

Mr. C. Mulvihill
D.O.A. Section

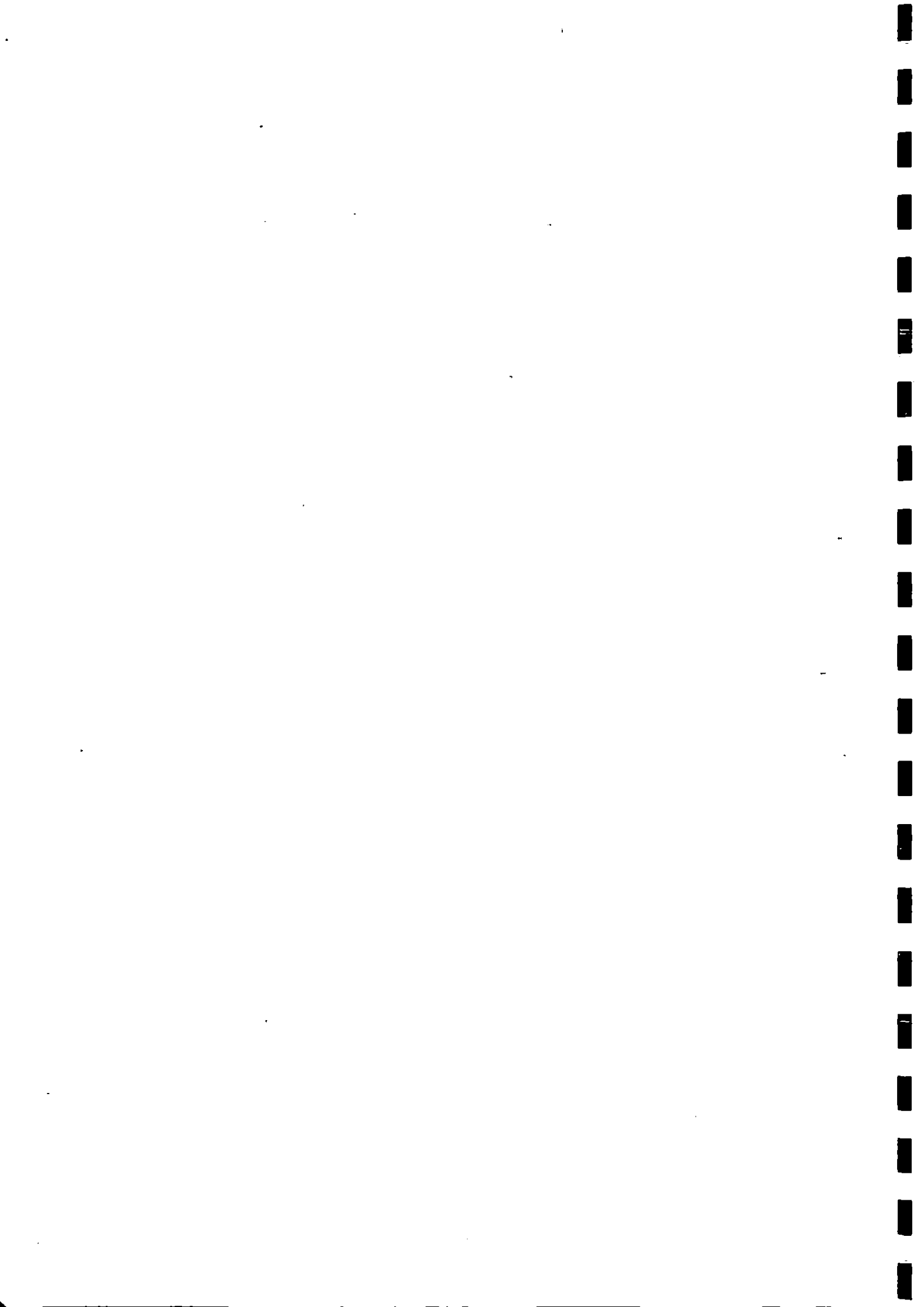
Irish Dental Association Annual
Scientific Conference,
Waterville,
Co. Kerry.

25th-28th April, 1979.

'DENTAL SERVICES IN THE
REPUBLIC OF IRELAND'

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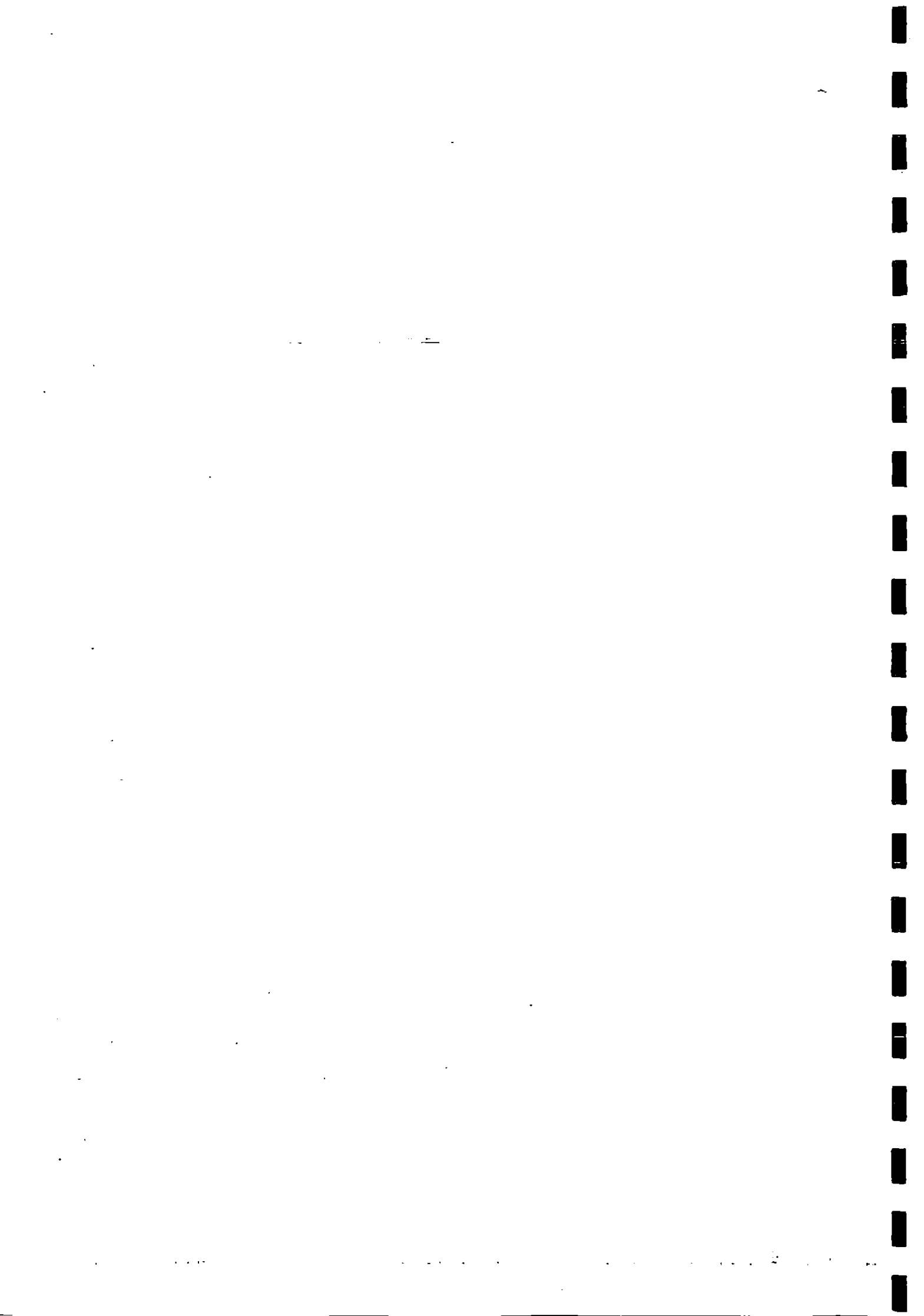
"Dental Services in the Republic of Ireland".

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Chief Dental Officer,

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Dublin.



Mr. President of the Association, Mr. Chairman,
Ladies and Gentlemen.

It is a great honour for me to be invited to participate in the Annual Scientific Conference of the Irish Dental Association. In the past 9 years this will be the sixth occasion on which I have participated at your annual conference; Bundoran, Ennis, Killarney, ~~Cork~~ Wexford and now Waterville. The subjects on which I have spoken at these scientific meetings have ranged from the clinical aspects of dentistry for children such as Techniques of giving Local Anaesthetics, ~~The Use of Sedation in the Management of Apprehensive Children~~ and Topical Fluoride Applications to the more theoretical aspects of prevention like Experimental Designs used for Clinical Trials of Caries Preventive Agents and the Statistical Methods used in Analysing Caries Data. My talk to-day is entitled "Dental Services in the

Republic of Ireland" and, even though at first glance it may not appear so, I believe it is no less scientific than my previous contributions. In the past twenty five years there has been a tremendous worldwide increase in interest in ~~methods~~ *the science* of delivering medical and dental care to ~~some~~ population groups. The reasons for this sudden increase in interest are probably complex, but two reasons stand out. On the one hand the remedies we dentists and doctors have devised for treating diseases which affect large sections of the population have grown increasingly sophisticated and expensive and outside the resources of many patients who need treatment. On the other hand most countries now take the principle of equal rights *for all* ~~more seriously~~ seriously and in the case of Health this has meant increasing involvement of the state in delivering health care especially to those who cannot afford to pay for it. Inevitably, once public funds

are being spent then the need to evaluate the efficiency of the system of delivering medical and dental care is essential if we are to be reasonably happy that the system in use is the best of the available alternatives and that our money is being well spent. In dentistry it is only in the past 10 - 15 years that active research in this field has taken place and it is only in the past five or so that worthwhile research papers have begun to appear; cost benefit analysis, cost effectiveness, treatment need and demand, ^{in general} Health care economics are concepts which are relatively new to dentistry but, whether we like it or not are likely to play an increasing role in the theory, practice and planning of Dentistry for many years to come //pause

I have had some difficulty in deciding on the topics to cover in this talk to-day but after ~~some~~ ^{MANY} ~~thought~~ changes of mind I have decided, taking into account the time available, to confine myself to considering

primary dental care services as distinct from specialist and consultant services. I can assure you that this decision does not mean a lack of interest on my part or that of the Department of Health in the Hospital and Consultant Dental services. Development of these services is essential and inevitable.

My talk to-day can be divided into five main sections. To begin with I would like to spend a few minutes looking at the different systems of delivering Dental care throughout the world. ~~Even though these systems vary enormously some patterns do emerge.~~ It will then be interesting, I hope,

Slide 1.

Provision of Dental Care.

System in Ireland

Need and Demand.

Manpower.

Priority Groups.

to look at the system of delivering Dental Care in Ireland

~~and here I will describe the characteristics of our system.~~

In the third section I will attempt to consider the need and demand for Dental treatment in Ireland taking into consideration the limited information available. Following on this it is logical to consider the manpower (Dentists) available and likely to be available to meet this need and demand. Finally since it will be apparent that neither resources or manpower will allow us to provide comprehensive Dental care for all members of the population, the selection of ~~priority groups~~ priority groups will continue to occupy our minds.

In this final section I will question the basis on which ^{on eligible groups} priority groups for Dental Care are currently selected.

Beginning then with a brief look at the systems of delivering Dental Care worldwide the World Health Organisation has taken considerable interest in this subject in recent years. Slide 2

Slide 2.

Provision of Dental Care

Mainly Private.

Private and State.

Mainly State.

It has classified medical and Dental personnel who provide care to communities according to their method of payment or employment. Not surprisingly the method of payment or employment ~~is~~ reflects the political and economic organisation of the country. Australia and the U.S. are countries whose political and economic philosophy favours free enterprise and the provision of dental care is based largely on private practice. It is interesting, however, that in recent years government involvement in the delivery of care in these countries has increased ~~and~~ and it would appear that countries such as the U.S. ~~with~~

~~mainly based on private practice~~, are gradually thinking of changing to a mixture of private and state. At the opposite end of this scale are the Eastern Bloc countries such as Bulgaria and Czechoslovakia where the system of providing dental care is mainly state-run with dentists being paid a salary. In Czechoslovakia for instance the dental service is almost entirely governmental, is developed in accordance with state economic plans, is financed from the State Budget and is delivered free of charge by salaried dentists through a network of basic and specialised dental health centres. ~~It is also interesting perhaps that 60 per cent of dentists in Czechoslovakia are women a feature in many countries in the Eastern bloc~~. As I said the method of employment or payment reflects the political and economic organisation of the country; Ireland is a country which has an economic system based largely on

free enterprise but has a social philosophy in which the government accepts a large responsibility for the provision of health care. Hence the system of delivery of dental care to the community in this country is a mixture of private and salaried dentistry. There is no reason to believe that this is likely to change in the near future.

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A country that has many characteristics similar to Ireland is Norway. It has a

Slide 3.

	Norway	Ireland
Pop.	4 m	3.2
Pop/KM ²	12	44
Dentists	4000	900
D : P	1 : 1000	1 : 3500
P.P.	54%	60%
P.H.	32%	22%

population of 4 m compared with 3.2 in Ireland.

DENSITY
The ~~density~~ of the population is low in both countries;

per square kilometre

12 in Norway as against 44 in Ireland; in England it is

230 KM². The number of dentists in Norway is considerably

greater than in Ireland. In Norway there are approximately

4000 dentists as compared with 900 or so in Ireland giving

one dentist for every 1000 of the population ⁱⁿ Norway compared

with 1 for every 3,700 in Ireland. Perhaps it is a sobering

thought that our presence, that is dentists, does not

necessarily mean that the level of dental disease will

Slide 4

be lower. As you can see on the slide the caries

experience of children aged 13-14 years in Norway in

1975 was 12.6 decayed, missing, or filled teeth; the

corresponding figure in Ireland 6.9 based on our most

recent national survey. In England and Wales it is

6.3. In a recent commentary on the Dental Services in

Norway, Dr. Per Baerum their Chief Dental Officer

Mean DMFT at 13-14 Years.

Norway (1975)	12.6
Ireland (1964)	6.9
England and Wales (1973)	6.3

pointed out that up to the early 1970^s little emphasis had been placed on prevention; the aim of the service was to restore all decayed teeth. This aim was achieved with resounding success: The mean DMFT score of 12.6 on the screen was almost entirely made up of the *No untreated Decay* F component; Since 1970 and particularly since 1975 many local authorities ~~with financial help from central government~~ have developed programs for organised *school preventive program* distribution of fluoride tablets. In 1976, 60 per cent of some 1,300 public health centres providing general.

maternity and child preventive services distributed the
the tablets. There are only about 150 Hygienists in
Norway with only 45 new students being trained annually
in the two-year courses run by the dental schools.

Because hygienists are in such short supply a trend is
developing for dental health assistants to be trained
locally to give preventive advice and distribute flouride
tablets. Retired or unemployed nurses and housewives for
example have been employed on a part-time basis after a
short training course. Since the change in philosophy in
the early 1970^s from a treatment orientated service to a
preventive orientated one there is growing evidence that
it is being successful. A number of limited recent studies
have shown that the decay experience of Norwegian children
is beginning to reach less dramatic levels (DMFT= 8.5).

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I do not wish to consider the Norwegian scene further

at this stage except to make two points. Firstly, there is a lesson to be learned, (^{indeed} if we here needed a lesson on this score at this stage) and that is that a treatment orientated dental service has little to offer in the long term. Secondly, the figures ~~quoted~~ for Ireland here are somewhat out of date and there is little doubt that studies on the level of dental disease in Ireland are required. Perhaps the figure of 6.9 quoted on this slide is less. There are a lot of reasons why it could be .

State involvement in providing dental care in Ireland is, as you all well know, divided into two groups; the Public Dental Service and the Social Welfare Dental Benefit Scheme. Certain sections of the population are entitled to dental treatment of varying sophistication under these schemes. No doubt you are all aware, as I am, of the limitations and problems of these schemes

and there is certainly a need for their planned improvement and development. Extensive debates are currently in progress with this aim in mind, and I do not wish to pre-empt these discussions by going into details *at this stage*

It is comforting in a way that similiar debates and reviews of dental services have recently taken place or are taking place in many other countries. We are not the only country which has carried out a "comprehensive review" of the dental services.

The World Health Organisation in collaboration with the U.S. Public Health Service is currently carrying out an International Study with a view to measuring the effectiveness and efficiency of the different systems of providing dental care in different countries. To date this study has been carried out in Norway, Australia, New Zealand, West

Germany and Japan. In two countries at least the findings of the collaborative study has had a dramatic effect on the administrators who are responsible for delivering dental care. I have already mentioned Norway. Perhaps it is also interesting to mention New Zealand. *Since the 1920s* a comprehensive dental treatment service, making widespread use of dental therapists or auxiliaries was rendered to all children up to the age of 13 years, and in the late 1930s this comprehensive treatment service was extended up to the age of 16 years. It has recently been extended to 18 years for those still dependent on their parents. After this age dental care is provided by private practitioners on a direct fee for service basis. The recent collaborative study showed that whilst the child population had a negligible tooth loss and

and almost no untreated caries, the population aged 35 to 45 years had the highest level of edentulousness of the five countries studied : Sydney (Australia) 12.8%, Trondelag (Norway) 5.8%, Hanover (West Germany) 2.0%, Yamanashi (Japan) 0% whilst Canterbury (New Zealand) had a staggering 35.6%. The authorities obviously were worried by these findings and a national study, with much wider coverage, was carried out in 1976. The figures of the collaborative study were confirmed.

soon after the Tooth loss commences during the years 20-24 years and steadily increases until by the age of 65 years, 73 per cent of the population is edentulous. *A treatment orientated service is a poor investment* ~~It is difficult to explain this but it has resulted in a major rethink in New Zealand.~~

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As I said the State involvement in delivering dental care in Ireland is divided into two groups;

the Public Dental service and the Social Welfare Dental Benefit Scheme. We do not have any figures to compare

the success of our system with that of other countries. *It would be helpful if we did.*

Slide 5.

Public Dental Service

Pre-school children

National School children

Medical card holders and dependants

Social Welfare Dental Benefit Scheme

Qualified Insured persons.

Under the public dental service preschool children, national school children and medical card holders and dependants are eligible for treatment and under the Social Welfare Dental Benefit Scheme qualified insured

persons are eligible for treatment; ^{for treatments} some ~~are~~ the patient being required to pay a proportion of the

cost. If we look at the total population, 3.162

million you will see that overall 69 per cent are

eligible for state help for dental treatment of

some kind or other. ① All preschool children are

eligible, ② children attending private schools (4%)

are excluded in the 5-12 year-olds leaving 96%

eligible overall, ③ only dependants of medical

card holders are eligible in the 13-16 year old

age group (37%), ④ and in the 17 plus age group there is

a mixture of medical card holders and those eligible

for treatment under Social Welfare Dental Benefit

Scheme (72%).

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form

Slide 6.

Dental Services Ireland		
Age	No. (1000 ⁹)	Eligible (%)
0-4	338	100
5-12	556	96
13-16	240	37
17+	2,028	72
Total	3,162	69

I would like you to take particular note of the figure for the 13-16 year-olds. You notice that the percentage eligible for treatment is the lowest of the four age groupings. Later when I deal with priority and special groups I will refer back to this point.

The allocation of eligibility for dental treatment by the age groupings which you see on the slide is ^{mainly a} historical accident and indeed follows to a degree a trend experienced by other countries. ^① Comprehensive care, medical and dental, for children under a Public Health Service is based on the idea that a healthier start to life will ensure, in the long term a healthier total population; ^② inclusion of the less well-off section of the population is based on, as I said earlier, the philosophy that Health is a social responsibility, ^{Accepted By} and the state ~~accepts~~ this responsibility ~~for the health of the underprivileged~~ hence inclusion of Medical Card Holders. A more recent development is the notion of Health Insurance, either private or state and dentistry in this development is represented in Ireland by the Social Welfare Dental Benefit Scheme. ^{// Please} The fact that somebody is eligible for

dental treatment does not necessarily mean of course that they receive it. We know for instance that in 1977, of the half a million or so national schoolchildren, less than 50 per cent received dental treatment. Little is known about the uptake of dental treatment in the 13-16 year-olds in the Public Dental Service but at a guess it is probably less than 10%. In the case of the two million or so aged 17 and over ^{THE UPTAKE WAS} only about 20 per cent ~~received treatment~~ during 1977. ^{Reasonable figure}

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But what proportion of the population need dental treatment and of those that need it what is the extent of the need? Well at the moment we can safely say I suppose that almost 100 per cent of the dentate population require some form of dental care.

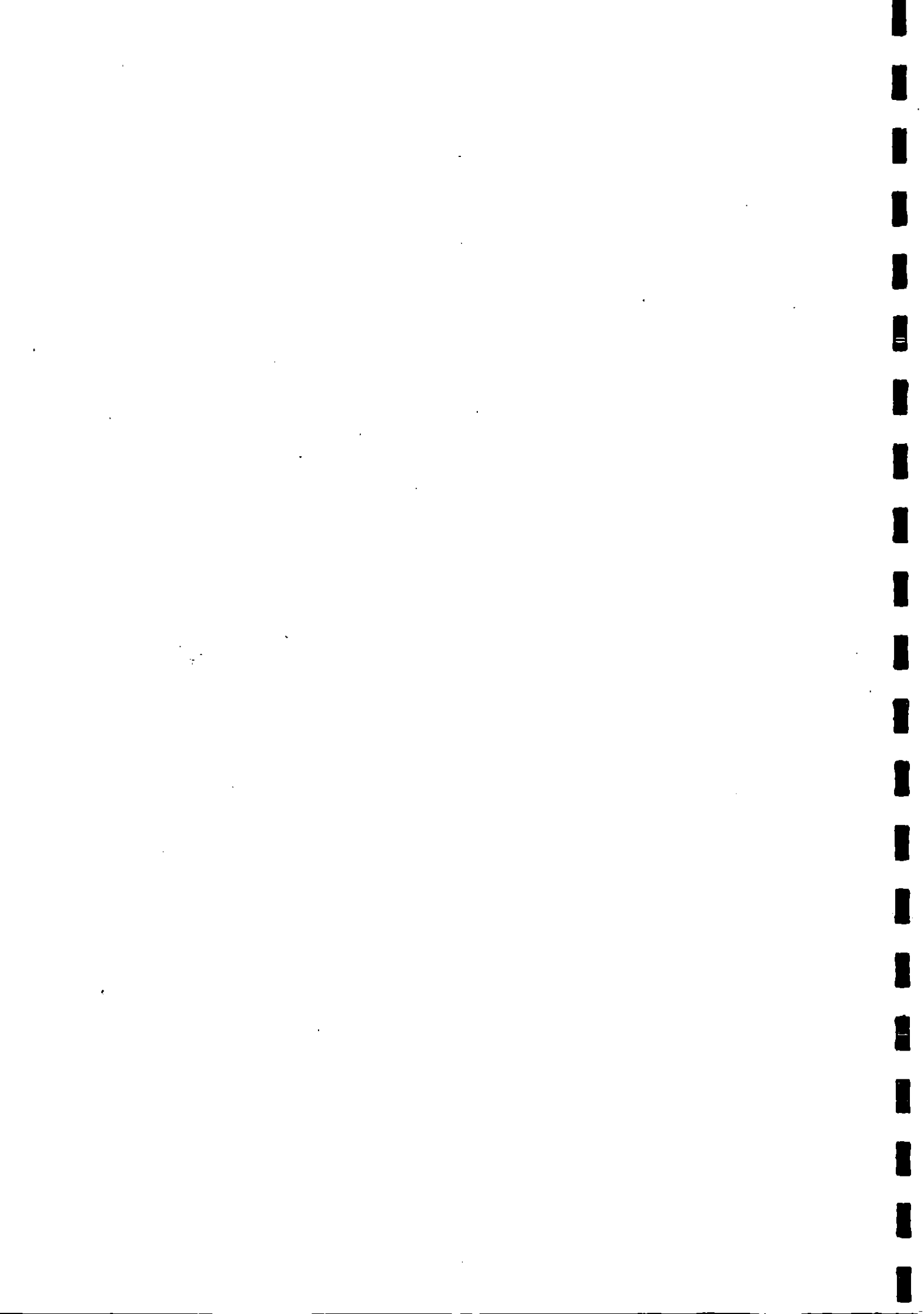
Slide 7.

Need for Dental Care

Present need.

Projected need.

With regard to the extent of the need at present well, in a word, we don't know. Only one treatment need survey that I know of has been conducted in Ireland; this was carried out by Roisin Gallagher in Donegal in the early 70^s in which the treatment needs of 7 and 12 year-old schoolchildren was assessed. In fact the study was mainly concerned with developing treatment need surveys because it has been realised for some time that the traditional dental survey is not



very useful in estimating dental treatment needs.

Lately

~~however~~ however, considerable advances have been

made in methods of conducting such surveys and it is

about time that estimates of dental treatment needs

were made in this country. // With regard to projected

treatment needs, well, the signs are that in the

case of dental caries at least, considerable reductions

can be expected. Efficient implementation of

Flouridation to what is now well over 50 per cent of

the population, ^{here} will no doubt lead to considerable reductions

in the need for treatment of dental caries. For example

in a recent study in Britain it was found that as well

as ^a 57 per cent reduction in dental caries it was also

found that fewer children had experienced toothache

in the flouridated area (19% as against 40%) and,

more relevant to this discussion, fewer had needed

Slide 8

extractions under general anaesthetic.

Slide 8.

Flouridation. 5 Year-old Children.		
	Toothache (%)	G.A. (%)
Flouride	19	15
Non-flouride	40	34

The cost of dental treatment was over 50 per cent less in the flouridated area. Martin Downer, whom you heard yesterday, confirmed these results ^{last year} in a study comparing Birmingham and Salford. Adult populations living in flouridated areas can ^{also} be

expected to show major reductions in tooth loss

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← due to caries. The effect of preventive programmes

other than flouridation such as flouride tablet

distribution, widespread awareness of the health

education message through efficient employment of

health educators such as hygienists all suggest that

the extent of treatment required for caries is likely

to be reduced and also, and probably of more significance

the nature and type of treatment required is likely to

alter; ~~as the result of~~ tooth loss, whether by local

~~or general anaesthesia~~, is likely to ^{fall} ~~be significantly~~

Future needs as a result of periodontal disease are less

clear at this stage but the evidence we have suggests that

~~with~~ an efficient dental health education message together

with increase in the demand and availability of

dental care will ^{also} lead to a reduction in the level of

tooth loss from periodontal disease in future years.

It would seem then that with flouridation^{AND} a genuine overall ϕ
preventive approach the high level of tooth loss which
as far as we know exists in this country at present will
diminish and the need for partial and full dentures
could well be less of a problem in future years.

The effect of preventive measures on the future
need for orthodontic treatment has me slightly
flumuxed. On the one hand it is claimed that early
loss of teeth particularly deciduous teeth is a factor
leading to orthodontic problems; on the other hand
retention of all the permanent teeth can lead to
overcrowding which again is a major contributing factor
in orthodontic problems. Researchers in the orthodontic
world would appear to have not solved this one as yet.
On balance, taking into account the studies that have been
conducted in this field and, I must admit one's clinical

experience, retention of all permanent teeth particularly the first permanent molars is likely to lead to an increase in the incidence of overcrowding which could well lead to an increase in the need for the more common orthodontic treatments.

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← The demand for dental care can again be considered under the present demand and the projected demand. As I said earlier, we know that in Ireland at present ~~less~~ ~~than 30 per cent~~ ⁱⁿ the population who would be reasonably expected to require regular dental care ~~approximately~~

II. THE uptake is less than 30 per cent

Slide 9.

Demand for Dental Care

Present demand

Projected demand

This is very low in comparison with other countries ~~and~~
~~and~~ and could be regarded as an indication of a
general apathy towards Dental Health. This no doubt is
part of the story. However a major factor also is the
availability, accessibility and acceptability of dentists
and dental manpower.

Slide 10

Slide 10.

Available

Accessible

Acceptable

The demand for a service that is in many areas scarce, difficult to get to and requires much time off school or work could well be low. To take this argument to the extreme the waiting list for heart transplants in Kerry is low at the moment simply because the service does not exist. The shortest waiting list of all is the non-existent one. Waiting lists and the number of complaints can be useful indications^{ors} of the demand for a service but are likely to underestimate it if the factors shown on the screen are not satisfactory.

With regard to the projected demand for dental care well in common with other countries it is likely to increase with increasing standard of living and increasing availability, accessibility and acceptability of dental care.

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Consulting the crystal ball then it would seem

that given a genuine ongoing preventive approach the
in the child population
 need for dental care is likely to fall and the type
for the adult population
 of dental care needed is likely to change, particularly
 in relation to tooth loss. At the same time a larger
 proportion of the population ~~are~~ ^{is} likely to demand and
 avail of regular dental care. *if it is available + accessible*

How available and accessible is the dental manpower,

Slide 11 ←
 to meet this changing need and increasing demand. Well
 if we look first of all at the availability, the numbers
 of dentists, in this country you will see that in the
 70^s there has been a steady slow increase in the
 numbers of dentists names appearing on the Dentists
 Register. We have not yet reached the magic figure
 of 1,000, though I have received inside information (another
 good tip !) from the President of the Dental Board
 that this figure could be reached this year.

Slide 11.

Dentists on Register.	
'70	697
'71	721
'72	749
'73	776
'74	826
'75	904
'76	897
'77	901
'78	954
'79	967

Coming from that source it must be a good bet and I hope to be invited along when the bottle of champagne is opened. Obviously all those appearing on the register are not actively engaged in clinical practice. If we take the active figure ^{at the moment} as being 850, with a population ^{of 900,000} of 3.162 million, this gives a dentist to population ratio of 1 to 3,700 considerably less than what is generally accepted as satisfactory. To give a dentist to population ratio of 1 to 2,000 ~~of the~~ ~~population~~, 1,580 dentists would be required. On the basis of the increase in the number of dentists registering in the 1970^s it can be estimated that it will be the year 2000 at least before the desired numbers will be available; this assumes, of course, no increase in the size of the population. Well will the trend shown on the screen change? Can we

Can we expect a dramatic ^{increase} in the numbers registering
 or indeed can we expect a decrease? It is difficult
 to say; it is so dependent on numbers trained,
 salary structures, movement of dentists to and from the
 U.K. and, now with the E.E. C. directives about to come
 into force, to and from other E.E.C. countries. Some
 of you may have views on this which would be welcome. //

One way or the other we have problems with the number of
 dentists available. However when we look at the
 distribution, the accessibility of dentists then the
 problem is even worse and less amenable to a solution.

Slide 12

07 Ireland has a low density of population for its size.

In comparison with countries ^{like} Holland Belgium
 and the U.K. countries such as Ireland, New Zealand,
 Norway and Australia are sparsely populated.

Slide 12.

Population per KM²

Netherlands	375
Belgium	319
U.K.	230
Ireland	44
New Zealand	12
Norway	12
Australia	2

As well as having an overall low population density countries like Ireland also have the fact of increasing urbanisation in which a larger and larger proportion of the population live in the larger cities

and towns and their surrounds. ↑ Extreme examples here
 are the counties of Dublin and Leitrim. From the Health
 Services point of view one third of the population here

Slide 13.

Population per KM ²	
Co. Dublin	925
Co. Leitrim	18.

live in the Eastern Health Area. Coupled with this is
 the fact that dentists tend to prefer to live and practice
 in the more urban areas. ⁶⁰ ~~one third~~, one third of the
 population live in the Eastern Health Board Area
considerably more than one third
 but also ^{practising} one half of the available dentists practice
 there. This phenomenon is illustrated on this slide.

Slide 14.

Health Board	D : P	Pop/KM ²
E	1 : 2, 830	212 (1)
S	1 : 4,050	38 (3)
S.E.	1 : 4,210	35 (4)
M.	1 : 4,710	31 (6)
W.	1 : 4,730	24 (8)
N.E.	1 : 5,010	49 (2)
N.W.	1 : 5,340	28 (7)
M.W.	1 : 5,400	34 (5)

As you can see the Eastern Health Board has by far the highest population number per square kilometre

but it also has the greatest dentist to population

ratio. *→ Point* The dentist to population ratios are arranged

in decreasing rank order here whilst in brackets *on the right* are

the rank orders of the density of population. The population densities in the remaining health Board areas are all very similiar and no consistent trend emerges in the relationship between the dentist to population ratios and the density of the population.)

Time does not permit me to breakdown ^{make a similar} ~~breakdown~~ into counties. But as I am sure most of you know even within the Health Board Areas there are wide discrepancies in the availability of dental manpower. This problem of course is not confined to Ireland and neither is it confined to dentistry. Many other services tend to be concentrated in the urban more densely populated areas.

Solutions to the problem of shortage of dental services in the less densely populated areas are difficult to come by. It has been suggested that

given an overall increase in the number of dentists the problem will solve itself; that new dentists entering the profession will tend to go to those areas where dentists are scarce. Well experience in other countries would suggest that this is unlikely. What tends to happen is that areas with the more favourable dentist to population ratios tend to become better off and those areas with a scarcity of dentists tend to improve very little if not at all. This trend would also appear to be occurring here. The increase in the number of dentists in the past 10 years, modest as it is (300), has made little or no difference to areas such as the North West and the Mid West. The problem exists then and is unlikely to go away, even if we have a dramatic increase in the number of dentists practising here. *Pause.*

elite ones

In countries where a comprehensive dental service
 is not available at all, efforts are made to do so
 partially and to select priority groups. The criteria
 used to select these varies and some of the following
 criteria are used or are proposed *by academics*
~~in textbooks.~~

Slide 15

Slide 15.

Selection of Priority Groups

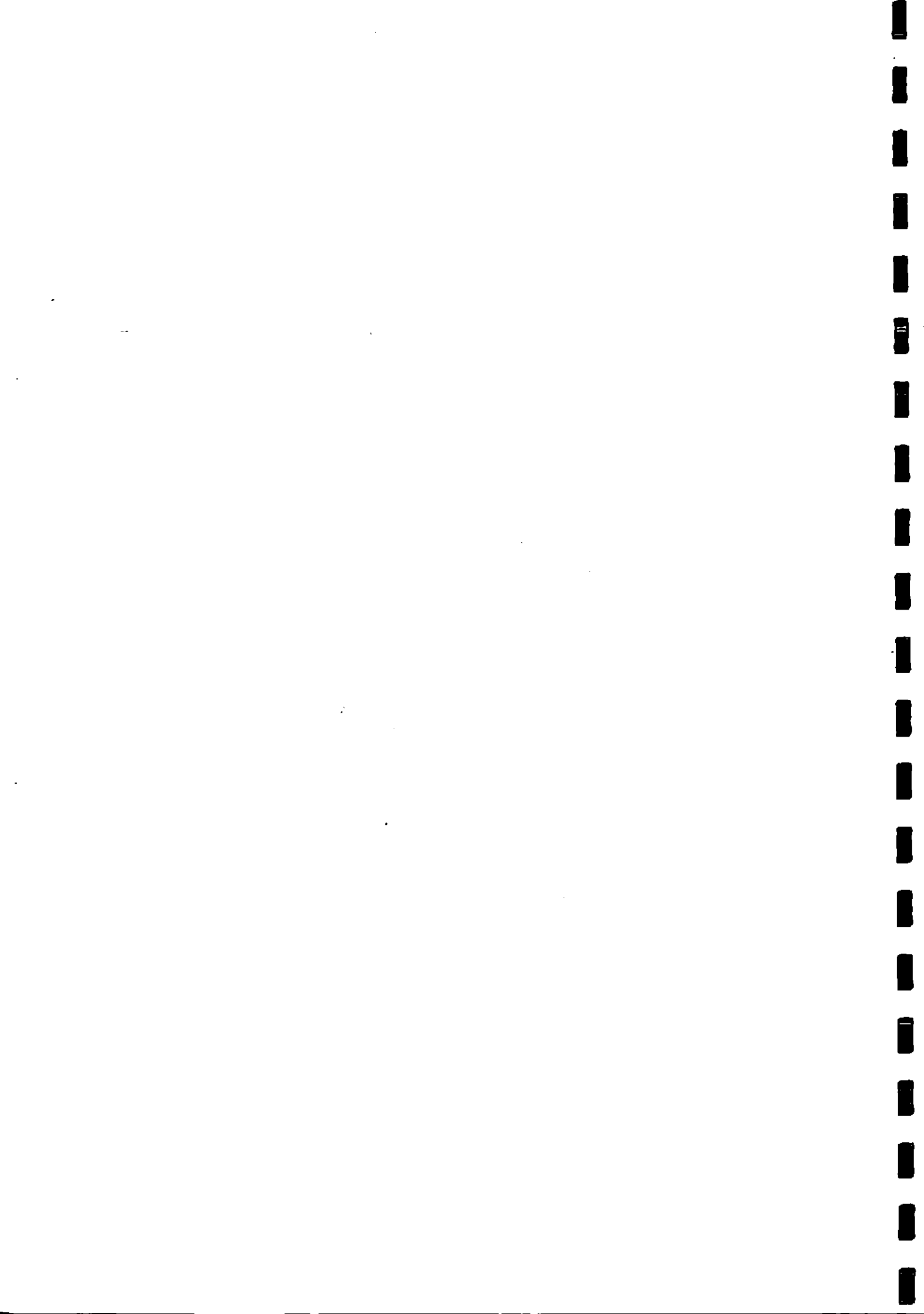
Dentally Handicapped

Prevention most effective.

Irregular Attenders

Low Income.

(i) Those for whom Dental disease or dental
 treatment is a problem, in other words the dentally



handicapped.

(ii) Those for whom prevention both primary and secondary, is likely to have the most beneficial effect in the long run; this is why children are invariably included. — *a good investment*

(iii) Those who attend a dentist only in emergencies - presumably in the hope of making them regular attenders.

(iv) And finally those who cannot afford to pay for regular treatment - the low income group.

If we concentrate for the moment on the second criterion, emphasis is generally given to the young because it is hoped that by exposure to dentistry at that age the young will eventually grow up

with better dental health and be more capable of looking after their dental health. In other words it is a good investment from the state's point of view. In Ireland at present the group with the least entitlement to dental care of any kind are the 13 to 16 year-olds. If you remember in a slide I showed earlier it was estimated that less than 40 per cent were eligible in this age group and *the average* ^{was} in all less than 10 per cent received treatment.

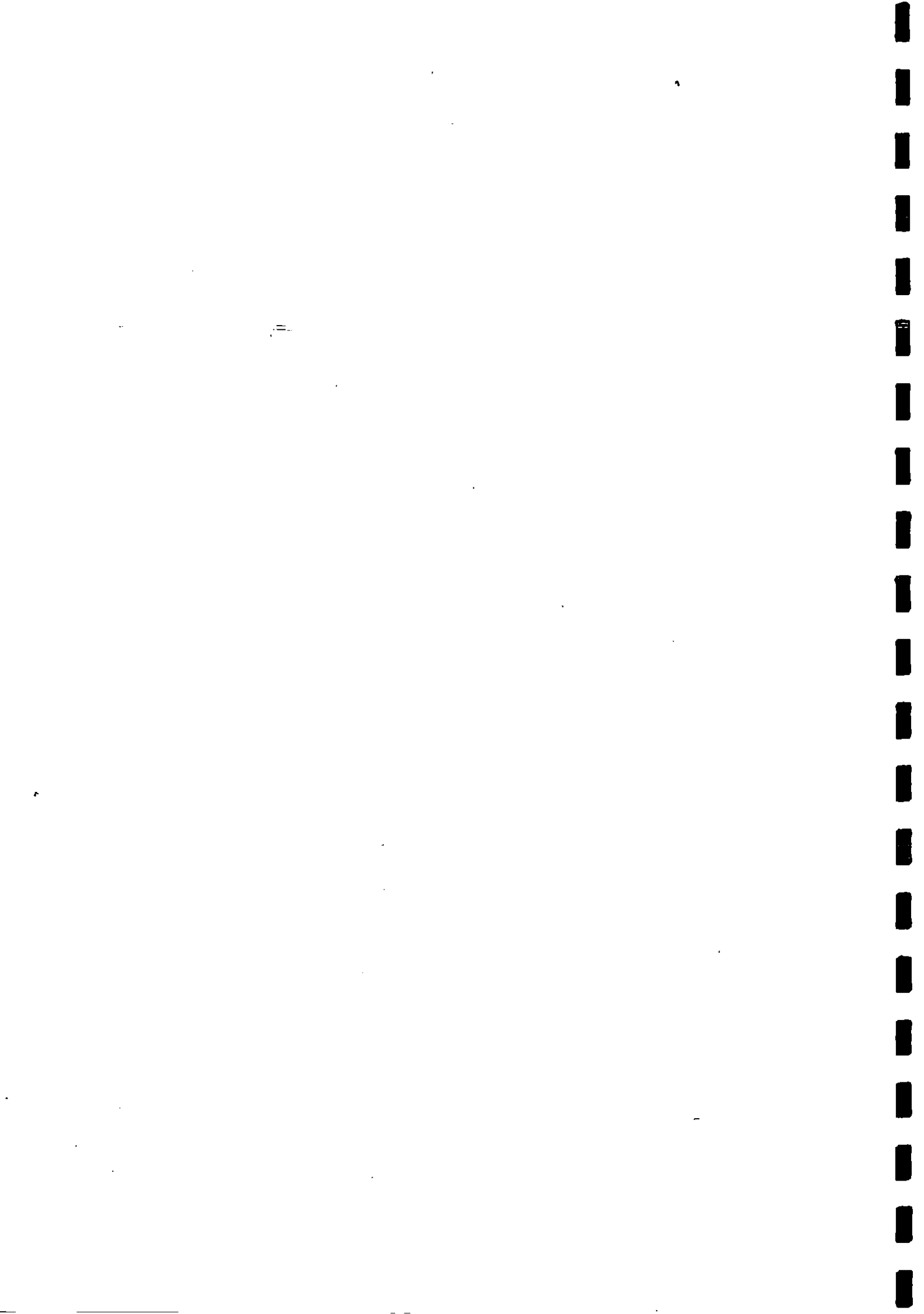
we know

However ~~it is known~~ that between ages 13 to 17

many of the teeth and surfaces which contribute a major part of the total caries increment erupt and develop contact points with their neighbours. ^{At}

the age of 12 for instance only 50 per cent or so

Slide 16

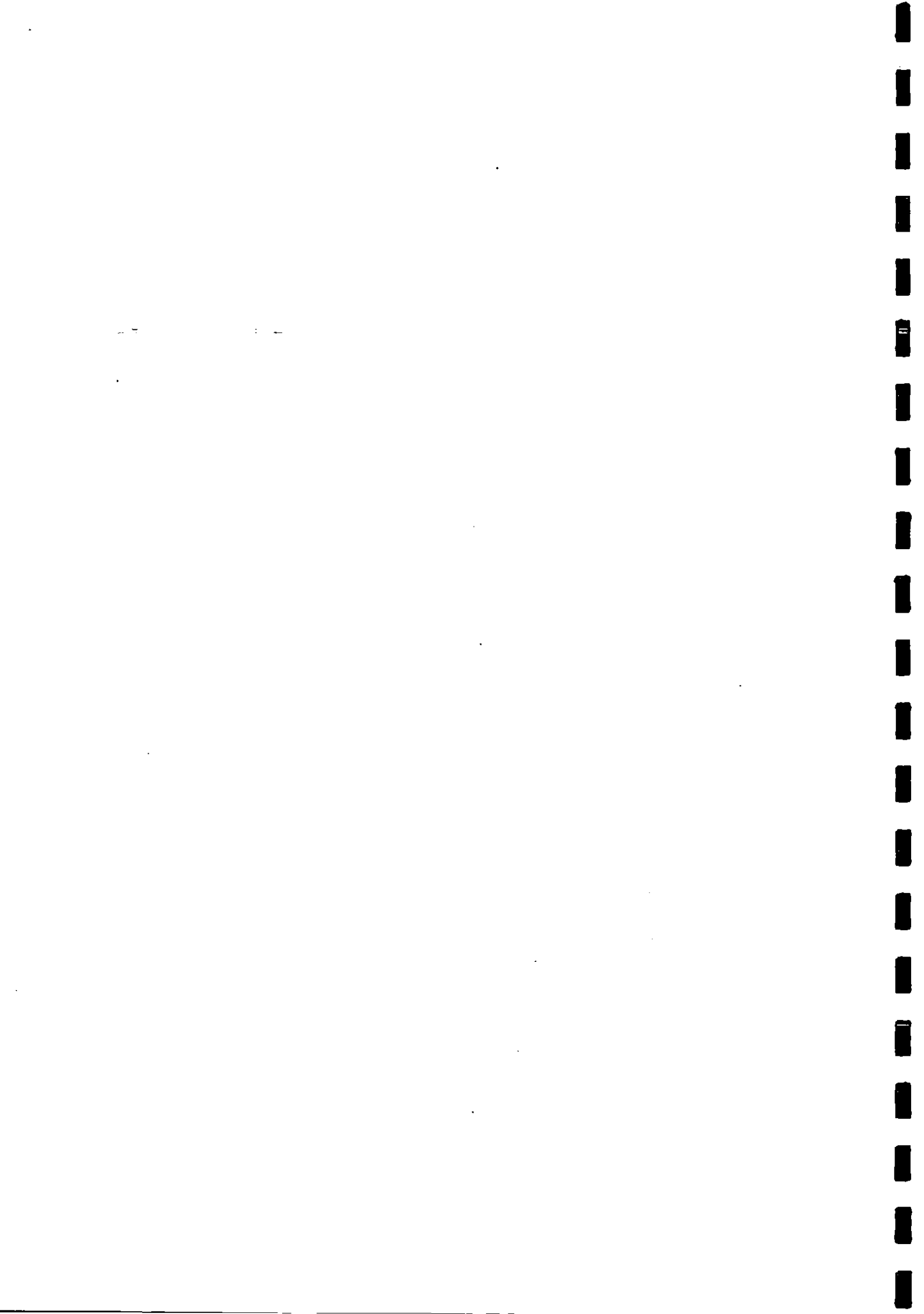


of the upper and lower 7^s are erupted and approximately one third of the L 5^s.

Slide 16.

Erupted Teeth (per cent).

Age	12	13	14	15
u4	85	93	97	98
u5	65	79	90	95
u7	49	67	91	98
L5	56	71	86	92
L7	59	77	93	98



It is not until children have reached the age of 15 or so that all posterior teeth are erupted and of course it will be some time after that before full contact points are established. We know that teeth are particularly prone to caries for a few years after eruption and we also know that during this time they are particularly amenable to some preventive techniques. This high incidence of dental caries during the ages 13 - 16 is borne out in many studies. In the National Study conducted here in 1964-'65 the average caries experience at the age of 17 was 11.5 D M F T. At the age of 12 the figure was 5.9. In other words almost 50 per cent of the caries experience of 17 year-olds occurred between

Slide
17

the ages 13 to 17. In the case of caries therefore, both from the point of view of its prevention and early treatment there is a strong argument to be made for regarding 13 to 17 year-olds as a major priority; that it would be a sound investment to include them in a comprehensive dental care scheme. Indeed it could be argued that 13 to 17 year olds are a greater priority than say 4, 5, and 6 year-olds or 8, 9, and 10 year-olds. With regard to periodontal disease there are again strong arguments to be made for inclusion of young teenagers in a dental service.

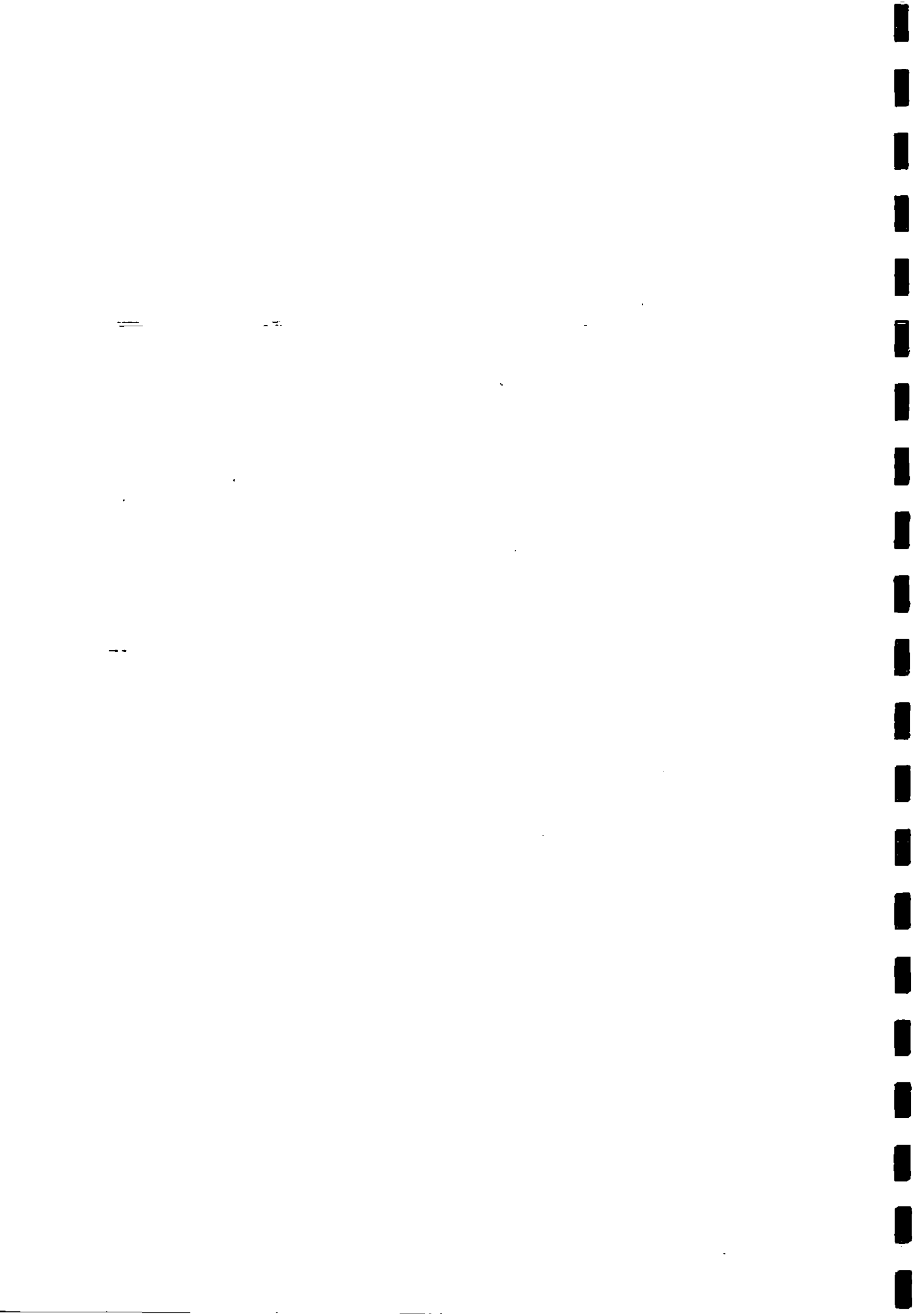
Slide 17.

Caries Experience Ireland.	
Age	Mean DMFT
12	5.9
17	11.5

We know for instance that early bone loss is
 already present in a *sizeable* ~~large~~ proportion of this age
 group and we also know that teenagers are particularly
 amenable to advice on *oral hygiene* ~~oral hygiene~~ practices. *PAUSE* ↑ The
 priority rating that should be accorded to different
 age groups in a dental service could be easily the
 subject of one or more entire lectures and seminars.

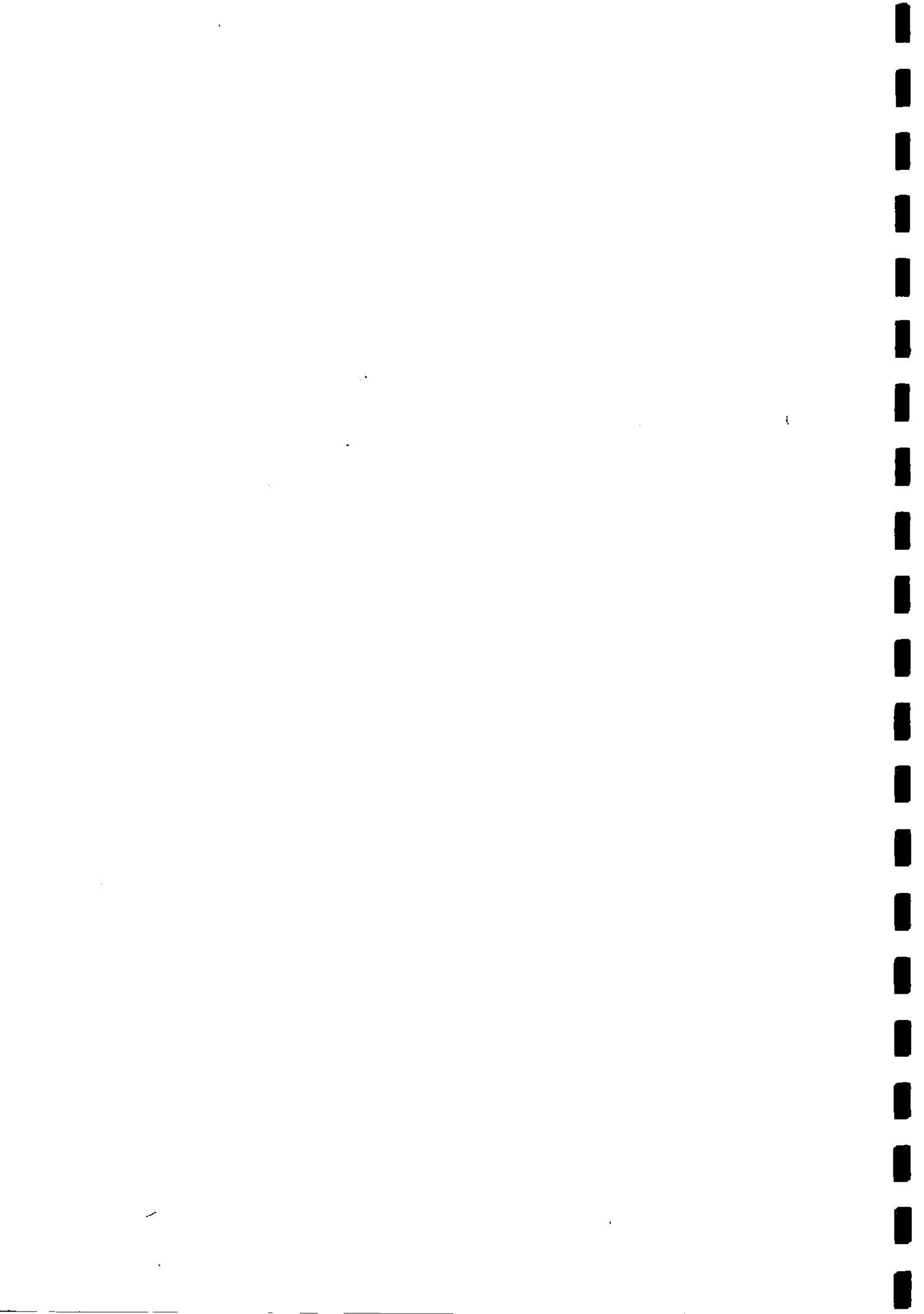
However at this stage I hope I have made the point
 that it is difficult to justify the present position
 whereby teenagers occupy the lowest priority rating in which
 less than 40 per cent of 13 to 16 year-olds are
 eligible for dental treatment and *less than 10* per
 cent ~~actually receive~~ it.

In conclusion may I summarise briefly what
 I have been saying. *1* The system of providing
 dental care in Ireland has some characteristics



Preventive approach

which are common to many other countries. (2) How effective this system is in preventing and treating dental disease and in achieving the long term aim of any dental service, namely the retention of all natural teeth, is not known. We lack basic information at this stage. This kind of information is required not alone to let us know where we are but also to allow us to evaluate later any changes that are made. (3) I pointed out that even though the present need and demand for dental care is not known we do know that they are not being met at this stage. I suggested that the future need for dental care ^{in children} could well fall and that the type of treatment needed could alter, particularly as



a result of a reduction ^{to 70%} ~~in~~ loss of ~~teeth~~. ⁽⁴⁾ In common
 with many other countries we are short of dentists
 and it is difficult to predict how quickly this
 will be solved but it will. We have a particular
 problem of unequal distribution of dentists and
 on the evidence we have available it would seem
 that this is much less amenable to a solution;
 that even with a major increase in the number of
 dentists some areas will still be without reasonable
 numbers. (5) Finally in a state such as ours whose resources ~~are~~
 unlikely to permit a complete and comprehensive
 dental care service for all it is important that groups
 selected for care are selected on rational grounds
 to ensure the best investment for money. ^{over a 1/2 century}

Thank you for your attention.