

# Public policies, rights, and dental health programs in the United States of America: implementation and access to care

## Políticas públicas, derechos y programas de salud dental en los Estados Unidos de América: implementación y acceso a la atención

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### Abstract

The purpose of the article is to identify the structure of public health policy in the United States of America (USA) and the execution of oral health programs, the means used and the population's access to them. It is oriented towards a qualitative approach, supported by the interpretive paradigm of documents that provide information from official government sources, public health entities, federal, state, and local agencies, scientific articles, and literature on the topic. The study is categorized with a documentary-bibliographic design, the method used was analysis-synthesis. The results reveal that public health policies are formulated according to the administrative levels: federal, state, and local; however, the autonomy in each state allows defining norms appropriate to its geographical context. Access to free or low-cost medical care is conditioned by certain terms of eligibility for government plans: Medicaid and Medicare, which do not include dental care. Prevention and fluoridation services are the most common strategies applied by dental health providers. It is concluded that, in the public health policy cycle, there is cohesion between the levels of government and the actors. The lack of prioritization of dental health as a public policy is not exclusive to the USA, it is a global pattern, violating the rights to access, inequality, conditioned by the high costs of dental services. It is recommended that the dental union's proposals for health policy reform should be promoted and visible to the whole stakeholders' community.

**Keywords:** dental health programs, public health, public policies, rights.

### Resumen

El artículo tiene como propósito identificar la estructura de la política de salud pública en los Estados Unidos de América (EE. UU.) y la ejecución de los programas de salud bucal, los medios utilizados y el acceso de la población a éstos. Se orienta al enfoque cualitativo, apoyado en el paradigma interpretativo de documentos que aportan información de fuentes oficiales del gobierno, de entidades de salud pública, dependencias federales, estatales y locales, artículos científicos y literatura acerca del tema. El estudio está categorizado con diseño documental-bibliográfico, el método utilizado fue el de análisis-síntesis. Los resultados revelan que las políticas de salud pública están formuladas según los niveles administrativos: federal, estatal y local, no obstante, la autonomía en cada estado permite definir normas adecuadas a su contexto geográfico. El acceso gratuito a la asistencia médica o de bajo costo, está condicionado a unos términos de elegibilidad a los planes del gobierno: Medicaid y Medicare, los cuales no contemplan asistencia dental. Servicios de prevención y fluoración son las estrategias más comunes aplicadas por proveedores de salud dental. Se concluye que, en el ciclo de la política de salud pública existe cohesión entre los niveles de gobierno y los actores. La falta de priorización de la salud dental como política pública no es exclusividad en USA, es un patrón mundial, vulnerando los derechos al acceso, desigualdad, condicionadas por costos elevados que representan servicios dentales. Se recomienda que las propuestas del gremio odontológico para la reformar la política de salud dental sean promovidas y visibles a toda la comunidad interesada en esta área.

**Palabras clave:** derechos, políticas públicas, programas de salud dental, salud pública.



## INTRODUCTION

This research is directed toward studying the approach on which the public health policy in the United States of America (USA) is based, specifically on oral health. It is essential to address the foundation on which the U.S. government is based. [The official White House website \(2023\)](#) states that the Federal Government comprises three branches: the legislative, the executive, and the judicial. Their powers are granted by the U.S. Constitution to the Congress, the President, and the federal courts, respectively.

Given the importance of the system of government that characterizes the USA, it is essential to synthesize the conceptualization of federalism. In this regard, [Brotschek \(2017\)](#) explains that the term “federalism” originates from the Latin word “foedus,” which means ‘treaty or agreement.’ At the root of federalism lies the idea of a voluntary agreement based on a pact for creating a union formed by entities or states that, until that moment, operated with autonomy (pg. 25).

Focusing on the structure of federalism, authors [Hofmeister and Tudela \(2017\)](#) assert that “it is a form of state organization, in which power is divided between the central government and regional entities, whether these are called federated states, autonomous regions, provinces, or otherwise” (pg. 8). In this regard, as [Contreras \(2012, pg. 6\)](#) articulates, a federal system distributes its competencies between the central power and the authorities that constitute the States.

So that the administrative model is structured at three federal, state, and local levels. The delegation of powers is expressed in the Tenth Amendment to the Constitution, primarily to the States and the people, except for those explicitly reserved for the federal government. States choose to exercise autonomy through their laws, which can be executed directly or delegated to local governments. This illustrates how federalism grants independence to the three levels of government.

The priorities set by the current government under President Biden ([White House official website, 2023](#)) are oriented towards controlling COVID-19, immigration reforms, economic assistance, climate change, restoring the US’s geopolitical standing in the world, racial equity, and health services. Regarding the priority in health, which is the focus of this topic, the government’s discourse is based on “protecting and expanding Americans’ access to affordable and quality healthcare services” and “reducing the costs of these services and making our healthcare system easier to navigate.

As public policies are formulated, they are adapted to the needs and priorities of the inhabitants in terms of health, so there is no single plan. From this derives the guidelines for the design, development, and implementation of programs, projects, and strategies, which are determined by factors such as available resources and financing systems.

However, due to the complexity and breadth of the topic addressed regarding the processes of design, formulation, implementation, and management of public health policy in the USA, along these lines of consideration, the aim is to identify the structure of public health policies and their oral health programs.

It is important to briefly mention the Open Government Plan (2016), whose principles are transparency, participation, and collaboration and applied throughout public administration. This plan commits its public officials to manage any requests from other sectors and actors, incorporate them into a discussion, and elevate their requests for public and open consultation before deciding. The exact same process applies to legislative proposals before adopting them.

The article's composition addresses the following aspects related to understanding the topic. Firstly, the public health system and its structure, followed by the role of state and local governments. The governance classifications in the Department of Health and Human Services (DHHS) in the USA are presented from there. Subsequently, the budgetary process for health is briefly explained. Later, the focus shifts to basic health programs and oral health programs, as well as the agencies that execute these programs. The oral health programs in the state of Florida are detailed, and the most common oral health issues in the USA are mentioned. Finally, some conclusions are presented.

## METHODOLOGY

This research is of a social and political nature, so the current study methodically leans towards a qualitative approach, relying on the interpretative paradigm. In this context, [Hernandez, Fernandez & Batista \(2014\)](#) explain that, from an epistemic perspective, it seeks to study reality and its characteristics. The purpose of this article is to identify the structure of public health policy in the USA, with a particular emphasis on oral health programs.

The documents that have been studied illustrate the pathways through which health policies are generated and implemented in the USA. Additionally, they identify the actors that serve as executing agents of public health policies and their programs related to oral health. Generally, these include official US Government documents, federal, state, and local health entities, official government websites, scientific articles, and literature.

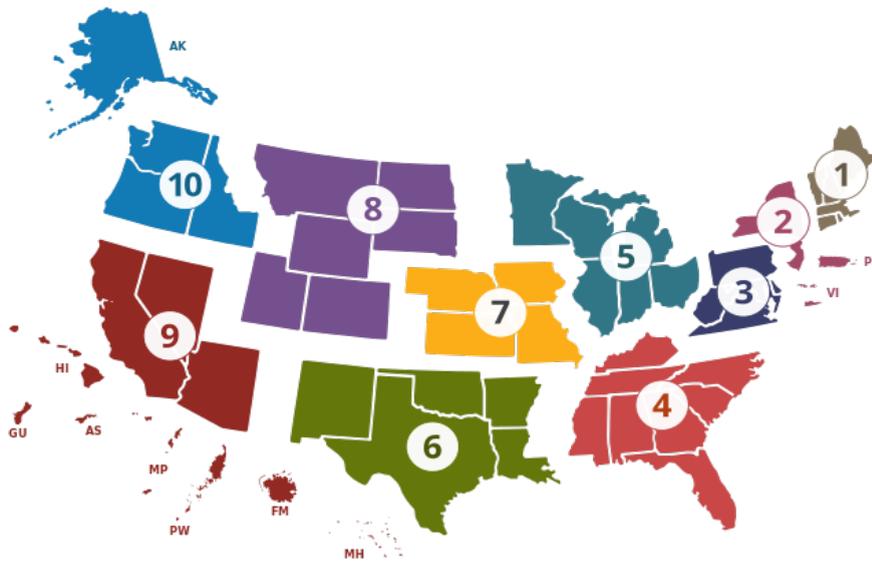
Consequently, the study is categorized with a documentary-bibliographic design through methodical actions and procedures for searching, selecting, and organizing information based on the consulted information sources. The method used for development was the analysis-synthesis method.

### ***Public Health System: Agencies that articulate the guidelines for their operation.***

The public health system in the USA is structured for implementation through federal and state programs. This means that there isn't a single design, a characteristic that corresponds to the federalist system of government, where the powers vested in the States ensure that each region tailors' responses to the needs of its context. However, this doesn't mean there's a separation from the significant health policies that generally originate from the Federal government.

Public health is affiliated with the DHHS at the federal level. In turn, it is organized into ten regions nationwide, illustrated in Map 1:

**Figure 1**



**Note:** Health and Human Services Regional Offices.

**Source:** U.S. Department of Health and Human Services (2023).

To detail the demarcation illustrated in figure 1 (map), the states represented in each region are subsequently specified:

- **Region 1, Boston:** Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont
- **Region 2, New York:** New Jersey, New York, Puerto Rico, and the Virgin Islands
- **Region 3, Philadelphia:** Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia
- **Region 4, Atlanta:** Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee
- **Region 5, Chicago:** Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin
- **Region 6, Dallas:** Arkansas, Louisiana, New Mexico, Oklahoma, and Texas
- **Region 7, Kansas City:** Iowa, Kansas, Missouri, and Nebraska
- **Region 8, Denver:** Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming
- **Region 9, San Francisco:** Arizona, California, Hawaii, Nevada, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Marshall Islands, and Republic of Palau
- **Region 10, Seattle:** Alaska, Idaho, Oregon, and Washington (DHHS, 2023)

One of its health entities responsible for implementing health programs is the Centers for Disease Control and Prevention (CDC), which works in conjunction with the States and other organizations to monitor and prevent disease outbreaks, apply

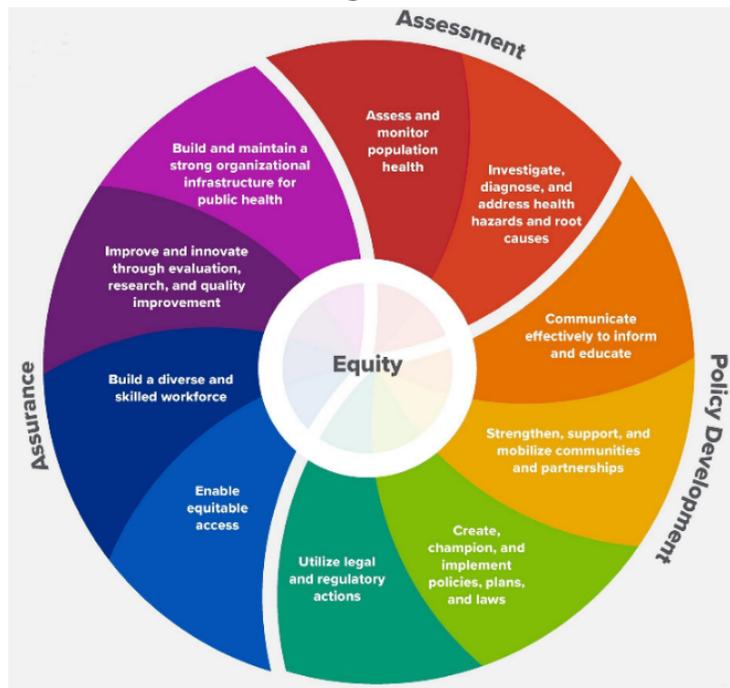
strategies, and update national statistics. The reach of the CDC in countering the spread of diseases extends to over 25 countries worldwide.

The perspectives of the health system are framed within the 10 Essential Public Health Services (EPHS), as published on the CDC’s website. All communities must develop these activities. The first publication of the EPHS was in 1994 by a federal working group, describing the activities that public health systems should promote and apply in communities. In 2020, a revised version of the EPHS was published to align the framework with current and future health practices. (CDC, 2020)

The current version of the EPHS was achieved in collaboration between the Public Health National Center for Innovations (PHNCI) and the [Beaumont Foundation \(2020\)](#). The team was composed of various agents: experts, leaders, public health professionals, and experts from federal agencies, including the CDC, to inform the changes incorporated into this EPHS action framework.

The action framework of the 10 Essential Public Health Services is organized into three main functions: Assessment, policy development, and assurance. Figure 2 presents in a circular format the 10 Essential Public Health Services and the function to which each corresponds, emphasizing that, in the field of public health, it’s a recognized graphic with which agents and actors are familiar. This framework is essential because health departments and national actors structure their work based on its content. It serves as guidance in schools and public health programs. Also, it serves as a guideline in the Public Health Accreditation Board (PHAB), which supports Health Departments in the accreditation and evaluation processes related to education, technical assistance, and research. (PHAB, 2023).

**Figure 2**



**Note:** 10 Essential Public Health Services Futures Initiative Task Force.  
**Source:** Public Health National Center for Innovations (2020).

Revisiting the previous statement, within the EPHS framework, three functions (Beaumont, 2020) are outlined in Figure 2. These functions encompass several essential services, emphasizing that the central theme is the principle of equity. These are described below:

1. “On the assessment function, the services are: Assess and monitor population health status, factors influencing health. Investigate, diagnose, and address health problems and hazards affecting the population.
2. Regarding the policy development function, the services are: Communicate effectively to inform and educate people about health, factors influencing it, and how to improve it. Strengthen, support, and mobilize communities and partnerships to improve health. Create, champion, and implement policies, plans, and laws that impact health. Utilize legal and regulatory actions to improve and protect public health.
3. Lastly, the services tied to the assurance function are: Assure an effective system. Build and support a diverse and skilled public health workforce. Improve and innovate public health functions. Build and maintain a solid organizational infrastructure for public health.” (pgs. 12-25)

Concerning the details shared in this section, the significant impact of the collective actions the government has cohesively implemented concerning public health policies stands out. It showcases the collaboration between the government, expert groups, stakeholders, and partners to formalize the programs designed under the EPHS framework. These objectives form a roadmap to reach the nation’s communities, ensuring they attain health in the best possible conditions. (Beaumont, 2020, pg. 11)

The 10 Essential Services for Public Health are regarded as a guiding framework across various governmental and administrative levels, among other stakeholders and institutions in the U.S. Therefore, if one were to assess the policy’s implementation, the outcome would likely be positive due to the collaboration of various actors.

### ***The role of State and Local Governments in the Public Health System***

Previously, we discussed those fundamental policies stem from the federal government. As Villalbi & Guix (2006) point out, states can design their policies and decide where to emphasize their implementation. On the local level, the counties’ actions are taken based on pressing needs. (pg. 73). Each State has its own State Health Department, structured to cater to its unique characteristics and peculiarities. This tailoring considers not just geographical contexts but also the governance styles of the officials in charge. In essence, the primary role of these state agencies is to define policies and standards, finance service provision, support expert staff, provide basic public health services through third parties within the state’s territory, and rely on other agents for assistance.

An example is the Florida Department of Health (2023), whose purposes are framed around the protection, promotion, and improvement of the health of Florida residents. In this regard, it integrates collaborative work with counties (localities) and communities to execute public health policies. Other significant actions include statistics registration, disease sanitary control, and regulations. The official web-

site of the [Florida Department of Health \(2023\)](#) explicitly handles the contingency and logistics for “emergencies and disaster response; ensures food and drug safety; and provides surveillance and control of radiological, chemical, biological, and other environmental hazards”. Policies implemented through programs are Children’s Medical Services (CMS), Community Public Health, Disability Determinations, and Medical Quality Assurance (MQA).

A second example is the [New York State Department of Health \(2023\)](#), which is focused on a similar direction. Focuses its attention on supervising the safety and well-being of its residents through the promotion of scientific advancements in the prevention and treatment of infectious diseases, as well as sanitation and vaccination. Public Health programs in New York are carried out through the Wadsworth Center. The official website of the Department of Health doesn’t detail the programs, there’s an emphasis on promoting the agencies they collaborate with, such as the Centers for Disease Control and Prevention (CDC), the Analytical Chemistry Laboratory, the Laboratory Response Network (LRN), and the Infectious Diseases Laboratories, to name a few.

In the case of local governments, health policies are subscribed to the Local Health Departments managed by major cities or, otherwise, by local government agencies. They are either an administrative or service unit affiliated with the state or local government. Their responsibility focuses on the execution of public health activities with communities. As [Villalbi & Guix \(2006\)](#) explain, due to the reasons stated earlier, there is a wide variety in size and population diversity of local agents on which implementation depends. This is in addition to sociopolitical, economic, and cultural differences. (pg. 74)

To specify the scope of the Local Health Departments, with an execution level of public health policy, we look at these units in New York, where they are assigned the priority of leading the community response to COVID-19, providing vaccination, testing, boosters, and guidelines on isolation and care. They also promote very specific community assistance topics such as health regulations, health violations, and animal vaccines, among others, representing the individual’s daily activities. Therefore, specific attention is given to needs by implementing the health policy. ([New York LHD, 2023](#)).

### ***Classification of governance in US Health Departments***

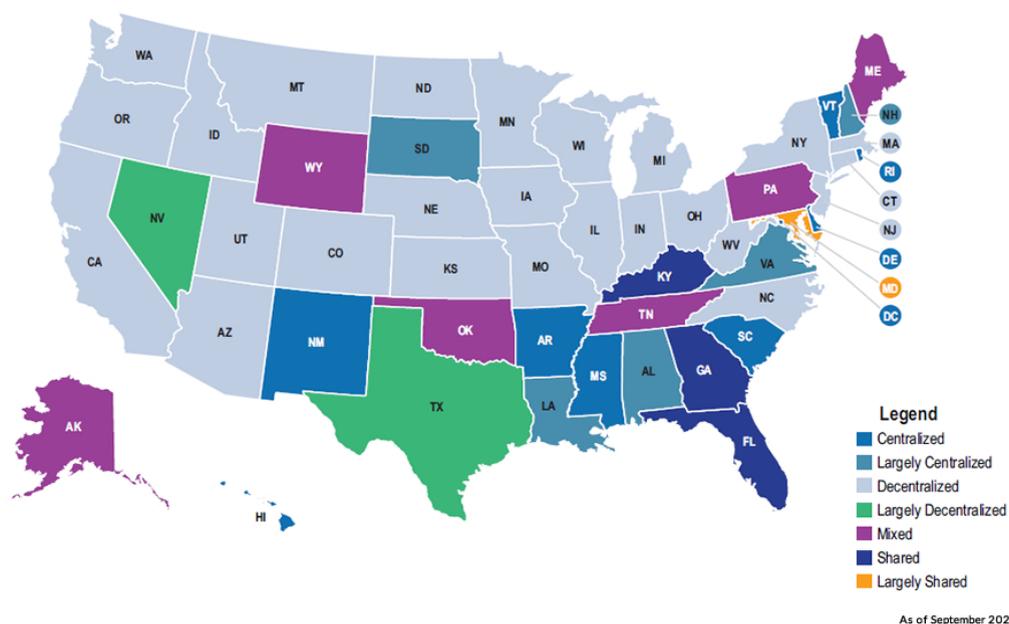
The purpose of this article is to identify the structure of public health policy in the US, with a special emphasis on oral health. Therefore, at this point, the classification of the US Department of Health and Human Services governance structure is presented. Drawing on the definition of governance proposed by the [Office of the High Commissioner for the United Nations \(2023\)](#), it refers to “all the processes of government, institutions, procedures, and practices through which matters concerning society as a whole are decided and regulated.”

To be precise on this point, it is necessary to add two other core concepts: centralization and decentralization. On this matter, [Boisier \(2004\)](#) does not consider

them a dichotomy since what lies in between represents a combination of both and operates in a given context. This statement is undoubtedly adaptable to the administrative model and authority control in the management and decision-making of the DHHS, the State and Local Health Departments.

According to the CDC (2023), the differences in structure have an impact when providing the 10 Essential Services of Public Health. It is necessary to identify them to glimpse the roles of each agent, as well as the “responsibilities and authorities at all levels of government for the services provided within the community.” The following is Map, in which the governance models applied in the DHHS are classified.

**Figure 3**



**Note:** State and Local Health Department Governance Classification Map.

**Source:** Centers for Disease Control and Prevention (2020)

As observed in the legend of Map, there are seven classifications of government structures for managing the Health Departments at the State and Local levels. These classifications are centralized (8 states), largely centralized (5 states), decentralized (25 states), largely decentralized (2 states), mixed (6 states), shared (3 states), and largely shared (1 state). It is evident that decentralized structures constitute 50% of the states.

A brief explanation of who oversees the local health units or agencies is as follows:

- In centralized and largely centralized structures, health units are run by state employees.
- On the other hand, decentralized and largely decentralized agencies mean local government employees direct the management of local health agencies.
- In mixed structures, some local health agencies are directed by state employees, and others by local government employees.

- In shared and broadly shared structures. If managed by state employees, the local government has authority in fiscal decision-making and/or issuing public health orders. If they are directed by local employees, the state has authority. (CDC, 2020).

### ***Budget allocation for the implementation of Public Health Policies***

According to [the Official Website of the US Government \(2023\)](#), the preparation of the annual federal budget is the responsibility of Congress. The three funding areas covered by this health budget are as follows: mandatory spending, discretionary spending, and interest in debt. The procedure for creating the Federal Government’s budget begins a year in advance and involves several stages drawn from the [Congressional Research Service \(2023\)](#), which are described as follow:

1. Federal government agencies prepare and submit budget requests to the White House Office of Management and Budget (OMB). (pg. 6)
2. The OMB uses these agency requests when crafting the budget proposal for the president. (pg. 14)
3. The president submits the budget proposal to Congress early in the following year. (pg. 13)
4. The proposed funding is distributed among 12 subcommittees holding hearings. Each of these is responsible for funding different government areas, such as defense spending or energy and water expenditures. (pg. 15)
5. The House of Representatives and the Senate create their budget requests, which must be agreed upon and consolidated. Both chambers must pass a single version of each funding bill. (pg. 25)
6. Congress sends the approved funding bills to the President, who decides whether to sign or veto them. (pg. 17)

Historically, since 1964, the [Department of Health and Human Services \(DHHS\)](#) annually publishes the total national health expenditure, designated as National Health Expenditure Accounts (NHEA), to measure the yearly amount spent on medical care, including investment in structures, equipment, and research for the sector. This stems from the NHEA Report (2021), where the three characteristics are outlined: its comprehensiveness includes all components of the health system; it is multidimensional, covering expenses for goods, medical services; and consistency in applying common definitions, which allows for comparison between categories. (pg. 3)

The report above reveals that in 2021, the medical care expenditure in the USA was \$4.3 trillion. The categories of hospital care, medical and clinical services, and prescription drugs accounted for 60%. We observed several interesting aspects of this report. One of the purposes of this study is to provide a list of the budget accounts related to health to which federal funds are allocated (pg. 3). Highlight is that the national budget execution reflects the comprehensive and unified structure of the health system. Finally, the NHEA report (2021) provides an extensive list of related expenditure accounts and the programs to which the budget is assigned. Among many others, we mention the following: Medicare, Medicaid, Maternal/Child Health, Worksite Health Care, Department of Veterans Affairs, and Prescription Drugs.

## ***Public politics***

The term public policy was used quite late in specialized studies but also in the current language of Romania (at the end of the 1990s). The term public policy was taken from the English language political; this is translated into Romanian with the name “*politică*”, but Romania used the term from French literature, specifically that of public policies (“*politiques Publicans*”). Mihaela, [Mihaela & Tasente, \(2020\)](#) express “Public policies are actions taken by the authorities (central or local) in response to the problems that come from the society.” Public policies are executed “when a public authority -central or local -intends, with the help of a coordinated action program, to modify the economic, social, cultural environment of social actors.” (pg. 3).

The study of public policies differs from traditional academic research by having an applied approach, aimed at: designing and developing solutions to society’s problems: public policy is not limited to investigating these problems, but has the role express to issue solutions and the framework in which they should be applied. Public policies and the offering of political alternatives are exercises of skill and we do not judge performance by the amount of information stored in the mind of the person acting or by the volume of formal planning information. Instead, we judge by criteria such as good time planning and attention to detail; by the ability to recognize the limits of possibilities, use limitations creatively and learn from mistakes; for the ability to make mistakes.

Policy researchers have come to accept that ideas should be taken seriously as a variable in explanations of public policy outcomes ([Cairney, 2019](#); [Mehta, 2011](#)). The corpus used suggests that the relationship between ideas and policy outcomes takes many forms and depends on the precise specification of what the ideas are. The concepts associated with ideas are widespread, bringing a conceptual minefield.

## ***Health programs in the USA***

The primary health access programs of the US Federal Government are called Medicare and Medicaid, which are considered insurance that supports individuals in covering their healthcare expenses. Based on information from the [Centers for Medicare & Medicaid Services \(2023\)](#), these programs are extended to all states with variations due to the specific characteristics of each population. Regardless of this, the conditions of Medicare and Medicaid are fully met. This refers to two aspects: the eligibility requirements and the coverage of each program.

The Medicaid program is aimed at low-income individuals. Although there are no restrictions for access, there are eligibility conditions governed by state and federal laws to ensure that it reaches those who need it the most. Its benefits are evident because services are low-cost; copayments tend to be low or even waived entirely. Regarding Medicare, it is aimed at individuals over 65, regardless of their income. This is exclusively a federal program, meaning it operates the same in all states. For coverage of minors, there is the Children’s Health Insurance Program (CHIP),

framed within the structure of the federal and state government, that provides low-cost health coverage to children whose families are not eligible for Medicaid. In some states, it also provides coverage to pregnant women.

The Tricare is the health insurance program of the Department of Defense directed at military personnel and their families, survivors, and retirees. Managed by the federal government, its coverage extends both domestically and abroad, emphasizing health services related to emotional support and mental health. Another program is the [Indian Health Service \(2023\)](#), an agency operating in conjunction with the Department of Health and Human Services, is responsible for providing health services to American Indians and Alaska Natives. The provision of health services to members of federally recognized tribes arose from the special government-to-government relationship between the federal government and Indian tribes in 1787.

In this brief review of the six health programs, it is understood that the federal government manages the resources for their implementation. In addition, the costs of these programs are partially borne by the beneficiaries, meaning there is shared responsibility between governments and citizens. Thus, there isn't full gratuity in medical services for the inhabitants of the USA.

### ***Oral health as a human right in the United States of America: rights-based approach to oral health systems design***

Finding a sustainable approach to addressing oral health inequalities in the United States of America in the view of Jean et al., (2020), has proven elusive, in recent years there has been growing interest in whether human rights can play a role in improving oral health outcomes in the United States of America. Now, the right to health is a fundamental human right protected in international law by the International Covenant on Economic, Social and Cultural Affairs. Within this context, The United Nations (ONU) 2016 and the World Health Organization (WHO) 2016, (cited in [Rueda & Albuquerque, 2017](#)), have mentioned that supporting the realization of the right to oral health to through the implementation of the human rights-based approach (RBA) to health system design.

Consequently, the [WHO \(2020\)](#) in its agenda for 2030 establishes that dental health must be improved through universal health coverage. This report mentions the most prevalent oral diseases, even though they are preventable and non-communicable: cavities, periodontal diseases, tooth loss, lip cancer, oral cavity cancer. An important fact in this report is “...that more than 3.5 million people suffer from oral diseases, with no significant improvement in the situation between 1990 and 2017” (p. 1). Additionally, the report states that due to the high cost for treatment of oral diseases, inequalities affect the marginalized and low-income population. A central focus of this agenda was the proposal to commit the international community to assuming universal health coverage as part of its policies to improve oral health.

In other geographical contexts, oral health occupies an important space in public health matters, as well as facing limitations and inequalities. For further review and comparison, it is appropriate to highlight a study carried out by [McAuliffe,](#)

Whelton, Harding & Burke (2022) in Ireland, which was aimed at examining the lack of priority policies in oral health during 1994-2021 in that country. The authors express that in Ireland oral health policy, as in other countries, is not considered a priority in the health issue. Therefore, unequal access to public dental services for children and people with special needs has persisted, while for adults, unmet needs have increased due to the cuts applied. In 2019, an oral health policy called “Smile and Health” was implemented to provide much-needed public services. Additionally, the authors emphasize that this policy would be successful to the extent that a reform supported by the actors is made, incorporating the WHO’s proposal on universal health coverage and with it, oral health as a priority.

However, to continue describing these aspects that limit access to oral health, it is necessary to detail that according to the [United States Department of Health and Human Services \(2021\)](#), oral health is recognized as a human and ethical right in the United States of America, where the access to dental care can be a challenge for low-income people; it is emphasized that more than 90% of Americans understand the importance of maintaining a healthy mouth.

### *Access to oral health programs: means, limitations, costs*

In this part, we focus on describing that access to dental health in the USA is conditioned by the dental health programs that are executed through providers and insurers, which implies that access to dental care requires a cost that not all the population can afford.

The government programs that cover Medicaid and Medicare health care for adults and seniors, respectively, neither have coverage for dental health. That is why an insurance plan is required to obtain dental care, which reduces access to dental care or causes people to bear high costs for this concept. It is important to clarify that these programs use eligibility criteria for free or lower cost in medical care, long-term care (it means home health care) however, for dental care it does not contemplate that option of free.

[The American Dental Association \(2024\)](#) presented an updated report titled: National Trends in Dental Care Use, Dental Insurance Coverage, and Cost Barriers. This has been based on the National Health Interview Survey (NHIS) and supported by statistics from the last 19 years until 2021, considering the following parameters: Dental care use, dental insurance status and cost barriers and showing results that include age, race/ethnicity, and income level criteria (p. 2). Here are some results:

- For 2021, they estimate that 43% of the population visited the dentist, of this figure 50% were children and only 39% between the ages of 19-64 (pg. 4)
- The percentage of children (ages 0-18) with no dental insurance decreased to 9% in 2021, continuing a long-term downward trend. The share of children with public dental insurance (Medicaid and CHIP) was 38% in 2021, significantly higher than in previous years (pg. 15). This could mean a relaxation in the eligibility criteria.
- The number of adults with private dental insurance has remained at 61% for the last 4 years. (p. 17)

- Compared to other types of health care services like medical, prescription and mental health, cost barriers are most severe for dental care services. (pg. 20)
- Children and seniors report lower levels of cost barriers to dental care than adults.
- Across all age groups, Hispanic people have the highest levels of cost barriers to dental care. However, racial/ethnic disparities in cost barriers to dental care are much narrower among children compared to working-age adults and seniors. (pg. 28)
- For all age groups, low-income people have higher cost barriers to dental care. However, the income disparities are narrower among children. (pg. 29)
- Across all age groups, compared to individuals with public dental insurance or no dental insurance, those with private dental benefits have the lowest levels of cost barriers to dental care. (pgs. 32-34)

These results demonstrate that the dental health landscape has undergone slight changes, although the study may have inaccuracies due to lack of data in some of the race/ethnicity categories and in dental services data for 2021 (pg. 38), however, it should be noted that the American Dental Association (ADA) is an organization that has prevailed in its role of documenting and generating statistical estimates of dental health status.

### ***Agencies and institutes: key to executing oral health programs.***

Throughout this article, we have laid out the structure of public health policies in the USA. Clearly, the implementation of the regulatory framework and policy execution is oriented to be carried out with the support of agencies and stakeholders in each state and its localities. As a result, health agencies' role in delivering health services is crucial, ensuring that everything outlined in the 10 Essential Health Services aligns with the government's objectives and those specific to each agency.

Indeed, there are notable aspects: the presence of each agency at the national level is undeniable, and their management is always accompanied by some state and local agencies, ensuring that work aligns with the general guidelines of the government plan. Given the expansive structure of the public health system in the USA, and in the interest of addressing oral health programs, in this section, we will briefly mention some key agencies and institutes to which the DHHS has assigned tasks related to oral health. In this regard, [Mosby's Review \(2015\)](#) details agencies whose remit includes oral health programs and services, as follows:

- **Administration for Children and Families (ACF):** This agency oversees programs including dental care, to preschool children from low-income families.
- **Centers for Medicare and Medicaid Services (CMS):** While neither of these programs generally cover dental care, comprehensive dental services for children are mandatory for the Medicaid program.
- **Health Resources and Services Administration (HRSA):** backs various oral health programs, encompassing prevention, fluoridation.

- **Centers for Disease Control and Prevention (CDC):** The CDC’s Division of Oral Health supports state and local oral disease prevention programs. Their areas of oversight include dental infection control, water fluoridation, oral health surveillance, and tobacco-related oral health issues.
- **National Institutes of Health (NIH):** It is a prominent research entity, houses institutes and centers, including the National Institute of Dental and Craniofacial Research (NIDCR). This institute research dental and craniofacial health and diseases. (p.236)

In addition to overseeing dental health programs, these agencies’ roles also encompass promoting oral health and access to dental care. Their contributions extend to other activities, such as conducting scientific research, ensuring service quality, and addressing issues in this domain.

### ***Oral Health Programs: The State of Florida as a model of implementation***

When implementing these policies at the state level, we now delve into a review of the State of Florida concerning the executed oral health programs. In this context, the Florida Department of Health (DOH) is responsible for regulating public health and operates under the law governing this body. Below, we briefly mention and describe the programs:

- **School-Based Sealant Programs—“Sealing Sunny Smiles Across Florida” Initiative:** It is executed by the County Health Departments (CHD) and is part of a broader state oral health plan. Its objective is to promote evidence-based prevention strategies. It is carried out through preventive dental services in early childhood educational settings, including exams, cleanings, fluoride treatments, sealants.
- **Not So Sweet Tooth Campaign:** Its goal is to reduce childhood obesity and dental caries. It allocates resources to dental providers and professionals to address this issue, emphasizing the significance of their diagnoses and patient guidance regarding proper nutrition.
- **Community Water Fluoridation:** Managed by the DOH, this program focuses on the benefits of adding fluoride to public drinking water sources, which helps reduce cavities. According to the United States Public Health Service, the recommended concentration is 0.7 milligrams per liter of drinking water. It’s worth noting that this action is endorsed by organizations such as the American Dental Association, the American Medical Association, and the World Health Organization.
- **Public Health Dental Program (PHDP):** Its work is geared towards collecting and analyzing data pertaining to oral health and access to dental services for residents in Florida. The findings from the information are utilized to address issues related to dental health. (pg. 235)

Additionally, the Florida Department of Health provides information on agencies and resources that promote dental health in the state. To summarize, we incorporate Table 1, which includes the level of government and/or organizations and the information, program, and focus they dedicate to dental health.

**Table 1**

*Organizations and Agencies Providing Information Related to Oral Health*

<b>Organization</b>	<b>Agency</b>	<b>Information and programs related to oral health</b>
Federal government	Centers for Disease Control and Prevention (CDC) – Oral Health	Offers information on oral health programs, water fluoridation, dental sealants, oral health data, infection control guidance, and research reports.
	US Centers for Medicare and Medicaid Services (CMS)	Contains information on dental care coverage through Medicaid, Medicaid services utilization data, and oral health initiatives.
	US Health Resources and Services Administration (HRSA) – Oral Health:	Offers resources on oral health programs and policies, the workforce, Health Professional Shortage Areas (HPSAs), oral health data, and grants.
State Government	Agency for Health Care Administration (AHCA)	Provides information on the Florida Medicaid Dental Program.
	Florida Department of Environmental Protection	Regulates public water systems in Florida and provides information on Florida’s public water systems and their fluoridation status.
Organizations	American Academy of Pediatric Dentistry (AAPD)	Represents the specialty of pediatric dentistry and provides resources for professionals to improve children’s oral health.
	American Association of Public Health Dentistry (AAPHD)	Focuses on meeting the challenges to improve the oral health of the public.
	American Dental Association (ADA)	Promotes good oral health habits to the public while representing the dental profession.
	Association of State and Territorial Dental Directors (ASTDD)	The association represents Florida’s dentists. Represents state public health agency programs for oral health
	Florida Dental Hygiene Association (FDHA)	Represents Florida’s dental hygienists and provides continuing education and support for dental hygienists.
	Hispanic Dental Association (HDA)	Focuses on the overall health of Hispanic and other underserved communities.
	National Dental Association (NDA)	Promotes oral health equity among people of color and mentor’s dental students of color.
	National Maternal and Child Health Oral Health Resource Center (OHRC)	Provides technical assistance, training, and resources for maternal and child health professionals to improve oral health services.
	National Network for Oral Health Access (NNOHA)	Offers resources and support for effective oral health safety-net programs.
	Oral Health Florida (OHF) coalition	Promotes optimal oral health and well-being for all persons in Florida.
	Oral Health Progress and Equity Network (OPEN)	Engages health equity advocates, community-based organizations, providers, policymakers, and health justice organizers to improve the oral health system.
	Rural Oral Health Information Hub	Provides information and resources on oral health in rural communities.
	Schools	Lake Erie College of Osteopathic Medicine School of Dentistry Nova Southeastern University College Dental Medicine University of Florida College of Dentistry

Note: Source: [The Florida State Department of Health \(2023\)](#). Adapted: Authors (2024)

In summary, each organization offers extensive resources and information on oral health directed at various users: residents, professionals, students, providers, and stakeholders.

### *Emphasis on dental health issues in the US: Investigative challenges*

According to [Xu, Murphy, Kochanek & Arias \(2022\)](#), health problems in the USA differ based on the unique conditions of each region. The authors mentioned above, in their research, pointed out that the leading causes of mortality in the US include the most prevalent health problems such as heart disease, cancer, COVID-19, stroke, chronic respiratory conditions, Alzheimer's, type 2 diabetes, and hypertension. (pg. 4)

Regarding oral health issues, according to the [National Institute of Dental and Craniofacial Research \(NIH, 2023\)](#), the most common problems include:

- **Cavities:** This is the USA's most frequent oral health issue.
- **Gum Disease:** Periodontal disease, conditions like gingivitis and periodontitis
- **Tooth Loss:** It is related to dental cavities and gum diseases.
- **Oral Cancer:** This is one of the most severe conditions, as it encompasses mouth and throat cancers.
- **Dental Erosion:** Often a result of the consumption of acidic foods and beverages.

In its diligent efforts, the NIH, as a national institute that supports and guides the development of oral health research, has various internal investigative priorities, meaning clinical priorities, currently focused on exploratory studies about: basic mechanisms of sensation, including taste, somatosensation, and pain. Cellular, molecular, and genetic mechanisms. Mucosal immunology, oral inflammatory diseases, and immune tolerance/autoimmunity (2023).

Some of our perspectives for future research development will focus on strategies to promote oral health and prevent related diseases. This would allow case studies and provide solutions to patients based on previously documented experiences. Similarly, the contribution of new studies would lead to the development of effective solutions.

## CONCLUSIONS

Throughout the discourse in each of the official US government documents, it is evident that from the design process of public health policy to its execution, there is cohesion and coordination with state governments and local governments. From these local entities, various agencies are organized that execute public health policy in each space. A testament to this is the 10 Essential Public Health Services framework, which guides health agencies, educational institutions, and public interest organizations.

Health policies, in their extensive design, come from the federal government. This entity utilizes its agencies for execution and sends resources to the states, which in turn define policies and execution norms according to their context and based on their autonomy. Finally, local governments, in the form of counties, are responsible for executing these health policies. It's crucial to highlight that the autonomous nature of each state does not detach from the government's plan. This results in applying regulations for its design and execution at both the local and state levels, reinforcing that the governance structures of health policies vary from state to state.

A federal structure present in each state is the Department of Health and Human Services (DHHS). Its management classification further exemplifies autonomy, especially when 50% of the states have decentralized management, and 10% are mostly centralized.

The intricate structure of the health system stems from the breadth of actors and agents involved, ranging from government to private entities. This has been crucial in coordinating administrative and operational bodies, coherently addressing public health, and encompassing all related aspects: health care, prevention, statistics, education, and information. Topics that also apply to oral health, which have the agencies and organizations responsible for actions outlined in health programs in this area. Therefore, the interest of this research lies in studying how public health policies and oral health programs are structured.

Several federal and state agencies are responsible for formulating the budget before submitting it to Congress. Within the areas of health financing and budget allocation are mandatory expenditures, which include free or low-cost health insurance programs such as Medicare, Medicaid, and veterans' assistance. These programs support medical assistance, with eligibility rules set by the federal government. Although there is no comprehensive health care coverage, the federal government's allotment covers the primary portion of medications and hospitalization for those eligible. Others must, depending on income level, turn to the insurance market, or bear the costs, including those who do not benefit from Medicare and Medicaid, remembering that these two programs do not include routine dental care.

The fact that dental health is not considered a priority for health policy leads to some of the problems highlighted in this research, and it is appropriate to point out that this is a pattern that prevails in other countries. Precisely because dental health is not prioritized, elements of discrimination, inequity and inequality persist in access to basic and routine services, which, due to their high cost, cannot be covered by the population.

An important finding of this study is the invisibility of health policy reform proposals and the contributions of the dental profession to the incorporation of dental health as a priority, especially if educational and research organizations have contributed clinical and theoretical advances that show that dental health has an impact on the life of every person, from childhood, adolescence to old age, it would be opportune to promote the participation of stakeholders in the dental field to promote dental health policies and advocate reforms for the incorporation of minor and major restorative diagnostic procedures. It is for this reason that the understanding and cohesion of the actors of the health system are crucial for the promotion of reforms.

Deepening and strengthening prevention programs is a fundamental strategy to combat common diseases and to prevent more complex problems such as throat and mouth cancer. Fortunately, oral health has agencies, institutions and organizations dedicated to addressing related problems. This is an area where the contribution of future research can be showcased as practical experience and study.

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