6.5. Inequalities in dentist consultations

Problems in access to dentists persist in many countries, most commonly among disadvantaged and low income groups. For example, 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).

Oral health care is mostly provided by private dental practitioners. Treatment is costly, averaging 5% of total health expenditure across OECD countries, with most of the spending paid for privately in many countries. On average across OECD countries, out-of-pocket payment for dental care represented 55% of total dental care expenditure in 2011, ranging from 18% in the Netherlands to 97% in Spain (Figure 6.5.1). In countries such as Spain, Israel and Switzerland, adult dental care is generally not part of the basic package of public health insurance, although some care may be provided for certain population groups. In most other countries, prevention and treatment are covered, but a significant share of the costs is borne by patients, and this may create access problems for low-income groups.

Recent OECD findings show that high income persons were more likely to visit a dentist within the last 12 months than low income persons (Figure 6.5.2). Inequalities are larger in countries with a lower probability of a dental visit such as Hungary, Poland, and the United States. Denmark and France have different recall periods, which affect 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, although the share of out-of-pocket payments in Denmark is much greater than in France.

There are also differences in the types of dental care received across different socio-economic groups. A Canadian study showed that access to preventive care is more common among higher income persons (Grignon et al., 2010). Income-related inequalities in dental service utilisation have also been found among Europeans aged 50 years and over, mostly due to inequalities in preventive dental visits (Listl, 2011).

A significant proportion of the population in different countries reports some unmet needs for dental care. Iceland (13.7%), Italy (11.5%) and Portugal (11.4%) reported the highest rates among EU countries in 2011, according to the European Union "Statistics on Income and Living Conditions survey" (Figure 6.5.3). In these three countries, there were large inequalities in unmet dental care needs between high and low income groups. On average across those European countries covered under this survey, slightly more than 10% of low income people reported having some unmet care needs for dental care, compared with 3.4% for high income people. The most common reason reported by low income people for unmet needs for dental care was cost (for 68% of respondents), followed by fear of dentists (9%). A much lower proportion of high income people reported that their unmet needs for dental care was due to cost (30%), while a higher share responded that this was due to a lack of time (17%), fear (15%) or waiting times to get an appointment (13%).

Strategies to improve access to dental care for disadvantaged or underserved populations need to include both reducing financial and non-financial barriers, as well as promoting an adequate supply of dentists and other dental care practitioners to respond to the demand.

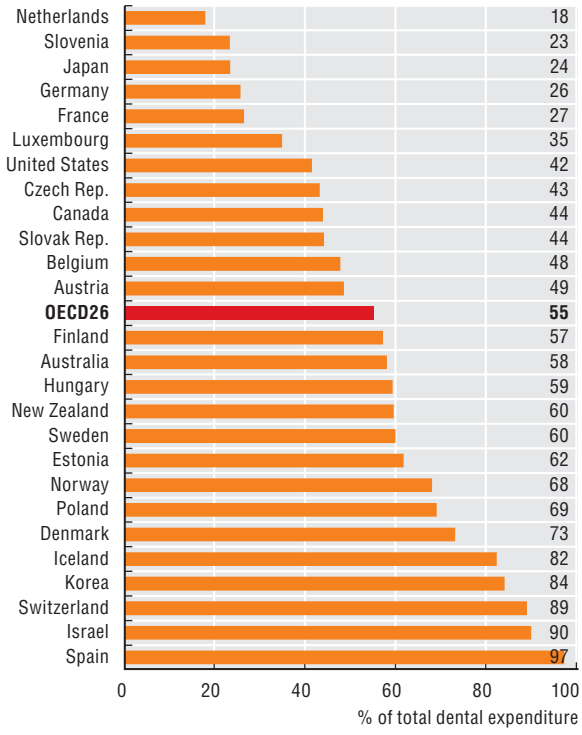
Definition and comparability

Data on the probability of a dentist visit come from health interview or household surveys, and rely on self-report. Inequalities in dental consultations are here assessed in terms of household income.

Differing survey questions and response categories may affect cross-national comparisons, 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.

Data on unmet health care needs come from the European Union Statistics on Income and Living Conditions survey (EU-SILC). No single survey or study on unmet care needs has been conducted across all OECD countries. To determine unmet dental care, EU-SILC asks whether there was a time in the previous 12 months when people felt they needed dental examinations but did not receive them. Cultural factors and policy debates may affect attitudes to unmet care. Caution is needed in comparing the magnitude of inequalities in unmet dental care needs across countries.

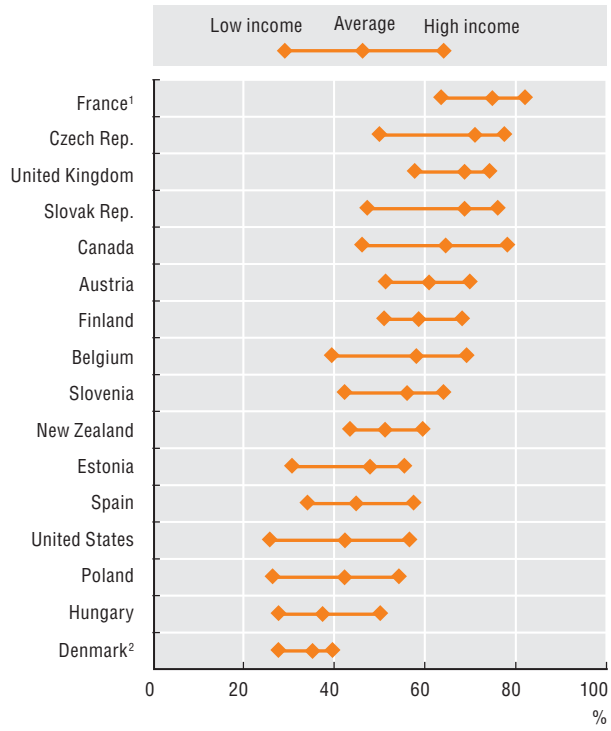
6.5.1. Out-of-pocket dental expenditure, 2011 (or nearest year)



Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888932918662

6.5.2. Probability of a dental visit in the past 12 months, by income group, 16 OECD countries, 2009 (or nearest year)

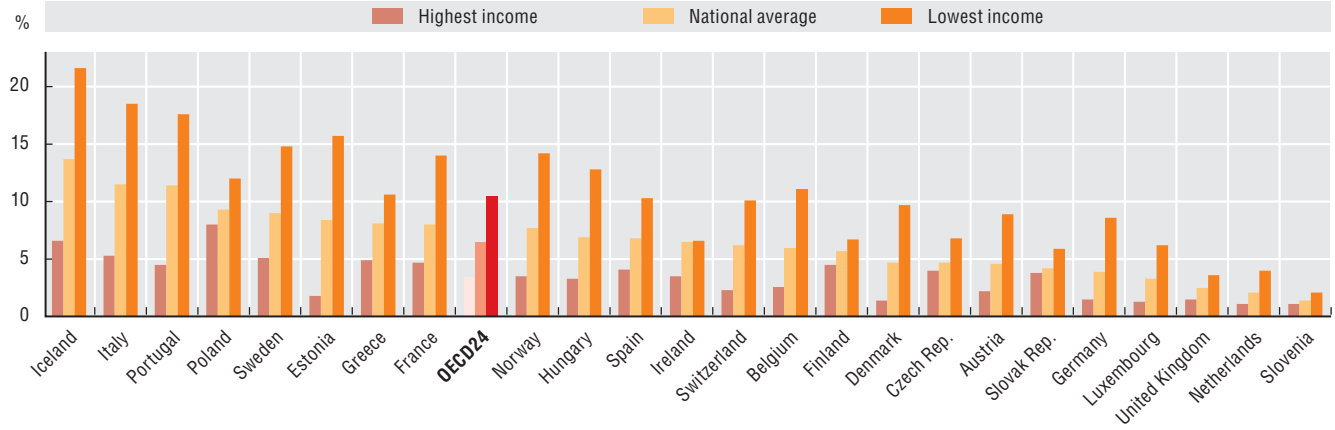


1. Visits in the past two years.
2. Visits in the past three months.

Source: Devaux and de Looper (2012).

StatLink http://dx.doi.org/10.1787/888932918681

6.5.3. Unmet need for a dental examination, by income quintile, European countries, 2011



Source: EU-SILC 2011.

StatLink http://dx.doi.org/10.1787/888932918700