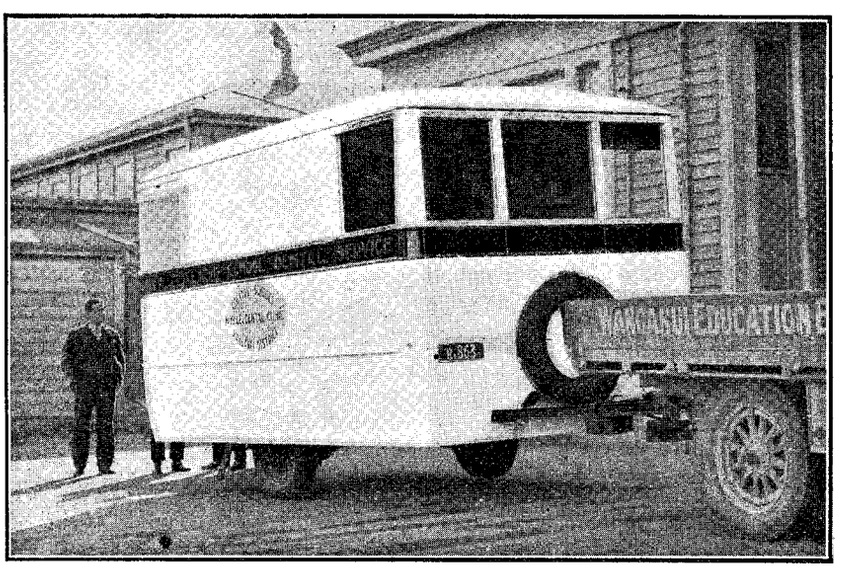
For the first time in the thirteen years during which the Service has operated, the extraction figure has ceased to fall ; in fact, it shows an infinitesimal rise, but, as this amounts to less than 0·2 extractions per 100 fillings, it can almost be said to have remained stationary during the past two years. Whether this index figure for unsaveable teeth will fall below seventeen under existing conditions it is difficult to foretell, but any marked increase in the number of pre-school patients will almost certainly lower it.

The following table shows the proportion of extractions to fillings since the inception of the Service :—

	Fillings.	Extractions.	Ratio : Extractions per Hundred Fillings.
1921–22	13,047	14,939	114·5
1922–23	24,603	25,436	103·3
1923–24	47,610	37,978	79·7
1924–25	59,322	43,181	72·6
1925–26	61,506	41,339	67·2
1926–27	84,723	53,232	62·8
1927–28	116,916	66,523	56·8
1928–29	146,354	76,555	52·3
1929–30	190,934	71,128	37·2
1930–31	258,546	75,973	25·5
1931–32	334,827	80,389	24·0
1932–33	382,289	74,633	19·5
1933–34	397,437	69,208	17·4
1934–35	399,560	70,207	17·5

The Mobile Clinic.

As noted elsewhere in this report, a mobile clinic was put into operation during the year as a unit of the School Dental Service, and at this period it would be appropriate to discuss the relative merits of the mobile and stationary systems in the light of the experience gained up to the present time.



Experimental Mobile Dental Clinic.

Established and maintained by the Wanganui Mobile Dental Clinic Committee, and operated as a unit of the School Dental Service. It serves a group of twenty country schools.

It is obvious that the chief advantages of the mobile system are its convenience and the saving of time that is effected by carrying out the treatment at the schools themselves. Under the other system, where a centrally situated permanent clinic serves a group of schools, many of the children have to travel some distance (frequently several miles) for treatment. This calls for a greater effort on the part of parents and local School Committees. On the other hand, the mobile system is more costly. In the first place, the vehicle costs more to build than does a standard stationary clinic. Then again, the latter, if built on school-grounds, as it usually is, is a school building, and is kept in repair by the local Education Board. The cost of maintaining a mobile clinic under existing conditions falls entirely on the local dental clinic committee. To this must be added the cost of haulage from school to school. It might be said that this item is offset in the case of a stationary clinic by the cost of transporting children from outlying schools to the central clinic. This, however, would depend entirely on the distances separating the different schools from the clinic and on the local organization. It has been argued that the matter of moving from school to school would be simplified if the clinic, instead of being built as a trailer, were built on a motor chassis, so that it could move under its own power. Here again, it is a matter of cost. Apart from the question of employing a competent driver for such a large and relatively unwieldy vehicle, both the first cost and the cost of maintenance would be much greater. Moreover, it is doubtful whether such a plan would be economical, as the vehicle would be standing much more than it would be moving. The Department's experience some years ago with a motor clinic did not prove satisfactory.