A Professional Imperative: Caring for the Oral Health of America's Children

A PROFESSIONAL IMPERATIVE

There are a number of imperatives for learned professions. However, the ultimate imperative was advanced by Abraham Flexner, the father of modern American medical education, when he said, "professions are organs contrived for the achievement of social ends rather than as bodies formed to stand together for the assertion of rights or for the protection and interests and privileges of their members. The "social end" currently at issue is ensuring that all children have access to oral health care.

The imperative advanced above is one of the six characteristics Flexner explicated, which subsequently contributed to the twentieth century understanding as to what constitutes a profession. Sociologically, a profession is a profit; that is, it is to profess—meaning to vow or promise. Thus, learned professions and professionals are understood to have promised society they will use their learning and expertise to advance societal well-being. Our profession has been granted a virtual monopoly by society to practice dentistry as a result of our vow to make the oral health of our patients and of society our primary purpose. Consequently, dentistry exists with a moral imperative—doing good. Caring for the oral health of all Americans is dentistry's professional calling. However, this responsibility is particularly crucial in the context of caring for our nation's children.

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THE MORAL PRIORITY OF CHILDREN

Philosophers Kopleman and Palumbo have published a thoughtful and compelling paper entitled "The U.S. Health Delivery System: Inefficient and Unfair to Children." The paper explores the four major ethical theories of distributive or social justice: utilitarianism, egalitarianism, libertarianism, and contractarianism. The authors conclude that no matter which theoretical stance you take, all support the perspective that children should receive priority consideration in receiving health care.

Norman Daniels, professor of bioethics and population health at the Harvard School of Public Health, argues that a just society should provide basic health care to all, but redistribute health care more favorably to children. He justifies this conclusion based on the effect health care has on equality of opportunity for children, with equality of opportunity being a fundamental requirement of justice.

The opportunity to realize one's full potential in life is markedly affected by one's childhood. What happens in the life of a child determines whether that child will have a fair opportunity to fulfill his or her unique potential. The worthiness of a society can be evaluated in terms of its concern for and care of the health of its children. President John F. Kennedy expressed it well, "Children may be the victims of fate—they must never be the victims of neglect." Today, many of our nation's children are being neglected. Disparities exist between the economically advantaged and the economically disadvantaged; and many children do not have the benefit of oral health.

PROBLEMS IN CARING FOR THE ORAL HEALTH OF AMERICA'S CHILDREN

Caring for the oral health of America's children is a multifaceted and complex problem. However, it is one for which the profession must provide leadership, in tandem with society, if our children are to grow to adulthood having experienced oral health, and with the potential for a lifetime of oral health. The current problem is documented, in part, by the following statistics:

- 80 percent of the dental disease in children is found in 20 to 25 percent of children, and these are primarily children from low-income and minority families, and there is a growing epidemic of early childhood caries.
- As a result of the expansion of the Children's Health Insurance Program (CHIP) and the Affordable Care Act, 40 million of America's 78.6 million children—the majority—are becoming eligible for public insurance.
- Fewer than 25 percent of America's dentists will treat a patient with public insurance; and of those who do treat children with public insurance, only 9.5 percent bill more than $10,000/year.

In the context of healthcare reform and the current movement to expand the dental workforce, leaders in the profession representing organized dentistry continually affirm that the problem is primarily a financial one—one that (evidently) only increased Medicaid/CHIP fees can solve. A recent past president of the American Academy of Pediatric Dentistry (AAPD)

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affirmed that “there is no access to care problem [for children] where dentists are reasonably reimbursed.” This is in contrast to the evidence that an increase in professional fees paid by public insurance only marginally improves dentists’ participation. The AAPD past president went on to say: "The United States has the best model of delivering care [to children] that exists. The chair of the American Dental Association’s Council of Government Affairs commented that ‘... the delivery system works extremely well for Americans and should be left untouched by any reform effort.’” He continued, “...the fundamental problem with access to dental care in America [is] improving funding for dental services under Medicaid.”

Dentistry is seeking a business model solution—more money in our pockets—when society clearly does not have any tolerance for devoting more money to public insurance programs. As the current budget deficit demonstrates, there is no more money. Our demand for increases in public insurance fees is in the context of us prospering economically in ways never before experienced. The average net annual income of general dentists in 2008 was $207,210 and for pediatric dentists it was $346,070. Dentists rank in the top 1–2 percent of income earners in the United States. Our professional speech and behavior seem to advocate for what is best for us as dentists, reflecting the culture of a business enterprise, rather than what is best for the oral health of children—a professional culture. While there is clearly a business dimension to managing a professional practice, professions are not primarily businesses. The late Talcott Parsons, considered the dean of modern sociology, expressed it well: “The core criterion of a full-fledged profession is that it must have means of ensuring that its competencies are put to socially responsible uses...professionals are not capitalists...and they certainly are not independent proprietors or members of proprietary groups.”

Rashi Fein, the noted Harvard health economist, expressed distress at the transformation occurring in American society. “A new language has infected the culture of health care. It is the language of the marketplace, of the tradesman, and of the cost accountant...It is a language that is dangerous.” Kenneth Arrow, emeritus professor at Stanford University, won the Nobel Prize in economics in 1972 partly due to his ability to demonstrate that health care
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cannot be considered a commodity of the marketplace. Health care, including oral health care, is not a business.

Society is simply exhausted with dentistry continuing to say, essentially, "give us more money and leave us alone." Public policy leaders and healthcare advocates are responding that the current paradigm for delivering care to children is just too expensive; particularly with the majority of children now eligible for public funding through Medicaid and the Children's Health Insurance Program (CHIP). The time has come for the profession and society to renegotiate their social contract. Society cannot pay us more money to care for our economically disadvantaged children; we dentists will accept no less. In such a quandary the profession must lead in advancing a model for an alternative delivery system that will enable our children to be cared for within the financial resources society can provide.

SCHOOL-BASED PEDIATRIC ORAL HEALTH (DENTAL) THERAPISTS

One such strategy is expanding the dental team to include a new member, a pediatric oral health (dental) therapist, an individual uniquely trained to provide basic primary care for children under the general supervision of a dentist. A recent report of the Pew Children's Dental Campaign identified eight benchmarks for evaluating states' responses to the crisis in dental health among America's disadvantaged children. Among the benchmarks was the "authorization of a new primary dental care provider." The reauthorization and expansion of the Children's Health Insurance Program called for an investigation into the use of "midlevel providers" to increase access to care for children. Congress understood the importance of oral health care for children as social policy in that the dental provisions of the healthcare reform (Affordable Care Act of 2010) focus on caring for children.

Therapists have provided basic primary care for children in New Zealand in a school-based delivery system since 1923, when the first therapists (then called school dental nurses) graduated from New Zealand's inaugural two-year training program. Since then, utilizing therapists to care for the oral health of children has spread throughout the world. Over 50 countries now count therapists as members of the dental team. New Zealand has an exemplary record of caring for its children. In a recent year, 97 percent of its children were enrolled in the School Dental Service and received their care from a therapist, and 56 percent of preschool children were seen by therapists in their neighborhood school. A 2003 report by New Zealand's Public Health Advisory Committee indicated that at the end of a typical elementary school year, essentially all schoolchildren are free of dental caries, with
carious teeth having been restored or extracted.

It is interesting to speculate on what the impact on the oral health of our children would be if elementary schools in America had a dental clinic, as in New Zealand, staffed by a dental therapist and dental assistant. While inadequate numbers of dentists willing to care for children with public insurance is a barrier to children’s receiving optimal dental care, parents are also a barrier. If children are to receive care we must remove the obstacles created by parents, for many of whom education and (understandable) life circumstances are such that the oral health of their children falls to a lower priority than desirable. As Dr. James Dunning, the dean of American public health dentistry, and at one time dean of the Harvard School of Dental Medicine, said over 40 years ago: "any large-scale incremental care plan for children, if it is to succeed, must be brought to them in their schools."

Today, school-based health programs are emerging as an important dimension of the nation’s healthcare delivery system. The establishment of school-based health centers is a significant dimension of the Affordable Care Act, which is reforming our healthcare system. The National Assembly on School-Based Health Care is the nation’s leading advocacy body for overcoming the structural barriers to children receiving health care by placing health care in schools. In comparing the costs of school-based health care in New Zealand provided by therapists, with private practice office-based models staffed by dentists in the United States, evidence suggests a public-supported school-based program in the United States staffed by therapists could result in dramatic financial savings, while also providing care for the overwhelming percentage of America’s schoolchildren, as well as a significant number of preschool children.

**THE WAY FORWARD**

Historically, the profession of dentistry has distinguished itself, and has been faithful to its calling as a profession, by strongly advocating for water fluoridation to improve oral health. The time has now arrived for the profession to advocate for a delivery system that will enable all children to have access to basic oral health care. School-based care utilizing pediatric oral health (dental) therapists is a proven, cost-effective strategy to accomplish this goal. It is a strategy that will enable dentistry to address its professional imperative.

A list of references appears in the online version of this article at http://www.nyu.edu/dental/nexus/index.html.

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