UDC 614.2:616.31(477)
https://doi.org/10.31612/2616-4868.6.2026.23

CHALLENGES AND MEDICAL-SOCIAL RATIONALE FOR DENTAL CARE IN THE CONTEXT OF SOCIO-ECONOMIC TRANSFORMATIONS IN UKRAINE

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Abstract

Introduction. The article analyzes problematic aspects of the organization of dental care for the population of Ukraine in the context of socio-economic transformations. Medical and social approaches to improving the accessibility and effectiveness of dental care are substantiated, taking into account the current challenges facing the healthcare system.
Aim. The aim of the study is to substantiate the medical and social aspects of the organization of dental care in Ukraine in the context of socio-economic transformations, identify systemic gaps in financing mechanisms and access to services within the framework of the Medical Guarantees Program, and determine strategic directions for optimizing the sector through the integration of dental prevention into the primary health care system.
Materials and methods. To achieve the stated aim, a comprehensive approach was applied using the following methods: bibliographic-semantic and analytical methods, system analysis, and comparative analysis.
Results. Dental care in Ukraine operates under a mixed model with limited public coverage, which, for adults, is largely limited to emergency interventions, while children and eligible groups are provided with a broader range of services. Insufficient funding, regional inequalities in access, and fragmentation of the system were identified. The integration of dentistry into primary health care remains limited, and the preventive role of family physicians is only partially implemented, reducing the effectiveness of early detection and population-level prevention.
Conclusions. The role of family physicians in the provision of dental care remains only partially implemented due to insufficient training, a lack of integrated clinical protocols, limited financial incentives for preventive activities, and fragmentation of the healthcare system. Improving the effectiveness of dental care requires expanding NHSU service packages, integrating dental prevention into primary health care, enhancing the training of family physicians, and implementing interdisciplinary collaboration.

Keywords: **oral health care; oral cavity sanitation; model of dental care organization; prevalence; key indicators of dental care; financing of the dental sector.**

INTRODUCTION

Oral health care is an essential component of public health, as dental diseases significantly affect the quality of life, ability to work, and economic well-being of the population [1]. In the current context of healthcare system reform in Ukraine, issues related to the accessibility, quality, and effectiveness of dental care are of particular relevance.

AIM

The aim of the study is to substantiate the medical and social aspects of the organization of dental care in Ukraine in the context of socio-economic transformations, identify systemic gaps in financing mechanisms and access to services within the framework of the Medical Guarantees Program, and determine strategic directions for optimizing the sector through the integration of dental prevention into the primary health care system.

MATERIALS AND METHODS

To achieve the stated aim, a comprehensive approach was applied using the following methods: bibliographic-semantic and analytical methods – for reviewing and summarizing current scientific publications,

WHO resolutions, and international clinical guidelines (in particular those of the FDI World Dental Federation and the American Academy of Family Physicians) regarding the role of family physicians in oral health care. System analysis – for studying the current structure of financing and the model of dental care organization in Ukraine (National Health Service of Ukraine, state programs, private sector). Comparative analysis – for comparing domestic primary health care practices with international standards and the experience of countries with well-developed preventive models (USA, EU countries, Scandinavia). Regulatory and legal analysis – for examining orders of the Ministry of Health of Ukraine, government resolutions, and provisions of the Medical Guarantees Program regulating the provision of dental services and the activities of family physicians.

The materials of the study included legislative and regulatory acts of Ukraine, statistical data on dental morbidity, reports of international organizations, and results of monitoring pilot projects on dental prosthetics.

The reform of the healthcare system and the dental sector in Ukraine (2024-2026) continues to focus on changing the model of financing medical services and expanding access to free services for critically important population groups. Thus, the Medical Guarantees Program clearly differentiates dental care into free (urgent) and paid (planned) services for most citizens, while at the same time the Government continues to expand access to dental care. Since 2024, a separate pilot project on dental prosthetics has been implemented, and a special program for veterans and privileged categories has been introduced, which was significantly expanded in 2026 by the Ministry of Health of Ukraine and the National Health Service of Ukraine, particularly for certain categories of individuals affected by the Chornobyl disaster [3,4].

The development of dental care organization has a significant socio-economic impact on the development of Ukrainian society, as oral health is an integral indicator of societal development. However, at the present stage, the sector faces a number of challenges, including long-standing issues such as the burden of disease, as well as new ones – privatization of the sector, the impact of war, and difficulties in accessing dental care.

RESULTS

At the present stage, the dental care system in Ukraine can be characterized as a mixed model combining public and private sectors. This model has developed historically and reflects broader trends in healthcare system reform; however, it has both certain advantages and significant limitations.

The National Health Service of Ukraine (NHSU) covers a limited range of dental services, primarily focusing on emergency care and specific population groups. For adults, this mainly includes urgent care, such as relief of acute pain and treatment of acute conditions. As a result, publicly funded dental care for adults is effectively limited to the management of acute conditions rather than preventive and health-promoting care. For children, a broader range of planned and emergency services is provided, excluding prosthetic and orthodontic treatment, which is generally consistent with international approaches. However, in practice, challenges include insufficient program funding, unequal access to services across regions, and a limited number of pediatric dentists.

For eligible population groups, extended treatment and prosthetic services, including dental prosthetics and planned care, are available. Nevertheless, a key issue is the mismatch between available funding and actual healthcare needs, which is reflected in waiting lists, limited choice of treatment options, and the use of outdated technologies.

The current model of dental care financing through the NHSU has a socially restrictive character. It provides a more comprehensive range of publicly funded care for children and eligible population groups, whereas, for the majority of adults, state-funded dental care is largely limited to emergency interventions, primarily pain relief. This creates a significant gap in access to planned treatment and shifts a substantial proportion of the financial burden to out-of-pocket expenditures by patients.

Funding of the dental sector is provided through state programs, local budgets, and private expenditures [5, 6]. Key indicators include dental morbidity, accessibility of care, and the volume of services provided. Such a three-component financing model (state funding, local community funding, and private expenditures) is characteristic of healthcare systems undergoing economic and institutional transformation. In Ukraine, however, it has specific quantitative and qualitative characteristics, highlighting the need to develop a prevention-oriented model of dental care integrated into the public health system while ensuring accessibility and efficient use of financial resources.

International and Ukrainian policy documents emphasize the important role of family physicians in the prevention of oral diseases through screening, counseling, risk-factor modification, and appropriate patient referral. In practice, however, this role remains only partially implemented because of limited training, insufficient integration of oral health into primary health care, and institutional barriers.

The integration of oral health care into the primary health care (PHC) system, in line with WHO resolutions and policy documents adopted in 2021-2022, is an important step toward achieving universal health coverage by 2030. Oral health should no longer be regarded as the responsibility of a separate healthcare sector; rather,

it should be integrated into national health policies and medical guarantee packages. This requires effective collaboration among dentists, family physicians, nurses, and other healthcare professionals to facilitate the early detection and prevention of oral diseases.

WHO experts emphasize the importance of addressing common risk factors, including tobacco use, unhealthy diet, alcohol consumption, and inadequate oral hygiene. Dental caries and periodontal diseases share common risk factors with diabetes, cancer, and cardiovascular diseases; therefore, their prevention should be addressed through integrated approaches [7]. For example, reducing the intake of free sugars contributes to the prevention of dental caries and obesity and may also support the prevention of other noncommunicable diseases (NCDs).

Population-level prevention extends beyond recommendations regarding the use of fluoridated toothpaste. The focus is shifting from treating individual patients toward implementing interventions that target entire population groups. Examples include water and salt fluoridation programs. Primary care providers can perform basic oral health assessments, support appropriate screening and referral, provide education on oral hygiene and healthy lifestyles, and implement preventive interventions, such as fissure sealing in children and the use of fluoride-containing agents.

The expected advantages of such an integrated model include improved financial accessibility, as prevention and treatment at early stages are generally less costly than complex interventions such as dental implantation and prosthetic rehabilitation, as well as earlier detection of certain noncommunicable diseases, since oral health may provide indications of systemic conditions, including diabetes and nutritional deficiencies.

In international practice, the role of the family physician in oral health care is increasingly defined within the concept of the «Primary Care Medical Home,» in which patients receive comprehensive and continuous care. International guidelines and policy documents, including those developed by WHO and the FDI World Dental Federation, emphasize the role of the family physician as a link between general health and oral health [8, 9].

According to the American Academy of Family Physicians (AAFP), the family physician should:

- conduct risk screening (oral hygiene, gum bleeding, dental visits);
- perform early detection of dental caries, periodontitis, and oral oncological conditions;
- provide counseling on oral hygiene and nutrition;
- refer patients to a dentist.

International standards, particularly the approaches promoted by the American Academy of Family Physicians (AAFP), position the family physician as the «first point of contact» for oral health promotion and prevention. Their role extends beyond the management of general medical conditions. The family physician is a central figure in the healthcare system, owing to the continuity of care, the ability to influence the family environment, and a comprehensive approach to patient health.

The preventive component of this model focuses on health education, dietary counseling, the use of fluoride-containing agents, and the reduction of modifiable risk factors, including alcohol consumption and tobacco use. Particular attention is paid to establishing sustainable interdisciplinary collaboration between family physicians and dentists as a foundation for comprehensive prevention [10].

An analysis of the current situation in Ukraine indicates a substantial structural gap between dentistry and general medicine. Although some Ukrainian researchers note that dental care is partially integrated into the activities of family physicians through preventive measures, health education, early detection of dental diseases, and referral to specialists [11], the direct integration of oral health care into primary health care (PHC) remains limited. At the PHC level, dentistry is rarely incorporated into the routine practice of family physicians. Family physicians and dentists often work in healthcare institutions with different organizational and legal structures, which may hinder joint patient assessments. Electronic medical records are maintained across fragmented information systems. As a result, family physicians may not always have access to patients' dental histories, which can be clinically relevant for individuals with diabetes or cardiovascular diseases.

Primary care facilities may also lack basic dental instruments required for routine oral examinations. In the Ukrainian healthcare model, dentistry functions largely as a separate sector with its own financing mechanisms. Dental care for adults covered by NHSU benefit packages is largely limited to urgent (emergency) services. Planned treatment is predominantly paid for out of pocket or financed through local budgets, which limits its integration with publicly funded primary health care services. Dentistry remains one of the most privatized areas of healthcare in Ukraine, creating additional challenges for population-level prevention, as private dental clinics are not always integrated into national public health programs.

Systematic oral health prevention in Ukraine remains insufficiently implemented, despite the inclusion of preventive examinations among the responsibilities of primary health care providers. Oral health therefore remains an underdeveloped area of family medicine practice. One contributing factor is the absence of clearly defined key performance indicators (KPIs) related

to oral health. Reporting by family physicians to the NHSU does not include specific indicators reflecting the condition of the teeth or oral mucosa. There is also a lack of a competency-based approach to oral health training for family physicians. Current training programs devote limited time to the diagnosis and prevention of oral diseases. As a result, physicians may limit oral assessment to a basic visual examination of the oral cavity, particularly when patients present with respiratory complaints.

Oncological vigilance is also insufficiently developed. Family physicians do not routinely perform detailed examinations of the oral mucosa and may therefore fail to recognize early signs of oral cancer, which ideally should be identified at the level of the first-contact physician.

The discrepancy between theory and practice is observed across all key components of medical care, as shown in Table 1.

Table 1

Non-compliance of current family physicians' practice in ensuring oral health with international standards in the public health system

No.	Requirement	International standard	Current practice
1	Oral health screening	Mandatory procedure at every visit to a family physician	Irregular in nature. Examination is performed only in the presence of specific patient complaints
2	Patient counseling	Systematic and structured provision of information on oral hygiene, nutrition, and risk factors	Occasional advice, usually lacking a comprehensive approach
3	Integration with dental services	Close interdisciplinary interaction, shared protocols, and continuous data exchange	Fragmentation: dentistry functions as an autonomous sector, almost detached from primary care
4	Education and training of physicians	In-depth study of oral health integrated into basic training programs and continuing professional development courses	Family physicians' knowledge in this area is limited due to insufficient training hours in educational programs
5	Role of primary health care (PHC)	Key link in problem identification and coordination of preventive measures	The potential of PHC remains underutilized due to a formal approach to preventive care

The transition from a reactive model in Ukraine, focused primarily on the treatment of acute conditions, to a prevention-oriented system could reduce the prevalence of dental diseases, improve the quality of life of the population [1], optimize healthcare expenditures, and facilitate the integration of dentistry into general medical practice.

The integration of dental prevention into primary health care is not only a medical necessity but also a strategic step toward ensuring the long-term economic sustainability of Ukraine's healthcare system. The role of family physicians in the prevention of oral diseases is critical within the public health model, as they serve as the «first point of contact» within the healthcare system.

Their key functions include assessment of oral health status, identification of risk factors, patient counseling, referral to dental specialists, and participation in preventive programs. The family physician acts as a «coordinator», not replacing the dentist but ensuring continuity of care and motivating patients to adopt preventive behaviors.

According to recommendations of the World Health Organization (WHO) and international standards, particularly those of the American Academy of Family Physicians (AAFP) [10], primary care physicians should play an important role in the early detection and prevention of oral diseases.

The integration of dental prevention into primary health care (PHC) enables a shift from a narrowly specialized approach to a comprehensive, patient-centered model, in which oral health is considered an integral part of overall health [5].

In Ukraine, the role of the family physician is defined by the primary health care (PHC) reform and the Medical Guarantees Program. Family physicians serve as the first point of contact for patients and play a key role in prevention. The PHC reform in Ukraine has established the family physician as the main coordinator of a patient's health.

In the context of dentistry, this implies a shift from passive waiting for complaints to active risk management. According to the PHC service delivery regulations, the family physician is required to conduct preventive examinations and interventions. They ensure timely referral to specialists and integration into the eHealth system.

Family physicians or pediatricians monitor the timing of tooth eruption and the condition of the lingual and labial frenula in infants. Since periodontal disease is recognized as the sixth complication of diabetes, the family physician is obliged to include oral examinations in the management protocols for such patients.

Family physicians also perform visual screening for neoplasms. Given that oral cancer is often diagnosed at advanced stages, such examinations at the primary care level can be life-saving [12].

The family physician plays a leading role in health education, as they typically enjoy a higher level of trust from

patients compared to specialized providers, who are visited less frequently. This enables them to effectively influence lifestyle behaviors and promote a culture of oral hygiene.

The PHC reform has created a legal framework for the family physician to act as a «manager» of oral health. However, to fully realize this potential, further professional training and the implementation of incentive mechanisms within contracts with the NHSU are required [6].

DISCUSSION

In modern healthcare systems of developed countries, prevention is a key component of dental care. The primary focus is placed not on the treatment of existing diseases, but on their prevention through systemic, population-level interventions. This approach significantly reduces the prevalence of dental diseases, lowers treatment costs, and improves the quality of life of the population.

Expanding the role of the family physician in disease prevention through the use of specific tools constitutes the foundation of the integrated healthcare model recommended by the World Health Organization and leading researchers. In this context, family physicians apply a range of instruments, including:

– **Oral health counselling.** The family physician acts as a primary source of reliable medical information. Numerous studies indicate that recommendations provided by primary care physicians demonstrate higher adherence among patients [13].

– **Motivational interviewing.** This evidence-based clinical counselling method can facilitate behavioral change, such as reducing sugar consumption or quitting smoking [14]. In such cases, the physician does not merely give instructions but helps the patient develop intrinsic motivation for maintaining oral health.

– **Integration of prevention into the management of chronic diseases.** This is one of the most scientifically grounded approaches, based on the link between oral infections and systemic conditions. For example, in patients with diabetes, family physicians should inform patients that untreated periodontitis complicates glycemic control, while in cardiovascular diseases, oral bacteria may contribute to bacteremia and vascular inflammation [8].

– **Referral for preventive examinations.** Timely referral to a dental hygienist or general dentist enables detection of problems at a preclinical stage. This represents a shift from «pain-driven» visits to planned check-ups every 6-12 months [1, 6].

The use of these four tools enables the integration of dental care into the public health system, where dentistry ceases to function as an isolated field and becomes part of a broader strategy for improving population health.

In the EU countries and the United States, family physicians are actively involved in the prevention of dental diseases, including the application of fluoride-based prevention and early detection of caries [7]. Scandinavian countries (Sweden, Norway, Denmark) serve as examples of effective preventive models. Their key features include a systematic approach to prevention, strong state involvement, regular free dental check-ups for children, and a high level of health literacy among the population. These measures result in significantly lower rates of dental caries, reduced tooth loss, and overall high levels of oral health.

In contrast, prevention in Ukraine remains limited. There is a lack of comprehensive state programs, and the population typically seeks dental care only when pain occurs. This underscores the need to implement international best practices. Global experience clearly demonstrates that an effective dental care system should be prevention-oriented. The use of such tools as fluoridation, school-based programs, regular check-ups, and educational campaigns can significantly reduce the prevalence of dental diseases and improve the overall effectiveness of the public health system.

CONCLUSIONS

Family physicians play a key role in disease prevention, including the prevention of oral diseases. The integration of oral health prevention into primary health care is an important prerequisite for improving the effectiveness of the public health system.

In summary, the role of family physicians in the provision of oral health care remains only partially implemented in practice. This is attributable to insufficient professional training, the lack of integrated clinical protocols, limited financial incentives for preventive activities, and fragmentation of the healthcare delivery system.

Perspectives for further research. In order to improve the effectiveness of dental care, it is advisable to expand the service packages of the National Health Service of Ukraine (NHSU), integrate dental prevention into the structure of primary health care, enhance the level of professional training of family physicians, and implement an interdisciplinary model of collaboration.

CONFLICT OF INTEREST

The Authors declare no conflict of interest.

Research ethics. This article is based on an analysis of publicly available scientific data published in peer-reviewed journals, clinical guidelines, and databases. No data that could identify patients were used during the study, and there was no need to obtain approval from an ethics committee,

as the study did not involve new clinical interventions or the primary collection of patient information.

The authors adhered to the ethical principles of the World Medical Association's Declaration of Helsinki and international standards for publication in medical journals, including the recommendations of the ICMJE (International Committee of Medical Journal Editors). No part of this work contains plagiarism or data fabrication. All sources of information are appropriately cited and properly formatted.

Declaration of artificial intelligence use (AI). In this work, artificial intelligence was not used to generate text, analyze data, or create images. All content was prepared by the authors, who bear full responsibility for its accuracy, originality, and adherence to ethical standards.

AUTHOR CONTRIBUTIONS

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Резюме

ПРОБЛЕМНІ АСПЕКТИ ТА МЕДИКО-СОЦІАЛЬНЕ ОБҐРУНТУВАННЯ СТОМАТОЛОГІЧНОЇ ДОПОМОГИ В УМОВАХ СОЦІАЛЬНО-ЕКОНОМІЧНИХ ТРАНСФОРМАЦІЙ В УКРАЇНІ

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Вступ. У статті проаналізовано проблемні питання організації стоматологічної допомоги населенню України в умовах соціально-економічних трансформацій. Обґрунтовано медико-соціальні підходи до підвищення доступності та ефективності стоматологічної допомоги з урахуванням сучасних викликів для системи охорони здоров'я.

Мета. Наукове обґрунтування медико-соціальних аспектів організації стоматологічної допомоги в Україні в умовах соціально-економічних трансформацій, виявлення системних прогалин у механізмах фінансування та доступності послуг у межах Програми медичних гарантій, а також визначення стратегічних напрямів оптимізації галузі шляхом інтеграції стоматологічної профілактики в систему первинної медичної допомоги.

Матеріали та методи. Для досягнення поставленої мети було використано комплексний підхід із застосуванням таких методів, як-от: бібліосемантичний та аналітичний методи; метод системного аналізу; метод порівняльного аналізу.

Результати. Стоматологічна допомога в Україні функціонує за змішаною моделлю з обмеженим державним покриттям, яке для дорослого населення зводиться переважно до невідкладних втручань, тоді як для дітей і пільгових груп передбачено ширший обсяг послуг. Виявлено недостатність фінансування, регіональну нерівність доступу та фрагментарність системи. Інтеграція стоматології у первинну медичну допомогу залишається обмеженою, а профілактична роль сімейних лікарів реалізується частково, що знижує ефективність раннього виявлення та популяційної профілактики.

Висновки. Роль сімейних лікарів у наданні стоматологічної допомоги реалізується частково, що зумовлено недостатнім рівнем підготовки, відсутністю інтегрованих протоколів, обмеженим фінансовим стимулюванням профілактики та фрагментарністю системи медичної допомоги. Підвищення ефективності стоматологічної допомоги потребує розширення пакетів НСЗУ, інтеграції стоматологічної профілактики у первинну медичну допомогу, удосконалення підготовки сімейних лікарів і впровадження міждисциплінарної взаємодії.

Ключові слова: **охорона здоров'я ротової порожнини; санація порожнини рота; модель організації медичної стоматологічної допомоги; поширеність; основні показники стоматологічної допомоги; фінансування стоматологічної галузі.**

Received: 24.04.2026
Accepted: 1.07.2026
Published: 11.09.2026