Oral Health Care Is Not an Entitlement

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Abstract

The basic system for distributing oral health care in America is economic. With the assistance of government support and insurance to smooth out wide swings, Americans choose the level of care they desire and can afford. Adjustments to this system are desirable to both increased the overall level of oral health and to achieve a fairer distribution. These adjustments can be approached through (a) positive personal responses such as voluntary service, (b) working to improve the social good through the political process, or (c) proclaiming a right guaranteeing a minimum level oral health care. The first two approaches have much to recommend them. The argument from rights is not currently accepted by moral philosophers and appears to be ineffective. Further, the rights approach is off-putting and not conducive to positive discussions. In addition, it both undercuts the political approach based on the social good and questions the moral virtue of volunteerism.

Few of the good things in life are uniformly distributed across society. National defense, highways, access to the courts, and free public education are possibilities. Oral health care is not. It falls closer to the class of positive goods such as housing, access to jobs, and the kind of car one drives, all of which depend heavily on what one is able and willing to pay. Insurance smooths out and constricts the range of goods by protecting against the worst outcomes and by partially shifting risk to others. Research advances and product innovations, public regulation, and efficiencies that drive down cost are examples of what economists call externalities; those who pay less get more than they are entitled to, and sometimes more than they really want, when standards rise, because of the advances made possible by the heavy users.

Health care is one of the positive goods whose distribution is very largely determined by patterns of economic resources in society. This is true in America and is codified as a worldwide aspiration in the United Nations Declaration of Human Rights, which does not make health care a right. Article 25 of that declaration states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family."

Although the fundamental basis for distributing oral health care is well established, many individuals in Western liberal democracies also believe that some adjustments are necessary to the system. Some feel that insufficient attention is being paid to oral health compared with other choices individuals make, that infusion of more public resources would produce important benefits for everyone, that the system leaves some individuals with an unacceptable level of care, or even that there is overuse of dental resources at the high end that is drawing care away from the poorest who need it most. There is plenty of reason to believe that supplementing the basic "you get what you can pay for" system of oral health care has much to offer.

In this essay, I will look at the three most obvious approaches to adjusting the market system of healthcare distribution to make it fairer. In the baldest terms, these can be called: (a) "let me do what I can to help" (charity), (b) "let's work together to see what improvements make sense" (the social good), and (c) "somebody ought to do something about this" (rights). I will briefly sketch the advantages of charity and the social good and then devote most of my attention to the argument that oral health care is an entitlement. I can find no good reasons to support this view. It is largely loose talk: well intended, even noble, but ultimately both an unnecessary duplication of effort compared to the position that oral health is a social good and a detraction from the wise allocation of resources and the motive of altruism common among professionals. It is difficult to take this strong stand. I favor

rights—they play an important role in human society. I also favor more and better oral health—the advantages to be gained in that direction are significant. I do not, however, favor the rights argument for oral health care: it is a bad argument for a good cause.

Positive Personal Responses

One way to address perceived inequities in society is to roll up one's sleeves and do something about it oneself. That is the response of dentists and their staffs who volunteer for Give Kids A Smile, A Thousand Smiles, Rotoplast, or the many other organized oral health outreach programs. Closer to the office, there are screenings for pregnant teens, talks in the grade school, and fee adjustments that allow the poor to upgrade to better treatments. There are careers of charity where dentists forgo more lucrative opportunities to work on reservations, in prisons, or Federally Qualified Health Care Centers (FQHCs). The ADA estimates that the value of donated dental services equals approximately 5% of the value of all oral health services annually. This amount matches or exceeds the total federal budget for oral health care.

Philosophers and psychologists debate whether there really is a motive called "altruism," and social policy critics note that the voluntary response from the profession is entirely too small to address existing disparities. Both of these concerns miss the point. A sizable proportion of the profession recognizes that improvements can be made in the current distribution of oral health services and have chosen to do something about it themselves. They respond above what they are required to do; they act rather than pointing to the problem and making arguments that somebody else should do something. It is a positive personal response.

There is a difference between the charity of dental professionals and that of the green movement, animal rights, and political action committees. The overwhelming voluntary contribution of oral healthcare professionals is "in-kind" and is "dental care" (both puns fully intended). Dentists go with their charity, in contrast to those who send a check to save the whales. One is on very firm moral ground when trying to correct a problem by taking direct personal action. The whole argument about who caused the problem in the first place and what everybody else ought to be doing is short-circuited. As we will discover soon, however, those who believe in oral health care as a right regard the voluntary service responses of dentists as a sham.

Oral Health as a Social Good

The social burden of poor oral health in America was chronicled in the Surgeon General's Report of 2000. We have objective measures of the benefits to society we might expect from making

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improvements. American school children lose about 75,000,000 hours of school because of dental disease, and three times that number of productive work hours are lost annually. The cost of nursing home care is inflated by nutritional problems and their attendant medical effects cause by inability to eat. Hospital care and emergency room responses to dental neglect are enormously expensive. Dentists in uniform know their mission is to ensure that our young men and women are service-ready. Oral health is more than a private benefit; it a common good that society as a whole enjoys.

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The ADA, state health departments, various specialty organizations, and groups representing classes of individuals in need of care are among those working in this rational-political arena. The argument is not that someone is morally flawed because a third party is not getting as much oral health care as someone would like. Instead, it is a positive argument that society would benefit from investing in the oral health of its citizens and that anticipated benefits justify the costs of making things better.

We may underestimate the impact of the social good because so many dentists practice solo. Politicians confuse the matter by focusing on headline cases such as Diamante Driver since concrete examples are more persuasive than collections of statistics. We are also held back because there is no word in our language for an individual who needs oral health care but is not a patient and because dentistry is paid for on a procedure basis rather than an outcome basis.

There can be defensible differences of opinion about how to value the benefits of oral health or its absence on an individual basis. How do we weigh veneers for a well-to-do individual compared with endodontics and a crown for someone who has completely neglected his or her oral and general health and has every prospect of continuing to do so? How many appointment slots should a dentist set aside for Medicaid patients, and at what reimbursement levels? As important as these issues may be in an economic and bioethical sense, we need not wait on answers to them before addressing the aggregate oral health of Americans as an issue of the social good.

Unlike the personal positive response of volunteerism, where the individual dentist has almost complete control over what actions take place, the argument from the social good involves complex, multiparty decisions about the common good. Like the argument from the personal positive response, it means getting one's hands "dirty." It involves political give and take, trade-offs, or adjustments to account for emerging technology or economic downturns. But there is no requirement that those working for adjustments to the basic economic foundation of our healthcare system know in advance who is morally right or wrong before and while engaging in the process. The guiding principle is approaching the common good.

Dentistry is already a notable public good, in America an outstanding one. It will never reach all people with all the benefits that can be imagined, but a sound approach to extending its reach involves making a clear and reasoned case for its contributions to society in total.

Oral Health Care as an Entitlement

There is another way to approach optimal oral health; one based on rights. On this view, society has a duty to provide protections, goods, and services that are universal and unconditional. Human rights are available to all humans; no one can be denied, even based on citizenship, criminal activity, or their own lack of interest or cooperation. When the class eligible for rights becomes restricted by characteristics of the recipient (as by age, income, years of residence, or oral status) or by limitations on the guarantor (such as whether there is enough money to fund the benefit), we use the term entitlement. The argument that oral health care is a right is an argument that there are classes of dental services that are due to all and that a society or dentist that fails to provide them is unethical, and in some cases acting illegally.

This position has been well laid out by Don Patthoff and David Ozar in *AGD Impact* (December 2007) and in chapter 13 of David Ozar and David Sokol's *Dental Ethics at Chairside*. They frame their position this way: all individuals are entitled to a certain level of dental care if a society can afford it because oral health is a basic need. The level of care is variously defined as response to pain severe enough to impair function and correction of defects that interfere with respiration, speech, nutrition, and speech; emergency care and care that ends life-threatening situations; universal access; and most patient education, restorative dentistry that preempts the need for later intervention, and some esthetic work.

The principle source for advocating from basic needs is Henry Shue's book *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy*. Shue arranges human needs in a hierarchy beginning with basic ones and progressing upward through social functioning and ultimately to flourishing. Basic needs include freedom from torture and freedom of movement, adequate nutrition to avoid starvation, and minimal preventive public health. Basic needs must satisfy two conditions: (a) it is not possible to pursue any other need unless basic needs are first met and (b) basic needs cannot be traded for other needs (thus, minimum income is not a basic need nor is health as defined by the United Nations). All of the discussions of basic needs or health as a right that I am familiar with are developed in the context of foreign aid to underdeveloped countries where conditions are truly horrific.

In moral philosophy, rights are recognized as having normative power: they oblige society to guarantee the rights. Societies that fail to do so are ethically flawed, and individuals who violate others' rights can be sued or even forfeit their own civil rights. Society may voluntarily accept such obligations by passing laws or developing regulations that create entitlements. When individuals are unable to engage the collective will of society, they sometimes still maintain a nominal claim for their assertion of a right. For example, the American colonies could not engage the interests of England, so they declared their independence, based on certain "self-evident truths" which were redeemed through war. Shue believes that any gap in basic needs automatically places the more favored nation under a moral obligation to eradicate the disparities in all other nations. Basic needs are not suggestions or theoretical ideals: they are ethical imperatives.

Rights arguments involve guaranteed minimums. We are not considering a fair distribution of services across the whole range of needs and resources. A society's resources must first be allocated to ensure a baseline standard for everyone. Remaining resources in the common pool are then distributed on other grounds. If the existing system is unable to provide this uniform base coverage, resources must be taken from some in the form of taxes or fees for redistribution or regulations must be crafted to redirect services.

The Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) already provides for that minimum access, regardless of income or citizenship, that the many healthcare rights advocates are campaigning for. It is true that emergency room care for the sequelae of oral problems is inefficient, undignified, and costly; but these are arguments from the perspective of the social good, not a rights concern.

The voluntary service approach to adjusting the fundamental economic oral healthcare model depends on those who care doing what they can. The social good model involves discussions among concerned parties for a continuously better use of common resources. Both of these are two-party approaches involving direct contact between the professional and the beneficiary. Three parties are involved in the entitlements argument: the beneficiary, those who are obliged to provide the benefit, and the ethical judge who speaks "on behalf of" the beneficiary and attempts to force the behavior of the provider.

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Difficulties in the Argument from Entitlement

Positive personal responses and working for the social good are complementary approaches to improving the distribution and overall level of oral health. The rights position is antagonistic to both. Noble language does not always lead to noble outcomes. We need to consider some of the difficulties that follow from claiming that oral health care is a right.

Of immediate concern is the fact that all moral philosophers are either silent on the question of health as an entitlement or, like such well-known writers as John Rawls and Norman Daniels, state clearly that it is not a right. The word "right" is sometimes used informally to mean something really important, or an aspiration. A teenager might stomp her feet and say "I have a right to a cell phone because every kid at my school has one." Someone advancing a social policy who has run out of arguments might resort to claiming their position as a "right" or if really pressed a "fundamental right, and there is the end of it." Rights language has a way of closing off rather than encouraging discussion. It is a loose way of talking. The English philosopher R. M. Hare finds this to be a positive danger rather than a simple inconvenience: "It is the unthinking appeal to ill-defined rights, unsupported by argument, that does the harm."

A clear and passionate voice for the intrinsic rightness of health is Martha Nussbaum, a lawyer concerned with the interests of those with disabilities, the international poor, and animals. She "insists" (that is her term for laying out a philosophical position) that we must declare health, among other capabilities, a necessary condition for dignity at the constitutional level. She concedes that there is currently no overlapping consensus on this position but is willing to leave it to the legislators, courts, and lawyers to bring about implementation of the ideal. In the legal sense, rights are not actionable; they must first be converted into laws or administrative regulations. This is the sense in which Nussbaum, Shue, and others in the international humanitarian rights movement write. Rights language diminishes other voices that should be heard, such as those of experts, the market, and even citizens who may prefer a different profile of what constitutes a good life. Deciding on behalf of others carries moral responsibility. Deciding on behalf of everyone is a very heavy responsibility, and making the decision a vague principle does not change that fact.

Rights are preemptory. Their posture is "I don't care what else you are doing to try to make things better, that will have to wait until all the rights of all people have first been satisfied." Rights, certainly the "basic needs" type, are not fungible. That means that they cannot be broken into parts and approached incrementally or worked into compromises, even with other rights. In theory, this entails that those who view oral health care as a right must bring this demand to the table as a precondition for even talking about improvements in our dental care system. They don't play well with others in the political process of strengthening oral health as part of the social good. (In practice, most individuals who use rights language are happy to be at the table and are willing to leave their rights in the hallway as "aspirations.")

Universal, unconditional entitlements to a level of oral health care run into conflict with the political process aiming for the maximum social good in these areas:

1. Other distributions of oral healthcare resources besides a universal minimal standard might be more effective in raising the overall level of oral health (this is the position of John Rawls). The best fire protection plan for a community may not be to sell some fire trucks to provide all citizens with fire extinguishers.
2. Oral health, despite its importance, may not be the most important issue facing society, and it would be prudent to work with those who are concerned about education, drunk driving, domestic violence, etc.
3. Oral health care might be optimized without optimizing oral health. Readers will note that I have consistently emphasized outcomes rather than processes (oral health rather than oral health care). Rights language speaks in terms of oral health care. A focus on ends rather than means will open more possibilities and promote more just distribution of resources.
4. Beginning from a position of ethical superiority based in asserted rights and coming to the conversation with a solution in hand that must be defended may actually shut off the search for the best common question and the best common solution.
5. In the end, rights language is a discussion stopper. Self-evident truths have a take-it-or-leave-it quality that does not invite constructive discussion.

There is also a tension between rights and positive personal responses. Rights language undercuts altruism and property rights. Shue, for example, describes basic needs as taking precedence over other rights, such as the right to own personal property, and thus concludes that legal action against thieves or cheats who are attempting to claim what they call basic needs is not warranted. Medicaid fraud in the name of helping the poor or failing to pay the part of one's health bill thought to be unfair are considered ethical responses to an unjust system. Shue goes further, finding no merit in the altruism of those helping the underserved. Because the underserved are already entitled to care, we deserve no credit for ministering to them and can only stand morally reprehensible for withholding it. Shue advocates the "coercion of the unresponsive." Nussbaum concedes that most of what she advocates is not enforceable, but she does quote approvingly Grotius and other historical philosophers who argue that no one has an ownership right in anything that others need.

Conclusion

A higher quality and more available oral health care is a worthy vision and something to work toward. This can be achieved through advances in oral healthcare technology, better delivery systems, more affordable financing, engagement of help organizations that advocate for and support marginalized citizens, and political and regulatory steps based on recognition that oral health is a public good. Volunteering service is an effective and uplifting part of this process.

Beginning this important work by claiming that oral health care is an entitlement is a distraction. Our society has not embraced this view and it is unlikely that it will be shamed into doing so any time soon. If "rights" language were merely an innocuous and noble ideal, we could continue to talk in such loose terms while pursuing the heavy lifting of improving oral health outcomes by other means. But there are negative side effects involved with the rights claim. First, it is poor philosophy. Second, it is off-putting to engage others who are key to advancing the cause of oral health by saying they are ethically off base. Third, entitlements are the business of legislators and lawyers, whereas oral health is a matter for professionals and patients. Fourth, the rights approach locks us into a strategy of moving up from the bottom at a uniform rate, and analysis from the perspective of the social good suggests there are more optimal approaches to triaging the shortage of oral health resources. Fifth, rights approaches undercut important norms such as private property and voluntary service to others. ■

Recommended Reading

Summaries are available for the four recommended readings with asterisks. Each is about eight pages long and conveys both the tone and content of the original source through extensive quotations. These summaries are designed for busy readers who want the essence of these references in 15 minutes rather than five hours. Summaries are available from the ACD Executive Offices in Gaithersburg. A donation to the ACD Foundation of $15 is suggested for the set of summaries on stress; a donation of $50 would bring you summaries for all the 2009 leadership topics.

Daniels, Norman (1985).
Just Health Care*
Cambridge, UK: Cambridge University Press.
ISBN 0-521-31790-0; 245 pages; about $20.

Although he denies that access to health care is a right, Daniels develops a theory of distributive justice based on a minimal threshold of access needed to provide equality of opportunity. This entails compensatory care for those with handicaps, greater needs (including those resulting from personal choices such as smoking), and age, but not for those who want to advance their station in life. Daniels tackles some hard issues such as fairness to providers, regulations designed to equalize risk, cost allocation, and implementation—without having clear answers to any of these.

Hare, R. M. (1979).
"What is Wrong with Slavery?"
Philosophy and Public Affairs, 8 (2), 103-121.

A strong statement of the dangers of vague moral talk, unsupported assertions about personally favored positions, that stands in the way of well-grounded approaches to addressing such issues of social importance as slavery. Despite being addressed in the *United Nations Declaration of Human Rights*, slavery remains a significant and widespread problem today, including in the United States.

Kidder, T. (2004).
Mountains Beyond Mountains
New York, NY: Random House Trade Paperbacks.

The inspiring story of Dr. Paul Farmer, a specialist in infectious diseases, whose mission trips to Haiti metastasized into a worldwide network of third-world health care. There is an undercurrent of liberation theology in Farmer's work, a Roman Catholic movement to bring social justice to the poor through aggressive political means.

Nussbaum, Martha C. (2006).
Frontiers of Justice: Disability, Nationality, Species Membership*
Cambridge, MA: The Belknap Press.
ISBN 978-0-674-02410-6; 487 pages; about $25.

The question of justice toward three groups is considered: individuals with physical and mental handicaps, the poor in other countries, and non-human animals. The common characteristic is that that none of these can negotiate for a share of justice based on contributing to and receiving mutual advantage. All are said by Nussbaum to be entitled to full dignity, defined in terms of ten capabilities, such as bodily integrity, life, and affiliation. Capabilities are defined as "being able to" achieve a threshold or minimal level of the ten characteristics needed for a life of dignity. This is a political philosophy argument that Nussbaum defends as being potentially realizable, say at the level of constitutional amendments, even if it does not now exist.

Rawls, J. A. (1999).
Theory of Justice (rev. ed.)
Cambridge, MA: Belknap Press.

The most influential voice in the Western liberal tradition. "Each person is to have an equal right to the most extensive scheme of equal basic liberties compatible with a similar scheme for liberties for others. Social and economic inequities are to be arranged so that they are both (a) reasonably expected to be to everyone's advantage, and (b) attached to positions and offices open to all." In this view there is equality of opportunity and those who are already well off are entitled to even more so long as that also benefits those worst off in society. There is no guaranteed minimum.

Sen, Amartya. (1992).
Inequality Reexamined*
Cambridge, MA: Harvard University Press.
ISBN 0-674-45255-0; 207 pages; price unknown.

Sen argues that there are multiple simultaneous dimensions over which we could argue for equality (income, liberty, satisfaction, etc.). Theories compete based on what they take to be the critical dimension of equality. He favors a dimension described as "capability" into which he combines resources necessary for effective functioning that realizes important life goals. The book is rich in discussions of issues such as the inability to clearly measure equality under any definition and the difficulty in answering questions about which aspects of initial starting positions should count are requiring remedy.

Shue, Henry. (1980).
Basic Rights: Subsistence, Affluence, and US Foreign Policy*
Princeton, NJ: Princeton University Press.
ISBN 0-691-07259-0; 231 pages; about $18.

Basic rights, such as security, subsistence, and some liberties, are necessary for the enjoyment of any other rights or preferences; they cannot be traded away without causing early death. The author argues that it is a duty for affluent countries to supply these if other governments fail to do so because degradingly extreme inequalities are unfair. "This is a book about the moral minimum—about the lower limits on tolerable human conduct individual, and institutional."