

Maximizing Community Voices to Address Health Inequities: How the Law Hinders and Helps

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A community's ability to develop public health policy solutions tailored for its needs and priorities is an essential part of achieving health equity.¹ Policies to address health inequities are more likely to succeed when they come from and are supported by the communities they are meant to serve. Authentic community engagement supports the development of laws tailored to meet specific community needs that carry legitimacy and will be sustainable over time. It also can foster innovative policy-making. Thus, an important goal of law should be to maximize community voices, and especially the voices of socially disadvantaged and marginalized groups, in public health solutions.

Unfortunately, the priorities of powerful interest groups such as Big Tobacco, Oil, Food, and even health-related trade organizations like the American Dental Association (ADA), often conflict with health equity and community goals. These industries also understand the power of community self-determination, and as a result, often push for preemption of state and/or local authority.² Preemption is a legal doctrine whereby governmental authority to regulate or act is limited or eliminated by another, typically broader, governmental authority.³ Specifically, federal law can preempt state and local laws, and state law can preempt local laws. The application of preemption must be assessed through an equity lens. If it helps to pro-

mote health equity and support socially disadvantaged groups, it may be a positive force, as with federal civil rights laws. But when it is used to hinder community efforts to improve the health of socially disadvantaged and marginalized groups, as is all too often the case, it perpetuates health inequities and should be challenged. We present two examples of this phenomenon, one related to federal law and tribal governments, and one related to state and local law.

The American Dental Association Acts to Perpetuate Oral Health Inequities in Indian Country

Many dentists are working hard to address oral health inequities, including volunteering to serve underserved populations. The ADA also provides strong oral health education resources. Volunteer dentistry and oral health education are not enough to reverse oral health disparities in underserved communities, however. These communities need and want access to consistent, affordable, and restorative dental care.

Due to a confluence of factors, including attempted genocide, displacement, racism, and poverty, American Indian/Alaska Native (AI/AN) communities experience some of the worst health and oral health disparities in the U.S. AI/AN children ages 2 to 5 suffer from tooth decay at nearly three times the U.S. average rate,⁴ and more than 40% of AI/AN children ages 3-5 have untreated tooth decay compared to 14% in the general population.⁵ AI/AN adults experience twice the prevalence of untreated caries compared to the general population and more than any other racial or ethnic group.⁶ AI/AN adults are also more likely to have missing teeth and to report poor oral health, pain, and food avoidance because of oral problems.⁷

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Tribal nations are actively seeking innovative solutions to reverse these severe disparities.

Alaska Natives and other Tribes are showing that adding dental therapists to dental teams is an effective approach. Dental therapists (or Dental Health Aid Therapists — DHATs) are primary oral healthcare professionals trained to provide a limited number of clinical dental procedures and preventive services such as simple extractions and fillings, diagnosis and treatment planning, and infection control, with off-site dentist supervision. This model is used in many countries and has proven to be a successful, community-based approach for improving access to oral healthcare for underserved communities, particularly in remote areas.⁸ In the U.S, the Alaska Native Tribal Health Consortium (ANTHC) pioneered use of dental therapists as part of the Alaska Community Health Aid Program (CHAP) established by the Indian Health Care Improvement Act (IHCIA).⁹ IHCIA establishes a framework with training requirements and standards to support the development of Native healthcare workers and paraprofessionals. ANTHC sent eight students to New Zealand to complete the dental therapy training program, certifying the first Native dental therapists in 2005.

Organized dentistry has actively opposed these safe, accessible, high-quality providers, out of what appears to be misguided economic self-interest and sense of privilege, at the expense of crushing health inequities. In early 2005, the Alaska Board of Dental Examiners urged Alaska to take action against these DHATs for practicing dentistry without licenses. Instead, the Alaska Attorney General issued a memorandum concluding that Alaska's dental licensing laws were preempted by federal law with respect to these DHATs. The memo reasoned that if state licensing laws applied to Native dental therapists trained according to CHAP, this would obstruct Congress's express objective to create a program for dental treatment by and for Alaska Natives using non-dentist, non-hygienist paraprofessionals who meet federal requirements.¹⁰ So in this situation, federal preemption was an important tool for protecting a community-based, health equity focused strategy from being stifled by a powerful industry group under the guise of state law.

Undeterred, in January 2006, the Alaska Dental Society and ADA sued the ANTHC and the state.¹¹ While the lawsuit was pending, the dental society president stated on a dentist listserv that lack of personal responsibility caused Native oral health disparities and that "[a]ny culture that allows such disease will soon disappear and rightfully so."¹² This statement reflected organized dentistry's lack of understanding

of barriers to care and how racist viewpoints can often enter policy discussions and block access to care.

In 2007, the Alaska Supreme Court ruled that state law did not apply to Alaska Native DHATs, using the same reasoning applied by the Alaska Attorney General's office.¹³ The court explained that Congress intended to create an independent statutory framework for providing healthcare to Alaska Natives, and this purpose would be defeated if a system that has failed to serve the dental healthcare needs of Alaska Natives were allowed to oversee and regulate the DHATs.¹⁴

The ADA then took its complaint to Congress when the IHCIA was up for permanent reauthorization in 2010, and the CHAP, tested in Alaska, was to be nationalized to serve Tribes in other parts of the U.S. Citing unproven and debunked concerns about patient safety and with blatant disregard for health equity, the ADA lobbied to include language to prohibit DHATs from being included in a national CHAP. The final IHCIA language did not completely exclude DHATs from a national CHAP as the ADA pushed for, but does purport to restrict DHATs in tribal programs unless midlevel dental providers are authorized by state law.¹⁵ This condition of state authorization of DHATs violates tribal sovereignty and contradicts the sovereign principle, as explicitly acknowledged by the IHCIA, that Tribes have the inherent right to promote the health and welfare of their peoples. The significance of this action must be viewed in the larger context of federal-tribal relations: Tribes as sovereign nations have a government-to-government relationship with the U.S. and states do not have jurisdiction over Tribes except as delegated by Congress or determined by federal courts.¹⁶ By purporting to make the availability of tribal DHATs under the federal CHAP contingent on state law (an action akin to preemption), this IHCIA provision inappropriately inserted states into the government-to-government relationship between Tribes and the federal government.

Undaunted by the ADA, Swinomish Indian Tribal Community (Swinomish) has decided to challenge the notion that sovereign tribal nations need permission from a state to utilize proven and effective providers to address the health and welfare needs of their peoples, and has created its own legal framework outside of the state system to license DHATs. This decision did not come lightly. Swinomish worked for six years with a statewide coalition of oral health advocates to try to pass statewide dental therapy legislation in Washington State to satisfy this new IHCIA language and clear the way for DHATs and other mid-level providers, a change that would have benefitted many people in the state, not just tribal members.

Due to strong lobbying by the Washington State Dental Association, state legislators have refused to pass such legislation in Washington, continuing to leave many without access to oral health care. Swinomish decided to move forward to meet its community's needs and implemented a plan to license and employ DHATs at Swinomish. In 2015 the Swinomish Senate passed the Swinomish Dental Practice Act, creating a tribal licensing scheme for DHATs.¹⁷ The scope

at least the duration of the project, allowing time for the Tribes to consider the best next steps to pursue.

Meanwhile, the ADA is pushing its own effort, and heavily promotes the Community Dental Health Coordinator role. This role has a much narrower scope of practice compared to DHATs (for example, coordinators cannot diagnose or do restorative procedures), and thus is not considered to be an adequate substitute or equivalent for Tribal DHATs.

It is resource intensive to create an entire legal structure and a department within the tribal government to license DHATs. While some Tribes have the means to utilize their sovereignty to do this, many do not, and the Tribes with the most need do not have the extra resources to spare. The ADA's effort to hinder the federal IHCIA option means that Tribes with the most staggering oral health needs are more likely to be unable to access DHATs, despite their proven effectiveness.

of practice, education, and supervision requirements are identical to federal requirements, and Swinomish added a cultural competency requirement. Unfortunately, residents lacking access to oral healthcare in the rest of the state will have to wait for the state legislature to act.

DHAT services became available at the Swinomish dental clinic in January 2016 and care wait times have decreased. Most importantly to the Tribe, because its dental provider team now includes DHATs, all providers are able to focus their skills and expertise more efficiently — to work to the top of their licenses. This means that DHATs are providing basic and routine preventive and restorative procedures, so that the Tribe's dentists have time to focus on more advanced, surgical procedures, and on serving aging tribal members who have complex and challenging oral healthcare needs as a consequence of growing up with poor oral healthcare due to itinerant dental care.

In Oregon, the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians (CTCLUSI) and the Coquille Indian Tribe, in collaboration with the Northwest Portland Area Indian Health Board, are taking a slightly different approach. These groups worked with the state to create a pilot project to train DHATs for employment by the tribal health program.¹⁸ Each Tribe sent two students to Alaska to train. The first student returns in the summer of 2017. This state-supported project will allow tribal DHATs to work in Oregon for

In the early work to bring DHATs to tribal communities, Native Alaskans were helped by federal preemption because it protected their program from the ADA's efforts to use state law to stymie the DHAT program. The ADA then used its lobbying muscle to undermine that protection for Tribes in the rest of the U.S. by subjecting the availability of DHATs to state law. By inserting states into the federal-tribal government-to-government relationship, the ADA has made it more challenging for Tribes to expand their dental teams and bring DHATs to their programs. It is resource intensive to create an entire legal structure and a department within the tribal government to license DHATs. While some Tribes have the means to utilize their sovereignty to do this, many do not, and the Tribes with the most need do not have the extra resources to spare. The ADA's effort to hinder the federal IHCIA option means that Tribes with the most staggering oral health needs are more likely to be unable to access DHATs, despite their proven effectiveness.

The Restaurant Association Perpetuates Food-Based Health Inequities across States

In March 2011, Cleveland launched a Healthy Cleveland initiative to promote “healthy neighborhoods and residents who enjoy longer and healthier lives and... combat[] chronic disease[s]... like chronic pulmonary disease, heart disease, diabetes, [and] obesity...”¹⁹ Right away, the city council passed a law prohibiting

artificial trans fat in restaurant foods.²⁰ Cleveland, with a majority African American population, wrestles with health inequities — specifically, health inequities based on racial and socioeconomic factors — many of which are related to diet. Numerous residents are food insecure, with many poor neighborhoods lacking full service grocery stores. At the same time, fast food is easily available, making up over half of restaurants in the area.²¹ Cleveland residents have higher rates of diabetes, hypertension, and obesity compared to Ohio and the nation, with predominantly African American neighborhoods having significantly higher prevalence.²²

The Ohio Restaurant Association quickly reacted to Cleveland's effort to address health inequities by proposing a state law, tucked inside a 5,000 page appropriations bill, to prohibit cities from regulating restaurants “based on...food-based health disparities” (among other things).²³ After the law was passed, the American Legislative Exchange Council (ALEC) adopted the Ohio language as a model bill, even including the typos.²⁴

ALEC is a self-proclaimed “right-of-center” group that connects business groups with state legislators to create model laws, many of which are about preempting local authority. ALEC is highly effective, based on its claim that its membership “surpassed all Democratic legislators in passing legislation by a two-to-one ratio.”²⁵ Mississippi lawmakers passed an expanded version of the Ohio/ALEC bill in 2013, followed by Kansas in 2016.²⁶ In both states, supporters touted the law as an “anti-Bloomberg” measure protecting extra-large sodas. It is unclear to what extent legislators understood the phrase “health disparities.” Ironically, Mississippi and Kansas are in the top ten for obesity rates.²⁷

Food-based health disparities are intimately linked with inequity and systemic barriers such as structural racism.²⁸ While every level and type of government has a role in addressing this problem, local governments are especially important. That is part of what makes this ALEC preemption bill particularly invidious — food-based health disparities are inherently local, depending on the type of food outlets available; whether the area is urban or rural; and on the specific community demographics (elderly, low income, etc.). These disparities require solutions tailored for local circumstances, the very thing the “model” forbids. Local governments are best positioned to understand community needs. Community members who will be impacted can have direct input into shaping solutions. Another invidious aspect of the ALEC bill is that it creates a void—the states that have passed the law have failed to offer policy solutions as an alternative

to local action. But even if these states offered such solutions, there is no compelling justification for prohibiting local governments from going beyond state requirements as needed to address inherently local health disparities. Laws that completely preempt local authority to address food-based health disparities not only stifle community voices, but also perpetuate systemic barriers to health equity.

Similar to the Swinomish, Cleveland chose to fight back. The city sued the state, alleging the law violated the Ohio constitution's home rule provision and single subject requirement that state bills address one subject. Cleveland won the case, invalidating the law.²⁹ As a side note (but one that was relevant to the home rule argument), the litigation uncovered an email between the state restaurant association and Ohio's agriculture department revealing that the association drafted the law specifically to protect fast food restaurants from Cleveland's law, despite clear evidence about artificial trans fat's health harms and Cleveland's health disparities.

For Mississippi and Kansas, this preemption law remains unchallenged (so far). According to advocates, it has caused uncertainty and slowed some efforts but not stopped them. For Kansas communities in particular, with its strong home rule tradition and emerging food and farm council movement, Cleveland provides inspiration and a road map for action.

Conclusion

Community self-determination is a powerful force for positive change and improving health equity. Innovative community policy efforts can change the conversation about how to promote social good and move closer to health equity — so that everyone can eat food that is free of harmful trans fat, or have easy access to affordable, quality primary dental care. When strategies such as preemption are used to limit community self-determination and stifle community voices, they must be fought if we are to make progress in promoting equity.

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