



**A FrameWorks Institute eZine  
Children's Oral Health**

This Kids Count eZine examines how the public views the issue of children's oral health, in conjunction with the release of the Surgeon General's report on May 25, 2000, and suggests a number of critical elements that children's advocates should consider in framing this issue for public support.

While some Kids Count projects may not have been active in piggybacking on the breaking news surrounding the report, there should be ample opportunity for many weeks to come to comment through op/eds, letters to the editor, and editorial board correspondence. Moreover, since health care and children's health issues will be with us throughout the election season, this memo can help suggest new angles to pursue in freshening that discussion.

The findings reported in this eZine build on research and communications applications first published by the FrameWorks Institute in December 1999. That Message Memo was based on a study by cognitive linguist Pamela Morgan of the conceptual frameworks that ordinary people use to reason about children's oral health, and a subsequent analysis of the news coverage accorded this topic, as well as professional material provided by children's oral health professionals. A subsequent addendum to the original research, provided by public opinion analyst Meg Bostrom, summarized recent survey research related to the public's attitudes concerning children's oral health. With the availability of funds to support further research, FrameWorks was able to further test the research and the recommendations in a series of six focus groups with parents of children of various ages conducted in February and March 2000 in Baltimore, Richmond and Riverside, CA. Finally, a national survey of 1,000 adults was conducted April 24 - 26, 2000. This Kids Count eZine combines and summarizes this research, adapting it to the interests of child advocates.

This eZine is not meant to replace the Surgeon General's report, with its factual information on the causes and consequences of poor oral health for children, but rather to

complement it by presenting the translation challenges associated with moving this issue, and policy-related solutions, higher on the public's agenda. To access the full report, go to [www.surgeongeneral.gov](http://www.surgeongeneral.gov) and find the link to the oral health report, or review the executive summary at [www.nidcr.nih.gov/sgr/execsumm.htm](http://www.nidcr.nih.gov/sgr/execsumm.htm).

### Overview of the Issue

The issue of children's oral health is virtually unknown to most Americans: what defines children's oral health, what contributes to it, what are the consequences of ignoring it, what can be done to improve it. It is, therefore, fertile ground for framing, with few associations to encumber it. Virtually invisible in the news until now, the stimulus of a report from the nation's top health officer is likely to prime new media interest in the topic. The opportunity to advance a "fresh issue," especially one that links to the broader problem of ensuring children's overall access to health care, should prove attractive to children's advocates.

The critical thresh-hold question for Kids Count projects is: does this issue help or hurt broader advocacy for children's health? The answer from the research is resoundingly positive. When adults are presented with compelling information about the consequences of children's oral health problems and the policy opportunities to address them, they automatically make the connection to children's overall health status. Moreover, the widely recognized tendency of insurers to exclude dental and vision care from coverage further fuels their ire at the nation's inadequate system of health care. Finally, when children's oral health care is explained as affecting adult health, it ceases to be a "children's issue," and achieves immediacy and salience to adults. In sum, children's oral health appears to prove useful as a prism issue for supporting a broader children's health agenda.

This is not to suggest that it does not easily reduce to the same kind of personalistic consumer responses that often plague children's issues. When people think of "oral health," they think of teeth, toothbrushes, smiles, and dentists, in that order. When asked to weigh the causes of poor oral health, people sight personal, consumer behavior: inadequate brushing, flossing and consumption of junk food. When asked to consider the consequences of poor oral health, they are most likely to mention cosmetic beauty and poor self-esteem. A minority mention discomfort or pain.

When children's oral health is specifically discussed, the issue conflates with parenting issues, discipline, and the importance of habits learned early. In sum, there is virtually no automatic linkage between children's oral health and adult physical health, between children's oral health and related social or environmental conditions, nor between children's oral health and achievement in school or ability to thrive.

However, when even a modicum of strategically calculated information is introduced into the discussion, people reconsider these shallowly held convictions and are easily able to prioritize the issue, to assign responsibility for it to someone other than parents, to see a clear role for the community, and to support systemic solutions.

And, although the information we placed before adults in our national survey was not specifically about poor children, it served to prioritize them. When you talk about this issue universally, in terms of all children, people understand that poor children are most likely to suffer.

What follows is a more detailed discussion of the negative frames and an overview of the communications elements necessary to reframe this issue for public support.

### The Frames We're Up Against

What people bring to this issue is simply captured by the following points:

Most Americans believe cavities are the prime effect of poor oral health, followed by cosmetic beauty and self-esteem.

They believe the primary responsibility for children's oral health lies with parents, and they are most likely to want to solve the problem through parent education or consumer outreach.

If there are to be systemic solutions, most adults expect schools to be involved.

When prompted, adults believe that oral health is part of overall health and well-being.

When prompted, adults can understand that children's oral health is a community responsibility.

Our focus group moderator asked the fathers of teenagers in Richmond: "In what ways does poor oral health affect a child?" And they answered:

*"Self-esteem, peer pressure." "Just physical discomfort." "Eating disorders." "You can't get a date with anyone."*

Our moderator asked: "Do most children have good oral health or not?" And mothers of teenagers in Riverside, CA answered:

*I say no because I see little kids coming out of school and they have bags of candy and cookies, and they don't take toothbrushes You have to tell take your toothbrush and then they forget...They don't spend a lot of time brushing and flossing."*

*"I think it depends on the parents."*

*"The parents don't make them brush."*

Dental visits are seen as important, but expendable. This line of reasoning includes the notion that, if money is scarce, dental care is easy to postpone and that, as one focus group participant said, "if you have the habits and you have everything else, a dental visit is a luxury."

Dentists were not viewed by the public as trusted sources on this issue for two important reasons. First, they were discounted as having too much self-interest in the topic. Second, the use of a dentist undercut the connection to a whole health model, since dentists are not automatically linked by many people to the health/medical profession.

In sum, this issue is not seen as important, it is viewed as evidence of bad parenting, it can only be fixed through parent education or by kids taking responsibility for themselves and the obvious spokespersons on the issue are not highly credible with the public.

By contrast, oral health experts tell us that the answer lies in an array of public health measures that include: water fluoridation, dental education to expand the number of public health dentists, Medicaid and CHIP reform to ensure that eligible children actually see dentists, expansion of workplace health insurance to include dental coverage for all dependents, and more aggressive application of proven prevention measures like sealants.

How can we convey these solutions, knowing what we know about the dominant frames people bring to the issue, and how will this affect their understanding of both children's oral health and children's issues in general?

### Reframing Children's Oral Health

There are a number of clear, effective ways suggested by the research to set up this new understanding. Key to this reframing is an emphasis on the *prevalence of the problem, the severity of the problem, the consequences of the problem, and the efficacy of prevention in solving this problem.*

Here are three statements that actualize these findings with reference to national data:

*Prevalence:* Dental caries is the most common chronic childhood disease in America. It affects 50% of first graders and 80% of 17-year-olds.

*Severity:* Researchers are currently exploring whether or not there is a link between adult oral infections--primarily gum diseases--and diabetes, heart disease, stroke, and pre-term, low weight births.

*Consequences:* Children with serious oral health problems have trouble eating and

sleeping, paying attention to parents and concentrating in school.

*Prevention:* Children's oral disease is entirely preventable. Fluoridation of the water supply reduces caries by about 26% in adolescents. Children with dental sealants and regular dental visits have only one fourth as much tooth decay as those without. Children and adults with dental insurance are much more likely to have timely visits to a dentist.

With reference to the communications research, two statements we tested clearly overcame public indifference and overrode the public's relative ignorance of the subject to connect it to topics they do discuss: health in general, insurance coverage, and the importance of prevention, especially the adult impact of childhood disease.

Those two statements emphasized:

(1) that *dental disease is disease* with health consequences across the life span, and that new scientific breakthroughs like sealants can prevent these chronic problems in adulthood

(2) that *dental health is part of whole health*, and that it's a crazy system when we allow insurance companies to cover our arms and legs but not our mouths

Moreover, these statements had the advantage of immediately connecting children's oral health to systemic solutions. By making clear that dental problems are *diseases*, not cosmetics, and chronic, the first statement overrides the natural tendency to assign responsibility to the family and, instead, elicits the community's responsibility to safeguard citizens from disease. It moves the issue from a personal to a public health responsibility.

The second statement, by evoking a whole health model, aligns children's oral health with other aspects of children's health for which we already assume responsibility as a society, through insurance pooling and through both private workplace solutions and public programs. Both of these statements accomplish the goal of taking children's oral health out of the public's default frame - teeth, brushing, cosmetics, parents - and into a social policy frame that opens the door to collective resolution.

The link between education and health is a strong one for people. If children's health is suggested to interact with their achievement, their concentration in school, their attendance, that immediately signals to people that a child's future is threatened. And the notion that screening and referral for children's oral health would occur in the schools seems natural to them, as long as this is not placed on the school and something else taken away. People are very sensitive to pressures on schools to "do everything."

While doctors, especially pediatricians, were highly credible and served the purpose of

linking the mouth to a whole health model, so were school nurses, who also had the advantage of making the locus of systemic action in the schools, where people are already used to fixing public problems affecting children and where the link can easily be made between health and achievement.

How do we translate these framing lessons to the issue of children's oral health? The research suggests that advocates for children's oral health policies and programs should:

*Link children's oral health to overall health.* The main message must be that children's oral health is an important part of overall health and well-being. Example: Too few people connect what happens in the mouth with the rest of the body. Like vision care and hearing, dental care has been marginalized. The truth is if you don't have oral health, you're not healthy.

*Define children's oral health problems as disease and make explicit the consequences of delayed attention to oral health problems.* Advocates must link children's oral health to long-term health effects in simple terms that most Americans can understand; they must go beyond "cavities" and "lack of self-esteem" as the ultimate consequences of doing nothing. Example: Dental disease begins early and takes its toll on adults whose problems began as children.

*Provide a clear solution or arena of responsibility (insurers, laws, schools, etc).* The list of policy solutions must be enumerated at every opportunity. Calling attention to states and cities that have made progress in addressing children's health helps. Americans are hungry for solutions to children's problems and, without them, they will default to the frame that bad parents aren't doing what they should, and there is little way to intervene. Example: Lack of dental care and coverage is widespread. In Washington state, 40% of employees lack dental coverage.

*Connect the consequences of children's oral health problems to other aspects of a child's achievement (attention to schoolwork, growth).* Example: Fifty-two million school hours are missed each year by children with oral disease.

*Emphasize a "can do" approach to children's problems that empowers community action.* Example: Many states are making progress on this problem. Connecticut reports it is covering its children's access to dental prevention for \$7.13 per child per month, and Massachusetts for \$6.08.

*Counteract the default frame of teeth, personal responsibility, family negligence, cosmetic consequences, self esteem, etc.* Example: Dental disease is disease; it is not merely a cosmetic problem that erodes our self-esteem. But don't start with this statement (restating a negative frame); use it as a secondary message linked to a powerful positive statement.

*Use messengers that underscore these messages and enhance the issue's importance in your community.* Example: School nurses, pediatricians, senior citizens, other health professionals should serve as the prime messengers. Dentists are seen as self-serving on this issue and not completely connected to a whole health model in the public's mind. Better to let others establish the problem, and let dentists be part of the solution. However, dentists in combination with these other spokespersons are a good combination. And dentists need to weigh in as experts when state legislators who go out on a limb to promote fluoridation or expansion of dental education.

*Don't overstate the issue.* While adults will prioritize children's oral health as an important social problem, calling it a "crisis" or an "epidemic" can actually backfire. As one reporter opined in response to the framing used in releasing the Surgeon General's report, "yet another epidemic." But, more importantly, this framing turns off that very segment of the public most likely to champion the issue: people who are already familiar with children's issues who believe they should be attended to. By calling children's oral health a "crisis," you remind them of all the other crises that they find even more compelling - from child poverty to child abuse and neglect - and children's oral health pales by comparison. Example: Dental caries is the most common chronic childhood disease in America, affecting 50% of first graders and 80% of 17-year-olds. This statement does not overstate, it merely prioritizes.

*Don't get seduced into visuals that undermine your message.* Example: No toothbrushes, no dental floss, no cute kids smiling with perfect teeth (unless you make the point that they had sealants). Also avoid dental offices, dental chairs and drills. So what should you show? Mobile vans finding kids who otherwise wouldn't get access, scientists discussing fluorides in the drinking water, pediatricians' offices where the docs also ask about the child's access to regular dental care, child health checklists that include oral health, school nurses who examine students for oral disease and refer them or who can attest to learning days lost due to dental disease.

### Reframing Effects

What do you get when you reframe? The answer in this case is a major shift in the prioritization of the solution, away from parent education toward more systemic solutions, including expanding access for poor children.

We conducted a random telephone survey of 1,000 adults nationwide on April 24-26, 2000 to study the impact of several problem statements on their support for policy solutions. Survey respondents were asked to allocate an imaginary \$100 contribution among four types of organizations. These were organizations that: provide free dental services to poor children, work to get better dental health insurance for all children, work

to get better dental screening into public schools, and educate parents about the importance of proper tooth brushing. Half the respondents were asked to allocate their dollars before they heard any information about children's oral health, while the other half allocated their dollars after hearing three persuasive messages about children's oral health. The messages were:

*"Brushing and flossing are not enough. Regular dental visits, optimal fluoride levels in the water, new scientific breakthroughs like sealants, are critical to good oral health. And some studies suggest that, without these actions to prevent dental problems, children with poor oral health may be more susceptible to all kinds of disease, such as infection, poor speech, diminished growth, and cardiac problems in adulthood."*

*"More than half of all children do not have dental insurance. This results in almost one third of a family's health expenses being spent against their children's oral health. We've allowed insurance companies to fragment coverage so that arms and legs are insured, but our eyes and mouths are not. That's a crazy approach to health care, with a direct impact on every family's checkbook."*

*"Children with poor oral health experience significant pain, which can affect their eating habits and growth, makes them more likely to get sick and miss school, and even affects their ability to concentrate in school. If we want children to succeed in school, we need to understand that learning and health are linked."*

All three messages tested proved convincing to more than two-thirds of adults. The message linking oral health and pain with ability to succeed in school was the strongest individual message tested, regardless of question order and the influence of other messages.

The next strongest message proved to be the "dramatic consequences" message. Overall, it was just as convincing as the school performance statement. Sixty-nine percent say it is convincing, with 31% rating it extremely convincing. Interestingly, when it was the first message respondents heard, it was rated as more convincing than when it was the last message heard. Bostrom hypothesizes that the shock value of the statement may be less compelling when the public has had the opportunity to consider other consequences, like educational achievement.

While the dental insurance message proved weakest of the three, it was aided by the other messages. When the message linking poor oral health to a variety of diseases was heard prior to this message, it caused people to place more priority on the dental insurance message.

A comparison of the responses between those allocating resources before hearing information and those allocating resources after hearing information demonstrates that

the messages increase the priority people place on free dental services for poor children. The average contribution for free dental services jumps by \$2.40, even though none of the messages tested referred to poor children or advocated for a specific policy solution.

What's in children's oral health for children's health advocates? A lot. Many of the solutions are the same: expand insurance coverage, ensure real access to providers, expand the provider network, stress prevention before treatment, enhance detection and referral, pursue public health measures like fluoridation of the water supply. But children's oral health is a "new story," as journalist Richard Louv has dubbed it. It can provide a new angle to help rekindle reporters' interest in child health access. To see how Louv undertook the task of writing this story, based on the communications research,

Take a look at his article on children's oral health posted on <http://www.connectforkids.org/node/193>.

For further communications research on children's oral health:

Bales, Susan Nall, *Framing Children's Oral Health for Public Attention and Support: A FrameWorks Message Memo*, Washington, D.C.: FrameWorks Institute, December 1999.

Bales, Susan Nall, *Parents Discuss Children's Oral Health: Findings from the Focus Groups*, Washington, D.C.: FrameWorks Institute, April 2000.

Bostrom, Meg, *FrameWorks Message Memo on Children's Oral Health: Addendum 2*, Washington, D. C.:FrameWorks Institute, December 1999.

Bostrom, Meg, *FrameWorks Message Memo on Children's Oral Health: Addendum 3*, Washington, D. C.: FrameWorks Institute, May 2000.

Morgan, Pamela S., Ph.D., *A Report on American Adults' Models for Children's Oral Health From Interviews*, Washington, DC: Benton Foundation, August 1999.

Morgan, Pamela S., Ph.D., *A Report on American Adults' Models for Children's Oral Health From Published Sources*, Washington, DC: Benton Foundation, August 1999.

The above articles have been combined in *FrameWorks Working Papers: Communicating Children's Oral Health* and are available for \$20.00 each prepaid from the FrameWorks Institute, 1001 Connecticut Avenue, NW, Suite 901, Washington, DC 20036.

This is the second in a series of occasional papers designed to translate important new communications research and techniques for Kids Count programs. Sponsored by a grant from the Annie E. Casey Foundation to the FrameWorks Institute, these eZines are complemented by communications workshops and workbooks. Discussion of related

issues is encouraged on the Kids Count listserv; however, to contact FrameWorks directly, email [susanb@frameworksinstitute.org](mailto:susanb@frameworksinstitute.org).

***About FrameWorks Institute:*** The FrameWorks Institute is an independent nonprofit organization founded in 1999 to advance science-based communications research and practice. The Institute conducts original, multi-method research to identify the communications strategies that will advance public understanding of social problems and improve public support for remedial policies. The Institute's work also includes teaching the nonprofit sector how to apply these science-based communications strategies in their work for social change. The Institute publishes its research and recommendations, as well as toolkits and other products for the nonprofit sector at [www.frameworksinstitute.org](http://www.frameworksinstitute.org).

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