A Public Health Perspective on Paying for Dentistry, the Affordable Care Act, and Looking to the Future

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KEYWORDS

• Triple aim/3-part aim • Value • Iron triangle • Payment innovation
• Dental care financing • Dental public health

KEY POINTS

- US health care financing is moving from volume-to-value as public and private payers seek improved health outcomes at lower cost.
- Conviction that cost, quality, and access present oppositional tradeoffs is being challenged as health care providers are financially incentivized through alternative payment mechanisms to reform health care with a focus on health outcomes rather than health care procedures.
- The Affordable Care Act (ACA) stimulated value-based innovation through a range of federally sponsored demonstrations and incentives.
- Efforts to repeal the ACA evinced a range of conservative approaches, some of which would reduce the numbers of people covered and reduce dental coverage.
- Dental public health philosophies, interventions, and skills are essential to integrating oral health within this complex and dynamic era of health reform.

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THE QUEST FOR VALUE IN HEALTH CARE FINANCING

Health care consumers, like all consumers, seek to get what they pay for. This holds true whether the health care consumer is a public health authority, a government, an employer, a union, a purchasing cooperative, an individual, or anything or anyone else charged with distributing scarce resources as effectively and efficiently as possible with the goal of improving and maintaining health.

Securing the most good for each dollar spent is the definition of value. To be successful, therefore, sellers of goods and services must demonstrate, or at least make a claim for, value. Providers of products and services claim value by asserting a value proposition:

> *A value proposition is a business or marketing statement that a company uses to summarize why a consumer should buy a product or use a service. This statement convinces a potential consumer that one particular product or service will add more value or better solve a problem than other similar offerings.*[1]

What then is dentistry's—in particular, dental public health's—value proposition? What arguments can be put forth to claim that particular clinical or programmatic offerings to oral health enhancement add more value or better solve the problem of poor oral health than competing offerings in dentistry? When comparing clinical care with the range of services available from dental public health authorities, what arguments are available to claim that public health services add more value or better solve oral health problems than clinical care alone? In an environment of ever greater oral health disparities and evermore limited financial resources, what can be expected of consumer and policymaker support for oral health? Will these purchasers elect to prioritize dental care and dental public health spending over competing health and social welfare issues?

This article seeks to place these questions within the larger frameworks of (1) tradeoffs, constraints, and opportunities in dental care financing and delivery and (2) impact of federal policy on dental care financing.

MOVING FROM THE IRON TRIANGLE TO THE 3-PART AIM AND DELIVERY INNOVATION

For all of health care, the traditional value proposition is that doctors, dentists, hospitals and other health care providers know what is best for a person—whether the person is called client, consumer, customer, or patient. They also know what is best for the payer—whether dollars that pay for care originate from individuals, employers, or governments. It is assumed and accepted by both persons and payers that charges levied are inherently appropriate to the quality, quantity, and potential benefit of each health service. Under this paradigm, more health care equates to better health care; more costly health care is more valuable than less costly health care; and health care is regarded as a significant, or even the primary, determinant of health outcomes. This understanding has led to the concept of the iron triangle, in which cost, access, and quality—quality of both care and benefits—function in tension with one another as tradeoffs. Under this conceptualization, desired goals can be accomplished only through compromise. Greater access to care necessitates either higher cost or lesser quality of care or benefits. Lower cost necessitates either lesser access or poorer quality of care or benefits. And greater access either costs more or requires poorer care or skimpier benefits.[2]

Dealing with these tradeoffs was central to the Patient Protection and Affordable Care Act (ACA) of 2010, or Obamacare. The law addressed the cost component of

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