Do high tuition fees make a difference in dentistry?

Do high tuition fees make a difference? Characteristics of applicants to UK medical and dental schools before and after the introduction of high tuition fees in 2012
Br Dent J 2017; **222:** 181–190 http://dx.doi.org/10.1038/sj.bdj.2017.122

For many, continuing their journey of higher education by going to university after college or sixth form is the next logical step of their professional development. Obtaining a qualification from a university often allows graduates increased chances of employment and enhancement of their CVs; not to mention the fact that universities offer so much satisfaction in terms of life experiences. It's no wonder why so many past graduates call their time at university the best chapter of their lives.

However, since the advent of the controversial increased tuition fee in 2012, it has been speculated that there is an increasing danger of depriving potential students of the aforementioned amenities.

This is because the increased fees have an alarming potential of deterring potential applicants from applying. Understandably so, since most dental and medical students are faced with graduating not only with degree but also stifling debt in excess of £60k. In order to clarify these speculations, Gallagher and colleagues carried out a study to compare trends in the 'volume, socio-demography and academic experience of UK applicants to medicine and dentistry UK, with university in general, before and after the major increase in university fees in England in 2012.'

The data obtained from University and College Admissions Services (UCAS) provided an indication of the likelihood of young people participating in further or higher education. The results of the study showed that in 2012 the volume of applicants to medicine and dentistry fell by 2.4% for medicine and 7.8% for dentistry, compared with 6.6% for university overall. Also whilst dental applications fell in both 2012 and 2013, they had increased by 15.6% to 3,410 in 2014, above 2010 levels. Black and minority ethnic group [BME] admissions to university, although rising (24% in 2014), are still less than for medicine (34%) and dentistry (48%). While the study does come with its limitations, such as: the assessor's inability to have access to individual data in order to undertake multivariate analysis and the rounding up and down of the data from each school which made robust analysis difficult.

The conclusions reached from the study were: the introduction of fees did affect admissions to dental school based on the statistical evidence, particularly for dentistry. Whilst there is some recuperation, social inequalities endure and present a test for widening contribution in the professions.

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Direct access: four more years?

Direct access: how is it working?
Br Dent J 2017; **222:** 191–197 http://dx.doi.org/110.1038/sj.bdj.2017.123

There has to be a sense with the whole issue of direct access (DA) that it represents something of half-hearted measure. As a politically motivated move it, presumably, provides politicians of whatever hue and persuasion to be able to claim that DA delivers the possibility of wider access and choice for patients (and consumers!) while reducing the monopoly on treatment by dentists and potentially improving care. But in reality has it done this?

This paper represents the first attempt at researching the question since the introduction of DA in 2013. Because much about the innovation is 'bity' it makes research tricky but this work does report some very useful data which gives us insights into the value or otherwise of the measure. I use the adjective bity because much about DA seems ill-thought through. To begin with, it is only available in the context of private practice and not through the NHS, and dental hygienists and dental therapists are not able to prescribe medicines, particularly local analgesia and fluoride. In all honesty these have to be seen as major barriers which might, with a following political willpower, be easily overcome. Yet there is nothing on the horizon to suggest any further movement or development in this direction, leaving readers, dental professionals and patients to make up their own minds on where it is on the spectrum between disinterest and inertia.

What does emerge though is an estimate that throughout the UK some 3,000 patients are being treated each month under DA regulations and that this is primarily for periodontally-related conditions. This is an almost desirably tiny number and can hardly be surprising. Similarly, this also reinforces why dental therapists are less enamoured with the arrangements since it does little if anything to allow them to work using the range of practice for which they have trained and which they are qualified to execute.

The authors tease out some potentially positive trends from their findings in that patients seem to quite like the arrangement, especially those who are anxious about 'the dentist', and that those dental professionals who are fortunate enough to find themselves in practices where DA is supported and well organised do indeed derive good job satisfaction. Who knows what may happen in the future in terms of the provision of oral care using skills-mix but if those seeking guidance on the subject need some indicative research on which to base their proposals then this paper is as good as it gets thus far.

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