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The WHO Action Plan for Oral Health – How Can the EADPH Contribute - Opportunities and Challenges

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This paper summarises the proceedings of a workshop organised by the European Association of Dental Public Health, held in Montpellier in September 2022. The full proceedings were transcribed and are available on the Community Dental Health website (https://www.cdhjournal.org/article/973). The WHO Action Plan for Oral Health provides a golden opportunity to help raise the profile of oral health, to put oral health on the global public health agenda and ultimately improve oral health. It is to be applauded. However, delivery will present a challenge. Those challenges and opportunities are detailed in this paper.

Keywords: *Oral health, UHC, prevention, global*

On 8 September 2022, a pre-conference workshop was held on the WHO Oral Health Action Plan, in Montpellier, France with a total of 128 participants. Since the conference was organised by the European Association of Dental Public Health (EADPH) and held conjointly with the Council of European Chief Dental Officers (CECDO), Chief Dental officers also contributed. The aim was to discuss the plan and explore how the members of the EADPH can contribute to its implementation.

Oral health is now recognised as a global public health emergency alongside other non-communicable diseases. The WHO Global Oral Health Report has highlighted 'the status of global oral health is alarming and requires urgent action' (WHO, 2022a). Oral diseases are ubiquitous across the life course, affecting one in two people, with significant oral health inequalities. Improvements in oral health cannot be tackled in isolation, but within the wider context of non-communicable diseases. Therefore, the WHO Oral Health Action Plan will co-exist alongside its Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013–2030 (WHO, 2012). As WHO Director General Dr Tedros concluded in the World Health Assembly 2021, the oral health resolution provided a welcome opportunity to address the public health challenges posed by the burden of oral diseases to reposition oral health as part of the global health agenda in the context of Universal Health Coverage (UHC).

The overarching aim of the Global Oral Health Action Plan (2023–2030) is the implementation of the resolution on oral health and the translation of the Global Strategy on Oral Health objectives into evidence-based public health actions. The six principles are: governance, promotion, oral health workforce, health care itself, information systems and research agenda (Figure 1). These were discussed in different breakout sessions.

There are two overarching global targets which need to be achieved by 2030:

A: UHC for oral health whereby 80% of the global population will have access to essential oral health care services

B: Reduced oral disease burden whereby the combined global prevalence of the main oral diseases and conditions over the life course will have reduced by 10%

The target for governance is that 80% of countries should have an operational national oral health policy embedded into all policies. This means identifying a national lead for oral health who will oversee the implementation of the action plan and securing funding dedicated to oral health. This will be challenging in countries with competing priorities including public health challenges, infectious diseases, workforce and finance.

The second target relates to the Minamata Convention with the aim of reducing Mercury in the environment including dental amalgam, 90% of which must be phased out by 2030. The EU regulations stipulate that amalgam use in dentistry should be phased out by 2023. Although a complete ban of amalgam is recommended, this may not be feasible and will need to be phased due to increased costs, limited alternative restorative materials, and potential destabilisation of dental services especially in countries relying on public health services (Aggarwal *et al*., 2019).

There is a clear strategy to implement evidence-based, cost-effective and sustainable oral health promotion and prevention. One target is that 70% of countries must have sugar taxation on beverages, a clear and concrete evidence-based fiscal policy. The WHO has endorsed this policy in line with tackling other NCDs, with excess sugar intake associated with tooth decay and weight gain, and subsequently obesity, cardiovascular diseases, type II diabetes

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Figure 1. The six principles of the WHO Global Strategy on Oral Health.

and cancers (WHO, 2022b). There are currently at least 85 countries that tax sugar sweetened beverages (SSB). This could reduce consumption and demand for sugary drinks as well as encourage manufacturers to reformulate their products (Andreyeva *et al*., 2022). However, additional research is required to explore the long-term impacts of SSB taxes on diet and health outcomes.

A second health promotion target is that 50% of countries must have a national guideline on fluoride delivery with countries deciding on delivery mechanisms (water fluoridation or topical fluorides) depending on political context, resources and infrastructure. Whilst the effectiveness of fluorides is known, evidence on the cost-effectiveness of different delivery modes in different contexts and settings is limited. There is good evidence from Childsmile in Scotland in which supervised tooth-brushing in nurseries and regular visits to dental clinics reduced dental caries incidence in areas of deprivation (Kidd *et al*., 2020). However, fluoride varnish applications alongside these interventions were not deemed to be cost effective (Anopa *et al*., 2022). Therefore, additional research is required when evaluating complex interventions in specific contexts.

The fourth objective is to ensure a sufficient, available and well-distributed skilled health workforce to deliver essential oral health services to meet population needs. One target is that 50% of countries have an operational national health workforce policy, plan or strategy to meet the oral health needs of the population by 2030. This ambitious target will require integration of the oral and primary care health workforces. Collaboration of dental teams (including the use of skill-mix) with wider primary and social care to include primary care doctors, nurses, pharmacists, social workers and community workers is vital in achieving this objective. Education needs to be inter-disciplinary, in line with WHO's vision of inter-professional practice (WHO, 2010). This means aligning curricula for health, allied health and dental health professionals. It is essential that the oral health workforce is embedded into Primary Health Care (PHC) teams and works in partnership, by adopting a common risk factor approach.

Primary Care teams should, on the other hand, understand the aetiology of dental diseases and be able to check the oral mucosa or ask about whether their patient has visited a dental practice or clinic. Doctors should be educated to prescribe sugar free medicine and deliver oral health advice to their patients. The importance of skill-mix was also highlighted to include integration and collaboration within the oral health team (dentists, dental specialists, dental hygienists and therapists, dental nurses and dental technicians). A public health module needs to be embedded into the curriculum for all oral health professionals. This might help them understand the importance of prevention, population health and population-based approaches and the importance of focussing on the patient as a whole.

Special consideration should be given to vulnerable groups. Undergraduate dental programmes need to include vulnerable groups in their curricula, so they understand their population profiles and oral health needs, to deliver evidence-based intervention in clinical but also public health settings.

The adoption of universal health coverage and integration of oral and primary care by 80% of countries by 2030 will ensure an adequate supply and distribution of dental care. An essential oral health care package as part of the national UHC approach includes prevention, emergency care and treatment to achieve population oral health. This can minimise individual costs as dental care carries one of the highest out-of-pocket shares for healthcare. A whole-systems and integrated approach will enable everyone to access essential oral care including vulnerable populations, which may address oral health inequalities. However, the definition of *'what constitutes essential oral health'* and what defines UHC may vary by country and context and needs to be clearly established. Essential oral health care could be interpreted in a variety of ways and raises many questions; are aesthetic dentistry, bleaching or veneers considered essential? Essential oral health care should be defined as maintaining a functional, pain-free dentition and which enables a person to eat, speak and be competent to take care of their oral health and their general health. The focus needs to change from a traditional provision of dental and curative treatment to more emphasis on prevention.

Realistically, providing a full range of care may not be achievable by all countries. Instead, essential intervention packages should be developed. This will need to consider several factors including workforce availability, capacity and education, including sustainability and environmental protection in oral health care. Financial protection for the most vulnerable groups to access UHC may not be achieved equally by public funding in all countries.

There are financial implications associated with oral health care. Although essential dentistry allows people to live healthy lives, with a feeling of wellbeing and being part of the society, it may be necessary to tailor care according to the oral health needs of different age groups. There needs to be a focus on early intervention and special packages for children. Although health spending has increased worldwide, this was unequal among low-, middle- and high-income countries (WHO, 2021). High income countries have the highest level of funding at 8.6% of the global economy compared with 0.4%-1% in Sub-Saharan Africa and low-income countries. High-income countries spent 130 times more on health per capita than low-income countries (Global Burden of Disease Health Financing Collaborator Network, 2021). It is therefore vital that funding for health is maintained by Governments to provide essential health services and achieve UHC and mitigate against the risks of out-of-pocket payments.

A target alongside UHC is to seek opportunities in expanding digital technologies to support diagnostic services and referral to relevant specialist services. The pandemic has demonstrated teledentistry allowed dental teams to triage patients needing urgent dental care, reducing the risk of COVID-19 transmission, avoidance of travel to and from the clinic and building rapport between patients and oral healthcare professionals (Mahdavi *et al*., 2022).

Developing efficient and integrated health information systems which incorporate oral health to support planning and policy makers in evidence-based decisions is the fifth principle of the strategy. By 2030, it is expected that 80% of countries have a monitoring framework for the national oral health policy, strategy or action plan. In Europe, the Organisation for Economic Cooperation and Development (OECD) and Eurostat databases profile the health of EU countries, oral health data are limited. There are 11 core and 29 additional indicators that will support monitoring toward the WHO Action Plan on Oral Health. The indicators include essential care, clinical and public health measures such as the implementation of a sugar tax. However, the indicators could be expanded to include measures of functional dentition and oral health-related quality of life, or mid-stage structural indicators such as the availability of oral health or public health initiatives. It is recognised that some of these indicators may pose challenges in terms of data collection and implementation. In terms of information systems and surveillance, oral health surveys may be resource-prohibitive in some countries. Therefore, innovative methods could be adopted to estimate the burden of oral diseases, recognising the limitations in terms of the validity and quality of the data.

Oral health research is recommended to be embedded within the principles of public health and population-based interventions. The target is that at least 20% of countries should have their own research agenda. Given the ample evidence on causes of oral health inequalities, research should move beyond epidemiology to translational research exploring evidence-based pragmatic interventions. This is a call for action on implementation research to drive improvements in population oral health.

Multi-disciplinary research with public health, behavioural and social sciences should be encouraged, with funding institutions reflecting these changing needs and priorities. Research should involve patients and the public and consider vulnerable groups, the social determinants of oral health inequalities and how these can influence patient-related behaviours with impacts on general and oral health. This means including dental public health specialists in clinical and public health research and adopting evidence-based global standards in research. Researchers need to be aware of conflicts of interest especially food and drink industry and health damaging commodities including tobacco and alcohol.

There is often a mismatch between science and decisions of policy makers with distrust between the politicians, scientists and media. This is further complicated by misinformation, political polarisation, changes in evidence and public involvement. Therefore, it is important that scientists are skilled in explaining the science, and in human storytelling, to influence policy makers to make evidence-based decisions to protect public health and prioritise oral health. As dental public health professionals we need to advocate for oral health and convey our messages to influence local and national governments in line with the closing remarks of Sir Richard Horton, editor in chief of the Lancet, during the launch of the Lancet Oral Health series 'Everyone who cares about global health should advocate to end the neglect of oral health.'

What factors need to be considered when implementing the WHO Global Oral Health Action Plan?

Four major factors need to be considered when translating the WHO Oral Health Action Plan: Translation into Government policy, universal health coverage, integration and oral health indicators and monitoring (Figure 2). All four themes refer to integration, which highlights the importance of placing oral health into wider public health initiatives and health care systems. This includes multi-disciplinary education and research with a focus on population and public health.

There are challenges in translating and implementing the WHO Oral Health Action Plan. Different organisational structures and systems require identifying the people who have insight and influence to bring policy into action. Therefore, it is vital to identify key stakeholders who can be interested in oral health and have the power to dictate public health policy. Such variations across different countries, for instance, the balance of the public and private sectors will require different policy levers. Oral health may not be a priority in all countries. Hence, this lack of alignment to the public health implications of oral health should be solution focused.

Implementation can be facilitated by seeking opportunities and learning from good practice. One example of integration of oral health into general health provision, came from developing diabetic care pathways using the common risk factor approach and building alliances within dentistry, but also inter-disciplinary alliances to highlight the impacts of oral health on general health. This ensures that we are adopting evidence-based care which informs wider health policies.

For surveillance and monitoring, wider indicators integrating oral and general health may be more feasible. For example, Belgium has integrated oral and general health indicators in national and local surveys, highlighting the importance of oral health. Ireland includes 23 oral health-related questions in its national health survey, providing a comprehensive picture of population health needs. Another facilitator would be to develop a practical guide alongside the WHO Oral Health Action Plan. The guide might identify a wide range of key stakeholders to develop national policy, giving everyone 'a voice' to mitigate the risk of one specialty or group influencing discussions. At the heart of this patient and public involvement should be key to achieving positive population oral health outcomes. Policy makers sometimes make decisions based on their personal experiences, but public/patient involvement can bring the experiences of health service users to complement the evidence-base to influence policy decisions.

A press pack on the Oral Health Action Plan would be useful in advocating for oral health across mass and social media.

In summary, developing criteria to shape policy with a primary care and public health approach needs to take into consideration all the key stakeholders keeping the public at the heart of policy. Interdisciplinary partnership between oral and general health professionals is key to developing, disseminating and implementing research integrating oral and general health and well-being and maximising improvements in oral health. There is also a need for advocacy at a macro level, so that when researchers apply for grants funders can see that the proposals are impact-related with tangible population benefits. This would lead to more holistic and comprehensive research. Dental education programmes should be based on best practice (educationally and scientifically evidence-based) and consider the health needs of the local populations (social responsibility).

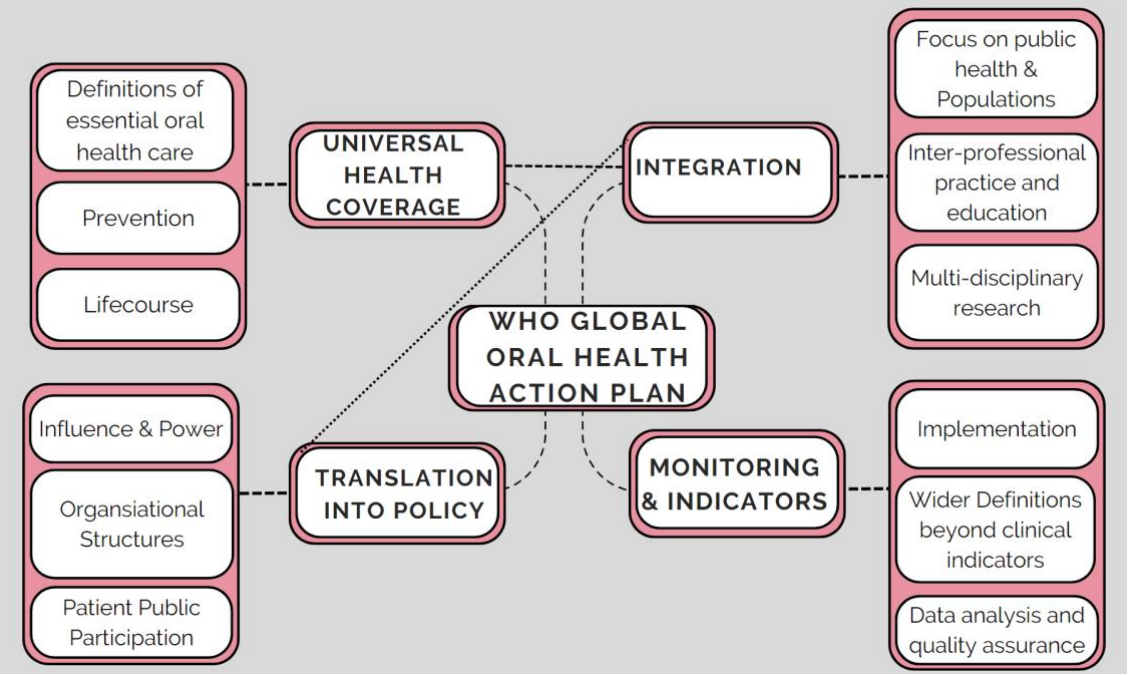

Figure 2. Approaches when implementing the WHO Action Plan for Oral Health.

WHO should be applauded for recognising the need to include oral diseases in its NCD strategy. The Action Plan for Oral Health is to be welcomed. Within the plan the adoption of essential oral health and UHC will be a priority within primary health care. Essential health care should focus on prevention by adopting a life course approach from conception to old age.

The COVID-19 pandemic had significant impacts on population health and oral health with exacerbation of oral health inequalities. It highlighted the fragility of health systems with impacts on poverty, education and mental well-being. However, it also brought opportunities for integration and multi-sectoral collaborations in responding to a global crisis and demonstrating the resilience of the oral health workforce. Maintaining this momentum and capacity building in public health leadership will facilitate the implementation of the action plan by committing to prevention and control of NCDs and advocating for oral health.

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