VI. PROVISION OF DENTAL SERVICES

a. Dental Workforce and Capacity

The oral health care workforce is critical to society's ability to deliver high-quality dental care in the United States. Effective health policies intended to expand access, improve quality, or constrain costs must take into consideration the supply, distribution, preparation, and utilization of the health workforce (see http://bhpr.hrsa.gov/healthworkforce/reports/profiles/).

b. Dental Workforce Diversity

One cause of oral health disparities is a lack of access to oral health services among under-represented minorities. Increasing the number of dental professionals from under-represented racial and ethnic groups is viewed as an integral part of the solution to improving access to care [USDHHS 2000b]. Data on the race/ethnicity of dental care providers were derived from surveys of professionally active dentists conducted by the American Dental Association [ADA 1999]. In 1997, 1.9 percent of active dentists in the United States identified themselves as black or African American, although that group constituted 12.1 percent of the U.S. population. Hispanic/Latino dentists made up 2.7 percent of U.S. dentists, compared with 10.9 percent of the U.S. population that was Hispanic/Latino.

State Health Workforce Profiles from the National Center for Health Workforce Analysis:
http://bhpr.hrsa.gov/healthworkforce/reports/profiles/

From the American Dental Education Association (www.adea.org):

American Dental Education Association: Dental Education At A Glance
http://www.adea.org/DEPR/2004_Dental_Ed_At_A_Glance.pdf

American Dental Education Association: Allied Dental Education At A Glance
http://www.adea.org/CEPRWeb/DEPR/Documents/2004_Allied_Dental_Education_At-A-Glance.pdf

American Dental Education Association: Annual ADEA Survey of Dental School Seniors, 2004
http://www.adea.org/CEPRWeb/DEPR/Documents/2004_Senior_Survey.pdf]

c. Use of Dental Services

i. General Population

Although appropriate home oral health care and population-based prevention are essential, professional care is also necessary to maintain optimal dental health. Regular dental visits provide an opportunity for the early diagnosis, prevention, and treatment of oral diseases and conditions for people of all ages, and for the assessment of self-care practices.

Adults who do not receive regular professional care can develop oral diseases that eventually require complex treatment and may lead to tooth loss and health problems. People who have lost all their natural teeth are less likely to seek periodic dental care than those with teeth, which, in turn, decreases the likelihood of early detection of oral cancer or soft tissue lesions from medications, medical conditions, and tobacco use, as well as from poor-fitting or poorly maintained dentures. Persons with visits to the dentist in the last 12 months are shown in Table XII.

Table XII. Proportion of Persons Aged 2 Years and Older Who Visited a Dentist in the Previous 12 Months[a]

	Dental Visit in Previous Year	
	United States* (%)	**<STATE>[d] (%)**
TOTAL	43	
Race and ethnicity		
American Indian or Alaska Native	41	
Asian or Pacific Islander	36	
Asian	DNA	
Native Hawaiian or Other Pacific Islander	DNA	
Black or African American	27	
White	46	
Hispanic or Latino	27	
Not Hispanic or Latino	45	
Black or African American, not Hispanic or Latino	28	
White, not Hispanic or Latino	48	
Sex		
Female	39	
Male	46	
Education Level (persons aged 25 years and over)		
Less than high school	24	
High school graduate	41	
At least some college	57	
Disability Status		
Persons with disabilities	30	
Persons without disabilities	43	
Select populations		
Children aged 2 to 17 years	48	
Children at first school experience (aged 5 years)	50[b]	
3rd grade students	55[c]	
Children, adolescents, and young adults aged 2 to 19 years <200% of poverty level	33	
Adults aged 18 years and older	41	
Adults aged 65 years and older	40	
Dentate adults aged 18 years and older	44	
Edentate adults 18 and older	23	
Adults aged 18 years and older with disabilities	DNA	

Table XII Sources:
H*ealthy People 2010, Progress Review, 2000*. U.S. Department of Health and Human Services.
Available at http://www.cdc.gov/nchs/ppt/hpdata2010/focusareas/fa21.xls.
<These data are released annually. 2002 national data are available from the Medical Expenditure Panel Survey at http://www.meps.ahrq.gov/.>

DNA = Data not analyzed

* National data are for 2000.
[a] Age-adjusted to 2000 U.S. standard population.
[b] Data are for children aged 5–6 years.
[c] Data are for children aged 8–9 years.
[d] <State Data Source(s)>

ii. Special Populations

Schoolchildren / Pregnant Women

[National YRBS data were collected in 2003 but have not yet been reported. If available, include state YRBS data or other state data on dental visits.]

Schoolchildren / Pregnant Women

Studies documenting the effects of hormones on the oral health of pregnant women suggest that 25–100 percent of these women experience gingivitis and up to 10 percent may develop more serious oral infections [Amar & Chung 1994; Mealey 1996]. Recent evidence suggests that oral infections such as periodontitis during pregnancy may increase the risk of preterm or low birthweight deliveries [Offenbacher et al. 2001]. During pregnancy, a woman may be particularly amenable to disease prevention and health promotion interventions that could enhance her health or that of her fetus [Gaffield et al. 2001].

d. Dental Medicaid and State Children's Health Insurance Programs

Medicaid is the primary source of health care for low-income families, the elderly and disabled persons in the United States. This program became law in 1965 and is jointly funded by the federal and state governments (including the District of Columbia and the Territories) to assist states in providing medical, dental, and long-term care assistance to people who meet certain eligibility criteria. People who are not U.S. citizens can receive Medicaid only to treat a life-threatening medical emergency; eligibility is determined on the basis of state and national criteria. Dental services are a required service for most Medicaid-eligible individuals under the age of 21 years, as a required component of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Services must include, at a minimum, relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services may not be limited to emergency services for EPSDT recipients [Centers for Medicare & Medicaid Services, 2004].

Nationally, federal Medicaid expenditures for Medicaid totaled $2.3 billion in 2003, or three percent of the $74.3 billion spent on dental services nationally [Centers for Medicare & Medicaid Services 2004].

[EXPENDITURES
MEDICAID ELIGIBLE CHILDREN
MEDICAID PARTICIPATING DENTISTS
SCOPE OF DENTAL SERVICES AVAILABLE
ELIGIBLE STATE RESIDENTS RECEIVING DENTAL SERVICES
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (S-CHIP) PROGRAM DETAILS]

e. Community and Migrant Health Centers and other State, County, and Local Programs

Community Health Centers (CHCs) provide family-oriented primary and preventive health care services for people living in rural and urban medically underserved communities. CHCs exist in areas where economic, geographic, or cultural barriers limit access to primary health care. The Migrant Health Program (MHP) supports the delivery of migrant health services, serving more than 650,000 migrant and seasonal farm workers. Among other services provided, many CHCs and Migrant Health Centers provide dental care services.

Healthy People 2010 objective 21-14 is to "Increase the proportion of local health departments and community-based health centers, including community, migrant, and homeless health centers, that have an oral health component" [USDHHS 2000b]. In 2002, 61 percent of local jurisdictions and health centers had an oral health component [USDHHS 2004b]; the *Healthy People 2010* target is 75 percent.