**A call to action for oral health**

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This issue of The Journal of the American Dental Association features a report on a nearly yearlong systematic review of scientific literature examining the use of various workforce models worldwide to perform such surgical procedures as restorations and extractions.[1](http://jada.ada.org/content/144/1/95.full#ref-1) It was important for the American Dental Association (ADA) to have undertaken this effort to assess whether change in disease increment, untreated dental disease or cost effectiveness of dental care can be documented by applying an objective, high-level, evidence-based discipline. We are grateful for the enormous amount of time and effort the highly qualified reviewers and authors dedicated to this process.

The paucity of high-quality evidence as a conclusion of this review is disappointing, but not surprising. Of the more than 7,000 citations initially identified, only 18 observational studies were found to address the proposed question; none were randomized clinical trials.

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The available literature does not address disease other than caries and revealed no evidence related to the cost effectiveness of utilizing these providers in place of dentists. Most significantly, there is no apparent difference in caries increment between populations receiving care from various alternative workforce models that perform surgical procedures and those receiving the same services solely from dentists.

Advocates for improving public oral health increasingly have called for the creation of alternative providers in the United States, citing a perceived shortage of dentists and a lack of sufficient numbers of dentists willing to care for underserved populations. Among the arguments for doing so is the “proven success” of various workforce models in improving access to care in numerous other countries. But the ADA systematic review found no evidence to support claims that utilizing new workforce models to perform surgical treatments improves the caries experience of the affected populations. In fact, one of the most significant findings is that despite decades of use of these workforce models in numerous countries, there is no apparent reduction in disease incidence.

Of course, the availability of more personnel to treat disease means that more disease will be treated. This extensive systematic review did find scientifically valid studies that supported this simple observation and expectation. However, there is no indication that using new workforce models to treat caries surgically will have any impact on the larger problems specific to U.S. populations, such as declining adult utilization; the lack of adequate, effective financing mechanisms; poor oral health literacy; and the need for better case management.

The debate over workforce models stems in part from a growing societal awareness of the importance of good oral health and concern over the extent and degree of disparities among certain populations. None of this is news to the dental profession. We collectively deserve credit for all we do to try to improve the oral health of those who, for any number of reasons, lack adequate access to care and the resulting improvement in oral health. That said, all we do—charity and volunteer efforts; caring for patients in public assistance programs that often fail to reimburse the cost to the provider; bringing care into schools and other institutions; advocating at the local, state and federal levels to increase funding for dental programs; attempting to locate dentists where they are most needed; and advocating for fluoridating community water systems—all that we do is not enough. Tens of millions of Americans continue to go without regular dental care, many of them suffering the expected consequences.

The intense focus among various stakeholders on the issue of whether to use alternative workforce models as dental surgeons is distracting attention from the “bandwidth” of access issues, and it threatens to sap resources from the need to solve a complex set of problems. The barriers that impede millions of Americans from attaining good oral health are numerous. No single solution, no single group can foster the kind of change needed to improve the dentally underserved. But I believe a carefully constructed “suite” of initiatives can make that change happen.

The ADA Board of Trustees has developed a “Call to Action for Oral Health,” a declaration of dentistry’s commitment to leadership in developing actionable, measurable solutions to oral health disparities, and has directed the organization to pursue its implementation aggressively. This “Call to Action” covers five broad concepts:

* providing care now, by leveraging the capacities within our current system;
* preventing disease, by focusing on known prevention methodologies and better aligning existing resources, such as school-based health programs;
* using the safety net effectively, fully utilizing existing infrastructure and funding while reducing administrative costs;
* advocating for healthier lives, through guidelines on healthy nutrition and marketing foods and beverages to children, providing nutrition education in the federal Supplemental Nutrition Assistance Program, and highlighting the dangers of tobacco use;
* leading the public to oral health literacy through increased outreach, such as the ADA’s new [MouthHealthy.org](http://MouthHealthy.org) consumer Web site and our participation in the Ad Council’s major advertising campaign aimed at improving families’ understanding of how to care for their own oral health.

These broad goals share two common elements. First, they won’t happen tomorrow. We all must make a sustainable commitment for the foreseeable future. Second, dentistry cannot accomplish them alone. But we can and must lead. Our capacity to make an impact at the individual level must be coupled with broad solutions to impact disease at the population level. This will happen not only by identifying what we need to do, but also by identifying and removing those barriers that keep us from doing it.

No single one of these actions will “solve” the nation’s oral health disparities. But addressing all of them strategically and tactically is the first step to achieving our collective goal to help those who need help most.

The ADA must be the standard bearer. We will advocate, innovate, build consensus and provide the tools for dentists and others to take on the enormous challenges the nation faces in improving oral health among those who lack adequate access to both knowledge and care. State and local dental societies will select the initiatives that best suit their members and the patients they serve. But ultimately, it rests with us—the dentists—to answer the call to action and make it more than just words.

My tenure as ADA president may last for only one year, but I will be a practicing dentist for many years to come. As such, I pledge to give my all toward making the ADA “Call to Action for Oral Health” the premier voice in the movement to build a healthier, more productive nation. I hope you will join me in answering the call.

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