British Dental Association response to the consultation on the Better health for all Londoners health inequalities strategy

The British Dental Association (BDA) is the professional association and trade union for dentists practising in the UK. BDA members are engaged in all aspects of dentistry including general practice, salaried primary care dental services, the armed forces, hospitals, academia and research, and include dental students.

The BDA welcomes the Mayor’s commitment to address the unacceptable health inequalities that persist in London, and the opportunity to respond to relevant questions in this consultation. We support the principles on which the draft strategy is based – including the need to focus on the prevention of ill-health, tackle the social determinants by considering health in all policies and adopt an approach based on proportionate universalism – and we agree that co-ordination and partnerships are central to its success.

However, the BDA is concerned that oral health receives only a cursory mention in the draft strategy and is not included in any of the proposed indicators, despite being a key component of overall health, having a substantial impact on wellbeing and quality of life and playing a crucially important role in children’s development.1 Although they are almost entirely preventable, oral diseases carry a huge societal and financial cost.2 Their burden is overwhelmingly borne by the most socio-economically disadvantaged and vulnerable members of the population; indeed, poor oral health is a strong marker of deprivation.3 Dental decay (caries), gum (periodontal) disease and oral cancer also share many risk factors with problems currently highlighted in the draft strategy and should therefore be considered as part of any plan to tackle issues such as obesity, and to promote healthy habits including dietary choices and alcohol/tobacco use.

The BDA has carried out a survey of member dentists practising in London, to gather information on their experience of oral health inequalities among patient populations, their involvement in any local schemes to address these inequalities and their perceptions of opportunities or barriers to improving the situation. Responses were received from 55 dentists practising in 22 out of the 33 London boroughs, with nearly half devoting over 80 per cent of their time to NHS work. Although almost three quarters (72 per cent) observed that oral health inequalities were a problem in their area, only 17 per cent were aware of any existing borough-wide oral health promotion schemes to address these. As dentists

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regularly see patients who are otherwise "healthy", they are ideally placed to engage with members of their local community on health and wellbeing issues, and should be an integral part of strategies to improve health and reduce inequalities. The need for co-ordination, as well as the eagerness of dental professionals to contribute to their communities, was captured in responses to the survey.

[We need to focus on] how dentists and dental care professionals can work together within their local communities to become advocates and lobbyists to help reduce oral health inequalities.

As detailed below, we urge the Mayor to make the reduction of inequalities in oral health an integral component of his strategy to improve the health of all Londoners and narrow the unacceptable gap in outcomes between the most and least deprived. Dentists in London are already engaged in a range of initiatives to address oral health inequalities in their own areas, and are ready to do more. The BDA would be delighted to work with the Mayor, the dental profession and other partners to support and facilitate this aim.

Summary of asks
1. We call on the Mayor, supported by expert advice, to co-ordinate evidence-based children’s oral health initiatives across London and disseminate good practice between boroughs.
2. We call on the Mayor to promote sustained Local Authority investment in cost-effective oral health improvement measures.
3. We call on the Mayor to encourage Local Authorities in the city to consider carrying out feasibility studies and local consultations on the introduction of water fluoridation, and to facilitate collaboration between areas sharing a water supply.
4. We call on the Mayor to ensure that oral health is integrated into arrangements for health and social care across London, via dialogue with the BDA and Local Dental Committees.
5. We call on the Mayor to consider the food environment as a key element of healthy streets.
6. We call on the Mayor to co-ordinate actions to improve the oral health of homeless people in London.
7. We call on the Mayor to co-ordinate a London-wide campaign to clarify dental charges and ensure that vulnerable patients understand their rights to exemptions and how to claim them.
8. We call on the Mayor to co-ordinate an integrated system to ensure that patients are provided with the translation services they need and healthcare professionals are not burdened with arranging them.
9. We call on the Mayor to facilitate partnerships between social care and primary dental services.
10. We call on the Mayor to foster links between pharmacists and Local Dental Committees throughout London.
11. We call on the Mayor to incorporate oral health as an integral component of the food plan and to ensure that dentists are included in local schemes to promote healthy nutrition, via Local Dental Committees.
12. We call on the Mayor to lead on making London a Sugar Smart city.
13. We call on the Mayor to engage with Local Authorities to discourage cuts to smoking cessation services.
14. We call on the Mayor to co-ordinate a campaign to provide accessible information for relevant communities across London on the risks of smokeless tobacco use.
15. We call on the Mayor to consider oral health in messages about healthy diet, and to seek expert dental input to ensure that recommendations are appropriate and consistent.
Healthy children

Q1: Is there more that the Mayor should do to reduce health inequalities for children and young people?

There is increasing acknowledgement across the public health sector that oral health is an essential component of overall health, and that establishing good oral health is central to providing children with the best possible start in life. This has been recognised by the inclusion of an oral health indicator for five-year-olds in the national Public Health Outcomes Framework, and Public Health England (PHE) has identified improving oral health of the 0-5 age group as a priority action area, which the Children’s Oral Health Improvement Programme Board has been established to co-ordinate and oversee.4

Evidence continues to emerge of a close inter-relationship between oral and systemic diseases,5 and signs of poor oral health in children can indicate where intervention is required to reverse early behaviours carrying risk of serious systemic disease in later life, in addition to improving the likelihood of maintaining sound adult dentition. There is an established association between deprivation and dental decay, whereby children from more deprived areas tend to have higher levels of caries.6,7

Overall, levels of dental disease in children have declined over the past 30 years, in large part due to the widespread adoption of fluoride toothpaste. However, children in London continue to have poorer oral health than those across England as a whole, with over half of London boroughs recording higher levels of tooth decay than the national average in surveys carried out by PHE. Twenty-seven per cent of London’s five-year-olds had experience of caries in 2015, compared to 25 per cent nationally. Yet, while 39 per cent of five-year-olds in Ealing had suffered decay, this was true of only 16 percent of their peers in Bromley – almost a 2.5-fold difference.

Figure 1. Percentage of five-year-old children with caries experience across London boroughs, PHE 2015

This pattern is replicated in three-year-olds: a PHE survey in 2013 showed that, whereas only 5.8 percent had experienced decay by age three in Sutton, 25.3 percent had already suffered from caries at this age in Hillingdon. This compared to a London average of 13.6 per cent and a national average of 11.7 per cent.

High incidence of caries in children in the poorly performing areas translates to a high volume of general anaesthetics for dental extractions, absence from school and days off work for parents/carers, in addition to pain and discomfort, anxiety and difficulty in eating, sleeping and socialising. However, the good standard of children’s oral health in some areas of London demonstrates that this burden is far from inevitable.

Unlike Scotland and Wales, England has no national children’s oral health improvement programme. The devolution of public health to Local Authorities is often cited as a barrier to establishing effective oral health schemes that are co-ordinated between areas and allow sharing of resources and dissemination of good practice. In London, there is now an opportunity for the Mayor to oversee and facilitate the expansion across the city of children’s oral health interventions with a demonstrable record of success. Our survey of London BDA members found that 93 per cent believed the capital would benefit from a city-wide programme offering both universal and targeted oral health support to school-aged children, similar to Scotland’s Childsmile initiative. The Mayor should work in partnership with Health and Wellbeing Boards and Local Dental Committees to ensure that oral health needs are identified in each area and plans and funding put in place to meet them. We support the call from the Federation of London Local Dental Committees to integrate oral health plans into schools and early years settings, with support from an expert adviser. As expressed in a response to our survey, co-ordination is key.

I am only in favour of initiatives when they are joined-up. We received free toothbrushes for children but then no-one came to ask for them, as nothing was publicised locally. I am not in favour of wasting money like that.

We call on the Mayor, supported by expert advice, to co-ordinate evidence-based children’s oral health initiatives across London and disseminate good practice between boroughs.

Adequate and sustained funding is key to delivering effective oral health initiatives to reduce inequalities. The BDA recognises that public health budgets are under ever-increasing pressure, but urges the Mayor to support a long-term view, whereby investment now in evidence-based preventive measures will prove cost-effective by reducing future expenditure on treatment. PHE has developed a Return on Investment tool, which enables Local Authorities to enter local population data and calculate the potential return on investment in a range of oral health improvement measures for children – from supervised toothbrushing schemes to fluoride varnish application or community water fluoridation.

We call on the Mayor to promote sustained Local Authority investment in cost-effective oral health improvement measures.

Although the proceeds of the Soft Drinks Industry Levy in England have been earmarked by Government to support school sports activities, 94 per cent of London dentists in our survey believed that some of

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the funds should be available for investment in dedicated oral health promotion schemes, since sugary drinks are a major contributor to dental disease among children.

Q2- How can you help to reduce health inequalities among children and young people?

The BDA has been at the forefront of efforts across the UK to improve children’s oral health and reduce inequalities. We have a long-standing campaign on sugar awareness and reduction, and have worked successfully with partners across the health sector to secure the Soft Drinks Industry Levy. We continue to apply pressure on Government to tighten regulation of advertising and promotion of unhealthy food and drink products, and are monitoring PHE’s reformulation programme. Collaboration via coalitions including the Obesity Health Alliance, Children’s Food Campaign and Sugar Smart is central to our work and ensures alignment of messages across broader health campaigns.

We call on the Mayor to lead on making London a Sugar Smart city. [See Q13]

We call on the Mayor to consider oral health in messages about healthy diet, and to seek expert dental input to ensure that recommendations are appropriate and consistent. [See Q14]

We also continue to promote other oral health-specific initiatives for children, including through our work with the Children’s Oral Health Improvement Programme Board. The Board aims to join up relevant organisations across health, education and local government to deliver integrated programmes, for example to promote the delivery of evidence-based oral health advice to parents by health visitors. We are currently working with the Office of the Chief Dental Officer for England to ensure that oral health advice and reminders are included in the digital version of the child health record (Red Book). The children’s dental health issue of PHE’s Health Matters resource,9 published by this group, outlines evidence-based actions for a range of stakeholders.

We call on the Mayor to promote co-ordination between dental and other health, social care and educational services for children in London.

There is general acceptance that the current NHS dental contract, introduced in 2006 and based on units of activity, does not favour a preventive approach to oral health, with dentists being paid to provide treatment. The response to this consultation by the Federation of London Local Dental Committees explains the system in more detail. Of the BDA members responding to our survey in London, 58 per cent said that the current NHS contract is limiting capacity to provide effective preventive care and 68 per cent said it is restricting their ability to treat high-needs patients. Reform of the contract is currently underway and different prototypes are being tested around the country; the BDA has been pressing hard for prevention to be at the heart of the final model. Meanwhile, BDA research has shown that morale among dentists is low; sixty per cent of London dental practice owners responding to a recent survey on working conditions and pay were considering leaving the profession within five years.10 This will place further strain on an already over-burdened system.

The BDA welcomes the principle of the Dental Check by One campaign initiated by the British Society for Paediatric Dentistry with backing from the Chief Dental Officer. All children should start visiting the dentist regularly as soon as their first tooth erupts, to receive oral health advice, become accustomed

to the surgery environment and establish a lifelong positive habit. However, the current dental contract does not support the additional volume of child patients that dentists would need to see to make this a reality. Until this issue can be resolved, we would welcome measures to target the campaign towards those who are most vulnerable and at risk of poor oral health, to prevent the system from being overwhelmed by the “worried well”.

Fluoridation of community water supplies is an effective and safe means of reducing dental decay, particularly in children. The BDA advocates the introduction of this measure where technically feasible and appropriate to local needs. We have previously provided support and advice for local campaigns to introduce water fluoridation in various parts of the country, and would be ready to do so again in London.

**We call on the Mayor to encourage Local Authorities in the city to consider carrying out feasibility studies and local consultations on the introduction of water fluoridation, and to facilitate collaboration between areas sharing a water supply.**

**Q3- What should be our measures of success and level of ambition for giving London’s children a healthy start to life?**

The five-year-old oral health indicator included in the national Public Health Outcomes Framework provides a useful measure of the prevalence of decay at a key stage of childhood; these data are already collected biennially by PHE. Sound oral health at age five is dependent on the prior establishment of good diet/feeding practices and effective oral hygiene routines, requiring engagement of all the child’s carers. (This should also produce secondary benefits for family members, who are likely to lead by example when teaching the child good oral hygiene practice.) Consistent messages and support from midwives, health visitors and any other professionals coming into contact with children and their carers, prenatally and during infancy, are essential and will be reflected in the data.

Additional measures of progress will include the number of schools and childcare settings participating in oral health programmes and the number of children requiring dental extractions for caries under general anaesthetic.

The ultimate ambition, as set out by the Children’s Oral Health Improvement Programme Board, is for every child to grow up free from preventable decay.

**Healthy minds**

**Q4- Is there more that the Mayor should do to make sure all Londoners can have the best mental health and reduce mental health inequalities?**

We welcome the Mayor’s recognition of the bi-directional relationship between mental health and inequality. Mental health conditions can impair an individual’s ability to self-care and increase the likelihood of engaging in unhealthy lifestyles and habits associated with oral diseases; conversely, poor

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oral health can lead to social anxiety and isolation due to pain and self-consciousness about appearance.

The latest Child Dental Health Survey of England, Wales and Northern Ireland (2013)\(^7\) highlighted the enormous impact of oral health on the quality of life and general wellbeing of children and their families. Over a third (35 per cent) of 12-year-olds and more than a quarter (28 per cent) of 15-year-olds reported being embarrassed to smile or laugh due to the condition of their teeth. Problems include both oral disease and orthodontic requirements; cosmetic concerns must not be discounted as unimportant, because they can have a substantial effect on mental wellbeing. Fifty-eight per cent of 12-year-olds and 45 per cent of 15-year-olds said that their daily life had been impacted by problems with their teeth and mouth in the past three months, including difficulty with eating in a fifth of respondents. More than a third (35 per cent) of the parents of 15-year-olds reported that their child’s oral health had affected family life in the last six months, with 23 per cent having taken time off work due to their child’s oral health in that period.

The BDA has been particularly concerned about the lack of integration of oral health into plans for the care of patients with mental health conditions. For example, when NICE consulted earlier this year on guidance for the recognition and treatment of eating disorders,\(^13\) we called for dental professionals to be included in the multi-disciplinary teams providing care to these patients, many of whom have dental problems linked to dietary factors or frequent vomiting; we were disappointed that NICE did not heed our request in its final recommendations. Similarly, oral health should be integrated into care plans for patients with Alzheimer’s or other dementias, who are at higher risk of disease due to impaired self-care and co-operation and the use of medications that can be detrimental to oral health.

We call on the Mayor to ensure that oral health is integrated into arrangements for health and social care across London, via dialogue with the BDA and Local Dental Committees.

**Q5- How can you help to reduce mental health inequalities?**

As discussed above, unmet orthodontic needs can have a substantial impact on people’s wellbeing and social confidence, especially for adolescents. The BDA has instigated a Judicial Review of the process by which orthodontic contracts are being procured in the South of England, including London. The current arrangements are creating difficulties for smaller independent practices in securing contracts, which could result in the loss of local orthodontic services in some areas.

We continue to call on NICE and policymakers to ensure that oral health is integrated into care plans and pathways for vulnerable patients, and to work with other stakeholders to promote good practice. For example, the BDA has supported recently-published guidance from the Faculty of General Dental Practice (UK) on dementia-friendly dentistry.\(^14\)

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Healthy places

Q7- Is there more that the Mayor should do to make London’s society, environment and economy better for health and reduce health inequalities?

We support the Mayor’s aim to reduce inequalities through good planning, and to regard health as an integral factor of the London Plan. We would urge him also to consider the food environment as a key element of “healthy streets”. This should include, for example, reductions in the number of outlets selling unhealthy food and drinks in the vicinity of schools, restriction of the sale of sugar- and calorie-rich options in vending machines within public facilities such as leisure centres, and stricter controls on billboards or other advertising that might be viewed by children.

We call on the Mayor to consider the food environment as a key element of healthy streets.

A recent report by the charity Groundswell has identified oral health as a particular problem for people experiencing homelessness. Levels of disease and pain among this group are extremely high, with many people trapped in a cycle of unhealthy behaviours (poor diet, smoking, alcohol and illicit drug use) and disease. Accessing dental care can be difficult and people in this situation are often uncertain of their entitlement to NHS dentistry. This can add to the strain on hospital emergency departments when people present with dental problems, or even lead to people extracting their own teeth when unable to find appropriate care. BDA-commissioned research by YouGov has also shown that poor oral health is felt to be significantly detrimental to people’s life chances, creating a barrier to securing employment. We urge the Mayor to create partnerships to address this issue in London, working with Local Authorities, homeless and social care organisations, Local Dental Committees and the BDA to ensure an integrated and properly resourced approach.

We call on the Mayor to co-ordinate actions to improve the oral health of homeless people in London.

Q8- How can you help to reduce inequalities in the environmental, social and economic causes of ill health?

The BDA is currently working with PHE as part of a stakeholder group to determine the carbon footprint of dentistry in England and how various treatments contribute to this, with a view to reducing their environmental impact and determining the most sustainable ways to practice. We are also awaiting the publication of a report on dentistry by the Centre for Sustainable Healthcare to consider incorporating measures of sustainability into the BDA’s Good Practice Scheme, which is a quality assurance programme that dental practices can join if they meet the required professional and legal standards.

We will continue to highlight the barriers to dental care faced by vulnerable groups including people experiencing homelessness, work with stakeholders to seek solutions to these problems and encourage dentists to participate in local initiatives. One respondent to our survey was considering setting up a mobile unit to treat homeless people, as local support was currently so inadequate.

Healthy communities
Q10- Is there more that the Mayor should do to help London’s diverse communities become healthy and thriving?

A recent report by the BDA has highlighted that NHS dental charges act as a barrier for many patients needing care and revealed widespread public confusion about eligibility for exemptions.\(^{17}\) Eighty-three per cent of respondents to our survey of London BDA members felt that the Mayor and London Assembly could help to raise awareness of the fact that NHS dentistry is free for children under the age of 18. Of particular concern, 40,000 patients per year in England, including some of the most vulnerable, are facing fines of £100 for incorrectly claiming free dental treatment. In many cases, the patients in question are eligible but are being penalised for mistakes in completing confusing paperwork; over 90 per cent of fines that have been challenged are overturned, having been applied unfairly. Dental charges and the paperwork for claiming exemption are set by NHS England, but dentists are burdened with the task of collecting them.

We call on the Mayor to co-ordinate a London-wide campaign to clarify dental charges and ensure that vulnerable patients understand their rights to exemptions and how to claim them.

For some patients, language is a barrier to receiving dental care. Dentists are currently left to make their own arrangements for translators to attend appointments and must then recover the cost from the NHS, which is highly inefficient.

We call on the Mayor to co-ordinate an integrated system to ensure that patients are provided with the translation services they need and healthcare professionals are not burdened with arranging them.

Many of the most vulnerable dental patients receive primary dental care within the Community Dental Service (CDS), which is equipped to treat people with additional needs, rather than from a high-street general dental practitioner. One respondent to our survey highlighted the importance of ensuring that the CDS in particular is not subject to the cuts facing other NHS and public health services, to protect the most vulnerable members of society.

The BDA has highlighted particular concerns about the oral health of older people, particularly those living in care homes. The UK population is aging and people are retaining more of their natural teeth into old age,\(^{18}\) when their ability to self-care may become limited, their diet may become more restricted or likely to cause dental decay and they may take medications that reduce the production of saliva and its ability to protect the teeth. Older adults living in care homes suffer poorer oral health than their peers living in the community. A report by the BDA showed that there is a high level of turnover and a lack of training in oral health among care home staff, and that residents are much less likely than the general population to access primary care dental services.\(^{19}\) NICE now recommends that all residents have an oral health assessment on entering a care home and should be assisted to find a dentist of their wish.


We call on the Mayor to facilitate partnerships between social care and primary dental services.

Community pharmacies often provide a source of health advice and information for people who are unwilling or unable to access other services. We would welcome the development of stronger partnerships between pharmacies and dental services, to facilitate signposting of appropriate dental care for patients who need it.

We call on the Mayor to foster links between pharmacists and Local Dental Committees throughout London.

Q11 - How can you help to support thriving communities?

The BDA partners with Colgate to deliver the Oral Health Month/Bright Smiles, Bright Futures™ campaign each September, providing educational materials and promoting oral health messages to the public and particularly to school children. We encourage dentists to engage with local communities via this programme, as well as through various other national campaigns that we actively support. Seventy per cent of London-based respondents to our survey indicated that they are already involved in some type of unfunded oral health promotion in their practice. Activities include visits to local schools and nurseries, providing information and leaflets, taking part in national campaigns such as National Smile Month, Mouth Cancer Action Month, Sugar Awareness Week or Sugar Swaps, and displaying posters in their practice, in addition to talking to their patients about their oral health. Building relationships and trust between health professionals and patients in these ways is central to the development of healthy communities.

We are currently working as part of a PHE-led group to characterise and quantify oral health inequalities in England, focusing on legally-protected characteristics in addition to socio-economic status. The output will enable us to identify particular groups needing additional support, and barriers that need to be overcome, to design effective and appropriately targeted interventions. In parallel with this, the BDA has convened its own expert group to determine the economic impact of poor oral health and inequalities, including personal and societal as well as financial costs. We also support the work of the International Centre for Oral Health Inequalities Research and Policy and its recommendations on addressing inequalities in oral health.

Healthy habits

Q13 - Is there more that the Mayor should do to help reduce health inequalities as well as improve overall health in work to support Londoners’ healthy lives and habits?

The BDA campaigned for the introduction of a national Childhood Obesity Strategy and was extremely disappointed with the weakened plan that was eventually announced by the Government. We welcome the Mayor’s ambition to address obesity in London via an “integrated food plan”. However, any such plan must explicitly include oral health considerations to be successful. Sugar consumption is a key common risk factor for oral and metabolic diseases, with a strong link to socio-economic deprivation in both cases. Dentists are well placed to discuss diet with their patients, since dental caries is a more

rapidly-developing disease and can be a less sensitive issue to discuss than obesity and related systemic conditions. Ninety-eight per cent of dentists responding to our survey said they already give dietary advice to their patients.

**We call on the Mayor to incorporate oral health as an integral component of the food plan and to ensure that dentists are included in local schemes to promote healthy nutrition, via Local Dental Committees.**

We welcome the commitment some London boroughs have already made to become Sugar Smart areas,\(^{22}\) whereby partnerships are created between Local Authorities, schools, businesses and other stakeholders to promote reduction of sugar purchase and consumption among the community. The BDA would like to see all London boroughs join this scheme.

**We call on the Mayor to lead on making London a Sugar Smart city.**

Tobacco and alcohol are important preventable causes of health inequality and oral disease, including oral cancers, and we welcome the Mayor’s commitment to address these in London. Dentists ask patients about these habits during medical history taking and offer a Very Brief Advice intervention to tobacco users,\(^{23}\) including referral to specialist stop-smoking services if the patient is amenable. However, despite their proven effectiveness, the availability of these services is being dramatically reduced as Local Authority public health budgets are under increasing pressure.\(^{24}\)

**We call on the Mayor to engage with Local Authorities to discourage cuts to smoking cessation services.**

A further issue of particular concern among South Asian communities is the use of smokeless tobacco in various forms. This is a significant risk factor for oral cancer, as identified by NICE,\(^ {25}\) but awareness of its harms is low and use is high among populations that are already at greater risk of poor health and may be less likely to engage with health services.

**We call on the Mayor to co-ordinate a campaign to provide accessible information for relevant communities across London on the risks of smokeless tobacco use.**

The BDA welcomes the Supreme Court’s ruling in favour of minimum unit pricing for alcohol in Scotland and would like to see similar legislation introduced in England. Meanwhile, we support the Mayor’s ambition to create partnerships across London to reduce the incidence and impact of harmful drinking.

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Q14- What can you do to help all Londoners to develop healthy habits? What is preventing you from doing more and what would help you?

The BDA has been working for several years with partners across the broader health sector on common issues related to diet and nutrition. We are a longstanding member of the Children's Food Campaign working party and have led, or supported, numerous initiatives including Chuck Junk off Checkouts and the campaign to introduce a 9 p.m. watershed for broadcast advertising of unhealthy products. We have also joined the Obesity Health Alliance, through which we work to advocate policies that promote improvements in oral and general health. A key aim for the BDA is to ensure that messages aimed at the public, policymakers and the media include oral health and are consistent in terms of the actions and behaviours recommended. This can be challenging when, for example, healthy weight messages suggest a switch from sugary drinks to “diet” versions that are still damaging to dental health due to their high acid content, which causes erosion of tooth enamel.

We call on the Mayor to consider oral health in messages about healthy diet, and to seek expert dental input to ensure that recommendations are appropriate and consistent.

The BDA will continue to engage with Government and other stakeholders to call for measures that drive reductions in the prevalence of tobacco and harmful alcohol use.

In summary, the BDA urges the Mayor to include oral health explicitly in the strategy and would be pleased to work with him, to provide information and advice and to facilitate partnerships that can deliver a reduction in health inequalities in London.

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