Letter to the Editor

Framing the Access to Dental Care Issue: An Opportunity for the Dental Education Community

Dear Dr. Brown:

Attention to the issue of access to dental care within the dental education community has so far been a bit like the blind people and the elephant: it seems very different depending on which part of the animal one touches. The purpose of this letter is to offer one approach to gaining a bigger picture on access to care and to urge the dental education community to take the lead in framing this issue. A first step in framing the issue would seem to be reaching agreement on the major forces and factors that can affect access to dental care: that is, a set of priority assumptions. Otherwise, the discussion has the potential to proceed in cells or pockets that tend to miss the totality of the issue, its big picture.

Many groups and organizations are actively involved in improving access to dental care, directly and indirectly. There have been many calls to action, inspiring writings, and programs on this subject, but I submit that, without a comprehensive framing of the issue, the actions may continue to be piecemeal and could result in unintended consequences. A secondary purpose of this letter is thus to offer some starter priority questions that can then lead to priority recommendations. To reiterate, the intent is not to say that these are the only priority assumptions, but to invite discussion on what the priority assumptions should be.

Following is a starter list for priority assumptions, trends, forces, etc. that can affect access to dental/oral care:

- There is no national game plan on access to dental/oral care.
- There is active discussion as to whether this is an access problem or a utilization problem.
- The majority of U.S. citizens have access to quality dental care in the private practice delivery mode/model.
- Access to dental care is a problem for many groups, including poor children, the elderly, particularly those in nursing homes, and individuals with special needs. A higher skill level among dental professionals will be needed to address the needs of these populations.
- Financing of dental care will remain relatively constant, with a small percentage from the government and the rest approximately evenly divided between cash payments and private insurance.
- Employee dental benefits will continue to be desirable for employers and employees.
- Access to dental care is a top five priority for several groups (Head Start, nursing homes, veterans, etc.), but translation to resources is challenging.
- The United States has more of a series of health care sectors than a health care system.
- Community health centers will continue to increase in scope, but their impact on access has not been seriously estimated, qualitatively and quantitatively. The envisioned role of the community health center on access to care has not been well defined.
- Dental therapists (mid-level providers) will continue to be controversial, but their impact on access has not been seriously estimated, qualitatively or quantitatively. It is doubtful that the mid-level provider could improve access for pre-cooperative low-income children, people in nursing homes, or individuals with special needs.
- The number of U.S. dental schools could be about seventy by 2020. There will be significant effects on the dental workforce beyond what we are likely to predict today. Long-term impact on the supply and demand for dentists is difficult to predict twenty years out.
- Distribution of the workforce will continue to be a problem.
- Workforce assumptions will be challenging to determine ten years out, including:
  - the adequacy of the current dentist workforce to meet future demand; and
  - potential changes to current dental practices to help meet demand through technology or changes in practice acts for dental assistants/hygienists.
• General dentists’ involvement in providing care for Medicaid recipients has varied considerably by state. In some states, improved reimbursement rates have improved participation, whereas in other states, that has not been the case. Dentist acceptance of adult patients with Medicaid will be especially important given the expansion of Medicaid insurance coverage in 2014.

• Long-term effects have not been estimated for the intended non-involvement of the profession in the most recent health care reform efforts. Advocacy groups have been effective in raising awareness of some access problems with decision makers.

• Dentistry is not in Medicare. This alone will continue to pose issues for seniors, training programs in geriatrics, and graduate medical education.

• Preservation of the fee-for-service private practice of dentistry will be a priority for the profession.

• Some specific changes (not yet fully developed) could still happen for dentistry in health care reform. But because dentistry is about half cash and because the profession was minimally involved in the health care reform debate, the reform will not likely transform the profession in the way medicine has been transformed since the Clinton effort.

Assuming that these priority assumptions have some merit, following is a starter list of priority questions that might follow:

• How can workforces and policies be developed to address access for the following groups (this is a different approach than to ask how can we fine-tune or retrofit the current workforce to address access for these groups)?
  o low-income children, particularly pre-cooperative children either susceptible to or already afflicted with Early Childhood Caries
  o senior citizens, particularly those in nursing homes
  o individuals with special needs
  o people in rural, particularly isolated, settings
  o people in inner cities

• What is the potential impact of new members of the dental team on access to care? Starting with the above groups, where will access be met and where will gaps remain?

• What is the role of community health centers for access to care?

• What is the interface between the private (general) practitioner and individuals with limited access?

• What can be the effectiveness of the profession in improving access?

• How can we anticipate education and training programs to address the greatest access needs and demands?

The academic dental community can and should play a leadership role in framing discussion of all the issues that affect it. While resolving the access to care issue is beyond the power of the dental education community, this community can and should play a leadership role in framing discussion of this major issue currently facing the profession of dentistry. Although it is beyond the scope of this letter to propose solutions, one guiding concept could be that of the social minimum as discussed by John Rawls in *A Theory of Justice* (Harvard University Press, 1979). Even though there will be (and should be) active debate on what this concept means, it could be a good starting point to focus debate on improved access to dental care.

Whatever the starting point turns out to be, the assumptions and questions I have proposed here are intended to spur discussions among the leadership and membership of the American Dental Education Association that will lead to a clearer understanding of the big picture of the access to dental/oral care problem. Our community possesses the many areas of expertise needed to refocus discussion of this issue toward the big picture; let us seize that opportunity.

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