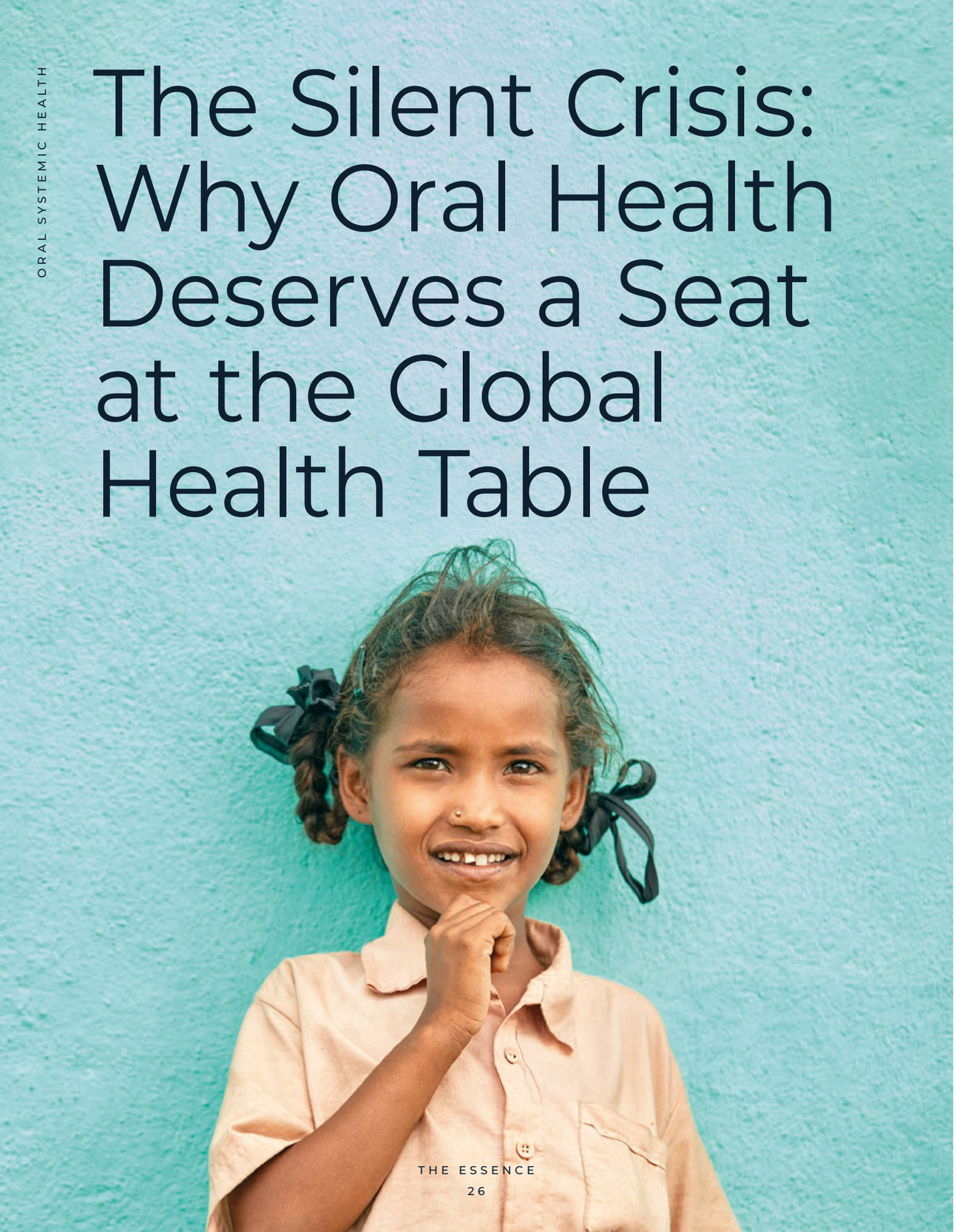
The Silent Crisis: Why Oral Health Deserves a Seat at the Global Health Table



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Oral health has long been neglected in global health discussions, despite its profound impact on billions of lives worldwide. With inequalities stark and preventable diseases rampant, the time has come to shift from neglect to action, integrating oral health into universal health coverage and making it a cornerstone of global health equity. Our author describes in his article the neglect of global oral health and delivers symptoms, root causes and possible solutions.



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Despite decades of growing scientific evidence and continued advocacy, oral health remains one of the most neglected areas of global health. With more than 3.6 billion people affected, oral diseases are the most prevalent non-communicable diseases (NCDs) worldwide.[1] They are also largely preventable, yet oftentimes left untreated, let alone systematically addressed. There is no other NCD with comparable numbers of untreated cases.

The global divide is stark: while affluent populations enjoy access to the full range of high-cost, high-tech dental care – often cosmetic and elective – billions of people around the world lack even the most basic oral health services. In many countries, oral health is excluded from Universal Health Coverage (UHC) schemes, marginalized in health planning, and financed largely through private out-of-pocket payments, creating major barriers to access.

This paradox – a massive disease burden, high overall spending, and limited population-level access – continues to plague health systems across high-, middle-, and low-income countries alike. The result is a reality of oral healthcare that serves the few, while neglecting the many.

This persistent neglect is not due to a lack of evidence or technical solutions. It reflects the consequences of fragmented systems, misguided policy priorities, and a global health architecture that has long tolerated, if not normalized, profound disparities in oral health.

A global disease burden – massive, preventable, and unjust

Oral diseases, including untreated dental caries, severe periodontal disease, tooth loss, oral cancers, rank among the most common conditions in the world. According to the WHO Global Oral Health Status Report 2022 and using estimates from 2019, more than 3.5 billion people live with untreated oral diseases. Dental caries of permanent

teeth alone affects 2.5 billion individuals, while an estimated 1 billion suffer from severe periodontal disease.[2,3] Since then, updated estimates for 2021 increased the number of cases of oral disease to almost 3.7 billion.[1]

Children are not spared. In many countries, tooth decay is the leading cause of chronic illness among children, leading to pain, missed school days, and long-term consequences for growth and development. Among adults, oral diseases reduce employability, quality of life, and self-esteem. Among older persons, tooth loss and poor oral function affect nutrition, speech, and mental health – especially in settings where rehabilitative care is unaffordable or unavailable.

The burden is highest in low- and middle-income countries (LMICs), where access to prevention and care is limited. But even in high-income settings, the distribution of oral diseases mirrors broader patterns of inequality: poverty, social exclusion, and limited access to care compound the effects of poor oral health. The global divide plays out not only in availability of services, but in lived experiences of pain, stigma, and neglect.[4]

Oral diseases are the most prevalent noncommunicable diseases (NCDs) worldwide.

What's more, the burden is intergenerational. Parents with poor oral health often pass on risk factors, habits, and vulnerabilities to their children, creating a vicious cycle of disease and disadvantage. Oral diseases may not rank high on mortality charts, but they cause extensive pain, suffering, stigma, and disability; and they interact with other chronic diseases and general health in complex, harmful ways.[5,6]

A cost spiral: High spending, low equity, poor outcomes

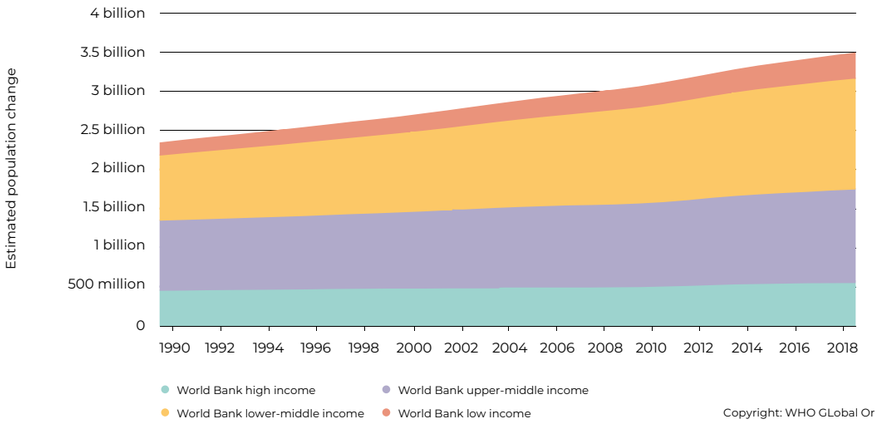
One of the most sobering features of global oral health is not only how much we fail to treat, but also how much we spend, and how little impact that spending has.

Estimates suggest that close to USD 390 billion are spent globally every year on oral health care, making it one of the most expensive disease categories. However, this figure is deceptive: the vast majority of this expenditure occurs in high-income countries and goes toward restorative or high-tech dental services – fillings, crowns, implants, and cosmetic procedures.[7]

Prevention, on the other hand, receives a tiny fraction of resources. Community-based programs like school toothbrushing or sugar reduction policies are

FIGURE 1

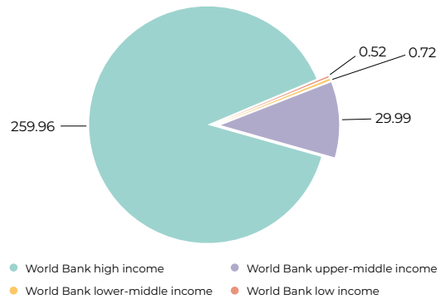
Estimated case numbers of the major oral diseases combined between 1990 and 2019 per WB country income group (excluding lip/oral cavity cancer)



Copyright: WHO GLobal Oral Health Status Report (2022)

FIGURE 2

Per capita direct dental expenditure in US$ per WB country income group (2019)



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underfunded or absent in most health systems. Worse still, oral health is predominantly financed through out-of-pocket (OOP) spending – more than any other area of healthcare. Across countries and income levels, oral health consistently ranks as the health sector with the highest share of private expenditure.[8–10]

This global divide in oral healthcare financing is especially harmful. In LMICs, even a simple tooth extraction may be unaffordable for many households. In high-income countries, those without dental insurance often face the choice between foregoing dental care or financial hardship. Meanwhile, those who are able and willing to pay have access to advanced treatments, often disconnected from actual health needs. This model violates the very principles of UHC and health equity.

At the same time, it appears that the burden of oral diseases has not markedly changed over the last 35 years. As Bernabé et al. state in the most recent publication of the global oral disease burden estimates: "The results show that insufficient action over the past three decades has led to little change in population oral health; without future sizeable and impactful action, this trend is likely to continue."[1]

Oral health has waited too long in the shadows of global health.

Structural causes of neglect: Why oral health stays marginal

The roots of this neglect run deep. Among the many reasons that contribute to the current state of global oral health, a few stand out as particularly impactful. First, there is a historical and institutional divide. Dentistry evolved as a separate profession, with its own training, infrastructure, and financing mechanisms, often outside the public health system. Integration in primary health care is limited. In most countries, dental care is almost exclusively provided through private providers and is considered an "optional" service rather than a core component of healthcare.[11]

Second, commercial determinants, especially the global sugar industry, continue to shape risk environments that promote oral diseases. Sugar consumption is a primary cause of dental caries, yet regulation is weak and often undermined or even resisted by powerful interests of the food and beverage industries and their allies who apply strategies similar to the tobacco industry to change the public discourse.[12] Public policies to reduce sugar intake, such as taxes, advertising restrictions, or front-of-pack labelling, as well as measures to reduce the negative health impacts of ultra-processed foods, remain politically contested and take time to gain traction.[13–15]

Third, political invisibility and lack of leadership have kept oral health off the global health agenda for decades. There has been no major donor investment, no vertical initiative, and no strong integration with NCD strategies. Oral health has lacked the institutional champions and advocacy networks that have helped drive progress in areas like HIV, maternal health, or immunization.[16–18]

Fourth, and perhaps most insidious, is the cultural perception that oral health is a personal matter, a question of hygiene, behaviour, and individual responsibility. This perception fosters the notion that public investments to control oral diseases are not justified and reinforces a private market approach that exacerbates inequality.

The turning point: From neglect to global commitment

Yet, for the first time in decades, global oral health may be at a turning point. One of the watershed moments came in 2019, when *The Lancet* published its groundbreaking Series on Oral Health, for the first time placing oral diseases on the agenda of one of the most influential medical journals.[19] The Series provided a stark critique of the global state of oral health, describing it as a "global public health failure" and exposing how

deeply inequities, commercial determinants, and systemic neglect shape outcomes across countries. It called for a paradigm shift: from treatment to prevention, from fragmentation to integration, and from commercial exploitation to public accountability.

The *Lancet* Series served as a wake-up call and laid the intellectual and policy foundations for renewed engagement from global health leaders, including the World Health Organization (WHO). Acknowledging the absence of oral health in global health discourses, the World Health Assembly in 2021 adopted a landmark resolution on oral health, the first in over 15 years.[20,21] This was followed by the development of the WHO Global Oral Health Strategy (2022), a bold document that recognizes oral health as integral to overall health and essential to achieving UHC. The Strategy outlines a vision for embedding oral health within national health systems, emphasizing prevention, primary care integration, and addressing commercial determinants. Building on this, the Global Oral Health Action Plan (2023–2030) was endorsed by WHO Member States.[22] It provides concrete targets and milestones for action at national and global levels, including universal access to oral health services by 2030, integration of oral health in UHC benefit packages, and reduction of the burden of oral diseases. For the first time in the history of global oral health, there is now a global monitoring framework and a defined path forward for tangible improvements.

This new momentum was reaffirmed at the first-ever WHO Global Oral Health Meeting in Bangkok in December 2024, where delegations from more than 100 countries gathered to discuss implementation progress of the Global Oral Health Action Plan. A key outcome was the *Bangkok Declaration: Towards Universal Health Coverage for Oral Health by 2030*, which emphasizes the core principle that "there is no health without oral health."[23] The Declaration calls on countries to translate commitments into national plans, to invest in prevention and service integration, and to hold themselves accountable for progress.

The adoption of the Bangkok Declaration was a moment of unprecedented consensus. But turning this consensus into real impact will require sustained political attention, cross-sectoral collaboration, and courageous leadership at all levels, from global actors to national ministries to frontline health workers and empowered communities.

Solutions that work: From evidence to action

What must change? First, oral health must be integrated into primary health care systems. This means that preventive, diagnostic, and essential oral healthcare services are available where people live and work, especially in community clinics, schools and workplaces, and underserved areas.

Second, we need robust public health approaches. Policies to control and reduce risks, like sugar taxes or tobacco control policies, combined with measures to improve access to fluorides, preventive interventions and health promotion campaigns must become standard features of national NCD strategies. Oral health must be visibly included and adequately addressed in health budgets, national plans, and accountability frameworks.

Third, workforce reform is essential. Task-shifting models, training of non-dental health professionals in basic oral health, and expansion of mid-level oral health providers can increase access and coverage in resource-constrained settings.

Fourth, financing must be restructured. Oral health services should be part of essential benefit packages in UHC systems and available without financial hardship. Relying on out-of-pocket payment is incompatible with equity and sustainability, particularly in LMICs.

Finally, we must build advocacy coalitions – across sectors, professions, and communities – to make oral health a political priority and ensure that the global divide in oral health does not deepen further.

A call to action: From recognition to reform

Oral health has waited too long in the shadows of global health. The burden is vast, the inequalities are stark, and the economic costs are significant. We can no longer afford to treat the mouth as separate from the body – or dental care as separate from health care.

The momentum is here: *The Lancet* Series lit the fuse, WHO has taken unprecedented steps, and countries have declared their intention to act. But declarations alone will not relieve pain, close gaps, or stop decay. Reform requires bold policy change, adequate financing, meaningful accountability, and the moral clarity to treat oral health as a right, not a privilege. Oral health is not cosmetic. It is not optional. It is not the concern of the privileged few.

It is a matter of justice, a test of our commitment to UHC, and a measure of whether our health systems truly serve people. There is no health without oral health.

Yet this call to action comes at a precarious time. The global health landscape is under increasing strain. A climate of insecurity, austerity, and shifting political priorities is sweeping across donor and domestic budgets alike. Development assistance is being reduced, multilateral institutions face tightening fiscal space, and national health systems are being forced to make difficult decisions about what services to prioritize, or sacrifice.

In this climate, oral health is at risk of once again being sidelined, deemed too costly, too specialized, or not "essential enough." The danger is that hard-won progress made in recent years could unravel just as implementation begins, especially in countries already facing severe health system constraints.

That makes it even more important to keep the momentum alive, and the voice for oral health loud and unified. Professional associations, advocates, policymakers, and the public must all play a role in ensuring that oral health remains visible, funded, and protected from the rollback of essential services.

A crucial moment is on the horizon: the 4th United Nations High-Level Meeting on Noncommunicable Diseases in September 2025.[24] This summit of heads of state and ministers from all 194 member states of the United Nations will review global progress on NCDs and UHC and define the path toward 2030 and beyond. It is an opportunity to reinforce oral health as a core component of NCD prevention and control and to solidify its place within future global health commitments.[25]

By that time, the aspirations of the WHO Global Oral Health Action Plan to provide essential oral health services for all must no longer be aspirations alone. There must be tangible progress in national policy, funded priorities, and measurable realities.

This is the moment to turn commitments into action, declarations into delivery of care, and promises into protection for all. We know what needs to be done. Now we must do it, with urgency, equity, and resolve. Because the mouth is not separate from the body. And people cannot wait any longer.

"We commit to ensuring essential oral health services are accessible, affordable and acceptable for all, without financial hardship."

A key statement of the Bangkok Declaration on Oral Health.

References

1. Bernabé E, Marcenes W, Abdulkader RS, Abreu LG, Afzal S, Alhalaiqa FN et al. Trends in the global, regional, and national burden of oral conditions from 1990 to 2021: a systematic analysis for the Global Burden of Disease Study 2021. The Lancet. 2025;405(10482):897-910.
2. World Health Organization (WHO). Global Oral Health Status Report - Towards Universal Health Coverage for Oral Health 2030. Available at: https://www.who.int/team/noncommunicable-diseases/global-status-report-on-oral-health-2022. Geneva: WHO; 2022
3. Benzian H, Watt R, Makino Y, Stauf N, Varenne B. WHO calls to end the global crisis of oral health. The Lancet. 2022;400(10367):1909-1910.
4. Kearns C, Taylor G, Oberoi S, Mertz E. Dominant power and the concept of caste: Implications for dentistry and oral health inequality. Community Dent Health. 2022;39(2):137-142.
5. Peres MA, Macpherson LMD, Weyant RJ, Daly B, Venturelli R, Mathur M, Listl S, Celeste RK, Guarnizo-Herreño C, Kearns C, Benzian H, Allison P, Watt RG. Oral diseases: a global public health challenge. Lancet. 2019;394:249-260.
6. Seitz MW, Listl S, Bartols A, Schubert I, Blaschke K, Haux C, Van Der Zande MM. Current knowledge on correlations between highly prevalent dental conditions and chronic diseases: An umbrella review. Prev Chronic Dis. 2019;16:E132.
7. Jevdjevic M, Listl S. Global, regional, and country-level economic impacts of oral conditions in 2019. Journal of Dental Research. 2025;104(1):17-21.
8. Benzian H, Schwendicke F. Economic considerations in oral health: Bridging gaps, broadening horizons. J Dent Res. 2024;103(12):1165-1166.
9. Bernabé E, Masood M, Vujicic M. The impact of out-of-pocket payments for dental care on household finances in low and middle income countries. BMC Public Health. 2017;17(1):109.
10. Winkelmann J, Gómez Rossi J, van Ginneken E. Oral health care in Europe: Financing, access and provision. Health Systems in Transition. Copenhagen: European Observatory on Health Systems and Policies, WHO; 2022
11. Watt RG, Daly B, Allison P, Macpherson LMD, Venturelli R, Listl S, Weyant RJ, Mathur M, Guarnizo-Herreño C, Celeste RK, Peres MA, Kearns C, Benzian H. Ending the neglect of global oral health – time for radical action. Lancet. 2019;394:261-272.
12. Kearns CE, Watt RG. Transnational corporations and oral health: examples from the sugar industry. Community Dent Health. 2019;36(2):157-162.
13. Global report on the use of sugar-sweetened beverage taxes 2023. Available from: https://www.who.int/publications/i/item/9789240084995. Geneva: World Health Organization (WHO);
14. Abbas H, Guarnizo-Herreño CC, El Tantawi M, Tsakos G, Peres MA. Challenges and way forward for implementation of sugar taxation in the Middle East and North Africa (MENA). Community Dent Oral Epidemiol. 2024;52(4):375-380.
15. Benzian H, Naidoo S, Wen Ng S. Beyond sugar-sweetened beverages: Tackling oral health risks of ultraprocessed foods. J Am Dent Ass. 2025;156(3):257-260.
16. Benzian H, Hobdell M, Holmgren C, Yee R, Monse B, Barnard JT, van Palenstein Helderman W. Political priority of global oral health: an analysis of reasons for international neglect. Int Dent J. 2011;61(3):124-130.
17. McAuliffe Ú, Whelton H, Harding M, Burke S. 'Toothless'-the absence of political priority for oral health: a case study of Ireland 1994-2021. BMC Oral Health. 2022;22(1):95.
18. Janakiram C, Sanjeevan V, BR R, Joseph J, Stauf N, Benzian H. Political priority of oral health in India: analysis of the reasons for neglect. Journal of Public Health Dent. 2018;78(2):144-153.
19. Oral health at a tipping point (Editorial). The Lancet. 2019;394:188.
20. World Health Organization (WHO). Oral Health. World Health Assembly Resolution WHA74/A74.R5 (31 May 2021) Available from: https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_R5-en.pdf.
21. Benzian H, Beltrán-Aguilar E. The return of oral health to global health is significant for public health everywhere. Journal of Public Health Dentistry. 2021;81(2):87-89.
22. World Health Organization (WHO). Global strategy and action plan on oral health 2023-2030. Available from: https://www.who.int/publications/i/item/9789240090538.
23. Bangkok Declaration – No Health without Oral Health. Towards Universal Health Coverage for oral health by 2030. Adopted 29 November 2024. Available from: https://cdn.who.int/media/docs/default-source/ncds/mnd/oral-health/bangkok-declaration-oral-health.pdf.
24. Alleyne G, Coll-Seck AM, Frieden TR, Tufton C. Fourth time a charm? How to make the UN High-Level Meeting on Noncommunicable Diseases effective. JAMA. 2025 (online first 10 Feb 2025)
25. Winkelmann J, Listl S, van Ginneken E, Vassallo P, Benzian H. Universal health coverage cannot be universal without oral health. Lancet Public Health. 2023;8(1):e8-e10.

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