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LETTER TO EDITOR

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Integrating Oral Health into the Core of Public Health

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Dear Editor,

Oral diseases affect 3.5 billion people [1]. Approximately 2.5 billion people suffer from untreated dental caries [2]; while severe periodontitis affects another 1 billion [3]. These are not just minor tooth issues that only dentists worry about —they are the most prevalent non-communicable diseases (NCDs) worldwide. We can flip through most national NCD strategies, and will find oral health buried in an annex, if it appears at all. This gap is increasingly difficult to justify in light of current epidemiological evidence.

The economic burden further strengthens this argument. The treatment of dental caries imposes substantial economic costs. From over $10 billion annually in Italy to $36.2 billion in Brazil—and those figures skew heavily toward the poorest populations [4]. Globally, the direct treatment bill for caries, periodontitis, and major tooth loss sits at roughly $357 billion [5]. That is not a side issue; that is an outflow of health-system resources. These expenditures are largely attributable to diseases that are substantially preventable. Diseases that are overwhelmingly avoidable [6].

The traditional infectious-disease model of dental caries is increasingly considered insufficient. Giacaman et al. [7] have shown convincingly that we must treat caries as a behavioral NCD that is driven by sugar, tobacco, and lifestyle, not just bacteria. But here is the rub: if we accept that framing, we have to accept the policy implications. That means sugar taxes, advertising restrictions, and fluoridation must sit alongside tobacco and alcohol control in every national NCD action plan. The WHO's Global Oral Health Action Plan (2023–2030) [8] emphasizes this explicitly. The FDI now backs it [9,10]. The evidence is robust.

Despite this evidence, implementation remains limited?

The WHO Bangkok meeting report [11] calls for integration, but "calls" are not enough. What we actually see is a persistent institutional silo—dentistry is still treated as a clinical specialty rather than a core public health lever. Benzian et al. [12] proposed expanding the NCD framework to a 6x6 model explicitly including oral diseases and sugar. I agree with them entirely, but I would go further: unless oral health metrics are embedded in routine NCD surveillance—right next to hypertension and diabetes—this integration will remain just verbal.

Prevention produces better economic returns than late-stage treatment. Nguyen et al. [13] systematic review confirms this. Despite this evidence most national budgets still pour money into fillings and extractions rather than upstream measures. This pattern suggests that policy priorities remain weighted toward treatment rather than prevention.

I would strongly encourage the journal to use this upcoming thematic issue as an opportunity to formally integrate oral diseases into the NCD prevention framework. Without this inclusion, the issue risks overlooking the most prevalent NCDs globally—and that would be a missed opportunity for the field. The epidemiological evidence—affecting 3.5 billion people—makes a strong case for treating oral health as a standard NCD indicator. This issue could advance the field considerably by taking that step. The WHO frameworks already support it, and the data are robust enough to act upon.

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