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Letter to Editor

Advocacy for Oral Health: From Global Commitment to Local Policy Action

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Dear Editor,

Oral diseases affect approximately 3.5 billion people worldwide, and untreated caries in permanent teeth remains the most common health condition globally. However, policy-makers do not pay attention to the scale of this burden. The difficulty is not scarcity of effective interventions. The greater challenge is putting them into practice. This requires political commitment, appropriate financing, health systems that can deliver services, and continued efforts from different sectors. Advocacy has a role in this process because it can keep oral health on the policy agenda, draw attention to inequalities, and support the goal of universal health coverage (UHC). At the same time, advocacy should not be considered a substitute for the wider public health measures needed to prevent and manage oral diseases.

In oral health, advocacy attempts to influence policy, financing, regulation, and implementation in ways that improve population health and reduce inequalities. It can take many forms, including building coalitions, mobilising communities, engaging policy-makers, communicating evidence, and participating in policy consultations. The World Health Organization (WHO) Global Oral Health Strategy and Action Plan reflects these priorities by identifying UHC for oral health as a global goal and emphasising prevention, integration of services, governance, workforce development, information systems, and research.[1] Moving from evidence to policy, however, is rarely a linear process. The outcome may depend on institutional structures, competing interests, available resources, timing, relationships, political influence, and the visibility of an issue.

The published literature reflects only part of advocacy activity. It is mostly informal, iterative, locally negotiated, unsuccessful, or undocumented. Failed campaigns, stalled proposals, fragmented coalitions, and initiatives that never reach legislative or budgetary decisions are less visible. Consequently, published documents may show that advocacy is straightforward. Successful advocacy depends on convening people, sustaining relationships, accessing decision-makers, maintaining organisational capacity, and getting funding. Advocates need to understand where decisions are made, who influences them, whose interests are represented, and whose voices are missing. Evidence is important but is rarely sufficient; it must connect to a population, a policy opportunity, a feasible financing pathway, and a clear strategy for engaging decision-makers.

As an example, the development of Australia's National Oral Health Plan 2025–2034 involved health departments, professional and educational organisations, consumer advocates, Aboriginal Community Controlled Health Organisations, universities, and providers.[2,3] Such a wide range of stakeholders may complicate the policy process and severely challenge priority setting. In the United States, the American Dental Association has developed advocacy tools focused on state Medicaid programmes and adult dental benefits. Another initiative involving six states brought dental associations, Medicaid agencies, managed care organisations, and coalitions together to address dentist participation in Medicaid.[4,5] These experiences emphasize that advocacy itself may not directly leads to policy change. Rather, they show how relationships, organisational resources, financing, and implementation can affect what advocacy is able to achieve.

The involvement of patients and communities in advocacy should complement population-level prevention and efforts to address structural determinants. Oral diseases are common, chronic, and largely preventable. Advocacy therefore needs to address community mobilisation, reduction of risk factors, prevention, and the integration of oral health into primary care. People with lived experience may identify inequalities that are not apparent from professional or administrative viewpoints. Community organisations can add local knowledge and credibility and may be able to maintain engagement over time. An outline reflecting professional interests may not adequately reflect wider health-system or social concerns. Professional organisations should therefore work with patients, communities, public-interest organisations, and those with greatest unmet needs.

Financing is another issue that deserves greater attention in oral health advocacy. Demonstrating that a health problem is important, or that an intervention is effective, does not

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by itself result in funding. Advocacy should determine appropriate services, coverage, and the way of payment for those services. This is particularly relevant to UHC. Necessity of a service is only part of the question; the way it is financed and delivered determines whether people can actually get it. Fisher et al reported that Medicare provides more equitable access to primary medical care in Australia, whereas dental care remains outside Medicare and depends more heavily on private insurance and co-payments, contributing to inequalities.[6] For oral health advocates, this means engaging beyond health ministries and departments. Finance ministries, insurers, purchasers, and service planners also have a role in determining what can be delivered. The design of benefits, affordability, financing arrangements, and the geographical distribution of services all influence whether a policy commitment results in real access.

The way evidence is communicated also matters. Researchers, policy-makers, community organisations, or financing bodies need different forms of a sole message. Advocacy therefore requires a specific policy objective and be adapted to the audience and institutional setting. Universities and academics may help generating and translating evidence, evaluating interventions, and identifying realistic policy options. Their involvement, however, does not automatically create political support for those options. An academic group may produce convincing evidence but have little influence if an organised part of population do not enquire it. This is one reason why advocacy should have a place in dental education. Training should not stop at understanding evidence; it should also introduce students to coalition building, stakeholder analysis, policy communication, health financing, negotiation, and the role of power in policy decisions.[7]

Stakeholder engagement should also go beyond preparing a list of organisations to consult. Advocacy requires an understanding of which interests overlap, where they conflict, and how much influence different groups have. Professional organisations, communities, civil society, government, and other sectors will not always agree, and conflicts of interest need to be made visible. Reaching complete agreement among all stakeholders may not be necessary. In many circumstances, a more practical objective is to identify sufficient common ground around a feasible policy goal. Examples include integrating oral health into primary care, strengthening prevention, expanding publicly financed benefits, addressing workforce and geographical maldistribution, and protecting public health policy from commercial interests that conflict with these objectives. Such changes require continued investment, and impediments should be expected as part of the policy process.

Oral health advocacy can help advance equity and UHC, but it is only one essential factor. Prevention, service delivery, workforce planning, regulation, financing, research, and attention to social and commercial determinants are also necessary. Advocacy is more likely to be useful when it involves affected communities and other sectors and when it is directed towards the level at which decisions are actually made. Academic institutions can contribute evidence and partnerships; professional associations and civil society organisations can sustain coalitions and articulate policy demands; and governments can establish the financing and policy arrangements required to make equitable oral healthcare part of UHC. Connecting these roles can help move oral health commitments from the international level towards sustained action in local health systems.

Disclosure of artificial intelligence (AI) use

I confirm that DeepSeek (a generative AI language model) was used as an assistive tool during the preparation of this manuscript. It was employed in language polishing, structural organization, and drafting assistance to improve clarity and readability of the manuscript.

I wish to emphasize that the core intellectual content, thematic direction, and selection of literature were entirely my own. Specifically:

- The topic selection, central thesis, and argumentative flow were conceived solely by me.
- All cited references were independently verified by me, one by one, via Google Scholar, to ensure accuracy, relevance, and correct interpretation. I manually confirmed each citation and cross-checked the findings before incorporating them into the final text.
- The final submitted manuscript underwent substantive human revision—I carefully reviewed, edited, and restructured the AI-generated draft to align precisely with my own scholarly voice and analytical perspective.

In line with *IJHPM*'s policy and COPE (Committee on Publication Ethics) guidelines, I fully recognize that AI tools cannot be listed as authors and that I bear full responsibility for the originality, accuracy, and integrity of the submitted work.

Ethical issues

Not applicable.

Conflicts of interest

Author declares that he has no conflicts of interest.

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