Addressing Common Challenges in Europe: Pan European Working in Support of Oral Health

(Speaker profiles and abstracts)

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Helen Whelton is a Professor of Dental Public Health and Preventive Dentistry. She has been awarded the UCC Staff Recognition Award for Leadership in 2012; IADR Distinguished Scientist Award, San Diego, in 2011; IADR Oral Health Research Group Award, Barcelona, in 2010; European Organisation for Caries Research (ORCA) Zsolnay Prize in 2009; Presidents Award for Excellence in Teaching and Learning, UCC, in 2006; Presidents Award for Research in Innovative forms of Teaching and Learning, UCC, in 2006. Her research interests encompass the many ways to prevent oral disease and improve oral health with a particular focus on effective and efficient measures for use at the population level. She is thus interested in fluoride, clinical trials and guideline development. She also runs a structured PhD programme in clinical and translational research, spanning four Universities.

Oral Health and Fluoride Toothpaste Use in Europe

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The decline in dental caries levels in established market economies over the last 40 years is well documented; reductions in caries levels in emerging economies have been reported more recently. Much of this improvement in oral health has been attributed to the use of fluorides, with high quality systematic reviews supporting the benefits of fluoride toothpaste in preventing caries in children. Fluoride toothpaste is one of the main pillars of caries prevention worldwide and although there is global variation in advice regarding the timing and pattern of toothpaste use for young children, there is a general consensus that daily use of toothpaste with a fluoride concentration of 1,000ppm or greater is effective in disease prevention. A number of surveys and reports in recent years illustrate considerable country-level variation in dental caries levels and also in potential explanatory variables such as reported tooth brushing frequency, use of toothpaste, consumption of soft drinks and strength of the economy as measured by a standardised measure Purchasing Power Standards (PPS). An ecological study of the association between these variables and dental caries is useful in generating hypotheses about the relative importance of these variables for population oral health. Aim: This presentation will describe the variation in per capita consumption of fluoride toothpaste in EU countries and explore its association with reported frequency of tooth brushing and dental caries levels against a background of divergent economic prosperity. Variation in consumption of soft drinks and dental fluorosis levels will also be considered. Methods: Country level

data were taken from the Euromonitor, Eurobarometer, EuroStat, the WHO Health Behaviour and Lifestyles survey, the WHO global oral health database, the database of the European Chief Dental Officers, PubMed and Google Scholar. Multiple linear regression was used to model the impact of selected variables on mean DMFT at age 12 among 14 countries for which sufficient data were available.

Results: The significant explanatory variables were PPS (p=0.0248) and tooth brushing (p=0.0183). A 10-unit increase in PPS was associated with a 0.1 decrease in mean DMFT, adjusting for tooth brushing. A 10% increase in percentage of 13 year-olds brushing more than once per day was associated with a 0.2 decrease in mean DMFT, adjusting for PPS. Conclusion: Caries, economy and toothbrushing /use of toothpaste are associated. Of these, tooth brushing/use of toothpaste is the most easily modifiable.

Professor Richard G. Watt

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Professor of Dental Public Health
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Dr Richard Watt is Professor of Dental Public Health and Head of the Department of Epidemiology and Public Health at University College London. Dr Watt graduated in dentistry from the University of Edinburgh in 1984 and proceeded to study for an MSc and PhD in Dental Public Health at the University of London.

Dr Watt's research has focused on the social determinants of oral health inequalities and the development and evaluation of oral health promotion interventions. He was co-founder and Past President of the Oral Health Promotion Research Group and past President of the British Association for the Study of Community Dentistry. He currently sits on a variety of expert working groups for the Department of Health, National Institute for Clinical Excellence, WHO and E.U. He is co-author of *Essential Dental Public Health* and has published more than 150 publications. He is currently principal investigator on three research studies funded by NIDCR, Food Standards Agency and NIHR.

Professor Lone Schou

PhD (Cph) PhD (Edin) MPA

Director and Dental Dean, University of Copenhagen Denmark

After graduation from the Royal Dental College, Prof Schou gained her first PhD degree in Preventive Dentistry from University of Copenhagen. After local postgraduate training, teaching and practising dentistry in the public as well as the private sector in Denmark, she took up the post as Senior lecturer at the University of Edinburgh, UK. At the same time she held the position as the National Dental Advisor to the Health Education Board of Scotland.

During the 10 years in Scotland she developed and evaluated a number of national and local community health programmes as well as many strategy and policy reports. She educated and up-dated a number of different groups of health professionals and organised national and local conferences. She was responsible for media co-work and building up network to coordinate and promote health projects.

Also while in Edinburgh, Prof Schou obtained her second PhD in social and health policies and authored numerous scientific publications. Over the years she has become an international well known speaker and has given over a hundred presentations all over the world. As publishing director for 2 of the largest international medical and dental publishers Prof Schou was responsible for a large proportion of high impact scientific literature including selection of the international best scientific authors and editors.

Dr Poul Erik Petersen DDS, Dr Public Health Science (DrOdontSci), BA, MSc(Sociology)

Chief, Global Oral Health Programme, World Health Organisation Headquarters, Geneva

In 2002, Dr Petersen was appointed Chief of the Global Oral Health Programme at the World Health Organization Headquarters in Geneva, Switzerland. Prior to this date, Dr Petersen was Professor in Community Dentistry at the University of Copenhagen, Denmark. He has an academic background encompassing dentistry, public health and sociology, combined with broad international experience. Dr Petersen has worked in community oral health research, enhancement of public health in universities worldwide, health systems development as well as in planning and implementation of community health projects in an extensive number of industrialised countries, countries with economies in
transition and in developing countries.

Dr Petersen worked in the WHO Regional Office for Europe as an oral health consultant for several years, as a Director for the WHO Collaborating Centre for Community Oral Health Programmes and Research, and worked closely with numerous WHO Collaborating Centres in the field of oral health. He has assisted ministries of health, health authorities and health care planners throughout the world.

In addition to Denmark, Dr Petersen has studied in the USA and the UK. He was elected Dean of the School of Dentistry at the University of Copenhagen, and was also Vice-Director of the School of Public Health at the University of Copenhagen. He has an extensive list of scientific publications within epidemiology, health sociology, health systems research, disease prevention and health promotion, and international health.

Within WHO Headquarters, the Oral Health Programme is part of the Department of Chronic Diseases and Health Promotion, this emphasizes the links between oral health and general chronic disease prevention. Within the department, oral health links with several of its activities, such as integrated NCD prevention networks, health promotion, diet and nutrition, school health and healthy ageing. In addition, oral health links with other departments for HIV/AIDS prevention, water and sanitation, and healthy environments.

Tackling Social Inequalities in Oral Health through Primary Health Care: WHO Update

The gaps between and within countries, in health status, and access to care are greater than at any time in recent history. Improving the health of populations, in genuine and lasting ways, ultimately depends on understanding the causes of health inequities and addressing them. By showing how social factors directly shape health outcomes and explain inequities, health research challenges the conventional public health thinking and policies to tackle the leading causes of ill-health at their roots. Public health research has provided sound evidence that the true upstream drivers of health inequities reside in the social, economic and political environments. These environments are shaped by policies, which make them amenable to change.

In 2010, WHO published an important report on “Equity, Social Determinants and Public Health Programmes”. It takes the challenges to public health several steps forward, with the aim of translating knowledge into concrete, workable actions. These may also include mid-stream and downstream actions. The four main criteria in identifying these priority public health conditions were:

- They represent a large aggregate burden of disease.
- They display large disparities across and within populations.
- They disproportionately affect certain populations or groups within populations.
- They are emerging or epidemic prone.

The problem of oral disease matches these four main criteria of critical public health conditions. The social determinants of oral health are largely universal, affecting a range of oral health outcomes and the exposure to risk factors. Underprivileged people are particularly at a higher risk of oral disease. Even within the wealthier

European countries with advanced oral health systems, high levels of oral disease are observed among deprived people. Moreover, deprived people are less likely to visit a dentist if available and they often have unhealthy lifestyles, and poor knowledge and attitudes to oral health.

The good news is that tools are available for breaking poverty and to reduce if not eliminate social inequalities in health. Whether public health actions are initiated simply depends on the political will. The WHO World Health Report 2008 calls for the return of the holistic Primary Health Care (PHC) approach to address health inequities. Its cornerstones are universal coverage, people-centered health systems, public policy for health promotion, and leadership. Additionally, this approach was reiterated in 2009 at the World Health Assembly where Member States were requested to address social determinants to reduce health inequities within and across countries to "close the gap in a generation". The WHO Primary Health Care (PHC), as applied to oral health, strives towards the universal coverage in oral health care through the establishment of financially fair systems. Strengthening of oral health systems, delivery of oral health service and PHC must involve health promotion and disease prevention. Leadership, multi-disciplinary approaches and working for health across sectors are crucial principals.

Sue Gregory OBE

BDS, MSc, MCCDRCS, MFDSRCS, FFPH, FFGDP

Deputy Chief Dental Officer Department of Health (England)

Improving Oral Health in Europe: Dental Public Health Opportunities

DCDO since January 2009 and as part of her wide portfolio, including dental public health, is heavily involved in the development and implementation of pilots to test a care pathway and quality and outcomes approach as a basis for reform of dental contract in England. Prior to moving to DH she worked across Bedfordshire, Luton and Hertfordshire PCTs. where she had a long standing interest in the primary/secondary care interface and ensuring equity of service provision alongside reducing inequalities.

Sue chaired the joint DH/BASCD working group which developed "Delivering better oral health" and is a Past President of the British Association for the Study of Community Dentistry (2006/2007) and British Society for Disability and Oral Health (1992).

Professor Jimmy Steele CBE

BDS, MSc, MCCDRCS, MFDSRCS, FFPH, FFGDP

Professor of Restorative Dentistry and Dental Dean
University of Newcastle

Professor Steele is a qualified and practising dentist with an honorary contract as a Consultant in Restorative Dentistry with Newcastle Acute Hospitals Trust. He qualified with BDS (Dundee) in 1985 and after 4 years in NHS hospital dentistry, moved to Newcastle to take a Lecturer position. He completed a PhD in 1994, clinical specialist training in 1998 and then became a Senior Lecturer/Honorary Consultant in 2003.

Professor Steele's s role now is as Head of School, but still with significant clinical, teaching and research activity. His clinical and teaching activity is in the field of restorative dentistry. His research is mostly based around population oral health and oral health services, including oral health policy and economics. He also has a number of external roles, and led the "Review of NHS Dental Services in England" for the Government in 2009. He has subsequently worked with the Department of Health to pilot and consider implementation of the recommendations. Professor Steele is currently the National Oral and Dental Specialty lead for the National Institute for Health Research, and sits on two Fellowship panels for NIHR. Professor Steele is one of the senior members of the consortium which worked with the Office for National Statistics on the 1998 and 2009 Adult Dental Health Surveys, and the 2003 Children's Dental Health Survey.

Improving Oral Health in England: Piloting Dental Care - The English Experience

The oral health of children and adults has transformed over the last 4 decades. A system of care and dentist remuneration was established at the inception of the NHS to deal with a caries epidemic and a backlog of disease and sepsis. This is no longer appropriate for a population where many younger people have good oral health yet the risk of disease is still high for a large minority. Any system also has to cope with the legacy of high levels of historic disease in the form of maintenance and rehabilitation.

The Government are committed to introducing a new contract for primary care dentistry that will focus on improving oral health and increasing access to services. It is intended therefore to introduce a contract that both supports dentists to treat disease and provides a clear focus on prevention within an overall approach based on continuing care. The aim is to improve patients' oral health over the longer term rather than simply treating the immediate presenting disease.

This presentation will cover the background, development and implementation of the dental contract reform pilots currently underway in England. Early learning from the first year of piloting will be shared.

The intended new contract will have three key elements; registration, capitation and quality. However, underlying these elements is a complex structure and in adjusting any system there will be unintended consequences Piloting is intended to address this and pilots to test elements needed to design a new contract began in mid 2011. Piloting has now been running in 70 dental practices for the last 12 months.

It will take some time to be certain of the impact of the new arrangements on behaviours, costs and access but this first stage of piloting has allowed testing of the principles on which any new contract will be based including the patient pathway, a Dental Quality and Outcomes Framework (DQOF) and simulations of capitation.

The work is underpinned by a chairside clinical software system. In addition to collecting clinical data across the four clinical domains of caries, periodontal disease, non carious tooth surface loss and soft tissue, the software enables collection of consistent oral health assessment data covering medical and social variables. Matrices within the software then provide a risk assessment shown by red, amber and green ratings for each clinical domain. An individual self care plan is then produced for each patient, using the "traffic lights" and detailing what patients can do for themselves to improve their oral health.

Professor Steele's report on behalf of the evidence and learning group was published in October along with a report commissioned from a market research company on patient and practice staff perceptions of the piloting experience. These reports cover the early learning from the first year of the pilots and demonstrate that significant challenges remain. Data suggest that the new arrangements are just settling down after a transition period but the dental staff taking part in the pilots and the patients seen under the new arrangements have been overwhelmingly positive about the new approach to clinical care. The OHA, pathway and software are far from the finished product though. Further development is now needed to hone them and ensure they are efficient and deliverable but we think a pathway approach should form a key part of any future contract.

Associate Professor Egita Senakola

Riga Stradins University, Latvia

Egita Senakola graduated from the Riga Medicine Institute in 1979, and obtained her PhD degree in 1998. She is currently an Associate Professor in the Department of Conservative Dentistry, Riga Stradins University, Latvia. She has also acted as the Director of the Dental Hygienist Academic School since 1995. She has been involved in the undergraduate training of dentists since 1985 in subjects such as Paediatric Dentistry, Periodontology, Preventive Dentistry, and is now leading teaching in the field of Dental Public Health. Her research interests primarily focus on the field of oral epidemiology and toothpaste clinical trials. As one of the authors of the National Preventive Programme in Dentistry, she has been working as an advisor for the State Dental Centre, and local Oral Health Centres in Latvia since 1995. Dr Senakola has been a member of the European Chief Dental Officers Council since 1997, and a representative of Latvia at the European Council of Dentists since 2009.

Improving Access to Quality care: the Latvian Experience

Health systems in the Baltic States, including Latvia, are structured according to a typical Eastern European Model. However, there has been a shift from predominantly public service provision to private service (only 11% public service left); insurance schemes are still developing. There is limited, but growing provision of free treatment for under 18 year olds, a growing number of dental hygienists, dental nurses and assistants (ratio dental personnel: dentists 57%: 43%), improving of oral health for children and young people (caries decline – 40%), a growing rate of regular attendance for oral health care (50-60% of the population annually) and mainly women working in dentistry (89% dentists and 98% dental hygienists).

Oral health care in Latvia is divided into private sector (89%) and public. Care for adults is privately financed. There is public finance from Sickness Funds for children up to the age of 18 years the (with exception of orthodontic treatment). In 2010, the average cost per child was 40 EUR per year and covered approximately 56% of all children in Latvia. Dental care is also financed for adults who are victims of the Chernobyl nuclear catastrophe, and for the persons who are in military service.

In 1995, in recognition of high caries levels in all age groups, a National Preventive Programme in Dentistry was initiated at the Oral Health Centre (Institute of Stomatology), in close cooperation with the State Dental Centre. The programme was divided into five blocks and the responsibilities were taken from the both sides: the education and health care systems. There were two phases (1995- 2005-2010). During that period 26 local Oral Health Centres were created. Assessment and effectiveness for preventing and curative work is based on regular accounting of oral health data in defined age groups. Prevention in Latvia is based on: the principles of health promotion, common risk factor approach, developing whole population strategy, involving dental and general health teams, School councils, Sickness funds, media and industry. There has been 40% decline in caries for children and young people, but not for adults. As Latvia is a small, but densely populated country,
there were reported problems with access to oral healthcare for patients. It was solved in 2007 by introducing the Mobile Dentistry project.

There is one dental faculty located Riga Stradins University, each year educating 50 dentists and 25 dental hygienists. Dental hygienists education commenced in 1995, and during this period 268 dental hygienists were educated (Ratio DH: Dentists 1: 6, 24 % working in Public Health). Other dental personnel types are educated at Riga first Medical College. Dental care professionals are obliged by legislation to maintain and develop their professional skills – mainly delivered by the professional associations.

In 2011, new Public Health Strategies in Latvia (2011-2017) were developed at the Ministry of Health and new guidelines were formulated at the State Dental Centre. They relate to a management system for good dental care and patient safety in oral health care. The competent authorities maintaining dental staff registration and dental practice accreditation is the National Health Agency and Heath Inspection. The Baltic Oral Health Strategy is currently being developed.

Dympna Anne Kavanagh
BDS PhD FDS DDPH MSc FDS (DPH)
National Oral Health Lead for Ireland Health Service Executive

Dympna is currently the National Oral Health Lead in Ireland's Health Service Executive and is a Dental Public Health specialist (Certificate of Completion of Specialist Training CCST), trained in the National Health Service (NHS) (United Kingdom) to Consultant level.

Dympna has experience working across multiple settings and disciplines within the Health Service Executive and NHS, and has a proven track record in reconfiguring services, performance monitoring and managing resources and budgets.

In previous roles Dympna has led as a clinical manager and also worked in general management and corporate managerial roles, managing a variety of disciplines and personnel in both clinical and nonclinical
settings. Dympna has provided clinical frontline services in a variety of clinical settings and roles including independent private and NHS practice, hospital and public health.

Change Management of Service Provision in Ireland: A Public Health Approach

Kavanagh D.A., Walshe M., Burke P., FitzPatrick M., PA Consulting

Aims: The main purpose of the Review was to consider whether the existing management arrangements (structures, management and governance arrangements) in the Health Service Executives (HSE) Public Primary Care Dental Services were/to:

1. Fit for purpose to achieve safe and high quality public dental services.
2. Ensure and support best practice in clinical and professional effectiveness
3. Facilitate public accountability and public confidence.
4. Support effective interdisciplinary and inter-agency relationships
5. Consistent with international best practice regarding dental services.

Methods: The Review was a short, intense process involving data and document analysis, consultation and expert inputs by Dental Public Health Consultants. Documentation both nationally and internationally was assessed. Consultation with people delivering services within the HSE and other outside agencies was also undertaken.

Results:
Public Dental Service (Salaried Service):

The Public Dental Service was divided into 32 local dental services with significant variations. It was difficult to get an accurate picture of what was being delivered and by whom. There was no single point of contact to establish what was being delivered across all of the 32 areas. The Service operated with significant operational discretion at local level and operated as a parallel service stream to other health and social care services. Referral pathways between services were unclear particularly between primary and tertiary care services. Services were not delivered on the basis of patient outcomes but were provided based on current resources rather than an agreed National Service model. There was also a strong sense among stakeholders that Oral Health policy was not prioritised and the Public Dental Service was not planned to deliver evidence based practices.

Dental Treatment Services Scheme (Adult Contracted Services):
There was wide agreement that probity arrangements were not sufficient. There was extensive data available centrally but this was not sufficiently used to manage the Scheme across the Service. Communication systems with General Dental Practitioners were inadequate; practitioners were not receiving feedback on how they were performing. The Contracted Services required a radical overhaul to ensure a focus on preventive care with nationally agreed oral health outcomes, whilst providing value for money.

Conclusions: While there were important differences between the delivery of the Salaried Service and the Contracted Scheme, they fundamentally have the same purpose; to improve the oral health of people who are eligible for the service. The principles for the future will be:

1. A service that will be based on need, with clinical governance and centrally focused clinically leadership, which is patient focused and not what the service or the profession can deliver.
2. A simple, clear, accountable structure with clear points of authority, responsibility at national, regional and local level.
3. Practitioners in both the Salaried Service and Contracted Care Service will be assigned based on competencies.
4. Collaboration between professional services in other agencies.
5. An intelligence led service to provide evidence based practice particularly in relation to prevention and special needs care.

Simone Boselli

Account Director, Public Affairs, Hill + Knowlton Strategies
Brussels

Simone Boselli joined Hill+ Knowlton team in September 2006. In his current role of account director he advises a range of international clients on pan-European regulatory and policy matters, as well as developing the digital communication and public affairs in the Brussels office. In particular in the healthcare field, Simone has extensive experience working for both corporate as well as public stakeholders and

has devised and implemented lobbying and advocacy campaigns at EU and national level. Simone is notably Vice-Chair of the Healthcare Committee of the American Chamber of Commerce to the EU. Before joining Hill + Knowlton, he worked at the European Parliament, following Development and International Trade issues. Prior to this, Simone's work focused on European funding for and project management of health, ICT, energy and environment. Simone graduated from the University of Bologna with a degree in Sciences of Communication. He holds a Masters in European Public Relations and Project Management from the Italian Institute for Foreign Commerce in Brussels.

Raising the Profile of Oral Health in Europe through Lobbying in Europe: The Platform for Better Oral Health in Europe

The Platform for Better Oral Health in Europe (www.oralhealthplatform.eu) brings together leading groups and experts – including European chief dental officers, Europe's dental schools and dental public health experts – with the aim of promoting oral health and the cost-effective prevention of oral diseases in Europe. The Platform has embarked on the ambitious journey to tackle this challenge, focusing on three work-streams:

1. To reach out to European and national decision-makers to agree on a common approach to prevention, education and access to better oral health in Europe.
2. To strengthen the dialogue with all those involved in the provision of oral and dental care to define and share good prevention practices.
3. To develop and disseminate practical oral health promotion and prevention tools that can make a real difference on the ground.

The tremendous progress and success of the initiative is evident from this year's campaign around World Oral Health Day (12 September): under the patronage of the Cypriot Presidency the Platform organised the 1st European Oral Health Summit at the European Parliament. More than 140 decision makers and experts gathered on 5 September to discuss the findings of the Platform-commissioned report on the State of Oral Health in Europe and defined 5 priorities for an oral health prevention strategy for Europe. In parallel, 50 free dental check-ups were performed in a mobile dental clinic on Place Luxembourg, and more than 2,000 oral hygiene packs were distributed. The proceedings of the Summit were disseminated via a live tweet feed and triggered media coverage across Europe. As H+K Strategies Brussels is running the Secretariat of the Platform since 2011, Simone will share the key milestones and learnings that are triggering change in oral health policy at European and national level through accurate and timely advocacy activities.

Professor Bettina Borisch

Institute of Social and Preventive Medicine, University of Geneva Medical School, Geneva, Switzerland
Executive Director of the World Federation of Public Health Associations

Professor Borisch is currently based at the Institute of Social and Preventive Medicine, at the University of Geneva Medical School in Switzerland. She gained her MD in 1984, and has specialised Molecular Pathology and Pathology. She holds a Masters degree in Public Health and her interests include: Cancer prevention and early detection programmes, health communication, and nutrition and cancer. Previous roles have included acting as the Head of Clinical Pathology at the University of Geneva Medical School, Switzerland. Specific activities in Public Health include serving as the Director and Secretary General of the World Federation of Public Health Associations in Geneva. She is a Board member of the Swiss Society of Public Health, and the Swiss Society of Health Politics. She is also a member of the Scientific Council of the International Agency for Research on Cancer.

Global Public Health Group: Dental Public Health Opportunities

The World Federation of Public Health Associations (WFPHA) is an international, non-governmental organization composed of multidisciplinary national public health associations. It is the only worldwide professional society representing and serving the broad field of public health. WFPHA's mission is to promote and protect global public health. It does this throughout the world by supporting the establishment and organizational development of public health associations and societies of public health, through facilitating and supporting the exchange of information, knowledge and the transfer of skills and resources, and through promoting and undertaking advocacy for public policies, programs and practices that will result in a healthy and productive world.

The importance of oral health for public health remains largely underestimated in the majority of WFPHA member countries. Oral health specialists are found among dentists, ENT doctors and some other health specialists. They are not necessarily trained in public health. These missing links between oral health and public health in large parts of the world have led to bad oral and in that bad general health for large populations. It was not until the recognition of the non communicable diseases (NCDs) as a “new epidemic” that oral health came in the focus of some health planners and public health specialists. Indeed most common NCDs have at least one oral aspect and have common risk factors with well know NCDs such as cancer, cardiovascular diseases and diabetes.

At a global level, oral health has to be fully integrated into public health planning. There may be enormous achievements for the health of people by using relatively little resources if the two sectors would interact more.

To try to improve the current situation, the most recent initiative comes from a decision of the WFPHA to form an Oral Health Group. The goals and visions of this newly established working group will be presented.