FROM THE EDITOR-IN-CHIEF

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Oral Health
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If one theme stands out in the collection of oral health papers that appear in this month’s issue of Health Affairs, it is that the divide between dental care and medical care is vast, has significant consequences for patients, and is entirely of our own making. Like so many health care challenges, naming it is a useful first step, but much more is required to generate change on the scale that is needed.

Elizabeth Mertz describes the many aspects of the dental-medical divide, from dental care’s separate education system and workforce, through financing and delivery, to research and quality measurement. Mertz views the isolation of dentistry as one of the root causes of the signal failure of the oral health enterprise, noting, “Adequate oral health is one of the largest unmet health needs in the United States—in fact, the largest unmet need among children—with significant disparities by socioeconomic status and race/ethnicity.”

The financial consequences of the divide for patients are made clear by Marko Vujicic and colleagues, who analyze survey data in which respondents reported the cost barriers they faced when seeking care. The authors find that not only are rates of forgoing care for cost reasons higher for dental care than for any other health care, but those results hold among people who report having both health insurance and dental insurance. Gayathri Subramanian provides a vivid narrative description of the consequences for a patient at University Hospital, in Newark, New Jersey.

The dental-medical divide is enshrined in Medicare law, creating significant cost barriers for elders seeking dental care. Amber Willink and colleagues find that only 12 percent of Medicare beneficiaries reported having dental insurance and that fewer than half of them had a dental visit in the past twelve months, with that rate falling to about one-quarter for those with incomes below the federal poverty level. The authors describe and model two policies designed to extend dental benefits to Medicare enrollees.

ORAL HEALTH WORKFORCE

While there may be a dental-medical divide, one thing dentistry and medicine have in common is disputes over different professionals’ appropriate scope of practice. Rating states according to the degree to which dental hygienists can practice autonomously, Margaret Langelier and colleagues find an overall increase in dental hygienists’ scope of practice between 2001 and 2014. The authors also find a positive correlation between a state’s more autonomous scope of practice and the oral health of that state’s adult population. Jane Koppelman and colleagues chronicle the dental therapy movement. From its origins in New Zealand in 1923, this approach to filling gaps in access to dental care has spread around the world, although the United States is decades behind other countries.

Federally qualified health centers (FQHCs) provide medical services to more than twenty million Americans each year—primarily the indigent, the uninsured, and those with Medicaid coverage. FQHCs are a natural place to link people to dental care, but as James Crall and colleagues point out, most centers do not provide dental services, leading to just one out of five center patients receiving dental care. The authors describe an initiative in Los Angeles County designed to increase the provision of dental care services within FQHCs, and they explain the various types of support that were provided to make this expansion of access to dental care possible.

POPULATION HEALTH

Many oral health needs can be met through population health interventions, thereby avoiding some of the provider supply and distribution challenges that have proved so difficult to overcome. Joan O’Connell and colleagues update fifteen-year-old estimates of the cost-effectiveness of community water fluoridation. While 73 percent of Americans living in communities with populations greater than 1,000 people have access to fluoridated water, the remaining 27 percent—seventy-eight million people—lack such access. The authors find that although the specific costs and benefits vary by community, the overall return on investment for fluoridation is twenty to one. Susan Griffin and colleagues analyze the benefits of school-based dental sealant programs, in which students’ molars are treated to prevent cavities. The authors find that these programs save money and improve the quality of life for children by averting the future need for fillings and the consequences of toothaches.

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