

# The Journal of the American College of Dentists

---

---

Summer 1995  
Volume 62  
Number 2

---

Managed Care  
1994 ACD Symposium

# The Journal of the American College of Dentists

A Publication Presenting Ideas,  
Advancements and Opinions  
in Dentistry

The *Journal of the American College of Dentists* (ISSN 0002-7979) is published quarterly by the American College of Dentists, Inc., 839 Quince Orchard Blvd., Suite J, Gaithersburg, MD 20878-1603 and at additional mailing office. Copyright 1995 by the American College of Dentists, Inc.

Postmaster — Send address changes to:  
Sherry Keramidas, PhD, CAE  
Managing Editor  
*Journal of the American College of Dentists*  
839 Quince Orchard Blvd., Suite J  
Gaithersburg, MD 20878-1603.

Subscription rate per year for members of the American College of Dentists is \$20 included in the annual membership dues. Subscription rate per year for nonmembers is \$30. Air mail to Canada and Mexico is an additional \$5, all other foreign addresses are an additional \$20. Single copies: \$6.

While every effort is made by the publishers and Editorial Board to see that no inaccurate or misleading opinions or statements appear in the *Journal*, they wish to make it clear that the opinions expressed in the articles, correspondence, etc. herein are the responsibility of the contributor. Accordingly, the publishers and the Editorial Board and their respective employees and officers accept no liability whatsoever for the consequences of any such inaccurate or misleading opinion or statement.

For bibliographic references, the *Journal* is abbreviated *J Am Coll Dent* and should be followed by the year, volume, number and page. The reference for this issue is *J Am Coll Dent* 1995;62(2):1-48.



Publication Member  
of the American Association  
of Dental Editors

## 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 graduate studies and continuing educational efforts by dentists and auxiliaries;
- D. To encourage, stimulate and promote research;
- E. To improve the public understanding and appreciation of oral health service and its importance to the optimum health of the patient;
- F. To encourage the free exchange of ideas and experiences in the interest of better service to the patient;
- G. To cooperate with other groups for the advancement of interprofessional relationships in the interest of the public;
- H. To make visible to professional persons the extent of their responsibilities to the community as well as to the field of health service and to urge the acceptance of them;
- I. To encourage individuals to further these objectives, and to recognize meritorious achievements and the potentials for contributions to dental science, art, education, literature, human relations or other areas which contribute to human welfare - by conferring Fellowship in the College on those persons properly selected for such honor.



# Features

## Editor

David W. Chambers, EdM, MBA, PhD

## Managing Editor

Sherry L. Keramidas, PhD, CAE

## Editorial Board

Muriel J. Bebeau, MA, PhD  
 Roger J. Bulger, MD  
 Paul S. Casamassimo, DDS, MS  
 Stephen B. Corbin, DDS, MPH  
 Eric K. Curtis, DDS  
 William W. Howard, DDS  
 John P. Howe, III, MD  
 James E. Kennedy, DDS, MS  
 William R. Maas, DDS, MPH, MS  
 Robert E. Mecklenburg, DDS, MPH  
 Lawrence H. Meskin, DDS, MSD, MPH, PhD  
 Edward S. Nacht, DDS  
 Nikolaj M. Petrovic, CAE  
 Jeanne C. Sinkford, DDS, PhD  
 Charles F. Sumner, III, DDS, JD

## Publications Staff

Jo-anne L. Frost, Production Manager  
 Kathleen R. Kalish, Subscriptions

Correspondence relating to the *Journal* should be addressed to the Editor:  
 American College of Dentists,  
 839 Quince Orchard Blvd., Suite J  
 Gaithersburg, MD 20878-1603

The business office of the *Journal of the American College of Dentists* can be reached by  
 Phone: (301) 977-3223  
 Fax: (301) 977-3330

## Officers

Juliann S. Bluit, President  
 Prem S. Sharma, President-Elect  
 Charles V. Farrell, Vice President  
 Alston J. McCaslin, V, Treasurer  
 Chris C. Sures, Past President

## Regents

Roger W. Triftshauser, Regency 1  
 James L. Palmisano, Regency 2  
 Bennett A. Malbon, Regency 3  
 James T. Fanno, Regency 4  
 Richard E. Bradley, Regency 5  
 Robert T. Ragan, Regency 6  
 Jack F. Conley, Regency 7  
 Walter N. Johnson, Regency 8

## Managed Care

- 7 Managed Medical and Dental Care:  
Current Status and Future Directions  
Howard Bailit, DMD, PhD, FACD
- 11 The Implementation of Managed Care in Dentistry  
Albert H. Guay, DMD, FACD
- 14 A Practitioner's Perspective on Managed Care  
Scott T. Jacks, DDS, FACD
- 17 Dental Capitation Programs — Key Decision Factors  
Marvin Zatz, DDS, MPH
- 21 Managed Care...It's BIG, BIG Business  
James R. Pride, DDS

## 1994 ACD Symposium

- 34 Introduction: *Quo Vadis Dentistry?*  
Prem S. Sharma, DDS, LDS, RCS, FACD
- 35 Policy for Dentistry's Future:  
The Pew Health Professions Commission  
Arthur A. Dugoni, DDS, MSD, FACD
- 39 A Policy Analyst's View of Healthcare Reform  
Maureen K. Byrnes, MPA
- 42 The Need for Professional Ethics is Greater Than Ever  
René M. Rosas, DDS, FACD
- 44 Questions & Answers

# Departments

- |    |                 |   |
|----|-----------------|---|
| 2  | From the Editor | <i>Beware the Fourth Party</i>                                |
| 5  | Letters         | <i>Fellows and Readers React</i>                              |
| 23 | Ethics          | <i>The Policy Problem</i>                                     |
| 27 | Agencies        | <i>American Dental Association<br/>Managed Care Resources</i> |
| 29 | Leadership      | <i>The Vision, the Voice, and the Values of a Leader</i>      |
| 32 | Profiles        | <i>Dr. Robert E. Lamb</i>                                     |

---

# FROM THE EDITOR

---

## *Beware the Fourth Party*

**R**elationships are built on interactions — the better the quality of the interaction, the more likely the relationship will last. Dentistry is uniquely built on the relationship between the patient and the dentist. And the quality of that two-party relationship is being threatened as never before.

### ***Two-Party Transactions***

In dental care, there is a mutual exchange in which both the patient and the dentist give and receive something of value and in the process become better for the interaction. Patients receive freedom from pain or potential pain, improved function, enhanced self image, and a sense of having done something for their families. They exchange this for the fees paid to the dentist, lost time (and income if self-employed), and the physical and psychological discomfort, if any, of the visit. Dentists, for their parts, offer their time, experience, and expertise; physical resources such as dental materials, equipment, and laboratory bills; and, the risk of an independent business person, represented by lease-hold improvements, staff salaries, personal insurance, and

other costs associated with making a service available to the public. For their effort and risk, dentists are rewarded with cash payments, personal satisfaction in the quality of work achieved, and typically, the respect of individual patients and the community where they work.

Relationships last as long as there is no better alternative available. There may be some disappointments over unfulfilled expectations, a little grouching about fees or late payments, and, of course, no one gets all the appreciation they are entitled to. But going without dental care or going without patients are not viable alternatives. Arguably, there is no better example of a mutually beneficial professional relationship than the American dental care system.

All of the mutual benefit of a transaction between patients and dentists is not available to them. Transaction costs must be subtracted. Bad debt runs about 5%. Somebody has to pay for the insurance processing, the “no shows,” and office down time. Healthy patients and professionals underwrite infection control. Patients pay in time and gas money for an honest remake. Everybody pays for frivolous lawsuits. Dentists can more

fully serve the public by offering better care and by reducing transaction costs as a percentage of value offered.

There are proven methods for reducing transaction costs. Developing long-term relationships, gathering relevant information, good communication, making the transaction concrete enough to be measured, or anything else that increases trust and reduces risk drives down transaction costs. The dentist-patient relationship is one of the most “trustworthy” of any transactions in American society. Many dentists are treating third generations in a single family; public opinion polls consistently place dentists among the most trusted professionals.

### ***Three-Party Transactions***

Transactions involving a third party share some of the same properties of two-party transactions, but they are different in important ways. Unlike medical and other insurance which is intended to spread potentially catastrophic risk across individuals, dental insurance came into existence as a means of spreading relatively predictable costs and payments across time and as a mechanism for shifting part of the cost to employers and other groups. Classic dental insurance



---

*Insinuating the actuarial perspective of third parties into the dental office as anything other than a clearly subordinate value changes the nature of the profession, to the detriment of the public.*

---

actually reduces some of the transaction costs to patients and dentists and has been the conduit through which a large number of new dental dollars have entered the profession.

Indemnity dental insurance has also increased transaction costs. The “costs of doing business” and reasonable profit for third parties must be subtracted from the benefits potentially available to patients and dentists. But, there are three other costs of third-party transactions that are more damaging.

The cost savings of the personal and trusting relationship between patients and dentists are not possible in third-party situations. The relationships are “arms length,” formal, stripped of individual character, conducted at a distance, and governed by rules and laws. Patients and dentists, as well as the care, are reduced to numbers in the computer. Besides being undignified, this system forgoes the element of trust that is so necessary for reducing transaction costs.

Second, and largely as a result of the formal, distanced relationship of third parties, there is an emphasis on measurability. Documentation, preauthorization, waiting periods, practice profiles, “report cards,” and

other methods are introduced by third parties to overcome their inherent disadvantage relative to the relationship between patient and dentist. The direct cost of these measures is large. The indirect cost is greater. Fee-for-service reimbursement insurance focuses on measurable procedures — amalgams, extractions, crowns, and other procedures that can be seen in radiographs. This makes sense for reducing the risk to third parties; but, it doesn't make sense in terms of patient health. Utilization profiles cannot be substituted for dentists' professional judgment when determining what is in the patients' best interests. The profession has not helped third parties on this matter by its focus on entry level licensure examination as a quality control mechanism rather than finding fraud and incompetence among practitioners — an activity that would reduce the cost to insurers. Because of the high cost of unmeasurable dental transactions, third parties have increasingly turned to capitation systems.

The most damaging cost of third-party involvement in dentistry stems from a difference of opinion about who is the customer. Dentists treat the individual patient, with all of his or her uniqueness; third parties insure cohorts

of people as actuarial averages. To a carrier, the treatment for a particular patient is judged against the norms from a database. To the dentist, treatment is a function of professional judgment considering the individuality and the history of each patient and what works in each practitioners' hands. This is more serious than a few cases where care is compromised for economic reasons. It represents a clash of fundamental perspectives. Dentists are by training — and in my experience, by personal temperament — dedicated first to the professional ethic of the highest standard of individual care. They do not think in terms of averages and patient populations. Insinuating the actuarial perspective of third parties into the dental office as anything other than a clearly subordinate value changes the nature of the profession, to the detriment of the public.

Capitation programs are another form of insurance intended to reduce transaction costs by eliminating the requirements of measurability for individual procedures and to shift the risk of transaction costs to the dentist. They are intrinsically neither better nor worse than other forms of insurance, but most of the plans offered so far are

just bad business. Dentists and patients are not adequately compensated for the increased risk they are assuming.

### ***Fourth-Party Transactions***

How can underfunded capitation plans be offered, and in some cases, be accepted? Part of the answer lies in the market configuration — although the point has been well made that dentistry is not in the same disastrous market position as medicine. The other part of the answer is fourth parties. These are lawyers, regulatory agencies, government, and special interest groups. Fourth parties pursue their own interests in the name of others. The “other” whose interests are being protected need not actually exist or be an active party. For example, in some states a divorce settlement among agreeing men and women can be set aside by lawyers acting on behalf of the state because one of the parties did not have benefit of counsel or even because their infant children did not have their own lawyers. OSHA regulations are enforceable in the absence of a complaining party or evidence of harm.

Third parties’ self-interests stop short of putting large numbers of dentists out of business; fourth parties are not limited in this regard. Fourth-party interactions are also non-voluntary. OSHA inspections cannot be

declined; responding to subpoenas is not optional. There is no best alternative to consider. Where insurance companies use the average as the unit of analysis rather than the individual patient, fourth parties typically focus on a hypothetical worst case. Because lawyers and bureaucrats are paid for their time, not their results, what others regard as a transaction cost is actually a transaction benefit for fourth parties. All of these characteristics combine to dramatically raise the costs of transactions involving fourth parties. But even more pernicious, the economics of conflicts under such circumstances place more pressure on those with the most to lose (usually the dentist, never the fourth party), often producing settlements which have nothing to do with justice.

What have fourth parties to do with underfunded capitation programs? The state of California recently developed a capitation plan for its Medicare patients. A suit by attorneys representing patients has won a stay for the present. One may ask why market forces have sustained capitation programs being developed by some of the third-party companies. The answer is an aberration in the market which concentrates disproportionate power in the hands of a few firms. In the eyes of the Federal Trade Commission, the largest insurance underwriter is an equal market

entity to a single private practice dentist. A market combination of several dentists (except under recently revised guidelines for Individual Practice Associations — IPAs) would be restraint of trade. A similar market combination of several insurance firms might not be. The McCarran-Ferguson Act exempts conduct that is the “business of insurance” from antitrust laws.

In the past months, more than one dinner meeting or lunch have been soured by hand wringing and moralizing over the inequities of managed care. There are forces inherent in some varieties of this payment system that would destroy the patient-dentist relationship that is a foundation for the quality and cost containment that distinguish dentistry from other parts of the healthcare system. But indignation is not an antidote. We must move to the table quickly and present the best alternative. Perhaps that is education, maybe IPAs, quite possibly direct reimbursement, or very likely a combination of these and other action-oriented approaches.

And always, beware the fourth party.



David W. Chambers, EdM, MBA, PhD, FACD  
Editor






---

# Letters to the Editor

---

Dear Editor,

The American Association of Dental Examiners (AADE) is to be applauded on its progressive actions toward reliable quality assurance. Many recognize that mere fulfillment of continuing education requirements guarantees neither the acquisition nor the use of knowledge. This issue was touched on in Dr. Newell Yapple's commentary on the Institute of Medicine report published in the Spring issue of the *Journal*.

In an effort to confirm the ongoing competency of practitioners, AADE has created and endorsed a sophisticated documented entitled *Criteria and Mechanisms for Continued Competency in Dentistry*. This document proposes a diversity of methods by which a practitioner might be determined to be, in fact, competent, and it is intended that the licensee being reviewed have the choice (and bear the cost) of the evaluation method chosen.

Certainly, real-world politics will require that any Board of Dental Examiners wishing to introduce this system through its legislature will need to *grandparent* those already licensed. Yet, think of what such an approach will mean to the dental care available to our great-grandchildren! Further, consider the "freedom of movement" that can be available to someone whose ongoing competence has been documented.

The American College of Dentists should make it a high priority to endorse this most praiseworthy undertaking and encourage everyone concerned to support, promote, and advance requirements for lifelong review of practitioners' competency.

Sincerely,

Don-N. Brotman, DDS  
Baltimore, MD

Dear Editor:

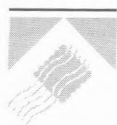
Thank you for the excellent series of articles commenting on the IOM study, *Dental Education at the Crossroads*, in the last issue of the *Journal*. I am concerned that many of our colleagues, both in dental education and in the practicing community, are either unaware of the contents of the report or are treating it in a casual manner. Conversely, there are those who consider the report as a mandate.

My interpretation is that it is a very thought-provoking document for those of us in the profession as we strive to predict what the future holds and how we must meet the new challenges that face us. I hope that there will be considerable discussion and response to the report, for that is its purpose. In that regard, we here at the University of Texas Houston, Dental Branch have instituted several measures. The Executive Council, consisting of all deans and department chairs, has discussed and responded to the document, noting the areas where we have programs in place or planned and discussing those areas where we are lacking. We have organized a half-day seminar, scheduled for May 30, 1995, with Dr. John Howe, Chair of the IOM Committee on the Future of Dental Education and President of our sister University of Texas institution at San Antonio, as our guest to present the report and lead an extended discussion. We have invited all of our faculty, staff, and students, as well as administration from the Medical School, School of Nursing, and the School of Public Health. We have invited dentists from the practicing community, alumni, State Board members, Board of Regents members, university officials, other representatives, and higher education and legislators. We hope to increase awareness of the report and stimulate productive discussion with our gathering.

I would hope that dental educators across the country would take the lead in initiating similar dialogues.

Sincerely,

Peggy A. O'Neill, PhD, DDS  
Houston, TX



To the Editor,

Is participation in managed cost dental benefit programs an issue of freedom? I believe that it is. Freedom has been defined as the absence of coercion. There is a significant element of coercion in all managed cost benefit programs. It begins with the employer. In my opinion, when an employer elects to enroll employees in a managed cost benefit program, that employer is contributing to the loss of freedom of the employees. The employee is economically coerced into participation in the plan. In addition, the employee often loses the right to make the choice of provider of services. Total freedom of choice is lost, including, in some cases, even the choice of treatment, or no treatment, and in most cases the type of treatment.

Dentists are coerced into participation in these programs with the threat of loss of patients if they do not join or with the promise of more patients if they will join. If the dentist chooses to participate in a managed cost program, that dentist will eventually be required by the contractor to offer discounted fees. This, along with utilization review, will be a requirement for participation in the plan without regard to the overhead situation in the particular dentist's office.

Discounted fees and restriction of treatment, in my opinion, benefit no one, as they ultimately lead to inferior treatment and increased economic and ethical stress on the participating dentist.

Dentists who choose to participate in these plans are very short sighted. They seek short-term reward at the expense of the long-term freedom of the dental profession and of the patients they are trying to serve.

All the above statements are or should be familiar to most dentists; however, how many think about the long-term freedom of all dentists and patients?

This is a moral/ethical consequence that needs to be considered by all dentists as they face the issue of participation in managed cost programs.

Are you contributing to the loss of our freedom?

Sincerely,

Charles V. Farrell, DMD

Bellingham, WA

Vice President, American College of Dentists

Dear Editor:

The recent issue highlighting the Institute of Medicine study serves not only to communicate this important assessment of dental education and recommendations for the future, it also adds to the credence of these critical issues through the commentaries from some of the most prominent voices in dentistry.

The process employed by the Institute of Medicine to develop the report, *Dental Education at the Crossroads*, also enhances its credibility. This report can now be added to a number of reports from around the world during the past five years (examples from the Pew Foundation, the World Health Organization, and the Nuffield Foundation in England) challenging dental education to change. Those reports can be grouped with the multitude of similar reports, papers, and conferences during my thirty years' experience in dentistry. I must quickly add that at this point there have been great advances in dental education and within the entire scope of oral health sciences. The profession has much to be proud of! However, we must continue to be challenged; we must continue to expect our leaders to be bold, innovative, and accountable; we must continue to support and strengthen our profession by seeking and confirming strategic alliances with all components of the health professions; and, we must continue to be critical thinkers as followers in pursuit of excellence.

Thank you,

Errol L. Reese, DDS, MS  
Baltimore, MD

Dear Editor,

One of the distinguishing features of a profession is an identifiable body of knowledge. For the profession of dentistry, this has evolved through various degrees of collaboration and independent effort over the centuries. We have learned that this knowledge is, of necessity, set against a background of more general medical knowledge. Indeed, modern dentistry cannot be practiced appropriately without incorporating some very important medical knowledge.

However, some of us practicing and teaching today graduated from programs that had common basic science teaching for medical and dental students. To be kind, I would simply urge caution before moving in that direction again.

Until our medical colleagues are prepared to learn and understand dentistry's contribution to health, and consequently treat dental students as future co-workers in health care, they are unlikely to address them appropriately and effectively. What is appropriate? Equality of purpose, respect for intellect, and choice of mission (profession). Dentistry is not a second choice profession. What is effective? The stimulation and support of learning for the development of dental students in their chosen profession. The medical knowledge that is essential to dentistry must be part of the knowledge that justifies dentistry as a profession. To go further, the movement to combine MD and DDS degrees will not enhance the strength and stature of dentistry but rather will contribute to the perception of inferiority of the DDS degree.

While patients are best served through the collaboration of professionals responsible for their care, it is important for dentistry's collaboration to come from a position of strength; strength of knowledge, skills, ethics and, where appropriate for the care required, leadership.

Yours sincerely,

Douglas V. Chaytor, DDS, MS, MEd, MRCD(C)  
Halifax, Nova Scotia



# Managed Medical and Dental Care: Current Status and Future Directions

Howard Bailit, DMD, PhD, FACD

**T**he medical care delivery system in the United States is undergoing rapid restructuring as employers and other group purchasers seek to control healthcare costs by enrolling members in Health Maintenance Organizations (HMOs) and other managed care plans. So far, the sweeping changes in medical care have had limited impact on the practice of dentistry. Although managed dental care plans are growing, relatively few Americans obtain dental care in these new organizations. The purpose of this paper is to review the current state of managed medical and dental care and to discuss several important factors that are likely to influence the future of managed dental care. Because of the need to be brief, the paper does not address related issues such as the long-term impact of managed care, healthcare reform, quality of care, or the uninsured.

## **Managed Medical Care**

As of July 1994, approximately 65% of the privately insured population of one hundred eighty million participate in some form of managed medical care (HMO, PPO, POS). The annual growth

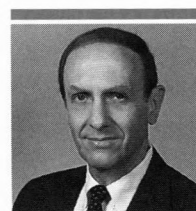
rate in managed care enrollment is over 10%.<sup>1</sup> On the public side, of the thirty-two million Medicaid eligibles, eight million are enrolled in managed care plans. This number is expected to double in the next eighteen to twenty-four months as many states attempt to control Medicaid costs through the use of managed care.<sup>2</sup> Medicare lags behind Medicaid with only three million of its thirty-six million members in managed care plans, but the annual increase in HMO participation is 13%.<sup>3</sup> These data suggest managed care is rapidly becoming the dominant organizational form for delivering medical services. The corollary is that only a small, residual indemnity health insurance market will exist five years from now.

As managed care penetration in local markets approaches 20%, consolidation of managed care organizations (MCOs) takes place through mergers and acquisitions; this is known as horizontal integration.<sup>4</sup> Of the nation's ninety-five largest cities, about 70% have reached the 20% level as of the end of 1993 so that MCO consolidation is now taking place in most metropolitan areas of the country.<sup>5</sup> The end point of this consolidation is seen in many

mature markets (e.g., Boston, Phoenix, Portland, and Minneapolis): three to five companies controlling 70% to 80% of the managed care business.<sup>6</sup>

Vertical integration is also taking place with hospitals and MCOs buying or building primary care group practices. There are even a few instances of hospitals joining with MCOs and traditional payers (e.g., Prudential and Rush Presbyterian Hospital System in Chicago and Blue Cross with the Graduate Hospital System in Pennsylvania).<sup>7</sup>

Eventually, the competitive forces causing horizontal and vertical integration of MCOs, payers, and provider organizations lead to the formation of integrated delivery systems (IDSs), which is the final stage in the restructuring of the delivery system.<sup>8</sup> Characteristically, IDSs own the major components of the delivery system (e.g., hospitals, group practices, surgicenters, home health care) and have very strong alliances



Dr. Bailit is Senior Vice President, Aetna Health Plans, 151 Farmington Ave., Hartford, CT 06156.

with the components not owned; accept one capitation rate for providing comprehensive care to the entire population; have one governing board and chief executive officer; and provide integrated patient care among the different delivery sites.<sup>9</sup> Importantly, IDSs have strong financial incentives to deliver care efficiently, leading to the reduction of excess system capacity including technology, hospital beds, and subspecialists. Some of the better known IDSs are HealthPartners and Allina in Minneapolis, the Henry Ford Health System in Detroit, UniHealth in Southern California, and Sentara in Norfolk.

tant limitation in mind, about fourteen to seventeen million Americans participate in managed dental care plans in 1994, and the annual growth rate is over 10%.<sup>11</sup> Three types of companies offer these plans. National commercial insurers — Prudential, CIGNA, Aetna, and Metropolitan — enroll about five million members.<sup>12</sup> State-based dental service organizations — Blue Cross/Blue Shield and Delta Dental Plans — cover three to four million people.<sup>13</sup> Regional, non-insurer related, dental managed care companies such as Dental Benefit Providers, Safe Guard, and MIDA, have about four to five million members. In addition, several managed

Another important difference between managed medical and dental plans is the cost-sharing arrangements. Dental plans require much higher patient cost sharing, especially under capitation. Typically, basic diagnostic and restorative services are covered under the capitation plan with low cost sharing. In contrast, patients are required to pay a large percentage of charges out-of-pocket for secondary and tertiary services such as periodontal surgery, crowns and bridges, and orthodontics.

Dental managed care is in an early stage of development and lags far behind medicine. The large commercial and not-for-profit indemnity insurers dominate the managed dental care business. However, independent for-profit companies are growing and consolidating and several MCOs have formed dental divisions. So far, the large MCOs and IDSs have not competed on the basis of their dental offerings. This is one reason for the relatively slow growth of managed dental care.

Managed medical care is rapidly becoming the dominant organizational form for delivering medical care. But what does the future hold for managed dental care? The next section considers some of the important supply and demand factors that will determine the future growth of managed dental care. As a general rule, factors increasing the supply or decreasing the demand for dental services lead to greater competition among dentists and in turn, to a business environment conducive to managed dental plan enrollment.

### Supply Factors

- *Dentists:* Relative to the growth of the population, the number of dentists in the work force will begin to decline in the next few years. By the turn of the century, the dentist-to-population ratio will decline sub-

---

***As a general rule, factors increasing the supply or decreasing the demand for dental services lead to greater competition among dentists and in turn, to a business environment conducive to managed dental plan enrollment.***

---

Unlike indemnity health insurance, managed medical care is dominated by strong local and regional companies.<sup>10</sup> Thus, it is no surprise that most IDSs are formed by local MCOs and hospital systems.

The end result of the current restructuring is a healthcare system made up of a few large, locally-based, competing integrated delivery systems, each having a large share of the eligible population. While the rate of IDS formation varies greatly by location, within five to seven years the majority of Americans are likely to receive health care within these organizations.

### Managed Dental Care

There is a paucity of data on managed dental care and the available information is often questionable. Thus, the numbers presented in this paper are, at best, approximations. With this impor-

care companies have small dental divisions including U.S. Health Care, Humana, Kaiser Permanente in Oregon, and FHP. However, most local and regional MCOs do not own or operate managed dental care plans. About 20% to 30% of these companies market the dental plans of local or regional managed dental care companies (e.g., Delta).<sup>14</sup> In almost all cases, dental premiums are separate from medical premiums.

The major managed dental care products are PPOs (68%), HMOs (30%), and POS (2%) plans.<sup>15</sup> Most managed dental plans are built on networks of solo and small group practices. There are very few large staff and group model dental plans, as there are in medicine. Further, compared to medicine, most dental networks are made up of a smaller number of dental practices.



stantially.<sup>16</sup> When dentists are fully booked with private indemnity and self-pay patients, they have less incentive to join managed care plans which require them to discount their fees or accept financial risk under withholds or capitation payment.

- *Technology:* The treatment of dental diseases is changing as basic science and clinical research result in many new and more effective procedures, drugs, and materials. Technological change in medicine has increased the intensity and cost of care.<sup>17</sup> This is likely to be the case in dentistry; the net effect is a decrease in the supply of services as dentists spend more time providing a complex set of preventive, diagnostic, and curative services to fewer patients.
- *Auxiliaries:* With the formation of IDSs, the use of advanced practice nurses as physician substitutes and supplements is increasing. In twenty-four states, midwives and nurse practitioners can practice with substantial autonomy and bill payers directly.<sup>18</sup> Some dental auxiliaries may seek an equivalent clinical autonomy now available to advanced practice nurses. If successful, the auxiliaries will increase the supply of dental services and, in turn, competition for patients.

### Demand Factors

Most of this section examines factors that increase members' demand for dental care. The discussion of "buying coalitions" and "integrated delivery systems" considers the demand for managed dental care. The demand for dental care and managed dental care are related but separate issues.

- *Insurance Coverage:* About ninety-five million Americans have private dental insurance; this number has declined somewhat in the past ten years as large companies reduced

the size of their workforces.<sup>19</sup> The growth of managed dental care is constrained as long as most people do not have dental insurance. With employers focusing on the control of medical care costs, significant expansion of dental benefits is unlikely in the foreseeable future. Indeed, further declines in the number of people with private dental insurance are possible.

- *Tax Cap:* The 1994 national health reform efforts were unsuccessful. Forty million Americans remain without health insurance for at least part of the year.<sup>20</sup> The number of uninsured is growing by over a million people annually, making this a very serious and potentially explosive political problem.<sup>21</sup> One way to finance the care of the uninsured and to slow the rate of healthcare costs is to tax a portion of employer and employee health premiums as earned income. In the unlikely event that the tax cap passes, dentistry may be particularly disadvantaged, leading to fewer people with dental insurance and less generous benefit plans. In effect, the expected impact of a tax cap is to decrease the demand for dental care.
- *Population Demographics:* The American population is aging and traditionally, the elderly have been low utilizers of dental care. This is changing as more senior citizens retain their teeth, are better educated, have greater wealth, and are living longer.<sup>22</sup> Thus, a substantial increase in the demand for dental care is likely as the population ages.
- *Oral Health:* The improvements in the oral health of the American population in the last fifty years are well-documented.<sup>23</sup> Contrary to expectations, the demand for dental services does not decline as oral health improves. In part, this is be-

cause more people retain their teeth and require more services. Also, some evidence suggests the concept of "good" oral health may be changing. Many patients are prepared to pay substantial monies to prevent disease, improve their appearance, and correct problems threatening the loss of function.<sup>24,25</sup> While the mix of services appears to be changing (e.g., fewer simple restorations), the net effect of improvements in oral health is greater demand for dental care.

- *Buying Coalitions:* In many large cities, employers have joined together to form coalitions to purchase health insurance.<sup>26</sup> These coalitions have substantial market clout and have a large say about the organizational forms used to deliver care. These coalitions have the potential for moving large segments of the population into managed dental care plans. So far, the coalitions have focused on medical care. Eventually they may turn to dental services, especially if dental expenditures continue to grow faster than the Consumer Price Index.<sup>27</sup>
- *Integrated Delivery Systems:* Once the medical delivery systems in most cities consist of IDSs, will competition force them to build their own managed dental care plans and to integrate them financially and administratively into their medical plans? This has not happened to date, but it may in the future. Clearly, buying coalitions and IDSs can significantly influence the demand for managed dental care.

As a final comment, it is important to remember the difficulty in predicting the future during a period of rapid and volatile change. We are only sure that the past is gone; the present is full of confusion, and the future is uncertain.

The opinions and assertions contained herein are those of the author and do not necessarily represent the views of the reviewers or Aetna Health Plans. The author acknowledges the help of several colleagues who reviewed drafts of the paper, including Drs. Brent Martin, Tom Gotowka, and David Wesley, Aetna Health Plans; Allan Vogel, Travelers; Jackson Brown, National Institute of Dental Research; and Chester Douglass, Harvard School of Dental Medicine, and the able assistance of Ms. Patricia Szostak for obtaining reference materials.

## References

1. Managed care digest: HMO edition. Marion Merrill Dow, 1994.
2. Personal communication with Mr. Chris Eisenberg, Office of Managed Care, Healthcare Financing Agency, August, 1994.
3. Medicare enrollment in HMOs up strongly since '92. Managed Healthcare Market Report, August 15, 1994. Source of data cited: Office of Managed Care, Health Care Financing Administration.
4. Unpublished data from Aetna Health Plans.
5. Unpublished data from the National Research Corporation Healthcare Market Guide IV, 1993. Made available to the Group Health Association of America.
6. 1993-94 Managed care overview. American Managed Care and Review Association Foundation, 1994.
7. Sanuss, Principal Aetna challenge HMO leaders in Chicago. Managed Health Care Market Report, 1994;2(10):6.
8. Shortell SM. What do ISNs look like now? Unpublished paper presented at a Robert Wood Johnson Foundation sponsored workshop, Integrated Service Networks Under Health Care Reform: From Theory into Practice, conducted by the Alpha Center: Vista Hotel, Washington, DC, March 9-10, 1994.
9. Shortell, SM. *et al.* Creating organized delivery systems: The barriers and facilitators. *Hosp Hlth Serv Admin* 1993;38(4):447-66.
10. Patterns in HMO enrollment. Group Health Association of America 1993, Third Edition.
11. Prepaid dental plan directory, 1993. National Association of Prepaid Dental Plans. Discussions with national leaders in managed dental care.
12. Defino, T. Managed dental catching up to managed medical. *Managed Hlth Care News* 1993 3;(6):30-3.
13. Lindstrand, AG. Dental PPOs come of age. *Amer Assoc Prof Prov Org J* 1994;25:2-7.
14. National survey of employer-sponsored health plans 1993. Foster Higgins Survey of Research Services.
15. Unpublished data obtained from discussions with national leaders in managed dental care.
16. Institute of Medicine, Committee on the Future of Dental Education, Dental education at the crossroads: Challenges and change. National Academy Press, Washington, DC: 1995.
17. Bumer, ST, Waldo, DR, McKusick, DR. National health expenditures projections through 2030. *Hlth Care Finance Rev* 1992;14(1):1-29.
18. Sckencenski ES, Sansom S, Bazell C, et al. State practice environments and the supply of physicians assistants, nurse practitioners and certified nurse midwives. *N Engl J Med* 1994;331(14):1266-71.
19. Facts and figures on the dental benefits market. Research Report. Delta Dental, 1994.
20. Health insurance coverage, 1993. U.S. Department of Commerce, Bureau of the Census Statistical Brief, Oct. 1994, U.S. Department of Commerce.
21. Sources of health insurance and characteristics of the uninsured. Employee Benefits Research Institute, January 1994.
22. Bailit HL. Environmental issues in dentistry: reflections on the practice of dentistry in the 21st Century. *Geriodont* 1987;3:184-92.
23. National Institute of Dental Research. Oral health of United States adults. NIH Publication No. 87-2568, Bethesda, MD: 1987.
24. Clift HC, Redford M. Oral health and quality of life. *Clin Geriat Med* 1992;8(3):673-83.
25. Douglas CW, Furino A. Balancing dental service requirements and supplies: epidemiologic and demographic evidence. *J Am Dent Assoc* 1990;121:587-92.
26. Zelman WA, Starr, P, Robinson *et al.* Perspectives: Health insurance purchasing cooperatives. *Hlth Affairs Suppl* 1993;12:49-137.
27. Williams KR, Bentley JE. Survey findings on dental fees: a comparison from 1982 to 1993. *J Am Dent Assoc* 1994;125:1260-62.

# The Implementation of Managed Care in Dentistry

Albert H. Guay, DMD, FACD

**T**he winds of “managed care” concepts are blowing full force across the medical landscape, leaving few segments of the medical establishment unshaken.

Long-standing relationships among doctors, patients, and hospitals have seen a strong-handed third party interposed. The referral patterns of patients from primary care providers to specialists have been completely changed by the evolution of the “gate-keeper” concept and financial risk assumption for care by primary care providers.

The net result of these changes has been a constriction of the medical care system that is trimming the perceived excess capacity in that system. By reducing payments to providers and limiting the utilization of medical services by patients, managed care organizations have reduced the rate of increase in healthcare costs and, in so doing, have amassed billions of dollars in surpluses.

Because of these financial successes, the projected penetration of the medical care market by managed care is very optimistic — 75% to 80% when all private and governmental programs are considered.

## *Is The Medical Model Applicable?*

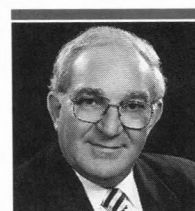
Throughout the history of the health insurance industry, dentistry has seen examples of medical models that have not been as successful when used to control the costs of dental care. Because of the significant differences between dental disease and general disease and the way dental care and medical care is delivered, separate strategies must be employed to solve similarly perceived problems common to both systems.

Several recent examples come to mind. The conversion of in-patient care to out-patient care has saved the medical system a great deal of money. Since dental care is already provided mostly as an out-patient service, no savings from changing the delivery site are available in dentistry. The imposition of a per-visit charge for all medical care restricts the utilization of care and, in turn, saves money. If the patient's natural healing takes place either through procedural delays or patient refusal to accept the per visit charge, it precludes the need for any medical treatment. Dental diseases rarely, if ever, heal without therapeutic intervention. Thus, financial barriers to early access to the dental care system should eventually add rather than save money.

Certainly, there is often a large number of doctors and medical institutions that an average patient must interact with in order to solve even a routine medical problem. Perhaps a point could be made for the added efficiency enjoyed with a primary care “gate-keeper” managing care and assisting patients in negotiating the medical care maze. Since about 80% of each patient's dental care is provided by one primary care provider at one ambulatory site, it may be difficult to see any added efficiency by “managing” dental care.

The two primary vehicles for implementing “managed care” in dentistry, capitation financing and deeply discounted fees, have little to do with the management of dental care, but deal with the management of the costs of dental care. “Managed costs” may be a more appropriate description than “managed care” in dentistry!

Monitoring and review by managed care organizations of the kinds of dental



Dr. Guay is the Associate Executive Director, Division of Dental Practice of the American Dental Association, 211 East Chicago Avenue, Chicago, IL 60611-2678



treatment provided often seem to be driven by the costs for that treatment. Little data exist about the outcomes of alternate treatment modalities in dentistry that can be used to enhance the management of care. "Report cards" issued by some managed care organizations deal primarily with patient satisfaction and the administrative policies of dental offices. While this may be valuable information, it speaks little of the true "quality" of the treatment provided.

### **The Essence of Dental Care**

The over-riding issue in any modifications contemplated for our healthcare system should be the preservation of individual freedom. The patient should be free to choose the doctor who provides treatment; from this it follows the doctor should have the reciprocal right of freedom to treat any patient who seeks care. Restrictions on the freedom of either the patient or provider potentially may lead to an inefficient and unsatisfactory healthcare system. It is clear that in today's healthcare market the purchasers of care are the driving force. They are demanding concessions by providers in both the price of health care and the amount and nature of the care provided. In macroeconomic terms, the power of purchasers to strongly influence the price, nature, and distribution of services is usually seen in markets where there is only one, or a few, purchasers who account for the majority of purchases of those services. Generally, the fewer the purchasers, the steeper the discounts demanded.

Slightly more than half of Americans have either private or publicly-funded dental benefits plans. It is questionable whether such plans will be able to extract the concessions that many are seeking, except in markets where they have dominant market power.

Utilization review using "norms" established by managed care organizations may be inappropriate if conclusions drawn from the review are based solely on statistics. Statistical variation from any norm should be an indicator of a need for a more in-depth evaluation. In the event of disagreements, all parties, including patients, need access to the appropriate professional society peer review system. Managed care participation agreements need not preclude external peer review.

If managed care in dentistry can truly add to the quality and the efficiency of the dental care system, it should be able to stand on its own merits without coercion on any of the participants. Patients should be allowed to enroll or disenroll at appropriate times. Equal dollars, not necessarily equal benefits, should be allocated to managed care plans and other alternatives. As in any free market system, the best plans will survive and prosper.

State and federal governments provide supervision and regulation of the insurance industry to protect the interests of the public. Managed care organizations, because of their direct influence in the amount and type of health care individuals can receive, are significantly important to the well-being of individuals. Thus, governmentally-enforced standards for managed care organizations may be warranted.

Modification or withholding of recommended treatment because of policies of managed care organizations may have untoward results. If this occurs, the managed care organization should share in the liability for such action or inaction. Although the practitioner is always professionally and ethically held to the same standard of patient care regardless of any financial considerations, managed care organizations which assume some control over treatment deci-

sions should share in the liability for those decisions.

### **Plausible Futures**

Predictions about managed care's impact in dentistry are difficult, at best, particularly in this rapidly evolving healthcare market. While no one has a crystal ball, here are some possibilities:

Managed care may not become as pervasive in dentistry as in medicine.

- ☐ Eighty-five percent of Americans have health insurance, less than 50% have dental benefits. Without coverage, there is no vehicle for the penetration of managed care for the major part of the dental care market.
- ☐ Dental services account for less than 5% of the total expenditures for all health care in the United States; thus, limited significant cost savings are available in dentistry.
- ☐ Dental care delivery is different from medicine — it is primarily an outpatient service and generally not a catastrophic financial event. For these reasons the "gate-keeper" concept is not as applicable; changing patterns of treatment and the decreased use of specialty care, as proposed for medicine, are not as applicable.
- ☐ Because patients pay a significant portion of the costs of dental care directly out of their own pockets, market competition has helped keep dental care costs under control through existing business practices.
- ☐ The dental care system is diffuse and not aggregated around hospitals. This means that consolidations

of practices or providers, especially in rural areas, may be very difficult to accomplish.

The effect of any managed care expansion on dental practices structure will significantly vary according to local market characteristics and population demographics.

- ☐ The greatest market penetration and the greatest influence on how dental practices are organized may occur in urban areas.
- ☐ Some dental networks may be included in broader integrated healthcare systems.
- ☐ Where there are large concentrations of managed care patients, there may be pressures to form more dental group practices.
- ☐ There may be relatively little penetration of managed care and little influence on how dental practices are organized in rural areas. Dental practices may be composed of multiple cohorts of patients with varying reimbursement mechanisms.

In general, managed care in dentistry may expand primarily in the preferred provider organization (PPO) mode more than capitation financing. This may occur because of the financial disincentives for providers to increase access to dental care, particularly for the lower socio-economic sectors of the population.

Fee-for-service through private care's continued prominence will depend on a variety of factors, especially patients' relative satisfaction with alternate delivery systems.

In reality, managed care has been a feature of the dental care system for some time. Service corporations have typically required discounts in dental fees as the price for dentist participation. Third-party payers, due to their size and market power, have influenced practice patterns and monitored the type and quality of dental care they administered.

Aside from capitated systems, dentists should have little trouble understanding how managed care operates in their practices. It may be just an intensification of the administrative procedures they have been living with for

some time and an increase in the proposed discounts for promises of access to patient groups under the managed care organization's control.

The key to success for each dentist under managed care is, as always, one of education — to understand all aspects of their practice, to clearly determine the implications a managed care contract would have on their practice, and to then decide whether participation is economically and professionally feasible for them, individually.

The strength of the dental profession rests with the quality of the care that dentists deliver, a proven ability to advance the oral health of the public, and a trusting doctor-patient relationship. If managed care in dentistry can further those goals it will succeed; if not, it will fail.

The predictions offered here are best guesses only. They should not be relied upon by any practitioner to reach a practice decision and are not intended to sway dentists to participate or not participate in managed care plans.

# A Practitioner's Perspective on Managed Care

Scott T. Jacks, DDS, FACD

**D**ental managed care suddenly has become the hot topic among dentists. Many are not sure what it is, but most know they don't like it. Dentists hear physicians complaining about the impact of managed care on medicine and conclude that dentistry must stand its ground and not succumb. They stick their heads in the sand and ignore marketplace realities. Perhaps this is the worst way one can respond to dental managed care. We need to expand our horizons to develop the ability to make appropriate decisions. These decisions cannot be made in the dark by a mind ignorant of the evolving marketplace.

Information is the key to practice success. Knowledgeable dentists are in the best position to determine if managed care works for their patients. Do they participate or do they position their practice so they don't need to participate? Most dentists have previously chosen not to become informed about the various types of dental delivery systems and how they are being impacted by the changing marketplace. Many dentists are frightened. They like the *status quo*. It has provided a nice lifestyle while enabling them to provide dental care to their patients with little interference from outside parties. Suddenly the apple cart is being upset. The marketplace is starting to displace the existing dental delivery system. Dentists are angry and are loudly complaining. Complaining is not going to accomplish

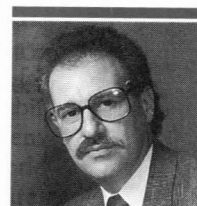
much in a changing marketplace. Many want organized dentistry to stop the trends. The fact of the matter is, organized dentistry's options are limited. We can inform the profession, as we are presently doing. We can inform the buying public and their employers, and they can help us to develop individual strategies on how to best respond to the specific dental needs of our communities. It is essential, however, to understand: How individual dentists choose to respond to managed care is ultimately their own decision. This decision should be made in a pragmatic way. The emotional component should be bracketed from the decision-making process and the facts must be considered.

These truly are very confusing times in health care; it is not obvious how to respond appropriately. Some dentists choose to believe this is happening because evil employers and managed care companies want to destroy dentistry. This is hardly the case. Employers want to contain their rising costs and insurance plans are responding to market forces. They too, want the best price. How many dentists forsake their local merchants to shop at the Price Club for bulk supplies? Is this fair to the local merchants? Is "fairness" the deciding factor? These dentists are trying to get the best deal and to pass these savings on to patients.

Dentists who adamantly demand preservation of existing traditional dental delivery systems defy their own

logic by personally enrolling in a managed care health plans. They imagine market forces do not affect them, even as they are responding to them. This is exactly what happened to the California dentists who are enrolled in the California Dental Association sponsored PPO health plan. If dentists weren't willing to pay the greater dollars for a traditional medical plan, how can they expect employers and employees to act differently and opt for dental plans costing more?

Dental managed care probably will continue to grow at a rapid pace. The marketplace presently wants it. However, managed care is not likely to overwhelm dentistry; it is one aspect of an extremely complex dental care delivery system. In contrast, however, HMO dentistry is not going away. By next summer, medical HMOs will have fifty-six million people enrolled. This is a five-fold increase since 1992. To what extent this pattern will repeat itself in dentistry is anyone's guess. But, the impact of HMOs has been devastating to many private fee-for-service physicians in Southern California. I personally know of two physicians who have had to close their offices. One went to work



Scott Jacks has a private practice in South Gate, California. He is a member of the panel assembled by the California Dental Association to present educational forums on managed care for dentists.



for an HMO clinic and the other left the state.

### ***A Personal Experience***

My dental practice is located in a blue collar suburb of Los Angeles. Dental managed care has been a fact of life in my community for over fifteen years. The large companies that introduced our community to dental HMOs initially gave their employees a dual choice benefit. When the dual choice option became too costly, they modified their dental and medical plans. Today, many companies in our town no longer offer dual choice. The only remaining choice for many prospective patients is whether to go to their assigned dental office or go to the dentist of their choice and pay for the dental care themselves. My patients are very price conscious. Their discretionary dollars are few and, when they have discretionary money available, they don't choose to use it on dentistry. When these patients lose their dual choice, most of them go to the "cap office" where they are assigned, rather than pay for dental services out of their own pockets.

The dilemma we faced with many of our patients and potential patients enrolled in dental HMOs was whether we wanted to lose these patients. Did we want to watch our practice dwindle; did we want to see the families we have treated for years reassigned by an administrator; or did we want to accept the challenges of managed care and become participants?

We made a decision in a pragmatic context, and we came to the conclusion that participation is the right choice for us. Our practice has grown and thrived.

Will it work for everyone? That is impossible to say. There are a multiplicity of factors to consider before a practice takes the plunge and becomes a capitated managed care provider: What is the plan's compensation rate (cap rate and copays)? What is your office hourly overhead? What is the anticipated utilization rate of the employer groups? Does your practice have available chair time to facilitate treating plan patients while not displacing full fee-for-service patients presently in the practice? Managed care works best, for most practitioners, as a supplement to a traditional practice with available chair time. During slow times, it is probably better to be compensated 80% of full fee than to receive no income at all. The dentists who are most opposed to managed care are those whose chairs are constantly full of UCR patients.

As our participation in managed care has grown and we progressed along the learning curve, one thing has become very clear — we do not sign up for all the dental plans. We only participate in plans that are designed well and work for us. If the plan is poorly structured, we cannot work with it, or if we cannot treat plan patients at the same level of care as our fee-for-service patients, we drop the plan. It is necessary to make choices. This is how den-

tists exert market pressure on plan developers.

It is essential to develop the business skills required to discriminate between good and bad plans. These skills are developed through taking classes and reading books. Without this knowledge, there is considerable risk of harming yourself and your patients. But, the responsibility to be educated remains with the dentist — not the patient or the plan administrator.

### ***Dental Insurance: Basic Concepts***

It is important to understand the concept of dental insurance is quite different from traditional medical insurance. Thirty years ago dental insurance barely existed. Traditional medical insurance covers recipients for preventive routine medical care and impending medical disasters — essentially low frequency catastrophic events. Dental need is a high frequency, non-catastrophic event. In most cases, there are naturally occurring or artificially imposed maximums which contain high costs.

Dental insurance is essentially a payment mechanism rather than a true insurance product. With traditional dental insurance, the plan still must be actuarially sound or it will go out of business. This is not necessarily the case with a capitated dental plan. Herein lies the problem with HMO dentistry. A properly structured, actuarially sound, capitated program will pay an adequate amount of money each month to enable the dentist to deliver good service

to his or her patients and make a reasonable profit. However, sometimes in order to increase market share, the HMO managed care company will underbid the market, resulting in an actuarially unsound premium. They will still make their profit on a percent of the total premium but, since the risk has been shifted to the provider, he or she will suffer the consequence. If all offered plans are taken regardless of compensation rate, there must be some way to pay for bad business decisions. In the long run, this will drive the market into a downward competitive spiral, bankrupting both the managerial unsound dentist and others as well. For this reason, one must learn to differentiate between the good and bad plans.

What is managed care really about? Managed care is fundamentally about more dental care for fewer dollars. For the practitioner, this means knowing your overhead costs per chair hour, getting maximum use of your dental office, and reducing your lab and dental supply costs. It's about understanding the managed care plans you have signed up for, including the exclusions, limitations, and benefits of those plans. It's about providing good dentistry and good service. It's about running your office like a business. It's about possibly spending more time in your office and less time on recreational activities.

Capitated managed care is not about cutting the phone lines and closing the appointment book. It's not about under diagnosing needed care. "More for less" is not about "less for less."

Before making the difficult decisions about participation in dental managed care it is essential to know what it costs to run the office on an hourly basis and then to relate this number to the different compensation levels of different managed care plans. One of the better

ways to make this evaluation is through a RVU (relative value unit) analysis. While this article is not intended to amplify on the different types of cost analyses that should be considered, readers are guided to Bryan Quattlebaum's book, *Managed Care in Dentistry*, for further information. This book presents the many different types of practice analyses necessary in evaluating whether integrating managed care into a practice makes sense.

Many readers may still be thinking, "Wait a minute, I still don't get it. If I normally charge \$150 for a new patient exam, radiographs, and charting, how can I possibly provide quality care on a monthly cap rate of \$10? I am losing money and I still haven't done any dentistry."

This is a matter of perspective — the view of a single patient at a time versus the view of managing a whole practice. Five hundred patients with a cap rate of \$10 means \$5,000 per month or \$60,000 per year. The utilization rate will normally be considerably less than 100%. Further, there normally are additional revenues from copayments and non-covered benefits demanded by patients, i.e., posterior composites, anterior veneers, bleaching, implants, TMJ, etc. Dentists who participate in these programs can augment their regular practice income by as much as 50%.

Whether this example works for a particular practice depends on the many factors, cited previously. Practices where there is empty chair time may benefit. In some cases, the reimbursement levels offered are too low to support quality care. In the latter instances, the dentist has an obligation to both understand the dangers of an unsound business practice and to avoid exposing his or her practice, patients, and family to unreasonable risk.

### Another Alternative

What can dentists collectively do when confronted with such a situation? We can't circle the wagons and in a uniform voice demand higher compensation from the dental plans. That is in violation of federal anti-trust laws. An alternative is to join or form IPAs (independent provider associations). As an IPA we become a single legal entity that can collectively negotiate and enter into contracting arrangements with dental plans on behalf of dentists. We can do this without violating existing federal trade and anti-trust laws. How effective would such IPAs be in improving the situation? Only time will tell.

There are many options, regardless of whether one decides to participate in managed care. However, if not participating, it is necessary to position one's practice so that patients perceive it to be unique and superior. It must be a practice that obviously justifies the additional out-of-pocket dollars.

Another action that is necessary, regardless of one's position on managed care, is to educate patients about managed care. This can be done through monthly newsletters and in-office patient educational experiences. Additionally, educate the employers who are your patients so that they can make more informed purchasing decisions.

We all must grow during these changing times. Those who are happy with their practices should stay with what works, improve it, and remain informed. Those who see an opportunity to grow their practices without compromising quality should become proactive. Scan the horizon, become a student of necessary change and make necessary corrective action. Those who do not respond appropriately are doomed to failure and will damage the profession in the process.

# Dental Capitation Programs — Key Decision Factors

Marvin Zatz, DDS, MPH

Opponents will cite a variety of reasons for their criticism of capitation-based dental benefit programs. Although publicly unstated, when the smoke and rhetoric settles, the real reason for dentist discontent almost always is fear of decreased income under such programs. Since it is less than politically correct for professionals to complain about loss of income, poor quality is frequently offered as the surrogate rationale. The implication is that capitation-based dental programs result in inferior care delivered to patients under traditional indemnity (fee-for-service) programs.

Since no valid and reliable studies currently exist to either confirm or refute quality measurements in any type of dental benefit program, it is easy for either proponents or opponents of any benefit plan methodology to make self-serving statements without fear of contradiction.

It is probable that the parameters to be issued by the American Dental Association (ADA) in spring, 1995 and principally meant to evaluate managed care dental benefit programs will be so broad and will do little to aid in objectively evaluating care delivered under benefit plans with differing provider incentives. At present, it appears there is no plan to compare capitation and fee-for-service plans in comparable situa-

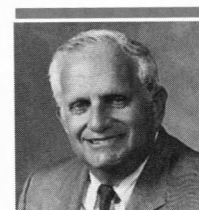
tions using a common measurement system. The almost totally discretionary nature of dental care delivery does make the establishment of dental standards more difficult when compared to medical services, where discretionary treatment is less permissible.

Paradoxically, the only benefit programs that currently have functional, formalized quality assessment and improvement programs in place are the capitation programs frequently maligned as poor quality. Many capitation programs also use patient satisfaction surveys; at least one now issues report cards on its providers. Provider office review is virtually non-existent in fee-for-service programs. At best, PPOs perform perfunctory credentialing and attempt computerized utilization review. Opponents of capitation would like purchasers of benefit programs to assume, without evidence, traditional fee-for-service based benefit programs are inherently quality focused and, conversely, all other programs are inherently compromised in the care delivered to covered enrollees.

The need of dentists for truly informative and easily used information to make informed value judgments concerning capitation-based plans has intensified because such programs have experienced significant growth in recent years. Capitation-based programs currently cover 15% of all those with

dental benefits. This figure is estimated to rise to 50% within the next ten years. If the number of individuals with dental benefit coverage remains stable at about ninety to ninety-five million, the growth of capitation-based benefit programs can only occur at the expense of traditional indemnity and PPO fee-for-service programs. The question many dentists are already facing and most others will soon need to address in order to sustain their income, is not *whether* to participate as a provider in capitation benefit plans but rather in *which* plans (if available) to participate.

A major reason for dentists participating in a wide variety of dental benefit programs is the continuing "business" problem many offices face. Dentists' recent response to a questionnaire in a pulp dental magazine indicated that 85% faced significant unappointed and unfilled chair time. For a variety of reasons the need for dental care by the reliable core of patients who routinely seek care (approximately 55-60% of those with dental benefits) continues to decrease. Although the percentage of individuals who routinely seek dental



Dr. Zatz is Vice President, Dental Relations for The Prudential Insurance Company, 56 Livingston Avenue, Roseland, NJ 07068.



care has increased over the past thirty years, approximately 40% or more of the population still only seek episodic care — even when they have relatively “rich” dental benefit programs requiring minimal out-of-pocket patient expenses.

Partially in an attempt to compensate for the decrease in need (disease model), dentists have greatly increased their delivery of demand services (treatment model), e.g., cosmetic care, soft tissue management programs, sale of hygiene materials, use of CAD-CAMs and lasers, adult orthodontics, whitening procedures, etc.

Many dentists have discovered the beneficial financial implications of a marginal product. That is, treating patients in otherwise unfilled chair time — even if at lower reimbursement than expected from traditional indemnity patients. Such blends of market customers can add significantly to overall office income, even though every patient does not make the maximum contribution.

Dentists who participate in successful capitation-based programs have come to appreciate the steady, predictable income, preservation of their patient base, many new referrals, reduced administrative burden, decreased collection problems, and increased overall income.

Managed care programs have alerted dentists that despite what patients may generally say about admiring and respecting their own dentists, the vast majority will only seek care in offices participating in their specific dental program. Health economists have long known that patient demand for dentistry is very elastic. Dental care is viewed as a luxury item by most patients, who overwhelmingly seek care where they have the least out-of-pocket expenses. While some patients may exhibit intense loyalty to an office regardless of the out-of-pocket costs, experi-

ence indicates this loyal segment is quite limited. This is especially true where a patient requires only routine treatment — a situation characterizing increasingly larger segments of the population.

### **Factors In Choosing a Plan**

On occasion articles have been written attempting to aid dentists in determining whether a capitation-based benefit program is financially viable for their participation. In an effort to remain objective, these articles often contain formidable-looking formulas that approximate a complex physical-chemical synthesis. As such, they lack real-world useful information and applicability.

A checklist of relatively simple factors can be developed to guide providers in making informed value judgments regarding possible participation in a particular benefit program.

A serious confounding factor for dentists curious about the financial viability of capitation-based programs is the existence of scores of such plans, each with significantly different benefit plan designs. New benefit plans seem to appear constantly. Those opposing capitation-based plans frequently brand all with the same negative brush. From the point of view of financial viability for the participating provider, both “good” and “bad” capitation plans exist. The dentists’ dilemma is to distinguish the significant differences among plans. Dentists often become unnecessarily bogged down in issues such as hold harmless clauses or fear of loss of malpractice coverage.

The remainder of this article will address key administrative and financial plan design elements that are major determinants of the potential viability of any capitation-based dental benefit program. The information concerning these factors should be readily obtainable from the plan administrator. Inabil-

ity to obtain these data should make any provider hesitant to participate in the particular plan.

1. *What are the recommendations of current program participants?* This should be the very first information a potential provider should obtain where the capitation program is in existence. What has been the experience of those participating dentists *whose opinions you have confidence in* concerning the program? How long have they been participants? Has the income been equitable? What has been the experience in getting responses in a timely fashion from the plan administrator? Have most of the covered groups maintained their coverage with this plan administrator? In short, would a currently participating provider recommend this plan to you?

It is important to reiterate, one should obtain the opinions of dentists in whom one has confidence! Beware of self-proclaimed experts with only theoretical experience or self-serving agendas.

2. *What is the reputation and “staying power” of the plan administrator?* How long has the program been administered by this company? Obtain a list of its clients in your geographic area. What is the potential this plan administrator and this program will continue to exist? Obtain a list of key contact personnel of the administrator. When will rosters and monthly compensation checks arrive in my office?

Although opponents of capitation frequently make much of contract issues, the most important contractual feature requiring clarification is a dentist’s ease in terminating participation in the program. The hold harmless issue is a “red herring” and should not be an obstacle to participation. Ask those who emphasize the potential downside of a hold harmless clause to identify instances when it has been implemented by a plan administrator.

## EXAMPLE OF AN EQUITABLY-DESIGNED CAPITATION PROGRAM

Basic Capitation*	\$7.00 PMPM
Actual Utilization	65%
Actual Capitation For Utilizers	\$10.77 PMPM (\$7.00/0.65)
Additional Copay Income (25%)**	\$2.69 PMFM
Non-Covered Plan Services (30%)**	\$3.23 PMPM
Specialty Services (20%)**	\$2.15 PMPM
Total Compensation	\$18.84 PMPM
\$18.84 x 12 Months	\$226.08 PM/YEAR
Average Patient Treatment Time***	1.5 HOURS/YEAR
New Referrals	???
Calculation of Gross	\$151/HOUR (\$226/1.5)

\* PMPM is per-member-per-month

\*\* Indicates estimated income in addition to basic monthly capitation compensation

\*\*\* Based on ADA Annual Survey of Dentists

The \$151/hour gross income estimate in the above example compares favorably with the \$185/hour gross income reported for today's average general practitioner, especially when treated as marginal (potential additional) income.

Any change in the variables in the above example can result in significant income variations. However, not all are obvious or intuitive. For example, some more recent dental capitation plan designs require no copayments from members. At first glance this appears to negatively impact provider compensation. However, this no copayment-type plan uses a per visit office copay (similar to medical HMOs) which actually results in increased provider income in almost every participating office. The exception is a participating office where current copayment income approximates 50% or more of base compensation — an infrequent situation.

Another factor affecting program income is that a new patient will generally require about 50% of the dentist's time in treatment while an established patient on maintenance only requires 20% to 30% of the dentist's time. The bulk of dental services needed by a program patient on maintenance (e.g., radiographs, prophylaxis, etc.) is appropriately delivered by trained and licensed auxiliaries. Patients on maintenance will result in considerably higher hourly income for participating offices. This explains why the true financial benefits for an office in a capitation program may not be fully experienced in the early years of participation.

Another "straw dog" issue is malpractice coverage. Participation in managed care programs does not result in any change in current malpractice liability coverage or premiums. To be assured on this point, contact your carrier.

3. *What is the per-member-per-month compensation (PMPM)?* This is

the basic capitation payment dentists will receive monthly for each individual on their roster of covered patients. Some plans compensate on a per member basis and others on a per family basis. In most cases, the total payment will be similar. In a well designed program the base capitation compensa-

tion should approximate 40% to 60% of total program income.

4. *What is the potential total number of members who will choose the office?* For any capitation-based benefit program to be financially viable, it is essential to have a significant number of plan members in any participating office. The viable total will obviously vary by office, but 200 to 300 members generally is an absolute minimum.

5. *Which covered procedures require a patient copayment?* There is a wide variation among plans of which procedures require no payment from members and which require a copayment. It is rare for any capitation benefit plan to require no payments from its members for all covered services. Knowing which procedures require copayments can aid in determining the additional income from this source. In many plans, additional income amounts to 20% to 30% of base compensation.

6. *Exactly which dental services are covered by the plan?* No dental benefit program covers all possible dental procedures. The non-covered services will result in considerable additional income for participating offices. Further income that can be related to the plan will vary depending on the skills of dentists and their staffs in "marketing" just as they do now traditional benefit plans or in case presentations to self-pay patients.

7. *How is specialty care handled?* It is essential to identify which specialty procedures the participating dentist is expected to perform as part of basic provider compensation. Many capitation programs offer additional provider compensation for services designated as "specialty" by the plan benefit design. Finally, "supplemental" provider compensation is offered by some capitation plans when actual member utilization exceeds expected utilization. This can be very important in the early

years of plan participation. Thus, provider compensation can be greater and more complex than the monthly basic compensation for each member on a participating provider's roster. Experience in a properly designed program indicates total capitation plan income frequently approximates twice the basic capitation compensation. If a prospective plan provider is to make informed value judgments, it is essential to make a suitable effort to obtain the pertinent information discussed above.

To successfully participate in a capitation-based benefit plan, healthcare providers must switch from the usual fee-for-service dentist mind-set to one using an hourly income approach. The need for dentists to make this switch is essential. In instances where dentists cannot make that transition and continue to calculate and compare income based on a separate fee for each procedure, the chance of a capitation program appearing financially successful in that office becomes nil.

The key to financial success in a capitated program must be to think of treatment needed by a population of people and not the fees for individual procedures needed to reach a predetermined income target. The care is deliv-

ered individually, however, the overall financial success is determined for the entire population treated and for the entire office operation. Hourly income may vary greatly because some patients require more or less care than others. The average hourly income for the entire population must be equitable for the patient, the dentist, and the plan administrator.

### Conclusion

Capitation-based dental benefit programs are significantly increasing their market share. It is unrealistic to believe that once purchasers of dental benefit programs, (i.e., employees and unions), analyze the cost and quality of care issues in the dental marketplace, they will support a continuation or return to more costly fee-for-service plan approaches for their employees or members.

As has already occurred with medical doctors, many dentists will "need" to participate in some capitation-based programs in their professional lives. These plans vary greatly in design and in financial and administrative equity. The choice of the wrong program by a dentist can lead to serious negative practice possibilities. Conversely, par-

ticipation in the right program can be a very positive experience. Information does exist, without the use of complex formulas, to help make an educated judgment as to which plans to participate in or which to avoid.

Dentists who allow opponents of capitation to sway their decisions with anecdotal horror tales or who do not do their "homework" on benefit plans they are considering are at risk of suffering significant financial setbacks in the future.

Quality is not truly an issue unless a dentist is inherently unethical or chooses the wrong programs, particularly those with inappropriate compensation. Participation in properly designed capitation programs will equitably compensate dentists and allow them to experience both professional and administrative satisfaction in their dental practices.

The opinions and assertions contained in the article are solely those of the author and do not represent the views of the reviewers or The Prudential Insurance Company.



# Managed Care...It's BIG, BIG Business

James R. Pride, DDS

A battle is being waged between private practitioners and insurance companies. Insurance giants, with billions of dollars in their reserves, are gobbling up hospitals, medical offices, and dental practices — like sharks engaged in a feeding frenzy, they are rushing in to buy up and control America's healthcare system.

Insurance companies are charging employers money, keeping a substantial amount of that money for their own use and profit, and then giving what is left over to doctors and hospitals to provide the needed medical care. Under the managed care systems the physicians and dentists lose control in determining what is the best care for the patient; insurance companies with eyes only for the bottom line are dictating who will receive what type of care and when.

It's managed costs, not managed care. And it's all in the name of profit. Read the *Wall Street Journal* and one will quickly find out that insurance companies are among the largest and fastest growing companies on the stock market and their executives are among the highest paid.

By now I'm sure you are throwing your hands in the air or waving a white handkerchief in defeat. Get your hands back down and put away the handkerchief. There is good news!

Yes, third party benefit companies are here to stay. They have as much right to be here as automobile, life, and other forms of insurance companies.

They won't go away, *but* neither will the private practitioner.

All dentists have a choice: participate in fee-for-service dentistry or participate in dental benefit programs offered by third-party providers. Some will choose one alternative over another; others will choose a combination. The point is, the choice belongs to you, the dentist — it always has and it always will.

The intent of this article is not to rate private dentistry above or below the dentistry provided by dentists in reduced-fee dental plans. The purpose is to assist dentists who have chosen to pursue private pay relationships with their patients through the effective and efficient operation of their dental practices.

## First Class or Coach...It's Your Call

There will always be a first class. There will always be discriminating consumers willing to pay for products and services reflecting excellence and meeting their needs. Managed care has segmented the healthcare market — much as the retail market has been segmented. Now, patients can choose between high-end practices like Nordstrom's or the price-competitive alternative, Cost Plus.

What it comes down to is "choice." The new healthcare environment is presenting more choices for the dental consumer...and for the dentist.

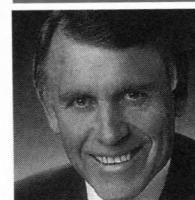
Last year, one of every three Americans visited an alternative healthcare practitioner and, collectively, spent

\$12.8 billion dollars out-of-pocket for those services. As the traditional, private healthcare model collapses, even more patients will seek the services of alternative healthcare practitioners.

What's the message here? I hope it is clear that patients are willing to use their discretionary dollars to pay for healthcare services that satisfy their wants and needs.

Today's dental consumer has an expanded concept of value which includes convenience, service, dependability, and affordability. Whether they are purchasing televisions or automobiles, discriminating consumers want to be sure the products they receive reflect excellence and superiority.

The same is true when patients purchase dentistry. They want the dental experience to be personalized and unique to their individual needs. But, dentists and their teams sometimes have fallen short in educating patients about the benefits they will receive from a "total" quality dental care experience. As a result, patients may have trouble discerning quality dentistry from non-quality dentistry. After all, patients don't know whether a crown's marginal integrity is good. They can only judge quality based on the "total" experience.



Dr. Pride is President of Pride Institute at 300 Drake's Landing, Suite 200, Greenbrae, California 94904, and has served on the California Dental Association membership educational program for managed care.

When patients can't discern between basic dental service and a total quality dental experience, they will make their decision based on price. This means the third party, reduced-fee practice will always win — unless the service provided to the patient is exceptional.

### **Basic Building Blocks of a Private Practice**

To maintain a fully private, fee-for-service practice and to create a total quality experience for the patient, there are four key areas that must be improved in the dental practice:

1. *Develop quality patient relationships.* Dentists wanting to remain in private practice must realize the importance of a transformed perspective on professional practice and education that focuses not only on the technical knowledge unique to dentistry but also on the competence to deliver relationship-centered care.

Fee-for-service dentists and their staffs will need to learn a new set of skills and competencies to deliver relationship-centered care, including methods to create and sustain healthy patient relationships and how to have conversations with patients so patients hear that the professionals care.

2. *Educate the patient about total quality dentistry.* Dental team members have an obligation to help patients realize they do have a choice when it comes to dental care. Many patients assume they will get the same dentistry in any office.

One should not stand idly by while patients go to dentists who are thought

to deliver care of a lower quality. The clarification that can be offered is that it is frequently impossible for any dentist, no matter how talented, to create a quality dental experience for a patient when appointment times are shortened and when less money is left to spend on staff, materials, labs, training, and equipment as a result of reduced fees.

Dentists should consider it their obligation to educate their patients. Their long-term oral health may depend on the dental choices they make today.

3. *Make the dentistry affordable.* Private dentists are going to have to consider financial arrangements to a greater extent than they have in the past. Making dentistry affordable does not mean discounting fees — it does mean making financial arrangements.

Use automated debiting, dental and other credit cards. Allow patients to spread payments over a number of months. Charge an annual interest rate for this service like all other businesses do. A program of financial arrangements, properly documented, monitored, and followed up on has proven to be a tremendous source of revenue for many dental practices. Most dentists who have not had success offering financial arrangements have not properly explained the programs to patients, have not properly executed written documents that set forth expectations for payment, and have not insisted that the staff properly follow up on delinquent or missing payments.

Ultimately, the patient will decide whether to stay with a practice or go to a dentist who is enrolled in their benefit plan. The only way to influence this de-

cision is for the private dentist to appear as economically viable as the alternative plans.

4. *Deliver superior patient service and increase marketing efforts.* As reduced-fee dental benefit plans become more prevalent across the country, the fee-for-service dental practice will need to become more involved in attracting patients who appreciate and are willing to pay for the high quality services provided.

The purpose of marketing is to create perceptions of unique value added. Marketing includes everything one does to attract patients, persuade them to accept treatments, inspire them to come back, and excite them enough to tell others about the practice. "Value added" should be the new buzzword among this segment of practicing dentists. The question should be faced daily: "What can I do to distinguish my practice from the others?"

Understanding these concepts and changing behaviors to implement these concepts in one's practice demands commitment on the part of the entire dental team. It takes time and effort to improve patient relationships and to perform patient education.

Through all of this, it must be kept in mind that the practice is committed to providing the patient with the finest dentistry available and that these changes will allow one to continue to provide top quality care. As important, these changes will improve the total dental experience provided to patients and will help make the experience a positive one. This is what keeps good patients coming back.



# The Policy Problem

## *The Policy Problem*

You have just been appointed to a state advisory committee representing organized dentistry in a multi-group effort to support a state law mandating fluoridation of drinking water. You are surprised by the diversity of perspectives represented on one side of this political issue.

One of your colleagues is eloquent in "raising prudent concerns about proceeding with due caution" on a matter that has potential for fundamentally rearranging the economics of private dental practice. He seems to have great command of statistics showing how much caries has fallen in the United States over the past thirty years. He asks, "Just for the sake of argument, let's weigh how credible we see as a profession when we represent ourselves to the public as supporting legislation that would put us out of business."

Another of your colleagues seems to have read the data differently. He believes that fluoride has expanded the American oral health care bill by allowing teeth to remain in the mouth longer and therefore they will receive more care. He cites evidence that helmet laws cost states money by prolonging the lives of accident victims and recounts stories of very expensive medical miracles. His view is that fluoride should be supported by the profession but it is misrepresentation to suggest that it will put dentists out of business.

A consultant on the committee with many years of experience fighting antifuoridationist is irritated with both of the previous committee members. He points out that the economics of oral health and the scientific background of fluoride are such complex issues that the public, and even many lawmakers, are turned off by the detail. Antifuoridationists have been so successful because they present a single clear position based on emotion and characterize the profession as bogged down in inconsistent and irrelevant research studies.

Your committee doesn't seem to be going anywhere fast. At this point, you are not certain where you stand.

*What is your obligation as a public trustee with regard to the factual foundations of public policy issues?*

*What is your obligation with regard to dealing with differences between yourself and others?*

*Can an issue be presented differently to different communities of interest?*

The American College of Dentists has taken a leadership position in dental ethics and professionalism. Part of its responsibility in this role involves continuing to place before Fellows and others practical ethical issues for analysis and discussion. Ethics is neither a private matter nor an academic one. Several Fellows were invited to analyze the first case below; you are invited to comment on the second one.



Bruce Peltier, PhD  
San Francisco, CA

One way to make sense of the conflict in this case is to compare the differing bases for business and health care ethics.

The conduct of business in a capitalist economy relies upon a competitive premise understood by all participants. "I will attempt to get the most from you while giving up the least. You, at the same time, will try to give me the least and get the most for yourself." Although this premise sounds crass when stated in its bare-bones fashion, it is a principle readily understood by any American shopper. Try to recall a time when you went to a store and insisted that the clerk take one extra dollar for the merchandise you purchased. It may seem this premise is better suited for a flea-market than for public policy decisions, but the fundamental reason





most businesses clearly exist is to make a profit.

Health care is built upon a different premise: the well-being of our patients is central to our work; our relationship is basically cooperative. Our "customers" do not expect us to give them the least we can get away with. Patients must be able to trust healthcare practitioners to make decisions on their behalf because it is difficult and often impossible for patients to research available treatment choices properly prior to making a decision. A burst appendix does not permit comparison shopping. Victims of accidents don't check the emergency room across town to see if they can get a better deal.

If we tamper with the basic idea of placing our patients' needs first, we risk the loss of their trust, and without patient trust, the healing relationship becomes twisted and perhaps impossible.

Because of this premise, we argue for fluoridation if, in our opinion the science indicates fluoride is good for patients. If this position creates business difficulties, we work to find creative solutions to new problems after we have made the patient-positive decision.



Howard Pollick, BDS, MPH  
San Francisco, CA

As an appointee to a state committee representing organized dentistry, it is important to represent established policies of organized dentistry. The ADA's policy since 1950 has been to support fluoridation. An ADA news release (January 29, 1990) stated, "Water fluoridation remains the safest, most effective and most economical health measure to prevent tooth decay and to improve

oral health for a lifetime. The ADA has firmly supported community water fluoridation since 1950 based on its continuing evaluation of the safety and efficacy of fluoridation."

The ADA publishes "Fluoridation Facts" (1993), a twenty-eight-page resource that can be provided to other members of the state committee. The ADA also provides reprints and other written material on fluoridation to inform its members and other interested parties.

My obligation in dealing with differences between myself and others is rooted in my view of society. I can and should express myself as clearly and forcefully as I feel is warranted. My role on the state advisory committee would differ as an officer or as a member. As a member, I should express myself without as much regard to the will of the committee as a whole as the chair of the committee should. The chair of the committee, I believe, must work towards developing consensus. If the committee is clearly divided, then the chair has a job to obtain the majority of votes. However, with an appointed committee, it is much more likely the members will be less divisive.

In dealing with colleagues, as described in this scenario, one should listen and discuss their concerns but point out the policies of organized dentistry. My role might be different if I disagreed with those policies; indeed, I should not accept the position in this case.

If I feel comfortable representing the policies of organized dentistry, then I have a further responsibility as a representative on this committee. I am obligated to communicate with those I represent and to seek answers to questions I cannot answer myself. This can be done by working with appointed and

elected individuals within organized dentistry with recognized expertise in this area.

There should be consistency in the message presented on an issue; although, it can be presented differently to various communities. With fluoridation, there are concerns raised about cost and unfunded mandates at a time of economic recession, as seen in AB733 currently being considered by the California legislature. Democrats generally are in favor of the bill, whereas Republicans are split with some indicating this is a local issue. Anti-fluoridation groups have actively lobbied but have been generally unconvincing. Several legislators have been quick to point out that pediatricians recommend fluoride supplements for children raised in non-fluoridated communities, since there is more tooth decay. Legislators are particularly persuaded by water engineers from their districts or by studies conducted in their communities. This policy problem is a real life issue. Real life is so exciting.



Donald J. Kleier, DMD  
Denver, CO

This is an archetype for many problems faced in dentistry. Fluoridation is a many faceted policy with many perspectives. The first is: *what is the charge to the committee?* In other words "What do we want?" This was answered in that the committee is to support mandatory fluoridation of drinking water. If the committee agrees to tackle the problem, the issue is how to get the task accomplished. If some committee members have a problem with mandatory fluoridation the issue should be settled before going any further.



Consensus must be reached to support such an issue. This is the obligation in dealing with differences between yourself and others. The way to deal with such differences is to talk them out. Certainly, this will not be a multi-year nuclear arms negotiation, but to skip this step will create many problems in the future. It is my observation that our colleagues unfortunately don't spend the necessary time talking problems out. If consensus cannot be reached, then this is the committee's report, complete with explanations. If I,

as an individual, cannot ethically support the group's direction or decisions then I must state so and possibly remove myself from the group.

The truth is what works. My obligation as a public trustee is to get and understand the facts. This means documenting data supporting one path or the other. Complete and total disclosure is the only safe way to deal with people on public issues.

Issues can certainly be presented differently to different communities of interest. Here the difference is one of

emphasis and style, not factual content. In any dilemma or decision there are polarities. To deny the downside of any action is to not connect with basic human understanding (*How to Win Friends and Influence People*). When both sides are reviewed and I truly understand and acknowledge the opposing point of view, I have the best chance of getting what I want. People might like to read about emotion, but they want to act rationally — it just feels better.

The *Journal* invites comment on  
*Trial by Innuendo*,  
the ethics case that  
appears on page 26.



The *Journal* invites comment on *Trial by Innuendo*, the ethics case that appears below. Views should be 200-400 words and should be faxed to the Editor (David W. Chambers) at (415) 929-6435 no later than Friday, 3 November 1995. Submissions will be peer reviewed and edited to fit with other responses. The most useful combination of responses will be published in the December issue of the *Journal*.



## In the Next Issue

### *Trial by Innuendo*

At the state dental association meeting you find yourself having a stand-up lunch with a dental school classmate you haven't seen in several years.

After the usual personal inquiries and pleasantries, your classmate broaches the topic of decaying standards in the profession. At first there are some general comments about insurance companies and recent graduates; then he focused on managed care and one particular dentist in his hometown (evidently there are only three or four dentists in his area).

"I never thought I would live to see the day when professionalism is reduced to being nothing more than the subject of editorials," he begins. "This guy in town — I won't mention any names because at least I'm professional — never produced the highest quality dentistry. I've seen a lot of his work. You can overlook a few problems. Who am I to judge; I mean, I didn't see the original cases. But recently it's become outrageous. I heard he signed up for several capitation programs, and who knows what they are paying. I have heard six or seven dollars. No one can provide ethical care at those rates. Don't you agree?"

You mumble something through your sandwich, surprised by the intensity of your classmate's attack. You are trying to be appropriately noncommittal.

Evidently, your classmate interprets your response as encouragement. "Somebody ought to get this guy before the ethics committee. This kind of thing is pulling down the whole profession. If I told you who it is you would be amazed. He went to school with us, just a few years behind us.

"Last week, Meg Priestly saw one of this guy's patients on an emergency basis and she said she wasn't certain whether she was more offended by the neglect or the shoddy work. I can believe it. I'll bet you've seen the same or worse where you practice because I know there are more of these 'mills' in the cities. Right?"

This time you just slowly sip your coffee and stare back. But that is sufficient agreement. "I would say something, but you know if you do you're going to get sued five ways to Sunday. Of course I wouldn't want to damage the reputation of one of our classmates who had a classic '52 Chevy in school and now can obviously afford better cars than either of us will ever own. Thank goodness there are still a few ethical dentists left in this world.

"Nice talking to you."

*What, if anything, should you say to your classmate at this point?*

*What, if anything, should you say to others?*

*Is there a general underlying ethical issue or principle involved in this case?*





# American Dental Association Managed Care Resources

When the ADA passed Resolution 122H at the 1994 Annual Session in New Orleans, it set in motion the development and coordination of a large number of resources for dentists on the vital topic of managed care. The Division of Dental Practice of the American Dental Association (ADA) was charged with assembling the most authoritative information available and providing education and other services to the profession. The managed care information and service activities of the ADA's Council on Dental Practice, Council on Dental Benefit Programs, the Division of Legal Affairs, and the Office of Quality Assessment and Improvement have been coordinated in this effort.

Dr. Al Guay, Assistant Executive Director of the Division of Dental Practice, oversees these activities. There is a combined ADA staff of over twenty-five individuals involved in the relevant councils and offices. Overall authority for this initiative to inform and assist the profession as it addresses managed care comes from the ADA House of Delegates. More detailed guidance comes from the Councils on Dental Practice and Dental Benefit Programs, each with sixteen elected members.

Dentists today must weigh a host of options and issues regarding the marketplace, managed care, and practice development. The ADA is committed to helping dentists understand and evaluate these alternatives. The ADA encourages dentists to take advantage of the resources listed. **Call 1-800-621-8099 and ask for the extension indicated.**

## Publications

### For Dentists:

#### *A Dentist's Guide to Managed Care Marketplace Information*

Provides marketplace information to help dentists understand the basic economics of managed care and assess the financial impact on a practice. Available this summer to ADA members for \$19.95 through the Department of Salable Materials at 1-800-947-4746.

#### *What Every Dentist Should Know Before Signing a Dental Provider Contract*

Designed to give dentists an overview of the legal implications of dental provider agreements. Available at no cost to ADA members. Contact your state dental society.

#### *Alternative Dental Benefit Models: Their Design and Impact on Your Practice*

Contains information about the most common dental benefit models and their impact on dental practices. Available at no cost to ADA members. Contact the Council on Dental Benefit Programs, x2746.

#### *The Antitrust Laws in Dentistry*

Offers dentists a guide on the civil and criminal implications of collective negotiations and other group activity. Available for \$5.00 through the Department of Salable Materials, 1-800-947-4746.

#### *PPOs Offering Dental Plans*

Provides a listing of PPOs offering dental plans, including names, addresses, and phone numbers. Available at no cost to ADA members through the Council on Dental Benefit Programs, x2746.

(continued on page 28)

This information has been compiled by Diane Noskin, Manager, Dental Practice Marketing, and Michele Thorne, Director, Contract Analysis Service of the American Dental Association, 211 East Chicago Avenue, Chicago, IL 60611-2676



### *HMOs Offering Dental Plans*

Lists HMOs offering a dental plan, including names, addresses, and phone numbers. Available at no cost to ADA members through the Council on Dental Benefit Programs, x2746.

### *Individual Practice Associations and Dentistry*

Explains the IPA concept to dentist groups considering forming or participating in an IPA group, and for others simply interested in the IPA concept. Available at no cost to ADA members through the Council on Dental Benefit Programs, x2746.

### *Policies on Dental Benefit Programs*

Provides an up-to-date listing of ADA policy on dental benefit programs. Available at no cost through the Council on Dental Benefit Programs, x2746.

### For Patients and Employers:

#### *Offering a Dental Benefits Plan*

Explains the advantages of offering a dental benefits plan, outlines the inherent differences between dental and medical care, and details the cost of offering a dental benefit. Available at no cost through the Council on Dental Benefit Programs, x2746.

#### *Direct Reimbursement: Tailor Your Own Employee Dental Benefit Plan*

Explains the concept of direct reimbursement and contains sample plans,

commonly asked questions, and answers. Available at no cost through the Council on Dental Benefit Programs, x2746.

### *Understanding Your Dental Benefits Plan*

Explains the most common types of dental benefit plans. The purpose is to help those covered by a dental plan to understand topics such as exclusions, limitations, and preauthorization. Available to ADA members for 25/\$7.40; 100/\$28.00; and 500/\$133.20 through the Department of Salable Materials, 1-800-947-4746.

### *Selecting A Dental Benefits Plan: A Guide for Employers*

Discusses considerations in choosing a plan and the differences between various types of dental benefits coverage. Provides questions to ask when evaluating plans. Available to ADA members for 25/\$7.40; 100/\$28.00; and 500/\$133.10 through the Department of Salable Materials, 1-800-947-4746.

### *Designing Your Dental Benefit Plan*

A complete guide for plan purchasers which includes dental plan options available. Available at no cost to ADA members through the Council on Dental Benefit Programs, x2746.

## Seminars

### *The Changing Face of the Marketplace: Is Managed Care Right for You?*

A seminar on the economic and legal aspects of managed care, contract analysis, marketplace issues, and the implications for dentists. Available for a nominal fee to constituent and component dental societies through ADA Seminar Services, x2908.



## Services

### *Contract Analysis Service*

Analyzes third-party contracts, including contracts from managed care companies and informs members in clear language about the provisions of the contracts so they can make informed decisions about the implications of participation. Available to ADA members free of charge through their state dental societies. Contact your state dental society.

### *Financial Impact Analysis*

A model for dentists to complete to help determine the potential financial impact on the practice of participation in a specific managed care plan. Available this summer to ADA members through the Council on Dental Practice at x2895.



Individual telephone assistance by ADA experts is provided at no cost to members.

Tap into ADA resources by calling 1-800-621-8099.

- Council on Dental Practice: x2895
- Council on Dental Benefit Programs: x2746
- Division of Legal Affairs: x2874
- Office of Quality Assessment and Improvement: x2746




---

# The Vision, the Voice, and the Values of a Leader

---

David W. Chambers, EdM, MBA, PhD, FACD

**L**eaders are individuals who are going somewhere and who have followers. Much has been written on the topic of leadership, but it all comes back to a clear image of the group's potential, the ability to inspire coordinated effort, and a sense of stewardship — vision, voice, and values. Dental offices have leaders, and there are leaders in organized dentistry, as well as in families, civic groups, and clubs. Sometimes groups have no leaders, and often the leader is not the person nominally in charge. The test is always: Who has the useful ideas, who gets others to go along with them, and who personifies integrity?

My youngest son showed leadership when his Little League baseball team was being clobbered in an exhibition game against a team from a higher division. He went from player to player along the bench, talking about personal bests and goals and exhorting them to forget the score and show their pride. (I think he used words like “you [epithet], you’re acting like a dork!”) The coach, normally very effective, was of little use in this circumstance because he held the traditional goal of winning, talked baseball strategy, and could not reach the boys on the level of their feelings

that morning. The team played better in the final innings, and although they did not win the game, they did win a significant measure of self-respect.

## Vision

Vision is the most obvious way to distinguish between leaders and managers. Leaders understand the potential for growth inherent in groups and organizations; managers tend not to be concerned about that. Managers accept the goals of an organization as given and work to achieve them in an efficient fashion. The manager is the one who has a set of skills such as management by objectives, zero-based budgets, CQI, incentive plans, and lots of rules and policy to hold them together.

Managers push; leaders pull. The leader uses articulate vision to inspire action. General Eisenhower used the analogy of moving a piece of string to express this concept. Pushing and poking at it produces little progress and no real order in the string. But it can be easily pulled toward oneself in a straight line. I like the analogy of a car. Regardless of whether the wheels that give the car its power are in front or in back, the wheels which give the car direction are always in the front. Managers tell, and leaders ask.

## Voice

The literature on leadership is curiously lacking in specific behavioral formulas for leaders. The reason, of course, is that leadership is not a behavior — it is a relationship. The phrases most often used to describe leadership are intangibles such as passion, trust, integrity, daring, curiosity, growth, point of view, stamina, intelligence, responsibility, competence, listening, motivating, courageous, confident, and flexible. One of the great mysteries of leadership is the relationship between the leader and the group. A leader is simultaneously “of the group” and distinct from it. Managers can be assigned subordinates. Leaders must earn followers and can only lead by the mutual consent of the group.

The relationship is created by the leader's voice — his or her ability to articulate the dreams and aspirations of those they represent. Lincoln constantly spoke of union when the nation was falling apart. Gandhi created the image of an independent India in the minds of millions of individuals. Churchill referred to England's stand with its back against the wall in the early years of World War II as “their finest hour.” Jimmy Carter, by contrast, did not have a firm grasp of this principle. He de-





scribed America as not doing particularly well in the 1970s (a true statement), and we turned him out. Ronald Reagan, however, said “we will do better,” and we kept him.

The role of followers in leadership is critical. It has been facetiously remarked, a leader is someone who finds a parade and gets out in front of it. There is enough truth in this remark to explain why leadership is such a difficult task these days. There simply are not as many parades. Mass media, economic security, cultural pluralism, and other homogenizing forces have created a nation of individuals for whom causes are somewhat suspect. We have become great “joiners,” subscribing to this and becoming a member of that, until our wallets cannot hold all of the cards of the groups we identify with. It is increasingly difficult for leaders to find and articulate the legitimate, potential interests of groups in America because the issues have become so com-

plex and interrelated, and the followership so diverse and fluid.

### Values

Finally, there is a moral dimension of leadership. Besides the criteria of efficiency and getting the job done, our leaders must personify the aspirations of groups. As John Gardner puts it, “ultimately, we judge our leaders in a framework of values.”

Although there are necessary checks and balances in the system, organizations understand that they cannot control leaders in the same sense as other group members. The leader, by definition, is going someplace other members of the group have never been before. Leaders must have flexibility and the freedom to negotiate with influential outside groups. All of this hinges on the moral characteristic of trust. Leaders earn it through their integrity. They also earn it by reflecting trust in those they lead. Unlike the manager who derives

power from a delegated office and achieves results by exercising control, the leader creates cohesiveness around core values and exercises personal influence.

Holding something in trust for the organization is called stewardship. This is a high calling — one is chosen to be a steward. This form of leadership implies the investment of the group’s talents and an ultimate return of a stronger organization than the one initially entrusted to the leader. It also implies responsibility without control. This is a concept that non-leaders find difficult to understand, and managers find repugnant. The highest form of leader is a servant who uses the moral power of the group for the benefit of the group.

As Max DuPree summarizes leadership, “The first responsibility of a leader is to define reality. The last is to say thank you. In between, the leader is a servant.”



## Recommended Reading

Academy of Management. The serious student of management issues, including leadership, might consider subscribing to *The Academy of Management Executive*. The Academy is a theory-minded organization composed of researchers who write scholarly journal articles — and the *Executive* is lighter and intended for practicing executives. Good book reviews. \$65 a year (419) 772-1953.

\* Bennis, W. *On Becoming a Leader*. Reading, MA: Addison-Wesley, 1989. ISBN 0-201-40929-1; 225 pages; about \$13.

Leadership is the lifelong process of expressing yourself through a group by personal insight and continual learning. Readable and filled with inspiring quotes, interviews, and examples.

\* Block, P. *Stewardship: Choosing Service Over Self-Interest*. San Francisco, CA: Berrett-Koehler, 1993. ISBN 1-881052-28-1; 264 pages; about \$25.

A curious blend of personal philosophy about the way people should treat each other (partnership over parenting, empowerment over dependence, and service over self-interest) and an alternative analysis of traditional organizational functions such as accounting and human relations. Definitely a challenge to managers who need to be in control.

Bach, M. *Major Religions of the World*. Nashville, TN: Abingdon, 1977.

All of the major religions of the world share a view of leadership that incorporates vision, articulation of the group's values, and service.

Franklin, B. *The Autobiography of Benjamin Franklin*. (Many editions exist).

Intensely personal recounting of the early years of Franklin's life through his service in the Pennsylvania Gen-

eral Assembly. Instructive commentary on blending a private business life with public life, fund raising, achieving cooperation on community projects, and personal time management.

\* Gardner, J.W. *On Leadership*. New York: The Free Press, 1990. ISBN 0-02-911311-3; 220 pages; about \$20.

Stresses the relationship between leaders and followers and stresses renewal. The book is rich in inspiration and offers a few concrete suggestions. Gardner, who has devoted his life to public service, emphasizes leadership in the political arena.

Machiavelli, N. *The Prince*. (Many editions are available.)

The classic. Written in Renaissance Italy by an advisor to Lorenzo de' Medici of Florence as a manual for the leader to maintaining rigid control and as a means for Machiavelli to win a patronage, the book has become so famous and so often quoted that Machiavellianism is now a dictionary word referring to a leadership style that relies on power and expediency.

**Trade Books.** Many publishers in the management market offer a line of "trade books," — normally hardbound volumes in the \$25 to \$30 range that are positioned between the popular pulp books and expensive, detailed text books. Some of the best publishers in this medium include:

Berrett-Koehler, San Francisco, CA (800) 929-2929  
The Free Press, New York, NY (800) 223-2336  
Hartwick College, Oneonta, NY (800) 942-2737  
Harvard Business School, Boston, MA (800) 545-7685  
JAI Press, Greenwich, CT (203) 661-7602  
Jossey-Bass, San Francisco, CA (415) 433-1767  
Oxford University Press, Cary, NC (800) 451-7556  
Sage Publications, Thousand Oaks, CA (805) 499-9774

## Editor's Note

Summaries are available for the three recommended readings preceded by an asterisk (\*). Each summary is about five pages long and conveys both the tone and content of the book through extensive quotations. These summaries are designed for busy readers who want the essence of these references in fifteen minutes rather than five hours. Summaries are available from the ACD Office in Gaithersburg. A donation to the ACD Foundation of \$15 is suggested for the set of summaries on leadership vision; a donation of \$50 would bring you summaries of all the leadership topics for a full year.

---

# Profiles in Professionalism:

## Dr. Robert E. Lamb

---

Robert E. Mecklenburg, DDS, MPH, FACD

In 1994, Dr. Robert Lamb completed his life as a distinguished dentist and Fellow of the American College of Dentists. His term as Regent, 1985-9, was only a later chapter in a career that had been exemplary of a professional's quest for truth and wisdom and for living a life finely proportioned between one's profession, community, and family.

This brief overview provides a glimpse of a remarkable man, for those who did not have the privilege of knowing him, and a reminder to those who did, of the many ways he touched their lives and contributed to the growth and development of the College, the dental profession, and humanity.

Like many dentists, Dr. Robert Lamb was unwavering in his sense of ethics and professionalism in practice. He was not a flamboyant man. He never sought the spotlight, but he was a professional leader, none-the-less. He led through earned respect by the quality of his every word and deed. Colleagues listened to Bob Lamb.

Like many dentists, Dr. Lamb did not seek professional organization office, but he accepted such responsibilities when invited to do so. To each of his varied terms of office he brought dignity, humor, and a sense of fairness. He contributed to each office with an

interest in the views of every person and a studied concern for every issue. Whether acting as chair or member, he endeavored to make groups unified bodies of reasoning.

Born in Omaha, Dr. Lamb attended the Universities of Nebraska and Texas before earning a degree in meteorology at UCLA. This education was invaluable when he then served his country as a Captain in the Eighth Air Force, 390th Heavy Bombardment Group. From Framlingham, England, among other missions, he was a part of the coordinating team that sent out the group's B-17 bombers for the D-Day invasion of Normandy.

Following the war, Dr. Lamb studied at the Baylor University, College of Dentistry. In 1949, he both graduated from Baylor and married Jacqueline Martin. They subsequently had three children, all of whom became adults with qualities that would make any parent proud. As wife, mother, neighbor, friend, and community volunteer, Jackie stood as a life-long testimony of his good judgment. Her warmth, ebullience, graciousness, sensitivity, and integrity; her skillful nurturing of an exemplary family partnership; and her consistent support of Bob's professional and civic endeavors served as a continuing source of energy that fueled his personal and professional growth.

Over twenty-four hundred years ago, Pericles said, "We regard the man who takes no part in civic affairs as useless." Pericles would have highly respected Dr. Lamb for his commitment to community service. He served in positions requiring sound judgment and leadership. In addition to being an elder in his church, he was an officer in the Inwood Lions Club, Dallas Community Action Committee for the "War on Poverty," Dallas Head Start Program, Boy Scouts of America, Young Men's Christian Association, the Dad's Club of his children's elementary, junior high, and high schools, and as a volunteer for the Wesley Community Center.

Virgil, a Roman who followed Pericles by four hundred years, observed, "We make our destinies by our choice of gods." Dr. Lamb chose to fashion his dental career into a quest for the highest ideals of dentistry. His was an unflagging pursuit of excellence in his individual practice and through the dental community.

During his thirty-five years of practice, Dr. Lamb guided his own and colleague's professional development in ways which would ensure the dental profession was always a wise steward of the public's trust. Among colleagues, he would occasionally make gentle, often humorous comments about instances of unprofessional behavior,





Dr. Robert E. Lamb

leaving no doubt in anyone's mind where lay the boundary of propriety and on which side of that boundary any dentist of integrity should endeavor to stand. With every breath, he taught ethics and professionalism. He was often invited to serve organized dentistry because of his devotion to high standards.

Dr. Lamb added value to the Dallas County Dental Society. He served four terms on the Board of Directors. He chaired, vice chaired, and co-chaired committees for fluoridation, dental health, continuing education, peer review, and finance. In 1976, the Society honored him as Dentist of the Year.

Dr. Lamb added value to the Texas Dental Association. He served three terms as chairman of the Council on Dental Health; served on the Interdisciplinary Committee of Dental Health, the Insurance Committee, and in the House of Delegates; represented the Association to the Texas Medical Care Advisory Committee; was Association Consultant to the Texas Educational Agency to write health curriculum for children, Director of the Texas Founda-

tion for Dental Health and Education, and Director, then Vice-President of the Texas Dental Association. In 1969 and again in 1975, the Texas Dental Association awarded him its Distinguished Service Key.

Dr. Lamb added value to the American Dental Association. He chaired the Council on Dental Health and Health Planning and Task Force on Fluoridation and was a member of the Council on Annual Sessions Committee on Local Arrangements. He served as an ADA liaison to the American Pharmaceutical Association, the National Health Council, the American Medical Association's Council on Rural Health, the National Institutes of Health's National Hypertension Committee, and the Centers for Disease Control for fluo-

Dr. Lamb was honored for work far beyond what is captured here. In 1964, Dr. Lamb was elected to the American College of Dentists. After thirteen years of holding state and committee offices, he was elected Regent for Regency 6. He was a life member

of the International College of Dentists, Pierre Fauchard Academy, and Federation Dentaire Internationale. In 1982 he received the Baylor College of Dentistry Distinguished Alumni Award, and in 1990 was elected to the Baylor College of Dentistry Hall of Fame. This quiet, gentle, gracious man got around and was noticed.

It is likely that virtually every reader of this article enjoys some of the fruits of Dr. Robert Lamb's labors. He stands among the saints of our profession. May we always aspire to the principles of ethics and professional practice that he pursued. By the measure of Pericles and the spirit of Virgil, it is simply making a choice about which gods we choose to follow.

# Quo Vadis Dentistry?

Prem S. Sharma, DDS LDS, RCS, FACD

A crucial issue facing dentistry today is: "*Quo Vadis* Dentistry?" Where are we headed? What is our future? Certainly, the leaders of the profession will play a role in determining the future of dentistry. However, what will be the influence of other disciplines? What will be the impact of societal needs and demands? What about the political climate and government control? It is critical to recognize the complexities of these factors and their influence on the future of dental practice.

The 1994 Symposium brought together a distinguished panel of experts to commence a quest of the future. Perspectives began with the Pew Health Professions Commission, followed by an agency now shaping dentistry's future — the Institute of Medicine's Committee on the Future of Dental Education. Healthcare reform stalled at the national level, but new directions were presented by the third speaker. Presentations concluded with the views of a "front-line" general practitioner. Finally, the future was discussed and debated with the audience.

The Pew Health Professions Commission has been instrumental in assessing healthcare needs of our nation and suggesting means for dentistry and other healthcare professions to respond. The Commission is now in the

second phase of its work. Its current areas of focus were presented by the only Commission member who is a dentist, Dr. Arthur A. Dugoni. Dr. Dugoni is Past President of the American Dental Association and the American Association of Dental Schools. He is Dean of the University of Pacific School of Dentistry and a Fellow of the American College of Dentists.

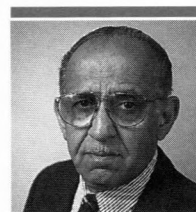
In early 1993, the Institute of Medicine of the National Academy of Sciences began its study on the future of dental education. This study was supported, in part, by federal agencies, the Robert Wood Johnson Foundation, and various dental organizations. An eighteen-member panel, including several ACD Fellows, sought input from the profession and from communities of interest. Dr. Marilyn J. Field, director for the project, presented an overview of the study.

[Editor's note: Dr. Field's presentation was published as an introduction to the set of reaction papers on the IOM report appearing in the Spring 1995 issue of the *Journal of the American College of Dentists*.]

Directions in health care are difficult to predict. While the Congress did not deal with national healthcare reform in 1994, discussions are under way at the state level, among insurance companies, care providers, and educational institutions about the future of health care. Insights into what may lie ahead, including opportunities and challenges,

were offered by Maureen K. Byrnes, Director of Federal Relations, at the Association of American Universities. Ms. Byrnes spoke on healthcare reform, universities as providers of care, educators, consumers, and research institutions.

How will directions in healthcare reform effect dentistry? The opinions of a general practitioner were offered by Dr. René M. Rosas, a Fellow of the College and an ADA Trustee from the 15th District.



Dr. Sharma is Associate Dean at the School of Dentistry, Marquette University, 604 North 16th Street, Milwaukee, WI 53233 and President-Elect of the American College of Dentists.

# Policy for Dentistry's Future: The Pew Health Professions Commission

Arthur A. Dugoni, DDS, MSD, FACD

**W**ill dentistry just survive the forces challenging its future, or will it take charge of the forces of change? As the driving forces for healthcare reform — expanding access, lowering costs, and improving quality — continue to embroil the health professions, the dental profession must look beyond survival and take command of the future. This can best be accomplished by maintaining an awareness of the forces and agents promoting change.

One of the agents of change is the Pew Health Professions Commission, whose work in Phase II is directed toward national health workforce policies for the United States.<sup>1</sup> The Pew Commission is a program of the Pew Charitable Trusts, administered by the Center for the Health Professions, University of California at San Francisco. The Trusts, a national and international philanthropic organization, support non-profit activities in the areas of conservation and the environment, culture, education, health and human services, public policy, and religion. Through grant making, the Pew Charitable Trusts encourage individual development and personal achievement, cross-disciplinary problem solving, and innovative practical approaches to meet the changing needs of society. Founded by two sons and two daughters of Sun Oil

Company founder, Joseph N. Pew, and his wife, Mary Anderson Pew, the Pew Charitable Trusts consist of seven individual trusts with \$3.4 billion in assets and annual grant making potential of approximately \$170 million.

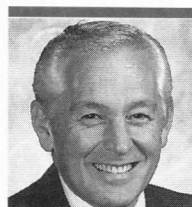
## *Phase II — The Workforce Context*

The focus for Phase II of the Pew Health Professions Commission is the workforce, with specific attention on the primary care workforce. Phase II, which began in September 1993, maintains that health professional institutions must prepare all healthcare providers, not just primary care providers, with the skills, competencies, values, and attitudes necessary to work in a reformed system. Ten and one-half million healthcare workers have a tremendous impact on the cost, quality, and accessibility of the system. Phase II will attempt to stimulate public demand for an appropriately trained and effectively deployed workforce as a central part of healthcare reform by promoting changes in health education. In 1993, personal healthcare expenditures exceeded \$803 billion, of which dental services were only \$41 billion. In contrast to hospital care and physician services, dental services as a percentage of personal healthcare costs will have decreased 50% between 1960 and the year 2000. In 1960, dentistry was 8.4% of personal health costs. In 1992, dental

services accounted for 5.4% of personal health costs; in the year 2000, it is projected to be at 4% of costs. This represents a remarkable commitment to cost containment by the dental profession.

The mission of the Pew Health Professions Commission is to assist policy makers and educational institutions in producing healthcare workers who can meet the changing needs of the American healthcare system. The central concern in the healthcare reform debate is our ability to provide all Americans with access to quality health care while restraining the growth in the cost of care. Although each health profession can contribute to the solutions, the major issues of cost and access reside in the medical care system, and it is here that most federal policy attention is turned.

The current medical care system supports a workforce dominated by medical specialists. A reformed system should strive to streamline patient access, coordinate service delivery, and promote cost efficiency. This will require a greatly expanded primary care orientation and workforce, including



Dr. Dugoni is Dean at the School of Dentistry, University of the Pacific, 2155 Webster Street, San Francisco, CA 94115 and a Commissioner on the Pew Commission for the Health Professions.



family physicians, general pediatricians, general internists, nurse practitioners, physician assistants, and certified nurse midwives.

The commission foresees the focus of healthcare delivery shifting from the individual to the overall population, i.e., to the community. Primary care providers form the foundation of the commission's recommendations and primary care workforce strategies are central to the theme of expanding access to care with lower costs and improved quality. Primary care is distinguished from secondary care (consultative) and tertiary (referral) care. Primary care includes: the delivery of first-contact medicine; the assumption of longitudinal responsibility for the patient, regardless of the presence or absence of disease; and the integration of physical and psychological and social aspects of health.

### *Six Strategies of the American Healthcare Workforce*

The following policy recommendations were developed by the Pew Health Professions Commission in the context of the Clinton administration's economic proposals and were presented in the commission's publication *A Vision for Change in America*.

Primary care workforce *strategy one* is to create an appropriately sized physician work-force characterized by at least 50% primary care physicians with the skills necessary to practice in a dramatically changed healthcare system. It is proposed to alter the workforce from one dominated by medical specialists by changing the generalist/specialist ratio to 50/50 from the current 20/80. This will be accomplished by decreasing the number of individuals in specialty training programs and increasing the number of individuals in primary care training programs. Current estimates indicate a shortage of 50,000 pri-

mary care providers and an oversupply of non-primary care providers of 100,000 or more. The anticipated surplus of physicians (which, depending on the study, ranges from a surplus of 165,000 to 328,000) must be reduced. The projection is for a 25% reduction in the number of physicians by the year 2005. This will be accomplished by reducing the medical class sizes by 30% or closing an appropriate number of schools. In addition, there will be a reduction in both number and size of subspecialty training programs. Also, to accomplish this first strategy, it will be necessary to: (a) close the compensation gap between generalist and specialist physicians; (b) reconstruct the system of federal support for graduate medical education to secure an adequately sized and appropriately trained primary care physician workforce; and (c) encourage medical

schools, teaching hospitals, and other healthcare delivery systems to develop retraining programs for equipping specialists with generalist skills.

Many of the problems associated with and identified in healthcare reform have been clearly addressed by the dental profession and dental education over the past decade. In contrast to medicine, approximately 80% of all dentists practice general dentistry. Oversupply of practitioners has also been corrected. In 1983, there were 5,756 dental school graduates; in 1993 there were 3,778 graduates. This represented a decrease of 34% and the fewest number of dental school graduates since 1971. In 1993, 35% percent of dental school graduates were female.<sup>3</sup> First-year enrollment in dental schools in 1978 was 6,301 students; in 1993 enrollment was 4,100 students. In the last four years, applicants increased 35%

### Phase I — Competencies for the Year 2005

In 1991, Phase I of the Pew Health Commission identified the challenges faced by health professions education in the coming decade and the competencies health professionals would require to practice in the next decade.<sup>2</sup> These practitioner competencies for the year 2005 include:

- Care for the community's health.
- Assess and use health technology appropriately.
- Expand access to care.
- Improve the health care system.
- Manage information.
- Provide contemporary clinical care.
- Emphasize primary care.
- Understand the role of the physical environment.
- Participate in coordinated care.
- Provide counseling on ethical issues.
- Ensure cost effective and appropriate care.
- Accommodate expanded accountability.
- Practice prevention.
- Involve patients and families in the decision making process.
- Participate in a racially and culturally diverse society.
- Promote healthy lifestyles.
- Continue to learn.

while first-year enrollment increased by only 3%. In the past decade, the following dental schools have closed: Oral Roberts, Emory, Washington University, Fairleigh Dickinson, Georgetown, and Loyola of Chicago.<sup>3</sup>

In contrast to medicine, the dental profession has responded to the challenges of the changing environment. For example, the peak dentist-to-population ratio in 1987 was 56.5 dentists per 100,000, with a projection in the year 2020 of 43.9 dentists per 100,000.<sup>4</sup> The American Association of Dental Schools projects the future aggregate supply of dentists will decline and the already evident decline in dentist-to-population ratio will worsen. Currently, about 25% of practicing dentists are over the age of fifty-five. A slight increase in enrollment will neither significantly offset the large number of dentists that will be retiring in the near future nor appreciably alter the projected aggregate supply of active dentists.<sup>3</sup>

In addition, first-year enrollments in allied dental education programs are: assisting — 5,338 in 1988 and 6,192 in 1991; dental hygiene — 4,866 in 1985 and 5,487 in 1991. Unfortunately, there continues to be a major reduction in laboratory technician training programs, with first-year enrollments in 1982 of 1,543, but only 932 in 1991.

Dentistry has not received as much attention in the recent work of the Pew Health Professions Commission because it provides an example for healthcare reform. Dentistry has maintained its focus on prevention, cost control, and entry-level care through the general practitioner.

The commission advocates that national healthcare workforce policies include a National Health Professions Development Board to set targets for the size of each of the health professions and to expand training programs for primary care providers, particularly

nurse practitioners, physician assistants, certified nurse midwives, and community health workers.

Primary care workforce *strategy two* is to increase the number of nurse practitioners, physician assistants, and certified nurse midwives and to expand their roles in the direct delivery of care. Policy recommendations for strategy two include: (a) increasing the number of training programs and expanding existing class size in order to double the number of nurse practitioners, physician assistants, and certified nurse midwife graduates by the year 2000; (b) expanding the role of the nurse practitioners, physician assistants, and certified nurse midwives in direct primary care service delivery; (c) doubling graduates by the year 2000; (d) removing barriers to usage; (e) training to competencies in primary care; (f) providing direct reimbursement for services; (g) closing the compensation gap; and (h) reimbursing at same levels for the same services.

Primary workforce *strategy three* is to create public-private partnerships to facilitate state-based planning for health professions education reform. Policy recommendations include: (a) establishing a working relationship between federal and state agencies responsible for workforce planning and private entities, including associations and foundations, interested in healthcare workforce issues; and (b) encouraging the formation of state-based coalitions on health professions education by providing planning and program grants. These grants should be funded from private and public sources. The national health workforce policy for the United States also should include an all payer financing account to ensure adequate funding for all health profession education, such as medical and dental school trust funds. The dental profession must be vigilant to ensure that the

dental school trust fund is a reality if healthcare reform policies are developed.

*Strategy four* is to create community-based programs for training health professionals and recruiting primary care providers to underserved areas. Incentives such as tax credits would be provided to primary care providers. In this regard, dentistry must ensure that tax credits are also provided to dentists who practice in underserved areas. Greater incentives to participate in the National Health Service Corps should be developed with the goal to eliminate all shortage areas by the year 2000. The American Association of Dental Schools reports that 25% of dental school graduates are establishing practices in rural and underserved areas. Developing tax deductibility for service in underserved areas and enhancing telecommunications links to academic health centers for continuing education and professional support should be high priorities.

The *fifth strategy* is to balance the current individual and curative orientation of medical systems with a more community and prevention oriented healthcare system.

Dentistry has an enviable record in prevention. The U.S. Department of Health and Human Services reported in 1992 healthcare savings due to more effective prevention of dental disease. Widespread use of fluorides, better oral hygiene practice, and an increase in preventive services such as sealants have worked to reduce oral healthcare costs. The recent report from the Institute of Medicine reveals that dental benefits save the American public \$4 billion per year due to the emphasis on prevention, early detection, and treatment.

*Strategy six* is to create a federally-supported research and development mechanism for a better understanding



of primary care education and care delivery issues. Dentistry must ensure an extension of graduate medical education reimbursement to dental school-based residency programs.

*Strategy seven* is to increase the number of underrepresented minorities and disadvantaged persons in the health professions, particularly in primary care. Minorities are 22% of the population, but only represent 10% of incoming medical students, 7% of the practicing physicians, and 3% of medical faculty. This strategy seeks to create parity by the year 2000. Recent studies from the American Dental Association and the American Association of Dental Schools reveal an increase in both women and minorities in dental education programs. First year enrollment of minority students has increased by more than 250% since 1980, from 13% to 32% in 1993.

## Strategies For Dentistry

Competition has reshaped the delivery of health care. Dental practice and education are not immune and are very affected by market forces. Dentistry has come a long way in 150 years, further along the road to prevention than any other health profession. It has evolved from a profession of exodontia and pain relief to repair and restoration, and the present progress in prevention and

health. As Dr. C. Everett Koop points out, "If you don't have oral health, you're not healthy." The health of the mouth, including the teeth, periodontium, jaws, and surrounding structures, contributes to the health of the whole body. One hundred twenty physical or mental diseases show symptoms in the oral cavity, including cancer, diabetes, and AIDS. Ensuring the continuing competency of an aging practice community in the face of an ever-increasing pace of technological expansion represents a growing challenge for dentistry.

Specific strategies for dentistry include:

1. Develop a more integrated continuum of the educational phases of dental practitioners over their lifetime. An aging population will demand a dentist who has a greater knowledge of internal medicine, clinical pharmacology, (treating patients with systemic diseases taking multiple medications), and dentists with new levels of sophistication in communication skills.

2. Restructure the process of accreditation, licensure, and relicensure, as well as certification and recertification, to ensure not only initial but continued competency of dental practitioners. The changing face of dentistry includes practitioners prepared to enhance healthier lifestyles and whose

dental practices are being transformed from a narrow concern to a fully redefined profession practiced by oral physicians.

3. Train and retrain dental faculty so they possess the competencies necessary to serve as role models for future practitioners.

4. Provide dental students and residents experience in delivering care to diverse segments of the population in community-based settings. Dentistry must come to be recognized as an integral part of health care and primary care. The future of dentistry will be different, but with close attention to our external environment, it can be better than ever.

## References

1. Pew Health Professions Commission. Primary care workforce 2000 — federal policy paper. San Francisco, California: UCSF Center for the Health Professions, 1994.
2. Pew Health Professions Commission. Health America: practitioners for the year 2005 — an agenda for the U.S. health professional schools. Durham, NC: October 1991.
3. American Association of Dental Schools. Deans' briefing book, academic year 1993-1994. AADS, Washington, DC: 1994.
4. U.S. Department of Health & Human Services. Eighth report to congress on health personnel in the United States. Rockville, MD: Bureau of Health Professions Projections, 1990.

The Chairman of the Pew Health Professions Commission is the former Governor of Colorado, Governor Richard D. Lamm, and the Executive Director is Edward H. O'Neil, Director of the Center for the Health Professions at the University of California at San Francisco. Members of the Commission include: Charles H. Bair, President and CEO of the Upper Valley Medical Center, Troy, Ohio; Paul Batalden, Vice President of Medical Care, Hospital Corporation of America, Nashville, Tennessee; Howard Berman, President, Blue Cross/Blue Shield, Rochester, New York; Barbara A. Brookmyer, medical student, Hahnemann University School of Medicine, Philadelphia, Pennsylvania; Oliver C. Bullock, Clinical Director, Cambria Medical Center, Philadelphia College of Osteopathic Medicine; Rhea de Tornay, Dean Emeritus, School of Nursing, University of Washington, Seattle, Washington; Barbara A. Donaho, President and CEO, St. Anthony Hospital, St. Petersburg, Florida; Arthur A. Dugoni, Dean, School of Dentistry, University of the Pacific, San Francisco, California; Claire Fagin, Interim President, University of Pennsylvania, Philadelphia, Pennsylvania; Bill Gradison, President, Health Insurance Association of America, Washington, D.C.; Robert Graham, Executive Vice President, American Academy of Family Physicians, Kansas City, Missouri; Fernando A. Guerra, Director of Health, San Antonio Metropolitan Health District; Paul B. Hofmann, Visiting Scholar, Center for Biomedical Ethics, Stanford University, Palo Alto, California; David C. Hollister, Mayor, Lansing, Michigan; John P. Howe, President, University of Texas, Health Science Center, San Antonio, Texas; Pamela J. Maraldo, President, Planned Parenthood Federation of America, New York, New York; Glenda D. Price, Provost, Spelman College, Atlanta, Georgia; Carl E. Trinca, Executive Director, American Association of Colleges of Pharmacy, Alexandria, Virginia; Gail L. Warden, President and CEO, Henry Ford Health Systems, Detroit, Michigan.



# A Policy Analyst's View of Healthcare Reform

Maureen K. Byrnes, MPA

**N**o matter what the federal government is about to do, or whether the federal legislature is able to do anything in the area of healthcare reform, change is occurring rapidly. The managed care revolution has exploded across the country — perhaps more quickly than many of us would have imagined. The explosion of managed care may well be one of the strongest arguments for reform if we are to see our academic health centers survive in an era based on a competitive system of market and price. In fact, our academic health centers may not all survive in a managed care system. It is only through the recognition of the executive and legislative branches of government that there must be special provisions and support for the multiple missions of academic health centers — education, care, and research — if some of the strongest components of our healthcare system are to continue in the future.

## Concerns Over National Reform

Many followed with great interest the events over the past year with healthcare reform. The bad news is that initially the process the Clinton administration, the First Lady, Ira Magaziner, and hundreds of other people put in place did not recognize the role of academic health centers and the important role they play. The good news is, education

works. The academic health center community recognized the need to impress upon the policy makers that it made no sense to be looking at a comprehensive healthcare package unless it provided the kinds of support needed for health professions training and research. Subsidies are needed for the academic health centers because they have costs that are different from other healthcare settings.

The educational efforts were quite successful with the Clinton Administration. Over time there was recognition that no one wants academic health centers to go out of business. There is a desire to see academic health centers become as efficient as possible, and to look quite carefully at how they are organized, who is being trained, and the role that research plays in healthcare reform. There was also a recognition that some specific provisions are needed to support academic health centers.

This message was taken to Capitol Hill as well. Again, I think we were quite successful. There are champions in the House and Senate who support health professions training and biomedical research and who appreciate the role of academic health centers in our healthcare system.

But it was an uphill battle, for a couple of reasons. First, as a community we do not always have a unified message. When healthcare reform first appeared on the scene, we were physi-

cians versus nurses versus dentists versus educators. The healthcare community seemed quite nervous about who was going to be identified as a priority and how the funding streams would be provided. We were not initially speaking with one voice. In addition, academic health centers do not tend to be what we call in Washington a "top-tier" issue in healthcare reform. Employer mandates, universal coverage, and how we will pay for whatever we include in a healthcare package dominated the Washington debate. Trying to explain GME, IME, nurse training, dental schools, and the importance of biomedical research was of interest to some supporters. But it was a hard case to make to people who are looking at reforming the system and focusing on issues such as employer mandates and universal coverage.

## Strategy for Academic Health Centers

The Association of American Universities (AAU) has been active in this arena. There are fifty-eight research-intensive universities in the AAU. The AAU university presidents and chancellors rec-



Ms. Byrnes is Director of Federal Relations and Research Policy at the Association of American Universities, One Dupont Circle, NW, Suite 730, Washington, DC 20036.

ognize the importance of academic health centers to our universities. There are also important employer issues for the universities if coverage for all employees is mandated. There are also questions about mandated coverage for students — graduate students in particular.

The AAU presidents and chancellors thought it would be a good idea to bring together a task force of academic health center representatives, vice presidents of health science centers, medical school deans, nursing school representatives, as well as the university presidents. This was an attempt to do what we don't often do very well — talk behind closed doors like a family, agree on what we can, but be quite clear about what will be said when we leave

and those from poor and disadvantaged communities. Universities provide innovations in health care; they employ thousands of people and provide comprehensive health benefits for employees. To continue to make these contributions, there is a need for designated and adequate funding for health professionals education and differential funding reflecting the costs inherent in institutions that teach, conduct research, and provide care for the underserved. This support is particularly important since many of the subsidies that academic health centers have relied upon in the past will no longer exist under a reformed system. Differential funding is necessary to ensure that academic health centers may participate fully in a competitive delivery system. Enhanced

mises have been made and the final proposal is put together. Identifying the funding streams is always extremely important. The academic health centers' strategy encouraged multiple funding streams. As a community of providers we did establish a series of trust funds dealing with graduate medical education; a subsidy to the academic health centers to replace the old indirect medical education funds; some medical school dollars, some dental school dollars in some of the legislation, some nursing school money; and a trust fund for research.

### **Who Are Primary Care Providers?**

One "top-tier" issue will continue to appear: generalists versus specialists. Washington will continue to discuss employer mandates, universal coverage, and how to pay for this coverage. Policy makers will also talk about how many specialists there are and point the finger at our academic health centers saying, "We expect to see more generalists." Usually they mean primary care providers when they say generalists, and usually it is not clear who is considered a primary care provider. The definition of primary care depends on who you ask or which bill is being considered.

There clearly are aspects of oral health and dentistry that fit within primary care. Having worked several years as the Executive Director of the National Commission on AIDS, I know that many of the early symptoms of HIV are first recognized by dentists. The dental schools have been among the heroes in the AIDS epidemic and have provided the services desperately needed by people with HIV.

### **Action Shifts to State Level**

At the end of the 1993 Congress, there was no consensus on healthcare reform legislation. A majority of Republicans

---

*...there may be some very useful experiments on the state level before we develop and implement a comprehensive federal plan. The healthcare problem is not going away. The question is whether reform can help to restructure the healthcare delivery system in a positive, constructive way.*

---

the room. The task force established some guiding principles on what was needed in any healthcare reform package — a template for measuring any proposal. As an association, the AAU never endorsed an individual plan or proposal, but did measure each proposal in terms of this template.

The principles stated that universities educate healthcare professionals at the undergraduate and graduate levels and provide continuing education for those in practice. Universities perform most of the nation's biomedical and health services research and research training. University-based academic health centers care for patients, especially those with complex problems,

support for biomedical research also will be an important component in any healthcare reform proposal.

Our efforts were quite successful. The two bills introduced in the United States Senate included provisions recognizing the need for support in many of the above areas. There was at least a recognition in the bill moving through the House that academic health centers exist and play a unique role in our system of care.

An important strategy for any organization concerned with monitoring healthcare legislation today and tomorrow: follow the money. The language of legislation is important, but it does not always survive once the compro-

believed the proposals went too far, and there was a significant number of Democrats who thought the compromise package didn't go far enough.

What can we look forward to in the coming months and years? Watch the states very carefully. There will most likely be an effort in the 104th Congress to reintroduce a healthcare proposal. President Clinton has clearly stated his commitment to doing so; the leadership in Congress, if they're still there, appears committed. But, many who have been watching this process closely, guess that any proposal will be more incremental than comprehensive.

The major action these days is in the state legislatures. The states are feeling the squeeze more than ever in terms of

the impact of healthcare costs on state budgets. In fact, there may be some very useful experiments on the state level before we develop and implement a comprehensive federal plan.

The healthcare problem is not going away. The question is whether reform can help to restructure the healthcare delivery system in a positive, constructive way.

As a personal observation, I believe there is a lot wrong with how our healthcare delivery system is organized and paid for. If you know anyone with a chronic or life-threatening illness, or who works hard at a full-time job but doesn't have health insurance and can't afford to buy it, you too will see that something is wrong with the system.

However, there is an awful lot right with the quality of care provided in the United States, the way we train our providers, and the commitment that is second to none in federal support for research. The challenge in the coming months and years is the same challenge we have faced for some time — to fix what is wrong and to preserve what is great. That is not going to be easy to do.

The opinions expressed in this article are the author's and not necessarily those of the Association of American Universities.



# The Need for Professional Ethics is Greater Than Ever

René M. Rosas, DDS, FACD

**T**oday we are examining the changing face of the dental profession and taking a glimpse into the future. It has been said, you don't know where you're going unless you know where you've been. I can only relate where I've been during the past thirty-two years of private practice in El Paso and share some concerns and personal opinions of some future influences on our profession.

In beginning a review of where dentistry has been, I can remember starting out in my office with the old manual peg board system and then going to computers and daily printouts on services, treatments, profit centers, and even the demographics of the practice. At the same time, we saw improvements in amalgam, amalgamators, light-cured composites, handpieces, fiber optics, x-rays and dry development, improved impression materials, electro-surgery, photography, imaging, lasers; the list goes on. What an exciting time we experienced and continue to experience today. We no sooner became acquainted with new materials and procedures when a new wave of technology hits the market place!

As professionals, we are consumed with the knowledge base and we are regular attendees at continuing education courses. We constantly thirst for new knowledge, new technology, new materials, and new techniques to pre-

pare us to deliver the finest dental treatments in the world to our patients. This is all well and good; it bolsters our competence and confidence; it feeds our egos and our personal pride of being the best. Perhaps this is the most important underlying trait we have as dentists — a desire to be the best. And you, my Fellow colleagues, are the best.

## *Ethics in Our Future*

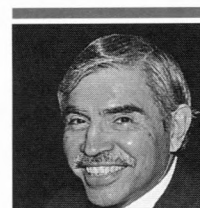
Having reviewed the road well traveled by the dental profession and the ACD Fellows, it is important to express a concern challenging dentistry on an increasing basis.

As dentistry works its way out of a job by virtue of successful preventive measures that have practically eradicated caries, work is getting diluted. There is less and less disease and there are more and more dentists. The traditional role of the dentist is changing. To fill the economic void, imaginative procedures are being performed and manipulative paper work is being developed. One only needs to sit in a state dental board hearing to learn that most of the infractions being reviewed deal with ethics. The new competitive marketplace environment makes ethical conduct by dentists more difficult — it also makes ethical conduct more critical if our profession is to remain a profession.

Dentists have always performed charity treatment, often free, for disadvantaged people. This has been done cheerfully as dentists view such service as an ethical obligation. With the advent of Medicaid, the state became involved in this process and interfered in the direct doctor-patient charitable arrangement. Doctors (now called vendors) provide services to patients (now called clients) with some remuneration, begrudgingly, because governmental bureaucracy is no substitute for ethical responsibility. The government is determined to replace the doctor-patient relationship with a vendor-client relationship.

The ethical implications of this shift are enormous. This is ultimately about how patients are treated, not how doctors are treated. Ethics is a voluntary mechanism that ensures that patients are treated well. Fortunately, when ethical behavior is the norm everyone benefits.

Selfless ethics is what distinguishes a profession from a trade, and the price society extracts from professions for their privileged status in society and



Dr. Rosas is an ADA Trustee from the 15th District and Director of Centro de Salud Familiar La Fe, 700 South Ochoa Street, El Paso, Texas 79901.

commerce. To make a vendor out of the professional undermines this concept, and for some, it may be an excuse for unethical conduct. It is as if someone said, "If they treat us as tradesmen, we can behave as tradesmen."

Some dentists will face a severe ethical challenge in the form of managed care, especially in capitation-funded dental plans. The economic health of the dentist may be the deciding factor in the treatment the patient receives, rather than the oral health of the patient.

As economic competition increases (a goal of healthcare reform), we may see more subtle undermining of our profession. There will be pressure to stop freely sharing professional information. Our ethical obligation now may be characterized as, roughly "Receive freely from our predecessors (ex-

cept for tuition) and pass on to our successors." We are already seeing compromise in the "passing on" phase by propriety continuing education programs offered outside the universities at high tuition rates. Some of our colleagues make a living on the education circuit, as opposed to treating patients. Their motivation may be more commercial than educational. The same phenomenon is occurring with patents, business ventures in the health field, and the number of dentists and physicians speculating as owners of managed care systems.

With the federal government increasingly considering the profession as just another business, these anti-ethical pressures are both increased and codified in the law.

It is believed that dentists form their professional behavior patterns very early in their practice history. With the

tremendous financial burdens facing many new dentists as they start practice today, they are the most vulnerable to economic pressures and to compromised ethical standards. These patterns, once formed, are very difficult to change.

This is where we, as established dentists, should be professionally supportive of new dentists during their difficult early practice years. It is gratifying to see dental students and new dentists who have a strong interest in ethics. They may have sensed a decline in dentistry and realized that ethics is the key to our survival as a learned profession.

It is appropriate for the American College of Dentists to address this issue. The ACD should be congratulated for their efforts.



# Questions & Answers

**Q** Dr. Robert A. Colantino (*Springfield, IL*): I was struck by the contrast in the Pew Health Professions Commission, which is composed of only one dentist, a few physicians, and a great number of other people. This is similar to the situation of the Ira Magaziner group, which had little input from providers of care, advising President Clinton on healthcare reform. I think it is important that the principal players, particularly dentists, should be strongly represented in policy formation. I am particularly concerned about the Pew Commission placing so much emphasis on medicine. It is implied that dentistry is well served by going along. Instead, I wonder whether dentistry shouldn't develop its own direction and future and not be tied so closely to the future of medicine.

**A** Dugoni: I agree and I appreciate your question. The problem is the public often sees dentistry in the same light as medicine. It remains for us to make a case for the difference between dentistry and medicine, including our unique role and the very positive things we have accomplished. We can't help but be influenced by the forces for change which are so preoccupied with the problems of medicine. It remains for us, as knowledgeable and informed people, to get our message across to the people, to Congress, the state legislators, etc. We must clearly identify who we are and how we have so dramatically improved the lives of our patients.

**Q** Dr. Tariq Javed (*College of Dental Medicine, Medical University of South Carolina*): There appears to be a significant overproduction of specialists in

medicine. I see increased interest among our dental students to pursue specialty practice. Are we headed in the wrong direction in this regard?

**A** Dugoni: Absolutely. You have put your finger on a concern of both educators and the practicing profession. As we have decreased the output of the DDS and DMD graduates, we have maintained the *status quo* of our graduate programs. This has changed the ratio of general practitioners to specialists. Predictions are that we will soon approach 25% specialists.

What has happened in the educational programs is the introduction of the General Practice Residencies (GPRs) and, more recently, the Advanced Education in General Dentistry (AEGD) programs. Ultimately, the goal is to provide every graduate the opportunity to experience an advanced general practice residency training — with the assumption they will move in that direction. Of course, economics always plays a factor. Recently in the *New England Journal of Medicine* there was a report comparing the return on investment of education in dentistry, medicine, law, and business. General practice dentists out-earn physicians in general practice and compare favorably to law and business. But, it is clear that specialists earn significantly more than generalists in dentistry, and by far the greatest economic return is to medical specialists. The young people of this country have ethical and honorable goals, but they also have to raise a family. This is a great concern, and the educational community has already responded with its emphasis on general practice residency experiences.

**Q** Dr. Javed: Dr. Ed O'Neil, referring to Pew Commission findings, has said recently that by the year 2000, we may have a shortage of dentists.

**A** Dugoni: To this point, the Pew Commission has concentrated primarily on issues in the physician workforce. But the projections for dentistry take into consideration the increasing numbers in the general population and the decreasing numbers of dentists. This is a complex issue, but it is the opinion of some that there will be a shortage about the year 2010. Dr. Rosas noted that the overall number of dentists has risen from 121,000 to 156,000. At the same time the population of this country increased by 30 million people. The population is living longer with all of their dentition and with increasing medical needs. It is projected that despite the wonderful things we have accomplished in caries prevention, there could be a shortage in oral healthcare providers due to the change from 56.6 dentists per 100,000 to 43.0 per 100,000 — which is the same ratio that existed at the time of the first World War. The peak dentist-to-population ratio was reached in 1987, and has declined since.

**Q** Dr. Robert F. Hawke (*Tucson, AZ*): Some educational institutions are in financial trouble. Under the American system of capitalism and free-market economy we must allow our institutions to both succeed and to fail. I feel it is unfair to ask tax payers to support institutions that can't make it on their own.

Further, there was no consensus on the healthcare bill. The Republicans



# American College of Dentists Symposium

October 21, 1994

New Orleans, Louisiana

thought we had gone too far and the Democrats felt we had not gone far enough; perhaps the reason that no bill was passed is that the American people looked at the alternatives and said "hell no." Comments please.

**A** Byrnes: Among the leaders of the academic health center community, there is a recognition that change does need to occur. The market-driven nature of much of the funding for academic health centers requires a reevaluation of their organization and their funding mechanisms. Quite likely, not all will survive.

There was an initial reaction to the proposed legislation that perhaps all academic health centers would be compromised. There seemed to be no recognition that time be allowed for a transition. I agree that market and legislative forces will legitimately force many institutions to change for the better, the changes that would have come about in a crisis of reorganization would not have been in the long-run best interests of any community of interest. Secondly, there is a concern regarding the nature of academic health centers that are different from other providers under a managed care system of reimbursement.

With regard to the issue of the American people — the American public is large, diverse, containing vocal and nonvocal elements. I think what happened in the Senate and the House reflects an ambivalence of some about how quickly we were moving and the fears of many that they might lose what they had. I don't think the issue is going to go away, and I think there is a large portion of the public that wants to

see some change. We just must be careful about how it is done.

**A** Field: The profession must have a clearheaded view of where the forces are that are threatening autonomy, ethics, and income. In the short term at least, I feel it is inappropriate to see government as the enemy. It's inaccurate, first, and probably not very helpful anyway. In terms of threats to the profession, managed care in its general sense is a phenomenon of corporate capitalism. To the extent that you may be an advocate of unfettered capitalism, then what is sauce for the goose is also sauce for the gander. Some academic health centers may fail, but then so may a lot of private practices in just the same environment. This unfortunate situation can only be avoided if we realize that there are some things that it is appropriate for the private sector to do and some that the public sector should do. We need to achieve a balance between them and get them both to be more effective.

**Q** Dr. Hawke: It has been implied that dentistry has been effective at doing many of the things expected of it in terms of care and management of patients. And yet, it is implied that the federal government should assist the schools in certain areas of financing. My experience has been that the federal government made a mistake in the early 1970s in attempting to stimulate the number of dentists through funding dental schools. While I would defend with every fiber of my life the equality of opportunity, I feel that affirmative action in the healthcare fields is a dangerous thing. We need to set our stan-

dards; we need to be blind to race, gender, and religion. But let's select the best and raise our standard as a result.

**A** Dugoni: Of course there's always a concern when you accept money from the federal government. If you look back at the period in the '60s and '70s, we find the deans of dental schools had very few choices. Most of the dental schools of this country were old and poorly equipped; there were few PhDs teaching in the programs, very few double degree, qualified researchers. Many dental schools were brought up to the standards of the time by the infusion of federal funds. There was nobody else lined up to support the educational community. I would not embarrass the leaders in dentistry who are now in this room by asking them to show by a raise of hands how many had put their dental school in their wills. If dental education is going to excel, then we, as the leaders of the profession, will have to provide the resources for it to excel.

The same needs exists now, and again there are few groups stepping forward to help. The academic health centers have made the case that they are different from other healthcare providers in a managed care model. But they have made this case primarily for the medical components of their programs and not for the dental schools. If there was going to be supplemental support for the medical schools in their role as primary care providers, the dental community felt that equally there had to be support for the dental schools.

I'm proud of the quality of the dental students of this country. I wish more

of you could share time with these outstanding young men and women. Every one of you, as a former student, understands the qualities of preparation, character, and dedication that are required to be accepted into and to complete a dental education. There is no necessary connection between diversity and lower standards.

**Q** Dr. Thomas R. Osterlind (*Portland, OR; Chair, Council on Dental Education for the Academy of General Dentistry*): I agree with Dr. Rosas that the primary problem with the competency of dental practitioners is a matter of an individual's ethics. Why is it then that the Pew Commission has suggested that there be periodic testing of practitioners throughout their lifetimes when ethics is the primary concern?

The Pew Commission has talked about creating early tracks for specialization. It has been my experience that the best specialists are those who have had a full range of experiences.

**A** Dugoni: Certainly we are all concerned with ethics. We have to look at a changing society. Ethics and family values are a general concern of society as a whole, and much of this is reflected in the dental profession. The reason the Pew Commission focused on technical skills is that we have a tradition of looking toward entry-level testing for licensure as a way to guarantee quality and as a counter-check of the educational programs. The Academy of General Dentistry has taken a lead role in emphasizing the importance of continuing education to maintain the competency of the profession. I think we must continue to look at that with changing science, changing knowledge, changing ethics. This is a responsibility of the educational programs in this country, and, I am sorry to say, some walked away from that responsibility a long time ago because of

economics and focus on other missions. We are seeing signs that this is changing. Finally, let me say that I do not necessarily equate technical skills and competency. It doesn't make any sense to me to call a dentist with questionable ethics competent, regardless of his or her level of technical skill.

The initial recommendation regarding early specialty tracking was made in Phase I of the Commission. It is my understanding that this position has been abandoned. I happen to completely agree with you about the value of general practice knowledge and experience for specialists.

**Q** Dr. Darrell R. Hazle (*PHS Indian Hospital, Claremore, OK*): I attended the National Primary Care Conference last month in Dallas. We need greater clarification of what primary care services and primary care health providers are. Can we envision educating some dentists to provide a narrower scope of services; lowering the level of dental services using larger staffs of expanded functions dental auxiliaries; and having more medical training in primary care to screen and refer patients with preventable medical problems influencing oral health? Examples of preventable problems include hypertension, diabetes, and alcohol.

**A** Rosas: I start from the view that dentists are in fact now being trained to provide primary care. There are market forces that may color our views on this question. We dentists are clearly primary care providers. With regard to the training of allied personnel, this matter quickly becomes one that involves states' rights. I am proud to say that we are the primary care source in dentistry. Speaking as the recently appointed Director of Dental Public Health in El Paso, I can tell you that we do deliver a lot of primary care, and we deliver it to the right people.

**Q** Dr. Jack M. Saroyan (*San Francisco, CA*): The title of this symposium is "The Forces Shaping Dentistry's Future," and I am glad to see explicit attention now being paid to the economic factors. The economic forces are pervasive. We came into existence partially because dentists were prosperous enough to form an organization such as the American College. I was a little bit alarmed to find that the Pew Commission is going to decide how many people should practice in various specialty areas of medicine. They can easily see what has happened in dentistry. In the thirty-two years I have practiced in San Francisco I have seen the number of endodontists increase from about five to about thirty. The same has happened with periodontics. What has happened is that the economic factors of public demand for the "specialty" services has stimulated schools to set up programs and general dentists to pursue specialty training. Let's not let some of the commissions tell us what kind of practitioners we need when the economic factors can handle the problem.

**A** Dugoni: Of course, economic factors are an important influence for change, and sometimes they are a painful influence. I think it is important to realize that the Pew Commission and other such groups do not write policy. They bring opinion and data together and try to establish a clearer vision of the future. My own view is that anyone who tries to use a crystal ball to look at the future had better be prepared to get some ground glass in their face. Although economic factors are an undeniable force, they may not be adequate in themselves to create overall policy that we would recognize years later as having been in the best interests of the public. The best example I can think of is the problems that medicine has created and the reactions it is generating

from the public and the legislators because so many primary care physicians followed the financial incentives into specialties. The country's needs are different from what the educational community has been producing and there is a clear possibility that the government will "correct" this distribution with economic forces of its own.

The Pew Commission may have influence. But so do you. Dentistry must find its place at the table. In Washington, the ADA has made its voice heard.

**A** Rosas: The technology explosion has to be figured in with the economic factors. There is greater demand from a better informed public. But let me ask you bluntly — who controls the marketplace? The future of the profession might just depend on how you answer that question and what you do about it.

**Q** Dr. Robert G. Griego (*Phoenix, AZ*): We have a system of dentistry in the United States that works and I don't think we have to apologize to anybody. We deliver the best quality of dental care in the world and for the past fifteen years I think we have done it under the cost of living. I don't understand this talk about change, and I certainly would not look to the government if the poor quality we find in Europe and other countries where government takes a more active role is any indication. I submit that if we follow a future of PPOs and capitation plans, there may be a better future, but it won't be better for the patient or for the dentist. For whom, then, will the future be better?

**A** Dugoni: I thoroughly agree that we don't have to apologize for the quality of dentistry in the United States. Certainly the quality of our practitioners, the quality of our educational programs, the quality of the profession

generally is at a very high level. I serve on an international commission, the Federation Dentaire Internationale, where I have the opportunity to look at the oral health of people in one hundred and four countries of the world. Parents in many countries want to send their children to the United States because of the quality of our educational programs. I am a strong advocate of where we are and what we are doing.

But certainly when the public points out to us the problems that exist, we must listen. When thirty-two to thirty-nine million people do not have medical insurance and one hundred million people don't have access to dental prepayment systems, it just means we have to do a better job. Why do I say the future is better? Because we are appreciated by the public of this country; they appreciate their care and they respect the provider. The profession is expanding; it is changing from a profession of pain relief and exodontia to broader avenues for serving the public.

**A** Byrnes: The crux of the debate in Congress is whether the market should be regulated or whether the market should be allowed to play itself out. There's a significant difference of opinion about this among policy makers. This is a reason, according to some, for the case that a little more time is needed. It appears that some of the problems have already begun to respond to market forces. But there is a mentality in Washington to want something quickly. But many of us have argued with those who want rapid change that it simply cannot be achieved, regardless of laws or financial incentives. For example, there would be a significant period of time needed to reach target proportions of generalists and specialists in medicine, even if the trends were reversed today. The federal government also recognizes that the overall market may be balanced

but underserved minorities and other disadvantaged groups can exist as pockets within the system. Historically the government has taken the position that a narrowly defined federal role exists to make certain that services are available where the market cannot reach certain groups of individuals.

**Q** Dr. Chris C. Scures (*Orlando, FL; Immediate Past President of the American College of Dentists*): California, Texas, and Florida are states that license dentists who have not graduated from accredited dental schools. What are the thoughts of the panel on preserving the standards of dentistry with regard to graduates of unaccredited dental schools?

**A** Dugoni: That is a difficult and emotional question which, of course, involves issues of states' rights. The American Dental Association has struggled with this issue for some time. The accreditation process plays a major role in maintaining the quality of dentists entering the profession. The American Dental Association has as its principal policy licensure by credential, it also has emphasized the rights of states to individually protect their publics.

The major concern in licensure right now is the question of whether entry-level licensure adequately protects the public. I recently gave a keynote address before state board examiners and found that few had actually taken the same exam they give and none who were present had participated in accreditation site visits at schools in their states (although this opportunity is available to all). We must look to the continuing competency of our professionals as well as the entry level of graduates to adequately protect the public.

**Q** Dr. Charles L. Wilkinson (*Memphis, TN*): Healthcare reform needs to



start with welfare reform. I would also like to see tort reform. Until this country gets back to basics and votes in farmers, teachers, dentists, physicians, and ethical businessmen we will never get reform.

**A** Byrnes: There are sitting members of Congress who agree with the position that welfare reform should come before healthcare reform. Part of what complicates this issue is the fact they are so intricately linked. Many of our health, welfare, education, and other programs are tied together, and there is a tendency to focus on cutting the budget without fully understanding the interconnections among these programs. There are even some who advocate restructuring all programs across the board.

**A** Dugoni: The American Dental Association has taken a position in favor of welfare reform. The Pew Commission is concerned about tort reform. But I would add a concern over education reform. It may be that now the United States is number one economically, but we rank thirtieth in the leading forty-six countries in terms of our overall educational system. We, as leaders, must address these concerns as well.

**Q** Dr. Harry M. Tuber (*East Orange, NJ; Chair, Counsel on Dental Insurance for the New Jersey State Dental Association*): It appears that the motivation behind the healthcare debate is to provide the greatest good for the greatest number of people, and this probably translates to mediocrity for all. It also means fewer healthcare dollars for more and more people and better care for many people. This all sounds wonderful, but it translates to less remuneration for the people providing the service. Based on my experience I can say that insurance companies can figure on 20% to 35%

for administration fees for the plans they sell. Now it seems to me that if we are going to take a lesser remuneration for our services, then the insurance companies should be forced to do the same thing. And I think we should lobby Congress for the repeal of the Furgason-McCaren Act which gives these companies a virtual monopoly. I think President Clinton was on the right track when he suggested community rating. I'd like your comments on that.

**A** Byrnes: Community rating is not supported by a number of members of congress; on the other hand, there are some who are strongly in favor of it. It normally comes up when you are talking about a short-term approach to healthcare reform. When people thought that a comprehensive plan might not come through, there were some who discussed doing away with the preexisting condition clause and talking about small market reform. But it appears that portability in the absence of preexisting conditions terms requires community ratings. The third piece seems to be necessary. Although some are willing to look at community rating, they almost never look at it as a separate piece. Community rating is back on the table.

**Q** Dr. Linda C. Niessen (*Chair of the Department of Public Health Sciences at Baylor College of Dentistry, Dallas, TX*): The majority of my practice has been in hospital settings and I see some differences between the hospital and the private office settings, particularly when looking at privileges, credentialing, quality assurance, and competency with our medical colleagues. While none of us would look forward to another examination, our medical colleagues are in fact granting an internal medicine board for only ten years. My question is, what role do you see professional organizations such as the

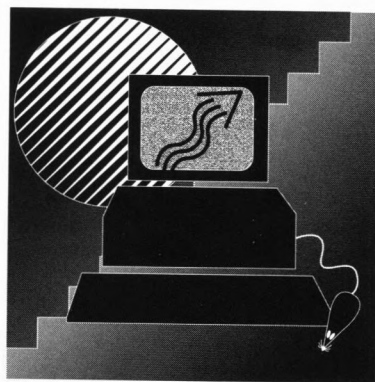
American College playing in helping the dental profession move forward in terms of continuing competency?

**A** Dugoni: I think you have touched upon a very important area of concern. The American Association of Dental Schools has a task force looking at continuing competency, as does the American Association of Dental Examiners. Of course this is an economic, emotional, and academic issue that has multiple concerns, but I don't think we can walk away from our responsibility in this regard. The medical profession has taken a clear stand that certification doesn't last a lifetime anymore. The specialty boards in dentistry have taken the same stand. Just because you are a diplomate does not mean you are through learning; you will have to prove you are still on the cutting edge. And I think that's appropriate.

**Q** Dr. Larry Le Vine (*San Rafael, CA*): Everyone this morning has alluded to the fact that healthcare reform is a dead issue. Well, in two weeks in California the voters will decide on Proposition 186 — a single payer plan.

**A** Byrnes: Yes, watch the states. Single payer was one of the first proposals in the congress, but it was rejected by the Clinton administration. In the next few years we are going to see a lot of proposals across the states. It remains to be seen whether they will fit together in light of the mobile nature of American society. It will be an enormous challenge to coordinate a federal system, if that is in fact what the people want, that is consistent with various state legislation.

[Editor's note: California Proposition 186 was defeated in October 1994 by a margin of approximately two-to-one.]



## **InfoTech**

**American College of Dentists  
InfoTech Conference  
July 15-18, 1995  
Lansdowne Conference Resort,  
Leesburg VA**

The road to the future is an information superhighway. Join leaders in dentistry, healthcare and technology to:

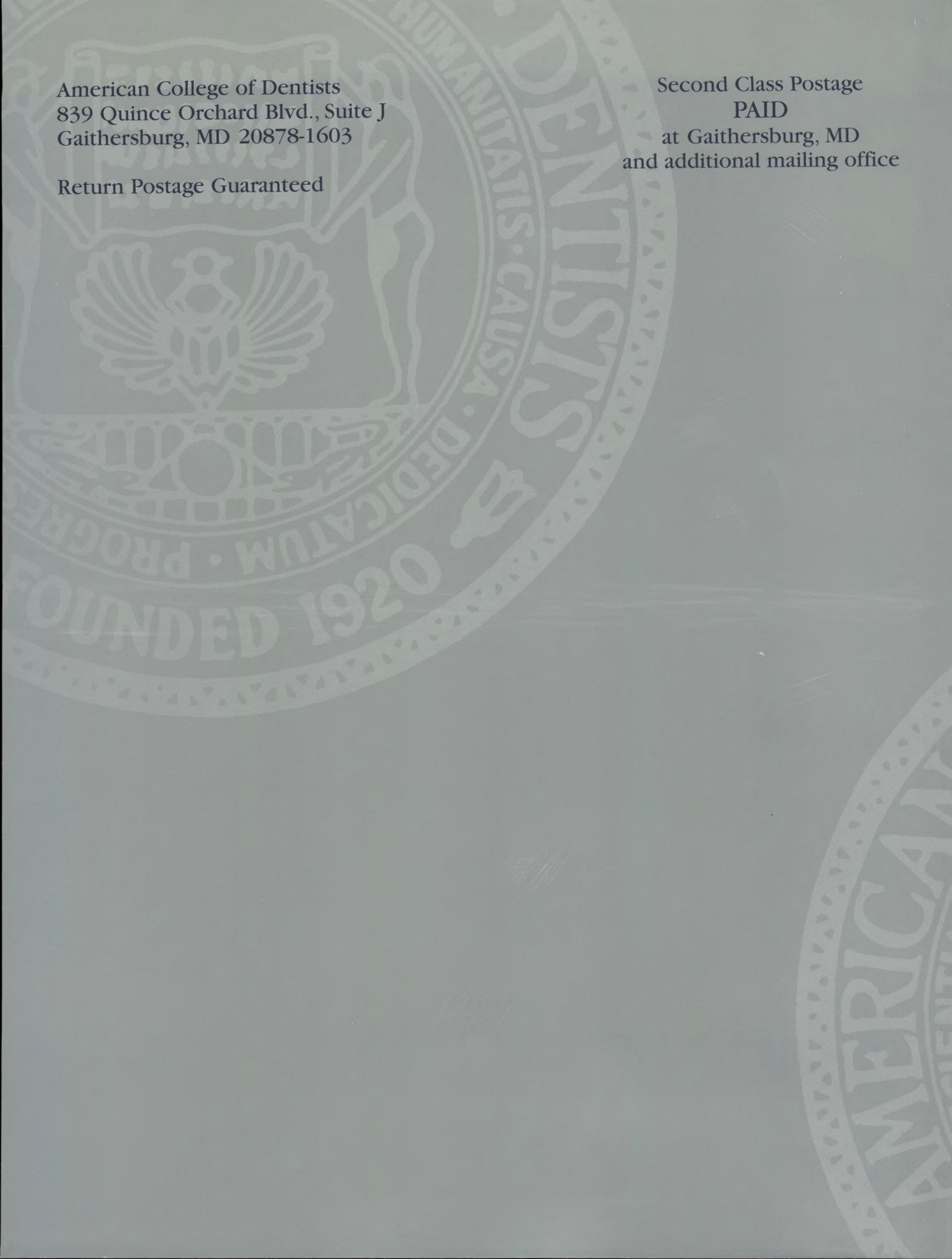
- Explore future technology trends
- Learn current and future applications in healthcare
- Probe issues that will landscape the superhighway
- Shape strategies for the future

The Lansdowne Conference Resort is 8 miles from Washington DC Dulles airport. Registration fee is \$435 before 5/15 and \$500 after (includes all meals, receptions and conference materials). For more information



and registration, contact the American College of Dentists at  
(301) 977-3223

or fax your request to  
(301) 977-3330



American College of Dentists  
839 Quince Orchard Blvd., Suite J  
Gaithersburg, MD 20878-1603

Return Postage Guaranteed

Second Class Postage  
PAID  
at Gaithersburg, MD  
and additional mailing office