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# DENTAL CARE SYSTEMS



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МИНИСТЕРСТВО ЗДРАВООХРАНЕНИЯ РЕСПУБЛИКИ БЕЛАРУСЬ
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# СИСТЕМЫ СТОМАТОЛОГИЧЕСКОЙ ПОМОЩИ

# DENTAL CARE SYSTEMS

Учебно-методическое пособие

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На английском языке

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## MOTIVATIONAL CHARACTERISTICS OF THE TOPIC

Therapeutic and prophylactic dental care for the population of a particular country is carried out, as a rule, within the framework of a specific health care system. The healthcare system in our country is constantly being improved along with the development of the society in the same way as in other countries of the world. In order to make a comparative assessment of the domestic health care system, it is necessary to make a scientific analysis of the existing world health systems and evaluate the alternative options known in the world.

Rational planning of dental care for the population requires a complete understanding of the principles of operation and organization of dental care. In this regard, the dentist needs to know about other systems of organizing dental care for the population.

**Purpose of the lesson:** to study the existing basic health care systems and systems of organizing dental care for the population.

**Lesson objectives:**

1. To study the classification of dental care organization systems for the population.
2. To study the history of the development of dental care for the population.
3. To study the advantages and disadvantages of the basic systems of organizing dental care for the population.
4. Be able to offer an alternative structure for organizing dental care for the population.

**Requirements for the initial level of knowledge.** The student must:

1) know the main components of long-term planning of dental care at the communal level;
2) know the criteria for the quality of dental care for the population;
3) be able to conduct a situational data analysis;
4) be able to plan and evaluate health care at the communal level.

**Control questions from related disciplines:**

1. Definition of the concept of "system".
2. WHO recommendations for planning health care for the population.
3. Legal aspects of the organization of medical care for the population.

**Control questions on the topic of the lesson:**

1. Definition of the concepts of “health care”, “health care system”, “dental care system”.
2. Social insurance system of health care.
3. State health care system.
4. Private health care system.
5. Insurance system of dental care.
6. State system of dental care.

7. Private dental care system.

8. Practical implementation of the organization of dental care systems for the population based on the example of some European countries.

## INTRODUCTION

Dental health of the population is the most important component of general health. The physical, social and psychological well-being of a person depends on the quality of dental care.

*Figure 1.* Pierre Fauchard (portrait engraving, Jean-Baptiste Scotin)

The development of dental care systems took place in close connection with the development of society, the changing needs of people and their attitude to their health, in particular to the health of the oral cavity. Dentistry as a medical specialty was born in the late 17th – early 18th centuries. This is primarily due to the works of the outstanding French physician Pierre Fauchard[1] (Fig. 1).

Pierre Fauchard was the first among European dentists to single out dentistry as a separate profession. Unlike his contemporaries, who tried to keep their skills and abilities a secret, P. Fauchard made his own knowledge, discoveries and inventions available to every-one. The main work of his life — the treatise "The Dentist Surgeon, or Treatise on Teeth" (published in 1728) — remained popular for a century. The book outlines the basics of the anatomy and function of the oral cavity organs, signs of pathology of the latter, surgical methods of caries treatment, methods of restoring decayed and missing teeth, and also discusses in detail many other advanced dental techniques of that time (some of them continue to be used in modern dentistry).

[1] P. Fauchard (French Pierre Fauchard, 1678–1761) — an outstanding French doctor, recognized as the "father of modern dentistry". He is considered the first person to put dentistry on a scientific basis and the first dentist in the modern sense. The two-volume textbook "Le Chirurgien dentiste, ou Traité des dents" (1728) is a key work in dentistry and is considered the first complete treatise on this branch of medicine. (Pierre Fauchard Academy [Electronic resource]. Access mode: https://fr.wikipedia.org. Access date: 20.04.2020)

By the 20s of the twentieth century, dentistry has developed as a medical discipline. Currently, therapeutic and prophylactic dental aid to the population is carried out within the framework of a specific health care system.

Health care is a branch of the state's activity, the purpose of which is to organize and provide affordable medical care for the population[2].

The health system is a collection of all organizations, institutions and resources, the main goal of which is to improve health. A health system requires human resources, financial resources, information, equipment and supplies, transportation, communications, and overall governance and leadership. The health system must provide services that are responsive and financially equitable, with respect for people[3].

Health systems have evolved under the influence of specific historical, economic, social and political factors. Experts of the World Health Organization (WHO), with a certain degree of conditionality, depending on the methods of financing, forms and methods of monitoring the volume and quality of medical care, incentive mechanisms for providers and consumers of medical services, proposed a classification according to which three primary types (three main models) of health systems are distinguished:

1) social insurance (based on comprehensive health insurance) health care system, or the Bismarck system;

2) the state (public, budgetary) health care system, or the Beveridge system;

3) non-state (market, private) health care system.

The social insurance and state healthcare systems were built on the basis of a solidary ideology (from the French *solidarism*e, from *solidaire* — acting at the same time), the essence of which is that the contribution of a citizen to public welfare should not determine his access to healthcare, as well as to other services and products that are considered socially important (education, nutrition, etc.).

The non-state (market, private) health care system is based on market principles using private health insurance. Private medicine is based on a liberal ideology (from Latin *liberalis* — free): if a citizen's contribution, that is, his work, determines access to the market for most products, then access to the healthcare system (as well as education, etc.) should be determined by the same factors. Medicine and healthcare in this case are treated like any other commodity.

[2] Law of the Republic of Belarus “On Health Care” dated June 18, 1993 No. 2435-XII [Electronic resource]. Access mode: http://pravo.by. Access date: 20.04.2020.

[3] World Health Organization [Electronic resource]. Access mode: https://www.who.int. Access date: 20.04.2020.

## HEALTHCARE MODELS

Each country has historically developed and developed its own way of attracting economic resources to provide medical care, preserve and improve the health of the population. The quantity and quality of resources allocated by society, the effectiveness of their use in the health sector is determined by a complex system of economic, political, moral, ethical and other relations that have historically developed in the country.

Before proceeding to the description of the specific characteristics of dental care systems for the population in some countries, let us consider the development of certain *models of health care systems*, which subsequently served as the basis for the formation of national services and health systems.

### SOCIAL INSURANCE HEALTHCARE SYSTEM

The first health system to emerge in modern history was the system created by German Chancellor Otto von Bismarck[4] in 1881. The system served the purpose of promoting the health of ordinary workers, as they were potential military personnel. The health system was an insurance program for workers and their families and was based on the Railway Workers' Compensation Act (1838) and the Mining Societies Act (1854), which were already in force at that time. The "hospital cash registers" later replaced the initially created social insurance funds, which paid, in addition to medical expenses, unemployment benefits, pensions, etc. The funds received two-thirds of their contributions from employees and a third from the employer. This system later served as a model for health insurance systems around the world.

*Figure 2.* Otto von Bismarck (1815–1898)

[4] Otto Eduard Leopold von Bismarck-Schönhausen, Duke zu Lauenburg (German Otto Eduard Leopold Fürst von Bismarck-Schönhausen, Herzog zu Lauenburg; 1815–1898) — the first Chancellor of the German Empire, who implemented the plan for the unification of Germany along the Lesser German path. Upon retirement, he received the non-inherited title of Duke of Lauenburg and the rank of Prussian Colonel General with the rank of Field Marshal. (Otto von Bismarck [Electronic resource]. Access mode: https://ru.wikipedia.org. Access date: 10.05.2020)

Having a decentralized nature of management (at the regional level), the Bismarck system was financed from three sources: mandatory contributions from employees, mandatory contributions from employers and a certain percentage of allocations from the state budget. This type of medical care insurance is called "compulsory health insurance". The dominant role in the financing of the system was played by insurance payments from the population and enterprises. Under this system, the workers and their families were guaranteed compulsory medical care and the conditions for financing this assistance were stipulated.

It should be noted that the targeted nature of the financing of the Bismarck system makes it possible to respond more flexibly and quickly to the expansion of needs for medical services. It offers the public a wide range of insurance companies, medical organizations and the services they provide, as well as medical and nursing stuff. Competition between organizations (insurance and medical) improves the quality of medical care. The Bismarck system presupposes a clear division of functions and responsibilities between the state, funding bodies and medical institutions.

In Europe, the social insurance model is most developed in Germany and France, but is also used by other countries, including the Netherlands, Austria, Belgium, Switzerland, Canada, and Japan. In some countries (Denmark, Norway, Finland, Canada), *public insurance* (voluntary or compulsory) dominates, in others (the USA, Israel) — *private insurance*. In France and Japan, health insurance is part of the general social insurance system. In Belgium, the Netherlands, Germany and Switzerland, the government only regulates the activities of various independent foundations. The differences between funding either from taxation or from social insurance funds are insignificant: insurance contributions are a certain fixed percentage of wages, which is equivalent to the established tax on it.

As an example of the functioning of the Bismarck health care system, let us briefly consider the German experience. Most experts agree that the German healthcare system is one of the most efficient in the world and continues to be constantly improved.

In Germany, 90 % of the population is covered by the national compulsory health insurance (CHI) system, which consists of approximately 150 health insurance funds (health insurance funds). CHI funds are formed from three sources: the state budget, contributions from employees and employers. Of the funds received by medical and preventive institutions, 60 % are compulsory medical insurance funds (of which 25 % are insurance for family members of workers); 10 % — funds of voluntary health insurance (VHI); 15 % — public funds from taxation; 15 % — personal funds of citizens.

The German health insurance system, based on the principles of solidarity and subsidiarity, copes with its tasks quite autonomously and independently of the state budget.

In a jointly financed health insurance system, the amount of contributions corresponds to the degree of the insured's wealth (the amount of their income), and services are provided in accordance with the state of health, regardless of the amount of personal contributions of each person. This method of determining the amount of contributions ensures solidarity, in which the healthy bear the costs for the sick, the young for the old, the single for families, and the well-off for the poor.

The principle of solidarity is supplemented by the principle of subsidiarity, so that the insured feels his own responsibility for his health, and the organization of the activities of insurance institutions is built in such a way that problems, whenever possible, are solved with the involvement of the insured themselves.

Subsidiarity and solidarity provide effective social protection in cooperation, without exceeding the limits of the possibilities of both the insured and the state.

## PUBLIC HEALTHCARE SYSTEM

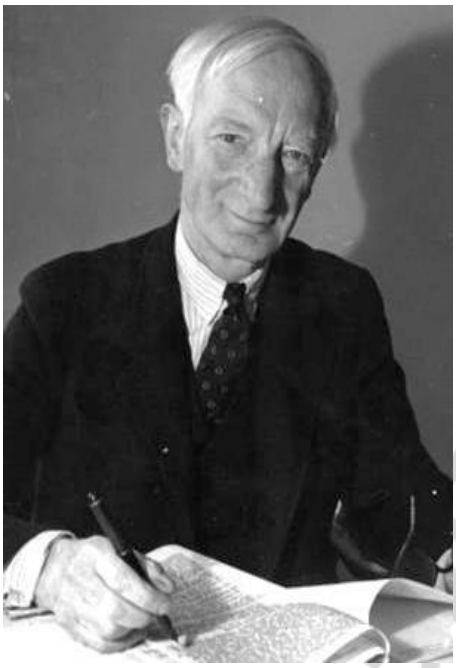

*Figure 3* William Beveridge (1879–1963)

The Beveridge model of social policy gets its name from William Henry Beveridge[5], an English economist who laid the conceptual foundations of the system of budgetary financing of health care. The British consider him one of the greatest social reformers of the last century.

During World War II, William Beveridge, on behalf of Winston Churchill, developed a program of post-war social reconstruction. The "Beveridge Report"[6], which he presented in a report to the British government in 1942, formed the basis for the future National Health Service, incorporating health care into the structure of general social policy. In 1948, the government established the State Health Service, which guarantees free medical care to all segments of the population.

[5] Beveridge, William Henry (1879–1963) — English politician and economist, after whom the Beveridge Social Security Plan is named. In 1934–1944 — Chairman of the Standing Committee on Unemployment Insurance. Since 1937 — Member of the British Academy. In 1940–1944 — President of the Royal Economic Society. ([Electronic resource]. Access mode: https://dic.academic.ru. Access date: 10.05.2020)

[6] The Beveridge Report is a report outlining the principles underlying the creation of the welfare state in the immediate aftermath of World War II (published in 1942). The formal title of the report is "Social Insurance and Allied Services". The report advocated the idea of introducing social insurance to create a universal social security system (including multi-family benefits) and a universal, comprehensive, free national health service. ([Electronic resource]. Access mode: https://ru.wikipedia.org/; https://blogs.bodleian.ox.ac.uk. Access date: 10.05.2020)

The main characteristics of this model are:

1) equal access to health care for all citizens of the country as a fundamental feature of the budgetary model of health care financing (the state system ensures the equality of citizens in receiving health care, which prevents the formation of social inequality in the field of public access to health care services; responsibility for ensuring access to health care is assigned to the Ministry of Health);

2) central and regional planning (when planning medical care, central planning has an advantage, despite the fact that the peculiarities of regional development are also taken into account);

3) control and management are carried out centrally through the supreme governing body of the health care system (with the bulk of medical institutions owned by the state).

In this model, two forms of health financing are possible:

1) through state funds, the resources of which are used to finance medical institutions (all funds (tax revenues) are accumulated, as a rule, in the state budget and distributed from top to bottom along the management vertical; centralized financing allows you to control the growth in the cost of medical services);

2) direct financing of medical institutions, bypassing state funds.

Currently, the health care system in Great Britain, as the most striking example of a public (state, budget) model, is financed mainly from citizens' tax revenues. The key provider of health care services is the National Health Service (NHS), which reports to the Department (Ministry) of Health. It provides residents with almost the entire range of necessary medical services, medicines in hospitals and medical products free of charge. With regard to the provision of prescription drugs for outpatient dispensing, the country has a balanced system of reimbursement of the cost of these funds, including a co-payment (£ 7.85 per prescription) for the working-age population. For socially vulnerable and low-income groups of the population, co-payment benefits are established. Thus, citizens under the age of 16, aged 60 and over, full-time students under the age of 19, patients with diseases included in a special list, military pensioners and war veterans are completely exempted from co-payments for medicines. Moderate co-payments apply to ophthalmic and dental services. The state pays for travel to the place of treatment for the poor, and also provides a number of other important benefits in the field of medical services.

The budgetary, or public health care system is also typical for Ireland (since 1971), Denmark (since 1973), Portugal (since 1979), Italy (since 1980), Greece (since 1983), Spain (since 1986) and a number of other countries.

## PRIVATE HEALTHCARE SYSTEM

The US healthcare market is a typical example of a market model. The healthcare sector is represented here by a developed system of private medical institutions and commercial medical insurance, where doctors are sellers of medical services, and patients are their buyers.

Such a market is the closest to a free market and has all its advantages and disadvantages.

Due to the intense competition, conditions are created for the growth of quality, the search for new products and technologies, and the strict rejection of economically ineffective strategies and market participants. This determines the positive aspects of the healthcare market model.

At the same time, insufficient consideration of the specifics of the type of product under consideration (unlimited demand for it, the seller's monopoly, etc.) causes certain negative aspects:

1) excessive growth in medical costs;

2) the impossibility of exercising state control and, consequently, difficulties in setting priorities between health care and other sectors of the economy;

3) the possibility of overproduction crises and stimulation of the supply of unjustified services;

4) preconditions for unfair competition methods;

5) excessive influence of fashion and advertising;

6) unequal access to health care.

In the market model, medical services are considered as any other commodity that can be bought or sold in accordance with the classical laws of the market (i. e., with minimal consideration of its social specifics).

The peculiarity of the private model is the absence of a unified system of public health care or insurance. Medical care is provided mainly on a paid basis, at the expense of private insurance or from the funds of the consumer of medical services, and the market is the main instrument for meeting the needs for medical services. The state undertakes to finance only those needs of society that cannot be met by the market (medical services for low-bracket category of the population, pensioners and the unemployed) by developing and financing public health care programs.

In a private healthcare system, there is no mechanism to influence the territorial distribution of medical services. On the part of the state, there is insufficient control over the activities of medical institutions; lawsuits are widely used to control the medical services and services provided to the population. Under this health care system, the "imposition" of unnecessary medical services is noted, since the ratio of supply and demand is inadequate — demand is significantly lower than supply.

The basis of the US health care system is the private market for health services, complemented by the state program of medical care for the poor "Medicade" and people of retirement age, as well as the disabled people of the program "Medicare". There is no national health care system that covers the entire population. The health care system is decentralized and controlled by private health insurance organizations. In the United States, there are two types of private health insurance: individual and group, which are funded by the state, personal funds of the population and insurance companies. State governments are also involved in regulating the activities of insurance companies — companies are required to be accredited by the National Committee for Quality Assurance, providing reports on certain indicators and evidence of their compliance with accepted standards.

The main problems of the private health care system are the high cost of medical care and the low priority of preventive work, the lack of access to medical care for the population of various social groups, and insufficient attention to patients.

These problems have led to the need for significant reform of the health care system. The current US health care reform is being implemented under the Patient Protection and Accessibility of Care Act, which includes four main areas of change:

1. Mandatory health insurance for the entire population.
2. Regulation of insurance rates and volume of medical care provided by insurance.
3. Simplification of the choice of an insurance plan by citizens.
4. Regulation of prices for medical services and improvement of their quality by specially created commissions.

Summarizing the above, it should be noted that in its pure form, none of the models presented exists in any of the states. For example, as the researchers note, despite the fact that the German model is social insurance, the state allocates significant funds for health care directly from the country's budget. This has become especially relevant in recent years due to the lack of health resources. In the UK, not all NHS needs are funded from general tax revenues, accounting for 76 % of its budget. The remaining 24 % is covered by employers "and workers" health insurance contributions (19 %), as well as other contributions and fees (5 %).

## "MIXED" HEALTHCARE SYSTEM

Currently, there is no single, most effective model of the health care system, which leads to the need for reforms even in countries with high indicators of public health and living standards. In almost all developed countries, medical care is provided by institutions of both forms of ownership, which contributes to the development of competition and, accordingly, to

the improvement of the quality of medical services. It is important to achieve universal coverage of the population with guaranteed medical services, as well as to eliminate duplication of costs, the availability of resources, their rational distribution and more efficient use.

The Canadian health care model is a typical example of a combination of two different approaches. It is generally considered to be socio-political, but in many ways it is similar to the state model. In Canada, 99 % of the population has universal access to health care through Medicare, which is governed by health insurance plans from ten provinces and three territories. The main source of Medicare funding comes not from employers "and workers" health insurance contributions, but from federal and provincial tax revenues, as in the budget model. In Canada, there is no legally approved package of health services that are subject to mandatory coverage from public funds. At the national level, Medicare covers the costs of necessary services for the entire population, including the assistance of family doctors, the provision of most types of specialized medical care, as well as medicines, and inpatient care. In Canada, the range of services and technologies reimbursed under the CHI is narrower: dentists, ophthalmologists, andrologists, home care and assistance, and (contrary to popular belief) outpatient prescription drugs are not covered. As a result, these drugs, as well as the services of these specialists, are paid for under private insurance plans, from the funds of the patients themselves and charitable foundations.

In Sweden, after the adoption of the Health and Medical Services Act in 1982, the entire population (except for illegal immigrants) received equal access to publicly funded health care services. The country does not have a legally approved package of medical services that are subject to mandatory coverage from public funds. At the same time, a very wide range of services is paid for within the framework of the state system for providing medical care, including: public health, including vaccination; prevention; primary health care; outpatient and inpatient specialized medical care; emergency medical care; psychiatric care; rehabilitation; support for people with disabilities; transportation of patients to the place of treatment; home care and long-term care, including nursing homes; full dental care for children and young citizens; dental care for adults (partially); provision of outpatient and inpatient prescription drugs. Since public health coverage is significant, only 4 % of Swedish residents buy additional private insurance plans.

The evolution of healthcare systems (Fig. 4) shows that under the influence of globalization, on the one hand, the role of market mechanisms is increasing, on the other hand, the control by the state and (or) international organizations is increasing. This is manifested in the fact that insurance funding is becoming more widespread, competition between providers of medical services is encouraged, the coverage of the country's population with medical care is growing, and international quality standards are being introduced.

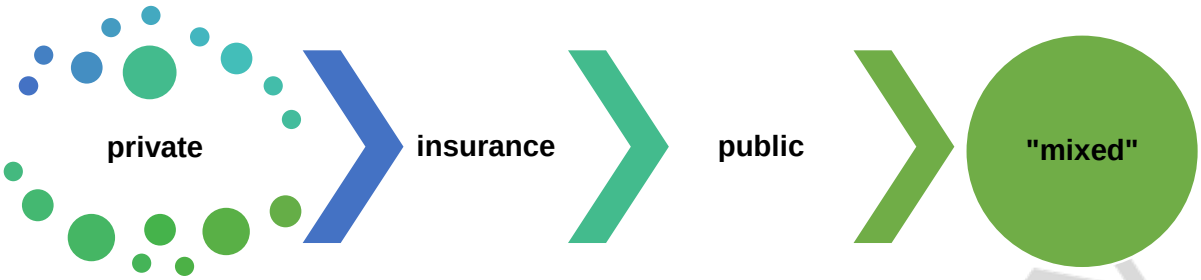


*Figure 4*. Evolution of healthcare models

Each country chooses for itself all the best that has been accumulated in the world experience and implements it depending on its own political, economic and other conditions and factors. In this regard, as a rule, one can observe a "mixing" of private, insurance, public health care systems with the predominance of one of them to some extent. The advantages and disadvantages of the considered health systems are given in Appendix 1.

## MODELS OF DENTAL CARE ORGANIZATION SYSTEMS

Providing adequate dental care is one of the important tasks of every state. Europe is characterized by a wide variety of cultural conditions, and each country strives to find solutions to its problems, including health and dental care in particular, taking into account its own characteristics. As a rule, dental services make up the largest segment of outpatient services in any country, while each country has historically developed its own way of attracting economic resources to provide dental care to the population. The quantity and quality of resources allocated by the society, the efficiency of their use are determined by a complex system of economic, political, moral, ethical and other relations that have historically developed in the country.

*The dental care system* is a set of governmental and healthcare institutions, acting in a certain order to provide dental care to the population[7].

According to the WHO recommendations (WHO OP No. 53, 1980), any system of organization of dental care for the population in the country should include:

1) primary prevention;
2) systematic dental care for children;
3) dental care for the adult population on request;
4) training of personnel in the required quantity, quality and types for the implementation of the above-mentioned parts of the system;
5) material and financial support of the system components;
6) assessment and monitoring (information system).

[7] Leus, P. A. Dental health of the population. Minsk: BSMU, 2009. P. 174.

If the system lacks a certain component or there is no consistency between them, dental care for the population cannot be effective and people's health, as a rule, deteriorates.

World experience shows that the organization of a well-coordinated interaction of the components of the dental care system is impossible without the use of several sources of funding, without taking into account social factors, without a pronounced interaction with state authorities. At the same time, the state cannot organize an effective system of providing dental care to the population without the support of professionals and the population. Thus, in the organization of optimal dental care for the population, there are three interested groups of society: the state and local authorities; population; medical personnel of dental organizations.

The interests of the state and authorities: ensuring a good level of health of the population; manageability of the dental service on the basis of the law; availability of dental care for different population groups; social and economic acceptability (for the state and the population).

The interests of the population: the availability of dental care; quality; social, economic acceptability and attractiveness of the form of care, responsibility for it; the possibility of choosing the form of care, dental organization and dentist.

The interests of the medical personnel of dental organizations: a decent level of pay; professional and social security; independence of choice (within the law) of the form, place of work, professional behavior; professional, functional and resource provision of the work of specialists and the possibility of their regular improvement.

In most countries, national dental care systems are composed of three components: private, public, and insurance. Let us consider each of them.

## DENTAL CARE INSURANCE SYSTEM

*The dental health insurance* system is a form of individual insurance that is funded from the funds contributed by the insured patient[8]. The aim of the dental insurance system is to remove financial barriers to the provision of dental care to the population.

Historically, the European trend in the organization of dental services to accommodate the growing demand for dental care, as well as to facilitate access to dental care for the entire population, led to the emergence of dental health insurance around 1880.

Dental insurance systems first began to develop in the former Austria-Hungary and Germany before and after World War I. Later, insurance systems appeared in Hungary, Poland, Romania, Czechoslovakia and Yugoslavia, and during and after World War II — in Belgium, Denmark, the Netherlands, France; they also developed in Greece, Spain and Italy.

[8] Dental health of the population / P. A. Leus. Minsk: BSMU, 2009. P. 177.

Initially, the insurance extended only to certain categories of employed persons, and only those who were directly insured received insurance benefits. Financial benefits were very small, but gradually expanded in three different directions: first, coverage gradually extended to other categories of workers, administrative employees in both the private and public sectors, and ultimately all employees; secondly, benefits were also paid to families and dependents of insured persons; third, the insurance system expanded the types of dental care (insurance began to cover all types of surgical treatment and basic types of restorative treatment, at least partially, and in some countries also some types of orthodontic treatment).

There are currently two types of dental insurance in Europe.

The first type is insurance in the classic form, which began to develop in Europe just over 100 years ago: individual, but compulsory insurance that guarantees each insured person reimbursement of dental treatment costs, and also helps to reduce health care costs of insured persons, since employers cover some of the premiums. In most European countries, employers and employees make the same contribution to insurance premiums. Issues related to the organization of the insurance system, benefits paid to insured persons and the amount of treatment provided in accordance with the insurance, as well as fees for dentists are resolved through discussions between representatives of insurance companies and professional dental organizations. These discussions are overseen by government officials and the resulting insurance rules are legally binding. However, in other respects, the organization of the health insurance system is mainly decided by the existing political influences, the economic situation of the country and the wishes of various interest groups. These are the health insurance systems that emerged in central Europe and then spread to Greece, Spain, Italy, the Netherlands, Turkey and France.

Another type of dental health insurance originated in Denmark and Sweden. In Denmark, the previous private health insurance system has undergone a transformation, while in Sweden a new type of national dental care system has been created, which has significantly changed the conditions of dental treatment, as well as the nature of the work of dentists. The differences between these varieties from the classic form of insurance in dentistry are insignificant and concern only their financing, which in the systems existing in Denmark and Sweden is carried out from the state budget. In practice, however, the distinction between these two types is fundamental, since by providing funding, the government is able to control the activities of the services and, therefore, to direct the work of the insurance system accordingly. By changing the financial benefits provided to patients, the government has the ability to influence the behavior of both patients and dentists so that preventive interventions are preferred over regular and comprehensive dental care. Thanks to this, the activity of the insurance system acquires a new direction, which is

not typical of the classical insurance system, and the public health authorities are able to direct the development of the insurance system so that it meets the needs and wishes of the population. In this sense, the type of insurance considered here represents a new type of service that occupies an intermediate position between the original insurance systems and the public dental care system.

The general dental service in the United Kingdom of Great Britain and Northern Ireland is of the same nature. It is also based on the principles of dental insurance, but is a national dental care system that is accessible to every citizen, with patients receiving substantial financial support to reimburse dental care costs. Dentists remain private practitioners who have their own dental office and employ dental ancillary personnel, but they also work under contracts with local administrations and are paid in the form of certain fees for each job performed. This is somewhat similar to the nature of payment for dental services in the insurance system, but the fees are paid by the Ministry of Health and Social Security at the expense of the national budget. In the United Kingdom of Great Britain and Northern Ireland, the general dental service is not identical to either the dental insurance system or the public dental service. It belongs to a group of national dental care systems that provide care to the entire population and whose development is directed in such a way that it constantly matches the economic situation of the country and the needs of the population. The volume and quality of the work carried out in such systems is being assessed and improvements are being made by strengthening their coordination with other components of the national health service.

However, it should be noted that there are still significant differences between European countries in the amount of benefits paid by insurance organizations to their members, in the proportion of the population covered by insurance, as well as in the relative number of dentists participating in insurance schemes. However, in general, there is a uniform trend towards expanding insurance and creating national systems covering therapeutic dental care for the entire population with the participation of all dentists.

## PUBLIC DENTAL CARE SYSTEM

The first elements of a public dental service in Europe appeared shortly after the advent of dental insurance. Dentists were keen to generate interest in this problem among administrative workers, and they gradually succeeded in obtaining support from the state budget and charitable funds to finance public dental outpatient clinics intended primarily for serving schoolchildren. The first outpatient clinics appeared in the late 19th and early 20th centuries in Strasbourg and Zurich. Until the end of the First World War, this process proceeded relatively slowly, but after the war, the public system of dental services developed in a number of European countries, covering pregnant women,

nursing mothers, and in some cases even the poor. The theory and practice of creating a gradually expanding system of comprehensive dental care for schoolchildren was developed in Germany. In the post-war period, public dental care continued to develop in Austria, Switzerland and other countries, and also spread in Scandinavia.

The goal of the public dental care system is to achieve an improvement in the dental status of the population by providing assistance to high-risk population groups, systematic treatment of schoolchildren, and participation in community prevention programs.

## PRIVATE DENTAL CARE SYSTEM

In a private dental practice, a dentist treats a certain number of patients, who pays him the full fee for the treatment. This was the nature of private practice at the beginning of the last century. Since then, the amount of care provided by private practitioners has declined, and the nature of private dental practice is directly influenced by the public health system on the one hand and indirectly influenced by other types of services with which private practice coexists within the national dental care system.

In its original form, private dental practice corresponds to the liberal economic and political concept, since it has the character of a free profession. This means that the dentist treats each patient individually in the way that best suits the interests of the latter, while adhering to scientific principles as well as to the rules of professional ethics, which are monitored by dental organizations. The country's administrative authorities ensure that private practice dentists comply with legal regulations, and the health authorities ensure that private practice is conducted in accordance with generally accepted rules and regulations. However, in other respects, society does not interfere with the practice of private dentists.

Unrestricted private practice in the original sense of the term currently plays a dominant role only in some European countries. For example, in Iceland, Norway, Switzerland, private dental practice continues to be the main one in providing dental care to the adult population. Until recently, the same could be said about Finland and Sweden.

The population of the Scandinavian countries and Switzerland was quite satisfied with private dental practice, probably because in these countries, firstly, the technical quality of dental treatment was always high, and secondly, the number of dentists grew relatively quickly, so the gap between demand never reached such a scale as to reorganize the national dental care system. The demand for dental care was also more easily met because national administrations in these countries at all levels showed a sense of responsibility for the health of individuals. As a result, public health systems in these countries

were created at a relatively early stage, which contributed to the solution of social problems associated with dental care, at least the problems of organizing medical care for children.

Summarizing the description of the systems of dental care for the population, we note that when assessing their advantages and disadvantages, it is necessary to focus on three important links that determine the operation of the entire system: the state, the population (patients) and the dental community (Appendix 2).

There is no single dental care system suitable for all countries. Each country forms its own model of dental care, which is suitable in terms of financial capabilities, political structure, economic conditions, habits and wishes of the population and the dental community.

Below is a brief description of the dental care systems in individual countries.

## ORGANIZATION OF DENTAL CARE SYSTEMS FOR THE POPULATION BASED ON THE EXAMPLE OF SOME COUNTRIES

### GERMANY

The dental care system in Germany is predominantly insurance and private. Patients receive treatment in private offices. In addition, there are a number of university clinics where dentists are government employees. Most dental procedures are covered by the health insurance, but some procedures, such as veneers, are the patient's responsibility to pay. The German dentist begins medical practice after five years of university studies. After graduation, a novice dentist must work under the guidance of an experienced dentist in his practice for at least 2 years. After that, he gets the right to organize his clinic. Most often it is concerned with buying a practice from a retiring doctor, as in many states the opening of new clinics is limited. Most German dentists have general practice, providing all types of care to the patient. In addition, there are specialists in specific areas of dentistry (orthodontics, endodontics, surgery), to whom dentists refer patients in difficult cases. Dental specialists receive additional training for 2–3 years. In most cases, a private dental clinic in Germany is equipped with two or three dental units. In practice, there is often one doctor and several assistants (from 2 to 4) with secondary medical education who perform the duties of assistants, hygienists, registrars. Often these functions are not fixed. In some cases, 2 or 3 doctors may work together in one practice, sharing the cost. In addition, a trainee doctor may work in the practice, then he receives a fixed salary from the owner of the clinic. The organization of patient reception in the western and eastern regions has its own characteristics. In the east, the dentist’s activities are more similar to the practice in our country. A dentist with one or two assistants work with a patient in one chair, while

a hygienist works in the next office. In the West, the so-called "delegation of powers" of doctors to assistants is more developed. Due to this, in practice, one doctor simultaneously accepts 2–3 patients in different rooms. The advantage of this approach is higher work efficiency, and the number of patients admitted during the working day increases significantly. It is necessary to emphasize a high level of equipment of dental clinics with high-class installations, modern apparatuses (devices) and materials. Speaking about the technologies used in German dentistry, it is necessary to note, first of all, a large share of indirect dental restorations. In cases where a Belarusian dentist performs a direct composite restoration, a German doctor mainly makes an inlay (onlay) or veneer. In orthopedic dentistry the widespread use of precious metals, the prevalence of telescopic systems in removable prosthetics are worth great attention. A high level of organization and professionalism is a characteristic feature of a dentist in Germany. A general dentist performs high-quality work in various directions (restoration, endodontics, prosthetics, orthodontics, etc.), if necessary, involves other specialists, providing the patient with highly qualified dental care.

## AUSTRIA

Insurance dental care appeared in Austria as early as 1888. Almost all workers and their families were covered by insurance. The insurance currently covers the costs of surgical and conservative dental treatment, as well as part of the costs (40–80 %) of prosthetics and orthodontic treatment. Special treatments (e. g. gold inlays or metal crowns and fixed dentures) are paid in full by the patient directly to the dentist. Poor citizens who are not covered by insurance can receive similar financial support from local or district government social services.

Dental care, both general and specialized, is provided in the offices of private dentists, in dental clinics of insurance companies and in public clinics for children. Insurance benefits also cover the treatment provided by university dental clinics or hospitals (oral and maxillofacial departments and dental clinics).

The ratio of dental professionals to population is 1 : 2,300. The main intervention for the prevention of dental caries is the regular distribution of fluoride tablets to schoolchildren through schools nationwide. Water fluoridation is not carried out. In all schools that are required to attend, there is an annual "healthy teeth day", when all children are taught how to prevent dental caries. Children entering primary school receive a free oral hygiene kit and information leaflet.

The disadvantage of this system is a low interest in the prevention of dental diseases. A nationwide information campaign to promote dental health may contribute to solving this problem and raising people's awareness and interest.

## FRANCE

Public health insurance is compulsory in France. The main fund covers about 80 % of the population, there are 2 additional funds intended for private entrepreneurs and working in the field of agriculture. The funds are replenished by contributions from employers, employees, as well as income tax (for entrepreneurs). The insurance premium levied on employees is 20 % of their pre-tax income.

An indispensable attribute of insurance is a compulsory health insurance card (Carte Vita1e), which guarantees protection in 5 cases: illness, industrial accident, occupational disease, pregnancy and childbirth, disability. If an accident occurs at work, 100 % of the costs are covered, in other circumstances 75 % are compensated, and the remainder is paid by the patient himself. This universal principle is applied while paying for doctor's visits, buying medicines at a pharmacy, and undergoing diagnostic examinations and procedures.

Dental care is provided by private practitioners, whose fees were paid in full by patients until 1930. The current system operates on the basis of decrees adopted in 1974 establishing a social security system, and at present the dental service system covers almost the entire population of France. Up to 75 % of the costs of dental care, prosthetics and oral and maxillofacial orthopedic treatment are reimbursed according to the price scale established as a result of an agreement reached between social security funds, government administrations and professional associations.

France is characterized by a high coverage of the population with CHI programs (already in 1988 CHI programs were extended to 80 % of the French), which reimburse the insured for 75 % of the costs of medical care. To receive 100 % reimbursement, the patient needs additional voluntary health insurance.

In terms of the number of insurance companies, France ranks third after Germany and Netherlands. They offer the population a wide range of health insurance services in addition to compulsory health insurance, making medical care in a market economy more accessible to the population.

## HUNGARY

Hungary has a public health system. General management and coordination of the activities of dental institutions is carried out by the Ministry of Health.

Currently, the system of organizing dental services is designed to provide assistance to the majority of the population on the basis of the principle of appeal. First of all, certain groups of the population such as schoolchildren, pregnant women, conscripts for military service, students of vocational schools are served — these groups receive dental care on a regular basis. The entire population is entitled to free dental care, but a minimum fee is charged for installing crowns, bridges and removable dentures, as well as using precious metals (gold alloys).

The main problem for dental services in Hungary is the relative shortage of dental personnel. Currently, there is an average of one dentist per 4000 inhabitants. In the long term, it is planned to expand the volume of comprehensive and systematic dental care to cover all children, both preschool and school age, as well as groups of workers exposed to occupational risk factors, and then the entire population.

## SWEDEN

The first law concerning public dental care in Sweden was passed in 1938. Under this law, dental care was primarily provided to children between the ages of 6 and 15. In 1965, this group also included adolescents aged 16 years. In 1973, the Swedish Parliament passed the General Dentistry Insurance Act, which entered into force on January 1, 1974. This Act provides the population with financial benefits for dental care, and the structure of the benefit system gives priority to prevention and treatment of those patients. whose general health is at risk. This law also regulates the fees of dentists by establishing a national scale of rates for services in both the private and public sectors.

The main types of dental care are provided, on the one hand, by private dental practitioners in their own offices, and on the other, through the public dental service system, mainly in public dental clinics. The scale of these polyclinics depends mainly on the number of children living in the area. According to the current Regulation, a dentist serves about 500 children.

Specialized dental care is provided mainly by the public dental service system and dental schools. There are four main dental specialties: Pediatric Dentistry, Orthodontics, Periodontology (Parodontology) and Surgical Dentistry. Surgical dental treatment is provided mainly in specialized dental clinics at the main hospitals. Specialized care (for example, orthodontics, X-ray diagnostics, treatment of oral diseases) is also provided in dental schools.

The main types of dental care are provided by a communal network of outpatient facilities. At the same time, the principle of free choice of dentists by patients is fully implemented. Specialized types of care (e. g. prosthetics, orthodontics, preventive measures, treatment of children, treatment of dental and oral diseases, surgery) are provided in all major cities through health centers. Systematic dental care for preschool children is provided on a very limited scale and only in large centers. Systematic assistance to schoolchildren is provided only in dental offices of schools, in children's clinics and health centers. In general, about 20 % of children undergo systematic dental examination, and about 5 % of all school-age children undergo systematic treatment. There is a shortage of outpatient dental facilities, especially in schools; there is also a shortage and uneven distribution of dentists. Plans have been drawn up to increase the number of dental facilities, carry out fluoridation of water, distribute fluoride tablets, and shift the focus from therapeutic to preventive activities.

In addition, it is planned to expand the systematic dental care for children and the working adult population.

Sweden has a system of insurance and private dental care. The dental insurance system is called "Folktandvarden". There are many private dentists in Sweden. The existing rules for the provision of dental services envisage different levels of payment, depending on the place of the patient's residence and the choice of the dentist.

Dental care in the country is largely based on preventive work. This means that you need to visit your dentist regularly to keep your mouth healthy.

All Swedish residents under the age of 20 can use dental services free of charge, both for visits to dental insurance companies and visits to private dentists. All children and adolescents are regularly invited for dental check-ups, treatment and preventive measures are offered. Adults can go to the dentist on their own initiative.

Health insurance covers dental care (both treatment and prophylaxis) if it is provided by the staff of the public dental service as well as private dentists. At the same time, dentists must adhere to the established price scale. For the course of treatment, the patient pays 60 % of the costs of up to 2500 SEK (Swedish kronor) and 25 % of the cost of treatment in excess of this amount. The Social Security Bureau then reimburses the doctor for the remaining amount.

Dental clinics that are part of the dental insurance system have a type of service that is offered at a fixed price. This form of service is called preventive. Each month the patient pays a certain amount, so that he can then seek preventive care free of charge. In order to benefit from preventive care, you must sign an agreement and undergo a preliminary examination to establish the cost of such preventive care.

## DENMARK

The Danish National Health Service has a dental department. The National Health Service is responsible for supervising the work of dental practitioners and public dental services, counseling the government, ministries, regional and local health administrations, and social welfare authorities (municipalities) on public health matters.

Until 1973, dental care for the majority of the population (adults and preschoolers) was based primarily on national and private dental insurance programs. Insured persons paid directly to local insurance committees, and insurance benefits were issued to partially or fully reimburse the fees paid to private dental practitioners. The share of expenses paid to the insured person depended on the level of his income. Prosthetics, as a rule, were fully paid by the patient. School children in many areas were able to get free help from the school dental service. Funding was provided by municipal administrative authorities.

On April 1, 1973, a new law on public health services was passed. In accordance with the provisions of this law, the cost of dental care for adult patients and preschool children is reimbursed from the budgets of the health authorities of municipalities, the budgets of which are formed entirely from state taxation. Financial assistance is provided for dental examinations, X-ray examinations, dental calculus removal, amalgam fillings, root canal filling and tooth extraction. Overall, 67 % of all costs are covered by the municipal health authorities. Persons who have reached the age of 16 are eligible to participate in the regular dental check-up system, which ensures that two examinations are mandatory to determine the condition of the teeth of the persons participating in this system. The municipal health authorities pay 100 % of the costs of these examinations and reimburse patients for 75 % of the costs of follow-up treatment. All schoolchildren (age group 7–18) are provided with free preventive and therapeutic dental care, including orthodontic treatment.

The Children's Dental Care Act requires the National Health Service to systematically evaluate dental care. National, regional and municipal statistical summaries, which reflect indicators related to oral hygiene, the incidence of dental caries and gingivitis, orthodontic anomalies and dysfunctions, as well as various pathological conditions of the oral cavity, are published annually.

## POLAND

The development of dental services in Poland began in the 18th–19th centuries in Krakow, where odontology was taught in medical schools as part of the surgery course. In the second half of the XIX century Warsaw became the center of odontology. The first dental institute was founded in 1903 and the Polish Dental Society was established in 1951.

In accordance with the order of the Minister of Health dated November 6, 2013 “On guaranteed services in the field of dental treatment”, patients have the right for:

1) dental medical examination with instructions on oral hygiene;
2) caries treatment;
3) services in the field of endodontic treatment of teeth with one root canal;
4) removal of dental plaque;
5) treatment of lesions of the oral mucosa;
6) tooth extraction and some surgical procedures;
7) intraoral x-rays if necessary;
8) anesthesia if necessary.

It implies guaranteed dental services, that is, those funded by the state. The list of these services is strictly regulated and has clear indications and conditions with prescribed materials, as well as the frequency of rendering a particular service.

For example, in the case of endodontic treatment, adult patients are legally provided with treatment only for the frontal group of teeth (from canine to canine). For endodontic treatment of another group of teeth, the patient can consult a private dentist. An alternative option is to extract a tooth and use the right for free prosthetics: in the absence of 5 or more teeth, the patient has indications for a partial removable plate prosthesis once every 5 years with repair every 2 years. At the same time, children and young people (up to 18 years old), as well as pregnant women (+ 42 days after childbirth) have the right to root canal treatment for all teeth (with the condition of treatment of up to 3 root canals in a tooth).

In addition, all patients (both adults and children) are entitled to a dental examination with instructions on oral hygiene — once a year; removal of dental plaque — once a year; applying for emergency care has no restrictions.

The list of dental services provided has been significantly expanded for the child population. In addition, on April 11, 2019, a law was signed regulating the provision of dental care (including prevention) to schoolchildren.

Among the interesting features of Polish dental care for children, it is worth mentioning:

1) provision of children under 18 years of age with cosmetic treatment for enamel hypoplasia;

2) provision of children under 12 years of age with free orthodontic treatment using removable appliances;

3) prevention of major dental diseases under the age of 19;

4) impregnation of the dentin of deciduous teeth.

In Poland, there is also insurance medicine — the rights of patients are guaranteed under health insurance, which in turn is “conditionally compulsory”. That is, if a person has a permanent place of work, the insurance fee is deducted from the salary and paid by the employer on a monthly basis. However, if a person does not have a permanent job and a fixed monthly salary, it is necessary to transfer money monthly to the insurance account.

## CONCLUSION

Oral health is an important part of the overall health and well-being of society. The system of dental care organization, despite preservation of its discrete sphere of responsibility, is nevertheless integrated into the system of general health care for the population.

Currently, all existing health care systems are reduced to three formed basic economic models. These are: the state (public) health care system with a budget financing system; social insurance health care system based on the principles of social insurance and market regulation with a multi-channel

financing system; a private health care system based on market principles using private health insurance.

The development of basic types of dental care is also continuing. In the public, insurance and private systems of organization of dental services, there is a tendency to expand dental care to outreach the entire population, to strengthen the management system of services with the focus on their organization. The prophylactic orientation of dental care is becoming more and more clearly manifested.

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*Appendix 1*

## COMPARATIVE CHARACTERISTICS F HEALTHCARE SYSTEMS[9]

| System | Advantages | Disadvantages |
|---|---|---|
| Insurance | Wide coverage of the population with medical care.<br>Distribution of the financial burden on health care between the state and the private sector.<br>High quality of medical services associated with the possibility of choosing an insurer by the population | Lack of equal accessibility of medical care for various social groups and remote areas.<br>The tendency towards unjustified growth in the cost of medical services.<br>Insufficient consideration of the interests of patients belonging to high-risk groups, long-term inpatient care or those beyond the social insurance system.<br>Private insurance violates the principle that the rich pay for the poor, the healthy for the sick |
| Public | Full coverage of the population with medical care.<br>Wide regulatory scope.<br>Wide range of tools for implementing plans | Insufficient stimulation of the growth of efficiency of medical services and public services.<br>Centralized government containment of rising health care costs.<br>Insufficient consideration of the patient's opinion when choosing a doctor and medical institution.<br>The queue is a regulator of medical care provision, therefore wealthy groups of the population prefer to consult private practicing doctors.<br>Insufficient choice of hospitalization conditions |
| Private | Competition leads to improved quality of medical services.<br>High cost of medical care increases the importance of the population health self-care | High cost of medical care.<br>Low priority of preventive work.<br>Lack of equal accessibility of medical care for the population of various social groups.<br>Lack of a mechanism to influence the territorial distribution of medical services.<br>"Imposing" unnecessary medical services, since the demand for medical services does not fully match the supply |

[9] Assessment of the effectiveness of the organization of the health care system: foreign experience [Electronic resource] / I. P. Shibalkov. Access mode : https://cyberleninka.ru. Access date : 01.06.2020.

*Appendix 2*

## COMPARATIVE CHARACTERISTICS OF DENTAL CARE SYSTEMS

| System | Advantages | Disadvantages |
|---|---|---|
| Insurance | *For the state:* high accessibility of assistance to the population, due to the formation of social standards for the provision of medical care, a sufficiently high level of health of the population, a constant income.<br>*For the patient:* high-quality and guaranteed medical care in the amount established by the insurance conditions, the ability to choose the conditions, volume and type of medical care.<br>*For a doctor:* stable and high income, conditions for constant professional and financial growth | *For the state:* the need to ensure stability and growth in the well-being of the population, the complexity of regulating insurance of different segments of the population.<br>*For the patient:* the need to have a steady income, some restrictions on the provision of medical care, established by the conditions of insurance.<br>*For a doctor:* dependence on the terms of the insurance contract |
| Public | *For the state:* maximum coverage and accessibility of assistance to the population, the formation of social standards for the provision of medical care, a sufficiently high level of health of the population and, as a result, reduction of treatment costs, a simpler mechanism for regulating the activities of the system.<br>*For the patient:* affordable and guaranteed medical care in the amount established by social standards, the priority of prevention.<br>*For a doctor:* availability of a job that does not depend on many external factors, the ability to regularly improve their qualifications, a stable salary | *For the state:* the need for a constant budget for the maintenance, development and modernization of the dental care system.<br>*For the patient:* limitations in the choice of the type, time, place and volume of medical care, established by social standards.<br>*For a doctor:* limited choice of work methods and materials, fixed salary |
| Private | *For the state:* an opportunity for the population to receive dental care of a higher level, a steady income.<br>*For the patient:* more diversified quality medical care, the ability to choose the conditions, volume and type of medical care.<br>*For a doctor:* high income, conditions for constant professional growth, the ability to choose working conditions | *For the state:* difficulties in regulating the operation of the system, low availability of assistance to the population, lack of priority for prevention.<br>*For the patient:* the inaccessibility of care for many groups of the population due to the high cost of services.<br>*For a doctor:* the difficulty of finding a job, high competition |

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