Oral health as a marker for poverty

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Although latest evidence demonstrates that there have been further improvements in adult oral health since 1998, which have been hailed by government, the same evidence identifies a serious underlying issue of social inequalities, and particularly the link between poverty and oral health **(Adult Dental Health Survey 2009. Theme 2: Disease and related disorders) (http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/adult-dental-health-survey-2009--summary-report-and-thematic-series)** .

The markers of an improvement in oral health over the past forty years are the increasing number of people retaining their teeth into old age, the falling proportion of people who are experiencing dental decay and its sequelae of pain and discomfort, and the limited experience that younger adults have of dental fillings. Increasingly two divergent groups in the population are being seen – the older 'heavy metal' generation, adults over the age of 45 who have had recurrent dental treatment, and a younger generation with limited experience of dental decay, but for whom the quest for a 'perfect smile' and cosmetic dental procedures is increasingly the goal, spurred on by a variety of TV and media articles.

This trend of improving oral health has also been shown in children and it is encouraging to see that for older children with permanent teeth, dental decay has reached an all time low **(Children's dental health in the United Kingdom 2003) (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4107310.pdf)** . It is hoped that further research will be commissioned in the next year or so to confirm these trends will continue.

The advent of improvements in oral health is attributed to an increased awareness of its importance and a better understanding of the causal link between dietary sugars, plaque bacteria and dental caries, as well as improved oral hygiene practices and the widespread use of fluoridated toothpaste for the last thirty years.

However, inequalities persist and the recent British Adult Dental Health Survey has shown that people from lower socio-economic households fare worse across a number of oral health indicators than their counterparts in higher socio-economic groups. They are more likely to have dental decay, fillings, poor gum health, pain and sepsis. Additionally they are less likely to visit the dentist and brush their teeth effectively. In fact, although the overall prevalence of decay has fallen, amongst those adults who have it, the levels of decay are disappointingly similar to eleven years previously.

That said, socio-economic background cannot be regarded as an individual risk factor for oral disease, but as part of a complex causal process which links factors related to where an individual was born, grew-up, lives and works alongside national factors such as distribution of money, power, and resources. A variety of theoretical models have been proposed to try and make sense of these inter-factorial relationships, but they are still not well-understood.

Globally, the World Health Organisation (WHO) is working through the Commission on Social Determinants of Health to tackle health inequalities and at a recent conference in Brazil, the International Association for Dental Research (IADR) launched a Global Oral Health Inequality Research Agenda (GOHIRA). This recognises the need for further research into the social determinants of oral health and aims to support the WHO goals by effecting a measurable reduction in oral health inequalities in a generation.

Professor Deborah White

School of Dentistry