MEPS
Medical Expenditure Panel Survey

AHRQ
Agency for Healthcare Research and Quality

STATISTICAL BRIEF #432

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Children's Dental Care: Advice and Visits, Ages 2-17, 2011

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Highlights

- In 2011, doctors or other health providers advised regular dental checkups for a little more than half of children between the ages of 2 and 17.
- Black, non-Hispanic and Hispanic children visited dentists at a lower rate than white, non-Hispanic children.
- Only about one-fourth of uninsured children visited a dentist in 2011.
- Poor children were less likely to receive dental care in 2011 than children from high income families.
- Children of college educated parents made dental visits at higher rates than those whose parents had completed high school or attained less than a high school education.

Introduction

According to the Centers for Disease Control and Prevention, tooth decay affects children in the United States more than any other chronic infectious disease. Untreated tooth decay causes pain and infections that may lead to other serious problems. Dental care visits are important to prevent and treat tooth decay and other dental problems in children. This Statistical Brief presents estimates based on the Household Component of the Medical Expenditure Panel Survey (MEPS-HC) on the advice given by a doctor or other health provider to the parents of children for their dental checkups and frequency of children's actual visits to the dentist. All differences between estimates noted in the text are statistically significant at the 0.05 level or better.

Findings

In 2011, a little more than half (52.1 percent) of children between the ages of 2 and 17 were offered advice from a doctor or other health provider about the need for routine dental checkups. Children between the ages of 13 and 17 were offered advice for a dental checkup at a lower rate than those between the ages of 2 to 5 and 6 to 12 (45.7 percent versus 57.3 percent and 53.7 percent) (figure 1).

In terms of actually receiving dental care, about half (50.5 percent) of the children had at least one visit to the dentist during 2011. Among the racial/ethnic groups, white, non-Hispanic children made one or more visits to the dentists in 2011 at rates higher than Hispanic and black, non-Hispanic children. More than half (56.1 percent) of white, non-Hispanic children visited the dentist at least once during 2011 compared with much lower rates for black, non-Hispanic (41.9 percent) and Hispanic children (43.9 percent) (figure 2).

Health insurance was associated with whether or not children visited the dentist during 2011. Only about one fourth (25.9 percent) of uninsured children visited the dentist in 2011, compared with much higher percentages for children who were covered by either public only or any private insurance (42.8 percent and 57.4 percent) (figure 3).

Poor children were much less likely to have received any dental care in 2011 than children from middle and high income families. Almost two-thirds (64.2 percent) of children from high income families and a little over half (52.8 percent) of children from middle income families reported at least one visit to the dentist during 2011, compared with 39.6 percent of children from poor families (figure 4).

The rate at which children visited a dentist was also related to the educational level of parents. Children whose parents had some college education made dental visits at higher rates (56.2 percent) than children whose parents had completed high school or attained less than a high school education (approximately 40 percent each) (figure 5).

Data Source

The estimates shown in this Statistical Brief are based on data from the MEPS 2011 Full Year Consolidated File (HC-147).

Definitions

Questions about advice regarding dental checkups were part of MEPS Child Preventive Care Questionnaire. The

question is: “Has a doctor or other health provider ever given advice about having a regular dental checkup?” Children were considered to have had dental care if the household respondent indicated that the child had at least one visit to a dentist or other dental health provider during 2011.

Age
Age is the last available age for the sampled person. For most persons, this was their age at the end of the year.

Educational level
The educational level of parents was measured by the reported highest grade of schooling ever completed as of the date of the interview: not a high school graduate, high school graduate, or some college.

Health insurance status
Individuals were classified in the following three insurance categories, based on household responses to health insurance status questions:

- Any private health insurance: Individuals who, at any time during the year, had insurance that provides coverage for hospital and physician care (other than Medicare, Medicaid, or other public hospital/physician coverage) were classified as having private insurance. Coverage by TRICARE (Armed Forces-related coverage) was also included as private health insurance. Insurance that provides coverage for a single service only, such as dental or vision coverage, was not included.
- Public coverage only: Individuals were considered to have public coverage only if they met both of the following criteria: 1) they were not covered by private insurance at any time during the year, and 2) they were covered by one of the following public programs at any point during the year: Medicare, Medicaid, or other public hospital/physician coverage.
- Uninsured: The uninsured were defined as people not covered by private hospital/physician insurance, Medicare, TRICARE, Medicaid, or other public hospital/physician programs at any time during the entire year or period of eligibility for the survey.

Poverty status
Four income groups are defined based on the percentage of the poverty line for total family income, adjusted for family size and composition. Four categories were used: poor/negative income (less than 100 percent of the poverty line), near poor/low income (100–199 percent of the poverty line), middle income (200–299 percent of the poverty line), and high income (greater than 400 percent of the poverty line) in the year of the data collection.

Racial and ethnic classifications
Classification by race and ethnicity was based on information reported for each family member. Respondents were asked if each family member’s race was best described as American Indian, Alaska Native, Asian or Pacific Islander, black, white, or other. They also were asked if each family member’s main national origin or ancestry was Puerto Rican; Cuban; Mexican, Mexicano, Mexican American, or Chicano; other Latin American; or other Spanish. All persons whose main national origin or ancestry was reported in one of these Hispanic groups, regardless of racial background, were classified as Hispanic. Since the Hispanic grouping can include black Hispanic, white Hispanic, Asian and Pacific Islanders Hispanic, and other Hispanic, the race categories of black, white, Asian and Pacific Islanders, and other do not include Hispanic. MEPS respondents who reported other single or multiple races and were non-Hispanic were included in the other category.

About MEPS-HC

MEPS-HC is a nationally representative longitudinal survey that collects detailed information on health care utilization and expenditures, health insurance, and health status, as well as a wide variety of social, demographic, and economic characteristics for the U.S. civilian noninstitutionalized population. It is cosponsored by the Agency for Healthcare Research and Quality and the National Center for Health Statistics.

For more information about MEPS, call the MEPS information coordinator at AHRQ 301-427-1656 or visit the MEPS Web site at http://www.meps.ahrq.gov/.

References

For a detailed description of the MEPS-HC survey design, sample design, and methods used to minimize sources of nonsampling errors, see the following publications:

Cohen, J. *Design and Methods of the Medical Expenditure Panel Survey Household Component*. MEPS Methodology Report No. 1. AHCPR Pub. No. 97-0026. Rockville, MD. Agency for Health Care Policy and Research, 1997. http://www.meps.ahrq.gov/mepsweb/data_files/publications/mr1/mr1.pdf

Cohen, S. *Sample Design of the 1996 Medical Expenditure Panel Survey Household Component*. MEPS Methodology Report No. 2. AHCPR Pub. No. 97-0027. Rockville, MD. Agency for Health Care Policy and Research, 1997. http://www.meps.ahrq.gov/mepsweb/data_files/publications/mr2/mr2.pdf

Cohen, S. Design strategies and innovations in the Medical Expenditure Panel Survey. *Medical Care*, July 2003: 41(7) Supplement: III-5–III-12.

Ezzati-Rice, T.M., Rohde, F., Greenblatt, J. *Sample Design of the Medical Expenditure Panel Survey Household Component, 1998–2007*. Methodology Report No. 22. March 2008. Agency for Healthcare Research and Quality, Rockville, MD. http://www.meps.ahrq.gov/mepsweb/data_files/publications/mr22/mr22.pdf

For more information about oral health, see the following publications:

Children's Oral Health: http://www.cdc.gov/OralHealth/children_adults/child.htm

Facts about Tooth Decay: http://www.ncohf.org/resources/tooth-decay-facts

Child Dental Health: http://www.nlm.nih.gov/medlineplus/childdentalhealth.html

Breaking down barriers to oral health for all Americans: http://www.ada.org/advocacy.aspx

Preventing tooth decay in children: http://www.aap.org/healthtopics/oralhealth.cfm

Children's dental health: http://www.aapd.org/

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AHRQ welcomes questions and comments from readers of this publication who are interested in obtaining more information about access, cost, use, financing, and quality of health care in the United States. We also invite you to tell us how you are using this Statistical Brief and other MEPS data and tools and to share suggestions on how MEPS products might be enhanced to further meet your needs. Please email us at MEPSProjectDirector@ahrq.hhs.gov or send a letter to the address below:

Steven B. Cohen, PhD, Director
Center for Financing, Access, and Cost Trends
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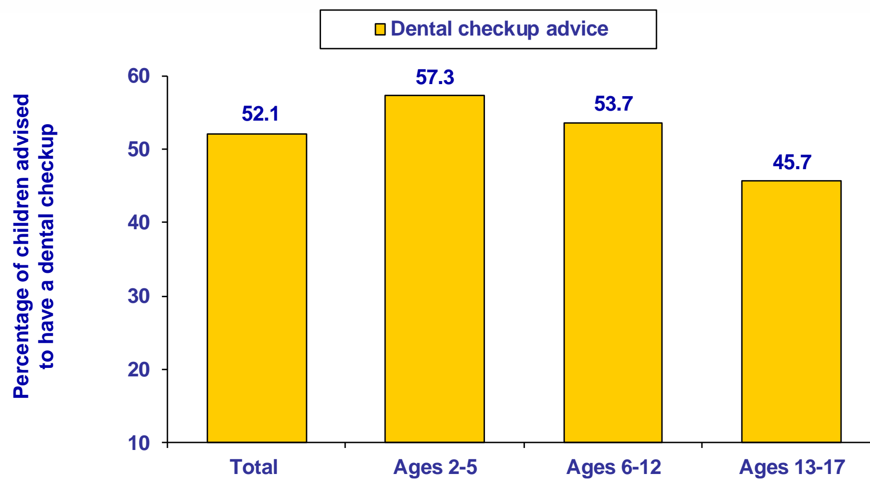
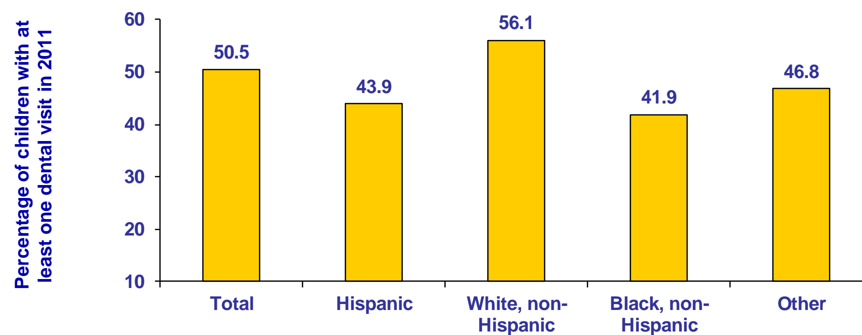
Figure 1. Percentage of children (ages 2–17) ever advised to have a dental checkup by a doctor or health provider, by age, 2011



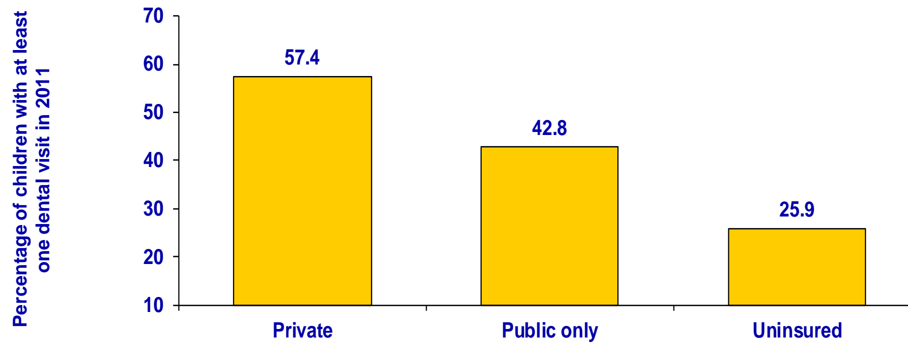
Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 2011

Figure 2. Percentage of children (ages 2–17) with at least one dental visit, by race, 2011



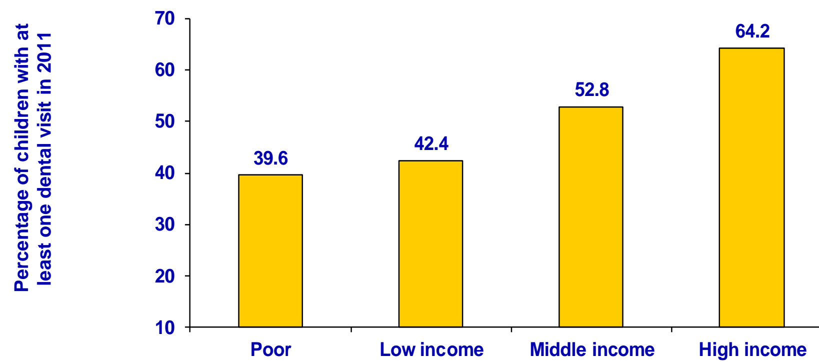
Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 2011

Figure 3. Percentage of children (ages 2–17) with at least one dental visit, by insurance status, 2011



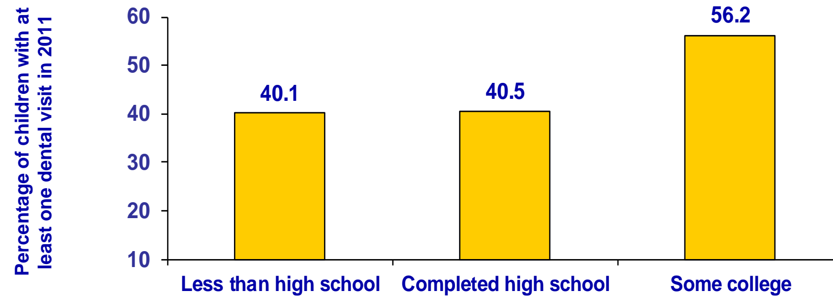
Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 2011

Figure 4. Percentage of children (ages 2–17) with at least one dental visit, by poverty status, 2011



Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 2011

Figure 5. Percentage of children (ages 2–17) with at least one dental visit, by parents' education level, 2011



Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 2011