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# Health Care Reform... Practical Manifestations of Theoretical Values

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The American Association of Dental Schools (AADS) represents all 55 of the nation's Colleges of Dentistry, those in Canada and Puerto Rico, and many other dental, advanced dental, and allied dental education programs. In addition, our organization has 3,500 individual members. In some of my remarks today I will speak for our Association and I will speak about our adopted position on health care reform. I do this in my role as Chair of the Association's Legislative Advisory Committee. I will not articulate all aspects of the Association's policy on health care reform for that is a matter of record and available for your reading. I will also present our Executive Committee's comment on the health care reform position of the American Dental Association. Subsequently I want to speak for myself and examine the conceptual bases that may account for whatever tensions exists between these two positions. Finally, I will conclude with my personally held view of what values should undergird health care reform: values grounded in what I understand to be the concept of a profession, specifically a health care profession.

I will move fairly quickly from the practical machinations of health care reform to the differing value theories that give rise to alternative views of reform.

I hold strongly to the intimate linkage between theory and practice. All practice is related to underlying premises and assumptions, whether identified and articulated, or not. Obviously, the better one understands one's theoretical base, the better one is able to understand what practices to advocate, and why one advocates the practices one does. In arguing for the nexus of theory and practice, I take encouragement from the celebrated American philosopher and a personal intellectual hero, John Dewey, who for many years served on this campus as a Columbia University distinguished professor; and today continues to be acknowledged as among America's most notable contributors to the funded intellectual wealth of our world. To not place my argument in a Deweyian context would be to fail to honor his spirit on this campus! Arguably, Dewey's greatest work was *The Quest for Certainty*, in which he affirmed the imperative of linking the practical and the theoretical, or of not failing to distinguish between the linking of means and ends. His constantly recurring emphasis upon the importance of an intimate, reciprocal relationship between theory and practice is one we must recur to in the context of our current discussion.[1]

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## AADS Statement on Health Care Reform

I begin by excerpting the major premises of our Association's position statement.[2]

> The American Association of Dental Schools believes that the health needs of the public require a health care system that provides access to care for all Americans and effective and therapeutic treatment at a cost that is affordable. The Association considers universal access to care a fundamental goal to be achieved in any restructuring of the health care system. We recognize that this goal may be achieved from federally-funded, federally-mandated, or private programs, and/or a combination thereof. The Association believes that federal funds must be included where no other funding is forthcoming to finance basic health care benefits.

To maintain and improve general health, oral health services must be an integral component of all health care financing and delivery systems. The development and health of the cranio-facial region has a direct bearing on general health and well-being, and is a basic element in the quality of life.

The Association strongly supports basic oral health care benefits for all persons. These benefits should include the provision of acute and primary care. Acute care is emergency care to treat pain, eliminate infection, treat life-threatening conditions like cellulitis and oral cancer, as well as to treat traumatic injuries. Primary care is diagnostic, preventive, restorative, and periodontal care. It also includes prosthodontic care to restore minimal function. The Association believes that rehabilitative care that has as its goal the enhancement of aesthetics to an otherwise functional dentition is beyond the scope of the basic benefits grouping.

The AADS recognizes that important groups of patients require extensive care because of developmental defects and acquired anomalies impairing function, as well as chronic conditions that have oral manifestations. The Association believes that the scope of health care benefits must be sufficiently broad to provide rehabilitative benefits as part of the basic benefit package for these persons.

We believe dental education plays a pivotal role in ensuring access to effective health care through the provision of care, training, and research. Thus the Association supports the incorporation of this national resource into the nation's health care system. To this end, health care reimbursement should include compensation to health care institutions for the teaching costs associated with the provision of oral health care.

The AADS supports the provision of federal and state grants to dental education institutions to establish and enhance primary oral health care training through residency programs in general dentistry, geriatric care, pediatric dentistry, and dental public health. These residency programs provide trained oral health care professionals who are needed to ensure access in under-served areas such as rural communities, as well as to geriatric, handicapped, developmental disabled, high risk, and other medically-compromised patients. To facilitate access, the Association supports the establishment of grants to dental education institutions to offset the cost of providing to unserved and under-served groups.

Practitioners who are skilled in diagnosis, risk assessment, and treatment are essential to the provision of oral health care. The role of dental education institutions in preparing an adequate supply of practitioners who have the skills necessary to provide effective primary care is a fundamental part of the health care system. The Association, therefore, advocates grants that will enhance the educational process and improve the effectiveness of education in the health professions.

The Association believes that the number of minority graduates of dental education institutions should better reflect their representation in the population, and supports programs that will achieve that goal. Additionally, the Association endorses efforts that result in improving the health of minority and underserved persons.

The Association recognizes the important contribution that accredited programs in allied health fields of dental hygiene, dental laboratory technology, and dental assisting make to the nation's health. The AADS strongly supports initiatives that encourage enrollment, support students who are enrolled, and improve the effectiveness of dental allied health education programs.

The AADS supports programs that provide grants and low-cost need-based loans to students. In addition, the Association urges direct public support for dental education.

The retention and graduation of practitioners from disadvantaged groups as a goal is important for the public's health. The Association supports grant and loan forgiveness programs for disadvantaged persons and minorities.





Research is critical to the health of the nation. Both basic and clinical research have led to improvements in oral health. Further improvements will be the result of continued efforts to produce new knowledge in the prevention and treatment of oral diseases. The Association believes that the allocation of resources for biomedical research must receive a high priority. The Association also supports funding for educational research. Similarly, research in health services has increased the knowledge in the area of effectiveness of treatment and health care delivery. The impact of this research will contribute to cost containment, improved quality of care, as well as to an understanding of barriers to access. Therefore, the AADS supports funding for oral health services research.

With this I conclude my excerpts from the written policy of the Association of American Dental Schools.

## AADS Response to the American Dental Association's Health Care Reform Policy

The AADS supports, in general, the positions taken by the American Dental Association (ADA) in their white paper on "Access, Health Care Financing, and Reform,"[3] ...those positions articulated here today by Trustee D'Eustachio. We both affirm, endorse, and support:

- Accessible, cost-effective oral health care for all Americans.
- Renewed national commitment to health education and prevention particularly among the disadvantaged.
- Medicaid reform to include comprehensive oral health care for individuals below the poverty line, and adequate compensation for health professionals.
- Oral health care for children through age 18.
- Increasing the population served by communities receiving optimal fluoridated water supplies.
- Integration of health education, including oral health, into primary and secondary schools' curricula.
- Federal incentives for health practitioners to establish and maintain practices in underserved areas.

Among the differences in the ADA and the AADS positions is that the AADS advocates for dental education's inclusion in the health care reform debate, and we do not advocate a particular model for a reformed health care system. The ADA does propose a number of reforms speaking specifically to the structure and functioning of a revised system.

As an Association, we do have concerns regarding the ADA position. One concern focuses on what appears to be an assumption of the ADA that dentistry should not necessarily be a part of a comprehensive reformed health care system in this country. In the ADA's White Paper the following two statements are made:

*"The U.S. health care system's problem is essentially a matter of costs; dentistry has not contributed appreciably to the inflation in charges for health care services, therefore dentistry should be excluded from reforms of the system that would correct this problem."*

*"The cost-related failings of the nation's health care system are not failings of the dental care system."*

These statements suggest dentistry has not been a part of the problem, and therefore, shouldn't be a part of the solution. We believe dentistry must participate vigorously in the debate concerning health care reform. We have much to teach policy makers about cost effective ways of providing ambulatory care.

The ADA Task Force recommends that dental benefit programs continue to be treated separately from other benefit programs — that they be treated as they have been since the inception of modern dental prepayment in 1954. It goes on to say: *"none of the failings (of the health care system) apply to the delivery of dental care or to dental benefits."* Accordingly dental benefit programs should continue to be treated separately from hospital-medical-surgical benefit programs.

Elsewhere in the report, dental costs are referenced as *"discretionary."* We believe it is critical to challenge this conception — that is, that oral health care is discretionary when thinking about health care generally — with the tacit assumption that it can be ignored by the public and society. The AADS believes that oral health care is an integral and essential component of health care. Enchancing the quality, utilization, availability, and affordability of oral health care benefits the public's general health and well-being. The continued fragmentation of dentistry from health care delivery and financing has neither been positive for the profession nor good for the public. It is the reason today that the acute exacerbation of an infection in the oral cavity is treated differently, that is, not paid for with general health benefits, while such an exacerbation of the large toe is!

We believe talking about dentistry in terms of *"discretionary"* undercuts the reality that the oral cavity is a part of the human body; and implies that one can be healthy with-

out oral health. To suggest that oral health is not integral to and important for health generally diminishes dentists and dentistry as a health profession. If I could appropriate a line from Linda Niessen, in her testimony at the recent Annual Session of the American Dental Association: *"I am confident that none of we dentists here who have the degree D.D.S. would ever want to have that designation identified as standing for a 'Doctor of Discretionary Services'."*[4]

Finally the ADA position states: *"The current health care and benefit system must be preserved to the fullest extent possible. Such preservation protects the interest of practitioners."* The AADS believes this could appear self-serving and inflexible to those outside the profession.

## From Practice to Theory

While the American Association of Dental Schools and the American Dental Association share many common concerns in health care reform, the tensions brought out in our differences, that is, the importance of dentistry being integrated into the health care system, and dentistry not being viewed as discretionary spending; are potentially rooted in different value systems, or theoretical approaches to the ethics of health care. It is prudent that we explore these, if only briefly, in order that we can better understand why differences exist in our national debate and further understand how we might communicate more effectively in working through these differences.

At a recent Executive Committee meeting of the Kentucky Dental Association, one of my colleagues articulated an ethic common in the profession, while arguing strongly against dentistry's participation in health care reform. He said he was *"unwilling to give up the prerogatives of private practice, freedom-of-choice, fee-for-service dentistry ... free enterprise dentistry!"* This I think reflects the general culture of the profession of dentistry in America today. In such thinking, the individual and individual rights are paramount. This view is characterized in the literature and language of ethics as a libertarian theory of justice. On this view the dentist is one who, through personal initiative and discipline, has earned the right to offer dental services. Similarly, patients have a right to seek from whomever, whatever care they want ... and can afford. On this view of justice, societal benefits are distributed based on individual merit, contribution, or effort; not on the basis of need or equality. Health care will be unevenly distributed, for wealth is unevenly distributed. The preservation of the traditional prerogatives and personal autonomy of dentists (and of patients) is a principle not to be violated by society's priorities for the distribution of health care resources.

In such a *"free enterprise system,"* the business or commercial model of providing health care undermines what I will subsequently characterize as a professional model ... or a model I will want to argue is rooted in a tradition of caring. Commercialization of dental care in the United States has transformed the culture of dentistry. Dentistry has become a commodity produced and sold for a profit. The marketplace is free enterprise — therefore dental producers compete, and publicize their competitive spirit through advertising. Not only do dentists compete with one another, but they compete with their patients. The patient attempts to gain the greatest service from the dentist for the least cost, while the dentist is attempting to gain as great a net financial benefit as possible. The fiduciary relationship between dentist and patient becomes fractured. In this model, dental care becomes "discretionary spending" and is purchased in much the same manner in which a vacation is purchased ... or a new automobile. If you can afford it, you buy it. If you cannot buy it, you do without. Dental care is a commodity that dentists sell and patients buy. The dentist is a producer, the patient is a consumer, and the interaction between dentist and patient is one of many transactions in the commercial marketplace. As one leading critic has said, *"A new language has infected the culture of American health care. It is the language of the marketplace, of the tradesman, and of the cost accountant."*[5]

This libertarian theory of justice, of ethics, is challenged by both egalitarian and utilitarian views. On an egalitarian concept of justice, social and economic inequalities are not just to be accepted as the law of nature, a type of "social Darwinism" where the fittest survive; but are to be arranged, so that they are both:

- "Reasonably expected to be to everyone's advantage."
- "Attached to positions and offices open to all."

According to John Rawls,[6] the distinguished Harvard philosopher, this is the way in which we can achieve fairness in the "social contract." Fairness requires that the arrangements of a society should be





distributed in such a way that the benefits and burdens of that society are allocated irrespective of a person's position in that society. In formulating this notion of distributive justice, Rawls developed his so-called "veil of ignorance," behind which rational people would stand, not knowing what position they would occupy in a hypothetical, but just society. They could be either rich or poor, well or sick, dentist or patient. In this hypothetical situation, rational humans would design a society where the lot of the least well-off would be maximized ... since in reality that life might turn out to be their own! Thus on an egalitarian model, we acknowledged the intrinsic worth of every human and affirm that except for the natural lottery, we could be the poor individual unable to purchase oral health care for ourself or our family.

This concept of justice affirms the value and worth of every human being. It is related to Immanuel Kant's second formulation of his categorical imperative - *"act so that you treat humanity whether in your own person, or that of another, always as an end, and never as a means."*[7] People are ends in themselves ... never a means for others. Said differently, all humans are worthy of respect ... just because they are humans. It is impossible to contrast the worth of persons with the price of things. The price of a thing is a relative measure of its value in the marketplace, based on supply and demand. But human beings have a value of an entirely different order, they are priceless ... they are beyond the contingencies of the market, of supply and demand.

However, just saying that humans have infinite worth and value does not mean or imply that society should, or could afford to, provide unlimited health services to all. The egalitarian view is tempered by a utilitarian theory of justice. Society's resources are not limitless. While humans have infinite value, we can only allocate finite resources to caring for human health; there are other human goods to be cared for as well. On utilitarian moral grounds we should allocate funds based on the principle of the greatest good for the greatest number. Our resource base forces us to ask the difficult, but essential, question of costs versus benefit and value. Limited resources require that we ask the questions of what is a *"decent basic minimum,"* ... and how much can we afford.

An egalitarian view of justice is embedded in the idea of what it means to be a profession and a professional. In 1915, in a speech before the National Conference of Charities and Corrections entitled, "Is Social Work A Profession?,"[8] Abraham Flexner ... yes, the same Flexner of the Flexner Report on Medical Education published in 1910, helped establish our contemporary criteria for what constitutes a profession by identifying six cardinal characteristics of a profession. I will focus only on one. He said, *"Professions ... view themselves as organs contrived for the achievement of social ends rather than as bodies formed to stand together for the assertion of rights or the protection of interests and privileges of their members."* Professions and professionals are professions and professionals because they pursue the common good of humanity not primarily or necessarily their individual personal good. Professions and professionals are professions and professionals because they organize — not to protect their own interests (as do labor unions and trade associations), but rather to promote the common good. Professions and professionals are professions and professionals because they are committed to respecting the inherent worth, value, and good of each person ... as an end ... and not as a means. Professions and professionals serve the *"end"* of human good. Professions and professionals do not make other humans the *"means"* to their good.

Ethics in health care on a libertarian account leads to more of that which we have; an increasing gap between those who have health ... oral health, because they can afford it; and those who do not have it because they cannot afford it. Practitioners and patients being free in the market rings as hollow justification for the existence of poor oral health by the many in our society deserving of such a benefit, but who, through no fault of their own, are unable to purchase it. It's an argument that rests uncomfortably in the face of poor children who suffer from pain and infection because their parents cannot purchase care from the local proprietor of such care, while children sitting next to them in the classroom have superb oral health, not through any merit of their own, but because in the natural lottery they were born to parents of means. What price do we, as a society, pay for worshiping at the feet of this idol of individualism and autonomy?! A society that does not care for its sick is not a moral community. In fact, the moral fabric of a society is best judged by how it treats its least

advantaged citizens. The index of a nation's character is how it treats its underclasses.

The egalitarian view offers a countervailing value to the libertarian one by an ***EQUALLY*** American notion ... a ***"republican"*** tradition that stresses our obligation to rise above self-interest and to focus on the common good of the society. Republican with a little "r" is, in its etymological roots, commonweal or the common good. Health care reform must draw on this tradition to balance what has become the dominant individualist model. A call to pursue the common good is a call to pursue the good — a life of health — a life of well-being ... in common! It is a formal acknowledgement that unless we are all stakeholders in the good society and the good life, ultimately none of us will be. It is an understanding that our personal best interest is served when we, in a burst of enlightenment, affirm that other persons' interests must be served as well. It is an acknowledgement of the essential qualities of cooperation, of reciprocity, of mutuality ... in a civil society.

## Conclusions

While this egalitarian idea of the common good may sound like an ethereal ideal, it is, in fact, not. In this regard I quote a noted entrepreneur of the marketplace, the Chief Executive Officer of General Motors at a time of the apogee of its success. Charles E. Wilson, in 1953, while appearing before a Congressional Committee made a comment, which is often misquoted. He is misquoted as saying what many would have expected him to say, given his business focus and leadership of America's largest corporation, "what is good for General Motors is good for the country." In fact that is ***NOT*** what he said, and he spent his entire life correcting people who misquoted him. What he said was ***"what is good for the country is good for General Motors!"***[9] What is good for the oral health of the nation's citizens is good for dentistry! However — we must be vigilant to ensure that we neither believe nor promulgate the reverse, that what is good for dentistry is good for the nation's oral health. We all acknowledge that such does not necessarily follow.

My vision is of a profession of dentistry committed to health care reform ... a profession committed to access, no matter what one's social or economic circumstance. Access to what has been called a "decent minimum" of oral health, with such a "decent minimum" being defined in a way not dissimilar to that described in the AADS's health care reform policy. My vision is of a profession of dentistry that acknowledges that the good of the profession is best achieved by vigorously pursuing the good of society. My vision is of a profession that is characterized by society as a profession of practitioners caring, compassionately caring, for the oral health of America and all Americans.

My appeal is for all of us in the profession to work together with society to pursue the common good in oral health — which is the pursuit of the good of oral health — in common!

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