Minutes of the meeting of the Western Health Board 8th January 1980 Part 3

6.23.1 The present need and demand for full dentures:

At present there is a considerable backlog of Medical Card holders requiring full dentures. In order to overcome this problem the Working Party has recommended (see para 5.11) that the services of private practitioners be used to an increasing extent by health boards with the specific remit of catering for adult Medical Card holders. It is expected that this will eliminate waiting lists for full dentures in a short period.

6.23.2 The future need and demand for full dentures:

Trends in other countries indicate that the development of preventive and treatment services, together with improving standards of living, will result in an increasing number of persons retaining some or all of their natural teeth throughout their lifetime. Hence, the need and demand for full dentures is likely to decrease. If the Working Party's recommendations for a committed preventive approach and for a wider availability of dental services are implemented, this trend is likely to become apparent in this country also.

In the circumstances therefore the Working Party does not recommend the introduction of denturists. In making this recommendation the Working Party is aware of the need for on-going evaluation of treatment needs, including the need for full dentures

Dental Hygienists

The role of the dental hygienist relates essentially to the preventive aspects of dental care involves the giving of instruction both to individuals and groups on preventive care measures, such as, oral hygiene, diet and dental health education in general. While the dentist is responsible in these areas, he is unlikely to have as much time at his disposal for this aspect of dental care, because of the increasing claims on his clinical knowledge and skills. He may also lack training in communication techniques. The dentist must, therefore, have the support of key auxiliary personnel, such as, hygienists.

Accordingly the Working Party recommends that:

6.25.1 provision should be made for the training and employment of dental hygienists who would work to the prescription of a dentist;

6.25.2 the primary function of the dental hygienist must lie in the field of disease prevention in the community and in the individual. Training

/25

as an educator is, therefore, essential. Clinical training is also required. This must cover the prevention and control of dental caries and periodontal disease.

6.25.3 dental hygienists should be trained in an undergraduate school alongside dental undergraduates;

6.25.4 the requirements for enrolment should be as for university entrants (or equivalent qualification) and such additional requirements as the particular dental school may lay down from time to time.

6.25.5 the training curriculum should be decided by the appropriate authority in discussion with the Department of Health, the health boards and the Irish Dental Association. In deciding on the training curriculum, regard should be had to the training provided for hygienists in other countries, particularly in Europe and North America. Particular regard should also be had to the role which hygienists would fulfill in the public health field in this country;

6.25.6 the scope and nature of the duties and the training envisaged for hygienists in this country would seem to indicate a training course of more than one year's duration. However, more information and advice is needed before a firm recommendation can be made.

6.25.7 it is desirable that dental hygienists should be registered with the Dental Board or other appropriate body.

6.25.8 dental legislation should be amended as soon as possible to enable these recommendations to be implemented.

Expanded Duty Dental Auxiliaries:

This category of auxiliary was developed in the U.S. and Canada. They are trained to carry out limited and clearly defined reversible procedures including the taking of radiographs and impressions, the placing of matrix bands, rubber dams and temporary restorations. At this stage, the Working Party recommends that no action on this category of dental auxiliary be taken but that developments in other countries should be monitored.

/26.....

Dental Therapists:

This category may be divided into two main groups-

(a) The New Zealand School Dental Nurse and

(b) The (New Cross) Dental Therapist

The essential difference between the two groups is that the New Zealand School dental Nurse works independantly of the dentist whereas the (New Cross) Dental Therapist works under the direction of a dentist. Both groups carry out clearly defined clinical procedures on children.

The Dental Profession in this country is overwhelmingly opposed to dental procedures in the mouth being carried out by auxiliaries unless this is on the prescription and under the direction of a dentist. They are, therefore, opposed to the introduction of New Zealand Dental Nurses or similar type auxiliaries into this country.

The Working Party accepts this view at the present time. However, on available evidence it would appear that irrespective of overall future increases in the number of dentists practising in this country, certain regions may continue to have unfavourable dentist/population ratios. Accordingly, the Working Party recommends that a demonstration study should be undertaken with a view to determining the feasibility of employing New Cross Dental Therapists in the Public Dental Service to carry out prescribed procedures and treatments for eligibile persons under the age of 16 years in areas with unfavourable dentist/ population ratios. An outline of a proposed study is attached (Appendix 4).

/27.....

HOSPITAL DENTAL SERVICES

The Provision of Secondary Dental Care

In the daily practise of Dentistry, the majority of patients presenting can be treated adequately by a dentist with normal training and experience and hence form the primary care aspect of dentistry. However, a number of patients, either because of a complication in the nature of the treatment or because the condition requiring treatment is rare, need to be referred to a dentist with special training and or experience. These latter patients represent the secondary care aspect of dentistry. The inadequacies in the provision of secondary care in Ireland were highlighted in a Report on the Hospital Dental Services by the Irish Committee on Higher Training in Dentistry which was presented to the Minister for Health by Professor N.P. Butler in 1978. In order to provide adequate treatment for those patients requiring secondary care, the development of 4 clinical specialties has been considered by the Working Party

Oral Surgery/Oral Medicine

At present, the ad hoc arrangements for patients requiring treatment in these disciplines vary throughout the country. While some services are provided in a number of centres around the country, the overall organisation is not sufficiently comprehensive. It is necessary, therefore, to establish consultant services at major centres.

The Working Party recommends that initially four consultant posts in Oral Surgery be established at major centres. In due course further posts may be necessary, including the making of paired appointments to ensure continuous consultant coverage. Since oral surgery facilities already exist to an extent in both Dublin and Cork, it is recommended that immediate priority in the expansion of the service should be given to the rest of the country with specific reference to the needs in the Western areas. The posts in the Eastern and Southern Health Board areas should be located in Dublin and Cork respectively and should be linked with arrangements to provide a training pathway for future consultant training. Accordingly, each of the consultant posts in Dublin and Cork should have clinical support staff which would provide training opportunities for persons aspiring to consultant status. It is envisaged that clinical support staff for the remaining consultant posts could be provided by Health Board Service personnel who have particular aptitude and training in oral surgery.

/28.....

In the case of Oral Medicine, the Working Party is aware that facilities for the diagnosis and treatment of conditions such as oral cancer and other pathological conditions are inadequate at present. It is recommended therefore that one consultant post in Oral Medicine be created, initially with the specific remit of establishing the level of oral pathology in Ireland and of setting up a national referral, diagnostic and treatment service for oral pathological conditions.

Orthodontics

At present, the arrangements for the referral and treatment of orthodontic patients vary in each health board area. In most areas, private practitioners who specialise in orthodontics are employed on a fee per course of treatment basis. At present the demands for orthodontic treatment, particularly those requiring more complicated therapy, are not being met and considerable waiting lists have built up in all areas. The Working Party recommends that to meet the immediate situation, five full-time consultant posts in orthodontics should be created on an appropriate population distribution basis. The posts in the Eastern and Southern Health Board areas should be located in Dublin and Cork respectively and should be linked with arrangements to provide a training pathway for future consultant training. Accordingly, each of the consultant posts in Dublin and Cork should have clinical support staff which would provide training opportunities for persons aspiring to consultant status. It is envisaged that clinical support for the remaining consultant orthodontists could be provided, in the first instance, by health board dental personnel who have particular aptitude and training in orthodontic procedures. Where such assistance is not available or is inadequate to meet the demand, it is recommended that consideration could be given to the involvement of private practitioners who possess orthodontic qualifications. It is envisaged that the holder of the consultant post in Dublin might be required to develop a national service for the care of severe cleft palate cases and that he should accordingly possess or acquire the necessary specialist expertise in that aspect of orthodontics.

Paediatric Dentistry

This specialty covers dentistry for the child patient and includes the care of mentally, physically and medically handicapped children for whom dentistry or dental disease is a major clinical problem. Example of patients in this category are institutionalised handicapped patients, Down's Syndrome patients and patients suffering from

/29.....

various blood disorders for whom dental treatment presents a serious hazard.

The services of the paediatric consultant may also be utilised in the care of adults who, by reason of medical, physical or mental disability are unable to care for their own teeth.

The organisation arrangements in this country for the dental care of the handicapped patients described above is inadequate at present. The creation of consultant posts in this discipline would offer a solution at this time. It is therefore recommended that two consultant posts in paediatric dentistry to serve the whole country be created in Dublin and Cork and advertised as soon as possible.

Restorative Dentistry/Periodontology

These specialities cover certain categories of patients whose treatment involves the fitting of highly sophisticated appliances and prostheses. For example, in the long-term care of cleft palate cases, as well the services of orthodontists, oral surgeons and plastic surgeons, the inclusion of a specialist restorative dentist in the team approach is also recommended. At present the extent of the need for a specialist service in resporative dentistry is difficult to assess. Unti such time, therefore, as the extent of the need becomes clearer, the Working Party recommends that in order to provide the service needed at this stage, arrangements be made with the appropriate specialties in the two Dental Schools and that the possibility of joint hospital/university appointments be considered.

Periodontology forms part of the training pathway of restorative dentistry as laid down by the Committee for Higher Training in Dentistry. Periodontal disease is a slow progressive disease and is estimated to affect over 90% of the adult population in whom it is a major cause of tooth loss. Individual advise on oral hygiene procedures is now regarded as more effective in halting or slowing its progress than periodontal surgery, which was the treatment of choice up to recently. Of course periodontal surgery is required in certain cases but a large part of this can be regarded as routine 'primary care' dental

/30.....

surgery. The extent to which the services of consultants are required to provide and develop secondary care is not clear. Until such time, therefore, as the extent of the need for periodontal treatment at secondary care level becomes clearer, the Working Party recommends that, in order to provide and develop a service at this stage, arrangements be made with the appropriate personnel in the two Dental Schools and also recommends consideration of the creation of a joint Hospital/University appointment in this specialty.

Support Staff

It is anticipated that it would be impracticable to provide each consultant post recommended above with the usual training hierarchy of house officer/registrar/senior registrar staff, as this would in effect mean the training of more consultants than could be absorbed by the service. In the case of the recommended posts in Oral Surgery/Oral Medicine and Orthodontics, it is recommended that two in both disciplines should have the trainee support staff and that these be based in Dublin and Cork. In the case of other posts in Oral Surgery/Oral Medicine Orthodontics Paediatric Dentistry and, it is recommended that support staff in the first instance be provided by the health board dental personnel who have a particular experience and/or training in the area in question. However the question of manpower requirements and trainee and support staff for all consultant posts should be reviewed within two years.

Provision of Primary Care

The provision of primary dental care in a hospital environment arises when services are provided for special category patients, such as those in long-stay special hospitals and those requiring general anaesthesia for the carrying out of certain procedures.

There are three main groups of patients in this category:

7.12.1 Patients in long-stay hospitals

As for other sections of the population this group requires a dental treatment service. At present, the arrangement for providing this service varies in each area. While the services are provided in a number of centres, the overall situation needs to be improved. The Working Party therefore recommends that health board dental surgeons be facilitated in making arrangements for providing dental care for eligible patients in long-stay hospitals.

7.12.2 Patients requiring primary care treatment services under general anaesthesia;

The frequent use of general anaesthesia when carrying out procedures

such as extractions demands that some aspects of primary dental care be provided in a hospital environment on a day stay basis. The efficient use of these day care centres requires further investigation. The Working Party recommends that the administration of general anaesthesia in dental surgeries should be discontinued unless adequate treatment and recovery facilities are provided.

7.12.3 Patients with medical/surgical problems

Such patients are the responsibility of the appropriate consultants, but health boards dental surgeons should be facilitated in making arrangements for providing the necessary dental care.

The health board dental service facilities in some health board areas for carrying out routine treatment, such as extractions, under general anaesthesia are inadequate, but proposals to improve the situation have been or are in the process of being formulated. However, it would appear that the measures proposed vary enormously as between health boards; the most notable variation being the extent to which general hospital beds are felt to be required.

The Working Party makes the following observations with a view to providing health boards with guidelines as to the facilities required.

Waiting and Reception Area:

7.14.1 An adequate waiting and reception area must be provided.

Assessment and Preoperative Area:

7.14.2 As the Anaesthetist will not have seen the patient prior to attending for treatment in most cases, an assessment area must be available at the time of the general anaesthetic. In many centres this area could be shared with other disciplines.

7.14.3 The Dental Surgery:

It is now widely accepted that anaesthetics are best administered when the patient is in the horizontal position. Therefore, in dental surgeries where treatment will be carried out under general anaesthesia, it is essential that the dental chairs/couches be capable of being adjusted to the horizontal position. From an anaesthetic point of view, the clinical facilities required are fairly standard

involve certain health board dental surgeons in extra duties of a higher clinical nature. Such a development would present grounds for consideration being given to an improvement in the career structure of the health board dental services.

The Working Party is aware that some concern has been expressed about the hazards to which dental personnel and dental patients may be exposed during the practise of dentistry. In addition to the usual hazards such as mercury contamination, dental personnel may, for example, be exposed to radiation in consequence of the more widespread use of x-rays and to the toxic effects of some sedatives and anaesthetic agents used in routine dentistry. There is also the risk of infection by hepatitis B surface antigens (HBsAg), either from known carriers or from those patients who are known to be specially at risk of infection with the disease. In the case of hazards to patients, the modern practice of treating them in the horizontal position requires that additional care be given to protecting the eyes and the airways during treatment. The Working Party recommends that an appropriate authority such as the Department of Health should issue guidelines on these matters to health boards and other relevant agencies from time to time.

The conditions of employment attaching to consultant dental appointments must take account of the responsibilities and duties attaching to the posts but should not be less advantageous than those attaching to similar medical consultant posts. Dental consultants should have the support of full ancillary services.

Consultation with the Irish Committee for Higher Training in Dentistry is considered desirable when the professional qualifications for appointment to consultant dental posts are being laid down. Medical qualifications should not be prescribed as essential qualifications.

It is recommended that in the planning of new hospitals appropriate facilities be made for dental treatment.

Where a health board dental surgeon is providing a specialist service, it is necessary that adequate and appropriate facilities be made available to him.

Social Welfare Dental Benefits Scheme

Persons insured under the Social Welfare Acts who satisfy certain contribution requirements are entitled to dental services from a dentist of their choice, if he has entered into an agreement to provide services under the scheme and is

./34.....

accordingly listed in the Dental Panel of the Department of Social Welfare.

Panel dentists are paid on a fixed fee basis for services other than the provision of crowns, inlays, bridges and chrome cobalt denture.

Eligible persons are provided with services such as fillings, extractions, scaling and polishing, free of charge. They have to pay a proportion (2/3rds) of the cost of dentures and in the case of crowns, inlays and bridges, they pay the balance of the cost in excess of the subvention paid by the Department of Social Welfare. Persons with dual entitlement under the DSW scheme and the health board service are generally refunded by the health board for any costs which they incur through availing of services under the DSW scheme.

There are approximately 650 dentists on the DSW Dental Panel. The number of eligible persons is of the order of 826,000.

There are in general relatively few complaints about the availability of services under the DSW scheme. An eligible person who is unable to obtain treatment in his own area may be allowed travelling or other expenses necessarily incurred in going to a convenient local centre where such treatment is available from another dentist on the DSW Panel.

Fees and range of procedures covered

The dental profession has been seeking an increase in the range of procedures available under the scheme, as well as a re-structuring of the fee basis and an increase in the level of fees. The present fee structure does not provide for payment in respect of clinical examinations and reports, except where a patient does not return for treatment or no treatment is prescribed. There have been considerable developments in clinical practice and procedures since the fee sturcture was originally drawn up. The dental profession considers that it is necessary, on ethical grounds, and for good patient care, that these practices and procedures should be followed, where indicated, and that appropriate levels of fees should be paid to the practitioner. In addition, it has been represented by the profession that the existing scale of fees requires to be restructured to take account of current dental practice needs. These proposals for improvements in

Furthermore, it is felt that as dentistry is a health profession the administration of the present dental welfare scheme could be best carried out by the Department of Health, so that all dental care of the community would be under the same administration.

Dental Schools

The Working Party recognises that a number of the recommendations in this report will have direct implications for the Universities and the Dental Schools and will stretch considerably the existing resources available. This situation will have to be rectified if the recommendations are to be implemented effectively.

APPENDIX 1

IRISH DENTAL ASSOCIATION

THE ROLE OF PREVENTIVE DENTISTRY IN THE PUBLIC HEALTH SERVICE

C.E. COLLINS.
M.D.S., F.D.S., F.F.D.,

8th September, 1978

The Role of Preventive Dentistry in the Public Health Service.

The need for prevention.

At present in the Republic of Ireland 520,000 children attending National Schools are eligible for free dental treatment. In addition children under 6 years of age, attending child welfare clinics are eligible. Furthermore eligible adults (holders of Medical Cards, and their dependants) are similarly entitled. In 1977 32% of the population (1,220,000 people) fell into this last category. There is at the present time the equivalent of 222 whole time Public Dental Officers to cater for these groups. This number is not adequate to cater for even the National School children, nor would it be adequate if double this number of dentists were made available. This inadequacy is primarily due to the high incidence of dental diseases which brings about an accumulated back-log of treatment need. The public dental officer is faced with this back-log.

The fact is however, that if the public dental officer confines himself to carrying out treatment procedures he will never bring about a reduction in the incidence of major dental diseases in the community. In the case of dental decay in school children for example, if the incidence of the disease (i.e., the number of new lesions per child per year) remains unaltered, then, whether treatment is given or not, no improvement in the total disease experience of school children can be expected. If a very large number of dentists are engaged in treating the whole group then the children who become too old for eligibility and leave the group may have more teeth, but the amount of disease experienced by the group as a whole remains the same.

Measures which lower the incidence of the disease achieve a permanent reduction in the size of the problem. With several such measures operating simultaneously very important improvements can be brought about, making it possible to clear the back-log and reach a situation where future increments of disease will be small enough to be managed satisfactorily. Whether this approach is applied to an individual by a dental practitioner, or to a community by a Public Dental Officer the philosophy involved is the same. When treatment is given to an individual or a group in the absence of prevention it appears an unsatisfactory ad hoc service, poorly planned and lacking awareness of the problem which it sets out to solve.

When treatment is carried out within a framework of a service where every preventive measure is enthusiastically pursued, it becomes rational rather than empirical, gives maximum satisfaction to the patient, and the operator, and has greatly enhanced prospects of success.

Why is Prevention not more widely practised?

It is sometimes suggested that prevention is not more widely practised because the financial return to the dentist is poor. This may be the case within the Social Welfare Scheme as it is at present in this country. But there are many patients who would willingly pay for a preventive service if its advantages were made known to them. Similarly, the Public Dental Officer receives the same salary whether he practises prevention or not. The explanation then is not purely financial.

The proportion of undergraduate time spent learning how to maintain health is small, compared to that spent learning how to treat disease. The result is a graduate more competent in treatment than in prevention. Whether he engages in practise or in public health his skills and deficiencies will be the same. (It should be noted that at the present time no post graduate training is required of the dentist who wishes to work in the field of public health).

Traditionally, the dental surgeon is expected by the community to relieve pain, and to restore comfort, function, and appearance. The healthy patient seldom presents, and if he does, a different philosophy is required from the dentist if he is to maintain the dental health of the patient.

Lack of training on the part of the dentist and lack of awareness on the part of the community are therefore suggested as important factors in limiting the spread and acceptance of preventive dentistry. Responsibility for both factors must be borne by the dental profession.

Techniques of Preventive Dentistry

Preventive dentistry can be practised on the community, on groups within the community, and on individuals.

At community level fluoridation of public water supplies, mandatory in this country, is the most important single preventive measure in the control

of dental cares. It is to be hoped that the practical difficulties (e.g., difficulties of supply) which have arisen in some cases, will be overcome, and that a standardised reliable method, together with some study of the effectiveness of the measure on a nationwide basis, will become the rule.

For school children without public piped water supplies fluoride mouth rinse schemes have been suggested. Evidence is available of the effectiveness of fluoride mouth rinsing under controlled conditions. If the measure can be shown to be cost-effective under everyday conditions in areas where close supervision by numbers of trained personnel would not be possible then the measure must be given very serious consideration.

Apart from the use of fluorides the second approach to improving community dental health is by education. Here the objective must be to make it possible to maintain health and prevent and control disease. This is clearly the function of the Health Education Bureau in consultation with the dental profession. The result of a successful Education Campaign must be to make dental health socially desirable, and to motivate the individual to seek detailed instruction, advice, and if necessary treatment of his or her individual dental problems.

In the case of smaller groups within the community (e.g., children, parents, or groups with some common interest) more detailed instruction (e.g., the techniques of oral hygiene, dietary factors in dental disease) can be given by expert personnel drawn from the dental profession.

In the case of the individual, preventive dentistry may be operative (e.g., prophylaxis, scaling, treatment of periodontal disease, topical fluoride applications, sealing of fisseres against carious attack) or educational. Individual education in diet, oral hygiene techniques and the maintenance of dental fitness is a highly skilled undertaking, involving as it does the imparting of precise factual information on a broad spectrum of topics together with the motivating of the individual to use these facts positively in a daily dental health programme designed to last for life.

Who carries our preventive procedures?

In this country at present all operative preventive measures must be carried out by the dental surgeon. If adequately trained hygienists are introduced these procedures can be carried out by the hygienist as a part, but by no means all of his or her duties. It can be argued that topical application

of fluorides, fissure sealing, scaling, and prophylaxis for example, may be more efficiently performed by someone whose training has placed special emphasis on these procedures than by a dental surgeon.

It would be a mistake, however, to suppose that these are the principal duties of the dental hygienist. In the United States and Canada the hygienist has a three year training which leads to a University Diploma and the community status of a recognised profession. This training is designed to produce a professional person skilled in certain aspects of operative dentistry, but skilled also in communication, capable of playing a vital role in health education programmes and equally at home, in the detailed instruction and motivation of an individual patient, or in conveying the principles of oral health to a group or community. Without adequate training and status, the hygienist is incapable, and may be reluctant to engage in community dental health programmes.

In the United Kingdom the dental hygienist receives a training of less than one years duration. (Training to become a Registered Animal Nursing Aurillary is a two year programme).

At present in the United Kingdom recruiting of dental hygienists to work in community dental health is said to be very difficult.

Adequately trained dental surgeons and hygienists, sharing a common philosophy, can form an effective team, whose objective is to achieve and maintain dental health in the individual and the community.

An opportunity for positive progress in the field of preventive dentistry exists in Ireland.

****

ATTACHMENT 2

December 1970

Working Papers

Need and Demand for Dental Care

Dental Manpower

Dental Auxiliary Personnel

Department of Health

1. Introduction.

Dental auxiliary personnel to provide certain specified treatment items in the Dental Care of patients have been introduced in many countries throughout the world in the past fifty years. There has been considerable confusion about the titles of the various categories and about the job specifications of each. Recent efforts to clarify this confusion must be welcomed (Allred 1977 Butler 1978). The rationale for the introduction of dental auxiliary personnel in each country has invariably been based on a desire to solve one or both of the following two problems:-

(1) Unsatisfactory dentist to population ratio.

(2) Unequal distribution of dental manpower.

Both of these problems have come to light because the need and more forcefully the demand for dental care is unmet either nationally (1) or locally (2). This understandable sequence of events would also appear to have occurred in Ireland and has led to the past and present discussions on the use of dental auxiliary personnel. Before a decision is made to introduce particular categories of dental auxiliary personnel it is important to be clear on the nature and extent of the procedures they will be expected to perform; in order to be clear on these points the present and projected need and demands for dental care must be considered in relation to the present and projected dental manpower numbers and manpower distribution available to provide it.

2. The need for Dental Care:

2.1 The Present Need

The inadequacies of traditional indices of dental disease such as DMF

and Russells Periodontal Index as measures of treatment need in a community are now internationally recognised (Davies 1977) and Dental epidemiologists have recently been concentrating on developing methododologies for treatment need surveys.

Though a number of traditional surveys of dental health in Ireland have been conducted, only one could be located which had been conducted with the specific objective of estimating dental treatment need rather than simply the state of dental health. This survey of a representative sample of the National School population in Co. Donegal was reported by Gallager (1974). The principal aim of this investigation was to devise a method of conducting a treatment need survey in a rural community by using the methodology developed. The findings suggested that a major part of the treatment needed in the community studied could be provided by auxiliary personnel under the direction of a dentist. Whilst the findings are interesting the inferences that can be drawn are limited.

Little is known therefore about the present need for dental care in Ireland.

2.2 The Projected Need.

In a recent survey in Newcastle-Upon-Tyne in the U.K. it was found that the cost of dental treatment needed in a group of five-year-old children living in a fluoridated area was over 50% less than in a comparable group in a non-fluoridated area; also there was a 45% reduction in episodes of toothache and a 45% reduction in general anaesthesia for extractions (Carmichael & Rugg-Gunn 1977). Similar findings have been reported elsewhere in Britain and the world. They suggest that given successful implementation in Ireland of fluoridation of water supplies the projected treatment need in

say 20-25 years could be considerably less than at present. Other preventive methods, such as fluoride tablet schemes could theoretically have a similar effect (probably less) on treatment need. However until studies of the effect of fluoridation on the treatment needed for e.g. caries, periodontal disease and orthodontics are undertaken in Ireland the projected treatment need must remain conjectural.

3. Demand for Dental Care.

3.1 Present Demand.

Increase in the uptake of dental care is a phenomenon repreatedly found to be associated with an increase in standard of living. Whether this increase is due to an increase in demand for dental services or due to an increase in the availability of dental services is subject to some debate. There is some evidence at the moment to suggest that it is the latter; that irrespective of the standard of living or social class structure of a community the uptake of dental services is to a great extent dependent on the availability of them. (O'Mullane & Robinson 1977). For that reason it is perhaps unwise to place too much emphasis on the length of waiting lists as a measure of the demand for dental services. Nevertheless, at the moment, this is probably best measure of demand for dental services in Ireland. Even though they underestimate the demand, waiting lists give some indication of the situation at present.

In table 1 the number on the waiting lists and the waiting periods for treatment under the health board services in Dublin are presented. Similar figures for Donegal are presented in Table 2.

Table 1

Health Board Services. Number on Waiting Lists and Waiting Periods for treatment in Dublin.

	Number Waiting		Waiting Period	
Category	Adults	Children	Adults	Children
1	3,400	8,000 (Appt.)	2 months	1-5 months
2	71	2,000 (No Appt.)	5 "	5-0 "
3	363		9 "	
4	568		12 "	

Table 2

Health Board Services. Number on Waiting Lists and Waiting Periods for Treatment in Donegal (N.A. = Not Available).

	Number Waiting			Waiting Period	
	Adults	Children		Adults	Children
Priority	7,000 for treatment 3,000 for Dentures	N.A.	Priority	2 weeks for routine treatment 3-5 months for Dentures	Extractions: Up to 4 weeks Fillings: 2-18 months
Non Priority	N.A.		Non Priority	5-6 yrs.	

Even though the method of presenting the figures is not consistent it would appear that the waiting period for treatment in Dublin is considerably less than in Donegal. The figures for these two counties are examples of the wide variation in the demand for treatment as measured by waiting lists. This variation as well as indicating a true state of affairs could also be partly explained by policy differences between counties on the compilation of waiting lists, the frequency of school inspections and the content and extent of dental health education.

A further indication of the demand for dental services is the proportion of the eligible population who avail of treatment under the Public Dental Service and the Social Welfare Scheme (O'Rourke 1976). It would seem that overall, this proportion is very low in Ireland. 'However as pointed out earlier the uptake of dental services as well as being an indication of the importance the population attaches to dental care is also dependant on the availability, accessibility and acceptability of dental services.

A third measure of demand for dental care is the number of complaints received concerning the inadequacy of services. It is not known whether these are increasing or decreasing at present.

Despite the fact that the level of demand for dental care in Ireland is uncertain at present, the general impression gained is that it is considerable and that it varies considerably between and within counties.

3.2 Projected Demand

In common with other countries the demand for dental services is likely to increase with increasing standard of living. The extend of this increase in Ireland is likely to be related to such factors as the efficiency of fluoridation and dental manpower numbers.