Access Denied; Invalid Password

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Abstract: Progress addressing access to oral health is difficult to evaluate because it is unclear what access means. Ozar’s proposal that access should be defined by dentists as true dental need is criticized. It is proposed that four different types of treatment are currently identifiable in dentistry: 1) traditional oral health care, 2) oral care that has minimal or no health component, 3) episodic care, and 4) oral health outcomes not resulting from dentist interventions such as fluoridation. Each of these models has a different definition of care and of access. The profession is becoming segmented—including growing disparities among dentists in earning potential—to the point where a single model may no longer be able to cover all needs for oral health.

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It would be easier to make progress on the “access issue” if we understood it better. Some people are telling each other that the gap between oral health care needs and care is growing wider and that this is an ethical black mark against dentistry. Whether this is an accurate framing of the problem or not, it is certainly too simplistic to support the reforms hoped for by socially sensitive observers and activists. I will argue that 1) there is no objectively useful definition of oral health need; 2) dentistry has become segmented to the point where there is no longer one definition of “care” or one definition of “access”; and 3) access is no worse now than it was ten years ago—the perception of its being a new issue is actually a consequence of accelerated fragmentation within the profession. Imagining that the access problem can be objectively defined and that what may be true for one part of the system should be true for all of it will only increase the frustration of well-intended professionals talking past each other in hopes of finding a solution to a real, but extremely complex, problem.

Who Decides What Care Is Appropriate?

Somebody has to make decisions about who gets health care and who does not simply because there is not enough of it to go around. Rationing is inescapable. Attempting to begin the conversation from the perspective of ethical principles, while seeming reasonable, too often leads to faux solutions of the sort “Someone else isn’t doing the right thing.” The position that oral health care is a right is an example that makes for better rhetoric than policy.¹

The fundamental question is who gets to decide, and the answer is typically those who have some resources to invest. The principal voices are patients, the profession, and government. In the American system, the basic rule is that patients and dentists negotiate individual agreements to determine this rationing. Intermediaries appear in the form of insurance companies. The government plays a somewhat more active role because it actually provides a small amount of care and because it pays for some of the care for groups felt to be at a social disadvantage. The government and other third parties also have something to say from time to time about informed consent, qualifications of practitioners, records, and even particulars about how care is delivered. But we are unlikely to move very far from the basic statement that patients and dentists negotiate the rationing of oral health care.

David Ozar has asked a powerful question that has the potential for framing the negotiations over rationing in a useful way.² He suggests that important questions such as the oral health of a nation should be grounded in considerations of need rather than personal wants. This moves us in the right direction because needs are not as extensive as wants are (although both may still be infinitely larger than available resources) and because the concept of “needs” seems to invite a more public discussion and implies that common resources and rewards might be at stake.

Ozar refines this approach by suggesting that dentists are the ones who should define oral health needs. There are two apparent advantages that flow from this position. Dentists can presumably define need objectively (while wants are inherently subjective), and because diagnosing needs is part of pro-

fessional training, the process is cloaked in ethical aspects from the beginning.

Aside from the problem of substituting a small infinity for a larger one and a vague feeling of discomfort over outlawing the personal desires of patients, I believe that dentists’ professional judgments are too wobbly to serve as the foundation for solving the access problem or the broader issue of a just system for addressing oral health disparities. It remains an open question to what degree dentists’ interpretations of oral health are objective and free from personal values.

One of the hottest topics in research today is the definition of a carious lesion. Science that has been available for some years is colliding with time-honored therapeutic options. It is by no means clear that the logical approach to treatment has any precedence over the teleological approach; or as Bader and Shugars have incisively put it, “Diagnosis is primarily the art of identifying treatable conditions.” Only a moment’s conversation with a dental consultant who works for a third-party carrier will suffice to explode the myth of an objective standard in dentistry. The advocates of evidence-based dentistry have created such a small platform of scientifically grounded practice that only a few stylites can find room. In 1997, William Ecenbarger wrote a piece for Reader’s Digest based on presenting himself as a patient to dentists across the country. The treatment offered to Ecenbarger for the same set of symptoms ranged from $460 to $29,850. The ADA got wind of the article before it appeared in print and organized a media response team and program to control the anticipated fallout. As David Ozar would have predicted, the public yawned. What organized dentistry has failed to respond to is the scientific evidence published in peer-reviewed journals showing that Ecenbarger substantially underestimated the variance in professional opinion regarding appropriate treatment of objectively identical conditions.

Not only is there variation in the interpretations dentists give to objective oral conditions, but it is possible that these differences are related to dentists’ personal interests. Dlugokinski and Browning reported that informed consent concerning posterior composite restorations differed based on the proportion of such procedures dentists provide. There is an old study that summarizes this point succinctly. When presented with a set of randomly selected cephalometric tracings, models, and photographs, one-third of the parents of the teenaged patients felt their sons or daughters needed orthodontic treatment; one-half of the families’ general dentists thought orthodontics appropriate; and two-thirds of consulted orthodontists saw a need for intervention.

I am not convinced on scientific grounds that “professionally defined need for oral health care” is robust enough to support an ethical discussion or even a public policy discussion of access. Placing one party in a position that permits defining perpetual shortages does not solve the rationing problem; it perpetuates it. Unless we want to entirely bag the notion of “fairness,” we need to build somewhere else. Perhaps I was right twenty years ago when I suggested that objective need is a poor predictor of oral health utilization and that “as dentistry offers better service and as patients’ oral health improves, so does the demand for dental care.”

Four Kinds of Dentistry

Let’s go back to Ozar’s starting point and see if we can find another way forward. He has raised the question, “Is there one thing called oral health care that is the subject of discussion about how resources (such as access) should be allocated?” He suggests that the answer is “no.” That is certainly a helpful observation because it can be used to explain why disagreements exist and may even persist among very similarly minded groups. Discussions, other than Ozar’s, that proceed along these lines include the following: 1) basic oral health vs. dental services that enhance the recipient; 2) primary vs. secondary and tertiary prevention; 3) treatment above vs. below the standard of care; 4) health care as a right vs. health care as a social good; and 5) universal acceptance vs. treatment. These approaches have in common an attempt to draw a line on a continuum where resources should be distributed one way above the line and another way below it with an avowed intent of achieving greater equity. Much more needs to be written about the struggle to make headway with this conception. It hasn’t worked very well so far.

A fresh look, at least one that hasn’t been analyzed thoroughly enough to find its real demerits, would be to consider several sets of dental care interventions that are qualitatively different—that is, that differ in goal and in underlying economic principles and hence quite possibly in ethical underpinnings as well. The typology below is meant to illustrate different segments or different channels in the marketing sense. It is certainly not intended to depict...
a taxonomy or hierarchy in the quality of care given or outcomes achieved. Because these are different “types” of delivery, there is no common theme across all of them; there is no single dimension or even a set of characteristics that forms a common structure. They are apples and oranges. Others will favor variations on these types, but that only proves the point that dentistry is no longer a single concept.

**Type I: Oral Health Care.** This is the system commonly known as “dentistry.” It exists in a variety of economic forms such as fee-for-services (50 percent of the market), insurance (45 percent), and government-supported and volunteer services (5 percent). The scope of services ranges widely from specialty treatment and high-end materials, procedures, and service to basics that approach the standards of care and involve minimal amenities. Safety net clinics define the lowest end of the range of care in this system.

In this system, “care” equals treatment that is above the standards of care and falls somewhere on a decreasingly accelerated curve relating value to cost. Although care is rendered in discrete billable procedures, the ideal is comprehensive and continuous engagement with the professional provider. “Access” is a matter of fannies in the chair and CDT codes. When access is said to be an issue, this normally means that presumed demand exceeds system capacity. Access takes on a moral tone when the disparity between demand and capacity is larger for protected groups than privileged ones.

**Type II: Oral Care.** A relatively new phenomenon is oral care that is not grounded in dental health considerations. There have always been (as one moved up the cost/value curve) enhancements to oral health care such as service, convenience, and professional courtesies. But we now have treatments where dental health, prevention, or function are secondary or nonexistent. Bleaching and much orthodontics, veneers, and other interventions collectively known as cosmetic dentistry are not aimed at health considerations. Quacks, holistic dentists, and others who offer to treat something other than dental disease also belong in this category.

In this system, “care” means that elective services are purchased as lifestyle enhancements in an open market. “Access” is either a neutral consideration or a negative one. Demand for cosmetic care defines half of the market, just as the availability of BMW or Prius cars does to affect price. The other half of the market mechanism is supply, and an access concern flows from dentists migrating to the “oral care” model and thus reducing the number of dentists available for “oral health care.”

**Type III: Oral Medical Care.** This category is defined by episodic and dentally noncomprehensive interventions. It ranges from trauma and cleft-palate surgery to TMD therapy, from emergency room endo accesses to dispensing palliative drugs. Patients do not recognize their providers as their “regular dentists” and in most cases do not have a regular dentist and do not engage in routine home care or other preventive patterns. The dentist in this system is often part of a team. Services are seldom paid for by the patient, medical billing codes are often charged, and patients typically postpone such treatment until pain drives them to seek relief.

In this system, “care” means episodic treatment for the relief of massive symptoms stemming from either neglect or trauma or other disease processes besides caries or periodontal diseases. “Access” is a major issue on two fronts: such patients seldom pay for their care, and they must use a system that is not part of routine dental care for those who are asymptomatic. Significant issues surround engaging both dentists and patients in this system; it is not clear what improvements in the system would look like.

**Type IV: Oral Health Improvement.** Systemic fluoride, cancer screenings at health fairs, the work of most hygienists, and fluoridated toothpaste are examples of indirect interventions, largely aimed at primary prevention and not delivered by dentists. Arguably, such health improvement schemes have had more impact on bettering oral health than the other three types. They encompass a wide range of methods and personnel and are characterized more accurately in terms of outcomes than delivery methods.

In this system, there is no “care” component, or the care component is secondary. “Access” also has a slightly different sense in oral health improvement systems. Usually, there are very small costs to recipients of help, and in some cases oral health care benefits may not even be recognized and are measured on a population basis. The costs are more likely to be borne by public institutions, industry, private institutions, or volunteers.

The implications of accepting this view, even provisionally, that dentistry is not of one piece are helpful. First, this might explain why we talk past each other so often. There is not one definition of care, nor a single definition of access. The goals and principles of operation are not the same in the various
systems. The notion of a Pareto optimal set of delivery options—presumably the set of possible “fair” distribution of resources—doesn’t even exist.\textsuperscript{23} In fact, this may be the greatest surprise of all. Viewed in this fashion, as four overlapping systems having to do with improving the appearance and function of the oral complex but addressing this challenge from diverse assumptions, the ethical ground for debate shifts. No longer is the principal question one of fairness, or equity, or just distribution of resources.

The large lever turns out to be the one Ozar has his hand on in the first place: liberty. The principle is that everyone is entitled to as much happiness, wealth, freedom, and opportunity as they can accumulate, subject only to consideration for the liberty of others. The question that must be answered is whether Type I dentistry (oral health care) is sufficient to meet the needs of patients, the public, and other willing and qualified providers, and if not, what is the role of organized dentistry in enhancing or limiting the development of other approaches to oral care and health. This is anything but a straightforward matter.

Organized dentistry appears to have been open to expansion into cosmetic dentistry, but is now losing ground to the likes of Invisalign and Johnson & Johnson. At the same time, organized dentistry is fighting the holistics, and I am sorry to see this battle wavering as some state legislatures weigh in for antidentistry and free trade. Turf wars flare up in Type III and Type IV areas. Cosmetic surgeons, for example, use the same arguments to keep oral and maxillofacial surgeons off the face that dentists use to keep dental hygienists in dental offices or nursing homes. We must carefully consider the impact on oral health of alternatives such as the Alaskan program, foreign-trained dentists who have not passed the same licensure examinations as U.S.-trained dentists providing care in underserved areas, and the scope of practice by hygienists. Outcomes data would be welcome. If the profession effectively serves the needs of patients, the public, and other willing and qualified providers, and if not, what is the role of organized dentistry in enhancing or limiting the development of other approaches to oral care and health. This is anything but a straightforward matter.

As it turns out, the percentage of Hispanics seeking a dentist regularly was 53 percent in both 1997 and 2002.\textsuperscript{24} Another study compared 1977 with 1996 and found a 17 percent increase for both African Americans and Hispanics and a 12 percent increase among the unemployed in access to dental care.\textsuperscript{25} If we have an access issue in 2005, we had one in 1990—and nobody said much about it. What begs for understanding about access is not what the numbers are, but why we feel we have a problem now.

I will sketch one hypothesis. It is possible that Ozar was right about the access problem being grounded in perceptions. But let’s at least consider the possibility that the access issue is not about oral health in populations but about changes in the dental profession. The evidence is fragmentary but includes expanded breadth in treatments provided, economic changes, and a movement away from the health base of dentistry. The disparities within dentistry are growing at a much faster rate than they are in the public. As Will and Ariel Durant remind us, “Inequality grows in an expanding economy.”\textsuperscript{26} Dentistry has attempted to shift into Type II care—the non-health aspect of oral care. Dentists advertise on television that “everyone deserves a beautiful smile.” And many believe that, including a large number of Americans who watch television but live below the poverty line. In its search for the elective market, the profession has cast its net too widely and created mass expectations that are both

\textbf{Not Objective: Not About Patients}

As the old vaudeville joke goes, “And now for some partial scores: ‘6,’ ‘3,’ ‘0,’ ‘another 0,’ and ‘12.’” If there is any humor in this line, it comes from the realization that numbers don’t really mean anything by themselves. We all know the litany from the U.S. surgeon general’s report on oral health. Every conference on access involves a little competition to see who can give the most recent or the most impressive-sounding figures. But what does it prove to cite that 53 percent of Hispanics attended a dentist in 2002?

If we draw nodding approval when we quote statistics, we should take it as a warning sign that we are talking with people who already think the way we do. Facts only gain moral traction when they reveal discrepancies between reality and normative positions. What should the percentage of Hispanics visiting the dentist in 2002 be? Why?

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inappropriate and cannot be fulfilled. If the public reads the advice in dental publications that dentists should select their patients to maximize office profit, they would turn cynical. Some in the practice community expect that dental schools and other safety net providers will pick up the patients uncovered in this shift.

In states such as Louisiana, physicians have built “surgi-centers” where they refer their own high-end patients. County and other hospitals have complained that this draws the high reimbursement patients away from public facilities, leaving them with the most expensive cases. In states such as California, this practice is prohibited by law, although there are crews working on the loopholes as we speak.

Has the strategy worked? Yes: for the past fifteen years the increase in net income of dentists has outpaced the increase in income of the average American by 150 percent. At the end of each year, on average, since 1990, the dentist’s dollar buys $1.50 worth of goods. This success has attracted competition from industry and from other parts of the health professions. Legislators are aware of this; they are adept at getting and understanding such statistics. The economic success of practitioners has created difficulties for dental education.

The nature of practice structures has changed. The fastest growing forms of practice are associate- ship and salaried positions—dentists working for other dentists. There are dental care companies traded on the stock exchange. This has created disparities in the incomes of dentists. Between 1996 and 2000, the American Dental Association reported that net incomes of general practitioners increased from $123,000 to $158,000 (28 percent); but the standard deviation of incomes—the disparity across the profession—increased 40 percent during this period. For specialists, average income rose 26 percent, while the standard deviation increased by 35 percent. What it means to practice dentistry is growing more diverse: the profession is segmenting, and this is reflected in varying approaches to patients.

Understanding the Problem

Charles II of England once challenged the fellows of the Royal Society to explain why a dead fish weighs more than it did when it was alive. Some of the answers from the best “scientists” of the age were ingenious. Eventually, Charles relented and explained that he knew of no evidence that a fish weighs more when dead. Before we go too much further with the access issue, we need to be certain we are not trying to solve the wrong problem. Access has not gotten worse recently. Disparities in oral health status do, however, remain an embarrassing sore in our system of just distribution of resources. This is not an issue that can be solved scientifically—for example, by asking dentists to objectively define dental need and then calling on someone else to assemble the resources to pay for it. It is also becoming clear that the oral health care market has grown in size and complexity to the point where the single model of comprehensive oral health care delivered by solo practitioners, Type I, may become strained beyond the profession’s ability to control. Finally, segmentation is beginning to emerge in the profession itself. Counting patients in dental chairs—as a measure of access—is unlikely to provide solutions to these concerns.

The current fee-for-service model is effective for the conditions that have prevailed in the United States for many years. The record of pro bono care is admirable. Doubling it—even increasing it five-fold—would not make the kind of dent in oral health disparities that is being called for. At the same time, it would be unwise to continue further migrations toward oral care (without the health component, Type II) and thus call more attention to the uncovering of underserved groups this is causing. It may also prove indefensible as well as unreasonable to oppose new initiatives of Type IV where traditional dentists cannot and often do not wish to provide care.

REFERENCES