Access to oral care is a human rights issue: a community action report from the Downtown Eastside of Vancouver, Canada

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Abstract
To offer a critical reflection on an impoverished neighborhood in Vancouver, Canada, and their access to oral health care. A review of how a lack of publicly funded oral health care affects the most vulnerable, uninsured, and underserved citizens is performed. Personal and professional accounts on how entrepreneurial innovations of not-for-profit organizations can help to close the gap in access to oral health care are offered using the Vancouver Area Network of drug users (VANDU) and the PHS Community Services Society as case studies in British Columbia. Despite the efforts put forward by not-for-profit organizations such as the VANDU and the PHS Community Services Society, a national oral health care plan is warranted though still not a political imperative. Underserved citizens have a right to oral health care that is compassionate, collaborative, accessible, and affordable.

Keywords: VANDU, Oral health, Underserved, Marginalized, Dentistry, People who use drugs, Subsidized, Downtown Eastside, Access to oral care, Stigma

Background
Every year, thousands of underserved citizens experience unnecessary suffering from oral conditions, mainly dental decay and periodontal diseases. Although largely preventable, these diseases are a threat to general health; they are a silent epidemic [1].

There are a number of chronic illnesses that are linked to poor oral health, including heart disease [2], stroke [3], type 2 diabetes [4], aspiration pneumonia [5], and possibly Alzheimer’s disease [6]. Moreover, there are reports on the direct link between timely oral health care and improved self-esteem [7], better dietary intake [8], and increased overall mental health and school performance [9].

Previous studies have also established links between oral health morbidity (dental caries, periodontal disease) and mortality (tooth loss) compounded by various factors including racism [10], lower income [11], rural residency [12], and lack of dental insurance [13]. While oral health disparities are prevalent across the globe [14], the financial impact of COVID-19 (SARS-CoV-2 novel coronavirus) has exacerbated the oral health inequities in advanced economies, as millions of citizens have lost employer-sponsored dental insurance [15].

For many ordinary citizen, accessing an oral health care provider for proper care has been inaccessible and expensive even before the pandemic [16]. Although certain provinces offer some form of government funded dental insurance [16, 17], public oral health care is not an integral part of the health care system in many nations as it is in other countries, such as Brazil and Sweden [18]. In Canada, for example, for those who can afford these costs, more than one-third of the 13 billion dollars spend annually in oral health care comes out of their

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pockets [26]; only about 6% of this expense comes from government-sponsored insurances—dental plans—at federal, provincial, or municipal levels [26]. It becomes clear that many underserved populations need a national oral health care plan based on principles of human rights and access to health care. Only recently has there been some interest in a publicly funded oral health care system in Canada, by government officials based on income [19]. Therefore, in this commentary that is driven by two prominent community organizations, we report on how a lack of publicly funded oral health care affects the most vulnerable, uninsured, and underserved citizens. While using the Downtown Eastside (DTES) of Vancouver in British Columbia as a context for this conversation, we also present the perspective of practitioners and how entrepreneurial innovations in the area of not-for-profit organizations have attempted to close the gap in access to oral health care. Ultimately, we argue that a national oral health care plan for underserved citizens is a human rights issue because oral health and dental disease are linked to many major health concerns with significant personal and societal implications.

**VANDU activisms on oral health**

Oral health has been an integral part of activism for the Vancouver Area Network of Drug User (VANDU) members who have fought for proper harm reduction supplies and safe spaces for people who use drugs [20]. For example, in early 2000, VANDU members distributed heat resistant pipes for people who smoke drugs (PWSDs) to prevent injury to their mouths, lips, tongue, and other oral structures [20]. At the same time, to prevent oral abscess and injury, VANDU members formed educational groups to teach PWSDs to use proper equipment (e.g., mouth pieces and brass screens) when smoking drugs to reduce blood borne infections (HIV, and Hepatitis C (HCV)) and prevent oral sores and blisters [20]. To reduce the risk of blood borne infections and overdose deaths among PWSDs, VANDU established the first unsanctioned smoking facility in the DTES of Vancouver [21]. The unsanctioned smoking facility has been studied by external researchers and has been shown to not only save tax payers dollars by preventing HCV cases among PWSDs [22], but to also decrease health-related harms within these underserved population [21].

However, access to oral care for VANDU members cannot be simply linked to harm reduction in the context of PWSDs, because access to care is acutely lacking within the criminalized and underserved drug-using population of the DTES. Many PWUDs in the DTES report high levels of dental caries and come to VANDU for information related to oral health support. Although there is no strong evidence to establish a direct link between opioid substitution treatment therapy, such as methadone usage, and increased dental caries [23], many VANDU members report poor dental care and high dental caries linked to higher sugar mixed with many opioid substitution therapies, lack of proper daily oral hygiene and nutritional diet. At the same time, many VANDU members have lost family members and loved ones to chronic illnesses linked to lack of access to oral health care, including, but not limited to, endocarditis and heart disease linked to oral abscesses; many members are highly traumatized.

In addition, many VANDU members have raised concerns about the stigma and discrimination they face when attempting to access much needed oral health care, and a lack of knowledge from oral care professionals when interacting with PWUDs. Additionally, there are also many incidents of refused oral health treatments for PWUDs. Many VANDU members have also felt pressured by dentists to have their tooth extracted as the only option, due to a lack of or limited dental coverage. As a result, many VANDU members have many missing teeth at an early age, which affects their confidence and self-esteem. Tooth loss also limits their ability to consume solid foods, which hinders their healthy food choices and overall well-being.

**The Portland Community Dental Clinic in the DTES community**

To begin to address some of the many issues described above among the underserved community members of the DTES, PHS Community Services Society established a not-for-profit dental clinic in the DTES in 2001. PHS was established in the early 1990s in order to provide housing, health care, and social services to people euphemistically referred to as “hard to house” [24]. PHS was an important originator of what is now referred to as Housing First, an approach to housing and services based on the philosophy of providing services in a relevant, low-barrier, and accessible way, where the underserved populations’ basic human rights, dignity, and respect are met in their community.

Since its inception, the community dental clinic has served 1448 patients annually. The clinic currently provides support to many residents of the DTES by providing oral health care to 8–12 patients per day on average. Two full-time staff dentists provide comprehensive oral health care to individuals on income assistance, job training, and other pre-employment programs. The clinic is currently welcoming many clients regardless of their socioeconomic background, lifestyle histories, or medical conditions based on the principles of dignity and trauma-informed care.

The clinic’s focus has been to provide oral health care that is comprehensive, which also includes restorative
and preventative dentistry. Annually, the clinic also provides extractions, fillings, root canals, dentures, and even crowns. What is more unique is the commitment to provide oral care in a very person-centered and thoughtful approach to a population that is often very unfamiliar with dentistry and oral health yet is at high risk of oral health complications.

The clinic has also been an affiliated teaching site for University of British Columbia (UBC)’s dentistry program, where senior 4th year students perform clinical work under the supervision of instructors. Also, the clinic provides delivery of care by UBC’s General Practitioner Residents also affiliate with the Faculty of Dentistry.

**Summative points**

As discussed above, oral health is linked to general health and well-being—the mouth belongs to the body. Also discussed was the fact that many Canadians, including those living in the DTES, face various barriers when attempting to obtain oral health care. One of these barriers is a lack of insurance or disposable income [25]. Not surprisingly, many patients are avoiding dentist due to affordability issues and are potentially at the greater risk of many preventable diseases. For example, 1 in every 5 Canadians avoid visiting a dentist because they cannot afford the costs [17]. The PHS clinic in the DTES has demonstrated how not-for-profit dentistry is increasingly filling the gap in oral health care for underserved citizens. Not-for-profit oral care has also shown to benefit the health care system as it provides educational opportunities to those involved via partnership, such as the UBC dentistry program, for many future dentist unfamiliar with social justice and health inequity issues.

The Canadian Association of Emergency Physicians supports the expansion of publicly funded and delivered oral health care, since patients covered by Medicare make emergency room visits for their dental-related problems, adding further strain on Emergency Departments [27, 28]. Similarly, one of the main Canadian political parties has recently advocated for a federally funded dental coverage to uninsured individuals with a household income of less than $70,000 a year [29]. This advocacy prompted the Office of the Parliamentary Budget Officer to generate a report estimating the cost of establishing a Federal dental care program for uninsured Canadians with a household income of less than $90,000 [30].

It seems that the idea of a national oral health care plan has gained momentum in some countries. Aside from the logistics of implementing such a plan, the (in)ability to pay for oral health care does not tell the whole story. The reasons behind these experiences can be due to the low payment most government-sponsored dental plans offer to providers, who then try to offset the substantial overhead many endure. But worse, it can be due to stigma and the discrimination members of underserved communities face when visiting a dental provider’s office [32–34, 37, 38] as experienced by the DTES residents and VANDU members; they also experience many other health inequities.

Therefore, a national oral health care plan is a human rights issue because healthy mouths are linked to a healthy body and poor access to dental services is having a significant impact on many underserved citizens [39]. Similar to other previous government and non-profit reports, we urgently call on governments and health agencies to ensure that oral health care and dental treatment is affordable and available to all people experiencing health disparities, homelessness, or poverty [39]. Similarly, we urge the dental schools around the world to focus on the training and education of future oral health care providers on the social determinants of health, social responsibility, trauma and violence informed care, cultural safety and humility, and person-centered care, so that stigma and discrimination is eliminated in dental medicine and oral care [40, 41]. Underserved citizens have a right to oral health care that is compassionate, accessible, collaborative, and affordable.

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