

DENTAL THERAPISTS IN ALASKA: ADDRESSING UNMET NEEDS AND REVIVING COMPETITION IN DENTAL CARE

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Dental healthcare is provided to Alaska Natives and all other Native Americans by the United States government as part of its unique legal and political relationship with the tribes. Although Alaska Natives do have some degree of access to dentists, they suffer from the worst dental health of any group in the United States. This crisis exists because of geographic, cultural, and economic constraints, and the dental profession has not acted sufficiently to address these constraints. To deal with this crisis, the federal government granted a special license for Dental Therapists to provide much needed care to Natives. Dental Therapists are a form of dental health professional somewhat analogous to a nurse practitioner and are used in many developed countries. This Note discusses the economic and legal foundations of professional regulation and explores the virtual monopoly that dentists have on the provision of dental care. It shows how Dental Therapists are a needed solution for addressing the Native dental health crisis and how their introduction will force the dental profession to more seriously address the nationwide need for enhanced access and availability of low-cost care for underserved populations.

I. INTRODUCTION

In the United States, healthcare regulation is largely dominated by dentists and doctors via the American Dental Association (ADA) and American Medical Association. In fact, the control of these professionals over their own licensure is unparalleled in any other economic sector in the United States. The fact that dentists and doctors enjoy so much control is no

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surprise since the lay public knows little about the technical basis of medical treatment. Therefore, society places a great deal of trust in dentists and doctors in not only the provision of medical care, but also the structure and regulation of the entire healthcare system. Dentists and doctors have effectively been able to stifle competition in the healthcare industry, and this lack of competition has caused segments of the United States population to be neglected. This neglect is a natural result of the absence of meaningful competition, for competition would ensure that every segment of the healthcare market was addressed.

The shockingly poor dental health of Alaska Natives is a reminder that, although the United States as a whole spends more money per capita on healthcare than any country in the world,¹ there are still many underserved groups that do not have fundamental access to care. Alaska Natives are one of these underserved groups, and despite some efforts to improve their overall health, their dental health is still the worst of any group in the United States.² A limited number of dentists do serve the Alaska Native population, but the available dentists are not enough to remedy the Alaska Native oral health crisis.³ The obvious reasons for this deficiency include the villages' geographical isolation and the prohibitive costs involved in supplying a sufficient number of dentists to each village.⁴

A recent solution to this crisis has been the introduction of Dental Therapists into Alaska. Despite their presence in a number of developed nations, the use of Dental Therapists in Alaska represents the first use of this form of dental professional in the

1. The United States spends roughly twice as much per capita as the majority of Organization for Economic Co-operation and Development (OECD) countries. Kaiser Family Foundation, *Health Care Spending in the United States and OECD Countries*, Jan. 2007, <http://www.kff.org/insurance/snapshot/chcm010307oth.cfm>.

2. See INDIAN HEALTH SERVICE, *THE 1999 ORAL HEALTH SURVEY OF AMERICAN INDIAN AND ALASKA NATIVE DENTAL PATIENTS: FINDINGS, REGIONAL DIFFERENCES AND NATIONAL COMPARISONS 9* (1999), available at http://www.hss.state.ak.us/dph/wcfh/Oralhealth/docs/Oral_Health_1999_IHS_Survey.pdf ("The oral health disparities of [Alaska Native] people are profound when compared to the general U.S. population.") [hereinafter IHS REPORT]; Eugene Sekiguchi, *Improving the Oral Health of Alaska Natives*, 95 AM. J. PUBLIC HEALTH 769, 769 (2004) (citing "a great disparity in oral health between the Alaska Natives and the general population of the United States").

3. See Sekiguchi, *supra* note 2, at 769 ("The [Alaska Native] villages are small and cannot support a full-time dentist or physician, let alone specialists.").

4. *Id.* at 769-70.

United States.⁵ Their introduction into Alaska relies on a new professional license given through the Indian Health and Welfare Act's provision for a Community Health Aide Program.⁶ Candidates for the program are selected from and by the Alaska Native villages, are trained in New Zealand for eighteen months, and are subsequently licensed to perform various dental health tasks for the Alaska Native population,⁷ including tooth extraction, cavity filling, and pulpotomies.⁸

Although they are not completely opposed to the use of Dental Therapists for the dental education of Alaska Natives, the ADA and the Alaska Dental Society are vehemently opposed to Dental Therapists performing the aforementioned procedures, as they are irreversible.⁹ In fact, the ADA and Alaska Dental Society have recently filed suit against the Alaska Native Tribal Health Consortium, the State of Alaska, and eight Dental Therapists, claiming that Dental Therapists are practicing dentistry without a license.¹⁰ This suit is still pending, though the Alaska Attorney General has written an opinion arguing that the scope of Dental Therapists' practice is legal due to their unique federal license.¹¹ Ultimately, the courts will decide the legality of the use of Dental Therapists in this case.

Regardless of the legality of Dental Therapists, their mere introduction has shaken up the structure of dental licensing and has threatened the exclusive control that dentists previously held over dental procedures. Competition in the dental field will be good for consumers because it sends a strong message to healthcare providers that those who cannot afford high-cost dental care need a low-cost alternative, which is already becoming available. It

5. See DEPARTMENT OF HUMAN HEALTH SERVICES, ALASKA DENTAL HEALTH AIDE PROGRAM BRIEF 3 (2005), available at http://www.phs-dental.org/depac/chap/Alaska%20Dental%20Health%20Aide%20Program_white%20paper%20update91405.doc [hereinafter DHA WHITE PAPER].

6. *Id.*

7. *Id.*

8. Pulpotomies are root canals where only part of the dental pulp is removed. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1544 (30th ed. 2003).

9. See *Alaska Dental Soc'y v. Alaska Native Tribal Health Consortium*, No. 3AN-06-04797CI (Alaska Super. Ct. filed Jan. 31, 2006). The jury trial is scheduled for Oct. 8, 2007.

10. *Id.*

11. Memorandum from Paul R. Lyle, Sr. Assistant Attorney Gen., State of Alaska, to Robert E. Warren, DDS, Alaska Bd. of Dental Examiners, File No: 663-05-0152 (Sept. 8, 2005), available at [http://notes4.state.ak.us/pn/pubnotic.nsf/53a2e6f2d0aafc648925672a00602f03/7dd55e5de43af6b58925707e007fceb8/\\$FILE/663-05-0152%20Dental%20Health%20Aides.pdf](http://notes4.state.ak.us/pn/pubnotic.nsf/53a2e6f2d0aafc648925672a00602f03/7dd55e5de43af6b58925707e007fceb8/$FILE/663-05-0152%20Dental%20Health%20Aides.pdf) [hereinafter Lyle Memorandum].

further emphasizes the importance of solutions that take into account the unique circumstances of a particular group. By addressing a part of the market that has been chronically underserved, Dental Therapists will force the dental establishment and legislators to more seriously pursue the goal of dental care for all Alaskans. Furthermore, the introduction of Dental Therapists is a great triumph for those who disagree with the ADA's monopolistic attitude regarding the provision of dental services,¹² and their introduction shows that consumer choice is an increasingly important concept in the creation of healthcare options.

This Note will give an overview of the dental licensing process, explain the dental healthcare crisis suffered by Alaska Natives, and describe the Dental Therapist program. It will then discuss the legality of the Dental Therapist program, particularly within the scope of a recent lawsuit waged by the ADA. Finally, it will highlight the significance of Dental Therapists as an effective means for providing cost-effective care to Alaska Natives as part of a regulatory regime and as a source of much-needed competition in the national dental industry.

II. DENTAL LICENSING

Dental licensing, as well as licensing for any health professional, is almost always within the purview of the states.¹³ These licensing laws need to pass rational basis review, which is a fairly easy standard to meet. Some note that the state regulation of health professionals is a remnant from earlier times and argue that federal regulation makes more sense now given our efficient communication and national standards of practice.¹⁴ Nonetheless, there is definite standardization imposed via instruction in dental school and by the heavy involvement of groups like the ADA, even with state regulation.¹⁵

Dental licensing is established by state legislation that outlines the requirements for dental practice in that state and establishes a state dental board.¹⁶ All states require a dental degree from an

12. See Bernard Friedland & Richard W. Valachovic, *The Regulation of Dental Licensing: The Dark Ages?*, 17 AM. J. L. & MED. 249, 251 (1991).

13. *Id.*

14. *Id.* at 251, 269.

15. *Id.* at 258–59.

16. AMERICAN DENTAL ASSOCIATION, NATIONAL BOARD DENTAL EXAMINATIONS (NBDE PART I & II, DENTAL HYGIENE), <http://www.ada.org/prof/ed/testing/index.asp> (last visited Feb. 4, 2007) [hereinafter

American or Canadian school, a successful written examination, and a sufficient clinical examination.¹⁷ With regard to the educational component, all dental schools must meet standards established by the ADA Commission of Dental Accreditation.¹⁸ The National Board Dental Examination fulfills the written examination requirement in many states to some degree.¹⁹ The Joint Commission on National Dental Examinations is responsible for administering the National Board Dental Examination.²⁰ State dental boards are usually affiliated with the American Association of Dental Examiners.²¹ Furthermore, state control of the scope of practice of both general practitioners and specialists is defined by the ADA Principles of Ethics and Code of Professional Conduct.²² In addition, almost all states also require continuing education for relicensure.²³ The ADA also has a large influence on the licensure of allied dental health professionals, including dental assistants,

AMERICAN DENTAL ASSOCIATION]. *See also* Alaska State Dentistry Act, ALASKA STAT. § 08.36 (2006).

17. AMERICAN DENTAL ASSOCIATION, *supra* note 16. Note that medical doctors, unlike dentists, are not required to pass a clinical examination, but require additional graduate education before full licensure. AMERICAN DENTAL ASSOCIATION COUNCIL ON DENTAL EDUCATION AND LICENSURE, DENTAL AND MEDICAL EDUCATION AND LICENSURE IN THE UNITED STATES: A COMPARISON (2001), *available at* http://www.ada.org/prof/prac/licensure/factsheets_compare_med.pdf (last visited Feb. 4, 2007). For more information, see ALASKA STAT. § 08.36.110 (2006), outlining the Alaska requirements for licensure, which are consistent with the requirements of other states.

18. AMERICAN DENTAL ASSOCIATION, DENTISTRY – THE MODEL PROFESSION 4, *available at* http://www.ada.org/prof/resources/positions/statements/statements_dentistry.pdf (last visited Feb. 4, 2007 [hereinafter ADA: THE MODEL PROFESSION]; *see also* ALASKA STAT. § 08.36.110 (2006) (requiring dentists to be graduates of an ADA accredited dental school).

19. *See* AMERICAN DENTAL ASSOCIATION, *supra* note 16 (“The National Board Dental Examination is intended to fulfill or partially fulfill the written examination requirement, but acceptance of National Board scores is completely at the discretion of the individual state.”); *see also* ALASKA STAT. § 08.36.110 (2006).

20. AMERICAN DENTAL ASSOCIATION, *supra* note 16.

21. ADA: THE MODEL PROFESSION, *supra* note 18, at 3; *see also* ALASKA STAT. § 08.36.070 (2006) (describing affiliation with American Association of Dental Examiners).

22. AMERICAN DENTAL ASSOCIATION, ADA PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT (2005), *available at* <http://www.ada.org/prof/prac/law/code/index.asp>; *see also* ALASKA STAT. § 08.36.360 (2006) (describing general dentistry practice in Alaska); ALASKA STAT. § 08.36.244–247 (2006) (describing specialist practice in Alaska).

23. ADA: THE MODEL PROFESSION, *supra* note 18, at 5.

hygienists, and laboratory technicians, as suggested by the ADA's Comprehensive Policy Statement on Dental Auxiliaries.²⁴

III. STRUCTURE OF ALASKA NATIVE DENTAL CARE AND HEALTHCARE

Due to their tribal membership, many Alaska Natives, like American Indians, are entitled to unique health services in addition to the health services granted to all American citizens.²⁵ Indian Health was first handled by the War Department in 1803, until this responsibility was transferred to the Bureau of Indian Affairs (BIA) in the Department of the Interior in 1849.²⁶ By the early 1900s, healthcare became more institutionalized nationwide, and an organized structure for providing healthcare to Indians was created.²⁷ Money was given to the BIA to hire physicians, to open hospitals, and to provide vaccinations.²⁸ The first broad policy regarding Indian health occurred with the passage of the Snyder Act in 1921, which authorized federal money “for relief of distress and conservation of health . . . of Indians throughout the United States.”²⁹ In 1955, authority over Indian healthcare was transferred from BIA to the Indian Health Service (IHS) within the Public Health Service, which was part of the Department of Health and Human Services (HHS).³⁰ HHS has recently been reorganized, and now the IHS has its own operating division within HHS.³¹

The Indian Health Care Improvement Act of 1976 and its 1992 amendments acknowledged the continuing federal responsibility of ensuring the “highest possible health status to Indians and to provid[ing] existing Indian health services with all resources necessary to effect that policy.”³² A Community Health Aide Program was developed specifically for Alaska by the IHS and

24. *Id.*; see also ALASKA STAT. § 08.32.010–.190 (2006) (describing licensure of dental hygienists in Alaska).

25. Rose Pfefferbaum et al., *Providing for the Health Care Needs of Native Americans: Policy, Programs, Procedures, and Practices*, 21 AM. INDIAN L. REV. 211, 218 (1997).

26. *Id.* at 214–15.

27. *Id.* at 215.

28. *Id.*

29. *Id.* (quoting the Snyder Act, 25 U.S.C. § 13 (2006)).

30. *Id.*

31. *Id.* That is, it is no longer a subdivision of PHS, although it still works with PHS.

32. *Id.* at 216 (citing Indian Health Care Improvement Act, 25 U.S.C. § 1602(a) (1992)).

approved and funded by Congress in 1968.³³ This program was later codified in the Indian Health Care Improvement Act.³⁴ The 1992 amendment to the Act requires a Community Health Aide Program that provides for the training of Alaska Natives as health aides or community health practitioners and the use of these aides or practitioners in the provision of healthcare and disease prevention to Alaska Natives living in villages in rural Alaska.³⁵ Currently there are over 550 Community Health Aides (CHAs) that perform over 350,000 patient visits a year, and these CHAs are essential to providing healthcare to rural Alaska Natives.³⁶

With regard to dental care, Congress set out seven specific dental objectives to be met by the Community Health Aide Program: (1) reducing dental caries³⁷ in children, (2) reducing untreated dental caries in children and adolescents, (3) reducing the proportion of adults sixty-five and older who have lost all of their natural teeth, (4) increasing the proportion of adults who have never lost a permanent tooth due to caries or periodontal disease, (5) reducing periodontal disease in adults, (6) increasing the use of protective sealants on permanent teeth in children, and (7) reducing the prevalence of gingivitis in adults.³⁸ These objectives are to be met by the Dental Health Aide Program.³⁹

Dental care for Alaska Natives is directly funded by the Indian Health Service. Currently, these services are organized by Alaska Natives via the Alaska Tribal Health System (IHS directly provided dental care for Alaska Natives until 1975, when the Indian Self-Determination and Education Assistance Act gave funding to Alaska Natives and allowed them to coordinate their own healthcare system).⁴⁰ Under the Alaska Native Claims Settlement Act, tribes are governed “by private, state-chartered, and state-regulated Native for-profit corporations.”⁴¹ The Act

33. DHA WHITE PAPER, *supra* note 5, at 4.

34. *Id.* (citing 25 U.S.C. § 1616l (2006)).

35. 25 U.S.C. § 1616l(a) (2006).

36. DHA WHITE PAPER, *supra* note 5, at 4.

37. Caries are “the molecular decay or death of a bone, in which it becomes softened, discolored, and porous.” DORLAND’S ILLUSTRATED MEDICAL DICTIONARY, *supra* note 8, at 298.

38. 25 U.S.C. §§ 1602(20)–(26) (2006).

39. *See* 25 U.S.C. § 1616l (2006).

40. Sekiguchi, *supra* note 2, at 770 (citing the Indian Self-Determination and Education Assistance Act, 25 U.S.C. §§ 450–58 (2006)).

41. *Id.*; *see also* Alaska Native Claims Settlement Act, 43 U.S.C. §§ 1601–42 (2006). IHS has the responsibility to assume control of the program if tribes forgo leadership or do not meet certain standards. 25 U.S.C. § 450m (2006).

further recognizes the ability of tribes to authorize non-profit organizations to organize healthcare.⁴² Most tribes have also entered into an agreement with the IHS called the Alaska Native Tribe Compact, which outlines healthcare funding and organization.⁴³

IHS-funded dental care for Alaska Natives is provided by dentists who contract with the Alaska Tribal health system or the IHS, dentists who are United States Public Health Service Corps officers, or dentists who volunteer their work.⁴⁴

IV. THE ALASKA NATIVE DENTAL HEALTH CRISIS

A. The Crisis Explained

The dental health of Alaska Natives is far below that of the general American public and is the worst of any group in the United States.⁴⁵ The Community Health Aide Certification Board found that “[o]nly 29% of Alaska Native children and even fewer adults have had access to dental care resulting in epidemic caries among children and loss of teeth among adults and elders.”⁴⁶ The disparity between Native oral health and that of the American public is especially striking among children and adolescents, who have two-and-a-half times the number of caries of their peers.⁴⁷ Similarly, 68% of Alaska Native children between two and five years old have untreated tooth decay, compared to only 19% in the general population.⁴⁸ Forty-six percent of Alaska Native children between six and fourteen years old have untreated permanent tooth decay, compared to 11% nationally.⁴⁹ Also, approximately 16% of Native adults have periodontal disease compared to

42. Sekiguchi, *supra* note 2, at 770.

43. *Id.*

44. *Id.*

45. David A. Nash & Ron J. Nagel, *Confronting Oral Health Disparities Among American Indian/Alaska Native Children: The Pediatric Oral Health Therapist*, 95 AM. J. PUBLIC HEALTH 1325, 1325 (2005). It is important to note that other American Indians suffer from many of the same oral health problems as Alaska Natives.

46. COMMUNITY HEALTH AIDE PROGRAM CERTIFICATION BOARD, STANDARDS AND PROCEDURES, § 1.40.010(7) (2005).

47. Sekiguchi, *supra* note 2, at 769.

48. IHS REPORT, *supra* note 2, at 18.

http://www.hss.state.ak.us/dph/wcfh/Oralhealth/docs/Oral_Health_1999_IHS_Survey.pdf (last visited Feb. 4, 2007).

49. *Id.* at 27.

roughly 3% in the general population.⁵⁰ One-third of Alaska Native children miss school due to dental pain, and one-quarter do not smile because they are embarrassed about how their teeth look.⁵¹ Of adults over fifty-five, nearly two-thirds of those who still have teeth at a minimum show signs of periodontal disease.⁵² In the same group, about two-thirds had twenty or less teeth, and 21% had no teeth at all.⁵³ By any metric, the oral health of Alaska Natives is unacceptably poor.

The oral health of Alaska Natives was significantly worse in the early 1980s, but the Indian Health Service (IHS), tribes, the ADA, and the state government worked together to provide access to dentists, fluorinate water, provide fluoride treatments and sealants, and give overall dental education.⁵⁴ Overall dental health was significantly improved as a result of these efforts.⁵⁵ Even though considerable progress was made, the current data show that much still needs to be accomplished. Using IHS estimates, the average Alaska Native patient needs five hours worth of dental work to fully restore his or her teeth.⁵⁶ With 85,000 Alaska Natives living in 200 villages,⁵⁷ this amounts to 425,000 hours of work required to fully address every Alaska Native patient's needs. Put into perspective, completing this amount of work would take 205 full-time dentists a year to complete.⁵⁸

B. Sources of the Alaska Native Dental Care Problem

A central challenge in providing dental care and healthcare to Alaska Natives is their geographical isolation. Over two-thirds of Alaska Natives live in rural areas with limited access by road.⁵⁹ These rural areas are widespread, and often access is limited to

50. *See id.* at 46.

51. Nash & Nagel, *supra* note 45, at 1325.

52. *See* IHS REPORT, *supra* note 2, at 52.

53. *Id.* at 56. The normal adult has thirty-two teeth, four of which are wisdom teeth. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, *supra* note 8, at 1922 (regarding permanent teeth).

54. Nash & Nagel, *supra* note 45, at 1325; *see also* IHS REPORT, *supra* note 2, at 1.

55. IHS REPORT, *supra* note 2, at 1.

56. *See id.* at 61. This figure was acquired by averaging IHS estimates of minutes required to bring the patient to optimal care. Five different age groups were averaged together. *Id.*

57. DHA WHITE PAPER, *supra* note 5, at 3.

58. This figure was determined by dividing 425,000 hours by 2080 hours per dentist (a forty-hour work week for fifty-two weeks).

59. *See* DHA WHITE PAPER, *supra* note 5, at 3.

boats, ATVs, airplanes, helicopters, and snowmobiles.⁶⁰ Additionally, the rural areas of Alaska have a population density of 0.5 persons per square mile, which is 150 times less dense than the United States average.⁶¹ With such sparsely inhabited communities separated by harsh geographic and weather barriers, it is not possible to support resident physicians or dentists in most villages.⁶² Therefore, dentists must either travel to the villages or residents must be transported to major cities or hub villages for treatment.⁶³ Travel must be done by bush plane or boat and the closest clinic is often hundreds of miles away.⁶⁴ Visits by dentists to the villages are limited by their availability and are fairly infrequent.⁶⁵ For example, contract dentists typically spend between two to six weeks per village and must work ten- to fourteen-hour days due to the large number of patients needing care.⁶⁶ Anecdotal evidence from volunteer dentists indicates that even when dentists visit a village, not everyone is seen, despite the dentists working practically all of their waking hours.⁶⁷

Beyond geographical isolation, there are several behavioral and general health issues that contribute to poor dental health. Alaska Natives consume large amounts of soda and sugary foods, which can lead to tooth decay and are major factors in the disproportionately high development of diabetes in the Native population.⁶⁸ Many Alaska Natives smoke and chew tobacco, starting as early as thirteen years old, which increases the risk of developing oral cancer and periodontal disease.⁶⁹ Finally, many

60. *Id.*; see also Sekiguchi, *supra* note 2, at 769.

61. Sekiguchi, *supra* note 2, at 769.

62. *Id.*

63. *Id.*

64. Nash & Nagel, *supra* note 45, at 1325.

65. DHA WHITE PAPER, *supra* note 5, at 3–4.

66. Jennifer Garvin, *Controversy in Alaska*, 33 AGD IMPACT 4 (April 2005), available at <http://www.agd.org/library/2005/april/garvin.asp>.

67. Robert Raiber, *Inside Alaska: The Long and Difficult Journey to Oral Health*, 17 NYSDA NEWS 1, 1–2, 4 (2004).

68. 1 DIV. OF PUB. HEALTH, ALASKA DEP'T OF HEALTH AND SOC. SERVICES, HEALTHY ALASKANS 2010, ch. 13, at 3–4 (2001), available at http://www.hss.state.ak.us/dph/targets/ha2010/PDFs/13_Oral_Health.pdf.

69. See IHS REPORT, *supra* note 2, at 2. Two percent of thirteen-year-olds, thirty-four percent of nineteen-year-olds, and thirty-eight percent of adults are habitual users of tobacco. Thirty-one percent of fifteen- to nineteen-year-olds, fifty-one percent of adults thirty-three to thirty-five, and twenty-eight percent of adults over fifty-five use tobacco. *Id.* at 2–3.

Alaska Natives simply do not brush their teeth, despite distribution of and education regarding toothbrushes and toothpaste.⁷⁰

Another large part of the problem is structural. In 2002, there were 463 dentists in the state of Alaska serving 642,000 people—the ratio was 1:1386 compared to the national average of 1:1695.⁷¹ Thus, despite a shortage of dentists serving the Native population, Alaska as a state has more dentists per capita than average. Although there were seventy-two dentists serving the Alaska Native community, there are ninety total IHS dental positions, leaving eighteen unfilled.⁷² Compounding this 20% vacancy, the turnover rate for dentists serving the Alaska Native community is 30%.⁷³ Because of this shortage, dentists are mainly available only for emergency services.⁷⁴ This lack of dentists and high degree of turnover is not surprising since geographically isolated communities may not be appealing to dentists, especially because, for the most part, the dentists who are serving the Alaska Native community are outsiders with no cultural ties.⁷⁵ Without these important cultural roots, it is difficult for foreign dentists to fully convince Alaska Natives, especially children, that changing their poor dental behavioral habits is a good thing.⁷⁶ As previously noted, it is impossible for IHS to put a dentist or a physician in every village. It would seem that the answer to the Alaska Native oral health problem is a culturally sensitive dental care provider

70. See Raiber, *supra* note 67, at 2.

71. See Sekiguchi, *supra* note 2, at 770.

72. *Id.*

73. COMMUNITY HEALTH AIDE PROGRAM CERTIFICATION BOARD, STANDARDS AND PROCEDURES § 1.40.010(9) (2005).

74. *Id.*

75. See Nash & Nagel, *supra* note 45, at 1325.

76. For an example of this phenomenon, consider this story told by Dr. Carl Jenkins: “Let me relate the story of the middle-school girl who came to me at lunch with a can of pop she had just bought from the school’s soda machine. . . . Knowing I was the dentist, she looked right at me and proudly exclaimed, ‘I’m drinking pop,’ as if to say, ‘What are you going to do about it?’ Did she need education? No! She knew the pop was bad for her but in her new culture enjoying that can of pop is a status symbol. What she needs is motivation by someone of her own culture. No white dentist from the mountains of Pennsylvania was going to change her mind of that. What is needed is an educated professional that can help treat but also live among the people.” Garvin, *supra* note 66.

that can live in the community to be a continual influence of good dental habits and earn the respect of the community.⁷⁷

Because this problem is persistent and needs urgent attention, immediate and long-term solutions must be implemented. In theory, more Alaska Natives could be trained as full-fledged dentists, but this would take at least four years of dental school on top of their undergraduate educations. Consider also that only 9% of Native Americans aged twenty-five or older are college graduates, compared to the rate of 20% in the general population.⁷⁸ Therefore, it is unrealistic to suggest that many Alaska Native dentists could be trained to address the Native dental health crisis in a time-sensitive manner.

In sum, the dental problem is marked by limited access to dentists, geographical barriers, and behavioral problems. The problem is urgent and requires an immediate solution to reverse the dental health crisis that plagues Alaska Natives. Compounding the shortage of dentists in general is a shortage of dentists from the same culture as their clients and who have ties to the community. The turnover rate among dentists is quite significant and the number of Native dentists is strikingly low. A solution to the problem is a low-cost, culturally sensitive, relatively quickly-trained dental health professional.

V. DENTAL HEALTH AIDES: A SOLUTION TO THE CRISIS

A. Overview of Dental Health Aides and Dental Therapists

The Dental Health Aide Program started in 2001 as part of the Community Health Aide Program (CHAP).⁷⁹ The CHAP generally trains Alaska Natives to become Community Health Aides, who provide overall healthcare and healthcare education to the Alaska Native villages.⁸⁰ Community Health Aides are

77. *Id.* (quoting Dr. Kelso: “No team of dentists, volunteers or public health dentists, will be able to do that because at one time or another, they will have to leave.”).

78. NAT’L CTR. FOR EDUC. STATISTICS, U.S. DEP’T OF EDUC., NCES 98-291, AMERICAN INDIANS AND ALASKA NATIVES IN POSTSECONDARY EDUCATION, ch. 1, at 14 (1998). This statistic is used to demonstrate that the process of training new dentists would take at least four, but more realistically eight or more years, for the majority of the Native population. This timeframe makes this solution an unlikely one in fixing the immediate Alaska Native dental health problem.

79. DHA WHITE PAPER, *supra* note 5, at 3–4.

80. *Id.* at 4, 5.

supervised by physicians located in hub communities, and these physicians advise the Aides via phone.⁸¹

The Dental Health Aide Program operates in a similar manner, with aides remotely supervised and advised by a dentist.⁸² It was developed by the Alaska Native Tribal Health Consortium in conjunction with the IHS and is funded by federal funds for the CHAP and by foundations, non-profit organizations, and the tribal health system.⁸³ There are four categories of Dental Health Aides: (1) Primary Dental Health Aides, who “provide dental education, dental assisting [and] preventative dentistry services,” (2) Expanded Function Dental Health Aides, who “serve as expanded duty dental assistants in regional clinics,” (3) Dental Health Aide Hygienists, who “provide dental hygiene services in regional clinics and villages,” and (4) Dental Health Aide Therapists (Dental Therapists), who provide “oral exams, preventative dental services, simple restorations, stainless steel crowns, extractions and take x-rays.”⁸⁴ Dental Therapists are the most controversial form of Dental Health Aide, since they perform some of the same procedures that had previously been limited to licensed dentists. However, while Dental Therapists can perform these procedures without direct dentist supervision, their performance is continually assessed to ensure that their work meets certain set standards.⁸⁵

Dental Therapists are trained at the University of Otago in New Zealand through a clinically-intensive two-year program based on New Zealand’s own very successful Dental Therapist program.⁸⁶ Candidates for the program are recruited by the individual Alaskan tribes.⁸⁷ As of September 2005, eight Alaska Native students were enrolled in the program.⁸⁸

To practice, Dental Therapists must meet the technical requirements outlined in the Standards and Procedures of the Federal Community Health Aide Program, administered by a twelve-member Certification Board, which is established by 25 U.S.C. § 1616l.⁸⁹ Before being allowed to practice without direct supervision, Dental Therapists must undergo a preceptorship,

81. *Id.* at 5.

82. *Id.* at 4.

83. *Id.*

84. *Id.* at 3.

85. *Id.* at 5.

86. *Id.*

87. *Id.* at 4.

88. *Id.* at 5.

89. *Id.* at 4–5.

under which their skills are assessed by a dentist.⁹⁰ This skills assessment is repeated every two years.⁹¹ Dental Therapists must also participate in continuing education in order to be recertified.⁹² The initial preceptorship lasts four hundred clinical hours under the direct supervision of a dentist.⁹³ When practicing in villages, the Dental Therapists are in regular phone contact with their supervising dentists, and they regularly send x-rays and photographs by email for evaluation and assessment on whether referral to a hub clinic is necessary.⁹⁴ Dental Therapists in the United States are licensed only through the Community Health Aide Program and may only service Alaska Natives in Native health clinics.⁹⁵

The World Health Organization (WHO) also reports that forty-two total countries have some form of Dental Therapist position.⁹⁶ In New Zealand, for instance, Dental Health Aides are nothing new. Since 1921, they have been providing dental care to New Zealand primary schools.⁹⁷ In New Zealand, children between six months to thirteen years old may participate in the School Dental Service program, where Dental Therapists provide free preventative and restorative care.⁹⁸ Ninety-seven percent of children are enrolled in this service.⁹⁹ Notably, virtually 100% of dental caries in New Zealand children were treated, compared to between 63% and 74% of child caries in the general United States population.¹⁰⁰ In further illustration, only 35% of caries in Alaska Native children aged two to five were treated.¹⁰¹ With the introduction of Dental Therapists in New Zealand, the ratio of

90. *Id.* at 5.

91. *Id.*

92. *Id.*

93. Ron Nagel, Alaska Native Tribal Health Consortium, Presentation at the 2006 American Association for Community Dental Programs' Annual Meeting and Symposium (Apr. 30, 2006), <http://www.aacdp.com/docs/2006Nagel.ppt> (PowerPoint presentation).

94. DHA WHITE PAPER, *supra* note 5, at 6.

95. See Lyle Memorandum, *supra* note 11.

96. Alaska Primary Care Association, Board of Directors, *Support of Dental Therapist/Dental Health Aide Program*, Res. 2006-05 (2006), available at <http://www.alaskapca.org/Programs/ALA/Resolutions/Res%202006-05%20Dental%20Therapists.doc>.

97. Nash & Nagel, *supra* note 45, at 1326.

98. *Id.*

99. *Id.*

100. *Id.* The data for the United States are for primary and permanent teeth through the age of fourteen.

101. *Id.*

extractions to restorations went from seventy-five extractions per one hundred restorations in the 1920s to 3.6 extractions per one hundred restorations in 1964.¹⁰²

Canada also trains Dental Therapists according to the New Zealand model, and these therapists work on First Nations reserves.¹⁰³ When Dental Therapists were introduced in Canada, the ratio of extractions per restorations went from fifty extractions per hundred restorations in 1974 to fewer than ten extractions per hundred restorations in 1986.¹⁰⁴ Furthermore, the work of restorations done by Dental Therapists in Canada was compared to those done by dentists in a double-blind study, and the quality of restorations between both groups was equal.¹⁰⁵

B. Opposition to Dental Health Aides and Alternative Solutions

Although the ADA supports the Dental Health Aide Program, the ADA is opposed to Dental Therapists to the extent that they perform irreversible procedures, and the organization contends that only licensed dentists are technically qualified to extract teeth, drill cavities, or perform pulpotomies.¹⁰⁶ As a foundation for its argument, the ADA cites the fact that many adults have medical conditions that add to the complexity of dental treatment, such that simple procedures can quickly become more complicated ones.¹⁰⁷

The ADA claims that the choice is not between no care and care provided by Dental Therapists; instead, it wants to bring more actual dentists to Native villages.¹⁰⁸ In conjunction with more dentists, the ADA wants a Dental Health Aide in every village to provide preventative and educational services.¹⁰⁹ Furthermore, it wants to make dentists more efficient by increasing the number of available dental aides and dental chairs.¹¹⁰ To help encourage more

102. *Id.* at 1327. Fluorination of water, among other things, could also partially account for some of this marked improvement.

103. *Id.* at 1326. First Nations people are the native inhabitants of Canada.

104. *Id.* at 1327.

105. *Id.*

106. ADA POSITION ON THE DENTAL HEALTH AIDE PROGRAM IN ALASKA, http://www.ada.org/prof/resources/positions/statements/position_dentalaide_alaska.pdf (last visited Apr. 3, 2007) [hereinafter ADA POSITION].

107. *Id.*

108. *Id.*

109. *Id.*

110. *Id.*

dentists to serve Alaska Natives, the ADA created “Operation Backlog,” though this effort was met with limited success.¹¹¹

Since the ADA recommends that Congress not permit Dental Therapists to practice dentistry in Alaska, some dentists have called for more Alaska Natives to attend dental school and return to serve their communities.¹¹² The ADA has suggested that dental clinics be set up in geographically appropriate villages, so that access by neighboring villages can be easier. Dentists have also called for the availability of potable fluorinated water, in order to reduce the consumption of soda.¹¹³ The ADA attempted to reduce the credentialing paperwork bureaucracy involved with allowing out-of-state volunteer dentists to practice on a temporary basis.¹¹⁴ Finally, the ADA and others have lobbied Congress to increase dental health funding to IHS.¹¹⁵

There are many problems with the ADA’s suggestions. The ADA position does not address the need for a local practitioner who can deal with local emergencies. Furthermore, the ADA ignores the tremendous amount of work that must be done in a short amount of time, which would truly require an army of dentists. It also does not fully address the vacancy problem or reluctance that many dentists would have in serving in rural Alaska.¹¹⁶ The ADA’s primary opposition rests on their assertion that Dental Therapists are not technically qualified to perform certain procedures, but they ignore the fact that Dental Therapists have been hugely successful worldwide. Most notably, the oral health crisis that had plagued the First Nations population in Canada, a very similar crisis to the one currently affecting Alaska Natives, was rectified in large part by the utilization of Dental Therapists.

111. *Id.*; see also American Dental Association, *Alaska Q & A: What Is the ADA’s Role?*, ADANEWS, Aug. 5, 2005, <http://www.ada.org/prof/advocacy/legal/alaska/adanews.asp?articleid=1502>.

112. Garvin, *supra* note 66.

113. Sekiguchi, *supra* note 2, at 772.

114. ADA POSITION, *supra* note 106.

115. ADA TESTIMONY ON THE FISCAL YEAR 2002 APPROPRIATION FOR THE INDIAN HEALTH SERVICE, http://www.ada.org/public/manage/you/working_access_testimony.pdf (Apr. 16, 2001).

116. For example, University of Washington Professor of Dentistry Louis Fiset notes that five full-time paid dentist positions in the Yukon-Kuskokwim Delta have been vacant for six years despite a salary/benefits package starting at \$177,000. Louis Fiset, *A Report on Quality Assessment of Primary Care Provided by Dental Therapists to Alaska Natives*, ANTHC.ORG, Sept. 30, 2005, at 2, <http://www.anthc.org/cs/chs/chap/upload/Fiset%20evaluation.pdf>.

It is also important to note that an independent evaluation of Dental Therapists' technical work in September 2005 was very positive.¹¹⁷ Dentists who worked directly with the Dental Therapists were enthusiastic about the quality of their work, and agreed that their work and their skills in dealing with children were especially good.¹¹⁸ None of the dentists who worked with and directly observed the Dental Therapists had any trepidation about the Therapists practicing in villages without supervision.¹¹⁹ The independent evaluator's assessment of Alaska Native Dental Therapists focused on record review, cavity preparation and restoration, patient management, and patient safety.¹²⁰ The evaluator found that the Dental Therapists met the established standard of care in every metric.¹²¹

Most importantly, the Dental Therapists were aware of the limits of their abilities and erred on the side of caution with regard to referring complicated problems to a licensed dentist.¹²² The evaluator concluded his assessment of the program by stating that he believed that Dental Therapists "have demonstrated their proficiency in providing competent and safe dental care to Alaska Natives," and that "the program deserves not only to continue but to expand."¹²³ He further stated that the Dental Therapist approach was successful in providing care "that gives priority to education, prevention, early intervention, and access."¹²⁴

VI. DENTAL THERAPISTS AND LEGAL ISSUES

A. Legal Overview

The legality of the Dental Therapist program is a complex issue that will ultimately have to be argued within and debated by the courts for a definitive answer. Again, state governments (in conjunction with professional organizations) are typically responsible for the licensing of dental professionals and other

117. *Id.*

118. *Id.* at 3. This report also notes that some dentists were originally skeptical about Dental Therapists, but upon observing the Therapists in action, they found that Therapist interaction with children was even better than the interaction of dentists.

119. *Id.*

120. *Id.* at 2-3.

121. *Id.* at 8.

122. *Id.*

123. *Id.*

124. *Id.*

healthcare professionals. What makes the Dental Therapist program so unique, legally speaking, are the novel federal licensing scheme and the foundations in American Indian law upon which the program is based.

The Alaska Board of Dental Examiners, unsure of the legality of the Dental Therapist program, sought an opinion from the Alaska Attorney General.¹²⁵ The Alaska Attorney General concluded that the Dental Therapist program was legal based on federal preemption theories and in doing so stated:

The state dental licensure laws stand as an obstacle to Congress' objective to provide dental treatment to Alaska Natives by using non-dentist, non-hygienist paraprofessionals. Therefore, the federal statute that mandates the development of the dental health aide standards and the certification of dental health aides displaces (or preempts) the state's dental licensure law and renders it unenforceable against federally-certified dental health aides.¹²⁶

The basis for federal supremacy is the Supremacy Clause of the United States Constitution, which states that federal law preempts state law whenever that state's law contradicts or interferes with an act of Congress.¹²⁷ Preemption can occur where "Congress has expressly preempted state law," where "Congress has legislated so comprehensively that federal law occupies an entire field of regulation and leaves no room for state law," or "where federal law conflicts with state law."¹²⁸

There is a presumption that state law applies over federal law in areas where the state is traditionally responsible, such as healthcare regulation, which is part of a state's police power.¹²⁹ Despite this presumption, state law is preempted when "state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress."¹³⁰

In its analysis, the Alaska Attorney General concluded that Alaska Statute chapter 08.32 and Alaska Statute chapter 08.36, which govern dentist and hygienist licensing, conflict with 25 U.S.C. § 1616*l*. Section 1616*l* allows for the creation of a Community Health Aide, in this case a Dental Therapist, to address the dental

125. See Lyle Memorandum, *supra* note 11.

126. *Id.* at 2.

127. *Id.* at 3 (citing *Fidelity Fed. Sav. & Loan Ass'n v. de la Cuesta*, 458 U.S. 141, 152 (1982); *Hayfield N. R.R. Co. v. Chicago & Nw. Transp. Co.*, 467 U.S. 622, 627 (1984)). See also U.S. CONST. art. VI, cl. 2.

128. Lyle Memorandum, *supra* note 11, at 3 (quoting *Wachovia Bank v. Burke*, 414 F.3d 305, 313 (2d. Cir. 2005)).

129. *Id.* at 4–5.

130. *Id.* at 6 (quoting *Hankins v. Finnel*, 964 F.2d 853, 861 (8th Cir. 1992)).

health objectives set forth in 25 U.S.C. §§ 1602(20)–(26).¹³¹ Congress' power to legislate in this area is further bolstered by the fact that the United States has had a legal and moral obligation to “provide adequate healthcare and services to Indian tribes and their members’ since the 19th century.”¹³² Thus, the Attorney General concluded that:

Congress intended to provide dental care to Alaska Natives through a comprehensive federal system of paraprofessional aides, trained by program-accredited teachers using a federally-developed curriculum and licensed by a federal board under federal standards, whose performance following certification would be closely supervised, reviewed and evaluated by the Secretary [of Health and Human Services] and updated through federally-mandated continuing education requirements.¹³³

As a result of this legislation and Congress' intent conflicting with state dental professional licensing laws, the Alaska Attorney General concluded that state laws are preempted by the federal law and the federal licensing of Dental Health Aides and Dental Therapists is legal.¹³⁴

Although the Alaska Attorney General is certainly an expert source of analysis on Alaska law, the office's memorandum opinions are not per se binding on any entity.¹³⁵ However, the Alaska State Dental Board has still not attempted to prosecute any Dental Therapists for violating the Alaska Dental Practice Act.¹³⁶ The ADA and the Alaska Dental Society were dissatisfied with the opinion regarding the legality of the Dental Therapist program and consequently initiated a lawsuit in an effort to end the program.

B. The American Dental Association Lawsuit

In conjunction with a public relations campaign against the use of Dental Therapists in Alaska, the ADA and the Alaska Dental Society filed suit against the Alaska Native Tribal Health

131. *Id.* at 8–9.

132. *Id.* at 4 n.8 (quoting S. REP. NO. 102-392, at 2 (1992)).

133. *Id.* at 10.

134. *Id.* at 15–16.

135. *Diaz v. Silver Bay Logging, Inc.*, 55 P.3d 732, 743 (Alaska 2002) (Fabe, C.J., dissenting).

136. By not further pursuing any state regulation or enforcement of existing laws on the Dental Therapist program, the State has effectively chosen to regulate by inaction. However, this is not a pure case of regulation by inaction because the federal government and IHS are responsible for the regulatory creation of the Dental Therapist program.

Consortium (ANTHC), the State of Alaska, and eight John Does.¹³⁷ The ADA alleged that the Dental Therapists controlled by the ANTHC were practicing dentistry without a license as they claim is required under the Alaska Dental Practice Act (“the Act”).¹³⁸ The ADA noted that, as of August 31, 2005, four Dental Therapists performed 765 patient exams, and in doing so they provided numerous services including preventative treatments, restorations, stainless steel crowns, pulpotomies, and extractions.¹³⁹ The ADA further alleged that the State of Alaska failed to enforce the State Dentistry Act, and that the Alaska State Dental Examiners Board, which the ADA claims has sole jurisdiction over licensing of any dental professional, has the obligation to enforce the Act.¹⁴⁰

The ADA initially asked for declaratory relief in the form of a holding that Dental Therapists’ practice fell within the scope of the Alaska Dental Practice Act and that the Act is enforceable against Dental Therapists.¹⁴¹ It also alleged an equal protection violation under the Alaska Constitution, claiming that the State has granted an exception to the Dental Therapist program from the Act and that no such exception has been granted to dentists.¹⁴² Accordingly, the ADA requested an injunction against the State, instructing it to enforce the Alaska Dental Practice Act against the Dental Therapist program.¹⁴³ Under the Act, the ADA requested a declaration that, to practice dentistry, a person must hold a certificate of successful examination granted by the ADA Joint Commission on National Dental Examinations, and that any person performing dental services without such a certificate is illegally practicing dentistry.¹⁴⁴ Furthermore, the ADA sought declarations that Dental Therapists do not hold this certification,

137. Plaintiffs’ First Amended Complaint for Declaratory and Injunctive Relief at 1–3, *Alaska Dental Soc’y v. State*, 3AN-06-04797 CI (Alaska Super. Ct. Jan. 31, 2006). The John Does sued are several unnamed practicing Dental Therapists.

138. *Id.* at 4–6.

139. *Id.* at 6. Note that this number only incorporates figures from four Dental Therapists over a period lasting slightly over a year. Since there are eight Dental Therapists currently practicing, with more on the way, the number of patients treated over the length of the program is likely to be a few times higher by the time of publication.

140. *Id.* at 7–9. Recall that the Alaska State Dental Examiners Board was the party that solicited the Alaska Attorney General opinion on the legality of the Dental Therapist program.

141. *Id.* at 10–13.

142. *Id.* at 13–14.

143. *Id.* at 14–15.

144. *Id.* at 15–16. The ADA’s injunctive and declaratory requests essentially amount to compelling the State Dental Board to regulate by litigation.

do not pay licensing fees to the Board of Dental Examiners, and are therefore violating the Act.¹⁴⁵ Finally, the ADA sought an injunction prohibiting Dental Therapists from practicing their current form of dentistry.¹⁴⁶

The ANTHC, in a motion for summary judgment, stated that the ADA is opposed to Dental Therapists providing care anywhere, and that state laws “give[] dentists a near-monopoly on dental health care.”¹⁴⁷ The ANTHC cited the Alaska Attorney General’s opinion to the Alaska State Dental Examiners Board, which highlighted federal conflict preemption.¹⁴⁸ More specifically, they argued, as the Alaska Attorney General did, that the Indian Self-Determination Act and Indian Health Care Improvement Act preempt the licensing requirements set forth in the Alaska Dental Practice Act.¹⁴⁹ The ANTHC also argued that the ADA has no statutory or implied private cause of action under the Alaska Dental Practice Act, and therefore has no cause of action upon which it can sue.¹⁵⁰ Additionally, the ANTHC argued that the ADA failed to join the United States as an indispensable party.¹⁵¹ The ANTHC disputed the ADA’s equal protection claim, noting that federal preemption excludes Dental Therapists from the Alaska Dental Practice Act, and it also argued that dentists and Dental Therapists are not “similarly situated groups,” and thus do not raise the question of whether similarly situated groups are treated differently.¹⁵² The State of Alaska also filed a motion for summary judgment on nearly the same grounds.¹⁵³

It is difficult to predict the outcome of this case, but the ANTHC has a very strong federal preemption claim that is bolstered by the previously discussed Alaska Attorney General’s memorandum opinion. As this Note goes to press, the case is still pending. In the meantime, Dental Therapists are still practicing in Alaska Native villages and new ones are being trained in New Zealand.

145. *Id.* at 16–18.

146. *Id.* at 19.

147. ANTHC Motion for Summary Judgment at 14, Alaska Dental Soc’y v. State, 3AN-06-04797 CI (Alaska Super. Ct. Dec. 1, 2006).

148. *Id.* at 15.

149. *Id.* at 16–17.

150. *Id.* at 21–27.

151. *Id.* at 28–38.

152. *Id.* at 38–45.

153. *See* State Defendants’ Motion for Summary Judgment, Alaska Dental Soc’y v. State, 3AN-06-04797 CI (Alaska Super. Ct. Dec. 1, 2006).

VII. REGULATION AND DENTAL THERAPISTS

A. Regulatory Foundations

In order to fully understand the policy implications and political motivation underlying the debate over Dental Therapists, it is important to first understand the nature of regulatory schemes, specifically healthcare regulation. When coupled with an examination of the unmet dental needs of Alaska Natives, such an understanding helps to answer the question of whom Alaskans can trust to bring the regulatory scheme into accord with the needs of the public.

1. *Theories of Regulation.* At the most basic level, there are two fundamental theories on regulation that illustrate whom regulation serves. The major theories are the Public Interest Theory and the Economic Theory of Regulation (also called Capture Theory).¹⁵⁴ In addition, there are some variants and synergisms of these two theories that merit discussion.

a. *Public Interest Theory.* The Public Interest Theory assumes that regulators act to improve national well-being via market regulation, and consequently special interests are not the intended beneficiaries of regulation.¹⁵⁵ The Public Interest Theory starts from the premise that markets are fragile and will operate inefficiently or inequitably without some degree of regulation.¹⁵⁶ Furthermore, the Public Interest Theory assumes that such regulation is effectively costless to the public.¹⁵⁷ Market fragility is especially problematic in industries that are prone to monopolization or where significant externalities negatively affect the market.¹⁵⁸ Regulations can therefore either prevent monopolization or control it, and externalities can be appropriately accounted for. The logic behind public interest regulation is especially compelling in dental and healthcare markets, since the

154. George Stigler originally named his theory “the Economic Theory of Regulation,” but it is also commonly referred to as “Capture Theory.”

155. Andrew P. Morriss, Bruce Yandle & Andrew Dorchak, *Choosing How to Regulate*, 29 HARV. ENVTL. L. REV. 179, 214 (2005).

156. Richard A. Posner, *Theories of Economic Regulation*, 5 BELL J. ECON. & MGMT. SCI. 335, 336 (1974).

157. *Id.*

158. *Id.*

licensing of healthcare professionals prevents unqualified people from providing medical services to the general public.¹⁵⁹

Under this theory, the fact that regulation sometimes harms the public can be attributed either to immaturity of new regulations that are destined to evolve once experience is gained with the market dynamic, or to regulator ineptitude.¹⁶⁰ Furthermore, the Public Interest Theory acknowledges that corruption of self-interested regulators does exist, but that such corruption is an exception rather than the rule.¹⁶¹ It also acknowledges that regulatory agencies may overly focus on their own jurisdiction to the detriment of other jurisdictions, and therefore limitations to the scope of a regulatory agency's operation are often necessary.¹⁶²

If the public interest were the sole impetus for regulation, we would expect to see regulation primarily in industries particularly susceptible to monopolization or high externalities, but empirical research has proven otherwise.¹⁶³ Furthermore, the reality is that the actual process of regulation is highly costly, and regulation frequently has high social costs because of inefficiencies in the process and because regulations are often squarely against promoting public interests.¹⁶⁴

b. Economic Theory of Regulation / Capture Theory. Inherent flaws in the Public Interest Theory spawned the development of the Capture Theory of regulation.¹⁶⁵ This theory argues that, in reality, industries welcome regulation since industry players can use political power to craft regulations that favor themselves.¹⁶⁶ Indeed, the government can exercise control over markets that market players could never create themselves, including subsidies, barriers to entry, control of substitutes to a product, and price fixing.¹⁶⁷ Capture Theory also argues that the benefits of such self-interested regulations to a particular group are

159. Externalities would be huge in a world without healthcare professional licensing, since many people would be injured by harmful care. Furthermore, it would be difficult for people to find qualified professionals without an adequate licensing regime.

160. Posner, *supra* note 156, at 337–39.

161. Morriss, *supra* note 155, at 214–16.

162. *Id.* at 215–16.

163. Posner, *supra* note 156, at 336.

164. *Id.* at 339–40.

165. George J. Stigler, *The Theory of Economic Regulation*, 2 BELL J. ECON. & MGMT. SCI. 2, 3 (1971).

166. *Id.* at 3.

167. *Id.* at 3–6.

always outweighed by the cost to the public—that is, such regulation actually causes a net economic loss to society.¹⁶⁸ In creating regulations that benefit a certain group, that group is said to have captured that market.

George Stigler, who first developed the Capture Theory, cited occupational licensing as a prime example of market capture.¹⁶⁹ Occupational licensing is subject to the political power of interest groups both because it is normally under the purview of the state police power and because professional licensing is a highly effective barrier to entry (practicing without a license in a profession is punishable by criminal sanctions).¹⁷⁰ Stigler noted that the level of political power of an occupation depends on the size of the occupation, the per capita income of its members, and the concentration of its members in large cities.¹⁷¹ This political power can potentially be countered by a strong opposition to licensing that particular group.¹⁷² Dentists and physicians are prime examples of occupations with large amounts of political power, because there are many of them in practice, they are among the highest-paid professionals in the nation, and they tend to concentrate in big cities.¹⁷³ Furthermore, there is virtually no opposition to the licensing of either group.

In many cases, a variety of special interest groups propose solutions that can arguably be of some public interest, but it is impossible for a politician to objectively determine the best regulatory solution.¹⁷⁴ In convincing a politician to regulate in the interest group's preferred manner, the group is said to have "captured" the politician.¹⁷⁵ The interest group must then maintain its influence over the politician in order to be able to maintain its preferred form of regulation.¹⁷⁶ The core conclusion from Capture Theory is that private organizations use legislators and agencies to create industry regulations that benefit a particular group's

168. *Id.* at 10–12 (“When an industry receives a grant of power from the state, the benefit to the industry will fall short of the damages to the rest of the community.”).

169. *Id.* at 13.

170. *Id.*

171. *Id.* at 13–14.

172. *Id.* at 14.

173. *See id.* at 15–17.

174. Morriss, *supra* note 155, at 218–19.

175. *Id.* at 219.

176. *Id.*

interest.¹⁷⁷ In other words, there is always significant self-interest in the regulatory process that the Public Interest Theory neglects.¹⁷⁸

c. Other Theories of Regulation. Although some industries may arguably be captured by one single interest group, many industries are in reality controlled by a few powerful groups, sometimes with diverging interests. One variation to the Economic Theory of Regulation addresses the power of ideology in regulation. This theory, entitled the “bootleggers and Baptists” theory, explains that lobbying efforts by one group with an arguably moral high-ground, the Baptists, can be combined with the lobbying efforts of another group, the bootleggers, to influence a particular form of regulation.¹⁷⁹ In providing an example of this theory, Bruce Yandle explained that Baptists wanted liquor sales prohibited on Sundays for moral reasons and bootleggers wanted the same thing because it would reduce their competition.¹⁸⁰ Legislators succumbed to these influences and prohibited Sunday sales of liquor, a result that neither group could have achieved by itself.¹⁸¹

While this model is effective in highlighting the dangers of affording too much regulatory control to private actors, it is important to note that regulation is still useful for promoting the general welfare of the public. Regulation can maintain markets

177. *Id.* at 220–21.

178. *Id.* at 220. In explaining his theory, Stigler argued that regulation can actually be thought of as a market good that certain industries seek, rather than one imposed upon them. *Id.* at 221. He illustrated, in economic terms, the benefits that regulation can give to an industry and the corresponding possible detriments to society. *See generally* Stigler, *supra* note 165. The desire of an industry to achieve these benefits via regulation represents a neoclassical economic demand for the regulation. *Id.* at 3. The nature of the political process represents a corresponding supply of regulation. *Id.* This supply and demand analysis explains why some groups vigorously solicit and achieve a particular form of regulation while others do not.

179. Bruce Yandle, *Bootleggers, Baptists, and the Global Warming Battle*, 26 HARV. ENVTL. L. REV. 177, 188 (2002).

180. *Id.*

181. *See id.* Yandle also analogized this situation to international negotiation on global warming. *Id.* at 189–90. In his observation, environmental groups and industry special interest groups standing to benefit from environmental regulation have together successfully lobbied for regulatory standards. *Id.* at 189–95. He argues that these standards are an inefficient means for environmental regulation and that penalty taxes would have been a more effective solution; however, these groups with divergent interests successfully lobbied for a socially undesirable result that served their respective interests. *Id.* at 194–95.

that are likely to operate inefficiently or inequitably without it. Dental professionals, like other professionals, must be licensed and regulated by the government to ensure reliability and consistency. However, the bootleggers and Baptists variation on Capture Theory is a reminder that socially undesirable results can emanate from unlikely collaborations between different, and sometimes very diverse, interest groups.

2. *Shifts in Regulation.* The paradigm of regulation has changed over the past thirty years from advancing “accepted goals of reliability” to one where competition is promoted and consumer choice is maximized.¹⁸² This change is seen in the shifts made in regulating the common carrier and public utilities industries.¹⁸³ The shift is marked by the lowering of entry barriers, the unbundling of previously packaged services, and by giving consumers tangible service choices.¹⁸⁴ The focus has moved from standardizing and controlling industries, to ensuring that bottlenecks are eliminated and that a tendency for natural monopolies does not stifle competition.¹⁸⁵ The impetus for all of these changes is difficult to pinpoint and is most likely a combination of new technologies, lobbying by interest groups, and most importantly an invigorated attitude toward the benefits of capitalistic competition.¹⁸⁶ Regulation in “deregulated” industries still exists, but it takes a less invasive role by allowing competition to be a more prominent normalizing force.¹⁸⁷

An example of this regulatory shift was evident in the airline industry, which deregulated pursuant to the Airline Deregulation Act of 1978. Prior to this Act, airlines were required to present proposed routes to the Civil Aeronautics Board (CAB), which would then decide whether the airline’s rates were for the “public convenience and necessity.”¹⁸⁸ Essentially, the CAB controlled entry, and the result was that in many occasions only one airline was afforded the opportunity to fly certain routes.¹⁸⁹ Now, airlines are able to fly whatever route at whatever rate desired, without

182. Joseph D. Kearney & Thomas W. Merrill, *The Great Transformation of Regulated Industries Law*, 98 COLUM. L. REV. 1323, 1323 (1998).

183. *Id.* at 1323–24.

184. *Id.* at 1325–26.

185. *Id.*

186. *Id.* at 1384–1403.

187. *Id.* at 1324–26.

188. *Id.* at 1335.

189. *Id.*

prior approval.¹⁹⁰ This deregulation caused an explosion in consumer choice, and the corresponding competition caused prices to drop and a great increase in the availability of flight access to many cities.

Another example is found by analyzing the FCC's policy of gradually unbundling telecommunication services, particularly local phone services from long distance services.¹⁹¹ Previously, the major phone companies had a monopoly over both local and long distance services, but the FCC eventually forced local carriers to afford customers the ability to purchase long distance services from a variety of carriers.¹⁹² Although this deregulation was not problem-free, phone service technology has been greatly enhanced and customers have far more options regarding what types of services they can buy.

Also, cross subsidies were ended in certain industries where universal access is required, such as in the case of the provision of rural telephone or electrical services.¹⁹³ These subsidies were not necessarily directly eliminated, but their form has changed. That is, since competition entered the market, industries could no longer charge above market rates to certain customers in order to subsidize higher cost customers; instead, these subsidies were either eliminated and paid for by the high cost customer, or more transparent fees were charged to maintain the subsidies more openly.¹⁹⁴

In the previously mentioned regulatory regime shifts, the old regimes all focused on the needs of monopolistic service providers and ignored competition to such an extent that competition was often completely eliminated.¹⁹⁵ The new goal is to promote competition in as many industries as possible with regulators playing less intrusive roles.¹⁹⁶ Before, agencies determined entry, types of service, rates, profits, and the acceptability of various types of transactions; now, the regulators permit the end user and the market to make these choices.¹⁹⁷ Regulators only intervene when it is unlikely that the market will function properly without a low degree of control.¹⁹⁸

190. *Id.*

191. *Id.* at 1340–43.

192. *Id.* at 1342–43.

193. *Id.* at 1346–49.

194. *Id.*

195. *Id.* at 1349–51.

196. *Id.* at 1350.

197. *Id.* at 1349–51.

198. *Id.* at 1361.

B. Regulation of Healthcare Professionals

I. Anticompetitive Tendencies Among Healthcare Providers.

A similar shift can be seen in healthcare markets due to more aggressive antitrust law enforcement. Though not industry specific regulation, antitrust laws enable the government to more generally protect competition in a variety of markets. In the healthcare context, antitrust laws exposed economically self-interested behavior veiled in the name of consumer protection and exposed claims that the most educated or traditional healthcare professionals were the only group qualified to make decisions about medical care.¹⁹⁹ Illustrative cases include *FTC v. Indiana Federation of Dentists*,²⁰⁰ in which the Federal Trade Commission filed a complaint alleging restraint of trade against the Indiana Federation of Dentists, which had agreed among its members that it would not submit x-rays to dental insurers in order to control decisions about care.²⁰¹ The Supreme Court refused to allow this activity, reasoning that consumers should be allowed to contract with insurers for particular services, and that these services were simply part of the functioning marketplace.²⁰² Similarly, in *California Dental Association v. FTC*²⁰³ the Court struck down the California Dental Association's prohibition on advertising prices and quality, reasoning that competition by its very nature involves information about price and quality.²⁰⁴ These rulings ensure that insurance companies can offer set services, and espouses the notion that competition is required in healthcare. It should be noted, however, that the application of antitrust law to the healthcare industry may not in fact strike a perfect balance between competition and quality assurance.²⁰⁵

Regulation of healthcare professionals relies on the state police power over occupational and professional licensing. Licensing of dentists, dental hygienists, doctors, nurses, and other health professionals acts as a way to ensure that only qualified professionals provide services to the public. Furthermore, licensing acts as a barrier to entry because practicing within the scope of the

199. William Sage & Peter Hammer, *Competing on Quality of Care: The Need to Develop a Competition Policy for Health Care Markets*, 32 U. MICH. J.L. REFORM 1069, 1075–76 (1999).

200. 476 U.S. 447 (1986).

201. *Id.* at 451–53; *see also* Sage & Hammer, *supra* note 199, at 1075.

202. *Indiana Federation of Dentists*, 476 U.S. at 463.

203. 526 U.S. 756 (1999).

204. *Id.* at 767.

205. *See generally* Sage & Hammer, *supra* note 199.

aforementioned professionals' domains without a license results in a criminal offense with severe sanctions.²⁰⁶ Since licensure of health professionals is highly intertwined with the positions of the AMA and ADA, these groups have tremendous influence in determining how healthcare will be administered and who can participate. Furthermore, they typically are responsible for much of the testing and certification of professionals.²⁰⁷

Doctors and dentists are among the most respected and trusted professionals in the United States, but still there is a clear problem in letting a group of professionals have sole control over their own industry. For a comparable example, consider the National Society of Professional Engineers (NSPE), another group of respected professionals, which decided in order to ensure adequate quality that its members would not compete with each other with regard to price.²⁰⁸ This arrangement did not hold up to antitrust scrutiny, and the Court, in ordering them to cease this activity, rightfully emphasized the importance of competition on both price and quality.²⁰⁹ The NSPE case is useful in emphasizing the notion that competition with regards to price does not necessarily mean that all quality is lost.²¹⁰ Perhaps more important, the NSPE case showed that educated professionals often seek anti-competitive regulation in the name of quality, and consequently should not be afforded excessive deference in their self-regulation.

Healthcare is a unique industry, because information deficits and asymmetries persist at every level.²¹¹ These asymmetries and deficiencies result in a high degree of trust in healthcare professionals for information, and consequently professionals have been able to achieve very comprehensive control over healthcare regulation.²¹² This control includes tight control over occupational

206. Stigler, *supra* note 165, at 13.

207. For example, the American Dental Association Joint Commission on National Dental Examinations is responsible for administering the National Dental Board Exam. See American Dental Association: Education and Testing, <http://www.ada.org/prof/ed/testing/nbde01/index.asp>.

208. Nat'l Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679, 682–83 (1978).

209. *Id.* at 691.

210. See *generally id.* The NSPE unsuccessfully argued that competition on price would lead to inadequate attention to quality work, and that such competition would be ruinous. The United States Supreme Court disagreed, and despite price competition in engineering services, engineers seem to be able to build numerous quality products.

211. See Sage & Hammer, *supra* note 199, at 1090. For example, patients rarely have any expertise regarding their ailments. *Id.*

212. *Id.*

licensing and an unusually high deference being afforded to self-regulatory bodies like the ADA and AMA.²¹³ This control strongly reduces competition, since professionals effectively control any new entry and require that particular standards be met in the administration of healthcare services.²¹⁴ While this control does ensure that only qualified professionals administer care, it is also problematic because the medical profession views a doctor or dentist's choices as purely technical "and does not acknowledge the legitimacy of balancing costs and benefits."²¹⁵ These choices are often wholly insulated from cost, and this standard has been adopted without explicit approval or oversight from the public.²¹⁶

A corresponding problem with healthcare has been the fact high costs often do not yield equally high levels of care. Perhaps even more important, low-cost options are infrequently provided, and consequently an unnecessarily "high" standard of care is offered that actually ends up harming those whom it is supposed to protect. In addition to the existence of tight professional control over licensing, this unnecessarily high standard is a product of the fact that most consumers of health and dental services, especially the politically powerful, are insured by their employers and therefore disconnected from the idea of the need for a low-cost alternative.²¹⁷ In other words, those who already have physical and financial access to doctors and dentists under the current regime have no reason to be sensitive to the situations of those who do not currently have either physical or financial access. Those without financial means typically lack strong political power, and therefore their needs are drawn out amongst a sea of politically powerful, complacent consumers of high-cost healthcare.

Professional organizations carrying the banners of standardization and protection of the public often try to eliminate competent competitors by excluding them via regulation. Such exclusion was seen when the American Medical Association, which is dominated by physicians with allopathic²¹⁸ training, attempted to eliminate AMA membership and state licensure of physicians with

213. *Id.*

214. *Id.* at 1090–91.

215. Clark Havighurst, *How the Health Care Revolution Fell Short*, 65 *LAW & CONTEMP. PROBS.* 55, 73–74 (2002).

216. *Id.*

217. *Id.* at 84, 86.

218. As opposed to "homeopathic," "allopathic" refers to the standard method of treating disease in which the treatment produces effects different from or opposed to the ailment being treated. *Merriam-Webster Online*, <http://www.m-w.com/dictionary/allopathic>.

osteopathic training.²¹⁹ The AMA successfully lobbied to limit physician licensure to those who had graduated from an AMA-accredited allopathic medical school; osteopathic doctors were consequently not able to be licensed in every state in the United States until 1974.²²⁰ This sort of opposition by the AMA is also currently seen with regard to most forms of alternative medicine; the AMA opposes the practice of alternative medicine even by allopathic doctors, despite significant evidence that these techniques can often have beneficial effects.²²¹ The irony is that the demand for alternative medicine, as measured by out-of-pocket payments, is steadily increasing, yet payments to physicians have decreased.²²² Some recent attempts to provide alternative medicine options include allowing licensed medical doctors to offer alternative treatments or allowing alternative medicine practitioners who are not doctors to practice as long as their practice does not cross over into allopathic medicine.²²³

Of course, some regulation is necessary to maintain decent standards at a level that serves most people, but the current regulatory regime forces high costs onto a minority that cannot afford them and as a result is harmed because it cannot gain access to proper care.²²⁴ Clark Havighurst notes that hyper-regulation occurs in the healthcare context because high level healthcare is symbolically powerful in politics, healthcare is fairly income-inelastic (since people with higher incomes spend a higher percentage on healthcare), and consumers are likely to believe the cost of artificially high standards will be borne by insurers.²²⁵ He points out that the political power of healthcare professionals and the political majority's demands for artificially high standards are likely to create a system which meets their needs but denies lower income groups access to care.²²⁶ This situation forces a choice between a "Cadillac" level of care and none at all.²²⁷ Thus, the healthcare system ignores the importance of a low-cost alternative,

219. Gregory Dolin, *Licensing Health Care Professionals: Has the United States Outlived the Need for Medical Licensure?*, 2 GEO. J. L. & PUB. POL'Y 315, 322–23 (2004).

220. *Id.* at 323.

221. *Id.*

222. *Id.* at 326.

223. *Id.* at 331.

224. Havighurst, *supra* note 215, at 85.

225. *Id.* at 85–86.

226. *Id.*

227. *Id.* at 86.

which would enhance competition in the market and give access to currently underserved groups.

The healthcare industry has changed due to heightened enforcement of antitrust laws against professionals since approximately 1975.²²⁸ This enforcement reversed previous professional collective behavior that restricted the ways in which consumers could access healthcare.²²⁹ More specifically, it allowed insurance plans to act as purchasing agents for patients and negotiate for reduced and consistent prices.²³⁰ Also, insurance providers may be more effective in compelling healthcare professionals to curb costs since they are now subject to oversight by the plan and are therefore more mindful of price.²³¹ An important result of the antitrust revolution in healthcare is the notion that consumers may now make choices involving balancing costs and types of services.²³²

2. *A History of Unmet Dental Needs.* Dental care has been identified as the most rampant unmet health need among children in the United States.²³³ The tragedy of this statistic is that early preventative services should be relatively inexpensive, but neglected oral disease spikes drastically in monetary cost and takes significant quality of life tolls on individuals.²³⁴ Recent research has also discovered associations of poor dental health with increased risk of cardiovascular disease, stroke, and risk of pregnancies ending in premature labor and decreased birth weight.²³⁵ Of course, preventive dental care would be the cheapest and least traumatic solution, but the reality is that Alaska Natives are already suffering from poor dental health and geographic barriers necessitate a low-cost solution.

The need for dental professionals in Alaska Native villages is just the tip of the iceberg, as approximately forty million Americans live in areas with shortages of dental professionals.²³⁶

228. *Id.* at 58–59.

229. *Id.*

230. *Id.* at 59.

231. *Id.* at 60–61.

232. *Id.* at 63–64.

233. Wendy E. Mouradian et al., *Disparities in Children's Oral Health and Access to Dental Care*, 284 J. AM. MED. ASS'N 2625, 2625 (2000).

234. *Id.* at 2625–26.

235. *Id.* at 2626.

236. N. Karl Haden et al., *Improving the Oral Health Status of All Americans: Roles and Responsibilities of Academic Dental Institutions*, 67 J. DENTAL EDUC. 563, 564 (2003).

Dental Therapists and Dental Health Aides are not the only legislative solution introduced to address the need for additional dentists and lower-cost dental health professionals. For example, the California legislature compelled the California State Board of Dental Examiners to allow graduates of foreign dental schools to take its state licensing exam.²³⁷ Similarly, some states have expanded the role of dental hygienists by loosening restrictions on required supervision and allowing them to perform unsupervised care in certain cases.²³⁸ In California, the legislature has also authorized the licensure of Registered Dental Hygienists in Alternative Practice (RDHAP), and they are permitted to examine and treat patients without dentist supervision or authorization.²³⁹ Another example is found in Connecticut, a state that allows hygienists to provide a variety of services without supervision in certain public institutions, public health facilities, group homes, and schools.²⁴⁰ Furthermore, North Carolina allows specially trained pediatricians to apply fluoride varnish to the teeth of children under the age of three.²⁴¹

State dental boards are often less than enthusiastic about the use of non-dentists in the provision of dental care to underserved populations. For example, the South Carolina State Dental Board opposed the South Carolina legislature, which amended its Dental Practice Act to allow dental hygienists to perform oral prophylaxis and apply sealants without the supervision of a dentist.²⁴² In response, the State Dental Board passed an emergency resolution preventing these unsupervised procedures by dental hygienists, effectively rendering that strategy useless.²⁴³ However, the FTC successfully brought an action against the Board on unfair competition grounds, and the Fourth Circuit dismissed the Board's interlocutory appeal, albeit on jurisdictional grounds.²⁴⁴

237. *Id.* at 564.

238. *Id.* at 564–65.

239. *Id.* at 574. In other states, the hygienist must only work when a dentist is present in the facility, and in some others, hygienists can work with less restrictive supervision. *Id.*

240. *Id.* at 575. Haden also cites similar examples in Colorado, New Mexico, Oregon, and Washington. *Id.*

241. Mouradian, *supra* note 233, at 2628.

242. S.C. State Bd. of Dentistry v. FTC, 455 F.3d 436, 438–39 (4th Cir. 2006).

243. *Id.*

244. *See id.* at 440, 447. The South Carolina State Dental Board argued that it was entitled to state action immunity from antitrust laws under *Parker v. Brown*, 317 U.S. 341 (1943), but the Fourth Circuit, siding with the FTC, affirmed the district court's holding. *Id.*

One might think that, with their vehement opposition to many non-dentist strategies to provide dental care to underserved populations, ADA member dentists would try to serve these populations themselves. But dental care is not covered by Medicare, and only approximately 25% of dentists agree to treat Medicaid-insured patients.²⁴⁵ Similarly, most underserved groups lack insurance and cannot pay high dentist rates, and most dentists are unwilling to accept Medicare or State Childhood Health Insurance Program (SCHIP) plans because of their low reimbursement rates.²⁴⁶ These uninsured or state-insured people have no alternative provider to see, since dental licensing regulations prevent non-dentists from providing any form of dental care. Since state-issued plans are not frequently accepted—as evidenced by the fact that only one in five children who are eligible for Medicaid receives the preventative services for which they are eligible²⁴⁷—access to third party insurance seems to be a determining factor in dental access. To their credit, several efforts by dentists have enhanced access to dental care for underserved populations in some cases.²⁴⁸

The ADA itself has predicted that the ratio of dentists to the general population will steadily decline, as it has for many years.²⁴⁹ This decline could provide an opportunity for enhanced roles for hygienists and other allied dental health personnel, including Dental Therapists.²⁵⁰ Standing in the way of this expansion, however, are regulatory barriers to entry that do not reflect what non-dentist dental professionals can actually do competently. If the dental profession continues to insist that even the simplest dental procedures can only be performed by licensed dentists, the needs of underserved populations will never be fully addressed.²⁵¹ This stance restricts output and raises costs beyond what is necessary, effectively preventing access of underserved populations to needed dental care.²⁵²

245. Haden, *supra* note 236, at 566.

246. *Id.*

247. Mouradian, *supra* note 233, at 2627.

248. See ADA: THE MODEL PROFESSION, *supra* note 18, at 2 (providing examples of initiatives and programs conducted by individual dentists and dentist organizations).

249. Haden, *supra* note 236, at 569.

250. *Id.* at 574.

251. Jay W. Friedman, *Letter: Oral Health Care and Professional Abstinence*, 95 AM. J. PUB. HEALTH 190, 190 (2005).

252. *Id.*

3. *Who should be trusted?* The ADA, state dental board, and local dental societies are no doubt valuable in creating regulations, because they possess an expertise that the general public and legislators definitely do not have. But should we fully trust them? For the most part yes, but it is important to realize that not all of their suggestions are fully altruistic, and this self-interest is no different than that seen in any other professional organization. Dentists and other healthcare professionals are no doubt largely professionally motivated to promote good health among the public, but as professionals they also have an interest in maintaining their economic well-being. Furthermore, it is important to keep in mind that for most Americans, the problem of access to a dentist is not immediate and therefore the current system works adequately for them. They are insulated from high costs due to their insurance, and they do not have to worry much about access or cost problems.²⁵³ The real problem is experienced by those who cannot afford insurance or by those that only have state insurance, for these people are often unable to get access to the dental care that they need.

It is easy to talk away a problem and provide theoretical solutions, but talk without action is a non-solution. Poor dental health has plagued the Alaska Native community since before Alaska became a state, but the problem, though discussed, has never been adequately addressed. Significant improvements have indeed been made by IHS and the ADA in providing access to dentists where before there was none, but even with some access the problem of poor dental health persists. Despite the urging of many dentists, the ADA has never fully addressed the poor access suffered by underserved populations and continues to block innovative dental care provision programs.²⁵⁴ Ultimately, we should trust dentists and the ADA for technical dental matters, but we must also realize that professionals and professional organizations can never fully escape self-interest. Thus, we must give due credit to healthcare strategies suggested by and for members of communities in need.

253. The combination of the ADA's political power and the political power of a population that accepts the current regime of dental licensing may also produce the effect described by the "bootleggers and Baptists" variant of Capture Theory. See *supra* Part VII.A.1.c.

254. Myron Allukian, Jr. et al., *APHA Presidents Support Dental Therapists*, 95 AM. J. PUB. HEALTH 1881, 1881 (2005).

VIII. DENTAL THERAPISTS AS A COMPETITIVE FORCE

The introduction of Dental Therapists represents a strong competitive force that will help keep healthcare regulators in check and force interested parties to support what they say with action in solving the dental health problems of Alaska Natives. It is indisputable that Alaska Natives have the poorest dental health of any population in the United States. Although they have access to dental care provided by IHS, their current form of access is inadequate to solve their dental problems. The ideal solution would be to train more Alaska Native dentists and hire more dentists in general to serve the Alaska Native community, but this is a solution that could only begin to reap benefits many years down the road. Ideally, a dentist would be put in every village to deal with emergencies and provide continuous social influence to change the poor hygiene and dietary habits of Alaska Natives.

The reality is that, unlike in an ideal world, there is not an endless supply of money or professional manpower. Many solutions are not feasible since Natives live in small, geographically-isolated communities. Furthermore, training more Native dentists would take eight or more years and non-Native dentists are understandably not drawn to serving in such harsh, unfamiliar localities. The Dental Therapist program addresses these deficiencies via a pragmatic and realistic approach that will drastically and quickly improve Alaska Native oral health. Particularly for the treatment of children, Dental Therapists have proven to be cost-effective providers of dental services, and they have the ability to perform the routine clinical procedures necessary for high-level dental health.²⁵⁵

Beyond the positive effect that Dental Therapists will have on the Alaska Native community, the introduction of the program will have positive effects nationwide. Even though Dental Therapists are limited to practice in Native villages, their introduction would be an improvement over the monopolistic control exercised by dentists and the ADA over many dental services. However altruistic a group may be, it rarely makes sense to grant undue deference to an inherently self-interested group. More specifically, giving de facto control to the ADA over dental licensing and the structure of dental services limits important discussion and

255. See generally Paul Riordan, *Can Organized Dental Care for Children be Both Good and Cheap?*, 25 COMMUNITY DENTISTRY & ORAL EPIDEMIOLOGY 119 (1997) (explaining that Dental Therapists provide most dental care to children in Western and Southern Australia, with outcomes equal to or better than that seen in countries that only provide care with dentists).

solutions for underserved populations. By insisting that certain routine services can only be performed by dentists despite the reality that there are not enough dentists willing to serve uninsured or state-insured people, the ADA has continually shown that its strategies are insufficient for providing access to those with limited resources.

The ADA is a politically and economically powerful group. It enjoys a significant moral high ground since the dental profession is highly regarded and has an inherently humanitarian mission. Furthermore, its arguments for quality and high standards are given more credibility than those of other groups since dental and health services are industries where a certain minimal level of quality is an unarguable necessity. This combination allowed the ADA to capture the market for dental licensing to the extent that it has completely excluded competition for dental services. It has successfully silenced competitive voices by exercising its private association's monopolistic mindset via governmental enforcement of licensing. However, in Alaska it became apparent to the Native population that such a dental licensing regime stood more as a barrier to care than an assurance of quality.

The creation of the Dental Therapist program is not surprising given the gradual shift toward less restrictive regulation in United States industries and the enforcement of antitrust laws against healthcare professionals.²⁵⁶ This trend is representative of changing attitudes toward regulation and the recognition that the inherent self-interest of professional organizations and industries should be acknowledged when assessing their proposed regulatory schemes. In healthcare specifically, there is a trend toward creating a structure with more consumer choice and allowing prices to be more of a factor than before.²⁵⁷ The consumer can either be the end user of a service or an insurance company, both of which can make decisions on quality and price.

By exercising its political and legislative power in response to an unmet need, the IHS has proven that competitive forces can come from unsuspected entities.²⁵⁸ In creating a new license, IHS has the power to end the market capture of the dental market by the ADA and dentists. This agency action was therefore crucial in effecting a change that individuals or collections of individuals have otherwise not been able to achieve.

256. Mouradian et al., *supra* note 233, at 2627–30.

257. Havighurst, *supra* note 215, at 63–64.

258. See, e.g., Sage & Hammer, *supra* note 199, at 1094–95 (noting the role of “competition as a vehicle to restructure Medicare and medical markets”).

Another reason that the IHS was in a prime position to create this change is that the IHS and Tribal Consortiums do not weigh the same risks that a private insurer would. That is, the situation in Alaska is graver than that of the average employed middle class American worker. Thus, the standard of care demanded by the ADA cannot properly account for risk and price in this graver situation. Indeed, this standard of care minimizes cost-sensitive product differentiation, or even the existence of a product for those without access. One result of the creation of a different—and not inferior—standard of care is that the ADA will be forced to address needs that its current preferred dental care administering system does not satisfy.

The other great triumph arising from the establishment of a Dental Therapist program is that it is a behaviorally and culturally sensitive solution. Even if more non-Native dentists were available to the Native population, Native behavior would probably not be changed. Therefore, the ability of the Dental Therapist program to train Natives themselves to provide dental care is invaluable because the problem cannot be solved by enhancing access alone.²⁵⁹ The ADA certainly recognized the importance of a culturally and behaviorally sensitive solution in its suggestion to train more Native dentists, but it did not acknowledge the fact that so few Natives graduate from college that the pool of potential Native dentists makes the ADA's suggested approach currently unattainable.

The Dental Therapist program is creating dental health professionals with community and cultural ties that can more effectively change the behavioral problems associated with poor dental health among Alaska Natives. By changing behavior through a culturally sensitive route, the quality of life of Alaska Natives, as well as their attitude toward dental health, will improve. Consequently, it is far more likely that Alaska Natives will then be inspired to pursue dentistry as a career goal. Thus, the Dental Therapist program will in fact prove essential in achieving the ADA's suggested goal of training more Native dentists.

IX. CONCLUSION

The oral health of Alaska Natives is and has been extremely poor since Alaska became a state, but the introduction of Dental

259. See Barak D. Richman, *Behavioral Economics and Health Policy: Understanding Medicaid's Failure*, 90 CORNELL L. REV. 705 (2005) (arguing that patient behavior must be a central factor in formulating sensible public healthcare policy).

Therapists via a unique federal license stands to vastly improve the situation. Similar improvements have been seen in New Zealand, Canada, and many other countries, all of which utilize some form of a Dental Therapist professional program. However, the ADA is opposed to this type of dental health professional, because they perform some of the same procedures that licensed dentists currently do. This opposition is tightly linked to the inherent self-interest of dentists in being the only source for dental services. This self-interest results in the neglect of underserved portions of the market. Dental Therapists are a viable low-cost alternative to dentists in offering access to dental care.

As a result of the creation of a non-dentist low-cost alternative, the ADA will have to address segments of the American population that it has been inadequately serving. Furthermore, the creation of Dental Therapists in Alaska is consistent with the trend toward less restrictive regulation in most American industries, and hopefully foreshadows the future development of other low-cost alternatives to current high-cost healthcare options. Ultimately, Dental Therapists will improve both the oral health of Alaska Natives and improve the overall market for dental healthcare by forcing a much needed form of competition back into the market.