Why is oral health important?
- Oral health has improved so much why do we need to do any more?
- Baby teeth don’t matter – they are lost and then the adult ones come in so why expend any effort on them?
- Decay can easily be treated with fillings

It is true that levels of dental decay are much lower than before we had fluoridated toothpaste but the overall figures mask a big problem in some areas where decay levels remain high. Dental decay can cause pain, infection, sleepless nights, poor concentration and exacerbation of other health problems.

Children with decay can have problems with their school attendance, behaviour and ability to eat.
Adults with gum disease may be at higher risk of cardiovascular disease and poorly controlled diabetes. They may also be prevented from attending work.

Pregnant women with gum disease are more likely to have a pre-term birth and/or a low-birth weight baby.

Adults and children with special needs may have their health problems exacerbated by dental pain or infection, for example increased frequency of epileptic attacks.

Baby teeth DO matter. A group of baby teeth start being shed at the age of six but others are not meant to be lost until about 6 years later. During childhood baby teeth hold the spaces open for adult teeth to grow into, so they are needed to reduce crowding. Decayed baby teeth can be painful and infection can make children very unwell. This leads to sleepless nights, missed time from school and a poor ability to learn. The treatment of decayed baby teeth can be very challenging and may often involve extractions. If multiple teeth need to be extracted or children are very young then admission to hospital may be the only option. This is traumatic for children and parents, has significant morbidity, leaves children with fewer teeth to chew with, often for 10 years or more, and is a costly use of NHS resources.

| 7% of adults in the North West have no teeth at all |
| Only 13% of adults in the North West have healthy gums |
| 30% of adults in the North West have untreated, decayed teeth |
| 11% of adults in the North West have dental pain at any point in time |
| 25% of adults in the North West have one or more urgent dental conditions |

| Five year olds in Greater Manchester have an average of 1.42 decayed baby teeth, compared with 0.88 in the rest of England |
| 5,544 children in Greater Manchester go to hospital for extraction of decayed teeth each year |
| More admissions to hospital are made for extraction of teeth than for any other childhood procedure |
Problems about oral health are caused by the lack of NHS dentists. Why don’t we just get more of them into the area?

**Dental decay and gum disease are caused by poor self-care, not by a lack of a treatment service.**

Decay is caused by having sugar too often in foods, sweets and drinks. If fluoride toothpaste is never or rarely used then natural repair to teeth following sugar attacks is limited. Adults and children who keep sugar to mealtimes, eat only sugar-free snacks, and who brush with adult fluoride toothpaste at least twice a day, every day, have far lower levels of decay than those who have sugar frequently and brush rarely.

Gum disease for the vast majority of people is caused by plaque which, if undisturbed, irritates the gum edge and causes inflammation. If this situation continues then irreversible gum disease sets in and becomes chronic, leading to loss of bony support and tooth loss. Gum disease can be prevented by effective removal of plaque every day. This requires careful toothbrushing and other aids.

These preventive behaviours are about individual self-care, none can be carried out by a dentist.

Most people will visit the dentist on about two days a year (0.5% of days) and the dental team can diagnose and treat disease and advise about home care. For all the rest of the time oral care is the responsibility of the individual or their parent or carer.

Local authorities now carry the responsibility of measuring and improving oral health in the population. They commission community and population level programmes to support families to improve their self care. Many of these programmes could be extended and intensified if the LA wishes to commission this.
It’s all down to the parents isn’t it? Why don’t we just educate them?

*It has been found that education alone is often insufficient to cause people to change to healthy habits. One only need think of reducing calorie intake, or increasing exercise for oneself to realise how difficult it can be to change an aspect of lifestyle. This is particularly so in more deprived households.*

Parents need to believe that they can have an influence over their child’s health and be willing to put in the effort to establish new habits. Research has shown that habits, healthy or detrimental to health, that are adopted in very early years are the ones that persist and the most difficult to change.

Many parents need help and support while trying to make changes to their child care routines and very few changes can be tackled at any one time. Only when parents perceive changes to be relevant and important to them are they likely to be able to muster and maintain the resources required to see the change through.

In some cases education and support need to be backed up by the provision of no- or low cost materials to families e.g. trainer cups to encourage discarding of a baby bottle, or toothpaste and brush to encourage commencement of twice daily supervised brushing.

Local authorities now carry the responsibility of measuring and improving oral health in the population. They commission community and population level programmes to support families to improve their self care. Many of these programmes could be extended and intensified if the LA wishes to commission this.

Social problems impact on the ability to adopt health advice – depression, unemployment, domestic violence, stresses of single parenthood…..
Why don’t we just fluoridate in the water?

Fluoridation of water supplies has been shown to be a safe and effective way of reducing decay levels in populations.

Fluoridation is not a stand-alone solution to all oral health problems and so should be considered as part of a wider strategy which includes a variety of approaches to tackle oral health and general health problems.

Local authorities now have powers to make proposals to implement new fluoridation schemes. Due to water supply arrangements most LAs would need to work in partnership with other LAs to establish a scheme. The introduction of fluoridated water follows a legislative process which can take some time. During this time efforts are still required to tackle poor oral health in the interim. Public Health England can give advice about this process to those who are interested in pursuing this option.

What can councillors / health and wellbeing boards / directors of public health / local authorities do about it?

Local authorities now carry the responsibility of measuring and improving oral health in the population. They commission community and population level programmes to support families to improve their self care. Many of these programmes could be extended and intensified if the LA wishes to commission this.

Councillors / health and wellbeing boards / directors of public health / can
- Establish a champion oral health to ensure someone has responsibility
- ensure that oral health is given higher priority and is made everyone’s business, not just that of the dental profession.
- They can ensure that oral health considerations are included in other council policies such as those relating to food in schools, nurseries and children’s centres. They can influence a variety of settings such as leisure centres to ensure that their vending machines provide an easy choice of lower cost sugar free options in foods and drinks.
- They can help to ensure that all in the health, education and social care workforce know, understand, can apply and communicate the key oral health messages. This requires training by specifically skilled, experienced and knowledgeable trainers.
- They can establish or review the oral strategy and ensure it is fit for purpose for the local health needs.
- They can then actively engage in the commissioning process, either directly or in partnership with NHSE, to ensure the required actions and programmes take place.
- PHE can assist with all of these steps
My constituents want to have a dentist near to them, why aren’t there more dentists?

**General dental practices are businesses so need to be viable to survive. There simply would not be enough demand if there was a dental practice on every street corner. This isn’t the case for doctor’s surgeries, or pharmacies, or even post offices.**

Dental practices usually set up on main roads or other sites where large numbers of people pass by. Owners look for good transport links so that their businesses become successful and the return on their considerable investment is more likely.

Recently there have been changes to the requirements for dental practice which are more difficult for single handed practices to adopt and there has been encouragement for such smaller practices to merge together. This helps clinical teams to provide better care, so having lots of small practices would run contrary to this.

Where patients maintain their own good oral health by having healthy habits their need to attend the dentist is much reduced. Among those with stable oral health they may only need to attend for a check-up once a year or even two years and this reduces the requirement for frequent travel to practices.