

DenatI care access

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M3 Populations: Dental Care Access to the Underserved First Middle initial
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Access to basic oral health care is a human right in my opinion. However, dental providers have often based their decision to treat patients after considering the patient's payment status. This has been a secret and core ideology based on which dentists screen their patients. The service costs of many dentists are not affordable to the underserved and dental offices restrict access to care for patients that have no ability to pay or have no insurance. Dental practices that have state of the art services sometimes do not provide dental services to patients because their quality of service exceeds the insurance coverage. Dental offices have therefore intentionally or unintentionally limited the access to care based on the cost of service. In fact in many dental offices, one cannot get treated until they pay for the service. These are some of the barriers that have been established by health care professionals.

Even dental school students are encourage and taught how to select and/or reject patients. The reason behind this is because students get into a tight spot if their patient doesn't pay and they might not receive credit for treatment. So, with this mental concept students develop an understanding of how to decide whether or not to treat a patient, because being a dental student takes time and money. The treatment and the dialogue with patients also take a lot of time, which translates into money earned. In other words, if a patient cannot pay, then it is considered that the dental student has wasted his time, even though the student provided treatment as required of him. There are even problems with cash only and fee-for-service practices
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because they have the potential to prohibit certain patients. Even agencies may impose such practices upon the individual providers they employ, suggesting that the ethical behavior of institutions can adversely impact access to care. In this paper I will explain the issues concerning access to dental care for the underserved, which includes the elderly, minorities, and children.

The current practice in dental care has resulted in the public, especially the vulnerable population, to receive inadequate access to care. Researchers have suggested many solutions to address this discrepancy in access to care which include:

strengthening the safety net system, provide adequate payment, optimize the use of appropriately educated or certified allied dental personnel, make special arrangements for special populations, develop cultural competency for providers and expand the mindset of dentistry to recognize that non conventional patients are as much a part of their responsibility as any other patient (Garetto & Yoder, 2006, p. 1168).

The only solution I find, that will address this issue effectively, is to have a system that gives every patient equal access, no matter what ethnicity or economic status they are from. In my research, I have found several articles that reveal that health care providers convince themselves that universal acceptance is important, but very little is done in practice. Many dentists overlook this issue as a potential way to exchange ideas and promote better access to dental care.

Without some type of universal dental care, dentists will continue to mutely engage in strong patterns that adversely affect access to the underserved population. In the upcoming election this will be the subject of ongoing

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review and debate. The conception of universal dental care is constructed to be one kind of applied ethical tool or strategy that allows the ethic of acceptance to be more effectively pursued in daily practice.

According to the research conducted by Bailit & Newhouse (1986) on preschool children who were randomly assigned different dental and medical insurance plans, “ children covered by the plan which required no cost sharing had significantly fewer decayed teeth and deft (decayed, extracted and filled teeth) at the end of the study than did children covered by the cost-sharing plan” (p. 773). I sincerely hope that universal healthcare will become the main focus for patients, practitioners, and public officials to create a dialogue that strengthens communities and results in solutions that improve the access to underserved populations. Netherlands is an example of a European country that provides regulated universal health care. In fact a 1996 survey in Hague revealed that there was a definite decline in the occurrence of dental caries among 12 year old native children who are from the low economic status (Truin et al., 1998).

The biggest issue with dentists giving back to their community is that the treatment is more driven towards what the practitioners consider limited care treatment and not necessarily addressing the needs of the patient or population. It is extremely important that dentist realize that population needs must be the priority in treatment for the underserved. Volunteer dental care is one temporary solution that depends on dentists who take the time out to provide dental care. Since, in most limited care, volunteer clinics, patients do not receive the best possible care that can be given. For example, let's say a twenty five years old Mexican female comes in to the dental office with pain in her lower molars. After oral examination the dentist

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finds that the patient is suffering from irreversible pulpitis. He explains the symptoms and her clinical treatment scenarios. Since, she is poor and does not have any health insurance her most likely accepted treatment will be an extraction and not root canal therapy. Therefore, dentists in this situation would not go in for the long term solution because of the issues concerning time and money. These are some examples of why it is so difficult to meet the needs for treatment.

Garetto and Yoder (2006) state that the location also has an effect on volunteer efforts, because there are limited sites and communities where dentists are willing to participate. There may be some communities that have dental care centers where dentists may volunteer at. But the greatest need is in a local nursing home, prison, half-way house, or outlying community where the dental care services available are very limited. Transportation and related costs may also be major barriers to access. Timing also is an important issue. For example, some underserved communities have many blue collar workers who prefer evening and weekend clinic hours so that they can access care when they get off from work. With the increase in Spanish speaking population, language barriers also cause problems with access. In communities where English is not the primary language, there may be a real need for translators and office personnel who can help individuals and families through the registration and care process. The overall emphasis on urgent needs deflects from the need to stress prevention at the individual and community level. Since volunteer efforts are often inconsistent, patients may see several different dentists who use different techniques which can create significant gaps in service over time. It is hard to ensure adequate treatment planning and

management on an ongoing basis with such arrangements.

The elderly is also affected with lack of access to proper dental care services.

Most elderly patients are on a fixed income that requires them to make choices for care. Sometimes, for an elderly patient, medical care may outweigh dental care. Community programs that cater to the elderly are needed to address the issue of lack of access to dental care for these patients. Transportation is also an important issue among the elderly population. There are several hospices or at home healthcare services that help with medical issues, but not too many dental offices have a mobile clinic available for these patients.

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