Access to Care for All

In the September 2005 issue of the *CDA Journal*, Christine Miller, RDH, MHS, MA, wrote an interesting article about "Access to Care for People With Special Needs." The abstract alluded to a population of special needs children of unknown number, but who are treated by only 10 percent of the general dentists. We then leave this population to discover that one-third of California's population (10.2 million) have no access to dental care. That's four times the population of the San Francisco Bay Area. And it's implied that the population will increase by 50 million, leaving us to calculate that 16.5 million Californians will have no access to care. Those are very big numbers that have no access to dental care. However, the middle of the article seems to be an argument to consider expanding duties for hygienists to include irreversible restorative duties to mainly care for schoolchildren. We are urged to believe that numerous studies have shown that training equivalent to the New Zealand School Nurse Program will allow hygienists to do procedures at a similar level of dentists. There is finally a quote at the end of the article that notes how we need to maintain and expand an adequate oral health work force in size, ethnicity, and linguistic competence to meet … the oral health problems of people with special needs.

I don't know for sure, but I don't think that the quoted number of Californians have no access to dental care. Many Californians have less-than-perfect access, some may have no access, and certainly many poor and underprivileged special needs children and adults are underserved. But training hygienists to work as school nurses will not solve the problem. It certainly won't address the lack of care for patients with special needs. It will provide a small group of patients with irreversible dental care by those who are less fully trained than dentists. It may be equivalent, because it has been shown over and over that it is possible to train someone to do a specific thing that dentists do with less training than a dentist receives, until the bur follows decay into the pulp. Then it won't be a dentist able to provide comprehensive care that solves the more complex problem. And how will the size, ethnicity, and linguistic competence of this group bring any additional care to patients with special needs? As is pointed out in other articles in the same issue, dentists need to be trained far beyond dental school to adequately treat those with special needs. And some major changes in funding are necessary to get enough money to bring treatment to this population. Training additional dentists or other therapists will have no effect without funding. It's been shown that auxiliaries with expanded duties do not automatically and altruistically provide services to those with special needs without compensation.

I find it irritating that an article uses the title of "special needs" to promote dental restorations by nondentists to patients in California or in any other ethnic, age, or health compromised group.

Working as a team, dentists, hygienists, assistants, and legislators can come up with a program to take care of everyone. Dentistry in the United States is the best in the world. It just isn't distributed perfectly. We should figure out a solution that offers all members of society, many the most needy and suffering, the opportunity to receive first-class care.

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