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Unhealthy Politics of Oral Health

Michele Leonardi Darby, BSDH, MS

Oral Health America, a national advocacy group, has released a national report card on our nation's oral health. The report card reveals that we are underachievers in access to care, oral disease prevention, availability of oral health professionals, the policies that we promote, and the oral health care delivery infrastructure that we have created. Our overall grade achieved is a "C." One of the reasons for this mediocre oral health rating may be that our "unhealthy" politics have prevented the full utilization of dental hygienists.

Today, success in oral health care should not be measured solely by the treatment of disease, or by the quality of care available to a small portion of the population. What is the benefit of quality care if its beneficiaries are limited? Even quality oral health care fails when the health of the entire population is not preserved. Once disease starts, it tends to be cumulative, chronic, complex, and expensive to treat. In contrast, we should gauge the success of oral health care in terms of the degree to which we keep the entire population healthy.

Achieving oral health for all, especially those who possess the highest disease levels, is one of the greatest challenges facing our nation. Unfortunately, this challenge is strained by the economic downturn of the market, downsizing of operating budgets, high cost of drugs and technology, unemployment and underemployment, and the top-heavy demograph-

ics of the aging American population.

So how can we reach dentally-underserved individuals and preserve oral health for all? Certainly there is no easy solution, but "healthy" dental hygiene practice laws, if implemented, can enable both dental hygienists and dentists to cost-effectively prevent most oral diseases, cost effectively treat some periodontal disease cases and promote health. "Unhealthy" supervision requirements that are inherent in some dental practice acts undermine the ability of dental hygienists to provide care under established protocols and limit our ability to serve the entire population. Government reports consistently document the shortage of dentists in rural and inner city communities and the fact that marginalized populations do not receive regular oral health care. If dental hygienists were allowed to function more autonomously within these communities and populations, many of the drawbacks instated by current practice restrictions could be avoided. For instance, dental hygienists cannot treat people unless they have a recently documented visit to a dentist—a catch 22 for those who have no dentist. Such "unhealthy" laws are barriers to those outside the health care system—those most in need.

Second, with finite resources supporting an expensive health care system, responsibility on the part of all citizens to stay healthy is crucial. A significant component of a person's oral health status is behaviorally

based (i.e., influenced by tobacco and substance abuse, diet, oral hygiene practices). People who participate in health-promoting behaviors can expect oral health, even into old age. Education is crucial. Via dental hygienists, people not already in the health care system can learn that oral health and general health are reciprocal and that self-care practices prevent disease. People separated from the health care system because of costs, geography, language, or culture should be proactively reached, assessed, and referred to dentists for needed oral health care. Dental hygienists, as health promoters and clinicians, can provide oral health care to people in schools, workplaces, health centers, extended care facilities, and adult daycare centers, just to mention a few. Using mobile dental trailers, dental hygienists can access populations in inner city and rural areas where too few dentists practice.

Third, an effective dental hygiene care arrangement could be structured on the nursing model in which nurses can successfully practice under standing protocols in collaboration with physicians. This arrangement can include dental hygienists working in underserved areas where they are connected to dentists and physicians via satellite communication or computer. When a dental diagnosis is necessary and a decision is beyond the scope of dental hygiene practice, the dentist can make clinical decisions and direct the hygienist in caring for the client. Telemedicine is now practiced in

intensive care and critical care units where there are shortages of specialist physicians known as intensivists. Using two-way communication, nurses in hospitals can care for and monitor critical-care patients under an intensivist's direction using established protocols. Even emergency medical technicians manage life-threatening situations while in telecommunications contact with the emergency room physician.

Failure to recognize that dental

hygienists can provide safe and effective care within their scope of practice translates into a failure to meet the needs of the underserved. Adopting "healthy" practice acts for dental hygienists would result in greater diffusion of preventive, educational and nonsurgical periodontal services to those outside of the private dental practice system, and would enable dental hygienists to direct persons to seek the care of dentists. Given the oral-systemic disease link, population-

based dental hygiene practice would contribute to the cost-effective management of heart disease, respiratory disease, diabetes, and premature births, thus comprising a major cost-cutting strategy if our nation is to afford entitlement programs such as Medicare, Medicaid, and the Family Access to Medical Insurance Security Plan (FAMIS). Dental hygienists may be part of the cost-effective solution to achieve oral and systemic health for all our citizens in the 21st century.

Upfront

New Findings in Preventing HIV-1 Infection

A human viral defense factor, named Ref-1, discovered a few years ago, has been found to produce anti-retroviral activity similar to antiviral defenses seen in monkeys and mice. Non-human primates cannot become infected with HIV-1 (the most common form of HIV) because the defense in these animals that is similar to Ref-1 successfully destroys the virus.

In humans, Ref-1 is able to attack viruses such as leukemia before infection is completed; however, HIV-1 shields itself from the defense factor with another human protein. This protein, cyclophilin A, attaches to the virus's exterior and protects HIV-1 from Ref-1's antiviral activity.

Jeremy Luban, MD, and colleagues at Columbia University have found that HIV-1 is prevented from shielding itself when cyclophilin A is disrupted, and as a result, Ref-1 impedes infection. Cyclophilin A binding can be interrupted by an anti-rejection drug that prevents rejection of organ transplants, but this drug, cyclosporine, cannot be used in treating HIV patients because

it weakens the immune system. Therefore, a non-immunosuppressive form of cyclosporine is best for

inhibiting HIV-1 in infected patients. In monkeys, protein binding has a reverse effect than it has in humans.

Use of Cholesterol Drugs May Decrease Breast Cancer Risk

Researchers from the University of Pittsburgh released a study reporting that cholesterol-lowering medications, including the top-selling class statins, may help reduce incidences of breast cancer, as well as heart disease.

The research involved 7,528 Caucasian women 65 years of age and older, who were participants in a study of osteoporosis-related factors, and followed them for seven years.

Of the 6,952 participants who reported no use of lipid-lowering drugs, 234 (3.3%) developed breast cancer. Two hundred ninety-two women used non-statin lipid-lowering drugs and four (1.3%) of these women developed breast cancer. In the group of 234 women who used statins, only six (2.1%) breast cancer cases were confirmed. This research revealed that the combined group using lipid-lowering drugs (7.7% of participants) had a 68% lower risk of developing breast cancer.

While statins have been found to inhibit the growth of tumors in animals, their effect on human tissue is still not clear.

The results of this study do not definitively prove the link between cholesterol-lowering drugs and reducing breast cancer risks. Though none of the women had breast cancer at the time the research began, how long they took the drugs was not recorded. Researchers concur that more wide-spread, randomized testing must be conducted on larger groups of women in order to achieve accurate results.

The Women's Health Initiative (WHI) is currently researching the link between total fat loss and breast cancer in trials among 161,000 women. These studies will help determine preventative measures for heart disease, osteoporosis, breast cancer, and colon cancer. Results of these studies are expected to be published in 2006.

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