Child dental health and the cost-of-living crisis

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With the current, somewhat difficult to comprehend, obsession of abbreviating everything possible, cost-of-living comes out as COL. For mountaineers, a col is defined as the lowest point of a ridge or saddle between two peaks. In meteorology it is a region of slightly elevated pressure between two anticyclones. For children caught up in the current COL crisis it must seem like a nightmare combination of these entities, being surrounded by bleak high mountains in the pouring rain with an empty stomach and aching teeth.

In researching this cover story I went first to find a *BDJ* editorial I remembered writing some time back entitled 'Suffer the little children'.[1] Because time passes so quickly I was surprised to find that it was published in April 2011. But my surprise turned to horror and I have to say anger and disappointment when noting what has changed in the intervening 12 years. Nothing. The points that I raised remain unchallenged by anyone outside dentistry, the questions I asked rest on the page undisturbed and unanswered and the action I commended has not happened. Nothing. Oh, actually, something. Lots and lots and lots of fine words; all of which, frankly, are empty.

Extractions under GA

The government agency The Office for Health Improvement and Disparities has just published the general anaesthetic (GA) data for 'tooth extractions episodes' (which I take to mean children since no clarification is given) for 0–9 year olds, for 2021–22, with a comparison of the previous annual figures.[2] Table 1 in the report usefully lists the number of 'caries extraction episodes' from 2012 to 2022 which cumulatively amounts to over 350,000 young people who have had GA extractions since that editorial was published. Some of them will now be in their late teens to late twenties and will harbour the psychological scars for the rest of their lives, probably with harm also to their relationship with dental professionals, oral health and prevention. Horrific on a human level and eye-watering that in just the 2021–2022 period reported, the costs to the NHS of hospital tooth extractions in these 0 to 19 year olds was estimated to be £81 million

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for all tooth extractions and £51 million for decay-related extractions.[2]

The COVID-19 pandemic has caused bumps in the analytic road in many walks of life and this area is no exception as the latest figures are lower than pre-COVID tooth extraction rates. However, this is almost certainly an indicator that secondary care dentistry is still recovering following the pandemic with a consequent underestimate of the true level of demand. Consequently, the BDA warns that the new data understate the level of demand, given huge backlogs and only partial recovery of elective services. While numbers remain well below pre-COVID levels for now, tooth decay remains the most common reason for hospital admissions in children aged between six and ten years.

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Further, rates for children and young people living in the most deprived communities are nearly 3.5 times that of those living in the most affluent. Indeed, the dip in extractions during the lockdown periods can only be masking a pent-up backlog of carious teeth yet to reach the gas canisters and forceps. An uphill march from the col to the mountain top would have seemed certain in the coming years anyway but the additional burden of the cost-of-living crisis will only pour more oil on the pile of smoking kindling. This is especially so since we know, and have known for decades, if not centuries, that inequality makes worse these conditions and that inequality thrives in poorer circumstances.

In response to the latest figures, BDA Chair Eddie Crouch commented: 'Tooth decay is still going unchallenged as the number one reason for hospital admissions among young children.

'Decay and deprivation are going hand in hand, and this inequality is set to widen. None of this is inevitable. This government

needs to be willing to take off the gloves when it comes to fighting a wholly preventable disease.'

Echoing these comments, Matthew Garrett, Dean of the Faculty of Dental Surgery said, 'Although we welcome the recovery of services after the pandemic and congratulate the community for their hard work, it is still shameful that preventable tooth decay is causing children to go to hospital and go under general anaesthetic. Tooth decay is consistently the main reason children are admitted to hospital and is a clear indicator of health inequalities.'

The government's own figures reveal the chasm between regions and social circumstances, showing that extraction episode rates per 100,000 population vary from 378 in Yorkshire and The Humber through 205 for England as a whole to 71 in the East Midlands.

Preventive measures

A new survey of secondary school teachers undertaken by grassroots hygiene poverty charity Beauty Banks in partnership with the BDA shows that the COL crisis is also having an impact on the oral health of children in classrooms across Britain.[3] The research revealed that most teachers are now stepping in to provide pupils with the basics with four in five (83%) reporting that they or their school have given students toothbrushes and toothpaste:

- 81% said there are children in their school who don't have regular access to toothpaste
- 40% said this leads to students being socially excluded by their peers because of oral hygiene issues
- 50% report children isolating themselves
- 33% have witnessed bullying directly
- 25% say children miss school because of poor oral hygiene.

In terms of oral conditions, three quarters (74%) of the teachers surveyed said children who don't have regular access to oral health products have discoloured teeth, while half said children had noticeable tooth decay. Thirty percent noted children in dental pain or suffering from halitosis and nearly a third (31%) of teachers who witness poverty in the classroom reported that it affected their mental health. One in four are kept awake at night worrying about their students' wellbeing.

The awareness of these depressing findings is being felt beyond the dental world. Earlier this year the Royal College of Paediatrics and Child Health described toothbrushes as becoming a 'luxury item' for some families, and that the state of children's dental health is a 'national disgrace'. The charity Beauty Banks, established in January 2018, supports individuals and families in the UK who can't afford to stay clean. One of its co-founders Jo Jones said: 'We work with charities including food banks, family centres, domestic abuse centres, homeless shelters. Universally, across the board toothpaste is now our most requested item. Before the cost-of-living-crisis, it wasn't even in the top three.'

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Unsurprisingly, this oral hygiene crisis creates a more challenging working environment for teachers. Another of Beauty Banks' co-founders Sali Hughes said: 'Our teaching workforce spends a significant amount of time dealing with the impact of poverty on pupils, that they want to spend on educating their classes. Hygiene poverty causes not only social exclusion in children but educational exclusion, too.'

Public health programmes

In Scotland and Wales, prior to the pandemic, the Childsmile[4] and Designed to Smile[5] national programmes were working systematically to reduce oral health inequalities. In England, by contrast, local authorities have been responsible since 2013 for public health in their areas while national initiatives, such as Starting Well, Smile4life, and the Child Oral Health Improvement Programme Board, were set up to galvanise oral health improvements in selected areas or ways. What seemed to be missing in England was a well-framed and targeted scheme, with national leadership.

However as Caroline Holland recently reported, 'now NHS England has acted to initiate just such a programme. CORE20PLUS5 (Core 20 plus 5), has been established to tackle inequalities, ensuring the 20% most deprived and vulnerable get additional support in five clinical areas; importantly, the children's scheme includes oral health as one of the five clinical areas chosen for accelerated improvement.'[6]

An administrative overhaul last year saw the launch of Integrated Care Boards (ICBs) in 42 areas of England;[7] ICBs, working in partnership with local authorities (Integrated Care Partnerships), are responsible for implementation of CORE20PLUS5. Collaboration is at the heart of the new approach. Dr Urshla Devalia, a consultant in paediatric dentistry and a media spokesperson for the British Society of Paediatric Dentistry (BSPD), said: 'This is a very clear statement from NHS England that children's oral health is a priority.'

CORE20PLUS[5] is expected to lead to an increased focus on children's oral health. The programme includes suggestions for ways in which ICBs and Integrated Care Partnerships can achieve oral health improvements. Dr Devalia added that another aim will be to find high-risk children and build an oral health offering around them, groups such as autistic children and young people, those with learning disabilities, looked-after children or children from asylum-seeking families. 'We need to identify vulnerable or high-risk children and ensure that enhanced prevention is available to them.'

She is also working with the Eastman Dental Hospital Education Centre (EDHEC) as clinical lead for a national programme of Child Focused Dental Practices (CFDP). They are being piloted across three regions: the South West, with seven practices, North West and North Central London with ten practices, and the East of England with five practices based in Norfolk and the Waveney area. CFDP have already worked successfully in Greater Manchester. The pilot scheme there was launched through a partnership between the Managed Clinical Network for Paediatric Dentistry, regional commissioners and the Local Dental Network.

The theory was that if dental practices received increased support and funding

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to deliver care for higher needs children, onward referrals to already stretched specialist services could be minimised. An evaluation demonstrated that the approach worked – two thirds of the total number of children who might otherwise be referred to hospital were treated in the child friendly practices.

As Matthew Garrett points out though, 'With the government dropping the Health Disparities White Paper, we urgently need a prevention strategy that prioritises children's oral health ... by implementing a coherent prevention strategy that includes supervised toothbrushing schemes, and using the upcoming budget to recommit to childhood obesity policies that reduce sugar consumption, millions could be diverted to improve access to dentistry.'

This touches on a further sore point, the lack of application of the revenues the government has received through the sugar tax being channelled in any way towards child dental health or prevention.

Then again there is the matter of community water fluoridation. The government has declared that it is committed to implement this but I draw attention once again to my editorial in 2011: 'We know, for example, that fluoridation of the water supply brings significant anti-caries benefits but we don't implement it. It is evidence-based. But we don't implement it. Instead we variously nod sagely at loose talk about mass-medication and acquiesce to the far less contentious but as yet evidence-baseless argument for improved oral health and dietary education for people whose children continue to "eat sweets"'.[1]

The good citizens of Birmingham and their children have been enjoying the benefits of fluoridated water since 1964. Sigh.

Access to care

There is a very real concern that whatever gains might have been made pre-pandemic they are set to have either already been undone or are threatened further decline by ongoing access problems in primary care. BDA's Eddie Crouch expressed the Association's worries thus: 'Our youngest patients face a perfect storm, with millions unable to access care, or even the basics to maintain good oral health underlining that deep health inequalities are set to widen. Yet while our children face an epidemic of decay, the government seems asleep at the wheel.'

The latest NHS dental statistics indicate that just 44.8% of children attended a dentist appointment in the last year, down from 58.7% in 2019/20, a net result of pandemic disruption. As readers here are aware, while NHS dentistry is free for children and some adults, often based on their benefit status, many on modest incomes have to pay. The irony is that dental charges were first introduced to discourage attendance, and nearly one in five adult patients have delayed treatment for cost reasons, according to the last Adult Dental Health Survey. The BDA is now deeply concerned that current economic conditions and access problems will inevitably see more patients both adults and children deferring treatment.

> 'Reducing the inequality of childhood caries is every politician and every parent and every adult's responsibility.'

The BBC reported in August that 91% of dental practices in England were unable to take on new adult NHS patients, with 79% unable to take on new child patients further supporting the BDA's deep concerns that ongoing and severe access problems, together with disruption to public health programmes and lockdown diets will widen these deep oral health inequalities. Nearly 50 million NHS dental appointments have been lost in England since lockdown, with dentists now reporting typical patients presenting with higher levels of need.

The Health and Social Care Committee is set to begin receiving oral evidence next month on the crisis in NHS dentistry in England. The BDA has accused government of failing to deliver needed reform and investment. This parlous state has not been helped by the recent revelation that over 10% of the service's already inadequate £3 billion budget is set to be handed back, as struggling practices are unable to hit government targets owing to widespread recruitment problems.

There are also concerns in the secondary care sector as pointed out in a 2020 research paper in the *BDJ*.[8] The results reported that by 2030 approximately 40% (n = 92) of currently registered specialists in paediatric dentistry and 37% (n = 487) of specialists in orthodontics will be aged 60 years or over. Forty-four percent (n = 54) of 124 UK postal areas had no specialist in paediatric dentistry while 2% (n = 3) had no specialist in orthodontics. The author concluded that 'such demographic profiling is likely to be of interest for those responsible for specialist workforce planning and funding NHS specialist dental care for children'. How much notice has been taken remains to be seen.

Inflation, reports, good intentions, funding schemes, fine words, plans that come and go; however much the blame is shifted or divided some hard truths remain. The dental profession has done everything it possibly can, and continues to do everything it possibly can, to eliminate the oral pain that children experience but reducing the inequality of childhood caries is also every politician and every parent and every adult's responsibility. Suffer the little children no more please. ◆

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