

# The History of Dental Programs for Older Adults

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## A b s t r a c t

*Compared with other age groups, the elderly have less access to oral health care services and poorer oral health status. Most provinces have no publicly funded programs to address these inequities and the volunteer efforts of professionals and hospital-based programs have had little effect. In Ontario, two expert committees have called for seniors' programs augmented by a strong outreach component to be delivered by public health services. Their recommendations have not been implemented and, worse, some public health programs have lost the capacity to maintain the preventive services they once provided. The development of public policy to address the needs of the elderly is thwarted by the narrow definition of public health problems, the reluctance of the dental profession to lobby for public funding, the bias toward investment in younger groups, and the persistence of a "reverse public funding program" whereby the employed, more affluent receive dental care as a tax-free benefit and the retired, lower-income elderly pay in after-tax dollars.*

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The dental care needs of Canadian seniors are not being met because of economic and other barriers. In 1994, only 34% of Canadians, aged 65 and older, reported having visited a dentist in the last year. In contrast, 87.5% of them had visited a primary care physician — a 2.5 fold difference.<sup>1</sup> Although Alberta, the Yukon, and the Northwest Territories offer seniors dental care as part of their universal health care programs, Ontario and eight other provinces do not.

The Canadian dental profession's interest in the special needs of the elderly first appears in the reports of the Council on Public Health in the late 1960s.<sup>2-4</sup> One of the earliest published references described the dental health care needs of seniors at Baycrest Geriatric Centre.<sup>5</sup> A flurry of regional and one province-wide (Quebec) studies followed and demonstrated that, over time, higher proportions of seniors were keeping their natural teeth and many of the dentate were visiting the dentist.<sup>6</sup> Along with increased lifespan, the trend toward more needs and more visits was seen to present challenges to Canadian policymakers and dental practitioners.

## Review of Dental Programs

### **Federal**

The Department of Veterans' Affairs has provided dental services to veterans since 1944. With the advancing age of veterans, this has become a seniors' program. The federal

government also provides care under the Non-Insured Health Benefits (NIHB) program for native peoples. Although this program is not specifically for seniors, elders are eligible for the services.<sup>7</sup>

### **Provincial and Territorial**

In 1973, Alberta introduced a program for seniors and their dependents that was extended in 1983 to low-income widows and their dependents. Over the first few years, utilization varied between 25.5% and 27.5%. After 1980, utilization rose to between 30 and 36%.<sup>7</sup> Since then, Lewis and Thompson<sup>8-10</sup> have examined the program in more detail; they estimated that about 45% of eligible people used the plan in 1991-92.

The governments of both the Yukon and Northwest Territories (NWT) offer seniors dental programs. Both programs are "payers of last resort" and, therefore, those who have private coverage or coverage under the NIHB federal program are not eligible. The Yukon program covers those aged 65 and over and their spouses aged 60 and older. In the NWT, residents aged 60 and older are eligible and the program is administered by Blue Cross, Alberta. Utilization of the program is estimated to be 25% of eligible seniors.

In Prince Edward Island, the Department of Health provides screening, referral and preventive measures to seniors in the provincial long-term care facility.<sup>11</sup>

## Focus on Ontario

### ***Expert Committee Recommendations***

In 1980, the Ontario Advisory Council on Senior Citizens<sup>12</sup> published a position paper on the dental care needs of Ontario's seniors. The report pointed out that 6 of 10 seniors living independently required dental care and that the needs of those in institutions were even greater. The council recommended that public health units conduct dental health promotion programs for seniors, carry out screening and referral, and provide follow-up activities in the community and institutions. They pointed out the need to locate dental clinics and staff in long-term care facilities and for better distribution of information about dentists willing to treat seniors.

In April 1989, the Ontario Minister of Health's Advisory Committee<sup>13</sup> reported on a provincial plan to provide dental care to seniors. The committee found that: many seniors had high levels of unmet needs; a growing number of seniors were retaining their natural teeth and expected a lifetime of good dental health; many could not afford dental care; those living in institutions and those who were home-bound had difficulty gaining access to services; and organized dental services reached only a small percentage of this population.

The advisory committee recommended a community-based health promotion program and a targeted dental treatment program. The health promotion program, to be provided by local public health unit staff, was to include dental screening; referral for those in need; provision of appropriate preventive measures; and annual in-service presentations to staff who provide personal care to the residents. The dental treatment program included a comprehensive list of services to be provided by dentists and denturists. To overcome the apparent barriers to utilization of even "free care" demonstrated in Alberta, the committee recommended a registration process, whereby specific encouragement to use the program could be aimed at those who were not using the services.

### ***Guidelines for Local Public Health Programs***

Until 1974, local dental public health programs in Ontario operated according to local identification of needs; there were no provincial guidelines. In 1974, the Task Force on Community Dental Services<sup>14</sup> recommended that more comprehensive services be provided to specific adult groups such as geriatric and handicapped people. In 1982, a revised draft guideline, under the then-proposed *Health Protection and Promotion Act*, was circulated for comment.<sup>15</sup> The draft guideline would have required health units to provide screening, referral and follow-up, clinical preventive measures, dental health education, and advisory services to seniors' facilities and all seniors. This was essentially a program of universal preventive services. However, by the time the guideline was published,<sup>16</sup> the proposed coverage was greatly reduced, namely, to residents of collective living centres, such as homes for the aged, chronic care hospitals and chronic-bed residents in general hospitals. Johnson and Deber<sup>15</sup> stated that "the final program appears to be largely a symbolic policy response

which is unlikely to have major implications for either efficiency or community effectiveness."

The most recent revision of these guidelines was released in December 1997.<sup>17</sup> Despite strong representation on behalf of the needs of seniors and on the effectiveness of prevention, preventive dental care for seniors was not included in the guidelines. The guidelines do call for the reduction of both tobacco and alcohol use, which should have a positive effect on periodontal health and in preventing oral cancer. Thus, in Ontario, preventive dental public health services for seniors are no longer mandated and, as a result, public health programs are losing the capacity to offer community-based preventive services.

### ***Initiatives of the Profession***

In 1973, the Ontario Dental Association (ODA) submitted a proposal to the provincial government for a publicly funded, dental health care program starting with young children and people aged 65 and older.<sup>18</sup> Again in July 1987, the ODA proposed a Dental Plan for Ontario's Elderly in which they called for universal dental coverage of those covered by OHIP, starting at age 65.<sup>19</sup>

In the early to mid-1980s, the ODA also encouraged local component societies to set up and maintain volunteer programs in the collective living centres in their area.<sup>20</sup> However, the volunteer approach was not successful.<sup>21</sup> This is not surprising, as others<sup>22</sup> had shown that many dentists were not interested in attending an institutionalized geriatric population and that their lack of participation in volunteer services to those in institutions was related to their anticipation of poor economic returns.<sup>23</sup>

## Local Efforts in Ontario

### ***Public Health***

In 1982,<sup>24</sup> 23 of 43 Ontario local health units offered community-based programs for seniors, but, by 1987,<sup>25</sup> and again in 1993-94,<sup>26</sup> the number reporting seniors' services had fallen to 16. Although many of the programs were minimal, the Simcoe County Health Unit<sup>27</sup> and the former City of Toronto<sup>28</sup> offered no-charge programs of screening, referral and follow-up, and clinical preventive services to residents of collective living centres. In Toronto, seniors can also receive treatment services from one of five community-based clinics.

### ***Hospitals and Institutions***

Few Ontario institutions for seniors offer in-house dental care. Two exceptions are Parkwood Chronic Care Hospital in London and the Baycrest Geriatric Centre. The program at Baycrest has also contracted to provide care for the residents of the Toronto Homes for the Aged. A third program operates out of St. Peter's Hospital in Hamilton. It is administered by a foundation supported by service clubs and agencies.<sup>29</sup>

## Observations

Four continuing problems are holding back the development of dental care programs for seniors. As a close observer of

the Ontario scene and a participant in dental health policy development in Ontario and elsewhere for over 30 years, I state these bluntly and in the extreme to emphasize my points.

The first problem, as demonstrated by the process of developing Ontario's 1997 mandatory public health program guidelines, is that health care policy increasingly tends to be defined more narrowly, largely in terms of the publicly funded, sick-care, delivery system. Bluntly stated, the perception is that if public money is not involved in treating the problem, then it can't be a real health problem and society doesn't need to develop a strategy to deal with it. In rebuttal, it is clear that national accounts do not differentiate between expenditures on health care paid directly and those paid via the progressive tax system. The fact that the costs of dental diseases to the economy are third highest, behind cardiovascular diseases and mental health, but ahead of all cancers,<sup>30</sup> appears to have escaped detection by many policymakers.

Second, as evidenced by my experience with the Ontario Minister's Advisory Committee, the dental profession, generally, holds that the needs of the population can be best (only?) met through patients' free choice of private dental practitioners and that private practitioners may only be paid on a fee-for-service basis. The recommendation for organized efforts to improve the utilization of the proposed seniors program, as recommended by two senior advisory committees, was opposed by the profession.<sup>31</sup> This produced a policy stalemate and contributed to the loss of an opportunity to capture some resources to address the dental needs of seniors. When it came to a decision, the dental profession was leery of public funding of seniors care because of a fear that the funds would be controlled or would be provided in an unusual manner. Thus, there was, and continues to be,<sup>29</sup> no strong provider lobby for publicly funded dental care for seniors.

Third, there is no demonstrated return on investment in dental care for the elderly. In contrast, there is strong evidence that investments in enrichment programs for young children pay off in improved development, better educational achievements, higher-income jobs and, ultimately, a net contribution through subsequent taxes to the funding of social programs.<sup>32,33</sup> Therefore, new funding for children's enrichment programs (e.g., enriched day care, school lunches) can sometimes be pried out of reluctant ministers of finance on the basis that they are prudent social investments; but the same argument cannot be made for seniors' dental care. This "investment" approach, of course, denies the tenet that health care is a fundamental right of all, not just those who are expected to be net economic contributors to society.

Fourth, most of those who decide that dental care is not sufficiently important, or is too costly to include in publicly funded health care programs, have access to tax-free dental care through employers' plans. Their decisions maintain a policy that might be called a "reverse public funding program" whereby the more affluent, employed people have the benefit of (largely) tax-free dental care, and the forgone taxes are made up by society as a whole (including the poor and the elderly). If society can support dental care for employed and affluent

citizens, through billions of dollars in tax expenditures, surely we can find money to level the field for others who are past working age and have lower incomes. Although it is still too early to tell if the new tax provision that allows individuals to deduct their insurance premiums will have any effect, the fact that the elderly and the working poor have had to pay for dental care in after-tax dollars is not consistent with the role of government in redistributing the benefits of Canadian society to those who need them most. ♦

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*The views expressed are those of the author and do not necessarily reflect the opinion or official policies of the Canadian Dental Association.*

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