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Inequalities and Dental Care Deserts: Socio-Economic Determinants and Professional Representations

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Abstract

La santé buccodentaire n’est pas un objet d’étude courant des sciences sociales en France. Elle est par ailleurs rarement mise en lien avec la désertification médicale.

Cet article s’appuie sur une partie des données issues du projet de recherche “L’autre désertification médicale, Déterminants socio-économiques et freins à l’accès aux soins buccodentaires” (DentalDesMed), conduit en 2022 en réponse à l'appel “Inégalités sociales et santé buccodentaire” de la Fondation Croix-Rouge française.

La recherche DentalDesMed interroge les représentations et pratiques des professionnels intervenant dans le champ de la santé buccodentaire. Elle vise à dépasser le paradigme des représentations sociales de la santé et des maladies focalisé sur les comportements et les croyances des patients, et à mieux prendre en compte les déterminants contextuels comme l’organisation des soins, les actions des professions médicales et paramédicales, les politiques économiques et sociales ou l’aménagement du territoire.

L’article décrit à partir des représentations et pratiques de professionnels de la santé orale les obstacles à l’accès aux soins buccodentaires en France.

Mots clés : santé, inégalités, médecine, discriminations, dents

Summary

Oral health is not a common subject of study in the social sciences in France. It is also rarely linked to medical deserts.

This article draws on some of the data from the research project “L'autre désertification médicale, Déterminants socio-économiques et freins à l'accès aux soins buccodentaires” (DentalDesMed), conducted in 2022 in response to the French Red Cross Foundation's call for “Social inequalities and oral health”.

DentalDesMed research examines the representations and practices of professionals working in the field of oral health. It aims to go beyond the paradigm of social representations of health and disease, focusing on patients' behaviours and beliefs, and to take better account of contextual determinants such as the organisation of care, the actions of the medical and paramedical professions, economic and social policies and regional planning.

Based on the representations and practices of oral health professionals, this article describes the obstacles to access to oral health care in France.

Keywords: health, inequality, medicine, discrimination, teeth

Inequalities and Dental Care Deserts: Socio-Economic Determinants and Professional Representations

Introduction

Medical deserts have become a prominent indicator of inequalities in healthcare access in France. The criteria describing this phenomenon have gradually evolved and broadened to reflect its multidimensional complexity, incorporating healthcare workforce density, general practitioner activity, proximity to primary, emergency and specialised care providers, pharmacy availability, service provision, and healthcare utilisation patterns. Studies have investigated potential solutions, emphasising health system reforms intended to improve access to primary care (Hassenteufel, Naiditch, & Schweyer, 2020; Hassenteufel et al., 2020; Bourgueil, 2010). Although medical deserts are generally addressed as a public health concern, this framing often overlooks specialities facing acute challenges, notably oral health, where disparities in access remain pronounced.

Unequal access to oral health services can be attributed, in part, to the marginal role of dentistry in the public health sector and the prevalence of private practice. In 2021, there were 43,422 dentists active in mainland France[1], with over 90% operating in the private sector and 43.7% charging fees above standard rates. Dental care funding is covered 40.3% by L’Assurance Maladie, the French national health insurance system, 44.7% by private health insurers, with the remaining 14.9% borne by households. There are significant disparities in the geographic distribution of dentists, with pronounced variations both between and within regions. Assessing oral health inequalities requires examining both regional dentist distribution and the socio-economic profile of populations living in identified dental care deserts.

Dental care deserts disproportionately affect rural and peri-urban areas, where the most vulnerable populations — older people, low-income or economically inactive individuals and social benefit recipients — are concentrated. Oral health is therefore a strong social marker, carrying a stigma, as reflected in the pejorative use of “toothless” to describe economically disadvantaged populations. This expression highlights social origin differences in both oral health status and access to dental care. Research consistently shows that children from disadvantaged backgrounds, such as those of farmers, workers or economically inactive parents, as well as those attending schools in rural or priority education areas, have a higher prevalence of dental caries. Similarly, individuals in higher professional and managerial occupations visit dentists more regularly than those in lower-skilled occupational groups, reflecting structural inequalities in access to dental care.

[1]National Observatory of Health Professionals Demography (ONDPS) website, https://sante.gouv.fr/IMG/pdf/ondps_nov_2021_rapport_la_demographie_des_chirurgiens-dentistes_etat_des_lieux_et_perspectives_web.pdf

A series of articles published in *The Lancet* (Peres, Macpherson, Weyant, Daly, Venturelli, Mathur et al., 2019) emphasised that oral health has long been marginalised compared with traditional healthcare and public health policies, despite its central role in essential human functions and personal identity. This observation is especially relevant in the context of French public policies on oral health. For example, during the first COVID-19 lockdown, dental consultations were suspended, and emergency dental care was restricted to strictly defined cases. There is, however, a well-established link between oral health and overall health. Dental diseases, including caries, periodontal diseases and oral cancers, are among the most common conditions globally, affecting nearly one in two people. The impact of these frequently underestimated conditions includes severe pain, reduced quality of life, difficulty eating and social isolation. Periodontal disorders are further associated with elevated risks of cardiovascular disease, diabetes, respiratory infections and rheumatoid arthritis.

Despite ongoing health system reforms in France aimed at reducing inequalities and improving patient care, oral health remains largely underprioritised. A more coherent integration of the various health dimensions is therefore essential to elucidate the mechanisms underlying the emergence of inequalities in access to care, especially in oral health.

Oral health has largely been neglected in French social science research, and available epidemiological data remain limited and often outdated. Existing research, mostly authored by dental professionals (Marchandot, 2014; Akodjenou Hvostoff, 2017; Pegon-Machat, Jourdan, & Tubert-Jeannin, 2018; Frédéric, 2020), typically explores individuals’ attitudes towards oral health, dental hygiene and the challenges of prevention and access to dental services. These analyses often adopt a patient-centred approach, aiming to better understand socio-economic characteristics, lifestyle habits and health behaviours. However, the central hypothesis of the DentalDesMed study posits that individual-level factors are insufficient to account for inequalities in access to dental care. Current reforms of the health system, which are redefining the welfare state by reorganising care delivery, funding and the involvement of multiple stakeholders, underscore the need to examine the social determinants of health more closely.

These determinants encompass both the health system, including its legal and social dimensions regarding the right to care, and the role of institutional actors overseeing territorial planning and healthcare organisation. Private organisations, such as the Red Cross and Signal, also play a key role by implementing practical measures to promote oral health. At the same time, it is important to consider the broader context of these issues, including their political, legislative, economic, demographic, socio-cultural and scientific aspects. *DentalDesMed* research adopts a comprehensive approach, shifting the focus from patients to healthcare professionals and medico-social stakeholders involved, either directly or indirectly, in addressing the medico-social challenges of oral health. It examines professional representations and practices in oral health and aims to understand how these practices potentially contribute to inequalities in access to care. This research, therefore, examines how the institutional contexts in which professionals operate contribute to persistent inequalities and which practices could alleviate them.

Methodology

The project was based on interviews with professionals in the sector to collect insights from a diverse group of individuals with varied experiences. The aim was to capture multiple perspectives on the challenges in oral health and potential strategies to improve access to dental care. Participants were selected as field experts based on their expertise and direct experience. The twelve (12) professionals included two private general practitioners (2), five (5) dentists (both private and hospital-based), two social workers (2), two Red Cross team leaders (2), and one (1) Red Cross nurse.

The interviews explored participants’ professional trajectories, roles and motivations for working in this specific field. Subsequent discussions examined the profiles of the individuals they support, the challenges encountered in dental care delivery and the social, economic, and logistical obstacles faced by patients. Participants were also asked about barriers to interprofessional collaboration and the organisational dimensions of the healthcare system, while reflecting on potential strategies to improve access to care. The questions were designed to encourage in-depth reflection, enabling participants not only to share their expertise but also to critically examine their own practices and formulate hypotheses regarding the underlying causes of the observed difficulties.

The interviews were conducted either in person or by telephone, recorded with participants’ consent, and then transcribed using the Otranscribe tool. Data analysis followed an inductive approach, identifying recurrent themes from the interviews, and was complemented by a documentary review. The documentary analysis encompassed Red Cross activity reports, legal documents, and studies from the Directorate for Research, Studies, Evaluation and Statistics (DREES), including those of the National Observatory on the Demography of Health Professions (ONDPS) and the Council of Dentists (ONCD). This review supplemented the interview findings by providing additional contextual and institutional data.

Findings

The findings reveal multiple obstacles to dental care access, several of which are rooted in the structural organisation of the care system. Oral health in France is unique within the healthcare sector, notably owing to the presence of two professions practising in the same field: dentists and stomatologists, the latter being extremely scarce. The two professions belong to separate professional organisations, namely the Council of Dentists (ONCD) and the Medical Council (CNOM), and they also differ in their practice modalities. Dentists mainly operate in private practices, whereas stomatologists are typically employed in hospital dentistry departments, with a minority practising privately in private hospitals. The division of professional practice fosters a perceived, often artificial, contrast between a profit-oriented approach among the former and a public service ethos among the latter.

Hospital dentistry departments — affiliated with dental faculties in the case of the largest institutions — play a central role in the training of dentists. Dental students also contribute substantially to the functioning of dental emergency departments, as noted by a hospital practitioner:

> “In our department, externs play a very active role, unlike in a medical department where they are primarily observers. This is because dental studies are

> shorter, and proportionally fewer students are interns. Consequently, a substantial proportion of clinical activity is carried out by fourth-, fifth-, and sixth-year students."

Access and Regional Inequalities

The problem of dental deserts is exacerbated by an ageing workforce and the retirement of practitioners. In certain local authorities, waiting times for treatment can be as long as six months, resulting in patients routinely turning to public hospitals, especially in emergencies. These inequalities affect all population groups, although they are particularly pronounced for individuals facing socioeconomic precarity or living in rural areas:

> "Since COVID, a growing number of patients have been travelling long distances because our service is their only option. Two weeks ago, I treated a teenager who had travelled from Aubuisson, almost a two-hour drive from Clermont."

Overcrowding in dental emergency departments is common, with demand largely driven by acute presentations resulting from the late identification of oral health problems.

Inadequate Integration into the Care Continuum

Although oral health is formally part of primary care, it remains poorly integrated into the care continuum established in France by the 2003 Health Insurance Act. General practitioners generally lack specific expertise in oral health and rarely seek further training in this area. This shortcoming in care coordination limits the provision of comprehensive, holistic patient support. As one practitioner notes, the preventive dimension of oral health is frequently overlooked:

> "Oral disease is too often overlooked as a chronic condition. It has the same risk factors as other chronic illnesses, including diabetes and cardiovascular disorders. Prevention relies on addressing common risk factors."

In nursing homes (EHPADs), oral care is often neglected due to the belief that patients can or should manage their own oral hygiene. According to one care assistant:

> "Often, caregivers do not examine the entire mouth. They look at the front, but not at the back teeth."

Financial Barriers

The cost of dental care remains a major barrier to access, particularly for socioeconomically disadvantaged groups. A substantial portion of dental care is only partially covered by the French national health insurance system, and many procedures are either not reimbursed or are subject to unrestricted fees. Populations most at risk, such as people without access to social benefits, face additional difficulties due to complex administrative procedures, as one practitioner explains:

> "Administrative processes are especially onerous for exiled individuals, especially as they add to the already complex residency-related processes."

Beneficiaries of complementary health coverage (CSS) for low-income individuals frequently experience discrimination, as certain healthcare providers refuse to treat them:

> “When a patient arrives and speaks with an accent, and mentions having CMU, I can tell you the answer is no.”

Local Initiatives and Their Limitations

Local initiatives, such as mobile dental units in rural areas, have shown some effectiveness, but their long-term sustainability is limited by a lack of staff. Innovative solutions, including telemedicine and the training of oral health mediators, are also being explored, although they continue to face institutional and professional resistance. For example, volunteer initiatives by retired dentists were blocked by the departmental Dental Council (ODCD) on the grounds of unfair competition:

> “We believe that the most appropriate way to support this project is to act as facilitators by providing the mobile unit, a driver and the necessary equipment. However, responsibility for dental care, sterilisation and patient management remains with the hospital.”

Representations and Their Social Implications

Perceptions of dental care continue to be shaped by significant mistrust and stigma associated with pain or past experiences of medical mistreatment. Such perceptions contribute to odontophobia, which affects 10%–15% of the population and further limit equal access to care. Demand for dental services is often driven more by cosmetic expectations than by health needs.

These observations point to contradictions in oral health provision in France, where public involvement is insufficient to address the shortcomings of a system largely centred on private care.

Discussion

Oral health in France reveals several paradoxes. Although health and the human body are widely studied in the social sciences, oral health and dentistry remain underinvestigated. In France, the state plays a significant role in healthcare, regulating medical and paramedical professions through funding of training, workforce regulation and the spatial allocation of professionals. A compromise, based on the “French corporatist idiom” (Sewell, 1983), ensures professional groups practical, social, and technical legitimacy, exclusive control over their activities, and autonomy that safeguards private practice and, in some cases, free pricing. In return, the state relies on their expertise to implement health policies in both hospitals and urban healthcare settings. Nevertheless, this investigation did not explore the representations of dentists, their professional organisations, aside from the Council of Dentists (ONCD), their grievances or professional advocacy, except in relation to negotiations with the French national health insurance system regarding the adjustment of certain fees. A historical examination of the dental profession may shed light on their preference for private practice and their unique

trajectory within France's healthcare system. Examining the integration of dentistry into public hospitals, notably during the formation of university hospital centres in 1958, would also provide valuable insight. How were the jurisdictions of the various subgroups determined, and in what ways did these definitions shape the division of labour between hospital dentists and their counterparts in private practice? The scheduled phase-out of stomatologists also warrants investigation: is it a consequence of the harmonisation of qualifications within the European Union, or does it indicate the emergence of a profession distinct from other medical specialities? Addressing these issues is crucial to gaining a full understanding of the present state of oral health in France.

The *DentalDesMed* programme sought to examine the representations and practices of healthcare professionals in the field of oral health. While certain stakeholders, except for dentists, describe oral health as a "public health priority", they paradoxically tend to maintain a symbolic detachment from it. The mouth occupies a distinct and often private role, which can be explained by enduring cultural associations between bodily phenomena such as sounds, odours and ailments and a sense of shame or discomfort. Oral healthcare has also historically been commodified, evolving into a standard consumer product. This commodification is apparent in the widespread availability of self-service oral care products, such as whitening kits and tartar-control items. The expense of dental care in private clinics has led to the emergence of a cross-border market, increasingly facilitated through the Internet. Key commercial players are engaged in initiatives promoting oral health: the National Union of Oral Health Professionals (UFSBD), for example, works with companies like MGC Prévention, Mars Wrigley and Phillips. These elements, positioned within the framework of "health capitalism" (Batifoulier, 2014; Batifoulier & Da Silva, 2022), remain poorly investigated and raise questions about corporate intentions and the mechanisms driving collaborations between commercial enterprises and nonprofit entities in a sector ostensibly managed by public authorities.

Individual approaches to and representations of dental care are often shaped by distrust of dentists and are usually associated with pain or, occasionally, medical mistreatment. Dental phobia, or odontophobia, affects 10%–15% of the population and is a recognised disorder that can be treated medically. Dental care is rarely requested for health reasons, but rather to conform with aesthetic standards (e.g., white, straight teeth) that signify social acceptance and status. Failing to comply with these norms can lead to social scrutiny. Addressing oral health inequalities through access to care provides a framework for documenting life trajectories and elucidating the construction of stigmas associated with dental treatment. Economic deprivation is a key cause of care avoidance, though it does not fully explain the totality of observed inequalities. They are also influenced by other determinants, including material living conditions, socioeconomic precarity and social isolation (notably among people with no fixed abode), digital illiteracy in a context of largely online appointment systems, and the distance to transport infrastructure, which limits access to follow-up appointments. Consequently, dental diseases have come to be regarded as "diseases of poverty".

An additional paradox lies in the lack of coordination between initiatives intended to enhance access to dental services. No integrated programme or collective health literacy currently exists to allow stakeholders, including patients, to share a common understanding of oral health and enhance the care continuum. Similarly, the impact of local initiatives designed to address dental care deserts and enhance access to care remains uncertain. The interviews

conducted demonstrate a notable capacity for reflection among professionals, which could be utilised by project developers and policymakers. Projects must be tailored to target groups: an initiative in a care home will affect outcomes differently from one aimed at people with no fixed abode, and preventive strategies should be adapted to children, adults experiencing loss of autonomy and socioeconomically disadvantaged groups.

Conclusion

Analysis of dental care deserts in France reveals deep inequalities in access to oral health services, largely shaped by the organisation of the healthcare system, the segmentation of professional practices and socio-economic inequalities. Geographical disparities, particularly in rural and peri-urban areas, heighten difficulties in accessing quality care, a situation worsened by the social and economic precarity of certain populations. Identified structural, financial and cultural barriers underscore how oral health remains isolated within broader public health initiatives, despite its clear connections to general health outcomes.

Representations of dental care among professionals and patients, particularly odontophobia and the commodification of services, reinforce existing inequalities and impede the delivery of optimal care. Limited integration of oral health into the general care continuum, together with unequal access to training and preventive programmes, hampers the impact of public health policies in dentistry.

Local initiatives and innovative solutions, though hampered by institutional resistance, illustrate the commitment of certain stakeholders to reducing these inequalities. Initiatives such as mobile care units and telemedicine provide only partial solutions, and their continuity remains uncertain without enhanced coordination among the different stakeholders within the healthcare system.

It is crucial to reorganise dental care in France to improve access and foster integration into the general health system. A more inclusive and coordinated approach, incorporating social determinants of health, could improve efforts to combat inequalities in access to oral health care and respond to the growing needs of the most vulnerable people. The findings of this study call for reflection on the future of oral health in France, particularly in the context of current health system reforms, in order to guarantee equitable and quality care for all.

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