



CALIFORNIA
HEALTHCARE
FOUNDATION

SNAPSHOT

Have and Have-Nots: A Look at Children's Use of Dental Care in California

2008

Introduction

Public health efforts to promote community water fluoridation and increased use of fluoridated products have significantly improved the oral health of children in California and nationally over the past 50 years. However, the burden of oral disease, particularly cavities, continues to fall more heavily on children from poor, minority households.

Several factors contribute to this inequality, including lack of access to dental care. The American Academy of Pediatric Dentistry recommends that children visit the dentist within six months of getting their first tooth and no later than their first birthday. However, many children from families living in poverty, facing language/cultural barriers, or with no dental insurance often do not visit the dentist until much later, after primary teeth have started to decay.

This snapshot, part of the California HealthCare Foundation’s new focus on oral health, examines the most recent data available from the 2005 California Health Interview Survey and presents a more detailed look at racial/ethnic differences and other factors that contribute to disparities in dental care for California’s children, aged 0 to 11, including infants with at least one tooth.

AMONG THE FINDINGS:

- 24 percent of all children in California have never visited the dentist.
- Significant racial/ethnic differences in dental visit rates exist, even among Latino and Asian subgroups.
- Dental insurance significantly increases the rates of dental visits and reduces racial/ethnic disparities in dental visits.

This snapshot concludes with suggestions for additional research and public health initiatives that could help underserved children get the dental care they need.

Dental Care Utilization

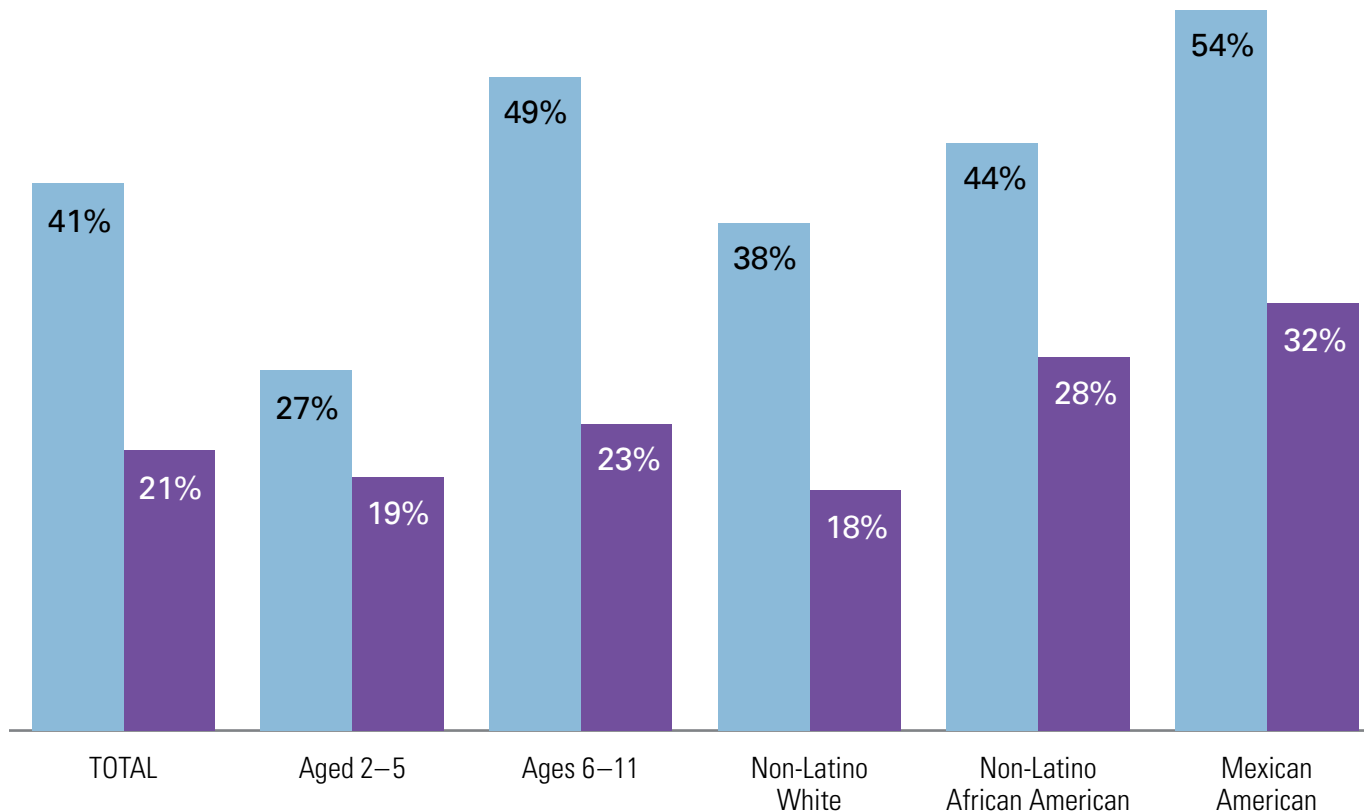
[NEXT >>](#)

CONTENTS

Tooth Decay in Children, by Age and Race/Ethnicity, U.S.	3
Cavities in Kindergarten and Third Grade Children	4
Time Since Last Dental Visit, Children Aged 0–11 Years.	5
Major Contributing Factors to Dental Visit Disparities, Children Aged 0–11 Years.	6
Time Since Last Dental Visit Younger Children, by Race/Ethnicity . . .	7
by Race/Ethnicity	8
by Latino Subgroup.	9
by Asian American Subgroup.	10
by Dental Coverage	11
Without Dental Insurance, by Race/Ethnicity	12
by Federal Poverty Level	13
by Parents’ English Fluency	14
Children of Parents Without a High School Diploma, by Race/Ethnicity . .	15
Recommendations for Eliminating Oral Health Disparities.	16
Acknowledgments.	18
Methodology.	19

Tooth Decay in Children, by Age and Race/Ethnicity, United States, 1999–2002

■ Filled Cavities ■ Untreated Cavities



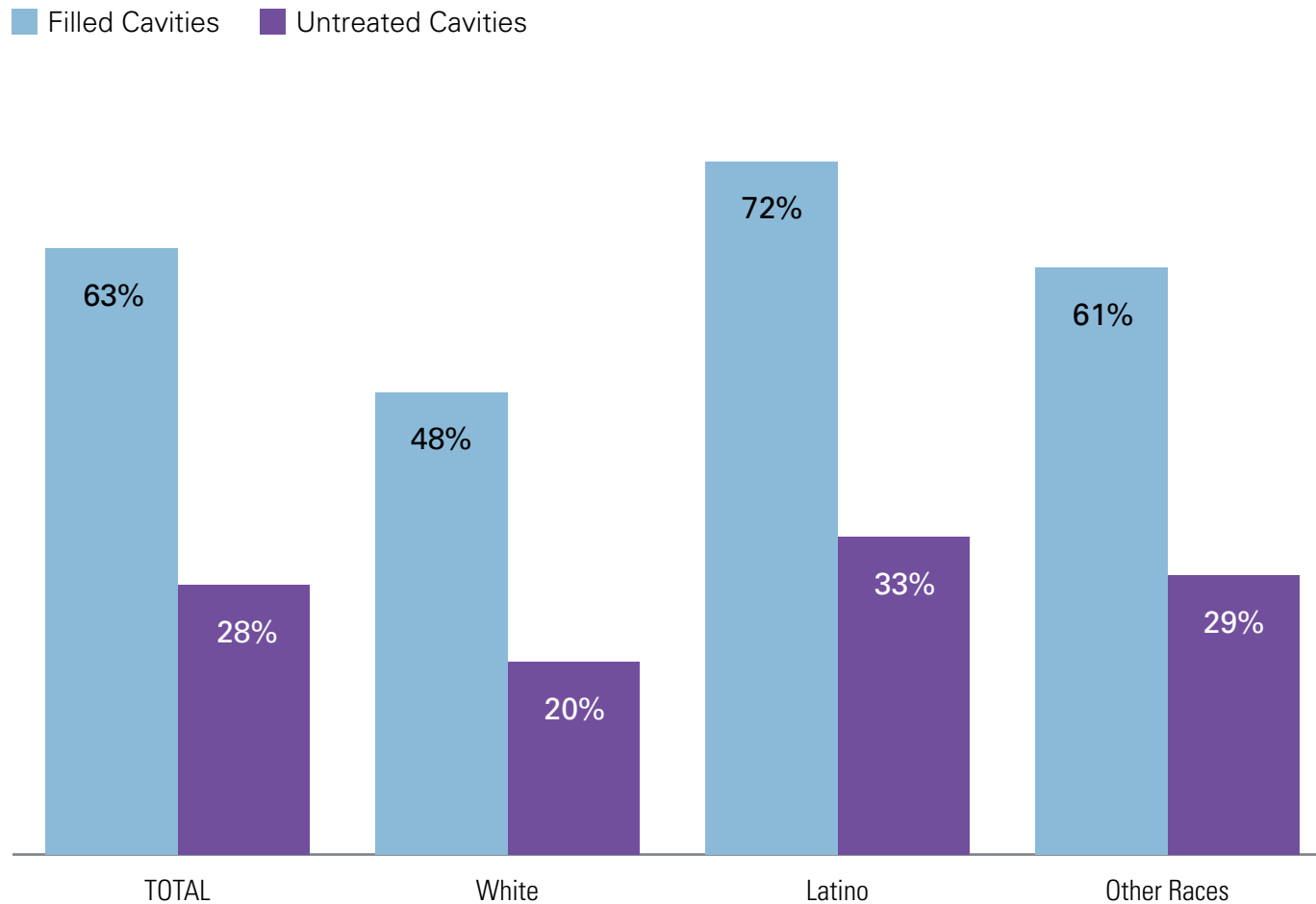
Source: Centers for Disease Control and Prevention. National Center for Health Statistics. National Health and Nutrition Examination Survey Data. Hyattsville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1999–2002., data analysis conducted on 12/03/07, http://drc.hhs.gov/create_query.htm.

Dental Care Utilization
Prevalence of Dental Disease
<< PREVIOUS NEXT >>

National data show a higher rate of untreated cavities or filled primary teeth among children aged 6 to 11 than in those aged 5 or younger. Rates are significantly higher among African American and Mexican American¹ children. The American Academy of Pediatric Dentistry recommends that children see the dentist within six months of getting their first tooth or by their first birthday.

1. Refers only to those individuals born in Mexico, not all Latinos.

Cavities in Kindergarten and Third Grade Children, California, 2005



Source: Dental Health Foundation. "Mommy, It Hurts to Chew," California Smile Survey, An Oral Health Assessment of California's Kindergarten and 3rd Grade Children, 2006.

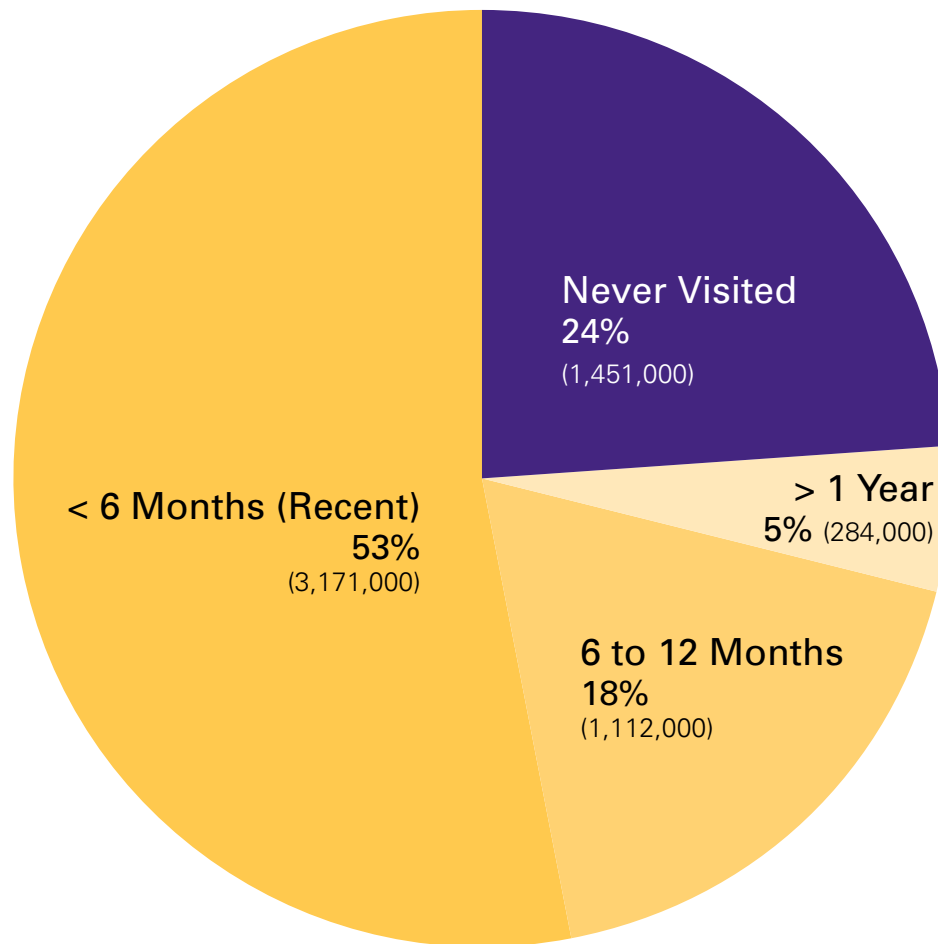
Dental Care Utilization Prevalence of Dental Disease

<< PREVIOUS

NEXT >>

California's elementary school children have high rates of cavities, higher among Latino (72 percent) than White (48 percent) children. Decayed teeth affect children's abilities to eat, sleep, and learn. Poor oral health early on may lead to a lifetime of dental, social, and other health issues.

Time Since Last Dental Visit, Children, Aged 0–11 Years, California, 2005



Source: 2005 California Health Interview Survey.

Dental Care Utilization in California

<< PREVIOUS

NEXT >>

In 2005, 24 percent of California's 6 million children had never visited a dentist. Over two-thirds had visited a dentist in the past year, including 53 percent who had visits within the past six months. Clinical guidelines on the frequency of dental visits are not established, although the American Academy of Pediatric Dentistry recommends visits every six months.

Major Contributing Factors* to Dental Visit Disparities, Children, Aged 0–11 Years, California, 2005

Dental Care Utilization

Contributing Factors

<< PREVIOUS

NEXT >>

Children with any of the following characteristics are more likely to fall through the dental safety net: aged five and under; without dental insurance; from low income, Latino, or African American families; or whose parents lack English fluency.



LEAST LIKELY TO VISIT OR HAVE A RECENT VISIT

Age 5 and Under
Without Dental Insurance
Parents Do Not Speak English or
Are Not Very Fluent
Low Income[†]
Latino or African American

MOST LIKELY TO VISIT OR HAVE A RECENT VISIT

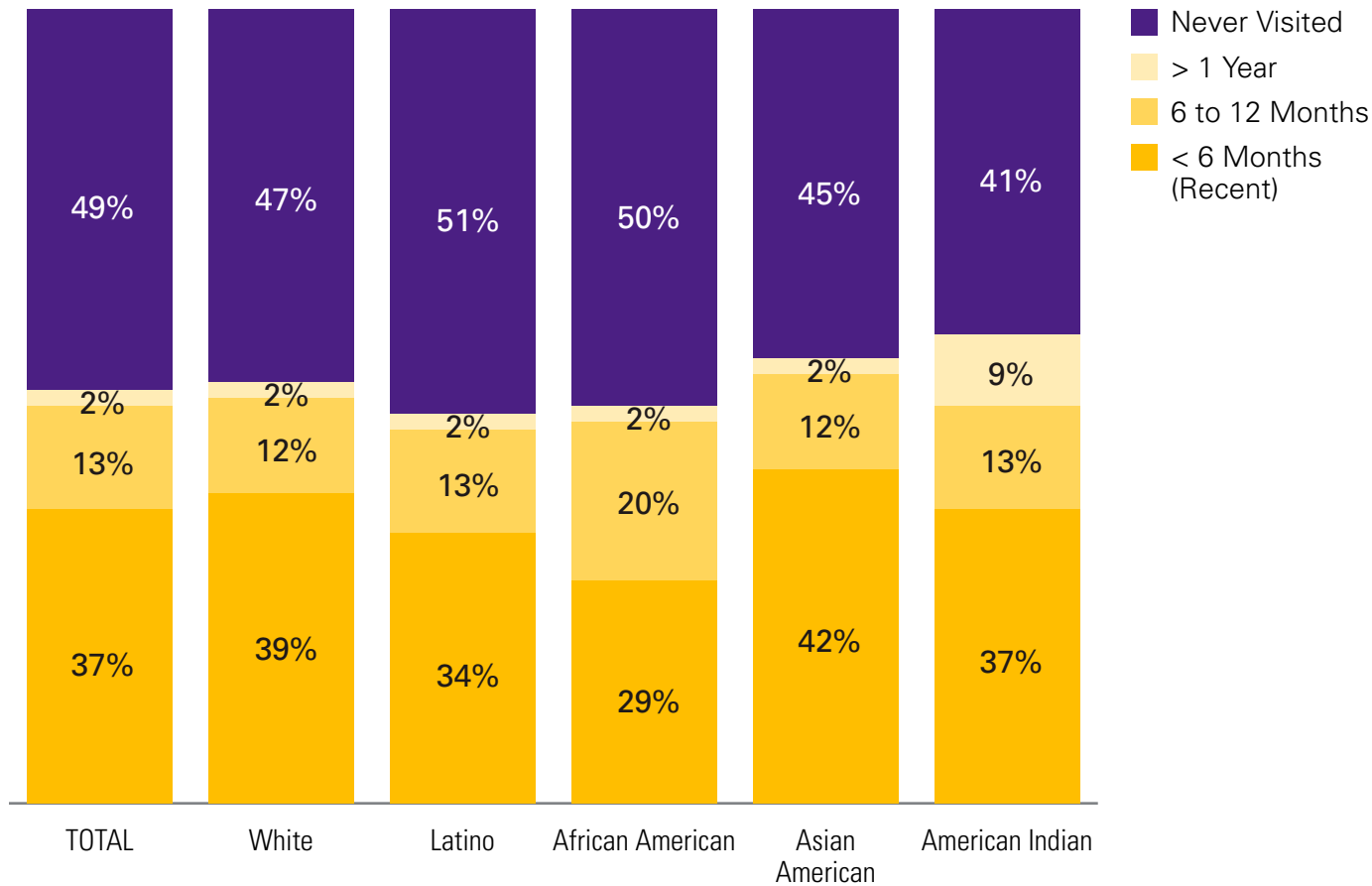
Over Age 5
With Dental Insurance
Parents are Native or
Very Fluent English Speakers
Higher Income[†]
White

*See methodology for details of multivariate analyses.

[†]“Low income” includes children from families living at less than 200 percent of the Federal Poverty Level (FPL). “Higher income” includes those living at 200 percent of the FPL and above. The 2005 FPL for a family of four was \$19,806.

Source: 2005 California Health Interview Survey.

Time Since Last Visit, Younger Children, by Race/Ethnicity, Aged 0–5 Years, California, 2005



Dental Care Utilization

Young Children

<< PREVIOUS

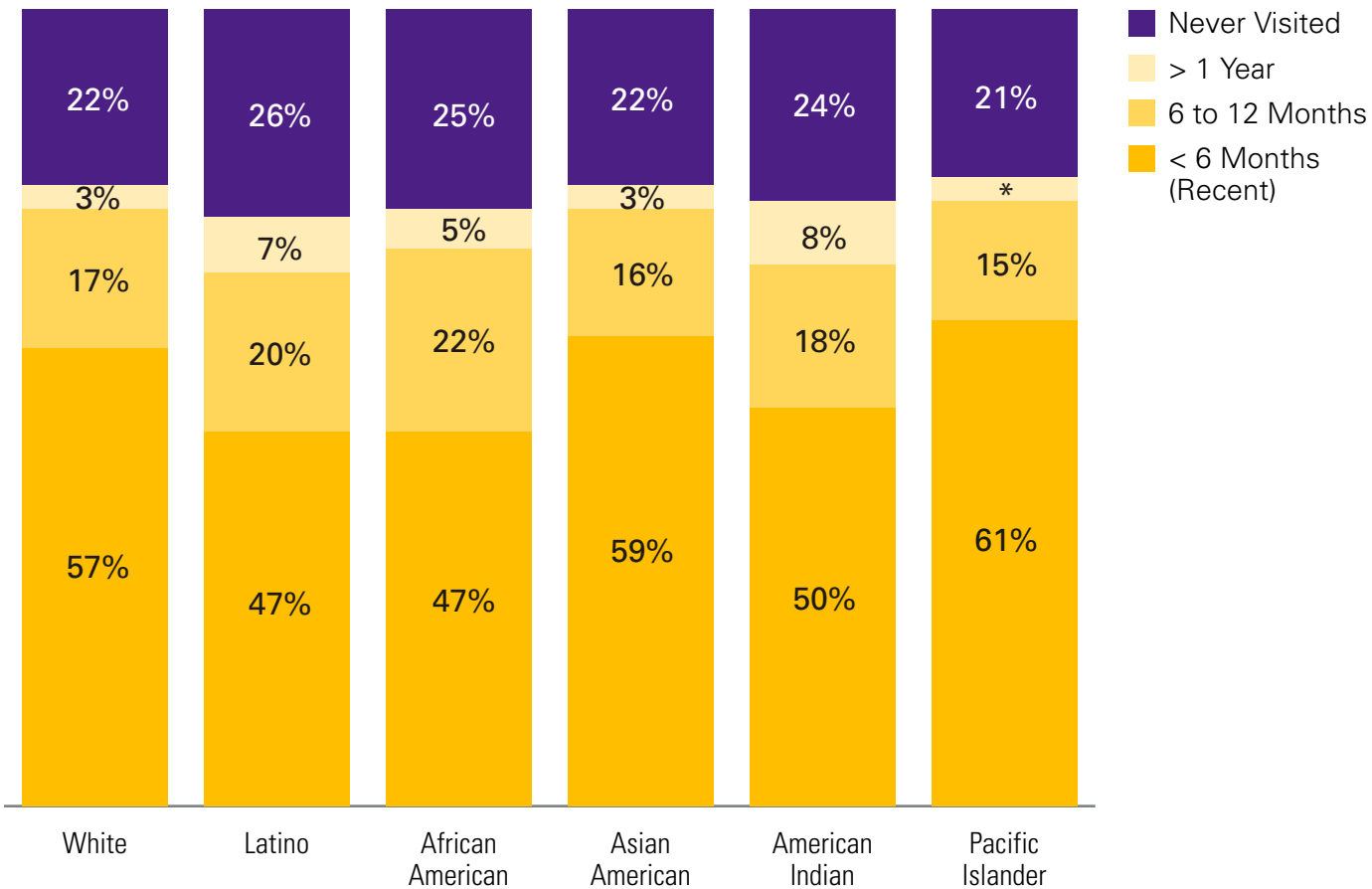
NEXT >>

Across all racial/ethnic groups, roughly one in every two young children have never visited the dentist. Young African American and Latino children were less likely to have had recent dental visits than Whites and Asian Americans.

Notes: The American Academy of Pediatric Dentistry recommends that children see the dentist after getting their first tooth and no later than 1 year of age to prevent tooth decay. http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf. Data for Pacific Islander and other/multiple race groups are not provided due to small sample sizes.

Source: 2005 California Health Interview Survey.

Time Since Last Dental Visit, by Race/Ethnicity, Children, Aged 0–11 Years, California, 2005



*Estimate not reported due to small sample size.

Note: Due to small sample sizes, the findings for American Indian and Pacific Islander groups were not statistically significant.

Source: 2005 California Health Interview Survey.

Dental Care Utilization

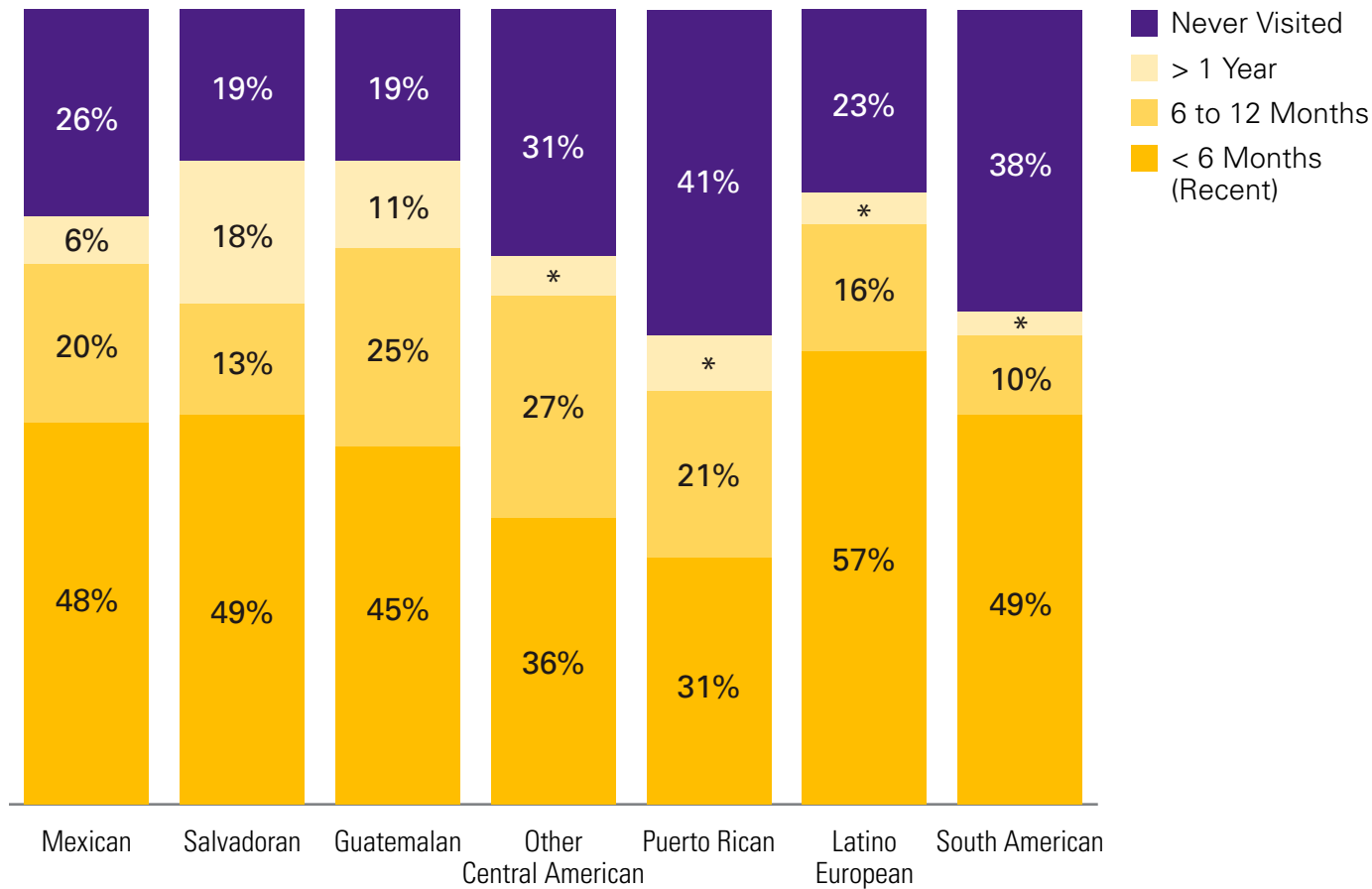
Race/Ethnicity

<< PREVIOUS

NEXT >>

In California, White and Asian American children had comparable rates of recent visits, while rates for Latino and African American children were lower. Latino children were less likely to have ever seen the dentist than White or Asian American children.

Time Since Last Dental Visit, by Latino Subgroup, Children, Aged 0–11 Years, California, 2005



Dental Care Utilization Race/Ethnicity

<< PREVIOUS

NEXT >>

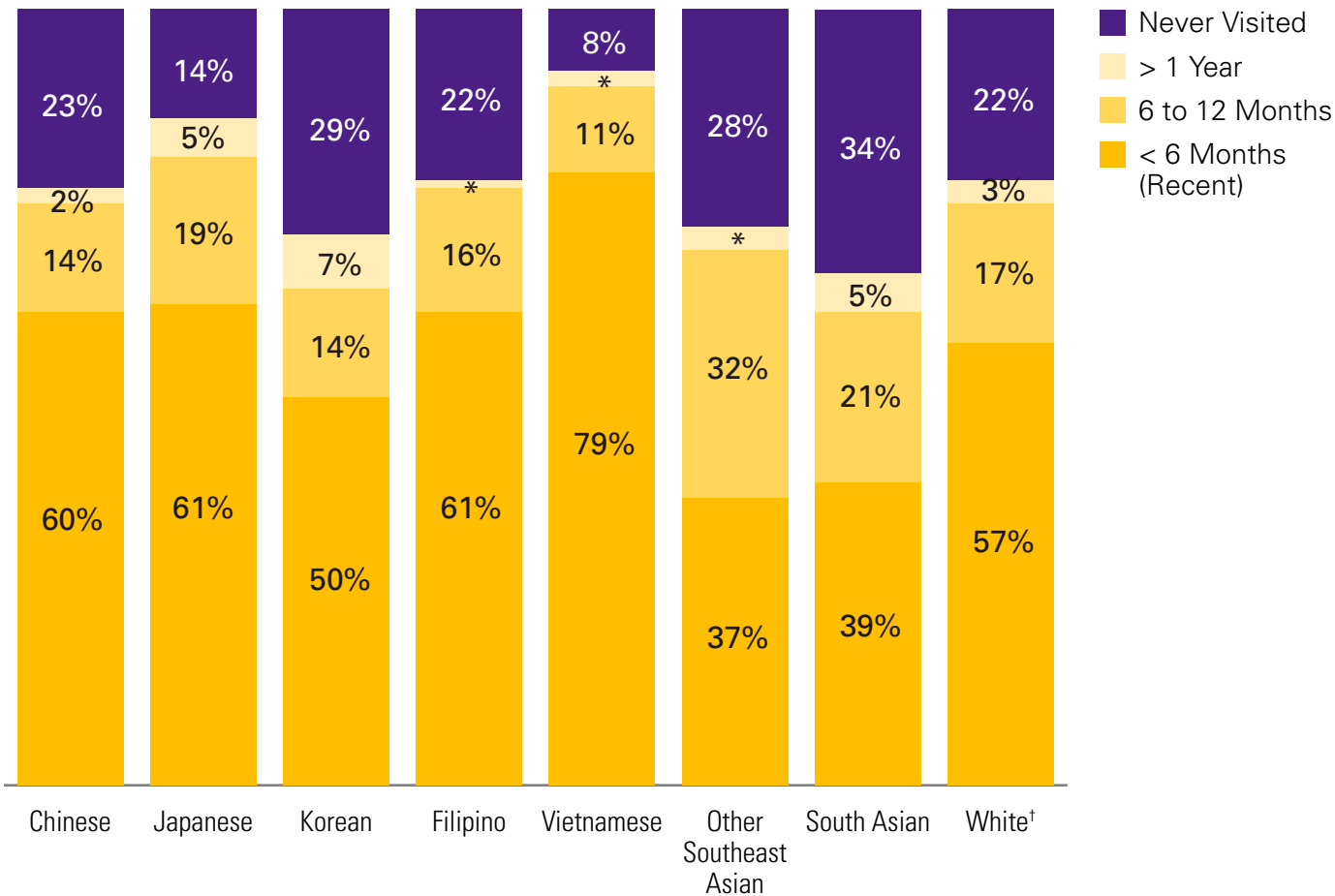
In 2005, Salvadorans were more likely to have seen the dentist than those from other Central American countries, Puerto Rico, or South America. Guatemalans were more likely to have seen the dentist than those from South America.

*Estimate not reported due to small sample size.

Notes: "Other Central American" includes Costa Rican, Honduran, Nicaraguan, and Panamanian. "Latin European" includes Spanish and Portuguese. Small sample sizes are the most likely reason for lack of significant differences among other Latino subgroups.

Source: 2005 California Health Interview Survey.

Time Since Last Dental Visit, by Asian American Subgroup, Children, Aged 0–11 Years, California, 2005



Dental Care Utilization Race/Ethnicity

<< PREVIOUS

NEXT >>

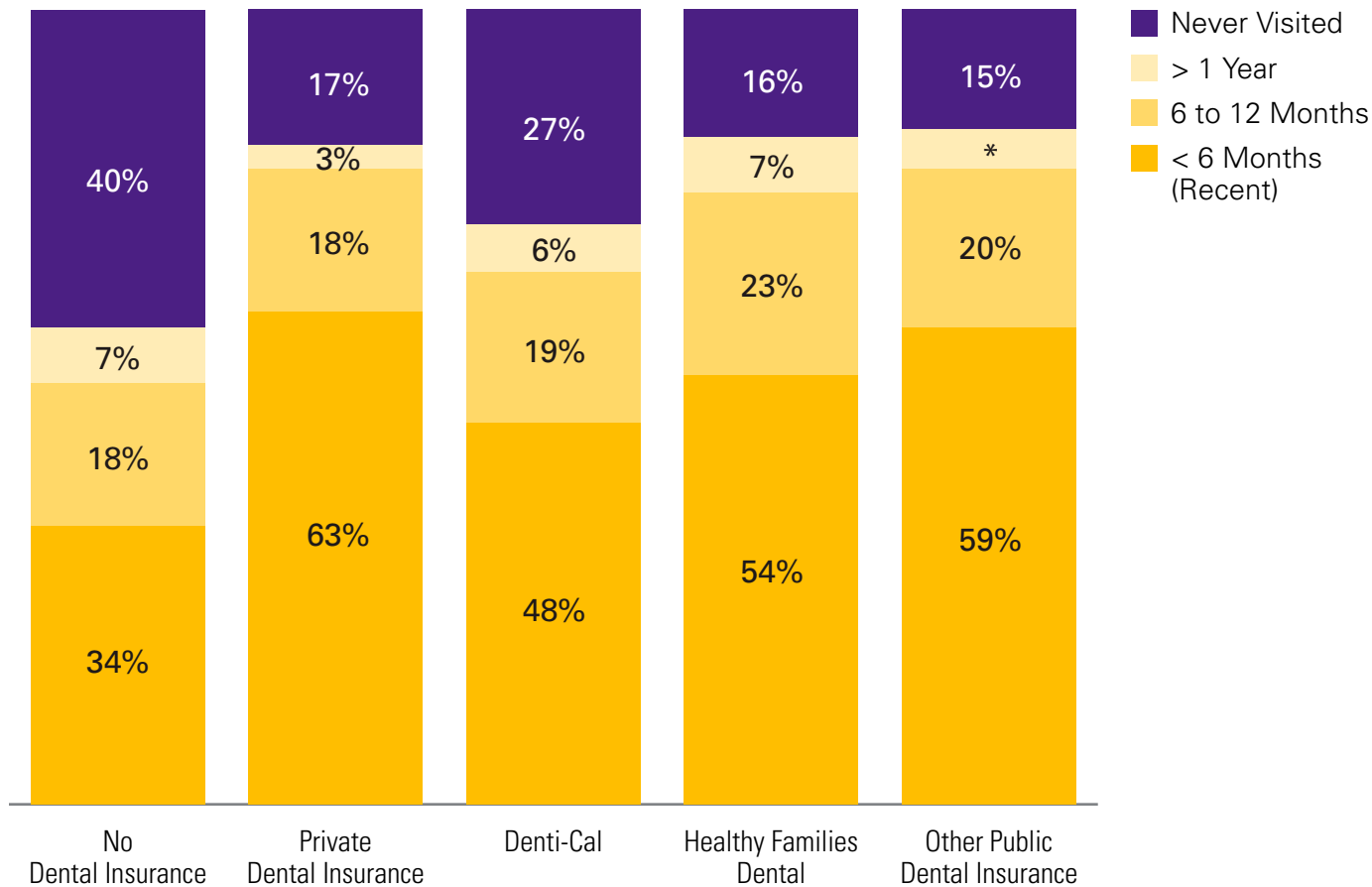
Vietnamese immigrants were most likely to have recent visits or to have ever visited the dentist than all other Asian subgroups. Chinese, Japanese, and Filipinos were also more likely to have recent visits, while South Asians and other Southeast Asians were least likely. South Asian, other Southeast Asians, and Koreans were least likely to have ever visited the dentist.

*Estimate not reported due to small sample size.

Notes: "Other Southeast Asian" includes Cambodian, Hmong, Indonesian, Burmese, Laotian, Malaysian, and Thai. "South Asian" includes Bangladeshi, Pakistani, Indian, Sri Lankan, Nepalese, and other South Asian heritage. Difference in rates between Vietnamese and Japanese for "never visited" was not statistically significant.

Source: 2005 California Health Interview Survey.

Time Since Last Dental Visit, by Dental Coverage, Children, Aged 0–11 Years, California, 2005



*Estimate not reported due to small sample size.

Source: 2005 California Health Interview Survey.

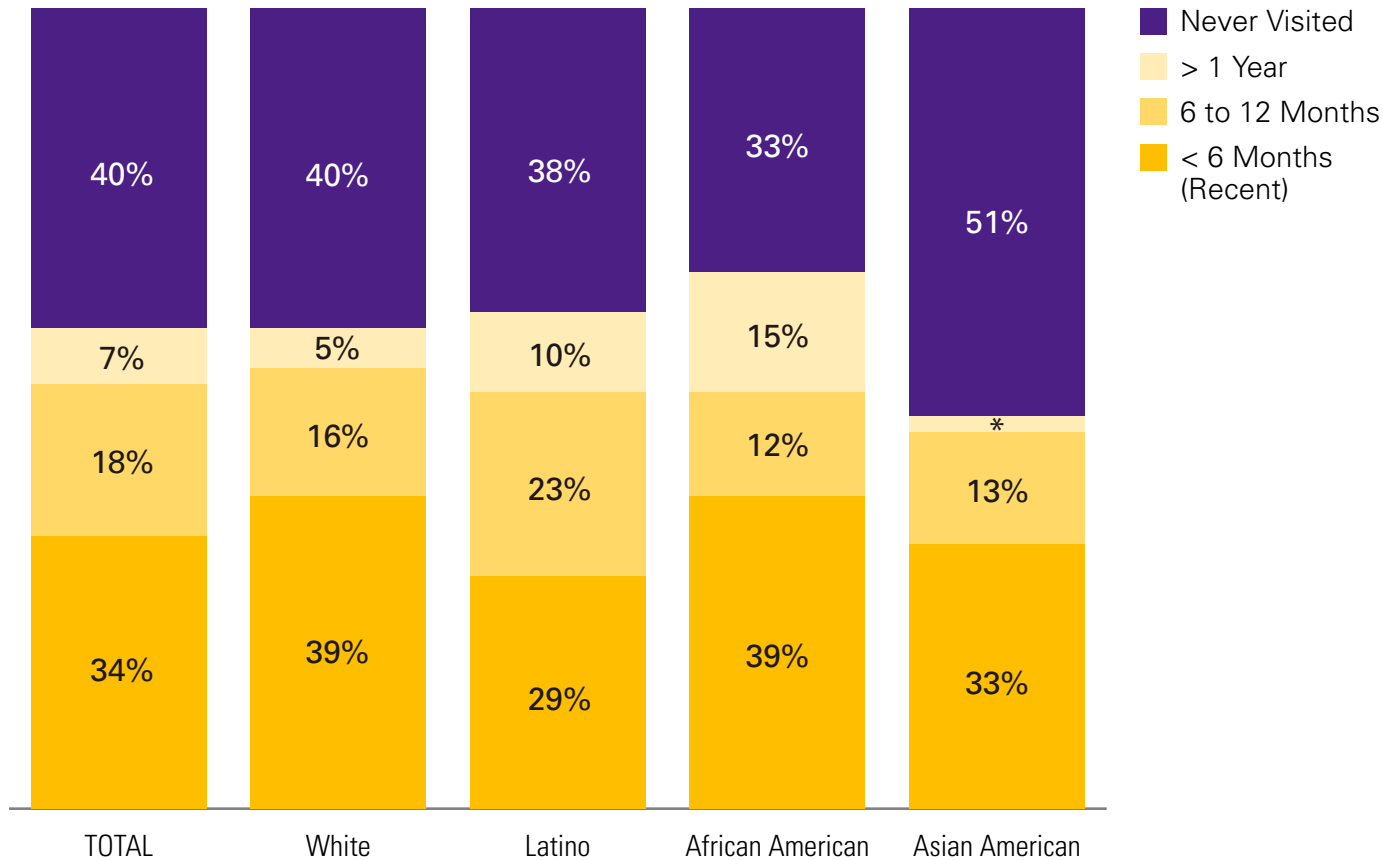
Dental Care Utilization Insurance Status

<< PREVIOUS

NEXT >>

Children without dental insurance were least likely to have had a recent dental visit and most likely to have never visited the dentist. Those with private dental insurance were more likely to have had a recent dental visit than Denti-Cal beneficiaries and Healthy Families enrollees. Although private and public dental insurance usually covers semi-annual visits, Denti-Cal beneficiaries were least likely to have ever seen the dentist compared to those with other insurance types.

Time Since Last Dental Visit for Children Without Dental Insurance, by Race/Ethnicity, Aged 0–11 Years, California, 2005



*Estimate not reported due to small sample size.

Note: Data for American Indian, Pacific Islander, and other/multiple race groups are not provided due to small sample sizes.

Source: 2005 California Health Interview Survey.

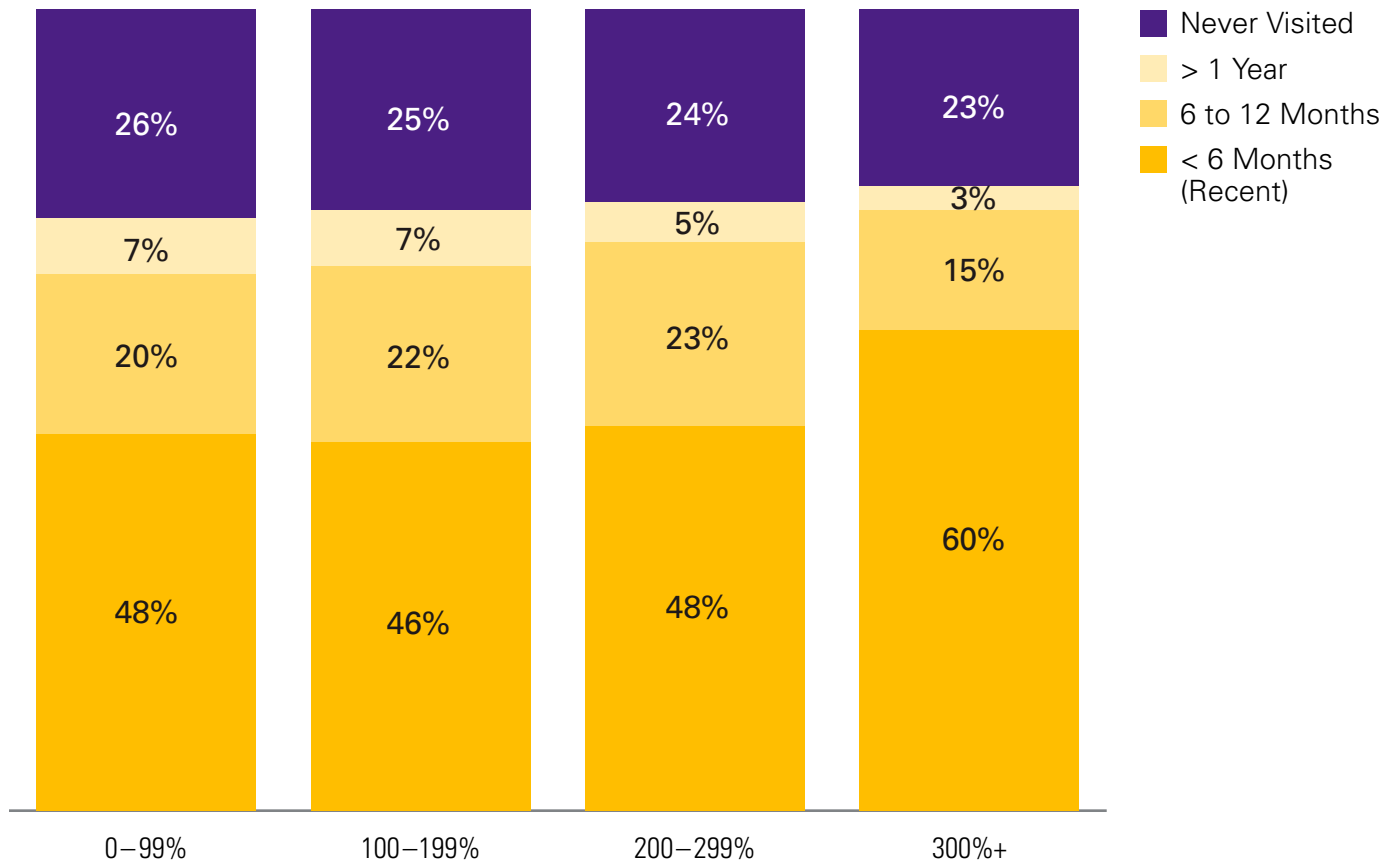
Dental Care Utilization Insurance Status

<< PREVIOUS

NEXT >>

Among children without dental insurance, Latinos were less likely than Whites to have seen the dentist recently, while half of all Asian Americans had never visited the dentist.

Time Since Last Dental Visit, by Federal Poverty Level,* Children, Aged 0–11 Years, California, 2005



Dental Care Utilization Economic Status

<< PREVIOUS

NEXT >>

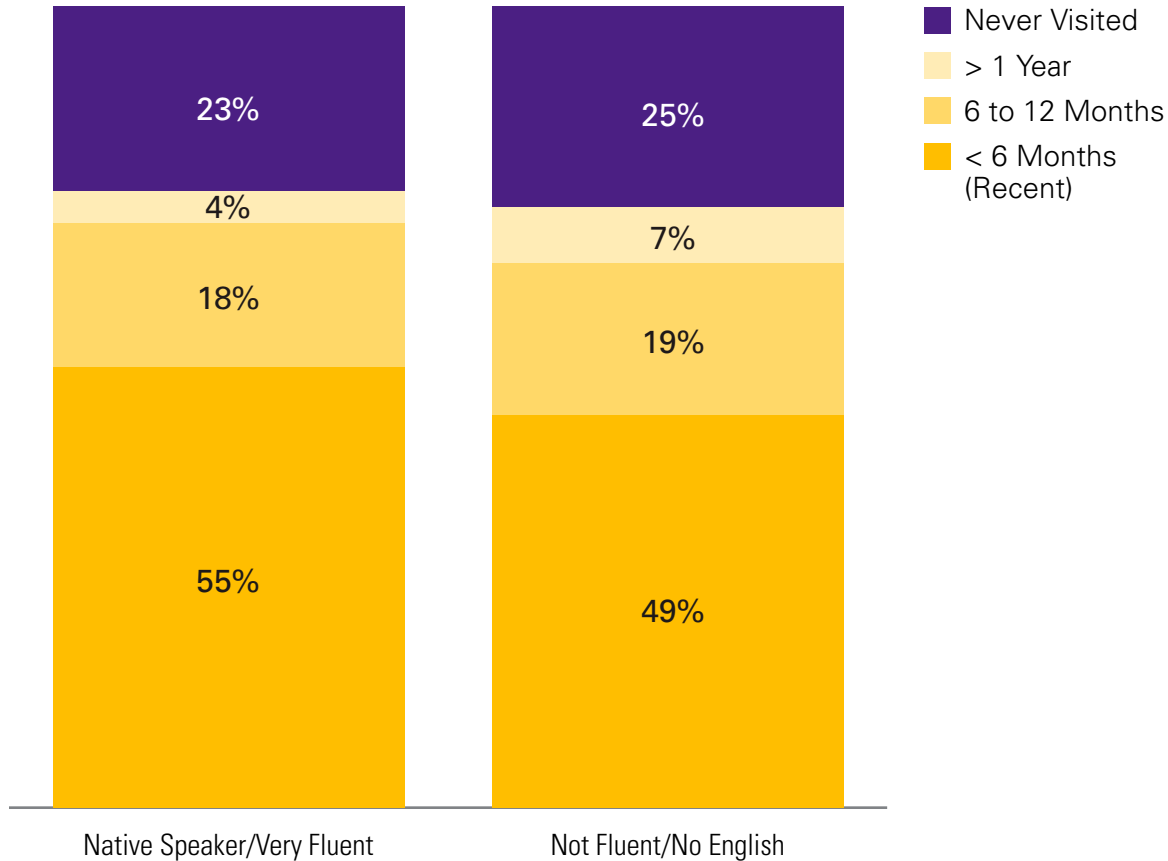
Children living in the highest income households were more likely to have had a recent dental visit than children living in poorer households. Children from the poorest families were less likely to have ever visited the dentist.

*The 2005 Federal Poverty Level for a family of four was \$19,806.

Note: Small sample sizes or inconsistent responses made it difficult to identify other statistically significant differences.

Source: 2005 California Health Interview Survey.

Time Since Last Dental Visit, by Parents' English Fluency, Children, Aged 0–11 Years, California, 2005



Source: 2005 California Health Interview Survey.

Dental Care Utilization

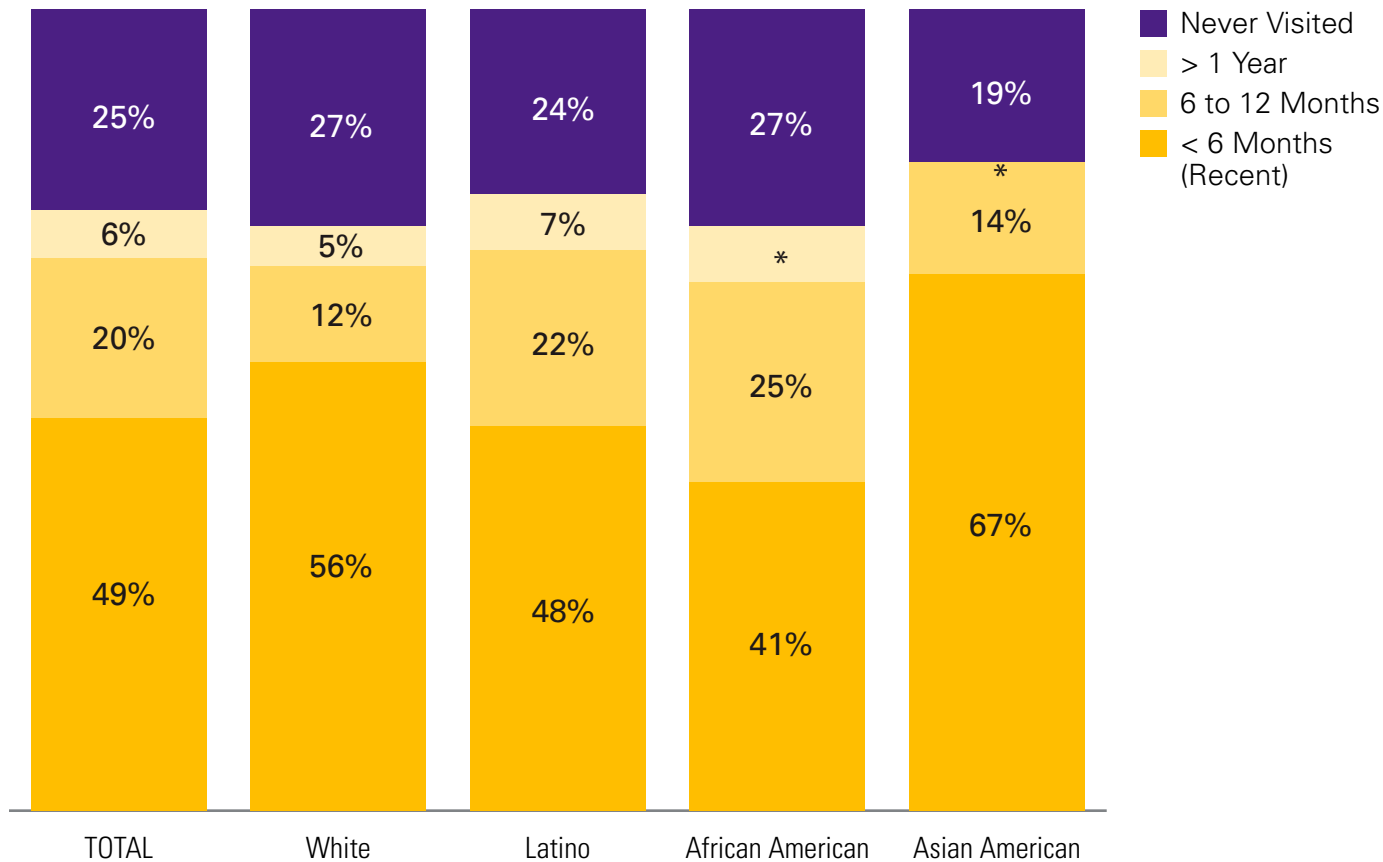
English Fluency

<< PREVIOUS

NEXT >>

Children with parents who are highly fluent or native English speakers were more likely to have visited the dentist and to have had a recent dental visit than those with parents who are not. More research is needed to show if this is due to a lack of culturally and linguistically competent providers or other factors.

Time Since Last Dental Visit, Children of Parents Without a High School Diploma, by Race/Ethnicity, Aged 0–11 Years, California, 2005



Dental Care Utilization

Education Level

<< PREVIOUS

NEXT >>

Among children with parents who did not finish high school, Latinos were less likely to have had a recent dental visit than Asian Americans.

*Estimate not reported due to small sample size.

Notes: Data for American Indian, Pacific Islander, and other/multiple race groups are not provided due to small sample sizes. Rates for “never visited” were statistically similar across racial/ethnic groups. Despite apparent differences in visit rates, the lack of statistical significance may be explained by small sample sizes or inconsistent responses.

Source: 2005 California Health Interview Survey.

Recommendations for Eliminating Oral Health Disparities

Oral Care for the Very Young

- **WIC programs, preschools, and childcare programs:** increase oral health outreach and education for children and parents. Increase outreach to children and parents through WIC programs, preschools, and childcare settings.
- **Major public payers such as Medi-Cal and Healthy Families:** offer payment incentives for general dentists to provide care to very young children.
- **Prenatal care providers:** offer oral health screening and education to pregnant women.
- **Professional societies and continuing education providers:** train pediatricians to counsel children and parents on the importance of oral health care.
- **Public health agencies and community-based organizations:** initiate a media campaign to increase understanding of the importance of oral health for young children.

Dental Insurance Coverage

- **Policymakers:** include dental benefits in national and state coverage expansion proposals and legislation aimed at expanding health insurance coverage for children.
- **Policymakers and employers:** reduce discrepancies in benefits, level of copayments for services, level of authorization, and reimbursement rates among public and private plans.

Recommendations for Eliminating Oral Health Disparities, continued

Cultural and Linguistic Competency

- **Dental service providers:** increase the availability of patient advisors, interpreters, and services offered in multiple languages, to improve parents' understanding of oral disease, and to help make appointments, complete paperwork, and reduce communication barriers during office visits.
- **Dentists and other oral health professionals:** improve the ability to provide culturally and linguistically competent care to limited-English proficient individuals from diverse cultures.

Understanding the Dental Care Delivery System and Racial/Ethnic Differences

Payers and health services researchers should consider studying:

- Other systemic factors that may contribute to racial/ethnic differences in dental visits.
- How the following affect dental visit rates: the supply of dentists in the area of residence, the availability of dentists accepting patients with public dental insurance, the availability of culturally or linguistically competent dentists, the availability of safety net dental care providers, and having an identified and usual source of dental care.
- How different racial/ethnic groups use specialty services or pediatric dentists.

Acknowledgments

Author

Nadereh Pourat, Ph.D.
UCLA Center for Health Policy Research
pourat@ucla.edu

The author would like to thank the following individuals for reviewing this snapshot and offering their expertise:

Elizabeth Mertz, M.P.A.
Program Director
UCSF Center for the Health Professions

Jane A. Weintraub, D.D.S., M.P.H.
Lee Hysan Professor, Chair, Division of Oral Epidemiology and Dental Public Health
Center to Address Disparities in Children's Oral Health
UCSF School of Dentistry

Joel Diring, J.D., M.P.H.
Diring & Associates

Dental Care Utilization Appendix

<< PREVIOUS

NEXT >>

GIVE US YOUR FEEDBACK

Was the information provided in this report of value? Are there additional kinds of information or data you would like to see included in future reports of this type? Is there other research in this subject area you would like to see? We would like to know.



PLEASE CLICK HERE
to give us your feedback.
Thank you.

FOR MORE INFORMATION



CALIFORNIA
HEALTHCARE
FOUNDATION

California HealthCare Foundation
1438 Webster Street, Suite 400
Oakland, CA 94612

510.238.1040
www.chcf.org

Methodology | Dental Care Utilization

The data for this report came from the 2005 California Health Interview Survey (CHIS), a representative survey of over 58,000 individuals, including over 11,300 children aged 0 to 11, conducted in five languages in addition to English to capture the majority of monolingual and linguistically isolated populations of the state. All children aged 0 to 11 with teeth were included in the analyses reported herein. Parents of these children were asked to report on visits to dental providers by answering the following question: “About how long has it been since your child last visited a dentist or dental clinic? Include dental hygienists and all types of dental specialists.” Response categories included 1) Less than 6 months; 2) 6 to 12 months; 3) 1 to 2 years; 4) 3 to 5 years; 5) longer than 5 years, and 6) has never visited. Few children reported visits of 3 to 5 years or longer than 5 years.

Thus, those in categories 3, 4, and 5 were combined into 1 or more years to provide sufficient sample sizes for accurate reporting of estimates. The category “less than 6 months” is slightly different from the conventional practice of visits every 6 months. However, both responses require an estimation of time by the respondent and are subject to the same level of recall bias, and thus remain relatively close. Furthermore, it is likely that a small group of children in the “less than 6 months” category had less frequent visits in the more distant past, or this visit was their first. This is a limitation of cross-sectional survey data where the same individuals are not followed over time. Therefore, this data may slightly overestimate the percent of children with recent visits.

Racial/ethnic categories included White, Latino, African American, Asian American, American Indian/Alaska Native (referred to as American Indian for ease of reporting), Pacific Islander, and those with multiple racial/ethnic origins who did not identify a primary racial/ethnic affiliation or an unspecified single race. Data on the last three categories were not reported when small sample sizes prohibited accurate estimates. Latino populations are grouped together and titled “Latino.” All other groups are non-Latino.

Age categories included children aged 5 years or younger and 6 to 11 years. These age groups represent the various stages of dental development among children as well as the beginning of school-based oral health promotion interventions.

English proficiency of parents was categorized into native English speakers and those who speak English very well; those speaking English well; and those who do not speak English well or not at all. The first category is intended to reflect the ability to communicate effectively in English in the medical context.¹ Those who are native English speakers or very fluent are expected to have no communication difficulties due to lack of English proficiency, while those speaking well are expected to have mild difficulties, and those not fluent or who only speak a language other than English to have the most difficulty.

Those reporting dental insurance coverage were further distinguished into Denti-Cal (Medi-Cal), Healthy Families, or other government programs. Those not enrolled

in public insurance programs consist of group and individually purchased policies and were referred to as private dental coverage for ease of reference.

The differences highlighted in the body of the report are statistically significant at $p < 0.05$, unless otherwise noted.

Statistical Analyses Methodology

The results and recommendations presented in this snapshot are based on the author’s extensive multivariate analyses of the 2005 California Health Interview Survey data. The following factors contributed to dental visit disparities, independent of other variables included in these analyses:

- 1) **Children aged 0 to 5**—statistically significant for any visit.
- 2) **Lack of dental insurance**—statistically significant for any visit and recent visits.
- 3) **Limited English fluency of parent**—statistically significant for any visit.
- 4) **Family income below 200 percent of the Federal Poverty Level**—statistically significant for recent visits.
- 5) **Being Latino or African American**—statistically significant for recent visits.

Variables included in multivariate analyses: age, race/ethnicity, dental insurance status, family’s income status with respect to the Federal Poverty Level, parents’ English fluency, immigration status, parents’ education level, geographic region, and overall health status.

1. Kominski, R. *How Good Is “How Well”? An Examination of the Census English-Speaking Question*. 1989. U.S. Bureau of the Census, Washington D.C.