Basic Oral Health Needs: A Public Priority

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Abstract: Is there a way to support a special ethical status for unmet oral health needs within our pluralistic, liberty-loving American society? Some people in American society, perhaps many people, believe that some kinds of human needs have special ethical importance. But very few people outside the oral health professions have ever considered that unmet oral health needs might belong to this category. This article will examine why some kinds of needs are thought to have special ethical importance and propose that certain categories of oral health care are needs that fit this description. Without thinking these issues through, we who argue for improved access to oral health care will remain unable to provide an adequate answer to a very legitimate question, namely: improved access to what? When this task has been completed, the article will consider some of the implications of such a view for our society.

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I is there a way to support a special ethical status for unmet oral health needs within our pluralistic, liberty-loving American society? Some people in American society, perhaps many people, believe that some kinds of human needs have special ethical importance. But very few people outside the oral health professions have ever considered that unmet oral health needs might belong to this category. This article will examine why some kinds of needs are thought to have special ethical importance and propose that certain categories of oral health care are needs that fit this description. When this task has been completed, it will consider some of the implications of such a view for our society.

This article will presuppose the correctness of the claim that needs are different from other desires in ethically significant ways, as was explained in “Ethics, Access, and Care.” What this article will argue first of all is that, among the things considered needs, there is a category of needs that are of sufficient ethical importance that they outrank all other values that are not needs and also all needs that do not belong to this special category. If this position can be shown to be correct, its implications for social policy are very significant, for this position implies that meeting unmet needs of this special sort ought to be one of the first things an ethical society structures itself to do if it is able. It also implies that an ethical society ought to be addressing the unmet needs of this sort for everyone in the society.

In claiming the highest priority for things in this special category of need, this position rejects a number of other points of view on how societies ought to operate, i.e., what it means to be an ethical and just society. Among the views rejected by this position are the views that a society should be structured so its resources are distributed according to a) people’s social class and birth-based social status; b) people’s social contribution or productivity; or c) people’s expenditure of effort in what they do. This position also rejects the view that a society’s resources should be distributed simply by means of whatever uncoerced choices and exchanges individuals choose to make; that is, d) in accord with the workings of an idealized free market. Each of these alternative views has been defended on ethical grounds and has been the basis of social practices in a number of societies, including our own. Further examination of these alternative positions is beyond the scope of this article, but they are discussed in more detail in chapter 13, “Social Justice and Access to Dental Care,” of Dental Ethics at Chairside.

With the publisher’s permission, a number of phrases and sometimes whole sentences have been incorporated into this article or closely paraphrased from chapter 13 of DT Ozar and DJ Sokol’s Dental Ethics at Chairside, 2nd ed. (Washington, DC: Georgetown University Press, 2002).
Basic Needs

Obviously every society, especially the complex societies of the contemporary world, has a system of social structures by which it manages the distribution of its resources among the individuals and groups that make up the society. Whenever a society is establishing or modifying one of these systems, one unavoidable question in a world of finite resources is the ethical question of how to prioritize the various benefits the society’s people will have access to or will fail to have access to by means of these systems. The position being proposed here is that, because certain kinds of human need have special ethical importance, the distribution systems should be so designed that everyone in the society can meet these needs, i.e., that providing everyone in the society access to the resources they require to meet these special needs must be one of the society’s highest ethical priorities.

In order to proceed, it will be helpful to provide a name for the class of needs that is claimed here to have special ethical priority. In recent years, many ethicists and social theorists have used the expression “basic needs” to refer to this class of needs, so this is the terminology that will be used here. This way of speaking will help differentiate this special class of needs from needs in general and from other kinds of desires, and it will help in formulating the question that needs to be asked next. Namely, why are the needs in this category ethically special? What is it about “basic-ness” that gives these needs their special ethical importance?

For most writers who use the expression “basic needs,” “basic” means necessary to normal or appropriate human functioning. It is well beyond the scope of this article to argue why certain kinds of functioning are taken as norms of how humans ought to function. But an example will help clarify the kind of thinking involved in the use of such a norm.

In discussing the central values of dental practice, Dental Ethics at Chairside identifies oral health as one of the central values and proposes that oral health can be defined as “appropriate and pain-free oral functioning” (69). How do oral health professionals, and in a less sophisticated way their patients, know what counts as appropriate oral functioning? How do they know why pain-free oral functioning counts as part of normal or appropriate human functioning? Complex standards of nutrition and speech capacity, to take just two examples, are involved in determining what is normal for the health professional. But even for the professional, these are standards that are difficult to fully articulate. They are learned by health professionals during their training and through years of practice, and they are learned, ordinarily in very oversimplified accounts, by laypersons in other ways. But learned they are, and they operate both in the layperson’s judgments about the need for dental treatment and in much more sophisticated ways in health professionals’ judgments about appropriate therapeutic interventions.

In other words, though unpacking the content of normal or appropriate human functioning is a complex task beyond the scope of this article, the content of this idea is not unknown to us and is not beyond our ability to understand. In any case, throughout this article, the word “basic” will be presumed to mean necessary for normal and appropriate human functioning.

But this clarification of terms still does not explain why basic needs are thought to have such special ethical importance that providing people with access to resources to meet their basic needs ought to be every society’s first ethical priority. The reasons for this proposal need additional explanation.

What are the chances that someone could achieve any of their goals, fulfill any of their desires, meet any of their needs, if they lacked the resources that are basic in the sense just explained, the resources humans absolutely need for a human being to be capable of normal and appropriate human functioning? Obviously, the chances would be very small! For these are resources without which typical humans could not do anything else. That is, no matter what other goal you imagine someone having, no matter what other desire you imagine them trying to fulfill, no matter what other need you imagine them trying to address, there are some resources without which no ordinary human could hope to achieve anything at all.

Admittedly, there are exceptional people who sacrifice things that are basic in this way for other things that are not. And there are people who sacrifice things that are basic for their own lives, necessary for their own ability to function within the range of what is appropriate and normal, for the sake of other persons. The former are ordinarily judged to be exceptional, but in the direction of foolishness. The latter are exceptional in the direction of being heroes. But both of these groups, the heroes and the fools, are very small; their ways of acting are not what we can reasonably expect of ordinary human beings. And it is ordinary human beings that a society needs to have in mind when it establishes or amends a social system to help distribute its resources to its people.
Against the background of these two reflections, the special ethical priority of basic needs can be explained. Unless ordinary people have access to the resources required to meet their basic needs, they will be unable to act in accord with any other standard that a society might propose. The point is not that other standards might not be more noble; the point is that people will not ordinarily be able to act to meet any social standard, for distributing resources or for any other social purpose, if their basic needs are not met. Therefore, when a society establishes (or amends) the social systems by which its resources will be distributed, the only reasonable thing to do is to give first priority to meeting basic needs in the society, since no other standard can possibly be met without this. (The notion of basic-ness and the ethical priority of basic needs in human societies are topics carefully developed in Henry Shue’s book, Basic Rights.)

**Basic Oral Health Needs**

Now that the notion of basic needs has been clarified, the next question is: What kinds of oral health needs are “basic” in the relevant sense? The easiest categories of oral health needs to identify as necessary to normal and appropriate human functioning are conditions involving serious oral pain and conditions that prevent or severely limit normal nutrition and speech. Note that many different kinds of dental interventions, including appropriate diagnostic procedures, radiography, etc., will ordinarily be involved in responding to these kinds of oral health need. There is no simple way to list the kinds of dental interventions that are responses to basic oral health needs as distinct from those that are not. Oral health care is too complex and depends too much on the clinical details of the patient’s condition for such a simplistic categorization. Instead, we must ask of every dental procedure what health conditions it is preserving or correcting or restoring in the patient and then whether any of these conditions is a necessary component of the patient’s capacity for normal and appropriate human functioning.

The two categories of intervention just mentioned, relief of severe pain and restoration of functions necessary to nutrition and speech, are themselves most obviously essential when the conditions to be corrected are emergent, i.e., when the pain is currently debilitating or the patient’s function is currently severely impaired. But it is clear that intervening at a point when the pain or impairment of function is less—i.e., it is not yet fully compromising the patient’s capacity for normal and appropriate human functioning—is ordinarily included by oral health professionals within the category of essential or nonoptional treatment, at least in any situation in which failing to treat these less burdensome conditions is likely to lead to more debilitating pain or more complete impairment. Treating sooner in this way limits the patient’s suffering, subjects the undesirable conditions to expert control at an earlier point in their development, and ordinarily ensures the use of dental resources more efficiently than waiting would do.

The oral health professions would therefore urge that the society’s distributive system include access to dental intervention at earlier points in the progress of such conditions. Providing access to earlier intervention would also provide potential patients, i.e., the public, with a sense of security that they will not have to wait till they are severely debilitated by such oral conditions to have access to treatment. The oral health professions would argue, in other words, that the most reasonable and efficient methods of addressing the needs that are clearly basic will ordinarily include intervening sooner and thus addressing needs that are important, but not yet basic in the sense defined above. Therefore, as our society works to identify what should count as adequate access to resources to meet its people’s basic oral health needs, it will have to determine its willingness to also provide access to health care that is more timely and efficient, but is meeting needs that are not strictly basic.

To expand on this point, there are many other professional interventions, such as patient education for self-care and after-care and other aspects of the professional-patient interaction, that properly accompany actual treatment and without which treatment could not be effectively performed. Because appropriate treatment depends on them, oral health professionals consider them to be essential rather than optional components of any oral health care procedure. Furthermore, oral health professionals have argued for many years that routine checkups and prophylaxis, the use of sealants on pits and fissures, and general patient education for self-care should be considered essential rather than optional elements of oral health care. But the inclusion of these forms of care within the ideal of oral health care practice espoused by oral health professionals in our society does not necessarily mean that such forms of care should count as necessary to normal and appropriate human functioning. So as the society considers how to structure access so its people

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can meet their basic oral health needs, it will also have to consider which of these accompaniments of professionally excellent care should be included among the resources it ensures.

Obviously, it would seem profoundly foolish of a society and a gross waste of its oral health care resources to give no attention or only optional attention to treating painful and function-impairing conditions only when they actually arise in their severest forms rather than supporting prevention of the need for more costly and risky forms of oral health care. The American health care system has been remarkably slow to recognize the inefficiency of such an approach in other aspects of health care, and the dental and dental hygiene professions are admired by many in the larger community for the nearly unique emphasis they give to prevention and patient education for self-care. So from a practical point of view, it may be a harder sell to persuade our society to provide its people with access to these other forms of oral health care when the only arguments available are arguments, even very strong arguments, of efficiency and timeliness.

Is there any other way to argue that these aspects of oral health care that oral health professionals consider essential (nonoptional) are necessary for normal and appropriate human functioning?

Two possibilities come to mind. One is that a society might determine that, in that society, a certain measure of security about being capable of normal and appropriate human functioning should be able to be taken for granted, i.e., should be considered necessary for normal and appropriate human functioning, not as something optional. Being secure about something requires access to three kinds of resources: resources to prevent it as soon as it begins to affect functioning; resources to prevent it from affecting functioning in advance when that can be foreseen; and resources to secure the most effective kinds of interventions regarding it. So if our society would determine that this measure of security in matters of health is part of our social standard for what is necessary for normal and appropriate human functioning in regard to health, then the elements of high-quality oral health care mentioned above would need to be included among the resources the society assured its people that they would receive to meet their basic health needs.

With the support of these two lines of argument, the proposal being defended here is that American society should include all the elements of what oral health professionals consider essential to the proper treatment of oral pain and dysfunction among the resources required for people’s basic oral health needs to be met and that, to be ethical and just, American society should ensure access to these resources for all its people.

In addition, with these two arguments in hand, we are also in a position to determine what should count as basic oral health care. Basic oral health care should be taken to include whatever oral health care is properly judged necessary in a given society for the people of the society to meet those oral health needs that the society properly judges to be basic, i.e., necessary for what the society reasonably counts as normal and appropriate human functioning.

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The Role of Oral Health Professions and Professionals

If the position just offered for consideration were accepted, it would follow that a society that
had sufficient resources to meet all its citizens’ basic needs would be ethical and just only if its distributive systems were structured in such a way that all members of the society had access to the categories of oral health care just discussed as necessary for normal and appropriate human functioning.

It is important to stress that this obligation would be an obligation of the whole society, not of any one group within it. The oral health professions would obviously have a role to play; indeed, they would probably play many roles in the society’s assuring everyone who needed it that they would receive basic oral health care. But it would be a serious mistake to conclude that the availability of these forms of oral health care ought to depend principally on the efforts and generosity of, much less major sacrifices by, the society’s oral health professionals.

Today, many of the professional societies and many individual dentists and dental hygienists are examining how effectively they are responding to their professional obligation to work for full access to needed oral health care for everyone. But the causes of unmet oral health needs in American society are systemic. So focusing narrowly on providing for the care of individual needy patients, or groups of such individuals in nursing homes, shelters, or other such institutions, only addresses the symptoms of the social problem around us. The oral health professions and their members, especially those with power of office or other sorts of influence within the oral health community or beyond it, should also be working to educate and motivate the society’s leaders and the public whose preferences the leaders claim to follow in order to change the system. That is the only way in which our society’s unmet oral health care needs, and its unmet health care needs generally, will be adequately addressed.

A Complication

But suppose the position being examined here were in fact adopted widely enough in American society that the system for distributing health care resources did change. And suppose that oral health came to be valued highly enough within the American health care system that our society mustered the political will to change the systems distributing oral health resources in order to provide everyone in the society with access to the resources required to meet their basic oral health needs. It is outside the scope of this article to try to imagine practically what the new system would look like. But there is one thing about this imaginary America that is certain: the resources for meeting unmet oral health needs would have to come from somewhere. Since such resources do not fall from the sky, it follows almost certainly that some people in the society would have less of something in this new system of distribution in order for all to have their basic oral health needs met.

Suppose, to consider a more concrete and not unlikely scenario, that our society determined that it was unethical that there are persons whose basic oral health needs are going unmet, but that our society was already spending as much of its total resources on oral health as it was willing to. In that case, obviously, some oral health resources would be redirected to provide for the current shortfall in meeting basic oral health needs. Some aspects of oral health care or of oral health research or of some other part of the oral health system would have to be sacrificed in order to meet the basic oral health needs of the people currently lacking access to it.

Here is an important thought experiment. Most people reading this article have access to oral health care beyond what is needed to meet basic oral health needs. Suppose something was going to be cut from your patients’ care or from your and your family’s oral health care. Since access to basic oral health care would be assured to individuals in the new system, the cut would come from what is nonessential and nonbasic, but that is currently available to you or your patients. If it is necessary to shift those resources elsewhere in order to use them to meet the needs of persons currently without access for basic needs, where would you make the cuts? What cuts would you recommend to the society if they affected your patients, or yourself and your family, and if it was clear that some cuts are needed to meet the goal of responding to everyone’s basic oral health needs?

When I proposed this thought experiment to a group of dental school faculty at an ethics workshop a few years ago, one of the dentists present who had been arguing most strenuously for a change in our society so that people’s basic oral health needs could be met suddenly stopped. “Wait a minute,” this dentist said. “If my children need orthodontia, they are going to get it. I am not giving that up!”

Now one thing to say about this is that orthodontia is sometimes without question a response to an instance of basic need in regard to nutrition, speech capacity, or physical appearance. But most likely, the need for orthodontia for this dentist’s children was not of that ethical importance. No
doubt orthodontists differentiate in their own minds between a treatment recommendation for a patient whose treatment is justifiably described as necessary for normal and appropriate human functioning (e.g., mastication, speech, certain minimums of physical appearance) and a treatment recommendation for a patient whom we would without thinking describe as “needing” orthodontic treatment, but whose need clearly does not count as a basic need. If the dentist who spoke up at the workshop would not support a social system in which there would be resources for her children to have orthodontia (assuming their need for it was not a basic need), where should the cuts be made, and why? It is a question each of us must think about carefully.

One might wish, of course, that the resources needed for improved access to basic oral health care would come from outside oral health rather than from within it. But even in this, the saying “Be careful what you wish for” may be very good advice. Should these resources come instead from education, housing, roads, Social Security, public transportation, the environment, other areas of health care, other social services, or where? Notice, too, that if one says that it should come from some area that is clearly optional—or even beyond optional, for example, from people’s excesses of consumerism—then a criterion is needed to determine what belongs to that category of “optional” or “excess,” and, in addition, an ethical justification is needed for using that criterion as the basis of social distribution and for claiming that our whole society should use it as well.

No pot of gold is likely to fall from the sky for the oral health community to use to improve access to basic oral health care or anything else. Therefore, either in terms like the ones used here or some other, proponents of change are going to have to offer careful criteria to indicate what categories of oral health care have priority over what other uses of society’s resources and provide a clear ethical explanation of why these are the criteria that our whole society, or possibly every society, ought to use.

Another Complication

A significant amount of dental practice today is focused on matters related only indirectly or not at all to addressing and preventing oral pain and impairments of nutrition or speech function. Many of the interventions going on in dentists’ offices today and the bulk of dental advertising that significantly shapes the public’s view of dental practice are concerned with improving appearance in ways that are clearly and frankly nonessential from an oral health point of view. Even granting their psychological importance to some of the patients who seek them, most such interventions are clearly outside the categories of care argued for above as required for people to meet their basic oral health needs.

To the extent that dentistry focuses its attention on interventions of this sort, and to the extent that the American public therefore comes to view the oral health professions as focused on nonessential treatments, to that extent it will be harder and harder to argue effectively for access to basic oral health care in our society. The public’s understanding of the relevant distinctions is dim and is likely to grow dimmer if the current advertising trends continue. Indeed, dentistry runs the risk that the public will conclude that the aim of the oral health professions is chiefly to respond to consumers’ desires rather than to patients’ needs; or, what will come to the same thing in practice, that there is no difference between needs and desires in matters of oral health care. (See “Ethics, Access, and Care” on what the loss of this distinction implies.)

Conclusion

There is no consensus within our society about what counts as normal human functioning and little consensus about what needs, if any, are basic in regard to it. If the oral health professions are going to have significant impact on the issue of access, they will have to address precisely the kinds of complex ethical questions discussed in this article.

It would be nice if ethical questions admitted of easier answers, just as it would be nice if resources for meeting human needs and fulfilling human desires were not limited. But the resources are limited and so the ethical questions are very complex, requiring subtle distinctions between basic needs, other needs, and desires generally. Luckily, many Americans are unhappy today about how health care resources in general are distributed in our society; and in any discussion about who ought to have access to what, there is the possibility that the question of needs and the category of basic needs can be raised for consideration. And that’s a start.

The oral health professions and their members can do a great deal to help bring about the social dialogue that will be necessary to change the social systems that control access to oral health care in our
society. If they can bring about a more robust and illuminating internal dialogue within the oral health professions, that will help a lot and could lead to a genuinely shared commitment within the oral health professions to take more effective action. This effort should surely engage the schools of dentistry and dental hygiene and other educational institutions in the oral health community to not only support this message, but to directly educate their students about it in all its subtlety in order to secure the message within the oral health community for years to come. There are also other potential allies in the oral health community—manufacturers, insurers, advertisers, management consultants, laboratories, owners of large practice settings, etc.—who ought to be part of this process as well, joining with the health professions in a united voice to seek access to basic oral health care for everyone in our society. But the process of seeking allies must not stop there. The oral health community, even if fully united, is still a niche community within American health care. Close collaboration with the other health professions and their professional schools and their allies in practice will be essential in the longer run.

But to my mind, as a philosopher and ethicist, I find it hard to see how such efforts can be effective unless they are based on a clear understanding of the sorts of ethical and conceptual issues described here and in “Ethics, Access, and Care.” These articles have been written out of the conviction that, even when the necessary concepts are difficult to understand, clear concepts are always good for people and they are essential for mutual understanding and effective action over the long run.

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