WINTER 1983

JOURNAL

AMERICAN COLLEGE of DENTISTS

CONVOCATION AWARDS
FELLOWSHIPS CONFERRED
CONTAINING HEALTH CARE COSTS
MEDICAID DENTISTRY

The Objectives of the American College of Dentists

The American College of Dentists in order to promote the highest ideals in health care, advance the standards and efficiency of dentistry, develop good human relations and understanding and extend the benefits of dental health to the greatest number, declares and adopts the following principles and ideals as ways and means for the attainment of these goals.

(a) To urge the extension and improvement of measures for the control and prevention of oral disorders;

(b) To encourage qualified persons to consider a career in dentistry so that dental health services will be available to all and to urge broad preparation for such a career at all educational levels;

(c) To encourage, stimulate and promote research;

(d) Through sound public health education, to improve the public understanding and appreciation of oral health service and its importance to the optimum health of the patient;

(e) To encourage the free exchange of ideas and experiences in the interest of better service to the patient;

(f) To cooperate with other groups for the advancement of interprofessional relationships in the interest of the public; and

(g) To make visible to the professional man the extent of his responsibilities to the community as well as to the field of health service and to urge his acceptance of them;

(h) In order to give encouragement to individuals to further these objectives, and to recognize meritorious achievements and potentials for contributions in dental science, art, education, literature, human relations and other areas that contribute to the human welfare and the promotion of these objectives — by conferring Fellowship in the College on such persons properly selected to receive such honor.

Revision adopted November 9, 1970.

(ISSN 0002-7979)

The JOURNAL of the AMERICAN COLLEGE of DENTISTS

Volume 50
Number 4
Winter 1983

A Quarterly Publication Presenting Ideas & Opinions In Dentistry

The Journal of the American College of Dentists (ISSN 0002-7979) is published quarterly by the American College of Dentists, Inc., McFarland Company, Harrisburg, Pennsylvania, with Second Class Postage paid at Harrisburg, Pennsylvania and additional points.

Subscription $15.00 a year. Cost of additional postage for airmail will be billed to subscriber. Single copies $6.00.

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Reprint requests should be directed to the author.

For bibliographic references the *Journal* is abbreviated J Am Col Dent and should be followed by the volume number, page, month and year. The reference for this issue is J Am Col Dent 50:1–32, Winter 1983.

The *Journal* is a Publication Member of the American Association of Dental Editors

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FROM THE EDITOR'S DESK

POLITICAL ACTION BY DENTISTS

—A Necessity in Current Times

Since government is increasingly becoming involved in health care and is dictating how dentistry will be practiced throughout the country, isn't it about time that individual dentists become involved in government by participating in political activities?

In recent years, government has increasingly intruded into the health professions through actions of the Supreme Court, the Federal Trade Commission, Health Service Agencies and other government organizations.

One of the main problems is that health care costs, in general, have gone up tremendously, all out of proportion to the cost of living in recent years. Hospital costs, which account for 40 percent of all health expenses, have risen spectacularly, three times faster than the cost of living. The Medicare Program is staggering under the load, paying out nearly 140 billion dollars this year. Under these circumstances, it is understandable that the government is serious about containing health care costs.

On the other hand, repeated economic surveys over the past fifteen years have shown that dental fees have remained consistently below the cost of living. These surveys have shown, without a doubt, that ***DENTAL FEES ARE NOT THE PROBLEM.***

Yet, dentistry is included in all government proposals to contain costs. To most dentists who are informed on these matters, it seems grossly unfair. If dentists have, as a group, held costs to under the cost

Keith P. Blair

of living increases, why is the dental profession also deemed guilty, by association, of contributing to high health care costs?

New programs being proposed in the Congress would encourage workers to reduce prepaid dental care coverage and would tax part of health care fringe benefits. So called flexible plans would allow workers the option of receiving cash payments from employers instead of having the funds allocated to dental insurance premiums.

Dentists think that most of these plans are not in the best interest of the patient and that these proposals will tend to lower the quality of dental care. Certainly there has to be a better way than that which government is now planning.

Must we throw out the best dental care system in the world, which has demonstrated that it can contain costs, simply because the cost of hospital care has tripled in recent years? Dental costs and hospital costs appear completely unrelated and certainly should be considered separately, each on their own merits.

This is where political action by dentists is most important in communicating with legislators. Of necessity, there already is a considerable amount of such activity by the dental profession. The American Dental Association maintains a Washington DC office for government related activities. Most state dental associations are active within their state. Dental political action committees (PAC's) work diligently to gain the ears of legislators. But they all fall into the category of special interest groups, in the eyes of politicians.

Another way for political action is through individual dentists who are personally known to the legislators as *CONSTITUENTS* whose opinions are important. Such contacts usually do not come by chance but by well-organized bipartisan activity by dentists in the community.

We can be involved with political action passively, as we are now, or we can be involved actively, taking the initiative whenever possible. Dentists, as a group, must be better informed on government activities affecting the dental profession in the 1980s.

That is our alternative: we can just wring our hands and bemoan recent trends or we can take positive political action, which has become a necessity in current times.

Keith P. Blair

VALUES THAT NEVER CHANGE

Address by Lynden M. Kennedy
President Elect
American College of Dentists

The foresight of the founders and organizers of the American College of Dentists brought the College into being in 1920. Their realization for the need of an organization imbued with the highest ideals for the dental profession and its service to humanity was the result of the many problems that were asserting themselves in dental education and in practice methods.

Crass commercialism permeated much of dentistry. Much of dental education was proprietary, dental journalism largely commercial, advertising was rampant and numerous practitioners were involved in dental commercial ventures. In effect, the occupation of dentistry had many of the characteristics of a trade rather than the attributes of a profession.

Hence, a few dedicated people banded together in order to promote the highest ideals in health care, advance the standards and efficiency of dentistry, develop good human relations and understanding and extend the benefits of dental health to the greatest number. And so, the American College of Dentists came into existence.

Wise old Solomon, in the first chapter of the book of Ecclesiastes, said that there is no new thing under the sun. The sun rises and the sun sets, the wind goes towards the south and turns about unto the north. The rivers run into the sea; yet the sea isn't full and unto the place from which the rivers come, there they return again.

Lynden M. Kennedy

In some ways, the profession seems to be back at square one! It reminds me of the story of the college professor who handed his secretary a list of questions to be typed and mimeographed for the final examination. The secretary looked at the questions and said, "But professor, these are the same questions you asked on the last examination!" And the professor answered, "Yes, I know, but I have changed the answers!"

And so while there are many disturbing problems confronting the profession today, perhaps they aren't new problems but are the old problems with changed answers.

The professions have been under heavy pressures for change. Undoubtedly, much of the criticism and pressure result from the fact that the costs of health care have risen faster than other costs. Unfortunately, health care costs are quite often lumped together and the fact that the major sources of increase have been hospital costs and medical costs isn't clearly explained. Dentistry's record in cost constraint has been rather enviable. Nevertheless, dentistry is painted with the same brush.

Not only have costs been instrumental in generating pressures for change but there have been other factors. It might be interesting to look at some of them.

One would be the development of the third party pay programs, the so-called dental insurance which, as you know, is in reality a form of prepaid dental care. As we look back, the cornerstone for this was the passage of the Taft-Hartley Labor Law in 1947 providing for the negotiation of health and welfare benefits by unions through collective bargaining. Then in 1954 the Pacific Maritime Association bargained for and won a dental benefits plan from the west coast shipping industry. Officials of the union's welfare fund sought the assistance of dental societies in California, Oregon and Washington in implementing the program and the first dental service corporation, now known as "Delta Plans", came into being.

The Longshoremen's Plan was limited in scope but its success in subsequent years made it clear that dental insurance had become a

sound marketing reality and was here to stay.

We tend to think of health insurance as a recent phenomenon but there were traces of it more than 2,000 years ago. Affluent people in ancient China paid the doctor as long as they were well; compensation stopped when they got sick; and the doctor was killed if they did not get well! That wasn't exactly a capitation program. It may well have been the first and only "decapitation" program!

There were many growing pains and sometimes downright frustration in the early days of the prepaid plans. There were concerns over possible intrusion into the dentist-patient relationship; the occasional interference with the professional and clinical judgments of the doctor; the question of submission of x-rays to third parties; a mish-mash of claim forms and numerous other problems.

As you know, the number of people covered by these plans increased explosively. We began to acquire additions to our vocabularies. Patients became consumers; doctors became providers; third parties became fiscal intermediaries. We became familiar with terms such as quality control, utilization, percentiles, fixed fees, copayments, deductibles, exclusions, less expensive alternate treatment, and on and on and on.

The heavy emphasis on quality control, cost control, over utilization, peer review, etc., was something of an irritant to many practitioners and some took it to be closely akin to accusations or indictments of inaptitude or dishonesty. There was such a hassle about the requests by third parties for x-rays, both pre and post operatively. There seemed to be an increasing loss of confidence and an increase of distrust by all parties.

Add to all of this the rise in consumerism, a general distrust of authority, a better informed public on health care coupled with the ever-increasing pressures being exerted for cost control and the result was that charges and counter charges began to flow freely.

Codes of ethics were accused of being self-serving. State Boards of Dentistry were accused of limiting competition and preventing the free-flow of practitioners and were also accused of restricting the allowable functions of auxiliaries. The FTC contended that many functions could be performed by those with lesser training at a lower cost and that the limitation of allowable duties was imposed to protect the income of the doctor. There were other accusations.

As a result of the attempt to control costs there developed a trend to look at health care services as commodities. This concept would embrace the view that a restoration, or the removal of an impacted tooth, or an endodontic procedure, or providing a prosthetic appliance would be like any other commodity. The reward would be per unit of service with no distinction made between a good or a mediocre service, or a wise service, or one that is thoughtful, or carried out with great skill versus services that are just adequate.

The idea that we are and should be competitors has been promoted; advertising has become legal. Historically, advertising and solicitation of patients have been ethical taboos.

Now, another term has emerged among health professions—that of marketing.

There were some interesting comments in an article in the July 1983 issue of The Journal of the American Medical Association regarding this subject: "A recent exploratory survey of physicians' attitudes at a regional meeting of the American College of Physicians disclosed strong sentiments against any type of public advertisement of physician's services. Furthermore, almost all respondents were of the opinion that standard marketing communications techniques, primarily advertising, would adversely affect the image of medicine without any beneficial impact on competition or fee reduction." Results of another survey of almost 800 Kentucky physicians were consistent. Thus, in the view of those surveyed, marketing modalities commonly used in other professions were not acceptable or desirable in medical practice.

The writers of the article then

went on to point out that prior to the 1970s, marketing was conceived as one that applied almost exclussively to goods and industrial organizations, but that in the late 1960s and into the 1970s there was a major rethinking that led to an expansion beyond the traditional business-for-profit boundaries. Marketing was reconceptualized so that it could be actuated in the management of service, government, education, cultural, and health care organizations.

It is extremely difficult for some of us to differentiate between the commercial marketing of a commodity and the professional marketing of a health service—or to distinguish between marketing and advertising. It makes one think of the alleged response of a congressman to the inquiry from a constituent. He answered that inquiry by saying:

> "My Dear Friend: I had not intended to discuss this controversial subject at this particular time. However, I want you to know that I do not shun a controversy—on the contrary, I will take a stand on any issue at any time regardless of how fraught with controversy it may be. You have asked me how I feel about whiskey. Here is how I stand on this question:
>
> "If you mean, when you say whiskey, the devil's brew, the poison scourge, the bloody monster that defiles innocence, dethrones reason, destroys the home, creates misery and poverty, yea; literally takes the bread from the mouths of little children—if you mean the evil drink that topples the Christian man and woman from the pinnacles and heights to despair, shame and hopelessness—then certainly, I am against it will all my power . . . BUT . . . If when you say whiskey, you mean the oil of conversation, the philosophic wine, the ale that is consumed when good fellows get together, that puts a song in their hearts and laughter on their lips and a warm glow of contentment in their eyes. If you mean the Christmas cheer; if you mean the stimulating drink that puts the spring in the old gentleman's step on a frosty morning; if you mean the drink that enables a man to magnify his joy and his happiness and to forget, if only for a little while, life's great sorrows, tragedies and heartbreaks; if you mean the drink, the sale of which pours into our treasurys untold millions of dollars which are used to provide tender care for little crippled children, our blind, our deaf, our dumb, our pitifully aged and infirm, to build highways and schools and hospitals, then certainly I am in favor of it.
>
> "This is my stand and I will not compromise.
>
> Sincerely,
> Your Congressman"

And so, if by marketing you mean the insensitive, indiscriminate, often misleading advertising of health services as though they were commercial commodities, then we'd be against it with all our power . . . But . . . If, by marketing, you mean the motivating of people to seek the care they need; if you mean that human activity directed at satisfying needs and wants through exchange processes, then certainly we'd be in favor of it and that would be our stand and we would not compromise!

You see, one accepted definition of marketing is: "Human activity directed at satisfying needs and wants through exchange processes". That definition, then, broadens marketing to the point that it encompasses almost anything where anyone exchanges most anything which has the capacity to create satisfaction in return for some form of compensation.

When viewed in this light, every person, every organization is already engaged in marketing whether one knows it or not and whether one likes it or not. To illustrate, the editor of the Internist Magazine, in the April 1983 issue, asked his readers: "Did you instruct your receptionist how best to handle patients, in person and on the telephone? Did you sometimes talk with colleagues about the going rate for office visits and procedures? Did you consider the potential for new patients when you first joined a church, a service club or a social club? Do you still take patient promotion expenses off your income tax?" There were other questions along the same line, but you get the idea.

But back to a part of the conclusion reached by the writers of the article in The Journal of the American Medical Association, they wrote: "If the physician community wants to respond affirmatively, technologies such as marketing and advertising cannot be rejected out of hand . . . physicians have the option to reciprocate and use marketing and advertising (where and if it is appropriate) to maintain the level of marketplace power they desire."

In our profession, the Board of Trustees of the American Dental

Association reported to the 1982 House of Delegates, ". . . A sizable portion of the Association's membership perceives urgent and immediate need to stimulate more Americans to seek regular dental care. It is the Board's opinion that the best way to satisfy this need is to provide tailored materials and services that will help the individual practitioner, and the various dental societies that represent them, achieve that goal."

In pursuing this, a resolution was passed, by the House, calling for the Association to establish a new Marketing Services Department to coordinate all marketing research and development activities throughout the Association and offer a broad array of marketing aids and "how to" information to individual practitioners, constituent and component societies.

Other health care societies and organizations have entered the marketing arena also. Commercial firms have been formed to "teach marketing."

A commonly occuring component of most marketing plans is the provision of the format for a newsletter which is educational and informational and which can be personalized, printed and mailed to patients of record, at least they are supposed to be patients of record, and I'm sure for the most part are. However, I've received several, unsolicited mailings and I have had patients bring in newsletters from people they say are total strangers.

A very deep concern is just how dignified and professional these marketing aids will be. Undoubtedly, those from the American Medical Community, if and when promulgated, will be proper and well done as will be, and are, those coming from the American Dental Association's Marketing Services Department. But there are some that smack of crass commercialism, and whose apparent goal is to enrich the practitioner and the newsletter producers. There are others, however, written in good taste and with dignity. It behooves the individual and the profession to be most discerning in making judgments in these areas.

Still another valid concern is the direction future trends will take. An article in the August 23rd, 1983, issue of the Wall Street Journal gives some indication of future trends. The article is entitled:

We were brought here by dentists who looked upon one another as . . . colleagues, not competitors, people having the conviction that we are a profession, not a trade . . . that we provide services, not commodities . . .

MORE DOCTORS TURN TO PRESS AGENTS DESPITE CRITICISM BY THEIR PEERS

Several instances were cited: A 39-year old specialist in Los Angeles pays a public relations firm $1,500 a month to publicize his practice, a 30-year old psychiatrist and nutritionist in Manhattan has made numerous TV and radio appearances. He pays a PR form $2,500 a month to get him on the air.

The article went on to say: "No one knows just how many doctors have press agents, but many press agents say their doctor business is booming. Some, like Kip Morrison & Associates, whose firm represents an orthopedic surgeon, who has been featured in several magazine articles and on a number of television and radio talk shows, are beginning to specialize in representing physicians. For a price ($50,000 to $150,000 a year at one firm) they seek media coverage for their doctors, groom them for talk shows and send out slick press kits touting their specialities. In effect, the publicists turn ordinary physicians into celebrities."

"Agencies that represent doctors are using innovative techniques to get press coverage. Lobsenz-Stevens, Inc. turns its physicians into book authors, developing a book idea, outlining it, finding a ghost writer and obtaining a contract. The physician "author" is often barely involved in the project."

"Art Stevens, president of the New York based firm, says this approach worked particularly well for a plastic surgeon from a small city in the Midwest, whom he declined to identify. Several years ago the surgeon went on a national publicity tour, promoting his book on talk shows and in newspapers in 20 cities. He signed autographs in bookstores. He appeared on the "Today" show. Several publications reviewed his book."

"We feel a book is a marvelous vehicle to gain respect," says Mr. Stevens, whose firm charges doctors a minimum of $50,000 a year for this and other services.

The article ended by saying: "For some, publicity can prove a mixed blessing. A dentist in Jersey City, N.J. hired Lobsenz-Stevens several years ago to publicize his unconventional approach to fitting dentures and his idea of franchised dentistry. The firm proved effective. The dentist appeared in Woman's Day, Forbes, The New York

Times, The New York Daily News, The Wall Street Journal and on radio and TV. Suddenly the dentist was a celebrity".

"But the publicity almost ruined me in a subsequent divorce settlement," the doctor said. In dividing assets between the doctor and his wife a New Jersey court added $500,000 to the pot for the value of the doctor's name alone. When the dentist protested, his wife's lawyers pulled out a New York Times article referring to his "Dental Empire".

The dentist said he also spent more than $40,000 in attorney's fees fighting State Board's attempts to revoke his license because they didn't like the publicity he was getting. And he said he was sued by several patients who didn't like the looks of their false teeth. "It's easy," said the dentist, "for them to feel they have been misled—that it's not what they saw on Channel 7."

Well, the American College of Dentists came into being as a result of the many problems concerning practice methods and dental education.

The need for an organization imbued with the highest ideals for the profession and for humanity is no less today than it was 64 years ago. Certainly, there are plenty of concerns about some of the changes and some of the practice methods today as well as concerns about the future status of our profession.

It isn't difficult to understand why so many in our profession are filled with frustration, anxieties, and disenchantments over the perceived de-professionalizing of dentistry and the de-personalization of the patient-doctor relationship.

Most of us have been quite comfortable in our traditional practices, pledged to our traditional codes of ethics and codes of conduct. We have been convinced that the profession has done most things right as we have the finest oral health care and best oral health care delivery system in history and this has been accomplished under those traditional circumstances. However, some of our colleagues have said they're so discouraged they are ready to give up.

A week ago last Sunday, I heard Richard DeHaan's service on the television program of the Radio Bible Class called "Day of Discovery." He said: "Wise is the person who refuses to give in to his doubts, his disappointments and his discouragements. He continues to do what is right regardless of the problems and the trials he faces in doing so." Then he told the story about Sir Francis Drake who was in a dangerous storm on the Thames River and was heard to say, "Must I, who have escaped the rage of the oceans, be drowned in a ditch?"

I know my colleagues well enough and I know this College well enough that I have no fear that our profession will be "drowned in a ditch!" When we look back at the long and proud history of dentistry, at the obstacles overcome, the struggles and the unswerving commitment of those who preceded us and how they conquered their raging oceans, I find it difficult to believe that the problems of today will cause us to drown in a "Thames River."

We simply need to remember that when a civilization or a profession stumbles, one condition can always be found: The people forgot where they came from. They lost sight of what brought them there.

We were brought here by a small group of consecrated people that formed a nucleus to lead the crusade to make dentistry the respected and noble profession it is today. These were principled people, people who wanted to dream and to build—who delighted in the challenges of life and the thrill of fulfillment, people who deeply and sincerely believed in the Golden Rule. People who were willing to lay it on the line and sacrifice and struggle for a cause.

We were brought here by dentists who looked upon one another as brothers in the profession—as colleagues, not competitors, people having the conviction that we are a profession, not a trade, servants not merchants, that we provide services, not commodities and that our allegiance is to mankind, not mammon.

This is where the challenge comes to us today. You are a very special group of people. It is up to you and to us to continue to be nucleus, the catalyst for that type of spiritual professionalism. We must continue to demonstrate that in a turbulent world there are values which will never change; the value and satisfaction that comes from serving one's fellowman, the pleasure of doing something for someone that he cannot do for himself—from placing his welfare above one's personal benefits.

When all is said and done, it is like the old proverb which says:

> "In the distance I saw what I thought was an animal.
> But when it came closer, I saw it was a man.
> And when it came very close, lo! It was my brother." △

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HAROLD HILLENBRAND PRESENTED THE AWARD FOR EXCELLENCE

Citation Presented by Incoming President Dr. L. M. Kennedy

On the occasion of the Golden Anniversary of the American College of Dentists, a high honor was created by the College. The American College of Dentists' Award for Excellence was developed to give recognition for outstanding contributions to the Art and Science of Dentistry, its practice, education, research, and organizations, and, further, for outstanding service to the community and the country with a broad appreciation of the arts and literature of humanity.

This special award was first presented to J. Ben Robinson, educator, leader, author, and administrator. On that occasion in 1970, Dr. Robinson addressed the term, "excellence." May I quote, "Excellence in performance means achievement of a superior or a passing quality. It is not a concrete entity ready at hand to respond to the call of those who would acquire it merely by wishing for it. There is no excellence without great labor."

These words apply most significantly to Harold Hillenbrand, Executive Director Emeritus, the American Dental Association, the individual whom the College has chosen to honor today with the American College of Dentists' Award for Excellence.

It is not possible to describe the achievements of this man in these few moments. As Chief Executive Officer of the American Dental Association for 23 years, Dr. Hillenbrand led the profession through many periods of growth and development which will go down in history for some of the greatest achievements in the profession of Dentistry.

Dr. Hillenbrand has served and continues to serve in many different capacities in the United States and abroad. He is recognized world wide for his excellence, his leadership and his high regard for the profession of Dentistry. Having had Fellowship conferred upon him by the American College of Dentists in 1950, being the recipient of the William John Gies Award of the American College of Dentists in 1959, and having had his name inscribed upon the Mace of the College in 1970, Dr. Hillenbrand does not lack for recognition by this College. However, his achievements have so influenced the profession and its character over the years that there are few walks of life in dentistry which do not owe some of their growth and development to Harold Hillenbrand. It is for this that he has been chosen now to wear the Medal of the Award for Excellence.

Harold Hillenbrand

Mr. President, it is with great honor and great pride that I present to you Harold Hillenbrand for the American College of Dentists' Award for Excellence. △

CONTAINING HEALTH CARE COSTS

Convocation Address

U.S. Senator David Durenberger

New flexible benefits programs provide a rare opportunity to get benefit costs under control. If an individual employee selects a less costly health plan, he or she will have additional fringe dollars to spend on pensions, life insurance or child care.

I am pleased to be here today to honor a record class of fellows of the American College of Dentists and a person who is special to me, your president, Odin Langsjoen. Odie and I come from the same roots in Stearns County, Minnesota. I am pleased with the commitment he has made to your profession.

I am also pleased that I missed yesterday's record-setting rainfall in this part of California. But, believe it or not, I was in Philadelphia last night launching the National Water Alliance.

Any solution to contain costs will affect *all* health care providers

Also last night the Congress of the United States set a record of sorts when it passed an 850 billion dollar continuing resolution to keep your federal government alive for another year, did it on a voice vote in record time without amendment, very little debate and a very brief conference.

Why was it so easy? Because only the hard things are left for us to do.

Senator Durenberger

The easy things like cutting spending in discretionary areas and cutting tax rates on middle income America we accomplished two years ago. There's nothing but hard spending and hard taxing decisions left to make. Oh, yes, there is one other thing and you'll be hearing about it a lot in the next year and that is the Democratic allegation that it took more than 200 years from Alexander Hamilton to Michael Blumenthal to raise the national debt to one trillion dollars and only four years for Don Regan to run up the second trillion.

Dave Broder wrote a column

that probably appeared in most of your newspapers a few weeks ago in which he said there's a big sign on the Capitol that says: "Congress and President out to lunch, be back in 15 months." Unless you are afraid it might be true, ask your own congressman or senator. What he will tell you is that on the spending side we're down to entitlements, debt service and defense all of which are indexed to inflation, interest rates or a President's commitment to real growth in national security spending; and on the tax side we are down to loophole closing and there are lots of loopees behind every hole protecting their vital interests.

So you may discover that everyone says we can't attack any one of these without attacking all of them and some political party or some interest group won't permit that to happen; so your elected officials facing re-election next November may join in the chorus of "don't blame me."

I am here this afternoon to take a look at one of these tough areas of spending and tax policy with your help. If you take a look at the leading indicators for health care in America you might conclude the future for costs containment in our future public policy isn't too bright. The numbers are scary. Health care costs continue their unprecedented rise. In 1950 costs were 12.7 billion dollars and 4.3 percent of GNP. In 1965 they were 6 percent of GNP and in 1970 they amounted in dollars to 73 billion. Last year—12 years later—the health care bill had more than quadrupled to 322 billion dollars and 10.5 percent of GNP. Last year's increase was 12.5 percent over the previous year or twice the general rate of inflation.

With the new emphasis on health care rather than sickness care, dentistry should do quite well. Dentistry has an exceptional record in promoting prevention and providing early intervention.

The Medicare program is going broke. Created less than 20 years ago, Medicare is now the second largest U.S. social program, and it's growing faster than number one: social security. This year Americans eligible for Medicare will pay out nearly 140 billion dollars for health services—of which 66 billion comes from trust fund and general revenue sources. Medicare tax fund expenditures alone will total over 110 billion dollars by 1988, and the trust fund will be on the brink of bankruptcy two years later.

The magnitude of the Medicare problem is staggering. If nothing is done, the cumulative deficit in the trust fund will approach $300 to $400 million by 1995.

And the options for reform are sobering. First option is to do what we did with the social security compromise and send the bill to the taxpayers. To maintain solvency of Medicare through increased revenue, the payroll tax would have to be doubled. In the alternative, cost-sharing by Medicare beneficiaries would have to be tripled.

These numbers cause concern. Concern by the public, which pays its own bills as well as those of public beneficiaries. Concern by employers, whose health insurance outlays have increased 133 percent over the past six years, from $33 billion to $77 billion a year. And concern by government. Elected officials are not thrilled about sending the country's ever increasing health bill back to the voting public. It's much easier for politicians to lay the blame—and the bill—on

you and other health care providers . . . simply because consumers are always most inclined to blame providers for high price.

Second, there is tremendous inertia in the health policy area. The government's approach to health policy issues has remained virtually unchanged for the past 30 years. When costs get too high, government simply tries to regulate them lower. And government has done a nice job of creating the federal agencies to do the regulation. From 1970 to 1975 alone, seven major federal regulatory agencies were created.

But regulating price in public goods or services can't work. It didn't in oil pricing and it doesn't in health pricing.

To alter the course of the regulatory steamroller will take more than a few individuals in Washington standing in its way. It will take a national consensus, a consensus that is only beginning to take form.

Third, we have a tendency to avoid recognizing a crisis until we are awash in its wake. Without fundamental reform, without the active support and participation of health care providers, without a recognition by the public that new treatments and new technologies cost more money, without a recognition by elected officials that there are no easy answers, and without these the private sector is doomed.

We cannot continue to feed our appetite for technological advancement without any appreciation for the price we are paying in other parts of the health care system. Until America wakes up to the fact that no change, however, is no option, the odds will remain against keeping health care in the private sector.

But the odds are getting better. There's hope. And there's opportunity for those able to recognize it.

The changes are coming, no doubt about it. But for dentistry, it is another opportunity. Dentistry will have to do a good job of marketing itself.

As dentists you might conclude that you are neither part of the problem nor part of the solution. Dental services account for 7 percent of total health expenditures, whereas hospital expenses account for 40 percent. Hospital costs rise three times faster than dental fees. And you rightfully believe you're in the prevention business and are not the "villain" in this health cost piece.

Yet any solution to contain costs will affect *all* health care providers. As spending tightens up dentists will feel the pinch, and you'll have to respond to the changing pressures.

Those changing pressures are well-characterized by two major pieces of Medicare reform enacted in the past 18 months.

Last year, Congress passed legislation to establish a private sector alternative for Medicare, the federal health program for the elderly. For the first time, Medicare beneficiaries will have the option of using their Medicare entitlement to purchase coverage in the private sector. Private health plans that keep their patients healthy and out of the hospital will do well. Their lower costs will be very attractive to beneficiaries. This change signals a move toward the marketplace.

And it also signals a move toward true *health* care, not sickness care. After all, the biggest problem presented by the figure 10.5 percent of GNP represented by the health care system is that it is all sick care. At some point, and maybe it's around 10.5 percent because I can see it already, we as individuals and government are taking money away from genuine health care. Dieting—nutrition—education—recreation—and a variety of preventive health care practices and needed wellness programs.

Our old, fee-for-service, cost-based system of paying for medical services has rewarded sickness care, not health care. The signal to hospitals and other health care providers has been, "The more you do, the more you get." Now, the signal is changing. As the buyers of health services become more sensitive to price, there will be a new emphasis on prevention. After all, it's less expensive to care for a healthy person than it is a sick one.

The second major piece of Medicare legislation creates a system of prospective payment for hospitals. Under the new prospective payment system, hospitals will be paid on the basis of each Medicare patient's diagnosis. The Medicare payment amounts will vary by

diagnosis, but they will be fixed in advance. If hospitals are able to provide services efficiently and at a level below the government's payment, they will be allowed to keep the difference. If, however, a hospital's expenditures exceed the government payment, they will have to absorb the loss.

As you can see, hospitals will be—for the first time—at risk—like any other business. If a hospital is efficient, it will have additional revenue to invest in new technology and patient services. If, however, it is inefficient, it will lose revenue and go out of business. And lest you fear hospitals can get around the prospective pricing system by farming out pieces of business to related providers outside the PPS system, never fear. Within 3 to 5 years you'll see skilled nursing facilities, home health care, hospice and, yes, even physicians included in a diagnostic-based prospective payment.

With a new emphasis on health care rather than sickness care, dentistry should do quite well. Dentistry has an exceptional record in promoting prevention and providing early intervention. I'm convinced the dental profession can adapt to these new pressures with relative ease.

Government involvement in the health sector will not be limited to reform of Medicare and Medicaid. There is, for example, the issue of the tax cap. For those of you not familiar with it, the tax cap proposal would protect employer contributions to employee health plans up to $175 per month from being taxed as income to the employee.

From a health policy standpoint, a tax cap makes sense. It helps to make individuals more cost conscious in purchasing health care. Employees would begin to examine whether they really need the first-dollar, comprehensive health care that costs over $300 a month. First-dollar coverage insulates the individual from the cost of health services. It eliminates price-sensitivity.

I believe health insurance—like casualty, disability, or life insurance—should be designed to help individuals defray the costs they cannot take care of by themselves—the catastrophic expenses. If individuals want to prepay their routine expenses, fine. But we should not give them a federal tax subsidy to do so. Routine expenses can be budgeted for.

From a tax equity standpoint, it hardly seems fair that American taxpayers should subsidize the purchase of comprehensive benefits only by employees of large companies. When auto workers receive over $300 a month in health care benefits, it's not just General Motors, Chrysler, and Ford that get stuck with the bill. You and I pay for it too. We're paying for it because our taxes have to be raised to compensate for the fact that all those health benefit dollars are going untaxed. It's the American taxpayer who is getting stuck with the bill for excess coverage.

It's much easier for politicians to lay the blame—and the bill—on you and other health care providers . . . simply because consumers are always most inclined to blame providers for high price.

It's no wonder that some in Congress are arguing to do away with this tax subsidy altogether. Those who propose a pure flat rate tax in which everyone pays a straight percentage of all their income, including benefits, would completely eliminate this important benefit.

I believe, and the Reagan Administration believes, that the health of America depends on wise investment in insurance against accident, illness, and catastrophe. The tax cap preserves this principle without abusing it.

The enactment of tax cap legislation is unlikely this year. But you can be assured that the issue will arise next year, the year after that, and the year after that. At some point, I believe, a limit will be passed. By that time, however, the issue may be moot. While Washington talks about benefits reform, the private sector is doing something about it.

Employers and insurance companies are becoming more and more active. HMOs, Preferred Provider Organizations and Peer Review programs are cropping up all over the country. So are health coalitions and business pressure for state rate-setting, certificate of need and all payers programs as a

well-intentioned but not very perceptive business community moves us unwittingly to replace provider competition with their own version of a public service marketplace. But the reality is major employers in this country are refusing to simply absorb health benefit cost increases. One of the good things they are doing—at a surprisingly rapid rate—asking their employees to pick up a greater portion of the tab through cost-sharing.

Furthermore, benefit consultants are telling employers that new flexible benefits programs provide a rare opportunity to get benefit costs under control. Under a flexible benefits program, employees are given a fixed number of dollars to spend on fringe benefits. If an individual employee selects a less costly health plan, he or she will have additional fringe dollars to spend on pensions, life insurance, or child care. By imposing an overall limit on available fringe benefit dollars, employers achieve the same employee price-sensitivity that would be achieved under the conditions or a tax cap.

Employees recognize that if they buy expensive, comprehensive health coverage, they'll have fewer dollars to spend elsewhere. Flexible benefits are proving very popular with both employers and employees—large groups and multi-employer groups—and you can expect dramatic growth in their use. It is the dramatic growth of employer-negotiated cost sharing and of flexible benefits that could concern your profession, *not* the tax cap.

The changes are coming, no doubt about it. But for dentistry it is another opportunity. Dentistry will have to do a good job of marketing itself. You spent all morning today in debate on that subject, and I congratulate you for it. I'm convinced you'll do very well. You've *always* done well in marketing because you have a keener sense of competition and choice within professional ethics. Your record demonstrates that.

We can't continue doubling the cost of sick care every five years. We can't shift the cost from employment to tax revenues and we can't achieve containment by regulation.

More and more individuals are realizing that preventive care is in their best interest. They *feel* better and *live* longer if they take care of themselves. No doubt part of this is due to dental advocacy and the inclusion of dental benefits in insurance plans. But I don't believe a heightened price-sensitivity on the part of individuals necessarily means that dental care will deteriorate.

Even if individuals decide they want to spend all of their fringe benefit dollars on hospital care and physician care, I am not convinced that they will abandon dental benefits. We have learned from federal employees that comprehensive benefits remain very attractive to individuals. They are willing to spend additional taxable dollars to purchase more extensive coverage. But because they are spending taxable dollars they take a much closer look at what they're getting.

If the purchase of prepaid dental care means less future cost for the individual, he or she should be willing to purchase such coverage with taxable dollars. It doesn't make sense to me that the only reason dental benefits sell is because of the tax subsidy. If I'm wrong, then prepaid dental care must not have a very strong case for being cost-effective.

In the new era of price-sensitivity, choice, and competition, you will have to sell your services directly to the public. You will have to convince the public that your services are worth the price. But then that's what the marketplace is all about.

As we move toward the marketplace, dentistry has an important role to play. With its emphasis on prevention and cost-containment, dentistry has been a leader among health care professionals. The representation of the profession in Washington has been excellent, and the input of the profession will continue to be needed in the development of crucial future policies.

We can't continue doubling the cost of sick care every 5 years. We can't shift the cost from employment to tax revenues. And we can't achieve containment by regulation. But we can turn the steamroller around. Whether we are successful depends entirely on what you and I can accomplish together. Without the cooperation and active participation of dentists in the field, efforts in Washington will be fruitless. △

GIES AWARD TO ROBERT I. KAPLAN

Citation Presented by Regent Dr. Norman H. Olsen

The William John Gies Award was established by the American College of Dentists in 1939 in order to recognize Fellows of the College for outstanding service in dentistry and its allied fields. This Award honors Dr. Gies for his outstanding contributions to all facets of the profession of Dentistry, but it also serves as an index of appreciation and esteem for those Fellows of the College whose works have merited exceptional recognition. There have been 57 distinguished Fellows of the College honored by this Award. These 57 Fellows represent the most noble and dedicated among us and personify professionalism in its finest form. Today, we honor a distinguished Editor, Educator, Clinician, and Administrator: Robert I. Kaplan.

Dr. Kaplan has served his profession in many capacities. He has been President of his local and state dental associations, as well as First Vice-President of the American Dental Association. He was a member of the American Dental Association House of Delegates for ten years and served as Chairman of

Robert I. Kaplan

the Council on Dental Health and as a Member of the Council on International Relations. He also served as a Consultant to the Council on Dental Education and the Council on Hospital Dental Service. He was a member of the Coordinating Committee on Preventive Dentistry which developed the ADA position policies in the field of prevention and on several occasions he testified for the ADA before committees of the U. S. Senate.

As a pedodontist, Dr. Kaplan has been recognized by his peers, having served as President of the American Academy of Pedodontics and the American Academy of Dentistry for the Handicapped as well as the New Jersey Society of Dentistry for Children.

It is especially for his contributions as an Editor that Dr. Kaplan is honored today, serving as Editor of the American College of Dentists for 11 years prior to assuming the position as First Vice President of the American Dental Association. During this time, he brought the Journal of the College into wide recognition with his well-written and incisive editorials which were widely reprinted in other journals. He received the William John Gies Foundation Award for the Outstanding Editorial in 1978.

Dr. Kaplan's entire life has been dedicated to the advancement of dentistry and its organizations to the best interests of the welfare of the public. His service to the College has been exemplary. He is well deserving of this honor.

Mr. President, it is with great honor and pleasure that I present to you Robert I. Kaplan for the William J. Gies Award of the American College of Dentists. △

JOHN A. GRAY AWARDED HONORARY FELLOWSHIP

Citation Presented by Regent Dr. Robert C. Coker

The College from time to time considers it a privilege to confer Honorary Fellowship to persons who, though not holding a dental degree, have contributed to the advancement of dentistry and to its service to the public. These contributions may have been made in many areas—education, research, administration, public service, public health, medicine and many others. To acknowledge such leadership and contributions, the College confers Honorary Fellowship upon those selected.

This year the person so honored is John A. Gray. Dr. Gray is currently the Executive Director of the International Association for Dental Research and the Secretary of the American Association for Dental Research. Graduating from Yale University in Chemistry and completing a Ph.D. in Physical Chemistry at Yale University, Dr. Gray entered the field of Dental Research through the Industrial Chemistry Laboratories of the Proctor & Gamble Company in Cincinnati, Ohio. Through his interest in research, in detergency, calcium and phosphate chemistry, fluoride chemistry and hard tissue

John A. Gray

dissolutions, he became closely associated with the research community of the dental profession. He reached the position as Section Head in charge of all Dental Research for the Proctor & Gamble Company before taking his current position with the International Association for Dental Research and its American Division in Washington, D. C. During his career, he has served as Vice President, President-Elect, and President of the International Association for Dental Research; Secretary-Treasurer of the American Association for Dental Research; President of the Mineralized Tissue Groups of the International Association for Dental Research; Member and Chairman of the Board of Scientific Counselors of the National Institute of Dental Research; as well as Co-Chairman of Gordon Research Conferences on Calcium Phosphates. His activities have brought him into an interface with the Ohio Dental Association Sub-committee on Fluoride, the American Chemical Society, the American Association for the Advancement of Science and the Sigma Xi, as well as the European organization for Caries Research. As a Deacon and Elder of the United Presbyterian Church of the United States, and Past President and Past Chairman of the Board of Trustees of Children's Dental Care Foundation, Dr. Gray has served the profession of Dentistry and his community well and has most certainly promoted the advancement of Dentistry throughout the world.

Mr. President, it is an honor and a pleasure to present Dr. John A. Gray to you for Honorary Fellowship. △

AWARD OF MERIT TO ESTHER F. RICHWINE

Citation Presented by Regent Dr. H. Curtis Hester

Esther F. Richwine

The supporting services of dentistry are universally recognized as being very important to the mission of the profession. From these derive many of the elements which enhance the effectiveness of dentistry for the delivery of care and the management of its own affairs. The Award of Merit of the American College of Dentists was established by the Board of Regents on February 8, 1959 in order to recognize unusual contributions made toward the advancement of the profession of dentistry and its service to humanity by persons who work with the profession in common purpose but are not Fellows of the College.

The recipient of this Award this year is Mrs. Esther Richwine, Executive Director of the Pennsylvania Dental Association. Mrs. Richwine's career has been devoted to business administration, government and the health professions. She has played an important role in the Pennsylvania Health Council since 1961, having served as its President in 1978–79. She has also served as Chairman of the Pennsylvania Health Conference as well as of major committees for both the Council and the Conference.

Mrs. Richwine joined the Pennsylvania Dental Association in 1971 as an Administrative Assistant whose principal duties were in legislation as a lobbyist. In 1974 she became Assistant Executive Director. She was responsible for the legislation which permitted a dental student who has completed two years of dental school to be licensed, after passing the Dental Hygiene Board, as a Dental Hygienist. She also affected a change which redefined Dental Hygiene in the Dental Law. Under her direction, an urban continuing education program was organized which brought clinicians into the outlying areas.

Mrs. Richwine was made Executive Director of the Pennsylvania Dental Association in 1975. Since that time, the management and organization of this association has blossomed and become most effective. Through her leadership, closer harmony and better understanding has been developed among the members of the ten districts of the society and the functions of the Association. Liaison was developed with the State Health Department, the State Dental Council and Examining Board and the State Welfare Department, with resulting better services. She has served the profession well.

Mr. President, it is a privilege and honor for me to present Mrs. Esther F. Richwine to you for the Award of Merit. △

FELLOWSHIPS CONFERRED

Fellowships in the American College of Dentists were conferred upon the following persons at the Annual Convocation in Anaheim, California on October 1, 1983

JACOB ABELSON
New York, New York

SIGMUND H. ABELSON
Los Angeles, California

RICHARD ADELSON
Washington, D. C.

CHARLES F. AINLEY
Paragould, Arkansas

JOHN W. ALLEN
Dallas, Texas

FRANK H. ANDERSON
Johnson City, Tennessee

STANLEY J. ANTONOFF
New York, New York

FREDERICK E. AURBACH
Dallas, Texas

JEROME H. BALBUS
Flushing, New York

EDWARD D. BARRETT
Auburn Heights, Michigan

DON H. BARROW
El Dorado, Arkansas

ROBERT L. BARTHELD
McAlester, Oklahoma

PAUL BARTON
Indianapolis, Indiana

HOWARD F. BEACHAM
Fayetteville, New York

PATRICIA L. BLANTON
Dallas, Texas

JAMES P. BORDELON
Thibodaux, Louisiana

E. WILLARD BOWDISH
Utica, New York

BENJAMIN V. BRALY
San Francisco, California

JAMES I. BRIDGES
Santa Rosa, California

SIDNEY R. BRIDGES
Philadelphia, Pennsylvania

FRED J. BRONSON
Cincinnati, Ohio

CHARLES L. BRORING
Bethesda, Maryland

LAUREL E. BROWN
Portland, Oregon

CLARENCE M. CALMAN
New York, New York

MALCOLM D. CAMPBELL
Dearborn, Michigan

PHILLIP M. CAMPBELL
Huntsville, Texas

JAMES J. CAVENEY
Wheeling, West Virginia

HARRY O. CHANNON
Elgin, Illinois

DONALD C. CHASE
Knoxville, Tennessee

GEORGE E. CLARK
Great Lakes, Illinois

EDGAR C. COHEN
New Orleans, Louisiana

WILLIAM O. COLEY, JR.
Memphis, Tennessee

CHARLES S. COLOMBO
Flushing, New York

H. DALTON CONNER
Colorado Springs, Colorado

JOHN R. COOK
Grand Rapids, Michigan

GOLDANNA CRAMER
Salem, New Jersey

STEPHEN R. DAILEY
Missoula, Montana

TROY E. DANIELS
San Francisco, California

JOHN A. De VOY
Short Hills, New Jersey

TERRY D. DICKINSON
Houston, Texas

MELVIN P. DUMKE
Mankato, Minnesota

EDDIE C. DuRANT
Sumter, South Carolina

GERALD R. DUSZA
Oak Park, Illinois

RICHARD J. ENNIS
San Francisco, California

ROBERT L. EWBANK
Danville, Illinois

WILLIAM S. FALLA
Hyannis, Massachusetts

JAMES W. FARER
New York, New York

RODDY N. FELDMAN
Fairfield, California

DEAN S. FIELDS, JR.
Rochester, Michigan

MICHAEL E. FLEMING
Troy, New York

JOHN H. FLOWER
Englewood, Florida

A. PETER FORTIER
New Orleans, Louisiana

HAROLD M. FOSTER
Bay Harbor, Florida

LOUIS V. FOURIE
Rockford, Illinois

H. WILLIAM FOWLER
St. Joseph, Michigan

JACK W. GAMBLE
Shreveport, Louisiana

R. HOGAN GASKINS, JR.
Jacksonville, North Carolina

HARRIET S. GOLDMAN
Brooklyn, New York

WILLIAM E. GOODMAN
Miami, Oklahoma

GEORGE J. GOODREAU, JR.
Panama City, Florida

IRA GOULD
Norfolk, Virginia

GARY W. GRAU
Chicago, Illinois

LUIS R. GUERRA
New Orleans, Louisiana

JAMES E. HAMNER, III
Memphis, Tennessee

JOHN W. HARRISON
Fort Hood, Texas

PAUL P. HATREL
New Orleans, Louisiana

CHARLES E. HAWLEY
Baltimore, Maryland

JAMES W. HEATH
Des Moines, Iowa

WILLIAM D. HEFFRON
Rockdale, NSW, Australia

JAY W. HILL
Burbank, California

LOUIS E. HIRSCHMAN
Huntington Woods, Michigan

DAVID HOGAN
Muskegon, Michigan

DANIEL L. HOHMAN
Hagerstown, Maryland

EUGENE E. HOUK
Jefferson, Iowa

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Floral Park, New York

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Van Nuys, California

STUART ISLER
Denville, New Jersey

PETER A. JENSEN, JR.
Tucker, Georgia

LYSLE E. JOHNSTON, JR.
St. Louis, Missouri

DONALD I. JONES
Pompton Plains, New Jersey

S. STEVEN JONES
New York, New York

ROBERT I. KAPLAN
Wantagh, New York

BERTRAM KASWINER
Springfield, New Jersey

BARBARA CLARK KAY
Danvers, Massachusetts

GEORGE E. KEARNS
Lake Forest, Illinois

MAURICE J. KELLER
Evansville, Indiana

EDWARD J. KERR
Glens Falls, New York

ROBERT L. KIMBROUGH
Chicago, Illinois

ROBERT W. KLINESTEKER
Grand Rapids, Michigan

ISAAC KONIGSBERG
Houston, Texas

DAVID L. KOTH
Chapel Hill, North Carolina

JOSEPH J. KRAJEWSKI
San Francisco, California

RAY S. KRUG
Lakewood, Colorado

ROBERT J. KUHN
Santa Barbara, California

CHARLES L. LAKE
South Charleston, W. Virginia

NORMAN K. LANDMAN
Hollywood, Florida

HOWARD M. LANG
Newport Beach, California

DANIEL A. LARSON
Duluth, Minnesota

JESUS L. LASTRA
Miami, Florida

JOHN P. LEHMAN
Whittier, California

LOWELL J. LEVINE
Huntington Station, New York

JAMES E. LINDENMUTH
Aurora, Colorado

GEORGE W. LINGEN, JR.
Oak Lawn, Illinois

W. BROOK LOVE
Winnipeg, Manitoba, Canada

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San Diego, California

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Chicago, Illinois

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Oakbrook, Illinois

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St. Louis, Missouri

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Memphis, Tennessee

GLENN M. MASUNAGA
Honolulu, Hawaii

WATANA MATHURASAI
Bangkok, Thailand

CHARLES J. MEHLUM
Phoenix, Arizona

JOHN C. MELTON
Las Cruces, New Mexico

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Atlanta, Georgia

MICHAEL R. MILLER
San Bernardino, California

FRANK J. MIRANDA
Oklahoma City, Oklahoma

CYRIL R. MIRMELSTEIN
Newport News, Virginia

JACK P. MOLLENKOPF
Lafayette, Indiana

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Montgomery, Alabama

ALSTON J. McCASLIN, V
Savannah, Georgia

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Minneapolis, Minnesota

WILLIAM H. McHORRIS
Memphis, Tennessee

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Jackson, Tennessee

DAN NATHANSON
Boston, Massachusetts

EDWARD T. NELSON
Thief River Falls, Minnesota

DALE C. NICKELSEN
Elgin, Illinois

KENNETH D. OLER
Redding, California

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Troy, New York

JACK S. OPINSKY
Hartford, Connecticut

ROBERT E. OSBON
Taylors, South Carolina

ROBERT J. OTT
Westfield, New Jersey

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Denver, Colorado

PAUL F. PEPPARD
Palos Verdes Peninsula, CA

RICHARD S. PEREZ
Fort Washington, Maryland

W. BAXTER PERKINSON, JR.
Richmond, Virginia

A. MAXWELL PERLSWEIG
Salem, New Jersey

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St. John's, Newfoundland

WILLIAM W. PETERS
DeRidder, Louisiana

JAMES R. PLATT
Fort Wayne, Indiana

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Gordonsville, Virginia

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West Allis, Wisconsin

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Worthington, Ohio

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Denton, Texas

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Jefferson City, Missouri

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Jacksonville, North Carolina

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New York, New York

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New York, New York

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Hinsdale, Illinois

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El Paso, Texas

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Richfield, Minnesota

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Philadelphia, Pennsylvania

MILTON F. RUBIN
Cuyahoga Falls, Ohio

FRIEDA G. RUDO
Baltimore, Maryland

RAYMOND T. RUFO
Augusta, Georgia

A. LYNN RYAN
Ridgefield, Washington

ROBERT G. RYAN
Duluth, Minnesota

ARTHUR J. SACHSEL
Bolling AFB, Washington, D.C.

RICHARD J. SCHOESSLER
Pierre, South Dakota

BENJAMIN SEDLEZKY
Westmount, Quebec, Canada

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Melrose, Massachusetts

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Reading, Massachusetts

ROBERT J. SHEMO
Wyoming, Pennsylvania

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Pensacola, Florida

WILLIAM B. SHROPSHIRE, SR.
Atlanta, Georgia

CLAUDE I. SIME
Madison, Wisconsin

JAMES H. S. SIMON
Long Beach, California

JULIAN SINGER
Los Angeles, California

HANS S. SJOREN
Rancho Mirage, California

CHARLES J. SLAGLE
Greenwich, Connecticut

CHARLES S. SOLOMON
New York, New York

JEROME G. SPIELBERGER
Manchester, Ohio

JERALD P. STARR
Columbus, Ohio

JOHN J. STEPANOVICH
Grand Rapids, Michigan

WILLIAM J. STOFFEL
Cicero, Illinois

FRED J. STOUT
Missoula, Montana

DONALD E. STROUD
Warren, Michigan

OLLIE L. STUKES
Hartsville, South Carolina

ROBERT E. SULLIVAN
Lincoln, Nebraska

THOMAS J. SWIFT
Andover, Massachusetts

GARY N. TAYLOR
LaGrange, Illinois

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Texarkana, Arkansas

GEORGE W. THOMAS
Waycross, Georgia

GORDON W. THOMPSON
Edmonton, Alberta, Canada

JOHN D. THORPE
Chicago, Illinois

JAMES A. TOBIAS
Clearwater, Florida

WILLIAM J. TROLLEY
Rochester, New York

FELIX T. TROMMER
Norwich, Connecticut

BERNARD TUCHMAN
New York, New York

HERBERT J. UNDERHILL
East Greenwich, Rhode Island

ROBERT L. VANARSDALL, JR.
Villanova, Pennsylvania

RICHARD J. Van SCIVER
Moorestown, New Jersey

JOHN R. VAROSCAK
New York, New York

MICHAEL VOLD
Skokie, Illinois

JAMES E. WADDELL
West Palm Beach, Florida

WILLIAM A. WAGNER
Fullerton, California

R. GENE WALKER
Clovis, New Mexico

IRWIN R. WEINER
Akron, Ohio

GERALD S. WEINTRAUB
Philadelphia, Pennsylvania

ROBERT B. WELDEN
Beaufort, South Carolina

THEODORE L. WEST
Englewood, New Jersey

WILLIAM F. WHITE
Ravenswood, West Virginia

JOSEPH M. WIESENBAUGH, JR.
Hagerstown, Maryland

FRED B. WILLARD
New Braunfels, Texas

LLOYD W. WILLIAMS
Schenectady, New York

ROBERT W. WILLIAMS
Boca Raton, Florida

ROBERT M. WOODSIDE
San Antonio, Texas

WARREN D. WOODWARD
Baton Rouge, Louisiana

TOBIAS YOSPIN
Roslyn, New York

MOHAMED ZAMALUDIN
Clinton, Maryland

POSTHUMOUSLY:

GORDON G. MACALASTER
Laconia, New Hampshire

ELIOT L. ZIGELBAUM
Framingham, Massachusetts

DECEASED FELLOWS

November, 1982–October 1983

*ANDERSON, LELAND D.
Stanton, NB

*ANDREWS, LAVERNE
St. Joseph, MI

*BAKER, FREDERICK C.
Crown Pt., IN

*BENTON, JACK R.
Appleton, WI

*BOWERS, DONALD E.
Toledo, OH

*BRADSHAW, JOHN P.
Norfolk, VA

*BROWN, COLEMAN T.
Dunedin, FL

*CAFFERATA, HAROLD
Reno, NV

CARARA, CHARLES E.
Burlingame, CA

*CARMAN, J. LYNDON
Littleton, CO

*CARSON, JAMES W.
Claremont, CA

*LIFE FELLOW

*CASEY, LEO J.
Chippewa Falls, WI

*COBIN, HAROLD P.
New Port Richey, FL

*CONGLETON, RALPH B.
Lexington, KY

*CUPPLES, ROBERT A.
San Jose, CA

*DAVIS, WILBUR M.
Winter Park, FL

*DICKERSON, LEON E.
White Plains, NY

*DINHAM, GEORGE A.
Duluth, MN

ECHLIN, ROBERT E.
Burlington, Ontario, Canada

EISSMAN, HAROLD
Reno, NV

*ENDICOTT, CLARENCE L.
London, England

FARR, CASWELL J.
Bellingham, WA

*FRANK, VICTOR H.
Philadelphia, PA

GELDART, S. GORDON
Alberta, Canada

*GERENDASY, SAMUEL
Southfield, MI

*GILBY, RAY
Cincinnati, OH

GRANDICH, RUSSELL
San Antonio, TX

*HAGEN, THOMAS J.
San Antonio, TX

HESS, ROBERT B.
Quarryville, PA

*HOOPER, ROBERT H.
Anderson, TX

*HUXTABLE, HARVEY S.
Mineral Point, WI

*JOHNSTON, LLOYD W.
Denver, CO

*KENNEDY, ROSS R.
Elkhart, IN

*KROMER, PAUL C.
San Antonio, TX

*LEONARD, RICHARD
Sykesville, MD

DECEASED FELLOWS

*MARKS, RODNEY H.
Sullivan, IL

*MCCARTHY, FRANK M.
Olean, NY

MERROW, WILLIAM W.
Morgantown, WV

*MEISEL, E. GEORGE
Pittsburgh, PA

MESSNER, JACK M.
Great Falls, VA

MICKLER, ARTHUR M.
Louisville, KY

*MITCHELL, ROY D.
Atlanta, GA

*MORREY, LON W.
St. Petersburg, FL

*MOSS, JR., DANIEL C.
Miami, FL

MURPHEY, MARCUS D.
Houston, TX

*NOBERT, OLIVER E.
Sun City, AZ

*LIFE FELLOW

*OSMUN, WILLIS R.
Elizabeth, NJ

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MEDICAID DENTISTRY

Xenophobia's Offspring:

H. Barry Waldman*

In the middle of the 1960s, during the Congressional review of then pending Medicare and Medicaid legislation, the American Dental Association opposed dental care for the aged under the Medicare bill and lobbied for the inclusion of dentistry as a benefit under the proposed extension to the Kerr-Mills legislation for services to the poor (Medicaid). Looking back after almost 20 years, the profession may have selected the wrong option at a crucial point in the nation's legislative history and hence, may have contributed to the difficulties currently facing the profession.

In the 1980s, we are aware of the impact of the energy crisis and the consequences of oil stagflation, spiraling unemployment and astronomical budget deficits. All of this was in the future. It was the mid 1960s and the nation was completing a host of health and social legislative efforts which would effect the direction for decades to come. But today the costs of health care have caught up with the entire economy.

For example, probably few are fully aware of the overall fiscal consequences of one minor extension to the Medicare program to meet the kidney disease problem. When the legislation was enacted in the early 1970s, the number of kidney disease beneficiaries was estimated at 11,000. By the early 1980s, it was approximately 50,000 and is expected to reach 90,000 by 1995. In 1974, the cost of the program to the federal government was more than $242 million; it was more than $1 billion in 1979 and is expected to top $4.5 billion in 1995. Already, 10 percent of all Medicare Part B funds are being spent on 50,000 kidney patients, while 23 million other enrollees divide the other 90 percent. Equally distressing is the fact that a recent study found that in 1979, 44 percent of kidney dialysis patients were unemployed and more than 50 percent were, in all probability too ill to hold a job. At least 20 percent could not lead independent lives.[2]

> At a time of major expansion of federal legislation into health and social welfare programs . . . the (American Dental) Association preferred, for the then perceived long-term political, professional, and community health benefits, to follow the path of optional, individual, state-initiated programs under the umbrella of Medicaid.[1]

The dental profession continues to be confronted by a host of new and changing dilemmas in the 1980s. But after almost 20 years of operation, it would seem to be appropriate to review dental care under the Medicaid program in an effort to understand the potential outcome of the number of legislative efforts currently under consideration which could curtail health care expenditures.

The following presentation will review the basic aspects of the Medicaid program, overall expenditures, the numerous dental components, expenditures for dental services and related factors.

Medicaid—what is it?

Title XIX of the Social Security Act provides for a program of medical assistance for specified low-income individuals and families. The program, known as Medicaid, was enacted in 1965. It succeeded earlier welfare-linked medical assistance programs, most notably the Kerr-Mills program of medical assistance for the aged. In 1981, Medicaid cost $31.3 billion in combined federal and state funds while providing benefits equal to 11.7 percent of personal health care

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expenditures. In 1981, hospital care and nursing home care each accounted for more than a third of program benefit expenditures.[3] It is the primary source of health care coverage for the poor in the United States.

Medicaid is financed jointly with state and federal funds. The federal share of Medicaid payments in a given state is derived from a formula based on the state's per capita income. The federal contribution ranges from 50 to 77 percent, averaging 55.2 percent nationwide.*

Medicaid is designed to provide assistance to those groups or categories of individuals who are eligible to receive cash payments under one of the existing welfare programs established under the Social Security Act:

(1) Title IV-A, the program of Aid to Families with Dependent Children (AFDC) which makes payments to members of families with dependent children where one parent is absent, incapacitated or unemployed. (Persons receiving unemployment compensation are precluded from coverage, although persons are permitted to refuse unemployment compensation and receive welfare benefits instead, if they are otherwise eligible.)

(2) Title XVI, the Supplemental Security Income (SSI) program for the aged, blind and disabled. In general, receipt of a welfare payment under one of these programs results in automatic eligibility for Medicaid. However, since 1974, when the welfare programs for the aged, blind and disabled were federalized as the SSI program, states may exclude some of the SSI cash assistance recipients from automatic medicaid eligibility if they are eligible only because the standards for the federal program are more liberal than those previously used by the state.

It is important to note that Medicaid does not provide medical assistance to all of the poor. Low income is only one test of eligibility. Resources also are considered. And most importantly, a prospect recipient must belong to one of the groups designated for welfare eligibility to be covered.

Many persons are covered under both the Medicare and Medicaid programs. Medicare covers both inpatient hospital and supplementary medical services. Coverage of inpatient services (Part A of Medicare) is automatic for persons over 65 years, specified disabled persons who have insured status under the Social Security System and patients eligible for the End Stage Renal Disease program benefits, e.g. kidney dialysis. Coverage for the supplementary medical insurance program (Part B of Medicare) requires payment of a monthly premium. Many states make this payment for their Medicaid eligibles who are also eligible for Medicare, but who are unable to afford the Part B Premiums. When individuals are eligible under both programs, Medicare makes the primary payment for the services and state Medicaid expenditure is limited to the deductible and co-payment amounts.

Title XIX of the Social Security Act requires that certain basic services must be offered in any state Medicaid program, including inpatient hospital services, outpatient hospital services, laboratory and x-ray services, skilled nursing facility services for individuals 21 years and older, home health services for individuals eligible for skilled nursing services, physicians' services, family planning services, rural health clinic services and early and periodic screening, diagnosis and treatment services for individuals under 21 years of age. In addition, states may elect to provide a number of other services, including pharmaceuticals, eyeglasses, private duty nursing, intermediate care facility services, physical therapy, dental care, etc.

States determine the scope of services that are offered. For example, they may limit the days of hospital care or the number of physicians' visits covered. They also, in general, determine the reimbursement rate for services, except for hospital care, where states are required to follow the Medicare reasonable cost payment system. Since 1976, they have been required to reimburse for skilled nursing facility and intermediate care facility services on a reasonable cost-related basis.

States exercise major control over the income eligibility levels for Medicaid by determining the eligibility level for the welfare programs. They set the AFDC level and determine the amount of supplement, if any, of the basic federal SSI payment. If the state covers the medically needy, (i.e. those individuals who meet all the requirements for AFDC or SSI, but whose income is higher than the level for eligibility set by the state before their income is adjusted for medical expenses) it may establish the income level for eligibility at any point between the cash assistance eligibility level for an AFDC family and 133 1/3 percent of the payment to such an AFDC family. As a consequences of all their variations—in benefits offered, in the groups covered, in income standards and in levels of reimbursement for providers, the resultant Medicaid programs differ greatly from state to state.

Medicaid operates as a vendor payment program. Payments are made directly to the provider of services. Providers must accept the Medicaid reimbursement level as payment in full. Individuals, however, are required to turn over excess income to help pay for their

*The actual formula used in determining the state and federal share is as follows:

$$\text{State share} = \frac{(\text{State per capita income})^2}{(\text{National per capita income})^2} \times 45\%$$

Federal share = 100 percent minus the state share (with minimum of 50 percent and a maximum of 83 percent)

It should be noted that no state currently receives more than 77 percent. In addition, no adjustment is made for varying costs of living indices in the states.

care in a nursing home. Co-payments may also be required.

Finally, all 50 states participate in the Medicaid program at their option. The State of Arizona joined the system in 1982 under a competitive bidding cost containment experimental arrangement. Dental services will be provided to children in the second year of the program. In addition, the District of Columbia, Puerto Rico, Guam and the Virgin Islands provide Medicaid coverage.[4]

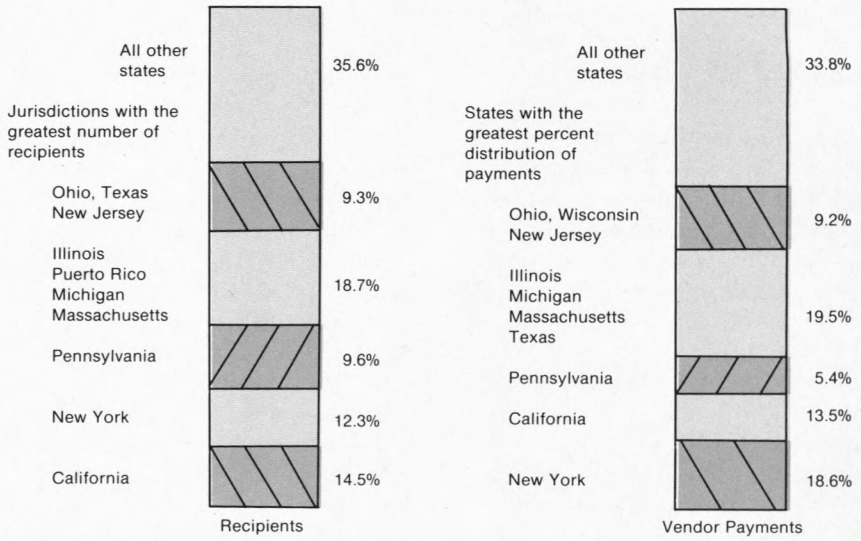
Overall Medicaid expenditures

Since the start of the Medicaid program in 1966, there has been dramatic growth in the overall Medicaid expenditures for health care services. The expenditure of $.3 billion in the first year of program has increased to over $3.13 billion in calendar year 1981. (Table I)

The largest states, especially New York and California account for a disproportionate share of total Medicaid expenditures. By the late 1970s, New York accounted for 18.6 percent of all Medicaid expenditures; California 13.5 percent, with 10 largest state programs expending 66.2 percent of total program dollars. (Chart I)

The Medicaid program finances more long-term non-acute, institutional care than does the Medicare program. Long term care includes services from nursing facilities, mental hospitals, and some health agencies. By far the fastest growing segment of the Medicaid program is the intermediate care facilities

Chart I. Percent distribution of Medicaid recipients and of Medicaid vendor payments by size of state programs: fiscal year 1977[7]



Adapted from Donabedian, A. et al. Medical Care Chart Book[6]

Table I. Total federal and state Medicaid and related program payments to providers of health services and percent increase over previous year: fiscal years 1966–1980 and calendar year 1981.[2,4,5]

Fiscal Year	(Amounts in Billions) Medicaid	Kerr-Mills and related programs	Total	Percent increase over previous year
Ending June				
1966	$ .3	$1.2	$ 1.5	—
1967	1.9	.3	2.2	42.7%
1968	3.2	.2	3.4	52.0
1969	4.1	.2	4.3	26.1
1970	4.9	.1	5.0	17.1
1971	6.3	—	6.3	24.6
1972	7.3	—	7.3	15.8
1973	8.6	—	8.6	17.8
1974	9.9	—	9.9	15.5
1975	12.2	—	12.2	23.1
1976	14.1	—	14.1	15.0
Ending Sept.				
1977	16.2	—	16.2	15.1
1978	17.9	—	17.9	10.4
1979	20.4	—	20.4	13.8
1980	23.2	—	23.2	13.8
Calendar Year				
1981	31.3	—	31.3	—

program for the mentally retarded.[3] Overall, between 1970 and 1980 there was a 350 percent increase in the intermediate care segment of Medicaid expenditures. During this same general period, the dental service segment of Medicaid expenditures decreases by 42 percent—the greatest decrease for all types of services. (Table II)

Medicaid recipients and expenditures

As noted above, Medicaid eligibility is linked to the federally assisted cash assistance programs. Medicaid recipients must quality on the basis of eligible categories: aged, blind disabled, children under 21 and adults in AFDC families. The number of recipients has varied at different points in time. However, children under age 21 consistently account for over 40 percent of recipients of benefits. Similarly, adults in families with dependent children continue to represent somewhat over 20 percent of recipients. (Table III)

Although children under age 21 and adults in families with dependent children constitute approximately two-thirds of the total number of recipients of Medicaid funds, in terms of actual expenditures, recipients in the aged category have consistently received a far greater share of the expenditures. In fiscal year 1980, the 15.8 percent of all recipients who were categorized as "aged" received 37.4 percent of all funds. The combined categories of children under age 21 and adults in families with dependent children received less than 28 percent of total expenditures during the same period. (Table IV)

Dental Programs

In the mid 1970s the staff of the subcommittee on Long-Term Care of the Special Senate Committee on Aging presented a general description of "medicaid mills" which may summarize the usual perceptions of services provided under this program.

> A "medicaid mill" is generally a hole-in-the-wall located in a dilapidated part of town . . . Most are designed for visibility. Many carry pennants and banners . . . Some advertise their presence with arrows painted on neighboring buildings and the words "centro medico" or "medical center" written above or below.
>
> . . . The doctors found in mills are also characteristic. They tend to be foreign medical graduates. They tend to be young. They tend to work "welfare medicine" exclusively and have no private practice.
>
> . . . The best thing that can be said for such facilities is that they are located in the ghettos—the areas of greatest need.[8]

But dental care under the Medicaid program is a nationwide program and it is far more extensive than the examples of abuse and fraud presented in the Senate staff committee report on "medicaid mills" in New York City. As of January 1982, 31 states offered a range of dental services to children. Adult dental benefits are more limited. Restrictions on adult services frequently exclude denture services, endodontic treatment and other forms of complex fixed and removable prosthetic therapy. Adult services may be limited to treatment only in emergency conditions. Eleven states provide comparable services to both adults and children. In eight states, dental benefits were offered only to chil-

Table II. The percent distribution of total federal and state Medicaid benefit expenditures by type of service and percent change between 1970 and 1981: selected fiscal years 1967–1980 and calendar year 1981.[3,4,7]

	1967	1970	1975	1976	1977	1978	1979	1980	1981	Percent change 1970–1981
Inpatient hospital care	40.2%	36.9%	31.8%	31.7%	31.5%	30.8%	31.4%	30.6%	34.1%	−7.5%
Nursing home care	33.7	25.8	20.1	18.2	17.2	17.7	16.4	15.9	38.3*	−38.4**
Intermediate care	—	5.9	17.7	19.5	22.0	24.2	25.7	26.6	NA	+350.8**
Physician services	9.9	11.3	10.0	9.7	9.2	8.8	8.0	8.0	8.9	−21.2
Dental Services	3.2	3.3	2.8	2.7	2.5	2.1	2.1	1.9	1.9	−42.2
Prescribed drugs	7.9	7.7	6.6	6.7	6.2	6.0	5.8	5.6	5.4***	−27.2**
Other services	5.1	8.9	11.0	11.3	11.4	10.5	10.6	11.4	11.3	+26.9
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	

*Percentages for nursing home and intermediate care are combined.
**Percent change between 1970–1980
***Includes some over-the-counter drugs and sundry items.

Table III. Number and percent of Medicaid recipients by basis of eligibility: fiscal years 1970, 1975, 1980.[4,5]

(Recipients in thousands)

	1970		1975		1980	
	No.	Percent	No.	Percent	No.	Percent
Aged	3,200	22.0%	3,643	16.5%	3,420	15.8%
Blind	107	.7	106	.5	92	.4
Disabled	1,200	8.3	2,265	10.3	2,727	12.6
Children under age 21	6,500	44.8	9,602	43.6	9,283	42.9
Adults in families with dependent children	3,500	24.1	4,573	20.8	4,784	22.1
Medically indigent	NA	—	1,824	8.2	1,507	6.9
TOTAL	14,507	99.9%	22,013	99.9%	21,617	100.7%

Table IV. Medicaid vendor payments by recipient eligibility category: fiscal years 1972, 1975, 1980.[5]

(Amount in millions)

	1972		1975		1980	
	Amount	Percent	Amount	Percent	Amount	Percent
Aged	$1,925	30.5%	$ 4,649	37.8%	$ 8,730	37.4%
Blind	45	.7	83	.7	131	.7
Disabled	1,354	21.7	2,874	23.4	7,004	30.1
Children under age 21	1,139	18.0	2,050	16.7	3,148	13.5
Adults in families with dependent children	962	15.2	2,013	16.3	3,357	14.4
Medically indigent	875	13.9	623	5.1	912	3.9
TOTAL	$6,299	100.1%	$12,292	100.0%	$23,283	99.8%

dren under the Early and Periodic Screening, Diagnosis and Treatment program (EPSDT).[9]

In 1981, the State of California provided at least one dental service to over one million adults and more than six hundred thousand children. On the other hand, Colorado, Utah, and the District of Columbia reported less than 1,000 adults receiving any dental service; and 1,259 children received dental treatment in the State of Utah.[9] (Table V)

Dental program expenditures

Between fiscal years 1967 and 1980, over $3.9 billion were expended by federal and state governments for dental services for Medicaid recipients. Since the mid 1970s, over four million individuals annually received dental care under the auspices of the Medicaid program.[3,4] In terms of expenditures per dental care Medicaid recipient, in fiscal year 1972, federal and state governments expended $70.92 per dental patient. By fiscal year 1980, this had increased to $99.18. However, in terms of constant dollars (i.e. eliminating the effects of inflation) expenditures has actually decreased 29 percent per recipient during the period. (Table VI)

In addition, because of the varied nature (or total absence) of dental programs offered by the many states and political jurisdictions, there has been a large variation in the amount of funds expended per recipient of support ranging in 1981 from $37.55 per individual in Idaho to over $100 per person in 19 states. (Table V) Overall expenditures in 1981 by individual states for dental services ranged from $225,000 by the State of Wyoming to over $133 million by the State of California. (Table V)

Finally, although federal, state, and local governments expended $460. million for all forms of dental services in 1980, total public per capita expenditures (for all U.S residents) amounted to $2.54 or about 3.6 percent of overall per

Table V. Expenditure per dental Medicaid recipient by state: fiscal years 1970 and 1975 and calendar year 1981; numbers of persons who received at least one dental service and overall expenditure for dental benefits by state: 1981.[3,9-11]

	Expenditure per dental Medicaid recipient			1981		
				No. recipients		Overall expenditure (in millions)
	1970	1975	1981	Adults	Children	
United States	$ 67.78	$ 92.65	$ 99.18*	TOTAL 4,658,000*		$ 462. *
Alabama	0	88.20	88.81	NA	43,290	3.8
Alaska	0	113.58	NA	2,850	5,625	1.3
Arizona	0	0	0	0	0	0
Arkansas	55.93	93.83	91.00	7,609	39,658	4.8
California	91.95	81.82	86.77	1,005,195	602,901	133.9
Colorado	0	0	86.61	473	23,438	2.1
Connecticut	47.54	63.00	70.84**	TOTAL of 60,244		4.3
Delaware	0	0	52.25	NA	8,244	.4
District of Columbia	0	94.09	107.25	814	10,656	1.2
Florida	0	83.62	119.66	28,424	58,235	10.4
Georgia	0	207.44	119.53	16.841	71,148	11.2
Guam	0	NA	NA	NA	NA	NA
Hawaii	100.32	93.47	67.30	15,476	26,677	7.6
Idaho	99.50	91.87	37.55	NA	10,664	.8
Illinois	65.50	88.13	36.60	152,433	193,615	37.6
Indiana	72.39	71.07	118.21	34,095	42,759	8.1
Iowa	71.25	80.12	130.74	62,000	23,000	9.5
Kansas	82.27	79.93	114.37	TOTAL of 50,031		5.7
Kentucky	27.39	50.48	94.93	TOTAL of 113,634		
Louisiana	140.71	49.99	NA	NA	NA	NA
Maine	0	60.52	59.21	4,909	31,635	2.2
Maryland	47.04	94.09	75.00	35,515	55,308	6.8
Massachusetts	NA	NA	77.98	87,500**	150,500**	25.9
Michigan	0	115.90	99.90*	54,775*	169,426*	22.4*
Minnesota	54.26	87.91	112.48**	57,078*	62,351*	17.9*

*1980 data
**Estimated

Table V. (continued) Expenditure per dental Medicaid recipient by state: fiscal years 1970 and 1975 and calendar year 1981; numbers of persons who received at least one dental service and overall expenditure for dental benefits by state: 1981.[3,9-11]

	Expenditure per dental Medicaid recipient			1981		
				No. recipients		Overall expenditure (in millions)
	1970	1975	1981	Adults	Children	
Mississippi	$ 21.38	$ 24.86	$ 76.34	19,363	43,841	$ 4.8
Missouri	48.94	46.75	119.38	50,553	64,078	13.7
Montana	77.84	48.03	NA	7,152	8,605	2.3
Nebraska	98.15	99.60	90.21	9,204	12,105	1.9
Nevada	59.10	153.04	176.07	2,500	3,800	1.1
New Hampshire	68.69	105.46	62.74	3,708	7,609	.7
New Jersey	93.43	105.22	117.00	78,523	131,458	24.6
New Mexico	53.98	61.93	102.11	10,920	15,343	2.7
New York	66.23	99.07	NA	NA	NA	45.4*
North Carolina	NA	156.48	138.00	44,586	60,261	14.5
North Dakota	80.08	94.84	187.23	3,971	6,999	2.1
Ohio	68.77	76.98	75.00	91,631	142,763	18.8
Oklahoma	35.79	64.49	175.04	4,414	30,024	6.0
Oregon	52.33	78.07	80.16	10,194	37,028	3.3
Pennsylvania	27.38	37.52	106.14	373,896	267,780	48.8
Puerto Rico	99.25	8.44	NA	NA	NA	NA
Rhode Island	54.14	69.59	NA	NA	NA	3.4
South Carolina	21.26	81.71	70.96	6,438	35,964	5.9
South Dakota	209.66	66.77	NA	NA	NA	.6
Tennessee	0	80.90	116.89	NA	36,835	4.3
Texas	0	0	119.45	NA	58,006	6.9
Utah	107.37	145.41	85.25	969	1,259	2.3
Vermont	79.25	93.84	38.10	NA	13,161	1.1
Virgin Islands	0	14.98	NA	NA	NA	NA
Virginia	146.18	92.50	96.80	NA	61,565	5.9
Washington	75.10	121.74	147.67	41,786	80,456	18.1
West Virginia	38.33	54.61	80.00	12,800	30,340	2.6
Wisconsin	62.50	86.62	113.26	81,895	107,765	21.4
Wyoming	0	80.05	86.68	NA	3,152	.2

*1980 data

Table VI. Federal and state expenditures for Medicaid dental services, dental care recipients, expenditures per dental recipient and expenditures in constant dollars per dental recipient: fiscal years 1972-1980[3]

	Expenditures (in millions)	Number of recipients (in thousands)	Expenditures per recipient	Consumer price index (1967=100)	Expenditures per recipient in constant dollars
1972	$170	2,397	$70.92	125.3	$56.60
1973	206	2,916	70.64	133.1	53.07
1974	265	3,489	75.95	147.7	51.42
1975	350	3,712	94.29*	161.2	58.49
1976	382	4,349	87.84	170.5	51.52
1977	429	4,654	92.18	181.5	50.79
1978	395	4,498	87.82	195.3	44.97
1979	431	4,430	97.29	217.4	44.75
1980	462	4,658	99.18	246.8	40.19

*Expenditures per recipient differ slightly from those presented in Table V. Various government agency documents report somewhat different data.

capita dental expenditures. (Table VII) On the other hand, public expenditures for physician services in 1980 amounted to $25.4 billion, or about $53 per individual and 26 percent of overall per capita physician expenditures.[12]

In terms of constant dollars, per capita public expenditures for dental services actually have decreased by about one third since their "high point" in 1975. (Table VIII) It should be noted that dental Medicaid funds constitute 81 percent of all public expenditures for dental services, with concentration of these services to support less than 10 percent of the population least able to provide private financial resources.[12]

General perceptions

"Many states considering cuts in spending for health care" was the lead headline of the February 4, 1983 issue of American Medical News.[13] The article reports the inaugural addresses of the governors who describe the financial problems facing Medicaid and other state-run programs. The basic problem is summed up by one governor with the statement that, "The major challenge to our health care system today is not medical, it is financial."

The effort to contain burgeoning Medicaid costs has long a dilemma for federal and state legislatures.

Table VII. Per capita dental expenditures by source of payment: selected year 1965–1980[12]

	Out of Pocket	Private Insurance	Federal	State & Local	Total Public	Overall Expenditures
1980	$51.61	$14.27	$1.45	$1.09	$2.54	$68.42
1979	44.02	12.66	1.26	1.00	2.26	58.95
1975	30.76	4.58	1.25	.87	2.12	37.46
1970	20.52	1.18	.62	.45	1.07	22.77
1965	13.74	.21	.16	.08	.25	14.19

Table VIII. Per capita dental expenditures in constant 1967 dollars and per cent distribution by source of payment: selected year 1965–1980[12]

Constant 1967 dollars

	Out of Pocket	Private Insurance	Federal	State & Local	Total Public	Overall Expenditures
1980	$20.90	$5.79	$.59	$.44	$1.03	$27.70
1979	20.33	5.81	.58	.46	1.04	27.18
1975	19.08	2.84	.78	.54	1.32	23.24
1970	17.65	1.01	.53	.39	.92	19.58
1965	14.53	.22	.17	.08	.25	15.01

Percent distribution

	Out of Pocket	Private Insurance	Federal	State & Local	Total Public	Overall Expenditures
1980	75.4%	20.9%	2.1%	1.5%	3.6%	99.9%
1979	74.7	21.3	2.1	1.6	3.7	99.7
1975	82.1	12.2	3.3	2.3	5.6	99.9
1970	90.1	5.2	2.7	1.9	4.6	99.9
1965	96.9	1.5	1.1	<0.1	1.2	99.6

President Reagan's 1982 proposal for "new federalism" (i.e. the "swapping" of programs wherein states would pay for food stamps and Aid to Families with Dependent Children while the federal government would assume all Medicaid costs[14]) is but one of the latest proposals to reorganize and contain costs.

The difficulty faced by the Medicaid program has been its lack of political lobbyists comparable to the "gray power" advocates for Medicare and the general Social Security program. Current efforts to restructure Social Security and Medicare (in an effort to bring them into financial solvency by reduction or delay in benefits) are confronted by unprecedented forces both within and external to the Administration and Congress. No similar organized force has come forth to ensure the continuance of the general Medicaid program.

With almost two decades of hindsight, it is relatively easy to describe the probable error made by the dental profession as it lobbied to be excluded from the proposed Medicare program and included under the Medicaid system. The resultant unreal collage within which dental practitioners find themselves delivering care to millions of Medicaid recipients is surely frustrating, economically impossible and at times demands the provision of services which run counter to sound principles of professional practice.

The lessons to be learned from the profession's and public's experience with Medicaid are many. But surely, the consequences of delivering a needed health service within such a chaotic arrangement must not be lost as the Congress considers the various proposals for pro-competition. The theory under these proposals is that if patients have to spend their own dollars on health care costs, utilization will not be abused, thereby reducing costs. In line with this view, proposals place a limit on the tax deductible amounts employers can spend on health insurance plans. Dentistry is not included in the minimum insurance plans employers must offer. And chances that employees will opt for plans including dental coverage are small, considering that cash rebates will be offered to those who select minimum plans. One commentator before the House Ways and Means Committee stated that excluding dentistry in minimum requirements of the bills would mean that "65 percent of the dental uses who say they now have dental insurance will find themselves without coverage that makes regular dental care affordable."[15]

The dental profession's experience with Medicaid provides ample reason to press for the *orderly* development of programs for third party dental insurance. Hopefully, by understanding the full scope of Medicaid dentistry, practitioners will be better prepared for the eventualities of the future. △

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