

# Social Values, Regulatory Tensions and Professional Practices with Underprivileged Populations: The Case of Quebec's Oral Healthcare System

## Valeurs sociales, tensions régulatrices et pratiques professionnelles auprès de populations défavorisées. Application au système de santé buccodentaire du Québec



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### Abstract

*Objective:* Dentists may experience frustration in their practice with people living on welfare, often perceiving them in a negative light. The difficulties encountered are detrimental to the patient–professional relationship and contribute to compromising access to care for this underprivileged population. In order to fully understand patient–professional interactions, we must consider the macroscopic contexts in which they occur. This paper examines the systemic influences of these interpersonal relationships to deepen our understanding of an important access-to-care determinant for people living on welfare.

*Methods:* Two frameworks are applied to the analysis of Quebec's oral healthcare system: the social values framework and the regulatory logics framework.

*Results:* Our assessment leads us to posit two phenomena: (1) certain negative stereotypes regarding patients living on welfare allow dentists to manage the inevitable regulatory conflicts (i.e., economic vs. professional) involved in their practice and (2) the behaviours of people living on welfare are frequently judged according to the social values embodied in the organization of Quebec's oral healthcare system, delivery and financing.

*Conclusion:* Quebec's oral healthcare system fails to provide effective access to care for individuals living in poverty, and the government must significantly augment its involvement in this healthcare sector. Dentists should also understand the impact that systemic influences have on their rapport with people living on welfare. We argue that new orientations for the field of dental professional education should be considered.

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## Résumé

*Objectif :* Les dentistes éprouvent des frustrations face aux personnes bénéficiaires de l'aide sociale et tendent à les considérer négativement. Ces difficultés affectent la qualité de la relation thérapeutique et même l'accès aux soins de cette clientèle. La compréhension de ces interactions entre professionnels et patients ne peut se faire qu'en appréhendant les contextes macroscopiques qui participent à leur structuration. Ce travail examine donc les influences systémiques des relations interpersonnelles afin de mieux comprendre un important déterminant de l'accès aux soins dentaires des bénéficiaires de l'aide sociale.

*Méthode :* Deux cadres d'analyse sont appliqués à l'étude du système de santé buccodentaire québécois, celui des valeurs sociales et celui des logiques de régulation.

*Résultats :* L'analyse amène deux constats : certains stéréotypes négatifs à l'égard des personnes assistées sociales permettent aux dentistes d'arbitrer les inévitables conflits entre les logiques de régulation (i.e. économique vs professionnelle) inhérents à leur pratique. Aussi, certains jugements portés par les dentistes sur les comportements des bénéficiaires de l'aide sociale sont le reflet de valeurs sociales exprimées dans l'organisation, la dispensation et le financement des soins dentaires.

*Conclusion :* Le système de santé buccodentaire québécois comporte d'importantes limites d'accès pour les personnes en situation de pauvreté, et l'État devrait s'engager plus massivement dans ce secteur de la santé. Les dentistes devraient aussi comprendre l'impact des influences systémiques sur leurs relations avec les bénéficiaires de l'aide sociale. Nous estimons donc que de nouvelles orientations devraient être envisagées pour la formation professionnelle dentaire.

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**T**HE PATIENT–PROFESSIONAL RELATIONSHIP LIES AT THE VERY HEART OF THE healthcare process. As such, it represents an important determinant of health services utilization (Donabedian 1973a). Nonetheless, in Quebec’s oral healthcare system, a certain segment of the population that has access to public oral healthcare coverage underutilizes these services because of difficulties in interpersonal relationships with dental professionals. Studies in Quebec have revealed that people living on welfare underutilize their basic oral healthcare coverage in part because of negative experiences with dentists. Underutilization of the oral healthcare system has been partly linked to feelings of rejection and stigmatization (Bedos et al. 2003). Similar phenomena have been documented among US Medicaid beneficiaries, who have described experiencing prejudice in their relationships with oral health professionals and have admitted feeling shame that can impede them from seeking treatment (Kelly et al. 2005; Mofidi et al. 2002).

Moreover, research conducted among dentists reveals a frequently negative image of underprivileged populations (Bedos et al. 2006; Loignon et al. 2010). In a qualitative study of Quebec dentists, participants expressed difficulty understanding the general lifestyle and health behaviours of the underprivileged. Also, dentists generally attribute emergency consultations and last-minute cancellations – significant irritants – to negligence or nonchalance (Bedos et al. 2006). Pegon-Machat and colleagues (2009) revealed the tendency of French dentists to think in dichotomous terms with respect to patients receiving social assistance, opposing the “good” patient to the “bad.” The latter judgment refers to the patient perceived as consulting sporadically, abandoning the treatment plan and underutilizing preventive services. The “bad” patient was also considered to be nonchalant, non-compliant and disrespectful of dental care professionals, in particular with regard to missed appointments (Pegon-Machat et al. 2009). The “good” patient/“bad” patient dichotomy mirrors Loignon and colleagues’ (2010) conceptualization of two predominant perspectives among Quebec dentists towards people living on welfare: the moralistic perspective, which attributes poverty to individual shortcomings, versus the humanistic perspective, which is more open to structural explanations of poverty.

Dentists’ negative perceptions, experiences and frustrations regarding people receiving social assistance are such that many resort to patient selection and scheduling strategies that contribute to this population’s exclusion from the oral healthcare system (Bedos et al. 2006, 2010). Cancelling non-confirmed appointments, double-booking patients or simply refusing to treat are examples of practices revealed during interviews with dentists (Bedos et al. 2006, 2010). Similar tactics have been observed among US front-office dental clinic personnel and dental assistants; staff members’ stereotypical beliefs and biases about Medicaid-insured patients have been considered a potential threat to equitable healthcare access policy (Lam et al. 1999).

These misconceptions and negative stereotypes have been associated with a lack of knowledge on the part of oral health professionals and with the need to improve their interpersonal skills and socio-cultural competencies (Loignon et al. 2010; Lévesque et al. 2009). Undergraduate and continued dental education in these areas has equally been recognized as insufficient. Yet, health professional–patient interactions unfold within service delivery organi-

zations and macroscopic socio-economic contexts that help to structure these relationships. Examining systemic influences on interpersonal relationships is thus essential to achieving a more thorough understanding of this important access-to-care and oral health equity determinant for people living in poverty. Through the analysis of Québec's oral healthcare system, this paper seeks to shed new light on the knowledge and empirical data regarding relational difficulties between dental professionals and people living on welfare, and proposes some educational orientations.

### **Analytical Frameworks**

Multiple analytical frameworks may be applied to the analysis of healthcare systems, whether to address system performance, elements of care and services integration or determinants of organizational change. All systems of care may also be considered from the point of view of their underlying social values, the latter being to a great extent responsible for a given society's institutional forms and the trajectories according to which they tend to evolve (Donabedian 1973b). It is all the more interesting to reflect critically on social values, given their largely implicit nature; acquired through lengthy socialization processes, social values are accepted rather than reasoned (Donabedian 1973b). Uncovering them thus represents a unique pathway towards new and original representations. Healthcare systems may equally be conceived as resulting from the interaction of and arbitration between four regulatory logics: the professional, technocratic, economic and democratic logics (Contandriopoulos 1999). The relative importance of each contributes to determining how healthcare system structures and processes are organized (Contandriopoulos 1999). Given that the analysis of regulatory logics takes into consideration the power positions of the actors involved, it is complementary to the application of the social values framework. Hence, following a description of Québec's oral healthcare system, the theoretical frameworks of both social values and regulatory logics will be applied to its analysis.

### **Oral Healthcare Service Delivery and Funding in Quebec**

Québec's oral healthcare services are delivered primarily through the private sector by dentists. Government-delivered care is limited to specialized in-patient, hospital-based interventions (e.g., bone grafts, jaw repositioning, abscess drainages) (RAMQ 2008) and services dispensed within the province's public dental health action plan, which refers mainly to specific prevention programs within schools and other settings (e.g., long-term care) (MSSS 2006).

Private sector oral healthcare is financed mainly through private insurance schemes or direct pay, as reflected by the distribution of dental office earnings according to the following patient categories (Lussier and Benigeri 2008): the privately insured (48%), the non-insured (29%), children under 10 who are government funded (11%), people living on welfare who are government funded (7%) and other government-funded patients (5%). In sum, only 23% of patients served in private dental clinics receive care that is government funded. Though the government covered 41% of total dental expenditures in 1980, its participation decreased to 10% in 1999 following the Québec government's cutbacks to public programs, most notably those

providing dental healthcare to children (Leake 2005). Indeed, before 1992, children's preventive dental care was covered until the age of 16, and extended coverage was provided for all children under the age of 13 (Msefer-Laroussi 2007). Since 2002, the decrease in public funding is also reflected in dental office earnings (2002: 28%; 2009: 23%) (Msefer-Laroussi 2007).

Government-funded programs vary in terms of the oral healthcare interventions they cover. For example, people living on welfare are eligible for basic dental coverage (e.g., dental exam, X-rays, fillings, extractions); they are not, however, eligible for endodontic care (RAMQ 2008). People covered under this plan must also have been on welfare for 12 consecutive months in order to be eligible for funding, with the exception of certain emergency procedures (RAMQ 2008). As well, a 24-month lag period is a prerequisite to accessing free prosthetic care within this same program.

Access to oral healthcare insurance in Quebec follows a social gradient. The 2007–2009 Canadian Health Measures Survey shows that 78.2% of individuals in the highest income bracket are privately insured, whereas only 32% of respondents from the lowest income bracket have private insurance (Health Canada 2010). Given the role of private dental insurance schemes in financing oral healthcare and their inequitable distribution among members of society, one can say that the core principles upon which general healthcare provision is founded – accessibility, universality, comprehensiveness, and so on – are not comparably upheld in the case of dental care.

### Quebec's Oral Healthcare System: A Social Values Perspective

The form in which any healthcare system is organized reflects a distinct configuration of social values. In reference to Donabedian's (1973b) archetype of viewpoints, social institutions may be said implicitly to embody certain societal positions or orientations on the following four foundational values: (1) personal responsibility, or the degree to which an individual is held accountable for his or her acts; (2) social concern, in reference to the interest one takes in another's welfare and that of society in general; (3) freedom, including the absence of constraints and individuals' autonomy or independence; and (4) equality, or the idea of parity or resemblance between individuals at various levels. Table 1 distinguishes two configurations, viewpoint A and viewpoint B, each representing specific interpretations of the four founding social values.

Given the preponderant role it attributes to personal accomplishment and freedom from political coercion, viewpoint A is associated with a libertarian ideology. Conversely, with its emphasis on equal opportunity, viewpoint B can be linked rather to a socialist ideology. According to Donabedian (1973b), these typologies cover a broad enough range of ideological currents within a society to be applicable to the analysis of healthcare systems. Agreement between the elements of the social values framework and Quebec's oral healthcare system illustrates the framework's usefulness.

Quebec's dental care system reflects a strong attachment to the importance of personal responsibility for one's achievement. Oral healthcare services generally constitute a privilege granted in proportion to one's efforts, consistent with viewpoint A. Indeed, access to dental

**TABLE 1.** Characteristics of viewpoints A and B for the four foundational social values (adapted from Donabedian 1973b)

	<b>Viewpoint A</b>	<b>Viewpoint B</b>
Personal responsibility	<ul style="list-style-type: none"> <li>• Strong emphasis on personal responsibility for successes and achievements</li> <li>• Nothing unearned should be given lest there be moral or economic injury to the recipient and to society</li> <li>• There is a positive relationship between personal effort and moral excellence</li> <li>• Medical care should remain part of the reward system</li> <li>• Confluence of the Protestant ethic, laissez-faire economics and social Darwinism</li> </ul>	<ul style="list-style-type: none"> <li>• Recognition of the importance of personal responsibility</li> <li>• Less emphasis on economic failure as moral failure</li> <li>• Healthcare should not be part of reward system for several reasons, including consumers' limited knowledge and control of their needs, the constraints of the medical services market and the public's interest for the individual's health</li> <li>• Health services are a public good</li> </ul>
Social concern	<ul style="list-style-type: none"> <li>• Recognition of partial incompatibility between personal responsibility for achievement and social concern for others</li> <li>• Reconciliation of this incompatibility through limited exercise of social concern and the recognition of the involuntary nature of the disease</li> <li>• Charity is an appropriate expression of social concern, as it is less likely to create a sense of entitlement to service or to violate personal responsibility, as needs are not fully met and services are provided under difficult conditions; as well, charity can be an expression of social elitism</li> <li>• Strict social Darwinism rejects social concern because it interferes with natural selection</li> </ul>	<ul style="list-style-type: none"> <li>• Charity represents the least desirable expression of social concern because it is demeaning to the recipient, leads to dependency and compromises one's ability to exercise personal responsibility</li> <li>• True expression of social concern is to reduce the need for charity to a minimum, thus fostering personal responsibility and initiative</li> </ul>
Freedom	<ul style="list-style-type: none"> <li>• Maintain maximum freedom</li> <li>• Emphasis on political freedom</li> <li>• Government perceived as a potential threat to individual freedom</li> <li>• Compulsion attenuates personal responsibility as well as voluntary expressions of social concern</li> <li>• Collective action is paternalism</li> <li>• A self-balancing state results if freedom is maintained, through the "invisible hand" of the market and social Darwinism</li> <li>• Perils of disturbing this "natural harmony"</li> </ul>	<ul style="list-style-type: none"> <li>• Maintain maximum freedom</li> <li>• Redefinition of freedom as possibility of alternative choices</li> <li>• Compulsion is not only political but also economic</li> <li>• Notion of trade-offs among freedoms, from group to group or from one type of freedom to another within one individual</li> <li>• Government as a liberator</li> <li>• Government as expression of public will or its agent</li> <li>• Much less fear of disturbing "natural harmony"</li> </ul>
Equality	<ul style="list-style-type: none"> <li>• Conceived mainly as equality before the law</li> <li>• Emphasis on potential for equality rather than its actual realization</li> <li>• Less concern about injustices suffered by the few if liberties of majority are thereby maintained</li> <li>• Perceived conflict between equality and competitive personal achievement</li> </ul>	<ul style="list-style-type: none"> <li>• Equality broadly defined as equal opportunity to achieve</li> <li>• Access to medical care as precondition of personal achievement; therefore, it cannot be used as a reward for achievement. Similar to education, it is a social right</li> <li>• Equality of opportunity is the foundation for morally acceptable contest to achieve</li> <li>• Equality as dissemination of liberty</li> </ul>

insurance is associated with achievement at the level of employment, given the earnings the latter provides alongside the private insurance schemes to which employers contribute. Affluence is the most important determinant of access to private dental insurance, and lower-income families are two-and-a-half times more likely to have no insurance whatsoever (Health Canada 2010). Access to public dental insurance is restricted to certain very underprivileged populations. Contrary to the viewpoint B position, which would suggest the removal of health services from the reward system and their recognition as a right, access to oral healthcare does not, overall, constitute an entitlement for members of society. This may seem odd in a society that values

universal and equitable access to general healthcare. This state of affairs has been directly linked to how oral health is conceived and valued by the general public (Msefer-Laroussi 2007).

The value of social concern, in viewpoint A, is posited to conflict with the value of personal responsibility (Donabedian 1973b). Indeed, viewpoint A accepts social concern as a moral imperative but considers that it must be exercised within certain boundaries. Quebec's oral healthcare system reflects this orientation. The province's dental care funding policy offers basic coverage to people living on welfare, and thus conveys recognition of the vulnerability of this segment of society. In addition, the one-year lag period for the initiation of dental coverage for individual recipients of social assistance ensures that only those most in need socially obtain free dental care. With regard to oral healthcare coverage for the very underprivileged (RAMQ 2008), programs are, thus, incomplete and discriminatory when compared to the equivalent services provided to the privately insured, a phenomenon that Donabedian would term the "temperance" of social concern. Also noteworthy, particular programs destined to improve access to dental care for underprivileged Quebecers (e.g., mobile outreach clinics) may be considered to fall within the realm of charity, given their reliance on private donations and various foundations (Allison et al. 2004). This approach is also consistent with viewpoint A's belief in charity as the proper vehicle for the implementation of social concern (Donabedian 1973b). Viewpoint B, on the contrary, emphasizes the need to reduce the role of charity to a minimum and to maintain and extend public dental insurance coverage to those not covered by private insurance.

Freedom, in viewpoint A, is put forth as "a supreme good" in itself (Donabedian 1973b). According to this position, freedom goes hand in hand with a strong emphasis on personal responsibility and maximal inclusion of commodities and services in the reward system; government involvement and responsibility are viewed with suspicion, and marketplace logics and free competition are held in high regard (Donabedian 1973b). Given that most oral healthcare services in Quebec are delivered via the private sector, and that 77% of patients seen within this sector are either privately insured or pay out of pocket (Lussier and Benigeri 2008), clearly government involvement may be considered limited. In addition, in most cases, private dental insurance schemes offered by employers remain optional. Many patients may choose either to insure themselves or to pay out of pocket. They may also decide on whom to consult and when. Dentists, on their part, may determine the location and the scope of their practice, the makeup of their clientele and whether or not they wish to participate in the government-funded programs (Lussier and Benigeri 2008). In other words, the current dental healthcare system affords a great deal of freedom, both to individuals and to dentists. This state of affairs is compatible with a maximalist perspective on freedom, consistent with viewpoint A, temporally and spatially. According to viewpoint B, it is necessary to seek compromises between the individual freedoms of different social groups within a society. In reference to this perspective, the Quebec government does not intervene sufficiently in the financing of oral healthcare to ensure the maximum number of citizens the freedom to exercise their right to dental healthcare.

Finally, the manner in which the oral healthcare system is configured also aligns predomi-

nantly with viewpoint A on equality. Indeed, though legally all individuals are equal in their potential to access dental insurance and healthcare, there remains great inequality of opportunity among Quebec citizens with respect to the actualization of their right to oral health. As stated above, oral healthcare belongs to the individual reward system such that viewpoint A's emphasis on personal responsibility remains unthreatened by the shape and nature of equality afforded to individuals.

The social values analysis of the Quebec oral healthcare system clearly reveals the commodification of dental care and sizeable societal acceptance by its membership of the reward system. On all four social value scales, Quebec's oral healthcare system is strongly oriented towards viewpoint A, the libertarian position. A critical application of the egalitarian or socialist perspective (viewpoint B) would raise issues of access-to-care equity, social justice, equal opportunity and government responsibility – matters that we will not address here. The purpose of this section is to explicate the dominance of viewpoint A within the system to explain the problems that arise in relationships between dentists and their socially assisted clients. Towards this end, the social values analysis will be linked with empirical data, both on the general motivations and attitudes of dentists towards their career of choice, as well as on their experiences, frustrations and perceptions of people living on welfare.

Some recent literature on dental students' motivations for their professional career choice reveals them to be highly compatible with the social values configuration depicted above. In studying final-year dentistry students' motivations for choosing their profession, Gallagher and colleagues (2008) found that responses focused – alongside personal aspirations and interests – predominantly on personal lifestyle issues, namely professional status, financial rewards and security, quality of life, independence and flexibility. In particular, the potential to work part-time and yet still earn a good income was reflected in focus group results (Gallagher et al. 2008). These results mirror those obtained with US first-year dental students who rated quality of life, self-employment and – in the case of the male majority in the sample – “being my own boss” – among the top five motivations (Scarbecz and Ross 2002). Gallagher and colleagues (2008) also proposed that the attraction of dentistry for the participants in their research could be described as gaining access to “a contained professional career” in healthcare, that is, one that does not require long hours, shifts or on-call duty and does not occupy the centre of their lives (Gallagher et al. 2008).

There are no up-to-date data on Quebec or Canadian dental students' motivations for entering dentistry. However, a 1977 survey of University of Toronto first-year students revealed very similar findings (Cohen and Coburn 1977), and there is no reason to think Quebec dental students' motivations would differ much from those of their European or American counterparts. In addition, a majority of Canadian dentists are against the idea of increased government involvement in the financing and delivery of oral healthcare, whether regarding new professional remuneration mechanisms or service delivery models (Quiñonez et al. 2009). This attitude reflects dentists' attachment to independence and freedom in their practice. The social values reflected by Quebec's oral healthcare system thus support the aspirations and individual goals

of graduating and practising dentists by fulfilling their desire for autonomy and flexibility. At the same time, dentists' desire to help people and serve society are also satisfied in a system that maintains a certain level of social concern, however tempered it may be.

A second angle under which the social values analysis may be tied to dentists' perceptions and values concerns the issue of personal responsibility. In 2007, research among dentists on the profession's social responsibility, as well as inquiry into their experiences with patients living on social assistance, revealed their tendency to consider oral healthcare as a privilege and reward for personal effort. Dentists have reported that poor people, with the exception of those physically or mentally disadvantaged, must "assume some responsibility for care" and not just "ride the system" (Dharamsi et al. 2007). Patients living on social assistance are considered "good" in part when they are perceived to appreciate the dental care benefits the welfare program provides (Pegon-Machet et al. 2009). A study in 2009 showed that many French dentists perceive that the public dental care program fails to instill a sense of responsibility and appreciation among beneficiaries of social assistance (Pegon-Machet et al. 2009). It is not surprising, then, that dentists are often bewildered by patients' missed and non-confirmed appointments and view these in a very negative light (Bedos et al. 2006, 2010; Pegon-Machet et al. 2009). All these perceptions may be considered consistent with the societal perspective on oral health as belonging to the reward system. Would there be such concern with patients' appreciation and responsibility for care were such care considered an individual right?

In sum, there is a very strong coherence between the social values reflected by the current organization of Quebec's oral healthcare system and what dentists value most about their profession (e.g., freedom, autonomy, lifestyle). This coherence translates into a certain expectation towards patients with respect to personal responsibility that is consistent with the libertarian social values configuration.

### Quebec's Oral Healthcare System: A Regulatory Logics Perspective

The organization of a healthcare system expresses not only a particular configuration of social values, but also reflects four co-existing and interacting regulatory logics: professional, technocratic, market-based and democratic (Contandriopoulos 1999). The value of each is weighed differently by the various actors within the system: health professionals, managers, politicians and business people. The relative importance of each of these logics determines how healthcare structures and processes are organized (Contandriopoulos 1999). The arbitrations between them also influence the degree to which healthcare systems may or may not adapt to changes in the environment, whether evolving population needs or technological advances. This section will present an overview of the four regulatory logics as described by Contandriopoulos (1999) and then apply them to an analysis of Quebec's oral healthcare system. Linkages with dentists' perceptions of their difficulties in treating underprivileged populations will follow.

The *professional* regulatory logic is that of the health professional. It dominated developed countries during the first half of the 20th century, mainly through the legitimizing progress of biomedical knowledge and its artful application by experts (Contandriopoulos 1999). The

professional logic assumes that professions will develop and implement self-regulatory mechanisms that oversee clinical practice and academic training, as well as quality and ethics of patient care (Contandriopoulos 1999).

The *technocratic* regulatory logic, generally associated with the roles and actions of government health managers and planners, opposes itself starkly to the professional logic in its application of rational decision-making towards optimal resource allocation, in accordance with planned priorities (Contandriopoulos 1999).

The *economic* regulatory logic is founded on classic neo-liberal economic theory that, applied to healthcare, defends commodification and subjugation to free-market laws (Contandriopoulos 1999).

Finally, the *democratic* regulatory logic refers to citizens' rights and responsibilities in socio-political decision-making. Democratic rights may be exercised indirectly through the voting process or more directly through debate and deliberation (Contandriopoulos 1999). Democracy aims to empower members of society to partake in various decisions regarding the healthcare system: priority setting, problem identification, management processes and so on. As such, a democratic culture should facilitate the subordination of the other four actor groups' power to that of the individuals who collectively constitute society (Contandriopoulos 1999).

Contandriopoulos (1999) also points to how each of these four logics is founded on significantly different and contradictory conceptions of the very definition of the healthcare system, its goals and the roles of the various actors within it. Any given organizational configuration of a healthcare system is thus the reflection of a societal compromise made up of mechanisms arbitrating between two or more regulatory logics. It is also important to note that each group of actors may be characterized in part by the resources it controls, by its potential to improve its position in society by mobilizing additional resources and by its perception of the role and relative pertinence of each of the four co-existing regulatory logics (Contandriopoulos 1999).

When these logics are applied to the analysis of Quebec's oral healthcare system, one cannot help but notice the absence of the democratic logic. Msefer-Laroussi's (2007) socio-historical analysis of Quebec's dental care financing led her to the conclusion that oral health does not constitute an electoral stake for political parties in that province owing to the lack of popular interest and the absence of union and professional pressures. Such a lack is itself linked to weak social awareness of the importance of oral health (Msefer-Laroussi 2007). Thus, from the politicians' perspective, the costs of public dental care coverage – to which the federal government does not contribute – are not justifiable, given the lack of a strong social demand for it. As a case in point, cutbacks made to the social assistance public dental care program in the 1970s met with little reaction on the part of the general public; the protests of those directly concerned by the welfare program cutbacks came up against the prejudice of the general population, which felt the cutbacks were justified (Msefer-Laroussi 2007). As for the technocratic regulatory logic, its expression is contingent upon government involvement in the funding or regulation of healthcare. In the field of oral health, weak social demand and government disinvestment are associated with a very restricted role for the technocratic logic, which is limited to

its expression in the administration and management of the public dental health action plan.

The near effacement of the democratic and technocratic logics leaves the field of oral healthcare open for the deployment of both the professional and economic logics. The professional logic would imply that dentists should advocate for the interests of their patients (Contandriopoulos 1999). However, in the absence of strong governmental response to any such pressure, expansion of the economic logic meets with little constraint. The oral healthcare market includes private insurance, dentistry materials, products and technology as well as actual dental care. Any rising costs of production in these industries are inevitably passed along to the consumer in the cost of dental care. As Msefer-Laroussi (2007) concluded, nearly all dentistry activities take place within the private sector and are thus subject, to some degree, to free-market laws. Dentists must manage the tensions between the economic logic and the logic dictated by their profession.

Dharamsi and colleagues' (2007) research into the perceptions of social responsibility by North American dental practitioners, administrators and educators revealed the intractable nature of the economic–professional logic duality in dentistry. According to the authors' survey of 34 dentists, despite general support for the idea of dentistry as an equitable and universally accessible service, the economic imperatives of running a dental practice constrain those ideals. With the exception of concerns regarding interventions aimed at relieving a patient's pain, preoccupations with economics dominated most of the interviews and represented the "bottom line against which other positions had to be justified" (Dharamsi et al. 2007). In addition, the proponents of a dental care "market" questioned whether social responsibility should be a collective and governmental responsibility, all the while expressing concern about the impact of governmental interference (Dharamsi et al. 2007). Given the importance of freedom and independence as motivations for graduating dental students, ambivalence about government involvement in financing and regulating dental care is hardly surprising.

Links can be made between the regulatory logics of Quebec's oral healthcare system and dentists' perceptions of patients who benefit from social assistance. Dentists report experiencing multiple forms of failure in their work with the "bad" category of patients living on social assistance: therapeutic, interpersonal, personal, and financial (Pegon-Machat et al. 2009; Bedos et al. 2010). These negative experiences are considered to result from patients' service utilization behaviours and the attitudes perceived to underlie them. What is particular to the experiences of dentists – as opposed to doctors of medicine or other health professionals working within public healthcare systems – is the fact that patients benefiting from social assistance are considered to represent a financial threat, given the fixed costs of a dental practice that continue to run independently of patient attendance, and the government's low reimbursement rates for services (Pegon-Machat et al. 2009; Bedos et al. 2010).

Though dentists evoke many reasons for purposefully excluding patients from their caseload and closing patients' files, they admit that missed appointments – with the associated financial loss – represent the "last straw" (Pegon-Machat et al. 2009; Bedos et al. 2010). In other words, the missed appointments and no-show behaviour that dentists equate with a

lack of respect or ignorance are what trigger exclusionary actions. Thus, the economic logic predominates in private dental practice (Dharamsi et al. 2007). Booking and managing two patients at once, shortening appointments or refusing patient care are not dictated by a professional logic. One might suppose that negative stereotyping of patients reflects the tensions caused by conflicting and asymmetrical regulatory logics. Indeed, it may appear much more justifiable to exclude a “bad” patient who does not comply with a treatment plan than simply to refuse to assume the financial risk that such a patient represents.

## Discussion

Consideration of the dual frameworks of social values and regulatory logics helps to identify important systemic characteristics that influence the interactions between oral healthcare professionals and patients living on welfare. The analysis also raises the following question: how does the fact of weak democratic regulation within the oral healthcare system affect how the general public’s values are represented and reflected in its organizational form? A survey among Canadians revealed that an important majority considers oral health to be a fundamental right deserving of universal coverage (Quiñonez and Locker 2007). This finding clearly contrasts with the social values reflected in the organization of the oral healthcare system. Thus, when discussing social values one must take into account the differential representation of the various groups of actors involved. It should come as no surprise, then, that a healthcare system dominated by an economic regulatory logic corresponds more closely with a libertarian view of social values.

The analytical approach taken in this paper contrasts with the tendency, in the dental education literature, to address relationship issues separately from systemic failings related to oral health disparities. Studies on social responsibility and ethics have deplored certain systemic dimensions of oral healthcare delivery and of organized dentistry without necessarily relating them to patient–professional interactions. And most studies of cultural competency training, though they may touch upon structural health determinants of underprivileged populations, do not integrate knowledge of the ways in which macroscopic determinants of oral healthcare organization may intervene, and sometimes interfere, with patient–professional interactions. Yet, relational obstacles might be reduced were health professionals to improve their knowledge regarding certain categories of patients, as well as raise their awareness of the systemic impacts on their relationships with these patients.

Notwithstanding the importance of focusing on the challenges, difficulties and health implications of poverty, socio-cultural competency cannot limit itself to the acquisition of knowledge sets. Indeed, educational approaches aimed at the attainment of established knowledge thresholds run the risk, paradoxically, of reinforcing stereotypical thinking on the part of professionals (Eriksen et al. 2008). As well, the development of socio-cultural competency does not always lead to patient-centred care, given that the clinician may integrate acquired knowledge of interpersonal relations that remains directive and biomedical (Eriksen et al. 2008). Rather, as many dental education authors have advocated (Eriksen et al. 2008; Stone 2008; Formicola et al. 2003; Ornelas 2008; Pilcher et al. 2008; Rule and Welie 2009), stu-

dents and learners must develop their ability to question and analyze their own biases, beliefs and interactions with underprivileged patients. According to Stone (2008), becoming aware of one's own prejudices and their impact on the patient–professional relationship is a key component of a transformative learning process. Dentists and students should reflect on how people living on welfare come to be categorized and responded to, as well as on how systemic dimensions interact with their own views on patients. They should be guided to appreciate the social values that are reflected in the organization of the oral healthcare system, and how they position themselves with regard to these values, in order to improve their treatment, as care-giving professionals, of people living on welfare. The regulatory logics embedded in the oral healthcare system and how they translate into private practice management should also be taught, both theoretically and through simulated scenarios.

Critical reflection on systemic dimensions may also potentially contribute to organizational change. Indeed, sensitized oral health professionals would perhaps be more inclined to advocate for government involvement (e.g., improved reimbursement rates for public dental care) rather than resort to strategies that compromise patient care. According to Msefer-Laroussi's (2007) analysis, organized dentistry has not always backed policy initiatives promoting increased government involvement. This author also established the democratic vacuum in the oral healthcare system, attributable in great part to a lack of social awareness of the value of oral health. Yet, dentists are naturally well positioned to argue the importance of oral health for all segments of society, a position that might, in turn, increase the social demand for services. Dentists' actions could include the support of public campaigning on the impacts of poor oral health on underprivileged individuals. Without eventual transformation in the relative importance of the four regulatory logics, it is doubtful that access to oral healthcare can improve for underprivileged patients, interpersonal relationships aside. And to this day, government disinvestment in oral health has met with little or no protest from mainstream society.

## Conclusion

The reflections presented here on relationships between dentists and patients benefiting from social assistance have purposefully remained focused on the oral health professional, despite the existence of interactions between system-level characteristics and patient perspectives and experiences. Yet, a modification in social values regarding oral health would improve access to care for all and would potentially have an impact on patients' sense of entitlement to dental care and level of comfort during interactions with dental professionals. Such improvements might alleviate feelings of shame at requesting services or even requesting information on services (Gallagher et al. 2008).

Were oral health to transcend the system of rewards and increase in value socially, then perhaps underprivileged people might be less inclined to assume they are non-deserving of oral healthcare.

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