Global oral health policy implementation: A narrative review of the World Health Organization's Strategic action plan 2023–2030

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ABSTRACT

The World Health Organization's Global Oral Health Action Plan (GOHAP) 2023–2030 marks a significant shift in global oral health policy, emphasizing universal coverage and primary care integration. This narrative review examines policy implementation approaches across different healthcare systems, focusing on universal coverage initiatives, primary care integration, and strategies for addressing health inequities. This narrative review synthesized evidence from policy documents, academic literature (PubMed, Scopus, Global Health databases; January 2019 to March 2024), and expert insights from a World Federation of Public Health Associations (WFPHA) webinar. The search strategy combined terms related to oral health policy implementation and health system integration. A total of 31 publications and policy documents were included in the final analysis. Analysis of regional experiences reveals diverse approaches to GOHAP implementation, from Denmark's comprehensive child coverage and Japan's life-course strategy, to Brazil's integrated primary care model. While some regions demonstrate successful approaches and improved outcomes, others face persistent challenges in workforce distribution, resource allocation, and health equity. Digital innovations in diagnosis, teledentistry, and integrated health records show promise for enhancing care delivery and access, though implementation requires careful consideration of local contexts and capabilities. Success in achieving GOHAP objectives depends on balancing global directives with local needs, emphasizing technological integration while addressing complex health determinants through multidisciplinary approaches. This analysis offers insights for policymakers and healthcare leaders implementing the WHO GOHAP framework while addressing regional challenges and priorities.

INTRODUCTION

Population-level oral health remains an important global public health challenge, with significant implications for healthcare systems and policy development. The global burden of oral diseases affects approximately 3.5 billion people worldwide, with untreated dental caries in permanent teeth remaining the most prevalent condition, impacting almost 2 billion individuals[1]. These conditions not only cause significant individual suffering but also create substantial economic burden on healthcare systems and society, estimated at US$544.41 billion annually[2-4].

The World Health Organization (WHO) Global Oral Health Action Plan (GOHAP) 2023–2030 represents a transformative policy framework for addressing these

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challenges. Unlike previous approaches that treated oral health in isolation, GOHAP advocates for comprehensive integration into universal health coverage initiatives and primary healthcare systems[5]. This strategic reorientation requires significant adaptation of existing healthcare structures and policies, particularly at the population health level[6].

Analysis of implementation patterns across different health systems reveals complex challenges and opportunities in translating global policy into effective local action[7]. While some regions have achieved reductions in disease prevalence, population growth and demographic shifts have led to increased absolute case numbers, particularly in Africa and the Eastern Mediterranean regions[1]. These trends highlight the need for population-specific approaches that consider both demographic transitions and health system capacities[6].

Healthcare systems have responded to these challenges through various policy mechanisms, from universal coverage initiatives to integrated primary care approaches[7]. These responses reflect diverse contextual factors including population needs, resource availability, and existing health system structures[8]. Understanding how different regions implement the WHO framework can provide insights for policymakers and public health practitioners working to strengthen oral health systems.

This narrative review examines how various healthcare systems are implementing GOHAP principles, focusing on three major dimensions: integration of oral health into primary care, approaches to achieving universal coverage, and strategies for addressing population health inequities. Through analysis of implementation experiences across different regions, we aim to identify effective strategies and persistent challenges in translating global oral health policy into actionable population-level interventions.

Review approach and sources

This narrative review synthesizes evidence from multiple sources to examine oral health policies and initiatives implemented across different health systems over the last five years (2019–2024), analyzing their alignment with principles now formalized in the WHO's Global Oral Health Action Plan. The review methodology encompassed three main components: analysis of primary policy documents, a focused search of academic literature, and synthesis of expert insights[9]. The primary policy documents included the WHO Global Oral Health Status Report 2022[1], the WHO Global Oral Health Action Plan 2023–2030[5], national oral health policy documents from selected countries, and regional implementation reports. For academic literature, we conducted searches in PubMed, Scopus, and Global Health databases, covering the period from January 2019 to March 2024. The most recent search was conducted in February 2024. The search was limited to English language publications. The search strategy combined terms related to oral health policy implementation and health system integration. Key search terms included variations of 'oral health policy', 'dental health policy', 'health system integration', 'policy implementation', 'health system reform', and 'universal health coverage'. These were combined with country and region-specific terms to capture diverse implementation contexts. Additionally expert insights were drawn from the World Federation of Public Health Associations (WFPHA) webinar on future directions in oral health[9], which provided expert presentations and regional implementation case studies.

Study selection

Studies and documents were included if they: 1) addressed oral health policy implementation at the population level; 2) focused on health system integration or universal health coverage; 3) reported implementation experiences, outcomes, or challenges; and 4) were published between January 2019 and March 2024. Documents were excluded if they focused solely on clinical interventions without policy context or did not relate to the WHO GOHAP framework principles.

The selection of countries for this review followed a purposive selection approach to capture diverse implementation contexts. Countries were selected to represent all six WHO regions (African Region, Region of the Americas, South-East Asia Region, European Region, Eastern Mediterranean Region, and Western Pacific Region), varied healthcare system typologies (tax-based, hybrid public-private, and market-oriented systems), different resource contexts (high, middle, and low-income settings), and varied stages of oral health policy implementation maturity. This selection strategy enabled analysis of how contextual factors influence policy translation and system-level adaptations across diverse global settings.

Data extraction and narrative synthesis

Two reviewers (GS and SM) independently screened titles and abstracts, with disagreements resolved through discussion. From an initial pool of 147 documents identified through database searches and policy sources, 31 publications and policy documents met the inclusion criteria of this narrative review and were included in the final analysis.

Data extraction focused on: 1) universal coverage approaches and financing mechanisms; 2) primary care integration models and structures; 3) health equity strategies and outcomes; 4) implementation barriers and facilitators; and 5) regional disease burden patterns. Information was systematically extracted into a structured framework aligned with GOHAP priorities.

The analysis employed narrative synthesis methods to identify patterns, themes, and lessons learned across different implementation contexts. Key findings were synthesized across the three main themes of universal coverage approaches, primary care integration models,

and health equity strategies, with particular attention to contextual factors affecting policy translation and system-level adaptations. Implementation experiences were analyzed with particular attention to contextual factors affecting policy translation and system-level adaptations, offering insights into approaches that may inform future implementation of the WHO Global Oral Health Action Plan.

The search identified 147 potentially relevant documents, of which 31 met the inclusion criteria and were included in this narrative review. These comprised 18 peer-reviewed articles, 12 policy documents and reports from national governments and WHO, and expert insights from the WFPHA webinar on future directions in oral health[9]. Studies represented all six WHO regions and covered diverse healthcare system contexts including high-income countries (n=15), middle-income countries (n=12), and low-income countries (n=8).

Analysis of oral health initiatives over the last five years reveals diverse approaches across healthcare systems that align with principles now formalized in the WHO's Global Oral Health Action Plan. These approaches have been shaped by regional disease burdens, existing health infrastructure, and socioeconomic contexts[1,5]. This section examines how different regions have addressed oral health challenges, analyzing patterns in disease distribution, universal coverage approaches, primary care integration models, and strategies for addressing health inequities that provide valuable insights for future GOHAP implementation.

GLOBAL ORAL HEALTH POLICY IMPLEMENTATION

Global burden and regional distribution

The distribution of oral disease burden reveals significant regional variations that influence policy implementation approaches (Table 1)[1]. Analysis of 2019 data show striking contrasts between prevalence rates and absolute case numbers. For primary teeth, while the Western Pacific region reported the highest prevalence (46.2%), South-East Asia had the largest burden with over 135 million cases despite a moderate prevalence rate of 43.8%. Population demographics, including large youth populations in certain regions, significantly influence the scale of public health challenges and resource allocation requirements[1].

For permanent teeth, the European region demonstrated the highest prevalence (33.6%), while South-East Asia dominated in absolute numbers with more than 525 million cases[1]. Temporal analysis between 1990 and 2019 reveals complex patterns of progress. The European region achieved a 7.22% reduction in primary teeth caries prevalence, while population growth in the African region led to an 87.2% increase in absolute case numbers for primary teeth and a striking 119.9% increase for permanent teeth, despite

Table 1. Regional distribution of dental caries: prevalence, cases, and temporal changes 1990 to 2019

WHO region	1990 Prevalence %	1990 Cases n	1990 to 2019 Prevalence change %	1990 to 2019 Cases change %
Primary teeth				
African	38.61	111024979	-3.4	87.19
Eastern Mediterranean	45.1	66378695	0.6	44.35
European	39.64	40853621	-7.22	22.1
Americans	43.21	57459634	-2.21	2.29
South-East Asia	43.77	135260519	-1.96	3.25
Western Pacific	46.2	102138618	-0.2	22.75
Global	42.71	513829451	-3.33	5.56
Permanent teeth				
African	28.5	262650114	-1.66	119.94*
Eastern Mediterranean	32.25	202193940	-0.27	102.94*
European	33.63	293866 294	-3.91	6.09
Americans	28.24	26446149	-0.05	46.35
South-East Asia	28.69	525752700	0.67	65.26
Western Pacific	25.41	463936789	-6.5	20.37
Global	28.7	2019706083	-2.59	46.07

Data source: WHO Global Oral Health Status Report1 2022. Sample: population-level data for all age groups. *Regions where absolute case numbers more than doubled from 1990 to 2019, despite stable or decreasing prevalence rates, demonstrating the substantial impact of population growth on disease burden. All permanent teeth data reflect the total population across all age groups.

relatively stable prevalence rates. The African and Eastern Mediterranean regions experienced the most dramatic increases in absolute case numbers, with permanent teeth caries cases more than doubling over the study period, underscoring the compound effect of population growth on disease burden[1].

These regional variations and demographic influences highlight the complexity of addressing oral health challenges globally. While some regions have made progress in reducing prevalence rates, population growth continues to increase the absolute burden of oral diseases, particularly in Africa and the Eastern Mediterranean regions where case numbers have more than doubled for permanent teeth over the study period[1].

Universal coverage implementation patterns

Healthcare systems worldwide demonstrate diverse approaches to achieving universal oral health coverage, revealing both innovations in funding mechanisms and persistent challenges in implementation. The experiences of Australia, Canada, and Denmark illustrate how different funding models and policy frameworks shape access to oral healthcare. The Australian system highlights the challenges of divided healthcare responsibilities between state and federal governments, particularly in financing oral health care[10]. Most treatment costs are borne by individuals, with around 86% of dental care performed in private practices. In 2020–2021, Australia's total expenditure on dental services reached AUD11.7 billion, with contributions from individuals (AUD 6.49 billion), insurance funds (AUD 2.24 billion) and government sources (AUD 2.29 billion)[10,11].

In Canada, the public health system (Medicare) provides free medical care to citizens, while most dental care is provided and funded by the private sector[12]. The recently introduced Canadian Dental Care Plan provides scaled benefits based on household income, offering 100% coverage for families with incomes below CA$70000, demonstrating a targeted approach to addressing access barriers among vulnerable populations[13]. Denmark's health financing model is predominantly tax-based, ensuring health services, including oral health, are funded by tax revenues[2]. While the system provides comprehensive coverage for children, adults and the elderly face considerable challenges, with limited coverage excluding essential services. A study of vulnerable Danish adults enrolled in special oral care programs found that 94% had untreated cavities, illustrating how coverage gaps affect health outcomes even in well-resourced systems[14].

Primary care integration models

Integration of oral health into primary care systems shows promising results across different contexts[15]. Digital innovations, including teledentistry and electronic records, further enhance this integrated approach[16]. Brazil's National Oral Health Policy demonstrates successful systematic integration through Oral Health Teams within the Family Health Strategy[17]. This approach has contributed to improved outcomes, with mean decayed, missing, and filled teeth (DMFT) at the age of 12 years decreasing from 2.8 in 2003 to 1.6 in 2020[18].

Globally, an estimated 514 million children are affected by dental caries in primary teeth (early childhood caries, ECC), with a global prevalence of about 43% [5]. The Pacific region bears the highest burden worldwide, affecting roughly one in two children[19]. In the Cook Islands, community screenings reveal marked disparities: 44% of children in Rarotonga, 47% in Aitutaki, 73% in Mangaia, and nearly 100% in some outer islands[20].

Recent research highlights strong community support for breastfeeding but also identifies barriers such as limited perinatal support, inadequate workplace accommodations, and sociocultural pressures that influence early-feeding decisions[21]. In response, the Ministry of Health launched the 'E Puapinga Katoa Te Nio Tamariki' (Baby Teeth Matter) program in 2024, which integrates oral health into the first 1000 days through community-based nutrition workshops and parent/caregiver education. The program also emphasizes workforce capacity-building and inter-professional collaboration among medical, nursing, midwifery, and dental teams to strengthen preventive practices and improve early-childhood oral-health outcomes[22,23]. This small-island approach illustrates how integration within existing maternal–child health services can advance GOHAP priorities in resource-constrained contexts.

Japan's '8020 Campaign' exemplifies a life-course approach to integration, incorporating mandatory school-based examinations and preventive care emphasis[24]. All citizens have dental insurance, with direct costs covered by local governments. Annual dental examinations are mandatory in schools from kindergarten to high school, with school dentists responsible for reporting children's dental conditions to parents and government referral as necessary[25].

Health equity approaches

Implementation experiences reveal persistent challenges in addressing health inequities, particularly in resource-constrained settings. South Africa's experience, where 85% of the population relies on an underfunded public sector, illustrates how structural inequities impact policy implementation[26,27]. The absence of mandated water fluoridation and infrastructure limitations significantly affect caries prevention, particularly in disadvantaged communities[5,28].

China's response through the Healthy China 2030 plan demonstrates a systematic approach to addressing inequities[29]. With more than 70% of 5-year-olds affected by tooth decay, initiatives focus on school-based interventions and early prevention. The plan aims to reduce tooth decay prevalence to less than 30% by 2025 through targeted

programs, though regional implementation variations persist[30].

The United States provides evidence of persistent disparities, despite advanced healthcare infrastructure[6]. Untreated caries affect over 40% of low-income groups, with higher prevalence among Black (36%) and Hispanic (23%) populations[31]. These patterns reflect how social determinants of health, including income, education, and access to preventive services, influence oral health outcomes in different population groups. The emerging strategies focus on expanding essential dental benefits in public insurance programs and integrating oral health services into broader healthcare delivery system[32].

The analysis of global oral health policy implementation reveals several important patterns and challenges in translating WHO's strategic framework into effective local action[1,5]. The diversity of implementation approaches across healthcare systems demonstrates both the adaptability of the GOHAP framework and the complexity of addressing oral health needs in different contexts[1,15].

Healthcare financing emerges as a fundamental determinant of implementation success. High-income countries like Australia, Canada, and Denmark, despite having robust healthcare systems, struggle with the dichotomy between universal medical coverage and limited dental care access[11,13,33]. The persistence of predominantly private financing for dental services, even in well-resourced systems, creates significant access barriers and perpetuates health inequities[34]. The Canadian Dental Care Plan's income-based approach represents an innovative solution, though its effectiveness in reducing access barriers requires further evaluation[13].

Integration of oral health into primary care demonstrates promising results but requires substantial system adaptation[15]. Brazil's success in reducing DMFT scores through integrated Oral Health Teams suggests that systematic integration can improve outcomes when supported by adequate resources and policy commitment[17,18]. Similarly, Japan's life-course approach, incorporating mandatory school-based examinations and universal insurance coverage, provides evidence that sustained preventive strategies can effectively improve population oral health outcomes[24,25]. However, the Cook Islands' experience highlights how resource constraints influence integration approaches, necessitating creative solutions that leverage existing healthcare structures[19,20].

Digital innovation emerges as a potential enabler of improved care delivery, yet implementation faces various barriers[35]. While teledentistry and electronic health records show promise for enhancing service integration and access, successful implementation requires addressing infrastructure limitations, professional training needs, and data privacy concerns[16]. The varying technological readiness of healthcare systems suggests the need for context-specific digital transformation strategies.

Health equity remains a persistent challenge across all implementation contexts[26,28]. The experience of South Africa demonstrates how structural inequities and resource limitations can impede policy implementation, while the United States' situation reveals how social determinants of health influence outcomes even in advanced healthcare systems[6,31]. China's targeted approach through school-based interventions provides insights into addressing inequities through systematic population-level interventions[30,34].

The analysis reveals several important implementation gaps and priorities for strengthening oral health policy implementation. First, workforce distribution and capacity building emerge as important challenges, particularly in resource-constrained settings[36]. Second, the integration of oral health with other non-communicable disease programs remains limited, suggesting missed opportunities for synergistic interventions[37]. Third, data systems for monitoring implementation progress and outcomes show considerable variation, hampering effective policy evaluation and adjustment[16].

Implementation success appears to depend on three key factors. Healthcare systems need sustainable financing mechanisms that reduce reliance on out-of-pocket payments while supporting universal coverage[11,13,33]. Digital transformation strategies must consider local technological capabilities and infrastructure limitations[16,36]. Integration efforts require careful attention to workforce development and system capacity building[36]. Evidence suggests that successful translation of WHO's framework requires balancing universal principles with local healthcare contexts while maintaining focus on core principles of universal coverage and health equity[2,3]. The experiences documented across different healthcare systems indicate that achieving GOHAP objectives by 2030 will require strengthened commitment to evidence-based preventive approaches[1], enhanced integration of oral health services with broader healthcare systems[15], and sustained focus on reducing health inequities[26]. The evidence points to the need for fundamental transformation in how oral healthcare is conceived, delivered, and integrated within population health systems[2,34].

Limitations

This narrative review has several limitations that should be considered when interpreting the findings. As a narrative rather than systematic review, the literature selection process, while purposive and structured, may not have captured all relevant publications on GOHAP implementation. The focus on English-language publications may have excluded relevant implementation experiences reported in other languages. The synthesis of results, given the nature of narrative review methodology, provides valuable information on implementation patterns but cannot establish causal relationships or definitively demonstrate the effectiveness of specific policies. The

heterogeneity of contexts, health systems, and data sources across included studies limits direct comparisons between regions. Additionally, as many GOHAP initiatives are in early implementation stages, long-term outcomes and sustained impacts remain to be evaluated. Future systematic reviews with meta-analyses, where feasible, could provide more definitive evidence on specific intervention effectiveness.

CONCLUSION

Our narrative review identified that successful implementation of the WHO Global Oral Health Action Plan requires balancing universal principles with local healthcare contexts and capabilities. Achieving GOHAP objectives by 2030 will necessitate substantial changes in how oral healthcare is conceived, delivered, and integrated within population health systems, including strengthened preventive approaches, enhanced health system integration, and sustained focus on reducing health inequities. Success depends on context-appropriate technological innovation and sustainable financing mechanisms that ensure universal access while addressing the needs of vulnerable populations.

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The authors have each completed and submitted an ICMJE form for disclosure of potential conflicts of interest. The authors declare that they have no competing interests, financial or otherwise, related to the current work. R. Martin reports that in the past 36 months had a leadership or fiduciary role as director of the Australian Network for the Integration of Oral Health.

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AUTHORS' CONTRIBUTIONS
All authors made substantial contributions to the development of this article. GS and SM: initial draft of the manuscript. AA: editing of the manuscript. All authors: revision of the manuscript. All authors read and approved the final version of the manuscript.

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During the preparation of this work, the authors used Quillbot to assist with paraphrasing and language refinement. After using this tool, the authors thoroughly reviewed and edited the content to ensure accuracy, coherence, and alignment with the article's objectives. The authors take full responsibility for the final content of the publication.

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