The link between dental health and general health has always been central to my philosophy as a dentist

Presidential address

Professor Ian McIntyre was installed as the new President of the British Dental Association at this year's 2003 National Annual Conference held in Manchester on April 24-26, 2003. The following is his presidential address.

It is very humbling for a man such as me, who has never served on any of the BDA's main committees or aspired to high office, to find myself standing here today, proudly wearing the Chain of the President that has been worn by so many illustrious dentists before me. I am therefore deeply grateful to the Armed Forces Group for nominating me and to the Representative Body for having the confidence to endorse that nomination. I will do my utmost in the forthcoming year to ensure that the confidence that has been placed in me is fulfilled.

As many of you will know I am no longer a member of the Royal Air Force, but am now working in Warwickshire, an ordinary enough move, but one that has given me an insight into one of the unsung benefits of BDA membership – the fellowship afforded to new comers to a region by their colleagues in the BDA sections. The warmth of the welcome Joan and I have enjoyed from the BDA South Warwickshire section and the Central Counties Branch has been instrumental in our smooth transition to civilian life. Dentists are really nice people and I am proud to be one. In this context it is pleasing to note that the BDA centrally is going to be doing so much more to support the branches. The role of the branches in supporting activity at a local level is becoming increasingly important with CPD and local commissioning on the horizon.

But, the BDA is much more than an agreeable social club; indeed I would suggest that it has never been more important for the BDA to protect the interests of members

in all areas of practice. We currently face serious issues over pay. The recent votes by the General Dental Practice Committee and Central Committee for Community and Public Health Dentistry both, in their different way, reflect the deepening frustration felt across the profession regarding under-investment in NHS dentistry. On the horizon too, is the move to local commissioning by PCTs and the changes that this will mean for those continuing to work within the NHS. All of this will be further complicated by the need for specific interpretation for the individual circumstances of the devolved authorities in Scotland, Wales and Northern Ireland.

With regard to pay we are clearly in a difficult period for the GDS, but there is an unsung success story.

Considerable credit is due to those who have been negotiating on behalf of the Armed Forces. The military pay award this year, around 20% for some dental officers, is in large part due to the persistence of the BDA for the past 6 years, pressing for parity with medical officers. Parity should never have been taken away, but the BDA has doggedly pursued the correction of this injustice. Following on from the award of trainer pay some years ago, which was solely due to the BDA pressure when MOD was not supporting it, military dentists have a lot to be grateful to the BDA for.

In the bigger picture, those who choose to contract with the NHS are in potentially turbulent waters that may yet get stormy; they will need a steady hand at the BDA tiller and sound advice if they are to continue to provide an NHS service. They will of course have the choice of moving to

what look like the relatively calmer waters of private practice, an option that the Government still seems slow to acknowledge. The transition to private practice is not necessarily easy but the BDA has resolved to provide help and advice about it. However, I sometimes feel that some of our very successful members in private practice forget that there is still a large number of BDA members who wish to stay with the NHS; the BDA must continue to represent them and strive to achieve the best possible arrangements for them and their patients. The advent of local commissioning is going to make this need for guidance even more important for those who wish to be involved. The attendance at the Options for Change road shows, which are supported by the BDA, clearly demonstrates that there is considerable interest in being involved at this stage. Only time will tell if this interest can be converted to action. The BDA is also organising a series of seminars aimed at local dental committees and other local practitioners, to ensure that people get the information they need to make informed decisions about the role they want to play in the new world order of NHS dentistry.

But what is clear is that dentists working in the NHS are going to need more than promises of jam tomorrow if they are to see their future as remaining in the health service.

One hundred and forty years ago Abraham Lincoln wrote:

"If we could judge where we are and where we are going, we could better tell what we are to do and how to do it."

Anyone planning a future in dentistry would echo his sentiments today. We need some certainty about cash flow and future direction from those whom we assume are doing the central thinking. However, there is a lack of guidance from the Department that makes planning at a practice, PCT or national level extremely difficult. We seem to get lots of pep talks and encouraging noises, but very little in the way of definitive statements. This is why the BDA's work on the Health and Social Care Bill, currently before Parliament, is so crucial. The clauses of the Bill are being closely scrutinised by the BDA to ascertain what they mean for the profession and amendments will be sought to safeguard the interests of members. We need this sort of clarity to judge 'where we are going'.

But, as dentists know, there is nothing new in this sense of uncertainty or in the hard work involved in getting dentistry on the agenda in the first place – and keeping it there. In 1926 the Royal Commission on National Health Insurance reported:

'Any system of public medical insurance can be not regarded as complete until it includes the provision of adequate dental treatment.'

Similarly in 1943 the Interdepartmental Committee on Dentistry – The Teviot Committee – reported:

'We have shown that dentistry is not an adjunct, but an organic part of health; therefore it is important to the success of the Health Service as a whole that dentistry should if possible form an integral part of it on a comprehensive basis.'

Depressingly these statements from before the launch of the NHS aspire to a status for dentistry that it has never truly achieved. As a newcomer to the NHS after 39 years in the RAF I am amazed at how little impact dentistry has had over the years on the thinking of NHS opinion formers. I came from a system in which dentistry was fully integrated into the Defence Medical Services, in which it had its own properly funded budget, its own Agency to manage a clear strategic direction from the MOD and an appropriate degree of autonomy to achieve its well defined targets. If the targets are changed the DDA is able to renegotiate the funding needed to meet them. There is a clear understanding that dentistry cannot be performed on the cheap. Fundamentally, it is clearly understood in the Defence Medical Services that primary care includes primary dental care.

Dentistry in the armed forces stands alongside medicine, equally respected by senior commanders who understand the importance of oral health as part of the general health of their personnel. Commanding officers are required to report on the level of dental fitness of their troops as one of their own performance indicators, which of course concentrates their minds on the role of their dental officer. Of course there are always competing priorities and sometimes dentistry slips, but there is always central direction and standard setting that ensures that the oral health of service personnel is a high priority in terms of their overall fitness. Indeed, dentistry is considered so important as a welfare function that dentists are deployed with our troops whenever they are away from base. A soldier in the field does not expect to have an extraction if a root filling would be the right option in other circumstances; a full range of treatments must be available as close to the front line as is practicable. In the current operation in Iraq 22 dental teams, consisting of oral surgeons, dentists, dental nurses, hygienists and technicians, are there, serving their country and their patients, one is even commanding a field hospital. We will all have individual opinions about the war, but as an association we should be proud of those of our members, and members of our sister associations, who are working for the good of others in such difficult circumstances.

Furthermore, in peacetime the oral health of individual groups is measured to ensure that resources are utilised appropriately, for example regiments recruited in Scotland and Northern Ireland tend to have higher disease levels and therefore attract more resources than the technical cadres and those recruited in the South. MOD understands inequalities as they apply in dentistry and addresses them.

The NHS by comparison feels to me like a collection of cottage industries; a collection in which dentistry has to fight for a place at table and in many instances hasn't yet been shown the way to the dining room.

Each PCT is different and has a different attitude to dentistry. Of the four that I work with two are committed to providing a comprehensive service, one is still working it out but is on side and one couldn't care less. How can

we avoid a postcode lottery for dentistry if this attitude is replicated across the country and remains unchanged? A chief executive said to me 'We aim to be a starred PCT Ian, and there are no stars in dentistry'. That PCT is still resolutely refusing to have any engagement with its local dentists.

But why should PCTs take an interest? In their 3-year plans each PCT had to address performance under some 80 trajectories, not one of the trajectories referred to dentistry. Similarly, the recently published expenditure report on delivering the NHS Plan fails to mention dentistry at all. From my perspective, taking the NHS as a whole, the danger is that dentistry could still end up left out in the cold. And yet it is, or perhaps used to be, the service that has the most daily contacts with the general public. We heard from John Renshaw this afternoon about what is happening in the political arena and the BDA plans for supporting dentists through this phase. The plans for the modernisation of NHS dentistry are not without merit; indeed in many ways they are a real attempt to bring in dentistry from the cold. But they will fail if not accompanied by proper levels of investment and the pay and conditions required to keep dentists in the NHS. It will be essential for us all to support the BDA executive with a unity of purpose to achieve our goals, for what has been said elsewhere, 'What is good for dentists will be good for patients', remains essentially true.

Integration of dentistry into the broader NHS is very important in terms of how we think about dentistry, or rather how we must encourage others to think about it. It is still too often seen as an optional extra, detached from real health issues. When I first got to Warwickshire I was asked to write the oral health chapter of the Public Health report. When I suggested that there should not be one, but

rather that dentistry should appear under inequalities, cancer, health promotion, smoking cessation and any other peg I could think of to hang it on, I was met with surprise. But why? There was no other chapter proposed on a part of the body as if it was a stand-alone part, it is as if oral health is in some way optional and needs its own chapter so that non-dental readers can ignore it.

The NHS makes a big play about inequalities, as it should, but then far too often ignores them with respect to dentistry. Who cares that it is nearly impossible in some areas for elderly residents of care homes to get dental treatment, or that in many areas of the country NHS full dentures are virtually unobtainable? We are knowledgeable about the dmfs of five year olds, but who cares about the elderly with limited incomes? What do we know of their treatment needs? Who cares about those with learning disabilities and special needs who cannot be treated effectively in the GDS, where it is available? There are many excellent community dental services caring for these vulnerable patients but they are commonly under resourced and too often under valued by their employers, particularly when it comes to allocating theatre time in competition with more high profile specialties or funding for the refurbishment of clinics.

The link between dental health and general health has always been central to my philosophy as a dentist. It also informs BDA policy work in a growing number of areas: older people, children, homeless people and fluoridation. This is important work in itself - oral health inequalities persist - but it is also important in order to get the idea of integration across - and to ram home those words of the Teviot Committee written sixty years ago:

'Dentistry is not an adjunct, but an organic part of health.'

How forward looking, proactive and successful the BDA is through its Chief Executive, Executive Board, and Rep Body...

Valedictory address

Professor Ian Benington OBE was installed as the President of the British Dental Association at last year's British and Irish Dental Associations' Annual Conference in Belfast 2002. At this year's 2003 British Dental Association's Annual Conference in Manchester on April 24-26, 2003, he gave his valedictory address.

Ladies and Gentlemen, Members of the BDA, Colleagues and Friends, I have, somewhat reluctantly, come to the end of what has been, without doubt, the most exciting and fulfilling year of my professional life. The excitement has emanated from the privileged task of travelling world-wide to fulfil the many kind invitations I have received to visit dental associations and branches abroad and at home, and at

the same time, carrying out what was feasible of my job at Queens University Belfast Dental School. Throughout my hectic travels I have been keenly aware of the great privilege and honour which was bestowed on me by the BDA and I thank them for their unfailing support for myself and for my wife Eileen. I reiterate my sincere thanks to the Northern Ireland Branch of the BDA whose loyalty and trust permitted

me to carry out this wonderful ambassadorial role. Had it not been for the generosity of Queens University Belfast and my colleagues at the Dental School, I could not have contemplated or, indeed, carried out my presidential duties.

At the culmination of this wonderful year I reflect with interest on the diversity of the presidential role: extending from light-hearted presentations to undergraduates in the dental schools accentuating the importance of BDA membership, to scientific presentations to various dental associations including the Hong Kong Dental Association and a seminar and lecture to The Prince Philip Dental School, and proposing toasts to many vibrant branches of the BDA in the UK. I must say that during the year I have found that colleagues' expectations of the president as the profession's ambassador both nationally and internationally are very high and this reflects directly the great esteem in which the BDA is held throughout the world. I am aware of the considerable demands undertaken as a result of these expectations, but it has been a great personal joy to have taken part in the social and scientific aspects of dental associations' programmes at home and abroad; meeting colleagues and friends, exchanging professional views, enjoying hospitality at many branch dinners and dances and naturally, of course, an occasional party! I thank all my colleagues at home and abroad for all their generosity, wonderful friendship and hospitality – it has been a privilege and great fun.

In my Presidential Address, and again at the New Year, I alluded to the significant changes taking place in dentistry particularly in the primary care sector. *Options for Change* predictably will take much longer than a short presidential year to come to fruition and, indeed, I have to ask – in that time, are the public any nearer to getting what they are entitled to – finding quality dental care at a price which they can afford on their doorstep. I am not aware of any optimism that the Government is going to provide increased NHS resource to solve the present problems of supplying a quality NHS service for those who require it.

Furthermore, I am certain that undergraduate dental education is under great pressure to deliver quality education at grass roots level to the required GDC standards. Academic recruitment is at an all time low as cited in my New Year Address, this is a sad reflection of the Government's poor investment in the universities described in the *Economist*, November 16 2002 'The Ruin of British Universities' and dentistry is by no means an exception, perhaps the rule. This can only be corrected by a government

and university strategy to increase funding for the undergraduate schools investing in the future of quality undergraduate education.

On a more optimistic note, as I have been privileged to be deeply involved in the boiler house of the BDA for the past year – I have realised how forward looking, proactive and successful the BDA is through its Chief Executive, Executive Board, and Rep Body in responding successfully to issues that have arisen both through the Government and media. We have all applauded the successful recruitment drive where the profession has voted with its feet to achieve a record membership of 21,000 plus, reflecting their trust in an organisation that supports them with a superb service. The Executive have worked hard and successfully in supporting

Options for Change, and responding to the Audit Commission report on dentistry and the Office of Fair Trading report on the private dental market. The overall success of the organisation is also reflected in the success of its publications, the *BDJ* and the *BDA News* now at record levels. These successes demand that every dentist should be proud to be a member of the BDA and we are working to achieve that!

The BDA is in good hands and equally good heart, and I wish to reiterate my sincere thanks to the Events Working Group and members of staff for their robust and efficient efforts on my behalf throughout the year. To Karen Robinson for all her help in organising my programme, and my secretary at the Dental School, Sally Meenan, without whom I could not have achieved the demands of a very busy year. Finally, but most certainly not least, my heartfelt thanks to my wife Eileen for all her hard work and support of myself and the Association.

To conclude, it is my great pleasure to return to the 2003 conference in Manchester 'Embracing Change' and induct my successor Ian McIntyre who qualified from Durham University following the award of an RAF Undergraduate Cadetship. Ian's career achieved meteoric rise through the RAF to the exalted position of Air Vice-Marshal in February 1997. Retiring from the RAF he succeeded to the post of Consultant in Dental Public Health in the Solihull and Warwickshire Dental Health Authorities. Ian has also been a great supporter of the BDA and, more recently, Chairman of the Benevolent Fund. He has been a tower of strength to the profession and has lectured extensively at home and abroad in his subject. It therefore gives me the greatest possible pleasure to induce Ian McIntyre as the 117th President of the BDA and congratulate him and wish him and his charming wife, Joan, a successful and enjoyable year.