

Integrating Primary Oral Health Care into Primary Care

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Abstract: Despite increasing national attention and emphasis on primary health care, there has been little impetus to define or specify the content of primary oral health care. This paper defines primary oral health care and the scope of services it includes, using an adaptation of a Health Resources and Services Administration definition of primary health care and its attributes as its model. The proposed scope of services encompassed by primary oral health care is a set of basic dental services used by the Indian Health Service. Policy recommendations are presented to improve the integration of primary oral health services with primary health care and primary health care delivery.

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The challenges currently facing the U.S. health care system are creating a political demand for major reforms of the system. These reforms inevitably deal with the broad issues of cost, quality, and access. More and more, these issues are being addressed by calls for increased emphasis on primary health care, which is most frequently interpreted to mean primary *medical* care. Much less attention has been directed to the question of whether the same issues affecting the delivery of medical care also affect the delivery of oral health care, and whether oral health care is, or should be, a component of primary health care. As a consequence, there has been relatively little impetus to try to define or specify the content of primary oral health care. It is important to define primary oral health care because the same issues that apply to medical care are equally applicable to oral health care.

The principal purpose of this paper is to define primary oral health care, its attributes, and the types of procedures it encompasses. Because oral health is an essential and integral component of health, the concept of "primary health care" is incomplete without the inclusion of an oral health

component. However, just as all medical procedures do not fall within the purview of primary medical care, all oral health procedures do not fall within the purview of primary oral health care; therefore, procedures commonly identified as within the purview of primary oral health care practice are also delineated. In addition, this paper will suggest how primary oral health care can be better integrated into primary health care and primary health care delivery.

DEFINITION OF PRIMARY HEALTH CARE

Primary health care is typically described as including first-contact, longitudinal care that is comprehensive and person-centered rather than disease- or problem-specific. It addresses the most common health problems by providing preventive, curative, or rehabilitative services to maximize health and well being.

Many definitions of primary health care have been proposed. Early ones emphasized first contact care, coordination and continuity of care, preven-

tion, and consumer dignity. More recent definitions have emphasized community and family orientation, cultural and developmental appropriateness, and accountability.

One definition, first proposed in 1977, and subsequently adopted by the World Health Organization, is still widely used today:

"Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community by means acceptable to them and at a cost that the community and the country can afford to maintain at every stage of their development in a spirit of self-reliance and self-determination. It forms an integral part of both the country's health system of which it is the central function and the main focus of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."¹

The inclusion of community orientation in definitions of primary health care has evolved into the concept of *community-oriented primary care (COPC)*. COPC is a modification of the traditional model of primary care in which a primary care practice or program systematically identifies and addresses the health problems of a defined population. The practice of COPC combines primary care skills and the principles of epidemiology.² Key elements of COPC are use of applied epidemiology to assess community health problems; collaboration with community leaders to identify needs, prioritize resources, and plan intervention strategies; and reliance on program evaluation and outcomes research to progressively and systematically modify health care services and redirect health care resources.

DEFINITION OF PRIMARY ORAL HEALTH CARE

The WHO definition includes most of the major attributes of primary health care on which there is consensus. Another definition of primary care that was recently adopted as policy for children and adolescents by the federal Maternal and Child Health Bureau added the attributes of cultural and developmental appropriateness and accountability.³ This paper proposes the following adaptation of that definition as a definition of primary oral health care:

Primary oral health care is personal oral health care, delivered in the context of family, culture and community, whose range of services meets all but the most specialized oral health needs of the individuals and families being served.

Primary oral health care is the integration of services that promote and preserve oral health; prevent oral disease, injury and dysfunction; and provide a regular source of care for acute and chronic oral diseases and disabilities. Primary oral health care serves as the usual entry point into the larger oral health services system and takes responsibility for assuring the coordination of oral health services with other health and human services. The primary oral health care provider incorporates community needs, risks, strengths, resources, and cultures into clinical practice. The primary oral health care provider shares with the family an ongoing responsibility for oral health care. In both the manner of its organization and the methods of its delivery, effective primary oral health care incorporates and manifests several essential attributes.

First Contact: "First contact" oral health care is the usual entry point into the expanded oral health care system. The primary oral health care provider is responsible for guiding the patient to the most appropriate source of care. Within the system, the provider is contacted for all non-referred oral health care needs so that an informed judgment is made, and guidance is given regarding the most appropriate source of care.

Continuous: "Continuous" oral health care refers to the longitudinal use of a regular source of care over time, regardless of the presence or absence of disease or injury. It involves a patient-provider relationship based on established trust and knowledge of the patient and his or her family. Within the system, an "oral health care home" is established for each individual. This home is the repository of a unified record of all oral health care that is provided.

Coordinated: "Coordinated" oral health care is the linking of oral health care events and services. It requires the establishment of mechanisms to transfer information and the incorporation of that information into the plan of oral health care. Primary oral health care has the responsibility and obligation to transfer information to and receive it from other resources that may be involved in the care of individuals; and, to lead in the development and implementation of an appropriate plan for management and prevention. Coordination ensures that the more narrowly focused perspectives of specialists are combined into a holistic view.

Comprehensive: "Comprehensive" oral health care provides a continuum of essential personal oral health services that promote and preserve oral health, prevent oral disease, injury and

dysfunction, as well as provide care for acute and chronic oral diseases and disabilities. Primary oral health care is inclusive of the many dimensions of oral health beyond physical components, including the social, environmental, and developmental aspects of health. It directly provides oral health services needed by a substantial proportion of the population and arranges referral for services to meet needs that are relatively uncommon or rare in that population.

Community-oriented: "Community-oriented" oral health care takes into account the needs of a defined population. Delivery of primary oral health care services is based on an understanding of community needs and the integration of a population perspective into clinical practice. Primary oral health care providers are responsible for supporting public health roles and activities through epidemiologic awareness and reporting of specific health problems identified in the course of delivering personal oral health care services. Primary oral health care providers contribute to and participate in community diagnosis, health and oral health surveillance, monitoring, and evaluation conducted as a routine function of public health agencies. Community-oriented primary oral health care assures that the views of community members are incorporated into decisions involving policies, priorities, and plans related to the delivery of primary oral health care.

Family-Centered: "Family-centered" oral health care recognizes that the family is a major participant in the assessment and treatment of an individual. As such, families have the right and responsibility to participate individually and collectively in determining and satisfying the health care needs of their members. Being family-centered means that policies regarding access, availability, and flexibility take into consideration the various structures and functions of families in the community being served. Finally, it means that primary oral health care needs to understand the nature, role, and impact of an individual's oral health, disease, disability, or injury in terms of the family's structure, function, and dynamics.

Accessible: "Accessible" oral health care facilitates the entry of a family seeking care. Accessibility involves going beyond interactions at the provider site and includes outreach, especially outreach targeted at categories of individuals at high risk. Access encompasses geographic location and transportation, affordability, community awareness, cultural relevance and sensitivity, user acceptance, hours of practice, and attention to the special needs of persons with disabilities.

Culturally Competent: "Culturally competent" oral health care incorporates cultural differences into the provision of oral health care. Services should be acceptable to all of the groups of people in the community who may be distinguished by common values, language, world view,

heritage, institutions, or beliefs about health and disease. A mechanism should be in place to represent the views of these groups and incorporate them into decisions involving policies, priorities, and plans related to the delivery of oral health services.

Developmentally Appropriate: "Developmentally appropriate" oral health services integrate the developmental levels of individuals into the assessment, prevention, and management of oral health conditions and into the design, location, and policies that provide the context for the services being delivered.

Accountable: "Accountable" oral health care establishes and monitors standards for each of the attributes listed above. For clinical services, it also assures that all services are delivered in accordance with current best professional practices.

SCOPE OF SERVICES ENCOMPASSED BY PRIMARY ORAL HEALTH CARE ■

One organization that appears to reflect the "state-of-the-art" in the evolution of attributes of primary oral health care as they are espoused in this paper is the Indian Health Service (IHS). The IHS dental program defines six levels of care: Level I (Emergency Dental Care); Level II (Primary Care); Level III (Secondary Care); Level IV (Limited Rehabilitation); Level V (Rehabilitation); and Level VI (Complex Rehabilitation). The first three levels, which together account for 94 percent of treatment delivered,⁴ are referred to by the IHS as "basic dental care," but encompass what most would consider to be primary oral health care services, in that they represent the most common procedures received by most people. A summary of these services can be found in Figure 1.⁵

What makes the IHS characterization of "basic dental care" unique is its inclusion and operationalization of community-based services. The IHS model is thus perhaps the first organized oral health care delivery system to intentionally incorporate the principles of COPC, and of primary care as defined by the World Health Organization.^{1,5}

The one area of primary oral health care practice that has not been fully defined yet by the IHS is community-based services. At a minimum, these services should include community-based prevention and oral health promotion programs and activities, such as community and school water fluoridation; use of topical fluorides, and dietary fluoride supplements where indicated; school-based preventive services, including clinical preventive services such as topical fluoride applications, sealants, and fabrication of mouthguards, as well as classroom-based preventive services such as fluoride mouthrinses, fluoride supplements, and oral health education; oral health

Figure 1. A Summary of Common Services Listed in the Indian Health Service Schedule of Oral Health Services (Levels I-III Defined as "Basic Dental Care")

Level I. Emergency Dental Care

- Limited exam and related diagnostics
- Simple tooth extraction due to oral disease
- Therapy for trauma of dentition, jaws and face
- Palliative treatment (e.g., temporary restorations)
- Prosthodontic repair, adjustment, recementation

Level II. Primary Care

- Ia. Community-based services, or
- Ib. Clinic-based services

- Routine examination, diagnostics and treatment plan
- Patient self-care education and related consultation
- Prophylaxis (if calculus and/or pocketing is present)
- Selective use of caries preventives—fluoride, sealants, other
- Other preventive measures, e.g., athletic mouth guards
- Health risk surveillance (e.g., diabetes, hypertension, tobacco use, other)

Level III. Secondary Care

- Simple restorations (silver alloy and composite resin)
- Space maintainers for primary teeth
- Pulp therapy in primary teeth
- Endodontics in anterior permanent teeth
- Periodontal charting and non-surgical pocket therapy

Level IV. Limited Rehabilitation

- Complex restorative care (including build-ups)
- Cast crowns/onlays/acid-etched bridges
- Bicuspid endodontics
- Deep root planing
- First time dentures or reline/rebase
- Prosthodontic surgery
- Surgical extractions (tissue impactions)
- Limited/interceptive orthodontics

Level V. Rehabilitation

- Molar endodontics
- Complex periodontal surgery
- Removable dentures
- Cast fixed bridgework
- Surgical extractions (most bony impactions)
- Premedication/sedation

Level VI. Complex Rehabilitation

- Exotic diagnostics and consultation
- Elective oral surgery (deep 3rd molar impactions)
- Maxillofacial or complex prosthetics including implants
- Comprehensive orthodontics
- TMJ therapy and occlusal adjustment therapy

surveillance; oral cancer screening; and tobacco education.⁶

The scope of services defined by IHS as "basic dental care," (which could more appropriately be termed "basic dental services" to reflect the inclusion of community-based services such as those described above), and the principles that underlie it, appear to incorporate all of the attributes of primary health care reflected in recent work on this subject, as well as the attributes of primary oral health care that this paper espouses. Accordingly, this scope of services is recommended as the scope of services that comprise primary oral health care.

PRIMARY ORAL HEALTH CARE AS A COMPONENT OF PRIMARY HEALTH CARE

What is the rationale for including primary oral health care as part of primary health care? This is not a rhetorical question to physicians and health policy makers who tend to undervalue oral health

services for several reasons. First, there has been a tendency toward professional isolationism within the dental profession, which may simply be a consequence of wanting to define itself as a unique profession and not a specialty of medicine.

Second, perhaps because specialization has tended to pervade medicine far more than dentistry, many physicians, health care administrators, and allied health workers seem to view dentistry almost as a specialty of medicine. However, because it really isn't, other health care professionals tend to be undereducated about oral health, and are not well equipped to know when to refer patients to a dental professional.

Third, dentists have relatively little interaction with other types of health care providers, external regulatory bodies, and community agencies, resulting in rather limited involvement in matters related to major health policy issues.⁷

Fourth, since many health professionals come from better educated and more affluent families who typically are covered by dental insurance, or who can afford to pay for dental services out-of-pocket, they tend not to have experienced the

kinds of dental problems experienced by their less affluent counterparts. Consequently, they tend not to view oral health problems in the same way in which other health problems are viewed. The pervasiveness of the major oral diseases also fosters the idea that oral health problems are an inevitable part of life.

Finally, there is a commonly held perception that oral health services "cost too much." It is true that the price of dental services has grown faster than the Consumer Price Index for urban areas for all goods and services since the early 1980s. However, growth in the price of dental services continues to be less than that of physician and hospital services. And while it is true that total expenditures for dental services continue to increase, the level of spending for dental services as a percentage of total personal health care spending continues to decline. In fact, since 1960, this percentage has fallen from over 8 percent to 5.3 percent in 1992.⁸ This trend is projected to continue, so that by the year 2000, dental expenditures will represent about 4 percent of personal health expenditures.

One of the most important reasons for including oral health care as part of primary health care is that the effects of oral health problems are not limited solely to the mouth; they often also profoundly affect general health. Too often neither the impact of oral health on general health nor the benefits of integrating oral health with general health are realized. For example, despite the national attention and funding support for research on cervical cancer, it is generally unrecognized that oral cancer kills more Americans than cervical cancer. Since dental professionals are trained to detect and diagnose oral cancer, they are far more likely to carefully examine patients' mouths than other health care providers. If regular oral examinations of older Americans are not considered part of primary health care, many persons will be denied the opportunity to have this life-threatening disease detected early, thus reducing their life expectancy, and increasing their chances of disfigurement.

Similarly, dental professionals are often the first health care providers to detect the changes in the mouth that represent the first indication of HIV infection, and also help assure that infected individuals are referred for counseling and into the medical care system for appropriate therapy and treatment. Through the early interventions afforded by the early detection of problems, the risk of transmission of HIV is reduced, and HIV-infected persons are able to lead longer, higher quality, and more productive lives.

RECOMMENDATIONS

The following strategies, in the form of recommendations, are suggested to improve the integration of primary oral health care with primary

health care and primary health care delivery:

1. **Continue and increase support for postdoctoral education and training for general practice residency (GPR) and advanced education in general dentistry (AEGD) programs.** *Rationale:* Projected increases in demand as a result of health care reform, and projected decreases in the supply of dentists as a result of declining dental school enrollment and an aging dentist population, necessitate the expansion of these programs.
2. **Increase the supply of dental public health professionals.** *Rationale:* State and national health care reform is expected to focus increased attention on and expand community and migrant health centers, other alternative delivery systems, and on school- and community-based models of prevention and health care delivery. An expanded dental public health workforce is needed to meet the expected increase in demand for individuals to administer and deliver these services.
3. **Determine and periodically reassess the supply and distribution needs for allied dental personnel based on the epidemiology of oral disease, projected demand for oral health services, and the cost-effective utilization of such workers.** *Rationale:* Even if incentives are provided for the increased use of allied dental personnel, there will be little effect on the delivery system until there is an adequate supply to meet the expected demand.
4. **Increase the supply of pediatric dentists.** *Rationale:* Children are the most likely group to have dental coverage as a result of national health care reform. Most general dentists do not see very young children, and there is an insufficient supply of pediatric dentists to meet the expected increase in demand for services.
5. **Increase education, training, and practice opportunities for oral health care workers to practice as part of multidisciplinary teams in primary health care settings.** *Rationale:* Oral health care services are unlikely to be integrated with primary health care services and delivery systems as long as oral health care workers remain trained in isolation from other health care workers.
6. **Develop public relations campaigns, targeted at health professionals, policy makers, and the public, that convey the value and importance of oral health and its inclusion in primary health care services and delivery systems.** *Rationale:* Oral health care services are generally undervalued by non-dental health professionals, policy makers, and the public. A well-designed public relations campaign can help mold public opinion to change prevalent attitudes that restrict the integration of oral health care services into primary health care services and delivery systems.
7. **Support the development and expansion of school-based dental clinics as part of school-**

based primary health care delivery systems.

Rationale: School-based clinics, particularly those that serve high proportions of economically disadvantaged students, represent important alternative delivery sites for primary health care services, including oral health services, because they can take advantage of the efficiencies of a "captive audience," they reduce the time lost from school as a result of having to see a health care provider, they can be integrated with other on-site preventive and health care services, and they offer the ability for early detection of health problems, thus reducing the time and expense of more elaborate treatment.

8. **Support innovative models using new and existing oral health care personnel and alternative oral health care delivery systems.** *Rationale:* National health care reform is likely to offer incentives for innovative and cost-effective use of delivery systems and personnel that result in positive health outcomes. Models that demonstrate equivalent health outcomes using less expensive personnel, or that better integrate oral health into primary health care, offer the potential to make more effective and efficient use of health care resources.
9. **Establish mechanisms to evaluate the cost, benefits, and quality of care outcomes resulting from different health care provider arrangement and delivery system models.** *Rationale:* Health care reform and changes in the education of health professionals will likely encourage a variety of innovative methods of delivering health services. No single model should be widely promulgated before it is adequately evaluated.
10. **Assure that oral health care services for adults are not overlooked in health care reform efforts.** *Rationale:* It makes no more sense to exclude or severely limit primary oral health care services to adults than it does to limit other primary health care services based on parts of the body. Such limits will present major barriers to the integration of oral health care services into primary health care services and delivery for both adults and children. Implicit in this recommendation is the amendment of Medicare statutes to add primary oral health care services in the event Medicare is retained after national health care reforms are enacted.
11. **Amend community and migrant health center authorizing legislation to require them to provide primary oral health care services as a component of primary health services. Require all new centers to offer dental services and phase-in dental services in existing centers.** *Rationale:* The lack of inclusion of primary oral health care services as a required component of primary health services in community and migrant health centers represents one of the most

significant barriers to the integration of oral health care services into primary health care services and delivery. These amendments will assure that these services are available to the substantial numbers of individuals served by these centers.

12. **Encourage states to implement the "partial provider" provision of current Medicaid law and to cross-refer between medical and dental providers.** *Rationale:* Many state Medicaid programs use medical provider "gatekeepers" to control referral to dentists. This acts as a barrier to dental care. Encouraging cross-referral between medical and dental providers is in the best interests of the patient and will facilitate the integration of services.
13. **Require cooperative agreements with state primary care offices to include consideration of indicators of need for primary oral health care services and personnel as part of their determination of needs assessment process for clinic site selection and health care personnel.** *Rationale:* Some states do not include indicators of need for oral health services and personnel when determining site selection for primary health care services. Such indicators may not coincide with indicators of need for medical care.
14. **Continue to support and expand existing and planned federal initiatives intended to improve integration of primary oral health care services into primary health care services and delivery.** *Rationale:* Many federal initiatives appear to be on the right track and are having their desired effect. Rather than reinventing wheels, such initiatives merit increased support.
15. **Provide a centralized focus for oral health policy within the Department of Health and Human Services (DHHS) and within state health departments.** *Rationale:* The lack of any organizational focus for dental policy within DHHS has been identified as a barrier to improved oral health. The development of a central focus to coordinate activities within DHHS would represent an important first step in assuring the integration of oral health services into federal primary health care services and delivery activities. Similarly, since it is expected that national health care reform will leave the states with considerable flexibility in how reforms are administered, it will become increasingly important for there to be a centralized focus of oral health expertise and coordination within state health departments.

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