Guest Editorial

Our dental care system is stuck

And here is what to do about it

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In 1926, the work of William Gies[1] helped chart a new course for dentistry. I think we are approaching another "Gies" moment in which the dental community must face some hard facts and ask itself how effectively the current system is improving the oral health of the American public. In my view, the current dental care delivery and financing model will not drive significant, sustained improvements in oral health going forward like it did in the past, particularly for key segments of the population. We are stuck. And the changes needed to get unstuck are not tweaks, but major reforms.

Let us first look at some important trends. Dental care use is rising among low-income and minority children,[2] and racial and economic disparities are narrowing.[3] Dental care use among seniors is also on the rise. However, unlike for children, high-income seniors are driving this trend, meaning income disparities are actually widening. For adults (those aged 19-64 years) dental care use has been fairly flat for several years.[2] Cost is, by far, the top reason adults avoid going to the dentist.[4] But despite steady reductions in cost barriers to dental care for adults in recent years,[5] there has been no appreciable bounce back in utilization. Looking forward, demand for dental care among working-aged adults (the engine of the dental economy) will continue to be sluggish, especially for restorative care.[6,7] In my view, the dental sector is in a low-level equilibrium. We will not see major expansions in dental care use and sustained improvements in oral health in the coming years, especially among those with the highest needs, under the status quo model. The dental care system needs major reforms in 4 areas (Box).

We will not see major expansions in dental care use and sustained improvements in oral health in the coming years, especially among those with the highest needs, under the status quo model. The dental care system needs major reforms.

First, we need to address the dental coverage gap. Only 10% of US children lack dental coverage, a rate that has steadily declined for decades.[8] However, a significant share of adults and most seniors lack dental coverage. Affordability issues are, by far, the top reason adults and seniors do not visit a dentist. Despite its major shortcomings,[9] dental coverage still drives dental care use.[10] The idea that demand for dental care can be stimulated by simply convincing people that it is "worth it" or "it will save money in the long term" and that they should just spend more out of pocket is, in my view, a complete fantasy. The past 50 years have seen major expansions of health insurance, most recently because of the Affordable Care Act. This has dramatically changed the consumer mentality toward health care services, dental care included. The patient mentality tends to be that if it is not covered, it is less important. If US health policy treated comprehensive dental care as an essential health benefit, it would be covered by public programs such as Medicaid and Medicare and would be a core component of private health insurance. This would significantly increase demand for dental care.

Second, we need to define and systematically measure oral health in ways that are meaningful and relevant for both patients and providers—but mostly for patients. Providers, payers, and regulators are meticulous about measuring what is done to patients (for example, prophylaxis, radiographs,

This column represents the opinions of the author and not necessarily those of the American Dental Association.

Box. Reforms needed to drive major expansions in dental care use and meaningful, sustained improvements in oral health.

Address the Dental Coverage Gap	Consider dental care an essential health benefit for all age groups. Provide comprehensive dental coverage in public health insurance programs and as a core benefit in private health insurance coverage.
Define and Systematically Measure Oral Health	Define and systematically measure oral health in ways that are meaningful and relevant for both patients and providers, but mostly for patients. Measure what is done for patients, not just what is done to patients.
Tie Reimbursement, Partly, to Outcomes	Make some small portion of provider compensation dependent on oral health outcomes or, at a minimum, on some intermediate measures that influence outcomes and are more within the direct control of providers.
Reform the Care Delivery Model	Get dentistry out of its care delivery silo. Engage the rest of the health care system to nudge people into dental care. Rise above scope of practice turf wars fueled by fee-for-service payment.

root canal treatment) but not what is done for patients (for example, relieving pain, improving mouth function, lowering risk of caries). The health care train is steadily moving toward more of an outcomes focus,[11] and the dental profession is starting down this path, too. For example, the World Dental Federation recently adopted a new definition of oral health that takes the crucial step of incorporating physiological and psychosocial elements.[12] Specific measures for oral health are being developed by an international, multiple stakeholder group.[13] Such measures should be tracked at the individual patient level and at the population level.

Third, we need to reform reimbursement so that it rewards what is done *for* patients rather than what is done *to* them: a model that is a little more focused on paying for oral health outcomes and a little less focused on paying for dental care procedures. I am not suggesting we abandon the fee-for-service model entirely. We are nowhere near ready for that kind of leap. Rather, we need to make some small portion of provider compensation dependent on oral health outcomes. There are immense challenges to this, no doubt. We know that oral health is influenced by a host of factors as broad as social determinants (for example, what neighborhood you live in) and as narrow as specific patient behavior at home (for example, flossing). Outcomes-based reimbursement, therefore, puts providers on the hook for things they perceive as beyond their control. However, these challenges can be addressed.[11,14] For example, reimbursement can be adjusted for risk and can be based not just on oral health, which can be thought of as the final outcome, but also on intermediate measures (for example, sealant rates) that are more within the direct control of providers.

Fourth, we need to explore different care delivery models. Once reimbursement is tied to outcomes rather than to procedures, a whole different set of incentives comes into play for providers. The financial incentive becomes to produce the biggest improvements in oral health at the lowest cost. The turf wars concerning which providers can do what procedures, fueled by the fee-for-service model, start to dissipate. Instead of "What do I do?" providers start to ask "What am I part of?"[15] Providers would have stronger financial incentives for prevention. The care delivery model would adjust to move everybody to the top of their license. In addition, there would be stronger incentives to get dentistry out of its care delivery silo. If dental care providers are a bit more accountable for oral health status, all of a sudden it becomes vital to engage the

rest of the health care system to help nudge people into dental homes. Imagine physicians referring all of their patients with diabetes into dental homes. Now, imagine if every CVS did the same thing.

Make no mistake, I fully recognize that the action areas I have outlined are disruptive. This is not about tinkering around the edges; it is about systems change. However, I am convinced these changes are absolutely necessary if the goal is to get more dental care to more people, especially those with the highest needs, and to improve the oral health of the American public in a meaningful and long-lasting way. Some of the changes I have outlined are already under way in both the public[16] and private[17] sectors. The key question the dental community and health policy makers more broadly need to ask is this: who will lead the change? ■

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