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# Policy concerns and recommendations for dental geriatrics

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## Abstract

**Background and objectives:** Policies and priorities for action in geriatric dentistry require strong professional and political advocacy. Whereas the oral health needs of children and adolescents are recognized in relationship to access equity and equality based on their dependency, the increasing proportion of frail and dependent elders has not received the same attention or support. This paper reviews the key issues associated with the lack of public investment in dental geriatrics related to perceived economic costs, attribution of responsibility for oral care, and prioritizing within overall health and oral healthcare. **Conclusion:** The inclusion of oral care within a universal healthcare system, together with a greater inter-professional collaboration and empowerment within the dental and allied health sectors, should be central elements within policy reforms.

## Introduction

Policies for oral care of older people are recognized more in principle than in action (MacEntee, 2013). Less than one-third (31%) of the 194 member states within the World Health Organization (WHO) “have an operational oral health policy, strategy or action plan and dedicated staff for oral health at the Ministry of Health” (World Health Organization, 2024). Furthermore, where there are policies, they tend to promote downstream personal hygiene and diet supplemented by fluoridating community water-supplies, but give minimal attention to the pathogenic influence of multinational industries (Watt *et al.*, 2019). A recent review of policies on oral healthcare for older people reported that “[i]n some countries, although no specific oral health policies and oral healthcare program/schemes are currently available for the older adult population, these countries are considering developing policy” (Jiang *et al.*, 2021). With the global pace of demographic ageing, and the current burden of oral disease, this is not an optimistic perspective. The WHO now recognizes the urgent need to integrate oral health within national policies, because “[m]ore of the same is no longer an option for policy makers—radical changes are needed in oral health policy and system reform to promote sustainable improvements in oral health equity” (Watt, 2023).

Dentistry is a discretionary and very expensive service in most countries, consequently, attempts by dental organizations in many jurisdictions have been unable to implement health-related policy and strategies when governments perceive more pressing health issues (Benzian *et al.*, 2011; Gore and Parker, 2019). Apart from severe pain, infection and life-threatening trauma, mouth-disorders are frequently overlooked, and when essential or basic oral/dental care is mentioned or even supported by some health agencies, it is usually without specifying the objectives or scope of care (Benzian *et al.*, 2022; Dharamsi and MacEntee, 2002). Further, the primacy of the biomedical model in oral health policy limits the recognition of the social determinants of health, and their crucial role in health inequality (Marmot, 2005).

We consider in this article the current development, adoption and implementation of policies on oral care for older people who are frail. Our aims are to: 1. review the key issues associated with the development of policies for healthcare; and 2. consider appropriate strategies for achieving effective oral care for older people.

## Human rights – a broad mandate

The Universal Declaration of Human Rights identifies health for everyone as a human right anchored in the principles of equality and non-discrimination (Pillay, 2008). The national constitutions and statutes of many countries do not acknowledge this right to health, much less the special needs of older people (Backman *et al.*, 2008). The Government of Canada adopted the *Health Field Concept* as an analytical framework for an innovative policy on healthcare entitled *Achieving health for all: a framework for health promotion* (Lalonde, 2002). The WHO adopted this framework in 1986 which led to the *Ottawa Charter on Health Promotion* and policies recognising the pervasive and very influential socioeconomic determinants of health, such as culture, education, employment, financial status, and commercial activities (Marmot, 2005). The complex and dynamic interconnections among the various determinants need careful consideration when developing and implementing health policies (Aloosh and Hopkins, 2024).

Previous policies on preventing oral disease focused mainly on modifying the harmful behaviors of individuals rather than the cultural, economic and commercial forces in society that elevate the risk of noncommunicable disease (NCD) including oral disorders (Alber *et al.*, 2021). There is, for instance, a steep social gradient to poor oral health across the life-course closely linked to poverty, personal development, social upheaval and geographical migration (MacEntee *et al.*, 2019).

Ageism inflicts another pervasive influence on healthcare generally, and no less so on oral health by stereotyping people because of their age (Inouye, 2021; Winkelmann *et al.*



*al.*, 2023; Commonwealth of Australia, 2021). It surfaces from investigations into neglect of mouth-care for elders who are frail and institutionalized (Benneyworth and Terroni, 2019; Watt *et al.*, 2019), and, in the extreme, it should be deemed a severe physical abuse (Brondani, 2020). Another, but less obvious example, is the mistaken belief in many cultures that tooth-loss is inevitable with advancing age (Goulart *et al.*, 2019; Russell *et al.*, 2013; Sussex *et al.*, 2010). In all, ageism denies dignity and equality to people who need and expect trust, and mostly it is ignored by health policies (Mikton, *et al.*, 2022; World Health Organization, 2021).

### Universal health coverage

The WHO and the United Nations together support a strategic policy for promoting universal health coverage (UHC) to provide basic/essential primary healthcare to everyone without financial hardship (World Health Organization, 2022). The WHO also advocates special care supported by universal health coverage for elders who are frail and struggle with personal care and burdened disproportionately by oral and other NCDs. Apparently, policies favouring fee-for-service in private or public insurance programs have done little over the years to address this burden (Grytten and Holst, 2013; MacEntee *et al.*, 2012). UHC through public or private health insurance can cover the cost of promotive, preventive, curative, rehabilitative and palliative services, while targeted taxation reduces the consumption of tobacco, alcohol and sugar (Marques dos Santos *et al.*, 2024; Mathur *et al.*, 2015; Winkelmann *et al.*, 2023). This policy, of course, is met by conflicting ideological, commercial, and institutional/professional interests that hover around the role of government in healthcare, redistribution of economic resources, and, most directly, volatile concerns about increasing taxes (Rizvi *et al.*, 2020). Redistributive policies targeting access to healthcare remain key political issues around inequality and inequity that need strong, cost-effective, evidence-based and integrated services. Consequently, policies and programs on oral care for older people are difficult to develop, and even more difficult to implement and sustain (Allin *et al.*, 2020; Benneyworth and Terroni, 2019; Jiang *et al.*, 2021).

### Burden and cost of oral diseases

The prevalence of oral NCDs—such as dental caries, periodontitis, tooth loss, and cancer—has increased over the last quarter century (Kassebaum *et al.*, 2017), and is exacerbated by the aggressive commercial marketing of transnational sugar, alcohol and tobacco industries (Jamieson *et al.*, 2020; MacEntee *et al.*, 2025; Watt *et al.*, 2019). The global economic costs of oral conditions in 2019 total about US\$710 billion—US\$387 billion on direct cost for treatments and US\$323 billion on loss of productivity, which is almost 5% of the global healthcare expenditure (Jevdjevic and Listl, 2025). There is a 500-fold difference between per capita spending on dental care between high-income (US\$260) and low-income (US\$0.52) countries largely because of the higher rates of oral disease and fewer dentists and other dental personnel per population in low-income countries (Luan *et al.*, 2024; Gallagher and Hutchinson, 2018).

Curative dentistry involving technically complex surgical, restorative and prosthodontic procedures is expensive and a major barrier to care for all age-groups. Consequently, policies on public dental services typically restrict access to only basic or essential oral care. However, the scope of basic care ranges from preventive and curative services to little more than emergency care and occasionally to very limited hospital-based care (Allin *et al.*, 2020; Benzian *et al.*, 2022; MacEntee *et al.*, 2012). Moreover, the poor results from both the full range of dental services offered, for example in the United Kingdom, and from the more restricted mix of publicly and privately insured services in the USA, indicate that the effectiveness of current policies on oral care is uncertain (Huang *et al.*, 2021; Royal College of Surgeons Faculty of Dental Surgery, 2017).

### Promoting oral healthcare policies

Policies that advocate for a more equitable distribution of health services focus usually on high-risk vulnerable communities that more easily draw political attention and acceptance (Dharamsi and MacEntee, 2002; Listl *et al.*, 2023). The European College of Gerodontology and the European Geriatric Medicine Society offer an action plan for a policy to integrate oral care within primary healthcare, educate non-dental care providers to use oral health indicators, and help older people to become more aware and seek appropriate care when needed (Kossioni *et al.*, 2018). However, although the potential benefits of integrating oral health generally into primary healthcare are widely acknowledged, the political practicalities of integration remain challenging and with few exceptions largely unfulfilled even in affluent countries (Bhuiya *et al.*, 2016; Patel and Gallagher, 2024; MacEntee, 2013).

The policy within the *Oral Health for an Ageing Population* produced by the FDI World Dental Federation integrates the levels of dependency identified in the *Seattle Care Pathway* (Pretty *et al.*, 2014) with three pillars of action for maintaining oral health (Glick *et al.*, 2021). The pillars support UHC for oral healthcare, an integration of oral and general healthcare throughout the life-course, and a resilient and sustainable workforce of oral care-providers. Actions also combat the risks common to all NCDs by mitigating the ill-effects of sugar, tobacco, and alcohol. Traditionally, policies have focused on downstream behavioral and biological strategies to promote oral health and reduce the risk of disease at the level of individual patients (Palmer *et al.*, 2023). There has been much less attention to commercial determinants of health and other upstream risks from multinational corporations.

In Japan a national strategic policy called the “8020 movement” has been successful with the proportion of elders over age 80y with 20 or more natural teeth increasing from 15% in 1999 to 51% in 2016. This was achieved through a universal health insurance system and a multidisciplinary collaboration between local health authorities and dental associations to accommodate home-care for people who are frail (Miura and Tano, 2019; Takehara *et al.*, 2025). As yet, this progressive policy in Japan does not apply to elders who are younger than 80y, and the clinical criteria for oral frailty or disorder are unclear.

## Multidisciplinary workforce

Current barriers to care for older people who are frail call for policies to build and sustain a suitably educated multidisciplinary oral health workforce beyond the services offered currently by dentists and dental hygienists/therapists in private clinics (Slack-Smith *et al.*, 2015; Wallace *et al.*, 2016; Wright, 2015). There are significant barriers (MacEntee *et al.*, 1999) but also helpful guiding principles for managing disability and different levels of dependency within aging communities (MacEntee, 2011; Petty *et al.*, 2014; Thorne *et al.*, 2001). Policies integrating oral and general health within primary care encourage an expanded scope of practice for all care-providers, increase disciplinary knowledge and therapy, and broaden access to care for all age-groups. A workforce that includes clinicians, sociologists and economists, while beyond the scope of traditional dentistry, is more likely to successfully obstruct the commercial distribution of harmful products by transnational corporations (MacEntee *et al.*, 2025), although this will need a strong global and local base of evidence on governance, structure, finance and community aspirations (Kittelsen *et al.*, 2019; Listl *et al.*, 2023; Raphael and Bryant, 2022).

## Conclusions

There is still much needed to formulate, adopt, implement and refine policies appropriate for combating the global burden of oral disease, and the persistent risk of NCDs in all age-groups. There are many countries where policies do not exist despite rampant disease, where the ratio of dental personnel to population is close to zero, and where the management of oral disease simply does not occur. However, there are high- and middle-income countries with vibrant dental health services directed by health policies outweighed by pervasive economic and commercial policies that are harmful to health. And so the burden of oral disease, like all NCDs persists despite an immense financial expenditure on direct cost of dental treatments and loss of productivity. These are problems throughout the life-course calling for effective and sustainable policies to counter the distress, poor quality of life, and frailty in old age caused by oral neglect. Nonetheless, policy development and implementation in general is a messy business, especially when implementation requires a substantial transfer of funds. It is not surprising therefore that “policy” and “politics” are words with the same meaning or at least interpretations in many languages.

## Recommendations

Policies for effective oral healthcare and health service should:

1. refocus oral health policies away from the primacy of the biomedical model of care to place greater significance on a psychosocial and life-course approach to care, and the the commercial determinants of health;
2. guide the scope of basic and essential oral care and treatment for people who are old and frail;
3. support health equity and universal health coverage as basic human rights;
4. focus attention on the individual and societal risks common to all NDCs, with special attention to the commercial determinants of health;

5. identify reliable indicators of oral disease linked to appropriate health services;
6. promote education, recruitment and retention of oral care personnel for public health service;
7. integrate oral care within primary and team-based care;
8. expand interprofessional education to include oral care;
9. address the special needs of low-income and cultural distinct communities and individuals.

## Author contributions

Both authors contributed to conception of the work, drafting and critical revision of the article, and final approval of the version to be published.

## Conflict of interest statement

The authors declare no conflicts of interests.

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