Barriers to oral health care access among socially vulnerable groups: a qualitative study

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Abstract

Objectives: To identify perceptions and underlying causes of important barriers to access for oral health care among socially vulnerable groups. Methods: In a qualitative approach, focus group discussions were organised to gather information concerning barriers to oral health care. The study was undertaken in the city of Ghent, one of the major capitals in Flanders. 150 participants with different backgrounds participated in 13 focus group discussions. Group moderators were experienced health care workers. A discussion guide based on a ‘domino’ game was developed especially for use in this study. The discussions were tape-recorded and transcribed verbatim. QSR Nudist software was used to organise the data. The health belief model was the main theoretical approach for the study. Results: From the users, the overall knowledge on preventive health care and on available dental care services and costs were limited. The importance of oral hygiene was well known but difficult to put into practice, the importance of the primary dentition was underestimated and tooth-unfriendly dietary habits were common. This was strengthened by cultural beliefs. Fear of pain and dental treatment, uncertainty about dental treatments, language barriers and out-of-pocket costs were reported. For the suppliers, the lack of information and negative experiences concerning dentists’ lack of responsiveness to patient concern were expressed. Conclusion: An important commitment, based on these results, consists of information and motivation of the target group. The framework reported in this study offers guidance for estimating barriers experienced by the target group and for evaluating the outcome of interventions to reduce these barriers.

Key words: Barriers to care, qualitative research, focus groups, oral health

Introduction

In different countries there is an increasing awareness that a number of populations are underserved by the health system (Ahmed et al., 2001; Kasper, 2001; Palmer et al., 2004).

The basis of this problem is a complex access to care problem. Two aspects have been reported: first, the availability of services and adequate supply of services, enabling a population to ‘have access’ to services (supplier’s side), and second, the extent to which a population group ‘gains access’, depending on financial, organisational, social, cultural or cognitive barriers that limit the utilisation of services (user’s side).

Access to services can be measured in a quantitative way in terms of affordability, accessibility, acceptability and adequacy (Ahmed et al., 2001; Gulliford et al., 2002). Barriers to health care access are more complex and difficult to assess. They are conceptualised as a multidimensional construct consisting of pragmatics, health knowledge and beliefs, expectations about care, skills and marginalisation (Seid et al., 2004).

In particular in dental care, a lot of individuals, families and groups in our society also face serious challenges accessing care (Guay, 2004). Notwithstanding an increasing level of good oral health worldwide, oral health improvements are not being experienced evenly across the population. Barriers to oral health care are considerable and reported to be mainly in the most vulnerable groups in the community: the poor, some minorities and those people in residential care. Yet, little is known about mechanisms behind major access barriers to health care, in our case, oral health care, for some groups in our society and whether
these barriers result in adverse health consequences (Watt and Sheiham, 1999).

Failure to understand these barriers to care and address them adequately will result in limited success in enhancing access to dental care for underserved populations. A better understanding of the barriers to care being experienced by any group under consideration must be achieved before any improvement plan can be designed (Guay, 2004). Primary research examining barriers to health care in Flanders-Belgium has been undertaken in the department of Family Medicine and Primary Health Care of the University of Ghent. In this study, emphasis has been placed on making an inventory and monitoring the barriers to health care rather than quantifying them. Concerning oral health care, a problem reported in this study is a lack of information about the costs of dental care resulting in a postponement or avoidance of necessary dental health care (De Maeseneer et al., 2003; Willems and De Maeseneer, 2003; Willems et al., 2004).

Dental services in Belgium, both preventive and restorative, are almost exclusively delivered in private dental practices. The system is based on a compulsory social insurance system with a reimbursement on a fee for item of service basis. Patients pay the dentist and are then reimbursed at about 75% (children aged 1–12 years: 100%) of the nationally agreed fees for restorative care, removable dentures (from the age of 50), minor oral surgery and limited preventive care.

As an initial step towards learning more about barriers to oral health care among socially vulnerable groups in Flanders, the aim of the present study was to identify perceptions and underlying causes of important access barriers to oral health care among the study group. For that, focus group discussions with the target group were conducted.

Material and methods

The study was undertaken in the city of Ghent, one of the major capitals in Flanders (population: 227,483), with an ethnically diverse population that included established minority ethnic communities, asylum seekers, immigrants and 'sans-papiers', and native deprived groups. Most of these socially vulnerable groups are situated in localised urban and suburban areas of the city.

The study project fitted in an awareness programme called “Niets aan de tand?” (Nothing wrong with my teeth?), a collaboration between the city’s District Health Care Centres ('Brugse Poort', 'De Sleep', 'Botermarkt'), the Ghent University (Department of Dentistry and Department of General Practice and Primary Health Care), the Flemish Public Agency ‘Child & Family’, the Dental Association and the city of Ghent.

In an attempt to acknowledge that patient personality and lifestyle should be considered in preventive and interventional health services and that patients and the community should be involved in health promotion interventions, a qualitative research design was used to gather as much information as possible concerning the nature of barriers to oral health care. The main aim was to discover the ‘who’, ‘what’ and ‘where’ of events or experiences perceived by the participants concerning oral health care. Rather than seeking to reach a general profile regarding the study population (goal of a quantitative approach), this qualitative approach had to provide conclusions which would account for the particulars of every case.

Focus group discussions were organised with participants recruited in social services, local neighbourhood groups and mother’s groups in primary schools. People who had previously lived in poverty but who were now employed as social workers in deprived areas, were not selected to participate in the different focus groups. Everyone who presented and joined the group was invited to participate. Each focus group involved between six and 12 participants. One hundred and fifty participants with different backgrounds participated in 13 focus group discussions in the spring and summer of 2003 (Table 1). Four focus group discussions took place with children, the remainder with female (mothers) adults. The number of focus groups was based on the completeness or saturation of data: the study continued until no new relevant data appeared. The data saturation point was confirmed independently by the two observers who analysed the data.

Participation was voluntary and the participants were assured of anonymity and confidentiality. Verbal consent

<table>
<thead>
<tr>
<th>Group</th>
<th>Number</th>
<th>Ethnicity + gender</th>
<th>Mean age (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7</td>
<td>Albanian mother's group</td>
<td>26 (22–30)</td>
</tr>
<tr>
<td>2</td>
<td>8</td>
<td>Albanian mother's group</td>
<td>25 (20–30)</td>
</tr>
<tr>
<td>3</td>
<td>7</td>
<td>Slovakian mother's group</td>
<td>31 (28–36)</td>
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<tr>
<td>4</td>
<td>11</td>
<td>Turkish mother's group</td>
<td>26 (24–32)</td>
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<tr>
<td>5</td>
<td>8</td>
<td>Turkish women</td>
<td>25 (n.a.)</td>
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<tr>
<td>6</td>
<td>9</td>
<td>Moroccan women</td>
<td>23 (n.a.)</td>
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<tr>
<td>7</td>
<td>10</td>
<td>6 indigenous (native) women, 4 Turkish women</td>
<td>24 (n.a.)</td>
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<td>8</td>
<td>7</td>
<td>Turkish women</td>
<td>24 (n.a.)</td>
</tr>
<tr>
<td>9</td>
<td>6</td>
<td>4 indigenous (native) women, 2 Turkish women</td>
<td>26 (n.a.)</td>
</tr>
<tr>
<td>4 groups of children</td>
<td>77</td>
<td>Mixed groups (gender and ethnicity)</td>
<td>11 (10–12)</td>
</tr>
</tbody>
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Figure 1. Picture of playing cards in the domino game
Key:
Picture 1 Why do you think a lot of people are aware of their physical appearance and the role of teeth into this?
Picture 2 Some people say a dentist is too expensive, what do you think?
Picture 3 Why are some children allowed to have a baby bottle in bed?
Picture 4 Who taught you to brush your teeth?
Picture 5 A lot of people are afraid to go to the dentist. Why?
Picture 6 In some schools children are not allowed to bring sweets, what is your opinion?

was provided. The study was approved by the Ethics committee of the Ghent University Hospital (OG017), Ghent, Belgium (ECUZG 2002/355).

Each focus group had a moderator to ensure that the discussion remained focused and kept to the topic. All moderators were experienced health care workers employed by one of the organising health care services. Training was provided to all group moderators in order to standardise the protocol of the focus group discussions. A semi-structured discussion guide based on ‘domino’ game (Figure 1) was developed especially for use in the focus group discussions. Simple items were combined with questions addressing the following topics:

• Participants’ perception about oral health care
• Barriers to oral health care and oral health care services perceived or experienced by participants and how
Participants dealt with these barriers

- Participants' knowledge and attitude towards oral hygiene and healthy food related to oral health
- Participants' perception of oral health as part of general health and well-being
- Participants' attitude towards oral health care for children.

Questions were posed in an open-ended manner. Example questions as shown in Figure 1 were: "Why do you think a lot of people are aware of their physical appearance and the role of teeth in this?", "Some people say a dentist is too expensive, what do you think?", "Why are some children allowed to have a baby bottle in bed?", "Who taught you to brush your teeth?", "A lot of people are afraid to go to the dentist, why?", "In some schools children are not allowed to bring sweets, what is your opinion?".

The use of the ‘domino’ game to guide the discussion randomised the order of the questions for each focus group. Since the order of the questions could have influenced a response and biased the respondents, the ‘domino’ game technique minimised this order bias. As focus group discussions were held with both children and adolescents, an adapted version of the game was developed with questions transcribed to a child's level of interest and language.

Focus group discussions were conducted in Dutch. When participants had problems speaking or understanding Dutch, the assistance of an interpreter was provided who undertook concurrent translation. The focus group discussions lasted approximately one-and-a-half hours.

With the participants’ permission the discussions were tape-recorded and then transcribed verbatim. Initially the transcripts were coded by the moderators concerned and the issues raised were mapped. QSR Nudist software version 5 was used by two independent analysts as a data storage tool to organise the data, and themes were devised using content analysis. Content summaries were developed with categories of beliefs. Categories used were knowledge about oral health care, perception of severity and susceptibility of the condition, motivation and perceived benefits and barriers. The Health Belief Model (HBM) was the main theoretical approach for the study (Andersen, 1995; Rosenstock, 2002). The HBM is one of the most widely used conceptual frameworks for understanding health behaviour. It is a socio-psychological model that attempts to explain and predict health behaviours, focusing on the attitudes and beliefs of individuals. The HBM was spelled out in terms of four constructs representing the perceived threat and net benefits: perceived susceptibility, perceived severity, perceived benefits and perceived barriers. Although this pre-determined set of codes remained the basis for organising the data, codes were, initially and gradually in the course of the analysis, generated from the data themselves to ensure the best fit of the data. Introducing a deductive reasoning approach in combination with the classical inductive approach, commonly used in qualitative research, represents an added value assuring conviction in qualitative research findings.

The final result was read and reread by the authors and the different moderators and different opinions were discussed.

Results

In the results, emphasis is put on knowledge and skills concerning oral health care (important to evaluate the perceived severity and susceptibility), barriers to oral health care and perceived benefits. These factors are listed without passing judgement on their importance. Barriers to seeking oral health care are classified into supplier-side barriers and user-side barriers. Both strongly influence participants’ motivation to attend oral health care services. General concepts are illustrated with quotations from the transcripts, translated in English but reflecting as much as possible the content of the participant’s words.

Knowledge

Knowledge of preventive oral health care seemed to be low among the participants. They expressed a lack of awareness of the importance of sugared drinks in baby bottles and their harmful effect on oral health. Prolonged use during the daytime of sugared drinks and sweetened dummies were common practice.

- ‘The bottle is easy to give milk, chocolate or juice.’
- ‘A lot of people put the dummy in windail [a sugared oil based on Dill Seed reputed to have a calming effect on crying children] that is good against cramps.’
- ‘By sucking the dummy, the gums become harder and the teeth will come through faster’

This habit is strengthened by cultural beliefs and by the fact that the choice for cake and sweets are preferred, out of laziness, to healthier snacks and drinks. In some cultural beliefs plumpness is seen as a picture of health and a sign of wealth.

- ‘If a kid is not chubby then the other mothers think: that mother is not good, she doesn’t raise her kid well and out of fear for that, we feed them the whole time.’
- ‘Children refuse any help, even if they could not do it themselves.’
- ‘Brushing teeth is too hard’.
- ‘Children refuse any help, even if they could not do it themselves.’
- ‘What’s the point in brushing those milk teeth, they will fall out anyway.’
- ‘It’s a waste of time to brush milk teeth.’
Further, a lack of theoretical and practical knowledge on types of toothbrushes, hardness of the toothbrush bristle, toothpaste and brushing methods became clear and was proved during the discussions.

'I think the rougher the better'.

'Children's toothpaste is good because it's got a special colour and taste'.

'All children's toothpastes are good, so I buy the cheapest one.'

Participants reported that information gained from health care providers was limited. They had mostly learned from friends and family, from 'the street' or from the media and this information was not always reliable.

'I watch Turkish advertising on TV.'

'I thought it myself, from seeing from others'.

Overall knowledge of available dental care services and costs was also limited. During the group discussions a lack of knowledge and experience of finding an appropriate dental office and requesting dental care was expressed (this item can also be considered as a barrier from the suppliers' side).

Most barriers expressed during the group discussions were on the user's side. Fear of pain and dental treatment has been reported as one of the major barriers to dental visits. This attitude resulted in unnecessary dental neglect, worsening dental condition, and future pain and expense. Moreover, fear and negligence were felt as the major reason for cancelling and postponing an appointment with the dentist.

'I prefer to suffer from toothache, rather than going to the dentist.'

'I am scared to death, we never went to the dentist unless the pain was intolerable.'

Closely connected with the preceding, travel and journey time were also reported as barriers. Appointments were cancelled or postponed at the last minute due to inappropriate transport or lack of time. This is correlated with inadequate home management and the establishment of other priorities.

'At the very last minute I could not keep my appointment with the dentist because …'

Participants described a great deal of uncertainty about dental treatments. They are afraid to ask the dentist what will happen and what the cost will be. Restlessness, anxiety and fear of the unknown are some of the most common negative feelings that participants perceived.

'Sometimes I don't know what they are going to do, they put something in your mouth, and they arrive with I don't know what, so I don't know at all what they are going to do.'

'I am scared about what the dentist will say and what I will have to go through.'

Adult participants reported that out-of-pocket cost was a substantial barrier to receiving care. The 'pay and then get reimbursed' approach of the insurance system is an access barrier, all the more since patients have to wait several weeks for reimbursement from the central office of the health care fund. Some participants expressed concern and a feeling of uncertainty over what their personal contribution would be.

'You get most of it paid back, but you first have to pay it out of your pocket.'

'You don't get it in hand anymore, it is being deposited on your account afterwards.'

The impact of language barriers on health care access and quality of access was demonstrated. Language barriers significantly hinder access to oral health care and compromise oral health care quality. Consequences of poor communication were keenly felt by the participants.

'It's difficult, I can't really explain it very well.'

Supplier-side barriers

Supplier-side barriers expressed during group discussions demonstrated the lack of information provided to this special need group concerning the availability of dental care services and costs for dental care.

'The problem is that you never know in advance how much you will pay at the dentist.'

'It's only when you leave that you know how much you have to pay at the dentist.'

Once dental care has been provided, subjects commented on negative experiences concerning dentists' lack of responsiveness to patients' concern and the 'clinical atmosphere' of most dental waiting rooms and offices. This provoked a rather negative image of the dental profession.

'He always makes me think of a hospital'.

'You can't just go and ask everything to your dentist, like you would with a family doctor, the gap is a lot bigger.'

One of the decisive factors in adopting proactive health behaviours, according to the health belief model, is obtaining benefits from this behaviour. Some of these benefits are quoted in the reported discussions:

To be attractive and avoid possible social rejection associated with bad breath and untidy teeth.

'The presentation, the looks, if you are amongst people then it's not very pleasant.'

To avoid pain and minimise dental care expenses.

'In the end, not going will become more expensive, because in the long run everything rots and then you come to an amount which you can't pay anymore and then you are buggered.'

Along with the said barriers, these benefits will influence the motivation of these vulnerable groups to receiving oral health care. In the reality of day to day living, where nothing is more important than trying to survive, parents tend to give dental care low priority if they have to spread their resources to cover extra medical bills as well as the costs of food and shelter.
Discussion

This study adopted a qualitative approach to collect and analyse data from focus group discussions bearing in mind one main question: what are the perceptions and underlying causes of important access barriers to oral health care among socially vulnerable groups in our target population? The main objective of this study was not to list the barriers and certainly not to order them but to learn more about the basic nature and shape of the barriers. This can be considered as the added value of the present report.

Discussions were chosen as the best method to obtain this information because, compared to an individual face-to-face interview, they provide a non-threatening environment in which participants can explore more easily their thoughts and feelings, especially because existing groups were involved. Furthermore, the focus group conversations allowed the participants to explore and explain oral health and oral health problems from the perspective of their own experiences, ideas, knowledge and emotions. This procedure initiated a process of sharing and comparing based on group dynamic and has a stimulating effect for expressing opinions. Individual interviews, on the other hand, could have revealed important information in-depth which did not emerge from groups.

Disadvantages emerging from either individual interviews or group discussions are that answers and opinions are vulnerable to a bias from social desirability. People, knowing that other people (interviewer or group participants) are watching them, will tend to behave and respond in a way they believe is socially acceptable and desirable. This leads to the assumption that the results of this study are rather an underestimation of the perceived barriers.

Looking at the results, the present report highlights that access to oral health care remains a huge problem, comparable to the findings of previous reports of international studies. Most of the reported barriers, both on the supplier side and the user side, are confirmed. Looking behind these similarities however, there are important specific emphases suggesting that barriers are contextual. The present report shows that the qualitative approach helped us reveal and better understand the nature and shape of barriers, specific for this targeted community. As already reported in previous studies dealing with access barriers to general health care in a comparable community, lack of information was shown to be an important problem (De Maeseneer et al., 2003; Willems and De Maeseneer, 2003; Willems et al., 2004). The consequences of poor communication for vulnerable groups within the community have to be highlighted, resulting in poor knowledge, uncertainty about dental treatments, costs and reimbursement facilities. Participants were often reluctant to initiate contact with oral health professionals because of this barrier. Moreover, where consultations did occur, poor communication often resulted in a lack of understanding of the dental health problem and treatment planning, and was likely to have a negative effect on oral health behaviour. Besides these communication and information problems, and at the same time linked to these, many participants appeared complacent and accepting of the status quo. They were not proactive in generating a demand for proper oral health services.

This, together with the social desirability bias as mentioned above, also explains some contradictory and inconsistent quotes expressed by the participants regarding their dental awareness. On the one hand participants are quite vain about their appearance and the appearance of their children and would in all probability be glad to have better access to dental services. On the other hand, they seem to be unable to apply this in practice. Participants offered a very practical interpretation of their predicaments and showed a pragmatism and resignation driven by the circumstances. This inability again is strengthened by a general lack of knowledge concerning both preventive measures and organisational aspects of delivering dental care, the whole resulting in a general dental neglect and a further postponement of oral health care, both curative as well as preventive. Moreover, it does seem that the adaptive ability of our participants was substantial and probably enhanced by the company of peers who accept oral problems and oral discomfort as almost the norm.

The reported attitude and motivation are certainly linked to the living circumstances of the target group. The context of the individual requiring oral health care is not as evident when financial and other problems impede the ability of parents to meet the basic needs of their children.

The private oriented organisation of oral health services works insidiously to shape people’s thoughts, perceptions and preferences such that they accept their role in the existing order of things, either because they cannot imagine any alternative to it, or because they feel it as natural and unchangeable. These perceptions, which may conceal even more than they reveal, are perhaps important to understand one of the main strategic health promotion action means issued by the World Health Organisation: “Reorienting health services also requires greater attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services, which refocuses on the total needs of the individual as a whole person.” (World Health Organisation, 1986).

In conclusion, the results of this study revealed the nature and shape of common reported barriers to oral health care access among socially vulnerable groups that can be summarised in four keywords: information, communication, coping with resignation and reorienting services. An important commitment, based on these results, should be appropriate information provision to, and motivation of, the target group adapted to their contextual needs. Due to the complexity of the problem, a multidisciplinary and community oriented approach will be preferred to a large-scale campaign. This allows us to anticipate and go along with the specific nature of problems and barriers, charac-
teristic for the targeted population group. The framework reported in this study offered guidance for innovative initiatives and interventions to reduce these barriers. Oral health education programmes were included in the existing health promoting projects directed to the target group and organised by the District Health Care Centres and the regional ‘Child and Family’ organisation (‘common risk approach’). An oral health care office was installed in one District Health Care Centre providing oral health care and oral health promotion, in a multidisciplinary context, targeted to the most vulnerable group in the community (‘reorient health services’ and ‘common risk approach’). Further research will be started to understand how the target group cope with their problems and how they respond to the innovative initiatives to reduce barriers to oral health care access.

References


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