Commentary

Children's Oral Health: The Time for Change is Now

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During my tenure as US Surgeon General, it was my privilege to work with leaders in the dental, public health, and research communities to generate *Oral Health in America—A Report of the Surgeon General,*[1] which we published in 2000. We made several very strong recommendations in the report with the hope that they would stimulate action. Indeed, a Surgeon General's worst nightmare is to produce a report that just sits on the shelf gathering dust. This special oral health issue of *Academic Pediatrics* is proof that that has not happened. Not only was there the very important follow-up workshop and conference, *The Face of a Child* in 2000,[2,3] and the publication *A National Call to Action to Promote Oral Health* in 2003,[4] but the intervening years have seen a growing movement to address the oral health needs of children.

In particular, the American Academy of Pediatrics held a PEDS21 symposium, Oral Health in the 21st Century, where I spoke,[5] followed by a national oral health summit in November 2008,[6] where experts from leading medical, dental, and other organizations, family advocates, and federal agencies described progress in meeting the recommendations of the 2000 Surgeon General's Report on oral health. Most importantly, the group discussed strategies to accelerate children's access to oral health care services in America in light of epidemiologic evidence of increasing dental disease in some of our very youngest children. The papers in this issue summarize the strides that have been made since 2000 but also identify areas where we can—and must—redouble our efforts to assure progress. I commend the American Academy of Pediatrics, the Academic Pediatric Association, their collaborators in the public and private sectors, and the editors of *Academic Pediatrics* for the leadership role they have played in making these results widely available.

In this country there is a gap between what we know and what we do. We have a remarkable record of achievements in basic science, but when it comes to conducting the translational research to move that science into services we fall short. When I was at the Centers for Disease Control and Prevention, we coined the term *silent epidemic* to describe serious health problems that were not getting the attention they deserved. The term very accurately applied to what the data were telling us at the time of our report about the oral health status of Americans: 80% of childhood dental disease is concentrated in 25% of children, and the burden falls heavily on low-income families. We are talking about tooth decay, a disease that is completely preventable. Yet since 2000, we have been alerted to the deaths of children because of complications of tooth decay: *that* is the gap between what we know and what we do.

Those tragedies occurred because children lacked access to oral health care, an example of the disparities in health that in 2000 saw 39 million Americans without health insurance and over 100 million Americans without dental insurance, whereas the country itself was spending $1.4 trillion in health care. Today we are spending $2.3 trillion a year; the number of uninsured has risen to 47 million; and the number without dental insurance remains near 100 million, a crisis that has made health care reform a central theme of the current administration. We have to work to make sure that *everyone* has access to health care, *including oral health care,* and we can, if we work together.

We must continue to conduct research and expand the science, but also make policy consistent with that science. Here I am pleased to note progress: at the federal level the collaborative efforts of many pediatricians, family physicians, dentists, and other key child health advocates led Congress to reauthorize the State Children's Health Insurance Program in 2009, a program that greatly expands children's access to oral health care. As well, recent federal policies require the inclusion of dental services in all new federally qualified health centers.

Those are excellent policies. However, they are occurring at a time of acute shortfalls in the dental workforce so that the very clinics mandating treatment for our most vulnerable patients lack dental personnel. Several papers

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in this special edition address this critical workforce shortage in both the private and public sectors, parsing a range of demographic, cultural, educational, financial, and insurance barriers, which we described initially in the Surgeon General's Report, and which in many cases have worsened over the decade. Gratifyingly, the authors also discuss programs already in place or in prospect to resolve the shortage, either through additional training of pediatricians or family physicians or the creation of new categories of health care workers skilled to provide routine oral health care. For the most part, these new oral care skills are being applied to children under the age of 5. Not only are these critical years of growth and development, but they also provide a window of opportunity to educate and guide parents on all they can do to promote healthy eating, regular exercise, appropriate oral hygiene, and all the other factors that contribute to oral and general health.

Much of our current knowledge of the health status of Americans comes from the Department of Health and Human Services' updates and goals for the decade in *Healthy People 2010.*[7] In that context we can take pride in the notable expansion of the average lifespan in America. But when we look at the quality of life of older people and not just the number of years they live, we find that many have significant health problems. Moreover, we tend to forget that the quality of life of these older Americans is not something that began at age 65; it reflects how they were treated as children. There is no better example of that than oral health. In our report we noted that 30% of adults over age 65 were edentulous. Their loss of quality of life affects what they eat, how they communicate, whether they shy away from social contacts, and how they feel about themselves. What they are experiencing as seniors reflects what they lacked as children, whether it was exposure to fluoride, healthy diets, regular dental visits and preventive treatments, or other factors that promote oral health. So in our report we emphasized recommendations to prevent oral diseases in children to promote lifelong oral health.

We also emphasized a second goal in our report: to target racial and ethnic disparities in oral health, recommendations that were also in keeping with the goals of *Healthy People 2010.* Here we identified as critical the need to improve access to care, but we underscored that family history, in terms of genetic and biological factors, as well as the physical and social environment, were also critical determinants of health. And of all of them, we said that behavior as it reflects and responds to all the other factors is the most important of all. Behavior is part of what children learn in their social environment.

Although we had been aware of the importance of the physical environment for some time (for example, the effects of environmental lead on children), we hadn't thought enough about the social environment, which turns out to be much more important than we ever appreciated. The World Health Organization recently released a landmark report by the Commission on Social Determinants of Health,[8] based on studies in countries throughout the world. The report documents changes in immune factors and other long-term health and social consequences for individuals living in poor environments who did not get the care they needed as children. Children are at the beginning of their lives; clearly, we have a moral obligation to intervene early and work with families so children can develop in a nurturing environment with the prospect of long-term benefits for their health and well-being.

Today we need a collaborative and integrated approach to oral and general health that includes social as well as biological determinants. For that we need leadership in our communities to ensure that children are getting the care they need. It is one thing to talk about good nutrition for oral and overall health, but if the community is not supportive, it's not going to happen. We are making some progress in the schools with regard to healthier snacks, but progress is not going to happen in the community if there are no decent grocery stores in the neighborhood or if there is no safe place where children can play.

It will take leadership in the community, particularly leadership by health professionals who can bring their expertise to formulating policies and programs. We invite oral health professionals, along with all child health professionals, to partner with families and others to strengthen our communities by supporting needed changes, not just in oral health care, but in all the other elements essential for healthy communities.[9]

The papers selected for this special issue of *Academic Pediatrics* are broad in scope, addressing key oral health determinants with elements that McKinlay[10] has termed *upstream* (putting the right policies in place), *midstream* (building components into communities, such as adequate workforce and grocery stores with healthy food), and *downstream* (providing guidance to parents and patients by health professionals, for example). As we have noted, the papers detail what has happened—as well as what has *not* happened—since the Surgeon General's Report. It is noteworthy that pediatricians and family physicians, who see very young children, have become sensitized to the importance of oral health and have initiated measures to expand their competencies, and in this way, relieve some of the workforce shortage. It will be important as well for general dentists to become skilled in treating toddlers and assume more active roles as community leaders. We are beginning to attack the barriers in the social and physical environment that contribute to unhealthy lifestyles, but it will take the concerted efforts of all the players and policymakers from the local community on up to the federal level. As such, they are a reminder that progress takes time. We published a report on mental health in America in 1999 and only now, almost a decade later, has Congress finally passed the act mandating parity between mental and physical health.

What is most encouraging is that these papers reflect a commitment to bringing the key players together, promoting collaboration and breaking down the traditional barriers between medicine and dentistry, with professionals in both camps finding common cause with leaders in the public and private sectors at all levels of society. *That* is the way to achieve success—the way to close the

gap between what we know and what we can *and must* do to improve the nation's general and oral health—starting with children.

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