

Improving Access to Dental Care for Vulnerable Elders

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Certain segments of the senior population of the United States have difficulty in gaining access to dental care.¹⁻⁶ In order to design and implement programs aimed at improving access to care for these groups, it is important to understand the nature of the groups and the specific problems associated with or responsible for the impaired access. It is also important to understand the critical basic factors that must be addressed in any effort to enhance access to care if there is to be a successful outcome. This article attempts to identify those groups of elders who have difficulties accessing care and to establish a contextual framework upon which programs aimed at improving access to dental care should be developed.

Senior citizens, or elders, have been defined in our population as those who are sixty-five years of age or older. This age-based definition is certainly arbitrary and is not reflective of the nature of the population so delineated. In fact, they are a significantly heterogeneous group,⁷ varying in self-sustainability from being completely independent to being totally dependent upon others. In addition, they are very different from the same age group a generation ago, generally being healthier and more active; they are "not your grandfather's seniors."

Because of the variation in the characteristics and the needs of individual seniors, any program designed to improve their access to dental care cannot embrace the "one size fits all" concept. This approach will likely miss the mark and will squander scarce resources.

The Access Triangle

Before considering the specifics of a program to enhance access to dental care for seniors, it is important to understand the three factors that are im-

portant to address in designing any such program.⁸ They make up the Access Triangle (Figure 1).

For any access program to be successful, there must be 1) an adequate dental workforce able and willing to provide dental care; 2) an adequate effective demand for dental care by the targeted population; and 3) an equitable economic environment for both providers and patients that allows them to participate in the program. In essence, this premise is an elaboration of the basic supply-demand relationship in classic economics.

The nature of the access program must provide a sufficient absolute number of dentists in an area so that an adequate workforce will be available to treat patients in the target group; a patient population that is interested in entering into a partnership with oral health providers; adequate reimbursement for providers; and an administrative system that is not burdensome. Patients must be aware of their dental needs, have an interest in having them attended to, and have the financial and physical means to do so in order to generate effective demand for dental care. The economic environment, beyond reimbursement and professional fees, must allow both dentists and patients to participate. Patients face costs beyond professional fees for dental care—for example, transportation, lost wages, childcare, etc. These acquisition or opportunity costs can be significant, and if patients are unable to meet them, then even "free care," i.e., no professional fee, is unaffordable.

Since no single access enhancement program can fulfill the needs of all seniors, the choice of which group's needs to address becomes a matter of priority setting and resource allocation. Logic would seem to dictate that those with the most severe difficulty in achieving access to care should be an important focus of activities to enhance access while access for all elders is being addressed.

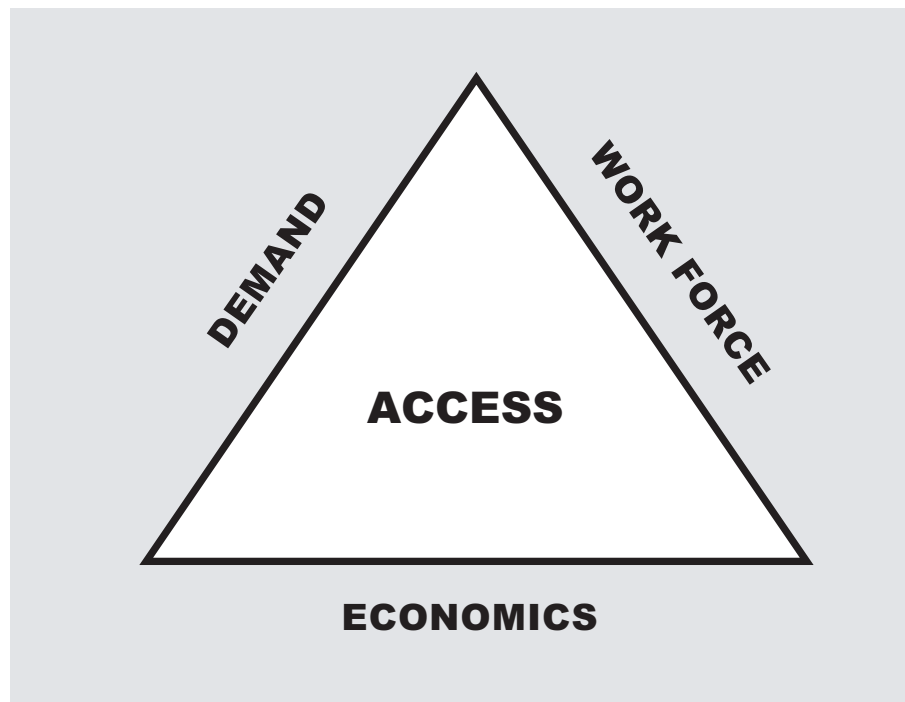


Figure 1. The access triangle

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Those elders who have the greatest need most often have the least resources and limited or no ability to travel to dental facilities for care.⁹ They are often partially or completely dependent upon others to care for their daily needs. They require providers with specialized skills and experience to treat them. Most often they have chronic diseases and conditions that make their care difficult and complex. Their medical problems complicate their dental care and, conversely, their dental problems frequently complicate their medical conditions. Interdisciplinary and coordinated professional care is essential for optimal outcomes.

These are the vulnerable elders—those with the most severe access to care problems. They should be the target group for focused efforts to enhance access to dental care and will require efforts that address a number of issues.

Vulnerable Elders

Solving the access to care problems for vulnerable elders will not be simple, for they present an assortment of distinctive characteristics that generally serve to inhibit access to dental care. In general, their daily support systems do not consider dental care to be a high priority in the scale of things. In fact, many elders themselves do not perceive a need for ongoing dental care.¹⁰ Governmental assistance is insufficient—or more likely, nonexistent—to meet their oral care needs. Residential facilities seldom have dental capability. This lack of facilities and/or financial support makes it impractical for the average dental provider to adequately serve the oral health needs of vulnerable elders.

The temptation to look to simplistic solutions should be resisted. “If you would only...” solutions

often have emotional appeal and seem like potential solutions. Some may be a component of a true solution, but none are solutions themselves. When suggested, solutions like “if only you would increase the number of dentists educated” or “if only you would expand the duties and relax the supervision requirements of dental auxiliaries” or “if only you would include dental benefits in Medicare,” etc., should be avoided.

In order to improve access to dental care for vulnerable elders, all health care providers who interact professionally with that population group, including dentists, must be educated about the population’s oral health needs. The special challenges that must be faced and the special skills that are needed in providing oral care to this population should be understood, due to the complexity of their general health status and the relationship between their oral health and general health. For those who are totally unable to leave their residential setting, the problems associated with severely diminished access to care and the difficulties dentists will face in delivering care under suboptimal conditions must be factored into any program to enhance access to oral care. Beyond understanding the oral health needs of vulnerable elders, dental health professionals must be mobilized to make elder care an integral part of their practices in an effort to address these needs.

Throughout most patients’ lives, they themselves bear the responsibility for their own oral health. Through good personal oral health practices and seeking regular dental care, they have a great deal of control over their oral health. When they become dependent upon others for their daily living needs, they often lose that control. Caregivers must fulfill that role. They must understand the importance of good oral health on the well-being of their charges and must know how to provide daily care to prevent disease and maintain patients’ well-being. They become the front line of defense against oral disease.

Because caregivers are so important in preventing oral disease in residential patients, they should receive appropriate training in good oral health practices for those under their care. Currently, many caregivers speak English as a second language. Their oral care instructions must be provided in a culturally sensitive manner in a language they can fully comprehend. They must have a level of understanding equivalent to that ordinarily expected of patients since they will be, in fact, doing the things patients would normally do themselves. It will be important

to recruit the assistance of caregivers, and it will also be critical to support their efforts.

We appreciate the fact that simply removing financial barriers to access to care will not solve diminished access problems. That may be an essential step, however. Should dental care be included in Medicare to remove financial barriers? For most, probably not. Because there is no means testing for Medicare eligibility and many individuals over age sixty-five have adequate resources to obtain appropriate dental care, blanket eligibility for federal assistance based on age will use scarce public resources inefficiently. It would be more effective to include dental care for all persons based upon having inadequate resources rather than by age. An assistance program based on need, like Medicaid or S-CHIP, should be considered as a vehicle for removing some of the financial barriers vulnerable elders face in gaining access to dental care.

Private dental prepayment plans should also be developed to help seniors manage the costs of regular dental care in their retirement years. Dental savings accounts, structured like medical savings accounts, could serve as a means for individuals to accumulate funds to pay for dental care, in a tax-advantaged manner for some.

The insurance industry has ignored a growing market and one that will continue to grow for many years: the individual dental plan market. Most insurers have avoided individual dental plans because of a fear of adverse selection; that is, only persons who expect significant dental expenses in the near future will purchase these plans and drop them when their immediate dental needs have been met. Each year there are many individuals who retire from work and lose the dental benefits they have enjoyed for years. Continuing a dental prepayment plan for those individuals, who are generally in good dental health, greatly minimizes the adverse selection risk. Although the administrative costs for individual plans are higher than for group plans, this should not serve as a strong disincentive.

The 2002 announcement of a pilot voluntary individual dental plan for American Association of Retired Persons (AARP) members over fifty years of age and their eligible dependents by AARP and selected Delta Dental plans represents the first serious attempt to serve that market, not including the Congress-mandated TRICARE Retiree Dental Program for retired members of the uniformed services and their dependents. (The TRICARE program be-

gan in 1998, is completely funded by those enrolled, and has continued to grow. It now covers 720,000, or 17 percent, of approximately 4.2 million eligible retirees.) The potential market for the AARP-Delta plan is 35 million AARP members (17 percent penetration would enroll almost 6 million members)! The pilot programs were extended to all Delta Dental plans in August 2004.

The AARP-Delta plan is completely funded by the enrollees. Potential adverse selection is controlled by deductibles, lowered annual maximum benefits, and waiting periods for other than basic services. No recognition is given for an individual's past dental plan participation. Care can be provided by any dentist, including non-Delta network dentists. If the AARP-Delta plan is successful, it can reasonably be expected that other insurance carriers will develop similar plans and enter that long neglected market.

In the current fiscal environment of the federal government and that of the states, it is unlikely that a governmentally financed dental benefits program for seniors will be enacted. Similarly, because of the tenuous nature of many American businesses' financial status, it is unlikely that there will be a federal mandate for employers to provide dental benefits for retirees. On the other hand, it is difficult to imagine that the growing numbers of retirees, many of whom have come to understand the value of good oral health and have had dental benefits through their employment, will not become restive when those benefits are not available to them.

Conclusions

Resolving this access to care problem for our vulnerable elders will involve many players:

- The health professions, which must understand the need and provide the treatment and disease prevention in a coordinated multidisciplinary effort. The current voluntary efforts of the profession are laudable, but charity is not a health care system. A sustainable system with broad professional participation must be developed.
- The health education system, which must increase education and training about this population group to expand the number of willing and competent providers.
- The nursing home and home health care industries, which must provide an environment in which the health professionals can function best, as well

as enlisting their caregivers as the front-line defense against oral disease.

- Government, which must provide assistance for those with inadequate resources and regulatory oversight.
- The insurance industry, which should provide vehicles whereby workers can accumulate funds during their working years to fund dental care after they retire and develop prepayment plans that offer assistance to retirees seeking dental care.
- Corporate America, which should play a role in helping retirees obtain the dental care they need, not abandoning them after completing their active employment lives.
- The public, which should be a positive influence on all the other players through effective advocacy to ensure that senior citizens have access to appropriate dental care.

There is a need for appropriate dental care throughout one's lifetime. A significant number of individuals beyond retirement age have difficulties in gaining access to the care they need. Many of them present oral health conditions that are complex and difficult to resolve, requiring a multidisciplinary effort. Lack of mobility and the incomplete ability to perform all of the tasks of daily living compound the problems related to providing good oral health care. Considerable effort on the part of all who play a role in the oral health of vulnerable elders will be required to improve their access to appropriate oral health care.

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