COMMENTARY

"Savage Inequities": Can Public/ Private Partnership Impact Oral Health Access in the United States?

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Alex White, editor of the 1993 overview paper "Toward Improving the Oral Health of Americans" (1), begins the paper with a moving excerpt from Jonathan Kozol's 1991 book "Savage Inequalities: Children in American Schools" (2). As White states, "Kozol describes a picture unseen by most policy makers, but all too common for those who have worked in public programs serving poor, minority, and underserved populations."

> Although dental problems don't command the instant fears associated with low birth weight, fetal death, or cholera, they do have the consequences of wearing down the stamina of children and defeating their ambitions. Bleeding gums, impacted teeth, and rotting teeth are routine matters for children I have interviewed in the South Bronx. Children get used to feeling constant pain. They go to sleep with it. They go to school with it. Sometimes their teachers are alarmed and try to get them to a clinic. But it's all so slow and heavily encumbered with red tape and waiting lists and missing, lost or canceled welfare cards, that dental care is long delayed. Children live for months with pain that grown-ups would find unendurable. The gradual attrition of accepted pain erodes their energy and aspirations. I have seen children in New York with teeth that look like brownish, broken sticks. I have also seen teenagers who were missing half their teeth. But, to me, most shocking is to see a child with an abscess that has been inflamed for weeks and that he has simply lived with and accepts as part of the routine of life.

Kozol's children, interviewed in the South Bronx in 1991, are the children we treat daily at the Dental Health Center of East Central Iowa. Our program is a hospital-based outpatient regional access program for low-income children and developmentally disabled adults. Until recent years the low-income uninsured children served were primarily from non-Medicaid families, vulnerable children not eligible for the so-called safety net of Medicaid. The uninsured receive free care or pay up to 40 percent of the total fee on a sliding scale based on income and number of family members up to 180 percent of poverty level. We routinely used to refer the nonspecial care Medicaid child to the private sector for care. This has become increasingly difficult. We now treat a number of "routine" Medicaid children because of the limited number of private dentists accepting Medicaid patients.

In addition to the increasing numbers of "routine" Medicaid cases, we are treating a growing number of special care cases. We had so many special cases in April 1997 that we documented the monthly management role. Of the several hundred patients treated that month, 55 on our list were particularly critical because of the amount of management time and energy they required. Many of these cases were referred by area dentists, physicians, public health nurses or hygienists, and school nurses or teachers, and had special problems that made continuity of care difficult and sometimes impossible. Some examples are listed:

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- A four-year-old girl with generalized chronic infection from the late stages of baby bottle tooth decay (17.4% of our new patients 5 years of age or younger have BBTD).
- An 18-year-old patient eight months pregnant with an abscessed molar and a severe case of pregnancy gingivitis (first-ever dental visit).
- A 21-year-old weighing 40 lbs with Pelizaeus-Merzbacher syndrome and facial trauma from a wheelchair accident. The endodontics on an avulsed reimplanted tooth and other traumatized anterior teeth was completed in the operating room under general anesthesia.
- A 12-year-old, 255 lb boy in the adolescent psychiatric ward of the hospital with an acute abscess and an acute fear of dental treatment.
- Four children aged 2 through 8 years with rampant caries now living with their aunt following their mother's placement in a drug treatment center.
- A 10-year-old girl with chronic toothaches identified six months before in school. Treatment was initiated after abuse/neglect charges were filed.
- A 4-year-old cerebral palsy patient who required three-month recall because of rapid deposit accumulation referred from the medical residency program.
- An adult patient with self-inflicted intraoral lesions from a developmentally disabled group home for the profoundly mentally retarded.
- The behavior management challenge of an adolescent from a local high-risk psychiatric treatment institution.
- A 7-year-old displaced flood victim from Grand Forks, ND, with rampant caries and severe mouth pain (staying with his aunt in Iowa).
- Another 2-year-old with baby bottle tooth decay to be completed in May in the operating room (at an average expense of $3,645).

And on and on (41 more patients were on our list).

Most of the patients used as examples require special outreach case management to ensure that pain is eliminated and that needed restorative and prevention services are delivered. Many of these patients are covered by Medicaid, but are unable to gain access in the private sector and now are served by our access program. Fortunately, we have dental student and resident assistance to ease an increased patient load. But what about other regions of the state? What about other states?

A Tattered Safety Net

The "Alex White" paper, as it is known in dental public health circles, concludes (1):

> While significant improvements have been made in preventing and controlling dental caries and periodontal diseases during the past two decades, millions of Americans have been left behind, resulting in needless pain, increased cost, decreased health, and loss of self-esteem. Access to primary and preventive dental care can be difficult, especially for those that cannot afford dental care. Regrettably, Americans for whom the burden of oral disease is greatest often have the most difficulty gaining access to the dental care system.

Nationally, 96 percent of dollars spent on dental services—nearly $46 billion in 1995—was from out-of-pocket or private dental insurance sources (3). Only $1.8 billion, or less than 4 percent, was funded by public sources. Because minority and low-income populations have limited private dental insurance options, most costs for dental services are borne by the individual and are therefore often prohibitive.

Limited federal, state, and local public access programs are available, typically acting in a safety-net role. Most states provide few dental services for adults. The Indian Health Service and community and migrant health centers are national programs that do provide a patchwork of services; however, these certainly are not found in every community. Few hospitals provide dental care. Limited numbers of local, county, and regional access programs exist, and those that do usually have long wait lists.

Routine preventive and primary care dental services are not covered by Medicare, and Medicaid dental benefits for eligible low-income and disabled individuals are limited. In the US, the burden of providing care to the underserved vulnerable population rests primarily with the private sector. Reimbursement from the public sector to the private sector for the provision of care has been eroding rapidly in programs such as Medicaid and is usually nonexistent for other non-Medicaid low-income populations. Only 20 percent of Medicaid-eligible children received dental services in 1993, according to a 1996 Department of Health and Human Services Office of Inspector General (OIG) study (4). This estimate was down from 22 percent in 1992. We can be assured it is even lower in 1997. To no one's surprise, 80 percent of the states in the OIG study attributed low utilization to a shortage of dentists willing to accept Medicaid. Inadequate reimbursement was the most significant reason dentists did not accept Medicaid patients. In many states reimbursement does not even cover overhead costs, with dentists losing money serving the Medicaid patient. This reimbursement below a "threshold line" coupled with some complex Medicaid claims processing procedures, slow payments, arbitrary denials, prior authorization requirements for routine services, and high broken appointment rates spell disaster for continuity of care for the Medicaid population.

The pendulum has swung far in the wrong direction. Dental public health must assume much of the responsibility for ensuring that oral health services are available for vulnerable populations. This role is within the basic substance of public health defined as organized community efforts aimed at prevention of disease and promotion of health. The three core functions of public health to be practiced by competent dental public health professionals are assessment, policy development, and assurance (5). Assurance means making sure that needed health services and functions are available to populations. In the United States assurance of oral health services must be secured primarily in the private sector.

Public/Private Partnerships: What Can be Done?

In 1996 I had the opportunity to be the project director of a meeting held in Bethesda, MD, on the subject of the assurance of oral health services to vulnerable US populations. The project was conducted under a federal Health Resources and Services Administration (HRSA) contract with the University of Iowa Department of Preventive and Community Dentistry.

The purpose of the Oral Health Access Public/Private Leadership Meeting was to bring together public and private dental organization leadership to discuss the problems and solutions associated with access to oral health care issues for vulnerable US populations.

The deliberations of this leadership group, as requested in the HRSA contract, would: (1) assist in the review of the current effort at defining roles, requirements, and responsibilities for the assurance of access to care for vulnerable populations by dental public health within the core functions of public health; (2) help clarify and define public and private roles, responsibilities, and opportunities to improve access to oral health care; and (3) develop strategies for improving relationships between the public and private systems of oral health care and for strengthening the position of dentistry within public health. Leadership from 14 public and private dental organizations (see Figure 1) came together with other national experts to begin a dialogue and focus on strategies to encourage public/private partnerships at the federal, state, and local levels for opening doors to oral health access.

The leadership found much in common on access issues such as Medicaid, special care patients, HIV/AIDS patients, and legislative perspectives (6). Dr. Albert Guay, American Dental Association (ADA) associate director who spoke at the meeting, said, "We're all on the same team trying to win the same game, increased oral health of the public." Dr. Wallin McMinn, then chair of the ADA Council on Access, Prevention, and Interprofessional Relations, described the meeting as a "worthy effort" toward public/private collaboration aimed at improving access for vulnerable population groups with "the secret to accomplishment being at the state and local levels." Dr. Robert (Skip) Collins, then president-elect of the American Association of Public Health Dentistry, stated, "What stuck in my mind was the degree of agreement on the issue of access and where the shortfalls were and a very strong desire of both the public and private sectors to work together."

During the course of the agenda at the Oral Health Access Public/Private Leadership Meeting a number of options, ideas, and recommendations were formulated by program speakers, audience participants, and in a workshop session. Nine recommendations were made on how an oral health public/private partnership could influence improved access to oral health services for vulnerable US populations. The recommendations that follow are not intended to be a consensus of all organizations and individuals in attendance at the meeting, nor are they a complete list of what should or could be accomplished. They are, however, a beginning and can be considered an important guide for further action by organizations and individuals.

Recommendation #1

Arrange an administrative meeting with Department of Health and Human Services Secretary Donna Shalala, and representatives from the Public/Private Oral Health Access Meeting Advisory Panel, Health Resources and Services Administration (HRSA), Health Care Financing Administration (HCFA), and the USPHS Oral Health Coordinating Committee to discuss the crisis of lack of access to needed dental care for vulnerable US populations. A meeting is timely due to the recently released recommendations and comments in the Office of Inspector General's report, "Children's Dental Services Under Medicaid: Access and Utilization," and the report from the Bethesda Oral Health Access Public/Private Leadership Meeting.

Recommendation #2

Form a "National Working Group on Access to Oral Health for vulnerable US Populations" based on the public/private partnership model similar to the National Cancer Institute's National Dental Tobacco-free Steering Committee (NDTFSC). Participation in this National Working Group should expand the Bethesda Advisory Panel to include nondental business, labor, advocacy, and other groups interested in access to oral health. [Note: The NDTFSC is a coalition of 14 dental organizations that meets every nine months in Bethesda, MD, at the National Institutes of Health.]

Recommendation #3

Obtain, maintain, and/or enhance a dental presence within federal government agencies by securing dental leadership involvement on advisory groups, task forces, committees, and panels addressing issues of relevance to oral health. Specific critical examples include: establish positions of dental policy and programmatic expertise (a dental presence) in the Medicaid Bureau, HCFA; the provision of public/private dental leadership representation on the Medicaid Technical Advisory Group, National Medicaid Advisory Committee; enhance the provision of public/private leadership advisory input to the US Public Health Service Oral Health Coordinating Committee; and ensure that each of the PHS Regional Offices has a Regional Dental Consultant.

Recommendation #4

Promote public/private forums at state and local levels similar to the Bethesda Oral Health Access Public/Private Leadership Meeting to foster collaboration on access issues of mutual interest. The collaboration would strive to improve access to care for vulnerable populations and to assure a dental presence on state and local advisory groups, task forces, committees, and panels addressing issues of relevance to oral health.

Recommendation #5

Assure public and private leadership participation in dental organization leadership training, management conferences, and policy forums. Examples include: ADA's President-elect's Conference and Executive Directors Management Conference, AGD's Biennial Leadership Conference, ADHA's Constituent

FIGURE 1
Organizations Represented at the Oral Health Access Public/Private Leadership Meeting, Bethesda, MD, 1996

Academy of General Dentistry
American Academy of Pediatric Dentistry
American Association of Dental Schools
American Association of Public Health Dentistry
American Dental Association
American Dental Hygienists' Association
American Public Health Association, Oral Health Section
Association of Community Dental Programs
Association of State and Territorial Dental Directors
Federation of Special Care Organizations in Dentistry
Hispanic Dental Association
National Dental Association
National Network for Oral Health Access
United States Public Health Service

Officers Workshop, AAPHD and APHA's annual meetings, and the National Oral Health Conference.

Recommendation #6

Encourage all public and private dental organizations to develop, update, and/or strengthen current policy that advocates for dental public health programs and representation within state and local health departments.

Recommendation #7

Through collaborative efforts of the public and private sector, expand and enhance current support of dental student loan repayment programs for the establishment of practices in underserved areas. These underserved areas should be defined and determined by public/private partnerships at state and local levels. New approaches for increasing the number of dental professionals in underserved areas should be explored.

Recommendation #8

Advocate the expansion of educational opportunities for students and oral health professionals to learn of the need, responsibility, and special care treatment of vulnerable US populations as discussed and recommended in the Institute of Medicine's Future of Dental Education Report, "Dental Education at the Crossroads: Challenges and Change" (7).

Recommendation #9

Identify successful state and local oral health access initiatives that benefit from public/private partnerships and promote replication of those models.

Follow-up to the Bethesda Meeting

The first three recommendations to improve access to oral health services for vulnerable US populations involve the federal government directly. As a result of Recommendation #1, a meeting was held in January 1997 with representatives of the US Department of Health and Human Services (DHHS) to discuss the federal issues relevant to the Oral Health Access Public/Private Leadership Meeting. DHHS representatives included the assistant secretary for health, chief medical officers of HRSA, and chief of the Medicaid Bureau of HFCA. Public/private partnership organizations represented at the DHHS meeting were the American Dental Association, American Association of Public Health Dentistry, Association of State and Territorial Dental Directors, Hispanic Dental Association, National Dental Association, and the National Network for Oral Health Access. Critical issues raised at the meeting by representatives of the Public/Private Partnership were:

- There must be support for oral health services as an integral part of total health and of comprehensive health care, and for their inclusion in primary care definitions. It is imperative that oral health be in all health initiatives at the secretary's level of DHHS.

Oral health is at a unique disadvantage in that it is underrepresented or has no representation or expertise in many public agencies. Oral health lacks a level of authority at the federal level of government. Other health professionals and policy administrators have little or no training, knowledge, or experience in oral disease or oral health services.

- In the Health Care Financing Administration (HCFA) there is no oral health expertise dedicated to oral health policy and training. We should have a chief dental officer with authority at HCFA. In Medicaid, an oral health director should be clearly identified and regular meetings should be held with an oral health provider coalition inclusive of all relevant public and private groups that provide oral health services to Medicaid beneficiaries. The dental leadership should be represented on the Medicaid Technical Advisory Group, National Medicaid Advisory Committee.

The oral health director should assist in providing the needed directives to states and information to Congress that will demonstrate progress in addressing unmet needs identified in the Office of Inspector General's report and many other state and local reports.

There has been a historic absence of any oral health expertise in HCFA. It is important for the administrator of HCFA to recognize and correct this deficiency. HCFA's recent participation on the PHS Oral Health Coordinating Committee (OHCC) is helpful and a good beginning. However, the OHCC has little authority or resources. It can make recommendations, but cannot take action. A political will to create a lasting solution to provide oral health leadership at HCFA must exist.

- The Public/Private Partnership strongly supports a proposed national conference for state Medicaid directors on the subject of oral health. This conference will be cosponsored by HCFA and HRSA. We recommend that our National Working Group on Access to Oral Health (see Recommendation #2) have input into the agenda and participation in the conference. We also strongly support the commitment for the future Surgeon General's Report on the Status of Oral Health. This document will assist those who strive to make oral health an integral part of overall health and oral health services an essential component of health programs.
- The American Association of Dental Schools and the American Dental Association have a standing request for the establishment of a Division of Oral Health in the Bureau of Health Professions, HRSA, to ensure that experienced dental personnel direct critical programs. The importance of a division level dental authority and the support of the oral health community for this level of activity have been demonstrated recently with the reestablishment of the Division of Oral Health at the Centers for Disease Control.
- A full-time chief dental officer with authority at HRSA is needed to provide an oral health emphasis at the administrative level. This reorganization can be accomplished with minimal budgetary impact. Again, only the political will is needed to do the job.
- Strong budget support for the National Health Service Corps (NHSC) and for dental participation in the program is needed. DHSS must respond to congressional report language in fiscal year 1997 to enhance dental participation in the program.
- Strong budget support for community and migrant health centers and mandates for oral health treatment and prevention services in these programs should be provided.
- Increased funding for health professions primary care training programs—such as general dentistry, pediatric dentistry, and dental public health residencies—should be made available. The dental public health residency funds (Section 763 Prev. Med:DPH, in Title VII of the PHS Act) are critical for access to oral health. These funds may be in danger in the new budget and must be protected and increased. Funding for these residencies could be doubled with little

impact on the overall budget.

- A critical need to strengthen oral health expertise and presence at the regional level exists. Unfortunately, over the past 10 years and, more importantly, during the last three years the oral health leadership role at the regional level has declined significantly. The number of regional dental consultants, their scope of work, and program support have decreased drastically. We need a strong dental presence in each Public Health Service regional office—that is, full-time regional dental consultants.
- We need a commitment at the secretary's level for an annual assessment meeting between the Oral Health Coordinating Committee and our leadership group to ensure continuing impact on oral health access. This commitment was articulated in Recommendation #2 from the 1996 Bethesda Oral Health Access Public/Private Leadership Meeting. The National Cancer Institute meets with public and private dental organization leadership on a nine-month interim. DHHS should do the same. A good beginning would be in conjunction with the HCFA/HRSA-sponsored 1998 national Medicaid directors conference on oral health.

The outcomes from this 1997 DHHS meeting are favorable. HCFA has filled the position of chief dental officer, a national conference for state Medicaid directors on the subject of oral health is planned for the spring of 1998, and the first "Surgeon General's Report on the Status of Oral Health" is moving forward. However, as emphasized in Dr. McMinn's comments at the Bethesda Oral Health Access Public/Private Leadership Meeting, the key to improving access through public/private partnerships is through activity at the state and local levels. The strong desire of national organization leadership to work together must be fostered at the state and local levels.

Numerous examples of public/private partnership successes exist at state and local levels; nevertheless, there could be many more. One with which I am now involved is a 1997 public/private partnership in Iowa that is attempting to impact the Medicaid access problem. Under the leadership of public health dentists Dr. Peter Damiano and Dr. Michael Kanellis and the Iowa Dental Association, a focus group has identified problems and solutions and developed an action plan based on the conclusions of a 1996 report on the Iowa Medicaid dental program (7). The action steps have been discussed in a meeting with the administrators of the Iowa Department of Human Services (as done nationally with DHHS) and many have been implemented. This coalition reflects the promotion of public/private forums at state and local levels identified in Recommendation #4. Iowa also has a statewide Oral Health Action Committee, which closely parallels the intent of Recommendation #3. The committee is composed of public and private oral health professionals and other nondental groups interested in oral health access.

We in the specialty of dental public health must actively seek out those partnerships to ensure access to oral health services and to assure the competency of the specialty. We must nurture those public/private relationships to help assure the care for vulnerable patients such as those highlighted in the introduction of this paper. There is much work to be done.

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