FGDP (UK)
The Faculty of General Dental Practice (UK)
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Health Select Committee Evidence Session

Children's Oral Health

Submission from the Faculty of General Dental Practice (UK)

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Executive summary

1. We believe that the considerable variation in the levels of oral diseases in children within the UK is unacceptable, particularly as in the majority the diseases are preventable and can be addressed through improvements in current oral health policy.

2. Disease levels are strongly correlated to socio-economic circumstances: those with the worst levels of oral health are to be found in the poorer socio-economic circumstances.

3. The FGDP(UK) wishes to distinguish between the determinants of disease, that in the majority lie outside of the current health care delivery system, and the delivery of care itself. For the former, alterations in welfare policies could have a major impact on reducing disease inequalities; for the latter, it is our view that an improved contractual agreement between the State and the dental profession will help reduce the impact of disease.

4. We would support the mantra of 'making the healthier choices the easier choices' for both patients and the dental profession. It is essential that the importance of continuity of care for children and their parents is recognised and reflected in the design of improved care delivery systems, and that there is the necessary collaborative working across the health and social care sectors to facilitate this change,

5. The FGDP(UK) would argue that the design of the system needs to encourage good standards of care for all children, and allow dental professionals to play an active role at both the patient and population level.

6. We would also highlight the importance of cross-generational effects. A major factor in attendance patterns of children is that of their parents' attendance patterns, which in themselves are influenced by their dental experiences. While the remit before the Committee is on children's oral health, it will require a broader view across all age groups in working to bring about oral health improvements in children.

1.0 Introduction

1.1 The FGDP(UK) believes that the dental profession can make a major contribution towards addressing the current inequalities that are evident in children's oral health across the UK. However, the constraints of the current care delivery arrangements place significant limitations on the profession in achieving these improvements.

1.2 More emphasis is also needed on the value of oral health promotion and education programmes, as well as support and training of dental team professionals to deliver such programmes. This will require a multi-agency approach that takes a holistic view of general health and wellbeing, as well as social factors.

2.0 Comments

2.1 The inequalities in children's oral health are consistent with findings of numerous epidemiology surveys at both local and national levels, which in turn reflect similar trends in the inequalities in levels of tooth decay, oral hygiene and malocclusions. These include:

- The decennial national children's oral health surveys that have been carried out since 1973
- British Association for the Study of Community Dentistry (BASCD) 5 year old biennial surveys carried out from 1995 to 1999
- One-off Public Health England/BASCD surveys of 3-, 5-, 12- and 14-year olds.

2.2 What is also apparent from the data is the relationship between socio-economic circumstances and levels of disease. Children in poverty have worse oral health on all counts: those in poorer socio-economic environments have higher levels of tooth decay, periodontal disease and poor malocclusion than their counterparts in the higher socio-economic environments. The FGDP(UK) would argue that not only is this unacceptable in health terms, not least as the vast majority of the aforementioned conditions are preventable, but the impact of poor oral health on children will be felt throughout their lives. Pain and suffering due to tooth decay in children can impact on a child's education, reducing their future career opportunities, and the stigma of malocclusions can impact on their relationships.

2.3 The FGDP(UK) would wish to distinguish between the determinants of disease (namely factors such as the social and economic environment, the physical environment, and the person's individual characteristics and behaviours) and the care management of the population (namely the delivery system). We would argue that the context of people's lives determine their health, and so blaming individuals for having poor health or crediting them for good health is inappropriate. Individuals are unlikely to be able to directly control many of the determinants of health.

2.4 A multi-agency approach is needed to address the multi-factorial basis of oral health, which includes:

- Education
- Diet
- Access
- Social groups
- Cultural factors, values and beliefs
- Advertising
- Peer pressure

- Determinants of health, and
- Behaviour change communication strategies.

2.5 We would argue that the design of the care system plays an important role in helping alleviate the problems arising from poor oral health, and the dental professions can play a major role in contributing to addressing those factors that influence the impact of poorer oral health. For example, children who do not attend for dental care will suffer from more pain, time off school and increased barriers to subsequent care when compared to those who attend on an appropriate regular basis allowing the management of the early stages of disease.

2.6 However, the system needs to recognize that this role is not confined to the dental profession working in surgeries, but acting as health promoting advocates working with other societal groups, for example schools or parenting classes, to promote an understanding of how potential oral health problems can be managed. Indeed, the major causes of poor oral health share commonalities with many other childhood health problems, for example obesity and Type II diabetes. If the potential role of the dental profession is to be maximized, the FGDP(UK) would argue that there needs to be adoption of a common risk approach and that all health, and indeed welfare, professions need to work collaboratively to help ensure a supportive environment exists to help parents make the 'healthier choices the easier choices'.

2.7 The ongoing programme of dental contract reform is key in facilitating improvements in children's oral health by the dental profession. The data reported by the Department of Health in their report 'NHS Dental Contract Pilots – Learning after first two years of piloting' (version 4.0, published February 2014) is largely positive in this regard, for example of the children identified as being at the highest risk of oral disease, only 36% remained in this group at the end of the pilot period. However, the FGDP(UK) has concerns on the report, including selective use of data. Furthermore, patient numbers fell significantly in almost all of the pilot practices and 'actual' versus 'desired' recall intervals for children show marked discrepancies (page 23).

2.8 The FGDP(UK) would also like to highlight the importance of parental attitudes towards dental care in influencing those of their children, as was noted by Badhri et al (2014), when reporting on children's dental attendance patterns including parents' education, socioeconomic status, behavioural beliefs, perceived power, and subjective norms. At the care provider level, the authors identified communication and professional skills. At the system level, the authors identified collaborations between communities and health care professionals, as well as a formal policy of referring patients from family physicians and paediatricians to dentists. We would fully support these findings.

2.9 The FGDP(UK) would wish to draw to the attention of the Health Committee, the variation that exists in the way that services are accessed within the population. Children from deprived backgrounds are not only more likely to have higher levels of clinical disease, but access dental services less than their counterparts from the higher social economic groups. We would argue that this is for a number of reasons, not least parental attitudes towards dental care. As has been highlighted by Sage and Olak (2014), parents' behaviour can impact their children's oral health habits. Behaviours include: dietary aspects, daily consumption of sugary drinks, especially during the night, and frequent snacking. Dental fear is also one of the important factors influencing the dental health of children; the relationship between dental anxiety and poor oral health is exacerbated by poor oral health habits

and irregular dental visits. Maternal dental anxiety is strongly correlated with children's anxiety, and mothers' dental fear manifests as poor dental health and poor oral hygiene in relation to both themselves and their children.

2.10 The FGDP(UK) would also wish to highlight the comments by Mouradian et al (2000). They state: "Childhood oral disease has significant medical and financial consequences that may not be appreciated because of the separation of medicine and dentistry. The infectious nature of dental caries, its early onset, and the potential of early interventions require an emphasis on preventive oral care in primary paediatric care to complement existing dental services.".

2.11 The exists are common concern around the exposure of infants to persistent and high levels of sugar through fruit juices or sugary drinks in bottles and no-spill trainer cups. The National Oral Health Promotion Group's position paper on this issue, published in December 2011, highlights the need to work with infant health professionals and parents to encourage the use of unlidded or free flow cups and, importantly, and to promote the use of water and milk over high sugar drinks (including fruit juices). The FGDP(UK) would fully support this as being necessary to reduce the risks of oral disease in children and to help to establish healthy behaviours from an early age.

3.0 Recommendations for action by Government

3.1 We would wish to see Government make note of the findings of Lee and Divaris (2014) who commented: "Because oral health disparities emanate from the unequal distribution of social, political, economic, and environmental resources, tangible progress is likely to be realized only by a global movement and concerted efforts by all stakeholders, including policymakers, the civil society, and academic, professional, and scientific bodies.".

3.2 We would wish to see Government develop a coherent food policy that has at its main aim a reduction in sugar consumption in line with World Health Organization's guidance. Sugars are the major cause of tooth decay and other childhood diseases, and such a policy would help reduce overall disease levels and the inequalities in their distribution.

3.3 We would recommend to Government that it must be a key priority to develop a contractual agreement between the State and the dental profession that supports tangible improvements in oral health. The dental contract should have at its core a set of incentives that encourage children, parents and the dental profession to work collaboratively together, alongside all health and social care workers, to provide a supportive environment to reduce the risks of oral disease and its impact on the individual.

3.4 From October 2015, commissioning responsibility for the healthy child programme for 0 to 5 year olds will transfer from the NHS to local Government, and local authorities will have a statutory responsibility to provide/commission oral health improvement programmes. We would seek assurances from the Government that the healthy child programme will receive the necessary support for it to take a holistic approach to child health, including oral health initiatives. Further, we would look to the Government to ensure that local authorities have the necessary flexibility in the commissioning of services in order to address regional inequalities in children's oral health.

References

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About the FGDP(UK)

The Faculty of General Dental Practice (UK) is based at The Royal College of Surgeons of England. We are the largest of the UK dental faculties and provide a national voice for over 4700 fellows and members.

Around 95% of dental care in the UK is provided in the primary dental care setting. The FGDP(UK) improves the standard of primary care dentistry delivered to patients through standard setting, postgraduate training and assessment, publications, policy development, and research. The FGDP(UK) offers continuing professional development and training opportunities for all registered dental professionals.

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