The dental care of the disadvantaged child

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There appears to be widespread lack of appreciation by the general public, the profession and the Government of the problems in obtaining dental care for the disadvantaged child.

At last April's conference on 'The Dental Care of the Disadvantaged Child', jointly organised by the Oral and Dental Research Trust and the Birmingham Dental School* it became apparent that the problems associated with obtaining adequate dental care for such children are not fully appreciated by the public, the dental profession nor, indeed the Government. Clearly, the recent changes in the provision of care under the terms of the NHS have contributed to these difficulties. This situation is perhaps understandable as the term *disadvantaged* covers a wide range of problems. Generally, a disadvantaged child is thought of as one who comes from a poor family and who lives in an area of deprivation. This may be largely so but, as was pointed out at the conference, the term disadvantaged can cover a wide spectrum of problems which include, in addition to poverty, chronic ill-health and disability, learning difficulties such as dyslexia, stress of many kinds within the home and the family, and over indulgence.

The merger of the Local Authority Dental Service — generally known as the School Dental Service — into the NHS to become known as the Community Dental Service (CDS) has seriously affected the overall provision of dental care for children, especially in the inner city areas where the proportion of disadvantaged children is the highest. Prior to 1974, school dental officers were local authority employed, and were required to carry out annual dental inspections; they contributed some 40% of the dental care provided for children. Since its inception the role of the CDS has gradually been modified and it is now required to provide facilities for a full range of treatment to patients who have experienced difficulty in obtaining treatment within the General Dental Service (GDS), or for whom there is evidence that they would not otherwise seek treatment from the GDS. These changes took place against a marked decline in caries prevalence throughout the Western World. However, despite the considerable improvements in health which have taken place during the twentieth century in the UK, there are still sub-sections of the population for whom these advances in health status have fallen short. Various reports have shown this to be the case for the prevalence of heart disease, cancer, accidental injuries, and dental and oral diseases. Such poor health has been related to low socioeconomic status, poor diet, smoking, alcohol misuse and lack of exercise. Children brought up in conditions of social deprivation are likely to follow the same downward course as their parents unless the cycle can be broken by health education, preventive procedures and prompt health care. As far as dental care is concerned it must be remembered that while caries prevalence has fallen markedly, there is still a significant cohort of children in whom caries prevalence is still high. A recent survey of 14-year-old children has revealed some with between 25 and 35 untreated carious lesions (Naylor; personal observation). These are children who in the past would have been identified at the annual statutory school dental inspection and offered treatment at the 'school clinic'. So where do such disadvantaged children obtain treatment now that the school clinic no longer exists?

Those fortunate few who live near a dental hospital may receive appropriate treatment but to obtain the necessary care in the GDS is often not easy. There are few incentives to encourage dentists to set up in practice in deprived inner city areas. Such areas have major drawbacks — there are few colleagues with whom to share the clinical load, transport to and from the practice, and drug problems are common causing difficulties for staff who have to deal with affected patients. Many, if not most, patients do not have a telephone, thus causing administrative difficulties, and there are frequently Travellers in the area who bring additional emergencies and who 'move on' before work has been completed. Furthermore, there are few, if any, incentives to encourage a dentist to set up in practice in a deprived area where the survival of the practice is dependent totally on NHS fees and where the more advanced forms of restorative treatment are unlikely to be approved. Patients provided with emergency treatment commonly fail to return for definitive treatment. And so one could go on.

So what is the solution? Obviously steps should be taken to provide the necessary incentives to encourage health authorities and dentists to establish practices in such areas together with increased integration of effort with local doctors, health visitors, teachers and social workers. But undoubtedly the long-term answers lie in nationwide fluoridation of the domestic water supplies and in the education of parents and children, that by simple and straightforward methods teeth can be kept for life. Fluoridation schemes covering the bulk of the population, the only preventive procedure which does not require personal involvement and which gets into 'the nooks and crannies of society', should be established and every effort made to discourage the between-meal consumption of sticky sugar-containing snacks and drinks, and promote good oral hygiene procedures. Schools should be encouraged to support such teaching in their personal and social education lessons and be persuaded to forego the profits which arise from the sales of cariogenic foods and drinks in the school tuck shops.

It is only then that the rising generations of children, who in one way or another fall into the category 'disadvantaged' will attain the optimal level of oral and dental health.

The proceedings of the conference will be published shortly. Some of the information given in this article is derived from papers given by Professors Nigel Pitts and Stanley Gelbier, Dr Nicola Marshall and Miss Audrey Milsom.

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