Public Programs, Insurance, and Dental Access

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• Public coverage

It is 1:15 in the afternoon, and Rep. Elijah E. Cummings has just challenged approximately 200 dental, dental hygiene, and dental postgraduate members of the class of 2008 to not forget those who have been left behind. He made this challenge as he reminds the class of 2008 of the consequences of dental neglect and relates the story of an unfortunate young man in Maryland who recently died as a result of a dental-related brain abscess. With a visceral and emotional oration, Rep. Cummings told the group ''Dentist after dentist after dentist refused to treat him.''

Across town just about 1 month later, a forum of advocates, public health experts, researchers, and clinicians gathered and spent a day together reflecting on the development of a comprehensive oral health policy. Topics included:

Achieving access and quality in dental care
Increasing the dental workforce and program participation of dental providers
Education to improve access to dental services

Three months earlier, approximately 100 dental students gathered and attended a practice management seminar, a seminar with the intended goal of teaching dentists how to market and optimize their dental practice. Midway through the seminar, the speaker told the audience that insurance is the disdain of dental practice, and most of his clients do not accept dental insurance. He continued and suggested that each and every member of the audience should also consider not accepting insurance and supported the argument with the view that dentists are well trained, work hard, deserve to be well-compensated, and therefore should be unencumbered with the nuisances of dental insurance. Just a few words in an otherwise well-presented seminar tell much. Although most of the presentation focused on preparing dental students to set up an efficient well-run practice to best serve the community, the

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feelings expressed about third-party coverage are telling of an adversarial relationship that has fomented over the years; an adversarial relationship between practitioners and the purveyors of dental care coverage both private and public alike.

Just a few years ago, Alaska native tribal health organizations responding to a paucity of dentists in rural areas developed a new solution to address the oral health needs of Alaska natives. The Dental Health Aide Therapist Initiative was designed to educate dental health aide therapists to provide dental care to Alaska natives in rural areas. The focus of the program is on prevention, pain and infection relief, and basic restorative services.[1,2] Several years later, the American Dental Association reported to its members that a licensing subcommittee of the Minnesota House of Representatives, also responding to a perceived paucity of dentist practitioners, approved the Advanced Dental Hygiene Practitioner workforce model. If enacted, this legislation would allow midlevel providers to perform surgical procedures including extractions and restorations without the supervision of a dentist.[3]

The problem of dental access, especially the availability and participation of dentists to provide care to disadvantaged children, is and has been for the last 20 years a hot topic of concern among elected officials, oral health advocates, and dental professionals. No longer just an issue of local concern, the Domestic Policy Subcommittee of the House Committee on Oversight and Government Reform recently held an oversight hearing on Reforms to Pediatric Dental Care in Medicaid. Concurrently, the Government Accountability Office (GAO) released a report showing that dental disease in children has not decreased.[4] Just a few months earlier, the Agency for Healthcare Research and Quality (AHRQ) released a report on Dental Use, Expenses, Dental Coverage, and Changes, 1996 and 2004 showing that the percentage of children who had public dental coverage increased from 1996 to 2004.[5] Additionally, children with public dental coverage had an increase in the likelihood of having a dental visit from 1996 to 2004.

Previously, Bailit and Beazoglou presented a thorough review and perspective on current trends in public and private expenditures for dental services. They summarized their discourse in part with an optimistic view of the future for middle and upper income families that have the resources to purchase dental services.[6] On the other hand, they follow that although overall use is likely to increase for the foreseeable future, the wide disparities in access to dental care may persist, with low income populations continuing to have major problems accessing dental care.

The purpose of this article is to begin where Bailit and Beazoglou finish and continue the assessment and provide a framework with which to possibly suggest improvements in the design of current programs. Whereas Bailit and Beazoglou examine and discuss person-level use and expenditures as a function of aggregate factors including the role of employer-sponsored dental coverage, federal and state financing, and workforce considerations, this assessment will examine person-level use and expenditures as a function of preferences, price, and the use of third-party coverage.

DENTAL CARE SERVICES USE

Several factors have been associated with the likelihood of having a dental visit. Age, income, race, sex, education, and dental insurance have been shown to be primary determinants of dental use. Other factors, including geographic location, employment status, marital status, and family composition also have been associated with dental use rates.[7–14]

Analyses of data from different survey sources historically have resulted in national estimates that vary.[15] Sources of data often used to depict national dental use rates