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Dental health as a component of public health: The problem of intersectoral interaction between dentists and primary care

Abstract. The aim of the study was to assess the role of dental health as a component of the public health system and to identify the key factors influencing its level. The methodology consisted of a comprehensive analysis of scientific literature on the social, behavioural, and organisational determinants of dental health, as well as an anonymous online survey conducted among 113 dental practitioners and primary care physicians to assess their views on intersectoral interaction in the field of prevention. The results indicated that dental health is a critical indicator of social inequality and overall health status. In the professional assessment of respondents, 69.64% of dentists rated the impact of untreated oral diseases on general health at the maximum level (5 points), while 64.91% of primary care physicians rated it at 4 points, confirming a high level of awareness of bidirectional links. At the same time, 60.71% of dentists considered primary screening to be the exclusive competence of the dentist, whereas 57.89% of primary care physicians regarded it as part of their own practice. The use of digital technologies for patient monitoring was reported by 49.12% of primary care physicians, while 66.07% of dentists used them mainly for internal clinical processes. The main barriers to cooperation included a lack of protocols and funding (66.67%) and time constraints among colleagues (58.93%), while preventive priorities differed between socio-economic factors and low health literacy (46.43%). The practical significance of the study lies in forming an evidence base for the development of integrated preventive strategies and intersectoral protocols aimed at reducing social inequalities and improving the effectiveness of population dental health

Keywords: oral cavity; social determinants; prevention; caries; periodontitis

INTRODUCTION

Dental health is predominantly viewed as an individual clinical issue; however, it has a key connection with overall health status, life expectancy, and the socio-economic development of the population. Dental diseases are characterised by high prevalence and have a significant impact on economic costs and access to healthcare. In Ukraine, a national analysis by the World Health Organization [1] records high levels of untreated caries among children, as well as the prevalence of periodontitis and complete and partial edentulism among adults, indicating a substantial burden of dental disease in the population. Economic losses, including direct treatment costs and indirect productivity losses, exceeded USD 800 million per year, highlighting the importance of dental diseases as a public health problem. Taken together, these data indicate the need to shift the focus from curative care to population-level prevention and to integrate the dental component into national health strategies.

Substantial evidence of the systemic impact of dental diseases on overall health was presented by P.E. Murray *et al.* [2], who summarised the results of 252 studies and demonstrated an association between oral infections and an increased risk of oncological, cardiovascular, and metabolic diseases. The findings confirmed that oral pathologies are not localised conditions but exert systemic effects. Similar results were reported by H. Larvin *et al.* [3], who found that periodontitis was associated with an increased risk of cardiovascular events (RR = 1.2), while an umbrella review

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by H.I. Arbildo-Vega *et al.* [4] confirmed a bidirectional relationship between periodontitis and diabetes mellitus. All these findings support the inclusion of dental health among public health policy priorities. At the same time, an analysis by O.I. Ruban & Y.B. Yashchenko [5] demonstrated a deterioration in the dental health status of the Ukrainian population, associated with weak development of preventive programmes and a reduction in state funding for the sector. The authors emphasised the need to modernise preventive activities, enhance interdisciplinary interaction, and improve service accessibility through the development of insurance and public-private mechanisms. The macroeconomic dimension of the problem was reflected in a study by J. Yang *et al.* [6], according to which global welfare losses due to dental diseases in 2021 amounted to USD 234.3 billion (international dollars), equivalent to 0.24% of global gross domestic product.

In Ukraine, the situation was further complicated by the absence of state programmes for the prevention of dental diseases, a decline in the number of dentists, and a reduction in the network of public clinics, as noted by L. Artemchuk *et al.* [7]. This was accompanied by an increased need for treatment, a rise in complicated forms of caries, and a growing prevalence of malignant neoplasms of the oral cavity. Limited resources and insufficient specialist training increased the relevance of studying the role of dental health within the public health system. An insufficient level of clinical staff training was also evident in the area of personalised approaches, as demonstrated by L.O. Turova *et al.* [8]. The authors showed that healthcare professionals in Ukraine had a low level of awareness regarding the implementation of personalised medicine, which hindered the development of innovative clinical strategies, including in dentistry. Additional gaps were identified by O. Detsyk & N. Fedoryka [9], who found low levels of use of preventive technologies for early detection of head and neck tumours in dental practice. This highlighted the need to improve educational and organisational approaches in the training system for dentists and primary care physicians. A study by I. Stovban & Y. Kuz [10] found that access to dental care remained limited: only 19.6% of respondents assessed it as fully accessible, while 64.6% considered it partially accessible and 15.8% inaccessible. Regular preventive check-ups were undertaken by only 27% of respondents, mainly due to financial barriers (65.1%) and insufficient awareness of their importance (41.5%). The most significant determinants of dental service utilisation were trust in the physician, professional reputation, and service cost, emphasising the leading role of social and economic factors in shaping access to dental care.

In view of these data, dental health should be regarded as an important structural element of public health policy. The aim of the study was to analyse the role of dental health within the public health system, identify the key factors shaping its level, and substantiate the possibilities for integrating preventive dental programmes into national health strategies. The objectives were to analyse the social determinants of dental health and its bidirectional relationship with overall health, and to conduct an anonymous survey among dentists and general practitioners to assess their views on intersectoral cooperation in dental prevention.

MATERIALS AND METHODS

The theoretical stage of the study was based on a comprehensive analysis of scientific literature to identify the key determinants of population dental health at the individual, socio-economic, and professional levels. The literature search was guided by the conceptual approaches of G. Dahlgren & M. Whitehead [11] regarding the multi-level model of health determinants, the concept of social inequalities proposed by M. Marmot [12], and the common risk factor approach by A. Sheiham & R.G. Watt [13]. Data from population-based, analytical, and clinical-social studies were systematised, covering epidemiological assessments of dental diseases, analyses of socio-economic and behavioural determinants, features of access to dental care, and organisational factors at the level of healthcare systems. The analysis included studies examining dental health inequalities among children and adults, models of dental service utilisation, regional and national health gradients, and structural political-economic mechanisms determining these inequalities. Particular attention was paid to socio-economic, behavioural, clinical, and organisational factors, as well as the accessibility of preventive and curative services. The analysis also included assessments of inequalities in dental health across different age and social groups, the effectiveness of comprehensive preventive programmes, and the economic efficiency of interventions. This approach made it possible to integrate theoretical models with empirical data, outline the interrelationship between social, behavioural, and professional determinants, and form the basis for subsequent physician surveys and assessment of interdisciplinary interaction in dental public health.

The empirical stage of the study was aimed at identifying professional perceptions, levels of awareness, and key differences between dentists and primary care physicians regarding the integration of dental prevention into the public health system. The methodological design was based on the use of a standardised online survey, enabling data collection within short time frames, coverage of specialists from different regions, and full anonymity of responses. The survey was conducted electronically using the secure Google Forms platform, in compliance with the ethical code of the American Sociological Association [14] and the European Commission guidelines [15] on ethics of data collection and personal data protection. The study was

organised as a voluntary anonymous survey in accordance with the Declaration of Helsinki [16]. The sample included 113 professionals: dentists and general practitioners providing outpatient or preventive medical services. The sample was formed using convenience sampling, which is acceptable for studies aimed at exploring professional views and practical aspects of interdisciplinary interaction (Table 1).

Table 1. Inclusion and exclusion criteria for study participants

Category	Criteria
Inclusion criteria	Dentists or general practitioners. Practice in outpatient, preventive, or family medicine. At least one year of professional experience. Voluntary participation and confirmed consent to complete the questionnaire. Complete questionnaire responses.
Exclusion criteria	Students, interns, or individuals without physician status. Specialists not working in fields related to preventive or outpatient care. Refusal to participate or withdrawal of consent. Incomplete or incorrectly completed questionnaires.

Source: compiled by the author

The questionnaire was developed based on the 2022 World Health Organization recommendations [17] for evaluating preventive models in dental public health, as well as structural components of interprofessional interaction. The instrument comprised four thematic sections, each reflecting a specific dimension of professional perception of integration. The first section addressed demographic characteristics and professional experience, enabling stratification of responses by age, length of service, specialisation, and type of practice. The second section focused on assessing awareness and understanding of the bidirectional relationship between dental and general health, including the role of periodontitis in systemic diseases. The third section evaluated attitudes towards preventive measures and practices, with an emphasis on defining the role of primary care in oral screening and risk identification. The fourth section addressed key barriers to integration, focusing on institutional, organisational, financial, and socially determined components.

Questionnaire items were formulated using Likert scales (1-5 points), multiple-choice questions, and closed categorical responses. This structure ensured data standardisation and enabled quantitative comparison between the two professional groups. No open-ended questions were included, which reduced interpretative variability and ensured data uniformity. Issues examined included the integration of dental prevention into the healthcare system: assessment of the necessity of primary oral screening by primary care physicians, perceptions of digital preventive and monitoring tools, identification of leading barriers to intersectoral interaction, and the role of social determinants in population dental risk structures. Data processing employed standard descriptive and comparative statistical methods, including analysis of response distributions, frequencies, and percentages, as well as assessment of the significance of differences between groups.

Data analysis was performed using IBM SPSS Statistics, version 28.0 (USA). Descriptive statistics included frequencies, proportions, and distributions of ranked scores (1-5 points). As variables were predominantly nominal and ordinal, Pearson's χ^2 test was used to compare responses between dentists and general practitioners, with adjustments applied when expected frequencies were below 5. Differences in ranked scores were analysed using the Mann-Whitney U test, appropriate in the absence of normal distribution. Statistical significance was set at $\alpha = 0.05$. This approach enabled reliable identification of both convergent views and differences between professional groups regarding competencies, barriers, and the role of preventive measures.

RESULTS

Comprehensive analysis of social, clinical, and political-economic determinants of population dental health

Population dental health is shaped by a complex set of interrelated factors operating at individual, social, and organisational levels. Changes in living conditions, social stressors, and access to preventive care significantly transform the risks of developing dental diseases across different population groups. This multidimensionality necessitates a systemic analysis of the determinants that drive dental health inequalities and determine the effectiveness of preventive measures. An analysis of the study by J.V. Gondro [18] showed that access to dental care among older adults in Canada was determined by a combination of socio-economic and individual determinants, with insurance coverage, income level, and self-rated health playing a leading role. Logistic modelling revealed clear stratification by financial status: having insurance more than doubled the likelihood of visiting a dentist, reflecting the presence of systemic barriers within the healthcare structure. A significant proportion of missed visits was associated with the high cost of services, indicating the political-economic nature of these constraints, consistent with the concept of the social gradient in health. These data allow dental health among older adults to be viewed as the result

of interaction between individual characteristics, social conditions, and systemic factors that determine real inequalities in the use of dental care.

In the same context, the findings of H. Stelling *et al.* [19] demonstrated that the sustainability of the dental workforce also depends on a set of professional, social, and political-economic determinants. Career opportunities, financial conditions, and the level of inter-institutional coordination play a leading role, while barriers – particularly the rigidity of National Health Service contracts in Great Britain, workforce distribution imbalances, and fragmented communication – create structural instability that exacerbates staff shortages in socially vulnerable regions. The identified determinant of "contentment" highlights the importance of psychological safety, professional recognition, and balanced workloads, fully aligning with M. Marmot's global approach [12] to the impact of working conditions on health and professional behaviour. The results confirm the need for systemic policies aimed at eliminating economic, organisational, and communication barriers and strengthening the workforce stability of dental services.

The comprehensive analysis by M.-P. Jadidfard *et al.* [20] deepens the understanding of political-economic and social determinants of dental health by revealing pronounced stratification of dental expenditures according to household socio-economic status. The increase in financial burden alongside rising welfare levels demonstrates the influence of individual and economic factors on dental service utilisation behaviour. Identified differences between urban and rural areas reproduce regional health gradients and logically align with the concept of social determinants. The findings indicate that population dental health largely depends on resource distribution, economic capacity, and social conditions, justifying the need for targeted interventions for groups with lower socio-economic status. The results of A.I. Hultquist *et al.* [21] showed that combining oral and social determinants more accurately predicts the risk of caries in preschool children. For this analysis, confirmation of the multilevel nature of risk is important: social characteristics create a background of vulnerability, while clinical factors determine the direct manifestation of the pathological process. Thus, isolated consideration of clinical signs is insufficient for accurate risk assessment.

The significance of macro-level determinants is described in the study by C. Triantafyllou *et al.* [22], which developed an integrated system for assessing socio-economic factors influencing population health in Greece. Economic and political conditions shape the structural level of dental inequalities, particularly through prevention funding, workforce resources, and patient referral organisation. Other studies have also demonstrated a significant impact of socio-economic status on adult dental health. In Portugal, I.C. Santos *et al.* [23] found that lower levels of education and income were associated with poorer oral health, a greater need for prosthetic treatment, and fewer dental visits. Similar conclusions were reached in Norway by H. Lyshol *et al.* [24], where a clear socio-economic gradient was observed in self-rated dental and general health. These data confirm the universality of the social gradient, regardless of the healthcare system model. This allows socio-economic status to be identified as one of the fundamental determinants shaping access to prevention, behavioural patterns, and early care-seeking. Thus, dental health is formed under the influence of multilevel determinants that combine social, clinical, and macro-level factors. Socio-economic conditions and stress factors define background population vulnerability, while preventive clinical interventions can partially compensate for the negative impact of adverse life circumstances. The identified patterns indicate that structural changes in the healthcare system, including workforce policy and prevention funding, significantly affect the dynamics of dental inequalities. The universality of the social gradient observed across countries highlights the key role of socio-economic status as a determining factor of access to dental care.

Social determinants of dental health: Global and local context (within M. Marmot's framework)

Within the framework of social determinants of health proposed by M. Marmot [12], numerous empirical and analytical studies demonstrate that oral health is a sensitive indicator of social and structural inequalities. Systematic reviews, population analyses, and regional studies confirm that the social gradient in dental health persists throughout the life course and across different socio-economic contexts. The analysis conducted by S. Du [25] demonstrated a complex interaction of socio-economic, educational, and territorial determinants shaping inequalities in caries prevalence among preschool children in China. Decadal dynamics showed a substantial narrowing of the socio-economic gradient in urban regions, indicating the positive impact of urbanised educational and preventive healthcare resources. At the same time, the persistence of inequality in rural areas and continued dependence on parental education level highlight the systemic nature of the problem, fitting within the global concept of social determinants of health. These findings confirm that educational and structural factors remain key regulators of dental health, requiring targeted political-economic solutions to reduce disparities between social groups.

The social determinants of health described by N. Pourat *et al.* [26] include economic hardship, chronic diseases, and behavioural factors. Within this analysis, these characteristics are interpreted as integrated risk factors that collectively, rather than in isolation, shape patients' dental status. The demonstrated impact of integrating dental care into primary care highlights

the role of organisational determinants that either exacerbate or mitigate the social gradient. The study by K. Sengupta *et al.* [27] described a reduction in caries prevalence in Denmark, while noting the persistence of socio-economic and geographical inequalities. In this analysis, these findings are interpreted as evidence that even with overall improvements in conditions, determinants linked to socio-economic status continue to drive differentiation in dental health outcomes. Children from families with lower socio-economic status had significantly higher levels of caries, demonstrating the direct influence of social capital and resource accessibility on dental health. A similar gradient was observed in the work of S.C. Rødseth *et al.* [28], where adults with lower education and income levels exhibited worse indices of decayed, filled, and missing teeth. From a determinant's perspective, this confirms that education functions not only as a social characteristic but also as a factor influencing awareness, preventive behaviour, and timely care-seeking. The greatest differences were observed for missing teeth, reflecting structural barriers to access to treatment.

Ethnic and social determinants reported by G. Campus *et al.* [29] show that children of non-European origin in Italy have significantly higher caries prevalence. Within the analytical framework, this is interpreted as the combined effect of cultural, migratory, and socio-economic factors shaping inequalities in dental health outcomes. Parental education and income emerge as key predictors, underscoring the role of family resources as fundamental determinants. Finally, the study by L. Limo *et al.* [30] demonstrated an association between suboptimal dental status and multimorbidity in a Canadian sample. In this analysis, this is viewed as an interaction of clinical and social determinants, where the presence of chronic diseases, compounded by access barriers, creates a combined risk for deterioration of dental status.

A. Joudi *et al.* [31] conducted a determinant analysis of socio-economic factors shaping access to dental care in an urban environment. It was found that individual behavioural practices and clinical markers (frequency of oral hygiene procedures, episodes of dental pain, aesthetic concern about dental condition) acted as key micro-determinants that intensified inequality in dental service utilisation. Political-economic disparities were identified, particularly uneven insurance coverage, which created a pro-rich gradient in dental service use and widened gaps between social groups. The complex interaction of social, economic, and behavioural determinants reflected patterns consistent with the concept of social health gradients, indicating the need for targeted interventions for groups with the lowest socio-economic status. In summary, the reviewed studies demonstrate that social, economic, behavioural, and commercial determinants form a clear social gradient in dental health, fully consistent with M. Marmot's theoretical framework [12] and confirming the need for multilevel policies aimed at eliminating structural inequalities. This evidence underscores the necessity of addressing both individual and systemic factors to ensure equitable access to dental care.

Comprehensive analysis of individual, social, and professional determinants of population dental health

The set of determinants identified in dental health research encompasses a wide range of individual behavioural factors, socio-economic conditions, and professional characteristics of medical practice. A combined analysis of these studies enables the formation of an integrated understanding of risk formation mechanisms and potential directions for improving preventive strategies. At the individual behavioural level, several studies emphasise the significant impact of dietary habits – particularly excessive consumption of simple sugars – on the development of inflammatory processes in periodontal tissues. In a narrative review, S. Shanmugasundaram & S. Karmakar [32] highlighted that excessive intake of fructose and sucrose triggers systemic low-grade inflammation and dysbiosis of the oral and gut microbiota, creating a metabolic background conducive to the progression of periodontal lesions. From a determinant's perspective, dietary behaviour emerges as a primary modifiable factor that initiates dysbiotic and metabolic risk mechanisms. Hypercaloric intake and the potentially addictive properties of simple sugars are considered determinants that create a long-term metabolic environment favourable to periodontal disease progression.

The findings of a systematic review by T. Kusama *et al.* [33] refine these observations, demonstrating a consistent association between frequent consumption of sugar-containing products and increased risk of periodontal disease. For determinant analysis, it is important that, regardless of study design, the frequency and pattern of sugar consumption determine the intensity of risk accumulation, not merely its presence in the diet. Methodological limitations of cross-sectional designs do not alter the overall conclusion regarding behaviour as a key individual determinant.

The economic dimension of preventive interventions, as shown in the systematic review by B. Zhang *et al.* [34], demonstrates the potential of fissure sealants and fluoride varnishes. More importantly, economic accessibility and standardisation of prevention act as structural determinants that define the real-world implementability of effective methods at the population level. Variability in models and costs confirms the need to adapt economic strategies to national resource contexts. Social gradients in dental health are also confirmed in the study by I.C. Santos *et al.* [23], which showed that lower educational attainment, lower income, and limited access to private dental care

were associated with poorer oral health among older adults in Portugal. From a determinant's perspective, these variables represent key features of the social environment shaping health maintenance opportunities: education influences awareness, income affects service accessibility, and family resources determine the capacity to offset age-related risks. Additional factors (age, sex, smoking, body mass index) act as modifiers that amplify the effects of core social conditions.

Important epidemiological patterns were also identified in the study by M. Usuga-Vacca *et al.* [35], where analysis of data from the Comprehensive Social Protection Information System showed that carries and periodontal disease indicators closely correlated with the frequency of consultations for metabolic and nutritional disorders. From a determinant's perspective, this indicates that dental health is shaped by a complex of medical and social factors, where systemic diseases and nutritional disorders are not isolated conditions but reflect broader social living conditions and access to prevention. Identification of pathology clusters highlights the interaction between social and biomedical determinants. The final dimension is the professional and organisational level, as revealed in the study by A.I. Hultquist *et al.* [21], where combined caries prediction models showed a significant increase in accuracy when social variables were included. In this context, clinical risk assessment is incomplete without consideration of social background, income, and family structure; thus, professional decision-making must be based on integration of medical and social parameters.

The professional dimension is further complemented by repeated mixed analyses of the Common Risk Factor Approach, which demonstrated the presence of barriers to implementing intersectoral approaches. These barriers are interpreted as organisational determinants that define the healthcare system's real capacity to control non-communicable and periodontal diseases. A high level of knowledge does not guarantee implementation in the absence of interprofessional coordination and policy-level support.

Empirical analysis of interprofessional interaction in dental prevention

The empirical stage of the study focused on examining the professional positions of dentists and general practitioners regarding the integration of dental prevention into the overall healthcare system. Analysis of respondents' answers showed a high level of awareness in both groups of the bidirectional relationship between periodontitis and systemic diseases. Dentists more often indicated the maximum level of significance of this relationship (69.64% chose 5 points), whereas general practitioners more often rated it at 4 points (64.91%). Despite minor differences in rating categories, both groups unequivocally recognised the impact of dental pathologies on general health as a critically important consequence of untreated oral problems. This conclusion confirms the need to integrate the dental component into systems of prevention and monitoring of general health.

In assessing the functional role of primary oral screening, substantial differences were identified. Dentists predominantly considered the initial examination to be the exclusive responsibility of dental practitioners (60.71%), whereas the majority of general practitioners (57.89%) noted its critical importance for their own practice, primarily as a rapid visual assessment for targeted referral of patients. This result indicates the presence of functional discrepancies that require clarification of responsibilities and intersectoral interaction protocols. The integration of digital technologies revealed another area of divergence. General practitioners more frequently used telemedicine and mobile channels for continuous monitoring and communication with patients (49.12%), whereas dentists used such technologies mainly for internal clinical processes and rarely engaged in remote contact with patients (66.07%). This difference indicates an uneven digitalisation focus: clinical optimisation among dentists versus communication support among general practitioners.

Analysis of key barriers to intersectoral collaboration showed a clear difference in problem perception. Dentists most often identified lack of time among primary care colleagues (58.93%) as the main factor, whereas general practitioners pointed to the absence of clear protocols and funding (66.67%) as the key obstacle. Differences in prevention priorities were also noted: dentists emphasised low health literacy in the population (46.43% rated this 4-5 points), while general practitioners paid greater attention to socio-economic determinants, particularly financial barriers and access to preventive measures. Based on the obtained data, an additional summary table was created combining assessments of factors, barriers, and competencies, illustrating the balance of consensus and divergences between groups (Table 2).

Table 2. Summary assessment of dentists' and general practitioners' views on integrating dental prevention (n = 113)

Category	Dentists' view	General practitioners' view	Conclusion
Significance of the impact of periodontitis on general health	Maximum score 5 (69.64%)	Score 4 (64.91%)	Consensus on critical importance; minor differences in ratings
Mandatory nature of primary screening	Exclusive competence of dentists (60.71%)	Role of general practitioners (57.89%)	Divergence in the functional scope of competencies

Table 2. *Continued*

Category	Dentists' view	General practitioners' view	Conclusion
Use of digital technologies	Mainly internal clinical processes (66.07% rarely)	Ongoing use for monitoring and communication (49.12%)	Divergence in the focus of digitalisation (clinical vs communication)
Main barrier to collaboration	Lack of time among general practitioners (58.93%)	Lack of protocols and funding (66.67%)	Divergence in problem framing (operational vs systemic)
Priority prevention barrier	Low health literacy (46.43%)	Financial barriers; social determinants	Divergence in priorities: individual vs social factors

Source: compiled by the author

Analysis of the table indicates that, despite general consensus between dentists and general practitioners regarding the high significance of the impact of periodontitis on patients' overall health, systemic differences persist between the groups in how mechanisms of intersectoral collaboration in dental prevention are understood. In particular, dentists display a categorical position regarding the critical role of dental diseases, reflected in the highest scores (5 points), whereas general practitioners rate the impact at 4 points, which is related to the broader clinical focus of their practice. Fundamental differences were identified in the question of whether primary screening should be mandatory: dentists view it as their exclusive competence, while general practitioners tend to see themselves as having an active role in early detection of dental problems. This indicates a lack of clarity in the functional distribution of responsibilities and the absence of unified interdisciplinary action algorithms. A similar situation is observed with respect to digital technologies: for dentists, digitalisation is associated mainly with internal clinical processes, whereas general practitioners regard it as a tool for continuous monitoring, communication, and coordination of care, which is critical for intersectoral interaction. Assessment of collaboration barriers also reflects different levels of problematisation: dentists focus on operational difficulties, particularly the lack of time among general practitioners, while general practitioners emphasise systemic constraints – namely, the absence of standardised protocols and adequate funding. A comparable dichotomy is also observed in defining priority barriers to prevention, with dentists emphasising patients' individual health literacy, and general practitioners emphasising broader socio-economic determinants of health. Taken together, these results indicate that intersectoral collaboration in dental prevention is constrained less by a lack of awareness of its importance than by differing professional perspectives and levels of responsibility. This substantiates the need to develop shared interdisciplinary protocols, aligned digital solutions, and organisational interaction models that integrate dental prevention into primary healthcare.

In summary, the results of the empirical stage showed that although both professional groups recognise the critical importance of dental health for patients' overall condition, there are significant functional and organisational divergences. These relate to the scope of competencies in primary screening, the use of digital technologies, and prevention priorities, which requires clarification of protocols and intersectoral planning. This level of detail makes it possible to formulate specific recommendations for integrating dental prevention into the public health system and optimising interaction between professional groups.

DISCUSSION

Integrating dental health into the healthcare system is regarded as a multilevel process combinin g strategic approaches, intersectoral interaction, and the day-to-day practice of professionals. However, as the results of this study show, a noticeable gap remains between conceptual integration models and their practical implementation. Differences in professional roles, levels of digitalisation, approaches to primary screening, and assessments of the significance of dental pathologies create a complex micro-level context that determines the effectiveness of implementing integrated models in practice. These discrepancies make it necessary to compare the findings with existing scientific approaches and empirical observations. In the study by E. Emami *et al.* [36], the integration of dental care was viewed primarily as a systemic concept aimed at overcoming structural barriers and expanding the role of dental professionals in primary care. The main focus was on creating integrated models as a general framework for overcoming fragmentation and improving the effectiveness of preventive work. In the present empirical analysis, by contrast, the emphasis was on practical aspects of interaction between dentists and general practitioners, specifically the assessment of functional competencies, the use of digital tools, and barriers in daily practice. The results showed that even with a high level of awareness of the importance of dental health, substantial structural and operational differences remain between professional groups. For example, when assessing the significance of the impact of periodontitis on general health, dentists more often gave the maximum score of 5, whereas general practitioners rated the impact at 4. These data refine the systemic approach of E. Emami *et al.*, showing that, at the practical level, integration is hindered by differences in assessments of professional roles.

The national strategy for integrating dental health presented by L.D. Rock & P.J. Allison [37] focuses on macro-level coordination, infrastructure development, and new methodologies to ensure intersectoral interaction. In contrast to this strategic approach, the empirical data of the present study detailed micro-level aspects of collaboration between dentists and general practitioners. For example, assessment of competencies in primary screening revealed a difference: dentists considered it an exclusive dental competence (60.71%), whereas general practitioners emphasised the critical importance of this element for their practice (57.89%). Similarly, in terms of digitalisation, asymmetry was observed: internal clinical use predominated among dentists (66.07%), whereas general practitioners used digital technologies mainly for monitoring and communication with patients (49.12%). These findings specify the conceptual provisions of NOHRS, demonstrating that strategic goals require detailed alignment at the level of professional roles and everyday work algorithms.

Comparison with the conclusions of M. Prasad *et al.* [38] also underscores a shared focus on integrating the dental component into primary healthcare. At the same time, the nature of the identified determinants differed substantially. In the review by M. Prasad *et al.*, integration was viewed primarily as a systemic strategy emphasising funding, interprofessional education, and expansion of partnership models, whereas in the empirical study the determining factors were professional-organisational barriers, particularly differences in functional competencies and roles in primary screening (60.71% of dentists versus 57.89% of general practitioners). In addition, the influence of digital inequality was noted: dentists rarely used remote technologies (66.07%), whereas general practitioners actively used them for patient monitoring (49.12%). The differing priorities of the groups confirm heterogeneity in determinant effects: dentists focused on improving individual health literacy (46.43%), while general practitioners focused on overcoming socio-economic barriers and limited funding. Thus, the results show that effective integration requires not only systemic planning but also alignment of roles, digital practices, and operational algorithms at the micro level.

Analysis of the results in comparison with the findings of R. Busse *et al.* [39] confirmed the key emphasis on the systemic nature of prevention; however, the empirical data of this study reveal much more pronounced professional differences. For example, R. Busse *et al.* emphasise the importance of harmonised protocols for improving quality, whereas in the present study their absence was identified as a critical problem by 66.67% of general practitioners, and dentists highlighted lack of time for additional tasks (58.93%). The identified digitalisation asymmetry also demonstrates uneven integration: general practitioners used digital technologies for patient monitoring almost twice as often as dentists. These data indicate that strategic recommendations regarding digitalisation and harmonised protocols require adaptation to the local context of professional interaction. Comparison with M.A. Peres *et al.* [40] confirms the key role of social and organisational determinants in shaping dental health. Unlike the global analysis, where the main factors are inequality in access, economic barriers, and structural constraints, the empirical study identified a decisive influence of local professional-functional aspects: distribution of competencies, use of digital tools, and intra-professional interaction barriers. Differences in approaches to primary screening and digitalisation underline that local conditions and the specificity of interprofessional work determine the effectiveness of integrating preventive measures, even if global factors remain important.

Comparison with the results of S. Listl & T. Bärnighausen [41] indicates that the recorded differences in perceptions of the significance of periodontal pathology (69.64% of dentists versus 64.91% of general practitioners) reflect micro-level differences in interaction among professionals, whereas the authors interpret dental health as a global indicator of social progress. The identified difference in approaches to primary screening (60.71% of dentists versus 57.89% of general practitioners) contrasts with the proposal by S. Listl & T. Bärnighausen for unified metrics, demonstrating the lack of standardisation of practices at the level of professional interaction. The asymmetry in digitalisation (66.07% internal processes among dentists versus 49.12% patient-oriented tools among general practitioners) also does not align with the authors' approach, which emphasises digital indicators as a component of assessing social progress.

Comparison with the review by R. Venturelli *et al.* [42] indicates a shared trend of insufficient integration of dental prevention into the healthcare system. In socially vulnerable groups in Britain, key outcomes include high prevalence of caries and periodontitis, while in the present study discrepancies are manifested in functional approaches between dentists and general practitioners. The main barriers identified were related to interprofessional interaction: lack of time among general practitioners (58.93%) and lack of protocols (66.67%). At the same time, the high awareness among dentists regarding the role of periodontitis contrasts with the low level of health literacy among vulnerable groups described in British studies. The digitalisation differences do not have a direct analogue in R. Venturelli *et al.*, but they reflect a similar problem of uneven access to preventive tools – at the population level in the UK and at the level of professional roles in the local context.

The present study confirmed that financial barriers, social determinants, and the absence of clear protocols affect the effectiveness of dental prevention, consistent with the conclusions of G. Dunleavy *et al.* [43]

on inequalities in access to treatment and resources. The active use of digital technologies by general practitioners (49.12%) may potentially reduce caries progression and associated costs, in line with modelling of preventive measures in high-risk groups. These data indicate that integrating the dental component into the healthcare system requires simultaneous consideration of professional, organisational, and social factors at both local and population levels. The economic consequences of caries among children become significantly more pronounced in families experiencing difficult life circumstances. Limited family resources increase the risk of inflammatory processes in periodontal tissues, which correlates with the empirical findings on the relationship between social background and dental disorders. Comparison with the work of A. Vukovic *et al.* [44] shows that socio-economic factors substantially determine oral health: in Western Europe, children have a lower risk of caries compared with Eastern European countries, while in the local study the impact of periodontitis on general health was indicated by 69.64% of dentists and 64.91% of general practitioners. Differences in perceptions of the role of primary screening reflect intra-professional differentiation, analogous to socio-economic imbalances in access to dental care.

Comparison with the study by S. Shanmugasundaram & S. Karmakar [32] confirms the impact of excessive sugar consumption on the development of inflammatory periodontal processes and increased risk of systemic complications. In the present study, dentists and general practitioners recognised the importance of dental pathologies for patients' overall health, while noting differences in perceptions of the role of primary screening and the use of digital technologies for monitoring. Both studies highlight the need for early identification of risk factors and preventive measures, confirming the importance of simultaneous emphasis on clinical and organisational aspects of preventing dental diseases. Comparison with F. Al-Habib *et al.* [45] demonstrates that physicians' high awareness of the link between periodontitis and systemic diseases is consistent with the present study, where dentists and general practitioners noted the critical impact of dental pathologies on general health. Differences in perceptions of the role of primary screening and the focus of digitalisation in the local study contrast with the correlation between awareness and frequency of referrals to dental practitioners reported in that work. The study by E. Akbeyaz Sivet *et al.* [46] confirms the importance of improving paediatricians' knowledge about oral health, aligning with results where general practitioners highlighted socio-economic determinants and financial barriers as key prevention factors. Both studies emphasise the need for an integrated approach and interprofessional coordination for effective prevention of dental diseases, while also demonstrating that translating conceptual strategies into practice requires specific micro-level solutions.

Overall, the findings demonstrate that the effectiveness of integrating dental health into the healthcare system is determined not only by broad strategic orientations but also by the concrete conditions of professional interaction. The identified differences in role perceptions, approaches to primary screening, and the use of digital technologies confirm the presence of structural and functional barriers that complicate the practical implementation of integrated models. The comprehensive analysis indicates that achieving consistency between conceptual recommendations and everyday operational algorithms requires a systematic review of professional functions, standardisation of protocols, and strengthened interprofessional communication.

CONCLUSIONS

The study produced comprehensive conclusions summarising the theoretical positions and the results of the empirical component, including quantitative survey data. The findings confirmed the strategic importance of dental health as an integral indicator of social determinants and the effectiveness of the public health system. The analysis demonstrated that dental health functions as a sensitive marker of social inequality, since clinical indicators such as caries prevalence and tooth loss show a direct relationship with income, education, and living conditions. The empirical study confirmed a high level of specialists' awareness of the relationship between periodontitis and systemic conditions, reflected in dentists' selection of the maximum significance score (69.64%) and the predominance of a score of 4 among general practitioners (64.91%). The analysis revealed functional differences in defining the role of primary screening: 60.71% of dentists consider it an exclusive competence, whereas 57.89% of general practitioners emphasise its necessity for patient referral. Digital technologies are used unevenly: general practitioners use telemedicine tools in 49.12% of cases, while 66.07% of dentists limit digital use to local internal clinical processes. Key interaction barriers also differ: dentists report time constraints (58.93%), while general practitioners report lack of protocols and funding (66.67%). The results indicate the need to standardise procedures and strengthen interprofessional coordination. Thus, the study findings confirm the need for systemic changes, including updating regulatory and financial support, scaling preventive programmes, and developing interdisciplinary interaction supported by technological resources. The data indicate that integrating dental health into the public health system is a justified, evidence-based, and socially significant direction.

The study limitations are that the results may partially reflect the subjectivity of respondents' answers and uneven regional representation, which limits generalisation of conclusions to the entire healthcare system. Future work should focus on developing and

testing integrated dental screening protocols for general practitioners, as well as assessing the economic feasibility of their implementation within the medical guarantees programme. Additional attention is required for piloting technological solutions capable of ensuring effective communication between physicians at different levels.

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CONFLICT OF INTEREST

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Стоматологічне здоров'я як складова громадського здоров'я: проблема міжсекторальної взаємодії стоматологів і первинної ланки

Анотація. Метою дослідження було оцінити роль стоматологічного здоров'я як складового елементу системи громадського здоров'я та визначити ключові чинники, що впливають на його рівень. Методологія складалася з комплексного аналізу наукової літератури щодо соціальних, поведінкових та організаційних детермінант стоматологічного здоров'я, та проведеного анонімного онлайн-анкетування серед 113 лікарів-стоматологів та лікарів первинної ланки для оцінки їхніх поглядів на міжсекторальну взаємодію у сфері профілактики. Результати дослідження засвідчили, що стоматологічне здоров'я є критичним індикатором соціальної нерівності та загального стану здоров'я. У професійній оцінці респондентів 69,64 % стоматологів відзначили максимальне значення (5 балів) впливу нелікованих захворювань ротової порожнини на загальне здоров'я, тоді як 64,91 % лікарів первинної ланки оцінили його на 4 бали, підтверджуючи високий рівень обізнаності щодо двосторонніх зв'язків. При цьому 60,71 % стоматологів вважали первинний скринінг виключною компетенцією стоматолога, а 57,89 % лікарів первинної ланки – частиною своєї практики. Використання цифрових технологій для моніторингу пацієнтів відзначили 49,12 % лікарів первинної ланки, тоді як 66,07 % стоматологів застосовували їх переважно для внутрішньоклінічних процесів. Основні бар'єри співпраці включали брак протоколів і фінансування (66,67 %) та обмеження часу у колег (58,93 %), а пріоритети профілактики розходилися між соціально-економічними чинниками та низькою медичною грамотністю (46,43 %). Практична значущість дослідження полягає у формуванні доказової основи для розробки інтегрованих профілактичних стратегій і міжсекторальних протоколів, спрямованих на зменшення соціальних нерівностей та підвищення ефективності стоматологічного здоров'я населення

Ключові слова: ротова порожнина; соціальні детермінанти; профілактика; карієс; пародонтит