Out of sight, out of care: The marginalisation of oral health in public policy

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When the mouth disappears, so does the patient

There is a strange quiet around oral health in South Africa: a kind of silence not born of irrelevance, but of omission. While the country mobilises around universal health coverage, builds policy frameworks for noncommunicable diseases and reimagines access to care, one part of the body continues to be left behind – the mouth.

It is a disappearance that is subtle, systemic and dangerous. Oral health is scarcely mentioned in national policy debates, barely represented in funding streams and routinely overlooked in health planning and reporting. Despite the mounting evidence that oral diseases are widespread, interconnected with systemic illness and deeply inequitable in their distribution, the mouth remains invisible in the very spaces where health priorities are defined.

This editorial is not a complaint, it is a call to clarity. It does not seek blame, but insight. We ask: How did we allow this erasure to happen? And, more urgently: How do we correct course before the cost becomes irreversible, not only for the dental profession but for the patients we are failing to serve?

What follows is not just a critique of policy, it is a differential diagnosis of collective blind spots, and a set of evidence-informed, practical actions to reposition oral health where it belongs – at the centre of care, within the broader story of health in South Africa.

The mouth is not a luxury. It is not optional. It is health, full stop.

The disappearing mouth: a metaphor for systemic blind spots

In the story of health in South Africa, the mouth has quietly disappeared. It is neither centre stage in policy discussions, nor given a meaningful line in the national script for health priorities. Yet its absence speaks volumes.

Oral health, unlike many other areas of healthcare, suffers not from lack of relevance, but from lack of recognition. It is a silent contributor to suffering, to school absenteeism, to avoidable hospital visits and to diminished quality of life. And while it is intimately linked to chronic conditions such as diabetes, cardiovascular disease and HIV/AIDS, it remains largely invisible in the design and delivery of health services.

As mentioned, this editorial is not a protest, but rather it is a provocation. It is an invitation to reflect on why oral health continues to fall through the cracks of policy, practice and planning. We ask not merely whether oral diseases are prevalent (they are) but why the institutional response has been so muted, and what this says about the way we define health in the South African context. The mouth may have disappeared from our policies, but it has not disappeared from our people. And if we are to build a truly integrated and equitable health system, it is time to bring it back into focus.

The forgotten front line: the real burden of oral diseases in South Africa

Oral diseases are neither rare nor benign. Globally, untreated dental caries in permanent teeth is the most common health condition, affecting an estimated 2.5 billion people. In South Africa, the situation is no less concerning, yet the data to quantify the full extent is outdated or absent. The last national oral health survey was conducted more than two decades ago (1999-2002),[1] and efforts to repeat it have not come to fruition, despite calls from both professional bodies and public health experts.

What we do know comes from regional and smaller-scale studies, which continue to reveal unacceptably high levels of dental decay and periodontal disease, especially in underserved populations: A 2023 study in Gauteng reported that more than 40% of school-aged children presented with untreated dental caries, leading to pain, absenteeism and disrupted learning.[2]

Periodontal disease remains highly prevalent among adults, with data from the South African Demographic and Health Survey indicating a growing burden of severe periodontitis, particularly in males and older populations. In communities with limited access to dental services, advanced oral infections – including those related to HIV, TB and poorly controlled diabetes – go undiagnosed, reinforcing health disparities.

These are not just dental problems; they are public health failures. Untreated oral diseases lead to difficulty eating and speaking, poor self-image, chronic infection and, in some cases, life-threatening complications. The cost of neglect is borne in the form of reduced productivity, impaired school performance and preventable hospitalisations. Yet oral health continues to be framed as a peripheral concern, if not omitted altogether, in national health policy.

The truth is that the burden of oral disease in South Africa is significant, predictable and largely preventable. But without comprehensive, up-to-date national data, and without systemic acknowledgment of the issue, oral diseases remain on the margins of both research and response. To speak of a disappearing mouth is not metaphor alone. It reflects a very real epidemiological gap: a health burden so widespread that it becomes invisible, because we have not chosen to see it clearly.

Not in the room: the downgrading of oral health from national policy agendas

In the architecture of South Africa's health policy, oral health remains an afterthought, if it appears at all. While the country has made commendable progress in building a more

equitable and integrated health system, oral health has too often been excluded from the rooms where decisions are made.

Nowhere is this more evident than in the National Health Insurance (NHI) Bill, the centerpiece of South Africa's push towards universal health coverage. Despite strong rhetoric around equity and accessibility, the bill makes only cursory mention of oral health, with little indication of how dental services will be integrated into primary care packages or funded sustainably across provinces. Without a defined oral health benefit, and with no clear roadmap for human resources or infrastructure investment, dental services risk being deprioritised in both planning and budgeting processes once the NHI is implemented.

The same absence is reflected in broader noncommunicable disease (NCD) strategies, where oral health, though inextricably linked to diabetes, cardiovascular disease and cancers, is often omitted from national frameworks and surveillance systems. Even within the Integrated School Health Policy, dental care features more as a footnote than a core pillar of child health.

This omission is not accidental; it is structural. For years, oral health has lacked formal representation at high-level planning tables, with few select dental professionals involved in national or provincial health strategy forums. The underrepresentation of oral health in governance means that critical decisions about resource allocation, workforce development and service delivery models are often made without considering their impact on the dental profession or the patients it serves.

It is not that oral health has no place in the system – it simply hasn't been invited in. And when health priorities are shaped without its input, the result is a slow erosion of relevance: budget lines shrink, registrar posts disappear, school programmes are cancelled and clinic shelves run empty.

I do not suggest that this is the result of malice or disregard. Rather, it reflects a system that has not yet come to see the mouth as integral to the body, and oral health as inseparable from general health. If we are to change this, the dental profession must not wait to be invited, we must step forward and claim our seat at the table, armed with evidence, policy fluency and the will to lead.

Symptoms of neglect: service, workforce and system failures

When oral health is not prioritised in policy, the symptoms manifest everywhere, in our clinics, in our classrooms and in our communities.

Across South Africa, dental professionals report frequent stock-outs of basic materials, including local anaesthetic, gloves and impression materials. Dental chairs, if even installed on site, sit idle for months awaiting repair, and sterilisation equipment often functions well beyond its safe operational lifespan. Oral health services may even be informally suspended in some public clinics to redirect limited resources elsewhere, leaving patients with pain, infection and few options.

At a systemic level, the picture becomes more concerning. Sessional and periodical contracts, once the backbone of clinical teaching and service delivery, are increasingly vulnerable to cost-cutting measures. Without these part-time clinician-teachers, dental schools cannot provide adequate clinical supervision. Students will then be forced to extend sharing of clinical sessions, further limiting their hands-on exposure and undermining the competency-based goals of their training.

Meanwhile, registrar posts in critical disciplines remain empty (for whatever reasons given), as we silently fall behind in specialist succession planning. Without a pipeline of trained academics and specialists, the burden shifts onto a shrinking cohort of overextended faculty, most of whom already wear the triple hats of clinician, educator and administrator. The system is not only overburdened; it is becoming structurally unsustainable.

At the community level, outreach programmes, once proudly integrated into school health and mobile services, have become patchy or nonexistent in many provinces. This regression is not only a missed opportunity for prevention and early intervention; it is a breach in the continuum of care that disproportionately harms children, the elderly and rural populations. Where such services persist, they do so despite policy support, not because of it, driven by local champions rather than systemic commitment.

These are not isolated frustrations, they are the predictable outcomes of a system that has not made oral health a priority. And they demand a national conversation not only about funding, but about values. What does it mean to speak of equity, prevention and access, while whole disciplines and service lines fade into the background? South Africa does not lack the clinical skill, professional commitment or some of the training infrastructure to deliver excellent oral healthcare. What it lacks is the policy recognition and system-level support to match the reality on the ground.

A mouth that connects: making the case for oral health as a multisectoral interface

The mouth is not an isolated structure – it is a mirror of systemic health and a gateway to broader disease. It speaks not only in words, but in lesions, inflammation and microbial shifts that often reveal what the rest of the body conceals. And yet, oral health remains siloed from the rest of the healthcare system, both in how we train and in how we treat, and perhaps how we are treated.

We can no longer afford to view oral healthcare as a standalone service. The evidence is clear: oral conditions are deeply intertwined with chronic illnesses such as diabetes, HIV/AIDS, cardiovascular disease and even adverse pregnancy outcomes. Periodontitis has been identified as a risk marker and modifiable factor in several systemic diseases. Oral lesions are often the first clinical signs of immunosuppression or systemic infection. In oncology, oral medicine specialists play an essential role in managing the oral toxicities of chemotherapy and radiotherapy, yet few are available in public sector settings.

Despite this, oral health professionals are still rarely integrated into interdisciplinary healthcare teams, and dental considerations are often omitted from clinical care pathways and referral systems. This gap not only undermines holistic patient care, it also represents a missed opportunity to prevent, detect and manage systemic conditions earlier and more effectively.

Reimagining oral health as a multisectoral interface opens the door to a new kind of relevance. It positions dental professionals as key contributors to team-based care, to early detection and to the management of shared risk factors across conditions. It invites stronger partnerships between oral health and primary care, infectious disease, maternal health, endocrinology, oncology, dermatology, pediatrics and geriatrics. It also calls on the dental profession itself to step into these spaces, not as guests, but as partners in the design and delivery of integrated health.

Training must reflect this shift. Dental students and specialists must be exposed to interdisciplinary education and practice. Public health policies must embed oral health into national screening, referral and chronic care frameworks. And, most importantly, healthcare administrators and policymakers must see oral health not as an adjunct, but as an amplifier of public health outcomes.

In an era where systems-thinking is rightly celebrated, we must ask: how can we claim to be integrated if the mouth remains disconnected?

Toward reclaiming the mouth: five calls to action

The road to reintegrating oral health into South Africa's health agenda is not without obstacles, but it is navigable. What is needed now is not more rhetoric, but deliberate and coordinated action, rooted in shared responsibility across disciplines, institutions and levels of government.

These five calls to action offer a starting point:

1. Put oral health in the room

Oral health must be formally included in strategic health decision-making bodies, from NHI steering committees to national NCD task teams and school health implementation groups. The absence of dental professionals from high-level planning structures leads to blind spots in policy and underinvestment in services. Inclusion is not symbolic, it is structural. Let oral health professionals shape the policies that govern them.

2. Fund the data

South Africa urgently needs a new national oral health survey, not just to understand the scope of disease but to inform resource allocation, workforce planning and service design. Without contemporary, disaggregated data, oral health remains an invisible burden. Funding must be prioritised to support routine oral epidemiological surveillance, integrated with existing NCD and primary care data systems. What we do not measure, we will not manage.

3. Train for tomorrow

We must invest in a future-ready oral health workforce. This includes restoring and protecting registrar posts in all specialties, enabling structured postgraduate training in the public sector. It also requires better utilisation of oral hygienists and dental therapists, whose roles in prevention, education and community-based care are underleveraged. Without training today, we will have no teachers, or clinicians, tomorrow.

4. Engage the community

The decline of outreach services and school-based oral health programmes is not just a loss of service, it's a missed opportunity for prevention, education and equity. Provinces must reinstate these programmes and grow existing ones further, supported by public-private partnerships and integrated with nutrition, hygiene and health literacy initiatives. Prevention is not a luxury, it is a necessity, especially for those with the least access.

5. Protect the pipeline

The stability of oral health training platforms, especially dental faculties embedded in public sector service models, must be safeguarded. These institutions are essential for producing competent practitioners, delivering care and generating research. National and provincial departments must collaborate to ensure these platforms are adequately staffed, resourced and retained. We cannot expect a pipeline to produce anything if we allow the source to run dry.

These actions are not radical. They are reasonable, feasible and overdue. More importantly, they reflect a shift in mindset, from treating oral health as a peripheral service to recognising it as a core component of public health.

Reclaiming what has been lost

The silence around oral health in South African policy is not benign. It is the quiet erosion of something vital: our ability to care holistically, equitably and responsibly for those who rely on the public health system. And like all things left unattended, it will not fix itself. The longer we wait to respond, the more invisible the problem becomes, until the mouth, and all it represents, vanishes from view entirely.

But the disappearance of oral health from our national priorities is not inevitable. It is the result of choices, of what we measure, fund, staff and elevate. And that means it can be reversed. We can choose to recentre oral health. We can choose to speak of it not in isolation, but as integral to dignity, nutrition, learning, chronic disease management and quality of life. We can choose to train, to serve, to lead.

There is no shortage of skill, passion or purpose within the dental profession. What is lacking is the systemic recognition that oral health is not a peripheral concern, but a public health necessity. It is time for policymakers to acknowledge this truth, not as a courtesy to the profession, but as a duty to the people. Because when oral health disappears from our planning tables, it disappears from our patients' lives. Their pain does not vanish. Their infection does not wait. Their dignity does not pause until a policy shift arrives. And their trust in a health system that sees everything but their mouth begins to fade.

The question, then, is not whether we can act. It is whether we are prepared to live with the consequences if we do not.

References:

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