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Why was dental care excluded from Canadian Medicare?

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Abstract

Internationally, health policy analysts are often surprised that Canada's national system of health insurance (Medicare) does not include dental care. Understanding the historical reasons for its exclusion can inform current domestic and international policy debates on dental care. This paper proposes five interrelated reasons for why dental care was not incorporated into Canadian Medicare (i.e. legislative, professional, socio-cultural, economic, and epidemiological). In summary, dental care was not included because of significant decreases in dental caries and limitations in dental human resources as the country's health legislation was being developed, alongside the presence of a viable alternative option to large-scale treatment services (i.e. fluoridation), and the belief that maintaining one's oral health and the ability to seek out dental care were individual responsibilities, not social ones. Reflecting on these historical reasons provides an important policy foil for current international efforts at expanding the public financing of dental care.

Keywords: Dentistry, History, Health insurance, Health policy, Public financing, Health systems

Introduction

Internationally, health policy analysts are often surprised that Canada's national system of health insurance (Medicare) does not include dental care. This is an understandable reaction given Canada's internationally lauded history of privileging equal access to health care. Answering the question of why Canada excluded dental care from Medicare holds lessons domestically and for international contexts; especially today, as over the last decade, publicly financed dental care has increased its prominence as a health policy issue in Canada, and in countries such as the United States, Australia, and the United Kingdom [1-4].

From an international perspective, why does understanding the reasons for why dental care was excluded from Canadian Medicare matter? Simply put, history matters to health policy. In a case study of the use of history in health policy making in the United Kingdom, Berridge [5] has demonstrated how history is used implicitly or explicitly in decision-making. From fulfilling a rhetorical role in policy justification, to defining precedent for

expert committees, Berridge argues that understanding history is fundamental to present-day decision-making. In the case of dentistry, for example, are the historical reasons for dental care's exclusion so entrenched in the country's socio-cultural context, that it makes discussions about the expansion of public financing in dental care irrelevant? Would this hold in similar Western States, and if not, what are the key differences?

This commentary will propose five interrelated reasons for why dental care was excluded from Canadian Medicare. It will attempt to clarify an important gap in our knowledge concerning the development of Canada's health and dental care systems. Ultimately, it will provide an answer to a long-standing policy question that has international relevance, as countries around the world engage in oral health care reforms.

Canadian governance and its health and dental care systems

Canada is a confederation, with powers divided between the federal government and ten provincial governments. The provinces have the major jurisdiction over health care delivery and each has its own health insurance plan that operates under standards established by federal legislation termed the Canada Health Act. The Act mandates the public financing of the majority of hospi-

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tal and physician care across the country, and is enforced by the federal government's ability to withhold transfer payments that supplement provincial health care funds. Importantly, with over two decades of health and social services re-structuring, municipalities now have major decision-making powers over public health and social welfare programming as well.

For publicly financed dental care, this breaks down in specific ways: the federal government finances dental care for specific groups, such as state-recognised Aboriginal groups and the country's Armed Forces, both due to historical custom and fiduciary responsibilities; the provinces finance dental care for such groups as low-income children, social welfare recipients, the disabled, and those with craniofacial disorders; and through cost-sharing agreements with the provinces, municipalities finance care for low-income children and social welfare recipients, and independently for groups such as low-income seniors [6].

Regardless of this activity, overall, among Organisation for Economic Cooperation and Development countries, Canada ranks very low in the public financing of dental care [7]. Dental care is almost wholly privately financed, with approximately 51% of the population paying for care through employment-based insurance, and 44% through out-of-pocket expenditures [8]. Of the 5% of public financing that remains, almost all is targeted to socially marginalised groups and delivered in the private sector through public forms of third party financing [6].

Why was dental care excluded from Canadian Medicare? The legislative reasons

The development of Canadian Medicare can be traced to major policy and legislative events. The first was the Royal Commission on Dominion-Provincial Relations (1937-1940). An outcome of the Great Depression, the Commission supported a federal role in the financing of provincial health services, yet no contributions materialised due to debates over taxation [9]. The Commission did discuss dental care, making a publicly financed system of dental health insurance a real prospect [10].

In 1943, the federal government proposed a draft bill for health insurance that included dental care [11]. Yet by the end of WWII, the Dominion-Provincial Conference on Reconstruction described dental care as a service that would be publicly financed at a 'later stage', behind 'physician and hospital services' [12]. The Conference did not yield the commitment needed for a national plan, this time due to debates regarding the legislative allocation of power. In 1957, the federal government then introduced the Hospital Insurance and Diagnostic Services Act, establishing financing for provincial hospital insurance plans, yet this did not include dentistry.

The Royal Commission on Health Services (1961-1964) represented the most important policy event to influence the development of Canada's health and dental care systems. The Commission undertook numerous studies on dentistry, and recognised "dental disease [as] one of the most frequent health de-

fects found in the community" [13:210]. The Commission recommended that the federal government enter into agreements with the provinces to "introduce and operate comprehensive, universal, provincial programmes of personal health services" [13: 19], describing six categories: medical services; dental services (for children, expectant mothers, and public assistance recipients); prescription drug services; optional services (for children and public assistance recipients); prosthetic services; homes care services. In other words, the Commission intended targeted rather than universal coverage for dentistry.

Of major importance here were the Commission's two foundational concepts. The first 'Basic Concept, the Individual Responsibility for Health' noted:

"The Commission believes that the individual's responsibility for his personal health [is] paramount to the extent of the individual's capacities. [...] Personal hygiene [and] balanced diets [are] under the control of the individual [and he] must assume responsibility for wise and prudent use of health services [...] including regular dental examinations" [13: 3-4].

The second concept, the 'Public Interest in Individual Health,' concerned 'Public and Group Responsibility.' These two concepts laid the ideological bases for how the Commission viewed oral health and dental care, namely as individual responsibilities, of which the 'public interest or group responsibility' was confined to 'the extent of the individual's capacity.' It then followed that there was a lessened capacity for individual responsibility in 'children, expectant mothers, and public assistance recipients.'

Thus the Medical Care Act of 1966, which created Medicare by dovetailing physician care with existing public coverage for hospital care, did not include dentistry. Nonetheless, to provide funds for uninsured health services, the federal government introduced the Canada Assistance Plan, which represented the major federal funding mechanism for provincial social welfare programs. The provinces used the Plan to invest in dental care for children and welfare recipients [14]. This resulted in the significant growth of public dental care programs, yet this growth sharply reversed in the early 1980s, as governments faced an economic recession [14]. Dental care was now far from the general health care ethos, and the Canada Health Act of 1984, the country's clearest statement on its distributive health care principles made no mention of dentistry, other than delineating "surgical-dental services delivered in hospital" [15], which were now a common provincial standard.

The professional reasons

The dental profession strongly shaped policy in order to promote the exclusion of dental care from Medicare. Similar to physicians, a publicly structured health system was not a preference [16]. Comments of the period demonstrate this:

“Before a packed audience [he] condemned governmental interference in such intimate relationships as those existing between patient and practitioner. [...] In the ordinary case the selection of the practitioner is [a] free choice [...]” [17: 211].

“[T]he moment any able-bodied individual holds out the hand and accepts something for nothing, that moment there begins [a] moral disintegration [...]. The thing most needed in society [is] individual responsibility” [18: 64-68].

“If we are to have a national health program [we] should emphasize dental care for the child rather than for the adult; [...] we should urge that [it] be done under the system of private practice” [19: 562].

At some level, dentists were nonetheless willing to interact with a public system, as they held long-established ideas for what a governmental role in dentistry should be. From the twentieth century onwards, clinical prevention and large-scale public health activities focussing on children were central to the professional approach [20,21]. Politically, prevention allowed dentists to focus governmental attention on the preventable aetiology of dental disease, mandating action in places other than in direct delivery. The argument was that public systems of delivery were unwarranted and could pose an economic risk to governments [20].

Limitations in human resources also aided dentists in their advice to governments, as can be seen here in a quote from a government report:

“[The] immediate institution of an insurance plan providing full dental care for persons of all ages would require [...] almost six times the present personnel [...]. However, the dental profession are convinced that the best method [of] attacking the problem [is] through the child [...] preceded by public health activities in education” [22: 38-40].

With the establishment of community water fluoridation in the 1950s, a cheap and effective public health measure became the obvious alternative. Fluoridation was strongly supported in federally, and was noted as an opportunity to take population-level action while limiting service costs [23].

By the 1960s, professional preference had turned to the role of private insurance: “Licensed commercial health insurers can be an effective partner of the dental profession in providing better dental care” [24: 549]. By 1967, as it became clear that Medicare would not include dentistry, the first prepaid dental care plans began to appear, covering members and families of major labour unions [25]. Across the country, employer contributions

to employee benefit plans increased substantially, becoming the country’s backbone for financing dental care [14].

The socio-cultural reasons

By the 1920s, Canadians were routinely exposed to print media that promoted links between oral health and social success [26,27]. The message was clear: brushing one’s teeth was a personal health behaviour that was socially desirable. As a cultural prerogative, having clean-straight-white teeth has now become one of the most pervading personal health ideals of modernity.

The working classes are important here, as the post-WWII economic boom promoted working class prosperity and the mass consumption of goods and services, including dental care. Coupled to the market push on oral health, this period observed the mass adoption of the nylon bristled toothbrush and the early adoption of fluoridated toothpaste [26]. It also observed the growth of an increasingly unionised, voting middle class, that through employer and employee tax incentives began to rapidly acquire non-wage benefits in the form of dental insurance [14]. Alongside technological advances in clinical practice that made dental care more comfortable and predictable, dental care was now not totally centred on pain and discomfort, instead replaced with notions of ease, affordability, health and success. The use of dental services effectively became commonplace [26].

Finally, through employment-based insurance, the general public really had no reason to challenge the individual ethos in dentistry. This was apparent in a public forum held to discuss the potential of a provincial ‘denti-care plan’ in the early 1970s: “[T]he recurrent theme throughout the evening [was] that the individual bears the chief responsibility in practising adequate dental hygiene and diet control, so as to protect his dental health” [28: 129]. Research was presented at the forum demonstrating the public’s withdrawal from the idea of denti-care writ large: while 92% of the public would support the idea in principle, the addition of a monthly premium lowered support to 43% [29].

The economic reasons

By the late 1940s, Canada did not have to look far to observe the economic impacts of publicly financing dental care:

“In the first few months of the establishment of the [National Health Service in the United Kingdom], 8 million people (16% of the population) sought dental treatment. [Dentistry was one of] the first services to be targeted for cost cutting measures” [30: 617].

Canadian data had confirmed that providing health insurance “would likely bring about a considerable rise in the demand for health services” [31: 205], and with “dental disease [being] one of the most frequent health defects found in the community” [13: 210], the potential economic impacts were clear. To this effect, the dental profession’s approach to governmental involvement

(i.e. health education and fluoridation) must have held significant economic appeal.

The epidemiological reasons

In 1964, 98% of Canadian children had one or more decayed teeth, and only 13% had no 'untreated dental defects' [13: 210]. Considerable differences in dental visits by income group were also present [13]. Yet with a population engaged in regular oral health promoting behaviours, and with fluoridation, a precipitous drop in dental disease was observed [14]. To some extent, the idea that dental disease would be a problem in future years was largely disregarded, as most would simply be 'caries immune' [32,33]. So as a health and social issue, dental disease and dental care became a niche problem for governments and slowly exited the public conscious as a major health problem.

Conclusion

This paper proposed five interrelated reasons for why dental care was excluded from Canadian Medicare (i.e. legislative, professional, socio-cultural, economic, and epidemiological). In summary, dental care was not included because of significant decreases in dental caries and limitations in dental human resources as the country's health legislation was being developed, alongside the presence of a viable alternative option to large-scale treatment services (i.e. fluoridation), and the belief that maintaining one's oral health and the ability to seek out dental care were individual responsibilities, not social ones.

Internationally, answering this question provides an important historical lens for current policy debates, and for existing efforts aimed at expanding the public funding of dental care. For example, is there an established legislative base for expanding public dental services? Is dentistry included in health care legislation or is it dealt with separately? What does the dental profession support and prefer? Is the profession an enabler or barrier to proposed reforms? Is there a history of major resistance to publicly financed care, and if so, can this be overcome? Is the place of dentistry socio-culturally positioned in such a manner as to make the expansion of publicly funded dental care plausible? Would there be broad-based public support for such a proposal, or is this the desire of specific niche groups? Are there economic arguments for expanding the public funding of dental care? Will this save governments money in other areas of the health and social services system (e.g. potential reductions in hospital visits for dental problems, or enhanced employability for social welfare recipients)? Is there even a need for the universal coverage of dental care? Is this a reasonable goal in the face of other population health challenges? Ultimately, historical analyses of dental care systems will be necessary to understand the context of current decision-making concerning publicly financed dental care.

References

1. Australian Council of Social Service (2007) "Australia Fair: Dental care out of reach to millions." News Release, August 3. Strawberry Hills:

- ACOSS News. http://www.acoss.org.au/media/release/australia_fair_dental_care_out_of_reach_for_millions. Accessed October 10, 2011.
2. Blackwell T (2007) "Extend dental coverage, doctors urge." *The National Post*. <http://www.nationalpost.com/news/story.html?id=aaed899d-e3ca-4e54-b5bd-88e18ae2dc64&k=0>. Accessed October 10, 2011.
3. Department of Health (2007) "NHS Dental Reforms: One year on." London: Government of the United Kingdom. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_077238. Accessed October 10, 2011.
4. Otto M (2007) "For want of a dentist: Pr. George's boy dies after bacteria from tooth spread to brain." *The Washington Post*. <http://www.washingtonpost.com/wp-dyn/content/article/2007/02/27/AR2007022702116.html>. Accessed October 10, 2011.
5. Berridge V (2008) "History matters? History's role in health policy making." *Medical History* 52(3): 311-26.
6. Quiñonez C, Locker D, Sherret L, Grootendorst P, Azarpazhooh A, Figueiredo R (2005) An environmental scan of publicly financed dental care in Canada. Community Dental Health Services Research Unit and Office of the Chief Dental Officer, Health Canada.
7. Parkin D and Devlin N (2003) "Measuring efficiency in dental care." In Scott A, Maynard A, and Elliott R (Eds.) *Advances in health economics*, p. 143-66. London: John Wiley & Sons Ltd.
8. Canadian Institute for Health Information (2010) *National Health Expenditure Trends, 1975-2010*. Toronto: CIHI.
9. Battle K (1998) "Transformation: Canadian social policy since 1985." *Social Policy and Administration* 32(4): 321-40.
10. Merkeley H (1939) "President's Address: Western Canada Dental Society Convention." *Journal of the Canadian Dental Association* 5: 487-88.
11. Canadian Dental Association (1943) "Canadian Dental Association News: Health Insurance." *Journal of the Canadian Dental Association* 9: 227-29.
12. Taylor M (1987) *Health insurance and Canadian public policy: The seven decisions that created the Canadian health insurance system and their outcomes*. 2nd ed. Ontario: McGill-Queen's University Press.
13. Government of Canada (1964) *Royal Commission on Health Services, Volumes I and II*. Ottawa: Government of Canada.
14. Stamm J, Waller M, Lewis D, and Stoddart G (1986) *Dental programs in Canada: Historical development, current status and future directions*. Ottawa: Health and Welfare Canada.
15. Government of Canada (1984) *Canada Health Act*. Ottawa: Government of Canada.
16. Naylor C (1986) *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966*. Kingston and Montreal: McGill-Queen's University Press.
17. Canadian Dental Association (1938) "Society hears Pettengill flay socialized dentistry." *Journal of the Canadian Dental Association* 4: 211-12.
18. Johnson C (1937) "The present needs of the community in the care of the teeth." *Journal of the Canadian Dental Association* 3: 63-68.
19. Ryan E (1939) "National Health Program." *Journal of the Canadian Dental Association* 5: 562.
20. Brownlee B (1935) "Canadian Foundation for Preventive Dentistry." *Journal of the Canadian Dental Association* 1: 461-64.
21. Garvin M (1941) "The future of dentistry in Canada." *Journal of the Canadian Dental Association* 7: 447-55.
22. Government of Canada (1947) *Survey of dentists in Canada*. Ottawa: Department of National Health and Welfare, Government of Canada.
23. Canadian Dental Association (1960) "Health Insurance—House of Commons Debates." *Journal of the Canadian Dental Association*. 286-89.
24. Morrison J (1964) "Insurance approach to prepaid dental care." *Journal of the Canadian Dental Association* 30: 549-54.
25. Canadian Dental Association (1967) "Dentistry in the news: Seventeen per cent use first BC prepayment plan." *Journal of the Canadian Dental Association* 33: 409.
26. Gullet D (1971) *A history of dentistry in Canada*. Toronto: University of Toronto Press.
27. Fox S (1997) *The mirror makers: A history of American advertising and its creators*. New York: Morrow.
28. Ontario Dental Association (1972) "Toronto Star Forum." *Journal of the Ontario Dental Association* 49(5): 129-39.
29. Canadian Dental Association (1972) "Dentistry in the news: Public shies away from denticare cost." *Journal of the Canadian Dental Association* 38: 10.

30. Jessop N, Kay E, Mellor C, Whittle J, Jenner A (2000) "Past and present attempts to control health service expenditure and its effects on National Health dentistry." *British Dental Journal* 189(11): 617-19.
31. Richter L (1944) "The effect of health insurance on the demand for health services." *The Canadian Journal of Economics and Political Science* 10(2): 179-205.
32. Dean H (1944) "Post-War implications of fluorine and dental health: Epidemiological aspects." *American Journal of Public Health* 34: 133-43.
33. McKay F (1948) "Mass control of dental caries through the use of domestic water supplies containing fluorine." *American Journal of Public Health* 38: 828-32.