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Dental Tourism in the United States: Exploring the Impact of Perceived Knowledge and Exposure on Clinical Screening Practices for a Sample of Dentists

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Abstract

Dental tourism (DT) is an expanding industry within medical tourism and involves patients traveling outside of their home country to other destinations to receive dental services, often due to cost issues. There has been very little research empirically studying DT from the dentists' perspective to date, including no studies of United States (US) dentist perceptions. An anonymous survey administered through Qualtrics was completed by 74 US dentists, assessing perceived DT knowledge, DT exposure, and DT clinical screening practices, along with demographic variables including gender, age, length of dental service, and dental specialty. These three DT multi-item measures are new to the DT literature. The mean for the DT clinical screening practices variable was very low indicating that dentists did not typically include screening patients for their DT history, asking about this on intake forms, or determining patient interest in DT. Only DT exposure significantly explained DT clinical screening practices. Male dentists had higher perceived DT knowledge than female dentists. Study limitations and future research directions are discussed.

Keywords: dental tourism, US dentist perceptions, knowledge, exposure, clinical screening practices

1. Introduction

Dental Tourism (DT) is a growing industry, within the overall field of medical tourism (MT), due to the demand for affordable restorative as well as cosmetic dental procedures (Mucaj, 2024). DT involves patients traveling to other countries outside of their homeland. For example, Mucaj (2024) noted that by traveling to Hungary, Poland or Turkey, patients could save between 30 to 60% average costs on dental implants and orthodontics, while traveling to Mexico, Costa Rica or Brazil for cosmetic dental care (e.g., veneers) could save 40 to 65%, compared to Western countries such as the United States (US). US dental care costs are among the highest in the world (Dhama et al., 2016). A 2023 cross-sectional study of over 205,000 US dentists (Rahman. Blossom, Kawachi, Tipirneni & Elani, 2024) found that over 24 million people in the US lived in dental care shortage areas. Garner (2019) found that many US patients travel to Mexico for lower cost dental care. Such a lack of access can also motivate DT, even for more routine procedures. Despite public interest and need, the authors were unable to identify a research study specifically sampling US dentists.

1.1 The Research Issue

The general purpose of the study was to explore variables affecting perceptions of DT for US dentists.

1.2 Literature Review

In a seminal study of DT in New Zealand (NZ) by Lovelock et al. (2018), a national survey was sent out to 1,287 practicing dentists, of which 337 (26%) NZ dental health practitioners responded. A demographic breakdown of the sample showed 65% were male, 48% over 50 years old, 55% had 20 or more years of practice and 87% were non-specialists/general dentists. Their items surveyed a wide range of dental tourism perceptions, e.g., knowledge of dental tourism, exposure to dental tourism, encounters with dental tourists, engaging patients about dental tourism, and performing remedial work. It is also important to note that given the variety of items asked, the response scales used by Lovelock et al. (2018) in their survey for these items had different verbal anchors. Their findings included that NZ dentists needed to increase their knowledge of DT when interacting with their

patients, getting more information from outside sources (e.g., colleagues, professional articles) and collecting more information (e.g., screening patients for prior DT history) and asking if the dentists had performed any remedial or corrective work on DT patients. One limitation of the Loveland et al. (2018) study was that only frequency data were reported on individual items and no descriptive or inferential statistics, e.g., scale reliabilities, correlation, regression, t-tests, were done on variables measured. The authors were unable to find previously validated multi-item DT scales in their literature review.

1.3 Study Research Question

Given the lack of existing empirical research, this study asked a general research question (RQ) for testing:

RQ - Beyond controlled-for variables, how do knowledge of dental tourism and exposure to dental tourism affect clinical screening practices perceptions for US dentists

2. Method

2.1 Sample and Procedure

All research was approved by the University Institutional Research Review Board (IRB) using expedited review (protocol 25697). Several initial US patient-oriented qualitative interviews probing into MT and DT suggested that DT was an area in greater need of study from a dental practitioner standpoint. This led to constructing an anonymous, voluntary 20-item Qualtrics survey for distribution to US dentists. Prior to administration, the survey was pilot tested by four US-based general dentists with a connection to the first author. Survey revisions were made for item clarity, and access for entry to a gift card raffle if the survey respondent desired. The survey was distributed to a random sample of dentists obtained from a US National Directory of 34,000 Dentists (n.d), dental school directories, and some dentists shared the survey with their network of eligible colleagues. Despite repeated emails over a period of 3 months, only 74 complete data respondents were received (0.2%). The difficulties in securing a high response rate from large US government surveys have been well-documented (Heffetz & Reeves, 2019).

2.2 Measures

Three multi-item scales. Three perception-based multi-item scales were used, based on combining individual items adapted from the Loveland et al. (2018) survey, Knowledge, Exposure and Clinical Screening Practices. All multi-item measures used a 6-point response scale from 0 to 5, and like Loveland et al. (2018), item response anchors varied. All items, by scale, are reported in the Appendix. Basic summary information on each scale, including a sample item, is as follows. *DT Knowledge*, two-items, internal consistency reliability estimate (α) = .65. A sample item is: "what is your knowledge level regarding dental tourism?" *DT Exposure,* four-items, α = .76. A sample item is "to what extend have you read research/professional articles about dental tourism?" *DT Clinical Screening Practices,* six-items, α = .77. A sample item is " To what extent do your intake forms and process include questions about dental tourism history?

Demographics. Following Loveland et al. (2018), four demographic items were asked, gender, age, dental specialty, and dentist service length. *Gender* was measured as 1 = male, 2 = female. *Age* was measured using the following interval-based scale (allowing time to graduate dental school after an undergraduate degree in the US): 1 = 26-25 years, 2 = 36 to 45 years, 3 = 46 to 55 years, 4 = 56 to 65 years, and 5 = over 66 years. *Dental specialty* was measured by asking for 1 = general dentistry 2 = specialty (e.g., pediatric, orthodontist, periodontist or gum specialist, endodontist or root canal specialist, oral surgeon, prosthodontist). *Dental service length* was measured using the following interval-based scale, 1 = 0 to 2 years, 2 = 2 to 4 years, 3 = 5 to 9 years, 4 = 10 to 14 years, 5 = 15 to 19 years, and 6 = at least 20 years.

2.3 Data Analysis

Since general research questions are being tested, two-tailed tests for significance will be used (Pituch & Stevens, 2015). All data were analyzed using SPSS (2023). Descriptive statistics for the sample demographics are reported, followed by means, standard deviations and correlations for continuous variables. A two-step hierarchical regression analysis was done to test the study research question. Finally, independent sample t-tests were conducted to see if there were demographic variable differences on any multi-item continuous variable.

3. Results

Table 1 below describes the demographic characteristics of the sample. As can be seen the sample is primarily male (58%), over 55 (56%), 65% general dentists, and 68% with at least 20 years of dental service. These demographics are consistent with the Loveland et al. (2018) study. Table 2 below shows the Means, Standard Deviations, and Correlations for the continuous study variables.

3.1 Sample Characteristics

Table 1

Variable	Response Category	Frequency (Percentage)
Gender	Male	43 (58%)
	Female	31 (42%)
Age	1 = 26-35 years	8 (11%)
	2 = 36-45 years	15 (20%)
	3 = 46-55 years	9 (12%)
	4 = 56-65 years	21 (28%)
	5 = Over 65	21 (28%)
Dental Specialty	1 = No (General Dentistry)	48 (65%)
	2 = Yes (Specialty)	26 (35%)
Dental Length of Service	1= 0-2 years	3 (4%)
	2 = 2-4 years	1 (1%)
	3 = 5-9 years	3 (4%)
	4 = 10-14 years	13 (18%)
	5 = 15-19 years	4 (5%)
	6 = Over 20 years	50 (68%)

3.2 Variable Means(M), Standard Deviations(SD) and Correlations for Continuous Variable

Table 2

Varible Name	M	SD	1	2	3	4	5
Age[a]	4.43	1.38	(---)				
Dental Service Length[b]	5.22	1.33	.84**	(---)			
DT Knowledge[c]	3.60	1.08	.25*	.26*	(---)		
DT Exposure[c]	1.69	.87	-.04	-.18	.42**	(---)	
DT Clinical Screening Practices[c]	1.32	.80	.09	.05	.41**	.64**	(---)

Note. N = 74. * $p < .05$; ** $p < .01$ (both two-tailed)

[a] Age, 1 = 26-35 years to 5 = over 65 years

[b] Dental Service Length, 1 = 0-2 years to 6 = over 20 years

[c] DT Knowledge, Exposure, and Clinical Screening Practices Scales each measured on a 6-point response, from 0 to 5. Please see Appendix for item breakdowns within each scale.

3.3 Test of Research Question

Table 3 below shows the final regression model for all variables. None of the demographic variables were significant for explaining DT Clinical Screening Practices, and only DT Exposure, but not DT Knowledge was significant, i.e., higher perceived exposure indicating higher clinical screening practices. Overall, 39% of the variance in DT Clinical Screening Practices was explained.

Table 3. Final Hierarchical Regression Model for Incrementally Testing After Demographics, the Contributions of Both DT Knowledge and DT Exposure for Explaining DT Clinical Screening Practices

Outcome: DT Clinical Screening Practices	**b**	**SE**	**R^2**	**ΔR^2**	**F**
Step 1 – Demographic Variables					
Age	-.04	.10			
Gender	-.16	.18			
Dental Service Length	.10	.12			
Dental Specialty	-.07	.16			
			.06		1.01
Step 2 –					
DT Knowledge	.07	.09			
DT Exposure	.51**	.10			
			.39**	.33**	7.06**

3.4 Independent Sample T-tests

Independent sample t-tests for demographic variable differences on gender and dental specialty for the three multi-item variables, i.e., knowledge, exposure, and clinical screening practices, revealed one significant difference. Male dentists perceived higher knowledge of DT (M = 3.88) than female dentists (M = 3.21), $t(72)$ = 2.78, $p < .01$ (two-tailed).

4. Discussion

As noted earlier, despite increased public interest in DT (Mucaj, 2024), as well as public need in the US (Rahman et al., 2024) there have been very few empirical research studies of DT sampling dental practitioners, and none using US dentists. This research extends the prior Loveland et al. (2018) study of New Zealand dentists in going beyond their reported frequency-only data to calculate multi-item scale reliabilities, to then test for correlation and regression findings for understanding clinical screening practices. Results showed that perceived exposure to DT, e.g., reading research/professional articles, exposure via conferences/workshops/lectures, discussing DT with colleagues, was more important than perceived knowledge for explaining the incorporation of DT into clinical screening practices. In addition male dentists perceived greater knowledge of DT than female dentists. No demographic variables measured were significant. The findings suggest DT remains a largely unscreened variable in US dental clinical workflows. Incorporating brief, standardized intake questions about care received abroad represents a practical, low-burden intervention that could normalize disclosure and support proactive shared decision-making. Professional associations and insurers could further assist by providing guidance on documentation, continuity-of-care expectations, and remedial treatment protocols.

4.1 Study Limitations and Future Research

While this study should be regarded as important step forward in understanding US dentist perceptions of DT, it is still exploratory given the study limitations. The sample size was very small, with an ultra-low response rate (0.2%), despite repeated attempts to increase it. This overall sample size limitation made it more difficult to identify subsample differences, e.g., general dentists versus specialty dentists. Sample demographics showed that the majority of respondents were older with more experience. The mean for clinical screening practices was very low on the multi-item 6-point response scale, revealing that dentists did not typically include screening patients for their DT history, asking about this on intake forms, or determining patient interest in DT. This low mean and standard deviation made it more difficult to explain its variance in the regression model. The reliability for the perceived knowledge scale was marginal (α) = .65. No open items were asked to probe further for dentists'

perceptions of DT. The study relies on self-reported perceptions rather than observed clinical behavior, and its cross-sectional design precludes examination of change over time. The sample is small and skewed toward general dentistry, limiting generalizability, and the exclusive focus on the provider perspective excludes patient motivations and outcomes. However, to the authors knowledge, these are the first formal DT-related scales being used.

Future research using US dentist samples should ideally be much larger, and longitudinal to allow for stronger causal interference, i.e., that exposure leads to clinical screening practices. Greater sample balance, not only across dental specialty, but also age/length of service is needed in future research. Continued testing of these three new scales is needed. Having a more balanced sample distribution of dentists across age or years of service would allow for stronger comparisons of DT perceptions, for example by dentist generation. Open item inclusion could give more insight into statistical findings. Increasing dentists' exposure to DT is important, as well as their comfort level discussing DT with their patients. Expanding the research design for further understanding DT should include investigating the perceived dentist-patient relationship, for example, trust is an important consideration (Song et al, 2020; Yuan et al, 2023).

As interest in DT continues to grow, both internationally and in the US, increased research is needed to understand the variables affecting DT, both from the dentist and patient perspectives. DT in US is projected to grow 20% by 2033 due to advanced techniques available, especially with dental implants (Grandview Research, 2026).

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Appendix. Multi-item Scales

Dental Tourism Knowledge	**0**	**1**	**2**	**3**	**4**	**5**
What is your comfort level discussing and answering patient questions about dental tourism?	Discomfort	Slight Discomfort	Neither Comfort nor Discomfort	Somewhat Comfortable	Moderate Comfort	Fully Comfortable
What is your knowledge level regarding dental tourism?	None	Minimal	Basic	Moderate	Good	Expert
Dental Tourism Exposure	**0**	**1**	**2**	**3**	**4**	**5**
To what extent have you encountered dental tourism in the media you interact with?	No Coverage	Minimal Coverage	Intermittent Coverage	Moderate Coverage	Regular Coverage	Significant Coverage
To what extent have you read research / professional articles about dental tourism?	Never	Minimal (one article)	A few related articles	Intermittent reading	Moderate reading	Significant reading
To what extent have you discussed dental tourism with colleagues?	Never	Minimally	Intermittently	Moderately	Regularly	Frequently
To what extent have you encountered medical tourism information in professional and/or industry settings such as attendance at conferences, workshops, or lectures?	Never	Minimally	Intermittently	Moderately	Regularly	Frequently
Clinical Screening Practices	**0**	**1**	**2**	**3**	**4**	**5**
To what extent do you screen your patients for past engagement in dental tourism?	Never Screen	Rarely Screen	Intermittent or Occasional	As needed for patient or exam	Regular Screening	Always Screen
To what extent do you think your intake forms and processes include questions about dental tourism?	No Questions	At least 1 about location location of past dental care	More than 1 about location of past dental care	At least 1 specifically about dental tourism history	More than 1 specifically about dental tourism history	Specific dental tourism questions and follow-up discussion during consult
To what extent do you engage in a patient's interest in dental tourism?	Never	Rarely	Engage if patient asks about it	Same as patients asking another US dental provider	Research dental tourism info to support discussions and decision-making at no extra cost	Research on dental tourism info to support discussions and decision-making for additional fee
To what extent does your office engage in a patient's interest in dental tourism? (same response scale is above item)						
To what extent do you perform remedial or corrective work on dental tourism patients?	Never or Unsure	Minimal/ very little	Intermittently/ occasionally	Moderate number/not uncommon	Regularly, normal to see patients needing such work	Frequently and/or seeing increase in these patients
How many patients over the past 2 years have asked you about dental tourism?	0 patients or unsure	1 – 5 patients	6 – 10 patients	11 – 20 patients	21 – 50 patients	Over 50 patients