

Oral Health and the Economy:

Overview of Key Global Initiatives

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RESEARCH ARTICLE

Consolidation in the dental industry: a closer look at dental payers and providers

Kamyar Nasheh¹ · John R. Bowblitz² · Marko Vojcic³ · Sean Shengshu Huang²

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Abstract We examine practices, their size, and how they have become more dominant in the dental market from the United States. We find that the size of the market is becoming more concentrated, with a few large commercial dental practices becoming dominant.

Keywords D · JEL Classification · Introduction

Traditionally, dental practices have been small, family-owned businesses. However, in recent years, there has been a trend towards consolidation in the dental industry, with larger, more commercial practices becoming dominant.

Our research shows that the dental market is becoming more concentrated, with a few large commercial dental practices becoming dominant. This is due to a variety of factors, including the growth of managed care, the rise of dental service organizations, and the consolidation of dental practices.

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ORAL HEALTH COST & USE

By Marko Vojcic, Thomas Buchwalter, and Rachel Klein

Dental Care Presents The Highest Level Of Financial Barriers, Compared To Other Types Of Health Care Services

HPI Health Policy Institute
ADA American Dental Association

Research Brief

Practice Setting Transitions and Career Satisfaction Among New Dentists

Authors: Marko Vojcic, Ph.D., Rebecca Stenberg, Ph.D., Brittany Harrison, M.A., Kamyar Nasheh, Ph.D., Adriana Meneses, B.S.

Key Messages

- When examining practice setting transitions, we find that new dentists are most likely to remain within the same setting over a five-year period. This is true for both practice size and dental support organization (DSO) affiliation. The two aspects of practice setting we focus on in our findings are those transitions to solo, free or most often "owned," meaning dentists move from larger practices to smaller ones. However, over a five-year period, only 10 to 15 percent of new dentists transition into solo practice.
- In terms of career satisfaction, our analysis suggests that, overall, new dentists have a preference for affiliated private practice, meaning they are not yet or affiliated with a multi-site group practice or a DSO. At the same time, our research indicates there are price and cost associated with different practice settings, and new dentists might be sorting into different settings based on how they value various aspects of the practice environment.
- Educational debt levels do not vary across practice settings for new dentists, suggesting debt is not a major driver of career choice for dentists, at least in the early career stage.

Introduction

Health practice consolidation comes in many forms: hospital networks, accountable care organizations, provider-owned large group practices, provider-owned large group practices, single-specialty group practices, multi-specialty group practices, and so on. Many health care professions have gone through various stages of consolidation. As of 2012, half of U.S. physicians are employees while 44.5 percent are practice owners, down from 53.2 percent in 2012. Nearly 1 in 5 (17.2 percent) physicians work in a practice with 50 or more other physicians while only 14.5 percent are in solo practice, down from 18.4 percent in 2012. Corporate entities such as hospitals and private equity firms own an estimated 52.1 percent of physician practices. These trends toward practice consolidation have been steadily increasing for decades and are unlikely to slow down given large institutionalized "strabbling interest in the health care sector" and the struggle of independent practices to maintain financial viability.^{1,2}

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International Students in U.S. Dental Schools

627 INTERNATIONAL DENTAL SCHOOL GRADUATES WERE ADMITTED WITH ADVANCED STANDING IN 2015-16, 62% OF U.S. DENTAL SCHOOLS (47 of 66) OFFERED ADVANCED STANDING

SECOND YEAR THIRD YEAR

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Dentist Earnings and Business in the U.S.

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AVERAGE ANNUAL NET INCOME, DENTISTS IN PRIVATE PRACTICE

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Dental Hygiene Education Program Characteristics

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USING DATA FROM THE 2013-14 SURVEY OF DENTAL HYGIENE EDUCATION PROGRAMS, WE EXAMINED PROGRAM CHARACTERISTICS BY TYPE OF Sponsoring Institution. The following types of programs are compared in this infographic, three of which are public: three at a university, technical college or institute, or community college, and two of which are private (non-profit and for-profit college and university).

AVERAGE FIRST-YEAR CAPACITY AT PUBLIC COLLEGE AND TECHNICAL COLLEGE WAS ABOUT HALF THAT OF PRIVATE FOR-PROFIT AND FOR-PROFIT COLLEGE AND UNIVERSITY.

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STUDENT-TO-FACULTY RATIO WAS NEARLY IDENTICAL FOR THREE TYPES OF PROGRAMS, HIGHER AT PRIVATE FOR-PROFIT PROGRAMS, AND LOWEST AT PRIVATE COLLEGE AND UNIVERSITY.

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THE AVERAGE TOTAL COST (tuition and fees, plus related costs like textbooks, uniforms, and lab fees) is two to four times as much at programs located at private schools than public technical or community colleges.

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TOTAL PROGRAM LENGTH (in weeks) WAS SLIGHTLY LONGER AT PRIVATE SCHOOLS THAN AT PUBLIC INSTITUTIONS.

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RESEARCH ARTICLE

Health Economics WILEY

How do dental practices respond to changes in scope of practice regulations?

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Commentary

Guest Editorial

Our dental care system is stuck

And here is what to do about it

Marko Vojcic, PhD

Health Economics

WILEY

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ORAL HEALTH

By Kamyar Nasheh, Anthony T. Ledano, and Marko Vojcic

Percentage Of Dentists And Dental Practices Affiliated With Private Equity Nearly Doubled, 2015-21

ABSTRACT Over the course of the past twenty years, private equity (PE) has played a role in acquiring medical practices, hospitals, and nursing homes. More recently, PE has taken a greater interest in acquiring dental practices, but few data exist about the scope of PE activity within dentistry. We analyzed dentist provider data for the period 2015-21 to examine trends in PE acquisition of dental practices. The percentage of dentists affiliated with PE increased from 6.6 percent in 2015 to 12.8 percent in 2021. During this period, PE affiliation increased particularly among larger dental practices and among dental specialists such as endodontists, oral surgeons, and pediatric dentists. PE-affiliated dental practices were more likely to participate in Medicaid than practices not affiliated with PE. Future research should investigate whether PE's role in dentistry affects the affordability and quality of dental services.

Private equity (PE) activity in health care has increased markedly during the past several decades.^{1,2} PE firms have acquired hospitals, medical specialty practices,³ ambulatory surgical centers,⁴ and nursing homes.⁵ Health care providers and organizations have looked to PE firms to provide investment capital and operational expertise to enhance profitability of institutions and to reduce costs. However, some have raised concerns that PE's profit motive can harm the quality of health care and cause upward pressure on prices, shifting health care access for vulnerable populations. Several studies have shown that PE activity within several health care sectors, including hospitals, has been linked to higher prices for patients without affecting quality of care.⁶⁻⁸ One study found that PE deals in dentistry resulted in increased free 2011 to 2019, particularly among non-Medicaid surgery practices. During this period, PE-affiliated dental practices accounted for about 8.4 billion of the dental provider market is highly fragmented,⁹ which makes it an attractive acquire-

882 HEALTH AFFAIRS / AUGUST 2024 / 43(8)

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Most dental offices' patient volume nearing normal, data suggests

The latest polling from American Dental Association's Health Policy Institute suggests over 60% of dental offices are running business as usual



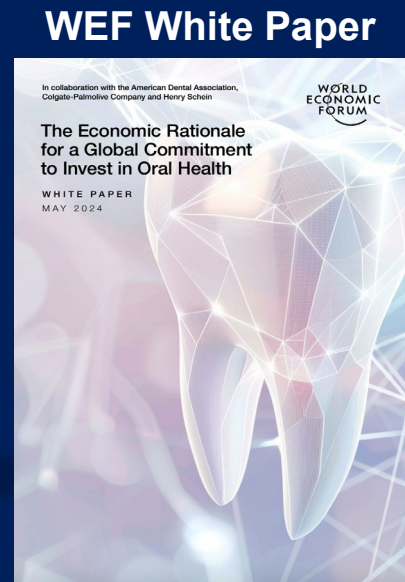
THE WALL STREET JOURNAL. Millions of Americans Are Skipping the Dentist. Lenders See a Financing Niche.



Why you don't need dental insurance to go to the dentist



Global Strategy and Action Plan on Oral Health 2023-2030



Global Strategy and Action Plan on Oral Health 2023-2030



One Vision

Universal Health Coverage for oral health
for all individuals and communities by 2030



11 global oral health targets, 6 Strategic
Objectives and 100 actions

for Member States, the WHO Secretariat,
international partners, civil society organizations
and the private sector



World Economic Forum Oral Health Affinity Group



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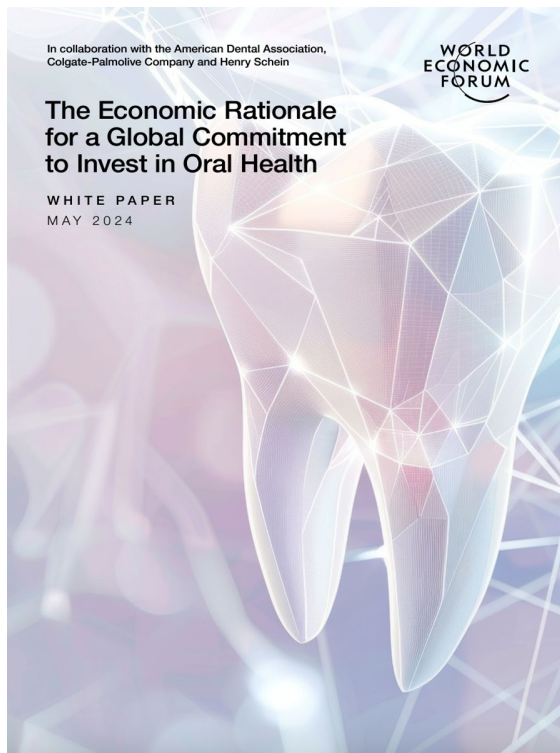


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Key Messages

3 Oral health is a key driver of economic well-being

Oral Health and Economic Well-being



“The appearance of my mouth and teeth affects my ability to interview for a job.”



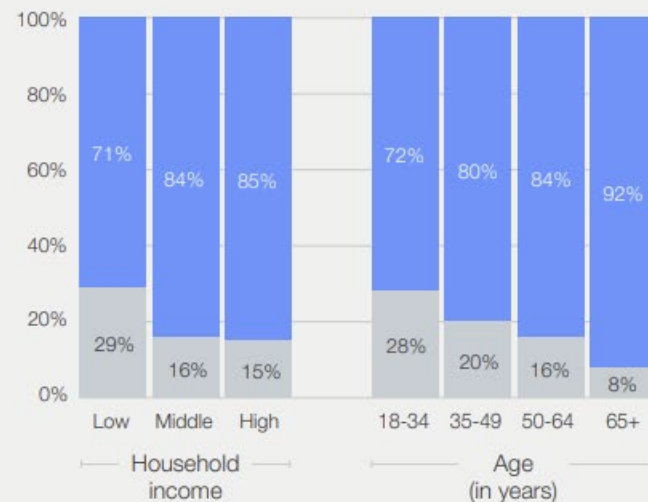
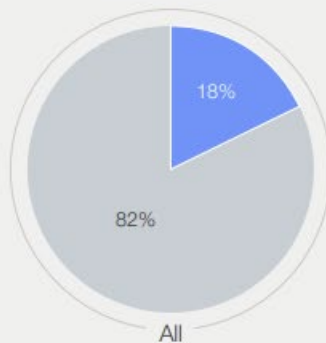
29%
low-income
adults



28%
young
adults

Appearance of mouth and teeth affects
ability to interview for a job

● Yes ● No



Oral Health and Economic Well-being

BOX 3

Poor oral health contributes to impoverishment in low- and middle-income countries

Oral health services are costly and beyond most people's means in low- and middle-income countries. Using World Health Survey data from households in 40 low- and middle-income countries (LMICs), researchers analysed the impact of out-of-pocket spending on oral health on household finances. Households with recent out-of-pocket spending were more likely to have used a large portion of their disposable household income and, as a result, fall below the poverty line.³⁸

Policy-makers should explore healthcare financing modalities that provide adequate financial protection for oral health-related spending. As most oral diseases are preventable, an investment in preventive strategies, coupled with healthcare financing modalities that provide adequate financial protection for oral health-related spending, could significantly lessen the financial burden of oral diseases in LMICs.

6

The cost of oral disease to the global economy is substantial

The Economic Cost of Poor Oral Health

Productivity losses due to poor oral health cost the global economy

\$323 billion

each year. This is close to the productivity losses from the top 10 diseases accounting for all deaths worldwide.

| | Treatment costs | | Productivity losses | |
|--|----------------------------|------------|----------------------------|------------|
| | Total (billion dollars) | Per capita | Total (billion dollars) | Per capita |
| African region | 3.10 | 2.84 | 4.58 | 4.19 |
| Eastern Mediterranean region | 6.97 | 9.78 | 9.59 | 13.47 |
| European region | 112.51 | 120.96 | 104.48 | 112.32 |
| Region of the Americas | 156.76 | 155.21 | 105.57 | 104.53 |
| South-east Asian region | 0.76 | 0.38 | 13.35 | 6.67 |
| Western Pacific region | 107.00 | 54.74 | 85.12 | 43.55 |
| World Bank low-income countries | 0.36 | 0.52 | 1.04 | 1.49 |
| World Bank lower-middle-income countries | 2.27 | 0.72 | 19.00 | 6.05 |
| World Bank upper-middle-income countries | 80.76 | 29.99 | 86.88 | 32.26 |
| World Bank high-income countries | 303.70 | 259.96 | 215.76 | 184.69 |

Source: Heidelberg Open Research Data (heiDATA), 2022.⁵⁴

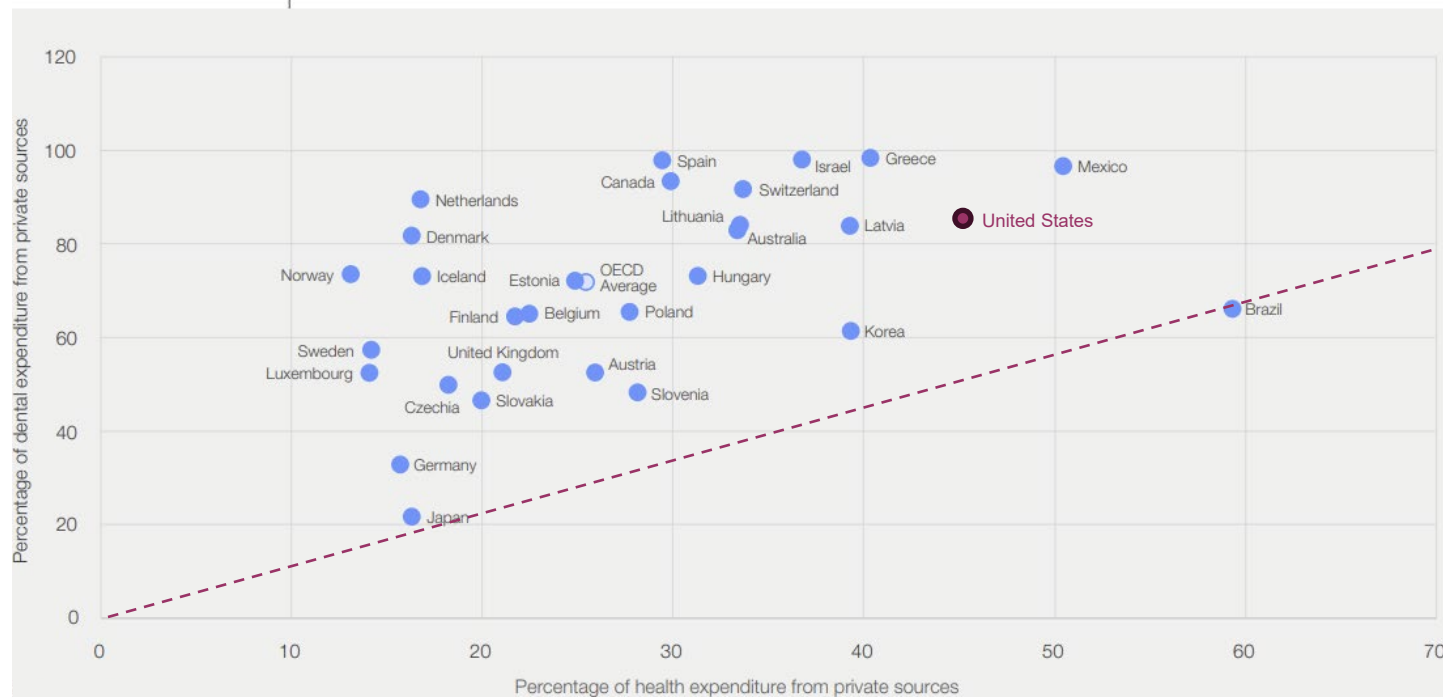
Estimates of the global economic cost of dental diseases, 2019

- 7 **The high level of unmet oral healthcare needs is rooted in health policy choices**

Oral Health Care Financed Very Differently

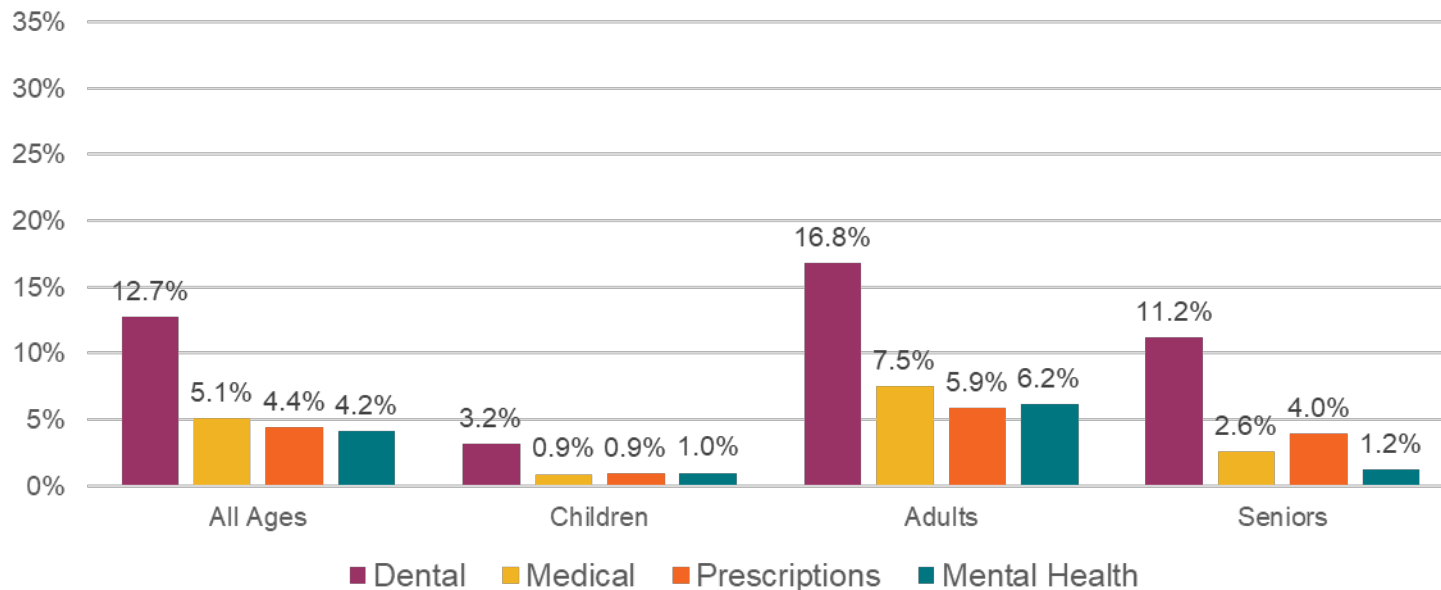
FIGURE 7 | Share of health and dental expenditure from private sources

The mouth has largely been separated from the body when it comes to how people pay for healthcare services. This traditional policy approach is at the core of why financial barriers to dental care are much higher than for other types of healthcare services.



Why Don't More People Visit the Dentist?

Percentage Reporting Unmet Health Care Needs During the Past 12 Months Due to Cost, by Health Care Service, 2022, United States



In the U.S., for all ages, dental care services stand out as being most unaffordable.

Economic Impact of Dental Offices



For detailed methodology and analysis of economic impact for each state visit [ADA.org/economicimpact](https://ada.org/economicimpact)

For more information, visit ADA.org/HPI or contact the Health Policy Institute at hpi@ada.org.

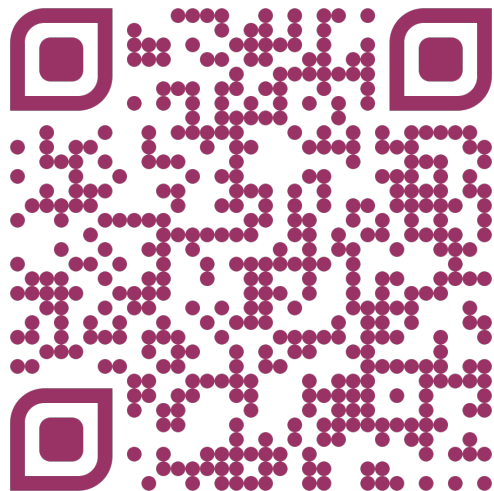
Economic Impact of Dental Offices

Total Economic Impact and Total Number of Jobs Supported by Offices of Dentists, 2022
[Return to Table of Contents](#)

| | Jobs in Offices of Dentists | Other Jobs Supported by Offices of Dentists | Total Jobs Supported By Offices of Dentists | Direct Dental Spending (\$ Millions) | Indirect and Induced Spending (\$ Millions) | Total Economic Impact of Offices of Dentists (\$ Millions) | Total Economic Impact per Dentist (\$ Millions) |
|-----------------------------|--------------------------------|--|--|--|--|---|--|
| United States | 1,010,040 | 1,443,347 | 2,453,387 | 165,276 | 312,524 | 477,800 | 2.36 |
| Alabama | 12,631 | 18,050 | 30,681 | 1,786 | 3,377 | 5,163 | 2.47 |
| Alaska | 2,432 | 3,475 | 5,907 | 508 | 960 | 1,468 | 2.49 |
| Arizona | 21,429 | 30,622 | 52,051 | 3,474 | 6,569 | 10,043 | 2.32 |
| Arkansas | 7,779 | 11,116 | 18,895 | 1,173 | 2,219 | 3,392 | 2.65 |
| California | 136,998 | 195,770 | 332,768 | 23,963 | 45,312 | 69,275 | 2.25 |
| Colorado | 20,675 | 29,545 | 50,220 | 3,569 | 6,748 | 10,317 | 2.59 |
| Connecticut | 11,880 | 16,977 | 28,857 | 2,240 | 4,235 | 6,474 | 2.49 |
| Delaware | 2,823 | 4,034 | 6,857 | 498 | 943 | 1,441 | 3.11 |
| District of Columbia | 1,664 | 2,378 | 4,042 | 413 | 781 | 1,194 | 1.59 |
| Florida | 66,025 | 94,350 | 160,375 | 9,856 | 18,636 | 28,492 | 2.37 |
| Georgia | 30,028 | 42,910 | 72,938 | 4,681 | 8,851 | 13,532 | 2.63 |
| Hawaii | 4,599 | 6,572 | 11,171 | 678 | 1,283 | 1,961 | 1.73 |
| Idaho | 7,286 | 10,412 | 17,698 | 1,007 | 1,905 | 2,912 | 2.80 |

ADA.org/economicimpact

Thank You!



[ADA.org/HPI](https://ada.org/HPI)

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