Insurance-Related Barriers to Accessing Dental Care Among African American Adults With Oral Health Symptoms in Harlem, New York City

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Although ability to pay is associated with dental care utilization, provision of public or private dental insurance has not eliminated dental care disparities between African American and White adults. We examined insurance-related barriers to dental care in interviews with a street-intercept sample of 118 African American adults in Harlem, New York City, with recent oral health symptoms. Although most participants reported having dental insurance (21% private, 50% Medicaid), reported barriers included (1) lack of coverage, (2) insufficient coverage, (3) inability to find a dentist who accepts their insurance, (4) having to wait for coverage to take effect, and (5) perceived poor quality of care for the uninsured or underinsured. These findings provide insights into why disparities persist and suggest strategies to removing these barriers to dental care. (*Am J Public Health.* 2011;101:1420–1428. doi:10.2105/AJPH.2010.300076)

Research has documented large racial/ethnic disparities in oral health among adults in the United States.[1–3] Specifically, African American adults are more likely to report tooth pain, tooth decay, loose teeth, and to have lost more teeth than are White adults.[1,4–6] Further, African Americans are less likely than are White adults to have visited a dentist in the past year.[2,7–9] In fact, even African Americans who experience dental symptoms are less likely to obtain dental care than are symptomatic Whites.[4,6] These disparities appear not to be attributable to differences in perceived need, as African Americans are more likely to perceive themselves in need of dental care than are Whites.[10] Given these disparities, it is not surprising that a household survey among African Americans in Harlem, New York City, found problems with their teeth and gums was the most commonly reported health complaint,[11] suggesting a large unmet need for dental care in this population.

One factor that may in part account for these disparities in oral health and dental care may be the financial barriers that limit access to dental care among minorities more often than among Whites. Indeed, major theories addressing health disparities consistently highlight the importance of differences in availability of financial resources to access health care.[12–15] Those with the ability to pay for dental care, either out of pocket or through dental insurance, are significantly more likely to obtain care than are those without such resources.[3,8,11,16–19] Although the financial inability to pay for dental care is not unique to African Americans, which is consistent with observed racial/ethnic disparities in dental visits, African Americans are both less likely to report being financially able to pay for dental care out of pocket[1,7] and less likely to have dental insurance[2,16,18,20] than are Whites.

However, several studies have documented that insurance status and the financial ability to pay do not account for the disparities in dental care and oral health that exist between African American and White adults.[2,3,5,8,18,19,21] Nevertheless, little research has examined the reasons why dental insurance fails to result in equal access to dental care. Dental insurance may not significantly reduce disparities in access to care if additional barriers to utilization of that insurance exist for African Americans. One such barrier may be that African Americans are disproportionately covered by public (i.e., Medicaid) rather than private insurance.[3,19,20] The limited dental services provided by adult Medicaid is associated with a lower likelihood of obtaining dental care[11,19] and potentially poorer quality care (i.e., a higher prevalence of tooth extractions rather than more expensive root canals)[3,22,23] among African American adults. Qualitative studies of caregivers' experiences in attempting to obtain dental care for their children[24,25] have identified additional barriers to obtaining care, including difficulty finding a dentist who accepts public dental insurance and perceptions that their children experience greater discrimination and poorer quality care because of their public dental insurance.[24,25]

To better understand the range and complexity of insurance-related barriers to obtaining dental care and the reasons why dental insurance does not always facilitate access to care among African American adults, we conducted qualitative interviews with 118 African Americans living in Central Harlem who had experienced a recent oral health symptom. This work extends existing work on barriers to accessing dental care by examining the insurance-related barriers to obtaining care experienced by both insured and uninsured African Americans, as well as the perceived quality of care received. Such information is important to efforts to remove or reduce barriers to quality dental care and in so doing decrease or eliminate racial/ethnic disparities in oral health.

METHODS

The participants of our study were 118 African American men and women living within the Central Harlem neighborhood of New York City. To be eligible, individuals must (1) have been born in the United States, (2) have parents who were both born in the United States, (3) self-identify as non-Hispanic African American, (4) have lived in Central Harlem for at least 5 years, (5) be aged at least 18 years, and (6) have experienced at least 1 oral

symptom or problem during the past 6 months that lasted 2 days or longer. We excluded first- or second-generation immigrants, those who did not identify as non-Hispanic African American, and those who lived outside Central Harlem because their cultural understandings and practices related to oral health care, as well as their access to care, might differ significantly from the majority of the residents of Central Harlem. We excluded them to reduce the heterogeneity of the sample and increase our ability to interpret the data.

The demographic characteristics of the sample are presented in Table 1. Participants ranged in age from 18 to 79 years (mean= 45.9; SD=14.7). Consistent with the population of Central Harlem,[11] the sample contained somewhat more women (59%) than men. The sample was generally of low socioeconomic status in terms of education, employment status, and income, with 64% reporting a high-school education or less, 25% reporting that they worked full time, and 41% reporting a personal income of less than $10 000 per year.

Overall, the sample self-reported poor dental health (Table 2). Most participants (84%) reported at least 1 missing tooth, and many reported several lost teeth (mean=9.3 teeth lost; SD=9.9). Despite these missing teeth, most participants reported that they did not have any type of tooth replacements (e.g., bridgework, partials, or implants) on either the upper (31% had replacements) or lower (23% had replacements) arch. Although eligibility required that participants had experienced at least 1 oral health problem during the past 6 months, participants self-reported an average of 3.1 symptoms in that period (SD=2.1; range 1–11). The prevalence of each of the 13 oral health symptoms assessed is presented in Table 3.

Recruitment

To recruit and screen potential participants in Central Harlem, we used a street intercept methodology in which a research team member approached pedestrians and requested that they complete a brief confidential screening survey that was used to determine their eligibility for participation in an interview study about dental health. The staff was trained to approach every potential adult pedestrian without regard to age, race, or gender when not otherwise engaged with another participant. This strategy prevented potential sampling bias that could be introduced by recruiters selecting only those pedestrians who they might assume would be most receptive to participating. The street-intercept method has been found to be an effective low-cost strategy for sampling a geographically defined population.[26] Its advantages over mail surveys or advertisements include reducing the biases introduced by self-referral and yielding higher response and completion rates than telephone surveys.[26]

Surveys were conducted from September 2004 through June 2005 in various locations throughout Central Harlem. To ensure that the sample contained participants from all areas of Central Harlem, the area was divided into 4 quadrants. Screening was carried out in each quadrant to obtain approximately equal numbers of eligible participants from each. The days (e.g., weekdays, weekends) and times (e.g., mornings, afternoons, and evenings) for conducting the surveys were systematically varied to avoid any potential bias.

Surveys were administered by teams typically composed of 3 to 5 female and male African American staff members. A staff member approached each potential participant that walked by the street corner on which surveys were being conducted and introduced themselves. They explained that they worked for the university and were conducting a confidential survey of dental health among residents of Harlem that would take less than 10 minutes. Participants were also informed that they would receive a $2 Metrocard (a 1-way fare card for the New York City subway) for completing the survey.

The street intercept survey contained questions designed to assess the eligibility of the participant for the larger interview study. As a preliminary screen, individuals who were approached were asked if they were aged 18 years or older and for their zip code to determine whether they were eligible for the screening survey. Surveys were discontinued for those who were younger than 18 years or who did not live in a Central Harlem zip code. All other participants were asked a series of questions to determine their study eligibility. In addition to reporting their racial/ethnic identity, participants were asked for their birthplace and the birthplace of both of their parents. Because some of the zip codes for Central Harlem also extend to areas beyond Central Harlem, to determine whether a potential participant lived in the Central Harlem section of Harlem they were asked to indicate on a map of Harlem the approximate

TABLE 1—Characteristics of Street-Intercept Sample of African American Adults Living in Central Harlem, New York City, 2004–2005

Characteristics	No. (%) or Mean (SD)
Black, non-Hispanic race/ethnicity	118 (100)
Gender	
Men	49 (42)
Women	69 (59)
Age, y	45.9 (14.7)
18–35	28 (24)
36–55	61 (52)
>55	29 (25)
Marital status	
Married or common law	24 (20)
Separated, divorced, or widowed	30 (25)
Single, never married	64 (54)
No. of children	2.2 (2.2)
None	31 (26)
1–2	48 (41)
3–4	21 (18)
≥5	18 (15)
Education	
Some high school	34 (29)
High school or GED	41 (35)
Some college	24 (20)
Associate's degree or technical college	6 (5)
≥ bachelor's degree	13 (11)
Employment status	
Working full time	30 (25)
Working part time	27 (23)
Not working–ill or disabled	28 (24)
Not working–retired	12 (10)
Not working–other	21 (18)
Personal yearly income	
<$10 000	48 (41)
$10 000–$19 999	26 (22)
$20 000–$34 999	23 (20)
$35 000–$49 999	10 (9)
≥$50 000	10 (9)

Note. GED = general equivalency diploma.

TABLE 2—Participant Self-Reported Dental Characteristics Among Street-Intercept Sample of African American Adults Living in Central Harlem, New York City, 2004–2005

Characteristic	No. (%) or Mean (SD)
Edentulous status	
Fully dentate	19 (16)
Any missing teeth	83 (70)
Edentulous–single arch	8 (7)
Fully edentulous	8 (7)
No. of teeth lost	9.3 (9.9)
None	19 (16)
1–5	40 (34)
6–10	20 (17)
11–20	16 (14)
21–30	14 (12)
All	8 (7)
No. of fillings (excluding fully edentulous)	
None	29 (27)
1 or 2	20 (19)
3–5	30 (28)
6–10	24 (22)
>10	4 (4)
Tooth replacements	
Upper: has bridges, partials, or implants	24 (20)
Upper: has full denture	13 (11)
Lower: has bridges, partials, or implants	22 (19)
Lower: has full denture	5 (4)
Medical insurance[a]	
None	9 (8)
Medicaid	67 (57)
Medicare	19 (16)
Private or HMO	29 (25)
Other	4 (3)
Dental insurance	
None	29 (25)
Medicaid	58 (50)
Private or DMO	25 (21)
Other	5 (4)
Time since most recent routine dental visit	
Within past 6 mo	39 (33)
Within past y	20 (17)
Within past 2 y	9 (8)
Within past 5 y	17 (14)
5 y or more ago	23 (20)
Never	10 (9)

Notes. DMO = dental maintenance organization; HMO = health maintenance organization.
[a]Because some participants were on Medicaid and Medicare, the percentages do not sum to equal 100.

location of their residence and approximately how long they had lived there. Finally, participants were asked a series of questions to determine their edentulous status, their dental behaviors, and if they had experienced during the past 6 months for at least 2 days any of 13 dental symptoms (Table 3 provides a list of the specific symptoms assessed). Individuals who completed the street intercept survey and were found to meet the eligibility criteria for the study were invited to participate in an interview about their dental health at a later date.

A total of 629 individuals were screened. Of these, 219 (35%) were determined to be eligible for the study. (Of the 410 individuals who were determined to be ineligible, most [36%] did not have any oral health symptoms, 16% were Hispanic, 13% did not identify as African American or Black, 16% did not live in Central Harlem or had not lived there for 5 years or more, and 19% were either not born in the United States or had a parent not born in the United States.) Of the eligible individuals, 46 refused to participate in the interview and 34 agreed to participate but could not subsequently be contacted and scheduled for an interview. This resulted in 139 (63%) eligible individuals being scheduled for interviews. Sixteen (12%) individuals failed to appear for their interviews and were not able to be rescheduled, 1 appeared for her interview but refused to sign the consent form, and 1 was not well enough to participate in the interview. A total of 121 interviews were completed. Three of these were excluded from the data analysis because they provided information in the interview that contradicted their screening questionnaire and indicated that they did not in fact meet the eligibility criteria. A total of 118 eligible participants completed interviews.

During the interview, participants provided a signed informed consent and then completed a brief interviewer-administered questionnaire regarding basic sociodemographic characteristics and an oral health history that included dental insurance status and a history of dental visits. Next, they participated in a semistructured focused interview.[27] The interview focused largely on their experiences with a single oral health symptom that they had reported experiencing in the past 6 months for at least 2 days and how they had managed this symptom. For participants who reported more than 1 oral symptom, a single symptom was selected to discuss, with preference given to symptoms that the participant had resolved or, if none had been resolved, the symptom that was perceived as the most serious or distressing. Among the questions asked in the interview were whether the participant had ever

TABLE 3—Self-Reported Oral Symptoms in the Past 6 Months Among Street-Intercept Sample of African American Adults Living in Central Harlem, New York City, 2004–2005

Oral Symptom[a]	Experienced, No. (%)	Interviewed, No. (%)
Have you had a . . .		
Pain or irritation of the tongue	5 (4)	0 (0)
Pain or irritation of the gums	33 (28)	11 (9)
Pain or irritation of the roof of the mouth	14 (12)	2 (2)
Pain or irritation of the floor of the mouth	6 (5)	1 (1)
Pain or irritation of the inside of your cheeks	12 (10)	3 (3)
Bleeding gums	37 (31)	9 (8)
Difficulty biting or chewing	40 (34)	15 (13)
Toothache	44 (38)	29 (25)
Tooth sensitive to cold	56 (48)	25 (21)
Tooth sensitive to heat	25 (21)	1 (1)
Tooth sensitive to sweets	43 (36)	8 (7)
Tooth sensitive to pressure	33 (28)	9 (8)
Sore or irritation from a denture	15 (13)	5 (4)

Note. Experienced = all the symptoms participants self-reported in the past 6 months that lasted for 2 days or more in a row. Interviewed = the self-reported symptoms selected to be discussed in the interview.
[a]Total number of symptoms experienced: mean = 3.1; SD = 2.1; range = 1–11.

considered seeing a dentist for his or her symptom (if not, why not), did they discuss the symptom with a dentist (if not, why not), and when was the last time he or she discussed the symptom with a dentist. In terms of barriers, participants were also asked if they currently have someone they regard as a regular dentist, how easy or difficult is it to get in touch with a dentist, how satisfied they are with the quality of care they have received from dentists in general, and have they had any difficulties in getting the dental care they wanted. Interviews averaged about 1 hour and 45 minutes (mean=104 minutes; SD=26 minutes) and were conducted by African American interviewers with master's or doctoral level training (e.g., psychology, public health, dentistry) who had been extensively trained in the conduct of semistructured qualitative interviews. At the completion of the interview, participants received $50 in cash and reimbursement for their transportation costs.

Data Analysis

All interviews were audio-recorded and transcribed verbatim for thematic analysis. First, 2 researchers independently read a subset of the transcribed interviews to identify the topics discussed. They then met to discuss the topics each had identified and constructed a single list of topic codes by reconciling any differences in the topics identified by each. Next, each researcher independently evaluated this coding scheme by applying it to a new set of interviews to determine whether the topics identified in the earlier transcripts covered all the topics identified in the new set of interviews and, if not, to identify any additional topics that needed to be added.

Next, 2 different researchers independently applied this revised coding scheme to the full set of interviews by using a qualitative data analysis software program, ATLAS.ti (Scientific Software Development, Berlin, Germany). They were trained and supervised throughout the coding process to ensure consistency and accuracy in the application of the topic codes. Finally, for the purpose of the current report the first author used ATLAS.ti to extract all text coded under the topic code "professional dental care," and the text was read by 2 additional researchers to identify perceived barriers to obtaining dental care. These researchers took detailed notes on each barrier to obtaining professional care that was identified, and common barriers were grouped together into themes. Insurance-related barriers were particularly common and are the focus of our report. We selected quotes that were judged to best represent the perceptions and experiences of the insurance-related barriers described by the majority of participants.

RESULTS

Although the majority (75%) of adults in Central Harlem reported at least some type of dental insurance coverage, it was largely limited to Medicaid (50%) rather than private or dental maintenance organization coverage (21%). For the 25% who reported having no dental insurance coverage, the costs of dental care and the lack of insurance coverage were consistently noted as critical barriers to obtaining quality dental treatment of their current and ongoing dental symptoms. Even among those who had some dental insurance (e.g., Medicaid), cost, limited coverage, and quality concerns remained as barriers. We have outlined the perceived insurance-related barriers adults in Central Harlem reported to obtaining oral health care treatment.

Lack of Dental Insurance Coverage

Lack of insurance was a significant barrier to seeking dental care among those who were uninsured. Individuals without any insurance described seeking only emergency dental care, based on the severity of the pain or symptom. A 49-year-old man complaining of a toothache, who was uninsured at the time he was interviewed and had not been to the dentist in 2 years, told us

> I'm a very stubborn person and until the toothache probably kicks in and kicks my butt at night. Then I'll get up and say okay, I should have followed that [advice] 6 months ago and went to the dentist. . . . That's also due to the fact that I don't have no dental coverage. . . . That's the biggest cause . . . how am I gonna pay for it. The little money that I work for part-time? I'm trying to sustain my, um, my other habits, which is like getting a haircut, keeping my clothes clean, trying to contribute a little bit to the household where, where I'm staying at. So it doesn't leave a lot of money to say, well, I can spend $45 on a dentist.

Another 46-year-old uninsured man suffering from a toothache who only made emergency visits to the dentist told us that he was planning to seek less expensive treatment if he could not pay for treatment at his current dentist:

> I have other bills; I have other things. And those prices are outrageous. It just make me want to pull everything out of your mouth and put fake

> ones in. But then again the fake ones are $500 a tooth—the implants. So it's like you can't win. It's nothing you can do. . . . I made the appointment, but then I had to cancel it because I didn't have the money at that time. Hopefully I'll be able to start paying something around January. If not, I'll probably have to go search and look for a cheaper dentist, which I'm not too happy about because I'm thinking if it's a cheaper dentist then the work may not be that good.

One woman aged 22 years could not get a tooth removed at a dentist she had seen before because she had no insurance at the time. She postponed treatment until a few months ago when she eventually had to seek out a less expensive dentist to have the extraction:

> I went to the dentist before, a while ago. My old dentist, who said, "You need to get it pulled," they wouldn't pull it because I didn't have insurance. So, I kept waiting, and I kept waiting. So eventually, I had to go to another inexpensive dentist, not as expensive, and then I told him, I said, "I need to get a tooth pulled." So when I went to that dentist, I knew exactly what needed to be done . . . so they pulled it. That was it.

For another participant, her difficulty biting and chewing was severe enough to motivate her to obtain dental insurance, so that she could receive treatment. The woman, aged 51 years, eventually enrolled in an insurance plan, after coping with the pain of her symptom for more than 2 years:

> [Did you ever discuss with the dentist the problems you're having?] Yeah. About 2 years ago I had been to the dentist and I found out I had pyorrhea of the gums. But my financial situation didn't allow me to continue on with it. I didn't have the knowledge of the free clinics and things. . . . . I didn't have the resources to continue. So I said okay, I just kind of put it out of my head. Dealt with the pain but like maybe April of this year I made up my mind I gotta go and that's when I started looking to ways to go.

Insufficient Dental Insurance Coverage

Only a minority of the participants was completely uninsured (25%). A majority of participants citing cost barriers had some insurance, although their dental coverage was frequently limited, and as a result, certain services or a portion of services had to be paid for out of pocket. A woman aged 53 years experiencing sensitivity to cold said that her Medicaid insurance covered less than she had expected when she visited the dentist for an emergency a few months before the interview: "I can't complain about it, but when I think of having insurance, I assumed that they would pay for everything . . . I would have to pay for things that I wanted, and my dental insurance won't cover that."

Even those who paid into a private or union insurance plan felt the services covered were inadequate. A woman aged 60 years also complaining of sensitivity to cold complained of the limited coverage her dental plan provided when she visited the dentist a year ago: "I have to pay too much out of pocket . . . but you pay so much into a dental plan like [her union] right here our policy that our agency has . . . we're payin' more money and gettin' nothing—not enough. The only thing a dental [plan] do is pay for cleaning you."

Likewise, a man aged 58 years with a toothache described the difficulty he had paying for out-of-pocket costs despite having dental coverage. Consequently, he sought only emergency dental care during the 5 years before his interview:

> [D]ental work is extremely expensive whether you go to a clinic or a private doctor. A lot of people don't have money for their rent; you talking about dental care. And you know the dental plan is only going to pay for so much. And then there are a lot of out-of-pocket expenses. . . . [I]f you don't have that dental care, you just go to the dentist on emergency when that teeth need to be come out or whatever. That's the only time you go to the dentist. But as going every 6 months to have your teeth cleaned and whatnot, you don't do that. You can't afford it.

Participants also described how their insurance would only pay for an extraction, but better treatment that preserved the tooth would have to be paid for out of pocket. A 42-year-old man with a toothache described how his private insurance would only cover an extraction, although his dentist had recommended a root canal during a visit 6 months earlier:

> [My dentist] said, I don't know how many times—I'm not going to tell you—"Your HMO won't pay for that [root canal]." She said, "I'll rip it out—take it out—but that's it. I'm not going to do any kind of, uh, major work on it, whatsoever, unless you come up with $500 to $565."

Inability to Find Dentists Who Accept Their Dental Insurance

Even those who had more adequate insurance coverage were not always able to make use of it. Several insured participants reported difficulty finding a dentist covered under their insurance plan or having to travel large distances to do so. As such, despite having insurance they continued to see cost as a barrier to obtaining dental care.

For example, a 56-year-old woman with tooth sensitivity to sweets reported that although she had considered seeking professional care, her inability to find a participating dentist was a barrier to utilizing her insurance and obtaining care. As such, she had not seen a dentist in 2 years. She told us: "I never saw a dentist. I was thinking about seeing a dentist. I was trying to find a dentist that would meet my insurance plan."

Similarly, a woman aged 50 years with difficulty biting and chewing had such problems locating a dentist who was in her plan that she was never able to make use of her insurance plan: "As a matter of fact, I had [the plan] for 10 years and I never used it once, you know. I can never find somebody that participated in that . . . program."

Even those who could locate a participating dentist who would take their insurance found that these dentists were not really a viable option because they were not located in the Harlem area. For example, a 35-year-old man with sensitivity to pressure who had not had a dental visit in more than 5 years described the inconvenience of trying to find a dentist under his insurance plan:

> [T]here's never nothing right in your area. [And those are dentists all connected to your plan?] Right, exactly, nothing that was in the immediate area or anywhere close to the area. It was, like, 2-hour rides or just wasn't made convenient ever—never convenient.

Waiting for Dental Insurance Coverage

Some interviewees also described having to wait for their insurance to become activated before they could see a dentist, and their attempts to cope with their pain or symptom until then. For example, a 41-year-old woman with a toothache had not seen a dentist in the past year because she was waiting to receive an appointment from her insurance company. Her only other option, she told us, was to go the emergency room if her pain were severe enough:

> I have to wait until they send me an appointment in the mail and go to the one that is picked out. . . . [So the way that your plan works is that you can't

> go until then? Could you say a little bit about how it works?] Just you can't go; it's like a planned appointment. . . . I won't know the name of the doctor until they send me that appointment. I have to wait. I'm in a medical plan. I just talked to the receptionist. She just said that I would have to wait for a scheduled appointment and, if not, if I can't wait, if I think it's an extreme emergency, go to the emergency room.

A 37-year-old man with sensitivity to cold described waiting for 4 months until his Medicaid became active so that he could see the dentist: "[And about how long after your tooth became sensitive to cold . . . did you see the dentist?] About 4 months after that. I had to wait for this, this medical plan first. I had to wait. Now that I got it, I can see the dentist more."

Having insurance did serve as a motivator for seeking dental care. A man aged 31 years with bleeding gums told us that he had previously put off going to the dentist for more than 5 years because he had no insurance coverage. However, he was currently planning to see a dentist now that he had dental insurance:

> Since I have that insurance now, I will make time [to go to the dentist]. . . . I never, if I don't have the money to go to the dentist, I'm not going to go. I'm not getting on Welfare to go do nothing. My teeth will just fall out. . . . Because dental visits are expensive and if I don't have the money to pay for it, I'm not going to go unless I really needed to go, an emergency, I wouldn't go.

Poor Care for the Uninsured or Underinsured

Even when participants were able to see a dentist with the limited insurance they had or while uninsured, many believed that because of their lack of private insurance they received a poorer quality of care than did others. A number of individuals cited a lack of faith that private-practice dentists had their best interests at heart. Specifically, when individuals had insufficient dental coverage or an inability to pay for dental care, interviewees described their dentists as lacking compassion and as seeming to only care about money. These participants blamed dentists for not offering what they perceived as the same services or quality of service they made available to other patients with more resources or better coverage. A 46-year-old woman on Medicaid with pain and irritation of her gums who had not been to the dentist in nearly 5 years said

> I feel as though that they didn't give me the best service that they could, and that's only because I didn't have the money or medical coverage to pay for it. It's all about money. And they showed it . . . you can see how they treat you differently than other patients that's have different coverages—different coverage. . . . They tell you—Medicaid only pay for this. You can only get this done. I don't trust them. [You don't trust them in terms of what?] Doing any work. It's all about money—business to them.

Likewise, a 42-year-old man with a toothache had a dissatisfying experience with a dentist recently and expressed his dentist's lack of compassion when his private insurance would not cover his root canal:

> She had no concern, whatsoever. She's just about the money. She recommended a root canal. And, if I didn't pay for that, she told me . . . the only thing else I can do is just take it out. [Is it cheaper to take it out?] Yeah, the HMO pay for that. Cold-blooded, huh? . . . I'm going to Harlem Hospital to see what they can do for me. 'Cause that—'cause, at least, they have a sliding scale, I heard . . . . [So, why do you no longer regard her as your usual dentist?] Because I can't afford her. And she can't help me.

Many of these participants described having received an unnecessary extraction, when they believed that the tooth could have been saved if they had had insurance to pay for it. For example, a 57-year-old man complaining of toothache discussed the quality of care he felt he received at a free clinic, which he described as a "mill":

> I don't like dentists, period. I felt like all they liked to do was pull teeth. See, when I was coming up, I believe a lot of my teeth that was pulled should have never been pulled . . . only as I got older and I could speak up a little more for myself to try to save my teeth. And then what I call the dentist mill, you know this guy is working on 20 different heads a day. . . . I went through the mill factory I believe the dentist and I still have that trauma on me.

A number of other participants had previously gone to free community dental clinics and, because of bad experiences there, even years earlier, would no longer seek care in these community clinics. As a result, they often went without any dental care. For example, a 57-year-old man experiencing sensitivity to pressure had not been to a dentist in the past year because of his experiences as a child with a free clinic in Harlem:

> I was in grade school. I'd say most of the Harlem community went or were forced to go to that facility, [because] it was a free facility. They had them for training facility at that time and you had the slow drill, so a lot of people they associated dentistry with pain. They did a lot of extractions at that time. It wasn't preventive care. And then during that time that's why I lost of a lot of teeth and not even knowing the options. We in the Harlem community were not taught the options available to us. Lack of funds limits the options that you have in terms of what you can have done—unless you're somewhat resourceful or have a lot of time. I know there's clinics, but you know how people have, you know, the 6 months to work on a tooth to come back and forth to do a little bit here a little there.

DISCUSSION

Although there have been numerous epidemiological studies documenting that insurance status alone does not explain the persistent disparities in dental care between African American and White adults,[2,3,5,8,18] few have investigated why insurance fails to eliminate these disparities. To address this issue, we examined the insurance-related barriers to accessing dental care reported by African American adults in Central Harlem. We identified several insurance-related barriers that limit African Americans' access to dental care and potentially explain the failure of insurance to increase access to dental care. Further, the qualitative methods used provide unique insight into African Americans' experiences contending with these barriers as they attempt to obtain treatment of their current oral health symptoms.

Consistent with a large body of quantitative research,[3,8,11,16–18] uninsured participants perceived the lack of dental insurance as a major barrier to their obtaining care. However, although most of the sample was either privately or publicly insured (75%) many of those who were insured reported that their insurance, both private and adult Medicaid, was often insufficient to pay for the care they needed. They described how insurance would pay for a cleaning but often would not cover more expensive treatments, including a root canal or tooth replacement. As such, many insured participants described how their insurance was inadequate when they experienced their recent symptoms and were in need of treatment rather than preventative care. Other participants described being unable to obtain care because of the need to wait for their dental insurance to take effect. For those who obtained a new job or who had just applied for Medicaid, this often meant a

significant delay until they received treatment of their symptoms. Finally, many insured participants described how their insurance did not facilitate obtaining care because they could not find a dentist who accepted Medicaid patients or patients with their type of private insurance. The lack of participating providers clearly impeded these participants from obtaining treatment of their symptoms. Together, the insurance-related barriers described by our participants emphasize that insurance alone is not enough because low-quality private insurance and publicly funded insurance programs (e.g., Medicaid) often do little to eliminate the barriers to obtaining needed dental treatment.

Even when participants were able to receive dental care by using adult Medicaid, many believed that they obtained poorer care (e.g., longer waits, fewer restorative treatments, more tooth extractions) than did those with private insurance. Similar experiences were reported by uninsured participants when they visited public dental clinics. Often, this expectation that they would receive substandard care served as a barrier to seeking dental care. Their reports of their negative experience with some Medicaid dental providers (both finding one and the care received) are consistent with the findings of previous qualitative research among low-income caregivers attempting to obtain care for their children on Medicaid.[24,25]

Our current study is unique because the qualitative methods allow African Americans to relate their experiences in their own words and thus provide important insights into their perceptions of the dental care system and the insurance-related barriers that limit their access to care. Clearly expressed in the quotes presented is the frustration many experienced when personally confronting these barriers. This frustration was present not only for the uninsured but also for the publicly and privately insured who described their inability to find a dentist or who felt that they were kept from obtaining what they saw as the best quality of care. The participants' quotes describing these barriers also clearly reflect the resignation that many African Americans felt regarding the futility of engaging with the oral health care system. Many described how Medicaid patients, and the residents of Central Harlem more generally, have such difficulty obtaining care that they delayed seeking treatment, had forgone treatment altogether because they believed it was not worth the hassle and would lead to a disappointing outcome, or it was simply not possible for them to obtain dental care.

The finding that participants on Medicaid reported a number of barriers is particularly important because this program is often promoted as a means to meaningfully reduce barriers to care and health disparities. That Medicaid was viewed as not facilitating care for adults in Central Harlem is particularly significant because the New York State Medicaid program provides more comprehensive dental benefits to adult Medicaid patients than most other states in the United States.[28,29] This finding suggests that dental patients in other states may be even more dissatisfied with the available dental services than those described in New York. Likewise, New York State reimburses dentists for services to Medicaid patients at a much higher rate than do other states.[28,29] Although this would lead to the expectation that more dentists in New York would be willing to accept Medicaid patients than in other states, studies have shown that reimbursement rates remain a barrier to dentists' participation in Medicaid.[30,31] The finding that participants had difficulty finding dentists who participate in Medicaid in New York suggests that this barrier may be even greater in states where Medicaid dental benefits are underfunded (or nonexistent).

The study findings identify barriers that must be addressed to improve the oral health of African Americans by increasing their access to oral health treatment. Clearly, efforts to increase the number of dentists participating in Medicaid and increase the types of services covered by Medicaid would improve the participants' ability to obtain care. Increasing the reimbursement rate for dental services for adult Medicaid patients is also necessary because even in New York State (where reimbursement is better than elsewhere), many dentists are unable to financially afford to treat adult Medicaid patients.[31] Likewise, providing tax incentives, student loan repayments, or other economic incentive programs for dentists who provide services to adult Medicaid patients in underserved urban areas may also address this barrier. Efforts to recruit and train more African American dental students, and providing financial support for them, may also encourage some of these minority dentists to serve underserved minority communities.[32] Furthermore, programs in which midlevel dental practitioners (e.g., dental therapists) provide oral health care to children from rural underserved areas (of Alaska, Minnesota, New Zealand, and Canada)[33,34] might be expanded to treat both children and adults in underserved urban areas to further reduce barriers to accessing care. Indeed, an expansion and evaluation of midlevel dental providers has been included in the 2010 US health care reform law.[35]

However, changes in current practices may not dispel existing and long-standing negative impressions of Medicaid dental care (and the resulting unwillingness to obtain care) unless outreach efforts are made. Such outreach is needed to educate the community about changes that have been made to the program, dispel old perceptions of Medicaid, and create a more positive impression about its dental benefits and services. Community outreach regarding where to obtain dental care from Medicaid-participating dentists would serve to reduce barriers to care as well. Such outreach could be implemented either through community-wide public health media campaigns or through the provision of dental case management to increase oral health literacy and assist patients in navigating the oral health care system, such as by identifying a participating dentist.[36] Additional outreach efforts to educate the community about the importance of keeping their dental appointments or providing advance notice if they are unable to do so may also encourage dentists to serve Medicaid patients. This problem of missed appointments is an oft-cited reason for nonparticipation in the dental Medicaid program,[36] and there is evidence that community outreach is effective in recruiting dentists, increasing patient participation, and increasing knowledge about the importance of keeping their dental appointments.[36]

It is clear that finding new methods of providing affordable options for quality dental care for the uninsured is essential, but the findings also suggest that additional sources of affordable dental care would also benefit Medicaid and underinsured participants. Although publicly funded providers (either dentists or midlevel dental therapists) would be 1

potential source of affordable dental care regardless of insurance status, all such clinics in the Harlem area were closed shortly after this study was completed because of city budget constraints, leaving only hospital-based emergency care. As the United States implements health care reform legislation,[35] many new and innovative models of health care provision and payment will be developed and evaluated through the Center for Medicare and Medicaid Innovation at both the state and local levels.[37] These models are designed to expand access, contain costs, and increase the quality of care provided. To the extent that access to dental care is included in health care reform, the expansion of affordable, quality dental care would be a great benefit to underserved communities such as Harlem. Clearly, these data provide not only evidence of the need to include dental care in health care reform but also a warning about potential pitfalls that new efforts need to avoid.

The current study is one of the first to qualitatively examine insurance-related barriers to obtaining dental care, but it does have potential limitations that must be noted. First, the sample is a small convenience sample, and therefore the results may not be generalizable to all African Americans living in Central Harlem. Nevertheless, the use of street-intercept recruitment does eliminate some of the self-referral bias that exists in many community-based studies and therefore is likely representative of this population. Further, the sample size, although small for statistical analyses, is rather large for a qualitative study, helping to ensure that the themes identified here are common within the Central Harlem community.

The restriction of the sample to only African American adults living in Central Harlem also potentially limits the generalizability of these findings to other African American samples. However, the focus on Central Harlem does provide critical data that will be useful in addressing the documented unmet oral health care needs within this community.[11] Although these findings may not generalize to uninsured and underinsured Whites, past research makes clear that financial barriers to dental care are not unique to African Americans. Therefore, future research should examine whether similar barriers exist in White samples, or whether White and African American samples report similar insurance-related barriers. Finally, because of the semistructured qualitative nature of the interviews in which participants self-nominated barriers, rather than being asked whether they had experienced a predetermined set of barriers, we cannot determine exactly how many participants experienced each barrier. Nevertheless, this method does ensure that the barriers described here are the most salient ones experienced by our participants.

Despite these limitations, the current study provides critical information on the insurance-related barriers that African Americans in Central Harlem experience when attempting to obtain care for their oral health symptoms. As such, the current research provides critical insights into the barriers that must be addressed to reduce the oral health disparities found between African American and White adults. ■

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E. W. Schrimshaw directed data collection, participated in data analysis and interpretation, and drafted the article. K. Siegel and C. Kunzel originated the study and its design, participated in data analysis and interpretation, and edited article drafts. N. H. Wolfson participated in data analysis and interpretation, assisted with drafting the findings, and edited article drafts. D. A. Mitchell contributed to the study design and edited article drafts.

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Human Participant Protection

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