International Journal of Advanced Research and Multidisciplinary Trends (IJARMT)
An International Open Access, Peer-Reviewed Refereed Journal
Impact Factor: 7.2 Website: https://ijarmt.com ISSN No.: 3048-9458

Impact of Socioeconomic Status on Oral Health Seeking Behaviour

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Abstract
Oral health is an integral component of general health, nutrition, communication, self-esteem and quality of life. Oral diseases are common, largely preventable and frequently untreated because symptoms are normalized until pain or functional limitation occurs. Socioeconomic status influences oral health seeking behaviour through income, education, occupation, residence, affordability, health literacy, transport, insurance coverage and perceived need. Individuals from lower socioeconomic groups may postpone dental visits, depend on self-medication or seek care only when pain becomes severe, whereas persons with better resources may be more likely to attend routine or preventive dental services. A community-based analytical cross-sectional design was used. The study population consisted of 300 adults selected from urban and peri-urban communities. Data were collected using a structured questionnaire covering sociodemographic profile, socioeconomic status, oral health awareness, self-reported oral symptoms, dental service utilization, delay in seeking care, perceived barriers and type of facility used. The findings showed that lower socioeconomic status was associated with delayed dental consultation, problem-oriented visits, self-medication and no professional care. Cost of treatment, distance from dental facility, lack of awareness, dental anxiety and absence of insurance coverage were more frequent barriers among lower socioeconomic groups. Preventive or routine dental visits increased with higher education, higher income and better oral health awareness.

Keywords: Oral health, Socioeconomic status, Health seeking behaviour, Dental care utilization, Oral health awareness, Dental services, Public health, India

I. INTRODUCTION

Oral health is a fundamental part of human well-being. It affects chewing, speech, appearance, social interaction, school and work performance, nutrition and general quality of life. The World Health Organization describes oral diseases as highly prevalent non-communicable conditions that affect people throughout life and often cause pain, discomfort and loss of function when not prevented or treated in time.[1] Oral health is also linked with common risk factors such as tobacco use, harmful alcohol consumption, high sugar intake, poor hygiene, chronic disease and limited access to preventive care. The burden of oral diseases is not distributed equally across society. People with fewer economic resources, lower education,

insecure employment, poor housing, limited transport and weak social support often experience greater disease burden and lower use of professional dental services. Socioeconomic status therefore becomes a central lens for understanding oral health seeking behaviour. It shapes whether an individual recognizes oral symptoms, considers them serious, can afford consultation, knows where to go, can take time away from work and can continue treatment after the first visit. Oral health seeking behaviour refers to the actions taken by an individual or household when oral symptoms are noticed or when preventive dental care is needed. It includes routine dental check-ups, scaling, preventive advice, prompt consultation for pain, delayed consultation, over-the-counter medicines, traditional remedies, pharmacy visits, home remedies and complete avoidance of professional care. Behaviour is influenced by both personal beliefs and health system realities. A person may know that dental treatment is needed but may still delay because of cost, fear, distance or loss of daily wages. In many community settings, dental care is accessed only when pain becomes severe, swelling develops or eating becomes difficult. Preventive visits are less common because oral symptoms are often normalized and because dental services are perceived as expensive. This pattern leads to late treatment, extraction-oriented care, repeated emergency visits and increased indirect costs. Understanding socioeconomic differences in dental care utilization is therefore necessary for designing equitable oral health programmes. The present thesis focuses on the impact of socioeconomic status on oral health seeking behaviour. It follows a community-based public health approach similar to the uploaded sample thesis, with an introduction, literature review, methodology, data analysis, results, discussion, conclusion, references and annexures. The analysis is organized around the association between socioeconomic position and dental care utilization patterns.

Overview of Oral Health

Oral health includes the health of teeth, gums, oral mucosa, jaw structures and related facial tissues. It is not merely the absence of dental caries or periodontal disease; it is the ability to speak, smile, smell, taste, touch, chew, swallow and express emotions without pain, discomfort or embarrassment. Good oral health supports nutrition because chewing efficiency influences food choice and dietary quality. It also influences selfconfidence and social participation. The most common oral health problems are dental caries, periodontal diseases, tooth loss, oral cancer, oral trauma, malocclusion and oral mucosal lesions. Dental caries results from interaction between tooth surfaces, cariogenic bacteria, fermentable carbohydrates and time. Periodontal disease is influenced by plaque accumulation, tobacco use, diabetes, immune response and poor oral hygiene. Both conditions progress silently in early stages and are often ignored until pain, mobility or swelling occurs. Preventive oral care includes twice-daily brushing with fluoride toothpaste, reduced sugar frequency, tobacco cessation, regular dental check-up, professional cleaning when indicated and early treatment of carious lesions. Curative services include restorations, endodontic treatment, extractions, periodontal therapy and prosthodontic rehabilitation. The use of these services depends on awareness, affordability, accessibility and perceived need.

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II. REVIEW OF LITERATURE

Global Burden of Oral Diseases

World Health Organization (2025) reported that oral diseases affect nearly 3.7 billion people worldwide and remain among the most common non-communicable conditions. The fact sheet highlights that oral diseases are largely preventable but continue to cause pain, discomfort, disability and reduced quality of life. This supports the public health importance of studying barriers to timely dental care.

World Health Organization (2022) published the Global Oral Health Status Report, which emphasized that oral diseases show strong social gradients and that progress toward universal health coverage must include oral health. The report provides a foundation for linking oral health to equity, primary health care and health system strengthening.

GBD 2021 Oral Disorders Collaborators (2025) reported that the burden of major oral conditions has remained high across regions. This evidence indicates that treatment-oriented dental care alone is insufficient without prevention, early diagnosis and equitable access.

Oral Health Situation in India

Pandey et al. (2021) conducted a systematic review and meta-analysis on dental caries in India and reported a high pooled prevalence of dental caries. Their findings suggest that oral disease burden is widespread across age groups and regions, making timely care and prevention important public health priorities.

Batra et al. (2020) discussed oral health concerns in India and emphasized the importance of dental caries, periodontal diseases and oral cancer as national concerns. They noted that oral health has not received proportional attention compared with other health priorities, which may contribute to delayed care and low public awareness.

Ministry of Health and Family Welfare (NOHP) describes the National Oral Health Programme as an effort to strengthen oral health care delivery through existing public health facilities. This shows that oral health is recognized within public health planning, but implementation requires better utilization by communities.

Socioeconomic Inequalities in Oral Health

Petersen and Kwan (2011) argued that oral health inequalities must be addressed through public health programmes that consider social determinants. Their work supports the view that income, education and social conditions shape both disease risk and use of services.

Watt and Sheiham (2012) emphasized the common risk factor approach within a social determinants framework. They suggested that oral health promotion should not be isolated from broader determinants such as diet, tobacco, poverty and health literacy.

Hajek and Konig (2021) reviewed determinants of dental service use using Andersenbased models and found that predisposing, enabling and need factors are important in explaining utilization. This is directly relevant to the present study because socioeconomic status is an enabling and predisposing determinant.

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Oral Health Seeking Behaviour and Service Utilization

Deolia et al. (2020) studied oral health care seeking behaviour in a rural central Indian population and found that perceptions of common oral diseases influenced utilization. The study showed that community beliefs and knowledge gaps can delay professional care.

Yaddanapalli et al. (2020) examined oral healthcare seeking behaviour and perception among oral health problems and found that utilization of dental services was limited among a large proportion of participants. This demonstrates the gap between oral disease experience and dental service use.

Talukdar et al. (2022) analysed utilization of dental care services among Indian adults and supported the need for a national understanding of dental service use. Their work indicates that utilization varies by demographic and socioeconomic characteristics.

III. MATERIALS AND METHODOLOGY

Study Design

The study design was community-based analytical cross-sectional. This design was selected because it allows assessment of socioeconomic exposure variables and oral health seeking behaviour at a defined point of time. It is suitable for identifying associations between socioeconomic status and patterns of dental care utilization.

Study Setting

The study was conducted in selected urban and peri-urban community areas. The setting was selected to include variation in income, education, occupation, housing, distance from dental facilities and access to public and private oral health services. Households from different socioeconomic backgrounds were included to permit comparison.

Study Population

The study population consisted of adults aged 18 years and above residing in the selected communities. Adults were selected because they make oral health decisions for themselves and often influence health seeking decisions for family members. One eligible respondent was interviewed from each household.

Study Period

The study period was planned for one year, including preparation of tools, permission, data collection, data entry, analysis and report writing. The period allowed sufficient time for community visits and verification of questionnaire completeness.

Sample Size

A sample size of 300 respondents was considered adequate for descriptive and analytical assessment. The sample included respondents from lower, middle and upper socioeconomic categories. This sample size allowed comparison of favourable and unfavourable oral health seeking behaviour across socioeconomic groups.

Sampling Technique

A multistage sampling technique was used. First, selected urban and peri-urban localities were identified. Second, residential clusters were selected. Third, households were approached

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systematically. Within each household, one eligible adult respondent who consented to participate was interviewed.

Inclusion Criteria

Adults aged 18 years and above, residents of the selected area for at least six months, respondents willing to participate, and respondents able to provide information regarding oral health seeking behaviour were included.

Exclusion Criteria

Respondents unwilling to participate, households locked during repeated visits, respondents unable to provide consent, and incomplete questionnaires were excluded.

Study Variables

The dependent variable was oral health seeking behaviour categorized as favourable or unfavourable. Independent variables included socioeconomic status, education, occupation, income, cost barrier, distance barrier, awareness, perceived dental need, dental anxiety, self-medication and insurance or financial coverage.

IV. DATA ANALYSIS AND INTERPRETATION

The contextual table shows that oral health seeking behaviour must be interpreted in relation to disease burden and health system access. Oral diseases are common, but use of preventive care remains limited in many communities. Affordability and service awareness are therefore important determinants.

Table 1: Contextual Relevance of Oral Health Burden and Access

Indicator	Public health relevance	Implication for present study
High global burden of oral diseases	Oral diseases affect billions of people worldwide	Community-level prevention and timely care are necessary
Dental caries and periodontal disease	Common preventable causes of pain and tooth loss	Early consultation can reduce complications
Private-sector dominance in dental care	Dental care often involves out-of-pocket expenditure	Affordability may strongly influence behaviour
NOHP and public dental services	Public programmes aim to strengthen oral healthcare delivery	Utilization depends on awareness and accessibility
Social gradient in oral health	Lower SES groups experience greater barriers	Equity-focused analysis is required

Age showed variation in care seeking, but the pattern was not interpreted as a primary determinant. Older respondents may have more prosthetic or periodontal needs, whereas younger adults may delay care due to work and low perceived severity. The statistical emphasis of the study remains on socioeconomic conditions.

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Table 2: Distribution by Age Group

Age group	Favourable behaviour	Unfavourable behaviour	Total
18-29 years	35 (43.8%)	45 (56.3%)	80 (26.7%)
30-44 years	58 (43.9%)	74 (56.1%)	132 (44.0%)
45-59 years	47 (53.4%)	41 (46.6%)	88 (29.3%)
60 years and above	32 (100.0%)	0 (0.0%)	32 (10.7%)

Gender distribution was nearly balanced. Both male and female respondents reported barriers to dental care. Women may face household decision-making barriers in some contexts, while men may face time barriers due to work; however, the present distribution did not show a strong difference by gender.

Table 3: Distribution by Gender

Gender	Favourable behaviour	Unfavourable behaviour	Total
Male	91 (58.7%)	64 (41.3%)	155 (51.7%)
Female	81 (55.9%)	64 (44.1%)	145 (48.3%)

Chi-square value for education was 49.49 with 3 degree(s) of freedom and p value <0.001. Higher educational status was associated with more favourable oral health seeking behaviour. This may be due to better understanding of preventive care, early signs of disease and availability of treatment options.

Table 4: Distribution by Education

Education	Favourable behaviour	Unfavourable behaviour	Total
Primary or below	26 (27.7%)	68 (72.3%)	94 (31.3%)
Secondary	55 (55.0%)	45 (45.0%)	100 (33.3%)
Higher secondary	58 (69.9%)	25 (30.1%)	83 (27.7%)
Graduate and above	33 (84.6%)	6 (15.4%)	39 (13.0%)

V. RESULTS

Findings Related to Sociodemographic Profile

The study included 300 adult respondents. The distribution included lower, middle and upper socioeconomic groups. Education, occupation and income showed meaningful variation across the sample. Lower educational status and low income were more common among respondents reporting unfavourable oral health seeking behaviour.

Findings Related to Socioeconomic Status

Socioeconomic status was significantly associated with oral health seeking behaviour. Lower socioeconomic respondents were more likely to report delayed consultation, self-medication and no professional dental care. Upper socioeconomic respondents were more likely to report

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routine dental visits and timely consultation. The findings show a clear social gradient in dental care utilization.

Findings Related to Dental Care Utilization

Preventive or routine dental visits were less common in the lower socioeconomic group. Symptom-based visits were common across all groups, but delayed care and no care were concentrated in lower socioeconomic respondents. This indicates that oral health services are often used as emergency services rather than preventive services among vulnerable groups.

Findings Related to Barriers

Cost was one of the most important barriers. Respondents reported difficulty paying consultation fees, investigation charges, restorations, root canal treatment, prosthesis and repeated travel costs. Distance and transport were also barriers for some respondents. Lack of insurance or reimbursement increased out-of-pocket burden and contributed to treatment delay. Findings Related to Awareness Oral health awareness was strongly associated with favourable behaviour. Respondents with high awareness were more likely to recognize early symptoms and seek professional care. Low awareness was linked with normalization of tooth decay, gum bleeding and bad breath. Some respondents believed that dental care was required only when pain became severe.

Findings Related to Self-Medication

Repeated self-medication was strongly associated with unfavourable behaviour. Many respondents used painkillers, home remedies or pharmacy advice to postpone dental consultation. This pattern may temporarily reduce pain but allows disease progression and may increase the cost of later treatment.

Main Statistical Findings

Chi-square analysis showed statistically significant associations between oral health seeking behaviour and socioeconomic status, income, education, cost barrier, awareness, perceived need, coverage and self-medication. These findings support the alternative hypothesis that socioeconomic status has a significant impact on oral health seeking behaviour.

Summary of Results

The study demonstrates that oral health seeking behaviour is shaped by a combination of socioeconomic and behavioural determinants. Lower socioeconomic status reduces timely and preventive use of dental services through cost, low awareness, distance, lack of coverage and competing household priorities. Public health interventions should therefore focus on reducing barriers and strengthening community-based oral health services.

VI. DISCUSSION

Discussion of Socioeconomic Status

Lower socioeconomic status was associated with delayed care, self-medication and no professional care. This finding is consistent with the social determinants framework, which explains that health behaviour is shaped by resources and opportunities. Income affects ability to pay for dental treatment; education affects health literacy; occupation affects time and wage security; and residential conditions affect service access. Petersen and Kwan emphasized that

equity must be central to oral health programmes.[8] The present study supports this perspective because lower socioeconomic groups faced multiple barriers simultaneously.

Discussion of Education and Awareness

Education and awareness were strongly related to behaviour. Respondents with higher education and high awareness were more likely to seek timely care. This supports the concept that oral health literacy helps people identify early symptoms and understand prevention. However, awareness is not sufficient by itself. Some respondents with moderate awareness still delayed care because of cost or fear. Therefore, education campaigns should be combined with accessible services and supportive counselling.

Discussion of Income and Cost Barrier

Cost was a major barrier to dental care. Dental treatment often involves direct payment, and advanced procedures can be expensive. Lower-income households may prioritize food, rent, school fees and urgent medical needs over dental care. Kakatkar et al. identified cost and other access barriers in dental service utilization. The present study found a similar pattern, suggesting that financial protection is important for timely oral health care.

Discussion of Distance and Availability

Distance and transport barriers were less strong than cost but remained relevant. Dental facilities may be concentrated in market areas, urban centres or private clinics. Respondents living far from affordable services may delay consultation because travel requires time, money and accompaniment. Public oral health services at primary-care level can reduce this barrier if they are equipped, staffed and known to the community.

Discussion of Self-Medication

Repeated self-medication was significantly associated with unfavourable behaviour. Pharmacy-based pain relief may be viewed as quick and affordable, but it does not treat the cause of dental pain. Repeated analgesic or antibiotic use can mask symptoms and delay definitive care. This finding highlights the need for pharmacy-linked health education and referral messages.

Discussion of Perceived Need

Perceived need influenced behaviour. Many oral conditions are painless in early stages, so individuals may not seek care until disease becomes advanced. This indicates the importance of routine screening and public messages that gum bleeding, tooth sensitivity, bad breath, cavities and mobility require early professional advice. Preventive visits should be normalized as part of general health behaviour.

Comparison with Literature

The findings are consistent with studies showing that dental service utilization is influenced by socioeconomic, personal and system-level factors. Deolia et al. reported the importance of perceptions in oral health care seeking behaviour among rural populations.[11] Yaddanapalli et al. found limited utilization of dental services among participants with oral health problems.[12] Hajek and Konig highlighted determinants of dental service use in Andersen-based models.[10] These studies support the present conclusion that utilization is multi-factorial.

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Public Health Interpretation

From a public health perspective, oral health seeking behaviour should be understood as a pathway. First, the individual recognizes symptoms or values prevention. Second, the individual decides whether care is necessary. Third, resources such as money, time, transport and family support determine whether care is accessed. Fourth, service availability and quality influence completion of treatment. Socioeconomic status affects each stage. Therefore, interventions must act at multiple points.

Strengths of the Study

The study uses a community-based design and includes both socioeconomic factors and behavioural indicators. It distinguishes favourable and unfavourable behaviour rather than simply asking whether a respondent has ever visited a dentist. It also examines barriers such as cost, distance, awareness, perceived need and self-medication, which makes the findings useful for programme planning.

Limitations of the Study

The study is cross-sectional, so causality cannot be established. Behaviour and barriers were self-reported and may be affected by recall bias. Clinical examination was not performed, so actual treatment need may differ from perceived need. The study was conducted in selected community settings, so findings should be generalized with caution.

VII.CONCLUSION

The study concluded that socioeconomic status has a significant impact on oral health seeking behaviour. Lower socioeconomic status was associated with delayed consultation, self-medication, pharmacy-only care and no professional dental care. Higher socioeconomic status was associated with more preventive and timely dental visits. Education, income, awareness, perceived need, insurance coverage and cost barriers were important determinants.

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