nored that this could be partly canal work, because it needs to be acknowledged as an advanced restorative procedure that requires a high degree of skill. ‘The current system can put pressure on dentists to extract teeth, rather than restore them.’

However, if statistics do show more extractions, it cannot be ignored that this could be partly due to the new opportunities that have opened up because of implants. For example, a tooth of dubious prognosis, which previously one may have restored and warned the patient about its limited prognosis can now be extracted and replaced with a much longer-lasting, more predictable implant.

‘We are lucky to be in a fairly affluent area here, so can make up the cost of Endodontics through private work with some of our patients. But in a poor area, where there is minimal private treatment, the cost of root-canal treatment cannot be made up, which could encourage more extractions.

‘Not acknowledging the complexity of endodontics devalues the work dentists do.

A definite re-think is needed.’

Mark Pulford, commissioning dental lead for Heart of Birmingham Trust PCT, says the PCT does provide Endodontics. He adds: ‘We recognise that Endodontics is an issue, but having said that, this PCT is providing Endodontics. We will be working with our dentists including, and in particular, dentists with an interest in Endodontics, to see if we can support services in HORT, through a clinical network approach involving High Street dentists and secondary dental care colleagues. This is in order that future contracting can be influenced by our dentists, now that we are more than two years into the new contract. Our work will include looking at contract values and we certainly will not be paying any less.’

An endodontics expert said endodontics and the NHS was a very delicate topic which needed attention from political, social and economic viewpoints.

He said community health covered the whole of society and implied the primary right of the ill individual to be helped and reintegrated back into society. He says:

‘Endodontics is a dental specialty, which covers the treatment of healthy or infected pulp and periradicular diseases. Each diagnostic requires a different treatment approach.

The more advanced the disease, the higher the qualification requirements for the practitioner, the higher the material...
and instrumental involvement, the higher the time demands and, of course, the financial implications.

Endodontic treatment of a multiple-rooted tooth, presenting a chronic apical periodontitis, may require between one and half to two and a half hours of clinical work. Financial remuneration as offered by the NHS cannot cover this.

The NHS recognises the need for differentiation and accordingly covers treatment costs for GDP and endodontic specialists within the funding available. As science advances, the previously allocated funding cannot continue to cover the costs, but one cannot blame the system for not providing funding for everything.

Offering the patient an up-to-date diagnosis and all available treatment options, including the coordination of specialist referral services, represents the optimum standard of NHS care.  

Eddie Crouch, of dental campaigning group, Challenge, said the Department of Health included funding for Endodontics in the contract value, but he adds that, “the funding was based on a year that may have been typical or atypical.

‘We need to start looking forwards, focusing on the massive change going on regarding the growth of prevention, the increased number of new dentists coming out of UK dental schools and the commitment made by the NHS to commission enough services to enable anyone who seeks NHS dental care to get it by April 2011 at the latest. There is a huge increase in preventive work, backed up by evidence.’

He said ‘preventive toolkits’ had been dispatched to every practice and there was a 153 per cent increase in fluoride-concentrated toothpaste, as well as evidence-based programmes using fluoride varnish.

Dr Barry Cockcroft has agreed to answer any questions our readers would like to raise on this subject matter. Simply email your queries to penny@dentaltribenew.com and we will publish his responses in a future issue.

CHRONIC PERIODONTAL DISEASE?
WHAT HAVE YOUR PATIENTS GOT TO LOSE?

Eddie Crouch, secretary of Birmingham LJD.

‘If a dentist is now seeing more new patients with higher treatment needs and therefore more endodontic treatment is required as a result, then the UDA system cannot recognise that.

The DH wants more dental access for patients, but it must recognise the effects on contracts.

‘It is no surprise that when dentists are faced with a target, they aim to achieve it by trying to get as many UDAs as quickly as possible. They can achieve this well through extractions, but root fillings do not get the same results so quickly.

Specialist in Endodontics, Jerry Watson said there had been a marked decrease in endodontics in the NHS. He adds: ‘To my knowledge the decay rate hasn’t changed significantly, it therefore follows that more extractions are being performed to alleviate pain. This situation is not in the patient’s best interest, as the cost of replacing long term tooth loss is much greater.’

In response to the views, Barry Cockcroft, chief dental officer for England, says dentists in general were earning more under the new system. He says: ‘All the RC data published shows no increase in extractions. A reduction in complex work, providing it is appropriate, is one of the aims of the new system.

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Dental Tribune
United Kingdom Edition • March 30–April 5, 2009

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