

**Oral Health America  
Policy Statement  
Oral Health and Healthcare Reform  
Updated April 2011**

**Oral Health America believes that the U.S. health care system must provide health care coverage including access to high-quality, cost-effective oral health care services for all Americans, especially those most vulnerable.**

Health care of the mouth should accord equal status with other medical services within the U.S. health care system. Integration of oral health care within the U.S. health care system requires commitment to disease prevention, public education, and the exploration and implementation of new models of care delivery.

Individuals, families, businesses, and federal, state, and local governments are collectively responsible for the oral health and well-being of our country. Specifically, this means:

- Focusing research and care on disease prevention.
- Providing public insurance options that include dental benefits for children, adults, and older adults.
- Ensuring that children and adults are able to obtain on-going high-quality, cost-effective preventive and restorative dental care.
- Investing in public health measures that improve our nation's capacity to meet the health care needs of all communities.
- Addressing workforce issues including diversity, function, education, and distribution of dental care providers.
- Ensuring integration of oral health and medical services.
- Ensuring oral health education for families.
- Addressing oral health care financing issues.

Nearly 2 in 3 U.S. adults (63%) think that it is important that dental coverage is part of an overall health reform package, and 40 percent say it is very important.<sup>i</sup>

**Oral Health Care is a Critical Part of Health Care**

The traditional delivery model for oral health care in America has been separate from health care in terms of insurance, financing, and treatment—but the connection between oral health and overall health is leading researchers, businesses, insurers, care providers, policymakers, and the public to bring them together. Oral health is integral to overall health and well-being. Oral conditions are associated with heart disease, stroke, diabetes, pre-term and low weight births and respiratory diseases. The mouth mirrors the state of general health, and health problems such as HIV and diabetes can affect oral health. Oral and pharyngeal cancers reflect and impact physical health. The vast majority of adults (92 percent) understand that the lack of proper dental care can lead to overall poor health.<sup>ii</sup>

**Cost**

At \$7,421 per person, health care spending accounted for 16.2 percent of our Gross Domestic Product (GDP), or \$2.2 trillion, in 2007.<sup>iii</sup> The federal government (40 percent), households (31 percent), businesses (25 percent), and other private entities (4 percent) paid for about the same share of health service and supplies as the previous year<sup>iv</sup> and face ever increasing health costs.

Dental expenditures account for about 5 percent of personal health care expenditures, though spending growth for dental services accelerated in 2007, increasing 5.2 percent to \$95.2 billion.<sup>v</sup> Medicaid dental expenditures are just over 1 percent of total Medicaid expenditures. In 2007, the government paid \$169 million for dental services under Medicare, just .03 percent of total Medicare spending of \$431 billion.<sup>vi</sup>

### **Why Prevention is Vital**

Most oral diseases are preventable, and early diagnosis and treatment is cost effective. Preventing and controlling diseases includes adequate financing of organized activities to promote and ensure the public's oral health through education, applied dental research, and the implementation of cost effective measures such as community water fluoridation and school dental sealant programs.

The cost of providing preventive dental treatment is estimated to be 10 times less than the cost of managing symptoms of dental disease in a hospital emergency room.<sup>vii</sup> Cost savings resulting from research on dental disease exceed cost savings from research on AIDS/HIV, influenza and a number of other diseases and conditions.<sup>viii</sup> Medicaid-enrolled children continuously enrolled for 5 years who received their first preventive dental visit by age 1 had 40% lower costs over 5 years than children who received their first preventive visit at a later age.<sup>ix</sup> Oral cancer treatment costs in the earliest stages of the disease are estimated to be 60 percent lower than those at an advanced stage of disease.<sup>x</sup> Every dollar invested in community water fluoridation yields approximately \$38 in savings on dental treatment costs.<sup>xi</sup>

The cost of caring for Americans without health insurance in emergency rooms adds approximately \$922 to the average cost of annual premiums for employer-sponsored family coverage.<sup>xii</sup> *For example, in 2007, more than 83,000 Californians ended up in emergency departments for urgent dental care, and the percentage of visits for preventable dental conditions increased dramatically. In fact, statewide, the emergency department visit rate for preventable dental conditions runs higher than that for diabetes.*<sup>xiii</sup>

### **Dental Coverage**

As of 2007, more than 75 million adults—42 percent of all adults ages 19 to 64—were either medically uninsured during the year or underinsured, up from 35 percent in 2003.<sup>xiv</sup> Half of those without medical insurance in 2003 reported putting off needed care.<sup>xv</sup>

Over 100 million adults and children do not have **dental** coverage, and having dental coverage is a determinant in who does and does not receive care. While 57% of those with private dental coverage had a visit during 2004, 32% with public dental coverage only and 27% with no dental coverage had a visit.<sup>xvi</sup> Uninsured individuals often delay dental treatment until serious or acute dental emergencies occur.<sup>xvii</sup> Children with no dental health coverage are 3 to 4 times more likely to have no regular dental care when compared with children on private or public dental health insurance.<sup>xviii</sup>

Four in five adults (81 percent) agree that dental benefits are as important as general medical benefits in an overall healthcare benefit package.<sup>xix</sup>

### **Effect on National Productivity**

More than one of every six working-age adults (18%) reported being unable to work or carry out everyday activities because of health problems in 2006—up from 15 percent in 2004.<sup>xx</sup> Over 51 million school hours are lost each year to dental-related illness, and employed adults lose more than 164 million hours of work each year due to dental disease or dental visits.<sup>xxi</sup>

## **Oral Health Disparities**

Significant oral health disparities exist for underserved or vulnerable populations, including racial/ethnic minority groups, people in rural areas and Health Professional Shortage Areas, immigrants, people who are homeless, older Americans, and people with developmental disabilities and chronic conditions. These groups benefit less from recent prevention and treatment innovations,<sup>xxii</sup> were generally *more likely* to wait when sick, to encounter delays and poorly coordinated care, and to have untreated dental caries, uncontrolled chronic disease, avoidable hospitalizations, and worse outcomes.

While tooth decay is the single most common chronic childhood disease, poor children suffer twice as much dental caries and their disease is more likely to be untreated.<sup>xxiii</sup> Roughly 75 percent of tooth decay in children aged six or older occurs in only 33 percent of children, concentrating in black, Mexican American, American Indian/Alaska Native, and low-income groups.

Low income, less educated, and racial/ethnic minority populations have higher prevalence of caries, periodontal diseases, and oral cancer than other adults. In 1994-2004, 60 percent of adults had prior-year dental visits, with fewer visits from racial/ethnic minorities (43-50 percent), populations below the poverty level (44 percent), and those with less than a high school education (38 percent).<sup>xxiv</sup>

## **Workforce Diversity**

Racial and ethnic diversity of health professionals contributes to improved access to care, greater patient choice and satisfaction, and enriched educational experiences for students.<sup>xxv</sup> This would ensure a workforce that is prepared to meet the needs of a diverse population that continues to expand. This responsibility includes preparing oral health care providers to care for a racially and ethnically diverse population, an aging population, and individuals with special needs.<sup>xxvi</sup>

## **Educating Americans About Their Mouths**

According to a public opinion survey conducted by OHA in 2008, most adults are unaware of the role that infectious bacteria can play in tooth decay.<sup>xxvii</sup> Oral health knowledge and practices differ by ethnicity and culture. Groups vary in beliefs about the usefulness of treating primary teeth, the reasons for tooth decay, the meaning of oral pain, dental discolorations, tooth loss, periodontal diseases, and poor oral hygiene.<sup>xxviii</sup> Dental concerns are not well addressed in public health policy (evidenced by poor funding for oral health services), leaving significant opportunities for improvement.

Overall, two-thirds (65%) of parents say school teaching children about taking care of their teeth is either extremely or very important, even as fewer children get this instruction at school, according to OHA's 2010 public opinion survey,

## **Recommendations**

**Oral Health America supports a comprehensive, multi-tiered Oral Health Equity Policy Agenda that would include access to basic oral health care for all, including:**

- Full funding for the oral health provisions in health care reform
- Coverage for vulnerable adult populations, including aged, blind and disabled
- Inclusion of a routine dental benefit in Medicare
- Support for the expansion of research and care that prevents oral disease

The Oral Health Equity Policy Agenda requires investments in dental public health and dental education, with a focus on building community infrastructure for oral health services—both preventive and restorative—as well as increasing the diversity of dental care providers. Through research and

technology advances, supported by federal and state funding, medical and dental care providers should integrate disease management practices to improve health outcomes and cut costs. States should be encouraged to realign practice acts to reflect current capabilities and education levels of dental care practitioners, and allow for greater participation in the appropriate treatment of underserved populations. Proposals to reform the U.S. health care system should include adequate funding for programs that are designed to increase the number of underrepresented minorities in the health professions.

Within ten years, all Americans should have an annual dental visit.

For more information, call 312.836.9900, e-mail [liz@oralhealthamerica.org](mailto:liz@oralhealthamerica.org), or visit [www.oralhealthamerica.org](http://www.oralhealthamerica.org).

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<sup>i</sup> Oral Health America Dental Survey conducted by telephone within the United States by Harris Interactive on behalf of Oral Health America between April 29 and May 3, 2009 among 1,011 adults ages 18 years and older.

<sup>ii</sup> Oral Health America Dental Survey conducted by telephone within the United States by Harris Interactive on behalf of Oral Health America between April 29 and May 3, 2009 among 1,011 adults ages 18 years and older.

<sup>iii</sup> Centers for Medicare and Medicaid Services. *National Health Expenditures: 2007 Highlights*.

<http://www.cms.hhs.gov/NationalHealthExpendData/downloads/highlights.pdf>

<sup>iv</sup> Centers for Medicare and Medicaid Services. National Health Expenditures Fact Sheet.

[http://www.cms.hhs.gov/NationalHealthExpendData/25\\_NHE\\_Fact\\_Sheet.asp](http://www.cms.hhs.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp). Accessed 10/17/09

<sup>v</sup> Ibid. Centers for Medicare and Medicaid Services. *National Health Expenditures: 2007 Highlights*.

<http://www.cms.hhs.gov/NationalHealthExpendData/downloads/highlights.pdf>

<sup>vi</sup> Ibid. Centers for Medicare and Medicaid Services. *National Health Expenditures: 2007 Highlights*.

<http://www.cms.hhs.gov/NationalHealthExpendData/downloads/highlights.pdf>

<sup>vii</sup> Pettinato E, Webb M, Seale NS. A comparison of Medicaid reimbursement for non-definitive pediatric dental treatment in the emergency room versus periodic preventive care. *Pediatric Dentistry*, 2000; 22(6), pp. 463-468.

<sup>viii</sup> Silverstein S, Garrison HH, Heinig SJ. *A few basic economic facts about research in the medical and related life sciences*. Federation of American Societies for Experimental Biology, 1995, 9:833-840.

<sup>ix</sup> Sinclair SA, Edelstein B. *Cost effectiveness of Preventive Dental Services*. Washington, DC: Children's Dental Health Project, February 2005.

<sup>x</sup> Zavras A, Andreopoulos N, Katsikeris N, Zavras D, Cartos V, Vamvakidis A. *Oral cancer treatment costs in Greece and the effect of advanced disease*. BMC Public Health 2002, 2:12. Available at [www.biomedcentral.com/1471-2458/2/12](http://www.biomedcentral.com/1471-2458/2/12).

<sup>xi</sup> U.S. Department of Health and Human Services. *Cost Savings of Community Water Fluoridation*. Atlanta, GA: Centers for Disease Control and Prevention, Division of Oral Health website, August 2007. Available at [www.cdc.gov/Fluoridation/fact\\_sheets/cost.htm](http://www.cdc.gov/Fluoridation/fact_sheets/cost.htm). Accessed June 19, 2008.

<sup>xii</sup> Stoll K, Thorpe K, Pollack R, Jones K, Schwartz S, Babaeva L. *Paying a Premium The Added Cost of Care for the Uninsured*. Washington, DC, Families U.S.A., June 2005.

<sup>xiii</sup> California Health Care Foundation. *Emergency Department Visits for Preventable Dental Conditions in California*. 2009. <http://lyris.chcf.org/t/5355/650166/6717/0/>.

<sup>xiv</sup> Commonwealth Fund National Score Card on U.S. Health Care Performance, 2008.

[www.commonwealthfund.org](http://www.commonwealthfund.org).

<sup>xv</sup> Ibid. Morone J, Litman T, Robins L. *Health Politics and Policy*, 4th Edition. Pg 9.

<sup>xvi</sup> MEPS data

<sup>xvii</sup> American Dental Education Association. *Oral Health Care: Essential to Health Care Reform*. Washington, DC. 2009.

<sup>xviii</sup> C.S. Mott Children's Hospital National Poll on Children's Health. Ann Arbor, MI. 2009.

<sup>xix</sup> Oral Health America Dental Survey conducted by telephone within the United States by Harris Interactive on behalf of Oral Health America between April 29 and May 3, 2009 among 1,011 adults ages 18 years and older.

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<sup>xx</sup> Ibid. Commonwealth Fund National Score Card On U.S. Health Care Performance, 2008.

[www.commonwealthfund.org](http://www.commonwealthfund.org).

<sup>xxi</sup> U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

<sup>xxii</sup> Fisher-Owens S, Barker J, Adams S, Chung L, Gansky S, Hyde S, and Weintraub J. Giving Policy Some Teeth: Routes to Reducing Disparities in Oral Health. *Health Affairs* 27, no. 2 (2008): 404-412; 10.1377/hlthaff.27.2.404.

<sup>xxiii</sup> U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

<sup>xxiv</sup> Dye B, et al. *Trends in Oral Health Status, United States, 1988- 1994 and 1999-2004*. Vital and Health Statistics Series II. no. 248 (April 2007), 5.

<sup>xxv</sup> Smedley BD, Butler AS, Bristow LR. *In the nation's compelling interest: ensuring diversity in the health care workforce*. Washington, DC: Institute of Medicine, Board on Health Sciences Policy, Committee on Institutional and Policy-Level Strategies for Increasing the Diversity of the U.S. Health Care Workforce. National Academies Press; 2004.

<sup>xxvi</sup> Ibid. American Dental Education Association. *Oral Health Care: Essential to Health Care Reform*. Washington, DC. 2009.

<sup>xxvii</sup> The national consumer survey was conducted by telephone within the United States by Harris Interactive on behalf of Oral Health America and Philips Sonicare between May 1 and May 4, 2008 among 1,001 adults ages 18 years and older.

<sup>xxviii</sup> Hilton I, et al. Cultural Factors and Children's Oral Health Care: A Qualitative Study of Caries of Young Children. *Community Dentistry and Oral Epidemiology* 35, no 6 (2007): 1-10.