Access & Prevention:

Achieving a Healthy Balance

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Essential PH Services

(1)

Monitor health status to identify and solve community health problems
Essential PH Services

(2)

Diagnose and investigate health problems and health hazards in the community
Essential PH Services

(3)

Inform, educate and empower people about health issues

(nothing precludes community-based methods to do so)
Essential PH Services

(4)

Mobilize community partnerships and action to identify and solve health problems
Essential PH Services

(5)

Develop policies and plans that support individual and community health efforts
Essential PH Services

(6)
Enforce laws and regulations that protect health and ensure safety

(inherently requires action in the community)
Essential PH Services

- (7)
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- (access)
Essential PH Services

(8)

Assure a competent public health and personal health care workforce
Essential PH Services

(9)

Evaluate effectiveness, accessibility, and quality of personal and population-based health services
(10)
Research for new insights and innovative solutions to health problems

(nothing precludes community-based research)
Essential PH Services

- Access only = 1
- Population-based approaches = 4
- Both = 5

BUT: Have DPH efforts been equal?
“Science is the great antidote to the poison of enthusiasm and superstition.”

--Adam Smith

Quoted in Schott’s Original Miscellany, by Ben Schott (Bloomsbury, 2002) p. 114
What’s the problem?

- Disproportionate emphasis on access to clinical, 1:1 care, given by a dental professional
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- Disease reduction: Mostly from water fluoridation and fluoride toothpaste
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- Disease reduction: Mostly from water fluoridation and fluoride toothpaste
- Need **BOTH** access and community-based prevention—if equal, could we achieve more progress?
More Than Clinical Care:

Other chronic disease programs have moved from clinical focus to more population-based approaches.
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- Heart disease: Worksite interventions
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– SIDS: “Back to Sleep” social marketing campaign
More Than Clinical Care:

Other chronic disease programs have moved from clinical focus to more population-based approaches:
- Diabetes: Support for regular physical activity
- Heart disease: Worksite interventions
- SIDS: “Back to Sleep” social marketing campaign

OH: Relatively little
Perhaps . . .

. . . we in DPH have been making program decisions based on our enthusiasm and fervent beliefs, rather than on regular assessments of a strong science base?
Need

Descriptive data may show improvement over time; patterns persist and are consistent.
Need

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- Highest prevalence and severity:
  - Lowest incomes
Need

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- Highest prevalence and severity:
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  - Least education
Need

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Highest prevalence and severity:

- Lowest incomes
- Least education
- Habit of tobacco use
Need

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Highest prevalence and severity:

– Lowest incomes
– Least education
– Habit of tobacco use
– Cultural, social, and genetic factors
Utilization of Care

- Highest among groups with the least disease. . . which came first?
Utilization of Care

- Highest among groups with the least disease... which came first?

- What clinical care needed to maintain health and prevent disease?
Utilization of Care

- Highest among groups with the least disease. . . which came first?
- What clinical care needed to maintain health and prevent disease?
- How much additional need could the care system accommodate?
Trends, Next 20-40 Years

- Higher % elders (12% → 20%)
- Biggest increases in racial and ethnic groups with highest prevalence (example: 13% → 22%, Hispanic)
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- Higher % elders (12% → 20%)
- Biggest increases in racial and ethnic groups with highest prevalence (example: 13% → 22%, Hispanic)
- Less generous fringe benefits
- Fewer labor unions
- Threats to “safety net” (MM)
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What do we **NOT** know. . .

. . . that could help make the case for our programs?
What do we NOT know . . . ?

What prevents disease among high-risk groups (both efficacy and effectiveness)?
What do we NOT know . . . ?

What prevents disease among high-risk groups (both efficacy *and* effectiveness)?
What treatment approaches are effective —and most cost-effective?
What do we NOT know . . . ?

- What prevents disease among high-risk groups (both efficacy and effectiveness)?
- What treatment approaches are effective—and most cost-effective?
- How can we extend our efforts through collaboration?
What do we NOT know . . . ?

- What prevents disease among high-risk groups (both efficacy and effectiveness)?
- What treatment approaches are effective — and most cost-effective?
- How can we extend our efforts through collaboration?
- What will foster adoption of interventions already judged effective?
What can we expect?

Clues from the past...
What can we expect?

- Clues from the past...
- Fierce competition for resources
What can we expect?

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- More documentation of ROI to society
What can we expect?

- Clues from the past. . .
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  - Centrality of OH to “health”
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  - Use of metrics that are widely accepted
What can we expect?

- Clues from our past.
- Fierce competition for resources
- More documentation of ROI to society
  - Centrality of OH to “health”
  - Contribution to goals society values
  - Use of metrics that are widely accepted
  - Need research NOW, if want to use in 2010
What can we expect?

- Quality evidence as basis for interventions
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  - Already required, many public programs
What can we expect?

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  - Already required, many public programs
  - Insurance coverage
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- Much OH evidence does not meet current standards
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  - Already required, many public programs
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- Much OH evidence does not meet current standards
  - Collaborate with others
  - Anecdotes not enough
If what you are doing is not achieving the results you seek, you have two choices:

– Continue what you’re doing. . .
– Try something else
Is it time for something else?
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