

This column represents the opinions of the author and not necessarily those of the American Dental Association.

HEALTH POLICY PERSPECTIVES

Where have all the dental care visits gone?

Marko Vujicic, PhD

Dental care use patterns have been shifting dramatically over the past decade. More children than ever are visiting the dentist. But dental care use among adults is declining steadily, among all income groups, a trend that emerged well before the recent economic downturn. These shifting dental care use patterns have had important implications. National dental care expenditure began to grow at a much lower rate beginning in the early 2000s, and it now has leveled off. Combined with a rising supply of dentists, this slow growth has contributed to sluggish dentist earnings and a sharp increase in open chair time. However, a closer look at the data on dental care visits shows a lot more is happening underneath the aggregate trends that the dental community needs to consider.

THE FACTS

The [figure¹⁻⁶](#) summarizes changes in the number of dental care visits, the number of practicing dentists, and the size of the US population between 2006 and 2012. The dental care visit data are broken down by the setting in which the dental care visit occurred. As far as I know, such a breakdown has never been analyzed and published before. The time frame, 2006 to 2012, was chosen based on data availability. Consistent, comparable data for all elements in the [figure¹⁻⁶](#) were not available before

2006, and the last year for which data are available is 2012.

The total number of dental care visits in the United States, across all settings, decreased by 7% between 2006 and 2012. There were approximately 271 million dental care visits nationwide in 2006 compared with 252 million in 2012. Over this same time frame, the US population increased by 5.3%, and the number of practicing dentists increased by 9.4%. As a result, average dental care visits per capita and per dentist decreased substantially. This finding is consistent with previous research showing that dentist busyness is down, appointment wait times are down, there is more open chair time, and working-age adults—the largest segment of the US population—are visiting the dentist less. The total volume of dentistry—as measured by visits—is declining, which should not be surprising to anyone who follows the Health Policy Institute's research.

What is surprising, in my view, and what has not been documented previously, to my knowledge, is how divergent the trends in dental care visits are across different dental care delivery settings. As the [figure¹⁻⁶](#) shows, the number of dental care visits that occurred in dental offices decreased by 9.1% between 2006 and 2012, whereas the number of dental care visits that occurred in Federally Qualified Health Centers (FQHCs) increased by a whopping 73.9%—from 6 million dental care visits in 2006 to more than 10 million in 2012. The number of dental care visits in hospital emergency departments

increased as well, by 19.7%, while in dental school clinics there was little change.

So where have all the dental care visits gone? Well, the data show clearly that they have gone out of private practices—dramatically—whereas, in contrast, FQHCs and hospital emergency departments are seeing significant influxes of dental patients.

It is important to highlight some of the underlying forces driving this shifting pattern of dental care visits. They are well documented. More adults report that they face financial barriers to dental care. Along with “no need,” the top reason, by far, that adults report they avoid visiting the dentist is “cost.”⁷ Households also are shifting around what they spend money on. Household spending on dental care is not rebounding, even as the US economy recovers, whereas for most other items (for example, vacations and cell phones) spending is in full recovery.⁸ Dental benefits for adults receiving Medicaid, which are not required by law, remain far less comprehensive than for children receiving Medicaid. All of these factors appear to be nudging adults, particularly low-income adults, to rely increasingly on settings other than dental offices for their dental care or to simply avoid or delay care. These settings include FQHCs and last resort settings such as hospital emergency departments.

At the same time, the data show that FQHCs clearly have been able to deliver more dental care. This

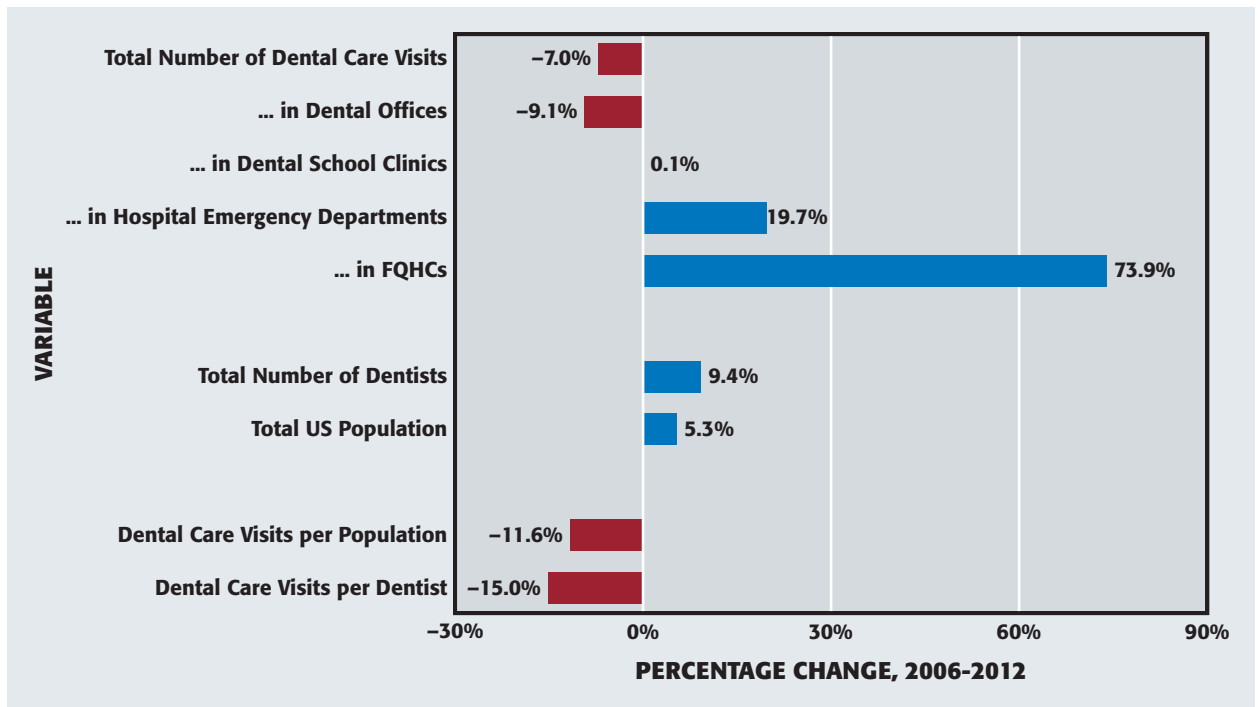


Figure. Changes in dental care visits, number of dentists, and US population from 2006 to 2012. FQHC: Federally Qualified Health Center. Sources: Agency for Healthcare Research and Quality,^{1,2} Health Resources and Services Administration,³ American Dental Association Health Policy Institute,^{4,5} and the US Census Bureau.⁶

success is, in part, likely due to increased federal funding^{9,10} and new innovative partnerships with private practice dentists and dental schools, as well as other reforms that merit further study.^{11,12}

LOOKING FORWARD

The past is the past. But what might the future bring? Looking forward, in my view, there is nothing on the horizon that will reverse the trends summarized in the figure.¹⁻⁶ In fact, on the basis of the best available evidence, I feel that if anything, these trends will intensify. Here is why.

First, Congress, through the Affordable Care Act (ACA), has made it clear that dental care for adults is not “essential” health care. This is what it means to be not included in the essential health benefits package under the ACA. Dental benefits remain a voluntary purchase for adults shopping for health insurance in the marketplaces and within state Medicaid programs.

Dental benefits coverage is a major driver of demand for dental care.

Second, the subjective value people place on a dental care visit—another key driver of demand for dental care—appears to be shifting over time and across generations. A lot more research is needed to understand more fully how oral health status and oral health literacy are evolving among key segments of the population, as well as the extent to which household priorities are changing with respect to dental care. However, new analysis suggests strongly that the consumer perspective is changing in a way that puts further downward pressure on demand for dental care, particularly among middle- and high-income households.⁸

Third, expansion in demand for dental care in the near term is likely to be concentrated within 3 groups: children, seniors, and the population receiving Medicaid. The traditional engine of the dental economy,

middle- and high-income working-age adults, is likely to see continued contraction. More than 8 million adults could gain some form of dental benefits through Medicaid expansion under the ACA. This number completely dwarfs the increase in private dental benefits coverage for adults through the health insurance marketplaces.¹³

With more low-income adults gaining dental benefits coverage via Medicaid, more will be looking to visit the dentist. Will this increased demand for dental care among Medicaid beneficiaries be met by dental offices that accept Medicaid, FQHCs, dental school clinics, or hospital emergency departments?

The ACA has some provisions for increased funding for FQHCs that could help facilitate further expansion of dental care delivery, but FQHCs continue to face challenges when it comes to dental care delivery, including recruiting providers. Many state Medicaid

programs also face challenges recruiting participating providers for a variety of reasons, including low reimbursement. Unlike for physicians, the ACA did not mandate that state Medicaid programs increase fees for dentists—a direct consequence of dentistry being “separate” from the health care system and not being “essential” health care.

WHAT NOW?

Zooming out, what does this all mean? Big picture, the analysis summarized in the figure¹⁻⁶ ought to be a major wake-up call for various stakeholders within the dental care sector. In my view, the data motivate 2 sets of policy questions.

First, if current trends continue and less dental care is sought in dental offices while more is sought in FQHCs, hospital emergency departments, and other settings, is the supply side ready to adjust? Are more dentists willing to work outside of dental offices? Are dental schools preparing graduates for nontraditional settings and more low-income patients? Will the United States face an oversupply of dentists in the coming years? Do FQHCs, which are severely stretched when it comes to dental care delivery, have the resources and the tools to expand dental care delivery further? Can the significant level of unused capacity within private dental practices be leveraged to treat low-income adults? What reforms need to happen within state Medicaid programs and within the dental education sector to make this happen?

Second, and more daring, what would it take to reverse the demand-side trends? How could the perceived cost-benefit equation for dental care be altered in the eyes of key stakeholders—for example,

households, physicians, governments, employers, and accountable care organizations? On the benefit side, how can the perceived value of a dental office visit be radically transformed? Are dentists interested, for example, in seizing the unprecedented opportunities to contribute to whole-body health that are emerging as a result of health care reform?¹⁴ On the cost side, how can cost barriers to dental care be reduced significantly for US adults? How do private dental benefits arrangements and Medicaid policies need to change to reduce financial barriers and promote increased access to dental care? What innovations in the dental care delivery model can reduce the cost of care?

This is a critical moment for dentistry: a once-in-a-century moment of profound change in the practice environment that is bringing new challenges and unprecedented opportunities. The time has come to explore the questions outlined here and to chart a course for the dental profession for decades to come. ■ <http://dx.doi.org/10.1016/j.adaj.2015.04.017>

Copyright © 2015 American Dental Association. All rights reserved.

Dr. Vujcic is chief economist and vice president, Health Policy Institute, American Dental Association, 211 E. Chicago Ave., Chicago, IL 60611, e-mail vujcicm@ada.org. Address correspondence to Dr. Vujcic.

Disclosure. Dr. Vujcic did not report any disclosures.

The author thanks Thomas Wall for research assistance and Cassandra Yarbrough, MPP, and Krishna Aravamudhan, MS, American Dental Association, for comments and insights on an early draft.

1. Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey. Available at: http://meps.ahrq.gov/mepsweb/data_stats/download_data_files.jsp. Accessed April 17, 2015.

2. Agency for Healthcare Research and Quality. Healthcare Cost and Utilization

Project: overview of the Nationwide Emergency Department Sample (NEDS). Available at: <http://www.hcup-us.ahrq.gov/nedsoverview.jsp>. Accessed April 17, 2015.

3. Health Resources and Services Administration. Health center data. Available at: <http://bphc.hrsa.gov/uds/datacenter.aspx?year=2012>. Accessed April 17, 2015.

4. American Dental Association. Health Policy Institute. Survey of dental education: report I—academic programs, enrollment and graduates. 2013-2014. Available at: <http://www.ada.org/en/science-research/health-policy-institute/data-center/dental-education>. Accessed April 17, 2015.

5. American Dental Association. Health Policy Institute. Supply of dentists. Available at: <http://www.ada.org/en/science-research/health-policy-institute/data-center/supply-of-dentists>. Accessed April 17, 2015.

6. United States Census Bureau. Population estimates: intercensal estimates. Available at: <http://www.census.gov/popest/data/intercensal/index.html>. Accessed April 17, 2015.

7. Yarbrough C, Nasseh K, Vujcic M. Why adults forgo dental care: evidence from a new national survey. Health Policy Institute Research Brief. American Dental Association; November 2014. Available at: http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1114_1.ashx. Accessed April 8, 2015.

8. Vujcic M. Of lawyers, lattes, and dentists. *JADA*. 2015;146(3):208-210.

9. Health Resources and Services Administration. The Affordable Care Act and Health Centers. Available at: <http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf>. Accessed April 3, 2015.

10. Katz A, Felland L, Hill I, Stark L. A long and winding road: federally qualified health centers, community variation and prospects under reform. Health System Change Research Brief No. 21. November 2011. Available at: <http://www.hschange.com/CONTENT/1257/>. Accessed April 3, 2015.

11. American Dental Association. Action for Dental Health Best Practices Guide. 10 steps to contracting with a health center. Available at: http://www.ada.org/~media/ADA/Public%20Programs/Files/ADH%20PDFs/10_Steps_to_Contracting_with_a_Health_Center.ashx. Accessed April 3, 2015.

12. Children’s Dental Health Project. FQHC Handbook: increasing access to dental care through public-private partnerships. Available at: <https://www.cdhp.org/resources/243-fqhc-handbook-increasing-access-to-dental-care-through-public-private-partnerships>. Accessed April 3, 2015.

13. Vujcic M. The booming Medicaid market. *JADA*. 2015;146(2):136-138.

14. Nasseh K, Greenberg B, Vujcic M, Glick M. The effect of chairside chronic disease screenings by oral health professionals on health care costs. *Am J Public Health*. 2014;104(4):744-750.