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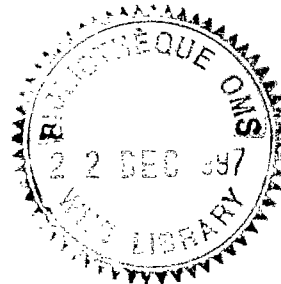
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COMPARING ORAL HEALTH CARE SYSTEMS

A SECOND INTERNATIONAL COLLABORATIVE STUDY

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Foreword

In 1985, as a result of the first International Collaborative Study on Oral Health Care Systems (ICS I), a monograph was published which stressed:

- (1) that oral health is inseparable from health;
- (2) that in developing oral health programmes, priority should be given to preventive approaches, optimizing those factors in the environment and lifestyles which can bring about decisive improvements in people's health and quality of life; and
- (3) that the practical, action-oriented approaches proposed by ICS I to improve the management of oral health care and services could be easily adapted to various health, social and economic environments and should be used in all communities.

The Second International Collaborative Study (ICS II) has reaffirmed and implemented these three principles. The methodology proposed by ICS I has proved very valuable, as evidenced by the number of countries which since then have decided to join as full participants in the collaborative study. The methodology has also been used frequently in independent community studies.

The impact of ICS I and its findings has been reinforced by the work done by the WHO Global Oral Data Bank. While ICS I has indicated the ways in which national programmes could best develop, the WHO Global Oral Data Bank has been providing updated information on past and current achievements, ongoing activities, and the extensive measures available to improve oral health.

With appropriate policy guidance and a regular source of sound and validated data, it is possible to continuously improve oral health, not only in the industrialized countries but in every nation and community. The challenge is also set for researchers to distinguish practices that should be continued from those that should be changed; for administrators to formulate appropriate goals and programmes for oral health; for educators to ensure that adequate human resources are available in future, when oral health needs have become very different from what they are today; and for all health professionals to prepare for the changes to come.

I refer to health professionals in general although the specific focus of ICS II is on oral health, because it is our conviction that specific areas of health are inseparable from health as a whole, and this must be reflected in practice.

The series of multinational studies carried out shows that oral health can serve to document current trends in the health sector as a whole, its goals, programmes, costs and achievements. The Second ICS exemplifies the fundamental role which the World

Health Organization is playing in conducting and promoting research to improve preventive methodologies, to optimize their implementation, to promote efficient health care services and systems, and to update training programmes so as to ensure that appropriate health personnel are available to meet various needs in different circumstances.

It is essential that health professionals, planners, administrators and researchers should acquaint themselves with this research and its outcomes. They should then be able to promote their wider application in all communities to improve the management of oral and other health services and enhance coordination in the health sector as a whole.



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General Introduction

Barnes, D. and Cohen, L.

The initiative to perform international collaborative studies on oral health that would combine clinical and sociological data originated in the study by Kohn and White (1976) on medical care utilization conducted from 1967 to 1974. Despite its pioneering status, that study fell short of the ultimate objective of matching a clinical survey with interview and questionnaire data from the same sample of consumers. From the 1970s to the present, two large series of investigations making up the first and second International Collaborative Studies (ICS I and ICS II) have been performed, under the auspices of the World Health Organization (WHO), in a wide range of communities. While this type of research is forever at the mercy of societal and system changes, sometimes with drastic effects on study protocol rules, as will become clear in this monograph, it is fitting to note that rarely has a set of international studies in the health sector had such impact on the existing health systems of nations.

The purpose of the ICS studies was and remains to compare oral health care systems and elements of those systems, using the epidemiological process, in order to discover the approaches that are effective in improving the oral health of communities, so as to guide all communities in confidence towards a system that best suits their health and social status. The results are of vital importance, not only to see what has been achieved but also to assess how systems that have been appropriate in the past need to change in order to cope with the rapid and massive changes in oral health status occurring in many countries. Therefore, in selecting the participants in ICS I – conducted from 1973 to 1981 – there was unequivocal emphasis on systems that had been in existence for at least 20 years and were well enough funded and organized to provide a solid reporting basis against which the value of the achievements of each system could be measured (Cohen, 1987). Though on the surface this emphasis could be construed as focusing on the needs of the highly developed/industrialized countries, the aim was exactly the opposite. The study was intended to show what had been “tried and succeeded”, or “tried and failed”, for what reasons and at what cost, in the hope that the most effective approaches would be chosen for all those developing countries just approaching the realization that oral health was no longer a heritage maintained without effort, but needed a carefully planned preventive and complementary curative national oral health programme.

The outcome of ICS I was spectacular in its impact on the remodelling of existing systems, even though the findings suffered from the fact that data was collected at only one point in time. That result suggests that the criticism labelling ICS I as a study only for the “haves” had some basis. However, less obvious but nevertheless substantial benefits came through the WHO oral health programme, because the lessons learned from ICS I were applied in many developing countries where WHO collaborated with health ministries in the development of appropriate national oral health plans.

Because of the impact of ICS I and the desirability of having a further set of data by which to gain some insight into the effects of national systems over time, WHO, in collaboration with the Center for Health Administration Studies (CHAS) at the University of Chicago, decided to conduct a second international collaborative study of oral health care systems (ICS II) (Leclercq, 1990). The study was undertaken from 1988 to 1992 at seven sites in five countries: Erfurt, Germany; Yamanashi, Japan; New Zealand; Lodz, Poland; and three sites in the United States of America, Baltimore and two Indian Health Service sites for the Navajo and Lakota peoples. It was also hoped to add some sites from developing countries which had reached the stage where oral health was being given a middle-level priority. However, funding and administrative difficulties proved to be insurmountable problems at the time. Eventually, the countries participating in ICS II included several which had taken part in ICS I and several others which were performing this type of study for the first time. Three additional sites: Rhone-Alpes, France; Latvia; and San Antonio, United States also participated; unfortunately, with the exception of the clinical examination data reported in Chapter 7, the findings from these sites were not available in time to be included in the main analysis.

ICS I aimed at identifying the relationships between the basic structural components of oral health care delivery systems, oral health status and the economic costs of care, and focused on human resources in oral health care systems (Arnljot et al., 1985). While ICS II followed logically from ICS I, its goals were significantly broader in scope. The aim was to investigate how factors in the oral health care system, the socioenvironmental characteristics and the individual characteristics of the populations served affected three sets of oral health outcomes: oral health behaviour, oral health status, and oral quality of life. Though the underlying intention was to keep the same research instrument in order to maximize the comparison between the two ICS studies, a number of both clinical and questionnaire/interview items had to be changed to be sure that the best possible data were collected, including more emphasis on behavioural rather than system information (availability, accessibility, acceptability). During the lapse of time between the two studies many changes occurred which had important effects on the response to a study of this type. The whole concept of linked clinical and questionnaire/interview data collection raised problems even at the time of ICS I. Resistance to each of these means of data collection has hardened in recent years, intensified by a perception of excessive surveying on a wide range of subjects. Furthermore, the social and political changes of various types across the different populations sampled, as well as spiralling research costs combined to cause many sampling problems for ICS II despite intense efforts to overcome these difficulties.

Nevertheless, ICS II has achieved the main goal of providing for all nations, both participant and non-participant, both highly developed and developing, a further comprehensive set of data which, when used together with those from ICS I, should enable administrators to plan national and subnational oral health programmes most relevant to their present and evolving oral health status (Barnes, 1994). It is hoped that

detailed study of these findings will not only help in solving existing problems, but will lead to use of the ICS approach at any community level in reaching solutions on the care system needed, whether by modifying an existing system or by making radical changes.

In presenting the results of ICS II, this book focuses on the factors that influence people's personal oral health practices and use of oral health services, and emphasizes how these behaviours are linked to health status and quality of life. Chapter 1 describes the research issues involved and the methods employed in the study. Chapter 2 gives details of the socioenvironmental characteristics and the oral health care system at each study site. This information provides the context for subsequent chapters, which examine and compare the relationships between these variables and oral health outcomes for individuals at each study site and consider the factors involved. Chapters 3, 4 and 5 focus on the analysis of the first set of oral health outcome variables, oral health behaviour. Chapters 6, 7, 8 and 9 cover the second set, oral health status, and chapters 10, 11 and 12 the final set, oral quality of life. The concluding chapter highlights some of the main findings of ICS II and considers their implications. Further details of the procedures, questionnaires and forms used in the study are provided in a series of Annexes.

