



Commentary

Oral Health as a Human Right: Support for a Rights-Based Approach to Oral Health System Design

Introduction

Oral health remains a matter of global concern. Improvements in the oral health of affluent populations are overshadowed by the persistent burden of oral disease linked to socioeconomic disadvantage.¹ The causes for the sustained disparities are multifaceted. There is conjecture that the profession is in part to blame. A growth in commercialism fuelled by the demand for complex restorative and aesthetic treatments, coupled with inadequate public funding of dental services, has encouraged the dental profession to turn its back on its social contract and neglect society's most basic oral health care needs.² There may be some truth in this, particularly in affluent nations, but clinical dentistry will always be the end point of managing oral disease. Within disadvantaged communities, elevating oral health, in tandem with elevating general health, is dependent on addressing social determinants including health education and nutrition. This is in addition to resolving deficiencies in health system structure, including health workforce shortages and problems associated with economic and spatial access to primary care. The impact of social determinants was again highlighted during the coronavirus 2019 (COVID-19) pandemic when disease outcome had a close correlation with socioeconomic status, race, ethnicity and place of residence.³

Finding a sustainable approach to tackling inequities in oral health has proved elusive. In recent years there has been growing interest in whether human rights can play a role in improving oral health outcomes. The right to health is a fundamental human right protected in international law by the International Covenant on Economic Social and Cultural Rights (ICESCR). From a rights-based perspective, a failure to achieve progress in realising the highest attainable standard of health is regarded as a health system failure and is framed as a human rights violation.⁴ The right to health is a complex concept that contains normative, philosophical, and practical dimensions.⁵ It is not without limits, and these are dictated by available resources and local priorities.⁶ Whether the right to health is universally inclusive of the right to oral health is unresolved. The acknowledged marginalisation of oral health from general health implies that in many situations it is not considered part of the right to health. In general health policy documents, reasons for the exclusion of oral health are not discussed. Despite the global burden of diseases study

identifying dental caries as the most common preventable disease worldwide, the oral health profession has been unable to persuade the general health sector to consider oral health as an integral element of general health in all countries. Oral health is simply not mentioned. Oral health indicators are excluded from major global health monitoring programs including the Sustainable Development Goals and the Noncommunicable Diseases (NCD) Global Monitoring Framework. The persistence of the truncation of oral health from general health is thought to stem from the entrenched patterns of health workforce education.⁷ The root cause may be a failure to promote the importance of oral health within medical and allied health curricula. This is then perpetuated by the inability of the dental profession to forge a pathway into the spheres of influence that determine health policy direction.

The marginalisation of oral health is unfortunate because there are significant benefits to a holistic approach. Elements of health system design including more efficient use of resources and a more flexible workforce are possible within an integrated system. This is a reciprocal opportunity. An example is the repositioning of the oral health workforce during the response to the COVID-19 pandemic. If the oral health workforce was considered to be part of the general health workforce, it might have been rapidly redeployed to manage testing centres and vaccination clinics.

The United Nations (UN) and World Health Organization (WHO) support the realisation of the right to health through the implementation of the human rights-based approach (RBA) to health system design. In other health settings it has a proven record for improving the health of populations.⁴ Irrespective of whether oral health has rights status, the application of an RBA could strengthen oral health systems. This commentary seeks to explore the purpose of human rights, develop a stronger understanding of the right to health and its role in shaping health policy, and support the drafting of oral health system policy that aligns with an RBA. A more prominent association of rights language with oral health system design has the potential to elevate the priority of oral health within a right to health context.

Human rights

Human rights are principles that define personal freedoms and entitlements.⁸ The Universal Declaration of Human Rights is the contemporary statement on human rights and was drafted by the UN in an attempt to reach global agreement about a set of standards that define acceptable relationships between citizens and the state.⁸ Rights are broadly

Ethics Statement. This article did not involve research with human participants. The policy of The University of Western Australia Human Research Ethics Committee did not require an application for ethics approval exemption for research that did not involve human participants.

divisible into 2 categories. Civil and political rights address freedoms, including a respect of the right to life, protections from abuse of state power, and respect for personal liberty. Economic social and cultural rights address entitlements, including those to the fundamental requirements for enjoyment of a life with dignity. Economic social and cultural rights are based on equality and inclusiveness and require consideration of the needs of all members of society with special protection for minority, marginalised, or vulnerable groups. This group of rights includes the right to shelter, clean water, sanitation, and food. The right to health is a social right.

Human rights are given legal protection in international law through covenants drafted by the UN. The 2 principal covenants are the International Covenant on Civil and Political Rights (ICCPR), and the International Covenant on Economic Social and Cultural Rights (ICESCR). Civil and political rights are subject to immediate implementation, whereas economic social and cultural rights are subject to progressive realisation conditional on available resources. Rights do not exist in isolation and are interdependent and unalienable. For example, respecting the right to health (a social right) is essential to fulfilling the right to a life with dignity (a civil right).

The right to health

The right to health is a social right included in Article 12.1 of the ICESCR:

“The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”⁹

The definition of health is written into the preamble of the WHO Constitution:

“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

The existence of the right to health is further supported by the 1978 Declaration of Alma Ata:

“The Conference strongly reaffirms that health, . . . , is a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal.”

In 1993, the UN Committee on Economic Social and Cultural Rights (CESCR) following recognition that the definition of the right to health was “imprecise,” agreed to coordinate discussion on the topic with the help of external expertise. The resultant consensus was published as General Comment 14 in 2000.¹⁰ This document offers the current definition of the right to health:

“a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.”¹⁰

General Comment 14 expanded further:

“the right to health, as defined in article 12.1 [of the ICESCR], is an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and

adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.”¹⁰

Implementation of the right to health

Ratification of a UN human rights covenant creates a mandate for governments to guarantee rights recognition. Signatories are required to incorporate UN covenants into domestic law. The mode of incorporation domestically varies.¹¹ Some countries include a comprehensive bill of rights in national constitutions; others either have legal frameworks that automatically incorporate international covenants into domestic legislation; or enact legislation that mirrors the UN covenants. Nations can make declarations about how articles will be interpreted locally and record reservations about rights content.¹¹ No UN covenant has been ratified universally. Also, not all nations that have ratified UN covenants have followed with full incorporation of UN human rights into domestic law.¹¹ The UN is unable to enforce the requirement for domestic human rights law legislation and an absence of domestic legislation weakens the obligations of governments to institute policy and regulation to oversee rights protection. In the absence of legal protections, human rights can be respected through progressive policy.

Content of the right to health

Rights are not without limits and these are dictated by resource constraints and local priorities.⁶ The right to health is broadly considered at a population level, and health resources cannot be unreasonably appropriated for personal advantage. Rights only become tangible when a relevant party accepts the role of duty bearer and acknowledges the obligation to respect, protect, and fulfil the rights recognised. Fiscal pressures dominate decisions about the extent of rights content, but other factors including community expectations, entrenched attitudes, and sectoral dominance within the health system can have a strong influence on resource allocation choices. Given these considerations, it becomes evident that oral health might not be considered part of the right to health in all situations (Figure 1).

Oral health and the right to oral health

The contemporary definition of oral health reflects the WHO definition of health by recognising the 3 moderating factors: “disease and condition status, physiological function, and psychosocial function.”¹² It is a holistic definition that centres oral health as an essential component of general health and identifies the connection between normal function including the absence of pain and the ability to “speak, smile, smell, taste, touch, chew, swallow, and convey a range of emotions through facial expressions” and physical and mental well-being.

From a rights perspective, the definition of oral health as a component of general health is relevant. Within a health system that is built to work towards the right to health, the

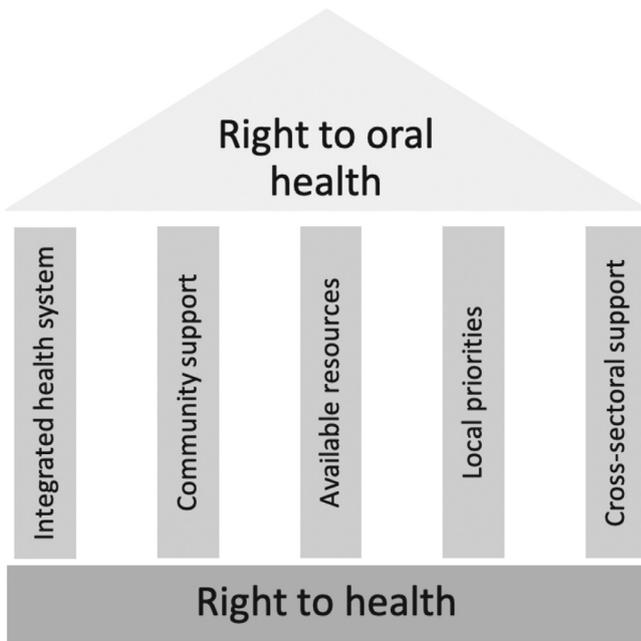


Fig. 1 – The external factors supporting the right to oral health, based on content of: UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health. UN = United Nations.

adoption of an inclusive definition of health automatically elevates oral health to rights status. A failure to include an oral health system as part of the broader health system breaches the obligation to health rights protection. But holding governments accountable for failures to consider all aspects of the right to health is difficult. The CESCR monitors human rights

compliance at a national level and will highlight deficiencies and issue recommendations. There is no imperative to adopt UN recommendations and the CESCR has traditionally been reticent to impose sanctions for breaches of economic social or cultural rights. Many health systems adopt siloed (vertical) designs that continue to marginalise oral health considerations and are more likely to result in oral health neglect.¹³ Ultimately the definitions of both health and oral health do not have seem to have a significant bearing on whether the right to oral health is recognised as an integral element of the right to health. Oral health system design is more indicative of whether oral health is elevated to rights status.

The right to oral health can be realised when oral health systems are designed to align with an RBA. This can happen either as part of an integrated health approach or if oral health system design stands alone. The proven value of an RBA in improving health outcomes warrants more universal consideration of its structure. The more rights language infiltrates oral health policy, the greater the influence of the right to health in achieving progress.

The human rights-based approach

The RBA is a health policy framework designed to assist governments that have ratified the ICESCR to meet their obligation to realise the right to health.¹⁴ Its purpose is to build a health system that is progressive, supports nondiscrimination, and maintains the goal of health equity as a primary consideration. The RBA addresses each element of a health system by considering 4 principle criteria: availability, accessibility, acceptability, and quality (Figure 2). In addition, an

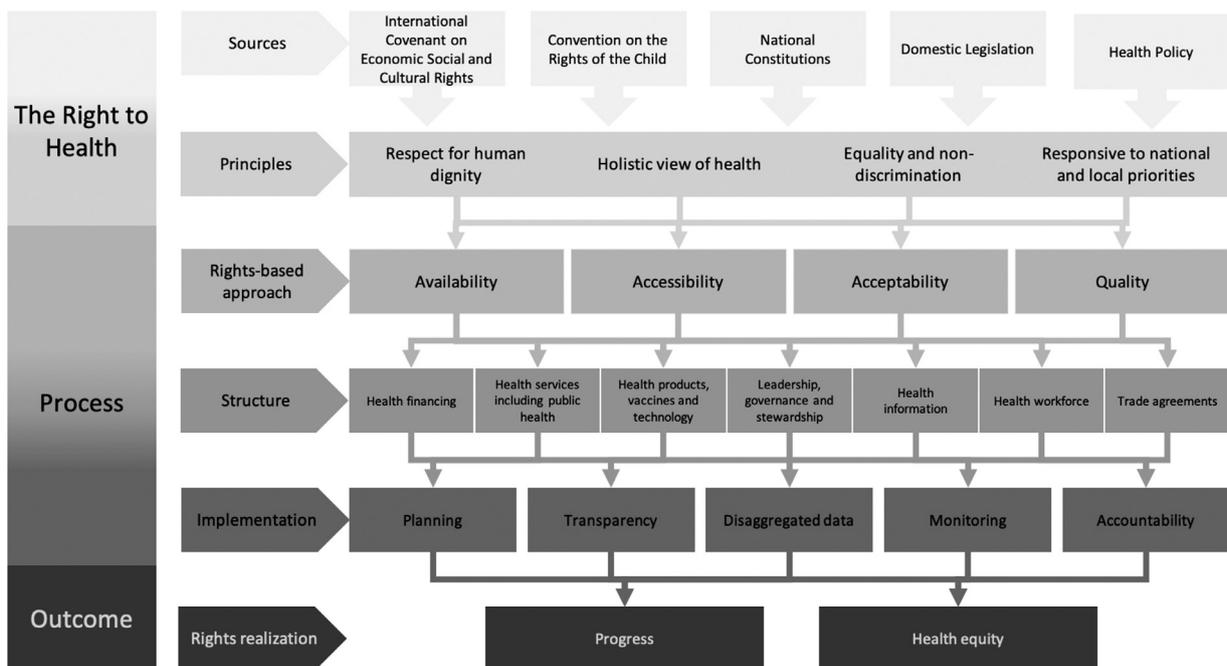


Fig. 2 – The human rights-based approach to health system design, based on content of UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health. UN = United Nations.

RBA must include a strong focus on community involvement and demonstrate steps towards target outcomes. The UN and WHO support the adoption of an RBA. The key to universal transition is to promote dialogue about the intrinsic advantages of an RBA in progressing the right to health. An RBA challenges policy makers to demonstrate progress towards health equity.¹⁴ Written into the ICESCR is a requirement to “take steps.” This necessitates comprehensive planning, which in turn is a core obligation of an RBA. The exact form the steps take are not defined and will vary according to country and health setting. Although many high-income countries continue to focus oral health system design on the westernised model of dental service provision with a strong focus on expanding access to dental care facilities, this approach is not appropriate in low- to middle-income countries. Universally, more can be achieved through thoughtful public health interventions, oral health education, and targeted legislation that promotes primary prevention.^{15,16}

Health equity in tandem with progressive realisation is the driver of an RBA. An RBA seeks to remove the barriers to health caused by discrimination on any grounds including socioeconomic status, gender, age, rurality, or ethnicity. An RBA requires a greater redirection of resources for the benefit of marginalised and vulnerable groups to minimise inequities. This is a departure from the more utilitarian approach to health system planning that has a strong focus on maximising net social utility. An illustrative example is the unequal distribution of health services between urban and rural settings. Positioning health services in metropolitan centres will achieve the greatest population coverage and maximise social utility, but it will marginalise rural populations further and increase inequities. An RBA should adopt clear strategies for the more equitable distribution of health resources.

Community consultation is also a core obligation of an RBA. This recognises the intuitive value that communities bring to discussions about health priorities. The consultation process must be more than tokenistic. Community participation should include representation by vulnerable and marginalised groups, and health policy should demonstrate evidence that their views are respected and incorporated into health system planning.

The right to health prohibits retrogressive steps.^{10,14} Retrogression can happen for many reasons including the withdrawal of health services, planning that does not expand health services in line with population needs, and interference by multinational corporations through the sale and marketing of unhealthy products. A dynamic health plan should incorporate systems to monitor rights progress and be able to respond to deficiencies and changing external factors that threaten progress.

Transparency and accountability to the population and international community is a key requirement of an RBA.^{10,14} Transparency starts with the publication of health policy that shows a commitment to health equity, includes clear indicators and targets and demonstrates the steps to be taken towards their fulfilment. Transparency also requires regular reporting of data that is disaggregated to identify the impact of health policy on marginalised and vulnerable groups.¹⁷ The WHO and UN encourage international cooperation to develop a universal set of indicators for inclusion in national policies.¹⁷ Reaching universal consensus is challenging, and the proliferation

and inconsistent reporting of oral health indicators is a barrier to progressive oral health rights realisation.¹⁷ Although some authorities include extensive lists of indicators, evidence for regular data collection is absent, and it is difficult to find consistent reporting that can demonstrate their use to measure progress. Australia offers an example of why a lack of cohesion in the use of key indicators can mask inequalities and hinder progress in rights realisation. Australia has a national oral health plan that includes a list of key indicators to measure health policy outcomes.¹⁸ The principal responsibility for oral health care in Australia is delegated to the 8 state and territory governments, and each is encouraged to develop an oral health plan at a local level. Only 5 state or territories publish a current oral health plan, the key indicators used differ, and they are not consistent with the national plan. Comparison of oral health outcomes according to state of residence are not possible.

Japan has a universal health insurance system that does recognise oral health as part of general health and embraces many of the attributes of an RBA. The scheme addresses spatial and economic access to primary oral health care and has invested resources into dental education and preventive programs.¹⁹ The inclusion of oral health within the scheme is credited with lowering lifetime dental disease experience, raising rates of tooth retention into old age, and improving oral health behaviours. Within Japan, there are still differences in oral health status based on socioeconomic profile and rurality. Progress towards full implementation of an RBA would require the redirection of resources to prioritise disadvantaged groups.

Conclusion

The rights status of oral health is not settled. Rights only exist when duty bearers accept the obligation to be accountable for progressive rights realisation. The definition of oral health supports the integration of oral health within the broader framework of general health, but the exclusion of oral health from the universal health care systems of many countries reduces its rights status. In the absence of integrated health system design, progress in realising the right to oral health can still be achieved through the drafting of oral health system policy that conforms to an RBA. This would be strengthened by the consistent use of rights language in oral health policy, the adoption of universal right to oral health indicators, the support of comprehensive data collection and analysis, transparent reporting, and proactive and responsive policy adjustments. To recognise the right to oral health as a fundamental human right, it is necessary to challenge health policy ideology and support a more integrated and universal RBA to oral health system design.

Acknowledgements

The authors would like to thank Professor Marc Tennant for his encouragement and critical insights in the drafting of this commentary.

Funding

None disclosed.

Conflict of Interest

None disclosed.

REFERENCES

1. Watt RG, Daly B, Allison P, et al. Ending the neglect of global oral health: time for radical action. *Lancet* 2019;394:261–72.
2. Moeller J, Quiñonez CR. Dentistry's social contract is at risk. *J Am Dent Assoc* 2020;151(5):334–9.
3. Abrams EM, Szeffler SJ. COVID-19 and the impact of social determinants of health. *Lancet Respir Med* 2020;8(7):659–61.
4. Secretary-General. The right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Geneva, Switzerland: United Nations; 2006 Report No.: A/61/338.
5. Tobin J. The right to health in international law. 1st ed Oxford, UK: Oxford University Press; 2012.
6. Hunt P. Interpreting the international right to health in a human rights-based approach to health. *Health Hum Rights* 2016;18(2):109–30.
7. Benzian H, Hobdell M, Holmgren C, et al. Political priority of global oral health: an analysis of reasons for international neglect. *Int Dent J* 2011;61(3):124–30.
8. United Nations General Assembly. Universal Declaration of Human Rights. Geneva, Switzerland: United Nations; 1948. Report No.: No Res 217A (III).
9. International Covenant on Economic, Social and Cultural Rights. Australian Treaty Series 1976 No. 5. Available from: <http://www.austlii.edu.au/au/other/dfat/treaties/1976/5.html>. Accessed June 19, 2017.
10. United Nations Committee on Economic, Social and Cultural Rights. General comment 14 on the right to the highest attainable standard of health. New York, NY: United Nations; 2000 Report No.: E/C.12/2000/4.
11. Lundy L, Kilkelly U, Byrne B. Incorporation of the United Nations Convention on the Rights of the Child in Law: A Comparative Review. *Int J Child Rights* 2013;21(3):442–63.
12. Glick M, Williams DM, Kleinman DV, Vujicic M, Watt RG, Weyant RJ. A new definition for oral health developed by the FDI World Dental Federation opens the door to a universal definition of oral health. *Int Dent J* 2016;66(6):322–4.
13. Hunt P, Backman G. Health systems and the right to the highest attainable standard of health. *Health Hum Rights J* 2008;10(1):81–92.
14. Hunt P. Report of the Special rapporteur for health: health systems and the right to the highest attainable standard of health, New York, NY: UN General Assembly; 2008. Report No.: UN Doc A/HRC/7/11.
15. Cohen LC, Dahlen G, Escobar A, Fejerskov O, Johnson NW, Manji F. Dentistry in crisis: time to change. La Cascada Declaration. *Aust Dent J* 2017;62(3):258–60.
16. Lawn JE, Rohde J, Rifkin S, Were M, Paul VK, Chopra M. Alma-Ata 30 years on: revolutionary, relevant, and time to revitalise. *Lancet* 2008;372(9642):917–27.
17. Hunt P. Report of the special rapporteur for health: The right of everyone to the enjoyment of the highest attainable standard of physical and mental health, New York, NY: UN Commission on Human Rights; 2003. Report No.: UN Doc E/CN.4/2003/58 1.
18. Oral Health Monitoring Group. Australia's National Oral Health Plan 2015–2024. Canberra, Australia: Australian Government; 2015. p. 92.
19. Zaitsev T, Saito T, Kawaguchi Y. The oral healthcare system in Japan. *Healthcare* 2018;6(3):79.

Gillian Jean *
Estie Kruger
Vanessa Lok

*International Research Collaborative – Oral Health and Equity,
School of Human Sciences, The University of Western Australia,
Crawley, WA 6009, Australia*

*Corresponding author. School of Human Sciences,
The University of Western Australia, 35 Stirling Highway,
Crawley, WA 6009, Australia

0020-6539/© 2020 The Authors. Published by Elsevier Inc. on
behalf of FDI World Dental Federation. This is an open access
article under the CC BY-NC-ND license
(<http://creativecommons.org/licenses/by-nc-nd/4.0/>)
<https://doi.org/10.1016/j.identj.2020.12.021>