An environmental scan of publicly financed dental care in Canada: 2015 update

Jodi L. Shaw, CD, DMD, MSc, FRCD(C) and Julie W. Farmer, RDH, MSc

This report was prepared under the direction of Dr. Peter Cooney, Chief Dental Officer Public Health Agency of Canada. It does not represent a policy statement by the federal government.

This serves as a descriptor of public dental care activities at the time of the scan and includes changes that have occurred since the previous scan with information provided by provincial, territorial, and federal representatives. For a thorough understanding of dental public health activities for each jurisdiction, the corresponding dental directors/departments should be contacted.

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Table of Contents

List of Abbreviations

AB	Alberta
AAHB	Alberta Adult Health Benefit
ACSD	Assistance for Children with Severe Disabilities
ACHB	Alberta Child Health Benefit
ADSC	Alberta Dental Services Corporation
AHS	Alberta Health Services
AHCIP	Alberta Health Care Insurance Plan
AISH	Assured Income for the Severely Handicapped
AWIS	Alberta Works Learner Income Support
ASDC	Assistance for Severely Disabled Children
BC	British Columbia
BCDA	British Columbia Dental Association
CCOH	Community Centre for Oral Health
CCPA	Canadian Centre for Policy Alternatives
CCCA	Committee on Clinical and Scientific Affairs
CDA	Canadian Dental Association
CHA	Canada Health Act
CIHI	Canadian Institute for Health Information
CINOT	Children In Need Of Treatment (CINOT)
COHC	Children's Oral Health Coalition
COHI	Children's Oral Health Initiative
COHP	Children’s Oral Health Program
DAP	Dental Assistance Program
DAPS	Dental Assistance Program for Seniors
DHE	Dental Health Educators
ECC	Early Childhood Caries
EHB	Extended Health Benefits
EIA	Employment Income Assistance
EPDS	Enhanced Preventive Dental Services
ETW	Expected to Work
FCS	Family and Community Services
FDCAC	Federal Dental Care Advisory Committee
FFV	Free First Visit
FHB	Family Health Benefits
FNHA	First Nations Health Authority
FPTDWG	Federal Provincial Territorial Dental Working Group
FTE	Full-time Equivalent
HC-FNIHB	Health Canada-First Nations and Inuit Health Branch
HDI	Human Development Index

HDR	Human Development Report
HELP	Human Early Learning Partnership
HICPS	Health Information and Claims Processing Services
HSHC	Healthy Smile – Happy Child
HSO	Healthy Smiles Ontario
IFHP	Interim Federal Health Program
IHDI	Inequality-Adjusted Human Development Report
IS	Income Support
IWK	Izaak Walton Killam Hospital
LGIC	Lieutenant Governor in Council
LHIN	Local Health Integration Networks
MB	Manitoba
MDA	Manitoba Dental Association
MDC	Manitoba Developmental Centre
MEIA	Ministry of Employment and Income Assistance
MHSD	Ministry of Housing and Social Development
MOH	Ministry of Health
MOHLTC	Ministry of Health and Long-Term Care
MSP	Medical Services Plan
NB	New Brunswick
NDP	New Democratic Party
NETW	Not Expected to Work
NHEX	National Health Expenditure
NHS	Northern Health Strategy
NHSWG	Northern Health Strategy Working Group
NIHB	Non-Insured Health Benefits
NL	Newfoundland and Labrador
NOHWG	Northern Oral Health Working Group
NPSCF	National Pensioners and Senior Citizens Federation
NS	Nova Scotia
NT	North West Territories
ODSP	Ontario Disability Support Program
OHAP	Oral Health Action Plan
OOHA	Ontario Oral Health Alliance
OPHS	Ontario Public Health Standards
OW	Ontario Works
PDSP	Pensioners' Dental Services Plan
PHO	Public Health Ontario
PSDCP	Public Service Dental Care Plan

RHA	Regional Health Authority
NU	Nunavut
OCDO	Office of the Chief Dental Officer
ODSP	Ontario Disability Support Program
OECD	Organisation for Economic Co-operation and Development
ON	Ontario
OOHA	Ontario Oral Health Alliance
OW	Ontario Works
PE	Prince Edward Island
QC	Quebec
SHP	Supplementary Health Program
SK	Saskatchewan
SMILE	Saving Mouths Income Limited Environment
SOMSB	Schedule of Oral and Maxillofacial Surgery Benefits
SPHERU	Saskatchewan Population Health and Evaluation Research Unit
SSI	Saskatchewan Surgical Initiative
STEP	Student Employment and Placement
UBC	University of British Columbia
UNDP	United Nations Development Programme
WRHA	Winnipeg Regional Health Authority
YT	Yukon

List of Tables

List of Figures

An environmental scan of publicly financed dental care in Canada

Executive Summary

- Dental public health in Canada is constantly evolving. There has been a renewed focus for the redirection of efforts toward evidence-based oral health strategies in several jurisdictions.

- Most oral health initiatives at the provincial/territorial level since 2005 continue to focus on children, primarily those who are socially disadvantaged.

- Expenditures for public dental programs have risen over the past decade, with investments in targeted dental public health activities and for socially marginalized populations varying by province/territory.

- The number of dental professionals in Canada has risen steadily over the last decade; however, efforts for improving leadership in dental public health have not been consistent across provinces and territories.

- Coordinated efforts at all levels of government are needed to reduce the country's oral health disparities. The oral health status of marginalized groups in Canada will only appreciably change if there is a greater commitment from government, dental professionals, and the public. A collaborative approach between key stakeholders in all health sectors is needed to improve equity in oral health.

Introduction

In 2005, the Office of the Chief Dental Officer (OCDO) and the Public Health Agency of Canada, through a contract with the Community Dental Health Services Research Unit, completed an environmental scan that culminated in a detailed report on public dental programming and human resources in Canada. The report also provided a summary of the literature on the historical background of public dentistry in Canada since the mid-19th century. In 2008, the tables in the original report were updated. Given the continued display of interest in this information from key stakeholders at both the provincial and federal levels, the OCDO established a 2014 update of the environmental scan as a priority project. The primary focus of this current report is the period from 2006 onwards, although references to earlier years are made for illustrative purposes.

The state of inequality of oral health care in Canada

While the number of dental professionals in Canada has risen steadily over the last decade, access to care and oral health disparities are still present (See Table 4 and 5). Since 2005, three national surveys, namely the Canadian Health Measures Survey 2007-2009, the First Nation Oral Health Survey 2009-2010, and the Inuit Oral Health Survey 2008-2009, have produced baseline information of the oral health status of Canadians.[1-3] These surveys have identified that most of the oral disease continues to be concentrated among disadvantaged groups, with those having the highest need often receiving the least care.[4] The sharp rise in the cost of dental care in Canada is concerning, especially since there has been no substantial change in incomes for those in the lowest economic groups over the past 25 years.[4]

Since 2005, there have been numerous studies conducted and reports written about the challenges that Canada faces in terms of dental disease prevention and the provision of basic dental care. In 2010, only 6% of dental care expenditures in Canada were publicly funded, which places Canada among the lowest of the Organisation for Economic Co-operation and Development (OECD) nations in terms of mean per capita expenditures for dental care. This is in contrast to other OECD countries such as Japan (77%), Finland (44%), and Sweden (41%), whose per capita contribution to dental care far exceeds that of Canada. Only Spain (1.5%) ranks lower than Canada.[3,5]

Since the target populations for public funding for dental treatment in Canada are predominately low-income and socially marginalized groups, a reduction in funding often has the biggest impact on these people. Out-of-pocket spending on dental care in Canada rose between 1997 and 2009, with the greatest increase observed for lower-income households. Furthermore, for those

who have insurance, premiums are typically a set rate and do not fluctuate based on income level. As such, insurance premiums often represent a higher proportion of household income for those with lower wages.[6]

There have been some positive initiatives at the federal level since 2005 aimed at improving the oral health status of Canadians, in particular that of children. In January 2007, a pilot project aimed at reducing wait times for children needing surgery in pediatric hospitals was introduced. The provision of dental treatment under general anesthesia was one of six pediatric surgical areas prioritized for this initiative. This announcement demonstrated that the federal government acknowledged the importance of the oral health of Canadian children and highlighted the urgent unmet need for dental care faced by so many.[7]

In 2005, the Federal Provincial Territorial Dental Working Group (FPTDWG) produced the Canadian Oral Health Strategy (COHS) 2005-2010. This document outlined objectives and goals aimed at improving the oral health status of Canadians, which were to be achieved by 2010. The main focus areas of the COHS were: to address the determinants of health through increased oral health promotion activities; to improve the overall oral health of Canadians; to improve access to care; to establish a country-wide standardized method of surveillance; and to assure appropriate numbers, distribution, and education of oral health professionals.[8]

Targeted programs aimed at improving the oral health status of Canadians often focus on children. While children, especially those in socially marginalized groups, often present the greatest risk factors for oral disease, it is important to underline that many seniors are also at risk. Canadians are living longer and are keeping their teeth longer, but many face barriers to dental care, whether financial, geographical or physical. Employer-based dental benefits usually cease upon retirement, rural living can make the distance to the closest dental clinic prohibitive, and those with physical limitations cannot be accommodated in all dental settings.[9]

Recognizing the need for improved oral health care for seniors, in 2005 the Canadian Dental Association (CDA) Board of Directors tasked the Committee on Clinical and Scientific Affairs (CCSA) to investigate the key issues surrounding oral health care for the elderly and to create a vision and an action plan on how best to address these concerns. The ensuing report, titled *Report on Seniors' Oral Health Care*, was released in 2008 and provided recommendations that focused on four main themes: increasing geriatric dental education for dental students and dental care providers; improving delivery of care by developing a service care delivery model as well as standards of care for long-term care facilities; increasing geriatric dental research; and developing a strategic plan that would encourage dentists to better incorporate geriatric care into

their practices and would raise awareness of the issues surrounding geriatric dental care with other health care professionals and key governmental stakeholders.[10] Another report issued by the OCDO expressed similar concerns for the aging population, identifying increased treatment needs and decreased proportion of Canadians aged 60-79 having private dental insurance coverage.[3]

The implementation of seniors' dental programs in some jurisdictions demonstrates the growing interest in promoting healthy and independent living for seniors, but more work is still needed. In a policy brief in February 2012 addressed to the Government of Canada, the National Pensioners and Senior Citizens Federation (NPSCF) proposed that "the Federal Government work with the Provincial Governments to develop and implement a dental care program for seniors on the same basis as PharmaCare".[11]

Canada's most at-risk group are the First Nations and Inuit populations with the children being the most vulnerable. In fiscal year 2012/2013, over 237 million dollars were spent on dental treatment costs for this population subset through the Non-Insured Health Benefits (NIHB) Program,[12] the Children's Oral Health Initiative (COHI), and the Dental Therapy Program (Table 8). This does not include transportation costs incurred when the patient must travel outside the community to receive treatment, either because there is no local dentist or dental therapist or because the treatment must be done in a hospital setting under general anaesthetic given the extent of the dental decay. Medical transportation costs for NIHB reported for fiscal year 2012/2013 totalled just over 351 million dollars. While this figure includes transportation for both medical and dental treatment needs, the cost associated with travel for dental treatment is still substantial. As dental caries is a preventable infectious disease, the large disparity that exists between the First Nations and Inuit populations and the rest of the Canadian population despite the large amount of money spent annually needs more attention. Access to care is an issue because of both the large distance that these people must often travel to reach the nearest dental clinic, and because there is a shortage of providers willing to work in the clinics and in the communities. First Nations and Inuit populations are increasing at a higher rate than the rest of the Canadian population. With a high proportion of children in this group, considerable changes are needed in order to decrease the disparities.[13] One approach aimed at improving the health of First Nations people, specifically in British Columbia, is the British Columbia Tripartite Framework Agreement, signed in 2011.[14] Continuing initiatives such as this one may prove helpful in increasing the overall health status of this population.

Following the 2005-2010 Canadian Oral Health Strategy, the FPTDWG produced the Canadian Oral Health Framework (COHF) 2013-2018. The framework identified strategies to improve the

oral health status of Canada's marginalized populations by reducing the burden of disease and increasing access. As stated in the COHF, "The way forward involves addressing the structural issues, proposing new approaches, encouraging change, following best practices and enhancing public services. [The COHF] is written from a public health perspective which allows the document to focus on valuable interventions (e.g. methodologies to discourage use of sugar, accessing government-funded, and/or university outreach clinics) which will require discussion with appropriate stakeholders".[15]

For more than a century, Canadian public health and dental public health (DPH) leaders have emphasized the importance of oral health and have advocated for the inclusion of dental treatment in the Canada's universal health care system. Lack of access to dental care continues to be an issue for the dental profession and for many socially marginalized subgroups of the Canadian population: children, elderly, Aboriginals, those with special needs, and those in low-income groups. In September 2014, the Canadian Academy of Health Sciences released a report entitled, *Improving Access to Dental Care for Vulnerable People Living in Canada*. The report explains that "there are significant income-related inequalities in oral health and inequity in access to oral health care [and that] those with the highest levels of oral health problems are also those with the greatest difficulty accessing oral health care."[16] The report adds that, "inequalities in access to dental care are contributing to inequalities in oral health," and highlights that "there is no consensus among federal, provincial, territorial, and municipal governments across Canada on the use of a range of dental and other health care professionals that might improve access to oral health care services, particularly for groups suffering the greatest burden of oral diseases."[16]

With the rising costs of dental care, the increasing cost of insurance, and the reduction in public dental coverage, innovative solutions and buy-in from all key stakeholders are needed. As such, a review of the changes to publicly financed dental care in Canada is warranted. Efforts are being made by the CDA to develop a consensus on a national oral health strategy.

This report will describe the current state of affairs of Canada's public dental health care system as well as developments since the completion of the 2005 Environmental Scan of Publicly Financed Dental Care in Canada.[17] Similar to the previous report, the current report describes provincial and territorial public dental programs, and details on associated legislation and financing trends. Also included in this environmental scan is information pertaining to dental public health human resources. Consistent with the previous scan, the ultimate aim of this report is to foster interest in public health dentistry and to improve access to dental care, especially to socially marginalized groups.

Methods

The 2005 Environmental Scan of Publicly Financed Dental Care in Canada served as an update to the 1983 Stamm Report. The update produced information on:

- Public dental programming for each province and territory;
- Provincial and territorial legislature related to public financing of dental care;
- Federal direct and indirect service delivery activity;
- Expenditure trends of per capita publicly financed dental care from 1960-2005; and
- Information on provincial household budgetary share for dental care represented in Engel curves.

In 2007, a second report was produced in collaboration with the OCDO, Health Canada, and the Community Dental Health Services Research Unit, Dental Research Institute, Faculty of Dentistry, University of Toronto to provide updated information on public dental care programming and human resources in Canada. This information was not previously released but has been included in this update.

As indicated in previous reports and discussions with key stakeholders, a periodic update of the report was recommended. With changes in legislation and public funding over the past decade, an update on dental programming in Canada will serve as an invaluable resource to all interested parties. It was suggested by the OCDO that including information regarding program reimbursement rates, human resources, and per diem rates would also prove useful.

The objectives of this scan are to provide information on:

- Changes in programming and legislation related to provincial and territorial public dental care activities since 2005;
- Enumeration and remuneration of dental public health human resources across provinces and territories;
- Public dental care programming reimbursement rates of provincial fee guides across Canada; and
- Expenditures on federal, provincial, and territorial direct and indirect service delivery activities.

A formal email correspondence was sent to each member of the Federal Provincial Territorial Dental Working Group (FPTDWG) and representatives of the Federal Dental Care Advisory Committee (FDCAC) to inform them of the intentions of the OCDO regarding this project. After reviewing the 2005 environmental scan methodology, a working document and instructional

email were created and reviewed by the OCDO. Once approved, both were translated into French and sent to FPTDWG members along with a reference document. A separate email was drafted and reviewed by the OCDO for representatives of the FDCAC. A return deadline of 9 July 2014 was given to the provincial/territorial dental representatives. Response rates were low for a myriad of reasons, and information from only three of thirteen provinces/territories directors had been received by the initial deadline. A description of the data collection instruments utilized for this report are found below (see appendix A to I).

Reference document

A reference document containing previous public dental programming and legislation (1983-2007) in tabular format and the previous narrative for each jurisdiction was consolidated and converted into a .pdf document. This document was sent to individual FPTDWG members to serve as a guide for completing the working document.

Working document

To enable standardization and comparison between jurisdictions, the tables produced in the 2005 environmental scan were used as a template for public dental programming and legislation tables for each province and territory. The descriptors in the programming tables correspond to Stamm et al.'s original typology for describing public dental programming. The main components include: program eligibility, types of services covered, utilization, service environments, administration, and expenditures. Additional jurisdiction-specific tables that were provided in the 2005 environmental scan were extended to 2013-2014 dates.

Updated legislative information was provided by provincial and territorial contacts and verified, when necessary, through utilization of the Canadian Legal Information Institute service (available at www.canlii.org). The legislative information presented in this report is not intended to be used as official documentation and should not be cited for the purposes of interpretation or application of the law. Rather, it serves as a guide that highlights each jurisdiction's current legislation and can be compared with the corresponding table in the previous report to illustrate changes over time.

To further understand the dynamics of public dental care programming across Canada, dental public health human resources information were requested from the FPTDWG. The tables included in the working documents were adapted from the *Public Dental Care Programming and Human Resources in Canada, 2007/08* report. Additional information pertaining to program reimbursement, per diem, and salary rates were presented in tabular format and reviewed by the

OCDO. Appendix J provides information on the data collection methodology for health human resources and per diem rates obtained for each province and territory.

Expenditure trends

Public dental programming expenditures were obtained from provincial, territorial, and federal contacts. Federal department representatives were asked to provide information on dental expenditures for the past three fiscal years in order to establish trends over time. Expenditure information on the Public Service Dental Care Plan (PSDCP) and the Pensioners' Dental Services Plan (PDSP) were also obtained and pooled with federal dental care expenditures to determine total federal contributions to dental care in Canada.

Limitations

There are limitations to the amount and depth of information that can be presented. Challenges faced included: the modest project timeline; the absence of key players during the summer leave period; the lack of dental directors in some jurisdictions; the requirement to liaise with multiple departments within a province/territory; and the continuous changes in programming and legislation, especially in jurisdictions that underwent recent elections. In many cases, it would have been helpful to have had a dental public health specialist in a leadership role at the provincial/territorial level, as not all jurisdictions currently have this expertise. Unlike the 2005 scan, Engel curves were not produced, as provincial/territorial level expenditures were not available through Canadian Institute for Health Information (CIHI). Other costs associated with dental care in Canada were not provided for all jurisdictions. Also not presented is dental care provided through charitable organizations, university programs, and private sector involvement. Tables in the scan may not contain 2014 information as updated information was either not provided or unavailable. Finally, the reports on health and human resources associated with public dental care activities at both the provincial and federal levels do not always consider administrative and auxiliary personnel.

It is understood that dental public health programming and human resources in Canada are constantly evolving. As such, this report serves as a descriptor of public dental care activities at the time of the environmental scan (summer 2014), as well as changes that have occurred since the previous scan. The intention is not to continuously update the document with each change, but rather to have periodic updates, ideally every five years. For a thorough understanding of dental public health activities for each jurisdiction, the corresponding dental directors/departments should be contacted.

Canada

In the 2014 Human Development Report (HDR), Canada ranks eighth of 187 nations. The HDR is an annual report from the United Nations Development Programme that provides a summary measure of a nation's human development based on income, education, and health.[18] This measure, namely the Human Development Index (HDI), is a gauge for human well-being of a country and allows for comparisons between nations, as well as within a given country over time.

Since the HDR was first launched in 1990, Canada has consistently been in the highest human development category. Even within this classification, Canada has consistently ranked high, being at the top of the list for much of the 1990s.[19] At the time of the 2005 Environmental Scan of Publicly Financed Dental Care in Canada, Canada was ranked fourth out of 177 nations, behind only Iceland, Norway, and Australia, with the United States ranked eleventh.[20] Since then, Canada's ranking declined steadily until 2012 when it dropped out of the top ten to number 11. In the most recent report, Canada has moved back into the top ten and now sits at eighth.[19] Norway and Australia still top the list, with the United States jumping ahead of Canada to fifth.[21]

As the HDI is an average score, it does not accurately reflect levels of inequality thus could, on its own, be misleading. In 2010, the HDR introduced the Inequality-Adjusted HDI (IHDI), which considers inequalities that exist in the areas of income, education, and health. The reduction in the human development score when inequalities are considered is expressed as a percentage. According to the 2014 HDR, which uses 2013 statistics, this represents a loss of 7.6% for Canada, as compared to 5.6% for Norway, 7.8% for Australia, and 17.9% for the United States.[21]

Understanding the inequalities that exist in Canada is significant in the context of the present report. While Canada is an affluent, developed nation where approximately three-quarters of Canadians visit the dentist annually, access to dental care is a major issue for disadvantaged Canadians, specifically children, elderly, immigrants, those with low incomes, those with disabilities, and the Aboriginal population.[3]

Between 2001 and 2011, Canada's population has grown by approximately three million. Higher than average increases in birth rates in Alberta and the three territories contributed largely to this growth. This decade also saw a large increase in the elderly population, again most notably in the territories where the number of people over 65 years of age almost doubled (Table 1). By 2036, it is expected that the number of seniors in Canada will double to 10.4 million, and by 2051 it is estimated that one quarter of Canadians will be over 65 years. In 2011, the highest proportion of

seniors was in the Atlantic Provinces, Quebec, and British Columbia, with Nova Scotia reporting the highest proportion at 16.5%. Since the growth rates of the senior population are different between provinces/territories, it is expected that by 2036 Newfoundland and Labrador will have the highest proportion of residents 65 years of age or older.[22]

Between 2006 and 2011, 62.5% of new immigrants to Canada settled in one of Canada's three major cities, namely Toronto (32.8%), Montreal (16.3%) or Vancouver (13.3%). This is up slightly from the 1970s when 58% of new immigrants established themselves in these cities.[23]

In 2011, Canada's Aboriginal population made up 4.3% of the overall Canadian population. The growth of this segment of population, which increased by 20.1% from 2006 to 2011,[24] is substantially higher than it is for the rest of Canada, which saw an increase of 5.9% over the same period.[25] As a result of the increased birth rate among the Aboriginal population, the median age of Aboriginal Canadians is 27.7 years, 13 years lower than that of non-Aboriginal Canadians at 40.6 years.[24]

Ontario and the four western provinces have the largest number of Aboriginal residents, Ontario with the highest at approximately 300,000. At just more than 27,000, the number of Aboriginal people in Nunavut is less than 10% of that in Ontario, though this represents 86.3% of the Nunavut's total population. This is in contrast to the proportion of Aboriginals in Ontario, at 2.4%.[26] Noteworthy is that of Canada's three Aboriginal groups, First Nations, Métis, and Inuit; almost half of the Inuit population live in Nunavut, totalling 85.4% of this territory's population. This is important given that the average age of the Inuit people is the lowest of all three groups at 21 years.[26]

The number of children living in poverty has decreased across all provinces between 2001 and 2011 and there has been an overall decrease in the number of Canadians covered by social assistance. However, the number of social assistance recipients increased in Ontario, Nunavut, the Northwest Territories, and Alberta, with the most significant increase in Ontario (Table 1).

There have been changes to dental public health infrastructure across numerous provinces in the past decade (Table 3). Restructuring and amalgamating of regions in Newfoundland and Labrador in 2005 reduced the number of regions from fourteen to four. In the same year, Prince Edward Island combined all four regions under the one authority. Important changes were made in Ontario in 2006 with the establishment of the Local Health System Integration Act, which created 14 Local Health Integration Networks (LHINs). Through these changes, Ontario retained 36 public health units that are independent from the LHINs. In 2008, New Brunswick

consolidated eight regional health authorities (RHAs) into two and similarly, in 2012, Manitoba reduced the number of RHAs from 11 to five in order to help "streamline administration and protect front-line health care".[27] British Columbia underwent a noteworthy public health infrastructure change in 2013 with the enactment of the First Nations Health Authority (FNHA). The FNHA is part of the British Columbia Tripartite Framework Agreement on First Nations and Health Governance and is responsible for the planning, delivery, and funding of health programs that were previously under the prevue of Health Canada's First Nations Inuit Health Branch Pacific Region.[28] As of April 1, 2015, Nova Scotia will change from nine District Health Authorities (DHA) to one provincial DHA.

There have been both positive and negative changes to dental public health human resources in Canada since the 2005 Environmental Scan of Publicly Financed Dental Care in Canada (Table 5). Nunavut has established a dental public health specialist position and plans to further increase the number of dental public health personnel as a result of the introduction of the Nunavut Oral Health Project. Northwest Territories now has a dental consultant specialist position, and the number of dental public health personnel in Alberta has also increased in recent years. The dental public health consultant position in Nova Scotia remains vacant. This province has also seen a decline in the number of dental hygienists working in public health roles. New Brunswick does not have any dental professionals working in dental public health roles, despite the 2012 submission from the New Brunswick Dental Society wherein the number one recommended change to improve oral health care service delivery in the province was to "appoint a Chief Dental Officer for New Brunswick to advise government on oral health issues".[29]

Some provinces and territories have reported increases in dental public expenditures in recent years (Table 6). In New Brunswick, there has been almost a threefold rise in Canada Health Act (CHA) dental expenditures (namely children's dental treatment under general anaesthetic in a hospital setting) since 2005. While Prince Edward Island's targeted dental disbursements have increased only slightly in the same period, the province's CHA expenses have almost doubled. Manitoba has seen similar increases in CHA expenditures, which close to doubled on dental treatment for the socially marginalized population. The Northwest Territories most noteworthy funding increase was also for this same population for which expenditures almost tripled in the past decade.

Reimbursement rates for treatment provided under dental public health programming vary between provinces/territories and between programs within the same jurisdiction (Table 86). Generally, the reimbursements rates, expressed as a percentage of the provincial fee guide, hover between 70 and 90%. The exception to this is Ontario, where the average reimbursement rate is

46%. As will be discussed in later sections, not all public dental programs in Canada follow a fee-for-service model.

Overall, federal public dental care expenditures have experienced slight changes since 2005 (Table 7). However, there have been noted decreases in some instances at the departmental level. In the last nine years, Veterans Affairs Canada has experienced a 5 million dollar reduction in spending on dental care. This could be attributable to the overall decline in the Veteran population. There have been fluctuations within Citizenship and Immigration Canada expenditures for dental care programming over the past decade. This is likely attributed to changes in the Interim Federal Health Program over the past few years. Expenditures on dental care for the Royal Canadian Mounted Police have remained relatively steady in recent years. As shown in Table 8, Health Canada expenditures have risen since 2005 by 70 million dollars (41%). There have been fluctuations in expenditures for the Children's Oral Health Initiative, with a net increase of approximately 1.4 million dollars in recent years. The Dental Therapy Program has seen a drop in expenditures of late. This may be attributable to the 2011 closure of Canada's only dental therapy training program, the National School of Dental Therapy in Prince Albert, Saskatchewan.[30]

A review of expenditures related to the PSDCP and PDSP provides additional information on dental-related expenditures at the federal level. The PSDCP and PDSP are part of private health service plans for federal public service employees, public service pensioners, and their dependents. While there were fluctuations in expenditures for PSDCP over the past decade, there was a net increase of 37% (Table 9). With regards to the PDSP, expenditures for dental care more than doubled (116%) with the largest per cent increase occurring between 2006 and 2007.

Table 1. 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[b] 2006	Persons covered by social assistance[b] 2009	Children (<18yr) living in poverty[c] 2009	Children (<18yr) living in poverty[c] 2011	Elderly living in special care facilities[d]	Persons with severe to very severe disabilities	
											0-14 years[e]	>15 years[f]
BC	4,400,055	219,670	457,700	275,165	688,715	140,500	160,800	136,000	153,000			255,990
AB	3,645,255	244,880	439,915	238,205	405,725	50,300	63,100	102,000	77,000			156,400
SK	1,033,380	68,760	129,100	71,755	153,700	4,710	41,300	29,000	25,000			49,440
MB	1,208,270	77,180	153,975	86,215	172,445	59,400	57,700	43,000	45,000			68,290
ON	12,851,820	704,260	1,476,505	863,635	1,878,320	688,400	757,000	381,000	364,000			827,880
QC	7,903,000	440,840	817,785	491,980	1,257,685	506,500	486,300	195,000	184,000			315,640
NB	751,170	36,530	77,050	45,850	123,630	44,300	38,900	13,000	14,000	g	g	52,120
NS	921,725	43,980	94,235	57,440	153,375	49,900	42,800	13,000	14,000			66,250
PE	140,205	7,270	15,790	9,650	24,465	6,400	5,700	3,000	g			7,530
NL	514,535	24,490	52,140	29,585	82,105	45,800	39,000	14,000	10,000			29,420
NU	31,905	3,965	6,450	3,060	1,065	14,300	16,000					440
NT	41,460	3,285	5,730	3,390	2,390	2,100	2,900	g	g			1,310
YK	33,900	1,975	3,885	2,205	3,090	g	g					1,660
Canada	33,476,690	1,877,095	3,730,245	2,178,135	4,945,055	1,612,610	1,711,500	929,000	886,000	224,280	84,280	1,832,370

[a] Statistics Canada, 2011 Census of Canada. Catalogue number 98-311-XCB2011018

[b] Institute de la statistique du Québec. Table 5.7 Clientèle de l'aide sociale, 2005-2009. Available at http://www.stat.gouv.qc.ca/statistiques/economie/comparaisons-economiques/interprovinciales/chap5.pdf

[c] Statistics Canada. Table 202-0802 - Persons in low income families, annual, CANSIM (database)

[d] Statistics Canada, 2011 Census of Canada. Living arrangements of seniors. Special care facilities include nursing homes, chronic care, and long-term care hospitals. Catalogue number 98—312-x-2011003. http://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-312-x/98-312-x2011003_4-eng.cfm

[e] Statistics Canada, 2007, Participation and Activity Limitation Survey 2006. Catalogue number 89-628-XIE-003

[f] Statistics Canada, 2012, Canadian Survey on Disability. Catalogue number 89-654-X

[g] Not reported

Table 2. Summary of dental public health programming in Canada, 2014

Province	Medical Care Plan	Social Assistance	Disability	Children[a]	Seniors
BC	X	X			
AB	X	X	X		X
SK	X	X			
MB	X	X			
ON	X	X	X		
QC	X	X	X	X	
NB	X	X			
NS	X	X	X	X	
PE	X	X	X	X	b
NL	X	X		X	
NU	X				X
NT	X				X
YK	X				

[a] Indicates province/territory has a universal children's program. Program eligibility and service schedule varies by province/territory
[b] Coverage for elderly in long-term care facilities

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	2013
AB	1919	1959	1992	1994	2002, 2003 and 2009
SK	1923	1948	1987	1882	2002
MB	1928	1946	1993	1997-98	2002 and 2012
ON	1923	1825	1994	2006	-
QC	1926	1943	N/A	1989-92	2001 and 2003-04
NB	1918	1948	1991	1992	2002 and 2008
NS	1930	1948	1988	1996	2001 and 2015[a]
PE	1931	1950	N/A	-	-
NL	1950	1952	1992	1994	2005

[a] As of April 1, 2015 Nova Scotia will be changing from 9 District Health Authorities (DHA) to one provincial DHA

Table 4. Dental public health human resources in Canada, full-time equivalents, 2007/08

Province	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	Allied DPH Human Resources (FTE)			
			Dental Hygienist	Dental Assistant	Dental Therapist	Other[a]
BC	1	0.6	35.2	23.9		
AB	0.63	4.8	35.21	40.46		12.73
SK		0.31		5	67.1	
MB		0.8	2	6		
ON	13.69	45.1	116.7	140.47		122.39
QC	29		229.7			
NB[a]						
NS		0.3	18.6			
PE	1	2.2	6.8	13.4		2
NL		6.4	1	7		2
NU					6	3
NT					11.5	
YK					8	2
Federal*	2	6	8		60	4
Total	**47.32**	**66.51**	**453.21**	**236.23**	**152.6**	**148.12**

[a] Not specified

Table 5. Dental public health human resources in Canada, full-time equivalents, 2013/14[a]

Province	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	Allied DPH Human Resources (FTE)			
			Dental Hygienist	Dental Assistant	Dental Therapist	Other
BC	b					
AB	1.3	2.4	31.71	39.06	-	4.3[c]
SK	-	d	0	22.12	15.15	19.3-22.3[c]
MB	1.5	1.92	2.5	6.38		2.5
ON	b					
QC	b					
NB	e					
NS	-	-	14.2	-	-	-
PE	1.0	2.2	5.0	13.0	-	2.0
NL	b					
NU	1.5	1.0[f]	0.1	1.0[g]		20.3[h]
NT	0.1	-	-	-	11.5	-
YK	b					
Federal					55.0	

[a] Does not include enumeration of on-reserve providers
[b] Not reported
[c] Not specified
[d] All health regions have contract dentists for consultation and referral purposes
[e] NB has no dental professionals practicing in public health
[f] Anticipated
[g] Includes Dental Aides and Dental Therapists working as Dental Hygiene Educators
[h] Includes Dental Therapists, COHC's, COHI aides

Table 6. Dental public health expenditures in Canada, 2013/14[a]

Province	Targeted dental public health expenditures ($000)	Targeted treatment expenditures for the socially marginalized ($000)	Canada Health Act expenditures ($000)	Total publicly financed dental care expenditures ($000)
BC	b	b	7,904[c]	b
AB	6,000	40,000[d]	7,077[c]	53,077
SK	2,875[c]	10,887	1,710[c]	15,472
MB	1,412	7,332	1,232[c]	9,976
ON	17,600[d]	100,132	12,525[c]	130,257
QC	b			
NB	50	6,600	664[c]	7,314
NS	5,296	5,547	1,397[c]	12,240
PE	2,668	471	137	3,276
NL	b	b	455[c]	b
NU	b	b	-	b
NT	1,495	1,044		2,539
YK	b	b	22[c]	

[a] Figures rounded
[b] Not reported
[c] Health Canada (2013) *Canada Health Act Annual Report 2012-2013*
[d] Estimate

Table 7. Federal public dental care expenditures, 2004-2014[a]

Federal organisation	Expenditures ($000)				
	2004/05[b]	2007/2008[c]	2011/12	2012/13	2013/14
Department of National Defence	19,400	27,000	Information not available		
Veterans Affairs Canada	19,300	18,000	18,100	15,900	14,400
Royal Canadian Mounted Police	9,100	8,888	12,208	12,589	12,838
Correctional Services Canada	2,800	2,800	4,923	5,058	4,650
Citizenship and Immigration Canada	1,000	999	3,480[d]	1,681[d]	612[d,e]
Health Canada[f]	173,400	190,000	234,912	237,504	245,509
Total Federal	225,000	247,687	270,143[g]	271,051[g]	277,397[g]

[a] Figures rounded
[b] 2005 Environmental Scan of Publicly Financed Dental Care in Canada. Source: http://www.fptdwg.ca/assets/PDF/Environmental_Scan.pdf
[c] 2007/08 Environmental Scan update (not published)
[d] The dental expenditures represent the claims reimbursement and the claims processing fees by Medavie Blue Cross. Other indirect costs such as prior-approvals fees, facility fees, or personnel costs are excluded from the analysis. Source: IFHP database on claims as of March 31, 2014
[e] The service providers have up to 6 months to send their claims for reimbursement. The data for fiscal year 2013/14 should be considered preliminary
[f] Estimate based on NIHB, COHI, and Dental Therapy program
[g] Does not include expenditures from the Department of National Defence

Table 8. Health Canada public dental care expenditures, by program, 2011-2014

Health Canada Programs	Expenditures ($)		
	2011/12	2012/13	2013/14
Non-Insured Health Benefits Program	219,100,000[a]	222,700,000[b]	230,729,100[c]
Children's Oral Health Initiative	5,370,923	5,257,934	6,720,944[d]
Dental Therapy Program	10,440,868	9,546,289	9,059,650
Total	234,911,791	237,504,223	245,509,694

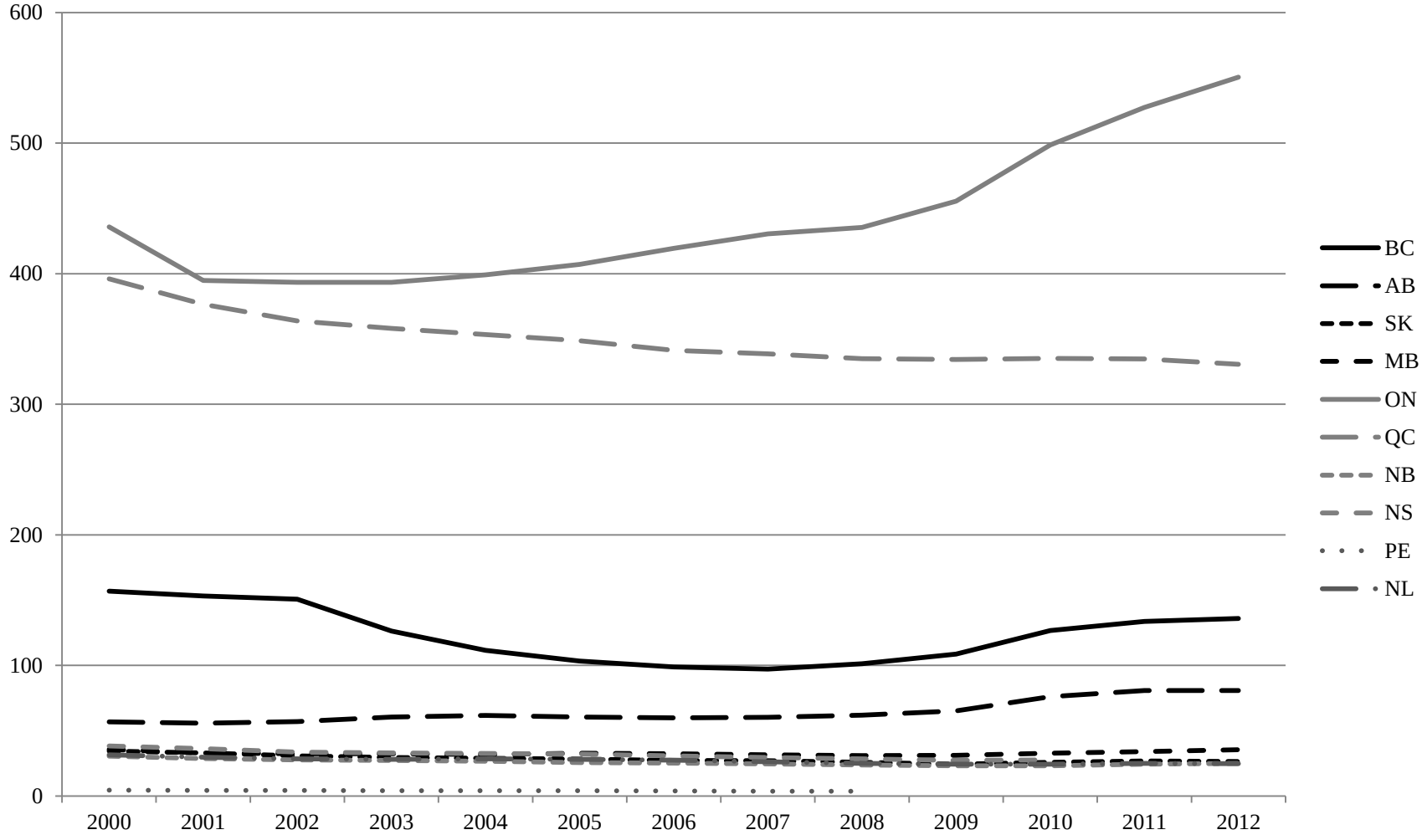
[a] Includes: fee-for-service dental costs (88.7%) paid through the HICPS system; contribution agreements (5.6%); contract dentists (4.3%); other costs (1.4%). Source: 2011/12 NIHB Annual Report
[b] Includes: fee-for-service dental costs (88.4%) paid through the HICPS system; contribution agreements (6.1%); contract dentists (4.2%); other costs (1.3%). Source: 2012/13 NIHB Annual Report
[c] Includes: fee-for-service dental costs (87.4%) paid through the HICPS system; contribution agreements (6.4%); contract dentists (4.7%); other costs (1.5%). Includes $23.5 million expenditure from First Nations Health Authority as managed by the BC Tripartite effective July 2, 2013. Sources: 2013/14 NIHB Annual Report (not published yet) & Health Information and Claims Processing Services (HICPS)
[d] Includes BC Tripartite expenditures

Table 9. Federal dental expenditures, 2006-2013

	Expenditures ($000)							
	2006[a]	**2007[a]**	**2008[b]**	**2009**	**2010**	**2011**	**2012**	**2013**
Public Service Dental Care Plan	194,491	207,833	229,227	251,100[c]	264,900[c]	271,310[c]	276,630[c]	266,970[c]
Pensioners' Dental Service Plan	31,977[f]	51,134[f]	56,369[f]	62,418[b,f]	70,810[d,f]	67,632[d,f]	67,247[e,f]	69,120[e,f]

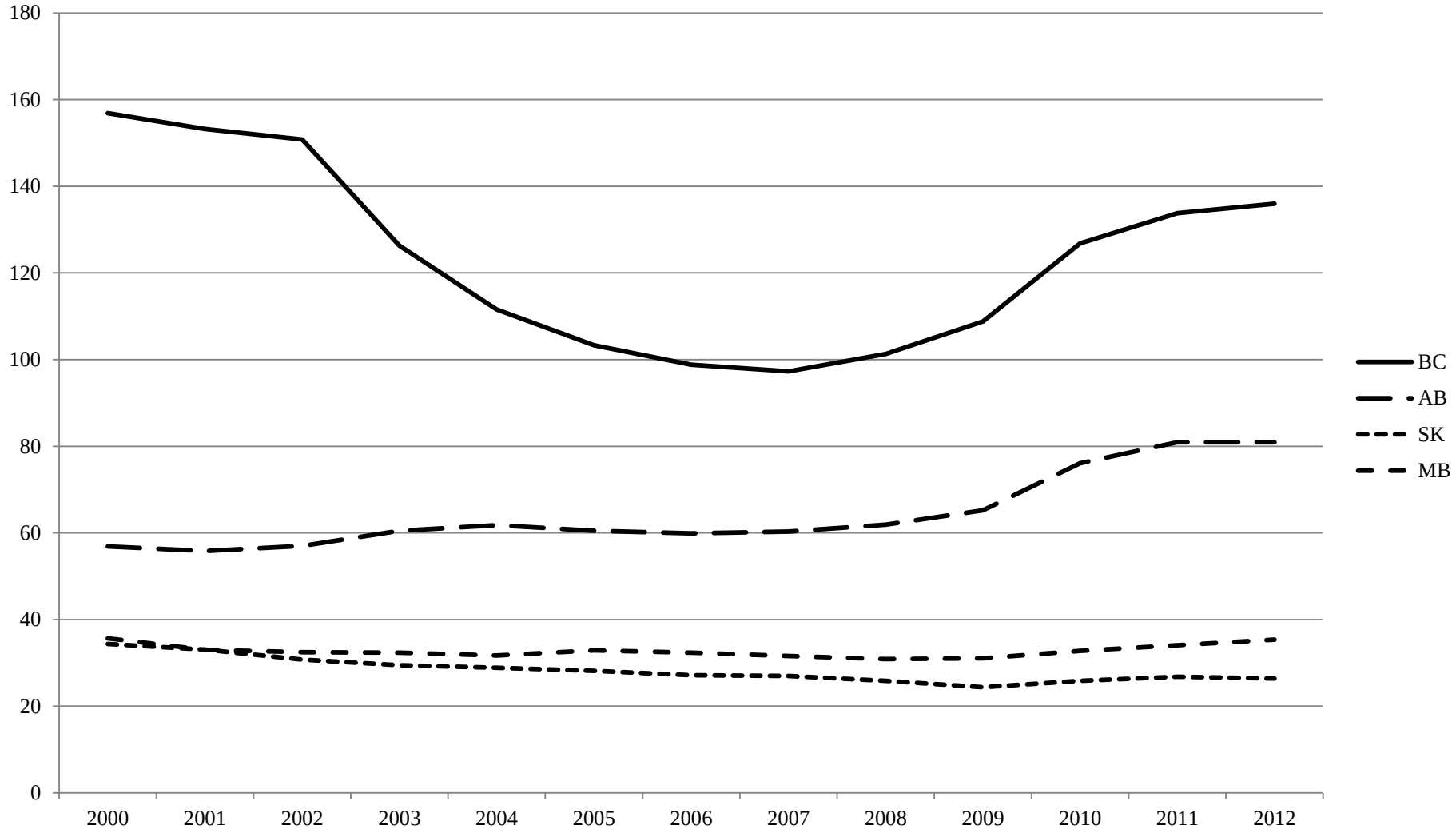
[a] 2006/07Departmental Performance Report: http://www.tbs-sct.gc.ca/dpr-rmr/2006-2007/inst/tbd/tbd03-eng.asp#Section%20III
[b] 2008/09 Departmental Performance Report: http://www.tbs-sct.gc.ca/dpr-rmr/2008-2009/inst/tbd/st-ts07-eng.asp
[c] June 2014 22nd Public Service Dental Care Plan: annual presentation plan. AGM
[d] 2010/11 Departmental Performance Report - http://www.tbs-sct.gc.ca/dpr-rmr/2010-2011/inst/tbd/st-ts06-eng.asp
[e] 2012/13 Departmental Performance Report: http://www.tbs-sct.gc.ca/dpr-rmr/2012-2013/tbd/tbd11-eng.asp
[f] Indicates total net costs of claims (total expenses subtracted recoveries)

Figure 1. Social assistance cases by province, 2000-2012 ('000)[a]



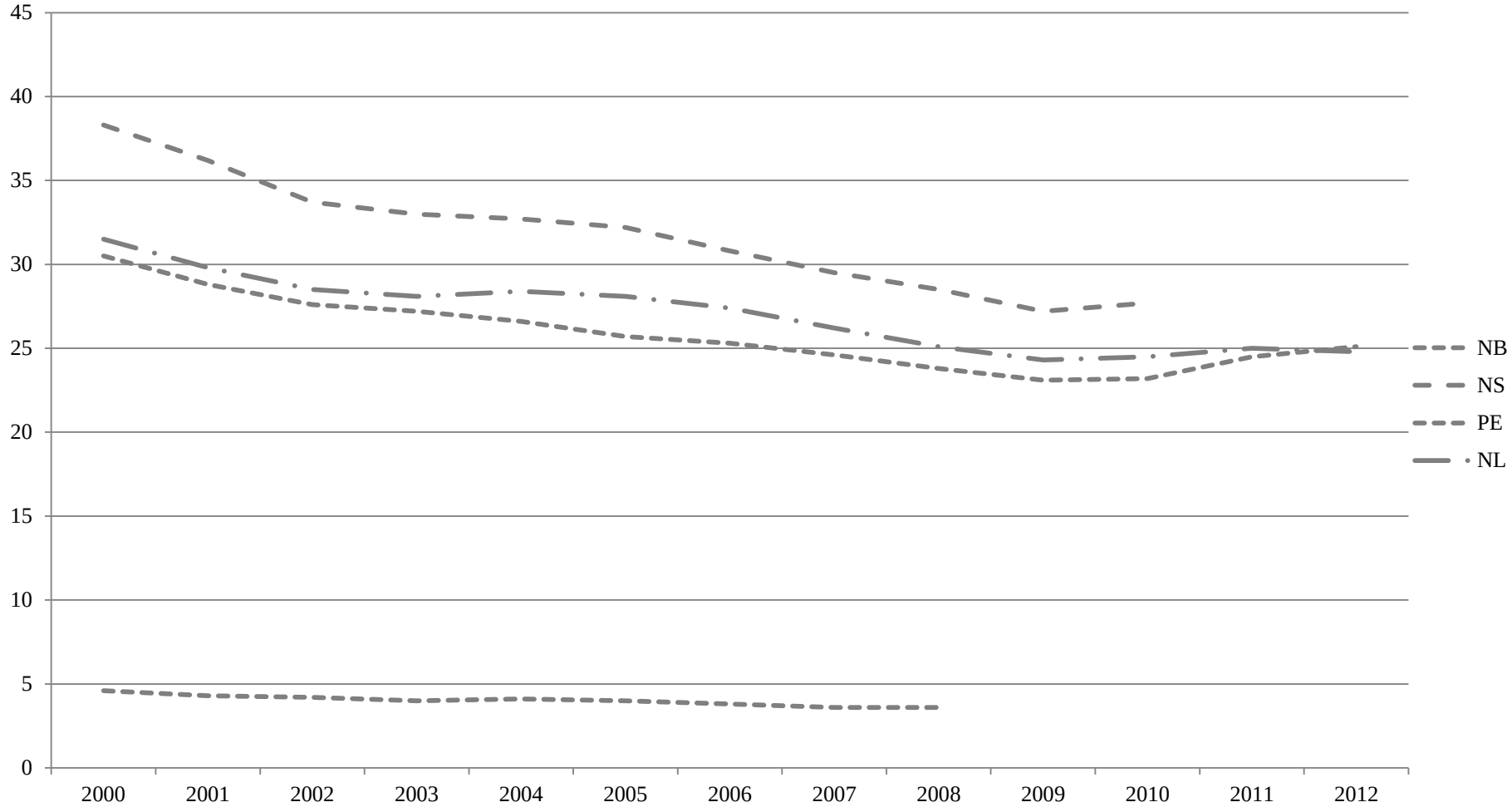
[a] Information adapted from Table 2, Social-assistance cases, by province, fiscal year, 1981-2012. Kneebone & White, 2014. The rise and fall of social-assistance use in Canada, 1969-2012

Figure 2. Social assistance cases, Western provinces, 2000-2012 ('000)[a]



[a] Information adapted from Table 2, Social-assistance cases, by province, fiscal year, 1981-2012. Kneebone & White, 2014. The rise and fall of social-assistance use in Canada, 1969-2012

Figure 3. Social assistance cases, Atlantic provinces, 2000-2012 ('000)[a]



[a] Information adapted from Table 2, Social-assistance cases, by province, fiscal year, 1981-2012. Kneebone & White, 2014. The rise and fall of social-assistance use in Canada, 1969-2012

British Columbia

The province of British Columbia has experienced notable changes related to dental public health programming since 2005. British Columbia runs six programs provincially through the Ministry of Employment and Income Assistance, Ministry of Children and Family Development, and Ministry of Health Services namely: Dental Supplements Program, Healthy Kids, Medical Benefits Program, Dental Benefits Program for Children in Foster Care and Youth Agreements, Medical Services Plan, and Preventive Dental Health Services Program.

To ensure best practices are implemented in public dental programming in British Columbia, a working group was established through the Ministry of Health and Health Authorities in British Columbia to produce a review of evidence and best practices as well as a model core program paper for dental public health; both were approved in 2005 and published in 2006.[31,32] These papers were a part of a larger 10-year Guiding Framework for British Columbia's public health system.[33]

The model core paper for dental public health recommended a set of core elements for dental public health programming that included, "Dental health promotion; prevention of dental diseases, with a focus on prevention of childhood diseases; surveillance, assessment and evaluation of dental health status and dental health programs".[32]

The paper also included nine better practices for professionals working within dental public health including, "1. Supporting dental skill-building workshops and providing education materials to health care professionals and care providers; 2. Facilitating the education of families with young children in effective dental practices; 3. Assessing dental health of young children and providing appropriate preventive care; 4. Advocating for fluoridation of public water systems where appropriate; 5. Community capacity-building to facilitate partnerships which will enhance dental health promotion and dental health programs; 6. Encouraging healthy public policy through collaborative approaches and advocacy with other public health and community-based partners; 7. Advocacy for access to dental health services for vulnerable populations such as adults in care, low income pregnant women and families and those with developmental disabilities; 8. Conducting surveys and measuring trends in the status of dental health among school entry children, aged 5-6 years; and 9. Establishing evaluation frameworks as a component of all dental health programs provided by a health authority".[32]

Ultimately, this framework serves as a guide to implementing and maintaining dental public health programming in British Columbia. As a result, several initiatives have been carried out since 2006.

A four-year evaluation of early childhood dental programs began in 2006 and was conducted by the Ministry of Health (MOH) and by the Human Early Learning Partnership (HELP) at the University of British Columbia (UBC). The aim was to evaluate surveillance, risk assessment, health promotion and prevention strategies, and partnerships associated with early childhood dental programs. The report helped determine if the province was reaching its 2005 goal for "60% of British Columbia's kindergarten population will have no visible decay experience".[34] Through utilization of the 2006-2017 and 2009-2010 Kindergarten Dental Surveys, the results of the evaluation found overall and region-specific improvements in the oral health of young children.[34] "In 2006/07, 61.1% of kindergarten students surveyed in British Columbia had no visible decay (Code 01); in 2009-2010, the percentage increased to 63.3%, which is 3.3% above the provincial target of 60%.".[34] Despite these improvements, it was apparent that regional disparities existed, either due to geographic location or socioeconomic status. Of important note, the report found "the highest absolute number of children with visible dental decay resides in midlevel socioeconomic neighbourhoods".[34]

In 2008, the British Columbia Dental Association (BCDA) produced a *Report on Seniors' Oral Health* to review current care practices and issues related to the oral health of seniors. The report evaluated a dental insurance pilot project for long-term care facilities, which was funded by the Ministry of Health, Ministry of Housing and Social Development, Vancouver Coastal Health Authority, Dentistry Canada Fund, and the Three Links Care Society.[35] The project provided $27,765 worth of basic dental care over a period of one year. Recommendations from the report included advocacy for a professional program in geriatrics at the UBC Faculty of Dentistry in order to familiarize dentists with the special needs of seniors. The report estimated that an annual $24 million investment would "help to deliver a basic care plan for low-income seniors" and that "[I]ncreasing this amount by $2.5 million to $26.5 million will extend coverage to all of the residents in long-term care facilities in British Columbia".[35] It noted that for a plan that covers basic dental care, dentures and access to emergency services, "[O]n average the cost per senior to fulfill these services is: $328.66 for basic care; $311.71 for emergency care; and $585.07 for denture services".[35]

Later in 2011, the British Columbia MOH funded another report from the Seniors' Oral Health Secretariat entitled *Oral Health Care Delivery in Residential Care Facilities: A report of the Seniors' Oral Health Secretariat*. Again, the report called for a basic preventive dental coverage

plan, refinement of provincial regulations, expansion of education in geriatric care for dental professionals, and standardized oral health care training for non-dental health care providers, along with other recommendations.[36]

In addition to recommendations to implement a geriatric education program at the University of British Columbia, in 2014, the University of British Columbia announced its combined Masters of Public Health and Diploma in Dental Public Health program, to begin in Fall 2014.[37] The implementation of this new academic program proves promising to promoting strong leadership and workforce in dental public health in British Columbia and across Canada.[38]

The Government of British Columbia has made several investments in dental initiatives over the past decade. Between 2006 and 2008 the Ministry of Employment and Income Assistance (MEIA) provided $357,000 in capital grants towards the opening and maintenance of dental clinics and an additional $500,000 for dental initiatives in British Columbia. In early 2006, a pain control dental clinic opened in Prince George, which was funded by a one-time $50,000 capital grant from the MEIA. This initiative provided emergency relief of pain and follow-up dental services that are managed by volunteer dentists, hygienists and assistants in the community.[39]

In 2007, through partnership with the BCDA, the Ministry provided a $7,000 capital grant to the New Life Mission dental clinic in Kamloops in order to maintain its pain relief and follow-up dental services to low-income individuals.[40] In the same year, the MEIA spent $500,000 towards the British Columbia Healthy Kids Program to provide toothbrushes and oral hygiene information to approximately 365,000 elementary and middle-school students, which included First Nations schools.[41] Later in 2008, the Ministry funded another grant of $300,000 to open a dental clinic for low-income residents in Dawson Creek.[42]

Along with the contributions provided by the MEIA, there continued to be a rise in the number of income assistance recipients between 2007 and 2012 (Figure 2). As a result of this increase, in 2010 the Government of British Columbia announced changes in dental service coverage. The Government of British Columbia proposed a plan to save 3.1 million dollars in dental services utilized by persons with disabilities and children in low-income families. The changes included: modifying the maximum annual limits for dental services from $700 per year to $1,400 every two years for children; in-hospital and approved facility dental services provided under general anaesthesia was increased from $500 to $1,000 per year for both children and persons with disabilities; reductions in frequency of examinations, polishing and fluoride treatment to once per year instead of twice per year; and an x-ray coverage limit of $54.71 extended to every two years rather than once per year.[43] The changes in the dental services program were one of many

services targeted for these recipients, with the Government's intention to redirect funds to programs that provide monthly support and shelter costs.[43]

Other Ministries have also been involved in funding dental initiatives since 2005. In 2007, the Ministry of Community Services provided a $280,000 provincial grant to the Portland Community Dental Clinic in order to educate residents in Vancouver's Downtown Eastside on the risks of oral cancer.[44] In 2013, the Ministry of Health provided $700,000 to the BC Dental Association for the purpose of reducing wait times for patients with severe dental-facial deformities. Considered as part of a service agreement with the BC Dental Association, the funding aimed to reduce the 65 patient wait list for dental-facial reconstruction surgeries.[45] More recently, in 2014, the Minister of Social Development and Social Innovation, Don McRae, announced $96,000 in funding for 19 clinics across British Columbia, which included a $20,000 investment in the BC Dental Association's Save a Smile Program. As a result, $4,000 will be granted to each of the 19 dental clinics.[46]

A more notable change related to public health programming in British Columbia has been the introduction of the British Columbia Tripartite Framework Agreement in 2011, between the federal government, the province of British Columbia, and BC First Nations. Negotiations began in 2006, with the purpose implementing a new governance structure that would support better health for BC First Nations.[14] The signing of the agreement resulted in transferring of the planning, design, management and delivery of First Nations health programs from the federal government to a new First Nations Health Authority (FNHA). The underlying goal of the agreement was to produce a health authority that would better incorporate cultural beliefs and practices of First Nations individuals into the design and delivery of health programs.

The Grand Chief Doug Kelly, Chair of the First Nations Health Council declared, "We will be the first in Canada to take over province-wide health service delivery from the federal government and will work closely with the provincial health system to enable it to better meet First Nations health needs and priorities. Through this new health governance approach, we will see remarkable improvements in the health and well-being of First Nations people in British Columbia within one generation, and contribute to the health services accessed by all British Columbians".[47]

The Assembly of First Nations National Chief Shawn A-in-chut Atleo also stated: "This Agreement is a result of years of work by BC First Nations to bring forward a First Nation vision of health care […]. We cannot be passive observers in our own lives and the lives of our families

and communities - this Agreement enables First Nations to take a step forward in taking back responsibility for our own lives and for our own communities and Nations".[48]

On July 2 2013, the FNHA Health Benefits Program was established, which replaced the Non-Insured Health Benefits program for First Nations residents of British Columbia that have a status number. The service delivery and processes did not change but were now the responsibility of the FNHA; the processing and administration of claims remained with Health Canada. A two-year buy-back agreement was established between the FNHA and Health Canada in order for the FNHA to build capacity to process its own claims during that time. The buy-back meant that the FNHA would receive transfer payments from Health Canada for their portion of the NIHB program, but then would buy-back the administration of claims processing and benefits review services from Health Canada. This agreement enabled service continuity while the FNHA built the appropriate systems on their end.[49]

In 2014, the FNHA developed the Healthy Smiles for Life: British Columbia's First Nations and Aboriginal Health Strategy aimed at improving the oral health of First Nations and Aboriginal children aged 0-18 and their caregivers. The report serves as a guideline for developing comprehensive, multi-level, evidence-informed oral health programs and policies.[50] This Strategy followed the Ministry of Health, Health Canada and British Columbia Regional Health Authorities scan on oral health services in British Columbia for First Nations and Aboriginal children aged 0-7 years as well as the Dental Survey of Aboriginal Kindergarten-Aged Children 2009-2010.[51] It provided six strategic directions revolving around oral health promotion, prevention and identification of caries risk, access to treatment, leadership and collaborative action, surveillance, monitoring, and evaluation, as well as human resources.[50]

Table 10. Public dental programming in British Columbia, 2014

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Ministry of Employment and Income Assistance (MEIA)						
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) http://www.eia.gov.bc.ca/factsheets/2005/dental.htm	All MEIA 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) $1000/2yrs - Person >65yrs who have retained eligibility for health supplements $1000/2yrs - Spouses of PWD and PPMB $1000/2yrs - Children <19yrs who are dependent on client of income or disability assistance and recipients of Children in the Home of a Relative (CIHR) assistance $1400/2yrs	Different levels of coverage provided depending on income assistance designation - Emergency: diagnostic, restorative, endodontic, periodontal, oral surgery, prosthodontic - Basic: diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral surgery - Orthodontic services	a	Dentist and denturist private practices Pays for some treatment performed under GA care in-hospital Instances of balance billing	Centrally administered, adjudication and payment functions the responsibility of Pacific Blue Cross	a
Healthy Kids http://www.eia.gov.bc.ca/factsheets/2005/healthy_kids.htm	- Dependent children <19yrs whose families are in receipt of premium assistance through MSP $700/yr Dependent children under 19 years of age, in families approved for premium assistance by the Medical Services Plan (MSP) through the Ministry of Health, are automatically registered with the Healthy Kids Program. Children are eligible for $1400 of basic dental services every two years. Coverage includes services such as exams, x-rays, fillings, cleanings and extractions. Dentists can advise families of other services that may be covered.	As above, except orthodontic services	a			a
Medical Benefits Program, Dental Benefits Program for Children in Foster Care and Youth Agreements	Children in foster care $700/yr	As above, orthodontic benefits available to children in foster care	a	As above	As above	a

Table 10. cont'd

Program	Eligibility	Services Covered	Utilization	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 specialists in oral medicine and surgery 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	50,813 services provided[b]	Specialists and generalists in hospitals, private anaesthesia clinics, private practices	Centrally administered	7,903[b]
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	a	Dental hygienists and assistants/ regional health units, schools, residential facilities	Regionally administered	a

[a] Not reported
[b] Government of Canada (2013) *Canada Health Act Annual Report*. Canada Health Act Division, Health Canada. http://www.hc-sc.gc.ca/hcs-sss/pubs/cha-lcs/2013-cha-lcs-ar-ra/index-eng.php

Table 11. Public dental programming in British Columbia, 2007/08

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Ministry of Employment and Income Assistance (MEIA)						
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 MEIA 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) $1000/2yrs - Person >65yrs who have retained eligibility for health supplements $1000/2yrs - Spouses of PWD and PPMB $1000/2yrs - Children <19yrs who are dependent on client of income or disability assistance and recipients of Children in the Home of a Relative (CIHR) 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	60,708/168,394	Dentist and denturist/ private practices Pays for some treatment performed under GA care in-hospital Instances of balance billing	Centrally administered, adjudication and payment functions the responsibility of Pacific Blue Cross	24,213
Healthy Kids	- Dependent children <19yrs whose families are in receipt of premium assistance through MSP $700/yr	As above, except orthodontic services	66,961/165,467			18,096
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	As above, orthodontic benefits available to children in foster care	Approx. 10,000 eligible	As above	As above	2,500

Table 11. cont'd

Program	Eligibility	Services Covered	Utilization	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 specialists in oral medicine and surgery 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	18,511 services provided $83.16 avg. payment per service	Specialists and generalists/ hospitals, private anaesthesia clinics, private practices	Centrally administered	1,539[b]
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	c	Dental hygienists and assistants/ regional health units, schools, residential facilities	Regionally administered	3,500

[a] Not reported
[b] Government of Canada (2006) Canada Health Act Annual Report. Canada Health Act Division, Health Canada
[c] 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 12. Dental public health human resources in British Columbia, 2007/08

	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	Allied DPH Human Resources (FTE)[a]		DPH Programming	DPH Human Resource Costs ($)	Total DPH Program Costs ($)
			DH	DA			
Ministry of Health	1				No	100-000-140,000[b]	NA
Fraser Health Authority Fraser East Fraser North Fraser South			 1.5 3.4 3.4	 1 2 2.6	Yes	3,500,000[c]	
Northern Health Authority Northwest Northeast Northern Interior			3.5	4.9	Yes		
Interior Health Authority East Kooteney Kooteney Boundary Okanagan Thompson/Caribou			8.5	5	Yes		
Vancouver Island Health Authority South Vancouver Island Central Vancouver Island North Vancouver Island			5.9	0.4	Yes		
Vancouver Coastal Health Authority Vancouver Richmond North Shore		0.6	 3 2 4	 8	Yes		

[a] Dental Hygienists and Assistants

[b] Consolidated Revenue Fund, Detailed Schedule of Payments for the Fiscal Year Ended March 31, 2005, Minister of Finance, Office of the Comptroller General, ISSN1187-8657, 2005

[c] Regional breakdowns not reported

Alberta

Public dental programming in Alberta is best known for its commitment to seniors' oral health. Today, Alberta has maintained its reputation for providing benefits to seniors, as well as other vulnerable populations.

Health regions in Alberta were restructured in April 2009 with the abolishment of regional health authorities. The nine existing health regions were dissolved into one provincial health authority, the Alberta Health Services (AHS), where five geographic zones were created. Minister of Health and Wellness Ron Liepert announced the new model of public health in May 2008 with the intent to "ensure a more streamlined system for patients and health professionals across the province".[52] The purpose of this restructuring was to reduce bureaucracy, improve access to services and reduce regional inequalities, and to centralize political accountability for health.[53]

The creation of AHS provided an opportunity for change in the planning and delivery of public dental care in Alberta. As such, a review of the current status of oral public health programs in AHS took place in 2010, where recommendations and a two-year action plan were produced. The 2010-2012 Oral Health Action Plan (OHAP) outlined priority areas for public dental care that included a renewed focus on the oral health of young children and the growing oral health needs of seniors in long-term care facilities.[54] Other recommendations included producing standardized and timely surveillance measures, cost-effective and evidence-based best practices for oral health programs, as well as services that reflect the geographic and resource specific needs of populations.[54]

Of importance, the report addressed the lack of provincial data available to show trends in oral disease rates among Albertans.[54] The majority of data used in the report were from separate screenings of school-aged children and seniors. Limitations to this approach are the different years and different methodology used to screen these groups. Previously, all grade two and six children were screened every five years, but due to lack of resources, surveys had been delayed in some health regions. It was proposed in the OHAP that all zones would conduct surveys in 2012-2013.

In 2012, the Office of Alberta's Chief Medical Officer commissioned the University of Alberta, School of Public Health to produce report summarizing the current evidence on the effects of dental health on the public.[55] The report noted the variation in dental health care coverage across the province with Alberta having a less comprehensive coverage plan compared to other provinces.[55] It further emphasized the need for better surveillance measures and analyses related

to the access and oral health status of Albertans. They state, "[T]here are insufficient data from existing sources to comprehensively describe the state of dental health in children and adults in Alberta. The most comprehensive survey available, the Canadian Health Measures Survey is designed to present results at a national level and does not sample sufficiently to present province-level results with great accuracy. The dental health items included in the Canadian Community Health Survey do provide important information at a provincial level, however they rely on self-report, rather than examination by a trained interviewer. Finally, the last provincial survey was conducted in 1985 and included only 13 year olds".[55]

The number of dental public health personnel in Alberta has risen since 2007 (Tables 16 and 17). The formation of the AHS enabled the establishment of two new Oral Health positions within the Population and Public Health Portfolio, for the purpose of developing the 2010 OHAP that would align with the AHS Strategic Plan.[56] The two new positions were a Dental Public Health Officer and an Oral Health Manager. In 2011, three team lead dental hygienist positions were added to the Provincial Oral Health Office to support the development of resources and support to zone managers and frontline staff that implemented OHAP.[54]

Seniors' care has remained an important topic in Alberta. Several investments have been made in seniors' benefits programs since 2004. In 2005, the Government of Alberta announced 52 million dollars to enhance optical and dental care programs for seniors through the Dental Assistance Program for Seniors (DAPS).[57] This investment provided an additional 35 million dollars in spending for dental coverage. The program covers a maximum of $5,000 in dental services every five years for those earning under $20,000 and partial assistance (10-90% coverage) for seniors earning between $20,000-$30,000.[57] Earlier, in 2004, the Government of Alberta announced increases in income eligibility thresholds for seniors that allowed for an additional 17,000 seniors to benefit from seniors' programs.[58]

Funding continued to persist for dental services under the Seniors Benefit Program with an additional 7 million dollars allocated to dental, optical, and education property tax assistance programs for seniors in 2006.[58] The overall increase for seniors' financial assistance programs was 8.1% in 2007-2008, and 12.3% in 2008-2009.[59-60]

Greater investments in seniors programs occurred between 2009 and 2012. During this time, income eligibility thresholds increased up to $25,100 for single seniors and $40,800 for couples.[60-61] These increases coincided with increases in monthly benefits for low income seniors and persons with disabilities.[61-62] In 2013, 69 million dollars was spent on dental benefits for

88,378 seniors under the DAPS.[63] For 2014, the Government of Alberta announced an 11 million dollar increase to seniors' supplementary health benefits, including dental.[63]

Investments in benefits for recipients of the Alberta Child Health Benefit (ACHB) and Alberta Works Income Support Program have also occurred over the past decade. With a $2,000 increase in income thresholds and an extension of coverage for 18 and 19 year olds who live with their parents and attend high school, an additional 14,000 households became eligible for the ACHB in 2004.[64] In 2010, the Government of Alberta adjusted benefits for "leaners" category of the Alberta Works Income Support Program to ensure that learners' benefits were aligned with that of Expected to Work (ETS) and Not Expected to Work (NETW) Income Support (IS) Program.[65]

Table 13. Public dental programming in Alberta, 2014

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Ministry of Human Services						
Alberta Works Income Supports (AWIS)	IS 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	a	Dentist and denturist/ Private practices	Centrally administered, adjudication and payment functions the responsibility of Alberta Dental Services Corporation (ADSC)	a
Alberta Child Health Benefit (ACHB)	ACHB is a premium-free health benefit plan for children <18yrs, and under 20 if attending high school, living in low-income families	Supplementary Dental Coverage	a	As above	As above	a
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 Pregnant women with low income and households with individuals with high drug needs in relation to their income regardless of source of income	Standard Dental Coverage for ETW leavers and high drug needs category Supplementary Dental Coverage for NETW and AISH leavers and pregnant women category	a	As above	As above	a

Table 13. cont'd

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
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[c]	As above	As above	210 (Total cost for dental benefits in 2013-14)
Family Support for Children with Disabilities	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	Total caseload at any one time 9,500 Average utilization of the dental benefit 6 or 7 per mth	As above	As above	(Avg cost per claim not available Avg cost per utilization approx.$2,500)
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	88,378 recipients[b]	As above	As above	6,900[b]

Table 13. cont'd

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Ministry of Health						
Alberta Health Care Insurance Plan (AHCIP)	The AHCIP covers all Albertans for medically necessary dental-surgical services, as mandated by the *Canada Health Act*. Coverage is limited to specific dental, oral and maxillofacial surgical services that are listed in the Schedule of Oral and Maxillofacial Benefits, and does not include routine dental care. 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	As of 2012-2013 20,192 services provided to 14,317 Albertans	Hospitals and facilities accredited by the College of Physicians and Surgeons of Alberta as a Non-Hospital Surgical Facility	Schedule of Oral and Maxillofacial Surgery Benefits (SOMSB) published by the AHCIP	7,144
Cleft Palate Dental Indemnity Program	Albertans under the age of 25 years, who are born with a congenital cleft palate and who; as a result require uninsured dental services. Patients must be registered with the Cleft Palate Clinic at the Stollery Children's Hospital in Edmonton, or the Alberta Children's Hospital in Calgary.	Under this Program, benefits are payable for dental services such as radiographs, restorations, extractions, orthodontics, crowns, bridges and dental implants. Eligible services are paid on a fee-for-service basis up to a maximum amount as listed in the Program's benefits schedule. The Program is the payer of last resort and designed to supplement third-party insurance coverage.	47 new patients	Hospitals, non-hospital surgical suites, general and specialist dental facilities	Established pursuant to the *Treatment Services Regulation* under the *Public Health Act* Services are funded in accordance with Ministerial Order 15/2014 Administered by Alberta Health Services	1,216

Table 13. cont'd

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Oral and Maxillofacial Devices and Services Program	Patients must be residents of Alberta, be registered under AHCIP and be referred to the program by an oral maxillofacial surgeon. The patient must require high cost dental treatment in conjunction with an oral surgical procedure insured under the AHCIP, and have a condition where an oral manifestation is present and conventional dental rehabilitation is not possible. Patients must require dental services in relation to severe oral/facial conditions caused by birth defect; or must require dental services in relation to severe oral/facial conditions caused by birth defect; or require procedures to correct the shape and/or alignment of the skull or jaw bones; have situations of severe facial trauma involving bone loss, loss of jaw bone from a tumour and temporomandibular joint disorder requiring surgery.	The Program was designed to provide coverage for some high-cost uninsured dental services that are required in conjunction with an oral surgical procedure insured under the AHCIP; including dental implants, orthodontic treatment, prosthodontic treatment and pre-surgical dental x-rays and models. Dentists are paid on a fee-for-service basis as listed in the OMDS Schedule of Benefits.	461 active cases	Hospitals, non-hospital surgical suites and specialist dental facilities	Established pursuant to the *Treatment Services Regulation* under the *Public Health Act* Services are funded in accordance with Ministerial Order 13/2014 Administered by Alberta Health	1,200
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	a	Dental hygienists and assistants, regional health units, schools, residential facilities; includes clinical dental services in Capital and Calgary health regions	Regionally administered	6,000[c]

Table 13. cont'd

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Alberta Health Services						
Preschool Fluoride Varnish Service	Ages 12- 35 months Objective is to see 50% of children in the lowest 20-30% socio economic status	Fluoride application two times a year. -Aim for 4 applications per child in program. -Late starters can be seen up to 42 months to complete 2-4 applications	This is a new program in 4 of the 5 Alberta Health Services zones. In second year of program achieved: 75% of population objective (6,920 children) 51% of visit objective (9515 applications)	Community group settings Clinical settings	Administration of the program is shared between the Provincial Oral Health Offices and the Zone Oral Health Managers as follows: Provincial Oral health office provides the manual outlining the tools and information to deliver standardized oral health services in accordance with the Oral Health Action Plan . Provincial marketing material have been developed for this program. Operation of the program is handled by Zone Management. Zones provide the Provincial Oral Health Office with quarterly activity reports on services provided. Provincial office tracks statistical data reports to zones and provincial aspects of the organization. Effective communication pathways have been established between the Provincial team and Zones and between the Zone Managers to improve the success of the program's development and growth.	(~$1.25 - $1.50 per child)
School Fluoride Varnish Service	Kindergarten, Grade 1 and 2 (Grade 3 check and repair only) Objective is to see 50% of children in the lowest 20-30% socio economic status	Fluoride application two times a year	This program was somewhat established in most zones. In second year of program achieved: 164% of population objective (23,199 students) 152% of visits objective (43,216 applications)	School setting		(~$1.25 - $1.50 per child)
School Dental Sealant Service	Grade 1 and 2 Objective is to see 50% of children in the lowest 20-30% socio economic status	Assess for need and place dental sealants on first permanent molars	This program was established in 3 of the 5 zones. It is new in one zone. In second year of program achieved: 110% of population objective (of 4 zones participating) for need assessment (5,175) Provided 4,853 children with 14,310 dental sealants	School setting		(~$1.25 - $1.50 per child)

Table 13. cont'd

Increase capacity of long-term care facilities to support oral health or residents	Stage 1: Pilot in LTC Facility in each zone Stage 2: Expand pilots in zones	Staff training in daily mouth care and oral health assessment	Stage 1 of the LTC pilots has begun in 3 zones as of July 2014. Anticipating a forth pilot to start in the fall of 2014.	LTC setting	As above This initiative is in collaboration with the Seniors Health Portfolio of Alberta Health Services.	

[a] Not reported
[b] http://alberta.ca/release.cfm?xID=36014F8CDCD7D-EAEE-C7D2-AD2E741BCD858232
[c] Estimate

Table 14. Public dental programming in Alberta, 2007/08

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Ministry of Alberta Employment, Immigration and Industry (AEII)						
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	Avg. # of eligible cases (households) per mth. 29,743 Avg. # of eligible recipients (individuals) per mth. 53,431 Avg. utilizing per mth. ETW 7.7% NETW 8.4% Learners 7.1%	Dentist and denturist/private practices	Centrally administered, adjudication and payment functions the responsibility of Alberta Dental Services Corporation (ADSC)	9,643 ETW 4,318 NETW 4,352 Learners 973 (Avg. cost per case ETW $24.83 NETW $30.49 Learners $14.87) (Avg. cost per utilization ETW $348.78 NETW $363.69 Learners $206)
Alberta Child Health Benefit (ACHB)	ACHB is a premium-free health benefit plan for children <18yrs, and under 20 if attending high school, living in low-income families	Supplementary Dental Coverage	Avg. # of eligible cases/recipients per mth. 72,165 Utilization 7.8%	As above	As above	16,534 (Avg. cost per case $17.50) (Avg. cost per utilization $223.84)

Table 14. cont'd

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
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 Pregnant women with low income and households with individuals with high drug needs in relation to their income regardless of source of income	Standard Dental Coverage for ETW leavers and high drug needs category Supplementary Dental Coverage for NETW and AISH leavers and pregnant women category	Avg. # of eligible cases (households) per mth. 2,371 Avg. # of eligible recipients (individuals) per mth. 5,355 Utilization 12.4%	As above	As above	1,007 (Avg. cost per case $36.18) (Avg. cost per utilization $289.15)
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	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	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 14. cont'd

Program	Eligibility	Services Covered	Utilization	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	17,007 services provided $192.63 average costs per patient[c]	Specialists and generalists/hospitals, private anaesthesia clinics, private practices	Centrally administered	3,276[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 (2006) *Canada Health Act Annual Report*. Canada Health Act Division, Health Canada
[d] Estimate

Table 15. 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 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
Alta. Reg. 86/2006, *Alberta Health Care Insurance Act - Oral and Maxillofacial Surgery Benefits Regulation*	As above	Benefits for oral and maxillofacial surgery services provided to a resident are those listed in the Schedule of Oral and Maxillofacial Surgery Benefits (s.3(1); Schedule attached to Regulation)	Minister of Health Oral and Maxillofacial Devices and Services Program

Table 15. cont'd

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
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.2(1)(a) and (b)) Provision of dental benefits subject to time-limitations (s.6) List of dentist goods and services provided in the Schedule	Minister of Health Dental Assistance for Seniors, administered by Minister of Health
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
Alta. Reg.244/1990 (62/2013), *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, or any Act of Alberta relating to workers' compensation,* unless approved by the Minister (s.4(2)(c))	Minister of Health
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 Services Alberta Adult Health Benefit Program Alberta Child Health Benefit Program
Alta. Reg. 60/2004, *Income and Employment Supports Act – Income Supports, Training and Health 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, he College of Alberta Denturists or the College of Registered Dental Hygienists of Alberta (s.73(1)(d) or those approved by the Health Benefits Exception Committee (s.73(1)(g)	Minister of Human Services

Table 15. cont'd

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Assured Income for the Severely Handicapped Act, S.A. 2006, c.A-45.1	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 Human Services
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 Services
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 Human 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 and are directly related to the child's disability (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))	Minister of Human Services
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) 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 Human 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 Human Services

Table 15. cont'd

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Victims of Crime Act, R.S.A. 2000, c.V-3	Victims of crime who have been injured (s.12(1)and meet the criteria in the regulations	The Lieutenant Governor in Council may make regulations for the operation of this Act (s.17)	Justice and Solicitor General

Table 16. Dental public health human resources in Alberta, 2014[a]

	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	Allied DPH Human Resources (FTE)			DPH Programming (Yes/No)	DPH Human Resource Costs ($)	Total DPH Program Costs ($)
			DH	DA	Other[b]			
Provincial Oral Health Office	1.3		3.0		2.1	Yes	511,701	42,379
North Zone			1.72	7.13		Yes	~7 million (individual zone financial information is not available at this time)	
Edmonton Zone			10.12	9.65		Yes		
Central Zone			6.70	8.3		Yes		
Calgary Zone			6.63	2.7		Yes		
South			2.1	4.48		Yes		
Community Oral Health		2.4	1.44	6.8	2.2	Yes	1,446,000	104,000

[a] Does not include enumeration of on-reserve providers
[b] Not specified

Note: In 2009 there was a provincial restructuring of the 9 former health boards into one super board – Alberta Health Services with 5 zones. Within the Population and Public Health portfolio there was the establishment of two new Oral Health positions – a Dental Public Health Officer and an Oral Health Manager to develop an Oral Health Action Plan to align with the AHS Strategic plan to address the three goals of quality, access and sustainability while 'Improving Population Health'. In 2011 the Provincial Oral Health Office added 3 team lead dental hygienist positions to support the development of resources and support to Zone managers and frontline staff implementing the Oral Health Action Plan.

Table 17. Dental public health human resources in Alberta 2007/08

	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	Allied DPH Human Resources (FTE)			DPH Programming (Yes/No)	DPH Human Resource Costs ($)	Total DPH Program Costs ($)
			DH	DA	Other			
Alberta Health and Wellness						No	NA	NA
Northern Lights	0.04			2.5	0.5	Yes	178,000[b]	190,000[b]
Peace Country	0.01		1	4.13	0.93	Yes	347,738	370,000[c]
Aspen	0.08		0.8	3.5		Yes	257,642	290,000[c]
David Thompson	0.12		5.76	4.6	1	Yes	747,493	800,000[c]
Palliser	0.04		1.35	2.87	0.2	Yes	248,851	270,000[c]
Capital Health	0.30		12.4	12.43	6.1	Yes	1,550,000	1,800,000[c]
East Central	0.04		2	1.63		Yes	200,000[b]	220,000
Calgary	0	4.8[a]	11.9	8.8	4	Yes	1,880,000[c]	2,200,000[c]
Chinook						No		

[a] Dentist manager has Masters in Business Administration
[b] Estimation based on reporting of total budget and partial human resource expenditures
[c] estimation based on reporting of human resource budget

Table 18. Remuneration rates for dental public health personnel in Alberta, 2014

	Hourly Rate
Dentist in Community Practice	-
Dental Hygienist	$35.43 - 47.12
Dental Assistant	$28.61 - 35.84
Other: Sterilization Processors	 $21.45 - 24.45

[a]AHS uses and 9 point salary grid for RDH and RDA and a 5 point salary grid for Surgical processors. The above gives you the start and end of the grid range. AHS Medical Affair established a salary grid for dentists who practice in AHS facilities. The grid may be provided by the Medical Affair office.

Saskatchewan

Dental public health in Saskatchewan is known for its previous universal children's dental program and its utilization of dental therapists. Today dental public health is painted much differently than its earlier years. In 2011, the Government of Saskatchewan introduced the Enhanced Preventive Dental Services (EPDS) Initiative, a health promotion and disease prevention program to target early childhood tooth decay in at risk populations. The program was initially implemented in schools in those regions with the highest need and expanded to the remaining health regions early in 2012. The enhanced services include: oral health assessments for all children from two months to five years of age, using the Saskatchewan Child Health Clinic Guidelines; referral for follow-up to an appropriate oral health professional for children with treatment needs; follow-up in the community by regional dental health staff for children who have dental treatment under general anesthesia in hospitals; fluoride varnish applications; and dental sealants to children in grade one and grade seven in high-risk schools. The enhanced dental services also include consultations with pre- and post-natal mothers to promote good oral health and ensure a healthy pregnancy and healthy development of their baby's teeth.[66, 67]

Saskatchewan continues to focus efforts on dental health in northern rural communities. The Northern Oral Health Working Group (NOHWG) is a collaboration between Saskatchewan Health, northern First Nations health organizations, northern regional health authorities and Health Canada. The primary objectives for the NOHWG include: 1. to be a resource for dental public health at the local, regional, provincial and national levels and: 2. to work as an inter-jurisdictional team to develop and implement best practices to improve oral and systemic health outcomes of Saskatchewan residents. As an example, the working group continues to engage with other public health staff and programs including public health nurses and nutritionists, Kids First North, and preschool programs to promote a child's first dental visit by age one.[68]

Table 19. Public dental programming in Saskatchewan, 2014

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Saskatchewan Health						
Supplementary Health Program (SHP)	Provides dental services for persons nominated by the Ministry of Social Services and Justice Wards of the provinces, those in correctional institutions. Nominated persons >65 years who are in special care homes or hospitals and whose income meets SAP levels	Employable adults are eligible for emergency benefits for 6 months from the time of being nominated, then eligible for full benefits Children qualify for full benefits Includes diagnostic, preventive, restorative, oral surgery, removable prosthodontics, limited endodontics, and orthodontics on a case by case basis	44,664 eligible	Dentists, dental therapists/private practice	Saskatchewan Health, Drug Plan and Extended Benefits Branch	7,950
Family Health Benefits (FHB)	An extension of SHP, assists recipients of Saskatchewan Child Benefit and/or the Sask-atchewan Employment Supplement with dental care costs of children <18 years	Includes diagnostic, preventive, restorative, oral surgery	49,604	Dentists, dental therapists/ private practice; if covered by FHB, provider can balance bill the difference between SHP fee guide and the lesser of the usual and/or customary fee or professional fee guide	As per above	2,937
Medical Services Plan	Insured surgical-dental services are those that are medically necessary and must be carried out in a hospital or office-based setting	Services included: oral surgery required as a result of trauma treatment for infants and children with cleft palate; hospital and office based dental care to support medical/ surgical care (e.g., extractions when medically necessary); and surgical treatment for temporomandibular joint dysfunction. Dental implants are only insured when required as a result of a tumour or congenital defects to restore function when other alternative treatments are not appropriate. The treatment must be provided by an oral and maxillofacial surgeon and is insured only after prior approval by Medical Services Branch.	16,094 services (2013-14) 83 dentists and dental specialists who participate	Specialists and generalists/hospitals, private practices	Saskatchewan Health, Medical Services Branch	1,694[a] (2013-14)

Table 19. cont'd

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Enhanced Preventive Dental Services (EPDS)	0-5 years of age Grade 1 & 7 children	An upstream intervention intended to supplement existing regional efforts to help improve children's oral health by increasing access to care, preventive services and early education for children at risk. These services focus on oral health assessments, referrals and follow-up services, fluoride varnish, dental sealants for grade 1 and 7 students in high risk schools.	37,285 children and students assessed in year 2 of program (includes all RHAs)	Community based services	Provincial Regional Health Authorities	1.0
Regional Health Authorities						
Athabasca Health Authority	Dental health education, prevention, diagnostic and restorative services for children 0-13 yrs All residents are provided with dental treatment and preventive services Tooth brushing programs in all schools for all ages Screening program for prenatal women	Preventive services: screening, sealants, oral hygiene education, fluoride applications and selective polishing and scaling Dental treatment: restorative care provided for all ages Dental health education: schools and community groups; referrals to dentists and dental specialists	Approx. 3,600 high need patients in the basin	Dental therapists, dental assistants, aides/dentists, community schools, primary health centres, preschools, daycares	Regionally Administered	c
Five Hills Health Region Dental Health Education Program	General public with focus on pre and post-natal moms, infants/parents, pre-schoolers, children, youth and older adults/seniors	Prevention and health promotion for all ages, fluoride program (mouthrinse and varnish) dental screening (selected age groups), dental consultations Enhanced Preventive Dental Services program: dental sealants for grade 1, 2, 7 and 8 students in high risk schools Follow-up and consultation with families of children who have had dental work completed under general anaesthetic		Dental therapists, dental assistants, Health educators/public health offices, primary health centres, preschools, daycares, schools, seniors' facilities, post-secondary institutions, community centres.	Regionally administered	c

Table 19. cont'd

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Cypress Health Region Dental Health Education Program	General public with focus on infants/parents, pre-schoolers, children, youth and older adults/seniors	Prevention and health promotion for all ages, fluoride varnish program (mouthrinse and varnish), dental screening (selected age groups) Sealant program (dental sealants for students in grade 1, 2, 7 and 8 in high risk schools; follow-up for children having treatment under general anaesthetic Post-natal education and consultation for caregivers; case conferences with caregivers and care plans for referred individuals in long-term care.	50,000 (target group)	Dental therapists/health educators, dental assistant/public health offices, primary health centres, preschools, daycares, schools, seniors facilities, post-secondary institutions	Regionally administered	c
Keewatin Yatthè Regional Health Authority Dental Program	All children 16 years and under residing in the KYRHA Communities	Full preventative services Full restorative services Surgical services	Approx. 3,000 eligible	Dental therapists, dental assistants, dental aides community schools, primary health centres, preschool, daycares	Regionally administered	c
Kelsey Trail Health Region	General public with focus on infants/parents, preschoolers, children, youth	Prevention and health promotion for all ages; fluoride programs: mouthrinse in 13 high risk schools and varnish programs to preschool and school aged children at risk Dental screening to selected age groups; Sealant Program: dental sealants for students in grade 1, 2,7 and 8 in 27 high risk schools; follow up for children having treatment under general anaesthetic Post-natal education, consultation and education for caregivers; referrals for treatment to children with unmet dental needs	42,000	Dental therapist/health educators; dental assistant; public health offices; primary health centres; preschools; daycares; schools; post-secondary institutions	Regionally administered	

Table 19. cont'd

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Heartland Health Region - Dental Health Education Program	General public with focus on infants/parents, preschoolers, kindergarten, Gr. 1, 2, 7 and 8 and older adults/seniors	Prevention and health promotion for all ages, fluoride programs (mouthrinse and varnish) targeted dental screening (selected age groups), Seal Today Prevent Decay Program –for grade 1 and 7 children in high risk schools as well as retention checks in grade 2 and 8.	50,000 (target group)	Public Health Offices, Primary Health Centres, preschools, daycares, schools, seniors' facilities, post-secondary institutions	Regionally administered	b
Mamawetan Churchill River Health Region's Dental Programs	Dental health education, prevention, diagnostic and limited restorative services for children <17 yrs. Screening program for prenatal women Oral health education, screening and prevention to La Ronge Scattered Site Outreach Program	Preventive services- Screening, sealants, oral hygiene education, fluoride applications and selective polishing and scaling Dental treatment: limited to restorative care for preschool, kindergarten, grades 1, 6, and 7 Emergency dental treatment: treatment of pain and/or infection for all children Dental Health Education to schools and community groups Referrals To private practice dentists and dental specialists	Approx. 8,700 eligible	Dental therapists, assistants, aides/Community schools, Primary health centres, Preschools, Daycares	Regionally administered	520
Prince Albert Parkland Health Region Dental Health Education Program	General public with focus on infants/parents, preschoolers, children, youth and older adults/seniors	Health Promotion, Fluoride Programs School based Fluoride Mouthrinse Program, Drop In Fluoride Varnish Clinics Brief oral assessments for children under 5 yrs. Dental Screening (selected age groups) Dental Sealant Program for Gr. 1 and 7 children in high risk schools. Dental resource to Newborn and Parents Resources to Education/Health and local Community Agencies	77,000 (target group)	Dental Therapists, Dental Health Educators /Public Health Offices, Primary Health Centres, preschools, daycares, schools, seniors' facilities, post-secondary institutions	Regionally administered	c

Table 19. cont'd

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Prince Albert Parkland Health Region Dental Health Education Program	General public with focus on infants/parents, preschoolers, children, youth and older adults/seniors	Health Promotion, Fluoride Programs School based Fluoride Mouthrinse Program, Drop In Fluoride Varnish Clinics Brief oral assessments for children under 5 yrs. Dental Screening (selected age groups) Dental Sealant Program for Gr. 1 and 7 children in high risk schools. Dental resource to Newborn and Parents Resources to Education/Health and local Community Agencies	77,000 (target group)	Dental Therapists, Dental Health Educators /Public Health Offices, Primary Health Centres, preschools, daycares, schools, seniors' facilities, post-secondary institutions	Regionally administered	c
Prairie North Health Region – Dental Health Education Program	General public with a focus on pre and post-natal women, preschoolers, school aged children in grades 1, 2, 7 & 8 in schools at high risk for dental caries and older adults/seniors in long-term care facilities	Prevention and health promotion for all ages -Fluoride programs (mouthrinse and varnish) Dental screening and referral (selected age groups) Sealant Program (dental sealants and fluoride varnish for students in grade 1, 2,7 and 8 in high risk schools) Pre- and post-natal education Consultation and education for caregivers and allied health professionals providing oral care in hospitals and institutions Case conferences with caregivers and families Individualized oral health care plans for individuals residing in long-term care	96,269 (including Lloydminster Alberta)	Dental Health Educator & Dental Health Assistants, contract and referral dentists, health educators, public health offices, primary health centres, preschools & daycares, schools, LTC facilities, hospitals, post-secondary institutions, community centres	Regionally administered	c
Prince Albert Co-operative Health Centre School Dental Program	Dental Health Education, Prevention, Diagnostic and Basic Restorative Dental services for children ages 4 years to	Preventive services: screening, sealants, oral hygiene education, fluoride applications and selective polishing and scaling	Approx 12,000	Dental therapists, assistants, aides / Community schools, Preschools, Daycares	Regionally administered	c

Table 19. cont'd

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
	14 years of age in 4 urban Prince Albert Schools Emergent care for children without dental coverage from other urban Prince Albert Schools on a case by case basis	Dental treatment: Basic restorative care for preschool to Grade 8 Emergency dental treatment for children without coverage from other schools on case by case basis Treatment of pain and/or infection for children through referral or treatment within scope Dental Health Education to four participating schools Referrals to private practice dentists and dental specialists				
Saskatoon Health Region						
Public Health Dental Clinics (2)	Children 0-18; one clinic also treats adults	Dental treatment and preventive services.	750 clients/yr	Dental Therapists/ Dental Assistants at Primary Health Centres	SHR	350
School-based Dental Sealant Program	Grade 1 and Grade 7 students, with follow-up in Grades 2 and 8	Sealants/varnish	1,500 clients/yr	Dental Therapists/ Dental Assistants in schools	SHR	225
Children 0-6 Fluoride Varnish Program	Children 0-6	Varnish	2,500 clients/yr	Dental Assistants in Health Centres	SHR	895
Regina Qu'Appelle Health Region						
Dental Sealant Program	Grade 1 & 7 students	Sealants/varnish/OHI	1,745	Dental Health Educators (DHE) & Assistants in schools	RQHR	525
	Gr 2 & 8	Retention Check, Reseal (if needed) & seal those missed the previous year	887			
Early Childhood program	Prekindergarten & Kindergarten	Fluoride Varnish/ Screening/ OHI	1,790			
Fluoride Varnish Program	Children 0-6	Drop in clinics (receive screening, OHI & Varnish)	1,113	DHE's & Dental Assistants in Public Health offices & various community based locations	RQHR	18

Table 19. cont'd

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Fluoride Mouth Rinse	Elementary school age children ages 6 and older Currently there is 43 schools participating	Fluoride Mouth Rinse on a weekly basis	4,979	School base	RQHR provides material & schools administer	12
Sunrise Health Region						
Dental Sealant Program	Grade 1 & 7 students	Screen/oral hygiene instruction, sealants, varnish	552[a]	Dental Health Educators (DHE) & Dental Assistant in 20 schools	Sunrise	c
	Grade 2 & 8 students	Rescreen, Oral hygiene instruction, sealant retention check, reseal (if needed) and seal those not erupted the previous year, varnish Referral to dental office for treatment	415[d]			
School Varnish Program	Kindergarten	Screening, oral hygiene, varnish and referral to dental office for treatment	77[d]	Dental Health Educators (DHE) & Dental Assistant in 20 schools	Sunrise	
Preschool Varnish Program	Children 0-6, pre-kindergarten	Screening, oral hygiene instruction and varnish application Referrals to dental clinics in the region Follow up for children having treatment under GA	1,831[d]	DHE's & Dental Assistants provide to Public Health offices & Pre-schools, *Daycares,	Sunrise	c
Fluoride Mouth Rinse	23 schools participating, Grade 1 - Grade 8	Fluoride mouth rinse on a weekly basis	3,100[d]	School based	School administered	12
Adult Education	Students in SIAST Continuing Care Certificate Program	Training facilities (SIAST) Continuing Care Programs	28[d]	SIAST Yorkton Canora		c
5 year screening (2013-2014)	Grade 1 and 7 students	Dental screening to evaluate oral health	1,010[d]	40 schools		c
Sun Country Health Region Dental Health Education Program 2013/14	General public with focus on: infants/parents (new comers), pre-natal, pre-schoolers, children/youth, older adults, seniors (LTC and diabetic clinic)	- Prevention and health promotion for all ages - Fluoride programs; mouthrinse SWISH in school program and varnish - Dental screening (selected age groups and target schools) - 5 year dental screening	50,000 (target group)	Dental Health Educators, Saskatchewan Dental Therapists, Dental Assistant, Public Health Offices, Primary Health Centres/clinics Preschools, Daycares, Schools	Regionally administered	

Table 19. cont'd

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Sunrise Health Region						
Sun Country	General public with focus on: - infants/parents (new comers) - pre-natal, - preschoolers -children/ youth -older adults -seniors (LTC and diabetic clinic)	- Dental screening and dental sealant program for students in grade 1,2,7 and 8 in high risk schools - Tobacco Cessation - Dental education upon referral - CHC varnish consents and referrals - Follow up for children having treatment under GA - Post natal education - Consultation and education for caregivers - Senior caregivers and care plans for referred individuals in long-term care -BFI-Breast feeding initiatives-networking with PHN and nutritionists Advising dentist: availability		-Seniors' facilities, -Training facilities -BFI -CHC/PHN varnish clinics, -referrals to dental clinics in the region or, -out of province referrals to meet the priority		c

[a] Benefits paid for insured services
[b] Represents the total amount allocated to RHAs to deliver program since 2011
[c] Not reported
[d] Indicates the number of children actually seen

Table 20. Public dental programming in Saskatchewan, 2007/08

Program	Eligibility	Services Covered	Utilization	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	39,378 eligible	Dentists, dental therapists/private practice	Saskatchewan Health, Drug Plan and Extended Benefits Branch	4,700
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, removable prosthodontics, limited endodontic, and orthodontic on a case by case basis	33,715 eligible	Dentists, denturists, dental lab/private practice service providers can balance bill FHB for the clients difference between SHP fee guide and the lesser of the usual and/or customary fee or professional fee guide		2,547
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	18,511 services provided $83.16 per service	Specialists and generalists/hospitals, private practices	Saskatchewan Heath, Medical Services Branch	1,539[a]

Table 20. cont'd

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Dental Health Education Program	General public with focus on infants/parents, preschoolers, children, youth and older adults/seniors	Prevention and health promotion for all ages, fluoride programs (mouthrinse and varnish) dental screening (selected age groups), Seal Today Prevent Decay program – dental sealants for grade 1 and 7 children in high risk schools	50,000 (target group)	Dental therapists, health educators, public health offices, primary health centres, preschools, daycares, schools, seniors' facilities, post-secondary institutions	Regionally administered	b
Saskatoon Health Region – Public Health Services – Dental Clinic	Children 0 to age 16 in Saskatoon Health Region who have unmet dental needs	Basic diagnostic, preventive, treatment and referral services	Approx. 14,000 children at high risk. Capacity 500 clients/year	Dental therapists, assistants, aides primary health centre	Regionally administered	140
Keewatin Yatthé Health Region Children's Dental Program	All children 16 years and under who fall under the Keewatin Yatthé Health Authority	Diagnostic services, Preventive, health promotion, restorative, and surgical services	Approx. 4,500 eligible	Dental therapists, assistants, aides, community schools, health facilities, preschools, daycares	Regionally administered	b
Mamawetan Churchill River Health Region's Dental Programs	Dental health education, prevention, diagnostic and limited restorative services for children >17 yrs	Preventive services -Screening, sealants, oral hygiene education, fluoride applications and selective polishing and scaling Dental treatment - Limited to restorative care for preschool, kindergarten, grades 1,6 and 7 emergency dental treatment Treatment of pain and/or infection for all children Dental Health Education to schools and community groups Referrals to private practice dentists and dental specialists	Approx. 8,700 eligible	Dental therapists, assistants, aides, community schools, primary health centres, preschools, daycares	Regionally administered	520

a Government of Canada (2006) *Canada Health Act Annual Report*. Canada Health Act Division, Health Canada
b Not reported

Table 21. Public dental care associated legislation in Saskatchewan

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
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
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)	Social Services
The Saskatchewan Assistance Regulations, S.Reg. 78/66	As above, provided they meet the eligibility criteria set (s.6)	Supplementary health benefits may be provided to recipients in accordance with the *Saskatchewan Assistance Plan Supplementary Health Benefits Regulations*	Social Services
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))	Social Services Supplementary Health Program
The Adoption Act, 1998, S.S. 1998, c.A-5.2	Those adopting Crown wards	The minister may provide financial assistance to 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)	Social Services
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)	Social Services

Table 21. cont'd

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
The Saskatchewan Dental Disciplines Act	Regulations of Dental Disciplines	Following associations fall under the provisions of the "Act" - The College of Dental Surgeons of Saskatchewan - The Dental Technicians Association of Saskatchewan - The Denturist Society of Saskatchewan - The Saskatchewan Dental Assistants Association - Saskatchewan Dental Hygienists' Association, - The Saskatchewan Dental Therapists Association	Each dental disciplinary body performs services within their scope of practise regulated by their legislative body

Table 22. Dental public health human resources in Saskatchewan, 2014[a]

	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	DPH Programming (Yes/No)	DPH Human Resource Costs ($)	Total DPH Program Costs ($)	Allied DPH Human Resources (FTE)			
						DT	DH	DA	Other
Saskatchewan Health						1 Contracted Technical Dental Consultant			
Sun Country			Yes			2		1.10	
Five Hills Health Region			Yes			2		0.6	
Cypress Health Region			Yes			1		.5	
Regina Qu'Appelle Health Region		N/A	Yes	551,993	679,412	3	2	4	
Sunrise Health Region		N/A	Yes	Salary	Salary	1.78		1.4	
Heartland Health Region			Yes			1		.25	
Kelsey Trail						2		.8	
Prairie North Regional			Yes	150,645.00	26,465.00	1		2	
Saskatoon	0	0	Yes	628,500	800,000	3.84	No	4.12	1.0 Dental aide
Prince Albert Parkland			Yes			1.72		.75	
Mamawetan Churchill River			Yes			5		3	1 Dental aide
Keewatin Yatthé Health Authority			Yes			5		1	3 Dental aides
Athabasca Health Authority		2 contract dentists (2 weeks every 6 weeks to provide treatment/preventive services)	Yes			2		1	1 Dental aide
All health regions have contract dentist for consultation and referral purposes									

[a] Does not include enumeration of on-reserve providers

Table 23. Full-time equivalent dental public health positions, 2014

Dental Position	Full-Time Equivalents
Dental Therapist	15.15
Dental Health Educator (DHE)	19.3
Dental Assistant	22.12
Dental Aide	3

Table 24. Dental therapists in Saskatchewan by practice environment, 2013

Practice Environment[a]	Total
Private Practice	146
Public Health[b]	36
First Nations Organizations	37
Health Canada	12
Provincial Teaching Institutions	3
TOTAL	234

[a] As reported by Saskatchewan Dental Therapist's Association
[b] Dental health educators and clinical dental therapist

Table 25. Dental public health human resources in Saskatchewan, 2007/08

	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	Allied DPH Human Resources (FTE)			DPH Programming (Yes/No)	DPH Human Resource Costs ($)	Total DPH Program Costs ($)
			DT	DHE	DA			
Saskatchewan Health	a		0.25			No	NA	NA
Sun Country				1.7		Yes	91,900[b]	e
Five Hills				1.5		Yes	81,100[b]	
Cypress				1.5		Yes	81,100[b]	
Regina Qu'Appelle				4.3		Yes	232,500[b]	
Sunrise				2		Yes	108,200[b]	
Heartland				1		Yes	54,000[b]	
Kelsey Trail			0.5	1		Yes	81,100[b]	
Prairie North Regional				1		Yes	54,000[b]	
Saskatoon		0.01[b]	0.75	2	1.5	Yes	140,000[b,c]	
Prince Albert Parkland		0.01[b]	0.85	1	2.5	Yes	100,000[b,c]	
Mamawetan Churchill River		0.2[b]	3	0.75		Yes	348,739[b]	442,162
Keewatin Yatthé		0.09	4		1	Yes	378,635[b]	472,424
Athabasca		d				Yes	e	e

[a] Dual trained dental therapist/hygienist acts as a provincial level dental consultant
[b] Estimate based on reporting of total budget for the health regions with partial human resources breakdowns
[c] Estimated from reported aggregate program costs for both Saskatoon and Prince Albert
[d] Athabasca receives clinical service days from Mamawetan Churchill River's contract dentist
[e] Not reported

Table 26. Dental therapists in Saskatchewan, by practice environment, 2007/08

Practice environment[a]	N
Private Practice	129
Public Health[b]	31
First Nations Organizations	30
Health Canada	9
Provincial teaching institutions	10
TOTAL	209

[a] As reported by Saskatchewan Dental Therapist's Association
[b] Dental health educators and clinical dental therapist

Table 27. Medical Services Plan dental health services data, 1997/98-2013/14

	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
2004/05[a]	-	-	-	-	-
2005/06[a]	-	-	-	-	-
2006/07[a]	-	-	-	-	-
2007/08[b]	16.4	16	1616	1593	96.48
2008/09[b]	18.2	17	1884	1817	101.76
2009/10[c]	22.3	22	2013	1943	90.07
2010/11[c]	17.8	17	1827	1707	102.61
2011/12[d]	17.4	16	1720	1586	98.72
2012/13[d]	18.1	17	1710	1568	94.38
2013/14[e]	16.0	14	1670	1448	104.27

[a] Information unavailable

[b] http://www.health.gov.sk.ca/medical-services-2008-09

[c] http://www.health.gov.sk.ca/msb-annual-report-2010-11

[d] http://www.health.gov.sk.ca/msb-annual-report-2012-13

[e] http://www.health.gov.sk.ca/msb-annual-report-2013-14

Manitoba

Manitoba runs province-wide dental programs through the Department of Jobs and the Economy (previously the Department of Family Services and Housing) and Manitoba Health: Health Services Dental Program, Medical Program, Healthy Smile-Happy Child (HSHC), and Public Health – Oral Health. In addition, Manitoba Health provides funding for dental initiatives run through the University of Manitoba's Center for Community Oral Health (CCOH).

There has been a substantial increase in the number of eligible clients and dental expenditures for the Health Services Dental Program run through the Department of Jobs and the Economy since 2007 (Table 28). In 2007, the Government of Manitoba announced its "Rewarding Work" welfare to work four-year strategy for low-income working families and Manitobans.[69] In the second year of implementation, The Rewarding Work Health Plan was introduced, which extended coverage for dental and optical services, as well as prescription drugs, to single parents and persons with disabilities to up to two full years after they left welfare for work.[70] Shown in Tables 27 and 28, there has been a 3 million dollar increase in dental expenditures as well as an additional 10,000 individuals eligible for the Health Services Dental Program since 2007. Changes in annual maximums of $600, which were previously set at $400 for individuals >18 years of age and $500 for individuals <18 years of age, may have also contributed to the rise in expenditures (see Tables 28 & 29).

As indicated in Table 27, dental expenditures for Manitoba Health's Medical Program have increased 25% between 2007 and 2014. The increases in CHA expenditures over the past decade are likely attributed to hospital waitlist initiatives implemented by the Government of Manitoba. In 2005, Health Minister Tim Sale announced increased funding of $400,000 over a three-year period for pediatric dental surgeries in Winnipeg as well as an expansion of pediatric dental surgery to Beausejour.[71] The outcome would provide yearly funding for extra dental surgeries performed in Misericordia Health Centre, with approximately 100 of the treatments each year performed in Beausejour, totaling 600 extra dental surgeries over the three year period. Chief nursing officer for Winnipeg's Regional Health Authority noted, "The extra 600 cases that will be undertaken should result in a significant cut to the province's pediatric dental wait-list… By expanding access to pediatric dental services we are helping to meet the dental needs of many children across Manitoba".[71]

After one year, a 60% reduction in children waiting for dental surgery from 1,400 in 2005 to 557 in 2006 was noted.[72] According to the 2013 CIHI report, Manitoba has the second highest rate of day surgeries for early childhood caries (ECC) in Canada. The estimated two-year pooled rate

(2010-2011 to 2011-2012) was 26.4 per 1,000 children aged 1 to 5.[73] The 2012-2013 Manitoba Health Annual Statistic report also found that for children under six years of age, there were 1,354 hospitalizations for dental extractions in the 2012-13 fiscal year.[74] Despite these statistics, significant improvements are being made in the number of in-hospital pediatric dental surgeries in Manitoba. Since 2005, the total number of dental surgeries for children under six has dropped from 25 to 13 per 1,000.[74] Today, the Government of Manitoba continues to support initiatives aimed at reducing wait times for pediatric dental surgeries through funding the expansion of dental surgery services and maintaining contract agreements between surgical centres and regional health authorities.[75,76]

2005 marked a significant year not only for in-hospital pediatric dental surgery initiatives, but also for the expansion of preventive dental programs. The HSHC Early Childhood Tooth Decay Prevention Project received 1.2 million dollars over a two-year period towards the expansion of its health promotion program for young parents and mothers-to-be[77] In addition to this funding, $225,000 in financial contributions and in-kind support was provided by HC-FNIHB, the Winnipeg Foundation, Children's Hospital Research Foundation, Healthy Child Manitoba, Manitoba Dental Association, Burntwood Regional Health Authority, Winnipeg Regional Health Authority (WRHA), and the University of Manitoba Centre for Community Oral Health.[77] The HSHC program promotes oral health material through a collaborative approach within regional health authorities. There is currently one dental hygienist and one administrative staff employed on a part-time basis for this program (Table 31). The program also utilizes non-dental professionals, such as public health nurses, to educate children, parents, and caregivers on proper oral hygiene techniques.

The Manitoba Dental Association (MDA) implemented its three-year Free First Visit (FFV) program in April 2010.[78] The program encourages dentists to provide free dental examinations for children aged 3 years and younger. Regional health authorities partner with the MDA to promote both HSHC and FFV programs.

As shown in Table 31, the CCOH at the University of Manitoba, receives provincial funding for oral health initiatives that are partnered with regional health authorities.[79] Manitoba Health provides funding for a dental director (0.5 FTE), one administrator, one dental hygienist and one dental assistant for CCOH programs (excluding the S.M.I.L.E. *plus* Dental Program) (Table 31). The University of Manitoba also encourages rural dental residency placements to its paediatric dentistry residents.[79] Due to geographical distribution of Manitoba, providing dentistry to rural and northern communities remains an issue. Aside from the rural placements arranged by the University of Manitoba, no permanent solutions have been established.

There is currently one full-time oral health consultant employed at the provincial level. Previous to the amalgamation of eleven regional health authorities to five in 2012, only two RHAs had dental public health programming (Table 31). The mergers were identified as one part of Manitoba's plan to protect universal health care to ensure health services to families as the population continues to increase and live longer, with administrative savings to be redirected to support front-line health care workers.[80]

Table 28. Public dental programming in Manitoba, 2014

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Department of Family Services and Housing						
Health Services - Dental Program 13/14	Those receiving: - Employment Income Assistance (EIA) - Single Parents General Assistance - Persons with Disabilities - Children in Care <18yrs $600/yr >18yrs $600/yr	Basic diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral surgery services Reimbursement rate 90% of current MDA fee guide	Approx. 65,000 eligible	Dentists and denturists/private practices, hospitals	Department of Jobs and the Economy	7,332
Manitoba Health						
Medical Program (2013)	Services performed by oral and maxillofacial surgeons or licensed dentists when hospitalization 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	5,236 services provided $235 per service[a]	Specialists and generalists/ hospitals, private practices	Manitoba Health Medical Program	1,232
Healthy Smile Happy Child (HSHC)	At risk children, families, caregivers in rural and urban populations	Educational resources, prevention	Accessed by all regional health authorities in Manitoba	Dentists, dental hygienists and public health staff, nurses, community facilitators, educators/ primary health centers, public health clinics, hospitals	HSHC	51 (annual)
Winnipeg Regional Health Authority (WRHA) – S.M.I.L.E. *plus*	At risk child populations	Preventive and basic treatment services	Approx 2234 patient apts/ visits	School based clinics, preschools, daycares.	Regionally administered	651[b]

Table 28. cont'd

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Manitoba Health, Healthy Living & Seniors 2013-14						
Public Health – Oral Health 2013-2014	Province wide	Education, prevention, policy, community water fluoridation	Province wide	Dentists, dental hygienists and health educators/ providers, public at large /primary health centres, public clinics, hospitals	Manitoba Health	153[c]
College of Dentistry, University of Manitoba						
Centre for Community Oral Health (2014)*	At risk children, developmentally disabled adults and children, senior populations, low income groups	Basic diagnostic, preventive, restorative, endodontic, periodontal, prosthodontics, oral surgery services	Patient Visits Churchill: 1000 HDCP: 3401 DLC: 1452 Access: 3359 St. Amant: 400 MDC: 450 Total: 10,062	Dentists/specialists/DH In hospitals, personal care homes, primary health clinics	Centre for Community Oral Health	557[d]

[a] Government of Canada (2013) *Canada Health Act Annual Report*. Canada Health Act Division, Health Canada
http://www.gov.mb.ca/health/documents/physmanual.pdf

[b] Excluded in the above expenditures is $50,000 for the *Healthy Smile, Happy Child* program that is flowed through WRHA to the University of Manitoba for provincial oral health promotion

[c] Includes 2 STEP student positions who work with HSHC program and costs associated with the water fluoridation program

[d] Includes direct funding from Manitoba Health for dental services for Manitoba Developmental Centre, (MDC) St. Amant Centre, S.M.I.L.E. *plus* Dental Program, and grant funding via Churchill and Winnipeg RHA to Churchill Dental Program, Access Main, Deer Lodge Centre (DLC), and Home Dental Care Program (HDCP)

Table 29. Public dental programming in Manitoba, 2007/08

Program	Eligibility	Services Covered	Utilization	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	4,205 services provided $234 per service[a]	Specialists and generalists/hospitals, private practices	Manitoba Health, Medical Program	985
Healthy Smile - Happy Child Winnipeg Regional Health Authority S.M.I.L.E. *plus* Dental Program	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 (2007) *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 S.M.I.L.E. *plus* Dental Program

Table 30. 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

Table 30. cont'd

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
The Dental Health Services Act, C.C.S.M., c. D33	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); 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))	Manitoba Health
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
Manitoba 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 Jobs and the Economy
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 Jobs and the Economy Health Services Dental Program Participants may receive dental services after three months of enrolment, except general assistance adults who must wait 6 months. Emergencies can be met during the waiting period.
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

Table 30. cont'd

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 31. Dental public health human resources in Manitoba, 2014[a]

	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	Allied DPH Human Resources (FTE)			DPH Human Resources Cost ($)	Total DPH Program Costs ($)
			DH	DA	Other		
CCOH Funded Programs (excluding S.M.I.L.E. *plus* Dental Program)[b]	.5	-	1.0	1.0	1.0[c]	b	557,000
WRHA –S.M.I.L.E. *plus* Dental Program	-	0.92[d]	1.0	5.38	0.5[e]	557,784	651,329
Healthy Smile – Happy Child	-	-	0.5	-	0.4[f]	47,715[g]	51,400
Public Health – Oral Health	1.0	1.0	-	-	0.6(2) [g,h]	140,000	152,900
Total	1.5	1.92	2.5	6.38	2.5		

[a] Does not include enumeration of on-reserve providers
[b] Not reported
[c] Other staff for CCOH programs are part of the College of Dentistry budget so not included here
[d] Purchased service from the University of Manitoba
[e] Other FTEs include 0.25 FTE Team Manager and 0.25 FTE Clerk
[f] Administrator
[g] Includes benefits but does not include 2 STEP student positions funded by MB government, working with HSHC program
[h] 2 STEP student positions funded by MB government, working for HSHC program

Table 32. Dental public health human resources in Manitoba, 2007/08

	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	Allied DPH Human Resources (FTE)[b]			DPH Programming (Yes/No)	DPH Human Resource Costs ($)	Total DPH Program Costs ($)
			DH	DA	Other			
Manitoba Health						No		[d]
Winnipeg Region		0.8[a]	2	6		Yes	[c]	1,800,000[e]
South Eastman						Yes		
Burntwood Region						Yes		
Brandon Region						No		
North Eastman						No		
Interlake Region						No		
Central Region						No		
Assiniboine Region						No		
Parkland Region						No		
Normal Region						No		
Churchill Region						No		

[a] Constitutes three positions
[b] Does not include human resources for Healthy Smile – Happy Child
[c] Not reported
[d] Does not report programming costs for the partially centralised management of municipal water fluoridation
[e] 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 Authorities S.M.I.L.E. *plus* Dental Program

Table 33. Remuneration rates for dental public health personnel in Manitoba, 2014

	Salary (equivalent to FTE)	Per Diem Rate
CCOH		
DPH - Director	$87,600	
DPH - Manager	$53,890 - $60,169	
Dentist in Community Practice	-	$500 - 850
Dental Hygienist	$69,365	$280 - 350
Dental Assistant	$36,946 - $46,410	
WHRA		
Dentist in Community Practice[a]	-	$525
Dental Hygienist	R: $57,834-$73,098 A: $73,098	
Dental Assistant	R: $39,159-$44,803 A: $43,280	
Team Manager	R: $78,887-$96,033 A: $85,866	
Clerk	R: $40,478-$47,425 A: $42,240	
HSHC		
Admin[b]	$17,370 (0.4FTE)	$21.10 – $22.39 per hour
Dental Hygienist[b]	$34,345 (0.5 FTE)	$27.22 – $38.11 per hour
Public Health – Oral Health		
DPH - Consultant	$116,500	-
Other: **STEP student x 2**	$23,600 (for two positions)	$13.74 per hour

[a] Dentist in Community Practice is a purchased service from University of Manitoba (U of M). Annual service days are not to exceed 240 and the blended per diem rate is $525. U of M may bill up to $600 per diem if a specialist is used.
[b] Includes benefits

Table 34. Mapping of old and new regional health authorities

Old RHAs	New RHAs (as of May 30, 2012)
Burntwood RHA	Northern Regional Health Authority
NOR-MAN RHA	
Interlake RHA	Interlake–Eastern Regional Health Authority
North Eastman RHA	
Central RHA	Southern Health–Santé Sud
South Eastman RHA	
Assiniboine RHA	Prairie Mountain Health
Brandon RHA	
Parkland RHA	
Churchill RHA	Winnipeg Regional Health Authority
Winnipeg RHA	

Table 35. Manitoba Medical Program, average and median payments, oral, dental, and periodontal surgery, 1996/97-2012/13

Year	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
2006/07	6	113,672	78,749
2007/08	6	127,985	77,729
2008/09	6	120,020	84,079
2009/10	6	152,884	92,276
2010/11	6	132,689	89,421
2011/12	6	137,620	75,726
2012/13	7	119,271	75,320

Note: Average and median payments ($50,000 gross) for oral, dental, and periodontal surgery. Represents gross payment by Manitoba Health from which the practitioners must pay overhead costs.

Table 36. Department of Jobs and the Economy Health Services Program expenditures, 1999/00-2013/14

	Year	Expenditures ($000)	Caseload per month
Total	1999/00	3,512.90	37,314
	2000/01	3,553.10	34,949
	2001/02	4,056.80	33,576
	2002/03	4,286.30	32,588
	2003/04	4,539.20	33,758
	2004/05	4,948.80	32,889
	2005/06	5256.70	32,770
	2006/07	5312.00	32,651
	2007/08	5,388.00	32,417
	2008/09	5,576.00	33,117
	2009/10	6,295.00	34,396
	2010/11	6,908.00	36,361
	2011/12	7,178.00	38,226
	2012/13	7,319.00	38,597
	2013/14	7,332.00	39,058

De-aggregated disabled person numbers not available past 2006/07

Ontario

The province of Ontario comprises the largest share of public dental programming expenditures and dental public health human resources across Canada. Among its 36 public health units, dental programming exists in all units. Ontario is one of the few provinces with provincially mandated programs, through the Health Protection and Promotion Act (1990) and exhibits diversity in municipal oral health initiatives. Ontario runs six public dental programs through the Ministry of Community and Social Services, Ministry of Children and Youth Services and Ministry of Health and Long-Term Care (MOHLTC).

The primary focus of public dental programming has been on children's oral health. All six existing public dental programs (Healthy Smiles Ontario (HSO), Children In Need Of Treatment (CINOT), Ontario Works (OW), the Ontario Disability Support Program (ODSP), Assistance for Children with Severe Disabilities (ACSD), and preventive services within the Ontario Public Health Standards (OPHS)) incorporate children into their service populations. Despite these efforts, eligibility criteria has made accessing dental care under public health programs limited due to either low income cut-offs or restricting program coverage for children up to 18 years of age.[81,82]

Prior to January 2009, the CINOT program provided dental coverage for low-income children from birth to age 13, or to the end of the grade eight school year, whichever was later. As part of the poverty reduction strategy, CINOT was extended to the 18th birthday and out-of-hospital anaesthetic coverage was added for children aged 5-13.[81,82] As part of this program expansion, between January and December 2013, 32,839 children and youth ages 0-17 were treated under the CINOT program.

In 2010, the HSO program was announced by Health Minister, Deb Matthews. This new provincially-mandated program provides no-cost preventive dental care to 130,000 children aged 17 and under who are members of a household with an adjusted family next income of $20,000 per year or less and do not have any form of dental coverage. Between October 2010 and September 2013, approximately 36% (47,000) of children that were eligible for HSO were enrolled in the program.[83] Despite these investments, there was still no consideration for low-income adults. In the same year, the Health Minister said that, "the province doesn't have the resources to keep a promise of providing a dental plan for Ontario's impoverished adults".[84]

In 2014, HSO experienced changes in eligibility by increasing the threshold of $20,000 to $21,513, which accommodated for an additional 70,000 eligible children under the new

guidelines in 2014.[84] In the same year, the MOHLTC announced that the six existing public dental programs in Ontario would be integrated into one program by 2015 for children 0-17 years of age that meet a recommended cut-off. The new program will provide a single fee schedule for dental providers that will include preventive and treatment programs, centralized and streamlined program administration to be performed by a third party administrator, and 100% funded by the MOHLTC.[81] Aside from its eligibility restrictions, this will be Ontario's first attempt at providing universal access to dental care for children.

The first recommendation for this integration occurred in 2012, with the Chief Medical Officer of Health, Dr. Arlene King, indicating in her Oral Health – More Than Just Cavities report, "Current publicly funded programs, while admirable in many respects, amount to a patchwork of services that are complex for clients to navigate, and difficult to assess in terms of health outcomes achieved and return on investment".[85]

Several policy recommendations on dental care arose from this report, including improvements in: access to water fluoridation; monitoring and evaluation of publicly funded oral health programs; integration of oral health services with the health care system; and oral health of First Nations people in Ontario.[85] In the same year, a collaborative report between local and provincial public health associations and the University of Toronto was produced as a result of a panel debate at the Ontario Public Health Convention. The recommendations formulated from this debate aligned with the Ministry's report, further emphasizing the need for centralization of management and administration and diversity of delivery models for public dental care programs across Ontario.[83]

These reports are of many discussions about the provision and financing dental care in Ontario. Reports on access to care and oral health disparities have been prevalent in Ontario with concerns about low-income and working poor adult populations rising over the past decade. Several news releases and coverage stories have contested the government's ability to provide equitable access to dental care and attempt to improve the health of Ontarians.[87-91] A 2012 report from Public Health Ontario (PHO) stated the need for affordable dental care for adults, specifically lower income earners, the uninsured, older adults, those with lower educational attainment.[87]

The Ontario Oral Health Alliance (OOHA) formed in 2007 as part of the Ontario election platform to unite the voices of those who advocate for better access to care.[92] For the 2014 election, the OOHA requested that "all parties in the Ontario election to commit to redirect the minimum 35 million dollars currently spent on dental pain in doctors' offices and emergency

rooms and top it up to develop a 90 million dollars public oral health program for low income adults and seniors".[90] It continues to advocate for increases in income eligibility for current provincial dental programs and the incorporation of more populations to be eligible.[93]

The Bridges Community Health Centre developed and administered a dental health survey in 2014. As a result, the survey found that only one in five have private dental coverage with "the remainder receiving emergency coverage through OW (16%), limited coverage through the ODSP (21%) or no coverage all (38%)".[94] Among the recommendations produced as a result of this survey, collaboration with Niagara Region Public Health to provide fluoride varnish clinics for children and youth who have no coverage and are ineligible for HSO or whose families are receiving OW/ODSP. Upstream approaches were also recommended due to living in poverty on a daily basis either because of inadequate pensions and social assistance rates, or because they are struggling due to precarious employment or a minimum wage that leaves even full-time earners living below the poverty line.[94]

In 2008, the MOHLTC formalized the OPHS protocols for assessment and surveillance, preventive health services, and water fluoridation in order to standardize delivery of programming across the province.[95] Aside from the data obtained from OPHS, there is no provincial-wide data on the oral health status of Ontarians.

Table 37. Public dental programming in Ontario, 2013/14

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Ministry of Health and Long-Term Care						
Public Health Programs - Ontario Public Health Standards: Child Health Standard:						
Elementary school screening and surveillance	Grades JK, SK and 2 in all schools. Grades 4, 6, 8 in high need schools; 2 and 8 in medium need schools	Provides parents/guardians with information on children's treatment and prevention needs. Streamlines children into publicly financed care. Collects limited surveillance data	b	Elementary Schools	Administered by Ontario's 36 Public Health Units Cost-shared between province and municipalities	b
Clinical Preventive Services	Offered to children meeting evidence-informed dental eligibility criteria who come from low-income families	Topical fluoride, fissure sealants and scaling	31,423 topical fluoride applications fissure sealants for 8,325 children; and Scaling for 27,803 children[c]	Private dental offices and community clinics		
Health Promotion	Development and implementation of healthy policies and creation of supportive environments. Increasing public awareness of oral health. Providing advice and information to link people to community programs and services. In collaboration with community partners, outreach to priority populations to link them to information, programs and services.	Population based	b	Schools, communities, health and social service providers, community partner agencies, etc.		
Children In Need Of Treatment (CINOT)	Children and youth <18years; identified condition requiring urgent care; parents have no dental insurance and the cost of care would result in financial hardship	Includes diagnostic, preventive, restorative, prosthodontic, endodontic, oral surgery, general anaesthesia (in a private facility) and conscious sedation	2013: 32,839 children & youth treated $537 average costs per child	Dentists, dental hygienists, denturists/ private practice, community clinics, hospitals		$17.6

Table 37. cont'd

Program	Eligibility	Services Covered	Utilization	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 coverage for <18yrs includes: diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, and oral surgery services	451,157 eligible[a]	Dentists/ private practices, hospitals	Centrally and regionally Funded 88.6:11.4 (province/ municipality) for treatment, 50:50 for administration. Administration is determined by municipality (in-house, third-party administration, or private insurer)	$100,132[a]
Ontario Disability Support Program	Basic coverage for disabled recipient, spouse and dependent children who are in receipt of ODSP income support Additional services are available under the Dental Special Care Plan (DSCP) to eligible recipients whose dental needs result from their disability	Basic diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic and oral surgery services The DSCP provides more frequent services such as recall exams, scaling/root planning and additional services such as bruxism appliances and grafts	440,972 eligible[a]	Dentists/ private practices, hospitals	Adjudication and payment functions are the responsebility of a third party administrator	

Table 37. cont'd

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
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 The DSCP provides more frequent services such as recall exams, scaling/root planning and additional services such as bruxism appliances and grafts	29,688 eligible[a]	Dentists/ private practices, hospitals	Adjudication and payment functions the responsibility of a third party administrator	ACSD expenditure is included in the Ontario Works/ODSP expenditure above.

[a] Government of Ontario (March 2014) *Ontario Social Assistance Monthly Statistical Report*. Ministry of Community and Social Services, Social Policy Development Division, Statistical and Analysis Unit

Table 38. Public dental programming in Ontario, 2007/08

Program	Eligibility	Services Covered	Utilization	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	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 who are in receipt of ODSP income support; Additional services are available under the DSCP to eligible recipients whose dental needs result from their disability	Basic diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral surgery services	294,354 eligible[a]		As above Adjudication and payment functions the responsibility of a third part administrator	
Assistance for Severely Disabled Children (ASDC)	Must be <18yrs living a 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 Additional services are available under the DSCP to eligible recipients whose dental needs result from their disability	24,338 eligible[a]		b	b

Table 38. cont'd

Program	Eligibility	Services Covered	Utilization	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
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	92,264 services provided[d] >10,000 registered for cleft lip/palate program	Specialists and generalists/ hospitals	Centrally and regionally administered	14,230[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 (2007) *Canada Health Act Annual Report*. Canada Health Act Division, Health Canada

Table 39. 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)) Regulations may be made by the Minister or LGIC in accordance with the Act (Part VIII, ss.96-99)	Minister of Health and Long-Term Care
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

Table 39. cont'd

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
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 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))	Minister of Community and Social Services Dental benefits may be issued to adults on Ontario Works at the discretion of the Administrator on a case-by-case basis. (Ontario Works Policy Directives, http://www.mcss.gov.on.ca/en/mcss/programs/social/directives/index.aspx#ow)
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) 2)	Minister of Community and Social Services LGIC may make regulations respecting benefits for ODSP benefit unit members.

Table 39. cont'd

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
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 services are a mandatory benefit for eligible recipients if the costs and items have been approved by the Minister.
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 Eligible for the same dental services as children on ODSP
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 residents (s.91(1)(c))	Minister of Children and Youth Services
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 40. Dental public health human resources in Ontario, 2007/08

	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	Allied DPH Human Resources (FTE)[a]				DPH Programming (Yes/No)	DPH Human Resource Costs ($)	Total DPH Program Costs ($)
			DH	DA	DHE	DE			
Ministry of Health and Long-Term Care	1						Yes	120,000-135,000[b]	c
Algoma		0.3	3		4.8	1.5	Yes	577,129	765,929
Brant County	0.4		3.6	3.6		1	Yes	390,634[d]	399,594
Chatham-Kent							Yes		
Durham Regional	1		4	9			Yes	e*	1,434,400
Eastern Ontario	1						Yes		
Elgin-St Thomas									
Grey Bruce	0.1		2.5		1	1	Yes	*	186,500
Haldiman-Norfolk	0.2		1	0.3		1	Yes	108,200	305,600
Haliburton, Kawartha, Pineridge	0.5		2	4	1	2.5	Yes	535,883[f]	1,071,765
Halton Region	0.5		2.4		3	2.4	Yes	604,000	909,812**
City of Hamilton	1.0	1.8	3	2.8		6.5	Yes	817,971[g]	1,278,080
Hastings and Prince Edward Counties	0.5		2.52	2.41		4	Yes	675,219	1,350,437
Huron County	0.05		0.7			0.7	Yes	83,064	144,794**
Kingsotn, Frontenac, Lennox, and Addington	0.2		2	2		1.3	Yes	322,048	552,698
Lambton	0.07		1		1	1	Yes	230,455	310,455
Leeds, Grenville, and Lanark District	0.4		2.5	1		1.2	Yes	25,000	290,000
Middlesex-London	0.7	1	2	4		2	Yes	710,360	1,204,000
Niagara Regional Area	1		7	6		2	Yes	106,000	1,187,733
North Bay-Parry Sound			2.83	2.83		0.5	Yes	*	*
Northwestern	0.28		2.8	2.4	3		Yes	326,850	501,606
City of Ottawa	0.1	10.8	4	10.5	2	7	Yes	2,370,208[h]	5,540,032**
Oxford County	0.2		1.86		0.86	1	Yes	270,000	462,000
Peel Region	1		5.8	5	3	4.5	Yes	1,490,060[l]	3,912,110
Perth District	0.1		1	1			Yes	124,000	200,000**
Peterborough County	0.09		0.8	0.8		0.47	Yes	132,603	269,588**
Porcupine			1.77		1	2	Yes	224,000	590,240
Renfrew County and District									
Simcoe Muskoka			7.36		7.56	3	Yes	957,644	1,266,409

Table 40. cont'd

	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	Allied DPH Human Resources (FTE)[a]				DPH Programming (Yes/No)	DPH Human Resource Costs ($)	Total DPH Program Costs ($)
			DH	DA	DHE	DE			
Sudbury and District	0.2		4	3		1	Yes	471,091	672,987
Thunder Bay District			2.8		1.8	1	Yes	234,715	499,689**
Timiskaming			1	1			Yes	*	*
City of Toronto	1	28.8	19	56.2		32	Yes	10,924,677[j]	*
Waterloo	0.5	1	4.06	5.23		4	Yes	716,286	1,174,240
Wellington-Dufferin-Guelph	0.4		1.4	0.4	0.2	1	Yes	*	350,000**
Windsor-Essex	0.2		5	5		2.2	Yes	492,739	530,739
York Region	1	1.4	12	12		4.4	Yes	109,564[k]	*

* Not reported

** Includes CINOT and/or Ontario Works programming expenditures

[a] Across the province, there is variability among position titles for those working in DPH; Dental Educators (DE), Others include non-dental managers, program coordinators, secretaries, clerks, data entry personnel

[b] Government of Ontario, Disclosure for 2003 under The Public Sector Disclosure Salary Disclosure Act, 1996, Government of Ontario Ministries, 2003

[c] The Ministry of Health and Long-Term Care spends $10,599,102 on CINOT programming; this figure captures both provincial and regional/municipal expenditures (Senior Dental Consultant, Personal Communication, March 2006)

[d] Dental director allocated 0.4 to dental programming and 0.6 to child health with a salary range of $85,000-$110,000 (Minister of Finance, Salary Disclosure for 2004, Hospitals and Boards of Public Health, 2005)

[e] Director of Oral Health with a salary range of $100,000-$130,000 (Minister of Finance, Salary Disclosure for 2004, Municipalities and Services, 2005)

[f] Director of Dental Programs with a salary range of $95,000-$130,000 (Minister of Finance, Salary Disclosure for 2004, Hospitals and Boards of Public Health, 2005)

[g] Director of Dental Programs with a salary range of $100,000-$130,000 (Minister of Finance, Salary Disclosure for 2004, Municipalities and Services, 2005)

[h] Human resource budget for clinical operations, does not include CINOT staff

[i] Dental consultant with a salary range of $85,000-$110,000 (Minister of Finance, Salary Disclosure for 2004, Municipalities and Services, 2005)

[j] Dental director and managers with salaries totalling $420,678 (Minister of Finance, Salary Disclosure for 2004, Municipalities and Services, 2005)

[k] Dental director with a salary range of $100,000-$130,000 (Minister of Finance, Salary Disclosure for 2004, Municipalities and Services, 2005)

Table 41. CINOT expenditures, 1990-2013

Year	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[b]	21,982	6,202,116	282
1997	21,309	5,798,256	272
1998[c]	19,529	5,661,643	290
1999[d]	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[e]	30,852	11,247,162	365
2007[f]	30,890	12,028,061	384
2008[g]	28,682	10,901,828	380
2009[h]	50,779	16,300,000	321
2010[i]	43,484	19,248,986	443
2011	40,360	18,790,078	466
2012[j]	33,548	17,562,005	523
2013	32,839	17,642,944	537

[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
[b]New fee schedule with added restrictions and removal of some items
[c]Social assistance changes in late 1990s with 1998 program being 100% municipally funded
[d]New fee schedule with approximately 5% increase in fees
[e]New fee schedules released with 4% increase and other changes
[f]New Fee Schedule released April 1 (2% increase)
[g]Number of children treated (versus number of courses of treatment in 2007 and earlier years)

[h]January 1, 2009: CINOT was expanded to include children up to their 18th birthday (up from the old cut-off of Grade 8 or the 14th birthday, whichever was later). General anaesthesia coverage was also added for children aged 5 years of age and older
[i]Healthy Smiles Ontario (HSO) introduced October 1, 2010 (NB: Some children who were formerly treated under CINOT, qualified for on-going coverage through HSO)
[j]June 2012: OHISS was updated to stop double counting children who had a birthday in the middle of treatment

Notes:
January 1, 2009: CINOT was expanded to include children up to their 18th birthday (up from the old cut-off of Grade 8 or 14th birthday, whichever was later). General anaesthesia coverage was also added for children aged 5 years of age and older.

2009 onwards: Data extracted from the Oral Health Information Support System (OHISS). Not verified with public health units.
Up to, and including 1997, funded 100% by the Ministry of Health. 1998 – downloaded 100% to municipalities. 1999 – uploaded starting at 55% and rising until the current funding split of 75% province:25% municipality.

Table 42. Dental preventive services provided through the Ontario Public Health Standards[a]

	2000-01	2001-02	2002-03	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
Topical Fluoride	8,685	27,539	27,624	17,729	18,760	19,389	20,883	19,828	15,056	19,249	30,465[b]
Fissure Sealants	4,452	10,541	10,007	7,704	8,907	8,734	8,501	8,265	3,353	5,264	8,303[b]
Scaling	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	10,743	13,394	27,425[b]

[a] Provided through the Ontario Public Health Standards, 2008, Child Health Standard, Requirement 13. Does not include clinical dental preventive services provided through the Children In Need Of Treatment (CINOT) Program; (NB: Data incomplete because some public health units failed to submit reports in some years)
[b] Provided in response to a 2012 Public Health Unit Survey. 35 out of 36 PHUs provided data
December 2008: Scaling introduced as a mandated clinical preventive service

Notes: For the clinical preventive services, data is provided on a "school-year". Definition: September 1 of the past year to June 30 of the current year. Services conducted between July 1 and August 31, are incorporated into the following school year's reporting.

Québec

No information provided.

Tables included are from the 2007/08 Environmental Scan.

Table 43. Public dental programming in Québec, 2007/08*

Program	Eligibility	Services Covered	Utilization[a]	Service Environments	Administration	Expenditures $(000)[a]
Ministère de la Santé et des 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				
Prosthèses 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

*Most recent information available

[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 44. Dental public health human resources in Québec, 2007/08

	Dentistes-conseils (FTE)	Other DPH Human Resources Hygiène dentaire (FTE)	DPH Programming (Yes/No)	DPH Human Resource Costs ($)	Total DPH Program Costs ($)
Santé Publique	1		Yes	b	b
Institut National de Santé Publique	1		N/A		
Agence (18) de la Santé et des Services Sociaux[a]	23		Yes		
RAMQ	4		Yes		
Centres (95) de santé et des services sociaux		229.7	Yes	12,402,947[c]	13,558,443

[a] Québec's health regions
[b] Not reported
[c] Direction général de la santé publique. Ministère Santé et Services sociaux, Programme national de santé 2003-2012, Plan d'action en matière de santé dentaire publique 2004-2012, Mai 2004, http://www.listes.umontreal.ca/wws/d_read/infosante-l/20040511160948_plandactionenmatieredesantedentaire20042012.pdf

New Brunswick

New Brunswick currently has five public dental programs that receive funding from the provincial government. The Healthy Smiles, Clear Vision Program, and the Health Services Dental Program fall within the jurisdiction of the Department of Social Development, whereas Insured Surgical-Dental Services, Cancer Related Osseo-integrated Implants and Oral Prosthetics Program (COIOPP) and the Fluoride Mouth Rinse Program are the responsibility of the Department of Health.

A survey launched in the spring of 2011 by the New Brunswick Dental Society assessed public perceptions on the importance of oral health. The results highlight that New Brunswickers almost unanimously support an increase in government involvement in oral health promotion initiatives, as well as in improvement in access to dental care for children and seniors.[29]

Also in 2011, the New Brunswick's legislative assembly announced an increase of 5.8%, or 56.5 million dollars, from the previous fiscal year to the Department of Social Development budget. This new money would be used to provide services to those in need, namely to children, the elderly, and the disabled. The increased investments included 1.2 million dollars that was allocated for a vision and dental plan for children of low income families.[96]

Just over a year later, the provincial government reached a new four-year agreement with the New Brunswick Dental Society and the provincial, retroactive to April 1, 2011. This contract allowed for the continuation of the provision of dental services to over 51,000 social development patients. Under the new contract, the reimbursement rate for service providers would gradually increase to 81.5% by April 1, 2014, up from 68% under the previous contract.[97]

The following month, in June 2012, following recommendations by the Advisory Committee of Health Benefits, the Social Development Minister announced a new vision and dental plan that would include coverage for children 18 years of age and younger from low-income families. Approximately 22,000 New Brunswick children would benefit from this initiative, and the children who already received benefits through the Social Development's Health Services Program were transferred to the new plan.[98]

A document released in July 2012 by the New Brunswick Dental Society entitled "New Brunswick Health Care Consultations", highlighted that much like other Canadian jurisdictions, the province is dedicated to improving the oral health of New Brunswickers by addressing disparities through a population-based approach. The report stated that the three principles and

goals of an effective oral health action plan for the province are, "oral health is an integral part of general health; all New Brunswickers have the right to good oral health; and tooth decay (dental caries) is a preventable disease".[29]

In addition to providing an action plan, the report proposed fifteen recommendations for changes that would improve the oral health of the provinces residents. At the top of the list was appointing a provincial Chief Dental Officer to "advise government on oral health issues [and to] develop and implement education programs for New Brunswickers." The remaining recommendations focused on issues such as wait times for dental surgery for children; early intervention for the prevention of dental caries; school fluoride oral rinse program; culturally-appropriate oral health education; oral health care those with chronic and systemic diseases; and oral health care for seniors.[29]

Table 45. Public dental programming in New Brunswick, 2014

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Department of Social Development						
Healthy Smiles, Clear Vision	Children of families in receipt of Social Assistance and children of low income families are eligible to receive dental services even if the parent(s) do not receive Social Assistance[a]	The dental program covers basic items, such as regular exams, X-rays, restorations, extractions, preventative treatments such as sealants and fluoride treatments. Note that there is a yearly maximum of $1,000 for dental coverage.	6,731	Dentists - private practices	Medavie Blue Cross	1,800
Health Services Dental Program	This program assists clients of this department who are over the age of 19 with coverage for specific dental benefits that are not covered by other agencies or private health insurance plans. Benefits are negotiated with the New Brunswick Dental Society and the New Brunswick Denturists Society. This program is available to: - Clients are this department and their dependents 19 years of age and older. - Individuals who have special health needs and who qualify for assisted health care under Section 4.4 of the Family Income Security Act and Regulations. Clients must have one of the following: - A valid white Health Services Card indicating "DENTAL" coverage in the BASIC HEALTH ELIGIBILTIY section	Benefits covered under this program are: Exam, x-rays Dentures and repairs Specific types of fillings This program does not cover: - Orthodontic services and appliances - Fluoride treatment - Sealants - Root canals on posterior teeth - Oral surgeries not specified in the contract with the NB Dental Society Clients are eligible for a maximum of $1,000 per year, excluding emergency and prosthetic services. Clients will be charged a 30% participation fee for dentures and denture repairs. Once a treatment plan has been determined the dental professional will advise of the amount payable. The participation fee is paid directly to the dental professional and may be required before dental services are provided.				

Table 45. cont'd

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
	OR A valid yellow Health Services Card with a "Y" or an "X" under DENT in the VALID ONLY FOR box Additional benefit-specific eligibility criteria may apply. This program is only available to clients who have no other dental coverage. Note: Coverage for children 18 years of age and under now falls under the Health Smiles, Clear Vision Program administered by Medavie Blue Cross effective September 1, 2012.	With the exception of certain types of fillings, there is no cost to eligible clients for (all) other dental services.	N/A	Dentist and denturists/private practices	Centrally administered	4,800
Department of Health						
Insured Surgical-Dental Services	Insured surgical-dental services are prescribed under the Medical Services Payment Act	Various oral and maxillofacial procedures	4,949[b] services provided	Specialists in hospitals only	Centrally administered	664 [b]
Cancer-Related Osseo-integrated Implants and Oral Prosthetics Program (COIOPP)	Dental work related to head or neck cancer – by prior approval only	Dental extractions, dental implants, obturators, various prostheses	N/A	Oral and maxillofacial specialists only		N/A
Fluoride Mouth Rinse Program	School age children, grade 1-5	Fluoride mouth rinse	54% participation Approx 36,000 eligible	Teachers and volunteers in participating schools		50

[a] Application process for Healthy Smiles, Clear Vision: http://www2.gnb.ca/content/gnb/en/departments/social_development/promos/healthy_smiles_clear_vision.html

[b] Health Canada (2013) Canada Health Act Annual Report 2012-2013

[*] 2013 calendar year

Table 46. Public dental programming in New Brunswick, 2007/08

Program	Eligibility	Services Covered	Utilization	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 recognized 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, prostho-dontic, surgical, and additional services Enhanced Dental benefits are subject to a 30% client participation fee	a	Dentists and denturists/private practices	Centrally administered	3.400[b]
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[c]	Specialists and generalists/hospitals	Centrally administered	505[c]
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] Department of Family and Community Services (2007) Annual Report. Government of New Brunswick. ISBN 978-1-55396-980-8
[c] Government of Canada (2005) *Canada Health Act Annual Report*. Canada Health Act Division, Health Canada**.**

Table 47. Public dental care associated legislation in New Brunswick, 2014

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Medical Services Payment Act, RSNB 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 f6or the establishment of a medical services plan for residents of the province (s.2) The LGIC may make regulations under this Act (s.12)	Minister of Health Medical Services Plan
General Regulation, NB Reg 84-20 Under the *Medical Services Payment Act (O.C. 84-64)*	Beneficiaries are those residents meeting the requirements specified in the regulations (ss.2 and 3, subject to s.4)	Entitled services shall be deemed to include the health services listed in Schedule 4 (s.22(1)), subject to the exclusions in Schedule 2 (s.10), when rendered by a qualified dental practitioner in a hospital facility if the condition of the patient is such that the services are medically required to be rendered in a hospital facility.	Minister of Health Services listed in Schedule 4 are limited to surgical dental procedures
Hospital Services Act, RSNB 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
General Regulation, NB Reg 84-168 Under the *Hospital Services Act (O.C. 84-580)*	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
Regional Health Authorities Act, RSNB 2011, c 217		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. 71)	Minister of Health In the *Community Health Centres Regulation, NB Reg 2002-87* under the *Regional Health Authorities Act (O.C. 2002-421),* dental services are not included in the definition of "Community health services" (s.3)
Family Income Security Act, RSNB 2011, c 154	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 operation of this Act (s. 17)	Minister of Social Development

Table 47. cont'd

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
General Regulation, NB Reg 95-61 Under the *Family Income Security Act (O.C. 95-470)*	Recipients of assistance, including their dependents, as well as those meeting the definitions of blind, deaf and disabled (s.1 and s 16)	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 of providing a Health Services Card under the *Health Services Act* (s.23). The system will automatically extend the Health Card every 6 months if case is still active. Requests for a health card from those who are not eligible for assistance must be assessed under Section 4(4). Health cards issued under this section will be approved for a period of 12 months, unless circumstances require a shorter duration	Minister of Social Development
Health Services Act, RSNB 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 Social Development Health Services Dental Program
General Regulation, NB Reg 84-115 Under the *Health Services Act (O.C. 84-447)*	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 services, emergency services, prosthetic services, and restorative services as listed in paragraphs 3(a) to (f) of Schedule II (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 to give pre-approval in specified instances (s.5.1)	Minister of Social Development

Table 47. cont'd

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
		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, SNB. 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 Social Development
Children in Care Services Regulation, NB Reg 91-170 Under the *Family Services Act (O.C. 91-882)*	As above	The Minister shall provide each child in care with a health services card (s.12)	Minister of Social Development
Custody and Detention of Young Persons Act, RSNB 2011, c 137	Young persons admitted to youth custodial facilities	Medical treatment includes surgical and dental treatment (s.1) The LGIC may make regulations for the operation of this Act (s.15)	Minister of Public Safety
General Regulation, NB Reg 92-7 Under the *Custody and Detention of Young Persons Act*	Young persons admitted to youth custodial facilities (s.4)	The facility supervisor shall arrange for dental examinations and treatment as appear necessary (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, SNB 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, NB Reg 96-81 Under the *Victims Services Act*	As above	Eligible expenses for financial compensation for dental expenses are limited to $1,000 (s.5(b))	Minister of Public Safety The maximum amounts of financial compensation for 7 of the 11 eligible expenses have increased by at least 50% since 2003, and financial compensation for 3 of the 11 eligible expenses

Table 47. cont'd

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
			has increased by 100% or more. Maximum amounts of financial compensation for dental, medical, physiotherapy, and child care expenses have not changed since 2003.
Act Respecting the New Brunswick College of Dental Hygienists, 2009, c.10		Deals with the regulation of dental hygienists in New Brunswick	Minister of Health

Note: Neither *RSNB 2011, c 132* (which replaced *Corrections Act RSNB 1973, c. C 26*) nor *General Regulation, NB Reg 84-257*, under the *Corrections Act (O.C. 84-908)* contain any information regarding the provision of dental services for the beneficiaries of these two statutes, namely inmates of provincial correctional facilities.

Table 48. Dental public health human resources in New Brunswick, 2014

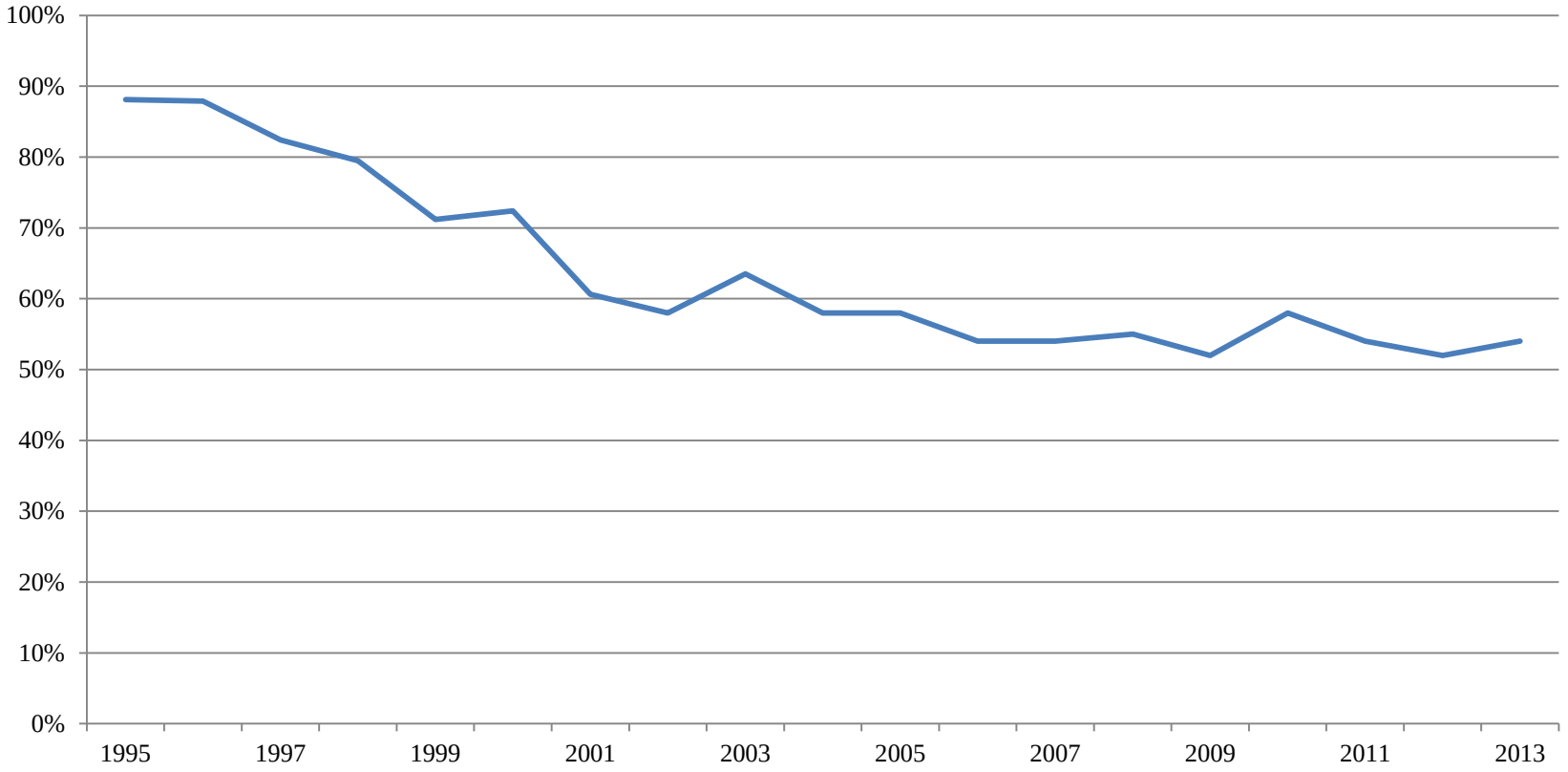
	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	Allied DPH Human Resources (FTE)			DPH Programming (Yes/No)	DPH Human Resource Costs ($)	Total DPH Program Costs ($)
			DH	DA	Other			
Department of Health	<0.1	0	0	0	0	Yes (FMR program)	< 8,000	50,000
Vitalité Health Network	0	0	0	0	0	0	0	0
Horizon Health Network	0	0	0	0	0	0	0	0

Note: New Brunswick does not have any Dental PH specialists at the Department of Health or in our 2 Health Networks (regions). A Senior Program Advisor at the Department of Health in the Public Health Practice and Population Health branch within the Office of the Chief Medical Officer of Health coordinates the Fluoride Mouth Rinse Program.

Table 49. Participation rates in New Brunswick's fluoride mouth rinse program

School year	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	58.0
2003/04	63.5
2004/05	58
2005/06	58
2006/07	54
2007/08	54
2008/09	55
2009/10	52
2010/11	58
2011/12	54
2012/13	52
2013/14	54

Figure 4. Participation rates in New Brunswick's fluoride mouth rinse program



Nova Scotia

Nova Scotia currently has six public dental programs that receive funding from the provincial government. Five of these programs fall within the jurisdiction of the Department of Health, namely: Children's Oral Health Program, Nova Scotia Cleft Palate/Craniofacial Program, Maxillofacial Prosthodontics Program, Mentally Challenged Program, and Dental Surgical (In-Hospital) Program. The Employment Support and Income Assistance Dental Program falls within the area of responsibility of the Department of Community Services.

Nova Scotia continues to be a leader in public dental programming, with the most notable recent change being the expansion of eligibility criteria for the Children's Oral Health Program. Prior to 1982, the cut-off age for publicly funded children's dental treatment had not been established. It was then that eligibility was defined, with 15 years being the maximum age. Specifically, children had coverage until their sixteenth birthday.[18] With changes in legislation in 1997, the maximum eligibility age was lowered to nine years. In April 2013, understanding that between 10 and 13 years of age represents an important period in tooth development as more permanent teeth erupt, the maximum eligibility was once again changed to include children up to the age of 13 years.[99]

Only four months later, in August 2013, a news release from the office of the province's Premier announced that Nova Scotia would again expand dental coverage to include children from birth to 17 years and younger. This increase in eligibility age, however, will occur in one year increments until April 2016, when the final maximum eligibility age would be reached. Of note is that the age limit of 17 will be the highest the province has ever seen. Services covered under COPH include coverage for basic treatment, namely yearly checkups, fillings and preventive services.[100]

In July 2013, the Government of Nova Scotia also established their commitment to improving the oral health of children by announcing that they would collaborate with the Izaak Walton Killam Hospital for Children to more than double the number of children in the province who receive dental surgery annually. Increases in the number of staff and the amount of equipment allows for 600 more Nova Scotia children to receive dental treatment in a hospital setting, thereby improving their quality of life and overall health and wellbeing.[101]

The important role that dental hygienists play in oral health promotion is reflected in the 2009 amendment to the *Dental Hygienists Act of Nova Scotia (2007) and Regulations*. Under previous legislation, dental hygienists were only authorized to provide care when employed and directly

supervised by a dentist, or when working in public health settings. The amendment now allows dental hygienists to self-initiate dental hygiene care by removing the requirement for patients to be examined by a dentist before being treated by a dental hygienist. The basis of this change was to improve the oral health of Nova Scotians by increasing access to dental preventative care.[102] However, dental hygienists are not approved health providers and cannot bill to publicly funded programs unless they are working under the supervision of a dentist.

In 2008 there was a review of oral health in Nova Scotia. The final report entitled *Nova Scotia Oral Health Review*, provided several recommendations that would aid in increasing the oral health of Nova Scotians.[103] There was one dentist employed part-time (0.3 FTE) who acted as the provincial Dental Consultant at the time of review. Although the report encouraged increases in dental public health leadership and workforce across the province - including implementation of a full-time provincial dental consultant - to date, the province has experienced decreases in the number of dental hygienists working in public health since 2005 and the provincial dental director position remains vacant.[103] In addition, the province is expected to undergo restructuring of its health regions from nine to two in the next year.

Surveillance measures for public dental programming in Nova Scotia are currently not conducted systematically. At present, the only program with ongoing surveillance measures is for the province's fluoride rinse program. Efforts by the Faculty of Dentistry at Dalhousie University have helped provide insight into the oral health needs of growing seniors' population over the years. However, with the last published report on oral health status of Nova Scotians in 1997, and a dental survey of grade two children in Nova Scotia last conducted 2005, it is evident that surveillance measures are lacking across the province. A review of all publicly funded dental programs partnered by the Department of Health and Wellness and the Nova Scotia Dental Association is currently underway. This review may result in changes to the Children's Oral Health Program, including the program eligibility criteria.

Table 50. Public dental programming in Nova Scotia, 2014

Program	Eligibility	Services Covered	Utilization[a]	Service Environments	Administration	Expenditures $[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. 28,969 eligible (March 31, 2014)	Dentists and denturists; private practices	Centrally administered	4,200,000
Services For Persons with Disabilities	Based on an assessment of financial need	Emergency dental care, some diagnostic, preventive, restorative, prosthodontic, endodontic, and oral surgical services Assistance pays 80% to 100% - Based on an assessment of financial need	Approx. 5,190	Dentist and Denturist; private plan	Administered by Caseworkers	943,772
Children In Care	In care of the Minister of Community Services	Diagnostic, preventive, and treatment services	Approx. 594	Dentist and Denturist; private plan	Administered by Caseworkers	402,628
Department of Health and Wellness						
Children's Oral Health Program (COHP)	Birth to end of the month of the 14th birthday; children are required to access private coverage first, program pays balance	Diagnostic, preventive, and treatment services Community-based prevention	37,911/89,560 160,767services rendered 4.2 services and $106 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 Quikcard Solutions Inc. (QSI) Public Health Services Division administers community-based prevention	4,026,000

Table 50. cont'd

Program	Eligibility	Services Covered	Utilization[a]	Service Environments	Administration	Expenditures $[a]
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	163 beneficiaries 734 services rendered 4.5 services & $852 per beneficiary	Specialists and generalists/ hospitals and private practices	MSI/QSI	138
Maxillofacial Prosthodontics Program	Those whose maxillofacial prosthodontic needs result from congenital facial disorders, cancer, trauma, and neurological deficit	Various oral surgical and prosthodontic services	741 beneficiaries 2,231 services rendered 3.1 services & $1,133 per beneficiary	As above	As above	839
Mentally Challenged Program	Anyone deemed mentally challenged by a medical authority, and whose dental needs may necessitate hospitalization	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	792 beneficiaries 4,168 services rendered 5.3 services & $370 per beneficiary	As above	As above	293
Dental Surgical (In-Hospital) Program	Anyone whose dental needs may necessitate hospitalization	Various oral surgical and dental procedures	2,468 beneficiaries 7,007 services rendered 2.8 services & $566 per beneficiary	Specialists and generalists/ hospitals	As above	1,397

[a] Government of Nova Scotia *Medical Services Insurance Annual Statistical Tables 12 Months Ending March 31, 2013*. Information Management, Nova Scotia Department of Health and Wellness
[b] Not reported

Table 51. Public dental programming in Nova Scotia, 2007/08

Program	Eligibility	Services Covered	Utilization[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	41,092/94,290 181,173 services rendered 4.3 services and $92.03 per beneficiary	Dentists and dental hygienists: private practices, community clinics, and 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	3,782
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	163 beneficiaries 649 services rendered 40 services and $567 per beneficiary	Specialists and generalists: hospitals and private practices	MSI/QSI	92

Table 51. cont'd

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Maxillofacial Prosthodontics Program	Those whose maxillofacial prosthodontic needs result from congenital facial disorders, cancer, trauma, and neurological deficit	Various oral surgical and prosthodontic services	462 beneficiaries 1,480 services rendered 3.2 services and $1,160 per beneficiary	As above		536
Mentally Challenged Program	Anyone deemed mentally challenged by a medical authority, and whose dental needs may necessitate hospitalization	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	397 beneficiaries 2,294 services rendered 5.8 services and $375 per beneficiary	As above	As above	149
IWK Dental Alternate Funded Program	IWK paediatric patients	Various oral surgical and dental procedures	1,120 beneficiaries 5,729 services rendered 5.1 services and $549 per beneficiary	Specialists and generalists: hospital	As above	614
Dental Surgical (In-Hospital) Program	Anyone whose dental needs may necessitate hospitalization	Various oral surgical and dental procedures	1,753 beneficiaries 5.120 services rendered 2.9 services and $607 per beneficiary	Specialists and generalists: hospitals	As above	1,064
Special Considerations – Adults\	Case by case bases	Diagnostic, preventive, and treatment services	43 beneficiaries 231 services rendered 5.4 services and $1,094 per beneficiary	Dentists: private practices		47

[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 52. 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) May 2008 amendment: Subject to subsection (2), a spouse or dependant of a member of the Canadian Forces moving to the Province from outside Canada is insured for the payment of the cost of insured services commencing on the day the spouse or dependant takes up residence in the Province. (s.4A)	Minister of Health and Wellness
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 and Wellness
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 and Wellness
Insured Dental Services Tariff Regulations, N.S., Reg. 62/2013	Persons indicated in Schedules A-E.	Sets out the tariff of fees for insured dental services in the following schedules: (a) Schedule A: Cleft Palate/Craniofacial Program (b) Schedule B: Children's Oral Health Program (c) Schedule C: Dental Surgical Program (d) Schedule D: Maxillofacial Prosthodontics Program (e) Schedule E: Mentally Challenged Program	Minister of Health and Wellness Amended to O.I.C. 2014-181 (May 20, 2014), N.S. Reg. 69/2014
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

Table 52. cont'd

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
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, 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)	Minister of Community Services
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
Dental Act, S.N.S. 1992, c.3		Sets out regulation of the dental profession in Nova Scotia. 2008 Amendment: In 2008, The Health Professions Disciplinary Proceedings Protection (2008) Act resulted in amendments to both the Dental Act and Dental Hygienists Act regarding protection of evidence in legal proceedings 2014 Amendment: In May 2014 a clause was added which clarified the corporate of the Provincial Dental Boards. Dental hygienists are no longer regulated under this Act.	Minister of Health and Wellness

Table 52. cont'd

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Dental Hygienists Act, S.N.S. 2007, c. 29		Dental hygienists in Nova Scotia regulate, license and discipline their own profession and can deliver care directly to the public (s4) 2008 amendment: In 2008, The Health Professions Disciplinary Proceedings Protection (2008) Act resulted in amendments to both the Dental Act and Dental Hygienists Act regarding protection of evidence in legal proceedings	Minister of Health and Wellness Proclamation took place in 2008
Insured Health Services Act, SNS 2012, c. 44	Residents of the province meeting the terms and conditions of the act and regulations (s.5)	The purpose of this Act is to establish and maintain (a) a program of insured health services for the public under which access to medically necessary care is based on need and not on an individual's ability to pay, and that satisfies the eligibility criteria for federal funding under the Canada Health Act; and (b) a program of insured designated services for the public (s2)	Minister of Health and Wellness Statute has not come into force
Regulated health Professions Network Act, SNS 2012 c. 48, s.1		In September 2013, the Regulated Health Professions Network Act was amended to include both the Provincial Dental Board and the College of Dental Hygienists as members.	

Table 53. Dental public health human resources in Nova Scotia, 2014[a]

	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	Allied DPH Human Resources (FTE)			DPH Programming (Yes/No)	DPH Human Resource Costs ($)	Total DPH Program Costs ($)
			DH	DA	Other			
Department of Health								
DHA 1			2			Yes	c	c
DHA 2			2					
DHA 3			1					
DHA 4			1.5					
DHA 5			0.8					
DHA 6			0.6					
DHA 7			1					
DHA 8			3					
DHA 9			2.3[b]					

[a] Does not include enumeration of on-reserve providers
[b] DHA 9 – 1 full time and 2 part-time (0.6, 0.7) hygienists
[c] Not reported

Table 54. Dental public health human resources in Nova Scotia, 2007/08

	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	Dental Hygienist (FTE)	DPH Programming (Yes/No)	DPH Human Resource Costs ($)	Total DPH Program Costs ($)
Department of Health		0.3		No	30,000 – 40,000[a]	1,000,000
Zone 1 – Zone 6			18.6	Yes		

[a] As reported by position holder

Table 55. Remuneration rates for DPH personnel in Nova Scotia, 2014

	Hourly Rate
Dental Hygienist	$26.44 - $30.8564

*25 year-long service retention bonus increases hygiene salary to $31.9363; only applies to Capital Health.

Table 56. Dental programs, payment summary, Nova Scotia, 1997/98-2012/13[a,b] (excluding Special Dental Programs, see next table)

	Children's Oral Health Program		Dental Surgical Program		Out-of-province Expenditures		IWK Dental Alternate Funded Program[c,d]		Total Dental Programs	
Year	$	% change	$	% change	$	% change	$	% change	$	% change
1997/98	6,100,705	-	1,514,346	-	965	-	-	-	7,616,016	-
1998/99[e]	7,109,061	16.5	1,725,024	13.9	1,622	68.1	217,073	N/A	9,052,780	18.9
1999/00[e]	6,963,583	-2	1,929,519	11.9	819	-49.5	468,363	115.8	9,362,284	3.4
2000/01[e,f,g]	6,563,854	-5.7	1,008,100[6]	-47.8	0	-100	495,271	5.7	8,067,225	-13.8
2001/02[f]	6,883,315	4.9	903,100	-10.4	0	N/A	458,873	-7.3	8,245,288	2.2
2002/03[f]	3,994,233[5]	-42	934,502	3.5	0	N/A	546,090	19	5,474,825	-33.6
2003/04[f]	3,850,099	-3.6	902,008	-3.5	0	N/A	468.762	-14.2	5,220,869	-4.6
2004/05[f]	3,820,536	-1.0	993,934	10.2			345,384	-26.3	5,159,854	-1.2
2005/06[f]	3,781,852	-1.0	1,058,860	6.5			614,368	77.9	5,455,080	5.7
2006/07[f]	3,698,283	-2.2	1,121,703	5.9			663,602	8.0	5,483,588	0.5
2007/08[f]	3,760,601	1.7	1,215,333	8.3			720,706	8.6	5,696,640	3.9
2008/09[f]	3,862,361	2.7	1,372,085	12.9			762,424	5.8	5,996,870	5.3
2009/10[f]	3,892,382	0.8	1.380,344	0.6			839,007	10.0	6,111,733	1.9
2010/11[f]	3,906,419	0.4	1,459,608	5.7			8.46,514	0.9	6,212,541	1.6
2011/12[e]	3,942,373	0.9	1,338,592	-8.3			780,389	-7.8	6,061,354	-2.4
2012/13[f]	4,026,471	2.1	1,397.223	4.4			776,469	-0.5	6,200,163	2.3

[a] Data provided for 1997/98 and 1998/99 are "date of payment". Data beginning in 1999/00 are "date of service"
[b] In 2002/3, the Department of Health became the "insurer of last resort"
[c] IWK Dental Alternate Funding Program began January 1, 1999
[d] 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. This is included in the Amount Paid in Table 60
[e] Totals include dental retroactive payments
[f] Totals include accounting adjustments
[g] A reduction in 2000/01 was due to some services being deinsured

Note: Information obtained from Nova Scotia Annual Statistical Report Supplement Medical Insurance Tables: http://novascotia.ca/dhw/annual-statistical-reports.asp

Table 57. Dental programs, payment summary, Nova Scotia, 1997/98-2012/13[a,b]

Payment Summary for Special Dental Programs[c]												
	Maxillofacial Prosthodontics		Cleft Palate		Mentally Challenged		Sir Frederick Fraser School		Special Considerations Adult		Total Special Dental Programs	
Year	$	% change	$	% change	$	% change	$	% change	$	% change	$	% change
1997/98	264,129	-	226,249	-	63,998	-	409	-	36,573	-	591,358	-
1998/99[d]	321,207	21.6	243,794	7.8	89,766	40.3	2	-99.5	41,131	12.5	695,899	17.7
1999/00[d]	311,835	-2.9	236,835	-2.8	86,985	-3.1	2	0	40,231	-2.2	675,903	-2.9
2000/01[d,e]	429,674	37.8	116,867	-50.7	993,370	7.3	0	-100	14,443	-64.1	654,353	-3.2
2001/02[e]	436,537	1.6	103,608	-11.3	101,671	8.9	0	N/A	21,984	52.2	663,800	1.4
2002/03[e]	530,671	21.6	134,058	29.4	107,353	5.6	0	N/A	16,418	-25.3	788,500	18.8
2003/04[e]	444,804	-16.2	132,706	-1.0	112.277	4.6			27,457	67.2	717,244	-5.2
2004/05[e]	376,459	-15.4	116.898	-11.9	100,699	-10.3			30,365	10.6	624,421	-12.9
2005/06[e]	543,976	44.5	85,085	-27.2	156.640	55.6			47,616	56.8	833,317	33.5
2006/07[e]	530,563	-2.5	85,724	0.8	159,347	1.7			93,352	96.1	868,986	4.3
2007/08[e]	636,990	20.1	84,934	-0.9	202,550	27.1			57,888	-38.0	982,362	13.0
2008/09[e]	722,798	13.5	86,294	1.6	177,291	-12.5			92,608	60.0	1,078,991	9.8
2009/10[e]	750,314	3.8	134,825	56.2	200,679	13.2			151,927	64.1	1,237,745	14.7
2010/11[e]	763,891	1.8	134,642	-0.1	229,825	14.5			81,598	-46.3	1,209,956	-2.2
2011/12[e]	718,880	-5.9	148,937	10.6	242,320	5.4			79,207	-2.9	1,189,344	-1.7
2012/13[e]	839,600	16.8	138,836	-6.8	293,175	21.0			107,621	35.9	1,379,232	16.0

[a] Data provided for 1997/98 and 1998/99 are "date of payment". Data beginning in 1999/00 are "date of service"
[b] In 2002/03 the Department of Health became "insurer of last resort"
[c] 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
[d] Totals include dental retroactive payments
[e] Totals include accounting adjustments

Note: Information obtained from Nova Scotia Annual Statistical Report Supplement Medical Insurance Tables: http://novascotia.ca/dhw/annual-statistical-reports.asp

Table 58. Children Oral Health Program, utilization summary, 1997/98-2012/13[a,b]

	Services Rendered		Amount Paid		Persons Insured[c]		Beneficiaries[d]		Services Per Insured Person		Paid Per Insured Person		Services Per Beneficiary		Paid Per Beneficiary	
Year	#	% change	$	% change	#	% change	#	% change	#	% change	$	% change	#	% change	$	% change
1997/98	263,845	-	6,100,705	-	117,400	-	64,017	-	2.2	-	51.97	-	4.1	-	95.3	-
1998/99[e]	298,557	13.2	7,109,061	16.5	115,300	-1.8	65,459	2.3	2.6	15.2	61.66	18.7	4.6	10.7	108.6	14.0
1999/00[e]	283,978	-4.9	6,963,583	-2.0	111,800	-3.0	64,375	-1.7	2.5	-1.9	62.29	1.0	4.4	-3.3	108.17	-0.4
2000/01[f]	266,392	-6.2	6,563,854	-5.7	108,500	-3.0	61,301	-4.8	2.5	-3-3	60.50	-2.9	4.3	-1.5	107.08	-1.0
2001/02[f]	260,387	-2.3	6,883,315	4.9	105,100	-3.1	59,868	-2.3	2.5	0.9	65.49	8.3	4.3	0.1	114.97	7.4
2002/03[f,g]	165,397[5]	-36.5	3,994,233[5]	-42	101,853	-3.1	38,747	-35.3	1.6	-34.5	39.22	-40.1	4.3	-1.9	103.08	-10.3
2003/04[f]	176,547	6.7	3,850,099	-3.6	98,515	-2.8	40,317	4.1	1.8	9.9	39.08	-0.8	4.4	2.6	95.50	-7.4
2004/05[f]	178,197	1.0	3,820,536	-1.0	95,818	-2.7	40,452	4.1	1.9	5.6	39.87	2.0	4.4	2.4	94.45	-1.1
2005/06[f]	181,173	1.7	3,781,852	-1.0	94,290	1.6	41,095	1.6	1.9	3.3	40.11	0.6	4.4	0.1	92.03	-2.6
2006/07[f]	174,143	-3.9	3,698,283	-2.2	91,700	-2.7	39,851	-3.0	1.9	-1.2	40.33	0.6	4.4	-0.9	92.08	0.8
2007/08[f]	175,725	0.9	3,800,499	2.8	89,300	-2.6	39,165	-1.7	2.0	3.6	42.56	5.5	4.5	2.7	97.04	4.6
2008/09[f]	166,985	-5.0	3,862.361	1.6	84,400	-5.5	38,669	-1.3	2.0	0.5	45.76	7.5	4.3	-3.8	99.88	2.9
2009/10[f]	162,460	-2.7	3,892,382	0.8	89,260	5.8	38,519	-0.4	1.8	-8.0	43.61	-4.7	4.2	-2.3	101.06	1.2
2010/11[f]	161,083	-0.8	3,906,416	0.4	89,100	-0.2	37,612	2.3	1.8	-0.7	43.84	0.5	4.3	1.5	103.86	2.8
2011/12[f]	161,107	0.0	3,942,373	0.9	90,078	1.1	37,828	0.6	1.8	-1.1	43.77	-0.2	4.3	-0.6	104.22	0.3
2012/13[f]	160,767	-0.2	4,026,471	2.1	89,560	-0.6	37,911	0.2	1.8	0.4	44.96	2.7	4.2	-0.4	106.21	1.9

[a] Data provided for 1997/98 and 1998/99 are "date of payment". Data beginning in 1999/00 are "date of service"
[b] Excludes services from the IWK Dental Alternate Funded Program. See Table 60 for the IWK Dental Alternate Funded Program services
[c] Insured population from Statistics Canada new estimates as of July 1st of each year
[d] Persons receiving insured services
[e] Totals include Dental Retroactive payments
[f] Totals include accounting adjustment
[g] In 2002/03 the Department of Health became "insurer of last resort"

Note: Information obtained from Nova Scotia Annual Statistical Report Supplement Medical Insurance Tables: http://novascotia.ca/dhw/annual-statistical-reports.asp

Table 59. Dental Surgical Program, utilization summary, 1997/98-2012/13[a,b]

	Services Rendered		Amount Paid		Persons Insured[c]		Beneficiaries[d]		Services Per Insured Person		Paid Per Insured Person		Services Per Beneficiary		Paid Per Beneficiary	
Year	#	% change	$	% change	#	% change	#	% change	#	% change	$	% change	#	% change	$	% change
1997/98	15,549	-	1,514,346	-	934,800	-	8,655	-	0.02	-	1.62	-	1.8	-	174.97	-
1998/99[e]	16,909	8.7	1,725,024	13.9	934,600	0	9,224	6.6	0.02	8.8	1.85	13.9	1.8	2.0	187.01	6.9
1999/00[e]	19,422	14.9	1,929,519	11.9	939,800	0.6	9,664	4.8	0.02	4.2	20.5	11.2	2.0	9.6	199.66	6.8
2000/01[f]	6,952	-64.2	1,008,100	-47.8	941,000	0.1	3,456	-64.2	0.0.1	-64.3	1.07	-47.8	2.0	0.1	291.70	46.1
2001/02[f]	4,407	-36.6	903,100	-10.4	942,700	0.2	1,501	-56.6	<0.01	-36.7	0.96	-10.6	2.9	46	601.67	106.3
2002/03[f]	4,363	-1.0	934,502	3.5	944,800	0.2	1,706	13.7	0	15.7	0.99	3.2	2.6	-12.9	547.77	-9.0
2003/04	3,741	-14.3	902,008	-3.5	936,000	0.2	1,536	-10.0	<0.1	15.7	0.96	-3.6	2.4	-4.8	587.24	7.2
2004/05	4,315	153	993,934	10.1	937,000	0.1	1,613	5.0	<0.1	15.2	1.03	10.4	2.7	12.5	579.00	-1.4
2005/06	5,120	18.7	1,064,409	7.1	937,900	0.1	1,753	8.7	<0.1	18.4	1.13	7.1	2.9	8.2	607.19	4.9
2006/07	5,298	3.5	1,121,703	5.4	935,100	-0.3	1,869	6.6	<0.1	3.8	1.2	5.7	2.8	-2.9	600.16	-1.2
2007/08	5,600	5.7	1,195,981	6.6	934,300	-0.1	1,923	2.9	<0.1	5.7	1.28	6.7	2.9	2.7	621.93	3.6
2008/09	6,243	11.5	1,372,085	14.7	932,900	-0.1	2,301	19.7	<0.1	5.7	1.47	14.9	2.7	-6.8	596.30	-4.1
2009/10	6,536	4.7	1,380,344	0.6	938,200	0.6	2,048	4.7	<0.1	0.0	1.47	0.0	2.7	0.0	573.23	-3.9
2010/11	6,913	5.8	1,459,608	5.7	942,500	0.5	2,338	-2.9	<0.1	0.0	1.55	5.3	3.0	8.9	624.30	8.9
2011/12	7,228	4.6	1,338,592	-8.3	945,400	0.3	2,422	3.6	<0.1	0.0	1.42	-8.6	3.0	0.9	552.68	-11.5
2012/13	7,007	-3.1	1,397,223	4.4	948,700	0.3	2,468	1.9	<0.1	0.0	1.47	4.0	2.8	-4.9	566.14	2.4

[a] Data provided for 1997/98 and 1998/99 are "date of payment." Data beginning in 1999/00 are "date of service"
[b] Excludes services from the IWK Dental Alternate Funded Program. See Table 60 for the IWK Dental Alternate Funded Program services
[c] Insured population from Statistics Canada new estimates as of July 1st of each year, include Armed Forces and RCMP personnel
[d] Persons receiving insured services
[e] Totals include dental retroactive payments
[f] Reduction due to some services being deinsured in August 2000 and further program change in 2001/02

Note: Information obtained from Nova Scotia Annual Statistical Report Supplement Medical Insurance Tables: http://novascotia.ca/dhw/annual-statistical-reports.asp

Table 60. IWK Dental Alternate Funded Program, utilization summary, 1997/98-2012/13[a,b]

											Services by Program									
	Services Rendered		Amount Paid		Beneficiaries[c]		Services Per Beneficiary		Paid Per Beneficiary		Children's Oral Health		Cleft Palate		Mentally Challenged		Dental Surgery		Special Considerations	
Year	#	% change	$	% change	#	% change	#	% change	$	% change	#	% change	#	% change	#	% change	#	% change	#	% change
2000/01[d]	5,960	-	495,271	-	914	-	6.5	-	541.87	-	5,035	-	525	-	338	-	22	-	40	-
2001/02[d]	6,391	7.2	458,873	-7.3	1,133	24.0	5.6	-13.2	405.01	-25.3	5,307	5.4	653	24.4	329	-2.7	90	309.1	12	-70.0
2002/03[d]	5,081	-20.5	546,090	19.0	999	-11.8	5.1	-9.8	546.64	35.0	4,329	-18.4	431	-34.0	240	-27.1	78	-13.3	3	-75.0
2003/04	4,701	-7.5	468,762	-14.2	875	-12.4	5.4	5.6	535.73	-2.0	3,906	-9.8	545	26.5	201	-16.3	39	-50.0	10	233.3
2004/05	4,612	-1.9	345,384	-26.3	865	-1.1	5.3	-0.8	399.29	-25.5	3,763	-3.7	410	-24.8	377	86.7	31	-20.5	31	210.0
2005/06	5,729	24.2	614,368	77.9	1,120	29.5	5.1	-4.1	548.54	37.4	4,866	29.3	327	-20.2	487	29.2	20	-35.5	29	-6.5
2006/07	6,398	11.7	663,602	8.0	1,201	7.2	5.3	4.1	552.54	0.7	5,500	13.0	277	-15.3	579	18.9	14	-30.0	27	-6.9
2007/08	6,261	-2.1	720,706	8.6	984	-18.1	6.4	19.4	732.42	32.6	5,483	-0.3	259	-6.5	483	-16.6	28	100.0	8	-70.4
2008/09	6,293	0.5	762,424	5.8	1,134	15.2	5.5	-12.8	672.33	-8.2	5,572	1.6	279	7.7	429	-11.2	1	-96.4	12	50.0
2009/10	7,352	16.8	839,007	10.	1,264	11.5	5.8	4.8	663.77	-1.3	6,502	16.7	194	-30.5	576	34.3	28	2,700.0	52	333.3
2010/11	8,219	11.8	846,514	0.9	1,452	14.9	5.7	-2.7	583.00	-12.2	7,331	12.7	266	37.1	500	-13.2	58	107.1	64	23.1
2011/12	9,507	15.7	780,389	-7.8	1,507	3.8	6.3	11.4	517.84	-11.2	8,546	16.4	275	3.4	559	11.8	21	-63.8	116	81.3
2012/13	9,364	-1.5	776,469	-0.5	1,476	-2.1	6.3	0.6	526.06	1.6	8,520	-0.2	162	-41.1	601	7.5	14	-33.3	67	-42.2

[a] Data provided are "date of service"
[b] Includes services from the IWK Dental Alternate Funded Program only
[c] Persons receiving insured services
[d] Totals include accounting adjustments

Note: Information obtained from Nova Scotia Annual Statistical Report Supplement Medical Insurance Tables: http://novascotia.ca/dhw/annual-statistical-reports.asp

Table 61. Special Dental Program-Maxillofacial Prosthodontics, utilization summary, 1997/98-2012/13[a,b]

	Services Rendered		Amount Paid		Beneficiaries[c]		Services Per Beneficiary		Paid Per Beneficiary	
Year	#	% change	$	% change	#	% change	#	% change	$	% change
1997/98	1,366	-	264,123	-	425	-	3.2	-	621.48	-
1998/99[c]	1,549	13.4	321,207	21.6	634	49.2	2.4	-24.0	506.64	-18.5
1999/00[c]	1,622	4.7	368,316	14.7	583	-8.0	2.8	13.9	631.76	24.7
2000/01[d]	1,626	0.2	429,674	16.7	484	-17.0	3.4	20.8	887.76	40.5
2001/02[d]	1,987	22.2	436,537	1.6	597	23.3	3.3	-0.9	731.22	-17.6
2002/03[d]	1,681	-15.4	530,671	21.6	531	-11.1	3.2	-4.9	999.38	36.7
2003/04	1,256	-25.3	444,804	-16.2	383	-27.9	3.3	3.6	1,161.37	16.2
2004/05	1,230	-2.1	376,459	-15.4	412	7.6	3.0	-9.1	913.74	-21.3
2005/06	1,480	20.3	536,261	42.4	462	12.1	3.2	7.3	1,160.74	27.0
2006/07	1,707	15.3	530,563	-1.1	499	8.0	3.4	6.8	1,063.25	-8.4
2007/08	1,947	14.1	636,990	20.1	535	7.2	3.6	6.4	1,190.64	12.0
2008/09	1,897	-2.6	722,798	13.5	566	5.8	3.4	-7.9	1,277.03	7.3
2009/10	1,966	3.6	750,314	3.8	628	11.0	3.1	-6.6	1,194.77	-6.4
2010/11	2,073	5.4	763,891	1.8	667	6.2	3.1	-0.7	1,145.26	-4.1
2011/12	2,081	0.4	718,880	-5.9	699	4.8	3.0	-4.2	1,028.44	-10.2
2012/13	2,231	7.2	839,600	16.8	741	6.0	3.0	1.1	1,133.06	10.2

[a] Data provided for 1997/98 and 1998/99 are "date of payment." Data beginning in 1999/00 are 'date of service"
[b] Excludes services from the IWK Dental Alternate Funded Program. See Table 60 for the IWK Dental Alternate Funded Program services
[d] Totals include Dental Retroactive payments
[e] Totals include accounting adjustments

Note: Information obtained from Nova Scotia Annual Statistical Report Supplement Medical Insurance Tables: http://novascotia.ca/dhw/annual-statistical-reports.asp

Table 62. Special Dental Program-Cleft palate, utilization summary, 1997/98-2012/13[a,b]

	Services Rendered		Amount Paid		Beneficiaries[c]		Services Per Beneficiary		Paid Per Beneficiary	
Year	#	% change	$	% change	#	% change	#	% change	$	% change
1997/98	3,029	-	226,249	-	404	-	7.5	-	560.02	-
1998/99[d]	3,019	-0.3	243,794	7.8	393	-2.7	7.7	2.5	620.34	10.8
1999/00[d]	2,146	-28.9	236,850	-2.8	443	12.7	4.8	-36.9	534.65	13.8
2000/01[e]	840	-60.9	116,867[f]	-50.7	183	-58.7	4.6	-5.2	638.62	19.4
2001/02[e]	1,007	19.9	103,608	-11.3	196	701	5.1	11.9	528.61	-17.2
2002/03[e]	1,029	2.2	134,058	29.4	185	-5.6	5.6	8.3	724.64	37.1
2003/04	1,092	6.1	132,706	-1.0	190	2.7	5.7	3.3	698.45	-3.6
2004/05	835	-23.5	116,898	-11.9	179	-5.8	4.7	-17.5	653.06	-6.5
2005/06	649	-22.3	92,422	-20.9	163	-8.9	4.0	-14.6	567.00	-13.2
2006/07	661	1.8	85,724	-7.2	141	-13.5	4.7	17.7	607.97	7.2
2007/08	674	2.0	84,934	-0.9	143	1.4	4.7	0.5	593.94	-2.3
2008/09	719	6.7	86,294	1.6	153	7.0	4.7	-0.3	564.01	-5.0
2009/10	847	17.8	134,825	56.2	146	-4.6	5.8	23.5	923.46	63.7
2010/11	759	-10.4	134,642	-0.1	141	-3.4	5.4	-7.2	954.91	3.4
2011/12	765	0.8	148,937	10.6	143	1.4	5.3	-0.6	1,041.52	9.1
2012/13	734	-4.1	138,836	-6.8	163	14.0	4.5	-15.8	851.75	-18.2

[a] Data provided for 1997/98 and 1998/99 are "date of payment." Data beginning in 1999/00 are 'date of service"
[b] Excludes services from the IWK Dental Alternate Funded Program. See Table 60 for the IWK Dental Alternate Funded Program services
[c] Persons receiving insured services
[d] Totals include Dental Retroactive payments
[e] Totals include accounting adjustments
[f] Decrease due to many procedures now being provided under the IWK Dental Alternate Funded Program

Note: Information obtained from Nova Scotia Annual Statistical Report Supplement Medical Insurance Tables: http://novascotia.ca/dhw/annual-statistical-reports.asp

Table 63. Special Dental Program-Mentally challenged, utilization summary, 1997/98-2012/13[a,b]

	Services Rendered		Amount Paid		Beneficiaries[c]		Services Per Beneficiary		Paid Per Beneficiary	
Year	#	% change	$	% change	#	% change	#	% change	$	% change
1997/98	1,368	-	63,998	-	192	-	7.1	-	333.32	-
1998/99[d]	1,564	14.3	89,766	40.3	196	2.1	8.0	12	457.99	37.4
1999/00[d]	1,469	-6.1	85,341	-4.9	210	7.1	7.0	-12.3	406.39	-11.3
2000/01[e]	1,419	-3.4	93,370	9.4	200	-4.8	7.1	1.4	466.85	14.9
2001/02[e]	1,578	11.2	101,671	8.9	202	1.0	7.8	10.1	503.32	7.8
2002/03[e]	1,647	4.4	107,353	5.6	216	6.9	7.6	-2.4	497.00	-1.3
2003/04	1,652	0.3	112,277	4.6	202	-6.5	8.2	7.3	55.83	11.8
2004/05	1,423	-14.0	100,699	-10.0	238	18	6.0	-27	423.11	-24
2005/06	2,294	61.2	148,786	47.8	397	66.8	5.8	-3.7	374.77	-11.4
2006/07	2,417	5.4	159,347	7.1	480	20.9	5.0	-12.9	331.97	-11.4
2007/08	2,593	7.3	202,550	27.1	451	-6.0	5.7	14.2	449.11	35.3
2008/09	2,468	-4.8	177,291	-12.5	501	11.1	4.9	-14.3	353.87	-21.2
2009/10	2,961	20.0	200,679	13.2	578	15.4	5.1	4.0	347.20	-1.9
2010/11	3,371	13.8	229,825	14.5	662	14.5	5.1	-0.6	347.17	0.0
2011/12	3,365	7.8	242,320	5.4	699	5.6	5.2	2.1	346.67	-0.1
2012/13	4,168	14.7	293,175	21.0	792	13.3	5.3	1.2	370.17	6.8

[a] Data provided for 1997/98 and 1998/99 are "date of payment". Data beginning in 1999/00 are 'date of service"
[b] Excludes services from the IWK Dental Alternate Funded Program. See Table 60 for the IWK Dental Alternate Funded Program services
[c] Persons receiving insured services
[d] Totals include Dental Retroactive payments
[e] Totals include accounting adjustments

Note: Information obtained from Nova Scotia Annual Statistical Report Supplement Medical Insurance Tables: http://novascotia.ca/dhw/annual-statistical-reports.asp

Table 64. Special Dental Program - Special Considerations-Adult, utilization summary, 1997/98-2012/13[a,b]

	Services Rendered		Amount Paid		Beneficiaries[c]		Services Per Beneficiary		Paid Per Beneficiary	
Year	#	% change	$	% change	#	% change	#	% change	$	% change
1997/98	222	-	36,573	-	27	-	8.2	-	1,354.56	-
1998/99[d]	260	17.1	41,131	12.5	31	14.8	8.4	2.0	1,326.81	-2.0
1999/00[d]	204	-21.5	54,217	31.8	38	22.6	5.4	-36.0	1,426.76	7.5
2000/01[e]	77	-62.3	14,443[f]	-73.4	21	-44.7	3.7	-31.7	687.77	-51.8
2001/02[e]	155	101.3	21,984	52.2	27	28.6	5.7	56.6	814.20	18.4
2002/03[e]	97	-37.4	16,418	-25.3	19	-29.6	5.1	-11.1	864.13	6.1
2003/04	130	34.0	27,457	67.2	20	5.3	6.5	27.3	1,372.86	58.9
2004/05	175	34.6	30,365	10.6	29	45.0	6.0	-7.7	1,047.07	-23.7
2005/06	231	32.0	47,056	55.0	43	48.3	5.4	-10.5	1,094.33	4.5
2006/07	371	60.6	93,352	98.4	58	349	6.4	19.1	1,609.52	47.1
2007/08	295	-20.5	57,888	-38.0	43	-25.9	6.9	7.3	1,346.23	-16.4
2008/09	287	-2.7	92,608	60.0	40	-7.0	7.2	4.6	2,315.20	72.0
2009/10	278	-3.1	151,927	64.1	39	-2.5	7.1	-0.7	3,895.56	68.3
2010/11	26	-4.3	81,598	-46.3	38	-2.6	7.0	-1.8	2,147.32	-44.9
2011/12	293	10.2	79,207	-2.9	46	21.1	6.4	-9.0	1,721.89	-19.8
2012/13	239	-18.4	107,621	35.9	43	-6.5	5.6	-12.7	2,502.81	45.4

[a] Data provided for 1997/98 and 1998/99 are "date of payment". Data beginning in 1999/00 are 'date of service"
[b] Excludes services from the IWK Dental Alternate Funded Program. See Table 60 for the IWK Dental Alternate Funded Program services
[c] Persons receiving insured services
[d] Totals include Dental Retroactive payments
[e] Totals include accounting adjustments
[f] Decrease due to many procedures now provided under the IWK Dental Alternate Funded Program

Note: Information obtained from Nova Scotia Annual Statistical Report Supplement Medical Insurance Tables: http://novascotia.ca/dhw/annual-statistical-reports.asp

Prince Edward Island

Prince Edward Island currently has seven public dental programs that receive funding from the provincial government. All but one (the Social Assistance Dental Services Program) of those programs are administered by Health PEI, a crown cooperation. These are, namely: Children's Dental Care Program, Early Childhood Dental Initiatives Program, Long-Term Care Facilities Dental Program, Paediatric Specialist Services Dental Program, the Cleft Palate Orthodontic Treatment Funding Program, and the in-Hospital Surgical-Dental Services Program.

In the fall of 2007, the Department's Minister announced changes to legislation that would improve the benefits under both the Family Health Benefit Program and the Children's Dental Health Program. The most significant change in terms of dental care was an increase in the maximum eligibility age by one year to 17 for the Children's Dental Health Program.[104]

In April 2012, Minister of Health and Wellness announced that: "The province is moving to a public model of dental care for children and will become the payer of last resort – available to families without dental insurance who make less than $35,000 per year. Moving to this model will ensure the children's basic dental care program is available in the future for those who need it the most. Our dental hygienists and assistants will continue to provide preventative care in schools and other sites".[105]

Consequently, the new guidelines limited eligibility for dental care to low income families or to those at "high risk", which had not been defined at the time of the announcement. Secondly, the change reduced physical accessibility to the program by limiting treatment under these programs to government clinics in Charlottetown and Summerside. Previously, these services could be rendered by a private practice of the parent's choice.[106]

These changes provoked frustration for many, including those working in the area of dental public health, as well as parents of children who would no longer qualify under the new criteria. The executive director of the Dental Association of Prince Edward Island (DAPEI), dubbed the decision a disaster and a step backwards, noting that Health PEI did not Consult DAPEI prior to making the decision. The primary fear was that children from families who could not afford dental care would go without treatment, and that the dental condition of many would deteriorate to a point that more would require in-hospital emergency dental services. Health PEI's Director of Public Health Programs advised that while the program, was successful, it was not sustainable under the currently financial climate.[106]

On October 1, 2012, following a thorough review of the program and a consultation with the key stakeholders, the Minister of Health and Wellness announced that the changes to the Children's Dental Care Program announced less than three months earlier would be revoked and that the program eligibility and services would continue to include children 3-17 years of age, regardless of family income level, but would be available to children who were not covered by a private dental insurance plan. Services covered under the program include examinations, x-rays, fillings, extractions, and root canal. The annual registration fee remained at $15 to a maximum of $35 per family. In addition, the fee is cost-shared with families paying 20% of treatment services. However, families can apply for an exemption of the 20% fee if the net family income is less than $30,000. Of note is that all children 3-17 years of age are also eligible for preventive services such as oral health education, cleaning and topical fluoride application, and dental sealants rendered by dental public health personnel in many schools throughout the province.[107] Not unlike other provinces and territories, dental caries is the leading cause of surgery for children in Prince Edward Island between the ages of one and five years old.

Table 65. Public dental programming in Prince Edward Island, 2014

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Children's Dental Care Program (CDCP)	All children aged 3-17 years	Preventative Services - Assessment of risk toward developing oral diseases - Oral health education - Topical fluoride - Dental sealants - Cleaning of teeth	52% of 26,948[a] eligible children participate Program provided in approx. 80% of schools – 86% of children in schools where dental staff provided services participate	Schools (mostly elementary and junior high schools) and Dental Public Health fixed clinics All preventative services are free and provided by dental hygienists and assistants employed by government	Administered by Heath PEI	2,667,600
	Children aged 3-17 years (coverage limited to children who are not covered by any private dental insurance plan) $15 annual registration fees per child, $35 maximum per family	Dental Treatment Services Basic dental services including: - Annual dental check-up and x-rays - Restorative dental services, fillings, and root canal treatment on front teeth - Extraction	Approx. 6,000 children received basic dental care during the 2012/13 fiscal year	Services provided in private/dental public health clinics by private/salaried dentists A funding contract with the Dental Association of Prince Edward Island (DAPEI) provides the terms of payment for CDCP covered services. A 20% parental contribution (except where exempt – family income less than $30,000 per year) applies to all services Government payment and the 20% parental contribution are approx. 85% of the DAPEI fees		
Preventative Orthodontic Program	Children aged 3-17 years	Minor preventative, interceptive orthodontic services	200-300 registered patients	General practitioners provide services in dental public health clinic. Parents pay lab fees for the appliances	As above	Included above

Table 65. cont'd

Paediatric Dental Specialist Services Program	Children without a private dental insurance plan who have medical and/or behavioural problems, which require that a paediatric dental specialist treated them	In-hospital provision of CDCP covered services.		Paediatric dental specialist	As above	Included above
Cleft Palate Orthodontic Treatment Funding Program	Children who require orthodontic treatment because of a cleft palate	Orthodontic treatment (must commence before age 18 years)	Approx. 20 children receive funding for various stages of treatment annually	Specialists at the IWK and orthodontists in private practice provide various stages of treatment to eligible children Program covers 50% of the cost of orthodontic treatment for all eligible children Depending on income and number of children in the household coverage increases to 75% or 100% of the cost of orthodontic treatment	As above	Included above
Early Childhood Tooth Decay Initiative	Children at Public Health Clinics	Use of parental self-referral tool and referral to Dental Public Health		Public Health Clinics	As above	Included above
Long-Term Care Facilities Dental Program	Residents of long-term care facilities (private and public) in P.E.I.	Annual screening and referral of residents Preventative services such as scaling fluoride varnish Denture cleaning and labelling In-service education for resident care workers	Approx 1,000 residents	Public health salaried dentists screen and refer residents Dental hygienists provide preventative services. Program is free and provided in the homes	As above	Included above

Table 65. cont'd

In-Hospital Surgical Dental Services	All P.E.I. residents, 140,204 (*2011 census*)	Medically necessary dental care as defined by the Canada Health Act *R.S.C., 1985, c. C-6* and provided under the *Health Services Payment Act*, R.S.P.E.I. 1988, c. H-2 (Amend 33)	58 patients treated during the 2013/14 fiscal year	Specialists and general practitioners providing covered services in hospital	Administered by Heath PEI	$137,665 during 2013/14 fiscal year
Social Assistance Dental Services Program	Adults recipients on assistance Those deemed physically or mentally challenged	Emergency dental care to eliminate pain/infection Removable prosthodontics that requires a 20% premium payment Diagnostic, preventative, and treatment services	972 clients had 1,829 individual claims[a]	Dentists in private offices	Centrally administered by the Department of Community Services and Seniors	471,500[a]

[a]2012/13 figure. 2013/14 estimate not available

Additional resources:

CDCP Brochure http://www.gov.pe.ca/photos/original/hpei_childoralh.pdf
Declaration Form – CDCP Treatment Services http://www.gov.pe.ca/forms/pdf/2208.pdf
CDCP Application for Exemption from Parental Contribution http://www.gov.pe.ca/forms/pdf/2206.pdf
Application for Orthodontic Treatment Funding for Cleft Palate Patients http://www.gov.pe.ca/forms/pdf/1711.pdf
Early Childhood Tooth Decay Parental Self-Assessment Tool http://www.gov.pe.ca/photos/original/HPEI_toothdecay.pdf
Social Assistance Policy http://www.gov.pe.ca/sss/index.php3?number=1048987&lang=E
Dental Benefits as included in the Social Assistance Policy http://www.gov.pe.ca/photos/original/CSS_SAP6-8b.pdf

Table 66. Public dental programming in Prince Edward Island, 2007/08

Program	Eligibility	Services Covered	Utilization	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	533
Children's Dental Care Program						
Diagnostic and Treatment Services	Children 3-17yrs 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	2,389
Preventive Services	Children 3-17yrs	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		
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	Approx 1000 residents of 18 facilities	Dentists/private practices	As above	Part of Child-ren's Dental Program expenditures

Table 66. cont'd

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
		Preventive services such as denture labelling and cleaning, scaling, fluoride varnish, in-service education sessions		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	Specialist/private practices		
Cleft Palate Orthodontic Treatment Funding Program	Assists those with hard tissue cleft palate or equivalent congenital disorder	Orthodontics; treatment must commence <18yrs 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	Specialist and generalists/in-hospital, private practices	Centrally administered by Hospital Services Commission	91

[a] Not reported

Table 67. Public dental care associated legislation in Prince Edward Island

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Health Services Act, 2009 c.7 R.S.P.E.I. 1988, c. H-1.6 (Amend 2010 c.31)	Province's residents	The Minister shall ensure the provision of health services in the province in accordance with the provincial health plan. 2009, c7,s.2 "Health services" means services related to the prevention of illness or injury, the promotion or maintenance of health, or the care and treatment of sick, infirm or injured person and includes:.. dental services (s.1(e) (xiii)) The services to be provided or made available in the province and the health facilities to be operated by Health PEI. (s3 (1) (c)) "Health PEI" means the Crown corporation established under subsection 6(1). (s1(d))	Minister of Health
Health Services Payment Act, R.S.P.E.I. 1988, c. H-2 (Amend 33)	All residents entitled to basic health services Part II 3 (1)	"Basic health services" means all services rendered by physicians that in the opinion of the Minister are medically required and such other health services as are rendered by such practitioners as may be prescribed by the regulations (s.1(d)) It the function of the Minister and the Minister has power (a) to develop and operate a health services plan for residents of the province which qualify for financial assistance under the *Canada Health Act* R.S.C. 1985, Chap. C-6 in accordance this Act and the Regulations; Part I (s.2(a)) The Lieutenant Governor in Council may make regulations for the operation of this Act (s.5)	Minister of Health Health Services Plan
Health Services Payment Act Regulations R.S.P.E.I. 1988,H-2 EC499/13	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 Schedule A lists dental procedures included in basic health services (if in association with a related pathological condition) Schedule B lists prosthodontic services included in basic health services (if necessitated by hard-tissue resection)	Minister of Health
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
Hospital and Diagnostic Services Insurance Act, R.S.P.E.I. 1988, c. H-8	All residents of P.E.I. (s.9)	"Insured services" means the hospital and diagnostic services to which a person is entitled under this Act and regulations (s.1(e)) The Lieutenant Governor in Council may make regulations for the operation of this Act (s.11(1))	Minister of Health

Table 67. cont'd

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
Hospital and Diagnostic Services Insurance Act, General Regulations, R.S.P.E.I.EC539/63	All residents of P.E.I. (s.1(f))	Defines medically necessary (s.13(3)) "insured services" (s.1(l), out-patient s.1 (n) and in-patient s.1(o) services covered by the Act	Minister of Health
Long-Term Care Subsidization Act, R.S.P.E.I. 1988, c.L-16.1	Persons needing "financial assistance" (s.1(c))	On application, the Minister shall, in accordance with this Act and the regulations, provide financial assistance to any person is a person in need (s2 (1) On application the Minister may, in accordance with this Act and the regulations, provide financial assistance to any person is a person in need (s2 (2) The Lieutenant Governor in Council may establish categories and rates of assistance under this Act (s.5(1)) The Lieutenant Governor in Council may make regulations for the operation of this Act (s.12)	Minister of Health
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, in accordance with the regulations, provide assistance to persons in need (s.2) The Minister may provide social assistance to an applicant who is not a person in need in accordance with regulations (s.3) Social assistance includes financial assistance and social services (s.1(h.1)) The Lieutenant Governor in Council may make regulations for the operation of this Act (s.7)	Minister of Community Services and Seniors Social Assistance Dental Services
Social Assistance Act, General Regulations, R.S.P.E.I. Reg. Ch S-43 EC396/03	Persons in receipt of social assistance ("applicant", s.1(d))	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 in receipt of social assistance are eligible for a range of emergency of pain and infection only; persons with disabilities are entitled to diagnostic, dental benefits for the relief emergency, prosthetic, preventive, and restorative services Social Assistance Policy http://www.gov.pe.ca/sss/index.php3?number=1048987&lang=E Dental Benefits as included in the Social Assistance Policy http://www.gov.pe.ca/photos/original/CSS_SAP6-8b.pdf	Minister of Community Services and Seniors All eligible children receive basic services
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 Community Services and Seniors Social Assistance Dental Services

Table 68. Dental public health human resources in Prince Edward Island, 2013/14[a]

	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	Allied DPH Human Resources (FTE)			DPH Programming (Yes/No)	DPH Human Resource Costs ($)	Total DPH Program Costs ($)
			DH	DA	Other[b]			
Health PEI	1.0				2.0	Yes		
Prince County		1.0	2.0	4.2		Yes		
Queens County		1.4	3.0	9.8		Yes		
Total	**1.0**	**2.4**	**5.0**	**14.0**	**2.0**	**Yes**	**[b]$1,364,317**	**$2,667,600**

[a] Does not include enumeration of on-reserve providers
[b] Not specified
[c] Excludes benefits

Table 69. Dental public health human resources in Prince Edward Island, 2007/08

	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	Allied DPH Human Resources (FTE)			DPH Programming (Yes/No)	DPH Human Resource Costs ($)	Total DPH Program Costs ($)
			DH	DA	Other			
Department of Social Services and Seniors	1	2.2	6.8[a]	13.4	2.0	Yes	1,319,900	2,389,000[b]

[a] Non-statutory (casual) 1.4 FTE
[b] Excludes costs of dental assistance for social welfare recipients and in-hospital dental services

Table 70. Remuneration rates for dental public health Personnel in Prince Edward Island, 2014

	Hourly Rate
DPH - Manager	$52.40 - $65.50
Dentist in Community Practice	$47.30 - $59.13
Dental Hygienist	$24.51 - $30.32
Dental Assistant	$20.62 - $22.43
Other: Dental Programs Coordinator Dental Technician	$25.16 - $30.46

[a] 0.4 FTE dentist is casual

Table 71. Public dental programming in Prince Edward Island, select program performance

Category	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Children's Dental Care Program - Basic Dental Treatment Services										
Number of children who received dental treatment	12,166	11,162	9,065	8,428	7,129	7,159	7,292	7,496	6, 872	5,880
Children's Dental Care Program - Preventative Dental Services[a]										
Number of children who participated in the school preventative program	14,907	14,997	15,440	13,844	13,787	16,659	15,752	14,286	12,216	13,239
Percentage of kindergarten students who had experienced tooth decay in their baby or adult teeth (average number of teeth affected)									29% (1.7)	23% (0.6)
Average number of decayed, missing or filled permanent (adult) teeth, grade 6 students	0.6	0.7	0.6	0.6	0.5	0.5	0.6	0.7	0.6	0.6
Percentage of grade 6 students who had not experienced tooth decay in their permanent (adult) teeth	73%	69%	70%	72%	78%	75%	73%	70%	70%	71%
Average number of decayed, missing or filled permanent (adult) teeth, grade 11 students	2	1.7	2.1	2.2	2.4	2.3	2.3	2.5	2.5	2.3
Percentage of grade 11 students who had not experienced tooth decay in their permanent (adult) teeth	40%	51%	42%	42%	36%	42%	36%	37%	40%	38%
Preventative Orthodontic Clinic										
Children registered	411	333	298	259	239	240	240	215	218	213
Orthodontic appliances - children treated	235	211	185	145	60	107	104	106	107	108
Cleft Palate Program										
Parent receiving funding	5	6	5	6	14	8	21	23	20	14
Long-Term Care Facilities Dental Program										
Clients screened in long-term care facilities	922	875	873	1,053[b]	943	1130	1084	1020	955	560[c]

[a] Data based on school year, not fiscal year
[b] More long-term care facilities were visited in 2006/07
[c] Some long-term care facilities (two of the largest ones) were visited early in 2012/13

Newfoundland and Labrador

There have been many positive changes to the state of Dental Public Health in Newfoundland and Labrador since the previous environmental scan. In 2006, a 4.1 million dollar government investment aimed at improving oral health programs for all children in the province was sanctioned. The funding was used to increase appreciably the fees for dental care services covered under the Medical Care Plan, benefitting approximately 67,000 children. Health and Community Services Minister Tom Osborne stated, "The health and well-being of the children of this province is a priority for our government and oral health is an important part of a child's overall health. Early dental care intervention, combined with sound oral hygiene practices, will have a positive impact on the health of our children well into their future. Through an increased investment in the children's dental health program, Government will eliminate the costs for dental services for children ages 12 and under, thereby ensuring that children have access to quality dental care, regardless of their financial situation".[108] This statement validated that the provincial government recognized the importance of oral health and was committed to investing in improvements for children by reducing the financial burden of the increasing costs of dental care on parents.

Just one year later, further underscoring this commitment, the Minister of Health and Community Services, the Honourable Ross Wiseman announced that an additional 23 million dollars would be used to expand the Children's Dental Health Program to include 13- to 17-year-olds of low-income families. This expansion was part of the province's Poverty Reduction Strategy that centered on improving the quality of life for members of low-income families. The Minister affirmed, "It is vital that our children have regular dental care to protect their overall health and well-being. Our government is committed to reducing the barriers that have historically restricted access to basic dental services for children in our province. By easing the financial burden for families with low incomes, this latest enhancement to the Children's Dental Health Program will see many more children benefit from dental care".[109]

In 2008, as a means of encouraging health professionals to practice in remote areas of the province, the government of Newfoundland and Labrador introduced the Rural Dentistry Bursary Program. Dentists who signed up for this initiative received $25,000 a year for a maximum of three years of service; twenty-nine dentists participated in this program from 2008 to 2012. It was concluded that maintaining bursary programs such as this one may address the access to care issues faced by many residence of remote and underserved areas.[110] Further improvements to the Children's Dental Health Program came in 2010 when an agreement was reached with the

Newfoundland and Labrador Dental Association (NLDA) to increase compensation received by participating dentists by 20% over four years.[111]

Low-income adults in the province have also benefitted from improvements to provincially funded dental programs in recent years. A 1.5 million dollar investment announced in 2011, which came into effect at the start of the following year, expanded dental coverage for qualifying adults beyond emergency extractions to include certain diagnostic and therapeutic services. Fully operational, the Adult Dental Health Program constituted a 6.1 million dollar annual investment.[112] As a result of the unprecedented number of participants in the two years following inception of these program improvements, in the interest of program sustainability, an approval process was instituted and an annual limit per eligible client was defined.[113] The 2014 budget announced the continuation of the Adult Dental Program, which included an increase in annual funding to 6.7 million dollars, as well as a 33% increase in the annual per-client limit.[114]

In terms of dental public health expenditures that fall under the Canada Health Act, primarily expenses for dental services rendered in a hospital setting, the amount spent in Newfoundland and Labrador has risen slightly over the past decade from approximately $419,000 in 2004 to $455,000 in fiscal year 2013-2014.

The most recent change to dental public health programming in Newfoundland and Labrador of late is the increase in reimbursement rates for publicly funded dental services. As of 1 April 2014, dentists were reimbursed on average 90% of the current NLDA fee guide rate for eligible services. This will increase by two percent in April 2016 and by an additional three percent the following April, raising the average reimbursement rate to 95% of the NLDA schedule by April 2017.[115,116]

Table 72. Public dental programming in Newfoundland/Labrador, 2013/14

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Department of Health and Community Services						
Dental Health Plan						
Children's Dental Health Plan	Children <13 yrs; universal	Diagnostic (exam once per 6 months); preventive (prophy: once per 12 months; fluoride: once per 12 months over age 6 yrs); basic restorative; oral surgery (extractions) Some services require prior approval Fees are paid based on 90% of NLDA Fee Schedule MOA with NLDA is for four years; expires 31 Mar 2018	Not reported	Dentists in private practice	Centrally administered Medical Care Plan	a
Income Support	13-17 yrs; for families in receipt of Income Support	Two year cycle for examination and x-rays Some diagnostic; basic restorative; oral surgery (extractions) Fees are paid based on 90% of NLDA Fee Schedule No preventive component Some diagnostic, restorative, oral surgical services				
Low Income Youth Program	13-17 yrs for families whose are enrolled in the Newfoundland and Labrador Prescription Drug Program (NLPDP) (low income)	Emergency examination and extractions only for recipients >17 yrs *Low Income Youth Program has the parameters as for Income Support but no adult component				

Table 72. cont'd

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Adult Dental Program	Beneficiaries must be enrolled in the Foundation, Access and 65+ programs of NLPDP. These are all needs based and are deemed our most financially vulnerable	Three year cycle for all basic services and a eight year cycle for denture services Fillings, extractions and dentures Some restrictions apply Fees are paid based on 90% of NLDA Fee Schedule except for dentures which we are in consultations for with dentists/denturists				
Insured 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	2,880 services provided[b]	Dentists in hospitals		455[b]

[a] Not reported
[b] Refer to Government of Canada (2013) *Canada Health Act Annual Report*. 2012-13 Canada Health Act Division, Health Canada. Retrieved from http://www.hc-sc.gc.ca/hcs-sss/alt_formats/pdf/pubs/cha-ics/2013-cha-lcs-ar-ra-eng.pdf

Table 73. Public dental programming in Newfoundland/Labrador, 2007/08

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Department of Health and Community Services						
Dental Health Plan						
Children's component	Children <13yrs	Diagnostic, preventive, periodontal, restorative, oral surgical services, and other specific procedures Some services require prior approval	Less than 50%	Dentists/private practices Instances of balance billing have been reduced to one service code	Centrally administered, Medical Care Plan	5,740
Income Support	13-17yrs for families in receipt of social assistance	Some diagnostic, restorative, oral surgical services Emergency examination and extractions only for recipients >17 yrs				
Low Income	13-17 yrs for families whose annual income <$30,000	Same as for Income Support but no adult component				
Insured Surgical-Dental Services	Anyone whose dental needs may necessitate hospitalisation	Various oral and maxillofacial procedures	2,633 services provided[a] $117 avg. payment per service[a]	Dentists/hospitals		313[a]

[a] Refer to Government of Canada (2006) *Canada Health Act Annual Report*. Canada Health Act Division, Health Canada.

Table 74. Dental public health human resources in Newfoundland and Labrador, 2007/08

	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	Allied DPH Human Resources (FTE)			DPH Programming (Yes/No)	DPH Human Resource Costs ($)	Total DPH Program Costs ($)
			DH	DA	Other			
Department of Health and Community Services		1				No	a	
L-GRIHA		6	1	7	2		a	a

[a] Not reported

Nunavut

Nunavut has six public dental programs that receive funding from the territorial government, all of which fall under the Department of Health and Social Services. These programs include: Contracted Dental Services Program, Seniors Extended Health Benefits Program, In-Hospital Surgical Dental Services Program, Prevention Programs, the Dental Therapy Program, and Nunavut Oral Health Project. Still in its developmental stage, the latter of these was initiated cooperatively in 2013 by the Government of Nunavut, the Public Health Agency of Canada, and Health Canada's Northern Region. The program will include a survey component, as well as screening, assessment, preventive, and treatment components. Providers will be comprised of dentists, dental assistants, dental therapists, dental hygienists, and community oral health coordinators.[117]

In addition to these programs and much like the Northwest Territories, there are a large number of First Nations and Inuit people living in Nunavut who qualify for dental benefits under NIHB. At 27,400, the total number of Aboriginals living in Nunavut is less than one tenth of those living on Ontario where the largest number live. However, of all provinces and territories, Nunavut has the highest proportion of Aboriginals at 86.3% of the total population,[26] as compared to 2.4% of the total population of Ontario. Almost half (45.5%) of the Canadian Inuit population live in Nunavut, where the average age of the Inuit people is 21 years. Of the three Aboriginal groups in Canada (First Nations, Métis, and Inuit), the Inuit have the lowest average age, at 23 nationally.[26,118] In addition, the CIHI report on day surgeries for dental care identified children in Nunavut as having the highest rate of hospitalization in Canada, with one in ten children requiring hospitalization for dental care.[66]

According to the *2011-2021 Inuit Health Human Resources Framework and Action Plan*, "the most common indicators of health are dismal on many fronts".[119] In terms of dental services, the main concern is access, specifically that Inuit people must often travel long distances to southern communities to receive dental treatment. "Some dentists complain that far too many Inuit are forced to have teeth removed rather than repaired and that this has become the norm".[119] One of the action steps described within the framework is to "provide resources to Inuit leaders to explore and design various models such as community health and dental aide programs".[119] This and other health goals highlighted in the framework are of particular significance for Nunavut given the positive impact they could incite for such a large proportion of the territories' residents.

Table 75. Public dental programming in Nunavut, 2014

Program	Eligibility	Services Covered	Utilization	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	Not reported	Dentists, denturists/community clinics and private practices	Centrally and regionally administered, adjudication and payment functions the responsibility of First Canadian Health	Not reported
Dental Therapy Program[b]	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, schools		
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		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		Specialist and generalists/hospitals		

[a] Not reported
[b] Federally funded program

Table 76. Public dental programming in Nunavut, 2007/08

Program	Eligibility	Services Covered	Utilization	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	1,700
Dental Therapy Program[b]	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, schools		
Seniors Extended Health Benefits	>60 yrs 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	Specialist and generalists/hospitals		

[a] Not reported
[b] Federally funded program

Table 77. 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)
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

Table 77. cont'd

Statutes and Regulations	Intended Beneficiaries	Relevant Provisions	Notes
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 78. Dental public health human resources in Nunavut, 2007/08

	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	Allied DPH Human Resources (FTE)		DPH Programming (Yes/No)	DPH Human Resource Costs ($)	Total DPH Program Costs ($)
			DT	Other			
Nunavut	a		6	3	Yes	b	1,700,000

[a] One dental health specialist manages the program in conjunction with two regional dental coordinators
[b] Not reported

Northwest Territories

Northwest Territories has five public dental programs that receive funding from the territorial government, all of which fall under the Department of Health and Social Services. These programs include: Metis Health Benefits Program; Extended Health Benefits Seniors Dental Plan; Indigent Health Benefits Program; Extended Health Benefits for Cleft Lip and Palate Program; and the Dental Therapy Program. In addition to these programs, given the large population of First Nations and Inuit people living in the Northwest Territories who qualify for coverage under the NIHB. Table 79 also includes the NIHB expenditure totals that were spent in this territory during fiscal year 2014. Of note is that the NIHB provides limited coverage of health-related goods and services that are not compulsory provisions of the Canada Health Act and for which First Nations and Inuit people do not otherwise have health coverage.[120]

The prevalence and severity of early childhood caries in the Northwest Territories continues to be a significant public health concern. In 2008, the *Journal of the Canadian Dental Association* published the results of a 2004-2005 survey of two to six year-old preschool children from across all 13 communities in the jurisdiction of Inuvik. The purpose of the survey was to illustrate the gravity of the oral health of the children of this area and to inform policy makers of the need to develop new strategies and refine existing strategies pertaining to oral prevention programs for local preschoolers. The survey findings were unsurprisingly grim, with 46% of children in this age group having early childhood caries and 12% requiring urgent dental care.[121]

In December 2008, just months later, there was a decision by the Health and Social Services Minister to reserve one day per month at the Stanton Territorial Hospital operating room for children's dental surgeries. This decision was made following the May/June sitting of the Legislative Assembly when questions were raised by an Assembly member regarding the oral health status of Northwest Territories' children. The member highlighted that while this was a positive change, further action is still required.[122]

A recent report by the Northwest Commission as part of Health Canada's Territorial Health System Sustainability Initiative states, "Health Canada and the Public Health Agency of Canada have recently noted that, in the North, "Oral health outcomes are alarmingly poor." Statistics confirm that First Nations and Inuit oral health status is two to three times worse than that of the general Canadian population".[123] Although a decade has passed since the 2004-2005 survey was conducted, the oral health status of an alarmingly large number of pre-school children still represents an important concern and a large expense. The 2014 report "outlines a vision for the Northwest Territories to restore oral health among children and youth through effective public

policy, healthy choices, and evidence-based care".[123] The report describes three overarching approaches to improving the oral health status of the people of the Northwest Territories. The first, "Re-envisioning the Funding Envelope", speaks of using existing resources in a different manner to make improvements to oral health initiatives. The second approach, "Re-envisioning Service Delivery", highlights the need for oral health programs to transition from a treatment approach to a preventative approach. The premise of this logic is that a reduction in the requirement for treatment services would eventually reduce the requirement for providers and would ultimately result in a significant reduction in dental care expenditures and other related costs. The third and final theme of the 2014 report is, "Re-envisioning Program Planning and Evaluation." It stresses the value of engaging all key stakeholders in all stages of program planning, as well as the importance of evaluating relevant and meaningful outcomes in order to make process improvements.[123]

Table 79. Public dental programming in the Northwest Territories, 2014

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Department of Health and Social Services						
Non Insured Health Benefits (NIHB)	Registered First Nations and Recognized Inuit	Emergency, diagnostic, restorative, endodontic, periodontal, prosthodontics, oral surgery, orthodontic services		Dentists, denturists/ private practices, community clinics	Centrally administered by the Health Services Administration Division. Adjudication and payment functions are administered by First Canadian Health	7,411
Métis Health Benefits (MHB)	Descendants of the Chipewyan, Slavey, Gwich'in, Dogrib, Hare or Cree people and reside in or used and occupied the Mackenzie Basin on or before January 1, 1921, or is a Community Acceptance Member, or was adopted as a minor under the laws of any Jurisdiction or any Metis custom by an eligible individual, or is a descendent of an eligible individual				Centrally administered by Health Services Administration Division. Adjudication and payment functions are contracted to Alberta Blue Cross	484
Extended Health Benefits (EHB) Seniors Dental Plan	Individuals who are >60 yrs and non-Native or Métis	Emergency, diagnostic, restorative, endodontic, periodontal, prosthodontics, oral surgery services				1,014
Indigent Health Benefits (IHB)	Individuals receiving income assistant payments from Education, Culture, and Employment and are not covered under the NIHB program	Short-term clients are eligible for emergency benefits only Long-term clients are eligible for NIHB coverage			Centrally administered by Health Services Administration Division	30

Table 79. cont'd

Program	Eligibility	Services Covered	Utilization	Service Environments	Administration	Expenditures $(000)
Department of Health and Social Services						
EHB for Cleft Lip and Palate	Individuals who require a hospital stay to receive service.	Various oral surgical and dental procedures.		Specialists and generalists/in-hospital.	Centrally administered by Health Services Administration Division. Adjudication and payment functions are contracted to Alberta Blue Cross.	0
Dental Therapy Program[b]	Children and emergencies in adults	Emergency, preventive, restorative, periodontal, and oral surgery services, and community health interventions	a	Dental therapists/community clinics, schools	Regionally administered by the Health and Social Services Authorities.	1,495

[a] Dental Therapy Program Expenditures are for compensation and benefits
[b] Federally funded program

Table 80. 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 NWT who are eligible (s.3)	Insured services are those which are medically required but does not include services that persons are entitled to under other statutes (s.1) Authorizes the establishment of a Medical Care Plan by the Commissioner 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.	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 NWT 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) but does not include services that persons are entitled to under other statues. The Minister may establish a hospital insurance plan (s.5) The Commissioner, on the recommendation of the Minister, may make regulations for the administration 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
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

[a] Only medically necessary oral surgery, done in hospital, is an insured service.

Table 81. Dental public health human Resources in the Northwest Territories 2014-2015[a]

	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	Dental Therapist	DPH Programming (Yes/No)	DPH Human Resource Costs ($)	Total DPH Program Costs ($)
Northwest Territories	0.11[b]		11.5[c]	Yes	1,450,000	1,495,000[d]

[a] Does not include enumeration of on-reserve providers
[b] The Dental Specialist is a consulting dentist providing clinical oversight and support to dental therapists
[c] Five of the 11.5 positions are currently staffed
[d] Additional O&M costs are approximately $8000/Dental Therapist, not included in total DPH Program Costs

Table 82. Dental public health human resources in the Northwest Territories, 2007/08

	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	Allied DPH Human Resources (FTE)		DPH Programming (Yes/No)	DPH Human Resource Costs ($)	Total DPH Program Costs ($)
			DT	Other			
Northwest Territories			11.5			970,912	1,067,912

Table 83. Remuneration rates for dental public health personnel in Northwest Territories, 2014

	Hourly Rate (equivalent to FTE)	Per Diem Rate
DPH Consultant	$80	$600
Dental Therapist	$43.33 - $51.73	-

Yukon

The Yukon has public dental programming for children that falls within the jurisdiction of the Department of Health and Social Services. Specifically, the Yukon Children's Dental Program has two components: the Yukon Pre-School Dental Program, which is for children under five years of age, and the Yukon Children's School-based Dental Program, which provides services for children from kindergarten to either grade 8 or 12, depending on if there is resident dentist in the community where the child resides. The pre-school program operates out Whitehorse at the Yukon Children's Dental Program main office. For the school-based program, a dental team, consisting of both dental hygienists and dental therapists, travel to schools throughout during the school year. The program's dental team consists of both dental therapists and dental hygienist who provide oral health education, as well as clinical treatments such as fluoride therapy, sealants, fillings, and extractions. Dental services provided under these programs are fully funded by Yukon Health and Social Services.[124]

Dental services for adults are not readily available in all areas of the territory. With a decrease in the early 2000s in dentists interested in working in rural Yukon, regular dental service was not available for adults living in most rural communities. In 2005, in response to this the concern, the Department of Health and Social Services signed an agreement with the Hay River Dental Clinic to provide dental services in each community where regular services were not available. Included in the costs that the government agreed to cover was travel and accommodation expenses for a visiting dentist, the wage for a dental assistant, as well as clinic space for the dentist to work. Although the human resource and logistical costs were covered, like elsewhere in Canada, government funding did not cover treatment costs.[125,126]

Adults in 14 Yukon communities would benefit from the services of a contracted dentist for two years. Unfortunately, as a result of a lack of interested dentists, the contract was not renewed beyond its second year. As such, by April 2007, adults residing in rural Yukon were once again without local dental services. The president of the Yukon dental association suggested that bigger incentives may be needed to encourage dentists to accept contracts to deliver services to rural regions of the territory, since some dentists felt that such work would otherwise be less profitable than private practice.[127]

Despite the challenges with the provision of adult care in remote areas of Yukon, the mandate of providing restorative and preventive services to children and youth was, nevertheless, still being accomplished. Dental therapists continued to visit the rural regions to provide preventive care and basic restorative treatment.[126] The Yukon Children's Dental Program, administered by the

Department of Health and Social Services is a school-based program that serves all children from kindergarten to grade 8 in communities where a dentist resides, and serves all children up to the end of grade 12 in communities that do not have a resident dentist.[125]

The Pre-School Dental Program, a new program focussing on children from birth to five years of age, was announced in 2009. An expansion to the Yukon Children's Dental Program, this initiative provides oral health education, as well as diagnostic, preventive, and restorative services to pre-school-aged children.[128]

In 2013, a new dental clinic opened in Watson Lake, eliminating the need for local residents to travel to Whitehorse for many of their oral health needs. While there is not a dentist working full-time at the clinic, the full-time dental therapist provides diagnosis and treatment within the profession's scope of practice, which responds to some of the communities dental needs. As the clinic is equipped with digital radiography, the dental therapist can take radiographs and consult with dentists in Whitehorse when advice on diagnosis or treatment planning is needed. A dentists visits the clinic monthly.[129]

Table 84. Dental public health human resources in Yukon, 2007/08

	DPH Specialist (FTE)	Dentists in Community Practice (FTE)	Allied DPH Human Resources (FTE)		DPH Programming (Yes/No)	DPH Human Resource Costs ($)	Total DPH Program Costs ($)
			DT	Other			
Yukon			8	2	Yes	742,262	1,063,616

Reimbursement Rates of Public Dental Programs

It is clear that there is a variation in reimbursement rates for public dental programs across Canada. On average, Ontario finances the lowest amount of dental care to providers compared to other jurisdictions (Table 85). However, the range of services and their respective reimbursement rates cannot be confirmed. An approximation of the overall average reimbursement rate as a percentage of the provincial/territorial fee guide was requested from all provincial and territorial representatives. This figure excludes a description of the range of reimbursement rates for different services provided. As an example, less frequent services are generally reimbursed at lower rates, whereas more common procedures, such as preventive services, tend to be reimbursed at 80-90% of the provincial/territorial fee guide.

As the majority of dental care services are provided in private practice settings, a consideration of the reimbursement rates for public dental program services helps determine the challenges associated with implementing a successful public dental program in its current delivery state. Since balance billing is prohibited in most provinces (excluding British Columbia and Saskatchewan), reimbursement rates that are significantly lower than the provincial/territorial fee guide may deter private dental providers from accepting patients who are covered under such programs. Conversely, the ability of balance billing practices in some provinces may deter patients from being able to afford treatment costs.

A survey in 2009 found that "When asked what specifically bothers [dentists] about publicly financed care, on average, dentists noted five things, indicating most frequently the limited services covered, low fees, broken appointments, slow payment, and denial of payment" Quiñonez 2009. "[C]lose to 70% of all Canadian dentists have less than 10% of their practice covered by public insurance, whereas only a small minority, 7.6%, have a majority of their practice publicly insured".[130]

Flat fee dental reimbursement programs exist in Winnipeg, Manitoba through the S.M.I.L.E. *plus* Dental Program that primarily targets low-income children. At a flat fee of $30.00 per appointment, recipients are covered for regular dental care services, including exams, cleanings, preventive sealants, restorations and extraction.[78]

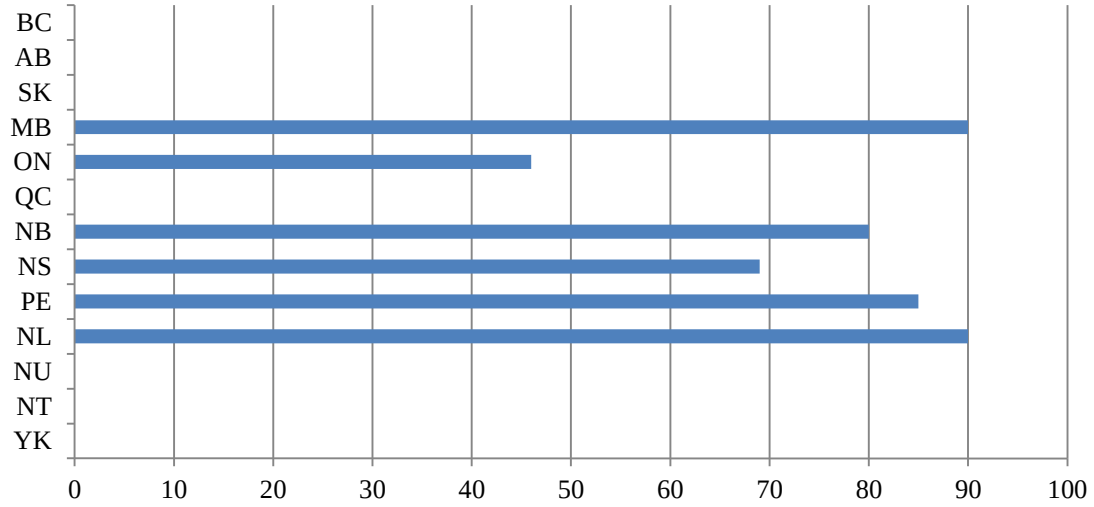
From the scan, conclusions cannot be drawn as to whether lower average reimbursement rates result in lower utilization of care. Other factors, such as extent of services covered, predeterminations, and eligibility, which were not evaluated here, could also influence service utilization.

Table 85. Provincial and territorial dental program reimbursement rates

Province/Territory	Percentage of provincial fee guide
BC	a
AB	a
SK	a
MB	90
ON	46[b]
QC	a
NB	80
NS	69-80[b]
PE	85-90[c]
NL	90
NU	a
NT	a
YK	a

[a] Not reported
[b] Range of the average reimbursement rates for provincial programs
[c] In Prince Edward Island, rates for the Children's Dental Care Plan are set at 85% of the provincial fee guide, and rates for the Social Assistance dental program are set at 90%. For the CDCP, the government contributes 65% of the fee guide and families contribute 20%.

Figure 5. Provincial and territorial dental program reimbursement rates (% of fee guide)



Remuneration Rates of Dental Public Health Personnel

Reporting remuneration rates for dental public health personnel in Canada provides a wider perspective for the costs associated with planning dental public health programs and initiatives. A breakdown of salaries or hourly rates for DPH professionals presents information on provider costs for front-line, managerial, or consultant positions. From Table 86, it is clear that remuneration rates of DPH personnel differ by jurisdiction.

The variation in remuneration rate can be attributed to several factors. Firstly, there is little standardisation of the role(s) for DPH personnel positions across Canada. For managerial level positions, such as dental consultant, dental director, and dental managers, there is a degree of variation in the job roles associated with these titles across jurisdictions. In Newfoundland and Labrador, a dental director is responsible for provincial dental public health programming, whereas in Ontario a person who holds the same title commonly has authority over regional health unit programming. Similarly, dental hygienist and dental therapy position could comprise of providing front-line clinical treatment or managing and implementing programs and initiatives. The qualifications required for senior level positions can also vary across jurisdictions. In Saskatchewan, a dual trained dental hygienists/therapist acts as the provincial dental consultant, whereas a dental public health specialist is responsible for the public dental programming in British Columbia.

Across provinces, there is a large discrepancy in hourly rates of front-line DPH personnel. For purposes of comparison, dental hygienist and dental assistant remuneration rates from national organisation have been provided in Table 87. These figures were obtained from 7,443 dental assistants and 5,400 dental hygienists across provinces. Overall, the greatest difference in remuneration appears to be between Atlantic and Western provinces.

It is advised that some degree of caution should be taken when evaluating these figures. Not all provinces/territories reported employee-based benefits, such as health care, or union dues (Table 86). Additionally, as this was the first attempt at gathering remuneration rates of DPH personnel in Canada, there were difficulties in retrieving comparable information from some of the provinces and territories. In turn, some rates had to be converted in order to produce uniform results. The “other” category contains allied human resource personnel, such as dental therapists, office assistants, secretaries, dental technicians. Despite these limitations, future reviews should consider including clerks, office assistants, secretaries, and programmers, as well as providing brief responsibilities and roles.

Table 86. Remuneration rates for dental public health personnel in Canada by province and territory, 2014

Prov	Dental Consultant	Dental Director	Dental Manager	Dentist in Community Practice	Allied DPH Human Resources		
					Dental Hygienist	Dental Assistant	Other
BC							
AB[a]					$35.43 - $47.12	$28.61 - $35.84	$21.45 - $24.45[b]
SK							
MB	$116,500	$87,600	$53,890 - $60,169 $21.10 - $22.39	$500 - $850/day	$69,365 $280 - $350/day	$36,946 - $46,410	$23,600[c]
ON							
QC							
NB							
NS					$26.44 - $30.85		
PE			$52.40 - $65.50	$47.30 - $59.13	$24.51 - $30.32	$20.62 - $22.43	$25.16 - $30.46[d]
NL							
NU	$100,000 $90,000	$60,000	$116,000	$300,000	$80,000		
NT	$80.00/hour $600.00/day $156,500						$43.33 - $51.73[e]
YK							

[a] AHS uses a 9 point salary grid for RDH and RDA and a 5-point salary grid for Surgical processors. The above gives you the start and end of the grid range. AHS Medical Affair established a salary grid for dentists who practice in AHS facilities. The grid may be provided by the Medical Affair office.
[b] Sterilization processors
[c] Admin
[d] Dental Programs Coordinator, Dental Technician
[e] Dental Therapist
Note: Figures for BC, SK, ON, QC, NL, YK not reported

Table 87. Average remuneration rates for dental hygienists and dental assistants in Canada, 2013

Province	Dental Hygienists[a]		Dental Assistant[b]	
	Average Salary ($)	Average Hourly Rate ($)	Average Hourly Rate ($)	Median Hourly Rate ($)
BC	57,703	41.77	25.29	24.15
AB	68,356	52.15	28.91	28.50
SK	74,285	38.55	22.44	22.00
MB	75,473	39.18	25.82	25.00
ON	51,020	36.05	22.16	21.36
QC	58,460	30.75	19.57	19.69
NB	58,000	30.31	19.34	19.00
NS	66,729	32.70	20.13	19.50
PE	c	33.54	19.65	17.25
NL	80,454	39.91	18.53	18.00
NU/NT	c	41.83		
YK		41.54		

[a] Canadian Dental Hygienists Association (2014). 2013 Job Market & Employment Survey. Salaries and hourly wages are based on primary place of work, which may be part-time or full-time.
[b] Canadian Dental Assistants Association – Salary and Benefits Survey 2013. http://www.cdaa.ca/wp-content/uploads/2014/03/CDAA-Salary-and-Benefits-Survey-2013-140307-3-No-Appendices.pdf
[c] Not available

Conclusions and Recommendations

The 2015 Environmental Scan of Publicly Financed Dental Care in Canada is a result of co-operation between the OCDO, provincial and territorial dental directors, and federal departmental representatives. The information presented in this scan serves as a reference document for those interested. The result of providing this publicly accessible report is to inform dental public health professionals, key informants, and the public on provincial and territorial efforts to preventing oral disease and promoting access to care.

This report provides comprehensive information regarding the legislation, financing, and delivery of public dental care programs in Canada. In addition to the updates to the 2005 environmental scan, this report provides additional information on remuneration rates of dental public health personnel and reimbursement rates of public dental programs across provinces and territories.

Recommendations stemming from the 2005 environmental scan highlighted the need to improve leadership, endorse program evaluation, enhance public policy, and promote the inclusion of oral health in the health care sector. Due to the challenging financial climate in Canada over the past decade, it has been difficult for key stakeholders to move forward with initiatives aimed at improving the oral health of Canadians.

The strategic direction of the OCDO 2010-2015 prioritizes oral health strategies within five overarching themes in support of its mission of helping the people of Canada maintain and improve their health:

1. Evidence based oral health needs assessment and surveillance;
2. Enhance oral health promotion and disease prevention;
3. Management of chronic oral health issues;
4. Legislation/Protection; and
5. Emergency preparedness.

Through creative collaboration, strong determination, and sufficient resources to support evidence-based approaches, key stakeholders will be better equipped to reduce oral health disparities nationwide.

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Appendix A: Initial project overview group email – provincial/territorial (English and French)
From Chief Dental Officer to provincial/territorial dental directors

Subject: Environmental Scan of Publicly Financed Dental Care in Canada

Dear colleagues and friends,

Based on our discussions at the FPTDWG meetings, there is interest in updating the Environmental Scan of Publicly Financed Dental Care in Canada. The initial scan proved to be a great resource, yet the last comprehensive update was conducted in 2005. I am fortunate enough this year to have two masters' students working with me for the summer who will take this on as a priority project.

Within the next few days, you will receive email correspondence with additional details. At first glance, the information may seem like a lot, however, much of it will be tables from previous years that will be provided as reference information.

With your help, we will be able to develop a comprehensive report regarding the legislation, financing, and delivery of public dental care programs in Canada. The final report will be posted on our FPTDWG website to serve as a reference document for those interested.

Thank you in advance for your support and cooperation.

Regards,

Objet : Analyse du contexte des soins dentaires financés par l'État au Canada

Chers collègues et amis,

D'après nos discussions des réunions du GTFPTSD, l'actualisation de l'analyse de la conjoncture relativement aux programmes de santé buccodentaire publics au Canada est une mesure souhaitée. La première analyse avait été très utile, mais la dernière mise à jour générale remonte à 2005. Cet été, j'ai la chance d'avoir deux étudiants à la maîtrise travaillant pour moi, qui s'attaqueront en priorité à ce projet.

D'ici quelques jours, vous recevrez un courriel renfermant d'autres renseignements à ce sujet. De prime abord, il semble y avoir énormément d'information, mais il s'agit le plus souvent de tableaux d'années précédentes fournis à titre consultatif.

Avec votre aide, nous pourrons produire un rapport général sur le financement et la prestation des programmes de santé buccodentaires publics au Canada et les dispositions législative qui les

encadrent. Le rapport final sera publié sur le site Web du GTFPTSD, où les personnes intéressées pourront le consulter.

Merci à l'avance de votre aide et de votre collaboration.

Veuillez agréer, chers collègues et amis, mes salutations les meilleures.

Dr. Peter Cooney
Chief Dental Officer / Dentiste en chef
Public Health Agency of Canada / Agence de la santé publique du Canada
A.L. 6809B, 785 Carling Avenue /L. d'a.: 6809B
Ottawa, Ontario K1A OK9 / Ottawa (Ontario) K1A 0K9
e-mail/courriel: peter_cooney@hc-sc.gc.ca

Appendix B: First individual email – provincial/territorial (English)
From Policy Intern to provincial/territorial dental directors

Subject: Environmental Scan of Publicly Financed Dental Care in [insert name of province/territory]

Dear [insert name of dental director],

In 2005, an environmental scan of publicly financed dental care in Canada was conducted in order to collect information on the types and methods of public dental care delivery and financing in Canada. Similarly, in 2007 a preliminary scan of dental public health human resources was conducted to enumerate and describe the dentists and allied oral health professionals involved in dental public health environments. The ensuing reports received much positive feedback from the provincial and territorial Senior Dental Consultants, Dental Advisors, and Dental Directors, and proved to be valuable reference documents that are still used today.

With changes in government expenditure and legislation over the past decade, a review of these documents is a necessary undertaking. The Office of the Chief Dental Officer of Canada has established this update as a priority project in order to accurately inform governmental and professional interest groups.

Your participation is necessary in order to provide up-to-date information on public dental systems, expenditures, and dental public health human resources in your region. The expected project completion date is mid-August 2014. The final report will be accessible through the Federal, Provincial, Territorial Dental Working Group (FPTDWG) website and will serve as a resource for interested stakeholders.

Attached you will find two documents:

1. the working document, in Word format, that you are requested to complete. There are specific instructions for the tables and questions embedded throughout the document (see yellow highlights). The tables follow the same format as those published in the previous reports; you may add additional cells to the tables as needed. For your convenience, if the information is available in an alternate format, you may provide it instead; and

2. a PDF file containing information published in the 2005 Environmental Scan of Publicly Financed Dental Care in Canada and in the 2007 Dental Public Health Human Resources Scan pertaining to dental public health programs, legislations/regulations, expenditures, and human resources in your region. This file may be helpful as a reference when completing the working document. You may also access the full document at the following link:
http://www.fptdwg.ca/assets/PDF/Environmental_Scan.pdf

Related information may be found in annual reports, practitioner manuals, fee guides, public information brochures, planning documents, and utilization data. If you ascertain that any

available information will render the final report more comprehensive, we respectfully request that you send it to us by email or mail to us at the address below.

It is understood that it may be necessary to contact different personnel in your region to obtain the information requested. We kindly ask that you gather all information and provide us with a consolidated return. If it is more appropriate that the primary point of contact for your region be someone other than you, please advise us by email at your earliest convenience so as to prevent any delay in the progress of this initiative.

We thank you in advance for your support of this worthwhile project. In order to respect the modest timeline, we kindly request that you provide all information not later than **Wednesday, 9 July 2014**. Please feel free to contact us if you have any questions or comments. We will follow up with you by phone in approximately one week to discuss any points you may have.

Respectfully,

Julie W. Farmer, RDH, MSc Candidate
Policy Intern
613-960-0412
julie.farmer@phac-aspc.gc.ca

Jodi L. Shaw, DMD, MSc Candidate
Policy Intern
613-960-0413
jodi.shaw@hc-sc.gc.ca

Office of the Chief Dental Officer of Canada
Public Health Agency of Canada
A.L. 6809B, 785 Carling Avenue
Ottawa, ON K1A 0K9

Appendix C: First individual email – provincial/territorial (French)
From Policy Intern to provincial/territorial dental directors

Objet: Analyse de l'environnement des activités de santé dentaire publique au Québec

[M./Mme] [insérer le nom du directeur/consultant],

En 2005, l'Analyse du contexte des soins dentaires financés par l'État au Canada a été menée afin de recueillir des informations sur les types et les méthodes de prestation de soins en santé dentaire publique ainsi que son financement au Canada. De même, en 2007, une analyse préliminaire des ressources humaines de la santé publique dentaire a été menée pour recenser et pour décrire le rôle des dentistes et autres professionnels de la santé buccodentaire impliqués dans des domaines de santé dentaire publique. Les rapports qui en ont découlés ont reçu beaucoup de commentaires positifs de la majorité des dentistes-conseil et et directeurs de santé dentaire provinciaux et territoriaux. Ils se sont avérés être des documents de référence précieux qui sont encore utilisés aujourd'hui.

À raison des changements dans les dépenses publiques et de nouvelles réglementations gouvernementales au cours de la dernière décennie, une mise à jour de ces documents est devenue nécessaire. Le Bureau du dentiste en chef du Canada a établi cette mise à jour comme étant un projet prioritaire en vue de mieux informer les groupes d'intérêts gouvernementaux et professionnels.

Votre participation est donc primordiale afin de fournir des informations à jour sur les systèmes publics de soins dentaires, ainsi que les dépenses et les ressources humaines allouées en santé dentaire publique de votre région. La finalité du projet est prévue pour la mi-août 2014. Le rapport final sera accessible sur le site web du Groupe de travail fédéral-provincial-territorial sur la santé dentaire et servira de ressource pour les partis intéressés.

Veuillez trouver en pièce jointe deux documents:

1. le document de travail, en format Word, que vous êtes priés de compléter. Il y a des instructions spécifiques pour les tableaux ainsi que des questions intégrées dans le document (voir la partie surlignée en jaune). Les tableaux suivent le même format que ceux publiés dans les rapports précédents; vous pouvez y ajouter des cellules supplémentaires si nécessaire. Pour simplifier, si l'information est disponible dans un format alternatif, vous pouvez nous le fournir à la place

2. un fichier PDF contenant des informations publiées dans l'Analyse du contexte de 2005 et dans l'Analyse des ressources humaines de la santé dentaire publique de 2007 portant sur les programmes de santé dentaire publique, les législations/réglementations, les dépenses et les ressources humaines dans votre région. Ce fichier peut servir de référence lorsque vous remplirez le document de travail. Le lien pour le document complet est fourni pour votre commodité. http://www.fptdwg.ca/assets/PDF/Environmental_Scan.pdf

Il est possible que certains renseignements pertinents se trouvent dans les rapports annuels, les manuels de praticiens, les guides des tarifs, les dépliants de renseignements, les documents de planification et les données d'utilisation. Si vous constatez que vous avez des informations supplémentaires qui rendraient le rapport final plus complet, nous vous demandons respectueusement de nous l'envoyer par courriel ou par courrier à l'adresse ci-dessous.

Il est entendu qu'il sera peut-être nécessaire de contacter différentes personnes de votre région afin d'obtenir les informations demandées. Nous vous demandons de recueillir toutes les informations et nous fournir une réponse consolidée. S'il est plus approprié que le principal point de contact de votre région soit quelqu'un d'autre que vous, veuillez nous en aviser par courriel le plus tôt possible afin d'éviter tout retard dans le déroulement de cette initiative.

Nous vous remercions à l'avance pour votre soutien à cet important projet. Afin de respecter l'échéancier restreint, nous vous prions de nous fournir tous les renseignements au plus tard **le mercredi 9 juillet 2014**. S'il vous plaît, n'hésitez pas à nous contacter si vous avez des questions ou des commentaires. Nous ferons un suivi par téléphone dans environ une semaine pour discuter de toutes questions que vous pourriez avoir.

Nous vous prions d'agréer, [Monsieur/Madame], l'expression de nos sentiments distingués.

Jodi L. Shaw, DMD, MSc Candidate
Stagiaire politique
613-960-0413
jodi.shaw@hc-sc.gc.ca

Julie W. Farmer, RDH, MSc Candidate
Stagiaire politique
613-960-0412
julie.farmer@phac-aspc.gc.ca

Bureau du dentiste en chef du Canada
Agence de la santé publique du Canada
A.L. 6809B, 785, avenue Carling
Ottawa Ontario K1A 0A9

Appendix D: Follow-up individual email – provincial/territorial (English)

From Policy Intern to provincial/territorial dental directors

Subject: Follow-up: Environmental Scan of Publicly Financed Dental Care in [insert name of province/territory]

Good day [insert name of dental director],

Thank you very much for taking the time to speak with Julie and me today. We recognize that you have a busy schedule and are appreciative of your time. We are reliant on the provincial and territorial representatives such as you to provide us with the information necessary to see this in project to fruition.

As discussed today, please include somewhere in the information you send to us an approximation of the overall average reimbursement rate for each public dental program, expressed as a as a percentage of the provincial fee guide.

We kindly request that the Wednesday 9 July 2014 deadline be respected such that we may comply with the submission deadline for the final report.

As indicated in a previous email, we understand that related information may be found in annual reports, practitioner manuals, fee guides, public information brochures, planning documents, and utilization data. We, therefore, ask that you also send us any available information that will render the final report more comprehensive.

Please do not hesitate to contact Julie or me if you have any questions. As per your request, I will send you a reminder email early next week.

I hope that beautiful Newfoundland blesses you with some warmer weather soon!

Kind regards,

Julie W. Farmer, RDH, MSc Candidate
Policy Intern
613-960-0412
julie.farmer@phac-aspc.gc.ca

Jodi L. Shaw, DMD, MSc Candidate
Policy Intern
613-960-0413
jodi.shaw@hc-sc.gc.ca

Office of the Chief Dental Officer of Canada
Public Health Agency of Canada
A.L. 6809B, 785 Carling Avenue
Ottawa, ON K1A 0K9

Appendix E: Follow-up individual email – provincial/territorial (French)
From Policy Intern to provincial/territorial dental directors

Objet: Suivi : Analyse de l'environnement des activités de santé dentaire publique au Québec

[M./Mme] [insérer le nom du directeur/consultant],

Merci beaucoup d'avoir pris le temps de parler avec moi ce matin. Je comprends que vous avez un horaire chargé et je suis reconnaissante de votre temps. Nous sommes dépendants des représentants provinciaux et territoriaux tels que vous de nous fournir les informations nécessaires pour voir ce à projet à terme.

Tel que discuté aujourd'hui, veuillez inclure à quelque part dans les informations que vous nous enverrez une bref explication de comment les taux de remboursement des programmes publiques de soins dentaires sont déterminés.

Tel qu'indiqué dans un courriel précédent, il est possible que certains renseignements pertinents se trouvent dans les rapports annuels, les manuels de praticiens, les guides des tarifs, les dépliants de renseignements, les documents de planification et les données d'utilisation. Je vous demande, alors, de nous envoyer aussi toutes informations supplémentaires qui rendraient le rapport final plus complet.

Nous vous demandons respectueusement d'honorer la date limite, le mercredi 9 juillet 2014, ce qui nous permettrons de respecter la date limite de soumission du rapport finale.

S'il vous plaît, n'hésitez pas à me contacter si vous avez des questions.

Merci, encore une fois!

Cordialement,

Jodi L. Shaw, DMD, MSc Candidate
Stagiaire politique
613-960-0413
jodi.shaw@hc-sc.gc.ca

Julie W. Farmer, RDH, MSc Candidate
Stagiaire politique
613-960-0412
julie.farmer@phac-aspc.gc.ca

Bureau du dentiste en chef du Canada
Agence de la santé publique du Canada
A.L. 6809B, 785, avenue Carling
Ottawa Ontario K1A 0A9

Appendix F: Reminder individual email – provincial/territorial (English)
From Policy Intern to provincial/territorial dental directors

Subject: Reminder: Environmental Scan of Publicly Financed Dental Care in [insert name of province/territory]

Good day [insert name of dental director],

This is just a friendly reminder to please send the [provincial/territorial] information for the Environmental Scan update by end of business Wednesday 9 July 2014.

Please remember to include somewhere in the information you send to us an approximation of the overall average reimbursement rate for each public dental program, expressed as a percentage of the provincial fee guide.

Lastly, we ask that you also send us any additional information that you have that may render the final report more comprehensive, e.g. annual reports, practitioner manuals, fee guides, public information brochures, planning documents, utilization data, etc.

Please do not hesitate to contact Julie or me if you have any questions.

Kind regards,

Julie W. Farmer, RDH, MSc Candidate
Policy Intern
613-960-0412
julie.farmer@phac-aspc.gc.ca

Jodi L. Shaw, DMD, MSc Candidate
Policy Intern
613-960-0413
jodi.shaw@hc-sc.gc.ca

Office of the Chief Dental Officer of Canada
Public Health Agency of Canada
A.L. 6809B, 785 Carling Avenue
Ottawa, ON K1A 0K9

Appendix G: Reminder individual email – provincial/territorial (French)
From Policy Intern to provincial/territorial dental directors

Objet: Rapel : Analyse du contexte des activités de santé dentaire publique au Québec

[M/Mme] [insérer le nom du directeur/consultant],

Ceci est simplement un petit rappel de nous envoyer l'information provinciale pour la mise à jour de l'analyse du contexte des activités de santé dentaire publique au plus tard le 9 juillet 2014.

Tel que discuté lors de notre conversation téléphonique, veuillez inclure à quelque part dans les informations que vous nous enverrez une bref explication de comment les taux de remboursement des programmes publiques de soins dentaires sont déterminés.

Enfin, nous vous demandons de nous envoyer également toute information supplémentaire que vous avez qui pourraient rendre le rapport final plus complet, ex. les rapports annuels, les manuels de praticiens, les guides des tarifs, les dépliants de renseignements, les documents de planification et les données d'utilisation.

S'il vous plaît, n'hésitez pas à me contacter si vous avez des questions.

Cordialement,

Jodi L. Shaw, DMD, MSc Candidate
Stagiaire politique
613-960-0413
jodi.shaw@hc-sc.gc.ca

Julie W. Farmer, RDH, MSc Candidate
Stagiaire politique
613-960-0412
julie.farmer@phac-aspc.gc.ca

Bureau du dentiste en chef du Canada
Agence de la santé publique du Canada
A.L. 6809B, 785, avenue Carling
Ottawa Ontario K1A 0A9

Appendix H: Initial project overview group email – federal (English and French)
From Policy Intern to federal dental program representatives

Subject: Federal Public Dental Care Expenditures in Canada - Environmental Scan Update

Dear Sir/Ma'am,

My name is Jodi Shaw. My colleague, Julie Farmer and I are master's students currently doing a project under the direction of Dr. Cooney, Chief Dental Officer of Canada, on public dental care programs in Canada.

With changes in government expenditures and legislation over the past decade, an update on public dental care activities is necessary, as the last review was conducted in 2005. Dr Cooney has established this update as a priority project in order to accurately inform governmental and professional interest groups. The project completion time is mid-August 2014.

In order to report on public dental care expenditures at the federal level, we require the total dollar amount spent on direct and indirect dental service activities for federal dental programs for the three most recent fiscal years on file and, as such, are requesting this information from you.

As a reference, attached is a table that shows the most recent information we currently have on file. Following this email you will receive an individual email that contains a table specific to your dental program with three cells for you to fill in, corresponding to the three most recent fiscal years' figures you have available. In order to respect out modest timeline, we respectfully request that you complete the table and return it to us not later than **Wednesday, 23 July 2014.**

We kindly ask that you acknowledge receipt of this email and advise if this request is better directed to someone else within your department. We will follow up by phone early the week of 7 July 2014 to see if you have any questions. In the meantime, please feel free to contact us at your convenience if needed.

Very respectfully,

Jodi L. Shaw, DMD, MSc Candidate
Policy Intern
613-960-0413
jodi.shaw@hc-sc.gc.ca

Julie W. Farmer, RDH, MSc Candidate
Policy Intern
613-960-0412
julie.farmer@phac-aspc.gc.ca

Office of the Chief Dental Officer of Canada
Public Health Agency of Canada
785 Carling Avenue, AL 6809B
Ottawa ON K1A 0K9

Objet : Dépenses fédérales en matière de soins dentaires publics au Canada – Mise à jour de l'analyse du contexte

Monsieur, Madame,

Je m'appelle Jodi Shaw. Ma collègue, Julie Farmer, et moi sommes des étudiantes du deuxième cycle universitaire et menons actuellement un projet sous la direction du D[r] Cooney, dentiste en chef du Canada, sur les programmes publics de soins dentaires au Canada.

En raison des changements survenus dans les dépenses publiques et la législation au cours de la dernière décennie, une mise à jour sur les activités liées aux soins dentaires publics est nécessaire, car le dernier examen a été effectué en 2005. Le D[r] Cooney a établi cette mise à jour en tant que projet prioritaire afin d'informer avec précision les groupes d'intérêts gouvernementaux et professionnels. La date d'achèvement prévue du projet est la mi-août 2014.

Afin de rendre compte des dépenses liées aux soins dentaires publics à l'échelle fédérale, nous avons besoin de connaître le montant total consacré aux activités liées aux services dentaires directs et indirects des programmes dentaires fédéraux des trois exercices les plus récents au dossier, donc nous vous demandons de nous faire parvenir ces renseignements.

À titre de référence, un tableau montant les données les plus récentes dont nous disposons actuellement sera fourni en pièce jointe. À la suite de ce courriel, vous recevrez un courriel distinct qui comporte un tableau propre à votre programme de soins dentaires où figurent trois cellules que vous devrez remplir, correspondant aux chiffres des trois exercices les plus récents dont vous disposez. Afin de respecter notre court échéancier, nous vous saurions gré de remplir le tableau et de nous le renvoyer au plus tard le **mercredi 23 juillet 2014**.

Veuillez accuser réception du présent courriel et, le cas échéant, indiquer s'il vaudrait mieux envoyer cette demande à quelqu'un d'autre au sein de votre ministère. Nous ferons un suivi, par téléphone, au début de la semaine du 7 juillet 2014 pour voir si vous avez des questions. Entre-temps, n'hésitez pas à communiquer avec nous si vous avez des questions.

Cordialement,

Jodi L. Shaw, DMD, candidate à la maîtrise
Stagiaire politique
613-960-0413
jodi.shaw@hc-sc.gc.ca

Julie W. Farmer, RDH, candidate à la maîtrise
Stagiaire politique
613-960-0412
julie.farmer@phac-aspc.gc.ca

Bureau du dentiste en chef de Santé Canada
Agence de la santé publique du Canada
785, avenue Carling, AL 6809B
Ottawa (Ontario) K1A 0K9

Appendix I: First individual email – federal (English and French)
From Policy Intern to federal dental program representatives

Subject: Federal Public Dental Care Expenditures in Canada - Environmental Scan Update

Dear [insert name of federal program representative],

As explained in the previous email sent moments ago, please find attached a table specific to your public dental program with three cells for you to fill in, corresponding to the public dental care expenditures for the three most recent fiscal years you have available. Please indicate in the heading row of the table the fiscal years to which the information corresponds.

You may use the "additional notes" column to explain what is included in the figures you provide (e.g. treatment cost, facility fees, personnel costs, administration, etc.)

Once again, we respectfully request that you return this to us not later than **Wednesday, 23 July 2014**.

Please feel free to contact us if you have any questions or comments.

Very respectfully,

Julie W. Farmer, RDH, MSc Candidate
Policy Intern
613-960-0412
julie.farmer@phac-aspc.gc.ca

Jodi L. Shaw, DMD, MSc Candidate
Policy Intern
613-960-0413
jodi.shaw@hc-sc.gc.ca

Office of the Chief Dental Officer of Canada
Public Health Agency of Canada
A.L. 6809B, 785 Carling Avenue
Ottawa ON K1A 0K9

Objet : Dépenses fédérales en matière de soins dentaires publics au Canada – Mise à jour de l'analyse du contexte

Madame, Monsieur,

Comme nous l'avons expliqué dans le courriel précédent que nous venons de vous envoyer, vous trouverez ci-joint un tableau propre à votre programme de soins dentaires publics, qui contient trois cellules dans lesquelles vous devez fournir les données concernant les dépenses liées aux

soins dentaires publics des trois exercices les plus récents dont vous disposez. Veuillez indiquer, dans la ligne de titre du tableau, les exercices financiers auxquels les données correspondent.

Vous pouvez utiliser la colonne « Remarques supplémentaires » pour expliquer ce qui est inclus dans les chiffres que vous fournissez (par exemple, le coût des traitements, les frais des établissements, les frais liés au personnel, l'administration, etc.).

Une fois de plus, nous vous demandons de bien vouloir nous le renvoyer, au plus tard, le **mercredi 23 juillet 2014**.

Si vous avez des questions ou des commentaires, n'hésitez pas à communiquer avec nous.

Cordialement,

Julie W. Farmer, RDH, candidate à la maîtrise
Stagiaire politique
613-960-0412
julie.farmer@phac-aspc.gc.ca

Jodi L. Shaw, DMD, candidate à la maîtrise
Stagiaire politique
613-960-0413
jodi.shaw@hc-sc.gc.ca

Bureau du dentiste en chef du Canada
Agence de la santé publique du Canada
A.L. 6809B, 785, avenue Carling
Ottawa (Ontario) K1A 0K9

Appendix J: Dental public health human resources data collection instrument

Dental Public Health Human Resource Data Collection Instrument

For the final two tables, please provide the number of full-time equivalent (FTE) dental personnel employed in your region and the total costs associated with dental public health human resources. The guide below provides the FTE ratios for you to use, which this will allow for comparisons between regions across Canada.

Guide for FTE Calculation

When possible, please use the conversion ratios provided in this table when inputting FTE values for personnel in the tables below.

Number of working days per week	FTE Ratio
0.5	0.1
1.0	0.2
1.5	0.3
2.0	0.4
2.5	0.5
3.0	0.6
3.5	0.7
4.0	0.8
4.5	0.9
5.0	1.0

- Please provide the most current data available and indicate the corresponding year in the space provided in the table title.
- If a position is filled by a non-DPH specialist, please use the comment section at the end of the table to provide the designation of the individual (i.e. The dentist manager of *Happy Region* health unit is a general dentist with a Master in Business Administration; The dental director of *Happy Region* is a nurse practitioner; etc.).
- DPH programming refers to all costs (preventive and treatment) of all dental public health activities within a health unit. If certain costs are excluded from the figures reported, please explain in the comments section at the end of the table (i.e. *School Prevention Program X* was not included in final costs for *Happy Region* health unit; The human resource cost for *Happy Region* health unit does not include human resources for *Smile Program X; etc.*).

Remuneration Rates for DPH Personnel in [province/territory]

Please provide the remuneration rates (average and range) for the following personnel. This information will be useful for administrative purposes of public health human resources departments and will serve as a reference guide for hiring personnel.

	FTE	Salary (equivalent to FTE)	Per Diem Rate
DPH Specialist			
- Consultant			
- Director			
- Manager			
Dentist in Community Practice			
Allied DPH Human Resources			
Dental Hygienist			
Dental Assistant			
Other (please specify)			
Additional Comments:			