

Aims of the study

These were the aims of the FDCS during its first phase of funding:

1. Describe the long-term changes in specific oral health outcomes.
2. Describe the demand for specific dental services over time.
3. Determine the predisposing, enabling, and oral health correlates of demand for specific dental services.
4. Determine the behavioral (especially dental care use behavior), attitudinal and socioeconomic correlates of longitudinal oral health outcomes.

In 1999, we successfully competed for funding to extend the FDCS to 72 months of data gathering. Building upon knowledge gained from the first four years of the FDCS, we refined and extended our aims to test 8 new hypotheses:

1. To test the hypothesis that self-reported dimensions of oral health are more predictive of incident dental care use during a 6-year period in diverse populations than measures determined by direct clinical examination.
2. To test the hypothesis that certain self-reported dimensions of oral health (self-reported oral disease & tissue damage, oral pain & discomfort, oral disadvantage due to disease & tissue damage, oral disadvantage due to pain, and perceived need for dental care) are more predictive of incident dental care use during a 6-year period in diverse populations than other self-reported dimensions (oral functional limitation, oral disadvantage due to functional limitation, self-rated oral health, satisfaction with oral health, and satisfaction with chewing ability).
3. To test the hypothesis that dental care use during a 6-year period in diverse populations is more strongly associated with recovery (i.e., moving from a state of decrement in oral health into a state of improved oral health) than it is with prevention of onset.
4. To test the hypothesis that dental care use during a 6-year period in diverse populations is more strongly associated with recovery when certain oral health dimensions are the outcomes of interest (self-reported oral disease & tissue damage, oral pain & discomfort, oral disadvantage due to disease & tissue damage, oral disadvantage due to pain, and perceived need for dental care) than when other dimensions are the outcomes of interest (oral functional limitation, oral disadvantage due to function limitation, self-rated oral health, satisfaction with oral health, and satisfaction with chewing ability).
5. To test the hypothesis that “acute care” dental services are the most strongly associated with recovery due to dental care, followed by “secondary care” services (restorative services, non-pain-related surgical services, and rehabilitative services), which in turn are more strongly associated with recovery than “primary care” dental services.
6. To test the hypothesis that “problem-oriented dental attenders” are most likely to seek dental care in response to change in dimensions of oral health that are the most strongly associated with recovery due to dental care (self-reported oral disease & tissue damage, oral pain & discomfort, oral disadvantage due to disease & tissue damage, oral disadvantage due to pain, and perceived need for dental care).
7. To test the hypothesis that “problem-oriented dental attenders” are most likely to seek specific dental services (“acute care” and “secondary care” services) that are the most strongly associated with recovery due to dental care than those services that are not (“primary care” services).
8. To test the hypothesis that “regular dental attendance” during a 6-year period is associated with improvement and/or maintenance in clinical measures of oral disease and in each self-reported dimension of oral health (oral disease & tissue damage, oral pain & discomfort, oral functional limitation, oral disadvantage, and self-rated oral health), while “problem-oriented dental attendance” is associated with decline in these measures in diverse patient populations.