



Factsheet n° 12: Oral Health

Facts and Figures:

- About 52% of the EU population suffer from oral diseases.¹
- Oral health expenditure accounted for 5.1% of total health spending in 2019.²
- In 2019, dental diseases were the third most expensive diseases to treat after diabetes and cardiovascular diseases and before cancer.³
- Out-of-pocket payments for dental services represent the largest source of funding, on average 59% of total dental care spending.⁴
- Dental Care is the most frequent type of care that people forgo due to financial reasons.⁵

Our recommendations

- ***Follow a life-course approach to oral health, understanding it as an integral part of health.***

Oral health is paramount to disease prevention as well as people's health status and quality of life. It has an enormous social and economic relevance. It has an impact on educational attainment, physical and mental health, employment status, work productivity and income, and social participation (to cite but a few). Untreated oral diseases can cause pain, sepsis, loss of school days and productivity, etc. Yet, oral health is often isolated and marginalised from health policy and healthcare systems. "Dental care and healthcare professionals currently operate in separate domains, with different education, policies and traditions".⁶ It is necessary to strengthen the integration of oral care into other care areas. As highlighted by the WHO in its 2022 Declaration⁷, that integration constitutes an essential component of Universal Healthcare Coverage (UHC). The achievement of UHC will require reforming health, education and resource planning "to ensure the health workforce has the needed competencies to provide essential oral services across the continuum of care".⁸ Encouraging the

¹ across 23 countries with available data; see: The European Observatory on Health Systems and Policies, *Oral health care in Europe: Financing, access and provision*, Health Systems in Transition, Vol. 24 No. 2, p. 31.

² *Idem*, p. 41.

³ The Lancet, *Oral diseases: a global public health challenge*, Volume 394, ISSUE 10194, P249-260, July 20, 2019.

⁴ The European Observatory on Health Systems and Policies, *Oral health care in Europe: Financing, access and provision*, Health Systems in Transition, Vol. 24 No. 2, p. 39.

⁵ *Idem*, p. 41.

⁶ *Idem*, p. 111.

⁷ WHO, *Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable disease*, 27 April 2022.

⁸ *Idem* p. 6

establishment of group practices, which enable the collaboration between professionals would be beneficial to that endeavour, just as the adaptation of curricula.

Vulnerable groups such as children and older people often enjoy a more comprehensive coverage than the rest of the population. While a focus on vulnerable groups is to be welcome, it is also vital to take a life-course perspective. Despite a shift in dental care towards more prevention, it is still widely treatment-dominated. Developing oral health promotion programmes for all age groups is essential to decrease the incidence of oral health diseases amongst all age groups, from children to older individuals.

- ***Focus on prevention and tackle the risk factors for oral health: include oral health in the EU NCD Agenda and improve levels of literacy.***

Modern dentistry, which is mostly treatment focussed, is inappropriate and unaffordable. As highlighted by The Lancet, it is increasingly focussing on the provision of aesthetic treatments, driven by profit and consumerism. There is therefore a clear need for a radical shift away from a treatment and technology dominated oral health systems⁹ to tackle the challenge of oral diseases¹⁰.

AIM recommends that oral health be included in the EU NCD agenda. Oral diseases are caused by a range of modifiable risk factors¹¹, some of which are common to NCDs: high sugar dietary intake, smoking, alcohol use, poor oral hygiene. It is therefore essential to adopt a health in all policies approach, by focussing on the social and commercial determinants of oral ill-health and on risk factors such as sugar consumption, alcohol consumption.

Cutting down the influence and effect of the global sugar industry via strict legislation, limiting the availability of foods and drinks with high levels of sugar, regulating the marketing and sponsorship of those types of food, but also introducing higher taxation rates for those products are only some of the strategies that are proven to be effective to reduce sugar consumption and nudge consumers towards healthier habits.¹² The interests of powerful economic operators (amongst which the global sugar industry) cannot stand in the way of public health protection and improvement.

In addition to tackling risk factors, it is equally important to expand access to preventive dental care, such as periodic checkups, fluoride treatments, and sealants, to reduce the need for more costly and invasive treatments. Providing more resources and organising awareness raising campaigns to improve patients' understanding of the importance of regular dental care and of proper oral hygiene is also key to preventing oral diseases. Starting education campaigns in schools allows to improve levels of literacy regarding oral hygiene of both children and, indirectly, their parents.

- ***Support the accessibility to oral healthcare by investing in compulsory and supplementary insurance, and limit profit in oral healthcare.***

Inadequate funding for the prevention and treatment of oral diseases is common across the EU, particularly in low and middle-income countries where treatment costs exceed available resources.¹³ Access to dental care is limited as service packages are more restricted than for medical care. It is

⁹ The European Observatory on Health Systems and Policies, *Oral health care in Europe: Financing, access and provision*, Health Systems in Transition, Vol. 24 No. 2, p. 133.

¹⁰ The Lancet, *Oral diseases: a global public health challenge*, Volume 394, ISSUE 10194, P249-260, July 20, 2019.

¹¹ <https://www.who.int/news-room/fact-sheets/detail/oral-health>

¹² See also this [Joint Call to Action](#)

¹³ The European Observatory on Health Systems and Policies, *Oral health care in Europe: Financing, access and provision*, Health Systems in Transition, Vol. 24 No. 2, p. 42

estimated that only a third of spending on oral care is paid by public schemes, resulting in high out-of-pocket payments and in voluntary health insurance playing a key role.¹⁴

The cost of treatment thus represents a large economic burden for both families and healthcare systems. Patients often postpone treatment till more serious problems occur, which results in higher demand for emergency care and higher costs for treatment.¹⁵ In Belgium for example, a study carried out by the Belgian Health Fund “Solidaris” on the “Postponement of care” showed that 30.7% of respondents (who would have needed dental care) had given it up in the previous year, with the high cost of dentistry, the often-inadequate coverage and the low rate of contracting of providers being the direct causes. It is therefore vital to improve financial accessibility to oral health by investing in compulsory and supplementary insurance.

According to a European Observatory report, oral health problems are also the main reason for hospital admissions among children in England.¹⁶ The report also found that out-of-pocket spendings and unmet needs for dental care are lower in countries where dental care is included in the benefits basket for the general population.

Voluntary health insurance covers 11,6% of total EU dental spending. At the same time, a trend of further privatization of dental care driven by corporate dentistry is observed.¹⁷ Such a trend threatens to further exacerbate inequities, leaving most vulnerable groups’ needs unattended. In order to cut down prices and limit profit in oral healthcare, it is essential to establish agreements between dentist and the government to cap prices but also to subsidise professionals and help them face the ever-growing costs of materials.

- ***Tackle the socioeconomic inequality in oral health, by effectively targeting vulnerable groups.***

Lower socioeconomic groups are more susceptible to the above-mentioned risk factors to oral health. Those factors are determined by socioeconomic status, lifestyle and the environment. In addition, the socioeconomic status is risk in itself and causes health disadvantages.¹⁸ Oral conditions are strongly socially patterned, with lower socio-economic groups having higher unmet needs, and children living in poverty and older people being the most affected.¹⁹

Dental care is thus a real marker of social inequalities in health, and, as shown by the Solidaris study mentioned above, it further reveals gender inequalities.

For both preventive and curative oral healthcare, it is essential to target actions to specific vulnerable groups. If more is done to target and sensitize young children in schools, the needs of older patients are still widely unmet. There is currently insufficient or poor training of dentists in providing care for patients with co-morbidities and complex medical problems.²⁰ In addition, due to that focus on children (both for access to treatment and for prevention actions), there is a large time frame of

¹⁴ *Idem*

¹⁵ The Lancet, *Oral diseases: a global public health challenge*, Volume 394, ISSUE 10194, P249-260, July 20, 2019.

¹⁶ The European Observatory on Health Systems and Policies, *Oral health care in Europe: Financing, access and provision*, Health Systems in Transition, Vol. 24 No. 2, p. 22

¹⁷ *Idem*, p. 132.

¹⁸ *Idem*, p. 33.

¹⁹ The Lancet, *Oral diseases: a global public health challenge*, Volume 394, ISSUE 10194, P249-260, July 20, 2019.

²⁰ *Idem*

inaction, which leads to an accumulation of conditions that are not treated. Improvements in that regard can also be achieved by following the above-mentioned life-course approach.

- ***Develop indicators for the systematic and standardised collection of oral health data.***

As highlighted by the European Observatory on Health Systems and Policies in their latest report, “there is currently no systematic data collection system on oral health status and dental care”. Data is indeed incomplete with little or no information on the burden of disease, on oral health risk factors, and on the special needs for services of vulnerable population groups (e.g. older people). Data on the oral health workforce are not collected systematically either.

An outcome measurement tool does exist, the “Decayed Missing and Filled Teeth Index” (DMFT). However, it has its limitations as it does not provide information on the causes behind specific conditions, and it is difficult to compare across countries. Other measures such as the “Community Periodontal Index of Treatment Needs” (CPITN) or the “Periodontal Screening Index” (PSI) are not used as widely as the DMFT. In addition, for all those tools, methodological differences impede cross-country comparison.²¹

AIM recommends the development of indicators for the systematic and standardised collection of oral health data. Indeed, a better understanding of the EU oral health landscape would contribute to the development of more efficient oral health interventions and the improvement of services and of their accessibility, by allowing performance measurement, a better monitoring of implemented policies and the continuous assessment of oral and related health inequities. In addition, a better information exchange between the utilization of dental services and medical health records would enable a better integration of specialties and multidisciplinary preventive strategies developed.²²

Best Practices

MSA – France

In addition to the actions listed below, the “Mutualité Sociale Agricole” (MSA) promotes prevention through advice, which it provides via flyers and brochures available to people over 60, children, pregnant women and their babies at birth, on the [MSA website](#) and in the MSA offices.

“M'T Dents” program for young people

Since 2007, the MSA (French social security for farmers) has been offering its young insured or beneficiaries aged 3 to 24, as part of the “M'T Dents” oral care program, preventive advice and an oral checkup fully paid for by the MSA, at the rate of one checkup appointment every three years, i.e. at 3, 6, 9, 12, 15, 18, 21 and 24 years of age.

In 2021, the MSA has invited 221,230 young to have an oral checkup as part of the “M'T Dents” program. The invitation is sent by personal mail including a cover sheet to each child eligible for this program. A total of 65,243 examinations were performed, representing a participation rate of 29.5%, an increase of 4.4 points compared to 2020 (25.1%).

Since 2016, this program has been reinforced by the M'T dents program for young people who do not seek dental care. This is a follow-up reminding action targeting young people aged 4, 7, 10 and 13 already invited to the M'T dents program but did not use it and did not have any oral health care in the year they were 3, 6, 9 and 12 years old. This action also includes a system of reminders sent to the

²¹ The European Observatory on Health Systems and Policies, *Oral health care in Europe: Financing, access and provision*, Health Systems in Transition, Vol. 24 No. 2, p.34.

²² *Idem*, p. 27.

eligible beneficiaries within 4 months of the invitation month. In 2021, 8,891 young people in the agricultural scheme received a fully covered oral examination. The national participation rate is 24.1%.

The "Bilan Bucco-Dentaire -BBD" program for pregnant women

Since 2007, an oral check-up fully covered by the MSA is offered to pregnant women before and after giving birth. Flyers are also made available to them for the oral health of their baby.

In 2021, 16,398 women were invited to have an oral health check-up before giving birth. Of these, 4,915 received a preventive check-up, a 30% participation rate. In 2021, 9,283 women were invited six months after giving birth for an oral health checkup. Of these, 2,383 received an oral check-up, a participation rate of 25.7%.

The "Bilan Bucco-Dentaire -BBD" program for people aged 60

An oral check-up, fully paid for by the MSA, has been offered to people aged 60 since 2006.

In 2021, the MSA invited 24,760 60-year-olds to have this oral check-up. Then the MSA sent reminders to 21,509 people reminding them of the importance and necessity of the proposed check-up. A total of 3,735 60-year-olds received an oral check-up, a participation rate of 15.1%.

Between 2006 and 2020, 37,141 people aged 65 received a free oral check-up offered by the MSA.

SVLFG – Germany

The Agricultural health insurance fund (LKK) as part of the SVLFG branches, offers comprehensive and free preventive measures, which include an examination of the oral cavity and the removal of tartar once a year. It is sufficient to present the health insurance card to the dentist.

In addition, the LKK dental team provides advice by telephone. Information on dental and oral hygiene can be found on the homepage.

Bonus Scheme

Those who do something to keep their teeth healthy and regularly attend dental check-ups are rewarded by the LKK - with a higher subsidy for their dentures.

The fixed allowance increases to 70 percent (bonus) if

the condition of the teeth indicates regular dental care and the insured person can provide evidence of regular dental examinations during the last five years before the start of treatment.

Regular examination means once every calendar half-year for insured persons who have not yet reached the age of 18 and once every calendar year for insured persons who are 18 years and older. This also applies to total prosthesis wearers.

The fixed allowance increases to 75 per cent if the previously mentioned evidence can be provided for the last ten calendar years prior to treatment. In justified exceptional cases, a single missed preventive check-up for the last 10 years will not have any consequences if evidence is provided of complete preventive check-ups with the dentist in at least the five years prior to the start of treatment.

Bonus booklet: All preventive dental check-ups should be entered by the dentist in the "bonus booklet". This can also be kept as an "electronic bonus booklet" in the electronic patient record (ePA). It serves as proof of these preventive examinations.

Comparable bonus schemes are also offered by other statutory health insurance funds in Germany.

Dental care for babies and toddlers

The LKK promotes breastfeeding not only as the best possible nutrition for children, but also as the best for their teeth and tooth development. After birth, the doctor will give advice on oral health, oral hygiene, tooth-friendly nutrition and dental care for the child during the child screening examinations. If necessary, the child is referred to the dentist for clarification of abnormalities in the teeth and mucous membrane.

In addition, dental care tips for infants and toddlers can be found on the LKK homepage.

Dental health at kindergarten age

The majority of children attend kindergarten, where they usually take part in group prophylaxis measures. They are examined and learn everything about optimal dental care and sensible protective measures against dental diseases. In addition, between the ages of 6 and 33 months, children have the opportunity to take part in three early dental check-ups at the dentist's office. In addition, there is an entitlement to the application of fluoride varnish for enamel hardening at this age.

From the age of 34 months until the age of 6 years, there is an entitlement to three further dental screening measures. The application of fluoride varnish may be indicated here for children with a high caries risk.

Preventive care for school children

At school, children receive instruction on proper dental care and learn how to brush their teeth properly. During examinations at school, teeth in need of treatment are identified and, if necessary, a referral is made to the dental practice. In addition, LKK pays for a six-monthly examination at the dentist's for children between the ages of 6 and 18 (individual prophylaxis).

For children and adolescents up to the age of 18 with a malformation of the dentition, LKK covers 80 or 90 percent of the costs. After successful completion of the medically necessary treatment, the remaining 20 or 10 per cent will be reimbursed.

Preventive benefits for people in need of care

People in need of care and people with disabilities often have an above-average risk of caries, periodontal and oral mucosa diseases due to their living situation. They therefore have a separate entitlement to benefits for the prevention of dental diseases.

In addition to the oral health status survey, these benefits also include the preparation of an individual oral health plan, oral health education and the entitlement to tartar removal, which is semi-annual for this group of people.

Check-ups

Once every six months, insured persons can have a check-up free of charge. This includes the examination to determine dental, oral and maxillofacial diseases, including the consultation. To receive the bonus for dental prostheses, this check-up must be performed at least once a year.

Treatment costs, education and therapy for periodontitis

The risk of developing periodontitis is particularly high in older age. If detected too late, it can lead to the loss of teeth. Periodontitis is a chronic inflammation of the gums and the periodontium. It is usually painless and is therefore only recognised at an advanced stage. Dentists can detect such a disease in time. The costs of the examination and possible treatment are covered by the LKK.

In addition to the actual treatment, LKK also covers the costs of a periodontal education and therapy talk, individual oral hygiene instruction and supportive periodontal therapy as part of follow-up care within 2 years after completion of the actual treatment.

Professional dental cleaning

As an additional service, the LKK contributes to the costs of professional dental cleaning. Reimbursement is 80 % of the actual costs incurred, but not more than 50 € per calendar year. The original invoice must be presented for reimbursement.

Professional dental cleaning is primarily used to prevent caries and chronic gingivitis (periodontitis). The causes are often tartar or plaque. These are removed by the dentist or a trained prophylaxis assistant during professional tooth cleaning. Afterwards, the cleaned surfaces are polished and hardened with fluoride. Advice is given on daily oral hygiene.

SVS – Austria

Offer for oral hygiene

As an important preventive measure, professional oral hygiene helps to contain caries, protect teeth and gums from disease and preserve teeth for as long as possible.

In Austria, children and adolescents between the ages of 10 and 18 are entitled to professional oral hygiene once a year (twice a year during fixed orthodontic treatment) as a benefit in kind from health insurance providers.

Self-employed people insured with the SVS receive a cost subsidy for dental oral hygiene services of € 40.00 once a year to enable more insured persons to have access to preventive dental care.

As of 01.01.2023, SVS insured people will also receive a cost subsidy of € 100.00 for the fabrication of fixed dentures if they have completed oral hygiene sessions, in order to create an incentive to invest in preventive health.

Caries prevention in children ([Auszug aus der Länder-Zahnstatuserhebung 2016 GÖG](#))

In Austria, oral prophylaxis efforts are found at various levels. In addition to publicity-related general measures via the media (e.g. Dental Health Month), dental health education activities are carried out in kindergartens and elementary schools. The 2015 caries prophylaxis documentation shows that comprehensive caries prophylaxis care for children under six has been successfully established in eight provinces (Gaiswinkler 2016). In Salzburg, Klagenfurt, Carinthia (PGA), Upper Austria, Tyrol, Styria, Lower Austria and Vorarlberg, campaigns have been extended to the target groups of pregnant women, mother-parent counselling centers (Tyrol) or parent-child groups. In six provinces (Carinthia (PGA), Upper Austria, Salzburg, Styria, Tyrol, Vienna), separate projects/programs are implemented for risk groups. Vorarlberg also provides nationwide care for eleven- to fourteen-year-olds with its caries prophylaxis program. As of 2015, the required standard of care for the central target group

(children in kindergarten and elementary school) has been implemented throughout Austria in all provinces with caries prophylaxis programs. Thus, as of 2015, it is possible to speak of a uniform basic level, although the content of the programs varies from province to province.

A new provincial dental status survey is planned for 2023, with results expected at the end of 2023.

Pilot project: brief intervention - tobacco in dental outpatient clinics

The Austrian Health Insurance Fund (ÖGK) is planning to implement a pilot project in ÖGK's own dental outpatient clinics.

This involves online training for dental staff (dentists, dental hygienists, dental assistants), with the aim of learning and practicing a minimal counselling procedure (max. 3 minutes) for tobacco cessation.

The online training teaches methods and techniques of smoking counselling and teaches the 3 A's method (address smoking behaviour, advise smoking cessation, refer to support services). Austria-wide, evidence-based cessation services of the ÖGK as well as the smoke-free telephone are also presented.

The training is scheduled for 2 x 1 hours. The refresher course takes place about 4 weeks after the training. The aim is to discuss the experiences made and to provide instructions that will improve implementation in practice.