

ORAL HEALTH FOR ALL: Policy for Available, Accessible, and Acceptable Care

*The most sacred place isn't the church, the mosque or the temple, it is the temple of the body.
That's where the spirit lives.*

–Susan Taylor, 1993

I. Broadening the Concepts of Health

Health is the synergistic relationship between the physical, social, psychological, and spiritual elements that create the well-being of individuals and/or groups in their physical and social environments (Warren 1998). Physicians as early as 2500 BC understood this relationship clearly (Rogers 1947). These early Egyptian physicians were also priests who treated general, oral and spiritual components of health. These holistic health care practitioners understood that influencing human behavior and social circumstances was key to maintaining one's physical well-being.

The World Health Organization (WHO) describes health as the physical, social and psychological well-being of the individual, not just the absence of disease (Hellberg and Makela 1994). Yet even WHO's definition of health lacks the expansive meaning that embraces a person's group affiliations or spirituality. Taylor, in the quotation above, places the importance of the human body in relationship to the other dimensions of life.

This focus on the dynamic between an individual and his or her environment incorporates all the elements of health and provides the underpinning to the quality of health care that is vital to underserved communities, particularly communities of color. There are several reasons for a broad focus. First, it is unlikely that any health delivery system will be effective in treating an individual isolated from his or her family and community. People seldom become ill without their family, friends, or others whom they trust being aware of their condition. People also often seek advice about cause and/or treatment of illness from friends and family prior to seeking professional care.

Secondly, the public health community has become increasingly aware of the role that values, belief systems, and spirituality play in maintaining individual health. Different population groups with similar illnesses and treatments can have different treatment outcomes that may be due in part to their spiritual beliefs, will and faith. Several authors suggest that some so-called "incurable" disorders have been eliminated by belief, will, and faith. These phenomena, including spontaneous remissions, fall within the context of metaphysics and embrace spiritual well-being (Chopra 1989). Dismissing, ignoring, or deriding the spiritual dimensions in the lives of underserved populations, especially populations of color, serves only to alienate them and promote their underutilization of available services.

Furthermore, treating a particular health condition without placing it in the context of the larger physical and social environment is both shortsighted and wasteful. We know from research, for instance, that physical and social environments are linked to several disorders. Studies implicate lead in contributing to learning disorders and anti-social behavior, including violence. Some research also links mercury to certain neurological and reproductive disorders. Consequently, dentists who limit their concern to the

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amount of mercury in amalgam fillings, but ignore the fact that their patients consume large amounts of mercury-polluted fish, miss the opportunity to fully understand the broad factors that may affect the health of their patients and will surely fall short of effectual treatment or interventions.

Changing Views of Health Care and Disease

While physical disease, disability, dysfunction, and premature death have long been the primary focus of modern medical care, secondary social and psychological parameters are now gaining increased recognition and acceptance (Giorgi 1974). Public health practitioners, departments of community health, preventive medicine and dentistry, and the general public increasingly recognize the social and behavioral factors that along with physical factors affect health and health care.

The face of disease in modern society is also changing. Infectious diseases have lost their prominence as the major killers of the population. A recent report from WHO indicates that by the year 2020 chronic diseases will surpass infectious diseases as the major killers and will account for 76 percent of the world's deaths (Rutter 1998). Heart disease, cancer, diabetes, cirrhosis, and other chronic diseases advance social and behavioral risk factors, stress, malnutrition, and poverty in contributing to poor health (U.S. DHHS 1985). Economic strife and other global risk factors, like wars that destroy the environment, are also growing health issues. The combination of these factors is slowly changing the way diseases and disabilities are introduced into populations.

Community and the Underserved in Modern Health Care

To earnestly address the range of needs implicit in a broader concept of health, one must also accept the fundamental importance of community. In *Community Health Psychology*, De La Cancela, Chin, and Jenkins (1998) define a community as "individuals who share certain commonalities be they cultural or geographical, social or political." This definition expands the traditionally narrow view that community refers only to groups, such as people of color or underserved populations. Wade Nobles (1980) goes a step further, defining community as "experiential commonality," that is, the sharing of a particular experience by a group of people. In a broad context, the term "underserved" refers to any group of people without access to available resources, either human or material, to enhance their quality of life. Examples include children who attend inadequate schools and lower income communities which do not have access to adequate sanitation and other public services.

In the context of health, underserved communities are demographically diverse. They consistently include groups who have disproportionate health needs and corresponding disparities in health due, in part, to a lack of geographic and/or financial access to health care. The underserved may include single mothers, the working poor, unemployed single men, people of color, elderly poor individuals and couples, low-income children, the homeless, and inner city and rural residents (Warren 1980). According to Nobles, then, the common experience that makes these groups underserved is their inadequate access to health care. Using this definition of underserved, interventions can more easily be designed, targeted and evaluated.

Thus, a major barrier to being healthy is inadequate access to care. Oftentimes, individuals whose circumstances overlap them in a number of underserved groups experience a layering effect, which compounds the problem and can worsen their health status (Warren 1990).

II. Describing Oral Health within the Broader Concept of Health

Within this expanded definition of general health, the physical, social, and psychological importance of oral health cannot be overstated. The reasons for this include:

- Oral health is integral to physical health. An individual must maintain his or her dental and maxillofacial structures in optimal anatomical and physiological states to be physically healthy.
- Socially, well-maintained and healthy oral structures and functions allow an individual to thrive in this complex society (i.e., employment and school).
- Psychologically, a lack of oral health can be a barrier to positive self-esteem and optimal psychological development. Missing teeth and halitosis can, and often do, lead to negative self-images, lack of self-confidence, and self-defeating behaviors. (Eds. Cohen and Gift 1995)

Like other maladies, most oral diseases and dysfunctions are chronic conditions, driven by social, behavioral, cultural, and economic factors. Because underserved communities include high-risk patients and special populations who have needs beyond simply preventing dental disease, they need more inclusive oral health care. Despite this need for holistic care, however, support systems and health delivery systems are seldom comprehensive enough, leaving many people chronically underserved.

For underserved populations, dentists are often forced to address health concerns only in the context of ill health and adverse living conditions. While dental professionals eliminate disease and prevent dysfunction by examining and treating oral and maxillofacial structures regularly, dentists who serve underserved populations must provide curative treatment for oral chronic conditions in addition to crisis care. The traditional “medical” model used by most dentists, however, does not allow the time or opportunity to set and address preventive priorities.

One way to better reach underserved communities is to coordinate and increase referrals between primary medical and dental practitioners because populations who need primary medical care generally also need oral health care. Holistic health care systems with easy, user-friendly access are critical to improving health in underserved communities. More and different public health teams must be developed to meet holistic health care needs (Terris 1992). To be effective, health care systems need to become multi-dimensional with the capability to address both medical and dental issues.

Oral health services must be integrated into the general health continuum. Leavell (1965) describes this continuum as “levels of prevention.”

- Primary prevention is effective in the absence of disease (i.e., pre-pathologic). This level requires health education, disease prevention, and health protection strategies (i.e., water fluoridation, sealants, prophylaxis, etc.).
- Secondary prevention eliminates or reduces diseases in their early stages. While this stage of prevention is effective, it is also more expensive, requires more technology, and is not as efficacious as primary prevention.
- Tertiary prevention requires extensive rehabilitation and surgical procedures, which are more expensive and require more provider training. It is less effective than primary and secondary prevention in improving health because it targets diseases in their later stages.

Primary prevention is more effective, less costly and requires less technology than other levels. Oftentimes primary prevention strategies do not require a dentist. Methods such as proper water fluorida-

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tion, improved nutrition, dietary encouragement and/or modification, and better personal hygiene occur outside the dental office. Looking through this lens, clinical oral health services become secondary to ensuring adequate primary prevention.

To reach the goal of integrated oral health care, assuring primary prevention services and improving access to care are two essential strategies. A third and possibly most important strategy is improving oral health policy, especially as it relates to prevention services or improving access to care. Adequate funding for services is also a key policy area. Developing oral health policy should start with a careful assessment of need. It is important to clearly understand the related health and oral health needs of underserved populations by first scientifically assessing their oral health status and then identifying associated enablers and barriers, many of which are socially, behaviorally, culturally, or economically related. The public policy context for oral health, then, fits appropriately within a larger social milieu to ensure the most complete form of care. With such limited historical attention given to oral health policy, the result has been unplanned policy focused on crisis care with little focus on disease prevention and oral health promotion.

Oral health professionals have the means to prevent most oral diseases; the technology is available (Warren 1996). All too often, however, underserved communities cannot access the systems to obtain this technology. To improve oral health for underserved communities, oral health care providers should strongly focus their attention on policies that target current technology effectively to prevent oral disease and promote health. This can be even more important than focusing on new technologies and cures. Policy must assure access to available technology for underserved communities.

Thus, dentists must shift their focus to total well-being for all populations, rather than focusing on curing or fixing specific oral diseases and maladies in a given population. Further, oral health policies must align available resources with immediate needs. This allows prioritized services to reach underserved populations because these groups often have the greatest health needs.

III. Defining the Oral Health Needs of Underserved Communities

Even as biomedical and public health research improves and is integrated into the health delivery system, income, racial and ethnic disparities, and the gap between those who receive services and those who do not continue to widen. Few of the biomedical and public health successes made in recent years have been equitably translated to underserved groups. The burdens of poverty and abuses, in addition biases of age, gender, education, income, race, and ethnicity limit the adequacy of such biomedical health approaches, even if they were available to underserved communities (Sigerist 1940). Scholars have known for over a century that health is adversely impacted by factors outside the control of health delivery systems.

- William Alison, Professor of Medical Jurisprudence at Edinburgh University, described the association between poverty and disease during his experience with epidemic typhus and relapsing fever in 1827, and again during the cholera epidemic of 1831. While Alison did not specifically address oral conditions, the literature from this time clearly identifies oral diseases within this context.
- In 1826, French scientist Louis Rene Villerme described impoverished living conditions that caused premature death (Terris 1992).
- John Snow's classic work on cholera described the various ways in which poverty and deprivation introduced the causative agents to the host and the environment (Terris 1992).

- Medical historian Henry E. Sigerist stated that “health is promoted by providing a decent standard of living, good labor conditions, education, physical exercise, culture, and means of rest and recreation.” By recognizing the value of a comprehensive approach to health, Sigerist called for the coordinated efforts of statesmen, laborers, industrialists, educators, and physicians to this end (Sigerist 1946).

The common risk factor for most adverse health conditions was, and continues to be, poverty. Because poverty is a social risk factor for disease, preventing disease due to poverty requires a full-fledged social response.

Recommendations for Improving Oral Health

Many of the recommendations for improving general health can also be applied to improving oral health. Chronic diseases like heart disease, cancer, and diabetes have no real biomedical cures, yet medical research efforts continue to primarily focus on finding cures instead of preventing disease. Of the dollars spent on health care in the United States, less than five percent target prevention; at the same time, the United States claims to have one of the best health care systems in the world (Warren 1997).

The majority of investment and efforts in oral health care and research are dedicated to curing oral diseases, yet cures for major oral diseases are distant. Thus, preventing oral diseases and promoting oral health are imperative to improving one’s overall health. Few of the already limited oral health funds go toward the prevention of oral diseases and dysfunctions.

Genuine improvement in oral health spending and policies is only possible with a paradigm shift from curing disease to disease prevention and promoting oral health. Ideally, the goal is successful primary prevention through overall health promotion. Nonetheless, in the midst of existing diseases and dysfunctions, disease prevention is an essential and critical step in achieving this goal.

To address oral health needs effectively, a comprehensive view of direct oral diseases and dysfunctions should at a minimum include: dental and periodontal infections, mucosa diseases, oral cancers, inherited diseases, injury and trauma, and chronic and disabling conditions, including temporomandibular disorders (Kevric.com 1999). However, the most efficacious method of specifically defining oral health needs of a population is a community-based approach using principles of public health.

Community-Based Oral Health Needs

Data from the National Center for Health Statistics (NCHS), National Institute of Dental and Craniofacial Research (NIDCR), the American Dental Association (ADA), and other sources indicate that oral health and oral health care continue to improve on a national level. During the last decade, for instance, progress in oral health care and research has led to a decrease in the incidence and prevalence rates for most oral diseases and disorders. Despite these decreases, more than one-third of all tooth surfaces in adults, ages 35 to 44 years old, have been affected by decay, while 44 percent of the population, ages 75 or older, are missing all of their teeth.

In contrast to decreased incidence and prevalence for many oral diseases, oropharyngeal cancer strikes an alarming 30,000 people in the country; 8,000 people die of the disease annually. But, because oral health care is a life-long process in response to a broad array of conditions ranging from baby-bottle tooth decay, to caries in primary and permanent teeth of children, to tooth replacement in adults, one or more oral diseases still affect most people in the United States. Interestingly, however, sources indicate that 80 percent of tooth decay is concentrated in 25 percent of the children in the United States.

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Even though conditions like dental caries, periodontal diseases, and oral cancer adversely impact all people regardless of income, education, gender, races, and ethnicity, those most impacted by these diseases are those who cannot access oral health services (Selwitz 1996; Drury 1996; U.S. DHHS 1999). A closer look at the national statistics that outline oral health successes and remaining needs indicates significant gaps in subsets of the national topography, particularly in and between underserved populations, specifically in terms of dental caries, periodontal diseases, tooth retention, tooth loss, and occlusal characteristics. While measures of general and oral health remain difficult to record, documenting the absence of disease has been used to chronicle health status. Consequently, lower disease rates have been one method to monitor and report the health of an individual and/or group. To identify strategies for disease prevention and oral health promotion, it is necessary to examine the statistics for these conditions more closely.

Dental Caries

Data gathered by NCHS, NIDCR, the ADA, and other sources for the years 1988-1991 indicated:

- Coronal caries rates in the primary and permanent teeth of Mexican-American and non-Hispanic black children and adolescents, ages one to 17, were similar for mean percentage of decayed, missing, and filled tooth surfaces. Both groups had rates significantly higher than those for non-Hispanic whites. (Kaste 1996)
- Non-Hispanic blacks and Mexican-American children and adolescents had higher percentages of decayed surfaces and lower percentages of filled surfaces compared to their non-Hispanic, white counterparts, which is a direct measure of oral health services provided.

The Third National Health and Nutrition Examination Survey (NHANES III), Phase 1, also revealed patterns in the high-decay, low-filled surface rate that indicate the amount of unmet needs and services provided are directly related to dental caries.

- Mexican-Americans and non-Hispanic blacks who are dentate (with teeth) across all age ranges had more decayed and not-filled/treated surfaces than non-Hispanic whites. In fact, non-Hispanic blacks and Mexican-American dentate persons averaged about half the number of decayed and filled coronal tooth surfaces as non-Hispanic whites, leaving a high number of decayed, untreated tooth surfaces (Winn 1996). Again, these data are a measure of services provided.
- Of the decayed and filled surfaces, decay accounted for 30 percent of tooth damage among non-Hispanic blacks and 20 percent of tooth damage in the Mexican-American population. In contrast, decay accounted for only six percent of the tooth damage within the non-Hispanic, white community.

Periodontal Diseases

While dental caries have historically been used as the best measure of oral health, Brown, Brunelli, and Kingman (1996) focused on the prevalence of periodontal disease. To identify oral health in this context, they used moderate or severe loss of attachment, moderate or deep pockets, and recession as criteria in their analysis. Their analysis revealed the following trends in periodontal diseases.

- Females in the study had better periodontal health than males.
- Non-Hispanic blacks and Mexican-Americans had better periodontal health than their non-Hispanic white counterparts.
- Adults showed a higher incidence of periodontal diseases than individuals of younger age.
- The severity of these diseases typically became worse with increased age.

Tooth Retention and Loss

Tooth retention, in terms of tooth loss and edentulism (a condition in which a person has lost all of his or her natural teeth), is another measure of oral health. The NHANES III analysis found that the incidence of tooth loss and edentulism has declined over the last few decades.

- Tooth loss and edentulism have been declining over the last few decades. Almost 90 percent of the U.S. population have some teeth.
- Tooth retention is directly related to age, but not specifically to gender; incidence rates were also loosely associated with race and ethnicity.
- Mexican-Americans had the lowest rates of tooth loss and non-Hispanic blacks had the highest.

From a psychosocial perspective, as suggested earlier in this paper, traumatized or missing teeth can be very damaging to an individual's psychological well-being. To measure the extent of this problem, Kaste, Orft, Bhat, and Swange (1996) reported incisor tooth trauma for dentate persons, ages six to 50 years.

- Males had a higher prevalence of tooth loss or trauma than females in all age categories.
- Researchers found no differences in incidence rates between blacks and whites.
- Older age groups showed higher numbers of traumatized teeth than their younger counterparts.

Occusal Characteristics

Because occusal characteristics have both physical (i.e., eating) and psychological (i.e., aesthetic) implications in health, they provide an additional measure for oral health comparison. Epidemiological analyses revealed:

- Eight percent of the U.S. population has a severe overbite of 6 millimeters or more.
- Diastmas (space between anterior central incisors) of more than 2mm occurred in 19 percent of eight to 11-year-olds, six percent of two to 17-year-olds, and five percent of 18 to 50-year-olds (Brunelle, Bhat, Lipton 1996).
- Non-Hispanic blacks had fewer malalignments in mandibular incisors than other groups. They were also three times more likely to have diastmas greater than 2mm.

Other Factors

While age, gender, race, and ethnicity affect the prevalence of oral diseases (with the exception of broken teeth), one must seriously consider issues of education, income, and geographic locale in describing community-based needs of the underserved and the impact of these factors on oral health needs. In fact, the oral health status of the elderly and migrant workers is significantly influenced by these factors.

For instance, the elderly, particularly the elderly poor, are now living longer and have an increasing need for oral health assurances. Additionally, because more elderly are dentate now than in the past, they require more than simple replacement dentures. Within the elderly population, unmet oral health needs are much greater among those who have teeth. However, it is important to clarify that using age alone to define the oral health needs in the elderly is inappropriate because of the tremendous variability in their physical, mental, and medical health status.

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Migrant workers and rural residents are another population with a tremendous number of unmet oral health needs for a variety of reasons. Their limited access to primary prevention strategies, like water fluoridation, is linked mostly to geography or location (Isman and Isman 1997). Frequently, these communities also have limited access to dentists, which may delay them from seeking secondary and tertiary care. As a result, these populations have higher prevalence of emergency care needs and experience more undue suffering than other groups. Financial barriers and the unequal distribution of dental personnel only heighten the problems of migrant workers and rural populations in seeking oral health care.

Policymakers and oral health care workers should conduct more research to better determine the necessary changes in public policy that will address the concerns of these communities.

IV. Barriers to Oral Health Care Service

Public Health Law 89-7491966 states:

The fulfillment of our national purpose depends on health and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living.

Despite the suggestions of this and other United States public health laws, numerous barriers still exist that prevent communities from accessing the care they need, leaving them underserved. Before policymakers and dental care providers revisit public health laws to remedy these problems, they should be aware of barriers and how they impact the oral health of the underserved.

Financial and Economic Barriers

Financing dental services remains one of the most significant barriers to accessing necessary oral care. For many underserved populations, financial barriers account for their failure to obtain oral health care at the primary, secondary, and tertiary level. The National Access to Care Survey indicates the following for the general U.S. population.

- The major reason for not obtaining dental services was financial (71.5 percent).
- Dental care demands, characterized as expressed “wants,” were higher than medical and surgical care demands.
- Financial inability to pay for care accounts for a disproportionate percentage of unmet dental needs. Statistics from as far back as 1987 illustrate that out-of-pocket, per capita payments for dental care in the United States were \$165 compared to \$122 for ambulatory medical services (Mueller 1998).

Because few oral health problems are life-threatening, most people delay treatment for long periods of time, which only increases the severity of the condition when they finally do seek care. With this in mind, it is less surprising that those who have the greatest unmet dental care “wants” were adult women, African-Americans, those in fair to poor health, those who live in the South, and low-income individuals (i.e., 150 percent of the poverty level and were uninsured) (Mueller 1998).

Insurance Barriers

Health insurance, even if dental coverage is not included, is a clear indicator of one’s ability to access dental care. The National Health Interview Survey reports:

- Children without health insurance are three times more likely to be unable to get dental care when they need it than children who are privately insured. For many children, being poor, a minority, and uninsured are all associated with lack of access to dental care.
- Working age adults (18-64) are four times more likely than their privately insured counterparts to be unable to get dental care when they need it.
- Older adults (65 and older) with no health insurance are twice as likely as privately insured adults to be unable to get dental care when they need it.

Geographic Barriers

Even though the number of active private practitioners seems adequate, disparity in the geographic distribution of these providers remains a barrier to service because dentists are not equally accessible in all regions. For example, the East South Central region of the United States has the smallest distribution of dentists. Historically, states within this region (Alabama, Kentucky, Mississippi, and Tennessee) house large numbers of underserved populations, based on the designation of federal Health Professional Shortage Areas (HPSAs). Geographic location has long been, and still remains a barrier to accessing oral health services.

- The largest distribution of professionally active dentists was found in the mid-Atlantic and Pacific regions (18 percent) respectively, while the smallest distribution was in the East South Central region (4.9 percent).
- Higher income areas have 66 percent more dentists per capita than low-income areas.
- Rural counties have fewer dentists than urban counties.
- Incentives to practice in rural areas are limited.
- Rural residents often do not seek services because of long and inconvenient travel time to the dentist.

Beyond the uneven regional distribution of providers, the number of dentists within a specific community also affects access to care. Federal efforts to improve the distribution of primary care providers have increased the number of providers both in urban and rural areas. Nonetheless, the national distribution of dentists according to HPSAs remains relatively unchanged over the past 15 years. While one might assume that increasing the number of dentists in a given area would improve access, little research exists to determine if that is actually the case. Moreover, no evidence exists to suggest that a larger supply of dentists improves oral health status.

Workforce Barriers

The infrastructure of dentistry, the willingness of dentists to provide high quality treatment to all populations, and reimbursement mechanisms can either become barriers or enablers to oral health services.

- According to the ADA, there were 152,205 professionally active dentists in 1996. Of those, 92.1 percent (140,248) were active in private practice.
- Approximately 80 percent of dentists indicated general practice as their practice, research, or administration area.
- The majority (81.5 percent) of active private practitioners worked full time in their private practice (30 or more hours per week) (ADA 1996).
- In a 1998 ADA survey of practitioners, the number of active dentists enrolled as providers in Medicaid ranged from one (DE) to 3,788 (NJ).

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Barriers Within the Dental Profession

The practice behaviors of dental professionals can have a considerable impact on the oral health of populations, and practitioners can differ greatly in their approaches to care of different populations. Dentists who do not value and practice in a culturally competent manner and who blame patients for being non-compliant may, themselves, be barriers to improving the oral health of the people they serve.

Though lack of cultural understanding occurs in both rural and inner city areas, the greater availability of dentists in urban areas provides better access to other providers (Buckley 1974). Similarly, providers' biases about racial and ethnic groups can lead to culturally offensive or even racist behavior in the health care setting. As a result of some of their biases, these dentists often choose less expensive treatment options because they may believe their patients do not care about their oral health. As a result, a dentist may choose to extract instead of save teeth. Characteristics and practice behaviors of some dentists result in rural people seeking treatment only for emergency care. A dentist who does not understand a rural culture, for instance, can become a barrier to the successful delivery of oral health services in these areas. Dentists who do not understand the living conditions of urban America may also become barriers to care.

V. Availability and Support for Oral Health Services

The Future of Public Health Report (1988), published by the Institute of Medicine, indicates that states “bear primary public sector responsibility for health.” At the primary prevention level, both the federal and state government have responsibility for general and oral health of residents at regional, state, and local levels. In 1994, the Centers for Disease Control and Prevention (CDC) reported that “substantially more oral health related assessment, policy development, and assurance activities occurred in states with a direct commitment of human resources.” That is, there were more dental and oral health activities in states where there was a full-time dental director in the state health agency than in states where there was no director or no oral health program at all.

As early as 1954, the ADA began urging constituent dental societies to strengthen oral health programs in their respective states. Specifically, they suggested that each state appoint a capable state dental director. Despite such recommendations, recent years have seen a decline in the number of dental personnel in state agency leadership roles (Isman and Isman 1997).

The National Dental Association (NDA), which represents more than 15,000 African-American dentists, dental hygienists, dental assistants, and dental students, also advocates increased participation in public health activities. Since its inception, the NDA has supported public health programs for improving the health of the underserved. In that regard, Clifton O. Dummett notes the degree of interest African-American dentists maintain in political organizations and activities, stating that “political and social concerns have many times overshadowed their bio-scientific yearnings, technical knowledge, and research aspirations.” (Dummett 1974) Still, endorsement for more state dental directors and more active involvement in providing oral health care go unheeded, with the majority of states sorely lacking oral health programs and activities.

The Hispanic Dental Association (HDA), a member organization that represents Hispanic/Latino dental professionals and students, is committed to addressing existing disparities in oral health and in access to care in Latino communities. Along with the other major dental associations, the HDA supports policies

at the federal and state levels that focus on provision of access to dental services, particularly for disadvantaged children.

Improving Access to Oral Health Care

Improving access of underserved populations to primary dental disease prevention requires collaboration between federal and state governments. Several possible avenues for accomplishing this collaboration merit further discussion, such as water fluoridation, dental sealants, improving insurance coverage for dental services, and ensuring that all eligible children receive EPSDT screening and appropriate treatment services for identified problems.

WATER FLUORIDATION

Over the past 50 years, fluoridating the water supply has contributed greatly to reducing dental caries. Even though the per capita cost of water fluoridation over an individual's lifetime is less costly than one dental filling, 38 percent of all Americans on public water systems do not have access to fluoridated water to protect their teeth (U.S. DHHS 1999). Community water fluoridation is implemented through a partnership between federal (CDC) and state government. In recent years, limited funding for oral health programs has led to reduced funding for water fluoridation programs. Additionally, funding is needed to monitor the fluoride levels in the public water supply to prevent fluorosis from occurring.

APPLICATION OF DENTAL SEALANTS

The use of dental sealants has also been effective in reducing dental caries, especially among children. *Healthy People 2000* recommends that 50 percent of children in the United States have these protective barriers against tooth decay placed on the biting surfaces of their teeth. Percentages indicate that only 9 percent of children with sealants and dental visits had incidence of untreated decay; in contrast, 37 percent of children without sealants or dental visits had untreated tooth decay. Despite the effectiveness of this primary preventive method, less than 30 percent of U.S. children have received it (Isman and Isman 1997).

INSURANCE COVERAGE FOR DENTAL SERVICES

Dental insurance, both public and private, enables individuals to receive oral health services. In 1996, approximately 117 million people had private dental insurance (Isman and Isman 1997). The insured population has experienced profound improvements in oral health, across all age groups, suggesting that access to dental services is instrumental in maintaining oral health. However, even while the number of people with insurance continues to increase, the amount and type of dental services covered varies tremendously by dental coverage plans.

Currently, the number of dental managed care plans is low but is increasing. Historically, oral health services have not been a real focus of managed care. Data for 1995 (Isman and Isman 1997) breaks the dental HMO business into three general categories.

- 3.8 percent of dental managed care business is Medicaid.
- 3.3 percent of dental managed care business is Medicare.
- 92 percent of dental managed care business is some form of private market benefits.

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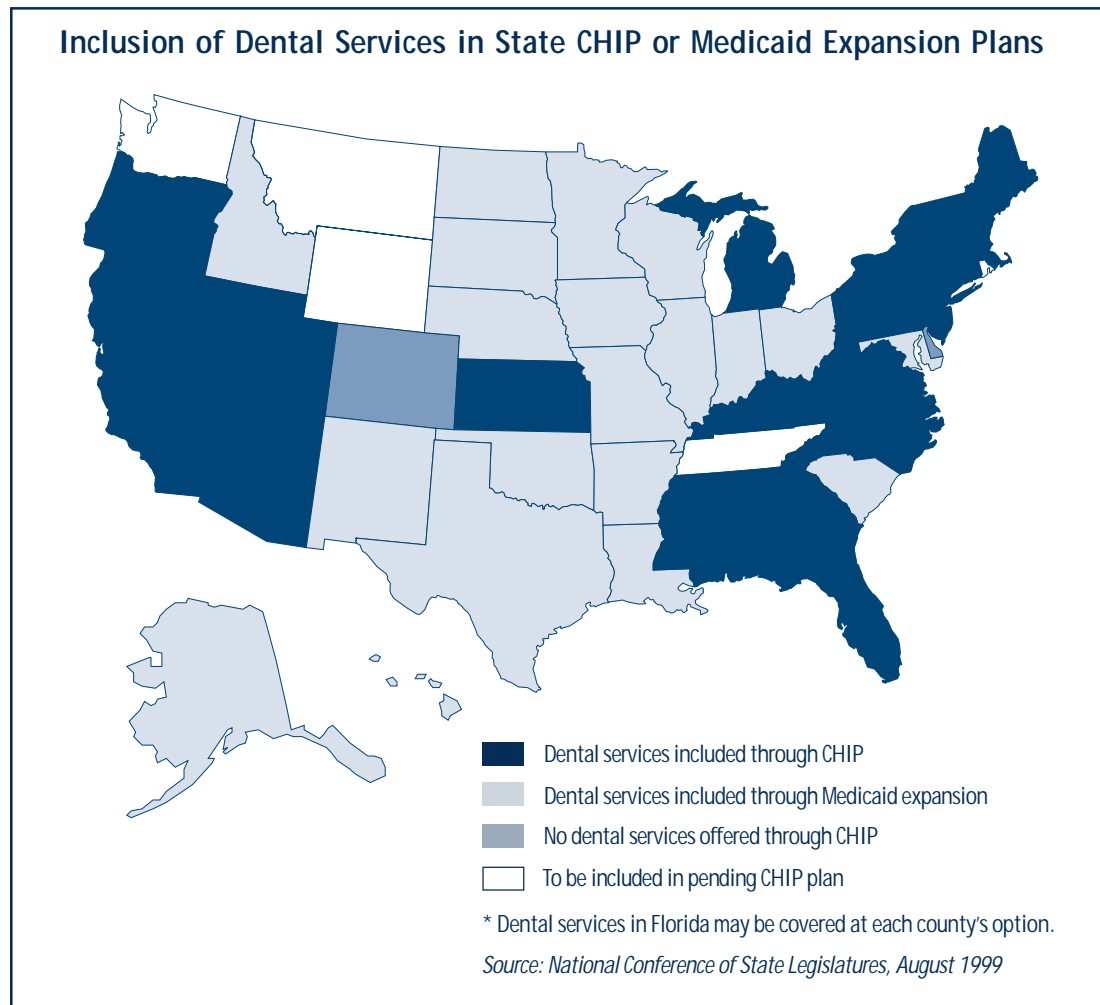
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Increasingly, high need populations who receive dental care do so through managed health care arrangements funded by primarily by Medicaid and, to a lesser degree, Medicare and the Children's Health Insurance Program (CHIP). The relationship between the programs and dental services is outlined below.

Medicaid

As the largest provider of medical and other health-related services for low-income populations, Medicaid currently covers approximately 42 million people (Urban Institute 1998). Under Medicaid, states are required to provide all Medicaid-eligible children under 21 years with comprehensive dental services. States may choose whether or not to provide adults with dental services. In 1997, the Health Care Finance Administration indicated that dental services were provided in 12 states for categorically-needy and medically-underserved adults. Six states offered dental services to adults as a part of demonstration programs. No information was given on the scope of services provided.

Although the federal government sets broad national guidelines, states have the authority to design programs according to their needs by setting eligibility standards and determining the type, amount, duration, scope, and rate of payment for services provided. Because the oral health needs of underserved populations typically do not correspond to state-perceived needs, the oral health status of these populations continues to decline.



In addition, dentists' behavior, including refusals to see Medicaid patients and longer waiting times for appointments, undoubtedly adds to poor utilization rates among underserved populations. While there is much to address in dental coverage under Medicaid, other barriers to access, like those mentioned earlier in this paper, must also be resolved if improvements in oral health for underserved populations is expected.

Children's Health Insurance Program

CHIP provides states the opportunity to expand insurance to nearly 2 million more children beyond those currently eligible for Medicaid. States can provide coverage through the expansion of existing Medicaid plans, through the adoption of a non-Medicaid plan or some combination of both. States choosing to expand existing Medicaid plans must provide standard Medicaid benefits for children.

Under a non-Medicaid plan, states can offer dental coverage in one of three ways:

1. equivalent services to those offered to federal employees in standard PPO plans, state benefit plans, or state HMO plans
2. the actuarially determined dollar value of the three "benchmark coverage" plans
3. currently offered U.S. Department of Health and Human Services "Secretary-approved coverage."

Policymakers need to be aware of the opportunities to expand oral health services through CHIP.

As of August 1999, according to the National Conference of State Legislatures:

- 22 states and five U.S. territories provide dental services to children through Medicaid expansion under CHIP.
- 23 states provide — at a minimum preventive, diagnostic, basic and restorative services — to children under their CHIP plan.
- Two states offer no dental services under CHIP.
- Two states have CHIP plans pending.
- One state has a Medicaid expansion plan pending.

EPSDT Screening and Treatment Services

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a pediatric component of the Medicaid program that does not include adults. While the program began in 1967, guidelines were not developed until 1980.

- EPSDT is designed to screen eligible children through the age of 21, to detect correctable conditions and provide the appropriate treatment.
- As of 1989, all states were required to provide EPSDT screening for vision, hearing, and dental services at intervals that meet reasonable standards of medical and dental practice. States were also ordered to provide medically necessary screening for vision, hearing, and dental services regardless of whether the services coincide with established periodicity schedules for the services.
- Most importantly, states were required to treat or ameliorate the problems identified by screening of EPSDT participants regardless of whether the necessary services were included in the state Medicaid plan.

In spite of these requirements, most states screen only a low percentage of their eligible children. Even with recent improvements in financial access to services, only 36 percent of Medicaid-eligible children see a dentist annually. Moreover, these children received emergency care (i.e., extraction) far more often than they received preventive services (i.e., cleaning) (Edelstein 1998).

Providers and patients alike must strive to improve accessibility and acceptability of dental services

CHIP PROVIDES STATES THE OPPORTUNITY TO EXPAND INSURANCE TO NEARLY TWO MILLION MORE CHILDREN BEYOND THOSE CURRENTLY ELIGIBLE FOR MEDICAID.

PROVIDERS AND PATIENTS ALIKE MUST STRIVE TO IMPROVE ACCESSIBILITY AND ACCEPTABILITY OF DENTAL SERVICES THROUGH PUBLIC HEALTH PROGRAMS.

PEOPLE OF COLOR,
PARTICULARLY
AFRICAN-AMERICANS,
HISPANICS,
AND NATIVE AMERICANS,
CONTINUE TO
HAVE SIGNIFICANT
UNMET HEALTH
NEEDS.

through public health programs. As managed care continues to evolve, strategies to assure oral health services and to integrate them into general health plans must evolve, too. For underserved groups who have limited access to the private market because of education, age, and/or employment status, public strategies are vital. While it appears that certain segments of the nation's population have access to oral health services, underserved communities remain largely neglected.

Addressing Levels of Prevention among Underserved Communities

In terms of primary prevention, dentists and pediatricians have worked closely together for many years to determine the patterns in and early risks of oral diseases, particularly dental caries, which are the most prevalent chronic dental disease among children. It is reasonable to expect that preventive and curative care should be available to all children, including those from underserved communities.

School-Based Health Systems

In 1979, dentists and pediatricians developed a school-based health delivery system in Hartford, Connecticut that provided medical and dental services to children and their families. These services had the advantage of both geographic and financial accessibility because they were located at the school facility. Most of the care provided was reimbursable because most of the children qualified for Medicaid coverage. Because the services were provided on the same campus as the school, children missed less school time. Additionally, by giving permission for their kids to receive medical and/or dental care prior to diagnosis, parents did not have to miss work. As an extra level of disease prevention and health promotion, teachers integrated and taught health education as part of the regular curriculum.

With the exception of the school nurse, all of the health professionals were employed by a local community health center that sponsored the school health services. The school nurse, who was also a nurse practitioner, provided most of the medical care, while a National Health Service Corps dentist and dental hygienist provided oral health services. Even though long-term evaluation of the program did not occur, short-term assessments indicated that the system provided excellent, high quality care at cost-effective rates through Medicaid reimbursement (Warren 1980). This primary prevention strategy may serve as a blueprint for future studies.

Racial and Ethnic Populations

An attempt to address medical access in demographically diverse communities in California found that the supply of physicians was strongly and inversely associated with a community's proportion of African-American and Hispanic residents. The supply of physicians differed only slightly across low-income areas versus higher income areas with similar racial and ethnic compositions. While data are not available, it is reasonable to assume that this pattern applies nationally and that the supply of dentists will follow a similar pattern.

Additionally, Linn (1972), Warren (1979), and Montoya (1979) found that African-American and Hispanic dentists disproportionately treat large numbers of African-Americans, Hispanics, and low-income people. Thus, increasing the number of African-American and Hispanic/Latino dentists should improve access for these communities.

Secondary prevention requires interaction with dental professionals during the early stages of disease. The driving forces in secondary prevention, then, are issues concerning access to oral health services. For

instance, because communities require clinical care by dental professionals to meet their oral health needs, geographic and financial access to these services strongly influence the oral health status of a population.

VI. Public Sector Oral Health Responsibilities

In the past, underserved populations relied on the public sector at federal, state, and local levels to maintain their oral health. Although the public sector has accomplished much in terms of population-based prevention, one-on-one prevention and curative care strategies, underserved communities need more than what has traditionally been offered. People of color, particularly African-Americans, Hispanics, and Native-Americans continue to have significant unmet health needs.

In 1985, former Secretary of Health and Human Services Margaret Heckler wrote in the federal publication *Report of the Secretary's Task Force on Black and Minority Health*, “[There is] a continuing disparity in the burden of death and illness experiences by Black and other minority Americans as compared to our nation as a whole. That disparity has existed ever since federal record-keeping began, more than a generation ago. Although our health charts reveal steady gains in the health of minority Americans, the stubborn disparity remains an affront to both our ideals and to the ongoing genius of American medicine” (Heckler 1985).

Oral disease among racial and ethnic populations follows trends similar to the general disease patterns the task force reported. Even when financial barriers are reduced, people of color, low-income, rural, and elderly persons still have major problems accessing oral health services. Language barriers, learning patterns, cultural biases, racism, and phobias not only prevent patients from accessing oral health services, but also prevent dentists from providing the best care technically available (Buckley 1974). Although most oral diseases are preventable, many children and adults do not benefit from the technology available to address these problems because of difficulties accessing care. Those who have access to care as children, often lose it as they enter adult life and elderly years. Thus, any oral health gains are lost.

Rethinking old policies and possibly articulating new ones are necessary to ensure oral health for all populations. Specifically, all persons would benefit from and should have access to population-based preventive strategies, as well as individual clinical prevention in the dental setting. Moreover, it becomes an ethical imperative that emergency treatment, though expensive, be provided regardless of one’s ability to pay. Revisiting these and other oral health care policies will improve access to oral health care services for many underserved communities.

State Oral Health Responsibilities

State and local governments are responsible for ensuring the health of their residents. To help define government’s role in oral health care, the Association of State and Territorial Dental Directors (ASTDD) established guidelines for oral health by categorizing State Dental Directors’ responsibilities into three areas: assessment, policy development, and assurance. These guidelines follow core principles of public health by clearly identifying problem areas, reviewing programs or activities initiated to address those problems, designing new programs and methodologies, and evaluating outcomes to determine effectiveness. While the authority and responsibility for oral health varies throughout the country, the ASTDD recommends the following conditions to maximize the opportunity to promote oral health at the state level.

TO SUSTAIN LONG-
LASTING ORAL
HEALTH FOR ALL
COMMUNITIES,
ORAL HEALTH
SERVICES MUST
BE AVAILABLE,
ACCESSIBLE, AND
ACCEPTABLE.

1. Each State Health Officer should ensure appropriate authenticity of the dental unit.
2. The dental unit should be positioned to provide overall agency coordination and leadership for oral health.
3. The unit should have responsibility for assessment, policy development, and assurance for oral health services.
4. Sufficient capacity and infrastructure should be available to help determine agency priorities, set agendas, develop plans, make funding decision, and establish policies.
5. The state health department, through the Dental Director, can and should assist local health departments in maximizing federal and state resources by avoiding duplication of efforts and curtailing wasted resources.

VII. Oral Health Policy Issues

To sustain long-lasting oral health for all communities, oral health services must be available, accessible, and acceptable.

Available services are suitable or ready for use.

Accessible services are able to be used, entered, or reached.

Acceptable services meet minimum requirements.

Health can only be achieved when enablers (factors that allow or encourage) override the barriers (factors that prevent or discourage). In terms of oral health, then, enablers and barriers should be discussed in the context of improving availability, accessibility, and acceptability of oral health care.

Finance

As the need for oral health care continues to mount, priority setting is imperative. In 1994, the national expenditures for dental care were well over \$1 billion, and little of that was public money. Overall, nearly 63 percent of children and 39 percent of adults do not receive oral health services each year. Only 20 percent of children who are eligible for Medicaid receive dental care each year. Upon retirement, most elderly persons lose their employment-sponsored insurance coverage. After age 65, 85 percent of Americans do not have dental insurance and Medicare does not pay for routine oral health care (Isman and Isman 1997).

Nearly one in four U.S. residents under the age of 21 is eligible for Medicaid. However, only 21 percent of eligible persons had one or more dental visits in 1997 compared to 61 percent of Medicaid-eligible children who had a medical visit. Mothers and children represent 70 percent of the eligible Medicaid enrollees but less than 30 percent of spending. Oral health services accounted for only 10 percent of expenditures. Only 2.4 percent of Medicaid children's health care costs are spent on oral health services. State spending ranges from one percent to 11.8 percent of Medicaid expenditures (Jones 1998). Policy must reduce or eliminate the existing barriers to oral health care.

Availability

POLICY RECOMMENDATIONS

- Make preventive and emergency dental care available to all underserved groups.
- Broaden eligibility criteria to cover an increased number of adults and children, thereby making oral health services more financially available.

OVERALL, NEARLY 63
PERCENT OF CHIL-
DREN AND 39
PERCENT OF ADULTS
DO NOT RECEIVE
ORAL HEALTH
SERVICES EACH YEAR.

Oral health services are generally not available to underserved populations primarily for financial reasons. With the exception of Medicaid-eligible mothers and children, oral health services for underserved populations are confined to specific groups under restricted arrangements. For example, the Indian Health Service (IHS) provides oral health services to eligible members of federally recognized tribes. Their services are provided on or around the reservation. However, American Indians/Alaskan Natives who are not from federally recognized tribes generally do not have access to oral health services through IHS. There are 34 recognized urban Indian programs funded through the IHS that do have the authority to provide services to tribes that are not federally recognized tribes. However, that funding is extremely limited and may or may not be used to provide oral health services.

Federal Medicaid policy towards adults and two-parent families is very restrictive. State Medicaid programs must cover families that meet the 1996 AFDC (Aid to Families with Dependent Children) eligibility criteria. In general, the financial eligibility standards that apply to these adults are much lower than those that apply to children. Furthermore, the non-financial eligibility criteria limits mandated Medicaid coverage to non-disabled adults in two-parent households where the principal earner is unemployed. This policy “forces” low-income fathers to leave their families in order for mothers and children to be eligible for oral health services under the Medicaid program. Rural families are more likely to have two-parent households, which makes the policy particularly difficult for these families. Elderly adults do not generally qualify for dental services through Medicaid and routine dental services are not covered through Medicare.

With the introduction of the CHIP, states have the opportunity to extend coverage for dental services to underserved children. In a 1998 study, the American Academy of Pediatrics (AAP) determined the premium cost that a state would have to pay an insurer to provide children with a comprehensive benefits package including comprehensive dental services. The study showed that the monthly cost per eligible CHIP child for medical and dental services is \$101.47. Approximately 20 percent of the total cost would be for oral health services. Other estimates range between 22 to 30 percent for dental services.

Similarly, the Milbank Memorial Fund (1999) commissioned an actuarial analysis of data from the California dental Medicaid program to project the costs and utilization of pediatric dental services. Based on utilization in California, the resulting estimate for the direct cost of services was determined to be \$16 to \$17 per member per month including administrative costs. This estimate was similar to the AAP study, after adjusting for a difference in administrative costs. These estimates are much greater than historical expenditures for Medicaid dental programs but are consistent with national data on dental spending for all children.

The potential for improving oral health through CHIP is great because this program includes low-income and working families. The safety net is much weaker in dentistry than in medicine, which makes CHIP even more important for oral health services. Both parents and low-income communities indicate the need for oral health services, particularly for children. Despite the decrease in childhood tooth decay, it is still the most common chronic disease among children.

CHIP offers a national strategy to address this problem by targeting those children most at risk. If oral health is a real goal, dental services must be required in all CHIP plans. Primary prevention of oral diseases will have the greatest impact. However, secondary and tertiary care should also be available. As with Medicaid, state CHIP plans should include underserved mothers if positive oral health outcomes are expected for their children and families.

Underserved adults also need to have oral health services made more available. Oral health services for adults should be assured independent of programs for children. In some states, low-income mothers are eligible for oral health services through Medicaid. However, in most instances, if a woman is not a mother, she is not eligible for those services. Oral health services should also be included in the package of medical services available to Medicaid-eligible adults. At a minimum, preventive and emergency care should be offered. Routine curative care should be strongly considered.

Accessibility

POLICY RECOMMENDATIONS

- Identify and encourage enablers for oral health services.
- Reduce barriers associated with obtaining oral health care, such as transportation and child care, to make it easier for patients to access primary care.

Beyond having available services, it is critical to identify and create enablers that will make oral health services more accessible. Oral health needs are seldom life-threatening. While there are many reasons why people do not seek care, cost is the major barrier associated with seeking and utilizing oral health services. Because most oral health services are elective, people have to struggle with whether they perceive that the services are worth the cost or not. Competing needs related to more urgent matters of living, such as food, clothing, or shelter usually take priority over maintaining oral health or going to the dentist. Although financial barriers have been reduced significantly for single mothers and children from low-income families by programs such as Medicaid and CHIP, for most others, financing oral health care remains a major barrier. Expanding the safety net for underserved populations will enable more people from these groups to be eligible for oral health services.

Alternative oral health delivery systems such as school health clinics, oral health services provided at the work place or faith-based health delivery systems will capture some of the groups that the current systems fail to reach. Moving toward population-based public health rather than a focus on serving individual patients is the paradigm shift that must be emphasized. With populations pre-paid, capitation and other financial arrangements based on captive audiences may prove beneficial.

Co-payments or sliding scale payments that often compete with financial needs of families usually result in oral health services being delayed. Costs associated with transportation, time off from work or school to keep dental appointments, and child care arrangements also make accessing oral health services problematic.

Several programs initiated by the federal government have improved the geographical availability of health care providers. In fact, more than 30 programs have been developed using one of three different models to increase access and include:

1. providing incentives to health professionals to practice in underserved areas;
2. paying clinics and other providers who serve people who cannot afford to pay; and
3. paying institutions to support the education and training of health professionals.

**REIMBURSEMENTS
FOR ORAL HEALTH
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TO ONE-THIRD OF
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OFFICES.**

The Government Accounting Office (GAO) evaluated all three models and concluded that none of the programs, although very important, were accountable for showing improved access (Isman and Isman 1997). In 1986, these federal programs, including Medicaid, spent over \$162 billion. Clearly, these and other federal programs must establish process and outcome evaluation systems if they expect continued support. Additionally, a GAO study on school-based health clinics concluded that school-based clinics do improve access though only a limited number of children were included in the study.

Acceptability

POLICY RECOMMENDATIONS

- Ensure that Medicaid reimbursement rates for oral health services are comparable to the usual and customary fees in most dental offices to make groups covered under public health programs more financially attractive to dentists.
- Improve reimbursement rates so they cover overhead costs for providers.

The financing of oral health services in the public sector remains problematic. Medicaid reimbursement rates for oral health services are lower than the usual and customary fees in most dental offices. Therefore, even with financial arrangements through Medicaid, dentists often will not accept eligible children or adults. Reimbursements for oral health services through Medicaid are usually one-half to one-third of reasonable and customary charges in private dental offices.

Moreover, issues related to malpractice and crisis care practices in underserved communities present special challenges for oral health providers. With increasing overhead in dental offices (60 to 75 percent), reimbursement for services must improve and utilization barriers must be reduced. If not, it is unlikely that providers' willingness to participate in publicly financed programs will improve.

Additionally, one should not assume oral health services are included in primary care when, all too often, they are not. Incentives must be designed to encourage access to oral health care wherever primary care is provided.

Sustainability

Sustainability is the ability to fully integrate and maintain the delivery of oral health services to underserved populations. Segmentation of health into subsets of well-being has resulted in a fragmented system that is expensive and very difficult to manage.

Availability

POLICY RECOMMENDATION

- Coordinate oral health services with other health and human services to allow underserved populations to sustain their oral health.

Oral health services are available to subsets of underserved people in some states and not in others. Services are also offered to some people under certain conditions for specific periods of time and not for

others. The array of services range from preventive to emergency care without a rational, scientific or consistent policy for that arrangement. Oral health will not be sustained unless there is strong coordination of oral health services with other health and human services.

Accessibility

POLICY RECOMMENDATIONS

- Require oral health services in all primary health care programs.
- Expand the safety net for underserved populations to include both emergency and preventative dental care to reduce oral disease, disability, and dysfunction.

As previously indicated, oral health services must be fully integrated into primary care. Managed care offers an opportunity to develop comprehensive services to include underserved populations. However, much work is needed to determine how best to include oral health services in a profitable way so that managed care can fully integrate oral health services into their primary care plans.

The importance of oral health must be articulated in language other than health outcomes if the services are to be sustained. Days missed from work or school due to oral health problems are excellent examples of articulating oral health needs to parents, teachers, employees, and policymakers.

Acceptability

POLICY RECOMMENDATIONS

- Include standard questions about oral health status and access as well as utilization of oral health services in national health surveys.
- Create flexible licensure policies to encourage a more even geographic distribution of providers.

People usually sustain and support systems that help them reach their life goals. Psychological enablers such as enhanced self-esteem resulting from orthodontic care or the removal of an oral health barrier, such as missing front teeth, will enhance the value of oral health services for individuals in underserved communities, as well as for society at large. As long as oral health services are isolated from other health and human services, and oral health is perceived as separate from general health, underserved groups will continue to prioritize oral health as important but not urgent, or desirable but expendable.

For oral health providers, particularly for dentists, incentives and enablers are needed to encourage the provision of services to underserved populations. For example, more flexible licensure policies will encourage a more even distribution of providers and will allow states to offer better incentives to attract dentists to underserved communities. Currently, most states have individual licensure examinations. Some regions have designed regional examinations that allow one clinical examination to qualify dentists to practice in several states in that region (e.g., Northeast, Southern, Western and Central Regional Examinations).

The regional licensure policy allows dentists to practice in areas that meet their needs, which should influence the distribution of dentists. The regional concept should be expanded to include all states in the

United States. Dental students are required to take a didactic National Board Part I and Part II examinations. A clinical Part III could be designed for a national licensure program. A national exam for licensure is given in medicine and appears to work satisfactorily. Offering reciprocity to dentists after a successful number of years in practice is another alternative. This policy occurs in medicine and in law. Dental students who graduate from accredited U.S. dental schools should be able to practice anywhere in the country upon successful completion of dental school if a national licensure policy establishes an exam given prior to graduation. Policymakers should strongly consider this option.

Technological advancements in oral health services in the U.S. are among the best in the world. Nevertheless, large percentages of the U.S. public cannot access this technology. The safety net is very small for those in need. Only 60 percent of Migrant and Community Health Centers offer oral health services (Isman and Isman 1997). Only a small percentage of the revenue of the 56 U.S. dental schools comes from Medicaid. Hospital emergency rooms rarely provide anything other than emergency oral health services. Oral health services should be a regular component of all systems targeting the underserved.

Capacity

Availability

POLICY RECOMMENDATION

- Identify the type of dental health practitioners needed to appropriately and adequately improve availability of oral health services to underserved populations.

There remains debate about the number of dentists needed to serve the nation. To date, no agreed upon answer exists. For populations with tremendous oral health needs and few resources, the issue is more bothersome. The type, distribution, and characteristics of oral health personnel influence whether oral health services will be provided to the underserved. While federal and state programs have been implemented to increase services, the more fundamental question of who serves the underserved has not been adequately addressed.

Accessibility

POLICY RECOMMENDATION

- Identify the types of dental and medical providers who can specifically address the needs of the underserved.

One should not assume that oral health services are included in primary care, when all too often they are not. A multi-disciplinary approach to oral health services should be embraced; an approach that reflects oral health as part of general health. Efforts to improve oral health for underserved populations must expand beyond providing emergency care to focusing on primary disease prevention and health promotion.

**TECHNOLOGICAL
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NEVERTHELESS,
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CANNOT ACCESS THIS
TECHNOLOGY.**

EDUCATIONAL
EFFORTS TO
INCREASE THE
NUMBER OF
MINORITY DENTAL
STUDENTS MUST
CONTINUE, AND ALL
DENTISTS AND
DENTAL STUDENTS
SHOULD BE
ENCOURAGED
TO TARGET
UNDERSERVED
POPULATIONS.

Acceptability

POLICY RECOMMENDATIONS

- Develop incentive programs for dentists to serve underserved communities.
- Develop mentoring programs to encourage students from underserved communities to select dental careers.
- Balance the costs of providing care to underserved communities in terms of resources, time, and reimbursement to make underserved populations a more desirable group of patients.

Even when services are available and accessible, providers must address additional challenges — financial, language, and other special needs (i.e., medically compromised health) — faced by underserved populations. In general, it is more expensive to provide care for the underserved. Dentists who serve underserved groups are required to do more with fewer resources. In other words, there is a backlog of unmet treatment needs which require more time, and the reimbursements for these services are less than the usual and customary fees. If these dentists are to continue to serve underserved populations, barriers, including financial barriers, must be removed. By reducing these barriers, more dentists may be willing to serve the underserved.

Educational efforts to increase the number of minority dental students must continue, and all dentists and dental students should be encouraged to target underserved populations. However, unless there are incentives such as reducing indebtedness for dental students and determining compatibility characteristics of dentists with underserved groups, it will be very difficult to reach the capacity necessary to provide oral health services to the underserved. Additionally, capacity-building must include human and financial resources to sustain primary prevention which will reduce the need for curative care in dental clinical settings.

Cultural Competency

Cultural competency is the ability of oral health providers and the delivery system to meet the oral health needs of underserved populations in the context of their cultural beliefs, values, language, practice and health behaviors (Buckley 1974).

Availability

POLICY RECOMMENDATION

- Educate dentists about the knowledge, skills, languages, circumstances, and criteria necessary to build respect and trust with the populations they serve and improve compliance and compatibility between these providers and those they serve.

While the underserved population in this paper refers to those who similarly experience lack of oral health services, other characteristics make the underserved diverse. Consequently, if these characteristics are not clearly delineated, they will prevent services from being provided. For example, dentists must have the knowledge, skills, and abilities to address language barriers, matters of trust and respect, and recognize the circumstances, which may limit underserved populations from complying with recommended positive oral health behaviors.

Accessibility

POLICY RECOMMENDATION

- Determine the compatibility of dentists with the groups that they serve prior to their establishing a practice to diminish the cultural, value, and language differences that lower utilization of services or reduce the quality of care.

The greater number of social and cultural characteristics that dentists share with the people they serve, the greater the likelihood that they will continue to serve those people. The literature has repeatedly shown that African-American and Hispanic-American dentists disproportionately serve African-American, Hispanic-American, and low-income populations in their private practices. If the majority of dentists are in private practice, it seems reasonable to conclude that more African-American and Hispanic dentists will increase oral health services to the underserved, particularly to racial and ethnic groups across the underserved spectrum (poor, children, and elderly).

Acceptability

POLICY RECOMMENDATIONS

- Solicit indicators from underserved community leaders to evaluate cultural competency of oral health providers.
- Conduct thorough research to determine the barriers and programs necessary to adequately serve migrant populations.

Underserved populations must strive to assume some personal and group behavior to improve and sustain their oral health. For example, Medicaid-eligible parents must look for ways to get themselves and their children to the dentists and follow personal prevention practices recommended by the dentist. Cultural competency will improve if social and behavioral sciences and bio-ethics can be taught in dental school and required in continuing education courses for re-licensure.

Infrastructure

Infrastructure must relate to individual training and practice requirements. However, expanding access through federal and state legislation will improve existing systems like Medicaid, EPSDT, and managed care. Evaluation of oral health care systems must also be considered as a component of infrastructure. The infrastructure of oral health services at the national level must support a clear vision of oral health for all. Federal leadership must be provided and coordination must occur among the federal, state, and local levels. *The Surgeon General's Report on Oral Health* should provide the vision. However, as the report develops, and data are gathered, information sought, analyzed and synthesized, the importance of the diversity of the U.S. population must be emphasized when oral health policies are recommended. Underserved groups must be included in the discussion of every aspect of the report.

As with the Surgeon General, the federal Chief Dental Officer must be given the authority, responsibility, and resources to set a national agenda to assure oral health. While the agenda must be implemented at the local level to be most effective, a national action plan must develop. Every state needs primary prevention to assure oral health. Community water fluoridation should be available and appropriately financed and implemented. Fluoride intake requires monitoring to reduce the growing problem of dental fluorosis, which is the discoloration of teeth due to the over ingestion of fluoride. The State Dental Directors should

**BALANCING THE
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AND REIMBURSE-
MENT COSTS OF
PROVIDING CARE
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OF PATIENTS.**

continue to monitor this problem.

POLICY RECOMMENDATIONS

- Delegate authority, responsibility, and resources to the Chief Dental Officer to allow him/her to set a strong national agenda for attaining oral health.
- Implement primary prevention strategies at the local level, such as water fluoridation, and include these strategies in the federal Chief Dental Officer's oral health agenda.

Availability

POLICY RECOMMENDATION

- Develop mentoring and incentive programs to encourage students from underserved communities to select dental careers.

National attention must be given to increasing the number and distribution of oral health providers. African-American and Hispanic students should be encouraged to seek dental careers because they are more likely to have private dental practices that are available, accessible, and acceptable to underserved populations. Additionally, because many of these students are from underserved communities themselves, the possibility of them providing culturally competent services will be greater. Strategies to increase the success of minority students in dental school have been identified, and expert advice from experienced dental educators will be helpful in graduating all students who are admitted.

Accessibility

POLICY RECOMMENDATION

- Include oral health in primary health care for all those with insurance coverage (public and private).

Oral health services are a part of primary care and should be included in the health care infrastructure along with the primary care specialties of family medicine, pediatrics, obstetrics, and gynecology. Financial availability for oral health services often is provided for low-income children and almost never for adults. Provision of accessible oral health services to underserved populations remains problematic.

Acceptability

POLICY RECOMMENDATION

- Determine the efficacy of the health delivery system for underserved populations.

Despite the existence of Migrant and Community Health Centers, dental school clinics and hospital dental services, the safety net for oral health services remains small. Health delivery systems desperately need to provide oral health services for the populations they serve. In order to fulfill their mission of caring for the general health of populations, they need to determine how to adequately access and provide quality oral health services. A health services research approach surely could address the efficacy of health delivery systems and resolve problematic issues to create a win-win situation for both providers and patients.

VIII. Policy Recommendations and Actions

In the previous sections the oral health policy issues were reviewed. Issues of availability, accessibility, and acceptability provided the framework for policy recommendations. The specific focus areas were finances, sustainability, capacity, cultural competency, and infrastructure. Barriers and enablers were cited. The final section provides policy recommendations and actions for improving the oral health of underserved communities.

Finance

Availability

Oral health services in underserved communities when available, are available mostly to low-income children and mothers. However, those services are not fully accessible. For underserved adults, with the exception of low-income mothers and some who are medically compromised, oral health services are not generally available.

POLICY RECOMMENDATIONS

- Preventive and emergency care should be available to all underserved groups.
- Oral health services should be included in all primary care programs targeting the underserved.
- Routine oral health services are strongly encouraged in all health care programs.

ACTION STEP

- Broaden eligibility criteria for public health programs like Medicaid to make oral health services more financially available to a greater number of people.

Accessibility

While financial availability of oral health services to the underserved needs improvement, Accessibility is a more complex issue. For a variety of reasons, many underserved groups, particularly low-income children, have a mechanism to pay for oral health services. However, many of these services are not used. Barriers that exist include, but are not limited to, low reimbursement, co-payments, scope of services, limited support systems, practice start-up and maintenance costs, student loan indebtedness, and few practice incentives.

POLICY RECOMMENDATIONS

- Identify and reduce access barriers to oral health services prior to program implementation.
- Identify and encourage enablers for oral health services.

ACTION STEP

- Reduce barriers associated with obtaining oral health care, such as transportation and child care, to lessen the burden of the patient in accessing primary care.

Acceptability

While financing oral health services is available through Medicaid, CHIP, and some managed care plans, the generally low fees are unacceptable to most dentists. Therefore, underserved populations have problems obtaining care. Unless more equitable reimbursement is considered, large numbers of underserved populations cannot improve their oral health care.

ORAL HEALTH SERVICES SHOULD BE INCLUDED IN ALL PRIMARY CARE PROGRAMS THAT TARGET THE UNDERSERVED.

EXPAND THE SAFETY NET FOR UNDERSERVED POPULATIONS TO INCLUDE BOTH EMERGENCY CARE AND PREVENTIVE CARE TO REDUCE ORAL DISEASE, DISABILITY, AND DYSFUNCTION.

POLICY RECOMMENDATIONS

- Establish competitive reimbursements for oral health services.
- Develop financial incentives for dentists to serve underserved groups.

ACTION STEPS

- Ensure that Medicaid reimbursement rates for oral health services are comparable to the usual and customary fees in most dental offices.
- Improve reimbursement rates so they cover overhead costs for providers.
- Create loan forgiveness programs for dental graduates who agree to serve in medically underserved areas.

Sustainability

Availability

Oral health services must be available to complement primary prevention programs for underserved populations (i.e., water fluoridation). If they are not, gains made from primary prevention will be lost. For example, home oral hygiene has limited utility without periodic examinations and prophylaxis (professional tooth scaling and polishing). In order to assure that excessive fluoride is not ingested, dentists must monitor fluoride intake. Hard and soft tissues need periodic examinations to detect early signs of disease and dysfunction. The continuum of care must be maintained to assure health and oral health.

POLICY RECOMMENDATIONS

- Align oral health services with other health and human services.
- Determine non-health outcome measures resulting from oral health services (i.e. reduction in days missed from school or work).

ACTION STEPS

- Design incentives for managed care plans to include oral health services in primary care.
- Stress the importance of oral health in the context of general health and well-being to increase the value of seeking oral health services to maintain health.
- Articulate the benefits of oral health in non-health related language (i.e., fewer days missed from work due to oral health issues) to encourage employers, teachers, parents, and policymakers to sustain oral health services for their employees, families, and constituents.

Accessibility

Service programs designed to improve oral health are highly utilized. Unless these programs are better used and outcome are quantified, reduction in size and scope of the programs may result. Ultimately, if programs such as Medicaid are better used, the prevalence of oral diseases will be reduced and improved personal health behavior and health outcomes will result.

POLICY RECOMMENDATIONS

- Increase use of publicly funded oral health services.
- Develop alternative sites for oral health delivery systems (i.e., schools, faith and work-based sites).
- Require oral health services in all primary care programs.
- Develop a national licensure policy.
- Require emergency oral health services in all hospitals serving the underserved.

ACTION STEPS

- Expand the safety net for underserved populations to include both emergency care and preventive care to reduce oral disease, disability, and dysfunction.

Acceptability

Oral health services are often provided in settings that alienate underserved populations. As a result only emergency care is sought which increases costs and reduces effectiveness. If the resources to maintain the services are not used, the services may be deemed unnecessary and, therefore, eliminated.

POLICY RECOMMENDATIONS

- Evaluate rationale for type and location of oral health services.
- Determine reasons oral health services are not used.

ACTION STEPS

- Create flexible licensure policies to encourage a more even distribution of providers.
- Include standard questions on oral health status and access to and utilization of oral health care in national health surveys.

Capacity

Availability

Capacity to improve oral health services to the underserved requires an in-depth assessment of who is providing services to these groups. A profile of dentists, other health professionals, and their practice patterns should provide adequate information to determine the critical elements needed to build capacity.

POLICY RECOMMENDATIONS

- Require oral health screening in all health care settings (i.e., nursing homes, schools, day care).
- Include oral health information in continuing education for physicians, nurses and other clinicians serving the underserved.

ACTION STEPS

- Identify the type of oral health practitioners needed to appropriately and adequately improve availability of oral health services to underserved populations.
- Expand support systems to the geographic location of dentists and assess the characteristics of dentists who provide service to underserved populations.

Accessibility

Underserved populations are required to go to a variety of locations to receive health and human services. This may lead to tardiness and underutilization. This inconvenience may even lead them not to seek services at all.

POLICY RECOMMENDATIONS

- Emphasize a user-friendly, multi-disciplinary approach to oral health services.
- Focus on health promotion and primary prevention.

ACTION STEPS

- Identify the types of dental and medical providers who can specifically address the needs of the underserved.

Acceptability

The dentist-to-population ratio among underserved groups is higher than in the nation as a whole. Distribution problems have also resulted in an uneven balance between where underserved populations reside and where dentists practice. The result is a maldistribution of providers.

POLICY RECOMMENDATIONS

- Develop incentive programs for dentists targeting underserved populations.
- Develop mentoring programs to encourage students from underserved communities to select dental careers.
- Select community residents to help recruit dentists.

ACTION STEPS

- Balance the costs of providing care to underserved communities, in terms of resources, time, and reimbursement to make underserved populations more desirable as patients.

Cultural Competency

Availability

Social and behavioral factors impact oral health and oral health services. These factors confound enablers and support systems that positively impact oral health services. Therefore, social and behavioral interventions must be designed.

POLICY RECOMMENDATIONS

- Require cultural competency training in dental schools and in continuing dental education courses.
- Build alliances with residents from underserved communities to educate dentists.

ACTION STEPS

- Educate dentists in the knowledge, skills, languages, circumstances, and criteria for respect and trust of the populations they are serving to improve compliance and understanding between providers and those seeking care.
- Provide incentives for young people from underserved communities to become dentists or dental care providers.

Accessibility

Residents from underserved communities who have experienced individual and institutional prejudices, gender, and racial/ethnic biases from the health delivery system are reluctant to use the system when it is available and accessible.

POLICY RECOMMENDATIONS

- Seek community participation in planning, implementing, and evaluating oral health services.
- Assure representation from underserved communities on all advisory committees.

ACTION STEPS

- Determine the compatibility of dentists with the groups that they serve prior to their establishing a practice to diminish the cultural, value, and language differences that lower utilization of services or reduce the quality of care.

Acceptability

POLICY RECOMMENDATIONS

- Solicit indicators from underserved community leaders to evaluate cultural competency of oral health providers.

ACTION STEP

- Conduct thorough research to determine the barriers and programs necessary to adequately serve migrant populations.

Infrastructure

Availability

The infrastructure to provide comprehensive oral health services is available. Populations who have access enjoy good general and oral health. The disparity in health between these populations and the underserved represents the lack of access for those without the ability to pay.

POLICY RECOMMENDATIONS

- Make the full scope of oral health services available to underserved populations.
- Require a core set of oral health services for the entire population.

ACTION STEPS

- Require emergency oral health services in all hospitals serving underserved communities.
- Give authority, responsibility, and resources to the federal Chief Dental Officer to allow him or her to set a national agenda for attaining oral health.
- Implement primary prevention strategies at the local level, like water fluoridation, and include these strategies in the federal Chief Dental Officer's oral health agenda.

Accessibility

Underserved populations seldom receive comprehensive care because oral health services are costly. The care often is episodic and short term; thus, oral health outcomes are compromised.

POLICY RECOMMENDATIONS

- Assure that a core set of oral health services is accessible to children and adults.

ACTION STEPS

- Expand access for underserved populations through federal and state legislation to improve systems like Medicaid, Medicare, and managed care plans.
- Include oral health in the primary health services provided to all those with insurance coverage (public and private) to improve the Accessibility and acceptability of oral health for a large percent of the population.

Acceptability

The health delivery system has worked well for many people in the U.S. Services have been available, accessible, and acceptable for those who have learned how to use the system. However, the growing diversity of the country warrants a careful reassessment.

POLICY RECOMMENDATIONS

- Determine the efficacy of the health delivery system for underserved populations and the growing diversity of the U.S. population.

ACTION STEPS

- Improve the payment infrastructure of public health plans, specifically those covering expenses for children, to ensure access to oral health care.

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