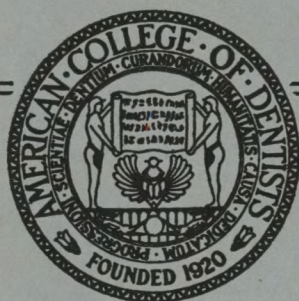


JOURNAL American College of Dentists



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American College of Dentists

Objects: The American College of Dentists "was established to promote the ideals of the dental profession; to advance the standards of efficiency of dentistry; to stimulate graduate study and effort by dentists; to confer Fellowship in recognition of meritorious achievement, especially in dental science, art, education and literature; and to improve public understanding and appreciation of oral health-service."—*Constitution, Article I.*

Fellowships and awards in dental research. The American College of Dentists, at its annual meeting in 1937 [*J. Am. Col. Den.*, 4, 100; Sept. and 256, Dec., 1937] inaugurated plans to promote research in dentistry. These plans include grants of funds (The William John Gies Fellowships) to applicants, in support of projected investigations; and also the formal recognition, through annual awards (The William John Gies Awards), of distinguished achievement in dental research. A standing committee of the International Association for Dental Research will actively cooperate with the College in the furtherance of these plans. Application for grants in aid of projected researches, and requests for information, may be sent to the Chairman of the Committee on Dental Research of the American College of Dentists, Dr. Albert L. Midgley, 1108 Union Trust Bldg., Providence, R. I. [See "The Gies Dental Research Fellowships and Awards for Achievement in Research," *J. Am. Col. Den.*, 5, 115; 1938, Sept.]

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PRESIDENTIAL ADDRESS

EARL W. SWINEHART

Baltimore

Today the American College of Dentists is passing an important milestone in its history. While retaining its honorary and cultural aspects, it is beginning to assume its obligations as a needed American institution, earnestly promoting the aims for which it was created. It is fitting that we, of today, render our thanks again to the farseeing men who founded the College upon the firm tripod of lofty ideals, high purposes and selected personnel. Such an organization has the requirements to endure and grow, being adaptable to the changing currents of human life around it.

As President, it is a pleasure for me to extend the congratulations and best wishes of the College to the large class of men who have been invested today. All those who have preceded you into the Fellowship understand the sense of pride and satisfaction that is now uppermost in your minds. It is natural that you should be gratified by such international acknowledgement of your character and accomplishment. However, it is hoped that when you return to your home life and activities, you will seek to understand the real meaning of what has occurred to you today. Do not harbor the idea that your investiture means merely a tribute to you for what you have been and have done. The real fact is that you have been selected because of your records in the belief that you can and will lend your valuable aid in the important work which the College has to do.

One of the constitutional duties of the President is to report at the Convocation upon the activities of the College during the year. It is gratifying that much of value can and should be stated concerning the year's record. Unquestionably, big strides have been made toward realizing the "Objectives of the College"—The Theme of the Year. Two impelling reasons have been mainly responsible for the unusual activity that has ensued:

1. There has been an ever-growing conviction that the College, now a mature body of chosen men, must accomplish more and must widen its beneficial influence.

2. Circumstances of dire import to the American Way of Life, particularly to Dental Service, have acted as a call to arms among the thinking men of the College. The more the Fellows consider the great and unique advantages the College possesses, the more they feel that the potentialities of this organization should be utilized through conferences at home in their Sections. Evidence of this realization is seen in the upsurge of applications to organize new Sections.

At this time, I wish to thank the many men comprising the Official Board,

the Committees and the Sections for their generous cooperation during the year. Without their willing aid, little could have been accomplished. My thanks are due particularly to our competent and omnipresent Secretary Brandhorst and to the members of the Committee on Socio-Economics into whose field has fallen much of the work of the year.

It would be interesting for you to learn in detail how much is being accomplished by the various Committees and Sections. However, this meeting is concentrated upon a subject of paramount importance. All possible time must be devoted to the presentation of material directly related to it. With your approval, the detailed information concerning the routine activities of the College will be omitted now but will be included in the published report.

At the beginning of the College year, it was generally believed that there was a preponderant trend toward the reestablishment of traditional democratic philosophy of government in America. With the prospect of more normal times ahead, the Officers began making plans to expand the activities of the College through greater participation by the Sections. This move was in response to changes in the Constitution made at the last Convocation which require the President and President-Elect to act as Counsellors to the Sections in promoting a comprehensive program of study extending into the future. Construction of such a broad program that would hold the necessary interest and be really valuable necessitated much time and thought. The Outline of Study as finally approved was distributed to the membership last March. However, in the meantime, measures of grave foreboding to Dental Health Service had been introduced in the Congress. In view of such danger to the integrity of the Profession itself, the Sections were urged to concentrate their studies upon this proposed national legislation. The Board of Trustees of the American Dental Association at its meeting in February had voted its opposition to these measures before Congress and had made extensive plans to combat them. The Board of Regents of the College, in session at the same time, had decided unanimously to give the full support of the College to the parent body of Dentistry in its efforts. As an initial step, it was further voted after consultation with officials of the A.D.A., that the College should send a commission to England, to gain first-hand information as to dental conditions in that country under compulsory health service.

Theretofores, the health professions of our country had been only parts of the grumbling but helpless unorganized majority opposed to such socialistic policies. With the introduction of Compulsory Health Service Legislation, they were forced into the front line of opposition against it. While, of themselves, they have far too little power to defeat such legislation, the fact is that it will eventually become Federal Law unless they do effectively direct the defensive campaign now and in the future. Without such guidance from the professions, the public will remain so hopelessly uninformed, confused and unorganized

that sooner or later we shall have socialized health service to the letter. In these circumstances, it is necessary that the professions and the other organized groups cooperating with them make cool and dispassionate appraisal of the situation, in order to determine the factors favorable or unfavorable to their cause.

As affairs have developed, it is fortunate that Compulsory Health Insurance Legislation was not urged earlier, and still more fortunate, that it has been further postponed by Congress at this session. Undoubtedly, the political philosophy which holds that the Federal Government should ever expand its control over the private lives of American citizens is at its lowest ebb and will sink still lower. Many are coming to believe that such control, while it may be beneficial to some, is killing the goose that has laid the Golden Egg which for one hundred and fifty years has meant the peerless American standards of freedom, of health, of education and of personal enjoyment of life.

Leaders who, with good intentions, formerly advocated that philosophy of government, are now publicly warning that if free-spending policies are continued, certain ruin to our economy will result. This opposition is non-partisan in Congress and among the public. The very decisive defeat, last August, of the bill to create a welfare department combining social security, education and health service showed how the wind is blowing. Admittedly, this defeat occurred because a large majority of Senators believed that the bill was a step toward socialized medicine which they did not want to see encouraged. Even the floor leader in charge of the bill, in arguing for it, stated that the issue was not socialized medicine, but that if it were he would oppose it himself.

These developments demonstrate that the character of the American people is still rooted deeply in the traditions of individual freedom, honest work and just payment of debts. Being among the best educated of peoples, with an unparalleled communication system, they are best prepared to understand the fallacies of government when they see them in action. Under our system of free enterprise millions have learned economics through practical experience. Other millions have studied its exacting principles in the school room. Our informed citizenry can understand what it means when they learn that our public debt is estimated to be equal to or in excess of all the property and wealth of the country. It is considered extremely unlikely that these debts can ever be paid off, but likely that billions of dollars of interest annually will remain a burden to this generation and their children.

The American public see that in addition to the debt cost, there have arisen numerous governmental bureaus and agencies, the cost of which runs into other billions annually. It has been said that Government bureaus, once created, never seem to die. They just get bigger and more expensive. In April of this year, the number of Federal, state and municipal employees reached 6,219,000. That means that one out of every eight employed citizens is on the public pay

roll. The public bill for salaries alone reached the unprecedented level of sixteen and a half billions of dollars annually, reflecting both higher pay and more employees.

In the four years since World War II ended—peace years—the Federal Government spent a fifth more than it did in the 100 years before World War II started. Those 100 years included the costly expenses of the Mexican, Civil, Spanish-American Wars and World War I, plus all of the ordinary governmental expenses for a century. Last year, the taxes of Federal, state and local government were \$374.00 for every man, woman and child in the country. Three-fourths of this figure went to the Federal Government.

The reading and thinking people of the nation are realizing that any new taxes must come out of the income and the savings of those people who work. The large accumulations of capital have been confiscated and scattered to the four winds. Industries cannot be taxed more without so crippling their expansion that millions of people would be without employment. Already life insurance executives are being called before committees of Congress to determine if there is not some way to tax these savings built up for benefit of loved ones left behind by death. There is concrete evidence that in learning these facts, our citizens are becoming fearful of the future. During the first six months of 1949, they earned less than in 1948 but they saved more. The buying of United States Savings Bonds was up and redemptions 12% less. Both building and loan savings accounts and savings banks deposits are at their peaks for all times.

Another favorable indication that should not be overlooked is that countries which have been governed under the socialistic philosophy of government are now turning away from it. One of the ablest and frankest of American business men, in reporting upon observations during an extended trip to Europe last summer as compared to those made on a similar visit in 1947, states: "Except in England, the trend of government leadership toward socialism has been halted and in fact reversed. The countries in which the trend away from socialism is most pronounced have made the greatest relative progress. I would say that France today stands actually to the right of center. In Italy, socialistic influence is decidedly on the wane." With the excellent system of public information that exists in our country, this evidence of failure in the practice of such government soon will be the common knowledge of millions of our citizens.

This evidence, favorable to our cause, is not offered to encourage lessening of effort, but instead, to instill confidence and to stimulate you to doubled and redoubled efforts. It must be kept ever in mind that there still exist in our country the same unfavorable conditions that have permitted the minority to rule the majority. Certain groups of individuals can be organized cohesively through the ties of mutual self-interest. The personnel of these groups need

only vote in national elections and pay dues. Their capable leaders can do the work of choosing favorable political candidates, of seeing that the group vote is tallied at the polls and of urging the group wishes upon Congressmen. Because of the complexity of our national system, the majority cannot approach such efficiency of expression upon all individual issues. Its wishes are made known only by voting at biennial elections when political platforms are hodge-podges of issues to gather votes from all directions. Other issues coming before the Congress have not been subjected to popular vote at all. Still others are of such character that they affect only segments of the people or are not generally understood by the voters. Upon most issues there is but scant and sporadic leadership in bringing the expression of majority opinion to the attention of the members of Congress. Thus, it does and will require not only a majority but a preponderance of opinion based upon democratic beliefs to preserve our form of government.

Fortunately, there is one question that is understood by all and is of concern to all. That is the value of health and the best measures for its preservation. Fortunately, also, in this instance a system of leadership has been established. Through past years, the public have through state licensure and state control selected the men of the health professions as their legal agents in the efforts to preserve the health of the public.

What, then, is the duty of men in the health professions, both as guardians of the public's health and as American citizens, in this situation? It appears to be three-fold in nature.

1. Their organizations should devote themselves wholeheartedly to the defeat of any health legislation threatening the best interests of the public.

2. The individuals of the professions are in honor bound to advise their patients against measures leading toward socialized practice if, as their health agents, they believe that such practice will lower the standards of health service and cost their patients more of their money. Giving such needed advice is as truly the duty of doctors as treating physical ailments in the sickroom or in the dental chair. Only they have the knowledge and practical experience to understand what is involved in giving and receiving the right kind of health service. Only they can foresee the harm that would come through adoption of this glowingly-tinted panacea to overcome the physical and mental ailments of Americans at one fell swoop. Personal explanation and advice by the members of the health professions would be more sound and effective than information emanating from any other source.

3. After the public has been correctly educated, a simple, easily operated but efficient plan for gathering and presenting mass opinion to Congressmen should be devised and held in readiness. There may be those who would hesitate to adopt such a direct measure; yet the right of petition is one of the

fundamental principles of our Constitution. Health is of primary importance to all citizens. Certainly in a democracy, this is one question on which the largest possible expression of opinion should be encouraged.

There is little doubt that there will be need for vigilance, despite the setback Compulsory Health Service received in the defeat of the Welfare Department Bill. Further attempts will be made by tying it to certain innocuous or otherwise beneficial measures. For instance, all agree that Voluntary Health Insurance is at present most praiseworthy. However, it will be very tempting to politicians and appealing to many policy-holders to have the Federal Government subsidize the funds of such projects. If that happens, it will be the end of Dental Service as we know it. That is the path which led to socialized health service in England.

Today the College is taking a further step toward giving to the American Dental Association the support of its membership and other resources in the splendid fight the Association is making. While most of the subjects on the Program are being presented by Fellows of the College, it is a pleasure to note that three of the most important phases of the subject are being handled by key men in the parent body of Dentistry. Because of the rank of the essayists, the quality of their material and the full coverage of the subject, it is believed that this study will be of great value. Therefore, it is recommended that the Officers of the College promptly consider having the Program material edited and put into printed form for generous distribution.

In closing, I not only hope but predict that during the coming year the College will rise to new heights in accomplishment and influence. This prediction is made in recognition of the high qualifications for leadership that distinguish my successor and the growing spirit of true Fellowship that will be expressed through helpful cooperation with him in all his efforts.

INAUGURAL ADDRESS

WALTER H. WRIGHT

New York

Since the founding of the College in 1920, our social order has undergone marked and rapid changes. Social unrest, following in the wake of wars, has now encircled the earth. Depleted by wars and frustrated, the nations of the world are impotent to continue but unwilling to end the strife. Everywhere we hear the cry of peace, peace; when there is no peace. Amid world-wide uncertainty, we assemble today to continue our study of ways and means for improving the dental health of the people of this nation, and to consider some of dentistry's most urgent concerns. We are aware that these problems are not confined to the dental profession; nor are they national in scope. They are world-wide and reflect the deep social unrest of our generation. Only as we study them in relation to society at large shall we be able to develop an acceptable pattern for dentistry of the future.

Dentistry has progressed since the founding of the American College of Dentists: expanding its educational program, developing its research, improving its methods of practice, cementing interprofessional relations, elevating its journals, and creating public esteem. It is a source of satisfaction that many of our members have labored for this advancement. No other profession has shown a more rapid advance than dentistry and none has developed under greater handicaps, or faces more serious problems.

We dentists, only 76,000 among a population of 140 millions, can lay just claim to public esteem and support only by virtue of our contribution to the oral health of the people. Our professional standing depends not on numbers but on the quality of our health service. Oral disease is widespread and dentists are few. Oral health service is necessary and urgent, and, through neglect, becomes time-consuming and expensive. Since there are not enough dentists to provide dental care for all of our citizenry under the prevailing widespread neglect, it would be in keeping with the American tradition to provide more and adequate facilities for the proper training of more dentists and for the wider distribution of oral health service under professional guidance. Instead, there is a growing desire on the part of ambitious political leaders and others to replace the dentist with less qualified auxiliary personnel in an effort to reduce the cost of dental care. Our democracy is founded on the principle of a just wage or fee for commensurate service. Dentists, whose service depends on work of the hand, as well as knowledge and judgment, know what it means to "work for a living." Nevertheless, in a unionized society where each group demands and usually gets the highest wage for the least amount of work, the

dental profession is expected to submit to control by outsiders who know little about the training for a professional career, less about the actual labor and mental effort involved in dental practice, and are practically oblivious to the ethical objectives of the dental profession. If this is the democratic spirit, it is not the brand which prompted Solyman Brown, in 1839, to write:

We should do to others precisely as we would desire and could reasonably require others to do to us in exactly corresponding circumstances.

The honorable dental practitioner will adopt such a tariff of charges as will not be extortionate, or disproportionate to the profits of the other professions on the one hand; nor degrade his calling to the level of a vulgar art on the other . . . the honorable practitioner will neither be oppressively high nor meanly low in his professional charges. Either of these extremes would bring detriment to society. (Remarks on Professional Morality. *Am. J. D. Science*. 1: 1-9, No. 2, 1839.)

At a time when dentistry is being impugned by some of its adjuncts and when the foundations of dental education and dental practice are being assailed, the profession must not expect to maintain its unity and the public esteem, unless its services are of a high order and capable of being expanded to meet the increasing oral health needs of the people.

Year after year, the profession has been aware of the increasing need for its services; yet there has been little financial aid for an increase in the annual number of dental graduates. At the same time, there appeared to be money for almost any project that was sponsored by importuning political advocates. We have seen increasing dental disease, with no effective methods of prevention and paltry resources for research. We have been compelled to devote most of our labors to restorative dental treatment which has resulted in the employment of industrial dental laboratories for much of the technical processing required in prosthetic dentistry. We have delegated certain oral services to dental hygienists who have been trained in various types of schools and indoctrinated with varying ideals of dental service. We have seen the slow but steady encroachment on our rights by auxiliary groups. Now the profession is aware of political forces which may go to great extremes in order to gain public approval of, and support for, government supervised dental care.

I do not intend to discuss in detail these problems which we now face, but I should be remiss if I did not call to your attention briefly some dangers which require vigilance on the part of the profession.

HEALTH INSURANCE

It is now 20 years since the College sponsored the study of health insurance in Europe by Simons and Sinai. Three years later, in 1933, the College assisted

in sponsoring a further study of conditions affecting the practice of medicine and dentistry in Europe, but particularly in England. Reporting to the College in 1934, Sinai said, in part:

Of all the professional organizations in the United States, the College alone had the courage to recognize and squarely face the growing dissatisfaction inside and outside our system of medicine and dentistry. It was the only organization with the courage and foresight to first study health insurance. And, sad to relate, it is one of the few professional organizations that can lay claim to the quality of intellectual honesty in its attempts to seek a way out of the economic dilemma of physicians, dentists, and the public. (*Medical and Dental Economics. J. Am. Col. Den. 1: 108, October 1934.*)

Today, we have heard reports on dental service under Compulsory Health Insurance in England. These indicate what we may expect if our government pursues its policy of intervention in the distribution of dental care. Compulsory health insurance is not new; it was tried and found wanting years ago. Political supervision of health service was planned long ago while the professions were still sleeping. To what purpose are the expenditure of money and the preparation of reports, if dentistry, the profession first alerted to health insurance trends in Europe, is still in the stage of watchful waiting? The College has played the role of the prophet in dentistry, and, as with the prophets of old, many of its warnings have gone unheeded.

DENTAL HYGIENISTS

Early in the history of the College, the profession was engaged in bitter arguments regarding the use of dental hygienists as auxiliary aids in the practice of dentistry. Some College members opposed the training of hygienists on the premise that sooner or later, their duties and rights would be expanded to include the filling of teeth and other dental procedures already delegated by law to the dentist. The passing years have justified their fears. For some time, health authorities have been urging greater responsibilities for dental hygienists. They have argued that the hygienist should be allowed to prepare and fill small cavities not involving the pulp. Their objective is to provide dental care for school children who are not now cared for by the dentist. At the present time the dental practice act in one state has been amended and one dental institution is now preparing a two-year course that will train dental hygienists who will place fillings and extract as well as clean the teeth. This is the first breach of the dental law aimed to permit sub-dentist personnel to operate on the teeth. Time does not allow further discussion of this trend which, unless challenged and curbed, will mark the beginning of the partition of dental practice, and the ascendancy of sub-dentists who will invade every area of dental service to the public.

DENTAL TECHNICIANS

The College appointed a Committee which began a study of dental technicians in relation to Dental Prosthetic Service in 1934, when commercial dental laboratories sought and obtained codification under the N.R.A. (National Recovery Administration) although opposed by the dental profession. The attitude of some laboratory leaders toward the profession, at that early date, caused the Committee on Dental Prosthetic Service to doubt their motives. Since then, this study has resulted in suggestions which have led to a plan for accreditation of Dental Laboratories by the American Dental Association. Instead of welcoming the profession's effort to help, there is strenuous and outspoken opposition to this plan which indicates that many dental laboratories will be satisfied with nothing less than state licensure. Time has confirmed the Committee's opinion that dental laboratories are maneuvering for legal recognition and autonomy, both of which would be favorable to their prospects if the practice of dentistry should be modified through social changes.

At present, in not less than nine states, dental laboratories are supporting legislative action in the hope that they will be granted state licensure. Unfortunately, some members of the dental profession are aiding this effort in the belief that it will curb the illegal practice of dentistry by some dental technicians. However, many dentists look upon licensure of dental technicians as a possible wedge for the partitioning of dental practice and they are using their influence to prevent the legal recognition of laboratories and technicians.

If the dental hygienist law can be amended to include fillings and surgery which have been the prerogative of dentists only, a law for dental technicians, if enacted in the future, could be amended to permit them to make impressions of the mouth, whereupon denture prosthesis would pass from the dental profession to the dental laboratory industry which is equipped for mass production.

PLANNED DISTRIBUTION OF DENTISTS

That dentistry has not discharged fully its responsibility to the public is evident in the lack of planning for the effective distribution of dental care. When dentists congregate in centers of heavy population they are subject to competition that is not good for themselves and worse for their patients. In times of business recession, competition can result in low-grade health service as well as widespread idleness among the profession. This situation deprives the people in smaller communities of much needed dental care and raises doubt as to the sincerity of the profession's avowed interest in the public welfare. A well-organized plan for distribution of dentists could begin with dental students still in dental colleges and result in locating them in communities where they would be wanted and welcomed and where they would have an opportunity to practice the most desirable form of dental service, including

dentistry for children. The planned distribution of those dentists who are now available for dental practice would do much to allay the increasing pressure from smaller communities for dental care. It would also increase the total dental service to the public since it would tend to keep all practicing dentists fully occupied. It is axiomatic that the people cannot come to the dentist; therefore dentists must go to the people. If the profession fails in this obligation, other agencies may be expected to provide and distribute dental care which may not be in accord with professional standards.

THE FUTURE

Enough has been said to indicate that those trends which, not long ago, were as small clouds on the horizon, have now broken in storm around us. In the years ahead, our profession will be subjected to external stress and internal strain. The cohesion and the resistance of its foundation will be tested, whether of sand or rock. In the midst of that testing there will stand at least one citadel of courage and strength, The American College of Dentists. As in the past, it will have the support of all who are altruistic and noble; those who have chosen dentistry in order to serve, not to exploit, the people; those who look to the future, not to the past; those who are willing to labor to improve the profession and to defend it against those who would weaken or destroy it.

Through the years, the College has been steadfast in its objectives: to advance the standards and efficiency of American dentistry, to cultivate and encourage the professional spirit and social responsibility, and to inculcate higher ideals within the profession. At times these have been difficult tasks; yet, within human limitations, the College has succeeded. At present, its membership includes many who are carrying forward the banner of dentistry in its organizations, schools, publications and research projects, and in the Armed Services and Public Health.

It would be safe to affirm that in no other dental group of corresponding size throughout the world is there a similar concentration of dentists who have done and are doing more for the profession and who are more concerned with the public welfare than the Fellows of the College. We acknowledge that we have not done our best and as we look to the year ahead, we resolve that nothing shall deter us from our privilege and duty of service to the profession and the public.

We see with alarm not only the trends, but also the realities, about us; and we are determined to assist in every way in maintaining the high standards of dental service to the public for which the College stands. This achievement depends on unity, not only among the members of the College, but also among the profession at large; and the resources of the College should be used immediately to alert the profession to the dangers that surround us and to the pro-

fessional responsibilities which make the dental health of the people our first and foremost concern.

We dare not retreat from the high ground which through the years has been gained and held by many of our illustrious members who have seen the vision and have devoted their lives to the betterment of mankind. Although we are few in number, we are mighty in faith, bold to uphold the rich professional heritage which is ours, and strong to defend and improve the standards of service which have made American dentistry an example throughout the world. With unity of purpose and fervor of spirit let us lift high the torch as the College moves forward into its thirtieth year of service for the people and for the profession.

JOURNAL

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EDITORIALLY EXPRESSED

The formal program arranged for the convocation of the American College of Dentists held in San Francisco on October 16, 1949, was planned to feature a discussion of the problem of oral health care for the American people. The purpose of the program was to examine those conditions that affect the distribution of oral health care, to appraise the status of the oral health services now provided the people of the United States under its free enterprise system, and to discuss some of the practical results of the effort to apply compulsory health insurance theories in the Health Service Act of Great Britain. The several papers presented by those on the program contributed materially to the clarification of some of the important questions that have been raised about the distribution of health care under the free enterprise plan, and sketched a realistic picture of the disadvantages of dental practice inherent in a federalized tax-supported plan of health care. This issue of the *Journal* includes a full report of the discussions presented at the convocation. A careful reading of the several papers is urged. A study of the facts and arguments presented will reveal the beneficial character of certain developments on the local and state levels which have come from the free enterprise system in this country and which, if expanded effectually to national proportions, would finally solve the problem of oral health care for all the people. Such a study will indicate also

the immediate and long-term dangers of regimented health care to both the public and the health professions.

* * * * *

Experience and reason point inexorably to the fact that dictatorship and democracy are as incompatible as oil and water. They will not mix even on a small scale. No matter what the effort is to reconcile them the fundamental principles underlying democracy on the one hand and totalitarianism on the other will always be in complete disagreement and wholly irreconcilable. Neither will tolerate the other. If regimentation and dictation are introduced into the functions of free government, inevitable coercion follows and the principles of freedom that characterize democracy must give way and disappear. Compulsory health insurance as outlined in S.1679 proposes a totalitarian authority over the health professions and over the distribution of health care to the people of the United States. The scheme is regimentation of a strict and positive nature. Physicians and dentists cannot long hold out in private practice against the subtle and hidden powers of compulsion inherent in the scheme; they must, soon or late, submit to its unstated but none-the-less powerful coercive authority; and no citizen can long continue to have free choice of health services as the American people have practiced and cherished their freedom in this respect. The plan outlined in this Federal proposal is state medicine plain, pure and simple. Its sponsors may and do declare that "it is not state medicine"; but such denial is a play on words and merely suggests to the thoughtful person that "a rose by any other name would smell as sweet." The plan to provide universal health care that has been proposed for the American people in S.1679 calls for a universal tax-supported arrangement that will provide health care without any direct cost to all the people eligible to receive its benefits. This taxing arrangement is clearly defined in the proposed act. The administration of the scheme is assigned in the Bill to the authority of the Federal Security Administrator and a National Health Insurance Board who will be responsible for announcing rules and regulations to govern the plan and for administering, through its agents, the operations of the plan. With these broad powers conferred on the Security Administrator and the Insurance Board, it follows that they will finally fix and direct the standards in dental education and practice. When the total scheme is carefully studied it may be readily seen that *the plan in effect in Great Britain and the one proposed for the people of the United States constitute state medicine of the most complete socialist type*. It is easy to deny these facts and to argue that this scheme is merely "a national health program." But it has all the appearance, all the characteristics, all the viciousness of so-called state medicine and promises to produce all the evil consequences that are to be found in existing socialist systems. It will cause the physician and dentist to serve the people by formula instead of by reason; it

will make the patient a number instead of a personality; it will reward all health workers alike regardless of quality of service; it will delay the health care which the patient should receive promptly; it will cost the patient more for his health bill than it costs him under the free enterprise system; it will destroy incentive, dull initiative and blight interest among members of the health professions; it will inevitably lower the quality and effectiveness of health care to which the American people have long been accustomed.

* * * * *

The medical and dental professions must share in solving the problems of providing adequate and competent health care for all those who need and demand it. The even distribution geographically of health service among the people and the guarantee of availability of health care to all persons on all economic levels of the population ought to be more than mere campaign issues upon which politicians take sides for the doubtful purpose of securing political advantage. The people of the forty-eight states and the District of Columbia have approved health practice acts designed to serve the health needs of the people and to protect the health of all the population by fixing standards in education and practice that are consistent with the varied requirements of the public. The definition and the promotion of such standards, as well as their enforcement in the interest of the common good, have been placed in the hands of the health professions. This arrangement is evidence of the confidence the people have in the integrity of the medical and dental professions. The growth in the quantity and the quality of health care that has taken place in America during the life history of the country is convincing evidence that this confidence has not been misplaced. In the circumstances it would appear that the representatives of these professions could be most useful in aiding the development of any plans that are necessary in expanding the distribution of health care to more of the population. It is significant that such cooperation has not been asked for by the promoters of compulsory health insurance and that current proposals for health legislation have issued not from physicians and dentists and *bona fide* health workers, but from so-called welfare leaders of doubtful political ideologies. The members of the medical and dental professions are deeply concerned about the proposals that have been made for socialist domination of the services which they are called upon to render the American public. This concern is not dictated by selfishness. It is true that physicians and dentists are dependent on their vocations for a livelihood but this fact is no indication that their first interest is to make a material profit. The nature of their services as health agents and the consequences of their acts as professional men are of too much importance to the health, welfare and happiness of society for them to accept their obligations lightly. As a group they are acutely social conscious and have endeavored in accord with the democratic

process to improve the quality of health care and to expand the quantity of health services to meet all demands that may be made on them. They realize that the time has come when some method must be devised to offer health care to the indigent on a welfare basis, and to assist many of the population in the low-income brackets to provide effectively for their health requirements. They know that these health problems are real and pressing; they are currently engaged in carefully and thoughtfully considering effective ways for solving them; and they have full confidence that any untoward situation can be finally adjusted in harmony with the democratic process and without threat to America's free institutions. And above all, they are profoundly sure that regimentation and dictation are not the formula that will cure for long any of the serious ills of a democratic people.

THE BRITISH HEALTH PLAN

HAROLD HILLENBRAND

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Chicago*

It should be made clear that spending seven days in a strange country does not make such a casual observer an expert in the social, political and economic life of the country visited. One week obviously is not sufficient for one to analyze thoroughly all of the phases of an immense social experiment such as Great Britain is conducting at the present time in the form of a comprehensive national health service. An inclusive study would require careful analysis of administrative procedures, a dissection of political pressures, a knowledge of the attitudes and policies of the organized profession and an opportunity to interview the members of a carefully chosen cross-section of both the public and the profession. Certainly none of these things was possible for the present observer, and his comments must be taken largely against the background of his studies of various national health programs in a period extending more than a decade. These studies, combined with certain information and observations gathered in Great Britain, justify the drawing of certain broad conclusions. It should also be noted here for those who wish to evaluate the comments made, that the present observer made contact largely with officials of the Ministry of Health, with representatives of the organized dental profession and with successful practitioners who, for one reason or another, have not entered the National Health Service. Opportunity was provided, however, for two visits with Mr. Aneurin Bevan, Minister of Health, one visit being a formal conference of some thirty minutes in the presence of the Chief Dental Officer, Dr. W. G. Senior.

This is not the place to enter into a discussion of the various acts which led to the adoption of the National Health Service Act in 1946. The present act, which became effective on July 5, 1948, replaced the National Health Insurance Act of 1912, under which dental benefits were provided only as an "additional benefit," to be given only when, and if, the insuring agency had prospered sufficiently to permit itself a dividend in the form of dental care.

The National Health Service Act of 1946 places on the Minister of Health "the duty of promoting for the people of England and Wales the establishment of a comprehensive health service." Under the Act it is the duty of the local health authorities to make "priority arrangements for the dental treatment of expectant and nursing mothers and pre-school children (in addition to the priority arrangements made for school children through the school health service)." Since this priority of treatment has not been established, since pre-

viously existing facilities for giving priority care have deteriorated, and since there seems to be little present hope of living up to the optimistic priority terms of the Act, the dental program in Great Britain can be said fairly to be a failure. The priority services do not exist in fact and, through the Act, Great Britain has spread her very limited dental population so thinly that it can do nothing but face the unending treatment of adults at the expense of the younger age groups in which preventive treatment would pay the best dividends in terms of national dental health.

The Act does not provide health care related to insurance as did the previous act. All persons, regardless of income or insurance payments, are entitled to "free dental care." And here, to interrupt the continuity of this description, is where the Act has failed. It has promised a "comprehensive health service" knowing that a comprehensive dental service could not be delivered owing to a shortage of dental personnel. It must be obvious, therefore, that the gain to be secured from such an empty promise could not be a social one in terms of improved national dental health, nor could it be a professional one in terms of new opportunities for the application of scientific principles for the prevention and control of dental diseases. The gain to be expected was obviously a political one. It is important to remember, therefore, that the Act can not be discussed in purely professional or public health terms since it is so deeply involved with the political struggle now going on in Britain. The National Health Service Act is certainly a political issue and no government, Labor or Tory, will risk its security or its ambitions in abolishing it no matter how costly it becomes or how inept its administration. It is likely that the Act—like most measures involving social security—will be transmuted by innumerable regulations, by trial and error, by ministerial fiat and by concessions made to, or won by, the public and the professions.

The dental service, unlike the medical service, is based on the fee for service principle; that is, each dental operation is performed for a stipulated fee established by the government. The patient pays no part of this fee unless he or she insists upon "luxury" dentistry involving the expensive use of precious metals or technics. In medicine, the physician is paid so much for every patient on his panel, no matter how much or what kind of treatment he renders.

Around this fee schedule centers much of the present discussion and it is important to know how it was established. Prior to the establishment of the Act, a governmental committee under Sir Will Spens made a study of incomes in the dental profession. It concluded that a dentist's gross earnings annually should be £3,858 for 1,500 chairside hours. This figure takes into consideration 52 per cent for overhead and 8 per cent paid by the government for retirement pension. The fee schedule under the Act was set up on the basis of this Spens Report, and an effort was made to relate the charge for each dental operation against an expected average income of £3,858 gross.

Dentists, responding to the demand for their services which the Act had created, worked considerably more than the optimal 33 hours per week (1,500 per year) and thus increased their incomes above the expected average and, inevitably, increased greatly the estimated national cost of the dental service.

As is inevitable when any agency, governmental or otherwise, in the United States and elsewhere, rushes heedlessly into a dental program without recognizing that there are severe differences between dental and medical problems, there was immediate complaint about costs and, as is also inevitable, the profession was asked to help repair the deficit by reducing its income. Regulations were amended to limit a dentist to 400 pounds per month, after which he received only 50 per cent of the sum earned. This arrangement was abrogated on June 1, 1949 when another amendment to the regulations substituted for the initial reduction a 20 per cent reduction in all fees. In other words, the mounting cost of an unrealistic scheme was checked by imposing a reduction in income on the dental profession. This was done without the passage of a new law and without consultation with the organized dental profession. This was done by the action of the Minister of Health, while the matter of fees was supposedly under study by another governmental commission.

These two arbitrary decisions by the government have certainly worked to cool the initial enthusiasm which prevailed in certain quarters when the original fee schedule was announced. The conclusion is inescapable that high fees were deliberately used by the government to get the system under way in the face of considerable opposition from the organized professions. When more than 90 per cent of the dentists had entered the scheme, willingly or under force of economic pressures, the government moved quickly for the curtailment of the dental fee schedule. But even after these two acts of the Minister, there is no assurance that further fee cuts will not be made in order to meet the fiscal obligations which the Minister has undertaken in regard to his health scheme. Indeed, the dental profession is facing this program with the full knowledge that the Minister of Health intends to work for a complete salaried system under which all dentists would be employees of the state. In the opinion of this observer, only the shortage of dentists prevents embarkation on such an adventure. The physicians, on the other hand, because of their united position have been able to secure a promise that no effort would be made to place physicians under a full salaried service without further consultation with the profession.

This discussion is not intended to relate a final evaluation of the British dental program to a rise or fall in professional fees; yet certain conclusions can be drawn validly. If dental fees do not adequately compensate the dentist for high quality work, the natural tendency will be to slight the quality of the work. Even in the professions, you can't buy something for nothing. It is foolish to advance the often heard argument that no professional man will knowingly

slight the quality of his work. If all incentive is removed, if intensive and conscientious effort produce no reward than further restrictions on one's income, no human being is likely to respond with his best measure of devotion.

More seriously, however, this governmental effort to restrict professional income has a deeper meaning for the public. The restriction of dental income necessarily means the restriction of the amount of dental service available to the public. With a profession seriously undermanned, with the government promising free dental care to all of the people and with a seriously increasing problem in dental health, it simply does not make sense to restrict the output of dental care. Yet that is what the British program is doing at the moment.

The problem of cost is not to be found only in the dental program, though the dental program is certainly one of the chief items. A recent official report stated that the cost of the whole service for 1948-49 would be 352 million pounds. The dental costs have mushroomed to two and one-half times their original estimate. Dental services for 1949-1950, it is estimated, will cost about 31 million pounds.

One of the other great weaknesses in the British program is the intervention of lay personnel in professional matters where trained opinion is essential in the interests of the health of the patient. This intervention is flagrantly obvious in the device known as the Dental Estimates Board.

Under the Act, a dentist is permitted to proceed with certain limited types of dental work. If his diagnosis entails services beyond these limited ones, he must complete the necessary blanks and submit them to the Dental Estimates Board. This Board has handled (to May, 1949) 6,324,000 estimates, which pour in at the rate of about 10,000 per day. The Board has seven dentists, not all of whom are engaged full time. The Board also has some 700 clerks, and it is obvious that the power to grant or withhold approval on a professional diagnosis rests with these lay persons. Under this arrangement, there can be no assurance whatever that the final decision will not be dictated by political or fiscal standards rather than by professional opinion.

These, then, are some of the observations on what must be recognized as a great social experiment. The Laborite Government brought it to full flower, but it has the tacit support of the Conservatives. The driving force is the Minister of Health, Aneurin Bevan, who uses his post to win prestige in his own party and with the public. His ambition to be Prime Minister is well known and the success of his health scheme will play no small part in its achievement. For this reason, it is inevitable that the scheme will take on an increasingly political nature and that Mr. Bevan will not be inclined to let professional standards and traditions stand in his way if political advantage can be gained. The entire scheme, therefore, in a manner not easily envisioned in this country, depends on Mr. Bevan's personal attitudes and program.

THE BRITISH DENTAL PLAN IN OPERATION

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THE SURVEY

In July and August of 1949, I spent approximately one month in England and Scotland studying the National Health Service of Britain under the sponsorship of the American College of Dentists.

In an effort to obtain firsthand information and to sample opinions of a representative cross-section of the population, I visited metropolitan, industrial and rural areas, including such cities and villages as London, Newcastle-upon-Tyne, Durham, Edinburgh, Glasgow, Manchester, Nelson, Burnley, Birmingham, Stratford-on-Avon, Bristol, Henley-on-Thames, Oxford and Newhaven. I interviewed dentists and physicians in their offices; I visited dental and medical schools, hospitals, public health clinics and dental supply houses; I inspected an open-cast coal mine and a textile weaving mill; and I was entertained in numerous British homes. Among the many people with whom I talked were nurses, social service workers, teachers, lawyers, business men, miners, hotel personnel, factory workers, taxi drivers, railroad men, pub keepers and housewives.

I was extended the courtesy of personal interviews with the Principal Dental Officer and the Senior Dental Officer in the Ministry of Health; the Secretary of the British Dental Association; the editor of the *British Dental Journal*; members of the Inter-Departmental Committee on Dentistry (the Tevoit Committee); the Chairman of the Dental Board; members of the Dental Consultative Committee of the British Dental Association; a member of the Penman Committee; officers of the American Dental Society of Europe; the editor of "News from Britain" to the *Journal of the American Dental Association*; the Chief Dental Officer and the Chief Medical Officer of the Department of Health for Scotland; officers of the American Dental Society of London; and Deans, Directors and Faculty Members of Dental and Medical Schools.

From these people came a wide diversity of viewpoints, personal experiences and opinions concerning the operation of the National Health Service of Britain. The information obtained from these sources and that represented by the appended bibliography, combined with my own personal observations, form the basis of this report.

All of the people with whom I had contacts during my visit in England and Scotland were most courteous and helpful to me; and in preparing the report of my survey it has not been my intention to, personally, express unfavorable criticism of any individual or of the country in general.

STATUS OF DENTISTRY IN BRITAIN BEFORE THE NATIONAL HEALTH SERVICE

In order to understand the present position of dentistry in the National Health Service, it appears desirable to have some understanding of the status of dentistry in Britain before the new Scheme was introduced.

Old Health Insurance Scheme

For many years there had existed in Britain a panel system of limited benefits for employees whose income was under a certain amount. The insurance companies which admitted health benefits for the government were called "approved societies." It was a non-profit-making Scheme. If, at the end of each five years, there was a surplus, this could be allocated to "additional benefits" including dental grants. The grant was usually 50 per cent of the cost and the remainder was paid by the patient. Approximately 13 million workers were covered by the Scheme, but not their dependents. Many physicians and dentists had been engaged for years in this type of practice.

Dentists, 1921

Until 1921, dentistry in Britain was an open profession. Anyone could practice it whether he was qualified or not. There were no effective restrictions and advertising of the most flagrant kind was rife. Many described themselves without justification as American Dental Specialists, etc., and gave their offices resounding titles such as Dental Parlors, Dental Institutes, and the like. In 1921 an Act was passed limiting practitioners of dentistry to academically-qualified dentists, registered medical practitioners, and those who either had been in practice for five years prior to the Act or had passed a special examination. At present about 4,000 out of approximately 12,000 practicing dentists in Britain are "Dentists, 1921," as they are called.

Public Estimation

It is an undisputed fact that dentistry in Britain has not enjoyed the prestige that it has in this country. This opinion was expressed by most of the dentists with whom I talked in England and Scotland. The following remarks are typical of what I heard: "dentists never stood very high in this country;" "medicine is held in esteem by the people but not dentistry;" "people in this area don't appreciate dental care—they only want dentures;" and, "in Britain, the man on the street looks down on the dentist, thinks only of 'pulling teeth and making plates'."

The Tevoit Report¹ to the Minister of Health (Henry Willink) in 1944, stated that "...at the present time the career of dentistry is relatively unattractive to boys and girls in comparison with other professional careers, especially medicine. . ." and "Practicing dentists feel that their work has not an important enough place in the minds of the public."

This situation may be somewhat reflected in the dental educational system of Britain. In contrast to the system in the United States, it appears that greater emphasis has been placed on the basic sciences and medical relationships at the expense of adequate technical training.

In a recent article² on dental education, published in the *British Dental Journal*, a group of English dentists who had studied in the United States and taken American degrees, criticized the British curriculum in that there was too much emphasis placed on the purely medical aspects of the training and too much emphasis on academic subjects. They felt that "a much higher standard of operative dentistry should be aimed at."

This trend in British dental education may possibly have developed as the result of an attempt to raise the prestige of dentistry in the public estimation, and it may partially account for the early adoption of the terms dental surgeon, instead of dentist; surgery, instead of office; and dental hospital, instead of dental school. And, furthermore, it may be responsible for the desire on the part of so many dentists to study for a medical qualification.

The Secretary of the Canadian Dental Association, in a report³ on Dental Education and Licensure in Great Britain, states that "Particularly in dental education . . . dentistry is under the control and direction of medicine" and he quotes the head of one of the schools as saying that "dentists in general feel that they receive some reflected glory from medicine by the present relationship. . ."

State of Dental Health

The indifferent attitude of the public toward dentistry is undoubtedly related to the admittedly deplorable state of the dental health of the people of Britain. In 1938, during the old panel system, the Chief Medical Officer of Health reported⁴ that 80 per cent of the total payments to dentists by the Approved Societies was "... in the respect of extractions of teeth and the provision of artificial substitutes."

And then, in 1944, the Tevoit Report⁵ to the Minister of Health contained this significant statement: "The state of dental health of our population is bad and its effect on the general health is bad. . . One Approved Society in its experience during one year, of the dental treatment of young people between the ages of 16 and 19, found that no less than 12.2 per cent of those who applied for treatment had needed full upper and lower dentures. . . Broadly, then, the picture is . . . of a public ill-educated and apathetic in regard to the care of the teeth."

Incomes of Dentists

This fact seems to have been substantiated by the Spens Committee⁶ when they reported that, from evidence secured of incomes received by dental prac-

tioners during the years 1936, 1937, and 1938, it was found that 75 per cent had net incomes under \$4,400 a year.

All financial figures in this report are translated at \$4.00 to the British pound, the approximate exchange rate prior to devaluation, which was announced on September 18, 1949.

AIM AND PURPOSE OF THE SCHEME

In introducing the new Health Scheme, the government promised the people a comprehensive health service. In a booklet⁷ prepared by the Ministry of Health and the Central Office of Information, the extensive provisions are enumerated as follows:

The aim of the National Health Service Act, which came into force on 5th July, 1948, is to make all the health services available to every man, woman and child in the population, irrespective of their age, or where they live, or how much money they have; and to make the total cost of the service a charge on the national income, in the same way as the Defense Services and other national necessities. . . .

The purpose of the Health Service is to provide advice or medical care for the individual man, woman, and child in need of them. Its range includes everything from advice on infant feeding to the surgery of the brain and the treatment of rare diseases, from care of mental defectives to blood transfusion, iron lungs, and artificial limbs; included also is all that goes with medical care, such as massage, the services of a midwife, treatment during convalescence, home nursing, use of ambulances, care of the eyes and teeth, drugs, special foods, spectacles, hearing aids and so forth.

WHY THE GOVERNMENT ATTEMPTED SO MUCH AT ONCE

Since the Labor Government knew that there was a shortage of dentists and physicians to meet the anticipated demand for services, it may well be asked why they instituted so comprehensive a Scheme which many think that the country can ill afford at the present time. Would it not have been wiser, as the professional organizations urged, to limit the initial program to the care of expectant mothers and children; thereafter, developing the Scheme concurrently with growing resources.

A person well informed on dentistry and governmental affairs dictated an answer⁸ for me as follows: "It must be remembered that in broad principle the National Health Service was first put forward by the War Coalition Government although all three parties, Conservative, Labor, and Liberal, subscribed to it. The explanation is that the political trends demanded improved social services for the bulk of the electorate. A satisfactory service for children could have been brought into being forthwith only at the expense of the adult population and, politically, it would have been highly inexpedient to require a substantial contribution from workers and to deny them the benefit to which, in part at least, they had been accustomed for more than twenty years."

That the government attempted to do too much at once was expressed again

and again by the laity as well as by the professions. A Lancashire dentist said, "The ideology of the present government is to pamper the masses. They are not interested in dentistry; hence, 'blood and vulcanite' dentistry is serving their purpose.

In defense of the government, I was told that it was the aim of the government to give "an adequate service to the many rather than a superlative service to the few." I replied that in my opinion such a philosophy might be applicable to some fields but in the matter of health service where the diagnosis and treatment of diseases are concerned, I question that any individual is satisfied with a service less than the best that the physician or dentist is capable of giving him.

ORGANIZATION AND ADMINISTRATION

Powers of the Minister

I shall omit any discussion of the complicated and intricate administrative set-up of the National Health Service except to mention the division of services and the tremendous authority that has been vested in the Minister of Health, one Mr. Aneurin Bevan, whose duty it is to promote the health service in England and Wales. (In Scotland, this function is assumed by the Secretary of State.)

In reading the Bill, I was struck by the dictatorial powers of the Minister, the exercise of which has already been experienced by the health professions of Britain. The National Health Service Act, 1946,⁹ allows the Minister to determine by regulation alone "the qualifications, remuneration and conditions of service" of all employees under the Act. The Bill¹⁰ provides for a Central Health Services Council to advise the Minister. The Council, composed of physicians, dentists, chemists, etc., appointed by the Minister, is to report annually to the Minister who will "lay the report before Parliament—with his own comments, if he wishes—unless he is satisfied that it would be contrary to the public interest to publish the report or any part of it."

Three other items of special significance are:

Where the Minister is satisfied . . . that the services provided by doctors, dentists or chemists . . . are not adequate he is empowered to take such steps as he considers necessary to secure an adequate service.¹¹

The Minister is given default powers against . . . any of the bodies constituted by the Bill. . . . He can make an order directing them to do whatever may be necessary and then, if still not satisfied, he may take over their functions, permanently or temporarily, himself.¹²

The Minister may acquire, either by agreement or compulsorily, any land required by him for the purposes of this Act.¹³

Division of Services

Briefly the health services themselves are divided into three main branches:

(1) The Hospital and Specialist Services. All voluntary and municipal hos-

pitals have been transferred to the formal ownership of the State; but teaching hospitals and medical and dental schools have not been transferred. Prior to the Scheme, the majority of dentists and physicians gave their services to the hospitals without remuneration. The honorary titles they held were much sought-after appointments. Now, there are no honorary members of the staff. The new system necessitates the use of detailed contracts, indicating the number of sessions and the scope of the work. While this change may be required by governmental policy with respect to controls; nevertheless, it has resulted in a number of these men resigning because of their dissatisfaction with regulations and also with their professional grading.

(2) Local Health Authorities. The Local Health Authorities, covering 146 districts in England and Wales, have the responsibility of providing a variety of services, such as maternity and child welfare and midwifery; health visiting and home nursing; domestic help; local mental health services; vaccination and immunization; ambulance and transport service; care and after-care of the sick; and health centres.

(3) The Family Practitioner Services. These include those of the family physician, the dentist, the pharmacist, the ophthalmic doctor, and the ophthalmic optician.

THE DENTIST IN THE SCHEME

The terms of service of the dentist in the Scheme and the conditions of practice are numerous and are described in detail in the Handbook for General Dental Practitioners,¹⁴ issued by the Ministry of Health. The following is a condensation of the more important items:

Scope of the General Dental Services

"Dental treatment provided under the general dental services is defined as 'all proper and necessary treatment which a dental practitioner usually undertakes.' Those dentists taking part in the service who are accustomed to undertake the less common dental operations are free to do so under the Scheme. Those who are not so accustomed will not be under any obligation to undertake treatment of this kind, but will be able to refer patients to colleagues on a dental list of an Executive Council who are able and willing to provide it."

The Dental List

Any registered dentist may have his name placed on the list by applying to the Executive Council of the area in which he practices. He fills out an application form in which he promises "to abide by the conditions and terms of service."

Terms of Service

The dentist agrees "To employ a proper degree of skill and attention; To provide and complete satisfactorily all the treatment necessary to secure dental

fitness which the patient is willing to have; To provide proper and sufficient surgery and waiting room accommodation, suitable equipment and instruments; To keep records of treatment provided; and To permit inspection of surgery and waiting room and to produce records."

Withdrawal from Dental List

A dentist may withdraw at any time from the Dental List by giving three months' written notice to the Executive Council.

The Patient

Anyone, including visitors from abroad, may apply for "free" treatment to any dentist whose name is on the list; and the patient is privileged to change his dentist whenever he wishes.

Ambulance Service

Ambulance or car service is provided by the Local Health Authority to take patients to and from the dentist's office if they are unfit to travel by ordinary means. This service is also available without cost for people who have made private arrangements for treatment.

Visiting Patients

When the condition of the patient makes it necessary, the dentist must visit him at his home provided the distance involved is not more than five miles. The dentist is entitled to an additional fee from public funds for these visits.

Supply of Drugs

Any drugs or medicine allowed by the Minister may be prescribed by the dentist for use of the patient at home.

Replacements

A patient is entitled to have dentures and other dental appliances replaced without charge unless the replacement has been necessitated by personal carelessness.

Deputies: Partners and Assistants

If the dentist is ill or on holiday, he should arrange for his partner or another dentist to treat patients on his behalf.

Authority for Treatment

The dentist may undertake certain items of treatment for the patient without prior approval. For other items, the prior approval of the Dental Estimates Board is needed. The Board, composed of six dental members and two lay members, approves estimates of treatment and claims for payment submitted

by dentists. The Board is also responsible for matters involving professional judgment as well as for the necessary financial scrutiny of dental estimates.

A. Examples of dental treatment not requiring prior approval (abridged) are:

1. Clinical examination and report
2. X-rays, within limits
3. Prophylaxis (normal scaling and gum treatment)
4. Amalgam and silicate fillings
5. Extractions not necessitating the supply of dentures
6. Repair of dentures
7. Emergency treatment (for the relief of pain)

B. Examples of dental treatment requiring prior approval (abridged) are:

1. Extensive and prolonged gum treatment
2. Gold fillings and inlays
3. Crown and bridge work
4. Dentures and obturators
5. Extractions necessitating the supply of dentures
6. Removal of impacted teeth, buried roots, cysts, etc.
7. Treatment of fractured jaws
8. Orthodontic treatment

It should be pointed out that the patient is contractually liable to examination by the Regional Dental Officer before treatment to confirm the clinical judgment of the dentist and after treatment to confirm the standard of the work and the completion of the service.

You may be sure that members of the dental profession are resentful of this interference with their exercise of professional judgment; and especially since they know that with respect to treatment, the decision of the Regional Dental Officer, no matter who he is, is final. A dentist I visited in Scotland related that in a recent case in his practice, the Dental Estimates Board demanded an outline of treatment before X-rays and diagnosis had been made, and he added, most indignantly, "Why should anyone pass on my recommendations?" The majority of the dentists with whom I talked also complained about the time involved in sending estimate forms back and forth and in getting authority for treatment. Not to speak of their aversion to the government's requirements of filling out forms and keeping special records.

They reported that the Dental Estimates Board was authorizing 16,000 cases of extractions and dentures per day. The Board was openly accused of rubber-stamping recommendations for this radical type of treatment because it is a non-recurring expense to the State; whereas estimates submitted for conservative treatment were said to be examined most cautiously and often required considerable correspondence before being finally authorized or disallowed. It is not surprising, therefore, that dentists are tempted to recommend the type of treatment they know will receive immediate authorization by the

Board rather than to become involved in the endless struggle of attempting to get approval of the kind of treatment which they think is best indicated for the patient but which they know is most costly to the State.

Sequence of Transaction

The sequence of transaction between the dentist and a patient is illustrated by the following example:

1. The patient selects a dentist in the Scheme by consulting the list at the local post office. He goes to the dentist and asks to be accepted as a patient. The dentist has the right to refuse.

2. If accepted, a government form is made out in the patient's name. The patient signs a section of the form indicating that he has chosen the dentist for services. The dentist signs a detachable portion of the form and presents it to the patient. This is the patient's guarantee of service by the dentist.

3. The dentist makes an oral examination and fills out a chart giving detailed information including the condition found, previous dental work, the treatment proposed and the fees for each operation. Part A of the form shows all the recommended treatment, whether or not prior approval is required. Part B shows fillings present, cavities to be treated, extractions to be done and any crowns or inlays that might be present in the mouth. Part 8 column I estimates the treatment to be given and the cost of such treatment. Part 8 column II shows treatment the patient wishes to undergo.

3. The form is then sent to the Dental Estimates Board for the approval of certain types of treatment. The Board may require the Dental Officer in the area to examine the patient.

5. If the service is approved, the form is returned to the dentist. Alterations in the recommendations may be made by the Board if they see fit to do so.

6. When treatment has been completed by the dentist, the patient is asked to sign a section of the form certifying that to the best of his knowledge the treatment proposed has been done. The dentist signs a section of the form certifying that the treatment has been completed and that he is entitled to the stated fees.

7. The dentist sends the form to the Dental Estimates Board and if the fees are authorized for payment, he is paid by the local Executive Council. The transaction between the dentist and the patient is complete.

Conditions with Respect to Materials

In studying the Handbook,¹⁴ I ran across a very amusing item under the heading "Conditions with Respect to Materials" which obviously appears to have been written by a government official. A few of the conditions are:

All filling materials shall be of first-grade quality and suitable for each individual cavity. . . .

Translucent silicate cements may be used in anterior teeth but are not to be used for fillings in teeth posterior to canines except in buccal cavities. . . .

All materials used in dentures shall be of first-grade quality. A plastic base material other than vulcanite shall be used only if it is an approved acrylic resin (that is, a brand of acrylic resin approved for the time being by the Minister for use in the making of dentures).

Bands and clasps shall be of either:

- (a) Alloys containing not less than 40 per cent of gold, platinum or palladium (including not less than 15 per cent of gold, and not more than 20 per cent of base metal) or
- (b) Stainless steel, or
- (c) Such other material as may be approved by the Minister.

Metal used . . . for denture plates, lingual or palatal bars, backings and tags, spiral springs, bolts and swivels, shall be:

- (a) Alloys containing not less than 33½ per cent of gold, platinum or palladium and not more than 20 per cent of base metal, or
- (b) Stainless steel, or
- (c) Such other materials as may be approved by the Minister, and shall be of adequate strength.

Remuneration

The dentists in the Scheme are paid by a fixed scale of fees for various dental operations; whereas the physicians are paid by capitation fees for each public patient.

Spens Committee

The now famous Spens Committee,¹⁵ appointed by the government to investigate the remuneration of dentists, had recommended that dentists working 33 chairside hours a week or 1500 a year should receive a net income of \$6,400 a year in terms of 1939 value of money.

Scale of Fees

Following the acceptance of this report, the Ministry made certain adjustments for the increase in the cost of living and allowed a 52 per cent discount for professional expenses. This brought the gross figure to just over \$16,000. Since the Spens Committee had suggested that dentists should not be expected to work more than 33 chairside hours a week without "loss of efficiency," the value of his time could be determined. With the aid of a committee of representatives of the dental profession, the average time required to do various dental operations was estimated. Based on this information a scale of fees was designed to produce for the fully-employed, experienced dentist a net income of just over \$7,000.^{16, 17, 18, 19}

Obviously, the preparation of the scale was made without accurate figures and in presenting it "the Minister stressed that it was temporary and would be reviewed in the light of experience within the first year."²⁰

Attitude of Profession

It is generally understood that the majority of the members of the profession felt that the scale of fees was fair and reasonable. In fact it was more reasonable

than had been expected, and many took the attitude that the Minister's generosity in respect to fees was in the form of a bribe to get them to join the Scheme. The objection was not to the fee scale, but to the fact that there was no guarantee that it would not be cut.

Results

Regardless of the Minister's motives or of the profession's objections, the National Health Service Act went into effect on July 5, 1948, with about 5,000 dentists, or approximately 50 per cent of those in general practice, enrolled. Today more than 90 per cent are in the Scheme according to the latest available figure of 9,349 released on May 1, 1949.²¹

Limitation on Earnings

Within a few months of operation of the Scheme it became obvious that certain dentists were earning a far higher rate than had been expected. Consequently, on February 1, 1949, a regulation became effective, whereby half of any gross income over \$19,200 was automatically taken by the government.

The editor of "News from Britain" to the *Journal of the American Dental Association*²² points out that a gross income of \$19,200 is only comparable to a net income of about \$9,200. Since no publicity was given to this fact, he says that "the \$19,200 figure stuck in the public mind and became the yardstick for all other salaries from Cabinet Ministers to messenger boys."

Penman Committee and Cut in Fees

Shortly after the limitation on earnings was made effective, the Minister appointed the Penman Committee to investigate the time factor of dental operations for the purpose of securing accurate information upon which a permanent fee scale could be established.

Without waiting for the Report of the Penman Committee, the Ministry of Health announced on May 19, 1949, an arbitrary reduction in the scale of fees for dentists. The new scale was to take effect on June 1, 1949, and was to supersede the limitation on earnings which was to be brought to an end on July 31, 1949. The Minister felt that the preparation of the Penman Report and the negotiations following it would take too much time.²³

While this alteration in the scale of fees has been expressed as an over-all 20 per cent cut, the editor of the *British Dental Journal* explains that, since a cut in gross fees cannot be accompanied by a corresponding reduction in expenses, the reduction in the net remuneration is of the order of 40 to 50 per cent.²⁴

Publicity

On the same day that the announcement was made of the cut in the scale of fees, the Ministry of Health issued a memorandum to the press showing an

analysis of the earnings of 5,078 dentists from October 1948 to March 1949. It showed that 1,066 were earning at the rate of more than \$24,000 a year (gross) and of these, 333 were exceeding \$33,600. Mr. Bevan said he could not allow the present "unjustifiable drain on the Exchequer" to continue.²⁵ This kind of publicity has been unfortunate for the dental profession and misleading to the public both there and here.

Commenting on the gross earnings of dentists, the editor of the *British Dental Journal*²⁶ said, "These, in the crude form in which the figures have so far been presented to the public, are a wholly unreliable guide to the actual net remuneration of the profession. In them no account is taken of the hours of work, nor of the possible effect on the costs of a practice of payments for overtime work."

Protest by the Profession

The decision of the Minister to reduce the scale of fees without waiting for the Penman Report or any effective consultation with the profession has evoked widespread protests.

Reports from all over the country indicate that many dentists are declining to accept new patients under the Scheme. In some areas, concerted action is being taken along this line.²⁷

Visit with Member of Penman Committee

On August 18, 1949, I visited a member of the Penman Committee. A copy of the Committee's final report had reached his desk the day before. It had not yet been released for publication and was confidential. He seemed to feel that the purpose of the Committee was only "window dressing" and had little confidence in the Minister's intention to implement their findings if not to his liking.

Statutory Powers of Minister

A startling legal interpretation recently came to light when the British Dental Association sought Counsel's opinion on the statutory powers of the Minister in the matter of remuneration. Counsel reports that the Minister not only has the right to make alterations in the scale of fees at any time and without prior notice but that there is nothing to prevent the Minister from making such alterations retrospective.²⁸

Examples of Fee Schedule

A few examples of the original scale of fees²⁹ and the reduction by amended regulations may be of interest.

	To May 31, 1949	Beginning June 1, 1949
Clinical examination and report	\$2.00	\$1.00
Amalgam filling (one surface)	4.00	3.00
Amalgam filling (more than one surface)	6.00	4.50
Extraction (one or two teeth)	2.00	1.50
Dentures (full upper and lower)	42.00	37.80
Gold Inlays (minimum)	16.50	14.50
Gold Inlays (maximum)	28.50	25.00
Gold Crowns	17.50	15.50
Jacket Crowns (minimum)	30.00	25.50
Jacket Crowns (maximum)	37.50	32.50
Orthodontic Treatment	Such fee as the Dental Estimates Board may approve.	

Rush for Service

With the launching of the New Health Scheme on July 5, 1948, the people of Britain made a mad rush for all of the numerous aids and services that had been promised them "without cost." Very soon the waiting rooms of the dentists and physicians in the Scheme were filled. Queues began forming at the establishments of chemists and opticians.

One night in Birmingham, I counted 37 people in a queue in front of a drug-store at 10:30 p.m. One of the attendants explained, "This goes on every night." Posted on the wall was a notice issued by the Ministry of Health which indicated the enormous demand for medicines and drugs. It read, "Please return all medicine bottles promptly and in a clean condition. By so doing you are assisting the smooth running of the National Health Service and are helping to keep down the cost."

As time went on the increased demand for dental service (a large part of which was, and still is, for dentures) created several abnormal and undesirable situations. Dentists began working overtime. They accepted patients at night and on weekends. They gave up their vacations.

The demand for dentures and other restorative appliances was so great that many laboratory technicians who had been privately employed by dentists left them to go into business for themselves. These dentists who were left short-handed and others who suddenly found themselves in need of auxiliary assistance were forced to employ unskilled personnel. Many women and even boys and girls were quickly recruited for this type of work.

In spite of the fact that longer hours were being spent by dentists in their offices, many people desiring dental service were unable to find dentists willing or able to accept them as patients. Many others who had been accepted were required to wait, often months, before being able to obtain dental treatment.

Of course, people complained about this situation, but so did the dentists. A young, recent graduate practicing in Glasgow lamented to me, "If a man tries

to do conscientious work he is criticized because the people can't get appointments; if he speeds up and takes care of a lot of people by working longer hours and killing himself, he is criticized for making too much money."

These problems and many others which have developed concurrently with the operation of the National Health Service were far from solution at the time of my visit which was more than a year after the introduction of the Scheme.

More Dentists Joining

At that time more than 90 per cent of the dentists of Britain were in the Service and others were being slowly drawn in. I talked to a number of dentists who had only recently joined up and others who said that they expected to do so very soon. These men explained that for economic reasons they were forced into this position because of the gradual withdrawal of their private patients.

Some of the dentists who were doing part-Scheme practice and part-private practice told me that an ever-increasing number of their private patients were asking to be changed from private-status to Scheme-status to avoid the "double cost" of dental service, and they said that eventually they would have no private patients.

Only about 5 to 10 per cent of the practicing dentists of Britain at the present time are completely out of the Scheme; many of these expressed their determination to remain outside even if it meant the sacrifice of their profession for some other means of livelihood.

Quality of Service

It was the consensus of the dentists I met everywhere that the quality of dental service was deteriorating under the Scheme. They pointed out that a higher quality of service is not accompanied by a higher fee; nor is additional time spent in striving for perfection rewarded by an increase in remuneration. What incentive, therefore, is there for a man to excel when all dentists are put on the same level?

Moreover the less conscientious or unscrupulous practitioner is placed in a position to profit financially in proportion to the degree of his dishonesty.

Typical of many of the remarks I heard about the quality of dental service were these: "practice under the Scheme is rotten;" "it's all slap-dash dentistry;" "all dentists are on the same level and the level is coming down;" "there is too much dental attention and not enough dental care."

Description of Surgeries

I saw much evidence of what the British call belt-line dentistry. I visited a surgery in the industrial section of a Midland town in England where I found such a practice. There were three dentists in partnership. The laboratory which

I was permitted to visit was staffed by twelve technicians, mostly boys. The place looked, literally, like a gypsum plant. The office was ill-kept. One dentist used a foot engine. I was told that many very old people who had never worn dentures before were having them made but wouldn't wear the dentures after they got them.

In another surgery occupied by two dentists and located in a poor neighborhood of one of Scotland's large cities, I found a similar situation. Seven laboratory technicians were busily engaged in constructing dentures. One of the assistants informed me that they were averaging 40 dentures a week. She talked about the Scheme with a great deal of emotional feeling and warned, "Don't have it in America."

The fact that denture service occupies so prominent a place in the scope of dental practice in the Scheme is not altogether the fault of the dental profession. Too large a proportion of the people now, as always, demand the extraction of their teeth and the replacement of them with dentures. In many cases, if one dentist refuses to perform these radical services because conservative treatment is indicated, the patient will seek another who is willing to abide by the patient's wishes.

All of the dental surgeries I visited in Britain, however, are not operated in the manner of the two I have just described. The majority of them are well-kept and conducted in accordance with the highest ethics of the dental profession. I was attracted by the fact that so many of the surgeries are in private homes, either in the dentist's own home or in rented quarters of some one else's home; others are in houses that have been converted to use of a group of dentists, or dentists and physicians. The equipment and facilities, in general, do not measure up to the standards in this country. The surgeries themselves are often designed and decorated to give the appearance of a living room, with the operating equipment occupying only one portion of the room. Paintings, statues, fireplaces with mantles, and other home-like appointments are accentuated.

Fear and Insecurity

In answer to the question of how the dentists of Britain feel about their position in the National Health Service, I can say with considerable self-confidence that I found a profession cowed and frightened, disillusioned and disappointed, resentful and bitter.

I talked to dentists all over England and Scotland who expressed to me their feeling of economic and social insecurity, and fear of what tomorrow might bring. Many of them said that they were reluctant to open the daily mail.

Typical were the remarks made by a general practitioner in Lancashire who said, "I am fearful of what may happen any day. Bevan is likely to do anything at any time." He added, "I am making more money than I made before; but

I have to work too hard; have patients on waiting list since last September and I can't take any new patients until I catch up on those."

The most somber topic of conversation everywhere was the expressed belief that ultimately the majority, if not all, of the dentists would be reduced to the status of civil servants working in Health Centres or Dental Centres on salary, and that the private practice of dentistry in Britain would be a thing of the past. There is sound basis for this belief, a discussion of which will be made later in this report.

Attitude Toward Minister

The dentists I talked with were quick to express their opinions about the Scheme, the government, and the Minister himself.

The attitude of the profession toward the Minister can be illustrated by a few sample remarks: "the whole thing is political and is engineered by a dictator;" "Bevan is a damn fool who knows nothing about medical or dental practice;" and, "too much power has been put in the hands of one man."

Referring to the Minister, a dentist in Bournemouth with a sense of humor wrote the *British Dental Journal*³⁰ that, "No responsible man breathing has done more to reduce the dental profession to the lowest common denominator and fostered the return of conditions existing before 1921. If, in his conceit, his absurd Scheme is a 'flop,' he has only himself to blame, not the dental profession, who can now see through him without the help of his unobtainable 'free' spectacles."

Priority Services

Almost everyone I talked with expressed the opinion that the greatest and most tragic failure of the Health Scheme is the virtual breakdown of the School Dental Service for children and the services for expectant and nursing mothers.

It should be remembered that the National Health Service Act³¹ had specifically provided a priority dental service for these classes.

As early as November, 1948, an editorial in the *British Dental Journal*³² stated that it was almost impossible to exaggerate the seriousness of the position which had developed in regard to the "priority" dental services; that from all parts of the country had come reports of the resignations of School Dental Officers, and that there were not enough recruits to fill their places.

The government was well informed that the cause of this situation was the disparity of income between the public dental officer and the general practitioner, but no proposal was made by the Minister to remedy the condition.

I discussed this problem with John R. Boyes, contributor of "News From Britain" to the *Journal of the American Dental Association*, during a personal interview with him at Newcastle-upon-Tyne. He states that,³³ "During the winter resignations from the School Dental Service reached the point where

some local authorities found themselves with only one or two dentists on their staffs and many dental clinics had to be closed. . . . To many, it seemed ironical that the government's declared priority classes for dental treatment—school children and expectant and nursing mothers—were the ones most to suffer in the new service."

The government is universally blamed for the present situation on two counts: first, because the remuneration of Public Dental Officers has not been adjusted to the proportionate level of that of private practice; and second, because, in view of the shortage of dentists, the scope of dental services to be provided in the Scheme is too broad with respect to the adult population.

Many believe that artificial dentures, for example, should not have been included, since their provision constitutes a large part of the present service. Only four months after the Scheme went into effect, Mr. Bevan stated in a written answer to the House of Commons³⁴ that 40 per cent of the \$19,000,000 paid or owing to dentists for work completed was for new dentures.

Today, after one year of the Health Plan, it is reported³⁵ that more than 2 million sets of dentures have been provided.

The *Practitioner*,³⁶ reviewing the first year of the Health Service, says, "Although it may be politically expedient, it is nevertheless scientifically wrong, as well as economically unsound, to provide dentures for octogenarians while allowing the teeth of the rising generation to be neglected."

A School Medical Officer is reported in the Manchester *Guardian* to have concluded,³⁷ "Once dentists were put to remedying dental defects in the adult population on a piece-work basis, there was enough work to keep them busy for a half century and there was an end to preventive dentistry."

COST OF THE SERVICE

The National Health Service is costing the British taxpayer about \$1,200,000,000 a year, according to a recent announcement by Mr. Bevan.³⁸ The government had previously estimated that the dental services alone would cost \$28 million annually. Actually it is running more than four times that amount. The British Dental Association predicts that it will cost \$120 million annually for years to come.

In the breakdown of the London costs for the first year of the Scheme,³⁹ it is significant to observe that the combined expenditure for pharmaceutical and ophthalmic services was about \$15 million; whereas, the total for medical and dental services was, by comparison, only \$20 million. In other words, three-fourths as much money was spent on pharmaceutical and ophthalmic services as was spent on medical and dental services. The conclusion that may be drawn from this fact is obvious.

The deductions from employed persons amount to about \$1 per week and the

employer pays the same amount. These payments cover unemployment and cash sickness benefits, retirement pensions and health service. The cost of the health service alone is about 17 cents per week.

SAMPLE OPINIONS

In recording the opinions expressed by Britons in every walk of life as to how they personally felt about their National Health Service, I found considerable uniformity in the remarks made by the group of persons who voiced their disapproval of the Scheme and, also, a similarity in the pattern of thought of the group who expressed themselves in favor of it. A few of the unusual and varied opinions may be of interest.

Dentist in London. "The whole story is about like this: You make Hot Cross buns. They tell you to make more buns. You say you can't. They tell you they will pay you twice as much for the buns. You can't turn that offer down. You work longer hours. You employ unskilled labor. You can't get more flour so you put in sawdust. People complain. Overwork makes the personnel irritable. You turn out lousy buns and in desperation you commit suicide. One dentist did, recently."

Physician in Edinburgh, Scotland. "I have seen a lot of sick people but I have never seen poison act so quickly."

Patient in Dental School at Newcastle. "I can get specialists I couldn't afford before. Some people around here say, 'You get glasses and teeth free and then pay 13 pounds a year for the use of them.' I spent more than 13 pounds a year for medical and dental service before the Scheme."

Dentist in Lancashire (in Scheme). "A patient came to me to have new dentures made. I asked him where his old ones were and he said he threw them in the canal. Dentists in Liverpool are very busy taking care of boat-loads of people brought over from Ireland to get free dental service."

Barber in London. "The Scheme's no damn good. The government's no damn good. You just pay and pay and pay. This is the worst country in Europe."

Dentist in Edinburgh, Scotland (in Scheme). "Two years ago if I had talked to you, I would have said that if I had my life to live over I would choose dentistry, but I can't say that now. Many service men voted for the labor government thinking that they would get out sooner. The Scheme encourages men to be dishonest. I know one dentist who put in 25 fillings in one hour."

Taxi Driver in Glasgow, Scotland. "It is good for a man with a family. There is nothing worse than worry for a sick man. I was in the hospital for seven weeks with a rupture operation and my wife didn't have to worry about a thing. I couldn't have done it without the Scheme."

Dentist in Stratford-on-Avon (in Scheme). "The government made a mistake in trying to do everything at once. People have gone crazy. I know a woman who stood in a queue for two hours to get an ounce and a half of birdseed and she had no bird."

Dentist in Manchester (not in Scheme). "England is facing financial crisis. The greatest fault of the Scheme is that it has wrecked the dental care of children in the school system, and care of children is much more important than repair for adult dental cripples—dentures should not have been included in the Scheme. Health care cannot be reduced to a uniform purchase price."

Waiter in Edinburgh, Scotland. "My idea of National Health is: Not getting something but rather not needing anything."

If all of the words I heard spoken by Britons and all of the publications I have read about the Scheme were put together, they would form an extensive volume. But, if one read that book he would have no clearer picture of my impression of how the dentists of Britain feel about their situation than he would have from reading a short letter written very recently to the *British Dental Journal*⁴⁰ by an English dentist. The letter reads:

The first twelve months are over. Gradually the net is tightening. The bureaucrats are winning. Directives are now issued. . . . It is difficult to get anything unusual approved. It's the same as the Forces except for the bowler hat.

What now for clinical freedom? Were we right or wrong in what we told you? First the \$19,200 ceiling—now a 20 per cent cut. What of the future and the Penman Report? Are you secure? Are you happy? . . .

The good will of the public has been lost. In their eyes we are all money grabbers making our fortunes. It is better nowadays not to tell anyone you're a dentist. Their antagonism is being fanned by the present press campaign. They are encouraged to make complaints by our enemies. No matter how frivolous the complaint, all the heavy machinery of bureaucratic rule is set in motion to investigate and protect the poor misguided and ill-used public. We are exposed to all manner of investigation by officials. . . . No wonder the soul of the profession has gone. Cast your minds back twelve months. We were warned that this would happen—some of us knew it but the others didn't believe it. They rushed in and made hay whilst the sun shone and we were dragged in after them. And now they can see it in its true glory. The Brass Hats of Eastbourne are in power and we are at their beck and call. . .

FUTURE OF THE SCHEME

What, then, can be said of the future of dentistry in Britain under National Health Service? Of course, any prediction must be based, to a limited extent, on speculation.

There are, however, certain facts and observations that appear to be of considerable importance in predicting the pattern of operation of the Scheme in the months to come.

It has been established that there are not enough dentists to meet the present demand for dental treatment and there is little likelihood that a sufficient number could be recruited any time soon by customary methods, "to provide complete conservative treatment for all those who need it, even if they could be persuaded to accept it."⁴¹

It has also been established that the "priority" service for expectant mothers and children has completely broken down; and that the dental program in the Scheme is costing too much money.

If it is the intention of the Government, as many believe, to continue to provide reparative services for the adult population, to attempt to correct the situation with respect to the "priority" services, and to reduce the cost of oper-

ation of the dental program, very drastic measures must of necessity be employed.

One of these measures will be the establishment of Health Centres or Dental Centres in which dentists will be employed on a salary basis. The Minister, himself, has stated⁴² that it was his intention to "develop general dental services in the Health Centres, or corresponding Dental Centres, as soon and as quickly as possible" and that dentists participating "shall be remunerated by appropriate salaries."

There is further evidence to show that the present system of treating patients in private surgeries on a scale of fees was instituted as a temporary measure until the Centres could be developed.⁴³

From the government's viewpoint, the Health Centres or Dental Centres would provide, by efficiency of operation, a more comprehensive service at reduced cost. Moreover, under this plan the scope of services could also be broadened by extending the use of auxiliary personnel.

It is interesting to note that the Tevoit Committee, in their report⁴⁴ to the Minister in 1946, had recommended that "the institution of any Scheme of dental operative assistants should await proof of a shortage of dentists to work a comprehensive dental service. . . ."

Today, it is obvious that a shortage of dentists does exist. Is it implied, then, that the use of operative assistants is recommended? I was reliably informed in Britain that the Ministry of Health was giving serious consideration to the training of "dental nurses" to do children's dentistry, including prophylaxis, fillings, extractions, and local anesthetics.

Captain John Baird, a dental surgeon as well as a Socialist member of Parliament, is reported⁴⁵ to have stated during a Parliamentary discussion, that he believed that in time to come it might be necessary to bring mechanics into the state service to do surgical work.

From the profession's viewpoint, the civil service status of dentists working in Health Centres would mean the further destruction of professional freedom. They point out that the system will thwart initiative and incentive; that the dentist will be under the supervision of the Dental Officer who will be a direct descendant of the Regional Dental Officer; that the decision of superiors will be final, from which there will be no appeal; and, finally, worst of all, the dentist will be subject to dismissal at any time.

From a long-range point of view, the most significant aspect of the situation is the effect it will have on the future of the dental profession and on the quality of dental service the people of Britain will receive.

Since the dental schools are in a very large measure responsible for the future of the profession, the effect of these events on dental education is important.

If it comes to pass that the system of salaried service in Health Centres essentially replaces the private practice of dentistry in Britain, it is difficult to

see how the dental schools will be able to recruit students without lowering the educational standards, with respect to the requirements for admission, the duration of the course, and the cost of the training.

If dentists must be recruited for these civil service positions, and the rewards of the profession in terms of prestige, independence, public esteem, and remuneration are not sufficient to justify the sacrifice which boys and girls have previously been willing to make, the dental curriculum will have to be adapted to a different objective.

That there is evidence of the recognition of this possibility is borne out in a discussion of "Measures to Secure an Adequate Number of Dentists" contained in the Tevoit Report⁴⁶ to the Minister of Health. It states:

As to the length of the course, we recommend that a review should be carried out as soon as practicable with a view to devising the shortest possible curriculum with the maintenance of a satisfactory standard of training.

Certain educational concessions may be made to dental mechanics wishing to become dentists. . . . It has been suggested to us that if, in addition, the higher grade of mechanics were encouraged to qualify by the provision of special bursaries, it would materially aid recruitment. We take the view that with careful selection and intensive whole-time instruction, the course for suitable ex-service men and women might be reduced to practical dimensions, so as to enable them to be trained to the necessary standards within a reasonable period.

Does this mean a lowering of the standards of dental education—and the inevitable lowering of the standards of the dental health of the nation—standards that are admittedly low already? Are the pressures being built up by the demands of the National Health Service Act going to defeat the very purpose of the Act? The answer lies in the future.

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DENTAL CARE FOR THE NEW YORK STATE SCHOOL CHILD

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Dental care for the New York school child is undergoing some important changes—changes which began in January 1949. Therefore, in discussing this subject, I shall briefly present the status prior to January 1949 and then give in some detail the changes made and contemplated.

The ways in which a New York State school child received dental care prior to 1949 probably did not vary greatly from those available in many of the other states. They might be covered by these seven headings: private dental offices, clinics of professional schools and foundations, local community programs, State Rehabilitation programs, State Welfare programs, Division of Health and Physical Education programs of the New York State Department of Education, and Division of Maternity and Child Welfare programs of the New York State Department of Health.

This paper will be confined principally to a consideration of the programs of the Department of Education and the Department of Health, especially program changes of the Department of Health. Our Council on Dental Health believes that these changes in the Department of Health program will stimulate greater interest in child dental care in all possible sources.

The Dental Health program in the schools of New York State represents a total of 31 years of service. This service has varied since 1918 from volunteer lectures and demonstration experiments to a more specific educational approach. The present program is closely allied to the general health service and teaching programs, which are in turn related to all the community programs of health.

Although this school dental program involves a great amount of dental prophylaxis, preventive treatments, emergency treatments and emergency extractions, we consider it more of a dental education program than a strictly dental care program.

The objects of the program are:

1. To determine the oral health of all pupils by examination usually done by hygienists—and to register the results on a dental record and on an accumulative health record.
2. To promote sound habits of dental hygiene.
3. To urge early and frequent visits to the dentist.
4. To foster better eating and living habits.

The organization and administration of this dental program is the responsibility of the school administrator and the local board of education. The per-

sonnel consists of dentists, dental hygienists and dental hygiene teachers. Our program is based on a ratio of 1 hygienist to 1650 pupils although we believe that 1 hygienist to 900 pupils is necessary for adequate follow-up procedures.

During the year 1947-8, of the 838,256 pupils outside New York City, Buffalo and Rochester, 95% received the annual examination; of these 68% had dental defects.

New York City, Buffalo and Rochester have separate health administrations within their own school systems and render equal or better dental care.

Children from low-income families can and do receive necessary care made available by public funds.

When the dental examination discloses defects a card is sent to the parent or guardian. When the dentist completes the care, he signs the card and sends it back to the teacher. The teacher maintains a follow-up on these cards.

A complete coverage on periodic examinations and follow-ups on defects requires more hygienists than have been available, but this deficiency is in the process of being corrected. Two years ago when this shortage became evident, the State Education Department established new schools for hygienists within the Technical Institutes of Applied Arts and Sciences. As a result we have about doubled the number of hygienists graduating each year.

Even with complete follow-up service by the school hygienist, we of the Council on Dental Health believe that there is still more to be desired. We feel that the motivating force to get the child into the dental office is the parent or guardian, and it is our hope to activate this force by a statewide education program under the joint auspices of the New York State Department of Health and the State Dental Society.

Then, too, there is the need to induce the dentist to accept his responsibility to provide dental work for children, either in his office or by proper reference. We have all had mothers call in and say, 'My dentist is too busy to take care of children and I would like to make an appointment with you for my little George.' In New York we hope to eliminate this stigma on the profession. We think it time to quit advocating early care and refusing to provide it.

So our school program is gradually undergoing improvement, and we are hopeful of greatly reducing dental defects in the children of our state.

Prior to 1949 the Dental Program of the New York State Department of Health was very limited in scope. This condition was probably due to the administrative planning, which assigned the dental program to the Division of Maternity and Child Welfare. It consisted of four projects:

1. The Pre-School Program, known as "Well Baby Clinics" or, in New York, as "Child Health Conferences".
2. The Orthodontic Program, for correcting crippling defects.

3. The Postgraduate Education Program, for providing refresher courses in pediodontia.
4. The Research Program: the Kingston-Newburgh fluorinated water supply study—a ten-year program begun five years ago.

The members of the Council on Dental Health realized the need for an expanded dental program in the State Health Department, and had noted the futile attempts made to extend its scope. They were aware that a hit-or-miss approach to the problem would result in failure. They wanted to know precisely the basic principles upon which to formulate a complete objective program. They found the answers in their dental conference study of the workshop type held in January 1947.

The findings and recommendations of this "Dental Health Planning" Conference were approved by the Executive Council of the State Dental Society in May 1947. The approval by the governing body of our Society gave the Council on Dental Health the support and encouragement that enabled them to proceed with authority in their endeavor to obtain an expanded dental program for the people of the state. This authorization constituted the first step toward obtaining better and more dentistry for our children.

The second step came in June 1947 when our Commissioner of Health, who was not sympathetic to dentistry, resigned and Governor Dewey appointed Dr. Herman E. Hilleboe, as Commissioner. Dr. Hilleboe came from the United States Public Health Service and was more appreciative of the importance of dentistry. Naturally we lost no time in informing the new Commissioner that the dental profession had something to offer to improve the health and well-being of the people of our great state and that we would welcome an opportunity to show how we could help.

There quickly followed a series of meetings attended by the Commissioner and some of his staff and a sub-committee of the Council on Dental Health. The conclusions derived from these meetings resulted in the development of the expanded dental program. One of the important points decided in formulating this program was that such a program involved too greatly the health and welfare of the people and required too much activity to be a part of the Bureau of Maternity and Child Welfare.

This tentative joint program was accepted in principle by the Health Department and the Dental Society, but it was agreed that it would be necessary to define the details and the scope of the program at a second health conference. This conference was held in October 1948.

The jointly formulated program as corrected and passed at this conference was approved by our Executive Council in December 1948. The final program consists of four principal parts: dental caries, oral cancer, malocclusion and industrial dentistry.

That you may have some idea of the content, I shall present in outline form some of the material under the caries section. This will no doubt be the first point of attack in applying the program.

A. Need for a public program.

1. From the analysis of the problem of dental caries it is apparent that the most efficient approach to its solution lies in the thorough application of the preventive measures as they are developed and in the shift of emphasis to the periodic examination and to the correction of the defects of the child with the view of obviating the accumulated oral problems of the adult.
2. Without a public program the control of dental caries, which now seems to be a practical possibility, is certain to be long delayed, if not completely precluded. It is estimated that only about 25% of our people receive dental care adequate in terms of control. The problem of reaching the other 75% is largely educational. This phase is certainly the function of a public health program.

B. Goals to be achieved.

C. Prevention of dental caries.

D. Dental services.

1. Early detection of decay.
2. Dental care.

It is expected that in the average community the majority of those requiring care will avail themselves of private dental services. The remainder, however, will require the corrective service through a public program. It is expected that the corrective program will include expanded coverage of the pre-school children, plus the inclusion of children through the third grade.

There are fifteen recommendations under the caries heading, which state what we hope to accomplish.

To date this much has been accomplished:

1. A separate Bureau of Dentistry in the New York State Department of Health, giving dentistry administrative parity with the other major health services.
2. An increase in the number of children receiving topical fluoride treatments.
3. An increase in the staff of the state dental bureau including the full-time employment of a health educator.
4. Progress toward financial parity of dental personnel with the equivalent medical personnel.

The next step about to be taken is a statewide education program based on recommendations of the Joint Program. In order to achieve the best results from this education program we must know how best to apportion and time

the use of the available media. So we are turning to a third Dental Conference, which we are planning for March 1950. This conference will be held to determine the best methods of accomplishing these objectives:

1. Convince parents of the advantages of taking children to the dentist for early and frequent examinations and care.
2. Teach the parents the advantages of proper diet, including a decreased carbohydrate consumption.
3. Teach the parents the advantages of proper home dental hygiene.
4. Teach dentists the advantage of accepting their responsibilities to children.

When such a program becomes effective to the point of persuading the adults to desire dental care for their children above other wants, then will the parents seek dental service and find a way to provide it.

In concluding, I would like to say a word about the distribution of dentistry to more people. I believe the profession must accept the responsibility for doing all it can to provide adequate dental care for more children, because the social trends demand that more than 25% of our people receive adequate dental care. Furthermore the profession must see to it that children are not turned away from dental offices. We must give them care or find dentists who will.

On the other hand the public must accept the responsibility for better co-operation with dentistry by helping the child to understand the importance of his dental needs and by getting the child excused from school.

If we do what we can to cause more children to receive adequate care in terms of prevention and control we shall be in a sound position in our campaign against compulsory health insurance.

We in New York State believe that the educational program we are about to launch as the next step in our Joint Program will cause more children to have adequate care. We expect it to get more people to think in terms of periodic dental attention. We expect it to get more dentists to realize that they have a stake in providing dental care for more children. We expect to get the parents and guardians to take a more serious attitude toward the cards received from schools requesting that the dental defects of their children be given attention.

In the June 1948 issue of the *Journal of the American College of Dentists*, our Editor, Dr. J. Ben Robinson, stated, "I believe that the health problem of the people can be solved permanently and more effectively through the individual's assuming a personal responsibility for satisfying his own wants." We in New York hope to show the people their responsibilities and wants and demonstrate how they may acquire the needed dental care.

DENTAL SERVICE FOR THE INDIGENT AS A PART OF THE
MEDICAL CARE PROGRAM OF THE DEPARTMENT OF
HEALTH OF THE STATE OF MARYLAND

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The *Washington Post*, May 1-5, 1949, published a series of articles written by Agnes E. Meyer entitled "Maryland Solves Health Problem without Federal Aid." A better title could have been used. The problem is not solved and may never be. A good start has been made. Four years' experience has shown that such a medical care service is needed and that the plan envisioned by its originators is capable of providing the needed service. However, as with all plans to improve and increase medical aid, costs run high. They are inhibitory. Even under such circumstances the service being rendered is to the satisfaction of the patient and to the professions, but the taxpayers' burdens increase and the officials of the state are weighted with the responsibility for supplying the funds.

The Meyer articles began as follows:

Maryland is giving the Nation convincing proof that a State can solve its own health problems without Federal aid. It is demonstrating in every county and city that local initiative, voluntary cooperation and citizen participation are the most powerful elements for constructive and efficient action upon which our democracy can count to solve its acute social problems.

Moreover, this State health plan proves that our medical leaders are in a better position than anyone else to mobilize and coordinate the forces involved in the achievement of a practical health plan responsive to our ever varying social and economic conditions. This decentralized program has in fact achieved more than an improvement in health conditions. It has brought about an education in the understanding of community organization and in the use of cooperative endeavor for the common good.

The Maryland plan, in existence for 3½ years, is past the stage of blueprints, theory and planning. It is a smooth functioning, constantly expanding Statewide organization which has been thought out on such sound principles that they can be adapted to the conditions that exist in a majority of our States. I chose for study the experiments being made in rural conditions as well as those of a large city that happens to have two outstanding medical centers, which have contributed their knowledge, talents and prestige to the origin and evolution of the program.

The over-all policy behind Maryland's expanded health program is simple. It is that those who can do so are expected to provide for their own health needs by paying for them as in the past or through the medium of voluntary health insurance. Those who are unable to pay will be cared for through services provided by tax funds. This group falls into two divisions: (1) those in full need

of relief or welfare support (17,500 in the State, outside of Baltimore City); (2) those who may have some funds but who cannot stand too much drain on their resources to provide health service (probably 20% of the population). The second group is known as the medically indigent, but because of cost limitations only a small part of it (about 7,500 in all) can be included at present under the program. The total number of patients receiving service during June 1949 was as follows:

Indigent.....	4,493
Medically ind.....	2,157
Total.....	6,650

In other words, the indigent, as of June, constituted $\frac{2}{3}$ of the program; the medically indigent, $\frac{1}{3}$.

A very real degree of responsibility for the success of the program has been assumed by the professions. They advocated it, they aided in organizing it, they aid in directing it, they willingly and unselfishly participate in it. As of June 1949, 60% of the practicing physicians and 40% of the practicing dentists provide service under the program. Administration is not overloaded with politically appointed individuals seeking soft berths and thereby diluting the effort and increasing the administrative cost, which at present is but 7% of the total available funds. The plan is not encumbered with political difficulties unless the increasing need for more tax funds be classified in that category.

This Maryland program is no recent effort to fit in with the present demand for additional health service facilities. Well over a decade ago sentiment crystallized in the State for a program designed to provide health services to those who at the time of need were unable to obtain them. Changes then advocated and since put into effect have gradually altered the activities of the State Public Health Department to such an extent that the previous objectives of providing educational and preventive services have been augmented by corrective and treatment measures up to that time not considered a function of a health department. Under the stimulus of the Medical and Chirurgical Faculty of Maryland a Medical Care Committee was created by the State Planning Commission and a plan was evolved to provide money by legislative enactment from tax funds for medical, dental, nursing, hospital and pharmaceutical services. For years there had been more State-provided, tax-supported health service of an uncoordinated nature than most people realized, but this program represented the first consolidated grouping, with financial backing by the State clearly defined and specifically designated to aid those unable to provide for their own health needs. As a part of the State Health Department administrative table a Bureau of Medical Services was created. Its chief is a trained medical public health worker. There is a minimum of red tape, forms and bureaucracy.

Actual operating costs are surprisingly low, for extravagance and waste are non-existent. Besides the good fortune in having paid, well-trained, energetic and honest people directing the program there is a non-paid advisory committee composed of physicians, a dentist, pharmacist, nurse, hospital administrator, welfare director and others who meet at monthly intervals to weigh past procedure and evolve future plans. The April, 1949 meeting was the 36th of this group and the director states that the advisory group has been an invaluable aid in the administration of the program. For closer contact on the county level there is another advisory committee in each county which knows the county problem in a way impossible to anyone not of the local scene. From the local level to the actual administrative staff and then to the advisory group go policy matters which later are reviewed by the State Board of Health. The Board, however, feels that the responsibility for the program is essentially in the hands of the administrative staff and the advisory groups. And that feeling accounts to a considerable degree for the success of the plan, for all members and all groups know their jobs and what their responsibilities are.

There is no need to outline for you the generalized medical, nursing, hospital and pharmaceutical services which are a part of the Maryland plan. It is important that you know in some detail the dental aspects. Many such plans ignore dentistry completely. From the beginning dentistry has been a limited part of the Maryland plan; about 7% of the total funds is used for dental service. For the month of June 1949 this amounted to nearly \$3000. The eligible patient seeks dental service just as he would seek medical treatment. In the counties of the State the patient eligible for service indicated by his possession of a welfare card (the card is good for six months) selects the dentist he prefers, who does the necessary work and bills the Medical Care Program for the cost. Except for some recent limitations on prosthetic service, the dentist does whatever his professional judgment indicates. A detailed fee schedule will be given a little later in this paper. The procedure to be followed in Baltimore will require the person needing dental aid to pass through a new type outpatient hospital clinic where his needs will be evaluated and he will be given a list of names of dentists who have indicated an interest in participating in the program of rendering dental service to those in need. The dentist will be paid for his services on a fee for service basis through funds provided by the Medical Care Bureau. Payment for services rendered has been prompt; there is no complaint on that point. Service is not restricted except as to prosthesis and that situation has come about because of the demand, the high cost and the insufficiency of general funds to permit a heavier allotment for dental needs.

At the outset of this paper I stated that the problem had not been solved and might never be for the simple reason that the cost of such a program is extremely high even with the professions working on a low return for service.

This is especially true under the dental aspects. Because the indigent person or the individual under welfare care has seldom had dental service, his needs fall more often into the fields of extraction and prosthesis. The medically indigent person is seldom much better off. What dental services are rendered, therefore, come high in cost. Prosthesis is expensive; yet the fee schedule will show that the dentist is not the beneficiary. His return is less than he would receive for the same service in private practice. Even so, as the need for his services has become evident, he has willingly cooperated in making them available. No effort has been made to stimulate greater participation in the eligible group or to have the dentist emphasize the availability of the Program. The allotted funds are not sufficient for what has been shown to be the voluntarily sought after dental services and the slightest prod would no doubt financially scuttle the program. In fact, the provided funds are so low in relation to the demands that those in charge have found it necessary to consider further adjustment in fees through the possibility of pro-rating payments. This situation is regrettable and indicates a basic weakness, for it is asking the professions to provide a service at their expense while the State publicly receives credit for providing the Program. However, the Governor has recently allotted additional funds to relieve the existing strain so that services need not be curtailed or the State fail to meet the obligation.

The fee schedule as set up is known to all dentists participating in the Program:

MANUAL OF MEDICAL CARE

FEE SCHEDULE FOR DENTISTS

Dental services

Extractions

Single extractions—not to exceed.....	\$2.00
Multiple extractions for same patient at same sitting—first tooth.....	\$2.00
Each additional tooth.....	\$1.00
Maximum payment for extractions for one patient at one sitting.....	\$10.00

Fillings

Silver amalgam fillings, single surface.....	\$2.00
Silver amalgam fillings, two or more surfaces.....	\$3.00
Silicate or other cement fillings.....	\$2.00

Dental X-ray examinations

Dental X-ray each.....	\$1.00
Maximum fee for dental X-rays on one patient.....	\$5.00

Special dental services

Other office treatments.....	\$2.00
Elective Dental surgery—prior authorization of Health Officer required	

Dentures

Prior authorization of Health Officer required.

Full dentures—to be made of vulcanite only:

Upper or lower denture—not to exceed.....	\$35.00
Upper and lower dentures—not to exceed.....	\$60.00
Repair of denture—not to exceed.....	\$6.00

In general there has been little complaint from the profession, which has been most cooperative in handling this indigent problem. I have come to think of the Program as not being provided by the State alone, but rather as coming through two sources: without financial support of the State it could not function; without the contributory financial support of the profession it could not function. Success that has come is as a result of the State and the profession's working together for the welfare of the needy citizen.

The extent of dental service under the Program is interesting. Certain charts for the year 1948 show:

PRELIMINARY DATA TABLE DC 1

SUMMARY OF PAYMENTS, NUMBER OF REPORTS AND SERVICES FOR DENTAL SERVICES IN 1948

County	Total Payments	Total No. of Reports	Teeth Ex-tracted	Fillings		X-rays	Dentures				Other Services
				One Surface	Two Surface		Re-paired	Partial	Upper or Lower	Upper and Lower	
All counties.....	\$38,635.00	3,771	7,734	3,124	1,024	1,656	113	55	129	326	710

PRELIMINARY DATA TABLE DC 2 (SECTION 1)

SUMMARY OF PAYMENTS OF REPORTS FOR DENTAL SERVICES IN 1948 BY INDIGENCY AND RACE

County	Total Payments	Payments for			
		Indigent	Medically Indigent	Colored	White
All counties.....	\$38,635.00	\$23,362.00	\$15,271.00	\$3,477.00	\$35,158.00

PRELIMINARY DATA TABLE DC 2 (SECTION 2)

SUMMARY OF NUMBER OF REPORTS FOR DENTAL SERVICES IN 1948 BY INDIGENCY, SEX AND RACE

County	Total	Indigent	Medically Indigent	Male	Female	White	Colored
All counties.....	3,771	2,290	1,481	823	2,948	3,169	602

PAYMENTS FOR MEDICAL CARE BY COUNTY AND BY BRANCH
OF SERVICE—APRIL, 1949

TABLE 4

County	Payments to				Total	Cumulative Expenditures Fiscal Year 1948-1949
	Physicians	Dentists	Pharmacists	Other		
All counties.....	\$33,138.36	\$2,877.00	\$10,785.24	\$484.50	\$47,285.10	\$464,507.76

MEDICAL PATIENTS BY INDIGENCY FOR APRIL 1949

TABLE 1

County	Number of patients receiving medical services during month			Per Cent Medically Indigent
	Total	Indigent	Medically Indigent	
All counties.....	6,077 (about 3% to the population)	4,198	1,879	30.9

SUMMARY

Aid to the indigent seems to be fairly sufficient. More funds would make a more extensive though probably not a better service available. The medically indigent, a large segment of the population, is barely touched.

Maryland has a population neither rural nor urban predominantly, so that a good cross-section of humanity is covered by the program.

Some services have been curtailed or eliminated because available funds would not pay the costs. Dental prosthetic service was affected by this move. In addition, pro-rating of payment for services has been considered as a possibility when funds are low, if the service is to be maintained. Unfortunately, this reduction means that the Program would be maintained at the expense of the professions through lesser service payments. The writer has always considered this a questionable procedure, indicative of insufficient monetary support. It would ask the professions to carry the Program when the plan called for the Program to be fully State supported.

The plan is good, the service is commendable, but financial support is a weakening factor. It is no handout to everyone, but a conservative, well-managed Program designed to give a good bit more for the dollar than most plans usually do.

Dental service is a minor portion of the whole Program. It could and should be more available, but lack of funds makes any effort to increase activity unwise. Cooperation by the profession has been good; there is no lack of interest or unwillingness to participate. In June 1949, 40% of the dentists in the counties participated and 60% of the physicians.

This Program may be on the way towards solving a difficult problem, but time alone will give the answer.

DENTISTRY UNDER GROUP HEALTH ASSOCIATION, INC.
IN THE DISTRICT OF COLUMBIA

HENRY A. SWANSON

Washington

As this paper is a factual presentation, I must take the liberty of quoting verbatim from several brochures, reports and letters. I do not present any personal opinions relative thereto, but merely stress certain factors.

In 1937 a group of Federal Government employees conceived the idea of an Association which would provide medical, surgical and hospital care for its membership. The result of that effort was the organization and incorporation of an association now known as the Group Health Association, Inc., of the District of Columbia.

It was built along the lines of a cooperative endeavor, and their relations with other cooperatives at that time in this area "were frequent and of mutual benefit." In 1944 the Association joined with other local cooperatives in sponsoring camps, conferences and forums, the purpose of such meetings being to foster "progressive developments in the economics of medical care."

In answer to the question of "What is Group Health?" let me quote from one of the brochures sent to prospective members:

Group Health Association, Inc., a Federal employees' medical cooperative, was established in 1937 to provide members and their dependents with medical, surgical and hospital service at the lowest cost consistent with high professional standards.

A pioneering effort to solve the troublesome problem of getting adequate medical care without financial hardship, its success is attested by the steady growth in its membership, the size of its professional staff, and its clinical facilities. It meets a need faced by everyone of moderate means.

Group Health is a cooperatively administered, non-profit institution. Each of the members owns a share in the organization. It is democratic. The members elect their own trustees from among themselves. Management policies, including the employment of the staff and the supervision of fiscal operations, are administered under the direction of a Board of Trustees.

In the same brochure the advantages of the Group Health Association plan are presented:

The professional qualifications of doctors are much better appraised by their fellow doctors than by laymen. Left to himself, the layman is as likely to choose a mediocre physician as a good one. Group Health has built its medical staff on the basis of a painstaking analysis and review of the qualifications of many applicants. Each appointment made by the Board of Trustees is based on the recommendation of the Medical Director and his staff. Medical knowledge has developed so rapidly that no physician can keep fully abreast of it. The Group Health method brings together the knowledge and skilled experience of general practitioners and specialists, so that each can consult the others when necessary.

Accurate diagnosis is imperative if patients are to obtain adequate medical care. But

diagnostic equipment is expensive, and the average physician finds it difficult to buy all he needs. By combining the resources of many patients, Group Health makes available, at little cost to the individual, the diagnostic and therapeutic equipment now needed in medical practice.

Since Group Health doctors are relieved of the business details that take up much of the time of doctors in private practice, they can devote their full time to the practice of medicine. They also can prescribe according to the patient's needs, without being limited to what he can afford.

The prepayment plan enables individuals to budget their medical expenses, thus eliminating the worry of unforeseen doctors 'bills.' A member does not incur a bill every time he sees a doctor; hence he does not wait until he is seriously ill before obtaining diagnosis or treatment. Emphasis on preventive medicine has been and will continue to be a basic objective of Group Health Association.

The legal right of the organization to engage in this activity has been squarely tested in the Courts within the jurisdiction of the District of Columbia. According to the court cases, this activity does not constitute the practice of the healing art without license; neither does it constitute an unlicensed insurance business. The opinions in these cases take the position that Group Health, even though it employs its physicians upon a salary basis, is nevertheless primarily a consumer cooperative founded not for the purpose of selling contracts of insurance or to circumvent the licensure requirements of the Healing Arts Practice Act, but to enable its members to secure professional services upon the most economical terms possible. Justice Rutledge, in the Jordon case, buttressed this view by the cogent observations that Group Health cannot and will not regulate or control the physician in his work. He is left free, in fact required, to exercise his own judgment entirely independently as to diagnosis and treatment; and, further, the only obligation which Group Health assumes toward its members is to make contracts of the character described with physicians and others—there is no agreement or binding obligation to provide the service or see that it is supplied; the undertaking is simply a contract for the rendition of the services by independent contractors, the corporation assuming no liability to guarantee the member medical service nor to indemnify him for negligent or inept performance of the service.

From the foregoing it would seem that the Group Health Association has the sanction of the Courts for its operation as a prepaid medical, surgical and hospital service. The acceptance by the Federal employees is attested by the fact that the membership is in the neighborhood of 17,000. At present, the membership is not limited to the Federal Services but is open to anyone 18 years or over, living in Greater Washington, regardless of occupation or employment. Members may enroll their immediate families and other dependents, and they are not required to take out a membership. There are two types of membership: (1) non-hospitalization or medical service only, and (2) full service, including both hospital and medical service.

The membership fees are \$10.00, paid only once by the members, and the monthly dues for the above services are under (1) \$3.00 for each adult and \$2.00 for each child; under (2) \$3.50 for each adult and \$2.25 for each child. For drugs, materials, auxiliary services, home visits by staff and special surgical services in connection with treatment or diagnosis, there is an additional charge.

In 1946, plans were initiated for the inclusion of dental services within the framework of the Association and it was stated that dentistry was to be made available to the members and to be operated on the same basic principles as the Medical Services.

In view of certain provisions of the Dental Practice Act for the District of Columbia, the proposed inauguration of such a service was presented to the Board of Dental Examiners for an opinion as to its legality. The Corporation Counsel of the District of Columbia, to whom it was referred by the Board, stated, in his official opinion, that the view expressed by the Courts in the case of the Medical and Hospital Services of the Group Health Association, applied equally to any plan proposed by Group Health to secure to its members dental services in the same fashion. He further stated there was no reason to conclude otherwise.

This opinion paved the way for the inclusion of dentistry in the activities of the Association. Accordingly, announcement was made in 1948 that a comprehensive dental health service would be made available to the membership in January 1949.

The brochure sent to the 17,000 members stated that the "purpose of this plan is to provide dental care of high quality at a reasonable cost," and further

Your good common sense tells you that it is better to take good care of your teeth and prevent tooth decay rather than to make repairs after the damage has been done. Group Health's program places primary emphasis on maintaining dental health.

A systematic program of dental care for each participant will include at least one cleaning each year, preferably two, one full-mouth x-ray annually, examination and diagnosis by the dentist after each cleaning, with dental care instruction and corrective treatment recommended by the dentist as essential.

Dental care for children should begin at three years of age. Systematic care during childhood will contribute toward good teeth throughout life. Safeguarding the first teeth is necessary to the growth and spacing of the second teeth.

All children participating in GHA's dental service will receive every possible service for the prevention of dental decay and malocclusion, including preventive orthodontic service. However, corrective orthodontic treatment will not be provided at the clinic. Orthodontic services may be arranged for outside of the clinic. Application of fluorine will be given all children to reduce dental decay.

Prompt treatment of defects found by the dentist will be given children and adults to prevent deterioration of the teeth, pain, and diseases of the teeth and gums. One's own teeth in good condition are better than any replacements.

Early, regular, and continuous dental care saves time, expense and insures a healthier mouth and body.

A child should have his first dental examination not later than the age of three (3).

From this statement it will be noted that preventive measures would be stressed and the maintenance of dental health would have primary emphasis.

In a communication from the present Director of the Dental Department, it was stated that the program was to be operated on a self-supporting basis although the entire Association would be responsible for all financial obligations of the plan. To be eligible for such service, it was necessary to hold membership in the Group Health Association under one of the two medical categories mentioned previously.

Within six weeks after the dental program was announced, 3,500 members applied for admission to the dental health service. Approximately twenty percent (20%) of the total membership expressed positive interest in the plan.

The Dental Center of the Association is modern and completely equipped with eleven operating rooms, a dental laboratory, an x-ray room, a reception room, and a business office. The present staff consists of a Dental Director, four dentists, two dental hygienists, five dental assistants, one laboratory technician, a receptionist, and a fiscal clerk. All personnel is full time. The Director, five dental operators, and the two hygienists are all licensed to practice in the District of Columbia.

The objective of the Dental Care Plan, as outlined by the Director, is

To make available prepaid dental care based on the principle of insurance. It is recognized that, until the mouths of the members have been put into a healthy condition, the principle of prepayment cannot be applied. The proposal is that all initial care be given immediately when the member comes into the program and that maintenance care thereafter be put on a prepaid basis. In planning the program, it was found that data simply do not exist that give an accurate basis for estimating the services required, and the cost of rendering service to a group of patients on a maintenance basis. It was decided, therefore, to set up the program in all details as though it were a prepayment plan, but for the first year or two, to charge for services rendered on the basis of giving the service. The members will be required to receive all care recommended as essential for health if they are to be permitted to continue in the program. It is considered essential to the successful operation of a prepaid maintenance dental care program that participants have all necessary dental work done. By requiring that members conform to this principle during the period when the program is on a 'service-at-cost' basis, it will be possible to simulate the conditions that will exist under a prepaid plan.

Attention is especially called to the fact that the dental care plan is not on a "prepaid" basis at the present time, nor can any assurance be given when the plan will be put on that basis. It is understandable that complete dental rehabilitation and the elimination of all diseased conditions must be established before the prepaid features can be inaugurated. In fact, it would appear that the "fee for service" plan may be "a continuous feature, for if the Dental Department is to serve the total membership, it will require several years of service to place all members in the status when the 'prepaid' plan can be put in operation. No doubt each case, when completed, can be placed on the pre-

paid plan and would not need to wait the rehabilitation of all cases. However, until sufficient data are accumulated on the cost of maintenance, it appears that 'fee for service' basis will be continued."

The policies of the Dental Program are outlined as follows:

1. To offer complete dental service of high quality.
2. The dental program is financed independently even though it operates within the organizational framework of GHA. Membership is limited to participants in GHA. The professional and administrative staffs of the dental clinic are an integral part of the GHA staff.
3. Dental service is rendered under the supervision of the Dental Director who is assistant to the Medical Director in Dentistry.
4. There is a close working relationship between the dental and medical staffs in connection with diagnosis, treatment, and prevention of oral manifestation of systemic disease and systemic manifestation of oral disease.
5. The dental service is furnished by dentists. The Board of Trustees in no way regulates or supervises the practice of dentistry by any dentist, nor does it interfere with the usual profession relationship between the dentist and his patient.

The Dental Director states that the following services will be provided to all participants:

A. Diagnostic and Preventive Services:

1. Prophylaxis
2. Full mouth x-ray series
3. Detailed examination
4. Instruction in the care of the teeth and the gums
5. Topical application of drugs proven to be beneficial in the prevention of dental caries (2% NaF solutions)
6. Preventive orthodontics—simple appliances to maintain normal tooth and jaw relationships.

B. Treatment Services:

1. Treatment of diseases of the supporting tissues of the teeth
2. Minor oral surgery
3. Complete restorative treatment (the replacement of tooth substance destroyed by caries—the replacement of a tooth, or teeth, of necessity lost).

Each member patient must agree to have all the dental treatment which the dental staff feels essential to sound oral health and to respond to recalls at regular intervals following complete initial care in order to remain in the program. Continued participation in the plan depends on the conformity to this requirement by the member.

The dental services provided appear to be a very complete service, and if it can be maintained along the present standards set up by the Director and his staff, there can be no criticism of the professional services rendered. It will be noted that, unless the members or other beneficiaries of the plan agree to accept without question the diagnosis and treatment planned by the staff, to assume the financial obligations involved, and to respond to recalls at regular intervals, they will not be accepted for dental service nor included in the dental health plan.

Relative to the charges for such services, the Director states:

At the present time, both initial and maintenance care are provided on a 'fee for service' basis until sufficient experience has been gained to establish an actuarial basis for prepayment.

Charges are based on the cost of operating the dental services which includes professional and technical salaries, cost of materials and overhead. Each adult participant pays annually an advance deposit of ten dollars for services. The annual deposit for each child is five dollars. Each participant receiving service is charged the GHA cost for the service given. Deferred payments may be arranged for when major dental services are necessary.

At the time of the preparation of this paper, there were no figures available as to the number of patients actually cared for nor any other statistics relative to the dental activity.

A prepaid plan for dentistry is not so easily established as a similar plan for medical services, for several reasons. If the elimination of diseased oral tissues, whether hard or soft, were the only factor, the plan could be very readily established; but mouth rehabilitation and the maintenance of healthy dental mechanisms are quite another matter. As there are no two cases alike, it would appear very difficult to establish a fee which would be a basis for such a plan.

It must be kept in mind that this Association is a part of the cooperative movement and if carried to its logical conclusion, would eventually encompass the entire population and engulf all members of the health professions in such a system.

Dentistry, as well as medicine, needs to do some serious thinking along the lines of prepaid planning, in order that we may render professional services on a basis which will be acceptable to the public and to the profession.

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DENTAL HEALTH PROGRAMS NOW IN OPERATION

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The extension of health services to a larger number of people through an organized plan has developed into a highly controversial issue. There can be

no question about the fact that it would be a fine thing if all interested persons would consider the public health problems that exist today with a minimum amount of emotion, with understanding and with an unselfish desire to solve them. Unfortunately, this has not been the case.

It is not my purpose during this discussion to present controversial issues. My object is solely to outline objectively the various types of dental plans or programs now in operation in this country as an aid in determining what might be done to reduce the size of the dental disease problem and to raise the level of dental health for all citizens.

A detailed account of all dental health programs would require much more time than could be allotted to this subject. Therefore, this report will be confined largely to brief descriptions of representative types of programs.

Several decades ago leaders in dentistry recognized that dental ill health affects the well-being of the community. The dental profession also recognized that many facets of the dental health problem that affect individuals, families and communities could not be solved through the individual efforts of the dentist in his dental office. Dental health education, for example, was one activity that was badly needed for the benefit of the community but could not be carried out effectively by the dental profession without the aid of teachers, nurses, health officers, nutritionists and community leaders. Thus, dental programs were born, mainly as the direct result of the efforts of dentists who were prominent leaders in their communities or of the official actions of dental societies. This is an extremely important point to remember because almost all dental programs and plans now in operation are the outgrowth of a movement which had its beginning within the dental profession itself.

Our dental literature reveals that the original purpose behind the development of school or community dental health programs was to educate the public as regards the value of oral health and the methods for obtaining it. As the sponsors of these programs became better acquainted with the problems, new activities gradually were added, so that today there is a great variation in the services that are rendered and in the methods by which they are provided.

In arranging a description of dental health programs, I have classified them as follows: (1) state, (2) district, county and municipal health departments, (3) primary and secondary schools, (4) voluntary health agencies, (5) voluntary prepayment plans, (6) dental societies, (7) industrial, (8) hospital and (9) research.

STATE HEALTH DEPARTMENT PROGRAMS

As I indicated earlier, dental units in state health departments were established at the request and, in many instances, at the insistence of state dental societies. Although in a few states there is some disagreement among health department officials and the dental societies as to the type of services the dental

unit should render, in the great majority of states the dental program of the health department is approved fully by the dental society.

In general terms, dental units of state health departments attempt to perform the following functions:

1. Health education of the public.
2. Epidemiologic studies of dental diseases.
3. Organization of preventive practices, especially those that can be applied on a mass basis.
4. Technical assistance in organizing community dental health programs.
5. Diagnostic services.

As examples of state dental health programs, I have selected those in Kansas, Minnesota, Michigan and Washington because they are representative of nearly all the state plans.

Kansas

In Kansas, an attempt is made to dramatize the dental program through all channels of public information on state and local levels.

The Division of Dental Hygiene of the Kansas State Board of Health carries on a dental caries control program. This program was initiated in the schools in 1940 and 1941. The basic functions are: (1) annual dental examinations in schools or in private dental offices, (2) classroom instruction, parent notification and follow-up by teachers, nurses and hygienists, (3) referral to the family dentists of children who can pay and provision for needed care for those who cannot pay, (4) excuse of children from school to fill dental appointments if necessary, and (5) evaluation of the program each year to determine progress.

Complete dental care for children of families unable to meet the costs is supplied through a plan developed by the county dental societies and welfare departments. One of the main features of the school dental health program is to obtain 100 per cent correction. Three large schools, those in Baldwin City, Prairie and Roseland, have reached that goal.

The state health department is conducting a study in Ottawa where sodium fluoride is being added to the water supply. Dental health courses are being conducted in medical, dental, nursing and teachers' colleges and also by means of state and county health workshops. Children's Dental Health Day was used to inform the public concerning all phases of dentistry which have public significance. In providing dental care, the following are utilized: welfare funds, public health clinics and mobile dental units, in addition to the services of private dentists.

Michigan

In Michigan, the dental health program is conducted under a Bureau of Public Health Dentistry in the Department of Health. In recent years an in-

creasing amount of emphasis is being placed on prevention of dental disease and on dental care for children.

The dental staff of the state health department consists of a director, assistant director, two clinic dentists, two dental health consultants, a bacteriologist, a dental clinic assistant, a part-time fellow in orthodontics and two clerical assistants.

The Bureau of Public Health Dentistry is interested in two types of education: first, to inform the public of the value of early, adequate and continuous dental health service and, second, to acquaint the dental profession with improved methods of giving service.

School and community dental health education, which is made available on the request of school and health administrators, includes lectures in the county normal training classes and teachers' colleges. The dental health consultants, who are assigned to certain areas for a definite period of time, work on a pre-arranged schedule, meeting with teacher and parent groups, civic organizations and selected school classes. Various types of visual aids, as well as demonstration examinations, are used. The Bureau also provides consultation services to public health nurses, nutritionists, teachers, health officers, school administrators and parent-teacher and civic organizations in planning or improving local dental service programs. Lectures are given by the director or other staff members to students in the Schools of Dentistry at both the University of Detroit and the University of Michigan and to graduate students and seminar groups in the School of Public Health, University of Michigan.

Professional education, which is one of the most appreciated services of the Bureau to the dental profession, consists of practical presentations by outstanding clinicians and essayists on the newest and improved technics. In 1948, the subject was fluorine; this year it is cancer detection and diagnosis. This project is financed by the dental society. It is an excellent means of stimulating the profession to render the type of service the public is being educated to seek.

The Bureau also participated in the first national Children's Dental Health Day.

Treatment service has not been a function of the Bureau, but two communities, Sturgis and Mt. Pleasant, have had the advantage of excellent dental care for some of their children through a fact-finding and demonstration program. The program at Sturgis will be described later. The corrective dental clinic at Mt. Pleasant was placed in operation early in the year as a demonstration project and as a part of the county health program. Complete initial and recall treatment for kindergarten children on a countywide basis is carried on. Two hundred and twenty-five children received dental care during the year.

Minnesota

The State of Minnesota has a Division of Dental Health in the Department of Health. The personnel of the Division consists of a director, a public health

dentist, four dental health advisers and two clerk-stenographers. The dental health advisers are dental hygienists with public health training. They act as consultants to the public health nurses, and to school and lay groups throughout the state, as well as coordinators between the dental profession and the public; they also carry on educational work with parent-teacher groups, teachers and schools.

In the dental health education program, factual literature, motion pictures and illustrated lectures are supplied on request to teachers, schools, P.T.A. groups and other organizations.

A dental card system has been used in the schools since 1939. A dental card is presented to the child at school, and the parent makes an appointment for a dental examination for the child. The dentists of the state give a free examination in the private dental office on presentation of the dental card. If the condition of the mouth is satisfactory, the dentist signs the card, and when the child returns the card to the teacher she gives him credit on his permanent health record card. At the end of the year the charts are sent to the Division of Dental Health for tabulating for an annual report. If dental care is needed a notice is sent to the parents, and they then assume the responsibility of seeing that the needs are corrected.

Growth of the program in 1947-1948 was even greater than had been anticipated. The four-year progress report shows that 752 more schools, totalling 55,200 more children, entered the program. Graded public schools averaged 50 per cent, parochial schools 57 per cent and rural public schools 47 per cent. Four hundred and ninety-three school rooms had 100 per cent returns of cards compared with 400 in 1946-1947. It is significant that, even though the state percentages remained about the same, thousands more children had complete dental care last year than records ever before had shown.

STATE WELFARE PROGRAMS

Maryland

The Maryland Medical Care Program was begun in 1945 after passage of a medical care law. This program, which was the first to provide general medical care for the needy under health department auspices, has as its object adequate medical, dental and nursing care for both the indigent and the medically indigent. A Council on Medical Care, which advises the State Department of Health, is composed of representatives named by official medical, dental, pharmaceutical, nursing and hospital associations, as well as representatives of the two medical schools and official state health and welfare agencies.

Administration is decentralized, with local responsibility in the county health departments on determination of services to be offered. All counties elected to provide for care of acute dental conditions; however, there are wide variations on the basis of budgetary limitations.

Although the dental phase of the program has made great progress, only a small part of the total dental needs is met. Owing to the limitations of budget and personnel, the emphasis must be on relatively complete dental care for children and young adults.

There are three great lacks in the dental care program: namely, (1) lack of knowledge that the service is available, (2) lack of knowledge as to the importance of dental health, and (3) lack of dentists. The first lack gradually will be overcome, and the second indicates a need for more dental health education. The lack of facilities for corrections will be the most difficult to solve.

Prior to the inauguration of the Medical Care Program, it was estimated that 20 per cent of the budget would be devoted to dental services. Although this percentage has not been reached, incomplete surveys indicate that the low dental expenditures are not attributable to a lack of need. Rather, even a reasonable approach to meeting the needs would tend to increase dental expenditures to or beyond the initial estimate of 20 per cent of the Program's budget.

Washington

Free medical and dental care is being given a trial in the State of Washington. This service is provided for the 144,000 persons who are on the state welfare rolls. The aim of the Citizens Security Act adopted in 1948 is to provide a "minimum of security" and to guarantee the needy "as far as it is within the State's power, freedom from want and freedom from fear." Anyone in Washington State, regardless of age, can get free medical or dental service if classed among the needy. A person, if able to get on the welfare rolls, can obtain from the local welfare office a "referral" to a physician or a dentist. He then can visit any physician or dentist of his choice who is participating in the health plan. Only 15 per cent of the members of the State Dental Association have agreed to cooperate with the program, and as a result most of the dental work for the needy is done by nonmembers and by "advertising" dentists who usually cater to low-income groups.

Dentists get \$4 for a filling, \$3 for an extraction, \$75 for an upper or lower artificial denture and \$2 for an X-ray examination. Physicians send their bills to county medical bureaus as they would to private patients and are paid from a fund controlled by the State Medical Association. The Association's fund is contributed by the State at the rate of \$2.50 a month for every person on relief. Hospitals, dentists and druggists send their bills for services and materials direct to the State.

The cost of medical and dental care for the needy is to total about \$22,000,000 during the 1949-1951 biennium. Some officials estimate that an employed person would have to earn \$5,000 a year to afford the type of medical care given in the average welfare case. Cost of the welfare plan will grow as medical aid and

other assistance are extended. Dentists already are dissatisfied with their fees and are negotiating for increases. Limited fees make many physicians and dentists reluctant to accept welfare cases.

DISTRICT, COUNTY AND MUNICIPAL HEALTH DEPARTMENT PROGRAMS

In district, county and municipal health departments, the dental program usually is carried on under the health officer, who is a physician. Some of the more thickly populated areas have a dental unit in the district or county health department. In general, the programs of these agencies are similar to that of the respective state health department or are a part of it.

Los Angeles

In Los Angeles the dental program is primarily one of prevention and education.

With the exception of a few expectant mothers referred from the prenatal clinics, the dental clinics are conducted exclusively for the care of children from families that cannot afford private care. The dental clinics are financed by county funds, and children under health department supervision are cared for without charge.

Children are accepted in the dental clinic at the age of 2 years and, if they remain under health department supervision, are cared for until the age of 14 years. The children are recalled every four months for re-examinations and corrective treatment, if necessary.

All types of corrective treatment for children are provided in the dental clinics, with heavy emphasis being placed on prophylaxis and mouth hygiene. All of the thirteen health department dental clinics have x-ray equipment, which is used routinely in examination and diagnosis. The clinics are maintained in the major health centers throughout Los Angeles County.

As part of the educational program, the Division of Public Health Dentistry maintains a staff of dental hygienists whose duties include mouth examinations of children in elementary grades. Written reports of the results of these examinations are given to parents and teachers. In addition to the mouth examinations, the hygienists give classroom talks relative to proper tooth-brushing technic, diet and general mouth health. On request, educational talks on dental health are given to parent-teacher organizations and other interested groups.

New York

In the city of New York, 88 per cent of the services rendered are given by the dentists in private practice. The city maintains dental clinics for persons unable to pay a private dentist. An attempt is being made to extend the public treatment facilities. This fall the Bureau of Dentistry of the Department of Health

is opening ten new school clinics, which will make a total of 128 one-chair school clinics and 17 health center clinics with four-chair units.

The staff of each health center unit consists of a senior dentist, a full-time dentist, an externe or a part-time dentist, a full-time dental hygienist and two dental assistants. The school clinic staff consists of a dentist and a dental hygienist.

The Bureau of Dentistry expects to have facilities for 20 per cent of the children attending elementary and parochial schools. This would mean facilities for the complete dental care of 200,000 children.

The staff of the Bureau of Dentistry consists of a director, an assistant director, a staff dentist (orthodontist) for the physically handicapped program, eleven supervising dentists, sixteen full-time dentists, eight externes, 143 dental hygienists, twenty-nine dental assistants and four clerical assistants.

The program for orthodontic treatment or dental care for physically handicapped children is operated by the Bureau of Dentistry in cooperation with the Bureau of Child Health.

St. Louis

The dental hygiene service of St. Louis has two main functions: a treatment program carried on by dental clinics and an inspection program in the schools.

In the dental clinics for corrective treatment, service is given to indigent and low-income group children of preschool and grade school ages. Because of an inability to provide care for all with the limited staff, a means test for eligibility is used. Last year more than 6,000 patients were given treatment. At present, to be eligible for dental care, the family income must not exceed \$150 per month if the family has one child, and \$10 additional for every other child. Recently the application of sodium fluoride was added to the program.

There are four clinics, one being for Negroes, both as to personnel and patients. The staff consists of a supervising dentist, three oral surgeons and three anesthetists who work in teams to do extractions under gas anesthesia (two teams are white and one, Negro), and eleven dentists employed half time to do extractions under local anesthesia, fillings, prophylaxis and root-canal therapy. There are six dental assistants and a stenographer.

The dental inspection program in the parochial schools is conducted during September and through May. This service is offered to approximately 36,000 grade and high school students who receive dental inspections about two times every three years. Three teams consisting of a dentist and dental assistant are used for the inspection program, which also includes lectures to parents and pupils. When defects are noted, the child is referred to the family dentist or, if he is eligible, to the dental clinic.

The public schools have a similar program of dental inspection. Whenever

corrective work is necessary, public school children of the low-income group are referred to the clinics in the same manner as are the parochial school children.

PRIMARY AND SECONDARY SCHOOL PROGRAMS

Cincinnati

The dental health program in the Cincinnati schools is directed by a dental supervisor of oral hygiene services. The program has developed in thirty-six years from one of emergency treatment for poor children to one of dental health education for all children and dental service for the underprivileged.

The dental health education program consists of (1) an annual dental examination, (2) dental health lectures in auditorium sessions, (3) classroom follow-up with a short talk and letters to parents, (4) professional health shows, (5) a circulating library of dental health posters, and (6) a summer round-up of preschool children.

A record of the child is kept throughout eight years of his school life. A letter is sent home to parents explaining the examination and giving hints on how to contribute at home to better teeth. A card is sent to the child's home which states that the child is in need of dental care. One side of the card is to be signed by the parent indicating that the child will be taken to the dentist; the other side is for the dentist to sign when he has completed the necessary treatment.

Specially trained personnel give talks in the classroom. The lectures, which are illustrated with chalk drawings, consume about thirty minutes. Children are invited to write in or to draw pictures following the lecture. A letter to the children over the lecturer's signature serves as a follow-up.

About two months after the original dental examination, a follow-up visit is made to the classrooms. The reason for the visit is explained to the children, and a count is made of cards returned by the dentist. The percentage of children who have had dental attention is calculated and registered on a large thermometer on the wall. Parents of children for whom there is no card signed by the dentist receive a follow-up letter urging that dental attention be given. Children who have had dental attention receive a pin in recognition of their cooperation.

Each year a poster contest for school children is conducted in connection with Children's Dental Health Day. Last year the luncheon on Children's Dental Health Day was attended by more than 400 persons from various civic and welfare organizations.

For children about to enter school, there is a summer round-up. From 3,000 to 4,000 children are examined annually in this round-up in an attempt to have all defects corrected before they start to school. The dental examinations are performed by volunteer dentists.

This dental health education program costs approximately \$11,414 a year and is financed by the Community Chest.

Dental service for underprivileged children is provided in six dental clinics operating full time. Services consist of fillings, extractions and prophylaxes. The upper limit for five of the clinics is the sixth grade. Services in the sixth clinic are devoted to children above the sixth grade. Eligibility for clinic service is determined by a means test. Patients for clinics are selected by the public health nurses who serve as school nurses. About 5,000 children are treated a year. Of this number, close to 4,000 cases are completed.

No charge is made for dental service, except in the one clinic operated for children above the sixth grade. If the child can afford to pay a nominal fee, arrangements are made for him to do so; however, there are more free cases in this clinic than there are pay cases.

The cost of the dental service part of the program, which is provided by the Board of Education is \$53,072 annually. This makes the cost of the combined program \$64,486.

Portland

The dental health program in the schools of Portland, Oregon, is administered by the Portland Schools Public Health Department.

Dental inspections are conducted by the dental counselor in the elementary schools twice each school year. Inspection is for the purpose of recording information. The Dental Health History Card, which is always available, furnishes a permanent record of the year-to-year findings. The dental card, which is issued at the first inspection each year, provides an accurate check on whether the child has visited the dentist for the examination and dental services begun. The inspection report is sent to the parent to be signed, and the attached coupon is returned to the classroom teacher. The dental health card, which is intended for the family dentist, also is sent home with the inspection report.

At the completion of the inspection in each classroom, the dental counselor discusses, with the aid of charts and tooth models, one of the following topics: correct toothbrushing, reasons for tooth decay, prevention, and other phases of dental health outlined by the supervisor and dental health advisory committee.

The classroom teacher keeps all returned dental health cards and inspection report coupons for use of the dental counselor in completing the records. The teacher then sends the student to the principal's office for the dental health recognition pin.

The dental counselor, during the inspection procedure in each classroom, issues the Dental Health Service Form if evidence indicates that the family is financially unable to afford regular dental services. This notifies the parent or guardian that dental services may be secured through the dental health department should financial circumstances prevent a child from visiting a regular

dentist. If the parents are interested, they may in turn apply for the Dental Health Service Application from the dental counselor or school principal. This questionnaire aids in determining the child's eligibility to receive operative dental services.

Of the children who present themselves as eligible patients, those in kindergarten and first to third grades inclusive are given first consideration for completing all necessary dental services, including sodium fluoride treatments. Children in grades above the third receive only limited dental services, that is, relief from pain and infection and possible treatment of first permanent molars, if time permits.

VOLUNTARY HEALTH AGENCIES

The number of voluntary agencies, both those primarily concerned with health and those organized for other purposes, that are interested in improving the dental health of the American people is noteworthy. The Community Chest, American Red Cross, National Tuberculosis Association, Visiting Nurse Association, Junior League, the Lions, Rotary and Kiwanis Clubs—to mention only a few—often either inaugurate or participate with dental societies, other health groups and educational systems in conducting dental programs. The voluntary health agencies' main interest in the dental field is to assist in making dental care available to underprivileged children.

One example of the work of a voluntary health agency will be described. In contrast to the statewide program of the Department of Health in Michigan, a dental program also is carried on by the Children's Fund administered by the Division of Child Health. This fund was established by James Couzens in 1929 as a charitable trust. A public health dentist is assigned to a county or smaller subdivision where in cooperation with public school and public health authorities, he treats the mouths of needy children. Owing to the shortage of dental personnel, it has been impossible since the beginning of World War II to build the staff to the desired size of about thirty dentists. During the last year nineteen dentists served 24,908 children. Beginning in December 1947, topical fluoride treatments were added to the list of clinic services.

Although the Children's Fund pays the salaries of the dentists, various agencies within the localities served make small contributions. In the last year, such outside gifts to the dental program amounted to more than \$22,000. It is one of the objectives of the Children's Fund dental program to stimulate interest in the communities to assume responsibility for the continuance of the clinic services for children when the foundation shall have passed out of existence.

VOLUNTARY PREPAYMENT PLANS

The success of budgeting hospital and medical care costs is evidenced by the increased demands of the public for further prepayment planning in the health

field. Although the successful application of the prepayment principle in meeting hospital and medical care costs has been well established, present knowledge is inadequate to determine whether a similar budgeting plan can be applied to dentistry.

A plan for budgeting the cost of dental care should (1) provide a service that contributes to a higher level of dental health, (2) assure persons in the medium- and low-income brackets of dental service without financial hardship, (3) provide adequate fees for the dental profession and (4) preserve the private practice of dentistry. The success of a prepayment plan depends on many factors: the dental needs of the subscribers, the amount paid by the subscribers, the types and amount of service, and the fee schedule.

There are three voluntary prepayment plans which include limited dental services: the Blue Shield Plan in Philadelphia (a hospital plan), the Group Health Association in Washington, D.C., and the Labor Health Institute in St. Louis.

Blue Shield

There are in existence numerous hospital dental programs, most of which provide emergency treatment for hospital patients. However, in Pennsylvania, the State Dental Society has completed an agreement with the Medical Service Association (Blue Shield) of Pennsylvania whereby subscribers to the plan, both children and adults, may receive limited dental treatment from dentists who are members of hospital staffs. The dental treatment may be provided only in hospitals and is limited to "cutting procedures for the treatment of diseases and injuries and the treatment of fractures and dislocations, but not including extraction of teeth except impacted teeth." The agreement was made possible by the passage of legislation sponsored by the dental society in the state legislature. The dental services are available under both surgical and surgical-medical plans operated by the Medical Service Association. Fee scales under the plan are related to the subscriber's income and additional charges may be made for individuals in the higher income groups. In all cases, dentists and physicians cooperating in the plan have the right to make the final determination of the accuracy of the reported income of the subscribers. Officials of the Pennsylvania State Dental Society report that the plan is being "well accepted" by dentists throughout the state. Membership costs in the surgical plan are 60 cents a month for the individual, \$1.25 a month for husband and wife with no obstetrical delivery, and \$2 a month for a family, including obstetrical delivery. The medical-surgical plan costs have been set at \$1.10 a month for the individual, \$2.20 for husband and wife, and \$3.25 for a family.

Group Health Association, Inc.

For a number of years Group Health Association in Washington, D. C., limited its health benefits to medical care for persons who were enrolled in the

voluntary prepayment plan. Recently dental benefits were added on an experimental basis to determine what the subscriber's payment should be for dental care. The dental services are provided in a clinic owned and operated by the Group Health Association. Dentists are employed on a salary basis. Until actuarial data are obtained, subscribers are entitled to examination, diagnosis and prophylaxis. The subscriber pays for other types of dental care in addition to his annual membership fees. The staff for the dental program includes a supervising dentist, staff dentists, hygienists, chair assistants and appointment clerks.

Labor Health Institute

The Labor Health Institute, which was established in St. Louis, Missouri, is a nonprofit organization incorporated under the laws of Missouri to contract with labor and business groups to give complete medical and dental care to participating groups and their families, in return for a 5 per cent deduction from each member's wages. Each person signing an agreement for a year becomes a member of the Labor Health Institute, and he and his family are automatically covered by Blue Cross Hospital Insurance. When members apply to the Institute for health care they are given a physical and dental examination and are treated not only for their complaint but also for any other ailment discovered during the examination. These services are provided at no additional cost, except for medications and dental restorative work, including fillings, bridges and dentures, which are furnished at cost. There is no limitation on the amount of service in any given year. In the past year the Institute has had a membership of 6,000 families and has expanded up to the present to about 9,000. It has a potential capacity of service to about 25,000 families when its entire building has been converted to medical and dental use. The staff consists of thirty-four physicians and dentists, employed on a part-time basis. Eight of these are dental surgeons.

INDUSTRIAL PROGRAMS

Many industrial oral health programs are in operation, although approximately only a tenth of industrial plants offer any type of dental attention today. The trend is toward preventive dentistry. Such a program may consist of pre-placement or pre-employment examination, dental health education, referral, follow-up and emergency treatment.

The Chicago Dental Society has originated and promoted an Industrial Diagnostic Service, a mobile service for industry which is most effective in improving the dental health of employees of participating organizations.

The Industrial Diagnostic Service is a program of dental health education for employed persons, under the sponsorship of the Chicago Dental Society in cooperation with employers. Its principal elements are (1) complete dental

roentgenograms, (2) distribution of dental health literature, (3) clinical examination of all employees by a dentist, (4) referral of each employee to his own dentist for treatment and (5) subsequent re-examination. The purposes of the Industrial Diagnostic Service are (1) to educate employed persons in the value of regular dental care, and (2) to encourage them to obtain dental care from their family dentist.

The methods to be followed are arranged between a representative of the Chicago Dental Society and an official of the company, usually the chief of the medical staff or the head of the personnel department. These details include the selection of suitable space for conducting examinations, installation of equipment, method of referring employees to the examination room, and manner in which each employee will be notified that this service is available.

The employer usually issues a memorandum about two weeks before the first examination to inform employees of the project, to impress on them the value of dental health, to arouse interest and to solicit cooperation. A card with the employee's name, address and department number accompanies this memorandum. The employee is asked to place the name and address of his own dentist on this card and to return it to the management. These cards then serve as a guide in arranging the examination schedule.

X-ray equipment is set up on the plant premises. The x-ray technician, selected by the Chicago Dental Society but reimbursed by the employer, makes fourteen roentgenographic exposures of the mouth of each employee. At the end of the day the exposed films are sent to an x-ray laboratory for processing. On their return, they are filed for the use of the dentist who subsequently makes the clinical examination.

A dentist, a member of the Society, makes a careful examination with the aid of the roentgenograms, and his findings, including the name and address of the employee's dentist, are recorded in triplicate on a special chart. The original copy is for the records of the Society. The duplicate is for the employee's dentist and is accompanied by an explanation of the program and the statement that the records are forwarded to the dentist for his information when the patient calls for his next appointment. The triplicate is for the employer to use in the follow-up program.

The actual charting of the examiner's findings is done by a trained dental assistant selected by the Chicago Dental Society. About five minutes is consumed in completing this phase of the service with each employee. An additional five minutes is then given to each for an informal discussion of his dental conditions. If indicated, charts, graphs and models, in addition to the roentgenograms, are used by the examiner to visualize for the patient certain mouth conditions and to impress on him the consequences of continued neglect.

When the dentist has completed his examination and educational talk, he asks the employee's permission to mail the roentgenograms to his dentist and

to make an appointment to begin actual treatment. At this point the greatest barrier to dental service—procrastination—must be overcome.

The Chicago Dental Society and the management of the commercial or industrial organization share the cost of the diagnostic service. The Society furnishes the necessary supervision and direction. The employer usually pays the following costs: rental of x-ray equipment including installation and dismantling; drayage; supplies such as film, mounts and envelopes; postage; x-ray technician and dental assistant; and examining dentist for expense of office maintenance during his absence. The Society has established a fee of \$15 per day for the examiner.

The Metropolitan Life Insurance Company has operated a dental clinic for employees at the home office in New York since 1915. In 1919, because of the interest that was created in dental health, it was decided to require examination and prophylaxis of the teeth of all workers twice a year. In 1942, because of war conditions, the plan was changed to one recall for examination and prophylaxis per employee annually on a wholly voluntary basis. If an employee prefers to have his dental work done by the family dentist rather than at the company clinic, it must be at his own expense.

The staff of the dental clinic includes one full-time and one part-time dentist, seven hygienists, two x-ray technicians and a clerical force of twelve. In 1942, with a total of 15,345 employees on the payroll, a total of 56,090 visits were made to the clinic by 16,493 patients, and dental examinations and prophylaxes totaled 25,360 sittings. Emergency dental procedures, including examinations, consultations, x-rays and treatment, totaled 12,444.

HOSPITAL DENTAL SERVICE

The Walter Reed General Hospital, Washington, D. C., has a fully equipped nineteen chair dental clinic with a dental laboratory. The present dental staff consists of nine dentists plus six interns. The dental services for inpatients (military personnel) consist of whatever is necessary to remove oral foci of infection, maintain oral health and supply adequate replacements to masticate the Army ration. For outpatients (nonmilitary personnel) the treatment is largely of an emergency nature and involves mostly exodontic care and oral surgical procedures.

The Walter G. Zoller Memorial Dental Clinic in Chicago has well-equipped dental clinics and laboratories of anatomy, bacteriology, biochemistry and pathology. There are fourteen dentists and four interns. The program consists of clinical service, teaching and research. Inpatients and outpatients receive all types of dental service with the exception of orthodontic care. There is no financial charge to the patients, all of whom have low incomes.

At the Jersey City Medical Center the dental facilities consist of sixteen children's dental chairs devoted to operative dentistry, one complete dental

unit for physically handicapped and cardiac children, seven chairs in the oral surgery clinic, a diagnostic room with complete dental unit, an oral surgery room, two x-ray rooms and an emergency room. The staff consists of seven dentists, twenty-eight interns and a resident. Inpatients receive examinations, extractions and treatment of fractures and surgical conditions. Outpatients, of which there were approximately 33,000 this last year, receive, in addition to the foregoing services, replacements for inoperable cleft palates. Only low-income patients are admitted.

RESEARCH

In a recent survey by the Council on Dental Health of dental programs, it was interesting and inspiring to note the number of replies that mentioned research projects. It is self-evident that the soundest approach to the development of effective programs is through experiment and study.

A study approved by the Minnesota State Dental Association and the Minnesota Department of Health has been inaugurated in Askov, Minnesota, to determine the benefits that will accrue to a group of children from 3 to 17 years of age when provided all preventive treatment, complete dental care and thorough dental health education. Approximately 350 children are included in the study. The investigation is based on six objectives:

1. To determine the result of a composite of dental caries preventive measures.
2. To determine the value of total dental care for a certain age group, particularly those entering the program at the age of 3, for a duration of ten years.
3. To correlate dental health education in the school and to determine methods by which it can be integrated with the curriculum.
4. To accumulate data on the procedures for establishing a dental care program.
5. To accumulate data on operating costs of a complete dental care program and of the separate segments of such a plan.
6. To accumulate time data on various dental operations and treatment.

In three communities—Richmond, Indiana; Woonsocket, Rhode Island; and Sturgis, Michigan—studies are being conducted to obtain data on the dental health needs of children and on the amount of dental care required. The first two projects are being conducted by the United States Public Health Service, in cooperation with the local and state dental societies. The purposes of the Richmond survey are:

1. To determine the dental care needs of school children on an annual increment basis.
2. To determine the amount of dental services that can be rendered by each dentist, and the manner in which auxiliary personnel and their services

can be utilized to increase the care rendered by each dentist. This phase of the study will also serve as a measurement for the demand for readily available dental care services.

3. To encourage the children who are at present being treated, or have been previously treated, by private dentists to continue as private patients. To encourage the development of proper habit patterns in all those participating in the program so that they will continue to seek adequate and regular dental care upon passing from the ninth to a higher school grade. The program is designed to augment, not supplant, private practice.

The program in Sturgis, which has been in operation for four years, is being conducted by the Michigan Department of Health and provides complete dental care on a progressive basis. An orthodontic study there, which is in its third year, is for the purpose of learning more about preventing and correcting mal-relation of teeth and jaws. Five hundred children have received complete dental care, some making as many as ten recall visits. Two hundred children have been placed under orthodontic supervision.

Studies on the addition of sodium fluoride to the drinking water are being conducted in approximately fifteen cities. Some of them are Grand Rapids and Midland, Michigan; Sheboygan, Elkhorn and Madison, Wisconsin; Newburgh, New York; Gainesville, Florida; Evanston, Illinois; Ottawa, Kansas; Marshall, Texas; Lewistown, Idaho; Crossett, Arkansas; and Charlotte, North Carolina.

Since laboratory evidence offered considerable promise that dental caries incidence could be reduced by the use of an ammoniated dentifrice, Dr. R. G. Kesel and co-workers established clinical studies in two communities in Illinois—Aurora and Peoria. The purpose is to determine to what extent dental caries can be prevented when teeth are brushed with

1. A dentifrice prepared according to a formula suggested by the Council on Dental Therapeutics of the American Dental Association, of a composition similar to those commonly used.
2. A dentifrice prepared according to the formula developed at the University of Illinois, containing dibasic ammonium phosphate (5 per cent) and carbamide (3 per cent).
3. A dentifrice identical with 2 except for the omission of the dibasic ammonium phosphate and carbamide.

The children in the fourth group, used as controls, have been encouraged to continue their usual habits of oral hygiene, without brushing instructions or the use of any particular dentifrice.

COMMENT

An attempt was made in this paper to present a broad picture of the dental health programs now operating in the various sections of this country. It was not possible to mention or describe all of them. Nor was an attempt made to justify their existence or to appraise their effectiveness.

It is a logical assumption that there will be further expansion of dental health programs. The more comprehensive approach probably will consist of greater health education activities, more intensive methods designed to prevent and control dental diseases and an expansion of school and community health services.

FUNDAMENTALS AND OUR STAKE IN SICKNESS INSURANCE PROGRAMS

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The strength of worthwhile opposition to compulsory health insurance has never been so formidable in this country as it is today. We must add to and build this strength. Time is on our side. The way we, who should know more about this subject than nearly any other group, use this time will have a telling effect on the outcome of this nearly unparalleled controversy.

Perhaps one of the greatest difficulties toward good orientation and intelligent understanding of forms of socialized health service lies in the fact that lecturers talk in one language and listeners hear in another. Readers of books and articles read the language and mistake its meaning and, indeed, too often the writer fails to define his terms even in his own mind. To illustrate. Two of the five basic methods of rendering health services are compulsory health insurance and State medicine. Both are thoroughly socialized, but State medicine is certainly the more highly socialized. I shall try to demonstrate this point later in this talk after one or two observations regarding careless and unwarranted use of basic terms.

Along about the close of the second World War, I listened to a man who is known to all of you here today. A great educator, he was prominently identified with the affairs of the American Medical Association and with governmental service at a high level, including the best part of the work done by the Committee on the Cost of Medical Care established during the Hoover administration. He was addressing an important meeting. He pointed his remarks to condemnation of Senate Bill 1606, the at that time Wagner, Murray, Dingell Bill, and the California Governor Warren's first compulsory health insurance bill. He said something like the following: "We have twelve million of America's youth today in the armed forces. A few have been discharged; nearly all of the remainder will be discharged within the next year. During their periods of service each was exposed to a system of medical care better than any heretofore known in America or in any other country of the world. Do you think for one

minute that when these men come back as American voting citizens, knowing as they do the excellence of medical care rendered under the system of care of which they were beneficiaries, they will, under any circumstances, tolerate a system as thoroughly socialized as is the Truman proposition or that now currently sponsored by California's Governor?"

This commentary sounds good but it certainly lacks perspective, for it condemns a socialized system of medical care for being socialized but embraces and recommends an even more highly socialized system. In short it condemns compulsory health insurance and recommends State medicine.

I propose very shortly to talk about the degree of socialization of the various basic forms of rendering health services. I think it can be easily demonstrated that with respect to degree of socialization, the system of Army and Navy health services, which is pure State medicine and nothing else, is much more highly socialized than even compulsory health insurance.

In the West we have listened to our California Governor repeatedly state that the system of compulsory health insurance that he proposes, is not a form of socialized medicine. All of us have heard President Truman state that his various proposals for systems of compulsory health insurance do not denote socialized medicine. Many others prominent in public affairs have spoken in similar fashion, but, to my knowledge, none of them has stated what, in his opinion, is socialized medicine. In view of this apparent dilemma as to the meanings of broad descriptive terms it is thoroughly apparent that some definitions and analysis of the basic forms of rendering health services are needed. As a prelude to such a discussion, a general and over-all criticism of our attacks on compulsory health insurance is in order.

For the past fifteen years I have lectured to each of my senior classes on Socio-Economics. Last year ten hours were devoted to explanations of socialized medicine. Naturally I acquired many volumes dealing with this subject. Recently the number of volumes in this classified library was counted. No doubt about twenty-five per cent have been loaned out and not yet returned, but still I have about a hundred of such books. The notable point is that not one of these defends the cause of our present system of doctor-patient-fee relationship. All promote directly or indirectly the cause of compulsory health insurance.

Why is there a paucity of volumes devoted to our cause? Perhaps it is for the reason that financial support has not been behind the system we know to be productive of the best results for our American people.

About two or three months ago I received an announcement telling of a book devoted to the case against compulsory health insurance. I was enthusiastic and sent for it. It was nearly a half inch thick, four inches wide and four and a half inches high. In the first chapter the tuberculosis death rate in the United States for the white population for 1948 was given twice. On one page the rate was quoted as 7. and a fraction per hundred thousand; three pages later in the same

chapter the tuberculosis death rate for the same group was quoted as 10. plus a larger fraction. I just could not bear further reading.

Why are there so many volume supporting the cause of compulsory health insurance? Primarily it is because our Federal government pays vast sums out of our tax money for the collection of data used in support of arguments for this system of health service.

The Hoover Committee on the Cost of Medical Care did not recommend compulsory health insurance through its majority report. But the many volumes produced thereafter by the Committee's technical workers, whose figures, tables, and statistics are from the Committee's investigations and are interpreted in the language of these workers, appear as designed to support compulsory health insurance. Indeed, the annual reports of the Social Security Board, particularly those originating in the Bureau of Research and Statistics of the Federal Security Administration, nearly all of which support the theory of compulsory health insurance, are produced on the taxpayer's money.

We have all read that the American Medical Association proposes to gather a fund of some \$3,000,000 with which to develop a campaign opposed to compulsory health insurance. I should like to see the Medical Association wisely employ one third of this sum in analyzing, not the factual data presented in the various volumes supporting compulsory health insurance, but instead the inferences drawn from such data.

All should be wary of inferences drawn from mathematical data. It is true that mathematical formulae afford precise information, but inferences derived from such data are often highly unreliable. Let me give examples in readily understandable terms. In this effort I shall assume my audience here is a legislative body and trust that my listeners will temporarily so consider themselves.

Now, let us suppose that I have either one or two points to make, but not both, with you as a legislative body. Point number one is that the people of the United States pay little or almost no attention to and spend nearly nothing for oral health service. I then plead with you regarding the importance of this service; but to illustrate my first point, i.e., that the people pay practically little or no attention to dentistry and spend nearly nothing for its services, I give you facts and figures to support my contention. These data are from the report of the Committee on the Cost of Medical Care. Although the report is nearly twenty years old the data are used because of their authenticity and, further, because comparative and related data are readily obtainable in this report.

In support of my contention that almost nothing is being spent for dental services I make this statement: In 1929 the people of the United States spent just one cent per day, per person, for dental services. This is only about one tenth of what the average cigarette smoker pays per day for taxes alone on his cigarettes. Something should be done about this situation, such as an appro-

priation for dental health education. The proof of this observation is that in 1929 the population of the United States and its possessions amounted to 120,000,000 people. The over-all expenditures for dental services in 1929 were \$445,000,000. If you take time out to multiply 120,000,000 by 3.65 (the annual per capita expenditure for dental services in that year) you will find the result to be nearly exactly \$445,000,000, or the total expenditure for dental services during that year.

This should prove that the over-all expenditure of the American public for dental services is (or was in that prosperous year) but one cent, per day, per person, a truly negligible amount, and that something should be done about it. This amount, in comparison with expenditures for non-essentials such as liquor, tobacco, cosmetics, and entertainment, suggests remedial action. Obviously this is a good argument in support of government subvention for dental education and for public support of school oral health services, etc.

In passing you may wish to know the per capita expenditure for dental services as of 1948. Well, it was 1.58 cents per day, per person. This compares with the consumer price index (cost of living) as 122.5 in 1929 compares with 171.1 in 1948. Thus the cost of living was 39.7 per cent higher in 1948 as compared with 1929; the expenditure for dental services was 58 per cent higher, an increase in line with the rise in the cost of living, and indicative of a growing appreciation of the value of oral health service.

But now suppose that you are an entirely different audience, but again a legislative body, and it is my idea to impress you with the tremendous costs of dental service and with the necessity of doing something to cut these costs. Note that I take the position with a different legislative body that expenditures are too high, not too low, as in the former argument. In support of my theory that the costs are entirely too high and that something should be done to reduce them I make this statement: Approximately 26 per cent of all money paid to both physicians and dentists is paid to dentists alone to treat one disease and its sequelae, i.e., dental caries. No other disease known to mankind, in fact no group of diseases, has cost our people so much in dollars spent as does dental caries.

Now let's prove this contention and again use the statistical data reported by the Committee on Medical Care for the year 1929. In that year \$1,090,000,000 was paid to physicians; \$445,000,000, to dentists. The total paid to both groups, therefore, amounts to \$1,535,000,000.

In 1932 a survey was conducted to determine the cost of the treatment of caries and its sequelae as compared with expenditures for all other dental services. The figures obtained were judged unreliable because of the relatively large amount of dental school patient statistics included therein. With this in mind I circularized a great many dentists, including orthodontists and other specialists, to get their opinions or best guesses as to the amount paid to dentists

for treatment of caries and its sequelae as contrasted with that paid for other dental services. The indications were that at that time (a period very close to 1929) ninety per cent of the dollars paid to dentists were for treatments made necessary (including the extraction of teeth, placement of dentures, and fixed bridges) by caries. Perhaps the ninety per cent estimate is now lower by reason of increased longevity and increased effectiveness of periodontal treatments, but ninety per cent was the consensus estimate for that year.

Returning again to the figures of the Committee on the Cost of Medical Care, ninety per cent of \$445,000,000 amounts to \$400,500,000 and this sum is approximately twenty-six per cent of all the dollars paid to both physicians and dentists for health services during the period under consideration. Thus these figures substantiate my statements that twenty-six per cent of all money paid to physicians and dentists was paid to dentists to treat dental caries and its sequelae, and that no other disease or group of diseases has ever cost the American public nearly as much. This evidence makes it thoroughly apparent that dentistry is too costly and that something should be done about it.

It appears now that with two sets of figures from the same source I have persuaded my listeners (if I had two sets of listeners) toward two entirely different conclusions. In one instance I used a very small item, i.e., one cent per day. In the other instance I used a very large item, i.e., 26 per cent of all dollars paid to physicians and dentists. I say examine carefully conclusions made from data. Don't be taken in by figures.

It seems to me that we who have a major interest and concern in the reaction of legislators and the public to plans for socialized health service should at least have common understanding as to terms. We must learn more and more about all forms of socialized medicine and school ourselves to discuss these problems with intelligence and without emotion. Too frequently those representing our cause scream "Moscow", "bureaucracy", "Marxism", and "regimentation" and seem quite willing to let their arguments rest on one or two of these exclamations. We can't afford to bury our heads in the sand and we can't achieve intelligent support with nothing to offer but exclamations and slogans.

In what little time remains, I propose to name and discuss the five basic forms for rendering health service, relate each proportionately to "socialized medicine," and add a few remarks about dentistry's historical and present concern in each. If we accept the thesis that health services or mining, or some other activity, is socialized in proportion to the degree that the people (society) own the service or inject themselves between the purveyor and the recipient of the services through laws or otherwise, then I believe that we have a reasonable and rational yardstick with which to measure the degree of socialization as it pertains to the industry or to the profession. In other words, the less the recipient and the purveyor of the service have to say regarding the conditions of rendering such service the more highly socialized the transaction. Thus in

my opinion it borders on fraud to have someone in high office assert that compulsory health insurance is not socialized medicine.

There are five basic patterns for rendering health service. I list them more or less according to their degree of socialization.

1. The doctor-patient fee relationship.
2. Voluntary health insurance.
3. Compulsory health insurance.
4. State medicine.
5. Public health service.

The last four are highly socialized plans, while the first stands out not because it is entirely without socialization but because it is so comparatively free of rules, regulations, and impositions established by sources other than the purveyor and the recipient that it should be properly held in contrast to socialized medicine.

I need not describe the doctor-fee relationship, for all of us have lived more or less under its arrangements. Under this basic and natural plan the standards of health services in America have risen to great heights. But to a small extent it is socialized. For instance, the people interpose themselves through the law requiring physicians and dentists to pass tests before being admitted to practice. In addition, if the services of the practitioner are negligent or incompetent, the people again interpose themselves between the purveyor and the recipient in the form of juries in malpractice cases. In these ways, and perhaps in these ways only, the doctor-patient fee relationship is socialized, but only to such a small degree that this method may be held to be in contrast to the other four basic patterns.

Voluntary health insurance is a plan operating without compulsion of law by which groups band together to protect themselves against the cost hazards of health services. The story of its growth, evolving as it did out of burial insurance schemes among the guilds in Western Europe, and the history of its ultimate influence on all social security legislation and on even compulsory health insurance plans provide an interesting chapter in the rise of Western civilization.

Until recently in America voluntary health insurance plans were carried on by insurance companies which operated mostly on the indemnification principle and by lodges, by unions and by small groups of doctors that operated on a service basis. The funds for operation were supplied by voluntary periodic contributions by the beneficiaries, and the purveyors of the services were compensated mostly on a salary basis. Many young physicians in beginning practice sought connections on a full-time basis under the doctor-group arrangement or on a part-time basis under a lodge or union arrangement.

These small entities, the lodges, etc., occasionally afforded dental services at no pay for the dentists. Dental services nearly always consisted of free examina-

tion and sometimes free extractions. Occasionally free x-rays were offered. The dentists were attracted to the arrangement under the assumption that if they rendered these services free, most patients would return and pay for additional needed services.

Dentists not "in" on such arrangements, because of choice or otherwise, objected to the advertising by these small groups through which these services were announced, and in California the free service arrangement was completely stamped out by threatening those dentists who participated with having their license revoked or suspended for aiding and abetting unlicensed practitioners of dentistry, i.e., the insurance group, to practice dentistry. This action and the no-pay element served to reduce the amount of dental services under such arrangements to just about nil and thus dentistry has not recently been much concerned with voluntary health insurance under the indemnity plan, the lodge plan, the union plan or under the small doctor-group plan, such as the Ross-Luce plan of Los Angeles and the Mt. Moriah system in San Francisco.

However, during the last decade other plans for voluntary health insurance have developed on statewide bases under the auspices of State Medical Associations and many have met with considerable success. The statewide plan, among other things, affords nearly complete free choice of physician on the part of the beneficiary or insured person, and the remuneration for services rendered is on a fee for service basis. Dentistry's interest and concern in statewide plans are vastly different from its interest in a small closed panel arrangement. To illustrate this interest I shall briefly recite the beginning of our California Physicians' Service, which is the California Medical Association's plan. This service now has 750,000 members.

In 1933, in 1935 and in 1937 high-powered compulsory health insurance bills were introduced in the California legislature. These were defeated, but the professions had no assurance that without something positive being done in the health service field by the professions a bill would not pass at a succeeding session of the legislature. It was thought then that if a good system of voluntary health insurance were introduced in which practically one hundred per cent of the physicians participated that this, to some extent, would provide an insurance system and would in turn provide formidable arguments against a compulsory system.

Your speaker was invited to participate in the formative details as the representative of the two California state dental associations. The work was difficult, many points were debated, and when the plan was nearing completion the question was asked, What of dentistry? The group, as would be expected, wanted to hold down the cost of the arrangement so that its monthly premiums could compete successfully with premiums charged by other and smaller systems. In answer to the question it was explained that ordinarily physicians do not practice dentistry and dentists do not practice medicine, that it is illegal in

California for dentists to practice medicine and for physicians to practice dentistry, but that there is one field of service that is common to both professions, i.e., oral surgery, including the removal of teeth. The group was asked to contemplate the growth of the proposal so as to embrace three quarters or more of the people of California and then to visualize a situation in which a beneficiary member who had paid his \$3.00 a month into the system for five years without receiving any benefits, falls down, bruises his shoulder, knocks a splinter off his tibia and incurs a badly fractured jaw. It was related that if that beneficiary went to his physician under then present conditions the likelihood would be that he would be referred to a dentist to treat him for his fractured jaw; but if the patient had been paying a premium of \$3.00 a month over a period of years and if dentists were not included in the voluntary health insurance system as professional members, then the dentist would not be eligible to receive a fee for his services.

Thus the patient would be deprived of the services of a dentist at the expense of the system, and for economic reasons be nearly compelled to find a physician member of the Service who would treat his fractured jaw. To obviate this situation it was recommended that such dentists as chose to be included as professional members would render those services legal to their field that may become available under the terms of the proposed contracts or policies. It was also recommended that dentists be entitled to exactly the same rights as those of the physicians in the organization.

The validity and equity of these proposals were agreed to by all, but it was contended that to rewrite the plan and particularly the legislation having to do with the plan so as to include dentists would delay initiating the plan far beyond its intended date and thus long after the opening of the 1939 California legislative session.

An alternative was proposed. It was to the effect that if dentists were not to be included as professional members, then every printed policy issued by the California Physicians Service would list in specified type among the services to be excluded as benefits, the following: "all services incidental to treatment of diseases, injuries, malformations of the jaws and their dependent tissues." Late in 1938, or early in 1939, the House of Delegates of the California Medical Association endorsed this exclusion and thus to that extent the public relations problem of the physicians and dentists was preserved. However, the plan has not worked out exactly as intended.

The long and short of it is that the Service has been reluctant to take advantage of the exclusion clause regarding the jaws and their dependent tissues. In fact, it has sought the services of dentists, paid dentists fees agreed on, and sometimes, when a dentist in the community would not handle the treatment, paid physicians for these services.

As late as last week a conference was held with representatives of the Physi-

cians Service looking to the adoption of the original suggestion: to invite dentists to become professional members and to render any service for which they are licensed and which is or may become available under the conditions of the contracts or policies. In the meantime throughout the whole ten years a dentist has been a member of the Administrative Committee which is the top management committee of the Service.

The many values to dentistry and to the cause of voluntary health insurance to be derived from dental participation in this large voluntary plan need not be explained here.

In order to have as much time as possible to discuss dentistry's relationship to compulsory health insurance, which is third on the list of basic methods of rendering health service, we shall proceed to identify briefly the fourth and fifth basic methods of rendering health services.

The fifth is Public Health Service. This method is concerned with the health of the masses as contrasted with services for individuals. Public Health Service, being government medicine, has met with considerable resistance throughout its history. Resistance is lessening but it is still present. This method is characterized by having its costs paid from general tax funds. Dental services have long been included as a part of public health service. If the fluorination of drinking water program lives up to expectations, dentistry certainly will rapidly become increasingly important in public health service programs.

The fourth basic method for rendering health service is State medicine. This is the method that prevails for all the people of Russia. For a reasonable account of this system read *Red Medicine* by John R. Kingsbury (formerly of the Milbank Fund) and Sir Arthur Nesholm, published about eighteen years ago and obviously in support of socialized health service schemes.

But most of us are familiar with its methods, for it is paralleled nearly exactly in health service arrangements for the personnel of our Army and Navy. It is characterized by having the cost borne by general taxation as contrasted with specific taxes. The purveyors of the services are paid on a salary basis. The patient has no choice as to who will treat him and the doctor has no choice as to whom he will treat. Dental services are nearly always of the kind that limits materials and types of service to keep down costs.

The third method listed and last to be described is compulsory health insurance. The designation is decidedly a misnomer for the reason that the compulsion is not related to health but instead relates to the payment of periodic fees. Compulsory health insurance should be more appropriately referred to as required periodic payments for health services. It is characterized by

1. Having its cost borne by specific taxes (periodic payments) required by law.
2. The purveyors of the services are paid for on a fee for service basis, on a

capitation basis, occasionally on a salary basis, or on a combination of two or three of these methods.

It is claimed that there is free choice on the part of the insured person and on the part of the purveyors of the service. This is only partly true. Compulsory health insurance is the health service system of almost all countries of Western Europe.

Dentistry has been traditionally opposed to compulsory health insurance. This being so, we have afforded very little counsel to those who write proposed laws regarding the manner by which dentistry is included or excluded from such propositions. But there are those in the profession who believe that counseling might be in order and that this does not necessarily presuppose lessening of opposition to these propositions. How has dentistry been treated in compulsory health insurance plans? The answer is all the way from not being mentioned up to and including programs of dental services that could not possibly be met without immediately multiplying dental manpower by about four hundred per cent. The European schemes invariably excluded dentistry in their initial stages but, after the formation of top management committees, took dentistry in bit by bit, usually through the back door and in the wrong way.

Each session of our Congress for the past eight years has seen one or more Wagner, Murray, Dingell bills. The first, Senate Bill 1161, did not mention dentists or dentistry. A careful analysis of that proposal proves that the services of dentists were excluded, but dental services were not. Two years ago President Truman introduced another Wagner, Murray, Dingell bill in the form of Senate Bill 1606. This provided for dental services far greater than could be rendered by twice the number of dentists we had in the United States at that time.

Failure to include the services of dentists and the inclusion of formulas for limiting the amount of dental services have always been based on attempts to hold down the costs of the system. Dental services were limited in three main ways under propositions submitted during the last fifteen years to State Legislatures and to the Congress.

1. Excluding the services of dentists.
2. Limiting the services of dentists to a certain area of service but then only on the prescription of the attending physician.
3. Limiting the fields of services and limiting the materials to be used for rendering such services.

The objections of dentists to rendering services under the prescription of attending physicians should be manifest. Dentists are entirely and thoroughly competent in their field of health service and should never submit to an arrangement through which they would become subservient as prescription fillers for another profession.

Dentistry must always have a strong objection to any plan that limits the

kind of materials used for its treatments. To name materials and allow only these stifles the progress of the profession. Indeed, a system has no more moral right to exclude gold for treatment services because it is presumed to be expensive than it has to exclude penicillin or insulin as a treatment simply because those agents are presumed to be expensive.

Now, let me repeat what I said at the outset: Never during the last fifteen years have the opponents to compulsory health insurance been in as strong a position as we are today. We must build and add to this strength and if we are to do a good job in that direction we must first of all know more about the issues.

DENTAL MANPOWER AND THE JOB AHEAD

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Adequate and competent dental personnel that might be required to meet any effective demand for oral health services is the keystone to the arch of any nationwide program of oral health care. The availability of manpower that can offer the types of oral health services upon which the people must depend and that can provide the amount of oral health care they may demand, is of primary importance, whether the distribution of health care is natural and spontaneous, or regulated by artificial planning.

The current supply of dental manpower and the extent of existing auxiliary dental personnel have been stimulated in their growth by the pressures created by a public demand made on the dental profession for dental health services. The present standards in dental education under which dental manpower is produced have evolved out of the conditions that go to make up the American way of life. If a sharply accentuated demand for dental services should be created by a change in conditions of dental practice brought on by proposed compulsory health legislation or by any other artificial planning, little *immediate* increase could be effected in the quantity of oral health services that might be required to satisfy such a demand. To educate more dentists requires extensive time in order to comply with the approved standards in dental education. Therefore, under any stepped-up arrangement any increase in the number of individuals that might be cared for could be accomplished only by dentists who would attempt to serve more patients than they could competently care for; but recourse to such a doubtful method of quantity production would inevitably lower the general quality of oral health care to which the American people have long been accustomed.

Many extensive studies have been made of the occurrence of dental diseases prevalent among the people of the United States. These studies have shown that dental defects are universal among the children of the nation, that the vast number of such defects are not treated in their incipency, and that as a result there is today a formidable accumulation of unmet oral health needs, the correction of which is of grave concern to the public and the dental profession alike. The evidence discovered and the conclusions reached from a study of these data have created in the minds of the public the erroneous impression that this backlog of unmet needs has accumulated because of a shortage of dental manpower; and the impression prevails that this untoward condition represents a demand that requires an immediate increase in dental personnel.

In order to gain a clear understanding of the meanings of *need for oral health services* and *demand for oral health care*, it will be profitable to our discussion to attempt definitions of the two terms and to emphasize distinctions that should be made between them.

The need for oral health care is measured by the total volume of dental defects that exist among the people as these defects are related to an ideal standard of national oral health; this ideal standard of health may be regarded theoretically as the total absence of all oral diseases or disorders of any disabling kind or character. The national need for dental services, then, is indicated by the sum total of all oral defects, without regard to the extent of definitive oral health care obtainable, to methods of distribution of such services, or to any desire on the part of the public to have any of the defects corrected.

Effective demand for oral health care is characterized by the pressures that are brought to bear on the dental profession by those who need dental services and who seek dental care. Such demand is based primarily on a positive need—that is, on the existence of specific dental defects or oral deficiencies; effective demand requires that those affected be clearly conscious of an existing need, that they manifest an active desire to provide for their needs, and that they be financially able to offer fair compensation for services sought.

It is thus shown that there are basic differences between the *potential needs* of society for complete oral health care for all the people and the *effective demand* for dental care which at any given time might be made on the profession by those who need dental services. Total competent care for all the oral ills of all the people may be regarded currently as *an ideal* whose chief value is to stimulate the people to greater effort in obtaining adequate oral health care. The studies that have been made of the needs of the population for oral health services reveal a national oral health deficiency that actually could not be corrected immediately, no matter how zealous we might be in our purpose, how energetic we might be in our efforts, or what method of distribution of dental services we might employ. However, the need for a wider distribution of oral health care exists, and the dental profession must assume the responsibility for

providing that quantity of oral health care which the public at any time may actually demand.

It should be noted that the supply of dental personnel and the effective demand for oral health care have been in reasonable balance in this country for many years. During the four decades from 1900 to 1940 the number of dentists in the United States increased 138 per cent, despite the lag in the number of dental school graduates from 1921 to 1941, a lag which was caused by the advance in the length of the dental course from three to four years, and by the sudden upgrading of the quantitative requirements that finally established a minimum two-year predental standard for admission to the dental curriculum. During this same period the population of the United States increased 73%—that is, the dental population increased twice as rapidly as the general population.

During the same period certain types of auxiliary dental personnel have appeared and have grown to such proportions as to materially increase the productivity of the dental practitioner. This personnel includes the dental laboratory technician group whose presence was scarcely felt at the turn of the century, but which has grown tremendously during the interim in numbers and in usefulness to the dentist. The introduction in 1913 of dental hygienists and the subsequent increase in their numbers have added to the total effectiveness of the dentist. While their number is much less than that of the laboratory technicians, the hygienists have done much toward enlarging the volume of dental services now available to the public. In 1900 dental office assistants were sparingly employed by dentists; since then, they have grown in favor and usefulness until today the assistant is an essential part of almost every dental office organization.

Because of the difficulties encountered in appraising accurately the contributions of these auxiliary groups, it is not possible to estimate the actual increase in the effective demand for dental care which has taken place in the United States during the past fifty years. It is fair to assume that the amount of health care provided the American people is now far in excess of what most of us believe it to be. Estimates of percentages of the public who avail themselves of dental care are largely guesses and under any conditions are wholly unreliable data to use in appraising potentials.

The changes that have taken place in the attitudes of both the dentist and the public toward the oral health of the people of the country are encouraging. The dentist has become more conscious of his social responsibilities; and the public has become more aware of the values of good oral health care and of the seriousness of the need for oral health services. The emphasis that has been placed on the relationship of oral health to general health has caused health departments in most states and in most large municipalities to include *divisions* of dental health in their plans of organization; and public school administrators

are now keenly aware of the basic importance of health education, of physical education, and of health services in effecting the complete education of the child. Today oral health education is an essential part of the child's classroom instruction, and dental clinics are being increasingly employed to provide oral health care for school children.

These public health and public school activities were begun and have been developed within the strength of existing dental personnel. The enlarged demand of the public for dental care, the rapid expansion of facilities necessary to provide oral health services within the organizations of health departments and public school programs, and the difficulties that have been encountered in many instances in recruiting dental personnel to carry on these planned activities have pointed up the existence of a current shortage in dental manpower and have emphasized the need for more dentists interested in these types of practice if the growing demand for such services is to be met.

The favorable effect of the G. I. Bill of Rights on student enrollment and the force of the demand that now exists for more dental services have stimulated current interest in dentistry as a profession to an all-time high. It is reasonable to expect that the high enrollments which have characterized the last four classes enrolled in the dental schools will continue during the decade 1951-1960. If so, the average annual number of dentists who will graduate annually in this decade will be 55% greater than the average annual number that graduated during the twenty years 1931-1950. These facts indicate the responsiveness of a democracy to any pressures for services which the people may demand.

The magnitude of the job ahead, as it relates to dental personnel which would be required to satisfy any demand made by the public, will be determined by the actions of the American people in making decisions with respect to local, state and national oral health planning. If the people are determined to maintain their independence and their control over their traditional democratic institutions, they will do so by accepting their responsibilities for planning such devices as are necessary to ensure fair opportunities for all those who may want to avail themselves of oral health care. The outline of a practicable plan which the people might develop to satisfy all their needs was approved a decade ago by the House of Delegates of the American Dental Association. Its philosophy and its recommendations are based on sound principles of democracy that will make the success of the plan readily possible if the people desire to secure for themselves adequate dental health care.

Obviously any gradually expanding health program will require an ever-increasing volume of dental personnel. Any increase in manpower that may be necessary at any time can be accomplished gradually by our dental education system in response to predictable demands. In this connection it should be noted that the dental profession and the people are constantly reacting to the need for more dentists to meet the increasing demand made on the profession

for dental services. This year a new state dental school will graduate its first class; another new state dental school will enroll its second class; while a third state has voted appropriations to construct dental school buildings for which plans are now being drawn. These activities are indicators of the manner in which democracy always functions in its tendencies to provide sufficiently for all its natural, normal needs.

A second proposal for broadening the distribution of dental services to include more of the population is a national compulsory health insurance plan. This plan proposes to make a Federal agency responsible for the conditions under which the health of all the people of all the forty-eight states and the District of Columbia shall be maintained. It provides for a National Health Insurance Board which shall have full authority to determine policies and to prescribe standards under which the health of the people may be served; it proposes that the Congress shall have authority to appropriate such funds as are necessary to maintain the system; it suggests a tax on all incomes up to \$4800 per year as the source of funds to be appropriated; it announces that the system will make health care available to all persons, and their dependents, who are taxed for the purpose; it proposes to administer the plan through state and local agencies whose duty it shall be to carry out the policies and to enforce the standards announced by the National Health Insurance Board. This plan, when viewed from the standpoint of its prescribed requirements and its ultimate possibilities, reveals all the characteristics of a socialist state. If put into operation in this country such a scheme would accomplish the complete regimentation of both the people and the members of the health service professions through the dictatorial powers vested in a National Board which can, through delegated authority, control the lives of the people.

The nature of the job ahead for the dental profession under conditions that would be imposed by compulsory health insurance is difficult to predict. Obviously under such a plan standards in dental practice and dental education would deteriorate.

In the operation of the plan the dentist would be forced by the nature of the circumstances to join the system. When the dentists of England protested the Health Service Act of Great Britain and were reluctant to join it, Minister of Health Bevan took the attitude that he might be obliged to ignore the dentist and employ hygienists to assume the responsibility for providing oral health care under the scheme. The political sponsors of compulsory health insurance, or the purveyors of any form of socialist control over health care distribution, have always shown a ready willingness to lower standards in education. In New Zealand the oral health care of the children—which includes health education, oral prophylaxis, restorative dentistry and oral surgery—is undertaken by the so-called dental nurse, an artisan of educational qualifications and clinical competency approximately the same in quantity and quality as those

prescribed for the dental hygienist in this country. One fact stands out as sure among the many uncertainties of the plan, namely, that no stable system of dental education can be devised to produce a sufficient number of dentists to care immediately for all the dental needs of all the people on the basis of quality which has always been demanded by the American people.

The simple fact is that under the influence of compulsory health insurance dental manpower would be in danger of being produced by improvised plans of dental education that would cause a lowering of standards. The course that such departures might take cannot be predicted. However, the inevitable conclusions must be that whatever comes, the American people would not enjoy under the new order the same quality of service to which they have been accustomed, and that they will be denied many personal freedoms which our country was originally designed to guarantee to its citizens. Beyond doubt compulsory health insurance would destroy the essential character of competent scientific health care which is a basically important phase of our cherished American way of life.

THE DENTAL HEALTH OF THE NATION

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One might just as well try to explain the details of nuclear fission in fifteen minutes as to attempt to delineate the Dental Health of the Nation in the same length of time. This fact was brought home to me with an increased impact when I began the necessary reading in the preparation of this presentation and, if the impression of the writer is correct, this will add but one more bead to the string of confusions already existing.

One cannot peruse the literature dealing with the findings which have derived from the multitude of studies on the dental condition of various segments of our population without arriving at the conclusion that almost every person in our population could judiciously receive dental attention in one form or another. Whether some of the treatment indicated would add to the total health of the individual is a moot question, and it is at this point that a clear line of demarcation needs to be drawn because many of the statistics which have been gathered are used to support the arguments for a Utopia which can never exist even in a completely Federalized State.

Repeated surveys have been made, some dealing with the child population of the nation, some with the child population in selected geographic areas, some with early adult life populations as found enrolled in universities, and some with

the patients already found in the practices of some cooperative members of the American Dental Association. Because of the facts already assembled, any effort to establish the dental health status of the nation's population becomes a complicated maze of variables and exceptions to rules of expectancy, all of which make the task of describing the incidence and prevalence of oral diseases and related conditions very difficult to delineate.

As an example of dental conditions of a certain segment of our population we have but to examine the early records of the physical examinations made by the Selective Service System during World War II. The nation as a whole was shocked, as was the dental profession, when it was learned that from November, 1940 through September, 1941 dental defects were the leading cause for rejection by local examining boards and accounted for 17.7 per cent of all rejections. After some time for sober reflection it was realized by many that these startling statistics had but little meaning as far as the oral health of the young men in our nation who were of draft age was concerned. Actually, it meant that 17.7 per cent of those young men did not have "A minimum of three serviceable natural masticating teeth above and three below opposing, and three serviceable natural incisors above and three below opposing. All of these teeth must be so opposed as to serve the purpose of incision and mastication."

It would be difficult indeed, if not impossible, to compute with any degree of accuracy the impact which this display of oral deficiency may have had on the general health of these young men, and it was demonstrated many times that men who had received the best of dental attention faced rejection because they could not meet the requirements which stated that the teeth must be "natural".

Later these requirements were lowered and as a consequence, the percentage of rejections dropped without any evident impairment of the fighting abilities of our men. All of this seems to indicate that here is an example in which the carefully gathered statistics were yet another bead on the string of confusions.

There are, however, many surveys which have supplied important and factual evidence that the incidence of dental disease is great. An example is a survey recently completed in Philadelphia the results of which have not been made public. Dr. Roscoe Kendall, Field Director of the American Public Health Association, and Dr. Carl Buck, School of Public Health, the University of Michigan, directed a survey of the school children in the Philadelphia schools. A total enrollment of 354,922 children were examined and 78 per cent, or 276,839, were found to have dental defects. As an interesting side light of this investigation it was found that 40 per cent of those having defects, or 110,736, secure correction of the defects through their own or through public sources.

These statistics would indicate that these children were not receiving sufficient dental care, that a great backlog of accumulating needs was being developed, and that this single instance multiplied by the number of times neces-

sary to cover the nation would produce a staggering total. A staggering total it is, because added to this evidence is that of the second dental health conference sponsored by the New York State Dental Society in 1948 where it was reported that 90 per cent of 6 year old children have carious teeth only 20 per cent of which have been treated; that of the South Dakota conference held in 1947 where it was reported that an estimate on the dental health of 180,000 persons, ages 3 to 21, would show 285,000 deciduous and 800,000 permanent teeth attacked by caries; and finally that of the National Health Assembly held in 1948 which presented national average figures showing a minimum of three decayed deciduous teeth per 6 year old child and indicating that 14 per cent of these children will experience decay of newly erupted first molars. It was further stated that at 16 the average person has seven teeth either decayed, missing or filled involving fourteen tooth surfaces.

Further studies, using another approach, have been made in an effort to demonstrate the magnitude of the problem. These studies have attempted to translate the needs for dental service into terms of the cost of disposing of the backlog of dentistry needed by what would appear to be a representative cross section of our adult population.

Two outstanding studies of this type were those conducted by the American Dental Association and the Chicago Industrial Diagnostic Service. In the first instance it was found that to provide the initial care needed to bring the patient to what could be considered a maintenance level, the cost would be \$48.96 for males and \$45.43 for females; while in the study conducted in Chicago it was determined that the average cost per person would be \$52.47. These estimates were based on the findings of need in the mouths of the persons examined and the fees were calculated on the basis of what were considered to be "low private fees".

It must be borne in mind that these studies were made in the late thirties when the economic circumstances were greatly different from those that prevail at the present time. Without question the average figures given above would be increased if the computation were to be made in terms of the present purchasing power of the dollar.

This approach does, however, present another view of the facts. It clearly demonstrates the oft repeated statement that there is a vast difference between the "need" and the "demand" for dental service. This point is forcibly brought home by examining the statistics growing out of estimated needs and the actual demand for service. To do so, we will accept the figure of \$52.47 as being the average cost of the needed dental service for our adult population in 1940. In that census year there were 65.6 per cent of our population above the age of 20. This, in round figures, is 86,375,000 persons. Multiplying the two indicates that if all of these persons had had the indicated amount of dentistry done the

expenditure would have amounted to almost $4\frac{1}{2}$ billion dollars. The United States Department of Commerce shows that in 1940 there were approximately \$419,000,000 expended for dental services, which is but about one-tenth of the indicated need figure. The expenditures in 1948 were \$864,000,000. This figure would indicate an improvement; but, again, because of different economic circumstances and because of increased population the comparison would not be in direct ratio.

Yet another approach has been made to demonstrate the need. In the Dental Division of the United States Public Health Service a statement was developed and presented, together with other material, at the National Health Assembly. That statement follows:

There were before the war, 65,000 dentists under 65 years of age practicing in the United States. If each of those dentists were to work at the chair forty hours a week for 50 weeks a year, there would be available 2000 hours per year per dentist, or a total of about 130,000,000 dentist-chair-hours a year. The need for fillings, extractions, crowns and bridges, plates and prophylaxis arising each year in the white population over 6 years of age demands just about 136,000,000 hours of dentist-time. Hence, what actually constitutes only a part of the total yearly crop of dental needs alone requires all the dentist-time that is available. To that figure (136 million hours) must be added the annual dentist-time required to service children under 6 years of age; the annual need in children for services other than fillings; services such as examinations, orthodontia, extractions and oral surgical treatment; the annual need among adults for treatment of the periodontal diseases and the disorders requiring surgery; and the annual dental needs of that large group of persons who are not of the white race. Considered all together, it becomes reasonable to assume that the total yearly crop of dental need in the whole American population requires for its service probably at least double the present volume of dentist-manpower; that is, instead of the 65,000 dentists, at least 130,000 are required, just for yearly maintenance.

When the accumulated need is also considered, 350,000,000 dentist-hours would be required, for these needs alone. Therefore, to clear up the whole need in one year, 5 times as much dentist-time as we now have would be required.

In the beginning of this presentation the writer admitted his own state of confusion which came as a result of preparing this presentation. At its completion the state of confusion was compounded and if any success should come from the presentation it will be because the listener or reader has become as confused as the writer. That was the avowed intention.

However, if confusion is the result, it is not a desirable one because certainly in a problem of such magnitude there should be some common ground on which an understanding can be had. It would appear, then, that a thorough study of the subject is indicated; but it must not be a study tinged by the wistful hopes of ambitious planners, rather it must be a study well salted with the practical knowledge of performance and reflecting the hope of solving the problem at a practical level.

Such a program seems to be under consideration. There is now a bill in the

Senate of the United States, Senate Bill 2584, entitled "a bill to provide for studies of the methods of determining the amount, distribution and effects of illness in the United States and for conducting periodic inventories of illness by the best methods developed through such studies". This bill has passed the Senate and has been referred to the Committee on Interstate and Foreign Commerce of the House of Representatives. Dentistry is not specifically mentioned in the Bill but it is not too late to have it included.

If this bill should become law, then the dental profession would have the opportunity and the obligation, for once and for all, to assist in finding the true picture of "The Dental Health of the Nation" and thus bring an end to this welter of confusion.

THE ROLE OF PREVENTION IN THE HEALTH PROGRAM

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There can be little doubt in the minds of those individuals charged with the preservation of health as to the paramount importance of the prevention of disease. Viewed from the standpoint of the dental profession, the problem more or less centers on the prevention of oral diseases. This means that in the average population group today, our task is primarily the prevention of dental caries and periodontal disease. In order to focus our endeavors as an organized body, I feel that we should concentrate this effort on some program aimed at the prevention of dental caries in children, at the same time recognizing the importance of other health hazards.

Too often, when the word "prevention" is used in reference to dental caries, it is assumed that the term means the treatment of an existing disease lesion, *preventing* its further progress and subsequent sequelae. This thought may stem from the adage, so often heard in dental school, that it is essential to have "extension for prevention" in those procedures designed for the restoration of diseased dental tissues. Such an interpretation of the term prevention is far from being adequate when speaking of preventive dentistry. It really defines a therapeutic procedure which has been universally accepted in the treatment of certain lesions of dental caries.

At the present time there are at least three clinically proven methods for the prevention of dental caries: first, the prophylactic contouring of deep pits and fissures in newly erupted teeth; second, the institution of a low carbohydrate

dietary regime; and third, the use of sodium fluoride solutions topically applied. None of these procedures is perfect but all have been used with a considerable degree of success. These methods also have certain inherent difficulties which are characteristic of each individual case. It is unfortunate, however, to find in our general population that these preventive procedures are used only on a very limited scale by the dental profession of today.

Why the profession uses these techniques so rarely is difficult to determine. It involves those philosophies which determine, first, the policies of dental education; second, the principles of professional relationships; and third, the problems of practice management. In order to carry out any program designed to increase the practice of preventive dentistry, it is necessary to recognize and evaluate these philosophies. It may well be that certain of the present-day concepts in this regard are not consistent with developing a profession primarily concerned with the prevention of disease. However, in order to fulfill our role as leaders in the dental profession, it is essential that we undertake the task as an organized group to improve our present situation. In so doing we can make *preventive dentistry* one of the major factors influencing the health problem of today.

The story of preventive service would not be complete without looking forward into future developments. Evidence on hand today suggests that the dental profession will have in the near future a method for the partial control of dental caries which can be applied on a mass population basis. I am referring now to the potentialities inherent in the fluoridation of public water supplies. Although none of the research projects have progressed far enough to permit an evaluation of the results, experiences to date suggest trends toward beneficial effects. Should artificially fluoridated water produce the same effects from a dental standpoint as natural fluoride-bearing waters, the practice of dentistry, as presently constituted, will be greatly altered. Conditions will be such that greater emphasis will naturally be placed on preventive service.

From what we know today, the change to fluoride waters will not cause an abrupt change in the dental caries picture. There will be a transitional period of considerable duration. The general public, on the other hand, will expect rather immediate relief from their dental troubles. It is the duty of all leaders in dentistry to become well versed on the subject of water fluoridation in order to educate the public as to the principles involved and the benefits to be derived. Such an educational service represents a small but important part of the dental profession's duty in today's health program.

THE ROLE OF RESEARCH: ITS POSSIBLE CONTRIBUTION TO HEALTH

THOMAS J. HILL

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The socio-economic needs of the public today emphasize the pressure for a more complete dental care of our people. The economic incompatibility of an adequate dental care with quality service appears the insurmountable barrier. The man-power inadequacy, the present high standard of reparative and restorative dentistry, the increasing need of dental service, together with the constant increase in appreciation of dental service, are contributing to a demand far beyond the capabilities of our profession. It would appear, then, that present methods of practice, which are largely reparative and restorative, do not cope with the need for dental service and that if the demand is to be met, changes in methods of practice will have to be made, or, ways must be found to reduce the need for service through prevention of the present incidence of dental disease.

The former method does not readily lend itself to the maintenance of quality service. The latter is the more promising solution and is research's contribution and obligation to the socio-economic crisis.

It should be borne in mind that until within the last decade and a half, research in dental problems was isolated and very poorly supported. The American College early recognized this fact and made a valuable contribution to the stimulation of research and to the encouragement of funds for this purpose. The Federal and other funds that have been provided are now paying dividends. The resultant store of added knowledge made available in the past decade has contributed much to the etiology and prevention of dental disease.

Any attempt to enumerate the benefits derived from past research which has influenced the dental health problem would be hopelessly incomplete. The ramifications of research activities are so many and their influences upon other professional activities are so profound that the progress of a profession can be measured by its interest and accomplishments in research.

May I, however, call your attention to the following salient factors. The scientific study of dental disease through prevention and treatment has shown us the possibility that the incidence of dental caries can be reduced, and promises for the future an even more effective control. Our present methods of prevention are not ideal nor are they wholly adequate but they have made a definite advancement. They are showing the way and are in advance of their application in practice. The average practitioner is not now utilizing to the fullest extent the advances already made by research. This lag in application

might naturally be expected. It is the history of medicine that the application of preventive measures requires time for complete acceptance. Of course, there is in addition much scientific research which is fundamental in character and not yet applicable but which will be the basis for applied research in the future.

The ideal solution of the socio-economic problem in dentistry is the establishment of methods of prevention of dental caries and periodontal disease which are not wholly dependent upon the time and effort of the profession. Whether research can accomplish this end is yet to be proved; but that is the challenge of research in the future and, based upon the accomplishments of the past, it is a predictable probability. Whatever progress has been made or will be made in the future requires a profession well informed, and imposes upon it the enormous task of public education. It is the profession's responsibility to inform the laity so that its conception or misconception of research activities is not gained from the advertising pages of the Sunday Supplement.

The contribution of dental research to dental health is not confined to the development of new methods of prevention. It has vastly improved methods of reparative and restorative service. It has been instrumental in the development of scientifically trained teachers. It has attracted to the profession a higher caliber of membership. It has done much to interest and enlist in our preventive efforts the allied health professions. It has been fundamental in the development of higher educational standards and has improved the curriculum content. Few would question that future advances in dental education will, in a large measure, be dependent upon the establishment of new facts, new methods, new truths.

Research has made definite progress and with the increasing emphasis that has been placed upon it there have come to the profession a new dignity, new self-reliance, and a new professional enthusiasm. Research is contributing its part to the creation of a more learned profession, which because of the resultant contributions in the field of oral health, has gained the appreciation and respect of allied health groups.

Of all the factors contributing to the oral health of our nation, none is carrying a greater responsibility than research; nor is there any which promises greater returns in the economic aspects of dental health problems.

In the past decade dental research has vastly improved both in quantity and quality. It has made definite progress and if that rate of progress can be maintained, the accumulated results are certain to build up to increasingly more efficient methods for the control of disease. If this premise can be accepted, then it behooves the profession and the public to urge that additional opportunities for research be provided and that funds be made available from Federal, private and commercial sources to further that end.

Research is the concentrated and systematic study of causes, of principles and their application; it is the pruning of half-truths, the eradication of false

ideas, the development of newly discovered facts, and the careful evaluation of all. It is a stimulus to advancement; it is the teacher, the leader in prevention and the determinator of educational standards. It is the basis upon which any scientific profession must rise or fall.

But research alone is not the complete answer. It is only a door through which the solution may be found, and if the method for the prevention of dental disease is beyond that door, then there must be a sufficient army of dentists who will make a well-trodden path to that solution; men who will earnestly seek those facts and who will diligently apply them in practice. Maximum value from research can be attained only by a profession constantly alert to the results of research, a profession that realizes that its contribution to the oral health of a nation is made by giving adequate time and effort to teach and practice known measures for the prevention of dental disease. Should not the Fellows of the American College, who are among the recognized leaders in our profession, be active not only in the promotion of research, but in the application of the results of research?

DENTAL ASPECTS OF FEDERAL LEGISLATION

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There are pending before the Congress of the United States today many bills which affect either dentists or the practice of dentistry directly or indirectly. Of primary interest to you all is, of course, S. 1679, the Thomas-Murray-Dingell Bill. This legislation, which seems to be stymied for this session, deals with compulsory health insurance. There are six other parts to the bill, but each of these is included to assist in the basic program proposed—compulsory health insurance.

The bill proposes to establish a system whereby the Federal Government would set apart a portion of its revenues equivalent to four per cent of the first \$4800 of all wages earned in the United States, for the purpose of bearing the costs of personal health services, including medical, dental, hospital, and auxiliary services, proposed to be furnished to about eighty per cent of the people of the United States. The law would be administered by the National Health Insurance Board proposed to be established as a new unit of the Federal Security Agency. The Board, consisting of five members, two of whom would be the Surgeon General of the United States Public Health Service and the Commissioner of Social Security, would serve *ex officio*. The remaining three, one of whom must be a doctor of medicine, would be appointed by the President subject to the approval of the Senate.

The Board, after consultation with a seventeen-member body to be known as the National Advisory Medical Policy Council and subject to the approval of the Federal Security Administrator, would promulgate the regulations to put the law into effect and administer it from the Federal level. At the state level, the scheme would be operated either by a state agency set up according to a plan submitted by the state to the Board for approval or by the National Health Insurance Board if no plan were submitted. At the state level there would be a State Advisory Council to assist the state-operated agency. At the local level there would be an administrative functionary which could either be a local area committee working through an executive officer or a local administrative officer assisted by a local advisory council. In addition, at the local level there would be a local professional committee to advise the local functionary with regard to professional problems.

Every person, except state employees and a relatively few others, who earned \$150 in any calendar year or who earned \$50 in half of the quarters of any three years would be eligible for benefits, as would Old Age and Insurance beneficiaries, retired Federal Civil Service personnel, and the dependents of anyone who was himself eligible.

Under the Act, practitioners agreeing to serve would enter into a contract for a definite period of time. They could agree to render either general, specialist, or auxiliary services. Payment would be made either on a per capita basis, a fee for service basis, a full-or part-time salary basis, or a combination of any of these methods. The manner of payment for dentists would be determined by majority vote of the dentists participating in a given health area. However, those who preferred some other method of payment would be permitted to make such arrangements.

Both patients and practitioners would have the right to complain to the local authorities concerning the administration of the law or the quality of treatment rendered. Either or both could appeal from the decision of the local functionary to an impartial tribunal and ultimately to the Supreme Court of the United States through either the Federal or state court systems.

If the bill were to be enacted, the practice of dentistry would be revolutionized. The excessive costs involved in providing this form of treatment would in time require that all participants be employed on a salary basis. Otherwise there could not even be the semblance of economical administration.

Another bill which is of interest to dentistry is S. 1453, which is an elaboration of Title I of the Wagner-Murray-Dingell Bill. This bill proposes to make grants to dental and other professional schools for the construction of additional facilities for professional training. It would also grant to each school a bonus based upon the number of students in attendance, with a larger bonus if the number enrolled exceeded a three-year average of students in each class year. The bill also proposes to pay the tuition of each student granted a scholarship

by his state out of funds provided by the bill and to pay to each student a maintenance allowance of \$125, \$150, \$175 per month, according to his dependency status, for each month he is actually enrolled. In return, the student after graduation would be required to practice his profession for one year for each two years he held a scholarship either in an area designated by the state as a state employee or, with the consent of the state, in the Federal service. A third bill with dental interest is the so-called school health service bill. This act would provide funds to the states to be expended for childrens' health services. Under its terms, each child of school age would be given periodical medical and dental examinations. If any defects were found, and the child's parents were unable to bear the costs of correcting such defects, they would be corrected at state expense. Each state would have the obligation of providing complete rehabilitation service to children whether or not their parents were able to pay.

Also of interest to dentistry are the army dental bills, which propose to establish in the dental services of the army and air force a parity of administration for dentistry with medicine so that dentists would be able to handle their own affairs. These are but a few of more than a hundred bills now pending which in some way affect dentistry.

Now, may I digress a minute to touch upon the political aspects of legislation. Laws are enacted by Congress and the members of Congress are elected by the people. In general, Congressmen try to act in a manner which will displease the smaller number of their constituents. Usually this means that they act in a manner which will not tend to displease the most vocal group. Now the purpose of the various dental organizations is not political, nor is it to act as a pressure group either to support or to defeat legislation. However, more and more legislation is being introduced which tends to affect directly or indirectly the practice of professions. Although it may not be practical for the various dental organizations to sponsor or to endorse or oppose particular candidates, there is certainly, if not an obligation, at least a personal necessity for every professional man to make a special inquiry into the position or stand of the various candidates for public office on questions which affect the practice of his profession. No longer can the average professional man merely follow his normal political inclinations or even refrain from exercising his right to vote. Those who sponsor legislative proposals which the professions believe are not in the public interest are certainly not reluctant to work actively for candidates of their own sentiments and to oppose actively candidates with whose positions they are not in sympathy. The time has come when everyone in this country must give intelligent examination to the issues before the country in each election and then vote according to his convictions.

DISCUSSION

LON W. MORREY

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Chicago*

I wish to congratulate the officers and committee of the College upon arranging today's excellent program. I also wish to congratulate the essayists for the manner in which they have carried out their assignments. Their contributions have enabled each of us here to comprehend, a little more clearly, the fact that this country, like most countries in the world today, is moving steadily toward statism. Some may question the rapidity of the movement but none can deny that the movement is taking place. We frequently hear the statement that we are drifting towards statism. "Drifting" is the wrong term. Judging by the events that have taken place during the past 20 years we are being impelled or propelled very rapidly towards an existence in which the Federal government is assuming many of the rights, privileges, responsibilities and duties which the founders of this democracy felt should belong to the individual and the family.

As has been pointed out so frequently, the enactment of national compulsory health insurance legislation is the first step in the program proposed by the advocates of statism. Once the nationalism of health services is achieved, the nationalization of other services can be accomplished more easily. That is the history of statism in other countries and history may repeat itself here.

This morning you heard Doctor Hillenbrand's very excellent description of his recent observations in Britain, including his interview with Aneurin Bevan in which the Minister of Health expressed himself freely as to the future of dental service in England. What has happened in Britain and what Mr. Bevan prophesies will happen to the British health services in the future must not happen here. Forewarned is forearmed. Doctor Hillenbrand's account adds one more chapter to the many already compiled as evidence against the adoption of compulsory health insurance in this country,

This afternoon Mr. Garvey presented a concise, complete picture of the health activities and legislation, including compulsory health insurance, now under consideration by our national legislators. Naturally much of this legislation will not be enacted. But some of it will. The dental profession must keep informed regarding the nature of this legislation. Dentistry should actively support practical bills which will improve dental health and which conform to the social philosophy of the profession. It should actively oppose all health legislation which in the studied opinion of the profession is not in the best interest of the public.

I am convinced that the dental health program developed by the American Dental Association over 10 years ago—a program based upon research, educa-

tion and service for children—a program which will enable the individual, family and community to assume their rightful responsibility in health matters—is the most practical long-range program that has as yet been devised. I recognize that many members of the profession, many local dental societies and perhaps some state dental societies have been somewhat slow in activating community dental programs. In my opinion the establishment of successful dental programs on a local basis—programs owned, operated, directed and controlled by the local community—is the best way to combat the dental aspect of national compulsory health insurance. It is dentistry's responsibility to stimulate the establishment of such programs and it is the dentist's responsibility to place in office legislators who favor that type of health program—rather than legislators who favor compulsory health insurance and statism.

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Special abbreviations besides of those of self-evident import.—A.A.A.S.: American Association for the Advancement of Science. A.A.D.E.: American Association of Dental Editors. A.A.D.S.: American Association of Dental Schools. A.C.D.: American College of Dentists. A.D.A.: American Dental Association. A.M.A.: American Medical Association. A.P.H.A.: American Public Health Association, D. or d.: dental or dentistry. I.A.D.R.: International Association for Dental Research. I.A.R.S.: International Anesthesia Research Society. J.A.C.D.: Journal of the American College of Dentists. J.D.R.: Journal of Dental Research.

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