Access to Care: The Role Of the State Dental Board In Public Access to Oral Health Care

The Report of the AADE Committee on Access, Licensure and Regulation

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Abstract: The oral health of Americans has improved dramatically over the last several decades. However, segments of the population in the United States do not utilize dental services or utilize dental services on a limited basis. Profound disparities in the oral health of Americans continue to exist as a result of economic, cultural, educational, and access barriers. State dental boards that oversee licensing of dental professionals are being pressured to improve access to care by reducing licensing requirements. The AADE Committee on Access, Regulation and Licensure responds to this issue. It articulates a Statement of Position, and provides guiding principles for state dental boards to assist them in doing all that they can to afford equitable access to dental services in their jurisdictions without compromising the quality of care.

Background

A number of adults and children in the United States have limited access to dental services or do not utilize dental services. Inadequate funding of Medicaid programs, the resulting lack of dentist participation in these programs, disparity in the demand for dental care, lack of dental service providers in certain areas, and other factors, including the current structure of the health care delivery system, contributes to this situation.

State dental boards have a statutory mandate to protect the health, safety and welfare of the public. To do this they use licensing, regulation, and discipline to assure the public that its health care providers are competent. Licensing systems in almost all states involve prerequisites: graduation from an accredited dental school, successful completion of Part I and Part 2 of the written National Board Dental Examination, and successful completion of a practical clinical examination. The clinical examination assesses candidate performance in certain critical areas of dentistry. This assessment assures the public that the candidate has demonstrated competence in these areas prior to initial licensure.

State dental boards that oversee the licensing of dental professionals are being pressured by state legislatures and consumer advocacy groups to address access to dental care in a variety of ways. For example, they are being pressured to reduce licensing requirements for those willing to practice in underserved areas. Boards, charged with protection of the public, face a dilemma: how to increase the access to dental services without compromising the quality of care.

To assist state dental boards the American Association of Dental Examiners appointed a Committee on Access, Licensure and Regulation to research and respond to access issues. This report and Statement of Position is the resulting work of this committee.

The report is organized as follows:

1. Access Barriers and Utilization of Dental Services
2. Dental Workforce
3. Access to Care: Role of the State Dental Board
4. Recommendations for State Dental Boards

The report contains a series of recommendations for consideration by state dental boards when they face issues regarding access to dental care in their jurisdictions. It concludes with the *Statement of Position* of the American Association of Dental Examiners relative to the role of the state dental board regarding access to oral health care.

Access Barriers and the Utilization of Dental Services

As used in the Surgeon General's Report, *need* for oral care is based on whether an individual requires clinical care to maintain full functionality of the oral and craniofacial complex.[1] There is evidence that a disproportionate incidence of oral disease and disorders in certain population groups creates for these groups a greater demand for dental services. However, demand is also influenced by the amount of services users can and would purchase given the cost of those services. In the United States the provision of health care services is subject to the incentives of a competitive marketplace. Factors influencing demand ultimately can be eclipsed by one major factor: the ability to pay.

While universal access to care is a frequently championed goal, practical considerations readily lead to the conclusion that this goal is, in fact, unattainable given the free market nature of the oral health care delivery system and level of resources the nation has committed to subsidizing oral health care for the disadvantaged families. Improvement in the provision of oral health care to those in need depends on specific interventions aimed at reducing barriers that limit access and therefore reduce the demand for care.

Some of the barriers that affect demand for oral health care services can be identified.

Knowledge and Values

Those in need of care sometimes lack knowledge of the preventability of oral health diseases and awareness of their need. They may not value the importance of oral health and may view it as independent from or secondary to general health. Public policymakers too frequently do not understand the value of oral health as a part of general health and marginalize oral health to a policy issue of lower priority. Public policy which diminishes or marginalizes the value of dental care ultimately reduces the perceived importance of dental care, which can reduce the demand for dental care in some disadvantaged or underserved populations, who actually might have increased needs.

Availability of Care

Persons in need may not have access to a provider within their community due to the geographic distribution of oral health care providers. The geographic distribution of dental health care providers however, oftentimes mirrors the relatively low number of other health care providers such as physicians, nurses, etc., and the relative paucity of services in a specific geographic area in general.

Many oral health care providers are unwilling to care for the members of some underserved population groups because of low reimbursement rates, lack of insurance, unreliability, insufficient capacity to accept additional patients, and other factors. Increased sensitivity to the cultural needs of diverse patient populations is needed. Additionally, some of the current workforce may not feel or may not be adequately prepared to treat certain populations, for example infants, geriatric, and special needs patients

Ability to Pay

Due to economic status, members of underserved population groups are frequently unable to pay for oral health care services. Many lack dental insurance. Low reimbursement rates for public programs such as Medicaid and the state Children's Health Insurance Program dissuade providers from rendering care to the poor. Nearly seventy-five percent of dentists do not participate in their state Medicaid program.[2] Many elderly are deterred from seeking oral health care because Medicare covers very minimal dental services.

Regulation

State laws and regulations impose licensing requirements that may complicate the movement of dentists from one jurisdiction to another. State laws and regulations should impose supervision requirements on allied dental personnel commensurate with the education and experience of these personnel with the appropriate supervisory requirements to insure public protection.

Systemic Barriers

The traditional model for the provision of oral health care is the solo practice dentist assisted by allied dental personnel working under the dentist's supervision. This model, which has changed little over the past century, will continue to serve an important role in meeting the nation's oral health needs, but additional new models must be explored to improve access for underserved populations. Development of additional models that enable increased use of allied dental personnel and integrate oral health and general health may help ensure greater access to oral health care for Americans.

Dental Workforce

Size

The American Dental Association Dentist Workforce Model (DWM), which considers numerous characteristics of the dental workforce and remains independent of those who seek specific answers for political purposes, projects a decline in the ratio of professionally active dentists to population from its peak of 60.2 per 100,000 in 1994 to 54.2 per 100,000 in 2020[3]. However the impact of this decline is more than mitigated by expected increases in the productivity of dentists. As a result, the ADA concludes in its 2001 report on the *Future of Dentistry* that "The national supply of dental services is likely to increase . . . that a major increase in the aggregate number of dentists is probably not necessary at this time."[4] Also, changing disease patterns and continuing improvement in the oral health of the population mean fewer dentists will be required to manage the population's dental needs. The current dental workforce also has reserve productive capacity in its allied dental personnel. Increased use of allied dental personnel would enable improved efficiency that may improve access to oral health care for some populations.[5]

The Institute of Medicine (IOM) Committee on the Future of Dental Education concluded in its 1995 report *Dental Education at the Crossroads* that there was no compelling reason to recommend that dental school enrollments be increased.[6] History demonstrates that stimulating the supply of dentists does little to reduce shortage areas or improve access to care by underserved populations. Since the date of the report, two new dental schools have opened and several others have made or are considering increases in class size. Hence, adequacy of the size of the current and projected dental workforce, if not clear, is not a serious concern.

Regardless of the current or projected number of dentists or of their current or projected level of productivity, segments of the population potentially have difficulty obtaining needed or wanted oral health care due to disparities in the geographic distribution of dentists. The number of Dental Health Professions Shortage Areas designated by the U.S. Health Resources and Services Administration (HRSA) Bureau of Health Professions grew from 792 in 1993 to 1,895 in 2002. In 1993 HRSA estimated that 1,400 dentists were needed in shortage areas. In 2002 the estimated need was more than 8,000 dentists. More than 40 million people live in designated shortage areas.[7] An adequate number of oral health care providers is essential but does not ensure universal access to care.

Care must be exercised in interpreting Dental Health Professions Shortage Areas data. The designation, as currently defined, relates more appropriately to geographic areas where unmet dental needs exist than to the number of dentists located in those areas. Unmet dental needs often are the result of factors other than the size of the dental workforce. Perceived workforce shortages may be the result of the decreased demand for dental services and therefore not to the cause of the unmet dental needs.

Distribution

Even with an aggregate workforce that may be adequate, geographic maldistribution of dental service providers obstructs access to needed dental care for some population groups. "Maldistribution" in this context refers to epidemiological distribution: a distribution of providers that reflects the population's need for dental services. In the current market-driven health care economy however, the distribution of providers is largely based on economics. Providers are free to locate where they will and frequently base location decisions on a host of factors, including the perceived desirability of an area. Still, in most cases these factors are overwhelmed by one major consideration: economic feasibility. The importance of economic viability is enhanced by the high cost of dental education and average indebtedness of dentists making professional entry-level location decisions. Regardless of the *need* for dental care in an underserved population, the *demand* for dental services must enable competitively profitable practice or no dentist will assume the task. This is not maldistribution, but economic distribution of oral health care professionals consistent with the marketplace economic system in which they labor. To attract providers and improve access to care for underserved populations whose existing demand for services is questionably adequate, without changing the underlying economic system of health care delivery, requires the injection of incentives such as government or community subsidies, student loan forgiveness, tax credits, etc.—something that modifies the system and makes practicing in the community competitively attractive.

Composition

The dental workforce consists of dentists (including specialists), dental hygienists, dental assistants, dental laboratory technicians, and administrative personnel. The Center for Health Workforce studies projects a 30 percent growth rate in health care occupations between 2000 and 2010. The growth rate for dentists, however, is projected at less than 6 percent. The growth rate for dental hygienists is projected at 37 percent.[8]

Most states allow dental hygienists to provide services under general supervision in some settings. This usually means that a dentist must authorize the procedures performed but need not be physically present in the treatment facility when they are performed. However, state dental practice acts vary widely as do definitions of general supervision and the scope of services dental hygienists are allowed to perform. In some states dental hygienists can practice only under direct supervision, which means that a dentist must be physically present in the facility while the dental hygienist provides care. In 14 states, dental hygienists may provide care in certain settings under some form of unsupervised practice or limited supervision.

In many states efforts have also been made to evaluate the potential of increasing the dental practitioners' production capability by increasing the types of services that dental assistants can legally perform under direct supervision.

In the light of the various supervisory constructs for dental hygienists and auxiliaries in various states, evaluations should be done on the effect if any; differing supervisory constructs have on access to care. Proposed changes in supervisory constructs advanced to improve access to care must be evaluated in their effectiveness in addressing comprehensive access to quality care in a safe environment. State dental boards must consider supervisory constructs that appropriately safeguard the public while improving access to quality care.

Mobility

Mobility of dental professionals is an appropriate concern. Professional mobility has dramatically increased over the past several decades. Many states now participate in regional testing agencies. Regional testing agencies have similar examinations and employ standardized testing practices. This has improved the quality of entry-level examinations and the portability of examination results. Many states now recognize several regional and state examinations. In addition, most states now license by credentials dentists and dental hygienists who meet certain criteria and have been practicing in good standing in another jurisdiction. These actions have dramatically improved mobility and their success portends wider adoption and further development that will continue to improve professional mobility.

The AADE facilitated a special committee with representation from regional testing agencies and independent states. The goal of this committee was to develop a uniform national clinical licensing examination to be administered by regional and state testing agencies. This committee has been replaced by a new organization, the American Board of Dental Examiners (ADEX). The completion of this project will markedly facilitate mobility and convenience for licensure candidates while still protecting the public.

Access to Care: The Role of the State Dental Board

Regulation

The state board's role, first and foremost, is to promulgate regulations that protect the health, safety and welfare of the public, and to maintain the integrity of its licensing and disciplinary processes. Much can be done in the areas of education and legislation to enhance access to needed dental care, but these activities are peripheral to the board's core responsibility. State dental boards adopt and enforce policies that adequately protect the public, public education, advocacy, development of socio-economic incentives, legislative education, and other peripheral activities in which a board sometimes engages should directly relate to and support the board's primary role. The state board's regulatory focus must not be distracted by pressure from special interest groups that distort access and workforce issues to advance their own political agenda, or by those who would lay greater responsibility for access problems at the feet of the board than for which it could possibly be accountable.

Active Collaboration

Access issues are complex and multifaceted. Improving access to care for underserved populations demands collaborative, integrated effort with patient advocates, consumers, community leaders, regulators, legislators, educators, federal and state governmental agencies, organized medical and dental communities, third party reimbursement

organizations and others. The scope of actions available and appropriate for state dental boards is limited. However, by virtue of their authority and the impact of their actions, state dental boards can contribute significantly to the viability of projects aimed at improving access to care. State boards should be well informed about access problems in their jurisdictions and should actively address access problems by working toward solutions together with other communities of interest. State dental boards best serve the interest of the public in their jurisdiction by actively participating—by learning about, considering and taking steps to implement viable policies that potentially improve access to dental services for underserved populations while maintaining the quality of care.

Recommendations for State Dental Boards

- With regard to the provision of dental services, state boards must vehemently and unrelentingly advocate quality oral health care for all Americans. This position must not be sacrificed in the interest of improving access.

- State dental boards must maintain the integrity of their licensing, regulating, and disciplinary processes. The state board's regulatory focus must not be distracted by pressure from special interest groups that distort access and workforce challenges to advance their own political agenda.

- State dental boards must implement and enforce policies that adequately protect the public, including policies that do not hamper the efficient entry and distribution of qualified dental service providers.

- In addressing access to care, state boards should consider the utilization of allied dental personnel and explore roles and responsibilities that further augment the productivity of the dental team using appropriate supervisory constructs..

- State boards should be well informed about access challenges in their jurisdictions and should actively work to address access challenges by collaborating with other communities of interest.

- To effectively address access to care issues state boards should actively interface with consumers, professional associations, dental educators and with dental regulators in other jurisdictions, and should actively participate in national, regional, and state forums that address access to care in order to learn of developments that might be implemented or modified for use in their own jurisdiction.

Statement of Position

Quality of Care

To protect the public in regard to the provision of dental services, it is of the utmost importance that the state dental boards vehemently and unrelentingly advocate quality care for all who reside within their jurisdiction.

State Dental Board's Role: Regulation

The state board's role is regulation. Policies of the state board are only one of many factors that impact public access to dental services. For the protection of the public state boards must maintain the integrity of their licensing and disciplinary processes. It is incumbent on state boards to have and enforce policies that adequately protect the public including policies that do not inappropriately hamper the efficient entry and distribution of qualified dental service providers. Public education, advocacy, development of socio-economic incentives, legislative education, and other peripheral activities in which they sometimes engage should directly relate to and support the board's regulatory role. Likewise, the state board's regulatory focus must not be distracted by pressure from special interest groups that distort access and workforce issues to advance their own political agenda. In the end state dental boards must insure that there is one standard of care for all its state residents. The quality of care should never be sacrificed in attempts to address access challenges.

Regulation at a State Level

Although some things to reduce access barriers can be initiated on a national level, consequential factors with regard to inequities in access to dental care are frequently unique, local characteristics--functions of the geography, economy, distribution, nature or education of an underserved population. These factors can be most efficiently and effectively addressed at a state or local level. State dental boards must understand dental care access problems in their jurisdictions and do all that they can to afford equitable access to dental services without compromising the quality of care.

Collaboration

To effectively address barriers to access to oral health care in their jurisdictions state dental boards must have intimate knowledge of the barriers underserved populations face and be prepared to work with communities of interest: patient advocates, consumers, community leaders, regulators, educators, legislators, federal and state government agencies, organized medical and dental communities, third-party reimbursement organizations, and others to remedy access deficiencies.

They must also actively participate in national, regional, and state forums that address access to care and regulatory issues in order to learn successful policies that might be implemented or modified for use in their own jurisdictions. They should be active participants, willing to share their experience and benefit from the experience of others, eager to standardize the definitions of professional practice, supervision, and other matters that facilitate regulation, understanding and, ultimately, improved access to oral health care for Americans.

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References

[1] Oral Health in America: a report of the surgeon general. Rockville, MD: National Institutes of Health, National Institute of Dental and Craniofacial Research, U.S. Department of Health and Human Services, 2000.

[2] American Dental Association Survey Center. 2000 survey of current issues in dentistry: dentists' participation in Medicaid. Chicago: American Dental Association 2000.

[3] 2003 American Dental Association Dental Workforce Model: 2001-2025. Chicago: American Dental Association, 2003.

[4] American Dental Association. Future of dentistry. Chicago: American Dental Association, Health Policy Resources Center, 2001.

[5] American Dental Education Association. Improving the oral health status of all Americans: roles and responsibilities of academic dental institutions. Report of the president's commission. Washington DC, March 2003.

[6] Institute of Medicine. Dental education at the crossroads: challenges and change. Field, MJ, ed. Washington, DC: National Academy Press, 1995.

[7] Division of Shortage Designation Bureau of Primary Health Care, HRSA. At: http://bphc.hrsa.gov/databases/newhpsa/newhpsa.cfm. Accessed November 26, 2002.

[8] Center for Health Workforce Studies. Healthcare employment projections: an analysis of Bureau of Labor Statistics occupational projections, 2000-2010. Rensselaer: University at Albany, State University of New York, School of Public Health, January 2002.

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