Early childhood caries: a private practitioner's perspective

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I was asked to discuss early childhood caries (ECC) from the perspective of the private practitioner. In my practice, new patients are now almost equally divided between private and Medicaid patients. The percentage of Medicaid patients has grown throughout the 28 years I've been in private practice.

More than half of the income in Washington County, Mississippi, comes from federal transfer payments. From a practical standpoint, baby bottle tooth decay (BBTD) is the only real problem I have to deal with in ECC, and it is becoming mostly symptomatic of the more serious problem of out-of-wedlock births. This is not to say I don't see far too many young children with severe caries, because I do. It is just much easier, and less expensive, to treat the 3-year-old and older child than it is those younger than 3 who have BBTD.

These data represent my geographic area and are not representative of the vast majority of our practices. Frankly, I hope these data *don't* relate very well to other areas, but I suspect that where pediatric dentists treat a significant number of Medicaid patients, the figures are similar. I will offer some personal thoughts, strictly from what I have seen in my 28 years of private pediatric practice. They will relate mostly to those children who can least afford to have dental disease.

Practice patterns 1970 to 1996

Fig 1 shows new exams and the number of BBTD patients in the first 6 months of 1993. Fig 2 is for the first four months of 1996. The number of BBTD children is less than in 1993, but continues to be far too high.

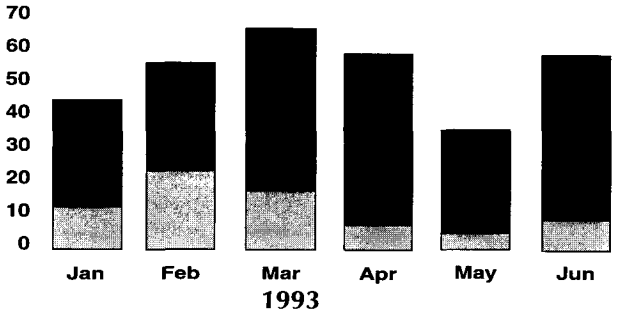

Fig 1. New exams by the month (gray area = BBTD).

Fig 3 shows that the percentage of parents of BBTD patients who were aware of BBTD and what it would do to their child's teeth has ranged from almost 30% to more than 70%. This is a good news-bad news scenario. The number of parents who know about BBTD is increasing, which is encouraging. It means we have done a remarkably good job in creating awareness. However, a very large number of primarily welfare parents who know about BBTD still put the child to sleep with a bottle.

Fig 4 shows that the percentage of BBTD children in my practice who are born to single parents is very high, ranging from 46% to 71.4%. The four-month average for single parents is 63.5%, representing private and Medicaid patients. More alarming than single parenthood is that the number of children born out of wedlock in my practice area has grown at an astonishing rate (Tables 1 and 2) between 1970 and 1994. In the past 20 years, the county's population has declined by 2646. Total births per year have declined by 516; illegitimate births have increased by 362. While births to teenagers have decreased by 163, illegitimate births to teenagers have increased by 62. The teen illegitimacy rate has increased from 55.9% to a staggering 92.9%.

Fig 4 shows the percentage of BBTD patients overall who have one parent. Fig 5 suggests that when I see a child on Medicaid with BBTD, there is an almost 100% chance that the parent is single. Certainly, we will continue to see BBTD patients whose parents are well-educated and financially secure, but these are, I think, becoming fewer or at least being overshadowed by the poor patients with BBTD.

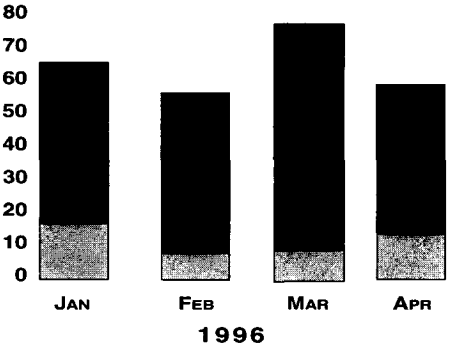

Fig 2. New exams by the month (gray area = BBTD).

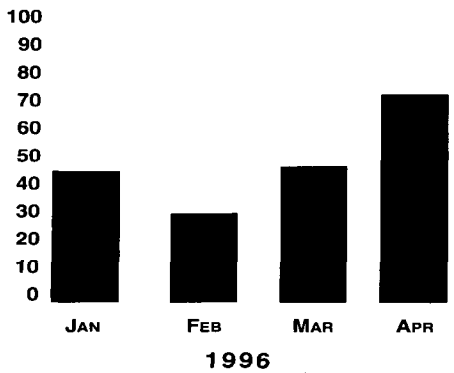

Fig 3. Percentage of BBTD patients whose parents were aware of BBTD.

TABLE 1. BIRTHS IN 1970, WASHINGTON COUNTY, MISSISSIPPI

Total population	70,581	
Total births	1,835	
Illegitimate births	564	(30.7%)
Teen births	576	
Teen illegitimate births	322	(55.9%)

TABLE 2. BIRTHS IN 1994, WASHINGTON COUNTY, MISSISSIPPI

Total population	67,935	
Total births	1,319	
Illegitimate births	926	(70.2%)
Teen births	413	
Teen illegitimate births	384	(92.9%)

Discussion

What these numbers mean to me is that I am dealing with more than a dental problem. BBTD may be the most immediate problem I see when I examine a child, but in many of my patients, it is simply one symptom of a pervasive problem in a growing segment of my patient population—and I don't think this is just confined to my practice. The key word appears to be responsibility. Children having children hardly gives the new children a chance. Most single parents in my practice now are not teenagers, but it would appear that with the present trend, it may just be a matter of time. An editorial[1] from *The Atlanta Constitution*, January 14, 1996, stated that 80% of teenage mothers in Georgia drop out of school. In 1991, Georgia taxpayers spent $253 million on welfare and medical costs for teen mothers and their children. This doesn't include single parents older than 19.

In a syndicated commentary from Suzanne Fields[2] in the Memphis *Commercial Appeal*, April 21, 1996, she points out that the teenage birth rate in the United States decreased in 1993-94 in 18- and 19-year-olds, but it *increased* in teenagers younger than age 17. The number of girls age 14 to 17 years old will increase by more than a million between 1996 and 2005. In California alone, more than 70,000 babies were born to teenagers in 1993—28,000 to teens 17 years old and younger.

Fields continues that the number of children born to children is likely to repeat the devastating cycle. While BBTD is not among the things she mentions, it is certainly one problem that will have to be addressed. Quite frankly, it's easier to treat BBTD than most of the other problems occurring in this group. In many cases of BBTD, we are not just dealing with a dental problem.

The ADA News[3] of May 6, 1996, printed an article regarding Medicaid difficulties. It states, "some 80% of states attribute the low utilization rate to a shortage of dentists willing to accept Medicaid patients". As a dentist deeply involved with ECC who does participate in the Medicaid program, I can completely understand why some dentists are not willing to participate. The fee schedules are abysmal, the paper work is mountainous, and is only exceeded by the broken appointment rate of the patients. Increased funding will not address the root causes of the problems. We must continue to provide the information to the public necessary to safeguard our children's oral health, but today we have to be more than just pediatric dentists. The related symptoms that we see can't be ignored if we are to make any progress in improving the health of these children who need help the most. I wish I had easy solutions to these problems. The first step is to recognize that current programs have had no positive effect on the numbers I deal with in my practice. I can take care of ECC among children whose parents care. I can't take care of the people who don't care. Their numbers are growing.

1. Stop Teenage Pregnancy. The Atlanta Journal/The Atlanta Constitution, Sunday, January 14, 1996. [Editorial]
2. Fields S: Teen Sex: Trouble Reproduces Trouble, The Commercial Appeal, Sunday, April 21, 1996.
3. Palmer C: Medicaid Difficulties Detailed in Report on Dental Care Access. ADA News, May 6, 1996.

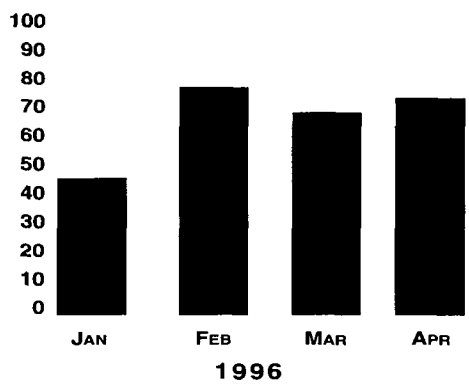

Fig 4. Percentage of BBTD patients with single parents.

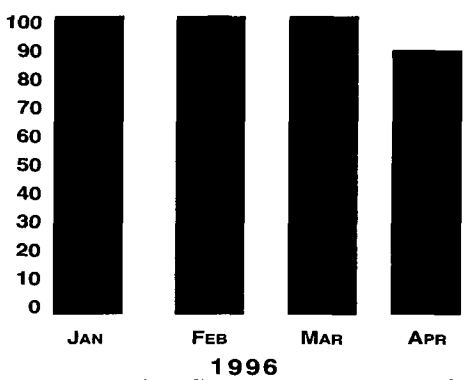

Fig 5. Percentage of Medicaid BBTD patients with single parents.