The Reaction of the Dental Profession to Changes in the 1970s

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Abstract: This paper explores the changing realities of dentistry in the 1970s: the development of denturism; the maldistribution of dental practitioners; the growth and activities of expanded function auxiliaries; the intrusion of the Federal Trade Commission into professional issues resulting in advertising, supermarket and franchise dentistry; and the effect of prepayment plans. These realities are considered in terms of their impact on the profession and the efforts by the individual practitioner and his representative organizations to come to terms with them. (*Am J Public Health* 70:619–624, 1980.)

In a previous paper,[1] this writer attempted to describe the dental profession's reluctant willingness to modify many of its traditional orientations and attitudes to health service delivery during the great social legislative upheavals of the mid-1960s. The present paper will provide an update for the profession's reactions during the 1970s. By understanding these responses, we may be able to more appropriately plan for dental services in the 1980s and thereafter.

Setting the Stage

Denturism

In November 1978, the citizens of Oregon voted to make their state the first in the nation to permit dental technicians to deal directly with the public in the fitting and dispensing of complete dentures. The denturism law was approved by 78 per cent of the voters regardless of age, level of income, or occupation.[2] The American Dental Association's (ADA) analysis of the election results succinctly presented the different perceptions of the profession and the general public:

> Oregon's dentists singlemindedly defined denturism as a health issue. . . . The public, on the other hand, overwhelmingly defined the issue as a non-medical one. Dentures were viewed as "appliances," and their availability at low cost was generally perceived as an economic convenience . . . [for] the elderly.[3]

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Probably no event in the modern era of dental services has had such a profound impact upon the profession. Denturism already had been legalized in the states of Maine and Arizona, but in both instances the denturist is required to work *under the supervision* of a licensed dental practitioner. (Similar supervisory-type legislation for denturists has been approved in the state of Colorado since the Oregon vote.) At the present time the ADA is advocating the development of inexpensive techniques to reduce the costs of prosthetic services as a method to reduce the impact of the denturists' claim to provide services at much lower costs.

It is ironic that the dilemma which now faces the profession may have been, to some degree, as a result of its own policies. In the mid-1960s, during the Congressional review of the then pending Medicare and Medicaid legislation, the ADA opposed dental care for the aged under the Medicare bill, while lobbying for the inclusion of dentistry as a benefit under the proposed extension to the Kerr-Mills legislation for services to the poor (Medicaid). At a time of major federal legislative expansion in health and social welfare programs, which potentially would offer mandated financial relief to the aged for general health services, the ADA preferred to follow the path of optional individual state initiated programs under the Medicaid umbrella. It is possible that denturism would never have taken hold in the public's mind as an economic solution to the dental needs of the elderly had dentists joined their medical colleagues in their reluctant involvement with the Medicare program.[4]

Attitudes

However, given the individual practitioner's and the general profession's long-standing resistance to involvement

with government agencies and programs, both then and now, it was to be expected that the ADA would prefer a variety of voluntary state initiated programs to a single mandatory federal operation.

This feeling that government programs are affecting the future of the profession sometimes expresses itself as resentment toward the dental educator and public health dentists employed in local, state, and federal government programs. For example, the editor of the Journal of the American Dental Association commented, in 1975, that there are " 'progressive' dental educators who appear to regard clinical dentistry as more craftmanship than scholarship."[5] He continued with the thought that ". . . 'creeping socialism' in the dental profession . . . has resulted in a drastic swing away from emphasis on clinical training." Another dentist, upon assuming the presidency of the New York Academy of Dentistry, commented on this supposed change in emphasis and asked, "Do we feel that clinical exposure should be sacrificed for didactic courses such as community dentistry and nutrition?"[6] The concern has been that schools were emphasizing courses in the behavioral sciences, community dentistry, and extramural service experiences for underserved populations. This attitude regarding the variety of forces internvening in the curricula of dental schools was voiced by the Indiana Dental Association delegation to the 1974 American Dental Association annual meeting. The delegation called for a thorough evaluation of dental school curricula throughout the country to ensure adequate attention to "total patient care" in the clinical area.[7] ADA responded to this call with a two-year study which included a thorough appraisal of student instruction and clinical experience.

The Traditional Practice Setting

Throughout the 1970s, the Association repeatedly presented its case for the continued private practice of dentistry with the need for strict limits on third party and government intervention in the doctor-patient relationship, the economics of practice, and the maintenance of the standard auxiliary-provider configuration. Often reports that could be used to buttress the arguments for a private practice fee for service system would be used in editorials, leadership bulletin messages, and proposed material for presentations by profession spokesmen or individual practitioners. For example, the ADA used *medical* visit cost data for neighborhood health centers to prove that private *dental* practice services were less expensive and more efficient.[8]

Size and Variety of the Dental Work Force

Number of Practitioners

Responding to the accepted view in the 1960s of a decline in the dentist-to-population ratio, the federal government passed legislation which provided construction funds for building new dental schools and expanding established schools. The number of dental schools increased from 47 in 1962 to 60 as we enter the 1980s. Because health professionals tend to establish practices in the same area in which they attend school,[9] the majority of new schools were located in the southern states, where the shortage of dentists was most pronounced. In addition, health manpower legislation enacted during the 1970s mandated dental class size increases as a condition for receiving capitation payments. The results of these efforts are manifested by a rise in dental school graduates from 3,290 in 1961 to 5,177 in 1977, a 57 per cent increase.[9]

By 1973, the Bureau of Economic Research and Statistics of the American Dental Association reported that the trend noted in the early 1960s had been reversed and that the number of professionally active dentists was growing proportionately faster than the United States' population.[10] This reversal was attributed not only to the substantial increase in the number of dental school graduates, but also to the unforeseen decline in population growth resulting from the decreasing fertility rates.

Major increases in practitioner productivity also were achieved by the increase in the number of dental auxiliaries and the number of dentists employing them. Through the development of the Dental Auxiliary Utilization (DAU) Programs in the 1960s, which were designed to train dental students to use the traditional services of an assistant, and the Training in Expanded Auxiliary Management (TEAM) Programs in the 1970s, which were developed for the student to deal with auxiliaries with expanded function skills, the United States Public Health Service provided the impetus for dramatic changes in the dental practice setting. Individuals, who traditionally had been attracted to the profession to "be their own boss" and do "their own work" or at most perform their services in small group settings, suddenly were confronted with approaches to practice which required that they also function in the role of office manager.

Expanded Duty Auxiliaries

The idea of allowing a non-dentist to perform designated dental procedures arose from the New Zealand dental nurse program. That program began in 1921 in response to a high incidence of dental disease and the inability of existing dental manpower to provide the needed services.[11]

In 1960, the American Dental Association advocated careful examination of the values of delegating to expanded functioning personnel those duties which were reversible (i.e., did not include the cutting of soft and hard tissues) or that would require the knowledge and skills of a dentist. Coupled with the then perceived dental manpower shortage, this statement led to a long series of studies from the mid-1960s through the mid-1970s which reviewed the educational requirements, productivity, and quality of services by expanded duty personnel.[12–15]

The results of all studies demonstrated that expanded function auxiliaries increased productivity substantially without a diminution in the level of quality of services and that the personnel could be trained to perform the desired services within considerably shorter periods of training than required for dental practitioners. However, by the early 1970s, the increased delegation of duties to ancillary personnel had become a controversial issue within the dental profession. The American Dental Association issued a call for a

moratorium on the licensure, registration, and certification of additional variety of auxiliaries until further information was available regarding the relationship between practitioners and auxiliaries.[16] In 1976, the American Dental Association House of Delegates issued a statement on expanded function auxiliaries which listed a long series of irreversible and reversible procedures which should not be delegated to dental auxiliaries.[17]

While the American Dental Association's surveys of dentists' opinions on the delegation of duties to auxiliaries have demonstrated increasing interest in this approach among younger practitioners, the majority of all practitioners would still retain significant numbers of procedurers within the sole province of the licensed dentist.[18] Nevertheless, at least 39 states have modified dental practice acts to permit the performance of particular functions by expanded function ancillary personnel, which traditionally had been reserved for the dental practitioner.[19]

In addition, recent reports have appeared documenting the delegation of duties to auxiliaries which would appear to run counter to dental practice act requirements.[20] In one study, 97 per cent of the dental assistants and 78 per cent of the dental hygienists reported performing duties in private dental practices which were not permitted under the existing state legislation.[21]

The Federal Trade Commission

Complicating the picture even further has been the intervention of the Federal Trade Commission (FTC) into the functioning of dental auxiliaries. In January 1979, the American Dental Association was notified by the FTC of its intent to make recommendations which would eliminate current laws restricting "the delegation of any and all dental functions to auxiliaries with the exception of diagnosis, treatment planning, drug prescription, and the overall responsibility for patient care."[22]

The notice of intent cited the numerous studies which have shown that the great majority of restrictions on the functions which may be delegated to a dental auxiliary are not justifiable as measures designed to ensure competence of care. In addition, the Commission sought to:

> eliminate current dental laws restricting: (1) a non-dentist having an ownership interest in a dental practice; (2) a person having an ownership interest in more than one dental practice . . . [and ensure that] any recommendation concerning pre-paid dental plans should be one best able to eliminate current laws more restrictive than necessary to protect the consumer.[22]

Finally, in September 1979, the Federal Trade Commission announced that it would seek nullification of state restrictions that require dental hygienists to work under the supervision of a licensed dentist.[23] The FTC staff maintained that the restrictions on independent practice by dental hygienists is a constraint that "unnecessarily limits the public's access to preventive care and may retard competition in the provision of preventive services."[23]

Supporting the change in relation between auxiliaries and the dentist has been the series of statements and recommendations by the 1979 report of the Council on State Governments on Dentistry and the Health Professions.[24] The recommendation by the Council was to establish "prosthetic auxiliaries" to provide service directly to the public under the direct, indirect, or general supervision of a dentist.

In response to these incursions in dental practice, among other actions, the American Dental Association joined several lobbying groups in late 1979 calling upon Congress to support legislation curbing the Federal Trade Commission's regulatory authority.[25] The American Dental Association argued that, ". . . There is a clear danger that unelected officials in Washington who are unfamiliar with state and local problems will seek to act as a national 'super-legislature'." As of this writing in early 1980, no final Congressional action has been taken, but extensive lobbying by the various industries affected by the Federal Trade Commission investigations may be having some impact upon Congressional actions.

Maldistribution

While most of the profession's attention to dental manpower issues has been related to the issues of denturism and delegation of responsibilities to expanded duty personnel, the continuing underlying problem of dental practitioner maldistribution has attracted the growing concern of health planners.[26] Dental schools may need to consider preferential acceptance of applicants who may be required to practice in underserved areas.[27]

In 1976, the average number of persons per dentist in the nation was 2,194. For metropolitan areas, the average number was 1,981, although ratios in inner city portions of many metropolitan areas were much higher. For non-metropolitan counties, the average was 3,137 persons per dentist. Out of the 3,114 counties in the United States, 710 have an unfavorable ratio of 5,000 or more inhabitants per dentist and an additional 267 counties have no dentist at all. At the other extreme, there are 373 counties with population-to-dentist ratios of less than 2,000 persons per dentist.[9]

In an effort to improve the distribution of dental (and other health) practitioners, various federal and state sponsored programs have been developed to encourage practitioners to establish offices in designated areas of shortage. The two most frequently cited examples of these programs are loan forgiveness (e.g., National Health Service Corps) and tuition remission.*

In general, it had been hoped that, through these various efforts, health services would be provided to communities in need, and young practitioners stimulated to continue practice in designated areas. Under the National Health Service Corps program in March 1979, 1,504 health professionals (including 242 dentists) were assigned to various designated areas.[29] By November 1979, 290 dentists and 15 dental hygienists had been positioned in many of the 773 designated dental shortage areas.[30]

*As an example, the annual tuition rate of $13,875 at the University of Colorado School of Dentistry in the mid-1970s was reduced to less than $2,000 for each year that a student contracted to practice in designated areas of shortage in Colorado.[28]

However, all too often, when these periods of service are completed, the practitioners tend to gravitate to the more over-doctored areas in the country, leaving their places to be taken by the new group of young practitioners. A survey of 11 long-established loan forgiveness programs noted that almost one-half of the physicians who, as students, made loans with an agreement to practice in designated areas, failed to follow through on these commitments, preferring to repay the money at substantial rates of interest.[31] The situation became so serious that under the 1976 Health Professions Educational Assistance Act, the penalty for failure to perform obligated services is increased to three times the amount of the scholarship assistance, plus interest at the maximum prevailing rate, and it is payable in one year. In addition, no relief from school loans is available for a borrower under the bankruptcy laws until five years after payment becomes due.[26] By 1979, there was some limited encouragement that the Health Service Corps was having some impact. About 15 per cent of the dental practitioners were remaining in their area of assignment to set up private practices.

An added dimension of the maldistribution practitioner problem has been the relatively limited mobility of dentists resulting from restrictive state licensing policies. This issue reached a highly visible point during the mid-1970s when an ADA nationwide membership survey reported that 69.5 per cent responded in favor of national licensing reciprocity.[32] Yet, the ADA House of Delegates subsequently defeated a resolution endorsing this principle.[33] To some degree, the increase in regional board examinations has assuaged the anger of many of the more vocal advocates of national licensure. Thirty-two states and the District of Columbia are members of four regional arrangements, ranging in size from the Northeast Regional Board with 14 states and the District of Columbia, to the Western Regional Board with three states. However, continued difficulties for older practitioners and individuals who have limited their practices to particular specialties have remained because of the particular clinical and written examination requirements.

Advertising and Supermarket Dentistry

"Shopping Center Shingles: Department Store Dentists, Lawyers Win Acceptance Despite Criticism from Peers," read the headline of a recent *Wall Street Journal* article.[34] And the lead story of a 1979 dental publication began with "Good Care Dental Center, the first franchised dental program in this country, is scheduled to become operational this month . . ."[35]

In response to the U.S. Supreme Court decision which upheld the right of lawyers to advertise their routine services, and in response to a complaint by the Federal Trade Commission that the American Dental Association, as well as two state and two local dental societies, were improperly involved in the prohibition of dentists from advertising, the ADA adopted an interim policy on advertising for its Principles of Ethics. The Association agreed "not to restrict or declare unethical truthful advertising by dentists, pending the final outcome of the Federal Trade Commission's case against the American Medical Association involving the same issue."[36, 37] (As of December 1979, the American Medical Association had filed an appeal in a Federal Court of Appeals in New York to the Federal Trade Commission ruling that it illegally restrained competition by restricting advertising.)[38]

The resultant avalanche of television, radio, newspaper, and telephone directory yellow page advertisements hawking dental wares, and the opening of dental offices in Sears Roebuck, Montgomery Ward, Times Square Stores, and other department stores,[39] with dentists on call seven days a week, at seemingly all hours at supposed reduced rates, seems to many practitioners to herald the return to the tooth drawers and itinerant hustlers of a bygone era.

For some, the potential for economies of scale, the employment of neophyte practitioners willing to work at reduced salaries, the full-time on-location employment of dental technicians and other auxiliaries, the flow of available "window shoppers" in suburban department stores and malls, the establishment of a closed panel relationship with a third party program, and seemingly endless variations for streamlining dental services offer improvements which could lead to highly effective designs for prepaid insurance plans and eventually national health insurance schemes. To others, these same arrangements spell the mediocrity of the sensationalized Medicaid mills of the 1960s.

Most dental practitioners view with alarm the uncontrolled publicizing of general information about the supposed expertise of individual dentists, the types of services provided, and fee schedules. They fear the adverse effect on the public image of the profession, unrealistic public expectations, more law suits, and eventually increased government intervention. Other practitioners are more concerned about the oversupply of dentists, health maintenance organizations, third party payment programs, and denturism. However, some investigators suggest that surveys conducted in the future may demonstrate significant shifts in opinion as practitioners experience the direct effects of free market advertising.[41]

Because the era of advertising and supermarket dentistry is so new, it is difficult to predict the full impact or long-term outcome. Many suggest that segments of the population formerly unable to secure dental care because of cost and/or inconvenience will now be served. Others contend that these changes in the delivery will provide care primarily to those who formerly received care from traditional practitioners. Furthermore, they maintain that when enough time has elapsed for the "cut-rate" dental services to deteriorate, the fad will pass. If the experience in the state of California is taken into account, where advertised cut-rate services have long been a part of the dental scene, the outcome of the present events may lie between the two extremes—i.e., the development of two approaches to dental care, the continuation of individualized private practice for those able to afford it and interested in the service, and a second option for other groups in the population. However, depending on developments in national health insurance or other third party programs, there could be significant emphasis on supermarket forms of practice.

Paying for Dental Care

In June 1979, the dental profession and labor unions marked the 25th anniversary of modern day prepaid dental plans.[42] While a dental prepayment plan was started as a fringe benefit for employees of the Denver and Rio Grande Railway company at the turn of the century,[43] it was not until the mid-1960s that almost two million individuals were covered by a variety of dental prepayment plans. Between 1970 and 1978, the population covered for dental services increased at an annual rate of 2.5 per cent (somewhat analogous to the growth rate for major medical coverage during its period of accelerated growth from 1955 through 1965).[44] In 1980, it is estimated that 71 million individuals will be covered for dental services and that almost 100 million will have prepaid benefits by 1985.

The much delayed growth in dental prepayment programs awaited the "completion" of coverage under hospitalization and medical practitioner costs and the development of actuarial experience with what appeared to many to be too all-pervasive a disease for insurance purposes. In reality, the need for unions to demonstrate to their membership progressive developments in benefits under new contract negotiations during the 1960s and 1970s, when most major industries had developed reasonable medical coverage, fortuitously coincided with the gradual development and experience with third party programs under the Medicaid legislation.

Despite the increasing growth of prepaid dental services during the past decade, a relatively high percentage of dental care expenses are paid directly by the consumer. Expenditures for dental care amounted to $45.41 per capita in 1977, about 7 per cent of the total per capita health care expenditure of $646.11. However, of the $196.09 out-of-pocket expenditures for health services, $36.10 (18 per cent) was for dental care. Private health insurance covered only 15.5 per cent of the total cost for dental care; public funding accounted for 5.0 per cent of expenditures, while direct payments for services accounted for 79.5 per cent.[45]

Thus the costs of dental care are "felt" more by the consumer than its price would indicate relative to other health services.[46] It is ironic that dentistry, which has been one of the least inflationary sectors of the health service industry (compared to hospital and general medical services), is considered as one of the more expensive commodities and out of proportion to its benefits.[43, 47]

However, because of the limited third party involvement in dental care services, most practitioners, until very recently, have experienced few of the restrictive rules and regulations with which medical practitioners have had to contend. Dental practitioners could refuse to provide services under state Medicaid programs, citing limited fee allowances under a system which requires "participation" with no supplemental consumer contribution. However, private third party insurance programs, offering the middle class consumer an opportunity for reduced costs, cannot easily be ignored by dentists. Suddenly the whole world of preauthorizations, audits, reviews, schedules of allowances, closed panels, usual, customary, and reasonable fees, HMOs, PSROs, and the rest of the "alphabet soup," and the "nightmare of regulations," became a part of the everyday practice of dentistry. The practitioner who entered the profession many years ago to be his/her own boss has, in short order, become a part of the "system" of prepaid health care.

As the burden for payment shifts to a prepaid system and is "felt" less by the consumer, it is possible to postulate that, as with medical services and hospitalization under prepaid insurance schemes, there will be increasing demands for sophisticated and expensive dental treatment. While past experience has shown that increasing the coverage for dental care did not necessarily cause large increases in the general use of dental services,[46, 47] the ADA has also noted that dental prepayment plans have "increased demand for higher levels of dental treatment than was feasible when the full brunt of cost for care had to be absorbed by the patient."[48] Eventually, prepaid dental insurance schemes may even help the consumers overcome their long-satirized fear of dentists and dental treatment.

Conclusion

A review of the profession's reactions to change could include a consideration of many other issues. However, it is enough to say that the world of dentistry in the 1980s and thereafter will undergo rapid change that could not have been anticipated 25 years ago when I first entered training, or for that matter in the mid-1970s when today's graduates took those same first steps.

Given the general character of many practitioners who were attracted to the profession to provide a health service to the general public in a "secure" environment comparable to the one in which many of them had received treatment as they grew to adulthood, and given the magnitude of the challenges to the profession, their reactions should come as no surprise.

Yet the challenges in today's society come as quickly and as regularly as the evening news or the morning newspaper. Because dental services traditionally have been provided by individual practitioner-entrepreneurs on an out-of-pocket, fee-for-service basis, dentists have thus far been "spared" many of the developments which are already a component of the world of their medical colleagues. Indeed, it will be quite some time before the individual practitioner can catch up with events and come to terms with them. By understanding the profession's reactions, health planners may be able to plan more appropriately for dental services in the future.

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