

Oral Health Disparities:

A Shift Toward Policy Work

Oral diseases and disorders occur frequently among all populations, but large disparities exist by region, age, socioeconomic status, and race and ethnicity. Despite the Surgeon General's call to action on oral health disparities in 2000, improvement in this area has been slow, and in some cases disparities have worsened. For example, although the use of sealants to prevent decay has risen overall, no increase has been seen in children of low-income families (CDC et al. 2009). Not much has changed when it comes to the prevalence of tooth decay and periodontal disease either; although almost always preventable, both are still extremely common.

In response, many oral health grantmakers have become more sharply focused on policy solutions to improve oral health. This transition has occurred, at least in part, because of the inability of more traditional approaches to successfully reduce oral health disparities. Policy change can shift funds and programming toward a wide variety of preventive measures and can increase care accessibility by reducing financial, geographic, cultural, and workforce barriers. But, as anyone who has worked in the policy world knows, it can be a long, complicated battle. The following examples provide a snapshot of foundation work in this area and

illustrate some of the challenges and accomplishments that can arise.

ACCESS

Oral health problems most heavily burden lower socioeconomic status groups who often lack dental insurance. From 2001 to 2009, The Health Foundation of Central Massachusetts funded two projects, the Central Massachusetts Oral Health Initiative (CMOHI) and the Oral Health Initiative of North Central Massachusetts (OHINCM), at a combined total of \$5.9 million.

Both projects aimed to increase access to oral health services for people who were uninsured or on MassHealth, the state's public insurance plan. Most of this work was done by influencing policy – both CMOHI and OHINCM grantees joined a statewide Oral Health Advocacy Task Force, which in turn worked with the legislature to create an Oral Health Caucus. The caucus' efforts helped lead to numerous legislative and regulatory changes, including full restoration of MassHealth adult dental benefits, which had been cut due to budget shortfalls, and increased MassHealth reimbursement for dental procedures. Funding for school-based oral health programs was also expanded, and care evolved from patchy and minimal preventive services, such as oral health screens and fluoride rinses, to more comprehensive services like oral exams, fluoride varnish, and sealants.

The results were dramatic. For instance, dentists accepting MassHealth patients grew from 10 in 2000 to over 200 in 2008, and the annual number of dental visits to local federally qualified health centers more than doubled. In one county, the number of students receiving school-based services grew from 438 during the 2001-02 school year to over 4,500 in 2008-09. By supporting systemwide changes, the foundation found access to oral health services increased for all low-income individuals in both target areas (The Health Foundation of Central Massachusetts 2009).

WATER FLUORIDATION

Community water fluoridation is a simple, inexpensive, and effective way to cut across populations and prevent dental decay and has been identified by the Centers for Disease Control and Prevention as one of the 10 greatest public health achievements of the 20th century. Yet, only 27 percent of water in Oregon is fluoridated (compared to 70 percent nationwide), exacerbating the state's disparities in oral health (CDC 2009b). The low-income population, which includes a disproportionate

A QUICK LOOK AT ORAL HEALTH DISPARITIES:

- African Americans, Latinos, American Indians, and Alaska Natives typically have the poorest oral health of all racial and ethnic groups in the United States (CDC 2009a).
- Children of low-income families suffer twice as much dental decay as their more affluent peers, and their condition is more likely to be untreated (The National Institute of Dental and Craniofacial Research 2002).
- Adults aged 35-44 with less than a high school education experience untreated tooth decay and destructive periodontal disease nearly three times more frequently than adults with at least some college education (CDC 2009a).
- Rural children are less likely to have insurance and receive oral health care than urban children (Liu et al. 2007).

ately large number of racial and ethnic minorities, is less likely to see a dentist and receive fluoride from a source other than water and thus more likely to have untreated decay.

In an effort to address this disparity, the Northwest Health Foundation has begun funding projects that aim to increase water fluoridation in the state. Despite the strong profluoride evidence base, these efforts have been met with resistance, as some individuals and groups believe fluoride is detrimental to health. In 2008 the foundation awarded a strategic planning grant of \$6,000 to Community Health Partnership, a public health institute that aims to improve the health of Oregonians through advocacy and support for effective public health policy. This project clarified the next steps for community water fluoridation efforts in the state. In late 2009 the foundation awarded \$20,000 to Upstream Public Health, another policy-focused organization, to develop a political feasibility assessment and a community engagement plan for a successful local fluoridation campaign. The campaign will include new partnership development, strategy meetings, and fluoride advocacy capacity building (Rebenal 2009).

WORKFORCE

When it comes to disparities by region, workforce shortages often play a large role. To fill current gaps in care and reduce disparities, models to train midlevel dental practitioners are being developed across the country. Again, policy comes into play as state laws, licensing bodies, and regulations define who is able to provide oral health care, their scope of practice, and how they are trained and supervised (Edelstein 2009).

For Alaska Natives, accessing dental care is difficult because of the isolation of their rural villages and the lack of local providers. Previous attempts to recruit and retain dentists from other communities have been unsuccessful, but the dental health aide therapist (DHAT) model is showing promise. This model provides two years of post-high school training to selected community members, preparing them to offer prevention services and perform fillings, extractions, and other limited dental care. Work is done under a dentist's supervision and is overseen by the Alaska Native Tribal Health Consortium. Initial funders included the Rasmuson Foundation and the Bethel Community Services Foundation (Edelstein 2009).

The DHAT program has been controversial in the United States, despite having been proven safe and of high-quality in other countries. Organizations such as the American Dental Association question the short training period and have attempted to prevent DHATs from practicing.

To help DHAT and similar midlevel dental practitioner models gain traction, the W.K. Kellogg Foundation issued the report *Training New Dental Health Providers in the U.S.* and an accompanying policy brief in December 2009. This report details how various types of midlevel dental providers can provide safe, high-quality, and cost-effective preventive and basic dental services. The foundation has also funded an evaluation of the Alaska program, with preliminary findings expected in

late 2010. Both of these products can be used to educate oral health advocates and policymakers.

Although Alaska Natives experience one of the worst disparities in access to oral health care in the nation, there is a severe shortage of dental health professionals in many other parts of the country as well. As a result, a handful of states, including New Mexico, California, and Kansas, are considering programs similar to the DHAT model. To accomplish this, numerous regulatory and policy changes will be required. Minnesota has made the most progress and has passed a state law allowing midlevel dental professionals who have completed five to six years of college training (including a four-year bachelor's program) to practice in the state (Edelstein 2009).

CONCLUSION

Like most oral health problems, oral health disparities are preventable. To reduce current disparities and prevent them in the future, access to high-quality, culturally appropriate oral health care must be readily available to people of all incomes, races, locations, and ages. Foundations have played a significant role in the progress that has been made thus far, but many opportunities still remain for responsible, impactful investment.

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