A Dialogue

Human Rights, Basic Needs, and Oral Health Care

The following letter was sent to *AGD Impact* in response to the December 2007 "Chairside Conscience" column, "Professional Sacrifice." This month's column will be the first of two columns devoted to a dialogue between the authors, David Ozar, PhD, and Donald Patthoff, DDS, MAGD, and David W. Chambers, EDM, MBA, PHD, about the ethics behind the issue of access to basic oral health care.

Are Americans entitled to dental care?

BY DAVID W. CHAMBERS, EdM, MBA, PhD

The ethics feature in the December 2007 issue of *AGD Impact* states the position that every person in a society with sufficient resources is entitled to access to basic oral health care. The argument is presented in three steps: A basic need is one that, if unmet, makes it impossible for individuals to strive effectively for any other goals; some medical conditions—those that threaten premature death, for example—meet the criterion of being basic; and that there are also oral conditions that satisfy this standard. Drs. Patthoff and Ozar frame this as a problem of government policies, which fail to provide sufficient resources to fulfill universal entitlement of the basic oral health needs that they have identified.

It would be difficult to find individuals to argue that better oral health is undesirable. Most dentists would favor infusions of funding into the profession under suitable circumstances. A plausible case can be made for both of these points, but not by means of the entitlement argument. I believe that the Patthoff and Ozar case fails on four grounds:

1. Most critically, the third step of their argument—the one where they must make the case that certain oral conditions are basic needs in the sense of making it impossible for individuals to meet life goals—simply is asserted as a personal preference: "we believe." Certainly it may be possible to make this argument; the authors did not do so. And step four—all or certain basic needs are rights—is never reached.

2. Basic needs, on the account of one cited expert, Henry Shue, are those that must be met to ensure effective striving for "any other goal" (presumably by all alternative means). Those who want to be weather reporters on television and have no possibility of diverting other personal resources to cosmetic care might, under this logic, argue that their basic needs have been abridged.

3. The entitlement argument has been developed by Robert Alexy and others as a relative standard; as modern society forces individuals away from independence, certain compensatory situations become welfare rights. Education, communication, and transportation appear to be good candidates for such emerging rights. Drs. Patthoff and Ozar are careful to limit their appeal for oral health entitlement only to those "societies with sufficient resources." The rub is that different individuals will define "sufficient" in different ways. And the first newly available dollar has many claimants waiting for it.

4. Under most interpretations of rights, there is a corresponding duty or obligation on "somebody's" part to guarantee entitlements. It is something like RNA; the two strands of the double helix are viable to the extent that they match. As Drs. Patthoff and Ozar emphasize in their essay, even wealthy societies have not embraced a general obligation for health or oral health. Perhaps

the best argument that can be advanced under these circumstances is that some people, such as Drs. Patthoff and Ozar, believe that there should be a right to basic oral health care in the face of the general public position that there is, in fact, no such entitlement.

There have been a number of attempts in the medical field to make the same argument based on entitlement that Drs. Patthoff and Ozar present, but none has been generally successful. Strangely, the more direct and philosophically valid argument that oral health is a social good is not as attractive as it deserves to be. A useful project would be to develop economic evidence for the case that dollars invested in improving oral health return a benefit to society. That approach has every prospect of meeting the goals of raising standards of oral health for the most unfortunate in America and increasing the general pool of resources in dentistry. I like it better than the suggestion in the December ethics column that dentists "should make sure that the patient realizes that he or she is a member of a society that ought to be responding to all its people's basic needs, but is not doing so."

The authors respond

Professor David Chambers of the University of the Pacific, Arthur A. Dugoni School of Dentistry has offered very thoughtful commentary about our December 2007 "Chairside Conscience" column. This response to his comments is the next step in a dialogue with Prof. Chambers that we hope will help our readers deepen their understanding of one of the most complex social ethical issues touching dentistry and health care. Namely, the question of whether our society has any obligation to attend to the unmet oral health needs of its people.

Preliminary points

The focus of the December 2007 "Chairside Conscience" column was on professional sacrifice (i.e., "going the extra mile" for patients) from the perspective of the social ethics of oral health care. We wrote the column because understanding the larger distribution system is crucial for a dentist trying to make the best ethical decisions about how much discounted and unreimbursed care to provide to patients who otherwise would lack access to needed dental care. We pointed out that one important reason why there are so many people who cannot pay for the oral health care they need is that our society's system for providing access to oral health care is not in fact designed to provide dependable access to everyone who needs it. One reason for this is the unfortunate fact that oral health care is not nearly as high a priority in our society as other aspects of health care. A second and more fundamental reason is that our society's distribution system for oral health care is principally a market system. It is a system that responds to patients' ability to pay rather than to their oral health needs. So while individual patients and families obviously make key priority decisions about oral health in the light of their available resources, the structure of the distribution system almost guarantees that there will be significant numbers of people in our society who will present themselves to dentists with oral health needs whose adequate treatment—never mind the best treatment—they cannot afford.

We stressed this point because it means that, while the professional generosity of so many dentists in our society is surely admirable, it addresses only the effects of a system not designed to meet everyone's oral health needs; dentists' generosity does not address the cause of this shortfall. Therefore, it is important for dentistry as a professional community to challenge our society, especially its leadership (not just our government representatives, but also the leaders of our health system, the leaders of industry, and philanthropy, education, and the media—all those who shape our society's priorities) to create a better system for addressing people's unmet oral health needs.

These were the main points of our essay, and Prof. Chambers' commentary does not challenge those points. In the course of explaining our points, we aimed to provide a justification for the idea that people's unmet needs should be considered morally significant, not just for oral health professionals, but for anyone who thinks about it carefully. Since we did not want to complicate that essay—which focused on a different topic—by offering a detailed explanation of the argument to which we were referring, we introduced the summary by saying "we believe" precisely to signal that the full argument was not included there. Oddly, Prof. Chambers' letter takes us to task for not offering the full argument, and even chides us for saying, "we believe," as if this phrase indicated that this merely is our personal preference, rather than signaling to our readers that only a summary of the relevant argument was being offered.

In addition, Prof. Chambers formed the impression that we were arguing for some sort of government-instituted entitlement program for oral health care. But nothing in our brief discussion of the rights-based argument that we summarized offered support for, or even mentioned, such a government-instituted entitlement program or any other specific social program for meeting our society's unmet oral health needs. That is an extremely complex matter which our December 2007 column did not address. Our point in the December essay was, if societies that have sufficient resources to do so fail to establish social systems to respond to their people's basic needs, and if some aspects of oral health care are among people's basic needs in such a society, then the dentists and the rest of the oral health community should be pressing the larger society to respond to this obligation. We did not discuss which kind of social response would best achieve this.

These two misunderstandings aside, however, we welcome Prof. Chambers' commentary. The question whether our

society has any obligation to attend to the unmet oral health needs of its people is one of the most complex social ethical issues touching dentistry and health care. We hope a dialogue with Prof. Chambers about this important question will assist our readers in thinking about it carefully themselves.

We should mention that, prior to developing this written dialogue with Prof. Chambers, we were able to exchange a number of communications with him to help clarify our points. Our comments that follow raise some of the points we discussed in those communications, but replicating those exchanges in their entirety would not be an efficient use of the space available here. Instead, Prof. Chambers will have the opportunity, in the next round of this dialogue, to comment on any of these points that he deems important.

Our December 2007 summary of the argument made three important social ethical assumptions. First, that our society (and any society with sufficient resources to do so) has an obligation to attend to the unmet oral health needs of its people. Second, that one way to argue for such an obligation is in terms of rights—specifically, that there is a human right that every person's basic needs be met in any society with sufficient resources to do so. And third, that at least some oral health needs are basic needs of this sort. We proposed that our society's obligation to attend to unmet oral health needs is at least one example of this kind of a rights-based obligation.

One set of questions about which Prof. Chambers has raised concerns is in regards to the soundness of the kind of human rights arguments about basic needs to which we referred. Another set of questions challenges our third assumption that some oral health needs are basic needs in the relevant sense. His third set of questions addresses our first assumption; namely, that our society has an obligation to attend to unmet oral health needs. He has proposed a different kind of argument—which does not depend on human rights claims—which might support this obligation.

Rights and needs

In the December 2007 column, we did not specify the type of rights about which we were talking. The argument we summarized was an argument based on human rights. But Prof. Chambers' misreading of it as an argument about entitlements indicates that it was quite possible to interpret it as if we were talking about legal rights and that our intention was to argue for government to fix our country's oral health needs. Professor Allen Buchanan in *Philosophy and Public Affairs* ("The Right to a Decent Minimum of Health Care"; Winter 1984), with some very narrow exceptions (e.g., those in prison, in some military services, and veterans to some extent), notes there clearly is no legal right to oral health care or to most other forms of health care in our society.

In addition, Prof. Chambers noted that when there are rights, someone has obligations, and he challenged the idea that meeting the unmet oral health needs of our society's people is an obligation of our government. Because we did not clearly explain which rights we were talking about, it would be easy to interpret our position as "tantamount to appealing for government to fix our country's oral health needs." That could, then, lead to the mistaken belief that we "framed this as a problem of government policies that fail to provide sufficient resources to fulfill universal entitlement of the basic oral health needs they have identified…in the face of the general public position that there is, in fact, no such entitlement [in our society]."

So our first task, now, is to state more clearly that our argument was intended to be an argument about human rights—the rights that all humans are widely believed to have in whichever society in which they live. And it was not intended to claim that the government in particular has obligations to do anything, but rather that society as a whole has an obligation to create institutions and social systems that are responsive to the basic unmet needs of its people.

> "One reason for doubting that oral health care is addressing any basic needs is the fact that most people consider oral health care to be elective health care."

Often society does fulfill its obligations to its people when government creates and/or manages these needed institutions. Part of that process typically involves the establishment and definition of the legal rights of whatever it is that the government institutions are trying to secure for the larger society. But there also are other processes available if a society truly is committed to something. The low priority assigned to oral health care by our society is not something that government can change in any direct way. Rather, it is a matter of enhanced societal and professional awareness of what goes into a healthy life, what can harm it, and the education a person receives. These are things that will not happen without a commitment of resources, especially human resources, across our society. But as Prof. Chambers rightly implies, this is a social change and one which cannot reasonably be the responsibility of the government alone.

Now we must explain more carefully the kind of human rights argument we tried to summarize in the December essay. The reader probably is aware that there are many people, including many political theorists, who believe that the theme of human rights is not useful in questions of social ethics. They believe that there are no characteristics of humans that are both extremely morally/ethically important and, at the same time, shared by every human being in such a way that respecting these characteristics would mean we all have obligations to treat every human being in certain ways. For example, we are not to harm them or interfere with their free choices and their resolutions and judgments.

One response to that negative view is the proposal that every human experiences a certain class of needs—often called "basic needs"—that are so fundamental to human functioning that, if they are not met, a person cannot pursue anything that humans value. This is a common feature of humans and it concerns something that is extremely morally and ethically important, namely, the ability to pursue any human values at all. Therefore, if humans ought to be concerned about the well-being of other humans, then our concern for others must include as one of its starting points a concern that others' basic needs be filled if this is at all possible. So, at the social level, this means that every society with the resources to do so—social ethical questions about the obligations of societies that do not have sufficient resources are more complex—ought to establish institutions or find other ways to define, rank, and address the unmet basic needs of its people.

There are dozens of theoretical discussions about human rights and there are many declarations and pronouncements about them. The most famous of the latter include our U.S. Declaration of Independence and the United Nations' Universal Declaration of Human Rights (1948). Our explanation here does not claim to answer every question about human rights, but we hope it clarifies the line of argument that we were proposing about the connection between basic needs and human rights in order to support our position that our society has an obligation to address the unmet basic oral health needs of its people.

"Therefore, it is important for dentistry as a professional community to challenge our society, especially its leadership (not just our government representatives, but also the leaders of our health system, the leaders of industry, and philanthropy, education, and the media—all those who shape our society's priorities) to create a better system for addressing people's unmet oral health needs."

Are any oral health needs *basic?*

Some of Prof. Chambers' most pointed comments concern the question about whether any oral health needs can count as *basic* needs. In the December column, for the sake of brevity, we simply quoted several sentences from Dr. Ozar's *Dental Ethics at Chairside*, rather than attempt to work out a careful answer to this question. Here is a more developed form of this proposal:

One reason for doubting that oral health care is addressing any basic needs is the fact that most people consider oral health care to be elective health care. There are, however, clear exceptions to this description. Oral health care, for example, includes the repair of oral deficits and complications that significantly interfere with respiration and other crucial components of health and well-being, such as nutrition and speech. There also is emergency oral health care through which dentists care for patients who feel pain that is extreme enough that it interferes with their ability to function. For the average dentist, these two types of care may constitute only a small fraction of his or her practice, and most patients rarely experience needs of these kinds, while some patients never do. Therefore, one might reformulate this objection by saying: Granting the statistically minor exceptions just noted, isn't oral health care elective care in our society? And, if so, how can oral health needs possibly be "so fundamental to human functioning that, if they are not met, then that person cannot pursue anything that humans value?"

It would be easy to summarize this objection by saying, "It seems to follow that people who lacked access to oral health care would then have to be incapable of functioning in any meaningful social capacity," and then conclude by saying something like "it is difficult to make the case that the American oral health care system places individuals below the subsistence level of life or prevents them from enjoying their liberties and other non-basic rights. The possibility of meaningful trades—say between televisions and oral care—appears to remove dentistry, and probably all of our health system, from the category of [what we define as] basic."

In order to respond to this objection, we must say that human rights arguments claim that societies have obligations to establish institutions and social systems to secure whatever the argument claims that people have a human right to; and obviously, for such social systems to achieve their goals, they need to be designed efficiently. Suppose for a moment that our society sought to establish a professional oral health care system aimed solely at responding to the oral deficits and complications that significantly interfere with respiration, nutrition, and speech, and emergent situations involving extreme pain. And also imagine that the oral health education of the public stressed that this is all that is considered necessary (in contrast with, among other things, the strong preventive oral health messages characteristic of our current dental professions). In such a society, some percentage of people still might seek routine oral health care and practice dental hygiene carefully; but the culture of oral health care, and arguably, how oral health is viewed and practiced by the majority of the population would likely be very different.

This means that dental-related consumables (both services and products) would be marketed and managed differently because the mix of desires, needs, and demands also would be changed. Many more people would need emergent care (because they are giving far less priority to care prior to emergency situations), and there probably would be many more instances of severe oral deficits that significantly interfere with respiration, nutrition, and speech.

A first point to make about this imaginary world is that many more people would suffer much more from oral maladies than do presently, and would, because of severe oral pain and malfunctions, be compromised in their ability to pursue their goals; health care discrepancies would likely expand. A second point is that running such a system arguably would be far more costly (assuming it did try to meet the oral health needs, as defined in the imaginary system, of every patient) than our present system, which is based on prevention, education for self-care, and routine dental care.

Our proposal, summarized far too briefly in the December 2007 column, is that many of the oral conditions that directly compromise people's ability to pursue their goals are the results of processes that can be halted or prevented much more cheaply and efficiently earlier on. So when a society is trying to secure for its people the avoidance of such events in the oral cavity, it makes far better sense to set up a system that does so efficiently; this means a system that is not only cost-effective but one that also reduces pain and deficit before they reach the experiential threshold that would identify them as clear instances of basic need.

Obviously this is a much more complicated position to explain and defend than the simple summary statement offered in our December 2007 column. More importantly, because this is a complicated position, there are many ways in which it may be in error. For example, demonstrating that prevention, education, and self-care are the most efficient ways to minimize oral health needs that are identified clearly as basic needs requires evidence that we have not tried to provide here. But our goal here is to pose the question to dentists and others concerned about oral health: Do any aspects of oral health care properly fulfill the definition of basic needs offered above, either directly or by being the most efficient and effective systematic approach to preventing direct basic needs from going unaddressed? If the answer to this question is "yes," then we propose that a society that has sufficient resources to respond to these needs for all of its people has an obligation to do so based on human rights.

If these two proposals from our December 2007 column are both correct, then dentists and others who believe that our society is wrong for failing to create institutions to meet its people's basic oral health needs have a very strong moral/ethical argument to support their view. But even if one or both of these claims were unfounded, it is still the case, as Prof. Chambers points out, that there is another kind of argument to make regarding why our society's current distribution system for oral health care should be fixed. In his letter, he writes: "A useful project would be to develop economic evidence for the case that dollars invested in improving oral health return a benefit to the society [in excess of the benefit that they can produce in other areas]. That approach has every prospect of meeting the goals of raising standards of oral health for the most unfortunate in America." We agree with Prof. Chambers about this, partly because so many people in our society view human rights to be relevant only to the actions of individuals, and not to the actions of groups and organizations, much less to whole societies. We are not saying this view is reasonably sound, only that this view is fairly common.

We support Prof. Chambers' reasoning, then, as another sound argument in favor of a social system that would secure access to basic oral health care for everyone in our society. We note, however, that arguments based on market efficiency usually are based purely on market measurements of what is valuable. It is not clear whether Prof. Chambers, in offering this argument, would allow other value measurements, such as oral health professionals' expert judgments about their patients' needs, as also relevant. In addition, in American society, market resolutions among competing values are based on competition. Does Prof. Chambers believe that competition is an adequate mechanism, on its own, to ensure that all members of society have access to the oral health care that they need? It is our view that there is no guarantee that those in a minority will be able to compete equally unless values other than those measured by the market are allowed a place in the system. Zygmunt Bauman proposes a strong argument for this view in *Does Ethics Have a Chance in a World of Consumers?* There is much, then, that still needs to be explained in Prof. Chambers' argument to assure us that it would yield the outcome he seeks.

We are most grateful for Prof. Chambers' efforts to analyze and critique our December 2007 column. We are hoping Prof. Chambers will respond to this column and that this further dialogue will illuminate still more of the complex social and ethical issues of human rights, basic needs, and oral health care. ◆

Donald Patthoff, DDS, MAGD, is a general dentist who has practiced in Martinsburg, W.V., since 1974. He has been a member of the American Society for Dental Ethics (ASDE), formerly known as Professional Ethics in Dentistry Network (PEDNET), since 1988, and has served as its president. He served as chair of the Ethics Committee of the Academy of Laser Dentistry from 1996 to 2003 and since 2006, and has been a member of the American College of Dentists ethics committee since 2001.

David Ozar, PhD, is professor and co-director of graduate studies in health care ethics in the Philosophy Department of Loyola University Chicago. He is an Honorary Fellow of the American College of Dentists and was the founder and first president of the American Society for Dental Ethics in 1987. He served as president again in 1998, as its unofficial executive director from 1989 until 1993, and formally as its executive director from 1999 until 2005.