Oral disease care or Oral health care – which one shall have priority?

Efficient health care is based on the balance and the interaction between several fields – as between clinical work and epidemiology, science and practice, curative care and prevention, aimed health objectives and societal and economic conditions. (The intention here is to point to the interrelation between the fields, as for example between curative care and prevention, that should be in balance.) When Damle advocated the balance between research and practical care in his editorial of this journal in 2012, January to March 3 (1),[1] he underlined the fact that the final objective of healthcare as a whole is the ‘well being of humans’. In view of this ethical objective another balance is crucial too: The balance between curative care and prevention.

Even though preventive dentistry in many countries has substantially contributed to quite a high average level of oral health, there is often no satisfactory balance between curative care and prevention (as well as methods of less invasive treatment) in both dental education and the oral health care practically carried out. Why?

How far can the balance described above be reached between both societal and economic conditions and the surroundings influences? Health care systems are not just influenced by such factors, they are even a part of our worldwide prevailing economic system (i.e. market system) itself. This means, besides its genuine objectives, medical care is a business too. This is, for example, shown by the fact that in the Organization for Economic Co-operation and Development (OECD) countries the healthcare system, on an average, contributes to 9% of the Gross national product (GNP). A business depends on the sales volume. In this instance, the sales volume of the healthcare industry is primarily disease – not health. This is one significant reason why treatment of disease is primarily the focus of the medical profession (s).

This, in a certain sense, interferes with what basically should be one of the most important objectives of HEALTH care, which is captured in the concept of health promotion, described by the World Health Organization as, ‘the process of enabling people to increase control over their health and its determinants, and thereby improve their health.’

No doubt, when it comes to disease, qualified diagnostics and therapies are indisputably among the high cultural and scientific achievements of mankind and should therefore be accessible and affordable to everybody in a society. Efforts to avoid disease, however, generate the highest benefit for both individuals and society – but not always for parts of the present medical industry, with their rather myopic view.

All these conditions result, to a large extent, in our systems being structured as SICKNESS care. In consequence, the maintenance and promotion of health and well-being has lower prestige and is mostly a comparatively small part of the professional education. This is also reflected by the fact that work in this field is in many cases paid less than work in the curative field.

Looking at the basic dental education around the world, 80-90% of the curriculum covers clinical treatment. Epidemiology, dental public health, community dentistry, health promotion patient–dentist communication, healthcare systems, and health economy are just (if at all) appendages of dental education. Therefore, it is easy to understand that if one has spent thousands of hours to learn clinical treatment he/she will focus on this competency within his/her daily work. This is a simple psychological mechanism and nobody can directly be blamed for that. In addition, as treatment is higher paid than all the work that is done to keep people healthy, this creates a strong incentive, which works in favor of treatment rather than disease prevention and health promotion.

In contrast, the fact that the best medical and health outcomes one can ever achieve are those of having successfully promoted and secured health and quality of life, should be appreciated, and promoting health and preventing
illness should be established in a manner that corresponds to its real value.

Meanwhile, those countries experiencing very rapid development, which also includes rapidly developing healthcare systems, face a great opportunity: This period of development may open ways to integrate the modern view of health care (i.e. health promotion and disease prevention) in their curricula. In that manner, they can avoid the mistake of creating the imbalance between treatment of disease and prevention of disease; and by doing that, at least partly avoid the explosion cost of the health care system, which is found to be one consequence in industrialized countries.

Models of curricula more supportive of health as well as role models of healthcare professionals, especially in the field of education, would be crucial for shifting trends in this direction. Furthermore, as a result, these countries might find themselves as models of change for countries that want to reform their healthcare systems and the corresponding curricula away from the antiquated and very expensive care structures that are focused on sickness.

It is easier to establish something the right way than to undo the wrong thing in order to rebuild a better one in its place. The time is right to learn from the mistakes and problems of the former industrialized countries and build from the ground up, a more effective and efficient healthcare system in which disease prevention, health promotion, and the needed skills play a significant role. Subsequently, after being trapped in partially outdated systems, we may learn from these new models of health care, which will themselves be healthy with regard to both their structure and performance.

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