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EDITORIAL

Singing from the same hymn sheet

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Dental caries is the world's most prevalent communicable disease, making this disease the largest burden of all diseases. The World Health Organisation reports that globally, an estimated 2 billion people suffer from caries of permanent teeth. The inequality in the prevalence and severity of disease is associated with social status. Northern European countries show lower caries prevalence than Southern and Eastern European countries. In general, more economically developed countries have the lowest burden of untreated dental caries and severe periodontitis.

The management of dental caries and periodontal disease, in the main preventable diseases, has been the backbone of professional practice in primary dental care. Dental Public Health and General Dental Practice have been the two professional areas of practice that provide direction to the delivery of care.

Dental Public Health takes a population approach to care delivery whereas General Dental Practice takes an individual approach to its delivery of care. It could be argued that Dental Public Health has an upstream view whereas General Dental Practice has a downstream perspective. The common risk factor approach is favoured by public health professionals and is an example of an upstream approach. In the UK, the utilisation of Units of Dental Activity (UDA) as an outcome measure in General Dental Practice is an example of downstream thinking. Dental Public Health focuses on collective outcomes and epidemiology while General Dental Practice focuses on individual dental fitness outcomes. Each discipline has its own relevant journals with published papers reflecting their remit.

Prevention is described as primary, secondary and tertiary: primary prevention is about preventing disease at source through appropriate behaviours in individuals; secondary prevention is about changing risky behaviours in individuals; and tertiary prevention is treating the consequences of disease through invasive treatments while also encouraging behaviour change. Within the upstream/downstream spectrum, primary prevention would be at the upstream end and tertiary prevention at the downstream end of the spectrum.

An evidence base by its nature is a reflection of the past, not the future. Therefore, if practice is only based on the past, the opportunities of the future may not be taken and optimised. Take for example the evidence that dental caries in the deciduous dentition is a predictor of the future disease experience within the individual. In this context, is there a potential for clinicians to conclude that secondary prevention will fail in certain individuals? If so, should there be research to challenge this belief? What are the modalities that are most effective to facilitate the change?

General dental practitioners will have been provided with the ability to risk assess patients following their undergraduate degree. Therefore, there is an argument to allow them the professional responsibility to do this. Then the clinician can apply treatment as deemed appropriate for their high- and low-risk patients.

There is a clear evidence base to the skewed distribution of dental caries in populations worldwide. Thus, the Common Risk approach promoted by Dental Public Health professionals. It has been reported that the common risk approach has been successful for 90% of the population in economically developed countries and has the potential in countries where caries prevalence is high. In economically developed countries, the high-risk sub-group will need an approach in addition to a Common Risk campaign to achieve improved health outcomes. The approach will need to apply a skilled behavioural approach to care. The high-risk patients correlate with deprivation as does attendance. An individual patient assessment of risk is vital, as a correlation between social status and behaviours does not include/exclude each and all. From a health perspective, the challenge to health carers is to engage populations and manage high-risk individuals, an opportunity to generate an evidence base.

The literature surrounding successful behavioural approaches highlights the need for ongoing care in order to manage the time frame of secondary prevention. Legget et al. (2023)[1] conclude that a multifaceted approach to improving dental prevention is needed. They offer the COM-B model of behaviour change as a modality. Other modalities such as motivational interviewing have also been seen to be effective. In addition to a knowledge base regarding behaviour management, the skills to perfect modalities need to be manifest. Effective modalities in General Dental Practice will need to be evidenced.

Appropriate attendance at the dentist is a key message for promotion. A fundamental behaviour change for the individual potential continuing care patient. Therefore, the general dental practitioner is a central piece in the jigsaw of oral health and a cavity-free future as proposed by the Alliance for a Cavity-Free Future. As researchers, consideration should be given to Bachelor

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(2012)[2] who suggests that upstream population approaches have the potential to increase social division when individual behaviour change is necessary within sub-groups – does this apply in regard to oral health?

There is a clear need for an ongoing Common Risk approach to oral health care worldwide. There is a need for an evidence base to facilitate service development on health and cavity-free futures. In order to improve community oral health, should General Dental Practice monitoring move to a population approach based on practice profiles? Essentially, are individuals from socially deprived sub-groups choosing not to attend for regular care or are there obstacles influencing choices?

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