Scottish child dental health is improving

Results of the 2006 Scottish National Dental Inspection Programme have been published by Scottish Dental Epidemiological Co-ordinating Committee. The key child age groups are at entry into school in primary one (P1) and in primary seven (P7) before the move to secondary school. In the school year 2005/06, the main focus was P1 children and the results from that work give an indication of dental health in that child age group.

The proportion of P1 children with no obvious decay experience:
Across Scotland, 54% of P1 children were found to have no obvious decay experience—this is a further improvement on the 51% seen in the same age group in 2004 and 47% in 2003. The range across the fifteen NHS Boards was 47% to 68%.

Dental caries experience (DMft) for Scotland:
The mean number of decayed (d), missing (m) and filled (f) teeth (t) per child was 2.16, a continuing improvement over the figure of 2.56 and 2.76 found in the 2004 and 2005 surveys respectively. The DMft range across the fifteen NHS Boards in 2006 was 1.51 to 2.68.

Trends over time:
There is an improving trend over time in the percentage of P1 children who showed no signs of having decay or restorative treatment of decay in any of their deciduous teeth. P1 children continue to make steady progress towards the 2010 national target of 80% having no obvious decay experience.

Depreciation:
The strong association between deprivation and dental disease seen in previous surveys is still apparent in 2006. P1 children in deprivation categories (DepCat) 1, 2 and 3 have already exceeded or nearly reached the national target, while children in the remaining groups are well below this. However, when compared to earlier surveys of this age group, children in DepCat groups 4, 5 and 6 show continued improvement over previous years, while those in DepCat 7 are a little lower than the 2004 NDIP survey.

Conclusions:
In the event of local and national oral health initiatives undertaken in recent years, these improving trends hold the increasing proportion of P1 children with no obvious decay experience and the decreasing average number of teeth affected by disease are very encouraging. It is to be hoped that these trends will be maintained in future years.

Responding to the findings, BDA Director for Scotland Andrew Lamb told Dental Tribune: “The increased percentage of children in Scotland with no obvious signs of tooth decay is welcome news. However, huge inequalities exist between children with the best and worst oral health and more must be done to help all four children grow up with smiles they can be proud of. The Scottish Executive must address the significant problems facing NHS dentistry in Scotland. The declining number of practices that provide NHS dentistry but are not deemed to be committed to the NHS is a serious concern and urgent attention is required to resolve this problem.”

More detailed information regarding the dental health of P1 children will be available in the full 2006 report of the National Dental Inspection Programme of Scotland to be published later in 2007.

Better dental care for US forces’ families

After years of bitter complaints, the European Regional Dental Command is hoping to make dental care less of a headache for military family members. U.S. Army Europe officials are seeking Pentagon approval to provide families with a list of ‘pre-favored’ providers local European dentists prove competent and dental advisers to help with questions and insurance paperwork.

Only dentists who do not demand upfront payment and are willing to file claims directly to insurers would make the list. “Our soldiers and their families should not be forced to guess about the quality of their overseas dentists, nor should they have to pay re-imbursement upfront,” said a letter signed by Gen. David McKiernan, USAFE-R commander, to the assistant Defense secretary for health affairs.

The letter points out that military families in the states insured through Tricare Dental Program have a quality-assured preferred provider network of dental advisers, and don’t have to pay the costs of the procedure upfront. Those in Europe don’t enjoy the same benefit. Because soldiers’ teeth come first, most family members nowadays must get their dental care off the record. They must seek out a local national dentist, whom they don’t know, possibly have trouble understanding and who demands payment upfront.

Go North West young therapist

From Alaska comes news that the University of Washington in Anchorage will be training dental therapists to work in villages where cavity rates are high and dentists are rare. Dental therapists will be able to examine patients, take X-rays, administer local anaesthetics, extract teeth and fill routine cavities, under the long-distance supervision of a dentist.

The Alaska Dental Society and American Dental Association objective is to get therapists working like this, however, and have a lawsuit pending in Anchorage Superior Court to try to stop people who aren’t dentists from ever filling or extracting teeth. The Alaska society supports training aides to prevent disease, president-elect Pete Higgins of Fairbanks Alaska, is pressing health officials but disagrees with their doing the rest of it. The two sides have been fighting over the issue for more than three years both in Alaska and Washington, D.C.

Alaska Native children get cavities at two and a half times the national average, according to a 1999 federal study, and few dentists are willing to set up shop in rural Alaska. The Alaska Native Tribal Health Consortium website says there’s a 25 percent vacancy rate for dentists in Alaska indigenous programs, and 30 percent annual turnover.

Eight dental health therapists trained in New Zealand are already working in rural Alaska and three more are nearly ready. The new training programme is funded almost entirely by the USA.

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