



The British Dental Association Oral Health Inequalities Policy

The British Dental Association

Oral Health Inequalities Policy

Introduction

An unacceptable and growing chasm exists in the UK between those with good and poor dental health. The 1998 Adult Dental Health Survey showed that many conditions in dental health are related to deprivation.¹ Fewer of those in the more deprived areas retained some of their own teeth in comparison to those in less deprived areas, and people in the most deprived areas were found to be more likely than those in the least deprived areas to have some teeth with cavitated decay.

Even though there have been some improvements in oral health over the past 30 years, inequalities still exist and are widely documented.² This is true especially for children. By the age of five, more than a third of British children have suffered tooth decay, missing teeth or fillings; in some parts of the UK as many as three-quarters of children are affected.³

Differences in dental health are found across the UK. In Scotland, tooth decay is strongly connected with deprivation and dental diseases are still common health problems. Recent figures in Wales show that over 50 per cent of five year-olds have experienced tooth decay.⁴ In Northern Ireland, two thirds of adults have gum disease, and children have among the highest levels of tooth decay in Europe.⁵ There is also a seven-fold difference between the populations of primary care trusts (PCTs) in England with the best dental health and those with the worst.⁶

Action to address this public health concern requires collaborative strategic input from all health and social care professionals. Improving oral health should be part of the government's wider public health strategy in all four UK countries, as many of the key factors that lead to poor oral health are risk factors for other diseases.⁷ Key factors that can influence poor oral health are: diet and nutrition; oral hygiene; fluoride exposure; tobacco; alcohol; and injury.

The British Dental Association (BDA) is committed to promoting initiatives and actions that tackle inequalities in oral health, which reflect broader health differences across the population, both in terms of pattern and cause. Socio-economic factors are recognised as being key determinants of oral health inequalities. These include deprivation, age, gender, ethnicity, environment, psycho-social, poverty and lifestyle. There are further examples to emphasise the relentless influence of poverty on disease, including oral diseases: gingival and periodontal disease, dental trauma and

¹ The Office of National Statistics, Adult Dental Health Survey, Oral health in the United Kingdom, 1998

² Independent Inquiry into Inequalities in Health (Acheson Report), 1998; Department of Health, Choosing Better Oral Health: An Oral Health Plan for England, 2005

³ British Association for the Study of Community Dentistry, 2005/06 survey of children five-year-olds

⁴ Designed to Smile – A National Oral Health Improvement Programme Promoting Better Oral Health and Delivering a Fluoride Supplementation Programme, 2008

⁵ Department of Health, Social Services and Public Safety Northern Ireland, Oral Health Strategy for Northern Ireland, 2007

⁶ British Association for the Study of Community Dentistry, 2003/04 survey of five-year-olds

⁷ Department of Health, Choosing better oral health: An oral health plan for England, 2005

oral cancer, plus general health indicators such as infant mortality or life expectancy. The socio-economic gradient in access to dental care, the inverse care law and the inverse dental care law are also factors. The Whitehead and Dahlgren diagram below helps to demonstrate this point.



The impact of government policy and dental contracts

Dentists and the dental team are ideally placed to provide prevention and promotion messages to patients, such as smoking cessation advice, healthy eating advice or advice on sensible alcohol use. However, it is essential that funding and remuneration systems recognise the resources needed for a preventive approach to be adopted. Government policy should emphasise the prevention of disease and promotion of oral health in conjunction with attempts to treat the damage caused by dental disease, to help reduce inequalities and improve the oral health of the nation.

The dental team has a vital role to play in maintaining the general and oral health of the nation. Commissioners of dental services need to access appropriate dental public health advice to ensure support of strategies that address inequalities in oral health and ensure that oral health is included in health-related initiatives. Dental services must be fully integrated within primary care to help develop local solutions for local needs, thus helping to tackle local oral health inequalities. Integration *per se* will not tackle oral health inequalities. However, there is agreement that dentistry should be more integrated in health services to improve holistic patient care.

Health Promotion and Health Education

The need to engage people in their health and to shift the emphasis from cure to prevention of illness has been identified by the Wanless reports.⁸ However, more emphasis is needed on health promotion and preventive approaches in conjunction with treatment of the damage caused by dental disease. Patients should be provided with the appropriate information in order to make informed decisions about their oral health, and information on dental services must be made available in an accessible format to the public, especially the “hard to reach” segments of the population.

Guidance to all members of the dental team on evidence based prevention has been produced.⁹ However, oral health prevention and education are not always part of general health promotion programmes. The dental team certainly has a role to play in this respect, provided an appropriate remuneration system is in place within the NHS. For preventive care to be effective, the dental team needs to be able to spend time with patients to counsel them about diet, drinking and smoking habits, to show them how to clean their teeth properly and to discuss any areas of concern. Meanwhile, there needs to be increased appreciation of cultural differences in relation to oral care, and cultural sensitivities ought to be respected. For example, leaflets on oral health should be available in languages other than English. Gender differences should also be considered when designing information campaigns, including the effects of pregnancy and hormonal flux on the oral health of women, and the impact of eating disorders, which are also a predominantly female issue.

Multi-agency working

Dental health is an important part of general health and should not be considered in isolation. More multi-agency working should promote collaboration between health, local authority and voluntary organisations to tackle health inequalities. The BDA supports initiatives such as Sure Start in England, which is focused on all aspects of the wellbeing of children, ChildSmile in Scotland and Designed to Smile in Wales, and hopes to see an expansion of such programmes following appropriate evaluation of their effectiveness.

In many areas, Sure Start has involved oral health initiatives, typically focusing on oral health promotion and fluoride toothpaste. There should be a more comprehensive and evidence based approach with every Sure Start Scheme having a dental care professional in the team. The latter can offer advice on all aspects of oral health including brushing teeth, use of fluoride toothpaste, advice to parents on breast- and bottle-feeding (to help reduce the incidence of bottle caries caused by sugary drinks fed to babies/young children in a bottle, especially at bedtime) and advice on the advantages of offering drinks such as water between meals rather than acidic or sugary alternatives.

The BDA supports schemes such as Brushing for Life, a scheme intended to promote regular brushing of children’s teeth with fluoride toothpaste. The programme is delivered by health visitors who provide toothbrushes, toothpaste and dental health education material at children’s eight, 18, and 36 month development checks.

⁸ Wanless, D., *Securing our Future Health: Taking a Long-term View*, HM Treasury, 2002; Wanless, D., *Securing Good Health for the Whole Population*, HM Treasury, 2004

⁹ Department of Health and the British Association for the Study of Community Dentistry, *Delivering Better Oral Health: An evidence-based toolkit for prevention*, 2007

Distribution of free toothpaste (1350 - 1500ppm F⁻) has a relatively good evidence base and should be developed as an initiative.

For new initiatives, robust evaluation should be built in at the planning stage to improve the evidence base. The World Health Organisation (WHO) suggests at least ten per cent of funding should be used for evaluating new initiatives. The dental profession, in particular, needs to use evidence from systematic reviews to drive oral health promotion activity.

Dental Public Health

Dental public health functions such as screening, epidemiological surveys, the identification of oral health inequalities and the evaluation of health improvement interventions designed to tackle these inequalities are all essential to service planning. These functions must be safeguarded and developed. In addition, dental public health advice must be available to commissioners of dental services.

The Adult Dental Health Survey (ADHS), Children's Dental Health Survey and the British Association for the Study of Community Dentistry (BASCD) surveys are invaluable means of identifying and tracking oral health inequalities. From the information they give, strategies can be developed to tailor services to the needs of the community. The surveys underpin effective planning for improvements to nationwide oral health. The results of these studies have supported all major policy developments in dentistry since the start of the programme, including the introduction of capitation remuneration for children in 1990 and the expansion of training places for dentists and dental therapists in England and Wales from 2006.

Dental surveys provide valuable information on the prevalence of oral disease in different population groups, the experience of dental treatment, the use of dental services and population attitudes towards oral health and services. The consistency of methodological approaches has allowed the identification of trends in these factors, arguably the most important aspect of the programme. The ADHS has been running every ten years since 1968, providing invaluable insight into dentistry and dental health. The survey is a very useful resource and the only study of its kind that can provide vital national information on dentistry and dental health. The next one is due in 2009/2010 and will be an important tool to inform local needs assessments.

PCTs have a responsibility to improve oral health in addition to carrying out dental public health functions. Oral health improvement can only happen if primary care organisations (PCOs) have the capacity within their structures to carry out the activities. PCO commissioning capacity and capability is variable, as acknowledged by a number of Health Select Committee reports, including the one on dentistry.¹⁰

Conducting high quality studies, including development of screening programmes, is essential to determining the efficacy and effectiveness of interventions. There needs to be more coordination and inclusion among all stakeholders involved in public health policy-making. Dentistry is often forgotten and policies harmful to oral health are introduced as a result. Decision-makers need to ensure that dental issues are considered and the dental public health community is consulted regarding all health and social care policy initiatives.

¹⁰ House of Commons Health Committee, Dental Services, Fifth Report of Session 2007–08

Inequalities in the oral health of children

Inequalities in child dental health are well documented. The 2003 Children's Dental Health Survey¹¹ found that children attending primary schools in socially-deprived areas of the UK were reported to have experienced more tooth decay than children in schools in non-deprived areas. In deprived areas, 60 per cent of five year-old and 70 per cent of eight year-old pupils have obvious decay in their primary "milk" teeth, compared with 40 per cent of five year-olds and 55 per cent of eight year-olds attending schools in non-deprived areas. Among both five and eight year-olds, the probability of having decay into dentine or obvious decay experience of the primary teeth was about 50 per cent higher in the lowest social group than in the highest. Inequalities in dental caries prevalence associated with some ethnic minority groups are more pronounced among pre-school children than in any other age group.¹² To date, most studies have focused on the South Asian community, where religious background and the ability of the mother to speak English have emerged as important determinants of oral health status. Little information is currently available for new migrant communities from Eastern Europe or for any ethnic minority groups not living in deprived areas; potential child oral health inequalities in these groups require investigation.¹³

In Scotland, deprivation categories or DepCat scores have been calculated for each postcode area. The scale runs from DepCat 1 (most prosperous) to DepCat 7 (least prosperous). The index has been shown to be closely linked with measures of death, illness and use of the health service, and a clear association has been established between DepCat-measured social deprivation and dental decay in children.¹⁴ The 2006 National Dental Inspection Programme found that children from DepCat 1 and 2 have already reached the 2010 National Target of 60 per cent with no obvious decay experience, while only 31 per cent of children from DepCat 7 have no obvious decay experience.¹⁵ The Scottish Government action plan, *Better Health, Better Care*, also highlights that standards of oral health in children have a strong relationship with deprivation. The report states that there is clear evidence that young children with decay in their baby teeth are very likely to have problems with their adult teeth, and that tooth decay can be prevented by establishing good habits in terms of diet and oral care at an early age.¹⁶ As Scottish water is not fluoridated, another effective measure, supported by the BDA, is fluoride varnishing delivered by dental nurses.

In Wales, over 50 per cent of five year-olds have experienced tooth decay. There is a widening gap between the oral health of children for the least well off and the most well off families in Wales.¹⁷ Under the *Eradicating Child Poverty in Wales – Measuring Success* strategy, the dental targets set are that by 2020, the dental health of five and twelve year-olds in the most deprived fifth of the population will

¹¹ Office of National Statistics, 2003 Children's Dental Health Survey

¹² Watt, R. and Sheiham, A. (1999) Inequalities in oral health: a review of the evidence and recommendations for action. *BDJ*, 187, 6-12.

¹³ See: www.library.nhs.uk/ETHNICITY/ViewResource.aspx?resID=295300 (ACCESSED May 2009)

¹⁴ Scottish Government now uses SIMD categories (Scottish Index of Multiple Deprivation)

¹⁵ National Dental Inspection Programme of Scotland Report of the 2006 Survey of P1 Children, Scottish Dental Epidemiological Co-ordinating Committee

¹⁶ *Better Health, Better Care: Action Plan* The Scottish Government, 2007

¹⁷ *Designed to Smile – A National Oral Health Improvement Programme Promoting Better Oral Health and Delivering a Fluoride Supplementation Programme*, 14 March 2008

improve to that presently found in the middle fifth. Designed to Smile is being developed through the National Child Oral Health Improvement Programme as a national programme to improve the dental health of children in Wales. This is the first “super pilot” tooth brushing scheme in parts of North and South East Wales, building on the experience of the established Fissure Sealant programme.

In Northern Ireland, dental caries in children have been addressed through a major fluoride toothpaste scheme, aimed at schools and children, in the Eastern Health and Social Services Board. This was introduced in 2003.¹⁸

The BDA supports initiatives such as Brushing for Life and Sure Start in England, the Fissure Sealant Schemes in Scotland and Wales. These initiatives promote oral health in children and aim to lessen oral health inequalities among children. Dentists have been also actively involved in the Healthy Schools programme and other local and national initiatives to improve children’s nutritional intake. In particular, many breakfast clubs have been set up and tooth brushing schemes have been built into these services in many disadvantaged areas. The BDA supports these nutritional programmes, including the Healthy Schools Programme and the School Fruit and Vegetable Scheme. Such interventions are best framed in the context of national nutritional guidelines, such as those published in Scotland in association with the Schools (Health Promotion and Nutrition) (Scotland) Act 2007.¹⁹

Children and adults with disabilities

Oral health is an important aspect of overall health and the benefits of good oral health should not be underestimated. Good oral health empowers adults and children with disabilities, and can give them the confidence to enable them to reach their full potential in participating in all aspects of society.²⁰ Enabling provision of responsive oral health services to these groups can require additional action and support. The 2007 Department of Health document *Valuing People’s Oral Health*⁶ suggests that competence in provision of oral health care to these groups can be developed through research, consistent advice, professional training and provision of specialist care. The recommendations given in this report include assessing need through local surveys, and ensuring children and adults with a disability receive the necessary information, advice and support to give them the best opportunity to achieve and maintain optimal oral health. This can include ensuring multilingual information is provided for people whose first language is not English. The report also recommends including oral health in every care plan. However, guarantees should be implemented to ensure that local authorities and social service providers effectively act in accordance with these recommendations. It should be also considered that children and adults with learning disabilities may have difficulty using the health information available to them.²¹

PCOs need to acknowledge that dentists will need additional time when dealing with patients with more specific needs, such as disabled children and adults as well as

¹⁸ Department of Health, Social Services and Public Safety Northern Ireland, Oral Health Strategy for Northern Ireland, June 2007

¹⁹ Health promotion guidance for local authorities and schools. See: <http://www.scotland.gov.uk/Publications/2008/05/08160456/0> (accessed January 2009)

²⁰ Department of Health, *Valuing People’s Oral Health: A good practice guide for improving the oral health of disabled children and adults*, 2007

²¹ Department of Health, *Choosing Health: Making healthy choices easier*, 2004

elderly or complex mental health patients. *Valuing People's Oral Health* alluded to this - one of the messages contained within was that disabled children and adults have an equal right to access dental care at their general dental practitioner (GDP) along with the rest of their family, rather than being sent off to the salaried services or dental hospital. The BDA recognises a spectrum of complexity from patients with mild to moderate disability, most of whom should have access to care in general dental practice, through moderate to severe cases requiring a service with facilities specific to particular needs, to extreme cases needing specialist services. Salaried services should focus on those for whom a general dental practice environment is unsuitable, with an option of shared care where appropriate, and encourage others to attend GDPs.

Inequalities in the oral health of older people

Increased life expectancy, coupled with a falling birth rate, means that by 2020 the proportion of people aged 65 and above is projected to rise from a current figure of 15.7 per cent to 18.9 per cent. At the same time as the population of older people is growing, it will become more ethnically diverse, and the imbalance in numbers between women and men will continue to increase. Older people will exhibit a broad spectrum of dependence. They will largely continue to live in their own homes. Nursing and care homes will provide accommodation for a group of older people who are most likely to be frail with complex clinical needs. The *National Diet and Nutrition Survey of Older People*²² showed that people living in institutions had more untreated disease and older and more poorly fitted dentures than free-living peers. Ensuring access to appropriate oral healthcare for dependent older people will continue to be an issue for the NHS. The Residential Oral Care in Sheffield (ROCS) programme is an excellent example of good practice.²³ It involves collaboration between GDPs supported by a senior dentist in the salaried service, oral health promotion and dental public health in delivering a comprehensive training, screening and treatment programme to residential homes for the elderly in the city.

There will be a broadening disparity between the amount of disposable income available to wealthier older people compared to that available to poorer sections of this population, with a significant number of people who can fund their own oral healthcare and a significant number who cannot. The change in the composition of the UK population will have an effect on dental practice and an impact on the training and skills required by health and social care professionals. There will be increasing numbers of older patients who need complex restorations to ensure that they retain many of their natural teeth.

Conditions such as root caries and dry mouth will continue to be prevalent, although new clinical technologies may be developed to prevent and treat them. Dental teams will be providing oral healthcare to a greater proportion of older patients with a range of complex needs for which they will require appropriate training and experience. As well as changing clinical needs, older people will have increasing expectations about retaining good oral health and appearance in old age. Many will have the resources to take advantage of advances in cosmetic procedures but many more will not. The

²² See: www.statistics.gov.uk/ssd/surveys/national_diet_nutrition_survey_adults.asp (accessed January 2009)

²³ G. Heyes (SDO) & K. Lines (GDP), Residential Oral Care in Sheffield - The ROCS Project, Royal College of Physicians, presented at BSG & BDA CDS Group Joint Scientific Meeting, 7 December 2006

BDA's policy paper *Oral Healthcare for Older People 2020 Vision* sets out recommendations to meet the needs of all older people, looking ahead to 2020.²⁴

Inequalities in the oral health of the prison population

The level of untreated dental disease within the prison population is approximately four times that found in the equivalent socio-economic groups of general society.²⁵ Furthermore, prisoners present with a higher proportion of emergency and urgent cases, corresponding to greater neglect of oral care.²⁶ Many of the factors contributing to poor oral and general health show increased prevalence or severity in prisons, including alcohol consumption, poor nutrition, mental health problems and substance abuse; over 75 per cent of prisoners smoke tobacco. The composition of prison populations is also demographically skewed, and is an important determinant of oral health needs: they are overwhelmingly (approximately 95 per cent) male and contain disproportionately high numbers of people from ethnic minorities, poorer backgrounds and groups with lower literacy rates.²⁷

As the prison population continues to grow,²⁸ a number of barriers to the provision of effective oral healthcare must be overcome. Turnover of prisoners is high, impeding continuity of care, and their behaviour as clients can be demanding.²⁹ Lack of motivation or ability to practise good oral hygiene can shift expectations towards treatment rather than prevention. These problems are compounded by prison-specific supply and resourcing issues including lack of adequate space, equipment and facilities, shortages in dental time exacerbated by security measures, difficulties in provision of out-of-hours cover and poor recruitment and retention of prison dentists and other members of the dental team.

In 2003, publication of the report *Strategy for Modernising Dental Services for Prisoners in England* by the Chief Dental Officer coincided with a handover of responsibility for prison health services from the Home Office to the Department of Health. The strategy recognised an urgent need for improvement in the quality, cost-effectiveness and provision for the specific operational demands of prison dental care, and laid out recommendations backed by an investment of £4.75 million over three years. According to a 2006 report by the Prison Health Research Network, significant progress was achieved in service specification and access, clinical governance, equipment inspections and dental team morale.³⁰ However, substantial challenges remain for PCTs, which have taken full responsibility for commissioning local prison health services since April 2006. In particular, standardised data sets and improved information systems are required to enable efficient commissioning and performance management of prison dental services.

²⁴ BDA, Key Issue Policy Paper – Oral Healthcare for Older People 2020 Vision, 2003

²⁵ Department of Public Health and Epidemiology, University of Birmingham, Health care in prisons: a health care needs assessment, February 2000

²⁶ NHS Primary Care Contracting/Faculty of General Dental Practice (UK), Guidelines for the appointment of dentists with Special Interests (DwSIs) in prison dentistry, 2007

²⁷ Department of Public Health and Epidemiology, University of Birmingham, Health care in prisons: a health care needs assessment, February 2000

²⁸ See: www.justice.gov.uk/publications/populationincustody.htm (accessed May 2009)

²⁹ NHS Primary Care Contracting/Faculty of General Dental Practice (UK), Guidelines for the appointment of dentists with Special Interests (DwSIs) in prison dentistry, 2007

³⁰ Prison Health Research Network, Evaluation for the Impact of the National Strategy for Improving Prison Dental Services in England, 2006

The BDA supports measures to match the dental care available to prisoners with that offered to the general population. High quality treatment should be provided according to need, and reduction of future levels of dental disease among prisoners should also be a primary aim. Emphasis and resources should therefore be shifted towards prevention, oral and general health education and increased availability of high quality, affordable dental health products to prisoners. The BDA supports the principles outlined in the draft *Guidance to PCTs for the Commissioning of Prison and Detention Centre Dental Services* of continuous dialogue between prisons and PCTs and coordination with non-dental health services to deliver oral healthcare according to the “common risk factor” approach; as in the general population, efforts in oral care should be integrated with other health initiatives such as smoking cessation and nutrition advice.³¹

The BDA recognises the importance of research in establishing a baseline for the prevalence and distribution of dental disease at the point of entry into prisons. Only about one in five prisons currently offers dental assessment to new prisoners.³² Screening programmes upon reception, transfer and departure have the potential to ensure more effective allocation of resources and continuity of care in the future.

Exposure to Fluoride

The promotion of measures that would bring teeth into contact with fluoride could make a real difference to the standard of oral health in the UK. York University researchers’ systematic review of fluoridation found that, on average, around 15 per cent more children in fluoridated areas are free from decay than in non-fluoridated areas.³³ In Sandwell, the water supply was fluoridated in 1986. Over the following ten years, the amount of tooth decay in children had decreased by more than 50 per cent. During the same period Bolton, with a comparable population mix, saw little change in its children’s oral health.³⁴ Fluoride – through targeted water fluoridation, tooth brushing campaigns, fluoride rinses, or being added to milk – has a track record of reducing caries.

Fluoridation is a good example of effective prevention strategy in reducing oral health inequalities in a population, as it reaches everyone who drinks the water, requires no change in lifestyle and has the greatest benefit for those most socially deprived or disadvantaged. However, fluoridation measures must be appropriate to the needs of the community. A good example is the recent decision, followed by extensive public consultation, made by the South Central Strategic Health Authority (SCSHA) to fluoridate the local water supply.³⁵ Ideally, a reduction in sugar consumption/healthier diet should be combined with appropriate use of fluoride.

Nutrition

³¹ Draft: Guidance to PCTs for the commissioning of prison and detention centre dental services

³² Prison Health Research Network, Evaluation for the Impact of the National Strategy for Improving Prison Dental Services in England, 2006

³³ M. McDonagh *et al.* NHS Centre for Reviews and Dissemination, A systematic review on water fluoridation, University of York, 2000

³⁴ Chief Dental Officer, Department of Health, Fluoridation of drinking water: Letter and Guidance, September 2005.

³⁵ See: www.southcentral.nhs.uk/news.php?news_id=177 (accessed March 2009)

Diet is also an important contributing factor to oral health. There is strong evidence to link frequency of sugar consumption and dental decay. There is a high consumption of sugary sweets and drinks among children and young people in lower income groups. Children have access to sugary drinks and foods through school tuck shops, canteens and dispensing machines. Activities that limit the amount of sugary food and drink in schools are supported, and cold water machines should be available in every school. There is a strong case for encouraging local education authorities and schools to reassess their policies on these facilities. In some circumstances a high sugar diet is essential to provide the nutritional value to sustain older people and consequently the impact that this will have on their oral health should be monitored closely.

New legislation such as the minimum nutrition standards for schools, proposals for new labelling schemes for food and restrictions on television advertising of high sugar food has the potential to have a strong impact on oral health inequalities through improving the diet of the wider population. Other measures such as reducing the use of medicines that contain sugar and promoting alternative delivery methods of medicines e.g. tablets, or if liquid medicine is the only method of delivery, ensuring that this is sugar-free wherever possible, should be encouraged.

Uniform dietary messages that go beyond oral health education should be promoted by the dental team as this would provide an opportunity to mention links to general health (e.g. obesity, diabetes, etc.) thus contributing to a consistent and holistic public health approach.³⁶

Tobacco

The BDA supports initiatives on smoking cessation including tobacco education programmes and the ban on tobacco advertising and promotion. More education programmes are needed to further reduce smoking rates amongst groups with high smoking prevalence, as part of a targeted campaign with multi-agency collaboration.

Some might argue that it is up to the individual whether they choose to smoke. This really depends on a number of factors including the individual's awareness and understanding of the risks of tobacco use. A study published by the British Medical Journal in 2006³⁷ concluded that lower socioeconomic status was associated with lower awareness of the harms of smoking and greater misunderstanding around nicotine. Of the four countries, the United States, Canada, the United Kingdom and Australia, awareness of the harms of smoking was lowest in the UK (highest in Canada). There is a genuine need to improve knowledge of the dangers of smoking among the disadvantaged segments of the population.

Younger people might not be able to comprehend fully the risks associated with tobacco use, especially when they first take up the habit. The British Dental Health Foundation National Dental Survey 2007 found that one in four people have never

³⁶ Department of Health and the British Association for the Study of Community Dentistry, *Delivering Better Oral Health: An evidence-based toolkit for prevention*, 2007

³⁷ M. Siahpush, A. McNeill, D Hammond, G.T. Fong (2006) Socioeconomic and country variations in knowledge of health risks of tobacco smoking and toxic constituents of smoke: results from the 2002 International Tobacco Control (ITC) Four Country Survey. *Tobacco Control*, **15**, supplement 3-

even heard of mouth cancer. One can assume that those that had not heard of it would not know that tobacco is a major factor in 90 per cent of cases, or that survival rates for mouth cancer are only 50 per cent. An individual should be allowed to make a choice based on an understanding of all the risks associated with that behaviour. One way in which inequalities here may be addressed is through a coordinated strategy across all local NHS services to ensure that patients who smoke are referred to NHS Stop Smoking Services. In addition, there should be accreditation in smoking cessation/prevention counselling and an extension of nicotine replacement therapy (NRT) prescribing to a wider range of healthcare professionals.

Awareness of the dangers of smokeless tobacco use should also be raised; campaigns should be targeted to relevant sections of society. The prevalence of oral cancer is particularly high among the South Asian community, correlating with use of smokeless tobacco, though survival rates of these patients reportedly compare favourably with those of oral cancer sufferers in other sections of British society.³⁸ Although smokeless tobacco products undoubtedly contain carcinogens, further research is required to clarify their contribution to ethnic variation in oral cancer rates as distinct from the influence of diet and genetic predisposition.

Dentists and the dental team are ideally positioned to offer advice to patients about a range of topics including tobacco cessation. The BDA supports *Smokefree and Smiling*, smoking cessation guidance for primary care dental teams.³⁹ Improving the referral rate to smoking cessation programmes is an important first step. However, it is essential that funding and remuneration systems are appropriate to ensure that this preventive approach can be adopted.

Alcohol

Along with tobacco, alcohol is one of the main risk factors for oral cancer. Activities that control alcohol consumption therefore have the potential to have a positive impact on combating inequalities in oral health. Again, if appropriately resourced, dentists and dental team members are well placed to offer preventative interventions in respect of alcohol consumption.

Conclusion

In sum, the BDA is committed to promoting initiatives and actions aimed at reducing oral health inequalities, which are still found across the UK. These actions require collaborative strategic input from all health and social care professionals. Improving oral health should be part of the government's wider public health strategy in all four UK countries also because many of the key factors that lead to poor oral health are risk factors for other diseases. Diet and nutrition, oral hygiene, fluoride exposure, tobacco and alcohol are all potential causes of poor oral health.

Dentists and the dental team are ideally placed to provide prevention and promotion messages to patients, such as smoking cessation advice, healthy eating advice or advice on sensible alcohol use. However, it is essential that funding and

³⁸ See: www.library.nhs.uk/ETHNICITY/ViewResource.aspx?resID=295300 (accessed May 2009)

³⁹ *Smokefree and Smiling: Helping dental patients to quit tobacco*, The Department of Health, 25 May 2007

remuneration systems recognise the resources needed for such a preventive approach to be adopted. Government policy should emphasise the prevention of disease and promotion of oral health to help reduce inequalities. In order for this approach to work best, dentistry should be more integrated with health services so as to provide patients with comprehensive and holistic care. Commissioners of services need appropriate dental public health advice to ensure support of strategies which address health inequalities and ensure that oral health is included in the wider agenda. In addition, the focus should be on the most vulnerable groups in society, such as children and adults with disabilities.