

Access to Care: An International Perspective

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Overview

- Assume you know the U.S. situation,
But help frame that understanding
- What can we learn from other countries?
- Access to oral health is not totally dependent on dental care, but dental care should make a difference.
- Prompt questions and discussion

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- Stephen Birch, DPhil & Rob Anderson, PhD
J Canadian Dental Association, April 2005
- <http://individual.utoronto.ca/accessandcare/index.html>

U.S. Picture in a Nutshell

(Bailit and Beazoglou, 2002)

- Access to services is determined by willingness and ability to pay.
- Little public funding; level is not increasing substantially.
- Provision dominated by private providers and private funding.
- Public funding alone does not guarantee access and services.

Cost, Not Access, Is Driving Health Policy

- Dental expenditures are growing faster than GDP.
- BUT, over past 40 years dental % of total HC expenditures is declining (7.5% to <5%), and public share is low.
- Result is less attention from policymakers and researchers as a problem to address.
- YET distinctions aren't made in the "solutions",
- Leading to Medicaid cuts, even when all data indicate inadequate spending for dental Medicaid.

Oral Health Status Has Never Been Better

- Prevalence of decay and DMFT in permanent teeth are lower in every age group.
- # of teeth are higher and prevalence of edentulousness is lower in every age group.
- Expectations are also higher
 - ❖ Only 1 in 12 children 6-19 y.o. >200% FPL has any untreated decay.
 - ❖ We notice if the 1 in 5 lower income kids who do have untreated decay have difficulty accessing care.

Increasing Recognition

- Oral health care is

 - Costly to society

 - Unaffordable and unattainable for many

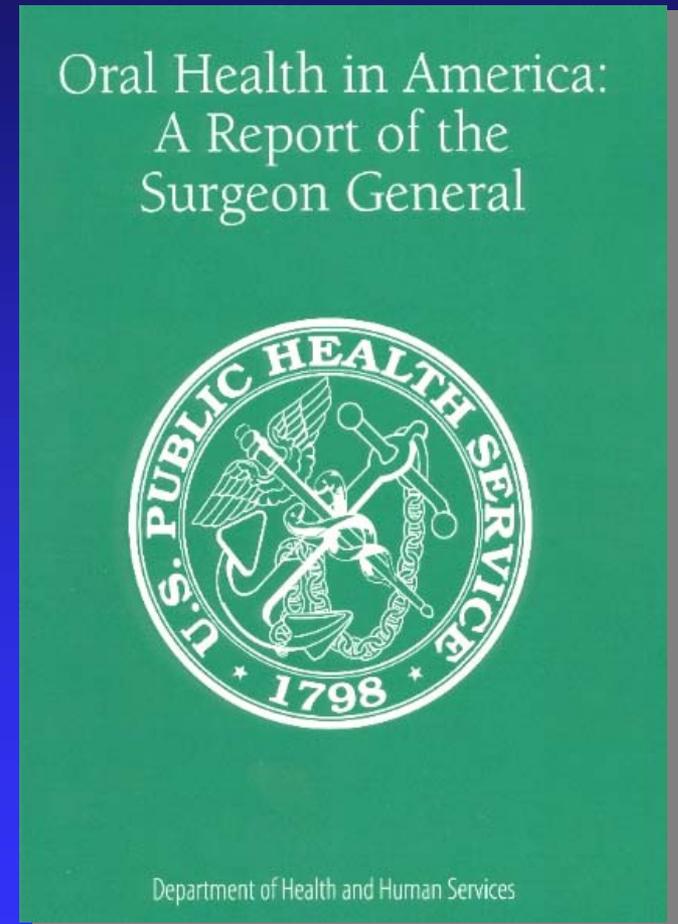
- Poor oral health

 - Undermines educational attainment

 - Compromises economic independence and social mobility

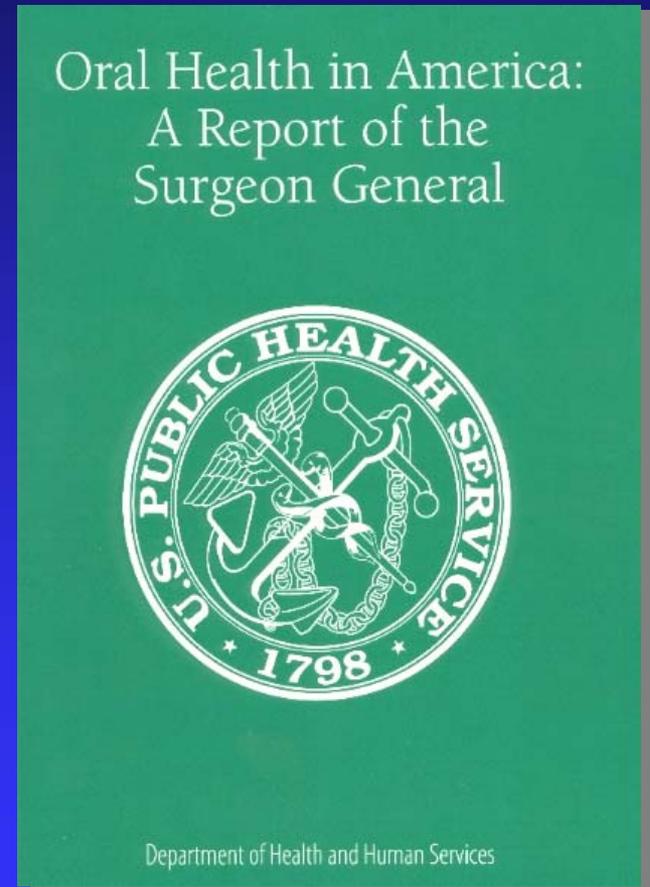
The Surgeon General's Report affirmed the importance of oral health

“Oral health is essential to the general health and well-being of all Americans... improved oral health can be achieved by all Americans...”



The Surgeon General's Report provides the nation with an alert

“Great progress has been made in reducing the extent and severity of common oral diseases ...however, not everyone is experiencing the same degree of improvement.”



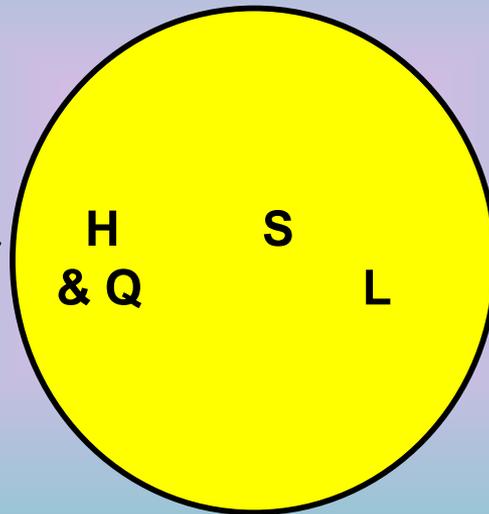
Important Themes of SGROH

- Available preventive measures are not uniformly applied
- Oral health is a societal responsibility
 - ❖ Variation in support of collective action to reduce inequalities
- Many sectors of society have a role in improving oral health

CULTURE



Biological Factors
Early Life Experiences
Individual Risk Factors
Personal Factors
Comorbid Diseases
Health Behaviors



H **S**
& Q **L**



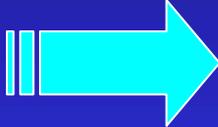
Health System
Health Providers
Health Policies
Social Factors

ENVIRONMENT

ICS-I Key Findings

- ❖ oral health status was apparently not related to availability and accessibility of services
- ❖ school-based systems effective in childhood, but didn't demonstrate long-term impact on adults
- ❖ primary barrier to receiving dental care appeared to be perceived lack of need and acceptability of services
- ❖ individual behaviors and preventive orientation of professionals may be most important determinants of oral health status

Shifting Emphasis

Treatment  Prevention

Cycle of Increasing Expectations



Prevention

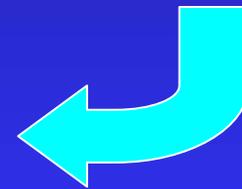


Demand for
Prevention

Improved Oral
Health



Higher
Expectations



Social, Economic And Cultural Variations

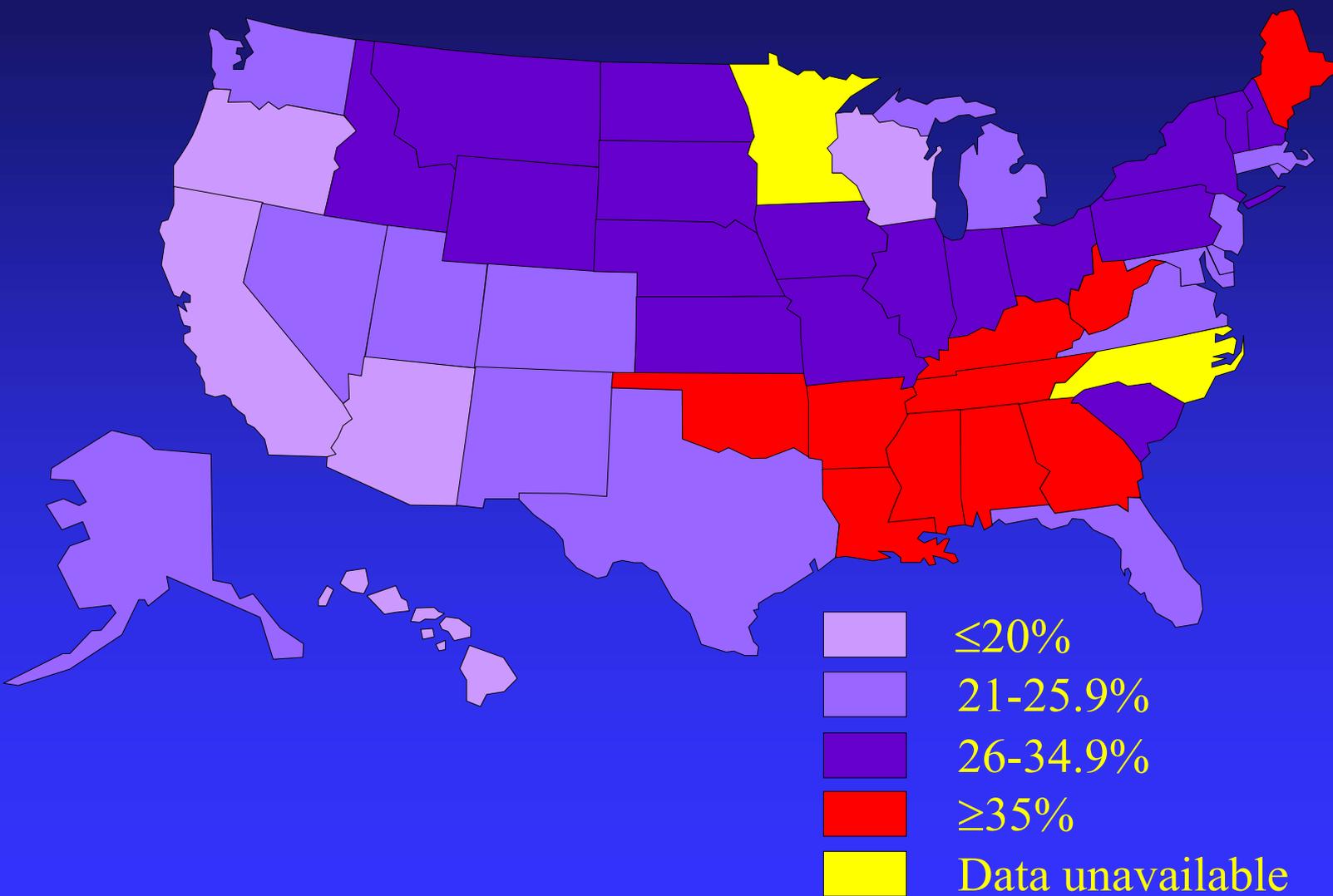
Experiences and expectations:

“Adults in northern England are 2 X as likely to have no natural teeth as those in the south.”

Conversely, adults in the south of England are only half as likely to have no natural teeth as those in the north.

How does this compare to the U.S.?

Behavioral Risk Factor Surveillance System (BRFSS), 1999



ICS-II USA Sites



Aggregate data do not provide information on the distribution of expenditures, services, and needs among various groups of the population

Non-U.S. Sites

- Erfurt, Germany
- Yamanashi, Japan
- New Zealand
- Lodz, Poland

Select Findings from ICS II

- Baltimore adolescents had lowest DMFT and second lowest number of decayed teeth.
- Personal characteristics, such as perceptions and behaviors, often fail to explain many of the variations in individuals' oral health outcomes.
- Organization and delivery of dental care systems are related to utilization.

Select Findings from ICS II

- In most settings, a usual source of care is critical to promoting regular access to OH services.
 - ❖ BUT this was not associated with better health status in children, or better periodontal status of adults, consistently.
- Availability and ability of dental care providers to provide, and reimbursement system to encourage, effective and appropriate services probably matters.

Publicly Funded vs Publicly Provided: No Easy Solutions

School dental services

- Constrained by resources as much as practice-based systems
 - ❖ Response is targeting
 - ❖ Which individuals are NOT targeted (denied care)?
 - ❖ Does it make a difference?
- Informed consent (evolving medical-legal and ethical standards)
 - ❖ Poorer and non-English speakers are less likely to receive care.

Publically Funded vs Publically Provided: No Easy Solutions

Community health centers

- Even NHS dentists in UK choose practice setting
 - ❖ 3 fold variation in dentists per capita
- Establish targeted, culturally appropriate centers
- Parallel to US community health centers
 - ❖ Popular with administration/Congress
 - ❖ Less so with organized dentistry
 - ❖ Safety net or pressure release valve?

Per Capita Spending vs % Publically Funded

- U.S. per capita spending exceeds UK or Australia per capita spending by at least 50%
- % publicly funded in Australia is 3 times higher than U.S., and it is even higher in the UK
- UK reform can be government driven
- US “reform” is “tinkering at the margins”

Distribution of the Public Subsidy

(Spencer 2001)

- Low % public funding conceals substantial public subsidization of dental care
- tax rebate = health benefit exemption = tax expenditure
- Tax rebates = 2X public funds spend for eligible adults
- Value of subsidy depends on marginal tax rate
 - ❖ \$14 per capita low income, \$60+ per capita high income
- Public funds that could be used to address access problems are inadvertently (?) being distributed to higher income groups

Economic Perspective

- Scarcity of resources
 - Not enough resources to satisfy all possible uses
- Choices
 - Must choose how to use available resources
(and hence how not to use them)
- Opportunity cost
 - Highest valued alternative use of resources

Economic Guide to Solution

- Compare benefits produced with benefits foregone (by not applying resources to an alternative approach.)
- Would using available resources in different ways generate greater value?

Will We Apply Lessons Learned?

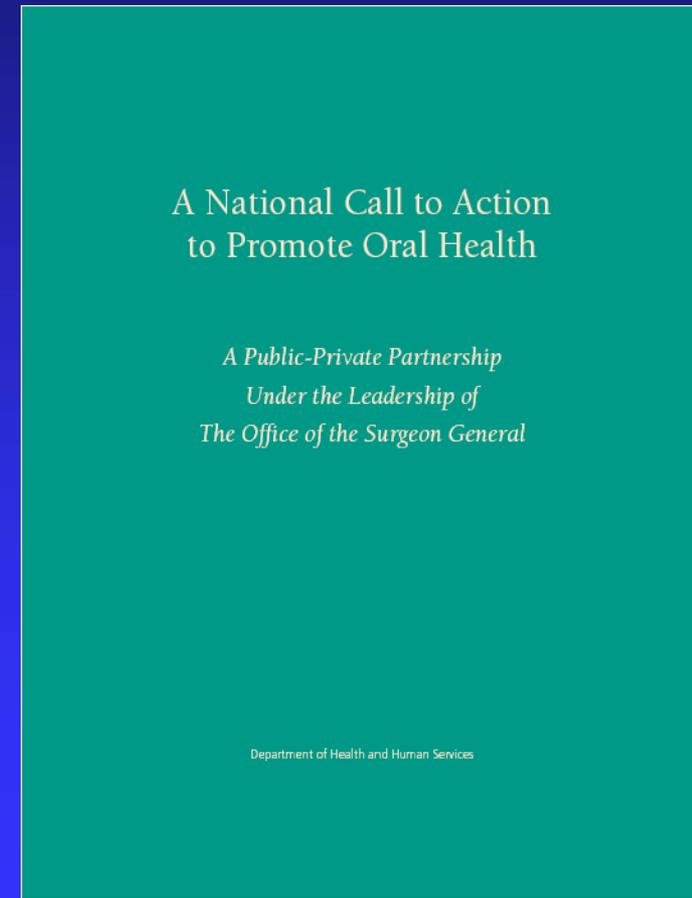
- Assumptions are misleading. Organization and financing and associated health outcomes may change?
- Who is studying changes? How do we share what is learned and discuss implications?
 - ❖ Public health or private sector?
- Global health services research versus observe reform and use common metrics to assess.
- Can the “best dental care system in the world” remain so without applying lessons from other countries?

QUESTIONS?

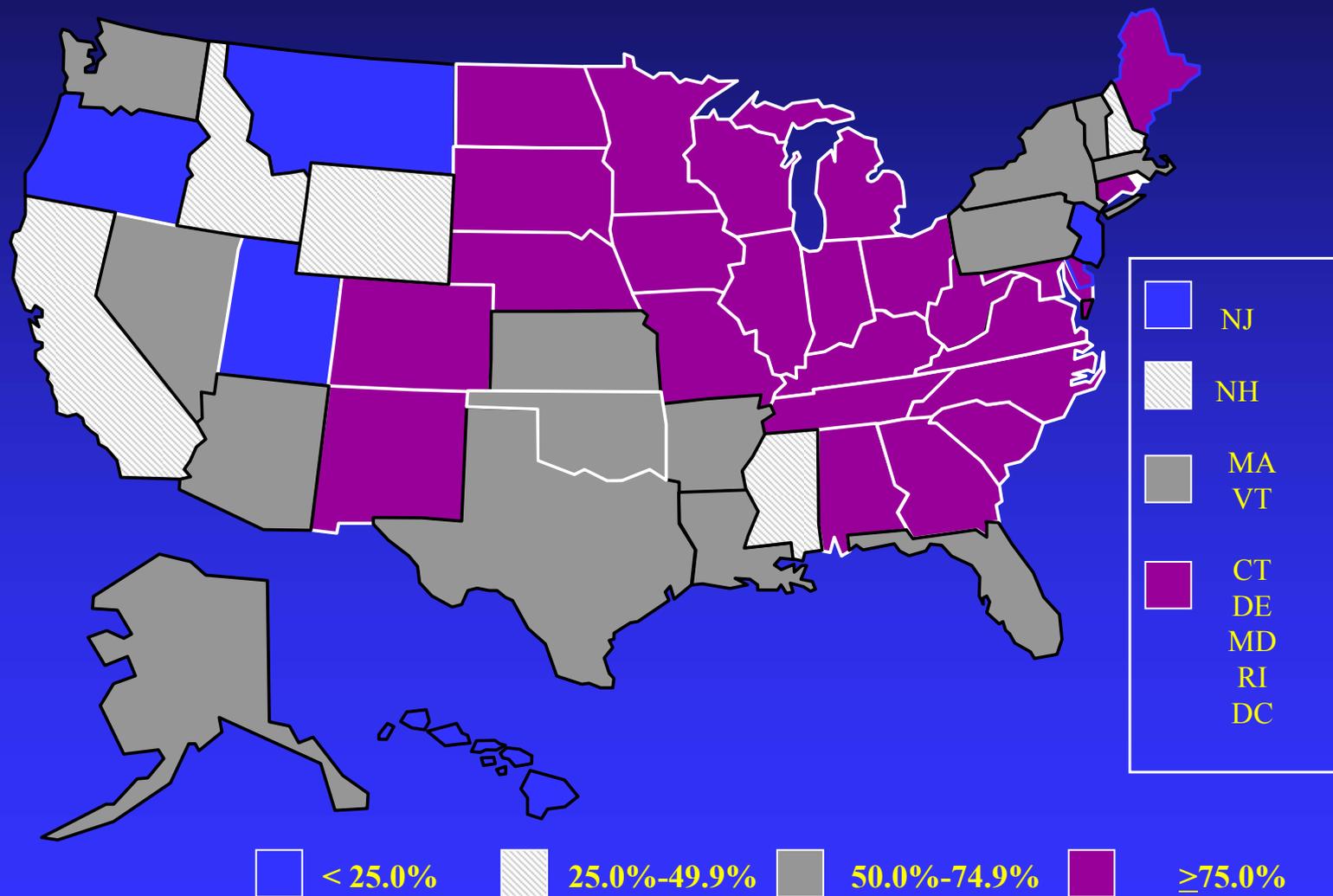


A National Call to Action to Promote Oral Health

- Endorses the Framework for Action from the Surgeon General's Report
- Has goals that reflect those of Healthy People 2010
 - ❖ To promote oral health
 - ❖ To improve quality of life
 - ❖ To eliminate oral health disparities



Percentage of State Populations on Public Water Systems with Access to Fluoridated Water 2000



Source: CDC, 2002

Implementing Policy Recommendations

Three levels of policy-making

Public Policy

- ❖ Community water fluoridation
- ❖ State Child Health Insurance Program
- ❖ School-based sealant programs
- ❖ Community and targeted mass media education

System-Level Policy

❖ Examples of systems:

- Health plans
- Insurance Companies
- Indian Health Service

❖ Examples of policies

- Coverage for sealants
- Providers paid to prevent
- Systems rewarded for increasing number of persons with access to care

Clinic/Patient Level Policy

- ❖ Clinic philosophy/orientation
- ❖ Individual treatment decisions
 - Beliefs of provider
 - Beliefs and demands of individual patients
 - Reimbursement incentives/disincentives