



From Coverage to Care:

An Evidence-informed Assessment of the
Canadian Dental Care Plan (CDCP)



Message from the CDA's President

The Canadian Dental Care Plan is a generational investment in the oral health of people in Canada. Its promise matters because oral health is not separate from overall health; it is part of it. As a practising dentist, I see that connection every week: infections and pain that ripple into a person's general health, chronic conditions that first show themselves in the mouth, and the difference that a healthy smile makes to how someone eats, sleeps, works, and lives. Improving access to oral health care for people across Canada has long been a priority for our profession and for CDA, and it is the work this policy paper is meant to advance.

Dentists have always worked to help patients get the care they need. Dentists across the country treat CDCP patients every day, and they want the program to work for those patients. They bring valuable, firsthand insight into what providers and patients have been experiencing with the program.

That insight points to a simple truth: coverage on paper only helps a patient if there is a dental team available to provide the care. A program succeeds when practices have the people and the capacity to turn coverage into appointments and completed treatment. In New Brunswick, where I practise, and in many regions like it, shortages place real pressure on care delivery. When a practice cannot staff a chair, it is the patient who waits.

Strengthening this program is about addressing barriers that stand between Canadians and the care they need, so that dentists can do what they do best: provide quality care to the patients in front of them.

I want to thank the many dentists, our provincial and territorial dental association colleagues, and the patients and contributors who shared the experiences and evidence that informed this work. This paper reflects their voices, and it is offered in the same spirit that has always guided our profession: a shared commitment to the oral health of every person in Canada.



Dr. Kirk Preston
President



Message from the CDA's CEO

The Canadian Dental Care Plan represents the most significant federal investment in oral health in Canada's history. From the outset, CDA's goal has been constructive: to help build a program that works for the patients who depend on it and for the dental teams who provide their care.

Over the past five years, CDA has worked to help improve the program as it took form, bringing forward evidence and practical recommendations at each stage. That engagement helped inform a number of improvements, including improved coverage and privacy protections for patients, claim-by-claim provider participation, simplified terms and conditions, more streamlined reimbursement, and operational and communication changes that supported patient uptake.

This paper is CDA's first comprehensive assessment of the CDCP as it operates today. It draws on a broad evidence base: national research with patients, direct feedback from more than a thousand dentists, the perspectives of employers, consultations with provincial and territorial dental associations, and available program data. Together, these sources let us take an evidence-informed assessment of how the program is delivering for patients and where barriers to care remain.

The findings point to a clear next phase. The first years of the CDCP were about establishing coverage. The work ahead is about strengthening the program to help ensure coverage turns into sustainable access: care that patients can actually obtain, afford, and rely on over the long term, supported by transparency and sound program design.

I want to thank CDA staff, our members, our provincial and territorial partners, and everyone who contributed their expertise and feedback. Their collective effort has produced an assessment we hope will help guide the program's next chapter, for the benefit of patients across Canada.



Dr. Aaron Burry
Chief Executive Officer



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Executive Summary



The Canadian Dental Care Plan (CDCP) marks a historic shift in Canadian health policy. For the first time, the federal government has extended dental coverage on a national scale to millions of people who lack private insurance, and for whom cost has long been the fundamental barrier to care. The program is large, ambitious, and already consequential: for the 2025–2026 benefit year (as of June 30, 2026) over 6.5 million patients have enrolled, close to four million have received care, and thousands of oral health providers are taking part. This is a generational achievement, and its gains for patients are worth protecting. The CDCP's purpose is straightforward and important: to help ensure that income and insurance status do not determine whether a person living in Canada can see an oral health professional when they need one.



6.5M+

Patients Enrolled



3.9M+

Have received care



28,600+

Providers taking part

**Stats are for the 2025–2026 benefit year.*

CDA has long advocated for enhanced access to oral health care for people living in Canada. Together with the provincial and territorial dental associations, we have engaged with the government throughout the program's design stages to provide advice and recommendations. CDA's aim is to help ensure the program delivers for the patients who depend on it and for the dental teams who provide care under it.

This paper is CDA's first comprehensive assessment of the CDCP as it operates today. It builds on CDA's 2023 policy paper, *Bridging the Financial Gap in Dental Care*, which set out how a federally funded program should work for patients. Now, we measure progress towards those recommendations, then examine, issue by issue, where it delivers and where barriers still exist for patients. From this assessment, the

paper puts forward a comprehensive set of recommendations to strengthen the program for patients. These are summarized at the end of this Executive Summary, and set out in full in the paper’s final section. The evidence base is broad, drawing together the experiences of patients, dentists, and dental organizations.

The Evidence Base at a Glance

 3,000 Canadians Source: National public survey, including CDCP patients (Abacus, for CDA, 2026)	 1,000 Employers Source: Employer survey (Abacus, 2026)	 1,081 Dentists Source: Dentist survey, nationwide (CDA, Apr-May 2026)
 2023 Policy Scorecard Source: Current program vs. CDA’s 2023 recommendations	 Stakeholder Consultations Source: Provincial and territorial dental associations	 Oral Health Data Source: Health Canada CDCP data, Statistics Canada

Main Findings

One of the central findings of this paper is that the CDCP is delivering value that extends well beyond coverage itself. Beyond expanding access to care, patients report a strongly positive experience, and the program enjoys broad public support. Most enrolled patients (88%) describe a positive experience and say their care is more affordable (75%). Many report better oral health since enrolling, and most Canadians (64%) support the program. The CDCP has also elevated oral health as a national priority and has avoided much of the delay and expense that building a separate public delivery system would have required, relying instead on Canada’s existing network of dental offices, an approach that supports patients’ choice of provider.

One of the program’s strongest foundations is provider participation. Early in implementation, dentist participation was uncertain. Today it is broad, and that change has been essential to turning coverage into care. The shift did not happen by chance. It followed important design changes informed by advocacy from the CDA and provincial and territorial dental associations. These changes included a claim-by-claim participation pathway for providers, simplified terms and conditions, fast claims processing and reimbursement, among others. They are part of what makes the program workable for dental offices and accessible for patients, and maintaining them is essential to preserving the access the program has achieved.

However, the program’s remaining challenges are significant, and each ultimately affects patients’ access to care. The paper’s central caution is that coverage has not consistently translated into affordable care and there is a gap between expectations and reality for patients. Even with the program’s help, 37% of enrolled patients still report financial barriers, and many who expected full coverage are surprised by

out-of-pocket costs, largely because CDCP fees were set below the true cost of delivering dental care. Confusion about coverage, exclusions, and out-of-pocket payments for patients exist, and dental offices have often been left to explain the program appointment by appointment.

Other barriers are more structural. Preauthorization remains one of the most significant sources of frustration for dentists and patients, with high denial rates, limited transparency, and unclear explanations when treatment is not approved. Limitations on covered procedures can leave patients without recommended care, particularly those with complex needs, those requiring specialized care, and those who would benefit from a stronger focus on prevention. Administrative burden, workforce constraints, non-financial barriers, gaps in oral health data, and the long-term risk of erosion in employer-sponsored dental benefits all pose challenges to the program's ability to deliver durable, equitable access in the long term.



88%

Of CDCP patients
report a positive
experience.



64%

Of Canadians
support the
program.



37%

Of CDCP patients still
report financial
barriers.



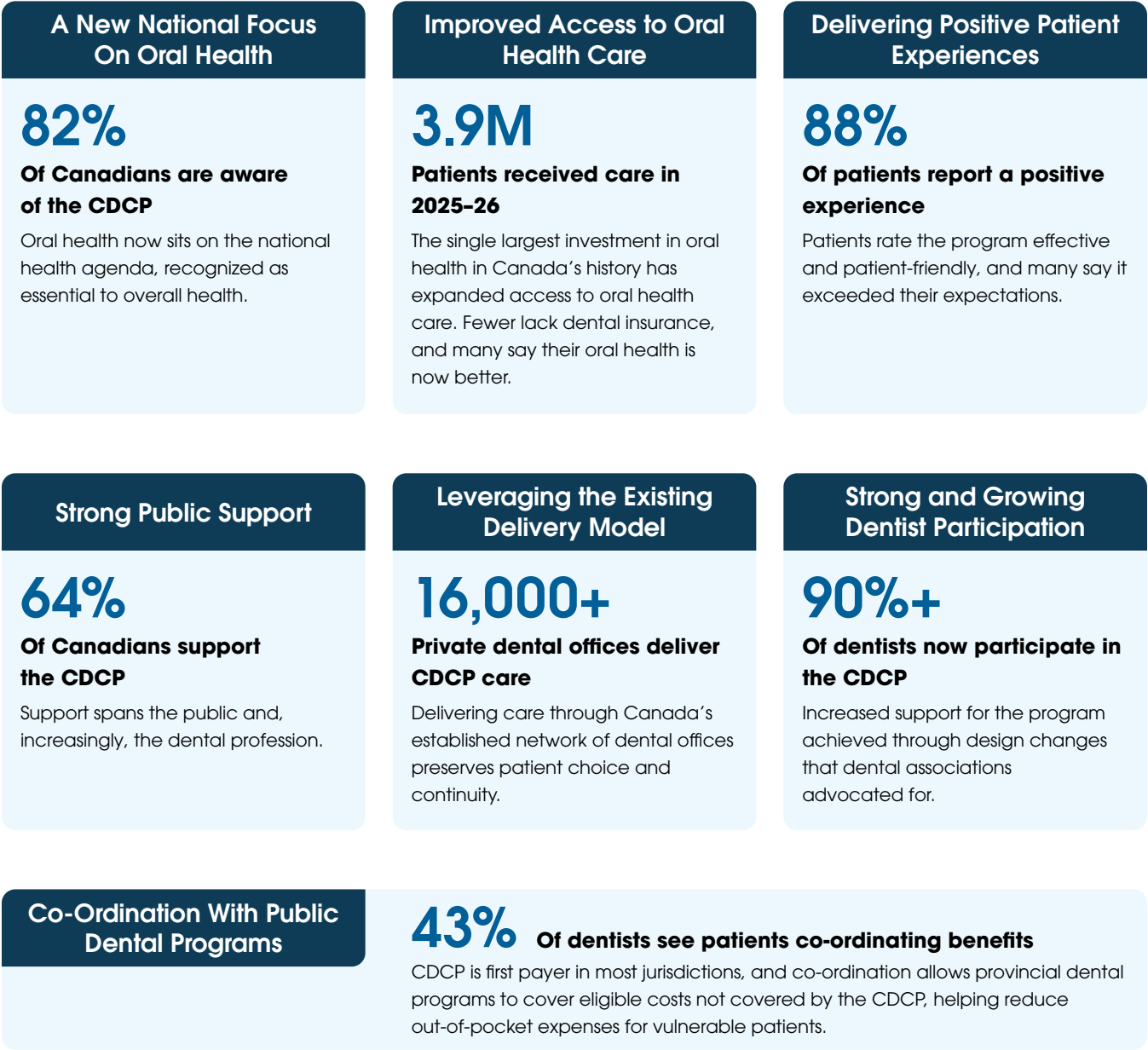
50%

Of complete
preauthorization
requests are denied.

This paper argues that the CDCP has built a strong foundation for increasing access to care we must now safeguard. Fortifying this base should be the focus of the next steps. The CDCP stands as a monumental investment in Canada's oral health system. The task now is to ensure that coverage seamlessly translates into accessible, equitable, timely, clinically suitable, and affordable care. The program's long-term viability for the patients, providers, and systems it supports must be maintained.

Areas of Progress

How the CDCP is Improving Access for Patients



Areas of Concern

Barriers and Risks for Patient Access



Program Evaluation Gaps

\$13B

In federal investment over five years, with no public framework to evaluate it

Neither program data nor a formal program evaluation plan has been made public. Without publicly available information, it is challenging to measure the program's impact.

Workforce Challenges and Capacity Constraints

7,200

Vacancies among dental hygienists and dental assistants

Staffing challenges restrict how many new patients dental offices can take, especially in rural and remote communities.

Patient Confusion and Program Complexity

59%

Of patients expected their care to be completely free

Expectation gaps surface at the dental chair, where offices are left explaining the program. Confusion also deters some patients from using the coverage they have.

Impact on Dental Education and Training

At risk **The clinical training that future dentists need**

As patients shift to private clinics, teaching clinics lose the case volume students need to graduate ready to practice.

Recommendations at a Glance

The CDCP is a monumental investment in Canada's oral health system and in improving access to care for patients. Building on this progress, CDA makes over 30 recommendations in this paper to help ensure the program remains sustainable and continues to improve access to care and oral health outcomes for patients. The recommendations on this page have been shortened and grouped for readability. The full recommendations are presented throughout the paper and compiled in the final section.

01 Patient Care



Align coverage with oral health needs. Adapt the basket of covered services, address coverage limitations, improve preventative and specialized care, and provide sustainable funding to protect long-term patient access.



Communicate clearly with patients. Improve communications, such as letters and government ads, and direct outreach to set clear expectations about coverage. Give patients and dentists advance notice of program policy changes.

02 Program Design



Cover cost of care for patients. Align CDCP fees with the real cost of delivering care to reduce costs for patients, tie annual CDCP fee increases to provincial and territorial fee guide updates and actual cost drivers (staffing, supplies, rent), and assess if the co-payment requirement is deterring care.



Reduce preauthorization barriers. Provide clear explanations for denied requests, share information on clinical criteria, streamline preauthorization systems, and invest in provider education.



Reduce administrative burden. Strengthen the administrator's contact centre with consistent training, continue providing dental offices with ready-to-use patient resources, simplify eligibility renewal and protect continuity of coverage for patients, improve the CDCP claims and verification process, and align CDCP treatment codes with the annual Uniform System of Coding and List of Services (USC&LS) cycle.



Keep coverage complementary. Work with provinces and territories to ensure the CDCP neither displaces nor delays modernization of other public dental programs while monitoring employer dental benefits, and using education and incentives to encourage employers not to drop coverage.

03 Oral Health Strategy



Reach who the program is missing. Commission an independent evaluation of CDCP targeting effectiveness, review eligibility and co-payment design for equity gaps, and reestablish the Oral Health Access Fund alongside a federal oral health equity strategy to tackle non-financial barriers and social determinants of oral health.



Address oral health workforce challenges. Fund a pan-Canadian workforce data modelling tool, work with provinces and territories on workforce planning, and make dental assisting eligible for key federal programs (loan forgiveness, the PGWP, Canada Student Grant).



Protect dental student training. Convene federal, provincial and territorial ministers on a sustainable funding and workforce models for teaching clinics, so future dentists train on the cases patients will rely on.



Evaluate and report on the program. Publish regular, disaggregated CDCP data, implement a periodic public review focused on oral health outcomes and long-term sustainability.



Rebuild oral health data. Restore national oral health surveys (COHS and SOHCP), include oral health in the Canadian Health Measures Survey every five years, and improve access to data with privacy safeguards.

Introduction



The Canadian Dental Care Plan (CDCP) marks the most significant expansion of publicly funded oral health care in Canada's history. Designed to improve access for individuals without private insurance, the program has expanded coverage and elevated the national profile of oral health.

While public attention on the program has often focused on its expansion of coverage, comparatively less attention has been given to how it operates on the ground and delivers care for patients. CDA continues to contribute to the discussion by elevating those issues, and drawing attention to successes, gaps, and opportunities. With this paper, we also aim to advance oral health care in Canada and strengthen the program's ability to deliver accessible, patient-centered care.

CDA has long advocated for greater investment in oral health care for Canadians who experience access barriers. Since the federal government first committed to dental care in 2022, CDA has worked directly with the federal government, providing research, technical analysis, and advice on how to build a dental program capable of translating coverage into real access for patients. In 2023, CDA set out detailed recommendations (Annex II) for what a sustainable and effective federally funded program should look like in *Bridging the Financial Gap in Dental Care*. CDA and the provincial and territorial dental associations also jointly developed *A Proposed Framework for the Canadian Dental Care Plan* (2023), which examined a range of policy models for publicly funded dental care. That input continued leading up to the CDCP's launch and has carried through implementation as CDA and the provincial and territorial dental associations have worked to identify challenges and recommend practical improvements



along the way. Together with the dentists who deliver care every day, CDA and the provincial and territorial dental associations (PTDAs) have played a meaningful role in shaping the program as it exists today and remain committed to advocating for the best possible program for patients and for the dentists who serve them.

As the CDA, the provincial and territorial dental associations, and dentists across Canada work to deliver the program across the country, we analyze how the CDCP measures in practice. This policy paper is built with a clear purpose: to improve access to care for patients and help ensure stronger oral health outcomes for patients. It is from that starting point that CDA examines the CDCP.

The CDCP has been implemented for about two and a half years, providing an important opportunity to assess its performance and impact. During this period, millions of patients have received care under the program, and patients and dentists have gained substantial firsthand experience with how it works in practice, enabling a more comprehensive evaluation of its impact.

The timing of this policy paper is especially significant. The Auditor General's 2026 report on the CDCP is expected to analyze how the program has been managed by the federal government to provide affordable dental care for eligible Canadian residents. At the same time, the federal government continues to face fiscal pressures and rising expectations that major public investments will deliver measurable results. In this environment, it is important that discussions about the CDCP's future be informed by evidence and a clear understanding of the program's achievements and the barriers to care that remain.

The paper is organized to reflect this purpose. It assesses the CDCP based on CDA's 2023 recommendations, reviews areas of progress, examines in detail current challenges and barriers for patients and dentists, and sets out recommendations to address remaining gaps. Through this analysis, CDA aims to support a more evidence-informed conversation about the program's future to help ensure that the CDCP works for the patients it is meant to serve and for the providers who deliver their care.

Methodology



This analysis examines how the CDCP is functioning on the ground and, most importantly, what it means for patients' ability to access timely, quality oral health care. It draws on multiple complementary lines of evidence to ensure findings are balanced, credible, and grounded in the real-world experiences of patients, the dentists who treat them, and the broader oral health system.

Survey Evidence

Three surveys form the core of the quantitative evidence base. For each survey, data was weighted to reflect the relevant population.

- **A survey of Canadians and CDCP patients**, conducted by Abacus Data with 3,000 Canadians aged 18 and over between March 24 and April 15, 2026. The margin of error for a comparable probability-based sample of this size is $\pm 1.8\%$, 19 times out of 20. This survey captures patient awareness, enrolment and treatment experiences, and the barriers Canadians encounter when seeking care.
- **A survey of dentists**, conducted by the Canadian Dental Association with 1,081 dentists between April and May 2026, distributed with the support of provincial and territorial dental associations. The estimated margin of error is approximately ± 2.9 percentage points, based on a population of approximately 21,110 corporate member dentists. While this survey captures dentists' experiences with program participation and administration, its purpose is to surface how those provider- and system-level pressures impact patient access to care.
- **A survey of employers**, conducted by Abacus Data with 1,000 Canadian employers between March 10 and 18, 2026. The margin of error for a comparable probability-based sample of this size is $\pm 3.09\%$, 19 times out of 20. This survey examines how the CDCP interacts with existing employer-provided dental coverage, a dynamic with direct consequences for the coverage patients ultimately rely on.

Policy Scorecard

In 2023, CDA's *Bridging the Financial Gap in Dental Care* outlined a series of recommendations for how federally funded dental care should be designed and delivered for patients. Drawing from those recommendations, a scorecard was created to assess how the CDCP is performing now that it has been fully implemented.

In the scorecard, each measure of success derived from the above-mentioned recommendations was assessed and assigned a label of 'Achieved', 'Mostly Achieved', 'Limited Progress' and 'Not Achieved' based on its overall score. Within each measure of success, individual concepts were scored on a four-point scale and weighed according to their relative importance. Scoring was informed by CDA's policy analysis, the surveys mentioned before, consultations with provincial and territorial dental associations, and publicly available program data.

Consultations and Qualitative Input

CDA also held consultations with provincial and territorial dental associations as well as other experts in the field. These consultations capture regional variation, system pressures, and on-the-ground realities that may not be fully visible through survey or administrative data alone, and they help ensure the analysis reflects the diversity of patient experiences across jurisdictions. Annex I includes a summary of responses from the PTDA's.

Supplementary Data and Research

Where available, the analysis is further informed by other research and publicly available Health Canada CDCP usage statistics and relevant Statistics Canada data.

Throughout, this paper is designed to keep the focus on outcomes for patients. When we examine provider or administrative issues, we do so to trace their effect on the broader impacts on access to oral health care.

Background: The Canadian Dental Care Plan

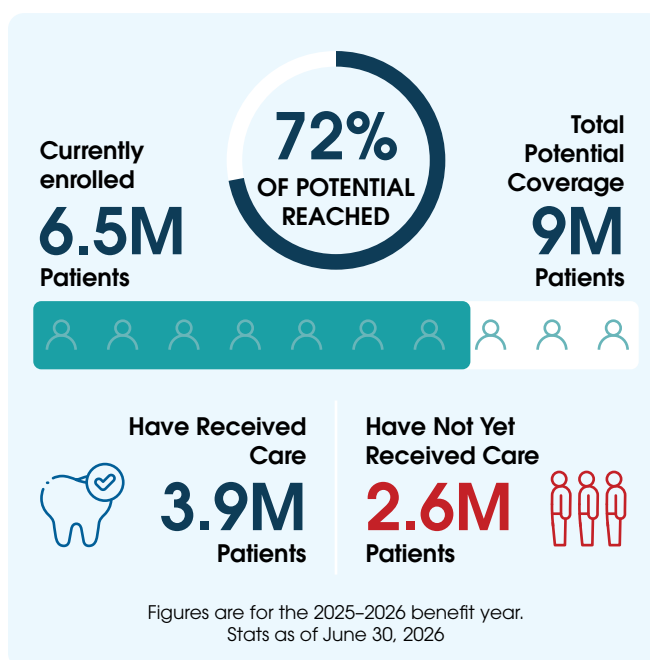


The CDCP is a federally funded program that helps cover the cost of oral health care for uninsured Canadian residents. It is administered by Sun Life on behalf of Health Canada and is designed for people with an adjusted family net income below \$90,000 who do not have access to private dental insurance. The total CDCP eligible population is estimated by the federal government to be up to nine million individuals.

By scale, the CDCP has quickly become one of the largest new federal social programs in recent decades. As of June 2026, for the 2025–2026 benefit year, more than 6.5 million were approved, and close to 4 million had received care during that period. Since the launch of the CDCP, over 4.5 million unique patients received care during at least one benefit year. More than 28,600 oral health providers participate in the program. Of these, over 24,800 are dentists and dental specialists. The federal government reports that the CDCP saves eligible patients an average of roughly \$900 per year.

Origins and Phased Rollout

The CDCP originated from the March 2022 confidence-and-supply agreement between the Liberal government and the New Democratic Party (NDP), under which NDP support in Parliament was tied to federal action on shared priorities, including national dental care. As an interim measure, the Canada Dental Benefit launched in late 2022 to provide up-front payments toward dental costs for uninsured children under 12. It served as a bridge until the permanent



program could be built and was wound down on June 30, 2024, as eligible children transitioned into the CDCP.

Budget 2023 committed \$13 billion over five years, with \$4.4 billion per year on an ongoing basis to fund the CDCP. The program began a staged rollout designed to bring large eligible groups online in sequence:



Older adults first. A phased enrolment by age group opened for seniors starting in December 2023, with coverage beginning for the first cohort in May 2024.



Children and persons with disabilities. In June 2024, the plan opened to children under 18 and to adults holding a valid Disability Tax Credit certificate.



Remaining adults. Applications for all remaining eligible residents aged 18 to 64 opened in May 2025, with coverage beginning June 1, 2025.

Who is Eligible

Eligibility rests on four requirements that an applicant must meet:

- no access to private dental insurance, whether through an employer, a pension, a group benefit plan, a school, or a personally-purchased plan (having public coverage, such as provincial social assistance, does not disqualify an applicant);
- an adjusted family net income below \$90,000;
- Canadian residency for tax purposes; and
- a filed income tax return for the previous year, with a Notice of Assessment received from the Canada Revenue Agency.

Coverage is neither automatic nor permanent. Patients must renew their enrolment each year, and their income, and therefore their level of coverage, is reassessed annually based on their most recent tax filing. In 2026, renewal windows for the 2026-27 benefit period were available between April 15 and June 1. Patients who did not renew by June 1 could face a gap in coverage during which services are not reimbursed.

What Patients Pay: The Co-payment Structure and Additional Fees

The portion of CDCP-established fees covered by the program depends on a member's adjusted family net income. Members in the lowest income band pay no co-payment, while those in higher bands pay a share of the cost.

Adjusted Family Net Income	How Much CDCP Covers	Patient Co-payment	Observation*
Under \$70,000	100% of the CDCP established fees	0% of the CDCP established fees	Patients may still be responsible to cover the remaining cost of the procedure
\$70,000 to \$79,999	60% of the CDCP established fees	40% of the CDCP established fees	
\$80,000 to \$89,999	40% of the CDCP established fees	60% of the CDCP established fees	

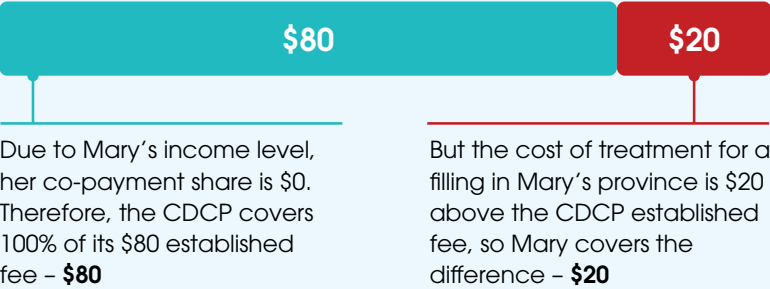
***An important caveat for patients:** these percentages apply to the CDCP’s own established fees, not to the full cost of a dental treatment. Because CDCP fees are usually lower than the cost of delivering dental care, the patient may be responsible for that difference in addition to any income-based co-payment. As a result, even patients in the no-co-payment band can face out-of-pocket costs at the point of care to cover the remaining costs of the procedures. These out-of-pocket costs for patients exist because the CDCP fees were designed to not cover the full costs of a dental treatment.

Meet Mary

Mary is 61 and works part time at a job with no dental benefits. Her adjusted family net income is about \$60,000, which makes her eligible for the CDCP with no co-payment: the program covers 100% of the CDCP established fee.

Mary needs a filling. The cost of treatment at the dentist is \$100; the CDCP's established fee for a filling is \$80.

What Mary pays:



Mary's total out-of-pocket cost: \$20.



Even though Mary qualifies for 100% of the CDCP established fee coverage and pays no co-payment, she still pays \$20 out of pocket. That \$20 exists entirely because the CDCP's fee sits below what it costs her dentist to provide the necessary care.

* This is a hypothetical example for illustration. The dollar amounts are simplified and do not represent actual CDCP fees or the cost of any specific treatment. It is intended only to show how the CDCP's co-payment structure and the gap between CDCP fees and the cost of care affect what a patient pays out of pocket.

Sources:

- Department of Finance Canada, *Budget 2023: A Made-in-Canada Plan—Strong Middle Class. Affordable Economy, Healthy Future*, March 28, 2023. <https://www.budget.canada.ca/2023/home-accueil-en.html>.
- Government of Canada, "Canadian Dental Care Plan Statistics," modified July 15, 2026. <https://www.canada.ca/en/services/benefits/dental/dental-care-plan/statistics.html>.
- Government of Canada, "Canadian Dental Care Plan: What Is Covered," modified May 21, 2026. <https://www.canada.ca/en/services/benefits/dental/dental-care-plan/coverage.html>.
- Office of the Prime Minister, "Delivering for Canadians Now: A Supply and Confidence Agreement," March 22, 2022. <https://www.pm.gc.ca/en/news/news-releases/2022/03/22/delivering-canadians-now>

Scorecard: Progress on CDA's 2023 Policy Paper



In 2023, CDA developed a policy paper called *Bridging the Financial Gap in Dental Care* outlining a series of recommendations (see Annex II for a full breakdown) for how federally funded dental care should be designed and delivered for patients. Drawing from those recommendations, this scorecard assesses how the CDCP is performing now that it has been fully implemented.

The expansion of access to dental care for millions of patients is a significant achievement, and the scorecard highlights where the CDCP has delivered based on CDA's 2023 recommendations. It also identifies areas where there is still scope for improvement to ensure the program delivers lasting results for patients.

Each measure of success (henceforth called a measure) in the scorecard was assessed and assigned a label based on its overall score (see below). Within each measure, individual concepts were scored on a four-point scale and weighted according to their relative importance. The final measure score reflected a structured assessment that combined these weighted concept scores, ensuring a balanced evaluation that considered all relevant factors while appropriately emphasizing those with the greatest impact. Scoring was informed by CDA's policy analysis, its 2026 public opinion survey conducted by Abacus Data, the CDA dentist survey, consultations with provincial and territorial dental associations, and publicly available program data.

While this scorecard measures progress based on CDA's 2023 recommendations, many aspects of the CDCP's design and implementation were not yet known when those recommendations were developed. The sections that follow our scorecard analysis move beyond benchmarking and examine how the program is operating in practice today. They explore both the benefits the CDCP is delivering and the challenges that remain, providing a clear assessment of where the program is working well and where patients continue to face barriers to care.

Sources:

- Canadian Dental Association, *Bridging the Financial Gap in Dental Care: Building a Sustainable and Effective Federally Funded Program*, 2023.

How to Read the Colour Label



Achieved

The metric has been achieved.



Mostly Achieved

The metric is largely in place, with some elements still outstanding.



Limited Progress

The metric has seen limited progress, with many elements left unaddressed.



Not Achieved

The metric has not been achieved.

The Scorecard



MEASURE OF SUCCESS	RATIONALE BASED ON 2023 CDA RECOMMENDATIONS	LABEL
PATIENT CARE		
Patient's Right to Choose Provider	Multiple pathways for providers to participate have resulted in the majority of providers engaging in the program, allowing greater flexibility for patients to choose their preferred provider.	 Achieved
Patient Care Experience	Enrollment is functioning and patients report strong positive experiences.	 Achieved
Prioritize and Promote Prevention	More patients are receiving care, but coverage limits constrain a true prevention focus for patients.	 Limited Progress
Holistic Model of Care	Despite improving access to care, the CDCP continues to face limitations in providing coverage for patients with complex needs, promoting equitable access, and supporting upstream initiatives.	 Limited Progress

MEASURE OF SUCCESS	RATIONALE BASED ON 2023 CDA RECOMMENDATIONS	LABEL
Patients Not Facing Arbitrary Limits	Preauthorization denials, coverage caps, and considerable out-of-pocket costs for many eligible users continue to shape care decisions for patients.	 Not Achieved
PROGRAM DESIGN		
Payor of Last Resort	Eligibility criteria excludes people with private dental coverage.	 Achieved
Use of Nationally Adopted Tools and Systems	The program runs on established claims infrastructure networks, providing ease of access for patients.	 Achieved
Delivery of Care Through Private Dental Infrastructure	Patients are served through the existing private dental office infrastructure. Policies that recognize the distinct scopes of practice of each provider type are required.	 Mostly Achieved
Designed to Complement Existing Public Dental Programs	CDCP co-ordinates benefits with public dental programs, acting as first payor in relation to many provincial programs. Provincial programs may cover the difference, though in some regions provincial programs could be scaled back for CDCP patients.	 Mostly Achieved
Match Current Provincial and Territorial Fee Guides	CDCP has adopted the USC&LS coding system but CDCP fees do not match suggested provincial fee guides and treatment codes are not updated in a timely manner.	 Limited Progress
Administrative Procedures do not Delay or Impede Patient Care	The CDCP has made improvements to provider enrollment and claim processing, but administrator issues, medical criteria not disclosed, preauthorization denials with limited or no explanation, and the requirement to check a patient's eligibility at every appointment still add burden.	 Limited Progress
Preserves and Promotes Private Dental Coverage	People with private insurance are excluded and there are annual eligibility checks, but no strategy to deter potential erosion of employer benefits exists.	 Limited Progress

MEASURE OF SUCCESS	RATIONALE BASED ON 2023 CDA RECOMMENDATIONS	LABEL
Cover Cost of Care	Persistent affordability concerns exist stemming from co-payment requirements and CDCP fees set below cost of treatment leaving patients facing out-of-pocket costs.	 Not Achieved
ORAL HEALTH STRATEGY		
Consultation and Collaboration	Stakeholder input provided to the federal government and engagement continues.	 Achieved
Comprehensive Oral Health Strategy	While the CDCP and related initiatives have expanded access, gaps remain in who the program is serving, addressing broader social determinants, and ensuring sustained funding for targeted access programs.	 Limited Progress
Set of Common National Standards	CDCP creates a national reference point, but its uniform income thresholds and co-payment structure across the country do not adequately reflect regional cost-of-living differences or oral health needs.	 Limited Progress
Human Resource Challenges	Efforts to address oral health workforce shortages that affect timely access to care remain limited, but some progress has been made, such as an expanded Student Loan Forgiveness Program.	 Limited Progress
Ongoing Plan Improvement	While some efforts have been made to address implementation issues and improve communications, there remains no clear public commitment to a comprehensive CDCP review.	 Limited Progress
Oral Health Data	No clear long-term strategy for using CDCP data to measure outcomes, limited access to data for researchers and uncertain future funding for key oral health data collection.	 Not Achieved

Note: ratings reflect CDA's assessment of program-wide progress as of June 2026 and are intended to track the overall direction of the CDCP. Recommendations have been shortened for readability.

Areas of Progress



How the CDCP is Improving Access for Patients

For many patients, the CDCP has meant something concrete: a first dental appointment in years, a filling that didn't mean choosing between dental care and groceries, or a child seen by a dentist for the first time before a small problem became a larger one. This section outlines how the CDCP is benefiting patients and advancing oral health across Canada.

A New National Focus on Oral Health

The CDCP's impact extends beyond individual patient care, having achieved something of immense value by placing oral health at the forefront of national attention. For the first time, oral health is now being delivered as a core component of federal health policy, bridging the care continuum to recognize that oral health is part of overall health. Parliamentary debates and increased media attention since the announcement of the program have elevated the importance of oral health, and it is now recognized by the public as an essential investment to support Canadians. It means greater recognition that oral health is an essential part of overall health, and greater awareness among Canadians of the care and types of support available to them. The program has brought about a significant and enduring change in awareness, which is a valuable outcome.

The CDCP has put oral health on the national agenda. Keeping it there is one of the program's most valuable and lasting contributions to the health of Canadians, just as access to universal health care remains one of Canada's most important public health achievements.

For Many Patients, the CDCP Means:



A first dental appointment in years



Not having to choose between dental care and groceries

Oral Health on the National Agenda

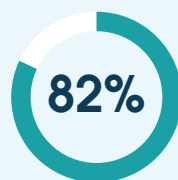
Historically, oral health in Canada has been largely siloed from broader health policy. Unlike medical care, dental care has sat outside the scope of public health insurance, and as a result, it has rarely featured prominently in national health conversations, too often treated as separate from, and secondary to, general health. The scale of federal investment in the CDCP, one of the largest expansions of public health coverage in a generation, has changed that. The magnitude of the commitment has, by itself, signaled to Canadians that oral health matters and that it belongs on the national health agenda alongside other critical priorities. It reinforces a principle that CDA has long championed: that oral health is inseparable from overall health and wellbeing, and this elevated standing within the broader health system creates a foundation for the kind of holistic, whole-person approach to care that ultimately produces the opportunity for preventative care and the best outcomes for patients and the health care system supporting them.

Raising Public Awareness and Changing Behaviour

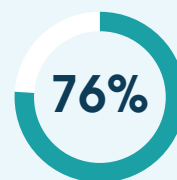
This elevated profile has translated into measurable gains in public awareness. CDA's 2026 Abacus Data survey with the public shows that **82% of Canadians are now aware of the CDCP**, a striking level of recognition for a program still in its early years. This awareness matters because it can change behaviour in ways that benefit oral health. Heightened media attention and public discussion of the CDCP have created opportunities for oral health promotion and education that simply did not exist before the program. When more Canadians are aware of oral health and motivated to seek care, more are seen, screened, and able to address problems earlier.

Patients themselves recognize the difference this national focus is making. Among Canadians eligible for the CDCP, **76% believe the program will make a meaningful difference to the dental care system in Canada**. This reflects a population that increasingly sees oral health as a priority worthy of attention and investment. This is a shift in mindset that supports better oral health behaviours and outcomes well beyond the reach of any single program. In this sense, the CDCP is functioning not only as a coverage program but also as a catalyst for broader public understanding of why oral health matters.

Changing Awareness About the CDCP in Canada



of Canadians are now aware of the CDCP.



of Canadians eligible for the CDCP believe the program will make a meaningful difference to the dental care system in Canada.

Source: 2026 Abacus Data

A Foundation to Build On

This national focus is valuable precisely because it creates the conditions for sustained progress. When oral health is recognized as a national priority, it becomes easier to advance the broader set of measures needed to improve outcomes. The CDCP has opened a window of attention and political will around oral health that has never been seen in Canadian history. Simultaneously, the program is building a

national oral health data resource that can support evidence-based policymaking and enhance future planning for oral health services across Canada. The opportunity now is to sustain that momentum, and to leverage the awareness that the program has created to advance a more comprehensive approach to oral health; one that continues to recognize oral health as an essential, inseparable component of overall health and wellbeing for all Canadians.

Improved Access to Oral Health Care in Canada

The CDCP has transformed access to care for millions of patients. This is a substantial milestone and an achievement worth celebrating. For the first time, coverage has been extended at a national scale to individuals who have historically gone without dental insurance. According to Health Canada, more than 6.5 million have enrolled in the program, and over 4.5 million unique patients have received care since the program has been in place.

By reducing the cost of treatment and expanding access to care, the program is enabling more patients than ever to visit oral health professionals, establish a dental home, access preventive, diagnostic and restorative care, and address oral health concerns before they progress into more serious and costly conditions.

*According to Health Canada, more than **6.5 million** have enrolled in the program, and over **4.5 million** unique patients have received care since the program has been in place.*

More Canadians, Especially Vulnerable Populations, Are Accessing Care

The clearest sign of this shift is the increase in the number of Canadians who now report having dental coverage. According to nationally representative Abacus surveys commissioned by CDA, in April 2024, before the CDCP launched, 35% of Canadians reported having no dental insurance. By March 2026, that figure had fallen to 25% while the proportion of Canadians that reported being covered by a government dental program rose from 15% to 27%. This is a dramatic expansion of coverage in a remarkably short period, bringing millions of people into a system that was previously out of reach and giving them a pathway to care that simply did not exist before.

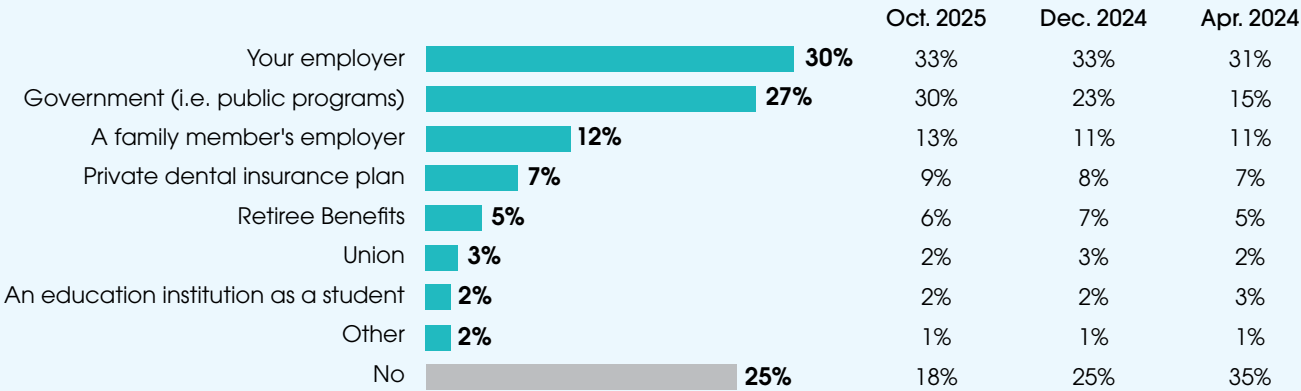
According to CDA’s 2026 Abacus Data survey with the public, perceptions of the CDCP’s ability to improve access to oral health care were strongest for seniors aged 65 and over, with more than two-thirds of respondents (67%) rating the program 7 and above on a scale of 1–10, with 1 being ‘Poor’ and 10 being ‘Excellent’. A majority also viewed the CDCP as effective in improving access for children under 18, with 54% providing a rating of 7 or higher. Ratings were somewhat lower for the adult population aged 18–64 (45%) and persons with disabilities (42%), indicating more moderate confidence in the program’s impact among these groups.

Canadians Without Dental Insurance



Dental Benefits Coverage

Do you currently have dental benefits coverage through any of the following?



Source: Abacus Data

(Base) n=3,000

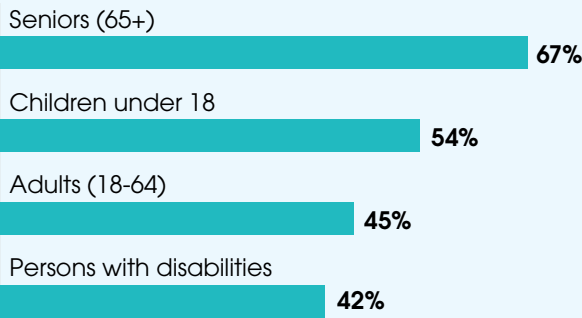
This expansion in coverage has also made care meaningfully more affordable, addressing one of the most significant barriers to oral health care. According to the same Abacus survey, 75% of CDCP patients say dental care is more affordable because of the program. By lowering out-of-pocket costs, the CDCP is enabling many individuals to seek care they might otherwise have delayed or gone without entirely due to cost.

The scale of the affordability barrier that the CDCP set out to address is well documented. Drawing on the 2023–2024 Canadian Oral Health Survey, Statistics Canada established a baseline of cost-related avoidance among CDCP-eligible individuals in the period before the program was launched: 47% of eligible individuals reported avoiding a visit to an oral health professional because of cost in the past year, and 38% reported avoiding recommended dental care for the same reason. Against that baseline, the coverage and affordability gains brought by the CDCP represent meaningful progress towards better oral health care in Canada.

Expanded access to care is also reflected in the number of dental claims submitted in Canada. The chart below shows the total number of claims per month submitted through CDAnet from February 2022 to June 2026, broken down

Perceptions of the CDCP's Impact on Access to Oral Health Care

Share of respondents rating the program 7 or higher on a 1–10 scale



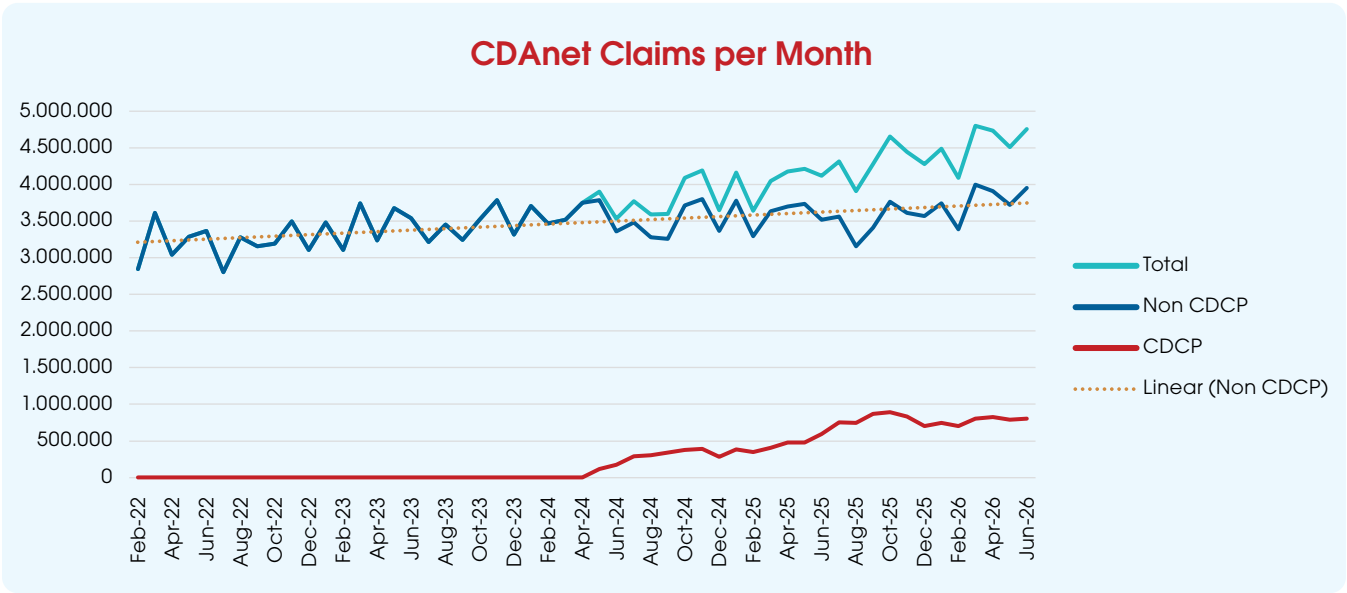
Perceptions of the CDCP's effectiveness were strongest for seniors, while views were more moderate for adults aged 18–64 and persons with disabilities.

Source: CDA 2026 Abacus Data survey.

47% of eligible individuals reported avoiding a visit to an oral health professional because of cost in the past year, and **38%** reported avoiding recommended dental care for the same reason.

between claims associated with the CDCP and all other claims. Total claims rose substantially over this period, climbing from roughly 2.8 million per month in early 2022 to nearly 4.75 million by June 2026. Claims unrelated to the CDCP held relatively steady throughout, with the trend line for non-CDCP claims growing slightly. CDCP claims grew to roughly 800,000 per month by early 2026.

CDAnet is the secure electronic claims network developed by the CDA and used by dental offices across Canada to submit claims to dental benefits providers. Because the vast majority of dental offices transmit their claims through it, CDAnet data offers a reliable, system-wide view of how many dental claims are being submitted each month.



Targeting of CDCP Benefits

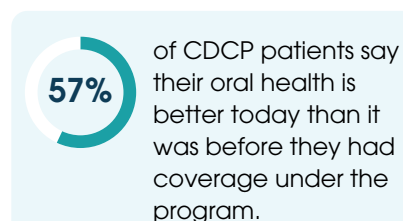
The *Dental Care Measures Act* strengthened the targeting of CDCP benefits by establishing mandatory reporting of dental coverage information through annual tax filings. By enabling the CRA and Health Canada to verify whether applicants have access to private dental insurance, the Act supports accurate eligibility determination and reduces duplication of coverage. The shift from automatic invitations based on government-held information to an application-based process also allows eligibility to be assessed more directly, with patients confirming their own circumstances. While this places some responsibility on applicants and may require clear communication and support, it strengthens program integrity and helps ensure federal dental investments are directed toward individuals without access to employer-sponsored dental benefits.

It is important to note, however, that application-based processes may in some cases lead to eligibility errors that result in approvals being rescinded later. When eligibility is confirmed at application and then revisited later, patients can be left unsure whether

the coverage they were approved for will hold. Anecdotally, dentists have reported that this uncertainty has left some patients hesitant to use their coverage at all, worried they could later be asked to repay costs they cannot afford.

Improving Oral Health Outcomes

Greater access to care is helping more patients receive routine examinations and necessary oral health treatment. According to the same Abacus survey mentioned before, 57% of CDCP patients say their oral health is better today than it was before they had coverage under the program.



Increased access to regular dental visits also creates more opportunities for dentists to identify oral health concerns at earlier stages. Regular checkups and screenings can identify oral diseases, help monitor chronic diseases and lead to early diagnoses which all assist with better patient results and less need for extensive treatment later on, provided that early detection leads to timely, appropriate care.

Further, national trends suggest that more patients are accessing oral health services than before the CDCP. CDA surveys found that the proportion of Canadians who reported seeing a dental professional within the previous 12 months increased from 62% in September 2023 to 68% in March 2026, and when compared to ineligible patients, a greater proportion of CDCP eligible patients have tried to get a dental appointment in the past 2 months.

Canadians Who Reported Seeing a Dental Professional in the Previous 12 Months

62%

September 2023



68%

March 2026

Source: CDA Survey

Positive Impacts Observed by Dental Professionals

Dentists across Canada are also reporting improvements in access to care within their communities. According to a 2026 CDA survey of dentists, 73.6% say that access to dental care in their community is better today than it was three years ago. Since the rollout of the CDCP, 72% of dentists report seeing an increase in the total number of patients they are treating.

Most dentists also believe that the program is having a positive impact on oral health outcomes. Nearly 80% say they believe the CDCP will improve oral health outcomes in Canada. In addition, a majority of dentists (55.6%) report that the program is meeting the oral health needs of their patients to a moderate extent, while 16% say it is meeting those needs to a great extent. A further 24.5% report that it is meeting those needs to a small extent.

Building on Early Successes

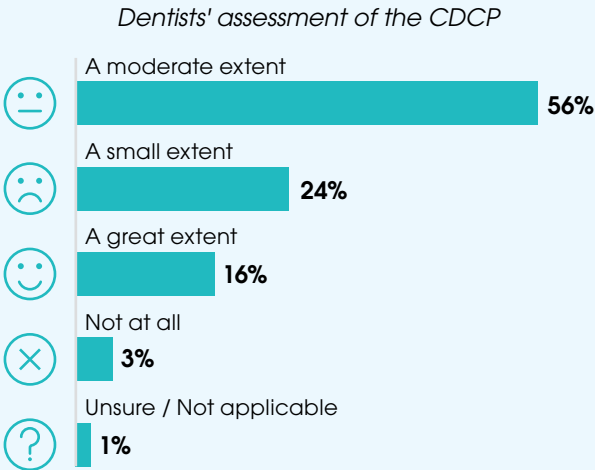
The early results of the CDCP demonstrate that reducing financial barriers can improve access to oral health care for people living in Canada. More people are receiving care, affordability has improved, and both patients and providers are reporting positive impacts.

Challenges remain, including financial barriers that persist, and they are explored in detail later in this paper. But the early evidence is clear: the CDCP is expanding access to care to millions of patients. This represents a significant expansion of publicly funded dental coverage, and the gains it has delivered for patients should be protected and built upon. The measure of the program’s success will ultimately be whether Canadians can count on getting the care they need, when they need it, for the long term. Safeguarding what is working today is the foundation for delivering on that promise. One important consideration is that the CDCP should be measured not only by how much it has increased access, but, most importantly, by population-level oral health outcomes.

Sources:

- *Dental Care Measures Act*, S.C. 2023, c. 26, s. 508, ss. 4–7.
- Canadian Dental Association, *CDAnet Monthly Claims Data, January 2023 to March 2026*, unpublished internal administrative data extract, prepared April 2026.
- Gondro, J.V., Emode, M., Ivancevic, D., Clarke, J., Ortlieb, K., & Farmer, J., *Characteristics of cost-related avoidance of oral health services among people in Canada eligible for the Canadian Dental Care Plan*, Health Reports 36, no. 8, Statistics Canada Catalogue no. 82-003-X, August 20, 2025.

To What Extent is the CDCP Meeting the Oral Health Needs of the Patients Treated So Far



KEY TAKEAWAY: Most dentists say the CDCP is meeting patients' oral health needs to at least a moderate extent.

Source: CDA Dentist Survey 2026.

CDCP Delivering Positive Patient Experiences

In addition to expanding access to care, as described in the previous section, the CDCP is delivering something equally important: a positive experience for the patients it serves. Access opens the door, but the value of the program is also measured by how patients experience care once they walk through it. On that measure, the early evidence is encouraging.

Patient experience data from Abacus Data’s March 2026 survey show that the CDCP is not only expanding access to care for patients but is also earning their confidence. **Patients consistently report high levels of satisfaction with the program, rate it as effective, and describe their interactions with it as positive and patient-friendly.** These results speak directly to the program’s core purpose, demonstrating that expanded coverage is translating into care that Canadians value and trust.

This is a notable achievement for a program of such scale and ambition. The CDCP is one of the largest new public programs Canada has launched in a generation, and standing up a national initiative of this size is a significant undertaking. That patients are reporting such consistently positive experiences this early speaks to how meaningful the program already is in their lives.

Meeting Patient Needs and Exceeding Expectations

Beyond overall satisfaction, the CDCP is performing strongly from the perception of Canadians

88% 

of CDCP patients report a positive experience with the program.

82% 

rate their overall experience 7 or higher on a 10-point scale.

55% 

say the program has freed up savings they can now put toward groceries and other necessities.

80% 

are satisfied with the dental care they receive through CDCP, and

56% of these reported that their experience exceeded expectations.

83% 

rate the CDCP as effective in how it currently operates, and

85% rate the patient-friendliness of the program a 7 or higher out of 10.

Among respondents with household incomes below \$70,000,

25% 

gave the highest possible patient-friendliness rating of 10 out of 10.

Source: Abacus Data, March 2026

Taken together, these findings show that the CDCP is achieving far more than a simple increase in the use of dental services. Patients are not only getting through the door; they are experiencing care that they regard as effective. That a majority say the program exceeded their expectations is significant, suggesting that for many patients the CDCP has delivered more than they anticipated when they first enrolled. The financial relief extends beyond the dental chair as well, with more than half of patients reporting that the savings have eased pressure on household budgets for essentials like groceries. Strong ratings among lower-income households are particularly significant, as these individuals were among those most likely to face affordability barriers before the program's introduction.

Ease of Enrolling

The application and enrollment process has evolved significantly since CDCP's initial launch. Early implementation involved a phased approach, with eligibility expanded gradually across age groups. As the program matured, application pathways were streamlined and eligibility verification processes became more efficient. An Abacus survey commissioned by CDA showed that CDCP-eligible patients demonstrated a strong understanding of the CDCP application and enrollment process. Prior to their first appointment, 94% of patients were aware of their application status, and only 2% indicated a need for step-by-step guidance on applications or claims. Overall, patient satisfaction with the enrollment process has been positive, particularly as:

- Communication regarding coverage, including eligible services and patient responsibilities, has become clearer and more consistent since program launch.
- More enrolled patients are successfully securing dental appointments and accessing needed oral health services through participating providers.

- Information about privacy protections and the collection, use, and disclosure of personal information has been clarified for applicants.

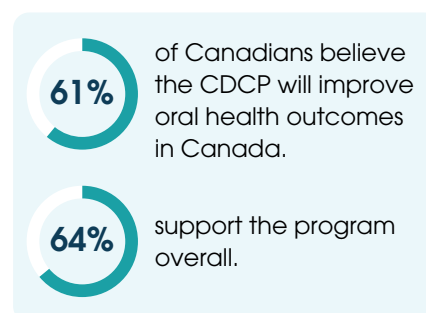
Implications for Long-term Success

The consistently positive patient experience documented in this section is the clearest signal of the program's long-term promise. High levels of satisfaction, strong ratings for effectiveness and accessibility, and the sense among many patients that the program has exceeded their expectations all point to a program that is delivering real and meaningful value to Canadians. This is the foundation on which the CDCP's future success will be built. While overall satisfaction is high, some persistent challenges and barriers for patients exist and must be addressed for the CDCP's long-term success. These subjects will be explored further in a later part of this document.

Strong Public Support for the CDCP

A key strength of the CDCP during its first two years is the considerable support it has from Canadians. The program is widely recognized and viewed positively as a tangible affordability measure at a time when many Canadians continue to face cost barriers to accessing dental care. According to the 2026 Abacus Data public survey commissioned by CDA, 82% of Canadians are aware of the CDCP, a significant level of public awareness for a relatively new federal program.

Canadians broadly support the program's purpose. According to the same survey, 61% of Canadians believe the CDCP will improve oral health outcomes in Canada, and 64% support the program overall. This level of support reflects a clear public expectation that the CDCP should help improve access to dental care by reducing financial barriers.



From Affordability Pressure to Tangible Health Policy

The CDCP's public support is rooted in its role as a practical affordability measure. Dental care is a necessary health service, but for many Canadians it has historically been difficult to access without private insurance. This is important for patients because cost is one of the most common reasons people delay or avoid dental care. The CDCP addresses a genuine household affordability issue by providing differing levels of coverage based on adjusted family net income.

Policy Durability Matters for Patients

The CDCP's broad recognition among both the public and the dental profession gives it a level of stability that matters directly for patient access. Dental care is rarely a one-time need: patients require preventive visits, follow-up appointments, and multi-stage treatment that unfolds over months or years. A program that is widely known and supported is more likely to be maintained, funded, and improved over time. This continuity is what allows patients to begin treatment plans with confidence rather than delaying care out of uncertainty about whether coverage will remain available.

Broad public support also signals acceptance by Canadians that access to dental care is a health priority worth sustaining. At the same time, strong support creates high expectations that the program should work well for patients and for providers, making it critical to ensure the program's design and day-to-day implementation keep pace with what patients actually need to get care.

Leveraging Canada's Existing Dental Care Delivery Model

One of the most consequential CDCP design decisions, and one of its clearest strengths, was the choice to deliver care through Canada's existing network of more than 16,000 private dental offices, rather than building a separate, parallel public delivery system from the ground up. This approach preserves patient choice, continuity of care, and the patient's relationship with their oral health home, while avoiding the substantial cost and delay of constructing new public infrastructure. It was a central recommendation of CDA's 2023 policy paper, and its adoption has had a direct and positive effect on patients' ability to access care. The strong provider uptake the program has seen would not have been possible under a model that required building infrastructure capacity from scratch.

Care Delivered Where Canadians Already Go

Canada's dental care system is delivered primarily through a national network of private dental offices, most of them small businesses embedded in the communities they serve. For patients, the advantage is immediate and practical. It means that coverage can translate into actual appointments quickly, without waiting years for new public infrastructure to be designed, funded, and built. By channeling the CDCP through this existing network, the program allows new coverage to reach patients in the places they already know, rather than concentrating care in a limited number of public facilities that many Canadians may struggle to reach.

It also allows CDCP members to receive care in the same settings as privately insured patients. For patients, this means they are not separated into a distinct, lower-tier stream of care and they can gain access the same dental offices as any other patient. Like other aspects of primary health care, preserving continuity of care is important for patients who already have an oral health home and a relationship with an oral health team before enrolling, and for those with complex needs for whom consistency of care matters most. Ensuring patients can choose their provider is critical as a patient's relationship with their dental team is itself an asset to good oral and general health.

The above is further facilitated by participation across multiple oral health provider groups, ensuring increasing service availability and creating more entry points into the oral health system. However, achieving the full benefits will require policies that recognize the distinct scopes of practice of each provider type and support seamless co-ordination of care. For example, if a dental hygienist performs a complete oral examination under the CDCP, a dentist would not be eligible to provide the same service within the frequency period. This change may unintentionally restrict access to appropriate care, as a dentist's examination differs in scope from a hygienist

examination, specifically when it comes to diagnosing oral health issues such as caries, periodontal diseases, etc.

Building on Systems That Already Work

The CDCP's use of the existing system goes beyond physical infrastructure. Just as it delivers care through the existing network of dental offices, the program also runs on the digital tools the dental profession has used for years to process dental claims.

Over time, the dental community has developed a set of shared national systems that allow offices to record treatments, transmit claims, and exchange information with insurers and other practices in a consistent and secure way. These include a common national coding system for dental procedures, known as the Uniform System of Coding and List of Services (USC&LS), and the electronic claims networks CDAnet and ITRANS, which let offices transmit claims and supporting documents electronically to insurers quickly and securely.

By building on these familiar systems rather than inventing new ones, the CDCP made it easier for dental offices to participate, and easier for patients to have their claims processed in a timely manner, much like how private dental plans work.

This is a strength of the program's design, where it met the dental profession where it already was, lowering the administrative barrier to joining the program and helping coverage translate into care more smoothly.

The volume of claims flowing through the CDCP helped accelerate the transition towards fully electronic claims across Canada. This enables less paperwork and faster processing.

The program has also had a positive ripple effect on these systems. Because so many claims now flow through the CDCP, it accelerated the move toward fully electronic claims across the country, most notably the use of electronic attachments, which allow dentists to securely send X-rays and supporting documents to insurers digitally rather than by mail or fax. In a recent comparison, the volume of these electronic attachments rose roughly tenfold over little more than a year, as more software providers enabled the feature and more offices adopted it as standard practice. The CDCP effectively made this modern, efficient way of working mainstream in Canadian dentistry. For dental offices, it means less paperwork and faster processing. For patients, it means quicker decisions and more timely access to the care they need. Further, policies that support infrastructure development for rural and remote internet coverage will improve these modern efficiencies.

Efficiency and Value of Public Investment

Relying on the existing delivery model is also a more efficient use of public funds, and that efficiency ultimately serves patients. Building a parallel public delivery infrastructure, including new clinics, equipment, staffing and digital systems would have required significant public investment and years of lead time before patients could receive care. By leveraging the systems that

By leveraging the systems that already exist, the federal government has extended care to millions far more quickly and at lower cost than a build-from-scratch model would have allowed.

already exist, the federal government has extended care to millions far more quickly and at lower cost than a build-from-scratch model would have allowed. This frees up resources that can instead be directed toward expanding access for those who need it most. This is a meaningful efficiency that delivers value for taxpayers while accelerating access for patients.

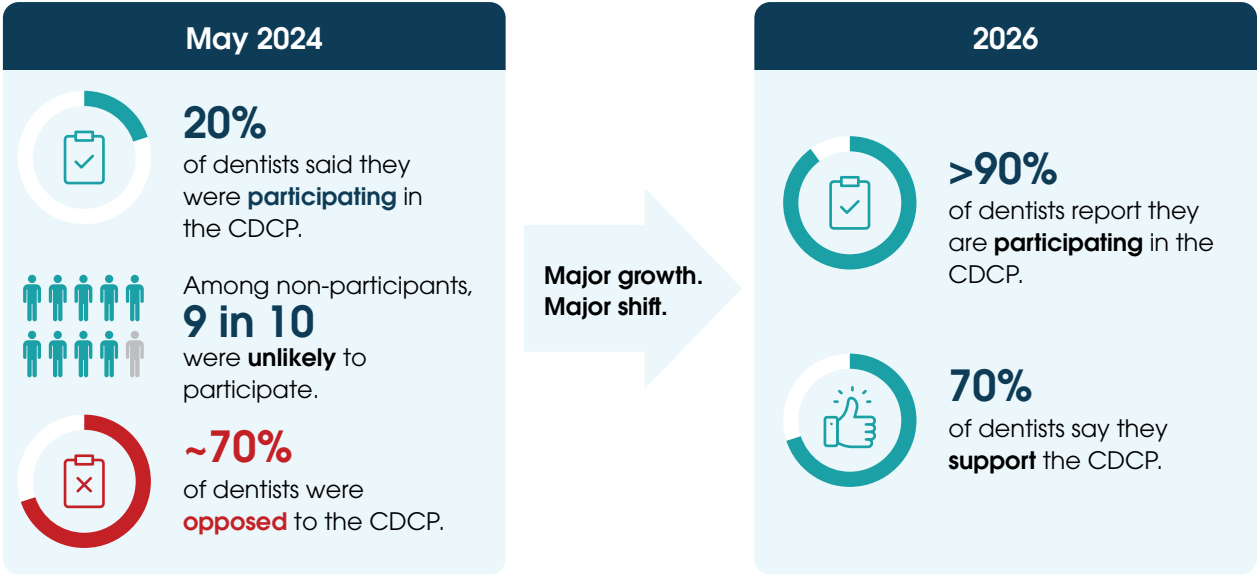
The strength of this approach is reflected in the breadth of provider participation the program has achieved, which is what makes patient choice and access possible in the first place. Broad participation across the existing network of dental offices is the mechanism that turns coverage into care and preserving the conditions that sustain that participation will help maintain and expand access for patients over the long term.

Strong and Growing Dentist Participation in the CDCP

Among the most significant developments in the CDCP’s first two years has been the substantial growth in dentist participation. According to Health Canada, as of June 30, 2026, 24,874 dentists and dental specialists were participating in the program. This is a level of provider engagement that has been essential to giving the CDCP its operational reach across the country. Patient access is built upon widespread dentist participation, and on this measure, the program is in a meaningfully stronger position today than it was at launch.

From Early Concerns to Broad Engagement

Dentist participation and support for the CDCP increased dramatically as the program matured.



The current participation rate is particularly notable when set against where the program stood at the outset. In May 2024, in the early days of CDCP implementation, only 20% of dentists said they were participating, according to CDA surveys with dentists. Of those not participating at that time, 9 in 10 said they were unlikely to participate in the program, and almost 70% of dentists were opposed to the CDCP

altogether. By 2026, that picture has changed dramatically. According to the 2026 CDA dentist survey, over 90% of dentists report they are participating in the CDCP and 70% of dentists now say they support the CDCP.

One of the reasons for the increase in dentist support is that, despite remaining challenges, the profession has seen improvements in program implementation that facilitate provider participation in delivering increased access to care. For patients, this matters directly. A program that is supported by both the public and the dental profession is more likely to be stable, workable, and capable of connecting patients with care in the long-term.

Why Dentists are Participating: Policy Changes That Responded to Real Concerns

The growth in participation did not happen by accident. It is the direct result of design changes the federal government made to the CDCP in response to concerted advocacy from the CDA, the provincial and territorial dental associations, and dentists across the country. In the early stages of the program, several features of the CDCP's design created real barriers to dentist participation. As the federal government listened to the concerns from dental associations, some of those features were addressed, and participation grew. While not all recommendations were adopted, continued collaboration has resulted in meaningful program improvements.

Key improvements and CDCP features sustaining broad dentist participation include:

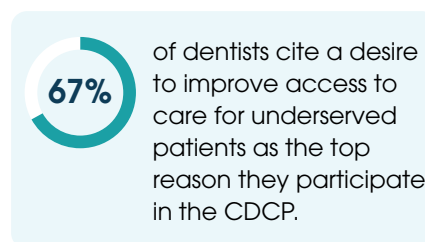
- Increased coverage for preventive services such as scaling and radiographs, the addition of a first dental visit benefit for children under three years of age, and the removal of preauthorization requirements for certain services.
- Removing the requirement for dentists to formally register with the CDCP and adopting a claim-by-claim participation model, which significantly lowered the threshold for dentists to begin seeing CDCP patients.
- Simplifying the terms and conditions that providers were initially asked to accept, which had raised significant concerns within the dental profession.
- The speed of payment and claims processing where preauthorization is not required, ensuring that dental offices were not bearing extended cash flow gaps as a result of program participation.
- Preserving the ability for dentists to charge the difference between CDCP fees and the cost of delivering dental care (balance billing), which allows practices to continue participating and delivering dental care in a sustainable way given that CDCP does not fully cover the cost of delivering care. This is a critical element that enables dentists to participate in the CDCP and that must be maintained.

The federal government's responsiveness on program operations has also helped sustain dentist engagement. When preauthorization was introduced in November 2024, requests could take weeks or even months to process, a delay that created friction for dental offices and risked discouraging participation. Health Canada has since reduced turnaround substantially, with most requests now processed within five

to seven business days. By easing one of the more burdensome aspects of working with the program, this improvement helps keep dentists engaged in treating CDCP patients.

These changes show what is possible when federal policy is responsive to the evidence and to the perspectives of providers who deliver the care. They are also, importantly, the conditions on which current participation levels depend. Maintaining and strengthening these foundations is required to preserve the acceptance of dentists and their participation in the program which ultimately is required for the CDCP to work. The current level of dentist participation also underscores the importance of federal government consultation with the oral health care providers who deliver the CDCP. Maintaining this engagement with oral health associations, especially through the CDCP Engagement Network, is essential to continue improving the program for patients.

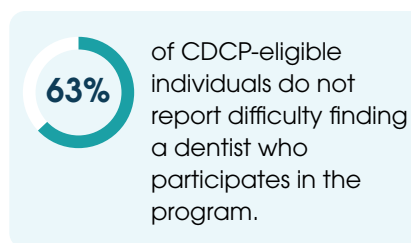
The motivations behind dentists' decision to participate also speak to the program's underlying purpose. According to the 2026 CDA dentist survey, 67% of dentists cite a desire to improve access to care for underserved patients as the top reason they chose to participate in the CDCP. This is a meaningful signal about how the profession views its role in the program: as a partner in expanding access, not simply as a service provider responding to a new payer.



At the same time, dentists are clear about what makes their continued participation possible. According to the same survey, 71% of dentists say the ability to engage in balance billing when CDCP fees do not cover full practice costs is the most important factor allowing them to continue participating in the CDCP. This reflects the operational reality that, given current reimbursement rates, balance billing is what allows dental practices to participate sustainably while continuing to serve their full patient base.

What Strong Participation Means for Patients

The strong dentist participation the CDCP enjoys today is the result of specific, responsive design choices in response to CDA and provincial and territorial dental association advocacy. These design features that have enabled broad provider participation include the claim-by-claim participation model, simplified terms and conditions, timely payment processes, and the ability to use balance billing. Maintaining these conditions is essential to preserving the dentist engagement on which patient access depends.



For most patients enrolled in the CDCP, broad dentist participation translates directly into the practical ability to find a provider when they need one. According to the 2026 Abacus Data public survey commissioned by CDA, 63% of CDCP-eligible individuals do not report difficulty finding a dentist who participates in the program, with only 16% saying they have experienced difficulty. Perceptions are broadly similar across community sizes, though respondents in larger urban centres are slightly

less likely to report challenges finding a participating dentist. This is a meaningful baseline of access that did not exist at the program’s launch and one that should be strengthened and maintained. However, in some provinces and territories with lower dentist-population ratios, patients experience significant challenges in finding a dentist.

Sources:

- CDA/PTDA survey with dentists, May 2024.

Co-ordination With Public Dental Programs

When it developed its first policy paper in 2023 titled *Bridging the Financial Gap in Dental Care*, CDA was clear that any federally-funded program had to be designed to complement and improve the care Canadians already receive through existing federal, provincial, and territorial programs. The CDA also stipulated that access to public programs should work “hand in hand” with the new federal investment, and that patients should not be limited to one or the other. Co-ordination of benefits is how those programs interact, and it is one area where, in most jurisdictions, the program is functioning largely as CDA had recommended. Jurisdiction-specific insights into co-ordination between federal and provincial dental programs can be found in Annex I.

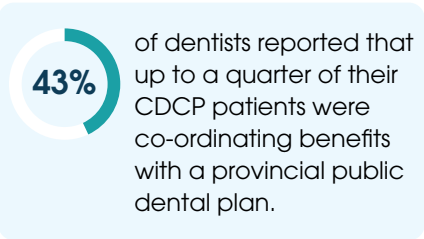
The CDCP as First Payer: What it Means for Patients’ Costs

Co-ordination of benefits means that when a patient is covered by more than one dental plan, those plans work together in a set order: one plan pays first, and the other helps cover eligible costs that remain. For a patient who qualifies for both the CDCP and a provincial or territorial program, this co-ordination can lower or eliminate what they ultimately pay. Across most provinces and territories, the CDCP has been positioned as the first payer ahead of existing public dental programs, with the provincial or territorial plan co-ordinating as the secondary payer. For patients, this ordering is important. Because the CDCP often reimburses at a higher percentage than provincial and territorial programs, co-ordination allows the provincial plan to support patients in paying the balance in some cases, reducing out-of-pocket costs further for many patients. In some cases, lower cost at the chair helps determine who avoids the dentist and whether or not they actually book and keep the appointment. Co-ordination of benefits with the CDCP has ultimately led to better access to care.

In CDA’s 2026 dentist survey, 43% of dentists reported that up to a quarter of their CDCP patients were co-ordinating benefits with a provincial public dental plan, confirming that, on the ground, a meaningful share of CDCP patients is drawing on both layers of coverage to enhance their access to care.

A broader key component has been federal engagement with provincial and territorial governments. Prior to implementation,

Co-ordination of benefits enables more comprehensive coverage and can optimize more equitable oral health care to the most vulnerable populations.



Health Canada worked with provincial ministries of health to discuss program design and co-ordination approaches. While some provinces have expressed concerns that the CDCP increases federal involvement in an area traditionally managed by provinces, the program has proceeded without constitutional challenges.

The Risk to Patients: Provinces Stepping Back

The expansion of federal dental coverage presents an opportunity to enhance overall access to care while maintaining the strength of established provincial programs. In 2023, CDA cautioned the federal government to ensure that federal investment should not become a reason for existing provincial and territorial programs to be scaled back or cancelled. That risk is now materializing in some jurisdictions. For example, in March 2026, Manitoba announced it will no longer provide dental benefits to individuals receiving income assistance from the province who are eligible for the CDCP. This change will fall hardest on the most vulnerable, many of whom cannot afford the difference between the CDCP fees and the provincial suggested fee guide. In British Columbia, the perception that the CDCP “fills the gap” has been cited in connection with frozen dental fee schedules for patients on social assistance and the discontinuation of funding from not-for-profit clinics serving vulnerable populations. In these cases, the consequence is not better co-ordination but the opposite: when provincial support disappears, the patient is left to absorb the gap, and access narrows for the very people public coverage is meant to protect.

When a Province Opts Out: Protecting Access to Care

Some provinces have indicated an intention to opt out of the CDCP. Alberta, for example, has notified the federal government of its intent to withdraw from the program. Furthermore, Quebec has likewise indicated intent to receive compensation and integrate any federal funding into its existing system. How federal, provincial, and territorial governments resolve these fiscal and jurisdictional questions is properly a matter for those governments.

However, patients must not be the ones left to absorb the consequences of how those arrangements are settled. The access to care that patients have gained through the historic federal investment in oral health should not be interrupted, reduced, or made harder to navigate simply because responsibility for it shifts from one government to another. Where a province or territory chooses to opt out, clear parameters should be agreed and in place before any transition takes effect, so that continuity of access is protected in practice and not only in principle.

Where a province or territory chooses to opt out, clear parameters should be agreed and in place before any transition takes effect, so that continuity of access is protected in practice and not only in principle.

At a minimum, this means patients should retain coverage that is comparable to or better than the CDCP; that there should be no gap in coverage while responsibility is transferred; that patients and dental offices should not be left to navigate a more complex or contradictory system during the change; and that transparent public reporting and data should confirm, on an ongoing basis, that access is being maintained. Where funding follows a province out of the program, it

should remain tied to patients' oral health outcomes rather than transferred without conditions, so that dollars intended to expand access continue to do so.

Legislative Clarity and Co-ordination Across Public Dental Plans

A clear legislative and policy framework can strengthen co-ordination between federal and provincial or territorial dental programs by providing greater certainty around roles, responsibilities, and benefit interactions. Current agreements between the federal government and individual provinces and territories are established separately, allowing jurisdictions flexibility in program design and administration. While this approach accommodates regional differences, it can also result in varying co-ordination models, including whether the CDCP functions as a first payer. This highlights opportunities for greater consistency and standardization over time to ensure that eligible individuals who cannot afford dental care do not fall through the gaps due to eligibility issues.

Quality and Standard of Care

The care covered through the CDCP is generally viewed as comparable to other federal and provincial dental programs. This alignment supports equitable access to clinically appropriate services and reinforces confidence among patients and providers. Maintaining consistent quality standards across public dental programs can help ensure that Canadians receive reliable and effective oral health care regardless of their source of coverage.

Consultation and Collaboration With Provinces and Territories

Given the diversity of provincial and territorial oral health systems, ongoing consultation and collaboration between federal, provincial, and territorial governments remains essential to ensure policies are responsive to regional needs and priorities. Early engagement between the various stakeholders helped inform implementation considerations, recognizing that each jurisdiction operates within a unique policy and program environment. While the extent of current discussions may vary, continued dialogue can support co-ordinated decision making and help address emerging challenges as public dental programs evolve.

What This Means for Patients

The overall picture is genuinely positive: where the CDCP has been co-ordinated with provincial and territorial plans as CDA recommended, patients are seeing lower costs, easier access, and the kind of "hand in hand" public coverage CDA's 2023 recommendations called for.

CDA Recommendations

To protect the long-term sustainability of the CDCP and preserve provincial and territorial dental coverage, CDA recommends that the federal government:

- **Work with provinces and territories to ensure that CDCP neither displaces public dental programs nor enables further delays in their critical modernization**, so that patients who rely on both layers of coverage are not left to absorb the costs when provincial or territorial support be scaled back.

Areas of Concern



Gaps and Risks for Patient Access and Outcomes

Coverage is not the same as access. A patient can be enrolled in the CDCP and still face obstacles to receiving timely access to appropriate care. This section examines where gaps remain and what they mean for patients. The concerns range from limited coverage, confusion about what is covered leading to unexpected out-of-pocket costs, financial barriers that persist, administrative friction and pressures that affect the availability of providers, and systems-level challenges.

Financial Barriers Persist for Many CDCP Patients

The CDCP has meaningfully reduced the cost of dental care for many patients, and the program's positive impact on affordability is real and well documented. According to a March 2026 national public survey commissioned by CDA and conducted by Abacus Data, 75% of CDCP patients say the program has made dental care more or somewhat more affordable for them, and 55% say the CDCP has generated additional savings they can now direct to groceries and other necessities. These are meaningful outcomes for lower-income Canadians and reflect real progress.

However, a significant proportion of patients enrolled in the CDCP continue to face financial barriers to care even with the program's assistance. According to the same survey, **37% of those eligible and enrolled say they are still experiencing financial barriers to dental care even with CDCP coverage.** This is not a marginal finding. It suggests that there is a structural gap between what the program promises and what many of its intended beneficiaries can actually afford.

The out-of-pocket costs patients face under the CDCP are the result of reimbursement rates set below the true cost of care. Addressing that gap is the only durable path to reducing financial barriers for patients.

37%

of those eligible and enrolled say they are still experiencing financial barriers to dental care even with CDCP coverage.

Source: Abacus Data, March 2026

What Patients Are Experiencing

Out-of-pocket costs under the CDCP, including co-payments and charges for services not fully covered, are a source of financial strain for many patients and, sometimes, a direct deterrent to using the program. This leaves a large portion of patients still at risk of not receiving care resulting in potential future impacts on the health care system due to missed early diagnoses and preventative care. Among CDCP-enrolled patients who have not yet used their coverage, 26% say the reason is that they cannot afford the co-pay or provider's costs, even with CDCP's subsidy. Furthermore, additional challenges patients face reflect early public messaging from the federal government that framed the CDCP as free dental care, a misconception that persists among patients today.

26%

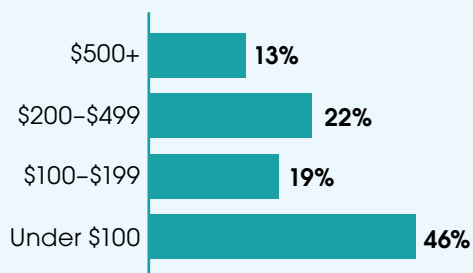
of patients enrolled in the CDCP who haven't used their coverage, blame unaffordable co-pays or provider costs, despite the subsidy.

For those who have used the program, the cost burden is often higher than expected:

- 13% of CDCP patients say they paid over \$500 on average for a single dental appointment; 41% paid between \$100 and \$499.
- However, 63% of CDCP patients say they would only be comfortable paying less than \$100 for costs not covered by the CDCP. This is a threshold that many appointments already exceed.

For many patients, out-of-pocket costs remain a significant barrier to accessing needed dental care.

What patients paid out-of-pocket for a single dental appointment



54%

More than half of patients paid over \$100 out-of-pocket for a single appointment.

Comfort level with paying for costs not covered by the CDCP



63%

of CDCP patients say they would only be comfortable paying **less than \$100** for costs not covered by the CDCP.

54%

of patients exceeded that \$100 threshold.

Source: Abacus Data, March 2026

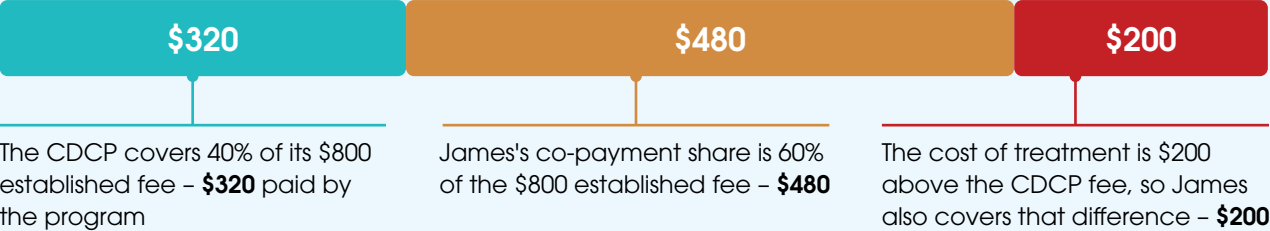
Meet James

James is 58 and self-employed, with no dental benefits through his work. His adjusted family net income is \$85,000, which places him in the CDCP's highest co-payment band: the program covers 40% of the CDCP fee, and James is responsible for the remaining 60% co-payment, plus any additional charges.

James needs a crown. The cost of treatment at the dentist is **\$1,000**; the CDCP's established fee for the same service is **\$800**.



What James pays:



James's total out-of-pocket cost: \$680.

* This is a hypothetical example for illustration. The dollar amounts are simplified and do not represent actual CDCP fees or the cost of any specific treatment. It is intended only to show how the CDCP's co-payment structure and the gap between CDCP fees and the cost of care affect what a patient pays out of pocket.

Why Out-of-Pocket Costs Persist: A Program Design Issue

The persistence of out-of-pocket costs under the CDCP is a direct consequence of how the program was designed. First, CDCP household income-based co-payment levels mean that some patients (those above the lowest income tier) do not receive the full CDCP established fee and have to pay a portion of it.

The second, and the more universal one, is that CDCP fees are set below the provincial and territorial suggested fee guides, which reflect the actual cost drivers of delivering care, including clinical materials, infection prevention and licensing, facility costs, staffing, and equipment. CDCP fees cover only a portion of dental treatment costs, and, in most cases, patients are left to cover the remaining balance. That balance is a normal part of how dental care is funded whenever a plan pays less than the cost of care, and it is the structural reason many CDCP patients face charges beyond their co-payment. The ability for providers to bill this difference is what makes their participation in the program sustainable, and it must be maintained. Because the size of that balance depends on how far CDCP fees sit below the cost of care, sustainable program funding is what keeps the amount patients pay out of pocket reasonable.

The most direct way to address financial barriers that still exist for patients is to bring CDCP fees closer to the actual and regional costs of providing dental care, so that less of the gap is passed to patients, paired with clearer public communication about what the CDCP does and does not cover would help patients better understand and access the program for their oral health needs.

CDA Recommendations

For the CDCP to deliver on its promise of meaningful financial relief for lower-income individuals, the federal government must address the reimbursement gap that is the root cause of persistent out-of-pocket costs. CDA recommends that the government:

- **Reduce or eliminate out-of-pocket costs for CDCP patients** by aligning CDCP fees with the actual costs of providing dental care.
- **Assess whether co-payment requirements are discouraging eligible patients from seeking dental care.** If evidence shows co-payments are creating affordability barriers, the program should be adjusted to better support access to care, especially for patients in income brackets requiring a co-payment.

Is the CDCP Reaching the Canadians It Was Designed to Serve?

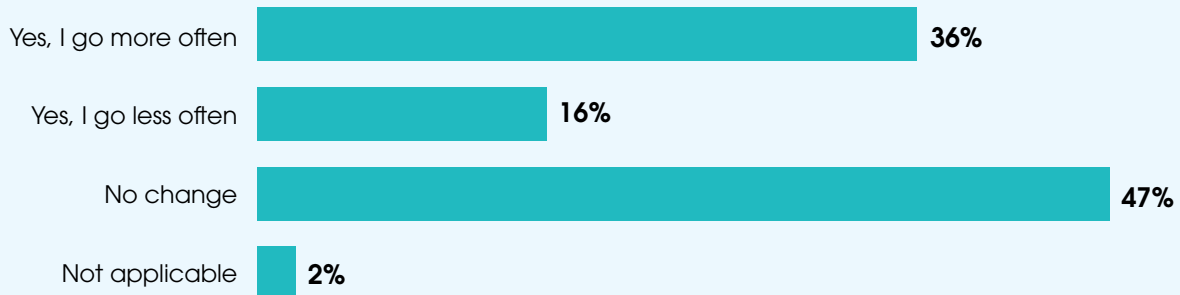
The CDCP was introduced with a clear policy intent, which was to expand access to dental care for individuals who lacked dental insurance and faced financial barriers to receiving care. Two and a half years into implementation, preliminary findings from a March 2026 national public survey commissioned by CDA raised an important question that warrants closer examination: how much has the program increased access for those who were not receiving care, as opposed to reducing costs for patients who were already receiving regular care?

What the Survey Data Suggests

The survey results point to a pattern that merits attention and suggests that the program may disproportionately benefit those who were already engaged in regular care. Among CDCP-eligible individuals, approximately half report having visited the dentist regularly prior to the program's introduction: 22% every twelve months and another 28% two to three times a year, while the other half went rarely or only when in pain. Among patients who have received at least one appointment under the CDCP, when asked if the CDCP has changed how often they go to the dentist, 36% report visiting more often than before, 16% report visiting less, 47% report no change in how often they go. When asked how the quality of dental care they receive now compares to before they had CDCP coverage, only 4% indicated they did not receive dental care prior to the CDCP (31% say better, 5% say worse, and 59% say about the same). Read together, these findings raise a preliminary question about whether the program is primarily expanding access for previously underserved Canadians or supplementing the costs of care for those who were already receiving it.

Change in Frequency of Dental Visits Since CDCP

Has the CDCP changed how often you go to the dentist?

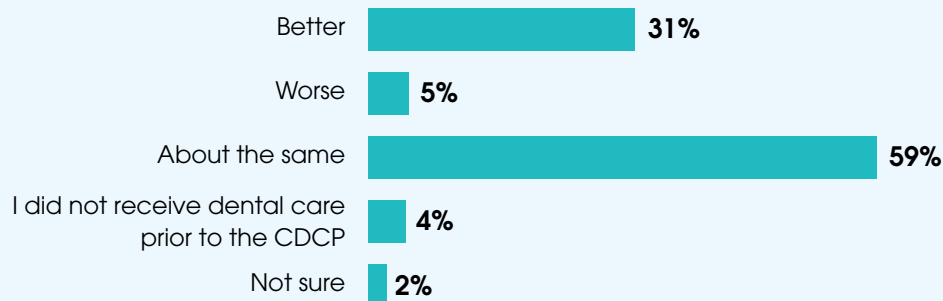


(Those who have had at least one appointment under the CDCP) n=669

Source: Abacus Data

Perceived Change in Quality of Dental Care Since CDCP

Compared to before you had CDCP coverage, the quality of dental care you receive now is...



(Those who have had at least one appointment under the CDCP) n=669

Source: Abacus Data

Qualitative survey data received by CDA from dentists across the country reinforces the broader survey findings. Practitioners report that a meaningful share of patients now using the CDCP were already established patients of record in their practices prior to the program. While anecdotal, this perspective is consistent with the survey data and adds to the case for a more rigorous examination.

It is important to be clear about what these findings do and do not show. Reducing out-of-pocket costs for those who were already accessing care has real value from an affordability standpoint, particularly for lower-income households. Many of these patients may have been stretching their budgets to maintain dental visits, and the program's role in easing that financial pressure should not be dismissed. But a program designed first and foremost to expand access to those previously uninsured delivers its greatest return when its support reaches those facing the highest barriers, including those who were not seeing a dentist at all. The survey data suggests that a considerable portion of the CDCP's benefits may be flowing to individuals who may already have been in the system and whose access patterns have not meaningfully changed. That is a signal worth investigating because it raises a legitimate question about whether the program's design and outreach could do more to draw in and

support those with the greatest unmet need, so that public investment delivers the largest possible gain in access for patients. Program evaluation should also review service coverage to ensure that current funding allocation aligns with clinical need and best serves the CDCP's target population.

These are self-reported survey findings and should not be interpreted as definitive conclusions about the program's targeting and performance. Surveys carry methodological limitations, and a full assessment of CDCP targeting effectiveness would require access to administrative claims data, tax filing information, and population-level health data that are not currently available in the public domain. What the survey findings provide, however, is a credible sign that suggests this is an area in which the program's real-world impact may diverge from its intended design, and one that justifies independent evaluation.

Structural Gaps in Eligibility Design

The CDCP relies on federal income tax filing to establish eligibility, which means individuals who do not file taxes (a group that disproportionately includes vulnerable individuals) may be unable to access the program. The reliance on income tax filing may be limiting the program's ability to reach segments of the population most likely to have lacked access to dental care in the first place.

The scale of this gap is not trivial. Research by Robson and Schwartz estimates that between 10% and 12% of Canadians do not file a tax return in a given year, and that some 2.4 million working-age adults did not file for the 2015 tax year alone, forgoing significant federal benefits they were entitled to. Canada Revenue Agency research further finds that non-filing is concentrated among adults under 30 and people who are housing-insecure, who are each meaningfully less likely to file than the general population. Because CDCP eligibility is established through the tax system, these are the same individuals most likely to be left outside the program by design, even when their income would otherwise qualify them.

Some Canadians Miss Out on Benefits Because They Don't File Tax Returns



10%–12%

of Canadians do not file a tax return.



2.4 million

working-age adults did not file a tax return for 2015.

Source: Robson and Schwartz

A 2025 peer-reviewed analysis published in the *Journal of the Canadian Dental Association* likewise identified reliance on tax filing as a structural constraint on the program's reach, noting that individuals below the poverty line, among those who would benefit most from the CDCP, are also among the least likely to file a return.

Recent government initiatives and changes to automatic tax-filing processes may help reduce this barrier over time for some individuals, but they are unlikely to fully address the underlying access gap. The Parliamentary Budget Officer has estimated that fully automating tax filing for non-filers could deliver up to \$1.7 billion in additional benefit payments annually (such as the Canada Child Benefit, GST/HST credit, etc.), underscoring both the size of the population currently missed and the potential reach

of automatic-filing measures. However, analysis by the C.D. Howe Institute cautions that recent federal automatic-filing initiatives are largely aimed at individuals who already file, and may not reach the hardest-to-reach non-filers.

At the other end of the spectrum, the program's reliance on household income alone, raises a separate equity question. Relying on income alone may, in some cases, result in support being directed to individuals with greater financial means than the eligibility criteria suggests. It is understandable that, in launching a program of this scale and scope within a relatively short timeframe, policymakers relied on federal income tax information as a readily available and administratively efficient means of determining eligibility. As the program matures, it will be important to assess whether reported household income remains the most appropriate proxy for affordability and to consider whether additional measures could improve the targeting of benefits. Evaluating the strengths and limitations of the current eligibility approach should form part of the program's ongoing review to ensure public resources meet the policy objectives of the program.

The Income Thresholds and Co-payment Structure

The way the program's income thresholds and co-payment criteria were set raises a further set of design questions. It remains unclear how the income thresholds were chosen, why eligibility rests on household rather than individual income, and what evidence established that households earning under \$90,000 were the most likely to lack dental coverage. These are reasonable questions for a program of this scale.

The reliance on a single national household-income threshold also raises an equity concern, because incomes and cost-of-living pressures vary widely across the country. A uniform threshold may produce a disproportionately large eligible population in some jurisdictions while failing to capture residents facing real financial hardship in others. For example, the cost of living and expenses for a person living on a \$75,000 salary in rural Ontario will vary significantly from someone living with the same salary in downtown Vancouver. Established federal measures of low income, such as the Market Basket Measure (MBM) and the Low Income Cut-Off (LICO), account for household size and regional cost differences precisely because living costs are not uniform across Canada.

There is also the question of whether co-payment itself blunts the program's reach. The co-payment applies only above the lowest income tier, so its effect falls on a specific band of enrollees, roughly those in households earning between \$70,000 and \$90,000. According to information received from Health Canada, only a small proportion of CDCP members have a co-payment, which concentrates its effect on that band. For those patients, even a modest, required contribution may be enough to delay or forgo recommended care, an affordability barrier documented in the section on financial barriers. If the co-payment is discouraging care-seeking among the very households the threshold was meant to capture, then enrollment is not translating into access, which is the question at the heart of this section. Again, this also creates significant equity issues: households earning between \$70,000 to 90,000

in some regions of the country may be experiencing affordability issues much more so than those in other parts of the country.

A Signal That Warrants Deeper Investigation

Some of the findings highlighted in this section are based on public survey data and should not be interpreted as definitive conclusions about the program's targeting and performance. A full assessment of CDCP targeting effectiveness would require access to administrative claims data, tax filing information, and population-level health data that is not currently available in the public domain. What the survey findings provide, however, is a credible sign that suggests this is an area in which the program's real-world impact may diverge from its intended design, and one that justifies a more thorough investigation.

CDA Recommendations

To ensure that the CDCP delivers on its core purpose of expanding access to dental care, CDA recommends that the federal government:

- **Commission a formal, independent evaluation of CDCP targeting effectiveness.** This evaluation should draw on administrative claims data, tax filing patterns, and population-level health data to assess whether the program is meaningfully reaching those who previously lacked access to dental care and consider if there are vulnerable populations outside of current eligibility requirements who may be underserved in access to oral health care.
- **Review eligibility and co-payment design** to address structural barriers and equity gaps. As part of any evaluation, the federal government should examine whether current criteria, including the reliance on federal income tax filing, the use of a single national income threshold without accounting for regional differences, and the co-payment structure, may be limiting the program's ability to reach patients it was intended to help.

Sources:

- Jennifer Robson & Saul Schwartz, "Who Doesn't File a Tax Return? A Portrait of Non-Filers," *Canadian Public Policy*, 46:3, 2020; 323.
- Office of the Parliamentary Budget Officer, *Delivering Automatic Federal Benefits for Low-Income Individuals*, 2026, and *Expansion of SimpleFile by Phone*, 2024.
- C.D. Howe Institute, *Simple on Paper, Complex in Practice: The Limits of Automatic Tax Filing*, 2026.
- Brondani, Faria-e-Silva, Jessani & Ardenghi, "Initial Findings from the Canadian Dental Care Plan: Policy in Action," *Journal of the Canadian Dental Association*, 2025; 91: p15.

Administrative Burden on Dental Offices Affecting Patient Outcomes

The CDCP generally does not work like most private dental plans that dental offices are typically accustomed to. Participating in the CDCP requires dental offices to absorb additional administrative workload, including time spent on claims submissions and verifications, eligibility confirmations, preauthorization requests, patient explanations, and navigating the operational mechanics of a large public program. Every minute spent on program administration is a minute not spent on patient care.

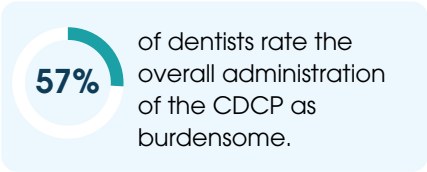
Administrative complexity affects treatment decisions, appointment scheduling, staff time, and patient understanding. The program has created an additional administrative layer between patient and provider. Patients feel that layer as well, encountering its effects through uncertainty about their coverage, delays

while approvals are resolved, and the need to keep their eligibility current from year to year. For a program whose success ultimately depends on willing provider participation, sustained administrative friction is a direct risk to patient access.

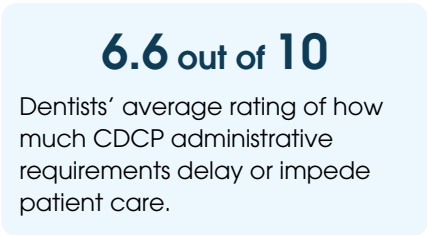
This section provides an overview of administrative challenges of CDCP participation for dentists, with attention to several structural issues that, while distinct, contribute to the overall burden.

How Dentists Are Experiencing CDCP Administration

According to a 2026 CDA survey of dentists, 57% of dentists rate the overall administration of the CDCP as burdensome, with another 30% describing it as only somewhat manageable. Critically, 68% of dentists say the administrative requirements of the CDCP are more difficult than those of other private insurance plans they work with. For practices that have decades of experience navigating private insurance, this comparison points to operational challenges specific to the design and execution of the CDCP itself.

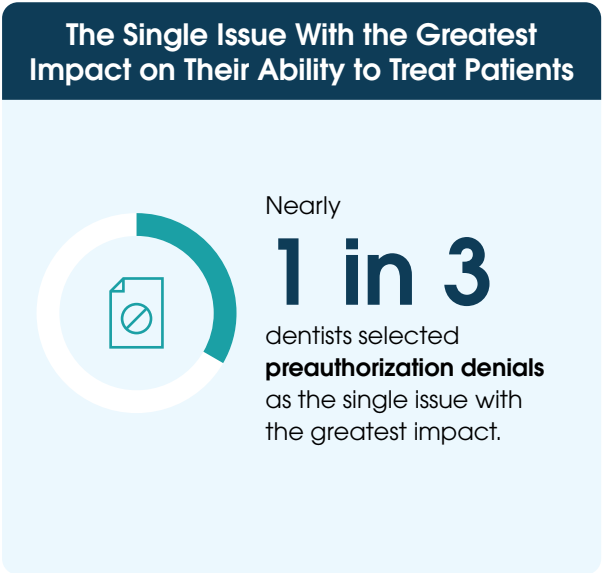
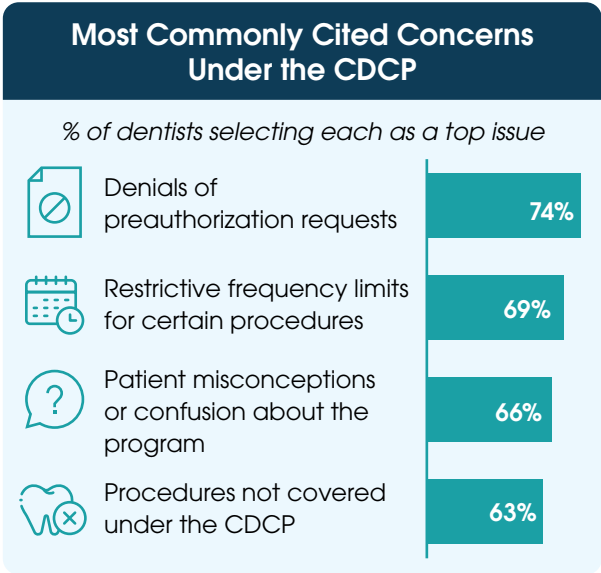


Dentists report that this burden has a tangible impact on patient care, rating the effect of CDCP administrative requirements on delaying or impeding patient care at 6.6 out of 10. When asked to identify the top issues they face under the CDCP, the most commonly cited concerns were denials of preauthorization requests (74%), restrictive frequency limits for certain procedures (69%), patient misconceptions or confusion about the program (66%), and procedures not covered under the CDCP (63%). When asked to select the *single* issue with the greatest impact on their ability to treat CDCP patients, nearly a third of dentists chose preauthorization denials.



Top Issues Faced by Dentists Under the CDC

What Dentists Say



Structural Administrative Issues Unique to the CDCP

Several structural features of the CDCP create administrative friction that does not arise to the same extent under standard private insurance plans:

- **Preauthorization challenges:** preauthorization denials are leaving patients with untreated conditions, and they lead to additional layers of administrative work: offices must submit requests, wait for responses, handle denials, and often resubmit. This issue will be addressed in greater detail in the following section.
- **Program complexity leading to patient confusion:** the same program complexity that creates administrative burden for providers also generates confusion for patients about their eligibility, coverage, and likely costs. That confusion is most often left for the dental office to resolve, with staff fielding questions and managing the frustration of patients who arrive with unclear expectations. This issue is examined in greater detail in the sections that follow.
- **Third-party administration challenges:** the CDCP is administered by a third-party insurer, and dentists report variability in training and service quality across call centre agents, and contradictory information depending on who they reach (which has resulted in incorrect information being shared with dental offices). These inconsistencies generate avoidable rework for dental offices and delays for patients.
- **Participation challenges:** providers generally report that participating in the CDCP has become more accessible, supported by improved terms and conditions and alternate pathways for submitting claims. However, one structural concern remains, related to the separation between the public CDCP and the private business lines of the program's third-party administrator. Under current practice, a dentist who is in good standing with their provincial regulatory college, but who has been removed from the administrator's private insurance network, can be prevented from participating in the CDCP (delisted). The concern is that eligibility to participate in a federal public program may effectively be determined by decisions taken within a separate, private commercial context, without an independent oversight or appeal pathway.
- **Claims process and verification:** for approved claims, reimbursement is generally efficient, with minimal payment delays. Friction arises mainly when a claim is selected for verification or audit, a process in which providers report receiving inconsistent information about what documentation is required and how decisions are reached. Formal reconsideration and appeal mechanisms exist for both preauthorization and claims verification decisions, but awareness of these mechanisms among providers is low, the process to use them is not well streamlined, and little information is available on how often they are used or with what outcomes. Some providers who have pursued appeals report that the original decision is rarely overturned, which discourages others from initiating the process at all.
- **Patient eligibility verification:** a consistent administrative challenge for dental offices relates to verifying patient eligibility. Eligibility can change throughout

the year as a result of changes in a patient's circumstances (income, employer-based benefits, etc.), and services are only covered if provided while the patient is eligible. This creates challenges when treatment plans extend over multiple appointments, and a patient loses eligibility midway through treatment. Providers must continuously verify eligibility through electronic data interchange (EDI) systems or by contacting the CDCP third-party administrator directly, and patients are required to reapply annually. For patients, the concern is about continuity of coverage. Because eligibility must be renewed each year and can lapse when a patient's circumstances change, a patient can move from eligible to ineligible partway through a planned course of treatment, leaving that treatment unfinished or resulting in an unexpected cost.

- **More burdensome than private plans:** participation in the CDCP is widely perceived as creating a greater administrative burden than managing comparable patients under private dental insurance plans. For example, preauthorization requirements are generally more extensive than private plans. Further, the CDCP does not allow non-assignment billing, a standard option under most private insurance plans in which the patient pays the dentist directly and is reimbursed by the insurer. The absence of this option means some dental offices must adapt their billing processes to accommodate program requirements that differ from standard industry practice.

What This Means for Patient Access

Administrative burden is a provider-facing issue with patient-facing consequences. It is also felt by patients directly: they navigate confusion about what is covered and what they will pay, they wait while preauthorization requests are prepared and resolved, and they can face a gap in coverage when annual eligibility is not renewed in time.

CDA recognizes that public programs carry layers of administration that other plans do not, and that mechanisms for verifying eligibility, processing claims, and documenting care also reflect the legitimate responsibility to manage public funds prudently, safeguard program integrity, and maintain accountability to Parliament and to the public. These are appropriate features of any publicly funded plan. At the same time, sustained administrative friction presents a risk to provider participation over time, and where providers find continued participation difficult to sustain, it is patients who ultimately bear the cost through reduced access to care. Streamlining program operations, without compromising the oversight that responsible stewardship requires, is therefore important to the CDCP's long-term ability to deliver on its access mandate.

CDA Recommendations

A program that is administratively sustainable for providers is a program that remains available to patients. Improving the operational design of the CDCP is foundational to the access outcomes it was created to deliver.

- **Strengthen the CDCP third-party administrator’s support contact centre**, with particular focus on consistent agent training and accurate information provided to dental offices and patients.
- **Improve the CDCP claims verification and appeals process** through clear and timely communication, third-party administrator system enhancement and flexibility, and greater transparency on reconsideration and appeal outcomes.
- **Simplify eligibility renewal and protect continuity of coverage** by providing patients with timely renewal reminders and establishing an exceptional circumstances pathway, so that eligible patients do not experience coverage gaps that interrupt an active course of treatment.

Preauthorization and Demonstrating Need as Barriers to Care

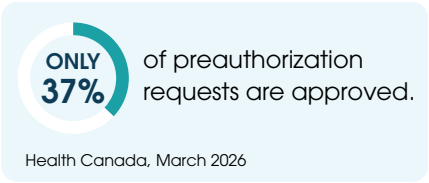
The CDCP funds dental care from a defined set of covered services, and it applies its own medical necessity criteria to determine which treatments qualify for coverage. For certain treatments, that determination is made in advance and case by case: before a patient can receive care, the program must approve the treatment through a process called preauthorization. Preauthorization was introduced as a program-integrity measure. In practice, it has a significant point of friction in the program. For patients, it delays or prevents access to recommended treatment.

Seven in ten dentists report that preauthorization denials are affecting their patients’ oral health outcomes, and half of patients say it is a barrier to routine care.

High Rate of Denials

The clearest sign of the problem is the denial rate. According to Health Canada, as of the end of March 2026, only 37% of preauthorization requests are approved when all submissions, including incomplete ones, are counted. When incomplete submissions are set aside, the approval rate is 50%, meaning that even among complete, properly prepared requests, half are denied. For a program designed to expand access to care, this is a high rate of refusal, and behind each denial is a patient whose recommended treatment is delayed, altered, or not received. Common reasons cited for denial include incomplete information, missing documentation, and not meeting the program’s medical necessity criteria.

It may be argued that preauthorization affects a small share of overall CDCP total claim volume. However, preauthorization denials can mean a recommended treatment is delayed, allowing a manageable condition to progress to pain, infection, tooth loss, or a more invasive and costly intervention later. For vulnerable populations and patients that have more complex oral health needs, this can have a significant impact on their oral health outcomes.



What Patients and Dentists Report

This challenge is felt by both dentists and patients. According to the 2026 Abacus Data survey, 23% of CDCP patients report that preauthorization requirements caused significant delays in their treatment or led them to postpone or cancel care altogether, and 50% report that preauthorization is a barrier to routine dental care. For patients already managing complex health needs and with limited capacity to navigate a complex approvals process, these challenges translate into deferred treatment and worsening oral health.

 A donut chart with a teal segment representing 23% of the total.

23%

of CDCP patients report that preauthorization requirements caused significant delays in their treatment or led them to postpone or cancel care altogether.

 A donut chart with a teal segment representing 50% of the total.

50%

report that preauthorization is a barrier to routine dental care.

Dentists share this concern. According to the 2026 CDA dentist survey, 45% of dentists view the preauthorization process negatively, citing delays, unclear requirements, and administrative burden. When dentists were asked to identify the top issues they face under the CDCP, the most commonly cited was denials of preauthorization requests (74%). When asked to select the single issue with the greatest impact on their ability to treat CDCP patients, nearly a third pointed to preauthorization denials. Critically, 71% of dentists report that their patients' oral health outcomes have been affected by preauthorization denials to a great or moderate extent.

 A donut chart with a teal segment representing 71% of the total.

71%

of dentists report that their patients' oral health outcomes have been affected by preauthorization denials to a great or moderate extent.

Source: CDA Dentist Survey, 2026

Where the Process Breaks Down

Denial notices and explanations of benefits are often too vague to act on: they may not specify why a treatment was refused, which criterion was not met, or what documentation would resolve it. This leaves patients waiting while their dentists try to determine what additional information is required, adding time before treatment can proceed. Dentists report that the most helpful improvements would be clear identification of the specific eligibility criteria that were not met and a fuller explanation of each denial. Patients need to know what will and will not be covered before treatment begins, both so they and their dentists can choose appropriate and timely treatment pathways. This also allows dentists to meet their regulatory and, where applicable, legislative obligations to obtain informed consent by discussing treatment options, costs, and any expected patient charges up front.

At the centre of preauthorization is the concept of medical necessity; the standard the CDCP uses to decide whether a treatment qualifies for coverage. The difficulty is that the specific criteria are not publicly disclosed. Dentists must plan treatment and justify their recommendations against a standard they cannot see, with no reliable way to tell a patient in advance whether the care they need will be covered. Many report that even when they submit extensive documentation, requests are frequently denied or returned as incomplete and that CDCP medical necessity criteria feel distinct from their own clinical assessment of what a patient needs. The CDCP Benefit Guide, the program's official document setting out its rules, limitations, and covered

services, has improved since implementation, but many dentists believe it could go further in recognizing their professional clinical judgment.

The process is also more demanding than what patients and dentists encounter elsewhere. Preauthorization is a feature of many private plans, but CDCP requirements are more documentation-intensive and harder to navigate, and some practice management software programs are still developing capability to submit attachments electronically, as required by the CDCP. This forces some offices back onto slower paper-based processes. The volume of incomplete submissions also points to a provider-education gap: targeted investment in provider education would help reduce an avoidable source of delay. These sources of friction are compounded by challenges within the preauthorization decision process, including unclear communication from the CDCP third-party administrator call centre representatives and inconsistent guidance. The system is meant to keep costs low for patients at the point of treatment, but it must also support timely access to care and reflect the practical realities faced by dental offices and patients when treatment cannot be delayed.

Improvements Thus Far

It is worth acknowledging that the CDCP remains a new and complex program, and that the federal government has made efforts to improve the information dentists receive when a denial is issued. These are steps in the right direction. However, the scale of the problem and its direct impact on patients requires sustained attention.

Importantly, one dimension of preauthorization has improved markedly, and that progress deserves recognition. When preauthorization was first introduced in November 2024, requests could take anywhere from several weeks to several months to be processed, leaving patients waiting extended periods before their dentists could proceed with treatment. The federal government has since made significant operational improvements, and most requests are now processed within five to seven business days. This is a significant achievement that has meaningfully reduced the time patients wait for a decision on recommended care. The challenges that remain with preauthorization are therefore the high rate of denials and the limited explanation provided when a request is not approved.

The Impact for Patients

The consequences of high denial rates are felt directly by patients. Care is paused while the dentist resubmits or appeals, and treatment that was clinically recommended can be deferred for weeks or abandoned altogether. Crowns have emerged as a particularly significant pain point, despite being a common restorative treatment that is generally easier to obtain coverage for under private insurance plans.

In summary, preauthorization denials are leaving patients with untreated conditions, and they lead to additional layers of administrative work: offices must submit requests, wait for responses, handle denials, and often resubmit. Patient confusion is placing an unnecessary burden on dental offices, who must explain the program rather than deliver care. It also frustrates patients who are struggling to understand

the disconnect between their provider's treatment recommendations and what is approved by the program, creating friction at the point of care that undermines the patient experience and patient-dentist relationship. These challenges matter for one reason: every added step between a recommended treatment and an approval is added time before a patient receives care.

CDA Recommendations

Oral health needs are best assessed by the treating provider, not solely through uniform coverage rules. Ensuring the CDCP delivers timely access to care to patients who need it most requires addressing barriers within the preauthorization process. CDA recommends that the federal government:

- **Improve the transparency and predictability of the preauthorization process** by providing dentists with clear information on clinical acceptance criteria, and specific explanations when requests are denied, identifying unmet needs.
- **Invest in targeted provider education and practical guidance on preauthorization requirements** to improve submission quality, reduce avoidable delays, and support more efficient access to care.
- **Modernize and streamline the CDCP's third-party administrator preauthorization systems and processes** by improving electronic submission capabilities, ensuring compatibility across practice management software platforms, reducing reliance on paper-based workflows, and providing timely, consistent communication throughout the adjudication process.

Sources:

- Health Canada, Canadian Dental Care Plan Program Data, as of March 31, 2026.

Coverage Limitations and Gaps

The CDCP offers a range of services that can meet the basic dental care needs of eligible patients. However, for patients, especially those with more complex dental needs, the program's coverage limitations create meaningful barriers to receiving the care they need and define the boundary between what dentists deem necessary and what is covered by the CDCP. Providers are required to comply with CDCP coverage criteria, guidelines, and policies, which means working within a defined basket of covered services.

Coverage Limitations: a Gap for Patients

Not all dental services are covered under the CDCP, and coverage limitations and frequency restrictions limit patients' access to recommended care. Some necessary or more complex treatments are only partially covered or not covered at all. Coverage for treatments such as crowns and dentures may be reduced under the CDCP non-insertion policy, which applies when a laboratory-fabricated item is completed but cannot be inserted for reasons beyond the provider's control. While dentists and patients generally retain the ability to make treatment decisions together, coverage limitations can influence treatment choices in practice. Some patients may opt for treatments that are covered under the CDCP rather than those

that are clinically preferred or recommended by their dentist because of cost considerations.

CDCP coverage decisions are also based on program-specific medical necessity thresholds as mentioned in the previous section, which may differ from the evidence-informed or preventive standards commonly used in clinical dental practice. As a result, treatments that a dentist would normally recommend based on preventive care, disease progression, or accepted best-practice standards may not meet the program's eligibility criteria, even when they are clinically appropriate and professionally justified.

The scale of this gap is significant. According to a 2026 CDA survey of dentists, when considering the care they recommend to patients, **70% say that some of the recommended care is covered under the CDCP. Only 17% say that most is covered, and 11% say very little is covered.**

This aligns with patient experience: a March 2026 national public survey commissioned by CDA and conducted by Abacus Data found that **20% of CDCP patients would like to see**

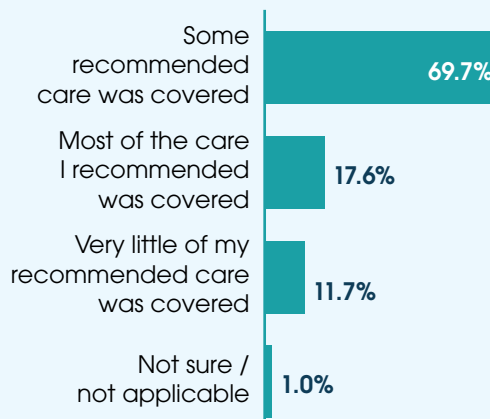
increased coverage for specific treatments and higher coverage limits under the program.

There is also a downstream concern stemming from coverage limitations worth highlighting. When patients are repeatedly told that certain services are not covered by the CDCP, many may infer that those services are simply unnecessary. This is a quiet but meaningful harm to oral health literacy. Over time, this can erode patients' understanding of what comprehensive dental care entails, with consequences for long-term oral health outcomes.

Dental Care Recommended to CDCP Patients

Which Statement Best Describes Dentists' Experiences? (n=1001)

Thinking about the dental care you recommend to CDCP patients, which statement best describes your experience?



Nearly 7 in 10 dentists say only some of the recommended care they advise is covered.

Coverage of Preventive Services and Prevention-Oriented Care

Dentists identify limitations in the coverage of preventive services under the CDCP, noting that preventive care appears to receive less emphasis than restorative treatment. Examples frequently cited include the lack of coverage for additional units of scaling, root planning, and fluoride treatments, along with no coverage for services like nutrition counselling, oral hygiene instruction, bruxism-related care and management of temporomandibular joint disorders. More broadly, the current design of the program focuses on restoring oral health needs after problems arise rather than emphasizing prevention, health promotion, and long-term disease reduction.

Prioritizing prevention within the CDCP can improve oral and overall health while making the program more sustainable. In addition to improving general access to dental care, by encouraging regular checkups, cleanings, and early intervention, the program can reduce the need for costly restorative treatments and prevent avoidable dental-related emergency department visits. Investing in prevention not only improves patient outcomes but also lowers long-term costs for the CDCP and the health care system as a whole.

Coverage Does Not Adequately Reflect Patient Risk or Complexity

Dentists expressed concerns that coverage rules do not sufficiently account for differences in patient risk, age, disability status, or the complexity and time required to provide treatment. Because CDCP coverage is generally based on standardized service limits rather than patient-specific risk factors, opportunities for targeted prevention may be missed. Dentists noted that patients with higher levels of need, such as seniors, individuals with disabilities, and those at elevated risk of oral disease, often require more intensive preventive care (particularly for services such as scaling and root planing) and ongoing management than is reflected in current coverage parameters.

Challenges Accessing Specialist Care

Coverage limitations also emerge when patients require specialist services. Patients with complex oral health conditions are often referred to specialists such as oral surgeons, endodontists, periodontists, or other dental specialists, yet some specialists do not participate in the CDCP, and the program's coverage for specialist services is more limited than for general dental care. The result is that patients with more complex oral health needs, who require specialist care, face challenges accessing it, leaving serious conditions untreated or requiring patients to pay out of pocket for recommended care. These limitations disproportionately affect patients with higher levels of need and may undermine the program's ability to improve access to comprehensive oral health care.

CDA Recommendations

Ensuring the CDCP delivers timely access to care to patients who need it most requires both expanding the range of covered services and the program's coverage. CDA recommends that the federal government:

- **Adapt the CDCP basket of covered services to better reflect the oral health needs of the populations it intends to serve** and that experience higher levels of disease burden and complexity. These populations include seniors, persons with disabilities, individuals with chronic health conditions, and others with elevated oral health risks.
- **Place greater emphasis on prevention by incorporating patient risk factors into coverage decisions and expanding access to preventive services**, which will help support earlier intervention, reduce disease progression, and improve long-term oral health outcomes.
- **Address coverage limitations that prevent patients from accessing clinically recommended treatments and specialist services** by ensuring coverage and overall program policies more closely reflect evidence-informed clinical practice care and reduce barriers to appropriate treatment.

Sources:

- Health Canada, Canadian Dental Care Plan Program Data, as of March 31, 2026.

CDCP Fee Increases Not Keeping up With the Costs of Delivering Dental Care

Dentists across Canada are largely participating in the CDCP today, and the program has so far drawn on a broad provider network to deliver care to enrolled patients. However, a central question for the program's future lies with how comparable the CDCP fees are with the dental treatments associated with them, which are updated regularly to reflect changes in dental procedures and their costs.

This section addresses a distinct dimension of the reimbursement question discussed earlier. While the *Financial Barriers* section focused on the current gap between CDCP fees and provincial and territorial fee guides and the resulting impact on patient out-of-pocket costs, this section examines a forward-looking concern: the methodology for updating CDCP fees over time, and whether it can keep pace with the real cost drivers of oral health care.

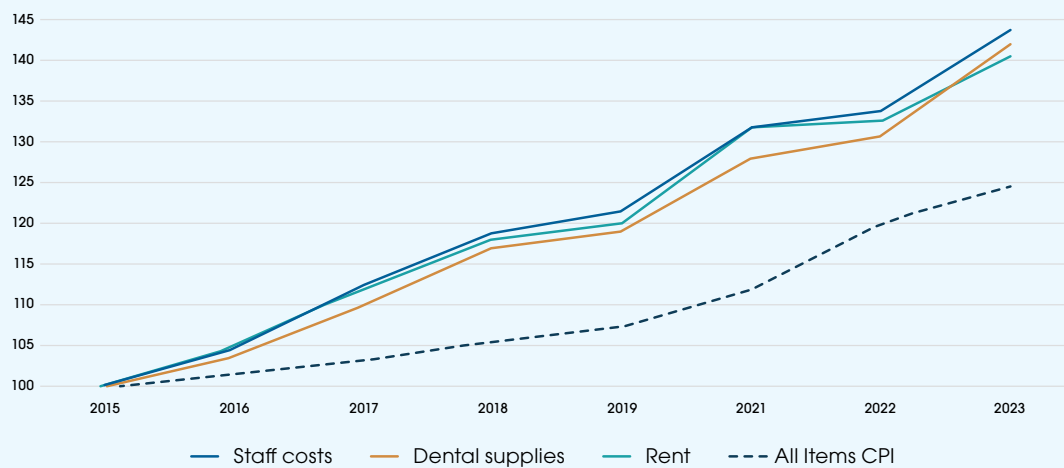
The Rising Cost of Delivering Dental Care

Operating a dental practice involves a complex mix of costs. Dental offices need to account for clinical materials, regulatory induced costs (infection prevention and control and licensing fees), rent and facility overhead, staffing and wages, and medical equipment costs. The top three expense categories (staffing, dental supplies, and rent) account for 64% to 68% of a typical dental practice's total expenses, with staffing alone representing up to 50% of costs. These categories are not discretionary and are not insulated from broader economic pressures. Workforce challenges in dental assisting and dental hygiene have placed sustained upward pressure on wages, while supply costs and commercial rents have continued to climb amid global and domestic economic pressures.

When CDCP fees fall behind the real cost of care, it is patients who absorb the difference.

Analysis of dental office expenses across four Canadian provinces by Impact Economics makes the trend clear: the real costs of running a dental practice have far outpaced general inflation over the past several years, with staff costs leading the way.

Comparing Dental Office Expenses in Four Provinces and Annual CPI



Between 2015 and 2023, staff costs, dental supplies, and rent each rose by roughly 40 to 44%, while general consumer prices rose by approximately 24%. In other words, dental practice cost growth has run at nearly double the rate of general inflation over this period. The trend lines diverge most sharply from 2020 onward, with little indication of convergence.

Against this backdrop, CDCP reimbursement fee increases have been modest, and more closely tied to general inflation growth than to the actual increases in dental practice cost drivers. This is a structural issue in how the program updates fees. If reimbursement updates continue to track inflation while practice costs grow at nearly twice that rate, the gap between what the CDCP pays and the costs of delivering care will widen each year. Aligning the methodology by which CDCP fees are updated would help ensure that reimbursement levels keep pace with reality on the ground.

What This Means for Patient Access

The risk of a widening reimbursement gap has direct consequences for patients. As the difference between CDCP reimbursement fees and the actual cost of delivering oral health care grows, an increasing share of those costs falls to patients. Because CDCP fees are already set below provincial and territorial fee guides, patients may face out-of-pocket expenses regardless of whether they are subject to a co-payment. If program fees continue to lag further behind the increasing costs of delivering dental care, this gap will only widen. As a result, patients will face steadily increasing out-of-pocket costs, potentially making care less affordable and undermining the program's ability to support those it was designed to help.

As CDCP fees fall further and further short of care costs, patients pay more.

An increasing reimbursement gap resulting in the program becoming unsustainable for patients also creates a structural risk to provider participation over the medium to long term. Dentists who participate accept the administrative requirements of a public plan. However, if patients increasingly cannot afford care under the CDCP,

participation becomes difficult to sustain for providers. A shrinking provider network would directly narrow patient access, particularly for CDCP patients in rural and remote communities, where provider availability is already constrained, and for patients with more complex needs whose care is more time- and resource-intensive.

Proactively implementing a sustainable fee update mechanism is important to maintaining the CDCP affordable for patients and to sustaining provider participation in the long-term.

Dental Treatment Code Alignment

A related but distinct alignment issue sits one level beneath the fees themselves, in the treatment codes used to process every CDCP claim. The CDCP processes claims using the Uniform System of Coding and List of Services (USC&LS), the national coding standard maintained by CDA and updated each year to reflect changes in dental procedures, and the standard relied on by dentists and insurance carriers across Canada. The CDCP's codes currently run roughly a year behind the annual USC&LS update. Apart from certain exceptions, such as anesthesia-related codes, there is no established process or timeline for keeping CDCP codes and descriptors aligned with each year's revisions.

This is more than an administrative inconvenience. It creates confusion and delays in delivering treatments as dentists are unsure of which codes to use when providing care under the program (i.e. a deactivated code that is still used by the CDCP). When the program's codes lag the current standard, dental offices and their software vendors must maintain outdated or inactive codes solely for CDCP billing, which adds complexity and raises the risk of claim errors.

For example, USC&LS changes involving sedation billing codes created uncertainty for dental offices about which codes should be submitted under the CDCP. Although a temporary solution was implemented in collaboration with Health Canada, dental offices and the dental claim ecosystem still had to operate with uncertainty which led to increased admin burden. This contributed to avoidable delays and impact for patients.

For patients, that friction surfaces in ways they rarely see the source of: claims that are delayed or denied, paperwork that must be redone, and uncertainty about the care they can receive. Establishing a clear, ongoing process to align CDCP codes with the annual USC&LS update would reduce that friction at its source and give patients a more predictable experience when accessing care under the program.

CDA Recommendations

Ensuring the long-term sustainability of patient access under the CDCP requires reimbursement rate updates to keep pace with the actual cost of delivering care. CDA recommends that the federal government:

- **Ensure that annual CDCP fee increases reflect updates to the provincial and territorial dental fee guides and increases in the actual costs of delivering dental care.** Annual CDCP fee adjustments should be linked to actual dental practice cost drivers including staffing, supplies, and rent, rather than relying primarily on general inflation measures.
- **Protect long-term patient access through sustainable program funding.** Regularly assess out-of-pocket costs for patients to identify emerging access risks before they become systemic.
- **Establish a process to align CDCP treatment codes with annual USC&LS updates,** through a transparent, predictable mechanism that reduces billing errors and administrative burden.

Sources:

- Impact Economics, *Dental office expenses (staff costs, dental supplies, rent) compared to all items CPI, 2015–2023, 2024*. Indexed to 2015 = 100.

Long-term Risks to Employer and Private Dental Insurance

Canada's dental care system has historically been built on a blended financing model, with approximately 95% of dental care funded through private dental plans. Employer-provided dental benefits sit at the heart of this system, covering approximately half of all Canadians and forming the foundation of oral health access for millions of working individuals and their families. The CDCP was designed to extend coverage to those who fall outside this system. However, as the CDCP matures, an important concern remains about the long-term risk of a decline in employer-sponsored dental benefits, which has been the backbone of dental delivery in Canada for decades.

This risk refers to the possibility that employers may choose to eliminate dental benefits for employees who could become eligible for the CDCP, effectively offloading coverage costs onto the public program. For employers facing cost pressures amid the current economic and global landscape, removing dental benefits for lower-income workers who may now have access to public coverage could serve as an incentive. In many cases, employers may not know an employee's household income, so they may eliminate dental benefits for employees who could end up not qualifying for the CDCP program at all, leading to potential access to care issues.

Employer-sponsored dental benefits are rarely offered in isolation. They are typically part of broader extended health benefit packages that also include prescription drugs, vision, mental health services, and other care not covered by provincial health plans. These extended health benefits have become an increasingly important pillar in the financing of Canada's overall health system, quietly absorbing a significant and growing share of health costs that would otherwise fall to governments or to patients directly. Dental coverage is one of the most widely used and valued components of these packages. Preserving employer participation in dental benefits is therefore connected to a larger question of health system sustainability:

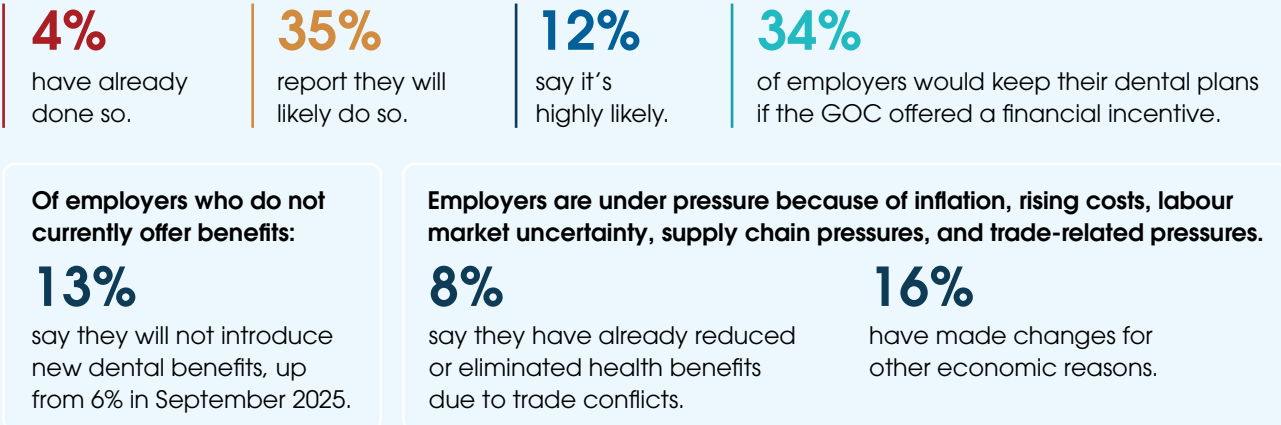
as extended health benefits carry more of the load in financing Canadians’ health care, the erosion of any one component, dental included, places added pressure on an already stretched public health system.

Employer Behaviour Trends: Stable for Now, but Increasingly Sensitive

Current evidence suggests that the CDCP has not led to widespread reductions in employer-sponsored dental coverage. Most employers have maintained their existing plans, and only a small proportion report making direct changes because of the CDCP. A 2026 CDA survey of Canadian employers found that only 4% report having already reduced their dental plans as a direct result of the CDCP. However, employers are becoming more sensitive to these pressures:

- 35% of employers report being likely to reduce coverage due to the CDCP, with 12% saying this is highly likely.
- Among employers who do not currently offer dental benefits, 13% are now less likely to introduce coverage because of the CDCP, up from 6% in September 2025.
- 34% of employers say they would keep their dental plan if the federal government offered a financial incentive to do so.
- Current economic conditions are amplifying these trends at a broader level. Inflation, rising operating costs, labour market uncertainty, supply chain disruptions, and trade-related pressures appear to have had a greater influence on benefits decisions at this stage. 8% of employers have already reduced or eliminated health benefits due to the impact of trade conflicts, independent of the CDCP, and 16% have made benefit changes for other economic reasons.

Are Employers Likely to Reduce Their Dental Plans Because of the CDCP?



Source: CDA Survey of Employers, 2026

The issue extends beyond traditional employer-sponsored plans. Stakeholders have also identified risks among certain groups that have historically relied on privately

purchased coverage. Some seniors (aged 65 and over) who retire may choose to discontinue privately purchased dental insurance and become eligible for the CDCP. Similarly, self-employed Canadians, small business owners, and individuals who would otherwise have purchased private coverage may increasingly rely on the public program if eligibility requirements permit. While the scale of these behavioural changes remains uncertain, they illustrate the importance of ensuring that the CDCP complements rather than displaces existing sources of dental coverage.

Continuous monitoring and proactive policy co-ordination are critical as the CDCP evolves. A purely passive or “wait and see” approach could lead to the CDCP being seen more as a substitute for private coverage rather than a supplement of it. Importantly, changes in employer-sponsored dental benefits may not be immediately visible in claims data, as there can be a significant lag before their effects appear. For this reason, it is essential to monitor a broader set of leading indicators and market signals, as incremental changes in employer behaviour can trigger broader shifts over time. Left unaddressed, these dynamics could gradually shift patients from private plans onto the public program. The risk for patients is that public investment intended for Canadians with no coverage is also absorbed by demand from those who previously had it, diluting the program’s capacity to serve those it was designed for.

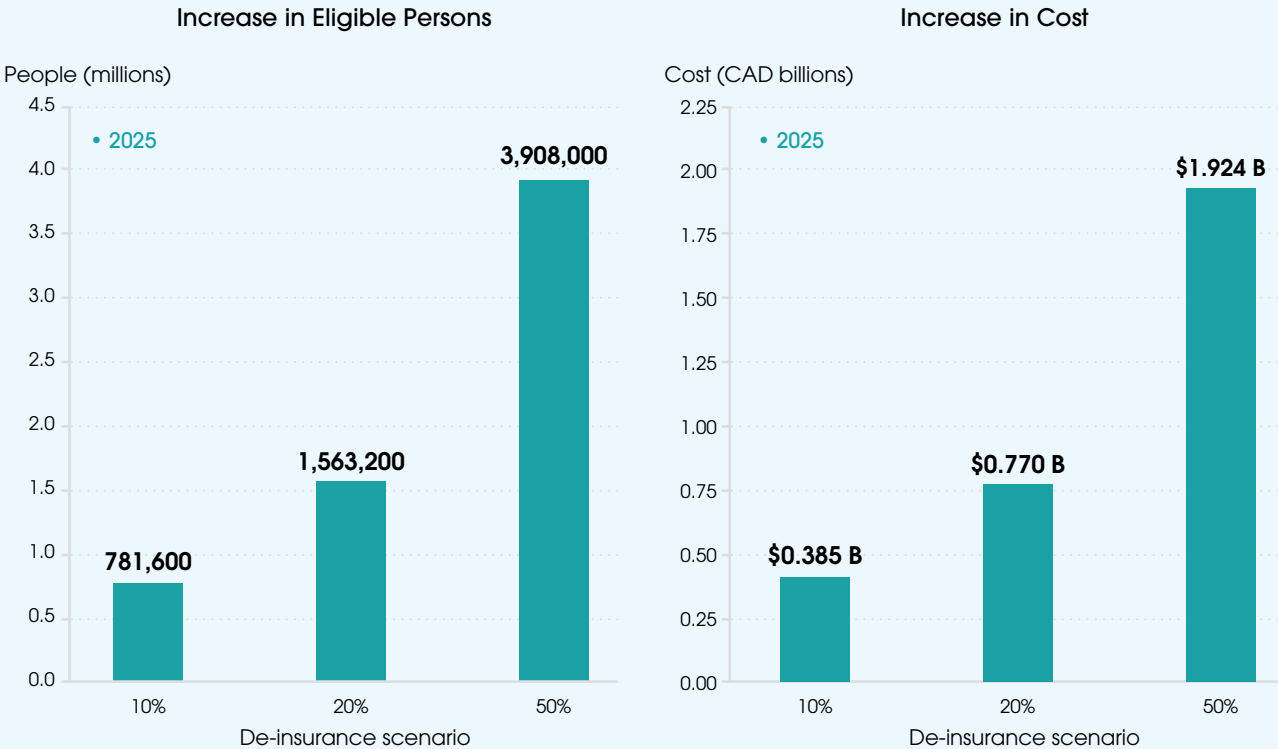
Furthermore, the current CDCP eligibility framework may overlook a group of Canadians who are in fact insured, but effectively underinsured due to significant coverage limitations. Many workers in lower-wage sectors have access to dental benefits that cover only a portion of their needs, yet their access to private coverage may preclude them from accessing the CDCP. If employers determine that the CDCP offers more comprehensive coverage than their existing dental benefits and choose to reduce or eliminate employee dental plans, this could put additional strain on the CDCP.

The Potential Impact on CDCP Sustainability for Patients

Beyond the direct fiscal implications, significant migration from private coverage to the CDCP could alter the program’s role within Canada’s oral health care system. If employer-sponsored plans, individually purchased coverage, or family-based private coverage were gradually replaced by public coverage, the resulting increase in demand could affect program sustainability, capacity planning, and the ability to prioritize populations for whom the CDCP was originally intended. Preserving a balanced mix of public and private financing remains important to maintaining access, patient choice, and long-term system stability.

Impact of De-Insurance* on the Canadian Dental Care Plan (CDCP)

Estimated increase in eligible persons and program costs under selected de-insurance scenarios.



*De-insurance = the erosion of private dental insurance due to CDCP

CDA modelling, 2023

To illustrate the potential impact on the program, early CDA modelling from 2023 estimated that, without mitigation measures, the number of Canadians eligible for the CDCP could rise significantly. Even a modest 10% erosion rate could add over 700,000 new patients and materially increase annual program costs. While this early modelling was for illustrative purposes, it underscores the importance of preserving a balanced oral health care system in which public and private coverage continue to work together effectively. A program-wide expansion of this magnitude, unplanned and unbudgeted, would place serious strain on the CDCP’s capacity to deliver meaningful access for the vulnerable populations it was originally designed to serve.

The CDCP was never intended to replace the private dental benefits system. It was designed to fill a gap for Canadians left behind by it. Protecting that distinction is essential to ensuring that the gains in access achieved under the CDCP are not offset by the potential erosion of coverage elsewhere in the system. Supporting stable employer-sponsored coverage alongside a strong public program will help maintain continuity of care, patient choice, and access to comprehensive oral health services across Canada.

Even a modest 10% erosion rate could add over 700,000 new patients and materially increase annual program costs.

As the program matures, governments may wish to examine policy mechanisms that encourage the continued maintenance of private dental coverage where it is

available and affordable, particularly among employers and individuals who have traditionally participated in the private market.

CDA Recommendations

To protect the long-term sustainability of the CDCP and preserve employer-sponsored dental coverage, CDA recommends that the federal government:

- **Establish a formal, ongoing monitoring mechanism to track employer and private dental benefit trends**, including changes to plan coverage, employee participation rates, and patterns of erosion.
- **Develop a contingency framework that includes employer educational campaigns and tax incentives** for employers who maintain dental benefits for lower-income employees who would otherwise be eligible for the CDCP.

Source:

- Canadian Dental Association (CDA), Briefing Note: De-Insurance Risk and Budgetary Impact, May 2023

Non-Financial Barriers to Access Left Unaddressed

Providing dental coverage is a necessary but insufficient condition for improving oral health outcomes. For many people living in Canada, particularly those living in rural, remote, and northern communities, as well as those facing language, mobility, or awareness barriers, the obstacles to accessing care go beyond whether a benefit card exists. The CDCP, as a coverage-based program, was never designed to address these structural access gaps on its own.

More broadly, oral health outcomes are influenced by a range of social determinants of health, including income, education, housing stability, transportation, disability status, language proficiency, social support networks, and health literacy. While the CDCP addresses one important determinant by reducing financial barriers to care, coverage alone cannot overcome the broader social, geographic, and systemic factors that influence whether individuals are able to seek, access, and maintain oral health care. For some populations, particularly those experiencing poverty, homelessness, social isolation, or limited engagement with government systems, barriers may begin long before a dental appointment is booked.

Obstacles to Seeking and Accessing Dental Care



That is why the federal government, in Budget 2023, announced the Oral Health Access Fund (OHAF): a dedicated \$250 million investment over three years, starting in 2025–26, with \$75 million in ongoing funding thereafter, specifically designed to complement the CDCP by tackling the non-financial dimensions of access. However, the federal government’s recent decision to cancel the OHAF has left a meaningful gap in the federal oral health policy landscape, one that the CDCP alone cannot fill.

The Access Gaps That Coverage Alone Cannot Close

Geographic access remains a significant and persistent challenge. According to Statistics Canada, about 18% of Canadians live in rural and remote communities, where access to a dental provider is not simply a matter of cost, it is a matter of whether an available provider exists within a reasonable distance at all.

Similarly, according to the *Canadian Survey on Disability*, Statistics Canada, 2022, approximately 8 million Canadians live with a disability, many of whom require providers with specific training, specialized equipment, or access to care under sedation, capacity that is unevenly distributed across the country. Language barriers, health literacy gaps, and low awareness of how to navigate the system further compound the challenge for vulnerable populations.

Financial eligibility also does not necessarily correspond with oral health needs. While income and lack of insurance are important predictors of unmet oral health needs and were appropriately used to design the CDCP, other factors can strongly influence whether individuals access care. People experiencing unstable housing, low health literacy, limited awareness of available benefits, transportation challenges,

competing life priorities, or difficulty navigating government programs may remain disconnected from care even when coverage is available. Some of the most vulnerable Canadians may never enroll in the CDCP simply because they do not file taxes, are unaware of their eligibility, or face barriers completing the application process. As a result, populations with the greatest oral health needs may not always be the ones most likely to access available care.

What the OHAF Was Designed to Do

The OHAF was announced in direct conjunction with the CDCP as a core component of the federal government's oral health investments. Its mandate was to expand training and educational opportunities for the oral health workforce, including by supporting dental schools and dental students; to fund targeted outreach programs for non-insured, low-income, and senior populations; and to support infrastructure and care delivery. Together, these investments were intended to build the supply-side and system-level conditions that would allow underserved individuals to benefit from the coverage the CDCP provides.

The OHAF was also intended to support upstream interventions that influence oral health outcomes beyond the dental office. Prior to the federal government's decision to cancel the OHAF, some projects had been already approved and launched, and will continue to be developed despite the fund's cancellation. Approved projects included initiatives focused on community outreach, oral health education, disease prevention, oral health literacy, workforce development, mobile and community-based service delivery, and improving access for rural, remote, Indigenous, and other underserved populations. Many projects sought to address barriers that traditional insurance coverage alone cannot resolve, such as transportation and accessibility challenges, lack of awareness, difficulties navigating the health system, and limited access to preventive services. In doing so, the OHAF recognized that improving oral health outcomes requires action on both the financial and non-financial determinants of access. Many initial OHAF projects also supported dental student training by offering free care for patients in dental school clinics.

The cancellation of the OHAF removes this layer of support for new projects entirely going forward.

The cancellation of the OHAF removes this layer of support for new projects entirely going forward. Without targeted outreach, eligible Canadians who face oral health literacy challenges, awareness and navigation barriers are less likely to enroll or use their coverage. Without investment in training and workforce development in schools, challenges for hands-on training opportunities and competency gaps in providing care for vulnerable populations will persist for providers. Without adequate investment to connect people to care, access in underserved communities will remain constrained. The federal government has invested substantially in the demand side of oral health access while stepping back from investments needed to help ensure that coverage can be used more equitably.

The Patient Impact

The consequences fall most heavily on those the CDCP was designed to help most. Canadians in rural and remote communities, older adults with mobility limitations,

and people with disabilities requiring specialized care are the groups for whom non-financial barriers are most acute, and for whom the absence of targeted support is most consequential.

CDA recognizes that the current fiscal environment has constrained the government's capacity to maintain every committed investment. However, the OHAF was not a supplementary program. It was the mechanism through which the CDCP's reach was meant to extend to those hardest to reach and help ensure greater equity in access to care.

More fundamentally, it reflected an understanding that improving oral health outcomes requires more than insurance coverage alone. Oral health is shaped by a complex interaction of social, economic, geographic, educational, and behavioural factors that influence whether people can access care, maintain healthy behaviours, and achieve good oral health over time. While the CDCP addresses an important financial barrier, progress on oral health outcomes will also require sustained attention to these broader determinants of health. The absence of the OHAF leaves a structural gap in the federal oral health architecture that will, over time, limit the program's ability to deliver meaningful and equitable improvements in oral health outcomes.

CDA Recommendations

Dental coverage alone cannot deliver equitable oral health outcomes. CDA recommends that the federal government take the following steps to address the non-financial barriers that prevent the most vulnerable from accessing the care they are entitled to:

- **Re-establish the Oral Health Access Fund at an appropriate funding level**, recognizing that the original \$250 million investment may need to be recalibrated in light of current fiscal constraints, with a mandate focused on outreach to underserved populations, provider workforce development, and infrastructure support.
- **Develop a federal oral health equity and access strategy** that complements the CDCP by addressing the broader social determinants of oral health and non-financial barriers to care.

Sources:

- Statistics Canada, "Population growth in Canada's rural areas, 2016 to 2021," *Census in Brief*, February 9, 2022, Catalogue no. 98-200-X, <https://www12.statcan.gc.ca/census-recensement/2021/as-sq/98-200-x/2021002/98-200-x2021002-eng.cfm>.
- Statistics Canada, "Canadian Survey on Disability, 2017 to 2022," *The Daily*, December 1, 2023. <https://www150.statcan.gc.ca/n1/daily-quotidien/231201/dq231201b-eng.htm>.

Gaps in Canada's Oral Health Data Landscape

Oral health is an essential component of overall health, yet it has not been routinely or consistently included in Canada's federal health strategy or surveys. Timely and accessible oral health data is not routinely collected or reported for analysis and use. This has left policymakers without a current, reliable picture of the oral health status of Canadians against which to measure the impact of the CDCP.

First, the Canadian Health Measures Survey (CHMS), a key national survey that includes clinical health indicators, has only included oral health components on an intermittent basis. There was a 15-year gap between the 2007–2009 and 2022–2024

cycles, meaning that for much of the period leading up to the CDCP's design, the most recent clinical baseline of Canadians' oral health was well over a decade old. Oral health needs to be included in the CHMS on a regular, predictable basis to support meaningful evaluation of population oral health outcomes over time.

Second, two dedicated oral health surveys created specifically to address data gaps have already been discontinued. Budget 2023 provided \$23.1 million over two years to Statistics Canada to establish the Canadian Oral Health Survey (COHS), which captures self-reported access to care, and the Survey of Oral Health Care Providers (SOHCP), intended to be conducted on a recurring basis. However, this funding was not renewed, and only a single iteration of each survey was completed before they were discontinued. The result is that two purpose-built instruments for monitoring oral health access and provider capacity, launched alongside the CDCP precisely to measure its impact, are no longer in operation, just as the data they would generate becomes most valuable.

Together, the COHS and the CHMS serve complementary purposes. The former captures self-reported access to care, and the latter captures clinical measures of oral health status and outcomes. Both are essential to evaluating whether the CDCP is improving outcomes for patients over time. Restoring and sustaining this data infrastructure is critical for credible, ongoing evaluation of the program. As a matter of principle, oral health data should be treated as no less important than other sources of health data and aligned with pan-Canadian health data and governance standards to ensure it is collected, shared, and reported with the same rigour.

Why This Matters for Patients

The absence of robust, timely data has direct consequences for patient access. Without a clear understanding of utilization patterns and patient needs, it is more difficult to identify barriers to care, detect regional disparities, target policy adjustments, and allocate resources to the communities where they are most needed. Emerging access problems may go unnoticed, and opportunities to improve the program for the patients who depend on it may be missed or delayed.

Ongoing Initiatives

Looking ahead, several initiatives will continue to strengthen the evidence base for oral health policy and planning in Canada. Funding provided through the Office of the Chief Dental Officer of Canada to the Canadian Institutes of Health Research (CIHR) is supporting research projects designed to address key national oral health questions identified by the Chief Dental Officer. In addition, the Canadian Oral Health Summit, supported through CIHR funding, continues to bring together researchers, policymakers, clinicians, and other stakeholders to advance the development of a National Oral Health Research Strategy. While these initiatives are separate from federal programs such as the CDCP, they contribute to improving oral health data, identifying research priorities, and supporting evidence-informed decision-making across the oral health sector.

CDA Recommendations

Ensuring the CDCP achieves its objectives requires a strong data and evaluation framework to support evidence-based decision-making and continuous improvement. CDA recommends that the federal government:

- **Restore consistent, ongoing funding to Statistics Canada to relaunch and sustain key oral health data initiatives**, including the Canadian Oral Health Survey (COHS) and the Survey of Oral Health Care Providers (SOHCP) on a regular, recurring basis.
- **Ensure that oral health components are included in the Canadian Health Measures Survey (CHMS)** on a regular and predictable basis, at a minimum every five years. Consistent clinical oral health data is necessary to establish baselines, track trends, and evaluate the long-term impact of the CDCP on oral health outcomes.
- **Improve access to oral health data through appropriate governance and privacy safeguards.** Broader access to data would strengthen independent evaluation, support innovation, and contribute to a more robust evidence base for oral health policy in Canada.

Program Evaluation and Ongoing Improvement

The CDCP represents a significant federal investment aimed at improving access to oral health care for Canadians. Yet over two years into implementation, the publicly available data needed to assess whether the program is achieving its objectives remains limited. A guiding principle of effective public programs is that what cannot be measured cannot be reliably improved and, at present there is no publicly detailed, consistent information required to understand how well the CDCP is working, who it is reaching, and where it may be falling short.

Limited Data to Assess Program Performance

At present, there is limited publicly available data on how the CDCP is functioning in practice. Critical information is not readily accessible to the public and stakeholders, including the most common treatments being delivered under the program, the demographic and regional profile of who is accessing care, and how frequently CDCP patients are visiting the dentist. Without this level of detail, it is difficult to understand who the program is reaching, how it is being used, and where gaps in access may persist.

For example, current public reporting does not shed light on two important questions. The first is why enrollment has reached roughly 6.5 million of an estimated 9 million eligible individuals, and what is keeping the remaining eligible population from applying. The second is why a meaningful share of enrolled patients have not yet received care: 4.5 million have had a dental visit through the program since its launch, leaving a substantial group who hold coverage but have not yet translated it into a visit to the dentist.

Without detailed recent data, it is difficult to understand who the program is reaching, how it is being used, and where gaps in access may persist.

The absence of a clearly defined strategy to evaluate program success further limits the ability to determine whether the CDCP is meeting its objectives. Notably, much

of the foundational information needed for this kind of analysis is already being generated through the program’s standard claims process. The opportunity lies in analyzing and reporting that information systematically and transparently.

Aging Population and Evolving Care Needs

Canada’s aging population represents one of the most important long-term considerations for the ongoing evaluation of the CDCP. According to recent data shared by Health Canada during an oral health conference, in 2025/26, adults aged 65 years and older represented approximately 45.5% of the 6.5 million approved applications, making them the largest beneficiary group. Seniors also remain the most active users of the program, with approximately 61% of eligible seniors accessing dental care compared with an overall program utilization rate of 58%. These findings demonstrate that older Canadians are likely to continue to represent the core population served by the CDCP.



Seniors Rely on the CDCP

Seniors are the largest single beneficiary group:

45.5%

of the 6.5 million approved applications.

Source: Health Canada data, 2025–2026

Seniors are the most active users of the CDCP:

61%

of eligible seniors access dental care through the program, compared to the overall utilization rate of **58%**.

1 in 5 

Canadians is a senior citizen. This cohort will eventually reach **35%**

Source: Statistics Canada

In the next two decades, the CDCP will need to increasingly adapt to serve their complex oral health care needs. Older adults are increasingly retaining their natural dentition and require ongoing care.

The importance of this population will only grow over time. Canada has reached a demographic milestone where seniors aged 65 and older account for one in five Canadians, a cohort projected by Statistics Canada to eventually reach up to 32.5% of the population. Furthermore, the Canadian Institute for Health Information (CIHI) reports that the steepest increase is occurring among older seniors, with the population aged 85 and older projected to triple over the next two decades. As more Canadians enter retirement and become eligible for the CDCP, the program must increasingly adapt to serve an older population with highly complex oral health and health-care needs.

Older adults are living longer and increasingly retaining their natural dentition, requiring ongoing preventive, restorative and periodontal care well into advanced age. The prevalence of multiple chronic conditions, cognitive impairment,

medication use, and physical frailty increases substantially with age. These factors often make dental treatment more complex, requiring longer appointment times, additional preventive interventions, greater co-ordination with caregivers and other healthcare providers, and increased attention to accessibility and mobility challenges. Many older adults may also require community-based, mobile or home-based models of care as functional limitations increase.

As currently structured, the CDCP is largely designed around the delivery of conventional dental services within traditional dental practice settings. As Canada's population continues to age, it will be important to evaluate whether the program is sufficiently responsive to the evolving needs of older adults with increasingly complex medical, functional and social circumstances.

Why This Matters for Patients

There is also a strategic dimension to this issue that bears directly on the program's future. In an environment of fiscal pressure and competing health priorities, the ability to clearly demonstrate measurable value, such as improved access, better oral health outcomes, and efficient use of public funds is essential to a program's long-term durability. A program whose outcomes cannot be evidenced is more exposed to funding pressures and eligibility restrictions than one that can point to demonstrated results.

Programs without proven results face higher risks of budget cuts and tighter eligibility rules.

Strong data is not only a tool for program improvement. It is also a safeguard for the continuity of the care that millions of patients now rely on. Other jurisdictions internationally have shown that the routine, transparent use of dental program data can drive measurable improvements in access, quality, and cost-effectiveness over time. This is an opportunity Canada is currently well positioned to seize, but has not yet fully realized.

Looking Ahead: The Need for a Sustainable and Clear Evaluation Strategy

In addition to evaluating patient outcomes and access to care, Health Canada should incorporate long-term sustainability into the CDCP evaluation framework. Canada's aging population is one important factor that is expected to increase the number of Canadians eligible for publicly funded dental care over the coming years.

However, population aging represents only one of several factors that may influence the program's future sustainability. As discussed throughout this report, other important considerations include the potential erosion of employer-sponsored dental benefits, the transfer or offloading of existing provincial and territorial public dental programs to the CDCP, and whether annual program funding and reimbursement levels keep pace with the actual cost of providing dental care. Collectively, these factors have the potential to significantly impact access to care for patients. Regular monitoring of demographic trends, eligibility, utilization, expenditures and broader system impacts should therefore form part of a comprehensive evaluation strategy.

The federal government has indicated that the CDCP is currently tracking within its projected budget and has signaled its readiness to adjust the program as it matures.

That commitment is welcome. The purpose of incorporating sustainability into the evaluation framework is to protect the access gains documented throughout this paper, so that the coverage patients now rely on remains dependable over the long term.

The long-term success of the CDCP will also depend on the ability to measure and evaluate its performance in a consistent and transparent manner. Currently, there is no publicly-defined framework to assess program outcomes, access, and system impacts. There is also no structured, periodic public review process to evaluate whether the program is meeting its objectives or to identify areas for improvement. While the CDCP was informed by evidence generated through national oral health surveys and related data initiatives, there remains no comprehensive strategy in the public domain for how program claims data will be analyzed and used to assess outcomes, guide policy decisions, and support continuous improvement.

To measure success, we should regularly check user demographics, eligibility, usage, costs, and broader impacts.

Another important consideration for program evaluation is how some administrative challenges remain. Continued monitoring of these issues can help identify opportunities to streamline processes and improve overall co-ordination in the design and delivery of the program. As the program evolves, ongoing assessment of administrative impacts, including emerging issues, will be important to support efficient program delivery and provider participation.

Establishing a clear evaluation strategy, supported by sustained investments in oral health surveillance and data infrastructure, would strengthen accountability, enable evidence-based adjustments as the program evolves, and ensure that the historic investment the CDCP represents continues to deliver measurable value for patients.

CDA Recommendations

- **Collect and report CDCP program data publicly.** Health Canada should establish a transparent reporting framework that publishes regular, disaggregated data on CDCP utilization, patient demographics, and care patterns. This data should support ongoing program evaluation, independent research, and evidence-based policy development.
- **Implement a structured, periodic public review of the CDCP with a focus on population-level oral health outcomes** to assess progress, identify challenges, and make evidence-based adjustments to the program over time.
- **Incorporate long-term sustainability into CDCP evaluation.** Health Canada should include long-term sustainability metrics within the CDCP evaluation framework by regularly monitoring changes in demographic trends, eligibility growth, utilization patterns and program expenditures.

Sources:

- Canadian Institute for Health Information, *Aging with dignity in Canada: Perceptions, pressures and planning for the future*, 2026.
- Statistics Canada, *Population projections for Canada (2025 to 2075), provinces and territories*, (Catalogue no. 17-20-0003), 2026.
- Health Canada, *Expanding oral health care access for Canadian residents through the Canadian Dental Care Plan* (presentation), Canadian Oral Health Summit, Saskatoon, SK, Canada, June 19, 2026.

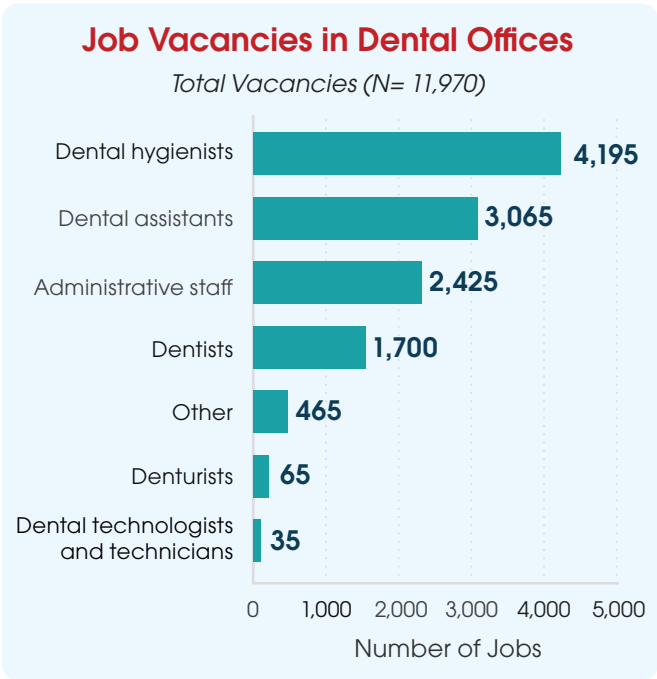
Oral Health Workforce Challenges and Capacity Constraints

Canada’s oral health workforce has faced persistent staffing challenges, recruitment difficulties, and uneven regional capacity for years. The CDCP is significantly accelerating demand for services at precisely a moment when the workforce is already under strain. While the CDCP is enhancing access to oral health care, there is no accompanying federal strategy to support workforce growth, training expansion, recruitment, or regional distribution. Without measures to address these challenges, there is risk that expanded demand will outpace workforce capacity, ultimately constraining access for the patients the program is designed to serve.

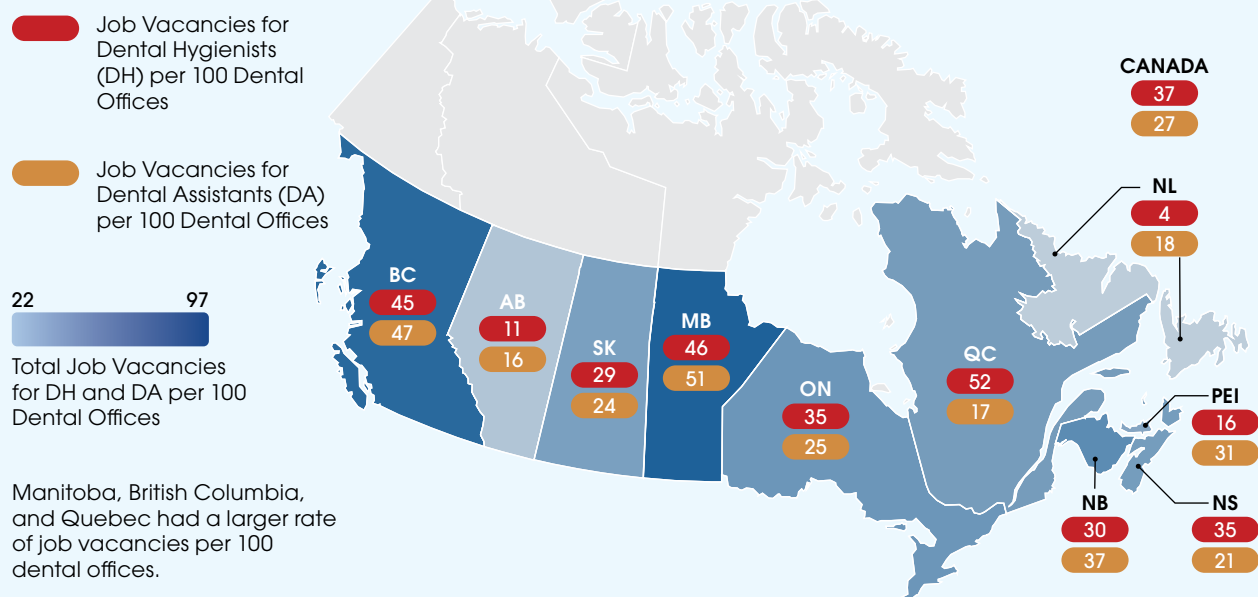
A Workforce Under Strain Before the CDCP

Canada’s oral health workforce includes more than 33,000 dental hygienists, 27,000 dentists, and nearly 23,000 dental assistants working across more than 11,000 dental offices. Despite this scale, capacity has been constrained by widespread vacancies and persistent recruitment and retention challenges. According to Statistics Canada’s 2024 Survey of Oral Health Care Providers (SOHCP), there are approximately 11,970 job vacancies in dental offices, affecting both clinical and administrative roles. Vacancies among dental assistants and dental hygienists are acute, accounting for 7,200 of those vacant positions.

Recruitment and retention pressures are widespread: 50% of dental offices report difficulty recruiting dental hygienists and 47% report difficulty recruiting dental assistants. Twenty-one percent of practices also report difficulty retaining staff in these two roles. Overall, 82% of dental offices report facing human resource challenges, with recruiting skilled employees identified as the primary issue. While Canada does not face a general shortage of dentists, the workforce is unevenly distributed, with urban centres well served and rural and remote areas facing real gaps in provider availability, a pattern that compounds capacity constraints in the communities where access is already most challenging.



Job Vacancies for Dental Hygienists and Dental Assistants per 100 Dental Offices by Provinces, 2023 (SOHCP)



These overall workforce pressures are not felt evenly across the country. They are particularly pronounced in many regions, especially in rural and remote communities, where patients can face difficulties finding a dentist able to accept them and dental offices can face significant challenges to recruit and retain the dental assistants and dental hygienists needed to provide care. While governments, regulators, educators, and professional organizations have undertaken various workforce planning initiatives in recent years, including improved data collection and workforce modelling efforts, many of the structural issues affecting distribution, training capacity, labour mobility, and recruitment remain unresolved. In these communities, workforce shortages are not an abstract risk but a present-day barrier to care.

In rural and remote communities, workforce shortages are not an abstract risk but a present-day barrier to care.

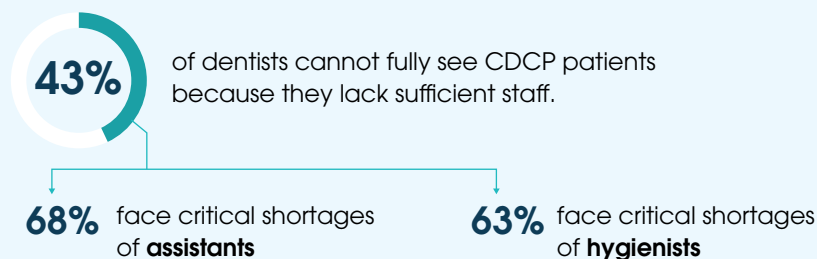
While the CDCP has increased demand for oral health services, the workforce challenges highlighted above predate the program. Persistent vacancies of dental assistants and dental hygienists, uneven provider distribution, limited educational capacity in some professions, and barriers affecting the integration and mobility of internationally trained oral health professionals have all contributed to existing capacity constraints. The CDCP has not created these challenges but has increased pressure on a system that was already operating with limited workforce flexibility.

CDCP Increased Demand is Intensifying Existing Pressures

The launch of the CDCP has meaningfully increased the volume of patients seeking dental care. CDA estimated that meeting the CDCP-driven demand would require

approximately 2,300 additional dental assistants and over 1,500 additional dental hygienists: staffing needs that the system has not been positioned to supply. There are already signals that workforce constraints are affecting the ability of dental offices to take on new patients. That constraint is showing up most visibly in CDCP access as the program remains the single largest source of new demand for oral health care. According to a 2026 CDA survey of dentists, 43% of dentists say staffing shortages are limiting their ability to see CDCP patients. Of those, 68% cited shortages of dental assistants and 63% cited shortages of dental hygienists as the limiting factor. This is a meaningful early indicator that workforce constraints are beginning to shape provider capacity to absorb new demand. That nearly half of dentists are reporting capacity constraints due to workforce issues suggests the system is operating with increased pressure and limited margin to accommodate further growth in demand. Furthermore, according to a March 2026 Abacus Data public survey commissioned by CDA, 21% of CDCP patients report having had an appointment cancelled, with 13% of those cancellations attributed to staffing challenges.

How Staffing Shortages Strain CDCP Delivery



Source: CDA Survey of Dentists, 2026



Source: Abacus Data, March 2026

The System is Stable, but Access Risks Loom

Data available on dental practice capacity comes from Statistics Canada's 2024 SOHCP, which measured conditions before the launch of the CDCP. At that point, 96% of practices were accepting new patients, 77% could offer existing patients a non-emergency appointment within a month, and 90% planned to maintain or expand their operations. These baseline figures provide a picture of capacity going into the launch of the program. Comprehensive system-wide wait times and access data reflecting post-CDCP conditions is not publicly available, which itself is a gap worth noting.

Over two years into CDCP implementation, **72% of dentists report having seen an increase in the total number of patients they are treating since the CDCP rollout**, according to CDA's 2026 survey with dentists. This indicates that practices have,

to date, been able to absorb some of the increase in demand generated by the program. However, this absorption is happening under increasing strain.

Several workforce pressures are expected to persist. A portion of the dental hygienist and dental assistant workforce is approaching retirement age or actively considering leaving the profession, which will further constrain supply in the coming years. While most practices reported under the SOHCP intend to expand capacity, the ongoing recruitment difficulties documented in the SOHCP suggest that these intentions may not translate fully into realized capacity gains. As CDCP utilization continues to grow, the system's ability to absorb that demand without affecting patient access may be impacted.

Further, although efforts are underway nationally to improve oral health workforce data, forecasting, and co-ordination, there remains no comprehensive strategy to address longstanding issues such as provider maldistribution, labour mobility barriers, educational capacity constraints, and workforce retention. These factors may limit the system's ability to translate workforce planning efforts into meaningful increases in patient access.

Workforce supply is also shaped by federal immigration policy, and changes to it over recent years have added pressure to an oral health workforce that was already constrained. The Post Graduate Work Permit prioritizes occupations facing workforce challenges, and dental hygiene is recognized among the eligible fields, a step CDA advocated for. Dental assisting, however, remains absent from it, even though dental assistants are essential to daily practice and dental offices cannot function without them. At a time when the CDCP is driving significant new demand for care, keeping an occupation already in shortage outside this pathway compounds existing capacity constraints and access to care. The effect is felt most acutely in rural and underserved communities, where offices already struggle to recruit and retain dental assistants and where any further limit on capacity means patients wait longer or cannot find care at all.

Federal, Provincial and Territorial Collaboration

The CDCP has increased the number of patients seeking care, but the workforce pipeline, including dentists, dental hygienists, dental assistants, dental therapists, and other oral health professionals, is governed primarily through provincial and territorial education, regulation, licensing, and workforce planning systems. Expanding dental care coverage through the CDCP has been a federal policy lever. Expanding workforce capacity is largely a provincial and territorial responsibility. At the same time, access to coverage may grow faster than access to treatment if workforce growth does not keep pace. Success will therefore depend on sustained collaboration between federal, provincial, and territorial governments, regulators, educational institutions, and professional organizations to address longstanding workforce challenges, including provider maldistribution, labour mobility barriers, training capacity, recruitment and retention, and the integration of internationally educated oral health professionals. While some initiatives have improved national dialogue and workforce planning efforts, more co-ordinated action will be required

to ensure that increased demand generated by the CDCP can be matched by sufficient provider capacity across all regions of the country.

What This Means for Patients

The long-term success of the CDCP will depend on whether Canada's oral health workforce can meet the increased demand for services. Current trends suggest this will be a key pressure point.

In rural and remote regions where workforce shortages are most acute, patients are already experiencing the gap between the promise of CDCP coverage and the reality of limited provider capacity. Many patients enrolling in the program expected that coverage would translate into timely access to care. When they find that no local dental office can accept them due to staffing constraints, the disappointment is real. Compounding this, patients often direct their frustration at the dental offices, not recognizing that the offices are constrained by labour market realities and are already stretched thin trying to serve current patients.

Without targeted action to address workforce constraints, capacity pressures are likely to intensify and spread across the country as CDCP utilization grows, with continued implications for patient access and system sustainability.

Fixing workforce shortages in oral health requires teamwork across all levels of government, schools, and professional groups.

Key focus areas include:

- *Government cooperation across federal, provincial, and territorial levels;*
- *System support from regulators, schools, and professional groups;*
- *Core solutions for staffing, training, and fair job mobility.*

CDA Recommendations

Ensuring the CDCP can deliver on its objective of improving access to care requires addressing the workforce capacity constraints that are limiting service delivery. Recognizing that oral health workforce planning is primarily a provincial and territorial responsibility, CDA recommends that the federal government:

- **Work with provinces, territories, regulators, educational institutions, and oral health stakeholders to address barriers and support workforce planning**, including forecasting, provider maldistribution, labour mobility, training and educational capacity, and the integration of internationally educated oral health professionals.
- **Make dental assisting eligible for key federal programs** to help address shortages:
 - **Federal student loan forgiveness program** to support workforce distribution and encourage dental assistants to work in rural and underserved communities.
 - **Post-Graduation Work Permit (PGWP) program** to help international students undergoing training in dental assisting to remain and be able to work in Canada.
 - **Extend an exemption for dental assisting programs of private career colleges from current eligibility limitations under the Canada Student Grant program for Full-Time Students** to reduce barriers to training and strengthen the pipeline of qualified dental assistants entering the workforce.

- **Invest \$2 million over two years to establish a pan-Canadian oral health workforce planning framework** to support the collection, analysis, and modelling of workforce data at the national and regional level, enabling governments and stakeholders to proactively identify and address workforce shortages, distribution challenges, and future capacity needs.

Patient Confusion and Program Complexity Acting as a Barrier to Care

One of the most consistent and significant challenges facing CDCP patients today is confusion about what the program is, what it covers, what patients can expect to pay, and how co-ordination works with existing provincial dental programs. The CDCP is a large, complex public program, and the responsibility for explaining how it works rests with the federal government. In practice, however, dental offices have been carrying much of the burden of explaining program coverage, costs, and procedures to patients at the point of care. Confusion about the program is resulting in a patient experience marked by misunderstanding, surprise, and in many cases, frustration, with direct consequences for whether eligible individuals use the coverage they have.

Patients are Arriving With the Wrong Expectations

The primary driver of patient confusion concerns the most basic aspect about the program: how much CDCP patients will pay out of pocket. According to a March 2026 national public survey commissioned by CDA, **59% of CDCP patients arrived at their first appointment believing their care would be completely free.** Among that group, 37% later learned they would have to pay something while 22% ended up paying nothing at all. The fact that more than half of these patients walked into their first appointment with this expectation points to a significant disconnect between public communication about the program and what financial coverage patients are actually expecting.

35% of CDCP patients say dental staff needed to explain the program to them at every or most visits.

There are several reasons for this disconnect, including early government communications about the program emphasizing free care. While those communications have since been updated, the original framing remains widely held among patients. Program policy has also abruptly changed mid-treatment for some patients. For example, changes to lab fee caps in the fall of 2025 affected what patients pay partway through the course of care. The cumulative effect is a lack of clear, consistent communication that affects patients' ability to plan their care and seek timely treatment. Confusion about the program also disproportionately affects vulnerable groups.

These expectations meet reality at the first appointment, often with frustrating results. According to a 2026 CDA survey:

- 27% of CDCP patients say their out-of-pocket costs at their first appointment were higher than expected.
- 24% expected to pay nothing but had to pay out of pocket.

- 23% found that some of the care their dentist recommended was not covered by the program.

According to a CDA 2026 survey with dentists, the most commonly explained topics to patients were CDCP balance billing or additional charges (61%), services not covered (61%), and preauthorization requirements (55%). There is also a pattern in what patients say they wished they had known before their first appointment. The top piece of information CDCP patients said they were missing before their first visit was which services are covered (38%), followed by likely out-of-pocket expenses (37%). The fact that 35% of CDCP patients say dental staff needed to explain the program to them at every or most visits points to a recurring communication gap that should be addressed by the federal government and not left to dental offices to fill repeatedly.

Dental Offices are Doing the Explaining

When the government's communications fall short, the explanation work falls to dental offices. 32% of CDCP patients say they received the clearest explanation of their CDCP coverage from the dentist, and 26% say it came from clinic staff. Only 23% identify the government as the source of their clearest explanation.

In other words, dental offices are the ones bearing the onus of explaining the public program, and this burden is having a measurable operational impact on dental practices. According to CDA's survey of dentists, one third of dentists report that they and their staff spend over 40 minutes every day explaining the CDCP to patients. This is time that takes away from patient care, and it represents a significant administrative burden.

What Has Been Done So Far

Health Canada has taken steps to support better communication around the program. The department has developed an online stakeholder toolkit that includes fact sheets, explanatory videos, and other resources designed to help dental teams better understand the CDCP and how to navigate it with their patients. The toolkit also includes patient-facing materials, such as fact sheets and printable posters that can be displayed in dental offices and shared directly with patients. These resources represent a positive step toward the federal government taking on greater ownership of communicating the program to patients. It is important that the federal government ensures that these materials are well publicized, kept current, and continually adapted as the program evolves, so the burden of explaining the CDCP does not remain on dental offices.

CDCP Is Not Communicating Effectively to Eligible Patients



According to a survey of CDCP patients:

59%

of patients expected completely free care.

24%

expected to pay nothing but had to pay out of pocket.

27%

said their out-of-pocket costs were higher than expected at their first appointment.

23%

found that some of the care their dentist recommended was not covered by the program.



Information CDCP patients said they were missing before their first visit:

38% said they didn't know which services are covered.

37% said they didn't know about likely out-of-pocket expenses.

35% said dental staff needed to explain the program to them at every or most visits.



Who explains the CDCP to patients?

32% of patients say the clearest explanation came from the dentist.

26% say it came from clinic staff.

23% identify the government as the clearest source of information.



The most common things dentists had to explain to patients:

61% CDCP balance billing or additional charges

61% services not covered

55% preauthorization requirements



One third of dentists report that they and their staff spend over 40 minutes a day explaining the CDCP to patients.

Source: CDA surveys, 2026

The Impact on Patients

Patient confusion is not a minor concern. It directly affects whether patients use the coverage they have. Among CDCP-enrolled individuals who have not yet used their coverage, **19% say they are unsure how to use it.**

The consequences of patient confusion are not limited to enrollment hesitation or unmet expectations. When patients arrive at appointments believing their care will be fully covered, or when a CDCP policy change unexpectedly increases their out-of-pocket costs mid-treatment without prior communication from the federal government, the frustration often falls directly on dental office staff. The fact that 59% of patients expected completely free care reflects in part how the program has been publicly communicated by the federal government during its initial launch phase, and in part the reality that for many patients, the CDCP subsidy does not go far enough to cover the full cost of the care they need.

Some patients, faced with unexpected charges, view their dental office as taking advantage of them, when in reality dental teams are working to navigate a complex program and help patients access the care they need. While anecdotal, this helps illustrate the issue. This misdirected frustration strains the patient-provider relationship, places emotional and operational pressure on dental office staff, and ultimately affects the patient experience that deters return visits and undermines continuity of care. In some cases, this can also be misconstrued as professional misconduct and reported to the provincial regulatory body, which may further lead to the erosion of the patient–dentist relationship.

Beyond these challenges, the broader cost of patient confusion is one of trust. When patients arrive at their dental appointment with expectations that the program cannot meet, the discrepancy registers as a failure of the program. This outcome erodes confidence in the CDCP and creates avoidable barriers to continued utilization.

CDA Recommendations

The federal government bears primary responsibility for ensuring that patients understand the CDCP they are enrolled in. CDA recommends that the government:

- **Improve and expand government patient-facing communications to set clear, accurate expectations about what the CDCP covers**, including what patients may be asked to pay, and how the program works before patients arrive for their appointments. This should include direct outreach to enrolled patients and accessible plain-language materials, such as letters and government ads, covering covered services, out-of-pocket costs, and preauthorization requirements.
- In consultation with oral health stakeholders, **continue to develop structured communication support for dental offices to help explain the CDCP to patients**, including ready-to-use patient resources that practices can share with CDCP patients to ensure consistent, accurate information at the point of care.
- **Establish clear, advanced communication protocols to patients and dental offices for changes to program policy** including changes to covered services, fee structures, or preauthorization requirements so that patients receiving care under the CDCP are not left navigating unexpected shifts mid-treatment.

Impact of the CDCP on Dental Education and Clinical Training



The CDCP is expanding access to dental care for millions of Canadians, representing a transformative public investment in oral health. However, the program's current design is creating an unintended consequence for the institutions that train Canada's future dentists and, in turn, for the patients those dentists will one day treat.

Dental school clinics occupy a distinctive role in the oral health system. They train students through hands-on clinical work while serving as an access point for patients who need lower-cost, comprehensive care and are willing to accept longer appointment times in exchange. The CDCP has shifted that dynamic. As private clinics take on CDCP patients, many people who once relied on dental school clinics can now access faster care closer to home with lower out-of-pocket costs. For these patients, that is a positive development. But it draws patients away from the teaching clinics that depend on them, weakening the training opportunities students need to develop clinical competency. If left unaddressed, it risks compromising the training quality of the future supply of dentists available to treat patients.

Loss of Patients: a Training Issue That Becomes a Future Access Issue

Dental students must complete a required volume and variety of clinical procedures to graduate prepared to treat patients safely. When patient volumes fall at teaching clinics, students have fewer opportunities to perform complex procedures, such as crowns, dentures, and root canals, that build readiness for independent practice. Preauthorization denials and delays add further pressure, removing or delaying cases that students were counting on for training. The combined impact is mounting pressure on Canada's ten dental schools to find patients requiring suitable treatments so that dental students can receive training. Consequently, the learning experiences for Canada's dental students, both in terms of quantity and quality, face a significant risk.

The introduction of the CDCP led to observable changes in patient behaviors within dental school clinics, though the impact was not uniform. Some dental schools report limited impact on new patient applications, while others are seeing more significant challenges in patient intake and clinical activity. In 2025, some dental schools noted a decline in patient volumes, particularly in their emergency clinics, though patient numbers have been on the rise again according to preliminary 2026 data. Further, dental schools had anticipated seeing more patients from households with incomes between \$70,000 and \$90,000. This is because these patients could have lower co-pays when receiving care at a dental school clinic. Despite this, the ten dental school clinics have reported that most patients they see have an annual household income below \$70,000. Dental school clinics also report that some lower-income patients cannot afford treatments not covered by CDCP.

Clinics are Also Absorbing Administrative and Financial Strain That Affects Their Ability to Serve Patients

To address these challenges, schools have drawn on internal funds and/or short-term support, including one-time funding received from the federal government through the Oral Health Access Fund (OHAF), to subsidize patient care so students can continue meeting clinical requirements.

The OHAF has supported multiple projects across the ten dental schools that train dental students in rural, remote and vulnerable communities. However, some schools have faced added administrative costs where existing systems are not compatible with CDCP claims processes, requiring manual claim submissions via courier and additional administrative staff. However, these are stopgaps and temporary solutions are not sustainable. A long-term model is needed to ensure patients can continue accessing care through dental school clinics and students can graduate with the competencies patients will rely on in the future. The CDCP is an important advancement in access to oral health care and Canada's dental schools are part of the same oral health system the program seeks to strengthen. Federal policy that improves access to oral health care must also protect the clinical education that supports Canada's oral health workforce. Without a sustainable model, teaching clinics face mounting pressure to maintain both the patient care they provide today and the training they deliver for tomorrow. Addressing these challenges requires a co-ordinated response across the federal, provincial, and territorial governments.

CDA Recommendations

The training dental students receive today determines the quality and capacity of patient care tomorrow. Acting now protects the future of care for patients across Canada. CDA recommends that the federal government:

- Convene federal, provincial, and territorial health and education ministers, together with oral health stakeholders, to **develop a sustainable model for clinical training in dental school settings** that stabilizes patient care at teaching clinics and ensures students across Canada can complete the training future patients will rely on.

Summary of Recommendations



This section brings together a list of all recommendations presented in this paper in one place. Each recommendation has appeared earlier alongside the detailed analysis that supports it. They are consolidated here so that readers can see the full set at a glance.

This summary organizes them against the scorecard presented earlier in this paper. The scorecard assesses how the CDCP is performing based on the recommendations CDA set out in 2023. The CDA's recommendations in this paper identify the actions needed to move each measure forward. Read together, they connect where the program stands today with the concrete steps that would most directly improve access to care and oral health outcomes for patients. Where a measure has been achieved, the priority is to protect that progress. Where progress remains limited or has not been achieved, the paired recommendations in the chart show the most direct path to improvement.

Recommendations are numbered and paired with the measure to which they most directly relate to. The labels shown here mirror the scorecard. The numbering of recommendations do not reflect their order of importance or priority.

CDA 2023 MEASURE OF SUCCESS	CDA 2026 RECOMMENDATION
PATIENT CARE	

Patient's Right to Choose Provider

No new recommendations; the priority is to protect this progress.



Achieved

Multiple pathways for providers to participate have resulted in the majority of providers engaging in the program, allowing greater flexibility for patients to choose their preferred provider.

CDA 2023 MEASURE OF SUCCESS	CDA 2026 RECOMMENDATION
Patient Care Experience  Achieved Enrollment is functioning and patients report strong positive experiences.	No new recommendations; the priority is to protect this progress.
Prioritize and Promote Prevention  Limited Progress More patients are receiving care, but coverage limits constrain a true prevention focus for patients.	1. Place greater emphasis on prevention by incorporating patient risk factors into coverage decisions and expanding access to preventive services, which will help to support earlier intervention, reduce disease progression, and improve long-term oral health outcomes.
Holistic Model of Care  Limited Progress Despite improving access to care, the CDCP continues to face limitations in providing coverage for patients with complex needs, promoting equitable access and supporting upstream initiatives.	2. Adapt the CDCP basket of covered services to better reflect the oral health needs of the populations it intends to serve and that experience higher levels of disease burden and complexity. These populations include seniors, persons with disabilities, individuals with chronic health conditions, and others with elevated oral health risks. 3. Develop a federal oral health equity and access strategy that complements the CDCP by addressing the broader social determinants of oral health and non-financial barriers to care.
Patients Not Facing Arbitrary Limits  Not Achieved Preauthorization denials, coverage caps and considerable out-of-pocket costs for many eligible users continue to shape care decisions for patients.	4. Address coverage limitations that prevent patients from accessing clinically recommended treatments and specialist services by ensuring coverage and overall program policies more closely reflect evidence-informed clinical practice care and reduce barriers to appropriate treatment. 5. Invest in targeted provider education and practical guidance on preauthorization requirements to improve submission quality, reduce avoidable delays, and support more efficient access to care. 6. Improve and expand government patient-facing communications to set clear, accurate expectations about what the CDCP covers, including what patients may be asked to pay and how the program works before patients arrive for their appointments. This should include direct outreach to enrolled patients and accessible plain-language materials, such as letters and government ads, covering covered services, out-of-pocket costs, and preauthorization requirements. 7. Protect long-term patient access through sustainable program funding. Regularly assess out-of-pocket costs for patients to identify emerging access risks before they become systemic.

CDA 2023 MEASURE OF SUCCESS	CDA 2026 RECOMMENDATION
PROGRAM DESIGN	
Payor of Last Resort  Achieved Eligibility criteria excludes people with private dental coverage.	No new recommendations; the priority is to protect this progress.
Use of Nationally Adopted Tools and Systems  Achieved The program runs on established claims infrastructure networks, providing ease of access for patients.	No new recommendations; the priority is to protect this progress.
Delivery of Care Through Private Dental Infrastructure  Mostly Achieved Patients are served through the existing private dental office infrastructure. Policies that recognize the distinct scopes of practice of each provider type are required.	No new recommendations paired with this metric.
Designed to Complement Existing Public Dental Programs  Mostly Achieved CDCP co-ordinates benefits with public dental programs, acting as first payor in relation to many provincial programs. Provincial programs may cover the difference, though in some regions provincial programs could be scaled back for CDCP patients.	8. Work with provinces and territories to ensure that CDCP neither displaces public dental programs nor enables further delays in their critical modernization, so that patients who rely on both layers of coverage are not left to absorb the gap when provincial or territorial support is scaled back.

CDA 2023 MEASURE OF SUCCESS	CDA 2026 RECOMMENDATION
Match Current Provincial and Territorial Fee Guides  Limited Progress CDCP had adopted the USC&LS coding system but CDCP fees do not match suggested provincial fee guides and treatment codes are not updated in a timely manner.	9. Ensure that annual CDCP fee increases reflect the updates to the provincial and territorial dental fee guides and increases in the actual costs of delivering dental care. Link annual CDCP fee adjustments to actual dental practice cost drivers including staffing, supplies, and rent, rather than relying primarily on general inflation measures. 10. Establish a process to align CDCP treatment codes with annual USC&LS updates, through a transparent, predictable mechanism that reduces billing errors and administrative burden.
Administrative Procedures Do Not Delay or Impede Patient Care  Limited Progress The CDCP has made improvements to provider enrollment and claim processing, but administrator issues, medical criteria not disclosed, preauthorization denials with limited or no explanation, and the requirement to check a patient's eligibility at every appointment still add burden.	11. Strengthen the CDCP third-party administrator's support contact centre, with particular focus on consistent agent training and accurate information provided to dental offices and patients. 12. Improve the CDCP claims verification and appeals process through clear and timely communication, third-party administrator system enhancement and flexibility and greater transparency on reconsideration and appeal outcomes. 13. Simplify eligibility renewal and protect continuity of coverage by providing patients with timely renewal reminders and establishing an exceptional circumstances pathway, so that eligible patients do not experience coverage gaps that interrupt an active course of treatment. 14. Modernize and streamline the CDCP's third-party administrator preauthorization systems and processes by improving electronic submission capabilities, ensuring compatibility across practice management software platforms, reducing reliance on paper-based workflows, and providing timely, consistent communication throughout the adjudication process. 15. Improve the transparency and predictability of the preauthorization process by providing dentists with clear information on clinical acceptance criteria, and specific explanations when requests are denied, identifying unmet needs. 16. In consultation with oral health stakeholders, continue to develop structured communication support for dental offices to help explain the CDCP to patients, including ready-to-use patient resources that practices can share with CDCP patients to ensure consistent, accurate information at the point of care.

CDA 2023 MEASURE OF SUCCESS	CDA 2026 RECOMMENDATION
Preserves and Promotes Private Dental Coverage  Limited Progress People with private insurance are excluded and there are annual eligibility checks, but no strategy to deter potential erosion of employer benefits exists.	17. Establish a formal, ongoing monitoring mechanism to track employer and private dental benefit trends, including changes to plan coverage, employee participation rates, and patterns of erosion. 18. Develop a contingency framework that includes employer educational campaigns and tax incentives for employers who maintain dental benefits for lower-income employees who would otherwise be eligible for the CDCP.
Cover Cost of Care  Not Achieved Persistent affordability concerns exist stemming from co-payment requirements and CDCP fees set below cost of treatment leaving patients facing out-of-pocket costs.	19. Reduce or eliminate out-of-pocket costs for CDCP patients by aligning CDCP fees with the actual costs of providing dental care. 20. Assess whether co-payment requirements are discouraging eligible patients from seeking dental care. If evidence shows co-payments are creating affordability barriers, the program should be adjusted to better support access to care, especially for patients in income brackets requiring a co-payment.

ORAL HEALTH STRATEGY

Consultation and Collaboration  Achieved Stakeholder input provided to the federal government and engagement continues.	No new recommendations; the priority is to protect this progress.
Comprehensive Oral Health Strategy  Limited Progress While the CDCP and related initiatives have expanded access, gaps remain in who the program is serving, addressing broader social determinants and ensuring sustained funding for targeted access programs.	21. Commission a formal, independent evaluation of CDCP targeting effectiveness. This evaluation should draw on administrative claims data, tax filing patterns, and population-level health data to assess whether the program is meaningfully reaching those who previously lacked access to dental care. 22. Re-establish the Oral Health Access Fund at an appropriate funding level, recognizing that the original \$250 million investment may need to be recalibrated in light of current fiscal constraints, with a mandate focused on outreach to underserved populations, provider workforce development, and infrastructure support. 23. Convene federal, provincial, and territorial health and education ministers, together with oral health stakeholders, to develop a sustainable model for clinical training in dental school settings that stabilizes patient care at teaching clinics and ensures students across Canada can complete the training future patients will rely on.

CDA 2023 MEASURE OF SUCCESS	CDA 2026 RECOMMENDATION
Set of Common National Standards  Limited Progress CDCP creates a national reference point, but its uniform income thresholds and co-payment structure across the country do not adequately reflect regional cost-of-living differences or oral health needs.	24. Review eligibility and co-payment design to address structural barriers and equity gaps. As part of any evaluation, the federal government should examine whether current criteria, including the reliance on federal income tax filing, the use of a single national income threshold without accounting for regional differences, and the co-payment structure, may be limiting the program’s ability to reach patients it was intended to help.
Human Resource Challenges  Limited Progress Efforts to address oral health workforce shortages that affect timely access to care remain limited, but some progress made, such as an expanded Student Loan Forgiveness Program.	25. Invest \$2 million over two years to establish a pan-Canadian oral health workforce planning framework to support the collection, analysis, and modelling of workforce data at the national and regional level, enabling governments and stakeholders to proactively identify and address workforce shortages, distribution challenges, and future capacity needs. 26. Work with provinces, territories, regulators, educational institutions, and oral health stakeholders to address barriers and support workforce planning, including forecasting, provider maldistribution, labour mobility, training and educational capacity, and the integration of internationally educated oral health professionals. 27. Make dental assisting eligible for key federal programs to help address shortages: • Federal student loan forgiveness program to support workforce distribution and encourage dental assistants to work in rural and underserved communities. • Post-Graduation Work Permit (PGWP) program to help international students undergoing training in dental assisting to remain and be able to work in Canada. • Extend an exemption for dental assisting programs of private career colleges from current eligibility limitations under the Canada Student Grant program for Full-Time Students to reduce barriers to training and strengthen the pipeline of qualified dental assistants entering the workforce.

CDA 2023 MEASURE OF SUCCESS	CDA 2026 RECOMMENDATION
Ongoing Plan Improvement  Limited Progress While some efforts have been made to address implementation issues and improve communications, there remains no clear public commitment to a comprehensive CDCP review.	28. Collect and report CDCP program data publicly. Health Canada should establish a transparent reporting framework that publishes regular, disaggregated data on CDCP utilization, patient demographics, and care patterns. This data should support ongoing program evaluation, independent research, and evidence-based policy development. 29. Establish clear, advanced communication protocols to patients and dental offices for changes to program policy including changes to covered services, fee structures, or preauthorization requirements so that patients receiving care under the CDCP are not left navigating unexpected shifts mid-treatment. 30. Implement a structured, periodic public review of the CDCP with a focus on population-level oral health outcomes to assess progress, identify challenges, and make evidence-based adjustments to the program over time. 31. Incorporate long-term sustainability into CDCP evaluation. Health Canada should include long-term sustainability metrics within the CDCP evaluation framework by regularly monitoring changes in demographic trends, eligibility growth, utilization patterns and program expenditures.
Oral Health Data  Not Achieved No clear long-term strategy for using CDCP data to measure outcomes, limited access to data for researchers and uncertain future funding for key oral health data collection.	32. Restore consistent, ongoing funding to Statistics Canada to relaunch and sustain key oral health data initiatives, including the Canadian Oral Health Survey (COHS) and the Survey of Oral Health Care Providers (SOHCP) on a regular, recurring basis. 33. Ensure that oral health components are included in the Canadian Health Measures Survey (CHMS) on a regular and predictable basis, at a minimum every five years. Consistent clinical oral health data is necessary to establish baselines, track trends, and evaluate the long-term impact of the CDCP on oral health outcomes. 34. Improve access to oral health data through appropriate governance and privacy safeguards. Broader access to data would strengthen independent evaluation, support innovation, and contribute to a more robust evidence base for oral health policy in Canada.

Note: Labels reflect CDA's assessment of program-wide progress based on its 2023 recommendations as of June 2026. Recommendations are reproduced in full from the corresponding sections of this paper.

Annexes

Annex I: Perspectives from the Provincial and Territorial Dental Associations

The Canadian Dental Association invited each provincial and territorial dental association (PTDA) to share its jurisdiction's experience with the Canadian Dental Care Plan. The summaries below reflect the perspectives of each individual PTDA as submitted to CDA.

They are presented to document the range of regional experiences with the program and do not necessarily represent the positions or recommendations of the CDA. Entries have been edited for length and consistency, and each PTDA reviewed and approved its summary prior to publication.

Alberta

Alberta Dental Association (ADA)

What is working: The CDCP has significantly improved access to dental care for eligible Albertans who previously faced financial barriers. It has also increased public awareness of oral health and available dental benefits, encouraging more individuals to seek routine and preventive care. The CDCP has been well received by many dental providers because it allows balance billing and its fee grid is more closely aligned with the Alberta Dental Association's Suggested Fee Guide than existing provincial public programs. As a result, more dental clinics are able and willing to accept patients enrolled in the program. Alberta's decision in 2026 to implement co-ordination of benefits (COB) between the CDCP and provincial dental programs has further strengthened patient access and provider participation. By enabling eligible patients to co-ordinate benefits between programs, the province has reduced financial barriers, improved continuity of care, and simplified the claims process for both patients and dental offices.

Challenges observed: While the CDCP has improved access to care, several challenges remain. Reimbursement levels for many procedures continue to fall below the Alberta Dental Association's Suggested Fee Guide, resulting in patient co-payments that can create confusion and, in some cases, become a barrier to receiving treatment. COB remains complex, particularly when the CDCP is combined with provincial dental programs or other insurance plans. Both dental providers and patients continue to seek clarification regarding eligibility, coverage, payment responsibilities, and claims processing. Administrative requirements for dental offices have also increased significantly. Practices must verify patient eligibility, manage preauthorization requests, navigate co-ordination of benefits, and educate patients about their coverage and financial responsibilities. In particular, preauthorization

requirements are consistently identified by providers as a source of delays, increased administrative burden, and uncertainty for both dental teams and patients.

System and workforce impacts: The added administrative workload has placed further pressure on clinical and administrative staff and created a need for additional staff training. Patients frequently experience confusion about how the CDCP interacts with private insurance and other government-funded programs. On the training pipeline, the University of Alberta School of Dentistry student clinic has largely retained its patients for clinical instruction.

Priority change identified: increase transparency around decision-making criteria and simplify and preauthorization requirements. On co-ordination, the ADA notes the Government of Alberta was initially silent on CDCP acceptance, creating confusion, until a December 2025 MOU established the CDCP as first payor and COB with provincial LIHB programs up to 100% of the Alberta Suggested Dental Fee Guide. Following the Province's signalled intent to exit the CDCP, the ADA has proposed a "Roadmap to a Made-in-Alberta Dental Plan" focused on reducing red tape, improving care, and addressing workforce and prevention. The ADA has indicated further detail on their proposed roadmap can be provided upon request.

British Columbia

British Columbia Dental Association (BCDA)

What is working: The CDCP has helped expand access to essential dental care for a portion of approximately 450,000-500,000 eligible British Columbians who face financial barriers, particularly seniors, low- and modest-income individuals, and those without employer-sponsored benefits. It has also raised public awareness of the link between oral and overall health. The CDCP has been particularly helpful for Ministry of Social Development and Poverty Reduction (MSDPR) clients (low-income residents, persons with disabilities and children) who also qualify for CDCP coverage, as the MSDPR dental plan has less coverage than the CDCP. The ability to balance bill has supported sustainable participation by providers.

Challenges observed: Dental offices report significant difficulty with preauthorization, with over 80% of BC dentists reporting challenges with these processes, including inconsistent information from the CDCP's call centre agents. This has led to an overall increase of administrative burden. Patients have, at times, misunderstood the scope of coverage—including co-payments and frequency limits, leading to difficult conversations in offices. In some cases, clinically appropriate treatment plans that clinicians would typically recommend based on preventive care, disease progression, or best practice standards may not meet CDCP eligibility criteria, so patients may have the mistaken impression that they are unnecessary.

System and workforce impacts: Surging demand has compounded an existing shortage of dental staff, with the BCDA estimating a shortfall of over 1,365 licensed dental assistants. Reimbursement rates averaging roughly 87% of the BCDA fee guide raise concerns about long-term provider participation and, by extension, patient access. The BCDA also notes a risk that the CDCP is perceived as filling gaps left by

outdated provincial programs, which it cautions could reduce pressure to modernize those programs and affect funding for not-for-profit clinics serving vulnerable patients.

Priority change identified: Allow patients to pay upfront and seek reimbursement directly.

New Brunswick

New Brunswick Dental Society (NBDS)

What is working: People who previously avoided the dentist because of cost are now able to seek care. The NBDS reports increased access, fast reimbursement to dentists, and smooth electronic submission through CDAnet. The ability to balance bill between the CDCP grid and the provincial fee guide is described as essential to participation.

Challenges observed: Because most New Brunswick practices are not accepting new patients, CDCP-eligible patients can find it difficult to establish a dental home. Preauthorization is reported as a significant administrative burden, often taking weeks, requiring more information than usual, and giving unclear reasons when denied. Some services required for preauthorization are not themselves covered, meaning patients may be charged simply to determine eligibility for further care. There are some issues with the CDCP's administrator website which have led to further administrative burden. Patients continue to expect the program to be free and are sometimes surprised by co-payments and higher-than-expected laboratory costs. Some patients are dropping their existing private coverage to enroll in the CDCP. The co-ordination with existing provincial plans is still being sorted out, but currently patients can only use one or the other. Denture eligibility criteria is noted as focused on appearance rather than function, so some preauthorization requests for necessary treatments are being denied. When patients are referred to specialists who do not participate in the CDCP, they are often unable to access covered specialist care because there is no mechanism for patients to pay for treatment and submit receipts to Sun Life for reimbursement.

System and workforce impacts: Workforce pressure is the dominant system impact, and most clinics are declining new patients altogether, placing particular strain on front-desk staff. New graduates require considerable mentorship, and the volume and pace of treatment add pressure for early-career dentists. Limited specialist participation places additional demand on general dentists.

Priority change identified: Improve the preauthorization process so that it is simpler and clearer for both patients and providers. Develop a reimbursement process that allows patients referred to non-participating specialists to pay for treatment and submit receipts to Sun Life (e.g., by mail or email) for reimbursement, particularly in jurisdictions where specialist participation in the CDCP is limited.

Newfoundland and Labrador

Newfoundland and Labrador Dental Association (NLDA)

What is working: The NLDA reports that more people now have access to care, including patients who had never previously seen a dentist. Dentists in rural communities are notably busier, and the association points to meaningful health gains, including patients returning to care and instances of oral cancer being identified in individuals who would not otherwise have visited a dental office.

Challenges observed: The principal challenge identified is long wait times to see a dentist. The association also points to the administrative burden of preauthorization paperwork as an area for improvement, along with a need for clearer explanations to patients of why specific services are not covered. They also noted that many potential patients do not know about the CDCP.

System and workforce impacts: Workforce pressure is the main emerging impact, with a particular need for more dental assistants to meet demand.

Priority change identified: Reduce the paperwork associated with preauthorizations and improve communication to patients about coverage decisions. The NLDA notes that greater public awareness of the program remains a priority.

Nova Scotia

Nova Scotia Dental Association (NSDA)

What is working: Patients, especially those with low incomes, are glad to have costs covered and dentists report patients coming in more regularly, rather than only for urgent treatment. The program has improved access and peace of mind, works well for basic services such as hygiene and basic restorations, and has seen good dentist uptake and participation. Dentists are satisfied they are able to sign up without having to register as a provider and are satisfied they are able to balance bill for services.

Challenges observed: Offices report inconsistent preauthorization results, with similar cases receiving different coverage decisions and the explanation for denials “does not meet criteria” is seen as insufficient. Considerable staff time is spent explaining coverage to patients, many of whom still believe the program is free or covers all costs. Patient frustration rises when laboratory bills are not fully covered or when clinically recommended treatment falls outside coverage. This frustration, in turn, weighs on already short-staffed dental teams. This, in turn is leading to increased staff burnout, more sick days and a greater chance of staff leaving the dental workforce entirely.

System and workforce impacts: After an initial surge of new CDCP patients, many offices report reaching capacity, with longer wait times for existing patients, and in some cases CDCP clients cannot find a dental office that is accepting new patients. The CDCP has exacerbated pre-existing staff shortages. The NSDA also notes that the program’s rollout appears to have given little consideration to its effect on dental schools, particularly the loss of patients from public teaching clinics. As well, program

eligibility means that those who do not file federal income tax returns cannot apply, and in many cases these are the people who need government coverage the most.

Priority change identified: Greater consistency and communication, so offices can speak with confidence about preauthorizations. The NSDA suggests the program could evolve toward an oral health spending account model, noting that members find the current system too complex for patients and offices. This would also create more patient-focused treatment options.

Ontario

Ontario Dental Association (ODA)

What is working: The program has broadened access to dental care, with approximately 36% of patients with CDCP coverage indicating limited access to care prior to the CDCP. Dentist participation is high, with 95% of Ontario dentists reporting participation. High dentist participation provides patients with more choice of oral health care providers accepting their coverage. The ability to balance bill makes delivery of care sustainable. Ontario's interim co-ordination-of-benefits approach with certain provincial programs (i.e. Healthy Smiles Ontario and the Ontario Disability Support Program) reduces out-of-pocket expenses and could save the province between \$85 and \$100 million annually, an arrangement the ODA urges be made permanent.

Challenges observed: Offices report frequent preauthorization denials (approximately 70%) without clarity, alongside claims denials and commercial laboratory fee caps introduced without consultation that can leave patients facing higher costs than quoted and harming the dentist-patient relationship. Lengthy preauthorization processing times, inconsistent claim submission requirements for services provided by denturists employed by dentists, clinical criteria not aligned with treatment completed by specialists, and the need to verify patient eligibility all contribute to increased administrative burden for dental offices and patients. Federal communication describing the program as "free" has left dental teams to explain co-payments and excluded services.

System and workforce impacts: The ODA identifies a risk of erosion of employer-based (third-party) coverage, severe workforce shortages worsened by increased demand, and open questions about the future role of provincial governments in public dental care. It also notes that administrative burden is straining the dentist-patient relationship, adding administrative costs for dental clinics and uncertainty for patients, and that declining patient volumes at dental school clinics are reducing students' clinical experience. Although data does not yet demonstrate this, the CDCP may be reducing hospital and physician visits for non-traumatic dental issues.

Priority change identified: The ODA urges a policy focus on long-term sustainability. It proposes re-structuring the CDCP as an oral health spending account, alongside measures such as non-assignment billing, co-ordination with private insurance to prevent de-insurance, improved federal public education, and a program

evaluation shift toward measuring oral health outcomes and preventative care. Maintaining funding and the ability to balance bill are identified as critical priorities.

Manitoba

Manitoba Dental Association (MDA)

What is working: The program has improved access for many Manitobans who previously delayed or avoided care because of cost. The MDA points to the ease of submission and payment for basic services that do not require preauthorization, the use of electronic submission through CDAnet, and improved access to preventive and diagnostic services for patients who previously had no coverage.

Challenges observed: Many patients incorrectly believe the program provides free dentistry, leading to difficult conversations about co-payments, frequency limits, excluded services, and balance billing. Administrative complexity—preauthorization requirements and delays, changing policies, co-ordination-of-benefits issues, and eligibility verification—remains a concern for offices. Reimbursement levels continue to create financial barriers for patients, and the MDA cautions that sustained reimbursement gaps may affect long-term provider participation and patient affordability.

System and workforce impacts: The MDA highlights a significant impact on dental education, the University of Manitoba's College of Dentistry has seen a large loss of teaching-clinic patients, raising concerns that students may graduate with less clinical preparation. It also notes uncertainty about the long-term interaction between the CDCP and private insurance, and increased pressure on appointment availability in rural and northern communities where shortages already exist.

Priority change identified: establish a federal policy on co-ordination of benefits that prevents the elimination of provincial benefits for those eligible for the CDCP, and bring CDCP reimbursement into closer alignment with the actual cost of delivering care in Manitoba. The MDA notes that the province has announced it will no longer provide income assistance dental benefits to individuals eligible for the CDCP, which it warns will disproportionately affect vulnerable patients unable to pay the difference between the CDCP and the suggested provincial fee guide.

Prince Edward Island

Dental Association of Prince Edward Island (DAPEI)

What is working: Access to care is described as the program's most significant benefit, with increased access for previously underserved populations across the province. The DAPEI reports that dental offices are seeing strong patient demand under the program.

Challenges observed: Administration is described as daunting, with claims reviews seen as too frequent and burdensome. Prince Edward Island offices report being flooded with patients while lacking enough dentists to serve them, and the DAPEI notes that the volume of audits and the time and resources required leave

practices struggling to accommodate all new patients. The CDCP has added to this administrative burden.

System and workforce impacts: Human resources are identified as a major pressure point across the oral health workforce, including dentists, dental hygienists, and dental assistants alike. The DAPEI also points to conflicts between the CDCP and the provincial dental plan, and expresses some uncertainty about the program's longer-term effect on private coverage, given its scale.

Priority change identified: Reduce the administrative burden associated with the program, including the frequency of audits and claims reviews, so that providers can spend more time treating patients. The DAPEI notes that the province is currently in negotiations on its provincial program, with the aim of incorporating the CDCP as the primary payer, and raises concerns about how program costs and the interaction with private plans will be managed over the long term.

Saskatchewan

College of Dental Surgeons of Saskatchewan (CDSS)

What is working: The CDSS reports that most clinics in Saskatchewan are currently accepting CDCP patients, and that it has received very few inquiries from registrants about the program since its introduction. The College suggests this may anecdotally indicate the absence of significant operational issues in the province.

Challenges observed: Based on interactions with both registrants and the public, communication and understanding of the program's details emerge as the most significant challenge for patients and clinics alike. The concept of "100% coverage" is frequently misunderstood by patients to mean that services are entirely free, when the nuances of coverage levels, co-payments, and balance billing are not always well understood. The CDSS notes that publicly available information can be difficult for patients to locate and interpret, and that the administrative burden of the program remains considerable for many practices, underscoring the importance of knowledgeable administrative staff who can clearly explain the program to patients.

System and workforce impacts: The CDSS does not have specific registrant data to report on broader system or workforce effects, but identifies clear patient communication and adequately supported front-office staff as central to the program working well in practice.

Priority change identified: Saskatchewan has recently made progress on co-ordination of benefits between the provincial dental program and the CDCP. The CDSS notes that, once implemented, this co-ordination will be very positive for both patients and providers.

Annex II: Summary of CDA's 2023 Recommendations

In 2023, CDA released *Bridging the Financial Gap in Dental Care*, a policy paper setting out the principles CDA believed were necessary for any federally funded dental care program to improve access to care and oral health outcomes for Canadians. That paper was published before the Canadian Dental Care Plan (CDCP) design was finalized and implementation began, and it has served as CDA's reference point for assessing the program ever since. This annex reproduces those 2023 recommendations in full, without edit or interpretation.

Key Principles (Executive Summary p.4)

Any federally funded dental care program or oral health initiative should be designed to:

- be compatible with a holistic approach to oral health that acknowledges the interconnection between oral health and general health and wellbeing.
- promote patient-centred care and a patient's right to choose their provider.
- prioritize preventative care.
- support the delivery of care primarily through the existing network of dental offices, supplemented as needed by public clinics.

CDA's Main Recommendations (Executive Summary p.5)

- A federally funded program should promote the delivery of dental care primarily through the existing network of dental offices, supplemented by public clinics, as needed.
- Public dental care programs should remain a payer of last resort, after any privately funded coverage.
- A federally funded program must be designed to complement and improve the care that Canadians have through existing federal, provincial and territorial programs.
- Program design should ensure that administrative procedures do not impact or delay the provision of care to patients.
- The federal government should address human resource challenges and staffing shortages in the oral health sector.
- Any federal dental care formula should ensure the cost of treatment provided to patients is fully covered.

Key Principles That Underline Our Recommendations (p.9)

- It is essential that any federally funded dental care program or oral health initiative be designed to be compatible with a holistic approach to oral health.
- Policy design should promote the concept of patient-centered care.

- The federally funded dental care program should be designed to prioritize and promote preventative care.
- Patients covered by any federally funded dental care program should not face arbitrary limits on type or cost of necessary dental treatment.
- While understandable in the case of complex treatment plans, predetermination requirements should not be used as a cost-control mechanism, especially when it impedes the provision of routine dental care.
- It is essential that any federal dental care formula ensures the cost of treatment provided to patients is fully covered.
- Any federally funded dental care program should use the most up-to-date version of provincial and territorial fee guides as the basis to determine funding of treatment.

Our Recommendations: A Broader Strategy on Oral Health (p.11)

- CDA believes that the federal government should develop a comprehensive federal oral health strategy that addresses a broader set of challenges facing Canadians in achieving optimal oral health.
- CDA urges the federal government to commit to a five-year program review of its approach to dental care, with a full report being made public upon completion.

Our Recommendations: Envisioning a Model for Federal Investment in Dental Care (p.12)

- The federal government should consult and collaborate with provincial and territorial governments, and oral health care stakeholders in designing and delivering initiatives to enhance equal access to dental care for Canadians coast to coast to coast.
- Federal, provincial and territorial governments should be encouraged to seek consensus on the best way to administer federally funded dental care initiatives within Canada's constitutional framework.
- A set of common national standards for publicly funded dental coverage should be established, with input from relevant stakeholders, to ensure that Canadians receive the quality dental care they need to achieve and maintain optimal oral health.

Our Recommendations: Program Delivery and Administration (p.14)

- Federally funded initiatives should promote the delivery of care primarily through the existing network of dental offices, supplemented as needed by public clinics.
- The advantages of providing care by dentist-led teams, with collaboration from other providers, should be clearly recognized and prioritized.
- In partnership with other levels of government, the federal government should work toward innovative approaches to supplement private delivery of care in specific circumstances where alternatives are needed.

- Any new federally funded initiatives should not create additional administrative burdens for dental offices.
- One way to streamline program administration would be to make use of several tools developed collaboratively by CDA and others and then widely adopted across Canada, such as Uniform System of Coding and List of Services, CDAnet and the ITRANS Claim Service & Standard Dental Claim Form.
- Public dental care programs should remain a payer-of-last resort, after any privately funded coverage.
- The federal government should also, in collaboration with other levels of government and industry stakeholders, explore ways to put in place a system that preserves and promotes further employer provided dental coverage.
- Resolving the potential challenge of widespread offloading of the responsibility for dental coverage from employers to the public sector needs to be a top priority for the federal government.

Our Recommendations: Federal Oral Health Strategy that Addresses Non-Financial Barriers to Better Oral Health (p.17).

- The federal government should commit to long-term, ongoing funding to ensure that oral health components are routinely included as part of both the Canada Health Measures Survey and the Canadian Community Health Survey.
- To address this, and as part of a broader oral health strategy, the federal government should make financial support available to oral health organizations who choose to participate in these activities, to offset the costs.
- CDA has also indicated that there is an increasing rate of dental appointment cancellations and increased patient wait times due to dental office staffing issues. CDA recommends that the federal government specifically address these human resource challenges and staffing shortages in the oral health sector.
- Efforts are also required to ensure that the dental workforce across Canada has the knowledge and expertise needed to provide all patients with the care they need—particularly those from high-needs demographics (i.e., children, seniors, persons with disabilities, etc.).

