CONFRONTING INEQUITY THROUGH GLOBAL HEALTH POLICIES

LOIS K. COHEN, Ph.D., CONSULTANT AND
PAUL G. ROGERS AMBASSADOR FOR GLOBAL HEALTH RESEARCH

AMERICAN INSTITUTE FOR DENTAL PUBLIC HEALTH,
SAN ANTONIO, TX, JANUARY 14-15, 2020

HEALTH

"Health is not only the absence of infirmity and disease, but also a state of physical, mental and social well being."

World Health Organization

GLOBAL HEALTH

"...health problems, issues and concerns that transcend national boundaries, may be influenced by circumstances or experience in other countries, and are best addressed by cooperative actions and solutions ."

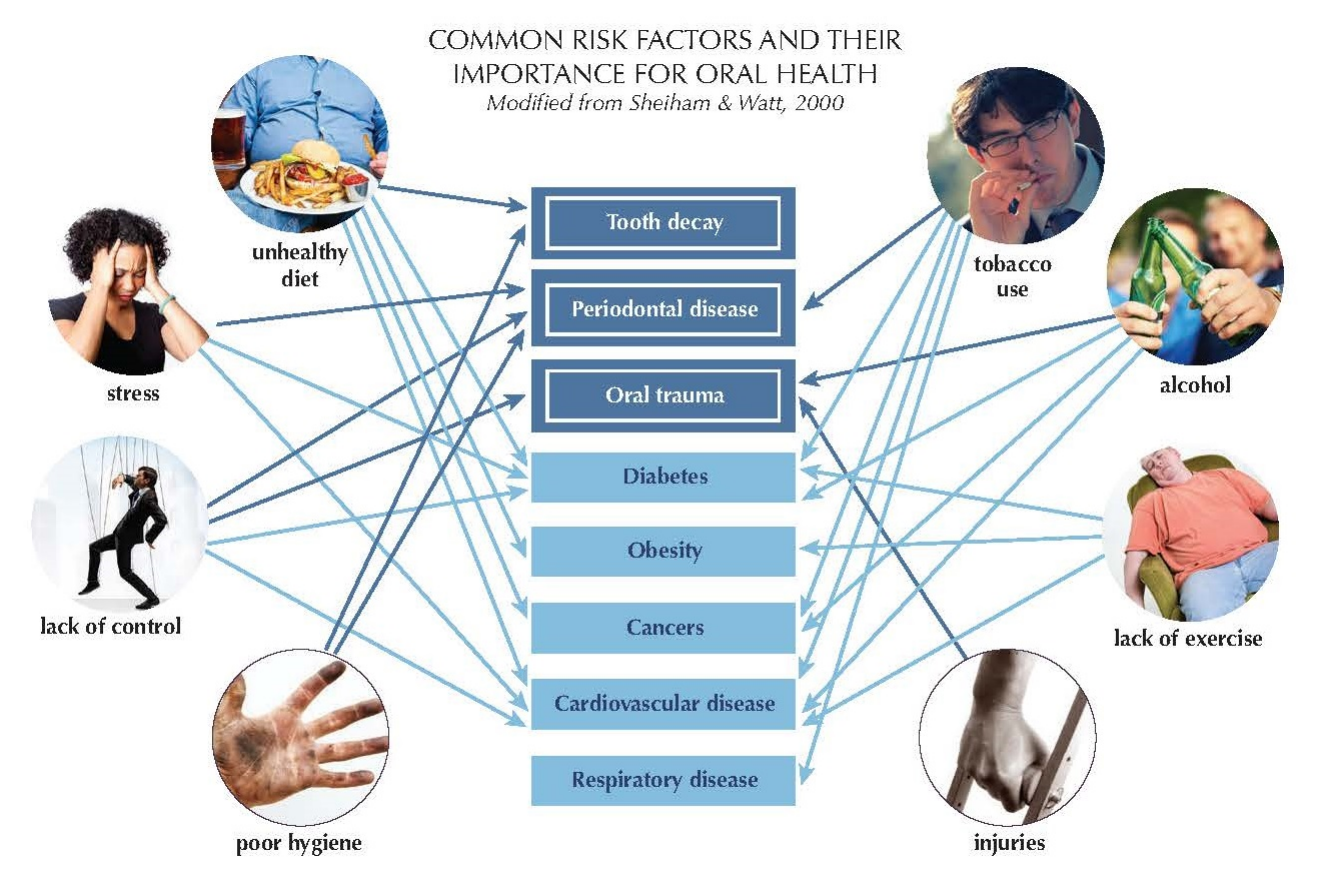
Institute of Medicine, National Academy of Science
"U.S. Commitment to Global Health"

GLOBAL ORAL HEALTH

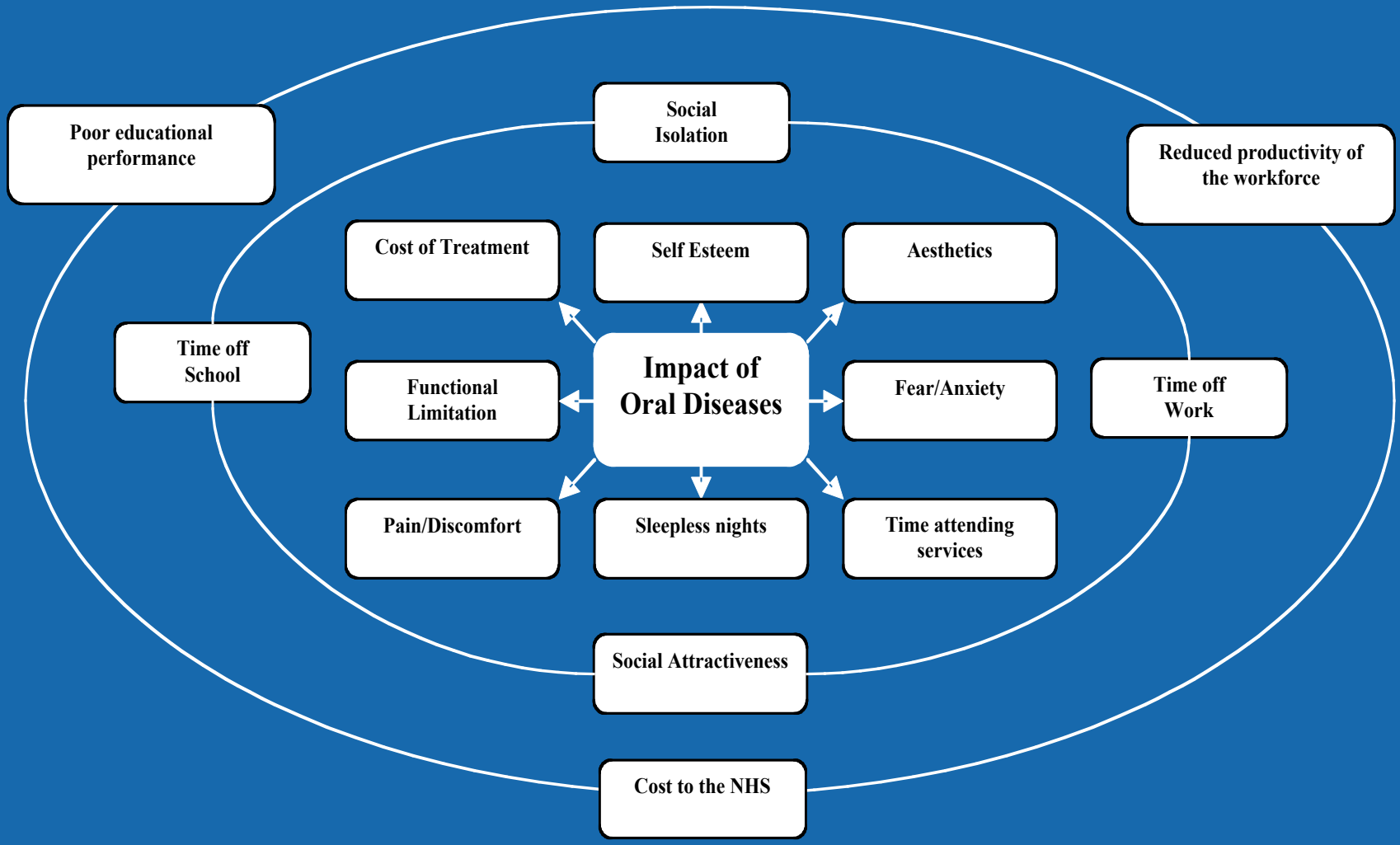
- Key indicator of over-all health and quality of life
- GBD Study (2016) estimates 3.5 billion have dental caries – most prevalent noncommunicable disease
- Severe periodontal disease 11th most prevalent
- IARC (2018) – Oral cancer in top 3 of all cancers in some Asian-Pacific countries
- Oro-dental trauma – 20% of all traumas worldwide
- Noma (1998) estimated of 140,000 new cases globally
- Congenital anomalies such as cleft-lip and palate most common of all birth defects – on average 1 in every 500-750 lives births

GLOBAL ORAL HEALTH THROUGH ORAL HEALTH

Risk factors



IMPACT OF ORAL DISEASES

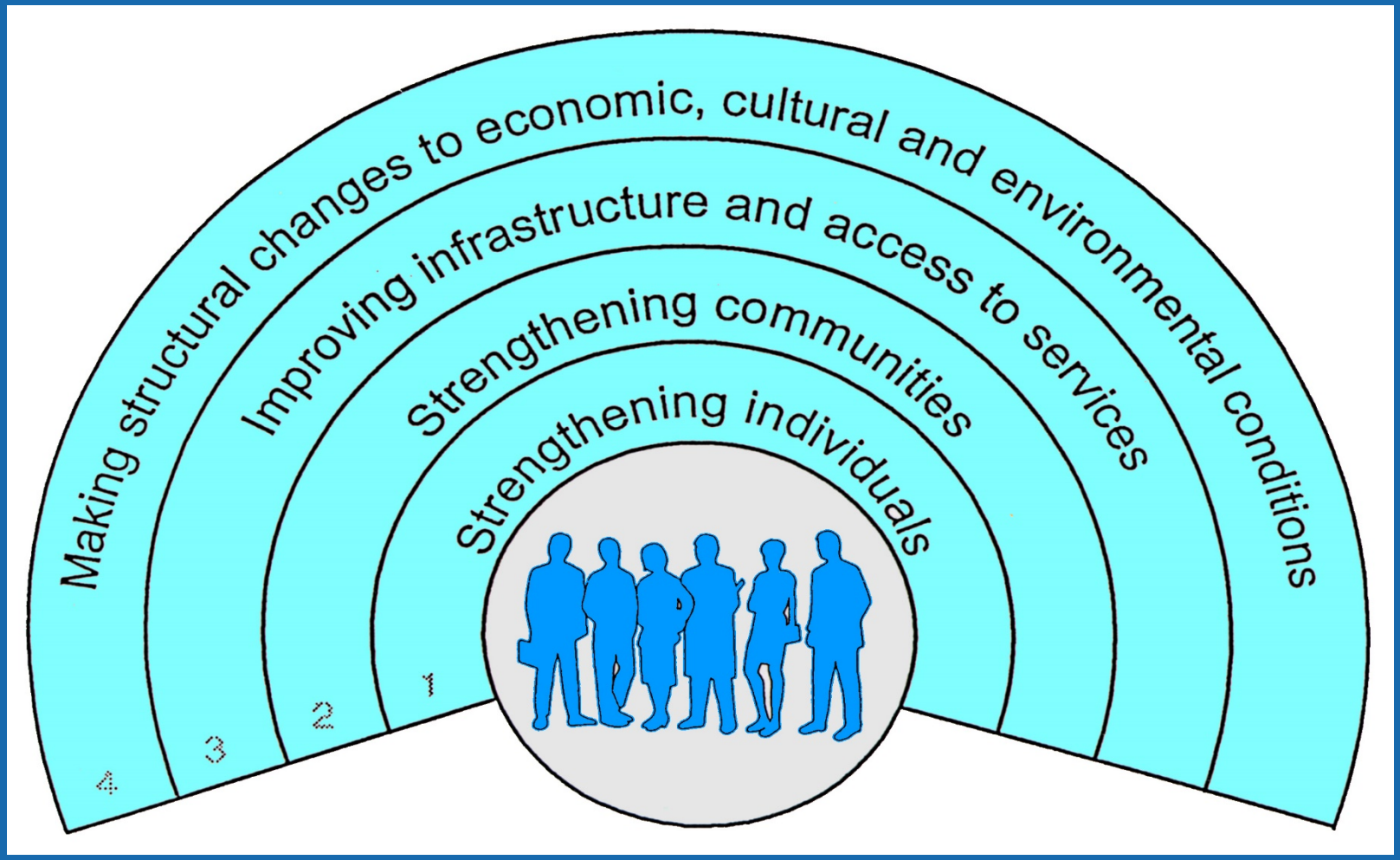


Source: Modified from Department of Human Services (1999)

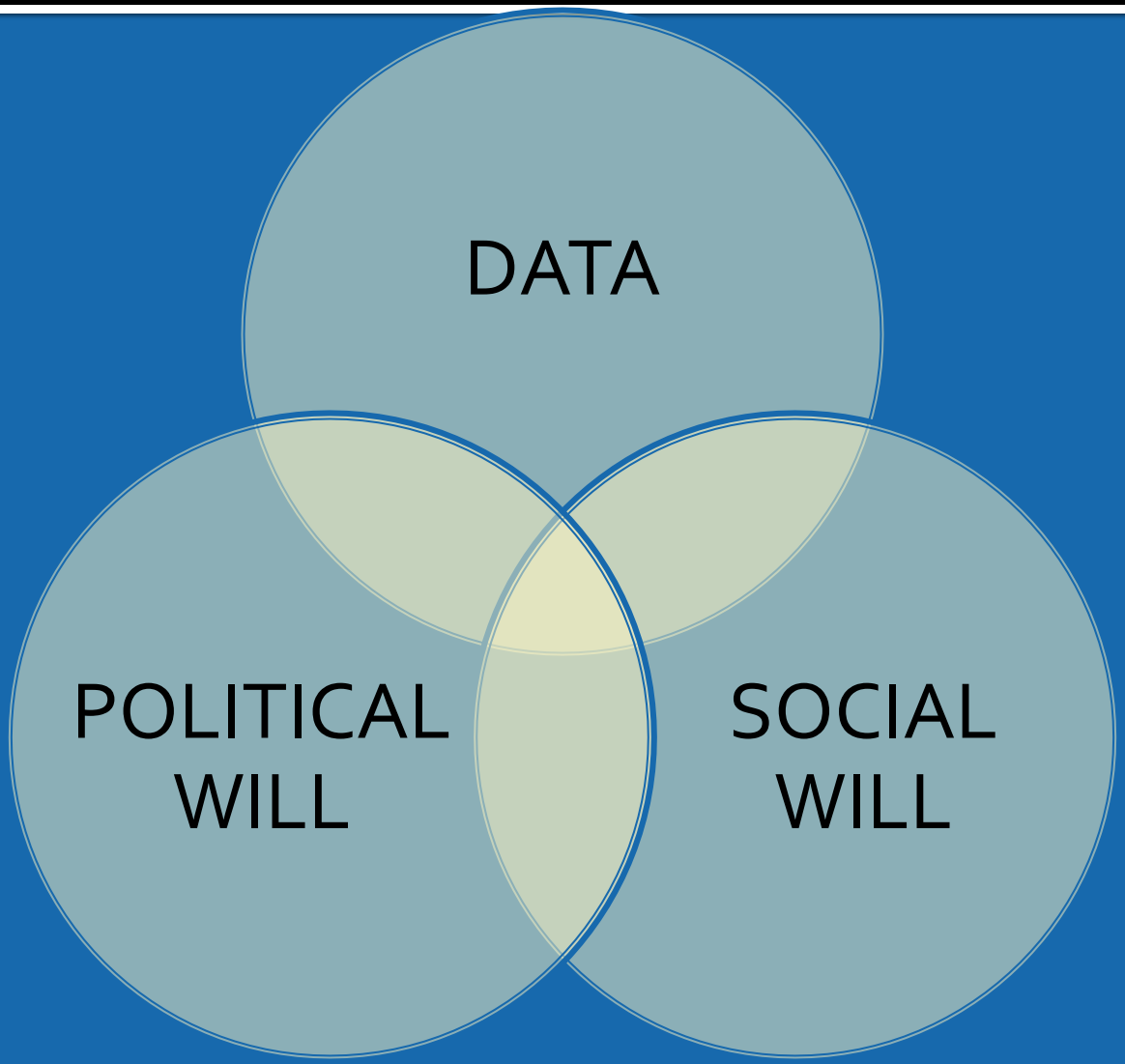
WHO RESPONDS

- Solutions for oral problems most effective when integrated with those for other NCDs and national public health programs
- WHO Global Oral Health Programme aligns with Shanghai Declaration on promoting health in the 2030 agenda for sustainable development

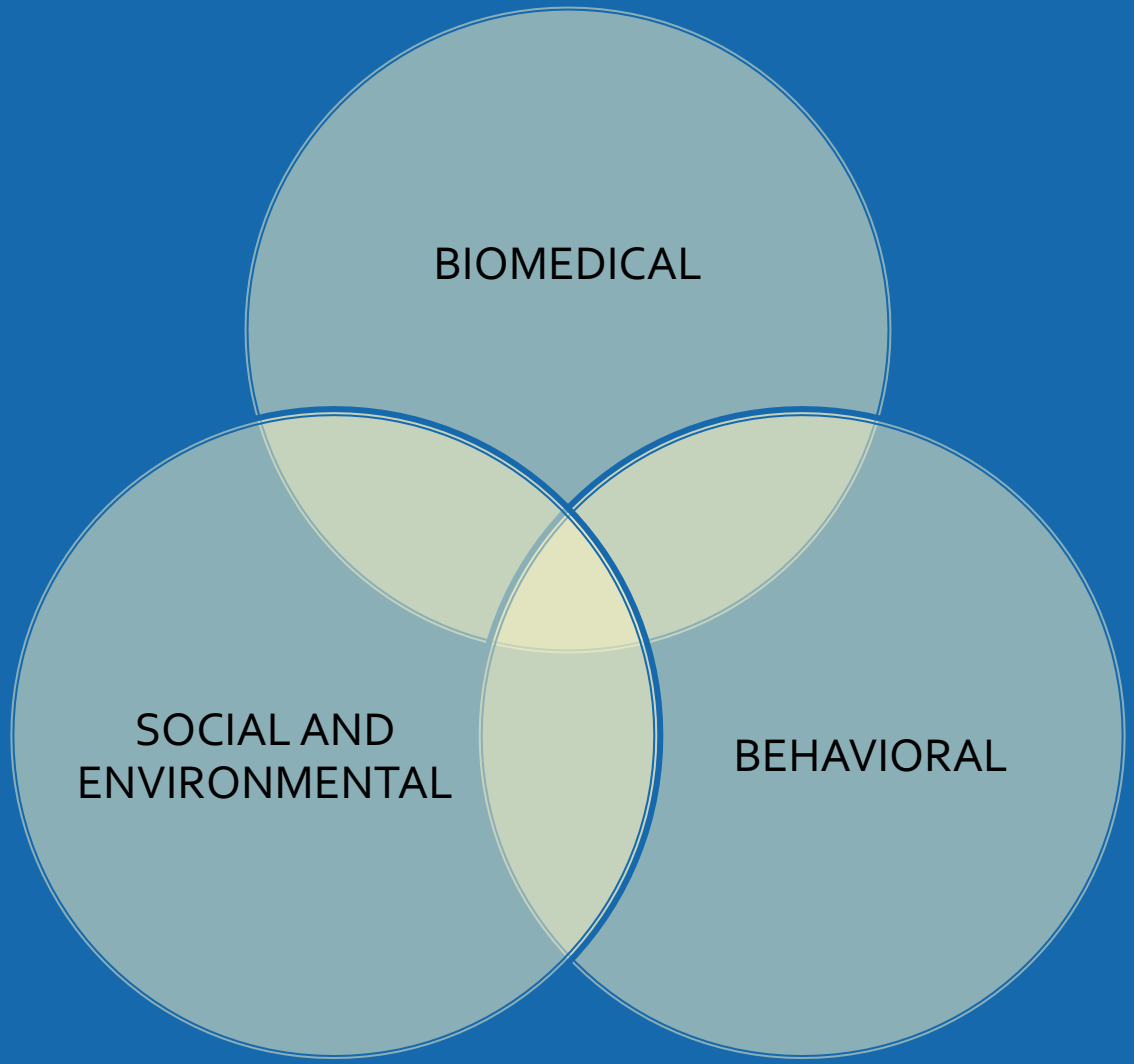
Policy Levels for Tackling Inequalities in Oral Health



EFFECTIVE HEALTH POLICY



DATA = RESEARCH



RESEARCH EXAMPLES IMPACTING ORAL HEALTH

BIOMEDICAL

- Oral microbiome – sugars and other nutrients and bacteria
- Regenerative Medicine – bone and enamel
- New Vaccines – HPV
- Gene Editing – Salivary
- Cancer – immunotherapy
- Pain Management
- Precision Medicine

SOCIAL AND ENVIRONMENTAL

- IADR GOHIRA
- Predictive modeling based on current data but projecting various trend scenarios (workforce modeling)
- Communicating science and disseminating of innovations
- OHRQ of L
- ICS I and II – learning from each other through systems research

EDITORIAL

H.D. Sgan-Cohen[1]*, R.W. Evans[2], H. Whelton[3], R.S. Villena[4], M. MacDougall[5], D.M. Williams[6], and IADR-GOHIRA Steering and Task Groups[†]

[1]IADR Regional Board Member for Europe, Community Dentistry, Hebrew University-Hadassah Faculty of Dental Medicine, Jerusalem, Israel; [2]IADR Past Regional Board Member for Asia-Pacific, Population Oral Health, The University of Sydney, Australia; [3]IADR President-elect, Oral Health Services Research Centre, University College Cork, Ireland; [4]IADR Regional Board Member for Latin America, Chair of Pediatric Dentistry, San Martin de Porres University, Lima, Peru; [5]IADR President, James Rosen Chair in Dental Research, School of Dentistry, University of Alabama at Birmingham, USA; and [6]IADR Past President, Institute of Dentistry, Barts and The London School of Medicine and Dentistry, Queen Mary University of London, London, England; *corresponding author, harold@hadassah.org.il

J Dent Res 92(3):209-211, 2013

KEY WORDS: stomatognathic diseases, socioeconomic factors, oral health, health behavior, health policy, evidence-based dentistry.

IADR Global Oral Health Inequalities Research Agenda (IADR-GOHIRA®): A Call to Action

BACKGROUND

While there have been major improvements in oral health in the past 30 years, with research leading to remarkable advances in the prevention and treatment of disease, inequalities remain, and a marked social gradient in oral health is seen similar to that in general health. Global inequalities in oral health persist, both between and within different regions and societies, and they undermine the fabric, productivity, and quality of life of many of the world's peoples. There has been much research into the biological and social determinants of general and oral health, including the influence of psychological, social, environmental, economic, cultural, and political factors on health outcomes (Marmot and Bell, 2011), but this has not led to the improvements that could be expected. The International Association for Dental Research (IADR) has invested in the Global Oral Health Inequalities Research Agenda (IADR-GOHIRA®) initiative, the key objective of which is to articulate a research agenda to generate the evidence for a strategy that, if properly implemented, will reduce inequalities in oral health within a generation (Williams, 2011a,b). IADR recognizes that, to date, there has been limited success in translating research into effective action to promote global oral health and eliminate inequalities. It is increasingly apparent that addressing this challenge will require closer and more robust engagement across sectors, including social policy, and the adoption of an upstream approach that integrates action on oral health with approaches to reduce the global burden of noncommunicable disease in general. The essence of the present call to action is to focus the attention of international leaders in oral health research on this issue. IADR is committed to accepting a scientific, social, and moral leadership role in achieving this goal.

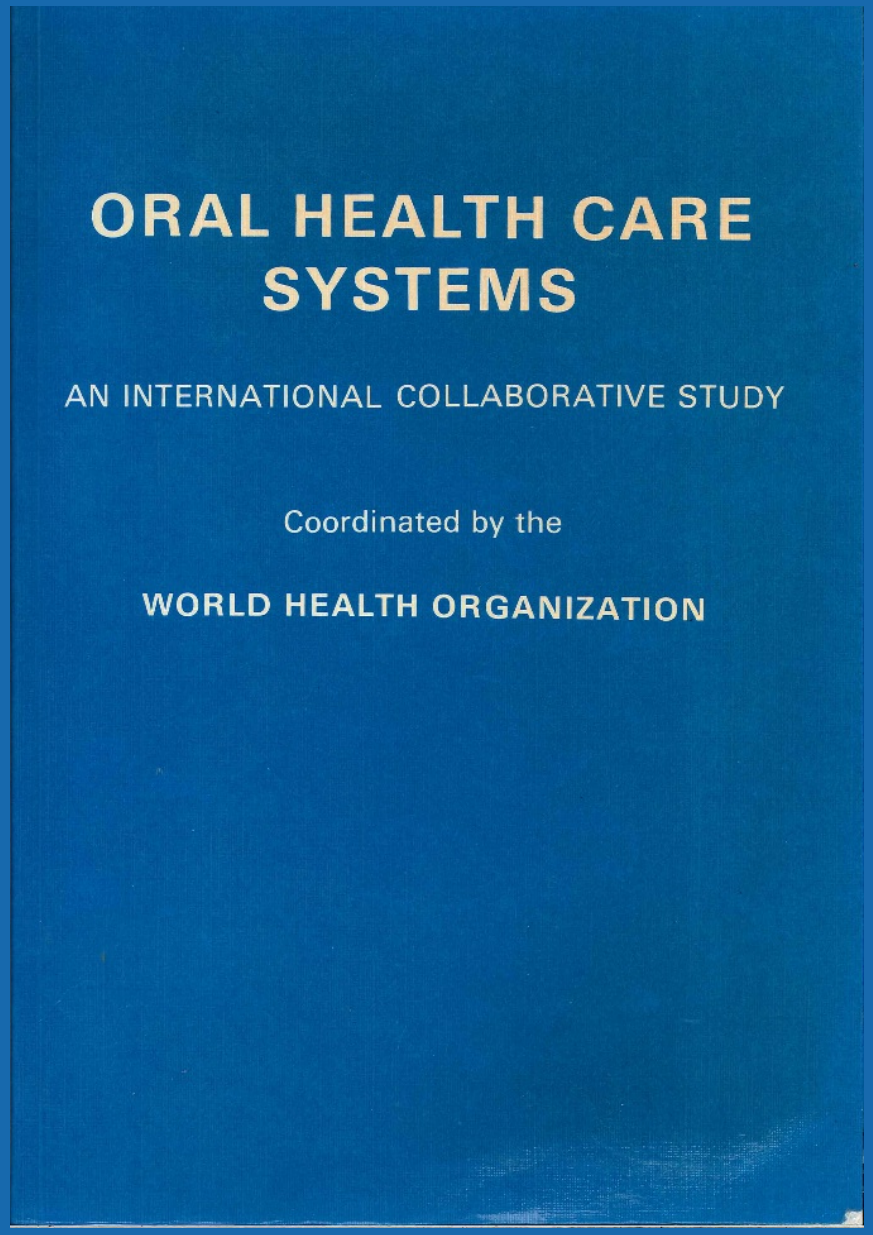
The underlying causes of global inequalities in general and oral health are

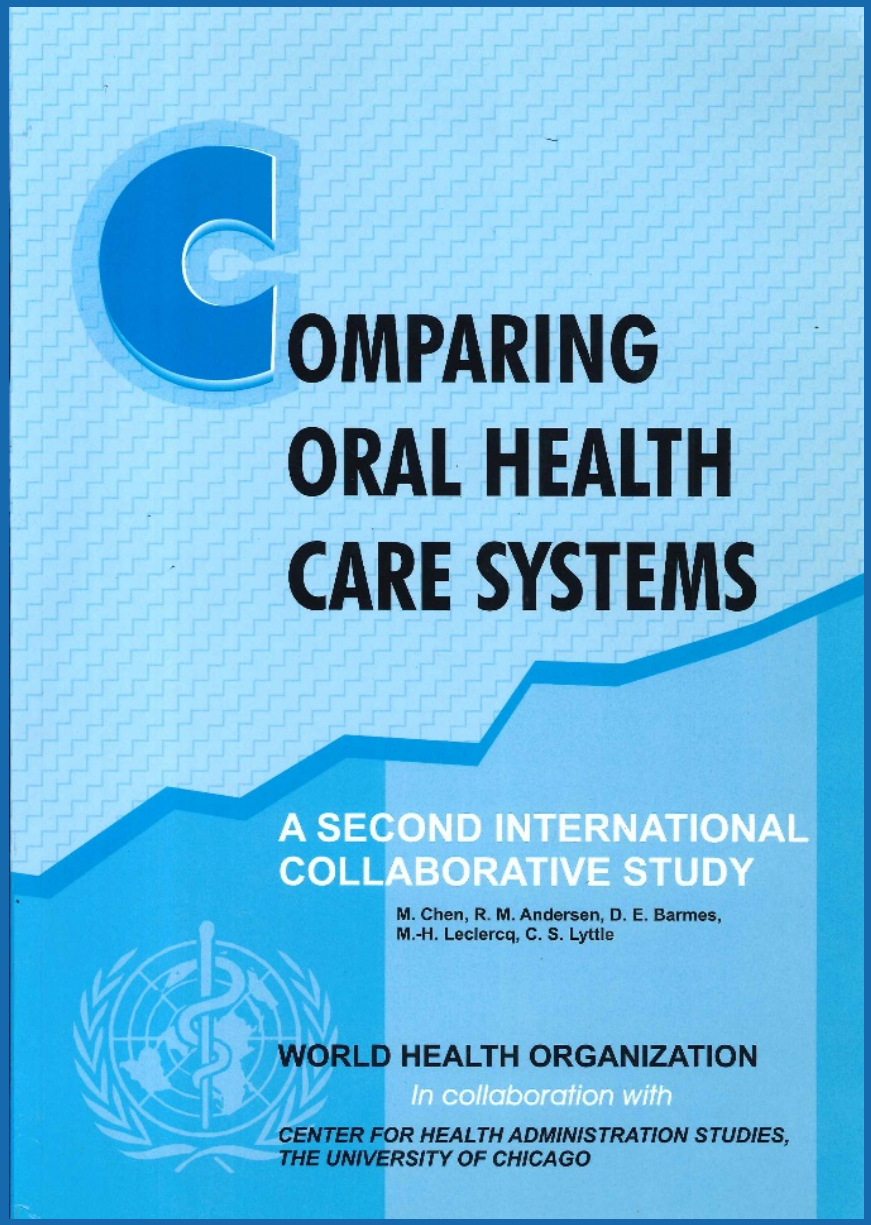
DOI: 10.1177/0022034512475214

Received October 8, 2012; Last revision December 23,

BEHAVIORAL RESEARCH

- Health literacy
- Taxation and personal behaviors
- Cultural variation and impact on personal behaviors. Psychological variation across the globe (literature missing on psychological variation)
- Global health malpractice – 10 fixes for global health consulting


ORAL HEALTH CARE SYSTEMS
AN INTERNATIONAL COLLABORATIVE STUDY
Coordinated by the
WORLD HEALTH ORGANIZATION


COMPARING ORAL HEALTH CARE SYSTEMS
A SECOND INTERNATIONAL COLLABORATIVE STUDY
M. Chen, R. M. Andersen, D. E. Barmes, M.-H. Leclercq, C. S. Lyttle
WORLD HEALTH ORGANIZATION
In collaboration with
CENTER FOR HEALTH ADMINISTRATION STUDIES, THE UNIVERSITY OF CHICAGO

INTERNATIONAL COLLABORATIVE STUDIES OF ORAL HEALTH SYSTEMS

Australia
Canada
Germany(2)
Ireland
Japan
New Zealand
Norway
Poland
US

WHO-ICS HYPOTHESES

The more available, accessible and acceptable the dental care provided to a population, the more positive is the effect on that population's oral health.

AVAILABILITY

- Manpower
- Supporting personnel
- Central control
- Personal time devoted to prevention

ACCESSIBILITY

- Physical ease of contact between consumer and provider
- Less direct payment for services
- More incentive given to provider to deliver services
- More initiative exerted by provider to enhance accessibility

ACCEPTABILITY

- Acceptability of services to a population
- Acceptability of services to the provider of services
- Quality control

Beneficial Effect to the Consumer

- Ratio of services to need = $\frac{S}{N}$

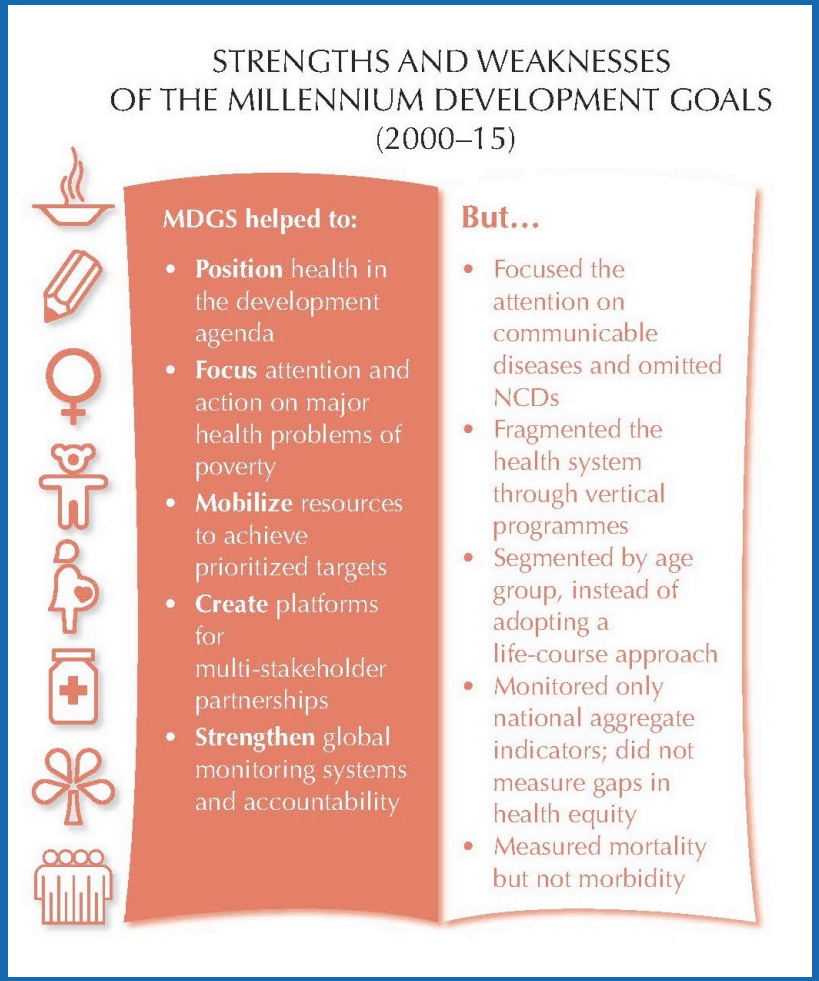
TABLE 1.1 STRUCTURAL CHARACTERISTICS OF THE ORAL HEALTH DELIVERY SYSTEMS IN THE STUDY AREAS

Study area	Type of provider employment	Types of provider	Provider payment procedures	Target population
Alberta*	Predominantly private practice	Dentists: moderate use of operating auxiliaries	Predominantly direct fee-for-service (FFS)	
Baltimore*	Predominantly private practice	Dentists: moderate use of operating auxiliaries	Predominantly direct FFS: some insurance	
Ontario*	Predominantly private practice	Dentists: moderate use of operating auxiliaries	Predominantly direct FFS. Some insurance	
Quebec	Predominantly private practice	Dentists: moderate use of operating auxiliaries	Predominantly direct FFS. Developing third-party payment programme for children	Children
Sydney	Predominantly private practice	Dentists: minor use of operating auxiliaries	Predominantly direct FFS	
Hannover	Predominantly private practice	Dentists: no operating auxiliaries	Predominantly insurance	Children (diagnostic)
Yamanashi	Predominantly private practice	Dentists: moderate use of operating auxiliaries	Predominantly insurance, some direct FFS	
Canterbury	Private practice and public programme	Dentists: major use of operating auxiliaries	Direct FFS for adults. Govt. payment for children and adolescents	Children and adolescents
Dublin*	Private practice and public programme	Dentists: no operating auxiliaries	Part insurance, part FFS, part Govt. payment	
Trondelag	Private practice and public programme	Dentists: minor use of operating auxiliaries	Part direct FFS, part insurance for adults, Govt.	Children and adolescents
Leipzig	Predominantly public programme, some private practice	Dentists: minor use of operating auxiliaries	Predominantly insurance	Children
Lodz	Predominantly public programme, some	Dentists: minor use of operating auxiliaries	Predominantly Govt. payment Payment for adolescents and children	Children and industrial workers

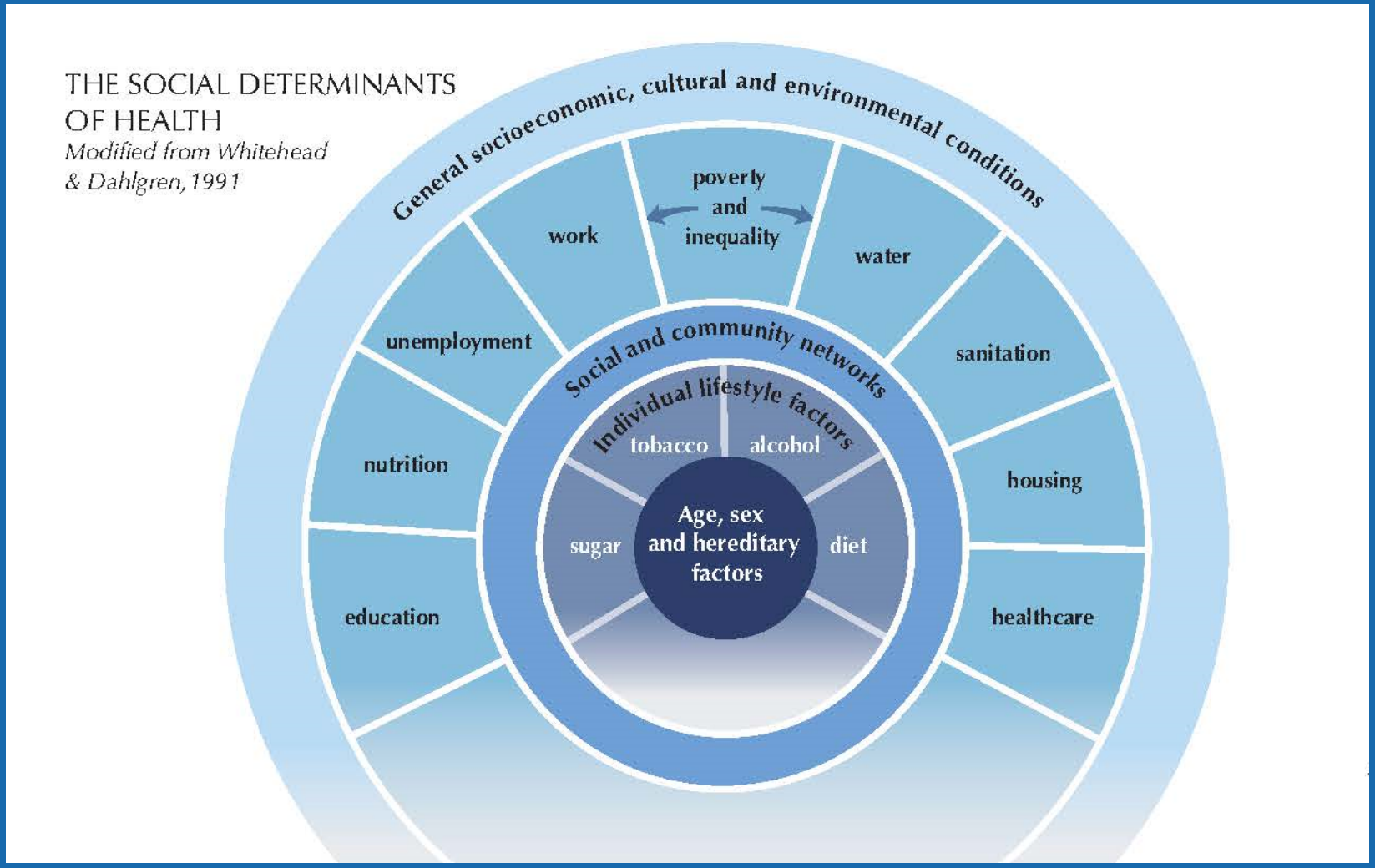
GLOBAL HEALTH POLICIES

- 2000 UN - MDGs
- 2001 UN – AIDS
- 2008 WHO Commission on Social Determinants
- 2011 UN – NCDs
- 2015 UN – SDGs
- 2019 UN - UHC

STRENGTHS AND WEAKNESS OF THE MILLENNIUM DEVELOPMENT GOALS



SOCIAL DETERMINANTS OF HEALTH



General Assembly

Distr.: General
24 January 2012

Sixty-sixth session
Agenda item 117

Resolution adopted by the General Assembly

[*without reference to a Main Committee (A/66/L.1)*]

66/2. Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases

The General Assembly

Adopts the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases annexed to the present resolution.

3rd plenary meeting
19 September 2011

Annex

Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases

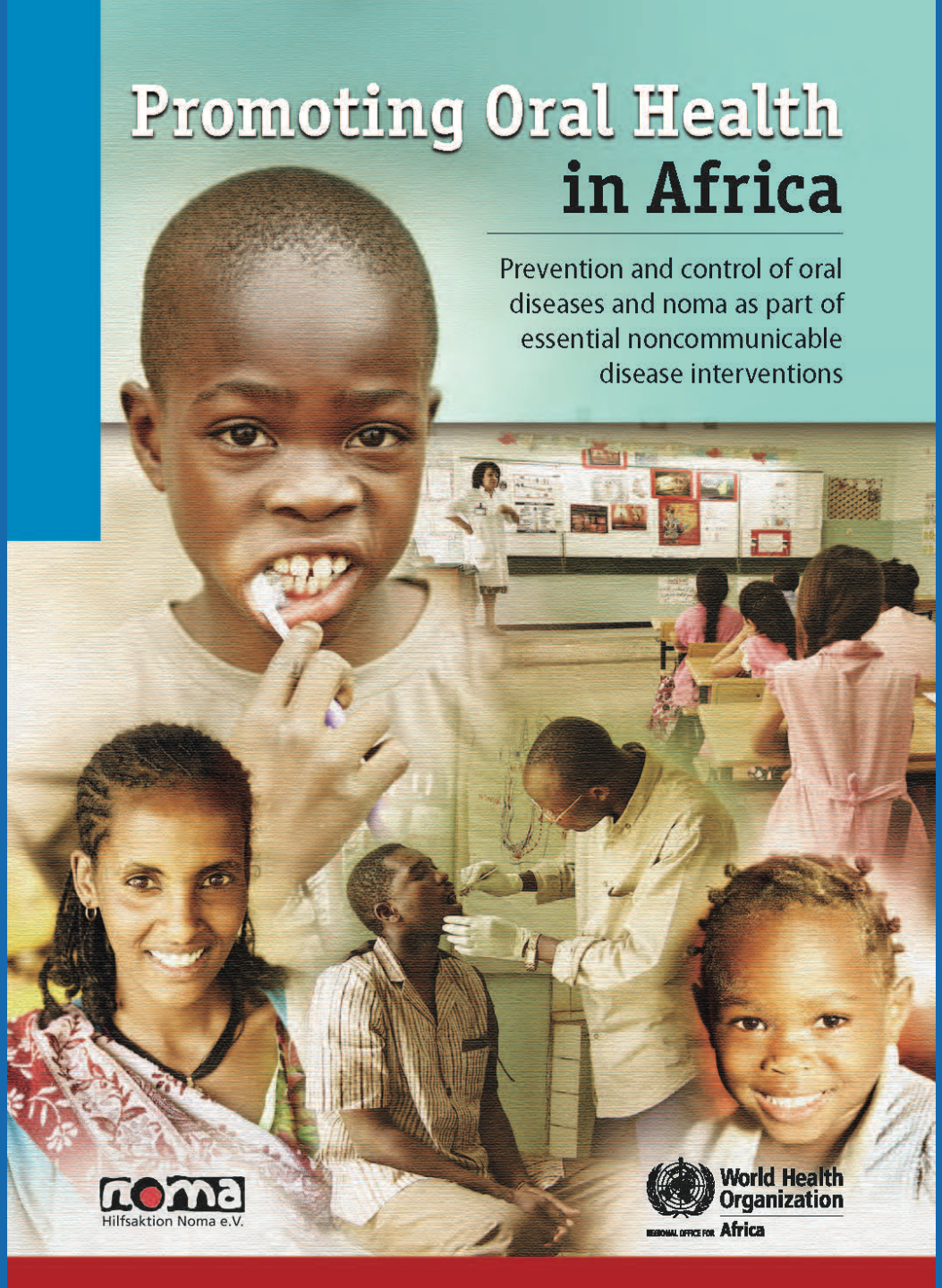
We, Heads of State and Government and representatives of States and Governments, assembled at the United Nations on 19 and 20 September 2011, to address the prevention and control of non-communicable diseases worldwide, with a particular focus on developmental and other challenges and social and economic impacts, particularly for developing countries,

1. Acknowledge that the global burden and threat of non-communicable diseases constitutes one of the major challenges for development in the twenty-first century, which undermines social and economic development throughout the world and threatens the achievement of internationally agreed development goals;

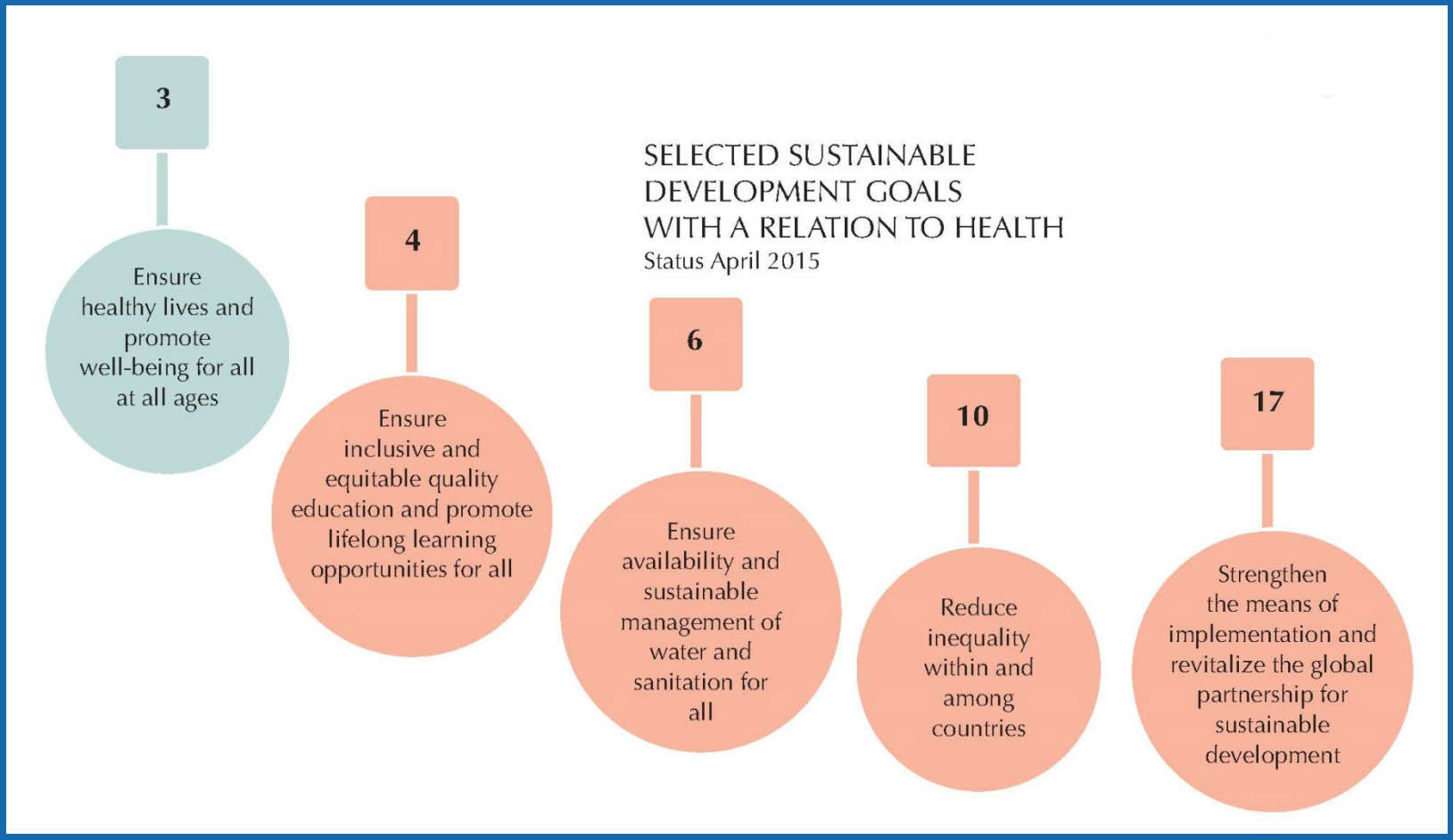
2. Recognize that non-communicable diseases are a threat to the economies of many Member States and may lead to increasing inequalities between countries and populations;

3. Recognize the primary role and responsibility of Governments in responding to the challenge of non-communicable diseases and the essential need for the efforts and engagement of all sectors of society to generate effective responses for the prevention and control of non-communicable diseases;

19. Recognize that renal, oral and eye diseases pose a major health burden for many countries and that these diseases share common risk factors and can benefit from common responses to non-communicable diseases;


Promoting Oral Health in Africa
Prevention and control of oral diseases and noma as part of essential noncommunicable disease interventions
noma
Hilfsaktion Noma e.V.
World Health Organization
REGIONAL OFFICE FOR Africa

SUSTAINABLE DEVELOPMENT GOALS AND HEALTH



Report finds U.S. not top-ranked for meeting U.N. goals

Sweden and other Scandinavian countries take top four spots

BY CHRIS MOONEY

In September, urged on by Pope Francis, the United Nations and its 193 member states embraced the most sweeping quest yet to, basically, save the world and everyone in it — dubbed the Sustainable Development Goals. It's a global agenda to fix climate change, stop hunger, end poverty, extend health and access to jobs, and vastly more — all by 2030.

The goals comprise no fewer than 17 items and 169 "targets." And this isn't just an airy exercise — the targets are quite specific ("By 2030, progressively achieve and sustain income growth of the bottom 40 per cent of the population at a rate higher than the national average"). That means that at least in many cases, countries can be measured on how they're faring in meeting these goals, based on a large range of sociological, economic and other indicators.

"In the global context, the idea that we should be both measuring and aiming for economic, social, and environmental goals simultaneously, a kind of triple bottom line, has become more and more a worldwide accepted idea," said Jeffrey Sachs, the Columbia University economist and U.N. adviser who has been closely involved in the goals and leads the Sustainable Development Solutions Network.

When it comes to sticking that "triple bottom line," not all countries are faring very well at the moment. That's the gist of a new report from Bertelsmann Stiftung, a large German foundation, and Sachs's Sustainable Development Solutions Network, which has ranked the countries of the world based on where they stand at the outset of trying to achieve these goals over the next decade and a half.

"What we've done in this report is a first scan of about 150 countries," Sachs said. "It's the first time anybody has taken a look across the world." There wasn't enough data, he said, to include all 193 countries that signed on to the goals.

Based on the data available, though, the report finds that Scandinavian countries — Sweden, Denmark, Norway, Finland — win top honors. Sweden was already "84.5 percent of the way to the best possible outcome across the 17 [Sustainable Development Goals]," the report found, ranking No. 1 in the world and receiving a corresponding score of 84.5. The other three Scandinavian nations then filled out the top four slots, followed by many European nations.

The United States, in contrast, ranked 25th, with a score of 72.7. It fared considerably worse than a comparable neighbor, Canada, which ranked 13th, with a score of 76.8.

In general, the report notes, poorer countries tended to fare worse in the rankings because sustainable development focuses so heavily on extending sustenance, health, advanced energy and infrastructure and much more to the world's billions. Indeed, the entire Sustainable Development Goals paradigm is based on the idea that richer countries will help poorer ones in achieving the goals.

The United States scored in the red, meaning "seriously far from achievement as of 2015," for 12 of 17 of the sustainable development goals, including "no poverty," "zero hunger," "gender equality" and "affordable and clean energy."

Still, the report also notes that "it is possible to be rich (high income) but with significant inequality and unsustainable environmental practices."

In fact, the United States scored in the red, meaning "seriously far from achievement as of 2015," for 12 of 17 of the sustainable development goals. Those goals were "no poverty," "zero hunger," "gender equality," "affordable and clean energy," "decent work and economic growth," "reduced inequalities," "responsible consumption and production," "climate action," "life below water," "life on land," "peace, justice and strong institutions," and "partnerships for the goals" (which involves establishing transnational collaborations to achieve them).

These poor rankings were doled out because (among other things) the United States has too many people below the poverty line, too much adult obesity, too little renewable energy, too many homicides and people in prison, and so on.

The report acknowledges that "some countries may be puzzled by their scores and that some will be unhappy with their place in the global rankings," promising "to correct errors and update the report as new data become available."

For Sachs, the poor score of the United States underscores that while the nation has done exceedingly well economically, it has neglected the social and the environmental dimensions of progress, including equality and ecosystem preservation.

"We've long been the richest big economy in the world, but it's pretty clear that something's really gone off the rails in our country, and it turns out that both the social indicators and the environmental indicators really show that that's the case," he said.

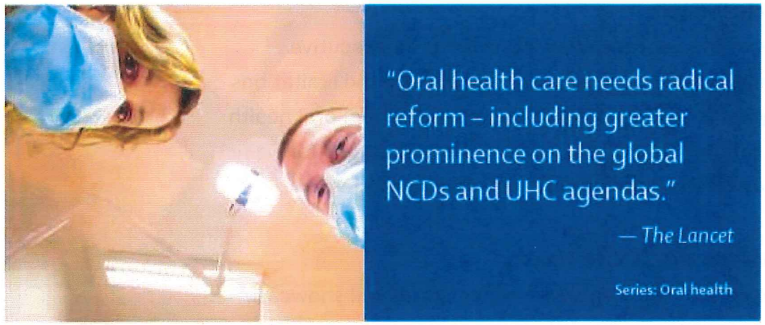
In contrast, the best-ranking country, Sweden, was in the red on only two indicators — "climate action" and "life on land," due to too many carbon dioxide emissions and too much deforestation. That was, in fact, a common theme. Amid an ongoing energy transition, even the four Scandinavian countries were rated as being in the red on climate action.

"The environment remains a challenge for everybody, which is why this basic question, can the world economy grow, and not destroy the planet, is still a question," Sachs said.

chris.mooney@washpost.com

www.sdgindex.org

UN High-level Meeting on Universal Health Coverage: Oral Health Side Event



THE LANCET

The best science for better lives

LEAVING NO ONE BEHIND:

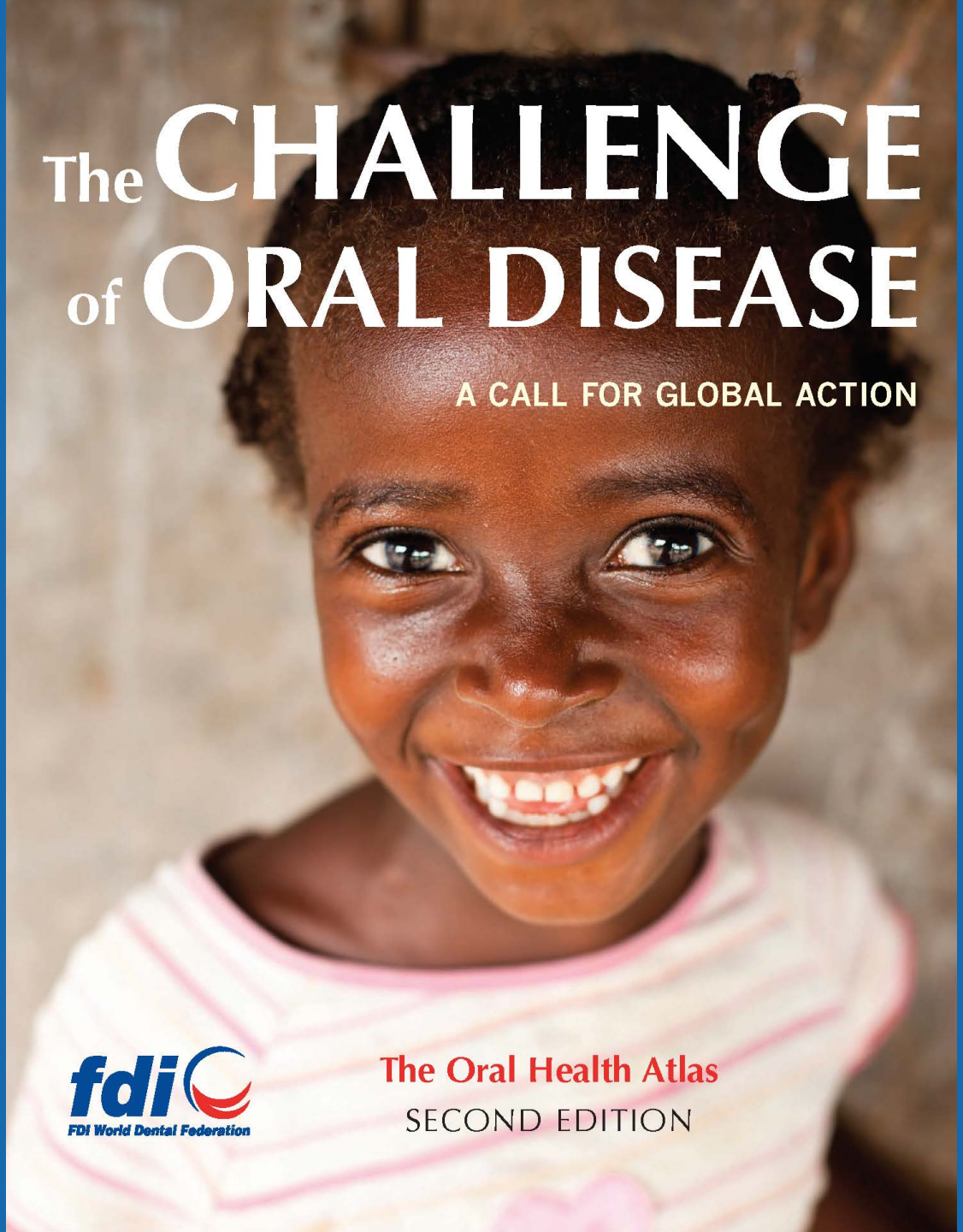
INTEGRATING UNIVERSAL HEALTH COVERAGE AND ESSENTIAL ORAL HEALTH CARE FOR ALL

Universal Health Coverage (UHC) is part of the Sustainable Development Goals (SDGs) and among the key health commitments of United Nations Member States. As part of the growing international momentum towards UHC, the United Nations General Assembly is staging the 1st High-level Meeting on UHC on 23 September 2019.

This provides a unique opportunity to accelerate global advocacy for oral health, knowledge sharing and translation of evidence into practice through a side event, jointly organized by the NYU College of Dentistry's WHO Collaborating Center for Quality-improvement, Evidence-based Dentistry and *The Lancet*, which published its first ever **Series on Oral Health** in July 2019, alerting the global health community to the largely unrecognized challenges of oral diseases worldwide.

The event will be co-sponsored by the governments of Egypt, Japan, and Thailand, as well as the World Economic Forum, and is supported by the Henry

dental.nyu.edu/faculty/epidemiology-health-promotion/who-cc/un-side-event.html


The CHALLENGE of ORAL DISEASE
A CALL FOR GLOBAL ACTION
fdi
FDI World Dental Federation
The Oral Health Atlas
SECOND EDITION

GLOBAL ORAL HEALTH MATTERS!

A movement is launched to advance population health through oral health

- La Cascada Declaration 2016
- *The Lancet* – Oral Health July 21, 2019
- WHO Briefing - Global oral health at the tipping point? December 5, 2019
- Lancet Commission on Global Oral Health

CONTENTS

LA CASCADA DECLARATION

DENTISTRY IN CRISIS: TIME TO CHANGE

LA CASCADA DECLARATION

We are concerned that the dental profession, worldwide, has lost its way.

We are a group of senior scientists—researchers, academics and intellectuals—from various parts of the world, with over 250 years' combined experience of working to improve the oral health of communities. The group is entirely independent of any institution, government body or corporate entity.

We met for a few days in March 2017 under the hospitality of Prof Emeritus Alfonso Escobar at his home in the Andes of Colombia, known as La Cascada

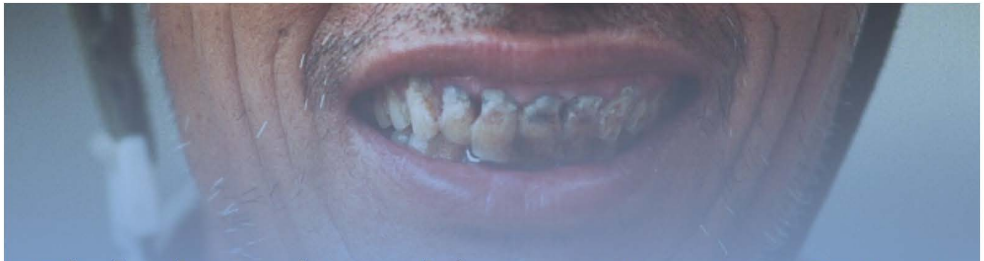
Previous: Preface

Next: Declaração de La Cascada

THE LANCET ORAL HEALTH SERIES

Key messages

- Why oral health has been neglected and need for radical reform
- Oral health must have a stronger place on global NCD agenda and UHC agenda, including primary health care
- Role of commercial determinants of disease, particularly dental caries
- Educate a future workforce that aligns with needs, rather than demand



Global Oral Health at a Tipping Point?

New Lancet Series highlighting the global neglect of oral health and the need for reform

Thursday 5 December 2019

Salle L10 | 12:00-14:00 | WHO HQ | Geneva

Organized by the Oral Health Programme, NCD Department, Universal Health Coverage/ Communicable and Noncommunicable Diseases Division

1 **CHERIAN V. VARGHESE**

Acting Director, Non-communicable Diseases, WHO HQ

The core of WHO's work on oral health (5min)

2 

JOCALYN CLARK

Public health scientist and Executive Editor, The Lancet, London

Introduction to the Lancet Series on Oral Health (5min)

3 

RICHARD WATT

Professor in Dental Public Health, University College London, Director WHO Collaborating Centre on Oral Health Inequalities and Public Health

Oral diseases: a global public health challenge (10min)

4 

BLANAID DALY

Professor in Dental Public Health and Consultant in Special Care Dentistry, Dublin Dental University Hospital, Trinity College, Dublin

Limitations of current dental health care systems (10 min)

5 

HABIB BENZIAN

Research Professor, Epidemiology & Health Promotion, Dental College, New York University, WHO Collaborating Center Quality Improvement & Evidence-based Dentistry

Strengthening global oral health policy & action - opportunities & way forward (10 min)

6 **GENERAL STATEMENTS**

Representatives from Permanent Missions of Japan, Malta, Netherlands, Sri Lanka and Sweden (3min each)

7 **QUESTIONS/ANSWERS**

Moderated discussion (30min)

World Health Organization

Join us for a discussion with key authors of

The Lancet Oral Health Series

on how effective oral health policies will reduce the burden of oral diseases and other NCDs and achieve UHC

Chaired by

Dr Ren Minghui

Assistant Director-General of Universal Health Coverage/Communicable and Noncommunicable Diseases Division

Refreshments and light lunch will be provided before the session

Commissions from the Lancet journals

Global Health Commissions

Showing: 1 - 45 of 45

A UNAIDS–Lancet Commission on Defeating AIDS—Advancing Global Health

Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission

Accelerating the elimination of viral hepatitis

Addressing liver disease in the UK: a blueprint for attaining excellence in health care and reducing premature mortality from lifestyle issues of excess consumption of alcohol, obesity, and viral hepatitis

Advancing global health and strengthening the HIV response in the era of the Sustainable Development Goals: the International AIDS Society—Lancet Commission

Alleviating the access abyss in palliative care and pain relief—an imperative of universal health coverage: the *Lancet* Commission report

Antibiotic resistance—the need for global solutions

Building a tuberculosis-free world: *The Lancet* Commission on tuberculosis

Challenges to effective cancer control in China, India, and Russia

Culture and health

Defeating Alzheimer's disease and other dementias

Delivering affordable cancer care in high-income countries

Diabetes in sub-Saharan Africa: from clinical care to health Policy

Drug-Resistant Tuberculosis

Essential Medicines

Food in the Anthropocene: the EAT–*Lancet* Commission on healthy diets from sustainable food systems

Global cancer surgery

Global health 2035: a world converging within a generation

High-quality health systems in the Sustainable Development Goals era: time for a revolution

Household Air Pollution Commission

International Society of Nephrology's 0by25 initiative for acute kidney injury

Liver diseases in the Asia-Pacific region: a Lancet Gastroenterology & Hepatology Commission

Medical education for the 21st century

Our future: a Lancet commission on adolescent health and wellbeing

Planning cancer control in Latin America and the Caribbean

Psychological treatments research in tomorrow's science

Safeguarding human health in the Anthropocene epoch: report of The Rockefeller Foundation–Lancet Commission on planetary health

Sepsis: a roadmap for future research

Sexually transmitted infections: challenges ahead

Shaping Cities for Health: Complexity and the Planning of Urban Environments in the 21st Century

Syria: Health in Conflict

Technologies for Global Health

The future of cystic fibrosis care: a global perspective

The Global Syndemic of Obesity, Undernutrition, and Climate Change: The Lancet Commission report

The Lancet Commission on global mental health and sustainable development

The Lancet Commission on Global Surgery

The Lancet Commission on pollution and health

The Lancet—University of Oslo Commission on Global Governance for Health

The legal determinants of health: harnessing the power of law for global health and sustainable development

The Millennium Development Goals: a cross-sectoral analysis and principles for goal setting

The path to longer and healthier lives for all Africans by 2030: the Lancet Commission on the future of health in sub-Saharan Africa

The Tsinghua-Lancet Commission on Healthy Cities in China: unlocking the power of cities for a healthy China

The UCL–Lancet Commission on Migration and Health: the health of a world on the move

Traumatic brain injury: integrated approaches to improve prevention, clinical care, and research

Women and Health: the key for sustainable development

Health and Climate Change

Health and climate change: policy responses to protect public health

Managing the health effects of climate change: and University College London Institute for Global Health Commission

CHALLENGES: GLOBAL VILLAGE OF IDEAS NEEDED!

- National platforms for discourse and debate
- Declines in wellness and increases in disparities
- Global food insecurities and declining nutrition
- Workforce focused on surgical interventions over prevention and needs assessment
- Siloed health care
- Slow progress on interprofessional education and collaborative integrated care
- Research on systems of other countries, components of which may assist our own system
- Reciprocity of learning globally
- Move from mainstreaming to transformation which is the essence of social movement

Commentary

Guest Editorial

Our dental care system is stuck

And here is what to do about it

Marko Vujicic, PhD

In 1926, the work of William Gies[1] helped chart a new course for dentistry. I think we are approaching another "Gies" moment in which the dental community must face some hard facts and ask itself how effectively the current system is improving the oral health of the American public. In my view, the current dental care delivery and financing model will not drive significant, sustained improvements in oral health going forward like it did in the past, particularly for key segments of the population. We are stuck. And the changes needed to get unstuck are not tweaks, but major reforms.

Let us first look at some important trends. Dental care use is rising among low-income and minority children,[2] and racial and economic disparities are narrowing.[3] Dental care use among seniors is also on the rise. However, unlike for children, high-income seniors are driving this trend, meaning i[illegible]ctu[illegible]. For adults (tho[illegible]) de[illegible] has been fairly flat for several years.[2] Cost is, by far, the top reason adults avoid going to the dentist.[4] But despite steady reductions in cost barriers to dental care for adults in recent years,[5] there has been no appreciable bounce back in utilization. Looking forward, demand for dental care among working-aged adults (the engine of the dental economy) will continue to be sluggish, especially for restorative care.[6,7] In my view, the dental sector is in a low-level equilibrium. We will not see major expansions in dental care use and sustained improvements in oral health in the coming years, especially among those with the highest needs, under the status quo model. The dental care system needs major reforms in 4 areas (Box).

What can be done??

[illegible] major expansions in dental care use and sustained improvements in oral health in the coming years, especially among those with the highest needs, under the status quo model. The dental care system needs major reforms.

First, we need to address the dental coverage gap. Only 10% of US children lack dental coverage, a rate that has steadily declined for decades.[8] However, a significant share of adults and most seniors lack dental coverage. Affordability issues are, by far, the top reason adults and seniors do not visit a dentist. Despite its major shortcomings,[9] dental coverage still drives dental care use.[10] The idea that demand for dental care can be stimulated by

Integratin into Dent Approach

Emily Sabato, EdD; DrPH, MSW; Sange

Abstract: Approaching patie but also psychosocial history inclusive education, includir social determinants of health level, work opportunities, liv be woven throughout dental situations rather than be limi into dental education and illu including how to weave soci for curricular innovation and

Dr. Sabato is Assistant Dean Director, Department of Peri Assistant Dean for Educatio Assistant to the Dean for Int is Associate Dean for Educa Associate Professor, Rutgers Medicine, 110 Bergen Street

Keywords: dental education, interprofessional education

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Consider this scen year-old homele passed out on the out a coat. Emergency res of alcohol, incoherent, h jaw, and moaning with sional team meets her at does the team need to c and care?

In this age of sw change in technology,

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COMMENTARY

WILEY

Renovating dental education: A public health issue

S. Tubert-Jeannin[1] | D. Jourdan[2]

[1]Centre de Recherche en Odontologie Clinique, Dental School, CROC-EA4847, Université Clermont Auvergne, Clermont-Ferrand, France

[2]Laboratoire Activité, Connaissance, Transmission, Education, ACTE- EA4281, School of Education, Université Clermont Auvergne, Clermont-Ferrand, France

Correspondence
Stéphanie Tubert-Jeannin, Faculté de chirurgie dentaire, Clermont-Ferrand, France.
Email: stephanie.tubert@uca.fr

KEYWORDS: dental education, oral health, teaching strategies

1 | INTRODUCTION

Oral health is a very real concern in Europe, particularly for the most vulnerable people, and accessibility to dental care is increasingly coming under discussion. Oral health inequalities are present from childhood.[1] At all ages, untreated dental diseases and impaired oral health impact on people's overall health with functional, but also psychological and social consequences, which are often underestimated.[2]

Within this context, the question of dental education is central. The way health professionals are trained has a public health impact because it partly determines the appropriateness, quality and efficiency of the treatment and preventive services available to the population.[3] Dental faculties thus have a social responsibility, and need to prioritise educational and research activities relating to the current and future health needs of society.[4]

With the mutual recognition of qualifications, the promotion of

2 | THE CURRENT SITUATION OF DENTAL EDUCATION

2.1 | Classic curricula with successive periods of learning

In many places, dentists' training classically involves academic teaching followed by periods of clinical traineeship in hospitals, dental clinics or professional settings. The pre-clinical stage includes academic courses associated with practical exercises on phantom heads. During the clinical phase, students first assist more experienced practitioners, then carry out dental treatment on patients, in the presence of senior professionals. A 2016 ADEE (Association for Dental Education in Europe) survey found that, within a 5-year curriculum, students generally start treating patients in their 3rd year. Only a quarter of dental programmes seem to organise early contact with patients in the first or second year of study.[5] Dental training is also carried out mainly with a single-discipline approach. Only 15% of European dental faculties

ntistry in

arning outcomes of "The tistry in Society. In addi- cus on promoting health, es of care at community population demography g health. A Dentist must he context of the health-

raduate

ctual influences: social, polit- heir influence on populations st be capable of promoting munity, and that of the wider

e dental undergraduate cur- ental Health," "Dental Public nay, in turn, be delivered by t not exclusively) Restorative Periodontics, Endodontics, ric Dentistry, Oral Medicine,

Teaching the Social Determinants of Health: A Path to Equity or a Road to Nowhere?

Malika Sharma, MD, MEd, Andrew D. Pinto, MD, MSc, and Arno K. Kumagai, MD

Abstract

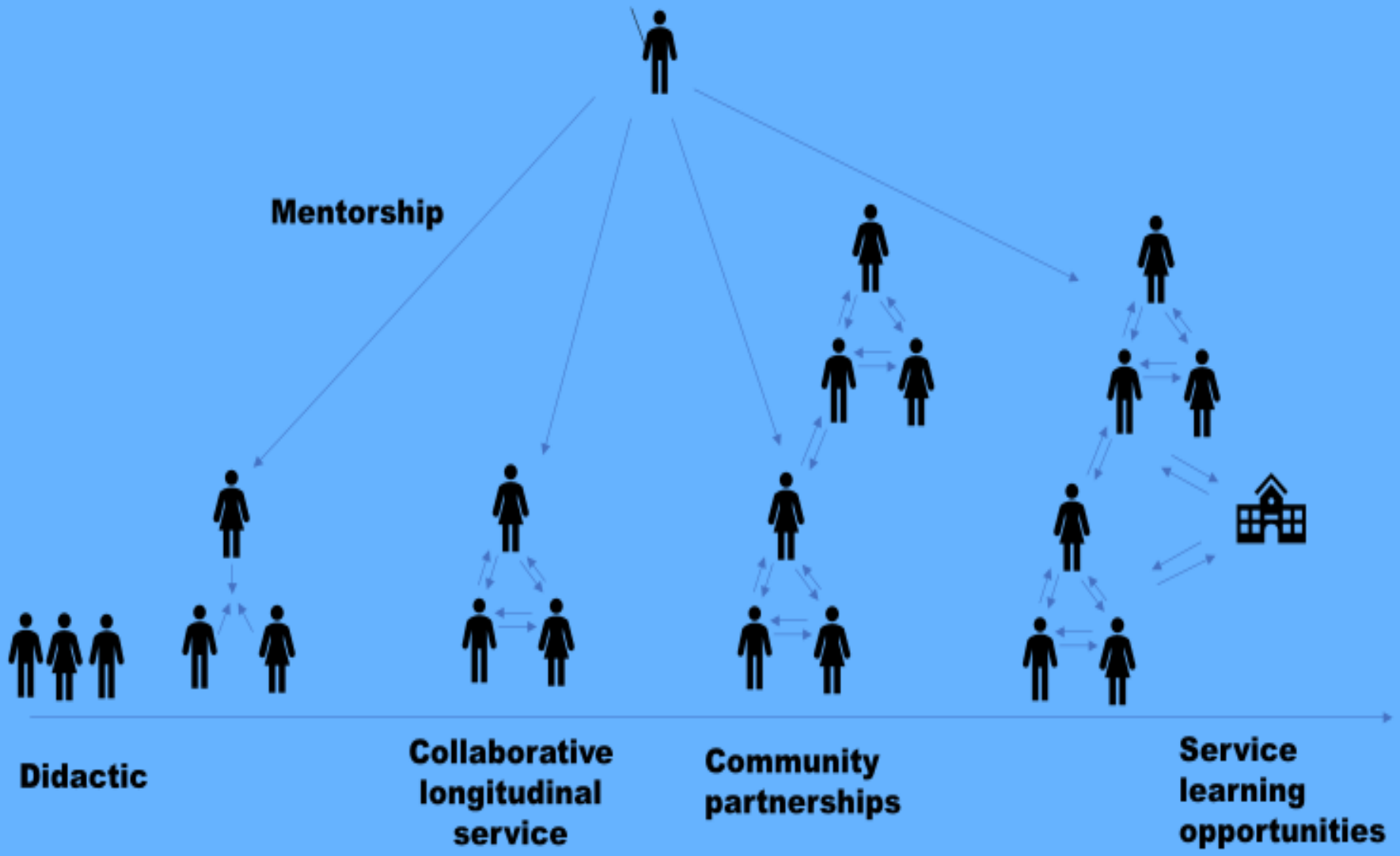
Medical schools are increasingly called to include social responsibility in their mandates. As such, they are focusing their attention on the social determinants of health (SDOH) as key drivers in the health of the patients and communities they serve. However, underlying this emphasis on the SDOH is the assumption that teaching medical students *about* the SDOH will lead future physicians to take *action* to help achieve health equity. There is little evidence to support this belief. In many ways, the current approach to the SDOH within medical education positions them as "facts to be known" rather than as "conditions to be challenged and changed." Educators talk about poverty but not oppression, race but not racism, sex but not sexism, and homosexuality but not homophobia. The current approach to the SDOH may constrain or even incapacitate the ability of medical education to achieve the very goals it lauds, and in fact perpetuate inequity. In this article, the authors explore how "critical consciousness" and a recentering of the SDOH around justice and inequity can be used to deepen collective understanding of power, privilege, and the inequities embedded in social relationships in order to foster an active commitment to social justice among medical trainees. Rather than calling for minor curricular modifications, the authors argue that major structural and cultural transformations within medical education need to occur to make educational institutions truly socially responsible.

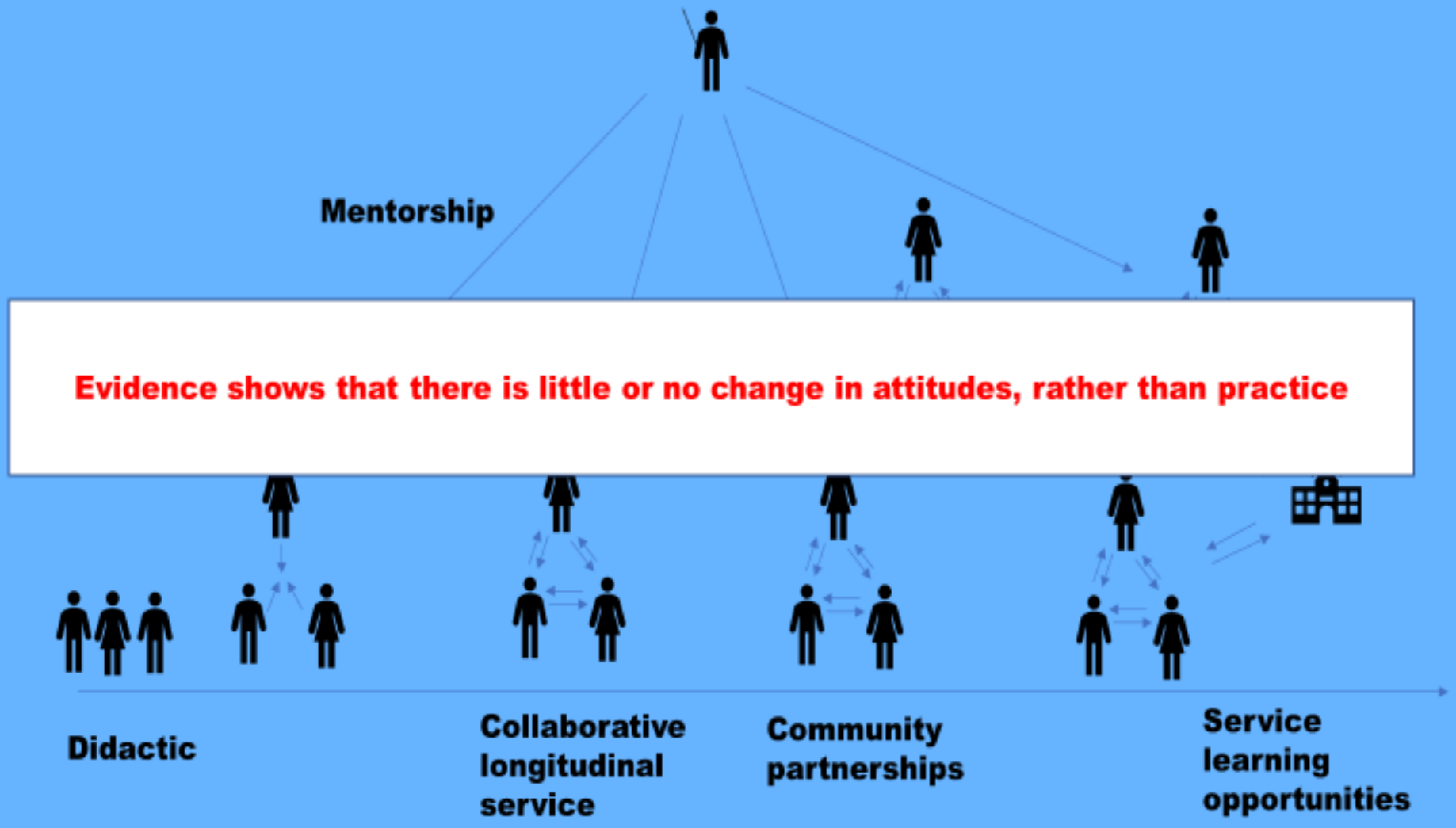
Year after year, black mothers bury sons who die in police custody, young undocumented women develop preventable invasive cervical cancer, and blue-collar workers struggle to return

of heart disease, and cancer deaths spread unevenly across our populations? Why do some people with diabetes have their disease under control while others progress toward lower limb amputation,

Understanding the SDOH

The SDOH are defined by the World Health Organization as the conditions in and under which people are born, grow, work, and live, and the broader


Mentorship
Didactic
Collaborative longitudinal service
Community partnerships
Service learning opportunities


Mentorship
Evidence shows that there is little or no change in attitudes, rather than practice
Didactic
Collaborative longitudinal service
Community partnerships
Service learning opportunities

WHAT CAN BE DONE?

- Change dental curriculum to include SDOH
- Incorporate SDOH into electronic health records
- Emphasize interprofessional education
- Modify accreditation standards
- Modify licensing

WHAT CAN BE DONE?

- Change reimbursement incentives
- Create and sustain collaborative workforce teams
- Broad collaboration between and among all sectors of society
- Accelerate knowledge

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