
7 Oral Health Status

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A major purpose of ICS II was to develop a methodology that could be employed at sites throughout the world to make a situation analysis and plan future oral health services on a continuing basis. Evidence that this purpose has been achieved is given by the number of additional sites which have adopted the ICS II protocol and conducted their own studies after those of the initial sites described in detail in this report. As these sites could not complete their data collection in time for the deadline applied to the initial seven sites, they could not be fully incorporated into the comparative framework and detailed analyses.

However, it was decided to include the findings on oral health status from three later sites and to compare them with results from the initial sites and ICS I data as an extension of the comparison described in Chapter 6. Consequently, this chapter differs from the others as it includes oral health status data collected in epidemiological surveys in San Antonio, Texas, USA; Latvia; and Rhone-Alpes, France. The characteristics of these sites are described in section 2.7. Also included here, but not in the rest of the volume, are data on older adults aged 65–74 years in Yamanashi, Japan, which were collected later than for younger adults and children.

As in ICS I, the data are not presented separately for males and females. The prime purpose of this chapter is to allow the reader to see a summary of the data as they were collected without statistical adjustment, except compilation of standard indices, means and percentages. These data are compared across sites and with ICS I data (Arnljot et al., 1985) where possible. They form a background in relation to similar data collected by age and standard measurements (in the case of DMF for more than 50 years) against which observed trends and disease levels as well as statistically analysed relationships can be assessed for practical action in the future. This action could take many forms including prevention, curative/restorative services, research or provision of personnel.

The tables in this chapter also differ from those presented in other chapters because they report unweighted data. Whereas weighted data are used elsewhere in the report for detailed comparisons and relationships between clinical and other data to take into account the complex sampling designs used at most sites, unweighted data are used here as they had already been reported by some of the initial sites and weighting was not used at the later sites. As a result, some estimates in this chapter will differ slightly from those presented elsewhere in the report for the initial sites. In no case were these differences substantial. Tabular data have been presented throughout this publication with two decimal places, but the text regularly refers to quantities rounded to one decimal place or to a whole number for easier perception and contemplation of differences.