

6.6. Inequalities in dentist consultations

Dental caries, periodontal (gum) disease and tooth loss are common problems in OECD countries. Despite improvements, problems in access persist, most commonly among disadvantaged and low income groups. In the United States, over 40% of low income persons aged 20-64 years had untreated dental caries in 2005-08, compared with only 16% of high income persons (NCHS, 2011). In Finland, one-quarter of adults with lower education had six or more missing teeth, while less than 10% of those with higher education had the same amount of tooth loss (Kaikkonen, 2007).

Strategies to improve access to dental care for disadvantaged or underserved populations include reducing financial and non-financial barriers, and promoting an adequate dental workforce to respond to demand.

Most public health authorities recommend an annual visit to a dentist. The average number of per capita consultations varied widely in 2009, from over three in Japan and over two in Belgium, the Netherlands and Israel, to 0.1 in Mexico and 0.3 in Turkey, with an OECD average of 1.3 (Figure 6.6.1). Some of this variation can be explained by the differing availability of dentists. In general, as the number of dentists increases, so does the number of consultations per capita (OECD, 2009b).

Recent OECD findings show that high income persons were more likely to visit a dentist within the last 12 months (Figure 6.6.2). This is despite differences in public or private dental coverage and the amount of reimbursement. Inequalities are larger in countries with a lower probability of a dental visit such as Hungary, Poland, the United States and Spain. Denmark and France have different recall periods and this affects the average probability of a dental visit, but not the level of inequality. Both countries are among the most equitable for the probability of a dental visit.

Inequalities in types of care, whether curative or preventive, are also apparent. A recent study in Canada shows that access to preventive care is more common among higher income persons (Grignon *et al.*, 2010). There are similar income-related inequalities in dental service utilisation among Europeans aged 50 years and over (Listl, 2011), mostly due to inequalities in preventive dental visits.

In the United States, more recent data confirms the wide differences between income groups in the probability of a dental visit. Less than half of poor and near-poor persons visited a dentist in 2009 compared with close to 70% of middle and high income persons. This gap has remained largely unchanged over the past decade (Figure 6.6.3). As in many other countries, access to dental care in the United

States is generally more difficult than for medical care, since a smaller proportion of persons have dental insurance. More adults report that they did not get needed dental care due to costs than medical care (see Indicator 6.1, “Unmet health care needs”).

Oral health care is mostly provided by private dental practitioners. Treatment is costly, averaging 5% of total health expenditure (and 16% of private health expenditure) across OECD countries in 2009. In countries such as Australia, Canada and New Zealand, adult dental care is generally not part of the basic package of public care insurance, although some care is provided for people with disabilities, those with low income and other disadvantaged groups. In other countries, prevention and treatment are covered, but a share of costs is borne by patients, and this may create access problems for low-income groups (Figure 6.6.4). Some countries, such as the Nordic countries and the United Kingdom, provide public dental care, particularly to children and disadvantaged groups.

Definition and comparability

Consultations with dentists refer to the probability and the number of contacts with dentists. Estimates usually come from health interview or household surveys, and rely on self-report, although some countries provide administrative data. In Germany, the Social Health Insurance Scheme only counts the first reimbursement during a three-month period, and so under-reporting may occur.

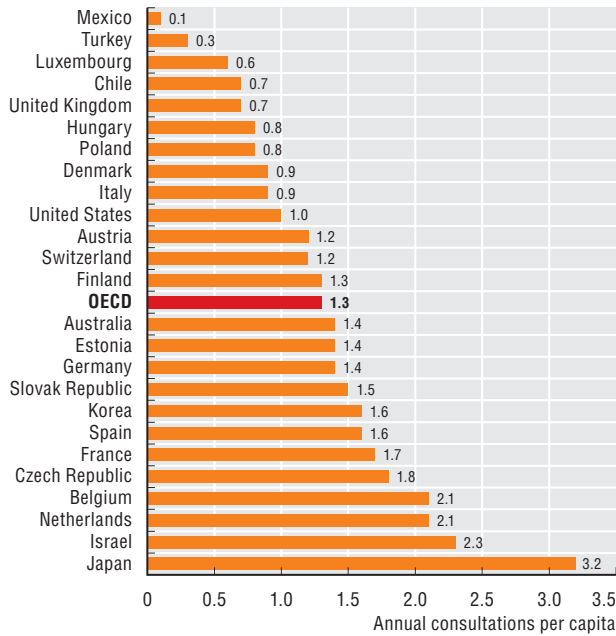
Inequalities in dental consultations are here assessed in terms of household income.

Differing survey questions and response categories may affect valid cross-national comparisons. Surveyed groups may vary in age range, and the measures used to grade income level can also vary. Most countries refer to dental consultations during the past 12 months, except for France (past 24 months) and Denmark (past three months). The difference in recall periods is likely to have an impact on the average probability of dentist visits, but not on the level of inequality. Caution is herefore needed when interpreting inequalities across countries.

Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

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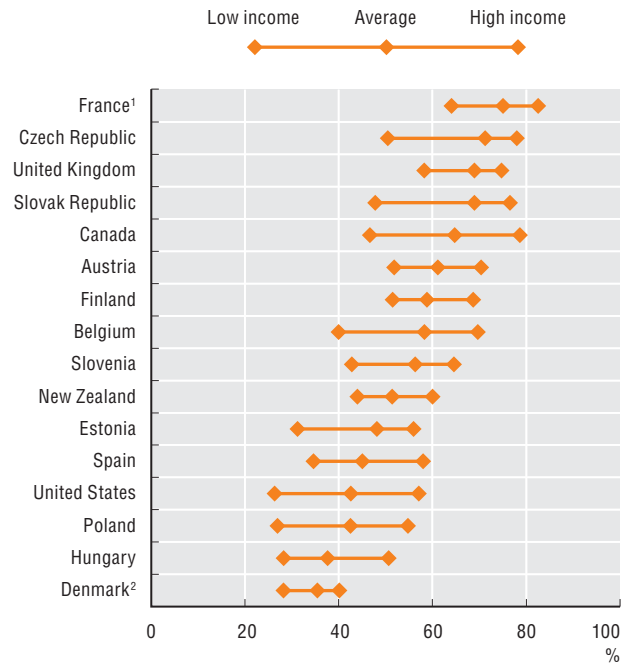
6.6.1 Average number of dentist consultations per capita, 2009 (or nearest year)



Source: OECD Health Data 2011.

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6.6.2 Probability of a dental visit in the past 12 months, by income group, 2009 (or nearest year)

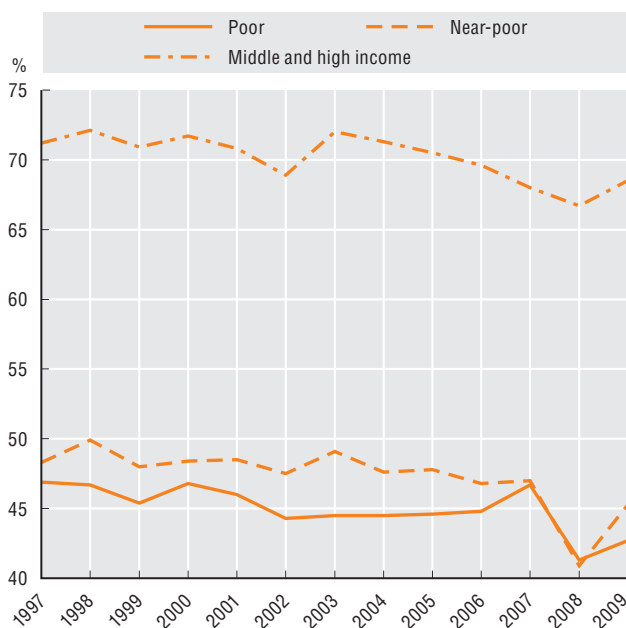


1. Visits in past two years.
2. Visits in past three months.

Source: OECD estimates (2011).

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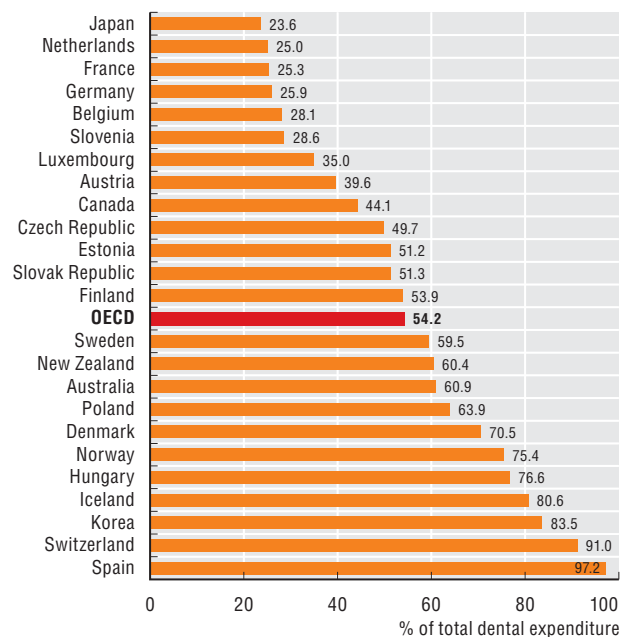
6.6.3 Proportion of adults visiting a dentist in the past year, by income group, United States, 1997-2009



Source: NCHS (2011).

StatLink <http://dx.doi.org/10.1787/888932525913>

6.6.4 Out-of-pocket dental expenditure, 2009 (or nearest year)



Source: OECD Health Data 2011.

StatLink <http://dx.doi.org/10.1787/888932525932>



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