003 (constant dollars)

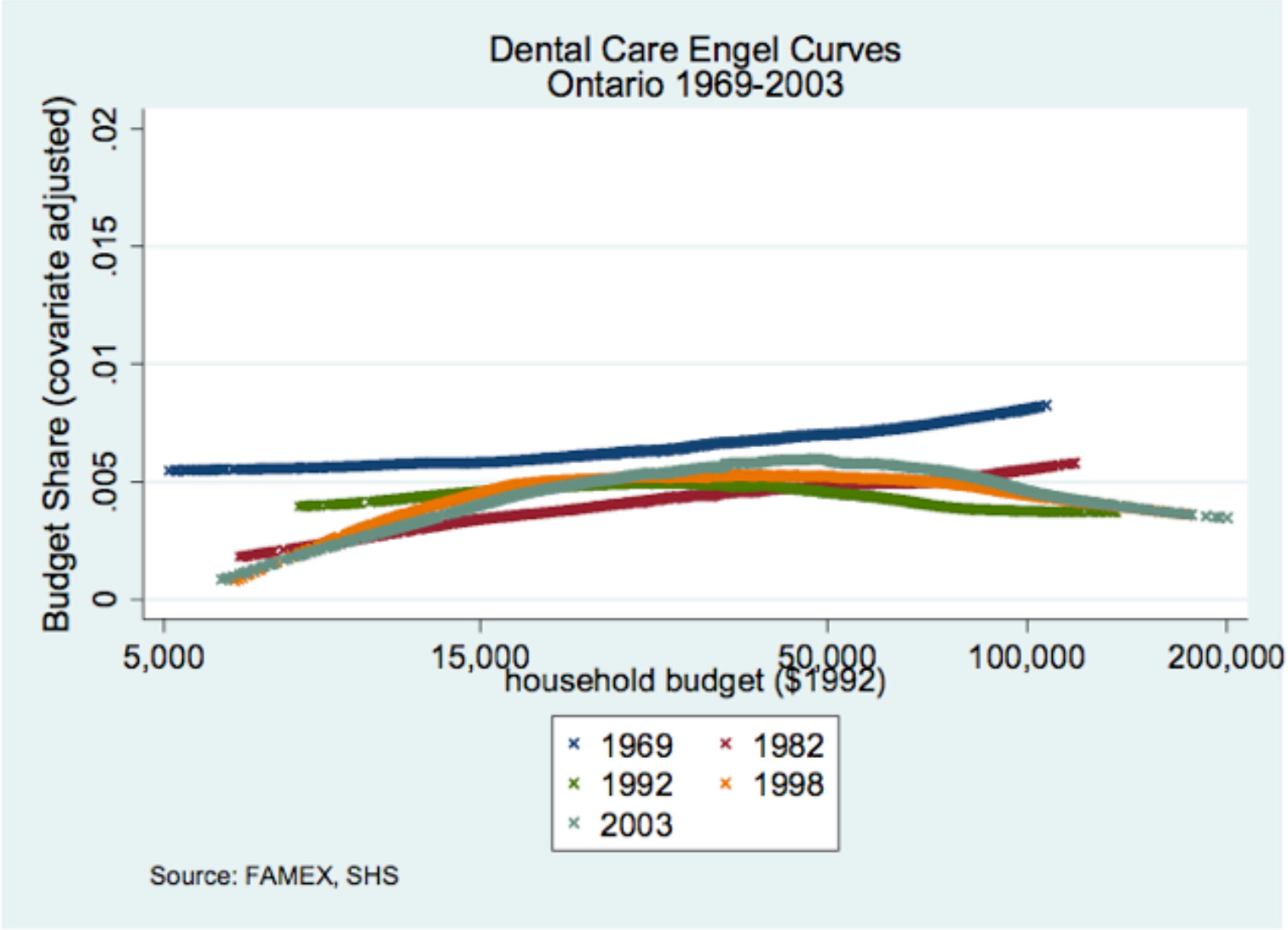


Figure 27. Social assistance expenditures in Ontario 1980/81-2002/03 (constant dollars, '000)

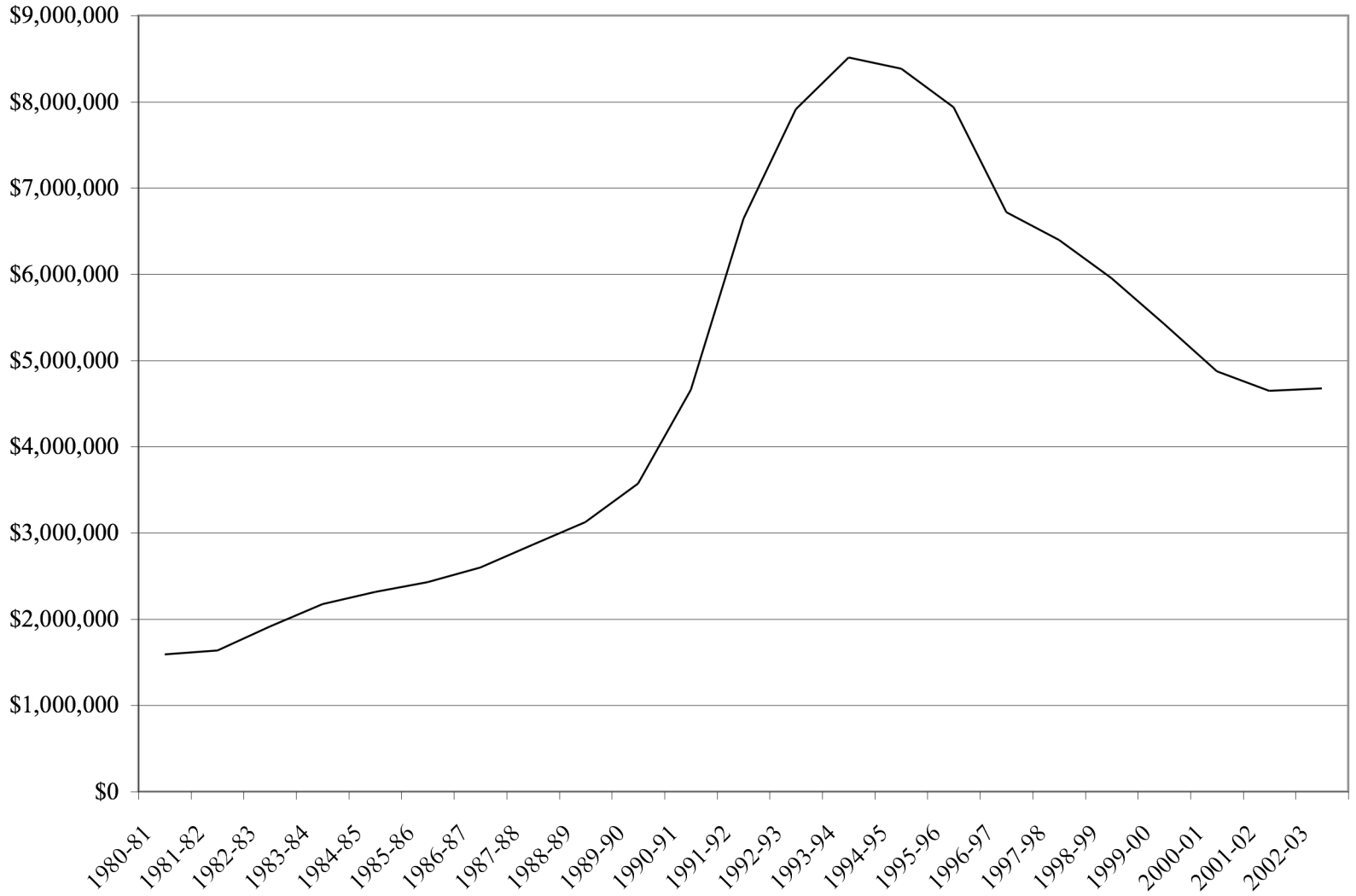


Figure 28. CINOT expenditures, non-social assistance children, 1990-2006

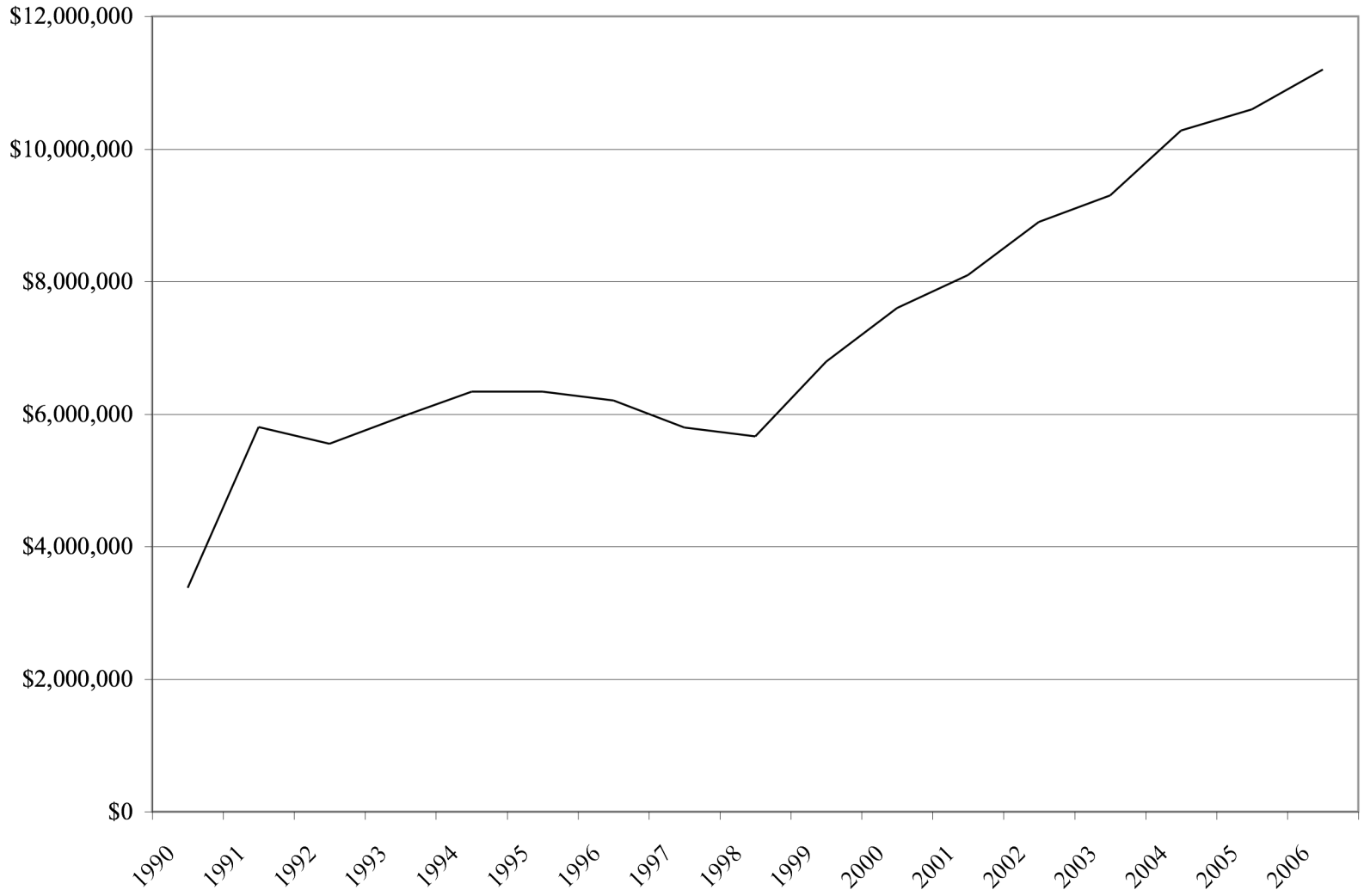


Figure 29. CINOT number of claims or courses of treatment, non-social assistance children, 1990-2005

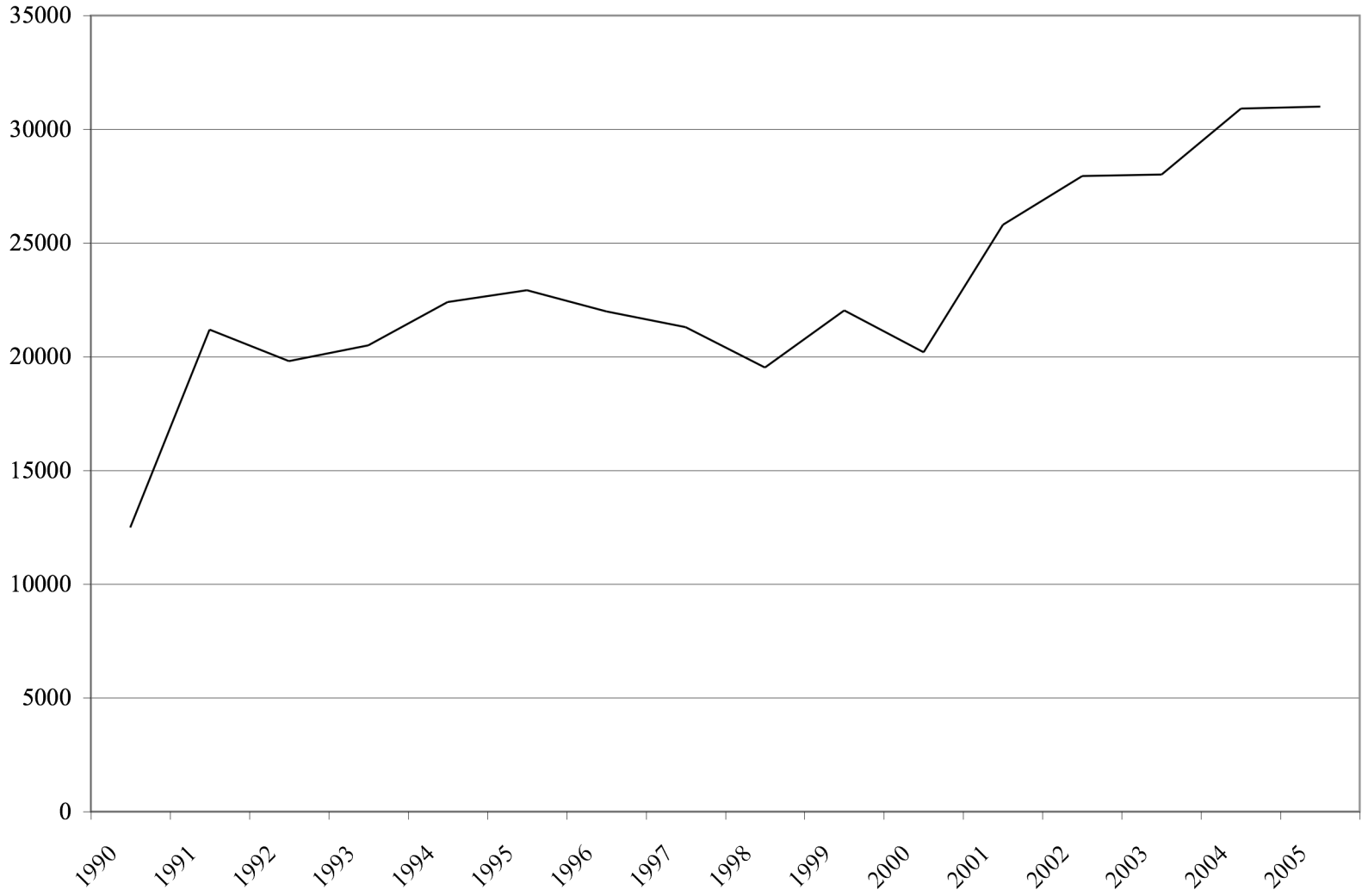


Figure 30. CINOT expenditures, by procedure, 1990-1999

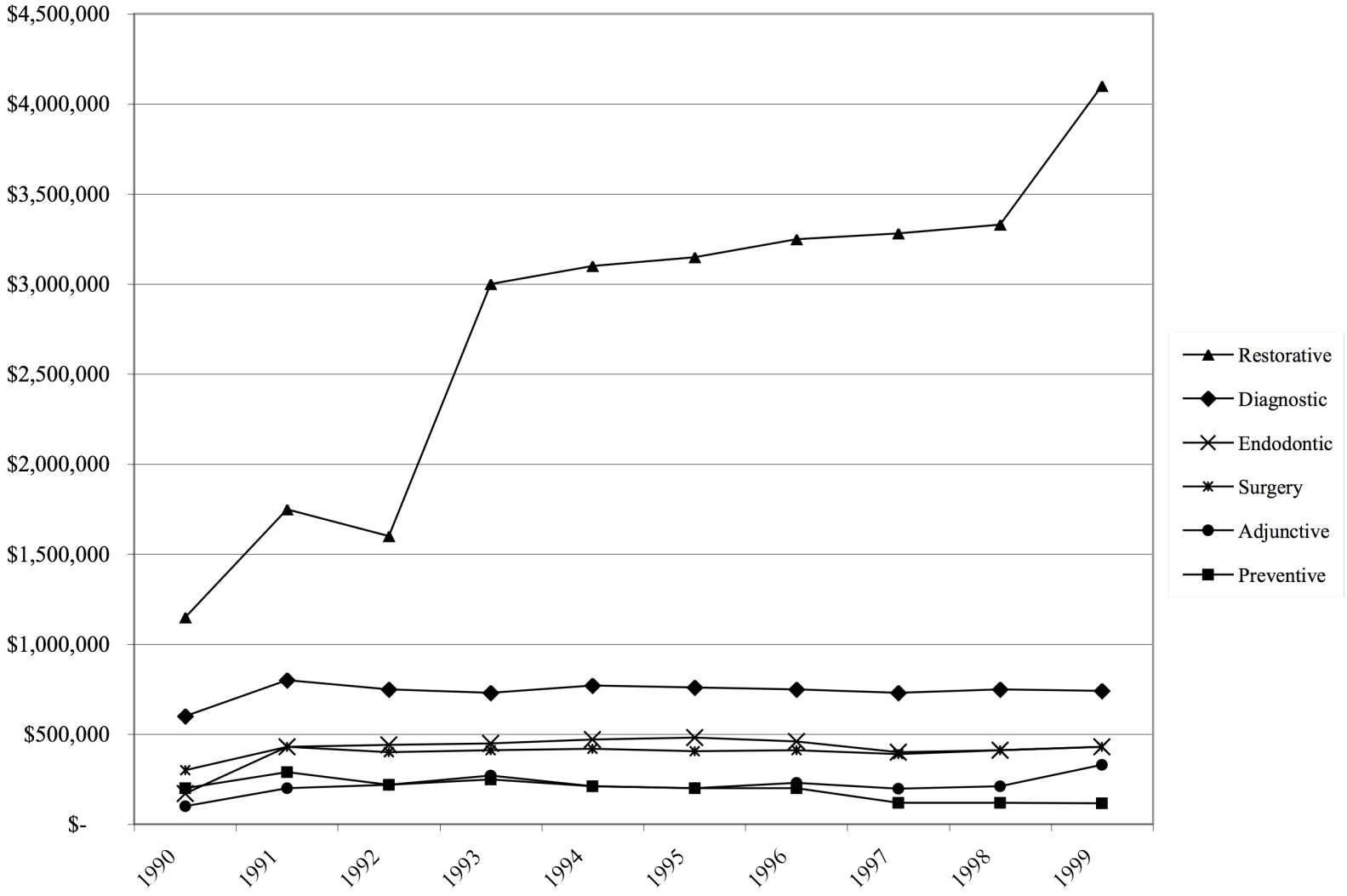


Figure 31. CINOT procedures, by number of procedures paid, 1990-2005

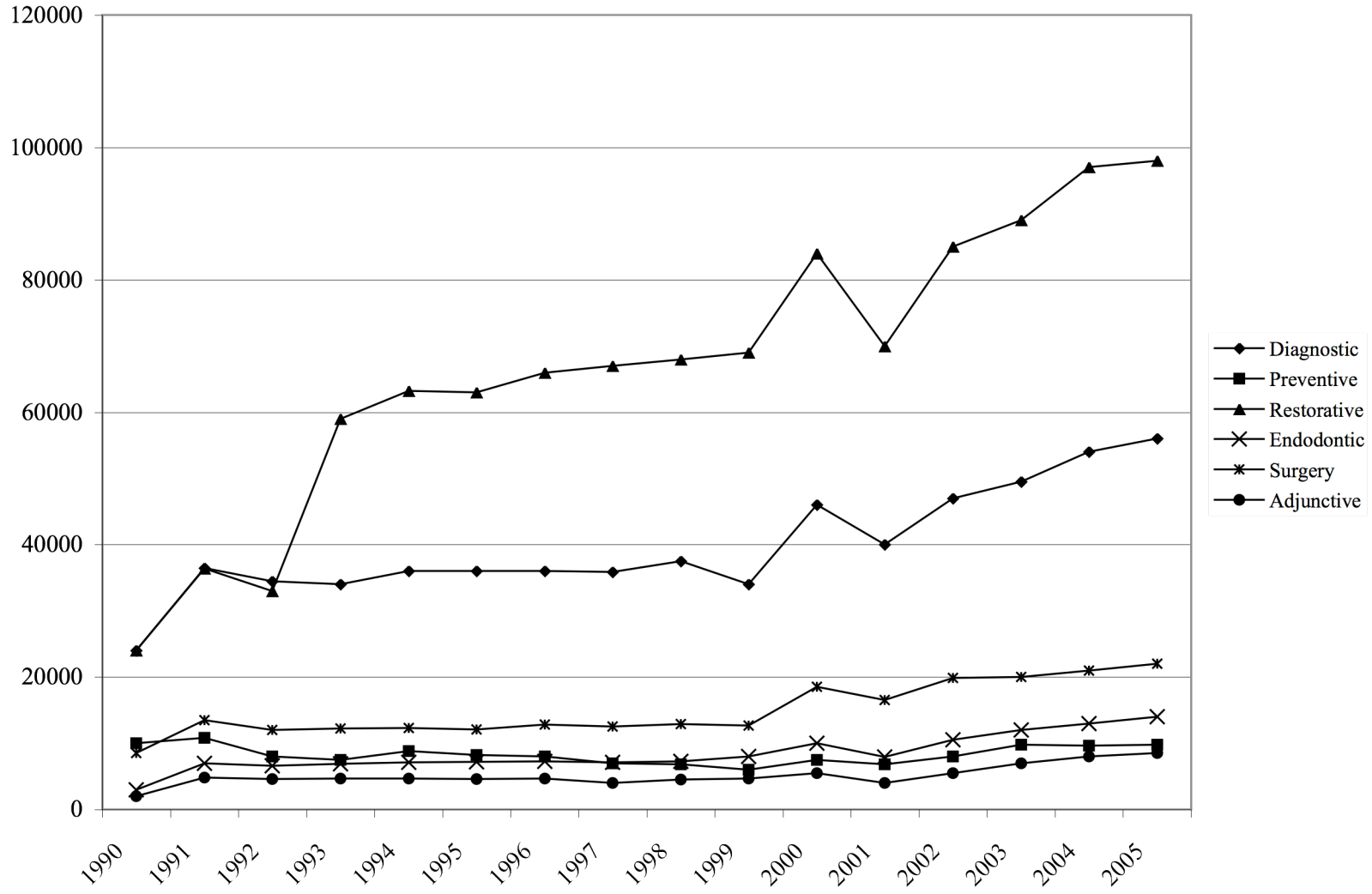


Figure 32. Percentage of 5 and 13 year old Ontario children with no caries history, 1972-1994

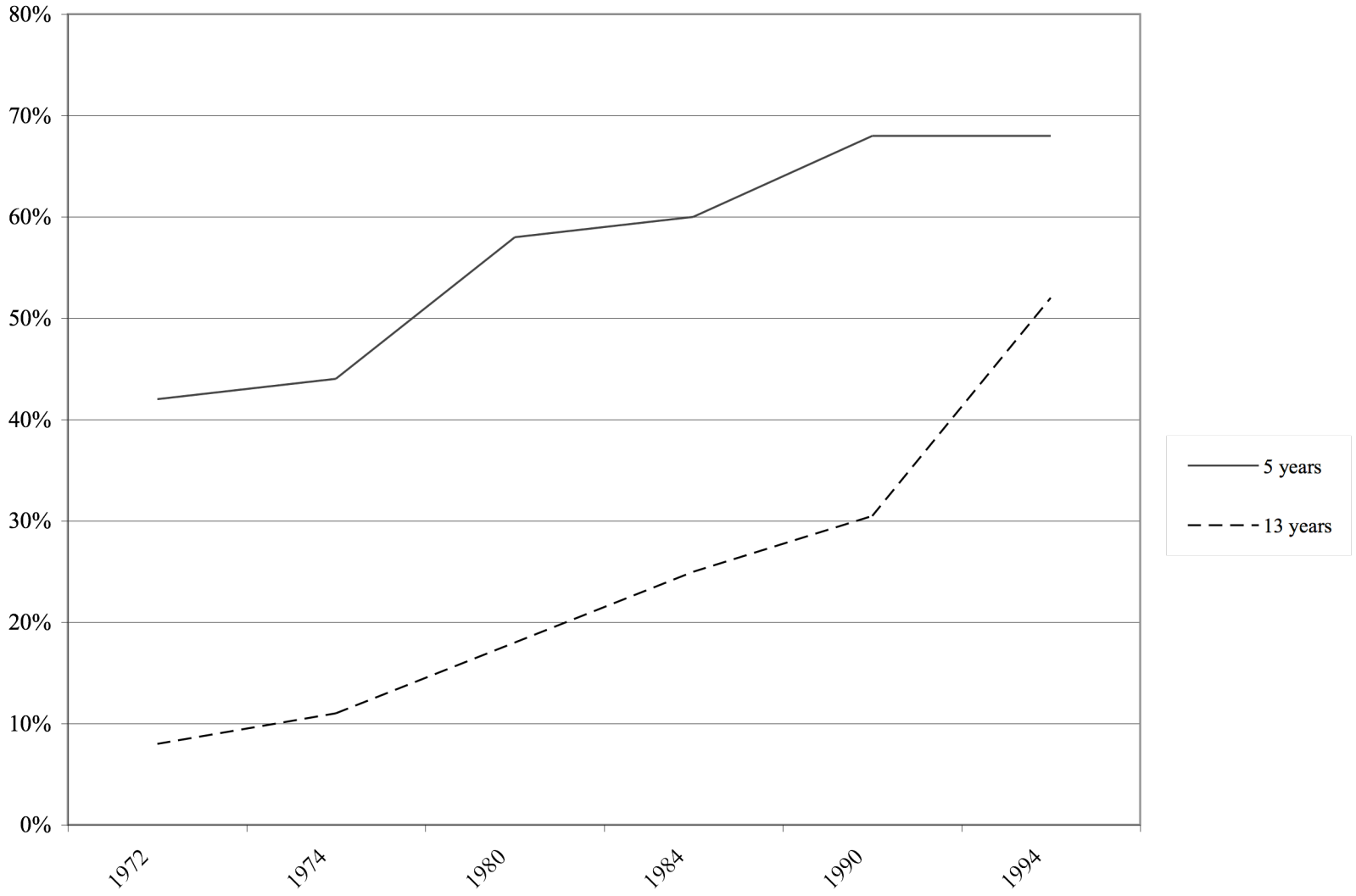


Figure 33. Mean caries scores for 5 and 13 year old Ontario children, 1972-1994

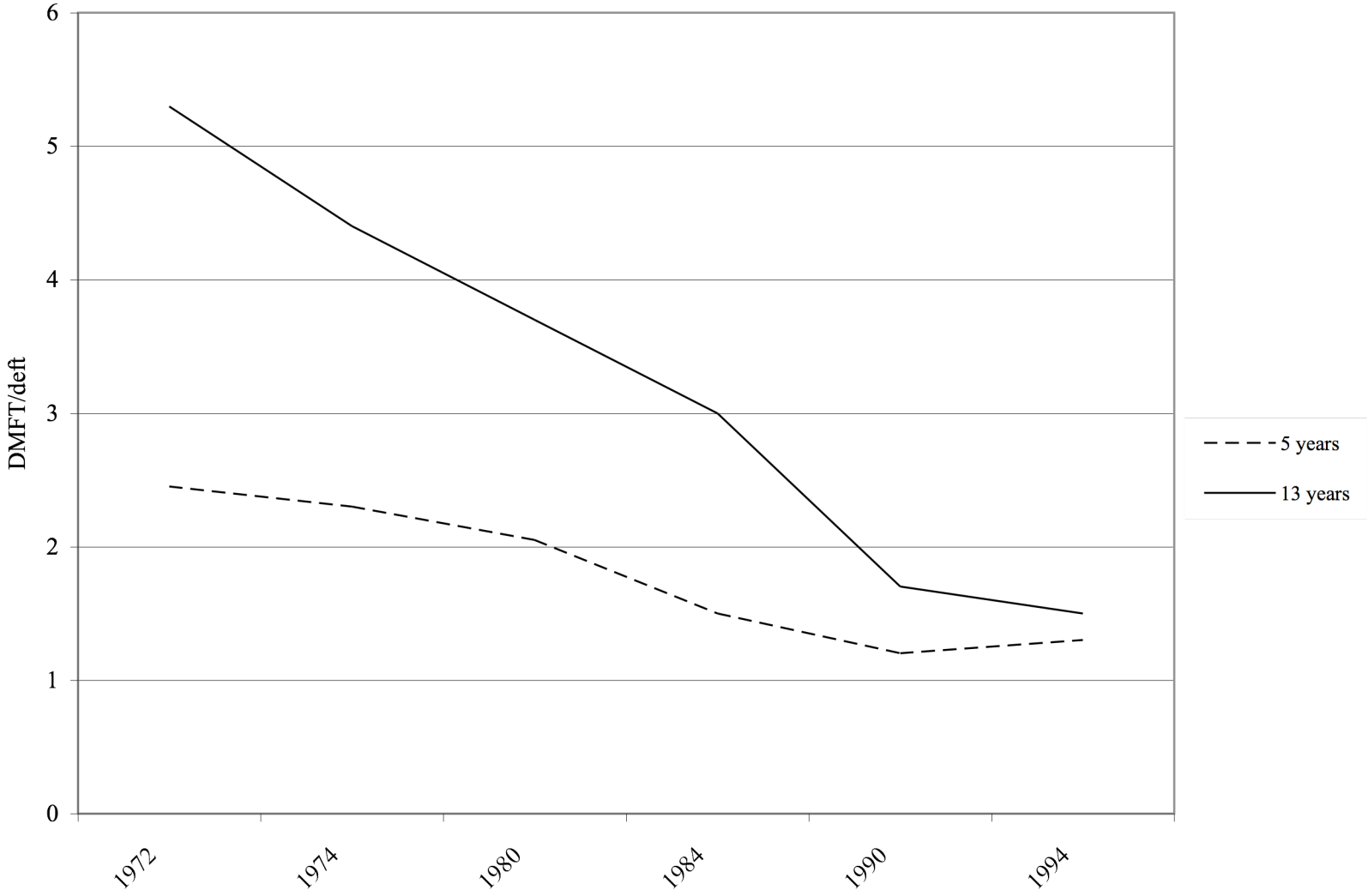


Figure 34. Public per capita dental expenditures in Québec, 1960/65/70, 1975-2005 (constant dollars)

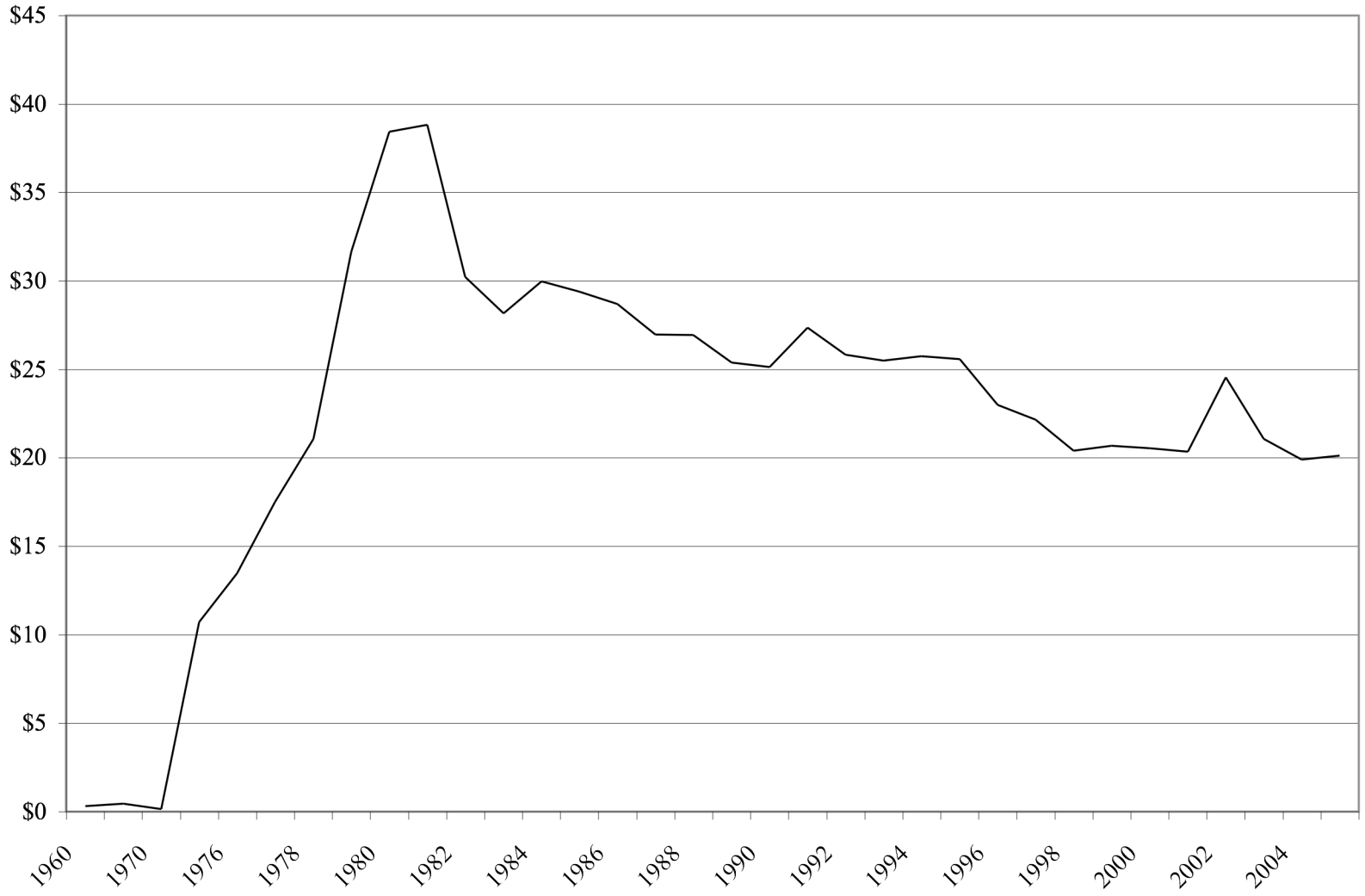


Figure 38. Household budgetary shares for dental care in Québec, 1969-2003 (constant dollars)

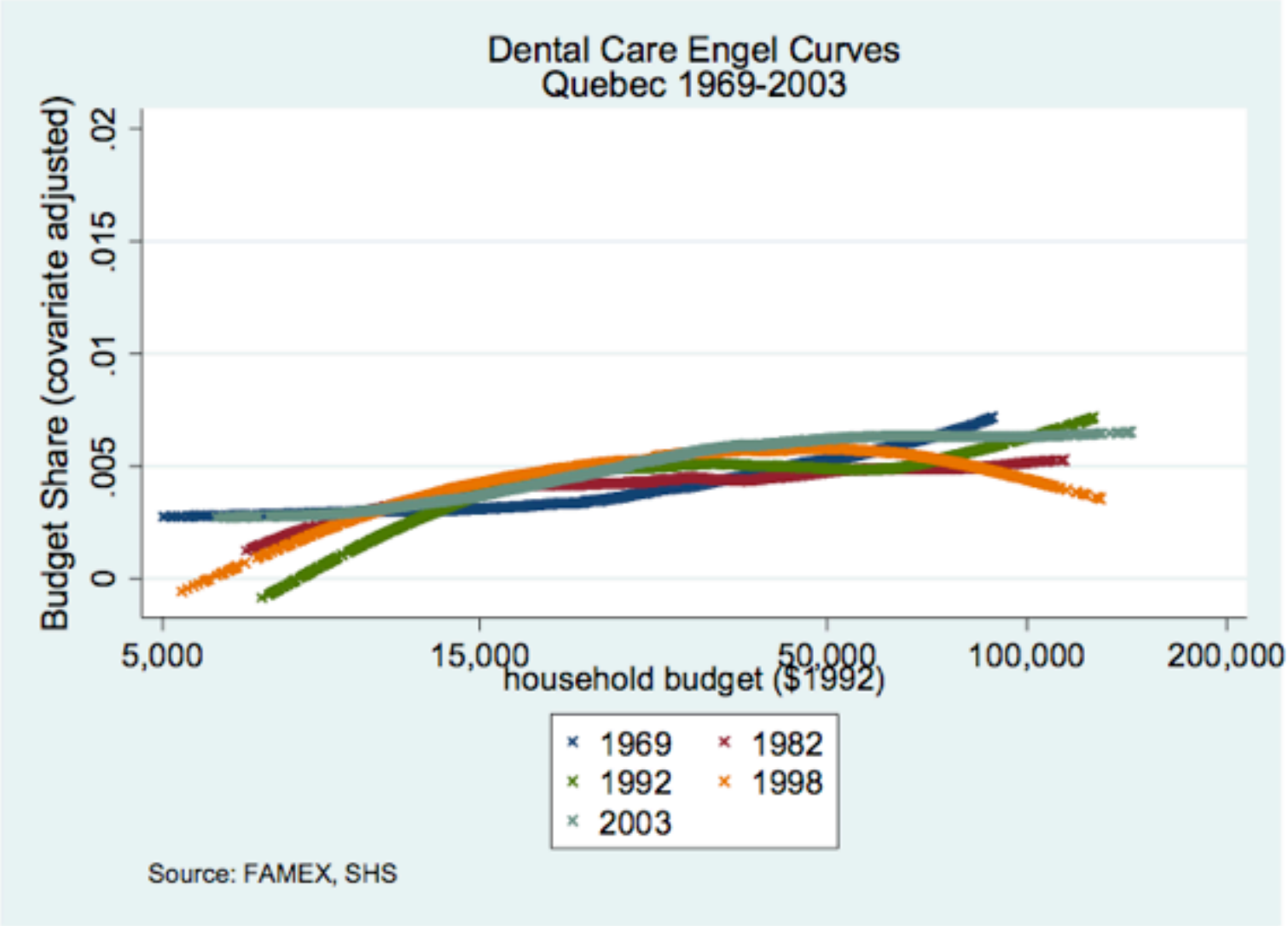


Figure 36. Social assistance expenditures in Québec, 1980/81-2002/03 (constant dollars, '000)

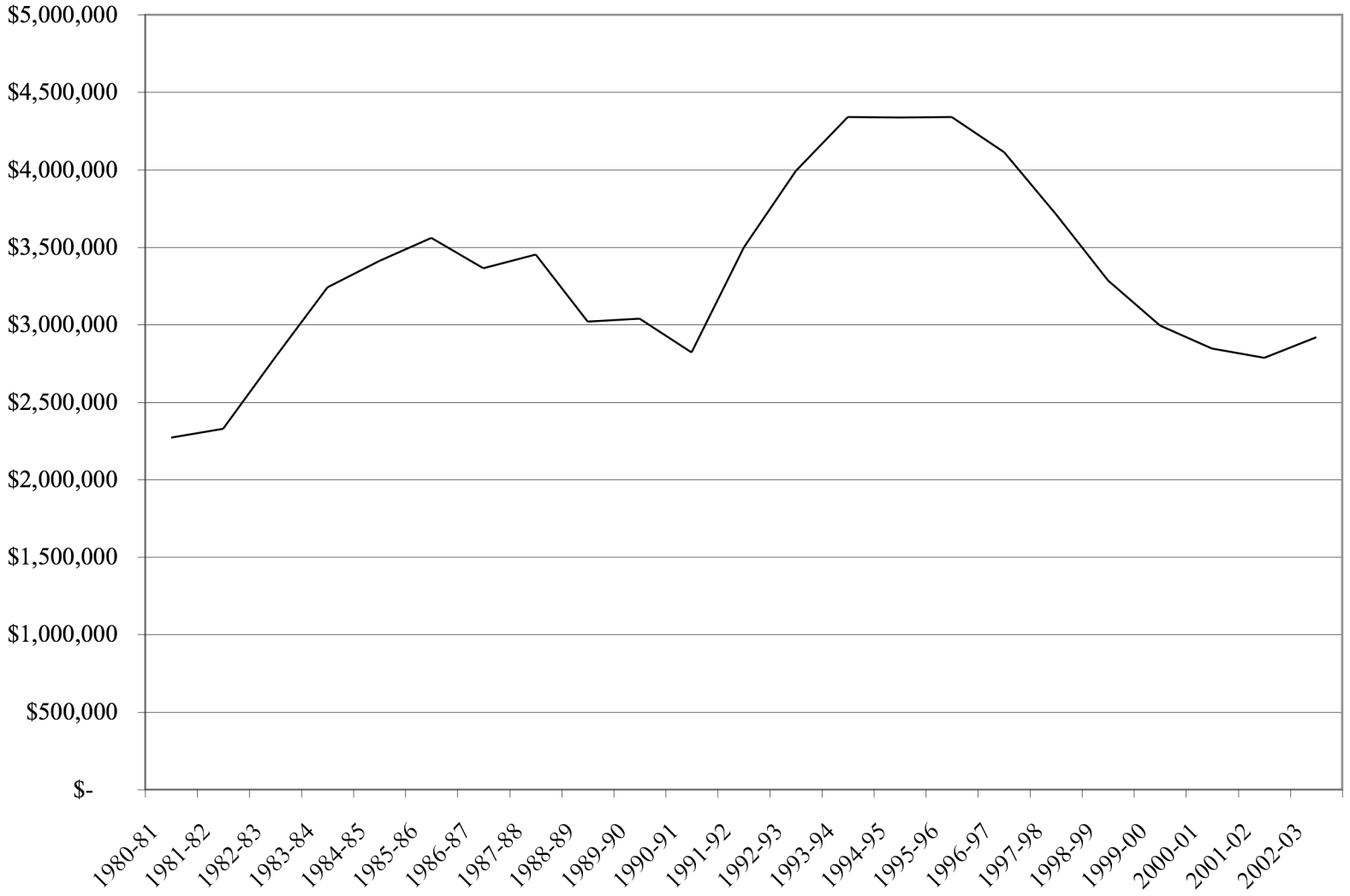


Figure 37. Public per capita dental expenditures in New Brunswick, 1960/65/70, 1975-2005 (constant dollars)

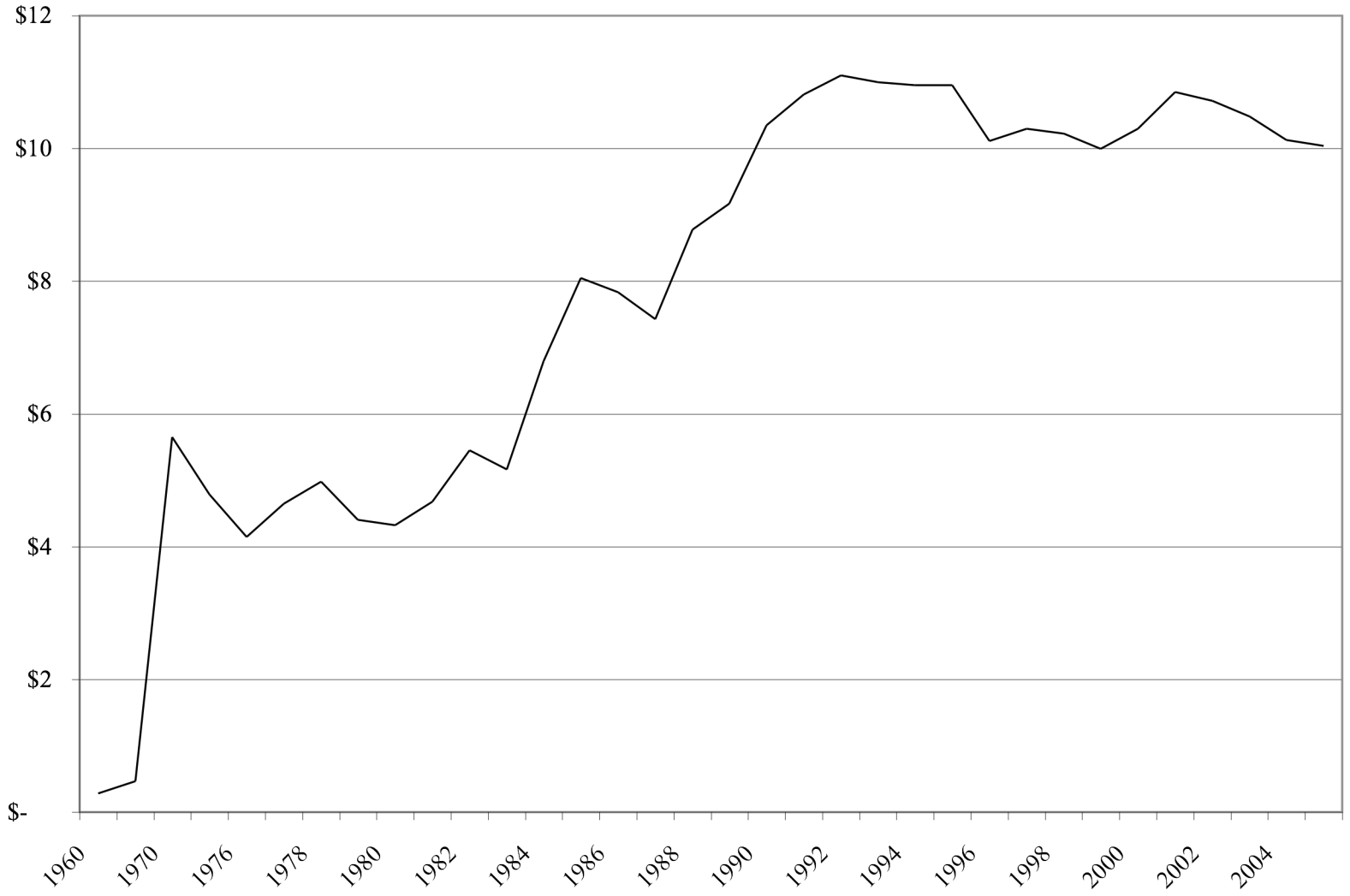


Figure 38. Household budgetary shares for dental care in the Atlantic Provinces, 1969-2003 (constant dollars)

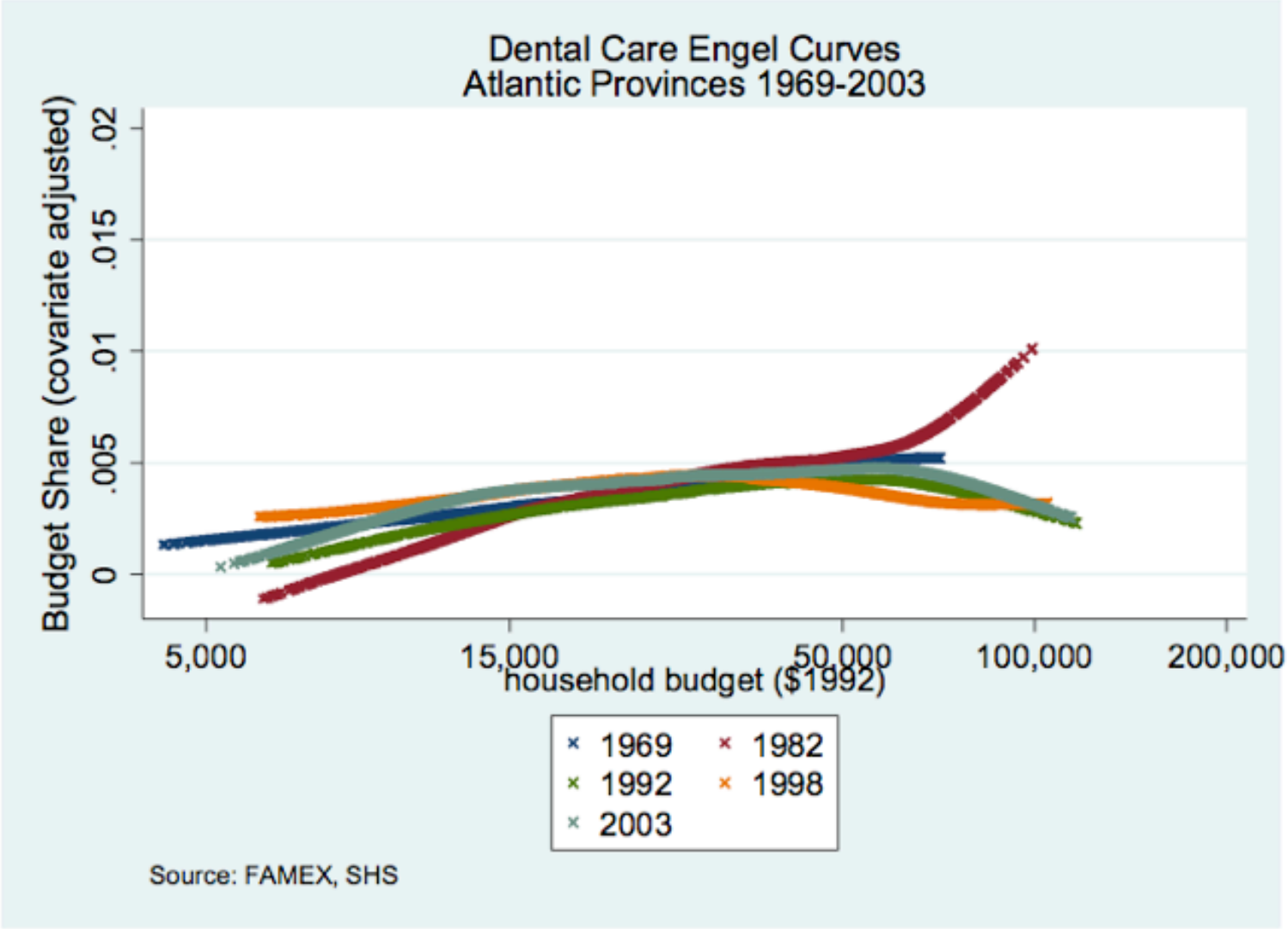


Figure 39. Social assistance expenditures in New Brunswick, 1980/81-2002/03 (constant dollars, '000)

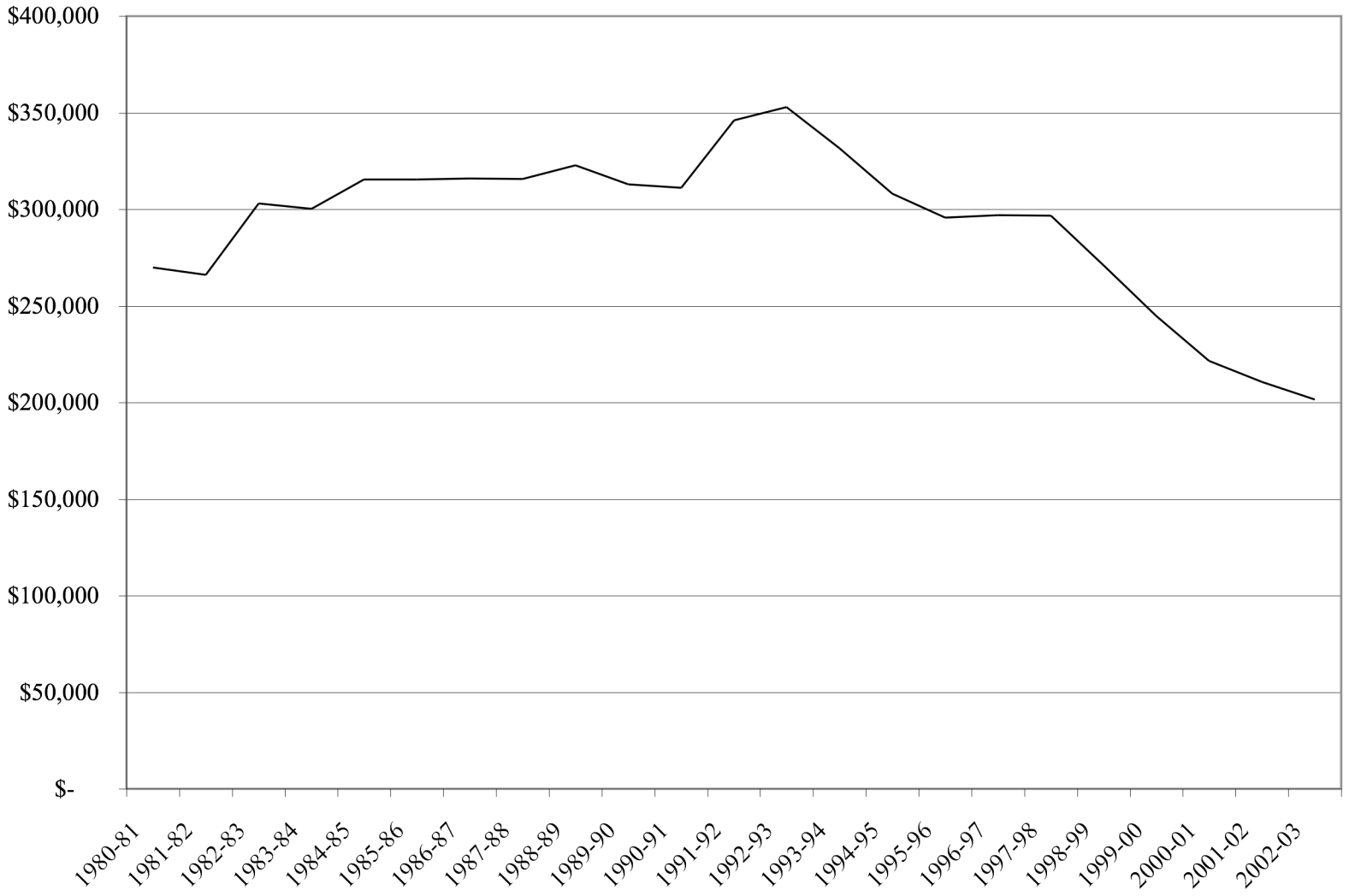


Figure 40. Public per capita dental expenditures in Nova Scotia, 1960/65/70, 1975-2005 (constant dollars)

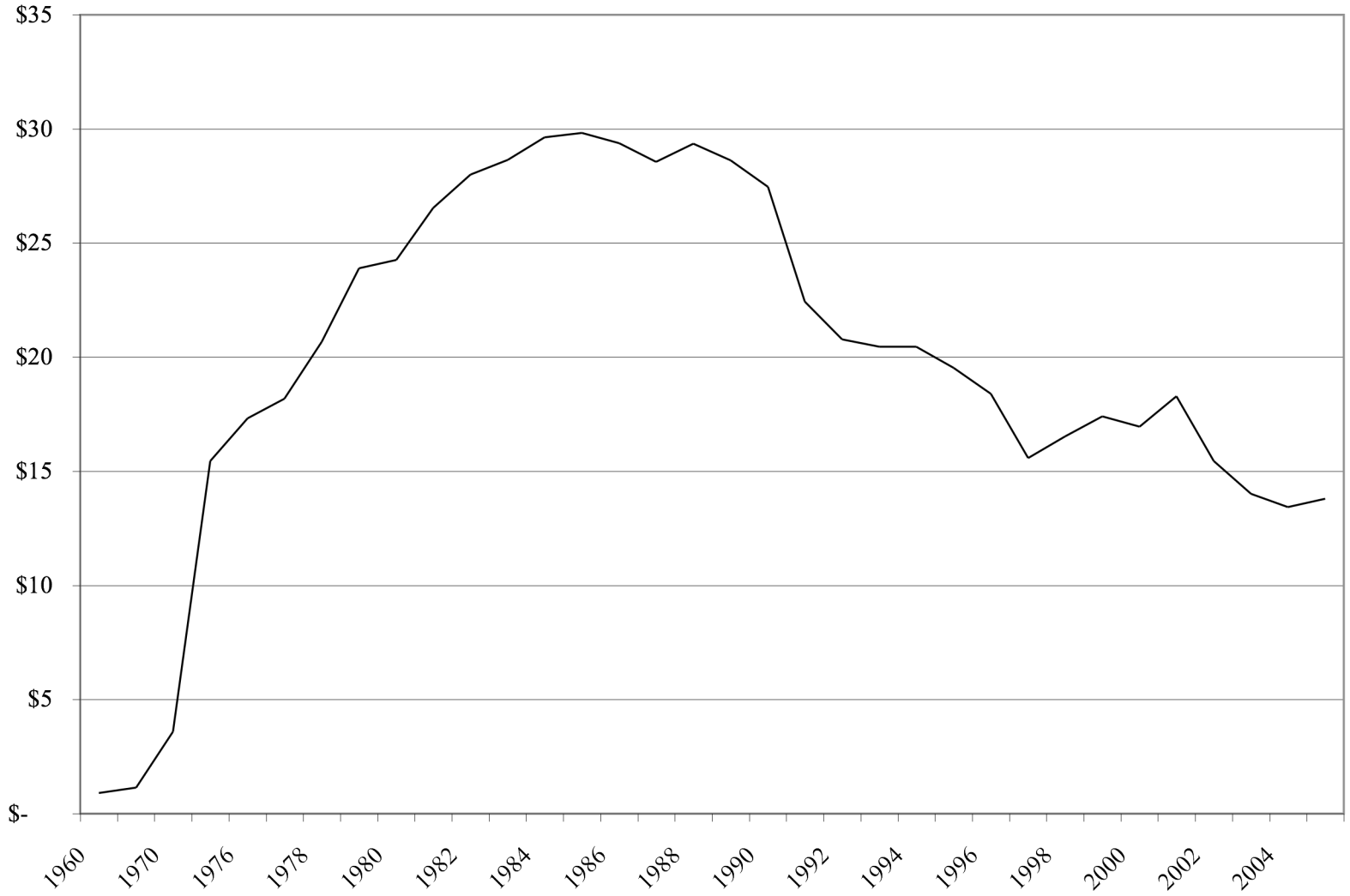


Figure 41. Social assistance expenditures in Nova Scotia, 1980/81-2002/03 (constant dollars, '000)

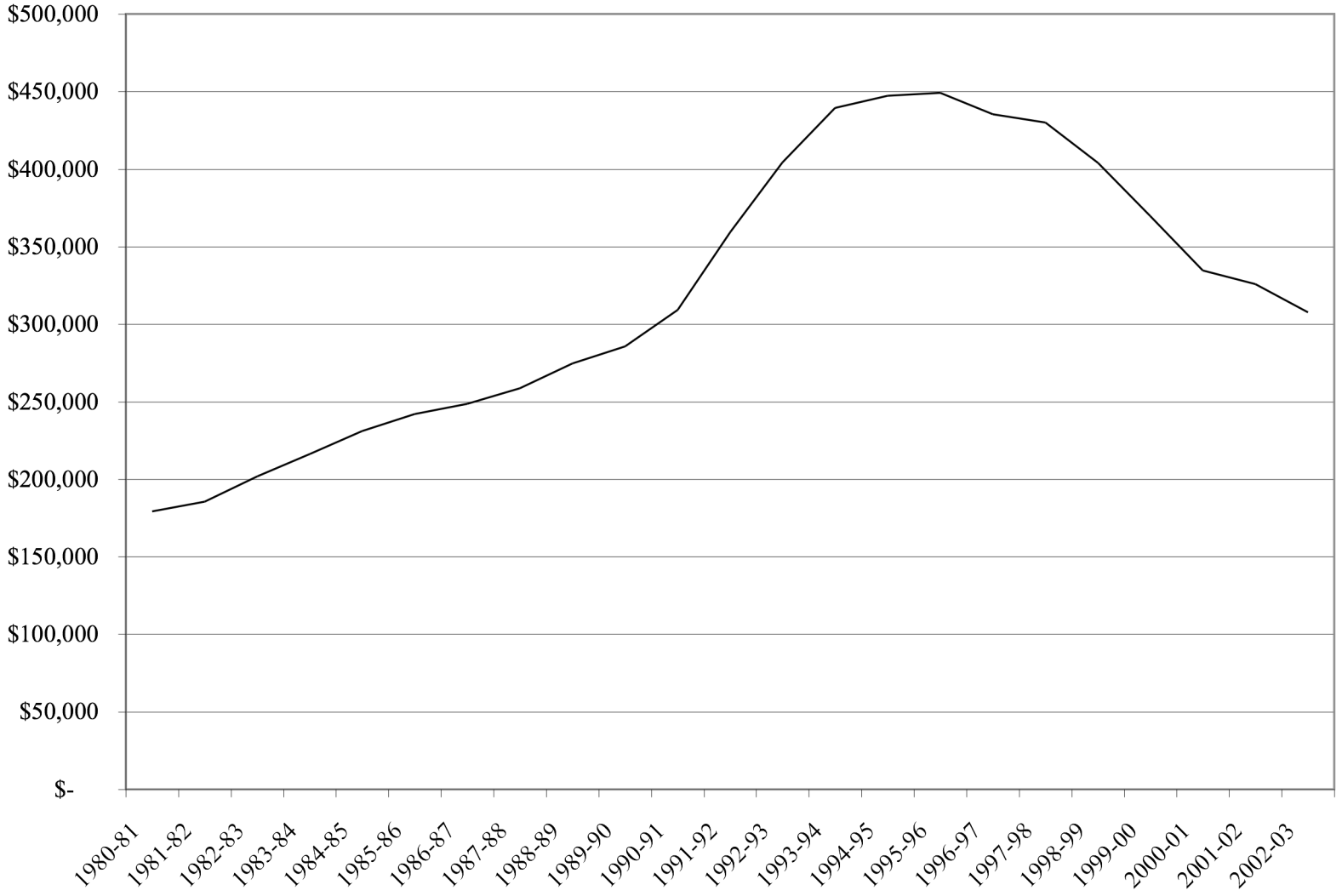


Figure 42. Public per capita dental expenditures in Prince Edward Island, 1960/65/70, 1975-2005 (constant dollars)

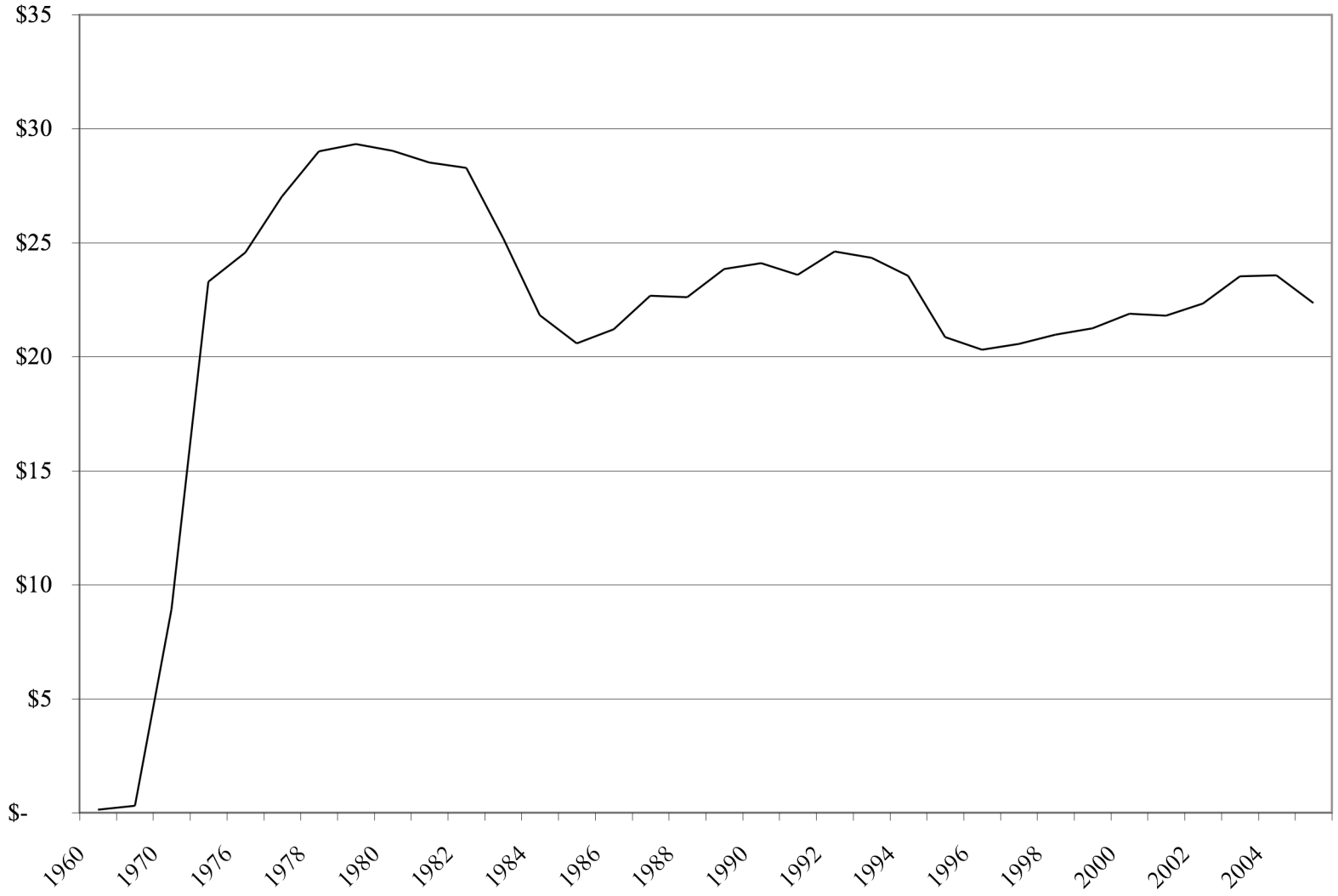


Figure 43. Social assistance expenditures in Prince Edward Island, 1980/81-2002/03 (constant dollars, '000)

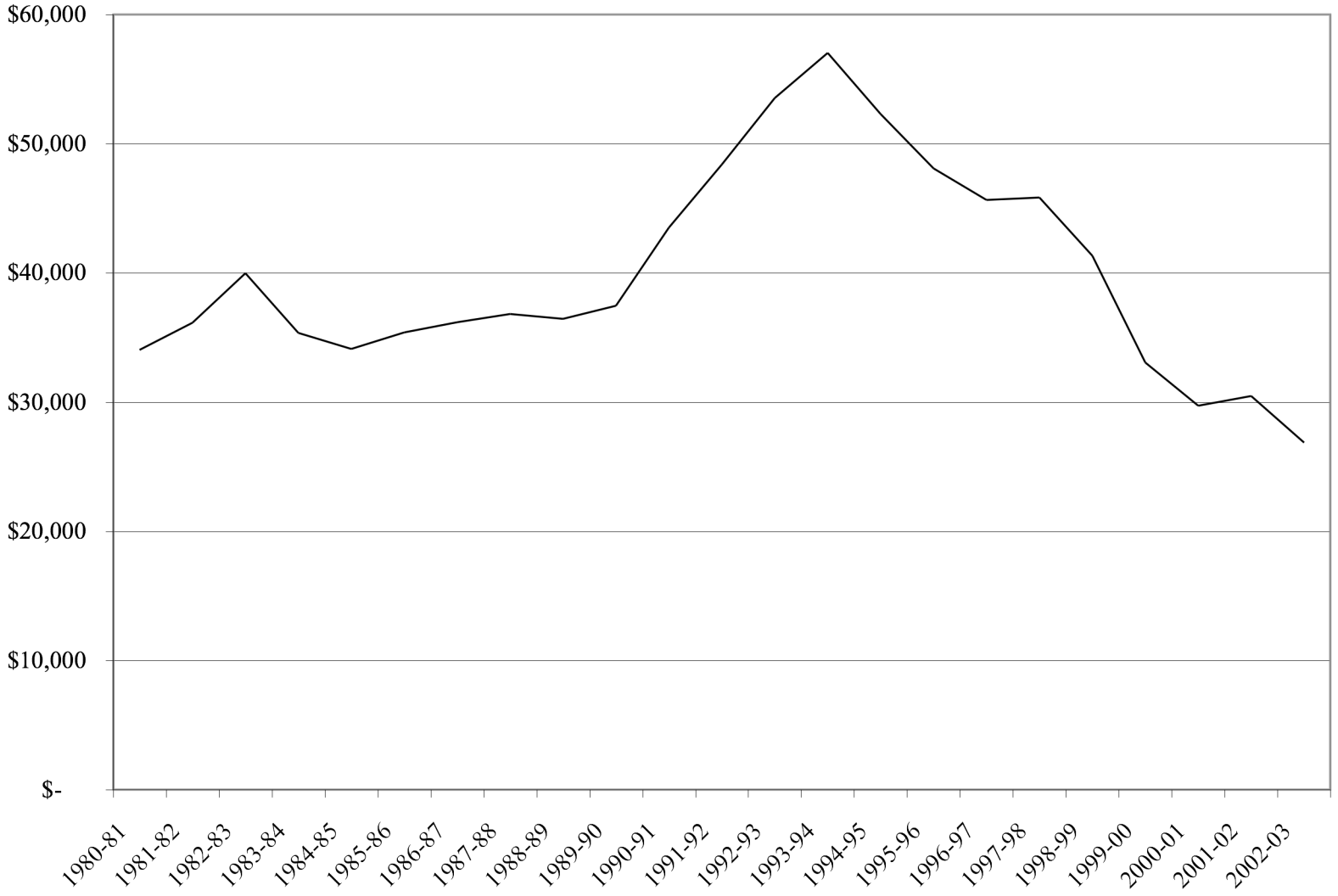


Figure 44. Public per capita dental expenditures in Newfoundland and Labrador, 1960/65/70, 1975-2005 (constant dollars)

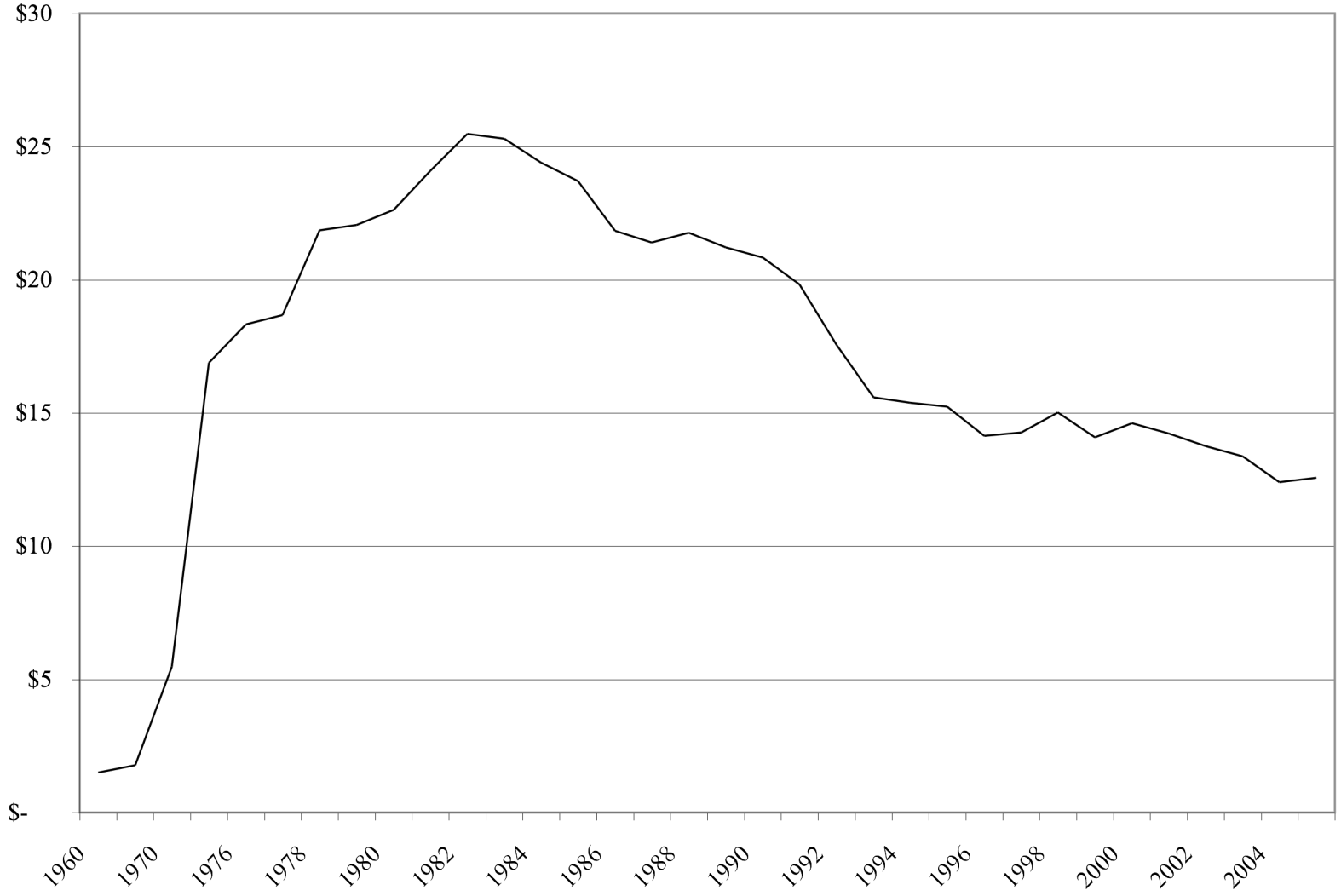


Figure 45. Social assistance expenditures in Newfoundland and Labrador, 1980/81-2002/03 (constant dollars, '000)

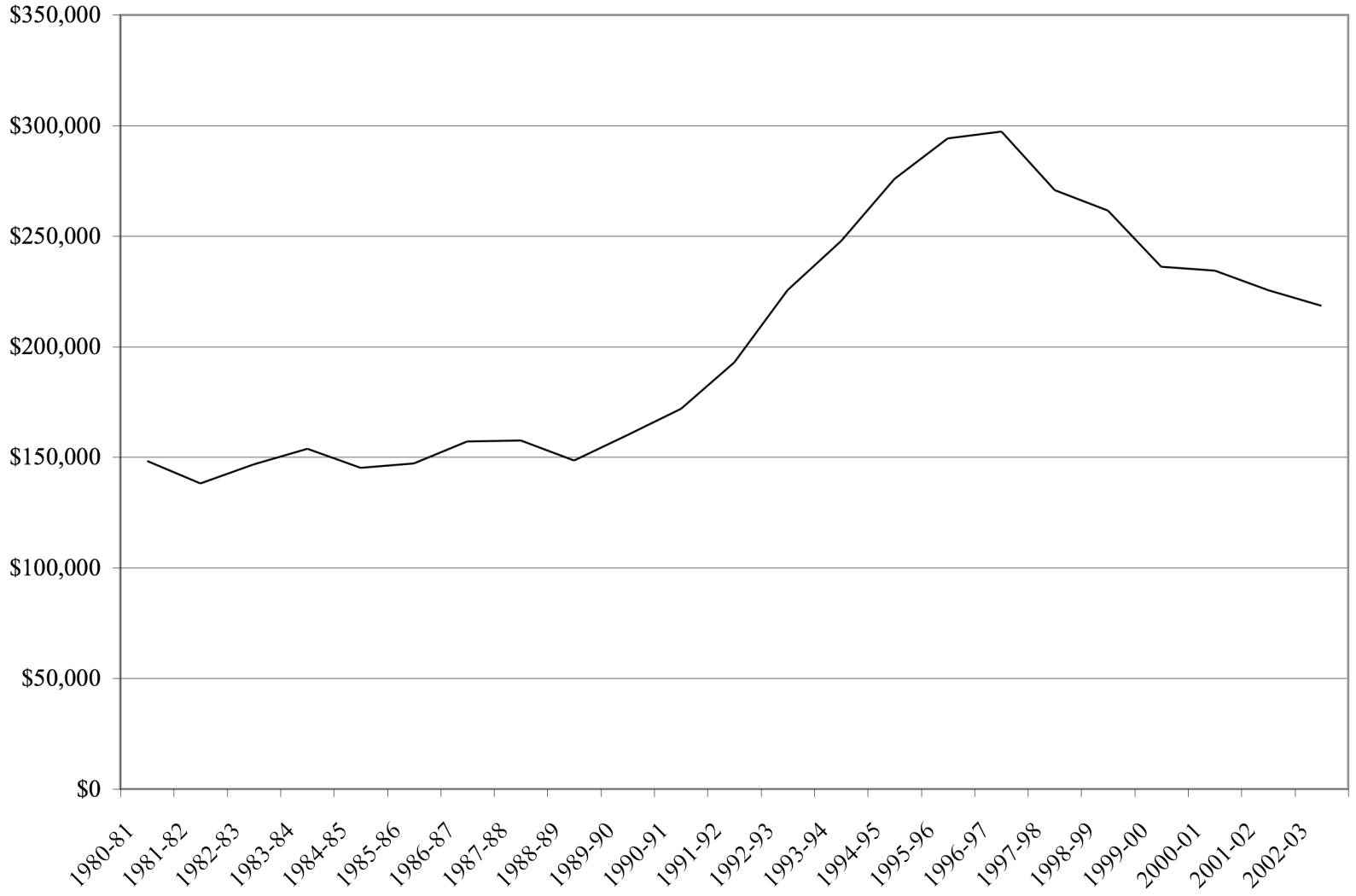


Figure 46. Public per capita dental expenditures in Nunavut, 1999-2005 (constant dollars)

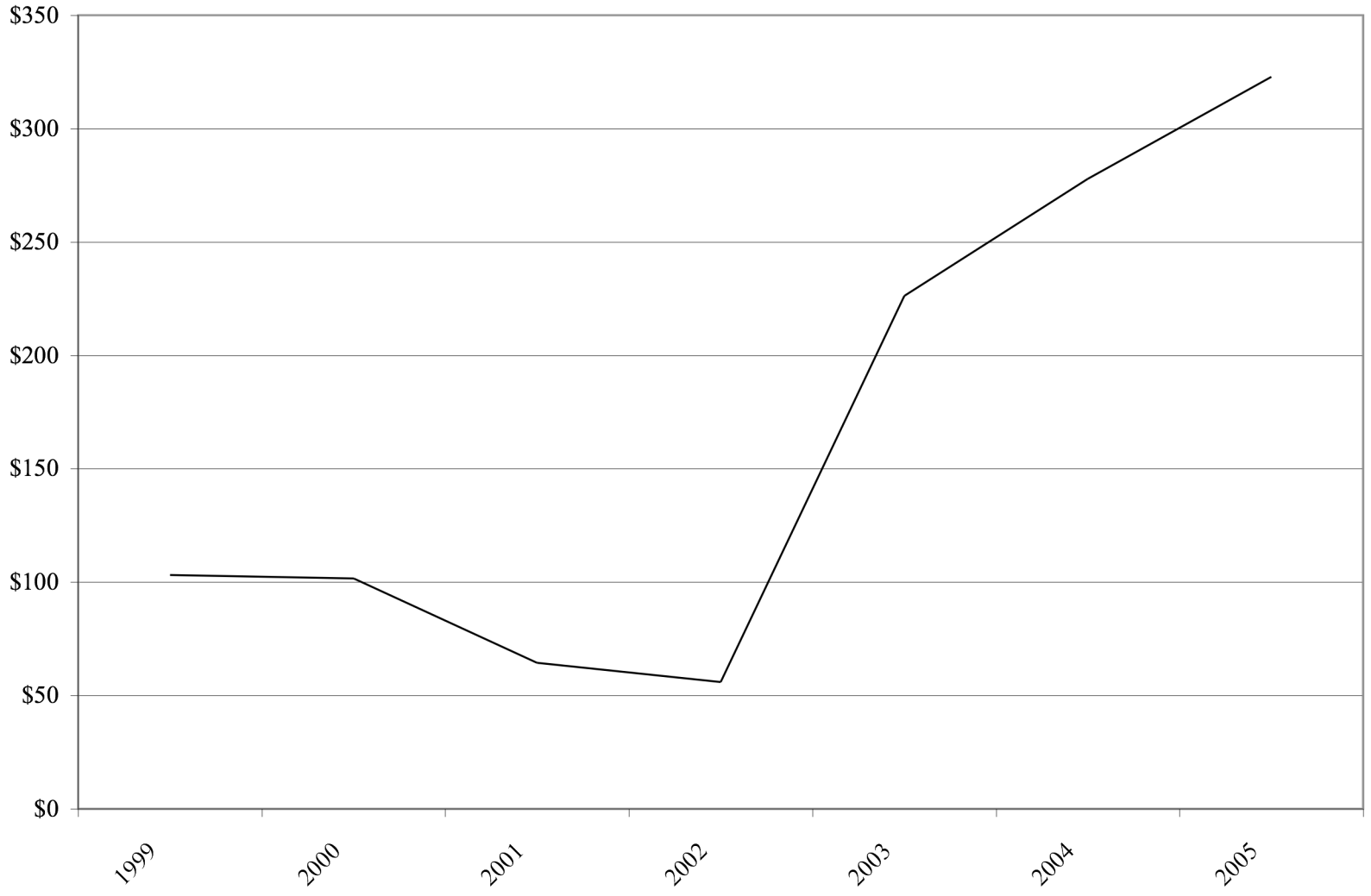


Figure 47. Social assistance expenditures in Nunavut, 1999/00-2002/03 (constant dollars, '000)

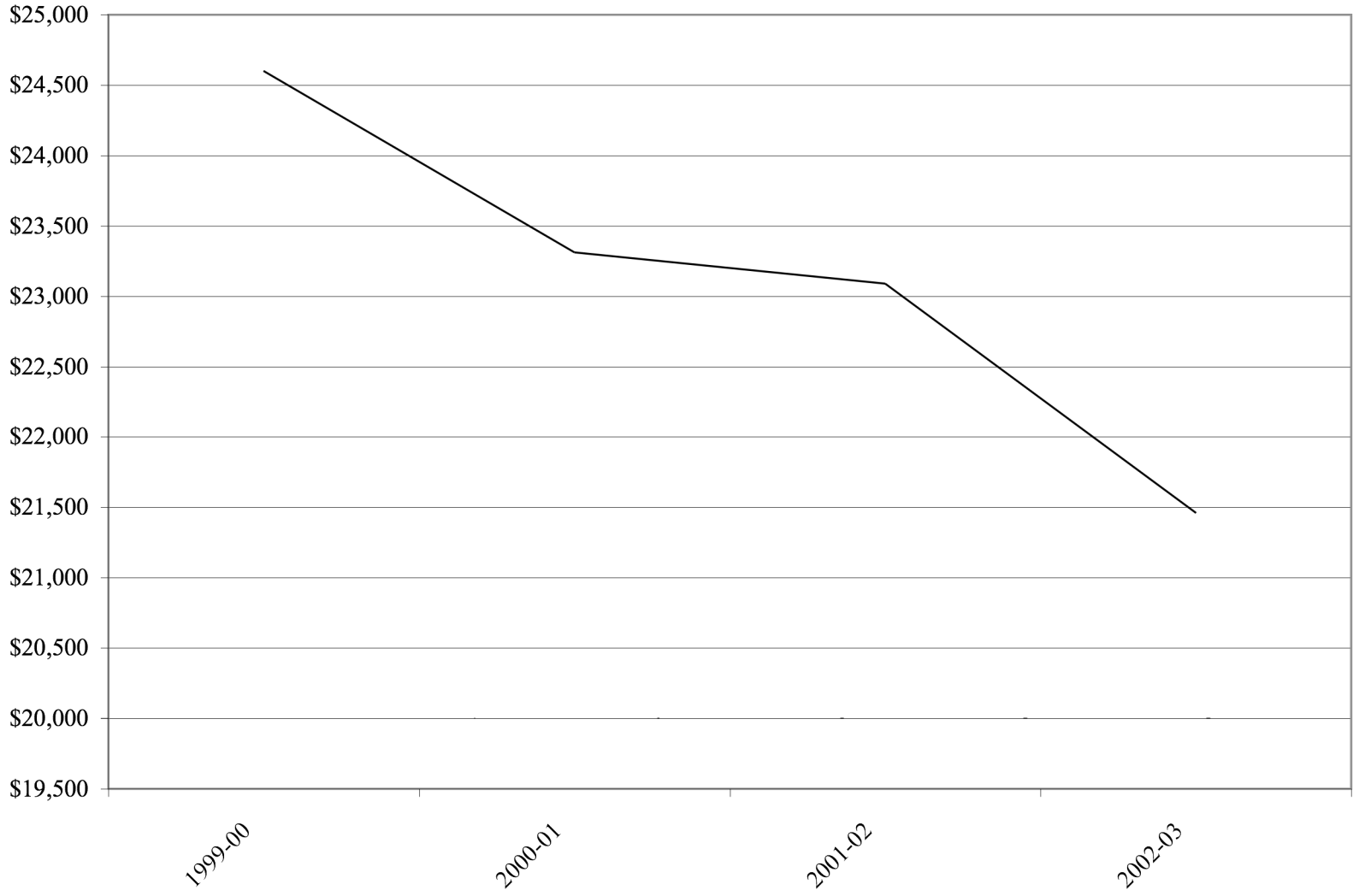


Figure 48. Public per capita dental expenditures in the Northwest Territories, 1975-2005 (constant dollars)

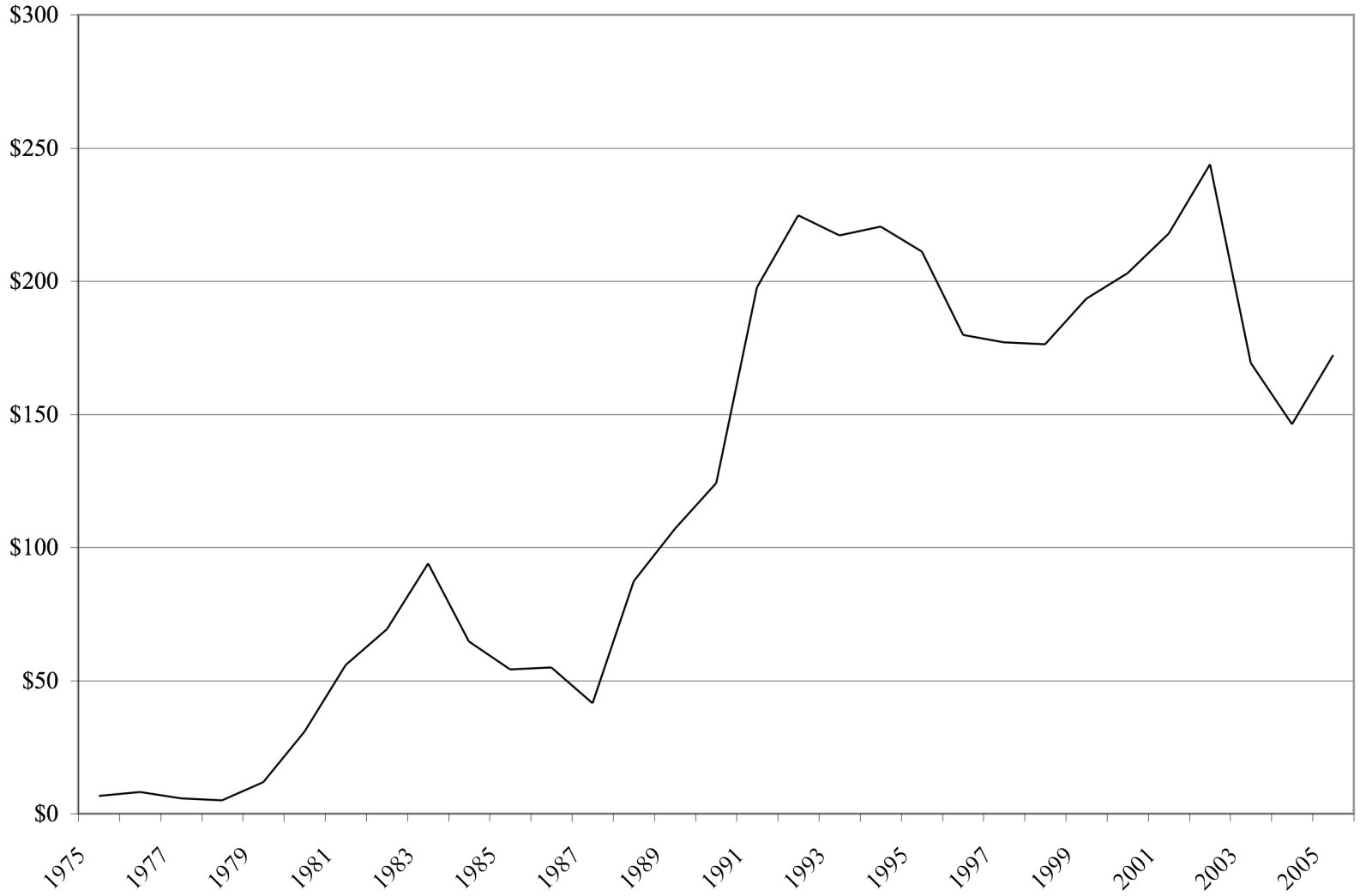


Figure 49. Social assistance expenditures in the Northwest Territories, 1980/81-2002/03 (constant dollars, '000)

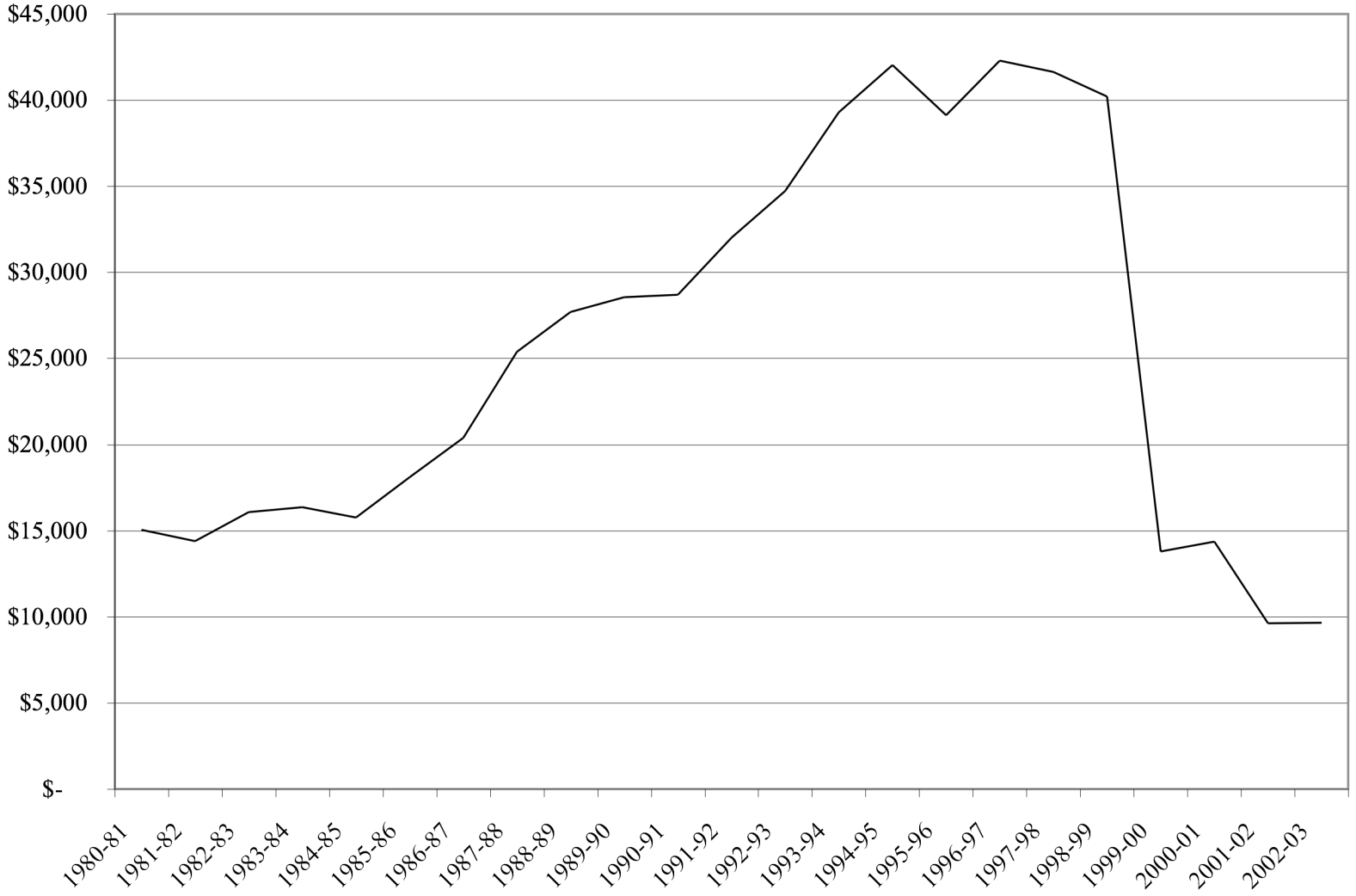


Figure 50. Public per capita dental expenditures in the Yukon Territory, 1975-2005 (constant dollars)

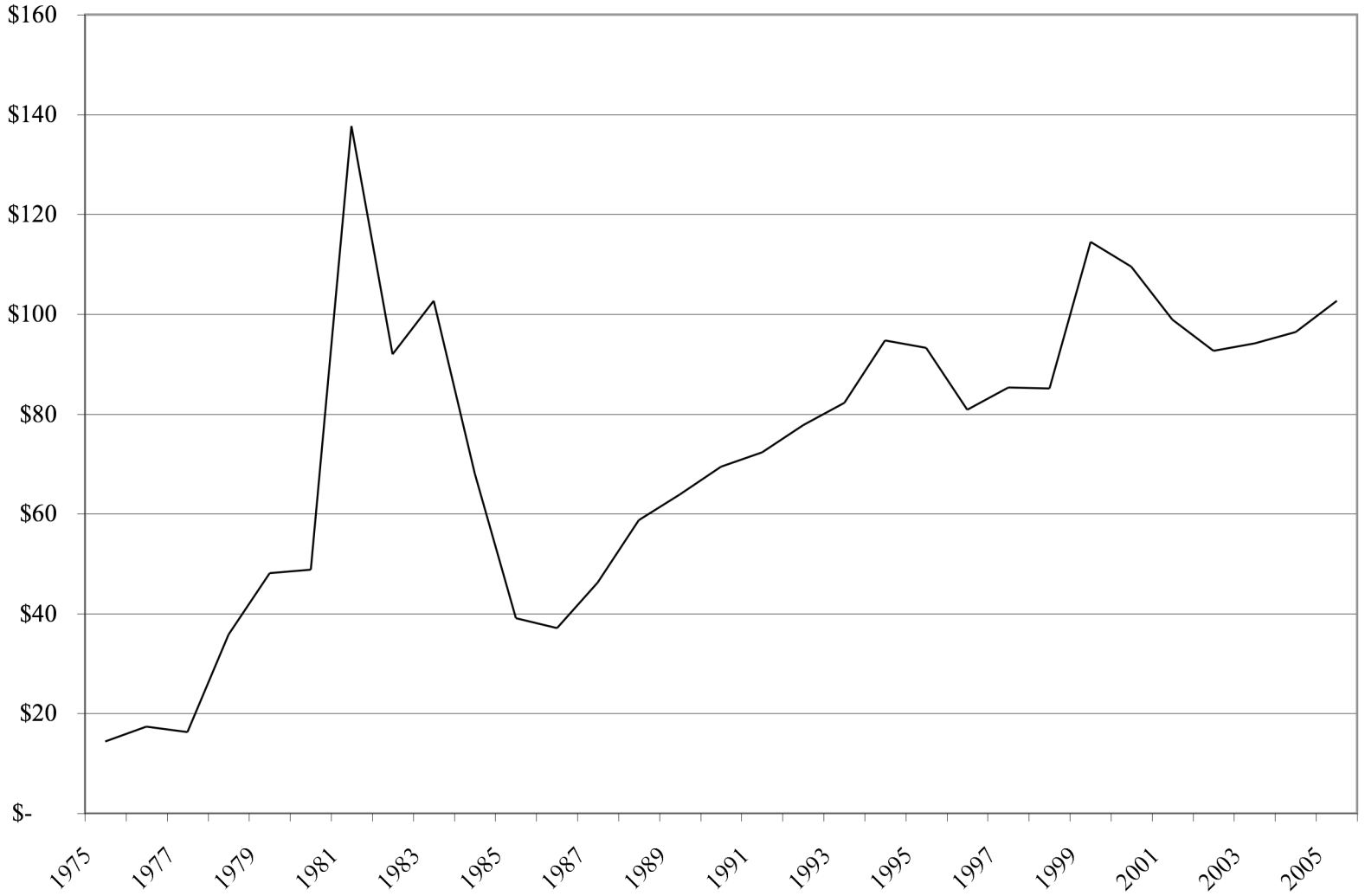
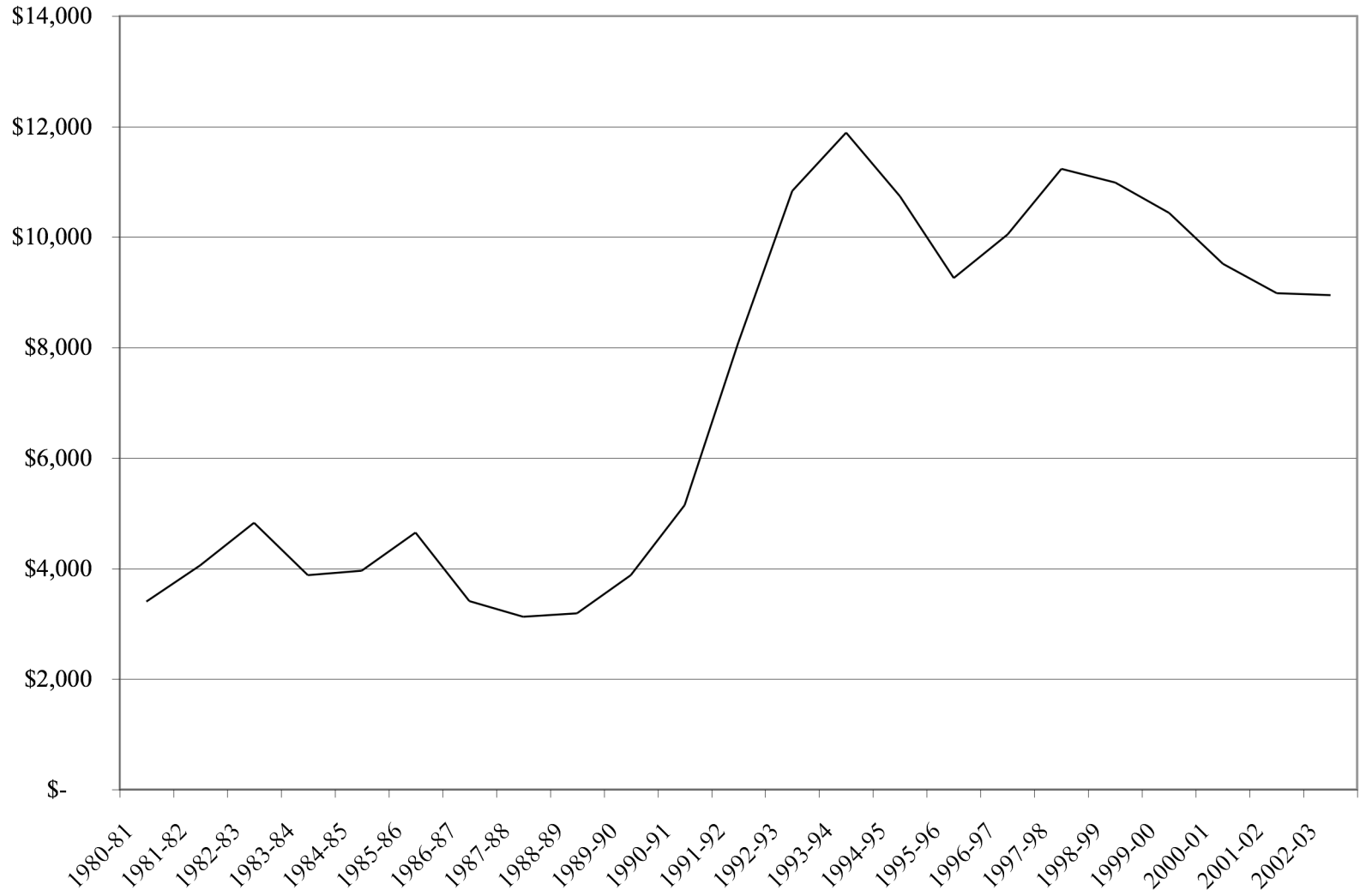


Figure 51. Social assistance expenditures in the Yukon Territory, 1980/81-2002/03 (constant dollars, '000)



References

1. Government of Canada (2005) Chief Dental Officer for Health Canada. News Release, October 28, Ottawa: Government of Canada. http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2005/2005_dent_e.html

2. Ministry of Health Services, Ministry of Human Resources (2005) Enhanced dental program benefits British Columbians. News Release, March 14, 2005HSER0027-000290, Vancouver: Ministry of Health Services, Ministry of Human Resources. http://www2.news.gov.bc.ca/nrm_news_releases/2005HSER0027-000290.htm

3. Manitoba Health (2005) Health Minister announces new initiatives to reduce tooth decay, lower paediatric dental wait times. News Release, November 10, Winnipeg: Manitoba Health. http://www.gov.mb.ca/chc/press/top/2005/11/2005-11-10-02.html

4. Government of Alberta (2004) Enhanced benefits for seniors announced. News Release, August 11, Edmonton: Government of Alberta. http://www.gov.ab.ca/acn/200408/1691214888E74-8CDC-4F8B-A67FA592A32300BB.html

5. Government of Newfoundland and Labrador (2006) Government announces improvements to children's dental program. News Release, August 23, St. John's: Health and Community Services. http://www.releases.gov.nl.ca/releases/2006/health/0823n01.htm

6. Canadian Dental Association (2002) Romanow Report: Where is oral health care? News Release, November 28, Ottawa: CDA.

7. Federal/Provincial/Territorial Dental Directors (2002) Oral health: Its place in a sustainable health care system for Canadians, Brief to the Commission on the Future of Health Care in Canada. Ottawa: FPTDD.

8. Toronto Dental Coalition (2002) Brief to the Commission on the Future of Health Care in Canada. Ottawa: Toronto Dental Coalition.

9. Armstrong RR (2005) Access and care: Towards a national oral health strategy - Report of the symposium. Journal of the Canadian Dental Association 71(1): 19-22.

10. Canadian Dental Hygienists Association (2003) Access angst: A CDHA position paper on access to oral health services. Ottawa: CDHA.

11. United States Surgeon General (2000) Oral health in America: A report of the Surgeon General. Washington: Government of the United States of America.

12. Canadian Institute for Health Information (1998) Economic Burden of Illness. Ottawa: CIHI.

13. Baldota KK and Leake JL (2004) A Macroeconomic Review of Dentistry in Canada in the 1990s. Journal of the Canadian Dental Association 70(9): 604-9.

14. Canadian Institute for Health Information (2005) National Health Expenditure Trends, 1975-2005. Ottawa: CIHI.

15. Leake JL (1984) Expenditures on dental services in Canada, Canadian Provinces and Territories, 1960-80. Journal of the Canadian Dental Association 50(5): 362-8.

16. Northridge M (2002) Reconnecting the Mouth to the Body of Public Health. American Journal of Public Health 92(1): 9.

17. Boggess KA, Lieff S, Murtha AP, Moss K, Beck J, Offenbacher S (2003) Maternal periodontal disease is associated with an increased risk for preeclampsia. Obstetrics & Gynaecology 101(2):227-31.

18. Deliargyris E, Madianos P, Kadoma W, Marron I, Smith S, Beck J, Offenbacher S (2004) Periodontal disease in patients with acute myocardial infarction: prevalence and contribution to elevated C-reactive protein levels. American Heart Journal 147(6): 1005-9.

19. Saremi A, Nelson RG, Tulloch-Reid M, Hanson RL, Sievers ML, Taylor GW, Shlossman M, Bennett PH, Genco R, Knowler WC (2005) Periodontal disease and mortality in type 2 diabetes. Diabetes Care 28(1): 27-32.

20. Locker D, Matear D (2001) Oral disorders, systemic health, well-being, and the quality of life. Community Dental Health Services Research Unit, University of Toronto. http://www.utoronto.ca/dentistry/facultyresearch/dri/cdhsru/health_measurement/7.%20%20No%2017.pdf

21. Stamm JW, Waller M, Lewis DW, and Stoddart GL (1986) Dental programs in Canada: Historical development, current status and future directions. Ottawa: Health and Welfare Canada.

22. Lewis D (1976) An evaluation of the dental effects of water fluoridation, City of Toronto, 1963-1975. City of Toronto: Department of Public Health.

23. Azarphazooh A (2006) Oral health consequences of the cessation of water fluoridation in Toronto. Dental Public Health Practicum Report, Faculty of Dentistry, University of Toronto.

24. Leake JL, Stahl-Quinlan B, Stewart H (2001) Report of the sample survey of the oral health of Toronto children aged 5, 7, and 13. Toronto: Toronto Public Health.

25. Saskatchewan Indian Federated College, National School of Dental Therapy (2000) Report on the 1996–7 Oral Health Survey of First Nation and Inuit Children in Canada Aged 6 and 12. Ottawa: Health Canada.

26. Statistics Canada (1951) Canadian Sickness Survey, 1950-51. Ottawa: Statistics Canada.

27. Statistics Canada (2003) Canadian Community Heath Survey. Ottawa: Health Division, Health Reports.

28. Canadian Dental Association (1962) A brief submitted to the Commission on Health Services. Ottawa: Canadian Dental Association.

29. Main PA (1995) Dental public health programs in Canada 1995: cross Canada dental check up. Canadian Journal of Community Dentistry 10(1): 12-5.

30. O'Keefe JP (1998) Public dental programs in Canada: a project update. Canadian Journal of Community Dentistry 13(2): 15-6.

31. Bennett S, Leake J (1999) Canada's publicly-funded dental programs. Canadian Journal of Community Dentistry 14(1): 33-44.

32. Bennett S, Leake J (2000) Canada's publicly-funded dental programs (addendum). Canadian Journal of Community Dentistry 15(1): 11-3.

33. Gullet DW (1971) A history of dentistry in Canada. Toronto: University of Toronto Press.

34. Adams TL (2000) A dentist and a gentlemen: Gender and the rise of dentistry in Ontario. Toronto: University of Toronto Press.

35. Davis P (1980) The social context of dentistry. London: Croom Helm Ltd.

36. Nettleton S (1992) Power, pain & dentistry. Buckingham: Open Univeristy Press.

37. Picard A (2004) Making the American mouth: dental professionalisation, dental public health, and the construction of identity in the 20th century United States. Ann Arbour: Unpublished Doctoral Thesis, Department of History, University of Michigan.

38. Sutherland N (1972) To create a strong and healthy race: School children in the public health movement, 1880-1914. History of Education Quarterly 12 (3): 304-333.

39. Dalhousie University Archives (1882-1966) The archives of the Halifax Visiting Dispensary, collection number: MS-13-84. http://www.library.dal.ca/archives/MS13/MS-13-84.htm

40. Notman W (1927) Junior League, dentist's examining room, Montreal, QC, Wm. Notman & Son 1927, 20th century, Silver salts on film - Gelatin silver process, 20 x 25 cm. Purchase from Associated Screen News Ltd. VIEW-24218 © McCord Museum.

41. Government of Canada (1967) A survey of dental public health within the dental profession and within public health agencies including those of government. Ottawa: Department of National Health and Welfare: Government of Canada.

42. Bouillon C (1964) Dental public health in Montreal, 1944-1963. Canadian Journal of Public Health 55: 75-9.

43. Rhodes AJ (1964) Recent revisions in basic and advanced courses in public health offered in Toronto. Canadian Journal of Public Health 55:435-44.

44. Zacherl W (1965) Trends in dental public health. Canadian Journal of Public Health 56: 509-11.

45. McPhail CWB (1965) Current advances in public health dentistry. Canadian Journal of Public Health 56: 512-16).

46. McIntosh WG (1966) Dental health for Canada. Canadian Journal of Public Health 57: 199-205.

47. Gray AS and Rothwell D (1968) An evaluation of a grade one dental health program. Canadian Journal of Public Health 59: 166-8.

48. Government of Canada (1966) What is the nature of dental public health – its objective? Ottawa: Department of National Health and Welfare: Government of Canada.

49. Government of Canada (1969) A survey of opinions on public dental programs (nature, relationships and outlook). Ottawa: Department of National Health and Welfare: Government of Canada.

50. Shosenberg JW (1988) A broader vision. Canadian Journal of Community Dentistry 3(2): 3.

51. Quiñonez C, Locker D, Main P, Clarke M (2006) Health human resources in Canada: Dental public health (dental public health specialists and dentists in community practice). Ottawa: Public Health Agency of Canada.

52. Lewis S, Kouri D (2004) Regionalisation: making sense of the Canadian experience. Healthcare Papers 5(1): 12-33.

53. Quiñonez CR (2006) A political economic history of medical and dental care in Nunavut. International Journal of Circumpolar Health 65(2): 101-16.

54. Quiñonez CR (2003) Dentistry in Nunavut: Inuit self-determination and the politics of health. In Oakes J, Riewe R, Wilde K, Edmunds A, Dubois A. (Eds.) Native Voices in Research. Winnipeg: Aboriginal Issues Press.

55. Adams TL (2003) Professionalisation, gender and female-dominated professions: dental hygiene in Ontario. Canadian Review of Sociology and Anthropology 40(3): 265-89.

56. Canadian Institute for Health Information (2004) Health personnel trends in Canada, 1993 to 2002. Ottawa: CIHI.

57. Ministry of Social Services (1996) Annual Report 1996/1997. Minister of Human Resources, Province of British Columbia.

58. Ministry for Children and Families (2001) Annual Performance Report 2000/01. Government of British Columbia.

59. Ministry of Children and Family Development (2002) Measuring Success: A Report On Child And Family Outcomes In BC. Government of British Columbia.

60. Ministry of Health Services (2004) Medical Services Plan Information Resource Manual Fee-For-Service Payment Statistics. Government of British Columbia.

61. Provincial Health Officer (2004) Report On The Health Of British Columbians, The Health and Well-being of Aboriginal People in British Columbia. Ministry of Health Planning, Office of the Provincial Health Officer.

62. Office of the Premiere, Ministry of Health Services (2005) B.C. expands early childhood health screening. News Release 2005HSER0022-000241, March 3. Vancouver: Government of British Columbia. http://www2.news.gov.bc.ca/archive/2001-2005/2005HSER0022-000241.htm

63. Ministry of Health Services (2005) Annual Service Report. Vancouver: Government of British Columbia, ISSN 1708-1017.

64. Government of British Columbia (2003) Annual Report on Early Childhood Development Activities - 2002/2003. Vancouver: Government of British Columbia, ISSN 1705-4303.

65. Ministry of Health Services, Ministry of Human Resources (2005) Background, Expansion of dental programs, 2005HSER0027-000290, March 14, Vancouver: Ministry of Health Services, Ministry of Human Resources.
http://www2.news.gov.bc.ca/nrm_news_releases/2005HSER0027-000290-Attachment1.htm

66. University of British Columbia, BC health services funding announcement.
http://www.dentistry.ubc.ca/news_/2005/march/funding_announcement.asp

67. University of British Columbia, Community development and service learning.
http://www.dentistry.ubc.ca/community_development

68. The Vancouver Agreement (2004) The first four years 2001-2004.
http://www.vancouveragreement.ca/TheAgreement.htm

69. MacEntee M, Harrison R, Wyatt C (2001) Strategies to enhance the oral health of British Columbians, specifically Aboriginal Peoples, tobacco-users, and those of low socioeconomic background. Prepared for Tobacco Reduction and Control Branch, Preventive and Health Promotion

Division, Ministry of Health, Government of British Columbia by Faculty of Dentistry, University of British Columbia.

70. Patterson S (2005) Alberta's Regional Health Authorities, Dental Public Health Programs. Presentation for 9th Annual Alberta Dental Public Health Conference, Dental Public Health Centre, University of Alberta. http://www.dent.ualberta.ca/ce/DPH_Index.htm

71. Curry T (1982) News from the Provinces. Canadian Society for Public Health Dentistry Newsletter, p. 28.

72. Curry T (1986) Provincial dental programs, Alberta. Canadian Journal of Community Dentistry 1(1): 28-32.

73. Curry T (1984) News from the Provinces. Canadian Society for Public Health Dentistry Newsletter, p. 26.

74. Desmarais B (1995) News from western Canada, Alberta. Canadian Journal of Community Dentistry 10(1): 6.

75. Smith W (1997) Community needs survey for the Alberta Dental Outreach Program. Canadian Journal of Community Dentistry 12(2): 39-43.

76. Alberta Family and Social Services (1999) Annual Report 1998/1999. Government of Alberta.

77. Alberta Health and Wellness (2000) Report to Albertans: Rationale of Minister's Approval of Oral Surgery Contracts. Government of Alberta. http://www.health.gov.ab.ca/resources/publications/oral_surgery_rationale.pdf

78. Health Resourcing Branch, Alberta Health and Wellness (2000-2006) Health costing in Alberta Annual Reports. Government of Alberta.

79. Ministry of Seniors (2003) Alberta Seniors Annual Report 2002-2003. Government of Alberta.

80. Ministry of Seniors (2004) Alberta Seniors Annual Report 2003-2004. Government of Alberta.

81. Nichols Applied Management (2003) Final report: Survey of recipients of the Alberta Child Health Benefit. Alberta Human Resources and Employment.

82. Alberta Public Health Association (2003, 1998, 1992) Resolutions, Annual General Meeting. http://www.apha.ab.ca/Resolutions/resols.htm

83. Toronto Dental Coalition (2002) Brief to the Commission on the Future of Health Care in Canada. Toronto Dental Coalition.

84. Association of Local Public Health Agencies (2005) Resolution A05-5 Access to dental care. http://www.alphaweb.org/dental_health.asp

85. Federation of Canadian Municipalities (2005) Resolutions, Access to dental care: a national dental care strategy. http://www.fcm.ca/english/policy/ac2005.html

86. Human Resources and Employment (2004) Ministry Annual Report. Government of Alberta.

87. Department of Dentistry (2005) Dental outreach clinics. Faculty of Medicine and Dentistry, University of Alberta. http://www.dent.ualberta.ca/dopclinic.cfm

88. Department of Dentistry (2005) Satellite dental clinics. Faculty of Medicine and Dentistry, University of Alberta. http://www.dent.ualberta.ca/satelliteclinic.cfm

89. Michener Services (2005) Quick facts. Red Deer: Michener Services – Persons with Development Disabilities Central Alberta Community Board. www.pdd.org/Central

90. Government of Alberta (2005) Budget 2005: Highlights. Government of Alberta.

91. Lewis M (1982) News from the Provinces. Canadian Society for Public Health Dentistry Newsletter, p. 27.

92. Lewis M (1983) News from the Provinces. Canadian Society for Public Health Dentistry Newsletter, p. 30.

93. Lewis DW (1981) Performance of the Saskatchewan Health Dental Plan 1974-1980. Government of Saskatchewan.

94. Lewis M (1986) Provincial dental programs: Saskatchewan. Canadian Journal of Community Dentistry 1(1): 33-4.

95. McDermott RE, Tynan JJ (1988) Attracting dental graduates to rural locations: evaluation of the Saskatchewan initiative. Canadian Journal of Community Dentistry 3(2): 24-8.

96. Saskatchewan Dental Therapists Association (2005) Personal communication. August 2005, Saskatoon.

97. Unknown author (1995) News from the Provinces, Saskatchewan. Canadian Journal of Community Dentistry 10(1): 7.

98. Legislative Hansard (1987) Routine proceedings, presenting petitions. Government of Saskatchewan, June 26.

99. Legislative Hansard (1987) Routine proceedings, notices of motions and questions. Government of Saskatchewan, September 1.

100. Legislative Hansard (1989) Routine proceedings, the sale of dental equipment. Government of Saskatchewan, May 25.

101. Saskatchewan Health (2000) Annual Statistical Report, 1999/00. Government of Saskatchewan.

102. Saskatchewan Health (2001) Annual Statistical Report, 2001/02. Government of Saskatchewan.

103. Saskatchewan Health (2002) Annual Statistical Report, 2002/03. Government of Saskatchewan.

104. Saskatchewan Health (2003) Annual Statistical Report, 2003/04. Government of Saskatchewan.

105. Saskatchewan Health (2001) Public health/population health services in Saskatchewan. Government of Saskatchewan.

106. Canadian Union of Public Employees (2001) Response to the Report of the Saskatchewan Commission on Medicare. Presented to the Standing Committee on Health Care.

107. Market Supplement Review Committee (2004) Dental therapist second annual review, Final Report. Market Supplement Review Committee.

108. Saskatchewan Surgical Care Network (2006) Wait times information, by specialist. http://www.sasksurgery.ca/index.htm

109. McCormick C (1982) News from the Provinces. Canadian Society for Public Health Dentistry Newsletter, p. 26.

110. McCormick C (1984) News from the Provinces. Canadian Society for Public Health Dentistry Newsletter, p. 11-12.

111. Cooney P (1988) Program update: Manitoba dental health care programs. Canadian Journal of Community Dentistry 3(2): 38-40.

112. Bedford W (1991) A federal viewpoint on perspectives for change in Canadian dental public health. The Canadian Journal of Community Dentistry, October Edition, p. 16.

113. Desmarais B (1995) News from Western Canada. Canadian Journal of Community Dentistry 10(1): 7.

114. Canadian Society of Public Health Dentists (1993) Annual Business Meeting Minutes. The Canadian Journal of Community Dentistry, August Edition, p. 10-11.

115. Government of Manitoba (1997) Core health services in Manitoba. Government of Manitoba.

116. Manitoba Health (1997) Annual Report 1998-1999. Government of Manitoba.

117. Aboriginal and Northern Affairs (2004) Annual Report. Government of Manitoba.

118. Manitoba Health (2002) Annual Report 2001-2002. Government of Manitoba.

119. Provincial Dental Consultant (2005) Personal communication. August 2005 and March 2006, Winnipeg.

120. Schroth B (2006) Personal communication. March 2006, Winnipeg.

121. Government of Manitoba (2004) Wait-list targeted for pediatric dental surgeries. News Release, December 1. Winnipeg: Government of Manitoba. http://www.gov.mb.ca/chc/press/top/2004/12/2004-12-01-04.html

122. Manitoba Centre for Health Policy and Evaluation (1999) Cost list for Manitoba health services. Winnipeg: Manitoba Centre for Health Policy and Evaluation, Department of Community Health Sciences, Faculty of Medicine, University of Manitoba.

123. Manitoba Family and Housing (2003) Annual Report 2002-2003. Government of Manitoba.

124. Winnipeg Regional Health Authority (2004) Financial statements. Winnipeg Regional Health Authority.

125. Moore P (2006) Personal Communication, March 2006.

126. Pfeifer R (2006) Personal Communication, March 2006.

127. Feasby R (1981) History of the Canadian Society of Public Health Dentists. Toronto: Canadian Society of Public Health Dentists.

128. Ryan K (1980) News from the Provinces. Canadian Society for Public Health Dentistry Newsletter, p. 24.

129. Ryan K (1982) News from the Provinces. Canadian Society for Public Health Dentistry Newsletter, p. 23-24.

130. Ontario Association of Public Health Dentistry (2005) Preparing for change, Retreat April 27 - 29, 2005. Barrie: Vision Management Services, Ontario Association of Public Health Dentistry.

131. Association of Public Health Epidemiologists in Ontario (2006) Core indicators for public health in Ontario. Date of last revision: June 1, 2006. http://www.apheo.ca/indicators/index.html

132. Ryan K (1985) News from the Provinces. Canadian Society for Public Health Dentistry Newsletter, p. 7.

133. Hicks T, Ryan K (1988) Ontario launches new dental program for children in need of treatment. Canadian Journal of Community Dentistry 3(4): 40-42.

134. Provincial Dental Consultant (2005) Personal Communication. August 2005, Toronto.

135. Leake JL (2000) The history of dental programs for older adults. Journal of the Canadian Dental Association 66(6): 316-19.

136. Ministry of Health and Long-Term Care (1984, 1989, 1997) Mandatory Health Programs and Service Guidelines pursuant to section 7 of the Health Protection and Promotion Act, 1983, C.10. Toronto: Government of Ontario.

137. Unknown Author (1990) Province of Ontario report to the Federal-Provincial Dental Health Council, tenth annual meeting. Canadian Journal of Community Dentistry 2(4); 7-13.

138. The Council of the Regional Municipality of Peel (1992) Council Minutes, July 9, Staff Reports, Proposed Provincial Dental Program for Seniors and Long Term Care Clients. Brampton: Regional Municipality of Peel.
http://www.region.peel.on.ca/council/council_minutes/1990s/1992/rcmin19920709.htm

139. Ontario Association of Public Health Dentistry (2006) Position Paper on Public Health Human Resources. Toronto: Ontario Association of Public Health Dentistry.

140. Wiebe D (1995) An overview of OSPHD activities in 1994. Canadian Journal of Community Dentistry 10(1): 8-9.

141. Williams B (1992) Summary of proposal by Ontario Society of Public Health Dentists: Dental health for Ontario seniors and long term care clients. Canadian Journal of Community Dentistry May: 5, 8.

142. Unknown Author (1995) Executive summary of the Ontario Dental Assistance Program proposed by the Ontario Society of Public Health Dentists. Canadian Journal of Community Dentistry 10(2): 49.

143. Medical Officer of Health (1999) City of Toronto Council and Committees, Toronto Board of Health. Toronto: City of Toronto Clerk's Office.
http://www.toronto.ca/legdocs/1999/agendas/committees/hl/hl990222/it002a.htm

144. Canadian Dental Hygienists Association (2001) Dental Hygiene Practice in Canada. Ottawa: Canadian Dental Hygienists Association.

145. Bennett S (1998) News Brief. Canadian Journal of Community Dentistry 13(1): 41.

146. Commissioner of Community and Neighbourhood Services (1998) City of Toronto Council and Committees, Community and Neighbourhood Services Committee. Toronto: City of Toronto Clerk's Office. http://www.city.toronto.on.ca/legdocs/agendas/committees/cn/cn980423/it007.htm

147. Bennett S (2001) Recent changes and evolution in care patterns in the children in need of treatment (CINOT) dental program: 1990 – 1999. Public Health and Epidemiology Report Ontario 12(3): 105-12.

148. Toronto Board of Health (2000) Agenda, Meeting No. 4. Toronto: City of Toronto Clerk's Office. http://www.toronto.ca/legdocs/2000/agendas/committees/hl/hl000501/agenda.pdf

149. City of Ottawa (2004) City Council, Minutes. Ottawa: City of Ottawa. http://www.ottawa.ca/calendar/ottawa/citycouncil/occ/2004/07-14/hrss/ACS2004-CCS-HRS-0015.htm

150. City of Kingston (2005) Report No. 63, City Council Meeting No. 14. Kingston: City of Kingston. www.cityofkingston.ca/pdf/council/agenda/2005/A14_Agenda.pdf

151. The Association of Ontario Health Centres (2001) Submission to the Romanow Commission: The best kept secret in health care, Community Health Centres. Ottawa: Association of Ontario Health Centres.

152. Association of Local Public Health Agencies (2000, 2001) alPHa Resolutions No. A00-3, 100% Ministry Funding for CINOT, and No. A01-17, Dental Care for Seniors in Need. Toronto: alPHa.

153. Ontario Public Health Association (2005) Position statement on poverty and children's oral health, code: 2005-02 (PP) / 2005-04 (RES). Ottawa: OPHA.

154. Bennett S (1996) Results from the 1993-94 Ontario Dental Health Indices Survey. Public Health Epidemiology Report Ontario 7(8): 355-58.

155. Bennett S (2001) Dental preventive services annual reports. Public Health and Epidemiology Report Ontario 12(10): 322-25.

156. Ministry of Northern Development and Mines (1999) Ontario announces $3.2 million for health facilities in Kenora/Fort Frances area. News Release, November 19, Toronto: Government of Ontario.

157. Ministry of Northern Development and Mines (2001) Ontario funds Ear Falls Dental Clinic. News Release, September 5, Toronto: Government of Ontario.

158. Ministry of Northern Development and Mines (2001) Machin Dental Clinic receives boost from Ontario Government. News Release, September 25, Toronto: Government of Ontario.

159. Ministry of Health and Long-Term Care (2001) Northern Health Travel Grants Program information for Dental Surgeons. Bulletin No. 9069, November 1, Toronto: Government of Ontario.

160. Ministry of Health and Long-Term Care (2003) Primary Health Care Transition Fund Operational Grant Funding, 2003-2004 funded projects (June 2003 round). Toronto: Government of Ontario. http://www.health.gov.on.ca/english/providers/project/phctf/proj_0304_fund.html

161. Unknown Author (2002) Life support: The newsletter for supporters of the Ottawa Hospital Foundation. Fall/Winter, p. 2.

162. Capacity Review Committee (2005) Revitalising Ontario's public health capacity: A discussion of issues and options. Toronto: Ministry of Health and Long-Term Care.

163. Crawford R (2002) A century of service: Optimal oral health for all Canadians (part seven of a series). Journal of the Canadian Dental Association 68(7): VII-1-VII-4.

164. Pelletier G (1984) Regime de soins dentaire au Quebec. Canadian Society for Public Health Dentistry Newsletter, p. 20-33.

165. La Régie de l'assurance maladie du Québec (2003) Les services dentaire. Ville de Québec: Gouvernement du Québec. https://www.prod.ramq.gouv.qc.ca/IST/CD/CDF_DifsnInfoStats/CDF1_CnsulInfoStatsCNC_iut/DifsnInfoStats.aspx?ETAPE_COUR=2&LANGUE=en-CA

166. Msefer-Laroussi S (2007) Analyse du système de couverture des services dentaires au Québec. Montréal: Groupe de recherché interdisciplinaire en santé, Université de Montréal.

167. Begin F (1982) A summary of a proposed dental health program from the Minister of Social Affairs in Quebec. Canadian Society for Public Health Dentistry Newsletter, p. 11-14.

168. Dussault J (1984) Dental services in Quebec: Issues and changes. Social Science and Medicine 18(3): 251-55.

169. Direction général de la santé publique (2004) Programme national de santé 2003-2012, Plan d'action en matière de santé dentaire publique 2004-2012. Ville de Québec: Ministère Santé et Services sociaux. http://www.listes.umontreal.ca/wws/d_read/infosante-l/20040511160948_plandactionenmatieredesantedentaire20042012.pdf

170. Laporte B (2005) Personal communication. March 2006, Toronto.

171. LaFontaine B (1989) A school food policy in Québec. Canadian Journal of Community Dentistry 2(2): 6-7.

172. La Régie de l'assurance maladie du Québec (2001) Communiqué – Couverture par la regime d'assurance maladie de certains services de santé durant le délai de carence (nouveau programme). Montréal: RAMQ. Available at: http://www.ramq.gouv.qc.ca/fr/professionnels/comm/2001/com072-1.pdf

173. Brodeur JM, Payette M, Olivier M, Chabot D, Benigeri M, Williamson S (1998) Étude 1994-95 sur la santé buccodentaire des adultes Québécois de 35 à 44 ans - Collection analyses et surveillance 8. Montréal: Direction de la santé publique de Montréal-Centre et du Groupe de recherche interdisciplinaire en santé de l'Université de Montréal, Ministère de la Santé et des Services sociaux, Gouvernement du Québec.

174. Brodeur JM, Benigeri M, Olivier M, Williamson S, Payette M (1998) Étude 1996-97 sur la santé buccodentaire des écoliers Québécois de sixième année - Résultats détaillés de la région Montréal-Centre et comparaisons avec l'ensemble du Québec. Montréal: Direction générale de la santé publique du Ministère Santé et Services sociaux.

175. Durocher J, Brodeur JM (1998) Évaluation de l'application du programme public de services dentaires préventifs - Collection analyses et surveillance 7. Montréal: Direction générale de la santé publique, Ministère de la Santé et des Services sociaux, Gouvernement du Québec.

176. Brodeur JM, Olivier M, Payette M, Benigeri M, Williamson S, Bedos C (1999) Étude 1996-97 sur la santé buccodentaire des élèves Québécois de 11-12 et 13-14 ans - Collection analyses et surveillance

11. Montréal: Direction de la santé publique de Montréal-Centre et du Groupe de recherche interdisciplinaire en santé de l'Université de Montréal, Ministère de la Santé et des Services sociaux, Gouvernement du Québec.

177. Brodeur JM, Olivier M, Benigeri M, Bedos C, Williamson S (2001) Étude 1999-99 sur la santé buccodentaire des élèves Québécois de 5-6 et 7-8 ans - Collection analyses et surveillance 18. Montréal: Direction de la santé publique de Montréal-Centre et du Groupe de recherche interdisciplinaire en santé de l'Université de Montréal, Ministère de la Santé et des Services sociaux, Gouvernement du Québec.

178. Corbeil P, Arpin S, Lévesque D, Brodeur JM (2006) Étude exploratoire des problèmes de santé de buccodentaires des personnes âgées en Montérégie. Montréal: Agence de la santé et des services sociaux de la Montérégie.

179. Allison P, Allington C, Stern J (2004) Access to dental care for under-privileged people in Quebec. Montréal: Faculty of Dentistry, McGill University.

180. Direction générale de la santé publique (2004) Programme nationale de sante publique 2003 – 2012: Plan d'action en matière de santé dentaire publique 2004 – 2012. Montréal: Ministère de la Santé et des Services sociaux

181. Blackmer J (1981) News from the Provinces. Canadian Society for Public Health Dentistry Newsletter, p. 15.

182. Provincial Consultant (2005) Personal Communication, August 2005, Toronto.

183. Dalhousie University Archives (1882-1966) The Archives of the Halifax Visiting Dispensary, Collection Number: MS-13-84. http://www.library.dal.ca/archives/MS13/MS-13-84.htm

184. Getty J (1980) News from the Provinces, Nova Scotia. Canadian Society for Public Health Dentistry Newsletter, p. 18.

185. Getty J (1983) News from the Provinces, Nova Scotia. Canadian Society for Public Health Dentistry Newsletter, p. 24.

186. Ad Hoc Committee for the Review of the Nova Scotia Fluoride Mouthrinse Program (2002) Phase I Summary Document: Revising the Fluoride Mouthrinse Program. Halifax: Government of Nova Scotia.

187. Ad Hoc Fluoride Mouthrinse Review Committee (2004) Nova Scotia Fluoride Mouthrinse Program Report of the Criteria Subcommittee. Halifax: Government of Nova Scotia.

188. McNally M, Lyons R (2004) The Silent Epidemic of Oral Disease: Evaluating Continuity of Care and Policies for the Oral Health Care of Seniors, Oral Health of Seniors Project, CHSRF Final Report. Halifax: Canadian Health Services Research Foundation, Atlantic Health Promotion Research Centre and Faculty of Dentistry, Dalhousie University.

189. Nova Scotia Department of Health Continuing Care Branch (2004) Special Needs Policy, Section 21 Dental Services. Halifax: Government of Nova Scotia.

190. Romcke B (1985) Provincial dental program, Prince Edward Island. Canadian Journal of Community Dentistry 1(1): 35-37.

191. Romcke B (1988) Program update: Prince Edward Island Dental Program. Canadian Journal of Community Dentistry 3(2): 31-32.

192. Maze B (1995) The Prince Edward Island dental program. Canadian Journal of Community Dentistry 10(2): 43.

193. Lewis D (1995) Bob Romcke: A man for all seasons. Canadian Journal of Community Dentistry 10(1): 10-11.

194. Department of Health and Social Services (2001) Strategic plan 2001-2005 for the Prince Edward Island health and social services system. Government of Prince Edward Island.

195. Legislative Hansard (2004) First Session of the Sixty-Second General Assembly, Routine proceedings, Estimates. Government of Prince Edward Island, May 11.

196. Ministry of Health and Social Services (2004) Program Profiles for the year ending March 31, 2004. Government of Prince Edward Island.

197. Messer J (1988) An overview of dental care delivery and dental health in Northern Newfoundland and Labrador. Canadian Journal of Community Dentistry 3(1): 45-53).

198. Doshi S (1984) Public Health Branch Newfoundland, Department of Health, December 1982. Canadian Society for Public Health Dentistry Newsletter, p. 42-43.

199. Doshi S (1984) News from the Provinces. Canadian Society for Public Health Dentistry Newsletter, p. 26-28.

200. Newfoundland Medical Care Commission (2000) 31st Annual Report for the year ended March 31, 2000. Government of Newfoundland and Labrador.

201. Provincial Dental Director (2005) Personal communication. August 2005, Ottawa.

202. Hornett P (2005) Charting a course to improve oral health facets of the publicly funded dental care system in Newfoundland and Labrador. Presentation at the 2005 General Annual Meeting of the Canadian Association of Public Health Dentistry, St. John's, Newfoundland and Labrador.

203. Hornett P (2005). Oral health care needs in Labrador: Children's dental health and consideration for further action. Presentation at the 2005 General Annual Meeting of the Canadian Association of Public Health Dentistry, St. John's, Newfoundland and Labrador.

204. McEuen CS (1938) An examination of the mouths of Eskimos in the Canadian eastern Arctic. Canadian Medical Association Journal 38: 374-77.

205. Leigh R (1925) Dental pathology of the Eskimo. Dental Cosmos 67: 884-99.

206. Bedford W, Davey K (1993) Indian and Inuit dental care in Canada: The past, the present and the future. Journal of the Canadian Dental Association 53(2): 126-32.

207. Four Directions Consulting Group (1997) First Nations demography. Ottawa: Department of Indian Affairs and Northern Development Research and Analysis Directorate.

208. Government of Canada, Department of Indian Affairs and Northern Development and Tunngavik Federation of Nunavut (1993) Agreement between the Inuit of the Nunavut Settlement Area and Her Majesty the Queen in Right of Canada (Nunavut Land Claims Agreement). Ottawa: Government of Canada.

209. Hammoud R (2005) Personal communication. July 2005, Toronto.

210. Northern Secretariat, Health Canada (2000) Deputy Ministers' Territorial Wellness Framework. Government of Canada.

211. Author Unknown (c. 1930) All Saints Hospital, early 1930's, lady in dentist chair. Northwest Territorial Archives. Accession number N-1979-050-0076 (1570065).

212. Author Unknown (c. 1930) Person – possibly a dentist inspecting someone's teeth, Coppermine. Northwest Territorial Archives. Accession number N-1987-033-0789 (1750076).

213. Pennington J (1994) Terrence Hunt Photographs: An Inventory. Culture and Heritage Division, Department of Education, Culture and Employment, Government of the Northwest Territories. NWT Archives. Accession Number N-1979-062.

214. Hardwick F, Schwartz A (1999) External review of the dental therapy program of the Saskatchewan Indian Federated College National School of Dental Therapy. Ottawa: Health Canada Medical Services Branch.

215. Canadian Dental Association (2003) Dentists North of 60: A breed apart. Communiqué September/October, Ottawa: Canadian Dental Association.

216. George B Cuff & Associates Ltd (2001) Report on the NWT Health and Social Services System. Yellowknife: Government of the Northwest Territories.

217. Research and Analysis Unit, Department of Health and Social Services (1999) The NWT health status report. Yellowknife: Government of the Northwest Territories.

218. Department of Health and Social Services (2002) A three-year summary of initiatives, Health Promotion Strategy Fund. Yellowknife: Government of the Northwest Territories.

219. Lemchuk-Favel L (2007) Federal health funding to First Nations in the Territories. A Discussion Document. Ottawa: Assembly of First Nations and FAV COM.

220. Inuvik Regional Health and Social Services Board (2005) Dental therapists (3 positions), Competition Number: 2005-94-3029. Yellowknife: Human Resource Services, Government of the Northwest Territories.
http://www.hr.gov.nt.ca/employment/Default.aspx?catid=2&location=-1&employer=-1&action=Allied+Health+and+Social+Services+Professionals#active

221. Yukon Health and Social Services (2006) Statistics, Health Services, Community Health, Dental Health. Whitehorse: Yukon Government.

222. Yukon Health and Social Services (2006) Dental Therapist (permanent full-time position), Competition Number: 07-ST14-06. Whitehorse: Yukon Government.
http://employment.gov.yk.ca/postings/1002.html

223. Ontario Liberal Party of Canada (2007) The Ontario Liberal Plan, 2007 costing summary. Toronto: Speech from the Throne, Government of Ontario.
http://www.ontarioliberal.ca/upload/dir/CostingMovingForwardTogetherEnglish.pdf

224. Quiñonez CR, Locker D, Figueiredo R (2007) Canadian dentists' opinions on publicly financed dental care. Community Dental Health Services Research Unit, Dental Research Institute, University of Toronto.

225. Quiñonez CR, Locker D (2007) Canadian opinions on publicly financed dental care. Canadian Journal of Public Health 98(6): 495-98.

226. Welsh M (2007) Plunged into darkness. April 28, The Toronto Star. http://www.thestar.com/News/article/208344

227. Welsh M. He has a new smile; system still in decay. July 10, The Toronto Star. http://www.thestar.com/News/Ontario/article/234155

228. Blackwell T. Extend dental coverage, doctors urge. October 12, The National Post. http://www.nationalpost.com/todays_paper/Story.html?id=30554

229. Picard A (2007) Doctors' orders: Expand medical coverage to long-term care. October 21, The Globe and Mail. http://www.theglobeandmail.com/servlet/Page/document/v5/content/subscribe?user_URL=http://www.theglobeandmail.com%2Fservlet%2Fstory%2FLAC.20070821.CMASIDE21%2FTPStory%2F%3Fquery%3Ddental%2Bcare&ord=34641461&brand=theglobeandmail&force_login=true

230. Canadian Institute for Health Information (2006) Health personnel trends, 1995-2004. Ottawa: CIHI.

231. Atchison K, Bibb C, Lefever K, Mito R, Lin S, Engelhardt R (2002) Gender differences in career and practice patterns of PGD-trained dentists. Journal of Dental Education 66(12): 1358-67.

232. Mathews R, Scully C (1994) Working patters of male and female dentists in the UK. British Dental Journal 176(12): 463-66.

233. Walton S, Byck G, Cooksey J, Kaste L (2004) Assessing differences in hours worked between male and female dentists: An analysis of cross-sectional national survey data from 1979 through 1999. Journal of the American Dental Association 135(5): 637-45.

234. Rees AM, Jutai DK (1979) Management, productivity and cost benefit of graduate dental therapist for years 1975-1979. Ottawa: Medical Services Branch, Health Canada.

235. Lewis DW. Performance of the Saskatchewan Health Dental Plan, 1974-1980. Toronto: University of Toronto; 1981.

236. Trueblood GR (1992) An analytical model for assessing the costs and benefits of training and utilizing auxiliary health personnel with application to the Canadian Dental Therapy Program. Unpublished doctoral dissertation. Concordia University, Montreal, Canada.

237. Veronneau J, Allison P (2006) Assessing the caries preventive effect of Preventive Public School Program. International Association of Dental Research Abstract. http://iadr.confex.com/iadr/2006Orld/techprogram/abstract_74248.htm

238. Ismail AI, Sohn W (2001) The impact of universal access to dental care on disparities in caries experience in children. J Am Dent Assoc 132(3): 295-303.

239. Lawrence H, Binguis D, Switzer B, McKeown L, Figueiredo R, Laporte A, Rogers J (2006) Randomized fluoride varnish trial for preventing ECC in Aboriginal communities. International Association of Dental Research Abstract. http://iadr.confex.com/iadr/2006Brisb/techprogram/abstract_83597.htm

240. 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.

241. 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.

242. Rozier RG, Stearns SC, Bhavna TP, Quiñonez RB (2007) Research brief: Evaluation of Into the Mouths of Babes Program. School of Public Health, Department of Health Policy and Administration, University of North Carolina.

Appendix A

Health Canada Santé Canada

Hon. [Name Health Minister
Address
City, Province
Postal Code]

Dear [Name Health Minister]:

This letter is to thank you for the support of [Title Province/Territorial Dental Director/Manager/Consultant], regarding the environmental scan of dental public health activities now underway in Canada. The project is collecting information on the types and methods of public dental care delivery and financing in the Provinces and Territories.

This review is taking place within the Office of the Chief Dental Officer, and has been established as a crucial and much needed undertaking by both governmental and dental professional interest and concern. In fact, it was in 1983, now upwards of 20 years ago, that the last indication of what and how public dental care programs exist in Canada was given.

We have received much positive feedback from the Federal, Provincial, and Territorial Dental Directors (FPTDD). We also anticipate support from the private sector through the Canadian Dental Association (CDA), the Canadian Dental Regulatory Authorities' Federation (CDRAF), the Registrars of Provincial and Territorial dental boards, and the Chief Executive Officers of Provincial and Territorial dental associations.

With the ever newer and significant linkages being established between oral and general health, this is an important step to identify and describe public programs that deliver services to populations that are otherwise not covered under private insurance.

We will of course be happy to share such information upon the project's completion.

Respectfully,

Dr. Peter Cooney
Chief Dental Officer
Health Canada

c.c.: [Title Province/Territorial Dental Director/Manager/Consultant]

Appendix B

Health Canada Santé Canada

OFFICE OF THE CHIEF DENTAL OFFICER
ENVIRONMENTAL SCAN OF DENTAL PUBLIC HEALTH PROGRAMS IN CANADA

Dear Dental Director/Consultant/Manager,

Thank you for taking the time to fill out this form.

As you are aware, such an endeavour was undertaken in the early 1980s, producing what is otherwise referred to as the Stamm Report. This report proved useful when current, providing a wide breadth of descriptive information about dental programs in Canada.

Upwards of twenty years later, we are attempting something similar. Most stakeholders would argue that it is time — time to understand what has happened to public dental care in the interim, and time to review the current state of public dental care funding and planning in Canada.

The information you provide will be fundamental and necessary to meet our goals. We hope that a compilation of such information will ultimately prove useful to you as a tool for comparison, and for maintaining and/or expanding your programs.

You can print this form and mail or fax it when complete, or you can fill it out electronically and email it. Some questions may be difficult to answer, some arguably impossible in certain situations. Nonetheless, we ask for your patience in trying to complete the form in full.

Thank you again for your time, and please feel free to contact us if you have any questions or comments.

Respectfully,

Peter V. Cooney BDS DDPH MSc FAGD FRCD(C)
Office of the Chief Dental Officer
Health Canada
Tunney's Pasture, A.L.: 1501A
Ottawa, ON K1A 0K9
tel: (613) 957-4748
fax: (613) 957-3687
email: peter_cooney@hc-sc.gc.ca

Carlos R. Quiñonez DDM MSc
Office of the Chief Dental Officer
Health Canada
Tunney's Pasture, A.L.: 1501A
Ottawa, ON K1A 0K9
tel: (613) 957-3679
fax: (613) 957-3687
email: carlos_quinonez@hc-sc.gc.ca

Health Canada Santé Canada

INSTRUCTIONS

This form is divided into two parts, and is provided as two separate PDF files.

The first part of this form asks general questions about public dental programs in your region.

The second part of this form requests specific information related to specific programs.

As you may find it necessary to describe a variety of programs, you can duplicate the second part of this form as needed.

Please feel free to fill out this form in whatever detail your busy work schedule may allow.

The form and its questions may appear onerous, and we apologise for this in advance, yet this information is required for us to complete the task we have set forth.

Some answers may be found in annual reports, practitioner manuals, fee guides, public information brochures, planning documents, and/or utilisation data. If possible, you can mail or email such documentation at your convenience and we will extract the information needed.

Thank you again!

Health Canada Santé Canada

PART 1

1. Is there legislation in your region that deals with public dental programs or services? If so, what is it?

2. What are the total funds allotted to public dental programs and services in your region every year for the last three fiscal years (this should include all public expenditures on prevention and treatment, whether delivered in a public or private setting)?

Health Canada Santé Canada

PART 1 – CONT'D

3. Can you give a sense of what has happened to public dental programs and services in your region over the last twenty years (major funding cuts, program closures, changes in administration, funding, or delivery)? Please feel free to write in point form. Any information is valid and appreciated.

Health Canada Santé Canada

PART 2

Please complete questions 1 through 20 for <u>each</u> of your public dental programs. As you may find it necessary to describe a variety of programs, you can duplicate the second part of this form as needed.

1. Program Name

2. Description of program (prevention, treatment, for children, for adults, for seniors, et cetera)

3. How long has the program operated?

Health Canada Santé Canada

PART 2 – CONT'D

4. What is this program's total budget every year for the last three fiscal years?

5. What government department provides the funds for this program?

6. Is this program listed as a line item in a budget or is it part of a larger global budget?

7. Who in government administers this program?

Health Canada Santé Canada

PART 2 – CONT'D

8. Where is this program administered (centrally, regionally)?

9. Who is eligible for this program?

10. Number of persons eligible for this program

11. What is covered under this program?

Health Canada Santé Canada

PART 2 – CONT'D

12. What is explicitly not covered under this program?

13. Where is the program or service provided (community clinic, schools, hospital, private practices, et cetera)?

14. Who is the service provider for this program (hygienists, public health nurse, dentist, community health representative, et cetera)?

Health Canada Santé Canada

PART 2 – CONT'D

15. Who manages the program if it is of a third-party payer type (dental association, contracted adjudicator, contracted corporation, et cetera)?

16. Do you have any information on the utilisation of the program? If so, please provide this information in as much detail as possible. If you have data available electronically and wish to share it, please send it along when returning this form.

Health Canada Santé Canada

PART 2 – CONT'D

17. Are there any user charges? If so, when were they implemented? Can you describe them?

18. Have there been any changes desired by government, by the provider, or by the client in the recent past? If so, what are they?

Health Canada Santé Canada

PART 2 – CONT'D

19. Have there been any major changes to the program over its history that you feel are important for us to know? Please feel free to write in point form. Any information is valid and appreciated.

Health Canada Santé Canada

PART 2 – CONT'D

20. Is there anything else that you think we should know?

Again, we ask if you can provide us with any annual reports, practitioner manuals, fee guides, public information brochures, planning documents, utilisation data, and/or anything else that you think would be relevant for our purposes.

Thank you once again for your time and patience!