The Public Looks at Dental Care

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HOW DOES THE public view the dentist and his practice? Are people satisfied with the dental care they get? How well informed are they about the value of regular visits to the dentist? Above all, what prevents the public from utilizing dental care more extensively?

Tentative answers to these questions were obtained from a national survey made in 1955 by the National Opinion Research Center of the University of Chicago, financed by a grant from Health Information Foundation. The survey sought to uncover public attitudes toward many aspects of health, most of which will be reported in a forthcoming volume by Paul B. Sheatsley and Jacob J. Feldman. Only a small portion of the full survey, however, referred to dental care—a portion that was not designed to be a full-fledged, intensive exploration of the subject. Rather, it consisted of obtaining a limited amount of information about the dental habits and attitudes toward dental care of a cross section of the American public.

Because it does not constitute an intensive study, the validity of its conclusions must be considered to be tentative, seen in the context of past studies,* and subject to correction by future studies. But because it is based on a representative, nationwide

* American Dental Association, Bureau of Economic Research and Statistics. Family dental survey I. *J.A.D.A.* 47:575 Nov. 1953; II. 48:74 Jan. III. 48:320 March 1954; Koos, E. L. *The Health of Regionville.* New York, Columbia University Press, 1954, p. 118-125; Hassinger, E., and McNamara, R. I. "Stated opinion and actual practice in health behavior in a rural area." *Midwest Sociologist* 19:93, 1957.

sample, the material can provide accurate perspective for local or regional studies, or for studies of particular segments of the population.

The survey shows, to begin with, that the prestige of the dentist in the United States is high. Presented with a list of selected professions, the public rated the general standing of the dentist above that of the pharmacist, hospital nurse, lawyer and public school teacher and below that only of the physician, as Figure 1 indicates. This finding is in accord with a more ela-

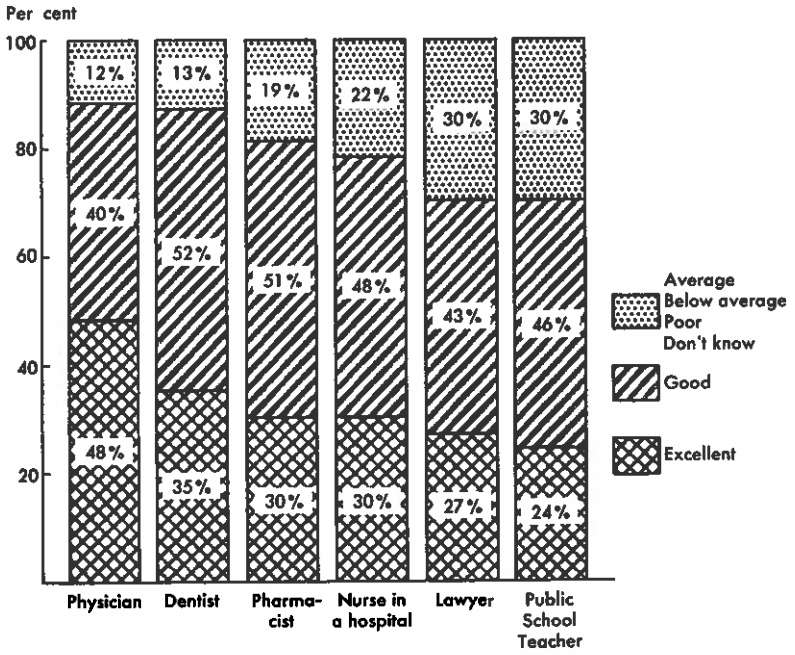

Figure 1

Public Rating of the "General Standing" of Six Occupations
(N = 2367-2370)

Health Information Foundation

borate study of the comparative prestige of occupation, in which the dentist was ranked below the physician, the state governor, the college professor and the scientist, but equal to the architect, the chemist, the lawyer, the member of the board of directors of a large corporation and the priest, and above many other occupations, including civil engineers, owners of factories employing 100 people, and accountants in large businesses.*

* National Opinion Research Center, "Jobs and Occupations: a Popular Evaluation" in *Class, Status and Power.* Bendix, Reinhard, and Lipset, Seymour M., editors. Chicago, Free Press, 1953, p. 411-426.

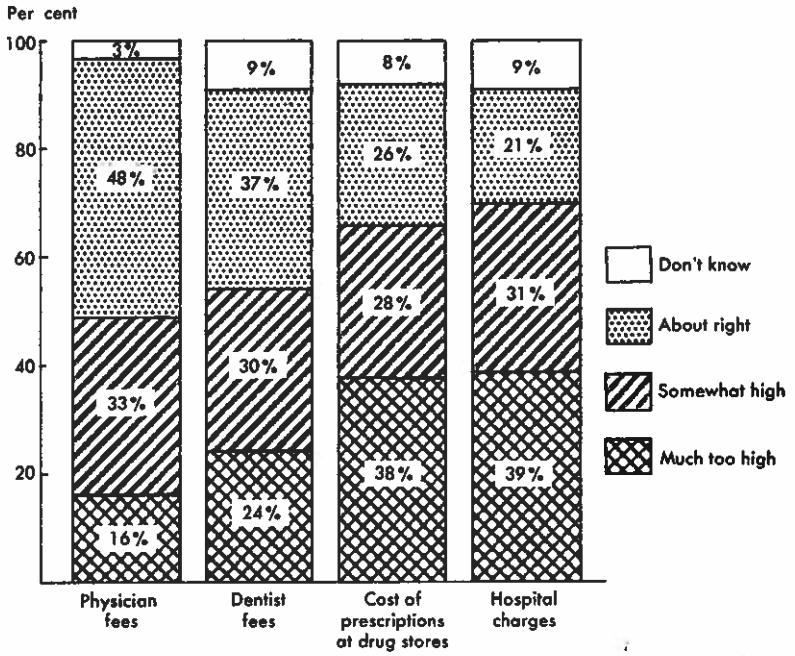

Figure 2

Public Evaluation of Cost of Selected Health Services
(N = 2366-2372)

Health Information Foundation

Almost everyone who saw a dentist during the past year was satisfied with the care and treatment he received. Eighty-nine per cent of those responding reported themselves "entirely satisfied."

Although there was some complaint about the number of dentists available in the locality—32 per cent of the public felt there were not enough dentists—this complaint was made less often than it was about physicians, for 46 per cent of the public felt that there were not enough physicians. Dentists' fees, however, were considered "much too high" by more of the public than were physicians' fees, although, as Figure 2 shows, dentists' fees were criticized by fewer people than was the cost of drugs and hospital services.

The public was asked about the cost of food, clothing and repairs, as well as of health care. In that context, health care turned out to be least criticized of all. Only 17 per cent of the population failed to criticize the cost of food, and only 18 per cent had no criticism of repair charges. Thirty per cent felt that clothing prices were "about right." But fully 35 per cent of the public had no criticism of the costs of health care. Thus, the cost of health care in general evokes relatively few criticisms; within it, the charges of the dentist are criticized relatively little.

This general satisfaction with dental care was expressed by those who actually received such care. But a large segment of the public—32 per cent—reported that neither they nor any other member of their family had been to a dentist during the year preceding the interview. This fact qualifies the predominant satisfaction of those who have seen their dentist, and it qualifies the general public's responses to the dentist and to dentistry. A major problem in the improvement of dental health is why so many Americans have not seen their dentists within the period of a year.

Knowledge and Practice

A number of factors must be examined as possible reasons for this failure. First, do people know that it is a good practice to see a dentist regularly? It appears that they do. When asked whether "a person should make a practice of seeing the dentist regularly, every six months or a year, even when his teeth are

all right, or is it not worth the trouble unless (he has) some complaint?" 88 per cent answered that such regular visits were a good idea. (It is of interest that fewer—80 per cent of the public—felt that regular medical examinations were a good idea.) There is, therefore, a distinct discrepancy between what the public knows to be good practice and what it actually does.

How can this discrepancy be explained? Is it a reflection of inevitable and irreducible differences between idea and fact, principle and practice? Or does it reflect fear of the dentist, inability to pay the dentist's fees, or some other factor that might be reduced or controlled in the future?

One way to begin answering this question is to see who actually does visit the dentist and who does not. Table 1 indicates that within families, some members of the household go more regularly to the dentist than others. Husbands see the dentist on a regular basis less than do wives, and adult members of families tend to see a dentist regularly less often than at least one of their children.

This same difference also holds for medical examinations. Only 29 per cent of the adults reported that they themselves receive a regular medical checkup. But 62 per cent of those with children reported that at least one child in the family gets a

Table 1

Per cent of public, married and with children, reporting members of the family see a dentist at least once a year (N=1,151)

	Husbands combined report* %	Wives combined report %	At least one of the children combined report %
Yes, see dentist regularly	38	49	62
No, do not see dentist regularly	62	51	38
Total	100	100	100

* Combining the report of the respondent for himself and the female respondent for her husband. The other column percentages were obtained in the same fashion.

regular medical checkup. Forty-four per cent of the married men reported that their wives get regular medical checkups, while 37 per cent of the wives reported this of their husbands.

There is of course some difficulty in the phrase, "At least one of the children," for this can mean all children in a large family, or only one. But given such factors as school dental and physical examinations, it does seem likely that these percentages reflect a significant difference between the generations.

These data refer to the reported practice of regular visits to the dentist. The report of actual visits over the year preceding the survey shows a bit more extensive contact with dentists, but in the same selective fashion. Forty-nine per cent of the adults, men less than women, reported having seen the dentist themselves during the year preceding the interviews; 50 per cent of those who are married, men more than women, reported that their spouse had been to a dentist; 65 per cent of those with children reported that at least one of their children had seen a dentist "during this past year."

It is clear that men more consistently than their wives, and parents more than their children, avoid doing what they "know" a person should do.

If the idea of regular dental visits is not given mere lip service, perhaps some of the failure to put it into practice is social and economic. And indeed, the report of regular visits varies regularly by occupation, income, education and age. As age increases, the proportion of people actually seeing a dentist decreases: Although 48 per cent of those between 21 and 34 make a practice of seeing the dentist at least once a year, only 16 per cent of those 65 and over do so. Second, seeing the dentist varies with occupation: 56 per cent of those in families whose main earner was in business or the professions, and in clerical or sales work, see the dentist at least once a year, but only 27 per cent of those in families whose main earner was an unskilled, semi-skilled or domestic worker, and 22 per cent of those in families whose main earner was a farmer, see him regularly. Third, seeing the dentist increases with income: 56 per cent of those in families earning $7,500 a year or more see the dentist at least

once a year. Only 17 per cent of those in families earning under $2,000 a year do so. And finally, as education increases, the proportion of those seeing a dentist regularly increases: Whereas 63 per cent of those who have attended college reported seeing a dentist at least once a year, only 18 per cent of those who have had eight years or less of schooling did so.

It may appear from this that it is not what people know to be good practice that matters, but only the extent to which their education, income, or age conditions their putting that knowledge into effect. But do all groupings of the population really agree that it is a good idea to see the dentist regularly and differ only in their use of dental services? The fact is that belief in the value of regular visits to the dentist varies, just as does report of regular visits. The answer that a person should see the dentist regularly "even when his teeth are all right" is given by a greater proportion of women than men, by fewer people as age increases, and as occupational status, income and education decrease. Thus, while there is a gross difference between principle and practice for the public as a whole, those groups in the population who don't visit their dentist regularly as extensively as others also don't believe as extensively in the value of regular visits.

Do the different groups show the same variation between the proportion reporting regular visits and the proportion reporting belief in the value of regular visits? If so—if the difference between belief and practice is about the same for the rich as for the poor, and for the well-educated as for the ill-educated—then the difference cannot be ascribed to those variables. It might have to be chalked up to "human nature," or to something about dental practice that has no necessary connection with knowledge, money, age, sex and occupation.

However, there is wide and consistent variation in the gap between knowledge of good practice and report of actual practice. Table 2 presents, as illustration, how the difference between belief and practice varies by income: the lower the income, the greater the discrepancy. And as age increases and as education and occupational status decrease, the greater is the gap between knowledge and practice.

How can this variability be interpreted? It might be that the

Table 2

The reported practice of actually seeing a dentist at least once a year of those saying that a person should see a dentist regularly, by income (N=2,074)

Income	Actually see a dentist at least once a year %	Do not see a dentist at least once a year %
Under $2,000	21	79
$2,000—4,999	37	63
$5,000—7,499	51	49
$7,500 or more	59	41

poor and the ill-educated do not believe strongly in seeing the dentist regularly, but merely pay lip service to the idea. If this were true, an information program would increase use of dental facilities. On the other hand, the aged, the poor and the ill-educated may constitute segments of the population that cannot afford the dental care they believe they need, which would explain the greater gap between their statement of knowledge and report of practice. If this is true, some economic program may increase use. Neither of these possibilities can be rejected by the data, but the likelihood of the latter is supported by evidence that those less able to afford dental care show greater dissatisfaction with the amount of care they have received.

In all, fully 34 per cent of the adult population felt that they or their spouse or children "should have had more dental care than they did during the past year." This belief was held by 22 per cent of those in families with an annual income of $7,500 or more, and by 38 per cent of those in families whose annual income was under $2,000. Twenty-five per cent of those who had attended college felt the need for more care; 38 per cent of those with an eighth grade education or less felt such a need.

Does the desire for more care vary with whether some dental care was received or not? Of those who reported that some dental care was received by someone in the family, 32 per cent felt that someone in the family ought to have had more care. In

contrast, of those who reported no dental care received by the family, 39 per cent—a small but probably significantly greater proportion—thought that someone in the family ought to have had more care.

But the detailed tabulations of these data reveal a more complicated picture. In families that have received some dental care, the proportion saying that someone ought to have had more dental care steadily increases as occupational status, income and education decrease. However, this pattern does not exist in families in which no dental care was received. The variables of occupational status, income and education are associated with no clear variation in belief that someone in the family ought to have had more dental care.

These data apparently reflect differences in attitude, perhaps involving self-diagnosis or disbelief in the efficacy of dental care, as well as in ability to pay. The variation by income, education and occupational status among those families in which some dental care was received can be explained by economic factors. The lack of variation by income, education and occupational status among families in which no dental care was received can be explained by indifference to dental care.

The aged best illustrate the attitude of this latter category. The older members of the population are among those who receive a relatively small amount of dental care. Up to this point their responses have been similar to those of the poor and the ill-educated. But the data clearly indicate that older people are not more dissatisfied than the younger with the amount of dental care they have received. In fact, the older the age of the respondent, the less is the tendency to be dissatisfied with the amount of dental care being received, even though the amount itself decreases as well.

Factors in the Use of Dental Services

What are the explanations people themselves give for not seeing the dentist regularly? Those who do not (among them, as noted, a disproportionate number of men, the aged, the poor, the ill-educated) were asked, "How is it that you don't see a dentist more often?" Their answers, presented in Table 3, give a glimpse of the variety of factors involved.

Table 3

Reasons for not seeing a dentist more often

	Per cent who do not see dentist regularly (N=1,448)
Have false teeth, dentures, plates	29
Don't have any teeth (no mention of plates)	7
Teeth so bad it isn't worthwhile to go	4
Teeth are all right, cause no trouble, no need to go	27
Negligence, laziness, keep putting it off	16
Can't afford it, costs too much, don't like to spend the money	14
Don't like to go, afraid of dentists, it hurts	9
Too busy to go, don't have the time to spare	6
Don't know any good dentists, or dentist too far away	3
Miscellaneous reasons: too old, sick, etc.	3
Don't know, too vague to classify	1
Total (some people gave more than one reason)	119

It can be seen first of all why the aged are so little dissatisfied with the amount of dental care they receive. Thirty-six per cent of all those who do not see their dentists regularly explained it by pointing out that they have false teeth or no teeth. Of these, 84 per cent were 45 or older. Seventy-two per cent of all people 65 or over who do not see a dentist at least once a year gave this explanation.

A number of other responses reflect the individual's own estimate of his dental health—that his teeth are so bad as to be hopeless, or so good that they require no care. Of the remaining responses, the most important quantitatively are "negligence" or "laziness," and the cost of dental services. Beyond these, there are references to fear of dentists or of the pain their work may involve, to lacking time to see the dentist, and to "not knowing" a good dentist or to the dentist's being too far away.

The number of "good" dentists available, the accessibility of

dentists, and the cost of the dentist's services seem to express for the people the way the organization of the practice of dentistry does or does not fit into the organization of their own lives. Emotional reluctance to visit the dentist, expressed as fear of pain, may reflect both the patient's own experience and the general reality of dental work itself. And, finally, there is the person's own knowledge or perception of his dental health. It is in terms of this last category—often labeled, "self-diagnosis"—that most of the respondents explained why they did not see the dentist regularly.

At least some portion of "negligence" should be included in this last category. On the surface this may seem inappropriate, for "negligence," "laziness," "putting visits off," and the like ostensibly refer to not seeing the dentist even though it may seem "right" to make the visit.

But what motivates the prospective patient in the first place? It is his perception of difficulty, or his expectation of difficulty. "Negligence," is not, then, sheer inertia, independent of the individual's assessment of the seriousness of his condition (or the seriousness of the consequences) and the discomforts and inconveniences of seeking care. Such negligence would vanish instantaneously if, for example, a severe toothache were experienced. In this sense, "negligence" involves the same kind of self-diagnosis, or assessment of one's condition, as the simple statement that one's teeth are "all right," or that there is nothing seriously the matter and nothing serious that could result from neglect or from "putting it off."

For the other reasons given, it is obvious that statements that the teeth are all right, or that they are too bad for treatment, constitute self-diagnosis. Similarly, citing "false teeth" and "no teeth" constitutes assumptions that only natural teeth require regular examination and professional care.

The relative importance of each of these factors in preventing the patient from seeing a dentist regularly can only be assessed crudely from the data in Table 3. Certainly, reasons that imply self-diagnosis, or lay knowledge of the teeth and of dental hygiene, are preeminent. The cost of dental care is cited by far fewer people, and all other reasons are cited by even fewer. It

appears that most people who have not seen a dentist regularly have not done so simply because, in one way or another, they don't believe such visits to be necessary.

Among the people who felt they should have gotten more care than they actually did, the emphasis of their explanations is understandably different. This group, when asked why they did not receive care, emphasized the cost of care considerably more. As Table 4 shows, fully one third claimed that they did not obtain needed dental care because of its cost. This answer is clearly related to socioeconomic status—it was given by only 8 per cent of those in families making $7,500 a year or more, but by 53 per cent of those in families making less than $2,000 a year.

Table 4

Reasons why respondent, or member of family, did not get needed dental care

	Per cent of those who failed to get needed dental care (N=779)
Couldn't afford it, costs too much, hated to spend money	34
Negligence, laziness, just didn't get around to it	33
Spouse doesn't believe in going, can't get him to go	5
Didn't think condition was serious enough	6
Afraid to go, dread it, it hurts too much	21
Too busy, didn't have the time	12
Didn't know a good dentist, hard to get appointment, dentist too far away	7
Miscellaneous reasons	6
Don't know, just didn't do it, etc.	4
Total (some people gave more than one reason)	128

One third of this group cited "negligence." Inaccessibility of the dentist (to the respondent at least), as well as lack of time to see the dentist, remained minor in their emphasis, but fear or dread of the dentist was cited by one fifth of all the respondents.

Neither reasons of negligence nor fear of the dentist varied regularly by socioeconomic status.

To gain further insight into why many people do not see their dentist as much as may be necessary, the question was asked, "Have you yourself, or anyone you know, ever had a dental experience of any kind that changed some of your own ideas or behavior?" Fully 82 per cent of the public answered, "No," which might be taken as evidence for the prosaic character of the experience most of the public has with its dentists. Those who did answer, "Yes," however, were also asked what the experience was and how it changed their ideas. Their responses are presented in Table 5.

Most noticeable in Table 5 is that most people report negative experiences or changes rather than positive ones. The most serious of these seem to be the belief that "the dentist made a mistake," and the suffering of roughness, pain and fright. The latter is emphasized much more here, in the case of dentists, than when people discuss their experiences with physicians.

Assessing Factors in Use of Dental Services

In analyzing the public's use of dental care, an important consideration seems to be what knowledge underlies the beliefs, attitudes and information that govern people's self-diagnoses, or assessments of their own health. Although, for example, the formal bit of information that it is a "good idea" to see the dentist regularly is very widespread, some segments of the population subscribe to it more extensively than do others. If this information were still more widely disseminated through an education campaign aimed at the poorer and less educated segments of the population, greater utilization of dental services might follow.

However, it is clear that an education campaign will not by itself bring about maximal utilization of dental services, for there is a considerable discrepancy between knowledge and actual practice. This discrepancy varies from one segment of the population to another, and the major principle of its variation seems to be one of economic differences. Some people, then, lack the means necessary to put their knowledge into practice. The pro-

Table 5

Dental experiences that have changed the public's ideas

	Per cent of those reporting experience that changed ideas (N=424)
Positive or neutral experience or change reported	29
Nature of experience	
Dentist was gentle, it didn't hurt	5
Dentist did a good job, treatment was effective	4
Failure to see dentist results in bad situation	11
Failure to take good care of teeth caused trouble	1
Miscellaneous	1
Vague, or only nature of change reported	7
Total	29
Nature of change	
Less afraid of dentist, more respect for them	6
Learned importance of seeing dentist often	11
Learned importance of dental hygiene, care of teeth	3
Miscellaneous	3
Vague, or only nature of experience reported	7
Total (some people mentioned more than one thing)	30
Negative experience or change reported	73
Nature of experience	
Especially rough, painful, frightening experience	30
Dentist made a serious mistake	32
Dentist advised unnecessary or unwise treatment	8
Dentist charged too much, was too mercenary	7
Miscellaneous	6
Vague, or only nature of change reported	3
Total (some people mentioned more than one thing)	86
Nature of change	
Afraid of dentists, lost confidence in them	22
Suspicious now of character, integrity of dentists	3
Changed dentists, didn't go back to that one	18
Miscellaneous	4
Vague, or only nature of experience reported	28
Total (some people mentioned more than one thing)	75
Grand total (a few people reported both types of experience)	102

portion of people absolutely unable to pay for dental care is no doubt small, but the proportion whose income is such that they are reluctant to allocate money for maximal use of dental services is certainly larger.

The economic factor, nonetheless, is not greatly emphasized by the public. Compared to their view of the cost of other services—or even of other health services—relatively few people criticize the size of dentists' fees. And in relatively free responses explaining why the dentist was not seen, economic cost received little emphasis.

In support of this, when the public was asked if comprehensive dental insurance seemed attractive, only 40 per cent answered that it was a good idea; 55 per cent felt they would be just as well off without it. (In contrast, 65 per cent felt that medical insurance of a comprehensive character would be a good idea, and only 27 per cent felt that they were as well off without it.) Obviously, significantly fewer people see the financing of dental care to be as pressing as that of medical care. This does not mean, of course, that the economic factor is of no significance at all. If some program made dental care financially more easy to obtain, there is no doubt that some of the discrepancy between knowledge and practice concerning regular dental examinations would be reduced.

Still other factors may contribute to the gap between knowledge and practice. The most important among them seems to be fear of the dentist and of pain anticipated in dental care. Part of this may be the result of a popular stereotype, while part may be the result of pain or fright that actually could have been avoided. If these things underlie a substantial part of fear of the dentist—and we are only guessing here—then greater care on the part of individual dentists and greater publicizing of the newer, less painful technics of dentistry might help increase use. If the fear derives from people's anticipation of pain that really cannot be avoided if the teeth are to be treated, increased use of services depends on educating people to emphasize the consequences of not getting dental care—that is, the even greater pain that will result if the lesser pain is temporarily avoided.

Finally, there are the factors that are emphasized least by

the public, but which may nonetheless turn out to be strategic in particular instances. These factors—being too busy, lacking the time, being too far away from the dentist, and the like—all refer to the extent to which seeing the dentist is inconvenient to the way the patient's everyday life is organized. They may be more important considerations for the working man than for the housewife, and may in fact explain some of the differences noted previously between the dental habits of men and women. They may also be more important considerations for the wage earner, to whom, literally, every hour spent in travel, or in waiting and consultation, costs money, than for the professional worker, who often has greater flexibility in working and earning time.

All these factors can be joined into a whole, from the point of view of the patient, by considering the use of dental services to stem from an over-all assessment, or definition, of the situation. The prospective patient assesses his dental condition and the seriousness of the consequences if he does not seek dental care. This self-diagnosis is weighed or balanced against the factors of cost, anticipated pain, and inconvenience, to see if going to the dentist "is worth it." The final result—the use or avoidance of dental services—is thus a complex product of the education involved in self-diagnosis, of the income level involved in weighing costs, of the dental health and past dental experience involved in anticipating pain, and of the social experience involved in assessing inconvenience.