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Why Inadequate Dental Care Leads to Escalating Health Problems for Low-Income Americans

Donald Chi, University of Washington-Seattle Campus

In 2007, a Maryland child named Deamonte Driver died because of an untreated cavity that led to a brain infection. As this unnecessary American tragedy shows, dental cavities are no trivial matter. And they are not rare, either. Cavities are more prevalent than all cases of pediatric obesity, overweight, and asthma combined. Since at least the 1990s, half of all U.S. children have suffered from cavities, making cavities the most common childhood disease.

Cavities Reflect Broader Social Inequalities

Cavity rates are significantly higher for low-income, minority children. Deamonte Driver was an African American. In a recent pilot study of Alaska Native children, my colleagues and I found that every single participating child had at least one cavity. Indigenous children had cavities at a rate 16 times higher than the national average.

When a weak social safety net combines with poverty, poor dental health can occur early and last for a lifetime. In clinics serving the highest-risk communities, dentists commonly do extractions of the four front teeth of infants barely a year old. In less extreme cases, the teeth look like burned tree stumps; and when decay has progressed past the gums, the flattened nubs are the only things visible. Cream-colored streams of pus often ooze from infected teeth.

Most privileged Americans are protected from tooth decay, a disease that is usually preventable. Middle and higher-income Americans shop at grocery stores with many choices and can afford healthy foods low in sugar. They brush their teeth with fluoride toothpaste and get regular checkups, because they usually have reasonably good insurance that dentists like. Family and friends do these things too, reinforcing behaviors within middle and higher-income communities. What is more, such communities are usually situated in safe neighborhoods with fluoridated drinking water and welcoming dental offices.

Experiences in poor communities, both urban and rural, are often the exact opposite – leading to poor oral health for many, yet another burden of inequality born by the poor and many minorities.

Coherent Steps to Improve Oral Health in Poor Communities

Several steps could be taken to correct for glaring inequalities in U.S. oral health:

- **Health programs for low-income adults should include comprehensive dental care.** In a situation that has persisted since the 1960s, dental coverage is optional under Medicaid and the Affordable Care Act, and excluded from Medicare. Adult dental care makes a difference for the adult patients themselves, of course, but also affects their families. My own research shows that when a mother uses dental care, her children are 40 percent more likely to visit a dentist. And adults themselves benefit from dental coverage. They avoid costly emergency department visits – a last resort for many uninsured adults with dental emergencies. And their job prospects improve, because many potential employers concerned with appearance tend to avoid applicants who have missing or rotting front teeth.

- **Within Medicaid, states should invest in specialized dental programs for babies, children with disabilities, and minorities.** A promising example is the Access to Baby and Child Dentistry program in Washington state. Because babies are known to have a particularly tough time getting into a dentist chair, the program addresses barriers to care for babies by training dentists on how to manage infant behaviors, expanding benefits (for example, paying for four instead of two fluoride treatments per

year), and boosting dentist reimbursement rates. Setting a successful example followed by other states, the Washington program stresses establishing a dental home for children by age 12 months, as recommended by the American Academy of Pediatric Dentistry.

- **Support research on ways to encourage good oral health behaviors.** Important behavioral research in dentistry focuses on finding ways to make sure people visit their dentist twice a year for check-ups and get the follow-up care they need. In the case of Deamonte Driver, a small tooth filling, root canal, or extraction at the right time could have prevented his death.

But research on dental care alone is not enough. More research is needed to help people to eat less sugar. Joel Gittelsohn and colleagues at Johns Hopkins found that corner stores in Baltimore could be successfully encouraged to stock healthy foods. Based on that example, my colleagues and I have been developing an intervention for Alaska Native children, working with families and local stores to reduce children's consumption of sugary fruit drinks. The idea has generated excitement among Alaska Native parents, many of who know about the harmful effects of sugary drinks but do not have access to attractive alternatives.

But Improved Dental Health Low-Income People is Now Threatened

Currently, the U.S. Congress under conservative leadership is debating health coverage cuts that would have a big negative impact on dental health for low-income Americans. Any roll-back of the Affordable Care Act could put millions of newly-insured children and adults at risk for losing dental coverage, especially the states that expanded Medicaid coverage to new groups. Even more fundamentally, proposals to reduce long term Medicaid spending would leave all states struggling to pay for many kinds of health care needs. In the past, such pressures have led states to eliminate dental coverage for adults in Medicaid. That history could be repeated – and future prospects to improve dental care for children could also be undercut.

Read more in Chi, Donald, Socioeconomic Status, Food Security, and Dental Caries in US Children (*American Journal of Public Health*, 2014).