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Discussion

For preventive medicine to include oral health care, the dental profession, licensing agencies, payers, and the public must effect change

Donald B. Giddon[a,b,*], Leon A. Assael[c,d]

[a] Developmental Biology Emeritus, Harvard School of Dental Medicine, Faculty of Medicine, Harvard University, 190 Longwood Ave, Boston, MA 02115, United States of America
[b] NYU College of Dentistry, United States of America
[c] Community Based Education and Practice, University of California San Francisco, United States of America
[d] Developmental and Surgical Sciences, University of Minnesota, United States of America

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ABSTRACT

Dentistry is represented to the US public in large part by the various professional associations, which speak for the interests of general and specialized dentists, mostly in private proprietary practice. Unfortunately, the interests of dental professional associations may often be in conflict with those of the public. To resolve this continued disparity, it behooves the dental leadership to become more involved with the overall health care system than continuing to enhance the economic interests of the profession without sufficient regard for the world-wide burden of unmet dental needs. An assessment of policy failures is provided with some recommendations for greater involvement of organized dentistry in the integration of oral and general health care. Dentistry must recommit itself to being a health profession rather focusing on the business aspects of health care. Another aspect to be considered is a reorganization of the American Dental Association to better represent the oral health care workforce.

1. Introduction

Essential primary care dental services are necessary to achieve human health. In his Surgeon General's report on oral health, David Satcher described America's oral health status as a hidden epidemic of untreated disease that causes a burden on those who are most vulnerable: children, the elderly, those with medical co-morbidities and patients with special needs (Oral health in America, 2000). The oral health disparities described in the report are noted because of the profound differences in the health care delivery and payment system between oral health and other aspects of health care, due in part to social determinants of health and inefficiencies in the oral health care workforce. The historical separation between oral health and overall health continues to be an additional barrier to integrated health prevention services in the US; and by not including dental with overall health has in fact been considered unethical (Simon, 2016).

Unfortunately, the period leading up to and following the Surgeon General's report (Oral health in America, 2000) has been inconsistent in the response to the need to reorganize the health care workforce with respect to the integration of oral care with systemic and mental health. Given the recent upheaval in the financing and application of health services, the dental profession is very much concerned about what role it might play in the future of health care (Guay, 2016). The dental profession and those advocating for oral health are represented to the public by the various dental professional organizations. Other critical decision makers and stakeholders in determining the future of oral health preventive services are state licensing agencies, public and private payers.

Dental professional organizations have a mission to enhance the reputation and support the policies of the membership. The interests served are those of general dentists and specialists, the majority of whom are proprietors of private practices. These clinicians and their representative professional organizations can often be in conflict with the public interest, as the goals of a successful dental visit in a proprietary practice are not naturally concomitant with the goals for improved population health, or even the health outcomes of active patients. The goals of successful proprietary practice sometimes cause dentists to seek higher per visit reimbursement over the clinical needs of the public.

For example, the concept of “slow dentistry” is gaining ground to

* Corresponding author at: Developmental Biology Emeritus, Harvard School of Dental Medicine, Faculty of Medicine, Harvard University, 190 Longwood Ave, Boston, MA 02115, United States of America.
E-mail address: Donald_Giddon@hms.harvard.edu (D.B. Giddon).

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raise the income of dentists and improve their lifestyle. In "slow dentistry" just 6–8 patients a day with high complexity needs are seen, warranting significantly greater compensation (Roig, 2017). Thus, patients with needs for less sophisticated care and fewer resources, in need of behavioral and/or primary care management, will have less access in this type of practice environment. Within this model, dentists can work 200 days per year to provide care for approximately 1200–1600 patient visits during this period. Based on about 149,000 (Kaiser Family Foundation, n.d.) practicing general dentists in the US, just an estimated 179–239 million patient visits would occur. Given that most actual patients require more than one visit, this number of available treatment slots is well under what is needed. In spite of this inadequacy, American dentistry strongly supports the "slow dentistry" era. Another way of looking at the problem is to determine the number of active patients seen by a dental practice in the prior 18 months (Schein, n.d.). A typical American general dental practice (among about 149,000 general practitioners) has under 1000 patients, leaving just 149 million of 320 million Americans being cared for by a general dentist. Thus the successful proprietary practice slow dentistry model or other high end practice models are adversely affecting the health care of the majority of the population, most acutely those on public assistance, especially those with special needs who have no access to care.

That is indeed the case in California, for example, where just 16% of dentists participate in Medicaid, with most restricting access to Medicaid patients. With approximately 13.5 million adults on Medicaid in California, 11 out of 58 counties have no Medicaid providers and 16 additional counties have grossly inadequate access (Klein, 2017). This disparity was most acutely recognized when in 2009 California eliminated its comprehensive adult dental benefit. This action resulted in an immediate and sustained increase in emergency department visits for preventable dental emergencies (Singhal et al., 2015). ER visits went from 30 per 100,000 population to 45 per 100,000 in just two years, exceeding the visits to the ER for diabetes-related acute illness.

This situation helped propel a best practice in organized dentistry, as the California Dental Association developed a plan entitled "Phased Strategies for Reducing the Barriers to Dental Care in California" (The California Dental Association, 2011). Organized dentistry thus advocated the optimizing of existing resources, focusing on prevention and development of innovative methods for delivering dental care. By advocating for improving the Medicaid system, the restoration of comprehensive adult care in 2017 will help, while creating a more robust workforce model that includes Federally Qualified Health Care Centers and expanded function dental hygienists. Thus, in response to this critical need, organized dentistry can be forthright by forging improved oral health while sustaining an acceptable practice model.

Unfortunately, such effective professional organization action has not been universally embraced by organized dentistry. Unlike other providers in the health care system, the dental professional organizations have an inordinately disproportionate influence on state dental boards which are often in conflict with the interests of the public. In "the Unexpected Political Power of Dentists" the Washington Post reported on dentists as "a political force so unified, so relentless, and so thoroughly woven into American communities that its clout rivals that of the gun lobby" (Jordan, 2017). Most recently, this legislative clout has mainly been used to thwart attempts by foundations and community organization to improve access by advancing the oral health care workforce with dental therapists.

2. Comparison with other oral health systems

In contrast to the US, which, as noted, continues to be unable to address its own oral care needs appropriately (Vujicic, 2018), other countries with more government-directed health care than the US have different experiences with the dental practice community and its role of licensure and regulation essential for a robust oral health team. The dental board of Australia licenses and defines the scope of practice of dentists as well as dental hygienists, dental therapists, oral health therapists, and dental prosthetists (Dental Board of Australia, 2014). In Australia where oral health therapists have been a part of the care team for decades, these bachelor level professionals provide care alongside dental technicians and dental hygienists as part of a team led by the dentist. In a recent study, over 31% of dentists employed these professionals with about 7% employing oral health therapists only (Kempster et al., 2015). Interestingly, young dentists were more than twice as likely as those near retirement to work with oral health therapists as employed members of their team. Consequently, oral health in Australia now reflects the values of this creditable policy provided by organized dentistry and other policy makers. Among four peer countries–Germany, Australia the UK and the US–Australians have the highest level of preventive care and the highest number of dental visits per year, resulting in retaining their natural dentition longer (Crocombe et al., 2009). This favorable outcome in Australia is due in part to the policies of the Australian Dental Association which supports universal access to care: "dentistry is an essential health service the benefit of which should be available to all people living in Australia" and dental therapists are oral health professionals devoted to "the prevention of dental diseases and control of dental caries in children" (https://www.ada.org.au/Dental-Professionals/Policies, n.d.).

Even more impressive, dental therapists in New Zealand are welcomed as team members by dentists. These mostly school-based dental therapists are a bulwark in the treatment of pediatric dental caries. In a recent survey 59% of New Zealand dentists expressed their support of dental therapists and 55% expressed an interest in working with or employing additional dental therapists (Moffat and Coates, 2011).

In contrast to these laudatory goals and objective accomplishments in other westernized countries, the US has found itself in opposition to measures that would improve the efficaciousness of the oral health workforce, including necessary changes in scopes of practice for the old and new members of the dental health team, e.g. dental therapists. A major effort of US organized dentistry during this period has been to oppose legislation in over a dozen states to create additional professionally-licensed providers to diagnose, prevent, and treat dental caries. After the Commission on Dental Accreditation in 2015 adopted educational standards for dental therapy, a new oral health profession which can address dental caries, the ADA responded by firmly opposing allowing non-dentists to perform surgical procedures. (The surgical procedure in this case is the removal of tooth decay and preparation of a tooth for restoration) (American Dental Association, 2017a).

This opposition is in contrast to nations where dental therapists have long-standing collaborative activities with dentists, which has resulted in a significant reduction in oral disease. For example, New Zealand has a decades-long experience with school based dental therapists, where 84% of carious teeth in children have been treated (Ministry of Health, 2010). This positive effect is in sharp contrast to countries without an integrated school based program such as Mexico, with a comparable economy (New Zealand per capita income is 28,000 compared to 19,500 for Mexico) (Central Intelligence Agency, 2004), where the restorative index was just 20% for 12 year old children (Medina-Solis et al., 2013). Thus New Zealand has over a 400% improvement (84% vs. 20%).

Compared to the token efforts of the ADA, the New Zealand Dental Association continued its support for these public health measures in a 2013 report that stated "all children in New Zealand are entitled to high quality oral health care … by dental professionals with appropriate skills and training."; the report pointed out the success of the school based public health program (*New Zealand Dental Association Position Statement on Child Oral Health Adopted March* 2013, n.d.). The success rate speaks for itself compared to the US with a far higher per capita income (59,000 per year vs. 38,500 for New Zealand) (Central Intelligence Agency, 2004), but with no school-based program, either dentist or dental therapist based; in the US 55% of 6–8 year old children have experienced dental caries and 44% of those children have gone