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Health workforce governance and oral health: Diversity and challenges in Europe

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ABSTRACT

Throughout the life course, oral diseases are some of the most common non-communicable diseases globally, and in Europe. Human resources for oral health are fundamental to health-care systems in general and dentistry is no exception. As political and healthcare systems change, so do forms of governance. The aim of this paper is to examine human resources for oral health in Europe, against a workforce governance framework, using England as a case study. The findings suggest that neo-liberalist philosophies are leading to multiple forms of soft governance at professional, system, organisational and individual levels, most notably in England, where there is no longer professional self-regulation. Benefits include professional regulation of a wider cadre of human resources for oral health, reorientation of care towards evidence-informed practice including prevention, and consideration of care pathways for patients. Across Europe there has been significant professional collaboration in relation to quality standards in the education of dentists, following transnational policies permitting freedom of movement of health professionals; however, the distribution of dentists is inequitable. Challenges include facilitating employment of graduates to serve the needs and demands of the population in certain countries, together with governance of workforce production and migration across Europe. Integrated trans-European approaches to monitoring mobility and governance are urgently required.

1. Introduction

Oral health is integral to health and wellbeing, and a human right. Despite being largely preventable, oral diseases are endemic [1,2]. Untreated dental caries in permanent teeth is the most common condition globally and periodontal (gum) diseases sixth. Evidence of associations between oral and general health is emerging [3]. Achieving universal health coverage is therefore important [4], and requires an oral health workforce [4,5].

Oral health inequalities are evident between, and within, European countries [1]. Where comparable data exist, there is a notable difference between west and east; the former showing significant reduction in prevalence of dental caries in children/young people, whilst the latter have currently a high prevalence [6]. Most adults across Europe have experienced significant oral disease, and are at risk of further diseases and their sequelae. Oral cancer rates are rising, while treatment outcomes including quality of life remain poor [7]. Furthermore all countries are experiencing the challenge of population growth and ageing [8].

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The function of governance is to "ensure that an organisation or partnership fulfils its overall purpose, achieves its intended outcomes for citizens and service users, and operates in an effective, efficient and ethical manner" [9]. Kuhlmann et al. [10], suggested that "governance includes qualitatively new dimensions of policy-making that attempt to connect 'regulation' and 'management'" arguing that greater attention should be paid to health workforce governance. Five dimensions for health workforce governance are recommended to assist the European situation and contribute to the development and implementation of multi-level governance: system, sector, occupational and socio-cultural integration and gender (cross-cutting) [10].

Within Europe, Human Resources for Oral Health [HROH] are well established, particularly dentists [11]. A number of agencies have been working to achieve pan-European integration of dentistry, most notably the Association for Dental Education in Europe, Council of European Chief Dental Officers, European Association of Dental Public Health and the Dental Health Foundation [12]. Together with the International Association for Dental Research's Pan European Regional group, European dental specialist associations, and others, they form The European Platform for Better Oral Health [13]. This independent organisation, launched on World Oral Health Day in 2011, promotes oral health and the cost-effective prevention of oral diseases and advocates for a common European approach towards data collection, education, prevention and access to better oral health.

England, the largest country in the United Kingdom, has state and private oral healthcare systems; a diverse range of HROH, including 13 specialties; and multiple forms of governance. Having embraced new public management, there is ongoing reform of oral healthcare and education which surpass those of the other three UK countries, whilst much professional regulation is under the wider influence of UK and European governments.

Against this background, the aim of this paper is to examine human resources for oral health in Europe, within a health workforce governance framework, using England as a case study; and to inform policy debate.

2. Methodology

In order to address the above aim, this paper will use a case study approach [14], to review oral health issues in England within the wider context of the UK and Europe, involving workforce data and health policy analysis. First, quantitative indicators of the health workforce from key sources such as the World Health Organization [15], the Council of Chief Dental Officers of Europe [12], and the UK General Dental Council [16], are presented (Section 3). Second, key policy documents from the EU, in general, and the UK, in particular, together with a literature search in relation to governance and dentistry across Europe are analysed (Sections 4–6). Third, English and wider European perspectives are mapped qualitatively against Kuhlmann et al.'s five dimensions of workforce governance: system, sector, occupational and socio-cultural integration, and gender [10] (Sections 7–11). The use of a published framework enables governance to examined, and unintended consequences considered, in a logical manner.

3. Dentistry in Europe – an overview

Current HROH in the EU exceed one million [6,12], with over 463,544 dentists [15] (Fig. 1), amounting to five per 10,000 population (Fig. 2). Spending on dental treatment in the EU-27 was estimated to be close to 79 billion Euro in 2011 [6].

For much of the last century, dentistry in Western Europe has largely been the preserve of men trained from an odontological perspective (individual discipline) [17], with 80–90% working in small dental practices (offices), run as businesses. Conversely in Eastern Europe, the traditionally state-run dental service was largely staffed by women where dentistry emerged from a stomatological philosophy as a specialty of medicine [17].

Across Europe, the dentist has been the main player in the provision of oral healthcare in many, but not all countries, as some were trained as doctors. The majority of dentists remain generalists with little or no postgraduate education. State provision of dentistry was the norm in the UK, some Nordic countries and the eastern bloc, with private dental care primarily for the elite [11]. Conversely in southern European countries, such as Italy and Spain, oral healthcare was, and is, largely provided in the private sector [11].

Dentists historically trained, and largely stayed, in their country of origin. However, with the creation of the EU, there has been freedom of movement of dental professionals since 1978 [18,19]. In parallel with the growth in dental education, expansion of the EU, and social change, professional movement is increasingly common. Where oral healthcare has been privatised and/or the system is unable to absorb new graduates and professional aspirations are unmet, movement increasingly occurs. The European Commission (EC) cannot enforce controls on the number of healthcare workers being trained. However, it may facilitate consensus and suggest guidelines amongst all Member States through 'Joint Actions' [20]. There is currently such as Joint Action on the Healthcare Workforce in Europe for 2050 and, in the opinion of the authors, a JA on oral health would help to highlight problems and explore possible solutions.

4. Professional regulation

Professional regulation of HROH differs across the EU. Broadly, three patterns exist. First, in Ireland, Malta and the UK, where the formal regulator is independent of both the dental professions and government. Second, in the Nordic countries, where the government is the regulator. The third is universal throughout other EU Member States, whereby the main Dental Association/Chamber/Order holds the regulatory powers, membership is compulsory and dentistry is described as a 'liberal profession'. The roots for this term relate to Napoleon who decreed that professions should be entitled to govern themselves.

Dentistry in England is professionally regulated at the UK level. Dentistry was historically a self-governing profession within the UK, emerging from governance by