Federal health programs continue to provide financial assistance for millions of Americans in need. While the existence of such programs have, no doubt, benefited communities throughout the nation it is important to understand that some programs have policies that create inequalities based on social, political, and economic circumstances. In this paper, I examine the effects of Medicaid policy on low-income minorities. I analyze several class readings and an interview with Ana Wu—a Chinese-Vietnamese American woman who immigrated to the United States as a refugee in 1979. I interviewed Ana because I wanted to learn more about how low-income families are affected by our current health care system. Furthermore, I chose to focus my analysis on dental care because I am pursuing a career in dentistry and understand it is not always viewed as a medical necessity. The combination of unfair policies and unrecognized importance of dental care creates disparities for those who seek dental services but fall through the cracks of the U.S. health care system. The notion that Medicaid is a privilege for the poor, rather than a right, leaves low-income immigrant families more vulnerable to bureaucratic acts of structural violence, especially for communities that suffer from oral health issues.

Not all federal programs are created equally. For instance, Medicare and Medicaid are both national health insurance programs with very distinct purposes. According to James Reid, author of ***The Healing of America***, Medicare is the “*government-run single-payer system created by Congress…to pay for basic health care for the elderly” (Reid 38).* On the other hand, Medicaid is a *“government insurance program for persons of all ages whose income and resources are insufficient to pay for health care”* (America's Health Insurance Plans (HIAA), 232). How exactly are these two programs distinguished from one another? According to Dr. Marieke van Eijk, a Medical Anthropologist and professor at the University of Washington, Medicare is seen as a right to health insurance, earned from years of employment (Eijk 04/08/15). On the other hand, Medicaid—and many other welfare programs—is not a right, but a privilege given to the poor. These programs are politically insecure and more vulnerable to cutbacks (Eijk 04/08/15). Here Dr. Eijk refers to the fluctuating circumstances of welfare programs that are dependent on continuously changing economic and political factors. Her views are also supported by Anika Jones’ article titled ***From Welfare Queens to Day-Care Queens***, which reveals “*during fiscal deficits governments tend to target development, municipalities, welfare and other social spending programs for cuts”* (Jones 37). In the article, a national program of welfare reform was instituted by President Bill Clinton to provide parents, who could not afford childcare, with subsidized day care programs. When the state of Wisconsin began to struggle from a financial deficit, African American day-care providers were criminalized and targeted to recoup money for the state. It is clear that welfare programs, including Medicaid, are vulnerable to fiscal cuts, but the problem extends further and influences the outcomes of patient health as well. The underfunding of welfare programs leave underprivileged populations vulnerable to bureaucratic acts of structural violence.

Before continuing, it is important to understand the concept of structural violence and its relation to bureaucracy. David Graeber, author of ***Dead zones of the imagination****,* defines structural violence as “…*forms of pervasive social inequality backed up by the threat of physical harm”* (Graeber 112). By this, he means that victims of structural violence aren’t necessarily in direct physical harm. However, the environment they are exposed to—whether it is physical, social, or economic—creates conditions that threaten their well-being by leaving them more vulnerable to danger than others who are not exposed to the same conditions. Graeber expands on sociologist Max Weber’s idea that bureaucracy threatens individual freedom. He explains *that bureaucratic acts are silent, omnipresent forms of structural violence that are shaping the parameters of human existence* (Graeber 105). He means that policies create structures of violence and certain groups are unequally constrained by the policies governing their health. My analysis will focus specifically on how Medicaid oral health care policies create structural violence and diminish oral health outcomes for low-income populations in the U.S.

The lack of funding for Medicaid discourages dentists from accepting Medicaid patients. As a result, these patients are limited in their choice of providers. According to Sarah Horton and Judith Barker, authors of ***Stigmatized Biologies: Examining the Cumulative effects of Oral Health disparities for Mexican American Farmworker Children***, The underfunding of Medicaid programs, such as Denti-Cal in the state of California, *“reduces reimbursement rates for private dentists at a rate of 30-40 percent of what they receive from private insurances” (Barker 208).* This means if a dentist were to perform the exact same dental procedure for a Medicaid patient as they would for a patient covered by private insurance, the dentist would lose a substantial percentage of profit for doing so. This is extremely problematic because there is no incentive for dental care providers to treat Medicaid patients. In fact, dentists who choose to care for Medicaid patients would suffer a great financial loss. Therefore, very few dentists are willing to serve patients on Medicaid. This is made apparent in my interview with Ana Wu. She said, *“There were a few dentists in the area who took DSHS and I heard one dentist specialized in taking care of DSHS children so we went to him”* (Interview 5). DSHS refers to the Department of Social and Health Services, which oversees the social services provided to citizens of Washington State, including Medicaid (DSHS). Ana reveals her difficulty in finding a dentist who would accept Medicaid patients. She first reported to have sorted through a list of dentists that accepted Medicaid before finding one in her community who agreed to treat her children. How might patients be vulnerable to structural violence with limited provider options? Well, Medicaid patients become vulnerable when reimbursement policies force dentists to work around obstacles in order to make a profit.

Dentists who do serve the Medicaid population receive little reimbursement and therefore must adopt specific strategies to remain financially viable. This leaves Medicaid patients more susceptible to oral health issues. *“One strategy is to keep the percentage of Medicaid patients at a constant level and refusing to exceed that limit” (Barker 209).* This means that dentists may only accept a set number of Medicaid patients before refusing to treat others who are seeking care. This ensures that dentists can limit financial loss to a minimum. For patients, however, this is distressing because those who do not make the cut do not have access to dental care. These patients would therefore be more likely to develop cavities or other oral health problems. Medicaid reimbursement policies also place more value on some procedures than others. Horton and Barker explain, *“Denti-Cal actually encourages the extraction rather than restoration of children’s teeth” (209)*. This statement reveals that reimbursement policies allow dentists to decide on the type of service they will provide, based on how much they will be reimbursed. This poses a problem because dentists hold authority and have the opportunity to convince patients and their families of what they believe is the best course of treatment. Furthermore, premature extraction lead to other problems as well. *“The premature loss of a child’s front teeth and the consumption of soft, processed foods may understimulate the jaw in particular places, leading to its uneven development” (Barker 210).* If extractions are encouraged over restorative procedures, then dentists will more frequently choose extraction. This leaves Medicaid children more prone to uneven mouth development and more oral health problems in the future. Another strategy dentists use to maximize their profits is to *“economize on the time spent on Denti-Cal patients*” (Barker 209). This strategy is known as the Medicaid Mill approach. With this approach, dentists provide as many dental services as possible in one sitting to ensure maximum reimbursement for their services. This strategy is confirmed by Ana’s account with the dentist she chose to seek care from in the previous section. She recalls, *“I thought my daughter only needed one cap and she came out with eight caps in her mouth. My English still was not good at that time and I was so mad I did not give them permission to do that” (Interview 5).* This dentist chose to use the Medicaid Mill approach to serving low-income families. Ana later recalls that he was sued for child abuse and malpractice. It was made public that he profited $1.5 million every year on children for performing extraneous dental procedures on Medicaid patients (Interview 5). While reimbursement and profitable strategies become structures of violence, policies have another way of leaving patients vulnerable to harm through lack of coverage for certain procedures altogether.

 Medicaid policies also limit the type of care that can be provided to low-income immigrant families, leaving certain patients with no option for treatment. In the previous section, I introduced the financial benefits dentists would receive for performing extractions over restoring teeth. However, the result of premature extractions lead to crooked teeth which, if goes untreated, can cause crowding and ultimately more decay. According to Sarah and Barker, *“Denti-Cal only covers braces in cases of medical necessity—if children’s crooked teeth hinder their bite or prevent their eating” (212)*. While Medicaid reimburses dentists more for performing extractions, the program doesn’t pay for orthodontic procedures that treat the problems those extractions caused. This, again, is a situation that is exists in real life. Ana brought her son to the dentist as a pre-teen. His dentist explained that he would need orthodontic work for his extreme case of crowded teeth, in order to prevent serious cavities from forming in the future. However, Ana decided to bypass treatment. She stated*, “My son had many cavities later and even had to pull out a tooth because it couldn’t be saved. I know my son needed braces, but what could I do? I couldn’t afford it and it was not covered by Medicaid.”(Interview 7)* In this example the treatment of caries through fillings or extractions is covered by Medicaid. Although the cause of caries is attributed to crowding teeth and could be prevented by braces, orthodontic work is not considered to be a significant health concern and is therefore not covered by Medicaid.

 In conclusion, federal programs provide financial assistance based on notions of “rights” and “privileges”. The fact that Medicaid is regarded as a privilege for the poor, rather than a right, makes funding for health coverage highly dependent on political and economic factors. The lack of funding that goes toward Medicaid dental coverage results in structures of violence, which are created by bureaucratic decisions and policies. Few providers are willing to treat patients covered by Medicaid because of low reimbursement rates. This greatly limits patient options in choosing a provider to treat their oral health issues. Furthermore, providers who do treat Medicaid patients seek out ways to maximize their profit. The combination of profit-driven strategies and Medicaid policies, which value certain procedures over others, perpetuate oral health issues to become serious oral health risks. This domino effect continues as probles are created through existing policies. These bureaucratic acts of violence leave Medicaid patients vulnerable to physical harm. The number of issues in the interview relating to policy is astonishing, especially when the examples come from just one family. Very few ethnographies about dental care have been conducting and I think it is something we must continue to do to expose these complex issues and change the way low-income families are assisted through the U.S. health care system.

Bibliography

Eijk, Marieke Van. "Health Care Closer To Home." Savery, Seattle. 8 Apr. 2015. Lecture.

Graeber, David. "Dead Zones of the Imagination." HAU: Journal of Ethnographic Theory 2.2 (2012): 105. Web.

Horton, Sarah, and Judith C. Barker. "Stigmatized Biologies:." Medical Anthropology Quarterly 24.2 (2010): 199-219. Web.

Jones, Anika. "From Welfare Queens to Day-Care Queens." JSTOR. Web. 03 June 2015.

"Money Interview 2." Personal interview. 15 May 2015.

Reid, T. R. The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care. New York: Penguin, 2009. Print.