
**Burden of oral health inequalities**

Oral diseases, despite being largely preventable, remain a major global public health problem. Dental caries, periodontal diseases and oral cancers, the main oral diseases are highly prevalent chronic conditions that have a significant negative impact on quality of life. Globally over 3 billion people suffer from untreated dental caries, making this the most common disease of mankind. Oral diseases are expensive to treat, and the costs of dental treatment are considerable to both the individuals affected, and the wider health care system. In recent decades significant overall improvements have occurred in dental caries and periodontal diseases in many high and middle-income countries. In many low-income countries caries levels appear to be increasing linked to economic development and the associated lifestyle changes, including higher consumption of free sugars. A major concern however is the existence of stark social inequalities in oral health.

Oral diseases disproportionately affect socially disadvantaged members of society. Oral health inequalities are therefore considered as differences in levels of oral health that are avoidable, and deemed both unfair and unjust. Oral health inequalities are not merely the differences in oral health status between the rich and poor. As is the case in general health, a consistent stepwise relationship exists across the entire social spectrum with oral health being worse at each point as one descends along the social hierarchy. Known as the social gradient, this consistent relationship between oral health and social status has profound implications for policy. The social gradient in oral health is a universal phenomenon found at all points in the life course and in different populations groups across the world.

**Social determinants of oral health inequalities**

International research has consequently shown that health inequalities are caused by the broad conditions in which people are born, grow, live, work and age, the so-called social determinants. These underlying causes equally apply to oral health inequalities, as oral diseases share common determinants with other non-communicable conditions. Oral behaviours such as tooth brushing, sugars consumption and smoking are all socially patterned and play a role in oral health inequalities. However, these behaviours alone do not fully account for the differences in oral health status. Oral health inequalities are caused by the conditions of daily living, the political, social and physical environments of modern societies, which in turn dictate the choices and options open to individuals.
Limitations of current preventive paradigm

Across the globe the dental profession, governments and other stakeholders have largely adopted a biomedical approach to prevention, focusing their efforts on delivering clinical preventive measures such as fluoride and fissure sealants, and providing oral health advice to patients. This approach may produce positive outcomes in the short term for certain patients, but is ineffective in reducing oral health inequalities across the population. By focusing on the individual, this approach fails to address the underlying causes of oral diseases and is often ‘victim blaming’ in nature. It also tends to isolate the mouth from the rest of the body, compartmentalising rather than integrating preventive measures. The professionally led approach to prevention is also very costly to deliver and beyond the health budgets of many low- and middle-income countries. A radical shift in preventive approach is now needed. More of the same is no longer an option. Downstream individualistic interventions alone will not reduce oral health inequalities.

Call for local, national and international action

An urgent reappraisal is needed on future action to reduce oral health inequalities. A more fundamental upstream public health agenda is required to tackle the underlying social, economic and political causes of oral health inequalities. Based upon the Common Risk Factor Approach, integrated policies to prevent non-communicable diseases (NCDs) including oral diseases are needed. Building healthy public policies, creating supportive environments, strengthening community action, developing personal skills and reorienting oral health services all provide opportunities for oral health improvement. Action is needed at local, regional, national and international levels. Collaborative efforts between researchers, policy makers, public health practitioners, clinical teams and the public are urgently needed.

Moving the agenda forwards

The participants at this conference 1 pledge to:

- Acknowledge that oral diseases are largely preventable and that oral health inequalities are unfair, unjust and can be avoided through action on the underlying causes of oral health inequalities in society.

1 The International Centre for Oral Health Inequalities Research and Policy (ICOHIRP) was formed in 2013. Committed to tackling oral health inequalities both within and between countries, academics and policy makers from 15 countries have formed a global network to explore the nature of oral health inequalities and to inform policy recommendations. On the 21st May 2015 the ICOHIRP held its launch conference in London where over 240 people from 20 countries attended. The ICOHIRP also launched a monograph Social inequalities in oral health: from evidence to action and a new website www.icohirp.com at the London conference.
• Act as an advocate for oral health equity in their local communities highlighting the public health significance of oral diseases, and the need for public health policies, and in particular upstream actions to tackle oral health inequalities, both within and between countries.

• Lobby local and national decision makers and those in positions of authority and power to acknowledge the importance of oral diseases and their shared common risks with other NCDs, and to provide assistance in developing and implementing the actions needed to tackle oral health inequalities.

• Work in partnership with their communities to develop and implement local and sustainable solutions to promoting oral health and general health in an integrated fashion.

• Encourage and enable local, national and international dental professional organisations to recognise the importance of oral health inequalities and support actions to promote oral health equity.

• Promote and facilitate the reorientation of dental services towards the promotion of oral health and engagement in efforts to reduce oral health inequalities within local communities.

• Work in partnership with the IADR-Global Oral Health Inequalities Research Network (GOHIRN) and other stakeholders to ensure that research on oral health inequalities is given priority for funding and support so that the understanding of the causes of oral health inequalities, as well as the implementation of effective actions to promote oral health equity can be strengthened.

• Share any examples of good practice and their expertise and experience to support others in their efforts to promote oral health equity.

• Incorporate an oral health inequalities agenda within dental professionals undergraduate and postgraduate curricula.