

More attention to public health in the European Union – implications for dentistry?

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At present the European Union is developing its competence on health and new important issues will be taken on board in European health policy. Increasing mobility of people and integration of the applicant countries puts pressure on the current health care provision systems. A mandate for an open co-ordination process in public health is expected to be given by the European Council. The process will start by exchange of information and best practice models. The next step will be the presentation of common targets between member countries, followed by national action programmes and indicators. It is likely that a lot of emphasis will be put on access to health services, comparisons of costs of health care and benchmarking the costs of items of care. In the long run this will mean convergence of the health care systems. If oral health is to be considered an integral part of general health dental professionals need to be aware of and be able to influence the actions to be taken.

Key words: Public oral health, health care provision, EU

Within the European Union (EU) the provision of health care is considered to be the responsibility of each country. However, irritation among people due to the Bovine Spongiform Encephalitis (BSE) crisis and other food scandals forced the European Commission to pay more attention to health related questions¹. People expect that food, other products, and services in the internal market area of EU meet high safety standards. It is also clear that infectious diseases do not stop at the borders of the individual member states and the same is true for water and air pollution. There is also an increasing awareness of differences in levels and standards of provision of health care and oral health care within and between member states resulting from increasing travel and mobility. Besides the traditionally highlighted employment and economic policies the social dimension of the European Union has progressively become more important and a modernisation of social protection, including pension and social security systems, fighting poverty, care of the aged and health care provision, has started. This is likely to result in the development of new models of social welfare in Europe.

A public health strategy was needed for other reasons

too¹. Inclusion of 10 new member countries, mostly from Eastern and Central Europe has been an important trigger for action. In addition, inside the EU the ageing populations put pressures on social and health care systems as the burden of paying for growing health care services will fall on a proportionately declining working population. At the same time the development of new technologies for diagnosis and treatment, and new and costly pharmaceuticals have a considerable impact on health care expenditure. The expectations among the public about what health services can provide as well as the demands about what they should provide are constantly rising.

The aim of this paper is to shed light on health political developments in the European Union and discuss future challenges for oral health care as part of general health care. In particular, consideration is given to factors influencing the development of public health policy and how this might impact on dentistry.

Public health challenges in the EU

Although health has generally improved and people

live longer in the EU than ever before, there are serious health problems that cannot be ignored². Life-style related diseases such as cardio-vascular diseases, cancers and traffic accidents cause substantial mortality. Smoking causes more than half a million deaths a year in the Union. Mental illness, musculo-skeletal diseases and diabetes are widespread. An increase is seen in the incidence of diseases related to old age such as stroke and impaired functional capacity through physical disabilities, mental disorders, and dementia². Some of the old infectious diseases like tuberculosis have returned. Resistance to anti-microbial drugs makes the situation worse.

There are wide variations and inequalities in both mortality and morbidity between population groups²⁻³. The same applies to oral health⁴⁻⁶. Prevention primarily based on healthy lifestyles is the key to future health policy. As oral diseases share risk factors⁷ with many other life-style related diseases it is natural not to separate prevention of oral diseases from the general approach.

The oral health of children and adults has improved significantly in Europe over the past 20 years, presumed mainly to be due to the widespread use of fluorides and improved living conditions. However, some important inequalities and problems remain. Generally, dental diseases affect the poorer sections of our communities more⁴⁻⁶. Oral health in young children in many migrant groups is considerably worse than in the established population. Also, in most of the countries on the eastern borders of the EU, oral health in children is still poor⁸. Adults, whose teeth erupted long before the advent of fluoride toothpastes in those countries, suffer from high levels of dental decay and edentulousness. In the main, oral diseases in adults have been successfully arrested by dentists but treatments such as restorations need periodic replacement. Oral diseases cause loss of working time and have a serious impact on individuals' quality of life. Today's 'greying' populations are no longer willing to accept edentulousness.

Actions used to harmonise welfare policies in the EU

The clauses on health matters in the Treaty of the European Union of 1992 were of a very general nature. Expressions such as "high level of health protection, preventing human illness and disease and fighting against health threats", were used. Proposals in other community activities such as the internal market, social affairs, research and development, agriculture, trade and environment etc. were aimed to promote health protection and facilitate health policies¹. The four freedoms behind the single market (free movement of goods, services, capital and people) and legislation on competition and social and consumer protection

have, however, influenced the member countries directly and indirectly. A factor of growing importance in this respect is the migration of patients as well as health care personnel across the borders of the member countries. As far as migration of dentists is concerned there seems to have been little migration within the EU/EEA during the 1990s, with the exception of a few member states.

The United Kingdom received nearly 1,000 dentists from Sweden between 1996 and 2000 and about half the new graduates (40) per year from Irish dental schools¹⁰ between 1990 and 1995. During the 1990s the UK also 'imported' dentists from countries outside the EU/EEA. Portugal and Spain have a tradition of importing dentists from South and Central America.

The free movement of health care professionals has been governed by legislation regulating the mutual recognition of professional qualifications aiming to harmonise dental education. The old sectoral directives^{9,10} are expected to be replaced in 2006 by a new EU directive aiming to consolidate and simplify the legal framework for free movement of different professional groups and to strengthen the interface between education, labour market and internal market policies. In practice the new directive implies changes for the regulatory authorities in the member countries. Community legislation also deals with provision of health care in the event of residence in another Member State. Legislation relating to the free movement of goods and services covers pharmaceuticals, medical and dental devices, health insurance and also food, alcohol and tobacco. In these directives, essential requirements are formulated concerning safety, health, environment and consumer protection with which a product has to comply to be sold freely in the internal market. The free movement of patients is promoted under the influence of case law from the European Court of Justice and some interesting decisions have already been taken concerning people's rights to use oral health care services in another country and have the same subsidies as in the home country.

Convergence programmes as a method of harmonisation

Since 1995 the European Union has run major public health programmes in eight main areas:

- Health promotion
- Cancer protection
- Prevention of AIDS and some other infectious diseases
- Prevention of drug abuse
- Handling of rare diseases
- Health monitoring
- Follow-up and prevention of accidents
- Prevention of diseases caused by pollution.

Although these programmes managed to raise

knowledge of the matters and their perceived importance in all countries and also resulted in useful international expert networks, they were considered to be too fragmented. The new public health programme covers them all.

Social dimension comes to the forefront

A modernisation of social protection and the construction of a European welfare model were started in mid-1990s. Convergence, harmonisation, social regulation and collective actions have all been used as steering mechanisms by the Union in social policy issues. Interestingly, open co-ordination of social protection seems to have become a more important working form than legislation, information steering and resource steering. The aim is a welfare model that stimulates uptake of work, and is not too costly.

In its report *Communication on Modernising and Improving Social Protection*, the Commission proposed a strategy on cooperation between and coordination of social security systems, which will also include work on certain features of health care systems, such as the reimbursement of health expenses between systems, and questions relating to costs and financing². Community policies are aimed to complement national actions dealing with issues that the member states cannot handle on their own. The organisation, financing and delivery of health care services as well as oral health care were, however, left as responsibilities of the member states. A growing tension between the implementation of the economic objectives of the free market on one hand and the assurance of high quality of health care in the member countries on the other hand has been noticed.

The different models¹³ of organising oral health care provision in Europe offer different treatment options for patients, different conditions for care providers and entail different costs for patients and third party payers. Typical for the Nordic countries is a large public sector with salaried personnel financed by general or local taxation and the state having a central role in guidance and supervision. There is a private sector that can be subsidised through a public health insurance. The Bismarkian system in Central Europe is based on statutory sickness insurance reimbursing oral health care and it is financed by employers and employees. Regional sick funds negotiate with dental associations about fees. The public sector is insignificant. In the Beveridgian system in the UK most general oral health care is provided by independent dentists in contract with National Health Service (NHS). Free care is provided for children and subsidised care for adults. Private treatments are also possible. The Southern European model is predominantly private without governmental involvement. Limited insurance schemes, often organised by employers, are available for some.

Public services can be available to children and to treat dental emergencies. Generally, between 6–10% of the National Health budgets are spent on oral health care in the EU/EEA member states. In 2004 the EU expanded by the addition of 10 new member states. In eight of them (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia) there used to be free or almost free public oral health care for all during the communist era. Due to financing problems and political changes, these countries have abolished most of the old system and are working with, or planning, insurance based oral health care¹³. However, relatively few means are available for this health care sector in relation to the treatment needs of the populations.

The new public health strategy focuses on information

In the health sector, as in the social dimension of the EU, regulation by peer pressure and voluntary convergence and compact seem to take the place of statutory norm setting. There are three priorities in the new programme of Community Action in the field of public health to be run from 2003–2008²: increasing knowledge and health information, rapid response to health threats, and tackling health determinants.

The new programme aims to create a comprehensive health information system which provides policy makers, researchers, health professionals and the general public with key data and information they need.

Agreed Community-wide indicators of health status, determinants of health, demographic and social factors, life style, living and working conditions as well as of disease prevention interventions will be needed. Information needs to be collected concerning cost-effectiveness of different health care systems, new health technologies and examples of best practice. Different output packages are planned for different target groups. The general public is expected to demand information on the accessibility of social and health care services and social insurance or public service coverage. Health professionals are expected to need information on evaluations of health interventions and new technology, analyses of good practice as well as guidelines, recommendations and advice that helps them to enhance their skills and knowledge. The authorities are expected to need comparative data on health trends and developments and established benchmarks to measure progress and effectiveness of health interventions and strategies. Legislative measures may be needed to improve the data collection in the member countries.

The Council of European Chief Dental Officers, inaugurated in 1992, comprised of the dental advisers to the national governments, has long emphasised a need for a comprehensive database in oral health care in the Union area. According to the chief dental

officers, a minimum set of information should include data on:

- Oral health status and treatment needs in different population groups
- Use and supply of services, treatments provided and the outcome of care
- Health workforce and costs
- Information on education systems
- Task delegation and oral care provision by dental teams.

In 2003 the dental faculty of the University Claude Bernard Lyon¹ received a grant from Sanco (Health and Consumer Protection Directorate – General) to conduct a systematic review and to outline a process for identifying a set of core indicators that can be used when comparing oral health status and outcomes of oral health care provision in the member states. The work is expected to be finished by later this year.

Responding effectively and in a co-ordinated way to potentially serious threats to public health from major diseases involves building up the necessary capacities (e.g. vaccinations) among authorities and centres of expertise. An effective early-warning system similar to the vigilance system in the market control of medical and dental devices will be established. New legislative actions will be taken in the veterinary and phytosanitary fields, and in the areas of blood, blood products and organ transplants.

Main priorities in the part of the programme that deals with health determinants², the underlying factors that affect people's health, focus on smoking, alcohol consumption, nutrition, obesity, physical activity, stress reduction, drug abuse and major socio-economic and environmental factors. Actions will especially be targeted at young people since lifestyles and health-related behaviours are formed in youth and intervention in young people pays the best returns. Fighting oral diseases should be included in these actions.

The European Commission has also realised that there is a need to strengthen health technology assessment structures and to disseminate more effectively the results in the field of health care as evidence-based best practice models.

Consumer protection work needs to be developed to deal with spurious health claims for what are called nutraceuticals and over the counter medicines. The Community can provide information about diet, nutritional values of foods, ingredients and additives, to encourage people to make healthy choices. It can also work with manufacturers to improve the nutritional value of processed food and dental expertise is needed in this context too.

Is there space for oral health care in the EU strategies?

With the new public health programme the European

Union clearly widens its working field. One of the aims¹⁴ is to achieve improvements in access, equity, accountability, cost-effectiveness and quality of the services provided. The health care systems in the individual countries will be assessed at multinational fora and, in the long run, there will be pressure to harmonise the national systems. Oral health care is seldom mentioned in general public health strategy papers although it concerns all citizens in the EU/EEA area¹⁵. More than €54 billion were used in oral health care and more than 900,000 persons were directly involved in providing care for dental patients in the now 28 individual member states of the EU/EEA in 2004¹³.

No formal EU oral health care strategies have been developed so far. Informal, but European wide, discussions have taken place in the Dental Liaison Committee (DLC), a forum for co-operation between the national dental associations, and in the Council of European Chief Dental Officers (CECDO). The DLC initiative is directed to maintaining dentistry as a liberal profession. The CECDO has emphasised the need for identification of the oral health 'black spots' across Europe and reducing inequalities as areas for priority action, and is working on an action list for further implementation of strategies. There is general agreement in the Council that targeting oral health care resources more effectively requires better information.

It has also been questioned whether dentistry fits in at all with the general approach applied to medicine, as the relative proportion of overall subsidies allocated to dentistry or financing through public health insurances has reduced in many countries. This has not been the case for medicine. On the contrary, as a sign of growing interest in health care and as a result of the improved economy, an increase in public spending for health care in general can be noted in all EU-countries, while oral care provisions are increasingly left to private arrangements. So far there is little information to allow monitoring of the effects of this situation. As the new public health strategy aims to improve consumers' position, it is obvious that lay people should know more about oral diseases, their own possibilities of preventing them, treatment options, treatment outcomes and longevity of technical solutions. More knowledgeable consumers can be expected to have higher demands on their oral health care.

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