IDA
irish dental association

Budget 2014 Submission

Executive summary

The Irish Dental Association is the professional, educational, scientific and advocacy body for over 1,600 dentists in Ireland. Our mission is to promote the interests of the dental profession and to promote the well-being of our country's population through the attainment of optimum oral health.

In Ireland, the majority of dental services are provided by dentists in the private sector, while the HSE is responsible for providing dental services to children and adults with special needs.

The most recent national survey of oral health in Ireland – National Survey of Oral Health in Irish Adults 2000-2002[1] – revealed considerable improvements in the level of oral health among Irish adults over the previous 20 years (1980 to 2000). This reflected the investment in the provision of oral health services during that period together with the benefits of fluoride and oral health promotion.

Unfortunately Budget 2010 introduced massive cuts to the State's dental schemes, and as a result we are now beginning to see a rapid reversal of these advances. We do not believe these cuts make sense; they will ultimately cost the State more in the long term. The failure by the Government to carry out any impact or cost–benefit analysis prior to the cuts may be explained by the lack of dental input at policy level.

For Budget 2014, we make the following recommendations:

Ten key recommendations for Budget 2014

ORAL HEALTHCARE PROVISION – ADULT DENTAL SERVICES

RECOMMENDATION 1

Reinstate preventive and restorative care under the Dental Treatment Benefit Scheme for PRSI payers and introduce a new voucher system for all eligible patients. (Page 4)

RECOMMENDATION 2

Reinstate preventive and restorative care under the Dental Treatment Services Scheme for medical card holders and introduce a new voucher system for all eligible patients. (Pages 6)

ORAL HEALTHCARE PROVISION – DENTAL SERVICES FOR CHILDREN AND PATIENTS WITH SPECIAL NEEDS

RECOMMENDATION 3

Reinstate sufficient number of staff in all HSE areas to ensure patients of the HSE's Public Dental Service and Orthodontic Service have access to equitable services irrespective of geographical location. (Page 9)

RECOMMENDATION 4

Engage with the IDA on the reconfiguration of the HSE's Public Dental Service and Orthodontic Service to ensure any changes fully reflect the best interests of the patient. We also make specific reference to the crisis in orthodontics and propose a five-point plan to address these difficulties. (Page 11)

ORAL HEALTHCARE POLICY

RECOMMENDATION 5

Introduce a National Oral Health Policy, which provides equitable access to a range of treatments required to achieve and maintain optimal oral health for all citizens. (Page 12)

RECOMMENDATION 6

Explore with the Irish Dental Association the potential participation of dentists in health promotion and chronic disease management. (Page 12)

RECOMMENDATION 7

Divert a percentage of any taxes raised through consumption taxes on tobacco or high sugar/fat products towards an oral healthcare programme. (Page 13)

RECOMMENDATION 8

Appoint a full-time Chief Dental Officer to the Department of Health. (Page 13)

RECOMMENDATION 9

Reinstate the HSE Vocational Training Scheme in Dentistry. (Page 13)

THE BUSINESS OF DENTISTRY

RECOMMENDATION 10

Introduce financial incentives to dentists similar to those provided to other healthcare professionals, and address the cost of doing business in Ireland. (Page 14)

[1] Whelton, H., Crowley, E., O'Mullane, D., Woods, N., McGrath, C.,Kelleher, V., Guiney, H., Byrtek, M. Oral Health of Irish Adults 2000-2002. Department of Health and Children: Dublin, 2007.

Recommendation 1

RECOMMENDATION 1

Reinstate preventive and restorative care under the Dental Treatment Benefit Scheme for PRSI payers and introduce a new voucher system for all eligible patients.

Dental decay (caries) and gum (periodontal) disease are the two most common dental diseases that result in chronic damage. Left unaddressed, these two major dental diseases have a cumulative cost to individuals and ultimately to the State. By taking a preventive approach, the level of dental disease can be contained, thereby reducing future demand and cost.

Over two million people are entitled to benefit under the Dental Treatment Benefit Scheme (DTBS). The Scheme is managed by the Department of Social Protection. Private dentists are contracted to provide the treatment in their own dental practices and are paid on a fee per item basis, i.e., not on a capitation basis.

The Scheme has been in existence since the 1940s and is funded by the Social Insurance Fund. Up to Budget 2010, the Scheme provided basic dental treatment necessary to achieve and maintain good oral health.

In order to qualify for the benefit, taxpayers are obliged to pay the requisite number of PRSI contributions.[2] Once you satisfy the PRSI conditions at age 60, you remain qualified for life. The Scheme is often the one tangible benefit taxpayers received in return for their contribution to the Social Insurance Fund.

In the Budget for 2010, the Scheme was restricted to one item – the annual oral examination (**Table 1**).

Public health implications

These cuts removed all preventive, restorative and emergency treatments from the Scheme and privatised dental care for over two million people who had up to then received state subsidisation for dentistry. Attendance levels among patients decreased immediately and are continuing to decline further. Dentists are seeing more patients delay treatments, ultimately resulting in more complex and costly treatment becoming necessary.

Financial implications for patients

Currently, over two million PRSI contributors and their dependant spouses remain eligible for the free dental examination. In 2012, €9 million was spent on the DTBS. This represents €5 spent by the State for every taxpayer who is entitled to treatment, a poor return for the increasing number of health contributions workers make.

The Scheme is funded by the Social Insurance Fund, which taxpayers contribute to throughout their working lives. It is grossly unfair that workers who spent their entire working lives contributing to the Social Insurance Fund are now denied the benefit.

Without State support patients are now faced with the full cost of private dental treatment, while paying an increasing rate of PRSI and new health levies. The removal of the benefit acts as a disincentive for patients who may simply not be in a position to afford private dentistry and are therefore unable to maintain their oral health.

Due to the inequalities in healthcare, these cuts are most harsh on the least well-off members of the working population. An ESRI study in 2004 found that there was a markedly lower likelihood of attendance at dental clinics by lower income groups. The changes to the DTBS will inevitably widen this divide in terms of dental health between the less well-off and those who can afford to be treated privately.

Financial implications for dentists

This sudden decrease in the scope of the Scheme had an immediate negative impact on the income of dentists. In response to the withdrawal of income, dentists reduced their working hours and reduced staff numbers. We estimate there have been approximately 1,500 job losses in the dental sector since April 2010.

Value for money

For many years there has been a widening gap between the cost of providing dental care and the fees paid under the State schemes. This means the fees paid to dentists participating in the Scheme offer excellent value for money for the State. However, for some dentists this growing gap is reaching the point where the fees for the State schemes are not viable. For example, the current fee for the oral examination paid under the DTBS is €33 (this fee includes any necessary x-rays). Research conducted by the National Consumer Agency in April 2010 shows that the average private fee for an oral examination is €44 (exclusive of any x-ray fees).

Cost–benefit analysis

Independent cost–benefit analysis conducted by Dr Brenda Gannon of the National University of Ireland, Galway, shows that the DTBS (up to 2010) provided the State with a return of 2.85 times the cost (**Table 2**).

Dr Gannon estimated the total societal benefit of the scheme at €194.45 million (**Table 3**).

[2] Under age 21 and age 21-24: 39 paid PRSI contributions since first starting work. Age 25-65: 260 paid PRSI contributions since first starting work.

Specific recommendations

- As part of a gradual restoration of key preventive treatments, we are suggesting that the six-monthly scale and polish is restored together with other preventive treatments such as gum treatments and a limited amount of fillings, as resources allow.
- The IDA believes that if the Government was to take a number of timely and cost-effective measures – including the introduction of a voucher system for the annual oral examination – it could arrest the shocking decline in the dental health of the nation.
- We suggest the introduction of a voucher system for the annual oral examination. Everyone covered by the DTBS (PRSI) scheme would have an entitlement to a voucher and would physically receive one. We think it would be seen as a service they have paid for in the case of PRSI employees. If people had an actual voucher they might be more inclined to avail of the service and this could save them painful and costly treatment down the line, as well as leading to higher detection rates for oral cancer at an early stage.

  It would also be easier to administer from the State's point of view and again more cost-effective. This system has worked well in Sweden, Australia, Canada and several US states. We need urgent action. The voucher system would be a good starting point and that's what we need right now.
- We also suggest that consideration should be given to the introduction of co-payment charges for certain treatment items as a way of limiting State expenditure while promoting attendance for key preventive treatments.

Table 1: Dental Treatment Benefit Scheme (PRSI Scheme).

Treatment available prior to 2010	**Treatment available 2010 onwards**
Annual oral examination	Annual oral examination
Biannual scale and polish	(No longer available)
Extended gum cleaning	(No longer available)
Fillings	(No longer available)
Extractions	(No longer available)
Root canal treatment	(No longer available)
X-rays	(No longer available)
Dentures	(No longer available)
Denture repairs	(No longer available)
Miscellaneous items	(No longer available)

Table 2: Cost.

	€m
Total cost to Exchequer (2008)	68.4

Table 3: Monetary benefits.

Benefits	**€m**
Improved general health from good dental health	14.35
Tax foregone	53.6
Social welfare payments	3.9
Private replacement costs	111.8
Medical card utilisation	9.6
Oral cancer treatment costs	1.2
Total benefits	**194.45**

Recommendation 2

RECOMMENDATION 2

Reinstate preventive and restorative care under the Dental Treatment Services Scheme for medical card holders and introduce a new voucher system for all eligible patients.

Currently, 1.4 million people are entitled to dental treatment under the Dental Treatment Services Scheme (DTSS).

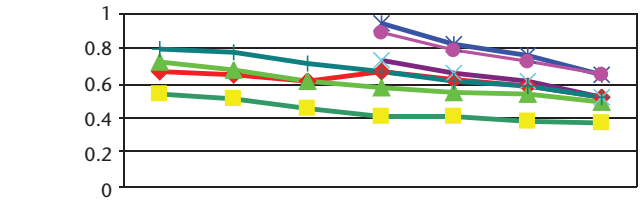
According to Section 67 of the Health Act, 1970, the HSE is obliged to provide dental treatment and dental appliances to persons with full and limited liability under their medical card. Since 1994 the HSE has fulfilled this obligation through the operation of the DTSS. The Scheme is managed by the HSE. Private dentists are contracted to provide the treatment in their own practice and are paid on a fee per item basis, i.e., not on a capitation basis.

According to a study conducted by the Oral Health Services Research Centre (OHSRC) in UCC, the DTSS was introduced in 1994 in order to address an anomaly highlighted by the results of the National Survey of Adult Health (1989/90): "*there was evidence of a lower level of oral health among some sections of the community such as medical cardholders… Consequently, optimal strategies should be identified to specifically target such groups.*"[3]

Proven improvements in oral health

Up to 2010, the treatment available under the Scheme consisted of routine dental treatment, which allowed medical card holders to maintain and improve their oral health. An examination of the Scheme in 2003 by the OHSRC revealed significant improvements in oral health since the introduction of the Scheme in 1994. The study showed a steady downward trend in the number of extractions for all age groups (**Figure 1**). The OHSRC's analysis also revealed:

- a downward trend from the year 2000 in the number of restorations (fillings) per patient;
- a downward trend from the year 2000 in the number of dentures per patient;
- a declining DMFT (Decayed, Missing, Filled Teeth) rate in all age groups with a steady decline in the 65+;
- a declining DT (Decayed Teeth) rate in all age groups, suggesting the level of untreated decay is falling; and,
- an increase in tooth retention in all age groups, particularly those aged 65+.



	1997	1998	1999	2000	2001	2002	2003
All	0.67	0.65	0.61	0.67	0.62	0.58	0.52
16-24	0.54	0.51	0.45	0.41	0.41	0.38	0.37
25-34	0.72	0.68	0.61	0.57	0.55	0.54	0.49
35-44				0.73	0.66	0.61	0.52
45-54				0.94	0.82	0.76	0.65
55-64				0.89	0.79	0.72	0.65
65+	0.8	0.78	0.71	0.67	0.61	0.58	0.52

FIGURE 1: Steady decrease in the mean number of extractions.

Budget 2010

In the Budget for 2010, the budget for the Scheme was capped at the level of expenditure in 2008 (€63 million) despite the surge in medical card holders. This was achieved by restricting treatment, as shown by **Table 4**.

It is particularly reprehensible to report that over three years since the HSE unilaterally introduced these radical cuts, the HSE has still not organised a public information campaign to advise eligible medical card holders of their entitlements when visiting their dentist. Neither has the HSE made any arrangement to organise care and treatment where it refuses to authorise general practitioners to provide badly needed dental care. Finally, it is shameful and unacceptable that the Department of Health has not arranged to undertake any assessment of the impact of these savage cuts on the oral health of medical card holders affected.

Table 4: DTSS (Medical Card Scheme).

Treatment available prior to 2010	Treatment available 2010 onwards
Annual oral examination	Annual oral examination
Biannual scale and polish	(Suspended)
Extended gum cleaning	(Suspended)
X-rays	(Suspended)
Fillings	(Two per annum in an 'emergency situation')
Root canal treatment	(In 'emergency circumstances' only)
Dentures	(In 'emergency circumstances' only)
Denture repairs	(In 'emergency circumstances' only)
Miscellaneous items	(In 'emergency circumstances' only)
Extractions	(Unlimited number provided!)

[3] O'Mullane and Whelton, 1992.

Recommendation 2

The decision by the HSE to restrict access to dental care in April 2010 fundamentally altered the scheme from a demand-led scheme to a budget-led scheme. Given the increase in the number of medical card holders, we estimate that at least €80 million is required to adequately fund the DTSS in 2014, even on the basis of the existing limited range of entitlements being offered.

The rationale behind a scheme that places a limit on fillings (i.e., saving a tooth) while allowing an unlimited number of extractions is extremely worrying. On a purely financial basis, the State may ultimately have to pay not only for the extraction but for the cost of a denture in the future. For the patient it means a lifetime of embarrassment, decreased nutrition and loss of wellbeing.

Rate of decrease in dental treatment for medical card holders

New analysis undertaken by the Irish Dental Association of the number of treatments provided in 2012 compared to 2010 shows:

- a stark decrease in the number of preventive and restorative treatments while (**Table 5**); and,
- emergency treatments such as surgical extractions are increasing (**Table 6**).

Increase in demand – decrease in expenditure

While expenditure on the Scheme has been capped, the number of eligible medical card holders has increased by nearly 30% (**Tables 7 and 8**).

Public health implications

Medical card patients have lower oral health levels, a greater need for treatment and a lower access rate to care and treatment. It is therefore extremely concerning that preventive and restorative treatment has been removed from the Scheme. The withholding of these types of treatments goes against everything a dental student is taught at dental school. It is also disconcerting that the Government has failed to actually inform medical card holders of the changes and has failed to give any warnings with regard to the implications for their oral health. The Irish Dental Association deals with queries on a daily basis from patients who are trying to figure out what they are entitled to. Patients and even treating dentists are unsure of what is provided and the availability of treatment is extremely subjective, e.g., a patient in Kerry may receive dentures, while his/her counterpart in Donegal may have to endure life without teeth and not knowing where to turn for help. A lot of the savings achieved by the HSE heretofore appear to be simply due to the confusion surrounding the scheme.

Survey results re effect on patients

The latest Irish Dental Association survey (November 2012) shows the impact of these cutbacks on patients.[4] The survey found that:

- 77% of dentists reported an increase of patients presenting in **pain**;
- 92% of dentists reported an increase in patients presenting with **gum disease**;
- 88.8% of dentists reported an increase in patients presenting as **emergencies**;

[4] Survey carried out November 2012. Response rate: 33% of general dentists. Total number of respondents: 312.

Table 5: Decrease in preventive and restorative treatment.

Treatment type	Number of treatments year to July 2010	Number of treatments year to June 2013	Rate of decline
X-rays	22,966	11	99.95%
Scaling and polishing	153,797	3,161	97.94%
Protracted periodontal treatment	36,023	4,497	87.52%
Fillings	411,000	234,006	43.06%

Table 6: Increase in emergency treatment.

Treatment type	Number of treatments year to July 2010	Number of treatments year to June 2013	Rate of increase
Surgical extractions	24,096	31,240	29.65%

Table 7: Increase in demand.

Year	No. of eligible persons	% Difference
2009	1,112,738	
2012	1,416,837	27% increase

Table 8: Decrease in expenditure.

Year	Total expenditure	% Difference
2009	€87,000,000	
2012	€63,000,000	27.59% decrease

Recommendation 2

- 88% of dentists reported an increase in patients presenting with **dental infections**; and,
- 84.6% of dentists reported an increase in patients presenting with **multiple decayed teeth**.

This is evidence of the infliction of unnecessary pain and suffering on the public at large. It is outrageous and unacceptable that preventable pain is being inflicted on patients. Clearly these cuts are resulting in the deterioration of oral health for the Irish nation. Can Ireland afford this?

Survey results re operation of the Scheme

The results of the survey further revealed that:

- 56.4% of dentists reported that the HSE does **not** provide an emergency dental service in their area;
- 98% believe that the DTSS does **not** provide adequate preventive treatment for patients;
- 89.4% do **not** have confidence in the HSE operating the DTSS; and,
- 87.7% of dentists do **not** believe the DTSS to be an effective scheme.

Survey of public entitlements to dental care

Behaviour and Attitudes, an independent research company, carried out a separate survey in November 2012 on the general public in relation to public entitlements to dental care. The results of the survey reveal that:

- **29%** of medical card holders (population estimate: 472,000) **postponed dental treatment** in the previous year due to the restrictions to dental benefits;
- **26%** of medical card holders (population estimate: 123,000) or a member of their family have **missed time from work** due to a dental problem; and,
- **38%** of medical card holders (population estimate: 604,000) said they would **visit their dentist less frequently** from now on **due to the restrictions** (this compared to 14% in 2010).

Financial implications for dentists

The income for dentists participating in the Scheme has been drastically affected. Dentists with a high reliance on the Scheme have reported a 90% decrease in income.

In response to the decrease in income:

- 64% of dentists decreased the number of staff in the practice; and,
- 74% of dentists reduced the working hours of staff.

We estimate there have been 1,500 job losses in the dental sector since April 2010.

Cost–benefit analysis

These cuts do not make economic sense. The current 'patch and forget' service provides no long-term benefit. Every case of delayed treatment will eventually require more complex treatment at a greater cost.

The true price of an extraction is not just the €39.50 fee the HSE pays the dentist to take out a tooth. Patients who undergo multiple extractions lose supporting bone and tissue, causing them to appear older beyond their years and confining them to a lifetime of denture-wearing, possibly at a greater cost than the treatment required to save the teeth in the first instance.

The Ombudsman's perspective

In 2011, the Ombudsman investigated a refusal by the HSE to provide dental treatment to a medical card holder and surmised that it is *"a sad reflection on a system where a person with decaying teeth, who has no resources to fund private treatment, has to put up with decaying teeth until his annual entitlements recommence*".

Specific recommendations

- As part of a gradual restoration of key preventive treatments, we are suggesting that the entitlement to a biannual scale and polish is restored along with other gum treatments and an increase in the annual number of fillings, as resources allow.
- As mentioned earlier, the IDA believes that if the Government was to take a number of timely and cost-effective measures – including the introduction of a voucher system for the annual oral examination – it could arrest the shocking decline in the dental health of the nation.
- We suggest the introduction of a voucher system for the annual oral examination. Everyone covered by the DTSS (medical card) scheme would have an entitlement to a voucher and would physically receive one. If people had an actual voucher they might be more inclined to avail of the service and this could save them painful and costly treatment down the line, as well as leading to higher detection rates for oral cancer at an early stage.

  It would also be easier to administer from the State's point of view and again more cost effective. This system has worked well in Sweden, Australia, Canada and several US states. We need urgent action. The voucher system would be a good starting point and that's what we need right now
- We would also suggest that consideration should be given to the introduction of co-payment charges for certain treatment items as a way of limiting State expenditure while promoting attendance for key preventive treatments.

RECOMMENDATION 3

Reinstate sufficient number of staff in all HSE areas to ensure patients of the HSE's Public Dental Service and Orthodontic Service have access to equitable services irrespective of geographical location.

Services for children

Dental services for children are provided by the HSE's Public Dental Service. The service is expected to target children at three stages in their development (in 2nd, 4th and 6th class) when children should be screened and provided with any follow-up treatment required. In addition, emergency dental treatment should be available to all children up to 16 years.

The demand for this service currently far outweighs the resources in terms of the workforce available to provide the services.

Staffing statistics of dentists working in the HSE

Since March 2009, the number of dentists working in the Public Dental Service has reduced by nearly 20% (from March 2009 to November 2012, the number of whole time equivalents (WTE) reduced by 67.4 from 360.1 to 292.7; see **Table 9**).

This reduction in head count, coupled with an increase in the target population, has led to huge pressure on the service, evidenced in the results below.

Evidence of pressure on the Public Dental Service

There is no consistency in the level of dental care children receive from the HSE. Continuing restrictions in recruitment in the HSE, such as the moratorium on recruitment, have led to clinic closures and suspension of screening services for school-aged children. As a result, the provision of care has been likened to a postcode lottery where the level of care a child receives depends solely on where they live.

Staff shortages are such that in some areas care is limited to treating emergency presentations, with little or no capacity to provide routine care and prevention. The focus in many areas has shifted from prevention to pain management. These limitations result in a 'stop gap' approach and make it difficult to address dental disease before it gets out of hand.

This service also plays a key role in the assessment and referral of children for orthodontic treatment. Care for schoolchildren is stretched further by the reliance on this overstretched and understaffed service to assist in pre-, during and post-orthodontic treatment.

Statistics on the full effect of these cuts are not available as the most recent national survey of children's oral health[5] is long out of date as it is now 11 years old.

The following information has been revealed by way of answers to parliamentary questions in the Dáil:

Clinic closures

Clinics have closed in the following areas:

- Athy and Kilcullen, Co. Kildare;
- Caherciveen, Listowel, Kenmare and Dingle, Co. Kerry; and,
- Carnew, Co. Wicklow.

This places an extra barrier to care for children in those areas who are now required to travel extra distances for any appointments they might receive.

Restrictions on school screenings

- Currently in Laois/Offaly, Galway, Kerry and part of Cork (North Lee) **the priority is emergency care, special needs and screening of children aged from 11 to 13 years.**
- According to the HSE Area Manager in the Midlands Area "80% of 6th class children in primary schools in County Laois have had their first dental check for the academic year 2011-2012. **It is estimated that all 6th class children in Laois will have their <u>first</u> dental check complete by the end of August 2012.**"
- According to the HSE Operations Manger in Cork, the waiting times for treatment in Youghal are such that **6th class children are called in secondary school**.
- According to the HSE General Manager in Co. Offaly:
  - all children up to 16 years will receive emergency dental care;
  - eligible special needs and medically compromised patients will be given priority for dental examination, preventative and primary care treatment;

Table 9: Number of dentists employed in the HSE Public Dental Service.

	Actual WTE Mar 2009	Actual WTE Dec 2011	Actual WTE Nov 2012	Change Mar 2009 to Nov 2012	% Change Mar 2009 to Nov 2012	Change Dec 2011 to Nov 2012	% Change Dec 2011 to Nov 2012
Totals	360.1	312.3	292.7	-67.4	-18.72%	-19.6	-6.28%

[5] North South Survey of Children's Oral Health in Ireland 2002. Department of Health and Children.

Recommendation 3

- **children in 6th class will receive a dental examination; and,**
- **children in 1st class will receive a dental examination when examination of 6th class children have been completed.**

Services for patients with special needs

The HSE Public Dental Service is also charged with the dental care of patients with special needs.

The reduction in the number of dentists working in this service has been devastating. We are all aware of the harsh economic times we are in but the non-replacement of front line clinical dental staff in the HSE is leading to pain, distress, medical complications and the unnecessary loss of teeth for many of our children and vulnerable adult patients.

Access to general anaesthesia (GA) by patients with special needs is extremely important as it allows them to undergo dental treatment that cannot be carried out in the usual dental practice setting. Currently in some areas of the country these patients are facing a wait of up to three years for treatment under GA as the public dental service sees further limits being placed on their theatre time.

Orthodontic Service

Similarly, the Orthodontic Service in the HSE is suffering as a result of the cutbacks and the moratorium on recruitment, which have led to the creation of long waiting lists for screening and for treatment. In some areas such as Dublin Mid-Leinster, the waiting list is as long as three years! In some HSE areas there is no clinical manager (Consultant Orthodontist) in charge of the service, which is particularly concerning. Waiting lists for both screening and treatment continue to be a major concern for the public (**Table 10**).

Table 10: Orthodontic treatment waiting list 2012

Area	Grade 5 (formerly Category A)	Waiting time (months)	Grade 4 (formerly Category B)	Waiting time (months)
South Western	505	n/a	693	n/a
Mid-Leinster	441	n/a	456	36
Midland	175	16	980	n/a
Northern/North Eastern	1,375	5	1,519	n/a
South Eastern	n/a	n/a	n/a	n/a
Southern	381	n/a	1,496	18
Western	n/a	n/a	n/a	n/a
Mid Western	1,252*	24*		
North Western	332	12	219	21

RECOMMENDATION 4

Engage with the IDA on the reconfiguration of the HSE's Public Dental Service and Orthodontic Service to ensure any changes fully reflect the best interests of the patient. We also make specific reference to the crisis in orthodontics and propose a five-point plan to address these difficulties.

HSE Public Dental Service

The HSE is currently in the process of reconfiguring the Public Dental Service. The Irish Dental Association would urge the Government to ensure that any changes are in the best interests of the patients who rely on this service.

In particular, we are concerned that this reconfiguration is taking place in circumstances where the oral health of children was not addressed in the most recent Oral Health Policy dating from 1994, which is now obsolete.

HSE Orthodontic Service

Five-point plan to tackle the crisis in orthodontics

The scale of the crisis in orthodontics demands new ideas and a fresh approach to dealing with an escalating problem in times of economic stringency.

We have referred earlier to the merit in providing dental vouchers to eligible DTSS and DTBS patients. In view of the massive waiting lists for orthodontic treatment, we feel that there would be merit in offering vouchers for orthodontic treatment where patients are on waiting lists of six months or more and, with appropriate assessment, are deemed suitable and ready for treatment. This could then be provided either through the HSE or privately, subject to appropriate criteria and evaluation, as deemed necessary from a clinical care and governance perspective.

We repeat the point that this approach would also be easier to administer from the State's point of view and more cost effective. This system has worked well in Sweden, Australia, Canada and several US states. We need urgent action. The voucher system would be a good starting point and that's what we need right now.

Secondly, we believe there is a case for restoring marginal rate tax relief for orthodontic and other selected specialist dental treatments in order to afford greater numbers access to such treatments.

Thirdly, we believe that the anomaly whereby those without an income are unable to claim tax relief for orthodontic treatment should be investigated and consideration given to a voucher system. This would be of considerable benefit in addressing public waiting lists given the profile of patients awaiting assessment/treatment.

Fourthly, we believe the dental schools should be assisted in developing training places for orthodontic therapists to complement the work of orthodontists in accordance with recognised scope of practice.

Finally, we believe funding for training of orthodontists in the Cork and Dublin dental schools also needs enhancement to meet the requirements of the Dental Council and relevant EU directives available to treat orthodontic patients.

Recommendations 5 and 6

RECOMMENDATION 5

Introduce a National Oral Health Policy which provides equitable access to a range of treatments required to achieve and maintain optimal oral health for all citizens.

The National Oral Health Policy has not been updated since 1994, despite the huge changes in the Government dental schemes. Any oral health policy the Department of Health is operating under is obsolete and should be reviewed. The Irish Dental Association is willing to take part in a consultation programme with the Department of Health to review the National Oral Health Policy.

RECOMMENDATION 6

Explore with the Irish Dental Association the potential participation of dentists in health promotion and chronic disease management.

The mouth is a gateway to the body and can be used as an early warning system for health practitioners. Oral diseases impact on general health and systemic diseases show symptoms in the oral structures. Oral diseases share common risk factors with chronic diseases, such as diabetes and heart disease.

As oral health is an integral part of general health and well-being, it must be integrated in general prevention and health promotion at national and EU level. Tackling oral diseases separately from general diseases is neither medically effective nor cost-efficient. Prevention and early treatment will substantially reduce the overall costs of oral diseases for the State and the patient.

The Platform for Better Oral Health in Europe recently issued the following key policy recommendations:

- recognise the common risk factors for oral disease and other chronic diseases; and,
- develop the role of oral health professionals in generic health promotion to address risk factors such as cigarette smoking, poor diet, high alcohol consumption, and sedentary lifestyles.

According to the Central Statistics Office, 43% of adults visit a dentist once a year. The highest incidence of visits occur in the age groups 34 to 44 (48% attendance rate) and 45 to 54 (47% attendance rate).[6]

Dentists are well placed in the community to fulfill this role of chronic disease management. They have regular contact with patients and are usually the first to see the effects of tobacco in the mouth. Dentists are therefore in an ideal position to reinforce the anti-tobacco message, as well as being able to motivate and support smokers willing to quit.

Dentists can also play a valuable role in health promotion campaigns with respect to the following conditions: osteoporosis, diabetes and renal disease. Dentists are also in a position to detect symptoms of many other general health conditions, drug use and a variety of disorders when examining patients.

Mouth Cancer Awareness Day is a voluntary initiative where dentists provide advice free of charge in an effort to raise awareness of mouth cancer. It is striking that 13 cases of mouth cancer were discovered in Mouth Cancer Awareness Day 2011 (the results for 2012 are currently being collected).

The Irish Dental Association's recommendation is that dentists can play an important role in chronic disease management and we urge the Government to explore this potential.

[6] Central Statistics Office, Quarterly National Household Survey, 2010 Health Module

Recommendations 7, 8 and 9

RECOMMENDATION 7

Divert a percentage of any taxes raised through consumption taxes on tobacco or high sugar/fat products towards an oral healthcare programme.

Due to the clear association between the consumption of tobacco products and the development of numerous oral health diseases, an allocation of the existing tax revenue could be allocated to fund dental services.

The introduction of a 'sugar' or 'fat' tax is currently being considered by the Department of Health. The Association is not persuaded of the merits of such a tax. However, in the event that such a tax is introduced, we would ask that a percentage is diverted towards an oral health programme.

RECOMMENDATION 8

Appoint a full-time Chief Dental Officer to the Department of Health.

The post of Chief Dental Officer in the Department of Health was, up to recently, vacant for almost a decade. In June 2013, the Department of Health announced that the HSE's Oral Health Lead was to be seconded to the post of Chief Dental Officer in the Department of Health for two days per week. While the Irish Dental Association welcomes this measure, we believe the post should be a full-time post, similar to all other clinical groups.

We ask the Government to fulfill its pre-election commitment of appointing a Chief Dental Officer. The Irish Dental Association is willing to take part in a consultation programme with the Department of Health to review the role of the Chief Dental Officer.

RECOMMENDATION 9

Reinstate the HSE Vocational Training Scheme in Dentistry.

In 2010, the HSE paused the Vocational Training Scheme in Dentistry. As a result there is no vocational training scheme for Irish graduates. The Scheme offered graduates an opportunity to practise under the guidance of experienced dentists in the HSE and in private practice. The Scheme also provided the HSE with a cost-effective way of treating patients.

The Irish Dental Association calls on the Government to reinstate the Vocational Training Scheme.

Recommendation 10

RECOMMENDATION 10

Introduce financial incentives to dentists similar to those provided to other healthcare professionals and address the cost of doing business in Ireland.

The majority of dentists in Ireland are self-employed practising in their own self-funded practices. The Government should consider introducing incentives to dentists similar to those provided to other healthcare professionals. We also believe that the Government should address the cost of doing business in Ireland.

Dentists are one of the only health professionals that do not receive any financial support from the State. Dentists rely solely on their own self-generated funds to set up in practice and adhere to increasing regulatory costs.

Whereas the State spends €3.6 billion annually building, staffing and equipping hospital medicine within the HSE, no such assistance is provided for dental care in the community. Likewise, before a penny is spent on caring for medical card patients, GMS doctors in general practice can receive up to €100,000 per annum in grants towards employing nurses, secretaries, practice managers, and where they are located in remote rural locations, while pension payments are also available to doctors.

Massive State support is provided to dentists in Northern Ireland in the form of grants and pensions, which leaves dentists in this State, particularly those close to the border, at a significant disadvantage. To reiterate, dentists in the Republic of Ireland do not receive a single cent toward the running of their practices (**Figure 2**).

As dentists rely entirely on generating attendance and income to cover costs (and most of these costs are fixed or State controlled), it is no surprise in these difficult times that, with falling attendances dental practices are closing and we estimate that there have been 1,500 redundancies in the sector in the past couple of years. Again this won't be noticed in the same way as the closure of a high profile multinational, but the effects are just as real. Equally, entire classes of dental graduates are forced to emigrate for the lack of viable opportunities (and not because of any professional control on numbers, which simply does not exist). Yet evidence also shows that dentists are continuing to reduce or freeze their fees in a highly open and competitive market.

Cost of doing business

A recent survey (May 2013) of Irish dentists undertaken by the Irish Dental Association reveals that in the previous two years, the income of a majority of dentists decreased with the majority suffering a decrease of between 20 and 40% (**Figure 3**). As the majority of costs in dental practices are fixed (often imposed by statutory bodies) dentists are

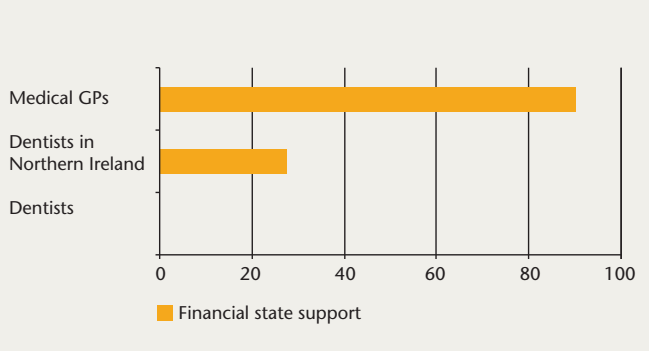


FIGURE 2: Absence of State support for dental care.

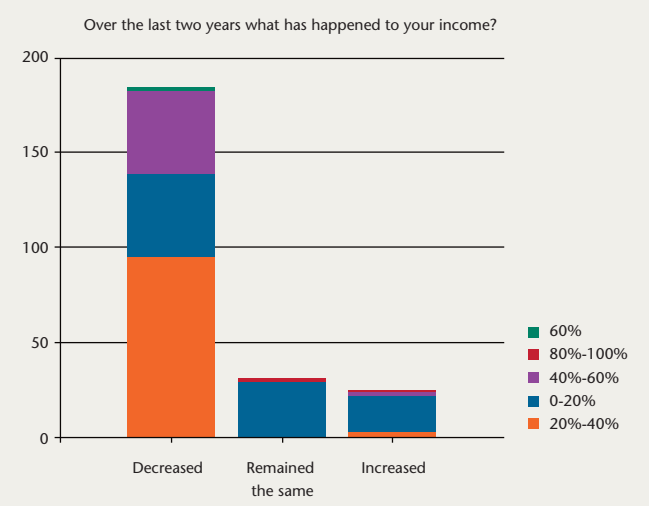


FIGURE 3: Changes to dentists' income since 2011.

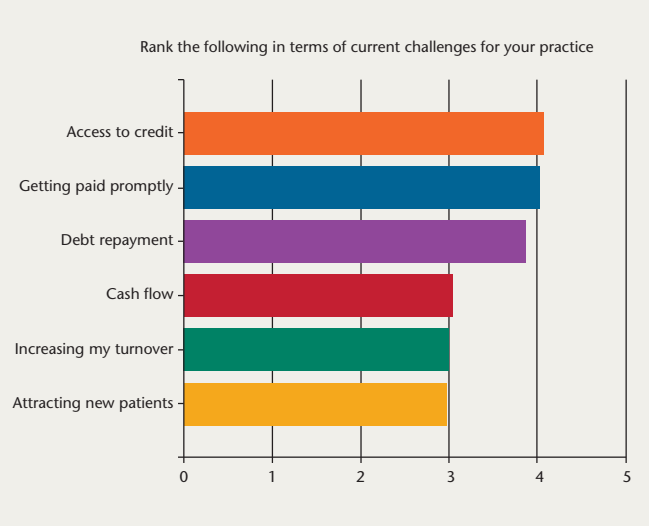


FIGURE 4: The main challenges for dental practices in Ireland.

unable to adjust their cost base to reflect the reducing turnover.
The survey also asked the current top challenges for dental practices (**Figure 4**).

Regulatory costs

The Irish Dental Association is, of course, supportive of proper regulation; however, the increasing cost of regulatory fees is having a severe negative effect on dental practices.

The following is a list of regulatory costs that a dental practice must discharge:

- Dental Council registration fees;
- professional indemnity subscription;
- Radiological Protection Society of Ireland licence fees;
- radiological protection advisor fees;
- waste management fees;
- data protection registration fees; and,
- commercial rates.

The Irish Dental Association has made a significant contribution to improving regulation in the dental sector. The Association collaborated with the Dental Council on introducing a fee display policy in dental practices. In 2012, the Association helped to establish the Dental Complaints Resolution Service, which deals with complaints relating to dentistry. The Association made this contribution in a genuine effort to improve the dental experience for patients.
We believe the Minister should pay particular attention to the negative effect the following costs have on small to medium-sized business in Ireland:

Commercial rates

In particular, the Government should examine the negative effect of exorbitant commercial rates on business.

Utility charges

The Government should tackle the high price of energy costs in Ireland.

Cost of employment

The Irish Dental Association is opposed to the Department of Social Protection's proposals to introduce mandatory sick pay, or increase employer's PRSI, and indeed to introduce mandatory provision for pensions. We believe such measures would act as severe inhibitor to employment in the dental sector.

CONCLUSION

Dentists witness the effect of the cuts to dental care on a daily basis and are extremely worried that the nation's oral health will revert to 1950s levels. Patient attendance levels have decreased substantially; medical card holders do not know what they are entitled to, and taxpayers are being denied the benefit of their PRSI contributions.
On an economic basis, the cuts to dental care do not make financial sense and will end up costing the State more in the long term.
We are calling on the Government to consider the recommendations we have set out in this submission.

References and appendices are available on request.

Irish Dental Association
Unit 2 Leopardstown Office Park
Sandyford
Dublin 18
Tel 01 295 0072
Fax 01 295 0092
Email: info@irishdentalassoc.ie

www.dentist.ie

Irish Dental Association

@irishdentists

ThinkMedia.ie