A Report of the Surgeon General (*Oral Health in America*) alerted Americans to the importance of oral health in their daily lives. The Report, issued in May 2000, provided state-of-the-science evidence on the growth and development of oral, dental and craniofacial tissues and organs; the diseases and conditions affecting them; and the integral relationship between oral health and general health, including recent reports of associations between chronic oral infections and diabetes, osteoporosis, heart and lung conditions, and certain adverse pregnancy outcomes. The text further detailed how oral health is promoted, how oral diseases and conditions are prevented and managed, and what needs and opportunities exist to enhance oral health. [1]

A National Call to Action to Promote Oral Health is addressed to professional organizations and individuals concerned with the health of their fellow Americans. It is an invitation to expand plans, activities, and programs designed to promote oral health and prevent disease, especially to reduce the health disparities that affect members of racial and ethnic groups, poor people, many who are geographically isolated, and others who are vulnerable because of special oral health care needs. *A National Call to Action to Promote Oral Health*, referred to as the *Call to Action*, reflects the work of a partnership of public and private organizations who have specified a vision, goals, and a series of actions to achieve the goals. It is their hope to inspire others to join in the effort, bringing their expertise and experience to enrich the partnership and thus accelerate a movement to enhance the oral and general health and well-being of all Americans.

The Burden of Oral Diseases and Disorders

Oral diseases are progressive and cumulative and become more complex over time. They can affect our ability to eat, the foods we choose, how we look, and the way we communicate. These diseases can affect economic productivity and compromise our ability to work at home, at school, or on the job. Health disparities exist across population groups at all ages. Over one third of the U.S. population (100 million people) has no access to community water fluoridation. Over 108 million children and adults lack dental insurance, which is over 2.5 times the number of those who lack medical insurance. [1]

The following are highlights of oral health data for adults, and the elderly. (Refer to the full report for details of these data and their sources).

Most adults show signs of periodontal or gingival diseases. Severe periodontal disease (measured as 6 millimeters of periodontal attachment loss) affects about 14 percent of adults aged 45-54.

Clinical symptoms of viral infections, such as herpes labialis (cold sores), and oral ulcers (canker sores) are common in adulthood affecting about 19 percent of adults 25 to 44 years of age.

Chronic disabling diseases such as temporomandibular disorders, Sjögren's syndrome, diabetes, and osteoporosis affect millions of Americans and compromise oral health and functioning.

Pain is a common symptom of craniofacial disorders and is accompanied by interference with vital functions such a eating, swallowing, and speech. Twenty-two percent of adults reported some form of oral-facial pain in the past 6 months. Pain is a major component of trigeminal neuralgia, facial shingles (post-herpetic neuralgia), temporomandibular disorders, fibromyalgia and Bell's palsy.

Population growth as well as diagnostics that are enabling earlier detection of cancer means that more patients than ever before are undergoing cancer treatments. More than 400,000 of these patients will develop oral complications annually.

Immune compromised patients, such as those with HIV infection and those undergoing organ transplantation, are at higher risk for oral problems such as candidiasis.

Employed adults lose more than 164 million hours of work each year due to dental disease or dental visits.

For every adult 19 years or older with medical insurance, there are three without dental insurance.

A little less than two thirds of adults report having visited a dentist in the past 12 months. Those with incomes at or above the poverty level are twice as likely to report a dental visit in the past 12 months as those who are below the poverty level.

Twenty-three percent of 65- to 74-year-olds have severe periodontal disease (measured as 6 millimeters of periodontal attachment loss). (Also, at all ages men are more likely than women to have more severe disease, and at all ages people at the lowest socioeconomic levels have more severe periodontal disease.)

About 30 percent of adults 65 years and older are edentulous, compared to 46 percent 20 years ago. These figures are higher for those living in poverty.

Oral and pharyngeal cancers are diagnosed in about 30,000 Americans annually; 8,000 die from these diseases each year. These cancers are primarily diagnosed in the elderly. Prognosis is poor. The 5-year survival rate for white patients is 56 percent; for blacks, it is only 34 percent.

Most older Americans take both prescription and over-the-counter drugs. In all probability, at least one of the medications used will have an oral side effect – usually dry mouth. The inhibition of salivary flow increases the risk for oral disease because saliva contains antimicrobial components as well as minerals that can help rebuild tooth enamel after attack by acid-producing, decay-causing bacteria. Individuals in long-term care facilities are prescribed an average of eight drugs.

At any given time, 5 percent of Americans aged 65 and older (currently some 1.65 million people) are living in a long-term care facility where dental care is problematic.

Many elderly individuals lose their dental insurance when they retire. The situation may be worse for older women, who generally have lower incomes and may never have had dental insurance. Medicaid funds dental care for the low-income and disabled elderly in some states, but reimbursements are low. Medicare is not designed to reimburse for routine dental care. [1]

Enhance oral health workforce capacity. The lack of progress in supplying dental health professional shortage areas with needed professional personnel underscores the need for attention to the distribution of care providers, as well as the overall capacity of the collective workforce to meet the anticipated demand for oral health care as public understanding of its importance increases.

To effect change in oral health workforce capacity, more training and recruitment efforts are needed. The lack of personnel with oral health expertise at all levels in public health programs remains a serious problem, as does the projected unmet oral health faculty and researcher needs.

The movement of some states towards more flexible laws, including licensing experienced dentists by credentials, is a positive one and today, 42 states currently permit this activity. The goal of moving society toward optimal use of its health professionals is especially important at a time when people have become increasingly mobile, moving from town to city and state to state, and when projected oral health workforce

shortages are already evident in many rural locales. State practice act changes that would permit, for example, alternative models of delivery of needed care for underserved populations, such as low-income children or institutionalized persons, would allow a more flexible and efficient workforce. Further, all health care professionals, whether trained at privately or publicly supported medical, dental, or allied health professional schools, need to be enlisted in local efforts to eliminate health disparities in America. These activities could include participating in state-funded programs for reducing disparities, part-time service in community clinics or in health care shortage areas, assisting in community-based surveillance and health assessment activities, participating in school-based disease prevention efforts, and volunteering in health-promotion and disease-prevention efforts such as tobacco cessation programs.

Whether individuals are moved to act as volunteers in a community program, as members of a health voluntary or patient advocacy organization, employees in a private or public health agency, or health professionals at any level of research, education, or practice, the essential first step is to conduct a needs assessment and develop an oral health plan. Because the concept of integrating oral health with general health is intrinsic to the goals of this *Call to Action*, oral health plans should be developed with the intent of incorporating them into existing general health plans.

[1] U S. Department of Health and Human Services. *Oral Health in America:, A National Call to Action to Promote Oral Health, A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.