Oral Health Disparities Across the Life Span

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KEYWORDS

• Oral health • Health status disparities • Social determinants of health
• Vulnerable populations • Epidemiology

KEY POINTS

- Oral health disparities in the United States are profound and individuals from low-income and minority populations tend to bear the greatest burden of oral diseases.
- It is vital that members of the dental profession understand the distribution of oral health and disease across different populations and the life span. There are few absolute patterns in the epidemiology of oral health disparities, with the exception of poverty. Poor individuals almost universally experience a greater burden of oral diseases and conditions than those with more resources. Individuals from racial and ethnic minority groups, in particular Native Americans, Alaskan Natives, Blacks, and Hispanics also generally experience higher levels of dental caries, periodontal disease, tooth loss, and orofacial pain as well as oral cancer incidence and survival rates than non-Hispanic Whites.
- Although the country has made strides to reduce some of the disparities originally described in *Oral Health in America*: *A Report of the Surgeon General*, released in 2000, much work remains.
- Unfortunately, many low-income, low-educated, and disadvantaged populations with the highest levels of untreated dental disease are the very people who lack access to high-quality care for the multitude of reasons outlined in this article. Importantly, many of these factors are under practitioners' control, so there is hope that by working collaboratively as individual practitioners and through dental societies and other dental and health professional organizations it is possible to bring an end to oral health disparities can be brought about in the United States.

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- Oral health professionals must also actively advocate for incorporation of oral health into new and existing health policy and form stronger alliances with the other health professions and health professional organizations to ensure optimal oral health for all populations.

INTRODUCTION

Good oral health is essential to overall health and well-being throughout life. Despite improvements in the oral health status of the United States population as a whole, a disproportionately higher burden of oral diseases and disorders are still borne by certain segments of the population. These differences in health status, health outcomes, or health care use between distinct socially disadvantaged and advantaged groups are known as health disparities. The definition of health disparity used by *Healthy People 2020* is "… a particular type of health difference that is closely linked with social, economic, social, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."[1]

Outside the United States, the term, *health inequalities*, is more commonly used than health disparities. Whitehead[2] defined health inequalities as health differences that are avoidable, unnecessary, and unjust. Not all health differences are avoidable, such as prostate cancer in men versus in women, or unjust, such as a difference in the proportion of basketball and nonbasketball players who have had sprained ankles. The unjust component pertains to the human rights principle of health equity, that people should not be denied health or health care because they belong to a particular group.[3] Braveman[4] points out that equal treatment may still be unjust if some disadvantaged groups need and do not receive more resources or services than others to be healthy. For example, a short child might need a stepstool to reach the sink to brush her teeth, a resource not needed by someone taller, but both should have toothbrushing opportunity (**Fig. 1**).

At the request of Congress, the Institute of Medicine (now the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine) explored why racial and ethnic disparities in health care exist, even when other factors, such as income, access to care, and insurance coverage, are comparable and found that "bias, discrimination, and stereotyping at the provider, patient, institutional, and health system levels…"[5] contribute to disparities. These findings were published in the report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, in 2002.[5] Almost a decade later, the US Department of Health and Human Services 2011 report, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*,[6] described health disparities between ethnic minority populations and Whites. These disparities include differences in access to care, preventive care, preventable hospitalizations, poorer overall health, and more severe forms of serious illness and are influenced by a diverse set of factors. For example, many American adults have limited English proficiency that exacerbates their inability to navigate the health care system and adhere to treatment recommendations.[7] Recent research has also explored some of the underlying biologic pathways of social determinants of health. For example,