

GREAT RECESSION

Impact of economic factors on dental care



BACKGROUND

The primary factors that influence the demand for general oral health care and orthodontic care are the prevalence of oral disease and of abnormalities in a particular population along with general economic conditions. The Great Recession, defined as that period from December 2007 through June 2009, had an important impact on the demand for oral health care. A study was undertaken to isolate the effects of the state of the economy on general oral health care and orthodontic care.

METHODS

The data from the Medical Expenditure Panel Survey (MEPS) over 2003 through 2015 were analyzed to determine patient demand for care before, during, and after the Great Recession. Because other factors can influence demand for oral health care, such as population data, availability of providers, and dental benefits plans, a specific focus on the economic conditions was maintained.

RESULTS

General Practitioner Visits

The percentage of the US population who visited a general dental practitioner slowly and steadily declined over the course of the Great Recession (Figure 1). Recovery was

incomplete for general practitioner visits at the end of the period of interest.

The population percentage who visited a general dental practitioner increased slightly among those age 8 to 18 years but declined steadily for adults age 19 years or older. Among children in lower-income groups, the final visit data in 2015 were just slightly lower than the levels in 2003. For higher-income groups, the final level was higher than in 2003.

The numbers of privately insured patients were slightly higher in 2015 than in 2003, as were those covered by Medicaid/CHIP payments. The private insurance payouts rose by 2.2%, whereas the Medicaid/CHIP payouts rose by 3.9%. Out-of-pocket expenditures for general oral health care decreased by 4.8%. Governmental assistance programs for both general dental care and orthodontic care showed significant payment increases, which may indicate these programs provided insulation for general economic trends or increased in response to the economic downturn.

Orthodontist Visits

Orthodontist visits suffered a steeper decline than general dental visits over the period under study. Orthodontic visits began to decline in 2003 when the percentage was 3.4%, but the fall leveled off before the recession. During the recession the decline continued and reached a low of 2.5%. From 2010 to the present,

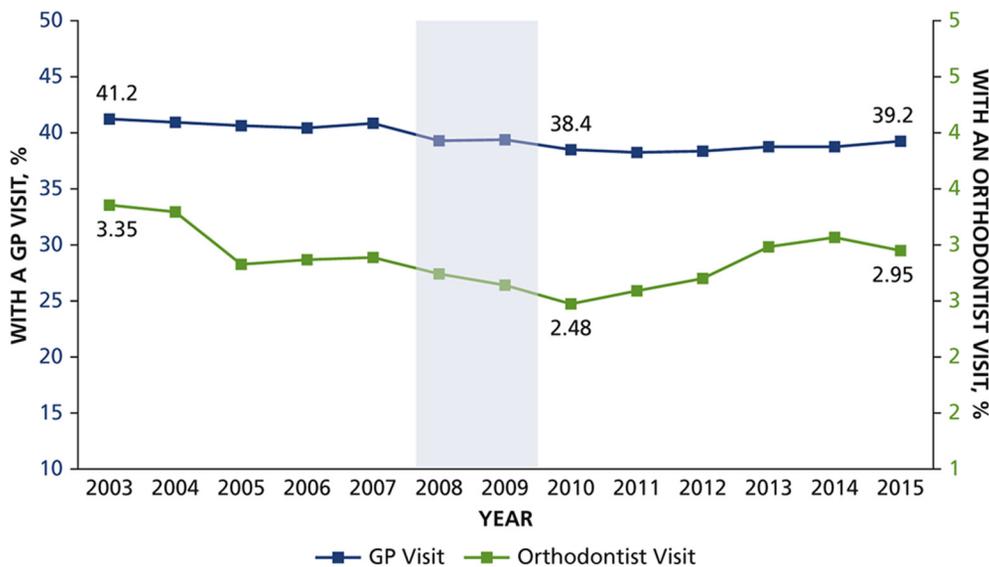


Figure 1. Percentage of the US population with general practitioner (GP) and orthodontist visits, 2003 through 2015. Source: Medical Expenditure Panel Survey, 2003 through 2015.⁴ Shaded portion represents the Great Recession period (December 2007–June 2009). (Courtesy of Guay AH, Blatz A: The effect of the Great Recession on the demand for general oral health care and orthodontic care. *J Am Dent Assoc* 150:287-293, 2019.)

the percentage of the population visiting an orthodontist rebounded to 3.1%.

The impact on orthodontic visits was most evident among adults age 19 years or older. The percentage visiting an orthodontist declined from 1.1% in 2008 to 0.7% in 2010, but then increased back to 1.1%. Both lower-income and higher-income individuals age 19 years or older evidenced the same pattern of impact from the economic conditions. When children 8 through 18 years were the focus, which is when most orthodontic treatment is undertaken, the higher-income group had a decline in attendance in the first half of the study period and recovered to a large degree in the second half. The lower income-group had a slight increase in visits by 2015 compared to 2003 data.

For orthodontic patients, private insurance expenditures fell by 8% through 2015. Medicaid/CHIP expenditures increased by 8.3%. As noted, out-of-pocket expenses showed similar patterns for general dental and orthodontic services, with the latter falling by just 0.04%. Differences in out-of-pocket spending can be explained by contractual time payments, which are a common method of payment for orthodontic patients. Governmental assistance programs paid for both types of services and the payouts increased for both.

DISCUSSION

The number of patient visits for general oral health care increased by 5.3% and expenditures for services increased by

6.5% from 2003 through 2015. For orthodontics, the number of patients increased by 2.4%, with expenditures for orthodontic services increasing by about 18.4% in inflation-adjusted dollars from 2003 through 2015. The changes in patient attendance were not statistically significant. Although the numbers of people treated in 2003 and 2015 remained about the same, the US population increased by about 28 million over that same time.

Clinical Significance

The conflicting trends between general dental and orthodontic visits emphasize the importance and immediate effect of the economic factors on demand for care. Orthodontic care was more deeply affected than general oral health care. These data should be carefully evaluated to help in planning for the next economic downturn.

Guay AH, Blatz A: The effect of the Great Recession on the demand for general oral health care and orthodontic care. *J Am Dent Assoc* 150:287-293, 2019

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HOMELESS ADULTS

Oral health and access to dental care



BACKGROUND

Oral disease has been termed a silent epidemic, with oral health improving minimally over the past 2 decades. Almost a quarter of US adults age 20 to 64 years have untreated dental caries and over half have lost a permanent tooth. Those who live in poverty or are homeless are at higher risk for poor oral health. People experiencing homelessness have inadequate resources for providing regular dental hygiene and a higher risk for tooth loss, which is a key indicator of poor oral health. Edentulism is also a risk factor for coronary artery plaque formation, diabetes, and some cancers. Older homeless persons not only suffer from the privation of homelessness but also have poorer oral health because of their age. The prevalence of tooth loss, oral pain, and denture fit was investigated in a population-

based cohort of older homeless adults in Oakland, California. In addition, factors associated with poor oral health were identified.

METHODS

The population-based study group included 350 homeless adults age 50 years or older (median age 58 years). Trained researchers conducted structured interviews with each participant, covering demographics, health-related behaviors, use of health care resources, and health status. The specific dental concerns evaluated were tooth loss, oral pain, and need for dental care that went unmet. Factors associated with missing half or more teeth were identified using multivariable logistic regression.