COMMENTARY

Oral health advocacy – state-based and federal priorities

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Edelstein's excellent review (1) of the progress made over the past decade in enacting the federal legislation that incorporates support of various oral health programs appropriately focuses on national initiatives that can form the future foundation for state plans, policies, and programs. Edelstein argues that "before these authorizations and funding streams can reach advocates and states, they must be funded by Congress and implemented by federal agencies. For this reason, oral health advocates in the states need to add yet one more action step to their plans: encouraging Congress to prioritize and support the many oral health provisions it has already enacted" (1).

There is a clear need for national action to improve oral health. Recently, the US Government Accountability Office (GAO) reported that "in 2008 less than 37 percent of children in Medicaid received any dental services under that program and that several states reported rates of 30 percent or less" (2). This followed GAO reports a decade ago that highlighted the dire state of oral health in the United States (3,4). However, the contemporary climate for increasing federal expenditures for such initiatives is not favorable, despite the evident needs. Similarly, the opportunities for state-based fiscal initiatives are constrained despite increased demands. The Robert Wood Johnson Foundation, in its 2011 report (5) on the "State of the States – Laying the Foundation for Health Reform," identified two key environmental trends that directly impacted states' capacity to act. These were declining state revenues and a concomitant rising need for state-based health care coverage. The 2010 US census also noted increases in both numbers of uninsured and of those covered by government-financed health insurance.

Nevertheless, as the late US Congressman and Speaker of the House Thomas P. "Tip" O'Neill, Jr., said, "all politics is local" and truer words were likely never spoken. The potential for state-based efforts to again lead the nation remains high. It is useful to remember that the genesis of US national health care reform, culminating in the Patient Protection and Affordable Care Act (ACA) of 2010 (6), was a local state-based initiative enacted in 2006 in Massachusetts (7).

One may argue that over the next several years, in combination with efforts at the federal level, a high priority should be given to supporting state-based efforts at reforming the ways in which dental care is delivered and financed. First and foremost is the need for adequate federal support of evidence-based prevention programs which are essential to any sustainable long-term solution to oral health disparities in the United States (8). Related to this is the need for federal support for state-based pilot or demonstration programs of novel means by which to deliver both prevention and restorative services to vulnerable populations (9-12). New models of care delivery are an essential part of any solution.

In their analysis of the consequences of the Patient Protection and ACA of 2010, Kocher and Sahni (13) aptly note that the mandated increase in the numbers of "insured Americans will expand demand and the need for labor" in the healthcare workforce. However, if we retain the current structure of the workforce, "total health care costs will increase by $112 billion, or 13%. Therefore, to be successful, any effort to slow the rate of growth of health care spending will require a change to the labor structure." They identify as one option the common sense solution of "replacing current workers with lower-cost (less skilled or more narrowly skilled) workers who can produce the same output." They suggest that we "we will need to redesign the care delivery model much more fundamentally to use a different quantity and mix of workers engaging in a much higher value set of activities." They also recognize that "a large obstacle to such a wholesale redesign is the complexity of the federal and state reimbursement rules and requirements for scope of practice [and] licensure." These opportunities and challenges are the same as we face in efforts to address disparities in oral health (14). It is clear that

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new dental workforce models, and related reforms in the delivery of oral health services, are needed in order to achieve equity in health care access and to eliminate oral health disparities (9-12). With appropriate federal support, a number of states are now ideally positioned to act to implement innovative programs to produce new types of dental practitioners, including the so-called "mid-level providers."

Conflict of interest

The author has declared no conflict of interest.

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COMMENTARY

Federal support for oral health care: the long view

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Public programs related to oral health generally have two broad aims: minimizing the impact of oral diseases on the population, and reducing barriers that limit access to basic or primary oral health care services. Examples of the former include water fluoridation, public health education, and programs that provide preventive services in community or school-based settings. Examples of the latter include various health professions education programs, the National Health Service Corps, the Indian Health Service, support for community health centers and programs that provide coverage for oral health care services, most notably Medicaid and the Children's Health Insurance Program (CHIP).

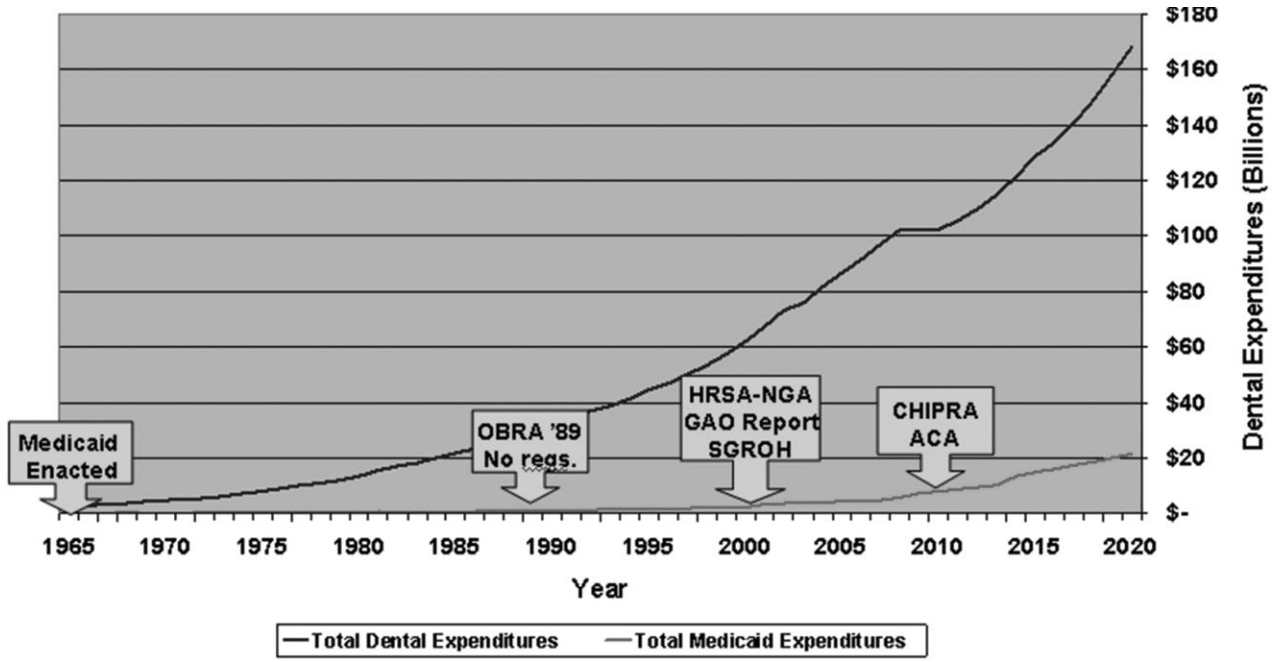

Figure 1 Medicaid versus total dental expenditures: 1965-2020 (expenditure levels beyond 2010 are projections).

Federal support for oral health care in the United States has largely been focused on children and has had a rather checkered, erratic history. As Figure 1 shows, the enactment of federal Medicaid legislation in 1965 was followed by a period of relatively little activity on the part of the states in terms of program implementation. Additional federal legislation (Omnibus Reconciliation Act of 1989) provided a new impetus for state action and policies that clarified that children on Medicaid are supposed to receive dental services consistent with what today is referred to as a dental home. Corresponding regulations were not forthcoming however; and another 7 years passed before a Department of Health & Human Services (DHHS) Office of the Inspector General report, noting that fewer than one in five Medicaid children were receiving any dental services, served to catalyze action in the form of an Oral Health Initiative mounted by the Health Resources & Services Administration (HRSA) and Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (CMS). Concerted, collaborative action on the part of several federal DHHS agencies provided support for states to engage in oral health policy academies convened by the National Governors Association and helped raise awareness of the magnitude and impact of oral health disparities via multiple activities organized by the US Surgeon General.

Nevertheless, progress and resources were slow in coming throughout the 1990s, highlighting a critical aspect of US health care program policy implementation – i.e., the controlling influence that states exercise in decisions that govern resource allocations and program administration in jointly funded federal-state programs such as Medicaid and CHIP. The result has been the noted checkered history, whereby many states have taken strategic actions that have resulted in substantial increases in the use of dental services by Medicaid children, even during the challenging economic times of the past decade, while other states have failed to make progress.

All of which brings us to the current nexus in US health care history, wherein the implementation of major federal health care legislation (some of which remains controversial) is underway within the context of a stalled and uncertain national economy, deeply divided federal and state politics, and growing pressures to curtail spending on public programs, including health care. In light of these circumstances, history would seem to hold some important lessons with respect to the need for and benefits of renewed federal-state collaborations and persistent commitments on the part of key stakeholders to devising and carrying out prioritized strategies that experience has shown to be effective and well suited for the diverse challenges of individual states.

Conflict of interest

The author declares no conflict of interest.