The State of Oral Health in Europe

Professor Kenneth Eaton
Chair of the Platform for Better Oral Health in Europe
TOPICS TO BE COVERED

• What is the Platform?
• Its aims and work
• The report (State of Oral Health in Europe 2012)
• Oral disease trends
• Systems for delivering oral health care
• Utilisation of oral healthcare services
• Oral healthcare workforce
The Platform for Better Oral Health in Europe

- The Platform was launched on WOHD 2011.
- It promotes oral health and the cost-effective prevention of oral diseases in Europe and it seeks a common European approach towards education, prevention and access to better oral health.
- It responded to the call to action handed over by Members of the European Parliament to Health Commissioner Dalli in 2011.
Acronyms Explained

Association for Dental Education in Europe
Council of European Chief Dental Officers
European Association of Dental Public Health
Glaxo Smith Klein
International Dental Health Foundation
Wrigley International

Secretariat: Hill & Knowlton Strategies
Platform’s Objectives

1. Promote oral health and the prevention of oral diseases as one of the fundamental actions for staying healthy

2. Address oral healthcare inequalities and the major oral health challenges of children and adolescents, of the increasing elderly population, and of the populations with special needs in Europe

3. Develop the knowledge base and strengthen the evidence-based case for EU action on oral health

4. Mainstream oral health across all EU health policies

5. Provide sound advice and recommendations to the European Institutions for action with regard to EU oral health policy developments
Platform’s activities

• Develop contacts with EU policymakers to advocate for OH prevention
• Develop our website as a central tool to access OH information
• Leverage World Oral Health Day since 2011
• Gather support to organise the first European Oral Health Summit
• Commission the « State of Oral Health in Europe 2012 » report to assess the situation
The « State of Oral Health in Europe » 2012
World Oral Health Day 2012

• 1st European Oral Health Summit organised in Brussels

• 140 participants met in the European Parliament

• Successful launch of the policy report on the “State of Oral Health in Europe 2012”

• Focus on oral health prevention

• Raising awareness: 2,000+ oral health bags distributed in front of the European Parliament
The State of Oral Health in Europe

- Focus on 12 EU countries with better available data
- Prevalence & trends of oral diseases
- Assessment of the economic impact of oral diseases
- Identification of best practices
- Key policy recommendations
KEY FACTS

• Oral health-related costs are still on the rise despite the fact that oral diseases are highly preventable
• Current spending in dental treatment in the EU-27 was estimated to be close to 79 billion EUR in 2012
• The current oral health workforce in the EU is over 1 million and includes over 390,000 dentists and over 400,000 dental chair-side assistants (nurses)
THE FACTS

• Only 41% of Europeans still have all their natural teeth.

• 50% of EU population may suffer from periodontitis and 10% have severe disease. Prevalence increases up to 70-85% of population aged 60-65 years old.

• Common risk factors with other chronic diseases and bi-directional relationship (diabetes/periodontal disease).

• Caries still remain a problem for many people in Eastern Europe and for those from socio-economically deprived groups in all EU Member States.

A major public health burden in Europe

Access to oral healthcare services remains a major problem among vulnerable and low income groups.
THE FACTS

- The EU 27 spent an estimated 79 billion EUR on oral health in 2012 and will spend around 93 billion EUR by 2020.
- Much of the burden in high-income countries is due to caries and its complications.
- Expenditure on treatment of oral conditions often exceeds that of cancer, heart disease, stroke and dementia.
- Delivering oral health services accounted for 5% of total health expenditure and 16% of private health expenditure in OECD countries in 2009.

Lack of data and challenge in estimating the expenditure on the provision of oral healthcare and in quantifying out-of-pocket and indirect costs.
Lack of policy emphasis placed on oral diseases’ prevention, partly due to the lack of available and comparable epidemiological & economic data.

THE FACTS

• Current negative trends in periodontal health and oral cancer
• Increasing oral health inequalities
• Lack of integration of oral health into national or community health programmes
• Lack of research in oral health promotion
• Scarce best practice principals in prevention & oral health promotion
• Limited and fragmented data and knowledge base
• Dental workforce limitations
5 key policy recommendations

1. Develop a **coherent European strategy** to improve oral health with commitments to **quantifiable targets by 2020**

2. Improve the **data and knowledge base** by developing **common methodologies** and bridging the research gap in oral health promotion

3. Support the development of **cross-sectoral approaches** with health and social care professions and support the development of the **dental workforce**

4. Address **increasing oral health inequalities** and **knowledge of prevention/oral hygiene practices** of the public and guarantee availability and access to high quality and affordable oral health care

5. Encourage **best practice sharing** across countries
Good practice examples

Switzerland: community-centred based programmes: oral health promotion targeted at immigrants families + advice for self-management of periodontal diseases

Denmark: preventative health care model

UK: evidence-based toolkit for prevention + Child Smile in Scotland

France: national prevention programme targeting teenagers

Mexico: public online best practice portals

France: promoting sugar-free products

Fluoridated salt programmes

Water fluoridation programmes (drinking water)

Hungary: Oral cancer screening in high-risk groups

UK: evidence-based toolkit for prevention + Child Smile in Scotland

Fluoridated milk programmes (targeted to the population)

Restricting marketing & improving the labelling of certain food products

UK: evidence-based toolkit for prevention + Child Smile in Scotland
OVERVIEW OF TRENDS

Population’s needs:

• Less caries
• ? periodontal breakdown
• More oral cancer
• Aging population
• “Heavy metal generation”
• Often unmet in the socio-economically deprived
CHANGES IN DMFT IN 12 YEAR OLDS

DMFT (1980s) vs DMFT (2000s) for various countries:

- Cyprus
- Denmark
- Germany
- UK
- Austria
- Italy
- France
- Spain
- Ireland
- Romania
- Poland
- Lithuania
TRENDS IN PERIODONTAL DISEASES

- Unclear
- Elderly are increasingly dentate
- Increasing prevalence of diabetes
- Virtually no comparable national studies
- Problems with definition of periodontitis (Savage et al. 2009)
- Problems with periodontal epidemiology (Leroy et al. 2010, König et al. 2010, Papapanou 2012)
TRENDS IN ORAL CANCER

- Higher mortality each year
- Growth in under 40-year-olds
- HPV
- Higher prevalence in Eastern Europe
OVERVIEW OF TRENDS

Population’s demands:

• Functional, pain free mouth
• Increasing demand for aesthetic embellishment (orthodontics, veneers, bleaching, implants, the Hollywood smile)
Systems to meet needs and demands:

- Nordic
- Bismarkian
- Beveridgian
- Hybrid
- Southern European
- Central and Eastern European

Widström and Eaton (1999 and 2004)
NORDIC MODEL (1)

• Found in Denmark, Finland, Norway and Sweden
• Large public dental service financed by national or local taxation with free services for under 18 year-olds and some adults
• Central guidance and supervision
• Private sector generally treats adults many of whom receive co-payment from the state
NORDIC MODEL (2)

• Well developed team dentistry with wide use of Dental Hygienists and Nurses (Chair-side Assistants)
• Clinical Dental Technicians, who provide removable prostheses directly to patients, are found in Denmark and Finland
• Over 90% of those under 18 years and 60% - 90% of adults attend regularly for oral health care
BISMARCKIAN MODEL (1)

- Found in Austria, Belgium, France, Germany, Luxembourg and (the Netherlands)
- Based on statutory sickness insurance paid for by employers and employees
- Costs of oral healthcare totally or partially reimbursed by the insurance scheme
- Fees negotiated between insurance agencies and dental associations
BISMARCKIAN MODEL (2)

• Very little Government involvement
• Very small public dental service
• Apart from in Germany and the Netherlands, little use of team dentistry
• No dental hygienists in Austria, Belgium, France and Luxembourg
• Dental nurses (chair-side assistants) relatively uncommon in Belgium, France and Luxembourg (? Culture)
BEVERIDGIAN MODEL (1)

- Unique to the United Kingdom
- Mixture of publicly and privately funded oral healthcare
- Publicly funded either in relatively small number of public service clinics or in private clinics where the owners contract with the state
- Free of charge to all under 18 years of age and “special groups”
BEVERIDGIAN MODEL (2)

• Widespread and increasing use of team dentistry
• Growing numbers of dental hygienists, dental therapists, dental nurses
• Also clinical dental technicians and orthodontic nurses all are registered
• Overall, 66% of population attend regularly for oral health care
SOUTHERN EUROPEAN MODEL (1)

- Found in Cyprus, Greece, Italy, Malta, Portugal and Spain
- Predominantly private provision of oral healthcare without Government involvement
- Very limited number of public clinics
- Limited number of insurance schemes
SOUTHERN EUROPEAN MODEL (2)

- Limited provision of free treatment for under 18 year olds
- Some team dentistry
- No dental hygienists in Greece
- Limited use of dental nurses in Greece
- Low rate of regular attendance for oral health care in Portugal and Spain (30-40% per year)
EASTERN EUROPEAN MODELS (1)

- Found in Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia
- Has changed from very largely public service, which was provided free of charge to a mainly private service
- In some countries, this appears to have been detrimental to the oral health of poorer people
- Some insurance schemes are developing
EASTERN EUROPEAN MODEL (2)

- Some team dentistry
- Dental hygienists are now trained in all countries, other than Bulgaria
- Dental nurses (chair-side assistants) often not employed (perceived cost)
- Improving oral health in the smaller countries e.g. Latvia and Slovenia
- Poor access – fewer 10% Romanians visited a dentist in 2012
UTILISATION OF SERVICES

• Wide variations

• 98% of school children in Denmark make annual visits for oral care and preventive advice

• 80% of Swedes visit a dental office annually

• Less than 35% of Spaniards visited a dentist in 2012

• Less than 10% of Romanians visited a dentist in 2012
EU ORAL HEALTH CARE WORKFORCE

In 2012, in European Union (27 countries) population of 500,000,000, there were an estimated:

400,000 “active dentists”
33,000 dental hygienists
150,000 dental technicians
400,000 dental nurses (chair-side assistants)

CECDO Database 2012
DENTISTS MIGRATION

• Free movement in the EU/EEA

• No barriers to relocating in a new EU/EEA Member State

• In UK in 2013, just over 11,000 dentists out of 40,000 did not graduate as dentists in the UK

• Of these 11,000 just over 7,000 graduated in other EU/EEA Member States

• Most of the other 4,000 have had to pass the Overseas Dentists Examination or its predecessor
Thank you for your attention!

kenneth.a.eaton@btinternet.com