



The Disparity Cavity

FILLING AMERICA'S ORAL HEALTH CARE GAP



Campaign for Oral Health Parity

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Most of us brush and floss our teeth and have regular dental check-ups; but otherwise, we don't pay much attention to our gums and teeth unless there's a problem. Maybe that's why oral health gets so little attention in debates about health care coverage. It's common knowledge that 43 million Americans have no private health insurance, but how many know more than 108 million have no private dental insurance—or why it is easily overlooked when we have other health worries or run out of time or money.

But oral health deserves better, for oral health should be a priority for all of us. At the moment, it is a priority only for the people who don't have it. Unlike medical care, which most people use only when they are sick, good dental care is always needed because good oral health is essential to good overall health.

As the nation's premier nonprofit organization dedicated to improving oral health, Oral Health America has initiated a 10-year Campaign for Oral Health Parity to make oral health a priority for everyone and increase access to care for the 22.5 million Americans who want but cannot obtain oral health care. An important goal in this first year of the campaign will be to help draw national attention to the Surgeon General's Report on Oral Health and sustain attention to the need to address the oral health disparities identified in that report. This paper lays out some of the reasons Oral Health America has taken on this challenge and examines some of the obstacles that must be overcome if the goal of parity in dental care is to be met.

Why Does Oral Health Matter?

Oral health is more than clean, white teeth, filled cavities, and healthy gums. Oral health means being free of disease. In a very real sense, the condition of the mouth mirrors the condition of the body. But good oral health also has an undeniable impact on well-being, because the way your mouth feels and looks affects how you eat and speak, how you smile, how you interact with other people, whether you sleep comfortably through the night, even whether you can make it through a day at work or school without being bothered by pain in the mouth.

Most of us take good oral health, and the benefits it brings, for granted but, points out Dr. Raul Garcia of the Boston University School of Dental Medicine, "to a huge number of people who are poor, ethnic minorities, people with physical and mental disabilities, dental problems can be really important." Missing and unfilled teeth mean pain, loss of sleep, poor performance, low self-esteem, and difficulty in getting and keeping a job.

Though the full impact is impossible to document, dental problems do affect work and school. A survey conducted in 1989 showed that children missed nearly 52 million hours of school, or an average of 1.17 hours per child, because of dental treatment and problems. That same year, more than 164 million work hours were lost, an average of 1.48 hours per worker.

Very young children with severe dental problems may not grow normally and show serious behavior and attention problems. When their teeth are fixed, they catch up with the growth curves—which suggests painful teeth and eating problems had caused malnutrition—and behavior and learning improve dramatically, simply because they sleep better, eat better and are in better overall shape to learn and play.

Some oral health problems are obvious. Dental and craniofacial diseases and disorders are among the nation's most common health problems, and tooth decay is the most common and the most preventable disease in children. Birth defects, such as cleft lip and palate occur in one in every 525 to 714 live births. Injuries to the head and face account for some 20 million emergency room visits each year. And treatments used for 1.2 million cancer patients each year can cause painful ulcers in the mouth, rampant caries, inflammation, infection and dry mouth.

Beyond the obvious problems, some researchers consider the mouth "the laboratory of the body," for its tissues reflect signs and symptoms of other problems. An examination of the mouth, for instance, can

detect early signs of such disparate problems as diabetes, bone and joint disease, and cancer. Sores and ulcerations can indicate a different set of problems, such as herpes, mononucleosis or HIV infection.

In children, an examination of the teeth and mouth can detect such signs of abuse and neglect as missing and fractured teeth; oral bruises and cuts; and other head, neck, and mouth injuries. An estimated 2.7 million cases of neglect and abuse are reported each year. A dental exam also picks up poor nutrition and hygiene, growth and development problems, improper jaw alignment, and oral tumors.

Literally hundreds of different kinds of bacteria and other microorganisms live in the mouth. Their presence is an important reason to maintain good oral hygiene, for some cause infection and disease. If they spread into the blood stream some organisms can cause bacterial endocarditis, an inflammation of the lining of the heart and heart valves, or blood poisoning, a problem that can be fatal if not recognized and treated swiftly.

For years, dentists have premedicated patients with heart valve problems or artificial parts because of the risk of infection. Beyond that, neither dentists, nor physicians for that matter, have paid much attention to the question of how the condition of the mouth might affect the rest of the body. A number of recent studies, though, suggest there may be links—nothing as definitive as cause and effect, yet—between gum disease and conditions such as heart disease, stroke, diabetes and premature delivery.

The idea that there might be an association between dental disease and heart disease and strokes gets support from animal and test tube studies that show the same organism that causes most gum disease produces substances known to cause inflammation in blood vessels and blood clotting. Other circumstantial evidence also suggests a link since a number of chronic infections with organisms not found in the mouth are known to increase the risk.

Most human studies of heart disease and stroke have not looked for this link, and those that have included dental health usually do not consider smoking, high cholesterol, obesity and other known risk factors, or have relied on self-reports of dental problems, not a professional assessment. "Even so, a lot of studies show an association linking the two," explains Dr. Garcia whose long-term study of veterans in the Boston area found those who had gum disease 35 years ago have two to three times the risk for heart disease and stroke. Another long-term study, this one involving health professionals, found an association between gum disease, heart disease, and people who also lost their teeth.

But an association is different from cause and effect. A well-controlled, long-term study to determine if the control of gum infection with antibiotics would reduce the risk of heart disease and stroke might answer that question.

Diabetes is another common disease associated with infections of the mouth. For years it has been recognized that diabetes predisposes to all types of bacterial infection, including infections in the mouth, and that infections hamper a patient's ability to control blood sugar levels. What has not been clear is what role gum infections play, though patients with severe periodontal disease do have trouble maintaining blood sugar levels. Recent work suggests treating and controlling gum disease means that diabetic patients need less insulin.

Pregnant women are advised to have regular dental care since oral infections produce high levels of substances, known as prostaglandin, which can induce premature labor and the delivery of low birth weight babies. One study found the risk of premature delivery and a low birth weight baby was seven times greater in women with severe gum disease.

The possible impact of gum infections on miscarriage or even on fertility is not clear, but one ongoing study is identifying pregnant women at risk for small babies to see if cleaning their teeth and controlling oral infection will cut the risk of premature delivery. Many of these women have other risks for premature delivery as well, including smoking and poor nutrition.

The new attention to possible links between oral health and problems elsewhere in the body has ramifications that go beyond health. "There's increasing evidence that controlling mouth problems can have a major impact on physical well-being and lowering the costs of care," comments Dr. Garcia. "If keeping mouths clean can lower the risk of diabetes, heart disease and low birth weight babies, we can have a major public health impact with a minor investment in dental care."

The Care Gap

Overall, American teeth are in better shape than they ever have been. Fluoridation of water supplies has reduced the amount of tooth decay by about 65 percent over the past decades, and a new sealant technique can protect vulnerable teeth surfaces from decay. But problems remain. As dental disease declined, it also became more concentrated in a subset of the population. Not all water supplies are treated with fluorides. Currently, some 18,000 community water supplies, which serve about 40 million children, are not fluoridated. And only 20 percent of the nation's children have plastic sealants on vulnerable teeth. That 20 percent does not include most of the low-income and minority children who have the greatest problem with tooth decay.

Other indicators, too, suggest an implicit rationing of dental care. The success with preventive measures has not translated to those who have dental problems. Statistics show the percentage of Americans who get cavities has dropped, but also show a decline in the percentage of those who do get cavities and have them repaired. For that group, the problem is getting worse. What studies have been done show that poor children have about five times more unfilled, decayed teeth than children above 300 percent of the poverty line.

The percentage of teeth that have been decayed and filled further document a care gap, for there's a four-fold difference between high- and low-income groups. Among children, the most recent National Health Examination and Nutrition Survey found that Mexican and African American children had twice the number of untreated cavities as white children. For adults in low-income groups, half of teeth that have decayed have never been filled. This situation has taken a striking toll, for among low-income people over the age of 35, nearly one-third have no teeth.

Limited studies of dental visits reinforce this suggestion. One such study showed that for the decade between 1983 and 1993, only 35 percent of those 25 and older in lower income groups had visited a dentist within the past year, compared with about 60 percent of those above the poverty level. In 1997, a study found that 80 percent of those in higher income groups had visited a dentist. That means at least twice as many more affluent people get dental care.

Looking only at children, two federal surveys came up with different answers. Healthy People 2000—an ongoing government project that identifies the status of specific health variables, then sets targets for improvement—reported that about 73 percent of children were getting dental services, but an analysis of medical expenditures in 1997 put the number at 43 percent. The truth is probably somewhere between the two, notes Dr. Burton Edelstein, director of the Children's Dental Health Project.

According to the National Institute of Dental Research, dental caries is the most common, preventable disease in children. Children can avoid cavities entirely if given early and proper dental care, but not all children get this attention. In 5- to 17-year-old children, 80 percent of cavities are found in a subgroup of the 25 percent at the lower end of the socioeconomic scale.

Problems start early. Healthy People 2000 reports 18 percent of 2 to 4 year olds have visible tooth decay, and the numbers keep climbing. More than half of elementary school children have dental decay, and by the time they graduate from high school, it has risen to 84 percent. By the time they reach the age of 45, more than 99 percent of this population has had tooth decay.

Disparities in oral health care do not stop with decay. Gingivitis, characterized by tender, puffy gums that bleed easily and the first stage of more severe periodontal disease, is seen in half of high school students; 15 percent of adult Americans have advanced periodontal disease and are in danger of losing their teeth. In

lower socioeconomic groups, 33 percent of people over the age of 35 are edentulous. In this category, the difference between lowest and highest socioeconomic groups is eight-fold.

In another indicator of the gap in care, Healthy People 2000 reports a marked disparity in outcome rates for oropharyngeal cancer, a disease—in this country at least—due almost entirely to smoking and the use of tobacco products. This is the 10th most common cancer in men, the 14th in women and is more common than such better known cancers as leukemia and Hodgkin's disease. Approximately 27,000 new cases are diagnosed each year, and 8,000 deaths are reported. Treatment is most successful when cancers are diagnosed early, but in terms of survival, only 31 percent of African Americans pass the 5-year mark, while 55 percent of white patients do.

A study published in 1998 addressed disparity in access by trying to identify people who believed they needed but had not received dental care. This approach identified differences by sex and ages. More than 12 percent of adult women, 19 to 64, identified unmet dental needs, compared with a national average of 8.5 percent. At 9.5 percent, unmet dental needs for men also topped the national average, and were greater than the 5.9 percent reported for children or the 3.6 percent for the elderly.

When race and ethnicity were considered, results were comparable for Hispanics, at 7.4 percent, and whites, at 8.3 percent, but 15 percent of African Americans reported unmet care needs. Other disparities were identified. People in fair or poor health were more than twice as likely to have unmet dental care problems than those who considered their health good or excellent, and people with chronic health problems were even more likely to have unmet needs.

Geography and education also play a role. Unmet care needs were greatest in the South, lowest in the Northeast and Midwest, and slightly higher in households where the head had less education. Income, though, was a more powerful indicator, for 16.4 percent of those below 150 percent of the poverty level reported unmet care wants compared with only 6.3 percent of families above that level. When insurance coverage was considered, the disparity became even greater for 22.6 percent without insurance reported unmet needs, compared with slightly less than 6 percent of those with private dental coverage. More than 12 percent of Medicaid recipients reported unmet wants.

Further questions revealed that more than two-fifths, or 9.3 million Americans, had limited their activities because of dental problems. When these problems were later evaluated, nearly three-quarters were classified as moderate to serious, less than a quarter as not serious at all. The results, the report's authors concluded, suggest that the populations that would benefit from more access to dental care were the same as those that would benefit from better access to medical or surgical care.

Looking only at children, a recently published analysis of the National Health Interview Survey showed 7.3 percent of parents thought their children had one or more unmet needs. For 73 percent of those children, that unmet need was dental. That means, notes Dr. Edelstein, that one in every 20 American children has an unmet dental need. The need for medical care was runner-up.

Who Does, and Who Does Not, Get Care?

No single study answers these questions. But a number of very different indicators suggest that the number of people who get dental care has increased in every age group, for both sexes, at all income and educational levels and across the major racial and ethnic groups.

Such data is encouraging, for it marks progress in efforts to make sure everyone in America gets dental care. But the improvement masks subtle but very important problems. Despite the increase, 100 million Americans don't visit a dentist each year. That 100 million includes many people with special dental care needs, including the elderly, those who live in nursing homes, the homeless, disabled populations, and very young children.

Of all the special needs groups, the homeless may be the most vulnerable and the most difficult to reach. Most don't have a regular place to brush their teeth or carry a toothbrush, so oral hygiene is poor. Since the homeless—a population estimated at 2 million people, about 25 percent of them children—also have problems with untreated mental illness, alcohol and substance abuse, domestic violence and access to health care, it follows that they would have serious dental problems, and they do. With no money, no health insurance and no home, they have trouble finding dentists who will care for them, and even though at least many of the children are eligible for care through Medicaid, little effort is made to see they get care.

Poor overall health and poor nutrition complicate the oral health picture. Dental problems are 12 times more likely among the homeless, and these problems tend to be serious. Slightly more than half of the homeless, 53 percent, have complete sets of teeth in contrast to 91 percent of the general population; and one survey found that 83 percent had not had their teeth cleaned in the previous four years. And, though 96 percent of homeless children age 5 to 9 were found to require dental care, most had never seen a dentist.

The 43 million Americans with physical or mental disabilities also seem to have higher rates of dental disease than other segments of the population. Some of these are due to medical problems or the side effects of medication, some to the disability itself. Proper oral hygiene—even the task of brushing and flossing on a regular basis—is challenging for many. Moreover, many dentists are not trained, or are not willing, to manage complex medical and behavioral problems experienced by many in this group. Many children rely on Medicaid for dental coverage but few states cover dental services for adults under Medicaid. Even with Medicaid, low reimbursement rates often don't permit the kind of care, including hospitalization and anesthesia, required for treating some disabled patients.

The need for dental care doesn't end with childhood and people with disabilities face even greater problems when they "graduate" from Medicaid. Each year, an estimated 100,000 children with disabilities lose the coverage they had under Medicaid and, with it, the guarantee of dental care. At that point, the cost of care combined with the fact that few private dental offices are equipped to deal with disabilities make care even more problematic.

Only a few small studies hint at the dental care needs of the adults in this group, but they suggest needs are great. For instance, at least a quarter of those with cerebral palsy have dental problems, 30 percent of those with head injuries, and 17 percent of the deaf.

The nation's growing senior citizen population also is at high risk for dental problems. The risk is greatest among the less able, who fail to get dental care for a variety of reasons: unpredictability of illness and energy, the time it takes to get to a dentist, and dependence on other people for transportation. And, of course, the cost. Only 15 percent of the over-65 population has any kind of dental coverage, so senior citizens with a fixed and limited income tend to give dental care low priority if they must spread their resources to cover drug and extra medical bills as well as the costs of food and shelter. Medicare covers no basic, preventive or reconstructive dental services, only dental problems related to a medical problem.

An estimated 70 percent of the nation's 2 million plus nursing home population has dental problems that include dentures that don't fit and loss of some or all of their teeth, but most significantly poor oral hygiene. Many nursing home patients are not able to brush and floss adequately on their own. Their oral care is provided by untrained, usually underpaid aides with little incentive or time to do a proper job. Consequently, sore and bleeding gums, oral infection and decay are frequently seen among nursing home residents. Since costs of providing care to these patients are high, treatment depends on Medicaid eligibility and the kinds of services that may be covered by a state. To make the problem even worse, one study showed that dentists who work in nursing homes don't offer a full range of services. Less than one-third, for instance, provides necessary cleaning and scaling.

Young children comprise a different type of high-risk group. Though the American Society of Pediatric Dentists recommends a first dental exam as early as the eruption of the first baby teeth, and certainly by one year, less than one percent of children actually get this kind of care. The still common practice of

putting infants to bed with a bottle of milk, juice or some sweet liquid means that liquid pools around the teeth, where bacteria in dental plaque breaks down the carbohydrates in the liquid, producing acids that attack dental enamel and cause decay, a process known as "nursing bottle tooth decay."

The fact that nearly one in five youngsters 2 to 4 years of age have visible tooth decay documents the need for this early examination. But another important reason comes from the relatively recent discovery that dental caries are infectious and can be transmitted to infants through the mother's saliva—a good reason not to share spoons or toothbrushes.

Tests can now detect which children have high levels of decay-causing bacteria so that disease prevention can be started at a very early age. Since teeth are susceptible to decay as soon as they erupt, and most children have no dental care during their early years, untreated disease and early tooth loss is common—and at least five times more common among the poor as their more affluent peers. Even preserving baby teeth is important, for they serve as space holders for the positioning of adult teeth.

The Barriers: Why some People Don't Get Care

The question of why so many people don't get regular dental care has no easy answer. Since about half the population has no form of dental insurance, cost—whether direct out-of-pocket payments for care or the perceived cost of adding dental benefits to existing public and private insurance programs—is usually cited as the main barrier. A number of studies show that, when financing is available, the poor use dental services at the same rate as the rest of the people.

Greater insurance coverage is no guarantee more people would receive care, for other barriers exist. About 90 percent of the nation's dentists are in private practice and don't work in inner cities and rural areas where poor and underserved people live. An impending dental manpower shortage and a drop in the numbers of minority dentists threaten to make this barrier even greater. Also, though dental treatment for Medicaid-eligible children is mandated by law, many dentists don't accept Medicaid patients because low reimbursement rates do not cover costs of care and they consider Medicaid, with its rules and regulations, an administrative "nightmare."

Less easy to document, priorities and attitudes also keep people from getting or giving care. To most people, other health conditions seem far more important than dental health when time and money are limited, especially since the link between dental health and overall health is not widely understood. Nor is the fact that medical and dental care are different. Everyone needs regular dental care, though only certain groups—the very young and the very old and those with chronic conditions—need regular medical care. The belief that oral diseases are inevitable also keeps many from preventive care. Some cultures simply accept, as a given, that the loss of some or all of their teeth is part of life.

Who Pays for Care?

The financial barrier to care is considerable. More than 150 million Americans, 55 percent of the population, have no dental insurance. Studies show that those without private dental insurance, which, like health insurance, is employer provided, are less likely to have seen a dentist recently than those with insurance. The uninsured tend to visit a dentist only when they have a problem, so are less likely to have a regular dentist, to use preventive care or to have all their dental needs met. One study done in 1989 found that nearly half of people without private insurance didn't visit a dentist in the prior year, compared with 28 percent of those with insurance.

Dental care accounts for a minute portion of the nation's trillion-dollar health care bill. In 1997, a total of \$50.6 billion was spent for dental care and nearly half, or 47 percent, was paid directly by patients. The public share was a mere 4.4 percent, most of that the \$2 billion federal and state contributions for Medicaid recipients—and most of that for children. Other government funding, while limited, comes through Medicare—though almost all of that is in managed care plans—Head Start and several programs operated through the Health Resources and Services Administration as well as "safety-net" services such as school-based clinics and community health centers.

With so many dentists in private practice, the mere existence of these limited public programs does not guarantee care. Other care for those who have trouble paying is provided by hospital and dental school clinics and by private dentists. A 1997 survey by the American Dental Association showed nearly half of all dentists provided some uncompensated care. The total amount of charitable care is an estimated \$2 billion a year, most for the poor and the near poor.

Because dental care for 20 million Medicaid-eligible children through age 18 is mandated by law and the new Child Health Insurance Program (CHIP) provides dental coverage for an additional 4 million low-income children, in theory at least, needy children should be able to get dental care. In practice, a majority of poor children still do not receive dental care, even though they are eligible. Despite the legal requirement, Congress has never provided enough money to carry out the program. "We have a program that made the promise but didn't deliver," reports Dr. Edelstein.

An estimated 16 million eligible poor children do not get dental care, and the main reason is lack of funding. In many states, Medicaid reimbursement rates for dental care are too low to even cover the costs of care, so many dentists can't afford to take Medicaid patients. States that have raised reimbursement rates or offered other incentives have found more dentists willing to participate. "The core problem is the tacit acceptance of this situation by the general public," says Dr. Howard Bailit of the University of Connecticut Health Center. "Because Medicaid is a program for poor people and because most people value dental care less than other medical services, there appears to be little public support to change this situation."

Dentists cite other problems with Medicaid. Payment is slow and unpredictable and, to the dentists at least, denials sometimes seem arbitrary. Even routine care may require prior authorization. Administrative requirements and paperwork needed to comply with Medicaid rules and regulations, which vary by state, are also cited as reasons for not accepting Medicaid patients. Some refuse, too, because they find Medicaid patients—many confronted with day care and transportation problems—often fail to keep appointments.

Distribution of dentists is also a problem. Though studies suggest people feel more comfortable with a practitioner of their own race, the number of minority dentists is not sufficient to meet the needs of the population. Few dentists practice in inner cities or rural areas, where the needs are greatest. For whatever reasons, the result is the same: children covered by Medicaid often cannot find a dentist who will treat them. A 1977 survey found that almost 30 percent of dentists had one or more Medicaid patients, but that less than half of them saw 10 beneficiaries in the month of the survey.

The problems don't stop with the dentists. Many parents do not realize their child may be eligible for government-funded programs and do not understand how to use the programs or even how to find a dentist. Dentists often worry about how to overcome what they see as "cultural differences" when parents accept the loss of teeth as an inevitable part of life because these parents don't understand the need for regular brushing and dental visits and only seek care when there is a problem. Some fail to understand that missed appointments are costly and disruptive to dentists, and because of language or educational differences don't always follow instructions for care or dietary changes.

Cultural differences work both ways. Dentists may lack the sensitivity and understanding of different cultures and fail to make sufficient accommodation for problems Medicaid patients confront simply to get care. Suggestions offered at a conference devoted to improving the access of Medicaid children included developing systems for transportation and child care, educating parents about the importance of oral health and how they can help, appropriate behavior in an office and the importance of keeping appointments—strategies that could ease problems for both parents and dentists.

If children fare poorly under Medicaid, adults have an even worse time. Only 32 states cover any kind of dental care for Medicaid-eligible adults, and that is mostly for emergency care. Rules often stipulate the least costly treatment, which, in most cases, means simply pulling an affected tooth.

In an effort to understand why many Medicaid beneficiaries do not seek dental care, even when it is covered and dentists will accept them, a study in the state of Washington found a lack of information about coverage was the greatest obstacle, followed by a perception that dentists who accept Medicaid are not available and the recognition that the need for preventive dental care was not sufficient to prompt recipients to find out about coverage or locate a dentist.

Who Will Provide Care?

The current access problems will only become more acute in the future as the supply of dental manpower declines. Many have worried that dental education is approaching a crisis with declines in applicants as well as graduates. The decline started when dental schools reduced their enrollment by about 30 percent in the 1980s and went from about 5,200 to the current 4,000 graduates a year. During that same time, six dental schools have closed and others face financial difficulties. Faculty salaries have not kept pace with dental income, which makes practice far more attractive than academic dentistry or dental research.

Especially worrisome in terms of providing care is the decline in the past few years in both minority applicants and enrollments, a problem that threatens to make the access problem in already underserved communities even greater than it is today. In 1996, African Americans made up 12 percent of the population, while African Americans accounted for only 2.2 percent of the dental workforce and Hispanics, with 10.7 percent of the population, had 2.8 percent of the dental workforce. Whites, who comprise 73.2 percent of the general population, accounted for 87.9 percent of the nation's dentists.

Native Americans, with a population of 2.4 million spread through 560 reservations, many isolated in the west, confront the most serious manpower problem, with a ratio of one Native American dentist for every 35,000 in the Native American population. Among non-Native Americans, the ratio is about one dentist to 900 people. With the exception of Asian Americans, whose numbers have increased, dental enrollments for all racial groups—including White—have declined over the past few years.

At the other end is an aging workforce. The average dentist is now 50 years old. Many are retiring and many are cutting back on the number of hours they practice. Several years ago, dentists averaged 42 hours a week; now the average dentist works 37 hours and nearly 30 percent work 30 hours or less each week. An increase in the number of female dentists may also reduce the supply of dental services because women tend to work fewer hours, especially when they have young children. In the next year, more dentists will leave the profession due to retirement and death than graduate from dental school, a trend that is expected to increase as the workforce ages even more. One projection shows that in 20 years, the relative number of dentists will decline by 10 percent, from the current 58 per 100,000 to less than 52.

Manpower concerns extend beyond clinical practice. Academic dentistry and research also suffer. Between 300 and 400 dental teaching positions are not filled, and probably will remain empty, leading to what Dr. Walter Cohen, former dean at the University of Pennsylvania School of Dentistry, calls a "crisis in dental education." Without good teachers, he worries, "the quality of the educational piece will decline." Compounding the teaching problem, the Journal of the American Dental Association reported that federal support for dental education has fallen sharply, from 27.6 percent in 1997 to less than 1 percent in 1997.

Dental research is also suffering, with a growing list of important research issues that cannot be studied because of a short supply of qualified researchers. One reason both academic dentistry and dental research are in such dire straits is money. The average dental graduate comes with a debt of \$100,000, but a debt as high as \$150,000 is not uncommon. Such an amount is almost impossible to repay on an academic or research salary, which forces young graduates into private practice. Congress has looked at solutions such as debt forgiveness for those who go into research, but so far the situation remains unresolved.

In 1995, Dental Education at the Crossroads, a report from the Institute of Medicine, addressed the issues that still confront dental education today. Among its recommendations, the report urged more support for dental education and "closer integration" of medical and dental curricula. The proposal would have eased the teaching problem, at least for the basic and behavioral sciences, brought the two professions closer together

and eased some of the financial pressures on both sides. Five years later, little has changed: medicine and dentistry remain separate.

What Can Be Done?

Most of the problems confronting dental care today could be overcome by putting more money into the system, more money for better and wider coverage—public and private—more money for dental education, more money for public education. But money is not the only answer. Developing the systems to deliver care to underserved areas and those with special dental needs is also essential.

Some of the solutions are self-evident. Dr. Bailit, for instance, thinks "a relative modest increase" of \$3 billion in the \$152 billion Medicaid budget would provide basic dental services for the entire Medicaid-eligible population and would make a significant difference in the access problem—as long as program administration improves and reimbursement levels increase.

None of this will happen until the public demands it, but there is no organized and vocal constituency for oral health. Even senior citizens have not lobbied for dental coverage through Medicare, though the elderly are at risk for serious, and expensive, dental problems and only 15 percent have dental insurance. "The general societal view is that dental care is not as important as medical care," worries Dr. Bailit. "There's not a constituency out there screaming for it." Without that constituency, and the votes it could carry, the elected health policy makers of this nation do not consider good oral health a high-priority issue.

That could change as the public becomes more aware of the strong link between good oral health and good overall health. The release of the Surgeon General's groundbreaking report on Oral Health and the ambitious goals for reducing disparities in care that are included in Healthy People 2010, the government's health goals for the nation of the next decade, should push the issue to the forefront of public attention.

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