Washington State Department of Health

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Oral Health

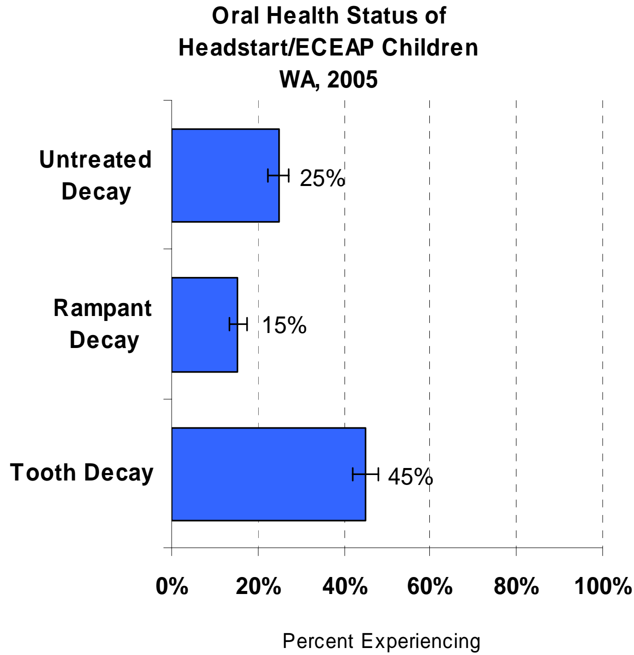
Publicly funded services to address Oral Health are described in Oral Health Services.

Definition: Oral health deals with the prevention and treatment of common oral and craniofacial diseases and conditions such as tooth decay and periodontal (gum) disease. In this chapter, tooth decay is used as a measure of poor oral health. Rampant decay is defined as 7 or more teeth decayed, missing, or filled.

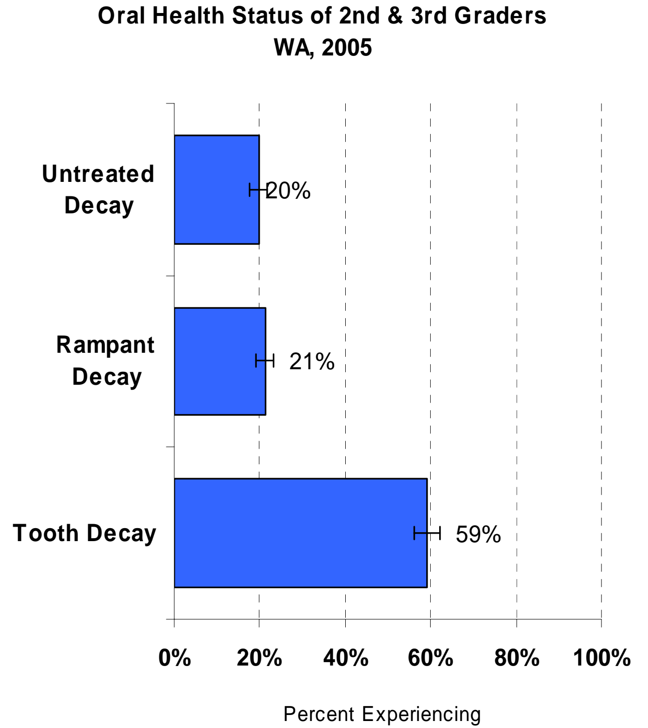
Key Findings:

- Oral health is an essential component of health and quality of life. Tooth decay is the single most common chronic disease of childhood (5 times more common than asthma), and affects about 78% of all children by age 17.[1]
- Poor oral health affects children's ability to concentrate and learn, as well as their speech development, eating habits, activity levels and self-esteem.[1]
- Tooth decay is a problem for Washington's children. In 2005, about 59% of 2nd-3rd graders experienced decay compared to the HP2010 objective of 42% for children 6-8 yrs. About 21% experienced rampant decay.[2,3]
- Many children are not getting the dental care they need. The 2005 Washington State Smile Survey showed that about 20% of 2nd-3rd graders experienced untreated decay, and only 45% had received dental sealants. HP2010 objectives are 21% and 50%, respectively.[2,3]
- Low income children also experience high rates of decay. No Washington data of all preschool children are available, however, 45% of Headstart/ECEAP children experienced decay compared to the HP2010 objective of 11% for all 2-4 year olds.[2,3]
- Oral health disparities persist in our state, with minority, low-income, and non-English speaking children having the highest levels of dental disease, highest levels of untreated decay, and the lowest levels of dental sealants.
- Community water fluoridation is the most cost-effective, equitable, and safe mans to provide protection from tooth decay. The Centers for Disease Control and Prevention indicate that 59% of the Washington population has access to optimally fluoridated water through public water systems compared to the HP2010 objective of 75%.[3,4]
- Research suggests a potential relationship between poor oral health during pregnancy and preterm/low birthweight deliveries. Treating periodontal disease during pregnancy may lead to improved birth outcomes. Cariogenic bacteria may also be transmitted by the mother to the child.[5]
- PRAMS data for 2001-2003 show that about 28% of mothers overall reported needing to see a dentist for a problem during their pregnancy, with women on Medicaid much more likely to report a dental problem than Non-Medicaid women.[6,7]
- Approximately 69% of mothers who reported a dental problem also reported they went to the dentist during their pregnancy. This varied by Medicaid status. Only about 58% of TANF women and S-women who reported a dental problem said they went to the dentist compared to about 84% of Non-Citizens and 76% of Non-Medicaid women who reported a dental problem.[6,7]

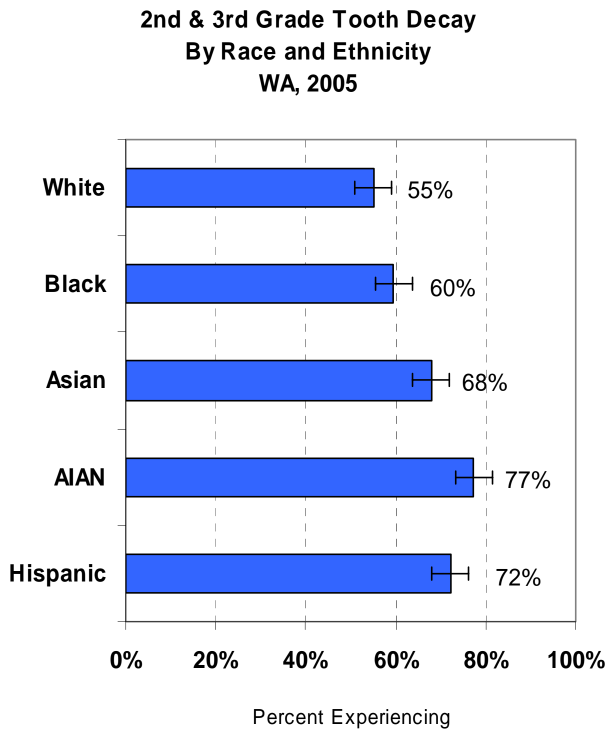
Head Start/ECEAP Children



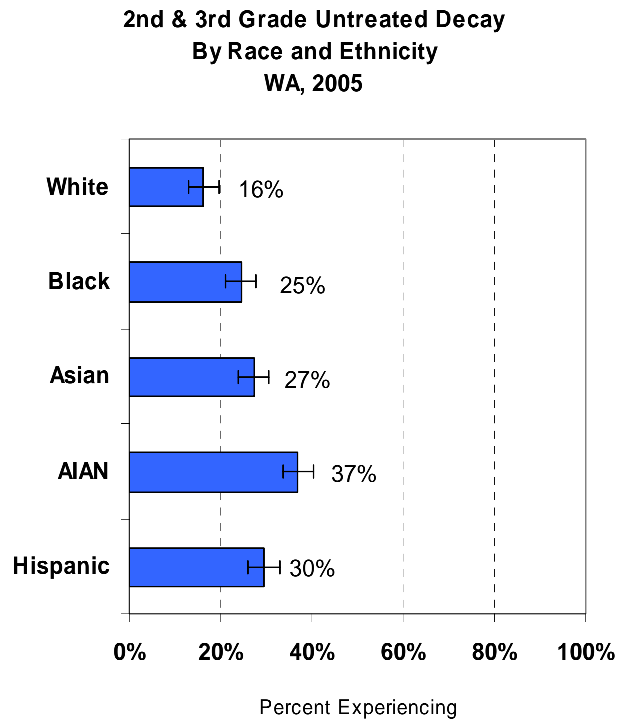
2nd and 3rd Graders



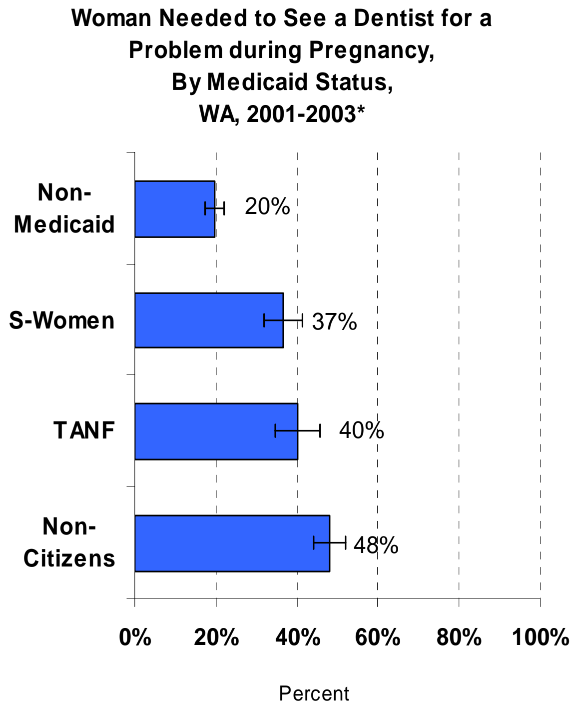
Tooth Decay



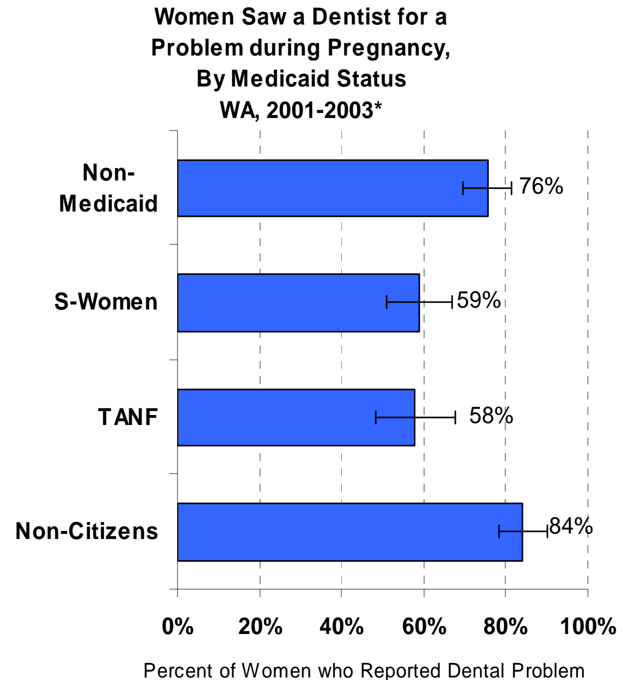
Untreated Decay



Needed Dental Care



Received Dental Care



* Medicaid women received maternity care paid for by Medicaid. They are divided into three major subgroups (from highest to lowest socioeconomic status): **S-Women** - those women who are citizens and eligible to receive Medicaid because they are pregnant and have incomes at or below 185% FPL, **TANF** - those women who are very low income (generally < 50% FPL) and receive cash assistance (TANF) in addition to Medicaid, and **Non-Citizens** - those women who are not citizens and are eligible to receive Medicaid because they are pregnant and have incomes at or below 185% FPL. Non-citizens are not eligible for TANF although their incomes are often lower than women on TANF. All three Medicaid groups have incomes below most Non-Medicaid women.

Data Sources

1. U.S. Department of Health and Human Services, Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.
2. Smile Survey 2005, Washington State Department of Health, Maternal and Child Health Office, July 2005.
3. Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. Oral Health Objectives. Washington, DC. http://www.healthypeople.gov/document/html/volume2/21oral.htm
4. Center for Disease Control and Prevention, Oral Health Resources. 2004 Data. Website: http://www2.cdc.gov/nccdphp/doh/synopses/StateDataV.asp?StateID=WA&Year=2004
5. Public health implications of periodontal infections in adults: conference proceedings. Journal of Public Health Dentistry, 65(1), Winter 2005.
6. Washington Pregnancy Risk Assessment Monitoring System (PRAMS), 2001-2003. Washington State Department of Health.
7. First Steps Database, Research and Data Analysis Division, Washington State Department of Social and Health Services.

Endnotes

a. AIAN – American Indian/Alaska Native
b. API – Asian or Pacific Islander
c. Significance based on 95% confidence intervals

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