

Oral health equity for persons with disabilities

A policy brief



World Health
Organization

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Cover photo: Girl with cleft palate receiving disability inclusive follow-up care at a dental clinic in Phnom Penh, Cambodia; 2023. © WHO / Miguel Jeronimo

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1. Oral health for persons with disabilities matters

The World Health Organization (WHO) defines oral health as the state of the mouth, teeth and orofacial structures that enables individuals to perform essential functions, such as eating, breathing and speaking, and encompasses psychosocial dimensions, such as self-confidence, well-being and the ability to socialize and work without pain, discomfort and embarrassment. Oral health varies over the life course from early life to old age, is integral to general health and supports all individuals in participating in society and achieving their potential (1). Yet oral diseases and oral dysfunction disproportionately affect persons with disabilities, who make up 16% of the global population (approximately 1.3 billion people as of 2021) and face additional barriers to access quality care that meets their needs (2, 3).

Persons with disabilities are part of human diversity; although often referred to as a single population, they are a very diverse group of people. The United Nations Convention on the Rights of Persons with Disabilities (CRPD) describes persons with disabilities as “those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (4).

The 2022 WHO Global report on health equity for persons with disabilities analyses the contributing factors to health inequities and outlines key recommendations to reduce them (2). In parallel, the Global oral health action plan 2023-2030 (GOHAP), provides concrete guidance to progress towards Universal Health Coverage (UHC) for oral health for all individuals and communities by 2030 (5). This policy brief seeks to show how the GOHAP can be implemented in a disability inclusive way, aligned with the recommended principles in the Global report on health equity for persons with disabilities (2).

2. Oral health inequities experienced by persons with disabilities

Globally, oral diseases affected an estimated 3.7 billion people in 2021, making them the most common disease or condition that affects humanity (6). The oral diseases and conditions (herein referred to collectively as oral diseases) representing the highest burden include untreated dental caries, severe periodontal disease, edentulism (total tooth loss) and cancer of the lip and oral cavity. Each of these diseases presents a public health and health equity problem on a global, regional and national level with their unparalleled burden, stark inequities and challenges in ensuring access to care.

In many countries, a wide range of differences in health outcomes persist between persons with disabilities and those without disabilities. Evidence has shown that persons with disabilities typically experience poorer oral health, with higher rates of dental caries, periodontal disease and tooth loss (7-21). In cases where persons with disabilities can access care, there is evidence of poorer treatment outcomes, for example, dental caries being treated by extraction rather than restoration. Additionally, poor oral health and oral function is associated with lower quality of life and disproportionately affects people with disabilities and their families (21-37).

Existing health system and other structural barriers such as financial protection policies and trained health workforce distribution also limit access to oral health care with large gaps in population coverage of essential preventive and oral disease management services (2). Even where services are available for the general population, they are not often adaptable or appropriate for people with disabilities who are less likely to access existing oral health care services (18, 38-42) despite having a higher incidence of unmet needs (8), and greater needs for treatment and preventive oral health interventions (7, 20, 35).

All persons with disabilities are subject to unjust or unfair social and structural determinants that are avoidable and cannot be explained by the underlying health condition or impairment (3). These are referred to as health inequities (2).

3. Contributing factors to oral health inequities for persons with disabilities

The burden of oral diseases is not uniformly distributed across populations. Instead, oral diseases are socially patterned and show strong social gradients, disproportionately affecting the most vulnerable and disadvantaged population groups, including many persons with disabilities. These differences in oral health status are not inevitable and do not occur by chance; inequities are caused by a complex array of interconnecting factors, many of which are largely beyond individuals' direct control. These can be summarised into four sets of contributing factors (2):

Four sets of contributing factors

1

STRUCTURAL FACTORS



referring to the social and political context that feed into the social stratification in society and can manifest as ableism, stigma and discrimination against persons with disabilities.

2

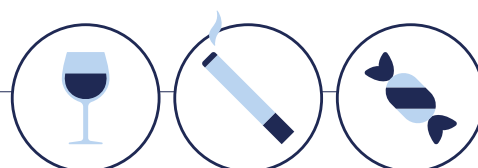
SOCIAL DETERMINANTS



referring to the conditions in which people are born, grow, live, work and age that influence their health outcomes (43). Many persons with disabilities experience the disproportionate and cumulative impact of problems in early life, education, employment, poor social status and poverty over the life course.

3

RISK FACTORS



including exposure to and consumption of unhealthy diets (specifically high sugars intake), alcohol, tobacco products and poor oral hygiene. Persons with disability who are dependent on others for their self-care and diet are particularly impacted.

4

HEALTH SYSTEM



the delivery of oral health services in many countries relies on specialised care models and can exclude people, especially persons with disabilities, from accessing quality and affordable essential oral health care. To ensure access for all, primary care facilities need to incorporate essential oral health care interventions and ensure these are adaptable to issues of communication, oral dysfunction, medical complexity and comorbidities, physical access, capacity to consent and patient autonomy.

4. Advancing oral health equity for persons with disabilities

There are challenges in many countries to secure sustainable political interest, commitment and public health policies on oral health (44-48), which affects people with and without disabilities. While momentum is growing for better recognition of oral diseases as a major public health issue, highlighted by the Bangkok Declaration (49), it is timely to harness this momentum to ensure that health system reforms aimed at improving access and affordability of oral health care, are inclusive of persons with disabilities. The GOHAP specifies 100 actions, according to different stakeholder groups, to improve oral health in countries towards the vision of UHC for all. These actions are adaptable to country context and provide opportunity to promote disability inclusion during implementation. Key aspects are described according to the implementation principles from the Global report on health equity for persons with disabilities (2). In practice, these implementation principles rely on engagement with a range of stakeholders, including those from both the private and public health sector and should involve persons with disabilities from their inception.

In the context of UHC, adopting a primary health care (PHC) approach ensures essential oral health care is available where and when needed. This includes oral diseases prevention and care accessible to all, supported by an effective referral system for the minority requiring additional adaptation. PHC is defined as a whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: (a) primary care and essential public health functions as the core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities (50). This is the fundamental approach advocated for by the GOHAP and contributes to the advancement of equity for persons with disabilities.

4.1 Recommended principle 1: Include health equity for persons with disabilities at the centre of any health sector action

Oral diseases prevention and management services included as part of UHC benefit packages should respond to the needs of the whole population including persons with disabilities. UHC benefit packages need to encompass an adaptation component to ensure there is financial recognition of the additional time and resources required for some persons with disability to receive equitable oral health care (2). Additional provisions may be needed to ensure that persons with disabilities receive the same quality and range of oral health care as others. Ensuring that oral health services are accessible for persons with disabilities, including for example, facilities that are wheelchair accessible, or oral health information in a range of formats (such as easy read versions), is essential.

Further, use of minimally invasive oral health care interventions, such as fluoride varnish and silver diamine fluoride application or glass ionomer cement restoration using hand instruments should be given due consideration (46, 51). These procedures are cost effective, readily implemented by PHC workers and well suited for preventing and arresting dental caries or restoring tooth structure especially when physical limitations or anxiety may prevent other types of treatment. Care should be taken however that treatment is of the same standard and level of acceptability for all populations, regardless of disability.

For persons with disability who cannot have their oral health needs met through a primary care facility, timely and streamlined referral pathways to facilities that can deliver adapted care are necessary. These facilities should be able to respond to specific needs, including access to sedation medicines, skilled workforce and other more specialised equipment. Ensuring such pathways helps guarantee that persons with disabilities receive the essential oral health care they require in a safe, appropriate and respectful manner. The suitability of oral health related equipment such as dental chairs should also be considered, as some persons with disabilities may not be able to transfer into or use standard dental chairs.

Additionally, digital health technologies have the potential to improve accessibility to oral health care for persons with disabilities. There are international standards such as the WHO-ITU Global Standard for accessibility of telehealth services (52). However, implementation of digital health programs and telehealth services must also consider equitable access to technological resources, reliable phone and internet networks, and the ability to navigate technology.

Lastly, the health workforce may contribute to poor health outcomes for persons with disabilities, including for example, by perpetuating stigma or non-referral within the health system. This can occur when health workforce equipped to meet the needs of oral diseases are not systematically trained to have the skills and experience to accommodate the needs of persons with disabilities (53-60). The health workforce on oral health needs training in all aspects of adapted care – communication, behaviour support techniques, adapting physical access, obtaining informed consent, and management of comorbidities. Conversely, those trained to care for persons with disabilities may not be trained in oral health care. Healthcare professionals working with persons with disabilities need training in oral disease prevention and management, including basic toothbrushing techniques, dietary advice and application of topical fluoride treatments. Currently, oral hygiene and functional exercise training programs to mitigate oral dysfunction are not readily available for caregivers of persons with disabilities, despite research showing their efficacy (61).

4.1.1 Relevant actions from GOHAP

The GOHAP proposes the following actions for Member States to respond to these challenges (5):

Action 62

Integrate oral health care into primary health care by integrating oral health care at all service levels, including required staffing, skill mix and competencies and establishing referral pathways and support mechanisms that streamline coordination of care with other areas of the health system. Establish referral pathways and support mechanisms that streamline coordination of care with other areas of the health system. In particular, streamlining referral pathways to special care dentistry when indicated.

Action 63

Work towards integrated oral health services as part of UHC by expanding coverage through on- demand care in primary care facilities using an essential oral health care package.

Action 65

Ensure essential oral health supplies by prioritizing the availability and distribution of essential oral health care supplies and consumables as part of public procurement mechanisms for primary care.

Action 69

Optimize digital technologies for oral health care by supporting digital access and consultation for oral disease early detection, management and referral.

Action 48

Reform intra- and inter-professional oral health education by preparing students for collaborative practice and integrating oral health into primary health care. Promote and safeguard equitable access to oral health professional education to increase socio-economic, gender, disability, ethnic and geographic diversity and cultural competency of the oral health workforce.

To complement the above efforts, the GOHAP also proposes actions for other non-government stakeholders, including (5):

Action 73

Strengthen oral health services as part of UHC by supporting the development and implementation of a package of essential oral health services. Provide platforms to share lessons learned and key success factors to integrate oral health services into UHC schemes, with consideration for persons with disabilities and the need for effective referral pathways.

Action 74

Mobilize stakeholders for oral health care by ensuring representation of civil society organizations to strengthen participation and ownership. Encourage new and support existing civil society organizations on the rights of persons with disabilities to incorporate access to essential oral health care and inclusion in UHC as part their advocacy efforts.

The GOHAP advocates for the integration of oral health care into PHC, including the availability and distribution of essential oral health care supplies, and streamlining referral pathways to favour coordination of care. This could be supported by piloting and scaling up (when appropriate) digital technologies that promote early detection, training and surveillance of oral diseases. These approaches favour a system-based approach that can accommodate diverse population needs, thereby targeting the health system factors that contribute to inequity for persons with disabilities.

Further, the GOHAP outlines actions that advocate for curricula on the needs of persons with disabilities for oral health professionals and accreditation mechanisms such as ongoing professional development. These actions are opportunities to promote inclusive practices in the delivery of oral health care that can evolve with societal and technological advancements. More broadly, the GOHAP advocates for innovation towards more dynamic health workforce models that include task shifting/sharing to respond to population needs, including those of persons with disabilities. These approaches target the health system and structural factors that contribute to inequity for persons with disabilities (5).

4.1.2 Country example – Brazil

Brazil has integrated oral health services into its public health system through the Unified Health System (SUS), thereby ensuring universal access. Oral health care is delivered as part of PHC through a network of Family Health Strategy (FHS) teams. Brazil's approach ensures oral health services are coordinated with other health disciplines and available across all levels of care. The country's oral health policies focus on health promotion and disease prevention through intersectoral collaboration, including partnerships with education, sanitation, and social services. Preventive measures such as fluoride application, supervised oral hygiene, and dietary counselling are routinely provided in PHC settings. This integrated model enhances access for marginalized populations, including persons with disabilities, ensuring that opportunities to essential oral health care are widely available and not limited to only special care arrangements (62).

4.1.3 Country example – Japan

In Japan, the integration of oral health into the UHC system provides financial protection for all citizens including people with disabilities. Under Japan's statutory health insurance system, essential dental treatments—including caries management, periodontal therapy, dentures, and oral surgery—are covered for all residents, with coinsurance rates typically capped at 30%, but significantly lower for low-income individuals and those with disabilities. This financial protection ensures that people with disabilities can access essential oral health care without facing prohibitive costs (63, 64). The Japanese Society for Disability and Oral Health complements this system by facilitating referrals from community providers to hospital-based dental units, ensuring continuity of care and clinical expertise for complex cases. Its collaboration with dental universities and certification programs further strengthens the quality and accessibility of oral health care for persons with disabilities (65).

4.2 Recommended principle 2:

Ensure empowerment and meaningful participation of persons with disabilities and their representative organizations when implementing any health sector action

Empowering individuals with lived experience, including persons with disabilities, is essential to advancing inclusive and effective health systems. WHO defines meaningful engagement as the respectful, dignified, and equitable inclusion of people with lived experience in diverse processes and activities, within environments that enable shared power and value experiential knowledge as a form of expertise (66). In the context of oral diseases and other noncommunicable diseases (NCDs), individuals and communities that experience disability bring critical insights that can shape more inclusive, equitable, and impactful oral health policies and programs.

In 2023, the WHO framework for meaningful engagement of people living with NCDs, and mental health and neurological conditions was released (66). The framework serves as a guide for WHO and Member States, outlining the key principles, enablers and actions to facilitate engagement with people with lived experience. This guidance can be readily adapted and applied to implementation of the GOHAP to further strengthen inclusivity of persons with disabilities.

Furthermore, this recommended principle is closely aligned with the PHC pillar of empowering people and communities which was recently reinforced in 2024 by adoption of the World Health Assembly Resolution on Social participation for universal health coverage, health and well-being (WHA77.2). This resolution is a signal from Member States emphasizing the importance of regular, meaningful social participation in health-related decision-making to advance UHC, equity, and trust in health systems. It specifically calls for inclusive engagement of vulnerable and marginalized groups, including persons with disabilities, to ensure that health policies and plans respond to their needs and uphold principles of equality and non-discrimination.

4.2.1 Relevant actions from GOHAP

The GOHAP proposes the following action for Member States to respond to these challenges (5):

Action 6

Engage with civil society about oral health by ensuring participation of civil society organizations and patient support groups in planning, implementing and monitoring of relevant programmes. Provide platforms for engagement and empowerment by increasing awareness of oral health equity, actively seeking representation from persons with disabilities, and involving them in oral health policy and guideline development as well as implementation and integration of oral health in wider health care and social services.

To complement the above efforts, the GOHAP also proposes actions for other non-government stakeholders, including (5):

Action 17

Promote a whole-of-government approach to oral health by engaging in multisectoral coordination mechanisms to deliver on oral health and other NCD targets within and beyond the health sector.

Action 18

Advance oral health as a public good by collaborating among civil society organizations, including oral health professional associations, to promote and protect oral health as a public good.

Action 20

Include people affected by oral diseases and conditions by calling for and participating in inclusive oral health governance mechanisms. Ensure that institutionalized oral health decision-making processes engage people living with oral diseases, special care needs or disabilities as well as oral health professionals.

The GOHAP aligns with the initiatives within the broader NCDs sector to better engage with people with lived experience. In advancing oral health equity for persons with disabilities, the GOHAP emphasizes the creation of platforms that enable individuals with disabilities and/or their representative groups to actively contribute to the development of policies and programs. It also calls for the institutionalization of mechanisms that support and sustain such inclusive participation.

4.2.2 Country example - Morocco

The WHO Framework for Meaningful Engagement of People Living with NCDs, Mental Health, and Neurological Conditions (66)—piloted in Morocco—demonstrates how elevating lived experience as expertise can drive inclusive health system reforms, a model highly relevant for

improving oral health equity for persons with disabilities. In Morocco, cancer survivors shared their challenges with access, stigma, and exclusion in education and the workforce, identifying the need for strengthened multistakeholder and multisectoral collaboration and capacity-building initiatives led by local civil society organisations. Civil society organizations in collaboration with government partners in Morocco have since made progress in establishing legal and social protections in the workforce for people living with cancer. Applying this approach to oral health, especially for persons with disabilities, could involve training individuals with lived experience in advocacy and communication, integrating their voices into policy design, and establishing referral and support networks across health, labor, education, and social sectors. Adapting such an approach for persons with disabilities could support institutionalisation of their participation in policy development processes that shape equitable health systems, including access to oral health care.

4.3 Recommended principle 3: Monitor and evaluate the extent to which the health sector actions are leading to health equity for persons with disabilities

Data on the oral health of persons with disabilities is currently limited to research findings available in the published peer-reviewed literature. Systemic data collection of oral health data rarely includes disaggregation by disability status or functional capacity. Persons with disability are often excluded from epidemiological data collection either explicitly by exclusion of institutional addresses, or implicitly by refusal of proxy representation or lack of appropriate communication. Disability status should be considered an essential primary variable in all data collection, in the same way as gender or age (3). Collecting data through instruments that explicitly gather information on disability ensures a standardized method that can generate cross-country and cross-cultural comparable data on oral health and disability. This is essential for highlighting health inequities experienced by persons with disabilities and identifying context-specific solutions (67, 68).

4.3.1 Relevant actions from GOHAP

The GOHAP proposes the following actions for Member States to respond to these challenges (5):

Action 79

Strengthen oral health information systems by supporting the development and improvement of oral health information and surveillance systems that have capacity to monitor risk factors and the social and commercial determinants of oral health inequities.

Action 82

Increase transparency and accessibility of oral health information by making anonymized information and appropriately disaggregated data on population oral health publicly available to inform research, analysis, planning, management, policy decision-making and advocacy.

Action 90

Prioritize oral health research of public health interest by strengthening implementation and operational research and closing gaps in translation of research into practice for oral health inequities.

To complement the above efforts, the GOHAP also proposes actions for other non-government stakeholders, including (5):

Action 86

Advance oral health metrics by promoting the use of oral health indicators aligned with global health metrics used to assess the burden of disease, such as prevalence and disability-adjusted life years and ensuring these data are disaggregated by age, gender and disability status.

One of the GOHAP's six strategic objectives is devoted only to oral health information systems highlighting its central importance in progressing the global health agenda with robust, timely and policy relevant information to inform decision making. The relevant actions to advance equity for persons with disability focus on development and integration of inclusive data inputs and outputs. These approaches respond to the health system factors that contribute to persistent inequities for persons with disabilities.

4.3.2 Country example - Australia

Australia provides a strong example of how disability-disaggregated oral health data can be systematically collected and analyzed. The 2018 Survey of Disability, Ageing and Carers (SDAC), conducted by the Australian Bureau of Statistics, and incorporated data on oral health care services use, cost barriers and delays in accessing care. The survey identifies disability through a standardized set of questions on limitations, restrictions, or impairments lasting six months or more, grouped across 10 daily living activities and two life domains—school and employment. The survey further classifies disability severity based on the need for assistance or use of aids in core activities such as self-care, mobility, and communication. This framework enabled detailed disaggregation of oral health indicators—by age, sex, geographic location, type of disability, and severity of functional limitation. Such granular data collection on oral health services for persons with disability enables policy issues to be identified and impact of policy measures to be monitored (69).

5. Conclusion

Oral diseases are the most common of NCDs globally, even though they are largely preventable. Persons with disabilities experience a disproportionately high prevalence of these oral diseases along with significant barriers to accessing appropriate and affordable oral health care in line with UHC principles. The global health ambitions towards UHC by 2030, including for oral health care, will not be achieved for the 16% of the world's population with disabilities without concerted efforts to ensure their inclusion (2).

This policy brief has outlined how the GOHAP offers practical opportunities to address these inequities. By implementing GOHAP actions in a disability-inclusive manner—particularly through equitable service delivery, meaningful engagement of persons with disabilities for health policy and program development, and strengthened oral health information systems—progress can be made towards ensuring the needs of persons with disabilities are recognized and met. Achieving the GOHAP's vision of UHC for oral health by 2030 requires commitment to inclusion, equity, and evidence-based action. Persons with disabilities must be engaged not only as beneficiaries but as active contributors to shaping oral health policies and programs that reflect their rights and needs.

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