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on oral health

gsk health partner

Oral Health Disparities Amongst Minorities & Underserved Populations

Dr. Courtney H. Chinn, DDS, MPH, NYU College of Dentistry, Associate Chair, Department of Pediatric Dentistry, Clinical Associate Professor, weighs in on disparities in oral health amongst minority groups and underserved populations groups in the USA.

Now is the right time to talk about oral health disparities again. I say "again" because we dentists are already familiar with the **2000 Surgeon General's Report on Oral Health in America** that stresses how essential oral health is to overall health, and how many do not achieve oral health to the same degree.[1] We have also read the subsequent **Call to Action** describing dental caries as a silent epidemic disproportionately hurting our most vulnerable.[2] And twenty years later, the recently published **2021 Oral Health in America Report** has given us our latest report card. How did we do? Some modest improvements, but the same oral health disparities persist.[3]

Oral health disparities

As a dentist whose entire career fits squarely into this timeline, this 2021 report feels like receiving a failing grade. I find myself defensive, frustrated, and if I'm being completely honest, a bit embarrassed.

I acknowledge that there are always larger issues that are outside my control, such as health policy and national budgets, but this is also the profession and area of expertise I have chosen for myself, and with that decision comes a measure of personal accountability. And I am troubled by these outcomes. Ethnic minorities and the economically disadvantaged continue to be at the top of the oral health disparities pyramid – they are more likely to have untreated cavities, more likely to experience dental pain, and less likely to be seen by a dentist.[4] Long-standing inequities in the social determinants of health, such as safe housing, job availability, language and literacy, and access to nutritious food are interrelated and compound a wide range of oral health and quality-of-life risks and outcomes.[5]

Prevalence of untreated decay

The overall prevalence of untreated decay in young children is down from two decades ago, but rates still vary greatly by socioeconomic status and racial/ethnic groups. Poor and non-white children continue to experience the highest burden. And it's not just limited to kids. Untreated tooth decay in older adults has similarly declined, but only marginally for those living in poverty compared to the more affluent.[3] Oral health disparities also remain in populations with medical vulnerability. Already, less than half of all expecting mothers receive preventative dental services, even though dental care during pregnancy is safe, reduces the risk of unfavorable birth outcomes, and recommended by multiple health organizations.[3] But those with lower incomes, who are on Medicaid, or belong to a racial or ethnic minority are half as likely again to obtain dental care compared to higher-income, privately insured white pregnant women.[6] This becomes more distressing when you consider that in the 3.6M births each year, almost half are from ethnic minority families and 42% are insured by Medicaid.[7] This compounding effect is the same with individuals with disabilities. Already at a greater risk for oral diseases and less likely to establish a dental home or receive preventative care[8], even greater disparities exist when one factors in race and ethnicity.

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Unaddressed health disparities from COVID-19

Now is also the right time to talk about oral health disparities again because COVID-19 has reminded us of the tragic results of unaddressed health disparities for the same marginalized groups. Black and hispanic people have had substantially higher rates of infection, hospitalization, and death compared with white people. In 2020, the hospitalization and death rates per 10,000 respectively, were 24.6 and 5.6 for black patients, 30.4 and 5.6 for hispanic patients, and 7.4 and 2.3 for white patients.[9] The determinants accounting for these outcomes are obvious with COVID: Ethnic minority groups were disproportionately represented in essential work settings that required close contact with others, couldn't be done from home, or came without paid sick days – our healthcare facilities, farms, grocery stores, and warehouses.[5] Ethnic minorities also faced disproportionate difficulties finding affordable housing, which led to crowded living conditions and an inability to effectively quarantine.[5] Barriers to health insurance, linguistically and culturally responsive health care and distrust of healthcare systems result in significantly less health promotion or receipt of health services.[5] The disease of dental caries is clearly not the same as COVID, but some similarities are undeniable. In both, minorities and under-served populations have suffered at a disproportionate level.

Innovations from COVID

As devastating as COVID has been, it has also inspired our nation to be more innovative and more prevention-minded than at any other time in recent history. This is yet another reason why now is the critical time to address disparities again. We quickly understood that ending the pandemic would happen, but by looking upstream and investing in vaccines, masks, and social distancing. As crisis often sparks the ingenuity necessary for solutions, dental professionals were at the forefront of innovation by finding creative ways to get back to providing needed dental services safely and effectively. Dentists mitigated transmission in the dental office by revamping disinfection protocols, wearing increased personal protective equipment, and creating new systems of scheduling.[10]

Oral health within a global pandemic

Dentists have demonstrated the resilience and ability to adjust and overcome a global pandemic. While oral health policy and codified efforts at the national, state, and regional levels are essential, it is also important to accept that each dentist is in a unique place and circumstance, and that individual efforts to eliminate oral health disparities may look different. We should expect a diversity of challenges as well as workable solutions.

Figure 1

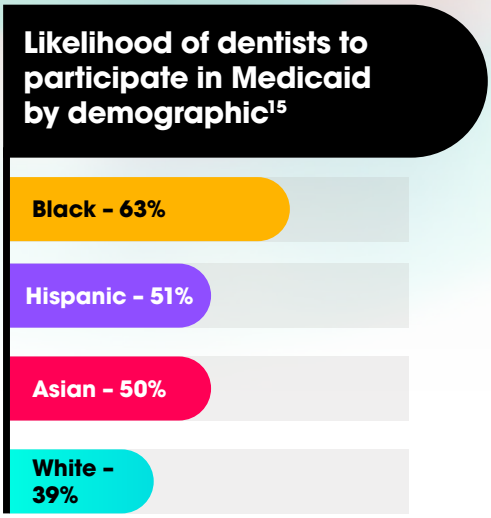
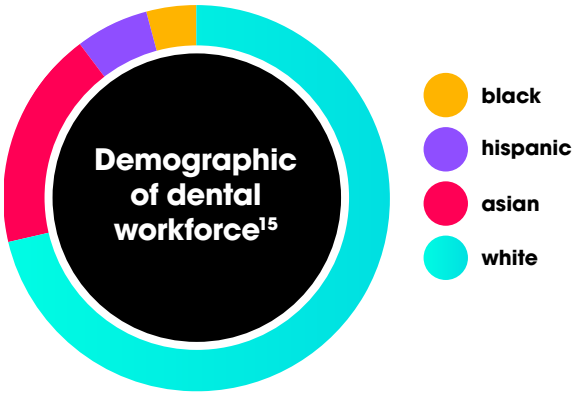


Figure 2



What are some of these specific concerns and what options might exist to creatively address them?

I'm not sure if I want to accept Medicaid in my practice:

It's true that some State Medicaid dental programs are unpopular with dentists – mostly due to low reimbursement rates. But it may still be worth taking another look at specific programs for both children and adults depending on where you practice. Thanks to recent state Medicaid reforms, reimbursement may now be found to be fairly competitive with private insurance, if not on par.[11] Another alternative to becoming a Medicaid provider may be working part-time with a community health clinic that accepts public insurance. In this setting you may still provide needed dental services to the same populations, but free of the additional administrative stressors. With the hiring and retention of dentists at health centers continuing to be a challenge there can often be some flexibility in the details of your arrangement, and this type of private-public collaboration has been well established.[12]

I'm worried about taking time away from practice:

This is understandable, especially as we are all still climbing out of the pandemic and many dental practices are just getting back on their feet. But we should consider existing technologies that can be creatively leveraged, including those that the pandemic brought to the forefront of our attention. Tele-dentistry, for example, has demonstrated its utility both before and during COVID.[13] Asynchronous tele-dentistry has the potential to be successfully accomplished outside traditional practice hours, especially if it is linked with the general supervision of a dental hygienist as allowed by your state.[14] Mentorship is also an under-appreciated approach to reducing oral health disparities. Black (63%), Hispanic (51%) and Asian (50%) dentists are more likely to participate in Medicaid than White dentists (39%) **(Figure 1)**, yet White dentists make up roughly 70% of the dentist workforce with 18% Asian, 6% Hispanic and 4% Black **(Figure 2)**.[15] Being a mentor and supporting an under-represented minority to become a dental professional and have a successful fulfilling career is a powerful way to promote health equity.

> Be willing to instruct non-dentists how to apply professional fluorides as allowable in your state.

I'm not comfortable with working with some vulnerable populations:

It's not uncommon to want to provide care for a specific population and also feel less than confident in regard to clinical management. Be open to mentorship and seek out support from your colleagues. Organizations such as the **Special Care Dentistry Association** and the **American Association of Public Health Dentistry** have many resources and opportunities for connection and support. Also remember that you are still a dentist even when you are not holding a handpiece. Dental professionals have recently proved this point by helping to administer COVID vaccinations during the pandemic. Incorporate the use of silver diamine fluoride and fluoride varnish programs into your practice. Be willing to instruct non-dentists how to apply professional fluorides as allowable in your state. Given dentists' unique position to communicate to patients, consider other health promotion and prevention programs, such as tobacco and e-cigarette prevention/cessation and HPV vaccinations.

> My hope is that we will no longer be able to find a difference in either access or quality of care when we look at our data by race, ethnicity, or income.

Learnings from the season of COVID

Now is the right time to talk about oral health disparities again because the challenge before our profession is daunting but not insurmountable. If any lesson is to be learned about the dental profession from this season of COVID, it is that dentists have an incredible capacity to achieve a goal if we are willing. What will be written in the next Oral Health in America report twenty years from today? My hope is that it will say that fewer children and older adults suffered from a toothache, that more women gave birth to healthy babies and those with disabilities were able to find the dental care they needed quickly. My hope is that we will no longer be able to find a difference in either access or quality of care when we look at our data by race, ethnicity, or income. My hope is that we will be able to say that oral health equity has arrived and that dentists were once again the innovators of change.

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