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HEALTH POLICY PERSPECTIVES

Solving dentistry's 'busyness' problem

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Dentistry has a busyness problem. As numerous analyses from the ADA Health Policy Institute show, the percentage of dentists who report they are not busy enough and can see more patients has been rising steadily for approximately a decade.[1] Nationally, approximately 1 of 3 dentists say they are not busy enough. This varies widely by state (1 of 2 in Florida compared with 1 of 20 in North Dakota[2]) and by practice characteristics—dentists who accept Medicaid tend to be much busier than those who do not.[3] Confirming this trend, appointment wait times have decreased steadily and dentist earnings are stagnating.[4]

The underlying drivers of dentistry's busyness problem are rooted in basic economics. Dental care utilization patterns have shifted dramatically. Namely, the percentage of working-age adults who visit the dentist within a 12-month period has been declining for more than a decade.[5] In contrast, dental care utilization among children and seniors has risen. But these increases do not compensate for the decline in dental care use among working-age adults, and the total number of dental visits per year in the United States is actually declining.[6] Coupled with the fact that total inflation-adjusted dental spending has been flat for several years,[7] it is clear that the demand side of dentistry is slumping.

On the supply side, the number of dentists has increased steadily since the mid-2000s. In 2013, there were 60.5 professionally active dentists per 100,000 population compared with 58.0 in 2005.[8] It does not take a PhD in economics to know that combining stagnating demand for dental care with a rising supply of dentists equates, in aggregate, to a busyness problem.

From my perspective,[6] there is nothing on the short-term horizon that will reverse the trends of declining dental care use among working-age adults and a rising supply of dentists. If anything, the coming years will see an acceleration of these aggregate trends with some important twists. For example, demand for dental care among Medicaid adults could expand significantly as a result of Medicaid expansion under the Affordable Care Act (ACA). The potential coverage expansion is significant, with up to 8.3 million adults gaining some form of dental benefits coverage through Medicaid.[9] Of course, coverage does not equal access to care and translating increased dental benefits coverage into increased access to care will require significant Medicaid reform in many states.[10] At this time, it is unclear whether these reforms will happen. In addition, due to population aging, demand for dental care among older patients will increase[11] as will demand among children due to the pediatric dental essential health benefit created through the ACA.[12] But the core engine of the dental economy—middle- and upper-income adults with private dental benefits—will likely see continued sluggishness for years to come unless something significant occurs to change dental-care seeking behavior.

In a nutshell, dentistry's busyness problem will not go away on its own any time soon. So what are some "big picture" ideas to explore that might address it?

Here again, basic economics helps. There are supply-side and demand-side responses. On the supply side, there is an urgent need to consider 2 issues. First, if trends in demand for dental care continue, does the United States need more dentists? Second, do tomorrow's dentists understand, and are they being trained for, the shifting patient mix? Fishing where the fish are usually gets you more fish, but it often entails moving the boat. Sometimes it entails completely abandoning the boat, donning the waders, and getting chest deep in the cold river.

Addressing dentistry's busyness problem through the demand side entails increasing the perceived value of a dental visit among key stakeholders. One key stakeholder is the person who decides whether or not to visit a dentist. A second is the employer, who decides on the type of dental benefits to provide to employees. A third is the collective

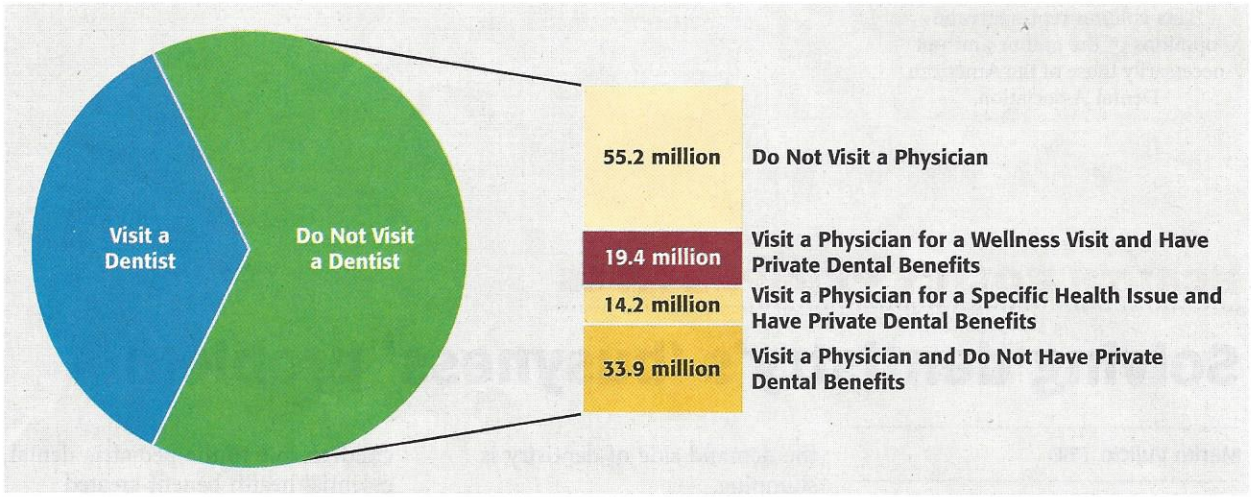

Figure. Breakdown of the US adult population (aged 19-64 years) by whether they visit a dentist or physician during the year and whether they have dental benefits. *Source: Agency for Healthcare Research and Quality.*[17]

government agencies who decide on dental benefits coverage in public programs such as Medicare and Medicaid and, in the case of the ACA, whether dental care is "essential." A fourth is what I call potential sources of referrals (or PSRs) within the health care system. A PSR is a health care provider that can potentially refer patients into a dental home if they do not have one.

The perceived value of a dental visit in the eyes of these 4 stakeholders is, in turn, driven by 1 simple relationship: the perceived cost of dental care compared with the perceived benefit. This value equation is critical in driving stakeholder behavior. For example, adults are increasingly reporting that they delay or avoid needed dental care because of cost.[13] Cost is the number 1 reason adults report not intending to visit a dentist. The number 2 reason is lack of perceived need. The empirical evidence suggests strongly that adults' "value equation" for a dental visit has probably tilted significantly (negatively) during the past decade.[14]

For employers, it is unclear how the value equation is changing. Employers consistently report that dental coverage is one of the most highly valued benefits among employees.[15] Yet, at the same time, the percentage of adults in the United States covered by private dental benefits has been falling steadily, at least through 2012, the most recent year reliable data are available.[16]

The federal government has a fairly clear position on the value of dental care for adults: it is not essential. Dental benefits are not required within Medicare or Medicaid and they are not part of the essential health benefits package under the ACA. Dental care for children, on the other hand, is treated differently. Coverage has long been mandated under Medicaid and the Children's Health Insurance Program and is one of the 10 essential benefits under the ACA.

PSRs are incredibly important. The figure illustrates an example of what might happen if the value proposition of a dental visit were to change in the eyes of, for example, physicians. There are 19.4 million adults in the United States with private dental benefits who do not visit a dentist in a 12-month period but see a physician for a wellness visit. Imagine if conversations around oral health and a dental home were part of the wellness visit and physicians could nudge patients to go visit a dentist. This nudging could take many forms, from "you should try to visit a dentist" to "my practice is affiliated with a large dental group, my front office staff can check which locations accept your dental plan, and we would be happy to go ahead and schedule an appointment for you." If just one-half of those 19.4 million adults were to actually visit a dentist, this would average out to approximately 50 new patients per practicing dentist in the United States. Would this solve the busyness problem? Probably not, but it certainly would help. It would undoubtedly improve the patient's health as well. One could think of other PSRs, such as a CVS Minute Clinic, a hospital emergency department or an endocrinologist group. All of these PSRs provide opportunities for collaboration that could result in increased patient volume in dental practices.

We are in a time of transformational change in health care.[18] Tremendous opportunities for enhanced collaboration among health care providers exist, and dentists have a chance to fundamentally rethink their role within the health care system. Taking advantage of

these new opportunities would not only help peck away at dentistry's busyness problem but would also allow dentists to contribute much more significantly to whole-body health. ■

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