

POVERTY & DENTISTRY

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OBJECTIVES

- Define poverty
- Explore relationship between poverty and oral health status

POVERTY

Definitions:

Poverty is the state of one who lacks a usual or socially acceptable amount of money or material possessions¹ (Merriam-Webster)

Absolute Poverty measure poverty in relation to the amount of money necessary to meet basic needs (food, clothing, shelter)²

Income Poverty is when a family's income fails to meet a federally established threshold³

2019 US Poverty Levels

| Income strata | Federal Poverty Level | Household income for a family of 4 in 2019 dollars |
|---------------|-----------------------|--|
| Poor | <100% | \$0-\$25,570 |
| Low income | 100-200% | \$25,571-\$51,500 |
| Middle Class | 200-400% | \$51,501-\$103,000 |
| Affluent | >400% | \$103,001 and above |



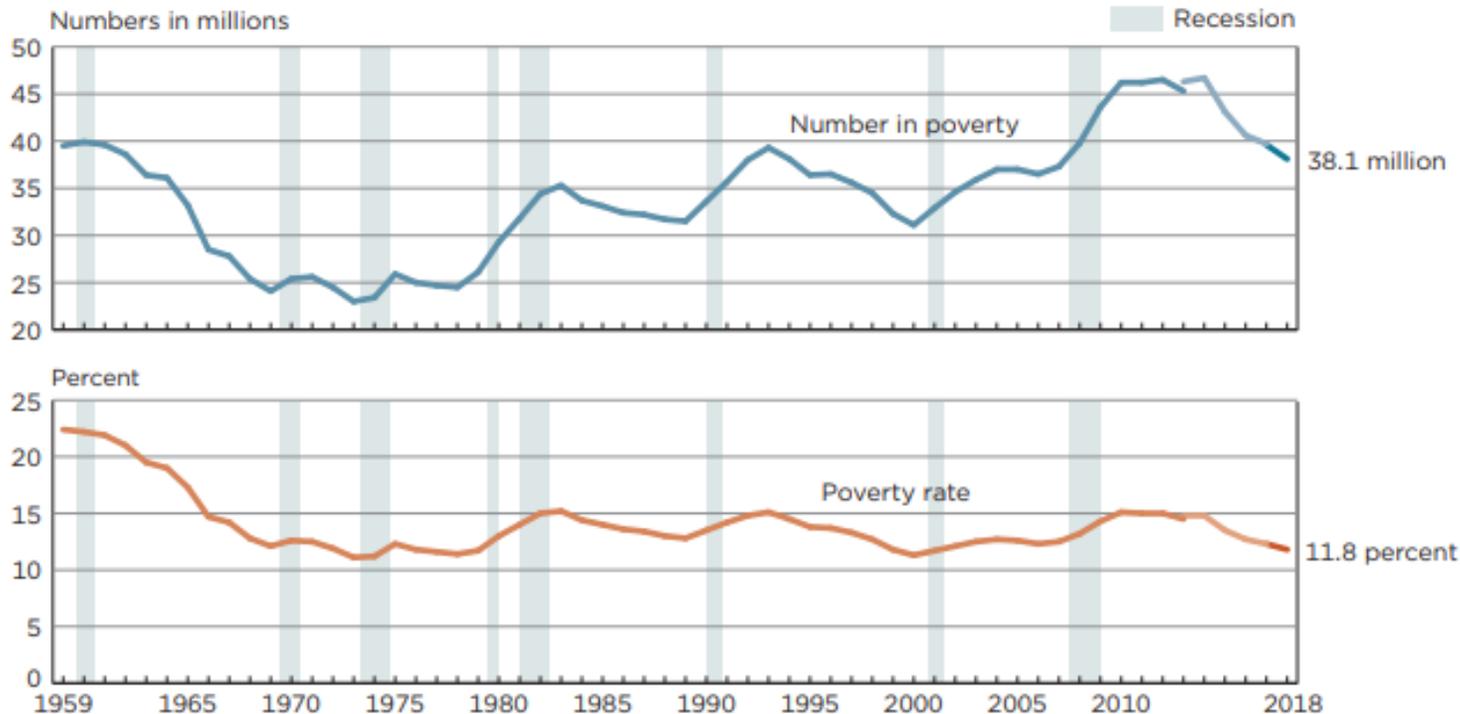
POVERTY: SELECTED FACTORS⁴

- **Labor market conditions**
 - availability of jobs and wages
- **Education**
 - < education = > poverty
- **Demographic Characteristics**
 - Age, Family Structure, Race



POVERTY: THE MAGNITUDE AND TRENDS

Figure 7.
Number in Poverty and Poverty Rate: 1959 to 2018



Note: The data for 2017 and beyond reflect the implementation of an updated processing system. See Appendix D for more information. The data for 2013 and beyond reflect the implementation of the redesigned income questions. The data points are placed at the midpoints of the respective years. For information on recessions, see Appendix A. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see <<https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar19.pdf>>.

Source: U.S. Census Bureau, Current Population Survey, 1960 to 2019 Annual Social and Economic Supplements.



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POVERTY: A SOCIAL DETERMINANT OF HEALTH

Social determinants of health (SDOH) are conditions in the places where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.⁵

Income is a key part of the social context of health.

Poverty limits access to:

- Healthy foods
- Safe neighborhoods
- Health care



POVERTY AND ORAL HEALTH

Original Contributions

Cover Story

Tooth loss among older adults according to poverty status in the United States from 2004 and 2009 through 2014

Bruce A. Dye, DDS, MPH; Darien J. Weatherspoon, DDS, MPH; Gabriela Lopez Mitnik, MS, MPH

ABSTRACT

Background. As tooth loss decreases in an aging United States, retaining enough natural dentition is important for quality of life.

Methods. The authors used data from the 1999 through 2004 and the 2009 through 2014 National Health and Nutrition Examination Surveys to assess changes in tooth loss in adults 50 years of age or older. The authors evaluated changes in edentulism, retaining all teeth, and having dentition (21 or more natural teeth) according to poverty status.

Results. Edentulism was lower in 2009 through 2014 than in 1999 through 2004 (11% for adults 50 years or older, but this decrease was not significant among the poor (people at or below the federal poverty guideline; $P > .05$). Complete tooth retention improved from 14% to 21% in 1999 through 2004 and 2009 through 2014 for people 50 years or older ($P < .05$), attributable mostly to adults who were nonpoor ($> 200\%$ federal poverty guideline). Adults had a functional dentition in 2009 through 2014 than in 1999 through 2004 (67% vs 62%; $P < .05$), although the increases generally were significant only for those not living in poverty.

Conclusions. Complete tooth loss has decreased by more than 75% for those aged 65 years over the past 5 decades in the United States. Improvements in tooth loss means edentulism and complete tooth retention, have been most significant among the nonpoor, those who are poor have experienced fewer improvements.

Practice Implications. An aging population is experiencing less edentulism and greater retention, so older adults may need more regular oral health care and prevention services, such as root caries and periodontal disease.

Key Words. Edentulism; functional dentition; poverty; oral health; epidemiology; dental care; National Health and Nutrition Examination Survey; health disparities; adults 50 years of age or older. <https://doi.org/10.1016/j.jada.2016.10.016>

The population of older adults in the United States continues to grow over time, with the number of people 65 years of age or older expected to double by 2050.¹ This trend has been projected to continue as the baby boomer population, and it will result in an increased geriatric population that the health care system will need to care. As it relates to oral health, older adults have unique needs for tooth loss, including the lack of a routine oral health benefit in Medicare, adverse effects of multiple medications such as xerostomia, and less access to oral health care.^{2,3}

The complete loss of natural teeth represents the cumulative adverse effect of several periodontal disease, both of which share recurring exposure to risk factors (for example, diet or tobacco use) commonly associated with other chronic diseases. Globally, edentulism affects approximately 30% of adults aged 65 through 74 years, with prevalence accelerating in middle-income countries.⁴ Although 2.5 billion people worldwide have untreated caries, accounts for much of the overall burden of prevalent adverse oral health conditions,

RESEARCH AND PRACTICE

Oral Health Equity and Unmet Dental Care Needs in a Population-Based Sample: Findings From the Survey of the Health of Wisconsin

Kristen Malecki, PhD, MPH, Lauren E. Wisk, PhD, Matthew Walsh, PhD, MPH, Christine McWilliams, MPH, Shoshana

Oral health is an essential and integral component of overall health, yet unmet health care needs and poor oral health are pervasive. Poor oral health care is associated with increased use of medical services, increased risk for several chronic conditions (including heart disease and diabetes),^{1,2} as well as reduced quality of life and employment opportunities.^{3,4} There is growing momentum both nationally and internationally for increased understanding and use of a more holistic social-ecological perspective to understanding and addressing oral health disparities.⁵ With the implementation of the Affordable Care Act and the potential for increased access to care among adults, there is a unique and novel opportunity to improve equity in oral health care and outcomes.

Spurred by a 2001 surgeon general's report in which poor oral health was described as a "Silent Epidemic" sweeping the nation, the Institute of Medicine convened experts to develop a vision for improved oral health care into the future. A 2011 Institute of Medicine report suggested that oral health care should be integrated into an overall model of health care delivery, with an emphasis on the primary care setting.⁶ National recommendations suggested that addressing oral health disparities would require a more fundamental shift toward viewing oral health as a medical issue. Improving access to primary care that includes education and training on the importance of oral health care during medical visits might be a solution to improving oral health equity.^{7,8}

Elucidating the true magnitude of oral health disparities and unmet needs, including the complex network of population-level predictors, is often limited. A 2010 report by the World Health Organization identified several research gaps, including understanding the social determinants and modifiable risk factors for poor oral health.⁹ Although many risk factors are well-established

Objectives. We used objective oral health screening data to assess oral health equity in a statewide population of adults.

Methods. We examined oral health status in a population-based sample of adults who participated in the Survey of the Health of Wisconsin project, conducted with the Wisconsin Department of Health Services during 2010.

Results. We found significant disparities in individual-, psychosocial-, and community-level oral health status. Individuals who self-reported unmet need for dental care were more likely to have untreated cavities as were those who were poor after controlling for socio-demographic and behavioral factors.

Conclusions. Our results suggested that oral health care access to care and poor oral health status, role that primary care, in conjunction with dental care, could play in promoting oral health care, particularly for those with unmet dental care needs (e.g., the costs associated with unmet dental care needs, such as teeth brushing, dental visits, and dental insurance). [doi:10.2105/AJPH.2014.3023105](https://doi.org/10.2105/AJPH.2014.3023105)

(age, gender, race/ethnicity, and access to care),¹⁰⁻¹³ others, such as psychosocial determinants and behaviors, are not as well understood.

Few, if any, population-based studies have included objective oral health screenings. Oral health screenings of children have been the national benchmark for tracking disparities among children for quite some time, but no analogous nationwide program exists for adults. The Association for State and Territorial Dental Directors (ASTDD) has developed tools, such as the Basic Screening Survey (BSS) protocol, for use in adults. However, access to representative population-based studies of adults is not often feasible or cost effective for most state-based programs. Consequently, most prevalence estimates of unmet oral health needs are based on self-reported, telephone-based surveys that do not include data on predictors, such as tooth brushing, psychosocial factors, and community-level data.

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ORAL HEALTH COST & USE

By Marko Vujcic, Thomas Buchmueller, and Rachel Klein

Dental Care Presents The Highest Level Of Financial Barriers, Compared To Other Types Of Health Care Services

ABSTRACT The Affordable Care Act is improving access to and the affordability of a wide range of health care services. While dental care for children is part of the law's essential health benefits and state Medicaid programs must cover it, coverage of dental care for adults is not guaranteed. As a result, even with the recent health insurance expansion, many Americans face financial barriers to receiving dental care that lead to unmet oral health needs. Using data from the 2014 National Health Interview Survey, we analyzed financial barriers to a wide range of health care services. We found that irrespective of age, income level, and type of insurance, more people reported financial barriers to receiving dental care, compared to any other type of health care. We discuss policy options to address financial barriers to dental care, particularly for adults.

The Affordable Care Act (ACA) is having a significant impact on the US health care system. Early evidence shows that the number of Americans without health insurance has declined and access to health care services has improved.¹⁻³ However, the percentage of Americans without dental insurance has always been higher than the percentage without health insurance, and there are large differences in dental coverage rates between children and adults. In 2013, 12 percent of children and 33 percent of nonelderly adults had no dental insurance, compared to 6 percent of children and 20 percent of nonelderly adults who lacked health insurance.^{4,5}

The higher rate of dental coverage for children, compared to nonelderly adults and seniors, is partly explained by the fact that dental services are a mandatory benefit within Medicaid for children. For child Medicaid beneficiaries, dental services are part of a comprehensive set of benefits provided through the Early and Periodic Screening, Diagnosis, and Treatment Program. Under the program, "dental services for children must minimally include: relief of pain

and infections, restoration of teeth, [and] maintenance of dental health," and "all services must be provided if determined medically necessary."⁶ In contrast, dental care for adults is not covered by Medicare and is an optional benefit in Medicaid, with no minimum standards. According to the most recent data available, over eight million adults are enrolled in Medicaid in the twenty-two states whose Medicaid programs do not provide adult dental benefits beyond emergency services.⁷

The ACA's essential health benefits package perpetuates the long-standing division between dental and other health care services by excluding dental coverage for adults. It requires dental coverage for children, although implementing these provisions has posed challenges. For example, because dental benefits are offered primarily as stand-alone products, not as part of a medical plan, the purchase of dental benefits cannot be enforced, and dental benefits are excluded from premium tax credit calculations.⁸

Even though the ACA does not have specific provisions that address adult dental care, it is likely that the law has modestly increased dental coverage through two channels. First, one provi-

among youth aged

300% or more

7.0

5

briefs/db307_table.pdf#3.

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POVERTY, ORAL HEALTH AND THE DENTAL SAFETY NET

Dental Safety Net – the system that supports the provision of dental care services to underserved patients ⁶

- **Facilities**
 - Health Centers
 - Free Clinical
 - Dental Schools
 - Emergency Rooms
- **Providers**
 - Private practice dentists offering sliding fee scale payments, income based payment plans, and those enrolled in (and accepting) Medicaid patients
- **Payment Systems**
 - Medicaid



DENTAL SAFETY NET: MEDICAID

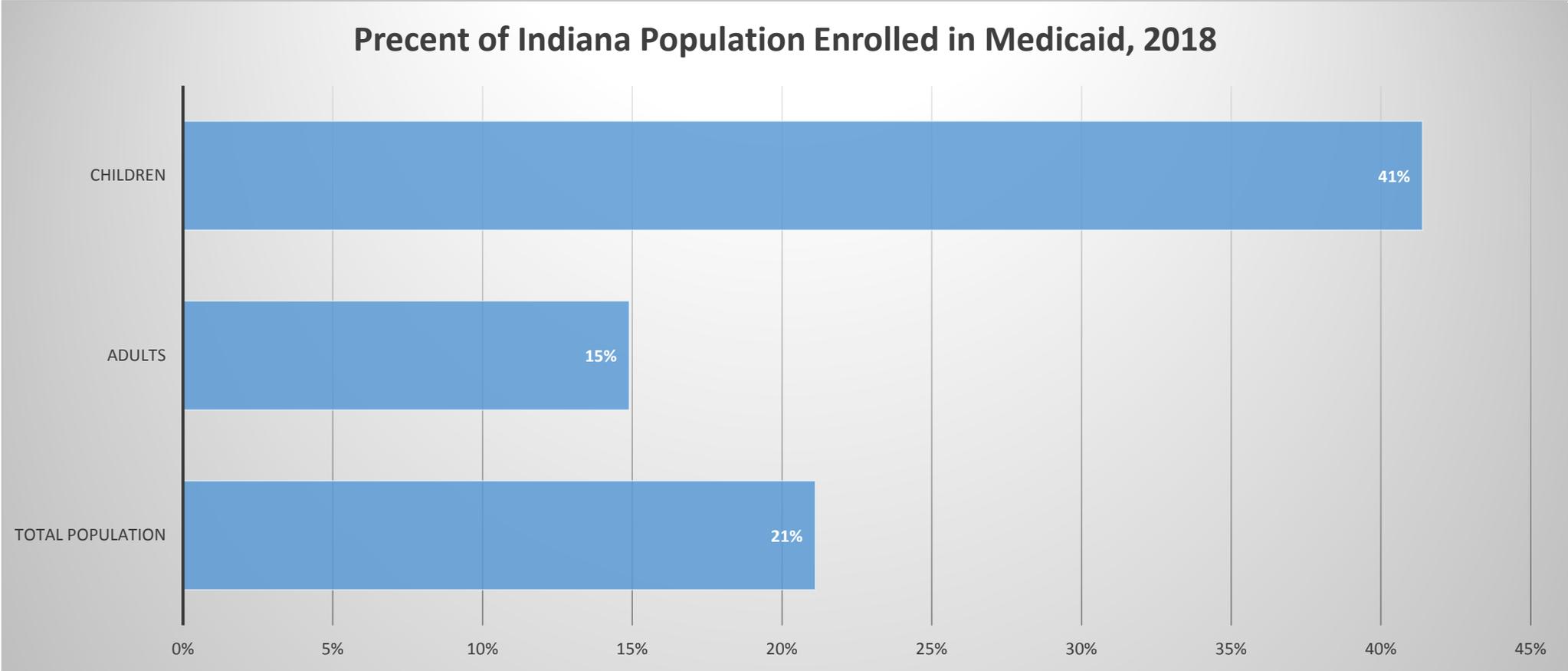
Medicaid is a policy solution to address cost of health care (especially important for people living in poverty)

What is it?

- Health coverage for eligible low-income adults, children, pregnant women, elderly adults and people with disabilities
- Authorized in 1965 by Title XIX of the Social Security Act in 1965
- All states, the District of Columbia, and the U.S. territories have Medicaid programs
- Federal government establishes certain parameters, each state administers their Medicaid program differently, resulting in variations in Medicaid coverage across the country
- Jointly funded by state and federal government



MEDICAID IN INDIANA^{8,9}

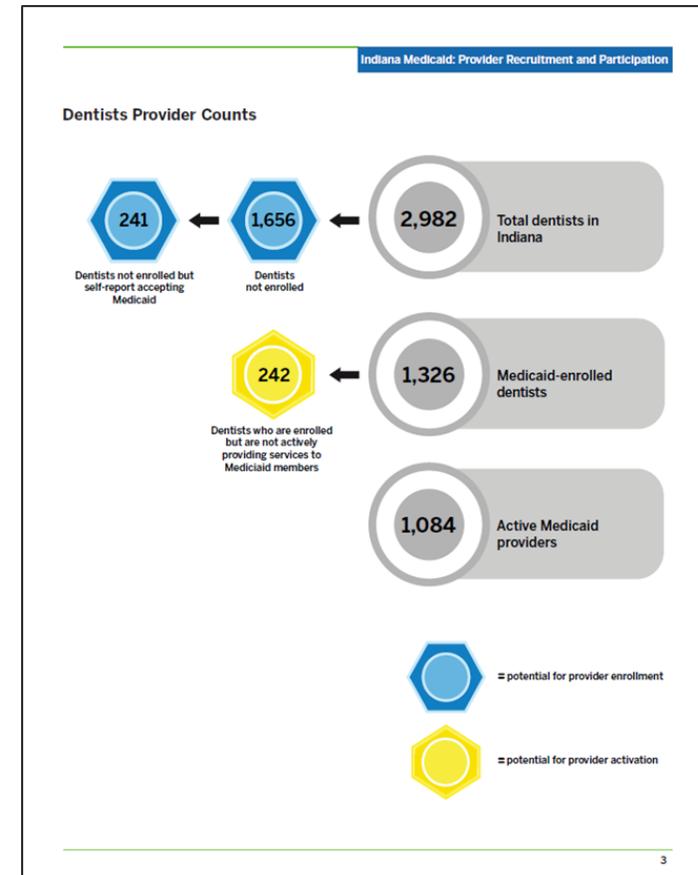


HEALTH INSURANCE ≠ ACCESS TO DENTAL CARE

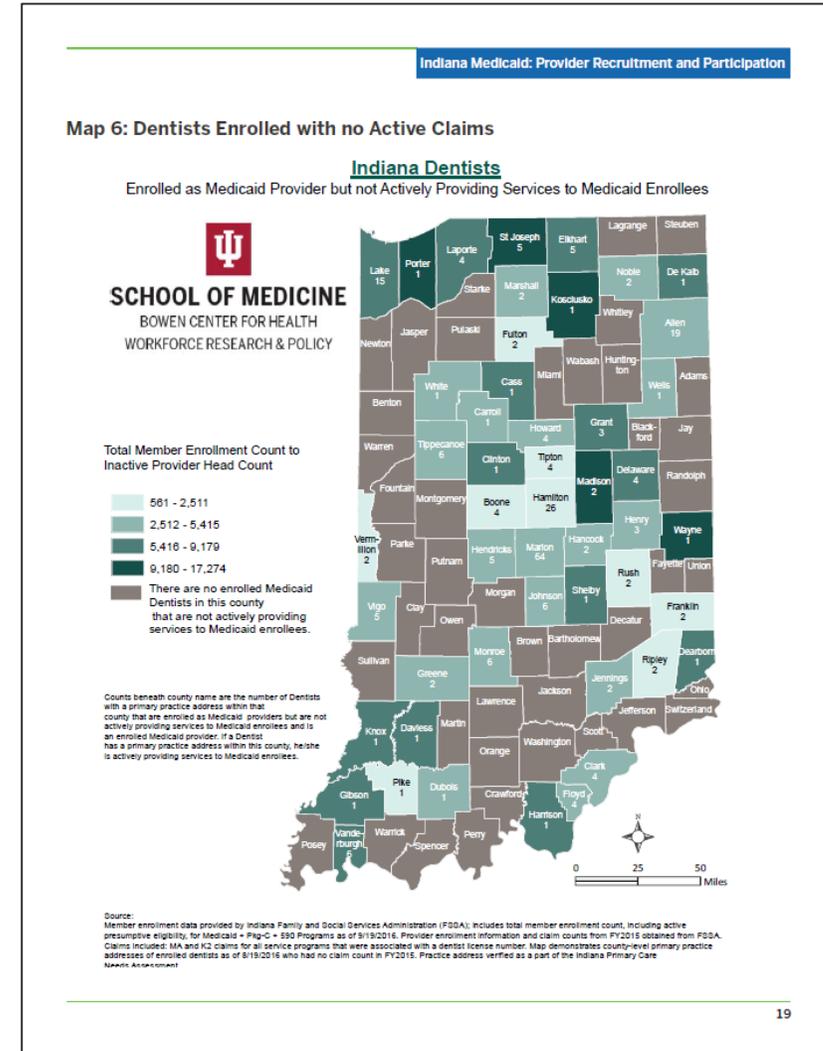
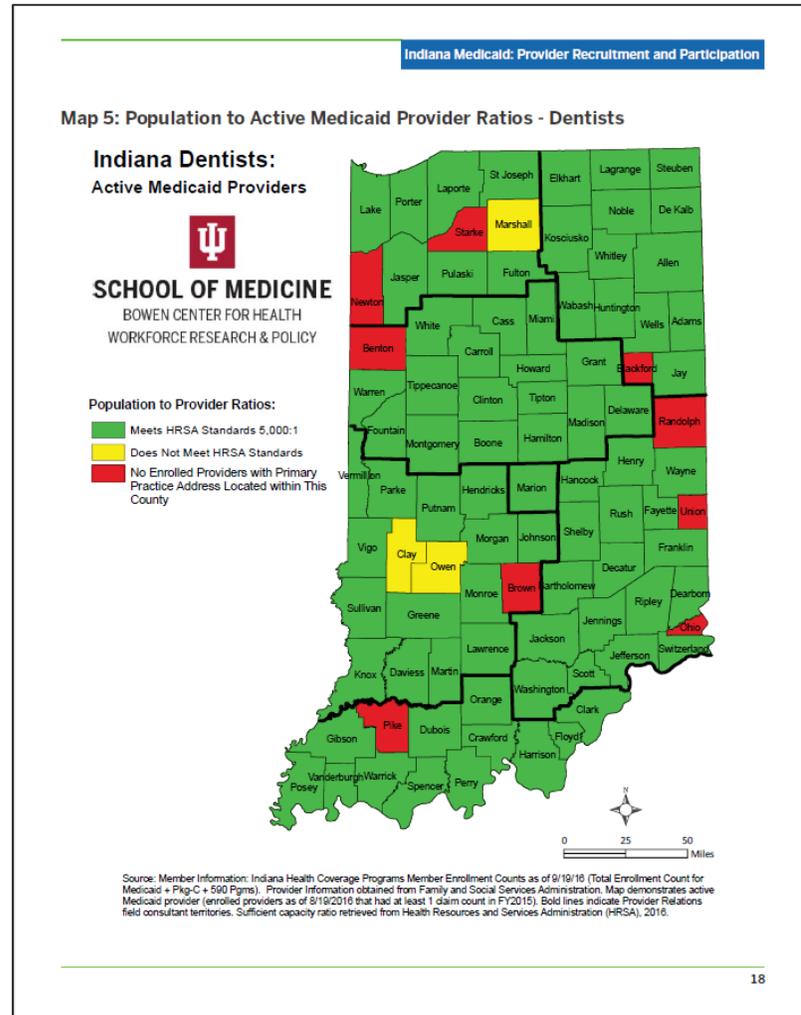
Having dental insurance does not guarantee access to dental care

People living in poverty have other barriers

- Transportation
- Time
- Availability of dental services



DIFFERENCE BETWEEN BEING A MEDICAID DENTIST AND PROVIDING CARE TO MEDICAID RECIPIENTS



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