Access to Oral Health Care: Professional and Societal Considerations

James J. Crall, D.D.S., Sc.D.

Abstract: Access to health care is a complex subject with vast personal, economic, political, and societal ramifications. Issues concerning the rights and responsibilities of health care professionals—collectively and as individual members of a profession—comprise an important topic within ongoing debates concerning access to care, and constituted the overarching focus of the deliberations that form the basis of this publication. This article provides definitions of key terms; data concerning demography, oral health status, and use of dental services for children and seniors; and a contextual framework for examining broad underlying professional and societal considerations. It concludes with reflections on joint responsibilities and guiding principles that apply to dental professionals and government agencies charged with administering public benefits programs and the consequences likely to ensue if these vital stakeholders fail to respect fundamental principles of professionalism and economics.

Dr. Crall is Professor and Chair of Pediatric Dentistry, UCLA School of Dentistry and Director, Maternal and Child Health Bureau, National Oral Health Policy Center, UCLA Center for Healthier Children, Families, and Communities. Direct correspondence to him at Section of Pediatric Dentistry, MCHB National Oral Health Policy Center, UCLA School of Dentistry, CHS 23-020A, 10833 LeConte Avenue, Los Angeles, CA 90095-1668; 310-206-3172 phone; 310-794-2728 fax; jcrall@dent.ucla.edu.

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Access to health care is a complex subject with vast personal, economic, political, and societal ramifications. Issues concerning the rights and responsibilities of health care professionals—collectively and as individual members of a profession—comprise an important topic within ongoing debates concerning access to care, and constituted the overarching focus of the deliberations that form the basis of this special issue. Within that milieu, this article provides definitions of key terms; data concerning demography, oral health status, and use of dental services for children and the elderly; and a contextual framework for examining broad underlying professional and societal considerations as a prelude to related discussions on various aspects of the ethics of access to oral health care.

Definitions of Key Terms

Establishing a common understanding of terms that relate to important fundamental concepts is an essential prerequisite for productive deliberations of complex subjects such as access to health care. Accordingly, this section provides definitions of "access," "accessibility," "utilization," and a number of related terms applicable to the context of this work. Distinctions among related sets of terms are delineated thereafter.

Here are some key definitions to start:

> *Access:* "Freedom or ability to obtain or make use of."[1]

> *Accessibility:* "The ease with which health care can be reached in the face of financial, organizational, cultural, and emotional barriers."[2]

> *Utilization:* "To make use of."[1]

The definition of access above depicts a potential or observable situation whereby individuals can obtain health services if they choose to do so. Accessibility, on the other hand, refers to how easy or difficult it is for individuals to initiate interactions with health care providers, including considerations such as geographic location of facilities, hours of operation, cost of services, and the extent to which a population perceives these aspects as convenient. Access and accessibility often are used interchangeably; however, in the extreme, individuals who have to travel substantial distances or overcome great difficulties to obtain services may be deemed to have access, even though the services they are able to obtain would not be considered to have a high degree or perhaps even a reasonable degree of "accessibility" (because of the difficulty involved in obtaining care). Utilization refers to observed behaviors or documented evidence of individuals' actual use of health services (e.g., frequency or patterns of dental visits, frequency or types of services provided). Utilization can reflect activities that are self-initiated by patients or recommended by clinicians.

Related terms from the fields of economics and health care evaluation that often appear in discussions of access to care include "availability" and

"supply"—which generally refer to goods or services being offered for purchase or use—and "demand" or "effective demand," which generally refer to willingness to purchase or use goods or services and, in the case of effective demand, the ability to do so. Another commonly referenced concept—"need"—generally refers to "the amount of care that experts believe a person should have to remain or become as healthy as possible, based on current knowledge."[3] "Need" has special relevance within the field of health policy as it relates to determinations of medical necessity, a concept that is elaborated on below.

Thus, an individual may have clinical treatment *needs* as determined by a health care professional, but fail to seek services because he or she either does not perceive a reason for seeking services (i.e., does not *demand* services) or lacks sufficient resources such as time, money, and/or transportation to initiate treatment (i.e., is not able to create *effective demand* that would allow him or her to utilize services). Alternatively, individuals may demand services such as routine cosmetic services from health professionals (including dentists), which are motivated by concerns that do not meet generally accepted criteria for medical necessity (that is, professionally determined *need*).

Disparities in Oral Health and Access to Oral Health Care for Children and Seniors

Disparities in Children's Oral Health

Analyses of data from the National Health and Nutrition Examination Survey (NHANES) clearly demonstrate disparities in the oral health of U.S. children. Vargas et al.[4] reported that children from households whose income was at or less than 100 percent of the federal poverty level (FPL, which in 2005 was $19,350 for a family of four; 200 percent of the FPL=$38,700) were three to five times more likely to have untreated decayed teeth compared to children from households with incomes over 300 percent of the FPL. Data from 1999-2002 NHANES cohorts[5] show that 55 percent of two- to eleven-year-old children from households with incomes less than 100 percent of the FPL had experienced dental caries (tooth decay) in their primary teeth (a slight increase from data collected from 1988 to 1994), compared with 31 percent for children from households with incomes over 200 percent of the FPL. Black and Hispanic children (the Hispanic sample in NHANES III was comprised of Mexican American children; the terms "blacks" and "whites" refer to those not of Hispanic origin) had higher prevalence rates than their white counterparts. Moreover, 33 percent of children from households with incomes less than 100 percent of the FPL had untreated caries, compared with 13 percent for children from households with incomes over 200 percent of the FPL.

Disparities in caries experience in children's permanent teeth also exist, with 48 percent of six- to nineteen-year-old children from households with incomes less than 100 percent of the FPL experiencing caries, compared to 36 percent for children from households with incomes above 200 percent of the FPL.[5] Significant disparities also exist with respect to untreated caries, with 20 percent of six- to nineteen-year-olds from households with incomes below 200 percent of the FPL having untreated decayed teeth, compared to 8 percent for children from households with incomes over 200 percent of the FPL.

Disparities in Children's Utilization of Dental Services

Federal reports also indicate significant disparities in U.S. children's utilization of dental services. According to the 2000 report issued by the General Accounting Office (GAO) of the U.S. Congress,[6] over 70 percent of children age six to eighteen years from households with income above 400 percent of the federal poverty level (FPL) and over 50 percent of children from households with incomes between 200 and 400 percent of the FPL visited the dentist in 1996. The same GAO report noted that fewer than 35 percent of six- to eighteen-year-old children from households with income less than 200 percent of the FPL had a dental visit in the prior twelve months. Access to dental services by children enrolled in Medicaid has been cited in GAO reports[7] as a chronic problem. Improvements in some states' dental Medicaid programs over the past seven years have resulted in higher levels of utilization for child Medicaid beneficiaries (from less than 20 percent of children receiving any dental service in a twelve-month period to about one in

four receiving at least one service); however, these rates remain substantially below those for children not covered by Medicaid.

Disparities in Seniors' Oral Health and Utilization of Dental Services

Analyses of recent national survey data[8] indicate that nearly one-third of seniors age sixty-five or older have untreated tooth decay. Detectable periodontal disease also was noted in about 40 percent of seniors. Seniors with incomes less than 100 percent of the FPL are three times more likely to have lost all their teeth compared to seniors with incomes over 200 percent of the FPL.[5] As is the case with children, seniors from racial and ethnic minorities tend to have poorer oral health than their white counterparts.

Among people age sixty-five and over, 49 percent of seniors with Medicare and private insurance and 34 percent of seniors with Medicare alone had at least one dental visit in 2000. However, only 17 percent of seniors with public insurance (e.g., Medicaid) in addition to Medicare (i.e., low-income seniors) received any dental care in 2000.[9] Approximately 70 percent of dentate seniors (seniors with teeth) are reported to utilize dental services annually.[8]

Putting the Data into Perspective

Children

The summaries above clearly demonstrate that children from low-income households are more likely to have untreated dental disease and lower levels of utilization than their more affluent counterparts. Moreover, black and Hispanic children have even higher levels of caries and untreated caries. Examining demographic data on U.S. children is useful for gaining a perspective on what these data mean in terms of the magnitude of the problem and steps likely to be necessary to reduce or eliminate the observed disparities.

There are approximately 75 million children (birth to age eighteen) living in the United States. Approximately 38 percent or 28.5 million children live in families with household incomes less than 200 percent of the federal poverty level (FPL), and 17 percent—nearly 11 million children—live in households with income less than 100 percent of the FPL.[10] Younger children are more likely to live in poverty and low-income households than older children.

Roughly 24 million children are covered by Medicaid. Medicaid pays for about 49 percent of the cost of dental care for poor children; however, nearly 40 percent of the costs of dental care for poor children are paid by "out-of-pocket expenses" (from family resources, not from public program expenditures).[9,11] Dentists also report providing significant amounts of pro bono services for poor children, including those covered by Medicaid.

Clearly, in light of the substantial number of low-income children and the relatively high levels of dental disease in these children, alleviating disparities in U.S. children's oral health status and use of oral health services cannot be achieved with sporadic or volunteer activities. Meaningful improvements will require substantial societal and professional commitments to mount the resources and develop the systems necessary to make effective oral health care reasonably accessible to all children.

Seniors

Elderly Americans represent a substantial and growing sector of the U.S. population. U.S. Census Bureau data show that there were approximately 36 million seniors age sixty-five or older in 2001.[12] However, the economic situation of seniors differs considerably from that of children. About 10.4 percent of seniors or roughly 4 million individuals age sixty-five or older live in poverty—less than one-fourth the number of children living in poverty. Moreover, per capita public expenditure on health care for seniors amounted to nearly $4,400 per senior in 2001—seventeen times the per capita public expenditure on health care for children.[12] Granted, relatively little in the way of public expenditures goes for dental care for the elderly, because coverage for adult dental services is largely at the discretion of individual states, and Medicare coverage provides almost no coverage for dental services. Nevertheless, as a group, the elderly are better off financially than children.

Interestingly, a recent survey of Americans revealed that respondents indicated widespread belief that the health care needs of children and the elderly are not being met; furthermore, respondents expressed strong support for the role of government in ensuring adequate health care for both children and seniors.[12] Even more interesting was the observation that the public believes that public funding for

health care for children and seniors is roughly similar although there is an eightfold difference in overall public spending and a seventeenfold difference in public per capita spending on health care for seniors vs. children—differences that are likely to increase with implementation of the Medicare prescription drug benefit.

A Conceptual Framework Concerning Access to Oral Health Services

As noted in the introduction, access to health care is a complex subject of vast significance, which continues to be examined from a variety of perspectives. Figure 1 provides a graphical depiction of a framework that incorporates several key considerations for dental care providers and societal/governmental agents with vital interests in access to oral health services. The primary focus of the ensuing discussion relates to public benefits programs such as Medicaid; however, the broader implications of how these issues are addressed in the limited context of public programs are raised in the concluding section.

Considerations for Agencies of Government

Public benefits programs such as Medicaid are generally designed to help finance coverage that will provide accessibility to a set of defined benefits or health care services for eligible beneficiaries. Prime considerations for the agencies responsible for administering these programs include the scope of benefits required by relevant statutes, regulations, or program policies; the health care needs of covered beneficiaries, generally determined by a set of criteria for what constitutes medically necessary services; and the extent of available resources. Agency administrators are responsible for implementing and overseeing programs that produce the optimal balance between proscribed benefits and the needs of the covered population on one hand and the resources allocated for the program on the other. The resources available for various public programs or types of care within programs are generally determined through political processes.

In the case of Medicaid, a program operated through federal-state partnerships, federal statutes and regulations delineate the broad parameters of the benefits that are to be provided and specify the

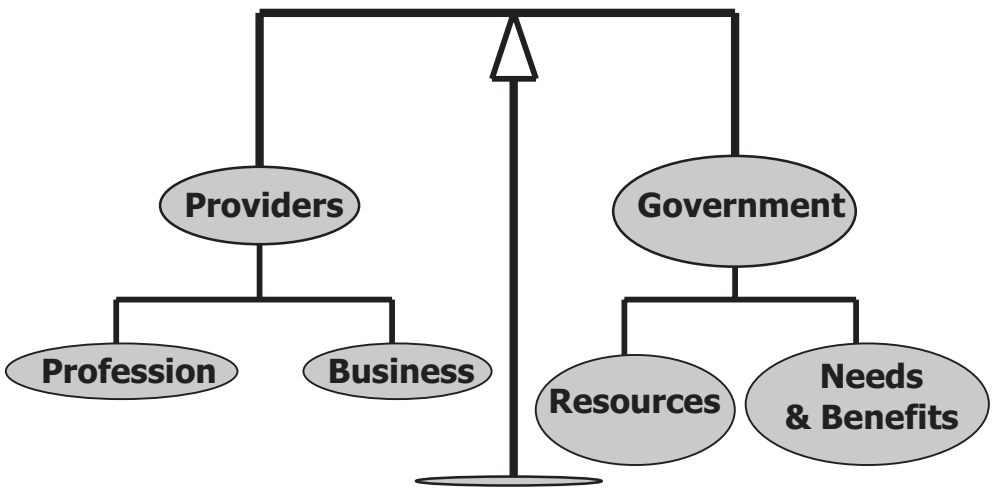

Figure 1. Diagram of primary considerations for professional and societal agents

level of financial support to be provided by the federal government. However, state officials including program administrators, legislators, and high-level executive branch officials have considerable say in determining the operational parameters of how Medicaid programs are conducted as well as the amount of financial resources that will be provided by a state's Medicaid program for various types of services (e.g., dental care, medical care, nursing home care, prescription drugs). Early on, states generally had considerable direct involvement in designing the operations of their respective Medicaid programs and the day-to-day operations involving benefits administration. However, states increasingly have turned to managed care programs and benefits managers over the course of the past decade and now rely frequently on these intermediaries to carry out many of the operational functions of benefits administration. Accordingly, many state agencies responsible for Medicaid and other health care benefits programs have undergone a transition from direct benefits administrators to purchasers of coverage for health care services from intermediaries with whom they contract (i.e., benefits managers or managed care organizations). Regardless of the mode of benefits administration, the majority of health services, including dental services, are produced or supplied by providers in the private sector.

Considerations for Professionals

Dentists, collectively and individually, value highly being recognized as health care professionals. However, the determination of what it means to be a professional and the extent to which dentists and dentistry meet society's expectations for that designation are open questions—the answers to which can vary over time. Definitions of "profession" and "professional" or "professionalism" abound. However, the following definition of "profession" put forth in a series of recent articles published in the *Journal of the Canadian Dental Association*[13-15] will be used for the purposes of this discussion: "a profession is a collective of expert service providers who have jointly and publicly committed to always give priority to the existential needs and interests of the public they serve above their own and who in turn are trusted by the public to do so."[13] Being a member of a profession carries with it a set of privileges granted by society that can be revoked if the criteria for being a profession or professional are no longer met. However, along with these privileges comes a set of responsibilities and duties, some of which relate to fostering access in an altruistic manner without discrimination so that all in need may benefit.[14]

Dentistry in the United States has not always met the criteria set forth by society for being a profession; in fact, before the mid-nineteenth century dentistry was largely regarded as a business.[15] Commitments on the part of organized dentistry beginning in the mid-nineteenth century to embrace principles and processes for ensuring competence, internal review, disciplinary actions, and other prominent hallmarks of a profession and to assume the responsibility for meeting the oral health needs of the (entire) public in an altruistic manner led to the recognition of dentistry as a profession.

One's status as a professional or a profession is not permanently endowed. Accordingly, dentistry could revert to the status of a business once again. By definition, dentistry does not qualify as a profession when and to the extent that the interventions performed are purely elective as opposed to being medically necessary.[13] Similarly, dentistry's status as a profession could be jeopardized if dentistry fails to uphold society's expectations for meeting the needs of the public in an altruistic manner. Thus, the extent to which dental practitioners, individually and collectively, demonstrate a willingness to meet the criteria society has set forth for being considered a profession will determine how dentistry is viewed and the extent of the privileges that society chooses to grant to dentistry and dentists.

Concluding Thoughts and Reflections

The overarching concept depicted in Figure 1 is that providing adequate access to health care for public benefit program beneficiaries is a joint responsibility of health care providers (who have the expertise to provide medically necessary services) and governmental agencies responsible for designing and overseeing programs in accordance with existing laws, regulations, and related policies. Dentists, by virtue of their status as health care professionals, have an obligation to provide services consistent with their expertise for the benefit of the entire public. However, in light of the substantial number of beneficiaries eligible for services, and the economic considerations inherent in providing broad access to services for large numbers of public beneficiaries, dentists

should not be expected to provide these services as a matter of charity; nor should government agencies expect beneficiaries' needs to be adequately met by dentists volunteering or donating services. Rather, the services should be purchased by the responsible government agencies according to reasonable business principles under arrangements that may provide dentists less compensation than they might be able to obtain from other types of patients (in exchange for the privileges society grants to health professionals), but which, at a minimum, cover the cost of providing services, including some compensation for the dentist providing services. Numerous court decisions in favor of plaintiffs in class action lawsuits brought against state Medicaid programs serve as prominent reminders that such principles have not been consistently applied to the administration of public benefits programs heretofore.

Failure on the part of responsible governmental agencies to adhere to reasonable business principles in the operation of public benefits programs leads to inadequate numbers of providers participating in public benefits programs, which, in turn makes services less accessible or inaccessible for beneficiaries and may have an adverse effect on the quality of services provided. Failure on the part of dentists to recognize their collective and individual responsibilities as health care professionals to address the oral health needs of the entire public (i.e., forsaking their role as health professionals in favor of business considerations) runs the risk that society and its agents (i.e., government officials) will revoke the privileges granted to dentists as health professionals along with dentistry's role as the authoritative voice on oral health matters concerning the public.

Dental care providers and governmental agencies responsible for administering public benefits programs are vital stakeholders with substantial respective resources and overlapping interests in providing access to appropriate care for the public. Consequently, collaboration between these parties is essential for the creation and maintenance of programs that adequately meet the needs of public program beneficiaries—a large and growing segment of the population—in a manner that is both fiscally responsible and professional.

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