Dental Disparities among Low-Income American Adults: A Social Work Perspective

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The Centers for Disease Control and Prevention (CDC, 2012) defines *health disparities* as “preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations” (para. 1). The lack of dental coverage available for low-income populations is a health disparity, and the affected populations deserve access to care. According to the Kaiser Family Foundation, “over a third (35 percent) of poor parents and 38 percent of poor adults without children were uninsured in 2013” (Majerol, Vann, & Rachel, 2014). Even as some gain coverage through state Medicaid expansions, it is estimated that only a quarter of states will offer comprehensive dental coverage (Nasseh, Vujicic, & O’Dell, 2013). Lack of access to dental care is not trivial. Mounting evidence suggests that poor oral health care leads to increased physical and mental health issues and greater cost to individuals and health care institutions. Ignoring dental health disparities in the United States has devastating social justice implications.

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA)

The lack of dental benefits available to low-income adults in the United States has been referred to as a “neglected epidemic” (Wallace, Carlson, Mosen, Snyder, & Wright, 2011). Despite the implementation of the ACA (P.L. 111-148) and the expansion of 28 state Medicaid plans (as of August 2014), some policymakers have neglected the oral health of low-income adults. The ACA did not deem dental care as an “essential health benefit,” and adult oral health services remain at state discretion. Many states have indicated that adult Medicaid dental benefits will only include “emergency or limited benefits” (Nasseh et al., 2013). The interpretation of “emergency benefits” varies widely by state, but generally care is only provided for traumatic injuries or extractions (Kaiser Family Foundation, 2012). The ACA lessened many

nondental health disparities, but oral health care remains disparate.

PHYSICAL HEALTH RAMIFICATIONS

Poor dental care does not exist in a vacuum. Any type of health issue poses the risk of creating an accumulation of health-related concerns. According to the 2000 U.S. Surgeon General’s Oral Health Report, linkage exists “between poor oral health and cardiovascular disease, respiratory infection, and adverse pregnancy outcomes such as preterm birth and low birth weight through bacteria and inflammation” (Choi, 2011). When oral health is addressed, other chronic conditions may be ameliorated in the process. Neglecting dental needs may lead to a host of additional concerns.

ECONOMIC COST

In a study conducted by the University of Minnesota School of Public Health, researchers discovered that in a one-year period dental visits in medical emergency rooms (ERs) cost \$5 million, with public programs reimbursing at 50 percent (Davis, Deinard, & Maiga, 2010). The study also found that “a population with commercial dental insurance rarely used hospital ERs for dental problems” (Davis et al., 2010). The high cost of ER care calls into question whether preventive care for the underinsured is more economically viable than tax payers absorbing ER costs. A Pew Trust study found that “the average cost of a Medicaid enrollee’s inpatient hospital treatment for dental problems is nearly 10 times more expensive than the cost of preventive care delivered in a dentist’s office” (Pew Center on the States, 2012). When states refuse to allocate money for preventive dental care visits, ER visits often become the only dental option for the uninsured.

IMPACT ON EMPLOYMENT

Not only does poor oral health care diminish state budgets, it can also contribute to unemployment and,

therefore, poverty. Focus groups in Massachusetts found that among Massachusetts Medicaid (that is, MassHealth) recipients with untreated dental issues, “nearly all respondents interviewed were living [with] . . . diminished self-esteem” (Wallace et al., 2011). Lack of self-esteem can greatly reduce employability and motivation to interact in the work world. Indeed, “according to the 1996 National Health Interview Survey (NHIS), 1.9 days of work were lost per 100 employed persons over age 18 because of dental symptoms or treatment” (Choi, 2011). These findings reveal a paradox in the current system: People in poverty who cannot receive dental care are encouraged to find work and subsequent insurance. However, this same population’s lack of dental care leads to diminished employability and subsequent lack of oral health care. Not taking the opportunity to expand dental access may contribute to continued reliance on public assistance as individuals face discrimination in the job market related to missing teeth or dental deformities.

MENTAL HEALTH

In addition to high health care expenditures and the physical health concerns that untreated dental issues create, mental health concerns may also increase as dental care decreases. Researchers have found that dental issues such as missing and decaying teeth are associated with depression (Coles et al., 2011). This correlation is not surprising as missing or decaying teeth may cause societal scrutiny and self-consciousness (Coles et al., 2011). Insurance that covers only tooth extractions rather than fillings or preventive care visits may increase stigma associated with missing teeth. Providing increased oral health services to all Americans is a concrete way to lessen some mental health concerns.

RECOMMENDATIONS

The bleak picture of dental access for low-income uninsured adults is facing a window of opportunity through ACA Medicaid expansions. However, a common complaint brought forth by the American Dental Association is that there would not be enough dentists to provide care should millions of uninsured adults receive coverage (Davis et al., 2010). This statement is true partially due to a lack of participation in Medicaid coverage plans. *The Journal of Public Health in Dentistry* states, “Fewer than half of all dentists participate in public dental insurance programs, and even those who do may restrict the number served” (Davis

et al., 2010). According to the U.S. Bureau of Labor Statistics (2013), the annual mean wage for a dentist in the United States in 2013 was \$164,570. Given the lucrative nature of dentistry, requiring participation in public programs such as Medicaid is reasonable and just.

Should the shortage of dentists prove insurmountable, there are possible alternatives. Both Alaska and Minnesota have been expanding the dental workforce with midlevel practitioners, referred to as dental health aide therapists (Davis et al., 2010). This option provides an increase in access to care through increased practitioners billing at a lower rate. In addition, some dentists are choosing health equality over private practice profits. Although these alternatives are helpful, researchers acknowledge the importance of changing the private practice dental industry to create sustainable progress.

SOCIAL WORK RELEVANCY

Dental health disparities are relevant to social work practice for two major reasons. First, because dental disparities affect underserved populations, social work attention must be paid. In the preamble of the National Association of Social Workers’ (NASW’s) (2015) *Code of Ethics*, social work is described as a profession that pays particular attention to the “empowerment of people who are vulnerable, oppressed, and living in poverty” (p. 1). Socioeconomic status is deeply intertwined with access to dental care and contributes to the stratification of social classes in the United States. By recognizing this inequity and making strides to promote equal access to dental care, social workers can uphold the *Code of Ethics*’ priority of empowerment. Second, social workers are uniquely poised to recognize dental health inequality as social injustice and provide multilevel interventions to ensure that low-income Americans receive care and advocacy. The profession of social work is particularly useful to the amelioration of dental health disparities because social workers are able to skillfully advocate for social justice, provide necessary education and resources, and promote policy change.

CONCLUSION

As with many issues of health inequity facing the United States, there are many dental health fronts to examine and improve on. Dental care deserves the attention of social workers as it is wrought with social inequity. Dental care is connected to an extensive list of nondental issues. As such, it must be a part of the

holistic health care approach. Our health care providers and policymakers cannot be so specialized that they lose sight of the entire body and its interconnectedness, including oral health. Financial concerns must also be prioritized in a nation attempting to reduce wasteful spending and advocate for preventive care. Finally, of utmost importance are the mental health and well-being of affected individuals; unemployment, alienation, and the inability to smile continue to be the reality of low-income adults in the United States. Deeming oral health care an unessential health benefit has medical and financial costs. These costs are acutely detrimental to those low-income individuals who go without oral health care. Oral health should no longer be neglected, and social workers should be pivotal in prioritizing care and ending inequity. **HSW**

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