 Costs, as much as location, impede dental-care access

Diverse testimony precedes proposed legislation

By Robert Selleck, Managing Editor

On June 7, Sen. Bernard Sanders, I-Vt., and Rep. Elijah Cummings, D-Md., introduced the Comprehensive Dental Reform Act of 2012 in the Senate and House. The proposed legislation is titled “A bill to improve access to oral health care for vulnerable and underserved populations.”

In February, the Senate Subcommittee on Primary Health and Aging heard nearly 100 minutes of testimony at its hearing, “Dental Crisis in America: The Need to Expand Access.” The hearing focused on how to serve the reported one-third of the U.S. population that is not receiving adequate dental care. Extensive and diverse written testimony was submitted as well.

Several witnesses at the hearing spoke in favor of creating a new licensing concept for midlevel care providers, such as the dental therapists practicing in Alaska and Minnesota, which to date are the only states to have passed laws creating such licensing. The Dental Reform Act proposes a similar concept.

The governor of Kansas last month signed a bill that expands treatment capabilities for dental hygienists, enabling them to pull loose primary teeth, manually scrape decay from teeth and place temporary fillings. The Kansas law was created in response to a dentist shortage in parts of the state and to improve dental care for other vulnerable and underserved populations.

The subcommittee’s investigation into access-to-care issues wasn’t limited to potential expansion of midlevel practitioner licensing, a concept that has been opposed by both the American Dental Association and the Academy of General Dentistry. Those organizations’ advocacy components contend that opening certain treatment capabilities to midlevel practitioners with less training than dentists is not the best strategy from a patient-care standpoint to address access-to-care challenges. Regarding other aspects of the proposed legislation, ADA President William "See ACCESS page A2"
R. Calnon, DDS, said in a news release, “We hope that our few areas of disagreement do not obscure our welcoming Sen. Sanders to this fight. His bill aims high, and that has long been needed. We fully support his intent, to help extend good oral health to all Americans.”

The proposed legislation addresses much of what the subcommittee heard from witnesses in February. That testimony frequently focused on the costs of dentistry and dentistry education — and the impact such costs have on where dentists practice and the types of patients they must typically serve (those with dental insurance or other means of paying for care). At the hearing’s 90-minute mark Subcommittee Chairman Sanders said, “Generically speaking, dentists make a pretty good income. Why is it that we have a dental shortage in this country? Why do we not have enough dentists?”

In response, Shelly Gehshan, MPP, director of the Pew Children’s Dental Campaign, Pew Center on the States, based in Washington, D.C., said the supply of dentists ebbs and flows with the economy, with the 1970s and 1980s producing a large contingent of dental school graduates before recessions forced closures of 15 dental schools as a result. Today, large numbers of dentists retiring every year exceeds the annual number of dental school graduates. Dr. Whitner, MSMS, executive director at Community Health Centers of the Rutland Region, Rutland, Vt., said his organization just hired two recent dental school graduates who earned more than $350,000 in debt from financing their educations. He said it was only because of the National Health Services Corps and loan repayment assistance that the two were able to take the positions, which focus on delivering care to underserved populations.

Burton Edelstein, DDS, MPH, professor of dentistry and health policy and management at Columbia University, New York, NY, said that dental training requires universities to fully fund their own operators and high-end equipment purchases, unlike medical schools, which can rely on non-university hospitals for clinical training. Dental training is rarely focused on the costs of dentistry and dentistry policy and management. At Columbia University, New York, NY, said that dental training requires universities to fully fund their own operators and high-end equipment purchases, unlike medical schools, which can rely on non-university hospitals for clinical training. Dental training is rarely focused on the costs of dentistry and dentistry policy and management.

Gregory Fiske, DDS, president of Outreach Dentistry in Lafayette, La., which is primarily a mobile concept serving the poor, disabled and elderly, praised the federal income tax system’s “incurred medical expense allowance,” which he said enables him to earn enough to focus his practice on underserved populations. But he acknowledged that the income expense places him in the lower 10 to 15 percent of the profession in earnings. He spoke in support of the Special Care Dentistry Act, which he said enables developing new programs for delivering treatment to underserved populations.

Subcommittee members repeatedly referred to the access-to-care issue as a crisis. Sen. Bernard Sanders, I–VT, chairman of the U.S. Senate Subcommittee on Primary Health and Aging, leads the hearing on “Dental Crisis in America: The Need to Expand Access.” Photo Provided by U.S. Senate Committee on Health, Education, Labor and Pensions

See page D2 for the American Dental Hygienists’ Association stance on the access-to-care proposals.

Dr. Dan Ward
Dr. Dennis Tartakow
Dr. Dan Nathanson
Dr. Carl E. Misch
Dr. James Doundoulakis
Dr. Rella Christensen
Dr. Joel Berg
Dr. David L. Hoexter
Dr. Eric Seid

The proposed legislation recognizes the need for nearly 9,500 additional health care providers to meet the nation’s current oral health needs. Various witnesses and subcommittee members spoke of the growing supply of research linking oral health to overall health. Also acknowledged were the financial implications on hospitals that have seen increasing numbers of patients using emergency rooms as their only option for dental care, which typically means just immediate symptoms are being addressed, not underlying causes and prevention.

The proposed legislation takes a multi-pronged approach with a variety of programs that would make it more financially viable for dental professionals to provide care to people falling outside of current care-delivery models. “We’re going to shine a spotlight on an issue that is not much discussed,” Sanders said. “We must address this problem.”

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The proposed legislation also includes tax incentives for dental schools to train more dentists and dentistry professionals to inform patients that better oral health is associated with better cardiovascular health in any way if used to encourage better periodontal health and improved home oral hygiene. Do the Circulation authors, editors and the AHA really believe that this is a sound message, especially in light of the fact that the majority of people do not have dental insurance or other means of paying for care. How do we know that we are not just moving an existing problem to another domain? How do we know that we are not just moving an existing problem to another domain? How do we know that we are not just moving an existing problem to another domain? How do we know that we are not just moving an existing problem to another domain?

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