Response to Drs. Bramson and Guay's Comments on the Proposed Pediatric Oral Health Therapist

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I am pleasantly surprised to have had the Executive Director of the American Dental Association (ADA), Dr. Bramson, and the Association's Associate Director for Policy, Dr. Guay, respond to the article on adding a pediatric oral health therapist to the dental team; surprised in that the ADA, as an organization, does not customarily respond to articles in the dental literature, and pleasantly so in that it suggests (to me) that possibly the leadership of the ADA is concerned that the proposal could gain traction in the United States—as it has in over 40 countries in the world.

Drs. Bramson and Guay suggest I am advocating the "development of a lower level practitioner as a dentist–substitute." No; I am recommending the addition of a pediatric oral health therapist as a member of the dental team—a dentist-extender, just as the dental hygienist is a valued dentist-extender. No one would refer to a dental hygienist as a "lower level practitioner" or as a "dentist substitute." Dental hygienists are acknowledged partners with dentists in caring for patients. Indeed, most dentists would prefer a hygienist for the scaling and polishing of their own teeth.

In Great Britain, where dental therapy is recognized and practiced, "dental nurses, dental hygienists and dental therapists form an essential part of the dental team (1)." And in the broader field of medicine we have an excellent model of health care extenders. Physicians could not care for the ever-expanding population of patients without nurse practitioners, physicians' assistants, and nurse anesthetists as members of their team. To imply, as Bramson and Guay do, that an oral health therapist would be a "lower-level" or incompetent health care extender is simply incorrect. As has been demonstrated internationally, therapists provide safe, quality treatment at a standard of care comparable to that of a dentist.

My ADA colleagues contend that it is not *just* to treat children (by the) "relegation of the dental care for children to an auxiliary with less education, skills, experience and training." In fact, a two-year training program for a pediatric oral health therapist would provide many more hours of clinical experience than that of the typical graduating student dentist, resulting in an individual with far more training, skills, and experience treating children. A recent study found that 33% of dental school graduates had not had any actual clinical experience in performing pulpotomies and preparing and placing stainless steel crowns (2). Official ADA policy also questions the adequacy of the dental curriculum in preparing dentists to treat children. A 2000 House of Delegates resolution called for "a review of the predoctoral education standard 2.25 regarding pediatric dentistry to assure adequate and sufficient clinical skills of graduates" (3). The background statement supporting the resolution suggested that inadequate educational preparation for treating children could be a barrier to access.

Drs. Bramson and Guay state that the "ADA has long favored the appropriate use of dental auxiliaries to enhance the efficiency and increase the productivity of dentists." An ADA task force issued a very thoughtful and comprehensive 1995 report entitled, "The Dental Team in 2020: Future Roles and Responsibilities of Allied Dental Personnel" (4). The report advocated a significant expansion of the types and roles for dental auxiliaries. However, the ADA leadership chose not to advance the report to the House of Delegates as it was deemed too politically controversial. There is little evidence for the ADA encouraging the expansion of roles for dental auxiliaries.

As Bramson and Guay stated, the New Zealand School Dental Nurse program (the progenitor of today's therapist) was launched in 1921 because of the poor oral health of the individuals being called into military service during World War I. Ironically, *The New York Times* recently reported that one of the significant impediments in the U.S. deploying troops to Iraq was poor oral health: "roughly a quarter of reservists in seven early-deploying Army units had dental problems that could require emergency attention within the next year." And, "some reservists and Guard members chose to have their teeth pulled so that they could be deployed"(5). Striking parallels.

The "adequacy of the dental workforce" is a major point of contention. Projections are always challenging as assumptions of future conditions (environmental and otherwise) are subject to error. In my paper, I reported a decline in the actual number of dentists in the future based on *The Surgeon General's Report: Oral Health in America* (6). The report went on to say that "the dentist-to-population ratio is declining, creating concern as to the capability of the dental

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workforce to meet the emerging demands of society and provide required services efficiently." Drs. Bramson and Guay report a 2003 ADA study that projects a real increase in the number of dentists, from approximately 170,000 in 2002 to approximately 185,000 in 2020. However, Dr. Jackson Brown, Associate Executive Director for the Health Policy Resource Center of the ADA, co-authored an article in the *Journal of the American Dental Association* in December 2000, indicating that beginning in 2008 there would be more dentists retiring than graduating, and that this trend would continue until 2020 (7). The American Dental Education Association estimates the aggregate number of dentists will begin declining in 2014 (8). These projections contradict those of Drs. Bramson and Guay. More recently, Solomon reported projections that are in keeping with the Surgeon General's Report and the ADEA estimates, indicating a significant decline in the actual number of dentists in the future (9). However, *all* agree that the dentist/population will decline, with the ADA calling the drop from 55/100,000 to their projected 52/100,000 "slight" in the present article, and "moderate" in an internal ADA document (10). Solomon's 2020 projection of 45/100,000 must be considered alarming. Regardless of which projection you accept, all indicate there will be relatively *fewer dentists* to treat *more patients* in the future. However, the issue is that we have significant access problems with the *current* workforce, not considering a reduced workforce in the future.

As Bramson and Guay point out, the issue of dentists failing to treat publicly insured patients is a multifaceted problem. They believe the primary impediment is under-funded reimbursement, which makes it financially infeasible for dentists to care for these patients. Actually, the addition of a pediatric oral health therapist to the dental team would help address this objection, just as including a dental hygienist on the dental team has been documented to be cost-effective for dentists, and economically advantageous for dentists and patients alike. The employment of a pediatric oral health therapist by a dentist (or other health care entity) would result in a delegation of restorative procedures for children to a dentist-extender, thus reducing actual costs and increasing the potential for dentists (and/or other entities) to provide care in a more financially efficient manner. Because therapists would earn less than dentists, services could be provided at a lower fee, and dentists could focus on therapy uniquely requiring their knowledge and skills, and for which they are better remunerated.

Bramson and Guay understate, largely by omission, the extent of the problem of oral health among American children. The results of the Surgeon General's Report have been disseminated so widely that it would seem unnecessary to review them (6):

- Dental caries is the single most common chronic childhood disease.
- Over 50% of 5-9 year old children have at least one cavity or filling and that figure increases to 78% among 17 year olds.
- There are striking disparities in dental disease based on family income. Poor children, one in four American children, suffer twice as much decay as their more affluent peers, and their disease is more likely to be untreated.
- Early professional care is necessary to prevent and maintain oral health, yet 25 % of poor children have not seen a dentist before kindergarten.
- The social impact of oral diseases in children is substantial. More than 51 million school hours are lost each year to dental-related illness. Poor children suffer nearly 12 times more restricted activity days due to dental problems than do children from higher income families.
- Oral health is critically important to well-being. Pain and suffering due to untreated dental disease can lead to problems with eating, speaking, and learning.

The core of the issue between the leadership of the ADA, ADA policy, and myself (and many others as well) is our philosophical assumptions regarding health care delivery. This is brought out in the rejoinder of Drs. Bramson and Guay. They rightly draw a distinction between the effective demand for dental care and the need for care. In doing so, they espouse a "self-producing system that operates without direct subsidization by government." They acknowledge that the trade-off in such a market-driven system is the maldistribution of resources in relationship to need. I contend that this is at the heart of our access and disparities problem today!

The eminent free market theorist, Adam Smith, in *The Wealth of Nations*, drew a distinction between *social* goods and *consumer* goods (11). He argued that for a market economy to function, it must be based on a foundation of what he called *social* goods. Among the identified foundational social goods are security, health, and education. Such social goods were, for Smith, outside the marketplace and not subject to the forces of supply and demand. Rather, they were seen as basic human needs and imperatives to be met by society in order for a marketplace to even exist. It is difficult to imagine our market-based economy surviving without citizens having a strong sense of personal safety and security, the physical health with which to work, and a basic education in the cognitive skills necessary to function in the marketplace. I join with Adam Smith in believing that health, including a "decent basic minimum" of oral health, is a social good, not a consumer good. As such it must be addressed outside the marketplace of consumer goods. Basic oral health care for children is not analogous to purchasing an automobile or buying a television. To understand basic dental care as a consumer good to be purchased in the marketplace is to accept the access problem children of poor families face today. A dental delivery system for children based on demand rather than need is not a system that meets the demands of social justice.

On the grounds of social justice, as advanced in my paper, it is unjust for children to have to suffer the ravages of oral disease—regardless of their race, ethnicity, socio-economic-cultural circumstance or any such environmental condition. Children are who they are, what they are, and where they are as a result of a natural lottery. They had no choice of the circumstance into which they were born. That is the reason the distinguished philosophers I quoted in the paper argue forcefully that social justice for children requires they receive priority consideration by society and be maximally benefited. The first grade child of a dentist has no greater right or claim to oral health than a classmate who is from a family living in poverty.

The profession of dentistry has a moral obligation—as a profession—to ensure that all children are provided with basic preventive and therapeutic oral health care. Society has granted dentistry the status of being a profession, with a monopoly to practice, in order to ensure the oral health of the public. Society could (and should) consider rescinding such protected status, absent the profession vigorously and courageously addressing the problem of access to oral health care, and disparities in the oral health among our children.

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