Urban population

81%

GDP

1,559,623,393

current USD,
World Bank 2015

Total population

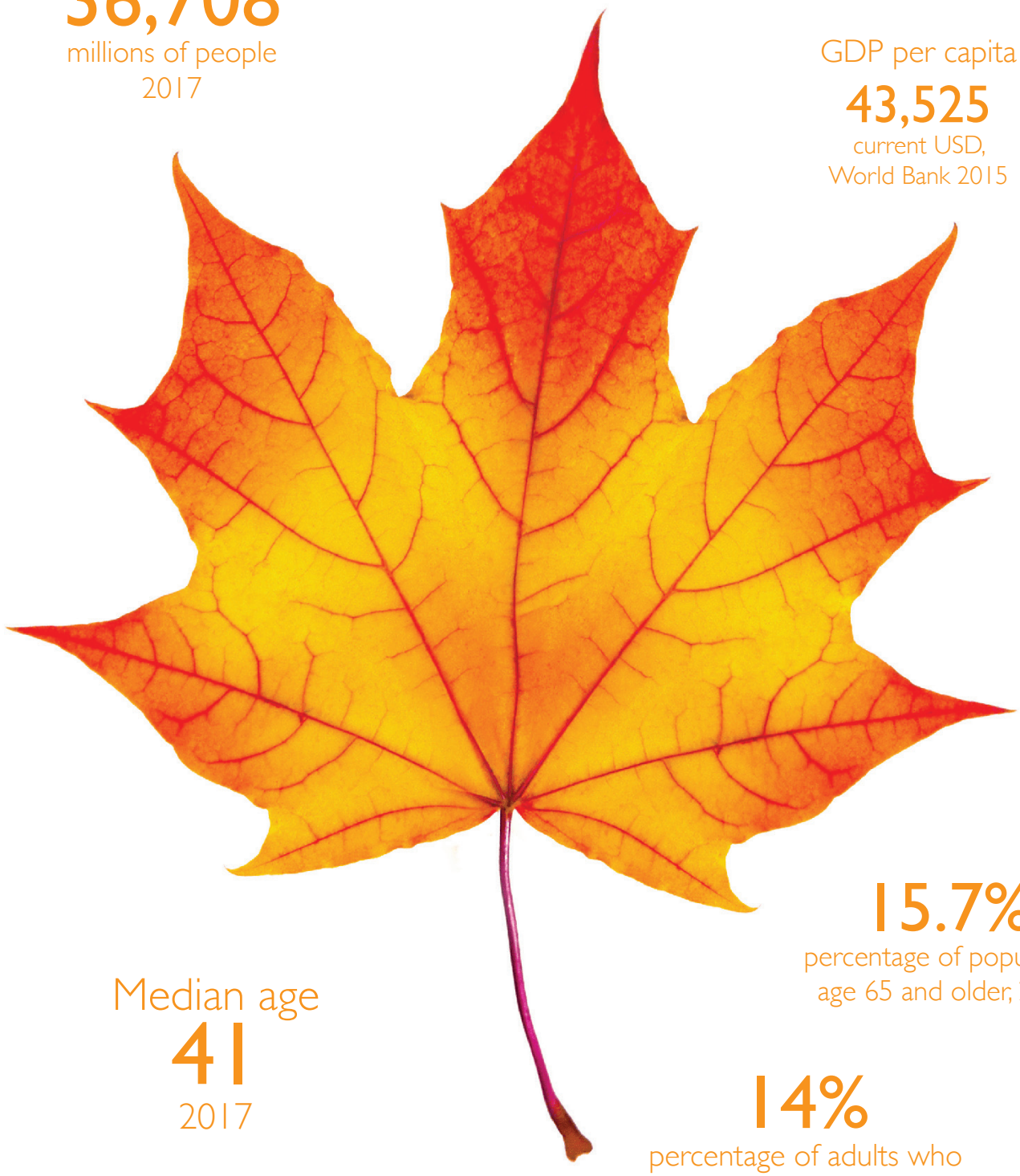
36,708

millions of people
2017

GDP per capita

43,525

current USD,
World Bank 2015



15.7%

percentage of population age 65 and older, 2014

Median age

41

2017

14%

percentage of adults who report being daily smokers, 2014

source: Infodent International | 4 2018

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Focus

The Privilege of Equal Access Within Canadian Healthcare

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Given Canada's internationally lauded history of high-quality healthcare system grounded in values of equity in access and solidarity, it is surprising that its national system of health insurance does not include services such as drugs, vision and dental care. Nonetheless, despite its separate position, statistics demonstrate that Canada has among the best access to dental care in the world with very good levels of oral health.

DO YOU KNOW THAT

The provinces and territories of Canada are sub-national governments within the geographical areas of Canada under the authority of the Canadian Constitution. Together, the 10 provinces and 3 territories make up the world's second-largest country by area. Provinces receive their power and authority from the *Constitution Act, 1867*, whereas territorial governments have powers delegated to them by the Parliament of Canada.

In modern Canadian constitutional theory, the provinces are considered to be sovereign within certain areas based on the divisions of responsibility between the provincial and federal government within the Constitution Act 1867, and each province thus has its own representative of the Canadian "Crown", the lieutenant governor. Unlike the provinces, the territories of Canada have no inherent sovereignty and have only those powers delegated to them by the federal government and as a result, have a commissioner instead of a lieutenant governor.

COMPARATIVE HEALTH INDICATORS, 2016

	CANADA	U.S.A.
Prevalence of obesity (BMI>30)	26 % (2014)	38 % (2014)
Life expectancy at birth (years)	82.8	78.5
Healthy life expectancy at birth (years)	73.2	68.5
Chronic bronchitis	6.3	4.0
Probability of dying from any of cardiovascular disease, cancer, diabetes or chronic respiratory disease between age 30 and exact age 70 (%)	9.8%	14.6%

Sources: https://international.commonwealthfund.org/countries/canada/ and WHO 2018

Healthcare in Canada is delivered through thirteen provincial and territorial systems of predominantly publicly funded healthcare, informally called Medicare, guided by the provisions of the Canada Health Act of 1984 which sets standards for "medically necessary" hospital, diagnostic and physician services. **The system is highly decentralized with provinces (10) and territories (3) having primary jurisdiction in terms of governance, organization and service delivery with medically necessary hospital, diagnostic and physician services free at the point of service for all residents.** The federal government, from its side, co-finances provincial and territorial programs which must adhere to the Canada Health Act, which states that to be eligible to receive full federal cash contributions for healthcare, each provincial and territorial healthcare insurance plan needs to be: publicly administered, comprehensive in coverage, universal, portable across provinces and accessible (for example, without user fees). Furthermore, the federal ministry of health, Health Canada, plays a role in promoting overall health; food and drug safety; medical device and technology review and funding and delivery of certain health services to certain groups of people (aboriginal groups, members of the Canadian Forces, veterans, inmates in federal penitentiaries and eligible refugee claimants).

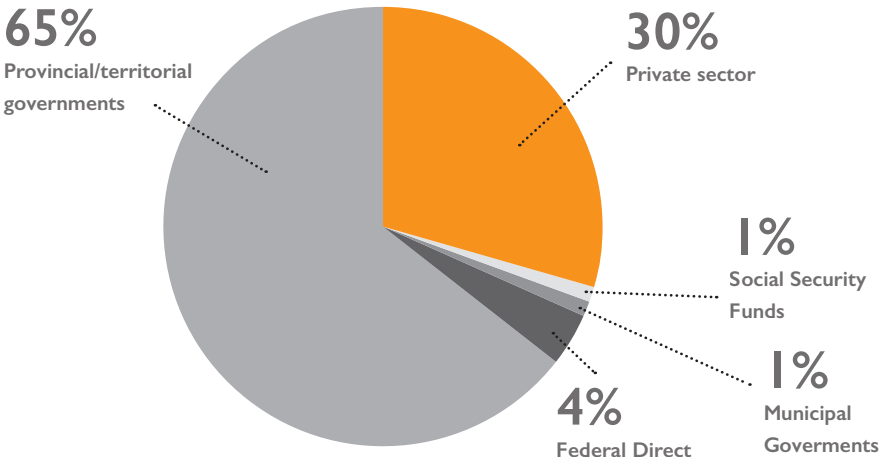
There is no nationally defined statutory benefit package; most public coverage decisions are made by provincial and territorial governments in conjunction with the medical profession and each province and territory has some reasons to determine what is considered essential and where, how and who should provide the services, resulting in a wide variance in what is covered across the country by the public health system, particularly in more controversial areas, such as midwifery or autism treatments. An expansion of the publicly funded basket of services and coordinated effort to reduce variation in outcomes between provinces and territories would hinge on more engaged roles for the federal government and the physician community than have existed.

Most publicly funded healthcare services are delivered privately through private for-profit, private non-profit as well as public organizations and by physicians who receive remuneration from provincial ministries of health. **Despite the reforms made over the past four decades in response to changes within medicine and throughout society the basics within Canada's healthcare system remain the same: universal coverage for medically necessary healthcare services are provided based on need, rather than ability to pay.** Nonetheless, in the setting of geographical and population diversity, long waits for elective care demand the capacity and commitment to scale up effective and sustainable models of care delivery across the country; furthermore, profound health inequities experienced by Indigenous populations and some vulnerable groups also require coordinated action and a need to be more effectively addressed.

The provinces and territories administer their own universal health insurance programs, covering all provincial and territorial residents in accordance with their own residency requirements.

More than 70% of healthcare in Canada is financed through general tax revenues. In 2016, total and publicly funded health expenditures were forecast to account for an estimated 11.1% and 8.0% of GDP, respectively; by that measure, 69.8% of total health spending came from public sources. The provinces and territories are most directly responsible for raising most of the financing, but the federal government contributes with an annual cash transfer on a per capita basis through the Canada Health Transfer. The provinces and territories administer their own universal health insurance programs, covering all provincial and territorial residents in accordance with their own residency requirements.

TOTAL HEALTH EXPENDITURES BY SOURCE OF FINANCE, 2010 FORECAST



Note: *Although the graph notes that provincial/territorial governments pay for 65% of health expenditures in Canada, the federal government supports provincial/territorial expenditures through fiscal transfers.*
Source: *Canadian Institute for Health Information. National Health Expenditure Trends, 1975 - 2010. https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html*

Hospitals account for the largest share of healthcare spending. Spending on drugs has accounted for the second-largest share since 1997, making up 16% of spending in 2010. The third-largest share of healthcare expenditures is accounted for by spending on physicians, which made up 14% of spending in 2010.

Almost all essential basic care is publicly covered, including primary care physicians, specialists and hospital services. The coverage includes prevention and treatment of common diseases and injuries; basic emergency services; referrals to and coordination with other levels of care, such as hospital and specialist care; primary mental healthcare; palliative and end-of-life care; health promotion; healthy child development; primary maternity care and rehabilitation services.

Universal health coverage: Financial protection Proportion of population with total household expenditures on health > 10% and > 25% of total household expenditure or income, latest available data, 2007–2015

	> 10%	> 25%
CANADA	2.6%	0.5%
U.S.A.	4.8%	0.8%

Proportion of total government spending on essential services (education, health and social protection) as a % of general government expenditure, 2015

CANADA	19.1%
U.S.A.	22.6%

Source: *World Health Statistics (WHO), 2018*

HEALTHCARE EXPENDITURE AND SOURCES OF FINANCING

Total healthcare expenditures (THCE), 2015 est.	**US$ 219.2 Billion**
Private-sector healthcare expenditures, 2015 est.	**US$ 64.2 Billion**
Total health expenditure per capita (2015)	**US$ 4,508**
Total per capita spending on drugs, 2015, est.	**US$ 959**
Total per capita spending on physician services, 2015, est.	**US$ 946**
Total per capita spending on oral healthcare, 2015, est.	**US$ 378.60**
Total out-of-pocket healthcare spending per capita, 2014 est.	**USD 644**
Total public healthcare expenditure, 2016 est.	**69.8%**
Private health insurance as % of THCE, 2014, est.	**12%**
Out-of-pocket payments as % of THCE, 2014, est.	**14%**

Source: *The Commonwealth Fund / WHO, 2018 / Canadian Dental Association*

IN BRIEF

GOVERNMENT ROLE - Regionally administered universal public insurance program that plans and funds (mainly private) provision

PUBLIC SYSTEM FINANCING - Provincial/federal general tax revenue

PRIVATE INSURANCE ROLE - 67% buy complementary coverage for noncovered benefits (e.g. private rooms in hospitals, pharmaceuticals, dental care, optometry)

Health services not covered by Medicare are largely privately financed and they vary depending on the province and territory but dental or vision care, cosmetic surgery and some forms of elective surgery are not considered essential. Pharmaceutical benefits are only available to the elderly, disabled or low-income earners, although all prescription drugs provided in hospitals are covered publicly, with outpatient coverage varying by province or territory. User fees for ambulance services vary considerably across provinces, private rooms in hospitals are also usually not covered. Individuals and families who do not qualify for publicly funded coverage may pay these costs directly, be covered under an employment-based group insurance plan or buy private insurance (although provinces and regions provide partial coverage for children, those living in poverty and seniors). Private insurance in Canada is therefore complementary and both the federal and provincial governments are involved in regulating the private health insurance market, but Canadian regulation of the design of insurance products, their pricing and their sale, are relatively weak by international standards. Private health expenditure accounts for around 30% of healthcare financing with out-of-pocket payments making up more than 50% of expenditures. At the same time, private health insurance is responsible for roughly 12-13% of total health expenditures. In 2014, out-of-pocket payments represented about 14% of total health spending, going mainly toward prescription drugs (21%), nonhospital institutions, mainly long-term care homes (22%), dental care (16%), vision care (9%), and over-the-counter medications (10%).

PROVIDER OWNERSHIP

PRIMARY CARE - Private sector

HOSPITALS - Public/private mix (proportions vary by region), mostly not-for-profit

PROVIDER PAYMENT

PRIMARY CARE PAYMENT - Mostly fee-for-service (45% to 85%, depending on province), but some alternatives (e.g., capitation) for group practices

HOSPITAL PAYMENT - Mostly global budgets, case-based payment in some provinces (does not include physician costs)

DELIVERY SYSTEM FOR PRIMARY CARE

REGISTRATION WITH GP REQUIRED - Not generally, but yes for some capitation models

GATEKEEPING - Yes, mainly through financial incentives varying across provinces (e.g., in most provinces, specialists receive lower fees for patients not referred)

BENEFIT DESIGN

CAPS ON COST-SHARING - No

EXEMPTIONS & LOW-INCOME PROTECTION - There is no cost-sharing for publicly covered services; protection for low-income people from cost of prescription drugs varies by region

Source: *https://international.commonwealthfund.org/countries/canada/*

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Canada's universal healthcare system is known as a single payer system, where basic services are provided by private doctors (they have been allowed to incorporate since 2002), with the entire fee paid for by the government. They are generally paid through fee-for-service schedules that itemize each service and pay a fee to the doctor for each service rendered. These are negotiated between each provincial and territorial ministry of health (for primary and specialist care) and the provincial and territorial medical associations in their respective jurisdictions. In some provinces, such as British Columbia and Ontario, payment incentives have been linked to performance. Physicians are not allowed to charge patients prices above the negotiated fee schedule. Those in other practice settings such as clinics, community health centers and group practices are more likely to be paid through an alternative payment scheme, such as salaries or a blended payment (e.g., fee-for-service payments plus incentives for providing certain services such as the enhanced management of chronic diseases etc.). Nurses and other health professionals are generally paid salaries that are negotiated between their unions and their employers.

Primary care - The traditional model of primary care in Canada has been based on individual, self-employed family physicians (often known as general practitioners or GPs), providing primary medical services in private practices remunerated on a fee-for-service basis, although there has been a movement toward alternative forms of payment such as capitation. In 2014–2015, fee-for-service payments made up 45% of payments to GPs in Ontario, compared with 68% in Quebec and 84% in British Columbia. **In the last decade, provincial and regional ministries of health have renewed efforts to reform primary care focusing on moving from the traditional physician-only practice to group practice, interprofessional primary care teams that provide a broader range of primary healthcare services on a 24-hour, 7-day-a week basis.** The networks of GPs working together and sharing resources varies across provinces in the composition and size of teams. In 2014, 46% of GPs reported to work in a group practice, 19% in an interprofessional practice and 15% in a solo practice. Patients are free to choose and change their family physicians, they can access specialists directly, but it is common for family physicians to act as gatekeepers and refer patients to specialty care. Many provinces pay lower fees to specialists for non-referred consultations.

Preventive care and early detection are considered critical in Canada and yearly checkups are recommended by public campaigns. Several are the programs, for seniors, those with disabilities, awareness campaigns for back injuries and many others, funded by the government to create public health awareness and to reduce healthcare costs.

In 2016, there were 230 practicing physicians per 100,000 population, about half of whom were general practitioners and the rest specialists, totaling 84,063 doctors, 92% of which working in urban areas. Total gross clinical payments to physicians in 2015–2016 increased 3.4% over the previous year to $25.7 billion. Fee-for-service payments accounted for 72% of gross clinical payments and alternative payments accounted for 28%. **Recent reports indicate that Canada may be heading toward an excess of doctors, though communities in rural, remote and northern regions, and some specialties, may still experience a shortage.** The gross average salary in 2016 was $339,000 per physician. Out of the gross amount, doctors pay for taxes, rent, staff salaries and equipment.

	CANADA	U.S.A.
Average Annual number of physician visits per capita, 2014	7.6	4.0
Density of nursing and midwifery personnel (per 1000 population), 2016	9.8	/

Source: *World Health Statistics (WHO), 2018 / https://international.commonwealthfund.org/countries/canada/*

Number of Family Medicine and Specialist Physicians, by Jurisdiction, Canada 2016

JURISDICTION	FAMILY MEDICINE	SPECIALISTS	TOTAL PHYSICIANS
Newfoundland and Labrador	682	633	1,315
Prince Edward Island	152	127	279
Nova Scotia	1,215	1,242	2,457
New Brunswick	960	775	1,735
Quebec	9,823	10,447	20,270
Ontario	15,417	15,600	31,017
Manitoba	1,423	1,325	2,748
Saskatchewan	1,241	1,041	2,282
Alberta	5,320	4,974	10,294
British Columbia	6,189	5,358	11,547
Yukon Territory	68	10	78
Northwest Territories	25	8	33
Nunavut	7	1	8
Canada	**42,522**	**41,541**	**84,063**

Notes:
-includes active physicians in clinical and non-clinical practice (e.g., research and academia) who have an MD degree and a valid mailing address.
-excludes residents, physicians in the military, and semi-retired physicians
-excludes non-registered physicians who requested that their information not be published as of December 31
Source: *Scott's Medical Database, 2016, Canadian Institute for Health Information https://www.cihi.ca/en/physicians-in-canada*

Average payment to family medicine physicians (2016)	$275,000
Average payment to medical specialists (2016)	$347,000
Average payment to surgical specialists (2016)	$461,000

Source: *Scott's Medical Database, 2016, Canadian Institute for Health Information https://www.cihi.ca/en/physicians-in-canada*

Outpatient specialist care - **Most outpatient specialist care is provided in hospitals, but there is a trend toward providing services in private non-hospital facilities, although this has not yet become the dominant mode of delivery.** In 2014, 65% of specialists reported to work in a hospital, compared with 24% in a private office or clinic. Specialists are mostly self-employed and paid fee-for-service, with a variation across provinces and territories. Those working in the public system are not permitted to receive payment from private patients for publicly insured services. There are few formal multispecialty clinics.

Canada's provincially and territorially based Medicare systems are cost-effective because of administrative simplicity. In each province and territory, physicians and specialists bill provincial/territorial governments directly, although some doctors are paid a salary by a hospital or facility. **There are no direct payments from patients to physicians so there is no need for patients who access healthcare to be involved in billing and reclaim.** There are no deductibles on basic healthcare and no cost-sharing for publicly covered services (insured physician, diagnostic, and hospital service). User fees are extremely low or non-existent. In general, user fees are not permitted by the Canada Health Act, but physicians may charge a small fee to the patient for reasons such as missed appointments, doctor's notes and for prescription refills done over the phone. Some physicians charge "annual fees" as part of a comprehensive package of services they offer their patients and their families. Such charges are completely optional and can only be for non-essential health options.

Hospitals - **Hospital care is delivered by publicly funded hospitals, most of which are independent institutions incorporated under provincial Corporations Acts and are required by law to operate within their annual global budgets, negotiated with the provincial or territorial ministry of health or regional health authority.** However, several provinces, including Ontario, Alberta and British Columbia, have considered introducing activity-based funding for hospitals. Hospital-based physicians generally are not hospital employees and are paid fee-for-service directly. Hospitals are a mix of public and private, predominantly not-for-profit, organizations, often managed locally by regional authorities or hospital boards representing the community. In provinces with regional health authorities, many hospitals are publicly owned, whereas in other provinces, such as Ontario, they are predominantly private nonprofit corporations. There are no data on the number of private for-profit clinics (which are mostly diagnostic and surgical). Canada (except for the province of Quebec) is one of the few countries with a universal healthcare system that does not include coverage of prescription drugs. Every provincial government has a prescription drug plan that covers outpatient prescription drugs only for designated populations (elderly or indigent), with the federal government providing drug coverage for eligible aboriginal groups. **More than 60% of prescription medications are paid for privately in Canada, through employment-based private insurance or paid for out-of-pocket.** Pharmaceutical costs are set at a global median by government price controls.

Ultimately, there is a clear trend in Canada for the consolidation of tertiary care in fewer and more specialized hospitals, as well as the spinning off of some types of elective surgery and advanced diagnostics to specialized clinics.

Regardless of this activity, overall, among the OECD countries, Canada ranks very low in the public financing of dental care.

Oral Healthcare system - Given Canada's internationally lauded history of privileging equal access to healthcare, health policy analysts are often surprised that Canada's national system of health insurance (Medicare) does not include dental care. **Only a small proportion of the population (around 5.5%) is covered by public dental insurance, almost all targeted to socially marginalized groups and delivered in the private sector through public forms of third-party financing.** For publicly financed dental care, this breaks down in specific ways: the federal government finances dental care for specific groups, such as state-recognized Aboriginal groups and the country's Armed Forces, both due to historical custom and fiduciary responsibilities; the provinces finance dental care for such groups as low-income children, social welfare recipients, the disabled and those with craniofacial disorders; and through cost-sharing agreements with the provinces, municipalities finance care for low-income children and social welfare recipients, and independently for groups such as low-income seniors. Regardless of this activity, overall, among the OECD countries, Canada ranks very low in the public financing of dental care. **Dental care is almost wholly privately financed, with private dental insurance covering around 62.6% of the population, mostly by way of employment-based benefit plans.** By the end of 2011, 87,500 group insured contracts provided 13.1 million workers and dependents with dental care benefits, while 31.9% of Canadians self-reported having neither public nor private dental insurance. Dental insurance plans coverage helps to pay for preventive and main-tenance services and root canals, periodontal cleaning and scaling. It may also extend to major restorative procedures, such as crowns, bridges, dentures, braces

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2016 Commonwealth Fund International Health Policy Survey, Comparative Figures

Access to care:

-able to get same-day/next-day appointment when sick: Canada: 43% / U.S.A. 51%
-very/somewhat easy to get care after hours: Canada 63% / U.S.A. 51%
-Waited two months or more for specialist appointment: Canada 30% / U.S.A. 6%
-Waited four months or more for elective surgery: Canada 18% / U.S.A. 4%
-Experiences access barrier because of cost* in past year: Canada: 16% / U.S.A. 33%
(*Access barrier because of cost defined as at least one of the following: Did not fill/skipped prescription, did not visit doctor with medical problem, and/or did not get recommended care)

Overall views of healthcare system:

Which of the following statements comes closest to expressing your overall view of the health care system in your country?'
A. "the system works pretty well and only minor changes are necessary to make it work better": Canada: 35% / U.S.A. 19%
B. "there are some good things in our health care system, but fundamental changes are needed to make it work better": Canada: 55% / U.S.A. 53%
C. "Our health care system has so much wrong with it that we need to completely rebuild it": Canada: 9% / U.S.A. 23%

Source: *https://international.commonwealthfund.org/countries/canada/*

and orthodontic services. Many plans typically reimburse most of the charges for primary dental care, plus 50% for major procedures to a maximum amount in any year and orthodontic services to a lifetime maximum. The benefits may also be subject to a deductible amount for which the insured is responsible. Research shows that access to dental care may be getting more difficult for the middle-income segment of the Canadian population as well. Middle-income workers have experienced significant changes in their work environments, which includes decreases to both the amount and availability of employment-based dental insurance. In addition, the provision of public dental benefits does not always ensure access to dental care for those who are covered, since there are often complicated insurance-related barriers to accessing dental treatment. **Nonetheless, when considering access to oral healthcare for entire populations, statistics show that Canada has among the best access to oral healthcare in the world.** The figures below reveal that all countries face similar challenges regarding access to oral health for the poorest segments of society, regardless of whether oral healthcare is publicly or privately delivered.

Percentage of Population Visiting Dentist in Past Year

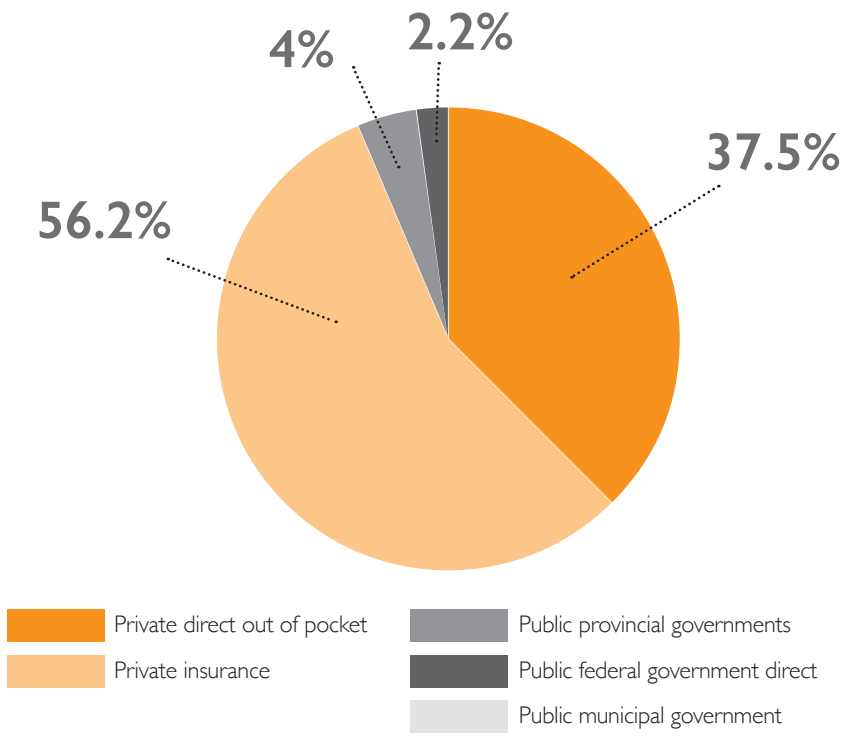
	POOREST	AVERAGE	RICHEST
France*	63.9	74.9	82.3
Czech Republic	50.3	71.0	77.8
United Kingdom	58.1	68.8	74.5
Slovak Republic	47.6	68.8	76.3
Canada	**46.5**	**64.6**	**78.5**
Austria	51.6	61.0	70.2
Finland	51.3	58.6	68.5
Belgium	39.8	58.1	69.5
Slovenia	42.6	56.1	64.4
New Zealand	43.8	51.2	59.8
Estonia	31.0	48.0	55.8
Spain	34.5	44.9	57.8
United States	26.2	42.4	56.9
Poland	26.8	42.3	54.6
Hungary	28.1	37.5	50.5
Denmark**	28.1	35.3	40.0

visits in past 2 years/visits in past 3 months.*
Source: *Health at a Glance 2011, OECD Indicators, 2011 (taken from Canadian Dental Ass. website https://www.cda-adc.ca/stateoforalhealth/canada/)*

Consequently, the major portion of payments for oral healthcare comes from private sources, either out-of-pocket (approx. 40%) or through private dental insurance (approx. 60%). According to the Canadian Dental Association, it is estimated that total expenditures on dental services in Canada in 2015 amounted to $13.6 billion, with the private sector making up the largest component of spending, estimated at $12.7 billion (93.8% of total spending), while public-sector expenditures were estimated at $846 million (6.2% of total spending).
On a per capita basis, the latest data available showed that total per capita expenditure on oral healthcare was estimated at $378.60 in 2015 (compared to $959 on drugs and $946 on physician services). Private per capita spending on dental services was estimated at $355 and public per capita spending at $23.60.

Independent practitioners operating their own practices deliver nearly all oral healthcare. A dental healthcare team of professionals supports dentists in their work, including dental hygienists, dental assistants and dental technologists. In select jurisdictions, dental therapists and denturists have legislated practice and offer services independent of dentists, such as basic dental treatment and preventive services as well as patient assistance and referrals. Dental hygiene is the 6th largest registered health profession in Canada with 29,246 registered dental hygienists (in 2016) working in a variety of settings, with people of all ages, addressing issues related to oral health. **There are around 21,109 dentists in Canada with a dentist/population ratio of 1/1,622,** meaning that for every dentist in Canada there are 1,622 people. A minority of these professionals practice in public health settings, with information collected from provincial, municipal and federal health jurisdictions showing that 47 public health specialists, 66 clinical dentists, 152 therapists and 453 dental hygienists were part of the public health workforce in 2007/2008. The distribution of dentists varies widely by province. **Currently, there is widespread debate regarding the "over- saturation" of dentists in Canada with a generally declining ratio over-time, signifying that there are increasing numbers of dentists relative to the population, suggesting greater overall availability of oral healthcare. Reports suggest that there is a growing per-capita pool of dentists in specific jurisdictions, primarily large urban centers like Toronto, Montreal and Vancouver, an "over-concentration" of dentists in urban areas with rural and remote areas having proportionally fewer dentists, making access to oral care in these regions more challenging.**
Recently, there has been a shift towards the corporatization of dentistry in Canada. In the US, corporate interests own 30–40% of all dental offices. In Canada this figure is 2% but steadily rising. It has been predicted that corporate practices will potentially find it increasingly easier to buy existing dental practices and to recruit the workforce needed to operate them. As a result, the future of solo practices in the current environment is set to decline.
To practice as a dentist, an individual must obtain a license from one of the dental authorities in Canada. Each province/territory has a dental regulatory authority/licensing body that establishes regulations and requirements for the licensure of general practitioners within its jurisdiction, although the Royal College of Dentists of Canada plays the role of setting standards for postgraduate specialty practice. The requirements to obtain a license are similar across the country but can vary slightly from one jurisdiction to another. To obtain a license, the applicant must hold a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DDM) degree from an accredited program, pass the National Dental Examining Board of Canada Written Examination and Objective Structured Clinical Examination as well as be registered with the pertinent regulatory body. In addition to a dental regulatory college, each jurisdiction also has a dental association. Membership in the provincial/territorial and national dental associations is a necessary component of licensure in all provinces except Ontario and Quebec. Also, in the territories, membership in the Yukon Dental Association and the Northwest Territories & Nunavut Dental Association is not mandatory for registration and licensing.
In 2010, Health Canada published a report on the dental health of Canadians, based on the Canadian Health Measures Survey (CHMS) conducted by Statistics Canada.

Dental Service Expenditures in Canada, 2015



In this chart, for illustrative purposes private insurance refers to all sources of private insurance including employment and non-employment related dental coverage
Source: *Health Expenditure Trends, CIHI, 2015 (taken from Canadian Dental Ass. website www.cda-adc.ca/stateoforalhealth/servicescanada/)*

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DO YOU KNOW THAT

Canada is a Constitutional Monarchy - Queen Elizabeth II is still the Head of State of Canada, a former British colony. Below a list of roles still served by "Elizabeth the Second, by the Grace of God, of the United Kingdom, Canada and Her other Realms and Territories, Queen, Head of the Commonwealth, Defender of the Faith" (her official full Canadian title).

- **She's the Head of State.** Technically speaking, Queen Elizabeth is the Sovereign of the parliamentary democracy and constitutional monarchy of Canada.
- **Government Officials and New Citizens Swear an Oath to Her.**
- **The Governor General is Appointed by Her.**
- **She Stays Neutral.** Because she is considered to be the personification of the state of Canada, she is meant to remain neutral on all matters of politics.
- **She Supports Many National Organizations.** The Queen is a patron of a number of Canadian organizations, including the Canadian Cancer Society, the Canadian Red Cross Society and the Royal Canadian Humane Association.
- **The Entire Royal Family Upholds Canadian Traditions and Ceremonies.** Most important anniversaries or celebrations are attended by the monarch herself, while other members of the royal family may attend lesser events in her place.
- **She Plays a (symbolic) Role in Canada's Armed Forces.** The Queen acts as Colonel-in-Chief of numerous Armed Forces regiments, such as the King's Own Calgary Regiment and The Canadian Grenadier Guards.
- **She Stays Informed on Political Matters.** The prime minister and the ministers in his cabinet are all appointed by the governor general on behalf of Queen Elizabeth.
- **Her Signature is Necessary for Certain Government Approvals.** The Queen must apply her royal sign-manual, or signature, as well as the Great Seal of Canada to patent letters, specific appointment papers of the governor general, the creation of additional Senate seats and any change in her Canadian style and title.
- **She can Grant Immunity from Prosecution.**

Dentists and Other Oral Healthcare Providers, Latest Data Available

Dentists (2013)	**21,109**
Population/dentist ratio (2016)	**1,622/1**
Dental hygienists (2016)	**29,246**
Dental assistants	**26,000 - 29,000**
Dental technicians	**NA**
Dental therapists	**300**
Denturists	**2,200**

*** NA= not available**

Source: *Canadian Dental Ass. https://www.cda-adc.ca/stateoforalhealth/ http://ncohr-rcrsb.ca/knowledge-sharing/working-paper-series/content/garbinneumann.pdf*

The results showed that 75% of Canadians visit a dental clinic annually and 86% do so at least once every 2 years. Overall, the survey indicates that Canadians have very good levels of oral health with significant decreases in levels of dental decay over the past 40 years. While Canada's oral healthcare measures are generally above average compared with countries around the world, there are inequities in oral care. Particularly, Canadian families and individuals with lower incomes and of lower socio-economic status, those without dental insurance, older Canadians and Indigenous Canadians experience worse overall oral health outcomes than the general population.

According to the report, the mean DMFT at age 12 was 1.02 and 38.7% of 12-year-old children had 1 or more permanent teeth affected by caries. Overall, dentate adults have an average of 0.58 teeth with untreated decay, 2.14 teeth extracted, and 7.95 teeth filled.

The level of edentulism (no teeth) among Canadians has fallen from 23.6% in 1970–72 to 6.4% in 2007-09. Approximately 2 out of 3 Canadians have no clinical needs as identified by dentist-examiners in the CHMS. **The CHMS also showed that the rate of annual visiting to obtain oral healthcare is greatly influenced by income and insurance; 83.8% of people from the most affluent and 82.3% of privately insured families visited a dentist compared to 60.0% of people from the lower income category and 59.3% of non-insured families.** At the same time, avoiding visit a dentist because of costs is an issue for more than 17% of Canadians, and this percentage can be higher among young adults with no insurance (49.9%) and lower incomes (46.7%), as well as among adults aged 40–59 years with no insurance (42.3%).

Among main sources:
- Extracts from "The Canadian Health Care System", The Commonwealth Fund
- https://international.commonwealthfund.org/countries/canada/
- The Government of Canada, for details on healthcare: https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html
- Extracts from "The State of Oral Health in

Outcome from the CHMS Survey

- **Roughly 80% of Canadians have a dentist**
- **Percentage of children with at least one decayed tooth, 23.6%**
- **Percentage of adolescents with at least one decayed tooth, 58.8%,**
- **Average number of decayed, missing or filled teeth (per child), 2.5**
- **34% of dentate Canadians 6-79 years of age had some sort of treatment need identified**
- **47% of lower-income Canadians had a need identified, compared to 26% of the higher-income group**
- **1 out of 3 Canadians has a need and only 1 out of 6 says they cannot address this need because of financial reasons**
- **Overall, Canadians from lower-income families were found to have two times worse outcomes compared to higher income families in many measures.**
- **84% of Canadians report their oral health as good or excellent**
- **5.5% of Canadians have untreated coronal cavities**
- **Most Canadians (73%) brush twice or more a day and over a quarter (28%) floss 5 times a week.**

Source: *Canadian Dental Ass. website - https://www.cda-adc.ca/stateoforalhealth/snap/*

For a detailed report on the State of Oral Health in Canada:
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www.cda-adc.ca/stateoforalhealth

Canada", Canadian Dental Association, https://www.cda-adc.ca/stateoforalhealth/
https://www.cda-adc.ca/stateoforalhealth/snap/
https://www.cda-adc.ca/en/services/internationally-trained/economic/
https://www.cda-adc.ca/en/services/internationally-trained/terms/
https://www.cda-adc.ca/en/services/internationally-trained/economic/
- Extracts from "A Comparative Analysis of Oral Healthcare Systems in the United States, United Kingdom, France, Canada, and Brazil" By Daniela Garbin Neumann and Carlos Quinonez., http://ncohr-rcrsb.ca/knowledge-sharing/working-paper-series/content/garbinneumann.pdf
- Canadian Institute for Health Information
- https://www.cihi.ca/en/dentists
- "Why was dental care excluded from Canadian Medicare?" by Carlos Quinonez Quiñonez NCOHR Working Papers Series 2013, 1:1, http://ncohr-rcrsb.ca/knowledge-sharing/working-paper-series/content/quinonez.pdf
- The Canadian Dental Hygienists Association, https://www.cdha.ca/cdha/The_Profession_folder/Resources_folder/The_Canadian_Institute_for_Health_Information_CIHI_folder/CDHA/The_Profession/Resources/CIHI.aspx
- https://www.statista.com/statistics/686355/number-of-licensed-dentists-in-canada-by-province/
Scott's Medical Database, 2016, Canadian Institute for Health Information - https://www.cihi.ca/en/physicians-in-canada
https://www.cihi.ca/en/infographic-a-profile-of-physicians-in-canada-in-2016
- World Health Statistics (WHO), 2018
- https://www.thelancet.com/journals/lancet/article/IIS0140-6736(18)30181-8/fulltext

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