The Failure of Dentistry’s Social Contract with America and California’s Search for Legislative Solutions?

What is the future of the oral health professions in the public sphere? Will oral health professionals as well as academic oral health educational organizations continue to be just one of the many competing interest groups whose influence will continue to wane? Or do we have a unique opportunity at this time in history to assume a new position of moral leadership in American health care? Notwithstanding our self-interest stake in many health policy questions and our perennial ranking near the top of political contributors, organized dentistry (ADA, ADEA, AADR, and so many others) has become conspicuous politically by its increasing marginality among a cacophony of players in the local, state, and national political arena.

Increasingly, strong competition and debate have developed outside of the dental profession over the issues of access and quality of oral health care, long monopolized by dental organizations through their control of education, training, and credentialing of dentists. Access and quality are now seen as legitimate concerns for purchasers, managed care plans, provider organizations, politicians, and consumers and have become the subject of serious measurement and reporting efforts under a variety of auspices. Examples include “The Silent Epidemic” published in 2000 by the California Dental Foundation, Oral Health in America: A Report of the Surgeon General released in May 2000, and state-by-state Oral Health Report Cards published in 2000 by the U.S. Health Resources and Services Administration.

As readers already know, California is a work in progress. One out of every eight Americans lives in California. Just over 30 percent of the population is foreign-born; immigration and births to immigrant women account for most of the population increase. The California population in 2000 was 34.9 million with a projected growth to 50 million people by 2028 and with one-fourth of the population living in Los Angeles County. In California, more than one-third of the population does not have access to oral health care. We further appreciate that the greatest burden of oral health disparities is found among poor and historically underserved minority children and among the elderly. In California, the underserved populations are predominantly Hispanic and African-American with vulnerable Social Economic Status (SES). We also appreciate that the number of Californians without dental insurance is threefold the number of people without medical insurance.

In California and beyond, each of us realizes that quality improvement of patient care requires effective management of complex health, economic, and social systems. At the same time, we are fragmented. All too often, dentists see their specialty or ethnic societies as their primary professional representatives, and our oral health profession has continued to splinter into many diverse organizations. From my perspective, we have an urgent and significant opportunity throughout America to revise or renew our social contract with the larger society. In particular, each of us in the dental profession(s) can profoundly influence and sustain the moral imperative to provide comprehensive oral health care to all Americans.

In this social and economic context, I want to focus on several attempts to address the failure of organized dentistry to sustain a social contract within California. As a consequence of this failure, California state legislators have sought and continue to seek legislative and political solutions that address the access and quality of oral health care. Over the last few years, I have increasingly experienced the candid frustration of legislators attempting to be advocates for their constituencies on mental health, vision health, and oral health issues. I have been educated to their concerns and now appreciate the profound frustration that all too many working poor and poor Californians experience regarding access
to quality oral health care. Their frustration also is associated with their perceived desire for linguistically and culturally competent health professionals. As examples of how legislators are addressing these frustrations, I wish to share several potentially useful examples.

Legislation Bill AB 1116, which became law in 1997, was designed to establish and maintain a single standard for dental licensure for all Californians. In essence, it says that all dentists seeking licensure in California must have graduated from a Commission on Dental Accreditation (CODA)-accredited dental program. This bill requires all foreign dental school graduates to satisfactorily complete an accredited two-year dental program in one of the California dental schools to be eligible to take the California dental licensure examination. This law further allows a graduate of a CODA-accredited foreign dental school or “CODA equivalent”-accredited foreign dental school to take the licensure examination. This law further specifies that, by 2003, the “technique examination” would cease to be used to qualify foreign dental school graduates. As an example, a Canadian dental school graduate would be allowed to take the California licensure examination because Canada uses CODA accreditation guidelines.

In 2003, Assemblyman Marcos Firebaugh authored Legislation Bill AB 1045, designed to increase the number of linguistically and culturally competent physicians and dentists to serve “specified underserved communities” in California. This legislation stipulates that thirty dentists from Mexico would be allowed to work in specified community-based dental clinics (rural agricultural areas with migrant farm workers), defined in the legislative language, under a permit issued by the California Dental Board to the dental graduates of Universidad Nacional Autonomous de Mexico (DF) [UNAM]. The bill further stipulates that the permit holders would be required to fulfill a continuing education program of study provided by one of the California dental schools to address and/or bridge any deficiencies in competencies between California and UNAM dental education. AB 1045 provides these dentists a three-year nonrenewable permit which is not a license to practice dentistry in California. Curiously, the California Dental Board and the Executive Officer were replaced by the California legislature when AB 1045 was becoming law in 2003. It is presumed that this decision for total dismissal of the board was the consequence of failure of the board to implement the previous Legislation Bill AB 1116. Recently, another dental school in Mexico—LaSalle University Dental School—gained a provisional accreditation. In this case dental graduates from the LaSalle Class of 2008 will be allowed to take the California Dental Board examinations as a “CODA-like” approved school of dentistry.

Importantly, these “solutions” being entertained by legislators in California are also receiving consideration in the southwest and southern states including Florida. What are the lessons to be learned from this commentary on California? How would you in your environment address the problem of lack of access to oral health by working poor and poor populations? How can dental schools positively influence the larger public discussions?

Access to care is understood as the ability of individuals and families to utilize professional health services in order to achieve optimal health results. Access to oral health care involves complex economic, social/cultural, political, and educational issues. Access also involves the oral health delivery system and the distribution of oral health professionals, behaviors of oral health professionals, and levels of reimbursement for care. Arguably, from my perspective the major barriers to access to comprehensive oral health care for underserved populations involve the essence of the dental education experience, the distribution of oral health professionals geographically, and our shared core values and attitudes about being a health professional in the twenty-first century. Is oral health a commodity to be sold in the marketplace, or is oral health an essential component of well-being and quality of life for all people? Can we tolerate that one-third of Americans are without access to oral health care as documented in the Surgeon General’s report?

Today we have the opportunity for the profession of dentistry to revisit our social contract with America and to enthusiastically provide access to oral health care for all Americans.

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