REPORT BY BRUCE WALLACE
PREPARED FOR THE VICTORIA COOL AID SOCIETY
IN COOPERATION WITH THE VANCOUVER ISLAND PUBLIC INTEREST RESEARCH GROUP

TOWARDS A DOWNTOWN COMMUNITY DENTAL CLINIC IN VICTORIA

FOR COPIES OR INFORMATION: WWW.VIPIRG.CA OR EMAIL RESEARCH@VIPIRG.CA

NOVEMBER 2001

Table of Contents

Background……………………………………………………..……….4

The Indicators: Measuring the Need in Victoria ……………….….….6
Poverty in the Capital Region ……………………………..……..8
No Oral Health in Universal Health …………………….…….10
The Inadequacy of Public Dental Insurance ……………….……12
The Current Lack of Alternatives ………………….…..…….14

Outcomes: The Effects of Unmet Dental Needs in Victoria ….….……16

Outcomes: When We Meet the Dental Needs in Victoria …………….24
Limited Public Oral Health Measures ………………………..26
Expected Outcomes *(Table)* ………………………………….…..27

Outline of Proposed Model …………………………………………...30
A Model for Victoria ……………………………………….…….31
Clients Served and Expected Revenues ……………………….32

Conclusion ……………………………………………………………33

Voices:

Ron's Story ………………………………………………….……….…. 5
Rev. Allan Tysick (Open Door) ……………………………………….……7
Alix Hotsenpiller (TAPS) ……………………………………….…………9
Brenda Macevicius (Esquimalt Neighbourhood House) ……………..11
Anita Vallee (Central Vancouver Island Health Region) …………….13
Richard's Story ……………………………………………….……..….15
Norma Strachan (ASPECT) ……………………………….……………17
Caite & Francoise (Cool Aid Community Health Centre) ……….….…19
Rosemary Mann (Young Parents' Support Network ……………….…..21
Mabel-Jean Rawlins (Community Social Planning Council) ……..…..23
Dr. Michael King-Brown (Private Practice Dentist) ………………….25
Dr. Bill Bassett & Shirley Bassett (Camosun College Dental) ……….29
Dorothy Rosenberg (CHR Community Dental Program) …………….29

Appendices

"Oral health is integral to general health. You cannot be healthy without oral health. Oral health and general health should not be interpreted as separate entities. Oral health is a critical component of health and must be included in the provision of health care and design of community programs."

Oral Health in America: A Report of the Surgeon General (2000)

"Encourage Health Regions to support in each region the infrastructure and staff for at least one public dental clinic suitable for low-income groups…"

Strategies to Enhance the Oral Health of British Columbians. 2001.

"So, I went downstairs and asked my landlord if I could borrow a pair of needle nose pliers. My mouth was so sore, I couldn't eat, I just had to. A couple of time I almost passed out. The important thing about pulling out your own teeth is - don't miss."

~ A Victoria B.C. resident

Background

This report is grounded in a local community development process that spans several years, incorporates a diversity of perspectives and draws on the findings of several community action research projects.

A working group on the issue of poverty and dental care emerged from the Capital Urban Poverty Project (CUPP) in 1999. Since then, we have undertaken research, held community meetings, raised the issue in the media, met with government, all of this while struggling with the ongoing requests for affordable dental care from desperate adults suffering from dental pain. In many respects, this extensive community development process may be seen as successful as we have effectively raised awareness and understanding of a crucial community health issue and possible strategies to address these needs in the capital region. However, the fact remains that even after all these efforts, there are still no options in Victoria for an adult who lives with dental pain and cannot afford necessary treatment.

This report provides a turning point. In this report I summarize the knowledge gained from these years of study and community engagement. I have also interviewed key informants from the region and in Vancouver and toured several community dental clinics in the Lower Mainland. And I share the stories of people who sat with me after they were refused dental treatment because of their inability to pay. Finally, I present an opportunity to start addressing these needs through the provision of operational funding for a community dental clinic in downtown Victoria. As with the identification of the needs, the definition of the response is based on extensive research and consultation.

The turning point is action.

Ron's Story

> *"So, I went downstairs and asked my landlord if I could borrow a pair of needle nose pliers. My mouth was so sore, I couldn't eat, I just had to. A couple of time I almost passed out. The important thing about pulling out your own teeth is - don't miss."*

That night, Ron pulled out four of his own teeth. When I met him he had no remaining upper teeth and no dentures. Ron is an older, dignified man. Wearing a tie and pressed shirt, he met me for a coffee before another day of "pounding the pavement", looking for a job in the service sector.

"I've worked in the service sector industry for my whole life, for forty-years. I've served royalty at the National Arts Centre in Ottawa, I've worked in 5-Star restaurants, and now it doesn't mean anything," says Ron.

"It's really difficult to be able to sell yourself to an employer when they can't understand your speech. You know, my whole diet's gone and I have a speech impediment," he says.

Ron is currently receiving welfare. He is a single employable, which means he receives $525 a month. His bachelor apartment in James Bay costs $485 a month. His dental coverage is limited to $250 a year – no dentures.

For Ron, his dental problems have meant terrible pain, limited employability, poor nutrition and health, poor speech, and a loss of dignity.

Imagine being in such distress that you are driven to pull out your own teeth. Ron's situation vividly illustrates the need for improved access to dental care in Victoria,

The Indicators: Measuring the Need in Victoria

There are few population health statistics collected to measure the oral health status of adults living in the capital region. So I asked people who deliver health and social services in the region to tell me what they know from their experience. Here is how they define the need:

> *"The Open Door sees 400 people a day and I estimate that only five per cent would not require immediate dental care. 95 per cent of the people who walk in here would require dental care if it were available."*
> Rev. Allan Tysick (Open Door)

> *"The reality is that for a working family who is above the cut-off for Healthy Kids who is going to get the dental appointments and check-ups? The kids are going to get it at the expense of the adults. The adults are going to make a choice that within our budget who can get a check-up, and as with everything else, the kids are going to get it first and the adults are not going to get care".*
> Rosemary Mann (Young Parents Support Network)

> *"There is virtually no dental care for our clients who are not on social services. A lot of our street clients who make their living off the streets panhandling, etc., they have no dental coverage at all."*
> Caite and Francoise (Street Nurse Practitioners)

> *"I believe that this is a life threatening need and in Victoria, people who have a financial barrier have no access to dental services. The BC Benefits system is extremely complex and difficult for people to access. There are barriers at every step of the way because even if a person gets benefits, the fee schedule is so low that they may be refused access to service."*
> Alix Hotsenpiller (Together Against Poverty Society)

> *"There is an image of people who really need dental care, an image of a street kid walking into a clinic, but the need is much wider and includes renters in James Bay and Cook Street Village who really can't afford care."*
> Dr. Bill Bassett (Camosun Dental Program)

Rev Allan. Tysick – Open Door

"It is an extreme need."

The need …

"The Open Door sees 400 people a day and I estimate that only 5 per cent would not require immediate dental care. Ninety five per cent of the people who walk in here would require dental care if it were available. It is an extreme need, the teeth of people downtown are in bad shape. Pyorrhoea of the gums is very evident, explains Rev. Al when I met him in the back office of the Open Door Drop-In Centre.

He adds, "To give you an idea of the need, I have a local dentist that offers the Open Door one free day a year for our population. I get around 500 requests for that dentist."

"While most people who ask me for help are in pain and want their tooth extracted, I also get many people asking if I have money for cleaning of teeth and dental hygiene, and the answer to that is 'No'."

"Because the government isn't meeting the need, the Open Door has decided to use our Social Service budget to pay for extractions. On average I pay for four extractions a month and that's at $100 a pop, so $400 a month. That's a lot of money for a little organization that has no government funds. This budget is traditionally supposed to buy people food vouchers and travel vouchers for trips to Vancouver for court appearances. Now it is more and more paying for people's immediate health needs. It is an area that I don't want to be in and one that I can't afford. It is a real burden on my budget that receives no government support and it only helps the worst cases, when the government keeps saying no to our requests."

The effects …

"I think poor dental health is one reason why many diseases are spread among the downtown population, for example hepatitis when gums are bleeding and there is pus around the mouth and people are kissing. I think the spread of hepatitis, and even AIDS, is a major issue downtown partly because of the lack of proper cheap dental care. It also keeps people from getting a job, their breath smells; it's a big impediment to employment."

The expected outcomes …

Rev. Al believes that a clinic would be a "good partial response to the needs" but to be relevant to the Open Door population the services would have to be free. He offers a list of other conditions he would like to see in a dental clinic for Victoria: "it should be located downtown, associated with an organization that is trusted by the population, the staff would have to be experienced (or trained) in working with inner-city populations and have knowledge of inner-city health issues and it must be a service developed for the people, not the bureaucracy."

Al also tells me what outcomes he expects from a clinic: reduced spreading of communicable disease, an improvement in the general health of the downtown community, increased employability of people and increased self worth and self esteem.

The need is "much bigger than those in immediate poverty"
Mabel-Jean Rawlins (Community Social Planning Council of Greater Victoria)

"Most people don't even look for help because the word on the street is that there is no help out there, so why call for help."
Anita Vallee (Regional Dental Hygienist, CVIHR)

The primary barrier to accessing dental care in Victoria is affordability. Dental care is a poverty issue. The relationship between income and dental health is undeniable. This is a consistent finding within the literature and from all interviews conducted for this report. The major barriers to dental care in Victoria are due to:

- The prevalence of poverty in the Capital Region
- The omission of oral health from universal health care
- The inadequacy of public dental coverage
- The lack of alternatives to the private fee-for-service system

Poverty in the Capital Region

Through processes such as the Capital Urban Poverty Project, of which the CHR was a vital partner, the extent of poverty and the implications of poverty for sustaining healthy communities is well recognized. The following are indicators of the extent of poverty in the Capital Region and B.C.:

- According to the Capital Urban Poverty Project[1], there are close to 50,000 people living in poverty in the Capital Region
- Victoria's Community Action Plan on Homelessness (2001)[2] reports that in the city of Victoria, 25 per cent of households and 39 per cent of unattached individuals are poor.
- In 1996, the costs of the Nutritious Food Basket for a family of four was over $100 more per month than what that same family would receive for all support costs from income assistance. [3]
- The waitlist for social housing in our region includes at least 200 seniors and 1,000 families, including over 1,500 children[4].
- A total number of 2,050 unique individuals were reported as accessing shelter beds in Victoria in 1997, up from 1,660 in 1996, and increase of 23.5 per cent over one year. [5]
- "There is a significant and growing number of the visible homeless in our city who are cold, wet and hungry, who suffer from serious physical and mental health conditions, and who are often isolated from family and friends. There are also the invisible homeless – people who have lost their jobs, who live in campgrounds, who move from friend to friend or sleep in accommodation that is neither safe nor secure," reports the recent (2001) Victoria Community Action Plan on Homelessness.[6]

Alix Hotsenpiller
Together Against Poverty Society

The need …

"I believe that this is a life threatening need and in Victoria, people who have a financial barrier have no access to dental services. It's amazing to know what people have been living with that I see. I remain shocked at that. Going outside with literally the stench of infectious disease in your mouth and poisoning your system day after day, month after month, year after year, growing worse and not being able to talk to people."

"Dental care is a fundamental health benefit that is key to people's independence. Dental problems affect people on a number of different levels – the most obvious one is the stigmatization that occurs. I think it effects people in a way that we have not even be able to properly gauge or assess because we probably don't even see a lot of people who know they are not eligible for quality dental care and so they disappear and we only see them when their health problems become more complicated and then you see them when they are in real emergencies, if at all."

Alix relates that in some months, all of her medical benefits advocacy cases have been dental concerns, "a significant part of our work is appealing for dentures for recipients who are only eligible for extractions and the dentures are not covered. The BC Benefits system is extremely complex and difficult for people to access. There are barriers at ever step of the way, because even if a person gets benefits the fee schedule is so low that they may be refused access to service."

The effects …

She tells of a woman who was in a literacy program and in so much dental pain that it affected her concentration. "It became such a debacle. Everywhere there was a barrier to care. She was taking so many painkillers and the stench of infection was affecting her confidence and working with classmates. Her two children were affected by this as well. She ended up dropping out of the program and finally received emergency dental care through the hospital."

"Just think of the consequences of having narcotic pain relief medications prescribed to you on an ongoing basis."

No Oral Health in Universal Healthcare

Access to dental care in Victoria is determined by the ability to pay rather than the need for care. Or, as Dr. MacEntee at UBC's Faculty of Dentistry explains, "Dental services in B.C., as in the rest of Canada, are not part of the provincial health care service, so they are not subject to the same legislative requirements of universality, comprehensiveness, public administration, portability and accessibility that regulates most other health services." [7]

In his support for the establishment of a community dental clinic in Victoria, the region's chief medical health officer, Dr. Richard Stanwick told the Times-Colonist, that "there's about 275 diseases that can affect the oral cavity …how we arbitrarily assign responsibility determines whether or not those diseases will be paid for. If they affect the teeth, in many areas of this country and seemingly in this region, people are being denied the opportunity to enjoy the same level of health as others in this community."[8]

The result is a two-tied oral health care system where people with high incomes in Victoria (as in the rest of the nation) purchase good oral health whereas lower income residents pay the price of losing their teeth and compromising their overall health.

- While 98 per cent of the highest income population in Canada have remaining natural teeth, one of every four person living on low-incomes are edentate – have no remaining natural teeth.[9]

- In B.C., accessibility to dental care is influenced strongly by income level and dental insurance. Only 25 per cent of low income individuals have dental insurance and only 45 per cent report visiting a dentist in the last year. In contrast, among high-income earners, 73 per cent were insured and 81 per cent reported visiting a dentist during the previous year.[10]

- "The implications of socioeconomic status for oral health, of course, is that people who struggle constantly to make ends meet have little money or time to spend on dental treatment. Their priorities must focus on food, shelter and clothing for themselves and their families, so prevention of disease assumes an even greater priority when resources are stretched," reports UBC's Dr. Michael MacEntee.[11]

- Statistics Canada reports that dental insurance coverage is strongly associated with household income. At the highest income level the rate of coverage was about triple that for the lowest level (70 per cent compared to 23 per cent).[12]

- According to Statistics Canada, there are large differences in dental visits by household income with only 41 per cent of people in the lowest income group visiting a dentist in the last year, while 78 per cent of individuals in the highest income group had done so.[13]

Brenda Macevicius
Esquimalt Neighbourhood House

From a letter to the Ministry. Access to the treatment requested was denied.

…I understand that (name) is not covered for dentures. I am writing to explain (name's) situation and the seriousness of his dental needs in the hopes that the Ministry will pay the $800 required for dentures when his 8 upper teeth will be removed a the end of September.

I met (name) when he approached me for counselling in June 2000. (He) had been referred by one of our staff from the Opportunity Centre. In May 2000, (he) left the full-time program he was enrolled in because of the intense tooth pain he was experiencing. He called the Emergency Dental Service listed in the yellow pages and he was told he had no coverage. (He) presumed that this meant he had no options and he tried to tolerate the pain as best as he could.

… My impression of (name) is that he is a very quiet and gentle man who feels ashamed to be on assistance. He would not ask of anything of anyone, even if the end result was tortuous dental pain. He wants nothing more than to "get off welfare and get a job". However, the seriousness of his dental needs has comprised his ability to stay in a job readiness program and now will continue to threaten his health if he cannot chew, never mind consider looking for work. And it is devastating to one's self-esteem.

… Before all of his upper teeth are removed and he is further humiliated by his inability to pay for something as essential as teeth, could the Ministry reconsider (his) needs? If the Health Services Branch could review (his) application and make a decision prior to his much needed extractions, I think (he) would make significant strides in his life and live up to his promise of getting off welfare.

- "It is clear that individuals in lower income groups use dental services less frequently. And when they do seek dental care, it is less likely to be for preventative reasons and more likely to be because of a dental emergency."[14]

- About a quarter of the population of Canada, usually those with low-incomes, go to dentists for little more than emergency care.[15]

The Inadequacy of Public Dental Insurance

Dental benefits for adults receiving welfare are incredibly inadequate, creating problems not only for welfare recipients but also for dentists.

- Many B.C. dentists consider the remuneration inadequate for treating recipients of social benefits, and so are reluctant to provide treatment.[16]

- In a recent Victoria survey, 20 per cent of low-income respondents reported that they had been refused treatment by a local dentist, most often because their Ministry benefits were inadequate.[17]

- In B.C. "… the refusal of some dentists to treat recipients of social benefits also are major impediments to care when financial resources are scarce". [18]

- A local dentist writes, "The costs of providing dental care is very high due to the costs of equipment and supplies. Most dental offices run at 70 per cent overhead. This means that if the dentist worked on a filling for free, a $100 filling still costs $70. I believe government funding will be required to make any attempt to provide low-cost dental care successful." [19]

A significant barrier to care is the fact that the Ministry's fee guide remains at 1995 prices, which can be up to 50 per cent below the dentists' fee schedule. For example, according to the Provincial fee guide, the cost of an average extraction is $126. However, if the dentist was treating a welfare recipient, s/he would only receive about $76 – a full 40 per cent below cost. See the Appendix for a detailed comparison of these fee guides.

The other significant barrier to care is due to the Ministry limiting dental benefits to $250 a year for employable adults (and Disability I), $500 for those individuals qualifying for Disability II benefits and $700 a year for children accessing Healthy Kids. It appears that while it may not be formal policy, the accepted practice in Victoria is that requests for emergency benefits are refused by the worker and the recipient is advised to appeal. The individual (who has the strength) then begins the appeal process, often taking six months, and eventually with the help of advocates such as the Together Against Poverty Society (TAPS) the Tribunal Board will often reverse the decision and fund the procedure.

Anita Vallee
Central Vancouver Island Health Region

"I've had one person call who was not able to get his hip replacement done until his teeth were fixed because of the chronic infection. And he had no access to dental treatment."

Anita reports that in her region she gets weekly calls from adults seeking affordable dental care and there is "absolutely no access for them". She expects most people don't even look for services because the word on the street is that there is no help out there, so why call for help.

"I think that there are a lot of people who are really desperate and have no other access to treat the emergency pain and infection in their mouth. Often times, if you can give them just a little support, these people are capable of carrying on as responsible citizens in the community. A lot of people probably have awareness of the need to take care of their teeth, but they have just lost hope of ever being able to get treatment."

"They are often quite capable people who are just in a real bind and I think that when you have dental pain, it almost takes you out of your mind, it is so severe that you can't think properly. You really become quite incapable. A lot people just need to get past this incredible pain and then they are okay."

Untreated dental pain affects people's ability to work as illustrated by Anita who hears examples such as people not showing up for work and losing their job, or being on codeine for the pain when their job requires that they drive.

"The mouth is not isolated from the rest of the body. A chronic infection in the mouth is an infection that the body will be constantly fighting. It has been related to heart disease, respiratory disease, it affects people's ability to heal with diabetes, and now periodontal disease has been linked with pre-term low birth weight babies."

When asked what the barriers are to people accessing dental services, Vallee unequivocally states - "finances". She notes that unlike some Northern areas, "there are plenty of dentists in town, but if you can't pay the fee you don't receive care."

"If I was going to pursue a clinic I would go for something that is multidisciplinary, one-stop shopping type, because most people have a lot of needs and are looking for support in many ways. I think a stand-alone dental clinic is not the way to go. I think it's time that dental care is looked at as a multidisciplinary health issue, not separate. It would be bad for the future of dentistry to continue to separate it."

When looking at various models of clinics from Vancouver, Vallee advises that we recognize the different needs on Vancouver Island. Many clinics in Vancouver serve children because of the large numbers of new immigrants. The barrier may not be financial as much as cultural and language; "they are not going to go to a regular dentist".

"I think you are looking at a very different population in Victoria than the Vancouver clinics are looking at." She predicts that the population in Victoria likely already believes that oral health is important to them, but that the barrier to care is essentially financial.

The Current Lack of Alternatives

In Victoria, if you are poor and can't afford dental treatment in a private clinic, there are no alternatives. We currently provide no affordable, publicly funded alternative for those in need who cannot pay market prices for treatment.

Every week in Victoria there are people suffering from abscesses and other complications phoning public health agencies such as the Capital Health Region and the Camosun Dental Program looking for referrals. I interviewed several employees of community agencies who say they regularly are asked about referrals to affordable dental treatment. While working on this report, I personally received at least a dozen calls asking for help from UVic students, working people and people receiving welfare. Unfortunately, I had no options to offer them as there is no help to offer. Most people know there is no help for them and never ask.

The current responses to dental need from the Capital Health Region emphasize prevention programs and primarily focus on children (with some specific services for adults with developmental disabilities). The CHR does not have a dentist on staff and therefore cannot provide dental treatment at this time. See the Appendix for a detailed description of the current CHR's response to dental needs.

Without a public health response to the oral health needs of adults in Victoria, the only other option has been charity. Currently the greatest source of reduced-fee dental care in Victoria is dentists willing to incorporate a certain amount of charitable work in their private practice. Both dentists and patients share their frustration with this inadequate response to a need that will not and cannot be fulfilled by charity. In a 1999 survey of local dentists, the following quotes express this frustration[20]:

> *"I don't see why as independent business operators we are supposed to step in and solve their social/economic problems that the government should address."*

> *"Have the Ministry cover their dental treatment. Therefore their needs are met by taxation of all rather than asking dentists and their staff to donate more."*

Richard's story

"I saw my doctor and he said it's really bad to have this chronic infection in my mouth. Like it's been almost a year, and he said its not good for my health and he said it could effect my heart or something. So, now, I'm also concerned about this heart thing. I don't want to leave this until it kills me, so I'm afraid of that now too."

I met Richard at the Together Against Poverty Society (TAPS). He has been trying to tolerate his dental problems because he knew that even though he had a steady job he could not afford the costs of treatment. He sought out help from his physician who told him that oral infections like his have been linked to heart disease. Richard then went to TAPS looking for help and was told that there are no services available to people who are employed. When Richard sought help, all he received was more to worry about.

"Starting in December 2000, I had an infection in my front, upper-teeth. I was able to get a dentist to do the minimal root canal required which cost me $275. But at the time he told me I had a small infection in nearby tooth with a cap that may flare-up, and if that happened I would need dental surgery. So, sure enough a few weeks later it did flare-up and the infection didn't go away even though the root canal was done.

"I was told that just to see the specialist would cost me $65 and the dental work could cost between $500 to $600. So then I just left it because I didn't have six hundred bucks.

"I started taking Echinacea and Golden Seal. And now I eat garlic every night, but it will still flare-up and I will pop the gum, as the pressure builds up due to the infection. But it's not a big toothache all the time, the pain fluctuates over time, now its just part of my life.

"And then three months ago a bottom, side molar broke all the way down to the gum. It flared up and really hurt but it's not so bad now, just infected. So, now I can only chew on my left side and it gives me bad breath, and, you know I'm single now.

Richard is 44 year old. He's employed part-time doing janitorial work for 3.5 days a week. He takes home $11,500 a year. He did receive welfare about six years ago, but only for two months as he was able to get a job quickly. Since then he's been employed and volunteers at a community garden.

He's been told that it will cost between $1,000 to $2,000 to do all the work necessary in his mouth. "I'm a productive person, but that's where my income level is at, and this is an extraordinary expense," he tells me.

I gave Richard the name of a charitable dentist to call and Richard tells me how embarrassing it is to go to a dentist office not being able to pay for work and have to beg.

"It's insane that dental care isn't covered as part of medicare. I don't understand it."

Outcomes: The effects of unmet dental needs in Victoria

"Poor oral health has a range of consequences. There are direct health effects including pain, difficulty eating and the avoidance of certain foods (which can lead to wider health problems), increased use of painkillers. But the health effects of dental pain and oral diseases extend far beyond the pain of a toothache. Dentally compromised individuals have a lower resistance to other diseases, which can result in further infections and overall sickness. There are also social and economic consequences, such as loss of self-esteem, impaired speech, restricted social and community participation, diminished job prospects, and increased likelihood of having problems dealing with landlords, bank managers, the police, doctors, lawyers and others necessary to escape marginalization. In general, a person's overall health status and quality of life are affected.

(Brushed Aside. 2000:9)

As Richard describes, his dental problems don't end at the gum line – they effect his whole health and well-being. Access to dental care is as much a health issue as a quality of life issue and employability issue. Not accessing treatment can be devastating not only to the individual but also to their families.

Think of how this sounds. Dental care is provided to all residents of the Capital Region who can afford treatment at a private clinic. How can we say no to two-tier medicare, but accept two-tiered dental care? It is all the same body, the same blood and the same quality of life.

Measuring the need for unmet dental treatment in Victoria is difficult due to a history of ignoring the issue and the resulting lack of statistics. However, there appears to be consensus that there is a significant, urgent need for emergency dental treatment and overall preventative dental care for people living on low-incomes in Victoria who cannot afford treatment.

While there are numerous outcomes resulting from unmet dental needs in Victoria, the following are the most cited health-related outcomes in the literature as well as those mentioned in the key informant interviews.

> ***Heart disease:*** A study of heart-attack patients found that 85 per cent also had periodontal disease.[21]

Norma Strachan
ASPECT: BC Community Based Trainers

"For a lot of people to be work-ready, dental treatment is important. How you look matters a lot, but it goes much deeper than that for people suffering with abscesses. I know the tourism industry in particular wants their staff to be presentable, acceptable and have nice bright smiles to welcome tourists with. But it does go beyond cosmetic to be a whole health issue also," says Strachan.

"I don't think until you've had a really bad toothache or abscessed tooth you can understand how awful the pain can be and to not be able to do anything about it, I can't imagine anything worse."

ASPECT is a provincial association of community-based employment programs that includes about twenty training programs in Greater Victoria (50 on Vancouver Island) mainly serving clients who receive Employment Insurance, B.C. Benefits, and some youth bridging programs and multicultural programs. The goal of these programs is to get people into the workforce. While these programs employ a number of interventions to achieve this goal such as money for clothes, transportation, and assistance in basics such as hygiene and haircuts, "overwhelmingly, dental care is one thing that we can't get people any assistance with", says Strachan.

Strachen relates that employment programs are often working with people who are at a stage of getting their lives back together after a rugged past. But then they have abscessed teeth, or pain or an absence of teeth and it's an obstacle to getting employment.

She definitely supports the establishment of a community dental clinic, adding "the job training programs in Victoria would be referring clients to it right away."

Her recommendation is that the clinic not be restricted to only people on income assistance, because a lot of people are working poor and need care. Also she advises establishing a database that could document people's issues and enable follow-up to demonstrate the cost savings related to receiving treatment at a clinic.

I asked Norma what outcomes she would expect from a clinic. She replied, "The most obvious expected outcome from a dental clinic would be several thousand of people not in pain unnecessarily. In regards to people becoming employable, they would now be rid of pain, more presentable, and an end to toxins leaking into their system."

As far as financial outcomes, Norma says, "it would save money if people didn't have compounding health issues as a result of having rotten teeth and rotten gums. It would save money if, as a result of getting your teeth fixed, you were able to be employed or gain confidence. This is a huge issue. If you can't smile without having a big black gap in your smile, it is awful."

A national study of Canadians aged 36 – 69 years found that people with severe gum disease had between three and seven times the risk of fatal heart disease.[22]

If you have periodontal disease, you may have a higher risk of heart disease. The germs that cause gum disease may also block arteries and lead to stroke, according to the Calgary Health Region's Healthy Communities Community Oral Health Program.[23]

Stroke: A U.S. study concludes periodontal disease increases stroke risk 15 per cent to 18 per cent in whites, 38 per cent in African-Americans.[24]

Diabetes: Diabetics whose periodontal disease is treated have a 10 per cent reduction in glycated hemolobin (a measure of long-term blood sugar levels) which can reduce the incidence of diabetes- related side effects.[25]

Gum disease can make diabetes worse by making blood sugar harder to control and people with diabetes may have trouble getting gums to heal, according to the Calgary Health Region's Healthy Communities Community Oral Health Program.[26]

Respiratory Disease: People with existing lung problems, weak immune systems, and elderly people are at higher risk of getting a lung infection from breathing in bacteria in the mouth, according to the Calgary Health Region's Healthy Communities Community Oral Health Program.[27]

PLBW (Pre-term low birth weight babies): One study found that women with severe gum disease have more than seven times the risk of PLPW deliveries.

Pregnant women with the severest form of periodontal disease had an eightfold risk of giving birth prematurely and a threefold risk if they had a milder infection.[28]

There are also some outcomes that are more specific to certain populations. For this reason I provide evidence of the outcomes as they affect children, homeless adults and street youth.

Children

B.C.'s Provincial Health Officer in 1997 reported that dental treatments were the most common hospital-based surgical procedure for children under 14 years of age in B.C, at an estimated cost of about $2.9 million for hospitalization, excluding the cost of dental treatment.[29]

A 2001 study of school age children in the South Fraser Health Region states, "Schools in higher income areas consistently show the best level of dental health. The children from the lowest income neighbourhoods demonstrate the highest number of untreated cavities, toothaches and infections. It is interesting to find

Caite & Francoise
Nurse Practitioners
Cool Aid Community Health Centre

The need …

"Poor dental hygiene creates the potential for disease transmission including Hepatitis and HIV. Open sores in the mouth due to abscess, ulceration, pulled teeth etc. are entry sites or portals for disease. As well, the blood from bleeding gums can be a potential carrier of disease especially in the case where the individual has HIV or Hepatitis."

"There is virtually no dental care for our clients who are not on social services. A lot of our street clients who make their living off the streets panhandling, etc… they have no dental care at all. There is definitely no prevention."

"Poor dental hygiene has also been indicated in increasing the risk of other diseases within the individual themselves such as sepsis, osteomyelitis and cardiovascular disease. Providing dental services and improving the dental hygiene of our clientele could play a large factor in decreasing the spread of disease."

Similar to the Open Door, the street nurses have established a relationship with a dentist that will accept their referrals.

The clinic…

"The staff need to be aware of the issues that the clientele deal with on a daily basis. The people working in the dental clinic need to have knowledge of harm reduction philosophy. And the hours of operation need to be flexible to include evenings and allow drop-ins and no-shows for appointments."

"Try to make it as friendly as possible and non-threatening as possible. If they feel they are being judged you won't see them again. In other words, do not put many expectations or restrictions on the clients. It should be as unconditional as possible."

"We need prevention and education because some people have been raised in poverty and may never have seen a dentist and may not know the basics of dental care. We also need the provision of free supplies, like toothbrushes and floss."

that children in the families in the mid-income range will often have experienced decay but have had it treated."[30]

"The higher the family income is, the better the dental health of the child is likely to be".[31]

"Thousands of children in Saskatchewan have decaying teeth more likely to match the dental records of young people in Third World countries than those living in Westernized nations… the population of Saskatchewan that have the poorest oral health are people or children living in poverty, First Nations children, Hutterite children and children who live in the inner city."[32]

The estimated cost for preventative dental services at a dental office for a family of four (2 adults and 2 children) is $912 a year (for two visits each).[33]

Homeless

While I have limited my research review to primarily B.C. and Canadian sources, a recent Canadian report (April 2001) concludes that the oral health status of homeless Canadians is consistent with the homeless in the U.S. – that "homeless adults have a higher degree of dental disease than the average population and that there is higher need for dental treatment due to pain, infection and gross caries."[34]

A Montreal study showed that even if homeless individuals have the right to free basic dental services, dentists are reluctant to see them in their private offices, especially during normal office hours.[35]

A study of Montreal homeless people found that 85 per cent required dental treatment of one kind or another.[36]

The Toronto Street Health Report found that the homeless were almost twice as likely not to have received dental care in the past year compared to the general Toronto population.[37]

UBC's Dr. MacEntee reports "it is highly likely that most of the homeless population do not avail themselves of their dental benefits through social assistance because of a general discomfort with the bureaucratic system."[38]

Street Youth

In a Toronto study of 174 street youth ages 14 to 25, over half (53%) of the youth reported having experienced dental pain in the past four weeks. Of these, 38 per cent were found to have caries while 40 per cent had calculus and/or were in urgent need of periodontal treatment. The mean DMFT (Decayed, Missing & Filled Teeth) was 5.7 in homeless youths, in contrast to a mean DMFT of 1.7 in

Rosemary Mann
Young Parents' Support Network

"People here are worn out from just struggling to meet their basic needs. Housing is a hassle and they are moving a lot, getting food to last till the end of the month is a problem and then there waiting in the food bank line. If their dental care can be one last thing that people have to struggle with, one last thing that feels like it's a challenge and a worry, then that just builds on a healthier person and a healthier community," says Rosemary Mann.

The need …

"A community dental clinic would be a great idea. People need to be able to access the care where they are, so a clinic that is rooted in the community is a good idea. For our population, I think kids are getting better dental care than the adults. There are programs out there to meet kids needs and there may be kids out there who are falling through the gaps but probably not as many as our young parent members."

"The reality is that for a working family who is above the cut-off for Healthy Kids who is going to get the dental appointments and check-ups? The kids are going to get it at the expense of the adults. The adults are going to make a choice that within our budget who can get a check-up, and as with everything else, the kids are going to get it first and the adults are not going to get care".

The effects …

"It's weird to me that we have a public medical system and we somehow separate our teeth and anything that happens there. Good dental health is just like good general health. It means increased self-esteem, getting a job, making social contacts. But poor dental health is linked with all sorts of stigma. You know you walk in and you're missing all sorts of teeth and that changes people's attitudes in terms of their first impressions."

The clinic …

"A clinic should cover a whole range of care options. Prevention is equally important to treatment."

"I imagine that a clinic would primarily serve adults. I don't know if it could serve both adults and kids. To do that, I think you would need staff that are good at working with kids, like a paediatric dentist where the whole setting is created for kids."

"The staff are critical. The people I work with tell me that from so many services they access, the people who are supposed to be there to help them are either not very good at being nice all the time, downright tired of doing it and cynical and not nice, or that the service just puts up all sorts of barriers. The access needs to be as easy and open as possible. The people who staff it have to be really dedicated to what they do, working with a really varied population with respect. If it's a free clinic, it still needs to be a quality service. It should still be a nice place to walk into. It needs to address people's anxieties about dentistry. You are often trying to bring people back into a system that they may have been out of for a dozen years or so and you need to treat them well."

15 year olds of the general population. In terms of gingival tissues, only 22 per cent had healthy gingiva. 32 per cent had some bleeding, 35 per cent had calculus, and 12 per cent had apparent periodontal involvement or excessive inflammation. Both the DMFT and gingival status worsened as the number of years on the street increased.[39]

Only 22 per cent of the youth surveyed in this Toronto study[40] reported visiting a dentist in the previous year, while 41 per cent had not done so in the previous two years. Of the street youth interviewed, 74 per cent thought they needed dental treatment or advice immediately. However, when asked where they would go for dental care, fully one-third responded that they did not know.[41]

Mabel-Jean Rawlins
Community Social Planning Council

"The most direct outcome will be the actual number of people served and the treatments. But another important outcome to document is the process in setting up the clinic, the way that this process has brought together new people around a common table to look at an issue: the professional dental community, Camosun College, community groups, the University. Whenever we bring together a new mix of individuals looking for community solutions, we are developing increased awareness and understanding of issues and developing skills within the community to be able to solve problems at the community level. These are factors that are hard to put dollar signs beside, but they are very real outcomes."

Rawlins emphasizes what she calls the "high human price" of so many people not being able to afford dental care in Victoria. The need is "much bigger than those in immediate deep poverty."

"A clinic is one really good first step, but it is not a complete answer at all." She advocates for comprehensive dental coverage with greater equity in the access to care.

Outcomes: When we meet the dental needs in Victoria

"The apparent "bottom-less" pit of public demand in the face of widespread fiscal retrenchments confronts health services everywhere. However, ultimately the principle of allocating oral health-care to benefit the least advantaged in society will benefit all, and does not necessarily need large financial resources.

- Strategies to Enhance the Oral Health of British Columbians[42]

Healthcare regions are not saving money by not providing access to affordable dental treatment to low-income adults. At the media release of the *Brushed Aside* report, Judy Burgess said "the cost of re-establishing a community dental clinic in Victoria is insignificant when you compare it to the costs of not providing preventative dental care in the first place, and then waiting until the problem is so intense that people are admitted to (hospital) emergency."[43] What is known is that dental illness is a major health cost.

- The Canadian Medical Association Journal ranks the costs treating dental illness a close third behind cardiovascular disease and mental disorders at $2.4 billion a year.[44]

- Another study estimated the direct costs of dental care in Canada in 1989 were $3.1 billion.[45]

- It has been estimated that treating dental illness costs more than treating cancer. The total amount for dental treatment is not evident because it is paid for privately versus cancer treatment, which is a public health expense.

- An article in the Journal of the American Dental Association (JADA) reports that when Maryland cut adult dental benefits from its Medicaid program there was a substantial increase in dental visits to hospital emergency departments by Medicaid recipients. The benefits were cut in an attempt to save money, however, researchers discovered a 39 per cent increase in dental visits to emergency departments. They further cautioned that because these people were not receiving full dental treatment in the emergency department (often just prescribing painkillers and antibiotics) "this pattern of care and associated costs may be repeated as patients are forced to return for treatment of the unresolved condition."[46]

Dr. Michael King-Brown
Private Practice Dentist, Downtown Victoria

Dr. King-Brown brings a valuable perspective to this project. Within his downtown private practice, he includes a commitment to incorporate patients who live in poverty. "Long ago I made the decision that I was going to treat welfare patients and not join the increasing number of guys who wouldn't do it unless they paid for it. Someone has to treat them, especially downtown, so I don't mind doing that at all.

Over the years he has tried different strategies to fit the downtown community into his practice. When the Victoria Street Community Association (VSCA) was operating in the 90s he would call them whenever he had a cancellation that he couldn't fill. The VSCA kept a list of people needing dental care and would send someone right over.

In previous years he has tried setting up a free dental day through the Mustard Seed, with limited success as many people didn't show up and a lot of the people who did show up could have been treated any day had they obtained an emergency dental form from the Ministry. He stresses the value of screening clients, basically determining individuals' eligibility for coverage.

Based on his experience, King-Brown defines the need as largely immediate major dental work, primarily extractions and getting rid of infections and the relief of pain. Then there is the need for restoring teeth that are saveable. A separate category is to try to get their smile back. And he notes that rarely is he able to get to the stage of crowns and bridges, "we never get that far".

I asked Dr. King-Brown if private practice can meet the needs that he identifies and he said no, because of the cost factor and the nature of the people needing help. King-Brown speaks from years of experience, "They tend to be fairly alienated from professional people in society. It's really tough for them to come into a regular dental office. Everyone else is sitting around, they come in and sometimes they smell, sometimes they are not very happy about things, sometimes they don't have many social skills, none of which would prevent me from treating anybody, but, it makes them very reluctant to come into an ordinary dental office. They tend not to be very reliable with keeping appointments. And then its difficult getting paid."

"It's difficult for me to give a significant amount of time or do things that are going to cost a lot of money and not get paid for it. I'll do that to a certain extent and everybody who treats welfare patients does that to about 33 per cent." As for the working poor, King-Brown says "they have a desperate need for inexpensive dentistry"; a need not being meet by private practice.

A clinic "would fill a huge need" he says, and adds its "a need my hands are somewhat tied in being able to provide". He recommends two chairs for hygiene and three more operative chairs and two receptionists to deal with the red tape and bureaucracy. As for the dentist, he advises paying a salary rather than fee-for-service, "but pay the dentist well." He adds, "Because you are treating people with very little money, it would be nice to leave money out of the equation."

Limited public oral health measures

Currently, overall population health data does not exist on adults' oral health in the Capital Region and therefore outcome indicators are limited to those who receive treatment (without being able to draw comparisons to the overall population). This situation is not distinct to the capital region.

- "There is no pan-Canadian study of dental decay. On a Canada-wide basis there is a lack of information about dental health," according to Dr. John O'Keefe, editor of the Journal of the Canadian Dental Association.[47]

- "There is no Canadian data available on the indirect costs of dental problems and visits, a measure that includes work loss days, school loss days, reduced activity days and bed disability days."[48]

- UBC's Dr. MacEntee's study of the oral health of British Columbians notes that "there is almost no information available on the oral health of Aboriginal adults on or off reserve in this province."[49]

- MacEntee also notes that "there is little information on the oral health of homeless people…"[50]

What does exist, is the Adult Dental Health Survey[51], published by the College of Dental Surgeons of B.C. Every five years, the College takes a one-day "snapshot" of the dental health of B.C. patients – not the dental health of all British Columbians but rather those people receiving treatment that day. The 1996 survey presents findings based on 9,000 adult patients. The next survey is scheduled for December 2001. One possibility would be for the clinic to use this same research tool to take a snapshot of its patients' dental health in order to draw comparisons with the general population of patients accessing treatment in traditional, private practices.

With limited baseline data, there are limits on how we can measure expected outcomes on the region's oral health status following the development of a community clinic. In addition, as with any outcome-based evaluation, there are many expected outcomes that are simply too difficult to isolate or too onerous to measure. While these are largely unmeasurable outcomes, the following table lists the many outcomes associated with an effective community-based response to the dental needs of a population.

Direct outcomes: Less untreated dental problems in CHR Increased use of preventative treatments by low-income residents Increased restorative services provided Lower levels of caries Reduced rate of edentulism in CHR	**Related social outcomes:** Increased self-esteem Increased ability to carry out daily functions and social relations Less loss work/school days Greater employability Greater civic involvement
Related health outcomes: Absence of infections Raised health status Lower risks of related health problems	**Related community outcomes:** Less use of emergency medical services Lower transmission of communicable diseases and infections Greater awareness of dental health issues Greater integration of public health needs in dentistry Greater equity in provision of oral health care in CHR More opportunities for dental professions to work/learn in community setting

Now, more specifically, what are the outcome-based measurements for a downtown community dental clinic in Victoria? With minimal base-line data, most indicators would be derived from program evaluations and therefore better able to measure the outcomes as they relate to those who access services rather than outcomes as they relate to the overall health of the community (population). The clinic can incorporate a comprehensive evaluation in its second year. Using the Provincial Adult Dental Health Survey and personal testimonies, the clinic can take a similar (and comparable) one-day snapshot of clinic patient's oral health. As well, follow-up interviews can measure the effects of dental treatment on patients' overall health and well-being.

Expected Outcomes

Objective	Outcome	Indicators/Measures
Access: to increase access to dental care services for people living on low-incomes in the CHR	A reduction in the number of low-income adults with untreated dental needs.	# per month receiving services. # of patients referred by community agencies # of patients facing multiple barriers to care # of patients who are First Nations (status). # of partnerships in each sector – social, health, dental.
Affordability: to provide services according to people's ability to pay.	Dental services are affordable to individuals on low-incomes.	% reduction in fees provided % of clients treated at no charge
Comprehensive: to provide comprehensive dental treatment that fully meets the dental needs of patients.	Dental services surpass relief of pain and include restorative work.	# of (and % of) patients who receive restorative dental work.
Prevention: To provide preventative treatment according to ability to pay.	Further dental problems are prevented.	# of preventative dental services provided
Efficiency: To deliver services in an efficient, cost-effective manner.	The clinic's objectives are met while operating within allocated funds.	$ in financial statement at year end.
Alternative: To provide an alternative to emergency department use for dental needs.	Individuals no longer seek dental treatment through ER.	# of patients requiring emergency treatment. % reduction in ER visits by low-income people seeking emergency dental care. (data may not exist)
Overall health: To reduce the negative impacts of dental problems on individuals' overall health.	Patient's overall health status is improved as a result of treatment.	# of patients treated with related health concerns (ie: infections, diabetes, HIV, Hepatitis C, heart disease, etc.).
Learning: To provide a community dentistry learning setting in the CHR	Greater experience, appreciation and knowledge of community-based dental services.	# of community-based dentistry learning opportunities provided.
Research: To develop exploratory public dental health measures, program evaluation and identification of needs.	Evidence-based decision making in clinic's service delivery and development of strategies for increased oral health status in CHR.	# of effective measures developed and implemented Completed program evaluation and strategy document/process.

Dr. Bill Bassett, Camosun College Dental Program
Shirley Bassett, Camosun College Dental Program
Dorothy Rosenberg, CHR Community Dental Hygienist

Dr. Bassett shares his unique experience of working at the Camosun Dental Program as well as being the dentist at Victoria's previous community clinic operated by Cool Aid in Fernwood Square. Both Shirley and Dorothy shared their experience as hygienists working in the area of public health. In a small office at Camosun College's dental program, they shared their visions for a community dental clinic.

"At the Fernwood we made sure that we were not looked at as a charity clinic. We tried to run it as much as a normal clinic as possible, so that people wouldn't think "I could get a filling done well or I could get it done at Fernwood," says Bill.

The group recommends three chairs as a minimum for a clinic (two operating and one hygiene) and possibly four chairs to offer mentorship opportunities for Camosun hygienist students.

A community clinic can offer a wonderful learning environment, however, permanent staff are needed for a clinic, who could then provide learning opportunities to hygienist students. "You cannot run the clinic only with students. It would be very inefficient," notes Bill who stresses the importance of having the dental staff "buy into" the whole concept.

"You want to attract a good core person who is paid a competitive wage and who can also embrace community-based work," says Bill. The group recommends paying a dentist salary, rather than fee for service, but still they recognized the risks with this model. Bill relates, "If you get a lazy dentist you are stuck with them for a year. But when I worked at the Fernwood clinic on salary I liked the fact that I could tell my patients that I had no monetary interests in this procedure. This is the best service."

Finally, there is an agreement that one clinic will not meet all the needs in Victoria. A clinic should be limited to serving adults, as there are no current options for this population.

Outline of Proposed Model

"… all of the treatment centres for low-income and homeless individuals are located in the Lower mainland… it seems reasonable to expect that similar services will be needed elsewhere"
Strategies to Enhance the Oral Health of British Columbians[52]

A reduced-fee dental clinic is not a new idea for Victoria, or for the Cool Aid Society. From about 1975 to 1986, Cool Aid operated a publicly funded, reduced fee clinic in Fernwood Square. The clinic closed when the provincial funding was withdrawn. Dr. Bill Bassett was the clinic's dentist and now can be found at Camosun College's Dental Program. Besides being a valuable source of information for this report, Bassett has also prepared an earlier report promoting the reestablishment of a clinic in Victoria. His report, "*Feasibility for a Reduced Fee Dental Clinic in Victoria*" describes Victoria's previous clinic:

> "The operating grant amounted to the equivalent of the assistant's and receptionist's salaries. The dentist's salary, supplies, and other overhead expenses were covered by client fees [which raged from 20% to 60% of the fee guide]. Every year a small funding surplus was returned to the parent organization. In 1986 the province withdrew its funding, and the service was discontinued. This clinic was very popular and at times there was over 200 names on a waiting list for service."[53]

In January 2000, the James Bay Community Project developed a business plan[54] for a community dental clinic. The goal was to create a model that could be financially viable without government funding. With finances fully generated by fee-for-service billings, the model provided only a 10 per cent reduction in fees. It focused more on the provision of payment plans and a community care model emphasising education, prevention and treatment that is integrated with health and community services. With no operational funding and considerable capital costs, the plan did not proceed.

In September 2001, I had the opportunity to tour three of the clinics for low-income and homeless individuals on the Lower Mainland - the Sunrise Hotel Clinic, the Mid Main Clinic and the North Community Health Clinic. Anita Vallee, the Regional Dental Hygienist for the Central Vancouver Island Health Region has provided this report with profiles of the clinics in the Lower Mainland and of the Northern Dental Van (see Appendix).

While Vallee is interested in the various ways community clinics offer dental treatment, she also sees the limits in transferring Vancouver models to the rest of B.C. She advises that we recognize the difference between needs in those communities from those on Vancouver Island. Many clinics in Vancouver serve children because of the large numbers of new immigrants. The barrier may not be financial as much as cultural and language; "they are not going to go to a regular dentist," she says.

"I think you are looking at a very different population in Victoria than the Vancouver clinics are looking at," says Vallee. She predicts that the population in Victoria likely already believes that oral health is important to them, but that the barrier to care is essentially financial. "A lot of people in Victoria probably have an awareness of the need to take care of their teeth, but they have just lost hope of ever being able to get treatment," says Vallee. So, while a primary barrier to care in Vancouver may be preschool age children's cultural and language issues and a major barrier to care in Northern B.C. may be the lack of dentists, in Victoria the barrier is primarily financial.

A Model for Victoria

The development of a proposed model for a downtown community dental clinic in Victoria and its estimated costs is based on extensive consultation with key stakeholders in this area and includes:

- Consultation with administrators of clinics
- Existing Business plans for community clinics
- Visits to three clinics in the Vancouver area
- Discussions with key informants and local dentists

The operating costs and start-up costs estimates are derived from the experiences of existing clinics and business plans. These estimates (attached as spreadsheets) have been reviewed and verified by dentists and individuals active in public health dentistry. The estimate of capital cost and set-up totals $290,000 as presented in the attached table. The operating costs of the proposed model effectively balances client's needs for significantly reduced fees for service and the actual costs of providing these public health needs. The difference requires a $150,000 annual subsidy, a subsidy that fills the gap and allows the clinic to fill the need.

The best set-up for Victoria is a three-chair, one dentist clinic. The clinic will also employ a dental hygienist and two dental assistants. The dentist, working with a certified dental assistant will serve patients in two chairs and the third chair will be for treatment provided by the hygienist. The second dental assistant will cover reception. Having a receptionist who is an experienced dental assistant is highly recommended. It requires some skill and experience to be able to advocate with the provincial bodies to access benefits and in high demand periods the receptionist can also help out in the back. The clinic will operate full time hours and all staff, including the dentist, will be paid on salary.

A part-time Administrator will be responsible for overall operations, including staffing, financial management, developing and sustaining vital partnerships and community connections, developing learning and volunteer opportunities, and public speaking, outreach and education.

As the only community-based dental clinic in the region, there will also be many opportunities to include volunteer and learning opportunities in the clinic. By including volunteers and students, the clinic will be able to lower costs and therefore offer more

free services, extended hours and expanded outreach and health promotion efforts while providing valuable public-health training to students and professionals. However, it is cautioned that the clinic not rely on volunteers and students for core staffing. In the future, the clinic may consider a fourth chair dedicated as a learning station.

The clinic will be developed according to community health promotion principles. Prevention, education and treatment will be provided in a team-based approach. The services of the clinic will be integrated with Cool Aid's Community Health Centre. As well, dental services will be linked to services addressing patients' housing needs, employment needs and other advocacy services.

As many people interviewed for this report mentioned, the staff who deliver the services are critical to its success, its credibility and its effectiveness with the marginalized communities it is serving. The clinic will follow the treatment protocols and practices employed by Cool Aid's Community Health Centre, practices that emphasis non-judgemental treatment, harm reduction principles, and the best ways to engage and retain individuals who have been marginalized from existing, mainstream services. An advisory group will guide the set-up, operations and evaluation of the clinic in it's first year(s).

Clients served and expected revenues

A review of existing clinics' statistics as well as revenue estimates from other business plans provides the groundwork for estimating the number of clients to be served and the expected revenues from their reduced fee-for-service.

The clinic expects to serve 20 patients a day plus 6 hygiene patients, totalling 5,000 dentists visits and 1,500 hygiene visits annually. The primary target group for the clinic will be adults and youth living on low-incomes in the capital region, especially those who face additional barriers to care.

The clinic's fee guide follows the Pay What You Can (PWYC) principle. Clients with Ministry coverage will be charged according to the Ministry's fee guide. Clients with other insurance plans will pay according to available coverage through their insurance plan. Clients with no coverage and limited ability to pay for dental services will be offered a 50 per cent reduction in fees and the option of a payment plan. Clients with no ability to pay will be treated at no cost.

With significantly reduced fees for service, and some free service, the chairs are expected to generate an average of $50 an hour. Based on 3 chairs each operating a 35-hour week, the expected annual fee for service revenue would total $262,000. In the following spreadsheet this expected revenue has been reduced by 10 per cent to $235,800 for first year of operation. These revenue estimates were considered to be realistic by people currently working in the field.

The clinic is dependent on an operating subsidy as well as these reduced fees generated from patients. The expected costs and revenues presented in the attached spreadsheet

have been independently reviewed and verified as accurate expectations from key professionals. Because this is a new service, there are several cautionary measures incorporated in the start-up of the clinic. Hiring of staff will be staggered as the clinic confirms the actual revenues from fee for service. The clinic's clientele will be a diverse mix of patients with various benefit plans and ability to pay the reduced fees. Patients will need to be prioritized to ensure a mix of payment plans that allow for a necessary recovery of fees while also serving those in greatest need.

Conclusion

This report is based on many people's struggles to meet the need for affordable, accessible dental care for people living in poverty in the capital region. People are struggling when they are refused necessary dental care. Instead they depend on self-care measures such as pulling out their own teeth with pliers, popping infections on their gums each morning and living on painkillers throughout the day. This report tells of people living with the fear of heart disease and necessary surgery being cancelled – due to raging infections in one's mouth. This report relates warnings from service providers of how healthy communities will not be realized without healthy oral health. Infectious are more easily transmitted and people's daily lives – their work, school and family – suffer when dental needs are not being addressed. This report cannot fully convey the loss of self-esteem, dignity and respect related to living in dental pain and knowing there is no help.

Just as there were overwhelming stories of the need, there was equally overwhelming support for the development of a community dental clinic in Victoria. A dental clinic will not only significantly address people's immediate need for treatment, it will also begin the process of integrating oral health into our communities. A clinic will offer more than treatment, it will offer hope. Whether it's a person living in social housing, on the streets, attending an employment training program, or in a Best Babies program – no longer should their dental health compromise their efforts of living a decent life.

A clinic will be a community-based response to a significant issue. By demonstrating its effects on improving the lives of individuals and the health of our communities, this community response can also demonstrate the need for a comprehensive system of oral health care – a universal, accessible system of care, based on one's need, not income.

Notes to the Operating Costs Estimates:

Fees from service: Assumes 26 patients a day and a 247 day year. Assumes 3 chairs each generating $50 an hour. ($150 an hour x 7 hours per day x 250 days = $259,350). A 10% reduction has been incorporated to allow for error; therefore the total fees from service totals $233,400.
CHR operational funding: The subsidy being requested in order to fill the gap between the costs of the service provided and the revenue generated when providing services at significantly reduced fees.
Cool Aid Dental Budget: Secured funding within the Cool Aid Community Health Centre.
Dentist salary: One FTE dentist on contract (no benefits) at $80,000.
Dental Assistants: Each paid $18/hr x 37.5 hrs x 52 weeks = $35,100 (x2 position for a total of $70,200) Salary based on average CDA wage in B.C.
Dental Hygienist: ($32/hr x 37.5 hours x 52 weeks = $62,400). Based on average DH salary in B.C.
Administrator: 0.5 FTE estimated annual salary of $27,600.
Benefits: At 25% of salaries (CDAs, DH, Administrator).
Relief staffing: 13% of clinic staff (Dentist, CDAs, DH).
Dental lab: Generally, in a private practice, lab fees would appear as identical expenses and revenue. In the clinic's estimates, this line reflects the subsidy required for lab work not covered by the patient's benefits/fees.
Supplies: Estimate based on discussions with existing clinics and dentists.
Rent: Without a secured location at this time, this is an estimated expense based on Cool Aid's current mortgages.
Utilities/telephone/supplies: Based on Cool Aid's existing costs.
Administrative & Technological support: Includes Insurance, repairs and maintenance of dental equipment and computers, bank charges, accounting and legal fees and basic administrative support.

Appendices

Please find attached:

- Operating Costs Estimates for a Victoria clinic (in Excel)
- Set-up costs estimates (in Excel)
- List of key informants and resource people
- Profiles of community dental clinics in B.C.
- Current CHR Responses to Dental Needs
- A comparison of dental fee guides (in Excel)
- Bibliography

Key Informants & Resource People

Jacquie Ackerly
Together Against Poverty Society

Sandy Bjola
CHR Regional Health Analysis and Planning

Dr. Bill Bassett
Camosun College Dental Program

Shirley Bassett
Camosun College Dental Program

Barbara Bell
REACH Community Health Centre (Vancouver)

Caite
Street Nurse Practitioner

Jane Dewing
Victoria Cool Aid Society

Francoise
Street Nurse Practitioner

Irene Haigh-Gidora
Cool Aid Community Health Clinic

Alix Hotsenpiller
Together Against Poverty Society

Dr. Michael King-Brown
Private Practice Dentist, Downtown Victoria

Brenda Macevicius
Esquimalt Neighbourhood House

Rosemary Mann
Young Parents' Support Network

Colleen Ming
Mid-Main Community Health Centre (Vancouver)

Mabel-Jean Rawlins
Community Social Planning Council of Greater Victoria

Tim Richards
Together Against Poverty Society

Dorthy Rosenberg
CHR Community Dental Hygienist

Norma Strachan
ASPECT: B.C. Community Based Trainers

Glen Turko
Ash Temple

Rev. Allan Tysick
Open Door Ministry

Anita Vallee
Regional Dental Hygienist, Central Vancouver Island Health Region

Dr. Malcolm Williamson
Ministry of Health, Senior Dental Health Consultant

Profiles of Community Dental Clinics in B.C.

Prepared by Anita Vallee,
Regional Dental Hygienist
Central Vancouver Island Health Region

Clinic: Mid Main
Address/Phone: 3998 Main St & 24th, Vancouver,

Contact: Colleen Ming, Executive Director, 604-873-3666
Julia Crawford, Dental Office Manager 604-873-3602
Denise Ralph, Medical Office Manager

Type:
- Multidisciplinary Clinic, focus on 0-5 years
- Non-profit Society with Board of Directors.
- Offers medical, dental & associated services.
- Started in 1988, as an off-shoot of REACH

Staffing:
- 2 full-time DDS's, 4 part-time DDS's; receive 40% of their billed services
- 1 DH – salaried 1 part time DH - salaried
- 4 operatories plus one hygiene operatory
- 3 CDA's, 2 reception and 1 manager
- Medical Doctors and staff

Hours: - 6 days/weeks, with Tuesday evening hours

Funding:
- Was a City of Van. clinic – Van City fronted 100% of the mortgage
- Private funding, donations for elevator, etc
- Board and staff originally put up $10,000 to get hygiene practice going, NB that staff buy into the vision for the clinic.
- get about 10% discount from labs
- Have contract for Physicians with MOH Alternate Payments Branch

Eligibility Criteria: - open to anyone in Dental, some limitations in medical

Clients & Fees:
- approximate 700/month, have about 7000 charts
- 40% - HR fee guide (50-80% of CDSBC fee guide)
- 30% - pay from pocket – charge 90% of CDSBC fee guide
- 30% - private dental plans
- 60 % children
- 40% adults
- see lots of new immigrants / non-English speaking people
- clients in pain

Referrals: - refer GA's to Dr Ros Harrison at Children's Hospital and private Pediatric Dentists

Comments: - Clinic carries a lot of debt, allows payment plans, multidisciplinary members work together with office manager to decide re budget expenditures. Manager keeps close watch on expenditures, looks after the overhead.
- translators for Cantonese, Punjabi, Vietnamese, Mandarin
- support clients to get coverage, eg: apply for MSP and premium assistance
- by appointment only, although emergency appointments available.

Services Offered: basic and prevention & txt, crowns, bridges, dentures, cosmetic and some orthodontics.

Clinic: UBC Dental Clinic
Address/Phone: UBC Campus (started in 1975) Douglas College Site, New Westminister (started in 1999)
Contact: check UBC website

Type: Dental clinic with dental students/hygiene/CDA students providing services under supervision of instructors.

Staffing: - Students with supervising instructors

Hours: - 4 afternoons/week, mid September – mid March (Douglas College) (4th year)
- UBC – twice weekly, March-June, 3rd year students

Funding:
- Financial grant from MCF for children to cover bus
- free treatment and prevention
- space maintainers – pay lab fees

Eligibility Criteria:
- # procedures and types of service needed – has to fit student needs for clients
- not income based
- not <5yrs of age

Clients:
- School bussing provided
- no charge for treatment
- Simon Fraser/South Fraser HR staff on bus and at clinic
- Bus criteria – K-4, anybody not on Healthy Kids or other plan
- any treatment needs
- # ? seen/year, 8 chairs at Douglas college,

Fees:
- charge approximately 70% of CDSBC fee schedule?
- $11.00 screening appointment
- $50.00 - $100.00 exam and x-rays.

Services Offered:
- offer all types of dental services, including specialties

Comments:
- long appointments, many, many appointments

Douglas College
- extension of UBC
- September – March (6-12 years)
- April – June (children 6-18)

Clinic: Rainbow
Address: #109-12414 82nd Ave, Surrey, Phone 604-596-7722

Started 1998

Contact for health unit: Jacqueline Gerry, South Fraser Health Region
Contact for clinic: Monica Verma 604-596-7722

Clinic is currently non-operational except for UBC study programs

Type: non profit cooperative society owns the clinic. Much of the equipment belongs to the SFHR(South Fraser Health Region)

Staffing: no staff. Staff has been provided by the SFHR for short sessional periods during the past two years. Dentist was contracted via funding from the SFHR

Funding: $25,000 initial set-up grant from "Health Innovations" from the SFHR
-Some equipment was donated by private dentists and companies.
-The co-op had a fund raiser - telethon- apparently raised less than $1000
- Clinic was originally funded to be an emergency dental clinic for very low-income families. Rainbow was to become self-sustaining. As of yet it is not.

Successes with Rainbow:
Two dental surveys are being conducted by UBC at the clinic. One for a rinse program for seniors and the other to assess the effect of motivational interviewing combined with a fluoride varnish program funded by UBC. Patients are paid to attend these programs.

SFHR conducted a program for low-income teenagers, that included education on several occasions and treatment at no cost. Teens were brought in as part of the ESL teen education program conducted by Jackie Gerry at the Secondary schools in Delta and Surrey.

SFHR for a short period of time, funded an emergency clinic mostly for adults to treat patients in pain and at the same time assess the numbers of treatment needs and what patients considered as emergencies. Very often cleaning was thought of as an emergency by the patients.

Eligibility: Adults - Pain relief
Co-op preferred adult patients to take out membership of $5
Cost for emergency treatment was $20 per procedure, fees were often waived or not collected.
Most frequent treatment = extractions or referrals to VCC for cleaning
Teens - must have participated in school program or have contacted a staff member of. SFHR. The first year students were asked to pay $15 to cover all treatment, many forgot to pay The 2nd year teens were free of charge. Basic dental treatment was provided.

Clinic: **REACH Community Health Centre (REACH = Research Education & Action in Community Health)**
Address/Phone: 1145 Commercial Drive, East Vancouver (between William & Napier St.)
Contact: Barbara Bell 604-254-1354

Type: -Part of a multidisciplinary health centre, includes medical, nutrition and counselling programs, a pharmacy and the Multicultural Family Centre
- Began over thirty years ago.

Staffing: 3 dentists who are on salary (about $70,000 to $75,000 for a 35-hour week),
1 Dental Hygienist (who is paid market rate),
2 4 Dental Assistants (chairsides)
3 2.5 support staff.

Clients:
- patient list of 5,000 to 6,000 patients.
- mainly serve adults (about 80%)
- will serve anyone, giving priority to residents of their community.
- there is a 4 to 6 week waitlist for first appointment.

Fees:
- About 40-45 per cent of patients are insured and pay full fees.
- Uninsured patients pay 20 per cent less than the fee guide
- HR Ministry and First Nations pay according to the fees set by the relevant Ministry.
- The clinic has special permission from the College of Dental Surgeons to operate outside of their fee schedule. The clinic operates at a loss and therefore receives additional funds from the Centre's general operating budget.

Other Services: - one-night a week Emergency Clinic where UBC students offer limited treatment (relief of pain) to ten patients a night for $7.00. People must call first thing in the morning to get one of the ten appointments (which demands that the patient have access to a phone).

Recommendations: While the clinic employs dentists on salary, it is a concern if this could be a reason for why the clinic has been unable to cover its direct costs. The clinic largely attracts young dentists who have student loan debts and want a salary for a couple of years and don't stay. However, they do have a dentist who has been employed for over eight years and the support staff do stay for a long time and have a good connection with the community.

Clinic: **Burnaby School District Dental Clinic**
Address/Phone: 5310 Woodsworth St. Burnaby, V5G 1S4, (604)664-8525
Contact Person: Dr. John Hung, Lynn Guest, DH II Simon Fraser Health Region

Type: - school based clinic
- started in the 1960's

Staffing: Sessional dentist,
2 full time CDA's, 1 DH, salaried

Hours for Service: unknown

Funding: Funding used to come from SD#41 and health region. School District withdrew its portion of funding effective April 1, 2001. Currently interim funding from the MOH (through the Simon Fraser Health Region) to operated the clinic until March 31, 2002. A formal evaluation of the dental program in the region (including the clinic) is taking place. Began in June 2001 with a completion date of March 31, 2002.

Eligibility Criteria: K and Grade 4 children living in Burnaby School District

Clients:
- 100% children, screen about 10,000 during the school year
- about 650 appointments/year, ½ for cleaning and fluoride, 1/3 have 1+ cavities
- complex cases referred to UBC/Douglas College or GA's to the hospitals

Fees: $10.00 fee to enroll in the program
- those on Healthy Kids encouraged to see private practice

Services Offered: Service by appointment
-preventive and treatment services

Setup Cost:

Cost to Run:

Comments: The review currently underway by the Simon Fraser Health Area should provide much more detail. The clinic is not currently running at full capacity.

Clinic: Seymour Strathcona Children's Dental Committee
Address: downtown eastside
Contact: Dr Malcolm Wiliamson, MoH

Type: non-profit group currently working to improve access to existing services and develop a
dental clinic in Stathcona School.
- Not yet started, still in planning stages

Planned Funding:
- local government
- agencies

Planned Clients:
- school aged
- low income
- 80% non english

Services planned:
- School Fluoride rinse program
- improve access to Healthy Kids using facilitators familiar with community
- study of unmet needs of children.

Clinic: **Vancouver Richmond Health Region**
Address: **South Community Health Office**
6504 Knight St.
Contact: Dr WC Hadaway, DDS 604-321-6151
Tana Wyman, DH II Vancouver/Richmond Health Region 604-872-2511
Address: North Community Health Office, 1651 Commercial St.
Contact: Dr Tracy Wong, DDS 604-215-3935
Tana Wyman, DH II Vancouver/Richmond Health Region 604-872-2511

Address: Downtown Community Health Office (DCHC)
-multidisciplinary services with medical clinic, pharmacy, food bank
412 E. Cordova St.
Contact: Dr Wendy Kwong, DDS 604-255-2729
Tana Wyman, DH II Vancouver/Richmond Health Region 604-872-2511

Type: - Health Region
- Started in the 1960's with the City of Vancouver and School Board funding, recognizing need to provide support for non-English speaking people and new immigrants who did not access routine dental services. DCHC is part of a multidisciplinary service, and there was a need to provide dental treatment for adults with cellulitis and abscesses, other than the hospital emergency.
- Became part of the Health Region in 1980's

Staffing: - 1 DDS in each clinic
- CDA's, DA's, OA's, Community Health DH uses clinic for pregnant moms

Hours: Monday – Friday 8:30 – 5:00

Funding: Subsidized by Health Region

Fees: - no fee for prevention for children
- basic treatment/sealants - $10.00/tooth to maximum $40.00/child
- adult fees based on ability to pay
- break even with cost of supplies

Eligibility Criteria: - any pre-K children
- K-2 for treatment, K-4 for prevention, ESL students in Canada < 1 year
- All students – emergency relief of pain
- Pregnant moms from Healthiest Babies Possible – no fees
- Residential address in Vancouver
- DCHC – not suitable for children, adults only, downtown east-side resident

Clients:
- # seen/month/year?
- 99% children K-Grade 2, no coverage or Refugee status
- not Healthy Kids, or other dental plans if will access dentist, but may require support of clinic for a few years
- DCHC sees about 12 adults/day plus walk in emergencies

Services Offered:
- Oral Hygiene room for family counselling
- recalls for some high needs

Comments:
- booked approximately 6 weeks in advance
- language is a big issue.

Clinic: **Sunrise Hotel Clinic**
Address: 360 Columbia St. (corner of Hastings & Columbia),
(604) 720-3050 / (604) 609-7362 Dental Clinic DDS
Portland Association 683-0073
Contact: Mark Townsend, Jim Green, Kirsten
Type:
- non-profit Portland Hotel Society
- Opened September 2001, little concrete data available yet

Staffing:
- 3 chairs
- 2 DDS'S sessional @ $600/day, each 3 days/week, & DDS students
- 2CDA' - salaried
- 1 DH planned for Jan 2001

Eligibility:
- on Income Assistance
- for residents of Downtown Eastside,

Hours:- 6 days/week (?)

Clients:
- 20 patients/day (capability)
- some children from local housing co-ops
- mostly adults
- refugee claimants seen, Non-english speaking

Fees: - Income Assistance level, no fees charged to client

Funding:
- public funding $225,000 from MSDES (NDP Government) for Downtown Eastside initiatives, estimate have funds to run for 3 years
- Health Canada – for capital funding, not operational
- WCB from back to work/educational funding to address cosmetic dentistry needs (employability project)
- Donations of equipment from dental companies to non-profit society
- UBC students/staff
- Annual cost to run estimated at $400,000, no current plans in place to earn this
- Building partnership of BC Housing, Regional Development and UBC

Comments: - ultra high tech clinic, completely paperless with monitor & keyboard at every station, panarex, video xrays
- flexibility re who attends, what services are provided, fitting in emergencies

Clinic: **BC Healthy Kids Dental Van**
Address/Phone: P.O. Box 9971, Stn Prov Govt, Victoria, BC V8W 9R5
Phone: 250-387-1979, Fax: 250-356-6682
Email: Mary.MorganPick@gems5.gov.bc.ca

Contact: Mary Morgan-Pick, Dental, Orthodontia and Optical Manager

Type: Extension of the Healthy Kids Dental Program. Has been travelling to northern BC communities **during the summer months** since 1998. These communities include Prince Rupert, Terrace, Kitimat, Hazelton, Smithers, Houston, Burns Lake, Vanderhoof, Prince George and Dawson Creek. The stay in each community varies from 1 day to several weeks, depending on past history of utilization in that community.

Appointments are booked by calling 1-888-219-2222.

Staffing: There is one dentist, Dr. Darryl Boag, and his wife, who is a CDA, both salaried.

Hours: Regular business hours, weekdays.

Funding: All funding comes from Ministry of Human Resources. Approximate operating cost per year is $100,000 which includes dental team salaries, operating costs for the van and dental supply costs. MHR owns the van.

Eligibility Criteria: Clients are children eligible for HK coverage, as well as DHSCL clients. Will see adults only if they are on income assistance (welfare) or in pain.

Clients and Fees: Treatment is free. Whatever treatment clients receive is not deducted from their annual dental coverage under HR.

Comments: It is unknown whether the van will operate next year, depending on cuts in government spending.

Set Up Cost: Set up as a pilot project in 1998 by Ministry of Human Resources.

Cost to Run: See above in "Funding". Approx. $100,000 per year.

Services Offered: Basic restorative, extractions, and preventive.

(This Page: MLBurleigh – Oct 01)

Current CHR Responses to Dental Needs
Submitted by
Dorthy Rosenberg, Community Dental Hygienist
Capital Health Region

Current CHR Responses to Dental Needs

- Dental programs are provided by the department of Child Youth and Family from 2 locations:
  1. Prevention Services - Dental Program - Saanich Health Unit
  2. Child and Family Rehabilitation Services – Dental Hygienist – Queen Alexandra Centre for Children's Health (QA)

- Programs are prevention based and do not provide dental treatment such as fillings because there are no dentists on staff. Dental hygienists and dental assistants provide screening for dental disease, dental health education, advocacy for dental treatment options, and support for people seeking dental services in the private sector. Most services are focused on children and their families. Some services are specific for children or adults with developmental disabilities.

Prevention Services - Dental Program

1. Dental Services – Saanich Health Unit

   - Conducts screening for dental disease in kindergartens and selected preschools as well as other students referred to them; provides referral and follow-up for children with decay including assistance finding funding for dental treatment; provides dental health education or resources to schools, preschools, New Moms' groups and professionals.

   Limitations to service:

   - No clinical services offered.
   - Services focus on children and staff can provide little or no support for adults and seniors who phone the program.
   - Because of staffing the school screening program is only able to visit half of the schools in the CHR each year so not all kindergarten children with decay are identified and supported. The program is looking at earlier intervention strategies.
   - Staff is able to link children with private dentists who can help them but it is very difficult to find dental services for adults on social service dental plans or with low incomes.
   - No prenatal classes are visited by dental staff although public health nurses who conduct "at risk" prenatal classes have access to dental information and resources.
   - Family income must be very low (an adjusted net income < $20,000/year) for children to be eligible for Healthy Kids Dental Plan so many families have difficulty paying for dental care. This plan is only available for children under 19 years old and there is no affordable dental coverage for low-income adults.

2. Dental Hygienist Services for Community Living – Saanich Health Unit

- Services for adults with developmental disabilities including oral screening, education and support for clients, caregivers and professionals, linkage with dental offices and other health professionals, assistance accessing dental care, personal oral care planning and desensitizing to receiving dental care.
- Limited in-home clinical oral hygiene services (i.e. scaling of teeth). Has some access to the dental clinic at Camosun College to provide desensitizing to the dental environment and clinical hygiene care.

Limitations to service:

- Only available to adults with developmental disabilities covered by Community Living Services in the Ministry of Children and Families. Does not include adults with other challenges such as mental health issues, head injuries, physical limitations, addictions etc.
- Difficulty finding accessible dental clinics for adults with mobility, financial and behavioral challenges. Many clients require specialized treatment options such as IV sedation, general anaesthetic, dental operatories with room for wheelchairs and dental professionals skilled and comfortable dealing with their needs.
- There is a discrepancy between what dentists charge and the amount that the dental plan for people on disability benefits pays. Clients are often charged the difference and do not have the discretionary funds to pay for it. Some dentists do not charge this difference for long term clients but are refusing to accept new clients.
- The program provides no treatment for dental decay and dental hygiene treatment is limited.

Dental Hygienist Services – QA

- Provided for children with developmental disabilities who access services at QA including oral assessments and referral to community dentists; education for parents and caregivers; desensitizing so children can ultimately visit the dentist in the community; and liaison with preschool and school program health professionals re dental issues.

Limitations to Services

- Available only 4 hours per week.
- No clinical services offered.
- Services only for children with disabilities.
- Dependent on referrals from health professionals many of whom are not aware of the services.

Bibliography

[1] Reitsma-Street Marge, Hopper Alan, Seright Jane (Eds). *Poverty and Inequality in the Capital Region of British Columbia: A Report of the Capital Urban Poverty Project*. University of Victoria Faculty of Human and Social Development. 2000.
[2] The Victoria Steering Committee on Homelessness. City of Victoria B.C. Community Action Plan on Homelessness. 2001
[3] Community Social Planning Council of Greater Victoria. *Quality of life in BC's Capital Region.* 1999
[4] Ibid
[5] BC Ministry of Social Development and Economic Security and BC Housing Management Commission. *Homelessness – Causes and effects: A profile, policy review and analysis of homelessness in BC*. 2001.
[6] The Victoria Steering Committee on Homelessness. City of Victoria B.C. Community Action Plan on Homelessness. 2001
[7] MacEntee Michael, Harrison Rosamund, Wyatt Chris. *Strategies to Enhance the Oral Health of British Columbians, specifically Aboriginal Peoples, Tobacco-Users and those of Low Socioeconomic Background.* UBC Faculty of Dentistry. 2001:25
[8] Times-Colonist (Victoria). *Poor urgently need better dental care, report says*. page C02, 14-March-2001
[9] Millar, Wayne J. & Locker, David. *Dental insurance and use of dental services*. Statistics Canada Health Reports. Vol. 11 (1) 1999
[10]MacEntee et al. 2001:19
[11] MacEntee et al. 2001:7
[12] Millar, Wayne J. & Locker, David. 1999
[13] Millar, Wayne J. & Locker, David. 1999
[14] Millar, Wayne J. & Locker, David. 1999
[15] MacEntee et al. 2001
[16] Association of Dental Surgeons of BC. Children's Dental Task Force. Unpublished data. 2000. Reported in MacEntee et al 2001.
[17] Wallace, Bruce. Brushed Aside: Poverty and Dental Care in Victoria. Vancouver Island Public Interest Research Group. 2000
[18] MacEntee et al. 2001:11
[19] Vancouver Island Public Interest Research Group. *Results from an Exploratory Survey of Dentists in Greater Victoria*. 1999
[20] Ibid.
[21] Times-Colonist (Victoria), *Periodontal Disease: Research points to gums as a root of health woes*. 19-October-2001
[22] Morrison H, Ellison L, Taylor G. *Periodontal disease and risk of fatal coronary heart and cerebrovascular diseases.* J Cardiovascular Risk (6: 7-11). 1999
[23] Shwart Luke E. *A Comparison of Reduced-fee Dental Resources for Low-income Adults in Calgary and Edmonton (Draft report*). Calgary Health Region, Community Oral Health Services. 2001
[24] Times-Colonist (Victoria), *Periodontal Disease: Research points to gums as a root of health woes*. 19-October-2001
[25] Ibid.
[26] Shwart Luke E. *A Comparison of Reduced-fee Dental Resources for Low-income Adults in Calgary and Edmonton (Draft report*). Calgary Health Region, Community Oral Health Services. 2001
[27] Ibid.
[28] Times-Colonist (Victoria), *Periodontal Disease: Research points to gums as a root of health woes*. 19-October-2001
[29] MacEntee, et al. 2001.
[30] Piters, Marilyn, Smith, Maureen, Westbrook, Verena. *The Interpretation of Dental Health Screening Data*. South Fraser Health Region (2001:2).
[31] Ibid. (page 5)

[32] National Post. *Saskatchewan children have Third World teeth: study*, 6-January-2001
[33] Based on the 2000 fee guide of the BC Association of Dental Surgeons
[34] Leake JL, Rosenbloom JM, Aslanyan G, Hyynh-Vo LN. *Investigating the student potential for providing dental services in community settings*. Presented at the CAPHD/ACSDP Annual Scientific Conference, April 2001:29
[35] Gelberg L, Linn LS, Rosenburg DJ. *Dental health of homeless adults*. Special Care in Dentistry. 8 (4): 167-172. 1998.
[36] Pizem P, Massicotte P, Vincent JR, & Barolet RY. *The state of oral and dental health of the homeless and vagrant population of Montreal.* Scientific J. 60(12):1061-1065. 1994.
[37] Ambrosio E, Baker D, Crowe C, Hardhill K. The street health report: A study of the health status and barriers to health care of homeless women and men in the City of Toronto. Toronto: Street Health.1992.
[38] MacEntee et al, 2001:17
[39] Lee J, Gaetz S, & Goettler F. *The oral health of Toronto's street youth*. Scientific J. 60(6):545-548. 1994.
[40] Ibid.
[41] In Leake JL, Rosenbloom JM, Aslanyan G, Hyynh-Vo LN. *Investigating the student potential for providing dental services in community settings.* Presented at the CAPHD/ACSDP Annual Scientific Conference, April 2001.
[42] MacEntee et al. 2001:4
[43] Times-Colonist (Victoria). *Poor urgently need better dental care, report says*. page C02, 14-March-2001
[44] Canadian Medical Association Journal. Vol. 157, #2, pg. 127. 1997
[45] Leake J, Porter J. *An economic analysis of dental care in Canada*. Journal of the Canadian Dental Association, 1993
[46] *"Study indicates cuts in Medicaid Dental Benefits can lead to increased emergency room use."* ADA News Releases, June 1996.
[47] National Post. *Saskatchewan children have Third World teeth: study*, 6-January-2001
[48] Locker David Dr. & Matear David Dr. *Oral disorders, systemic health, well-being and the quality of life: A summary of recent research evidence*. University of Toronto Faculty of Dentistry. 2001
[49] MacEntee, et al. 2001:16
[50] MacEntee, et al. 2001:17
[51] College of Dental Surgeons of B.C. *1996 Adult Dental Health Survey Vol. 1 &* 2. 1997.
[52] MacEntee, et al. 2001:29
[53] Bassett, Bill Dr. *Feasibility for a Reduced Fee Dental Clinic in Victoria*. page 7.
[54] James Bay Community Project. *Business Plan for a Community Dental Clinic*. 2000