
MINORITY ORAL HEALTH IN AMERICA: DESPITE PROGRESS, DISPARITIES PERSIST

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Although oral health in the United States has by many measures improved dramatically over the past 50 years, it still represents a significant public health issue that affects low-income and minority populations disproportionately. Recently released data from the Centers for Disease Control and Prevention (CDC) underscore these disparities, showing significantly greater rates of *untreated* dental caries (cavities) among African Americans and Hispanics than among their White, non-Hispanic counterparts. Black and Hispanic populations also suffer disproportionate rates of tooth loss. Although the exact relationships between dental disease and other chronic diseases are not fully known, it is safe to say that maintaining good oral health is critical to achieving good overall health. Put simply, the prevalence of preventable, untreated dental disease among racial and ethnic minority populations is unacceptable. We as a nation must do better.

BARRIERS TO CARE TIED TO SOCIOECONOMIC FACTORS

“When you talk about racial barriers, you can’t avoid talking about economic barriers,” says Dr. Ada Cooper, an African American dentist practicing in New York City. “I think increasingly today as historical racial barriers are being broken down on some levels, the economic barriers continue to persist.”

According to the U.S. Census Bureau, in 2013, African Americans made up 13.2 percent of the American population, while Hispanics comprised 17 percent.¹ Yet racial minorities constitute a disproportionate share of the nation’s Medicaid beneficiaries compared to representation in the overall population: 21 percent of Medicaid beneficiaries are African American and 30 percent are Hispanic.² (It is important to note that the ethnicities and races categorically measured by the U.S. Census Bureau do not account for the broad diversity of cultures and numerous other factors affecting people’s health and access to health care.)

Medicaid-enrolled children in some states are currently receiving dental care at a rate equivalent to those covered by private insurance. But most state Medicaid dental programs fail to provide adequate care,

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especially to adults. The average state Medicaid program allocates less than two percent of its budget for dental services.

This is reflected in the fees state Medicaid programs set for various dental procedures. According to the American Dental Association Health Policy Institute (HPI), Medicaid fees ranged from a low of 30 percent of market rates for the same procedures (California) to a high of 69 percent of market rates (Arkansas) in 2012.³ Overhead for dental offices in many cases is significantly greater than Medicaid reimbursement rates, meaning that in many states, dentists actually lose money caring for Medicaid enrolled patients. Initial credentialing to qualify as a Medicaid provider can take months, and excessive administrative burdens are additional disincentives for dentists who might otherwise participate in the program.

Supported by vigorous advocacy by state dental societies, a handful of state legislatures have significantly improved their adult dental Medicaid benefits in recent years. Colorado now provides a number of adult dental services, including restorations (fillings), root canals, crowns, surgical procedures, and partial or full dentures. Adult Medicaid enrollees are allowed up to \$1,000 annually in dental services. But Colorado is an outlier. At this writing, 12 states provide comprehensive coverage, 20 provide limited coverage, 15 provide emergency-only coverage and four provide no coverage for adult Medicaid enrollees. States in which African Americans comprise a high percentage of all

residents also tend to be those with some of the poorest Medicaid dental benefits. There is also an increasing, recurring pattern of African Americans migrating to southern states, many of which have the most limited Medicaid dental benefits.

For instance, nearly one-third of Mississippi and Louisiana's populations are African American, yet the states have emergency-only and limited dental coverage, respectively.

Children fare better than adults under Medicaid, owing to the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provision, which specifies a comprehensive set of benefits for enrollees under age 21. But coverage is one thing; actually receiving care is another. Although Medicaid utilization among children increased from 2011 to 2012 in all but 13 states and Washington, D.C., underfunding inhibits provider participation, making it difficult for many eligible children to find a dentist who accepts Medicaid.⁴ Even when dentists who will accept Medicaid patients are available, many families don't know how to connect with these dentists.

UNTREATED CARIES AND TOOTH DECAY

Dental caries is an infectious disease in which bacteria that cause cavities can be transmitted from one person to another. Cavities can be prevented very early in the disease process, so that less treatment is ultimately needed, reducing the risk of catastrophic damage and serious infection.

A May 2015 CDC data brief casts the dental divide in America in sharp relief: More than one in four adults ages 20-to-64 has untreated dental caries.⁵ A breakdown by ethnicity is particularly troubling. Forty-two percent of African American adults and 36 percent of Hispanic adults have untreated disease, as compared to the 22 percent of Caucasians. An earlier CDC data brief found that untreated tooth decay in primary teeth among children ages two to eight is twice as high for Hispanic and African American children, compared with Caucasian children.⁶

Disparities also affect critical preventive treatments. Dental sealants, used to prevent cavities, are more prevalent in Caucasian children (44 percent) compared with African American and Asian children (31 percent, each) and Hispanic children (40 percent).

Native American communities face some of the greatest challenges in accessing dental care and, as a result, have punishingly high levels of dental disease. Access issues include:

- Geographic isolation;
- Low population densities;
- Jurisdictional and regulatory complexity;
- Lack of economic development;
- High unemployment and poverty;
- Low educational attainment;
- Lack of social, economic and transportation infrastructure; and
- Severe political, cultural, social and economic disenfranchisement.

A 2014 IHS survey found that 37 percent of American Indian children ages one to five had untreated dental decay. One major obstacle to addressing the astonishing decay rates among Native Americans is the fragmented way federal agencies compile data.⁷

THE ROLE OF MINORITY PROVIDERS

In a recent New York Times guest column, psychiatrist Damon Tweedy wrote, "As a general rule, black patients are more likely to feel comfortable with black doctors. Studies have shown that they are more likely to seek them out for treatment, and to report higher satisfaction with their care. In addition, more black doctors practice in high-poverty communities of color..."⁸

National Dental Association President Dr. Carrie E. Brown points out that African American and Hispanic dental providers disproportionately serve African American and Hispanic patients.

"It is important to note that the increasing costs of care delivery, coupled with low Medicaid reimbursement rates, continues to challenge our members' efforts to deliver quality dental care to those most in need," she said.

The Robert Wood Johnson Foundation in 2001 created Pipeline, Profession and Practice: Community-Based Dental Education, also known as the Dental Pipeline Program, a 10-year initiative to help dental schools increase access to dental care for underserved populations.⁹ Twenty-three schools participated in the program, which included an increased focus on community-based clinical education programs, revising dental school curricula to support these programs, and increasing recruitment and retention of underrepresented minority and low-income students. A similar program, granted by the Robert Wood Johnson Foundation in 1971, more than doubled the number of

Hispanic students attending the University of California, San Francisco School of Dentistry.

“We were very pleased with the increase in number of minority applicants and those matriculating to medical and dental schools,” said Dr. Donna Grant-Mills, Associate Dean for Student Affairs and Admissions at the Howard University College of Dentistry.

Because minority dentists comprise a disproportionately small percent of the overall number of practicing dentists, it is important that all dentists be aware of the needs of underserved communities and are willing to meet those needs.

The American Dental Association in 2003 developed the ADA Institute for Diversity in Leadership, which is designed to enhance the leadership skills of dentists from racial, ethnic or other groups that have historically been underrepresented in those roles.

BRINGING BETTER ORAL HEALTH INTO UNDERSERVED COMMUNITIES

Even when dental care is available to residents of underserved communities, connecting patients with dentists can be challenging.

Dentists in Washington, D.C. organized that city’s first Give Kids A Smile (GKAS) event in 2003, which is when the American Dental Association launched the program.

Working in the Howard University dental clinic, volunteer dentists—including a substantial cadre of Howard faculty—screened more than 200 children from Abram Simon Elementary School, located in one of the city’s poorest wards and with a largely African American student body. About half of the children required follow-up care—many of them suffered from severe tooth decay. DC Dental Society member dentists agreed to provide the follow-up care at no cost.

“We had only three parents who called,” said Dr. Sally Cram, an organizer of the event and ADA spokesperson. “Two of the parents took the referral list but never made an appointment to see a dentist. The third parent scheduled an appointment, but the child never showed up.”

Clearly, simply having dental care available to underserved populations is not enough.

“Effective follow up and outreach to incorporate strategies that will improve community participation has been a long-time puzzle to dentistry,” said Dr. Michael James Lopez, a Hispanic Dental Association

trustee. “Success in education and treatment comes from building relationships, trust and respect.”

Providing culturally competent oral health education, and helping patients navigate an often daunting and confusing public health system, are critical to helping families in underserved communities. The ADA in 2006 launched the Community Dental Health Coordinator (CDHC) pilot program to train community health workers who help people overcome barriers to optimal oral health and connect with dentists who can provide needed care. Now, community colleges in New Mexico, Illinois, Arizona, Florida and Virginia are either already offering the CDHC curriculum or are expected to do so as soon as Fall 2015.

While treating existing disease is imperative, oral health education and disease prevention are the ultimate answers. Long-term oral health improvements will occur when more parents understand—and convey to their children—the benefits of good nutrition, and the dangers of tobacco, poor nutrition, excessive alcohol intake, drug use and other unhealthy behaviors. Simple measures, such as regular brushing and flossing, can dramatically improve the oral health of millions who do not understand how to take care of their families’ teeth and gums.

Community water fluoridation is the most economical tool in disease prevention, and also has the advantage of not requiring any action from those who benefit from it. Fluoride in community water systems prevents at least 25 percent of tooth decay in children and adults, even in an era with widespread availability of fluoride from other sources, such as toothpaste. The ADA is collaborating with other public health advocates and federal agencies with the goal of increasing the availability of optimally fluoridated drinking water to 80 percent of the U.S. population on public water systems by 2020, up from the current level of 74.6 percent.¹⁰

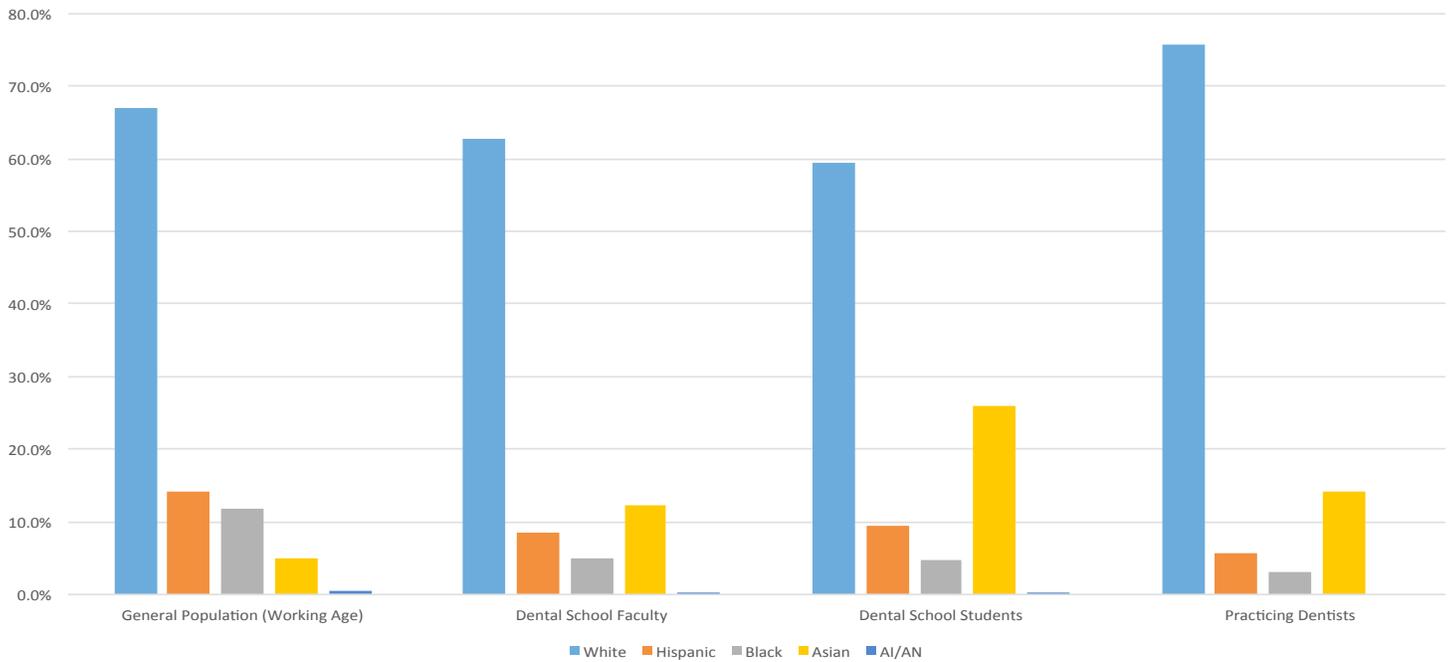
BRIDGING THE DENTAL DIVIDE

Economic, geographic, cultural and language barriers continue to impede too many people—especially racial and ethnic minorities—from attaining good oral health. Change is possible, but not until we as a nation commit to it.

THE ROLE OF GOVERNMENT

- **The Action for Dental Health Act (H.R. 539)**, introduced by Congresswoman Robin Kelly of Illinois, would allow organizations to qualify for CDC oral health grants to support activities that improve oral health education and disease prevention. The grants

GENERAL POPULATION, DENTAL SCHOOL FACULTY, STUDENTS AND PRACTICING DENTISTS BY ETHNICITY

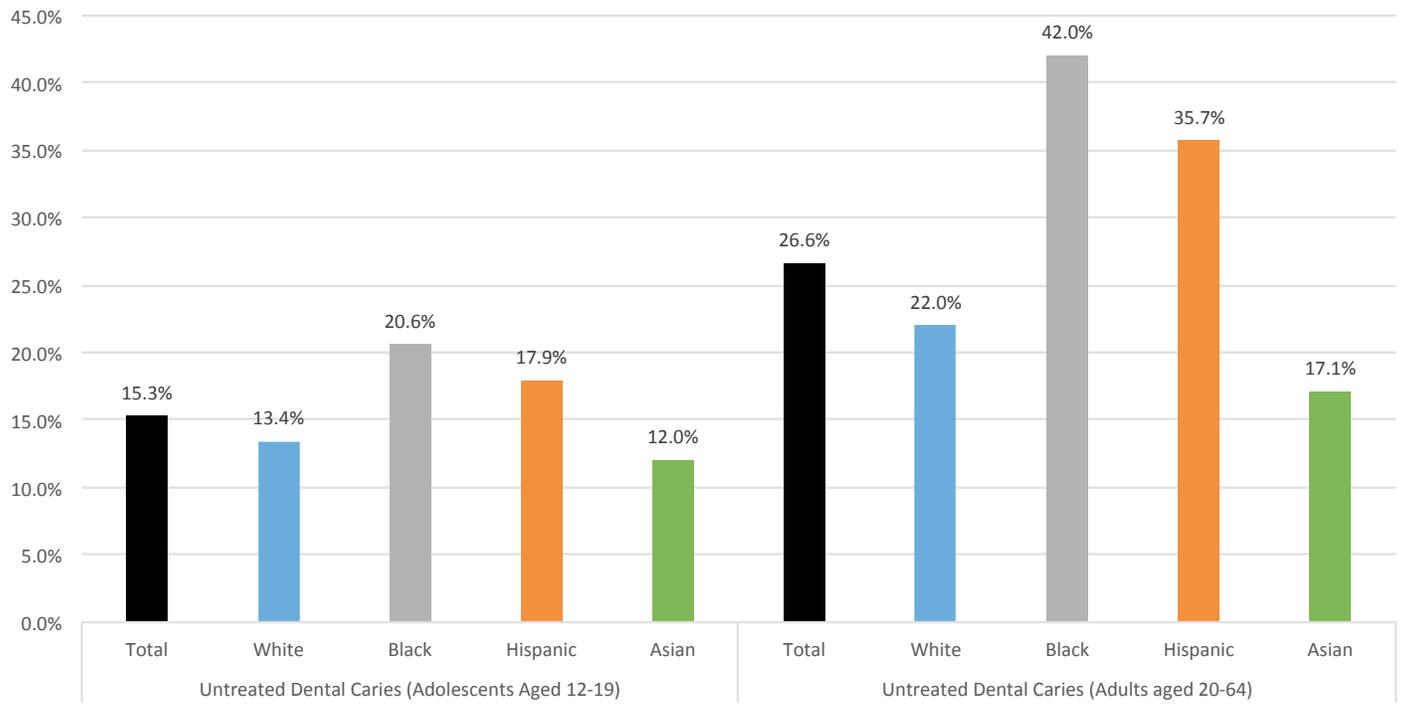


would also be used to develop and expand outreach programs establishing dental homes for children and adults, including the elderly, blind and disabled.

- Many of the federal programs designed to alleviate the stresses associated with poverty, especially for children, constantly face the threat of crippling budget cuts. When adequately funded, programs like **Women, Infants, and Children** and the **Supplemental Nutrition Assistance Program** can help educate families about the importance of healthy behaviors.
- **Medicaid** is the single largest source of health care for the poor. Yet many states fail to provide statutory minimum benefits to a majority of enrolled children, and adult benefits are almost universally inadequate. Congress should consider adding a dental benefit for adults under Medicaid.

- **Federal Dental Services** – The CDC Division of Oral Health supports community prevention programs, and conducts population-based research to better understand the nation’s oral health. One of the division’s primary goals is to “reduce inequalities in oral health.”
- Dentists in the Commissioned Corps of the U.S. Public Health Service, the Indian Health Service and the National Health Service Corps all have roles in bringing badly needed preventive and restorative oral health care and education to underserved and disadvantaged populations throughout the country. These federal services have long used student loan repayment incentives to successfully recruit dentists to work in underserved areas. Many of these dentists choose to locate permanently in those areas after fulfilling their contractual obligations to these agencies.

PREVALENCE OF DENTAL CARIES IN PERMANENT TEETH BY AGE AND RACE



States also must act to improve the oral health of their neediest residents by:

- Improving Medicaid funding and administration;
- Implementing strategies to redirect people seeking dental treatment in emergency rooms to dental offices in order to establish dental homes;
- Supporting programs that target at-risk children and adults in schools, community centers and other locations; and
- Working with private organizations and dentists to coordinate dental care for the vulnerable elderly and other special needs populations.

Dentists have fought for decades to improve the oral health of the underserved, and we will continue to do so. The American Dental Association in 2013 created Action for Dental Health, a nationwide, community-based movement to provide care *now* to people already suffering with dental disease, strengthen and expand the public/private safety net, and bring oral health education and disease prevention into the communities in greatest need.

We know that the nation’s dentists can make a difference. But dentists alone cannot win the war on untreated disease. For that to occur, every relevant sector of society must take part—government, the private and charitable sectors, educators, the other health professions—everyone with a stake in a healthier, more productive nation.

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