

Back to the future

For dentists who suffered through the less-than-professionally-satisfying times of the 1970s and 1980s, the recent decade of prosperity has just started to remove the bad memories of the 'oversupply' days.

Most JADA readers were still in high school when President Lyndon Johnson launched his "War on Poverty." Designed to cure the country's social ills, the program included a goal of improving access to health care. Dentistry, believed to have a serious shortage of personnel, was spotlighted as a profession needing extensive financial assistance to achieve the nation's health goals.

What followed was a massive influx of federal funds for dental education. New dental schools were built. Existing schools were renovated. Curricula were shortened to allow for early graduation.

The results: too many dental personnel for a delivery system that would be adversely affected by two economic recessions, miscalculated predictions of U.S. population increases and a failure to account for the impact of fluoride on dental needs.

It took years for the dental marketplace to recover from these ill-conceived presidential initiatives. For dentists who suffered through those less-than-professionally-satisfying times, the recent decade of prosperity has just started to remove the bad memories of the "oversupply" days.

EDITORIAL

Now, almost a half-century later, voices are being raised to say that we may again have a shortage of dental personnel. Gear up the institutions and increase dental class size, some insist. Lack of access to dental care is a national problem, and national solutions are necessary, say others.

Whether valid or not, such phrases recall a past filled with well-intentioned but misdirected initiatives.

Let's examine the present situation. The U.S. surgeon general's report "Oral Health in America," while acknowledging dramatic improvements in oral health over the last 50 years, notes "profound" health disparities mainly among those "without the knowledge and resources to achieve good oral care." Specifically mentioned in the report were poor Americans—especially children—the elderly, members of various racial and ethnic groups, and those with disabilities and complex health conditions.

Would enlarging the pool of dental practitioners necessarily improve the health status for these populations? Probably not.

For example, the lack of access to dental care for Medicaid patients most often is a remuneration issue, which will not be

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solved by simply increasing the number of dentists. Regardless of how many dentists are serving a community, a system that asks them to deliver care at rates that are lower than their costs cannot be sustained. When the cost barrier is obviated, access improves, often dramatically.

In Michigan, for example, the state's Children's Health Insurance Program converted its Medicaid program to a private administration that paid the dentists' usual and customary fees. The result: a 50 percent increase in the number of children receiving care.

Even adequate compensation, however, often will not be enough to eliminate disparities in oral health status. Last month's JADA cover story demonstrated that even with a

universal, publicly financed dental insurance care program for children, oral health disparities among specific children's groups still remain.

Improving access to dental services entails more than educating more dentists or even offering a just payment system. Access involves complex interactions, often requiring the attention of the social scientist as well as of the health care professional.

Still, some opinion leaders insist there should be an immediate increase in the number of dentists. In addition to anecdotal reports of shortages, they point to work-force models that purportedly show more dentists leaving than entering the profession over the next two decades. They predict more early retirements and an in-

crease in the number of part-time dental workers set against an overall rise in U.S. population. Within these observations, they see the potential for a major dentist/population imbalance.

Is this the time for preemptive action? Should dental schools be encouraged to increase their class sizes? I think not.

Remember the overproduction of dentists that occurred in the 1970s and 1980s. We learned from that period that the complex variables affecting the demand for dental care and dental personnel are exceedingly difficult to understand. While the prediction process has been refined over the years, few would assert that today's estimates will prove correct. Unfortunately, false prophecies that

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cause us to produce more dentists can become a 35-year mistake spread across the entire profession.

In 1977,¹ I published an opinion piece titled, "Too Many Dentists? If So, What Then?" At that time, dental care system "improvements" driven by LBJ's "War on Poverty" were starting to show some obvious cracks.

Acknowledging the difficulty of predicting dental personnel needs, I proposed a system that expands or contracts by alter-

ing the number and duties of auxiliaries, not by increasing the numbers of dentists. Auxiliaries would be provided with continuing education programs that offer upward mobility, skill enhancement and retraining as cost-effective components of the delivery system.

For more than two decades, I have persisted in promoting this concept, firmly believing that it displays an inherent flexibility capable of responding quickly to changes in consumer demand. While minimizing the

chance of a dentist oversupply, the model is responsive to the professional needs of the dental team member, offering a meaningful opportunity for professional advancement.

I've heard it said that a profession that ignores its past has no future. That's a bit strong. Rather, focusing on the issue of the dental work force, I would say that a profession that ignores its past fails to secure its future. •