Costs, as much as location, impede dental-care access

Diverse testimony precedes proposed legislation

By Robert Selleck, Managing Editor

On June 7, Sen. Bernard Sanders, I-Vt., and Rep. Elijah Cummings, D-Md., introduced the Comprehensive Dental Reform Act of 2012 in the Senate and House. The proposed legislation is titled “A bill to improve access to oral health care for vulnerable and underserved populations.”

In February, the Senate Subcommittee on Primary Health and Aging heard nearly 100 minutes of testimony at its hearing, “Dental Crisis in America: The Need to Expand Access.” The hearing focused on how to serve the reported one-third of the U.S. population that is not receiving adequate dental care. Extensive and diverse written testimony was submitted as well.

Several witnesses at the hearing spoke in favor of creating a new licensing concept for midlevel care providers, such as the dental therapists practicing in Alaska and Minnesota, which to date are the only states to have passed laws creating such licensing. The Dental Reform Act proposes a similar concept.

The governor of Kansas last month signed a bill that expands treatment capabilities for dental hygienists, enabling them to pull loose primary teeth, manually scrape decay from teeth and place temporary fillings. The Kansas law was created in response to a dentist shortage in parts of the state and to improve dental care for other vulnerable and underserved populations. The law also includes a provision enabling retired dentists to treat low-income patients or patients living in underserved areas of the state.

The subcommittee’s investigation into access-to-care issues wasn’t limited to potential expansion of midlevel-practitioner licensing, a concept that has been opposed by both the American Dental Association and the Academy of General Dentistry.

Those organizations’ advocacy components contend that opening certain treatment capabilities to midlevel practitioners with less training than dentists is not the best strategy from a patient-care standpoint to address access-to-care challenges.

Regarding other aspects of the proposed legislation, ADA President William P. Hall said: “The ADA endorses the comprehensive dental reform legislation introduced by Sen. Sanders and Rep. Cummings. The ADA supports any and all legislation enabling access to care. The ADA has long advocated for increased dental access for vulnerable populations.”

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The American Dental Association’s (ADA) response highlights the need for comprehensive dental reform legislation to address access issues.

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Letter to the editor in chief

Questions on American Heart Association’s stance on periodontal disease and heart health

Dear Dr. Hoester,

The recent article in the American Heart Association’s journal Circulation, [title] “Periodontal Disease and Atherosclerotic Vascular Disease: Does the Evidence Support an Independent Association?” A Scientific Statement From the American Heart Association” (published online 4/18/2012), combined with the American Heart Association’s press release of the same day, was discouraging in and of itself, and made more so by the prototypical way The New York Times reported on the story the next day.

Although I suspect that Circulation is not responsible for the AHA’s press release, the statement in the announcement that researchers who showed a “stronger relationship between” chronic periodontitis (PD) and ASVD “did not account for the risk factors common to both diseases,” is incorrect and inconsistent with the manuscript.

Unfortunately, the Circulation article is not available to the public, so as its authors appear to have had an agenda that was beyond the scientific publications they reviewed. Although I agree with the authors that an unquantifiable number of ill-informed or unscrupulous practitioners engage in bucksticker with regard to the several putative periodontal-systemic disease links, the statement in the article’s abstract that “Patients and providers are increasingly presented with claims that PD treatment strategies offer ASVD protection, these claims are often endorsed by professional and industrial stakeholders” is not supported by the data presented in the review.

Also revealing of the authors’ apparent bias is the final sentence of the article, which reads “…statements that imply a causative association between PD and specific ASVD events or claims that therapeutic interventions may be useful on the basis of that assumption are unwarranted.”

Hence, it appears as if the AHA’s recommendation to dentists, dental hygienists and others may be accurately paraphrased “Although we at AHA acknowledge that there are unexplained links between the incidence of PD and ASVD, because we can find no clear causal links, it is unwarranted for dental professionals to inform patients that periodontal health is associated with better cardiovascular health in any way if used to encourage better periodontal health and improved home oral hygiene.”

Do the Circulation authors, editors and the AHA really believe that this is a sound message, especially in light of the reality that an overwhelming majority of care to people falling outside of current care-delivery models. “We’re going to shine a spotlight on an issue that is not much talked about and we are going to do our best to solve this problem,” Sanders said.

Sen. Bernard Sanders, I-Vt., chairman of the U.S. Senate Subcommittee on Primary Health and Aging, leads the hearing on “Dental Crisis in America: The Need to Expand Access.” Photo Provided by U.S. Senate Committee on Health, Education, Labor and Pensions

See page D2 for the American Dental Hygienists’ Association stance on the access-to-care proposals

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