Dentistry and distributive justice

Shafik Dharamsi, Michael I. MacEntee*

Abstract

There is a growing concern in most countries to address the problem of inequities in health-care within the context of financial restraints on the public purse and the realities of health professions that are influenced strongly by the economic priorities of free-market economies. Dental professionals, like other health professionals, are well aware that the public expects oral health-related services that are effective, accessible, available and affordable. Yet, there is remarkably little reference in the literature to the theories of distributive justice that might offer guidance on how an equitable oral health service could be achieved. This paper considers three prominent theories of distributive justice—libertarianism, egalitarianism and contractarianism—within the controversial context of basic care and quality of life. The discussion leads towards a socially responsible, egalitarian perspective on prevention augmented by a social contract for curative care with the aim of providing maximum benefit to the least advantaged in society.

Introduction

There is the view that dentistry is a health service accessible only to the more advantaged members of society (Field, 1995; Chen, Anderson, Barmes, Leclercq, & Lyttle, 1997; Jones, 1998), yet, evidence is mounting that loss of teeth and other dental problems are more prevalent, and the consequences more serious, among lower income groups (Miller, Brunelle, Carlos, Brown, & Loe, 1987; Todd & Lader, 1991; Charette, 1993; DHHLGCS, 1993). Discussions in several countries and councils in Canada, USA, UK and Sweden about equity, accessibility and justice in health-care generally are changing the delivery of health services, including dental services. (Epp, 1986; Atchison & Schoen, 1990; Rosenthal, 1992; ADA Council on Ethics, 1995; Bradshaw and Bradshaw, 1995; Hill, 1996). There is favour for some level of universal health-care and it is high on the policy agenda in many industrialized countries (General Accounting Office, 1991; Cust, 1997). A Presidential Commission in the USA (1983), for example, proclaimed society’s “moral obligation” to ensure adequate health-care for all, and the American College of Physicians (1990) called for a national policy to “minimize financial barriers and assure access” to health-care. There is general agreement today that basic health-care should be distributed equitably, however, there is little consensus on what is meant by basic care, especially within the context of oral health (WHO, 1978). Inequities in oral health abound because of social and economic factors. Children from low-income families in the USA have substantially more decayed teeth and more untreated oral disease generally than other more affluent children (US Department of Health and Human Services, 2000), and social status is the most important factor explaining differences in caries among European children (Bolin, 1997; Sweeney & Gelbier, 1999). Moreover, the promotion of foods high in sugar content is targeted frequently at poorer groups who, as a result, are placed at an increased risk to caries and tooth-loss (Gamble & Cotugna, 1999). This tooth loss can limit employment opportunities and compromise
the nutrition and health of individuals. The problem is compounded even further in dentistry by tensions between the moral values that identify it as a health profession and the commercial values of practice where the impetus is on entrepreneurial self-interest. In an effort to clarify the options available to the dental professions and to societies feeling this tension, we have introduced here the prominent concepts of distributive justice that can lead to an equitable distribution of oral health-care.

The right to health-care

In 1948, the Universal Declaration of Human Rights from the United Nations asserts “everyone has the right to a standard of living adequate for... health and well-being... including... medical care and necessary social services”. Although the current debate on health-care as a moral right is rooted in social and religious concepts of charity, beneficence and compassion (Chapman & Talmadge, 1971), recently there has been an effort to promote a more inclusive view of health-care and equity in health that recognizes the significance of distributive justice (Barry, 1989; Whitehead, 1992). The World Health Organization (1998), for example, has refined its view to include the various rights and responsibilities of individuals and of society to promote health. The theoretical support for this more inclusive view is derived more from the egalitarian and contractarian theories of justice than from libertarianism. Essentially, the responsibility of health promotion poses the obligation on individuals and on society to develop healthy practices and to refrain from actions that threaten health, with the clear possibility of forfeiting rights when there is intentional participation in risky or careless behaviour (Lindbladh, Lyttkens, Hanson, & Ostergren, 1998). Libertarians, on the other hand, support the right of personal autonomy over the demand of health promotion, despite the risks. Yet, struggles with the inequities of health-care continue to revolve around the distinction between basic care and elective or discretionary care.

About a quarter of the population in North America, usually the least advantaged in society, visit dentists for little more than emergency care (Miller et al., 1987; Charette, 1993). In South Africa, over 75% of the black population reported visiting the dentist or dental clinic for symptomatic reasons (Van Wyk, Faber, Van Rooy, & Olivier, 1994). Although it is not clear how much of this behaviour is due simply to poverty, at least it does raise concern about the way dentistry is offered (Weiss, MacEntee, Morrison, & Waxler-Morrison, 1993). Dental services through Medicaid in the USA are unique among all the health services to have sustained a decline (30%) in public expenditures since 1975 (Oral Health Coordinating Committee, 1993). Similar concerns about access to other health services prompted Daniels (1985) to suggest that everyone should have an “equality of opportunity” as proposed by Rawls (1971) to maintain a reasonable quality of life through an equal opportunity for basic care. Daniels’ suggestion addresses five essential services: (i) food and shelter; (ii) safe and clean habitat; (iii) exercise, rest and recreation; (iv) health-care; and (v) social supports. He did not define “quality of life” or “basic care”, nor did he indicate how much opportunity a society can afford or who should have access to the opportunities. Nonetheless, it is a four-tiered management process that addresses prevention, rehabilitation, management of chronic disorder, and palliative care. However, it has also the potential of being a very expensive approach to health-care, almost to the point where financial costs could overwhelm benefits. Concern for costs in many countries, most notably in the Netherlands (Government Committee on Choices in Health-Care, 1992), Britain (Roberts, 1992) and Canada (Mhatre & Deber, 1992), and even more so in developing countries, poses a significant challenge to universal care and endorses the idea of rationing care in favour of those with greatest need.

Quality of life

Quality of life is a complex and multidimensional concept that has been associated in recent years with the outcome of health-care. It refers usually to a mix of biological, psychological and social dimensions of illness from the perspective of the patient (O’Boyle, 1997). Its influence on physical functions, emotions, cognitive awareness, life satisfaction and economic status has caught the attention of researchers interested particularly in chronic disease, yet it remains a vague concept. More recently, the term “health-related quality of life” has emerged to focus on “the value assigned to the duration of life as modified by the social opportunities, perceptions, functional states and impairments that are influenced by disease, injuries, treatments or policy” (Patrick & Erickson, 1993). Unfortunately, there is no agreement either on how this relates specifically to basic care, and, like the expansive 1947 WHO definition of health, it probably has little practical value for public policy (Evans & Stoddart, 1994). Nonetheless, the concept of health-related quality of life could have practical meaning within the specific confines of oral health-care (Slade, 1997). Oral health is an essential part of the daily comfort, hygiene and general health of older adults (MacEntee, Hole, & Stolar, 1997), and oral health-care a constant concern for caregivers in long-term facilities (MacEntee, Thorne, & Kazanjian, 1999). Despite the apparent banality of tooth-loss, a defective dentition can disturb eating, speaking, general appear-
 ance and comfort, and it does precipitate serious illness (Reisine, 1988). In fact, there are few adults who have not experienced some problems relating to oral pain, eating or appearance. Sick-leave is attributed more to dental problems than to most other disorders (Hollister & Weintraub, 1993), and the Provincial Health Officer in British Columbia has disclosed recently that dental treatments are the most common hospital-based surgical procedures, usually involving general anesthesia, for children under 14 years of age in the province (Provincial Health Officer's Annual Report, 1997). Caries in children disturbs their growth and ability to thrive (Acs, Lodolini, & Kaminsky, 1992; Ayhan, Suskan, & Yildirim, 1996), whilst older adults are very concerned about the social and personal implications of their oral hygiene (MacEntee et al., 1997). In addition, there is also some evidence linking poor oral hygiene and periodontal disease with coronary heart disease, although a causal relationship has not been established (Mattila, Valtonen, & Huttunen, 1995; Beck, Garcia, Heiss, Vokonas, & Offenbacher, 1996; Joshipura et al., 1996; Howell, Ridker, Ajani, Hennekens, & Christen, 2001). In summary, it is increasingly more difficult to justify the separation of oral health-care from other health services.

**Basic oral health-care**

The varied circumstances of different communities preclude a universal definition of basic health or basic care. Therefore, each community defines its own health-related expectations and requires appropriate resources to meet those needs so that, according to the World Health Organization (WHO), “everyone should have a fair opportunity to attain their full potential” to “lead a socially and economically productive life” (1995, p. 64). The WHO falls short of providing guidance on how a fair opportunity or equity can be attained. Attempts have been made in several jurisdictions to ensure that basic oral health-care is accessible to all. The State of Oregon, for example, rations health-care to its residents who are less well-off by measuring the cost-effectiveness of various medical and dental services, with the idea that cost-effective care refers solely to simple, preventive, primary, inexpensive or acute care (Block & Freed, 1996). On the other hand, the very idea of basic care has been challenged as morally untenable because it excludes “non-basic” care from the less affluent segments of society (Veatch, 1991a, b). Indeed the concepts of cost-effectiveness, cost-benefit and cost-utility of health-care are all complicated and contentious measures (MacEntee & Walton, 1998), and there are dentists who feel that cost-effectiveness as a measure of basic care conflicts with their ethical principles (Bryant, MacEntee, & Browne, 1995). The Berlin Oral Health Declaration (1995) contends that oral health can be maintained simply and cheaply as part of an overall “prevention” strategy to restrict sugar consumption and enhance personal hygiene. Curative strategies, in contrast, are technically demanding and costly, especially when replacing teeth and tooth-structure, and it is in the realm of curative treatment where demands for basic care so frequently conflict with treatment needs, in large part because providers and recipients frequently have very different perceptions of health. In any event, basic oral health cannot be defined or addressed in isolation of the general political and economic structures of society. Healthy diets need food, and personal hygiene needs clean water, while curative treatments need skilled clinicians with costly equipment and supplies. However, no matter how it is defined or identified, the need for basic oral health-care is vast, even in North America, and especially among those in the lower socio-economic bracket (Mojon & MacEntee, 1994).

**Distributive justice**

Distributive justice addresses the distribution of benefits and burdens in society (Cupit, 1998). It is based fundamentally on the principles of social justice, which offer moral directives to a just allocation of resources, a fair compensation to providers, and a reasonable range of services (Annas, 1995). There is a growing sensitivity worldwide to the principles of social justice in an effort to distribute health-care equitably (Whitehead, 1999). The problem extends well beyond a discussion of simple supply and demand, with factors such as social structure influencing demand, and wealth or opportunity influencing resources (Lamont, 1999). Nonetheless, we will offer here a brief explanation of the more dominant theories underlying the current concepts of social justice to provide a context for distributing oral health-care equitably.

**Theories**

Theories on social and distributive justice, of which libertarianism, egalitarianism and contractarianism are the most prominent, have emerged to support health-care policies (Roemer, 1996; Van Doorslaer, Wagstaff, & Calonge, 1992).

*Libertarian theory* is the hallmark of a free-market economy where freedom of choice lies on the highest moral ground (Nozick, 1974). Libertarianism in the United States and Britain, for example, supports a multi-tiered structure in which basic health-care is financed publicly and elective care is bought privately. The distinction between basic and elective care, however, is frequently very unclear. Libertarianism has been used also to support the rights of individuals to neglect
their health without social interference unless the neglect causes damage to others. This concern about damage to others has centred largely in the debate about tobacco use and the right of society to limit the liberty of some for the betterment of all (Beauchamp, 1991).

Egalitarianism, in contrast, holds that everyone should have an equal claim on all available resources, and that health is a necessary precondition to an “equality of opportunity” in life (Outka, 1974). It supports the principle of sharing all health resources equally as a social responsibility (Veatch, 1991a,b). The Canadian health-care system, for instance, professes a health service to all without inequalities or disadvantages (Naylor, 1998), although there is a growing concern that access to health-care in Canada is less egalitarian today than originally intended. The feasibility of an egalitarian health service hinges on the scope of the service and the economic support available, which harks back to the idea of “basic” health-care and the “bottomless pit” of demand. The European office of the WHO favours the principles of equal access to available health-care, equal utilization for equal need, and equal quality of care for all (Whitehead, 1992). When pitched against these principles, the curative focus of contemporary dentistry appears quite inequitable.

Contractarian theory evolved from the belief, focused by Rawls (1971), that social inequalities and disadvantages are unavoidable, and that a fair and unbiased social contract could be struck for distributing basic needs to the population. In contrast to egalitarianism, Rawls and his followers advocate a system whereby inequalities and disadvantages are managed by distributing our limited resources and services to the maximum benefit of the least advantaged in society. Rawls produces a scenario in which individuals sit around a table to negotiate and formulate the immutable principles that will govern their social practices. He poses that everyone at the table is informed fully about the issues involved in the negotiations, including the knowledge required to balance personal interests with the potential fate of everyone else involved. All in attendance know the relevant facts that affect life, including the knowledge to balance personal interests with potential fate. What is not known, however, is everyone’s actual fate that deals out natural assets and abilities, intellectual capacity and strength, and other features such as gender, race, etc.; therefore, decisions around the table are biased by the rational self-interest of each individual. Rawls describes this feature of the scenario as the “veil of ignorance” that provides a measure of impartiality to the deliberations. Given this scenario, Rawls believes that everyone at the table will act with self-interest to gain maximum advantage, especially since there is the very real possibility that each individual could be the least well off because of fate. Although it is not easy to make complicated moral decisions involving all members of society, he contends that it is relatively easy to make personal decisions in an effort to gain a reasonable share of the benefits and burdens of society. This “maximin” imperative, as he calls it, offers everyone the possibility of protecting and maximizing interests that are important and minimizing burdens as much as possible. Certainly, inequalities are not eliminated in this system, but they are arranged by a social contract that justly provides the least well off with the greatest opportunity to access all goods and services, including health-care.

A proposal for equitable oral health-care

The policies and practices of dental professionals like other health professionals reflect health-care increasingly as a monopolized commodity serviced extensively for profit (PEW Health Professions Commission, 1995; Woodstock, 1995). Libertarian theory, as the hallmark of a free-market economy, has widespread appeal in many professional organizations. It favours the more affluent members of society, especially in countries with unstable economies, and it does not lead necessarily to an equitable distribution of care (Mautsch & Sheiham, 1995). Egalitarian theory supports the distribution of health-care without limits so that everyone can have ready access to all available resources with health considered as an essential resource. This idea has much utopian appeal but it is losing support in many countries because of growing concerns about public debt. Health-care expenditures in affluent countries already run close to 10% of the gross national product (USA 14%; Germany 11%; Canada 9%; Australia 9%; and UK 7%) with the emerging view that the demand for health-care is a bottomless pit (WHO, 1999). Hence, today the moral resolve to provide care for the poor, the aged and the disabled is constrained by strong economic and professional factors. Nonetheless, we believe that most health-care professionals take pride in offering a public service that promotes the public interest and the common good.

The principle of distributive justice that addresses the fair sharing of benefits and burdens in society is described most aptly in Rawls’ contractarian theory. It promotes the cooperation of free and equal persons to establish health-care as an essential benefit and burden of society. We are attracted to this theory because it has had a substantial impact on the topic of distributive justice generally and it has been adopted, we believe successfully, to address the unique concerns of health-care. Moreover, Rawls’ “veil of ignorance” brings impartiality or fairness to decisions about the distribution of care. There is no universally accepted definition of basic care, nor is there agreement on how health and health-care interacts with quality of life. According to
the Berlin Declaration, the scope and content of care remains for each society to define for itself based on its specific resources and expectations. Clearly, expectations of care vary greatly between wealthy industrialized communities and less wealthy agrarian communities. Indeed, this negotiation process is far more complicated than Rawls suggests, particularly in communities or countries where language, culture, education, and economic status differ greatly. However, valid concerns have been raised about the benefits of modern dentistry with its emphasis on complicated curative treatments. If the expensive curative model of dentistry continues to prevail, as it has over the last century, then there is a very urgent need for a social contract to ensure that the maximum benefit will go to the least advantaged in society. Indeed, this contract seems to be the most socially responsible and self-interested course of action given the very real possibility that fate could place anyone of us among the least well off in society. Alternatively, if the preventive model of care assumes its rightful place in containing oral diseases and sickness, then it might be possible fiscally to adopt an egalitarian approach to oral health-care so that everyone can benefit without distinction.

Conclusions

Dentistry is evolving to address personal and social problems that stem in large part from a widespread ignorance of diet and nutrition, hygiene and dental services. The potential demands globally for oral health-care are enormous, yet it is offered predominantly as a curative art with only a small emphasis on the prevention of disease. Moreover, there is no obvious agreement on what constitutes a reasonable range of oral health-care services, a just allocation of resources, nor a fair compensation to providers. Delivery of care can be viewed from several theoretical perspectives, but the greatest rewards for society can be derived from an egalitarian perspective on prevention supplemented by a social contract for curative care that will render maximum benefit to the least advantaged.

References


Further reading