Editorial

School oral health

Once upon a time, elementary school meant readin', 'ritin' and 'rithmetic, but a few generations ago, when infectious disease and other health problems began to take their toll on the student body, it also came to mean rhinitis, rubella and remedies, and school health clinics became commonplace. A half century ago or more, health facilities including dental operatories were not unusual in primary schools. Today, there is talk of bringing them back.

Are they needed? Jonathan Kozol, well-known author of Savage Inequalities, *the telling exposé of continuing segregation in our schools, describes the dental problems in poor school districts,*

"Bleeding gums, impacted teeth and rotting teeth are routine matters for the children I have interviewed in the South Bronx. Children get used to constant pain. They go to sleep with it. They go to school with it. Sometimes their teachers are alarmed and try to get them to a clinic. But it's all so slow and heavily encumbered with red tape and waiting lists and missing, lost or canceled welfare cards, that dental care is long delayed. Children live for months with pain that grown-ups would find unendurable."[1]

Dental health problems in school-age children cross the color line, affecting those outside the inner city. Marcia Burchby, a teacher from Ohio's Appalachian hills, told U.S. governors that before she could teach reading and math, she had to deal with children "if they come to school in pain because they have not seen a dentist."[2] *The American Academy of Pediatrics surveyed American teachers earlier this decade and almost two-thirds said they were seeing more health problems than in the past.*[3] *The problem is that for many children, dental care is difficult if not impossible to get because of poverty, family dysfunction, and lack of access. The interest in bringing dental health care back to schools is growing.*

Model programs in oral health care delivery can be found all over the country, from mobile vans to in-house clinics. The school sealant program is national in scope. Proponents of school health maintain that no single model fits all situations, but that each must be, to use the jargon of contemporary social policy thinkers, contextual. That is, the school health program must "fit" the needs of the population and community it is intended to serve. Within this diverse and often confusing perspective of what school health should be, lie opportunity and challenge for pediatric dentistry.

In the best of worlds, in a given community, a school oral health program would maximize existing resources, involve the practice and public health communities in partnership with educators and community leaders, and have a minimal fiscal impact. This may not always be the case. Could a school clinic appear across the street from a dental practice? Might a future-thinking managed care plan place a contract dentist in a large school in a community with adequate dental resources? What is the role of a sealant program in a school system? These are all questions to ponder as more and more attention is given to school-based oral health. Our interest in school health as community leaders, practitioners, tax-payers, and parents ought to be high.

The Academy has done its homework on this issue and has been involved in school health discussions for several years. We have representatives at the table at national meetings and working in the field. But the real work is done at the local level, in the "contextual" trenches by local practitioners who know dentistry and their community. Pediatric dentists need to be aware of school health and involved in the discussions. We need to be willing to look at alternatives that can get children cared for, minimize the impact on their education, and maximize the resources already present in the community.

A colleague shared with me a clipping from a dental products publication recently that described an inner-city school in Chicago where a group of children had been screened and found to have significant decay. A year after screening and referral out for care, the same group had much of the decay untreated and more lesions than when first seen. No money, no priority, no dentist equals no care is an elementary equation repeated countless times each year in our schools. It's time for our specialty to go back to school — literally — to exercise leadership in making school oral health restored, readily accessible and a reality.

1. *Kozol J: Savage Inequalities: Children in America's Schools. New York:Crown Publishers, 1991.*
2. *Lowe RK: Ohio teacher details daily struggle for children's minds. Columbus Dispatch, February 3, 1992.*
3. *American Academy of Pediatrics: Health care and a child's ability to learn: a survey of elementary school teachers, Chicago, 1992.*

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