Access to Dental Care for Low-Income Residents of Campbell River and Courtenay-Comox

Prepared by Bruce Wallace
2010
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Acknowledgments

I would first like to acknowledge that overall funding for this research was provided by the Vancouver Island Health Authority (VIHA) with additional support by a grant from the Canadian Institutes of Health Research (CIHR grant #DOH87104). I received ongoing support and supervision from Anita Vallee at VIHA and from Michael MacEntee at UBC. From within VIHA I would like to also acknowledge; Esther Pace, Charmaine Enns, Sharon Stead, Brenda Morris, Brett Hodson and Cheryl Damstetter. Thanks also to Fiona Lawson and Michael Pennock at VIHA’s Public and Population Health Observatory. From UBC I would also like to thank Judy Laird and my PhD committee members; Rosamund Harrison, Malcolm Williamson, Craig Mitton and Rachael Hole. Thanks to Victoria Cool Aid Society and especially Irene Haigh-Gidora at the Community Health Centre for supporting my ongoing research and for providing a webpage for accessing this report. Thanks to Sue Parker for her transcription services. Special thanks to everyone who agreed to be interviewed for this project and for everybody who facilitated these interviews notably Sian and Jim at the Island Jade Society and Maggie and Patricia at the Comox Valley Nursing Centre.
Access to Dental Care for Low-Income Residents of Campbell River and Courtenay-Comox

Executive Summary

The objective of this research is to investigate access to dental care issues and possible barriers for low-income adults in the North Vancouver Island communities of Campbell River and Courtenay-Comox. Public health dental staff in these communities had consistently reported anecdotal evidence of their first-hand experience with low-income people expressing barriers to accessing dental care and living with unmet dental needs. This research project emerged to further explore the experiences and perspectives of low income people, local dentists, health and social service providers to document the perceived needs, barriers and responses.

Information was gathered from 60 interviews among three cohort groups: people who have experienced difficulty accessing dental care because of financial circumstances (N=41), dentists (N=6) and local health and social service providers (N=13). Interviews took place from November 2009 to February 2010. This research is complemented by descriptive population health and income statistics for the area.

Over 100,000 people live in the Campbell River and Courtenay-Comox area, with close to 70,000 living directly within these municipalities. There is a significantly higher percentage of Aboriginal Peoples living in North Vancouver Island communities than in the province overall. Standard indicators of economic hardship statistics indicate that the area experiences greater levels of economic hardship than the provincial average, including consistently higher levels of dependency on income assistance and employment insurance and rates of childhood vulnerability that are similar or higher than provincial averages and which exceed provincial targets.

Population health and income statistics for North Vancouver Island show evidence of the well-known links between income, oral health and access to oral health services; including:

- Overall, high income residents are twice as likely to report excellent oral health when compared to low-income residents. On North Vancouver Island, over 40 percent of low-income residents report that their oral health is fair or poor, while very few high income earners (7%) report experiencing fair or poor oral health.
- Forty-one percent of low income residents report experiencing dental pain sometimes or often in the previous month, a rate that is much greater than the 14.5 percent of high income earners reporting dental pain and discomfort.
- Residents with higher incomes were much more likely to visit the dentist than those with lower incomes. Half of low-income residents (50%) report visiting a dentist in the previous year compared to eight-five percent of high income residents visiting the dentist.

While the survey of 41 low-income residents for this study is primarily qualitative and not intended to be representative, it does include close-ended demographic and standardized health questions which provide a snapshot of experiences in these communities; including:
Over half (56%) of study respondents report experiencing dental pain often or sometimes.
Most respondents (78%) make visits to the dentist for emergency care only, with far fewer reporting regular care or preventive care.
A quarter of respondents (24%) had a tooth extracted by a dentist in the past year.
Almost half of respondents (46%) had accessed the medical system due to dental pain.
Over a quarter (27%) report visiting the Emergency Department due to dental pain, and half of these individuals report also making visits to a medical clinic or doctor’s office.

The research documents the complex, multi-dimensional barriers to accessing and providing care faced by both low-income patients and providers by exploring the interaction between low-income individuals and dental practices on three dimensions – affordability, availability and acceptability.

Overall, the research heard from both dentists and low-income patients that the current service delivery model and payment options are not working well for either party and that while respondents overwhelmingly consider affordability (financial access) to be the predominant barrier to accessing care, the related issues of availability (physical access) and acceptability (cultural access) must also be addressed if access is to be improved. Specifically:

- The interviews document the inadequacy of public dental benefits to ensure access from the perspective of the providers and patients. Dentists expressed the challenges of treating publically funded patients in the private practice business model. The most frequent complaint by all involved – dentists, low-income respondents and health and social service providers – is the discrepancy between the fees paid by provincial dental plans and the fee guide established by dentists in BC.
- While the number of practicing dentists may be a good fit for the area’s general population to ensure access and business viability, this research documents the considerable barriers to access for low-income residents and particularly the lack of available dental practices accepting patients with public dental benefits and those facing probable financial barriers to paying for fees for services.
- The research uncovers patient and provider’s beliefs and perceptions about the other. It would appear that the generalizations made about low income patients by dentists and those of dentists by low-income residents, illustrate the tension of private practice businesses’ ability to ensure public access to dental health without financial barriers.
- Fear of dentists and dental treatment was also expressed by many low-income respondents as a considerable barrier to accessing dental care. Potential patients expected pain and in some cases blame and humiliation for their dental hygiene which discouraged them from pursuing dental care.
- Dentists expressed the frequency of missed appointments as a barrier to providing care and interviews with health and social service providers gave insights into the social determinants of oral health and specifically the challenges faced by clientele in maintaining oral health and keeping appointments.
This research sought to assess what current responses possibly exist in Campbell River and Courtenay-Comox to enable access to dental care for low-income and vulnerable populations. The most frequent response to this inquiry was that there was no known resource for people who sought dental care but faced financial challenges to afford treatment. While there may not be a designated service to enable access to dental care, there is indeed evidence of responses that are assisting individuals in need including public dental benefits, compassionate and charitable dental professionals, facilitated access by non-profit social service agencies.

The interviews in Campbell River and Courtenay-Comox generated ideas and reactions to potential responses that could respond to the potential local unmet needs. These included:

- Improved public dental benefits
- Coordinated dental volunteerism
- Dental access assistance
- Community dental clinic

Overall, the findings from these North Vancouver Island communities are not unique to evidence from throughout British Columbia and elsewhere. Rather, the research provides a local example of the oral health inequities known to prevail in Canada. However, while the needs in Campbell River and Courtenay-Comox may reflect the inequities found elsewhere, there are few or no local resources for people who seek dental care but unable to afford or access treatment.

The urgent call for responses to enable access dental care in Campbell River and Courtenay-Comox was repeated by participants in this research. While addressing the financial barriers to affording dental care is paramount, there is a need for responses that simultaneously increase the availability of dental services for the low-income population and ensure services are appropriately delivered to the unique needs of vulnerable populations.
1. Background: Dental Access in BC

A review of the available evidence from within British Columbia indicates that access to dental care is an issue of concern throughout the province.

In recent years there have been several appeals for action to address oral health inequities in BC:

- In 2007, the Public Health Association of BC passed a formal resolution to request the Provincial Health Officer to address the relationship between dental health and chronic disease and the issue of dental health inequity and equitable access to dental care services in a future Provincial Health Officer’s report.

- In 2008, a resolution was forwarded to the Union of BC Municipalities (UBCM) requesting action to improve access to basic dental care in the province; specifically, that the UBCM “lobby the Provincial Government to take immediate steps to remove access barriers to dental healthcare, allocate more funding for basic dental health care insurance for low income individuals and families in the Province, and work with the BC Dental Association to resolve the discrepancy between the BC Dental Fee Guide and the actual fees charged by dentists.”

- A proposed Poverty Reduction Plan for BC recommends the expansion of the public health care system and specifically improving and expanding the current dental benefits provided through the welfare and Healthy Kids to include low-wage workers and seniors living on low incomes and without benefits (Klein et al., 2008).

- The 2008 and 2009 Child Poverty Report Cards by BC Campaign 2000 recommends that “All British Columbians need coverage for prescription drugs and dental care. While some workers already have access to extended medical and dental benefits through their work, universal public plans would be even better and also less expensive” as “universal public plans would expand and stabilize coverage for all and reduce costs through economies of scale.”

- The BC Association for Community Living presents the brief “Nothing to Smile About” in which they make requests to the Provincial Government to address barriers to accessing dental care for people with developmental disabilities in the province; specifically recommending increasing dental benefits and “resolve the critical issue of access to dental care by upgrading the fee schedule and addressing bureaucratic obstacles that affect dentists and their patients.”

- A 2008 review of income assistance adequacy in BC recommends that employable welfare recipients who are required to look for employment be provided the same extended dental benefits as clients with disabilities arguing that “not providing coverage for items such as dental care can create barriers for clients seeking employment (2008:12).”

Previous reports from the BC Provincial Health Officer (PHO) confirm the oral health inequities within the province. The 1999, PHO Report on the Health of British Columbians reports data suggesting “that many British Columbia adults are experiencing financial or other barriers to regular dental care (pg 89)” and recommends that the health system “[i]mprove access to dental health education and regular dental care, through universal access programs or through specific support to groups without insurance (pg. 92).”

“High income British Columbians are more likely to have made a recent dental visit (79 per cent) and to have dental insurance (78 per cent) than those in the low or lower-middle income groups. In the lowest income groups, 57 per cent of people reported visiting a dentist in the past year, and 24 per cent said they had dental insurance (pg 88).”
In the 2002, PHO Report on “The Health and Well-Being of People in BC” it is again documented that dental visits are evidently linked to ability to pay. The cost of dental care is a major deterrent for low-income families, and some groups need more help. The recommendation is again made to governments and health authorities to “[i]mprove access to dental health education and regular dental care, through universal access programs or through specific support to groups without insurance. (pg 108).”

In British Columbia, a recent report on health inequalities provides statistics illustrating inequalities in accessing dental services in the province. In 2008, the Health Officers Council of BC defined “The BC Paradox” where despite having some of the best overall health outcomes in Canada, BC also has the highest rates of socioeconomic disadvantage in the country. Their report on health inequalities in BC cites statistics that indicate individuals in the highest income households in BC are twice as likely as individuals in low-income households to report they have visited a dentist within the past year. This finding is in stark contrast to accessing publicly funded health services where the lowest income British Columbians utilize more health services covered by the Canada Health Act such as higher number of family physician contacts and more hospital stays.

A report from UBC’s Faculty of Dentistry (M. I. MacEntee, Harrison, & Wyatt, 2001) for the BC Ministry of Health notes that dental programs serving low-income populations in the Lower Mainland are needed in the interior and northern regions of the province. It recommends that the Province “encourage Health Regions to support in each region the infrastructure and staff for at least one public dental clinic suitable for low-income groups, and ask local professional associations to seek volunteers willing to provide treatment at reduced fees. (pg. 30)”

Dental health is identified by the Ministry of Health as one of the CORE Public Health Functions for BC. In its Model Core Program Paper, the Ministry recognizes high levels of decay among vulnerable populations and inequities in access to regular preventive and restorative dental care. The paper outlines the role of health authorities in dental public health and recognizes that marginalized at-risk populations are challenged to access dental care. Significantly, it recommends that:

“Health authorities may decide to assist people to access dental care or may support selected treatment services for selected clients. Advocacy for access to dental treatment for vulnerable populations is recognized as a best practice (Pg5-6).”

The Provincial government recognizes access to dental care for those most in need as a priority issue. In 2005, the province announced a range of measures to enhance dental health, stating:

“Our government is committed to helping British Columbians achieve and maintain excellent dental health through its focus on children and the more vulnerable members of society … Dental services are so very important for BC families and we want to be sure that low-income families have better access to dental care.”

Evidence of Provincial initiatives to improve access to dental care can be found throughout the Province:

- In Dawson Creek the Province provided a $300,000 to support the Gateway Dental Clinic in providing closer-to home dental services to low-income residents. The Minister states that “[b]y investing in low-cost dental clinics, government is helping income assistance clients and eligible clients under the BC Healthy Kids Program have more access to the dental services they need to ensure good oral health.”
• The First Nations Friendship Centre in Vernon received $50,000 to support dental services for those who need it most.
• Salmon Arm was provided $50,000 to expand the services of the Kamloops New Life Mission to serve the needs with a second clinic.
• In Prince George, a community dental clinic was established with a $50,000 capital grant from the Province and sustained by ongoing support from Northern Health to fund some staffing and supplies.\textsuperscript{10}
• In Kelowna, $52,000 was provided to the Kelowna Gospel Mission to improve dental services for the most vulnerable.

In summary, at least a half a million dollars has been distributed by the Provincial Government in recent years to support local initiatives aimed at improving access to oral health and dental care for low income residents of BC. There has been no such support provided on Northern Vancouver Island and yet there is every reason to assume the needs would be similar.

This research was undertaken to document the experiences of people on low incomes, local dentists and health and social service providers in Campbell River and Courtney-Comox to provide evidence to inform policy and practice to best enable access to dental care in these communities. Information was gathered from 60 interviews among three cohort groups: people who have experienced difficulty accessing dental care because of financial circumstances (N=41), dentists (N=6) and local health and social service providers (N=13). Interviews took place from November 2009 to February 2010. This research is complemented by descriptive population health and income statistics for the area. Details about the research and methods are included in the Appendix to this report.
2. Context: Evidence from North Vancouver Island

An objective of this research project was to collect and assess the available population data that could be useful for indicating potential inequities or oral health disparities linked to income. There are duel purposes linked to this activity. The first purpose is to provide a profile of the communities under investigation, with particular focus on those indicators that describe low-income, affordability, and oral health. The second purpose is to provide an assessment of this process that would identify what information is currently available and what are the knowledge gaps, a process that could be useful for future research with communities in the province. Nationally, there is recognition of the paucity of population oral health to inform policy and practice.

2.1 Area & Populations

The Vancouver Island Health Authority (VIHA) provides health services to people on Vancouver Island, the Gulf and Discovery Islands and part of the mainland area opposite Northern Vancouver Island. This research focused on the communities of Campbell River and Courtenay-Comox. These communities are located in the North Vancouver Island Health Service Delivery Area (HSDA 43), (see Appendix for map) and include two Local Health Areas; Campbell River (LHA 72) and Courtenay (LHA 71). It is estimated that the population of the two LHAs is approximately 105,000 people, and that close to 70,000 reside in the municipalities of Campbell River and Courtenay-Comox. Over half (59%) of the population of the Local Health Area 71 is within the City of Courtenay and the Town of Comox, and of the Local Health Area 72, seventy-five percent of the population resides in the City of Campbell River.

<table>
<thead>
<tr>
<th>Table 1: Area Population Estimates</th>
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<tbody>
<tr>
<td><strong>Population Estimate (2009)</strong></td>
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<tr>
<td>---------------------------------</td>
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<tr>
<td>64,084</td>
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</table>


According to the Provincial Health Officer’s most recent Annual Report which focuses on the health and well-being of Aboriginal People in BC, Aboriginal People comprise 4.8 percent of the population in BC, and in North Vancouver Island (HSDA 43) the proportion of Aboriginal people is higher at 8.9 percent which represents about 10,000 residents. Approximately one-third of the Aboriginal population resides on reserve (3,235) and two-thirds reside off-reserve (6,755).

<table>
<thead>
<tr>
<th>Table 2: Aboriginal Population</th>
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<tbody>
<tr>
<td><strong>Aboriginal population (2006)</strong></td>
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<tr>
<td>---------------------------------</td>
</tr>
<tr>
<td>Total Aboriginal People</td>
</tr>
<tr>
<td>Percent Distribution (%)</td>
</tr>
</tbody>
</table>


*Source: [Pathways to Health and Healing (2009)](http://www.hls.gov.bc.ca/pho/pdf/abohlth11-var7.pdf) the Provincial Health Officer’s (second) report on the health and well-being of Aboriginal people in B.C.
2.2 Indicators of Economic Hardship

Quarterly statistics are produced by BC Stats\(^1\) for the Comox-Strathcona Region, which include Campbell River, Courtenay and Comox. These reports indicate that the region experiences increasing levels of dependency on income assistance and employment insurance, and that these rates are consistently higher than the overall provincial rates. Over the last two years (June 2007 – June 2009) the rate of dependency on both basic income assistance and/or employment insurance has more than doubled in the region, rising from 2.9 percent of the population to 6.7 percent of the population who would be considered employable but in receipt of welfare or EI.

The routinely releasable BC Stats reports for Local Health Areas (72 & 71) provide data on the standard indicators of “economic hardship.” The table below illustrates that for all three indicators, the North Vancouver Island population experience greater levels of economic hardship than the provincial average. While these rates of economic hardship are useful, they do not provide actual numbers of individuals who may be receiving social assistance benefits and experiencing poverty.

The most recent income assistance statistics report only on the population considered employable and receiving basic income assistance, which does not reflect the portion of the welfare caseload population who are in receipt of disability benefits. We know that in September 2009, there were 2,287 individuals on basic income assistance in the Region, or 2.6 percent of the population. An email request to BC Stats uncovered that the actual numbers (rather than percentages) of individuals in the region in receipt of welfare benefits (temporary and disability) was 5,188 (based on September 2009 raw postal code data). Add to this a similar number of individuals receiving employment insurance to begin to estimate the actual number of individuals receiving financial assistance.

| Table 3: Economic, health, and social indicators for Local Health Areas 71 & 72 and BC |
|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|
| Indicator                                      | Courtenay (LHA 71) | Campbell River (LHA 72) | British Columbia |
| % of population receiving Income Assistance Benefits (Sept. 2009) | 5.2 | 6.8 | 4.5 |
| % of children receiving Income Assistance Benefits (Sept. 2009) | 4.8 | 7.3 | 4.0 |
| % population receiving Employment Insurance (4 quarter average to Sept. 2009) | 4.0 | 5.7 | 3.0 |


The Human Early Learning Partnership\(^2\) (HELP)’s Mapping Project involves mapping child development data, socio-economic characteristics and community assets. A key measure used in this project is the Early Development Instrument (EDI), a population-based research tool used to measure vulnerability of children. The 2008/09 EDI data shows that province wide 28.6 percent of children in kindergarten were vulnerable. The BC government has established a goal of reducing this EDI vulnerability to 15 percent by the year 2015.\(^3\)

Current data (2008/09)\(^4\) from this research process indicates a significant level of vulnerability in both the Campbell River and Comox Valley regions. In the Comox Valley, 34.8 percent of children were
vulnerable, a rate that is higher than the provincial average and double the provincial goal. In Campbell River, the EDI data shows 28.1 percent of children were vulnerable, a rate that matches the provincial average. The project collects data by neighbourhood to illustrate disparities. In Comox Valley, vulnerability rates in neighbourhoods ranged from 17.6 percent to a high of 60 percent in Black Creek/Merville and 47 percent in West Courtenay where approximately half of children are assessed as vulnerable. In Campbell River the range is from 19% to 37%. In both districts there were no neighbourhoods below the 15% threshold.

In its 2009 Quality of Life Report\textsuperscript{15}, the Comox Valley Social Planning Society provides statistics indicating the prevalence of food insecurity in the area. There are six main emergency food support programs: Comox Valley Food Bank, Courtenay Foursquare Church, the Salvation Army, St. George’s Pantry, St. Vincent de Paul, and AIDS Vancouver Island Cold Weather Outreach. The Comox Valley Food Bank alone distributed 7,711 bags of food at their depot in 2007/2008. Meal programs are also filling a need as indicated by usage statistics from the Sonshine Lunch Club that served an average of 170 people a day for a total of over 35,000 meals in 2008.

The City of Courtenay Mayor’s Task Force on Breaking the Cycle of Mental Illness, Addictions and Homelessness in the Comox Valley estimates\textsuperscript{16} that there are 250 truly homeless people in Comox Valley, with at least another 3,100 at risk of becoming homeless. Service usage statistics reported by the Task Force include the Salvation Army Emergency Shelter, providing shelter to an estimated 340 homeless persons in a year; the Wachiay Friendship Centre Homelessness Prevention/Intervention Centre reporting having 367 Aboriginal clients, most who are at risk for homelessness; and, the Adult Addiction Community Treatment Program identified 125 homeless persons among their clients in the most recent 12-month period.

The City of Campbell River also recently released a report and recommendation from its Homeless Task Force\textsuperscript{17}. The Task Force estimates the number of people who are absolutely homeless to be approximately 35 to 50 and a much larger group, up to an additional 450 people meet the broader definition of homeless. Of the homeless individuals surveyed (N=388), a third had visited the emergency room in the last three months. Dental care is included in The Homeless Task Force recommendations as the Task Force recommends VIHA to “Ensure necessary health and dental services are accessible and available to all in our community, including those who are homeless.”
3. Results: Low Income and Health Survey Data

This research initiative included collaborating with VIHA’s Public and Population Health Observatory to access and analyze potentially relevant data from the most recent cycle of the Canadian Community Health Survey (CCHS-4.1). The CCHS is a longitudinal survey carried out by Statistics Canada, and we accessed data from the survey carried out in 2007-08. The tables present data for the North Island Health Service Delivery Area, which includes Campbell River and Courtenay-Comox but also the population residing in the larger surrounding geographical area (map is included in appendix). Results are presented for the overall North Island population as well as for low-income and high-income groups. Low-income includes households with annual incomes below $20,000 and high income represents respondents with household incomes of $80,000 or more.

While the interviews of 41 low-income residents in Campbell River and Courtenay-Comox were primarily qualitative and focused on open-ended questions that facilitated individuals expressing their experiences and opinions, the surveys also included a more structured section of close-ended questions. Several of the questions asked were Canadian Community Health Survey (CCHS) questions, thereby permitting comparisons with the data presented in the previous section. While these findings are not intended to be representative of any population, they do provide a snapshot of the experiences of low income individuals in these communities.

3.1 Self-rated health

The CCHS data shows a total of 63 percent of North Vancouver Island residents report their health as excellent or very good. However, there are considerable differences based on income. High income residents are three times as likely to report excellent health than low income residents. The low-income survey respondents in Campbell River and Courtenay-Comox were also asked this CCHS question. The results for the cohort in this study show that few (22%) reported their health as excellent or very good. These results could perhaps reflect some of the core need in the area. The poor health status could also be reflective of the high numbers of respondents who have disability status with the Ministry of Human Resources and Social Development.

<table>
<thead>
<tr>
<th>Self Rated General Health</th>
<th>Campbell River and Courtenay-Comox Survey</th>
<th>Canadian Community Health Survey (CCHS)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Excellent</td>
<td>5</td>
<td>12.2</td>
</tr>
<tr>
<td>Very Good</td>
<td>4</td>
<td>9.8</td>
</tr>
<tr>
<td>Good</td>
<td>12</td>
<td>29.2</td>
</tr>
<tr>
<td>Fair</td>
<td>16</td>
<td>39</td>
</tr>
<tr>
<td>Poor</td>
<td>4</td>
<td>9.8</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100</td>
</tr>
</tbody>
</table>
3.2 Regular medical doctor

Most residents (87%) on North Vancouver Island report having a regular medical doctor, a finding that remains high for both income groups. Interestingly, low-income residents are more likely to report having a regular medical doctor than high income residents. Most of the study respondents (73%) report having a regular doctor.

<table>
<thead>
<tr>
<th>Regular Medical Doctor</th>
<th>Campbell River and Courtenay-Comox Survey</th>
<th>Canadian Community Health Survey (CCHS)</th>
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<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>30</td>
<td>73</td>
</tr>
<tr>
<td>No</td>
<td>11</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100</td>
</tr>
</tbody>
</table>

3.3 Self-rated oral health

Overall, about half (54%) of the general population rate the health of their teeth and mouth as excellent or very good. Similar to overall health, high income respondents were over twice as likely to report excellent oral health when compared to low income respondents. Most noticeable is the strong relationship between those reporting fair or poor oral health and income. On North Vancouver Island, over 40 percent of low-income residents report that their oral health is fair or poor, while very few high income earners (7%) report experiencing fair or poor oral health. The self-rated oral health for the study respondents continues this trend, as 63 percent fair or poor.

<table>
<thead>
<tr>
<th>Self Rated Dental Health</th>
<th>Campbell River and Courtenay-Comox Survey</th>
<th>Canadian Community Health Survey (CCHS)</th>
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<tr>
<td></td>
<td>N</td>
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</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100</td>
</tr>
</tbody>
</table>
### 3.4 Dental pain

In the general population on North Vancouver Island, most people (81%) said they rarely or never experienced dental pain in the previous month. However, some people do live with dental pain as 41 percent of low income residents report experiencing dental pain sometimes or often in the previous month, a rate that is much greater than the 14.5 percent of high income earners reporting dental pain and discomfort. Over half (56%) of the study respondents report experiencing dental pain often or sometimes.

<table>
<thead>
<tr>
<th>Experience dental pain</th>
<th>Campbell River and Courtenay-Comox Survey</th>
<th>Canadian Community Health Survey (CCHS)</th>
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<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Often</td>
<td>7</td>
<td>17.1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>16</td>
<td>39</td>
</tr>
<tr>
<td>Rarely</td>
<td>8</td>
<td>19.5</td>
</tr>
<tr>
<td>Never</td>
<td>10</td>
<td>24.4</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100</td>
</tr>
</tbody>
</table>

### 3.5 Dentist visit in past year

About two-thirds (63.5%) of residents on North Vancouver Island report visiting a dentist in the past year. Residents with higher incomes were much more likely to visit the dentist than those with lower incomes. Half of low-income residents (50%) report visiting a dentist compared to eight-five percent of high income residents visiting the dentist.

<table>
<thead>
<tr>
<th>Consulted with dentist in past 12 months</th>
<th>Total Population %</th>
<th>Low Income %</th>
<th>High Income %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>63.5</td>
<td>50.2</td>
<td>85.2</td>
</tr>
<tr>
<td>No</td>
<td>36.5</td>
<td>49.8</td>
<td>14.8</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

While this question was not included in the survey, respondents were asked several other CCHS questions regarding their utilization of dental services. Most respondents (78%) make visits to the dentist for emergency care only, with far fewer having regular dental care or preventive care. When asked for reasons for not visiting the dentist, the most frequent response was cost and the second most frequent response was fear, or a combination of fear and costs. A quarter of respondents (24%) had a tooth extracted by a dentist in the past year. Almost half of respondents (46%) had accessed the medical...
system due to dental pain. Over a quarter (27%) report visiting the Emergency Department due to dental pain, and half of these individuals report also making visits to a medical clinic or doctor’s office.

<table>
<thead>
<tr>
<th>Dental Visits</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than once a year (check-ups)</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>About once a year (check-ups)</td>
<td>5</td>
<td>12.2</td>
</tr>
<tr>
<td>Less than once a year (check-ups)</td>
<td>3</td>
<td>7.3</td>
</tr>
<tr>
<td>Only for emergency care</td>
<td>32</td>
<td>78.1</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason for not visiting dentist</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost</td>
<td>16</td>
<td>44.4</td>
</tr>
<tr>
<td>Cost &amp; fear or transportation problems</td>
<td>8</td>
<td>22.2</td>
</tr>
<tr>
<td>Fear</td>
<td>4</td>
<td>11.1</td>
</tr>
<tr>
<td>Have not gotten around to it</td>
<td>5</td>
<td>13.9</td>
</tr>
<tr>
<td>Did not think it was necessary</td>
<td>1</td>
<td>2.8</td>
</tr>
<tr>
<td>Not available in the area</td>
<td>1</td>
<td>2.8</td>
</tr>
<tr>
<td>Wears dentures</td>
<td>1</td>
<td>2.8</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Teeth removed in last 12 months</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>10</td>
<td>24.4</td>
</tr>
<tr>
<td>No</td>
<td>31</td>
<td>75.6</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Access dental pain services elsewhere</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>22</td>
<td>53.7</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>11</td>
<td>26.8</td>
</tr>
<tr>
<td>Doctor</td>
<td>8</td>
<td>19.5</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100</td>
</tr>
</tbody>
</table>

Overall, the results of these data suggest a relationship between health status, health care utilization and income on North Vancouver Island as well as differences between accessing publically funded medical doctors versus accessing private practice dentists. People with lower income are more likely to report poor general health and almost all report having a regular doctor. This finding is consistent with other research that shows a low-income gradient of health and health care utilization, with poor health more prevalent among poor people who are more likely to utilize health services than higher income residents.
The data regarding oral health demonstrates what is called an inverse law of care. Low-income residents in the North Island are much more likely to report fair or poor oral health and much more likely to be experiencing dental pain and discomfort, however, they are also much less likely to access dental treatment from a dentist. The inverse law of care, as illustrated here in the North Island, sees the population with the greatest needs being the least likely to utilize services, while the population reporting the best overall dental health is more likely to utilize dental services. While the relationship may seem simplistic, the phenomenon is quite complex, as multiple explanations for the disparity exist.
4. Results – Qualitative findings

Local dentists were asked if there were people with dental needs not accessing care in the community. The prevailing responses were; vulnerable groups who live on low incomes, including those on fixed incomes that rely on public dental benefits. The groups experiencing need, as identified by dentists, are people receiving welfare, children on Healthy Kids, the working poor, homeless, elderly and people with physical and mental disabilities;

“That’s about it; the poor, the working poor, the dysfunctional and the physically handicapped.”

“Those who are working but they don’t have dental insurance, you know, the working poor or young people with minimum wage jobs.”

“Most important to me is elderly and disabled who are in long-term care facilities or in extended care.”

The level of unmet need was described by one dentist as “huge” and another expressed “there’s loads of them not accessing dental care.” While also expressing that these needs are not unique to these communities, as the “huge” need would be found “in almost any area in BC” and another stating “I don’t know if it’s worse than any other area.”

Dentists emphasized the unmet dental needs faced by individuals with mental and mobility challenges, notably seniors. Repeatedly dentists described the challenges of providing treatment to individuals with mobility limitations (in wheelchairs specifically), those who required sedation due to mental or developmental disabilities and the frail elderly in facilities where dental facilities were not existing and therefore dependent on either limited mobile services or facilitating transportation to an outside dental practice.

For non-dental professionals, the interviews with other service providers, dental need was often described as those populations with visible decay and noticeable dental pain – almost always populations experiencing poverty. Closely related to this need for emergency dental care, was the significant challenges faced by clients and their advocates in affording dentures following emergency extractions;

“It seems an inability to access dental assistance and the inability to access housing go hand in hand, not exclusively, but certainly there’s a high profile of people in that category who are walking around with infected teeth and getting sick from that.”

“You see a lot of low income workers that are in pretty bad dental health. You see them at Zellers and you see them at, you know, the $8 an hour job places and Tim Horton’s and stuff and their teeth are disgusting and dental ... for a lot of people obviously is low on the list of priorities.”

“What we see quite a lot is women who have a mouthful of black stumps [they] require a lot of dental work sometimes because they have been on the street for a long time and, you know,
may have been addicted for a long time, and may still be addicted and have neglected dental care for a long time.”

Low-income respondents described their dental needs in several ways. The most predominant response equated dental pain with need for treatment. For some people, dental care is only sought out when there is a need, and that need is signaled by persistent dental pain. However, a considerable number of respondents consider preventive dental work (check-ups and cleaning) as a critical need – often an unmet need due to restrictions/limits of public dental benefits or competing financial demands if self-financed. Finally, the unmet need for dentures was visibly obvious during interviews and raised by several respondents who overcame challenges to access extractions but not able to afford dentures. The expressed need for dentures included dentures for individuals who had all teeth upper and/or lower teeth extracted, partials, and replacement of dentures.

4.1 Impacts

There was little variation found in the participants’ descriptions of the impacts of not accessing dental care. The impacts on overall health and well-being and employment were heard consistently from a diversity of experiential interviews, dentists and social and health care providers.

4.1.1 Overall health

“Why is it not included in the healthcare system? Why do we have to pay for them? I mean, basically, if I lose all my teeth because they’re all rotten, then I can’t eat. I can’t. Therefore, I can’t prevent disease because I’m not eating properly etc. etc. So, to me, it’s a health issue. So how come dental has never been included with those systems?”

A woman in her late 50s was living with diabetes and no teeth for the last two years. She expressed how she could not eat properly – “my digestive system is going all out of whack all because I’m not being able to chew my food ... you know there’s going to be problems in the end, and then I’ll probably end up in hospital really ill and it's going to cost them even more money.”

“People with rotting teeth or decaying teeth, teeth affected by crystal meth use of whatever it’s really bad for your health, and people who are suffering from other illnesses as well and chronic liver disease or whatever are then doubly affected by the toxins running through your body.”

“Number one you want to make sure people are out of pain. But the challenge is that you have individuals where you’re extracting teeth, they’ve had previous extractions, and they’re having difficulty eating.”

4.1.2 Well-being

“Poor self esteem ... when you see people covering their mouth before they’ll smile or speak ...”
“Their self-esteem and their dignity and their ability to either hold work or find jobs and their health so they can keep up with their daily living activities, it’s all impacted.”

“The barriers for these women are huge because, you know, as soon as they open their mouth they’re not going to get a job. I mean they are easily labeled. I think it makes it more difficult for them to obtain housing, you know, every time they open their mouth it looks really bad. And I think it has a real impact on their health as well in terms of nutrition and what they are able to eat.”

4.1.3 Employment

“The kind of work that many people would be eligible for is going to include someone seeing your face and if you’ve got no teeth or you have really rotten teeth, McDonalds doesn’t want you serving their counter or Tim Horton’s or anybody else. ... Income assistance are pressuring you to go out and do your work plan and yet it is not realistic unless you get a chambermaid job or something where people aren’t going to see your face.”

“Some of the Ministry individuals, I mean there’s just no way you’re going to get a job when you smile at somebody and your teeth are rotten and you’ve got holes everywhere. I mean you’re not the type of person to go to Wal-Mart and work as a cashier or meet the public.”

An older man on a work related disability expressed how his teeth are “holding me in a spot where it’s hard to get a job even in the service industry. You know, in the construction industry it didn’t matter, but I can’t do that anymore.”

4.1.4 Endentulism

There were multiple observations made about the impact of public dental plans providing coverage for emergency extractions but not for restorative work, and with inadequate or no coverage for dentures when needed. As one dentist stated, “I think the biggest thing that’s missing, that I see within a lot of these people that are coming in, is they have no way to get teeth made if they have to lose all their teeth.” A community worker in Campbell River relates, “I had a single mom who is ready and willing to work. She was on income assistance but she didn’t have any teeth at all and couldn’t get dentures. Her qualifications were basically service industry and she was very motivated to work and no one would hire her because she didn’t have any teeth and the Ministry wouldn’t pay for it so they were quite happy to keep her on income assistance rather than a one-time payment to get her the dentures she needed.”

At a soup kitchen, a staff person observes, “lots of people walking around with no teeth because, I don’t know how you access denture services through the Ministry but I know that if it was possible a lot more people would have teeth.” According to another, “We have people coming in who have just had their teeth pulled because they’ve been told once your teeth are pulled you can get dentures [from welfare] and then it turns out they can’t get dentures and they’re walking around with no teeth.”
4.2 Relief of Dental Pain Strategies

If people have significant dental needs and are living with dental pain and/or infections but not accessing care through dental practices, how are they coping and are they seeking care from sources other than from local dental offices? The interviews provide repeated evidence of individuals who turn to the health care system to address dental issues; these include walk-in clinics, doctor offices and the emergency department. The interviews also provide evidence of individuals seeking pain relief through prescription and non-prescription drugs and self-care (pulling one’s own teeth).

4.2.1 Emergency Department Visits

“I truly believe that you should be able to go to hospital and have teeth removed when it’s necessary ... If you go there with a broken finger or broken something they will mend it for you right? Why can’t they do it to your teeth, like I mean, it’s just stupidity to me.”

There are ongoing reports of individuals with persistent dental pain making visits to the emergency department (ED). The frequency of these visits in the local hospitals is not known. The evidence from the interviews would indicate that people are making visits to EDs predominantly because they lack coverage to pay for a visit to a dentist. The visits are primarily to request analgesics and/or antibiotics. It would appear that most, although definitely not all, people are aware that an ED visit will not likely result in the provision of dental treatment. One dentist comments “the hospital isn’t to be used for a money management problem. The hospital is to be used for patients who need to be treated in the hospital.”

There are reports of people not making ED visits due to their perception that EDs do not welcome people who may appear to be homeless or currently using illicit drugs. As an outreach worker states, “I think the majority of our clients know that if you go to the ER you’re getting squat.” One person relates “I went to the emergency at the hospital but ... because I’m an addict I don’t get help nowhere. That’s the first thing that comes up on the computer ... I just gave up. I couldn’t even get a painkiller from them.”

An older man who attributes his poor oral health to past addictions relates making a visit to the ED seeking treatment for pain and infection related to an abscess. “About three or four months ago I started getting an abscess and so I got to the hospital and they gave me a prescription for antibiotics to bring the swelling down but they still won’t pull it out right ... but it costs money to get it pulled out and I don’t have the money, and I have two or three teeth that are just like broken off right at the gum line now.” The man relates that he had to pay for the prescription and after he took the antibiotics, the swelling went down, but he had no plan until it happens again.

His was a common story. A low-income person experiencing persistent dental pain and infection seeks a medical responses from Emergency, receives pharmaceuticals but no resolution of the dental problem and the person returns home to take pharmaceuticals with no perceived options for actual treatment of the problem, which continues to persist. As a service provider in Campbell River relates; “They can’t
afford dental so they go to the emergency room and get out of trouble for ten days and then they’re back again.”

“I went to the emergency room and the doctor had a look at it and prescribed me Tylenol 3’s and an antibiotic, and then I basically went home and I sat there and took my antibiotics for the duration of the prescription... and I just kept taking the Tylenol 3’s.”

Individuals did report dental problems that became so severe they received treatment within the hospital. One man, described living on a nearby farm and taking Tylenols to relieve the pain, when swelling of his face quickly became severe and was treated for several days at St. Joseph’s Hospital with IV antibiotics.

4.2.2 Doctor’s offices and Walk-in Medical Clinics

“You can get to see a doctor for free but a dentist you have to pay for the appointment.”

A dentist comments that “the medical clinic is the frontline for dental infections” as people may call the doctor before calling his office, noting “some people, all they want is relief, they don’t have any hope to deal with the problem fundamentally.”

4.2.3 Self-care

The interviews revealed many accounts from individuals who sought relief from dental pain and infections from the medical system rather than from a dental office. Often, individuals would make repeated visits to their doctor or to a walk-in medical clinic (or both) for painkillers and antibiotics. Most often people mentioned heavy use of Tylenol 3s. Several people talked of continual, heavy use of Tylenol 3s. One man saying “I eat acetaminophens like candy, Tylenol is my buddy” and another stating “I became a pill popper, I’m eating almost twenty Tylenol 3s a day.” According to this respondent, welfare won’t pay for his dental work but will pay for weekly prescriptions of 100 Tylenol 3’s a week.

A 62-year old man, describing repairing his broken upper dentures states “I’m patching it up with cement to weld pipes together, so you know, it’s probably not even that healthy to do that.”

“Yeah, they go to their drug dealers, I hate to be blunt, but that is what they are doing.”

4.3 Dimensions of Access

Access to care is consistently identified as a goal of public health care policy, however, the meaning of access to healthcare is often unclear (McIntyre, Thiede, & Birch, 2009). To analyze and present the findings from this research, I have utilized the framework for defining access that was conceived by Penchansky and Thomas (1981) and more recently modified by McIntyre, Thiede and Birch (2009).

The definition of access provided by Penchansky and Thomas (1981:128) is the degree of “fit” between the clients and the system. The framework presents access not as a passive concept singularly focuses
on either the clients or the resources, but rather the interaction between individuals and the health care system (McIntyre, et al. 2009). It is a multidimensional definition, and the original framework presents five dimensions describing the fit between the patient and the health care system, these are; availability, accessibility, accommodation, affordability and acceptability. McIntyre, Thiede and Birch (2009) follow this same framework, however, collapsing the original five As of access to three dimensions. Here I define these three dimensions that I use to analyze and present the findings of the research.

1. **Affordability**: describes the fit between the providers’ charges and the client’s ability and willingness to pay for services.

2. **Availability**: is concerned with whether there is a fit between the volume and type of existing dental services and this population’s volume and type of needs.

3. **Acceptability**: describes the fit between provider and patient attitudes towards and expectations of each other.

### 4.3.1 Affordability

While the issues are complex, there is an overall assessment by all involved that there is a poor fit between patients, providers and public insurance. In the words of a dentist, “I think the biggest barrier is the economic one from the point of view of the dentists ... economically it’s not viable” and from the person needing care, it is explained it is the people who are always struggling to get by “they really can’t afford it.” Respondents expressed a poor fit between their ability to pay for dental services and the actual costs of necessary dental treatment. Related to this poor fit is the equally poor fit between public dental benefits availability and adequacy to access treatment.

**Prevention and early treatment.** There are multiple accounts of individuals not accessing preventive dental services or early treatment of dental issues, but rather only accessing emergency services in emergency situations. There are many explanations for this situation, several of which relate to affordability. The most dramatic example of not accessing regular dental care was a 49-year old man who was asked when he last saw a dentist and replied “Oh God, twenty years ago.” From young and old, with public dental insurance or no insurance similar comments were heard about the unaffordability of regular dental care:

“I only go for emergencies, that’s all I can afford. “

“Only for emergency care because that’s all I’m covered for. “

“I would like to get my teeth cleaned or scaled, it needs it badly, but that is not covered and I have no idea how much it is... you would think that you would get at least one cleaning a year, you don’t even get that.”

**Financial priorities** Dental expenses are a significant expense considering low and fixed incomes. Individuals and families on low and fixed incomes continually face competing financial priorities and
dental care, notably regular and preventative dental care, is one of many competing priorities. Low income respondents expressed how dental treatment would not be accessed due to everyday competing priorities, such as paying rent and buying groceries.

A woman in her sixties receives disability and hasn’t seen a dentist in three years. She says finances are the reason, explaining “I’m getting around $900 a month and rent is $500 so I go to the food bank for food … and I’m buying my clothes at the Salvation Army, so it’s hard.” A man who is receiving temporary social assistance said “After I pay my rent and my hydro and my phone, I’m left with about forty bucks a month to live on.” While a recently unemployed man relates similar financial pressures when employed “Any money I would earn would have to go for rent, you know, buy groceries and stuff like that, you know, just lack of funding.” A woman with children working part-time also explains “oh I definitely need dental care but it’s a matter of finances … my income just won’t cover the extras like going to the dentist … so the only time I go is when I’m in severe pain … it’s one of those things that are in the lower list.” She believes her situation is typical of other low-income families without dental coverage where “housing and food are the priorities … we have to pick our priorities in what we want to pay for and dental is not up there.”

These statements were similarly expressed by the health and social service providers interviewed. As a nurse explains, “It’s just not their priority, their money has to go to other things – food and childcare and transportation – and all of those sorts of things.” She adds an opinion that there is perception among many “that things like glasses and teeth are luxuries”, expenses that come after the necessities of housing and food.

Dentists also discussed the financial challenges faced by low-income residents in accessing dental care from their offices. One dentist stated that the greatest barrier is not that people don’t want dental care but that “economically it’s not viable” and adds “we’ll see emergencies or something like that but for the routine care, it becomes prohibitive.” Another dentist acknowledges there are real financial needs but also “a couple of experiences where people … say they can’t afford dentistry who suddenly show up in a new car … it’s a priorities question.” Another dentist, also questions the financial barrier as he mentions seeing “too many people that are on assistance come in with their cellphones” and smokers and concludes “they think it is too expensive because they don’t value their health enough to say if I give up smoking I can afford to get my teeth fixed.”

Public dental benefits and access. The interviews documented the inadequacy of public dental benefits to ensure access from the perspective of the providers and patients.

Dentists express multiple frustrations with public dental plans, notably the provincial benefits provided to individuals receiving social assistance, but also the provincial Health Kids program and the federal Non-Insured Health benefits (NIHB) program for Aboriginal patients. Dentist expressed the poor fit between operating their dental practices as efficient businesses with dealing with government bureaucracies for revenue.

Describing the provincial dental benefits, a dentist states;
“Administratively its onerous having to deal with the bureaucracy that comes with this … the paperwork that they require of us in order to see them, you know, consumes a lot of my staff time and again that’s the part of economics of why these people are not being seen, because, you know, you can’t afford to treat them.

A different dentist describes the challenges with the NIHB dental plans;

“The authorization is absolutely the stupidest thing I’ve ever seen in my life. We can go for post-approval but you don’t know if you are going to get paid. If somebody comes in with a roaring toothache and it’s a difficult extraction you’re supposed to write away and get permission which doesn’t make any sense at all because it takes them three or four weeks to get back to you and people with an abscess tooth can’t wait two or three weeks. So we end up doing it and then hoping that Indian Affairs will come through and pay the bill.”

The most frequent complaint by all involved – dentists, low-income respondents and health and social service providers – is the discrepancy between the fees paid by Ministry dental plans and the fee guide established by dentists in BC. Related to this complaint, was the poor fit between patients’ dental needs, dentists’ treatment plans, and the Ministry’s limited coverage and caps on coverage.

Dentists expressed the challenge of publically funded patients being treated in private businesses.

“I mean dentistry has to run as a business first and healthcare second … it’s not a benevolent healthcare service.”

“To me, it’s not fair for the dental profession to have to absorb that which is expected of us. You know our costs are no different when we do a filling on somebody on MHR coverage versus somebody else. Our staff doesn’t take seventy percent of their wages, suppliers don’t. And yet, we are expected to do that. ... Economics play a huge part of it, you now. The local grocery store doesn’t charge them less for their milk or the corner store for their cigarettes, you know.”

“The [Ministry] fee schedule is totally out of date, it has no basis in what the current fee schedule is for everybody else. Because it is so out of date, it becomes virtually unprofitable to see these people and that to me becomes a barrier. ... It seems to be that the government thinks we should be subsidizing seeing these people out of our own pockets and that’s what it boils down. ... So, consequently ... they have to pay the difference so they are treated the same as every other patient, you know, whether they’re on insurance or paying out of their own pocket. Basically, everybody pays the same fee.”

“Their limits are very low. So, you know, to do virtually anything, the person uses up their limits in a very short order. And unfortunately, these people are usually the ones that need the most amount of work and, you know, I’m not sure what the current limit is – whether it is $500 or $700 a year – that’s used up pretty quick to do just routine stuff.”
Low-income respondents are aware of these views held by dentists, as one expressed “I heard, their reasons were that like they do the work on you and submit their bill to the Ministry or whatever and by the time they got their money back for that work it would take months and months right, so that it would put them financially back a bit, eh? That’s what I heard.” Another person says she believes that dentists may not accept patients with welfare benefits because the Ministry limits payments and when treatment exceeds the limits the patient has to pay and dentists may be “concerned about getting their share ... that they’re not going to have patients that can afford to pay for the rest.”

4.3.2 Availability

Availability as a dimension of access to dental care is concerned with whether there is a fit between the volume and type of existing dental services and this population’s volume and type of needs. For people with low-incomes and those with public dental benefits, availability includes the ability and willingness of service providers to serve this population in accordance to their needs and their resources.

Often the concept of availability focuses on spatial access or the geographical distribution of health services, and notably this can be a concern in more rural areas such as North Vancouver Island. In this research there was no noticeable variation concerning availability from interviews conducted in Campbell River and those conducted in Comox Valley communities. Overall, comments from dentists expressed a “good balance” between demand for dental care and the number of practices operating in the region. However, there were mentions of concern regarding the future, with a perceived need to ensure new dentists establish practices in the region when current dentists retire over the upcoming years.

The need to travel to access health services, including dental care was often mentioned, however, more as a reality of life on the North Island than as the predominant barrier. When low-income respondents mentioned travel as a barrier to accessing urgent care, they were often relating experiences from when they lived in more remote North Island areas than the communities of Campbell River and Courtenay-Comox that this study focuses on.

While the number of practicing dentists may be a good fit for the general population to ensure access and business viability, this research documents the considerable barriers to access for low-income residents and particularly the lack of available dental practices accepting patients with public dental benefits and those facing probable financial barriers to paying for fees for services. The issues of affordability and availability intersect in many ways. The availability of dentists willing to accept patients with public dental benefits is often a conditional acceptance. The interviews indicate that it is standard for these practices to;

- “balance bill” meaning billing the patient on social assistance or Health Kids the balance between what the Ministry pays and what the dentists bill,
- Require patients to pay some or all fees up-front, out-of-pocket, and then be reimbursed the total or portion of fees that are provided by the Ministry post-treatment.

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Access to Dental Care for Low-Income Residents of Campbell River and Courtenay-Comox
As a woman with NIHB dental benefits explained “I have a really difficult time finding a dentist that actually takes you and bills the government. All of them now want you to pay and then get reimbursed ... they prefer to see patients that have the means and the money to get their teeth fixed so they’re automatically paid.”

People often provided estimates of the number of dental offices accepting of patients with public dental benefits, most often referring to provincial benefits provided to individuals receiving social assistance. The following comments from dentists provide assessments of the availability of dental practices for people with public benefits;

“In the Valley, I think there are about four offices that will take Ministry patients.”

“Most dentists ... a lot don’t even accept social services because they, you now, they pay so little.”

“We’ll see emergencies or something like that, but just for routine care, I don’t. It becomes prohibitive.”

Health and social service providers assessed the availability of dental care services for the vulnerable populations they work with as follows:

“The number one barrier here is that there are not many dentists that work at income assistance rates. I think there is only two. So people on income assistance don’t have easy access to it.”

“There are only a few dentists in the community that do dental services at the Ministry rates.”

“There’s one dentist in town that agrees to do some work periodically without charging over the fee schedule that welfare will pay. But, of course, he would be inundated if he did it for everybody.”

“There might be one dentist in town who will do the work for the rates provided by the provincial government, and the rest will charge on top, and if you are on income assistance you can’t possibly pay the on-top piece.

“There isn’t any, okay? Basically there is none, period. I don’t know of any dentists who take people who can’t afford to pay because they are on income assistance and they can’t even pay for food – those are my clients.”

“There’s not one single dentist in Campbell River who will do that, nor is there a dentist who will take payments on the balance.”

“I see my clients and they are in pain and they can’t even afford to have all of their teeth extracted. There’s nobody to do it, there’s nobody in our communities.”
For some low-income residents, access to dental care is denied due to outstanding debts to dental offices – a situation that is detrimental to both the patient and the provider and which was mentioned repeatedly. In one example, a man in his 60’s received upper dentures two years ago but has been living with no bottom teeth or dentures since. He explains his upper dentures were mostly paid through his disability benefits but he also had to pay a portion of the costs “and I still owe that denturist $300 and I need, bottom ones, right? I can’t go back to her or anything till I resolve this payment ... and when you get dentures you’ve got to back and get adjustments and I can’t go back because I owe that money you see and ... they keep falling and moving.” A consequence of bad debts is dentists being less accepting of payment plans, as one woman notes “the dentists don’t do payments anymore, they want the money up front even before they look at you.”

4.3.3 Acceptability

The third dimension of access is concerned with the fit between provider and patient attitudes towards and expectations of each other. This research uncovers considerable evidence that defines the interactions between low-income residents and dental offices, and patient and provider’s beliefs and perceptions about the other. Fear of dentists and dental treatment was also expressed by many low-income respondents as a considerable barrier to accessing dental care. Potential patients expected pain and in some cases blame and humiliation for their dental hygiene which discouraged them from pursuing dental care.

It would appear that the generalizations made about low income patients by dentists and those of dentists by low-income residents, illustrate the tension of private practice businesses’ ability to ensure public access to dental health without financial barriers. One dentist comments that social service agencies in town “tend to paint the dentists ... like we should be guilty because we are not seeing these people.” Another dentist describes how one of the biggest hindrances for a lot of people is they “just don’t show respect for the practice”:

“They are not a great segment of the population and they usually don’t show up for their appointments, they usually don’t call, they are unreliable, and so yeah, a lot of dental offices won’t treat them because they are giving it away. Basically you are doing it at cost and they don’t even show anyway so it’s completely wasted your time and your space.”

On the other hand, some low-income respondents call dentists greedy. As one woman states, “I think they are greedy, you know, and it is very poor people and people like us that have to suffer because of it. If you don’t have the money you can’t get it.” A woman on disability benefits similarly states, dentists are “getting a lot of money you know, surely there’s got to be a little mercy for people that for one reason or another are on the bottom of the rung with income, you know. It would be nice if there was mercy shown.”

Similar comments were stated by health and social service providers;

“Dentists go into dentistry because it is profitable.”
“[Dentistry] was a health profession, right up there with nursing and medical, and now it is becoming a business. It is a down and out, drag them out business, and I don’t like to see that. It really upsets me.”

“Why are they going into dentistry? You know, for the greens fees and fancy homes and summer homes? Or are they going into it to help people?”

When it comes to missed appointments and outstanding debts, there was evidence of dentists showing “mercy” and also evidence of practices that one dentist admits are “fairly ruthless.” Missed appointments, and the consequences of missed appointments were often mentioned as a barrier to accessing care and as a barrier to providing care. As one example, a man in his 50’s has an active addiction and very noticeable dental decay. He relates that he saw the dentist in town that accepts welfare benefits six weeks ago and was assessed as needing considerable work, but then he missed an appointment. “I can’t believe I did not make the third appointment, I’m such an idiot … now I have to come up with eighty bucks … he wants to be paid for that appointment.”

Interviews with health and social service providers give insights into the social determinants of oral health, and specifically of the challenges faced by clientele in keeping appointments. An outreach worker admits “truth is, so many of the people I work with don’t remember appointments, they don’t even remember appointments they make with me.” This worker explains

“If I am not available on a drop-in basis, I would never see anybody because so much of it is about living day to day, getting your immediate needs met … I don’t mean that in a disrespectful way, I’m talking about; am I going to find some food today? Do I have housing today? Like, for many people who are living in poverty it’s a constant state of crisis.”

Several social service workers discussed the challenges in serving clients without phones and those who are couch surfing, inadequately housed or homeless;

“The majority of my clients are not able to follow through with going to an appointment, so you know, if they have major work to be done and its over six or seven appointments – there’s no way its going to happen. I work with mostly addicted people and people with mental health issues, so that says it all right there. Major issues for dentists to try and work with that population.”

“The vast majority of my clients do not have a telephone … they make appointments with all good intentions but it could be six weeks down the road... The whole system is built on assumptions that everyone is the very organized sort of middle class lifestyle where we have phones, and day timers, and palm pilots and things like that.”

“The way they present dental offices .... They’re not very accessible places. They’re worse than doctor’s offices in my own personal experience. They’re stuffier, and you know, everybody from receptionists to everybody’s outfits are perfect. I mean it’s just they make a lot of money so they
usually look really nice and you send in one of my guys in there – messes up the whole atmosphere, right?”

Acceptability (as a dimension of access) includes patient’s willingness to receive care. This research documents that a considerable barrier to accessing care for this population is fear and anxiety.

“My biggest barriers are ‘fear and money.’

“Dentists scare the hell out of me because of what I went through as a kid, so that’s it. And plus, financially I could never afford to go see a dentist.”

“Who likes to see a dentist … the sound of the tools” explains a woman who says that is one obvious reason for not seeing a dentist, and the other would be not having coverage.

“I got false teeth because I was petrified of dentists, because of bad experiences in the past.”

“I’m very nervous going to the dentist, like I get kind of jumpy.”

“I’m going to be really truthful about this, I’m blatantly scared of dentists. I don’t why, I think it’s from when I was a kid and it’s the needle aspect of it. It’s why it takes me awhile to trust a dentist.”

“I have a really hard time with dentists, I suffer from anxiety … I’ve been kicked out of dentists offices because I’ve been reduced to tears because they were demeaning to me … so to find a dentist who has the patience and who can work with me, that’s my hardest part finding a dentist.”

Perhaps a survey of the general population would uncover similar levels of fear and its role in not accessing dental care, or perhaps the low-income population interviewed in this research project have higher levels of fears, anxiety, trauma and related mental health issues. The fact that many people are not accessing dental care due to fear was verified with comments from both dentists and health and social service providers.

4.4 Current Responses

This research sought to assess what current responses possibly exist in Campbell River and Courtenay-Comox to enable access to dental care for low-income and vulnerable populations. The most frequent response to this inquiry was that there was no known resource for people who sought dental care but faced financial challenges to afford treatment. While there may not be a designated service to enable access to dental care, there is indeed evidence of responses that are assisting individuals in need.

4.4.1 Public dental benefits

The majority of low-income respondents in this research are individuals with public dental plans and most of the respondents have a history of accessing dental care – even if only for emergency treatment.
Amongst the evidence of barriers there is also evidence that people who have public dental benefits are able to access care when needed.

A young woman with NIHB coverage, announced, “my dental care has actually been pretty easy for me because whenever I had a problem I’d just go to a dentist and just show my Status Card and book an appointment.”

A middle-age man had no dental coverage and was not accessing care while employed, but five years ago had a work related back injury and has been in receipt of Disability Benefits for several years. He has experienced ongoing dental pain and is thankful for now having public dental benefits which he is maximizing. He used his maximum benefits almost two years ago and he has been waiting to be eligible again for benefits to complete the work.

4.4.2 Compassionate dentists

Several people attributed their success at accessing dental care to a compassionate dentist. Dentists do provide treatment to individuals in need and with public benefits, and there is recognition that dentists do not disclose this fact out of fear of being inundated with requests for services as the need would overwhelm a single dental practice.

4.4.3 Funding from non-profits

In recognition of the considerable dental costs faced by clients, some non-profits are utilizing their programming funds to cover costs when possible – although infrequently and without capacity to be sustainable. As one explained, “because it is run by volunteers and because it’s limited funding, it’s hard when the procedures are really expensive … so things like dentures we can’t cover but if it was an extraction or a small bill of under a hundred dollars, we could sometimes cover that.” A separate agency notes how they use donations to assist clients in need of transportation, a damage deposit for housing, or clothing for work, “We do a lot of that, but we simply can’t fund dental because it is so expensive.”

In more than one interview it was learned that agencies use emergency food budgets to assist people to get out of dental pain and enable healthy eating. There were also references to seeking funds from service clubs to offset dental bills, notably the considerable expenses of dentures. Social service providers on two occasions mentioned attempts to establish dental access funds, dedicated to fundraising and distributing funds to offset dental costs, but these attempts were unsuccessful.

4.4.4 Dental advocacy

There were numerous examples of how health and social service providers play a critical role in assisting individuals in accessing dental care by; advocating for their needs to the Ministry or to a local dentist, facilitating making and keeping appointments and general social supports through the process.
“We’ve advocated on behalf of people in crisis situations a number of times where we’ve called dentists and said hey, look, I’ve got a guy in my office right now; does he have any outstanding bills with you and they’ll tell us. And then on the odd occasion we’ve actually helped to clear like a thirty, forty dollar bill so that the dentist would do the work because sometimes the problem is outstanding bills. They won’t touch their teeth because they’re like you owe me thirty bucks. It’s like okay, so we’ll clear that up and send them in.”

4.4.5 Soft food supplies

Several social service providers serving low-income populations with food programs mentioned ensuring that soft foods are made available for clients with no teeth, or having difficulties chewing firm foods.

“At our Drop-In I provide food that people who don’t have teeth can eat, you know, yogurt, bananas, stone wheat thins with cream cheese is quite popular. I guess you can sort of manage to get that down even if your teeth aren’t great. And soups, we put on a really hearty soup for each of the lunches. We really have to think in terms of what people can actually manage to eat if they’ve got bad teeth.”

4.5 Possible responses

This research sought opinions on possible responses to enable access to dental care services for low-income residents in Campbell River and Courtenay-Comox. These questions were very exploratory. The results provide views on whether responses are warranted considering the perceived needs and the size of the communities and what are the possible responses to explore.

4.5.1 Improved Public Dental Benefits

There appears to be a consensus among patients and providers that improving public dental plans – Ministry dental plans for those on social assistance, Healthy Kids and federal NIHB – would significantly improve access for those with benefits. The most frequent recommendation (regardless of being a patient or provider) was for a resolution to the disparity between the fee guides used by the Ministry and by dentists in BC. Separate, but very related, was the recommendation for improvements to the established treatment limits enforced by the Ministry to better allow completion of dentists’ recommended treatment plans. The primary recommendation to improve access for residents with federal NIHB benefits was a resolution to the pre-authorization process for the billing of recommended treatment – a process that was perceived to hinder access to immediate treatment and put payment for completed work in jeopardy. Finally, both dentists and patients observed that the best way to improve access is to treat dental care like healthcare – the more a visit to the dentist could be like a visit to the doctor the better.

“If the fee guide were to become more in line with what economic realities are. If the limits were raised and if the paperwork were made less onerous... I really think if the fee guide were to
become more realistic – it would have to be much more realistic – I think a lot of the financial barriers would be reduced.” [dentist]

“I think all of the solutions are with the government ... the government is quite happy to ... pay the eighty percent and those people don’t have the other twenty percent. So yeah, you dentists you suck it up. Like, nobody can afford that.” [dentist]

“Getting basic healthcare, much like going to the physician. I think that for some disadvantaged people, at least the basics need to be covered. Not that it needs to be crowns or bridges or things along those lines, but if the fillings could be covered ... you know, forget the limits just allow them to get their dental work and maybe every three years get it done again.” [dentist]

“It’s a growing problem and if the government doesn’t do something soon it’s going to be huge. And I think they’ve just got to realize, the bottom line is dentistry. The mouth is part of the body and dentistry is part of healthcare.” [dentist]

“The basics should be covered. I don’t know what the difference is between having an abscessed tooth or an abscessed finger ... you know you are in pain, you have an infection, exactly the same thing ... If someone is in pain the government should pick up the cost to get them out of pain if they cannot afford it or have a dental plan or whatever the reason.” [dentist]

“What I think would cure this whole issue is if the government invoked a dental services plan like they have a Medical Services Plan for every citizen that covers medical and dental work. That’s what I think should happen carte blanche.” [healthcare provider]

4.5.2 Coordinated dental volunteerism

There were recommendations to develop the capacity for a coordinated volunteer dental program. If several dental offices agreed to take on a defined number of patients there could be less risk of one office being flooded with requests for assistance. The idea was promoted as better utilizing our existing dental capacity rather than establishing a new service.

“Even if six dentists in town ... giving one day a month. That could sure help the community.” [dentist]

“I’m not aware of any pro-bono program in Campbell River that’s ever existed and I believe dentists need to do what lawyers do.” [healthcare provider]

“Maybe they could come up with some kind of thing where dentists would give a certain amount of time. Just sort of spread it out so every dentist was doing some of it, enough so that they could pick up some of the work for some of these people who have actually nothing.” [social service provider]
“We would sustain a dental clinic … I think if we built it they would come, but at the same time more of my thoughts have circled around with what we could do with our existing dental offices.” [social service provider]

4.5.3 Dental Access Assistance

If people lack funds to access dental treatment, the idea of having a fund to provide to people in need is an obvious solution. Dental Access funds have been tried in similar sized BC communities in the North Okanagan and the Kootenay Boundary region. The idea is to fundraise, screen potential recipients, and facilitate access with a dental office utilizing the funds from the program to reduce financial barriers. Also, several low-income individuals mentioned the help received from existing social service providers. Outreach workers, street nurses and others are often advocates for clients and liaise with local dental offices to reduce barriers and sometimes facilitate the client’s attendance to appointments and completing treatment. Due to the known benefits, there were recommendations to expand these services.

“Having someone whose job it is to help coordinate, find the services that the people need ... something like that, a liaison.” [dentist]

“I think we could work something out with dentists where as a community agency somehow we brokered the client relationship for them. It’s almost like a referral process. I think our dentists in the Valley would probably be actually almost excited about that ... I mean, it’s the Valley. Most people here have a heart, you know it’s not, they’re not just in dental to make a pile of money or they’d move to a big city and make way more, right?” [social service provider]

4.6.5 Dental Clinic

Low-income respondents were asked for their positive or negative comments regarding establishing a non-profit dental clinic in the community or a dental van service. The results of these basic questions was overall positive, however, lacking any details or depth to the responses. From dentists and other service providers there was some interesting input. Generally, there was a perception that the need in the communities justified such a response. Some people thought a part-time service could be appropriate while others estimated the demand to warrant a full-time service. Visions of a non-profit dental clinic varied. Some respondents assumed the more volunteer-charitable model of clinic that exists in many BC communities, others assumed a staffed clinic such as the Victoria Cool Aid Dental Clinic that several respondents were aware of because it exists within VIHA. Locations that were suggested included, integrated within a hospital, included in long-term care facilities, integrated within a VIHA primary care setting, or stand-alone site. The greater benefit of a non-profit clinic is its ability to more fully address the social determinants of oral health, not only the financial barrier but also the other challenges noted in this research such as missed appointments, mental health issues and active addictions. There was more curiosity rather than opinions about a mobile dental service, generally because no such (non-profit) service currently exists in the province and there is little knowledge available to inform opinions.
“You know there are a lot of dentists who are retiring that might be willing to do ... a couple of days a month or something like that. Where’s there no overhead, kind of a minimal fee to have his services taken care of, but you know, it’s for the day and it doesn’t matter what he does.” [dentist]

“Oh, there’s enough need, but you haven’t got a large enough pool [of dentists] ... try to find enough dentists who can take the time out of their practices ... Its your staffing of them that’s going to be a problem, the cost of setting them up.” [dentist]

“So what I propose, so what the government should do is take the initiative and put a little room in all of these long-term care facilities.” [dentist]

“If we have a new hospital built it should have a dentistry room ... if the hospital had a basic room where you could just treat people. You know, they have a big abscess, big toothache but they are not going to the private dental office number one because most of them won’t accept their coverage, right? So if it were done in hospital, you know, there’s no overhead ... I think dentists would be more likely to ... you’re only getting a fraction of the fee but you don’t have any overhead to pay you’re just getting that fee. It would be profitable, the dentists would be willing to do it because it’s not costing them money and that’s pretty good care.” [dentist]

“I think of the Reach Clinic in Vancouver where dentistry is included. You have this sort of basic clinic for people who are, you know, marginalized and you can do basic care.” [dentist]

“A resident dentist in the hospital might be a good idea. Somebody to help these people. Like a dental clinic set-up in a hospital and then somehow access Medicare through that.” [healthcare provider]

“I think dental therapists are a really good solution.” [healthcare provider]
5. DISCUSSION

This study explores issues of access to dental care services for low-income adults in the North Vancouver Island communities of Campbell River and Courtenay-Comox. The results from the analysis of existing statistics and the original qualitative research in the communities provides evidence illustrating the complex barriers to accessing necessary dental care when living on a low-income. In this section of the report, these findings are discussed in relation to the existing literature on the topic. The discussion covers the issues of impacts, the three dimensions of access, and the four possible responses raised by research participants.

5.1 Accessing alternative care

This research uncovered evidence of people not accessing dental care for dental pain and infection, but rather turning to publically funded health care services or self-care strategies to manage unmet dental needs. These findings echo similar findings from a provincial study by the author where evidence from communities in all health regions in BC reported that adults who were unable to afford dental treatment were instead utilizing Emergency Department and primary health care services (Wallace, 2008).

There is ongoing evidence that those facing barriers to accessing dental care utilize various self-care strategies in response to toothache. Reports from both Canada and the US document evidence of self-medication (Bedos et al., 2003; Bedos et al., 2005) and self-treatment, specifically extracting a tooth using pliers (Bedos et al., 2003). Bedos et al. (2003) in Montreal have documented that welfare recipients with public dental benefits often seek relief for dental pain through over-the-counter analgesics rather than consult a dentist. An American study of low-income persons used pain medications as well as self-extractions and extractions performed by non-dentists, and noted that self-extractions may be more prevalent than previously realized (Cohen et al., 2007).

There are also Canadian and American reports on the use of Emergency departments for dental problems when faced with barriers to accessing care from dentists. A study of emergency department use in Ontario found that visits for non-traumatic dental problems can be significant, and typically due to dental abscesses, toothaches and caries. Findings indicate that the level of care for dental problems in emergency departments is inadequate, mostly involving little more than symptomatic advice or prescriptions for antibiotics and painkillers without addressing the source of the problem (Quinonez, Gibson, Jokovic, & Locker, 2009). Similarly, an American study (Cohen et al., 2009) also found people seeking relief from non-dentists including hospital emergency departments. This study reports that these attempts at self-care and alternative care appear to play a palliative role until care from a dentist is possible. In other words, the process of self-care is typically followed by visits to dentists when pain levels increase and self-care alternatives ineffective (Cohen et al., 2009).

5.2 Dimensions of Access

This research documents the complex, multi-dimensional barriers to access to care faced by both low-income patients and providers. Using the framework provided by McIntyre, Thiede and Birch (2009), the
research illustrated the poor fit between private practice dentistry and the public oral health needs of low-income residents of Campbell River and Courtenay-Comox. Overall, the research heard from both dentists and low-income patients that the current service delivery model and payment options are not working well for either party and that while respondents overwhelmingly consider affordability (financial access) to be the predominant barrier to accessing care, the related issues of availability (physical access) and acceptability (cultural access) must also be addressed if access is to be improved.

5.2.1 Affordability

There is a strong link between socio-economic status and health, and an abundance of evidence linking low-income with poor oral health in Canada (Lawrence & Leake, 2001; Locker, 2000; MacEntee et al., 2001). Those with lowest incomes have the most oral disease yet face the highest barriers to accessing dental care (Asadoorian, 2008). There exists a socioeconomic gradient in the use of dental services (Bhatti, Rana, & Grootendorst, 2007) with less affluent, uninsured Canadians much less likely to receive regular dental care than higher income residents of the country (Millar & Locker, 1999). This represents a clear example of the inverse care law, with those most needing care being the least likely to receive it (Leake, 2006).

Affordability of dental treatment costs is relative to income and there is ongoing research illustrating the concept of competing priorities and how people are forced to make difficult choice between basic needs such as housing and food and their health care needs (Reid, Vittinghoff, & Kushel, 2008). People experiencing homelessness and other vulnerable groups face a range of critical needs such as food, shelter, safety and access to income sources. Therefore, dental care is probably not a priority for people without a home (Daiski, 2007; De Palma & Nordenram, 2005; Gelberg, Lin, & Rosenberg, 2008).

Recent Canadian studies (Muirhead et al., 2009a; Muirhead et al., 2009b) explored disparities in oral health status and access for the working poor population that experience food insecurities. Using population health and income statistics, one study showed that the cost of dental care was a competing financial demand for food-insecure working poor persons who would use their food budget to pay for needed dental care. Based on the results of the study, the authors conclude:

"We suggest that improving access to dental care without addressing income insecurity or examining the types of dental services offered and the relationship between dentists and marginalized individuals may have limited effect (2009:303)."

The other study similarly sought to identify the complexity of barriers faced by working poor persons to access dental treatment, with a goal of informing effective oral health service planning and social-policy making. The results of this telephone survey of working poor Canadians again found accessing dental services required relinquishing spending on other goods and services “which suggests that dental care utilization is a competing financial demand for economically constrained adults (2009:199).” The researchers recommend alternative models of dental care services such as dental clinics within community health centres could better serve the working poor who are faced with competing financial needs.
5.2.2 Availability

Results from this study in Campbell River and Courtenay-Comox do not indicate significant barriers due to a shortage of dentists, wait times, transportation issues, or the physical location of dental practices throughout the communities. While these factors may exist, they were not identified by participants as predominant barriers. However, availability of dental care was noted as a significant factor by both patients and providers due to reports of extremely limited numbers of dentists known to be accepting of patients with public benefits or those with inadequate funds to afford anticipated dental costs. A major reason why public dental benefits do not guarantee access to dental treatment is the reluctance or refusal of dentists in private practice to accept patients with public benefits. Such conclusions have been made in both Canada (Birch & Anderson, 2005) and in the United States (Patrick et al., 2006).

In other studies, beneficiaries with public dental benefits often attribute their low rate of dental service use to the difficulty of finding dentists who will accept them (Greenberg, Kumar, & Stevenson, 2008). At the same time, dentists cite low reimbursement rates, excessive paperwork, billing and administrative complexities and requirements, patients’ not keeping scheduled appointments, and patients’ poor awareness of the importance of oral health as reasons for their reluctance to accept patients with public dental benefits (Greenberg et al., 2008) (Patrick et al., 2006) (Quiñonez, Figueiredo, & Locker, 2009). A survey of Canadian dentists found that they support governmental spending for publically insured populations, however, relatively few of them actually see patients who are eligible for publically-supported dental benefits (Quiñonez et al., 2009).

Dentists’ reluctance to accept vulnerable patients with complex social needs is not just due to misconceptions or unfair stereotypes, but also to a realistic awareness of the challenges in providing appropriate care to a population facing multiple barriers and who also pose considerable financial risks to dentists in private practice. Patients with mental health or substance abuse problems can be very unpredictable and disruptive to the a private dental practice (Allukian, 1995; Clarke, Locker, Murray, & Payne, 1996; De Palma & Nordenram, 2005; Falvo, 2009; Lee, Gaetz, & Goettler, 1994; McCormack & MacIntosh, 2001; Pizem, Massicotte, Vincent, & Barolet, 1994). Consequently, patients who present with these potentially disruptive tendencies tend to be stigmatized and shunned by dentists and other healthcare providers in private practices (De Palma & Nordenram, 2005; Frankish, Hwang, & Quantz, 2005; Hwang, 2001; Hwang, 2002; Moore, Gerdtz, & Manias, 2007).

5.2.3 Acceptability

Clearly there is a wide gulf between people who live in great poverty and the dental care system offered to them (Bedos et al., 2003). People experiencing poverty and social exclusion frequently distrust the unrealistic expectations of some healthcare professionals (Daiski, 2007; Frankish et al., 2005; Han, Wells, & Taylor, 2003). They can hold very critical opinions about dentists, who they see as rich and unsympathetic people at the opposite end of the social scale who are motivated more by money than by their patients’ health (Bedos et al., 2003). Considerable misconceptions and negative stereotypes are also often held by dental care providers towards people living on welfare (Levesque et al., 2009).
A survey of working poor in Canada indicated that increasing access to dental care has little effect unless the relationship between dentists and patients with low incomes are enhanced (Muirhead, Quiñonez et al., 2009). A study with welfare recipients in Quebec (Bedos et al., 2003) uncovered significant financial barriers to access due to inadequate of public dental coverage, and also acceptability barriers as low-income participants related feelings of rejection and stigmatization resulting in a culture of rejection. These findings, are not unlike similar findings from research focused on low-income Canadian’s accessing physician care (Loignon et al., 2010) and other health care providers (Williamson et al., 2006).

Researchers in Montreal have explored how people on social assistance feel powerless to improve their oral health and that perception of oral health plays a considerable role in when and how disadvantaged populations use dental services (Bedos, Levine, & Brodeur, 2009). These researchers conclude:

“Contrary to common belief, people on social assistance care about their oral health and appearance. The profession should be responsive to these concerns, adopting a patient-centered approach to find a common ground when planning treatment. At a population level, we urge the dental profession to increase efforts toward improving access to dental services for people on social assistance (2009:657)”

This cultural gap between private practice dentistry and populations experiencing poverty is one factor defining acceptability. Another factor is patients’ perception of dental needs, their self-esteem and their own beliefs and perceptions of when dental access is necessary. Previous research documents that nonusers perceive no need for dental care (Guay, 2004), a finding that often leads to a call for dental education.

This current research documents how fear of dental treatment plays a considerable contributing role in the decision to access or afford dental care. This finding resembles results from Montreal research with individuals on public assistance (Bedos et al., 2005);

“When tooth pain occurs, person’s receiving public assistance perceived a need for professional treatment but preferred to wait and suffer because of their fear of pain during dental treatments and their reluctance to undertake certain treatments. To improve access to dental care among persons receiving public assistance, it is important to change their dental nosological models and help them reduce dental anxiety (2005:134)3.”

There appears to be a high level of dental anxiety within the homeless population which has been attributed to the higher levels of psychological distress and trauma (Collins & Freeman, 2007; British Dental Association, 2003).

5.3 Potential responses

There is considerably more research published documenting oral health disparities and inequitable access to dental care than there is research informing potential policies and practices to address these realities. The interviews in Campbell River and Courtenay-Comox generated ideas and reactions to
potential responses that could respond to the potential local unmet needs. Literature informing these four main priorities for action is presented here.

5.3.1 Improve public dental benefits

In Canada, there are publicly funded dental benefit programs for specific populations, such as welfare recipients, children, and Aboriginal peoples. Approximately four percent of Canadians use public dental benefits when paying for dental treatment (Muirhead et al., 2009). In BC, as in other provinces, these public dental benefits have been criticized as overly restrictive, burdened by red tape and based on payment fees significantly below the fees received by dentists in private practice. Improving public dental benefits might reduce the financial barriers to accessing dental care by encouraging more dentists to participate in the service (Dharamsi & MacEntee, 2002; Birch & Anderson, 2005; Patrick et al., 2006).

A considerable limitation of public dental benefits has been the continued discrepancy between government dental fees for services and private practice dentistry’s fee guide. With dentists unwilling to treat patients at the rates provided by publicly funded programmes, these policies have limited impact on improving access to care (Leake & Birch, 2008). According to Leake & Birch (2008): “[a] major problem with non-universal systems is that the publicly funded sector is competing with the privately funded sector for the time of providers who work in both. In the absence of any constraints on either prices or the range of services in the private sector, public sector provision may become unattractive to providers faced with sufficient private demand for their services (Leake & Birch, 2008).”

Access to insurance can be a very strong predictor of dental service utilization; however, it must be recognized that there are many other determinants of utilization that influence use (Muirhead et al., 2009). A study of financing and delivery of oral health services in several countries stresses that there are so many factors at the individual, environmental, and delivery system levels that affect oral health and that expanding and enhancing public dental benefits alone has been shown to not ensure access (Maas, 2006). Furthermore, improving access does not necessarily improve inequalities in oral health status (Ismail & Sohn, 2001).

Throughout BC, previous research by the author has documented the overwhelming dissatisfaction from both dentists and recipients towards provincial dental benefits who report the benefits are not sufficiently enabling access for these vulnerable populations (Wallace, 2008). The complaints are similar, most frequently that discrepancy between fee guides, and consensus among stakeholders in the recommendation for harmonized fee guides and expanding the scope and limits of treatment options.

5.3.2 Organized Dental Charity

The dental profession is aware that the current service delivery model does not adequately meet the needs of low-income and vulnerable populations (Mouradian, 2006). To fill the gap, the dental profession often promotes charitable dentistry provided by volunteer dentists and staff.
Charitable dentistry in BC takes several forms. As in every profession, dentists routinely provide charitable care to their patients and others. The British Columbia Dental Association (BCDA) has estimated that 78 percent of their member dentists provide some free treatment (Wallace, 2008). The BCDA also organizes an annual Community Dental Day (CDD), described as a volunteer initiative of the dentists of BC designed to meet some of the urgent dental care needs of low-income working adults in British Columbia that are not covered through public or private dental plans (as well as organizing Save a Smile, a charitable program for vulnerable children). Many of the province’s locally organized dental clinics are charitable, volunteer clinics. These are described further in the discussion of community dental clinics as one potential response.

Reviews and evaluations of these responses in both Canada and the U.S. concludes that these are in effect “band-aid solutions” that may be laudable but in fact inadequate to solve dental access problems (Mouradian, 2006; Crall, 2006). Some regard volunteerism and charitable dentistry as important and necessary but insufficient (Garetto & Yoder, 2006). Others have concluded that dentistry’s charitable responses are impractical and inefficient (Benn, 2003). Some go as far as to say that band-aid solutions to the dental access crisis are not morally defensible (Mouradian, 2006). This argument contends that these efforts are provider-driven and not necessarily responsive to patient or population needs. Such solutions, it is argued, maintain the status quo and the idea that dental volunteer efforts by the dental profession are all that is required.

Overall, there is recognition that access to dental care should not and cannot be adequately met by dentists volunteering or donating services as the needs are too big and the issues too complex for a charitable response (Crall, 2006). For example, the British Dental Association, firmly states that charitable dentistry by unpaid volunteers “is clearly no substitute for a coherent and properly-funded dental access strategy for homeless people” and adds “that homeless people, just as much as any other section of the community, are entitled to adequate and accessible dental care as a right, and should not be forced to rely on charity (British Dental Association, 2003:37).”

These arguments generally advocate a “justice not charity” response to the access to care situation. Policy change is required to improve access to dental care for the poor and dentistry needs to take political and professional leadership to influence policy makers, the public and politicians (Garetto & Yoder, 2006; Smith, 2006). Lawrence and Leake (2001) describe how the dental profession in this country can be influential in ensuring oral health is seen as integral to general health and to develop the necessary policy changes and the private-public partnerships that would remove barriers to care (Lawrence & Leake, 2001).

### 5.3.3 Dental access assistance

There were reports of individuals in Campbell River and Courtenay-Comox of successfully overcoming barriers to accessing dental care due to the support of an advocate and/or the support of a cash donation from a non-profit agency. Based on these experiences and the knowledge of programs in other
BC communities, there were several recommendations to develop dental access funds and support
dental advocates.

Dental Access Funds have been pursued in a few BC communities and documented in a 2008 report by
the author (Wallace, 2008). Dental access funds are programs designed to provide funds to subsidize the
costs of accessing dental treatment in the private practice setting. The programs are based on the
premise that if people are facing financial barriers to accessing dental care a solution is to raise money
and give it to those in need. Funds are raised through charitable fundraising, a process that also raises
awareness of dental access and oral health issues in the broader community. The facilitators of
Kootenay’s Dental Access Fund consider this to be a good rural model of a community-based response
to the financial barriers to accessing care, as people access care in willing dental offices in their own
area. The Vernon Dental Access program operated for about seven years but volunteers decided to end
the program in 2009 in recognition that the needs far outstripped the capacity of the program’s finances
and the volunteerism available in the area. In the year before it closed the volunteer-charitable program
enable access to $27,000 in free emergency dental work for low-income residents in the North
Okanagan. The volunteers seek to continue their efforts by seeking funding to develop and operate a
staffed community dental clinic.

The provincial study from 2008 notes the many benefits to dental access funds. They can address rural
transportation barriers by enabling individuals to access treatment from a clinician in their geographic
area, rather than requiring patients to travel to a fixed-site clinic; they are cost-effective compared to
establishing a dental clinic; they provide a liaison, advocacy and support to facilitate screening and
eligibility, access to willing dentists and better ensure completion of treatment plans. The primary
limitation for these initiatives is that the needs overwhelm the amount of funds raised through
fundraising efforts. Other limitations have been the recognition that programs require significant human
resources for the fundraising, screening, recruitment of dentists etc, and therefore a paid staff position
can be more realistic than ongoing coordination by volunteers. A dental access fund also requires
dentists, and a certain proportion of an area’s dentist to prevent burnout if only a few offices
participate. Finally, the provincial review notes that a dental access fund “does not really address the
root causes of the problem and is really a bandaid.” Dental access funds focus on individual solutions,
helping one person at a time rather than making collective changes that would benefit entire
populations. Because the greatest limitation of these programs appears to be the limits of donated
funds, expansion of these programs could be facilitated by consistent government grants, with funds
allocated to patients as well as financial resources to administer the program.

5.3.4 Community Dental Clinics

Concerned individuals and community groups witnessing the despair of individuals with untreated
dental pain and infection are beginning to address the problem through community dental clinics
(Leake, 2005; Melanson, 2008; Wallace, 2008). Indeed, social welfare groups in Canada prefer to see
governments invest financially in the direct delivery of dental care to vulnerable groups through
community clinics rather than through private dental practice (Quiñonez, Figueiredo, Azarpazhooh, & Locker, 2010).

Communities are attempting to address unmet dental needs by means of available resources, although with little or no funding available, they are often dependent on the charity of volunteers. Community-based responses are often the result of a “dental champion” (MacEntee, Thorne, & Kazanjian, 1999; Melanson, 2008; Thorne, Kazanjian, & MacEntee, 2001) who facilitates the necessary collaboration between willing dental professionals and community partners, including a non-profit host agency.

The initiatives generally develop locally and independently of similar experiences elsewhere. At the most basic, some seek to set-up a dental operatory in a low-cost space with volunteers willing and able to provide emergency care for a few hours a month. Others have budgets that allow a full-time paid staff, several dental operatories, and a range of preventive and restorative treatments. However, the financial risks increase as the services expand because they must rely on relatively low fees for services (Wallace, 2009).

The literature on community dental clinics in Canada and the US confirms that they can provide unique and valuable roles as a source of dental care to groups with traditional access barriers (Byck, Cooksey, & Russinof, 2005). Indeed, they have been deemed by some as a “mandatory” health service due to the shortcomings of the existing dental care delivery system and the overwhelming unmet dental health needs of the underserved (Slott, 2005).

Recognizing the limited evidence available about community dental clinics in Canada (Allison, Allington, & Stern, 2004; Wallace, 2008) over the last several years the author has undertook a research program that seeks evidence to inform policy and community-based practice. A provincial scan of community-based dental programs confirms that in every region of the province, people are responding to public oral health needs by organizing locally to create community-based dental care programs. In recent years these community-by-community types of responses have increased dramatically. Since 2001, it is estimated that there has been at least one new community dental clinic established in BC per year (Wallace, 2008).

The community dental clinics in BC can be described as (1) student teaching clinics; (2) charitable-volunteer dental clinics, and (3) non-profit dental clinics.

**Teaching clinics:** In cities with dental schools and teaching clinics for students of dentistry, dental hygiene and dental assisting, there is opportunity for oral healthcare from the students at a reduced fee. Dental schools across Canada offer their students experience in community service-learning (Brothwell, 2008; Brondani, *et al.*, 2008) including the University of BC which operates an on-campus teaching clinic that includes patients facing barriers to accessing private dental care, and the residency program at UBC rotates dentists through various community dental clinics throughout the province. Schools with programs for Dental Hygienists and Certified Dental Assistants also run clinics on campuses in several BC communities. These clinics generally offer preventive dental services at costs somewhat below the standard fee guide. Because of the teaching mandate of these clinics, the appointments can take longer
than treatment in a private practice. Also, some teaching clinics can require some reduced-fees for service from patients which can be a barrier or deterrent to some low-income people.

**Charitable-volunteer dental clinics:** There is significant variation in the services provided by these programs, but in most the mandate is restricted to “relief of pain and infection” typically by extracting teeth. Examples of volunteer clinics in BC include, the Vancouver’s East Side Walk-In Dental Clinic which opened its doors in 2005 with a mandate to provide relief of pain and infection free of financial cost to the population of Vancouver’s Downtown Eastside. The Kelowna Gospel Mission was established in 2004 as a free dental clinic, and in 2006 in Prince George a free dental clinic was established and operates with volunteers several evenings a month to relieve dental pain. More and more low-income British Columbians are now accessing free dental care from volunteers through these clinics.

The growth of these clinics in the province has undoubtedly enabled access to emergency dental care for low-income residents. The clinics generally operate minimal hours (a few evenings or days a month), and located within a host non-profit agency, and benefit from a paid administrator position. Concerns exist that the limitations of the services offered by most of them – usually to relieve pain - could become the basic and “legitimate” level of care for lower-income and vulnerable populations, although once established many clinics seek to expand services when fiscally possible to facilitate access to dentures for patients whom have had all of their teeth removed at the clinic.

**Non-profit dental clinics:** These community dental clinics resemble Community Health Centres (CHCs) and are often part of these integrated healthcare settings. A recent case study (Wallace, 2009) of five such clinics in BC defined them as community dental clinics that provide oral health treatment beyond pain relief and treatment of infection, including basic diagnostic, preventive, restorative, and periodontal services at a standard of care equivalent to private dental practice in the province. Three of the clinics were ‘social enterprise clinics’ because they do not receive annual government funding, rely totally on fees for services, and therefore must ensure that their mix of patients includes patients who pay full fees through employer dental plans or other private dental insurance. There were also two ‘subsidized clinics’ that depend on receiving reduced fees from patients but also receive an annual subsidy from regional health authorities to supplement the revenue from patients.

A defining characteristic of these dental clinics is their integration with other health and social services and their commitment to addressing oral health as a part of overall health and well-being. The clinics are designed to address not only the financial barriers but also the complex patient-related factors that can be challenging for private practice dentistry to accommodate. As one example, the clinics report a high rate of missed appointments for treatment; however, there is also high demand for unscheduled emergency treatments. These challenges actually complement each other and the clinics can keep the clinicians very busy despite the broken appointments.

Data from the case study (Wallace, 2009) of these BC community dental clinics provides an overview of the patients, procedures and finances of these services. Compared to private dental practices in BC, the dental clinics serve a unique population, defined by low-incomes and public benefits. At the community
clinics, on average, half of the patients have dental benefits through welfare when in comparison, less than 2 percent of patients in private practices are those receiving welfare dental benefits.

### Table 9: Distribution of dental benefits in community clinics and private practices in BC

<table>
<thead>
<tr>
<th>Source</th>
<th>Community clinics</th>
<th>Private practices*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welfare Dental Benefits</td>
<td>51%</td>
<td>2%</td>
</tr>
<tr>
<td>No benefits</td>
<td>30%</td>
<td>24%</td>
</tr>
<tr>
<td>NIHB Benefits</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Private Insurance (and other)</td>
<td>23%</td>
<td>73%</td>
</tr>
</tbody>
</table>


Data from the case study also indicates that these community dental clinics are providing a full range of diagnostic and restorative services as would be provided in private practices. In other words, their mandate clearly exceeds emergency, relief of pain treatments.

### Table 10: Distribution of dental services in community clinics and private practices

<table>
<thead>
<tr>
<th>Services</th>
<th>Community clinics</th>
<th>Private practice*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>29%</td>
<td>31%</td>
</tr>
<tr>
<td>Prevention</td>
<td>33%</td>
<td>45%</td>
</tr>
<tr>
<td>Restorations</td>
<td>19%</td>
<td>13%</td>
</tr>
<tr>
<td>Periodontics</td>
<td>8%</td>
<td>1%</td>
</tr>
<tr>
<td>Surgery</td>
<td>8%</td>
<td>2%</td>
</tr>
<tr>
<td>Other procedures</td>
<td>3%</td>
<td>9%</td>
</tr>
</tbody>
</table>


While there are many obvious benefits to establishing and operating a community dental clinic that employ paid dental professionals to provide basic dental care to economically vulnerable patients, there are equally obvious questions about the operating costs and revenue sources to afford these services. Compared to volunteer-charitable clinics and dental access funds, these clinics have considerable operational costs and present a financial risk to the non-profit agencies.

In total, the five clinics in the case study have 21 clinical operatories which are staffed by the full-time equivalents of approximately ten dentists, five dental hygienists, 13 certified dental assistants, eight reception staff, as well as managerial and administrative staff support. The case study reports that in a single year (2007/08) there were approximately 23,000 patient visits to the five clinics, and patients
received over 64,000 dental treatments. The combined value of the dental services provided is estimated at $4 million annually.

Revenues for the five clinics was based on two primary models; the two subsidized clinics received approximately 25% of their funding from an annual subsidy from a health authority which allows the clinics to treat patients exclusively with financial barriers to care. The three clinics without annual government subsidy relied almost completely on patient fees supplemented by fundraising or grants. Without government support, community dental clinics require considerable revenue from patients with private dental plans paying full fees for service. The greater reliance on revenues from these patients results in reduced services for those patients requiring subsidized fees.

The case study research provides evidence from these existing clinics to inform communities and government on the potential to expand these services to other areas of the province. The existing clinics are effectively providing dental care at reduced fees to underserved populations; however the services are financially vulnerable.

A typical 3-chair community dental clinic can be expected to provide approximately $500,000 in dental care. The clinic could provide an estimated 3,000 patient visits, and patients would receive about 7,000 dental treatment. The clinics would benefit from annual subsidies from government, without the subsidies they must treat patients who can pay full fees, which detracts from their primary focus on the vulnerable members of society at reduced fees. An annual subsidy of $250,000 allows clinics to dedicate services to underserved patients requiring reduced fees-for-service. The outcome is a $1 investment providing $2 in dental treatment to patients without dental plans or to those with public benefits.
6. Conclusion

The objective of this research was to investigate access to dental care issues and possible barriers for low-income adults in the North Vancouver Island communities of Campbell River and Courtenay-Comox. The findings present the perspectives and experiences of low-income people, local dentists and health and social service providers as well as current population health and income data for the region.

The evidence from the existing statistics and the original qualitative research illustrates the complex barriers to accessing necessary dental care when living on a low-income and also the challenges expressed by dental professionals ensuring the public oral needs of the population are fulfilled within the constraints of the current private practice model of dentistry.

Examining the multiple dimensions of access, specifically, affordability, availability and acceptability, the research documents the poor fit between private practice dentistry and the public oral health needs of many low-income residents. Availability of dental care was noted as a significant factor by both patients and providers due to limited numbers of dental professionals known to be unconditionally accepting of patients with public benefits or those with inadequate funds to fully afford anticipated dental costs. There appears to be consensus among patients and providers that improving public dental plans would significantly improve access for those with benefits.

Beyond, affordability there is some evidence of a cultural gap between private practice dentistry and populations experiencing poverty, with negative stereotypes, deep fears and real challenges expressed. Dentists express the challenges of missed appointments and social and health service providers explain the social determinants that can contribute to poor oral health as well as the frequency of missed appointments. The research notes that fear of dental treatment plays a considerable contributing role in the decision to access dental care.

Overall, the findings from these North Vancouver Island communities are not unique to evidence from throughout British Columbia and elsewhere. Rather, the research provides a local example of the oral health inequities known to prevail in Canada. These inequities of access, utilization and outcomes linked to income are well-documented elsewhere and local substantiated in this report.

This research also documents that while the needs in Campbell River and Courtenay-Comox may reflect the inequities found elsewhere, there are few or no local resources for people who seek dental care but unable to afford or access treatment. Several options are discussed including improved public dental benefits, coordinated dental volunteerism, dental access assistance and a community dental clinic.

The urgent call for responses to enable access dental care in Campbell River and Courtenay-Comox was repeated by participants in this research. While addressing the financial barriers to affording dental care is paramount, there is a need for responses that simultaneously increase the availability of dental services for the low-income population and ensure services are appropriately delivered to the unique needs of vulnerable populations.
Appendix 1
Map of VIHA and North Island Area
Appendix 2

Methods

Public health dental staff for many years had first-hand experience with low-income people expressing barriers to accessing dental care and living with unmet dental needs in the North Vancouver Island communities of Campbell River and Courtenay-Comox. This research project emerged to further explore the experiences and perspectives of low income people needing dental care in these communities. Ethical approval was provided by the Vancouver Island Health Authority (VIHA) Health Research Ethics Board as well as UBC’s Ethical Review Board. The researcher regularly reported to, and was provided support from, an advisory committee for the project composed of relevant VIHA staff and managers. The project also benefitted from support from UBC Faculty of Dentistry where I am enrolled in Doctorial studies.

The research is based on an inductive analysis of questions posed to low-income people, dentists and health and social service providers to investigate their experiences in related to accessing dental care (Lincoln & Guba, 1985). It is designed to complement available statistics of these issues.

Sampling & Recruitment

Information was gathered from 60 interviews among three cohort groups: people who have experienced difficulty accessing dental care because of financial circumstances (N=41), dentists (N=6) and local health and social service providers (N=13). Interviews took place from November 2009 to February 2010. Selection of participants combined convenience and purposeful techniques based largely on who was available and willing to participate.

Low income participants were recruited indirectly through postings and handbills distributed by email to community social service and health providers, and printed in the regional newspaper. Other social agencies were systematically selected to provide a diversity of communities. From these agencies, two referral sources played a leading role in recruitment – the Comox Nursing Station in Courtenay, and the Island Jade Society in Campbell.

Demographic data for low-income respondents is included in this Appendix. Overall, the sample is fairly evenly divided between the two research communities and an equal number of men and women participated. The participants’ ages range from 21 to 62 and the average age is 45. The sample includes a significant proportion (27%) of individuals who identify as Aboriginal, and all but one responded as Status. The sample is predominantly individuals who receive social assistance benefits. This research under-represents the number of low-income employed residents (i.e. working-poor) however, it should be noted that many of the respondents were recently employed and their dental history reflects both their experiences being employed and unemployed. The majority of respondents (73%) with public dental benefits reflects the similar proportion of respondents receiving some form of social assistance.
Dentists were sent a letter of invitation to participate in the study. The Health Authority maintains a mailing list of general practice dental offices for the region which contained 36 dental offices and listed 50 individual dentists’ names. Six dentists volunteered and were interviewed.

Sampling of key informants was again a mixture of convenience and purposive sampling. In both Campbell River and the Comox Valley, an email invitation for health and social service providers to be interviewed was circulated through existing email lists of social service agencies. From this invite, key informants directly contacted the researcher and interviews were arranged. Follow-up invitations to participate were purposively sent to agencies mid-way to seek out informants from underrepresented sectors. Of the thirteen interviews, six were conducted in Campbell River and seven were conducted in Courtenay-Comox.

When recruiting participants every effort was made to maximize participation and monitor progress to purposefully seek the inclusion of identified categories of respondents. For example, the sampling of experiential participants sought participants who receive social assistance, those with low or no incomes, singles and families, a diversity of ages, a gender balance and individuals identifying as Aboriginal. Sampling of dentists sought to include offices throughout the region being studied, and key informants were sought from agencies throughout the region providing services to distinct groups such as homeless, Aboriginal, women and children, and also by the type of services provided, medical services, income and housing supports, social support and advocacy.

Interviews were semi-structured. The experiential interview guides began with open-ended questions that allowed respondents to tell their experiences and perspectives in their own words. At the end of each interview the respondents were asked a series of close-ended questions that provide basic demographic information as well as standardized oral health information. The interview guides for key informant and dentists interviews were also semi-structured and allowed for interviews to be flexible enough to be relevant for the participants’ experiences and perspectives. All interviews were recorded with a digital voice recorder, and the participants received a small financial token to recognize the value of their time and input, along with a copy of the signed consent forms.

**Data Analysis**

All interviews were transcribed verbatim. NVivo software was used to facilitate data management. Data analysis followed standard techniques for thematic identification and coding (Charmaz, 2000). Initially the data was organized into categories coinciding with the research questions. The researcher then analyzed the data by looking for themes emerging from the data, using an inductive analysis that moves from the particular experiences of the participants to general categories (Lincoln & Guba, 1985). With the emerging themes identified, the text was coded and an iterative coding process undertaken to refine themes. The close-ended questions from the experiential interviews were inputted into Excel and basic descriptive statistics used to present this data.
### Appendix 3

#### Low income Respondents Demographics

<table>
<thead>
<tr>
<th>Low Income Respondents Demographics</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interview Location</strong></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Campbell River</td>
<td>19</td>
<td>46</td>
</tr>
<tr>
<td>Courtenay-Comox</td>
<td>22</td>
<td>54</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>41</td>
<td>100</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>21</td>
<td>51</td>
</tr>
<tr>
<td>Female</td>
<td>20</td>
<td>49</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>41</td>
<td>100</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 to 24</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>25 to 54</td>
<td>28</td>
<td>72</td>
</tr>
<tr>
<td>55 to 64</td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>39</td>
<td>100</td>
</tr>
<tr>
<td><strong>Aboriginal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>11</td>
<td>27</td>
</tr>
<tr>
<td>No</td>
<td>30</td>
<td>73</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>41</td>
<td>100</td>
</tr>
<tr>
<td><strong>Source of Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Job</td>
<td>4</td>
<td>9.8</td>
</tr>
<tr>
<td>Income Assistance - Temp</td>
<td>13</td>
<td>31.7</td>
</tr>
<tr>
<td>Income Assistance - Disability</td>
<td>18</td>
<td>43.9</td>
</tr>
<tr>
<td>Income Assistance - PPMB</td>
<td>2</td>
<td>4.9</td>
</tr>
<tr>
<td>Employment Insurance</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>No Income</td>
<td>3</td>
<td>7.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>41</td>
<td>100</td>
</tr>
<tr>
<td><strong>Insurance for dental expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, government sponsored</td>
<td>30</td>
<td>73.2</td>
</tr>
<tr>
<td>Yes, employer sponsored</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>19.5</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2</td>
<td>4.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>41</td>
<td>100</td>
</tr>
</tbody>
</table>
Appendix 4
An overview of publicly-funded dental services and benefits in BC

This section provides a basic overview of main public dental services and benefits in BC. It is not intended to be comprehensive, and it should be noted that programs frequently change. The program descriptions are as described by the provider. The following programs are outlined in this attachment:

1. Federal Non-Insured Benefits (NIHB)
2. Provincial dental benefits
3. Interim Federal Health Program
4. VIHA dental programs


The NIHB Program provides eligible First Nations and Inuit with a limited range of medically necessary health-related goods and services not provided through private insurance plans, provincial/territorial health or social programs or other publicly funded programs. The dental component of the NIHB Program covers most dental procedures that treat dental disease or the consequences of dental disease including: diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral surgery, orthodontic and adjunctive services. The range of dental services covered by the NIHB Program, includes:

- Diagnostic services such as examinations or radiographs;
- Preventive services such as cleaning, polishing, fluorides and sealants;
- Restorative services such as fillings*;
- Endodontics such as root canal treatments*;
- Periodontal services such as scaling*;
- Prosthodontics including removable dentures*;
- Oral surgery such as simple extractions of teeth*;
- Orthodontics to correct significant irregularities in teeth and jaws (predetermination applies); and
- Adjunctive services such as sedation (predetermination applies).

* Predetermination applies for some dental services within these categories.

Some dental services are not covered under the NIHB Program, such as extensive rehabilitation and cosmetic treatment and some dental services require predetermination prior to the initiation of treatment. Predetermination is a review to determine if the proposed dental services are covered under the Program's criteria, guidelines and policies. During the predetermination process, the NIHB Program reviews the dental services submitted against its established Dental Policy Framework which outlines clear definitions of the types of benefits available to clients.

The NIHB Program Annual Report 2008/2009\(^2\) estimates that in BC there are approximately 121,000 eligible clients and the annual spending on dental benefits totals almost $25 million. The estimated utilization rate for dental benefits in BC is 39% which reflects those clients who received one (claimed) dental service during the fiscal year as a proportion of the total number of eligible clients.

2. **Provincial (BC) Dental Program: BC Ministry of Housing and Social Development (HSD)**

The Province reportedly spends about $43 million on dental services for about 130,000 clients.\(^3\) The utilization rate for programs is considered to be about 40%. Rates paid to dentists only apply to services for eligible clients under the BC Employment and Assistance’s dental program. The Ministry’s fee guide is not updated annually and does not correspond with the dentists’ fee guide and therefore fees paid by the Ministry have been reported to be as high as 80% and as low as 63% of the dentist fee guide.\(^4\) The BC Ministry of Human and Social Development provides public dental benefits that vary according to eligibility. Fact Sheets provided by the Ministry provide some details of these programs.\(^5\)

2.1 **Persons with Disabilities (PWD) and Persons with Persistent Multiple Barriers (PPMB)**

The BC Employment and Assistance Program’s dental program provides basic dental services to income assistance clients who are least likely to become financially independent – Persons with Disabilities (PWD) and Persons with Persistent Multiple Barriers (PPMB). Basic dental plan coverage is provided for PWD and PPMB with a maximum coverage limit of $1000 over two calendar years. Dental

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services beyond annual limits will be covered when emergency services are needed to relieve pain. PWD and PPMB who have a dental condition that cannot be corrected through basic dental services and have a medical condition that prevents the use of a removable denture are also eligible for funding for crown and bridgework. PWD and PPMB are eligible for funding for partial dentures, replacement dentures, or reline/re-base of dentures, based on the ministry’s fee schedule.

2.2 All other Income Assistance clients (ie; those deemed employable)

All other income assistance clients and individuals receiving hardship assistance are eligible for emergency dental services to relieve pain. All clients who have had their complete upper and/or lower arch of teeth extracted in the previous six months for the relief of pain on recommendation of a dentist are eligible for funding for complete dentures (single or full) according to the ministry’s fee schedule.

2.3 Healthy Kids

The Healthy Kids Program helps low-income families with costs associated with basic dental care and prescription glasses for their children. Dependent children under 19 years of age, in families approved for premium assistance by the Medical Services Plan (MSP) through the Ministry of Health Services, are automatically registered with the Healthy Kids Program. Children are eligible for $1400 of basic dental services every two years. This coverage includes services such as exams, x-rays, fillings, cleanings and extractions. Dentists can advise families of other services that may be covered. Additional charges over and above what the Healthy Kids Program will cover are the responsibility of the family.

3. Interim Federal Health Program

The Interim Federal Health Program provides temporary health insurance to refugees, protected persons and refugee claimants, as well as to their dependants, in Canada who are not yet covered by a provincial or territorial health insurance plan. Applicants must meet the following criteria: demonstrate that they are unable to pay for their own medical services; not be covered by private health insurance plans (other criteria may apply).

Only emergency/essential dental services are covered. Emergency services are defined as procedures to alleviate pain and active infection, hemorrhage and the result of oral trauma. Essential services are procedures for serious dental problems that remain once the emergency services have been provided. These services which are defined below must be submitted to FAS for pre-determination. Although emergency benefits are not subject to a dollar maximum, allocation to emergency treatment will be carefully scrutinized and enforced. Dentists should evaluate treatment on a priority basis.6

(Accessed July 13, 2010)
4. **VIHA Dental Programs**

The purpose of the dental program is to reduce preventable dental disease among children and other selected groups in the Health Region through dental health promotion, early childhood interventions and surveillance and monitoring of dental health. Services are described by age group:

- **Prenatal to Preschool**: Education, skill building and support for families to access dental services; dental screening for infants and preschoolers referred by public health nurses; and oral health teaching and resource kits available for loan to group leaders.
- **School Age**: Dental screening and support for students of any age referred by public health nurses; school newsletter articles on dental health promotion topics; and oral health teaching resources available for loan (lesson plans, videos, tooth brushing models, posters).

**Services for Children and Adults with Developmental Disabilities**: This program is provided for children and adults with developmental disabilities who need help to achieve good oral health and to access private professional dental care in the community. Services are available for clients, caregivers, family members, professionals and Community Living Agencies. Services include; oral assessments; oral hygiene counseling; referrals to community dentists; advocacy and client support; education for caregivers; and, limited clinical dental hygiene services.

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References


RESOLUTION: 2007-01 – DENTAL HEALTH: WHEREAS oral health is an essential pre-requisite to healthy eating and quality of life, WHEREAS the consequences of poor oral health can be serious and costly to individuals and the health system, and include such problems as pain, infection and tooth loss, poor nutrition, impaired social relationships and self-esteem, increased absenteeism from work and school, increased risk for diabetes, heart disease and stroke as well as greater risk for delivering a low birth-weight baby, WHEREAS dental care is not an included service under Canada’s publicly funded medical care system, WHEREAS there are residents of British Columbia who cannot obtain basic dental care because of financial barriers, and WHEREAS there is a need for more attention to population health interventions in dental health services and recognizing that these may not be widely understood by people working within the dental field, THEREFORE BE IT RESOLVED THAT the Public Health Association of BC formally requests the Provincial Health Officer to address the relationship between dental health and chronic disease, the issue of dental health inequity and equitable access to dental care services in a future Provincial Health Officer’s report. http://www.phabc.org/pdf/agm2007/Resolution_07_01_Dental_Health.pdf


2 BC Association for Community Living (February 2007). “Nothing to Smile About: A Brief addressing the inadequate levels of Dental and Medical Coverage for People with Disabilities receiving income assistance.” Vancouver: BCACL


10 Accessed on April 30 2010.


12 www.earlylearning.ubc.ca


17 City of Campbell River Homelessness Task Force Report (2009). City of Campbell River

Endnotes