The neglect of global oral health: symptoms and solutions

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Citation for published version (APA):

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CHAPTER 2

Political priority of global oral health: an analysis of reasons for international neglect

Abstract

Global Oral Health suffers from a lack of political attention, particularly in low- and middle-income countries. This paper analyses the reasons for this political neglect through the lens of four areas of political power: the power of the ideas, the power of the issue, the power of the actors, and the power of the political context (using a modified Political Power Framework by Shiffman and Smith (2007). The analysis reveals that political priority for global oral health is low, resulting from a set of complex issues deeply rooted in the current global oral health sector, its stakeholders and their remit, the lack of coherence and coalescence; as well as the lack of agreement on the problem, its portrayal and possible solutions. The shortcomings and weaknesses demonstrated in the analysis range from rather basic matters, such as defining the issue in an agreed way, to complex and multi-levelled issues concerning appropriate data collection and agreement on adequate solutions. The political priority of Global Oral Health can only be improved by addressing the underlying reasons that resulted in the wide disconnection between the international health discourse and the small sector of Global Oral Health. We hope that this analysis may serve as a starting point for a long overdue, broad and candid international analysis of political, social, cultural, communication, financial and other factors related to better prioritisation of oral health. Without such an analysis and the resulting concerted action the inequities in Global Oral Health will grow and increasingly impact on health systems, development and, most importantly, human lives.
The dynamics of global public health and political priorities
Public health priorities and political priorities are not necessarily aligned. There are numerous examples of a disproportionate attention and allocation of resources to specific diseases despite a rather limited impact on morbidity and mortality (i.e. polio eradication). On the other hand, major killer diseases such as diarrhoea and infectious causes of childhood deaths are not able to attract adequate political and donor attention. Knowledge about the processes and underlying reasons for such mismatches is limited and virtually absent for oral diseases and their political priority status.

While all major international stakeholders in oral health deplore the neglected state of oral health worldwide they only had limited success so far in generating major international interest and action in oral health. The broader international health community in general is unaware of this critical situation and the striking disparities in global oral disease burden and access to care. Even among the dental profession only few seem to note the incredible neglect of oral diseases, and even fewer are determined to take bold and tangible action to address this neglect.

This paper examines the area of global oral health through an analytical framework to assess essential factors determining political priorities. The analysis is a first step towards more effective and impactful global oral health advocacy.

Global oral health – symptoms of neglect
The area of global oral health is very small compared to the highly diverse medical, pharmaceutical and development scene active in international public health. This lack of critical mass certainly is one of the aspects contributing to the low visibility of oral health internationally. There are, however, a number of deeper and more serious flaws that characterise the current global oral health community.

The world of oral health experts, dental professionals, dental public health academics and the mainstream of international public health, medicine and general health are worlds apart. Symptoms of this disconnection are the missing inclusion of oral care in most primary health care systems, the lack of dental health systems research related to low- and middle-income countries, continued adhesion to workforce models monopolising the dentist’s role, limited focus on health policy analysis and the lack of attention to oral care in the context of
emerging social health insurance models. None of the major international government agencies for Official Development Assistance has any recognisable health activities addressing oral diseases or prevention.

Stemming from this, there is a disconnection between existing evidence-based, practical and realistic approaches and policy tools to improve oral health, and their implementation with broad-scale population effects. This is evidenced by the still missing shift from individual clinical care to population-based preventive interventions, and the persisting misconception that appropriate oral care is necessarily costly and thus unaffordable for low- and middle-income countries.

The persisting and growing inequities between and within countries in terms of risk exposure, disease burden and access to care are symptoms of the inability of the current global oral health actors, their governance structures, their remit, scope of activities and their ways of interaction to effectively address the situation.

**A framework for analysing political priorities in health**

How to create critical momentum for oral health? What are the factors that determine political priorities in health? Shiffman & Smith (2007) proposed a framework for analysis of policy priority generation in global health, based on research on the Global Safe Motherhood Initiative\textsuperscript{7-9}. The framework is based on the analysis of political power in four categories: (1) the power of ideas, (2) the power of the issue, (3) the power of the actors, and (4) the power of the political context. Furthermore, the framework defines 11 factors across the categories that shape political priority (see table 1 for details). In the following we will apply a modification of this framework to examine the case of global oral health, based on profound knowledge of the sector, review of relevant literature, and long-term involvement with a variety of stakeholders and organisations active in global oral health. The modification lies in a different order of the analysis categories and of the related factors that is better related to the cause of global oral health.
<table>
<thead>
<tr>
<th>Analysis category</th>
<th>Factors shaping political priority</th>
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<tbody>
<tr>
<td><strong>Ideas:</strong></td>
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<td>The ways in which those involved with the issue understand and portray it</td>
<td><strong>Internal frame:</strong> the degree to which the policy community agrees on the definition of causes and solutions to the problem</td>
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<td><strong>Political contexts:</strong></td>
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<td>The environments in which actors operate</td>
<td><strong>Policy windows:</strong> political moments when global conditions align favourably for an issue, presenting opportunities for advocates to influence decision makers</td>
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<td><strong>Global governance structure:</strong> the degree to which norms and institutions operating in a sector provide a platform for effective action</td>
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The power of ideas – Global oral health as a neglected issue in international health

Framing is an important communication tool used in advocacy and related to the way an issue is portrayed and communicated – both internally and externally. The neglect of Global Oral Health, however, is not defined as a problem and thus makes effective message framing impossible. The most basic agreed concept is the fact that oral health is important to general health and well-being. There is also agreement on the notion that good oral health is integral part of the basic human right to health\textsuperscript{10-12}. While these two fundamentals are the basis for a common problem definition, the definition of neglect itself is missing.

Since the problem is not defined as an issue, different organisations or individuals have a widely differing understanding of the matter. With this lack of problem definition it is difficult to achieve alignment and cohesion in policy approaches.

The external framing of oral health as a neglected issue is scattered and anecdotal. While some of the international stakeholders and actors use the adjective “neglected”, they do so without common understanding of the term and without anticipating how such messages resonate with the wider international health community, where the term “neglected” may evoke very different associations and is not self-explanatory for the uninitiated.

The power of the issue – why care for global oral health?

To oral health experts it seems obvious that oral health is important to human health. They often forget that the indicators used to assess oral health status and disease burden are not well-fitted to provide clear and transparent information about the true extent of the disease burden, are not suitable to monitor progress over time and are difficult to understand for policy makers and non-dental audiences. In addition, oral health indicators are not fully integrated into the general health indicator framework that is used and accepted by health decision makers, such as the Disability-Adjusted-Life-Years (DALY) concept. The existing DALY data for oral diseases are based on intransparent assumptions and apparently do not take the episodic character of many oral diseases in to account\textsuperscript{13}. In addition, it is not possible to transfer data from traditional oral health indicators into the DALY framework. Most oral health indicators are not connected at all to the indicators applied to monitor progress with the Millennium Development Goals, further contributing to the niche status of global oral health\textsuperscript{14}.

Resulting from the lack of suitable indicators and the scarcity of relevant data, detailed and well-founded estimations of oral disease burdens relative to other disease groups are
limited. This seriously hampers effective framing of messages and arguments in advocacy and does not allow for serious evidence-based justification to prioritise oral health.

The evidence for interventions addressing oral diseases exists, mainly for the prevention of dental decay by appropriate fluoride on a population basis. The traditional restorative technology-focussed approach of dentistry is clearly not affordable for the majority of health systems worldwide, resulting in the predominant model of provision of oral care through the private sector. Although low-cost, realistic and scalable intervention packages exist, such as the WHO-endorsed Basic Package of Oral Care, they have not gained sustained and widespread momentum, often because of professional’s resistance to delegation and task-shifting, and lack rigorous evaluation of implementation models.

The power of actors – how powerful are they in global oral health?
The sector of global oral health consists of a handful of international organisations with varying influence, such as the World Health Organization (WHO), through its Global Oral Health Unit and the Regional Advisers, the FDI World Dental Federation, the International Association for Research (IADR), the International Federation of Dental Education Associations (IFDEA), and national professional organisations, some of them well-resourced and powerful. Among these organisations there is little alignment in terms of policy direction or cohesiveness of action. In real life the agendas of these organisations are determined completely independent of each other by fundamentally different constituencies with limited common interest. Furthermore, none of these organisations has a mandate for coordination of the entire sector and each of them protects its remit within a limited area that is closely guarded against external competing interests. Currently there are no strong leaders in the oral health community who are able to unite and inspire the entire sector.

The WHO provides some degree of authoritative policy guidance through various documents and resolutions, although many of them were not developed in a participatory and inclusive manner with other stakeholders of the sector. Yet tangible and broad-scale action on most of them is missing due to lack of resources in follow-up and translation into regional and national policies.

The FDI has gained some momentum in global oral health. While the moral prerogative to engage in “leading the world to optimal oral health” is at the core of FDI’s vision and missions, the organisation is often limited due to internal politics and conflicting interests within its constituent base of private practitioner associations. IADR and IFDEA recognise
and emphasise the need to engage in global oral health advocacy to reduce inequalities, but such activities are only a small part of their overall remit\textsuperscript{5,32,33}.

An organised international civil society for global oral health, apart from national dental associations, does not exist. Some high-income countries, such as the US or the UK have national civil society stakeholders with considerable power, such as foundations or national oral health initiatives; yet in the absence of a unifying and coherent problem definition their activities are not well aligned. Most of these organisations are initiated, led and funded by the dental community in the largest sense; true patient organisations advocating for patient rights, access to care or basic coverage are virtually absent on the national and international scene. The sector of “dental aid organisations”, comprising NGOs of industrialised countries giving assistance to low- and middle-income countries is underdeveloped, uses outdated and inappropriate approaches and plays no significant role internationally\textsuperscript{34,35}.

The role of the oral care industry in promoting oral health has largely been neglected in academic research. The handful of global multinational companies are a distinctive force in global oral health, yet their characteristics, agendas and actions are poorly documented and analysed. Their research and consumer-oriented products have contributed greatly to the global decline of dental decay over the last 50 years\textsuperscript{36}. Recently, activities that are broadly summarised under the title “Corporate Social Responsibility” reached a limited level of attention, yet serious and large-scale Public-Private Partnerships are missing. The global budgets of such companies combined largely exceed the budgets of the WHO and the health budgets of all least-developed countries together, yet the potential that lies in purposeful partnerships and sustained involvement in global public health remains untapped\textsuperscript{37,38}.

**The power of political context – creating, using and anticipating opportunities**

The sector of global oral health suffers from a lack of analysis, connection and insight into political contexts. Unlike in other areas of international health, there are no Thinktanks or institutions for policy and political analysis. Policy windows on the international level do not come often, and if they arise it requires a degree of coalescence between stakeholders to use them effectively. The adoption of an action plan on oral health by the 60\textsuperscript{th} World Health Assembly in 2007 could have been such a policy window if efforts to exploit the opportunity would have been planned ahead, coordinated and agreed between the various international and national stakeholders, based on a common understanding and a participatory agenda related to the promoting oral health\textsuperscript{39}. While the first set of Global Goals for Oral Health
by 2000 created some momentum through a competitive process to reach the targets, the current set of Global Goals by 2020 has not reached critical momentum. But there are also examples of successful policy windows\textsuperscript{40-42}. The sad case of Deamonte Driver, a boy dying from preventable dental infection in the US, created an opportunity for the American Dental Association and others in advocating for improved child oral health care\textsuperscript{43,44}. Preparedness for such policy windows is essential because they usually require a quick reaction.

Table 2 summarises the results and relates the details to the modified framework of Shiffman & Smith. The table also adds a scoring dimension to the analysis, showing red, yellow or green scores, depending on whether the criteria of the framework factors are fully, partially or not sufficiently met.

**Making global oral health a policy priority – a roadmap**

All four power categories of the analysis framework showed essential shortcomings and weaknesses ranging from the most basic matters, such as defining the issue in an agreed way, to complex and multi-levelled issues related to appropriate data collection and agreement on adequate solutions. The analysis does not pretend to be a comprehensive assessment of diverse realities. The model applied was appropriate for the initial analysis of the factors that currently limit the global oral health community; but other, more sophisticated methodologies may reveal further important aspects.

The overall diagnosis of the area of global oral health should be seen as starting point for further investigation and a candid and honest assessment of the status quo. The fact that no area of power in global oral health scored green and five out of the eleven categories scored red may be difficult to understand or accept for some; but it will hopefully open a constructive international debate on these matters. Only with such a baseline it will be possible to develop a roadmap for improvements in some or all areas analysed, which should be in the best interest of all those involved in the sector.

We believe that only with a fundamentally new approach and joint effort it will be possible to give global oral health a new orientation and impetus. The details of such an approach will need to be determined among all involved and it will be essential to base efforts on an agreed problem definition. The need to address the growing inequities may be a realistic starting point; as well as the recognition that the traditional dichotomous division of the world in developed and developing countries is no longer real, nor helpful. Health and oral health inequities in a globalised world follow social gradients that are largely determined
outside of the oral health arena, and they go across countries and different populations within countries.\textsuperscript{45,46}

The consequences of such new thinking are fundamental. The health equity debate will no longer focus on disparities between countries or within countries, but between socio-economic groups, the determinants of their health and ways to address them. Such thinking will lead to an alignment of agendas because all stakeholders, be it in oral health or in the wider international health arena, will discover broad areas of common interest that may be tackled with similar and integrated approaches, irrespective of the average income classification of the country.

**Conclusion**

Political priority for global oral health is low, resulting from a set of complex issues deeply rooted in the current global oral health sector, its stakeholders and their remit, the lack of coherence and coalescence; as well as the lack of agreement on the problem, its portrayal and possible solutions. This paper can only be a start for a long overdue, broad and candid international analysis of political, social, cultural, communication, financial and other factors related to better prioritisation of oral health. Such a discussion will reveal further painful truths, but without such an analysis and resulting concerted action the global inequities in oral health will grow and increasingly impact on health systems, development and human lives.
<table>
<thead>
<tr>
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<th>Factors shaping political priority</th>
<th>Analysis of Global Oral Health</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideas: The ways in which those involved with the issue understand and portray it</td>
<td>Internal frame: the degree to which the policy community agrees on the definition of causes and solutions to the problem</td>
<td>No common understanding of the neglect of Global Oral Health as an issue</td>
<td></td>
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<tr>
<td></td>
<td>External frame: public portrayals of the issue in ways that resonate with external audiences, especially the political leaders that control resources</td>
<td>No common understanding of effective external portrayal of Global Oral Health as a neglected issue</td>
<td></td>
</tr>
<tr>
<td>Issue characteristics: Features of the problem</td>
<td>Credible indicators: clear measures that show the severity of the problem and that can be used to monitor progress</td>
<td>Oral health indicators have limited value in monitoring or showing severity of disease, not linked to established general health indicators</td>
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<td></td>
<td>Severity: the size of the burden relative to other problems, as indicated by objective measurement such as mortality and morbidity levels</td>
<td>Oral health indicators not linked to established general health indicators assessing morbidity, such as DALYs</td>
<td></td>
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<td></td>
<td>Effective interventions: the extent to which proposed means of addressing the problem are clearly explained, cost-effective, backed by scientific evidence, simple to implement and inexpensive</td>
<td>Cost-effective and evidence based interventions exist for prevention of dental decay, restorative care models expensive and dependent on technology</td>
<td></td>
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<tr>
<td>Actor power: Strength of the individuals and organisations concerned with the issue</td>
<td>Guiding institutions: the effectiveness of organisations or coordinating mechanisms with a mandate to lead the initiative</td>
<td>Small sector, diverse interests, limited remits</td>
<td></td>
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<td></td>
<td>Policy Community cohesion: the degree of coalescence among the network of individuals and institutions centrally involved with the issue at the global level</td>
<td>Lack of problem definition and alignment, formation of alliances and organisational cooperation not prioritised, little agreement on possible solutions on a global level</td>
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<td></td>
<td>Leadership: the presence of individuals capable of uniting the policy community and acknowledged as particularly strong leaders for the cause</td>
<td>No generally accepted individual leaders</td>
<td></td>
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<td></td>
<td>Civil society mobilisation: the extent to which grassroots organisations have mobilised to press international and national political authorities to address the issue at the global level</td>
<td>No civil society mobilisation with significant impact</td>
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</tr>
<tr>
<td>Political contexts: The environments in which actors operate</td>
<td>Policy windows: political moments when global conditions align favourably for an issue, presenting opportunities for advocates to influence decision makers</td>
<td>Policy window occurred in the past, but were not effectively used, questionable preparedness for future policy windows</td>
<td></td>
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<tr>
<td></td>
<td>Global governance structure: the degree to which norms and institutions operating in a sector provide a platform for effective action</td>
<td>No agreed global governance for oral health, no institution with clear mandate for coordination of the entire sector</td>
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References


