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AIHW Dental Statistics and Research Unit Research Report No. 2

Access to dental services of Australian children and adolescents 1999

THE UNIVERSITY OF ADELAIDE AUSTRALIA

This research report provides information on the use of dental services by children and adolescents in Australia. Data were collected for the National Dental Telephone Interview Survey in 1994–96 and in 1999. Since the 1970s school dental services have provided dental care for large numbers of Australian children. Since 1994–96 variations to the provision of school dental services have occurred with the introduction of fees in some States.

Data collection

National Dental Telephone Interview Surveys (NDTIS) used random samples of Australians aged 5 years and over from all States and Territories. The surveys were conducted in the first quarter of each of the years 1994–96 and 1999, using computer-assisted telephone interviewing techniques.

A primary approach letter was sent to each sampled household approximately 10 days prior to the initial phone call. Once contact was made with the household, a person aged 5 years or older was chosen at random from that household. Proxy interviews were conducted for children under 16 years of age. These surveys collected information about the use of dental services, frequency of dental problems and dental visiting characteristics.

This report uses data from NDTIS 1999 and makes some comparisons with the combined data from the three surveys 1994–96 in this study of children and adolescents. The data were weighted to ensure that the weighted data reflected the age and sex distribution of the Australian population for each region as estimated by the Australian Bureau of Statistics.

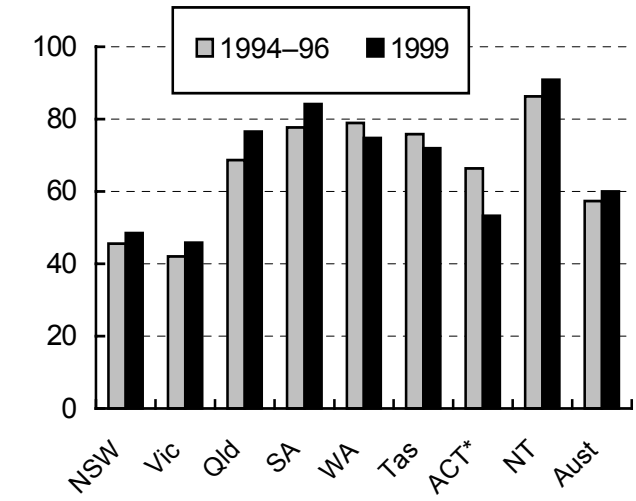
Response rates

The response rate in the survey was 75% of all households with whom contact was made. This resulted in 625 children aged from 6 to 12 years and 392 adolescents aged 13 to 16 years in 1999, and 1,979 children aged from 6 to 12 years and 1,074 adolescents aged 13 to 16 years from the combined surveys of 1994–96. These data were then analysed by State and Territory to ascertain regional differences.

Place of last dental visit

In 1999 more than 70% of primary school children (aged 6 to 12 years) had visited the School Dental Service (SDS) in Queensland (Qld), South Australia (SA), Western Australia (WA), Tasmania (Tas) and the Northern Territory (NT). In the Australian Capital Territory (ACT) 52% had used SDS and in New South Wales (NSW) and Victoria (Vic) less than 50%. Since 1994–96 there had been small increases in the use of SDS in New South Wales, Victoria, Queensland, South Australia and the Northern Territory and small decreases in Western Australia and Tasmania. A more substantial decrease in use of SDS was observed in the Australian Capital Territory, which had an approximately equal increase in use of private practitioners.

Figure 1: Use of SDS by 6–12-year-olds (%)

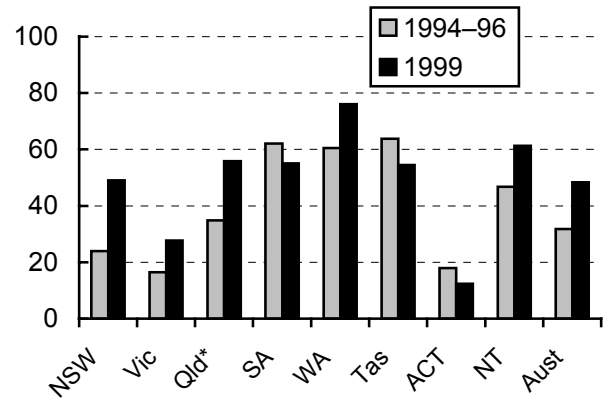


* p<0.05 (t-test)

In 1999 over 50% of children aged 13 to 16 years had visited a SDS clinic for their last visit in Queensland, South Australia, Western Australia, Tasmania and the Northern Territory. In New South Wales slightly less than 50% had used SDS whereas in Victoria and the Australian Capital Territory far fewer had visited SDS. Increases in the percentage who reported using SDS at their last visit were seen in New South Wales, Victoria, Queensland, Western Australia and Northern Territory, with decreases in

South Australia, Tasmania and the Australian Capital Territory.

Figure 2: Use of SDS by 13–16-year-olds (%)



* p<0.05 (t-test)

Use of School Dental Services by sociodemographic groups

Figure 3 shows that among children aged 6–12 years a greater proportion of male children used SDS than female children, a higher percentage of Indigenous children than non-Indigenous, more of those whose mother has had no tertiary education, more holders of government concession cards than non-holders, more of those not covered by private health insurance, and more of those with an income of less than $30,000 than those with more.

Figure 3: Use of SDS by sociodemographic status 1999 (6–12-year-olds)

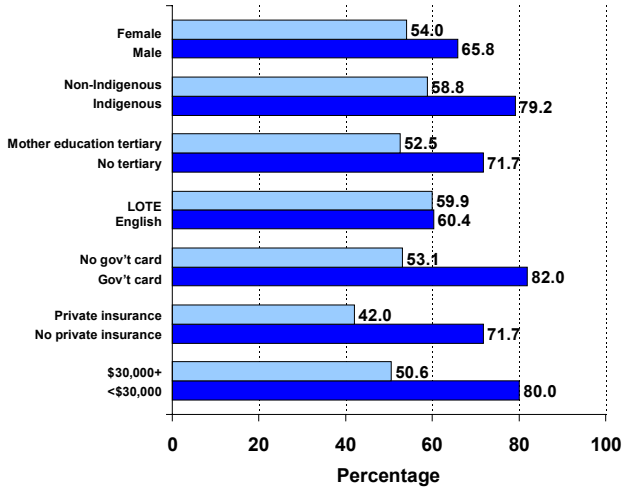
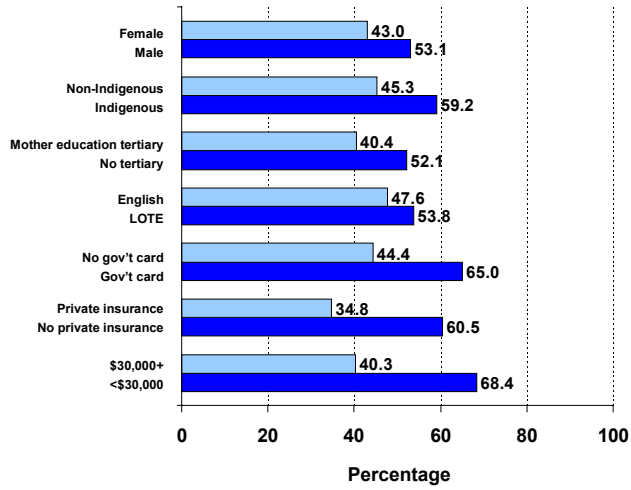


Figure 4 presents the use of SDS at last visit by sociodemographic factors by 13–16-year-olds. A greater percentage of male adolescents used SDS than female, more of Indigenous background, more of those whose mother has had no tertiary education, more of those who speak a language other than English (LOTE), more holders of government cards and more of those who do not hold private dental insurance than those who do.

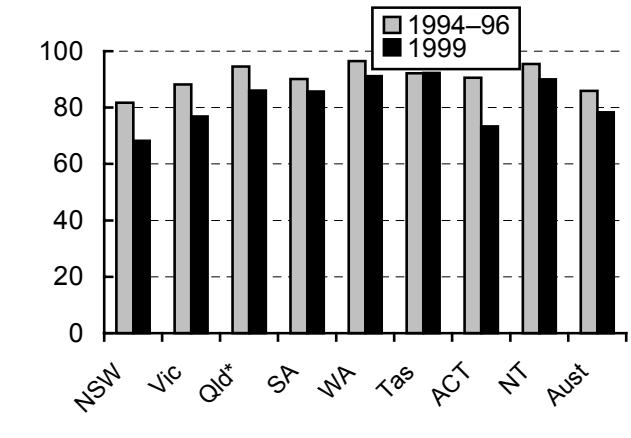
Figure 4: Use of SDS by sociodemographic status 1999 (13–16-year-olds)



Time since last dental visit

Figure 5 shows the percentage of children who had made a dental visit in the previous 12 months in 6–12-year age groups in the States and Territories in 1994–96 and 1999. Over 80% of the younger age group had made a dental visit in 1994–96 but this had fallen to between 60% and 80% in New South Wales, Victoria and the Australian Capital Territory in 1999.

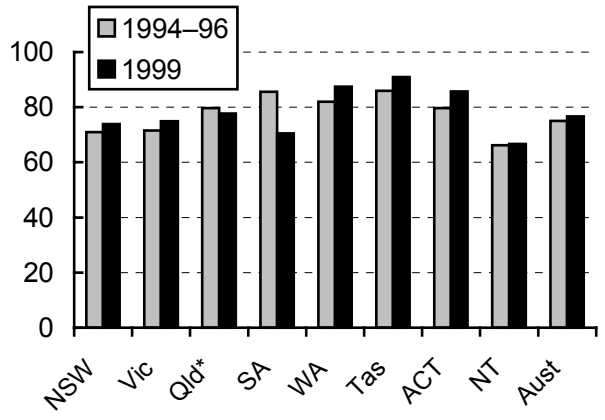
Figure 5: Percentage making a dental visit in last 12 months (6–12-year-olds)



* p<0.05 (t-test)

Among 13–16-year-old adolescents there had been a slight increase in the percentage who had made a dental visit in the previous 12 months in most States and Territories; in Queensland there was a slight decrease and in South Australia a more substantial decrease (Figure 6).

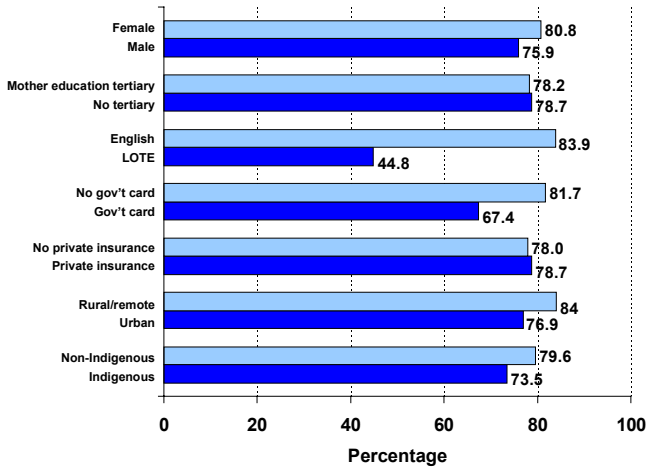
Figure 6: Percentage making a dental visit in last 12 months (13–16-year-olds)



* p<0.05 (t-test)

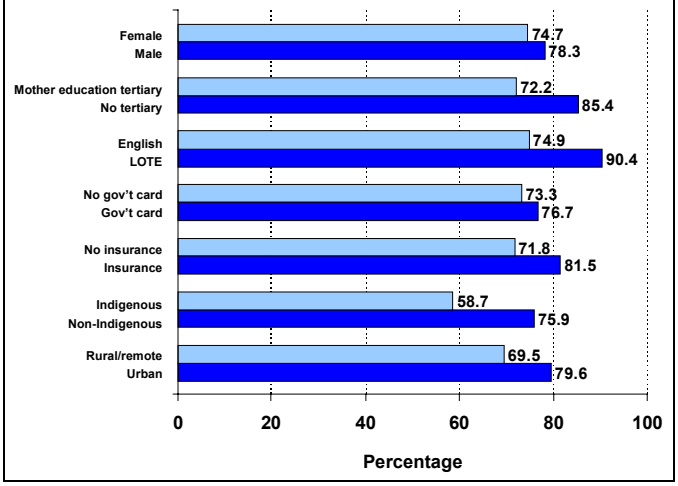
The relationship between sociodemographic status and having made a dental visit in the last 12 months by 6–12-year-old children is presented in Figure 7. A greater percentage of females had made a visit than males, more English speakers than those who speak a language other than English (LOTE), more of those without government cards than those with cards, more in rural/remote areas than in urban centres, and a higher proportion of non-Indigenous children than Indigenous. There was very little difference by insurance and mothers' education.

Figure 7: Percentage making a dental visit in last 12 months by SES 1999 (6–12-year-olds)



Greater disparities were evident among adolescents 13–16 years (Figure 8). A greater proportion of males than females had visited in the previous 12 months, more of those whose mothers did not have tertiary education, more who spoke a language other than English, more without a government card than with a card, more who had private health insurance than without, a higher percentage of non-Indigenous than Indigenous adolescents, and more urban residents than from rural/remote areas.

Figure 8: Percentage making a dental visit in last 12 months by SES 1999 (13–16-year-olds)

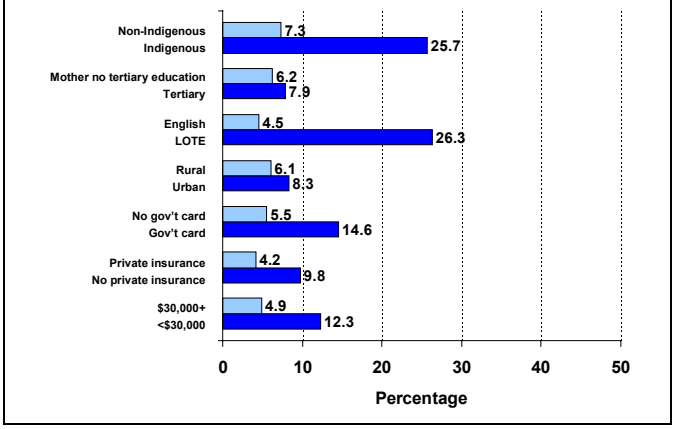


The following section presents the percentage of children who had not made a dental visit in the previous two years in both age groups in the States/Territories. In the younger age group, 2% or less had not visited for two or more years in all States except New South Wales (13%) the Australian Capital Territory (12%) Victoria (8%) and Queensland (6%). Nationally 7.6% of 6–12-year-olds had not made a dental visit in over two years.

In contrast, over 8% of 13–16-year-olds in Victoria, South Australia and Northern Territory, and less than 4% in Western Australia and Tasmania, had not made a dental visit in the previous two years. The percentage of 13–16-year-olds in Australia who had not made a visit in over two years was 7.4%.

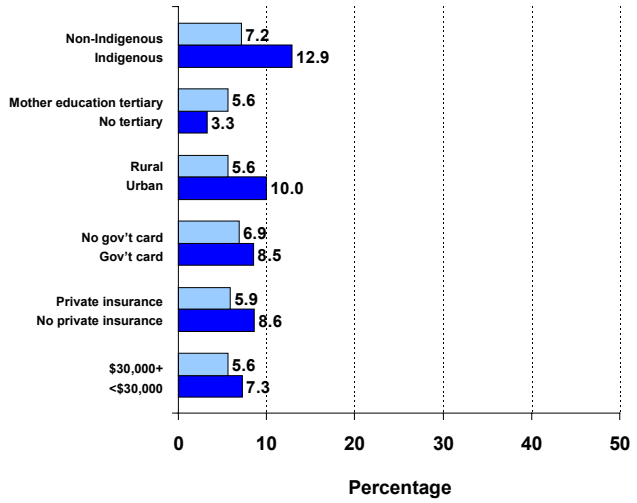
In relation to those aged 6–12 years who had not made a dental visit in the previous two years, some large disparities between sociodemographic groups were apparent (Figure 9). Large differences were evident in relation to Indigenous status, language, government card status, private dental insurance, income and locality.

Figure 9: No dental visit in last two years by SES 1999 (6–12-year-olds)



Similarly, amongst adolescents there were large differences by sociodemographic status factors in those who had not made a dental visit in the previous two years. These differences were particularly evident in relation to Indigenous status and language, but were also present for government card status, insurance, income and locality.

Figure 10: No dental visit in last two years by SES 1999 (13–16-year-olds)



Usual reason for dental visit

Visits which are undertaken for a check-up are more likely to result in timely preventive and treatment interventions compared to those sought because of a problem. Figures 11 and 12 show that a greater proportion of 13–16-year-olds reported that their usual reason for a dental visit was for a problem than 6–12-year-old children. The difference in usual reason for visit between children and adolescents was greatest in New South Wales and Queensland and least in South Australia.

Figure 11: Usual reason for visit is a problem (6–12-year-olds) (%)

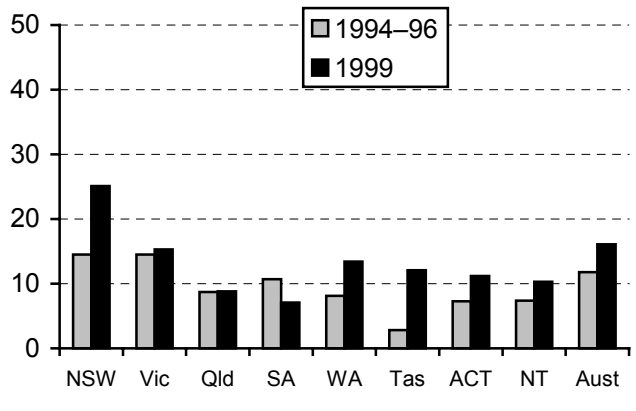
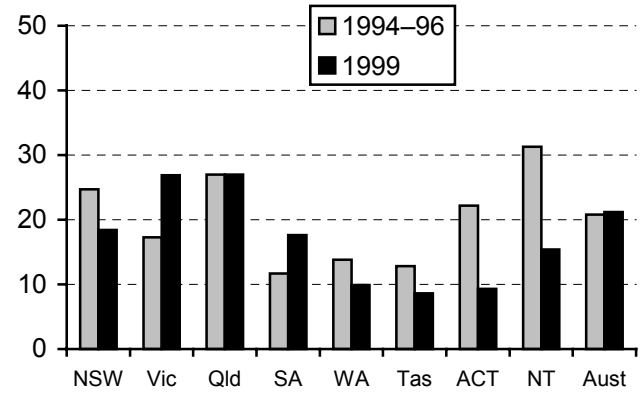


Figure 12: Usual reason for visit is a problem (13–16-year-olds) (%)



Conclusions

Although the School Dental Service treats more of those in disadvantaged groups, children in these groups are less likely to receive dental care. Among 6–12-year-olds, those of Indigenous status, those who speak a language other than English, those of low income and those who do not have insurance experience barriers to dental care. Among adolescents, those who are Indigenous, are cardholders, have mothers with higher education, live in urban areas, have no insurance and have low incomes are less likely to have visited in the last two years.

Acknowledgements

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The AIHW Dental Statistics and Research Unit (DSRU) is a collaborating unit of the Australian Institute of Health and Welfare established in 1988 at The University of Adelaide. The DSRU aims to improve the oral health of Australians through the collection, analysis and reporting of information on oral health and access to dental care, the practice of dentistry and the dental labour force in Australia.

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AIHW Dental Statistics and Research Unit
The University of Adelaide
SOUTH AUSTRALIA 5005

Email: aihw.dsru@adelaide.edu.au
Phone: 61 8/(08) 8303 4051
Fax: 61 8/(08) 8303 4858
www.adelaide.edu.au/socprev-dent/dsru

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