Politics of Dental Health Care

Every few years in the United States, we see attention being paid to health care, specifically the funding of health care. It is a predictable, recurrent event that gives politicians something to discuss, oftentimes with the level of rancor that, at least to this outside observer, seems almost juvenile. Since there is no one approach that provides consistently excellent health care to every member of society while considering factors such as costs, ethics, access, and quality, there will always be opportunities for debate. Indeed, the consistent inability to create the perfect health care system, whether this would be in the United States or in any other country, ensures that this topic will provide fertile ground for ongoing talks. What more could politicians desire?

There is one discussion, however, that never appears to gain traction regardless of the political party that is driving the debate. That topic is dental care as a critical component of overall care. Despite the general appreciation that oral health is important for patient well-being, dental care seems to consistently be ignored in health care debates.

There are a number of reasons for the exclusion of dental care from the health care debate, but what remains unclear is how the situation developed and how it could ever be changed. The problem develops from the way that dentistry addresses group or private dental insurance. Dental insurance policies generally have a very clearly defined maximum annual benefit. That annual benefit limits the amount of reimbursable care that can be provided on an annual basis. Obviously, any patient who wishes to self-fund dental care has the opportunity to do so at whatever level that they find acceptable. However, most of the practitioners that I know recognize that there is frequently a desire on the part of the patient to limit their out-of-pocket expenses.

Third-party dental coverage is very effective at providing reimbursement for preventive care. It is also effective at providing funds for patients who have minimal dental restorative needs. The existence of the annual maximum benefit limits the protective capacity of dental insurance, providing little benefit for the patient with extensive dental disease. In essence, dental insurance works well for the patient who is doing well or for the patient who has undergone reconstructive care and wishes to maintain their dental health from that point forward, but it fails to assist, in a meaningful way, patients who find themselves at the brink of dental disaster. The dissenting opinion that dental disease is preventable often comes across as a punitive comment.

Patients who seek dental insurance to assist them in funding reconstruction following advanced disease or catastrophic events that have resulted in severe dental disabilities are usually quite disappointed by the benefits that they receive from the insurance. It is interesting that dental insurance is dramatically different from most insurance. When we think about other forms of insurance that we use in our lives, the insurance is there to protect against catastrophic events that could wreak havoc for an individual. This occurs with homeowners insurance, automobile insurance, and, yes, medical insurance, because these insurance policies, although having limits, set the limits at much higher levels.

Thinking back to the political debates, it would be hard to imagine anyone standing before the Congress arguing in favor of medical insurance that would limit the annual benefit for any organ system to a few thousand dollars. Such a politician would have to be delivering the speech and thinking about their exit strategy, because their future in Congress would be quite limited with such an approach.

It is interesting when you think about the way that most insurance works. Except for dental insurance, every other insurance benefit that I can think of depends upon the establishment of a diagnosis. Although we might not use the term "diagnosis" when describing a roof that has been destroyed by a tornado or for the identification of damage to an automobile after a motor vehicle accident, both of those examples are evaluated by "appraisers" before any final settlements are established. In medicine, the medical appraiser identifies a diagnosis for the medical condition that the patient experiences, and the treatment that is provided is dependent upon the diagnosis rather than the procedure that is performed to address the diagnosis.

In medical practice, there are diagnostic-related groups (DRGs) that are reimbursed based upon the level of severity of the specific diagnosis. In dentistry, we do the exact opposite. Dental fees are established on a procedural basis, and there is very little regard for the level of complexity associated with the specific diagnosis. Certainly, we all realize that there are variable levels of complexity for every procedure that we perform. The factors that create these levels of complexity may be related to the extent of disease, the anatomical location of the disease process, and

doi: 10.11607/jomi.2017.3.e

the level of cooperation on the part of the patient, to name but a few of the complicating factors. In many instances, there is additional variability derived from the level of anxiety of the patient that can increase complexity of treatment by many multiples.

Perhaps the last question relates to the desire on the part of dentistry to be appreciated as a vital component of the health care delivery system. To its credit, dentistry has maintained costs for services quite well over the years. Whereas the cost of medical care has skyrocketed, the cost of dental care has increased at a much more controlled rate. Of course, part of that may be because the technology in dentistry has been relatively well controlled. However, technology is definitely moving into the dental practice in areas that we might not have predicted just a few decades ago. The equipment acquisition costs for three-dimensional imaging, digital workflow, and laser therapy multiply the cost of the traditional two-chair dental office manyfold. Couple this with the understanding that technology alone is of little use without the well-educated clinician who can apply that technology and the further understanding that this technology is changing so rapidly that the educational expenses to maintain expertise will continue to grow in the future.

My interpretation is that organized dentistry, particularly groups such as the ADA, FDI, and WHO, are very committed to ensuring the quality of dental care for society. Although I think that these organizations appropriately consider dental professionals as critical contributors to overall health, I also think that there are many clinicians who would work hard to maintain the current approach of self-determination of dental care.

Maybe my initial statements about politicians were a little too caustic. The topics that we can raise in this discussion are numerous and remain intellectually stimulating. Before I get started on a discussion of neuroplasticity, it might be enough to just observe the health care debates over the upcoming months while appreciating that our profession contributes much to health care and should be part of the debate.

Steven E. Eckert, DDS, MS
Editor-in-Chief