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Accessibility to oral health care for people on social assistance: a survey of social service providers from Public Welfare Centers in Flanders

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Objectives: The goals of the present study were as follows: (i) to explore the characteristics of the Flemish Public Centers for Social Welfare (PCSW) concerning oral health care; (ii) to explore possible barriers experienced by people on social assistance and oral health-care providers; and (iii) to explore the accessibility of general and oral health care for people on social assistance. **Methods:** The data of this cross-sectional study were obtained by a survey of social service providers working in a PCSW. For this purpose, a new questionnaire was developed. The survey was validated by means of a pilot study. All 306 PCSWs in Flanders were invited to participate in this survey, of which 192 (62.7%) responded. **Results:** The findings demonstrate that for people on social assistance, financial limitations and low prioritisation of oral health are the main barriers to good oral health care. The study reveals that such individuals experience greater financial barriers and poorer access to a dentist than to a general medical practitioner. The study also reveals that dentists report financial concerns and administrative burdens as the main barriers in treating this subgroup. The responses of PCSWs demonstrate that local dentists are reluctant to treat this subgroup. **Conclusion:** Additional efforts are needed to improve the accessibility of oral health care for people on social assistance. Recommended improvements at the organisational level could improve increased education to target the population on the importance of oral health care. Administrative burden and financial concerns of the providers also need to be addressed to decrease their reluctance to work with those on social assistance.

Key words: *Oral health care for people on social assistance, oral health care for asylum seekers, oral health care for undocumented immigrants*

INTRODUCTION

The link between socio-economic status and oral health has been confirmed by various studies in the past[1]. Despite the higher treatment need of low-income subgroups, research reveals that such groups are less likely to seek care for oral health[2,3]. This income-related inequity is even more pronounced in the case of preventive oral health care[4]. In Belgium, only 20% of people on social assistance received preventive oral health care in 2010–2011, as opposed to 40% in more affluent groups[5]. People who require social assistance experience multiple barriers to access of oral health care, of which financial limitations are the most important to overcome[6]. Other possible obstacles include anxiety, transportation problems, other priorities and language restrictions[7,8]. People on social assistance can experience low self-esteem and low employability because of their declining dental appearance[9]. Organisations such as the World Health Organization have stressed the importance of tackling this social injustice[10].

The Belgian health-care system

In Belgium the dentist is the only professional providing chairside preventive and curative oral health care. There are currently no dental hygienists or therapists, although an organised training programme was introduced in 2016. Dental care is almost exclusively

delivered in private practice with <5% delivered in public clinics, usually hospital based[11]. Most general medical practitioners (GPs) and dentists in Belgium work within the state health insurance plan (so-called 'convention'). Belgian citizens, once registered with the health-care system, are free to select their health-care providers. The patients pay the dentist based on a fee-for-service model.

Health insurance is mandatory for all Belgian citizens and is represented by different 'sick-funds'. Working adults have compulsory deductions from their income to contribute to the National Health Insurance and can pay an additional small fee to the sick-fund of their choice for additional health-care coverage. People on social assistance are also covered by these sick-funds but they can be exempt from their contributions. The sick-funds provide partial reimbursement of the dental costs for the patient. Restorative care, limited preventive care, minor oral surgery and removable dentures are reimbursed at 75% for adults and 100% for children. There is a very limited reimbursement for oral implants and orthodontics, and no reimbursement for indirect restorations[12,13].

Approaches to reduce financial barriers

The Belgian health-care system currently provides some protective measures to reduce the financial barrier to health care. One measure is that people with lower incomes can request a status of increased reimbursement, which lowers their out-of-pocket fees. Increased reimbursement is automatically assigned to each individual receiving social benefits (living wage).

Another measure is the application of a third-party payment. In this system, the patient does not have to advance the whole dental fee. The insurance agency pays the health-care provider directly for his services, instead of the patient. The patient only has to pay the part of the treatment cost which is not reimbursed. The application of this measure is very strictly regulated and can only be used for people who have qualified for an increased reimbursement, are chronically ill and/or have been unemployed for a qualifying period of time. For these subgroups, all Belgian GPs apply this measure. Dentists, by contrast, are not obligated to do the same[14].

The Public Center for Social Welfare

The Public Centers for Social Welfare (PCSW) are Belgian government institutions providing social assistance at the municipal level. These institutions provide financial support and guidance to people with insufficient resources. In order to be eligible for social assistance, conditions have to be met concerning nationality, residence, age, willingness to work and exhaustion of other social benefits. The administered support varies from psychosocial and medical assistance to employment programmes, budget counselling and provision of a living wage. In addition, the PCSW is responsible for assisting specific target groups, such as asylum-seekers and undocumented immigrants[15,16].

In 2013 the PCSWs provided a living wage or employment to 108,924 Belgian citizens and financial support to 21,525 asylum seekers and undocumented immigrants. In addition, the PCSWs financed the medical care of 14,414 asylum seekers and undocumented migrants[15].

Health care and social assistance

The PCSW assists people with lower incomes to obtain medical care or oral health care. Social workers provide information about qualifying for the status of increased-reimbursement, third-party payments. The PCSW also provides direct financial support through loans or by reimbursing part of the cost for the qualifying health-care expenses.

In addition, the PCSW is responsible by law for financing emergency medical care for illegal immigrants. Emergency medical care includes both preventive and curative care[17]. The PCSW also covers the medical expenses of asylum seekers staying in a Local Reception Initiative, a reception facility in the municipalities covered by the PCSWs[18,19].

Although the Belgian health-care system provides various protective measures to reduce the financial barrier to care, there are currently no data available on how people who qualify for assistance experience access to oral health care in Belgium.

The goal of the present study was to explore Flemish PCSWs perspectives regarding oral health care for people on social assistance regarding: (i) oral health-care delivery (e.g. guidelines, collaborations); (ii) barriers experienced by both people on social assistance and oral health-care providers; and (iii) disparities between the accessibility of general and oral health care.

METHODS

This cross-sectional study explored the perceived accessibility of oral health care of populations with lower income by means of a validated questionnaire to be completed by staff employees working in a PCSW.

According to the convention of Helsinki, the Ethics Committee of the Ghent University Hospital approved this study as EC/2015/0008 and approved the consent procedure.

Population

All ($N = 306$) Public Centers for Social Welfare in Flanders were invited to participate in this survey. The questionnaire was addressed to the secretary of each PCSW. A cover letter was included which guaranteed confidentiality and anonymity of the survey, so no personal data (such as age or gender) were requested from the respondents.

Questionnaire development

The content of the questionnaire was based on existing literature[7,20] and explorative interviews with staff employees of two PCSWs.

The questions covered three content categories: (i) characteristics of PCSWs; (ii) barriers to care; and (iii) accessibility of oral health care.

A draft questionnaire was developed and evaluated with regard to content validity. The questionnaire was further validated through a pilot study in two PCSWs.

The questionnaire consisted of 37 questions, divided into three sections. The first section consisted of eight multiple-choice questions. The second section included 22 statements. The staff employees of the PCSWs were asked to indicate to what extent they agreed with these statements on a six-point scale, ranging from 'strongly disagree' to 'strongly agree'. They were forced to choose sides, as there was no neutral middle option. There was also an option of 'no information' provided. The third section consisted of a visual analogue scale (VAS) with seven questions that could be answered by indicating a percentage on a continuous scale from 0% to 100%.

Data collection

The questionnaire was sent by post to the secretary of each Flemish PCSW in December 2014, along with an explanatory letter and a stamped addressed envelope. The two PCSWs that participated in the pilot study were excluded. As there was a high response rate (62.7%), no reminder had to be sent. No questionnaires were excluded.

Data analysis

Data were collected in a database and analysed using SPSS statistics 22.0 (Chicago, IL, USA). Descriptive frequencies were calculated for all categorical variables. For all continuous variables; the median, mean, standard deviation, minimum and maximum were computed.

The significance level was set at $P < 0.05$. All statements that were originally rated on a six-point scale with the additional option of 'no information' were divided into three categories: 'disagree'; 'agree'; and 'no information'. Respondents who selected the option of 'no information' were excluded from statistical analysis for the respective statement.Chi-square tests were used to test the relation between different categorical variables. If the conditions of the chi-square test were not met, the Fisher's exact test was used. The McNemar test and Cochran's Q-test were used to compare proportions of paired samples. The Mann–Whitney U-test, the Friedman test and the Kruskall–Wallis test were used for statistical analysis based on continuous variables.

This article only discusses a selection of the results obtained.

RESULTS

All results reported stem from the opinions of social service providers working in a PCSW.

Characteristics of the participating PCSWs

For this study, 306 Flemish PCSWs were contacted, of which 192 (62.7%) responded (*Figure 1*). In each province a response rate higher than 50% was obtained (*Table 1*). The vast majority of the participating PCSWs operated in a municipality with <25,000 residents (75.5%). Only 5.2% of the PCSWs had a working area of more than 50,000 residents. A comparison of this data with recent population figures shows a proportionally higher response rate of PCSWs with a working area of >50,000 residents (>80%) as opposed to PCSWs with a working area of <25,000 residents (<60%).

The frequency in which PCSWs have guidelines concerning the support of their clients in need of dental treatment varies depending on the target group ($P < 0.001$). PCSWs are more likely to have guidelines for asylum seekers (63.0%) and undocumented immigrants (58.2%) than for their clients who receive a living wage (36.8%) or budget counselling (36.2%). Only 26.6% have guidelines for all subgroups, while more than 30% have no guidelines at all.

Based on analysis of the data, 59% of PCSWs advise their clients to use the on-call service for dental emergencies, but only a minority do so systematically (12.2%). In addition, 47% of PCSWs encourage preventive dental check-ups. When the PCSWs take on the costs of a dental treatment, the dentist is usually paid within a month (73.9%).

The data also reveal that collaborations with health-care providers are not limited to GPs and dentists who work under convention (44.7% and 42.6% respectively), but only a minority of PCSWs work exclusively with GPs (18.8%) and dentists (16.8%) that accept the third-party payment system.

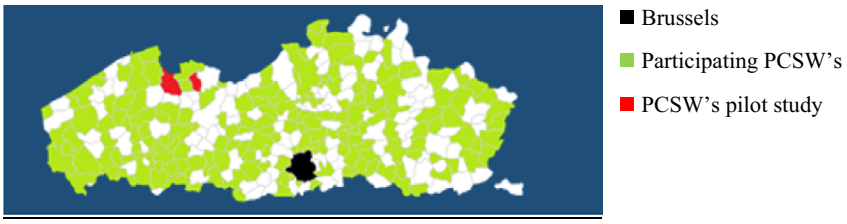

Figure 1. Geographical distribution of the responding Public Centers for Social Welfare (PCSW) in Flanders.

Table 1 Response rate according to province

Province	Response rate(%)
Antwerp	55.7
West Flanders	70.6
East Flanders	57.8
Limburg	52.3
Flemish Brabant	61.5

Barriers

The results of the questionnaire show that social service providers labelled financial limitations and not prioritising oral health as the most important barriers for people on social assistance in obtaining oral health care (*Figure 2*). The results showed that fear, shame and language restrictions were other potential, but seemingly less important, barriers. Financial barriers for medical care were also apparent (80.6%), but these barriers were more often reported for the dentist than for the GP ($P < 0.001$). The knowledge of PCSW beneficiaries on existing measures to reduce the financial barriers to oral health care, such as third party-payment assistance, was low (34.9%), but the reported percentages varied greatly depending on the municipality (standard deviation = 0.205).

The questionnaire revealed that one (19.4%) in five of the PCSWs reported that their clients experienced social discrimination in the dental office.

According to the social service providers, dentists also experience various barriers to treating patients with lower incomes, of which financial issues and additional administrative burden were rated as the most important (*Figure 3*). However, many PCSWs could not fully assess these barriers, which was reflected in a frequent choice for the option of 'no information' ($n = 55$) and a high number of missing values ($n = 30$). As shown in *Figure 4*, the extent to which dentists were reluctant to treat people on social assistance varied depending on the target group ($P < 0.001$), as assessed by the social service providers. Dentists were reportedly more reluctant to treat undocumented immigrants (mean = 34.9%) and asylum seekers (mean = 27.6%) than people on a living wage (mean = 23.8%) or budget counselling (mean = 21.6%).

About 15% of the PCSWs experience communication issues with the local dentists. The occurrence of consultations between social service providers and local dentists on the necessity of a dental treatment were reported by 27.2% of the PCSWs. These discussions occurred more frequently (46.8%) with the PCSW beneficiaries.

Accessibility to oral and medical health care

As shown in *Figure 5*, people on social assistance experienced more difficulties in accessing oral health care as opposed to medical care, both in urgent ($P < 0.001$) and in non-urgent situations ($P < 0.001$). In addition, 77.4% of the PCSWs expressed that the GP was more accessible than the dentist. Data also show that more difficulties were experienced in urgent situations compared with non-urgent situations, and this difference was statistically significant for both medical ($P = 0.002$) and dental ($P = 0.001$) care.

Improving access to oral health care

The Belgian government provides several measures to reduce financial barriers to care. This study examined whether the current knowledge that people on social assistance have on these measures helped to reduce the financial barriers they experience. Statistical analysis of the data could not confirm this ($P = 0.471$).

PCSWs who provide timely payment to the dentist experience less reluctance from local dentists to treat people on social assistance ($P = 0.016$).

DISCUSSION

The response rate of this study (62.7%) was notably higher than the average response rate of studies that collected data from similar organisations (35.8%; SD = 0.188), as described by Baruch and Holtom[21]. This could indicate that the PCSWs who participated in the present study have a keen interest in the accessibility to oral health care for their beneficiaries.

Previous studies on the accessibility to oral health care were mainly focussed on the perception of either the dentist[20,22,23,24] or the identified study population.[8,9]. This study involved a survey of social service

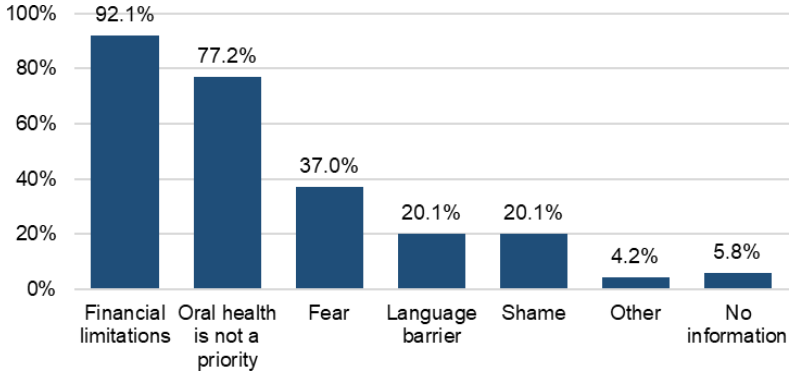

Figure 2. Barriers to dental care experienced by people on social assistance.

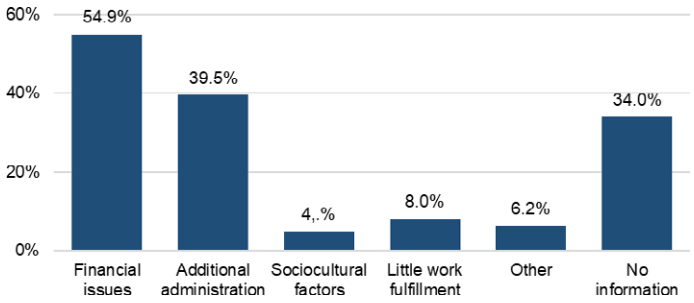

Figure 3. Barriers to treating people on social assistance experienced by dentists.

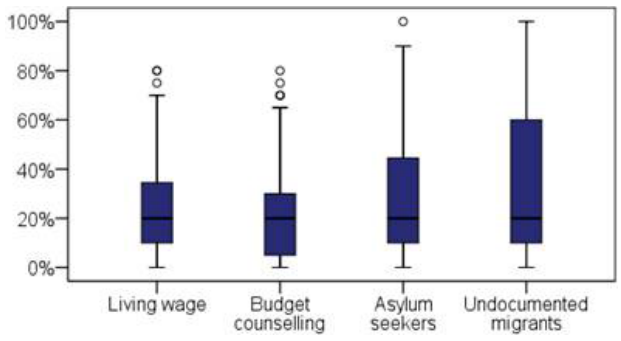

Figure 4. Dentist's reluctance to treat people on social assistance.

providers who work with both parties. Consequently, a larger target population could be reached, although indirectly. Wallace and MacEntee[7] had already included social service providers in their research on the accessibility of dental care through interviews based on open questions, albeit on a smaller scale (n = 13).

PCSWs do not limit their collaborations to health-care providers who accept the convention and/or third-party payment. As people on social assistance have little knowledge of these measures[25], they may not always opt for health-care providers who meet these requirements. Furthermore, in some provinces, more than half of dentists do not accept the convention[26]. A recent survey of Belgian GPs also showed limited enthusiasm for, and use of, third-party payment because of the deferred payment and administrative burden[27]. The results of the present study are therefore not surprising.

According to this study, financial limitations are the greatest barriers to dental care. This is consistent with the findings of Wall *et al.*[6] The Belgian health-care system, however, provides various protective measures to reduce this financial barrier[14]. The majority of people on social assistance are unaware of these measures, as reported by social service providers. Educational campaigns could be the first step to increase knowledge and therefore reduce financial barriers, but our findings could not prove this hypothesis. This study also suggests that oral health care was a low priority for people on social assistance, confirming the findings of Wallace and MacEntee[7]. While language barriers were not identified as a major problem for all PCSWs (mean = 20.1%), this turned out to be a noteworthy problem in the larger municipalities. In fact, 70% of the PCSWs with a working area of more than 50,000 residents identified language as a barrier.

Financial limitations and administrative burdens were, according to the present study, the main reasons why dentists are reluctant to treat PCSW beneficiaries. Previous studies confirm these results and additionally

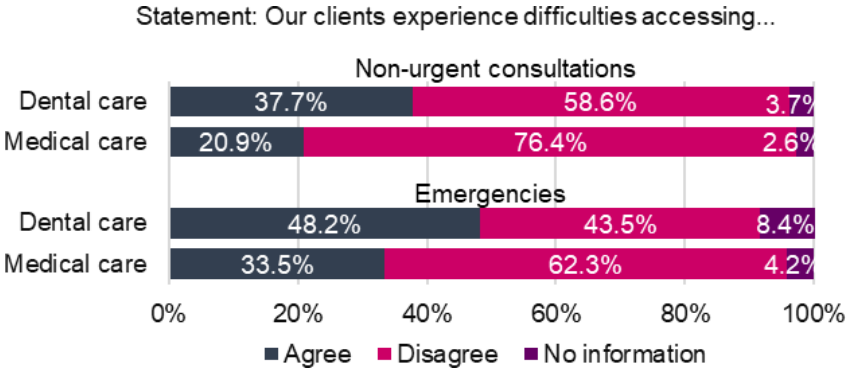

Figure 5. Accessibility to the general practitioners and the dentists.

cite that dentists are frustrated by the often irregular attendance of people on social assistance[20,24,28]. Dentists are therefore often not keen to treat this population. In this study, 21.6%–34.9% of dentists were identified as reluctant to treat people on social assistance. This reluctance was similarly found in other developed countries. Desprès (2010, France) experienced a 39.1% refusal rate among dentists to treat people with low incomes and complementary health insurance[22]. This problem is also encountered in the USA. A study by the United States General Accounting Office showed limited dentist participation in the Medicaid program[28]. In 27 of 39 participating states, fewer than half of the dentists had treated at least one Medicaid patient in 1999.

The present study revealed that dentists reportedly are more reluctant to treat undocumented immigrants and asylum seekers compared with people with low incomes who are Belgian nationals. This could possibly be explained by the additional effort and time that is required for communication as a result of language barriers and sociocultural differences. Furthermore, racism could play a role, but no conclusive literature is available on this subject. The observed dispersion of the refusal rate was considerable. The percentage of dentists reluctant to treat people on social assistance varied from 0% to 100%, depending on the municipality. In certain municipalities the problem is substantial.

Furthermore, this study revealed that people on social assistance experience more difficulties in accessing oral health care than in accessing medical care, both in urgent and in non-urgent situations. This study suggests that the difficulty is mainly a result of financial barriers, which are more apparent for the dentist than for the GP. Dental fees are often unpredictable and can add up quickly without the use of a third-party payment. Additionally, one of the Flemish professional dental organisations recently raised awareness regarding the growing lack of dental providers[28]. The aging and feminisation of the dental profession in Belgium and an increased dental awareness in modern society may cause supply-related barriers. This can increase the waiting time for dental appointments. As people with lower incomes tend to consult in emergencies, these waiting times can pose a problem. Fewer problems are encountered concerning the accessibility of GPs because no appointment is needed during consulting hours.

While the chosen study design had practical advantages and made it possible to reach a large target population, the research design also created some limitations. Although social service providers are in contact with both people on social assistance and local dentists, they do not always have accurate insight into the perceptions of the populations. For certain questions, this was reflected by many missing values and a frequent choice of the option 'no information'. In addition, all questions answered by a VAS showed a high dispersion, each with an SD >20%. Finally, some less-relevant questions could have been excluded from the questionnaire. Further research should explore the opinion of both the health-care providers and the population with lower incomes without any intermediary. The opinions of people on social assistance should also be correlated to their dental treatment needs. In addition, further research should be carried out in the francophone part of Belgium to obtain a more comprehensive view of the entire country.

CONCLUSION

The findings in this study identify that additional efforts are needed to improve the accessibility of oral health care for people on social assistance in Flanders. The study indicates that increased education and awareness of the importance of oral health care may be a way to increase motivation for the population to seek care. Furthermore, the study suggests that the interaction between the PCSW and the dentist could be more effective concerning guidelines and

collaborations with local health-care providers. Finally, this study indicates that more dentists may be willing to treat people on social assistance if the administrative burden were reduced and payment by reimbursement entities was prompt. Further investigations, with expansion into other areas of Belgium, including Brussels and Wallonia, and including input from the perspective of dental professionals, are needed to obtain more information to support policy changes.

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Competing interest

None declared.

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APPENDIX
Questionnaire

Name PCSW:

Optional:
E-mail address:

Phone number:

Filling out this information is optional and strictly confidential. Participants will only be contacted in case of ambiguities

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1 What is the size of the **working area** of your PCSW?
- ○ <10,000 residents
- ○ 10,000–25,000 residents
- ○ 25,000–50,000 residents
- ○ 50,000–80,000 residents
- ○ >80,000 residents

2 Does your PCSW cooperate with **private facilities**, such as an associated hospital, to provide…
a Medical care for your clients?
- ○ No
- ○ Occasionally
- ○ Systematically

b Oral health care for your clients?
- ○ No
- ○ Occasionally
- ○ Systematically

3 Does your PCSW cooperate with **community health centers** to provide…
a Medical care for your clients?
- ○ No
- ○ Occasionally
- ○ Systematically

b Oral health care for your clients?
- ○ No
- ○ Occasionally
- ○ Systematically

4 Are there **guidelines** within your organisation regarding the procedure for the financial support of dental treatments for clients…
a Receiving a living wage?
- ○ Yes
- ○ No

b On budget counselling?
- ○ Yes
- ○ No

c In asylum procedure?
- ○ Yes
- ○ No

d Without legal residency?
- ○ Yes
- ○ No

5 Does your PCSW recommend using the **on-call service** for dentists in emergencies?
- ○ No
- ○ Occasional
- ○ Systematically

6 How long does it usually take until your PCSW pays the dentist when providing financial support?
- ○ Less than a week
- ○ Less than a month
- ○ More than 1 month

7 Does your organisation observe barriers to dental care concerning your **clients**? If so, indicate the respective barriers (multiple answers are allowed).
- ○ Financial limitations
- ○ Dental anxiety
- ○ Oral health is not a priority
- ○ Shame
- ○ Language barrier
- ○ Other: _____
- ○ No information

8 Does your organisation observe barriers concerning the **dentists** to treating people on social assistance? If so, indicate the respective barriers (multiple answers are allowed).
- ○ Financial issues
- ○ Additional administrative work
- ○ Sociocultural factors
- ○ Little work fulfillment
- ○ Other: _____
- ○ No information

Indicate to what extent your PCSW agrees with the following statements by ticking the correct box:

Accessibility

9 Our clients experience difficulties accessing adequate medical care in emergencies.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

10 Our clients experience difficulties accessing adequate dental care in emergencies.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

11 Our clients experience difficulties accessing adequate medical care in non-urgent situations.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

12 Our clients experience difficulties accessing adequate dental care in non-urgent situations.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

13 The GP is more accessible to our clients than the dentist.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

14 According to our clients, the dentist is more accessible for children than for adults.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

15 According to our clients, the dentist is less accessible for people over 65 years old than for younger adults.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

The dentist

16 Disagreements with local dentists on the 'necessity' of a dental treatment are common.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

17 Communication issues often occur between the local dentists and our organisation.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

Opinion of the patient

18 Disagreements with the clients on the 'necessity' of a dental treatment are common.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

19 According to our clients, they feel disadvantaged by the dentist due to their social status (discrimination, negative attitude, making less effort, etc.)

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

20 Financial difficulties are a barrier for our clients to visit a doctor.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

21 Financial difficulties are a barrier for our clients to visit a dentist.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

Collaborations

22 Our PCSW only collaborates with GPs who work under convention.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

23 Our PCSW only collaborates with dentists who work under convention.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

24 Our PCSW only collaborates with GPs who accept the third-party payment system.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

25 Our PCSW only collaborates with dentists who accept the third-party payment system.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

Additional role PCSW

26 We encourage our clients to pursue preventive dental care.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

27 Our PCSW seldom provides financial support by taking on the costs of a dental treatment in addition to an intermediation for our clients receiving a living wage.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

28 Our PCSW seldom provides financial support by taking on the costs of a dental treatment in addition to an intermediation for our clients on budget counselling.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

29 Our PCSW seldom provides financial support by taking on the costs of a dental treatment in addition to an intermediation for our clients in asylum procedure.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

30 Our PCSW seldom provides financial support by taking on the costs of a dental treatment in addition to an intermediation for our clients without legal residency.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	No information

Using the scale below, indicate the opinion of your PCSW.

31 To what extent are the dentists in your working area reluctant to treat people on a living wage?

32 To what extent are the dentists in your working area reluctant to treat people on budget counselling?

33 To what extent are the dentists in your working area reluctant to treat people in asylum procedure?

34 To what extent are the dentists in your working area reluctant to treat people without legal residency?

35 To what extent are the dentists in your working area aware of the practical procedure to be followed for PCSW-beneficiaries?

36 To what extent do the dentists in your working area apply the proper practical procedures in treating PCSW-beneficiaries?

37 To what extent are your clients aware of the social arrangements intended to reduce financial barriers to oral health care (third-party payment, free yearly dental check-ups for children, etc.)?