GLOBAL PERSPECTIVE ON INTEGRATED CARE MODELS

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Bridging Evidence with Public Policy for Global Health through Oral Health
Science knows no country because knowledge belongs to humanity, and it is the torch which illuminates the world

L. Pasteur
1876
"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 experiences 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”
Rio Political Declaration on Social Determinants of Health

Rio de Janeiro, Brazil, 21 October 2011

1. Invited by the World Health Organization, we, Heads of Government, Ministers and government representatives came together on the 21st day of October 2011 in Rio de Janeiro to express our determination to achieve social and health equity through action on social determinants of health and well-being by a comprehensive intersectoral approach.

2. We understand that health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an "all for equity" and "health for all" global action.

3. We underscore the principles and provisions set out in the World Health Organization Constitution and in the 1978 Declaration of Alma-Ata as well as in the 1986 Ottawa Charter and in the series of international health promotion conferences, which reaffirmed the essential value of equity in health and recognized that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". We recognize that governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures and that national efforts need to be supported by an enabling international environment.

4. We reaffirm that health inequities within and between countries are politically, socially and economically unacceptable, as well as unfair and largely avoidable, and that the promotion of health equity is essential to sustainable development and to a better quality of life and well-being for all, which in turn can contribute to peace and security.

5. We reiterate our determination to take action on social determinants of health as collectively agreed by the World Health Assembly and reflected in resolution WHA62.14 ("Reducing health inequities through action on the social determinants of health"), which notes the three overarching recommendations of the Commission on Social Determinants of Health: to improve daily living conditions; to tackle the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action.
UN Political Declaration on NCDs

“NCDs - a challenge of epidemic proportion and its socio-economic and developmental impacts”

Common Risk Factors

- TOBACCO USE
- CVD
- DIABETES
- CANCER
- UNHEALTHY DIET
- COPD
- PHYSICAL INACTIVITY
- MUSCULOSCELETAL
- ALCOHOL
- ORAL HEALTH
- POVERTY, ACCESS

UN High Level Meeting – Historic Event
(New York, 19-20 September 2011)

....Article 19

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;
Executive summary

Background
Noncommunicable diseases (NCDs) are the main contributor to mortality and morbidity globally, currently accounting for 43% of disease burden (1). More than 36 million die annually from NCDs (63% of global deaths), with more than 90% of these premature deaths occurring in low- and middle-income countries. Modifiable risk factors such as poor diet and physical inactivity are some of the most common causes of NCDs; they are also risk factors for obesity—an independent risk factor for many NCDs that is also rapidly increasing globally (2). A high level of consumption of free sugars is of concern, because of its association with poor dietary quality, obesity and NCD risk (3, 4).

Free sugars contribute to the overall energy density of diets (5-7). Ensuring energy balance is critical to maintaining healthy body weight and ensuring that nutrient intake is optimal (8). There is increasing concern that consumption of free sugars—particularly in the form of sugar-sweetened beverages—increases overall energy intake and may reduce the intake of foods containing more nutritionally adequate calories, leading to an unhealthy diet, weight gain and increased risk of NCDs (9-11). Another concern is the association between free sugars consumption and dental caries. Dental diseases are the most prevalent NCDs globally and, although great improvements have occurred in the past decades, problems still persist, causing pain, anxiety, functional limitation and social handicap through tooth loss. The treatment of dental diseases is expensive; it costs 5–10% of health care budgets in industrialized countries, and would exceed the entire financial resources available for health care for children in most lower income countries (12, 13).

Objective
The objective of this guideline is to provide recommendations on the consumption of free sugars to reduce the risk of NCDs in adults and children. The guideline has a particular focus on the prevention and control of weight gain (in recognition of the rapidly growing epidemic of overweight and obesity around the globe, and of the role of obesity as a risk factor for several NCDs), and on dental caries because it is the most common NCD, and the cost of treatment of caries is placing a heavy burden on health-care budgets in many countries. The recommendations in this guideline can be used by programme managers and policy planners to assess current intake levels of free sugars relative to a benchmark, and to develop measures to decrease free sugars intake, where necessary, through public health interventions such as food and product labelling, consumer education and the establishment of food-based dietary guidelines.

1 Overweight and obesity are defined as follows:
- Children (<5 years of age):
  - Overweight: weight for height >+2 standard deviations (SD) of the WHO Child Growth Standards median
  - School-aged children and adolescents (5–10 years):
    - Overweight: body mass index (BMI) for age >+1SD of the WHO growth reference for school-aged children and adolescents (equivalent to BMI 25 kg/m² at 19 years)
    - Obesity: >+2SD of the WHO growth reference for school-aged children and adolescents (equivalent to BMI 30 kg/m² at 19 years)
- Adults (≥20 years):
  - Overweight: BMI ≥25.0 kg/m²
  - Obesity: BMI ≥30.0 kg/m²
EDITORIAL

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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 non-communicable 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 the structural determinants and conditions of daily life. These include gross economic disparities between and within countries, and policies and programs that emanate from the failure of governments to address the social determinants of health. This leads to the conclusion that if systematic improvements in the health of societies are to be achieved, then all sectors of society must