Some are more equal than others

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'Oral diseases are preventable, and ... social inequity in oral health is avoidable'. So states the World Health Organisation's recent report *Equity, social determinants and health programmes*. Disease vulnerability and oral health outcomes are strongly linked to education, environment, psycho-social factors and behavioural contributors – tobacco use, alcohol consumption and poor nutrition – all of which show pronounced socio-economic gradients.

Worldwide, oral ill-health accounts for an alarming rate of morbidity, absence from work or school and poor quality of life. The UK has seen major improvements in oral health and today's young people no longer face a one in three chance of becoming edentulous by middle age, as their predecessors did in 1978.^{1,2} But this encouraging overall trend masks a growing disparity in our nation between those with the best and worst oral health.

Our NHS system means that we should all be able to access dental care and with readily available oral hygiene products whatever our background or home town, we should all have a healthy mouth. In reality though, the poorest populations in the UK suffer the highest levels of oral disease. Thirty-two percent of three-year-old children in deprived areas of Glasgow have caries experience, compared with an average of 25% across the city.³ And there is a seven-fold difference in dental health between five-year-olds in the best and worst PCTs in England.⁴

The BDA's paper *Oral health inequalities*⁵ condemns this chasm in standards of oral health in the UK. It calls for improved integration of oral care into general health programmes, a common risk factor approach between oral and systemic diseases, greater support for dental public health initiatives and an increased emphasis on preventive measures. Vulnerable groups suffering the greatest inequalities – those with disabilities, older people, children and the prison population – are at the heart of the paper's recommendations. In February the All Party Parliamentary Group for Dentistry, with the BDA as its elected secretariat, focused on delivery of oral care to prisoners and care home residents. Members of parliament and peers heard about challenges faced by the dental team in these settings, and about models of good practice such as the Residential Oral Care Scheme in Sheffield.

The BDA continues to take these messages to politicians as it strives to improve the working lives of practitioners and thereby benefit patients. As we enter the season of political party conferences, the BDA will be co-hosting fringe events on the theme, *Unheard voices: are oral health services failing the most vulnerable?* Three ongoing BDA projects will be highlighted

that address issues raised in the oral health inequalities paper.

Firstly, the BDA is calling for healthcare commissioners to understand the needs of prisoners and those who provide oral care for them, and to supply the special training and ensure the contractual flexibility required in this environment. A BDA survey this summer highlighted the struggle prison dentists face in meeting soaring levels of dental need while juggling UDA targets, decontamination guidelines and challenging conditions created by prison security and facilities.

In a second project, the BDA is updating its 2003 paper on oral care for older people.⁶ A series of modules will address different sectors of this age group, including those with dementia, the 'heavy metal' generation and the edentulous. Patients in domiciliary care, the subject of the first module, suffer higher levels of untreated dental disease than their free-living peers. The BDA's work will consider how best to meet these needs within the changing commissioning landscape.

Thirdly, the BDA is asking how we can encourage people to seek dental care when there is both need and availability but a lack of willingness to do so. Focus groups of residents in one of London's most deprived areas considered this question, in a collaborative project with the local PCT and a medical/dental public health expert. Barriers identified include misconceptions about the availability of local NHS services and traumatic memories of childhood dentistry experiences. Next, a social marketing-based intervention will address these stumbling blocks sensitively, to alter perceptions of the service among the target population.

At this time of unparalleled stringency in public finances, a striking emphasis is being placed on equity as a guiding principle. Dentistry minister Earl Howe pledged on 26 July to tackle inequalities faced by prisoners and older people. The new government's healthcare White Paper, *Equity and excellence: liberating the NHS*, must not draw back from the opportunity for innovation to achieve greater equity in oral health.

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