Dentistry and Childhood Poverty in the United States

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The proportion and numbers of children living in low income families and without health insurance continues to increase. The magnitude of these problems is considered at localized levels in terms of the impact on the use of dental services.

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> "…The American Community Survey found that the child poverty rate continued to rise even after the recession, with 22 percent of children living in poverty in 2010." [1]

> "More than half of low income (below 200% of the poverty level) children without health insurance had no preventive dental care visits." [2]

INTRODUCTION

It seems almost unnecessary to emphasize the repeated reports in the literature that children in low income families and those without health insurance are faced with limited access to dental care and increased levels of unmet of dental needs.[2-7] And if the child has special care needs, then the extent of unmet dental services increases dramatically.[8,9] The results from the latest national study of children with special health needs highlighted the fact that, "The service most commonly reported as needed but not received was preventive dental care..."[10]

The emphasis on unmet dental needs should not overshadow the many other health issues faced by children raised in families faced with economic deficiencies. Children living in poverty grow up with stresses that can impact their physical development and make them vulnerable to infection and disease for the rest of their lives. "In adulthood, this often leads to metabolic syndrome – high blood pressure, impaired regulation of blood sugar and facts, fat around the waist – that are precursors to diabetes, heart disease and other conditions." [11]

Mega numbers

The use of national numbers in terms of millions of people, hundreds of billions of dollars for health costs and even trillions of dollars to describe our national debt is beyond the comprehension of most people. For example:

"The national percentage of low-income (below 200% of the poverty level) children rose from 39 percent (28.6 million children) in 2007 to 44 percent (32.2 million children) in 2010." [12]

We find it difficult to personalize such information and tend to skip over the data without considering the consequences for individual children and their families. While we cannot document the impact on each family, the use of more specific information at more local levels and by race/ethnicity can assist in understanding the magnitude of the wide variations in the extent of poverty, the availability of health insurance, and the ability to obtain dental services for children.

Dentists and other health professionals provide services at local community levels. The need is to develop awareness as to the extent of the limited finances which impact the use of health services for children. As an illustration, while having some form of dental insurance is associated with higher care utilization, having Medicaid coverage, a cornerstone of health care for low income children, offers limited potential for children. Only about 20 percent of eligible children receive preventive services under the Medicaid programs.[13] Dentists consistently report low reimbursement rates, bureaucracy and problems with patients as deterrents to Medicaid acceptance.

Poverty levels

The federal poverty level is the minimum income needed for most families to make ends meet. Families and their children experience poverty when they are unable to achieve a minimum, decent standard of living that allows them to participate fully in mainstream society. In 2009-2010, the

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poverty level for a family of four in the forty-eight contiguous states and the District of Columbia was $22,050, $25,360 in Hawaii and $27,570 in Alaska.[14]

The 200% level ($44,000 for a family of four) or "low income" level is used to include those individuals living in poverty and those who are just slightly above the poverty level. Although families with incomes between 100 and 200 percent of the poverty level are not officially classified as poor, many face material hardships and financial pressures similar to families with incomes below the poverty level. Missed rent payments, utility shut offs, inadequate access to health care, unstable child care arrangements, and running out of food are not uncommon for such families.[15]

In 2010, the proportion of children living in low income families ranged from 26% in New Hampshire to 57% in Mississippi. The numbers ranged from 49,000 in Vermont to 4,234,000 in California. (Table 1)

Table 1. Range of proportion and numbers in 000s of U.S. children living below 200 percent of the poverty level by states: 2010 [16]

Total		Low		High
Proportion				
U.S.	New Hampshire	26%	Mississippi	57%
44%	Connecticut	28	Arkansas	
			New Mexico	55
Numbers (in 000s)				
U.S.	Vermont	49	California	4,234
32,166	Wyoming	52	Texas	3,455

Low-income families in large cities

Among the largest cities in the country, the differences in the proportion of children living in low-income (below 200% of the poverty level) families in 2010 ranged from Milwaukee WI (81%) and Cleveland OH (80%) to Virginia Beach VA (32%) and Seattle WA (29%). The greatest increase in rates of children living in low-income families between 2007 and 2010 was the 37% increase in Mesa AZ and the 24% increase in Charlotte NC. [12]

Living in poverty by race/ethnicity in states

Nationally in 2010, 13 and 14 percent of white and Asian/Pacific Islander children, compared to over 30 percent of children from other minority populations were living in poverty. Among the states for which data are available, there were marked differences in the proportion of children living in poverty for each racial/ethnic population. For example:

- Asian/Pacific Islanders - 2% in Delaware and 24% in Minnesota and Indiana.
- Blacks – 5% in Alaska and 53% in Wisconsin.
- Whites – 5% in Connecticut and 24% in West Virginia. (Table 2)

Table 2. Range of proportion of U.S. children living in poverty by race/ethnicity and states: 2010 [16]

Total*		Low		High
Proportion				
U.S.	New Hampshire	10%	Mississippi	33%
22%	Connecticut, Maryland	13	New Mexico	30
Non-Hispanic White	District of Columbia	< .5	West Virginia	24
13%	Connecticut	5	Kentucky	23
Black	Alaska	5	Wisconsin	53
38%	Maryland	22	Mississippi	49
Asian/Pacific Islander	Delaware	2	Minnesota	24
14%	Connecticut	5	Indiana	24
American Indian	Alaska	24	South Dakota	54
35%	California	31	New Mexico	44
Hispanic	Alaska	11	South Carolina	44
32%	Maryland	16	North Carolina	43

* Totals and data for non-Hispanic white children include all states.

Data by state include 33 states for blacks, 28 states for Asian/Pacific Islanders, 7 states for American Indians and 40 states for Hispanics.

The categories black, American Indian, and Asian and Pacific Islander include both Hispanic and non-Hispanic. Those in the Hispanic category include those identified as being in one of the non-white race groups.

The great numeric ranges of children in poverty in each of the population categories are a reflection of the greater overall population in some states. Nevertheless it provides a picture of the magnitude of the difficulties to be considered.

- Hispanics – 2,000 in Alaska and 1,425,000 in California.
- American Indians – 8,000 in Alaska and 38,000 in Arizona.
- Total for all population groups – 19,000 in Wyoming and 2,013,000 in California. (Table 3).

Children without health insurance

The availability of some form of health insurance (whether private or some governmental program) is a critical element in securing needed health services. The reality is that in 2009, 10 percent of children (7,389,000 children) lacked any form of health insurance, including 17 percent of the children in Texas and Nevada and more than a million children in Texas and California. (Table 4)

Proportions, numbers and politics

Listing too many proportions and numbers in more localized terms can be just as much "a turn-off" as coming to

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Table 3. Range of numbers in 000s of U.S. children living in poverty by race/ethnicity and states: 2010 [16]

Numbers (in 000s)				
Total *		Low		High
U.S. 15,749	Wyoming	19	California	2,013
	Vermont	21	Texas	1,751
Non-Hispanic White 5,103	Hawaii	4	Ohio	347
	Alaska	9	New York	265
Black 4,025	Kansas	17	Florida	324
	Delaware	18	Georgia	305
Asian/Pacific Islanders 455	Connecticut	2	California	132
	Colorado, Missouri Kansas	3	New York	59
American Indian 254	Alaska	8	Arizona	38
	Washington	9	Oklahoma	26
Hispanic 5,472	Alaska	2	California	1,415
	Hawaii	9	Texas	1,176

* Totals and data for non-Hispanic white children include all states.

Data by state include 33 states for blacks, 28 states for Asian/Pacific Islanders, 7 states for American Indians and 40 states for Hispanics.

The categories black, American Indian, and Asian and Pacific Islander include both Hispanic and non-Hispanic. Those in the Hispanic category include those identified as being in one of the non-white race groups.

Table 4. Range of proportion and numbers in 000s of U.S. children without health insurance by states: 2009 16

Proportion				
Total		Low		High
U.S. 10%	Massachusetts	3%	Texas, Nevada	17%
	Hawaii, Vermont, New Hampshire	4	Florida	16
Numbers (in 000s)				
U.S. 7,389	Vermont	6	Texas	1,173
	Hawaii	11	California	1,010

terms with “mega numbers.” Nevertheless, each provides a quantitative description of children living in levels of poverty and with no health insurance — two factors which are the cornerstone factors in the utilization of dental services.

The traditional image of many dentists is of individuals who provide an essential service, but whose perception of care needs tends to be limited to those who seek care within the confines of his/her practice. All too often, the magnitude of the number of children who seldom seek care from individual dentists is lost — due to economic limitations, lack of insurance (including the non-acceptance of Medicaid patients), as well as the reluctance to provide care to children with special needs.

The reality is that various dental hygienist and dental assistant groups, dental educators and government agencies are lobbying (in some states) successfully to meet the need with the development of mid-level dental professionals. Perhaps the combined use of mega numbers, proportions and numbers in more localized terms will provide a greater appreciation of the need for dental care of underserved youngsters in the practitioner’s community.

CONCLUSION

The truth is that significant numbers of children living in conditions of poverty lack health insurances and are unable to secure necessary dental services. The need is to increase practitioner awareness that unless innovate efforts are initiated to meet this crisis, the public and their legislative representatives may seek to establish programs which may not be in the best interests of the youngsters we serve.

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