IMPROVING ACCESS TO DENTAL SERVICES FOR LOW-INCOME ADULTS IN BC

BY BRUCE WALLACE | 2008
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The opinions expressed in this report, and any errors, are those of the author and do not necessarily reflect the views of the collaborating partners.

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EXECUTIVE SUMMARY

In British Columbia there are significant disparities in oral health, with low-income and socially disadvantaged groups having a disproportionately high level of dental problems. These health disparities are linked to inequalities in access to oral health care. In BC, oral health care for adults is typically delivered by dental professionals in private practice, with services delivered on a fee-for-service basis. This service structure creates financial and other barriers for many low-income adults.

Throughout the province, people are responding to this public health need primarily 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, there has been at least one new community dental clinic established in BC per year.

This study set out to explore the context for this recent growth in community organizing around dental care, and to better understand the possibilities and limits of a community-based response to provincial oral health disparities. Sixty-three individuals involved in BC community dental access initiatives were interviewed during site visits throughout the province.

The inaccessibility of dental treatment for low-income adults and the urgency of the need for a public health response was heard repeatedly during site visits. In every region of the province participants described dentists routinely refusing to treat patients in need due to inadequate funds. Multiple access barriers were described by participants in rural and northern areas and by participants working with immigrant and refugee populations in the Lower Mainland. The partial government dental benefits system that provides limited coverage for specific populations (immigrants and refugees, First Nations people, and people receiving provincial social assistance) was repeatedly described by service providers as part of the problem rather than as a solution. The consequence of these interlocking access barriers is that throughout BC low-income adults are presenting at hospitals with severe dental pain and other oral health emergencies.

The four types of community initiatives described in this study – dental access funds, volunteer charitable clinics, social enterprise clinics, and teaching clinics – reflect both the tremendous creativity of rural and urban communities in BC, and also the challenges faced by communities in attempting to ensure that low-income adults across the province have adequate access to oral health care. This study explores the strengths and weaknesses of each model from the “on-the-ground” perspective of those trying to provide care.

Where to go from here? In recent years the provincial government has supported the establishment and growth of community dental clinics as a way to fill a recognized gap in health care (although much of this support has been limited to one-time contributions for capital costs). There has been little to no evaluation of this community-by-community approach, and also little evaluation of the various clinic models that currently exist in BC. As the number of vulnerable adults accessing treatment through community-based dental services increases, there is a concomitant need for increased evaluation, coordination, and support of evidence-based planning. Caution is recommended. As community-based responses expand across the province, there is a need to ensure that interim band-aid solutions to a health care crisis are not confused with a comprehensive, systematic, and sustainable response to oral health care needs across the province.
Participants’ recommendations reflect this tension between immediate needs and long-term sustainability. While communities seek support in their efforts to reduce the immediate barriers faced by low-income children and adults in accessing dental care, there is greater support for policy changes that ensure equitable access for all British Columbians over the long term.

Recommendations from this research are that:

1. the Provincial Government, regional health authorities, professional associations, community organizations, and other interested parties, collaborate strategically to reduce the multiple barriers to oral healthcare currently experienced by people with low-incomes in BC;

2. the Provincial Government and Health Authorities integrate service planning, delivery, and evaluation to recognize oral healthcare as an essential and integral component of primary healthcare;

3. basic oral healthcare services be covered fully for BC residents as part of the BC Medical Services Plan;

4. the provincial and federal government agencies and the British Columbia Dental Association harmonize treatment fee guides so that dentists in private practice will be encouraged to care for all British Columbians;

5. the appropriate BC Ministries collaborating with regional health authorities provide sufficient capital and operating funds for community dental clinics to offer oral healthcare services at a standard of care similar to most private dental practices in BC; and to implement quality assurance controls and evaluative processes in community dental clinics comparable to other primary care services;

6. governmental and professional agencies assess the capacity of private practitioners to address the needs of low income and other vulnerable residents of BC;

7. the regulation and education of dental professionals be reviewed in light of the growing disparities in healthcare and the particular needs of the least advantaged members in our society.
INTRODUCTION

This exploratory study emerged from requests by community agencies and individuals throughout British Columbia seeking to help improve access to dental services for low-income adults in their communities.

In British Columbia, as in the rest of Canada, there is a gap in health policy and programming that leaves many low-income adults unable to access dental care. Although the resulting disparity in dental care access is a province-wide problem, the primary strategy thus far has been a community-by-community establishment of dental clinics or dental access funds aimed at serving low-income adults. In many areas the oral health needs of vulnerable British Columbians are becoming the responsibility of charities and volunteers; in other communities clinics are run as social enterprises dependent on balancing the health needs of patients with financial sustainability.

This study set out to talk to the individuals and groups who have been developing these local dental access initiatives. The result is a snapshot of the current state of BC community-based dental care programs, and the possibilities and limits of a community-oriented response to oral health disparities. We hope that this information will be used by community organizations, health regions, and the provincial government to better inform future planning to address oral health disparities.
STUDY METHODS

This paper provides an overview of community-based responses to address the oral health needs of low-income adults in BC. Research consisted of site visits and interviews throughout BC (see profiles in Appendix A). Sampling was purposive, which means the researcher purposefully – not randomly – selected specific people to interview. Sampling was guided by three objectives: (1) to gather information about every community-based dental care initiative in BC, (2) to gather information about the dental care access needs of low-income adults in areas where there is no known community-based response, and (3) to ensure diversity of geographic representation.

The research was conducted over a three-month period between late May 2007 and early August 2007. Initially, email contact was made with key informants from all known community-based responses as well as with key informants from dental public health programs. Through this process, new contacts were made and included in the sampling. Every group that was contacted agreed to participate.

Site visits were organized in each health region with a total of 63 people participating in individual or group interviews: Vancouver Coastal health region (11), Vancouver Island health region (10), Northern health region (8), Interior health region (20), Fraser health region (14). Interviews were semi-structured (see interview guide in Appendix B) and the format and locations were developed collaboratively with each site hosts. Those interviewed included: (a) individuals responsible for delivering community-based dental care services – clinical dental staff/volunteers and administrative staff/managers, (b) public health hygienists and other dental staff employed by health regions who do not deliver adult services but are contacted by low-income adults seeking treatment options, and (c) individuals involved in community dental access coalitions (dental professionals, poverty advocates, and other social and health service providers). Interview notes and recordings were analyzed. Quotes from these interviews are included throughout this report. These quotes are not attributed to any individual participants to protect confidentiality.

The study does not claim to be comprehensive or representative of all individuals and groups concerned with dental care in BC. The provincial scan of community responses is limited to adults, so does not include programs delivered to children. The study also does not seek to review the distinct programs that seek to make dental care accessible to First Nations adults living on-reserve, adults living in residential care, or adults who are incarcerated. Additionally, as a review of community-based responses, the paper does not include a review of government benefit programs that relate to dental care.

As an exploratory study, there are several limitations which should be acknowledged. This report does not attempt to provide a comprehensive review of the literature or link these findings to findings from similar research. The review of community-based services is descriptive. Comparison of programs is not possible as it is out of the scope of this project to provide a thorough evaluation of each program. Finally, the review does not attempt to include the views of those most affected – individuals unable to access dental care. Just as there is a need for research that documents the impacts of the inequality of access, there is a need for research on how we can respond. This project understands the importance of both and here strives to stay focused on the latter.
WHAT ARE COMMUNITIES RESPONDING TO?

The following section provides findings from the interviews regarding the current context: the factors contributing to the need to improve access to dental services for low-income adults.

INAPPROPRIATE USE OF EMERGENCY AND PRIMARY CARE CLINICS FOR DENTAL CARE

Throughout this research there was repeated reference to the link between hospital Emergency Room (ER) use and the access to dental care. Participants in Kelowna, Vancouver, Victoria, Prince George, and Vernon reported that adults with dental pain who were unable to afford dental treatment were instead utilizing ER services. Although not a systematic review of emergency room utilization for dental care, participants’ strong concern about this trend speaks to both the need for dental care and the necessity to adequately respond. A Steering Committee in Vernon has been meeting to develop a sustainable dental clinic, with one of the goals being to reduce visits to the hospital ER department. Exploratory research from Kelowna estimated approximately two to three ER cases per day of people in dental pain who do not have the financial resources for treatment in a dental office.

Public dental staff from two health regions lacking community-based clinics reported that when they get calls from adults with dental pain or infection, if the individuals don’t have funds to pay for dental care they refer them to primary or emergency health care services. One stated, “We refer a lot of people to walk-in clinics…if they have nowhere else to turn we say just go to a walk-in clinic as a medical emergency to get relief of pain”.

Another reported, “People phone up, they want to go to a dentist, we say if you have medical go to a physician and at least you can get antibiotics. But then we have people who have been on the antibiotics for many, many, many months and still haven’t been treated.”

“there is roughly one visit per day to the Vernon Jubilee Hospital ER for dental problems. Of those, half are due to abscess and serious infection. The cost of these visits to the taxpayers is approximately $350,000 per year. The estimate does not include visits to doctors’ offices and walk-in clinics.”

- Vernon’s Dental Access Initiative

“The Emergency Room at the hospital is our biggest referral source...they really have nowhere to send these clients, they just give them a prescription.”

- Prince George Dental Clinic

“If they don’t get treated in these clinics they will end up in Emergency Departments.”

- BC Dental Association

FINANCIAL BARRIERS FOR INDIVIDUALS WITHOUT DENTAL INSURANCE

This provincial consultation with community-based responders heard clearly and forcefully that the primary barrier for adults accessing dental care in BC was financial, while also recognizing additional barriers unique to specific populations.

Many adults who are unemployed, or employed at low wage jobs (the “working poor”), neither have money to pay for dental care nor the funds to pay for dental insurance. These adults often struggle just to pay the rent and feed the kids – in this context, regular teeth cleaning or other preventive dental care is an unaffordable luxury item, and so is dental insurance.
Many interview participants expressed frustration with the lack of options for low-income people without dental benefits. As one public hygienist explained, “We are getting phone calls all the time with people in pain, people without any dental coverage. They can’t afford to go and they don’t have any credit and so they just can’t go to a dental office.” Another hygienist questioned, “Is it ethical to treat somebody differently because they don’t have money…[to have] treatment plans determined by the finances available? In other words, are you going to pull a tooth out or are you going to do a root canal on it? Would I pull a tooth out of your head that I could save if you had five hundred extra dollars?”

THE LIMITS OF PUBLIC DENTAL BENEFITS

Dental professionals expressed overwhelming dissatisfaction with the provincial public dental benefits provided for clients receiving income assistance. They also felt strongly that dental benefits provided by the Ministry of Employment and Income Assistance (MEIA) are not sufficiently enabling access for this vulnerable population.

By far the most frequent grievance reported by participants from all regions was the discrepancy between fee guides. The welfare ministry’s (MEIA)’s fee schedule is approximately 70 percent of the fee guide developed by dentists. While the BC Dental Association’s fee guide is reviewed and increased annually, MEIA’s fee guide is negotiated with the dental profession but increased less frequently – resulting in increasing discrepancies over time.

The most detrimental outcome of this disparity between the BC Dental Association’s fee guide and that negotiated with MEIA is dentists in private practice refusing to accept patients who are on welfare due to the reduced fees received for their services. In all regions participants reported that even when dentists would see patients receiving benefits, they often made the patient pay the difference between the BC Dental Association fee guide and the amount paid by benefits, referred to as balance billing. In all of these cases, the result is the same: the patient cannot access treatment.

Dentist attitudes on this issue vary. According to the BC Dental Association, 80% of their members accept patients receiving MEIA benefits, but many set a quota so that only 4-5% of their patient load are MEIA clients. In some communities, participants stated that no dentists would accept any welfare clients as patients; in others, only one dentist was willing to treat people receiving MEIA benefits. It was commonly observed that if a dentist helps welfare clients “they get flooded with referrals” and many eventually stop altogether or limit their MEIA caseload.

An obvious solution to many is harmonization of the fee guides. But is one fee guide too high, or the other too low? Public dental health participants had conflicting views on this issue. One public hygienist commented that MEIA “paying the full rate would solve so many problems, our life would be so much easier.” Another stated, “I don’t think it’s the [ministry] fee guide that’s the problem, I personally think it’s the [BCDA] dental fee guide that’s the problem.”

A further problem is MEIA’s restrictions of costs, defined by client category. Some welfare clients struggle with dental costs that exceed the total amount provided by the ministry in a two-year period. Some clients receive coverage for emergency treatment but have severely limited funding for preventive care or necessary restorative treatment.
There was overall frustration expressed by dental providers in dealing with public benefits, both provincial and federal, and therefore their clients who receive benefits. For all public benefit programs, there were complaints of red tape, delayed payments, and the uncertainty of what procedures will be reimbursed. The problems with the current system clearly extend beyond debates about the fee amount, suggesting that harmonization of the fee guides will not, in and of itself, solve all of the access problems experienced by people on welfare.

**REFUSAL OF CARE**

In every region of the province, participants noted that dentists routinely refused to treat patients in need. Throughout the province there are reports of dentists in private practice refusing to accept patients with inadequate funds, and often refusing to accept any public benefit plans including benefits for refugees, benefits for people living on welfare, and First Nations benefits.

The issue of refusing to accept patients was described by participants as an ethical issue, a business issue, a public health issue, and always an emotional issue. According to one service provider, “Society [not just government] needs to be more aware so that they can say that this is unacceptable, then the dental professionals have to step up and say ‘I won’t refuse someone in my office who is in pain because they can’t pay’ – it’s in their ethics and they are not stepping up to the plate. I think there are three tiers to solving the problem; not just government, but society and the dental profession.”

**THE LIMITS OF PRIVATE PRACTICE DENTISTRY**

Is it realistic to expect private practice dentistry to fulfill the public oral health needs of British Columbia? Private practice dental offices don’t have a mandate to address the social determinants of health, but rather operate primarily as businesses. What is good for business is not always good for public health. This is most obvious in the examples described earlier where dentists refused care to patients in need because the patient had inadequate funds or was receiving government benefits that paid less than the amounts in the BC Dental Association’s fee guide.

Several participants acknowledged the frustrations experienced by dentists in private practice who incurred overhead expenses when clients came late or did not show up at all for appointments. According to the BC Dental Association, “If you talk to any dentist the biggest problem is no shows.” It is financially undesirable for dentists in

“I phone for some of my clients and the front desk will say ‘we don’t take those people and we charge on top of the dental plan’ and I’m shocked at what happened to me as a professional calling an office. So, what would happen to the people themselves? They are mortified; they can’t even get through the red tape from a person at the front desk. When they say that to me, as a professional phoning for somebody, I find that awful. It is embarrassing, and when you are a person in pain and you need the service and you get treated like you shouldn’t be here and they are mortified and they would have to sit in the dental chair when it is so uncomfortable and scary and you get the feeling that everyone around you is staring at you and you shouldn’t be there.”

- Public health hygienist

“I’m going to get evicted tomorrow and I have a dental appointment, or they are going to cut off my hydro. I think for us, because we live in a different world we just don’t get that concept of why people don’t just show up. But if we had something where it would be accessible for them and it would work for their schedule not our schedule. Consider the scenario of people who don’t have phones or a fixed address trying to access treatment. So how can a dental office connect with them?”

- Public dental hygienist
private practice to accept patients facing multiple social and personal challenges as there is a risk of a higher “no show” rate due to life circumstances.

In several communities, the initial concern that dentists might view community-based dental clinics as competition has been replaced with the opposite concern – “they were so happy to get that marginalized population out of their offices,” stated one clinic manager. Several participants expressed the view that dentistry is moving further and further from public health as technology increases and private practices become more and more upscale, referring to dental offices and public oral health needs as “different ends of the world”. Participants described dental offices as resembling spas, and private practice patients escalating in their expectations of service. In this environment, “Do they want the homeless person who’s got the clothes on that haven’t been washed in two months, laying in the chair before they go lay in the chair next?”

THE LIMITS OF CHARITABLE DENTISTRY

Because dental costs are expensive for everyone (regardless of income level), many dentists offer some pro-bono care to their existing patient base. Repeatedly, individuals within community dental programs and public dental health recognized the charitable work of dental offices in their communities. “There are a lot of good dentists,” was a statement often raised to balance the frustrations of seeing clients refused treatment. The BC Dental Association told us “many dentists provide free treatment year round to disadvantaged clients in their practices.” In its survey of members, they report 78% of their members provided free treatment, with an estimated annual average cost of free treatment provided totaling $2,583. Other participants predicted that the majority of charitable dental work provided by dentist went to their own patients in need, still leaving those without dentists without access to free or reduced fee services.

When interviewed, the BCDA spokesperson explained that “charitable dentistry is there to fill the cracks in the system” while recognizing that “charitable dentistry is not the solution.” The limits of charitable dentistry were a concern to many participants. “There are dentists in every community [that will help out when asked] but you can’t go to everybody, you can’t help everybody,” stated one respondent.

There appears to be some dissatisfaction surrounding Community Dental Day, an annual day to provide free dental treatment. The day is organized by the BCDA as part of National Oral Health Month. According to the BCDA, since the inception of Community Dental Day in 2003, “BC dentists have provided over $1.8 million of free dental treatment to approximately 5,200 low-income adults province-wide.” For those individuals and groups working with low-income adults needing urgent care year round, the promotion of a single-day event as a viable response to inequitable access to dental care is clearly not enough.

The perception is that Community Dental Day doesn’t work well for all dentists involved either, who express frustration with scheduling challenges and other limitations. Several people believe that dentists are opting out of Community Dental Day and instead providing free services in their own ways. A related comment was “the real charitable dentists do their free dentistry through the year.”

“Community Dental Day gives great PR for the BC Dental Association, and they do great work, but people don’t get toothaches on one day, they have it throughout the year.”

“One day doesn’t do it, not everyone gets a toothache on Tuesday the 9th of June ... it’s a PR thing that doesn’t work.”

“In my area I have no dentists that will participate.”
INSUFFICIENT NUMBERS OF DENTISTS TO MEET PATIENTS’ NEEDS

In Northern BC, participants described the multiple barriers faced by low-income adults needing dental care. Many northern communities have insufficient dentists and in many communities dentists are not taking new patients. As one respondent explained, “We have remote and rural areas where dentists’ practices are full, there isn’t a dentist within an hour or two or three that you may be able to access.” Some communities reported a nine-month waitlist to get an appointment, regardless of being insured or not.

With patient demand exceeding the number of dentists available, dentists can be selective in deciding which patients to treat. Several participants reported small Northern communities where no dental care can be accessed by individuals receiving public benefits because all of the local dentists are either refusing outright to treat government patients, or are using prohibitively expensive practices such as requiring fees upfront, billing the difference between the fee guides, or charging $50-$100 administrative fees to process benefits paperwork. As discussed previously these practices are a problem around the province, but are magnified in the North.

THE LIMITED CAPACITY OF DENTAL PROFESSIONALS

This study heard several related concerns from participants about the ability of the dental profession as it is currently structured to best respond to the public health needs of vulnerable British Columbians. Participants questioned whether the private practice dental sector is equipped and able to meet the oral health needs being identified by communities.

Many participating clinicians did not feel their education adequately prepared graduates to meet the dental needs of vulnerable populations or to work in community-based dental programs. One respondent added that the problematic isolation of oral health care from the rest of the health care system began with their education, stating “we are disconnecting the mouth from other health professionals by isolating our education.”

Both dental hygienists and certified dental assistants working in public health repeatedly raised concerns that provincial “scope of practice” regulations limited their ability to best respond to the oral health needs of vulnerable populations. Individuals from both professions raised concerns about regulations that they contend limit what services they can provide to vulnerable populations as well as limiting their ability to work in community-based, salaried settings. There was related interest from several participants in the role that dental therapists could play in meeting dental needs of adults unable to access care in private dental offices.

CULTURAL AND LINGUISTIC BARRIERS

Lower Mainland respondents often discussed the barriers faced by immigrant and refugee populations seeking dental care from traditional dental practices. A public hygienist reported that in her area, “We have a really high refugee population who are covered by the Interim Federal Health program, but there is nowhere to refer them because no one will accept them because they are not consistently paid and there is no consistency as to what is covered and what is not. So, they go without. When they call us, we tell them we don’t have any dental office that we know of that will accept that program. Sorry.” Participants identified what was called “a real need” for services in languages other than English.
PATIENT BELIEFS ABOUT DENTAL CARE

Several participants felt that to improve access to dental care it is also necessary to improve access to information relating to oral health promotion. One clinic manager participating in this project pointed out that fear of dentists and lack of consideration of dental care as a personal priority are barriers which affect access for all adults, regardless of dental insurance plans or income level. In an interview the BCDA spokesperson prioritized this issue, stating, “The problem is not a fee problem but a utilization issue,” and suggested “maybe raising awareness does more than raising funding.”
COMMUNITY-BASED RESPONSES IN BC

The establishment of community dental clinics and dental access funds as a response to oral health disparities began in the 1970s with the establishment of dental services as part of the REACH community health centre in Vancouver. In the 1980s Vancouver’s Mid-Main community health centre followed suit, and in the 1990s a volunteer dentist in Kamloops started a public dental clinic. In the past seven years, the pace of development has dramatically increased in BC. Since 2001 there has been at least one new community dental clinic established per year. Currently in BC there are ten community-based dental clinics, with at least three new community dental clinics being planned for 2007-2009. As well, dental access funds have been established in two communities.

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<th>YEAR</th>
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<tr>
<td>1970s</td>
<td>REACH Dental Clinic (Vancouver)</td>
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<td>1980s</td>
<td>Mid-Main Dental Clinic (Vancouver)</td>
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<td>1990s</td>
<td>Kamloops New Life Mission Dental Clinic</td>
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<td>2001</td>
<td>Portland Dental Clinic (Vancouver)</td>
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<td></td>
<td>Kootenay Dental Access Fund</td>
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<td>2002</td>
<td>Strathcona Community Dental Clinic (Vancouver)</td>
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<td>Cool Aid Dental Clinic (Victoria)</td>
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<td></td>
<td>Vernon Community Dental Access Fund</td>
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<td>2004</td>
<td>Kelowna Gospel Mission Dental Clinic</td>
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<td>2005</td>
<td>East-side Walk in Dental Clinic (Vancouver)</td>
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<td>2006</td>
<td>Prince George Emergency Dental Clinic</td>
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<td>2007</td>
<td>Salmon Arm Dental Clinic</td>
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<td>2007/08</td>
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In addition to organizing dental clinics, communities around the province are organizing tasks groups and coalitions to try to improve adults’ access to dental care. In Terrace there is now a committee on access to dental care, in nearby Smithers there is a Young Parents Dental Program Committee, and one of the five task forces in the Victoria Quality of Life Challenge is a Dental Task Force. Most notable is the organizing within the Kootenay Boundary area of BC, where the Healthy Teeth for Healthy Eating project has brought together numerous groups to raise public and government awareness and promote policy change to improve oral health and access to dental health care.

This provincial scan clearly shows that the need to provide treatment options to those unable to afford dental care has been identified by communities throughout the province. It is clear from those who participated in this research that while the issue is complex and the needs and barriers diverse, financial barriers are the primary source of inequitable access to dental care among low-income adults. Financial barriers to accessing dental care is increasingly being recognized by urban, rural, remote, and Northern communities as a health issue demanding a response.
There is not a coordinated or consistent response to the issue but rather a diversity of community-based responses in the provinces, responses that generally have not been evaluated. While many of the services were modeled on the workings of existing clinics in similar communities, it appears that few or none have been evaluated. As the numbers of clinics and related initiatives in the province and the number of vulnerable adults accessing treatment through these services increases there is increasing need for evaluation, coordination, and support of evidence-based planning. Currently there is very little communication between local initiatives and little or no overall strategy to supporting this emerging ad hoc sector.

This section describes models of community-based treatment initiatives in BC, and the strengths and weaknesses of each approach as defined by the research participants.

**DENTAL ACCESS FUNDS**

Dental access funds are programs designed to provide funds to subsidize the costs of accessing dental treatment in the private practice setting. Examples in BC include Vernon’s Dental Access Bursary, the Trail Dental Access Fund (servicing several communities in the Kootenay Boundary region), and the REACH Community Health Centre’s Emergency Dental Fund in Vancouver. Currently, a community coalition in Terrace is working to establish a ‘dental trust fund’ while in Smithers the Young Parents Dental Program Committee has been raising funds to offset the costs of dental care for young mothers with dental pain and/or infection but no means to pay for the treatment.

A dental access fund is perhaps the most direct response to the financial barrier to accessing dental care. It is based on the premise that the problem is a lack of money, and so 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.

Each dental access fund defines financial eligibility criteria for recipients, with some funds simply using Medical Services Plan’s (MSP) criteria for premium health assistance. The scope of services is also defined, with some funds available only for relief of pain or infection, and others providing coverage that is inclusive of full restorative services. Allocation of funds is limited by the resources available. In BC, one fund has a maximum of $500; another’s maximum is $175, although both programs will accept wait lists when funds run out.

**Perceived Strengths**

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. This opinion is obviously shared by others in rural communities such as Smithers and Terrace that are seeking to establish similar funds. A dental access fund addresses 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. In the words of one participant, “Because we have such a large geographical area, the only way a clinic would work is if you had a transportation budget to get people there. By having a fund like this it is accessible in each area.”

Those involved in dental access funds perceived them as a very cost-effective response compared to a clinic, as funds go directly to clients rather than the establishment and operation of a facility. Also, setting up a fund was viewed as easier than establishing a clinic. By creating a service that provides immediate benefits, communities starting to mobilize around dental access issues can feel a sense of satisfaction that they are able to take meaningful action.
There are also some unexpected outcomes of dental access funds. In some cases, dentists were more willing to accept marginalized patients in their practice. One program coordinator commented, “When a dental office knows there is funding, there is more acceptance to work with our clients”. Participants reported that dentists also appreciated the role of the access fund in screening and supporting patients, thereby reducing the risk of no-shows.

When a client is accepted as a patient in an established dental practice, dentists may be motivated to provide pro bono services beyond the allocated funds to complete treatment. In the Kootenays, organizers estimated that the $10,000 access fund resulted in $30,000 worth of services. “Before we started it was very difficult to even get any dentists to see any of our clients. With us now subsidizing or paying for their dental work, we have encouraged dentists to take low-income, desperate clientele. It has also opened the doors so that many dentists now see that this is a problem and a lot of them have started to help in their own way.”

**Perceived Limitations**

The most obvious limitation is the magnitude of need compared to money that can be fundraised. One coordinator stated, “There is no way we can siphon enough donations from the community to address this issue.” In the Kootenays the facilitators of the fund currently do not promote the program to people in need as they don’t have the resources to accommodate additional recipients. At the time of the interviews the fund had a wait list of 20 individuals, and administrators admitted, “We are just scratching the surface of the actual need…we are just chipping at the iceberg.” In Vernon, as of 2007 the fund had been depleted and was consequently not available to people in need of dental care.

Administration of a dental access fund requires human resources. As with many community-based responses to dental access inequities, access funds were most often started by public dental health staff who get ongoing requests for services but lack a mandate to fully respond. The time required to administer a fund was raised as a concern in several communities where public health staff are managing the funds on top of full workloads, especially if the requests for services far exceeded the resources. In the Kootenays, the fund is housed in a non-profit organization but there are still no staff dedicated to administering the fund. The time-consuming tasks of fundraising and screening are performed on a primarily volunteer basis, by committed public dental staff working beyond their paid hours.

A dental access fund also requires dentists. In many northern communities there are insufficient dentists, a barrier that extra funds cannot overcome. In these communities few dentists are taking new patients, and those who are can afford to be selective as to which patients they will or will not treat.

Finally, participants recognized that a dental access fund “does not really address the root causes of the problem and is really a bandaid”. Participants in Terrace felt that although the fund could, in the short-term, help some people on welfare access care by paying the difference between the dentists’ fees and the Ministry’s fee guide, over the long-term they felt that “unfortunately this would just continue the lack of coverage by MEIA”. Dental access funds focus on individual solutions, helping one person at a time rather than making collective changes that would benefit entire populations.

**Summary**

Although dental access funds do not address the root causes of inequitable access to dental care and can only meet a portion of the need for subsidized care, many participants in rural areas were enthusiastic about
dental access funds as a viable and practical response to the needs of low-income adults living in rural areas. 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. Financial support for these programs was recommended, with funds allocated to patients as well as financial resources to administer the program. As dental access funds typically emerge from requests for treatment made to public dental health staff, dental access funds could be supported by dedicating resources to support these staff to respond to these requests. Alternatively, with proper financial supports access funds could be effectively integrated as part of existing non-profit community organizations or community health centres.

**VOLUNTEER CHARITABLE CLINICS**

The number of volunteer charitable dental clinics in BC is significantly increasing. Over the last four years, at least four new volunteer charitable clinics have been established in the province. The Kelowna Gospel Mission Dental Clinic opened in 2004, Vancouver’s East-side Walk-in Dental Clinic opened in 2005, Prince George’s Emergency Outreach Dental Clinic opened in 2006, and during this project a new clinic was under development in Abbotsford. More and more British Columbians are now accessing dental care from volunteers through these clinics. The Prince George clinic is accessed by approximately 200 patients per year, for a value of approximately $30,000 in free treatment. In Vancouver, the East Side Walk-in dental clinic treats approximately 500 patients per year.

A consistent theme in the successful development of each clinic involved in this project was the presence of a ‘champion’ – a person (or persons) often described as compassionate, benevolent, or socially conscious – whose persistent effort was crucial in the clinic’s development. For example, Dr. Alex Yule has been instrumental in establishing clinics in Kamloops, the Vancouver East Side, and Abbotsford. In Kelowna and Prince George, volunteer charitable clinics emerged from community-based processes. Needs assessments were conducted and partnerships developed that would secure initial funding, donations, and a host agency to locate a clinic.

While each clinic surveyed as part of this project was unique, there were some common features among them. Generally, the clinics were established with the mandate to relieve pain, with a focus on extractions. Services are free. Clients are most often adults who cannot afford private treatment, and/or do not access treatment for other reasons such as mental health, addictions, or homelessness. The services are usually limited to a few evenings or days a month. They typically operate out of an existing non-profit agency that donates space.

The central defining feature is volunteerism. These clinics do not have to charge clients a fee for service because the services are provided for free by volunteer dental staff. As Dr. Yule explains, with volunteers, “It is completely free, we don’t have to collect money, that isn’t important here. It is relief of pain by a compassionate person, that is the bottom line, and that gives a different flavour to the whole office. Patients are aware of that, they know that these people are giving up their time, you only have to look at their faces.” Although the compassion demonstrated by the volunteers is key in the service, as Dr. Yule points out, the service is vulnerable: “If we ever lose the volunteer dentists we are going to lose a vital content of the whole thing”.

Although clinical staff are volunteers, a paid coordinator is essential for stability. All of the existing volunteer charitable clinics in BC currently have a part-time paid coordinator position, typically a certified dental assistant (CDA). The position may be funded by grants or through collection of fees collected from charging patient’s public benefit plans.
While extractions are the predominant services offered in these clinics, all of the clinics involved in this project were seeking ways to expand their services. Some have been able to provide additional care. For example, the Prince George clinic also offers hygiene services and through the UBC Dentistry Residence Program can now offer restorative services at some points in the year. The Kelowna clinic has created a denture program for clients who end up needing all of their teeth extracted. While the Vancouver East Side walk-in dental clinic operates with a relief-of-pain mandate, the pain treatment services are not limited to extractions, and some hygiene services are available for oral health promotion.

**Perceived benefits**

Volunteer charitable dental clinics are compassionate responses to inequality and despair. The response is simple and direct – establish a free dental service for those unable to access fee-for-service dentistry. As the value of free access to emergency dental care is being recognized, these clinics are expanding throughout the province. This expansion of charitable clinics has been supported not just by the individual efforts of volunteers in each community but also through financial support from the provincial government and the BC Dental Association. In many communities there is also support from dental schools, dental supply companies, and labs; according to one participant, “They like the volunteer model where the community comes together”.

The most obvious benefit of volunteer charitable clinics is the essential services provided for those with emergency needs. The clients of these services are extremely grateful not just for the relief of pain but also grateful that people care enough to volunteer their services. One dentist stated that their role “is to solve the pain and dispense a little love, understanding and respect”.

It is also recognized that the volunteers themselves benefit from this service delivery model. According to one clinic organizer, “the dentists get the most gratifying experience out of it”. Just as the patients are appreciative of the volunteer service, the volunteering dental staff gain satisfaction from the grateful patients.

The volunteer model seems most appealing to dentists in smaller communities rather than larger urban areas. In Prince George almost half of local dentists volunteer at the clinic; in Vernon 70% of area dentists (40% of Vernon’s dentists) participate in their similar Dental Access Program. A past review of Kelowna’s clinic also found a considerable proportion of the area’s dentists – nearly one in four dentists – volunteering at the clinic. However, in Vancouver’s East Side walk-in dental clinic the lack of volunteers is perceived to be the clinic’s greatest limitation. One Vancouver participant stated, “The biggest need that I have is volunteers, it is bowing me down. We really need lots more volunteer dentists and the rest will take care of itself”.

**Perceived limitations**

The volunteers who initiated and sustain these charitable clinics openly acknowledged the limitations of the services. Volunteer charitable dental clinics are also questioned by those not involved.

The most frequently discussed limitation is the acknowledgement that these clinics have limited hours, and the needs are greater than the services that can be provided. As a volunteer at one participating clinic commented, “We send patients away every day. Last Monday we had sixteen patients and treated six”. As a fixed-site service, the clinics are also limited in their ability to serve wider geographic areas, especially in rural areas where transportation costs can be significant and patients may need to travel long distances while in severe pain.
The predominant focus on extractions to provide emergency relief of pain is also a serious limitation. While the thousands of free extractions provided by volunteers are valuable services, oral health needs include preventive services, treatment other than extraction, and restorative work. As expected, extractions can negatively impact ability to chew and also have cosmetic impacts that can affect self-esteem and create barriers to employment.

Because the number of volunteer charitable clinics in the Province is increasing and because this increase is being supported by the dental profession and the provincial government, there is growing concern about the institutionalization of charitable dentistry as a replacement for dealing with economic inequalities. Participants repeatedly compared volunteer charitable dental clinics to food banks as a response to poverty. Additionally, concerns were raised that the limited services that can be provided in volunteer charitable dentistry are being enfranchised as a “legitimate” standard of care for lower-income British Columbians. One participant bluntly remarked:

“Just because people don’t have money we give them a substandard service and we basically dismember people. We take out their tooth. It is like showing up at hospital and if you don’t have medical we would take off your left arm but we are not going to give you a prosthesis. We pull out their teeth and send them on their way and haven’t really done them a service.”

There is a related concern that the support for charitable clinics is encouraging segregation of people who live in poverty. One participant felt charitable clinics let the dental profession, “Off the hook by saying ‘now there’s a dentist for your type over there and I want you to go over there’”. Another respondent questioned, “Are you increasing the number of people who are getting dental care through this type of system, which is a haphazard one, or are you letting private dentists clear their conscience by saying ‘you can go over there’?”

The sustainability of volunteer charitable dental clinics is a concern repeated by respondents. Overall it appears that with appropriate funding support these clinics are potentially sustainable over time, although clinic facilitators note this sustainability is dependent on several factors. Most significantly, dental professionals must continue to want to volunteer for these clinics to survive. Also, as with dental access funds, it is generally acknowledged that paid support staff are necessary to sustain volunteer clinics. While the provincial government has provided start-up funds and capital funds, most clinics are not receiving annual operating funds for ongoing staffing and supplies. The financial sustainability is therefore typically dependent on securing ongoing donations, including the donation of clinic space and utilities.

**SOCIAL ENTERPRISE & SUBSIDIZED CLINICS**

Social enterprise and subsidized dental clinics are non-profit community health services requiring revenue from patient fees to be sustaining. The clinics typically provide the same dental services as those available in the private practice setting, including preventive and full restorative services. The clinics are typically financially self-sustaining, with significant annual operating costs.

Social enterprise clinics have limited or no ongoing government financial assistance, while subsidized clinics receive annual government support which reduces – but not eliminates – the need for fee-for-service revenue. The fact that subsidized clinics are supported by a government grant and social enterprise clinics are not is a significant difference; however, in most other ways these clinics are similar and share common features.
Social enterprise clinics in BC include Vancouver’s REACH clinic, Mid-Main Dental clinic, and Strathcona Community Dental Clinic; the Kamloops New Life Mission Dental Clinic; and the just-launched social enterprise dental clinic in Salmon Arm’s Living Waters Church. Two subsidized dental clinics in BC are Vancouver’s Portland Community Dental Clinic and Victoria’s Cool Aid Dental clinic.

Most social enterprise clinics generate revenue by charging some patients reduced fees for services (ranging from 10-100% below the standard fee guide), with billing determined by the patient’s public dental benefits rates and restrictions. The economic feasibility is dependent on an often precarious balancing of the patients’ needs for discounted dental services and the agency’s need for revenue. Some of the clinics’ financing resembles co-op principles, where patients with dental insurance subsidize the care for those without. According to the Mid-Main dental clinic’s promotional materials, “the money paid to us by our patients’ insurance companies helps allow Mid Main offer non-insured patients a 10% discount”. The Kamloops clinic uses a similar fee structure: “We run a half private and a half public clinic in the same location, with some patients with full benefits and some without”.

The two subsidized dental clinics in BC receive annual operational funding from their health authorities, although the clinics are similar to social enterprise models as the grants provide only a fraction of the necessary revenues. The clinic in Victoria was established with a commitment of not just start-up funds but also an annual grant from the health region which accounts for approximately 25 percent of the necessary revenue. The Portland clinic in Vancouver’s Downtown Eastside also has annual operational funding from the health region in addition to funding from a federal/provincial/municipal endowment for services in Vancouver’s downtown core. Both clinics still rely on collecting reduced fees-for-service from patients for revenue. However, the financial cushion provided by the government annual operating grants means that these two clinics do not seek out patients with dental insurance to compensate for lower revenues from those with public or no benefits. The entire patient load for the two subsidized clinics is comprised of people in financial need who could not afford to pay for dental services in another setting.

Several of these social enterprise and subsidized clinics operate within community health centres (CHC) and share many of the defining characteristics of CHCs. In these settings dental care is an integrated component of primary health care, with services delivered by professionals from across disciplines within a health promotion framework that addresses a community’s unique social determinants of health (e.g., culture, language, and access to shelter, food, and income security). Other clinics are integrated into an inner-city school or within agencies providing comprehensive services for populations at risk (e.g., housing, job training, and addiction services).

A defining characteristic of social enterprise and subsidized clinics is staffing: the clinics have paid staff, not volunteers. Additionally, the clinics are generally full-service clinics, providing comprehensive treatment and open full-time hours. The costs are obviously considerably more than a part-time, volunteer charitable clinic. Therefore revenues must be generated to support this model of clinic.

**Perceived strengths**

Social enterprise and subsidized clinics pride themselves in being able to offer full dental services at lower costs, in settings that can address both financial and other possible barriers to accessing care. They are models that in many ways most resemble private practice dentistry, albeit within community settings. While they may focus their services to those marginalized from traditional dentistry, they seek to provide high-
quality, professional, comprehensive services. As one clinic manager stated, “If I’m down and out, I don’t want to be going someplace that labels me as down and out. I’d be trying to not be down and out. I want to be like everyone else.” Or as a manager of another clinic explained, “When we first started, one of [the] things we made sure [of was that] we were not going to be known as a place where somebody came and had their teeth pulled and that was it. We thought that there had to be some dignity involved here and that our patients were having the same treatment at our dental clinic as anywhere else.” The social enterprise clinics often have the dual requirement to create a setting that provides respectful care to vulnerable patients while also attracting patients with private dental plans:

“If you have a good clinic you can attract people with good dental plans. As long as you are a free, scary looking clinic, people with plans are not going to come anywhere near you so there is never going to be any revenue from that….They come here because they get really good dental care, they don’t come here to be self-sacrificing. But by coming here with their good plans and getting good care they make it possible for a lot of other people to come here to also get good care but not pay as much. I think that is the ideal, an excellent clinic that gives excellent care and some of the patients are being subsidized and some are paying the full [cost].”

- Respondent from a social enterprise clinic

Social enterprise and subsidized clinics are not dependent on volunteerism: the dental staff are paid. There is the capacity to treat many more patients than charitable clinics, as many of the clinics are open full-time hours and are fully staffed. While there are many benefits to volunteering (and many of the clinics do seek out and utilize volunteers) these clinics can offer paid careers to those interested in community-based dentistry.

These clinics do not limit their mandate to relief of dental pain, but rather provide a full range of oral health preventive services, treatment services, and restorative treatment. There is the potential for hygiene services to be well integrated into the patient’s care, and continuity of staff means relationships can more readily be established between the patients and their dental providers. A hygienist stated,

“I see more and more of our patients now that we are keeping them out of the actual dental chair, the restorative end of it… We see patients now who are not in need of emergency they are in need of hygiene, they are in need of just regular care which is really nice to see. We have gone from pure emergency situations and the word has gotten out that prevention is huge and it makes them feel much better about themselves as well”.

Many people see these clinics as successful models to emulate because of their ability to provide full dental care services – not just relief of pain – to those in need. There is increasing recognition of the many benefits for government funded community dental clinics. When annual operating funding is available for community dental clinics, there is less pressure to balance the bills by charging low-income patients fees they struggle to afford, thereby truly reducing the financial barriers to accessing care. Many participants expressed the need and desire for a full-treatment clinic to serve the needs of their community, but without an annual subsidy they could not perceive such a clinic being financially feasible.

Perceived limitations

The limitation most often cited by participants is that both social enterprise and subsidized clinics have limited capacity to fully meet the need for affordable dentistry. The managers of several clinics tell of
constant financial pressures and risks, and the frustrations of balancing the need for revenues and the desperate needs of low-income patients.

Generally these clinics depend on collecting some fees from patients, which appears to be an inherent limitation to fully reducing the financial barriers to accessing dental care. The 10-30% percent reduction in fees typically offered by these clinics is seen as not a significant enough reduction for many in need. Individuals with limited incomes and no dental benefits require deeper discounted services for costs to be realistic within their limited budgets.

As in private practice dentistry, the tension between the commitment to providing access to care and the need to be financially self-sustaining can put a strain on clinic staff. Many expressed the wish that the clinic could further reduce their fees. According to one participant, “The fee reduction makes it very difficult for us in terms of financial balance at the end of the year but it is something we are really committed to.” Repeatedly, clinic staff expressed concern about the tenuous financial situation faced by the clinics: “If you don’t have the money you can’t proceed, tradeoffs have to be sustainable.”

The need to recover fees can negatively influence treatment plans. According to one participant, “When the dentists are thinking of treatment plans they are very careful to know what parameters they are working within, so I think they make recommendations [that are] maybe not necessarily the ideal but they make recommendations that are the best within the parameters”. As a participant in another clinic explained, “They have to take a realistic approach with clients and do work in blocks not to financially overwhelm both the patient or the clinic’s resources. Treatment plans start with the most urgent needs then when the patient has the opportunity to pay that off then we can move on to other restorative work.”

The full-spectrum services are a clear strength of these clinics but create additional funding challenges. With public benefits focused on emergency treatment, preventative care can be difficult to fund. Restorative treatment requiring outside lab fees was a challenge for some clinics that could cut costs within their clinic but were less able to reduce external lab fees for patients needing services such as dentures and crowns.

Although the clinics must charge fees to be self-sustaining, there is still a constant provision of pro bono work. As described by one manager, “If we are treating someone who is in urgent pain, we have to get them out of pain whether they have money or not, so we do quite a bit of pro-bono. You just can’t leave a person. What are they going to do? They will go home and try to pull their own teeth.” Pro bono work is not just limited to emergency situations. Initial exams are often write-offs in a model that seeks to increase access to comprehensive oral health care. According to one service provider, sometimes care “is just getting people in and giving them a sense of what is going on in their mouth, what the priorities are. They often just know they have a toothache, and they may assume the worst, that it will be a root canal, a crown, or a bridge and cost thousands of dollars and so we get them in here and give them an estimate.”

As fixed-site services, all dental clinics are limited in their ability to serve wide geographic areas, and even within urban Vancouver transportation barriers were noted. As described by hygienists in the Fraser Valley, “For a person to travel from Abbotsford, Chilliwack, Maple Ridge, or even from Burnaby which is only the next community over [from Vancouver]; by the time you travel over there and back and pay for your transit or pay for parking you have more than used your ten percent discount up anyway.”

As with all other models, the demand for services at clinics often exceeds the clinics’ capacities. The Cool Aid dental clinic in Victoria currently has a three-month waitlist as the sole community dental clinic on
Vancouver Island. There is also recognition that one clinic can’t effectively meet the diverse needs of low-income populations. For example, it can be challenging to meet the needs of single parents and families, low-income seniors, individuals who are homeless, and youth all within one site. As one participant commented, “Victoria needs more than one clinic, one response, to meet the diverse populations and needs.”

Many participants questioned the long-term viability of running clinics without operational funding. While the respondents involved in social enterprise clinics felt the model was working, they were also concerned about the risks. Social enterprise dentistry was described by one respondent as “fragile”, with nothing protecting it. “If people, or circumstances, or politics, change, we are too vulnerable. We are so close to the ground that it worries me. Even if someone came along and said ‘I want to run a clinic exactly like this one.’ In fact they do that all the time. They come and ask us, it’s like, first you need a miracle, first you need a building to fall into your lap.”

TEACHING CLINICS

In BC, as in other provinces, the education of dental professional students has included service learning opportunities. While these services were not a focus of this research, it is well recognized that teaching clinics and other service learning programs are viewed by many as a source of reduced-cost dentistry.

The University of British Columbia’s Faculty of Dentistry is an on-campus teaching clinic that reports seeing many patients who have multiple barriers to accessing care, not just financial but also active addictions and mental health issues. In an interview the administrator explains how the clinic operates with two mandates: “to service our patients while educating our students”. The UBC clinic resembles social enterprise clinics in that reduced fees are charged to patients, fees that are critical for the sustainability of the clinic. The fees are approximately 60 percent of the BCDA fee guide (a 40 percent reduction) and for Ministry patients it is explained, “we charge their fees, even if our fees are higher.” The exception is lab work, which the clinic pays at full costs.

There are limitations. As in other teaching clinics, treatment at the UBC Clinic takes longer than in a traditional private practice, and may include multiple screening appointments. As stated, “Sometimes it may not be convenient for the patient to come in as we have three hour appointments. Not everyone wants to be in a dentist’s chair for three hours”. No-shows are challenging for the clinic, not just financially but also because it impacts the students’ education. Finally the location on-campus means the clinic is not easy to access from some of the geographic areas populated by patients with the greatest needs.

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 take longer than treatment in a private practice.

UBC also provides community dental services through its off-campus training programs. The Skidegate Dental Clinic uses both UBC students and federal funding to provide cost-effective, comprehensive dental care for the residents of the First Nations communities of Skidegate, Old Masset, and Queen Charlotte Island. In addition, several community dental clinics in BC now partner with UBC’s Community Dental Residency Program to include resident positions in both volunteer charitable clinics and social enterprise clinics.
DISCUSSION

This study sought to better understand the ways communities throughout British Columbia are trying to improve access to dental services for low-income adults.

In recent years, there has been increased public awareness of the importance of oral health care as part of well-being, the inequities of access to dental services, and the links between poverty and poor oral health. Access to dental care was identified as a key issue in recent BC reports on the health needs of people who are homeless, sex trade workers, people with disabilities, and individuals receiving income assistance. As awareness has increased so has the urgency for communities to respond.

In 2005, the provincial ministries of Health Services and Human Resources announced funding to improve access to dental treatment. $47 million over three years was invested in not just improving dental coverage for children but also for vulnerable adults. Adults would benefit from funding to increase the provincial dental fee guides (from 63 percent to 80 percent of the dentists’ fee guide). In addition, the number of post-graduate dental resident positions was expanded for communities where access to dental services is a challenge, and there was funding for an increase in community dental hygienists and dental assistant positions. It was at this time that the provincial ministries also announced their support for increased community dental services, including the establishment of community-based dental clinics in communities where dental access is limited.

The BC government has played an important role in financially supporting the establishment and growth of community dental clinics. In 2001, the previous provincial government advanced over $1 million to open the Portland clinic, arguing dental health is important for people seeking work. In March 2005, the Minister of Human Resources announced $1.5 million over three years ($500,000 per year) to increase community dental services. In 2006, in partnership with the British Columbia Dental Association, this provincial Ministry allocated one-time contributions to seven community dental clinics totaling $230,000. In 2007 provincial support included the Ministry of Employment and Income Assistance allocating $449,000 in one-time funding to establish dental clinics in Kamloops, Prince George, Salmon Arm, Vancouver, and Vernon, aimed at providing “preventive and restorative dental care to low-income and homeless individuals.” According to individuals interviewed in this project, an additional $300,000 has been allocated by the provincial government to establish a dental program for low-income adults in Fort St. John.

BC Employment and Income Assistance minister Claude Richmond says that he supports government funding for community dental clinics because he believes they improve dental services for the most vulnerable people. “We’re committed to providing the best system of support in Canada for people most in need, and we know that access to dental services is important for all British Columbians... Community dental clinics provide a valuable service to some of our most barriered citizens. By assisting this dental clinic to purchase urgently needed equipment, we’re helping to make a difference in people’s lives.”

The provincial Ministry’s support for community dental clinics has even been mentioned as part of the “Five Great Goals” strategy, as explained by MLA Pat Bell when providing funds to establish the pain control dental clinic in Prince George: “The BC government, as one of its Five Great Goals, is committed to providing the best system of support in Canada for people most in need...[C]ommunity-driven projects such as this clinic are helping all British Columbians receive the services and support they require.”
In announcing funding for the Salmon Arm clinic, Minister of Health and local MLA George Abbott explains the government’s position on community dental clinics: “Community dental clinics are specifically designed to meet the unique dental needs of the most vulnerable citizens and provide them with a comfortable, familiar and convenient setting to access the services they require….Our Government has committed itself to providing the best system of support for British Columbians in need. By partnering with community dental clinics like this one, we’re not only making that commitment a reality, we’re helping to ensure that all British Columbians have access to the services they need to lead healthy and meaningful lives.”

To date, provincial support for community dental clinics has been limited to these one-time contributions. However, there appears to be growing acceptance from the provincial Ministry of Employment and Income Assistance that community-based dental clinics are a suitable response to this issue and through their limited support we see community dental clinics increasingly entrenched as a response to oral health disparities based on income.

Where to go from here? Communities throughout BC seek support in their efforts to reduce the financial barriers being faced by low-income adults in accessing dental care. This request, however, is tempered by concern that further support for community-based responses will in effect further institutionalize a two-tiered system of oral health care in the province.

One respondent had sought government support to establish a community-based alternative in her area, but at the same time stated, “I worry that it isolates us even further from the private practice dental community because we can look after the poor folk and just send them the Type A, cream patients with two dental plans”. Another voiced her concern of, “A two-tiered system where for public health you get almost cast-off dentistry, the bare minimum”. One participant advocated for two-tiered dentistry as a realistic response to the limits of the current situation, stating, “It almost seems that there has to be a two-tiered system, one for the rich and one for the poor”.

A manager of a dental clinic summed up the contradiction: “We run a dental clinic because we see the need, not because we agree in dental clinics… I think every clinic is a band-aid, but I think we are forced into having to try to do something.” Another respondent added, “We’re running around like chickens with our heads cut off trying to go to charities, setting up dental access funds…we can’t keep up”.

For these reasons, the recommendations from participants appear contradictory – communities want support for effective, sustainable community-based treatment options but there is a greater recommendation for policy changes that equate dental care with health care and ensure equitable access. According to one participant, “The ideal situation would really be a dental plan, then you don’t have to create another one of our clinics… That seems to be the first step – then creating our hodge-podge model is second. It’s not like we would go out of business if there was a full dental plan out in the province. People still have needs that can be met through a non-profit model.”

An integrated provincial strategy to improve access to dental treatment for low-income and vulnerable adults in BC could be a first step to addressing the needs identified in this report and supporting the community-based responses emerging throughout the province. This strategy could build on existing planning initiatives and current developments throughout BC. The individuals and groups currently responding to these needs through their community clinics, dental access funds, and advocacy efforts are a valuable resource to be engaged in the development of a provincial strategy. The dedication and innovation within these community-based responses is impressive.
The community projects surveyed as part of this research help thousands of British Columbians who otherwise could not access dental care, and yet they are inadequate to solve the dental access problem in BC. A coordinated, evidence-based strategy that recognizes the diverse needs of individuals and communities and ensures best clinical practices while improving access for the most economically vulnerable citizens would be prudent, considering the current growth-without-planning situation experienced in the province. Arguably, if this community-based sector is to receive continued support, that support should also be coordinated, strategic, province-wide, adequate, and dependable.

The recommendations, summarized in this section, include: (a) policy and legislative changes to address the systematic inequalities that create oral health disparities based on socio-economic status, (b) improvements to existing public benefits and acceptance of these benefits by dentists in private practice, and (c) support of community-based responses to ensure sustainability and appropriate clinical standards of oral health care. Caution is also recommended. As community-based responses continue to expand across the province, we need to ensure that band-aid solutions are not being supported as a just response to the province’s population oral health care needs.

1. That the Provincial Government, regional health authorities, professional associations, community organizations, and other interested parties, collaborate strategically to reduce the multiple barriers to oral healthcare currently experienced by people with low-incomes in BC.

This research describes how communities throughout BC are struggling to provide access to treatment for the many adults in their communities who cannot afford necessary dental care. With little data available on communities’ oral health needs and with no evaluation of the existing responses to inequities in accessing care, there is little evidence to guide and support attempts to reduce barriers for adults accessing dental treatment. Despite inadequate evidence, community programs are receiving increasing funding in a way that appears to lack overall strategic planning or coordination. Communities would be better supported by funding that was evidence-based, and developed in collaboration with public, private, and non-profit stakeholders. With funds already being made available to address this issue, it is time to develop a plan that ensures that funding effectively reduces inequitable access to dental treatment, addresses the oral health disparities linked to socio-economic status, and meets the unique needs of specific population groups in BC.

2. That the Provincial Government and Health Authorities integrate service planning, delivery, and evaluation to recognize oral healthcare as an essential and integral component of primary healthcare.

This research heard repeated calls for effective integration of community-based dental treatment options within primary health care initiatives. Within several of the communities visited, primary health care initiatives were emerging such as interdisciplinary health centres providing a range of health care and social services often geared to at-risk groups. The request was for the inclusion of funded, staffed dental clinics within these programs. The integration of community dental clinics within community health centres was viewed as fulfilling a primary health mandate, but sufficient funding is needed for the dental side of the health centres to ensure effective service delivery.
3. That basic oral healthcare services be covered fully for BC residents as part of the BC Medical Services Plan. While struggling with the day to day impacts on individuals, the larger, structural issues were not forgotten by the clinicians and administrators interviewed in this project. In fact, for many participants each individual need was a reminder of the effects of omitting adult dental care from the public health care system. The financial barriers for adults accessing care would be significantly reduced if dental care was, like medical care, covered under a universal provincial insurance plan, and access based on need rather than the ability to pay. While respondents recommend immediate help for those in need, they first recommend publicly funded access to dental care.

4. That the provincial and federal government agencies and the British Columbia Dental Association harmonize treatment fee guides so that dentists in private practice will be encouraged to care for all British Columbians. There was consensus among participants in this project that the existing public benefits for the province’s most vulnerable adults are not adequately ensuring access to necessary dental care treatment. It is strongly recommended that; (a) the public and private dental fee guides be harmonized, (b) the provincial government improve public benefit plans by expanding the scope and limits of treatment options, assure timely payments to dental offices, (c) extend public dental benefits to the working poor and other populations who currently have no access to dental coverage, and finally (d) that dentists treating patients using government negotiated fee schedules should not be permitted to balance bill.

5. That appropriate BC Ministries collaborating with regional health authorities provide sufficient capital and operating funds for community dental clinics to offer oral healthcare services at a standard of care similar to most private dental practices in BC; and to implement quality assurance controls and evaluative processes in community dental clinics comparable to other primary care services. Community-based responses are successful in partially addressing the needs of the communities they serve. However, facilitators of these initiatives are concerned about their precarious balancing of needs and resources and their inability to adequately respond to patient needs within existing resources. While each health authority in the province delivers public dental health programs, few resources are dedicated to improving adults’ access to dental care. Sustainable funding for community-based responses throughout the province would improve the ability of communities to respond effectively to the demand for services.

6. That governmental and professional agencies assess the capacity of private practitioners to address the needs of low income and other vulnerable residents of BC. The limits of private practice dentistry to meet the public oral health needs of all adults in BC were made very apparent by participants in this research project. Participants made a variety of recommendations towards enhancing public oral health service delivery. While public dental staff are often the primary contact for adults in need, their mandate is for the most part focused on children’s oral health rather than adults. Without a mandate to respond to adults’ needs for dental care, public dental staff struggle with how to respond.

7. That the regulation and education of dental professionals be reviewed in light of the growing disparities in healthcare and the particular needs of the least advantaged members in our society. Participants recommended that university and college curricula prepare dental professionals to serve the oral health needs of vulnerable adult populations as well as ensuring that regulations best utilize dental hygienists and certified dental assistants in responding to public dental health needs.
REFERENCES


BC Ministry of Employment and Income Assistance


APPENDIX A:
COMMUNITY-BASED DENTAL PROGRAMS FOR LOW-INCOME ADULTS IN BC

DENTAL ACCESS FUNDS

KOOTENAY BOUNDARY DENTAL ACCESS FUND

A Dental Access Fund was created in 2001 to facilitate access to dental care for people unable to afford the costs of treatment or facing barriers to treatment due to their limited public benefits. The Fund is presently hosted by a charitable, non-governmental agency (Trail Family and Individual Resource Centre Society or FAIR).

Each Dental Health Month (April) fundraising efforts are launched. This is the most time-consuming task related to operating the fund. In recent years the fund has raised approximately $10,000 a year. Patients who qualify for premium assistance for the provincial Medical Services Plan are considered eligible for up to a maximum of $500 from the Dental Access Fund if they meet the criteria (pain /infection). All clients referred to the Dental Access Fund are pre-screened and must meet the established dental and financial criteria before any funding allocations are made.

Approximately 300 individuals have accessed funds thus far, with subsidies ranging from $50 to the maximum $500. The focus of the program is on relief of pain and infection, and most of the funds are directed to these services (largely extractions); however, funds permitting, money may be provided for restorative work or dentures.

Local participants involved in the Dental Access Fund are keen to continue as they feel it is a limited but viable response to the dental access needs of low income adults living in a rural area.

SMITHERS: THE YOUNG PARENTS DENTAL PROGRAM (YPDP)

In Smithers, the YPDP Committee was established in October 2006 by a public health nurse who was contacted by young mothers with dental pain and/or infection and no means to pay for treatment. With Committee members working off of the side of their desks, they applied for and received, small grants to try to cover the costs for young parents who could not pay for dental care, had dental treatment needs not covered by their dental plan, or could not find a dental office that would accept their benefits coverage. In its first year, the Committee has raised $6,300.

The goals of the YPDP are:

1. Build and maintain relationships with the dental community, service providers, young families and financial partners to increase coordination of dental care services for parents of young children who are currently unable to access dental care.
2. Raise awareness and understanding of the dental gap for young parents and how dental health has an impact on overall health for parents and their children.
3. Raise awareness of the dental access barriers that families face and work with dentists and service providers to address and reduce access barriers.
4. Support families to meet their dental treatment needs (including financial), improving the oral health of parents and their children and creating a better quality of life for current and future generations.
NORTH OKANAGAN DENTAL ACCESS BURSARY FUND

Ongoing fundraising supports the Dental Access Bursary Fund. The fund aims to reduce the financial barrier for individuals who may not be in urgent need, but still require necessary dental treatment – “to help people get treatment that was other than urgent but that was really needed for employment and for function – like eating.” To qualify, a treatment plan from a dentist/denturist is required. The same financial criteria used by MSP for premium assistance is used to qualify for the Dental Access Bursary Fund. The program is limited by resources. Bursaries pay half of dental treatment costs, but only to a maximum of $175 and as of 2007 the fund had been depleted and consequently was not available for individuals in need.

VOLUNTEER CHARITABLE DENTAL CLINICS

EAST SIDE WALK IN DENTAL CLINIC

The volunteer, walk-in clinic is located in Vancouver’s Downtown Eastside in space donated by the Vancouver Native Health Society which also operates a medical clinic. Volunteers provide relief of pain services at no cost to “the very poor”. The dental clinic opened in May 2005 and by the end of that year 129 patients had been treated by 24 volunteer dentists; the annual report for 2006 records 77 clinic days with 500 patients treated by 34 volunteer dentists, five hygienists, and twenty-five CDAs, dental assistants or students. The clinic currently operates two days a week.

The East Side dental clinic exists through the support of the Christian Medical and Dental Society, the BC Dental Association, the donation of space from the Vancouver Native Health Society, and the dedication of volunteer clinicians. Most recently the clinic developed a partnership with the Vancouver College of Dental Hygiene which will supply two students every session. The clinic now has a staff person which provides stability and continuity to the clinic. Up to this point the stability of the clinic has depended on its volunteer founder, Dr. Alex Yule.

KELOWNA GOSPEL MISSION DENTAL CLINIC

Kelowna’s free dental clinic, open since 2004, is the result of a community development process that took several years. The clinic was made possible with start-up funds ($116,000) from the National Homeless Initiative and space provided by the Kelowna Gospel Mission. The Kelowna model is an emergency two-chair clinic staffed by volunteers providing free dental care to people experiencing dental pain or infection who cannot afford treatment in a private clinic. Volunteer dentists and their CDAs staff the clinic two evenings a month, with a part-time (paid) clinic coordinator responsible for the overall coordination and operations of the clinic. The clinic treats an average of 12-13 patients per clinic night.

The clinic recognizes both the necessity and the limits of these services as well as the challenges of providing more comprehensive dental services. The most significant expansion of services has been their evolving denture program that links funds from billings, reduced charges from a lab, and a rotation of approximately 12 dentists who provide the work in their own practices according to the financial need (free if there is no coverage, or billing benefits if the patient has coverage). The clinic is currently able to provide 12 dentures a year; there are 11 on a waitlist so the service would need to double to meet the existing patient demand.

While the clinic received a $52,000 capital grant from the provincial government in 2006, this was a one-time grant and the clinic is currently sustained without government funding. The clinic currently relies on a
combination of low overhead costs, volunteerism, recovered fees from patients’ public dental plans, and charitable donations. Financial support includes subsidies and donations from dental supply companies and labs.

**PRINCE GEORGE EMERGENCY OUTREACH DENTAL CLINIC**

The Prince George Emergency Outreach Dental Clinic is located within the Native Friendship Centre and is currently operating the 2nd and 4th Tuesday evening of each month. The clinic is staffed by volunteer dentists, dental assistants, hygienists, and a part-time paid coordinator. Services are provided to individuals who are experiencing dental pain and/or infection or want their teeth cleaned, and who are not able to afford dental treatment in a private office.

The services provided by the clinic are primarily assessments, extractions, and oral hygiene. On average, about 10 patients are treated during each three-hour clinic session. In each year, over 200 patients receive care (200 extractions) at an estimated treatment value of $30,000 a year.

A partnership with UBC dental resident students has allowed the clinic to expand to basic restorative services. The Dentistry Residence Program’s four weeks in the clinic provides over $25,000 treatment to eighty clients. This treatment includes approximately 70 extractions, over 100 fillings/restorations, 40 sealants, and other services.

**NORTH OKANAGAN’S DENTAL ACCESS PROGRAM CLINIC**

Housed in the Vernon First Nations Friendship Centre, this clinic is open weekly for individuals who are in need of urgent dental treatment and are unable to pay for private services. The clinic is staffed by a dental hygienist. The hygienist provides a visual screening and financial assessment and if the individual qualifies for the program, they are referred to a participating dental practice which volunteers to provide the emergency dental services. “They will get the individual out of urgent need. They don’t tend to do crowns, they don’t tend to do root canals. It’s mainly extractions and maybe some fillings.” Fifty-seven percent of dentists in the North Okanagan participate in the Dental Access Program. Organizers note that “the need for the emergency dental services is growing as agencies and the public learn about the Dental Access Program.”

**SOCIAL ENTERPRISE & SUBSIDIZED DENTAL CLINICS**

**KAMLOOPS NEW LIFE MISSION DENTAL CLINIC**

The New Life Mission is a faith-based social agency providing multiple services to people in Kamloops who are poor, homeless, and/or substance-dependent. The dental clinic, part of the New Life Health Centre, was started by Dr. Alex Yule in 1998 with a mandate to provide relief-of-pain services.

In 2002, a $32,000 federal homelessness grant was secured and a part-time receptionist/volunteer coordinator was hired. With twelve local dentists volunteering their services by this time and the coordinator resources provided by the grant, the clinic expanded its scope of practice from just extractions to also providing fillings, and also switched from being a volunteer clinic to its current social enterprise model. Dental services are provided by a single dentist. Individuals in the community with private dental plans are charged full fees, which underwrites the costs of providing reduced-fee services to low-income community members as well as subsidizing the clinic’s supplies and overhead costs. Any remaining profits go to the dentist.
The busy two-chair clinic operates two days a week and now includes full restorative treatment. The dentist does “drilling, filling, pulling, crowns, bridges, we are doing it all. And he will do it all whether they have money, whether they have a dental plan, whether MEIA pays for it, whether they give him $5”. In addition, the social enterprise model results in the dentist donating funds back to the clinic’s operations and keeping a significant profit for himself. Government partially supports this innovative model, providing a capital funding grant ($7,000) in 2006 and $50,000 to expand the model to Salmon Arm in 2007.

Financial sustainability is attributed largely to the in-house production of dentures, but also to initiatives such as staff at New Life Mission programs using the clinic with their full dental plans.

**MID-MAIN DENTAL CLINIC**

The Mid-Main Community Health Centre started in 1988 as an expansion of the REACH vision of community health centres throughout Vancouver. Fees for their dental services are charged according to public dental insurance plans; individuals without dental insurance are charged 10 per cent below the fee guide. This is a full-service dental clinic with paid staff specializing in “serving the whole family”.

Both Mid-Main and REACH write-off a considerable amount of dental work, estimated at approximately $30,000 to $50,000 by each clinic per year. Most of this unbilled work is initial examinations, which aims to get people in the door and give them a sense of what is going on in their mouth. The initial examination helps alleviate patient fears and provide a realistic sense of treatment options.

**PORTLAND COMMUNITY DENTAL CLINIC**

The Portland Community Dental Clinic provides comprehensive dental care to adults living in Vancouver’s Downtown Eastside. Patients are charged the amount covered by their dental benefits, or a reduced fee if they have no benefits. This is a fully staffed, full-service clinic providing emergency, restorative, and prevention services. The clinic opened in September 2001 and in its first six years has seen more than 3,500 patients.

The Clinic has a unique funding mechanism. The University of BC manages the Portland Dental Clinic Endowment Fund, established in 2004 with a $500,000 grant from the provincial government and the Vancouver Agreement. The fund generates interest revenue for the clinic and also provides a mechanism for further government and private donations; since its establishment it has doubled and now contains $1 million. In addition, the Vancouver Coastal Health Authority provides $100,000 per year in operational funding.

**REACH CLINIC**

The REACH Community Health Centre has provided dental service in East Vancouver since 1973. The Clinic operates as a non-profit, social enterprise model encouraging people with private dental insurance to seek services at their clinic which helps to subsidize those who do not have insurance. Following the community-health centre (CHC) principle, the dental staff are salaried rather than relying on a fee-for-service model. Recent reports indicate that approximately 6,500 patients are treated annually, resulting in approximately $750,000 in dental fees being collected. Fees and services are geared to one’s benefit plan; low-income, non-insured patients are offered a 10 percent reduction.

In recent years, REACH ended their emergency dentistry program which involved UBC dental students treating people with dental emergencies for a flat fee of $7. This program operated every Tuesday evening.
for nearly 25 years, treating an average of ten patients (primarily with extractions) each night. The UBC students volunteered and facilitated the clinic, with volunteer dentists from the community (most graduates of UBC) providing supervision. The minimal fees covered the costs of supplies and materials. REACH now operates an Emergency Dental Fund, which assisted 30 patients in 2006.

**STRATHCONA COMMUNITY DENTAL CLINIC**

Vancouver’s Strathcona Community Dental Clinic is a project managed by the Strathcona Health Society that operates out of the basement of the Strathcona Elementary School. The clinic primarily serves the needs of children in this low-income, ethnically diverse neighbourhood, but with a mandate to serve families also treats parents and seniors. As a social enterprise clinic, the financing strategy combines revenue from donations, grants, and recovered fees-for-service. The clinic started with $200,000 in government grants, approximately $100,000 from foundations and donations, as well as a $50,000 start-up loan and operating line of credit from a major credit union. Currently, 85 percent of its revenue is generated through fees-for-service such as billings to Healthy Kids. The Clinic offers a 20 percent fee reduction and conducts annual fundraising to cover the costs of treatment for families without the ability to pay.

**VICTORIA COOL AID SOCIETY’S DENTAL CLINIC**

Victoria’s dental clinic is the outcome of a three-year community development initiative coordinated by the Victoria Cool Aid Society that included a survey of 150 low-income individuals and a dental clinic feasibility study. The Health Authority then partnered with the Cool Aid Society, providing start-up funding and an annual subsidy of $150,000.

Opened in 2002, the dental clinic is part of a comprehensive community health centre designed to reduce the significant barriers facing the downtown population in accessing health services. The dental clinic is a three-chair practice, open five days a week, with paid dental staff who provide a full range of dental services (including hygiene and restorative care) to over 4,500 patients per year.

Financial sustainability of the clinic depends on the annual health region grant and the collection of reduced fees from patients. Approximately two-thirds of patients have public dental benefits (primarily through MEIA). Overall, fees are reduced by 30 percent, with negotiable payment plans. Treatment plans take what clinic staff call “a realistic approach”, starting with the most urgent needs and moving on to restorative work when the patient has paid the initial bill. Work is done in blocks so as “not to financially overwhelm both the patient or the clinic’s resources”.

**COMMUNITY COALITIONS & DENTAL ADVOCACY**

**HEALTHY TEETH FOR HEALTHY EATING PROJECT**

In the Nelson and Kootenay Boundary area of BC, 15 organizations and programs have come together to increase public and government awareness and promote policy change regarding the health impacts of inadequate access to dental health care. The project links oral health with healthy eating, working to raise awareness that “access to dental care is as important as access to food” and that “you can’t eat healthy food if you don’t have healthy teeth”.

The project began in late 2006 with the support of the Interior Health Authority’s Community Action
Health Initiative. Thus far the coalition has prepared a Community Policy Action Paper, hosted public meetings and day-long planning sessions, and raised the issues in the local media.

The coalition’s draft goals for a “Local Rural System for Dental Care Access” are:

- To improve and support oral health for all community members.
- To increase access to dental care for people who do not have effective access.
- To promote policy change at all levels to increase dental care access and support dental health for all.
- To raise public awareness and “popularize” the issue of dental care access.
- To foster positive public attitudes about people living with low incomes and other challenges.
- To have a sustainable, functioning local system that works to attain these goals.

TERRACE DENTAL ACCESS ORGANIZING

In 2006, the Executive Director of a local social service agency approached the local public health hygienist to collaborate on increasing access to dental care. The barriers were listed as “low income, lack of dental insurance and no transportation to dental offices”, and the groups with particularly high unmet dental needs identified as “young pregnant mothers, seniors, mental health clients, and the working poor”. The Society is working to establish a ’dental trust fund’ similar to the program in Trail. The fund will hopefully assist working families with no benefits as well as paying the difference between actual dental costs and public insurance coverage for individuals receiving welfare or other public benefits.

NORTH OKANAGAN’S COMMUNITY DENTAL ACCESS INITIATIVE

In September 2006, a group of individuals from non-profit agencies approached the Dental Access Program with the concern that their clients’ dental needs were not being met. In response, a low-cost dental clinic for Vernon was proposed and received what one participant called an “overwhelming response”. The Steering Committee was created to guide the development of the clinic.

The goal is “provide barrier-free access to quality restorative and preventive dental care”. The Committee specifically aims to develop a service that will reduce visits to the hospital ER and resolve dental issues that are preventing individuals from gaining employment.

In April 2007, the project received financial support from the provincial government. The media release states “$20,000 will be used to purchase capital equipment for the new low-cost community dental clinic opening next year”. The Committee estimates start-up costs of $250,000 will be necessary, stating, “We will be seeking donations of equipment and supplies and we hope to get a reduction in the cost of building materials. Therefore, we are estimating a cost of a minimum $160,000 to equip three operatories, a sterilization station, reception area and waiting room.”

The Steering Committee is currently researching models of dental care used by other low-cost clinics to help them develop a plan for financial sustainability. According to one participant, “Our goal is to choose a model that is a non-profit and would generate enough income to pay for the clinic to operate without a subsidy.” They also dream of an integrated service, possibly to be a part of the new Primary Health Care centre currently under development in Vernon.
APPENDIX B – INTERVIEW GUIDE

Questions for communities

1. What are the needs being identified by your community/group? (focus on adults' needs)
2. Tell me the history of how your community has noticed these needs and how you have been responding.
3. What are the current responses to the needs? (clinics, access funds, grant writing, etc.)
4. What oral health care policies are in existence to meet adults' need for dental care? (MEIA benefits, refugee benefits, etc…)
5. What oral health care services are in existence to meet the need? (clinics, volunteers, charities, benefits/insurance plans, hospital ER, etc)
6. Are the services effective and sustainable?
7. How are services evaluated (criteria; by whom), and are recommendations from program evaluations implemented?
8. What plans are available to change oral health services?
9. What would help your community to respond to the needs and be effective?

Extra questions for clinics

1. Describe clinic (as detailed information as possible; revenues, expenditures, size and staffing, services offered/not offered, etc.)
2. What is the history of this clinic?
3. What are the challenges and barriers to establishing and operating a clinic?
4. What research would be beneficial?
5. What plans do you have for the future?
NOTES

1 “Low income adults” is not strictly defined in this paper nor in the community initiatives profiled. Some community projects defined income eligibility simply as “not able to afford dental treatment in a private dental office” while others used the criteria for provincial medical premium assistance (MSP) to define income eligibility. Full MSP assistance is provided for individuals in BC with a net income below $20,000 and partial reductions provided for those with incomes up to $28,000 a year.

2 Currently in BC dental care is primarily provided by dentists, dental hygienists, dental assistants and denturists. Dental therapists provide primary dental health care services (fillings, extractions and caries preventive services) but currently in BC limited to on reserve populations.


4 Victoria's most recent homeless count (Victoria Cool Aid Society, 2007) reported that 34 percent of those surveyed named lack of dental care as a barrier to finding work; “Lack of dental care, which is excluded from our medicare system, is an ongoing barrier for many people to participate broadly in the community” (p. 51).

5 Over a one year period (2006-2007), Victoria's Prostitutes Empowerment, Education, and Resource Society (PEERS) surveyed 57 clients. The survey unexpectedly found half of the respondents cited dental problems as a health concern. In fact, dental problems were the leading health concern of the sex workers surveyed, ahead of mental health diagnosis, Hepatitis C, and all other concerns (PEERS, 2007).

6 The BC Association for Community Living met with the Minister of Employment and Income Assistance in spring 2007 to present their brief “Nothing to Smile About – a brief addressing the inadequate levels of dental and medical coverage for people with disabilities receiving income assistance.” The report states that “In BC many people with developmental disabilities continue to report that their dental care needs are unmet” (p. 3) and includes a recommendation to “resolve the critical issue of access to dental care by upgrading the fee schedule and addressing bureaucratic obstacles that affect dentists and their patients” (p. 6).

7 In a meeting with the Ministry of Employment and Income Assistance in March 2007, legal advocates from across BC identified the lack and inadequacy of dental benefits for people receiving welfare as a priority issue. See BC Government (2007).

8 BC Ministry of Health Services & Ministry of Human Resources. (2005).


10 BC Ministry of Health Services & Ministry of Human Resources. (2005).


17 Wallace (2000).

18 Wallace (2001).
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The Victoria Cool Aid Society advocates for and provides integrated health care services, supported housing and emergency shelter to marginalized adults in the Victoria area. In 2002, a dental clinic was established as part of its comprehensive community health centre. Currently the ACCESS health centre is being developed as a new home for these integrated services.