The right to oral health in the *Liverpool Declaration*

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Abstract

Based on the analysis of discursive practices, this article aims to outline the link between the right to oral health and the right to health contained in the *Liverpool Declaration*. An examination of this document identified the incorporation of the precepts of the normative-theoretical framework of the right to health, as set out by the Committee on Economic, Social and Cultural Rights. The *Liverpool Declaration* does not agree completely with the precepts of the aforementioned reference, although it expresses oral health as a human right in its preamble. Considering that the *Liverpool Declaration* focuses on the obligations of states, it is important that it is based on this normative-theoretical framework. Such measure would confer a more consistent ethical and legal basis, as well as contributing to the consolidation of global recognition of the fact that the right to oral health is a human right.

Keywords: Bioethics. Human rights. Oral health. Dental health services.

Resumo

O direito à saúde bucal na *Declaração de Liverpool*

Baseado na análise de práticas discursivas, este artigo visa esboçar o liame entre direito à saúde bucal e direito à saúde na *Declaração de Liverpool*, que estabelece áreas de trabalho em saúde bucal que deverão ser fortalecidas pelos Estados até 2020. O exame desse documento permitiu verificar a incorporação dos preceitos do referencial teórico-normativo do direito à saúde, esmiuçado pelo Comitê de Direitos Econômicos, Sociais e Culturais. A *Declaração de Liverpool* não comunga completamente com os preceitos do mencionado referencial, apesar de expressar a saúde bucal como direito humano em seu preâmbulo. Considerando que a Declaração assenta deveres dirigidos aos Estados, seria importante que tivesse sido ancorada nesse referencial, pois essa medida lhe conferiria fundamento ético-jurídico mais consistente, além de contribuir para consolidar o reconhecimento global de que o direito à saúde bucal é direito humano.

Palavras-chave: Bioética. Direitos humanos. Saúde bucal. Serviços de saúde bucal.

Resumen

El derecho a la salud bucal en la *Declaración de Liverpool*

Con base en el análisis de prácticas discursivas, este artículo pretende esbozar la relación entre el derecho a la salud bucal y el derecho a la salud, en la *Declaración de Liverpool*, la cual establece áreas de trabajo en salud bucal que deberán ser fortalecidas por los Estados hasta el año 2020. La revisión de dicho documento permitió verificar la incorporación de los preceptos del referencial teórico-normativo del derecho a la salud, tratado minuciosamente por el Comité de Derechos Económicos, Sociales y Culturales. La *Declaración de Liverpool* no confluye completamente con los preceptos del referencial mencionado, a pesar de que expresa a la salud bucal como un derecho humano en su preámbulo. Considerando que la Declaración establece deberes dirigidos a los Estados, sería importante que hubiese sido anclada a ese referencial, pues tal medida le conferiría fundamento ético-jurídico más consistente, además de contribuir a la consolidación del reconocimiento global de que el derecho a la salud bucal es un derecho humano.

Palabras clave: Bioética. Derechos humanos. Salud bucal. Servicios de salud dental.

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The persistence of social inequalities is reflected on the status of oral health, which has differences in availability, accessibility, acceptability and quality of dental care to individuals [1]. To Evans [2], the inequalities in access to this type of care has fostered the global debate because they are reproduced in different countries and social groups, directly impacting the quality of life of populations. Thus, social and economic factors impact the dental clinical status and quality of life of people, especially teenagers [1] and elderly people [3].

Such problem is associated with the budget of health systems, as the provision of oral health care is hindered by the low budgetary availability for this type of service [4]. It must be acknowledged that the challenges of public services of dental health involve the State and allocation of resources, which must agree with their national and international commitments. The reflection about international documents that ground the right to dental health to overcome inequalities in this field is a tool to understand the way international bodies orient the States to assure this right.

Moreover, it is required to point out that oral health as part of general health was already defined on resolution enacted by World Health Assembly [5]. Thus, oral health, similarly to general health, is not only associated with care, but also, and intrinsically, to social determinants of health.

Consequently, it is inferred that the right to oral health also includes the four elements of right to health -availability, accessibility, acceptability and quality -in addition to state obligations and social determinants made explicit in General Comment CESCR 14 [6]. Prepared in 2000 by the Committee on Economic, Social and Cultural Rights (CESCR) of United Nations, this document intends to outline the content of right to health set out in article 12 of International Covenant on Economic, Social and Cultural Rights (ICESCR) [7]. It must be noticed that the General Comment CESCR 14/2000 is acknowledged as ground to comprehend the content of article 12 [8].

Therefore, under the perspective of right to health, grounded on General Comment CESCR 14/2000, the objective of this article is analyzing the connection between the right to oral health and the right to health through study of Liverpool Declaration [9]. Enacted in 2005, the Declaration was prepared by World Health Organization (WHO) in partnership with International Association for Dental Research (IADR), European Association of Dental Public Health (EADPH) and British Association for the Study of Community Dentistry (BASCD). This analysis enabled to check if there was an incorporation of provisions of normative-theoretical referential of right to health set out at General Comment CESCR 14/2000.

Methodological way

This article is structured in three parts (Table 1). The first shows the grounding of referential of human right to health grounded on General Comment CESCR 14/2000. The second one handles the content of Liverpool Declaration and the third one shows the analytical exercise of systematic comparison between both documents. The employed method in the latter was analysis of discursive practices suggested by Spink [10], applied to a public document.

According to Spink [10], the discursive practices have as elements linguistic repertoires defined as figures of speech oriented to construction of senses. The survey of linguistic repertoires of Liverpool Declaration was made upon preparation of maps of association of ideas that induce the adjustment of general categories related to theoretical referential.

Table 1. Illustrative structure of the article: Developed items

Grounding of normative-theoretical referential of human right to health	Exposure of content of this right, which involves social determinants of health; description of its elements and, finally, submission of obligations of Member States
Content of Liverpool Declaration	Submission of acceptances of this document and suggested nine areas of work
Analytical examination of content of Liverpool Declaration	Analysis method of discursive practices, by Spink [10] Deep reading of Liverpool Declaration and brief submission of its content; Preparation of maps of association of ideas, which are instruments to visualize linguistic repertoires that are defined as concepts, words and figures of speech that outline the construction of senses Adjustment of analysis categories related to referential of human right to health Inferences and comments about those maps

Such classifications comprise the content of human right to health, including social determinants, elements of this right and state obligations. The constructed maps are fragments associated with the interconnection between right to oral health and right to health. The following step was the preparation of comments and inferences about the maps, which provide sense to such relationship.

Normative-theoretical referential of right to health

Definition of human right to health

According to General Comment CESCR 14/2000, the right to health is defined as right to required facilities, goods, services and conditions to reach the highest standard of physical and mental health. In other words, the understanding of such right is not limited to healthcare, but it involves the right to social determinants, which directly impact the health-disease process. Thus, it is emphasized the right to health as an inclusive right, which includes the right to underlying social factors, such as nutrition, dwelling, access to potable water, safety, proper sanitary conditions and, finally, health work conditions and environment [6].

The social determinants are understood in that document as conditions where people are born, raised, work, live and get old, which, on the other hand, determine the amount of diseases. Under such perspective, they are related to political, economic, social, cultural and environmental determinants that impact health [11]. It must be clarified that the notion of right to health, according to CESCR, involves biological, social, economic conditions and availability of funds by States. Nevertheless, the control of health of people is not solely responsibility of the state, as there are many aspects of interference, in other words, genetic factors, individual susceptibility to diseases and adoption of unhealthy lifestyles that influence individual health [6].

The right to health was defined as independent from the exercise of other human rights, but at the same time crucial to the exercise of the latter. Thus, different rights are interconnected, as the right to access to health services, which must provide equitative opportunities to people have the highest health level that can reached. Furthermore, it is involved, among others, the right to manage their own body and health, in other words, self-determination in decision making about sexual and reproductive life, and the right to be free from interferences, either in clinical field or in the field of biomedical investigation [6].

Elements of right to health

The CESCR mentioned four inter related and essential elements of right to health -availability, accessibility, acceptability and quality -, which will be developed below [6]. Availability is considered the provision of enough quantity of facilities, goods and services, including medical personnel and health professionals [6]. It also includes underlying determinants, as availability of potable water

Accessibility means that everyone can benefit from facilities, goods and services. Thus, accessibility must include four dimensions: No discrimination; physical accessibility, making available appropriate constructions to displacement of people with special necessities; economical accessibility; and accessibility to information, which includes the right to seek, receive and disclose information and ideas related to health subjects [6].

Acceptability is understood as the element of right to health directly interconnected to ethics, as it is set out in its definition: The health services must observe medical ethics, as well as cultural specificities. Facilities, goods and services must consider the gender perspective and requirements of different stages of life cycle, as well as observe the confidentiality and improve health state of those to whom they are targeted [6]. Finally, quality consists in adequacy of facilities, goods and services under the scientific and medical point of view. Such definition implies the adequate qualification of health professionals and hospital teams, use of scientifically approved medicines and appropriate and safe sanitary conditions [6].

Obligations of member states about right to health

The General Comment CESCR 14/2000 emphasizes state obligations classified in general, specific, international and essential [6].

General obligations

It is explicit in this type of duties the progressive realization of right to health. In other words, the legislation in human rights acknowledges the fact that the immediate satisfaction of this type of right is not always possible, especially in low-income countries. In this regard, it is imposed to States obligations of immediate type, such as assure that the right to

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health is carried out without any discrimination and the duty of starting concrete managements towards full protection and realization of article 12 of ICESCR [6].

Specific obligations

It must be emphasized that the right to health, as all human rights, imposes three types of obligations: To respect, protect and realize. In the field of right to health, respect is related to the obligation of States not harm, either directly or indirectly, the enjoyment of right. It includes, for instance, to avoid imposing limitations to accessibility to health services, goods and facilities, which must be equally provided to everyone, including inmates, people deprived of freedom, minorities and illegal immigrants. Moreover, they refrain from imposing discriminatory practices, treatments and policies related to health of those groups [6].

The obligation to protect requires mechanisms that prevent third parties or private instances to violate the right to health. Consequently, it is crucial to enact laws and regulations that supervise the privatization of health services, so that they do not become unavailable or inaccessible. It must be added that the right to protect makes it fundamental the state control over commercialization of medicines by third parties. It also requires that health professionals have appropriate standards of education that assure their skills and observance of professional codes of ethics [6].

Finally, the duty to realize is related to enactment of standards and administrative, budgetary and judicial steps that intend to realize the right to health. In this regard, realization includes actions towards facilitating, providing and fostering such right. It is understood that the obligation of facilitating includes the creation and implementation of steps that enable individuals and communities enjoy the right to health.

The right to provide considers cases where people or groups are incapable of accomplishing by themselves the satisfaction of right to health. Finally, the obligation to foster includes the performance of actions to create, maintain and restore the health of population. Na example of such obligation is adopting national health policies that assure the provision of health care and equal access to determinants, such as potable water, nutrition and adequate sanitary conditions [6].

International obligations

The observance of right to health means the acknowledgment of international cooperation, in other words, the States and international community have responsibility in humanitary assistance to refugees. Additionally, international cooperation involves adoption of preventive steps with the purpose of avoiding third parties to violate such right in other countries [6].

Essential obligations

They consist in indispensable duties to reach the minimum acceptable level in health and, thus decent conditions of life. Such type of obligation must not depend on financial resources of States [6]. The essential obligations are irreplaceable instruments to guide the discussion about the allocation of scarce resources, services and facilities that the State must prioritize to assure the immediate right to health. Due to such normativity, it is possible to observe approximations with bioethical principles set out in Universal Declaration on Bioethics and Human Rights (UDBHR) [12], understood as international instrument about bioethics that grounds the connection of this field with human rights

It is observed the value of such document, proclaimed at 33rd session of General Conference of United Nations Educational, Scientific and Cultural Organization, in 2005, since its preamble. Two aspects must be emphasized. It is acknowledged that health depends on integration of multiple factors, such as results of scientifical and technological developments and psychological, social and cultural factors. The second aspect is the acknowledgment of impact of ethical matters in medicine, life sciences and associated technologies in different levels that include from the individual until humankind as a whole [12].

From such premises, it is adopted the bioethics conception grounded on universalism of referential of human rights. Thus, it must be invoked the consideration of integral health, according to broadened vision of bioethics, mostly concerned with specific requirements of vulnerable populations, given that interpretation of ethical principles is something inherent to human rights. Considering the interfaces between bioethics and human rights included on UDBHR, it must be highlighted convergence points between such fields, which are inevitably related to right to health.

The human dignity is the central axiological ground, both of bioethics and human rights [13]. The human rights are of ethical nature, justified in its ground on moral principles. Such ethical character of human rights is materialized in the reception of

dignity at UDBHR, in its article 3 that mentions the duty to observe such value together with human rights and fundamental freedoms. The dignity is also mentioned in paragraph 1 of General Comment CESCR 14/2000: *Each human being has the right to enjoy the highest level of health, which leads to live a decent life* [6].

The insertion of such value in these guidelines are justified by their association with human health. In other words, to have a decent life is represented in the assurance of availability of health goods, facilities and services of quality, both ethically and culturally acceptable. Another point of convergence between bioethics and human rights with regard to right to health is the mention to ethical goods, defined as concrete aspects of well being of human beings connected to live and conditions that make it decent, and whose accomplishment is determined by cooperation between people [14].

The bioethics is formed by those goods to be preserved and made effective that have an inviolable character and provide a decent life. As a result of such claims, both bioethics and human rights have the scope to protect ethical goods. Health is no instrumental ethical good, an essential purpose of human action, indispensable to survive and live with dignity [14]. The mention to ethical goods is made at UDBHR by ethical principles sheltered on its content, especially in article 14 that deals with social responsibility and health, characterizing health as social and human good [15].

Liverpool Declaration: Constitution and content

The Liverpool Declaration was prepared in 8th World Congress on Preventive Dentistry, held by WHO in cooperation with IADR, EADPH and BASCD. Forty three countries participated in such event intending to emphasize the prevention of oral diseases in children and adults worldwide [9]. IADR is the maximum world instance that encourages dentistry research in all their specialities [16]. EADPH is the independent association towards interested professionals in dental public health and holds meetings and exchange of information between dentistry managers and professionals [17].

On the other hand, BASCD is responsible for coordinating clinical tests made in the United Kingdom about dental health of children and has the objective of discussing results and setting out quality standards in Program of Dental Epidemiology of this region [18]. WHO is the international body whose target is assuring a healthier future to people worldwide. Such body works in partnership with governments and other parties to assure the highest possible level of health to everyone [19]. The IADR, EADPH and BASCD are organizations that foster dentistry research on world and local grounds, towards improving the prevention and treatment of dental and oral diseases. Furthermore, those are instances that facilitate the scientific cooperation between researchers and professionals, which is enough reason to reception of their publications related to right to oral health.

The selection of Liverpool Declaration is justified for being the single document adopted by WHO and world dentistry research bodies that acknowledge oral health as human right. Although it acknowledges the intrinsic connection between oral health, general health and quality of life, the Resolution WHA 60.17, World Health Assembly called "Oral health: Action plan to promotion and prevention connected to morbidity" [5] does not state this right in an explicit way.

It must be pointed out that such guideline encourages Member States to adopt and implement strategies that intend to optimize dental services, prevent oral diseases and integrate oral health to prevention policies of not transmissible chronical diseases and policies mother and children health.

A The Liverpool Declaration: promoting oral health in the 21st century [9] consists in calling to action in nine prioritary areas of work of oral health, which must be strengthened by countries up to 2020. The undersigned of such Declaration undertake to support actions by national and international authorities, research institutions, non-governmental organizations and civil society to foster health and prevent oral diseases. The Declaration supports initiatives by WHO, such as Global Oral Health Programme that intends to coordinate and support sharing experiences between countries related to promotion and prevention of oral health [9].

The Liverpool Declaration [9] determines the improvement of nine aspects of health management in its Member States. It must be assured to population the access to clean water, adequate sanitary conditions and healthy nutrition; assure economically accessible fluorination programs to prevent cavities. Moreover, the countries must adopt programs to foster health and healthy lifestyles intending to reduce the modifiable risk factors shared between oral health and general health; consider schools as a platform to promote health, quality of life and prevent diseases in children and youths.

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Moreover, it is obligation of State to assure access to primary care in oral health, emphasizing the promotion and prevention of health; strengthen the promotion of oral health of elderly people intending to improve their quality of life; prepare policies about oral health as integral part of national health programs.

It also includes state support to investigation in public health and, finally, it sets out information systems of health that assess oral health and performance of programs grounded on scientific evidence, related to prevention of disease, fostering health and international disclosure of results of researches [9].

Documental analytical exercise

Right to oral health and state duties

In view of the exposed, the States are responsible for, in the light of human rights, assuring the right to oral health [9], as stated by General Comment CESCR 14/2000 when it mentions general, specific, international and essential state obligations [6]. The Declaration confirms in its preamble that oral health is a basic human right [9] and, thus, it manifests the broadened notion of oral health that creates the element to be reached in the enjoyment of the highest possible level of health.

It is observed that, despite the reference to right to oral health, the examined Declaration does not develop a specific definition or content about such right, which can result in obstacles to implement it and monitor its observance by WHO. It is fundamental to detail the state obligations in the context of oral health and the way elements of right to health are expressed in the context of dental services, goods and facilities in order to instruct agents involved in the materialization and correct application of such right.

It was observed that the only action area grounded on *Liverpool Declaration* that is not directly related to the state agent sets out that *the school must be used as platform to promote health, quality of life and prevention of disease in children and youths, involving families and communities* [20]. Still, the duty of employing schools to reach specific objectives of oral health inevitably incorporates the adoption of strategies by state agent, specifically converging to the obligation of realizing the right to health. Thus, it is interpreted that such strategy also includes the State as main responsible.

Therefore, it is observed the understanding of Liverpool Declaration to strengthen the role of education in order to accomplish the right to oral health. The accomplishment of such right was also identified in the content of third and seven suggested action areas, transcribed below: *The countries must provide programs grounded on evidence to foster healthy lifestyles and reduction of common risk factors to oral and chronical general diseases.* (...) *The countries must prepare oral health policies as integral part of national health programs* [21].

Thus, it is clear the call of Liverpool Declaration to States implement programs to prevent oral and chronical diseases. Furthermore, it calls the inclusion of oral health policies in general health programs, as oral health is conceived as a crucial component to have quality of life and well being. Additionally, other statements of Liverpool Declaration that highlight the accomplishment of right to oral health are submitted in their two last enunciations, which emphasize:

The countries should support public health investigation and specifically consider the recommendation of WHO which suggests 10% of a total health promotion programme budget be devoted to programme evaluation;

The countries should establish health information systems that evaluate oral health and programme implementation, support the development of the evidence base in health promotion and disease prevention through research and support the international dissemination of research findings [22].

In this regard, the provisions set out by the Declaration agree with the accomplishment of right to oral health, especially with actions over promotion, as they mentioned the performance of state actions to institute, keep and restore oral-dental health of population. According to General Comment CESCR 14/2000 [6], fostering the right to health also include the duty of assuring that health services are culturally appropriate. It also includes the proper qualification of professionals to be liable for specific requirements of marginalized groups, orienting them to make informed decisions about their health [6].

It must be emphasized that the obligations to respect and protect such right were not observed in action areas set out at *Liverpool Declaration*, which prioritarily highlight the observance of right to oral health. The document does not have statements that show the state duty of not directly or indirectly

harming the enjoyment of right to oral health. Similarly, it was not outlined the duty of putting into practice strategies that prevent third parties from violating such right. With regard to essential obligations set out in the Declaration, which imply its immediate effectiveness, it must be emphasized the first action area, which determines that *countries should ensure that the population has access to clean water, proper sanitation facilities, a healthy diet and good nutrition* [23].

It is verified that mentioning such duties agree with decent conditions of existence. Nevertheless, it was not found in the document mentions to other essential duties, such as assurance of right to access goods, facilities and services of oral-dental health, without discrimination, the effectiveness of its equitative distribution and obligation to provide medicines according to provisions by WHO.

According to such body, the list of essential medicines includes different drugs used to treat prioritary health problems to the population. Their selection is grounded on prevalence of diseases, safety, efficiency and comparison between cost and efficiency [24].

It is emphasized that medicines, such as local anesthetics, pre operatory sedations, disinfectants/antiseptics, analgesics, antibiotics, anti-herpetics and antifungals used in dentistry are included in model-list of essential medicines adopted by such body in 2007 [25]; Thus, it is justified the development of such topic at *Liverpool Declaration*.

Right to oral health and its social determinants

The content of Liverpool Declaration expresses the social determinants in its first work area, as explained in previous item. Therefore, it is observed that occasional mention to such determinants shows a confluence between right to oral health and right to health. However, the Declaration in focus does not mention other social determinants of oral diseases. For instance, scarce income of the patient and his family is strongly associated with the occurrence of cavities and other dental diseases, considering that economical shortages negatively impact the quality of diet and access to dental services, goods and facilities.

It must be added that the unfavorable economic situation also influences the adoption of negative behaviors to proper oral health, such as smoking and bad diet [26]. With regard to clean water, it must be highlighted the matter of its fluoration, set out at Liverpool Declaration in second work area: *Countries should ensure appropriate and affordable fluoride programmes for the prevention of tooth decay* [27]. Fluoride is the most effective mechanism to prevent cavities and the permanent exposure to it helps to reduce levels of deterioration of teeth, both in children and adults.

Therefore, public health programs must implement appropriate means to keep the level of such element in the mouth, considering that fluoride can be obtained in water sources of public storage, salt, milk, oral mouthwashes and mouth creams and upon professional application [28]. Nevertheless, it is acknowledged that the fluoride content below or beyond the concentration between 0.6 and 0.8 mg/L is unacceptable to prevent cavities and fluorosis [28]. Fluorosis is the condition produced by toxic effect of fluoride, which produces mineralization defects of enamel in teeth on a permanent basis. In this regard, the Declaration does not call attention of oral health managers or States about the requirement of strict and permanent control of fluoration of waters of public facility so that it is not exceeded the limit of content of such chemical element. It is limited to mere mention of obligation to assure such programs.

Right to oral health and its elements

Due to interface between the right to oral health and right to health at Liverpool Declaration, it was assessed the mention to each element. The first of them, accessibility, is named in the work area about clean water and adequate nutrition and in the fifth area, which states that *countries should ensure access to primary oral health care with emphasis on prevention and health promotion* [29]. The enunciate about fluoration programs, already mentioned in this text, highlights the economical dimension of accessibility, and it confirms the duty of State to assure that such programs are economically accessible.

On the other hand, the accessibility to information was outlined in the last provision of Declaration, when it mentioned the state support in international disclosure of results of researches about oral-dental health [9]. Nevertheless, it was observed that other dimensions that constitute such element, such as no discrimination and physical accessibility are not handled at Liverpool Declaration. It is also observed that the lack of development of concept of right to oral health in analyzed instrument is reflected in the precarious mention to elements that form it. Such fact confirms fragilities in instruction to States. Therefore, the elements of acceptability, availability and quality are not mentioned in enunciated adopted by Liverpool Declaration.

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Right to oral health and populational groups

According to previously mentioned in this section, children and youths are incorporated in work areas in oral health to be strengthened from education. The matters related to elderly people are submitted as follows: *Countries should strengthen promotion of oral health for the growing numbers of older people, aiming at improving their quality of life* [30]. However, the provision did not consider the requirement of implementing an integral approach of oral health in this population that also gathers aspects such as preventive, curative and recovery dental programs towards the preservation of functions of mouth.

The interconnection between oral health and general health manifests itself especially in elderly people, due to progressive and cumulative characteristics of oral diseases and susceptibility to chronic diseases, which increases as years pass by. Thus, the improvement of oral health of elderly people must be a commitment accomplished in a broader context. On the other hand, it was observed that other populational groups, such as women, people with special necessities, inmates, people deprived of freedom and indigenous groups are not mentioned in the Declaration.

Such absence shows a distance from provisions about right to health, especially of two essential obligations approached by General Comment CESCR 14/2000: *To assure the right to access to facilities, health goods and services on no discriminatory ground, particularly to vulnerable or marginalized groups* [31] *and assure the equitative distribution of all health goods, services and facilities* [32].

Final considerations

The examination of discursive practices of Liverpool Declaration enabled to identify that such guideline does not agree completely with the provisions of theoretical-normative referential of General Comment CESCR 14/2000, despite defining oral health as a basic human right in its preamble. It also enabled to verify that it is grounded on referential of human rights, as it sets out obligations to States. Moreover, it was shown that the content of Declaration provides more visibility to the accessibility element, disregarding other aspects of right to health, which are reciprocal and interconnected.

It was observed a complete omission about vulnerable populations who also suffer serious mouth-dental changes worsened by social exclusion [33-36]. The General Comment CESCR 14/2000 recommends to States the particularized integration of those populations in programs and policies that intend to reach the highest possible level of health. Similarly, it prohibits any discrimination, either in healthcare or in its underlying social determinants, emphasizing such provision as essential obligation of state agent.

Such acceptions repercute in implementation of right to health, as the comprehension of health as ethical good to be realized by States imposes the observance of duties to state agent, which is reinforced by international instances in health. An incomplete international instruction, from the point of view of human rights, can lead to no accomplishment of such obligations. This fact perpetuates social inequalities that are manifested in unfavorable mouth condition and reinforces the cycle of stigma and discrimination of certain groups, keeping their social exclusion.

In this regard, it must be pointed out that the assurance of right to access goods, facilities and services of mouth-dental health, without any discrimination and surveillance of its equitative distribution are not announced at Liverpool Declaration, which weakens the document.

It was observed that such Declaration merely mentions the right to assure oral health programs, but it does not consider the obligation of monitoring its implementation and performance, as it happens in public policies about fluoration of waters of public storage. Therefore, it is claimed that the limit between right and oral health and right to health at Liverpool Declaration was not properly developed.

It is concluded that such systematic comparison shows the importance of encouraging the connection between the fields of health and human rights, considering the latter consist in internationally consolidated tools, instituting ethical-legal obligations to States. Finally, considering that Liverpool Declaration grounds duties towards States in the area of oral health, it would be important it was grounded on theoretical-normative referential of human rights.

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Referências

1. Fonseca LLV, Mota JAC, Gonçalves PF. Public primary oral health care: a bioethical reflection. Rev Odonto Cienc. 2011;26(2):165-71.
2. Evans CA. Eliminating oral health disparities: ethics workshop reactor comments. J Dent Educ. 2006;70(11):1180-3.
3. Rebelo MA, Cardoso EM, Robinson PG, Vettore MV. Demographics, social position, dental status and oral health-related quality of life in community-dwelling older adults. Qual Life Res. 2016;25(7):1735-42.
4. Moimaz SAS, Garbin CAS, Garbin AJI, Ferreira NF, Gonçalves PE. Desafios e dificuldades do financiamento em saúde bucal: uma análise qualitativa. Rev Adm Pública. 2008;42(6):1121-35.
5. Organización Mundial de la Salud. 60ª Asamblea Mundial de la Salud. Salud bucodental: plan de acción para la promoción y la prevención integrada de la morbilidad [Internet]. 23 maio 2007 [acesso 15 jun 2016]. Disponível: http://bit.ly/2oyucaH
6. United Nations Economic and Social Council. General comment nº 14: the right to the highest attainable standard of health [Internet]. Geneva: WHO; 2000 [acesso 15 mar 2016]. Disponível: http://bit.ly/1Rs5H5m
7. United Nations. General Assembly. International covenant on economic, social and cultural rights [Internet]. 3 jan 1976 [acesso 10 jan 2016]. Disponível: http://bit.ly/2oyI84D
8. Albuquerque A. Direito à saúde: conteúdo, essencialidade e monitoramento. Revista CEJ. 2010;14(48):92-100.
9. World Health Organization. International Association for Dental Research. European Association of Dental Public Health. The Liverpool Declaration: promoting oral health in the 21st century [Internet]. 2005 [acesso 25 mar 2016]. Disponível: http://bit.ly/2qgPxSm
10. Spink MJ. Linguagem e produção de sentidos no cotidiano [Internet]. Rio de Janeiro: Centro Edelstein de Pesquisas Sociais; 2010 [acesso 25 mar 2016]. Disponível: http://bit.ly/2qh2bkh
11. World Health Organization. A conceptual framework for action on the social determinants of health [Internet]. Geneva: WHO; 2010 [acesso 20 maio 2016]. Disponível: http://bit.ly/2axMe4a
12. Organização das Nações Unidas para Educação, Ciência e a Cultura. Declaração universal sobre bioética e direitos humanos [Internet]. Genebra: Unesco; 2005 [acesso 1 jul 2013]. Disponível: http://bit.ly/2kgv9lt
13. Albuquerque A. Interface entre bioética e direitos humanos: o conceito ontológico de dignidade humana e seus desdobramentos. Rev. Bioética. 2007;15(2):170-85.
14. Albuquerque A. Interface entre bioética e direitos humanos: perspectiva teórica, institucional e normativa [tese]. Brasília: Universidade de Brasília; 2010.
15. Organização das Nações Unidas para Educação, Ciência e a Cultura. Op. cit. Artigo 14, alínea "b", inciso "i".
16. International Association for Dental Research. About us [Internet]. Alexandria: IADR; [acesso 15 jun 2016]. Disponível: http://www.iadr.org/About-Us
17. European Association of Dental Public Health. About the EADPH [Internet]. Waiblingen: EADPH; [acesso 15 jun 2016]. Disponível: http://bit.ly/2oONnce
18. Pine CM, Pitts NB, Nugent ZJ. British Association for the Study of Community Dentistry (BASCD) guidance on sampling for surveys of child dental health: a BASCD coordinated dental epidemiology programme quality standard [Internet]. Community Dent Health. 1997 [acesso 15 jun 2016];14(1 Suppl):10-7. Disponível: http://bit.ly/2q9ekJ0
19. World Health Organization. About WHO [Internet]. Geneva: WHO; [acesso 25 mar 2016]. Disponível: http://bit.ly/1aigf45
20. World Health Organization. International Association for Dental Research. European Association of Dental Public Health. Op. cit. Item 4.
21. World Health Organization. International Association for Dental Research. European Association of Dental Public Health. Op. cit. Itens 3 e 7.
22. World Health Organization. International Association for Dental Research. European Association of Dental Public Health. Op. cit. Itens 8 e 9.
23. World Health Organization. International Association for Dental Research. European Association of Dental Public Health. Op. cit. Item 1.
24. Organización Mundial de la Salud. 10 datos sobre los medicamentos esenciales [Internet]. 2010 [acesso 3 ago 2016]. Disponível: http://bit.ly/2oOQ9hy
25. Organización Mundial de la Salud. Lista modelo de medicamentos esenciales de la OMS [Internet]. 2007 [acesso 3 ago 2016]. Disponível: http://bit.ly/1Gtf53t
26. Moreira TP, Nations MK, Alves MSCF. Dentes da desigualdade: marcas bucais da experiência vivida na pobreza pela comunidade do Dendê, Fortaleza, Ceará, Brasil. Cad Saúde Pública. 2007;23(6):1383-92.
27. World Health Organization. International Association for Dental Research. European Association of Dental Public Health. Op. cit. Item 2.
28. Ramires I, Buzalaf MAR. A fluoretação da água de abastecimento público e seus benefícios no controle da cárie dentária: cinquenta anos no Brasil. Ciênc Saúde Coletiva. 2007;12(4):1057-65.

 http://dx.doi.org/10.1590/1983-80422017252182

29. World Health Organization, International Association for Dental Research, European Association of Dental Public Health. Op. cit. Item 5.
30. World Health Organization. International Association for Dental Research. European Association of Dental Public Health. Op. cit. Item 6.
31. United Nations Economic and Social Council. Op. cit. Item 43, alínea "a".
32. United Nations Economic and Social Council. Op. cit. Item 43, alínea "e".
33. Organización de las Naciones Unidas. Convención sobre la eliminación de todas las formas de discriminación contra la mujer [Internet]. 18 dez 1979 [acesso 3 ago 2016]. Disponível: http://bit.ly/VJkZJY
34. Anders PL, Davis EL. Oral health of patients with intellectual disabilities: a systematic review. Spec Care Dentist. 2010;30(3):110-7.
35. Rocha A, Patiño AA. Salud bucal de las personas privadas de la libertad: un planteamiento justo. Rev Fac Nac Salud Pública. 2011;28(3):294-300.
36. Lozano EJO, Ortiz CB. Autoatención en salud oral en el pueblo Yanacona de los Andes del sur de Colombia. Acta Odontol Colomb. 2011;1(2):85-101.

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