



Better
Health
Briefing

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**Oral health and
access to
dental services
for people from
black and
minority ethnic
groups.**

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Key messages

- 1 Poor oral health remains a significant public health problem in England, particularly among people living in deprived areas.
- 2 While the links between oral health and ethnicity are complicated and often confounded by socio-economic status, the prevalence of certain oral diseases is higher in some ethnic groups.
- 3 Attempts have been made to improve the availability of NHS dental services in many parts of the country although there is some evidence to suggest that utilisation of dental services varies between different ethnic groups.
- 4 Further research is needed into ways to improve the acceptability of dental services for people from black and minority ethnic groups.

Introduction

Poor oral health remains a significant public health problem in England. Dental diseases such as dental caries (tooth decay) and periodontal disease (disease of the tooth-supporting structures) are common, and the impact on people's daily lives in terms of pain and difficulty eating and the treatment of such diseases has significant costs to individuals and society. Unlike dental caries and periodontal disease, oral (mouth) cancer is much less common but is significant in terms of mortality and morbidity with only 50% of people with oral cancer surviving for five years or more. Inequalities in oral diseases exist with people living in deprived areas experiencing more tooth decay, periodontal disease and oral cancer than those living in more affluent areas. There is also variation in some oral diseases between different ethnic groups which is, in the main, related to social inequalities.

There is some evidence from surveys to suggest differences in the way certain black and minority ethnic groups utilise dental services compared to the general population. The NHS constitution which applies to dental services states that a comprehensive service is available to all irrespective of race and that people have a right not to be discriminated against in the provision of NHS services on the grounds of race (NHS Constitution 2013).

This briefing considers differences in dental diseases and in the utilisation of dental services between black and minority ethnic groups and the general population in the UK. It highlights ways to improve their oral health and dental service experiences and makes recommendations for future research.

1 Dental disease experience

The most significant oral diseases in England are dental caries, periodontal disease and oral cancer. This section briefly compares the prevalence of these in general as well as amongst black and minority ethnic communities.

Dental caries

Dental caries occurs when bacteria in the mouth produce acids from sugars in foods. The acids break down the surface of the tooth resulting in pain or abscesses if left untreated. There are marked inequalities in dental caries experience between those living in areas which are more or less deprived. Links have been made from many surveys between dental caries prevalence and ethnicity with suggestions that people from black and minority ethnic groups have higher dental caries experience. However, this relationship is complicated by the influence of socio-economic factors with variations found between ethnic groups and between primary (baby) and permanent teeth. Although the relationship between ethnicity and dental caries is complex and controversial, higher levels of dental caries are generally seen in the primary teeth of children of Pakistani or Bangladeshi origin (Conway *et al.*, 2007, Marcenes *et al* 2013) even after adjusting for socio-economic status.

The main risk factor for dental caries is sugar consumption. For young children weaning practices are particularly important in terms of the risk of dental caries. Guidance from the Department of Health recommends that babies start drinking plain water from a cup from six months, and stop using bottles by the age of one year to avoid dental caries. A study comparing the weaning habits of Bangladeshi, Indian, Pakistani and white mothers in England found that Asian women were more likely to bottle feed for longer, and to add sugar, rusks, baby rice or cereals to bottled drinks (Watt, 2000).

Likewise, a study by Scambler and colleagues (2010) highlighted that the role of diet within the culture of Hasidic Jews in north London was more important than the risks to health or oral health. With clear links between sweets, rewards and religious ceremonies, it was felt that there was “a reluctance to admit the full impact of diet on oral disease”.

Periodontal diseases

Gum and periodontal disease are characterised by bleeding and redness of the gums and bone that supports natural teeth. This is caused by an accumulation of plaque containing bacteria around the teeth and gums. Asian adults have more gingivitis compared to blacks and whites (Marcenes *et al*, 2012).

Oral cancer

Oral (mouth) cancer is a term used for cancer of different sites in the mouth. It is the 15th most common cancer in the UK but its incidence is increasing. The risk factors for oral cancer include tobacco, alcohol and diet (Cancer Research, 2012).

Evidence suggests that oral cancer in some sites in the mouth is more prevalent among some black and minority ethnic groups compared to their white counterparts (Millward and Karlsen, 2011). A study of people in London diagnosed with oral cancer found higher incidence rates of nasopharyngeal cancer in Chinese people compared to the white population or people of other ethnic groups. Less obvious patterns were observed for oral cancers of other sites among different ethnic groups (Donaldson *et al* 2012). A study conducted in West Yorkshire found South Asian people to be at a higher risk of being diagnosed with oral cancer than those from other ethnic groups (Csikar *et al* 2013). The authors recommended further research into the links between oral cancer, the use of smokeless tobacco and diet on the development of oral cancer (Csikar *et al* 2013).

Studies conducted in South Asia suggest chewing betel quid and areca nut use to be the primary cause of the very high incidence of pre-cancer and oral cancer observed there (Lee *et al*, 2012). In the UK, people of Bangladeshi origin are the most likely to chew betel quid with an estimated 9% of men and 16% of women using smokeless tobacco (Bedi 1996, NHS Health and Social Care Information 2005).

In terms of the role for dental teams in preventing oral cancer, a Cochrane systematic review found that smokeless tobacco users were likely to heed advice on cessation from dentists (Carr and Ebbert 2012). Whilst the evidence for population screening for mouth cancer is unclear there is evidence that screening of high risk individuals by dentists may be a cost effective strategy for preventing mouth cancer (Brocklehurst *et al* 2010).

Oral manifestation of systemic diseases

Systemic diseases such as diabetes, Behcet's syndrome and HIV which are more common in certain black and minority ethnic groups have oral manifestations which can impact on an individual's daily life and require dental management. For example, periodontal disease is more common in people with diabetes with evidence to link severity of periodontal disease, levels of glycaemic control and other complications of diabetes (Borgnakke *et al* 2013). Behcet's syndrome, which is more common among people from Turkish and Iranian backgrounds, can include severe oral ulceration, whilst oral lesions and thrush are common symptoms and early signifiers of HIV status.

In summary, the links between the prevalence of oral diseases and conditions and ethnicity are complicated and often confounded by socio-economic status. If future surveys are designed to look at the oral health of black and minority ethnic groups compared to the general population then the design of the sampling strategy needs to include sufficient numbers from different groups and account for factors such as duration of UK residence and socio-economic status (Robinson *et al* 2000).

2 Uptake of dental services

There is some evidence from health and oral health surveys that there are differences in the use of dental services among ethnic groups compared to the general population of England. For example, children in all minority ethnic groups but especially Pakistani and Bangladeshi children were found to be

less likely to have visited a dentist. Among those who have visited a dentist, the reason for the last visit was less likely to be for a routine check-up, and more likely to be due to problems with their teeth, in all minority ethnic groups compared to the general population (Health Survey for England, 2005). No statistical tests were performed to assess whether these differences were statistically significant and this survey did not account for the influence of social status. However, a more recent study in London found Asian people were more likely to have visited the dentists in the past two years than white people or black people when social economic status was adjusted for. There were no differences found in patient satisfaction according to ethnic groups (Al-Haboubi *et al* 2013). The recording of the ethnicity of attenders at dental practices, on FP17 forms completed by patients, will allow monitoring of ethnicity to be conducted and analysed.

Barriers to access

Several qualitative studies have explored the barriers to accessing dental services by people from black and minority ethnic groups. Barriers identified included: language issues, a mistrust of dentists, organisational issues for those in large families, cost, anxiety, cultural misunderstandings and concern about standards of hygiene (Newton *et al* 2001, Scambler *et al* 2010). The type of barrier identified differed between ethnic groups, though mistrust of dentists was common to all groups (Newton *et al* 2001).

Cost

In terms of cost, while NHS dental services for children are free, adults pay for dental care unless they are exempt from payment. Those who wish to apply for exemption must complete a number of lengthy forms which may be difficult for patients with language and literacy difficulties.

Language

Language problems have been cited as a barrier to black and minority ethnic groups accessing dental services. Language barriers may exacerbate the complexities of issues including the charging and appointment system, use of technical terminology, and the need for dentists to obtain both a medical history and informed consent from patients. While interpreting services for use by dental practices are available in some areas, in others there is a lack of resources for interpreting services. Where an interpreter is not available dentists may have to turn patients away or communicate through their friends, families or other patients (Thalassis, 2009).

Whilst anxiety is a barrier to accessing dental treatment for both black and minority communities and the general population (Croucher and Sohanpal 2006; Gibbons *et al.*, 2000, cited in Mullen *et al.*, 2007) such problems may be exacerbated by communication problems.

Mistrust of dentists

Again, mistrust of the dentist occurs in the general population as well as across black and minority ethnic groups. A study of people from black and minority ethnic groups in London found that participants felt that they received a poorer service as a result of their background and believed that dentists did not respect them, listen to them or care about them as much as they did other patients. In turn, they perceived this as the cause of clinical errors, pain, teeth being extracted without all other treatment being exhausted, treatment being rushed and a lack of thought to the true cause of oral problems (Thalassis, 2009).

Culture and religious influences

Little research has been conducted on the cultural and religious barriers to people from black and minority ethnic groups accessing a dentist and the impact this has on oral health. An impact for some patients may come from the gender of the dentist. For example, one study found that some Indian and Pakistani women did not want to visit a male Indian or Pakistani dentist, although they were happy to visit a white British male dentist (Mullen *et al.*, 2007). A potential impact for dentists may be that for those who work in areas with a high proportion of Muslim patients they will experience a reduction in the use of dental services during the fasting month of Ramadan (Darwish, 2005). This is because dental treatment may result in breaking the fast as water may be swallowed during treatment.

Differences in reasons for attendance

Several studies conducted in London have suggested that certain black and minority ethnic groups may be more inclined to take a "symptom-oriented" view of visiting the dentist, rather than for regular check-ups. These groups include Bangladeshi and Vietnamese communities (Health and Public Services Committee, Greater London Assembly, 2007, Pearson *et al.*, 1999, Croucher and Sohanpal, 2006). Such perceptions may be influenced by age. A study of second generation minority ethnic groups in Glasgow suggested that older family members were not only more likely to experience language difficulties at the dentist, but were also less likely to consider regular check-ups as necessary (Mullen *et al.*, 2007). In a project of oral health in Luton, a preference for using home remedies rather than visiting the dentist was noted amongst older South Asian people (Bignall, 2012).

Given political priorities to improve access to dental services and apparent differences between ethnic groups and utilisation of dental services, further research is needed into ways to improve the acceptability of dental services for people from black and minority ethnic groups.

3 Case studies

Case study 1: Tower Hamlets PCT

Barts Health Community Dental Service has increased uptake of dental care among vulnerable and hard to reach communities in the Boroughs of Tower Hamlets and City and Hackney through the use of mobile dental surgeries and a topical fluoride school programme. There is a dedicated outreach team who proactively seek out these groups and work with their representatives in partnership to create a bespoke service model to meet their needs. The team includes link workers, clinicians and dental care professionals who represent several ethnic minorities and this multicultural workforce helps reduce barriers in communication and facilitates an empathic service which is aware of clients local beliefs. The mobiles have made services more visible and accessible, as they are able go directly to centres where the vulnerable groups attend. The link workers provide information and resources in community languages and by maintaining regular face to face contact with the client groups provide a safe

non-threatening environment for the clients to discuss their oral health needs. They will also refer them to other health services such as tobacco cessation services.

Case study 2: Bradford and Airedale PCT

The 'Smile with the Prophet' project worked with mosques to deliver culturally appropriate messages to Muslim children in Bradford. After first recruiting and training mosque teachers in oral health techniques, the oral health team also developed a resource pack, which combined oral health guidance with religious, cultural and ritualistic messages about hygiene.

www.raceforhealth.org/members/pcts/bradford_and_airedale_teaching

Conclusion

Some surveys of oral health and ethnicity have suggested that people from black and minority ethnic groups have higher dental caries experience than the general population. However, this relationship is complicated by the influence of socio-economic factors with variations found between ethnic groups, duration of UK residence and between primary (baby) and permanent teeth. Any future studies to investigate the oral health of black and minority ethnic groups compared to the general population should be designed to include sufficient numbers of participants from different groups and account for potentially confounding factors (Robinson *et al* 2000).

There is some evidence to suggest that different black and minority ethnic groups utilise dental services differently with several barriers identified including: language, a mistrust of dentists, organisational issues for those in large families, cost, anxiety and cultural issues. Commissioners of dental services should consider the importance of ensuring interpreting services are available. Further research is needed into ways to improve the acceptability of dental services for people from black and minority ethnic groups.

Resources

Citizens' Advice Bureau

NHS dental treatment: How to find an NHS dentist. Leaflet with details of the process to obtain dental health and signposting for further advice, available at: www.adviceguide.org.uk/index/h_nhs_dental_treatment.pdf

NHS Choices website

Find a dentist near you: www.nhs.uk/Pages/HomePage.aspx

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