

Foreword

Dental access is a multifaceted problem and this issue of *Dental Clinics of North America* is equally multifaceted. Its contributors consider a wide range of issues: from ethical conundrums to logistic considerations, from private financing to national health policy, to informatics technology, and to workforce dynamics. Dr. Gary Colangelo, the Guest Editor for this issue, has approached the topic with a net as wide as the questions involved, engaging contributors who represent an equally wide range of philosophical and pragmatic perspectives.

Therefore, before launching into this text, it may be particularly helpful to gain an orientation to the problem of dental access. Stepping back to gain perspective before, and recurrently, during your reading of this text may help you identify the “take home” messages that will help define your personal response to the “access problem.”

Since at least the late 1990s, access to healthcare, including oral healthcare, has been approached by government, the press, the healing professions, and advocates as a “disparities issue.” The goal of much healthcare policy, whether public or private, local or national, has been to attain “health equity.” Yet this approach is inherently curious as all of us recognize and typically accept the plethora of other social disparities daily: disparities in access to sound housing, effective transportation, fresh and nutritious foods, quality education, and safe streets. Unlike concerns for healthcare disparities, these other important social disparities are less commonly approached as issues of equity. Rather, they are typically addressed more from the perspective of assuring “basic” services. Judging from observations about our attitudes, actions, and public policies, our social compact appears to call for the guarantee of minimal, basic, humane levels of social services that are decent, if not equitable. Social Security, fair housing laws, building codes, mandatory public education, COBRA insurance continuation, the Food Stamp Program, Medicaid and Medicare, the Federal Deposit Insurance Corporation, and many other public programs all seek to ensure that everyone has access to basic social assurances. None of these typically American programs, however, calls for equity.

Yet healthcare is regarded differently, treated as an equity issue as though fairness in healthcare was of a different quality or magnitude than fairness in other social needs. This distinction is compounded by the growing understanding that health status is more significantly influenced by social determinants than by healthcare, making housing, education, safety, and nutrition issues more important than healthcare in achieving and maintaining health. One key question for the reader of this issue to keep in mind is the “what question”: what is the goal of addressing dental access?

If the answer is minimal basic levels that are decent, if not equitable, the answer may lie in universal access to core services that at least relieve pain and infection. Current public policy, however, does not support even this level of response, because Medicare provides no coverage for treatment of dental conditions, and Medicaid leaves it to each state to determine whether even emergency oral health services are available to adults. Until the Children’s Health Insurance Program was amended in February 2009, not even children were assured of dental services as an essential component of basic healthcare coverage.

If the answer is that all should have access to more sophisticated dental services, for example, access to services that restore people to oral function or reasonable aesthetics, then the access problem and challenges to its solution are considerably more demanding. Thus, a second question to keep in mind as you consider the contributions to this issue is “Access to what oral healthcare?”

Even as healthcare equity is debated, the question of personal versus public responsibility comes into play, particularly with regard to those made vulnerable by very young or very old age, by complicating health conditions (including both defects of birth and acquired diseases), and by our nation’s racial and ethnic cultural diversity. Our collective legacy and continued attribute as a nation of immigrants further complicates this question of responsibility. The next question to keep in mind is “Whose problem is it?” Are differentials in access to oral healthcare a problem of government, the professions, parents, individuals, or all of the above?

Assuming that the answer is “all of the above,” who has responsibility for which aspect? Is it essential that government provide, at a minimum, oral healthcare coverage for all and that the professions then deal with how to translate that coverage into care? Or is assurance of access to care a shared social responsibility, therefore attributable to government, and it is then the responsibility of individuals to use that care? These questions beg additional contextual questions. For example, are professional responses to access like Donated Dental Services, Missions of Mercy, Remote Access Medical, local voluntary efforts, and Give Kids a Smile exemplary displays of professional responsibility or insufficient patches to a failed system of care?

Policymakers speak of the “iron triangle,” which details the seemingly irrefutable tradeoffs between cost, quality, and quantity of healthcare services. If we ensure that more people have access to care, it will either result in higher costs or will come at the cost of quality. Controlling costs must be offset either by providing fewer services or reducing quality of care. Raising quality can be offset either by spending more or providing care to fewer people. Already, healthcare costs are the single greatest expenditure in state budgets, with only public education competing for first place. In the larger context, US healthcare expenditures, of which oral healthcare comprises only one-twentieth, are the highest per capita and largest as a percentage of gross domestic product among developed countries, but our health outcomes are lower on almost every measure.

In working our way out of this triangle, some people call for massive deflation of our collective healthcare budget by emulating other countries’ far lower payments to everyone involved in delivering services or by instituting more efficient administrative systems, like a single payer approach. Some people call for massive increases in spending to solve the access problem by using the approaches now in place to extend care to more people. Other people look to health information technology to reduce healthcare costs significantly by promoting best practices that deliver the most favorable outcomes at the lowest costs as defined by comparative health services research. Volunteerism is championed by others who see the best solution to access disparities in the professional compact and ethical charge to oral healthcare providers. Some people advocate building a safety net (our constellation of Federally Qualified Health Centers and community and school-based dental clinics) but others criticize it as “two-tiered healthcare.” Rationing of some sort, whether explicit or implicit (as is now effectively the case with the lowest 20% of US population [per income] receiving the benefits of only 5% of dental expenditures) is intrinsic to the access issue, yet anathema to many and rarely discussed openly. Others look to competitive enterprise and to American private sector capitalism to solve the problems of access to oral healthcare. Indeed, Medicaid-only privately owned clinics for children have

stepped into the access breach, taking risk, seeking reward, and in turn generating controversy among mainstream providers and the public. A completely alternative approach is to focus intensely on health promotion and disease prevention. Advocates for this approach note that dental services are overwhelmingly surgical and reparative, and they focus little on bona fide disease management techniques that include anticipatory guidance, primary prevention, and pharmaco-behavioral therapies for disease suppression. Each competing approach raises questions about resource allocation, personal and professional responsibility, roles for government and public policies, and even personal and shared values.

Questions as challenging as these lead inevitably to the “so what” question. Why does access to oral healthcare matter at either the individual or collective level? At last, this question has a clear answer and may serve as the basis for best understanding the contributions to this issue. Poor oral health and the failure to attend to acute treatment needs is consequential to individuals and to society, because it creates eating, speaking, and sleeping dysfunctions, lost productivity, impaired attentiveness to learning, and even lesser military readiness. From this observation, all must conclude that the question of access to oral healthcare services is important, timely, urgent, and worthy of your thoughtful consideration.

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