

Problem

The declining dental public health infrastructure in states is a prime example of the failure of the health care system to meet the needs of all Americans.¹ The important role that oral health services play in the current health care delivery system has often been overlooked or minimized by federal and state policymakers who themselves may not have any background, experience and/or knowledge of oral health issues.

It wasn't until 2000, when the U.S. Surgeon General's first ever report on oral health entitled, "*Oral Health in America*," was released that the role and importance of oral health gained public attention. This seminal document encompassed two major themes; that "oral health means much more than healthy teeth" and that "oral health is integral to general health." It also noted "oral diseases are progressive and cumulative and become more complex over time."² These diseases can affect economic productivity and compromise an individual's ability to work at home, at school, or on the job. Oral diseases significantly impact the nation's domestic productivity and global competitiveness.³ More than 51 million school hours and 164 million hours of work are lost each year due to dental-related absences.⁴ The mouth mirrors the state of general health with oral conditions being associated with heart disease, HIV, stroke, diabetes, pre-term and low weight births and respiratory diseases. Oral and pharyngeal cancers reflect and impact physical health.²

Oral health disparities are most apparent among individuals with special health care needs, with low incomes, and from underrepresented minorities, and among those who live in underserved rural, urban, and frontier communities.² These inequities challenge policy makers to make adequate investments in a strong dental public health infrastructure that extends beyond the traditional, economically driven model of health care and dental care. "The current model may well serve a majority of U.S. citizens, but it is not achieving universal coverage and equitable access to oral health for everyone."⁵

Financial barriers remain the primary reason individuals lack access to oral health services. About 35 percent of the U.S. population lacks dental coverage – significantly more than those medically uninsured.⁶ For every child without medical insurance, there are nearly three children without dental insurance.⁷ Children without medical insurance are 2.5 times less likely than children with insurance to receive dental care.^{8,9,10} Many individuals, particularly those who are uninsured, often delay dental treatment until serious or acute dental emergencies occur.⁵ Oral health problems addressed in the

emergency room cost considerably more than the average cost of care in a dental setting and often result in costly temporary relief of pain that may result in unnecessary return visits or surgical care.¹¹

Focusing on prevention and early detection saves money. Providing regular preventive dental care for children is estimated to be ten times less costly than managing symptoms of dental disease in a hospital emergency room.¹² Biomedical research indicates the cost savings of prevention of dental diseases exceeds the cost savings from HIV screening and influenza immunization and a number of other diseases and conditions.¹³ Children continuously enrolled in Medicaid for five years who received their first preventive dental visit by age one had 40 percent lower dental costs over five years than children who received their first preventive visit at a later age.¹⁴ Costs of treating oral cancer in the earliest stages of the disease are estimated to be 60 percent lower than those at an advanced stage of disease.¹⁵ Every dollar invested in community water fluoridation yields approximately \$38 in savings on dental treatment costs.¹⁶

Geographic isolation, whether it is in rural/frontier areas or urban settings, has created growing concerns about the distribution of dental professionals. As of July 2010, the Health Resources and Services Administration (HRSA) reported there were 4,377 federally designated dental health professional shortage areas in the United States. HRSA estimated it would take 7,008 full-time equivalent dentists to meet the dental needs in those communities.¹⁷

Ensuring that people have oral health care is a shared responsibility of individuals and families, the private sector, and federal, state, and local governments.⁵ The Surgeon General's Report *Oral Health in America* noted that "the public health infrastructure for oral health is insufficient to address the needs of disadvantaged groups and the integration of oral and general health programs is lacking."² Cooperative agreements between states and federal agencies (Centers for Disease Control and Prevention (CDC) and HRSA) have attempted to build the infrastructure and capacity of state oral health programs. Longer term solutions and resources are needed to meet the needs of the underserved.

Methods

Congress must address oral health comprehensively in any effort to reform health and health care in this country. Oral health is essential to maintaining overall health. Dental caries, the most common chronic disease in children, is largely preventable and can be cost effective to manage and treat if detected early.² Adult related oral conditions such as periodontal disease and oral cancer can also be treated more cost effectively if identified and addressed early.

ASTDD recognizes that prevention is the strategic centerpiece of modern dentistry and public health programs, initiatives and strategies can result in extensive cost savings and healthier populations if everyone has equal and early access to these interventions. While the passage of the Patient Protection and Affordable Care Act (ACA) focused primarily on the financing of health care, oral disease prevention

received significant additional attention. The new law expands access to dental coverage for children, but additionally promotes prevention of oral diseases to the public, strengthens the dental public health infrastructure, and supports the current and future dental workforce. The health care reform legislation contains the following provisions.

Coverage and Access

- Oral Health Services for Children [SEC. 1302(b)(4); SEC. 1001] requires that all insurance plans that are offered under the state-based Exchanges include oral care for children. Additionally, insurance plans operating under the Exchange are barred from charging out of pocket expenses for preventive services, including preventive pediatric oral health services.
- Stand-alone Dental Plans [SEC. 3202] allows stand-alone dental plans to participate in the state-based Exchanges, as long as they offer pediatric dental benefits. Purchasers will have the option to buy pediatric dental coverage directly from standalone dental plans or through medical plans.
- Medicare Advantage [SEC. 3202] Allows Medicare Advantage Plans to use rebates to pay for supplemental benefits, such as dental coverage.
- Provider payments [SEC 2801] charges the Medicaid and CHIP Payment and Access Commission to review and report to Congress on payments to health professionals, including dental professionals.

Prevention & Disease Management Opportunities

- Oral Health Prevention Education Campaign [Sec. 4102] charges the Secretary of the Department of Health and Human Services (DHHS) to prepare for a five-year national public education campaign focused on oral health and disease prevention and education. Building on the CDC's Center for Chronic Disease Control and Prevention experience with education campaigns, this program will inform the public about the preventable nature of all three primary oral diseases, thereby improving health and decreasing treatment costs.
- Research-based Dental Caries Disease Management [Sec 4102] charges the Secretary with awarding grants to demonstrate the effectiveness of dental caries disease management activities. Dental caries is an infectious, transmissible and progressive disease that can have severe consequences. Building the evidence-base for dental caries management will provide the necessary information to control disease and dental expenditures long-term.
- School-based Dental Sealant Programs [Sec 4102(b)] expands existing public health prevention interventions to all 50 states and territories. School-based sealant programs are critical to reaching low-income children who are less likely to have access to dental coverage or services. These programs have been established because sealants are identified as being cost-effective¹⁸ and potentially cost saving.¹⁹

Workforce Enhancement Opportunities

- Alternative Dental Health Care Providers [Sec 4303] authorizes five year demonstrations to develop new dental health care providers and directs the Institute of Medicine (IOM) to evaluate the outcomes. The U. S. General Accounting Office (GAO) has reported that “several factors contribute to the low use of dental services among low-income persons who have coverage; the major factor is difficulty finding dentists to treat them.”²⁰ Therefore, states have begun to seek alternative dental workforce models. These demonstration grants provide the incentive to test new workforce models that meet the unique demands of a community within the parameters of prevailing dental practice acts.
- Training in General, Pediatric, and Public Health Dentistry [Sec 5303] enhances existing Title VII health professionals training by authorizing grants for technical assistance to pediatric training programs to emphasize care for underserved children. Additionally, dental school faculty are supported to educate students on risk-based care and primary prevention. These provisions directly address the need to shift the focus of primary care dentistry toward prevention and disease management in addition to traditional educational experience with treatment.

Surveillance & Quality Assurance Opportunities

- National Oral Healthcare Surveillance [Sec 4102] supports the data collection that allows comparison of state and national statistics for indicators on oral health status, oral health services and community water fluoridation based on population demographics. This ongoing data collection and analysis allows for long-term evaluation of the impact on the oral health of target populations.

Infrastructure Building Opportunities

- Oral Health Infrastructure Cooperative Agreements [Sec 4102] expands existing cooperative agreements to states to establish a multidimensional oral health care delivery system and dental public health infrastructure from 19 states to all 50 states and U.S. territories. Funding establishes leadership in the state, monitoring oral disease risk factors, and establishing, implementing and evaluating prevention programs (specifically community water fluoridation and school-based sealant programs).

Policy Statement

The Association of State and Territorial Dental Directors (ASTDD) supports the full funding of all oral health provisions in the Patient Protection and Affordable Care Act Health Care Reform legislation signed into law on March 23, 2010. The role of state oral health programs in assuring that evidence-based oral health care benefits are available to the entire U.S. population is advanced by Health Care Reform oral health provisions that support 1) adequate funding for dental public health infrastructure, 2) evidence-based interventions that prevent oral diseases, and 3) elimination of financial barriers that ensure coverage and increase access to oral health services. ASTDD requests that all health care reform policy development initiatives include adequate representation by oral health professionals.

¹ Association of State and Territorial Dental Directors. Issue brief – Health reform; The dental public health infrastructure: Failing to meet the needs of the underserved. Association of State and Territorial Dental Directors Web site. <http://www.astdd.org/docs/HCRIssueBrieffinal4.1.2009IINVinfo.pdf>. Published April 2009. Accessed July 28, 2010.

² U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD.: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health; 2000.

³ U.S. Department of Health and Human Services. *National Call to Action to Promote Oral Health*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute of Dental and Craniofacial Research. NIH Publication No. 03-5303; Spring 2003.

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⁵ American Dental Education Association. ADEA policy statement on health care reform. Oral health care: Essential to health care reform (as approved by the 2009 ADEA House of Delegates). *J Dent Educ*. 2009; 73(7):856-859.

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¹² Pettinato ES, Webb MD, Seale NS. A comparison of Medicaid reimbursement for non-definitive pediatric dental treatment in the emergency room versus periodic preventive care. *Pediatr Dent*. 2000; 22(6):463-468.

¹³ Silverstein SC, Garrison HH, Heinig SJ. A few basic economic facts about research in the medical and related life sciences. *FASEB J*. 1995;9 (10):833-840.

¹⁴ Savage M F, Lee JY, Kotch JB, Vann W F Jr. Early preventive dental visits: effects on subsequent utilization and costs. *Pediatrics*. 2004;114 (4):418-423.

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