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Private practice dentists' views of oral health injustice

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Objectives: There is a lack of research examining how dentists in private practice conceptualise the challenge presented by oral health injustice and how attitudes towards low-income patients might be influenced by the commercial nature of private dental care. This study provides insights into how dentists navigated the interactions between the commercial nature of dental practice and the provision of care to patients who either struggled to (or could not) afford the cost of self-funded care in private practice. ***Methods***: Participants took part in semi-structured interviews and were invited to keep an online diary of reflections. Thematic analysis was used to examine the data to extract and synthesise understanding of how practitioners conceptualised issues surrounding providing care for the disadvantaged and how this related to the economic realities of private practice. ***Results***: Twenty participants were recruited and interviewed from a variety of private practice environments and roles. This report focuses on one specific theme within the data that explored how participants viewed patients who received public dental care, as well as those privately funded patients who could ill-afford their treatment. ***Conclusions***: The findings raise how neoliberal attitudes towards oral healthcare and dental disease may act as a social determinant of health and contribute to the sustaining of structural barriers and inaction towards oral health injustice. For low-income patients, practitioners distinguish between (a) those who are deemed to be deserving of professional care and the charitable endeavours of the profession, and (b) those who are not. There appears to be no overt professional obligation to actively work towards the amelioration of oral health injustice.

Keywords*: Access to care, Dentistry, Professionalism, Commercialism, Injustice, Qualitative research*

Introduction

There is marked international variation in the provisions made for publicly funded care. In Australia, roughly one-third of the population are eligible to receive publicly funded dental treatment. However, constrained funding for the public dental system means that only about 20% of eligible people can receive care (Duckett *et al*., 2019), with many of those seeking treatment being left to wait for more than a year to be assessed (Australian Government Productivity Commission, 2019). In New South Wales (NSW), following assessment by the public service, some patients may be offered publicly funded care from participating private practitioners within the community, funded through the Oral Health Fee For Service Scheme (Centre for Oral Health Strategy, 2016b). Private dentists must apply to be part of the scheme and operate under a prescribed fee schedule (Centre for Oral Health Strategy, 2016a). Patients who are referred to the private sector are given a voucher that details the services to which they are entitled. Around 85% of dentistry in Australia is provided privately (Chrisopoulis *et al*., 2016); given this dominance, it is important to understand whether dentists working within private practice see themselves as being part of a wider oral healthcare system and how those who cannot access care are perceived.

Previous research suggested that the dental profession may exacerbate social stigma relating to oral health through its engagement in 'clinical conflicts'; that is, dentists engage with patients from low socio-economic status backgrounds, unaware of their own lack of knowledge and competence in respect of the structural barriers to oral health care that these individuals face. This leads to victim-blaming and the perpetuation of inequity (Nations & Nuto, 2002). Neoliberal attitudes towards healthcare provision; defined as referring to "the superiority of individualized, market-based competition over other modes of organization" (Mudge, 2008) have been identified in previous work examining how dentistry and oral health are portrayed in the media. This included how dentists providing charitable care might present their views on dental disease and access to care (Holden, 2019). The ideology of neoliberalism is characterised through emphasis on: the privatisation of public services (Leal, 2007); the deregulation of private business (Lazzarato, 2009); personal responsibility and choices (Dilts, 2011); and the use of market forces for societal governance (Mudge, 2008).

The current research examines the phenomenon of neo-liberalism in dental practice further, building insight into how dentists may contribute to stigmatisation of socioeconomic status and personal responsibility for an individual's own oral health. In this research, we understand stigma and stigmatisation in reference to the mark of disgrace that both poor oral health and low socioeconomic status may confer upon an individual's identity. Sweet (2018) classified neoliberalism as an important contemporary social determinant of health, calling for further examination of the effects of neoliberalism on population health. Labonté and Stuckler (2016) regarded the privatisation of healthcare and the shift in costs of treatment and prevention to individual consumers as obvious way that neoliberalism impacts upon population health; one that is particularly applicable to the private sector-dominated paradigm of dental care that

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exists in Australia and similar jurisdictions. However, other neoliberal impacts upon healthcare are important to consider and understand, such as the size and level of universal affordable healthcare coverage provided to citizens, and the existence of targeted political attacks, through hostile policy, on the poor (Beckfield & Bambra, 2016; Chung & Muntaner, 2007; Collins & McCartney, 2011; Navarro & Shi, 2001).

This paper reports on a single yet important theme which emerged as part of a larger, expansive examination of private dental practitioners' lived experiences of how professional duties and values interact with the commercial realities of providing private dental care (Holden *et al*., 2020a; Holden *et al*., 2021). This research was driven by a lack of prior investigation into this area, identified through a scoping review (Holden *et al*., 2020b), particularly focusing on the impacts of advertising, marketplace competition and the selling of dental treatments. Being initiated by this broader exploration, the themes reported in this study unveil important insights into how private dentists viewed their practice in relation to the perception of patients receiving publicly funded care and those who struggle to afford the costs of private, self-funded dentistry. Understanding professional attitudes towards inequity in access to care and the injustice that this may create is important, especially for jurisdictions considering how oral health injustice might be addressed through the expansion of access to professional services.

While this research took place in Australia, our findings have relevance for all jurisdictions where oral healthcare is supported to some degree by public funding. This work is especially relevant where funding may be precarious, or not well engaged with or supported by the dental profession.

Methods

Ethics approval was obtained from the University of Sydney Human Research Ethics Committee (project number: 2019/687). A convenience sample of dental practitioners was recruited by advertising through a social media group and by invitations being sent out through a dental professional association and a corporate dental group's graduate training scheme. The social media group contained over 15,000 members from across Australia, with the corporate group having practices in multiple states and territory.

Dentists who held current registration and worked either part-time or full-time in private practice were included. Data were collected from participants through recorded interviews and journal entries. Participants were invited to take part in an initial interview, with a follow-up interview being offered around one month later. Participants were invited to keep an online journal to record their thoughts between the two interviews. Some participants opted to complete a written reflection rather than engage in a second interview. All participants were sent a participant information statement and gave verbal informed consent to participate in this research, as approved by the human research ethics committee. The interviews were semi-structured, and questions were developed from insights discovered through a previously conducted scoping review (Holden, Adam & Thomson, 2020b). All interviews were conducted by one author (ACLH) by phone. The recorded interviews were transcribed verbatim by a professional transcription service and then coded to allow for data analysis.

A thematic analysis was used, involving the process described by Braun and Clarke (2006). Both concept and narrative coding were applied in combination. Concept coding considers a 'bigger picture' within the data that goes beyond what is tangible and apparent within the texts (Saldana, 2016). This approach revealed underpinning concepts behind participant's attitudes and beliefs relating to socioeconomic status, ability to pay for care and patients' responsibility and attitudes towards their oral health and dental treatment. Through consideration of these uniting and overarching themes, the deeper elements of the data were able to be brought forward. The use of concept coding helped to link themes that flowed across cases to broader ideas and constructs within the analysis. The narrative approach examined the narratives of participants on how particular phenomena have contributed to their lived experiences. This complemented the broader concept coding to capture elements within the data relating to how professional responsibility is valued, perceived and developed by participants (Murray, 2008). The rich and complex nature of narratives within qualitative data allowed the researchers to explore how participants positioned themselves on issues and how this impacted on their sense of professional self and identity (Goffman, 1959). The narrative approach helped to reveal aspects of participants' experiences with commercialism in the context of dentistry as life experience.

Thematic analysis is 'a method for identifying, analysing and reporting patterns (themes) within data' (Braun & Clarke, 2006). This analytical approach was chosen because it allows for a detailed and rich exploration of the attitudes and perspectives conveyed by the participants. The patterns and themes that emerge from a process of reading and re-reading the transcribed data then develop into the categorical framework that enables comparisons and further analysis (Vaismoradi *et al.*, 2013). The coding in this study developed over several different iterations, identifying common aspects related to the research questions concerning professional and commercial tensions, beliefs about practising as a professional and the nature of dentistry as a business and healthcare pursuit. In refining the coding over multiple iterations, the relationships among different themes became stronger, resulting in a final group of key themes that was irreducible. The development of themes and categories in this way helped to cultivate meaning, imparting order and structure into the data (Anfara, 2008).

Results

A total of 20 dentists participated, as summarised in Table 1.

Twenty-two interviews took place (two participants felt that they had further insights to offer through another interview) and ten reflective accounts were provided by five participants. Saturation was determined when subsequent interviews did not elicit new data, where new interviews did not reveal new themes or contribute new data to existing categories (Saunders *et al*., 2018;

Table 1. Participant demographic characteristics

Characteristic	*Number of participants*
Sex	Male – 12
	Female – 8
Years since qualification (average 17 years)	0-1 – 1
	1-10 – 6
	11-20 – 7
	21-30 – 2
	31-40 – 4
Type of practice (role)	
Private (independent)	Principal/owner – 7
	Self-employed associate – 9
Corporate	Clinical director – 1
	Self-employed associate – 3
Scope of practice	General dentist – 17
	Specialist dentist – 3
Current location of practice in Australia (one participant practised in multiple states)	NSW – 15
	VIC – 3
	SA – 1
	QLD – 2

Grady, 1998). Three main themes were identified from the analysis: dentists and their role in society; the relationship between commercialism and professionalism in dentistry; and the effects of commercialism on patients and professionals.

This paper specifically reports on an emergent theme that related to how private dentists perceived patients who could not afford care. While all participants commented on the difficulty faced by managing professional obligations while managing a business, this particular subtheme was spoken about at length by several participants, exploring the phenomenon of personal responsibility for oral health, how this manifested in the environment of private dentistry, and describing how dentists might act as the arbiters of "oral health deservedness". The interview guide used to develop the course of the discussion with each participant centred on the nexus between commercialism encountered when operating or working within a private dental business, and participants' professional duty. None of the questions were intended to direct the conversation with participants towards the broader issues raised in this paper. The other themes developed from this research have been reported in other published work (Holden *et al*., 2020a; Holden *et al*., 2021).

Participants were sensitive to the political structures that surround the provision of healthcare and how they saw their own personal roles and those of the wider profession within this. Several participants expressed concern at the conflict between wanting to provide care and the realities of business ownership:

"There's definitely conflict when it comes to running a business, but at the end of the day we live in a capitalist environment and we all have staff and bills to pay, and ultimately, I think it shouldn't fall on the individual dentists to do pro bono work."

In this account, the political structure around their perception that health is embedded within a market-driven framework legitimises their dismissal of any obligation that dentists might have to personally contribute towards addressing access issues. This was associated with a feeling that the provision of pro-bono dental care in private practice amounted to an over-investment in another's health:

"*I also don't think that I can be more concerned about somebody's dental health than they can be themselves*."

This statement also illustrates a belief that an individual's health is a matter of personal responsibility. In discussing how public funding could assist with private sector dentists being involved in the provision of dental care to those who cannot afford it, participants were concerned with how this might interact with the professional autonomy of practitioners:

"I certainly wouldn't make it compulsory that dentists would have to do pro bono work. It would be great if there was some sort of government subsidy for treatment maybe, or something like that. And that would help cover the dentist's costs, but maybe it'd fall on the dentist's shoulders, him or herself, to be like, well okay, well at least I'm covering my costs here with the Medicare payments."

Such participants views are consistent with other findings. A previous analysis of online media stories about dentistry and oral health (Holden, 2019) found several stories that detailed how dentists were engaging with community-based projects, in both their home countries and abroad, where they provided pro-bono care. These activities were often sponsored by local or national dental professional associations. It was noted that many of the attitudes reporting such initiatives were replete with heavy neoliberal sentiments in respect of personal responsibility.

Participants shared their perceptions of the phenomenon that patients who privately funded their dental care were more "appreciative" than patients who received free care through the public system:

"I much prefer being in private practice, just from the work that I do, the patients that I treat are much more thankful, even though they're paying for it, whereas working in the [public services] the most painful patients to deal with were the people who had nothing to pay, and they didn't value it.

[public patients are] not appreciative...They wanted to be seen today, they wanted the best treatment, and they didn't want to pay for it."

One participant stated that they felt that publicly funded patients acted in a way that was more "entitled" than private patients:

"And in public, it's a bit of the reverse. They're entitled to everything and therefore they think they should have everything whether or not they're compliant with symptoms, the treatment plans prescribed for them, and then when they find they're not compliant in their oral hygiene care and they've got, say, advanced periodontal problems, then they're still expecting amazing, top-end treatment and they don't want to understand their role in that."

This view contrasted with the observation that some private patients recognised dentists' time and wanted to volunteer to pay for this, even when it wasn't required:

"I don't charge for my follow up things and follow up visits, stuff like that, and sometimes I've known these patients for a long time, and they'll say to me 'No, no I'd like to pay something. You're running a business.' Or something like that. I think they are cognisant that there are commercial realities of what we do to provide care."

Where practitioners encounter such awareness from patients of the commercial elements of practice, it reinforces the need to operate within these parameters, which may further the gap between those who are able to access private care and those not financially empowered to do so. One participant referred to this dichotomy:

"*at the moment we certainly could take [publicly-funded] patients, but we don't, because we're busy enough as it is, and that's not the type of practice that I'm building*."

Statements such as these suggest an attitude where some dentists do not perceive an obligation to commit to oral health justice to be part of their duty to the public in practising. The sense that low-income people receiving welfare don't 'fit in' to the practice also highlights the stigmatisation of those afflicted by poverty experience when trying to access care. While it may be initially concerning for dentists to come across circumstances where a patient's financial situation dictates their options, one participant recalled how they did not allow themselves to invest in this issue:

"If somebody comes in in pain, they've got a problem, and they want you to do treatment but they can't afford treatment, then I suppose there is a conflict there in that you kind of feel, oh well I want to help this person, but they can't afford to do it...If it's a case of doing root canal treatment or having a tooth out, I don't sit at bed and night and can't sleep because I've taken somebody's tooth out. I'm comfortable with that, and I understand that people, everybody has their limitations and we can't have everything that we want. So yeah, that's not something I'd lose sleep over."

While it is possible to sympathise with the business constraints of private practice, it is noteworthy that the issue of losing a tooth is spoken about in a way that suggests that it isn't a particularly serious matter; being a 'want' rather than a 'need'. While tooth loss might not immediately impact an individual's quality of life, the social stigmatisation of losing a front tooth (Bedos *et al*., 2009; Dos Santos *et al*., 2017; Rousseau *et al*., 2014), or of gradually losing multiple teeth so as to impair function (Offenbacher *et al*., 2012; Saintrain & De Souza, 2012), should be of concern. The structural assumptions around healthy bodily norms implicitly stigmatise those individuals who fall outside accepted bodily norms (Kirkland, 2008).

Participants reported providing pro-bono treatment for patients who they perceived were deserving:

"I think it was four fillings for her, and she told me… that she couldn't afford to get all four of them done, but she'd already shown me that she was really interested in having the best done, keeping her teeth even though finances were a massive concern, and so I just did the work for her and didn't charge her anything for any of the fillings, and just did it all for her, and got it done. So look, I do that occasionally, but I don't want to be known for doing it either."

This participant also stated that they were cautious about being taken advantage of:

"So I don't want to be known for somebody who, if you give me a sob story that I'll do free treatments, so it's more like that kind of case basis where it was just the nice thing to do for her, and she was really, really appreciative of it, 'cause obviously she saved up several hundred dollars to have work done, and then she's able to keep a hold of it."

Generosity to those considered to be deserving was encountered several times in the interviews, with one participant recounting how they felt very concerned about a patient being exposed to great financial hardship because of a need to fund dental treatment:

"And the amount of financial strain it put them under was devastating and it made me really question my role as, you know, a healthcare provider because I need to consider the whole wellbeing of my patient. It's very easy to get very clinically focused and be like this is the absolute right treatment, which is what I did in that case where I was like there is no other option, like this is what the only treatment is. And this patient ended up in a lot of financial difficulties and I actually ended up waiving my fees for her because I realised how devastating it was going to be for her. And so I think you have to kind of keep that in mind when you present a treatment plan how well the patient can actually afford it."

On many occasions during the interviews, dentists detailed instances where they had provided care to patients without charge on the basis that they felt it was the right thing to do for that patient. As discussed, this generosity is usually underpinned by that professional having assessed the patient as being deserving of help, with the understanding that this approach should be used with caution:

"Oh look, it'd be great if there was some system whereby you could do that, and people would appreciate it and value it, and not waste your time or do that...But like when you're talking to people who have particularly high treatment needs, and maybe spending a lot of time doing pro bono work for them might actually not be the best thing in the long term, if they're not willing to look after it."

While there was considerable evidence of the generosity and charity of dentists, it is also clear that there is no perception that engaging with the public in this way is a professional obligation; rather, it is an *ad hoc* behaviour in special cases. It is certainly admirable that many dentists consciously donate their time and skills to helping those who would otherwise struggle to access dental care. In assessing the American Dental Association's (2018), now revised, document on professional ethics, *The Principles of Ethics and the Code of Professional Conduct*, Welie (2006) noted: "the Code reiterates that "dentists shall not refuse to accept patients into their practice or deny dental service to patients because of the patient's race, creed, color, gender, sexual orientation, gender identity, national origin". Note that the patient's financial status is not included in the list. Apparently, dentists may refuse to accept patients into their practice when and because the patients are poor". Welie suggested that this attitude in the code reflects the neoliberal ethos of the dental profession. Where oral health disparities are viewed as

being unfortunate but ultimately not unfair due to a belief that they are created by the individual's free choices, this prompts acceptance from the profession that there is no need for anything to be done—individually or collectively—to address oral health disparities linked to poverty.

Discussion

These data suggest that receiving public dental treatment has a stigmatising effect upon how patients are viewed by some dentists within the private sector. Work in the social sciences suggests that stigma can be located not only within the attitudes of individuals but also within institutions, markets and healthcare systems (Bonilla-Silva, 1997; Hatzenbuehler & Link, 2014; Metzl & Hansen, 2014). Stigma surrounding the social determinants of oral health needs to be addressed at the level of institutions (universities during training and professional associations) as well as within those health professionals who will have 'on-the-ground' encounters with those seeking care. Metzl and Hansen (2014) discussed the concept of 'structural violence', a term they defined as "systemic institutional stigmatization and marginalization". Where the dental profession is conditioned through education, health systems, and professional culture to accept the exclusion of the most vulnerable in society from the majority of most available services, it is hard not to see this concept applying to dentistry. Earlier work has shown that dental students report feeling a lack of professional obligation to help reduce oral health inequalities (Chen *et al*., 2016). Stigma in oral health cannot solely be attributed to the attitudes of individual practitioners. Failure to address the stigma surrounding oral health at structural levels will ensure that a culture of stigma in oral health persists through being passed on to the next generation of professionals (Pavalko, 1971).

Some dentists do not engage with publicly funded dental schemes or wish to see these schemes expanded due to a belief that practitioners providing care under such arrangements are not appropriately remunerated. This sentiment is illustrated by the American Dental Association (undated): "Excessive administrative burdens and reimbursement rates that are below the cost of providing care deter dentists from participating in Medicaid programs and there is a need to reverse this trend to ensure more dentists can provide care to more people in need." This research has provided further context to why dentists may not wish to contribute to providing publicly-funded oral health care within private practice.

Participants discussed their perceptions of patients being deserving or non-deserving of subsidised or free care, and how they could justify patients not being able to access the care they needed because of cost. Those who spoke about this issue did not express that they felt that dentists had any role to play in the alleviation and management of oral health disparities within society; this responsibility was reported to lie solely with the government and public services. This position is troubling, because it suggests that dentistry may be non-essential, rather than a professional activity concerned with the amelioration of an important source of disease and social burden. A damaged smile may contribute to a spoiled social identity (Goffman, 1963; Holden, 2020; Khalid & Quiñonez, 2015) and can impact the social opportunities available to an individual (Bedos *et al*., 2009). Holding patients responsible for their 'failed selves' (Illouz, 2003) creates an ethical quandary, given that patients are already infused with blame, guilt and stigma for having placed themselves in the position of needing care (Gibert *et al*., 2017). Dentists are placed by society in the powerful position of acting as a source of authority on what is acceptable in oral health, and that acceptability is typically derived from middle-class (or professional) values and privileges (Shilling, 2012). The suggestion from participants that those who have poor oral health are largely responsible for their situation, linked with the fact that these individuals are those same individuals who are poor, supports the assertion of Hill (2015), who stated that the aetiology for these individuals' condition is that they did not conform to middle-class norms. From these data, it appears that patients whom dentists arbitrarily perceive to be unable to afford dentistry yet show a noticeable cognisance of the dentist's role and the importance of oral health are perceived as deserving. Characteristics of patients being non-deserving link to being seen as entitled to care, coupled with being viewed as unaware of their own responsibility for having developed dental disease and the associated treatment need.

The statement from one participant who commented that they would not lose sleep over a patient not being able to have a tooth retained through root canal treatment supports the narrative that oral health is not an essential component of health. A suggestion promulgated by several participants was that dental disease and a need for dental treatment can simply be avoided through engagement with self-care and taking responsibility for one's health. This expert view, common in professional messaging in the media (Holden, 2019), both supports and is supported by a lack of public investment in oral health. It is the 'structural violence' within institutions and structures of power towards those who cannot afford to access private dental services that helps to perpetuate and reinforce stigma towards those with poor oral health who are afflicted by poverty. The notion that those who suffer from poor oral health are irresponsible or lacking in care and wish to prioritise their own health helps to justify a lack of structural attention to addressing oral health disparities.

Dentistry is not included within Australia's Medicare scheme, meaning that there is a considerable contrast in accessibility between general and oral healthcare. The Royal Commission into Aged Care Quality and Safety (an Australian inquiry into the aged care system, 2021) has recently recommended that that Australian Federal government establish a Senior Dental Benefits Scheme to fund oral healthcare to older people in the community and in facilities. While investment in oral health should be welcomed, these findings suggest that such changes may need to be accompanied by awareness-raising and engagement to ensure that the care provided is patient-centred (Apelian *et al*., 2020). Other jurisdictions may also consider how professional attitudes towards the nature of oral diseases may impact willingness to engage with and advocate for the establishment or maintenance of publicly-funded oral healthcare (Holden & Quiñonez, 2020). How individual behaviours are viewed to contribute

to ill-health is exceptionally important. Wikler (2005) stated: "The locus of blame is key, for if blame is placed on the individual, social structure is exculpated, and the resulting suffering…will not be counted as a social injustice. Narrowing health inequalities among social groups would thus not be of special urgency, either as a matter of prevention or of remedy".

Our findings suggest a need for renewed efforts to challenge attitudes within the profession, through education and scholarly discussion, in order to ensure that dentists are able to provide socially competent care.

The trustworthiness measures for qualitative research defined by Lincoln and Guba (1985) were used to direct the rigor of the study. Data credibility was assured through the use of verbatim translation, with the lead analyst having conducted the interviews. While we make no claims over the generalisability of the data, we invite academic and clinical practitioners to reflect upon the transferability of the findings to their own context of practice. Through the use of quotes, as well as demonstrating the methodological steps taken in the work, the dependability and confirmability of this research has been demonstrated. A feature of qualitative research is the incorporation of subjective elements from both participants and researchers. Thus, a research team with a different composition and an alternate participant base would provide new perspectives being embedded within an analysis (Holden, 2019). This means that great importance is placed on how analytical approaches and the methods are applied and described, allowing the reader to understand how the data led to the inferences drawn (Chapman & Lupton, 1994). The research strives for "analytical modesty", (Tonkiss, 1998), whereby the authors wish the arguments presented and the conclusions arrived at to be persuasive, rather than making claims of universal truth and applicability. We acknowledge that, as researchers in this study, we have become deeply embedded within it and the demand for reflexive attention that this requires. Our part is not passive, and other investigators with different perspectives might have drawn different insights from the data.

This paper has reported the detailed narratives of a small number of private practitioners who shared their attitudes and beliefs towards the provision of publicly funded and *pro bono* care within the private practice sector. Owing to the approach taken and the small numbers of participants, we do not claim universality; we present our insights, which may have important impacts upon the provision of care to vulnerable individuals who are not surfeited with options for where to seek care.

Conclusions

This research demonstrates an urgent need to infuse the culture of dentistry with an intolerance to oral health injustice. The profession should appreciate the need for action above individual charity and generosity to include systematic advocacy for effective oral health policy with government by the profession and its allies. Dentists may be disempowered to act individually to promote oral health justice within some environments, highlighting the importance of dental professional associations as agents of the profession's collective advocacy and values. Similarly, while dentists are part of a far greater cast of actors against the social determinants of health, their responsibility to act as individuals and as a collective profession cannot be neglected. Dental schools must consider a sensitivity to oral health injustice to be a key attribute in both choosing which applicants to accept on dental courses, as well as being an assessed competency when judging whether students are ready to graduate and serve the community. Similarly, after graduation, dentists should be supported through continuing professional development to consider the impacts of the social determinants of health on health behaviours. Dentistry is first and foremost a health profession, and its professional members must play a more significant and active role in reducing oral health injustice in society.

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