A Preferred Future Through Informed Choice

by Christian B. Sager *Reprinted from Dental Clinics of North America,Vol. 32, No. 1, January, 1988

We are experiencing a rapid decline in provider dominance of delivery methods in dental and health care and the rise of purchaser and consumer control of delivery modes and expenditures.

The language defining this shift— Tier I, II, III, HMO, PPO, DMO, CDO, IPA— appears in almost anything written that does not devote itself exclusively to clinical concepts. Typical of most significant changes in life or society, there are those who herald the change as a great opportunity and others who are fearful of or threatened by the new realities. Larry Dossey, M.D. spoke appropriately to the realities being experienced by other scientific disciplines in his significant contribution to literature, Space, Time and Medicine, which details the impact of Belgium chemist Ilya Prigogine's 1977 Nobel Prize winning "theory of dissipative structures" on physics and perhaps all things in the universe.

The classical way of viewing the universe has embodied an attitude of hopelessness because it has seemed that everything was inexorably running down–fluctuation can give rise to forms of a new complexity. The resulting configurations in nature begin to behave like a "dissipative structure," Prigogine's term, implying that they interact with the local environments by consuming energy from it, and by eliminating the by-products of this energy utilization back into the environment.

...but ironically it is this feature of the dissipative structure that is the key to its further evolution toward greater complexity. For if the internal perturbation is great enough the system may undergo a sudden reorganization, a kind of shuffling, and "escape to a higher order," organizing in a more complex way. It is the quality of fragility, the capacity for being "shaken up", that paradoxically is the key to growth. Structures that are insulated from disturbance are protected from change. They are stagnant and never evolve toward a more complex form.

The Motivators of Change
A review of what fueled the forces of change in the health care delivery system of the U.S. would be incomplete unless it encompassed the motivators for the easing or elimination of legislated restrictions on trade in other industries. While at risk of over simplification, these forces could be characterized as consumerism, free trade, and the government's support of competition, which it believed to be in the best interest of many. It is the right of the individual in democratic societies to ask the question "as compared to what?" The same open market philosophy that will force the U.S. shoe industry, auto manufacturers and steel producers, among others, to compete in an unregulated market or face drastic changes in their future opportunity is being applied by our federal government to the health care industry.

Additionally, a public that is increasingly seeking health and wellness and an objective measurement of its health care providers' competence is making its desires known to legislators, employers, and health professionals.

The Bates decision by the U.S. Supreme Court substantially amended, perhaps forever, the authority of the self governing bodies of our professions. Enter then the corporations and venture groups into the competition for the health-care dollars, and we arrive at a language of three characters and Roman numerals defining our health delivery mechanisms. What is the future of dentistry? There are many. However, before we explore these, let us look at how some of the forces, desiring or motivating the changes, view dentistry.

The Federal Trade Commission's View
Unlimited Competition On All Levels
By their definition, professions are service industries and are accordingly governed by the trade regulations. Even though this federal agency is in limbo regarding its limits of authority, and successful lobbying has assured decisions more representative of congressional will, they will remain a formidable opponent to any trade activities they determine restrictive of the public's right of informed choice.

The Corporate Human Resources Manager's View
A Commodity to be Purchased as Part of the Employee Benefit Package
These executives are expected to satisfy the basic health requirements determined by collective bargaining and individual corporate conscience. They are to deliver the determined benefit at the least

expense. Therefore, to this group, dentists are vendors of a service. As to quality of care, laymen must assume that if the professionals delivering the care are licensed and in good standing with their profession's governing bodies, they are qualified. These executives also are intent on assuring the greatest economies in treatment and are willing to fund second opinions on significant expenditures. If not funding second opinions, then they are capping their coverage. They also are watching with great interest the number of dentists willing to sign up with programs that reimburse the dentist with 80 percent of usual and customary fees as full payment, wondering if this is just competitive pressure or signaling high profit margins in dentistry. One of America's largest corporations recently made a statement of some importance:

In a departure from its usual policy, General Motors (GM) will eliminate fee for service care in favor of HMOs or PPOs in medical benefits offered to United Auto Workers (UAW) members who will be employed at its plant in Spring Hill, TN. No decision has been reached on how dental benefits will be provided.

The Insurance Community's View
A Profit Center

This is one more leveraged health care risk, but one without a great opportunity for the long term payouts occurring in medicine. Also advantageous to the carrier, it is a health benefit for those insured who are accustomed to limited coverage. Some major insurance corporations are currently exploring the establishment of health care facilities with themselves as employers of the professionals delivering the care. Their sales group will be responsible for delivering the users. Insurance corporations are perhaps America's best funded enterprises and one of the most effective legislative lobby groups. Therefore, if it is determined in their boardrooms that the delivery of care, not just insuring the users, is their business, then they represent the greatest motivator of change to America's current health care delivery system. I offer as confirmation of this fact information which was quoted in the March 1986 issue of Medical Economics:

Prudential Insurance Company of America, which has 500,000 HMO enrollees in 19 cities, aims to put HMOs and PPOs in 80 major metropolitan areas within four years."

Lincoln National Life is forming joint ventures with alternative providers, such as the MNO chain U.S. Health Care Systems Inc., to create new plans and market triple-option packages in 40 to 50 cities. The firm projects that 50 to 60 percent of those it insures will be in an HMO or PPO by 1990.

CIGNA Corp. is offering a triple-option product called Flexcare through its subsidiaries, CIGNA Healthplan Inc. and Connecticut General Life Insurance Co. The largest for profit HMO chain, CIGNA Healthplan has about 900,000 enrollees in 17 HMO's. It's shooting for 50 plans by 1988. Mutual of Omaha Insurance Co. got its first PPO off the ground in June 1985 and has since enrolled 100,000 people in nine PPOs. An equal number of plans are about to come on-line. The company intends to build a nationwide PPO network.

Metropolitan Life Insurance Co., along with local partners such as hospitals, will spend $210 million to start HMOs in most major metropolitan areas in the next several months.

Blue Cross and Blue Shield, which covers 80 million people. The Blues have 75 HMOs linked in a National network. Current enrollment is about 2 million—and projected to go as high as 9 million by 1990.

Paul Starr, in his book, The Social Transformation of Medicine states,

Of all the forces fragmenting the professions in the 1980s, none promises to introduce more antagonistic division than the growing presence of corporations in medical care.

The Investment Community's View
Uncertainty

Wall Street and its investment bankers have yet to see the new concept of dental-delivery retail companies achieve the equity or price/earnings growth heralded in the late '70s and early '80s.

U.S. bankers no longer give carte blanche loans to young dentists establishing new practices; rather, a careful review of loan requests and a limit on available funding for new practices is today's norm. This revision in philosophy has occurred as a result of historical highs in loan defaults in many geographical regions.

The Film and Entertainment Industry's View
A Caricature Role

Dentistry is a profession reflected through comedy, derision, or pain. General typecasting includes, Walter Matthau in "Cactus Flower," Tim Conway of the Carol Burnett Show; Jerry the orthodontist in the Bob Newhart Show; a torturer in "The Marathon Man," and Alan Arkin's statement in "Freebie and the Bean," "You're not a doctor, you're a dentist." In the film "Rueben, Rueben," the cuckolded dentist vindictively extracts the philandering poets only barrier to an upper denture. In short, this industry is a powerful public influence that has done very little to enhance dentistry's public image and nothing for the scientific or diagnostic advances the profession has achieved.

The Print Media's View
Another Part of the American Mosaic

Newspapers report the positive scientific advances and benefits of new treatment methodologies in their health science sections. Business sections and human interest pages catalogue the changing experience in delivery modalities and success/failure of the evolving consumer and corporate model of health care. High interest news items such as malpractice awards and the human failings of the professional receive attention based upon the worthiness of the item relative to selling newspapers.

Grocery store checkout counter family magazines are generally more favorable to the value of dentistry. Their purpose is to aid their audience in understanding options in treatment and selection.

Business and intellectual publications devote their coverage to what they determine to be significant changes and visions of the future of health, delivery of care and venture opportunity.

Health care is a business undergoing a devastating revolution. We hesitate to call it an industry at this point because it is emerging from a period of unprecedented favored status in American life. Health care has been a seller's market for so long that the people in it have had no concept of competition, marketing, pricing or promotion. The wrenching changes that have hit health care in the last five years have caused confusion, pain and a very late awakening.

All of the aforementioned forces plus others not specified, e.g., public and commercial television, combine to create a scenario of the future for dentistry and all of health care that simply cannot be reduced to one answer for the question "what is the future of dentistry?" The answers will be as diverse as the questions, expectations, and desires of the consumer. Health care delivery mechanisms will be created, designed or evolved which will service the real and perceived needs of the public.

As the health care market becomes more turbulent, more and more innovative options for service appear. For example, the freestanding emergency center, sometimes called the emergi-center, or ambulatory care center is a walk-in facility where people can obtain immediate care, and not necessarily only for emergencies. Many physicians and hospital executives complain that these "doc-in-a-box" businesses are "creaming" the top of the market, but it's an everyone-for-himself situation. Anything that is legal, ethical, and profitable will probably be tried.

Clarifying the Options

At the Pankey Institute, we begin each of our weeks with a session defining the expectations of our participants. We categorize their goals for the course and their concerns. We never complete this process without the "future of dentistry" being placed in the concern category. In order to be specific in formulating information that will speak to this concern we must first discover which of the styles of practice best defines the future that each participant prefers. For defining the styles, we have found most useful the language developed by Avrom King in his Nexus publications. He divides the delivery systems and deliverers into three distinct categories or "tiers" of dentistry.

TIER 1 signifies the involuntary closed panel or contract programs such as USPHS, military, and HMOs.

TIER II represents the voluntary contract or retail programs such as Sears, "Doc in the box" and others who are using public media to attract a steady stream of new customers.

TIER III denotes the fee for service community of health professionals. This group of individuals repre-

sents the evolved cottage industry. Opportunity here rests heavily on their ability to provide “high touch” care. It is not a style of practice that relies on public media for new patients, but rather flourishes through its referral network.

Generally, we find our participants are desirous of achieving or enhancing the TIER III style of dental practice. It is not surprising, since this style more nearly represents what has been the traditional mode. However, the TIER III practice of today and the future will experience the greatest challenge to its economic viability. It can no longer be traditional in its approach to dental care if it is to meet the challenge of corporate or retail dentistry. Far too frequently the traditional approach represented a processing of people–an often impersonal approach to “fixing” teeth with insufficient attention to creating value for wellness. Accordingly, there are a great number of consumers who have a low appreciation for excellent dentistry and will search for the most expeditious mode of treatment. The numbers game (processing large quantities of people) will be the province of the TIER II entrepreneurial administrative model. Why? Because today’s dentists are unprepared and under-capitalized to compete with the mass marketers for that segment of the market searching convenience and maintenance type dentistry. In other words, one probably cannot “out K-Mart, K-Mart.”

On the other hand, the major retail organizations and entrepreneurial franchise type centers require volume to meet profit expectations. Many utilize income per square foot of space allocated as a benchmark of success and, when a venture produces less income than planned, there are no compunctions to cancel or cease the operation of that venture.

The scientific advances that are reducing the incidence of dental disease and subsequent requirement for maintenance dentistry in the future, cloud the long-range plans of the Tier II group. However, entrepreneurial organizations find ways to profit from windows of opportunity and move on to others when one opportunity is no longer viable.

A retail organization such as Sears has a very different corporate philosophy. They are endeavoring to become a complete supplier to America’s needs. They recognize that nearly one-half of our population changes residences every five years and that these individuals require some consistent expectation of quality and service in their relocation process. The consumer knows Sears will back up the warranty and service contract on the refrigerator purchased in Los Angeles that now resides in Dallas. The same is true of Allstate Insurance in servicing the anterior bridge or lower denture. In these times of government security scams and failing banks, this is a powerful consumer motivator.

Consistent with the long term goal of being a complete supplier to mobile American consumers, Sears, the retailing giant, doubled its number of dental centers from 15 to 33 in just two years.

Each of these TIER II organizations require employees or independent contractors to provide their offered services, and there are sufficient numbers of professionals willing to fulfill their requirements. Those dentists who do not enjoy the sponsoring role required of the wellness professional or who do not want to become proficient in the business aspects of practice will gravitate toward this segment of delivery. Their employers will give them company cars, pension and bonus plans, and the freedom from any management responsibilities. Production goals, however, are a way of life under this arrangement as a quantification of value of the employee, the dentist.

TIER I providers of dentistry match the traditional medical model of sick care. Capitation plans, HMO/DMO, and military or public health facilities have generally been administered under a bureaucratic model. The incentive in most is to “fix what’s broken.” Capitation plans certainly do not provide short-term compensation to the provider for preventive activity and are generally low or no profit until the third year of a contract.

HMOs evolved as a reaction to the “crisis in healthcare expenses” first pronounced in the early ‘70s. In the mid-80s, they are viewed by the corporate world as the best opportunity for gaining control of provider dominated pricing. Virtually every employer has been faced with what they believe to be irresponsible escalation of healthcare expenses. Dentistry has not been a material part of these escalations. Nevertheless, it

is viewed by corporate managers as part of the health benefit expenses problem. Enter then the DMO section of HMO. Unlike the TIER II retail or TIER III fee-for-service models, TIER I's HMO/DMO format affords the business community a predictable employee benefit expense. Accordingly, this form of delivery will probably be the one of choice for those who employ large numbers of people and will be dominated by what is being termed the "supermeds." Quoting again theMedical Economics article:

In this fiercely competitive climate, the outlook for small HMOs and PPOs isn't bright. "Jake's Discount HMO on the local scene is out," asserts Kaplan of the Blues. "The Big corporations have the dollars, and they tell us: "We don't like getting 120 bills, having to do 120 reconciliations, or calling 120 administrators when we have a problem. We want a single cage to rattle.

This Philosophy may well have great bearing on the hopes of those that see direct reimbursement as the effective alternative to DMOs.

What about TIER III? Some predict that this style of practice will represent only 25 percent of the total within the next few years, and current trends lend credence to such projections. Trends become historical facts unless significant change in the motivators of the trends occur. If most dentists choose to treat the disease and contend with the person, then most will achieve due reward for such action, and the trends diagnosed today will evolve into fact. Should, however, a "them and us" attitude rapidly become a "we're in this together" environment, substantial amendment to projections and concurrent results will occur. The last paragraph of Paul Starr's The Social Transformation of American Medicine speaks appropriately to any such predictions:

...but a trend is not necessarily fate. Images of the future are usually only caricatures of the present. Perhaps this picture of the future of medical care will also prove to be a caricature. Whether it does depends on choices that Americans still have to make.

Choices

Selection of a specific provider for dental and medical health care is a most difficult task for the average American. Economists call these "credence goods" or a faith purchase. Most consumers cannot make their selection through an objective evaluation of the clinical competence of the doctor. They generally rely on the recommendation of others, convenient access, and/or price during the initial selection process. And, unless they are "stuck" in a closed panel, the ability of the selected delivery mechanism to service their expectations will determine continued patronage.

A significant percentage of the population welcomes someone or something else making the selection for them, especially if that venue is convenient, economical, and perceived as a "one stop" center. Therefore, when the employer selects an HMO/DMO or capitation clinic, the employee is relieved of a great many objective decisions for which he feels unprepared to make alone. Individuals will generally follow their employer's lead unless treatment methods or systems force an exodus.

Another percentage of the population includes informed consumers. They have a high appreciation for quality caring professionals and choose to make their own decisions about who will help them maintain or enhance their health. Convenience and economics are important, but genuine concern for their well-being by the health professional will take precedence in their selection process, irrespective of where they may be told to go. Simply put:

Ambivalent Appreciation = Simplistic Choice

High APPRECIATION = Sophisticated Choice

The health and wellness movement in the population is a rapidly expanding segment. Therefore, those professionals who genuinely enjoy helping people attain health and wellness and can communicate their commitment to this preferred future can anticipate a more rewarding practice.

These professionals are also keenly aware that their previous education may have prepared them to adequately attend to the clinical requirements of their patients/clients health but was woefully deficient in addressing the skills required of a "service" business.

SERVICE AMERICA, an excellent publication devoted to defining the shift from an industrial society (production oriented) to a service society (performance oriented), provides insight to those seeking guidance.

Organizations concerned with honing a competitive edge for the 1980s, 90's and beyond must develop two new capacities. The first is the ability to think strategically about service and to build a strong service orientation around and into the vision of their strategic future. The second capacity, which is perhaps more difficult to develop, is the ability to effectively and efficiently manage the design, development, and delivery of service. In our own view the ability to manage the production and delivery of a service differs from the ability to manage the production and delivery of a commodity. It requires a familiarity with the idea of an intangible having economic value, and a deftness in conceptualizing intangible outcomes. It requires a tolerance for ambiguity, an ease in dealing with lack of direct control over every key process, and a finely tuned appreciation of the notion that the organization is equally dependent on soft (or people-related) skills and hard (or production-related) skills. Last but not least, it requires a tolerance for–perhaps even an enjoyment of–sudden and sometimes dramatic change. The only constant in service is change.

The air of this highly creative process is to invent, discover, or evolve a service strategy that can unify the people of the organization. An effective service strategy is a statement of intent that meets at least the following conditions:

1. It is nontrivial; it has weight. It must be more than simply a "motherhood" statement or slogan. It must be reasonably concrete and action-oriented.

2. It must convey a concept or a mission which people in the organization can understand, relate to, and somehow put into action.

3. It must offer or relate to a critical benefit premise that is important to the customer. It must focus on something the customer is willing to pay for.

4. It must differentiate the organization in some meaningful way from its competitors in the eyes of the customer.

5. If at all possible, it should be simple, unitary, easy to put into words, and easy to explain to the customer.

Conversely, those professionals who just want to do what they were trained to do and not involve themselves in the lives or wellness goals of their patients can expect an environment that gives them ample opportunity for employee status.

The biggest threat to those who choose this insulated opportunity is science. Based upon the rapid pace of scientific advancements in the "machinery of health care," how long before robots are outperforming humans in surgical procedures? Dental science has essentially created materials and procedures that will eliminate caries. Dare we doubt that eventually laser surgery by robots, watched over by paraprofessionals, will not be doing most of the operative procedures? Is it possible that electronic stimulation of bone could straighten teeth and adjust occlusion without wire or grinding? That biomaterial research will not provide a substance that can be fabricated into an artificial TM joint or a disc that will be implanted through robotic surgery? Dr. Omer Reed reported on a significant technological advance in his newsletter Teethtalk in January 1986.

I report to you the following events with great enthusiasm, and I've been there, firsthand, and feel that they are the cutting edge of the new technology in the profession, reflecting the experiences we'll enjoy for the next fifteen years or so. Roy Hammond and I took the time to leave the slopes and go to Lyon to visit with a major international electronics firm, Hennson, its Director General, Gilles Dechelette, and a dentist, Francois Duret. Dr. Duret has, for the past fifteen years, been working to perfect a laser scanner/computer combination that will drive a micro-milling machine to produce dental prosthetic products more rapidly, more efficiently, more accurately and with a higher quality of material characteristics.

Roy and I were literally astounded as the entire process unfolded before our eyes! We watched on closed circuit video as Francois prepared a lower

bicuspid on his wife, scanned the preparation with the laser scanner and put a block of Dicor in the micro-milling machine and, with the computer imaging that had been accomplished by the scanner, the micro-milling machine did the occlusal surface, the occlusal half of the crown, flopped the block over and milled out the intaglio; then did the gingival half of the crown including the razor sharp margins. Fifty minutes after his wife entered the dental chair, she left, smiling, with a color matched dicor single crown that fit within three-thousandths, was bonded to the tooth, was properly shaded. She had neither an impression nor a temporary.

We Are Living in a New World

Dr. Duret's remarkable assemblage can do inlays, onlays, three-quarter crowns, full crowns, three-unit bridges and full upper or lower dentures, milled out of solid block, fitting the person immediately as they presently are in a remarkable fashion. He has a computer-recording apparatus for temporomandibular joint function. The memory bank can complete the morphology of the individual tooth if its been damaged severely; or the scanning prior to prep can reproduce the existing tooth's morphology exactly, including facets and/or whatever you choose to include. The past dam on the denture is entered with the keyboard and/or is taken out of the computer's memory bank. The crowns can be fabricated out of gold, composites non-precious, or dicor. Some of the new composites that are factory fabricated, not laboratory processed, will be introduced, even, perhaps, some of the carbon fiber materials. We're in for a new world in prosthetics material. Dr. Duret projects that these will be available in late 1986, early 1987.

Additionally, our society will need a series of sophisticated policies on genetic engineering because the future is the ability to correct a predisposition toward skeletal or soft tissue malformations.

But, can you imagine ever creating a machine that has warmth and concern or the ability to place a hand on a troubled shoulder and state empathetically, "We are glad you chose us to help you with your health." Can excellent video instruction replace the warmth of a team of individuals highly skilled in the behavioral sciences and capable of performing exquisite clinical dentistry who enthusiastically sponsor an individual's search for wellness? Dialogue, not monologue, is the avenue of human enrichment.

The preferred future of dentistry belongs to the educators, diagnosticians and communicators who help people grow and appreciate wellness and who do not compromise their integrity or lose sight of their intuitive ethics. These professionals can conceivably be at home in the variety of delivery mechanisms because the search for individual excellence only can be regulated by self, and quality care is always in the hands and heart of the person delivering the treatment. I firmly believe, however, that the most fulfilling rewards will be found in those practices that treat humans according to their expertly diagnosed needs and genuinely relish the opportunity to do so and that have time to take the time such enrichment requires.

For those desiring this preferred future, the Pankey Institute's mission "To be an entity devoted to bridging the gulf between what is known and what is practiced," takes on great meaning. We are guiding our participants on this path with the principles of the Pankey philosophy. It is a timeless philosophy that directs dental professionals to know themselves, understand and appreciate the individual under their care, strive for perfection in the clinical areas, and then apply their wisdom in the appropriate manner. The thousands who have adhered to this philosophy are experiencing spiritual and material reward and are the captains of their fate.

In closing, I believe that this passage from Dr. Fritjof Capra's monumental work, The Turning Point, speaks appropriately to the preferred future.

The main purpose of the first encounter between patient and general practitioner, apart from emergency measures, will be to educate the patient about the nature and meaning of the illness, and about the possibilities of changing the patterns in the patient's life that have led to it. This, in fact, is the original role of the doctor, which comes from the Latin docere ("to teach").

Footnotes

1. Dossey, 1982:83-84.

2. ADA News, Oct 1985.

3. Frederick et al., 1986: 73.

4. Starr, 1982: 427.

5. Albrecht and Zemke, 1985:187.

6. Ibid:188.

7. J of Am Dent Assoc. Chicago: ADA. October 1984. 109:621.

8. Frederick et al., 1986:77.

9. Starr, 1982: 449.

10. Albrecht and Zemke, 1985: 85.

11. Ibid:174.

12. Reed, 1986.

13. Capra, 1982: 132.

References

1. Albrecht K, Zemke R. Service America! 1985. Homewood, IL. Dow Jones-Irwin.

2. Bloom P N. "Effective Marketing for Professional Services." Harvard Business Review 1984. 65(5): 102-110.

3. Bolton R, Bolton DG. Social Style/Management Style 1984. New York American Management Associations.

4. Capra F, MD. The Turning Point: Science, Society and the Rising Culture.1982.New York Simon and Schuster.

5. Dossey L, MD. Space, Time and Medicine. 1982. Boulder Shambhala Publications, Inc.

6. Dugoni A. "The Future of the Dental Profession." Jour nal of Dental Education 1985. 49(12):795-798.

7. Frederick L, Gray J, Holoweiko J et al. "What Will Be Your Practice Environment?" Medical Economics 1986. 68-80.

8. Heskett J L. Managing in theService Economy 1986. Boston Harvard Business School Press.

9. Hickman CR, Silva MA. Creating Excellence 1984. New York New American Library.

10. King A. Nexus. 1986. Phoenix: The Nexus Group, Inc.

11. Naisbet J. Megatrends: Ten New Directions Transforming Our Lives 1982. New York Warner Books.

12. Peters TJ, Waterman RH. In Search of Excellence 1982. New York Harper & Rowe.

13. Reed O. Teethtalk. 1986. Phoenix: Napili, Ltd.

14. Sorenson CM. "Bringing The Best of the Behavioral Sciences Dialogue With the Health Professions." Premier 1986. 11(3):1-4.

15. Starr P. The Social Transformation of American Medicine 1982. New York Basic Books, Inc.

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