

# Investigating the “inverse care law” in dental care: A comparative analysis of Canadian jurisdictions

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## ABSTRACT

**OBJECTIVES:** To compare physician and dentist visits nationally and at the provincial/territorial level and to assess the extent of the “inverse care law” in dental care among different age groups in the same way.

**METHODS:** Publicly available data from the 2007 to 2008 Canadian Community Health Survey were utilized to investigate physician and dentist visits in the past 12 months in relation to self-perceived general and oral health by performing descriptive statistics and binary logistic regression, controlling for age, sex, education, income, and physician/dentist population ratios. Analysis was conducted for all participants and stratified by age groups – children (12–17 years), adults (18–64 years) and seniors (65 years and over).

**RESULTS:** Nationally and provincially/territorially, it appears that the “inverse care law” persists for dental care but is not present for physician care. Specifically, when comparing to those with excellent general/oral health, individuals with poor general health were 2.71 (95% confidence interval [CI]: 2.70–2.72) times more likely to visit physicians, and individuals with poor oral health were 2.16 (95% CI: 2.16–2.17) times less likely to visit dentists. Stratified analyses by age showed more variability in the extent of the “inverse care law” in children and seniors compared to adults.

**CONCLUSIONS:** The “inverse care law” in dental care exists both nationally and provincially/territorially among different age groups. Given this, it is important to assess the government’s role in improving access to, and utilization of, dental care in Canada.

**KEY WORDS:** Dental health services; health services; health care utilization; oral health

La traduction du résumé se trouve à la fin de l’article.

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According to the Canada Health Act, the major goal of Canadian health care policy is to provide reasonable access to care regardless of any financial or other barriers.<sup>1</sup> While the aim of Canada’s national system of health care insurance (Medicare) is to achieve this stated objective, variation is possible in terms of the planning, administration and delivery of health care services among its 13 jurisdictions (10 provinces and 3 territories), affecting the utilization of health care services.

There is even greater variability in the public financing and delivery of dental care among Canadian jurisdictions. Compared to the universality of medical care, public spending on dental care is limited and targeted to specific populations in Canada. The federal government finances dental care for state-recognized Aboriginal groups, the country’s Armed Forces, veterans, and refugees.<sup>2–4</sup> The Canadian provinces/territories provide public subsidies for specific groups such as children from low-income families, low-income seniors, social welfare recipients, and the disabled.<sup>2</sup> Yet despite this public spending on targeted dental care programs, Canada still ranks very low in public spending on dental care among Organization for Economic Cooperation and Development countries.<sup>5</sup> Most dental care in Canada is still paid through employment-based insurance and/or out-of-pocket, which leaves many Canadians without access to optimal dental care.<sup>6,7</sup>

In this context, current literature suggests an association between physician/dentist visits and self-perceived general/oral health in

Canada.<sup>6,8</sup> People with poor self-perceived general health are more likely to visit physicians, while people with poor self-perceived oral health are less likely to visit dentists.<sup>6,8</sup> In other words, those with the highest need for medical care access the required services the most, while those with the highest need for dental care access the required services the least. This situation in dental care is described as the “inverse care law”. The difference between the physician and dentist visits appears to be related to the universality of physician care and the private funding of dental care in Canada. Further, social attributes, such as income, education, and employment/working condition are major social determinants of health in general.<sup>9</sup> In Canada, these determinants contribute differently for general and oral health care. For example, because of the universality of medical care, all Canadians have access to health care services, including preventive measures, such as vaccination and screening; however, access to dental care and specifically preventive care is arguably limited to a greater extent by such social attributes as listed above, due to limited public dental care programs. With equitable access to

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preventive dental care, one could expect a lower need for curative or rehabilitative dental care and better oral health overall. Yet, due to limited dental care funding and population coverage, more individuals in Canadian society arguably experience poorer oral health. So, unlike physician care, income and insurance coverage are more important factors affecting an individual’s decision to visit a dentist in Canada.<sup>8,10–13</sup> More people with poor oral health thus face greater financial barriers to accessing care as a result of low income.<sup>11</sup> Also, these individuals may not have employment-based insurance and may rely on public dental care coverage, since only about half of the population is covered by private insurance.<sup>10,11</sup>

As current literature in this area is available only at the national level based on the data from 2000 to 2001 and 2003,<sup>6,8</sup> this study updates our knowledge on physician/dentist visits at the national level using more current data from 2007 to 2008. Additionally, our study is the first to: compare physician and dentist visits in relation to self-perceived general/oral health at provincial/territorial levels; and assess the extent of the “inverse care law” for dental care among different age groups in Canada.

## METHODS

### Dataset

We used publicly available data files from the 2007 to 2008 Canadian Community Health Survey (CCHS). A national response rate of 76% was achieved in this survey, which included detailed information regarding the health status and health care utilization of 131,061 individuals aged 12 years and older. Among the completed surveys, responses for some questions were achieved at 100% (e.g., age, sex), but for some others, response was as low as 84% (e.g., income adequacy). The survey statistically represented 98% of the Canadian population. Individuals who were excluded from the survey included: those living on reserves, those working full time in the Canadian forces, and those living in long-term facilities, hospitals, and in the Quebec health regions of Région du Nunavik and Région des Terres-Cries-de-la-Baie-James.<sup>14</sup>

### Dependent variables

Dependent variables in our study included physician and dentist visits in the past 12 months. This information was assessed using these questions: “In the past 12 months, how many times have you seen or talked on the telephone, about your physical, emotional or mental health with...”:

- a family doctor/general practitioner or other medical doctors (excluding eye specialist)? (physician visits)
- a dentist or orthodontist? (dentist visit)

The responses to these questions were recoded as dichotomous variables to indicate use (one or more visits) or no-use of physicians and dentists in the past 12 months.

### Independent variables

The predictor variables were self-perceived general and oral health. This information was assessed with the following questions: “In general, would you say your health is: excellent, very good, good, fair, poor?” and “In general, would you say the health of your teeth and mouth is: excellent, very good, good, fair, poor?” We recoded

these variables into three groups by combining the excellent and very good categories into one category collectively named “excellent”; keeping the good category as “good”; and combining fair and poor into another category collectively named “poor”. Categories were combined specifically to execute regression analysis on these data, as some categories had limited numbers of cases among a few provinces.

### Control variables

We controlled for age, sex (female, male), household education (less than secondary, secondary graduate, other post-secondary, post-secondary graduate) and income adequacy (low, middle, high). Income adequacy was determined by adjusting household income based on the household size.<sup>15</sup> Additionally, we controlled for provincial/territorial physician/dentist per 100,000 population in the national level analysis.<sup>16–18</sup> For the provincial/territorial level analysis, we could not adjust for physician/dentist population ratios, as regional estimates were not available in this regard.

### Data analysis

We performed descriptive statistics and binary logistic regression on weighted data while controlling for the above variables, using IBM SPSS Statistics 20.0. Participants with missing data on any variables of interest were excluded from further analysis (listwise deletion approach). As a result, 104,571 and 102,295 out of 131,061 participants were included in the physician and dentist visits analysis respectively (Table 1). We then performed chi-square analysis to compare the socio-demographic characteristics of included and excluded participants in the physician and dentist visits analysis. We also conducted chi-square analysis to obtain unadjusted odds ratio (OR) and 95% confidence interval (CI), followed by logistic regression analysis to obtain adjusted OR and 95% CI by having the excellent general/oral health as our reference category in all analyses (shown as a straight line crossing at 1 in Figures 2 and 3). The effect of an OR above 1 is easy to visualize; however, it is harder to interpret the magnitude of the relationship when the OR is less than 1. As a result, we calculated the inverted OR (1/OR) for values less than 1 in order to better understand the magnitude of the relationship. Higher adjusted inverted OR (adj. IOR) values mean a lower likelihood of that variable. We also conducted stratified analyses on three age groups – children (12–17 years), adults (18–64 years) and seniors (65 years and over) – and calculated the corresponding IOR and 95% CI when adjusted for control variables.

## RESULTS

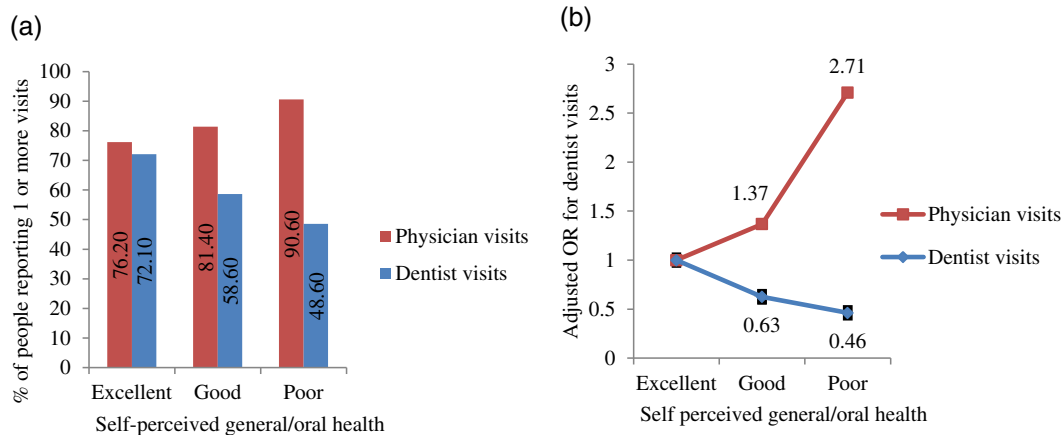
Participants in the 2007–2008 CCHS were mostly adults ages 18–64 years (68.5%). Similar numbers of males and females (45.5%:54.5%) participated in this survey. About a third (33.5%) of participants were residents of Ontario. More than half (68.8%) had post-secondary education degrees. More than a third (45.4%) were in the middle-income category. About half of the sample reported excellent general (55.7%) and oral (55.4%) health (Table 1). Comparing included and excluded participants’ socio-demographic characteristics, the differences in proportions were not large, but were statistically significant (Table 1).

Our first objective was to compare physician and dentist visits nationally and provincially/territorially. Across Canada, we found that, in 2007–2008, approximately 80% of the included sample

**Table 1.** Socio-demographic characteristics of total respondents and included and excluded participants for dentist and physician visits analysis, 2007–2008 CCHS

	Total respondents (N = 131,061) n (%)	Excluded participants from physician visits analysis (N = 26,490) n (%)	Included participants for physician visits analysis (N = 104,571) n (%)	Chi-square analysis (p value)	Excluded participants from dentist visits analysis (N = 28,766) n (%)	Included participants from dentist visits analysis (N = 102,295) n (%)	Chi-square analysis (p value)
Age (years)							
12–17	11,050 (8.4)	4068 (15.4)	6982 (6.7)	<0.001	4411 (15.3)	6639 (6.5)	<0.001
18–64	89,832 (68.5)	15,130 (57.1)	74,702 (71.4)		16,049 (55.8)	73,783 (72.1)	
≥65	30,179 (23.0)	7292 (27.5)	22,887 (21.9)	<0.001	8306 (28.9)	21,873 (21.4)	0.005
Sex							
Male	59,568 (45.5)	11,411 (43.1)	48,157 (46.1)	<0.001	12,867 (44.7)	46,701 (45.7)	<0.001
Female	71,493 (54.5)	15,079 (56.9)	56,414 (53.9)		15,899 (55.3)	55,594 (54.3)	
Province of residence							
NL	4098 (3.1)	759 (2.9)	3339 (3.2)	<0.001	893 (3.1)	3205 (3.1)	<0.001
PEI	2367 (1.8)	483 (1.8)	1884 (1.8)		531 (1.8)	1836 (1.8)	
NS	5152 (3.9)	920 (3.5)	4232 (4.0)		1019 (3.5)	4133 (4.0)	
NB	5509 (4.2)	968 (3.7)	4541 (4.3)		1139 (4.0)	4370 (4.3)	
QC	23,545 (18.0)	4065 (15.3)	19,480 (18.6)		4384 (15.2)	19,161 (18.7)	
ON	43,958 (33.5)	8754 (33.0)	35,204 (33.7)		9400 (32.7)	34,558 (33.8)	
MB	7520 (5.7)	1608 (6.1)	5912 (5.7)		1694 (5.9)	5826 (5.7)	
SK	7819 (6.0)	1819 (6.9)	6000 (5.7)		1942 (6.8)	5877 (5.7)	
AB	11,925 (9.1)	2799 (10.6)	9126 (8.7)		3003 (10.4)	8922 (8.7)	
BC	15,903 (12.1)	3647 (13.8)	12,256 (11.7)		4037 (14.0)	11,866 (11.6)	
TR	3265 (2.5)	668 (2.5)	2597 (2.5)	<0.001	724 (2.5)	2541 (2.5)	<0.001
Education							
Less than secondary	15,985 (13.3)	2813 (17.8)	13,172 (12.6)	<0.001	3179 (17.6)	12,806 (12.5)	<0.001
Secondary graduate	14,839 (12.3)	2334 (14.8)	12,505 (12.0)		2638 (14.6)	12,201 (11.9)	
Other post-secondary	6769 (5.6)	809 (5.1)	5960 (5.7)		915 (5.1)	5854 (5.7)	
Post-secondary graduate	82,770 (68.8)	9836 (62.3)	72,934 (69.7)		11,336 (62.7)	71,434 (69.8)	
Income adequacy							
Low income	16,971 (15.4)	895 (16.1)	16,076 (15.4)	0.002	1181 (15.1)	15,790 (15.4)	<0.001
Middle income	49,981 (45.4)	2601 (46.9)	47,380 (45.3)		3921 (50.1)	46,060 (45.0)	
High income	43,167 (39.2)	2052 (37.0)	41,115 (39.3)		2722 (34.8)	40,445 (39.5)	
Self-perceived general health							
Excellent	72,848 (55.7)	13,582 (51.7)	59,266 (56.7)	<0.001	–	–	<0.001
Good	39,640 (30.3)	8605 (32.7)	31,035 (29.7)		–	–	
Poor	18,363 (14.0)	4093 (15.6)	14,270 (13.6)		–	–	
Self-perceived oral health							
Excellent	70,685 (55.4)	–	–		13,403 (52.9)	57,282 (56.0)	
Good	38,902 (30.5)	–	–		8431 (33.3)	30,471 (29.8)	
Poor	18,060 (14.1)	–	–		3518 (13.9)	14,542 (14.2)	

Note: NL = Newfoundland and Labrador; PEI = Prince Edward Island; NS = Nova Scotia; NB = New Brunswick; QC = Quebec; ON = Ontario; MB = Manitoba; SK = Saskatchewan; AB = Alberta; BC = British Columbia; TR = territories.

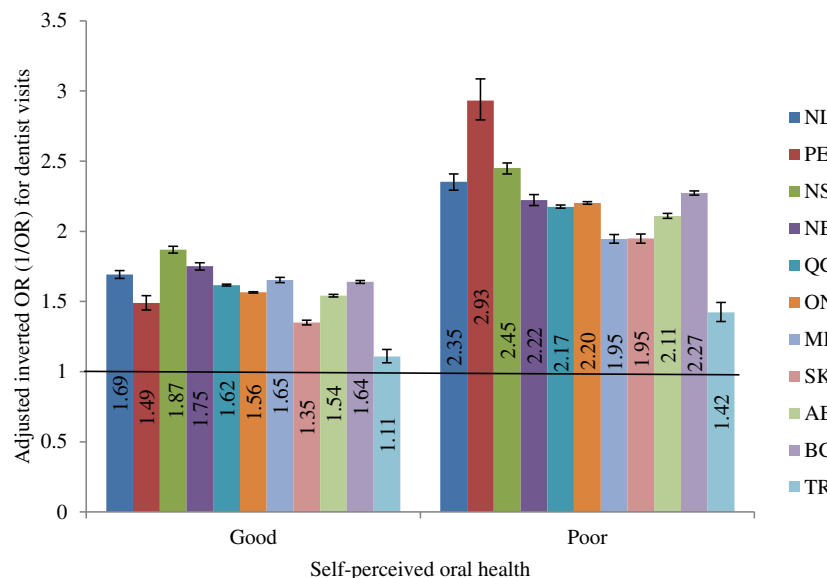


**Figure 1.** National summary of people reporting one or more physician and dentist visits in 2007–2008 in percentages (a) and based on the odds ratio adjusted for control variables (b)

population visited physicians at least once in the past 12 months. However, only 64% of individuals had one or more visits to a dentist in the same year. Further, 91% of the sample population with poor general health visited physicians while only about half (48.6%) of individuals with poor oral health visited dentists in the previous year (Figure 1a). Adjusted analysis at the national level showed that individuals with poor general health were approximately 2.71 (95% CI: 2.70–2.72) times more likely to visit physicians while individuals with poor oral health were approximately 2.16 (95% CI: 2.16–2.17) times less likely to visit dentists compared to those with excellent general/oral health (Figure 1b). Adjusted analysis at the provincial/territorial level showed similar trends (Table 2 and Figure 2) for both physician and dentist visits. Specifically for dentist visits, though the trends of people with poor oral health being less likely to visit a dentist was similar across jurisdictions, the likelihood of not visiting varied – with the highest likelihood in PEI and the lowest in the territories (please refer to Figure 2 for adj. IOR and 95% CI).

Similar trends were present in the stratified analyses based on the age groups. At the national level, among all three age groups, individuals with poor oral health had higher odds of not visiting dentists compared to those with excellent oral health; however, it varied across the age groups – being the highest among the adults (adj. IOR: 2.39, 95% CI: 2.38–2.40) and the lowest among the seniors (adj. IOR: 1.40, 95% CI: 1.39–1.41). At the provincial/territorial level, the pattern of visiting a dentist remained consistent across different jurisdictions in the adults but not so in children and seniors (please refer to Figure 3 for adj. IOR).

Among all jurisdictions, children with poor oral health had higher odds of not visiting dentists compared to those with excellent oral health, except in the territories (Figure 3a). In the territories, children with poor oral health were 2.34 times (95% CI: 1.77–3.10) more likely to visit dentists compared to those with excellent oral health. Furthermore, children in Newfoundland with poor oral health had the highest odds of not visiting dentists

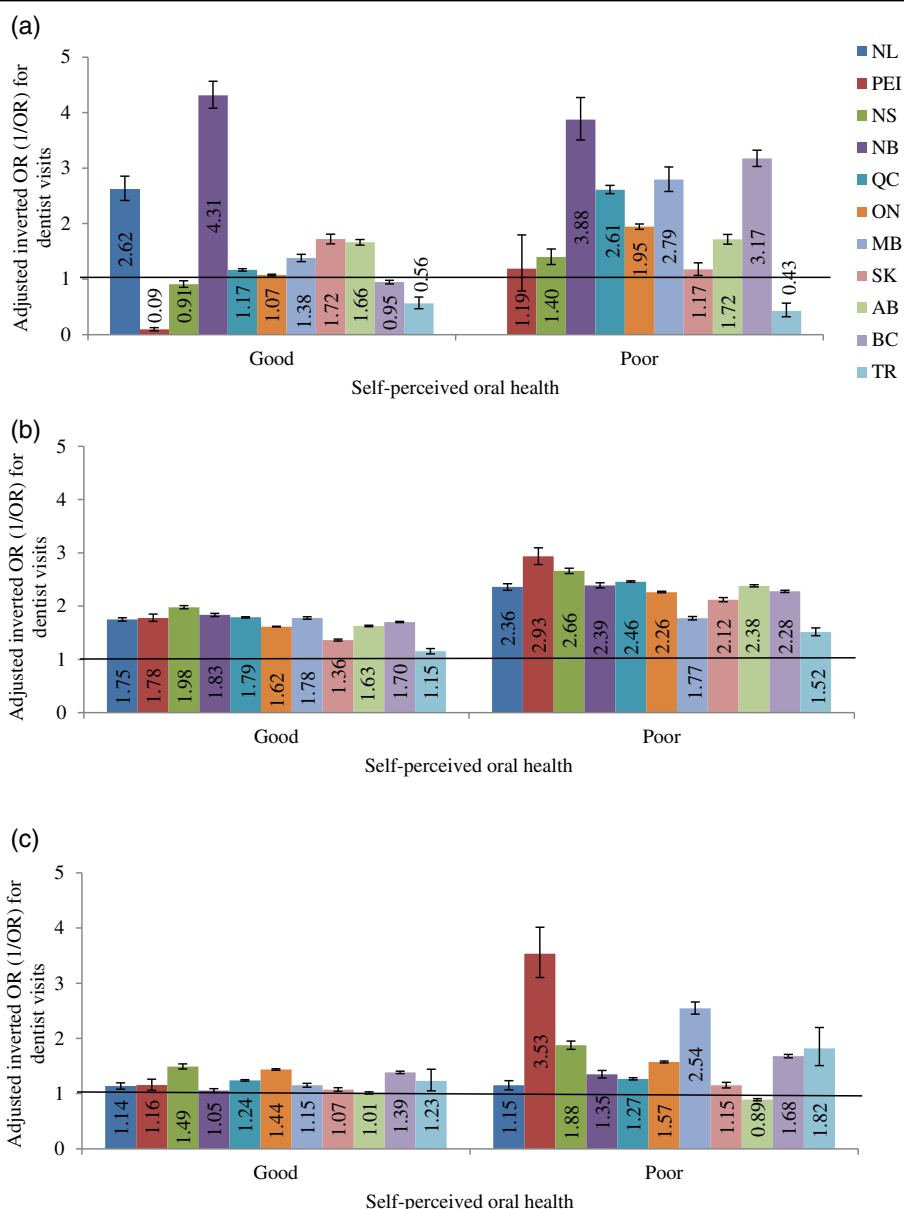


**Figure 2.** Provincial/territorial comparison of the adjusted inverted OR (1/OR) for dentist visits as a function of self-perceived oral health

**Table 2.** Odds of visiting physicians/dentists among individuals with good and poor general/oral health across different jurisdictions

Jurisdictions	Physician visits among people with good general health		Dentist visits among people with good oral health		Physician visits among people with poor general health		Dentist visits among people with poor oral health	
	Adjusted OR	95% CI	Adjusted OR	95% CI	Adjusted OR	95% CI	Adjusted OR	95% CI
NL	1.34	1.31–1.36	0.59	0.58–0.60	4.67	4.46–4.88	0.43	0.42–0.44
PEI	1.29	1.23–1.34	0.67	0.65–0.70	3.95	3.63–4.29	0.34	0.32–0.36
NS	1.34	1.32–1.36	0.54	0.53–0.54	2.67	2.60–2.75	0.41	0.40–0.42
NB	1.48	1.46–1.51	0.57	0.56–0.58	3.22	3.12–3.31	0.45	0.44–0.46
QC	1.44	1.44–1.45	0.62	0.62–0.62	2.41	2.39–2.43	0.46	0.46–0.46
ON	1.35	1.34–1.36	0.64	0.64–0.64	2.96	2.94–2.99	0.45	0.45–0.46
MB	1.53	1.51–1.55	0.61	0.60–0.61	2.23	2.18–2.29	0.51	0.51–0.52
SK	1.32	1.30–1.34	0.74	0.73–0.75	2.33	2.27–2.39	0.51	0.51–0.52
AB	1.40	1.39–1.41	0.65	0.65–0.65	2.27	2.23–2.30	0.47	0.47–0.48
BC	1.22	1.22–1.23	0.61	0.61–0.61	3.10	3.05–3.14	0.44	0.44–0.44
TR	1.43	1.37–1.49	0.90	0.86–0.94	1.84	1.71–1.98	0.70	0.67–0.74

Note: Excellent general/oral health was used as the reference category for all analyses.



**Figure 3.** Provincial/territorial comparison of the adjusted inverted OR (1/OR) for dentist visits as a function of self-perceived oral health among children aged 12–17 years (a), adults aged 18–64 years (b), and seniors aged 65 years and over (c)

compared to those with excellent oral health (adj. IOR: 24.39, 95% CI: 20.83–28.57, not included in Figure 3a). With regard to the adults, we observed the same trends as the whole population analysis at the provincial/territorial level – among all jurisdictions, adults with poor oral health had higher odds of not visiting dentists compared to the reference, with the highest in PEI (Figure 3b). With respect to the seniors, Alberta was the only jurisdiction that showed lower adjusted IOR (adj. IOR: 0.89, 95% CI: 0.87–0.91; Figure 3c), meaning higher odds of dentist visits among seniors with poor oral health compared to those with excellent oral health. In this province, seniors with poor oral health were 1.12 times (95% CI: 1.10–1.15) more likely to visit dentists compared to the reference.

## DISCUSSION

This study extends previous findings on physician and dentist visits in Canada. Our analysis demonstrated that in Canada, individuals who perceived their general health as poor were more likely to visit physicians compared to those with excellent general health. However, the results were opposite for the dental care – individuals who perceived their oral health as poor were less likely to visit dentists. These findings are consistent with the past literature.<sup>6,8</sup> These observed differences between the physician and dentist visits appear to be related to the funding of Canada's health care system, which essentially means publicly funded general health care and almost entirely privately funded dental care. In this context, our study suggested the persistence of the "inverse care law" in dental care in Canadian provinces/territories, as seen in Sabbah and Leake's study.<sup>6</sup>

Importantly, the variability seen in the extent of the "inverse care law" for dentistry among jurisdictions may be related to differences in public investment for dental care, as was evident from another study conducted among Australian states.<sup>19</sup> We found that in the Canadian territories, with the highest per capita public dental care expenditure, individuals with poorer oral health were more likely to visit dentists compared to those in 10 other jurisdictions.<sup>20</sup> However, Ontario, which has the least per capita public spending on dental care, did not show the lowest odds of dentist visits among individuals with poorer oral health.<sup>20</sup> This suggests that other factors, such as the availability of dentists across health regions, are at play, which may have contributed to variability in dentist visits observed across provinces/territories.

In stratified analyses based on the age groups, we observed that adults had a lower likelihood of dentist visits compared to children and seniors at the national level. This might be related to higher numbers of provincially/territorially legislated dental care programs targeted towards children and seniors compared to dental care programs targeted towards adults. We also found more variability in the extent of the "inverse care law" in dental care among jurisdictions in children and seniors compared to the adults. This variation may be explained by differences in provincially/territorially legislated dental care programs, such as children and seniors' services, among jurisdictions. Further research is required to investigate the potential role of public investment and provincially/territorially legislated dental care programs on the frequency of dentist visits in Canada.

## Limitations and strengths

There exist some limitations in this study. The first concerns the question used in the CCHS to measure the dependent variable (physician/dentist visits). The responses to the question used to determine these visits not only included in-person visits but also - telephone conversations between the respondents and physicians/dentists, regardless of whether the visits were for preventive or curative treatments. Further, the data used to determine dentist visits also included visits to orthodontists. Although these limitations might have resulted in an overestimation of our results to some extent, nonetheless we see a strong inverse relationship between dentist visits and oral health status based on our analysis that is supported by earlier studies.<sup>6,8</sup>

Additionally, the CCHS only included individuals aged 12 and older, and data were collected in several ways ranging from short telephone conversations to three-hour appointments. However, this dataset is the only one accessible to investigate these kinds of research questions in Canada and has been used in previous studies to explore similar research questions.<sup>6,8</sup> Additionally, this survey was not complete in terms of participants' responses to all variables and as a result, participants with missing responses for the variables of interest were excluded from the analysis (listwise deletion approach). Our chi-square analysis revealed that the differences between socio-demographic characteristics of included and excluded participants were statistically significant. However, as expected, with a large sample size, even small differences (as in this case) can be statistically significant.<sup>21</sup> Thus, it is arguable that the listwise deletion approach may not have substantially affected the power and validity of our results since our study was based on a population-based survey with a large sample size. Furthermore, there were no data available on physicians/dentists to population ratios at the health regional level in order to control for this variable at the provincial/territorial level analysis. However, when we controlled for this variable at the national-level analysis (physicians/dentists to population ratio was constant among respondents of a jurisdiction), the results did not change significantly.

Furthermore, although dental insurance is known to be one of the most important factors affecting dentist visits, this information in the 2007–2008 CCHS was only available for one province, New Brunswick. Only the 2003 CCHS contained information on total dental insurance (combined public and private insurances) for different jurisdictions, in which the highest and the lowest percentages of individuals with dental insurance were seen in the territories (80.8%) and Newfoundland (49.5%) respectively.<sup>22</sup> Based on a 2008 survey by Locker et al. (2011), about two thirds of the lower income families paid out-of-pocket for dental care and higher numbers reported financial barriers to dental care compared to the higher income families.<sup>11</sup> On the other hand, more than two thirds of the higher income families were covered by private dental insurance and faced less financial barriers compared to the lower income families.<sup>11</sup> As a result, with higher income, individuals are more likely to have dental insurance and to visit dentists regularly compared to those with lower income. Thus, our income variable is arguably a good proxy for dental insurance in our analysis, as a strong correlation is consistently reported between the two.<sup>8,11,13</sup> Additionally, Locker and Leake (1993) showed that dental insurance has an independent effect on the nature of dentist

visits, particularly in the low income population.<sup>23</sup> Dental care coverage increased dentist visits across all age groups but only in the low income population.<sup>23</sup> Thus, it is important in future research to further investigate the role of population coverage on the frequency of the dentist visits in the disadvantaged populations among different jurisdictions.

Finally, although objective health measures may be superior to self-perceived general/oral health, which also suffers from recall bias, they are costly, time consuming, and may not be feasible at the national level. In fact, Pitiphat et al. (2002) suggested that self-perceived oral health is reasonably valid, particularly in terms of the numbers of fillings, remaining teeth, root canal therapy, and removable and fixed prosthesis.<sup>24</sup> Thus, data used from the CCHS regarding self-perceived general/oral health are arguably reasonably valid estimates to be used in our analysis.

## CONCLUSION

Ultimately, our study provides support for the presence of the “inverse care law” at national and provincial/territorial levels. There exists more variability in the extent of the “inverse care law” in dental care among jurisdictions for children and seniors compared to adults. This appears to be related to the variability in provincially/territorially legislated dental care programs targeted towards children and seniors and in public dental care expenditure in different jurisdictions. Thus, it is important to further investigate the government’s role in reducing financial barriers, thereby improving access to and utilization of dental care in Canada.

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## RÉSUMÉ

**OBJECTIFS :** Comparer les visites chez le médecin et chez le dentiste à l’échelle nationale et à l’échelle provinciale/territoriale et évaluer de la même façon l’ampleur de la « loi inverse des soins » dans les soins dentaires selon différents groupes d’âge.

**MÉTHODE :** Nous avons utilisé les données publiquement disponibles de l’Enquête sur la santé dans les collectivités canadiennes de 2007 à 2008 pour étudier les visites chez le médecin et chez le dentiste au cours des 12 mois antérieurs par rapport à la santé générale et à la santé buccodentaire autoperçues, à l’aide de statistiques descriptives et d’une analyse de régression logistique binaire, après avoir apporté des ajustements pour tenir compte des effets de l’âge, du sexe, de l’instruction, du revenu et du nombre de médecins ou dentistes par habitant. Cette analyse a été effectuée pour tous les participants et stratifiée par groupe d’âge : enfants (12–17 ans), adultes (18–64 ans) et aînés (65 ans et plus).

**RÉSULTATS :** À l’échelle nationale et à l’échelle provinciale/territoriale, il semble que la « loi inverse des soins » joue encore dans les soins dentaires, mais pas dans les soins médicaux. Plus précisément, comparativement aux personnes dont la santé générale ou la santé buccodentaire est excellente, les personnes en mauvaise santé générale étaient 2,71 fois (intervalle de confiance de 95 % [IC] : 2,70–2,72) plus susceptibles d’aller chez le médecin, et les personnes en mauvaise santé buccodentaire étaient 2,16 fois (IC de 95 % : 2,16–2,17) moins susceptibles d’aller chez le dentiste. Les analyses stratifiées selon l’âge indiquent une plus grande variabilité dans l’ampleur de la « loi inverse des soins » chez les enfants et les aînés que chez les adultes.

**CONCLUSIONS :** La « loi inverse des soins » dans les soins dentaires existe à la fois à l’échelle nationale et à l’échelle provinciale/territoriale dans différents groupes d’âge. Il est donc important d’évaluer le rôle du gouvernement pour améliorer l’accès et le recours aux soins dentaires au Canada.

**MOTS CLÉS :** services de santé buccodentaire; services de santé; utilisation des soins de santé; santé buccodentaire