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An Examination of Québec's Universal Dental Services Program for Children

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Abstract

Although the Canada Health Act does not include dental services in the list of services that must be covered publicly, provinces retain the prerogative to provide supplementary, publicly funded dental services. These provincial programs are most often directed towards groups deemed vulnerable, such as children and youth, but there is a high degree of program variation between provinces. Where all other provinces have means-tested eligibility criteria based on household income, Québec is the only province with a universal program for children under 10 years of age. Using the 3-I framework (ideas, interests, and institutions), we explore why a universal approach was adopted in Québec. The analysis focuses primarily on policy legacies of the Quiet Revolution: first, a new form of state interventionism as defined by the ideology of new nationalism, and second, the principle of universalism that emphasized population health promotion and the integration of health and social services in its policy programming.

Bien que la Loi sur la Santé du Canada ne mentionne pas les soins buccodentaires dans la liste des services devant être assurés publiquement, les provinces conservent la prérogative d'offrir des services buccodentaires supplémentaires financés par la province. Ces programmes s'adressent le plus souvent aux groupes considérés comme vulnérables, par exemple les enfants et les jeunes, mais il existe une grande diversité dans les programmes provinciaux. Alors que toutes les autres provinces ont des critères d'admissibilité basés sur le revenu du ménage, le Québec est la seule province à offrir un programme universel pour les enfants moins de 10 ans. À partir du cadre analytique des 3-I (idées, intérêts, et institutions), nous explorons les raisons pour lesquelles une approche universelle a été adoptée au Québec. L'analyse se concentre principalement sur l'héritage politique de la Révolution tranquille: premièrement, une nouvelle forme d'interventionnisme étatique telle que définie par l'idéologie du « new nationalism » et, deuxièmement, le principe d'universalisme, qui mettait l'accent sur la promotion de la santé de la population et l'intégration des services de santé et des services sociaux dans ses programmes politiques.

Key Messages

- Policy legacies of the Quiet Revolution shaped the creation of Québec's universal dental services program for children (DSPC) and youth.
- The Quiet Revolution shaped Québec's policy commitment to universalism, a new form of nationalism, with an emphasis on health promotion, and integrated health and social services.
- The introduction of the Canadian federal government's national dental plan in 2023 signals a shifting policy landscape in which Québec must decide whether to maintain its existing DSPC, adopt the federal policy, or negotiate a hybrid solution.

Messages-clés

- *L'héritage politique de la Révolution tranquille a façonné la création du programme québécois de services buccodentaires universels pour les enfants et les jeunes.*
- *La Révolution tranquille a façonné l'engagement politique du Québec envers l'universalisme, une nouvelle forme de nationalisme mettant l'accent sur la promotion de la santé et sur l'intégration des services de santé et des services sociaux.*
- *La mise en place du régime dentaire national du gouvernement fédéral en 2023 marque un changement dans le paysage politique, dans lequel le Québec doit décider s'il maintient son programme actuel de services buccodentaires pour les enfants, s'il adopte la politique fédérale ou s'il négocie une solution hybride.*

1 BRIEF DESCRIPTION OF THE HEALTH POLICY

In 1974, Robert Bourassa's Liberal Party of Québec (LPQ) government introduced a universal dental services program, the Dental Services Program for Children (DSPC) that publicly covered a range of preventive and restorative dental services for children, recognizing that cost was a major barrier to accessing dental care (MSSS [Ministère de la Santé et des Services sociaux] 2009). While some notable amendments have been made since its inception, the DSPC has not been modified since 1997. Today, the program covers one dental visit per year and other odontological services for children under 10 years of age (RAMQ [Régie de l'assurance maladie du Québec] 2024b). This program is managed by RAMQ, which administers health-related services and programs in accordance with the laws, regulations, and agreements between the MSSS and the province's professional federations, such as the Association des chirurgiens dentistes du Québec (MSSS 2021).

This health reform analysis explores why Québec adopted a universal, public-first insurance program for children, by focusing on two policy legacies of the Quiet Revolution: first, a new form of state interventionism rooted in the ideology of new nationalism, and second, the principle of universalism, which reinforced a focus on population health promotion and the integration of health and social services in policy development. This analysis was informed by a series of rapid jurisdictional reviews of provincial supplementary dental programs, described in Supplementary Material, Table S1.

2 HISTORY AND CONTEXT

2.1 Health Services in Canada: A brief overview of the private/public dichotomy

Canada's public health care system is unique among Organisation for Economic Co-operation and Development (OECD) countries: although it maintains generous universal coverage for physician and hospital services, Canadian Medicare does not publicly insure dental services (OECD 2021). Coverage for these services rather relies on private insurance — often employer-based if available — or direct out-of-pocket payments. This has created long-standing barriers to dental services for Canadians. In 2019, 23% of uninsured households with children reported cost as a major barrier to dental services (Murphy, Gondro, and Moharrami 2024).

The exclusion of dental services from Medicare dates back to the Royal Commission on Health Services (1961-1964), also known as the Hall Commission (Quiñonez 2013), where good oral health was deemed an individual responsibility. However, the Commission recommended the implementation of public programs for certain vulnerable populations only, namely children (Quiñonez 2013). As a result, many provinces created supplementary programs directed towards groups deemed vulnerable, including children and youth, as well as welfare beneficiaries and the elderly (Martine, Quiñonez, and Marchildon 2025).

In the early 1970s, six of the 10 Canadian provinces developed universal public dental programs for children (British Columbia, Newfoundland and Labrador, Nova Scotia, Prince Edward Island, Québec, and Saskatchewan), while Manitoba, New Brunswick, and Ontario implemented programs that included eligibility criteria based on income and geography; Alberta introduced a program focused on seniors (Martine, Quiñonez, and Marchildon 2025). An additional feature of Québec's program is that it is public-first, meaning that publicly funded coverage acts as the primary payer of services, rather than a last resort, regardless of whether individuals have private insurance. This is in opposition to a private-first approach where private dental insurance must be used first before any public program. While several Canadian provinces had public-first dental programs for children in the 1970s, most have been terminated and replaced with a private-first approach, apart from Québec and Newfoundland and Labrador (Government of Canada 2011).

2.2 A timeline of the DSPC in Québec

In 1974, the DSPC was introduced for those under the age of eight. The Québec government's interventionist stance continued throughout the 1980s by the Parti Québécois (PQ). Under René Levesque, the PQ expanded the age range for the program to include children 15 and under and removed the preventive services covered. While some dental services have been added since the program's inception, such as a varying number of dentist visits and different surgeries, few changes have been made to the program since the 1990s. Today, Québec maintains its universal insurance program for all children under 10 years of age which allows them to receive free, publicly insured preventive services and one dental examination per year (MSSS 2009). A timeline of the evolution of the program is presented in Table 1.

Table 1: Changes in Québec's DSPC, 1974-1996*

Year	**Government implementing**	**Age**	**Publicly insured dental services**	**Non-insured dental services**	**Key modifications**
1974	LPQ, Robert Bourassa	0-7	Preventive care; dentist visits; odontology; surgery	n/a	Program established under Loi Assurance Maladie, 1970

Table 1: Changes in Québec's DSPC, 1974-1996*

Year	**Government implementing**	**Age**	**Publicly insured dental services**	**Non-insured dental services**	**Key modifications**
1982	PQ, René Levesque	0-11	dentist visits; surgery	preventive care; fluoride; bucco-dental care; oral health education	Removal of preventive measures including oral health education; expansion of age coverage.
1982	PQ, René Levesque	13-15	preventive care; surgery	odontology	Expansion of age coverage; access to odontology removed.
1992	LPQ, Robert Bourassa	0-9	two dentist visits per year; odontology	preventive care; fluoride; bucco-dental care; oral health education	Restrictions added to dentist visits; access to odontology reinstated.
1992	LPQ, Robert Bourassa	10-15	No coverage	n/a	Public coverage of all services removed for children aged 10-15.
1997	PQ, Lucien Bouchard	0-9	one dentist visit per year	fluoride; bucco-dental care; oral health education	Further restrictions added to dentist visits; final modifications to program enacted.

* Adapted from: Msefer-Laroussi S. 2010. Analyse sociohistorique du système de couverture des services dentaires au Québec. Pratiques et organisation des soins 41(3): 257-267.

3 GOALS OF THE REFORM

3.1 Implicit and explicit goals of the program

The explicit goal of the DSPC was twofold. First, it addressed children's health inequalities by improving access to dental services regardless of the ability to pay or availability of private insurance (MSSS 2009). Major socio-economic inequalities in children's oral health

include decayed, missing, and filled teeth (Benigeri et al. 2002; Bernabé, Sheiham, and Sabbah 2009; Elani et al. 2012). The second explicit goal pertains to children's status as a vulnerable group (Ashkin 2018).

Implicitly, the DSPC reflected the push to strengthen Québec nationalism through the creation of progressive, universal social policies (Béland and Lecours 2008; Vaillancourt 2012). The policy legacy deriving from the Quiet Revolution is characterized by universalism as both an instrument and enduring symbol of Québec nationalism (Noël 2018; Rocher and Smith 2003). In this way, the DSPC reflects one of many policies that embeds the universalistic ideals in Québec's nation-building projects.

4 THE POLICY-MAKING PROCESS

Using the 3-I framework (ideas, interests, and institutions), we seek to understand the key factors that influenced the creation and adoption of Québec's DSPC. At the time of its implementation in the 1970s, Québec was expanding its social programs and was at the forefront of social reforms in Canada. The progressive and expansionary social programs and policies implemented by Robert Bourassa's provincial Liberal government was in part a continuation of the drastic changes that emerged out of the Quiet Revolution and in the context of Québec nationalism — notably the rise of new nationalism (Béland and Lecours 2008). We centre our analysis on two key policy legacies of the Quiet Revolution: first, a new form of state interventionism as defined by the ideology of new nationalism, and second, the principle of universalism.

4.1 State intervention and nation-building: A new nationalism in Québec

New nationalism was an explicit nation-building endeavour that distinguished itself from the federal government and other provinces and was partially realized through the creation of ambitious social policies. Where the federal government leveraged national social programs to foster a pan-Canadian identity, Québec used its own social programs to build a distinct community reliant on the provincial government (Béland and Lecours 2008; Boychuk 2009).

Québec's unique health and social policies reflect its distinct political identity and historical trajectory stemming from the Quiet Revolution. In the 1960s, Québec undertook massive social, economic, and cultural shifts. Before this period, the Catholic Church worked as a junior state, controlling social services and health (Vaillancourt 2012). The movement's objective was "to build a strong, pluralist state that reflects the dynamism, inventiveness, solidarity and universalist spirit inherent in the Québec nation" (Paquin and Rioux 2022, 18). The Quiet Revolution set Québec on a path of rapid secularization and industrialization while adopting a distinct form of nationalism rooted in its French-speaking majority (Béland and Lecours 2008; Rocher and Smith 2003). The legacy of the Quiet Revolution has profoundly shaped Québec's welfare state, namely through the production of a unique model of social policy (Noël 2018; Vaillancourt 2012).

The Quiet Revolution was a transformative period that redefined Québec nationalism through a dynamic of competitive state-building (Béland and Lecours 2008), where both federal and provincial levels of government used social policy as a tool to advance competing national visions (Béland and Lecours 2008). During the Quiet Revolution, new leadership under Premier Jean Lesage spearheaded significant reforms under the slogan *maîtres chez nous* (masters in our own home), dramatically increasing the Québec government's role in social policy. This process of new nationalism (Béland and Lecours 2008; Vaillancourt 2012) was rooted in a re-territorialization of the pan-Canadian Francophone identity to the Québécois identity, characterized by growing intervention by the Québec government, particularly in social policy. New nationalism allowed Québec to distinguish itself from the federal government and other provinces by investing in programs within its jurisdictional authority, namely education, health care, and social assistance (Béland and Lecours 2008).

4.2 Universality: A product of the Quiet Revolution

During the Quiet Revolution, the core policy ideal of universalism rose out of new nationalism. The DSPC is one example of many such programs that mobilized universalism through progressive and comprehensive province-wide policy instruments (Bernier 2006). Other programs in this expansionary period include public funding for private and higher education, generous parental leave (including paternity leave), universal and progressive child care programs (Connolly, Fontaine, and Haek 2020), and public pharmaceutical coverage (Carter and Quesnel-Vallée, 2014). Its universality reflects interventionist, progressive, and nationalist social policy expansion — a legacy that has endured across multiple areas of collective life in Québec (Vaillancourt 2012).

The principles of universalism partially rose out of new nationalism and became embedded into Québec's welfare state during the Quiet Revolution. Its value, as a historical legacy, was institutionalized into contemporary social policies. Progressive social policy expansion was implemented by Claude Castonguay as the chair of a commission of inquiry on health and social welfare within the first Bourassa government, from 1970 to 1973 (Palard 2018; Vaillancourt 2012). This government's welfare state reforms built strong state-run infrastructure for coordinating and distributing services across regional and local areas (Boychuk 2009; Vaillancourt 2012). The reforms promoted universality in health and social services by merging the two ministries into the MSSS, creating an integrated system grounded in a progressive agenda that reinforced public health and health promotion (Bernier 2006).

The MSSS formed the "basis for the policy of universal accessibility to full, continuous, complementary and quality care and services" (MSSS 2009, 40). Its social innovation lies in its role of health promotion through universality, integrating health and social services from scattered national, regional, and local levels into one single system (Bernier 2006; Vaillancourt 2012), demonstrating robust investments in public health promotion and universality.

The historical legacies of the Quiet Revolution reflect a long-term process of institutionalization and mobilization of universalism and health promotion in three ways. First,

universal social protection seeks to promote rights, social cohesion, and a wide set of social benefits (Slater 2023). This is in opposition to targeted programs that often attempt to balance between protecting the most vulnerable and a pragmatic solution to the affordability of universal benefits. The comprehensive nature of the MSSS shows how ideals of universalism allowed state investment into programs that sought to benefit all Quebecers regardless of income. Second, universalism can be seen as a key tool in Québec's nation-building kit, where a generous social safety net sought to increase solidarity with the province over the federal government. Finally, the cross-cutting constituency of universal programs helps to shield them from political attacks and program termination (Greenstein 2022; Slater 2023), thus, there are robust and long-standing social programs in Québec that have been protected from cessation. This does not mean that universal programs do not face cuts or disinvestment (discussed earlier); however, we can point to the DSPC as an example of Québec's universalist progressive agenda across social policy expansion.

4.3 The influence of the profession-state relationship

Alongside political culture and structures of interest, provincial economies have driven significant "variations in coverage for drugs, long-term care, and other health care goods and services" (Tuohy 2013, 293). The profession-state relationship governs the operation of supplementary health programs in each province, including Québec's DSPC. Powerful interests were present in the initial adoption of the DSPC and in its subsequent iterations.

As the Medicare system was developing in the 1970s, formal and informal avenues of interest representation emerged through consultations established by government commissions, such as the Castonguay Report; informal networks included lobbying by organized labour, professional groups, and grassroots activism, "aided by a wave of government recruitment from the ranks of community organising in the 1970s" (White 2009, 5). The promotion of community participation included technocrats and professional groups in the health and welfare sector, who developed and maintained their own power bases over grassroots community organization (O'Neill 1992). This was evident in the adoption of the DSPC by the influence of the dental profession.

While community participation of civil society actors figured prominently in the early design of programs like the DSPC (Usher and Denis 2022), the provincial dental association had to be appeased to ensure its longevity. The association's advocacy and political pressure has influenced the program since its inception, and the decrease in public funding is demonstrated in dental office earnings (Lévesque and Bedos 2011; Martine, Quiñonez, and Marchildon 2025). This is characterized by dentists having the freedom to opt out of the Québec program's fee schedule. Dentists are paid less when they provide services through the public program rather than their own private practice because non-participating dentists can choose their own rates and "do not agree to be remunerated in accordance with the tariffs provided in the agreement" (RAMQ 2020). Nevertheless, dentists are key actors in the success or failure of this program, and their buy-in is instrumental, so they have had

room to advocate for a "great deal of freedom" (Lévesque and Bedos 2011, e107). This is a key barrier to reducing ongoing dental health inequities within the public-first DSPC in Québec.

5 IMPLEMENTATION AND EVALUATION

Two key issues emerge when evaluating the state of the DSPC. First, the lack of changes to the program since 1997 identify the effect of "permanent austerity" (Pierson 2001) in Québec's social policies. While there have been no major cutbacks, there also have been no changes to the program meaning it has essentially been frozen. Second, program implementation relies on dentists administering services; however, they can opt-out of delivering the services provided under the DSPC. Dentists "determine the location and the scope of their practice, the makeup of their clientele and whether or not they wish to participate in the government-funded programs" (Lévesque and Bedos 2011, e107). Opting-out shields dentists from having to deliver services to children across Québec, thus dentist buy-in is essential to the continued success of the program.

The LPQ and PQ governments' policy shift during the 1990s aligns with "retrenchment era" (Pierson 2001) reforms of the late 1980s into the early 2000s when governments across advanced industrialized democracies actively cut back or paused the expansion of social programs and public services (Bhatia 2010; Tuohy 2013). The programmatic changes reflect the austerity politics reshaping Canada in the 1990s, which saw major rollbacks and restructuring of welfare state programs (Banting 2020; Bhatia 2010; Huber and Stephens 2001). Unsurprisingly, the 1990s austerity measures have led to less frequent visits to the dentist (MSSS 2021). Retrenchment "cuts into the 'soft underbelly' of social services" (Breunig and Busemeyer 2012, 921), while preserving the core tenets of programs.

Despite the program being universal and public-first, significant barriers remain. In 2017, only half of eligible children under the program received dental services (MSSS 2021, 4). In a Government of Québec survey, respondents were asked about individuals with dental coverage provided by the province, including children eligible under the DSPC (MSSS 2021, 33); financial and mobility barriers were identified, as well as general awareness about the program. Seventy-six percent of respondents believed people were not aware of the dental services they were entitled to; 60% of respondents cited "hidden fees" that might be charged after treatment as a key issue; 12% of respondents cited mobility-related barriers, such as proximity to clinics. The report also identified scarcity of professionals in remote communities and difficulty obtaining accessible transport as key mobility barriers (MSSS 2021, 5).

The survey results provide insights into the inequalities in access that vulnerable populations experience despite their eligibility for dental coverage. As the survey exemplifies, universal programs are not always more effective in terms of access than targeted programs (Greenstein 2022); however, targeted programs tend to increase costs, both in terms of ad-

ministrative burdens for recipients and state resources to determine eligibility for services (Slater 2023). While targeted programs also create a greater potential for exclusion or inclusion errors, there are persistent structural inequalities hindering universal access. Thus, it becomes evident that the existence of a universal program does not necessarily guarantee realized access to care and health equity, particularly when programs face permanent austerity (Andersen and Aday 1978). The DSPC exemplifies how the 1990s austerity measures conciliated efforts to balance the budget while appeasing voters, especially families, who favoured Québec's strong investment in families and the prevention of rising inequality (Noël 2018; Vaillancourt 2012).

The DSPC demonstrates that welfare state restructuring "cannot be reduced to straightforward retrenchment" (Pierson 2001, 8). Policymakers resolved complex political trade-offs by engaging "in the long and arduous process of changing the respective entitlement laws ... such as eligibility criteria or benefit calculation formulas" (Breunig and Busemeyer 2012, 924). Institutions are key, as they demonstrate how "structure may facilitate or inhibit the formation of viable political coalitions and structure the terms on which such coalitions can proceed" (Pierson 2001, 12). Revisions to the program reflect the key trade-offs of competing priorities meeting the needs of various interest groups, recipients, and institutions. While the austerity politics of the 1990s represents the government's efforts to minimize the electoral costs associated with unpopular retrenchment reforms, they also attempted to maintain programs' core values.

6 CONCLUSION

The DSPC is one of Québec's many social programs embedding core principles from the Quiet Revolution. Between the integration of the health and social services ministries and the development of new nationalism, the Québec model of social policy is characterized by "greater state involvement in the economy than elsewhere in Canada, by better-funded social programs by greater redistribution of wealth and by much more developed social dialogue between the state, the unions, the business community, the financial sector and civil society" (Paquin and Rioux 2022, 7). This assessment holds, despite the 1990s austerity politics that saw retrenchment reforms to social policy. Health promotion and population health remain core tenets of Québec's welfare state: the universal, public-first DSPC remains an innovative social policy, yet it still reflects key trade-offs between ideas, interests, and institutions.

In 2023, the federal government announced the Canadian Dental Care Plan (CDCP), a national dental plan to provide coverage to households with an income of less than $90,000 a year (Government of Canada 2023). This created tensions with the *Coalition Avenir Québec's* provincial government which almost immediately announced that Québec would opt out of the program and request compensation for it (Laberge 2023). Provinces may choose how they wish to coordinate their existing public dental programs with the new federal program. In the case of Québec, similarly covered services are reimbursed by the

provincial RAMQ program first, and the federal program is strictly remedial (Government of Canada 2024; RAMQ 2024a). Specifically, where "services are not covered by RAMQ and are eligible for coverage under the CDCP," claims could be made to the CDCP (Government of Canada 2024). While it is too early to assess the outcomes of the federal program, it is evident that there will be intergovernmental tensions in the negotiations between the Canadian and Québec governments. Future analyses may draw on historical legacies of the Quiet Revolution and strong nation-building efforts in Québec to understand these tensions and policy decisions.

7 STRENGTHS, WEAKNESSES, OPPORTUNITIES, THREATS

Table 2: SWOT Analysis

Strengths	Weaknesses
• The program is universal for all children under the age of 10 regardless of family income. • The public-first design means the program acts as the first payer of services for those eligible regardless of whether individuals also hold private insurance. • The program aligns with Québec's broader objectives related to population health promotion and universalism.	• Dentists can opt out of service provision which undermines universal access. • Poor uptake of eligible recipients limits program success and identifies key barriers, including transparency and inequalities in access. • The program age limit (< 10) excludes adolescents, narrowing its reach relative to full population coverage.
Opportunities	**Threats**
• The introduction of the federal CDCP creates an opportunity for expanded coverage between federal and provincial programs.	• The program has effectively been frozen since 1997, with no significant expansion or reinvestment. • Ongoing fiscal pressures and austerity threaten the program's sustainability.

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9 REFERENCES

Andersen R, Aday LA. 1978. Access to medical care in the U.S.: realized and potential. *Medical Care* 16(7): 533-546. https://pubmed.ncbi.nlm.nih.gov/642481/

Arsenault G. 2018. *L'économie sociale au Québec: une perspective politique*. Québec: Presses de l'Université du Québec.

Ashkin E. 2018. Vulnerable populations. In *Chronic illness care: principles and practice*, ed. Daaleman T, Helton M, 331-341. Cham: Springer.

Banting K. 2020. The three federalisms and change in social policy. In *Canadian federalism: performance, effectiveness, and legitimacy*, ed. Bakvis H, Skogstad GD, 282-309. 4th ed. Toronto: University of Toronto Press.

Béland D, Lecours A. 2008. Nationalism and social policy: the politics of territorial solidarity. Oxford: Oxford University Press.

Béland D, Marchildon GP, Prince MJ, eds. 2019. *Universality and social policy in Canada*. Toronto: University of Toronto Press.

Benigeri M, Brodeur J-M, Olivier M, Bedos C. 2002. Connaissances et perceptions des adolescents face à la santé dentaire. *Canadian Journal of Public Health* 93(1): 54-58. https://doi.org/10.1007/BF03404419

Bernabé E, Sheiham A, Sabbah W. 2009. Income, income inequality, dental caries and dental care levels: an ecological study in rich countries. *Caries Research* 43(4): 294-301. https://doi.org/10.1159/000217862

Bernier NF. 2006. Quebec's approach to population health: an overview of policy content and organization. *Journal of Public Health Policy* 27(1): 22-37. https://doi.org/10.1057/palgrave.jphp.3200057

Bhatia V. 2010. Social rights, civil rights, and health reform in Canada. *Governance* 23(1): 37-58. https://doi.org/10.1111/j.1468-0491.2009.01466.x

Boychuk T. 2009. After Medicare: regionalization and Canadian health care reform. *Canadian Bulletin of Medical History* 26(2): 353-378. https://doi.org/10.3138/cbmh.26.2.353

Breunig C, Busemeyer MR. 2012. Fiscal austerity and the trade-off between public investment and social spending. *Journal of European Public Policy* 19(6): 921-938. https://doi.org/10.1080/13501763.2011.614158

Brodeur J-M, Bedos C, Olivier M, Payette M, Durocher J, Gagnon P. 1998. Effets de l'abolition de la couverture des soins dentaires par la Régie de l'assurance-maladie du Québec chez les enfants de plus de neuf ans en fonction des facteurs socio-économiques. Université de Montréal. https://collections.banq.qc.ca/document/s/t/6eQNWHd2OSciuD_5X_T8Uw

Connolly M, Fontaine MM, Haek C. 2020. Les politiques familiales du Québec évaluées à partir des trajectoires de revenus d'emploi des parents et des personnes sans enfant. CIRANO. https://crdcn.ca/publication/les-politiques-familiales-du-quebec-evaluees-a

-partir-des-trajectoires-de-revenus-demploi-des-parents-et-des-personnes-sans-enfant/

Elani HW, Harper S, Allison PJ, Bedos C, Kaufman JS. 2012. Socio-economic inequalities and oral health in Canada and the United States. *Journal of Dental Research* 91(9): 865-870. https://doi.org/10.1177/0022034512455062

Fierlbeck K, Lahey W, eds. 2013. *Health care federalism in Canada: critical junctures and critical perspectives*. Montreal and Kingston: McGill-Queen's University Press.

Ghanbarzadegan A, Balasubramanian M, Luzzi L, Brennan D, Bastani P. 2021. Inequality in dental services: a scoping review on the role of access toward achieving universal health coverage in oral health. *BMC Oral Health* 21: 404. https://doi.org/10.1186/s12903-021-01765-z

Government of Canada. 2011. Canada's health care system. https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html

Government of Canada. 2023. Canadian dental care plan. https://www.canada.ca/en/services/benefits/dental/dental-care-plan.html

Government of Canada. 2024. Coordination of benefits between the CDCP and Quebec's provincial dental programs. https://www.canada.ca/en/services/benefits/dental/dental-care-plan/providers/fact-sheet-qc.html

Greenstein R. 2022. Targeting vs. universalism, and other factors that affect social programs' political strength and durability. Brookings Institution. https://www.brookings.edu/articles/targeting-vs-universalism-and-other-factors-that-affect-social-programs-political-strength-and-durability/

Huber E, Stephens JD. 2001. Welfare state and production regimes in the era of retrenchment. In *The new politics of the welfare state*, ed. Pierson P, 107-145. Oxford: Oxford University Press.

Laberge T. 2023. Quebec to opt out of federal dental plan, seek $3 billion in compensation. *The Montreal Gazette*, March 29. https://montrealgazette.com/news/quebec/quebec-to-opt-out-of-federal-dental-plan-to-seek-3-billion-in-compensation

Lévesque MC, Bedos C. 2011. Social values, regulatory tensions and professional practices with underprivileged populations: the case of Quebec's oral healthcare system. *Healthcare Policy* 7(1): e101-e115. https://doi.org/10.12927/hcpol.2011.22512

Maioni A. 2015. *Health care in Canada*. Toronto: Oxford University Press.

Marchildon GP. 2014. The three dimensions of universal Medicare in Canada. *Canadian Public Administration* 57(3): 362-382. https://doi.org/10.1111/capa.12083

Martine C, Quiñonez C, Marchildon GP. 2025. Improving equity in access to dental care in Canada: historical lessons for policy change. *Journal of Public Health Dentistry* 85(4): 388-398. https://doi.org/10.1111/jphd.70002

MSSS (Ministère de la Santé et des Services sociaux). 2009. Focus on the Québec health and social services system. https://publications.msss.gouv.qc.ca/msss/fichiers/2009/09-731-01A.pdf

MSSS (Ministère de la Santé et des Services sociaux). 2021. Le système de santé et de services sociaux au Québec en bref. https://publications.msss.gouv.qc.ca/msss/document-000152/

Murphy K, Gondro JV, Moharrami M. 2024. Factors associated with the use of oral health care services among Canadian children and youth. *Health Reports* 35(4): 15-26. https://doi.org/10.25318/82-003-x202400400002-eng

National Advisory Council on Poverty. 2021. Understanding systems: the 2021 report of the National Advisory Council on Poverty. Employment and Social Development Canada. https://www.canada.ca/en/employment-social-development/programs/poverty-reduction/national-advisory-council/reports/2021-annual.html

Noël A. 2018. Quebec's new politics of redistribution meets austerity. In *Federalism and the welfare state in a multicultural world*, ed. Goodyear-Grant E, Myles J, Kymlicka W, Johnston R, 74-100. Montreal and Kingston: McGill-Queen's University Press.

OECD (Organisation for Economic Co-operation and Development). 2021. *Health at a glance 2021: OECD indicators*. Paris: OECD Publishing. https://doi.org/10.1787/ae3016b9-en

O'Neill M. 1992. Community participation in Quebec's health system: a strategy to curtail community empowerment? *International Journal of Health Services* 22(2): 287-301. https://pubmed.ncbi.nlm.nih.gov/1601548/

Palard J. 2018. Les acteurs catholiques et le processus d'émergence des politiques publiques sanitaires et sociales dans le Québec de la Révolution tranquille. In *Les catholiques québécois et la laïcité*, ed. Koussens D, Foisy C, 139-163. Québec: Les Presses de l'Université Laval.

Paquin S, Rioux XH. 2022. *La révolution tranquille 60 ans après: rétrospective et avenir*. Montréal: Les Presses de l'Université de Montréal.

Pierson P, ed. 2001. *The new politics of the welfare state*. Oxford: Oxford University Press.

Quiñonez C. 2013. Why was dental care excluded from Canadian Medicare? Network for Canadian Oral Health Research Working Papers Series. http://ncohr-rcrsb.ca/knowledge-sharing/working-paper-series/content/quinonez.pdf

Quiñonez C. 2021. *The politics of dental care in Canada*. Toronto: Canadian Scholars' Press.

RAMQ (Régie de l'assurance maladie du Québec). 2020. Professionals offering covered services. https://www.ramq.gouv.qc.ca/en/citizens/health-insurance/professionals-offering-covered-services

RAMQ (Régie de l'assurance maladie du Québec). 2024a. Régime canadien de soins dentaires. https://www.ramq.gouv.qc.ca/fr/professionnels/media/28161

RAMQ (Régie de l'assurance maladie du Québec). 2024b. Dental services. https://www.ramq.gouv.qc.ca/en/citizens/health-insurance/dental-services

Rocher F, Smith MC, eds. 2003. *New trends in Canadian federalism*. 2nd ed. Peterborough: Broadview Press.

Slater R. 2023. Universal, categorical and targeted social protection: issues, debates and solutions. In *Handbook on social protection and social development in the global south*, ed. Patel L, Plagerson S, Chinyoka I, 188-204. Cheltenham: Edward Elgar Publishing. https://doi.org/10.4337/9781800378421.00024

Tuohy C. 2013. Health care policy after universalism. In *Inequality and the fading of redistributive politics*, ed. Banting K, Myles J, 285-311. Vancouver: UBC Press.

Usher S, Denis J-L. 2022. Network-building by community actors to develop capacities for coproduction of health services following reforms: a case study. *Health Expectations* 25(5): 2275-2286. https://doi.org/10.1111/hex.13491

Vaillancourt Y. 2012. The Quebec model of social policy, past and present. In *Canadian social policy: issues and perspectives*, ed. Westhues A, Wharf B, 115-144. Waterloo: Wilfrid Laurier University Press.

White D. 2009. Network governance and democracy: can grassroots participation influence national policy orientation? Paper presented at the International Sociological Association, 20-22 August, Université de Montréal, Montréal.