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Health insurance and socioeconomic disparities in childhood caries: impact on prevalence, treatment, and recurrence in a Swiss private practice

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Keywords

Survey, French-speaking dentists, general anesthesia, caries, socio-economic status

Abstract

Social inequalities are strongly associated with disparities in oral health, particularly in the development of childhood caries. This 4-year cohort study analyzed the impact of socioeconomic status (SES)- defined on the basis of the health insurance type- on the prevalence, treatment, and recurrence of dental caries in children. A total of 198 children (21 with social insurance, 177 with private insurance) were included. Caries prevalence at baseline was significantly higher in children with social insurance (95 % with >4 caries) compared to those with private insurance (29 % with >4 caries). No children with social insurance were caries-free, whereas 35 % of those with private insurance were caries-free. Pulpotomy and extraction needs were higher in the socially insured group, with 43 % requiring pulpotomies and 62 % requiring extractions, compared to 12 % and 10 %, respectively, in the privately insured group. General anesthesia (GA) use was more frequent in the socially insured group (72 % vs. 13 %), especially among younger children (100 % of 2-4 years old vs. 25 % in the private insurance group). In contrast, conventional anesthesia was more frequently used in the private insurance group (31 % vs. 14 %). Recall appointments were less frequent in the socially insured group, with 24% having no follow-up, compared to 12 % in the privately insured group. Caries recurrence was higher in the socially insured group (62 % had >3 new carious lesions) compared to the privately insured group, where 38 % of children had no new caries at follow-up. These findings highlight the impact of SES on caries burden, treatment modalities, and the importance of preventive measures for disadvantaged groups.

Introduction

Early childhood caries (ECC) is one of the most severe forms of dental caries affecting disproportionately disadvantaged populations (1). Although several promising methods for ECC prevention have been identified, the Global Burden of Disease Study of 2017 reports that more than 530 million children globally have dental caries of the primary teeth. Specifically, ECC is more widespread in developing countries due to limited access to dental care, low awareness of oral hygiene, and higher consumption of sugary processed foods. ECC prevalence can range from 50 % to 90 % in some low- and middle-income countries (2). The low socioeconomic status of the parents has been described as the most important risk factor. It seems that early childhood caries is significantly influenced by income, maternal education, maternal age at childbirth, child's age, and birth order. Behavioral factors like breastfeeding and bottle-feeding habits, timing of solid food introduction, and dental hygiene practices also influence the appearance of ECC (3). Finally, environmental factors, such as the consumption of food "deserts" mainly by low-income families who have limited access to affordable, nutritious food, augment the incidence of ECC. What's more, access to dental care remains inequitable in many countries, as lack of access to health insurance leaves poor children and families underserved.

Contrary to several countries, Switzerland is a country with a high level of obligatory health care coverage. Health care insurance has been compulsory for all residents since the Federal Health Insurance Act in 1996 (4). The country has a completely private system of dental practices. Compulsory basic insurance (LAMal) only covers dental treatment in certain very specific cases when "the dental problems caused must be through no fault of the insured person." The LAMal specifically refers to a serious and non-avoidable disease of the masticatory system, another serious disease or its sequelae, as well as injuries to the masticatory system caused by an accident, if they are not covered by accident insurance. All other treatments are paid for by the patient or by optional insurance, commonly known as supplementary insurance. Supplementary insurance (CA) covers those costs not covered by the basic insurance, such as annual checkups, dental hygiene, cavity treatment, root canal treatment, etc. Where financial resources are lacking dental treatment may be covered by social assistance. In this respect, a recent study conducted in Switzerland over a period of three decades reported that "even in countries like Switzerland, with a low prevalence of caries experience, untreated carious lesions remain a problem as the number remained constant over this period" (5).

Health insurance type is frequently utilized as a proxy for socioeconomic status (SES) in medical research. Public insurance programs are often associated with lower-income populations, while private insurance is typically linked to higher-income groups. However, it's important to note that using insurance status as a surrogate for SES has limitations. For instance, a study found that insurance status misclassified SES in up to 23 % of pediatric patients when compared to caregivers' education and income levels. Despite these limitations, insurance status remains a commonly used and accessible indicator of SES in clinical settings (6).

Dental treatment of young children is complicated due to agerelated cognitive and communication limitations. In some cases, general anesthesia (GA) is used to facilitate complex or extensive dental treatment in children. In several countries, the demand for pediatric dental GA is constantly increasing (7). Furthermore, many children who undergo dental GA continue to develop new carious lesions and symptoms; some of whom required further treatment under GA once again (8).

This study aims to assess the prevalence of new carious lesions post-treatment in a cohort of young children attending a private dental practice in Romandy. Additionally, it seeks to investigate whether socioeconomic status, as inferred from the type of health insurance (private versus social), serves as an indicator for the development of new caries.

Materials and methods

Sample and data collection

This is a 4-year retrospective cohort study completed in a private dental practice between 2017 and 2021. The protocol was approved by the Cantonal Ethics Committee for Research on Human Beings of the Canton of Vaud (CER-VD), Switzerland, (N° 2025-00950). First, dental charts were reviewed for 1739 patients between 2-10 years old who had comprehensive dental care by four dental practitioners. All practitioners had at least 5 years' experience in dentistry. To be included in the study, patients had to attend a recall appointment with the dentist or the hygienist. Patients with severe medical conditions as well as those with developmental dental defects such as hypomineralized second primary molar (HSPM), molar incisor hypomineralisation (MIH), amelogenesis imperfecta (AI) or dentinogenesis imperfecta (DI) were not included. Children seen by specialists for endodontic care, surgery, orthodontics or accident cases were also excluded from the study.

Clinical and /or radiographic examinations were carried out by the dentists present at the dental practice during the 4-year period. After the initial selection, out of the pool of 1739 patients, 1113 patients were excluded from the study because of various reasons: 456 patients were the wrong age, 198 did not come between 2017 and 2021, 37 were followed up for orthodontic reasons, 53 patients attended the clinic following an accident, 9 patients had severe pathologies, 11 were referred to specialists, 25 patients were excluded for lack of information and 324 patients were excluded because they had missed the follow-up visit. Of the remaining 626 patients, 198 were eligible for the study. Briefly, the study was based on two questionnaires that were part of the standard treatment protocol during the initial consultation for all clinic patients. One questionnaire was completed by the children's parents, while the other was filled out by the dental practitioner. The first questionnaire addressed to the parents included mainly the dietary and oral hygiene habits. The other questionnaire was completed by the dentist who provided information on the number of caries the participants presented at first appointment, the type of treatment (conventional versus GA), the frequency of follow-up visits and the occurrence of new caries at follow-up.

Statistical analysis

We utilized descriptive statistics, including frequency and percentages, to analyze the various items related to the study.

Results

Study Population and Caries Prevalence

The final sample consisted of 198 children. As shown in Table 1, more than two-thirds of the population had at least one carious lesion at baseline, and over 60% developed at least one new carious lesion at follow-up. To further analyze the data, we categorized the children into two groups based on their health insurance status. Among the entire cohort, 21 children were covered by social insurance (Group 1), while 177 had private insurance (Group 2).

Table 1. Characteristics of the study population, distribution of dental caries at baseline and recurrence of caries at follow-up.

	Whole cohort (n = 198)
Gender	
Male	103 (52 %)
Female	95 (48 %)
Age (years), mean	
2-4 years	59 (30 %)
5-7 years	109 (55 %)
8-10 years	30 (15 %)
Nationality	
Swiss	60 (30 %)
Foreign	138 (70 %)
Origin	
Central Europe	122 (61 %)
East Europe	35 (17.5 %)
North America	6 (4 %)
South America	11 (6 %)
Africa	9 (5 %)
Oceania	15 (7.5 %)
Educational level of the parents	
University	130 (65.6 %)
Secondary School	27 (13.6 %)
Primary School	38 (19 %)
Nb of children at baseline wirh	
No caries	62 (31.3 %)
1-3 caries	64 (32.3 %)
> 4 caries	72 (36.3 %)
Nb of children at follow-up with	
No caries	67 (33.8 %)
1 carious lesion	43 (21.7 %)
2-3 new caries	33 (16.6 %)
> 3 new caries	49 (24.7 %)
No data	6 (3 %)

Demographic Characteristics, Oral Hygiene, and Dietary Habits

Table 2 presents the demographic, oral hygiene, and dietary characteristics of the 2 groups of the participants. Gender and age distribution were balanced in both groups, with most children being between 5 and 7 years old.

Table 2. Characteristics of the study population and reported habits on oral health and eating habits (Group 1: social insurance; Group 2: private insurance).

	Group 1 (n = 21)	Group 2 (n = 177)
Gender		
Male	10 (48 %)	93 (52 %)
Female	11 (52 %)	84 (48 %)
Age (years), mean		
2-4 years	8 (38 %)	51 (29 %)
5-7 years	11 (52 %)	98 (55 %)
8-10 years	2 (10 %)	28 (16 %)
Nationality		
Swiss	2 (10 %)	58 (33 %)
Foreign	19 (90 %)	119 (67 %)
Origin		
Central Europe	3 (14 %)	119 (67 %)
East Europe	17 (81 %)	18 (10 %)
North America	0	6 (4 %)
South America	0	11 (6 %)
Africa	0	9 (5)
Oceania	1(5 %)	14 (8 %)
Educational level of the parents		
University	0	130 (73 %)
Secondary School	6 (29 %)	21 (12 %)
Primary School	15 (71 %)	23 (15 %)
Tooth brushing		
Once a day	15 (71 %)	6 (3 %)
Twice a day	5 (24 %)	79 (45 %)
> 2 times a day	1 (5 %)	92 (52 %)
Time for tooth brushing		
Always 3 min	5 (24 %)	86 (49 %)
Sometimes 3 min	10 (48 %)	60 (34 %)
Never 3 min	6 (28 %)	31 (17 %)
Flossing habits		
At least once a week	0	30 (17 %)
Sometimes	6 (28 %)	70 (40 %)
Never	15 (72 %)	77 (43 %)
McDonald's		
Once a month	13 (62 %)	124 (70 %)
More than once a month	1 (5 %)	5 (3 %)
Once a week	6 (28 %)	11 (6 %)
Never	1 (5 %)	37 (21 %)
Type of Juice		
Capri-Sun	11 (52 %)	38 (21 %)
Classic	6 (28 %)	51 (29 %)
Bio	2 (10 %)	42 (24 %)
Home made	2 (10 %)	36 (20 %)
Never	0	10 (6 %)
Brush after eating something		
Always	0	25 (14 %)
Sometimes	8 (38 %)	102 (58 %)
Never	13 (62 %)	50 (28 %)
Magic Wardrobe		
Yes	18 (86 %)	104 (59 %)
No	1 (5 %)	21 (12 %)
Certainly	2 (9 %)	52 (29 %)

However, significant differences emerged in nationality and maternal education. In Group 1, 90 % of children were of foreign origin, primarily from Eastern Europe, whereas in Group 2, the majority of foreign parents were from Central Europe. Maternal education levels also varied notably: 73 % of mothers in Group 2 had a university degree, while none in Group 1 had higher education. Instead, 71 % of mothers in Group 1 had only completed primary education.

Oral hygiene habits showed striking disparities. While 97 % of children in Group 2 brushed their teeth at least twice daily, only 24 % in Group 1 followed the same routine. Dietary habits also differed significantly. Children in Group 1 were more likely to consume Capri-Sun, whereas bio and homemade juices were more commonly consumed in Group 2. Additionally, fast-food consumption was higher in Group 1, with many children eating fast food at least once per week. Brushing after meals was also less frequent in Group 1, where 62 % of children reported never brushing after eating.

Caries Distribution and Treatment Needs

As presented in Table 3, caries prevalence was significantly higher in Group 1. A total of 95 % of children in this group had more than four carious lesions at baseline, compared to only 29 % in Group 2.

Table 3. Distribution of dental caries and treatment needs at baseline in the two groups (Group1: social insurance; Group 2: private insurance).

	No caries	1-3 caries	> 4 caries
Group 1 (n=21)	0 (0 %)	1 (5 %)	20 (95 %)
Group 2 (n=177)	62 (35 %)	63 (36 %)	52 (29 %)
	No pulpotomy	**1-3 pulpotomy**	**> 4 pulpotomy**
Group 1 (n=21)	12 (57 %)	5 (24 %)	4 (19 %)
Group 2 (n=177)	156 (88 %)	17 (10 %)	4 (2 %)
	No extractions	**1-3 extractions**	**> 4 extractions**
Group 1 (n=21)	8 (38 %)	6 (29 %)	7 (33 %)
Group 2 (n=177)	159 (90 %)	14 (8 %)	4 (2 %)

The need for extensive dental treatment was also greater in Group 1. Pulpotomies were required in 43 % of children in Group 1, compared to just 12 % in Group 2. Similarly, extractions were necessary for 62 % of children in Group 1, whereas only 10 % in Group 2 required this treatment.

Age Distribution and Anesthesia Use

Tables 4 and 5 illustrate the type of anesthesia used for treatment across both groups and in relation to age.

Table 4. Type of anesthesia used in each group (Group1: social insurance; Group 2: private insurance).

	Group 1 (n = 21)	Group 2 (n = 177)
No treatment	0 %	32 %
Conventional Anesthesia	3 (14 %)	56 (31 %)
MEOPA	3 (14 %)	32 (18 %)
GA	15 (72 %)	23 (13 %)
Treatment without Anesthesia	0 %	(4) 2 %

*GA: general anesthesia, **MEOPA**: "Mélange Equimolaire d'Oxygène et de Protoxyde d'Azote", which translates to Equimolar Mixture of Oxygen and Nitrous Oxide.

Table 5. Age distribution (in years) in the two groups according to the type of anesthesia (Group 1: social insurance; Group 2: private insurance).

Anesthesia type	Group	2-4 years	5-7 years	8-10 years
GA	1	8 (100 %)	7 (64 %)	0 (0 %)
	2	13 (25 %)	9 (9 %)	1 (9 %)
MEOPA	1	0 (0 %)	3 (27 %)	0 (0 %)
	2	11 (22 %)	18 (20 %)	3 (20 %)
Conventional Anesthesia	1	0 (0 %)	1 (9 %)	2 (100 %)
	2	7 (16 %)	36 (38 %)	13 (38 %)
No need for treatment	1	0 (0 %)	0 (0 %)	0 (0 %)
	2	19 (35 %)	33 (31 %)	10 (31 %)

*GA: general anesthesia, **MEOPA**: "Mélange Equimolaire d'Oxygène et de Protoxyde d'Azote", which translates to Equimolar Mixture of Oxygen and Nitrous Oxide.

General anesthesia (GA) was administered to all children aged 2–4 years in Group 1 and to 25 % of those in Group 2. The use of MEOPA (nitrous oxide sedation) was limited, with 27 % of children aged 5–7 years in Group 1 receiving it, compared to 18 % of children across all age groups in Group 2. Conventional local anesthesia was more frequently used in Group 2 than in Group 1 (31 % vs. 14 %).

Recall Frequency and Caries Recurrence

Table 6 presents data on dental recall frequency and caries recurrence. Recall appointments were more frequent in Group 2 compared to Group 1. In Group 1, attendance was evenly distributed across different recall frequencies; however, 24 % of children had no follow-up visits or returned for recalls only after more than two years. In contrast, the majority of children in Group 2 (55 %) attended yearly recall visits, and only 12 % had no follow-up or a recall visit after more than two years.

Table 6. Frequency of recalls and recurrence of new caries after treatment in the two groups (Group1: social insurance; Group 2: private insurance).

Category	Subcategory	Group 1 (n = 21)	Group 2 (n = 177)
Frequency of dental recalls	Never (or > 2y)	5 (24 %)	22 (12 %)
	Once a year	6 (28 %)	97 (55 %)
	Twice a year	5 (24 %)	49 (28 %)
	> 2 times a year	5 (24 %)	9 (5 %)
Recurrence of new caries at recall	1 carious lesion	3 (14 %)	40 (22 %)
	2-3 new caries	2 (10 %)	31 (18 %)
	> 3 new caries	13 (62 %)	36 (20 %)
	0 new caries	0 (0 %)	67 (38 %)
	Lost	3 (14 %)	3 (2 %)

Caries recurrence was significantly higher in Group 1. At follow-up, 62 % of children in this group developed more than three new carious lesions, and none were caries-free. Conversely, in Group 2, 38 % of children remained caries-free, although 20 % had more than three new lesions.

Socioeconomic Disparities in Oral Health

Overall, children in Group 1—representing a socioeconomically disadvantaged population based on social insurance status and maternal education—had a significantly higher burden of caries, required more extensive dental treatment, and experienced a higher recurrence of new caries. This group also exhibited poorer oral hygiene, lower maternal education levels, and less frequent recall appointments compared to Group 2.

In contrast, children in Group 2 demonstrated better oral health outcomes, more frequent use of preventive care, and lower rates of caries recurrence. These disparities underscore the profound impact of socioeconomic factors on oral health and highlight the urgent need for targeted interventions to promote oral health equity.

Discussion

The present study highlights the influence of socioeconomic status (SES) on the development, treatment, and recurrence of carious lesions in children. The findings reveal that children from socioeconomically disadvantaged backgrounds (Group 1) exhibit a significantly higher burden of caries, more extensive treatment needs, and increased rates of caries relapse compared to children from higher socioeconomic backgrounds (Group 2). These results are consistent with previous studies, which have established that children from lower SES backgrounds are at greater risk for early childhood caries (ECC) due to factors such as limited access to preventive dental care, poorer oral hygiene habits, and lower parental educational attainment (9, 10).

Caries prevalence at baseline was markedly higher in Group 1, where 95 % of children presented with more than four carious lesions, compared to only 29 % in Group 2. In contrast, 35 % of children in Group 2 were caries-free, while none of the children in Group 1 achieved this status. These results are consistent with a systematic review of 41 studies found that lower educational level, income, and occupation are significantly associated with an increased risk of dental caries (11). Similar conclusions were drawn in a longitudinal study by LOPEZ et al. (2023), which reported that ECC prevalence and severity were significantly higher among children from marginalized communities, including those with culturally and linguistically diverse status, indigenous background, or residence in remote geographic areas (12). Furthermore, data from the 2017 National Health Survey in Spain revealed that children from immigrant families had a caries prevalence of 18.58 %, compared to 9.29 % in Spanish children (13).

Although the size of the groups in our study was unequal, we found that 71 % of the mothers in Group 1 had only completed primary education, while 73 % of mothers in Group 2 had a university education. Parental education, particularly maternal education, has been identified as a critical determinant of oral health outcomes in children. Children whose mothers had higher education were more likely to have better oral health outcomes, as higher parental education is associated with increased knowledge of oral hygiene practices, healthier dietary choices, and more frequent use of preventive dental care (9, 14).

General anesthesia (GA) was predominantly used in younger children from Group 1, with 100 % of 2–4-year-olds and 64 % of 5–7-year-olds requiring GA, compared to only 25 % and 9 %, respectively, in Group 2, reflecting a higher reliance on GA in socioeconomically disadvantaged groups. This aligns with findings from British children, where lower socioeconomic status, higher dental anxiety, and more extensive treatment needs were associated with increased use of GA for dental procedures (15).

Previous studies have shown that children adhering to regular recalls exhibit lower caries incidence and receive more preventive guidance on oral hygiene and dietary habits (16-18). The lack of follow-up in Group 1 likely contributed to higher rates of caries relapse, with 62 % of children developing more than three new lesions. Addressing socioeconomic barriers to recall visits could improve oral health equity, as suggested by evidence from school-based programs and community dental services (19).

One of the limitations of this study is the unequal group sizes, with 21 children in the social insurance group (Group 1) and 177 in the private insurance group (Group 2). This imbalance primarily results from the limited number of socially insured patients in the practice, compounded by a higher rate of lost follow-ups in this group. However, the distribution of patients in our study reflects the demographic composition of the practice's patient base and corresponds approximately to the proportion of individuals receiving social assistance in Switzerland. According to the Swiss Federal Statistical Office (OFS), 9.2 % of the Swiss population received means-tested social benefits in 2022, with this figure decreasing to 2.8 % in 2023. While these statistics encompass various forms of social assistance and are not specific to dental care, they provide relevant context for understanding the representation of socially insured patients in our study (20).

Additionally, the study includes a broad age range, covering children from 2 to 10 years old. This wide range reflects the natural variability in pediatric dental care needs and allows for a more comprehensive analysis of caries prevalence, treatment, and recurrence across different stages of dental development—from early primary dentition to late mixed dentition. However, we acknowledge that this diversity in age may introduce variability in oral hygiene habits, dietary behaviors, and treatment approaches, which could influence the outcomes. For example, younger children may require more frequent recall visits due to a higher risk of caries progression and behavioral challenges during treatment, whereas older children may have more established oral hygiene routines and greater compliance with preventive measures (21). While the inclusion of a wide age range strengthens the generalizability of the findings, it is also recognized as a potential confounding factor, and this limitation should be considered when interpreting the results.

The findings of this study highlight significant public health implications, particularly the need to reduce oral health disparities among socioeconomically disadvantaged children. Ensuring regular follow-up appointments is essential, as early detection and timely treatment can prevent caries relapse and reduce the need for invasive procedures. Public health initiatives should prioritize access to affordable dental care for low-income families and promote community-based oral health education to support preventive care and parental involvement.

Conclusions

Children from disadvantaged socioeconomic backgrounds face a higher burden of caries, more complex treatment needs, and increased risk of relapse. These findings underscore the importance of equity-focused public health measures aimed at improving access to early dental care, strengthening preventive strategies, and supporting parental education to reduce the disproportionate impact of caries on vulnerable populations.

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Zusammenfassung

Einleitung

Soziale Ungleichheiten stehen in engem Zusammenhang mit Unterschieden in der Mundgesundheit, insbesondere bei der Entwicklung von frühkindlicher Karies. In dieser vierjährigen Kohortenstudie wurde der Einfluss des sozioökonomischen Status (SES) auf die Prävalenz, die Behandlung und das Wiederauftreten von Karies bei Kindern analysiert.

Material und Methoden

Insgesamt wurden 198 Kinder (davon 21 mit sozialer Krankenversicherung und 177 mit privater Krankenversicherung) eingeschlossen.

Resultate

Die Kariesprävalenz zu Studienbeginn war bei Kindern mit sozialer Krankenversicherung signifikant höher (95 % mit >4 Karies) im Vergleich zu Kindern mit privater Krankenversicherung (29 % mit >4 Karies). Kein Kind mit sozialer Krankenversicherung war kariesfrei, während 35 % der Kinder mit privater Krankenversicherung kariesfrei waren.

Der Bedarf an Pulpotomien und Extraktionen war in der Gruppe mit sozialer Krankenversicherung höher: 43 % der Kinder benötigten Pulpotomien und 62 % benötigten Extraktionen, verglichen mit 12 % bzw. 10 % in der Gruppe mit privater Krankenversicherung. Der Einsatz von Allgemeinanästhesie (GA) war in der Gruppe mit sozialer Krankenversicherung häufiger (72 % vs. 13 %), insbesondere bei jüngeren Kindern (100 % der 2- bis 4-Jährigen vs. 25 % in der privaten Versicherungsgruppe). Im Gegensatz dazu wurde konventionelle Anästhesie häufiger in der privaten Versicherungsgruppe angewendet (31 % vs. 14 %).

Nachsorgetermine waren in der sozial versicherten Gruppe seltener: 24 % hatten keine Nachsorge, verglichen mit 12 % in der privat versicherten Gruppe. Das Wiederauftreten von Karies war in der sozial versicherten Gruppe höher (62 % hatten >3 neue kariöse Läsionen) im Vergleich zur privat versicherten Gruppe, wo 38 % der Kinder bei der Nachuntersuchung keine neue Karies aufwiesen.

Diskussion

Diese Ergebnisse verdeutlichen den Einfluss des sozioökonomischen Status auf die Kariesbelastung, die Behandlungsmodalitäten und die Bedeutung präventiver Maßnahmen für benachteiligte Gruppen.

Résumé

Introduction

Les inégalités sociales sont fortement corrélées aux disparités en matière de santé bucco-dentaire, en particulier dans le développement des caries précoces de l'enfant. Cette étude de cohorte, réalisée sur une période de quatre ans, a examiné l'impact du statut socio-économique (SES) sur la prévalence, la prise en charge et la récurrence des caries chez les enfants.

Matériels et méthodes

L'étude a inclus un total de 198 enfants, dont 21 bénéficiaient d'une assurance maladie sociale et 177 d'une assurance maladie privée.

Résultats

Au début de l'étude, la prévalence des caries était significativement plus élevée chez les enfants bénéficiant d'une assurance sociale (95 % avec plus de 4 caries) par rapport à ceux disposant d'une assurance privée (29 % avec plus de 4 caries). Aucun enfant assuré socialement n'était exempt de caries, tandis que 35 % des enfants ayant une assurance privée étaient indemnes de caries.

Les besoins en pulpotomies et en extractions dentaires étaient plus importants dans le groupe bénéficiant d'une assurance sociale : 43 % nécessitaient des pulpotomies et 62 % des extractions, contre respectivement 12 % et 10 % dans le groupe avec assurance privée. L'anesthésie générale (AG) était également plus souvent utilisée chez les enfants avec une assurance sociale (72 % contre 13 %), en particulier chez les plus jeunes (100 % des 2 à 4 ans contre 25 % dans le groupe privé). En revanche, l'anesthésie conventionnelle était plus fréquemment employée dans le groupe avec assurance privée (31 % contre 14 %).

Les consultations de suivi étaient moins fréquentes dans le groupe bénéficiant d'une assurance sociale : 24 % des enfants n'ont eu aucun suivi, contre 12 % dans le groupe avec assurance privée. De plus, la récurrence des caries était plus élevée chez les enfants bénéficiant d'une assurance sociale (62 % avaient plus de 3 nouvelles lésions carieuses) comparée au groupe avec assurance privée, où 38 % des enfants ne présentaient aucune nouvelle carie lors du suivi.

Discussion

Ces résultats illustrent l'impact du statut socio-économique sur la prévalence des caries, les choix thérapeutiques et la nécessité d'interventions préventives adaptées aux groupes socialement défavorisés.

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