Down Under model

Sir, Having read your article in May's issue of *BDJ in Practice*,[1] I then had an email from the Christian Dental Fellowship (CDF) about a *Zoom* meeting to discuss this very topic, and now today I see the same discussion sprawled over the front covers of the *Daily Mail*. So I thought I would respond to your 'call to arms'.

I believe that the NHS has become a political tool and no one is prepared to make bold – but ethical –and honest approaches to make the right changes. I believe that there are plenty of funds being put towards NHS dentistry but they are spread way to thin and clinical outcomes and standards fall very short. My belief is that the NHS and who is legible for care under NHS should follow a similar system to that I worked under in Australia:

- All U18s (and students) can access health care system
- Means tested/exempt patients can access care
- Any retired person (over 65) can receive care
- Other - trauma, clefts, orthodontics, hypodontia, rare genetic disorders s/a hypoplasias, imperfecta's etc.

All clinicians, nurses and technicians working in this service should be salaried. This would be based on a tiered level to be confirmed (public funds should have clear transparency on pay grades in my opinion, just like teachers, police, army services etc). Surgeries would be like mini outreach clinics (e.g. six rooms minimum) that offer emergency clinic only in the morning and then the afternoon is for continuing care cases. Emergency clinics are accessible to all those that qualify (as above U18, exempt, pensioners, trauma).

Access to continuing care is given and there would be a waiting list. Whilst on the waiting list the patient has to attend OHI/prevention and education sessions. These are delivered by dedicated therapy/hygiene departments that include nurses being able to deliver the correct dental public health messages. Failure to attend these sessions or non-compliance in any way means that access to full treatment plans. The same team provides dental public health school visits , giving nurses and hygienists far more empowerment than they currently receive. It will be very cost effective and ticks all the boxes for upstream care.

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Those that are newly qualified have to spend 2-3 years in the salaried services, acting as a bridge for them to develop their skills in a good team environment and be able to ensure they can plan correct career moves. They work nine-day fortnights and there is opportunity for them to use the facility for private work on the additional day if they wish to. Existing hospital posts stay the same way and are regional hubs that are the top of the NHS tree, so to speak.

For dental practices, all dentistry services are independent businesses that we are already used to running as fully private providers of care. It is likely insurance companies will reach out for supporting patients budgeting for private care. In reality, nothing really needs to change here but what stops straight away is this idea of 'mixed practice'. No more can dentists or corporates 'play' a system that offers substandard care and unethical practice with supervised neglect and inappropriate prescription of care.

The result? Care for patients will be far better and appropriate competition in the private market will allow for patients to choose where they want to receive care. My experience is when people pay, they tend to look after things! One would probably find that many children and retired people will still choose to use a private practice, but this is exactly the point – the choice is there.

My conclusion? The whole profession will be better placed. No more grey (mixed practice) – just black and white (public services are over here and private over there). Clear definitions to what the NHS provides and who for. No more corporate capitalism that makes a mockery of how the public purse is used for the gain of chief executives and managers who aren't even on the front line of dental care

No more unethical incomes that so many dentists are gaining by playing the system. It is wrong that dentists can have no upper limit when care is so compromised. On a salary, ethics return and the focus is maintained for what is best for the patient.

There are far more opportunities for young dentists, overseas dentists to develop their skills and career pathway. There's good scope for DCPs to be promoted to frontline of care with OHI, education clinics, school visits, for example, which ticks an upstream approach to care and utilises the workforce more efficiently.

It is very likely that given the amount we spend on NHS services already that there will be a far better outcome with the budget being used in this manner. It also starts to fill the void with newly qualified dentists not being prepared for practice and the VT system being short of ideal.

Problem solved. Just get on and do it. Be bold. Be clear. Be honest. Be ethical. Be standard setters.

J. Gollings, Dorset, via email

Reference

1. Westgarth D. Draft day dentistry. *BDJ In Pract* 2023; **36:** 4.