What explains socioeconomic inequality in dental caries among school children in west of Iran? A Blinder-Oaxaca decomposition

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Abstract

BACKGROUND AND AIM: Dental caries among children is considered as a main public health concern in most of the countries over world and its prevalence is widespread in low-income countries like Iran. The aim of this study was to measure socioeconomic-related inequality in poor decayed, missing, filled (DMF) index and identify the determinants among school children in west of Iran.

METHODS: A survey was carried out among school children aged 12 to 15 years in Kermanshah City, Iran, in 2018, to collect data on dental caries, demographic characteristics, and socioeconomic status (SES). A total of 1457 students were included in the analysis of this cross-sectional study. Logistic regression analysis examined the association of poor DMF index with the socioeconomic and behavioral determinants. We used the relative index of inequality (RII) and the slope index of inequality (SII) to measure wealth-related inequality in poor DMF index. The Blinder-Oaxaca (BO) decomposition technique was also employed to identify the factors of the difference in poor DMF prevalence between the poorest and the richest groups.

RESULTS: The overall and age-adjusted prevalence of poor DMF index was 36.92\% [95\% confidence interval (CI): 34.48-39.43] and 37.32\% (95\% CI: 34.64-40.08), respectively. The SII and RII indicated that the poor DMF index was mainly prevalent among poorer children. The absolute gap (%) in the incidence of poor DMF index between children from the richest and the poorest groups was 22.50. The BO results showed that the most important factors affecting the difference in poor DMF index were mother’s education (18.23\%), being girl (6.12\%), and visit to dentist (2.93\%).

CONCLUSION: There was a significant pro-rich distribution of poor DMF index among school children in the capital of Kermanshah Province. Interventions aimed at increasing mother’s education and good oral health behavior among poorer children could contribute to decline of the difference in poor DMF index between the highest and the lowest SES groups.

KEYWORDS: Inequality; Dental Caries; Adult Children; Socioeconomic Factors; Iran


Oral health is a fundamental component of overall health, wellbeing, and quality of life.\textsuperscript{1} One of the most important oral health indicators is decayed, missing, filled teeth (DMFT) index, which is used as the oral health assessment criteria in most epidemiological studies.\textsuperscript{2,3} DMFT is the mean number of DMF teeth in a group of individuals and its total score ranges from 0 to 28 or 32.\textsuperscript{4,5} Dental caries among children is a major public health problem.\textsuperscript{1} According to

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the World Health Organization (WHO), about 60%-90% of school children worldwide have dental caries and this disease is more prevalent in low- and middle-income countries. The number of children who suffer from pain and discomfort and miss school lessons is increasing in developing countries. It is estimated that more than 51 million school hours are lost each year worldwide due to dental-related illness. Dental health indices could be hallmarks of socioeconomic conditions and oral health inequalities exist within and between different population groups through the life course and are associated with socioeconomic status (SES).

Previous studies have shown that a significant inequality in oral health outcomes exists across social groups. Oral health inequalities are caused by a broad range of interacting biological, socio-behavioral, psychosocial, societal, and political factors that create ‘the conditions in which people are born, grow, live, work, and age’ - the so-called social determinants of health. SES is highly associated with oral health condition. Although the effect of SES on oral health has been extensively examined, there is little information on socioeconomic-related inequalities in oral health and its main determinants among school children in Iran. Then, the aim of this study was to quantify the extent of socioeconomic inequality in poor DMFT index and identify the main factors that explain this inequality among 12-15-year-old students in Kermanshah City, western Iran.

**Methods**

A cross-sectional survey was conducted from October to November 2018 in Kermanshah City, the capital of Kermanshah Province. The study population was school children aged 12 to 15 years. The multistage sampling technique was employed to choose the sample population. We first divided the Kermanshah City into five areas of central, western, eastern, southern, and northern to select our sample. Secondly, at least one girl’s school and one boy’s school were randomly selected from each area. Finally, all school children in each school were included using census method. If the number of sample in a school was not sufficient, more than one school was included in the study. Finally, 14 schools (8 girl’s schools and 6 boy’s schools) were selected for data collection in the survey. Data were collected by public health students (bachelor of science) who were trained by the authors. A total of 1577 school children were selected to complete the questionnaire. Due to missing data, 120 observations were excluded which resulted in a final sample of 1457 school children for statistical analysis.

The questionnaire had two parts: sociodemographic part and status of dental caries and dental care utilization. The first part consisted of questions about age, gender of child, sex of household head, father’s education, mother’s education, and household durable assets (house, car, computer/laptop, access to internet, freezer, dishwasher, TV, and etc.). The second part included questions on regular brushing, visiting dentist in every six months, and number of DMFT of the school children.

The prevalence of poor DMFT index (as a binary variable) was used as an outcome variable of this study; we followed Moradi et al. to construct this variable. We first gave more weight to missed teeth (multiplied by 2), less weight to filled teeth (multiplied by 0.5), and counted decayed teeth multiplied by 1. Then a cut-off point was used to define poor and good oral health condition and the cut-off point was set at the mean of DMF score. The subjects with score above cut-off point were considered as poor DMF index and the rest of subjects with score less than mean of DMF score were defined as good DMF index. The principal component analysis (PCA) was used to develop the wealth index. The items included in the wealth index are having car, color TV, computer/laptop, cell phone, freezer,
dishwasher, microwave, vacuum cleaner, motorcycle, and bicycle, number of rooms per capita, type of house ownership, and house size per square meter. We divided households into five categories (quintiles) from the poorest to the richest based on wealth score. We used age of children, gender of children, gender of household head, mother’s education, father’s education, regular brushing, regular dentist visit per 6 months, and wealth index as the determinants of prevalence of poor DMF index in the study.

The slope index of inequality (SII) and relative index of inequality (RII) were used to measure socioeconomic-related inequality in poor DMF score. We also employed multivariate logistic regression model to examine the association between poor DMF score and independent variables. Finally, the Blinder-Oaxaca (BO) decomposition approach was used to quantify the contribution of each dependent variable. We used the following formulas to estimate the gap between the poorest and the richest in poor DMF: (in these equations P is the poorest and R is the richest)

\[ y_i = \begin{cases} 
\beta^P x_i + \varepsilon^P_i & \text{if } P \\
\beta^R x_i + \varepsilon^R_i & \text{if } R
\end{cases} \]

The gap between the mean outcomes, \( y^P \) and \( y^R \), is equal to:

\[ y^R - y^P = \Delta x \beta^R + \Delta \beta x^R \]

Where

\[ \Delta x = x^R - x^P \text{ and } \Delta \beta = \beta^R - \beta^P \]

\[ y^R - y^P = \Delta x \beta^R + \Delta \beta x^P \]

It can be written as follow:

\[ y^R - y^P = \Delta x \beta^P + \Delta \beta x^P + \Delta x \Delta \beta = E + C + CE \]

Where \( x^R \) and \( x^P \) are the average independent variables for the richest (Rich group in above formula) and the poorest (Poor group in above formula). The mean difference in the outcome variable (in this study, poor DMF score) was separated into three components. E (explained part) is the gap in the average value of the explanatory variables, C shows the difference in the mean \( \beta \) (coefficient/unexplained part), and CE is the multiplication between the difference in mean of independent variables and their coefficients. If there are only two explanatory variables, the following formula can be used:

\[ y^R - y^P = (\beta^R - \beta^P) + (\beta^R x^R - \beta^P x^P) + (\beta^R x^R - \beta^P x^P) = W_0 + W_1 + W_2 \]

Where \( y \) is the poor DMF, \( W_0 \) shows the differences in the constant, \( W_1 \) is the difference between \( x_1 \) and \( \beta_1 \), and \( W_2 \) is the difference between \( x_2 \) and \( \beta_2 \). We used the non-linear BO decomposition method to decompose the factors explaining the gap in poor DMF score between the poorest and the wealthiest children. All statistical analyses were performed in Stata software (version 14.1, Stata Corporation, College Station, TX, USA) and P-value less than 0.05 was used as the level of significance.

The Ethics Committee of the Deputy of Research of Kermanshah University of Medical Sciences reviewed and approved the study protocol (KUMS.REC.1397.436).

### Results

Table 1 presents the descriptive statistics of the sample. The number of girls was 945 and the remaining 512 were boys. The mean age of the children was 13.15 years with a standard deviation (SD) of 0.99. The overall and age-adjusted prevalence of poor DMF index was estimated to be 36.92% [95% confidence interval (CI): 34.48-39.43] and 37.32% (95% CI: 34.64-40.08) for the entire sample, respectively. The crude prevalence of poor DMF score between boys and girls was different; it was 42.75% (95% CI: 39.62-45.93) for girls and 26.17% (95% CI: 22.53-30.16) for boys.

Table 2 reports the results of multivariate logistic regression analysis on the determinants of poor DMF index. The results showed an inverse association between prevalence of poor DMF score and wealth status.

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http://johoe.kmu.ac.ir, 06 July
For example, the likelihood of poor DMF score was 63% [odds ratio (OR): 0.37, 95% CI: 0.26-0.53] among the children belonging to the richest wealth quintile compared to the children from the lowest quintile. The prevalence of poor DMF score was more than two times (OR: 2.10, 95% CI: 1.93-2.31) when we adjusted for age and sex. The RII was 2.33 (95% CI: 1.72-3.16) when we adjusted for age and 1.93 (95% CI: 1.40-2.68) when we adjusted for age and sex. This suggests that the poor DMF score was more prevalent among poorer children.

Table 3 presents the results of the BO decomposition. The prevalence of poor DMF score for the poorest and the richest wealth groups was 49.65% (95% CI: 43.92-55.39) and 27.14% (95% CI: 22.09-32.20), respectively. The gap between the lowest and the highest wealth groups was 22.50% (95% CI: 22.09-27.83). About 97.3% of this gap between them was because of the differences in the distribution of independents variables (i.e., sex of child, mother’s education, brushing, and visit to dentist) of the analysis. The difference in sex of child, mother’s education, and brushing were found as the main determinants of gap in the prevalence of poor DMF score between the better-off and the worse-off groups. 39.7% of this difference between two groups was related to the differences in the coefficient of variables (response) or other factors that were not considered in our study. Additionally, -37.05% of the gap between two groups was attributed to the interactions (Table 3).
Table 2. Association between independent variables and poor decayed, missing, filled (DMF) index (logistic regression model)

<table>
<thead>
<tr>
<th>Explanatory variables</th>
<th>OR Crude (95% CI)</th>
<th>P</th>
<th>OR Adjusted (95% CI)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>1.10 (0.99-1.22)</td>
<td>0.071</td>
<td>1.07 (0.95-1.20)</td>
<td>0.214</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.00 (Reference)</td>
<td></td>
<td>1.00 (Reference)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>2.10 (0.29-0.43)</td>
<td>0.001</td>
<td>1.66 (1.28-2.16)</td>
<td>0.001</td>
</tr>
<tr>
<td>Mother education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Academic degree</td>
<td>1.00 (Reference)</td>
<td></td>
<td>1.00 (Reference)</td>
<td></td>
</tr>
<tr>
<td>Uneducated or elementary</td>
<td>2.27 (1.83-2.83)</td>
<td>0.001</td>
<td>1.55 (1.17-2.04)</td>
<td>0.002</td>
</tr>
<tr>
<td>Father education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Academic degree</td>
<td>1.00 (Reference)</td>
<td></td>
<td>1.00 (Reference)</td>
<td></td>
</tr>
<tr>
<td>Uneducated or elementary</td>
<td>2.08 (1.66-2.60)</td>
<td>0.001</td>
<td>1.26 (0.95-1.67)</td>
<td>0.108</td>
</tr>
<tr>
<td>Gender of household head</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.00 (Reference)</td>
<td></td>
<td>1.00 (Reference)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1.16 (0.74-1.91)</td>
<td>0.558</td>
<td>1.10 (0.65-1.87)</td>
<td>0.700</td>
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<tr>
<td>Wealth index of households</td>
<td></td>
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<td></td>
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<tr>
<td>Poorest</td>
<td>1.00 (Reference)</td>
<td></td>
<td>1.00 (Reference)</td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>0.76 (0.55-1.05)</td>
<td>0.105</td>
<td>0.83 (0.59-1.18)</td>
<td>0.314</td>
</tr>
<tr>
<td>Middle</td>
<td>0.62 (0.44-0.85)</td>
<td>0.004</td>
<td>0.78 (0.55-1.12)</td>
<td>0.188</td>
</tr>
<tr>
<td>Rich</td>
<td>0.37 (0.26-0.52)</td>
<td>0.001</td>
<td>0.52 (0.35-0.76)</td>
<td>0.001</td>
</tr>
<tr>
<td>Richest</td>
<td>0.37 (0.26-0.53)</td>
<td>0.001</td>
<td>0.21 (0.41-0.96)</td>
<td>0.033</td>
</tr>
<tr>
<td>Regular brushing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1.00 (Reference)</td>
<td></td>
<td>1.00 (Reference)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1.50 (1.13-2.00)</td>
<td>0.005</td>
<td>1.54 (0.46-0.77)</td>
<td>0.006</td>
</tr>
<tr>
<td>Visiting dentist per six months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1.00 (Reference)</td>
<td></td>
<td>1.00 (Reference)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1.27 (0.48-0.62)</td>
<td>0.001</td>
<td>1.66 (1.28-2.16)</td>
<td>0.001</td>
</tr>
</tbody>
</table>

OR: Odds ratio; CI: Confidence interval

Figure 1 summarizes the share of each factor to the difference in prevalence of poor DMF score between the lowest and the highest SES groups due to distribution (explained part) and coefficient effects (unexplained part). The most important factors affecting the difference in poor DMF score were mother’s education (18.23%), sex of children (6.12%), and visit to dentist (2.93%).

Discussion

Although the occurrence of dental caries decreased in developed countries over the past 30 years, its prevalence remains high in children living in developing countries.3 This study examined SES inequality in oral health among school children in Kermanshah. In our study, the overall prevalence of poor DMF index was 36.92% among school children in Kermanshah which was higher than the results found in other studies.17,18 The logistic regression results indicated that being girl, low education of mother, irregular brushing, and no visit to dentist per six months were associated with poor DMF index. Our results suggested that poor DMF index was more prevalent among poorer children and the incidence of this indicator across SES groups was different. It was also different between boys and girls and the prevalence of poor DMF between girls (42.75%) was more than boys (26.17%).
The inequality indices indicated that there was a pro-rich inequality in poor DMF index among the study samples. The RII showed that the prevalence of poor DMF index among the poorest children was 2.33 times higher than the richest children. The SII revealed that the prevalence of poor DMF index among the poorest children was 0.29 higher than the wealthiest ones. In other words, the prevalence of poor DMF index for the poorest was more than the richest and the gap difference between the poorest and the richest wealth status groups was 22.50%. It could be explained by this fact that oral health care are very expensive and patients face high out-of-pocket payments to use these services. Negative statistical association between wealth status and DMF index are well established in studies conducted in developing and developed countries. For example, SES was the important factor affecting teeth caries and had an inverse relation with the DMF index in Iran. Furthermore, Hosseinpoor et al., Pothidee et al. in Thailand, Martins et al. in Brazil, and Moradi et al. in Kurdistan Province, west of Iran found that there was a positive association between poor oral health and lower SES.

We found that poor DMF index was about two times more prevalent among girls than boys. This is contrasting to the finding of a previous study from Kurdistan, which reported poor DMF index more prevalent.
among boys. Nonetheless, similar studies found that boys had a healthier oral health. Our results suggest a significant association between prevalence of poor DMF index and irregular brushing. Subjects who brushed their teeth regularly had better oral health status, while those who did not brush their teeth had poorer DMF index. The possible explanation is that children with a high caries rate could have lack of fluoride. These findings are similar to studies conducted by Shirzaiy and Mohageri. The current study indicated that poor DMF index was associated with lower education level and the poor DMF index among school children who had a parent with academic degree was almost 2.27 times less than children who had a parent without academic degree.

Our analysis recommends that poor DMF index among school children who visited dentists in every six months was less than those who did not have regular visits to dentists. The reason behind this finding could be that children from poorer families could not visit dentist regularly and among this children, visits were mostly problem- or symptom-driven. On the other hand, children from richer families, visited dentist for preventive purposes. These findings follow the results reported by Mouradian et al.

Our study had few limitations and any interpretation of the results should be based on these limitations. Firstly, this was a cross-sectional study which did not allow to establish any causal relationship between prevalence of poor DMF index and its determinants. Secondly, the current study was undertaken in one city which could preclude the generalization of our results to Kermanshah Province and Iran. Further studies from different regions of Iran are required to make the results more robust and generalizable.

Conclusion
Monitoring socioeconomic inequality in DMF index is a major step for designing and implementing of effective interventions to reduce inequalities in oral health. The findings of this study suggested a high prevalence of poor DMF among school children from poorer households. Despite of having higher dental disease burden, these populations often have limited or no access to dental care. Inadequate access to essential health services may be one of the main drivers affecting social inequalities in oral health among school-going children. A holistic approach is needed to decrease these inequalities and oral health education for children should involve the poorest children and their parents.

Conflict of Interests
Authors have no conflict of interest.

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