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Data day

Sometimes circumstances conspire to make interesting connections that one might otherwise not have made.

Hardly had the metaphorical ink dried on the previous editorial, on the subject of changes in oral health and their effects on the development of the current new contract, than the proofs of this issue of the journal landed on my desk. Amongst them were the pages for the new series of six papers derived from the Child Dental Health Survey 2003. The connection is that the gradual realisation of changing disease patterns in the UK was to some extent lead, and in other ways reinforced, by data from the Adult Dental Health Surveys (ADHS), and later the Child Dental Health Surveys.

It is less easy to understand the attitude now, but in the mid 1960s the idea of dental epidemiology was nascent to say the least. For one thing, there was so much disease around that people wondered why it was even necessary to quantify it. If it was for the fear of the need for treatment running out then the proposal seemed far fetched, while further, in some quarters, it was thought better to more profitably employ those undertaking the surveying to do something about the treatment instead of spending valuable time measuring the disease levels.

Thank goodness that some wise individuals saw beyond the immediate situation and persisted. The far sighted nature of their vision has paid so many dividends in the intervening years since the first ADHS of England and Wales (the UK wide version was to follow later) in 1968. The early results were viewed with a little passing comment and some novelty but the interest began to grow in earnest after the 1978 survey provided data to compare with the earlier situation. Suddenly it all began to make more sense and the impact of the huge amount of information and analysis from the subsequently held surveys at 10 yearly intervals has been of unquestionable significance. This is true also of the equivalent material from child surveys and the additional updates from the British Association for the Study of Community Dentistry (BASCD) mediated studies in the interim years.

But at the same time that the connection of the value and the significance of such knowledge at this particular juncture in the profession's struggles struck me, so too did the realisation that another powerful source of accumulating data is about to be cruelly smothered. I refer to the absence of the need in future to report item by item each element of treatment performed under the NHS. For as well as the valuable data provided by the decennial national surveys, the Dental Practice Board has also got a vast legacy of records, which will cease to be accumulated in as detailed a form ever again as from the end of this month. Computers in Eastbourne may in future be able to call up the number of units of dental activity but how much value will they have in the detailed analysis of current trends in treatment and use for future prediction of need and planning of services?

Will Primary Care Trusts have the resources, the inclination or indeed see the need to collect information and survey their local populations in the same way? Will it lead to a rise in individual and groups of practitioners undertaking more in-practice research on the topic? It seems unlikely.

Whatever else does or does not happen it becomes increasingly obvious that we must, simply must, retain the adult and child surveys to enable us to maintain regular information on the nation's oral health status. One unlooked for consequence of the present upheaval is that the ADHS due in 2008 and those beyond will become even more essential components of our day to day existence.

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doi: 10.1038/sj.bdj.4813449