Oral Health vs General Health

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Oral diseases are largely preventable. If identified early, they do not require emergency attention and can be managed in primary care. However, due to poor coverage and high out-of-pocket payments, far too many people do not have access to appropriate oral healthcare and oral diseases remain an important economic and health burden.

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Oral diseases are among the most common noncommunicable diseases worldwide, affecting an estimated 3.5 billion people. In Europe, despite decreasing prevalence in all age groups and stronger focus on preventive care, oral diseases are increasingly recognized as one of the most prevalent conditions, affecting nearly 52% of the European population. **In spite of the high prevalence, statutory coverage of dental care is limited in many European countries with restricted service packages and high private funding, compared to other health services.** As there is no over-riding European policy on systems for the provision of healthcare, there are wide variations in the way in which oral healthcare is delivered, its cost and the extent to which the cost of treatment is subsidized, either from state or private funds.

Furthermore, we know relatively little about the differences in dental care, financing, and coverage between European countries. **Data is lacking on virtually all areas of oral healthcare and cross-country comparison of oral health status is hampered by the absence of systematic, standardized collection of epidemiological oral health data, thus impeding informed policy making.**

A case study (Int Dent J, 69: 130-140[1], conducted among oral health policymakers, on a sample of European countries, gives us a general overview by comparing the provision and point of delivery costs (price) of dental treatments in a general dental practice. The study uses a well-defined case description of a patient presenting for care: *the case of a patient called Maria who re-*

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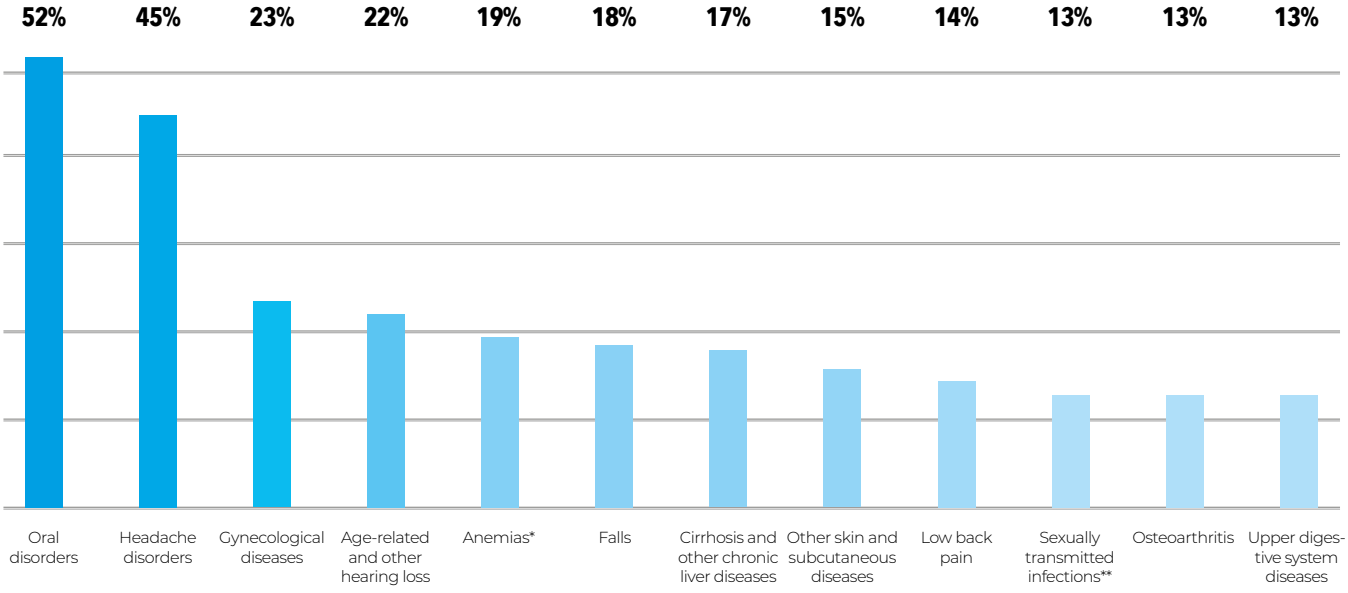
MOST PREVALENT HEALTH CONDITIONS IN THE EU, 2019



Source: IHME (2022), Global Burden of Disease, 2019.
*Notes: *Haemoglobinopathies and haemolytic anaemias; ** without HIV.*
Taken from: Winkelmann J, Gómez Rossi J, van Ginneken E. Oral health care in Europe: Financing, access and provision. Health Systems in Transition, 2022; 24(2): pp. 1–169.

"The WHO defines oral health as the state of the mouth, teeth and orofacial structures that enables individuals to perform essential functions, such as eating, breathing, and speaking, and encompasses psychosocial dimensions, such as self-confidence, well-being, and the ability to socialize and work without pain, discomfort, and embarrassment."

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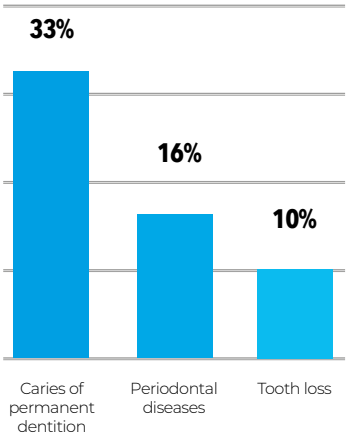
PREVALENT ORAL DISEASE IN THE EU, 2019



quired an examination, two small intraoral radiographs, two fillings and some relatively minor periodontal treatment.

Among the studied countries are Denmark, England, France, Germany, Hungary, Italy, the Netherlands, Poland, Romania, and Spain. The figures reported in the tables below are approximate and apply purely to general dental practices and not to public clinics or hospitals, or other locations where oral healthcare is provided. A further possible limitation of the study is the accuracy of the reported costs. Where the treatment is provided in countries with a fixed scale of fees for oral healthcare, they should be accurate, for example in England, France, and Germany. However, even in the public systems in Germany (Krankenkasse) and England (National Health System, NHS), there are variations. In Germany, fees are based on a points system and the value of a point varies from region to region. In England, within the NHS the cost to the patient is consistent; however, the value of Units of Dental Activity (UDAs), which are used to remunerate general dentists, vary. In countries where the patients are not treated within a state-funded system, or in a private insurance system with a fixed tariff of fees, the resulting private fees reported in this study (paid direct from patient to dentists without insurance cover) were invariably an estimate and should be viewed as such. Nevertheless, because respondents were asked to report 'average fees' for general dental practices not located in capital cities, where the costs may have been higher and sought this information from a range of general dentists, it may be that the 'private fees' reported are typical for the countries concerned. It would be most unwise to assume that they are exact. Nevertheless, the data described below do give an overall picture of oral healthcare fee for the countries included and items of treatment concerned.

DENTAL WORKFORCE CHARACTERISTICS OF COUNTRIES IN CASE STUDY

Country	Number of Working (active) Dentists	Number of Registered Dental Hygienists	Number of dental nurses	Number of dentists/ practice	Male : female ratio of dentists (%)	Practice owner private/corporate/ publicly funded
Denmark	4,740	3,174 (The majority of practices employ a dental hygienist	At least one per dentist	Generally two or more	37/63	Often "large dental clinics"
England	41,000 (UK total)	7,535 (The majority of practices employ a dental hygienist, often part-time)	At least one per dentist	In over 80% of practices two or more	50/50	60%, two or more practice owners (co-owners) < 20% owned by single dentist < 20% owned by companies
France	46,000	None (No dental hygienists are registered to work in France)	50% work without a full-time dental nurse	Generally only one	55/45	Generally owned by the dentists who work there

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Country	Number of Working (active) Dentists	Number of Registered Dental Hygienists	Number of dental nurses	Number of dentists/ practice	Male : female ratio of dentists (%)	Practice owner private/corporate/ publicly funded
Germany	72,592	1,600 (estimate) (Few dental hygienists, but over 13,000 dental nurses with additional training who carry out supra-gingival scaling)	Often two per dentist, many of whom have further training	1–3 tendency for larger dental clinics with several dentists and specially trained dental chairside assistants to become the norm	Approaching 50:50 in practice 30:70 Student intake	Generally owned by the dentist or dentists who work (s) there
Hungary	5,800	3,785 (Many working as dental nurses)	In general, most dentists work with a dental nurse		48/52	Owned by one dentist or an investor
Italy	59,824 (No data for active dentists)	4,000	One per dentist	Usually one, but with visiting specialists	63/37	One practice owner (dentist) - 80% of all practices - 10% company run "dental services"
Netherlands	9,697	3,569 (some own their own practices)	Two per dentist	Usually more than 1 (1.8 is the average)	59/41	
Poland	37,773	2,260	In public dental service in 2014 : 13,056 dentists and only 5,288 dental nurses	Usually one, but sometimes with visiting specialists	23/77	Majority owned by a single practitioner (77%) or private healthcare clinics
Romania	22,263	100	As there are 6,000 dental nurses it appears that many dentists work without dental nurses	Generally one but increasing numbers of dental companies with multiple dentists	33/67	Owned by a single practitioner
Spain	38,077	13,200 (The majority of practices employ a dental hygienist, often part-time)	At least one per dentist	Usually one but sometimes with visiting specialists	43/57	Generally owned by one private dentists (most cases but decreasing), increasing number of company-operated (with 6-10 dental units per practice)

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Expected Total Cost of Treatment for Scenario-based Items (for patient Maria) in Each of the Countries Analyzed Together with Cost Incurred by the Patient and by the State.

Country	Total fee in Euro	Cost paid by the patient in Euro	% of overall treatment cost covered by the State
Denmark	€603	€465 paid by patient of which €138 paid by public (state) health insurance scheme	23%
England (£1 = €1.20)	€72 (If all treatment is covered by band 2 NHS Charge) up to €323 (If private elements are incorporated)	NHS 85.3% paid by a non-exempt charges patient (€61 for a band 2 course of treatment, same charge in England and Wales at all NHS practices)	Dependent on UDA/contract value, if UDA = €24 then band 2 (3 UDAs = €72) therefore state would contribute 14.7%
France	€158	€47, reimbursed if patient has private insurance (95% of pop. have complementary insurance) they would pay this additional amount so patient overall charge would be 0	70% of cost (€111) reimbursed by public health insurance system (all items discussed in this scenario are regulated by this system, of which 98% of dentists have a contract)
Germany	€448	€200	€248
Hungary (1HUF = 0.0032 €)	€250 ± €100 for treatment in private practice, free if treated in either a state-owned or contracted dental office	100% if private, 0% if regional practice has contract with Health Insurance Office of Hungary	100% if regional practice has contract with Health Insurance Office of Hungary
Italy	€380	100% (0% if patient has insurance but only 10% patients have it)	0%
The Netherlands	€505	100% but voluntary supplemental insurance reimbursement varies between 75% and 100% up to a max. that varies between 100 and 1,750	0%
Poland	Approx. €260	100% if private, though 15% of pop. receive state-funded dental treatment (conservative, preventive and oral surgery)	Composite fillings not provided by the state, amalgam paid for by state insurance system
Romania	€210	40% of fee (if dentist has a contract with the National Health Insurance House-minority)	If dentist has a contract with the National Health Insurance House – minority of practices, if so 60% paid for by the state but fixed at €300 paid to general dentists and 400 to specialist dentists
Spain	€510	100% (< 1% of pop. covered by private insurance)	0% (only extractions covered by Spanish NHS equivalent, salaried dentists perform this)

Data sources: answers from respondents in this current study (as 1 April 2016) / Council of European Chief Dental Officers CEDCO database The Council of European Chief Dental Officers- https://cecdo.org/oral-healthcare/cecdo-database/ and https://onlinelibrary.wiley.com/doi/full/10.1111/idj.12437

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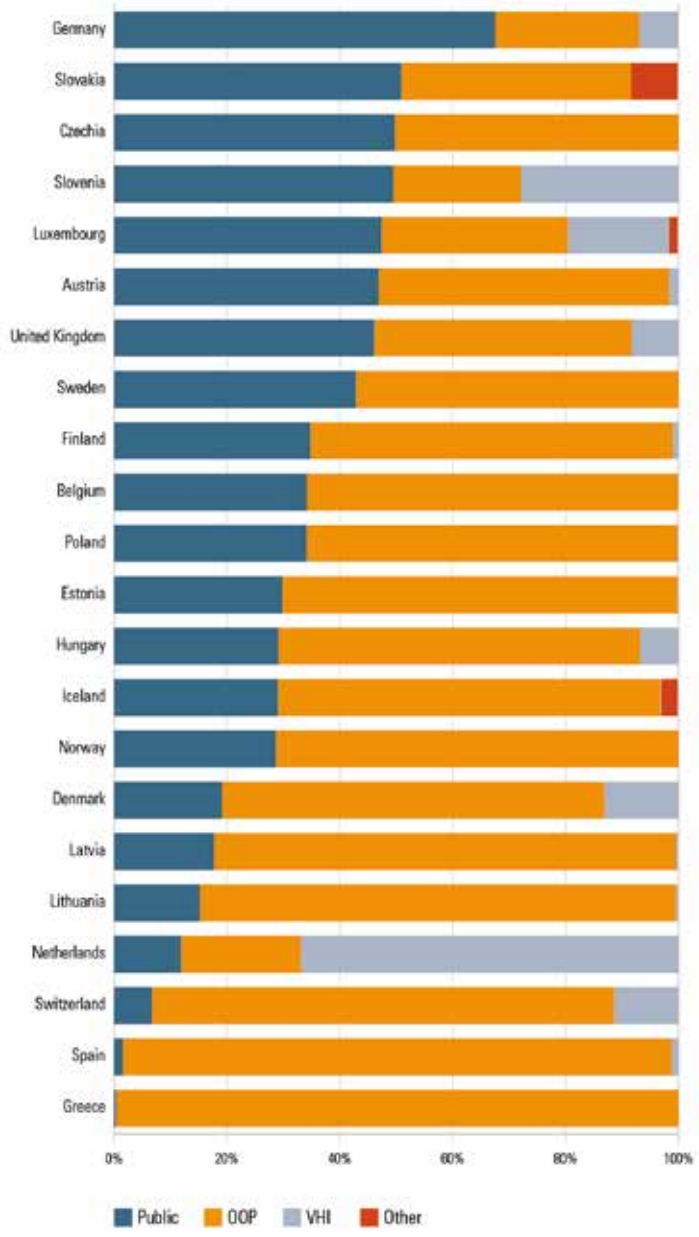
Out-of-pocket (OOP), Voluntary health insurance (VHI) and public spending for dental care as % of total dental expenditure, 2019



> Within Europe, on average, only one third of dental care is borne by government schemes or compulsory insurance while more than two thirds of dental care spending is paid out-of-pocket (OOP) or by Voluntary Health Insurance (VHI).

Source: OECD Health Statistics, 2021. Taken from: Winkelmann J, Gómez Rossi J, van Ginneken E. Oral health care in Europe: Financing, access and provision. Health Systems in Transition, 2022; 24(2): pp. 1–169.

The European Observatory on Health Systems and Policies further gives an in-depth analysis[2] of oral healthcare in Europe, concluding that the share of public funding in dental care is relatively low compared to most other health services. Within Europe, on average, only one third of dental care is borne by government schemes or compulsory insurance while more than two thirds of dental care spending is paid out-of-pocket (OOP) or by Voluntary Health Insurance (VHI). **In 2019 private spending accounted for more than half of total dental care expenditure in almost all countries. On average, public spending accounted for 31% of total dental care spending in 2019 across 22 countries for which data were available. Direct payments (OOP) for dental services made up 59% of total dental care expenditure while VHI contribution was relatively low compared to OOP spending, accounting, on average, for 11.6% of total dental spending.** Oral diseases further ranked third behind diabetes and cardiovascular diseases in terms of expenditures per disease in the European Union. In most European countries surveyed, spending on dental care increased both in absolute terms and as a share of GDP.

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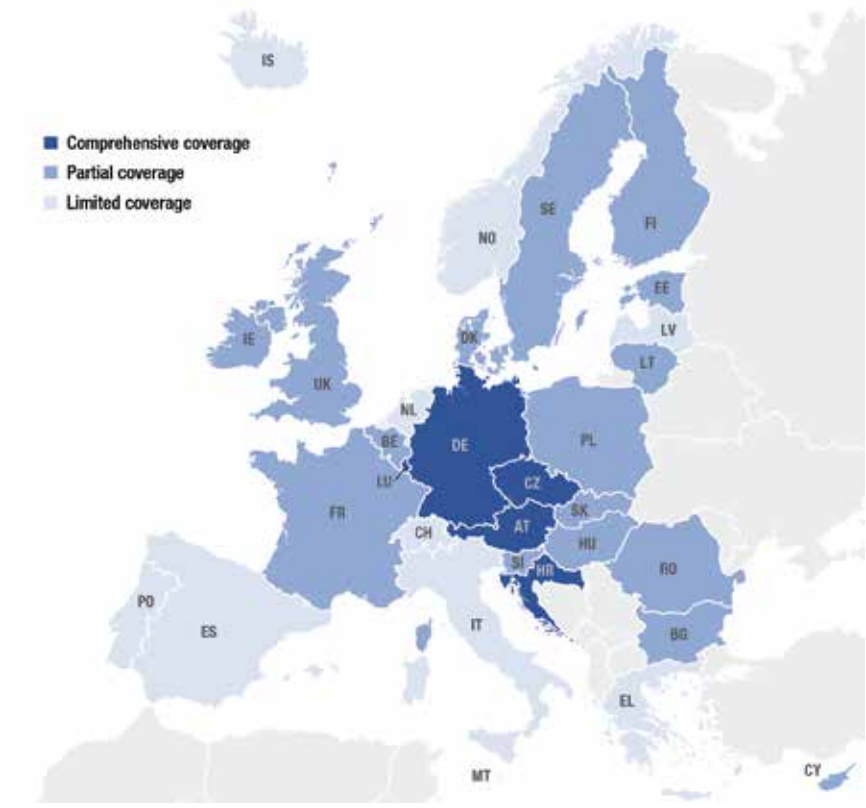
Dental Care Coverage in Europe



Categories of Statutory Dental Care Coverage

Category	Level of Dental Coverage
Limited Statutory Coverage	·These countries explicitly exclude most dental care services from statutory coverage, although they provide (at least in theory) some basic coverage. · Preventive and restorative dental care services are available for specific population subgroups (children, older adults), and/or based on income or clinical need/health status, but coverage might vary across regions. · In most countries with limited coverage for dental care, voluntary health insurance plays an important role in providing access to dental care and financial protection.
Partial Statutory Coverage	Children and adolescents (up to age 23) are fully covered, all others are partially covered (population coverage) · Basic treatments are covered for children, all dental treatments for adults require cost-sharing, prosthesis and/or orthodontics are not covered (service coverage) · Cost-sharing is substantial (usually ranging between 25% and 80% of costs) (cost coverage)
Comprehensive Statutory Coverage	· Many preventive and curative dental care services are included in the statutory benefits package for children up to 18 or 19 years, for vulnerable groups and for adults. · Co-payments apply for adults for certain above-standard treatments such as dentures, implants, surgical extractions, and prostheses. · Co-payments vary largely by type of treatment but usually do not exceed 25–30% of treatment costs.

Note: Given the extensive variation within countries, this classification makes no claim to depict all the specific rules. Rather, the typology provides a simplification of the complex reality of statutory dental care coverage and variation across countries. It must further be noted that in many countries the statutory coverage of dental care does not necessarily imply that people with a statutory entitlement to dental care can access it.

Source: Winkelmann J, Gómez Rossi J, van Ginneken E. Oral health care in Europe: Financing, access and provision. Health Systems in Transition, 2022; 24(2): pp. 1–169.

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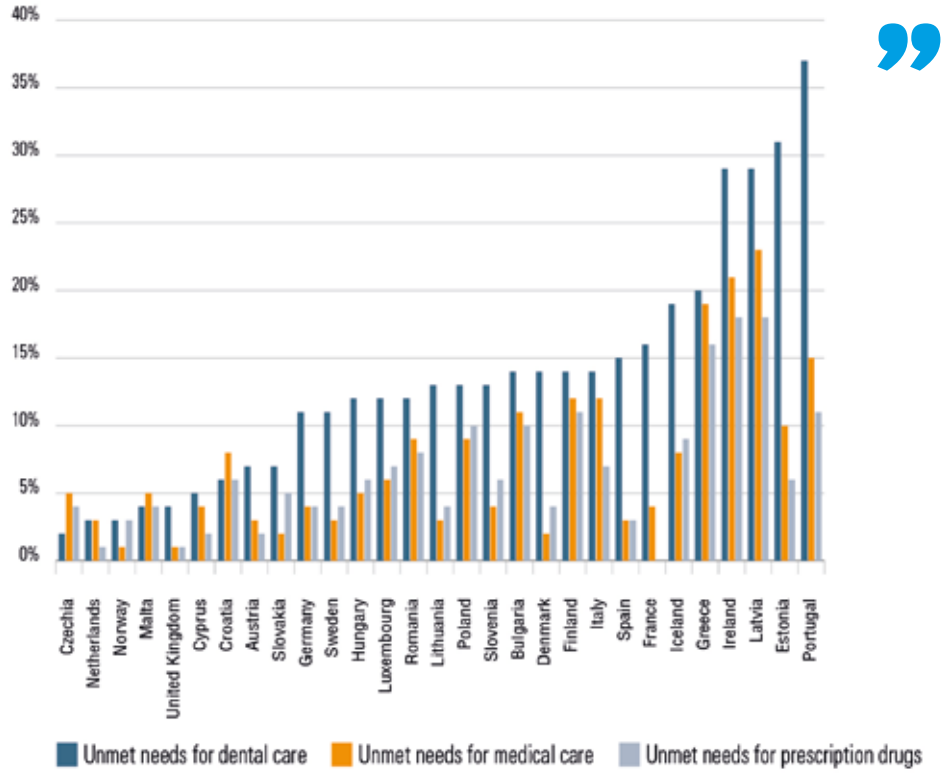
Share of Adults Reporting Unmet Needs for Dental Care, Medical Care and Prescription Drugs Due to Financial Reasons (EHIS 2014)



Notes: In France and Sweden the proportions are calculated over the total adult population (including both people who have needs for care and those who have no needs), resulting in an underestimation in comparison to the other countries, where the proportions are over the adult population which has needs. Source: OECD, 2019a (based on national health survey data). Taken from: Winkelmann J, Gómez Rossi J, van Ginneken E. Oral health care in Europe: Financing, access and provision. Health Systems in Transition, 2022; 24(2): pp. 1–169.

> There is clear evidence that dental care is the most frequent type of care for which people report unmet needs due to financial reasons, particularly between vulnerable and low-income populations.

There is clear evidence that dental care is the most frequent type of care for which people report unmet needs due to financial reasons, particularly between vulnerable and low-income populations. The consequences of untreated oral diseases, which include physical symptoms, functional limitations, and detrimental impacts on emotional, mental, and social well-being, can be severe and debilitating. The importance of oral health for overall health, links with other chronic diseases (risk factors) and the need for a holistic approach, especially in prevention, is gaining importance. Enhanced cooperation between general medical practitioners and oral health professionals would be critical.

The biggest challenge is ensuring that all people can access to prevention and care when they need it. **Oral health has long been neglected in the global health agenda, yet individual oral health promotion strategies and population prevention strategies are safe, clinically effective, and cost-effective.** Concerned about the lack of attention to oral diseases, the World Health Assembly adopted in May 2021 a historic resolution (WHA74.5) recognizing that oral health should be firmly embedded within the noncommunicable disease agenda and that oral healthcare interventions should be included in universal health coverage programs. The World Health Assembly delegates asked WHO to develop a draft global strategy for tackling oral diseases that was adopted during the seventy-fifth session of the WHA in May 2022, to develop by 2023 an action plan including a monitoring framework for tracking progress with clear measurable targets to be achieved by 2030; to develop "best buy" interventions on oral health; and to explore the inclusion of noma in the road map for neglected tropical diseases 2021–2030.

An important step forward in the larger process of mobilizing political action and resources for oral health!

Among main sources:
- [1] case study: Eaton, K.A., Ramsdale, M., Leggett, H., Csikar, J., Vinall, K., Whelton, H. and Douglas, G. (2019), Variations in the provision and cost of oral healthcare in 11 European countries: a case study. Int Dent J, 69: 130-140. https://doi.org/10.1111/idj.12437
For full study- https://onlinelibrary.wiley.com/doi/full/10.1111/idj.12437
- [2] Winkelmann J, Gómez Rossi J, van Ginneken E. Oral health care in Europe: Financing, access and provision. Health Systems in Transition, 2022; 24(2): pp. 1–169.
For full report - www.eurohealthobservatory.who.int/publications/i/oral-health-care-in-europe-financing-access-and-provision
- Global oral health status report: towards universal health coverage for oral health by 2030. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO.
-CECDO, The Council of European Chief Dental Officers- https://cecdo.org/oral-healthcare/cecdo-database/

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