Letters to the Editor

Pediatric Oral Health Therapists Are Important to Address the Access to Care Problem for Children

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In the September/October 2009 issue of *Pediatric Dentistry*, Dr. Pitts Hinson wrote a rejoinder to Dr. Frank Catalanotto's Letter to the Editor regarding access to care published in the May/June issue. I write to take issue with some of Dr. Hinson's comments, and in support of Dr. Catalanotto.

Clearly, as Dr. Hinson comments, health care reform must focus on primary care. However, there is a significant role for non-dentists in providing primary oral health care for children. Dental therapists, with two years of training, similar to our dental hygienists, provide essentially all of the primary care for children in many countries of the world. (In my writings advocating the adoption of dental therapists in caring for children in the United States, I have employed the designation *pediatric oral health therapists*.[1,2]) The prototypical example is New Zealand, where school-based dental therapists provide care for 97% of the children in New Zealand, and have been doing so effectively and safely since 1921.[3] A recent study found that at the end of a school year, essentially all of New Zealand's children are free of dental caries![4] The dental care provided children in Australia and Malaysia is also essentially all by dental therapists.[5] Dental therapists practice in 53 countries of the world.[5] While primarily caring for children, in some countries basic care for adults is also provided.

There are only 4,568 pediatric dentists in the United States.[6] Obviously, we cannot provide primary care for all children, nor should we. We are specialists and should be focusing our talents and skills on the children who require the care of a specialist. According to the American Dental Association, the four most common procedures in a pediatric dentist's office are periodic oral examinations (recalls), bitewing radiographs, prophylaxis and topical fluoride therapy. One does not require 10-11 years of post-secondary education to provide primary oral health care for children. New Zealand has the same population as my home state of Kentucky, with equivalent numbers of children. New Zealand provides primary oral health care for its children in schools (No access barriers there), with pediatric dentists providing secondary and tertiary care; that is, care that is outside the school dental therapists' scope of practice. There are eleven pediatric dentists serving all of New Zealand;[7] they are practicing as specialists, providing advanced care; yet we have 77 pediatric dentists in my state of Kentucky.[8] In contrast to New Zealand's outstanding record of oral health for its children, the status of the oral health of Kentucky's children can only be characterized in very negative terms.[9,10] Pediatric dentists are not the solution to our access problem.

We do not need, nor can we afford as a nation, to continue to train pediatric dentists with average earnings of $338,000,[11] to accomplish primary care procedures that years of experience has demonstrated can be safely and effectively provided by individuals with two years of education.[12-21] What business organization could survive paying highly educated and highly paid individuals to accomplish tasks that could effectively be delegated to a lesser educated and lower salaried individual? Doing so violates a basic organizational management principle.

Dr. Hinson argues against a dual standard of care. I do as well. Research has demonstrated that dental therapists do not provide a different standard of care than dentists for their scope of practice. He also suggests that the access problem can be resolved if society would increase dentists' reimbursement rates. There is scant evidence for that being true. Our Academy colleague, Dr. Burt Edelstein, in his testimony before Congress on health care reform, cited evidence that an increase in professional fees appears to only marginally improve dentists' participation in Medicaid.[22] Even if it were true, surely we understand the financial shortages that exist in state and federal budgets. Society is becoming increasing upset with our profession's lack of responsiveness, and is beginning to demand alternative, creative solutions to ensuring that every child in America has equal opportunity to flourish in life by having good oral health.

A 2004 study indicated that only 45 percent of California pediatric dentists treated children with public insurance.[23] Another recent survey found that 53.2 percent of pediatric dentists care for children with public insurance.[24] Recently, the Kaiser Family Foundation reported that, as a result of the recent expansion of the Children's Health Insurance Program (CHIP), the majority of our nation's children, 40 million out of 78.6 million, are being covered with public insurance, either Medicaid or CHIP.[25] Academy data indicate that children with public insurance comprise only 19.5 percent of pediatric dentists patient visits.[6] As data indicate, the problem of dental caries is with children from lower socio-economic groups; those covered with public insurance.[26,27] It appears that pediatric dentists are providing the overwhelming majority of their care for children who may need the services of a pediatric dentist the least. Why are we not open to adding a therapist to the

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workforce to help us care for children? If an office had one or more *pediatric oral health therapists* working on the dental team, we could afford to care for many more public insurance recipients, at fees that society can afford to pay. After a recent presentation, in which I discussed the addition of a *pediatric oral health therapist* to the dental team, a pediatric dentist approached me lamenting the lack of such a trained individual; affirming that he could use such a person in his office immediately in order to be able to expand his care for public insurance recipients.

I will only cite the Surgeon General's report, *Oral Health in America*,[28] with its many references, to challenge Dr. Hinson's view that "The United States has the best model of delivering dental care that exists." I note with interest that he offers no references to support this assertion. There are none. Nor are there any references to support his objection to dental therapists.

The time has arrived for our specialty and our profession to acknowledge that change must come—it is coming. Society has provided us a virtual monopoly to care for its oral health, and the evidence is that we are failing with our current delivery model and workforce. The Alaska Native Tribal Health Consortium's successful initiative of introducing dental therapists in Alaska (treating primarily children) gives testimony to our failing.[29,30] The Minnesota Legislature passing legislation authorizing the training and practice of dental therapists documents our failing.[31] The interest of the Kellogg Foundation in funding dental therapists training further serves to suggest our failure. Finally, on October 8, the Health Research and Services Administration (HRSA) announced funding of $2.4 million to the Institute of Medicine of the National Academy of Sciences to study ways to guide "federal investments in service delivery models that expand access to oral health care and improve its quality."[32]

It is no longer reasonable, nor practical, nor effective for us to pontificate in defense of the current oral health care delivery system and oral health workforce for children. Society is simply exhausted with us continually saying essentially give us more money and leave us alone. [33] Dr. Hinson's letter suggests an attitude and orientation–protectionism of our professional prerogatives–to the problem of access to oral health care for America's children that is endemic in our Academy; an attitude that will only result in a diminution of the leadership and respect we have earned over many years of advocating for what is best for the oral health of children; not necessarily what is best for us as pediatric dentists.

As a member of this Academy for almost 42 years, I encourage our leadership to rise to the challenge and provide creative, thoughtful, powerful leadership for any and all initiatives that have the potential to improve access to care for our most vulnerable population, our children. Developing and deploying *pediatric oral health therapists* is certainly one initiative that deserves strong consideration.

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