Guest Editorial: Quality care for children under threat

Over the past 50 years great advances have been made within Paediatric Dentistry for the dental care of children in many countries both in Europe and worldwide. As a result we can be justly proud that today most children, probably at least 80%, experience little or no dental caries and reach adulthood with acceptable primary and permanent dentitions. Thanks to discoveries and advances in preventive paediatric dental care, severe caries is confined to less than a fifth of children in most populations. We have evidence of which groups of children are more likely to be caries-prone and who are mainly located in disadvantaged groups. Those in dental societies/academies concerned with children’s oral health continue to work hard to develop strategies to bring quality care to this last 20%. We are not complacent about this and continue to strive, as clinicians, teachers and researchers to find ways of reducing the prevalence of dental diseases and improving oral health in children.

Thunderclouds are now unfortunately imminent, challenging the current systems of dental care for children and threatening to undermine the advances that have occurred in providing quality paediatric dental care with well researched outcomes. The suggested delivery of care, by our adversaries, appears to be at the level that was being provided in the UK and elsewhere in Europe before World War II. This statement is not made lightly because several reports in recent years have recommended changes to the way paediatric dental care is delivered, valued and paid for. These reports have completely ignored the considerable body of research showing the improved oral health-related quality-of-life outcomes that care achieves in the primary dentition. These challenges have come from within the dental profession and from government funding and private insurance agencies. The dentists who make these challenges appear to rely on misguided arguments that children do not suffer pain from teeth, that restorations in primary teeth do not survive, chronic infection is not a problem, quality of life is not affected by oral sepsis or that dental care for all children results in significant anxiety. For the funding agencies, these opinions are seductive as it encourages moves to reduce the costs of dental care in these financially hard times.

These adverse statements are appearing in many countries. Recently articles and statements have appeared in Ireland, The Netherlands and United Kingdom, amongst others within Europe, and worldwide colleagues report similar events in North America, New Zealand and Australia. The details of these claims that paediatric dental care is excessive fall into two groups.

Quality preventive and restorative oral health care is not necessary. In this approach dentists, some in private practice and/or some in dental public health state that attempting to restore children’s teeth is unnecessary for several reasons. A prominent claim is the hoary old one - ‘...primary teeth fall out anyway and therefore restoration is a waste of time’. The proponents of this view are largely dentists who have chosen not to develop skills to manage and treat children often because they do not like treating children or never treat children anyway. Those in family practice may want to keep the adults but do not have the patience or skills to care for the children but realise that having the children in their practices keeps the parents and other family members. Thus they take an avoidance strategy and salve their consciences with their non-treatment argument.

Recently some of the proponents of this approach to dental care of children have advocated ‘self-cleansing’. This means taking
a dental bur and slicing away the tooth structure of primary molars mesially and distally, so allowing saliva to access the carious surfaces and improve the chances of remineralising early lesions. What would our orthodontic colleagues think of the recommendation of the wholesale removal of the leeway space that nature has provided for the permanent dentition by allowing subsequent mesial drift? It is a totally obsolete idea.

Restoration of primary teeth is costly and not cost-effective. Those promoting this view come from different backgrounds including those who are providing some clinical care for children and those who are in management positions. Their motivation tends to be related to their budgets and financial constraints. These people know the cost of everything and the value of nothing, but appear to disregard the oral health related outcomes. They ignore or undervalue that the maintenance of a primary dentition in good function maintains the space for the eruption of the permanent teeth and decreases some of the risk of carries in the permanent dentition. By advocating this ‘supervised neglect’ they are sending a very clear message to people and particularly families that high quality dental care is unimportant and that oral health has no relevance to general health. It is difficult to understand how anyone in the dental profession could be trying to isolate oral health from the promotion of general health in this way, particularly for children.

In many European countries the dental care of children is provided by the state at government, national or local, cost. There is always the conflict that such agencies want care but at minimal cost. Those involved with managing this funding are required to ‘spend’ it wisely. But they appear in some instances to be failing in their responsibility to apply the finance related to the most appropriate outcomes when the very research that supports the care is either ignored, or dismissed. But short term savings in children inevitably will mean long term higher costs to deal with the ravages of dental disease in adults.

Other proponents of doing as little as possible for the lowest expense are located within funding agencies who always want lower costs. This ignores the longer-term increased costs of low quality care. It behoves these agencies to be supporting good quality research to investigate outcomes of care to support their funding models. It is totally negligent, especially when public money is being applied, to refuse funding because the evidence is not present. Where is their evidence that their funding is appropriate?

Speaking out. As paediatric dentists who care passionately about children’s oral health we must all be vigilant and speak out loudly and continuously to challenge these retrograde moves. As noted at the beginning of this editorial paediatric dental specialists have worked with determination in research, teaching and practice over many decades to provide excellent quality care for children. We must ensure that there is no going back and that we are not overwhelmed by those in our dental profession who diminish our specialty. It is curious that these challenges to care are not occurring for other patient groups and that they are being made against children who have no voice of their own. Children deserve nothing less than we act as their advocates in this. Within this issue of the EAPD are included a number of papers concerned with clinical care that will add to our ability to provide quality care. In addition, and uniquely, we publish, with permission, a paper from the Irish Dental Journal by David Finucane entitled ‘Rationale for the restoration of carious primary teeth: A review’. This paper is a most comprehensive discussion of the subject and substantially referenced. This is most pertinent to the developments outlined here and the Editors felt that it should be more widely publicised. Hence our inclusion of a copy of this paper herein. It answers many of the criticisms of our quality approach noted above and should be kept as a valuable resource statement of why quality really does matter.

Martin Curzon

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