EDITORIAL

Bringing Oral Health Care to School-aged Children

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The *Healthy People 2010*'s modest goal of increasing annual oral health care utilization among children from 20 to 57 percent is unlikely to be achieved without a major change in the delivery system (1). Good intentions notwithstanding, the barriers that prevent many school-aged children, not all of whom are poor, from accessing dental care cannot be overcome by traditional private practice for reasons that are well known: the high cost of fee-for-service and the refusal of many dentists to accept the lower payments of Medicaid; the increasing shortage and geographic maldistribution of dentists; the disinclination of many dentists to treat poor and minority children, or to treat children at all. No less significant are the social barriers that include ethnic/cultural attitudes and values, deficient education, single parentage, household debts and inadequate transportation (2).

There is even underutilization when dental care is free. As Maserejian, *et al.*, stated, ". . . children from low-income families who are entitled to comprehensive oral health coverage through Medicaid [e.g., free care] are less likely to utilize dental care than children from higher-income families (2)." This is not true, however, in countries that have publicly funded, salaried dental therapists providing preventive and curative care for school-aged children where utilization of over 90 to nearly 100 percent is achieved (3). The service is usually located in school dental clinics or mobile trailers stationed on school grounds. Parenthetically, preschoolers could also be provided preventive and early interceptive care in these programs, as well as in the offices of pediatricians and family physicians.

If we are content with a goal of 57% utilization by children to the neglect, through no fault of their own, of millions of other mainly poor or marginally poor children comprising the other 43%, then we stick with the traditional system that requires transportation to health care providers. But if we really want to care for all children in the United States, rich and poor alike, then we have to consider better ways of bringing oral health care to children who cannot access private practices, free clinics or community health centers. We must acknowledge the obvious fact that, with respect to health care, *children are essentially non-ambulatory.* They must have someone with the desire, time, money and means to take them to health care providers. Since many children lack that caregiver, they will not receive preventive and curative health care, even if it is free. If there is no one to bring these children to dental care, then dental care must be provided for them in schools, preferably by dental therapists whose competency has been well documented.

Where is the money to come from? School-based health programs require public funding, a concept that is anathema to private health care advocates but which, in these economic hard times, can no longer be ignored. Administrative costs to administer commercial insurance ranges from 25 to 30%, compared to 5% for Medicare (4). If only 10 percent of the nearly $2 trillion annual health care expenditure was saved by adopting universal single payer health insurance, approximately $20 billion could be made available to support development and deployment of school-based programs staffed by dental therapists and pediatric nurses, as well as providing basic health insurance for the remainder of the uninsured population.

How we allocate available funds and services will determine if we fail or succeed in meeting the goals of *Healthy People 2010* and beyond. If we want all school-aged children to benefit from adequate oral health care, it needs to be provided in school-based programs where it can be easily accessed.

References

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