6.6. Inequalities in dentist consultations

Dental caries, periodontal (gum) disease and tooth loss are common problems in OECD countries, variously affecting almost all adults and 60-90% of school children (see Indicator 1.10 "Dental health among children"). Despite great improvements problems persist, occurring most commonly among disadvantaged and low income groups. In the United States for example, almost 50% of low income persons aged 20-64 years had untreated dental caries in 2001-04, compared with only 20% of high income persons (NCHS, 2009). In Finland, one-quarter of adults with lower education were found to have 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 underserviced populations include reducing financial and non-financial barriers, and promoting an adequate dental workforce in all regions to respond to demand.

In most OECD countries, public health authorities recommend an annual visit to a dentist. The average number of per capita consultations with dentists varied widely in 2007, from over three in Japan and over two in Belgium, to 0.2 in Turkey (2002) and 0.1 in Mexico, 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 (see Indicator 3.11 "Dentists").

Van Doorslaer *et al.* (2004) found that high income persons were more likely to visit a dentist within the last 12 months, in all OECD countries where data were available (Figure 6.6.2). This was despite differences in public and private dental coverage and the amount of reimbursement. There was, however, wide variation. At the time of this study, inequalities were smaller in countries with a higher probability of a dental visit such as Sweden and the Netherlands, and larger in Portugal, the United States, Finland and Canada.

Sweden was the most equitable country for the probability of a dental visit. Dental care is largely subsidised through a national dental insurance system. Free care is provided for children and young people to age 19, and a number of services, including prosthetic treatment, are fully subsidised for older people. Reforms in July 2008 have extended care by introducing vouchers for people aged 20 years and over, as well as a high-cost protection scheme. In 2006, Sweden spent 3.4% of public expenditure on health on dental services, well ahead of the OECD average of 2.5%.

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 2006 compared with 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, financial 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. In 2001, only 61% of American adults had some form of dental insurance, compared to 86% of adults with medical insurance. On average in 2003, one-half of total dental care costs were paid out-of-pocket (NCHS, 2007), and 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").

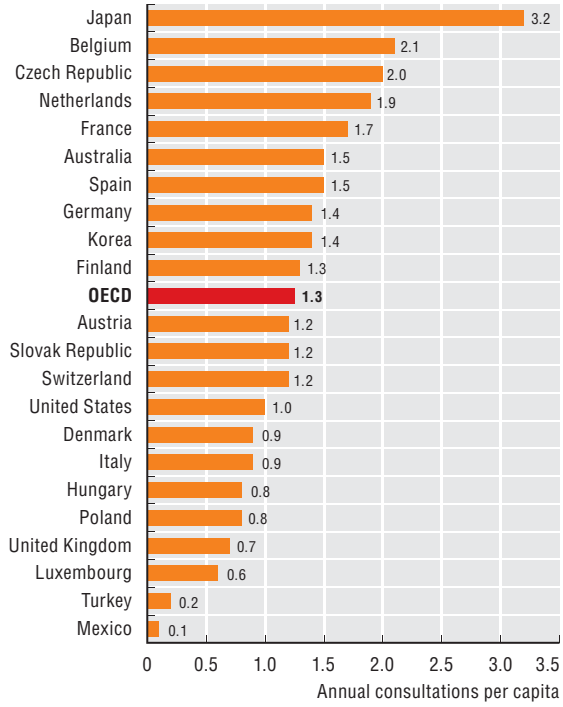
Oral health care is mostly provided by private dental practitioners. Treatment is costly, averaging 6% of total health expenditure (and 16% of private health expenditure) across OECD countries in 2006. In countries such as Australia, Canada and New Zealand, adult dental care is not part of the basic packages of services which is included in public care insurance. In other countries, prevention and treatment are covered, but a varying share of costs is born 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 deviations

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. Inequalities in dental consultations are here assessed in terms of people's income.

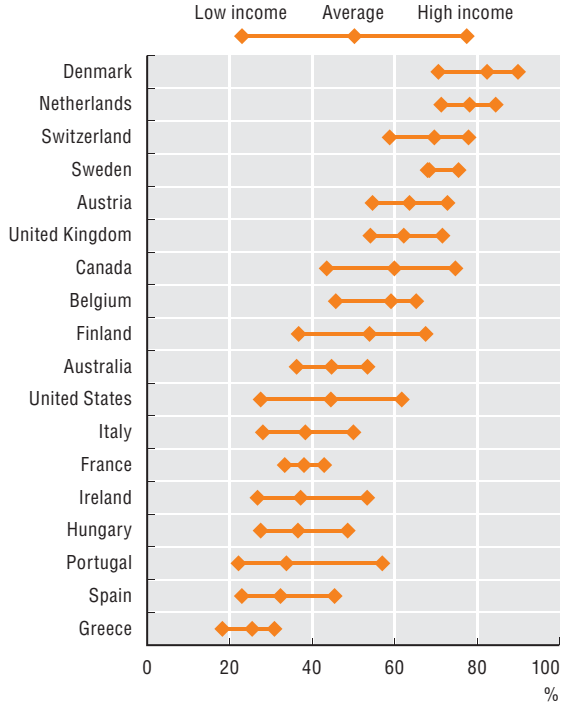
Differing survey questions and response categories may affect the ability to make valid cross-national comparisons. Surveyed groups may vary in age range, and the measures used to grade income level can also vary. Caution is therefore needed when interpreting inequalities across countries.

6.6.1 Average number of dentist consultations per capita, 2007 (or latest year available)



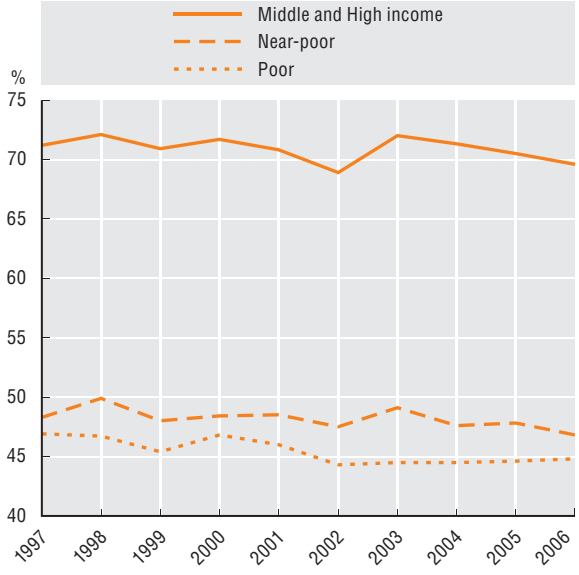
Source: OECD Health Data 2009.

6.6.2 Probability of a dental visit in the past 12 months, by income group, 18 OECD countries, 2000 (or latest year available)



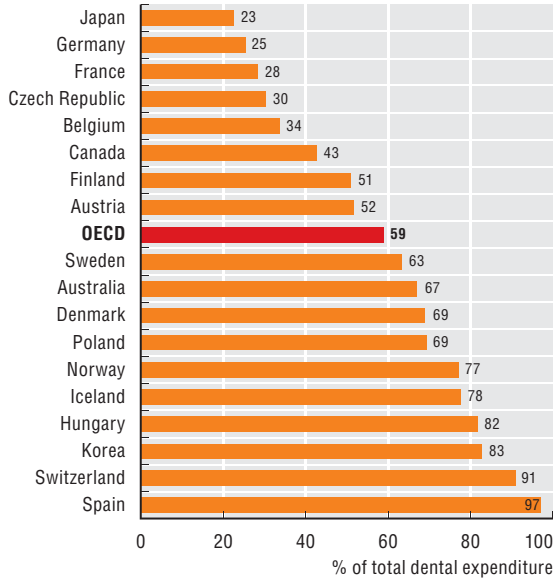
Source: Van Doorslaer *et al.* (2004).

6.6.3 Proportion of adults visiting a dentist in the past year, by income group, United States, 1997-2006



Source: NCHS (2009).

6.6.4 Out-of-pocket dental expenditure, 2006 (or latest year available)



Source: OECD Health Data 2009.

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