A Report of the Toronto Dental Coalition

December, 2001

Member Agencies of the Toronto Dental Coalition

Anishnawbe Health Toronto

Central Toronto Community Health Centres

Community Dentistry, Faculty of Dentistry, University of Toronto

Regent Park Community Health Centre

Sherbourne Health Centre

South East Toronto Project

St. Michael's Hospital

Street Health Nursing Foundation

Toronto Public Health

Wellesley Central Health Bus

Wellesley Central Health Corporation

A Report of the Toronto Dental Coalition

Foreward

In recent years the downtown area of Toronto has been growing and changing, becoming more diverse. The population of over 330,000 includes both wealthy and low-income neighbourhoods. The diversity of the area and its ability to adapt indicate its great strength as a community.

Still, despite its vibrancy, east downtown Toronto shows evidence of widening disparities in housing, health, and social capital. Many of its neighbourhoods have a high percentage of residents living on low incomes. The area has high unemployment and more single-parent families, higher teen birth rates, and higher mortality rates than other parts of the city. Many local people face strict barriers to health care, health information, and involvement in decision-making.

Access to dental care is a major problem in the community. For people who are socially and economically disadvantaged, regular access to basic primary dental health services is largely unavailable. Dental care stands outside Canada's publicly funded universal health-care delivery system. It operates primarily in a private market, with private insurance funding care only for people in certain employed groups. Community-based agencies that try to assist these people face great difficulties in sustaining their programs—as evidenced by the Regent Park Community Health Centre's struggle to secure funds for their dental clinic.

Several Toronto agencies, concerned about the increasing demand for dental services, and believing that dental care should not be separated off from overall health care, have formed a coalition to explore in greater detail the need for, and delivery of, dental services.

The coalition has decided that its first step will be to explore the issues and offer a forum for dialogue and debate. We trust and hope that this discussion will lead to a strategy for taking action. This document, then, is not an attempt to offer solutions, but is meant as a way of beginning discussion about what we can do to ensure that everyone can have access to the dental care they need.

Executive Committee

Toronto Dental Coalition

September 2001

The Importance of Oral Health

A study in Australia found that only 6.8 per cent of homeless people went to the dentist routinely. Some 22% had never visited a dentist...

Oral health is an essential component of general health throughout life. Poor oral health and untreated oral diseases and conditions can undermine the quality of life (1). Few of us are fortunate enough never to have been afflicted with an ailment of the mouth—whether it is a cavity, a swelling, an infection, or a simple fracture of a tooth. In fact, dental caries (the medical term for cavities) is the single most common chronic disease of childhood, occurring five times more often than asthma and seven times more often than hay fever (2).

In the United States a new study documents that millions of people experience dental caries, gum disease, and cleft lip and cleft palate. The results are needless pain and suffering; difficulties speaking, chewing, and swallowing; increased costs of care; loss of self-esteem; decreased economic productivity through lost work and lost school days; and, in extreme cases, death (1). Canada would have proportionately similar figures. The United States has no universal publicly financed health-care systems, let alone a publicly financed dental care system. Canada does have publicly financed medicare, but no publicly financed dental care system.

But the blanket statements and monstrous numbers, though revealing, do not begin to cover the whole array of emotions and sufferings of the individuals whose lives are affected by these conditions.

Eric Rubery

Take, for example, the case of Eric Rubery, a well-spoken man with the mannerisms of a successful, well-travelled businessman—which he once was. Now, at age 57, Eric lives on the streets. For the time being he is making do with social assistance as he starts to rebuild his life.

Eric sees a dentist only when he thinks he has a problem with his teeth. That pattern of dental care is common among homeless adults. A study in Australia found that only 6.8 per cent of homeless people went to the dentist routinely. Some 22 per cent had never visited a dentist, and 33 per cent were going only when a need arose (3). The high percentage of homeless adults without regular dental care is disturbing, because numerous studies have reported significantly poorer oral health among this group than in the

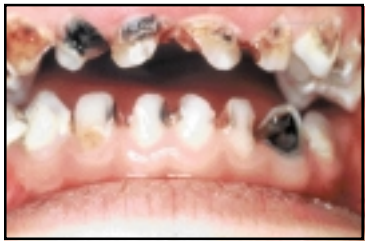
People with periodontal disease are at 1.5 to 2.7 times greater risk for heart disease and 1.48 to 2.80 times greater risk for stroke.

general population (1, 2, 4, 5, 6). Compared to the general population, homeless adults have larger numbers of grossly decayed and missing teeth. Indeed, they are more likely to have no natural teeth remaining (5).

Oral health, though, is about much more than just teeth. Oral health reflects general health and well-being. The oral cavity is a site in which serious systemic conditions such as diabetes, AIDS, or cancer can manifest themselves. Dentists, as specialists of the oral cavity, play an important role in the early detection and management of a wide range of complex oral and systemic diseases and conditions. That is why regular dental checkups are so important. They allow early detection of an array of diseases, which in turn leads to a prognosis. Lack of this service reflects an inferior level of health care—and it is a level that a rich country such as Canada should be able to surpass.

But more than being simply a reflection of general health, oral health also has its own effect on physical well-being. A recent U.S. Surgeon General's report, *Oral Health in America*, concludes that people cannot be healthy without oral health (2). The oral cavity is a portal of entry for micro-organisms that are capable of causing both local and systemic infections. When two Toronto researchers, Dr. David Locker and Dr. David Matear, carried out an extensive review of the literature, their results, reported in 2000, also indicated that oral disorders can lead to significant systemic problems (7). Some of the more notable findings follow.

Children with severe early childhood cavities weighed significantly less than children in a control group ...



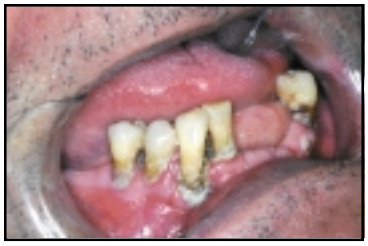
* Severe dental decay undermines the quality of life of young children through pain and problems with sleeping, eating, and behaviour. It can also be a contributing factor in a failure to thrive, a condition whose manifestations include low weight or height for age. Children with severe early childhood cavities weighed significantly less than children in a control group and were more likely to fall into the lowest percentile categories for height.

  But dental treatment helped to eliminate problems of pain, sleeping, eating, and behaviour. Furthermore, after dental treatment children who had serious early childhood cavities showed a significantly higher growth velocity than did children from the control group: within 18 months they were catching up in both height and weight.

* Periodontal disease is an infectious oral condition more commonly known as gum disease. Animal studies and human case control studies indicate that females with severe periodontal disease are at about seven times greater risk of giving birth to preterm low birth-weight babies.

* Periodontal disease has also been associated with heart disease and stroke. People with periodontal disease are at 1.5 to 2.7 times greater risk for heart disease and 1.48 to 2.80 times greater risk for stroke.

* Poor oral health and the resulting loss of teeth can have a significant impact on nutrition and diet choices. This is particularly true for the elderly population. Studies from hospitals and nursing homes indicate that oral health problems, particularly problems with chewing, are associated with low body mass and involuntary weight loss. People with no natural teeth are twice as likely to experience significant weight loss, after controlling for other risk factors.



Adult with poor oral health

Assessing the Risk Factors

To appreciate the significance of oral health and its impact on overall well-being, we need to put the various risk factors and ratios into perspective. The increased risk of heart disease from poor oral health may not seem significant until we recognize that heart disease is the number one killer in Western countries, contributing to 50 per cent of deaths (7).

Similarly, the increased risk of having preterm low birth-weight babies may not seem significant until we realize that the preterm low birth weight is one of the major causes of perinatal mortality and morbidity. Preterm babies who do survive birth tend to require longer hospitalization and are more likely to be hospitalized in the first year of life. They also have high rates of abnormal growth and development, in addition to long-term disabilities (7).

Studies have also indicated that oral diseases, particularly periodontal disease, are associated with respiratory disorders such as chronic obstructive pulmonary disease (7). It is likely that continued research will also discover other systemic effects of poor oral health. But even without extensive research, the link between oral health and general health is clear. Eric Rubery himself expressed the systemic importance of dental health in simple words: "Dental health affects the rest of your health because it can travel and infect you."

This seemingly simple statement holds much truth. Indeed, oral diseases and a lack of subsequent dental treatment can lead to death. In Toronto in 1998, for instance, a 24-year-old otherwise healthy man died from a tooth infection. He had suffered from a toothache, which led to a swelling of his mouth, and with no timely treatment the swelling spread along his throat and obstructed his breathing (*The Toronto Star*, March 1, 1998). His was just one case—one incident that was reported—in which a clear link existed between death and a dental problem. We can only wonder how many more cases have occurred and gone unnoticed, and how many more must occur, before we recognize that dental diseases can and will kill.

The Impact of Limited Care

"When your teeth look bad, you don't feel good about yourself because having wonderful teeth is a part of the person that people want to see. It affects your ability to get a job. You just don't feel that good about yourself so you lose self-esteem about being able to go and get a job . . . or to go and get THAT job."

Eric Rubery

Eric Rubery's last dental visit had been to get an upper denture, and he had to wait four months before getting the denture. While he was waiting Eric went without a front tooth and had to use his old broken denture. Because of this, Eric appreciates the importance of dental well-being for reasons beyond medical.

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As extreme as this may sound, Eric's feelings are not untypical. In 1998 a team of researchers reported that homeless adults with a greater number of missing teeth had very weak perceptions of their current health status and their abilities to perform physical functions such as running, walking several blocks, or bending, much less of their ability to hold a job (5). Because Eric is working at putting his life back together, a low self-esteem as a result of poor dental appearance can be devastating. Eric explained:

"What I want to do is marketing. And part of marketing is the visual presentation, eye contact. Well, if the person is looking at my missing teeth, they're not listening to what I'm saying and thereby they probably won't buy what I'm trying to sell. Whether I'm right or wrong in my perception, by having that perception, I have less faith in myself."

Eric's fears are backed up by the *Oral Health in America* report, which describes oral health as being related to the quality of life based on functional, psychosocial, and economic measures (2). According to the report, oral and craniofacial health has an impact on diet, nutrition, sleep, psychological status, social interaction, school, and work. People with facial disfigurements due to craniofacial conditions and their treatments can experience a loss of self-image and self-esteem, anxiety, and depression. The condition can also lead to a social stigma. All of this in turn can limit educational, career, and marital opportunities and undermine other social relations.

The homeless and other members of low-income populations have often been condemned for supposedly not making the effort to seek and/or maintain suitable employment. But the stories of Eric and others indicate otherwise. Certainly, some people do voluntarily depend on government assistance, but there are also many others living on assistance or low incomes who want to

change their lives for the better, and are struggling to do so. Unfortunately, in addition to other disadvantages, poor oral health adds to the difficulty of obtaining good jobs.

"You see somebody who has teeth that are really bombed out and they have had to let them go one after the other and you see the rotting roots in there..."

SusanThornley

For individuals like Eric, oral health can form at least a part of the bridge to employment and financial independence. If such is the case, it is surprising that in its health-care policies the Canadian government is not paying more attention to and placing more investment in dentistry—given that this same government has held out promises of bringing down the country's level of unemployment.

Not only do oral diseases and their consequences make it more difficult for unemployed adults like Eric to obtain employment, but they also hurt those who do have jobs. In 1996, for instance, employed adults in the United States were losing more than 164 million hours of work each year due to dental disease or dental visits (2). Every 100 unemployed U.S. adults were experiencing an average loss of 3.7 restricted activity days, 1.7 bed days, and 1.9 days of work each year because of acute dental conditions or dental visits (8). Children were experiencing the heavy social impact of oral diseases, with more than 51 million school hours, or 3.1 school days per 100 school children, lost each year due to dental-related illness (2). Poor children experience nearly 12 times more restricted-activity days than do children from higher-income families (2).

Susan Thornley, a dental hygienist who works with the City of Toronto Public Health, has provided on-site dental screening and referral services for over two thousand Toronto high school students. She told us:

"You see somebody who has teeth that are really bombed out and they have had to let them go one after the other and you see the rotting roots in there. . . . At that point in time, they may not be that badly off in terms of pain and suffering. But you know over the years, they must have had some pain and suffering. I feel bad for them because it's unfortunate that they had to go through that pain and infection. I can't even imagine how that would impact on their school work, their social activities. . . . I can't imagine having to deal with that pain and getting through your high school education."

Canada's Health-Care System

Canada enjoys a well-established universal and comprehensive medical and hospital care system. Unfortunately, dental care has remained outside of the Canada Health Act and most provincial health plans. Although at various times different provinces have provided dental health insurance, particularly for members of the community with limited means to pay for those services, there is no federal mandate that calls for that service.

According to Carol Kushner, a health policy analyst and author of two books on Canada's health-care system, historically dentistry has not had a high priority in our national health-care policies. The onus is entirely on the provincial and municipal governments to provide funding for dental services.

As a result, the dental care system in Canada consists of publicly financed but limited services for people on income support, publicly financed universal children's dental programs in four provinces, seniors' care in one province and the territories, private insurance for employed individuals and their dependants, and out-of-pocket payments for most others (9).

Access to Medical and Dental Services

The limited public financing of dental services has a direct influence on the accessibility of those services, particularly for people who have to pay from their own savings and those whose treatment needs do not belong to the limited list of publicly covered services.

Vernon Dabasi

Vernon Dabasi lives on the streets in downtown Toronto and receives financial support from social services. While he sees a physician every five to six months for "regular checkups," Vernon only sees a dentist when he has problems with his teeth. Vernon's case is typical, and not surprising. Canadians see physicians more frequently than they see dentists, and this is because of the narrow spectrum of Canada's publicly financed dental care system compared to its comprehensive medical care system.

In 1993-94 two researchers in Canada carried out a study to identify why people go to see doctors and dentists. They found several independent predictors of visits to a dentist: younger age, higher level of education, higher household income, residence in a

province with a lower population-to-dentist ratio, non-smoking, employment, and good general health (9). In contrast, factors that independently predicted visits to family physicians were: pregnancy, using medications, taking precautions to avoid injuries, poor general health, needing help for activities of daily living, being female, and being a non-smoker.

These findings suggest that sicker and more dependent people are more likely to pay a visit to a physician; and healthy, young, highly educated, high-income people are more likely to go to the dentist. What this seems to indicate is that Canada's existing dental health-care system is serving the more affluent populations well, but leaving out those who may be most in need of care—those who are at a financial disadvantage.

Commenting on the contrast between his access to dental care and to medical care, Eric said, *"All you need to do for medical problems is show your [OHIP] card and you're looked after. With dental work, there is a series of forms that have to signed, there is a period of waiting for the reply."*

Implicit in this comment is the reality that for those on social services the publicly financed dental care system is limited in its coverage. Major treatments, such as dentures, need prior approval before work can be started. Many times the limitations are such that the options left to people like Eric and Vernon—people who already have trouble making ends meet—are few or non-existent. When asked why he does not go to a dentist regularly for checkups, Vernon replied:

"I know what you're entitled to and not entitled to. I know it's useless to go and try to fight for something that I know they [the dentists] are going to say, `No, we can't do it because it's not covered.' Simple as that. I go only when they [the teeth] hurt . . . just go get 'em ripped out."

Vernon's comments reflect the impact of government cutbacks in funding for dental services. Prior to 1992 in Ontario, social service recipients were entitled to basic dental care (consisting of regular checkups and cleanings) as well as emergency care. With modifications over time, most people with low incomes fell under a municipally funded program known as Ontario Works. This modified program covers only emergency services, defined as "an immediate circumstance where the patient appears in immediate suffering, requires care and immediate appropriate treatment is instituted to correct the problem" (10). Yet even when someone does have an "emergency" condition, the plan covers only a very restricted list of treatments.

One limitation—and perhaps the one with the strongest impact on recipients of this program—is the lack of coverage for root canal treatment. Without

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Vernon Dabasi

public coverage for root canal services, people who require that treatment to save a tooth must either pay for the root canal out of their own pockets, or have the tooth extracted.

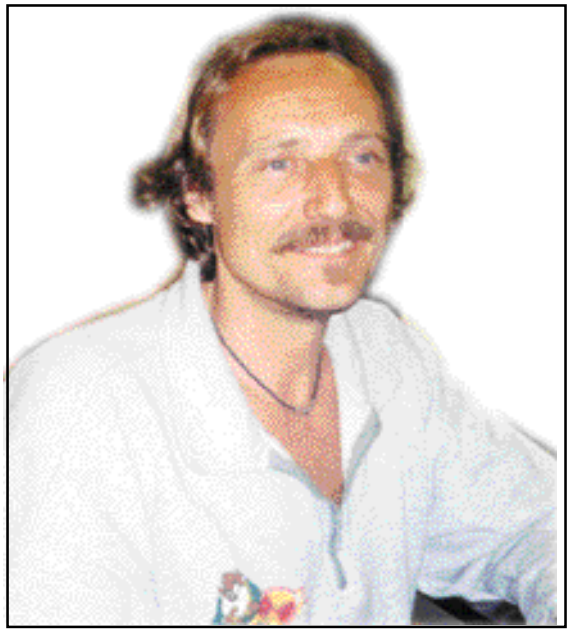
"When I got a problem, I go and pull them out. . . . They [the dentists] would rather pull them out than fix them. Maybe that's why I have that mentality—because it's the only stuff I've been able to afford. I'm not used to having a dentist sit back and ask, `Hey, what do you want?' Rip 'em out, that's it."

Vernon Dabasi

For those on income support, like Vernon, extraction is the only viable option because it is a covered service. At his most recent dental visit, just a few weeks before our interview with him, Vernon had two teeth taken out. He still needed to have additional teeth removed before getting a denture. Vernon explained:

"When I got a problem, I go and pull them out. . . . They [the dentists] would rather pull them out than fix them. Maybe that's why I have that mentality—because it's the only stuff I've been able to afford. I'm not used to having a dentist sit back and ask, `Hey, what do you want?' Rip 'em out, that's it."

But in many cases extraction is not the best choice. Not many of us would willingly substitute a set of plastic teeth for our natural ones. Werner Grill, a graduate of the University of Guelph and a former owner of a landscaping business, finds himself facing a dead end. His front tooth has a large cavity and requires root canal treatment if it is to be saved. But a root canal is beyond what Werner can now afford. He says: *"I'm in a position of `Do I wait till this rots out and drops?' It's one of my front teeth, so it's pretty important. . . . I just wish that they [the government] would cover more of these situations, especially when it's your front teeth. I mean, that's your smile—that's the way people look at you."*



Werner Grill

Werner's concerns echo the findings about the impact of oral health on self-esteem:

"If it were a back tooth, I wouldn't care so much. But it's the front tooth here and that worries me. It makes it harder to get a job because, let's face it, people go on appearance. Here I am trying to rebuild my life—the last thing I need is to start losing teeth. I'd like to start my landscaping business again so I'd be meeting people and getting my own customers. If they see someone with hardly any teeth, they'll think, `Well, he's probably not a very good gardener either.'. . . It worries me. Everyday I look in there and I see it's getting a little more brown at the edge. . . . I would love to fix this thing once and for all. It would give me more confidence, it would be something less to worry about, and it would help me start working full-time again."

Clearly, increasing public funding for dental care would improve access to dental services and help people like Eric and Werner re-establish their position in society. But as stated in the surgeon general's report, Oral Health in America, access to care is determined by a complex set of factors, including the need to have an informed public and policy-makers, integrated and culturally competent programs, and the resources to pay and reimburse for the care. In Canada public financing of health care is dominated by hospital and physician care, and only a small portion goes towards services such as dentistry.

Canada lags behind many European countries that offer long-term care, home care, dental care, and pharmaceutical benefits, among others, as part of their much more expansive coverage. It is almost shocking to know that Third World countries, such as Mozambique, and many European countries, such as Sweden, France, and Germany, can afford to at least provide some of their citizens with publicly financed dental care—while a rich and technologically advanced country such as Canada leaves its citizens to fend for themselves.

Despite a number of attempts made in the past to include dental services in Canada's publicly financed medical and hospital care system, the results have been discouraging. According to Carol Kushner, the reasons for this failure are manifold. For one thing, the country lacks a strong, organized consumer voice for dentistry. The general public has not made dental services a priority, and it has not been fully appreciated that what happens in the mouth connects to what happens in the rest of the body. Kushner explains: "You can't capture the public's attention if they don't think what you're talking about is important." Added to this is the perception that dental care is expensive and a great deal of it is discretionary. As a result, there has been no strong public outcry about the lack of public financing for dental care.

The Professional Point of View

The dental profession side tends not to offer a strong supportive voice for dental care as part of the universal medical care system. According to Kushner, the profession believes that a government role as the payer of dental services would be a potential threat to its autonomy.

Conservation of autonomy was also a strong reason for the opposition from physicians when the existing national public medical care insurance was first introduced in the 1960s and early 1970s. The fear is that there may be a reorganization of the workforce and dentists may be forced into different models of service deliveries, in which they would have to work with other providers and be subjected to more scrutiny and potential interference from others. Furthermore, there is a fear that to decrease costs the government

would attempt to substitute lower-cost providers for higher-cost providers. An example is the use of dental hygienists rather than dentists to provide cleanings. *"This is not an easy truth for any professional to accept—that someone can do as good, or in some cases better, a job than fully trained professionals," says Kushner.*

But incorporating dental care into Canada's existing public financing of physician and hospital care could bring many potential gains. The economy as a whole would benefit because a system with one payer of services would be more efficient than one that has mixed private and public financing. On the consumer side, having a universal publicly funded dental care system would improve access to care, particularly for those vulnerable people who would not otherwise have been able to afford treatment.The dental profession as a whole also stands to gain from changing the system of coverage. Given large employers' concerns over the rapidly increasing costs of dental insurance (11), it seems unlikely that private dental insurance is sustainable in its present form. Thus dentists ultimately will benefit from a system that provides better access to a full range of services to those who are most in need.

Equality OR Disparity

To Go or Not to Go: Dental Insurance

Given that a large percentage of dental financing is now being provided privately, it is not difficult to understand that, among other factors, the availability of insurance increases access to care for those with the coverage (2).

Michelle & Eirik

For practical purposes, an individual's ability to gain access to professional services is indicated by visits to a health-care provider at least once a year (8). In Canada, adults with dental insurance are 2.7 times more likely than those not insured to report a dental visit in the past year (8). Furthermore, insured children are 2.5 times more likely than uninsured children to receive dental care (8). This is true even though children from families without dental insurance are three times more likely to have dental needs than are children with either public or private insurance (8).

People's personal stories also indicate that the pattern of dental visits tends to vary within an individual's lifetime depending on the availability of dental insurance. For instance, Michelle Leake and Eirik Rutherford, a young married couple, are each building

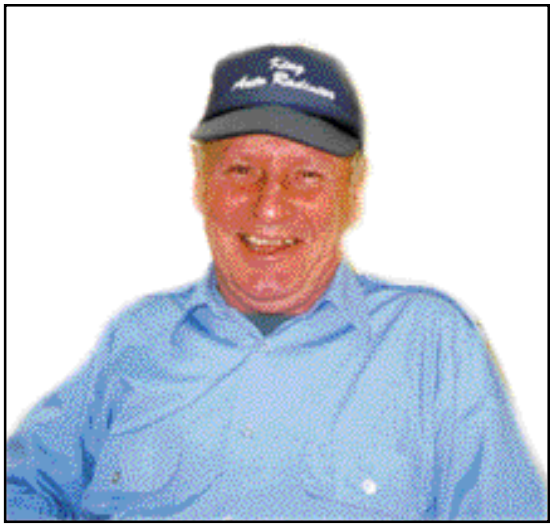
successful careers. When they were children, Michelle and Eirik were both covered under their parents' dental insurance plans, and both of them visited the dentist twice a year. Once they reached the age of 18 the coverage was no longer available, and Michelle and Eirik both went through periods during which they didn't have dental insurance. During five years without dental coverage, Michelle didn't visit the dentist because she "could not afford to go." Similarly, Eirik didn't go to the dentist during a seven-year period when he was uninsured. It was "too expensive," he told us.

Michelle and Eirik are now both receiving dental benefits through their places of employment, and they are re-establishing their regular dental attendance of at least once a year. Despite going through a period without professional care, they still enjoy excellent oral health. Even though both of them required new fillings when they returned to the dentist, they found no other irreparable effects on their oral condition.

Not everyone is as lucky. Gerald Quirke, at 61 years of age, is wearing partial dentures. When we asked him why he lost his teeth, Gerald replied:

"When I started to work on my own, with no dental plan, I just let it go bad and if it felt bad, just pull it out. It didn't bother me then but now I wish I hadn't done that."

"I used to work in big companies and it was all covered. . . . I always had my teeth done, always. When I started to work on my own, with no dental plan, I just let it go bad and if it felt bad, just pull it out. It didn't bother me then but now I wish I hadn't done that."



Gerald Quirke

Though he is comfortable with his dentures, Gerald recognizes that his natural teeth would probably have served him better, and he wishes he had more of them left.

In Gerald's case, then, financial constraints and the resulting lack of professional dental care have led to a significant compromise in his oral health: the loss of teeth. That a period of financial trouble can give rise to such a deleterious lifelong effect is, unfortunately, an ugly reality of our present dental health-care system.

While Gerald has probably gone through his worst period of suffering from dental problems, Fernanda Freitas may only be starting hers. At age 43 Fernanda has no income, no government assistance, and no coverage for dental care. Two years before our interview, Fernanda was working full-time and had full dental coverage. At that time she got her teeth cleaned every few months. But then she lost her job, and ever since she hasn't been to the dentist: "Because I was covered by insurance at that time. Now I'm not. . . . They [the dental office] called me whenever it was time to go. But when I'm not covered, they don't bother calling."

When we asked her if she thought she was in need of dental treatment, Fernanda said, "I could use a cleaning. There's pain sometimes, but I don't have any money." She also complained about food getting stuck in her back teeth, causing her pain. Although she sees her physician "all the time" for medical treatment, she doesn't feel able to make an appointment with a dentist: "Because then I'd have to pay and it's so expensive."

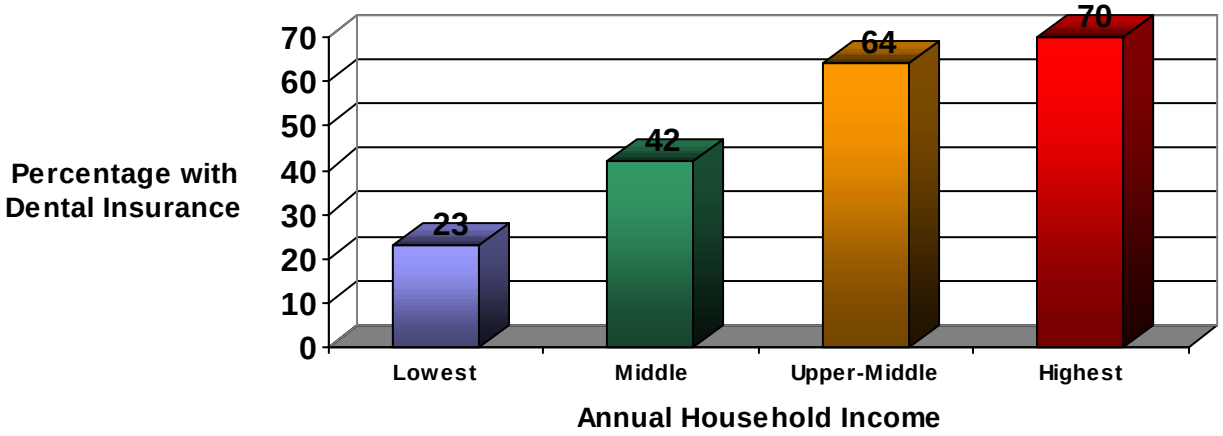
"But when I'm not covered, they don't bother calling."

From all accounts it is obvious that the availability of insurance has a close connection to the frequency of dental visits. In Canada about 53 per cent of all persons aged 15 and older have dental insurance (8). Dental coverage varies with income: those in higher income brackets are more likely to have dental insurance (see Figure 1). This trend is ironic, because it shows that the people with the lowest incomes—those most in need of dental coverage because of their limited ability to pay—are left to fend for themselves. And because these people have very limited incomes that must go to essential needs such as food and shelter, they usually neglect dental care.

Fernanda Freitas

Not surprisingly, then, the *Oral Health in America* report concludes that "the burden of oral diseases and conditions is disproportionately borne by individuals with low socioeconomic status" (2). In both the United States and Canada, people with incomes at or above the poverty level are about twice as likely to report a dental visit in the past twelve months as those who are below the poverty level (8).

Figure 1: Dental Insurance Coverage by Annual Household Income



Source: Adapted from Lawrence and Leake, 2000 (8).

Youth

Ian Armstrong and Omar Guled belong to the same generation. They are teenagers, with only two years separating them in age. But their backgrounds and life experiences could not be more different. Ian comes from a financially stable family and makes a comfortable living, while Omar finds himself living on and off the streets. Ian visits the dentist every six months for checkups and cleanings. Omar has not been to the dentist for over two years.

Omar Guled

Omar's pattern of dental visits is not uncommon. A study of Toronto's 174 street youth found that only 22.4 per cent reported visiting a dentist in the previous year, while 40.8 per cent had not done so in the previous two years (12). The difference in Ian's and Omar's frequency of visits is also not surprising. At the age of 18-19 years, some 85 per cent of adolescents from high-income families with dental insurance had seen a dentist in the previous year, compared to 52 per cent of adolescents from low-income families without dental insurance (7). Furthermore, 73 per cent of Canadian-born adolescents reported regular preventive dental visits compared to 43 per cent of those who had immigrated.

Susan Thornley, a dental hygienist working for the City of Toronto Public Health, refers over one-third of the Toronto high-school students that she screens to dental clinics for treatment. She says that the major barrier for most of these youths is a financial one. "It's not infrequent that I see bombed out teeth and swelling and a lot of infection. There are students that go around with missing front teeth."

Studies show that low-income or street youths have poorer oral health than their more affluent peers. A Toronto study found that the average number of decayed/ missing/filled teeth (DMFT) was 5.7 in homeless youths; the DMFT in 15-year-olds of the general Toronto population was only 1.7 (12). Furthermore, both the DMFT and gum condition worsen as the number of years on the street increase (10). When we asked him what would make it easier for him to make regular trips to the dentist, Omar responded:

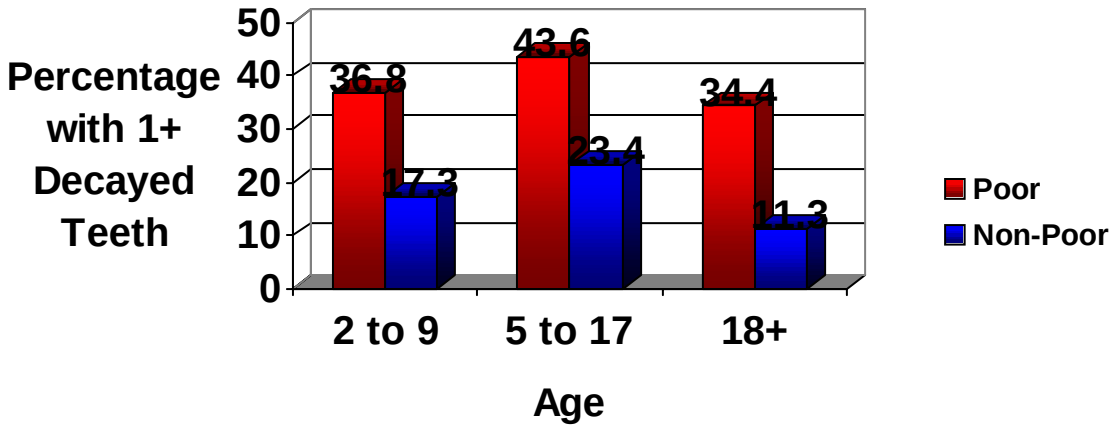
"I'd prefer it to be like the health card. If somebody loses their teeth, it's like losing somebody's fingers. By the time you're 30 years old, you have bad teeth at the front. That wouldn't make no-one happy."

With the institution of fluoridated water and a strong preventive philosophy, the rate of cavities has declined significantly over the years (1, 2, 7).

"I'd prefer it to be like the health card. If somebody loses their teeth, it's like losing somebody's fingers. By the time you're 30 years old, you have bad teeth at the front. That wouldn't make no-one happy."

However, the reduction has not been uniform across different populations. *Oral Health in America* states that children in families living below the poverty level experience twice as much dental decay as those who are economically better off. More significantly, the cavities of poor children are more likely to be untreated than are the cavities of children in more affluent families (see Figure 2). Studies in England, Scotland, and the United States have consistently found an association between low socio-economic status and poor oral health on the one side and infrequent dental visits in children on the other (13, 14, 15, 16, 17).

Figure 2: Percentage of People with At Least One Untreated Decayed Tooth, U.S.



Source: adapted from Lawrence and Leake, 2000 (8).

Ethnicity

In addition to income, ethnicity also has an influence on oral health and access to dental care. In Ontario, Aboriginal children and children born outside of Canada have fewer healthy teeth, higher decayed/missing/filled teeth, and more untreated decay than other children (7). In a group of children aged 13 to l4 living in North York, 3.5 per cent of those born in Canada needed restorations—compared to 22.9 per cent of those who had immigrated to Canada in the past two years. Only a minuscule 0.5 per cent of those born in Canada needed emergency care, compared to 10.4 per cent of those who had immigrated (7).

Seniors

Low-income seniors are another vulnerable group. The percentage of people over 65 years of age without any natural teeth remaining is higher among those living in poverty (2).

The City of Toronto is one of the few municipalities in Canada that has public funding of dental services for the two at-risk groups: low-income seniors (over 65 years old) and children from low-income families. This service has been of great assistance to so many who would otherwise have nowhere to go. Serge Sturgis, at 82 years of age, has been attending the City of Toronto Public Health dental clinic for a number of years. He has no teeth remaining on the top jaw and wears a complete denture. On his bottom jaw Serge has one remaining natural tooth, which now needs to be extracted. Serge doesn't know where he would go for treatment if the Public Health clinic was not available. When asked why he would not go to another dentist, Serge answered, "I'm not able to pay."

"I'm not able to pay."

SergeSturgis

The Working Poor

Betty M. attends the same dental clinic as Serge. For a time she saw a private dentist after arriving in Canada three years ago. Because Betty has not been in Canada for the required length of time, she is not qualified to receive government assistance and now has no choice but to get her treatment at the City of Toronto Public Health dental clinic. "It's just that I realize I wasn't going to be able to continue paying," Betty says.

Asha Aden, a single mother with six children, takes her two daughters to the Public Health dental clinic for treatment. The girls, ages seven and eight, were referred to the clinic when dental screenings in their school identified a number of cavities. Before that, the girls and the remaining four children all had not seen a dentist. *"Because it costs money, a lot of money,"* says Asha. *"Sometimes my youngest son [18 months old] has problems with his teeth and I didn't know who to call."*

Asha is happy that her children are now able to receive the treatments they need. Without screenings at public schools and without the availability of Public Health clinics, Asha's children would most likely suffer from dental problems long before the family could afford to see a dentist. Dr. Mark Merryfield, a dentist who has been with City of Toronto Public Health for

over ten years, says: "We hear it almost everyday from parents, that if they had to pay from their pocket, they simply could not afford to get treatment."

As for herself, Asha went to the dentist once to get her teeth cleaned, but it cost more than she could afford and she doesn't "have enough money to go back." She says, "No, I don't have it [dental coverage]. That's why I have a lot of problems with my teeth." She points to a front tooth that has a visible cavity. It hurts every time she drinks cold water. But until she can save up enough money, Asha's only option is to live with the discomfort.

"Because it costs money, a lot of money," says Asha. "Sometimes my youngest son [18 months old] has problems with his teeth and I didn't know who to call."

Public Dental Services

Asha's situation illustrates a serious shortcoming of the existing publicly funded dental services. The City of Toronto offers free dental services to low-income children and seniors even though there is no provincial or federal mandate to do so. In the rest of Ontario only limited services for adults on government assistance are available. However, no support at all is available to the working poor—adults who have just enough money to meet their daily needs but nothing left over for the "luxury" of dental care.

Asha Aden & daughter

Mitra Kermani-Hojjatian, who works with her husband in a small business, faces this very situation. Her three children receive treatment from Public Health dental clinics, but Mitra and her husband can't afford to see the dentist.

"My husband went for cleaning. They found he had teeth that need to be filled. Exam, cleaning, X-ray, and fill out one tooth—they charge three hundred dollars. . . . They asked him to come back for two more teeth. But he couldn't afford to come back and he was shy so he said, `I'm busy. I come another month.' But the truth was the money."

Mitra herself hasn't gone to the dentist in four years. "For me, when I see three hundred dollars I say `no' because my kids need glasses . . . I couldn't pay." Mitra believes that she has a lot of problems with her teeth. She asks:

"When my kids come [to Public Health dental clinics], why can't I come too? Teeth are a part of health. . . . They cover me for my eyes and the regular family doctor. They should cover for the dentist too. Teeth is part of the body. They cannot say your eyes are important but your teeth are not. It means you're missing something in the whole body. . . . Lots of people like me are around and they need care."

Mitra is right. There are many people like her, adults who fall between the cracks of the system and are left to fend for themselves—adults like Zulikha Wahidi, a 38-year-old mother of four, who goes to the dentist "only when something hurts, swelling, or pain." Her most recent exposure to dentistry was two months before we talked to her, and consisted of a brief checkup provided by a dentist who visits local drop-in centres as part of an outreach dental program. Zulikha says: *"Some people go every six months or four months, but I don't. . . . I don't have any money. When I go to the dentist, they charge me. For example, for cleaning they charge forty or sixty dollars, but I don't have sixty dollars to pay. So I don't go."*

"Some people go every six months or four months, but I don't. . . . I don't have any money. When I go to the dentist, they charge me. For example, for cleaning they charge forty or sixty dollars, but I don't have sixty dollars to pay. So I don't go."

There are many others who can't go to the dentist despite having dental needs: people like Gradiz Gutierez, who says "I can't smile well" because of an upper missing tooth that shows in her smile profile. When asked why she doesn't get an upper denture to replace the missing tooth, Gradiz's reason was simple: "money."

So often members of the working poor have to make a choice between dental care and other necessary needs of daily living. Certainly, when dental needs have to compete with the more critical needs such as food, clothing, and shelter, it is easy to see why dentistry usually comes last. Although it appears to be an obvious choice, it is not one without consequences. With dental neglect comes much pain and suffering, and in many cases the ultimate fate of the teeth will be extraction. A study of 162 homeless men in Brisbane found that 29 per cent of them were without their natural teeth, which was higher than the Australian average of 20 per cent (3). Although they had a higher rate of tooth loss, only 53 per cent of the homeless individuals with no teeth had complete removable dentures, as compared to 91 per cent of those in the general population (5).

Zulikha Wahidi

In Toronto John Widdowson has had a similar experience with dentistry. At the age of 54, John has gone without natural teeth for the last six years. And like the 47.8 per cent of the men who did have dentures in the Brisbane study, John also does not wear the full dentures that he had been provided with. He is not happy with his dentures because, he says, they don't fit on his gums. When we asked him why he lost his natural teeth, John replied:

"They [the teeth] were all messed up. I guess I wasn't looking after them too well. I just didn't bother going [to the dentist]. . . . Money could have been a problem at the time. You see, I wasn't covered by all this [dental coverage] before. That's why they didn't put in the fillings and

stuff. I could have gotten some fillings in there instead of getting the dentures. They make you feel uncomfortable. . . . I should have gotten the fillings. Maybe I waited too long and that's why they gave me dentures."

Towards a New System

In a country as rich and technologically advanced as Canada, a country that honours and values equity in access to health care, why then must some of its citizens accept compromised oral health as a fact of life? Obviously, we need changes. We need a system that serves the dental needs of all Canadians, a system accessible to the poor and rich alike.

Even the smallest and most gradual changes can make a difference—but only if those changes arise from a united effort. The public, the policy-makers, and the dental profession must recognize the existing problems and join hands to work towards a common goal. We need an immediate response to the problems: knowing what we know about the system's shortcomings, and the effects of those shortcomings on the most vulnerable populations, we simply cannot afford just to discuss what *could* be done. Rather, this is the time to take action and to build a better, more equitable system of health care in Canada.

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