

Dental Public Health in California: A Mixed Picture

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ABSTRACT

Californians face significant dental public health problems. To address these problems, state government, professional organizations, and philanthropic entities in some areas have joined forces. Major issues such as fluoridation, access to care, and the role of the Dental Board of California are examined in terms of the varying roles these critical segments play in affecting the oral health of Californians.

This issue of the *Journal* is dedicated to an examination of public health dentistry in California. While often thought of as innovative and at the “cutting-edge,” the state presents a mixed picture of publicly funded oral health programs. Public health concerns sometimes take a lower priority or are overlooked by state government in an era of cutbacks. California lags behind other states in many public goods crucial to the overall quality of life of its residents. This dichotomy is evident in dental public health as it is in education, general health, and air quality. This paper assesses selected dental public health programs, identifying those where innovations have occurred and other program areas where the state has inadequately addressed the dental public health needs of its population.

The Association of State and Territorial Dental Directors and the Centers for Disease Control and Prevention report that more than two-thirds of the states employ full-time dental directors; however, California is not one of them. Usually state governments employ dental directors who use a public health approach to plan innovative oral health programs, implement them, and monitor outcomes. Instead, California has an Office of Oral Health whose chief and four employees oversee the state’s Children’s Dental Disease Prevention Program and Community Water Fluoridation Program. The children’s program serves about 300,000 preschool and elementary school-children annually through contracts with nonprofit organizations, local health departments, and school districts. The other program provides technical assistance to communities on fluoridating its water supplies. In 1995, California passed legislation that paved the way for communities to add fluoride to its water supplies. This legislation exemplifies how public oral health initiatives work in California, as the bill did not provide state money to implement fluoridation, stating rather that funding should come from federal grants or private sources. The California

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Endowment, a private, statewide health foundation, granted \$15 million to assist in implementing the measure through a public-private partnership with the California Department of Health Services, the California Dental Association, the Dental Health Foundation, and the Los Angeles County Department of Health Services. Oral Health America, a non-profit organization, awarded California an "A" for its fluoridation efforts in a 2005 report on eight states that advanced one or more of the action steps outlined in the U.S. surgeon general's National Call to Action to Promote Oral Health.¹⁻² Until recently, only 17 percent of the state's population accessed fluoridated water supplies, compared to the estimated 50 percent of Californians who currently have access. Although realizing a marked improvement in this preventive benefit by bringing fluoridated water to more than 18 million residents in six counties, California still ranks 40th in the nation in water supply fluoridation.

Foundation Partnerships

California also received an "A" in Oral Health America's 2005 report for its efforts to "increase oral health workforce diversity, capacity, and flexibility."¹ Here again, partnerships between foundations, professional organizations and dental schools have been chiefly responsible for addressing issues of diversity in the dental profession and in providing dental services to underserved populations. The Robert Wood Johnson Foundation and The California Endowment jointly funded all California dental schools in an effort called Pipeline, Profession and Practice: Community-Based Dental Education.³ The initiative seeks to establish community-based clinical education programs, integrate community-based practice experiences into educational programs, and also increase recruitment and reten-

tion of disadvantaged students. Through this joint funding effort, innovative postbaccalaureate programs have been created to assist disadvantaged students in preparing themselves for the competitive process of applying to dental school. The "Pipeline" initiative has generated two additional funding partnerships to date. The CDA Foundation has contributed funds to help the dental schools develop Northern and Southern California regional postbac-

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calaureate programs. The W.K. Kellogg Foundation has provided scholarships for disadvantaged students through a program administrated by the American Association of Dental Educators.

With waning public support, California has been fortunate that private funders have come forward to assist its dental schools in meeting the needs of the community. Nonprofit sector health philanthropies have also been instrumental in assisting the state in addressing dental public health issues in the face of declining public support. The California Endowment, the California Wellness Foundation, and the California HealthCare Foundation grew out of governmental requirements that such foundations be established when health care organizations converted from not-for-profit to for-profit entities.⁴ Other foundations have been established by individuals to support their philanthropic interests. Regardless of their genesis, dentistry is fortunate that these foundations have begun to take an interest in oral health issues. Although this paper focuses on statewide efforts, it should be noted there are many foundations working at the local level, such as the

UniHealth Foundation to fund programs addressing public oral health concerns.

The Impact of Voter Propositions

In 1988, the voters passed Proposition 99, the California Tobacco Tax and Health Promotion Act, with tax revenues earmarked for health research, preventive education, and health care for the medically indigent.⁵ Ten years later, Proposition 10, the California Children and Families First Act of 1998, was passed and is expected to generate \$700 million annually on behalf of community health care, smoking cessation for pregnant women and young parents, child care and early child development programs.⁶ The California

Children and Families Commission, or First 5 California, was established with Proposition 10 funds to support children's readiness for school and school's readiness for children, the latter promoting the success of young children as they move from early care settings to elementary school.

In 2004, First 5 California launched two major oral health programs.⁷ The first, the California Oral Health Initiative, is a \$7 million effort to prevent caries in very young children through an education and training program for dentists and primary care medical providers, and a consumer education program. The CDA Foundation and Dental Health Foundation have primary responsibility for this partnership of professional associations, dental schools, and other health and provider organizations. The second, the Insurance-Based Oral Health Demonstration Project, seeks innovative ways to provide preventive and restorative services to young children, including those with disabilities and special needs, and those living in rural, frontier, and underserved areas. This \$3 million, three-year effort currently funds 21 projects throughout the state administered by Delta Dental, Access Dental,



Health Plan of San Joaquin, and the Santa Barbara County Health Plan. These First 5 California efforts use public funds, namely tobacco tax revenues, which have been funneled through commissions to address educational and public health needs of children in the state. The mechanism for this approach was the statewide proposition, a legislative process that narrowed the funding gap in children's oral health care through bypassing competition in state budgets and governmental executive prerogatives.

A Changing Dental Board

A traditional state function is the regulation of dental practice through dental boards. In recent years, the Dental Board of California has undergone considerable pressure from the state's executive and legislative branches. In 2001, there were two senate bills that impacted the state Dental Board. Senate Bill 26 required that a monitor be appointed to evaluate the board's disciplinary system. The second, Senate Bill 134, signed into law by former Gov. Gray Davis, disbanded the Dental Board of California on July 1, 2002. This legislation resulted in appointment of a new board, one more sympathetic to the "mercury in amalgam" issue. Earlier this year, Gov. Arnold Schwarzenegger proposed to abolish all independent boards, including the Dental Board. This approach is consistent with the governor's political philosophy to reduce government regulation; however the proposal met with strong opposition and the governor backed down. Although the proposed 2005-2006 budget funds the Dental Board at approximately \$11.5 million, the board's role is clearly changing; the degree to which it will be involved in board examinations, in disciplinary actions, and in regulating dental practice will be closely watched.

Unmet Needs

The last major area involves the financing of needs-based dental services. In California, low-income individuals may access a number of existing pro-

grams based upon their level of poverty. These include Healthy Families, the Child Health and Disability Prevention Program, and Denti-Cal, for both adults and children. The latter program is by far the largest and is a part of the Medi-Cal program. The Medi-Cal program, administered by the California Department of Health Services, is a major source for health care in poor and underserved communities. The 2005-2006 California state budget request for this program is \$12.9 billion, an 8.2 percent increase over last year.⁸ Denti-Cal, the state's Medicaid dental program, serves about 4.75 million Medi-Cal beneficiaries. In most California counties, Denti-Cal is administered by Delta Dental through a competitive contract with the Department of Health Services, which has overall responsibility for the program. Serving as the fiscal intermediary, Delta Dental authorizes or denies treatment and processes claims; hence, it has a great deal of administrative responsibility. In Los Angeles, Riverside, and San Bernardino counties, many Medi-Cal beneficiaries receive dental services through a managed care dental plan. In Sacramento County, Medi-Cal beneficiaries can only receive Denti-Cal services through private dental HMOs through a program known as Geographic Managed Care.

In 2002, the Health Consumer Alliance produced a report based on an analysis of calls received by Medi-Cal consumers about problems accessing dental care. The report stated there were a number of barriers to access, specifically for children who were being denied access to medically necessary dental care guaranteed by federal law.⁹ One allegation for limited access was that the Department of Health Services apparently had not abided by its own written standards ensuring access to essential dental care. The other allegation was that providers were not fully informed about Denti-Cal services available to Medi-Cal beneficiaries. There also were burdensome authorization procedures, with requests not processed in a timely

manner, and often denied for unsound reasons. The barriers low-income younger consumers face in accessing Denti-Cal services are especially disconcerting in light of the surgeon general's findings in Oral Health in America that conditions of the mouth in children and youth, left untreated, can cause infection and signal more systemic health problems, which may result in lifelong personal, educational, and social consequences.¹⁰ Low-income adults may also face barriers in the form of limits on Denti-Cal benefits, as Gov. Schwarzenegger has proposed a \$1,000 cap on adult dental services per year as part of his Medi-Cal redesign proposal. With respect to this dental benefit limit for adults, the Legislative Analyst's Office has withheld "recommendation at this time, pending additional information from the administration."¹¹ CDA has also expressed concern over the proposed \$1,000 cap.¹²

A Mixed Picture

To address its residents' dental public health needs, the state will be required to embrace many types of programs that involve partnerships among government agencies, professionals, and nonprofit organizations. Because of the scale of public oral health challenges in California, especially access and prevention, the three sectors will need to work collaboratively to resolve them, even though interests may not always be compatible. As members of the professional sector, together with their colleagues in dental education programs, practicing dentists will need to understand the issues, and become involved at a number of levels. This may involve individual voluntary efforts on behalf of free clinics, dental school-operated clinics and other community dental sites. Individuals may also take a leadership role in local professional, nonprofit and community organizations as board members and advisers. With the increased focus on oral health issues at the state level, it is becoming more important for practitioners to take an

advocacy role on behalf of significant dental public health issues. In the current policy arena, where there is an opportunity to increase the state government's role in public oral health, the involvement of the professional sector is essential. As discussed in this paper, private philanthropy has been actively engaged in supporting a number of oral health initiatives throughout the state. However, foundations do not view their role as sustaining these initiatives permanently because of their interest in spearheading and shepherding promising programs. It then becomes critical for the governmental and professional sectors to work together to develop mechanisms that will sustain effective dental public health programs in the long term. **CDA**

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