
Does Oral Health Matter?



“Oral health is an essential and integral component of health throughout life.”

– *Healthy People 2010*

Introduction: *Why's of Health Series*

The notion that there are benefits of good health and costs of poor health is a deceptively simple one. In fact, few of us stop to consider the value of health.

Clearly, health care policy is at the forefront of national and state agendas. And public polling data show that health policy is a leading area of concern for the general population. Intuitively, we know that health is an asset—an investment for the individual, our communities, employers, and society. But how do we assess the value of this asset? And how does the value of health set the stage for important national and state debates on complicated issues surrounding health care financing, health care delivery, and health outcomes?



Does Oral Health Matter? is part of the *Why's of Health* series of publications from the Health Policy Institute of Ohio. The series explores some of the complex systems issues surrounding individual and community health. Among the papers (and topics addressed) in the series are:

- *Does Health Matter?* closely examines the value of health, which is at the very core of all health care debates, health care policymaking, and health care evaluation;
- *Does Mental Health Matter?* assesses how mental health affects individuals, families, employers, and society;
- *Does Health Care Coverage Matter?* explores whether health care coverage makes a difference in the well-being of individuals, providers, and communities;*
- *Why Health Care Coverage Is Not Enough* discusses the role of factors other than health care coverage in advancing health;*
- *Why Are Health Care Costs Increasing* examines factors that account for rising health care costs in Ohio and the nation;*
- *Why Health Care Quality Matters* discusses what is meant by quality, what role it plays in health outcomes, how it is related to health care costs, and what the challenges are in improving health quality.*

Each paper will include leading national research on the topic, explain and explore the compelling arguments that comprise the current debate, and integrate Ohio-specific data and research findings, where available. These papers should contribute to a deeper understanding of the basic facets of health, health care coverage, health care financing, and health care delivery, particularly as they intersect with policymaking to impact the health of Ohioans.

The Health Policy Institute of Ohio also intends that the papers provide a framework for thinking about the value of health care in Ohio and the nation and about the interplay between policy decisions and the health care delivery systems. Ultimately, it's important to know whether health care systems are effective in helping individuals and communities achieve good outcomes.

Frequently, health policy debates focus solely on the roles of health care services and health care coverage in achieving optimal health. In fact, other influences are at work as well—environmental, social, and individual characteristics that make up who we are and why we act the way we do. These papers look at all these factors, as well as services and coverage, and their impact on the ability of individuals to function at their highest physical, mental, and spiritual capacity—in short, to achieve and enjoy good health.

For more information on any of these health issues or publications, please contact the Institute at 614-224-4950 or go to our website at www.healthpolicyohio.org.

* These papers will be published in the coming months. Please check with the Institute for exact publication dates.

Does Oral Health Matter?

Despite advances in oral health due to the introduction of water fluoridation and dental sealants, many Americans still suffer pain and disability from what are often preventable dental diseases. In June 2000, the first-ever U.S. Surgeon General's Report on Oral Health referred to dental disease as a costly, painful, and preventable "silent epidemic" affecting millions of vulnerable Americans everyday.¹ That same year, the Ohio Department of Health's (ODH) "Access to Dental Care Report" echoed the findings of the Surgeon General. The ODH report confirmed that many Ohioans, particularly low-income, minority, and rural populations have significant oral health needs and limited access to dental care. Two years prior to these reports, the Ohio Family Health Survey identified dental care as the number one unmet health care need of Ohioans.²

Unfortunately, many people lack a basic understanding of the importance of oral health. As emphasized in the Surgeon General's report, oral health means more than just healthy teeth. The report highlighted the following lesser known facts about oral health:

- Oral health is integral to one's general health and well-being;
- Left untreated, oral diseases can infect the bloodstream and lead to severe systemic infections in other parts of the body;
- While most common dental diseases are preventable, too often they go untreated, often due to limited access to oral health care;
- Profound and consequential oral health disparities exist within the U.S. population.^{1,3}

The purpose of this paper is to present an overview of the significance of oral health. It will report on the status of oral health at the national and state levels, examine disparities in access to oral health care, identify barriers to oral health care, discuss the role of safety net clinics, and review recommendations for improvement.

Significance of Oral Health

Oral health means more than just healthy teeth and an attractive smile. The mouth and its supporting structures play an important role in chewing, swallowing, smiling, speaking, and protecting against microbial infections and environmental allergens.⁵

Oral diseases include conditions such as tooth decay, gum disease, oral infections, birth defects, and oral cancer. The most prevalent diseases of the oral cavity, tooth decay and gum disease, are caused by bacterial infections. If left untreated, they can cause significant infection in the mouth and damage teeth, jaw bones, and the head and face.¹ In addition, poor oral health has been linked to many systemic diseases. As pointed out in the Surgeon General's report, the condition of the mouth mirrors the condition of the rest of the body. In recent years, a growing body of evidence points to the relationship between oral diseases and medical conditions such as coronary heart disease, stroke, preterm delivery, low birth weight, pneumonia, chronic obstructive pulmonary disease, osteoporosis, and diabetes. Likewise, a majority of systemic diseases have oral manifestations.^{1, 5}

Poor oral health and untreated oral diseases can have a significant impact on quality of life:

- Oral health problems can interfere with vital functions such as eating, swallowing, speaking, and breathing



- Oral health problems may result in altered appearance;
- Untreated disease can result in pain, causing distraction, dysfunction, inability to learn, and decreased economic productivity through lost work and school days;
- Poor oral health can contribute to failure to thrive and growth problems in children because of poor nutrition;
- Oral health problems are linked to problems with social behavior such as low self-esteem, teen delinquency, and adolescent pregnancy.⁵

Gum disease may increase the risk of premature delivery.⁶ On average, treatment costs per first-year survivor for premature infants can range from \$93,800 to \$273,900.⁷

Oral Health Status of Americans and Ohioans

Significant gains in oral health at the national and state levels have been achieved over the last 50 years. The application of low cost, safe and effective preventive measures has helped more Americans maintain their teeth throughout their lives. Community water fluoridation, one of the top 10 public health achievements of the century, along with the use of dental sealants, routine professional care, daily oral hygiene and positive diet practices have reduced the burden of most common oral diseases.⁵ However, millions of Americans still suffer from preventable oral diseases.

The Oral Health America National Grading Project, an organization that releases state-by-state report cards measuring the status of oral health across the nation, gave the nation an overall grade of C for oral health in 2003. The state of Ohio fared somewhat better, achieving a grade of B-. Although Ohio was the only state to receive an A for prevention, access to dental health care was a significant area of concern.⁸

Table 1
Grading Oral Health: Ohio vs. U.S.

Categories	Grade	
	Ohio	U.S.
Prevention	A	C
Access	C-	C-
Infrastructure	B+	C+
Policies	C-	C-
Oral Health Status	B-	C

Source: The Oral Health America National Grading Project 2003

Adults

Although preventive measures have improved oral health overall, the majority of adults still suffers from gingivitis or gum disease. Nationally, 14 percent of adults aged 45 to 54 are affected by severe gum disease that leads to early tooth loss.³ In Ohio, more than 50 percent of Ohio adults have had some teeth removed due to dental disease, while nine percent have had all of their teeth removed due to tooth decay or gum disease.² Nineteen percent of adults 25 to 44 years of age are affected by cold sores and canker sores—clinical symptoms of several types of viral infection.³ In a national survey, 22 percent of adults reported some form of oral-facial pain in the past six months, and only two thirds reported that they had visited a dentist in the last 12 months.³ A similar survey of adults in the Greater Cincinnati area found that while 71 percent had visited a dentist in the last 12 months, 11 percent



had not seen a dentist in more than five years.¹⁷ Nationally, it is estimated that adults lose more than 164 million hours of work each year due to dental disease or dental visits.⁵

Older Adults

Poor oral health is a significant problem for older Americans. Twenty-three percent of 65- to 74-year-olds are affected by severe gum disease, and 30 percent of adults 65 years and older are toothless. In addition, oral and pharyngeal cancers are significant problems for this population. Each year, about 30,000 Americans are diagnosed with oral cancer, and 8,000 die from these cancers annually.³

Elderly oral health problems are associated with multiple factors. Poor oral health throughout life can result in more complicated dental problems in old age, and chronic health conditions common in the elderly can exacerbate existing oral health problems or complicate dental care. In addition, older Americans take a lot of medications, many of which have oral side effects. The most common side effect is dry mouth, a condition that increases the risk of tooth decay. Many elderly people live in long-term care facilities that are ill-equipped to provide appropriate dental care. Finally, many elderly individuals do not have dental insurance, and Medicare does not reimburse for routine dental care.³

Children

Tooth decay is the most common chronic childhood disease, five times more common than asthma and seven times more common than hay fever. Nationally, tooth decay affects 18 percent of 2- to 4-year-olds, more than half of children between 5 and 9, and 61 percent of 17-year-olds.⁵ A 1998–99 oral health screening survey by ODH found similar results in Ohio: 46 percent of all 6- to 8-year-olds experienced tooth decay, and 26.3 percent had not had a dental visit within the past 12 months.²

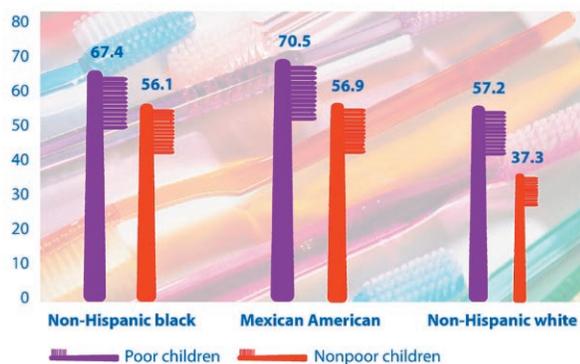
Children are also faced with developmental problems and injuries that affect the oral facial structures. Cleft lip/palate, one of the most common birth defects, and other craniofacial defects cause lifetime problems that can be devastating to children and their families. In addition, unintentional injuries to the head, mouth, and neck are common in children and considered a major public health problem. Preventing these injuries can significantly reduce oral health problems. In addition, children with chronic illnesses and disabilities suffer from a higher proportion of oral diseases largely due to poor oral hygiene.³

According to the Surgeon General, “the social impact of oral diseases in children is substantial.” Untreated dental disease can cause problems with eating, speaking, and the ability to learn. It is estimated that more than 51 million school hours are lost each year to dental-related illness. In addition, untreated dental disease leads to pain, poor self-esteem, and overuse of the emergency room.¹

Oral Health Disparities

Perhaps one of the most significant findings of the Surgeon General’s report is that profound oral health disparities exist within the U.S. population, and not all Americans have benefited from the oral health gains of the last 50 years. There are striking disparities in dental disease by income, race/ethnicity, age, sex, geographic location, education level, and disability, with income and race/ethnicity being the major determinants of oral health disparities.¹ In Ohio, disparities in oral health and access to care have been linked to low family income, residence in an Appalachian county, and race.²

Table 2
Percentage of Decayed Primary Teeth That Are Untreated Per Child



Source: U.S. Surgeon General Report on Oral Health 2000

Income

Low-income individuals are disproportionately burdened with oral health problems. Compared to their more affluent peers, individuals from poor families experience more tooth decay

and have higher rates of untreated dental disease.¹ In fact, 50 percent of the decayed teeth of the low-income adult population have never been filled.⁵ Adults at or above the poverty level are twice as likely to report a dental visit in the past 12 months compared to those who are below the poverty level.¹ In Ohio, more than 20 percent of adults earning less than \$20,000 per year were completely toothless and had all of their teeth extracted.² Low-income children are at the greatest risk for dental disease. Compared to children who are not poor, poor children are twice as likely to suffer from tooth decay and twice as likely to not receive treatment. In fact, 25 percent of children from low-income families have not seen a dentist before entering kindergarten. As a result of these problems, low-income children experience 12 times more dental-related restricted-activity days than non poor children.¹

In Ohio, more than one third of 6- to 8-year-olds from poor families had untreated dental disease, twice the rate of children from families who earn more than 185 percent of the poverty level.² It is estimated that 43 percent of Cincinnati’s 8-year-olds living in low-income homes have significant tooth decay.⁹ Ohio children from low-income families were four times less likely to get the dental care their parents felt they needed.²

Recent oral screenings conducted on Ohio’s Head Start children found that 38 percent of 3- to 5-year-olds had experienced tooth decay, and 28 percent had at least one untreated decayed tooth. Although 85 percent of Head Start children had visited a dentist in the last 12 months, three fourths of the children with tooth decay did not have care completed by the time they were screened during the second half of the school year. On a positive note, the screenings revealed no evidence of oral health disparities by race or payment method.¹⁹

Race and Ethnicity

As with general health, there are racial and ethnic disparities in oral health. Minority populations are disproportionately affected by poor oral health. As these populations increase in size, so too will the rate of oral health problems in the United States and Ohio. Compared to whites, blacks in the U.S. are more likely to have untreated tooth decay or missing teeth. In addition, blacks experience the highest rate of oral and pharyngeal cancers.¹ Compared to children from other racial or ethnic groups, Mexican-American children ages 12 to 23 months are more likely to experience dental caries.⁵

In Ohio, 23 percent of 6- to 8-year-old whites had untreated cavities as compared to 29 percent of blacks and 34 percent of others. Among Ohio adults, 51 percent of non whites had a tooth removed due to pain or infection as compared to 42 percent of the whites. For both adults and children, black Ohioans reported poorer access and lower utilization rates than white Ohioans.²

Barriers to Access to Oral Health Care

The ability to access dental care remains a significant problem for many Americans.¹² Dental care access is defined by the Institutes of Medicine as “the ability of all people to acquire timely oral health care services necessary to assure oral function and freedom from pain/infection.” There are many factors that contribute to the lack of access to dental care services. The 2000 Access to Dental Care Report identified several major reasons for Ohioans not getting dental care: lack of a perception of need; financial and insurance barriers; a shortage of dentists accepting Medicaid patients; and geographic barriers.²

Perception of Need

The lack of a perception of need to see a dentist contributes to the low rate of utilization of dental services. Unless there is pain or swelling, dental care is not perceived as a high priority by many people. Because most dental diseases are silent in nature and are not perceived as life-threatening conditions, most people delay treatment for long periods of time, exacerbating the severity of the condition when they finally do seek care.²

Financial and Insurance Barriers

The National Access to Care Survey found that financial barriers were the major reason individuals did not seek dental care services (71.5 percent).¹³ Similarly, a statewide survey found that financial barriers (e.g., lack of money or insurance) accounted for about two thirds of the reasons given by Ohioans for not seeking needed dental care; among low-income Ohioans, this figure climbs to 78.4 percent.²

Although insurance coverage for dental care does not eliminate financial hardship, it increases access to care and helps to defray the cost of at least some dental services. Unfortunately, dental care coverage is less common than coverage for medical care. In the United States, dental care coverage comes through either commercial insurance (employer-based or individual purchase) or Medicaid/State Children’s Health Insurance Program (SCHIP). Medicare, the primary source of medical insurance coverage for the elderly, does not provide coverage for dental services.²

Only about half of the U.S. population is covered by a third-party dental care plan. For every child who does not have medical insurance, there are at least 2.6 children without dental insurance. In addition, children without dental insurance are three times more likely to have dental problems than children with either public or private insurance.¹

Similarly, a 1998 survey found that 4.6 million, or 41 percent of the Ohio population was without dental insurance. Compared to those with dental insurance, those uninsured for dental care



were less likely to have had a dental visit in the past year and more likely to report having an unmet dental need.²

Medicaid and SCHIP remain the major sources of financing dental care for low-income adults and children. For children, Medicaid provides comprehensive dental coverage under the required Early and Periodic Screening, Diagnostic, and Treatment Program (EPSDT). SCHIP was created in 1997 to give additional funding to states to expand health coverage to uninsured children with incomes below 200 percent of the Federal Poverty Level. In Ohio, SCHIP expanded Medicaid eligibility for children up to age 19. Despite such coverage, the utilization of dental services remains low for these populations. Only 20 percent of children covered by Medicaid received preventive dental services in a year. Low enrollment of eligible children in Medicaid and SCHIP also contributes to poor oral health among children.^{2,4,5}

Medicaid also provides some dental coverage for low-income adults. However, the fact that dental service is an optional service that states may elect to provide as part of the Medicaid benefit package places such benefits in jeopardy when states are faced with budget cuts. In 2003, 247,000 (31 percent) of the 800,000 adult Medicaid recipients in Ohio received dental benefits.²¹ In Governor Taft’s proposed 2005 state budget, dental care coverage for adult Medicaid recipients is eliminated.

Low-income elderly and disabled individuals, many of whom are covered by Medicaid, face additional barriers to care. Individuals with disabilities often exhibit more severe forms of dental disease, have complicated medical conditions, and often require special accommodations and scheduling. Most dentists do not have adequate training to provide care to this population. According to the 1994–95 National Health Interview Survey on Disability, 1 in 12 children with special health care needs were not able to get needed care. One in four parents of special needs child indicated their child needed dental care.^{2,4,5,14}

Shortage of Dentists Accepting Medicaid

Another barrier to accessing dental care services, particularly for low-income families, is the low number of dentists participating in Medicaid. In Ohio, only 25 percent of dentists are active Medicaid providers and only 11 percent treat at least 50 Medicaid recipients per year. In Ashland County, Ohio, where the ratio of dentists to residents is 1 to 3,085, only one full-time dentist serves more than 16,000 low-income Medicaid recipients.² The problem is compounded for low-income children. While pediatric dentists are significantly more likely to participate in Medicaid than general dentists (probability of 0.58 vs. 0.20),²² they comprise only 2.5 percent of dentists nationwide.^{2,4,5,11-13}

Low dentist participation in public programs has been linked to low Medicaid reimbursement rates, cumbersome administrative paperwork, and a high rate of patients who missed appointments. Compared to third-party payers, Medicaid pays significantly less for dental services. The U.S. General Accounting Office (GAO) study in 2000 revealed that Medicaid payment rates for many states were about 30 to 40 percent of the average regional private fee charged by dentists. In 2000, Medicaid reimbursement rates increased in Ohio (greater than 50 percent over some previous fees); however, this has not resulted in significant dentist participation, in part due to a remaining reimbursement differential as compared to the fee-for-service rate. In addition, dentists often cite administrative issues such as preauthorization requirements, complicated eligibility and claim forms, and delayed payment as reasons for opting out of Medicaid participation.

Dentists may also be reluctant to serve Medicaid patients because this group has a higher rate of missed or late appointments as compared to private patients. Lack of transportation, inability to take time off work, and lack of child care are factors that contribute to missed appointments. Unfortunately, due to the nature of private practice in dentistry and the high cost of overhead, missed appointments are costly to dentists and may affect their attitude toward Medicaid patients.^{2, 4, 5,12}

Geographic Barriers

Geographic location, particularly with respect to the distribution of dental care providers in a region, is a significant barrier to access to care. Compared to urban areas, rural counties have fewer dental providers.¹³ In Ohio, the rural-urban disparities that exist in the distribution of dentists across the state is striking: 69.4 percent of Ohio's dentists practice in 12 metropolitan counties, 14 percent in 17 suburban counties, and 16.6 percent in 59 rural counties (rural non-Appalachian counties plus Appalachian counties). In Appalachia, the dentist-to-population ratio is about one half that of the metropolitan counties.²³ In addition, 12 of Ohio's Appalachian counties (concentrated in the southeast part of the state) are designated

as Dental Professional Shortage Areas—regions where there is less than one full-time dentist per 5,000 residents. Ohio residents in these areas often delay seeking care because of the inconvenience, cost, and time involved with traveling long distances—sometimes 20 to 30 miles—to see a dentist.¹⁸ Hence, they have a significant number of unmet oral health needs and more emergency visits.

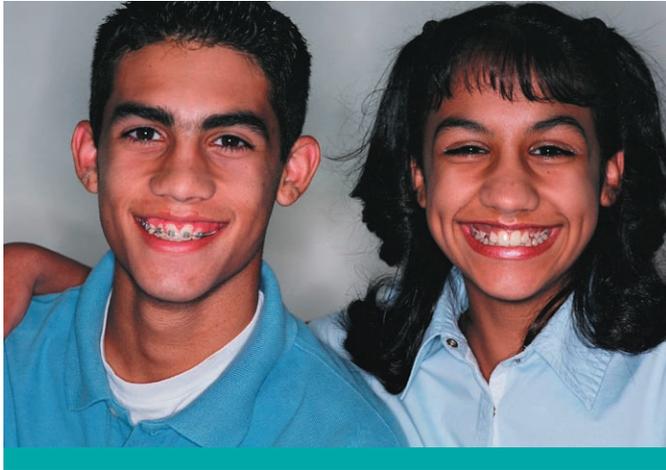
Access to dental care is also limited in geographic regions that tend to attract fewer dental practices. Unlike in the medical care system, the majority of dental care services are delivered in private practice settings where most general practitioners operate as small businesses. Therefore, most dentists establish practices in higher income suburban areas where the demand for their services is greatest. Nationally, the number of dentists per capita is 66 percent higher in high-income areas than in low-income areas.¹³ In Cuyahoga County, Ohio, where there is one dentist for every 1,200 residents—a number that is better than the national average—some low-income neighborhoods in Cleveland have just one dentist for 23,000 residents.

Safety Net Clinics

Since the number of dentists treating the Medicaid population is low, safety net clinics provided through health departments, community health centers, dental schools, and hospital outpatient clinics become the primary source of dental care for the low-income population. However, the number of safety net clinics is relatively small and not necessarily distributed according to need. In Ohio, where there are more than 80 safety net clinics, more than half of the 88 counties have none.²⁰ In 1999, one third of the state's safety net clinics saw three fourths of the safety net dental patients.²

In addition, because the need for services is so great, these dental clinics often have long waiting times for appointments. While the average wait for a private dental appointment in Ohio is just over one week, securing an appointment at one of Ohio's safety net clinics often takes one to three months, and, in some cases, over six months.² Cincinnati's six city health clinics have seen a three-fold increase in the number of urgent dental cases since 1990, from 3,437 to 10,030, a caseload that has resulted in a two-year waiting list of about 4,000 patients.⁹

Furthermore, the scope of dental services provided at safety net clinics is usually limited and varies widely among such clinics. This is because safety net clinics have limited financial resources. The free or reduced-fee services provided by the clinics must be subsidized by state and federal funding if the clinics are to remain operational.² The Greater Cincinnati Oral Health Council, for example, receives 25 percent of its \$1.4 million operating budget from state dollars.⁹



Strategies to Improve Oral Health

Improving the oral health of our nation requires the development of strategies at multiple levels. Federal, state, and local government initiatives must be considered in conjunction with partnerships with the private sector and community groups. In addition, these initiatives must be supported by appropriate policies that enhance the feasibility of such efforts. These strategies need to address a wide array of issues, such as prevention, access, infrastructure, and delivery, related to oral health.⁵

The Surgeon General's report offered a number of recommendations geared toward improving the nation's oral health status and obtaining meaningful access to care:

- Improve the public's knowledge and understanding of significance of oral health;
- Enhance policymakers' awareness so they can create effective policies to improve oral health;
- Expand research in oral health and use the findings to develop disease prevention programs;
- Establish an effective oral health infrastructure integrated with overall health needs; and
- Remove barriers to oral health services.¹

In the absence of these safety net clinics, individuals who cannot afford private dental services or who lack adequate private or public dental coverage often delay preventive or routine dental care and instead seek treatment at a local hospital emergency room when the problem becomes acute. At University Hospital in Cincinnati, dental pain and infection are now the top reasons for emergency room visits.⁹

According to the Ohio Dental Association (ODA), most hospitals are not equipped to provide dental services; therefore, patients can incur charges in excess of \$400 for an exam, X-rays, and prescription drugs without having their underlying oral health problem solved.⁹ In a recent press release supporting the retention of the adult dental benefit under Ohio's Medicaid program, the ODA noted that the cost to Medicaid for an adult patient who seeks treatment in a dental office for an abscessed tooth is \$79 versus \$307 for a patient who seeks treatment in a local emergency room. In the first case, the patient's problem is resolved at the point of service by extracting the tooth; in the second case, the patient's tooth remains abscessed and return visits to the emergency room for pain are likely.²¹

As Dr. Scott Polsky, chair of Emergency Medicine at Summa Health System in Akron stated, "We see many of these patients repeatedly in the emergency department for problems with the same tooth... The tooth gets worse with each presentation, at times leading to hospitalization."² On average, hospital costs associated with admission due to dental infections are estimated to be about \$3,223 per day nationwide.¹⁰

In 2000, similar recommendations were issued by the Ohio Task Force on Access to Dental Care. This group, with representatives from state and local agencies, the Ohio General Assembly, dental schools and residency programs, professional associations, non-profit organizations, consumers, business, and labor, was assembled by the Director of the Ohio Department of Health to address the need to increase access to dental care for vulnerable Ohioans. The group issued the following recommendations:

- Reduce financial barriers to dental access by improving and expanding the Medicaid and State Children's Health Insurance (SCHIP) programs;
- Increase the capacity of the dental care delivery system to serve vulnerable populations;
- Support community partnerships and actions to improve dental access and enhance the community-level oral health infrastructure;
- Increase decision makers' and the public's awareness of oral health and dental care access issues.

For each recommendation, the task force developed a set of proposed activities to reach the desired objectives. For example, enhancing publicly financed health insurance programs may be achieved by increasing the reimbursement rates to be

more consistent with private insurance plans; reducing administrative burdens; expanding dental coverage for children, adults, the elderly, and special populations; and improving the operation and efficacy of these programs by adopting standard approaches.

The dental delivery system may be strengthened by providing incentives, such as loan repayment or tax credits, to dentists who serve low-income and underserved populations; providing training on cultural competency to dental care providers; training a more diverse dental workforce; increasing the number of pediatric dentists; increasing the number and capacity of safety net clinics; revising licensure and scope of practice; and expanding the provider base by engaging primary care providers.^{4,5,15,16}

Since the formation of the Ohio Task Force on Access to Dental Care in 2000, the Ohio Department of Health has made dental care access one of its top 10 priorities. As such, Ohio has made many recent strides in improving access to dental care for Ohioans. Among the state's accomplishments are the following:

- The Ohio Department of Health, along with multiple charitable foundations, awarded approximately \$21 million in grants to many local dental programs across the state between 2000 and 2003;
- The number of safety net dental clinics increased to 89 in 2003, and multiple case-management programs were developed to link high-risk patients with dentists and clinics to assure that appointments are kept;
- Ohio's school-based dental sealant programs reached more children than in any other state;
- The Robert Wood Johnson Foundation awarded the Ohio State University a five-year \$1.5 million grant to establish community-based education models to enhance the diversity of the future dental workforce and increase access to dental care in community settings;
- The Ohio Dentist Loan Repayment Program was created in 2003 to encourage new dentists to practice in underserved areas of the state.^{15,16}

The director's task force reconvened at the end of 2003 to review and revise the initial set of recommendations. Although the task force recognized the state's accomplishments, they also acknowledged that access to dental care remains a significant problem for the most vulnerable Ohioans. The group issued a revised set of recommendations in 2004 that outlines an ambitious plan for continuing to expand access to dental care in Ohio.

Conclusion

Despite advancements in oral health at both the national and state levels, there are still countless numbers of Americans and Ohioans who suffer from poor oral health. As we have seen, minorities and low-income populations are particularly at risk. As an integral part of general health and well-being, improving oral health is critical to enhancing the status of the nation's health. As stated by the U.S. Surgeon General, we must "ensure that all people have access to health care and can acquire the health literacy necessary to make use of health promotion and disease prevention information and activities."¹ To that end, policymakers, health providers, and community groups must work to change the perception of oral health, implement effective prevention measures, increase the diversity and capacity of the oral health workforce, and establish partnerships and collaborations to enhance access and the quality of dental care.

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References

1. United States Department of Health and Human Services. "Oral Health in America: A Report of the Surgeon General." National Institutes of Health, National Institute of Dental and Craniofacial Research, 2000. NIH publication 00-4713.
2. Ohio Department of Health (ODH). "Access to Dental Care in Ohio 2000." Accessed October 10, 2004, at <http://www.odh.state.oh.us/ODHPrograms/ORAL/Rpt2000/dentalrpt2000.pdf>.
3. United States Department of Health and Human Services. "A National Call to Action to Promote Oral Health." Public Health Service, Centers for Disease Control and Prevention and the National Institutes of Health, National Institute of Dental and Craniofacial Research; 2003. NIH publication 03-5303.
4. J. Ryan. "Improving Oral Health: Promise and Prospects." National Health Policy Forum. Accessed October 10, 2004, at http://www.nhpf.org/pdfs_bp/BP_OralHealth_6-03.pdf#search=Improving%20oral%20health.
5. Grantmakers In Health. "Filling the Gap: Strategies for Improving Oral Health." Issue Brief No. 10. Based on a Grantmakers in Health Issue Dialogue, November 2001, Washington, D.C. Accessed October 10, 2004, at http://www.gih.org/usr_doc/oralhealthid.pdf.
6. M. Jeffcoat, J. Hauth, N. Geurs, M. Reddy, S. Cliver, P. Hodgkins, and R. Goldenberg. "Periodontal Disease and Preterm Birth: Results of a Pilot Intervention Study." *Journal of Periodontology*; August 2003 (Vol. 074, No. 08).
7. J. Rogowski. "Cost-Effectiveness of Care for Very Low Birth Weight Infants" *Pediatrics*, Vol. 102 No. 1 July 1998, pp. 35-43. Accessed October 10, 2004, at <http://pediatrics.aappublications.org/cgi/content/abstract/102/1/35>.
8. Oral Health America. "Keep Smiling America: The Oral Health America National Grading Project 2003." Accessed October 10, 2004, at <http://www.oral-healthamerica.org/pdf/2003ReportCard.pdf>.
9. E. Solvig. "Special Report: Cincinnati's Dental Crisis." *The Cincinnati Enquirer*. October 6, 2002. Accessed October 10, 2004, at http://www.enquirer.com/editions/2002/10/06/loc_special_report.html.
10. K. Ettlbrick, M. Webb, and N. Seale. "Hospital Charges for Dental Caries Related Emergency Admissions." *Pediatric Dentistry* 2000. Jan-Feb: 22(1):21-5.
11. United States General Accounting Office. "Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations." Report to Congressional Requesters, September, 2000; GAO/HEHS-00-149. Accessed October 10, 2004, at <http://www.gao.gov/new.items/he00149.pdf>.
12. S. Gehshan and T. Straw. "Access to Oral Health Services for Low-Income People: Policy Barriers and Opportunities for Intervention for The Robert Wood Johnson Foundation." October 2002. Accessed October 10, 2004, at <http://www.ncsl.org/programs/health/forum/rwjoral.htm>.
13. Community Voices. "Oral Health For All: Policy for Available, Accessible, and Acceptable Care." Accessed March 30, 2005 at http://www.communityvoices.org/Uploads/vgon0eagtnzjfwbujlpvmb55_20020813104505.pdf.
14. Louisiana Children's Oral Health Initiative. "Brushing Up on Children's Oral Health in Louisiana: A Policy Brief. A Project of Agenda for Children and the Oral Health Program." Oral Health Program, Office of Public Health, Department of Health and Hospitals. Accessed March 30, 2005 at http://www.lsuhs.edu/policy_brief.pdf.
15. Ohio Department of Health (ODH). "Recommendations of the Director of Health's Task Force on Access to Dental Care—2000." Accessed October 10, 2004, at <http://www.odh.state.oh.us/ODHPrograms/ORAL/dentalaccess.pdf>.
16. Ohio Department of Health (ODH). "Recommendations of the Director of Health's Task Force on Access to Dental Care—2004." Accessed October 10, 2004, at <http://www.odh.state.oh.us/ODHPrograms/ORAL/Rpt2000/DTFRpt04.pdf>.
17. R. Ludke, E. Rademacher, and A. Tuchfarber. "The Greater Cincinnati Community Health Status Survey 2002." Institute for Health Policy and Health Services Research and the Institute for Policy Research, University of Cincinnati. Accessed March 25, 2005 at <http://www.ihphsr.uc.edu/PDF/reports/FinalReportFebruary12-2003.pdf>.
18. Children's Defense Fund-Ohio. "Ohio's Appalachian Children." 2001. Accessed March 25, 2005 at http://www.cdfohio.org/publications_research/pub_library/appalachia_report/pdfs/ohios_appalachian_children.pdf.
19. M. Siegal, M. Yeager, and A. Davis. "Oral Health Status and Access to Dental Care for Ohio Head Start." *American Academy of Pediatric Dentistry*. Journal Abstract. Accessed March 24, 2005 at http://www.aapd.org/searcharticles/article.asp?ARTICLE_ID=1991.
20. The Associated Press. "Ohio's Extra Dental Aid Doesn't Go Far: Free or Reduced-Fee Services Limited." *The Cincinnati Enquirer*. August 23, 2004. Accessed March 28, 2005 at http://www.enquirer.com/editions/2004/08/23/loc_loc1ohdent.html.
21. Ohio Dental Association. "News Release: Elimination of Medicaid Adult Dental Benefit Will Cause Unintended Consequences for State Coffers, Rural Communities, and Dental Education." March 16, 2005.
22. Agency for Healthcare Research and Quality. "Dental Care: Improving Access and Quality." *Research in Action*; Issue No. 13. Accessed March 28, 2005 at <http://www.ahrq.gov/research/dentalcare/dentria.htm>.
23. L. Susi and A. Mascarenhas. "Using a Geographical Information System to Map the Distribution of Dentists in Ohio." *The Journal of the American Dental Association*, May 2002, vol. 133, no. 5, pp. 636-642(7).

About the Researchers

Principal Researcher and Author

Homa Amini, DDS, MS, MPH

Dr. Amini received her dental degree in 1993 and a Master in Public Health in 1996 from the Ohio State University. She received a Master of Science and Certificate in Pediatric Dentistry from the University of Illinois at Chicago in 1997, and she is licensed to practice dentistry in Ohio and Florida. Currently, Dr. Amini practices pediatric dentistry at Columbus Children's Hospital where she serves as Chief and Dental Clinic Director for the section of Pediatric Dentistry and is an assistant clinical professor in the section of Pediatric Dentistry at the Ohio State University College of Dentistry.

She is board certified and a Diplomate of the American Board of Pediatric Dentistry since 2002. She is a reviewer for *Pediatric Dentistry* and *Journal of Dentistry for Children*. She serves on the New Mother Kit Task Force and the Editorial Board and Journal-Based Continuing Education Committee of the American Academy of Pediatric Dentistry. She also serves on the Committee of Perioperative Services and Conscious Sedation Advisory Group at Columbus Children's Hospital.

Her areas of interests include oral health disparities and access to dental care. She is currently working on a three year grant awarded by the Osteopathic Heritage Foundation to improve access to dental care for low income pregnant adolescents in central Ohio. Dr. Amini is a member of a number of professional organizations including the American Dental Association, American Dental Education Association, American Academy of Pediatric Dentistry, and Ohio Dental Association.

Supporting Researchers

Janet Goldberg, MPA

Janet Goldberg holds a Master of Public Administration from the Ohio State University School of Public Policy and Management. Before joining the Health Policy Institute of Ohio, she worked as an analyst/senior consultant for M.S. Gerber & Associates, Inc.

Jill Huntley, MPA

Jill Huntley has over 17 years experience working in state government on health care policy issues, most recently at the Ohio Department of Job & Family Services. She holds a Master of Public Administration from the Ohio State University School of Public Policy and Management.

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Does Oral Health Matter? provides a brief overview on oral health issues. For more information about oral health nationwide, please refer to the website of the Centers for Disease Control and Prevention at <http://www.cdc.gov/OralHealth>.

For more information about oral health issues in Ohio, please visit the Ohio Department of Health's Oral Health Services website at <http://www.odh.ohio.gov/ODHPrograms/ORAL/Oral1.htm>.

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37 West Broad Street, Suite 350
Columbus, OH 43215-4198
Phone: 614-224-4950; Fax: 614-224-2205
www.healthpolicyohio.org