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Trevor Burke

Inappropriate behaviour

Readers cannot have missed the frequent media outpourings of angst in relation to inappropriate behaviour towards women, most of which appears to be entirely justified, and readers in the UK will also not have missed the 100th anniversary of (some) women being given the right to vote. The enlightenment on equal pay, indeed equality in all walks of life, for both sexes, which has come from public discourse is only just beginning, and all of this has made the masculinists (yes, there is such a word, defined as[1] denoting attitudes held to be typical of men) realize how terrible they have been. However, when I started to digest all of this news on the long history of unfair treatment and repression of women, something in the back of my mind made me feel that I had heard all of this before! Let me outline what I mean.

The National Health Service in the UK was founded in 1948 and dentistry was a part of this, free at the point of delivery as with the rest of the NHS. This made dentistry affordable to everyone and, in the first nine months, four million cavities were filled and queues formed outside dental surgeries. In an effort to quell such demand, patient charges were introduced to NHS dentistry in 1951, the first example of dentistry being outwith mainstream NHS arrangements, with those on Income Support or who were pregnant or nursing mothers being exempt. Perhaps this was also the first example of mixed purchasing, something which came into vogue much more recently within the NHS?

NHS dentistry continued to thrive: it was a big success story in terms of the nation's oral health. For example, in 1948, a large proportion the population was edentulous. Figures are not readily available but it was 37% in 1968[2] and anecdotally (I wasn't there at the time!), having all one's teeth removed and dentures placed was considered the perfect gift for the would-be bride in order to provide the perfect smile. However, by the time of the last Adult Dental Health Report, only 6% of the population of England and Wales had no natural teeth.[2] Notwithstanding this success story, the Government became increasingly concerned about the cost of NHS dentistry to the Exchequer and steps were taken to bring spending on NHS Dentistry under control. Dentists were treating increasing numbers of patients because there was demand and, as a result, they were earning more: however, in a perverse understanding of economic theory, fees for NHS Dentistry were reduced by 7% in 1992–93. Put a different way, the more patients you, as a dentist, treated the more you were punished! Understandably, this resulted in great disquiet in the UK dental profession, and it has been concluded that the 1992–93 dispute resulted in 'a defined haemorrhage of dentists away from the NHS'.[3] Recalling conversations with colleagues at the time, I am certain that this was the greatest gift that organizations such as *Denplan* could have wished for, and another example of how NHS Dentistry was treated poorly, and differently, from mainstream NHS.

Nevertheless, NHS Dentistry provided treatment which could have been considered great value for money, with survival rates for restorations demonstrating excellent service[4] for low fees. Dentists continued to be paid on a fee per item basis, as they were in 1948, and the Department of Health argued that this payment system created incentives for drilling and filling,[3] despite the fact that they themselves employed a team of over 50 Reference Dental Officers who were the guardians of probity, being employed to ensure that treatment that had been claimed for actually had been carried out, and to a reasonable quality. The Chief Dental Officer, at that time, in evidence to the House of Commons Health Committee,[3] stated that the payment system 'provided incentives for some dentists to overtreat patients', although he argued that the vast majority of dentists only treated patients according to clinical need. It was also argued that there was little incentive for preventive treatment, but the real problem was that no-one knew how to reimburse dentists for prevention without going full scale over to a capitation system. This is not a problem related solely to the UK – perhaps overseas readers can tell me if they know of any system, anywhere, where a state-funded system has found a way of remunerating prevention. In all of this, the NHS was building itself up for one conclusion, namely, the fee per item system, which had served NHS Dentistry so well for so long, had to go. However, this was smoke and mirrors. What the Government really wanted was a way of controlling exactly the amount of cash spent on NHS Dentistry and, as a result, the Unit of Dental Activity payment system was introduced in 2006. More dentists left the NHS, and, of those who remained, some appear to have managed to adapt the system to a workable compromise. It has been eloquently argued that this was Government control for minimum cost.[5] Whatever, the UDA system was discredited three years later,[6] but the UDA system is a survivor because it keeps the Government in control of the cost, despite its serious

limitations, an example of this being that the fee for a molar root filling is the same as for an occlusal amalgam. I have previously argued that a return to fee per item is unlikely,[7,8] but that a system which is largely based on capitation would work, but with a cash-limited add-on fee per item arrangement for those dentists who wished to increase their access to NHS dentistry and bring new patients into their practices, with patients paying their charges in much the same way as we pay the road tax for our cars.

The latest insult is the total disregard of the evidence presented annually by the BDA to the Review Body on Doctors' and Dentists' Remuneration. Readers who are not aware of this are directed towards a detailed exposition, by David Westgarth,[9] of how the BDA, every year, gathers and submits evidence on what it believes to be a fair remuneration settlement and 'every year the Review Body recommends 1%', resulting in a cumulative drop in income of up to 30%, given that practice expenses have risen at a much higher rate.[9]

So, NHS Dentistry has gone from being an integral part of the NHS for its first three years from 1948, and its part in mainstream NHS has been eroded by successive insults and changes, none of which are to the betterment of patient care. As a result, one gets the impression that dentistry is a thorn in the side of the NHS which they can do without and there must be financial attractions to Government in abandoning the system as it stands, or even completely. Little will happen quickly because the Government has its hands full with Brexit. Nevertheless, given that results of a survey of 500 UK dentists have indicated that NHS provision of dentistry has dropped to below 50% for the first time,[10] is it not time to ask why Dentistry has become increasingly marginalized and to say 'Time's up', in the same way as those who have suffered 'inappropriate behaviour' and feel marginalized because of gender, have done?

References

1. Oxford English Dictionary **http;// en.oxforddictionaries.com**
2. Steele JG, Treasure ET, O'Sullivan I, Morris J, Murray JJ. Transformations in British Oral Health 1968–2009. *Br Dent J* 2012; **212**: 523–527.
3. House of Commons. Select Committee on Health: Fifth Report.
4. Lucarotti PSK, Holder RL, Burke FJT. Outcome of direct restorations placed within the General Dental Services in England and Wales (Part 1): Variation by type of restoration and re-intervention. J Dent 2005; **33**: 805–815.
5. Kelleher M. State-sponsored dental terrorism. *Br Dent J* 2017; **223**: 759–764.
6. NHS Dental Services in England. An independent review led by Professor Jimmy Steele. London: DH Publications, June 2009.
7. Burke FJT. Dawn or disaster. *Dent Update* 2009; **36**: 525–526.
8. Burke FJT. Was fee per item really that bad? *Dent Update* 2015; **41**: 901–902.
9. Westgarth D. Same old brand new. *BDJ in Practice* 2018; **31**: 8–13.
10. Wilson NHF, Burke FJT, Brunton PA, Creanor S. Dental practice in the UK in 2015/2016. Paper submitted for editorial consideration.