

An Obligation Unmet?

Te have commented previously on the positive impact the Give Kids a Smile program has made on many individuals throughout our state and the country. The improvement in the quality of life of those children who received treatment cannot be underestimated or understated. Indeed, one positive dental experience facilitated by one caring individual can prove to be a turning point in a young person's life. It has the power to elevate their awareness of oral health and establish attitudes and habits that will improve their chances of maintaining optimum oral health for a lifetime.

Behind these success stories and the many photos of smiling kids, dentists, hygienists, dental assistants, corporate sponsors and other volunteers, is a deeper and broader story. Some call it "access to care" and it has appeared at the front of every major dental publication and on the agenda of every major and minor dental organization. Give Kids a Smile and access to care are often talked about in the same breath, yet they are entirely different. Our profession does an admirable job donating dental services to the needy. In addressing the access to care problem, we have been less successful. It is the latter that warrants a focused, proactive, and collaborative effort that is led by the dental profession. And perhaps, a somewhat different tack than the one we've been taking.

One reason access to care is a difficult issue for us as a profession to get our hands around, is that it is poorly defined. Many in our profession have opined about whether there is a shortage of dentists, an unequal distribution of dentists, or both, that is limiting dental care in certain populations. For many living in California and across

the nation, the problem may not be due to access. Rather, it would be more accurately defined as "unmet dental needs."

Unmet dental needs in our population have two root causes. One of them is true access to dental care limited by geography, cost, or both. The other is personal neglect, either through conscious lifestyle decisions, lack of education about proper oral care, or unaddressed fear of dental treatment. When we as a society look for solutions to America's unmet dental needs, both of these potential causes must be considered.

Tulare County in California's San Joaquin Valley may very well be the epicenter of unmet dental needs in the state, and possibly the nation. It is not surprising then that local newspaper *Valley Voice* recently published an article, "Tooth Decay Most Common Health Problem Among Valley Children." The statistics are sobering: Tooth decay in California's children tops 60 percent; the next most common health condition, asthma, is slightly over 10 percent. Most will certainly agree that the health fallout from this epidemic is unacceptable. Yet, is the response of the dental profession proactive, reactive, or a little of both? Surprisingly, the article did not once mention the California Dental Association. And it mentioned the ADA only as a source of demographic statistics. Why do our profession's efforts go unnoticed once the buzz of excitement from Give Kids a Smile wears off?

Many are by now aware of the ADA's lawsuit against the Alaskan Native Tribal Health Consortium to halt the delivery of care by dental health aide therapists. While



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helping to uphold each state's dental practices act is likely a necessary and appropriate pursuit, some within our profession question its direction and timing. Ronald Hsu, DDS, said it quite succinctly in a letter published in the April 17, 2006, *ADA News*. "As long as we the dentists continue to ignore the access to care problem, creative means of getting care to those who need it the most will continue to spring up." Others wonder why the response seemed a bit reactionary; a response evoked because

someone else came up with a solution that we did not like.

Regardless of one's personal feelings, continued support of our profession's efforts to address unmet dental needs is imperative. To our ADA leaders' credit, the recent proposition to create a new category of allied dental health professional — community dental health coordinator — is right on target. This will likely pave the road to real long-term results in getting dental care to the underserved. Yet, this is a vision that

may have a tortuous path to fruition. The final report to the ADA House of Delegates this year is months away. The development of educational curricula and the amending of dental practice acts are years away. Creating an actual impact on the dental health of underserved populations will take even longer.

What can we do in the meantime? One suggestion made recently by one of our CDA leaders seems to have merit. It would call for the creation of a paid staff position for a dentist within CDA, a "Dental Czar," if you will, who could better coordinate local efforts that are taking place right now. We often hear of the great work being done by community clinics and individuals. Yet some gaps remain. A full-time dental staff person, devoted solely to our state's unmet dental needs could help to fill in some of those gaps. For example, care could certainly reach more individuals if patients' transportation needs were addressed. And placing at least one full-time health professional, such as a dental hygienist, at every school will give all children the opportunity to be educated about oral health care and screened for dental disease. Not to be overlooked is the fact that the public will see the dental profession put its money where its mouth is to make a tangible difference in the lives of those who need our assistance.

We do not need to seek to thrust ourselves into a leadership role on this issue. We, as dentists, are already looked upon by the public as the pivotal player in addressing unmet dental needs. We must, however, coordinate and maximize our efforts and be more proactive as a profession so that we live up to that role and meet our obligation. ■■■■