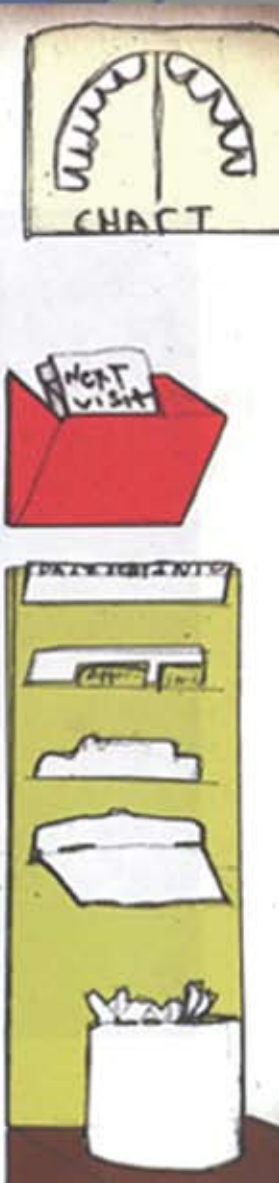
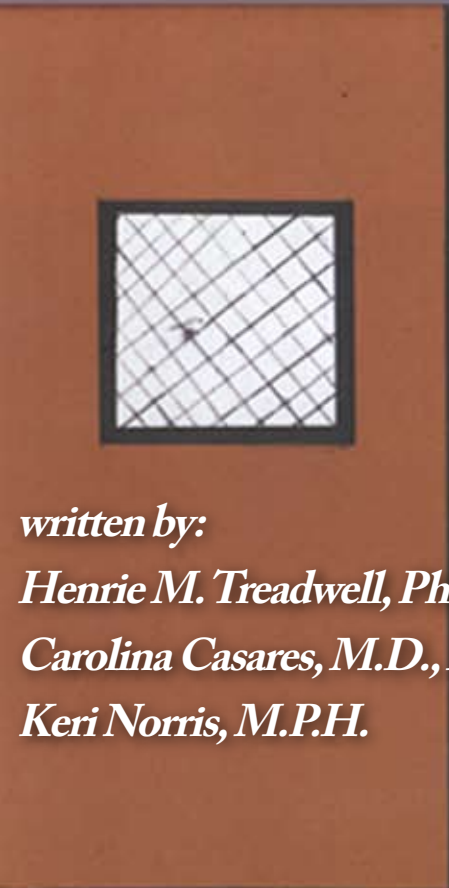




Community Health: Who Cares? Who Should Care?

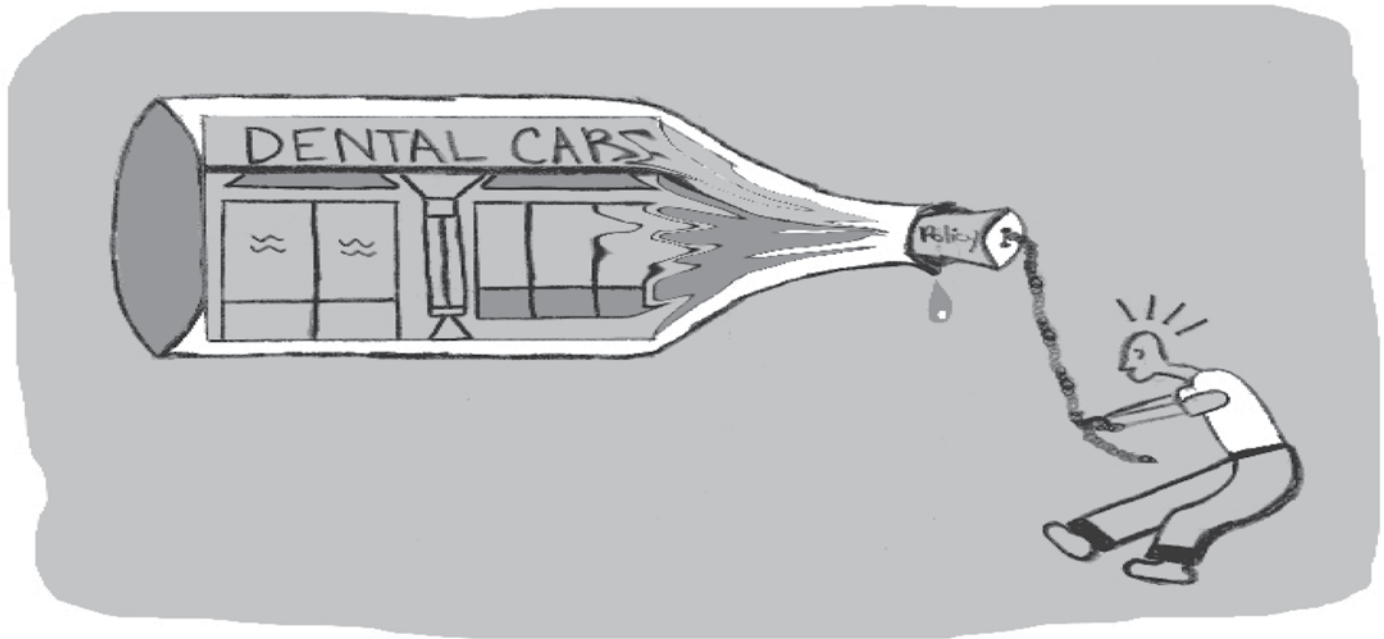


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Community Voices

Community Voices: Healthcare for the Underserved is working to make health care available to all. With eight sites across the country and managed by the National Center for Primary Care at the Morehouse School of Medicine, Community Voices is helping to ensure the survival of safety-net providers and strengthen community support services. Launched in 1998 by the W.K. Kellogg Foundation, the sites are part of a national effort to sort out what works from what does not in meeting the needs of those who receive inadequate or no health care.



Oral Health: Who Cares? Who Should Care?

Written by:

Henrie M. Treadwell, Ph.D., Carolina Casares, M.D., M.P.H., Keri Norris, M.P.H.

In the United States, health systems, practices, policies, and payment mechanisms continue to differentiate between physical health and oral health. But within the human body, no such distinction exists. An infected tooth is no different than strep throat or any other threat to physical well-being. Yet for too many people – across the nation and in our own State of Georgia – the crying need for oral health care, both to prevent illness and treat disease, goes unanswered.

From a policy perspective, understanding the extent of unmet need among a particular constituency is essential to finding a way to address it. Only with adequate information, and a breakdown on how and where existing resources are currently being deployed, can institutional decision makers, public policymakers, and advocates begin to redress gaps in services.

In the case of oral health policy, data – especially state-level subsets – are scanty. However, by pooling what we do know – about the status of oral health and population trends, about dental care expenditures and the existing workforce, about health professions institutions and the practice environment in Georgia – it is possible to identify action steps that will begin to address inequities

in oral health care across our state. This policy brief was developed to expedite that process.

Within the following pages, readers will find:

- Information on oral health status in the United States including available oral health data on traditionally underserved populations such as the poor, African American adults, and people in prisons and jails;
- Available oral health status data on the people of Georgia;
- Data on workforce, ethnicity, and oral health discrepancies;
- Information on the oral health infrastructure related to the needs of the people of Georgia (including availability of professionals, programs that prepare oral health professionals, practice parameters, and expenditures);
- Recommendations for decision makers in institutions and public policy; and
- A complete listing of source materials referenced throughout this document.

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The Status of Oral Health in the General Population

In 2003, statistics from the Centers for Disease Control and Prevention indicated that eight percent of the adult population in the United States reported not having any of their natural teeth.¹ In addition, data indicate that:

- Severe gum disease affects 14 percent of adults 45 to 54 years old.^{2 3}
- Women, more than men, report painful mouth and facial conditions such as migraines, burning mouth syndrome, and *Temporomandibular Joint* (TMJ) disorders.⁴
- Thirty-three percent of poor adults have at least one untreated decayed tooth compared to 11 percent of non-poor adults.⁵
- Each year employed adults lose more than 164 million hours of work due to oral health problems or dental visits.^{6 7}
- Ninety percent of adults are affected by tooth decay.⁸
- Adults under 65 years old and covered by Medicaid were more likely to have lost all their natural teeth when compared to those with private or no insurance.⁹

The U.S. Healthy People 2010 Oral Health Goal and Objective is to prevent and control oral and craniofacial diseases, conditions, and injuries and improve access to related services for all U.S. citizens.¹⁰ The goal statement is based on the recognition that oral health is essential to maintaining and improving individual health. Even so, statistics on the prevalence of tooth decay, gum disease, and untreated dental infections point to serious gaps in access to oral health services. And although the Surgeon General's Oral Health in America report (2000) documented improvement in oral health, analysis also highlighted a persistent and troubling disparity in oral health status – particularly between the white population and communities

of color. Inadequate access to oral health care is, in fact, a growing American health care crisis.¹¹

Impact of Inadequate Oral Health Care on Racial and Ethnic Populations

As the Surgeon General's Oral Health in America report noted, the burden of oral diseases is spread unevenly throughout the population. Poor people, people with limited education, and members of some racial/ethnic groups have higher incidence of untreated oral disease than the population as a whole. For example, data indicate:

- Adults with incomes at or above poverty level are twice as likely to report a dental visit within the past 12 months.^{12 13}
- The poor and near poor are more likely to have lost all their natural teeth.¹⁴
- Sixteen percent of adults with less education than a high school diploma reported having no natural teeth.¹⁵
- Overall, African American adults are more likely to have lost all of their natural teeth than Hispanic or white adults.¹⁶
- Among older Americans, African Americans have a higher prevalence of periodontal disease.¹⁷

Oral health has been associated with other chronic conditions such as diabetes and heart disease. Racial and ethnic minorities, prisoners, and seniors suffer disproportionately from oral diseases and conditions due to societal prejudices that place them at risk over and above any risk associated with their economic means. It is suggested that oral health should be addressed as a social justice issue and a right for all, not just for some.¹⁸

The long-term impact of little or no oral health care

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emerges in statistics related to particular diseases, such as oral cancer. Historically, oral cancer has received limited attention, despite the functional, psychological, and financial toll it takes on patients and their families. And while early detection of oral cancer is possible with a simple noninvasive oral examination, five-year survival rates have not improved since the 1970s.¹⁹ In this case, statistics underscore the result of inattention among the most vulnerable population groups. Among men, and specifically men of color, African American men have the highest incidence (Fig.1) and mortality (Fig.2) rates for oral cancer in the U.S. regardless of age group.²⁰ Risk reduction and early detection can reduce oral cancer morbidity and mortality, but few interventions target African Americans and especially men.²¹

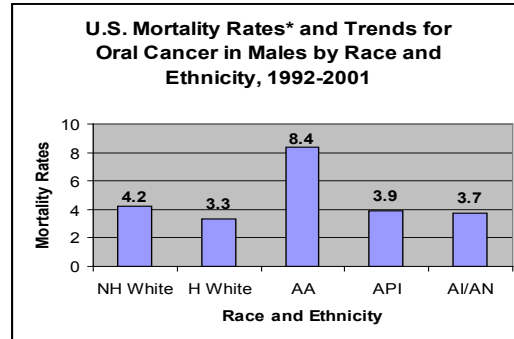


Figure 2 Key: NH White = Non Hispanic White; H White = Hispanic White; AA = African American; API = Asian Pacific Islander; AI/AN = American Indian/Alaska Native - **Source of data:** National Center for Health Statistics public-use data file for the total U.S.

* Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population

Oral Health Needs of People in Jails and Prisons

The U.S. prison population represents disparate groups of people with varying access to health care in their communities – due to fewer services, a lack of insurance as a result of low wages in jobs that do not provide insurance, or as a result of social policies that exclude poor men, particularly poor men of color.²² In 2005, over 7 million people or 1 in every 32 adults in the United States were on probation, in jail or prison, or on parole. Of these, 3,145 per 100,000 African American males were among this group compared to 1,244 per 100,000 Hispanic males and 471 white males.²³ These adults are often in poor oral, mental, and physical health as a result of inadequate access to needed health services. In addition, many in these groups experience longer periods of time in prison due to sentencing inequities that tend to penalize African Americans more than whites for the same crime.²⁴

Despite the absence of data on the oral health status or unmet oral health needs of juvenile offenders, data on the general population suggest a significant problem. Overall, 80 percent of tooth decay occurs among 25 percent of

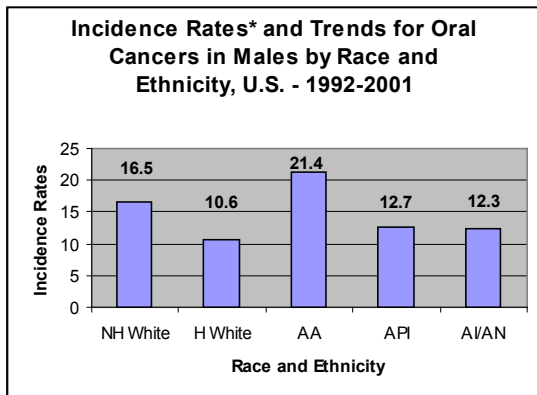


Figure 1 Key: NH White = Non Hispanic White; H White = Hispanic White; AA = African American; API = Asian Pacific Islander; AI/AN = American Indian/Alaska Native - **Source of data:** SEER Incidence Rates and Trends for Oral Cavity and Pharynx Cancers in Males by Race and Ethnicity for 1992–2001

* Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population

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children aged 5–17 years, primarily in those from minority and low-income families and in those with low educational levels. These are the children who are disproportionately represented in juvenile justice facilities.

Prisons are required to provide health services under the U.S. Constitution to avoid cruel and unusual punishment.²⁵ Yet the health status of inmates in the prison system is not routinely incorporated into data and reports that summarize the state of the nation's health. The number of imprisoned citizens is already terribly high, yet further increases are expected if current policies remain in place. Although these people are hidden from the public eye and from data sets, the health of prisoners is an integral part of the nation's health.²⁶ And considering that more than 630,000 people migrate back and forth across the "border" between prisons and communities, incarcerated and newly-released prisoners in poor health represent a public health opportunity to address neglected health issues, including oral health.²⁷ In the absence of adequate resources, however, oral health care remains just one of many health issues that confront those charged with providing prison health care.

Oral Health Status of Adults in Georgia

Although adult oral health statistics are not collected by the State of Georgia, economic, health, and population data reported by philanthropic organizations and federal agencies suggest the scope of unmet need for oral health care. For example:

- In 2004, 68.2 percent of adults visited the dentist or a dental clinic.²⁸
- Medicaid only covers emergency extractions in Georgia.
- In 2005, of the 14.4 percent of people living in

poverty in Georgia, an estimated 21.3 percent were tax-paying workers.²⁹

- The Governor's Fiscal Year 2004 and 2005 Medicaid Budget Proposal included a Department of Community Health plan to eliminate adult dental services for Fiscal Year 2005 for a savings of \$5.6 million in state funds.³⁰

Economic status and dental insurance are often predictors of access to oral health care. For low-income workers and the poor, emergency rooms are often the only care option for oral diseases.

Data regarding the use of emergency departments for the treatment of dental problems are limited. A prospective study found that almost 69% of hospital dental emergency patients, children and adults, did not see a dentist regularly³¹ and had still not done so one year later.³²

Data collected retrospectively on all patients presenting with dental complaints between January 1, 1987 and December 31, 1995 in an urban hospital emergency department in Louisiana, revealed that of the 3,943 charts reviewed, 1,892 (48%) patients required emergent oral surgery management and 2,051 (52%) emergency physician management only. The frequency of dental patients increased from 4.4/1,000 total ED patients in 1987 to 11.5/1,000 in 1995 as did the rate of emergent dental trauma, emergent non traumatic dental care, and non emergent non traumatic dental care. Approximately one-half did not require specialist consultation and could potentially have been managed by a primary care dental practitioner.³³

In 1999, 11.3% of the emergency room visits in the NHAMCS data set were due to craniofacial injuries and are often the ones most reported upon.³⁴

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Of people visiting an emergency room in 1999 ³⁵ (Figure 3)

- A greater percent age of people aged 24 years and younger and aged 75 years and older had a craniofacial injury compared with 25- to 74-year-olds.
- The percent ages of whites and blacks with craniofacial injuries were similar.
- A greater percent age of females than males had a craniofacial injury.

- In 2003, 43.1 percent of the United States population had dental expenditures paid by private insurance, whereas 36 percent of Georgians had their expenditures paid by private insurance.
- In 2003, 48.2 percent of the United States population paid dental expenditures out of pocket, whereas 56.5 percent of Georgians paid their dental expenditures out of pocket.

Emergency room visits for craniofacial injuries by selected demographic characteristics

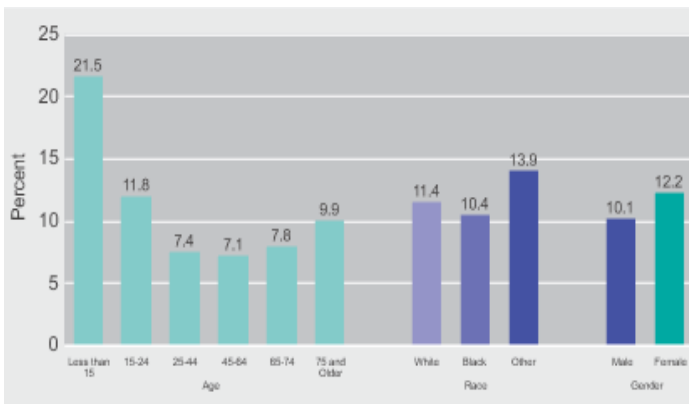


Figure 3 Data source: 1999 National Hospital Ambulatory Medical Care Survey, National Center for Health Statistics, Centers for Disease Control and Prevention.

Even so, dollars committed to dental care expenditures in Georgia are roughly on par with national averages. For example:

- In 2003, 42.7 percent of the United States population had a dental expenditure compared with 42.3 percent of those in Georgia. ³⁶
- In 2003, the average dental expenditure for persons in the United States was \$540 compared to those in Georgia with dental expenditures of \$560.

Oral Health Care of Prisoners in Georgia

According to the Georgia Department of Corrections in fiscal year 2004 (the most recent data available), newly imprisoned Georgia inmates receive dental screening, evaluation, and referral for appropriate services. However, approximately 50-60 percent of provided services are emergent and/or urgent care. A closer look at the available resources for care suggests that the dental care demand for oral health care in prison exceeds the capacity of health professionals and existing funding. In Georgia prisons there are approximately 40,000 contacts a year with oral health providers. The Georgia Department of Corrections (GDC) reports that currently there are 51,417 people in prison between the ages of 15 and 85 years. ³⁷ Yet in 2004, for example, the Georgia prison system reported that there were 30 dental clinics with 22 fulltime dentists, 29 dental assistants, and 8 hygienists. That translates into approximately 0.5 dentists per 1,000 inmates. And the funding for oral health care is shrinking. The total dental expenditure for fiscal year 2006 was \$1,475,072.00 amounting to \$0.09 per day for each inmate, compared to \$3,424,995 and \$0.21 per day for fiscal year 2004. ³⁸

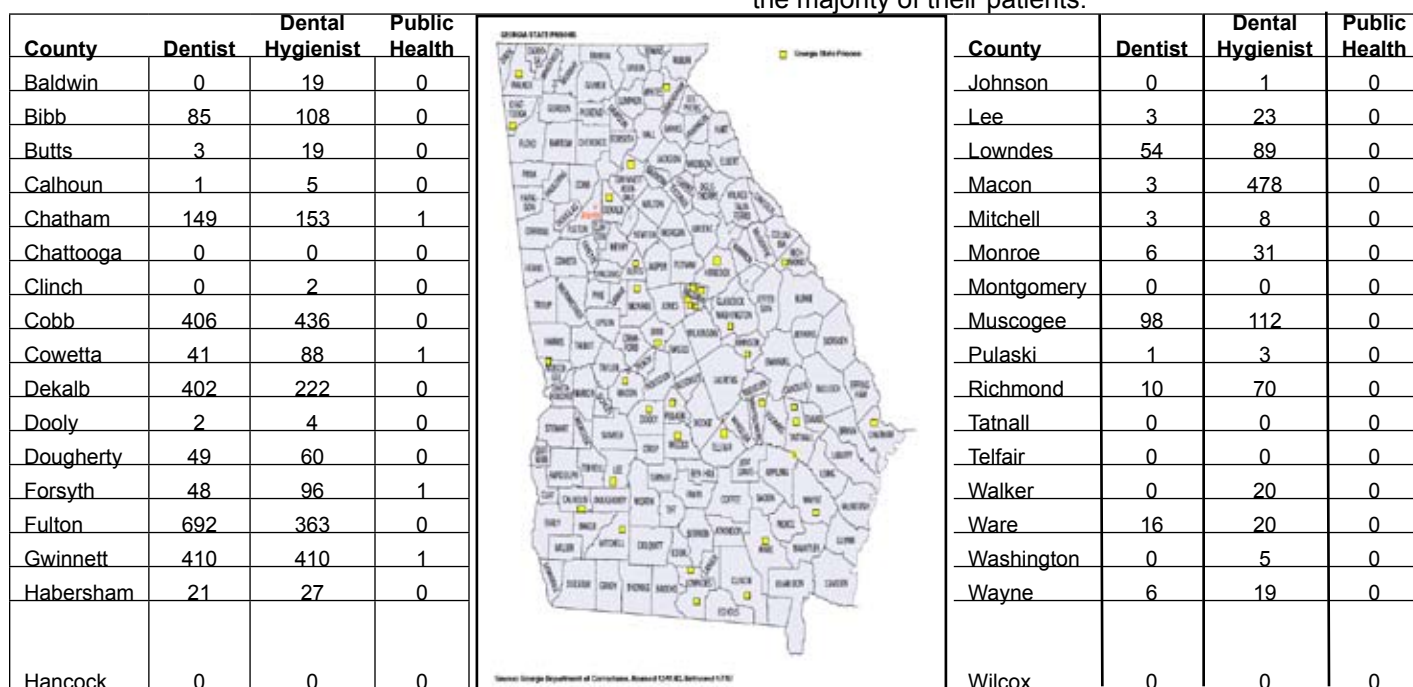
In terms of opportunities for ex-offenders to seek oral health care upon release, the distribution of providers across the state of Georgia suggest limited available resources.

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A county-by-county analysis shows that fewer dental professionals practice in areas with the largest number of people re-entering communities upon release from prison. (See Figure 4)

are not reflected in the oral health care workforce. The ADA believes changes in recruitment will necessary to meet the demands of a more diverse population.³⁹

Fig. 4
Distribution of Providers and State Prisons in Georgia by County



National data presented at the American Dental Association’s April 2006 *Outreach Forum: Increasing Diversity in the Dental Profession* showed a high correlation between dentists’ race/ethnicity and the race/ethnicity of the majority of their patients.

Oral Health Infrastructure – Workforce Diversity and Oral Health Disparities

Researchers have looked at health disparities in light of workforce diversity and cultural competence to identify promising methods for reducing gaps in care. By looking at population trends, groups in greater need of oral health care, and practice trends among providers, the American Dental Association (ADA) and other professional groups note that demographic changes in the general population

African American dentists have the largest proportion of African American patients (61 percent); Hispanic dentists see a greater percentage of Hispanic patients (45 percent) than other dentists.⁴⁰ Yet enrollments in dental schools are not keeping pace with a changing society. The proportion of minority students enrolled in U.S. dental schools between the years 2000 and 2004 does not adequately reflect the race and ethnicity of patients in the U.S.⁴¹ Data illustrate the need for an increase in minority dental school admissions to broaden access to services for people in the United States.⁴²

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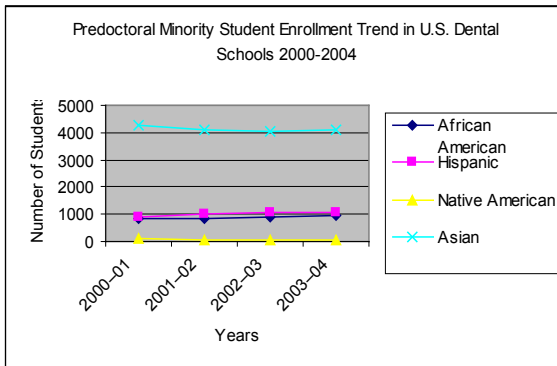


Figure 5 Source: ADA Survey of Predoctoral Dental Educational Institutions

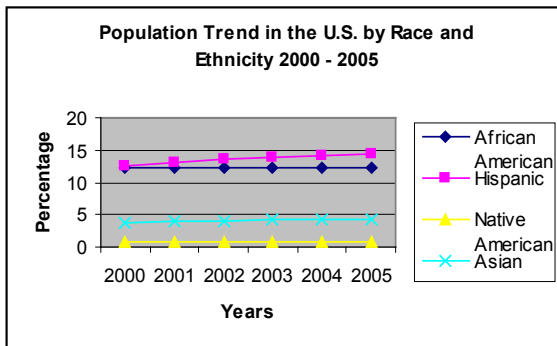


Figure 6 Source: 2004 - 2005 American Community Surveys

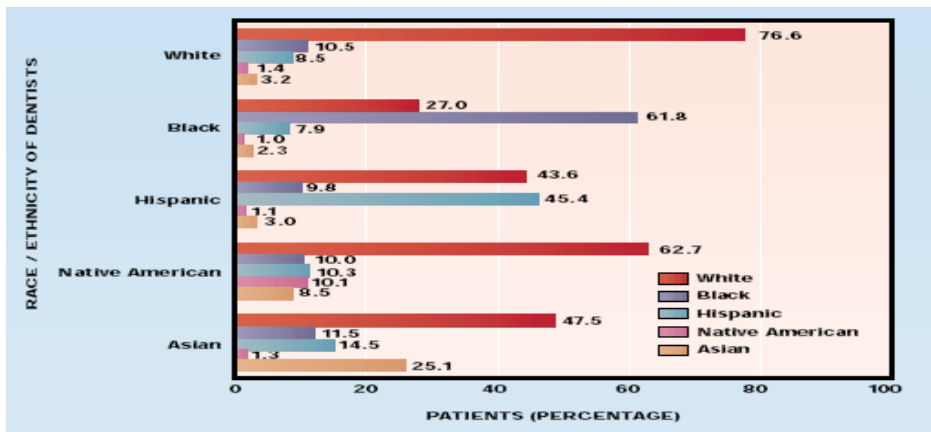


Figure 7 Source: American Dental Association Survey Center - 1996 Dentist Profile Survey

Data from the ADA Health Policy Resource Center and U.S. Census show a dentist-to-population ratio around 74 dentists per 100,000 for states including New Jersey, Massachusetts, Hawaii and New York. However for states in the south and southwest, including Mississippi, Arkansas, North Carolina, Nevada and New Mexico, the ratio is lower – between 35 and 40 dentists per 100,000.⁴³

The overall ratio of dentists-to-people in the United States is 54.1 dentists per 100,000. And for white residents, the ratio is similar at 55.3 per 100,000. But an examination of the ratio of dentists to their particular ethnicity underscores existing disparities in access to oral health care. Data show the ratio for Asian dentists to the Asian population is 113 per 100,000, whereas there are 11.5 Hispanic dentists per 100,000 Hispanics, 12 American Indian dentists per 100,000 American Indian people, and 15.1 African American dentists per 100,000 African Americans.⁴⁴ To equalize the dentist-to-population ratio for underrepresented minorities, it is estimated that 13,830 more African American dentists would need to enter the profession, along with 16,383 more Hispanic dentists and 925 more American Indian dentists.⁴⁵

The U.S. population is also an indication of the benchmark for the desired racial diversity in allied dental education such as dental hygiene programs.⁴⁶

As in dental schools, people of white ethnic backgrounds predominate in allied dental education programs. (See Table 1) Dental hygiene exhibits the least diversity, with more than 80 percent white graduates.

Both dental assisting and dental laboratory technology have higher proportions of graduates who identify themselves as black, Hispanic

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or American Indian, and these disciplines come closer to reaching a level of diversity that is comparable with that of the U.S. population. ⁴⁷

non-Hispanic, 0.8 percent Asian, 0.3 percent Hispanic, and 0 percent American Indian. ⁵¹

Table 1 Total Enrollment of Dental Hygiene Programs by Race/Ethnicity and Gender, 1998

Ethnicity/Race	Full-Time Male	Full-Time Female	Part-Time Male	Part-Time Female	Total Male	Total Female	Grand Total	Percent
White	128	5059	83	5071	211	10130	10341	86
Black	24	187	8	158	32	345	377	3
Hispanic	32	281	16	235	48	516	564	4.7
Native American	0	37	0	21	0	58	58	0.5
Asian	32	259	24	246	56	505	561	4.7
Unknown	6	42	5	82	11	124	135	1
Total Enrollment	222	5865	136	5813	358	11678	12036	100

Source: American Dental Association. 1998/99 Survey of Allied Dental Education. Chicago: American Dental Association, 2000.

The Oral Health Workforce in Georgia

- There are currently 5,203 licensed dentists in the state of Georgia for a population of over 9 million – an estimated 59 dentists per 100,000 residents. Of these, only half are Medicaid providers, translating into approximately 2.4 dentists per 1,000 children enrolled in Medicaid. ⁴⁸ (See Table 2)
- The average annual expected salary for a dentist in the United States is currently estimated at \$120,864 and \$121,655 across Georgia. In contrast the average annual expected salary for a general physician in Atlanta is currently estimated at \$153,400 and \$149,800 across Georgia. ⁴⁹
- The average salary for a dental hygienist in the United States and in Georgia is estimated at \$61,000 with an expected job growth in the next few years. ⁵⁰
- The most recent available data from the U.S. Census bureau indicates that in Georgia an estimated 92.8 percent of dental hygienists were reported white non-Hispanic, 6.1 percent black

Table 2

Number of Active Licensees in Georgia as of 1/10/2007	
Type	Count
Dentist	5,203
Public Health	4
Dental Faculty	63
Dental Hygienist	6,035
Dental Hygiene Faculty	14
General Anesthesia Permit	151
Conscious Sedation Permit	187
Temporary Dental Hygienist	1
Volunteer Dental	2
Enteral/Inhalation Conscious Sedation	99

Source: Georgia Board of Dentistry, Secretary of State. (2006). ⁵²

In Georgia, as in the rest of the United States, the oral health workforce does not reflect the general population. A cursory examination of the race and ethnicity of graduates during the last six years at Georgia's single dental school (Medical College of Georgia School of Dentistry) underscores the difficulty in turning this trend. While almost 30 percent of the people in Georgia are African Americans, only a handful of graduates are. ⁵³ In 2006, a total of 246 students enrolled at the Medical College of Georgia School

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of Dentistry of which 8.9 percent were African American, 4 percent Hispanic, and 0.4 percent American Indian.⁵⁴ In fact, since 1989, of the 1,029 graduates in Georgia only 6.2 percent have been African American.⁵⁵ (See Table 3)

In many states and communities, practice parameters are changed to increase access to needed care. However, the Georgia legislature has not yet considered a change in the Dental Practice Act that would provide greater opportunities for hygienists to serve in settings that are not directly

Table 3

GA Trend 2000-2006	White non Hispanic DMD Graduates	percent age White non Hispanic Population	African American DMD Graduates	percent age African American Population	Hispanic DMD Graduates	percent age Hispanic Population	Native American DMD Graduates	percent age Native American Population
2000-01	215	67	3	28.6	0	5.4	0	0.2
2001-02	209	67.1	1	28.4	0	5.4	0	0.2
2002-03	208	66.1	1	28.7	0	6	0	0.2
2003-04	212	66.8	4	27.9	0	6.3	0	0.2
2004-05	218	64.5	3	29.1	0	6.7	0	0.2
2005-06	213	62.5	5	29.2	0	7.1	0	0.2

Source: African American, Latino and Native American Students and Graduates of the Medical College of Georgia School of Dentistry⁵⁶.

The Georgia Dental Practice Act specifies that persons practicing in Georgia must be licensed in Georgia. The Georgia Board of Dentistry has reciprocity with other states and allows for licensure by credentials. In addition, each candidate (dentist or dental hygienist) is also required to take the ADHLEX examination administered by the Central Regional Testing Service (CRDTS) and the Georgia Jurisprudence examination. Georgia issues several different types of licenses. Each type of license has a non-refundable application fee that ranges from \$50 - \$3000. The approval and notification process takes approximately two weeks.⁵⁷

There are currently thirteen dental hygiene schools throughout Georgia, and more dental hygienists practicing across the state than dentists. The Georgia Dental Practice Act specifies that dental hygienist practice under the direct supervision of the dentist, thereby restricting the use of hygienists' practice in school-based or community-based settings to provide some degree of access and serve as a referral source particularly where there are limited services.

supervised by dentists; nor have State Representatives conducted a review of licensure to determine if optimal conditions and processes exist for attracting providers to practice in Georgia, particularly in underserved communities.

Dental students at the Medical College of Georgia School of Dentistry receive clinical training both on campus and in clinics and volunteer programs throughout the community and state. Before their senior year, dental students are assigned clerkships in community health centers and social service agencies throughout the state, and a local military base. In addition, students have a community health center practice site in the nearby rural town of Warrenton, GA, and a dentistry clinic at the Augusta Barnyard Flea Market. However, the Oral Health Office reports that Georgia has only 28 community-based low income dental clinics and 16 tribal, state or local agencies with service populations of 250,000 or more which have dental programs and are directed by a dental professional. Currently, the CDC, in cooperative agreement, provides \$3.8 million in funding to twelve U.S. States (excluding Georgia) and Palau to help reduce oral health disparities by strengthening existing oral health programs.⁵⁸

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Conclusions

Well-being and oral health are inextricably linked. As such, we have a responsibility as a society to ensure that oral health services are available and accessible as part of health care delivery systems, in particular to low-income workers, the poor, and people behind bars.⁵⁹ Data illustrate that minority dentists are more likely to treat minority patients. Given trends in oral health disparities, workforce diversity is essential for increasing access to oral health services in Georgia and across the United States. The need is even more urgent considering American Dental Education Association estimates of a serious nationwide shortage of dentists by 2010. Nevertheless, dental school enrollments among African American, Hispanic, and other minority students continues to decrease while the percentage of people of color in the general population grows.⁶⁰

Innovative programs like the Dental Pipeline (jointly funded by The Robert Wood Johnson Foundation, The California Endowment, and the W.K. Kellogg Foundation) are models for increasing minority enrollment, retention, and graduation from dental schools in the United States.⁶¹ Currently there are 15 Dental Pipeline schools, none of which are in Georgia and only two of which are Historically Black Colleges and Universities.⁶² In Georgia, a task force has developed an alternative seven-year program that could involve both a Historically Black College and the Medical College of Georgia School of Dentistry. This and other creative and collaborative options must be explored to address the disparities in oral health status and access to care for the people of Georgia.⁶³

Opportunities for Action

In Workforce~

- Given the projected demographics and the anticipated shortage of dentists, Georgia must

develop and implement its own version of the dental pipeline program at its one dental school.⁶⁴

- Given the projected growth in jobs for dental hygienists, it may be necessary to allow them have the same rights and privileges as a Physician Assistant or a nurse practitioner.

In Access to Care~

- Given the health disparities in oral care and the disparate proportion of minorities in prison, it is necessary to increase support prison oral health programs.
- Given the lack of coverage for dental expenses by Medicaid beyond emergency extractions, expanded coverage to include routine and preventive oral health care for the poor and working poor can target oral health disparities and improve overall health in vulnerable populations.

In Leadership~

- The Governor should consider the formation of an oral health task force or commission to bring information to policy dialogues that can formulate better strategies which have a greater likelihood of serving all Georgians. The Commission should be comprised of providers, educators, community groups, and elementary school personnel, as well as prison and juvenile justice providers, and the citizens representing the underserved populations returning to their community who have experienced access to care in jail and prison.

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U P O N

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Special thanks to Mary B. Cohen for your writing and copyediting contributions.

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