Budget 2017 Submission

KEY RECOMMENDATIONS FOR BUDGET 2017

The Irish Dental Association is the professional, educational, scientific and advocacy body for over 1,800 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.

For Budget 2017, we make the following recommendations:

IMPROVING ACCESS FOR ADULTS TO DENTAL CARE

Recommendation 1
Reform and expand the Med 2 Scheme.

Recommendation 2
Reinstate preventive and restorative care under the Dental Treatment Benefit Scheme for PRSI payers.

Recommendation 3
Set aside additional funding for the replacement of the Dental Treatment Services Scheme for medical card holders and enter negotiations with IDA on a new state dental scheme.

DENTAL SERVICES FOR CHILDREN AND PATIENTS WITH SPECIAL NEEDS

Recommendation 4
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.

Recommendation 5
Implement the key recommendations of the National Clinical Programme for Paediatrics and Neonatology model of care for paediatric healthcare services in Ireland.

Recommendation 6
Urgently tackle the crisis in Orthodontics.

PREVENTION AND HEALTH PROMOTION – TAPPING THE HUGE POTENTIAL DENTISTS OFFER

Recommendation 7

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

Recommendation 8

Divert a percentage of any taxes raised through a sugar tax towards an oral healthcare programme.

ADDRESSING THE BUSINESS COSTS OF DENTISTRY

Recommendation 9

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

IMPROVING ACCESS FOR ADULTS TO DENTAL CARE

Recommendation 1

Reform and expand the Med 2 Scheme.

Background

Traditionally, perhaps the most significant supports offered by the state have been tax reliefs available for prescribed dental treatments under what is known as the Med 2 scheme. These were seen as affording support to those who did not have access to medical card benefits and many of whom did not enjoy PRSI dental benefits.

It was also a recognition of the fact that whereas the state invests literally billions in acute and general hospitals and offers practice supports, grants and pension benefits worth over €100,000 per annum per doctor to many medical GP practices, no equivalent support is provided to dental practices. This is in spite of the fact that the costs of running dental practices are considerably greater than those associated with medical practices.

There is a clear and obvious link between state support towards providing health care services and enabling and facilitating access to care. The value of the Med 2 system of reliefs for dental health was inestimable in circumstances where the costs of providing care were not being offset in any other way by state supports.

Effective from January 2009, the state decided to restrict relief which could be claimed against the costs of dental treatment to the standard rate under the Med 2 scheme only, thereby halving the value of the support offered to patients.

The decision to restrict Med 2 relief to standard rate only in 2009 had a very real impact on the level of access to dental care in its own right. It immediately meant the withdrawal of reliefs towards the cost of dental treatment worth almost €30m per annum[1].

2010 and the Tsunami of Cuts in Dental Care Supports

However, this was soon overshadowed by the decision of the state to slash the benefits available under the PRSI dental benefit scheme and the large cuts made in the scope of cover available under the medical card scheme from 2010.

[1] At the time of the decision to restrict Med 2 relief to the standard rate effective from January 2009, the Revenue Commissioners estimated that the cost of reliefs for dental treatment amounted to €25.5m, equivalent to 19% of the total reliefs claimed (€134m) in the most recent year for which full figures were available (2005). Assuming the same proportion was accounted for by reliefs claimed for dental treatment, the savings achieved by restricting reliefs for a full year of €150m (ref: Department of Finance Estimates Summary Statement, October 15th 2009) would have comprised cuts in dental spend reliefs of almost €30m per annum.

We estimate that all of these combined have had the effect of reducing the level of state support towards accessing dental care in the private sector by well over €100m per annum (€28.5m cut in Med 2 reliefs, €60m p.a. cuts in PRSI benefits, €40m estimated cuts associated with restrictions in DTSS benefits and noting the 20% rise in eligible beneficiaries) since 2010 (well over €600m since 2010).

On top of this we have seen significant cuts in the funding of publicly provided dental care (i.e. in the staffing and funding levels obtaining within the HSE public dental service).

Time to Revisit the Med 2 Scheme

We are seeking that the Exchequer would revisit the operation of the Med 2 scheme in the 2017 Budget for the following reasons:

1. A start needs to be made in redressing the damage done by previous cuts in state support towards accessing dental care (cuts we contend which were unprecedented in magnitude and impact)
2. The Med 2 scheme provides real value to groups of the populace who have no or limited access to medical card or PRSI dental benefits
3. Expansion of the scheme will generate greater access and attendance, improve dental health and bolster economic activity and returns to the Exchequer ultimately
4. Expansion of the Med 2 scheme is merited having regard to the relative lack of support for access to dental care, as contrasted with supports provided to ensure access to hospital and primary medical care
5. The Med 2 scheme offers huge value in achieving real oral health gains without the administrative, payroll or oversight costs associated with either direct provision or procurement of dental care

Specific Proposals

The options for reform of the Med 2 Scheme include the following:

I. Expanding the definition of treatments to be covered by the Med 2 Scheme to include essential preventive treatments
II. Restoration of marginal rate relief to all treatments
III. Provision of marginal rate reliefs on certain treatments
IV. Provision of marginal rate reliefs up to a specified spending ceiling per annum
V. Provision of marginal rate reliefs subject to a ceiling within a multi-annual period per annum

Recommendation 2

Reinstate preventive and restorative care under the Dental Treatment Benefit Scheme for PRSI payers.

Recommendation 3

Set aside additional funding for the replacement of the Dental Treatment Services Scheme for medical card holders and enter negotiations with IDA on a new state dental scheme.

Medical Card Dental Scheme

Under 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 medical card patients have received dental care under the Dental Treatment Services Scheme (DTSS), which is managed by the HSE. Medical cards holders receive treatment free of charge. 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.

In 2010, the HSE imposed unilateral cuts to the scheme without informing or consulting with the Irish Dental Association, contractor dentists or patients. The cuts fundamentally altered the scheme from a demand-led scheme to a budget-led scheme. This was done by restricting treatment under the scheme to clinical emergency circumstances only and effectively abandoned all elective dental treatment.

Treatment available prior to 2010	Treatment Available 2010 Onwards
Biannual Scale and Polish	Suspended
Extended gum cleaning	Suspended
X-rays	Suspended
Fillings	2 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!**

PRSI Dental Scheme

The PRSI Dental Scheme was established in 1952 and is funded though the Social Insurance Fund. The Scheme is managed by the Department of Social Protection. 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.

Under the Scheme, taxpayers and retirees (with the sufficient number of PRSI contributions) were entitled to a range of preventive and restorative care and treatment items (please see

table below). In the Budget for 2009, this scheme was restricted to a one item scheme – the annual oral examination.

While the benefits available under the Scheme decreased, the rate of PRSI has actually increased. It is particularly unfair for workers, who have been contributing PRSI all of their working lives, to now find they are unable to available of dental treatment. Persons, who qualified for treatment under at the age of 65, remained qualified for life.

Currently, over 2 million PRSI contributors and their dependent spouses remain eligible for the free dental examination. The Dental Treatment Benefit Scheme was availed of by 312,659 people during 2015 at a cost of €10.3 million. In 2009, the last year the scheme operated unrestricted, the cost of the scheme was €62.3 million.

The table below shows the curtailment of treatment under the PRSI Dental 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

Public Health Implications of the Budget Cuts to Dental Schemes

According to the Irish Dental Council's *Code of Practice relating to Professional Behaviour and Ethical Conduct*, a dentist's primary duty is to ***ensure the safety and welfare of your patients no matter what their gender; marital status; family status; sexual orientation; religion; age; disability; race; or membership of the Traveller community.***

Medical card patients have lower oral health levels, a greater need for treatment and a lower access rate to the care and treatment. Therefore, it is extremely worrying that preventive and restorative treatment has been removed from the Scheme. The withholding of this type of treatment goes against everything a dental student is taught at dental school.

Research has shown that the costs of poor dental health are largely borne by the most disadvantaged in society. In some cases, this means people are living with painful and possibly unsightly dental issues that can cause or exacerbate other illness and reduce the capacity to obtain and retain employment. Poor dental health and the inability to afford

private healthcare undermine a person's ability to participate in the social and economic aspects of life.

Increase in patient numbers but decrease in treatments funded

There has been a very significant increase in eligible medical card patients in recent years. As at 31st December 2009, the number of patients for dental care stood at 1,478,560, representing 34.87% of the population. As at 31st December 2015, the number of patients eligible for dental care stood at 1,734,853, representing 37.43% of the population. So between December 2009 and December 2015**,** we have seen an increase in eligible patients of 256,293 (17.33%).

Yet while the number of eligible patients has increased by over 17% the amount of treatments funded by the HSE has fallen by 20%. Included amongst the findings below, we see that while the number of patients attending for examinations has increased by 34.6%, the amounts of scale and polish treatments has fallen by 97%, fillings have fallen by up over 33% while surgical extractions have increased by 53% and routine extractions have increased by over 14%.

The number of protracted periodontal treatments funded by the HSE has fallen by 80% while the numbers of dentures funded by the HSE has fallen by 15%.

DTSS Treatments Funded by the HSE 2009 - 2015

Treatment Code	Treatment Type	No. of Treatments 2009	No. of Treatments 2015	Difference	% Change
Above the Line					
A1	Oral Examination	312,190	420,275	**108,085**	**+34.6%**
A2	Prophylaxis	254,931	8,226	**-246,705**	**-96.8%**
A3A	Amalgam Restoration	386,092	260,376	**-125,716**	**-32.6%**
A3C	Composite Restoration	218,680	139,437	**-79,243**	**-36.2%**
A4	Exodontics	108,059	123,667	**15,608**	**+14.4%**
A5	Surgical Extraction	37,208	56,845	**19,637**	**+52.8%**
A6	Miscellaneous	70,275	133,225	**62,950**	**+89.6%**
A7	1st Stage Endodontic	8,496	7,779	**-717**	**-8.4%**
A8	Denture Repairs	21,677	36,512	**14,835**	**+68.4%**
ATL Totals		**1,417,608**	**1,186,342**	**-231,266**	**-16.3%**
Below the Line					
B1	Endodontics	6,853	6,452	**-401**	**-5.9%**
B2	Apicectomy/Amputation of Roots	132	92	**-40**	**-30.3%**
B3	Protracted Periodontal	57,547	11,387	**-46,160**	**-80.2%**
B4	Radiographs	38,629	10	**-38,619**	**-99.9%**
B5	Prosthetics	40,580	46,642	**6,062**	**-14.9%**
BTL Totals		**143,741**	**64,583**	**-79,158**	**-55.1%**
Overall Totals		**1,561,349**	**1,250,925**	**-310,424**	**-19.9%**

The rationale behind a scheme that places a limit on fillings (i.e. saving a tooth) while allowing an unlimited number of extractions are extremely worrying. On a pure financial basis, the state will 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.

Impact on Patients

A survey by the Irish Dental Association shows the impact of these cutbacks on patients[2]. 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 in gum disease;
- 88.8% of dentists reported an increase in patients presenting as emergencies;
- 88% of dentists reported an increase in patients presenting with dental infections;
- 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 pain that could be prevented is being inflicted on patients. Clearly these cuts are resulting in the deterioration of oral health for the Irish nation. Can Ireland afford this?

In a separate survey[3], IDA members were asked to comment on the impact of the cuts on patients. They said:

- *It is horrendously stressful trying to explain to patients routinely that you cannot provide the basic care that require.*
- *It is worrying no to be allowed to do the treatment needed, can do multiple extractions but only 2 fillings in the calendar year.*
- *A patient presented with a number of decayed teeth, all sore. I was not able to treat them all and had to choose two.*
- *Emergency patch-up jobs only for DTSS patients, no comprehensive care and this is very damaging to long term health.*
- *Increased extractions because only 2 fillings covered.*
- *Prioritising most decayed teeth over treating caries.*
- *More or less just doing extractions now.*
- *Conduct more extractions for patients.*
- *Treatment leaning more towards extractions and provision of dentures than conserving teeth.*

[2] Survey carried out November 2012. Response Rate 33% of general dentists. Total number of respondents 312.

[3] Survey carried out April 2016. Response Rate 20% of general dentists. Total number of respondents 240.

- *More likely to extract teeth / Extracting a lot more teeth.*
- *Inability to provide the correct treatment.*
- *Not doing scale and polish in mouths that clearly need it because patient can't afford it. Only filling the 2 worst teeth and neglecting other that require treatment because patient can't pay. Giving prescriptions for pain where a filling would fix the problem but quota has been reached for the year.*
- *I'm practising old-style dentistry, extractions, dentures, amalgam etc.*

Increase in hospital admissions for severe dental infections

Recent academic research[4] has found that there has been a notable rise in the number of people with severe dental infections requiring hospital admissions since the cuts were made to both the medical card and PRSI dental schemes in 2010. The research shows that there was a 38% increase in the number of patients admitted to hospital with severe infections in 2011 and 2012 following the introduction of those cuts.

According to the study, a worrying trend has emerged of increasing numbers of patients accessing the emergency department and ultimately requiring secondary and tertiary level care for the management of dental infections. It also found that most patients in the study required surgical intervention and noted a worrying increase in the number of patients being operated on for dental caries, a condition that should be dealt with long before it gets to the operating theatre.

Reflecting the more serious nature of the admissions in such cases, the authors pointed out that in 2011, 70% of patients were brought to theatre on the first day of admission compared with just 27% in 2008. It should also be noted that the average length of stay for patients admitted with dental infections as in-patients stands at 5.5 days.

Increase in use of antibiotics

In the six years since the implementation of cutbacks to preventative treatments under the State Dental Schemes there have been increasing waiting lists for oral surgery. This in turn has meant that medical card and other patients on waiting lists are being forced to use antibiotics for prolonged periods. These patients are being exposed to health risks caused by repeated use of antibiotics.

A recent survey[5] carried out by the IDA found that 86% of DTSS contract holders have prescribed medications on multiple occasions for DTSS patients on Oral Surgery waiting lists. In the main, the medications prescribed were antibiotics and analgesics. The average

[4] Bowe, Gargan, Kearns & Stassen (2015) 'Odontogenic infections and their management: A four year retrospective study.'

[5] Survey carried out April 2016. Response Rate 20% of general dentists. Total number of respondents 240.

number of repeat prescriptions issued for antibiotics was three per patient, with some dentists having to issue five antibiotic prescriptions to a single patient.

Cost-Benefit Analysis of Cuts to the State Dental Schemes

On a pure financial basis, the cuts to the schemes do not make sense. Dental disease does not get better or go away without treatment. Every cost of delayed treatment will cost the State more in the long-term. In the context of dental health **'prevention is cheaper than cure'.** Every case of delayed treatment will require more expensive treatment in future years.

Independent analysis has shown that that abolition of the PRSI Dental Scheme would result in a real cost to the State of twice the amount of its cost. We have no doubt that the same findings would result from an analysis of the cuts to the DTSS. Emergency dental treatment costs more; untreated dental difficulties lead to more complications that might require more specialized care or even hospitalisation.

Specific Proposals

I. Restore key preventive treatments under the DTBS scheme, including the six monthly scale and polish, other gum treatments and a limited amount of fillings.

II. We would also suggest the introduction of co-payment charges for certain treatment items as a way of limiting state expenditure while promoting attendance for key preventive treatments.

III. Urgently enter talks with the IDA on a new State dental scheme that is fit for purpose. It is essential that discussions commence sooner rather than later given the great harm that is being done to the oral health of the nation because of the maladministration and inadequate funding of the Schemes at present. We believe a new approach is required and that is why we have taken to identifying priorities and principles for a new State funded dental scheme as follows:

- The scheme would be modelled on the basis of the PRSI dental scheme as it operated until 2009 – i.e. a combination of full state cover for certain treatments / below agreed income thresholds and partial payment by the state towards certain treatments / above agreed income thresholds.
- The scheme should be patient focused with properly resourced infrastructure to deliver safe care with clear oral health objectives, timely and accessible care and priority given to preventive treatment.
- Patients would have access to participating dentists of their choice.
- Patients would continue to enjoy the same level of care as available to those treated privately.

- The range of treatments covered would be expressly stated and would only be modified through discussion with the IDU and with reasonable notice given to patients.
- There must be an agreed fee determination system and agreement between the parties that the scheme will be overseen and administered on the basis of partnership and without the unilateral changes we have seen in recent times.
- Ownership of the scheme would have to be agreed, noting that two separate Departments are responsible for the two state schemes at present.
- There would be significant savings for the state in the administration of the scheme which would allow the redeployment of clerical staff and the better use of senior dentists in the public dental service through reducing their administrative workloads.
- The public would be offered greater clarity as to their entitlements.
- The state would be able to more readily budget for and control expenditure.
- In time the scheme would allow the greater expansion of supports provided.
- An agreed system for resolving contractual disputes would be critically important.
- Quality assurance and agreed probity mechanisms are essential.
- Proper integration of all dental services i.e. those provided by general dental practitioners, hospital services, dentists in limited and specialist practice and those employed by the HSE is essential along with a properly integrated role for dentistry within primary care.

DENTAL SERVICES FOR CHILDREN AND PATIENTS WITH SPECIAL NEEDS

Recommendation 4

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.

HSE Staffing

The HSE has accepted that the current staffing levels in the public dental service of around 300 are well below levels of up to 387 which pertained in 2008. Increased dental employment levels and appropriately directed staff resource allocation are urgently required.

It is commonly accepted that there has been a significant deterioration in the level of service provided and particularly the extent to which preventative care and screening is taking place in schools, with the consequence that children are seeing their dentist for the first time at far too late a stage in their development. International guidelines suggest that children should have their first dental examination by their first birthday. For most children in Ireland, their first scheduled encounter with the public dental service is at age seven or eight and for many, they are seen by a dentist for the first time, under the school screening programme, in sixth class; age twelve. This absence of a preventative strategy in the critical early years means that for many children their first encounter with a dentist is in pain at an emergency visit.

Specific Proposal

A recruitment campaign needs to be commenced, at the direction of the Minister for Health, to achieve a complement of 400 whole time equivalent posts in the HSE public dental service by the end of 2018 in order to address the difficulties apparent in the service and to enable the service deliver on its stated objectives of preventing dental health difficulties, caring for and treating children and other vulnerable groups.

Recommendation 5

Implement the key recommendations of the National Clinical Programme for Paediatrics and Neonatology model of care for paediatric healthcare services in Ireland.

Background

The National Clinical Programme for Paediatrics and Neonatology has found that there is currently a significant unmet dental treatment need for severely medically compromised children, children with significant intellectual / developmental / behavioural / psychosocial disabilities, children with complex inherited and acquired dental conditions and children with complex dental trauma who require treatment in a paediatric hospital.

Waiting Lists for General Anaesthetic and Admission to Hospital for Dental Treatment

In a survey carried out in October 2015[6], difficulties in arranging access to secondary care emerged as the single greatest cause of stress to IDA members employed by the HSE. The shocking nature of many of the individual case histories highlighted at the 2015 IDA Public Dental Surgeons conference, including stories of delays in treatment for very young children in extreme pain and with severe infection, explained this anxiety amongst dentists trained to care for and to treat children.

Figures sourced by IDA, estimate that there were 2,500 children and special needs patients on waiting lists for dental procedures - mainly extractions under general anaesthetic – in October 2015. Most were waiting in excess of six months and many had been waiting for around 12 months. The closure of the out-patients GA Extraction Clinic at St James' Hospital in Dublin on 1st October 2014 has had a significant impact on this issue. Over 3,000 children were treated in this clinic annually. The problem is further compounded by the fact that dental cases are not included on hospital priority lists, and this results in theatre slots for dental cases being cancelled on a regular basis in favour of other paediatric cases.

While a limited number of theatre slots have been sourced in the private sector, there are hundreds of children awaiting "emergency" treatment. These children are suffering needless hardship, pain, enduring ongoing sepsis, requiring repeated courses of antibiotics and are at risk of serious, potentially life threatening complications. It is incomprehensible that a so called first world country allows its youngest and most vulnerable citizens to suffer in this way.

According to HIPE figures from the draft 'National Clinical Programme for Paediatrics and Neonatology model of care for paediatric healthcare services in Ireland', in 2012 there were 8,601 inpatient dental procedures carried out on children under 15 years of age. The number of procedures carried out on children is second only to ENT surgery. However, the report states that the dental figures do not count minor surgical procedures under local

[6] Survey carried out September 2015. Response Rate 50% of HSE dentists. Total number of respondents 82.

anaesthetic, many GA dental procedures that are not recorded on HIPE (such as the 3,000 plus children treated each year in the St James' Clinic prior to its closure) or about 1,000 children per year who are treated in the private sector. The draft report states: "Unfortunately, much dental activity under general anaesthesia (GA) is not recorded on HIPE, so the recorded figure likely represents a gross under-representation… The lack of accurate HIPE data leads to underfunding of services". On this point and in contradiction of the figures now published in the model of care for paediatric healthcare services in Ireland', it is of note that in 2015 the HSE strongly rebuffed IDA's assertion that up to 10,000 children under the age of 15 are being hospitalised for dental procedures every year.

Specific Proposals

1. Sufficient resources must be allocated to ensure implementation of the recommendations as they relate to paediatric dentistry contained in the National Clinical Programme for Paediatrics and Neonatology model of care for paediatric healthcare services in Ireland. These include:
    a. An increase from 2WTE to 6WTE consultant paediatric dentists at the new children's hospital.
    b. The appointment of consultant paediatric dentists at secondary care level in the regional paediatric units.
    c. Data concerning all children who are awaiting, and who have, dental treatment provided under GA in public hospitals must be recorded on the inpatient and day case waiting lists and on the HIPE system.
    d. Data concerning the number of children who are treated under GA in the private sector on referral (with funding) from the HSE dental services, and procedures undertaken, should be recorded to inform future development and planning of a national dental service for children.

Recommendation 6

Urgently tackle the crisis in Orthodontics.

HSE Orthodontic Service

The Orthodontic Service in the HSE is also hugely 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 hundreds of patients have been waiting for treatment for more than four years.

Orthodontic Waiting List Q4 2015

Waiting time from assessment to commencement of treatment	Less than 2 years	2 to 4 years	More than 4 years	TOTAL
HSE Dublin Mid-Leinster	3,174	1,577	447	5,198
HSE Dublin North East	1,707	1,327	466	3,500
HSE South	2,483	1,364	164	4,011
HSE West	2,193	901	27	3,121
Total	9,557	5,169	1,104	15,830

Specific Proposal

We believe there is a clear need to publish in the first instance the report commissioned by the HSE on Orthodontic Care and Treatment as an important first step in debating how best to tackle these persistent difficulties.

Recommendation 7

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

Background

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).[7] Dentists are therefore well-placed in the community to fulfil a role in chronic disease management.

Dentists 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, renal disease as well as the fact that dentists are often in a position to detect symptoms of many other general health conditions, drug use and a variety of disorders when examining patients.

Dentists Can Tackle Chronic Diseases

The mouth is a gateway to the body and is 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. Research has shown links between poor oral health and chronic diseases.

Cardiovascular disease, a leading killer of men and women, is a major public health issue. Research has shown that people with gum disease are almost twice as likely to suffer from coronary artery disease.

Periodontal disease (gum disease), a chronic inflammatory disease that destroys bone and gum tissues that support teeth is a major case of adult tooth loss.

Both periodontal disease and cardiovascular disease are inflammatory diseases, and inflammation is the common mechanism which connects them. Managing one disease may reduce the risk of the other.

Research has shown that periodontal disease may increase a woman's risk of delivering a baby prematurely. Premature babies are at greater risk or long-term health problems, and those who are born before their lungs have fully developed may not survive.

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

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.

Recommendation 8

Divert a percentage of any taxes raised through a sugar tax towards an oral healthcare programme.

Background

The Association is not persuaded of the merits of a 'sugar' tax. However, in the event that such a tax is introduced, we would ask that a percentage is diverted towards an oral health programme in order to help combat the one chronic disease that is definitively associated with dietary sugar intake, dental caries.

While any measures that help reduce the frequency and volume of sugar intake should be beneficial to oral health, research commissioned by the IDA has questioned the strength of evidence to demonstrate that a measurable drop in consumption will occur following the imposition of a tax on sugar or on sugar sweetened beverages[8]. The Association believes a more holistic and multi-sectorial approach is needed, which includes governments, restaurants, food producers and suppliers, retailers, the media, employers and educators. Initiatives need to address education, personal responsibility and environment and social norms. Educational initiatives need to be introduced through changes in school curriculum, education for parents and at a population level through public health campaigns. Personal responsibility needs to be taken through healthy cooking, personal weight management and increased activity. Changes to environment and social norms should be addressed through clear labelling, media restrictions, reformulation, pricing and promotions, subsidies and taxes, portion control and improved access to healthier alternatives.

[8] King, C. and Crowe, M. (2016) Sugar Tax, Obesity and Dental Health: A Review

Recommendation 9

Introduce financial incentives to dentists similar to those provided to other healthcare professionals. These should be provided to all dentists and not only to those who are based in primary care centres.

Absence of State Support for Dental Care

Dentists are one of the only health professionals which 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. We have set out in Appendix Two examples of the financial support available to medical doctors participating in the GMS and dentists in Northern Ireland.

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 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.