



## Challenges to Pediatric Dentists

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**T**hank you, Dr. Ignelzi. It is an honor for me to be here among all of you. In front of you, you have a speaker who has been a little bit of everything. I have been a left-handed Puerto Rican medical school graduate; a winner of the Chamber Pot award at the University of Michigan Medical Center; a nephrologist at Georgetown with an I.Q. higher than my BUN; the first woman Surgeon General of the United States; a Doctor of Public Health graduate of Johns Hopkins University; and most recently the 13<sup>th</sup> Health Commissioner of the great State of New York. As you can see, I'm still trying to figure out what I'm going to be when I grow up.

It has been said that if you wish to take the measure of a nation, you need look no further than how it treats its children. In America today, of 281 million people, more than 70 million children are under the age of 18, and approximately 1 out of every 7 under the age of 19 are without any form of health insurance.

The reality is that in this U.S., 1 in 5 children are living in poverty - including more than 5 million children under the age of 6. We live in a time when many diseases have been conquered or a least prevented. We have an international space station. We have new surgical procedures, new prescription drugs and new cancer treatments that can greatly extend lives. Given that we have accomplished all this, I ask, how is it that this nation continues to tolerate the lack of health insurance, and even the lack of oral health among its children? I believe there is no more noble mission in life than protecting and improving children's health. So I want to congratulate all of you in the Academy, for the efforts you are making to improve the health of our children. After all, for 53 years you have been advocating for access to high-quality oral health care for all children; And you are making a huge commitment to reduce oral health disparities affecting our most vulnerable.

As a former Surgeon General and now as Commissioner of Health for the State of New York, like you, I have learned what it means to serve public health for the public good. But I also have come to realize that it was the pediatrician in me - behind those titles - that allowed me to speak for those who do not have a voice, who do not complain, who do not accuse, do not sue, do not go on strike, and most importantly, do not vote. I am speaking about the most vulnerable members of society - the children. During the years I was Surgeon General, I learned many things. I learned that the world may love you, but owes you nothing. To expect the world to treat you fairly because you're a dentist, or for that matter, a Surgeon General, is like expecting a bull not to charge at you because you are a vegetarian. I also learned that having a vision is tremendously important because, after all, if you don't know where you're going, you're already there. But more than anything, I

learned, as it has been said, that service is the rent we pay for living - and that service will set us apart - service to God, to country, and to our communities.

Colleagues, we are in this business because we cherish children. We protect and nurture them because they are our future leaders. But I must remind you that the United Nations' Declaration of the Rights of the Child begins with this simple statement: "Mankind owes to the child the best it has to give." In spite of this, however, too many children are being neglected, not because parents are neglecting them, but because society has so neglected them that even the constant, reliable and self-sacrificial care of parents has not counteracted the neglect of society. I am afraid that many catastrophes in the lives of children are tolerated because they are overwhelmingly the catastrophes of poor children, whose families and communities traditionally lack clout to make the world stand up and take notice. The aura of inevitability or even failure that has surrounded poverty for so many centuries is perpetuated today by indifference and loss of hope. But there is nothing inevitable or unavoidable about continuation of the worst aspects of poverty on the beginnings of the 21<sup>st</sup> Century.

There has been a lot of debate recently about how we are evolving into a country of haves and have nots. The debate hasn't been so much about what to do about it, as it has been about why this is so. Some blame trade policy. Some blame technology. Some say it's corporate greed. Some say it's too much big, intrusive government. Others say it's because it's an uncaring society.

The recent Surgeon General's report, "*Oral Health in America*," has put this in perspective and in turn has helped to focus the nation's attention on this most serious health problem among children. Colleagues, let's set the record straight: dental caries is the most common chronic disease affecting children and a common reason why children miss school; dental caries is 5 times more prevalent than asthma, and still some people refuse to understand that tooth decay is an infectious disease that greatly impacts our children's health. The reality is that 1 in 5 poor children have serious dental caries experience that can threaten their lives, and a disturbing 18 percent of those children between 2-4 have visible caries, as well.

The Surgeon General's report cited dental health care as the greatest unmet health care need for the nation's children.

In fact, according to the report, the need for dental care is:

- 3 times greater than for medical care
- 4 times greater than for prescription medicines
- 5 times greater than for vision care

Colleagues, we know that children who can't eat well, can't sleep and are constantly hurting will become "failures to thrive" - becoming underweight, undernourished, and as a consequence undereducated, underachievers. A 1997 study by the

World Health Organization of Navajo school children living in parts of Arizona and New Mexico found that 25 percent of children avoided laughing or smiling, and 20 percent avoided meeting other people because of the way their teeth looked. Other research has also shown that 80 percent of tooth decay is found in 25 percent of school-age children ages 5 to 17 years; many of them among minorities:

- African-American children having 1.4 times more decay
- Hispanic children 1.7 times more decay
- Asian and Native American children having 2.7 times more decay than white children.

I am also concerned that chronic pain might be affecting children's neurological development. After all, studies have found disturbances in pain perception pathways in young children with chronic pain. In effect, they may become hypersensitized to pain. As pediatric dentists, I am sure that you see these conditions every day, and I share your frustration.

Remember, children do not vote. But one day, they will win the elections. And when that day comes, we will be rewarded for our actions, or punished by our indifference. Allow me then to come before you today to pose some challenges. Challenges that we must all work together to address if we are going to deal with children's health in a comprehensive vision.

The first challenge is that of eliminating the disparities in oral health affecting this nation's minorities and poor. All of us must respond to the health care needs of an increasingly diverse society with rapidly changing demographics.

Consider that in this diverse nation of 281 million people:

- More than one-half of the population are women
- 12.3 percent of our population are African-American
- 13 percent are Hispanic
- Nearly 4 percent are Asian or Pacific Islander
- Nearly 1 percent Native American and Alaska Native
- Nearly 7 million people, or 2 percent, are multi-racial almost one-in-five being under the age of 12 and one-in-ten older than 65
- Households with children headed by single mothers, account for 7 percent.

All of these facts give us the first glimpse into the shifting and complicated make-up of American families, and carry wide-ranging implications that all healthcare providers like you and me need to address.

The reality is that, in America today, 38 percent of Hispanics, 24 percent of African Americans, and 24 percent of Asian/Pacific Islanders lack medical health insurance compared to 14 percent of whites.

If the lack of health care insurance as a whole is great; far greater is the lack of dental insurance. In fact, 45 percent of all Americans lack any dental insurance. The reality is that for every child with no medical coverage in the United States, there are 2.6 children with no dental coverage.

Tragically, in poor children with tooth decay, as much as 80 percent remains untreated. In New York, the Medicaid program - which serves over 2.5 million residents, including more than 1.3 million children - provides a large package of dental health services. Less than 30 percent of children through age 17, however, have some form of dental insurance and worse, less than 18 percent of those eligible for Medicaid receive any dental services at all.

In New York - there are 17,231 registered dentists and currently only 1,771 participate in the Medicaid program. Over

600 orthodontists are enrolled to participate in the state's Physically Handicapped Children's program, but only about 250 are providing treatment on a continuous basis.

The issue of access to dentists in Medicaid, is most critical in upstate counties, particularly in the Adirondack region, the Southern Tier, and rural central New York regions. And in some specific counties like Hamilton, there is no dentist at all.

Currently there are 105 federally designated primary care shortage areas in New York State; with more than 3.8 million people residing in those areas. One reason for this is the lack of dentists who participate in the Medicaid program and even those who do participate accept only a few Medicaid patients. A study by the Department of Health and Human Services found that nationwide less than 1 child in every 5 Medicaid eligible children received any preventive dental services. The study found that 18 percent of children nationwide covered by Medicaid had had at least one dental visit during the previous year, compared to 80 percent of them having at least one medical visit. A major reason given by dentists of why more of them did not participate in the Medicaid program is the low Medicaid reimbursement rates for dental services provided to Medicaid recipients.

Currently, because dental coverage for adults is optional under Medicaid, some 18 states have opted not to provide coverage above and beyond basic emergency services. Still, about two-thirds of the states provide some form of dental coverage for adults. In some states, and to the credit of some dentists, they have undertaken their own initiatives to increase dentist participation in the Medicaid program. In the recent past, the New York State Dental Association sued the State of New York for increased Medicaid funding and reimbursement for dentists. There are at least similar active lawsuits in at least seven other states. New York State settled the lawsuit and agreed to provide an additional \$576 million dollars in funding over four years to support increases in Medicaid fees paid to dentists. As part of the agreement, the New York State Dental Association agreed to work with the State to increase the number of dentists who participate in Medicaid and to accept more Medicaid patients.

Monthly enrollment in Medicaid by private dental practitioners has increased markedly since the June 2000 fee increase. Since August 2000, an average of 30 dental practitioners have enrolled each month in Medicaid. I believe the recent April 2001 fee increase will lead to further increases in dentist participation.

Currently, I am watching the experiments of other States to increase access to dental care for the poor. In Michigan, for example, over an 8-month period, the State's Medicaid program increased the number of Medicaid children accessing dental care from 18 percent to 34 percent by enrolling beneficiaries in a large private dental commercial network. Most recently in New York, the Governor created a Medicaid Dental Advisory Committee - with the hope of improving access for Medicaid clients into the offices of private dental practitioners.

Colleagues, I understand the necessity of earning a living. But I also understand the necessity of charity and service to others. Remember - the dentist's primary professional obligation shall be service to the public. According to your code of ethics - "A dentist should strive to make her/his services accessible to all who are in need."

Colleagues, we must recognize that advocating for the needs of dentists may not be the same as advocating for the needs of

the patients. The terrible instability in health care financing and delivery has placed enormous pressure on different professional groups, including your own. But it is important that we not fool ourselves that what is best for dentists is always what's best for the patient. This is an important distinction; one that must inform our deliberations as we shape and press our vision of a just and healthy future for our people. We health care professionals have the opportunity and the privilege to make a difference for someone in how they will have a better life. To have the opportunity is a privilege, but one that does not come without a price. And that price is not only doing all we can to improve the health of American citizens, but to do so in a manner that is deserving of their trust and respect. To approach our work with a professionalism that keeps the health care profession a sacred institution not only for those of us who work in it, but more importantly for all those who depend on it. Remember, the test of making a living may be how much you get. But the test of making a life is how much you give.

The second challenge is to help recruit, train and retain oral health professionals that will help us meet the need for oral health services across the nation. The reality is that we are facing an acute shortage of dentists particularly in our rural and inner city areas. A survey of the American Dental Association found that dental practices tend to be disproportionately concentrated in suburban areas of high income and education, and dentists are less available in inner cities or rural areas. According to the American Dental Association, there are about 156,000 total dentists practicing nationwide, and over 90 percent of them are in private practice. In 1996, the federal government reported that in the U.S. there were an estimated 58.4 dentists in private practice per 100,000 population; a decline from 59.5 dentists per 100,000 population in 1990. By the year 2020, the dentist-to-population ratio is expected to drop even further to around 52.7 per 100,000 population.

Not only the number of dentists is growing smaller, but the availability of dentists per State is changing as well. In Mississippi, there are only about 37.7 dentists per 100,000 population compared to 82.7 dentists per 100,000 population in New York State.

Similarly, while dental schools continue to receive high numbers of applications for admissions, fewer students are being accepted today than in the past. There is also a shortage of dental school faculty. Today, dental schools are graduating only two-thirds the number of dentists they graduated 20 years ago. The reality is that for every 3 dentists who will be retiring from practice, there are only 2 available to replace them.

Similarly, the number of under-represented minority dentists in the United States is sorely inadequate to meet the needs of rapidly growing ethnic and minority groups. There is a tremendous need for greater numbers of dentists who are minorities. As shown in a recent national study, minority dentists, and minority physicians are the chief source of health care delivery in minority communities. African Americans account for 12.3 percent of the nation's population, represent 2.2 percent of active dentists, and take care of 62 percent of African American clients. Hispanics comprise 13 percent of the population, represent 2.8 percent of dentists, and take care of 45 percent of Hispanic clients as well.

Colleagues, in the presence of these numbers, we will need to work together to promote the profession of dentistry among all groups and increase this nation's capacity to provide dental services to all in need. And in doing so, we will need to form strong partnerships with academic centers to increase the ca-

capacity of dental schools for dental training, so that they can provide us with more oral health professionals.

A third challenge is the challenge of achieving a greater focus on the prevention of oral health problems, and the availability of such prevention earlier in the lives of our children. I believe that, in order to succeed, we must achieve consensus among the medical and dental community on the age at which children should begin seeing a dentist.

The American Academy of Pediatric Dentistry, the American Dental Association, and the Oral Health Section of the American Public Health Association all recommend that a child's first visit to the dentist occur at age 1. Yet, most pediatricians are still advising parents to schedule their child's first dental visit at age 3. According to one national study, 18 percent of U.S. children have already experienced tooth decay by ages 2 to 4. By ages 6 to 8, 52 percent of U.S. children have experienced tooth decay. By age 17, more than 80 percent of the adolescent population is affected by dental caries.

So what are we going to do? First, we must get the word out that not only can dental caries be prevented; but the use of fluorides, dental sealants, accompanied by daily brushing, flossing, and eating a diet low in refined sugars will help prevent tooth decay. Today, the Centers for Disease Control (CDC) and Prevention has determined that fluoridation of community water supplies is safe, effective, and cost-saving. Yet the CDC reports that community water fluoridation is available to only 62 percent of the U.S. population on public water supplies. A recent study in Louisiana found that Medicaid-eligible pre-school children living in communities where the water was not fluoridated were three times more likely than those with fluoridated water to require dental treatment in a hospital operating room.

The CDC has determined that the cost of preventing one cavity through water fluoridation is about \$4 dollars versus \$64 dollars for the cost of a simple dental restoration. Therefore, let's educate the public regarding oral health. Let's not leave, however, all the responsibility for community education about oral health to public health agencies and schools. We must be much more effective, and that comes from working together.

We, the health care professionals, are the experts on health care, we know what is best for the people we care for, and we must be involved in shaping the policies and practices governing their care.

In practical terms it means we must extend our reach and influence as health care professionals to positively impact not only those we see in our offices, clinics, and hospitals, but those who live in our neighborhoods and communities as well. Because even though the practice of dentistry has changed - the perceptions of the communities we practice, and live in, have not.

A fourth challenge is the challenge of integrating dental care into the mainstream of health care. After all, oral health is an essential and integral component of health throughout life. I ask you - if oral health is so integral to our overall health, why is it that dental care is still viewed as an extra or peripheral health service on the outside of mainstream health care? We must change this perception.

If we are to be successful in our efforts to convince policymakers and the public that oral health is important to the overall health and well-being of children, we must continue to integrate oral health into the mainstream health care system. Colleagues, I don't need to tell you that the future of health care is paved with complex issues ... but I can certainly tell you

that the future is already here, and much remains to be done to integrate dental care into our health care system. I am reminded of a very simple yet profound observation of Mark Twain ... who said: "Good judgment comes from experience. And where does experience come from? Experience comes from bad judgment."

I can tell you that if we are going to meet the nation's complex and difficult public health challenges, we're going to need healthy doses of both experience and judgment. Today we have an image of a fast-paced, high-tech, dollar-conscious health care system that sometimes seems to leave little room for the needs of the human equation. Where patients change health care providers, often quite literally as often as they change jobs. Where a trip to the emergency room even for a real emergency can mean calling the health plan first – to make sure that charges are approved. And where hospitals and clinics are all seeking the best return on their health care dollar in an increasingly competitive marketplace.

Today, as it has been said, the business of health care has grown leaner. Sometimes meaner. The marketplace is looking for value — which should translate into high quality, cost-effective care, but from the patient's perspective does not appear to be good old time health care. Ultimately, however, the degree to which health care succeeds or fails for patients and caregivers alike depends on the answer to one very important question. And that is: Can we, the health care providers, maintain the traditional humanistic qualities of health care delivery within an increasingly corporate structure? I say we can!

To start, we must become a voice for the disenfranchised — the young, the poor, the disabled, and the elderly — those who might be shut out of the health care system through no fault of their own. We must use our voice in Washington, our State Houses, and local communities as well. The likes of what Dr. Burt Edelstein and Dr. Jim Crall are doing in Washington and with Congress to advocate for improved oral health for children. They are helping to get oral health on our nation's radar screen. But it is up to us to respond to the challenge. After all, it has been said that, whether administrator or surgeon, internist, or pediatric dentist — you will not lead our country into the 21<sup>st</sup> Century regarding health care if you operate with tunnel vision, if your administrative ability is bounded by red ink, if your surgery reveals simply a superb artist, or if your eyes cannot see beyond the immediate cause of a toothache. I submit that your God-given vocation goes beyond your ability to cure!

May I suggest then, that irrespective of what the future of health care might bring, that you, this nation's pediatric dentists, be concerned with discovering where your patients come from, and where they've been.

Not only their dental history on a reception-room questionnaire: but their broader experience of human and inhuman living — in reality, their total persona, their integral humanity. Remember, your patients will not care how much you know, until they know how much you care.

Colleagues, my final challenge to you is that we must continue to base our approaches to dental health on sound science and research. We must press forward with biomedical, behavioral, and health services research that can identify preventive interventions and new therapies to reduce the burden of dental disease. After all, it is known that: dental x-rays are now available digitally instead of on film; intra-oral cameras can magnify teeth 400 times, allowing better visibility of any decay; high-powered air abrasion is replacing some drills; and laser technology is changing the industry.

If we have all this knowledge, why can't we increase research into the complex factors associated with higher risk for dental caries and oral disease among clients, especially minorities, and determine the preventive interventions that will work best with emerging population groups. More importantly, let's continue to work on techniques that help teeth heal the damage caused by dental caries, such as remineralizing approaches that will not require drilling out a cavity and placing a filling.

Colleagues, a word of caution — remember, that the therapeutic effects of machines and gadgets are only enhanced by the touch of a healing hand or a caring word. And while we have an obligation to advance the technology and science of dentistry — and advocate for needed research — we must always maintain the human element of the work we do. Because as much as our health care system has changed — the vulnerability and the needs of the sick patient has not.

So there you have it, some challenges from your Health Commissioner. A "hit list" if you will, but of the healthiest variety. The going will be tough, but as I look out at you I am encouraged. I believe that the Surgeon General's Report on oral health has helped focus the attention of the public and policy makers on the importance of oral health and the lack of access to dental services by many Americans. But that is as far as the Surgeon General can go. I know. I was one. The reality is that you and people like me back in our states and communities must take the real action to address the problems, and challenges, presented to you this morning. As I am fond of saying, Washington talks, but States act. If I may leave you with something I heard, that we all must remember—Please:

- Take care of people, not just patients. And certainly not consumers or covered lives. People.
- Find ways to work together. Not just side by side, but hand in hand. Mind cooperating with mind — a powerful synergy.
- Uphold the high ethical standards on which the dental profession was founded. Live the standards, and encourage, even demand it, from others.

Finally, light a path so that others can follow. That means protecting autonomy, speaking of the joy, and embracing the intensity of the profession. The great Holocaust historian, Yehuda Bauer, said it best: "Thou shall not be a victim. Thou shall not be a perpetrator. But above all, thou shall not be a bystander." As protectors of the public's health, let us not be bystanders.

Thank you, and God bless.