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# Access to Dental Care: A National Scandal

**By Emily Friedman**

**With all of the attention being paid to health care reform, Medicaid and Medicare, one area of clinical need largely has been ignored: dentistry.**

***Emily Friedman***

Dylan was 5 years old. Jacobi was 6. David was 5. Akasmse Rose was 4. Deamonte was 12.

They all died as a result of tooth decay — either from infection or the effects of emergency sedation or treatment.

Indeed, Burton Edelstein, D.D.S., M.P.H., professor of dentistry at Columbia University in New York and founder of the Children's Dental Health Project, says that "more children [with untreated oral disease] die of mismanaged attempts to treat them than of dental caries." In most cases, timely intervention would have saved their lives.

But how can this be? We have had a federal children's health insurance program since 1997; it was reauthorized by Congress in 2009. We have Medicaid, in one form or another, in every state, territory and the District of Columbia. The Affordable Care Act (the health reform law) allows young people to remain on their parents' health insurance policies until age 26. There is private dental insurance available.

## Why Is This Happening?

So why are children dying of treatable oral disease?

Unfortunately, the overall answer is simple. As Jack Dillenberg, D.D.S., M.P.H., dean of the Arizona School of Dentistry and Oral Health at A.T. Stull University in Mesa, Ariz., observes, "Oral health is always an afterthought."

When it comes to public policy and private insurance, it most definitely seems to be the case. But oral disease is hardly an afterthought in terms of its clinical impact.

Dental caries and related conditions constitute the most common diseases among American children. Candice Driskell, M.S., R.N., executive director of Access Partnership in Norfolk, Va., recalls that in one hospital where she worked, patients with severe cardiac problems could not be treated because of dental caries. Abscessed teeth can produce spreading infections that are, in the end, fatal, as happened in 2007 to 12-year-old Deamonte Driver in Maryland, who could have been saved by a simple tooth extraction if his mother had been able to find a dentist willing to treat him.

Poor oral health has a negative effect on birth outcomes and can exacerbate heart disease, diabetes and other conditions. Decayed, broken and/or missing teeth also affect self-esteem, employability and communication skills. Furthermore, according to David Krol, M.D., a pediatrician who serves as a senior program officer for the Robert Wood Johnson Foundation, "If you look at the statistics, many hospital emergency department visits are related to dental problems."

Yet with all this evidence of clinical need, says Krol, "Even if there is available surgical treatment of advanced dental problems in kids, it's not treating the disease; it's treating the results of the disease. It's like treating diabetes with dialysis. If you pull a tooth, you're not treating the disease; you're just treating the symptoms."

## A History of Exclusion

So how did oral health fall by the public policy and insurance wayside?
One reason is the early split between dentistry and medicine as clinical professions. At the 2009 American Dental Association summit on access to dental care, participants noted that most early dentistry was performed in barber shops, which gave it a much different history than that of allopathic medicine. (Although some surgery was once performed by barbers, surgeons eventually melded with medicine.) Edelstein adds that "the separation between dentistry and medicine originated in the mid-19th century in Maryland, where some dentists tried to establish a department at the Baltimore College of Medicine and were rebuffed. They started their own school."

As a result, he says, "We have two different educational systems — nurses are not analogous to dental hygienists — two different sets of professional associations, two different delivery systems and two different financing systems." At least where the latter exist at all.

Dillenberg says, "Organized dentistry, later on, did not want its services included in Medicare or Medicaid and fought vociferously against it." The effort was, by and large, successful. Dentistry also was excluded from the original State Children's Health Insurance Program. That further strengthened the gap between oral health and other types of care.

Participants in the 2009 ADA summit also noted that beginning in the 19th century, dental care was viewed "primarily as a personal responsibility. There was little social pressure to keep one's teeth."

All this, of course, has left dentistry, for the most part, as a cash-on-the-barrelhead operation, which makes life simpler for dentists and often for patients, if they can afford the cost. But it also means that tens of millions of Americans are uninsured for dental care. The website Brighter.com reported in August 2011 that 150 million people have no private dental coverage. The figures are worse for low-income Americans, 59 percent of whom are reported to have no dental insurance of any kind, according to the Kaiser Commission on Medicaid and the Uninsured.

## Spotty or Nonexistent Funding

Clearly, dental coverage, whether public or private, is hardly pervasive. Private insurance, when it is available, largely is offered through employers, and it is becoming less accessible because of higher cost-sharing requirements, overall reductions in employee health benefits, skyrocketing premiums and unemployment. Furthermore, most private policies are rife with exclusions, restrictions and exemptions.

In any case, private dental insurance follows a different model than traditional medical coverage. Dillenberg says, "Right now, there is no meaningful private dental insurance — it's like a Christmas Club; you get out what you pay in, and no more. It's not really insurance, and the caps are way too low."

Sheila Brown, D.D.S., a Chicago dentist who is the immediate past president of the National Dental Association, agrees. "The annual caps were $1,000 or $1,500 when I got out of dental school 30 years ago, and they're still $1,000 or $1,500. Too often, dental coverage is thrown in as an afterthought to medical insurance by the employer. Instead, employers must value oral health as part of the total package."

As for the Affordable Care Act - and who knows what will happen to it? - the picture is a bit murky. It does mandate coverage of dental care for children, but the case for adults is unclear. Some employee dental plans will qualify for an exemption to many of the provisions of the law; others will not. What will happen regarding individual dental policies is still up in the air. Until the law's mandated "essential health benefits" package is defined — and apparently the states will have a major say in that definition — no one really knows if oral health will be a robust part of the package.

The situation with public coverage is equally troubling, but much more complicated. Medicare does not cover dental services except as an adjunct if they are needed in order for other care — for example, cardiac surgery — to be provided. Some private Medicare Advantage plans offer dental benefits, but that's about it. Driskell observes, "I don't understand why Medicare doesn't cover dental care, especially when seniors tend to have more problems."

Dillenberg considers the Medicare situation to be an outrage: "Medicare has to be the next battleground. It is criminal that there is no dental benefit under the program. A beneficiary has a stroke or some other serious issue, and then periodontal disease occurs, and within 18 months, all of his or her teeth will have to be pulled."

Children tend to have a better shot at public coverage than adults. Low-income kids who qualify have access to at least some dental services through the federal Early and Periodic Screening, Diagnosis, and Treatment Program, even if the state in which they live does not cover them through Medicaid. When the State Children's Health Insurance Program was reauthorized in 2009, some oral health services were included in the new version, the Children's Health Insurance Program Reauthorization Act. These include services that are necessary for preventing disease, promotion of oral health, restoration of oral structures to good health and function, and treatment of emergency conditions.

Not surprisingly, for this country's most complex public coverage program, the Medicaid situation is tangled, fluid and inconsistent. Some states cover full oral health services for adults; most do not. Many state governments, struggling with deficits and the economic crisis, have cut adult dental services. As of 2010, according to Edelstein, nine states covered full benefits for adults, 19 covered limited services, 16 covered only emergency services and seven did not cover adult services at all. Some of these policies are historical, and others reflect recent budget cutting. For example, the state of Indiana recently placed a $1,000 limit on Medicaid dental outlays; the cap was struck down by a federal court on the grounds that Medicaid requires coverage of "medically necessary treatments."

## The Trouble with Medicaid

Furthermore, as is true on the medical side, having Medicaid does not mean that a dental provider will take you on as a patient. According to Catherine Dunham, executive director of the Children's Dental Health Project in Washington, D.C., "Only two-thirds of children who are on Medicaid ever see a dentist. And that doesn't mean that they have continuing care or that anyone is managing it. The visit could just be for screening; it doesn't mean that they are getting treatment." She adds that studies suggest that fewer than 25 percent of all dentists accept Medicaid patients, and fewer than 10 percent have at least 30 percent of their practice represented by Medicaid beneficiaries.

Some of the reasons why dentists avoid Medicaid patients are obvious: Reimbursement is low and slow, the paperwork is nightmarish and the hassle factor is high.

But it's more than that. Many dentists simply do not want Medicaid beneficiaries as patients. Edelstein explains, "There are social and normative values involved. How do dentists feel about the program, and how do they feel about Medicaid patients? Are they comfortable treating them?"

He tells of an experiment conducted in Michigan several years ago, when children on Medicaid were given private Delta Dental membership cards, after which their parents sought care from dentists in private practice. About two-thirds of the gap in utilization between Medicaid and non-Medicaid children closed. His conclusion was that "two-thirds of the gap was caused by constrained access, and one-third by lack of utilization," which he says is also a problem area. "Will a low-income mom go to an affluent suburb, miss work, deal with transportation issues, decide how to allocate what funds she has and confront the logistics of life to get dental care for her child? Even when we say a certain problem is due to voluntary lack of utilization as opposed to lack of access, it's not that simple."

Dillenberg adds that the Medicaid population is anything but homogeneous, and cites special-needs patients as a particular problem. Many dentists are not trained in how to treat patients with autism, developmental disabilities or other challenges and, thus, are uncomfortable taking them on.

Furthermore, says Driskell, despite efforts to help them navigate the system, Medicaid patients are notorious for a high no-show rate, which is even more problematic for dentists than it is for physicians. A primary care physician may be able to rush through a routine physical, but a dentist can spend an hour or two — or more — with a patient. Even with mid-level practitioners doing cleaning, polishing and other tasks, the average dental visit takes much longer than the average medical visit, and no-show patients can have a major financial impact.

And although dentistry has changed greatly since olden times, when cartoons of bloody extractions with no anesthesia were commonplace, the fact is that most people fear going to the dentist, even for a routine cleaning. Throwing other obstacles in their way provides a grand excuse to forget about it.

## Preventing a Worse Situation

One could get depressed surveying the rather grim landscape of access to dental services, especially for vulnerable populations. Yet the situation is better than it would be if many extraordinary programs were not filling the gaps that inattentive public policy and other failures have created. Here is only a small sample of what is being done.

**The Deamonte Driver Dental Project.** Outraged — and, quite frankly, embarrassed — by the avoidable death of Deamonte Driver in 2007, Maryland Governor Martin O'Malley and other key policymakers decided to address access to oral health services. "While there is nothing we can ever do to compensate for the loss of Deamonte, we can honor his memory by doing everything in our power to make sure that his death was not in vain – by doing all that we can to ensure that no child ever dies for want of care for a toothache," the governor said at the time.

According to Betty Thomas, director of the Deamonte Driver Dental Project, based in Washington, D.C., the Maryland Dental Action Coalition, the Robert T. Freeman Dental Society, and several leading dentists asked the state to fund oral health services for underinsured and uninsured children in Title 1 schools, where a large percentage of students are eligible for free or reduced-cost school lunches — a common measure of poverty.

In 2008, members of the Robert T. Freeman Dental Society and other local dentists formed Dentists in Action, a group of 47 volunteers who give their time to go into the schools and provide *pro bono* dental care. Children are seen only with their parents' permission.

When the program began, it used a rented mobile unit in which the volunteer dentists could screen at-risk children at the targeted schools. Nine schools in Prince George's County, where Deamonte lived, and one in Montgomery County were included at first. The following year, the state government funded "a state-of-the-art mobile unit with three dental chairs," Thomas says. "We are now going into the schools again to do more than screenings to ensure that there aren't any more Deamontes out there." Any child found to need care and who does not already have a dentist is referred to a nearby member of Dentists in Action. The program offers screenings, cleaning and fluoride treatments, and its leaders hope that X-rays and other services soon will be available.

All children are treated regardless of their insurance status.

Brown believes this project is an excellent — and replicable — model. "We [the National Dental Association] are working to get vans going in other parts of the country to visit areas where there are no dentists. The mobile dental van is an innovative way to make care available, and it can offer opportunities for recent dental graduates to provide care and get tuition reimbursement as well as to allow them to work in an environment where they will learn additional skills."

**The Children's Dental Health Project.** Dunham reports that "the CDHP is a small, research-based consumer advocacy organization founded in 1997 to improve access to dental care for children. We also want to reduce the isolation of oral health from other health services and prevention strategies." Recently, the project has been focused on ensuring that oral health receives equal status under the health reform law and the essential benefits package that it will create. "Lack of access to dental services for vulnerable, high-risk children is totally unacceptable," Dunham says. "Complications of dental caries are completely preventable, and children of the middle and upper classes are getting care that prevents both pain and the burden of infection. But for low-income children, rural children, disabled children and children of color, the incidence of chronic mouth infections is rising."

**Access Partnership, Inc.** In Norfolk, Va., an alliance among Access Partnership — a nonprofit organization seeking to improve the health status of people in the Hampton Roads area — the United Way and the Pankey Institute, a postgraduate dental school in Florida, has produced a program that links patients with providers and holds dental outreach events that have provided care to hundreds of low-income and otherwise vulnerable patients.

The United Way of South Hampton Roads provides space for the project, which has established a dental access phone line. Landmark Communications Inc. has donated $500,000 to fund the project. Patients in need of dental services call the access line and leave their contact data, and within 48 hours an Access representative calls the patient back with information about a source of available care. "It isn't always free," says Driskell, "but we try to get them a reduced rate."

The outreach events have been very successful; 198 patients were treated at the first one, which lasted 14 hours. At the next one, 150 patients were treated. "Part of that lower number was that our lead dentist wanted to provide more thorough care," says Driskell, "and if it took 2 ½ hours in the chair, then so be it." Although the program does not yet provide root canals or dentures, it does try to address the most pressing and serious needs.

Its efforts have not gone unnoticed; the program has received a great deal of press coverage, and now dental hygienists are asking if they can volunteer. "It has been successful enough that other cities are now fighting to have these events — they want the institute dentists to come to their locations as well," Driskell says proudly.

**BEST Oral Health.** Although hospital-based programs are not common, there are some outstanding examples. BEST (Bringing early Education, Screening and Treatment) Oral Health was created by Baystate Health in Springfield, Mass., and Partners for a Healthier Community, also based in Springfield.

Realizing that many preschool-age children already have begun to suffer dental problems — more than 25 percent have evidence of dental decay, and more than 50 percent of vulnerable children have dental disease and constrained access to care — PHC devised a program to prevent and treat oral disease in this very young population.

The program began by focusing on low-income families in the Springfield area, and by providing services at early education and care organization preschool sites using a mobile dental clinic. Part and parcel of its efforts are train-the-trainer activities and instruction of early childhood educators in oral health issues. BEST Oral Health is being replicated in other locations, specifically two other counties in Massachusetts; 30 organizations and 45 sites have been touched by the program. As of 2011, 5,428 children were enrolled. That figure includes students in primary schools, to which BEST Oral Health expanded in 2010.

Says Frank Robinson, executive director of PHC, who is also an executive with Baystate Health, "In Springfield, 22 schools are participating, and two other school districts have joined the program. The youngsters who receive care in a preschool setting still need services when they enter school, so we are working to fulfill that need."

Among the services offered are fluoride varnish treatments, preventive care, sealants and fillings.

Robinson adds that Baystate Health also has integrated oral health into its pediatric program. "As part of the regular well-child exam, the child also receives an oral health check, and a number of sites are doing fluoride varnish applications. This is something that hospitals and health systems can integrate simply into their practices. And it is not solely altruistic; it can make money for them. It's a reimbursable service for providers who have large Medicaid populations, and some enlightened insurers have picked up on it and are paying for it. And it keeps kids out of the emergency department."

**Remote Area Medical USA.** Remote Area Medical originally was founded in 1985 by Stan Brock, who had spent 15 years working with indigenous people in isolated Amazon locations and was shocked by their lack of health care. The program was intended to provide needed clinical services to people living in such circumstances worldwide.

However, RAM's leaders soon realized that there was pressing need here at home, and in 1992 the organization began providing medical and vision services to low-income residents of Appalachia in Tennessee.

Ron Brewer, RAM's director for rural America, who is based in Knoxville, explains, "Here in Appalachia, we found that there was a big need for dental services, so we started incorporating them into our general medical and vision services. Our first program was in Hawkins County, Tennessee, in 1992."

That original effort soon expanded to what RAM calls its "expeditions," in keeping with its founding mission. These events are held around the United States in large public venues, offering medical, dental and vision care. Brewer stresses that in every case, a local organization invites RAM to hold an expedition; "for any and all clinics that we offer, we are invited."

Brewer reports that potential patients begin lining up hours before the clinic begins. I can vouch for this. I was in Los Angeles when a RAM event was being held, and the line stretched for more than a block before the sun came up. Clinics generally are held on Saturdays and Sundays so that low-income working people can attend. All oral health services are provided by volunteer dentists who, says Brewer, "are such a blessing. They come to our events from all over the United States. And once they have participated, they often want to come back, so we have many physicians and dentists who volunteer repeatedly. We also have vision and dental students who come to help out. It's a real eye-opener for them; it makes better citizens of them."

At least 22 domestic expeditions are planned for 2012.

One cannot help but wonder that in the richest nation in the world, an organization that was established to help the poorest of the world's poor has found such a mission in our midst.

## Wanted: Dental Homes

The work of these organizations and volunteers — and hundreds of others that I did not mention — should be admired, indeed, celebrated. But in the end, they are often a one-time-only Band-Aid. Terry Dickinson, D.D.S., who organizes dental fairs, said in 2009, "Dental disease is everywhere, and we can go anywhere and set up a project and [people] will line up for five or six hours. That's not the answer. We can't keep being the safety net for this immense problem."

The fact is that volunteering a few days a year, valuable and needed though it is, does not equate with ongoing, consistent, reliable dental care over time. As with medical care, episodic treatment with little or no follow-up — especially when the treatment is limited — will not solve the underlying oral health problems that plague so many Americans.

There is much talk these days about medical homes, where patients and their medical histories are known, preventive services and treatment are ongoing, and there is a guarantee of continued access. Little is heard about "dental homes," which are just as important. In either case, patients without such a lifeline often end up in the emergency department.

Dillenberg adds that this concept should apply to all vulnerable populations, including those with special needs and low-income adults. "We need someone to champion adult dentistry; children have more champions."

## Making Things Better

Another way to improve the situation, says Brown, is to capitalize on dentistry's traditional stance in support of prevention. She laments the lack of knowledge about oral health displayed by parents and children alike. "We must start educating about diet; sugar cannot be a staple of life, because that eventually requires a high level of dentistry. Also, habits start so early with children that you must begin when they are very young. And the educational process cannot only take place in the dentist's office; it has to be a national campaign. We once had dental hygienists in every school; we don't anymore. We have nurses in many schools, but oral health is often outside their scope."

I recently visited Singapore, where there is a dental clinic in every primary school in the country. Perhaps this is one wheel worth reinventing.

Although many school districts are improving the healthfulness of food in both vending machines and cafeterias — efforts designed to combat obesity that also will have positive effects on oral health — we are a long way from changing the unhealthful eating and drinking habits of many of our children.

But schools are still key to improving pediatric dental health; BEST Oral Health and other programs are demonstrating that. Edelstein recently was quoted in *Health Affairs* as saying that efforts should "target schools where there are populations of underserved children in locations with inadequate supplies of dental care. Using that school base, there needs to be a comprehensive and integrated intervention that goes from classroom to clinic" (Donna Behrens and Julia Graham Lear, "Strengthening Children's Oral Health: Views from the Field," *Health Affairs*, vol. 30, no. 11 [2011]: 2208-2213).

Another way to improve access and care, says Dillenberg, is for dental schools to be more astute when selecting students. "We need dentists who are ready, willing and able to address the needs of the underserved. At our university, we identify individuals who want to do that, who have done volunteer work, whether in school or through the military or wherever, and who want to continue along that line during the course of their education. That is the model we have identified, and 36 percent of all of our graduates are engaged in community service or the military."

Both Dillenberg and Brown stress that community health centers also offer a rich possibility of employment for dentists, as well as for expanded access to oral care for underserved populations.

Other proposed approaches are more controversial. Dillenberg says, "We have to refuse to allow states to opt out of the adult dental benefit under Medicaid. I also believe that every dentist who has a license must take a minimum number of Medicaid patients into his or her practice to keep that license. Even if he or she went to a private school, if there were any public support of any kind for him or her or the school, this should be a mandate. The federal government should make the states require dentists to treat at least a low number of Medicaid patients."

Given the history of such proposals on the medical side, we should probably not hold our breath on this one.

Brown believes that "we also need expanded-duty dental hygienists and expanded-duty dental assistants. That concept has not been universally embraced." That is not a surprise; no proposal that would expand the scope of practice of allied health practitioners is welcomed by most professionals who are at the top of their sector's food chain. It's a matter of turf.

But a Kellogg Foundation survey released in October 2011 found that 78 percent of Americans were supportive of allowing dental therapists and other mid-level practitioners to provide such routine care as cleanings and fillings.

## Getting It Together

Other proposed solutions are rooted in the idea of partnership. More than 30 years ago, I was visiting a large urban public hospital, and was surprised to find a complete dental clinic with several chairs. This was a rare service for a hospital to offer at that time. I asked the hospital CEO about it, and he replied starkly, "People who are malnourished and eat out of garbage cans have bad teeth."

Some 30 years later, most hospitals still are not with the program when it comes to oral health services. Baystate Health is, but it is the exception. Yet, there is enormous opportunity in this area. As Brewer of Remote Area Medical says, if a patient needs care and there is no dentist available, "I can call the University of Tennessee Medical Center, and they will welcome my call and will accept the patient. I think that more hospitals are opening their eyes about the need to provide dental services. It's hard to get some dentists to open their doors and take patients *pro bono*, and if hospitals would open their doors and do it, that would be an enormous improvement."

Driskell warns that there are obstacles to hospital-based oral health services, including the individualistic culture of dentistry. "Hospitals can offer to subsidize the cost of equipment and share other expenses, but most dentists just don't seem to want to work in the hospital context. They want to work individually." On the other hand, says Dillenberg, "There is a significant role for hospitals to play in encouraging young people to enter dental school and then work in a hospital residency program, including offering loan repayments, scholarships or other incentives."

Finally, many observers say it is high time that we get over the historic schism between medicine and dentistry and reintegrate them into a holistic vision of care for the whole person. Thomas of the Deamonte Driver Dental Project says, "There is some talk regarding combining oral health and allopathic health. At a recent meeting of a dental coalition, there was quite a bit of discussion about oral health being recognized as a medical issue. If your mouth is hurting, how can that not be a part of your overall health? The two must work together. I hope that in the future we will see more cooperation, as opposed to dentistry being at the very end of the line."

Driskell agrees: "Merging medical and dental services has to happen; dental health has everything to do with your health and well-being. There shouldn't be a division; there's no difference."

In the end, bringing dental services into the mainstream — whether financially, socially or policy-wise — is critical to improving overall physical health. Whatever the history, the isolation of dentistry does not benefit anyone. As Brown says, "The mouth is not a separate entity in the body. We have to convince our colleagues in medicine that we must take care of the mouth so that we can take care of the rest of the body."

In 2000, the U.S. surgeon general issued a report on oral health, describing a "silent epidemic" of preventable, serious disease among vulnerable populations. Twelve years later, that epidemic continues to claim lives, often in the shadow of ineffective policy and lackadaisical attitudes about the problem.

In 2010, total dental spending in the United States was $104.8 billion. Perhaps if we could spend some of that money more wisely and compassionately, we would not be haunted by the ghosts of children who should not have died.



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