TOWARDS SUSTAINABLE NATIONAL ORAL HEALTH SERVICES

AN IDA POSITION PAPER

IDA
irish dental association

Delivering the WHO Oral Healthcare Strategy for Ireland

Published by the Irish Dental Association | March 2024

CONTENTS

1. Foreword
2. Understanding our starting point
3. Guiding Principles
4. Strategic Objectives
5. Where we are & where we need to get to
6. Background
7. Current Challenges
8. Building Blocks
7. Fundamentals to delivering success

Appendices

Foreword

In 2023, the Irish Dental Association (IDA) marked its centenary year. Our mission is and has always been to advocate for the highest standards in oral health provision on behalf of over 1,800 members.

A century after the formation of the State, State-funded healthcare is not delivering as it should.

Oral healthcare is a historical "blind spot", as described by Minister for Health, Stephen Donnelly in the Houses of the Oireachtas in May 2023. This is to the disadvantage of large numbers of the Irish public with children and the many who are eligible for State subsidised oral healthcare being failed the most.

These facts stand in stark contrast to Ireland's commitment to the World Health Organization's (WHO) ambitious strategy for the integration of oral healthcare into universal healthcare in the next seven years. Universal healthcare is also a target of the UN's 2030 Agenda for Sustainable Development (Goal 3).

In 2018, the IDA published its vision for the oral health of the Irish public. 'Towards a Vision for Oral Health in Ireland' captured the Association's concerns around state-funded dental schemes while outlining the requirements for an innovative oral health policy providing the Irish public with a flexible, evidence-based, prevention-driven, people-centred service.

The Government's national oral healthcare policy, Smile agus Sláinte, followed in 2019. It was launched from behind a veil of secrecy, a residency it continues to inhabit. Despite numerous requests, Department of Health officials have yet to explain to stakeholders, including dental healthcare professionals, how its vision may be enacted.

The Irish Dental Association appreciates that while it might share and could ultimately support many of the aspirations of Smile agus Sláinte, it cannot support a piecemeal roll-out of a new service that history tells us will be with us for a long time to come. Such a service will fail and fail quickly. A cursory glance at the history of State-funded oral healthcare over the past 100 years is evidence of this truth.

The WHO is explicit that dental associations have a significant role in the planning and delivery of services. Our Association is no exception; we are ready and willing, under the principles of cooperation and coordination, to be a positive influence in the eventual delivery of a future facing, sustainable oral healthcare service.

This paper aims to provide solid groundwork for the development of sustainable oral healthcare services - services in which all stakeholders have confidence. Using the WHO's strategy as its foundation and building blocks, it sets out the steps now essential to delivering the best in Smile agus Sláinte for the benefit of all stakeholders, especially patients, and dental professionals.

Let there be no mistake a seismic shift in the planning and delivery of sustainable healthcare systems is required. It demands working relationships. This is not simply the ambition of the Irish Dental Association; the WHO's strategy stipulates this.

We invite all who share our ambition for a more equitable and sustainable model of state-funded oral healthcare - not least Government - to join us in initiating progressive stakeholder collaboration and setting a roadmap for success.

Let the work begin.

Dr Eamon Croke
President, Irish Dental Association

Understanding our starting point

The Irish Government has committed to the World Health Organization's (WHO) strategies on universal healthcare. In its Global Strategy on Oral Health (2022), the WHO sets out it aims, objectives and goal with clarity.

The vision of the strategy is Universal Healthcare (UHC) for all individuals and communities by 2030, enabling them to enjoy the highest attainable state of oral health and contributing to healthy and productive lives (150/7 Annex 3, 21).

"UHC means that all individuals and communities have access to essential, quality health services that respond to their needs and that they can use without suffering financial hardship. In addition, upstream interventions are needed to strengthen the prevention of oral diseases and reduce oral health inequalities. Achieving the highest attainable standard of oral health is a fundamental right of every human being."

The strategy also recognises that ***"political commitment and resources for oral health care systems often are limited at the ministry of health level. Typically, the oral health care system is inadequately funded...and isolated from the broader health care system."***

This is an assessment that is highly applicable to the position and prioritisation of oral healthcare in Ireland by the Irish Government and policy makers.

In setting out its global strategy, the WHO provides an overarching goal guiding Member States to:

(a) develop ambitious national responses to promote oral health;

(b) reduce oral diseases, other oral conditions and oral health inequalities;

(c) strengthen efforts to address oral diseases and conditions as part of UHC; and

(d) consider the development of targets and indicators, based on national and subnational contexts, building on the guidance to be provided by WHO's global action plan on oral health, in order to prioritize efforts and assess the progress made by 2030 (23).

"Achieving the highest attainable standard of oral health is a fundamental right of every human being"

WHO Global Strategy on Oral Health

Guiding Principles

Realising the strategy's goal evolves from the strategy's guiding principles ('where we want to be') and its strategic objectives ('how we get there').

	GUIDING PRINCIPLE	STRATEGIC OBJECTIVE
1	A public health approach to oral health	Oral health governance
2	Integration of oral health in PHC (Primary Healthcare)	Oral health promotion and oral disease prevention
3	Innovative workforce models to respond to population needs for oral health	Health workforce
4	People-centred oral health care	Oral health care
5	Tailored oral health interventions across the life course	Oral health information systems
6	Optimizing digital technologies for oral health	Oral health research agendas

Strategic Objectives

Realising the strategy's goal evolves from the strategy's guiding principles ('where we want to be') and its strategic objectives ('how we get there').

Strategic Objective 1

Oral health governance - Improve political and resource commitment to oral health, strengthen leadership and create win-win partnerships within and outside the health sector.

- Increased political and resource commitment to oral health are vital at the national and subnational levels.
- Central to this process is establishing or strengthening the capacity of a national oral health unit with professionals trained in public health.
- Dedicated, qualified, functional, well-resourced, and accountable oral health unit should be established or reinforced within NCD (non-communicable disease) structures.

Strategic Objective 2

Oral health promotion and oral disease prevention – Enable all people to achieve the best possible oral health and address the social and commercial determinants and risk factors of oral diseases and conditions.

- Evidence-based, cost-effective, and sustainable interventions to promote oral health and prevent oral diseases and conditions.
- Prevention efforts target key risk factors and the social and commercial determinants of oral diseases and other oral conditions. These initiatives should be fully integrated and mutually reinforcing Annex 3 EB150/7 31 with other relevant NCD prevention strategies.
- Safe and cost-effective community-based methods to prevent dental caries.

Strategic Objective 3

Health workforce: Develop innovative workforce models and revise and expand competency-based education to respond to population oral health needs.

- Adequate number, availability, and distribution of skilled health workers to deliver an essential package of oral health services to meet population needs. This requires that the planning and prioritisation of oral health services be explicitly included in all costed health workforce strategies and investment plans.
- A new mix of dentists, mid-level oral health care providers (such as dental assistants, dental nurses, dental prosthetists, dental therapists, and dental hygienists), community-based health workers and other relevant health professionals who have not traditionally been involved in oral health care, such as primary care physicians and nurses.
- Curricula and training programmes need to adequately prepare health workers to manage and respond to the public health aspects of oral health and address the environmental impact of oral health services on planetary health.

Strategic Objective 4

Oral health care – Integrate essential oral health care and ensure related financial protection and essential supplies in Public Health Care (PHC).

- Increase access by the entire population to safe, effective, and affordable essential oral health care as part of the Universal Health Care (UHC) benefit package.
- Financial protection through expanded private and public insurance policies and programmes, including coverage of oral health services, is one of the cornerstones of UHC.
- The appropriate consumables must be available for the delivery of the services.
- The development of policy, legislation, and infrastructure to expand the use of digital health technologies, such as mobile phones, intra-oral cameras, and other digital technologies, to support remote access and consultation for early detection and referral to services for the management of oral diseases and conditions.

Strategic Objective 5

Oral health information systems – Enhance surveillance and information systems to provide timely and relevant feedback on oral health to decision-makers for evidence-based policymaking.

- Developing more efficient, effective, and inclusive integrated information systems on oral health to inform planning, management and policymaking.
- The systematic collection of data on oral health status, social and commercial determinants, risk factors, workforce, oral health services readiness and resource spending.
- Protect patient data.
- Monitor patterns and trends in oral health inequalities and track the implementation and impact of existing policies and programmes related to oral health.

Strategic Objective 6

Oral health research agendas – Create and continuously update context and needs-specific research that is focused on the public health aspects of oral health.

- Create and implement new oral health research agendas that are oriented towards public health programmes and population-based interventions. These should include research on learning health systems, implementation sciences, workforce models, digital technologies and the public health aspects of oral diseases and conditions.
- Other research priorities include upstream interventions; Public Health Care (PHC) interventions; mercury-free dental restorative materials; barriers to access to oral health care; oral health inequalities; oral health promotion in key settings such as schools; environmentally sustainable practices; and economic analyses to identify cost-effective interventions.
- The translation of research findings into practice is equally important and should include the development of regionally specific, evidence-informed clinical practice guidelines.

Summary

The WHO has set out a holistic vision with a strategy that sets a long-term goal and enables governments to set short-term milestones. Achieving the WHO's goal demands 'joined-up thinking'.

Under Strategic Objective 1, the WHO sets out the elements of governance, which, the Irish Dental Association advocates, should be the starting point for all discussions and any development at national level. While each objective has multiple influences on the outcome, governance has an overarching effect on all other objectives and all guiding principles.

For the Irish Government to achieve this objective, it needs to break new ground, not least making a meaningful political and budgetary commitment to tackle oral diseases, which, to the frustration of the profession, has not been the case heretofore.

National Oral Healthcare Policy: Where we are today

DELIVERY OF NATIONAL ORAL HEALTHCARE SERVICES						
AGE GROUP		COMMUNITY (NON-DENTAL)	PUBLIC DENTAL SERVICE	PRIVATE DENTAL SERVICE	SECONDARY CARE (INCL. SPECIALISTS)	TERTIARY CARE (INCL. CONSULTANTS)
0 - 5 years	Prevention			●		
	Treatment		◉	◉	●	●
6 – 16 years	Prevention		◉			
	Treatment		◉	◉	●	●
17-25 years	Prevention			●		
	Treatment			◉	●	●
26 -66 years	Prevention			●		
	Treatment			◉	●	●
67+ years	Prevention			●		
	Treatment			◉	●	●
Institutionalised communities	Prevention			●		
	Treatment			●	●	●

KEY:

● Basic Level ◉ Intermediate Level ◉ Advanced Level

DELIVERY OF NATIONAL ORAL HEALTHCARE SERVICES						
AGE GROUP		COMMUNITY (NON-DENTAL)	PUBLIC DENTAL SERVICE	PRIVATE DENTAL SERVICE	SECONDARY CARE (INCL. SPECIALISTS)	TERTIARY CARE (INCL. CONSULTANTS)
0 - 5 years	Prevention	◉	◉	◉		
	Treatment		◉	◉	◉	◉
6 – 16 years	Prevention		◉	◉		
	Treatment		◉	◉	◉	◉
17-25 years	Prevention			◉		
	Treatment			◉	◉	◉
26 -66 years	Prevention			◉		
	Treatment			◉	◉	◉
67+ years	Prevention			◉		
	Treatment			◉	◉	◉
Institutionalised communities	Prevention	◉	◉	◉		
	Treatment		◉	◉	◉	◉

KEY:
● Basic Level ◉ Intermediate Level ◉ Advanced Level

National Oral Healthcare Policy:
Where we need to get to

Background

Oral diseases are among the most common noncommunicable diseases worldwide, affecting an estimated 3 out of 4 people in middle-income countries or 3.5 billion people globally.

Oral diseases disproportionally affect the poor and socially disadvantaged members of society. Untreated tooth decay (dental caries) is the most common health condition according to the Global Burden of Disease 2019.

Oral diseases cause pain, disfigurement and even death and are on the increase. These diseases result in a reduction in quality of life and the loss of self-esteem. They can lead to absenteeism from education and employment. Oral diseases are a burden on the person and the State.

Oral diseases are largely preventable as they are caused by a range of modifiable factors common to many noncommunicable diseases (NCDs).

The World Health Organization (WHO) has adopted and got acceptance from its members, of whom Ireland is one, for a strategy to deliver integrated universal healthcare. This strategy envisages the provision of oral healthcare that, in time, will be integrated into universal healthcare with a particular emphasis on the prevention of non-communicable diseases.

The WHO's vision for universal healthcare requires a change in our approach to healthcare in recognition of the present failures. The WHO is explicit that dental associations have a significant role in the planning and delivery of services.

The Irish Dental Association's 'Towards a Vision for Oral Health' was published in 2018. The Department of Health's National Oral Health Policy, Smile agus Sláinte, was published in 2019. It is the State's response to Ireland and the EU's acceptance of the WHO's aim to develop a global strategy on oral health and for the prevention and treatment of noncommunicable diseases.

Smile agus Sláinte and Towards a Vision for Oral Health have much in common. Both documents were developed by small, select groups of people, albeit all were eminently qualified to express a vision for oral health. The Association's vision was developed after severely limited consultation with the Association by Department of Health officials.

The vision that both documents share for oral health in Ireland is broadly similar. Equally, and importantly, neither document is a roadmap for the practical delivery of these visions.

Smile agus Sláinte has admirable aspirations, but it was developed in the absence of representative consultation with stakeholders, especially the dental healthcare professionals who deliver primary oral healthcare in Ireland. It suffers from many issues including the absence of constructive road maps, financial responsibility and assurance.

Indeed, limited conversations with officials of the Department of Health and the unwillingness of the Minister for Health to meet the Association, the dentists' representative body, further heightens the profession's frustration and cynicism at how genuine Government is in delivering on its ambition.

At present, primary, secondary, and tertiary oral healthcare is being provided in spite of, rather than because of, active State investment and support. In effect, secondary care is provided by non-recognised specialities in the private and public sectors and tertiary care is provided by consultants, mostly employed as academics, in the public sector.

The Irish Dental Association's aim is to work cooperatively and in a coordinated manner with stakeholders to develop a sustainable oral healthcare system for the people of Ireland. We believe that all stakeholders must seek the merits in both Smile agus Sláinte and the WHO Strategy - neither of which will work in the present Irish oral healthcare context - to provide a once-in-a-lifetime review and overhaul of the oral health ecosystem.

"Our fundamental ask of Government as part of this process is to establish a collaborative process around sustainable partnerships to progress a future-facing, people-centred, equitable national oral health policy that is in harmony with the principles and objectives of the World Health Organization Global Strategy on Oral Health (Annex 3, EB150/7, January 2022) and develops the shared values of Smile agus Sláinte."

Irish Dental Association

Current challenges in delivering a sustainable model for oral healthcare in ireland

The WHO's aim is for an expanded oral healthcare service; this requires it to be fully resourced.

We know that right now, in the public dental service, the numbers of dentists have dropped by almost one quarter over the past 15 years; neither are we producing nearly enough dental graduates to supply the public and private sectors.

Years of underinvestment - despite more promises by successive Governments of otherwise - means that our dental schools do not have the basic capacity to educate and train enough dental practitioners to meet population needs and account for dentists retiring from the sector.

Oral healthcare budgets will benefit in a relatively short time from properly funded, carefully planned systems if these systems are provided for from the beginning.

A holistic and honest appreciation of resources, human and financial, is required. Realistically, resources will need to be targeted, even with a very significant improvement in public funding.

In our most recent pre-budget submission (Budget 2024), the Irish Dental Association estimates that an additional allocation of €71m is required to address the resourcing crisis in the public dental service and training and an allocation of between €108 – €232.5 million to deliver a reformed medical card scheme (DTSS).

Successful realisation of any strategy or plan will depend on commitment, cooperation, and coordination. Honesty and respect are imperative if trust is to be established between all sides.

Provision of oral healthcare: overview

There is a well-publicised workforce crisis in Ireland and neighbouring countries. There has also been a change in work profiles, further limiting team availability. A sudden increase in workforce numbers is unlikely. There is a need to look at the scope of practice of the dental team and potentially, new categories of dental healthcare professionals.

Non-dental personnel – from the outset oral disease prevention and health promotion will require upskilling.

Specialities – the WHO strategy is driven by public health targets, which requires a workforce skilled in its delivery and audit. Clinical Leadership will require appropriate specialist knowledge and skills. The strategy envisages the presence of a National Oral Health Unit.

Education and skills development - educational demands include expanded infrastructure, increases in pedagogical staff and associated costs of teaching/service delivery with the aim of preparing in skills, knowledge, and numbers a workforce capable of delivering the required service. Integration of disease prevention and health promotion into universal healthcare will require regular upskilling of all involved.

Health promotion – the development and delivery of health promotion is a synergistic tool when combined with prevention programmes.

Service systems – oral healthcare services will be expected to deliver on disease prevention and health promotion/corrective modalities/ data collection and audit. These interdependent systems will require the skills of primary, secondary, and tertiary practitioners in private and public service. Obviously, considerable discussion will revolve around what is considered to be ‘essential, quality health services that respond to peoples’ needs and that can be used without suffering financial hardship’. Appropriate payment for services delivered by private practitioners will need the protection of enforceable law/mediation to ensure respect and fairness. This demands a ground-breaking shift in present approaches to the delivery of oral healthcare services.

The current Dentist Act, 1985 is not fit for purpose. The Department of Health received a submission from the Dental Council in October 2021 on proposals for a new Act, which is supported by the Irish Dental Association.

People-centred healthcare, which moves away from the previous models of healthcare, should respond to peoples’ needs, improve service delivery and feedback and will become a pivot point in partnerships.

The building blocks of integrated, sustainable and responsive oral healthcare

The Irish Dental Association has developed a 'building block' approach to the establishment of integrated, sustainable, and responsive oral healthcare, which accepts the principles and objectives of WHO's Global Strategy on Oral Health (Annex 3, EB150/7, January 2022).

The 'building block' approach supports **a phased introduction of a new agreed oral health plan laying the foundations based on the required political and financial commitment along with the accompanying legislative and leadership changes.**

The required changes include the necessary support to ensure our dental schools provide the appropriately skilled personnel to implement an agreed plan.

The WHO accepts that its ambitious strategy may take years to have in place, but it has set specific but informative principles, or aims, and objectives within the Policy to guide progress. It requires a radical approach to the delivery of the strategy; previous methodologies will not work.

A future-facing healthcare system is required to be sustainable – including environmentally – over time in its delivery and outcomes for patients and healthcare providers. This means "the provision of equitable, ethical, high quality, inclusive and safe care with effective and efficient uses of resources. Through this, the healthcare opportunities of current and future generations are respected and protected by actively minimising negative environmental impacts" (FDI World Dental Federation). Sustainable dentistry is dependent on the practise of good dentistry.

In line with the WHO's strategy, the Irish Dental Association recognises the following building blocks as a strong foundation enabling a sustainable oral healthcare system include:

1. / Explicit political and financial commitment

Functional governments assess the public needs and how those needs are best served with the resources available. Healthcare is expensive and, in Ireland, the delivery of healthcare is stratified, providing those who can pay with a competitive edge in health stakes.

The Irish Dental Association recognises that healthcare provision can become 'a bottomless pit'; it is an important realisation of fact that no government has the money or capacity to provide healthcare that fulfils all personal needs.

The present political and financial commitment is totally inadequate and will fail the people of Ireland again and again. Globally, Governments have defaulted on social contract responsibilities as they have assumed ongoing participation by the dental profession to work for the greater good while not placing a just financial value on the services provided. Ireland is no different. We have seen it first hand in our own Government and Minister for Health's repeated call on dental professionals to "work with me...to deliver a more modern service" despite a crumbling medical card scheme and trust being completely eroded following years of neglect.

The Association's position is that a properly funded Exchequer budget should be first directed towards the disadvantaged in our society, who often share common social and economic determinants, and adequately funded services are cultivated to meet their personal dental needs.

2. / The establishment of win-win partnerships.

People-centred healthcare can grow and mature from trustful partnerships. The WHO objective is to engage and empower users and stakeholders of oral healthcare services. Successful, sustainable outcomes for each phase of the WHO strategy will only occur in respectful, functioning partnerships. Empowered participation by users and stakeholders is essential to the sustainability of the system and the environment. Collaboration is encouraged by the WHO but was entirely absent in the development of Smile agus Sláinte.

The Association advocates for the development of an oversight group comprised of sectoral specific individuals from all areas of the oral healthcare sector. We call on the Irish Government to demonstrate a measurable commitment to the WHO objectives by establishing working partnerships with stakeholders, including the Irish Dental Association, as a first step to development of sustainable oral healthcare services. This will require innovative approaches to policy development.

3. / The establishment of a new oral health reform oversight group

There must be clear agreement before the outset as to the governance of the partnerships with a means for independent mediation for impasses. Department of Health officials have, to this point, steadfastly refused to acknowledge the need for industry collaboration and partnership. This must change.

The Association has recently called on the Taoiseach to establish a new oral health reform oversight group comprised of a strong and independent chairperson and with suitable representation from key stakeholders such as the IDA. The oversight group should be given clear terms of reference, authority, resources, and a timeline to complete the transition process to the sustainable model of oral healthcare.

4. / Appointment of Clinical leadership

Clinical leadership is an important element in both WHO Policy and Smile agus Sláinte. Clinical Leadership, as applied to medicine, is not applicable to dentistry where the vast majority of treatment, and its hands-on dispensing, is undertaken in private, primary care settings. In addition, the culture within the Executive of the HSE has failed oral healthcare delivery so embedding Clinical Leadership at an unspecified level within the HSE is problematic.

Instead, the Association recommends that the role be integrated within the Medical Clinical Leadership structure, which is linked to the Chief Clinical Officer. This would be a start towards the WHO's objective of an Oral Health Unit and allow coordination of the progressive integration of oral healthcare into universal healthcare.

In addition, the roles and responsibilities of the Clinical Leadership must be clear and acceptable to stakeholders. The Clinical Leadership must be empathetic to the requirements of all stakeholders and the visions they hold and must be willing to work with all. The Clinical Leadership must be empowered and allowed to flourish without any form of cultural or organisational malaise.

5. / All stakeholders to be represented in an Implementation Group

This multi-stakeholder group, in partnership with the Clinical Leadership, will be directed with the task of developing a modern, sustainable oral healthcare service.

The Association advocates that the partnerships operational in the oral health reform oversight group, will work with the Clinical Leadership in an Implementation Group to develop and then improve the provision of oral healthcare services at all levels, primary, secondary, and tertiary.
At the outset, the structure, role, and governance of the Implementation Group must be agreed.
This group is to bring the full policy into practice following on from the work of the Oversight Group.
This group will not be exclusive of the Oversight Group and will comprise of a mix of Oversight members and non-members.

6. / Consensus on a new model of funding for oral healthcare

Historically oral healthcare schemes and services in Ireland have been grossly underfunded and, essentially, have been dismantled since 2009.
The WHO suggests that oral healthcare be an agreed percentage of the annual healthcare budget; the Association considers this approach worthy of investigation provided the agreed percentage supports progressive, responsive services. This will fund a best-in-class, world-first example of joined-up oral healthcare provision which follows the WHO aims and objectives.

7. / Introduction of a new Dental Act

Legislation for the dental sector is primitive and does not serve the public or profession in a fitting manner. A new Dental Act is essential to oversee changes, which have occurred since the last Act in 1985 - almost four decades ago. The Irish Dental Association calls for the Dental Act of 1985 to be updated and modernised to protect patients and ensures the highest standards of education and training of dentists, as well as to allow for the mandatory licensing and inspection of dental practices.

8. / Recognition of a broad range of dental specialities

Regulation and legislation are needed to meet the requirements of the WHO's Strategy, in particular, the recognition of a broad range of dental specialities. The WHO strategy requires public health specialists at the centre of policy development, assessment, and evolution.
The Department of Health and HSE must recognise the role of specialities in the delivery of oral healthcare services. Primary care will remain the foremost delivery mechanism of healthcare, but specialists are essential to supporting primary care and the development of secondary and tertiary care services.

The Association supports the recognition and regulation of dental specialities required to deliver oral healthcare. The Dental Council has recommended recognition of nine additional dental specialties to the Department of Health. [List of specialties to be found in appendix 2].

9. / Enhanced education and skills development

Education and skills development is fundamental to achieve a sustainable model of oral healthcare. This will require partnerships between the academic and regulatory sector to ensure the highest standards of care and patient safety. It will require appropriate levels of funding to increase the number of graduates available to work in the planned services and ensure that the workforce has the skills, including specialist skills, required to provide the highest standards of care.

The Association welcomes the creation of a new dental school in the RCSI. Fundamental to increasing the number of dental graduates that will practice in Ireland is to address the funding and capacity crises in the TCD and UCC dental schools. Furthermore, the Association advocates for the reintroduction of a Foundation Training Scheme to facilitate new graduates in gaining experience in a mentored environment and capital investment to deliver the overdue new dental hospital in UCC. Currently, the campus of Cork University Dental School is overcapacity and unfit for purpose. A bespoke dental school which can cater for additional graduates is required to meet patient demands and our workforce planning needs.

Fundamentals to delivering a successful national oral healthcare policy

The Association believes that further to the nine building blocks outlined in the previous section, the core fundamentals to a successful, integrated, and sustainable oral healthcare policy must include the following principles:

> **A people-centred approach** to oral healthcare policies will respond to the peoples' needs, improve service delivery and feedback, and will become a pivot point in partnerships. People-centred healthcare moves away from the previous models of healthcare, which focused on rigid schemes bowing to the requirement of government with lesser attention to those receiving the care or providing it.

> The **prioritisation of prevention** over the cure is to the benefit of the participant, the planet, and the Exchequer. A prevention programme for the youngest is possibly the optimum system to roll-out within an agreed National Oral Health Policy as the prevention of dental caries improves not just the health of children but also improves their well-being and quality of life. The positive effect of this programme is amplified by the timeline of parental and child exposure to the programme.

Prevention programmes should also be established for adults, young and old, independent of the children's programme. These programmes should focus on all non-communicable diseases as part of the integration of the dental healthcare environment in relevant health programmes, providing age-appropriate, evidence-based interventions across the life course.

> Prevention requires an **innovative approach and the upskilling of workforces**, within and outside of dental healthcare professionals.

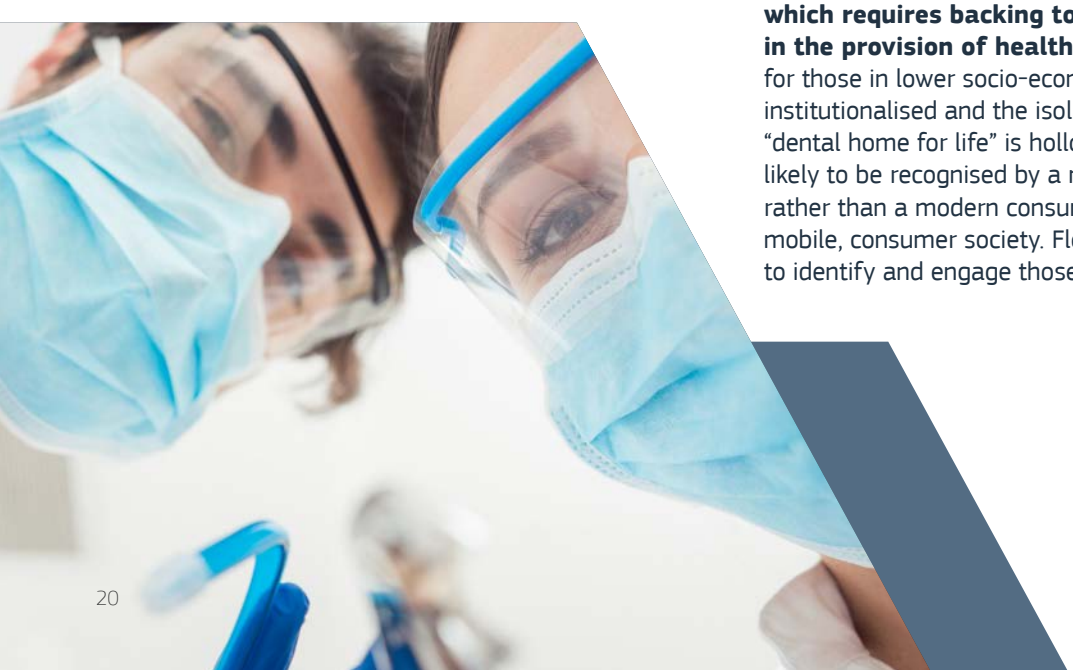
Childsmile (Scotland) and the Basque "PADI" scheme are good examples of what works in preventing dental disease, in this case childhood dental caries, using and upskilling widespread resources in a tested and co-ordinated manner and, in doing so, reducing inequities in oral health.

Cost analysis of the Childsmile programme, in 2015, comparing the costs of providing the programme versus those for avoided dental treatments found promising results for supervised toothbrushing in the nursery/kindergarten setting, with **savings in the eighth year of the programme of approximately GBP £3.0m with the largest decrease in modelled costs for the most deprived cohort of children.**

> The principles and objectives of WHO's Global Strategy for integrated universal healthcare will take years to rollout and will be very costly, especially until the benefits of prevention programmes begin to take effect. Initially, **services must target those in greatest need,** the most vulnerable in society coupled with the appropriate funding/personnel to manage the most prevalent and/or severe oral diseases and conditions.

> Currently, without any change in the scope of practice, there is a workforce crisis in the dental profession in Ireland. It is essential that **Government policy acknowledges the present capacity of the dental workforce to deliver on the public's expectations of that policy.** No workforce planning has ever been undertaken for the wider dental workforce in Ireland. There is no knowledge of current population needs and no national clinical care pathways exist in dentistry. Unlike in medicine, there is no accurate information available on the number of dentists available to work and the number of hours they are working. The Government needs to plan for the education of a workforce with the required range of skills and knowledge to deliver a sustainable service. In addition, the Government needs to consider how to encourage the establishment of primary and secondary privately-run care centres in rural settings.

> It is of critical importance that **standards of healthcare delivery and patient safety** are not only maintained but are seen to improve as roles within the dental team change to meet present and future service needs. The appropriate education and regulation of the dental team is as indispensable as the required levels of funding of our dental schools. The IDA recognises that changes in the scope of practice of the dental team and the potential introduction of new dental healthcare professionals will be required to ensure access to dental services in future.



> **A properly developed public dental service is central to universal healthcare delivery.** The public dental service is a service trusted by parents across the country. It has provided generations with valuable care and has been a hugely important safety net for children and parents fulfilling a universal role for primary school children. Today, however, the number of dentists in the public services has dropped by 23% over the past 15 years; in that period the under-16 population in Ireland has grown by over 20%.

The current physical regional infrastructure is a good foundation for an expansion of public dental services delivering targeted, equitable care.

> There is an **immediate requirement for the acceptance of additional dental specialties, and also public and private service availability of a broad range of specialties.** Ireland has only two dental specialties, as provided for by a 1980 EEC Directive for Dental Practitioners. The WHO strategy advocates that specialists in Public Health are an essential component to healthcare planning, delivery and audit. The use of special care specialists and other specialists in caring for those with disabilities, through the NHS (UK), is noteworthy. The majority of care is in primary care settings, but the availability of specialists ensures people get the care they need in public and private settings.

> **Patient choice is a quintessential driver, which requires backing to ensure justice in the provision of healthcare services** for those in lower socio-economic groups, the institutionalised and the isolated. The concept of a "dental home for life" is hollow; it is a phrase more likely to be recognised by a marketing executive rather than a modern consumer. We live in a mobile, consumer society. Flexibility is essential to identify and engage those most at risk.

> **A strong private primary and secondary dental sector is key to universal oral healthcare delivery.** The private dental sector will remain the primary delivery mechanism for oral healthcare in Ireland. Globally, underfunded, rigid and, ultimately, stressful national schemes have been roundly rejected by dental teams as unworkable and outmoded. Private practice will view any unilateral move by Government with suspicion grown out of repeated experiences. The Association believes that clinical decision-making, independent of third-party restrictions best serves practitioners in general practice to deliver contemporary, evidence-based care in the best interests of their patients and, ultimately, the environment.

> Access to **secondary and tertiary healthcare** is a critical part of universal healthcare and is significantly underdeveloped in Ireland, often to the detriment of the most disadvantaged. The importance of these layers manifests themselves in the example of special care provision where primary care, follow up care and emergency care are all needed facilities. Employment of a broad range of specialists in the public and private sectors and the provision of the required infrastructure, in education and healthcare delivery, is an investment that is inseparable from the delivery of integrated universal healthcare across the nation. In Ireland, post graduate training is self-funded and consultant training does not exist. Consultant appointments are made by equivalence.

> **Tailored age-appropriate interventions** will need to be **integrated within universal healthcare** if the burden of non-communicable diseases to the individual and the health system is to be reduced. These interventions should be evidence-based. This policy will enable the dental team to engage in the prevention of other non-communicable diseases associated with oral health.

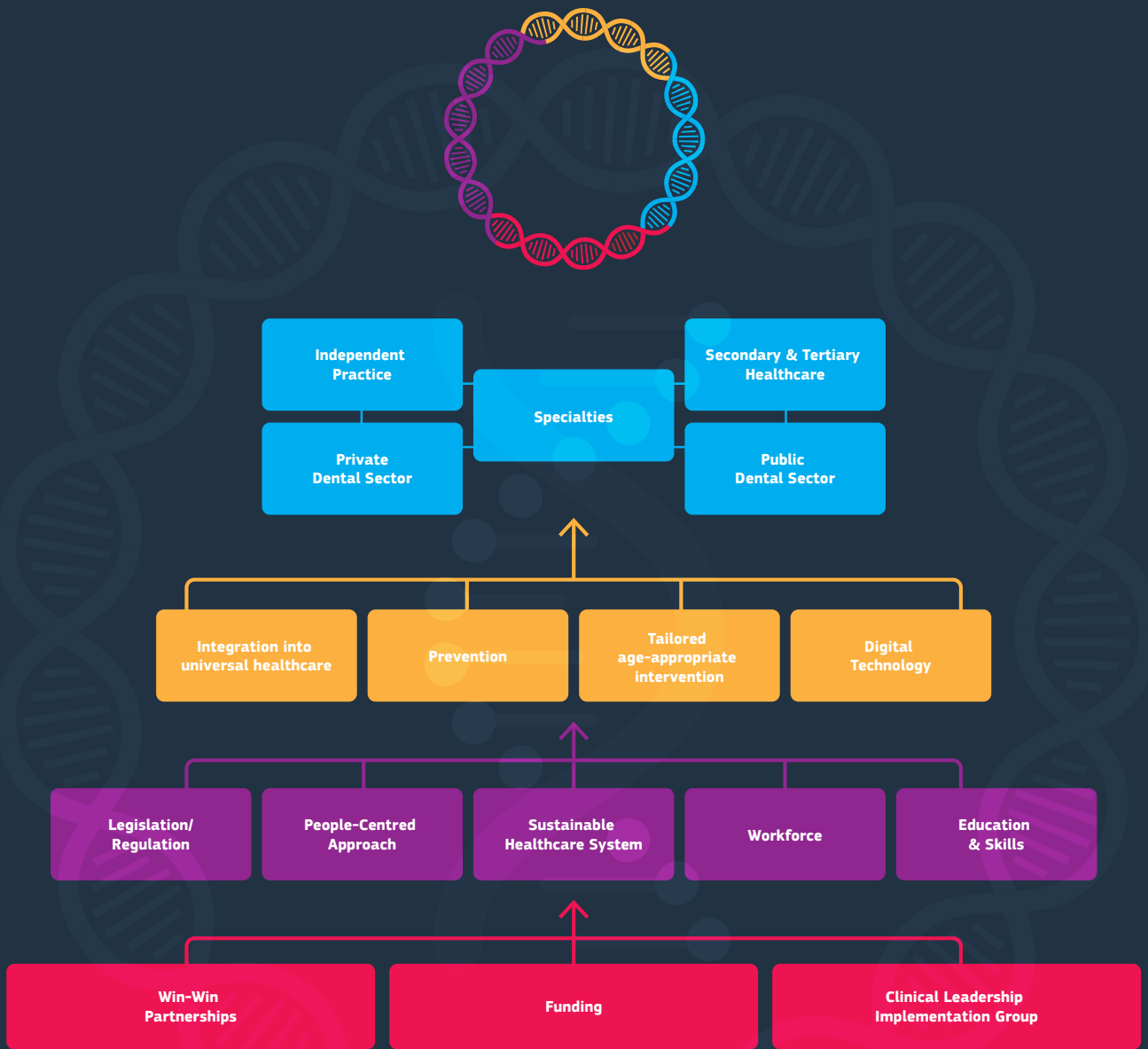
> **Data collection and audit** needs to be assimilated into modern healthcare systems to allow assessment of healthcare policy and evidence-based improvements. Investment in **digital technology** is fundamental to appropriate and adequate data collection. Planning for the quantity of patients, the type of care patients require and the challenges facing the profession require careful data collection and data sharing amongst the Department of Health, the higher education institutes, the HSE and the profession. This will allow for policymakers and practitioners to make informed decisions on the provision of oral healthcare services.

> Autonomy in healthcare and the value in delivering high standards of dental care by independent practitioners requires an innovative approach. The Association supports the use of a **credit/voucher** payment scheme - a simple scheme that retains the confidence of all shareholders, providing an entitlement to a specified level of subsidy to the recipient for the receipt of care from participating dentists.

Issues that would need careful consideration include: eligibility; the range of services to be covered; the level of the subsidy; the frequency of renewal; whether the patient pays up front and recoups costs or whether the state pays on presentation of evidence of treatment; governance arrangements; whether the value of the voucher varies by patient types and; the range of additional measures relates, for example, to the supply of information to the public that may be required. Voucher-based schemes are used in Portugal and Australia, amongst others.

Conclusion

A sustainable national oral health service has to be approached in a systematic way. The below elements, as expanded on in this document, demonstrates what is needed to get there.



This consultative narrative is based on the following:

Appendix 1.

BMC Oral Health:

- McAuliffe U, Whelton H, Harding M, Burke S 'Toothless' – the absence of political priority for oral health: a case study of Ireland 1994-2021 BMC Oral Health (2022) 22:95

  https://doi.org/10.1186/s12903-022-02125-1

Community Dentistry and Oral Epidemiology:

- Ross AJ, Sherriff A, Kidd J, Deas L, Eaves J, Blokland A, Wright B, King P, McMahon AD, Conway DI, Macpherson LMD Evaluating childsmile, Scotland's National Oral Health Improvement Programme for children CDOE (2023) 51(1): 133 – 138

  https://doi.org/10.1111/cdoe.12790

Department of Health:

- Smile agus Sláinte (2019)

FDI World dental Federation:

- Glick M, Williams DM, Ben Yahya I, et al. Vision 2030: Delivering Optimal Oral Health for All. Geneva: FDI World Dental Federation; 2021.
- FDI World Dental Federation. Vision 2030: Advocacy in Action Implementation Toolkit. Geneva: FDI; 2023.

Irish Dental Association:

- The Irish Dental Association: A Centenary History
- IDA Pre-Budget Submission 2024 (2023)
- Oireachtas Health Committee presentation – Workforce Planning (2023)
- Providing Dental Care in Ireland: A Workforce Crisis (2023)
- IDA Pre-Budget Submission 2023 (2022)
- Improving Access to Dental Care for Medical Card Patients (2022)
- IDA Submission re dental legislative priorities (2022)
- Oireachtas presentation Providing Dental Care for All our Community (2022)
- IDA Submission to DTSS Fees Consultation (2022)
- A Better Alternative to the DTSS: A Principle Centred Approach (2020)
- Irish Times Opinion piece (2019)
- IDA Promoting Independent Practice (2019)
- IDA Towards a Vision for Oral Health (2018)
- Submission by the Irish Dental Association to the Oireachtas Committee on the Future of Healthcare (2016)
- A Vision for Improved Oral Health (2013)

Institute for Health Metrics and Evaluation:

- Global Burden of Disease Study 2019 (GBD 2019)

The World Health Organization:

- Seventh Fourth World Health Assembly: Oral Health, WH74.5, 31 May 2021
- Political declaration of the third high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases EB150/7, 11 January 2022
- Global oral health status report 2022
- Global Competency for Universal Health Coverage 2022

  https://www.geeksforgeeks.org/difference-between-coordination-and-cooperation/
  (last viewed 15 08 2023)

The recognition of the following additional specialties (adding to Oral surgery and Orthodontics) is supported by the Irish Dental Association and Dental Council.

Appendix 2.

- Periodontics
- Prosthodontics
- Endodontics
- Paediatric dentistry
- Special care dentistry
- Dental public health
- Oral medicine
- Oral pathology
- Oral radiology

IDA
irish dental
association