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A dental passport for children

by Nigel Knott

While the past few decades have seen a constant stream of initiatives to tackle the dental health of our children, the epidemiological data speaks for itself, with almost half of children aged 15 years and a third of those aged 12 years having obvious decay in their permanent teeth. Could an idea that has been muted for more than a decade finally have its moment?

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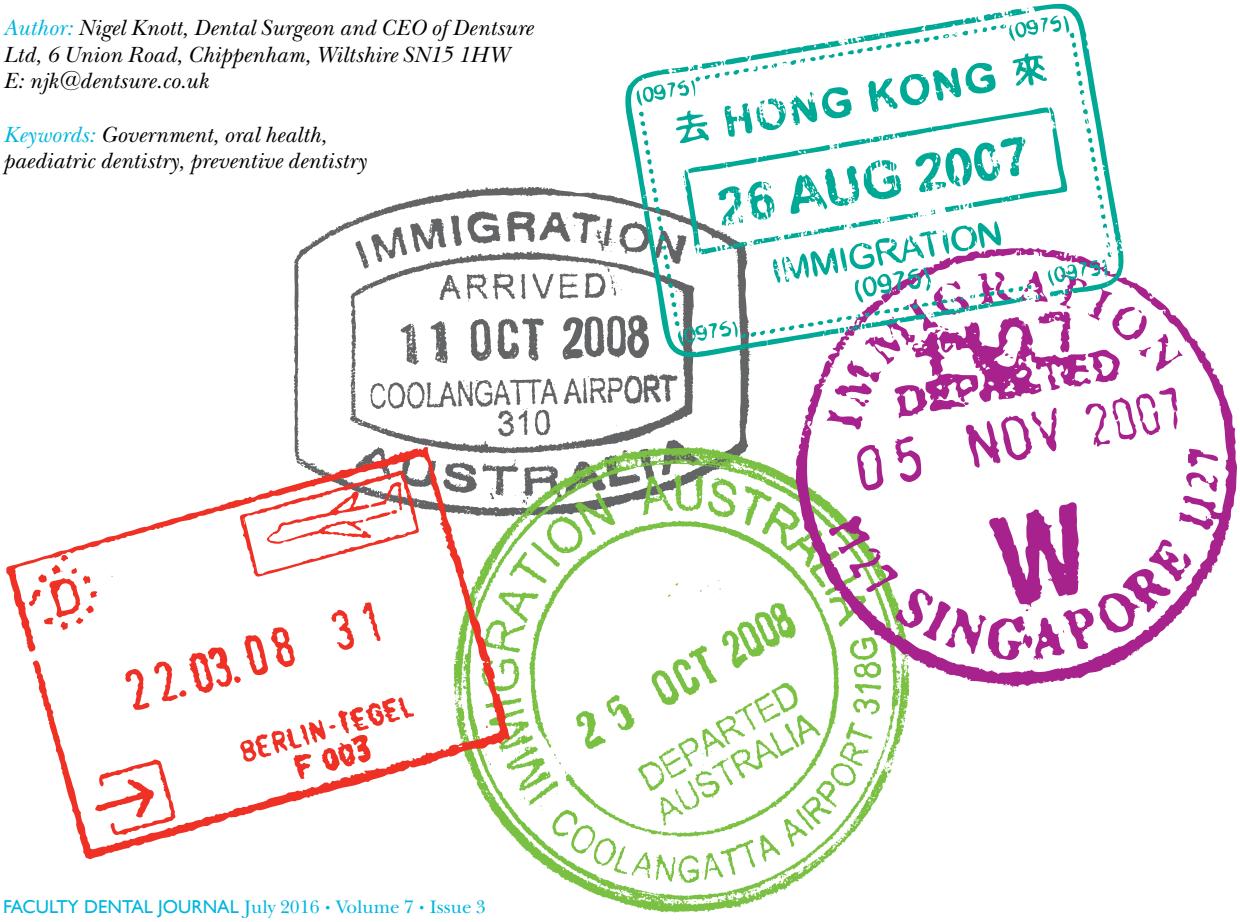

Now in the twilight of my professional career, I sometimes reflect in despair at the lost opportunities that I have witnessed where the oral healthcare of the nation's children is concerned. The mandarins of medicine and the doctors of dentistry have spent nearly 70 years poring over various NHS policies. They should – in our digital age of record numbers of diabetics, overweight children and rampant tooth decay in the very young requiring dental extractions under general anaesthesia – hang their heads in shame. Here is a helpless nursery of patients who are in a pandemic class of preventive failure.

Every schoolboy knows how difficult it is nowadays to get high-quality dental care free of charge, and large numbers of parents know the high cost of the private alternative. Indeed, the profession has voted with its feet during the past two decades and the ratio of NHS to private spending on dentistry has shifted dramatically from more than 90% to less than 60%.[1] To a complete stranger, reading through *Improving Dental Care and Oral Health – A Call to Action*, published by NHS England,[1] would leave a strong impression of nearly 70 years being wasted. Oh, and here are some bright ideas for a brand new concept of the future delivery of socialised dental care in the community! On page 31, Question 12 (of 22) asks: 'How can we support dental services in providing a preventative focused practice?' At long last, there seems to be recognition that the prevention of dental disease is better than cure, and that a dental practice might be a better place to domicile NHS Dental Contracts than with dentists themselves.[1]

Although I have been an outspoken critic of the now-defunct NHS General Dental Service (GDS), never in my wildest dreams did I think it would be replaced by something much worse! It saddens me to witness the disintegration of NHS dental services and to see that there is so little remaining worthy of praise and preservation. Not even the basic ingredient of any advanced healthcare system remains in evidence; namely, a high-quality preventive dental care programme for children provided without cost to the patients! There was a glimmer of hope when the concept of capitation was embraced in the dim and distant past of the early 1990s but, when the Unit of Dental Activity (UDA) was introduced within the NHS, the politics of the lunatic asylum seemed to have taken over.

A possible solution, in the form of an NHS Dental Passport for Children, brought a realistic prospect of 'Teeth for Life'. This idea was floated within the Conservative Party General Election Manifesto of 2005,[2] and then dumped unceremoniously in electoral defeat. The idea of a Children's Dental Passport dated back to the evidence that I supplied to Sir Kenneth Bloomfield, which he referred to in his 1992 report (see paragraphs 12.34 and 12.35).[3]

Physician, surgeon or maybe both?

The extraordinary debate that took place within the GDC fairly recently over whether or not dentists should be titled 'Dr' probably says it all. The courtesy title adopted by general medical practitioners and consultant physicians had muddied the waters from the beginning, with only 'proper doctors' having achieved formal PhD status. Where do dentists fit in? While the surgeon is traditionally known as 'Mr', the argument over the work of dental surgeons contracted to the NHS ignores the existence of any possible dimension that might be attributed to the remunerated work of a physician. Although general dental practice clearly embraces both, the boffins of NHS bureaucracy have decreed that no fees should be paid for the unseen educational aspects of preventive dentistry, which became such a force to be reckoned with in private practice in the 1970s. The theory of preventive dentistry is simple, inasmuch as there is little point in treating dental caries until the cause of the decay has been diagnosed, isolated and treated. Why waste money on decorating the bedroom when the roof above the ceiling continues to leak? Surprising as it may seem, although general medical practitioners and lawyers are paid for their cerebral activities in giving everyday healthcare and legal advice, an unseen decree exists that dentists must continue to be shackled to a treadmill of measurable physical activity (now known as UDAs). Herein lies the central madness of NHS dental remuneration, whereby the State exercises an obsessional control over dental incomes, which must depend purely and solely on measuring dental output in terms of timed productivity in the dental surgery. No benchmarked value of the quality of the services themselves or that of

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restorative treatments and consumer products (dental prostheses) in relation to their effectiveness has ever been established! Being remunerated for maintaining dental fitness has not entered the heads of those who establish the remuneration of dentists working within the NHS. Perhaps our dental lives should be organised differently, with a smart consulting room providing the first part of the essential treatment planning and care before Doctor Dental 'scrubs up' and enters the operating theatre as 'Mr' for any necessary surgical treatment?

The spotting of a cancerous lesion, a breathless patient who has climbed the stairs to the first-floor dental suite with possible symptoms of angina, or the hyperactive patient with prominent eyes and a swollen thyroid, all meriting letters of referral and/or urgent phone calls for specialist medical support... These must count as acts of dental altruism in the eyes of the NHS. Yet, in recent years, the link between gum disease and serious underlying medical conditions such as heart disease has acquired much greater significance.

My early life in general dental practice was dominated by the British Dental Association (BDA) spending far too much time and money locking horns with the government of the day over perpetual disputes concerning the remuneration of dentists working for the NHS. But let us not get carried away here on an emotional tide; rather, we should concentrate on the matter in hand of devoting our resources to the elimination of decay within the mouths of the nation's children. Better still, when a child enters the world dentally fit, how about providing an NHS Dental Contract that is focused purely and solely on maintaining dental fitness into the later years of adulthood? Maybe Dental Fitness Centres would be a good idea?

The evidence of political failure

As I have mentioned, the concept of a Children's Dental Passport was introduced in 2005 in the Conservative Party Manifesto, in which a rare reference to dentistry was made ('changing the way in which dentists are paid').[2] It is unfortunate that politics have taken centre stage, but the NHS is a political animal. I have witnessed excellent ideas rising from the grass roots, only to be torpedoed by a different Health Minister taking over the dental brief as a result of a Cabinet reshuffle.

In 1996, the dental profession in Wiltshire, strongly supported by the Family Health Services Authority Executive, put forward comprehensive plans to introduce a pilot Dental Health Trust, which was first mooted in Sir Kenneth Bloomfield's Report (para 8.9).[3] However, the *Government Response to the Fourth Report from the Health Committee Session 1992–93*[4] carried a gloomy warning: 'The government is committed to funding a service within a proper framework of (central) financial control', and the idea of a (local) Dental Health Trust was obviously a step too far! Even our own professional body, the BDA, continues to be signed up to an extraordinary restriction of NHS incomes, whereby everything is costed and nothing is valued. For years, the BDA provided a statistician to participate in the now-defunct Dental Rates Study Group to measure and price dental productivity, parcelled up within a fixed-income budget that demanded more work for less pay. But as the Fourth Report observes so aptly:[5] 'There was much more consensus amongst Committee witnesses concerning the problems than concerning the solutions.' Sadly, that remains the case today.

The epidemiology of dental disease in children speaks for itself, and the Children's Dental Health Survey 2013 is an unfortunate indictment of the failure of prevention.[6] The Executive Summary begins with the statement that, in 2013, nearly half (46%) of 15-year-olds and at third (34%) of 12-year-olds had 'obvious decay experience in their permanent teeth', whereas in 5-year-olds the percentage affected by obvious decay experience in their primary teeth was 31% and the number of teeth affected with any such decay was 3.0 (15% of the deciduous teeth). Every schoolboy knows that, if the teeth remain within an inclement environment long enough, their progressive destruction will become a certainty. The survey confirms that dental decay more than doubles in children whose families are on low incomes and entitled to free school meals. I just love the jargon that conveys the 'science' in the latest National Diet and Nutrition Survey (NDNS):[7] 'Analysis by equivalised income quintile showed some evidence of income differences in diet and nutrient intake with those in lower-income quintiles tending to have poorer diets, particularly with respect to fruit and vegetable consumption.'

It would be interesting to know the actual cost of the Technical Report for the Children's Dental Health Survey.[8] This beautifully produced document runs to 167 pages of statistics concerning the mechanics of the survey, including an Examiner Calibration Exercise using the Kappa method of standardisation, which notes that 'the children taking part in the calibration had been screened to ensure that relevant oral conditions were present in their mouths'!

To summarise, a total of 9,866 dental examinations took place in various schools in England, with the

children grouped into ages 5, 8, 12 and 15 years, containing approximately 2,500 patients each. This basic method of selection had changed, however, from previous OH surveys, with the introduction of 'opt-in' requirements for the 5- and 8-years groups.

An NHS Children's Dental Passport

Every newborn child being born dentally fit provides an obvious opportunity to prevent dental caries ever establishing a presence. The Chinese, in days of yore, paid doctors to keep the population healthy, so why not pay the dental profession for succeeding in the prevention of dental disease? In other words, create an NHS Dental Contract in which every newborn child is maintained in a state of dental fitness for the first 18 years of life, and remunerate contracted dental practices for doing just that. The quality measure would be simple and those practices that delivered high levels of dental fitness would benefit from having larger numbers of contracted NHS Dental Passport holders. Passports would contain an 'I promise' contract in a spirit similar to the one on our promissory banknotes.

In our Wiltshire Dental Health Pilot Study, we paid significant attention to the vitally important first years of life. We collected statistics relating to the annual birth rate in Wiltshire and, from the Dental Estimates Board (DEB), we collected dental attendance patterns at 0–2 years of age and 3–4 years of age. Of the 0–2-year-old group, 28.8% attended dental examinations (national average 19%), while 62.5% of 3–5-year-olds attended (national average 59%). We believe that these figures would have risen significantly with passport contracts.

Less than 50% of children aged 3 years and 6 months had seen a dentist, with their deciduous dentitions being exposed to possible damage without any oversight. When we consider the exposure of newly erupted teeth to a potentially hostile environment, we are looking at the incisors appearing at between 3–6 months of age and the molars all being visible by about 2 years of age. Here, therefore, is the key to the problem, as the signs of decay will become apparent before the age of 2 years if the oral environment is not monitored at regular intervals and the causes of dental decay are diagnosed beforehand. As time progresses, so does the potential threat of dental disease increase and, of course, the onward march of neglect soon takes a permanent toll not just upon the teeth themselves but also deep inside the body. The die has been cast and, as time progresses, decay prevention becomes much more difficult.

The Wiltshire plan was simple and would have been very cost-effective. We had envisaged one of the major toothbrush manufacturers sponsoring the pilot project, in which every expectant mother attending their GP would be invited to register with a Wiltshire practice under contract with the NHS for free dental care and educational advice. A Dental Health Passport voucher would qualify every expectant mother for 18 months of free dental care and education, beginning 6 months before the birth of a child and lasting for 12 months afterwards, at which point a Dental Passport would be issued.

Perhaps the most important ingredient of all was the willingness of more than 200 general dental practitioners in Wiltshire (more than 90% of the total) to enter into contracts with the parents of the newborn to create an NHS dental partnership. Wiltshire dentists were prepared to offer the necessary dental services to maintain the dental fitness of children from birth to 18 years of age. Remuneration was to be based upon the maintenance of dental fitness, and practices with the most effective dental care outcomes would attract the largest lists of eligible children. Each passport would have been monitored, with regular electronic data recorded from each attendance and a database maintained by the Wiltshire Dental Health Trust. This was to be a local purchaser/provider model, with the dental profession working in harmony with the local NHS executive and contracted patients. Most importantly of all would be the ability to monitor the pilot dynamics to distil out the most effective providers of paediatric dentistry and recognise their worth with Merit Awards.

....and finally the Sugar Tax?

How about using it to fund an NHS Dental Passport for Children?

Postscript

In order that the Secretary of State for Health should be given an opportunity to read a draft of this article and perhaps even comment upon it before publication, I gave a copy to a member of staff while at 10 Downing Street on 25 April 2016 with a request to deliver it to Jeremy Hunt personally. One month later I received a letter from the DHSS instructing me to send the correspondence to NHS England, the authority responsible for commissioning dental services in England. How can NHS England (or any other NHS authority come to that) commission a dental service that is not part of any government policy? Am I missing something here or should I just keep taking the tablets and give up all hope of any meaningful change and maybe too the forlorn hope this article might be read by the newly appointed Chief Dental Officer?

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