Taking a Bite Out of Oral Health Inequities:

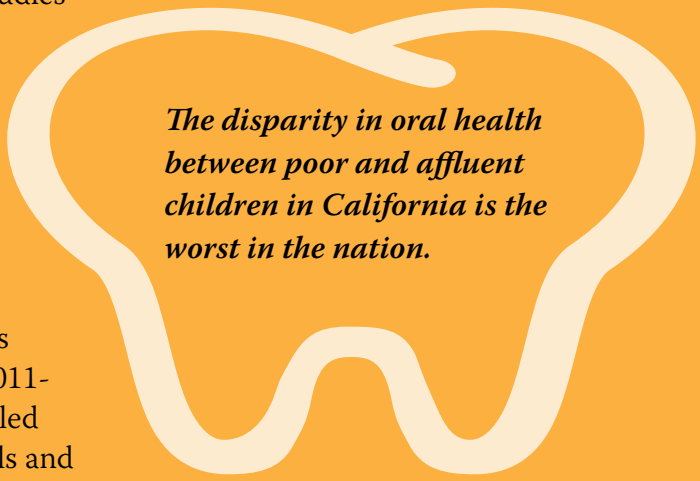
Promoting Equitable Oral Health Policies for Communities of Color

CPEHN
California Pan-Ethnic Health Network

Introduction and Background

Oral health is more than toothaches, caries, and plaque. In fact, oral health can significantly impact one's overall health. It contributes to school absences and poor academic performance. It can lead to missed work days and even trouble getting a job. And it can also contribute to and worsen serious chronic conditions such as heart disease, diabetes, and stroke. However, oral health is often overlooked as a pressing health issue.

The causes of poor oral health are numerous, including an inability to access dental providers, barriers due to limited English proficiency, and the cost of dental insurance.[1] And, as with many health disparities, what often doesn't get considered are the other factors that contribute to poor oral health such as poverty and food security. In California, 23% of children between the ages of 0-18 live in poverty.[2] Studies show that children living in poverty have five times more untreated dental decay than children from families with higher incomes.[3] As one researcher stated: "The disparity in oral health between poor and affluent children in California is the worst in the nation," even though California has more dentists per capita, compared to other states.[4,5]



A consequence of poverty is food insecurity, which is the inability to consistently afford enough food. In 2011-12, at least 4 million low-income Californians struggled with food insecurity.[6] Research shows that individuals and families experiencing food insecurity select high density, high fat foods over healthy foods due to cost and volume.[7] Even without food insecurity, many high poverty neighborhoods have fewer grocery stores that sell fresh produce and instead are host to numerous fast food outlets, corner stores, and markets selling foods high in sugar and simple carbohydrates.[8] Often this dearth of healthy food options leads to an increased consumption of sugary foods – the greatest contributor to dental caries.[9] The combination of limited access to a dental provider and high consumption of unhealthy foods results in poor oral health, a higher likelihood of chronic health conditions, lower school and work attendance, and a lower quality of life for low-income Californians.

If we want to improve the overall health of low-income, communities of color increasing oral health outcomes must also be central to any health equity agenda. Advancing oral health equity will require a multipronged approach to address access to care, quality of care, and the underlying social and environmental conditions that impact oral health. This brief highlights oral health disparities within communities of color, identifies some of the causes of inequities, and provides policy recommendations to advance oral health equity in communities of color.

Oral Health Disparities

Oral health disparities disproportionately impact communities of color, Limited English Proficient (LEP) populations, and low-income communities, and an inability to access dental care services contributes to these disparities. For example, African American and Latino children are less likely to have seen a dental provider and often wait longer between visits.[10] Other studies have found that Latino children have disproportionately lower oral health rankings and less access to dental care than any other ethnic group in the state.[11] We do not have comparable data on Native Americans in California due to a lack of appropriate data collection, but nationally, American Indian and Alaska Native children are four times more likely to have untreated tooth decay than White children, and two times more likely than Hispanic and Black children.[12]

While we know that low-income adults face oral health disparities, the systems to collect and monitor data by demographics such as race, ethnicity, immigration status, language, gender, age, and sexual orientation are severely lacking. Additionally children's access to dental care is impacted by their parents' ability to get care. When parents have a regular source of dental care so do their children.[13] Recent cuts in California's state budget included the elimination of dental care for adults in California's Medi-Cal program, called Denti-Cal, in 2009.[14] During the years that adult dental benefits were cut, spending on children's coverage in California actually went up, presumably due to the drop in adult patients seeking coverage and appointments.[15] While dental benefits were partially restored in 2014, the long gap in coverage has resulted in a decrease in dental providers serving the program and higher demand. For example, a recent state audit of Denti-Cal found that patients experienced difficulties finding dental providers who would treat them.[16]

The inability to access dental health care services results in high proportions of disparities among children and adults within low-income and communities of color.

This is especially important due to the impact oral health has on other health conditions, disproportionately seen in communities of color. For example, American Indians/Alaskan Natives, African Americans, Latinos, and Asian Americans have higher rates of diabetes compared to non-Hispanic Whites.[17] These communities also experience environmental challenges, food insecurity, and less access to dental providers at higher proportions. The combined impact of these inequities creates an urgent health situation for many within communities of color.

The Impact of Oral Health Inequities on Communities of Color

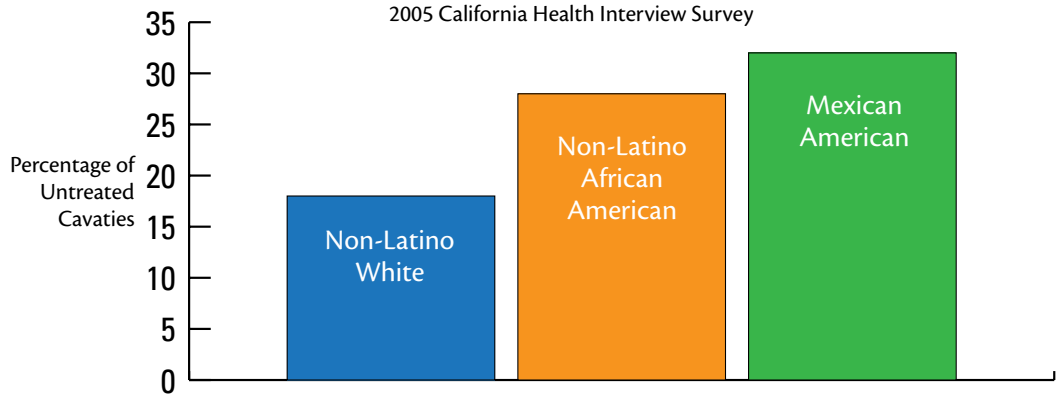
Oral health disparities impact communities of color in many ways. Not only can dealing with an oral health issue keep children from attending school and being successful in their studies, it can mean missed work days for adults and potentially impacts their ability to find a job if unemployed. Poor oral health also has long-term impacts on overall health.

Oral Health and Children

Dental problems account for 874,000 missed days of school and cost schools over $29 million annually.

Poor oral health can prevent a child's success in school. Tooth decay is one of the most common chronic illnesses for school-age children in the United States,[18] and children of color are impacted at higher rates than White children (see Figure 1). Poor oral health in children can lead to pain, susceptibility to infections, nutritional problems, sleep deprivation, and poor concentration, all of which affect a child's ability to be present and fully participate in school.[19] In fact, children who do not have dental insurance or are unable to use their coverage have lower school performance than their peers who regularly go to the dentist.[20] Additionally, students who reported recent tooth pain were four times more likely to have a lower grade point average.[21] Aside from the high cost to schools, missing school contributes to a vicious cycle – missed school days leads to low school performance, which increases the likelihood of not receiving a high school diploma and obtaining a job with dental insurance.

Figure 1: Tooth Decay in Children by Race/Ethnicity
2005 California Health Interview Survey



Oral Health and Employment

Employed adults miss 164 million hours of work each year due to oral health problems or dental visits.

Poor oral health results in millions of missed work hours each year, and can even potentially cause job loss. Adults with missing teeth are more likely to report having trouble finding employment due to negative judgments on their appearance or speech.[22] While data is limited, research shows that treatment for oral health conditions can improve employment opportunities for low-income adults.[23] In addition to hours of work lost and the impact of lost salaries and benefits, oral pain can limit day-to-day activity, including impacting one's ability to sleep, and can lessen overall quality of life.

Oral Health and Chronic Conditions

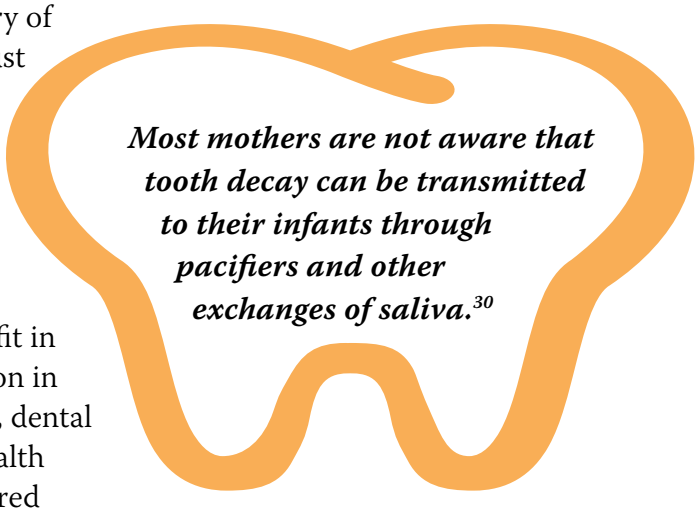
Dental disease can exacerbate and often initiate other health problems, leading to a diminished quality of life. Oral diseases such as gingivitis and periodontal disease can be a risk to general health, particularly for those with other chronic conditions.[24] The relationship between diabetes and periodontal disease is reciprocal. Gum disease makes it hard for diabetics to control their blood sugar and often can increase one's blood sugar, putting them at higher risk of diabetes-related complications.[25] At the same time, the bacteria produced by food consumption can turn into toxins which can stimulate a chronic inflammatory response, causing the body to break down tissue and bones in the mouth.[26] This inflammatory response can also impact the body's ability to manage other health conditions such as high blood pressure and diabetes.[27] Oral health is also extremely important for pregnant mothers because it can impact the birth of the child.[28] Maternal periodontal disease during pregnancy is associated with increased pre-term deliveries and low birth weight.[29] Most mothers are not aware that tooth decay can be transmitted to their infants through pacifiers and other exchanges of saliva.[30] Thus, treating gum disease may positively impact the management of health conditions.

Causes of Oral Health Inequities in Communities of Color

Good oral health is determined by much more than the ability to go to the dentist. How a person utilizes dental care can depend on any number of factors including access to affordable dental coverage, availability of culturally and linguistically appropriate dental care, and the social and environmental landscape in which we live. Given that communities of color often face a number of these barriers simultaneously, the challenge to improve oral health requires work on multiple fronts. Some of the key obstacles impacting low-income, communities of color include:

Lack of Access to Affordable Dental Care

The inability to afford dental care is one of the most challenging barriers to good oral health. Dental care is the greatest unmet health need of American children.[31] Traditionally, dental care and coverage have been separated from the delivery of primary health care. To access dental care, one must purchase coverage through an employer, if those benefits are offered. Or, if eligible for a public health care program, such as Medi-Cal, children and families can receive free and low-cost dental coverage – if they are even aware that they are eligible for the benefit. Although partially restored in 2014, adult dental care is not a mandatory benefit in Medi-Cal and it remains under threat of elimination in tight budget years. Under the Affordable Care Act, dental insurance for children is one of the 10 essential health benefits and is included in all health plans in Covered California. Starting in 2016, optional dental coverage for adults will be available for purchase, but will not be eligible for subsidies. Additionally, undocumented immigrants have even fewer options for oral health coverage due to eligibility restrictions in Medi-Cal and Covered California. While community health centers have been a key source of oral health care they may not always have the capacity to provide the full range of preventive services.



Even with dental coverage, many families struggle to find a provider. For example, children in low income families and rural communities have had the most difficulty accessing dental care.[32] In addition, many families in the Denti-Cal program have not been able to access services. According to a recent state audit, more than half of the 5.1 million children enrolled in Denti-Cal did not receive dental care in 2014, and some counties lack sufficient providers to meet the demand for services and care.[33] One of the most common reasons providers cite for not accepting Denti-Cal patients is the historically low reimbursement rate.[34]

A Limited Culturally and Linguistically Competent Workforce

The shortage of dental providers, especially providers of color, creates challenges for communities of color accessing oral health care. California has the largest number of dentists in the country; however, many counties across the state face a shortage of dentists. In California, there are approximately 31,520 licensed dentists with about half actively practicing. However, only 14% work in community clinics, which are generally located in underserved areas and serve low-income communities of color.[35]

Even with dental coverage, language barriers often deter Limited English Proficient patients from seeking oral health care. One study of Medicaid dental enrollees found that Latinos often said that being able to speak to someone in their language on the phone and in person was a major barrier to receiving dental care for their children.[36] In addition, Latinos and Asians often experience difficulty understanding their health care provider at higher rates.[37] Communities of color also experience negative attitudes in dental offices more often. According to one study, African Americans, Latinos, and Native Americans felt that they and their children were treated differently because of their race while White respondents reported no such problems.[38] Even though these families had access to dental care, the care they received was so unsatisfactory that some parents postponed or even canceled visits in order to avoid interacting with office staff.[39]

Underlying Social and Environmental Inequities

In California, the disparity in children's oral health based on socioeconomic status is among the worst in the United States.[40] As discussed above, economic status is highly correlated with whether a person has seen a provider or has untreated tooth decay. In California, communities of color bear the brunt of poverty. A staggering 24% of Blacks and 20% of Latinos live in poverty compared to 11% of Whites.[41] Close to 13% of Blacks and 8% of Latinos are unemployed compared to 6% of Whites.[42] Native Americans experience unemployment at similar rates as African Americans.[43] The high cost of housing, food, and transportation forces families to make difficult decisions as they struggle to make ends meet.

The environments in which low income and communities of color reside also impact oral health disparities. For example, research shows that neighborhoods with high poverty and a larger percentage of people of color also have higher numbers of unhealthy food retail outlets, including fast food and corner stores. Many low-income neighborhoods do not have grocery stores with fresh fruits and vegetables or farmers' markets, and even those that do are slow to accept payment from food support programs such as the Women, Infants, and Children (WIC) program. This lack of access to healthy, nutritious foods often leads to the consumption of high-fat, high-sugar foods, which promotes caries[44] and can increase the likelihood of developing a chronic health condition.[45] In addition, environmental conditions can promote disparities. Most California water contains the recommended levels of fluoride, which is the best prevention of tooth decay and caries.[46] However, many communities face concerns about the safety and quality of drinking water due to contamination from pesticides near agricultural farms.[47]

Policy Recommendations

Good oral health has the potential to help children and families live healthy lives, succeed in school and work, and improve their quality of life. Conversely, poor oral health impacts communities of color disproportionately and has the potential to exacerbate health disparities. To turn the tide of this epidemic, we must address the factors driving health inequities.

Improve Access to and the Quality of Dental Care

- **Expand access and integrate oral health into primary health care.** The first step towards ensuring oral health equity is to increase access to services for those communities lacking coverage, including expanding full dental benefits to low-income adults in the Denti-Cal program. We must also ensure that affordable dental coverage alternatives are available to those ineligible for public programs. It is essential that we take steps towards seeing oral health as part of our overall health. To do this, efforts should be taken to better integrate oral health care into primary care. Further, outreach and education campaigns must focus on informing consumers about how to use dental coverage as well as the benefits of good oral health in culturally and linguistically appropriate ways.

- **Improve data collection, analysis and reporting of oral health disparities.** Data collection is essential to identify and analyze inequities in oral health care and outcomes. We must institute standard systems to collect and analyze data by demographics such as race, ethnicity, gender, sexual orientation, gender identity, and language to develop policy and practices to improve access and reduce disparities.

- **Increase reimbursements for dental care providers, especially those in underserved areas.** One of the key barriers to care is the inaccessibility of providers in rural and underserved communities as well as those caring for patients in the Denti-Cal program. Consistent cuts to reimbursement rates with an increasing need for care results in a distressed dental health system. While we look to increase rates, however, we must also ensure that communities who

need care the most are not overlooked. Rates should be tied to incentives or performance measures that result in improved health outcomes for vulnerable communities and reductions in health disparities.

Develop a Culturally Competent Workforce

- **Expand and diversify the dental care workforce.** A larger and more diverse workforce is one step towards ensuring cultural and linguistic competency in dental care. The state must establish programs to train, recruit, and retain people of color in the oral health fields. California must also implement programs or incentives to ensure that all regions and areas of the state have adequate access to dentists near them. We must monitor compliance with state laws requiring the collection of demographic data on health and dental health occupations and allied professions to identify workforce gaps and develop solutions for comprehensive, culturally appropriate care. We must also improve employment opportunities in communities of color so that they have stable jobs, a living wage, and, ideally, access to employee-based oral health coverage.

- **Provide culturally and linguistically competent care.** We must ensure communities of color have access to culturally and linguistically appropriate services. California has been at the forefront of requiring translation and interpretation services in health care settings and we must ensure that providers and plans are complying with current standards. We must also prioritize culturally competent care that acknowledges and recognizes the background, cultures, and beliefs of the community receiving services.

- **Address racism and discrimination in oral health care.** Many people of color face racism and discrimination both inside and outside of the dental office. In order to counter discrimination we must ensure that health care providers receive ongoing cultural competency training, and acknowledge that cultural competence evolves over time as we gain experience and knowledge of the cultures and communities around us.

Support Efforts to Improve Underlying Socioeconomic Inequities

- **Advance wealth building opportunities for low-income, communities of color.** Income inequality is a key driver of health inequities. We must support efforts to increase wages and promote sustainable careers as well as ensure that safety net programs for those without health coverage are fully funded to provide vital services. Additionally, the government must modernize the system for measuring poverty to reflect the true cost of living and provide working families with opportunities to thrive.

- **Improve unhealthy food and environmental conditions.** The connection between oral health and what we eat and drink requires us to improve the availability of healthy foods in our communities. We must encourage healthy food retail in underserved areas through land use and planning efforts and incentives. We must also improve access to clean drinking water. Improving water quality statewide and ensuring that all areas of the state have access to fluoridated water could improve oral health outcomes, especially in low-income communities of color.

Conclusion

Advancing equity in oral health requires multiple approaches to successfully address the issues that contribute to poor oral health outcomes for low-income, communities of color. In addition to educating our communities about the importance of oral health and how to access to services, we must focus on systemic changes including improving access to culturally and linguistically competent oral health care and addressing the social and environmental factors that impact oral health. As California's diversity increases, our infrastructure must promote quality oral health for everyone. With advocacy and education, together we can take a bite out of oral health inequities.

Endnotes

1. Ramos-Gomez, Francisco. "Oral Health Disparities among Latinos in California: Implications for a Binational Agenda." California Program on Access to Care, UC Berkeley School of Public Health. June 2008. Accessed on September 14, 2015. http://cpac.berkeley.edu/documents/ramos_gomez_findings.pdf.
2. State Health Facts: Poverty by Age. Kaiser Family Foundation. 2013. Accessed on September 15, 2015. http://kff.org/other/state-indicator/poverty-rate-by-age/
3. Oral Health: Dental Disease is a chronic problem among Low-income populations. United States General Accounting Office (GAO). Report to Congressional Requesters: April 2000. Accessed on September 14, 2015. http://www.gao.gov/new.items/he00072.pdf
4. Schor, Edward L. Dental Care Access for Children in California: Institutionalized Inequality. Lucile Packard Foundation for Children's Health. February 2014. Accessed on September 14, 2015. http://www.lpfch.org/sites/default/files/field/publications/dental_care_issue_brief.pdf
5. Ibid.
6. California Food Policy Advocates Nutrition and Food Insecurity Profile. Accessed December 22, 2015. http://cfpa.net/county-profiles.
7. Drewnowski, Adam and Darmon, Nicole. "The Economics of Obesity: Dietary Energy Density and Energy Cost." Am J Clin Nutr, vol. 82, no. 1 2655-2735. July 2005. Accessed on September 14, 2015. http://ajcn.nutrition.org/content/82/1/265S.full.pdf+html.
8. Babey, Susan H., Wolstein, Joelle, and Diamant, Allison L.. "Food Environments Near Home and School Related to Consumption of Soda and Fast Food." UCLA Center for Health Policy Research, 2011. Accessed on September 14, 2015. http://healthpolicy.ucla.edu/publications/Documents/PDF/Food%20Environments%20Near%20Home%20and%20School%20Related%20to%20Consumption%20of%20Soda%20and%20Fast%20Food.pdf
9. Huff, Qadira Ali. "A Perfect Smile Comes at a Cost: How Poverty and Food Insecurity Cement Disparities in Oral Health." July 8, 2015. Accessed on September 14, 2015. http://ilikemyteeth.org/a-perfect-smile-comes-at-a-cost-how-poverty-and-food-insecuritycementdisparities-in-oral-health/
10. Pourat, Nadereh, and Finocchio, Len. "Racial And Ethnic Disparities In Dental Care For Publicly Insured Children." Health Affairs, 20, no.7 (2010): 1356-1363. July 2010. Accessed on May 20, 2015. http://content.healthaffairs.org/content/29/7/1356.full.pdf+html.
11. Ramos-Gomez, Francisco. "Oral Health Disparities among Latinos in California: Implications for a Binational Agenda." California Program on Access to Care, UC Berkeley School of Public Health. June 2008. Accessed on September 14, 2015. http://cpac.berkeley.edu/documents/ramos_gomez_findings.pdf.
12. Phipps, Kathy R., and Ricks, Timothy L. The Oral Health of American Indian and Alaska Native Children Aged 1-5 Years: Results of the 2014 IHS Oral Health Survey. Indian Health Service. April 2015. https://www.ihs.gov/doh/documents/IHS_Data_Brief_1-5_Year-Old.pdf
13. Schor, Edward L., Dental Care Access for Children in California: Institutionalized Inequality. Lucile Packard Foundation for Children's Health. February 2014. Accessed on September 14, 2015. http://first5association.org/wp-content/uploads/2014/09/Dental-Care-Access-in-CA-2-2014-Lucile-Packard-Foundation.pdf.
14. Medi-Cal is California's Medicaid program which provides health care to low income communities under 138% of the FPL. For children, benefits are provided to those in households under 250% of FPL.
15. Maiuro, Laura. Eliminating Adult Dental Benefits in Medi-Cal: An Analysis of Impact. California HealthCare Foundation. December 2011. Accessed on October 1, 2015. http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20E/PDF%20EliminatingAdultDentalMediCalcx.pdf.
16. California Department of Health Care Services: Weaknesses in Its Medi-Cal Dental Program Limit Children's Access to Dental Care.California State Auditor. December 2014. https://www.auditor.ca.gov/pdfs/reports/2013-125.pdf
17. National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States, 2014. Centers for Disease Control and Prevention. U.S. Department of Health and Human Services. 2014. Accessed December 24, 2015. http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf

18. Elo, Jeffery A., Venugopal, Nithya, and McClendon, Grant. Exploring Denti-Cal Provider Reimbursement and its Impact on Access to Dental Care for California's Children. Center for Oral Health. April 2014. Accessed on September 14, 2015. http://www.centerfororalhealth.org/images/lib_PDF/Denti-Cal_Reimbursement_Issue_Brief_April_2014.pdf
19. Pourat, Nadereh, and Finocchio, Len. "Racial And Ethnic Disparities In Dental Care For Publicly Insured Children." Health Affairs, 20, no.7 (2010): 1356-1363. July 2010. Accessed on May 20, 2015. http://content.healthaffairs.org/content/29/7/1356.full.pdf+html.
20. Elo, Jeffery A., Venugopal, Nithya, and McClendon, Grant. Exploring Denti-Cal Provider Reimbursement and its Impact on Access to Dental Care for California's Children. Center for Oral Health. April 2014. Accessed on September 14, 2015. http://www.centerfororalhealth.org/images/lib_PDF/Denti-Cal_Reimbursement_Issue_Brief_April_2014.pdf
21. Ibid.
22. Hummel, Jeffrey, Phillips, Kathryn E., Holt, Bre, and Hayes, Catherine. Oral Health: An Essential Component of Primary Care. Commissioned by National Interprofessional Initiative on Oral Health. June 2015. Accessed on September 15, 2015. https://dphhs.mt.gov/Portals/85/publichealth/documents/OralHealth/White-Paper-Oral-Health-Primary-Care.pdf
23. Ibid.
24. Ibid.
25. Ibid.
26. Ibid.
27. Ibid.
28. Ibid.
29. Ibid.
30. Schor, Edward L., Dental Care Access for Children in California: Institutionalized Inequality. Lucile Packard Foundation for Children's Health. February 2014. Accessed on September 14, 2015. http://first5association.org/wp-content/uploads/2014/09/Dental-Care-Access-in-CA-2-2014-Lucile-Packard-Foundation.pdf.
31. Pourat, Nadereh, and Finocchio, Len. "Racial And Ethnic Disparities In Dental Care For Publicly Insured Children." Health Affairs, 20, no.7 (2010): 1356-1363. July 2010. Accessed on May 20, 2015. http://content.healthaffairs.org/content/29/7/1356.full.pdf+html.
32. Schor, Edward L., Dental Care Access for Children in California: Institutionalized Inequality. Lucile Packard Foundation for Children's Health. February 2014. Accessed on September 14, 2015. http://first5association.org/wp-content/uploads/2014/09/Dental-Care-Access-in-CA-2-2014-Lucile-Packard-Foundation.pdf.
33. California Department of Health Care Services: Weaknesses in Its Medi-Cal Dental Program Limit Children's Access to Dental Care.California State Auditor. December 2014. https://www.auditor.ca.gov/pdfs/reports/2013-125.pdf
34. Elo, Jeffery A., Venugopal, Nithya, and McClendon, Grant. Exploring Denti-Cal Provider Reimbursement and its Impact on Access to Dental Care for California's Children. Center for Oral Health. April 2014. Accessed on September 14, 2015. http://www.centerfororalhealth.org/images/lib_PDF/Denti-Cal_Reimbursement_Issue_Brief_April_2014.pdf
35. Schor, Edward L., Dental Care Access for Children in California: Institutionalized Inequality. Lucile Packard Foundation for Children's Health. February 2014. Accessed on September 14, 2015. http://first5association.org/wp-content/uploads/2014/09/Dental-Care-Access-in-CA-2-2014-Lucile-Packard-Foundation.pdf.
36. Mofidi, Mahyar, Rozier, R. Gary, and King, Rebecca S. "Problems With Access to Dental Care for Medicaid-Insured Children: What Caregivers Think." Am J Public Health. 2002 January; 92(1): 53-58. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447388/pdf/0920053.pdf.
37. Collins, Karen Scott, Hughes, Dora L., Doty, Michelle M., Ives, Brett L., Edwards, Jennifer N., and Tenney, Katie. "Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans." The Commonwealth Fund. March 2002.
38. Mofidi, Mahyar, Rozier, R. Gary, and King, Rebecca S. "Problems With Access to Dental Care for Medicaid-Insured Children: What Caregivers Think." Am J Public Health. 2002 January; 92(1): 53-58. Accessed on September 14, 2015. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447388/pdf/0920053.pdf.
39. Ibid.
40. Schor, Edward L., Dental Care Access for Children in California: Institutionalized Inequality. Lucile Packard Foundation for Children's Health. February 2014. Accessed on September 14, 2015. http://first5association.org/wp-content/uploads/2014/09/Dental-Care-Access-in-CA-2-2014-Lucile-Packard-Foundation.pdf.
41. State Health Facts: Poverty by Race/Ethnicity. Kaiser Family Foundation. 2013. Accessed on September 15, 2015. http://kff.org/other/state-indicator/poverty-rate-by-raceethnicity/.
42. Employment Summary Table. State of California Employment Development Department. July 2015. Accessed on September 15, 2015. http://www.calmis.ca.gov/specialreports/CA_Employment_Summary_Table.pdf.
43. Labor Force Characteristics by Race and Ethnicity, 2012. U. S. Labor of Statistics, Report 1044. October 2013. Accessed December 24, 2015. http://www.bls.gov/opub/reports/cps/race_ethnicity_2012.pdf
44. Mobley, Connie, Marshall, Teresa A., Milgrom, Peter, and Coldwell, Susan E. "The Contribution of Dietary Factors to Dental Caries and Disparities in Caries." Acad Pediatr. 2009 Nov-Dec; 9(6): 410-414. Accessed September 15, 2015. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2862385/
45. Ramos-Gomez, Francisco. "Oral Health Disparities among Latinos in California: Implications for a Binational Agenda." California Program on Access to Care, UC Berkeley School of Public Health. June 2008. Accessed on September 14, 2015. http://cpac.berkeley.edu/documents/ramos_gomez_findings.pdf.
46. Schor, Edward L., Dental Care Access for Children in California: Institutionalized Inequality. Lucile Packard Foundation for Children's Health. February 2014. Accessed on September 14, 2015. http://first5association.org/wp-content/uploads/2014/09/Dental-Care-Access-in-CA-2-2014-Lucile-Packard-Foundation.pdf.
47. Ramos-Gomez, Francisco. "Oral Health Disparities among Latinos in California: Implications for a Binational Agenda." California Program on Access to Care, UC Berkeley School of Public Health. June 2008. Accessed on September 14, 2015. http://cpac.berkeley.edu/documents/ramos_gomez_findings.pdf.

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