

HEALTH INSURANCE IN DENTAL MEDICAL SERVICES

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I. INTRODUCTION

Oral diseases, such as dental caries, periodontal disease, and edentulism, consistently rank among the most prevalent health conditions worldwide, despite being largely preventable [1]. These conditions may generate important clinical, social, and economic consequences, including persistent pain, severe infections, reduced quality of life, school absenteeism, impaired family life, and decreased work productivity. Consequently, oral diseases constitute a major burden not only for individuals and families, but also for healthcare systems and society as a whole [2,3].

Regular access to primary dental care services enables the early identification of oral conditions, the initiation of appropriate treatment, and the reduction of negative effects on general health status [4]. In recent years, oral health has gained increased visibility within the public health agenda. Both the Resolution of the 74th World Health Assembly on oral health and The Lancet Oral Health Series emphasized the need to transition from a predominantly curative model to one focused on prevention, integrating oral health into primary healthcare and universal health coverage strategies [2–5].

Oral diseases represent a significant public health burden, with major implications for quality of life, productivity, and healthcare expenditures borne by individuals, families, and society. In this context, integrating oral health into primary healthcare services and developing efficient financial protection mechanisms are essential directions for improving access to dental care. Considerable differences persist at both European and national levels regarding dental service coverage, while the absence of unified guidelines contributes to maintaining significant inequalities in access to care. Limited reimbursement of dental services and the high proportion of out-of-pocket expenditures may lead to delayed treatment and worsening oral conditions.

The present study analyses the perception of the general population regarding dental health insurance, the utilization of dental services, and the role of financial barriers in accessing such services. The results highlight the need to expand reimbursement mechanisms and improve public awareness regarding compensated and free dental services.

Keywords: oral health, dental medical services, dental health insurance, access to care, financial protection.

In many healthcare systems, dental services benefit from more limited public coverage compared to other categories of medical services. Cost-sharing mechanisms vary considerably among countries and may include co-insurance, co-payments, deductibles, or fixed subsidies. Furthermore, in many countries the number of covered services is limited annually or within defined periods of time, while public coverage frequently applies only to standard materials. These aspects indicate incomplete financial protection in oral healthcare and contribute to increased out-of-pocket expenditures.

II. AIM AND OBJECTIVES OF THE STUDY

The aim of the present study was to highlight the importance of dental health insurance in improving access to dental medical services and promoting oral health in the general population.

The secondary objectives of the study were:

- to analyse the utilization of dental medical services in the general population;
- to evaluate the use of dental services reimbursed by the National Health Insurance House (CNAS);
- to identify the need for dental medical services and the financial barriers associated with access to them;
- to assess the level of public awareness regarding compensated or free dental services.

III. HEALTH INSURANCE IN DENTAL MEDICINE

Dental care is generally associated with higher direct costs and more restrictive coverage compared to other healthcare domains. This situation results in insufficient financial protection for oral healthcare expenditures in many countries [6]. On average, approximately 14% of adults in European Union countries report unmet dental care needs due to costs [7].

Financial protection measures are often directed toward specific groups, such as low-income individuals, children, pregnant women, older adults, or patients with chronic diseases, mental disabilities, or physical impairments [8]. For example, in Estonia and Lithuania, pensioners benefit from higher reimbursements for prosthetic treatments compared to younger adults. In Sweden, individuals over 65 years of age, as well as those aged 24–29 years, may receive general dental care subsidies [8]. However, even in systems with reimbursement mechanisms or financial protection ceilings, out-of-pocket expenditures may remain substantial. For services provided exclusively in the private sector without public coverage, prices are often unregulated and direct patient expenditures can become considerable [3,9].

Coverage of dental services may generate different and sometimes contradictory incentives. In some systems, dental extractions are better covered than conservative procedures such as endodontic treatment, which may influence therapeutic choices. Other countries have introduced mechanisms encouraging prevention. In Slovakia, for example, patients may benefit from an annual dental allowance only if they underwent a dental examination in the previous year. In Sweden, the general dental care subsidy aims to encourage regular dental check-ups and preventive care utilization. These examples highlight the need to reorient oral healthcare systems from treating complications toward preventing oral diseases and integrating dental services into primary healthcare [4,5,10,11].

Despite the significant impact of oral health on general health and quality of life, many countries restrict dental benefits covered by public health systems to certain treatments, age groups, or patient categories [8,12]. Available evidence indicates that limited coverage reduces both financial protection and the ability of individuals to access dental care when unable to afford treatment costs [13,14]. Consequently, inequalities in access to oral healthcare arise both within and between countries, with potential effects on oral health inequities [5,8,15,16]. A survey conducted in 2019 regarding healthcare areas where access may represent a problem in European countries identified oral health as one of the fields with major coverage and access gaps [17].

Changes in benefit packages and in the financing and delivery of dental services are therefore necessary to improve coverage and integrate dental care into healthcare systems [8,13,17].

In Ireland, publicly funded dental services are delivered through three main schemes: The Public Dental Service, intended for children under 16 years of age and certain vulnerable groups; the Dental Treatment Services Scheme, which entitles certain adults to free services; and the Dental Treatment Benefit Scheme, available to individuals who have contributed to the social insurance system [18–20]. In addition, private dental care is available for patients paying directly for services, with partial cost recovery possible through fiscal mechanisms for certain non-routine procedures [21].

In Sweden, dental care is free up to the age of 23, while adults benefit from an annual general dental allowance aimed at encouraging regular check-ups and

preventive services. Individuals with certain chronic conditions may also receive additional subsidies. In the Netherlands, most dental services for adults are not covered through the basic public package, but voluntary complementary insurance plays an important role in partially reimbursing costs. In France, private insurance also contributes to covering dental services that are not fully reimbursed by the public system.

International comparative studies using clinical vignettes to assess dental service coverage have highlighted important differences between countries regarding the reimbursement of emergency treatments, periodontal therapy, prosthetic rehabilitation, and dental implants [8]. In most of the analyzed systems, emergency services benefit from a higher level of coverage compared with complex restorative treatments or dental implants, which frequently remain partially or entirely the financial responsibility of the patient. These differences confirm the heterogeneous nature of financial protection in oral health care and support the need to further examine access to dental services in the Romanian context as well.

IV. DENTAL SERVICES REIMBURSED BY THE NATIONAL HEALTH INSURANCE HOUSE

Dental services for insured individuals

According to the healthcare service packages applicable during 2021–2022, regulated by Government Decision no. 696/2021, both insured and uninsured individuals may benefit from certain dental services reimbursed through health insurance houses [22].

Within the basic healthcare package, insured individuals benefit from a broader range of dental services compared to uninsured persons. Reimbursement of dental services may be differentiated as follows: full coverage for children, full or partial coverage for adults, and full coverage for beneficiaries of special legal provisions.

The methodological norms implementing the framework contract stipulate that adults may benefit from one free dental consultation per year, while children are entitled to two consultations annually. In order to provide these services, dentists conclude additional agreements with health insurance houses, supplementing their contracts for dental medical services.

Dental services for uninsured individuals

Uninsured persons benefit from a minimal dental service package, more limited than the one available for insured individuals. This package mainly includes emergency or immediately necessary interventions, such as treatment of dento-alveolar trauma, sedative dressings, endodontic drainage, treatment of apical periodontitis through incision with anaesthesia, alveolar curettage, haemorrhage management, reduction of temporomandibular joint dislocation, repair and rebasing of dentures, as well as orthodontic appliance repairs.

Services included in the minimal package may be provided by healthcare providers contracted with health insurance houses. Nevertheless, recommended paraclinical investigations, such as dental radiographs, as well as

certain prescribed treatments, may remain the financial responsibility of the beneficiary.

V. MATERIALS AND METHODS

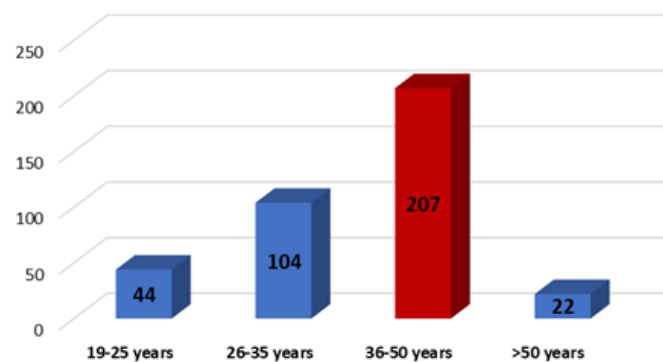
The study employed an observational, transversal design based on the administration of an online questionnaire. The research instrument aimed to evaluate the perception of the general population regarding dental health insurance, the utilization of dental services, and the financial barriers associated with access to care.

The questionnaire included 19 questions, of which 5 addressed socio-demographic characteristics, while 14 referred to the frequency of dental visits, reasons for presentation, use of reimbursed or compensated services, existence of employer-provided benefits, and respondents' willingness to use dental insurance schemes.

The sample was constituted through voluntary participation, the questionnaire being distributed online through various informal groups and networks. During the three-week period in April 2022 in which the questionnaire was available, 379 responses were recorded. The data were analyzed descriptively by calculating absolute and relative frequencies for categorical variables and the mean and standard deviation for quantitative variables.

The mean age of respondents was 38.05 years, with a standard deviation of 9.49 years. The minimum age was 19 years and the maximum age was 83 years. Distribution by age groups indicated 44 respondents aged 19–25 years, 104 respondents aged 26–35 years, 207 respondents aged 35–50 years, and 22 respondents older than 50 years (Figure 1). Most participants were female (89.7%), originated from urban areas (79.8%), and were married (69.7%).

Figure 1 - Distribution by age groups

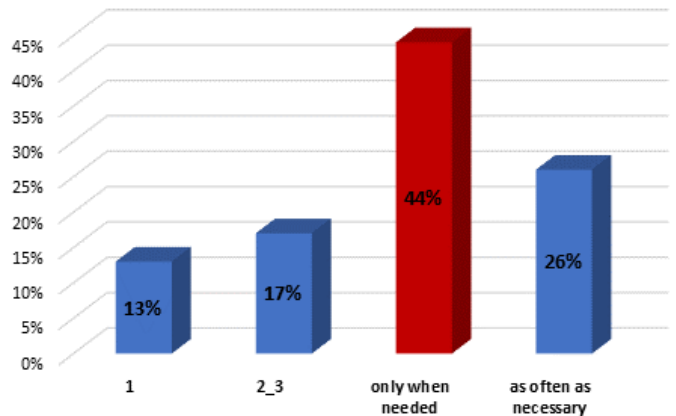


VI. RESULTS

The frequency of dental visits was variable. Thirteen percent of respondents stated that they visited the dentist once per year, while 17% attended two to three times annually. A substantial proportion of participants mentioned that they did not attend regular dental check-ups, but rather sought care only when problems occurred, whereas 26% reported visiting the dentist whenever necessary (Figure 2).

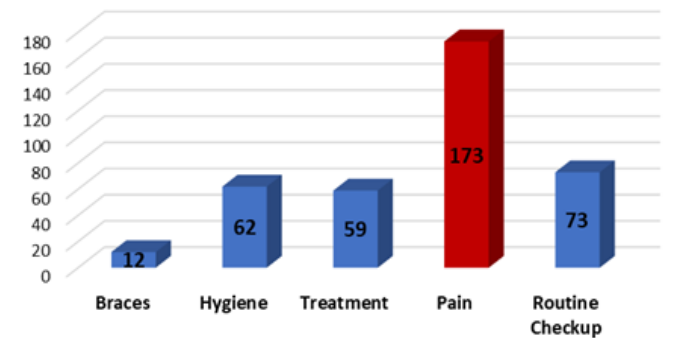
The most common reason for the last dental visit was pain, reported by 173 respondents. Other reasons included rou-

Figure 2 - Frequency of visits to the dentist



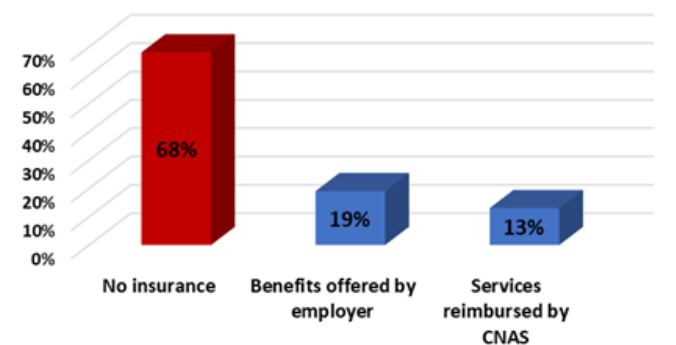
tine check-ups (73 respondents), professional dental cleaning (62 respondents), dental treatment (59 respondents), and problems related to orthodontic appliances (12 respondents) (Figure3).

Figure 3 - Reason for visiting the dentist in the last year



Regarding the existence of insurance or reimbursement mechanisms for dental services, 66% of respondents stated that they did not have any form of dental health insurance or were unaware of such coverage. Nineteen percent mentioned employer-provided benefits, such as allocated sums or treatments available at specific clinics, while only 13% stated that they benefited from services reimbursed by the National Health Insurance House (Figure 4).

Figure 4 - The existence of an insurance form



Only 24% of respondents reported that during the previous year they had benefited from at least one

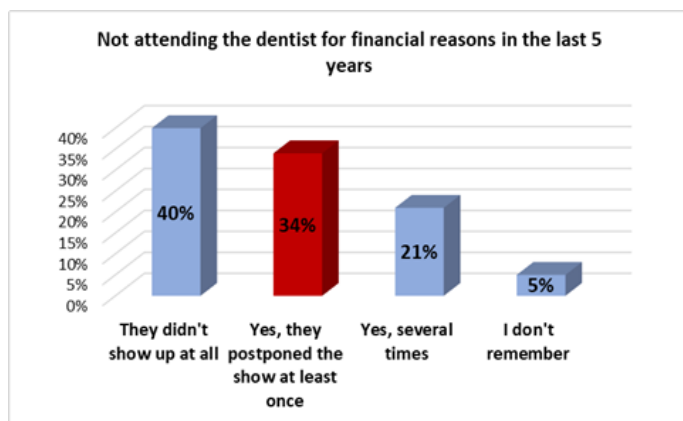
dental visit reimbursed or compensated by CNAS, private insurance, or employer-provided benefits. At the same time, 90% of participants stated that they did not know any dentist contracted with CNAS, suggesting a low level of public awareness regarding the availability of such services.

Ninety-four percent of respondents declared that they had not been informed by their dentist about the possibility of accessing free or compensated services through CNAS, either for themselves or for their children. In this context, 24% stated that they would consider purchasing a subscription for dental services at their preferred clinic, while 44% would opt for a subscription to a private healthcare network including dental services.

Regarding willingness to purchase private dental insurance, 21% of respondents expressed interest in such an option, particularly due to the high costs of treatments such as orthodontic appliances or dental implants. Ten percent remained unconvinced about the usefulness of such benefits.

Financial barriers were highlighted by the proportion of respondents who postponed dental visits during the past five years. Overall, 209 respondents reported either not attending dental services at all or having postponed at least one dental visit due to financial reasons within the last five years. Among them, 40% reported that they had not attended dental services at all, 34% stated that the situation had occurred once, and 21% reported that it had occurred two to three times during the same period (Figure 5).

Figure 5- Financial barriers



Among the 209 respondents who postponed dental care for financial reasons, 85% stated that they would have attended in a timely manner if the services had been reimbursed by CNAS, covered by private insurance, or included within a healthcare subscription.

Furthermore, 40% of respondents declared that they knew at least one person who had postponed dental care because of financial constraints, suggesting that economic barriers are not merely individual experiences, but may represent a broader community issue.

VII. DISCUSSION

The study results highlight the determining role of financial factors in accessing dental services. The propor-

tion of respondents who postponed dental visits because of costs, as well as their willingness to access services under conditions of public or private reimbursement, indicate that the lack of financial protection constitutes one of the main barriers to oral healthcare. These findings are consistent with the scientific literature, which demonstrates that dental services are frequently associated with high levels of out-of-pocket payments and more limited public coverage compared to other healthcare services.

An important finding of the study concerns the low level of awareness regarding dentists contracted with CNAS and the services that may be reimbursed or compensated. The fact that most respondents were unfamiliar with providers contracted within the public system and had not been informed about the possibility of accessing free or compensated services suggests a dual problem: on the one hand, the availability of contracted services may be insufficient or insufficiently visible; on the other hand, public communication regarding existing rights and benefits remains limited. In the absence of adequate information, even services formally included in the benefit package may remain underutilized.

The data also suggest that the current public coverage does not fully meet the population's needs. Reimbursed dental services are perceived as limited, while dentists' interest in contracting with CNAS may be reduced under conditions of tariffs, reimbursement ceilings, or administrative requirements considered insufficiently attractive. This situation may contribute to maintaining unequal access, especially for low-income individuals, rural populations, or patients living in areas with limited provider availability.

Inequalities in access may be further aggravated by the uneven geographical distribution of dental services. Individuals living in rural or socio-economically disadvantaged regions may encounter difficulties not only in identifying a provider, but also in covering transportation, consultation, and treatment costs. Under such circumstances, access to oral healthcare depends not only on the formal existence of entitlements, but also on the actual availability of providers, physical accessibility, and the patient's financial capacity.

Special attention should be given to vulnerable groups, including individuals with physical disabilities, cognitive impairments, chronic diseases, or functional dependency. For these categories, barriers are not only financial, but also organizational, informational, and related to physical accessibility. Dental clinics located in older buildings without appropriate adaptations may limit access for patients with reduced mobility. At the same time, patients with cognitive impairments may require adapted communication and additional support in understanding therapeutic options. Public policies in oral healthcare should explicitly address these dimensions of access.

From a systemic perspective, the results support the need for a paradigm shift in oral healthcare: from a predominantly curative and episodic model toward a preventive, integrated, and patient-centred model. Dental attendance mainly motivated by pain indicates late utilization of services, occurring after complications have already developed, rather than regular preventive use. This

situation may lead to more complex treatments, higher costs, and less favourable outcomes for patients.

At the European level, differences between systems covering dental services demonstrate the absence of a unified model for financing and organizing oral healthcare. Some countries use subsidies, others rely on complementary insurance schemes, while in many cases prosthetic services, implants, or complex treatments remain partially or entirely the patient's responsibility. The lack of common guidelines and harmonized standards regarding therapeutic pathways complicates comparative evaluation of coverage and access, as well as the development of coherent policies at the European level.

The study also highlights the potential of private insurance and healthcare subscriptions as complementary financial protection mechanisms. However, respondents' willingness to pay individually for such products was relatively moderate. A considerable proportion of participants would prefer these benefits to be offered through employers, suggesting the possibility of developing occupational benefit packages including preventive or basic dental services. Nevertheless, such an approach should be regarded as complementary rather than substitutive to strengthening public coverage, since inactive individuals, retirees, unemployed persons, or informal workers may remain exposed to the risk of limited access.

The present study has several limitations. First, the sample was constituted through voluntary participation based on an online questionnaire, which may introduce selection bias. The high proportion of female respondents and the predominantly urban origin of participants limit the generalizability of the results to the entire population. Second, the data were self-reported, which may generate recall or interpretation errors. Third, the study did not include an objective verification of the services actually available through CNAS contracts in the respondents' areas of residence. Nevertheless, the results provide a relevant perspective on population perceptions and on the financial and informational barriers influencing dental service utilization.

The findings indicate the need for further research conducted on nationally representative samples, analysing the association between socio-economic status, area of resi-

dence, educational level, existence of dental insurance, and utilization of dental services. Moreover, evaluations regarding the cost-effectiveness of expanding reimbursed dental service packages are necessary, with particular emphasis on prevention, early diagnosis, and conservative treatment. Improved data collection regarding oral health and service utilization could support the development of evidence-based public policies.

Overall, the study confirms that access to dental services is influenced by the interaction between costs, information, provider availability, and the structure of benefits offered by the healthcare system. Expanding coverage, increasing transparency regarding reimbursed services, encouraging providers to contract with CNAS, and integrating oral prevention into primary healthcare may contribute to reducing inequalities and improving the oral health of the population.

VIII. CONCLUSIONS

The study results demonstrate that financial barriers represent an important determinant of access to dental services. A significant proportion of respondents postponed dental visits because of costs, while most individuals in this situation stated that they would have accessed services if they had been reimbursed or covered through an insurance scheme.

The low level of awareness regarding reimbursed dental services and dentists contracted with CNAS indicates the need for more effective public communication interventions. At the same time, the limited availability of contracted providers may reduce actual access to services formally included within the benefit package.

Expanding reimbursed dental services, developing complementary dental insurance mechanisms, and strengthening preventive approaches may contribute to reducing inequalities in oral health. Public policies should aim not only to increase financial coverage, but also to improve the physical, geographical, and informational accessibility of dental services.

Integrating oral health into primary healthcare and orienting the healthcare system toward prevention represent essential directions for reducing the burden of oral diseases and improving population quality of life.

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