The effective use of fluorides in public health
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Abstract Dental caries remain a public health problem for many developing countries and for underprivileged populations in developed countries. This paper outlines the historical development of public health approaches to the use of fluoride and comments on their effectiveness. Early research and development was concerned with waterborne fluorides, both naturally occurring and added, and their effects on the prevalence and incidence of dental caries and dental fluorosis. In the latter half of the 20th century, the focus of research was on fluoride toothpastes and mouth rinses. More recently, systematic reviews summarizing these extensive databases have indicated that water fluoridation and fluoride toothpastes both substantially reduce the prevalence and incidence of dental caries. We present four case studies that illustrate the use of fluoride in modern public health practice, focusing on: recent water fluoridation schemes in California, USA; salt fluoridation in Jamaica; milk fluoridation in Chile; and the development of “affordable” fluoride toothpastes in Indonesia.

Common themes are the concern to reduce demands for compliance with fluoride regimes that rely upon action by individuals and their families, and the issue of cost. We recommend that a community should use no more than one systemic fluoride (i.e. water or salt or milk fluoridation) combined with the use of fluoride toothpastes, and that the prevalence of dental fluorosis should be monitored in order to detect increases in or higher-than-acceptable levels.

Keywords Fluorides/therapeutic use; Fluorides, Topical/therapeutic use; Dental caries/prevention and control; Fluoridation; Water supply; Milk; Sodium chloride, Dietary; Toothpaste/therapeutic use; Case reports; Meta-analysis; Review literature; United States; Jamaica; Chile; Indonesia (source: MeSH, NLM).

Mots clés Fluorures/usage thérapeutique; Fluorure usage local/usage thérapeutique; Carie dentaire/prévention et contrôle; Fluoruration; Alimentation eau; Lait; Chlorure sodium diététique; Pâte dentifrice/usage thérapeutique; Étude de cas; Méta-analyse; Revue de la littérature; États-Unis; Jamaïque; Chili; Indonésie (source: MeSH, INSERM).

Palabras clave Fluoruros/uso terapéutico; Fluoruros tópicos/uso terapéutico; Caries dental/prevención y control; Fluoruración; Abastecimiento de agua; Leche; Cloruro de sodio dietético; Pasta de dientes/uso terapéutico; Casos clínicos; Meta-análisis; Literatura de revisión; Estados Unidos; Jamaica; Chile; Indonesia (fuente: DeCS, BIREME).

Introduction
WHO recently published a global overview of oral health, which included a description of the WHO Oral Health Programme’s approach to promoting further improvement in oral health during the 21st century (1, 2). According to this report, dental caries continue to pose an important public health problem in most developed countries, where it affects 60–90% of schoolchildren and the vast majority of adults. It is also the most prevalent oral disease in several countries in Asia and Latin America. Although dental caries appear to be less common and less severe in most of Africa at the moment, the WHO report anticipates that, in the light of changing living conditions and dietary habits, the incidence of dental caries will increase in many of the developing countries in this continent. The principal reasons for this increase appear to be increasing consumption of sugar and inadequate exposure to fluorides (3). Few developing countries have large-scale fluoridation programmes in operation. Some countries in Latin America have introduced water and salt fluoridation, but exposure to fluoride is still fairly limited. In China, while the use of fluoride toothpaste is becoming more common, its use is not the norm even among
those who brush twice a day, and it is more likely to be used in urban than in rural communities (4, 5).

Fluoride is a key agent in reducing the prevalence of dental caries, which it achieves in at least three ways (6, 7):

- by encouraging repair (remineralization) of early damage to enamel caused by acid produced by the breakdown of sugar by plaque bacteria;
- by improving the chemical structure of the enamel, making it more resistant to acid attack; and
- by reducing the ability of the plaque bacteria to produce acid.

The WHO oral health report 2003 (2) noted that the prevalence and incidence of dental caries can be controlled by the joint action of communities, professionals and individuals. In many developing countries, however, access to oral health services is very limited, while in developed countries significant numbers of population groups are underserved. For these reasons, professionally applied fluorides were not considered to be relevant to this review. Rather this review will focus on public health approaches including:

- water fluoridation
- salt fluoridation
- milk fluoridation; and
- the development of affordable fluoride toothpastes.

The paper will outline the historical development of these approaches, comment on their effectiveness and illustrate their use in modern-day public health practice by means of four case studies.

**Background**

Research on the effects of fluoride on oral health started about 100 years ago. For about the first 50 years it focused on the link between waterborne fluoride — both natural and adjusted — and dental caries and dental fluorosis. In the second half of the 20th century this focus gradually shifted to the development and evaluation of fluoride toothpastes and mouth rinses and, to a lesser extent, public health alternatives to water fluoridation. More recently, efforts have been made to summarize these extensive data sets through systematic reviews, such as those conducted on water fluoridation by the University of York National Health Service Centre for Reviews and Dissemination (8), on fluoride ingestion and bone fractures (9), and on fluoride toothpastes and mouth rinses by the Cochrane Collaboration Oral Health Group (10, 11).

These systematic reviews concluded that:

- Water fluoridation reduces the prevalence of dental caries — % of the population with decayed teeth — filled primary teeth (dmft)/decayed and filled permanent teeth (DMFT) > 0 — by an average of 15%, and reduces the incidence of caries by an average of 2.3 dmft/DMFT in children aged 5—14 years (12).
- Fluoride toothpastes and mouth rinses reduce the DMFT 3-year increment (the number of new dental caries developing over 3 years) by 23% and 24%, respectively (10, 11).
- Water fluoridation has benefits in addition to those associated with the use of fluoride toothpastes alone (8, 10).
- There is no credible evidence that water fluoridation is associated with any adverse health effects (8, 9).
- Water fluoridation (fluoride, 1 mg/l) is associated with an increase of 13% in the risk of unesthetic dental fluorosis (8), although further analysis suggested that the risk might be substantially higher in areas in which the water is naturally fluoridated, and lower in areas in which the concentration of fluoride in water has been adjusted (12, 13).

**Water fluoridation**

The first community programme for water fluoridation was instituted at Grand Rapids in the United States of America (USA) in 1945 and the first results were published by Arnold et al. (14). Other major evaluation programmes followed: in the USA in Newburgh in 1945, and in Evanston, Illinois in 1946; in Canada in Brantford, Ontario in 1945; in the Netherlands in 1953; in New Zealand in 1954; in the United Kingdom in 1955; and in the German Democratic Republic in 1959. The results of these programmes were published mainly in the 1950s and 1960s (15–21). As a result, many community water fluoridation programmes were introduced in the largest cities of the USA, including Indianapolis (1951), San Francisco (1952), Philadelphia (1954), Chicago (1956), New York (1965), Dallas (1966), and Detroit (1967). At the present time, the public water supply in 43 out of the 50 largest cities in the USA is fluoridated. The average cost of water fluoridation in the USA has been estimated at US$ 0.72 per person per year (1999 prices) (22). Worldwide, extensive fluoridation programmes have also been introduced in Australia, Brazil, Chile, Colombia, Canada, Hong Kong Special Administrative Region of China, Ireland, Israel, Malaysia, New Zealand, Singapore, the United Kingdom, and elsewhere. More recently, new programmes have been introduced in large conurbations in the south and west of the USA, including Los Angeles (in 1999), Las Vegas (in 2000), Sacramento (in 2000), and San Antonio (in 2002). The recent and interesting example of California is described in case study 1.

**Salt fluoridation**

One of the objections to water fluoridation is that it limits consumers’ choice. If the public water supply is fluoridated, a consumer has few practical alternatives other than to purchase bottled drinking-water that does not contain fluoride. One of the attractions of fluoridated salt is that it can be sold alongside a non-fluoridated alternative. When most salt for human consumption is fluoridated, the effectiveness of salt fluoridation approximates that of water fluoridation. The first studies of the effects on the incidence and prevalence of dental caries of fluoride added to alimentary salt were carried out from around 1965 to 1985 in Colombia, Hungary and Switzerland, with rather similar results to those observed after the introduction of water fluoridation (27, 28). These authors also explain that fluoridated salt reaches the consumer through several channels, including domestic salt, meals at schools, large kitchens, and in bread. In Colombia, Costa Rica, Jamaica, and the Canton of Vaud in Switzerland, most, if not all, of these channels are used; in France and Germany the focus is on fluoridating domestic salt. Jamaica provides another interesting example (see case study 2), because virtually all salt destined for human consumption on the island has been fluoridated since 1987 (29, 30).
Fluoride in salt could simply be increased appropriately. Indeed, reduced consumption of salt could and should be encouraged and, where this is successful, the concentration of fluoride in salt used around the world range from 90 mg/kg to 350 mg/kg, although later studies suggested an optimal concentration of around 250 mg/kg (31). Marthaler & Petersen (27) provide a helpful overview of some practical aspects relating to the implementation of salt fluoridation programmes. One concern expressed — for example, in the United Kingdom — is that promotion of the dental benefits of fluoridated salt would be unacceptable and contradictory to public health messages that encourage the reduction of consumption of salt and thus decrease the risk of hypertension. However, those who make this objection rather misunderstand the approaches used in France, Switzerland and elsewhere. The populations of these countries are not encouraged to consume more salt to improve their dental health; rather, the “automatic” or passive effect of fluoridated salt is accepted. In other words, people do not need to change their usual behaviour to benefit. Indeed, reduced consumption of salt could and should be encouraged and, where this is successful, the concentration of fluoride in salt could simply be increased appropriately.

**Milk fluoridation**

The fluoridation of milk is another example of an attempt by public health dentistry to provide the benefits of fluoride without requiring the consumers to take on particular responsibilities or change their behaviour. The potential of milk as an alternative vehicle for fluoride was first reported from Switzerland by Ziegler in 1962 (33). Further programmes were reported by Stephen et al. (34) in Scotland, and by Banoczy et al. in Hungary (35). The results of these and other programmes targeted at children have been summarized by Ketley et al. (36). Various channels have been used, including programmes distributing milk in kindergartens (37), and schools (38), and powdered milk and milk-cereal distributed as part of the National Complementary Feeding Programme in Chile (39). The latter is described in more detail in case study 3. In all these studies, it is emphasized that it is important to start the programme in early childhood to ensure an optimal effect on the deciduous teeth (39), and to maintain the consumption of milk for at least 180 days per year (40). Interesting initiatives such as sending school milk home.

**Case study 2**

**Salt fluoridation in Jamaica**

Salt fluoridation was introduced into Jamaica (population, 2.5 million) in 1987; all salt for human consumption is fluoridated (30). Fluoride toothpastes had been available in the country since 1972, and while their use may have had a protective effect (32), the notable decline in the prevalence of dental caries after 1984 may be considered to be primarily attributable to the introduction of fluoridated salt (27).

In 1984, a survey of oral health carried out by the Ministry of Health reported that Jamaican children had an alarmingly high incidence of dental caries (mean DMFT, 6.7 at age 12 years). Naturally occurring concentrations of fluoride in water were uniformly low (<0.3 mg/l), but the complexities of the public water supplies ruled out water fluoridation as a measure to address these very high levels of disease. However, as there was only one producer of salt for the whole population, salt fluoridation seemed to be the ideal alternative.

After studies of household salt consumption, a recommendation to implement a salt fluoridation programme was widely endorsed, and was approved by the Parliament in 1986 (29). With technical assistance from the Pan American Health Organization (PAHO), salt was fluoridated using potassium fluoride at a concentration of 250 mg/kg. Studies of the urinary excretion of fluoride, conducted at baseline in 1987 and 20 months later, indicated that concentrations of fluoride were not above those associated with water fluoridation in temperate climates.

A national survey of oral health in 1995 confirmed striking reductions in the incidence of caries in all age groups (Table 1). Jamaica’s salt fluoridation programme is apparently working well (29). As discussed above, salt fluoridation does not in general constrain consumer’s freedom of choice. Interestingly, however, because the only salt available on Jamaica is fluoridated, that advantage clearly does not apply in this case; nevertheless, fluoridated salt is apparently well accepted by the public.
on a Friday evening for consumption over the weekend have been reported by Bian et al. in Beijing, where milk consumption has been maintained for more than 300 days per year (41). To date no milk fluoridation programmes have been targeted at and evaluated in adult populations.

Fluoride toothpastes

Probably the most widespread and significant vehicle used for fluoride has been toothpastes. Introduced in the late 1960s and early 1970s, their rapid increase in market share was remarkable. The consensus view from developed countries was that the introduction of fluoride toothpaste was the single factor most responsible for the massive reduction in dental caries seen in many countries during the 1970s and 1980s (43). Furthermore, of the various vehicles for fluoride, toothpaste has been the most rigorously evaluated. Marinho et al. (10) included 74 randomized, controlled clinical trials of good quality in their systematic review of fluoride toothpastes. However, an important limitation is that the effectiveness of these toothpastes depends upon the behaviour of the individual and the family in purchasing and regularly using the products. Uptake and use has not been uniform and is less likely among underprivileged groups. In the United Kingdom, for example, the incidence of dental caries in children was uniformly high in all social groups in the late 1950s; indeed, in Edinburgh, DMFT values for children aged 14 years were slightly higher in groups of higher social class than in those of lower social class (44). The fall in the incidence of dental caries after the introduction of fluoride into toothpaste formulations, although seen in all social classes, was particularly noticeable in higher social classes; consequently a very marked social-class gradient now exists in the United Kingdom (45) and in many other countries (46).

In response to this and similar situations in many parts of the world, the WHO Oral Health Programme has promoted the development and use of “affordable” fluoride toothpaste. The annual cost of toothpaste in the USA is between US$ 6 and US$ 12 per person per year (1999 prices) (22). An “affordable” toothpaste is one that is available at a price that allows people on a low income to purchase it. Important elements in the cost of production are the choice and availability of raw materials. Critically, the abrasive agent and the fluoride source should be compatible over time. Precipitated calcium carbonate is the abrasive agent of choice because of its low cost and ready availability in developing countries (47). A school-based programme for “affordable” fluoride toothpaste in Indonesia is described in case study 4. This study confirms that companies can manufacture effective toothpastes that are also of low cost. However, it remains to be seen whether the marketing of such toothpastes will increase demand and use among low-income groups. Meanwhile, to encourage use it might be in the interest of countries to exempt these effective fluoride toothpastes from the duties and taxation that are imposed on cosmetics (46, 48).

Discussion

The WHO Oral Health Programme continues to emphasize the importance of public health approaches to the effective use of fluorides for the prevention of dental caries in the 21st century. Everyone should be encouraged to brush daily with a fluoride toothpaste. In addition, where the incidence and prevalence of dental caries in the community is high to moderate, or where there are firm indications that the incidence of caries is increasing, an additional source of fluoride (water, salt or milk) should be considered. Where the country (or area of the country) has a moderate level of economic and technological development, a municipal water supply reaching a large population, trained water engineers and favourable public opinion, water fluoridation using fluoride at a concentration of 0.5–1 mg/l is the method of choice (48). Salt fluoridation is a widely practised

| Case study 3 |
| Milk fluoridation project in Chile |

In Chile, the National Complementary Feeding Programme (PNAC) was established by the government in the early 1960s. Under this programme, every Chilean child is entitled to receive 2 kg of powdered cows’ milk per month from birth until age 2 years, at no charge. After that, and until age 6 years, the child is eligible for 1 kg of milk–cereal product per month. The national coverage of this programme is around 90%. Although water fluoridation is practised extensively in Chile, it is not always practical or economic in rural communities. In 1994, the Institute of Nutrition and Food Technology of the University of Chile established a programme to assess the feasibility of using PNAC products as a vehicle for disodium monofluorophosphate. Studies of the bioavailability and absorption of fluoride derived from disodium monofluorophosphate in milk were undertaken. The community trial was undertaken in the rural community of Codegua, 100 km south of Santiago, with the assistance of La Punta, some 10 km from Codegua, being used as the control. The daily dose of fluoride from fluoridated powdered milk was 0.25 mg for infants aged 0–2 years, 0.5 mg for children aged 2–3 years and 0.75 mg for children aged 3–6 years. Results obtained after 4 years of milk fluoridation indicated that it was possible to reduce the prevalence and severity of dental caries in the primary dentition, especially in those children either born after the start of the programme or aged around 1 year when it started. The fluoride programme did not cause an additional administrative burden on the existing programme for the distribution of powdered milk and milk-cereal. Termination of the programme resulted in a deterioration in the dental health of the children in Codegua. In 2002, 3 years after the programme ended, the prevalence of dental caries was higher than that recorded immediately after the end of the programme and was equivalent to that of the children in La Punta, the community that had been used as a control. The authors recommended the extension of milk fluoridation to other rural and semi-rural areas in Chile where water fluoridation was not technically feasible (39, 42).
Cardiff University School of Dentistry has a long history of health services research ranging from the early studies in the 1950s to the present day. The research has been diverse, often addressing problems of low income family dental health care and more recently dental care for the elderly. The research has been unique in that it has primarily used qualitative approaches and has always been committed to participatory research. The research has sought to develop and improve access to dental care by working with community organizations, primary care workers, general dental practitioners and other dental professionals. The research has also been instrumental in developing dental care policies and strategies that have been used in many countries around the world.

This paper provides a brief overview of the Cardiff University School of Dentistry’s research, and highlights some of the recent research projects that have been funded by the British Fluoridation Society. The research has been carried out with a wide variety of partners, including community organizations, health care providers, and other dental professionals. The research has been successful in developing and improving access to dental care by working with community organizations, primary care workers, general dental practitioners and other dental professionals. The research has also been instrumental in developing dental care policies and strategies that have been used in many countries around the world.

alternative that has the advantage of allowing consumer choice. It should be emphasized that "topical" fluorides such as toothpaste can also have a "systemic" effect when they are inadvertently ingested by young children. Indeed, three independent studies in Australia, Canada and the USA indicate that 47–72% of dental fluorosis in children can be attributed to the systemic effect of fluoride toothpastes (49). Dispensing a pea-sized amount of toothpaste, encouraging parents to supervise toothbrushing by their young children, and the use of toothpastes containing less fluoride by young children are approaches to ameliorating this problem. It is recommended that dental fluorosis be monitored periodically to detect increases in or higher-than-acceptable levels of fluorosis. Action, such as adjusting intake of fluoride from water, salt or other sources, should be taken when the prevalence of fluorosis is found to be excessive (48).

In parallel, it is important to maintain and foster a programme of health-services research that might seek to:

• update our information on the cost-effectiveness of water, salt and milk fluoridation against a background of the now widespread use of fluoride toothpastes;
• continue to develop and update our knowledge of the health effects of ingested fluoride;
• further develop affordable techniques for the removal of fluoride from the public water supply in communities where natural concentrations of fluoride are above the guideline value of 1.5 mg/l set by WHO (50);
• better understand the public perception of dental fluorosis; and
• evaluate the effects of the introduction of affordable fluoride toothpastes on purchase and use by the public.

Such a programme of health-services research will help to maintain and develop the outstanding progress made over the past half century in harnessing the beneficial effects of fluorides.

Competing interests: Sheila Jones is a paid officer of the British Fluoridation Society — a not-for-profit organization funded largely by United Kingdom government health promotion grants to support water fluoridation initiatives. Michael A. Lennon is unpaid Chairman of the British Fluoridation Society.

Résumé

Usage efficace du fluor en santé publique

Les caries dentaires demeurent un problème de santé publique pour de nombreux pays en développement et pour les populations démunies des pays développés. Le présent article présente l'évolution historique des stratégies de santé publique concernant l'utilisation du fluor et des observations quant à leur efficacité. Les premiers travaux de recherche et développement portaient sur les fluorures véhiculés par l'eau (d'origine naturelle ou ajoutés) et leurs effets sur la prévalence et l'incidence des caries dentaires et de la fluorose dentaire. Au cours de la seconde moitié du XXe siècle, les recherches se sont focalisées sur les dentifrices et les bains de bouche au fluor. Plus récemment, des revues systématiques récapitulant le contenu des grandes bases de données ainsi obtenues ont indiqué que la fluoruration de l'eau, comme la présence de fluorures dans les dentifrices, permettaient de réduire substantiellement à la fois la prévalence et l'incidence des caries dentaires. L'article présente quatre études de cas illustrant l'utilisation du fluor en santé publique moderne et portant sur :

• les programmes récents de fluoruration de l'eau en Californie, États-unis,
• la fluoruration du sel en Jamaïque,
Sheila Jones et al.

• la fluoración del lait au Chili, et
• la mise au point de dentífricos au fluor « abordables » en Indonésie.

On se préoccupe actuellement de réduire la nécessité de suivre des régimes fluorés reposant uniquement sur l’action des individus et de leurs familles et de diminuer les coûts de la supplémentation en fluor.

Resumen

Uso eficaz de fluoruros en la salud pública

La caries dental sigue siendo un problema de salud pública en muchos países en desarrollo y en las poblaciones desfavorecidas de los países desarrollados. En este artículo se describe a grandes rasgos la historia de las estrategias de uso de fluoruros en el ámbito de la salud pública y se comenta la eficacia de las mismas. Las primeras actividades de investigación y desarrollo se centraron en el consumo de fluoruros a través del agua, ya fuera porque ésta los contuviera naturalmente o porque se añadieran a ella, así como en sus efectos en la prevalencia y la incidencia de caries dental y fluorosis dental. En la segunda mitad del siglo XX las investigaciones pasaron a centrarse en los dentífricos y los colutorios fluorados. Más recientemente, las revisiones sistemáticas efectuadas en las amplias bases de datos existentes al respecto muestran que la fluoración del agua y los dentífricos fluorados han contribuido ambos a reducir sustancialmente la prevalencia y la incidencia de caries dental. Presentamos aquí cuatro estudios de casos que ilustran el uso de los fluoruros como parte de las prácticas modernas de salud pública. Los estudios versan sobre lo siguiente:

• sistemas recientes de fluoración del agua en California, EE.UU.;
• fluoración de la sal en Jamaica;
• fluoración de la leche en Chile; y
• desarrollo de dentífricos fluorados «asequibles» en Indonesia.

El interés por reducir las exigencias de observancia de los regímenes de administración de fluoruros que dependen de la acción de los individuos y sus familias, así como el aspecto de los costos, son cuestiones recurrentes.

Recomendamos que en cada comunidad se utilice sólo un tipo de fluoración sistémica (es decir, del agua, la sal o la leche), combinándola con el uso de dentífricos fluorados, y que se vigile la prevalencia de fluorosis dental para detectar cualquier aumento de la incidencia y evitar que supere los niveles admisibles.

References

Special Theme — Oral Health
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Sheila Jones et al.