

## Response to Edelstein: Access to Dental Care from the State Perspective

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Dr. Edelstein's informative essay speaks volumes about the critical issue of access to oral health care services. He correctly characterizes the dire situation regarding poor oral health and the related issue of access to care, especially with regard to poor children. However, he also describes a scenario of optimism regarding recent policy and research developments at the national and state levels. Little needs to be added to his excellent narrative except to reexamine his analysis with emphasis on programs and opportunities at the state level.

From the perspective of this state dental director, state dental programs cannot develop effective population-based interventions to prevent oral disease unless systems serving high-risk children and adults have the ability to adequately fund oral health care services. It is shocking that the world's richest country still does not have resources or even a coherent plan for its indigent populations who suffer from the pain, infection, and pathology associated with preventable oral disease. For instance, why has it taken so long for many of our health care financing systems to even cover dental sealants, a relatively low-cost preventive procedure resulting in long-term savings to the industry? Perhaps oral health care, even today, is not viewed as a health care issue. It is bewildering that, in arguing for oral health inclusion in the major health care financing systems in this country, oral health advocates continually must resort to reminding key stakeholders that oral health is part of overall health. As Dr. C. Everett Koop expressed so simply, "You are not healthy without good oral health."

This environment of exclusion is partly fueled, however, by dentistry's own political actions in the past, as well as the terminology it continues to use. One can only contemplate what might have been if dentistry had been

more forceful in the mid-1960s about inclusion, when Medicaid and Medicare were first being developed and legislated. Further, the unique terminology used in dentistry to describe oral conditions that substitutes a "cavity" for disease, an "abscess" for an "infection," and an "extraction" for an "amputation" undermines the ability to understand oral health care. The public also receives messages from the media that "getting your teeth cleaned" or "getting your tooth filled" is a technical service rather than health care. Moreover, the discomfort associated with some dental procedures continues to be part of the comedic repertoire of late-night television hosts, perhaps because dentists, unlike many other health care practitioners, perform therapy while the patient is conscious. I cannot think of another treatment for infection in the body that is a laughing matter.

Politicians and policy makers continue to hear little more than a pin drop regarding the need for oral health care from constituents, despite the numerous reports by high-risk groups listing oral health at the top of their health concerns. While the calm over what should be a storm is likely due to the high risk groups' lack of access to and poor understanding of the political system, the prominent concerns among high-risk populations are not in concert with their reported poor appointment-keeping behaviors. Such low compliance also speaks to the public's apparent lack of understanding of the seriousness of oral disease, and its relationship to systemic and psychological well-being.

An example at the state and local level of the continued perception gap between what is good for health and what is good for oral health is the policies regarding general anesthesia for dental care. This issue involves the fre-

quent denial by insurance companies for general anesthesia coverage for dental procedures unless medically necessary. Usually an exhaustive state legislative initiative is required to assure insurance coverage for these general anesthesia services. Why isn't it understood intuitively that providing dental services to individuals unable to receive dental treatment in outpatient settings is important enough to require coverage of general anesthesia services? While it is clearly understood that the insurance industry is reticent in covering dental services requiring general anesthesia because of cost, why such resistance for the few numbers of cases this would involve? While the ambivalence of the health care financing and political systems in this country to oral health has lessened in recent years, access to oral health care services will continue to be restricted unless oral health truly is perceived as playing a role in good health.

It has been said that the "stars are starting to align" for oral health issues because two parallel independent tracks—research and policy—have crossed randomly at a remarkable point in time. While more research is needed to establish concrete outcomes, recent studies indicate the relationship of oral disease with systemic disease and development, such as cardiovascular disease, stroke, ulcers, low birth weight infants, and failure to thrive. Other research establishing dental caries as an infectious disease has provided further proof that more complex diagnostic, preventive, educational, and treatment solutions are needed to combat oral disease.

Yet, it had been well established for years that periodontal disease was intimately associated with diabetes. While it can be said that diabetes itself is only now being perceived with the seriousness it deserves, why until only recently was there a lack of awareness

about the role of oral health in somatic health? Why is it only now that oral cancer—despite being known to have one of the poorest five-year survival rates of all the major cancers, with scant improvement over the past 40 years—is finally being addressed through federal and state initiatives? Why is it only now that—despite the presence and influence of very effective chief dental health officers—the surgeon general has released the first Report on Oral Health and sponsor a related national conference on oral health? Why is it only now that—despite incredible individual efforts for many years by key dental advocates within the federal government—the HRSA/HCFA Oral Health Initiative is finally taking place? And why is it only now that—despite strong advocacy all along by effective federal, state, and local dental leaders—funding and coverage have been increased for many state Medicaid dental programs for the first time in years?

To put it simply, with apologies to a national presidential campaign, "it is the economy, stupid." Even with the right people in place, if it is the wrong time, the oral health message is ignored. Why? Because it is not perceived to be serious enough and therefore is given a lower priority. However, we are in the midst of one of the strongest economic periods in recent American history. And similar to the private dental community, which traditionally benefits when the economy is strong, the public health dental community accordingly also is finally reaping the awards of this economic boom.

We are in the midst of an unprecedented window of opportunity to improve access to dental services. But it is only a window, and similar to forecasting economic cycles that it so depends upon, this is an unpredictable window that in time can close rather abruptly. Therefore, the time to act to improve oral health and related access to care issues is now. Our memories cannot be so short as not to recall the dismantling of federal, state, and local dental public health programs in the 1980s and early 1990s, when the US economy was in a tailspin. If we don't act now, similar to our opportunities in the mid-1960s, we once again will be left imagining what might have been.

Unfortunately, many states and localities either lack or have small oral

health programs, and therefore are hindered in their abilities to take advantage of this window of opportunity. It is important, if not absolutely essential, that every state and large local community have a dental public health presence in state and local health departments. However, only 31 states and five territories currently have full-time state dental directors. Approximately 50 percent of those states with dental programs have a budget of \$500,000 or less. In addition, 66 percent of states have five or fewer local health departments with oral health programs (1).

But even communities with small or no dental programs have the capability to take advantage of the recent interest in oral health by integrating this message into existing programs such as Women, Infants, and Children (WIC) and Title V Maternal and Child Health programs, among others, either to strengthen or build effective dental public health programs. Oral health directors or advocates can work with their State Primary Care Program to develop Dental Health Profession Shortage Areas (Dental HPSAs) that facilitate federal assistance programs such as the recently enacted National Health Service Corps (NHSC) Dental Scholarship Pilot Program. Broad-based partnerships using a dental school as a focal point can apply for grants from the National Institute of Dental and Craniofacial Research (NIDCR) to fund a Center for Research to Reduce Oral Health Disparities. The Association of State and Territorial Dental Directors (ASTDD), through its contractual agreements with the Centers for Disease Control and Prevention (CDC) and the Health Resources Services Administration (HRSA) MCH Bureau, also can assist states and localities to develop and/or strengthen dental public health programs. Additionally, HRSA supports states and local dental programs through its Community Integrated Service System program or CISS grants that are aimed to improve the health of mothers and children through the development and expansion of community integrated service systems. ASTDD has and is continuing to develop a number of models and tools designed to assist state and local programs in conducting needed assurance, assessment, and policy development oral health activities.

For states and localities with or without dental programs, broad-based constituency or advisory groups can and should be established to advocate for oral health and related access issues. These groups can be a potent political force as either an official governmental adviser or as an outside advocacy group that can actively lobby and give testimony before legislators. Maryland was fortunate to have a supportive health officer and a state legislative champion for oral health who worked together to write into statute the development and monitoring of dental services utilization targets for Medicaid-eligible children, the establishment of an Office of Oral Health, and the creation of an Oral Health Advisory Committee. The Oral Health Advisory Committee advises the health secretary and meets at the State Health Department on a regular basis. Facilitated through the Office of Oral Health, it is composed of representatives from dental professional groups, private dental practitioners, the state Medicaid program, child advocacy groups, and managed care organizations. This committee has become a central clearinghouse in Maryland for recommendations, initiatives, and new ideas for oral health and has been an effective and influential advocate for access to oral health care services and the state Office of Oral Health.

The principal recommendation of this group has been to increase funding for the Medicaid dental program allowing for retention and recruitment of dentists who will see poor children. The need to increase funding for Medicaid dental programs has been well documented through two national conferences on children's access to Medicaid oral health services sponsored by HRSA/HCFA (2) and the American Dental Association (3), as well as a Milbank Memorial Fund Report that has proposed a model dental insurance program (4). While increasing funding is a complex process that entails enormous and continued advocacy and lobbying efforts, with many state budgets running sizable surpluses for the first time in years, the likelihood of this happening has now increased. One only needs to look at states such as Indiana, Nebraska, Pennsylvania, and others to realize that such an outcome is achievable. Other cost-related initiatives worth ex-

ploring are increasing fees for specific diagnostic, preventive, and restorative dental procedures, and/or enhancing benefit schedules for specific geographic locales such as rural areas.

Ironically, one result of the current economic expansion that does not bode well for low-income children is that private dental offices are currently very busy and have little incentive, outside of altruistic concerns, to provide care to low-income patients. This situation is especially acute in rural areas, where the population-to-dentist ratio is higher. It is not difficult to understand a dentist's perspective as to why he or she would not want to substitute private pay patient chair time for individuals with lower reimbursement rates who also are perceived as being poorly compliant with appointments. Innovative ideas need to be fashioned with state Medicaid programs and/or third party payers to provide more incentive for dentists to treat Medicaid-eligible children, especially in rural areas. Solutions to this challenge include more flexible Medicaid contracts allowing dentists greater flexibility in the number and age level of patients they are expected to treat, universal electronic claims submission, less stringent eligibility verification procedures, and fewer predetermination requests on basic dental procedures. For those states with managed care Medicaid programs, community health centers, local health departments, and/or regional cooperatives in rural areas should be given the flexibility to subcontract with dentists who choose not to participate in a managed care network.

Other initiatives to increase access to oral health care services currently being explored in some states are addressing the capacity of general dentists and pediatric specialists. One idea recently passed by the Maryland State General Assembly is to forgive dental school loans for dentists who treat Medicaid-eligible clients for a certain proportion of their patient chair time.

An additional critical need is the availability of dentists who have experience in treating preschool children. One possible solution is for state dental programs to collaborate with a local dental school pediatric dental department to strategically place trained pediatric dental fellows or residents in underserved areas. In addition, state dental programs also can collaborate with a local dental school to apply for training grants that not only increase the number of pediatric dental fellows or residents, but also serve to provide pediatric dental training to general dentists.

The University of Maryland Dental School, in partnership with the state Office of Oral Health, is conducting Demonstration Projects aimed at increasing utilization of oral health care services in an urban and rural area of the state. These projects entail the development of intensive education, outreach, and case management efforts to engage both the public and private dental practitioners into the state Medicaid program. The education initiatives directed to dental providers address concerns over Medicaid bureaucratic procedures, and to make dentists aware of positive changes achieved through the work of the Oral Health Advisory Committee. In addition, private dental practitioners satisfied with the system serve as "ambassadors" to convince other dentists of potential financial benefits derived from the program. Additionally, the Demonstration Projects employ outreach workers who operate through schools, local health departments, and community health agencies to link children with dental care providers. In some cases, the linkage entails physically taking a patient to a dentist or arranging for suitable transportation. The outreach workers also provide education for children, and orientation of parents and caseworkers at local agencies to make them aware of the value of oral health and to emphasize the need to be compliant in making dental appointments. These efforts

also involve the integration of oral health into WIC clinics to make parents aware of identifying and preventing early disease in their children. An excellent model that ties into this theme and also involves physicians in this process is the Access to Baby and Child Dentistry (ABCD) Program in Washington State.

Such initiatives represent only a small sample of the ongoing activities at the state and local level in this country that address access to oral health care services. Of course, no access program at the state or local level is complete without addressing community water fluoridation. Community water fluoridation needs to be supported with the same resolve as it received when first introduced to the public.

In closing, as Alice exclaimed when she came back through the looking-glass, "Such a nice dream!" When we come back from our window of opportunity, those who did not take advantage will wake up from their nice dreams to find the world exactly the same, and then imagine what might have been. And poor children in this country will continue to wake up in the middle of the night to the nightmare of the pain and anguish associated with oral disease. With our help, these children can pay attention and learn in school, can smile without being ashamed, and can fulfill their own nice dreams.

## References

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