COMMENTARY

Reaction to "Oral Epidemiological Trends in Maryland"

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The paper by Vargas *et al*. describes trends in oral health in Maryland over the past 10 years, illustrating Maryland's considerable progress in improving oral health for children covered by Medicaid (1). Some of the factors identified that impact children's oral health included the following:

- Strong dental and dental hygiene workforce.
- Death of 12-year-old Deamonte Driver because of a dentally related infection.
- Strong water fluoridation program statewide.
- Doubling of the percentage of Medicaid enrolled children under 21 years of age.
- Physician's participation in providing oral health preventive service.
- Increase in school-based sealant program resulting in a doubling of the percentage of Maryland children with sealants.

The net result of these factors, as well as others, has been positive for the oral health of Maryland's children. In addition, over the past 10 years, Maryland has also seen modest reductions in edentulism and age-adjusted oral cancer incidence and mortality. While this is all good news, the findings of Vargas *et al*. also illustrate the oral health chasm that still exists in Maryland and, indeed, throughout the nation (1). The "chasm" issues include the apparent continuing disparities in oral health, which are largely related to geography, income, socioeconomic-ethnic status, and oral health literacy. While the caries experience in children declined over a 10-year period, there still remains a gap of 25-30 percent untreated caries, which is close to the national average. From this author's perspective, the benchmark comparison of Health People 2020's objective of 25.9 percent of 6- to 9-year-olds with untreated caries is appropriate but, simply stated, the benchmark itself is too low, given the resources in the nation and the amount of money spent on health care.

The paper demonstrated Maryland's commitment to preventive care and their willingness to use the eight benchmarks created by the Pew Center for the States. However, the data reveal that the percentage of children with a preventive visit and who received dental treatment in 2009 still ranks below the national average. The lack of a statewide sealant program is a further illustration of the gap in prevention that continues. So, although Maryland has achieved success in reducing caries in children, it has probably reached a steady state until prevention becomes more widespread and the diagnostic coding and reimbursement system rewards the oral health workforce for preventive services and for rewarding improvements in health outcomes rather than paying for procedures.

The unsettled state of the US economy and the resultant reductions in funding for Medicaid across many states suggests an increase in oral and systemic chronic disease problems in the future. A recent report in the *New York Times* demonstrated that more places are "defluoridating" water supplies to save money (2)! How can that be helpful?

Vargas *et al*. also point out that the poverty index has been increasing, thus putting more individuals with declining incomes into the Medicaid-eligible category. Indeed, at the national level, recent studies on The Pine Ridge Reservation in South Dakota demonstrated that 90 percent of adults and children had active decay and about half were missing teeth (3). Batliner points out that in the Pine Ridge community oral diseases are rampant and access to care is a "cruel joke" (2,4). The call by Batliner and others is to rethink the make up of the oral health workforce to include a midlevel provider (dental therapist) (2-6). There is considerable discussion of this issue as the most appropriate comprehensive means to address the oral health-care access problem.

This author's reaction to the data of Vargas *et al*. is to compliment Maryland on its proactive status as it moves forward with health-care reform and health exchange to include dental. At the same time, there remains disappointment in how far Maryland and the nation needs to go to truly improve access to quality oral health care and to reduce the burden of disease. The data show that Maryland can be recognized as a leader at a pivotal time in the nation's commitment to the

elimination of disparities, which improve access to care and for demonstrating the power of a committed coalition aimed at improving the oral and systemic health of its citizens.

Conflict of interest

The author declares no conflict of interest.

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Good oral health and a system that supports it have never been more important

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In the pediatric age group, dental decay is now considered an epidemic by many in the field. This is critical when one considers the educational and sociodevelopmental effects of untreated caries on an individual child. These effects can include poor academic performance due to inability to concentrate because of dental pain – through limited social connections because of low–self esteem due to appearance. In adults, the consequences of unmet dental needs can have significant negative economic consequences. Edentulism and unesthetic dentition can exclude individuals from certain sectors of the labor force.

The advancements in oral health Maryland has realized in the past 10 years have been significant, but I would argue have not been enough.

We need more dentists and other oral health professionals – plain and simple. Furthermore, we need more of these professionals to provide services to Medicaid populations. The work the Baltimore City Health Department is currently engaged in revolves around addressing social determinants of health, and where we live, work, learn, and play have as a significant role to play in keeping us healthy as they do in making us sick. Lack of access to dental care because there are no dentists in one's geographic area is a problem that is solvable. Though admittedly controversial when it has been considered in other states such as Minnesota, perhaps the time has come to examine and expand the scope of practice for the spectrum of dental health professionals as a way to expand access to oral health care.

The Vargas paper reports that "according to data from the Behavioral Risk Factor Surveillance System, the percentage of Maryland adults reporting a dental visit in the past year did not change between 2002 and 2010 (76 and 75.5 percent, respectively)." That is not surprising as very little if anything has been done to change the financing of dental services. A dental benefit within a third party payment system, whether public or private, is essential if greater access is to be realized by children, adults, and the elderly. It is not enough to say that we need more dental health professionals; clearly, we need to compensate them accordingly. Additionally, the system for compensation must be one that incentivizes evidence-based preventive and diagnostic outpatient services.

Another component in the spectrum of dental health services is public health education. In addition to continuing to stress the importance of regular brushing, more attention needs to be given to the transmission of cariogenic bacteria from adults to infants. It is distressing to know that "Medicaid coverage for oral health for pregnant women was reduced from 6 weeks postpartum to the day of the birth."

Lastly, and perhaps most importantly, is public health disease prevention. Maryland is to be applauded for exceeding

the Healthy People 2020 goal for water fluoridation, 99.8 percent versus 79.6 percent, respectively. This should not be taken for granted because in these difficult economic times some localities in other parts of the country are looking to eliminate fluoride in the water supply as a cost saving measure.[1] Fluoridating public water supplies has been a major public health advance that must be continued.

[1] Looking to Save Money, More Places Decide to Stop Fluoridating the Water, New York Times http://www.nytimes.com/2011/10/14/us/more-places-change-course-on-fluoride-in-water.html?_r=1 Last accessed 10/14/11.

Though much remains to be done to improve the dental health of all Marylanders, it is clear from the advances made in the last decade that substantive changes with resultant positive health outcomes are possible when resources are aligned. I look forward to the next 10 years of continuing positive outcomes.

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