Report and Agenda Item for ERO Working Group OH/GH

As I have heard nothing to the contrary, the previous white paper submitted to the group has formed the basis of our further discussions to develop our approach.

Because Universal Health Coverage based on oral health improvement and prevention of oral disease also yields an improvement in general health and wellbeing, I consider that is where we should continue to focus our efforts.

It has been recommended by the ERO Board that we focus on “quick and easy wins”. This has its challenges, for as we know, despite its simple concept, a significant amount of the responsibility for implementation of a comprehensive prevention strategy rests with national governments, which, somewhat perplexingly, seems neither quick nor easy for them. However, dental teams know what works and are effective in delivering, so we must continue to demand governments’ attention and lobby for a much greater focus and investment in oral health.

I note Vojtěch’s Perina’s desire to focus on highlighting the impact of poor oral health on general health and the emerging evidence for a direct correlation. The dental team could, with further training, contribute significantly to the diagnosis and even treatment of undiagnosed hypertension, diabetes, heart disease, dementia etc but this I feel is not where we should focus our efforts at the moment. It may come further down the line, and it should be highlighted as a reason for our main demand. The development of a detailed proposal for dental teams to get involved more in general health care can be developed by the group at a later date but this will be complex, inter-professionally sensitive, and potentially expensive. In addition, the sharing and access to medical records is not there yet and nor is the professional capacity if we stimulate patient demand for these services. I accept there may be a counter argument that if the profession demonstrate a value, then the investment will follow. Im happy to discuss this further

The group has met and exchanged emails since the ERO meeting in Cyprus and I am grateful to the group for all their contributions. I am also grateful to Monika Lang for her excellent minutes and organisation of meetings and to Elaine Boylan and Ulrike Matthesius at the BDA for their assistance in drafting my thoughts.

Some members have found it difficult to attend meetings and I can only encourage them to do so or to contribute by email.

Recently the group has focused on what might be ‘quick and easy” wins as well as examples that already work in certain countries. The main points from our exchanges are bulleted below.

- Fluoridation of water or other widely consumed nutrients and regular application of topical fluoride reduces dental decay levels, fissure sealants prevent dental caries.
- Sugar tax/levy has ben shown to reduce sugar in foods, overall consumption and raises revenue. Dietary free sugars are a direct cause of caries (as well as obesity)

- Early intervention and schools-based programmes, supervised brushing in schools improves oral health and reduces disease levels
- Raising the importance of oral health with the education of other healthcare and social care professionals improves outcomes
- Better access to oral health services and oral health products improves oral health. This includes better distribution of oral health services and lower cost or even free services and tooth care products to low-income families
- Remove VAT on tooth care products
- Wider public health education and information is essential
- The health, wellbeing and financial return on any investment in oral healthcare are potentially enormous and therefore politically beneficial
- Working with other agencies and lobbying groups to ensure that our messages are consistent and reach the widest possible audience and have the greatest impact eg WHO, NCDA, NMAs, Nutritional Groups, Patient Representatives
- E Health. The development of wider record sharing with other health and social care professions is essential for effective prevention across a population.

As has been stated previously dental teams are highly effective in providing prevention for the patients under our regular care but that equates to only 50% of the population in some countries. Achieving Universal Health Coverage (UHC) is a huge challenge. Most of the above points are achievable and if implemented would have significant impact on the entire population.

For many reasons, some external and some internal, there is a shortage of a workforce to deliver UHC. We need to decide if we are committed as a profession, to expanding the workforce.

A prevention strategy requires a dentist to design and oversee a prevention strategy. It does not require a dentist to deliver it to individuals but of course they may do so. The entire dental team, appropriately trained, is ideal to deliver prevention messages, techniques and treatment to any given population. Indeed, they can train and supervise other health and social care professions in prevention eg, general medical personnel, health visitors, care home staff, social workers and educational professionals.

It is advocated that a basic oral healthcare module is a compulsory part of the educational /induction of these groups.
In the UK we employ Oral Health Educators, who are qualified dental nurses with additional qualifications who can work, unsupervised and directly with patients or small groups of patients on oral hygiene, diet and, on prescription, fluoride applications. They are very effective. They can be empowered to be peripatetic visiting hospitals, care homes, or schools. They can also advise patients to visit a dentist where there are signs of obvious significant oral disease. However, we don't have enough of them or resources to recruit, educate, and retain them.

WGOH suggest that one of our aims be: "increase the headcount, recognise and "standardise" the role across the EU regions and wider." Clearly that would require a collective will, and resources and that is what we should lobby for from our paymasters

and partners. Currently there is no training or delivery system in the world that is sufficiently well organised and remunerated to deliver this vital element of a prevention strategy.

Also, undoubtedly, members of the dental team (dentists, dental hygienists, dental technicians) could be increased in number and empowered and appropriately funded to deliver UHC. The level of education and supervision required is a matter for discussion but surely the concept is unarguable. We, the profession, need to agree the size and shape of the workforce we need to achieve our aim. It is both complex and challenging to our principles, but we are best placed to design it. If we avoid doing so, we risk the imposition of others' ideas.

Mick Armstrong