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Universal Health Coverage and Oral Health

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Universal Health Coverage

Everyone at one time or another needs access to healthcare services which includes prevention, treatment and rehabilitation; access to these services must not expose the patient to financial hardships. Three branches imperative to healthcare (HC) coverage should include: 1) The national population 2) All healthcare services 3) All or most of the financial coverage of treatment. The WHO has divided the East Mediterranean region (EMR) into countries with a high level of vulnerability and GCC countries with a relatively low level of vulnerability The EMR spent US$ 125 billion on healthcare in 2011; 1.8% of total world health expenditure. Each year, up to 16.5 million people face financial catastrophes and up to 7.5 million individuals become poor due to "out-of-pocket" payment for healthcare in EMR [1-6]. Healthcare services coverage including oral health is considered a difficult and complicated component of UHC. To assess the services covered the accessibility of all services need assessment as it varies in different countries. Universal health coverage should ensure that "all people" are covered by the healthcare insurance services not only the citizens or the eligible population. This population must include: employees in the governmental, public and/or private sectors as well as those in the rural sectors as well as vulnerable groups, e.g. the poor, children or elderly. Dental insurance has had a significant impact on dentistry and dental care use. Dental insurance coverage may influence people's decisions to use dental care [7]. The majority of studies regarding demand for and utilization of oral health care services by insurance status have been conducted in developed countries, i.e. European countries, the USA, and Australia. Such studies in developing countries are rare, especially in the Middle East. Dental insurance has an impact on the demand for oral health care. Having dental insurance as a factor to remove or reduce the cost of oral health care services has resulted in a higher demand for oral health care [8]

In EMR countries the HC coverage is favorable for national citizens; but is problematic with the foreigners. In some countries such as Qatar and the Emirates, there are some regulations in favor of insurance providers of foreign workers. The EMR does not have quantitative evidence about trade in the health services. However, there is some qualitative information on areas such as the movement of health professionals, hospital and dental care, and insurance-related arrangements [9].

Thailand is one of the best examples in implementation of UCH. In this country a special office the "national health security office" aimed at controlling healthcare funds has been established. Government revenues have shifted from line- item budgets into "premiums" transferred to NHSO; all Thais who are covered by the private sector health insurance policy and civil servants are eligible [2]. Because there are always some who cannot contribute directly; most countries with UCH rely on general budget revenues (in whole or in part) particularly to subsidize the poor. In the Thai oral health system, treatment fees for oral healthcare provided by public sectors are regulated by Ministry of Public Health and Ministry of Finance while private sectors are emancipated to set the fee or adjust it as preferred. The issue that needs investigation is how well the current health system protects individual against the financial consequence of experiencing oral health problem and then utilizing oral healthcare [10].

Mexico has a social protection system in healthcare (SPS) where the federal government transfers SPS insurance premiums subsidies to provide health insurance to all Mexicans [3]. More than 6,467 million pesos (MP) were spent in 2000 (8.5 percent of all households had some expenditure), over 3,925 MP in 2002 (4 percent households), and above 5,136 MP in 2004 (5 percent households), with an average expenditure of $806, $1,000, and $987 pesos, respectively. Prevalence of catastrophic expenditure because of dental health care was 0.8 percent in 2000 compared to 0.01 and 1.8 percent in 2002 and 2004, respectively. The Heckman model showed that municipal development, stratum, and age of the head of household significantly influenced the amount spent on dental care in all 3 years. Household capacity to pay and wealth index had a positive and statistically significant association in the 3 years with the preceding decision to spend [11].

In Turkey the money flows to the SSI, which acts separately from the general funds. In this country health outcomes have improved (e.g. in reduction of the infant as well as the maternal mortality rate). Also, financial protection has improved (especially for the poor); immunization coverage has also increased [4]. Key elements of the benefits package covered by the unified General Health Insurance include: Inpatient and outpatient oral health care, including oral and dental examinations, diagnostic tests and procedures, all medical interventions and treatments after diagnosis, tooth extraction, conservative dental treatment and endodontic treatment, follow-up services, oral prostheses, emergency services, and orthodontic treatment, free (at point of delivery) health care and dental care provision for children less than 18 years of age, irrespective of their insurance status [12].

In Kyrgyztan the mandatory health insurance agency or MHI transfers social funds from mandatory premiums. The ministry of finance transfers funding for the State [5]. In Kyrgyzstan, a state-guaranteed benefit package was piloted in 2001 and rolled out

nationwide in 2004. In Kazakhstan, a basic benefit package existed between 1996 and 1998 as part of the short-lived health insurance system; a new basic benefit package was adopted in 2005. [5]

In Abu Dhabi all citizens are enrolled in a government-owned health insurance company (Daman) [**6**]. Employers are obligated to enroll all their migrant workers in either Daman or a private health insurance company. Government providers are transferred to a government-owned corporation (SEHA). The GCC's total healthcare expenditure is forecast to triple by 2018, according to a report by Frost & Sullivan. Healthcare spend in the region in 2011 was estimated to be $46.12bn and this is expected to reach $133.19bn in 2018, at a compound annual growth rate (CAGR) of 10.3 percent from 2010 to 2018 due to its expanding population, higher incidence of lifestyle diseases, and deeper insurancpenetration [13].

In Iran a clear need to modify dental insurance systems in Iran to facilitate optimal use of oral health care services to maximize the oral health of the population. A special emphasis in the insurance schemes should be focused on preventive care. In Iran, having commercial insurance as a fringe benefit from employers may lead to higher demand, particularly since insured people have to use up their benefits annually. Further, compared with publicly insured respondents, those commercially insured have a free choice to visit any contracted dentist. That means easy access to oral health care, which certainly has influenced demand among those respondents employed and having commercial insurance [8].

Despite WHO mandates, access to healthcare services and universal health coverage is lacking in many third-world countries and most countries do not get access to UHC, and rely on voluntary health insurance which increase out-of-pocket expenditure; this and other aforementioned issues must be addressed if infectious diseases and epidemics (AIDS, hepatitis , TB etc.) are to be controlled.

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