

Insights Into Oral and Systemic Health in Older Adults: Barriers, Current Strategies, and Recommendations for the Caribbean

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With increasing life expectancy, the elderly population is growing globally and faces unique oral health challenges that impact overall health and quality of life. In the Caribbean, high chronic disease rates prevail, and health care access disparities leave geriatric oral health care underserved. Poor oral health is not inevitable with aging but instead stems from financial constraints, limited specialized services, and poor medical–dental integration. This narrative review synthesizes literature from major databases on the relationships between systemic and oral health in older adults. It identifies geriatric dental barriers, evaluates current strategies, and highlights interdisciplinary collaboration needs. The review presents structured guidelines for the management of older patients in dental clinics and provides evidence-based recommendations, including workforce training, teledentistry, and integration of dental care into general health care. By addressing these gaps, this work aims to guide Caribbean policymakers and health care providers in improving geriatric oral health services, ultimately enhancing quality of life for the region's aging population.

[P R Health Sci J 2026;45(2):57-64]

Key words: Geriatric dentistry, Systemic conditions, Oral health, Caribbean health care

I ncreased life expectancy is now common worldwide, with more people living into their sixties and beyond due to advances in the health sciences. Every country is witnessing a rise in the total number and proportion of elderly people in its population. By 2050, the global population of those aged 60 and above is expected to double, reaching 2.1 billion. Furthermore, the number of individuals aged 80 and older is anticipated to triple between 2020 and 2050, reaching 426 million (1). The Caribbean region is experiencing rapid population aging, with the old-age dependency ratio expected to reach 28 by 2045. Between 2020 and 2045, the number of people aged 65 and above in the Caribbean will double. Though the pace of aging varies across countries in the Caribbean region, there are common health challenges, such as the increasing prevalence of chronic non-communicable diseases and their associated inequalities (2). Four non-communicable diseases (NCDs) account for 39–67% of deaths across Caribbean countries and territories (3). Puerto Rico, a Caribbean island and territory of the United States, has one of the fastest aging populations globally, with the proportion of adults 65 and over nearly doubling between 2010 to 2019. High rates of chronic conditions have also been reported, with hypertension at 66.4%, arthritis at 42.2%, and diabetes at 33.5% (4).

The relationship between oral health and overall health is widely recognized. In 2016, the FDI World Dental Federation defined oral health as “a fundamental component of health and physical and mental well-being”, highlighting its integral role in overall health (5).

With the increase in the elderly population, the demand for geriatric dental care is expected to grow. Geriatric dentistry, also known as Gerodontics, focuses on providing dental care to elderly individuals. It includes diagnosing, preventing, and treating oral

health issues related to normal aging and age-associated diseases (6). Despite its importance, geriatric oral health remains a neglected and underexplored area, globally. Many older adults experience oral conditions such as cavities, periodontal disease, xerostomia, edentulism, and reduced chewing ability, which are worsened by physical decline and past dental neglect. They are also at higher risk of oral cancer because of their less resilient and more permeable oral mucosa.

While the connection between oral and systemic health in aging populations is well established, there is a lack of comprehensive resources offering a holistic perspective on geriatric oral health. Much of the existing research focuses on individual issues without considering them together. This gap is particularly evident in the Caribbean, where the aging population faces high rates of chronic diseases and limited access to geriatric dental services (7).

This narrative review was developed through a focused search of major electronic databases, including PubMed, Scopus, and Google Scholar, using combinations of keywords related to geriatric oral health, systemic diseases, oral–systemic relationships, Caribbean health care, and older adults. The search was limited to articles published between 2000 and 2025 to capture contemporary evidence while encompassing foundational

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The authors have no conflict of interest to disclose.

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studies in the field. Peer-reviewed articles, review papers, policy documents, and relevant regional reports were screened and thematically synthesized to provide a structured overview of the available evidence.

Barriers to Oral Health Services for the Elderly

Within a context of cultural diversity, the Caribbean region faces significant challenges, including high poverty rates, limited resources, and social inequalities. While all Caribbean countries and territories have vulnerable populations, such as the elderly, the exact prevalence and geographic distribution of these groups remain unclear. Barriers to oral health care utilization among elderly individuals are multidimensional and can be broadly categorized into financial, physical, psychological, and systemic (8). Financial constraints, such as the high cost of dental treatment and a lack of adequate insurance coverage, remain significant obstacles, particularly as many elderly individuals do not have access to dental benefits under health programs. Physical and logistical barriers, including limited mobility, lack of transportation, and inadequate accessibility of dental facilities, especially among individuals living in rural areas or residing in elderly care homes, further restrict access to care (8).

Many elderly individuals are also dependent on family members, including adult children, for transportation to dental visits, which can cause delays or prevent timely treatment. Psychological barriers, including fear, anxiety, and misconceptions (e.g., the belief that tooth loss is part of aging), discourage many elderly individuals from seeking dental care. Comorbidities, such as diabetes and heart disease, can also complicate oral health management and are associated with reduced dental visits (9). On a psychosocial level, isolation, lack of awareness of the importance of dental care, and the perception that dental treatment is necessary only when there is pain further limit oral health care utilization. Additionally, systemic barriers, such as the lack of integration between medical and dental care and insufficient training among dental professionals to address the specific needs of elderly individuals, further worsen the situation (10).

Common Systemic Conditions in Elderly Populations

Diabetes Mellitus

With the global increase in life expectancy, there has been a simultaneous increase in individuals diagnosed with type 2 diabetes mellitus (T2DM). Age is a well-known risk factor for T2DM; approximately 50% of patients diagnosed with T2DM are members of the elderly population (those 65 years and older). In fact, from 2017 to 2045 the number of persons 65 years and over with T2DM is expected to grow by 131million, alongside growth of the aging population by millions over the same period (11). Hyperglycemia in the elderly is a result of decreased insulin secretion and increased insulin resistance, both associated with aging. Insulin secretion in the elderly is significantly lower than in younger individuals and is more irregular, even after accounting for obesity and fat distribution (12). The increased insulin resistance accompanying age is linked to reduced sensitivity of the pancreatic beta cells to peptide signaling hormones released from the gut after eating. With age, changes in the distribution of adipose tissue coupled with reduced muscle mass (sarcopenia) are a major factor

in insulin resistance. This is further exacerbated by a reduction in physical activity, the presence of comorbidities, and medication use, all of which are common among the aging population (13). In older adults in Puerto Rico, poorly controlled diabetes (33.5% prevalence) is linked to a higher risk of periodontal disease and may complicate dental implant outcomes, highlighting the need for integrated medical–dental care. (14).

Cardiovascular Disease

The incidence of cardiovascular disease is higher in the elderly population, including atherosclerosis, myocardial infarction, and stroke. With aging, the heart undergoes changes in systolic and diastolic function, as well as in electrical conduction, all of which can result in arrhythmias and heart failure. Structural changes of the heart, such as fibrosis, increase the risk of myocardial infarction and are associated with hypertension and stroke (15). An increase with age in reactive oxygen species has been linked to impaired lipid metabolism, leading to hyperlipidemia and the development of atherosclerotic plaques; the latter are known risk factors for hypertension, stroke, and heart attack (16). The rising incidence of cardiovascular disease in the elderly population can be attributed to a multitude of factors, including increased inflammation, oxidative stress, cell death, overall degeneration of the vascular and cardiac tissues, and concomitant age-related risk factors such as obesity, hypertension, and T2DM (17).

Cancer

Advancing age is a significant risk factor for cancer in general and for numerous specific cancer types. This could be attributed to prolonged exposure to carcinogens, DNA damage accumulation, weakened immunity, and slower cellular repair mechanisms (18). The senescence-associated secretory phenotype released by aging cells has been linked to the development of epithelial cancers, such as oral squamous cell carcinoma, which is the most prevalent type of oral cancer (19). Approximately 60% of cancer diagnoses are made in and 70% of cancer-related deaths happen in people aged 65 and older. Globally, the number of cancer cases is expected to increase from 14 million in 2012 to 22 million by 2032, with a significant portion of this growth expected in developing countries. Common types of cancer in the elderly include lung, breast, cervical, colorectal, and prostate cancer. Lung cancer is the leading cause of cancer-related deaths worldwide - with smoking being the primary risk factor - and its incidence is notably high in elderly individuals (20).

Osteoporosis

Osteoporosis is an age-related disease characterized by an increased risk of bone fracture due to decreased bone mass or quality or increased porosity. The prevalence of bone fractures due to osteoporosis increases steadily with age in individuals over 50 years. Moreover, the effects of fractures have significantly greater consequences in elderly populations, with a higher proportion resulting in mortality (21). Globally, osteoporosis affects more than 35% of older women and 12% of older men. A multitude of interlinked risk factors have been identified. Chronic inflammation due to aging can lead to bone resorption. Age-related metabolic decline, hormonal dysregulation, and disrupted circadian rhythms

have also been linked to osteoporosis. All these factors contribute to decreased bone mass and strength and altered bone structure; in addition, when these changes are compounded by the increased fall incidence associated with cognitive decline, the risk of bone fracture is significantly increased in the elderly population. They also tend to have a more sedentary lifestyle with less mechanical loading, which causes a decline in the osteogenic response to replace resorbed bone. There is an underutilization of nutrients, and many elderly adults have diets low in nutritional value, leading to deficiencies in nutrients such as vitamin D and impaired bone remineralization (22).

Chronic Obstructive Pulmonary Disease

Chronic obstructive pulmonary disease (COPD) is the fourth leading cause of death globally. Advancing age is a recognized risk factor for COPD development, partly because the condition progresses slowly over time. Factors such as exposure to cigarette smoke, exposure to biomass smoke, and occupational exposures to dust and fumes require prolonged periods to contribute to COPD. However, there is some overlap between the typical signs of aging and the cellular mechanisms involved in COPD (23). Aging causes changes in lung tissue, the chest wall, and respiratory muscles. There is a progressive increase in the size of alveoli within the lung tissue due to loss of parenchyma, decreased elastic recoil, and reduced overall gaseous exchange. Intrathoracic volume is known to reduce due to decreased thickness of intervertebral discs or disc fracture caused by osteoporosis, and the function of the diaphragm is compromised as muscles weaken with age. External factors such as exposure to noxious fumes cause remodeling of the lung tissue, which can lead to fibrosis and scarring. When this occurs in an already aged lung, the risk of developing emphysema increases significantly (24). Patients with COPD, an illness common among Caribbean smokers, face heightened oral infection risk from steroid inhalers and reduced salivary clearance, requiring specialized respiratory–dental coordination rarely available in rural island clinics.

Neurodegenerative and Mental Disorders

As people age, they are at increased risk for a variety of mental and neurodegenerative conditions that affect cognitive function, memory, mood, and overall brain health. Some of the most common conditions are Alzheimer's disease, Parkinson's disease, and dementia. Additionally, elderly individuals are prone to depression and anxiety disorders (25). Various theories suggest that these disorders result from genetic and environmental factors that cause accumulated cellular damage. Caribbean dementia rates are rising rapidly; cognitive decline impairs oral hygiene, doubling caries and periodontal disease prevalence and necessitating caregiver training programs absent across most Caribbean countries and territories (26).

Chronic Kidney Disease

Old age is a key predictive factor of chronic kidney disease (CKD). Aging is naturally accompanied by a decline in glomerular filtration rate. On top of this, elderly persons are more at risk of acute kidney injury due to urinary tract blockage, hypovolemia, infection leading to sepsis, and polypharmacy (especially involving

nonsteroidal anti-inflammatory drugs, which are nephrotoxic) (27). Additionally, modifiable risk factors such as obesity, diabetes mellitus, and hypertension, which are commonly associated with aging, are also linked to the development of CKD. The rising prevalence of CKD among older adults, often associated with diabetes and hypertension, increases the risk of bleeding during dental procedures and may cause salivary dysfunction, underscoring the need for coordinated care between physicians and dentists (28).

Malnutrition and Frailty

Malnutrition is common in the elderly population, and this is thought to be due to numerous factors, such as declining sense of smell and taste, reduced appetite, and consequent changes in dietary habits. The decrease in appetite may be due to the medications these individuals are taking, and their diet may be altered by their dental status (for example, edentulism or ill-fitting dentures). Psychological factors also have a part to play in the diet of the elderly, in that depression, loneliness, and dementia have been shown to negatively affect dietary intake (29).

With the rapid growth of the geriatric population, there has been a parallel increase in the frail elderly. Frailty has been recognized as one of the more serious global public health issues of the coming century. It is a clinical state in which persons are more likely to have negative health-related events when exposed to stressors. Malnutrition is a significant causative factor in the progression of frailty because it can lead to weight loss, fatigue, and weakness (30). Frailty, per Fried et al, is defined by the fulfillment of 3 of the following 5 criteria: unintentional weight loss, self-reported exhaustion, weakness, reduced physical activity, and walking speed (31).

Polypharmacy

Globally, older adults commonly take 5 or more medications daily, with up to 40% of those aged 65 and over experiencing medication-induced xerostomia from antihypertensives and antidepressants. This increases caries risk in settings such as the Caribbean, where saliva substitutes and geriatric pharmacovigilance are lacking. While medications are meant to improve health, taking too many can increase the risk of adverse drug reactions, drug interactions, and cognitive decline, which in turn can complicate medication management and increase the risk of adverse outcomes. Polypharmacy is associated with poor oral health status; therefore, medications in use may be helpful in identifying oral problems in elderly patients (32).

Oral Health Implications of Systemic Conditions in the Elderly

As people age, they are more likely to face common oral health issues such as periodontal disease, dental caries, tooth loss, tooth wear, xerostomia (dry mouth), and oral cancer. The relationship between oral health and systemic conditions in elderly individuals is bidirectional; maintaining oral hygiene can improve both oral and systemic health outcomes (33).

Periodontal disease, affecting nearly half of the geriatric population, can lead to tooth loss and reduced masticatory function, which in turn negatively impacts eating, speaking, and

overall quality of life. Dental caries remains a significant concern due to factors such as reduced salivary flow and increased root exposure, with elderly individuals at higher risk. Research has shown that caries prevalence, measured by decayed, missing, and filled tooth surfaces, is high among older adults in Puerto Rico, and is higher than that reported for the United States (34). While diabetes can contribute to periodontal disease, the inflammation of periodontal tissues also has a negative effect on glycemic control. This may be because both diabetes mellitus and periodontitis are inflammatory diseases.

Edentulism, or tooth loss, can lead to malnutrition, social stigma, and even depression. Xerostomia, caused by age-related changes and medications, increases the risk of caries and periodontal issues (35). Although diabetic patients have similar rates of osseointegration and implant survival as non-diabetics, they are more likely to develop peri-implantitis, highlighting the importance of careful implant maintenance to avoid complications. Tooth wear, including attrition, abrasion, or erosion, becomes more prevalent with age, affecting tooth structure and leading to sensitivity or more severe complications. The constant mechanical trauma caused by dentures, particularly ill-fitting ones, can contribute to the development of oral precancerous and cancerous lesions. Other denture-related oral lesions include denture stomatitis (DS), the most common, angular cheilitis, inflammatory fibrous hyperplasia, and traumatic ulcers (36). Among systemic musculoskeletal conditions, rheumatoid arthritis can impair manual dexterity, making it difficult for patients to maintain oral hygiene, while also increasing the risk of dry mouth and periodontal disease, especially when complicated by secondary Sjogren's syndrome (37).

Oral manifestations associated with CKD include periodontitis, uremic stomatitis, candidiasis, oral hairy leukoplakia, and dysgeusia; even oral malignancy has been noted. Patients may also suffer from renal osteodystrophy manifesting as decreased trabeculation, jaw fractures, and abnormal bone healing, all of which need to be considered prior to extractions. It is also critical to note that those on dialysis or with end-stage renal disease are likely to have an increased bleeding risk, and this must be considered prior to procedures that elicit bleeding (38).

Cancer therapies such as chemotherapy and head and neck radiation therapy can have a multitude of implications for oral health, including inflammation of the oral mucosa, xerostomia, increased risk of dental caries, altered sense of taste, trismus, and candidiasis, among others. Resultantly, preventive dentistry is key in the management of cancer patients, as is proper palliative care (39). Nutritional deficiencies can lead to oxidative stress and inflammation, thereby becoming a potential risk factor in periodontal disease. Malnutrition can impede remineralization, having potential implications for the development of dental caries (40). Conversely, poor oral health is associated with malnutrition, as tooth loss and reduced chewing ability with age can limit

the food choices of older adults. Periodontal disease is considered a risk factor in the progression of sarcopenia and frailty in the elderly population. Medications prescribed to elderly patients for chronic systemic conditions may cause salivary hypofunction, which can in turn lead to qualitative and quantitative changes in saliva. Saliva is crucial for maintaining oral health. It also plays important roles in speech, swallowing, and taste, and contributes to acid buffering, tooth remineralization, and infection prevention. Its reduction can therefore result in various complications. These include xerostomia, dental caries, candidiasis, burning tongue, tooth surface loss, fissured tongue, difficulty swallowing and speaking, mucositis, and loss of taste perception. As a result, salivary hypofunction can significantly impact a patient's quality of life (41). Some of the common oral conditions in elderly individuals, namely dental caries, periodontitis, partial or complete edentulism, tooth wear, and denture stomatitis, are illustrated in Figure 1.

Management of the Elderly at a Dental Clinic

Table 1 summarizes the clinical approach to managing elderly patients at a dental clinic, organized by assessment, prevention, and treatment considerations. Dental diseases in the geriatric population need careful, individualized management based on patient-specific needs. Dental caries, including both coronal and root caries, is common in this age group, and its incidence is increasing due to factors such as tobacco use, poor oral hygiene, and gingival recession. Root caries are challenging to treat and often do not respond well to restorative materials such as glass ionomer cement and composite resins. Fluoride treatments, including professionally applied high-fluoride toothpaste and silver diamine fluoride, play a key role in preventing and controlling caries (42). Another frequent concern is periodontal disease, which can lead to tooth mobility and eventual loss. In such cases, treatment may involve improved oral hygiene, splinting, or even tooth extraction, if necessary. Maintaining proper oral hygiene can be difficult for elderly individuals due to issues such as reduced hand dexterity; however, assistive devices such as foam-handled toothbrushes or electric toothbrushes can help (43). For patients with missing teeth, tooth replacement is important so that both function and

Figure 1. Common oral conditions in geriatric patients: a. multiple carious lesions; b. chronic periodontitis; c. partial edentulism; d. complete edentulism; e. tooth wear; f. lesions due to ill-fitting dentures (denture stomatitis).

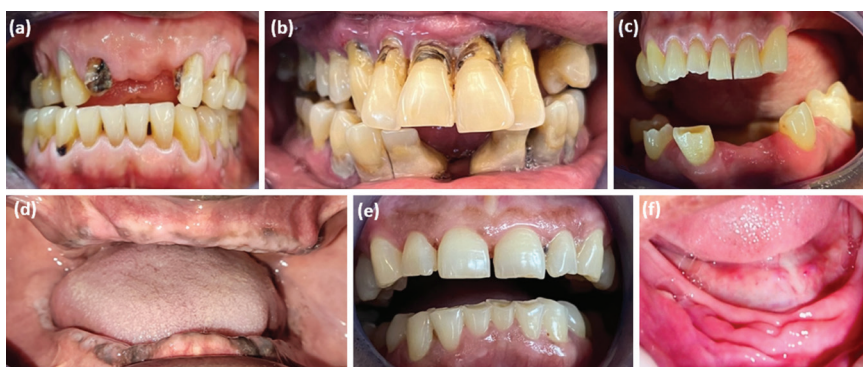


Table 1. General management protocol for geriatric patients in a Dental clinic

Steps	Description
Comprehensive medical history	Record comorbidities, surgeries, medications, allergies, and prior dental emergencies
Risk stratification	- Assess risk to stratify patients based on their medical complexity and treatment risks - Modify plans for uncontrolled systemic disease
Consultation with medical specialists	- Coordinate with physicians for complex comorbidities or polypharmacy before treatment - Formulate a tailored treatment plan that integrates both medical and dental considerations - Obtain medical clearance from the physician when indicated
Preoperative assessment and optimization	- Perform thorough preoperative assessment to identify risk factors - Check vital signs, laboratory values, and cardiac/pulmonary status, as indicated
Modification of treatment plans	- Adapt dental treatment plans to the specific needs and medical conditions of the patient - Adjust procedures for anticoagulants, immunosuppressants, or high-risk medications
Medication management	- Adjust dosages or substitute medications when indicated - Review for oral adverse effects and drug interactions; coordinate changes with physician(s)
Emergency preparedness	Maintain emergency drugs, equipment, and trained staff for medically complex patients
Patient education and empowerment	- Empower geriatric patients with medical comorbidities by encouraging them to actively participate in their dental care so that they can make informed decisions about their oral health - Educate patients on the importance of maintaining good oral hygiene - Instruct caregivers on oral hygiene, medication adherence, warning signs, and follow-up care

appearance can be restored. While the shortened dental arch approach may work for some, dental implants are becoming the preferred option; however, they may not be suitable for all patients, particularly those with conditions such as diabetes. In some cases, removable dentures may be an alternative, though they lose retention and stability over time. Finally, managing oral cancers in older patients involves stringent oral hygiene, fluoride treatments, and vigilant monitoring for precancerous lesions, as poorly fitting dentures and periodontal disease have been implicated as risk factors for cancer (6).

The management of DS involves improving oral and denture hygiene, correcting poorly fitting dentures, avoiding nocturnal denture wear, smoking cessation, and the use of antifungal treatments, either topical or systemic. While alternative therapies such as microwave disinfection, phytomedicine, and antifungal-infused denture resins show promise, more research is needed before they can be routinely recommended (44). Management of tooth wear in older patients focuses on prevention by identifying and controlling risk factors through a thorough assessment, including medical history, oral examinations, and, possibly, salivary tests. Preventive measures include changing dietary habits, avoiding erosive foods, and managing conditions

such as hyposalivation and bruxism. Non-restorative treatments, including fluoride and desensitizing agents, can help reduce wear, while restorative options should be conservative and minimally invasive. Regular monitoring using clinical indices such as the Basic Erosive Wear Examination index is essential to track wear progression and determine whether further intervention is needed (45).

Dentists should adopt a multidisciplinary approach to medication management, collaborating closely with primary care providers, specialists, and pharmacists to optimize drug therapy regimens for elderly patients, especially to overcome the anticholinergic effects of some medications. Recommended dental interventions for patients with salivary hypofunction include salivary stimulation with sugar-free gum, xylitol-based lozenges and spray, and fluoride treatments (46). However, patients with xerostomia should visit the dentist every 3 months for comprehensive oral examinations, including checks for new carious lesions and soft tissue changes and a review of oral hygiene practices to prevent complications caused by medications. Oral health professionals must exercise empathy and be able to adapt their approach to providing comprehensive dental care specifically tailored to the unique challenges of a given elderly patient. Compassionate care fosters confidence in the dentist, leads to a good dentist–patient rapport, enhances

communication, and ultimately allows for more satisfactory treatment outcomes.

Current Dental Care Strategies for the Elderly

The Caribbean region has experienced a shift from infectious diseases toward chronic conditions such as obesity and cardiovascular disease. Regional data align with global findings linking periodontal disease to diabetes. The Caribbean Health Research Council advises screening for periodontal disease during diabetes management (47). Several Caribbean countries and territories have introduced policies, especially for elderly individuals, aimed at improving oral health. In 2009, Barbados launched a policy promoting oral health through education for all age groups and early screening for oral cancer. A year later, in 2010, Trinidad and Tobago created a policy to reduce tooth loss and oral cancer rates among those 65 and over, recognizing this group as vulnerable and ensuring they had access to comprehensive dental care. Grenada followed suit in 2014, starting oral health education programs for seniors over 60 and their families to prevent common dental issues. In 2017, Jamaica introduced a policy to provide affordable, high-quality dental care to its elderly population, emphasizing the connection between oral health and overall well-

being. The policy also included education, cancer screening, and preventive dental treatments, along with the integration of dental services into health care facilities to better serve the elderly (48). However, the implementation and effectiveness of these strategies remain to be fully assessed.

Oral health care financing in Europe varies by country but is typically funded through national social security, insurance, out-of-pocket payments, or combinations of these. Vulnerable groups such as older adults and low-income individuals are eligible to receive free dental services in public clinics. The European College of Gerodontology and the European Geriatric Medicine Society emphasize integrating oral health into geriatric care, with recommendations to promote education, interprofessional collaboration, and promoting oral health literacy. They advocate for including oral health in general health care policies, with a focus on research, domiciliary care, and institutional care protocols in settings like nursing homes and other long-term care facilities. Japan's health policy, particularly since the 2011 Dental and Oral Health Promotion Act, links oral health with general health, focusing on the prevention of NCDs, frailty, and dependency. National programs such as Health Japan 21, along with initiatives targeting cancer, dementia, diabetes, and frailty prevention, include dental care as a key component. Health Japan 21 focuses on NCD prevention, elderly health, and promoting dental care alongside exercise, nutrition, smoking cessation, and other healthy behaviors (49). In the United States, the Centers for Medicare and Medicaid Services oversees federal health care for those 65 years and older through Medicare and Medicaid. Medicare excludes dental care, except in specific situations such as hospitalization or when certain oral exams are performed. Medicare Advantage may cover dental care at an additional cost, yet nearly half of enrollees lack dental insurance coverage. The Program of All-Inclusive Care for the Elderly is a Medicare and Medicaid program that provides health services, including dental care, to individuals aged 55 and older, enabling them to receive care in their community rather than in a nursing home (50).

Strategies to Enhance Geriatric Dental Care in the Caribbean

a) Government Action, Policy Development, and Community Interventions

- The government should prioritize geriatric dental care by increasing funding and resources for programs that focus on the elderly. Oral health should be included as part of general health care systems. Policies should be developed to address the specific oral health needs of underserved communities in the Caribbean and should include measures to improve insurance coverage for geriatric dental care (49).
- Governments across the Caribbean should collaborate and share resources and knowledge to overcome language and geographical challenges. Local community-based programs, mobile dental units, and accessible clinics should be set up to bring dental care closer to the elderly, especially in remote and underprivileged areas (49).
- "One-stop" health care centers that combine oral and general health care should be established, with staff roles such as patient navigators and insurance specialists to help

older adults access care more easily. Governments, health care professionals, and communities must work together to ensure everyone shares responsibility for promoting oral health and disease prevention (49).

b) Workforce Development and Regional Institutions

- Regional training programs focusing on geriatric care should be established for dental professionals. These programs should address the specific needs of the elderly populations in each country. Academic institutions and professional organizations should collaborate to integrate geriatric care into the curriculum of dental training courses, ensuring that all professionals are well-prepared to care for older adults (7, 49).
- Regional dental institutions should play a key role in strengthening the dental workforce by offering ongoing professional development and fostering empathy in the care of geriatric patients. Teledentistry and other technological innovations can be used to expand service access, especially in remote areas. A thorough assessment of regional workforce training needs should be conducted to identify gaps and areas for capacity building.

c) Disease Prevention and Health Promotion

- Oral health should be integrated with general health care for elderly people, particularly to address conditions such as diabetes and cardiovascular disease. Governments, health care providers, and community organizations should collaborate to create programs that promote disease prevention in elderly populations (7).
- Strong partnerships between government bodies, health care organizations, and communities should be formed to raise awareness about the importance of oral health and preventive care, especially for vulnerable elderly populations (7).

d) Research and Development

- A comprehensive research agenda for oral health should focus on aging, the link between oral and systemic diseases, and the impact of dental care on elderly individuals. Supported by a strong infrastructure, this agenda should involve regional academic and professional bodies and use participatory action research to engage communities in identifying and solving local oral health issues. Research should aim at identifying solutions that can help policymakers develop impactful public health policies (7).

Conclusion

Population aging in the Caribbean and globally poses a significant challenge to oral health care, given the bidirectional relationship between systemic diseases and oral conditions, which can greatly influence both overall health and quality of life. In older adults, poor oral health is both a consequence of and a contributor to broader medical issues. It is not an inherent consequence of aging, but instead stems from factors that are

preventable and manageable, such as financial constraints, gaps in the health care system, and the lack of integration between medical and dental services. Without targeted interventions, the growing elderly population in the Caribbean will continue to experience disparities in oral health care, exacerbating chronic conditions and diminishing their quality of life. Therefore, there is an urgent need for policy reform, workforce expansion, and improved health care accessibility through innovative solutions such as teledentistry. Strengthening interdisciplinary collaboration between medical and dental professionals, investing in geriatric dentistry education, and integrating oral health care into routine medical care are key strategies for advancing the field of geriatric dental care. Moving forward, policymakers, health care providers, and academic institutions must work together to close the gaps in care, expand research on regional oral-systemic health trends, and develop sustainable, community-based interventions. Ultimately, recognizing oral health as a fundamental determinant of healthy aging is essential to prioritizing geriatric oral care as a public health concern.

Resumen

Con el aumento de la esperanza de vida, la población de adultos mayores está creciendo a nivel mundial y enfrenta desafíos únicos en la salud bucal que afectan la salud general y la calidad de vida. En el Caribe, prevalecen altas tasas de enfermedades crónicas, y las disparidades en el acceso a la atención sanitaria dejan desatendida la atención bucodental geriátrica. La mala salud bucal no es inevitable con el envejecimiento, sino que se debe a limitaciones financieras, servicios especializados limitados y una deficiente integración médico-odontológica. Esta revisión narrativa sintetiza la literatura de bases de datos importantes sobre las relaciones entre la salud sistémica y la salud bucal en los adultos mayores. Identifica las barreras en la odontología geriátrica, evalúa las estrategias actuales y destaca la necesidad de colaboración interdisciplinaria. La revisión presenta directrices estructuradas para el manejo de pacientes mayores en clínicas dentales y ofrece recomendaciones basadas en evidencia, incluyendo la capacitación de la fuerza laboral, la teledontología y la integración de la atención dental en la atención sanitaria general. Al abordar estas brechas, este trabajo tiene como objetivo orientar a los responsables de políticas y a los proveedores de atención sanitaria del Caribe en la mejora de los servicios de salud bucodental geriátrica, con el fin de mejorar la calidad de vida de la población envejecida de la región.

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