

Increasing Use of Dental Services by Children, but Many Are Unable to Secure Needed Care

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National studies indicate that an increasing proportion of children are receiving needed oral health care. However, this increase is not uniform throughout all populations of youngsters. Overall national study findings regarding the use of dental services mask the fact that, a significant subset of low-income, minority, medically and developmentally compromised and socially vulnerable children continue to lack access to care and suffer significant and consequential dental and oral disease. In addition, these same children will face continued difficulties in securing needed care as they reach their early adult years.

Key words: dental visits, unmet needs, poverty, insurance, disability

INTRODUCTION

The results from a series of national studies indicate that an increasing proportion of children are receiving needed oral health care. By comparison, other studies report that while there have been improvements, particular populations are underserved.

The results of surveys from the Data Resource Center for Child and Adolescent Health ⁽¹⁾ for the period between 2000 and 2011 indicate a general increase (except in the periods around the 2001 and 2007-09 recessions) in the national proportion of children (2-17 years) with a dental visit in the past year. The percent of youngsters 2-4 years of age that visited a dentist in the previous year increased from 44% in 2000 to 58% in 2011. During the same period, the percent of children 5-17 years of age that visited a dentist in the previous year increased from 82% to 88%. ¹

Increases in the proportion of youngsters with visits to dentists in the previous year were reported for: 1) children in families with incomes below and above the poverty level, 2) children with private and public insurance coverage, as well as children with no insurance, and 3) children of various race and ethnic heritages. (Table 1)

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Differences

However, there were some differences in reported visit patterns between various population groups.

Children 2-4 years of age:

- Limited differences between youngsters living below and above the poverty level.
- Limited differences in visit patterns between youngsters with private and public insurance, but a smaller proportion of youngsters with visits among those with no insurance.
- Between 2000 and 2011, Hispanic youngsters had the largest increase in the proportion with a visit to the dentist in the past year, as well as the population with the greatest proportion with a visit in 2011. (Table 1)

Children 5-17 years of age:

- A greater proportion of children above the poverty level, compared to children living in poverty, visited a dentist in the previous year.
- A greater proportion of children with private insurance than children with public insurance visited a dentist in the previous year. Children with no insurance had the lowest proportion with a dental visit in the previous year.
- In 2011, Asian and Hispanic children had the smallest proportion with a dental visit in the previous year. (Table 1)

¹ The Data Resource Center for Child and Adolescent Health is a project of the Child and Adolescent Health Measurement Initiative from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. The surveys were conducted by the Centers for Disease Control and Prevention's National Center for Health Statistics.

Note: The basic web site: (<http://www.childstats.gov>) provides an entry point for an extended number of surveys, including: 2011/12 National Survey of Children's Health, 2009/10 National Survey of Children with Special Health Care Needs and the National Health and Nutrition Examination Survey.

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Table 1. Percent of children 2-17 years with a dental visit in the past year by age, poverty level, type of insurance, and race/ethnicity: selected years 2000-2011¹

	2000	2004	2006	2008	2011
Ages 2-4 yrs	44.1%	46.6%	45.6%	50.9%	57.5%
Poverty level					
Below level	47.0	43.8	43.5	51.7	56.3
200% + of level	43.7	48.9	48.3	51.4	57.3
Type of insurance					
Private	44.8	48.7	49.5	51.3	56.8
Public	46.3	48.3	45.0	54.8	59.9
No insurance	37.3	24.9	23.8	35.2	47.6
Race/Ethnicity					
White, nonHisp.	45.1	47.8	45.9	48.9	53.6
Black, nonHisp.	43.3	38.2	39.9	60.5	59.5
Asian	40.3	44.9	47.4	38.7	55.0
Hispanic	39.2	46.9	45.4	52.7	64.1
Ages 5-17 yrs	80.6	83.2	82.9	83.9	87.3
Poverty level					
Below level	66.1	71.5	74.9	75.7	81.7
200% + of level	87.8	89.5	88.8	89.6	91.3
Type of insurance					
Private	86.9	89.2	89.5	89.6	91.0
Public	74.9	78.1	79.3	82.6	87.0
No insurance	53.1	53.5	53.2	51.0	60.0
Race/ethnicity					
White, nonHisp.	85.7	88.0	87.3	87.5	89.1
Black, nonHisp.	75.6	80.3	79.4	82.9	87.1
Asian	81.9	79.8	82.7	82.1	81.9
Hispanic	65.9	70.4	71.9	75.1	84.3

Table 2. Percent of children ages 5-17 years with untreated dental caries, by age, poverty status and race/ethnicity: 1999-2004, 2009-2010²

	1999-2004	2009-2010
Age 5-11	27.1%	15.7%
Poverty level		
Below level	37.5	23.4
200% + of level	17.3	10.6
Race/ethnicity		
White, nonHisp.	23.3	12.3
Black, nonHisp.	39.0	17.9
Mexican American	42.5	27.0
Age 12-17		
Poverty level		
Below level	28.1	19.3
200% + of level	11.6	8.5
Race/ethnicity		
White, nonHisp.	15.5	10.4
Black, nonHisp.	24.1	23.8
Mexican American	27.2	13.8

Table 3. 2011/12 National Survey of Children's Health. Condition of child's teeth by race, ethnicity²

	Excellent/very good condition	Fair/poor condition
White, non-Hispanic	80.3%	4.2%
Black, non-Hispanic	66.8	7.6
Other, non-Hispanic	72.3	7.6
Hispanic	53.4	15.2
Hispanic, Spanish is primary household language	38.0	21.9
Hispanic, English is primary household language	70.6	7.7

Ongoing concerns

The increasing proportion of youngsters with dental visits in the past year is an indirect measure when reviewing oral health. Details from the publication, *America's Children: Key National Indicators of Well-Being, 2013*,² provide a more specific overview of improving oral health. Between 1999-2004 and 2009-2010, there was a decrease in the proportion of younger and older children with untreated dental caries by income, race and ethnicity. Nevertheless:

- In 2009-2010, among young children, almost one-in-four children in families with incomes below the poverty level and more than one-in-four of Mexican American children had untreated dental caries. Among older children almost one-in-four black children had untreated caries. (Table 2)

- The 2011/12 National Survey of Children's Health reported that among Hispanic children where Spanish is the primary household language, parents reported that 22% of their children's teeth were in fair or poor condition. (Table 3)
- Nationally, 7.6% of parents reported that their children's teeth were in fair/poor condition; ranging from 2.8% in Vermont 12.3% in Nevada.¹

Results from the 2009/10 National Survey of Children with Special Health Care Needs indicated that:

- Nationally, 4.6% of children with special needs did not receive preventive dental care in the last twelve months; ranging from less than 3% in Pennsylvania, Rhode Island,

Massachusetts, Vermont, Indiana, Delaware, Kansas and the District of Columbia to 12.9% in Florida. “The service most commonly reported as needed but not received was dental care...”³ 81% of parents of children with special health care recognized the need for preventive dental care. (The greatest proportion for any clinical service.)⁴

- Nationally, 5.4% of children with special needs had unmet other dental care needs or orthodontic treatment; ranging from 2.3% and 2.4% in New Hampshire and Rhode Island to 8.4% and 8.7%, respectively, in Florida and Wyoming.⁵

An indication of some of the difficulties faced by individuals with special needs and their families in their effort to secure needed dental services is summarized in a letter to the editor of *Special Care in Dentistry*.

“I am one of only two dentists in the state of Oklahoma who devotes a major portion of my practice to caring for patients with special health care needs. The other dentist is in Tulsa (90 miles away). Patients travel from all over the state to come to my office; many having to travel 3 hours or more one way. Some have to stay the night in a hotel because it is too taxing on the patient to travel that far in one day. Many of my referrals come from pediatric dentists who don’t feel qualified to provide general dental services adult patients often require (endodontics, periodontics surgical extractions, fixed and removable prosthodontics, and implant therapy).” (Personal communication with the author of the letter)

Note: The writer refers to the fact that pediatric dentists often are called upon to care for their pediatric patients who have reached adulthood, but who are unable to find general dentists to provide the needed care.

This reality continues despite the establishment of a new accreditation standard by The Commission on Dental Accreditation (CODA) that was implemented in 2006 for dental schools, stating that “Graduates must be competent in assessing the treatment needs of patients with special needs.”⁶ However, a survey conducted several years after the new CODA standard was introduced, concluded that less than three-quarters of U.S. dental schools have predoctoral students actively involved in the treatment patients with special needs.⁷

Transition to adulthood

The era of institutionalization of most youngsters and adults with special needs has been replaced with mainstreaming, establishment of community oriented group residential settings, as well as family support locations—all of which has led to increased dependency upon private community practitioners to provide needed dental and medical services.

Whether because of the financial and bureaucratic limitations of Medicaid, the Children Health Insurance Program (CHIP) or other factors, the reality is that general and specialist practitioners are providing only limited oral health services for children and adults with disabilities and a wide range of special needs. The facts are:

- Dentistry is a mandatory service for children under the Medicaid Early and Periodic Screening, Diagnostic and Treatment program. However, Medicaid dentistry is an elective service for adults. As a consequence of efforts

by states to control costs (particularly during and since the recent recession) Medicaid dental care coverage for adults has been limited to relief of pain and infection. The outcome is that many children are aging out of programs that provide support for oral health care into a virtual void of financial assistance in most states.

- Only 10% of general dentists report that they treat children with cerebral palsy, intellectual disabilities or medically compromising conditions often or very often.
- 70% report that they rarely or never treated children with cerebral palsy in their practice.⁸

The unresolved issue is that adult Medicaid dentistry in many states is limited to relief of pain and infection—even for adults with disabilities. In essence youngsters with special needs are aging out of dentistry.

CONCLUSION

Overall national study findings regarding the use of dental services mask the fact that, “... a significant subset of low-income, minority, medically and developmentally compromised and socially vulnerable children continue to suffer significant and consequential dental and oral disease. Demographic trends suggest that the problem of disparities in both oral status and access to competent dental services will continue to worsen for young children.”⁹ In addition, these same children will face continued difficulties in securing needed care as they reach their early adult years, due to pediatric dental providers being unwilling to see adults and children’s hospitals setting arbitrary age cutoffs, which could lead to increased medical complications and associated greater costs.

REFERENCES

1. Data Resource Center for Child and Adolescent Health. Oral health. Web site: <http://www.childstats.gov> Accessed September 20, 2013.
2. *Forum on Child and Family Statistics. America’s Children: Key National Indicators of Well-Being, 2013.* Web site: <http://www.childstats.gov/americaschildren/index.asp> Accessed September 24, 2013.
3. *Maternal and Child Health Bureau. The National Survey of Children with Special Health Care Needs: Chartbook 2001.* Rockville, MD: Department of Health and Human Services, 2004.
4. *Maternal and Child Health Bureau. The National Survey of Children with Special Health Care Needs: Chartbook 2005-2006.* Rockville, MD: Department of Health and Human Services, 2007.
5. *Data Resource Center for Child and Adolescent Health. National Survey of Children with Special Health Care Needs.* Web site: <http://www.child-healthdata.org> Accessed September 26, 2013
6. *Commission on Dental Accreditation. Accreditation standards for dental education programs.* Chicago: American Dental Association, 2004.
7. *Clemetson JC, Jones DL, Lacy ES, Hale D, Bolin KA. Preparing dental students to treat patients with special needs: changes in predoctoral education after the revised accreditation standard. J Dent Educ;76:1,457-65. 2012.*
8. *Casamassimo PS, Seale NS, Ruchs K. General practitioners’ perceptions of educational and treatment issues affecting access to care for children with health care need. J Dent Educ;68:23-8. 2004.*
9. *Edelson BL. Dental care consideration for young children. Special Care Dentistry;22(3 Suppl):11S-25S. 2002.*