1st EADPH Congress

26-27th September 1997, Cittadella, Italy

The first congress of the European Association of Dental Public Health (EADPH) was held in Cittadella, Italy on 26th and 27th of September 1997. The presidents of the congress formed the programme committee and were Dr. Roberto Ferro, Cittadella, Italy; Professor Guiliano Falcolini, Sardinia, Italy; and Dr. Cynthia Pine, Dundee, Scotland. The abstracts of the invited speakers presentations are published below.

Invited speakers' abstracts

1 Demographic trends and prerequisites for health in Europe.
P. E. Petersen, Department of Community Dentistry, Faculty of Health Science, University of Copenhagen, Denmark.

The demographic background is important for understanding the present and future health situation in Europe. Recent figures on European population growth show some divergence. Falling birth rates are observed in most countries of Central and Eastern Europe (CCEE) and the Newly Independent States (NIS), whereas stability or slightly increasing birth rates are found elsewhere in Europe. For example, in the Russian Federation birth rates dropped from the level of 17 live births per 1000 population in 1987 to 11 live births in 1992. In Denmark, an increase in birth rate was noticed from 11 live births per 1000 population in 1987 to 13 live births in 1992. A most important development throughout Europe appears to be the further ageing of the population. The proportion of people over 65 years of age, especially the very old, will continue to rise. The extraordinary reduction in birth rate in most of the CCEE and NIS, comparable to the effect of war, has accelerated population ageing. The combined effects of ageing and declining fertility influence the conditions under which children are growing up, raise questions about the claims and social role of elderly people, and pose major economic and health challenges for the future. Health and wellbeing are inextricably linked to the overall condition of life. The prerequisites for both health and healthy living include feeling free from life's threats, and having proper education and living conditions. These factors have increased their influence also on oral health for the population of Europe.

2 National health service models of northern Europe: is the state reducing provision?

D. Holst, Institute of Community Dentistry, University of Oslo, Norway.

Northern Europe is defined as the Nordic Countries: Sweden, Denmark, Finland, Iceland, and Norway. The main steps in the development of the public dental services are presented. Some major similarities and differences in the structure of the oral health care delivery systems between the countries will be shown. The Nordic model of oral health care for the population is unique with regard to the following structures: universality (defined target groups), the combination of salaried services and dental health insurance, free or almost free services for 0 to 18 year olds, regulations on fees, providers, and treatment. The main analytic question of the presentation discusses why dental care became a public concern in the Nordic countries in the beginning of this century, and how this concern developed and expanded. The perspective of the development of the welfare state, and the change in the delivery system of oral health care is related to the changing role of the welfare state. Lastly, the key question whether the state is reducing provision is addressed. If so, the reasons for this and some possible consequences will be discussed.

3 Changing models in eastern Europe: What are the effects of changing to private care?
A. Borutta, Department of Preventive Dentistry, Friedrich Schiller University of Jena, Erfurt, Germany.

Since the political changes in eastern European countries, a transformation process has been underway which aims to establish mainly private dental practices and an appropriate insurance system for the population. In eastern Germany, the establishment of the new dental care delivery system and insurance system was completed relatively shortly after unification by transferring West German structures in accordance with the reunification treaties. Using oral health status as an indicator of effectiveness of the oral health care delivery system, it is evident that there are many differences between eastern European populations. In eastern Germany, caries prevalence for 12-year-old children dropped from a mean of 3.8 in the eighties to 2.5 in 1995. Additionally, the proportion of caries-free subjects and the percentage of coverage increased during this time. A trend for caries reduction was also observed in Hungary, Latvia, in the Czech Republic, Poland, and other countries, though DMFT values are higher in Eastern Germany and have not reached the WHO indicator of 3 DMFT for the year 2000. Furthermore, in most of the eastern countries, treatment need for primary and permanent teeth is high. This has occurred because low levels of public resources have resulted in neglect of public dental care for children, both preventive and restorative. Poor economic conditions in these countries delay the transformation process of the dental care delivery system and the development of an insurance system, which both tend to have a negative influence on the oral health of the whole population.

4 Private practice models in Southern Europe: what is the Spanish experience?
C. Manau, Department of Preventive and Community Dentistry, University of Barcelona, Spain.

Spain has a mixed public-private system for provision and financing of dental care. Under the public system, salaried dentists provide emergency dental care and oral and maxillofacial surgery free of charge to the whole population. Publicly financed programmes for 6 to 14 year old children started in the late 80s, including screening, preventive care, and dental treatment. The most comprehensive children's programmes are those in the Basque country and Navarra. Catalonia has a preventive treatment programme for high-risk children. All other dental care is delivered in private practices and paid for by patients. Private dental treatment insurance is poorly developed. In spite of the shortcomings of the system, oral health indicators for Spain (1994) compare well with other European countries (5-year-olds: dmft 1, caries-free 62 per cent; 12-year-olds: DMFf 2.3, caries-free 32 per cent; 35-44-year-olds: mean number of teeth 26, edentulous 0.2 per cent; 65-74-year-olds: 12.5 and 31 per cent respectively). These outcomes put into question the need for a comprehensive (and expensive!) dental care system paid for by collective funds. The number of dentists has been increasing rapidly in recent years,

from one dentist per 10,200 inhabitants (1970), to one dentist per 2,650 (1997), which has resulted in some unemployment. In spite of the oversupply of dentists, unmet dental treatment needs are considerable.

5 Private practice models in southern Europe: what is the Italian experience?
G. Falcolini and R Ferro, Clinica Odontostomatologica, University of Sassari, Ital.

In Italy, until some years ago, no national data were available on the prevalence of caries. From a few studies, some data were available but only on a local basis. The first national survey was conducted in 1988 by the Italian Academic Society (SIOCMF) sponsored by ASSILS, a non-profit organisation, founded in 1980, of integrative health care services in co-operation with the NHS. More recently, the Italian Society of Paediatric Dentistry (SOI) organised a working group on prevention, which undertook an epidemiological national survey of 12 year olds, sponsored by the Colgate Palmolive Company. DMF was recorded for each Italian region and indicated similar levels to other European countries, ranging from 1.7 to 2.6. Regular oral hygiene and fluoridated toothpastes, promoted both by the dental profession and by industry through mass media, seem to account for the low prevalence. The dental profession in private practice helps this goal by preventive measures on individual patients and by dental hygienist involvement, but in addition, the public services should promote education and dental care of the population. Examples of public service involvement include two different programmes organised in local communities, one in Citadella (Padua) and another one in Sassari. In Citadella, a new community programme for oral health promotion was implemented in May 1996, by modifying a previous plan. The programme involves both prospective mothers during pregnancy and their babies with the aim of rearing the local population caries-free. Some of the principles behind this approach include: 1) the chance to deliver dental assistance and prevention to a target group that traditionally does not have any contact with a dentist; 2) at a time in which prospective mothers are very prone to obtain any advice about their children's health; 3) and trying to prevent or delay the intra-familiar transmission of streptococcus mutans. The programme in Sassari was co-ordinated between the dental faculty's Paedodontic Department, the local NHS, and local education authority. The programme is developed in three steps. First, education in primary schools, directed to parents and pupils, undertaken especially by teachers. Secondly, oral hygiene instruction in dental clinics, undertaken by students of the dental hygiene school. Finally, screening of all pupils to identify those at risk for interceptive treatment in dental clinics by dental students under supervision.

6 Nutrition and dietary habits: which are the best strategies to improve the oral health of Italian children and adults?
L. Strohmenger, WHO Collaboration Centre for Epidemiology and Oral Prevention, ISB San Paolo, University of Milan, Italy.

A significant reduction in dental caries in 12 year old Italian children was recorded between 1983 and 1996. In 1983 the Centre for Epidemiology and Dental Prevention of the University of Milan conducted a national survey of 13 year old subjects and the mean DMFT was 6.5. A similar survey was conducted in 1995-1996 by the WHO Co-operative Centre of Milan and SIOI (Italian Society of Paediatric Dentistry). The data collected covered 10 of the 20 Italian regions and gave a mean DMFT value of 2.12. In 1996, another epidemiological survey assessed the prevalence of baby-bottle tooth decay in three to four year old children in Milan and in other northern regions. Data showed that this condition is confined to a limited number of children. We propose that a multidisciplinary approach should be developed based on dietary habits, caries prevalence data and the current levels of knowledge of preventive dentistry in pregnant women and young mothers in order to establish correct oral health habits to transmit to their children.

7 Dental public health initiatives by AS SILT an Italian integrated health care fund.
ASSILT the Associzione per l'Assistenza Sanitaria Integrativa a Lavoratori della Telecom Italia

Sede Centra le, Roma, Italy.

ASSILT is an integrated health care fund based on voluntary membership for employees working in the telecommunications field and their families. The organisation has around 250,000 members across Italy. The aims of ASSILT include the promotion of social medical schemes and refunding a percentage of medical fees in fields where state coverage is inadequate for members' needs. One example in this area is dental care which is a particularly neglected area of health care in the Italian public administration. ASSILT refunds a percentage of dental treatment fees and in 1996, this averaged 60 per cent of total costs, amounting to 60 billion Italian lira. Since 1981, ASSILT has actioned numerous dental initiatives and is currently engaged in a 5 year dental campaign. This initiative comprises: epidemiological studies of the oral health of ASSILT members; after epidemiological evaluation of need and dental care provision, including orthodontic care from 0 to 12 years; dental prevention schemes for all members and their families, including oral hygiene instruction, topical fluoride applications, and fissure sealants. ASSILT is considering new strategies in dental health coverage provided taking into account that costs are maintained in this health care sector given the frequency and nature of dental care required by its members. These new strategies include agreements between ASSILT and professional bodies across Italy to cover services available and professional tariffs. ASSILT aims to publish an informative leaflet on dental care to provide easily understood guidelines for optimal oral health for all its members.

8 Working with the oral health care industry to promote dental health.
D. O'Mullane, University Dental School and Hospital, University College, Cork, Ireland.

The purpose of this presentation is to outline the role which the oral care industry has played in dental research and oral health promotion during the last 50 years. It is inevitable that the example of the development of fluoride toothpastes during the late 1950s and 1960s and their subsequent use throughout the world should be quoted as an example of collaboration between industry and public health. This example will also serve to illustrate how industry can collaborate with universities in training research workers and conducting important research. In this presentation also, current and future trends in EU funded biomedical research will be described in which partnerships involving third level institutions and industry are encouraged.

9 Working with the food industry.
J. T. Winkler, Food and Health Research, 28 St. Paul Street, London, England, UK.

The paper considers the practical options for collaboration between the dental professions and the food industry to advance public health. Beginning with industry, the paper will consider the spectrum of business attitudes and responses to public concern about diet and health considering why the sugar and sweet foods industries are most resistant to changes for public health. The changing strategy of the sugar and sweet foods industries toward diet is explained from political lobbying to scientific rebuttal, together with varied tactics of these industries, ranging from social responsibility to dirty tricks. There are considerable variations between companies and products as well as variation in the composition and promotion of foods. Examples are presented as well as goals which include the revision of dietary advice on sugars. Next, the paper will consider the roles of governments. The options of fluoridation and dietary change are presented: dietary recommendations around the world; the failure of the European Union; the passivity of national governments; the reliance on nutrition education and why. This section is completed by exploring the politics of change. Finally, the role of dentistry is debated: educational v structural approaches to change; individualist education; the role of professional associations; engagement with public policy and corporate practice. Some technical aspects which will influence future relations between dentistry and industry are highlighted including new sweeteners, new foods and fluoridation. Some options for working with industry are developed: What can dentistry expect from food companies? Who can we work with successfully to promote change: companies, trade associations, international groups? What alliances should we be

developing with other health professions?

10 Working with national governments and the EU Commission: how can we put dental health on the agenda?

E. Widstroem, Ministry of Social Affairs and Health, National Research and Development Centre for Welfare and Health, Helsinki, Finland.

New conditions facing health care including dental care provision in recent years have brought pressure for changes in most European countries. A wide-ranging debate about new forms of oral health care provision and the character of funding and service priorities is taking place. It is generally agreed that high quality and comprehensive coverage should be guaranteed even in a financially tighter policy climate. It appears that the organisation and funding systems of dental care in Europe can be categorised under five or six broad headings including the eastern European countries (in transition). All patterns seem to provide some basic care for children and the socially and economically deprived. Great variations are seen in such areas as refund of treatment cost. In all EU and EEA countries considerable amounts of money are spent on dental care and there may be too many rather than too few dental personnel. Present information on dental care and oral health make it, however, difficult to assess health gains in terms of funds spent. For them cost control, value for money, managed clinical competencies, effectiveness and health and safety are key words. For various reasons which include improved dental health and better access to care in addition to new life-saving medical treatments, expensive medicines and drug control, dental care is not a top priority for governments.