World Health Organization

EXECUTIVE BOARD
148th session
Provisional agenda item 6

EB148/8
23 December 2020

Oral health

Achieving better oral health as part of the universal health coverage and noncommunicable disease agendas towards 2030

Report by the Director-General

1. Following a request from a Member State and the recommendation of the Officers of the Board and the Director-General in September 2020 to include an item on oral health in the provisional agenda of its 148th session, this report outlines the enduring global health challenges posed by oral diseases and details WHO's recent activities and regional and international initiatives to renew the political commitment to oral health. A set of actions is proposed, aimed at achieving better oral health as part of WHO's noncommunicable diseases and universal health coverage agendas, thus contributing to the achievement of the United Nations 2030 Agenda for Sustainable Development and its Sustainable Development Goals.

BURDEN AND IMPACT OF ORAL DISEASES

2. The most prevalent oral diseases include dental caries (tooth decay), periodontal (gum) disease, tooth loss, and cancers of the lips and oral cavity. Despite being largely preventable, these diseases are among the most prevalent noncommunicable diseases globally, with significant health, social and economic impacts. People are affected over their life course, from early childhood to adolescence, adulthood and later life.

3. More than 3.5 billion people suffer from oral diseases, without any notable improvement of the situation between 1990 and 2017. Untreated dental caries in permanent teeth is the single most prevalent condition globally, affecting 2.3 billion people. Severe periodontal disease, a major cause of total tooth loss, is estimated to affect 267 million people, particularly older people.

4. Cancers of the lip and oral cavity are among the top 15 most common cancers worldwide, with over 500 000 cases and nearly 180 000 deaths each year. In parts of the South-East Asia and Western Pacific regions, they are the leading cause of cancer-related deaths among males. Noma, a necrotizing disease starting in the mouth and fatal for 90% of the children affected, is a marker of extreme poverty. It leads to lifelong disability, affects learning opportunities and often results in social exclusion.

5. The burden of oral diseases shows significant inequalities, disproportionally affecting marginalized populations and those of lower economic status. Inequalities are found, as in other noncommunicable diseases, throughout the life course and across populations in low-, middle- and high-income countries. With limited resources for prevention and control, low- and middle-income countries face the highest burden of oral diseases.

6. Oral diseases are caused by a range of modifiable risk factors, including sugar consumption, tobacco use, alcohol use and poor hygiene, and their underlying social and commercial determinants. These determinants, together with common risk factors shared by noncommunicable diseases, provide the basis for integrated strategies for prevention and control.

7. Oral health is essential to good health and well-being. However, many people have untreated oral diseases, resulting in preventable pain, infection and reduced quality of life, in addition to missed school and productivity losses. Good oral health is also vital for healthy ageing, playing a crucial role with regard to nutrition, employment, self-esteem and continued social interaction.

8. Worldwide, oral diseases accounted in 2015 for US$ 357 billion in direct costs and US$ 188 billion in indirect costs. The same year, €90 billion was spent on treatment of oral diseases across the European Union, the third-highest total among noncommunicable diseases, behind diabetes and cardiovascular diseases. Oral health care is often not covered in primary health care, leading to considerable expense for individuals and society. High out-of-pocket expenditures particularly affect disadvantaged populations.

CHALLENGES TO MEETING THE ORAL HEALTH NEEDS OF POPULATIONS

9. Lack of political commitment and resources limit action on oral health. Opportunities to advocate for making essential oral health needs a higher priority, for example through integration with noncommunicable disease, maternal, child and adolescent health, and ageing and life course programmes, are often not utilized. Overall, the largely unchanging global burden of untreated oral diseases, the enduring lack of coverage of essential oral health care for large segments of the world's population, and increasing inequalities, are some of the symptoms of the continued low priority accorded to oral health.

10. Availability of technical capacity within ministries of health to develop, implement and evaluate cost-effective and integrated oral health action plans is often limited. Vertical disease-focused programming inhibits cross-sectoral collaboration and financing so that potential synergies are not leveraged.

11. Prevention of oral diseases is frequently not prioritized. Opportunities for oral health promotion in key settings – such as schools, communities and workplaces – are not systematically used. The use of fluorides for prevention of dental caries is limited, and essential prevention methods, such as use of fluoridated toothpaste, are often not affordable for many people. Moreover, oral health promotion is rarely integrated into other noncommunicable disease programmes that share major common risk factors and social determinants.

12. Current oral health systems have largely failed to reduce the burden and inequalities of oral diseases. Most countries rely on dentist-centred models with high technology and do not sufficiently encourage prevention. Low workforce numbers, especially in low- and middle-income countries, limit coverage and availability of essential oral health services that are usually not part of universal health coverage benefit packages. However, some countries have adopted workforce models that include primary health care and mid-level providers, such as dental therapists and hygienists, to improve access.

13. Adequate and up-to-date information about the burden of oral diseases is scarce, with indicators rarely included in national health information systems. Available oral health modules within existing WHO surveillance tools are not systematically used, and integration within national noncommunicable disease and risk factors surveillance is limited.

14. Monitoring and evaluation of existing programmes is generally weak, existing tools underutilized and results poorly documented. Oral health research output does not prioritize public health.

15. Awareness of the environmental impact of oral health care on planetary health, and of the challenges related to chemicals and management of waste (including mercury) need strengthening, in line with resolution WHA67.11 (2014) on implementation of the Minamata Convention on Mercury.

16. In the context of the COVID-19 pandemic, oral health services are among the most disrupted essential health services, with 60% of countries reporting partial and 17% severe/complete disruption of such services.[1] Oral health inequalities have been worsening as the COVID-19 pandemic evolves.

REGIONAL AND INTERNATIONAL COMMITMENT TO IMPROVING ORAL HEALTH

17. In 2007, resolution WHA60.17 set out effective oral disease prevention and control measures that need to be renewed and intensified as part of both the noncommunicable disease and universal health coverage agendas.

18. In 2011, the Political Declaration of the first High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases recognized that oral diseases pose a major challenge and could benefit from a common response.[2] This provided a strong policy basis for the integrated approach to the prevention and control of oral diseases.

19. The Minamata Convention on Mercury, which entered into force in 2017, obliges Parties to take selected measures to phase down the use of dental amalgam, a common mercury-containing dental filling material. Measures include the setting of national objectives aimed at dental caries prevention and oral health promotion, and encouraging insurance policies and programmes that favour the use of high-quality alternatives to dental amalgam for dental restoration.

20. The Political Declaration of the first High-level Meeting of the General Assembly on Universal Health Coverage (2019) included commitments to step up efforts to strengthen universal health coverage with the inclusion of oral health, providing a policy basis for accelerated action by Member States, the United Nations system and oral health stakeholders.[3]

21. The Lancet Commission on Oral Health, established in 2019 with WHO participation, aims to develop a new policy framework for ending the neglect of oral health in the global and national health agendas.

[1] Pulse survey on continuity of essential health services during the COVID-19 pandemic: interim report, 27 August 2020. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/rest/bitstreams/1297631/retrieve, accessed 29 October 2020).

[2] United Nations General Assembly resolution 66/2.

[3] United Nations General Assembly resolution 74/2.

PRIORITIES OF THE WHO GLOBAL ORAL HEALTH PROGRAMME

22. The priorities of the Global Oral Health Programme are as follows:

- implementing, in collaboration with WHO collaborating centres, academic partners and non-State actors, normative work and practical support to countries, with a focus on poor and marginalized populations, through a set of priority activities aligned with WHO's Thirteenth General Programme of Work;

- launching, in 2021, a global oral health report as a global public health good. Targeting policy- and decision-makers, the report will describe the burden, challenges and priority actions for renewing global commitment to improving oral health within the noncommunicable disease and universal health coverage agendas;

- ensuring the integration of oral health into other cross-cutting initiatives from different WHO programmes, including the Global Competency Framework for Universal Health Coverage and the UHC Intervention Compendium, as well as developing technical guidance, on topics such as ending childhood dental caries, tobacco cessation and oral health, and the provision of essential oral health services in the context of COVID-19;

- supporting implementation by Member States of the Minamata Convention as part of a broader environmental agenda, including through the road map for enhancing health sector engagement in the Strategic Approach to International Chemicals Management approved in decision WHA70(23) (2017), thus becoming a catalyst for reorienting dentistry and tackling the health, social and economic burden of oral diseases;

- developing, as part of the joint WHO-ITU BeHe@lthy, BeMobile initiative, an mOralHealth programme to improve oral health worldwide. Digital technologies can be used for health literacy, oral health behaviour change messaging, e-training, provider-to-provider telehealth and early detection and surveillance;

- strengthening oral health information systems and surveillance activities under integrated public health programmes through the development of standardized oral health indicators for population health surveys and facilitating their inclusion into national routine health information systems.

OPPORTUNITIES TO ADDRESS ORAL DISEASES IN NATIONAL AND INTERNATIONAL POLICY AGENDAS

23. Despite the efforts outlined above, access to prevention, early diagnosis and treatment of oral diseases is far from universal and remains unattainable for millions of people. Member States' commitment to strengthening and accelerating action on oral health, in their statement during the 146th session of the Executive Board, offers a firm basis for further action to boost national and international oral health policy agendas. Such action may include, but not be limited to:

- reducing common risk factors and promoting healthy environments by:

  – addressing the common risk factors of oral diseases and other noncommunicable diseases through an integrated approach, focusing on key risks, such as tobacco and harmful alcohol use, unhealthy diets and poor hygiene;

  - advocating for health taxes or bans on the sale and advertisement of unhealthy products, such as alcohol, tobacco and unhealthy food and sugary drinks, and counteracting the underlying commercial interests that drive key risks;

  - strengthening health-promoting environments in key settings, such as schools, workplaces and communities, through multisectoral action and a Health in All Policies approach;

  - promoting legislation to increase the affordability and accessibility of high-quality fluoride toothpaste and advocating for its recognition as an essential health product;

- strengthening health system capacities by:

  - focusing on integrated, population-wide prevention measures and access to primary oral health care as part of universal health coverage benefit packages;

  - accelerating the development of essential oral health care packages with evidence-based, cost-effective interventions to address population needs;

  - ensuring the affordability of essential medical consumables, generic drugs and other equipment or supplies for the management of oral diseases and other noncommunicable diseases;

  - supporting the development of digital health policy, legislation and infrastructure to expand the use of mobile technologies within (oral) health service provision;

  - reorienting the oral health workforce to foster integrated, people-centred health services by enabling interprofessional education and a wider team approach that involves mid-level and community health providers;

  - including communities in the planning, implementation and monitoring of programmes related to promotion, prevention and oral health care;

  - strengthening noma prevention and control within broader regional and global efforts, as part of neglected tropical diseases programmes;

- improving surveillance, data collection and monitoring by:

  - strengthening integrated disease surveillance, collection and analysis of health system and policy data to inform monitoring frameworks, evaluation of programmes and operational research;

  - promoting routine collection of oral disease data using digital technology and existing national health information systems to inform decision-making and advocacy;

- accelerating advocacy, leadership and partnership by:

  - facilitating collaboration among stakeholders, including non-State actors from different sectors, based on clear roles and responsibilities;

– fostering political leadership in relation to universal health coverage, with essential interventions for oral diseases and noncommunicable diseases as key components;

– establishing or enlarging oral health budgets based on intervention costing and investment cases, to increase population coverage.

ACTION BY THE EXECUTIVE BOARD

24. The Executive Board is invited to note the report and provide further guidance on action that could be taken by the Organization in response to the oral disease burden.

= = =