ORAL HEALTH AROUND THE WORLD

WITH PROFESSIONAL EXPERIENCE IN FOUR DIFFERENT COUNTRIES – THE UNITED STATES, ITALY, SWITZERLAND AND THE UNITED KINGDOM, MAURIZIO TONETTI, CHAIR OF THE DIVISION OF PERIODONTOLOGY AT THE UNIVERSITY OF CONNECTICUT HEALTH SCIENCES CENTER HAS A TRULY GLOBAL PERSPECTIVE ON ORAL HEALTH. HERE HE OFFERS A FEW INSIGHTS ON ORAL HEALTH AND SYSTEMIC DISEASE:

ON EDUCATION AND THE CONVERGENCE OF DENTISTRY AND MEDICINE: A common biomedical curriculum is much more prevalent in Europe than in the U.S. Until 1980, in most countries, dentistry was a medical specialty, so you became a physician, and then specialized in dentistry—rather than, say, cardiology or orthopedics. So, the foundation of dentistry in the majority of European countries has very, very deep medical roots. In the United States most dental schools have their own faculty teaching such courses as anatomy, pharmacology and biology. In Europe it's not like this. There is a biomedical science faculty that includes medicine and dentistry.

A strong biomedical curriculum is needed not only because of the possible systemic implications of oral diseases, but also because of the fact that people are living longer. So all of a sudden, dentistry has become an important component of life expectancy, of the well-being of people.

ON RESEARCH ADDRESSING THE ORAL-SYSTEMIC LINK OUTSIDE THE U.S.: There's lots of enthusiasm and attention, but unfortunately all of this has translated into fragmented efforts. There is no body, no organization that has been able to catalyze and focus research activity in places as diverse as Africa, the Far East, Europe—even within Europe—and in the United States.

We are missing a tremendous opportunity because there are lots of people around the world that are doing research with very, very few resources, but the usefulness of what they are doing is limited by the fact that there is no coordination or consistent methodology being employed. In Europe we have been—and in other areas of the world we are still—at the level of pilot [studies] involving a few hundred patients. The building blocks to be able to do the real clinical trial are there. Now it's time to do the real studies. We need to focus efforts and develop a vision in order to make a coordinated research effort happen.

ON PRESS COVERAGE OF THE ORAL CONNECTIONS TO OVERALL HEALTH: In Europe we have been much more cautious than in the U.S. We have kept the dental profession very well informed by making sure that these topics are discussed at professional meetings, but by and large we have not had major press releases on the topic. Over the last two years there has been an increased awareness, and the media has started to communicate. I think this is perhaps a better approach than the U.S. media hype; wait until you have enough data and then go to the people. Ideally, communication should include both the problem and the recommendation of effective and accessible interventions or preventive measures.

Also, in Western society, these messages are likely to reach the portion of the population that could benefit least. The people you reach with these messages are the ones whose "health IQ," or health awareness, is so developed that they are unlikely to be the ones harboring massive undetected disease.

ON CHANGES AT THE WORLD HEALTH ORGANIZATION (WHO) ON ORAL HEALTH: Historically, before a relatively recent reorganization in the 1990s, oral health was part of a WHO branch that focused on infections. Now, they have placed it with chronic noncommunicable diseases. They have grouped together areas where risk factors of the population base are similar because they think this is the best way to fight these diseases; many countries are following this approach.

ON ORAL HEALTH IN EUROPE: Europe is not a homogeneous reality. You have countries that are responsive to the needs of populations: they have public health systems that are probably the envy of the world—probably, I would say, better than the U.S. But Europe, being made of 25 states these days, has a wider discrepancy of care than between, say, Connecticut—which is probably one of the states with the best access to dental care and best health policy in the U.S.—and Louisiana, or rural Alabama. Health care is a state issue, not a European Union issue. Oral health care in traditional EU countries is generally good, but significant disparities among the various countries and disadvantaged groups and individuals exist. As in the U.S., in Europe the major burden of oral disease is to be found in a minority of the population.

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