Will the new health care "reform" pediatric dentistry?

As the bureaucrats say, the President's plan has been put forth to all Americans in "broad brush strokes." This is a visually tantalizing euphemism, perhaps, for the colorful discussions that will occur in Washington over the next few years as our nation tries to adjust to the new emphases of universal coverage and managed competition.

The details are anything but clear, but we do believe that dentistry for children will be included and ultimately survive the negotiations that are sure to follow September's announcement of the plan. Washington's wording describes these dental services as preventive, but most believe that basic restorative care will be included under that rubric.

The Academy lobbied hard for inclusion of children's dental benefits with a strategy of realism and specific services. In fact, our lobbying efforts predated the Clinton plan with our support of the Matsui bill in Congress. During the early planning by the Clinton administration, we stood fast to our "children first" philosophy, believing — as we still do — that the noble goal of universal access to oral health is unrealistic in view of our nation's staggering deficit, ailing economy, and potentially lethal national debt. We have worked diligently and actively to convey our point of view to those in the federal government.

Since the September revelations, the administration has opened discussion to a broader constituency in anticipation of the debate that will occur as the "devil in the details" is exorcised in Congress. For what it's worth, and if anyone's listening, here are some thoughts based on our own history, the failures and successes of others, and the need for good planning.

In spite of strides made in some states to improve Medicaid reimbursement, fees remain low and can be blamed in large part for the dismal failure of the program. If we've learned one lesson from a generation of Medicaid, it is that reimbursement must be adequate to secure the involvement of providers. Medicaid is supposed to die with health care reform, but somewhere in Washington a bureaucrat is searching for a model for children's dental services for the Health Security Act of 1993. Let's hope it's not Medicaid!

The delicate balance between training and service must be nurtured. Recently, in one Canadian province, dental residencies were put on the block as the government tried to balance its budget. Pediatric dental residency programs in hospitals here in the United States have enjoyed the benefits of the existing marriage of education and service. Health care reform must not inject additional stresses into this relationship to the detriment of training. These dental programs are at risk—in double jeopardy—because they don't "feed" the hospitals' appetites for inpatients and because educational requirements make them inefficient care providers.

Managed care brings with it a set of potential evils that are tolerated by the god of efficiency. "Cherry-picking" involves selecting the low-disease, low-cost patients and sending the more difficult- and costly-to-treat cases elsewhere. Might managed care set up situations like that for children who are handicapped, behaviorally difficult, or in need of complex dental treatment? Worse yet, might the new system force those children to be treated by providers ill-prepared to care for them? Tune in for future reports!

What scares many health planners is that there is no model for this magnitude of change. A range of potential scenarios exist as patients and health providers begin to manipulate the system. One of these has healthy, white, middle-class patients seeking care in well-kept, well-funded suburban facilities with little to do, while the poor and minorities, who suffer differentially from disease, stay in the inner city with less than adequate care in aging facilities with resources crushed under the weight of disease. What's new about that? Nothing, but health care reform is supposed to change that, remember?

What effect will managed competition and capitation have on interprofessional relationships and patterns of practice? On the positive side, it will force groups to talk. Across the country, hospital medical staff and administrators, once sworn opponents, are now forming provider-hospital organizations and making cooperative decisions in order to survive. We may also see outcome-based care in dentistry which, from the perspective of occlusal management, would be a blessing for those nonorthodontists doing quality care. At the same time, such a change would put the issue of who provides dental hygiene care into a whole new perspective.

The reform movement has just begun! The Academy's job is far from over and as the economic implications emerge and federal decisions ripple into licensure, education, interspecialty relationships and actual health outcomes, we'll need to be busy in Washington. Let's hope the color of those broad brush strokes turns out rose, not scarlet!

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