

# Oral Health Disparities

One of the two major goals of Healthy People 2010 is to decrease disparities. Despite some of the gains in oral health status for Washingtonians as a whole, disparities persist.

**Race and ethnicity.** Non-Hispanic Blacks, Hispanics, and American Indians/Alaska Natives generally have the poorest oral health of any of the racial and ethnic groups in the United States. African American adults are more likely than other racial or ethnic minorities to have periodontal disease. Compared to whites, African Americans are more likely to develop oral or pharyngeal cancer, are less likely to have it diagnosed at early stages, and will have lower five-year survival rates. Racial and ethnic minorities in general are also more likely to be uninsured and have poor access to dental care.

**Gender.** Most oral diseases and conditions are complex and represent the combination of interactions between genetic, socioeconomic, behavioral, environmental, and general health influences. Multiple factors may act together to place some women at higher risk for oral diseases. For example, the comparative longevity of women, compromised physical status over time, and the combined effects of multiple chronic conditions, often with multiple medications, can result in increased risk of oral disease. [66] A greater share of women than men have oral-facial pain, including pain from oral sores, jaw joints, face and cheek pain, and burning mouth syndrome. But many statistical indicators also show women to have better oral health status compared to men. [1] Adult women are less likely than men of every age group to have severe periodontal disease. Both African American and white women have a substantially lower incidence rate of oral and pharyngeal cancers compared to African American and white males, respectively. Also, females tend to visit the dentist more frequently than do men.

**Age.** Most children at all income levels are covered by private insurance or through Medicaid and related programs. This is not the case for adults. Washington State provides limited Medicaid coverage for low-income adults, and adults working full-time usually receive health insurance through their employers. But adults living just above the federal poverty level and part-time employees generally are not covered by any dental insurance plan. This situation leads to untreated oral diseases in adults, which can cause pain, infection, missing days at work, low productivity, and low self-esteem. Washington's 2005 Smile Survey shows that disparities continue in terms of caries and sealants for children.

**Rural and urban.** People living in rural areas have a higher disease burden due primarily to difficulties in accessing preventive and treatment services. Nationally, dental care utilization differs between rural and urban residents, with rural residents tending to underutilize dental care. [67] National and state rural health experts have identified oral health as the third major rural health priority. [68] Access to dental care is further undermined in rural areas because of a shortage of dental professionals and difficulties with transportation. Additionally, a higher proportion of dentists are expected to retire by 2013 in the rural areas (57 percent) than in the urban areas of Washington (50 percent).

**Individuals with disabilities and children with special health care needs (CSHCN).** Overall caries rates are higher among those with disabilities than those without. [1] Access to dental care is also compromised for this group of individuals because insurance coverage may not always be sufficiently comprehensive, and it may be difficult to find dental professionals trained to provide care.



**Income level.** People living in low-income families bear a disproportionate burden from oral diseases and conditions. For example, despite progress in reducing dental caries in the United States, individuals in families living in poverty experience more dental caries than those who are economically better-off. The caries seen in these individuals are more likely to be untreated than caries in those living above FPL. Nationally, 37 percent of low-income children ages 2-9 have one or more untreated caries in primary teeth, compared to 17 percent of other children. [1] Poor adolescents ages 12-17 years in each racial and ethnic group have a higher percentage of untreated decayed permanent teeth than the corresponding, non-poor adolescent group. Poor Hispanics (47.2 percent) and poor non-Hispanic black adolescents (43.6 percent) have more than twice the proportion of untreated decayed teeth than poor non-Hispanic white adolescents (20.7 percent). For non-poor adolescents, the proportion of untreated decayed permanent teeth is highest in non-Hispanic black adolescents (41.7 percent)—a proportion only slightly lower than for this group's poor counterparts (43.6 percent). The mean number of permanent teeth affected by dental caries (decayed or filled) for this age group is similar among Hispanics (2.7), non-Hispanic whites (2.5), and non-Hispanic blacks (2.3). As income level increases, the percentage of adolescents with decayed teeth decreases and the proportion of decayed teeth that have been filled increases. [69]

At every age, a higher proportion of those at the lowest income level have periodontitis than do those at higher income levels. Adults with only a high school education or less are 2 to 2.5 times more likely to have destructive periodontal disease than those with some college education. [33] Overall, a higher percentage of Americans living below the poverty level are edentulous (lost all their natural teeth) than are those living above. [1] Among persons ages 65 years and older, 40 percent with less than a high school education were edentulous in 2004, compared with 10 percent of persons with at least some college education. People living in rural areas also have a higher disease burden due primarily to difficulties in accessing preventive services and treatment.