The dental care of U.S. children

Access, use and referrals by nondentist providers, 2003

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Most Americans today benefit from the dramatic improvements in oral health care services gained during the past few years. However, these benefits have not reached evenly across every segment of American society. Significant differences in oral health continue to remain for some population groups, with variations occurring according to sex, age, geographical location, income, race/ethnicity, education level and insurance coverage status.

Caries continues to be the single most prevalent chronic disease among children in the United States, despite its being highly preventable through early and sustained home care and regular professional preventive services.[1] The U.S. surgeon general's 2000 report Oral Health in America[2] highlighted the fact that "dental caries is the single most common chronic childhood disease—5 times more common than asthma and 7 times more common than hay fever." The report noted that one-fifth of America's preschoolers and one-half of second graders had experienced caries. Among the highlights of the report's data on children's oral health was the emphasis on the striking disparities in dental disease according to income, with one of four children in America born into poverty and having twice as much dental caries as their more affluent peers.[2] According to the

ABSTRACT

Background. Improvements in oral health care services have not reached evenly across every segment of American society. The authors examine the role of nondentist practitioners in referring child patients for dental care by analyzing data from the 2003 Medical Expenditure Panel Survey conducted by the Agency for Healthcare Research and Quality and the National Center for Health Statistics.

Methods. The authors provide national estimates of the percentage of the civilian noninstitutionalized population of the United States aged 2 through 17 years who had a dental visit, who had a dental checkup and who received advice from a nondentist health care provider to have a dental checkup.

Results. Overall, 38 percent of all poor, near-poor or low-income children and 60 percent of all middle- or high-income children aged 2 through 17 years reported having had a dental checkup during 2003. The authors observed no significant differences between poor, near-poor and low-income children and higher-income children in terms of having been advised by a nondentist health care provider to have a dental checkup.

Conclusion. Although income may not predict the likelihood of patients' receiving advice from a nondentist health care provider to have a dental checkup, children from families with higher levels of income were more likely to seek dental care than were children from families with lower levels of income.

Practice Implications. Efforts to increase access to dental care should aim to maximize the benefit of advice provided by nondentist health care practitioners to receive a dental checkup, so that children from families with limited income are as likely to receive a dental checkup as are children from families with higher levels of income.

Key Words. Dental care; utilization; access; checkup; Medical Expenditure Panel Survey; referrals.

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U.S. surgeon general's report, more than 108 million children and adults lacked dental insurance in 2000, which was more than 2.5 times the number who lacked medical insurance that year; these children also were 2.5 times less likely than insured children to receive dental care.[2]

An important factor to address is the importance of enhancing an understanding of the relationship between the oral cavity and the rest of the body. Dental health assessments often reveal warning signs of various systemic diseases. Unfortunately, the popular misconception that oral health is less important than, and separate from, general health may contribute to avoidance of or postponement of much-needed care and may affect existing conditions. Therefore, efforts to gain acceptance of the importance of oral health and its interdependence with general health should include a focus on medical practitioners and other nondental health care professionals as part of routine medical visits.

The American Academy of Pediatric Dentistry[3] and the American Dental Association[4] recommend that children have two dental visits per year beginning at the age of 1 year. In addition, the American Academy of Pediatrics[5] recommends that children begin regular visits to a dental professional "six months after the first tooth erupts or by 12 months of age."

The literature on nondentists' referral of young patients to dentists concentrates mostly on pediatricians, since they see a large number of young patients in well-child visits who may not have been seen by a dentist. If pediatricians' awareness about oral health is increased, they may play an important role in establishing good oral health for their patients by referring them at an early age to a dentist for preventive treatment, therapeutic treatment or both.[6] A survey done by University of Washington researchers revealed that pediatricians saw dental problems regularly. They reported some difficulty in achieving successful referrals. More that 90 percent said they felt they have an important role in identifying dental problems and providing preventive information to caregivers.[6]

Pediatric primary care providers in North Carolina who were surveyed indicated that they were very likely (78 percent) to refer children who had clinical caries or were at high risk of developing caries.[7] The chances for an early referral increased as clinicians expressed confidence in their ability to adequately screen patients, they experienced little difficulty in arranging the referral and were in group practices.[7] It appears that dental screenings can be incorporated easily into pediatric primary care practices,[8] although in the North Carolina survey, practitioners not in group practices whose practices contained more than 60 percent infants and toddlers were less likely to refer their patients to dentists.[7] Educational programs aimed at enhancing physicians' knowledge of oral health and oral disease prevention can have a positive impact on physicians' referring patients to dentists when patients are at an early age.[9]

Education also should be aimed at administrators and at nondental providers besides pediatricians. Such efforts could include an attempt to demonstrate the advantages of early referral to dentists, and the benefit of making a recommendation for referral on the basis of disease risk assessment and the esthetic and functional benefits to be gained by early intervention.[10]

This article examines the practice of nondentist health care providers in the role of providing advice to children and adolescents to obtain a dental checkup. Specifically, we study the patient practices of nondentist health providers as measured by their providing advice to child and adolescent patients to obtain a dental checkup and the relationship of this advice with actual dental visits, dental care checkups in the context of family income and other sociodemographic characteristics by analyzing data from the 2003 Medical Panel Expenditure Survey (MEPS)[11] conducted by the Agency for Healthcare Research and Quality (AHRQ) (described in Cohen[12]).

METHODS

The 2003 MEPS is the third in a series of nationally representative health surveys of the U.S. community-based population sponsored by AHRQ and the National Center for Health Statistics. The MEPS collects data on people's health care expenditures, use and payment sources, along with information about their socioeconomic status, demographic characteristics and health insurance. The target for the 2003 MEPS was a sample of 16,440 households who had participated in the 2001 or 2002 National Health Interview Survey (NHIS). To collect health expenditure and use data for 2003, MEPS personnel interviewed each MEPS household in person three times across approximately 18 months. The combined NHIS response rate and full-year 2003

ABBREVIATION KEY. AHRQ: Agency for Healthcare Research and Quality. **FPG:** Federal poverty guideline. **MEPS:** Medical Expenditure Panel Survey. **MSA:** Metropolitan Statistical Area. **NHIS:** National Health Interview Survey.