

September 5, 2017

## **Squabble Over Alberta Dental Fees Highlights Broader Need to Rethink What is Publicly Insured**

**By:** Lorian Hardcastle

A 2016 [government report](#) revealed that dental procedures cost up to 44% more in Alberta than in neighbouring provinces. In addition, 62% of Albertans reported limiting dental visits due to cost concerns. The resulting fallout from this 2016 report led the Alberta Dental Association and College (ADAC) to respond with a new [fee guide](#) on August 17, 2017. When the ADAC stopped publishing its fee guide in 1997, Alberta became the only province without such a guide, which may have contributed to the current high cost of dental care. Although dentists are not bound by the fees listed in these guides, they can encourage price competition, improve transparency, and better inform patients. Alberta's Minister of Health was "[not satisfied](#)" with the new guide, which proposed a 3% across-the-board reduction in dental fees. She stated that Albertans "deserve better" and has sent the ADAC back to the table to rethink the new fee guide.

While a 3% savings will benefit private insurers and those who can already afford to visit a dentist, this very modest reduction is unlikely to persuade many individuals who are currently cost-prohibited from seeing a dentist to seek treatment. Unfortunately, those who need dental care most are those most likely to be deterred by cost. Furthermore, even with reduced fees, Albertans will continue to pay high costs. For example, the new Alberta guide recommends that a standard oral exam for a new patient cost [\\$75.36](#), compared to the suggested \$43.10 in British Columbia's fee guide.

Although Albertans pay the highest fees for dental care in Canada, high costs and low rates of public funding are a problem across the country. [Most OECD countries](#) far exceed Canada's per capita expenditure on dental care and several include dental services as part of their national health insurance programs. In Canada, private expenditures, either through private insurance or out-of-pocket payment, represent [93.8%](#) of total expenditures, while public spending accounts for only 6.2%. Although coverage varies across the country, publicly-funded programs primarily target children, seniors, Indigenous individuals, and those with disabilities.

Evidence indicates that these public plans are insufficient. A [study](#) by the Canadian Academy of Health Sciences found that approximately six million Canadians avoid visiting the dentist every year because of the cost and those most likely to be deterred have the greatest need for dental care. Unsurprisingly, [research](#) from Europe confirms that inequities in access to dental care are highest in countries with no public dental coverage.

Lack of dental care affects more than oral health and has been linked to cardiovascular and respiratory problems and diabetes. Those who cannot afford dental care may wait until the problem is severe enough to necessitate an emergency room visit, where doctors are not trained to treat underlying dental issues and offer band-aid solutions such as antibiotics and painkillers.

These patients often end up back in the emergency room. According to the [Association of Ontario Health Centres](#), approximately 60,000 patients with dental problems that should have been managed in the community visited Ontario emergency rooms in 2014, at a cost of \$30 million. An additional 230,000 patients visited family doctors at a cost of \$8 million, where they often received powerful painkillers such as narcotics. As such, poor access to dental care may indirectly contribute to our current opioid crisis.

Although there is a perception that Canada has universal public health insurance, the reality is much more complex. The reality is that [30%](#) of health spending in Canada is private, either through private insurance or out-of-pocket payment. Although the *Canada Health Act*, [RSC 1985, c C-6](#), refers to universal insurance for “medically necessary services”, this is interpreted to mean hospital and physician care, while other important services, such as dental care, pharmaceuticals, long-term care, and home care are funded through a mix of out-of-pocket payments, private insurance, and a patchwork of public programs.

The effects of inadequate public funding are not only well-documented in the case of dental care, but have been demonstrated with pharmaceuticals. Among [OECD countries](#), only the United States and Poland have a lower percentage of drug costs paid by public programs than Canada. This lack of public funding has been linked to patient outcomes. For example, an Ontario [study](#) of approximately 600,000 diabetic patients found that lower income groups with diabetes had a significantly higher risk of heart attack, stroke or death compared with more affluent individuals. This finding was most marked among patients under 65 years of age who rely primarily on private insurance or pay out-of-pocket, while those over age 65 receive subsidized drug costs through the provincial drug benefit program. The researchers concluded that “as many as 5000 deaths and nearly 2700 [heart attacks] or strokes could have been avoided” if the younger diabetics had similar access to drugs as the older publicly-insured group.

The suggestion that we expand universal public insurance beyond hospital and physician services is not uncontroversial, with opponents noting that many provinces already spend more than 40% of their annual budgets on health. For example, Alberta spends [41%](#) of its budget on health care, which equals [\\$2.5 million dollars](#) per hour or \$59 million per day. An added concern is that health care may crowd out spending on other programs, such as education, affordable housing, and social assistance, which may actually do more to improve health than health care services, and which are particularly effective in narrowing the health equity gap.

Therefore, we should not merely expand universal public insurance to cover additional services, but rather we must take a hard look at the services that we currently insure. Instead of funding an ever-expanding list of hospital and physician services, some of which deliver relatively limited clinical benefits at very high cost, Canadian provinces must target public spending at the services that evidence demonstrates are most cost-effective. This sounds obvious and it would surprise many Canadians to learn that this is not how we currently determine what is publicly covered.

Instead, the list of “medically necessary services” (i.e. those that attract universal insurance under the *Canada Health Act*) are determined through closed-door negotiations between provincial ministries of health and provincial medical associations. The focus of these provincial associations is advocating for their physician members, rather than furthering the public interest. As such, their incentive is to push governments to insure as many services as possible at the

highest rate possible. In turn, physicians are incentivized to provide these services at high volumes, given that most are reimbursed on a fee-for-service basis.

It will not be easy for provinces to take on provincial medical associations and to disrupt the status quo. Indeed, [Ontario](#) is already embroiled in controversy over releasing the names of the highest billing doctors and physicians are currently fighting with the federal government over [tax changes](#). However, if we are to have a health care system that delivers the best possible outcomes for patients without taking over provincial budgets, all health care services must be on the table for debate—both expanding public insurance for new services (such as dental care and pharmaceuticals) and de-insuring hospital and physician services that are not cost-effective. Furthermore, instead of these debates taking place through closed-door negotiations, this process must be transparent and evidence-based.

*This blog post is based on a shorter piece that appeared in the Globe and Mail on September 2, 2017: <https://beta.theglobeandmail.com/opinion/the-exorbitant-cost-of-dentist-visits-in-alberta-cannot-be-brushed-off/article36153690/?ref=http://www.theglobeandmail.com&>*

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This post may be cited as: Lorian Hardcastle “Squabble Over Alberta Dental Fees Highlights Broader Need to Rethink What is Publicly Insured” (5 September, 2017), online: ABlawg, [http://ablawg.ca/wp-content/uploads/2017/09/Blog\\_LH\\_DentalFees.pdf](http://ablawg.ca/wp-content/uploads/2017/09/Blog_LH_DentalFees.pdf)

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