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Introduction

The Association is keenly aware of the deteriorating state of the public finances. However, we feel equally that the case for investment in oral health remains greater than ever. According to the World Health Organisation (WHO), oral health is integral to general health and essential for well-being.¹

This submission focuses on ways which encourage better oral health by actively encouraging ways of alleviating the cost for patients presenting to dentists and subsequently following courses of care as prescribed by their dentists.

In addition, we wish that assistance be provided in the development of dentists' surgical practices, equipment and education (continuing professional education) for the benefit of the entire population.

In both instances, and recognising the difficulties apparent with the public finances, we see that **the primary vehicle for such assistance will be through tax relief and allowances** rather than direct state investment above and beyond existing state supports (which should be at least enhanced to meet the costs of medical inflation in a manner which maintains existing levels of service).

This approach will also have the effect of stimulating expenditure with obvious revenue benefits for the Exchequer as well as contributing to optimal oral health for the population.

In addition, we make specific proposals for the enhancement of public dental services provided by the HSE, primarily for children under 16 years of age and patients with special needs.

¹ There is evidence to support the interrelationship between oral and general health; for example, severe periodontal disease may be associated with diabetes and heart disease. Dental caries and periodontal diseases have historically been considered the most important global oral health burdens. Both can be effectively prevented and controlled through a combination of community, professional and individual action. Many general disease conditions also have oral manifestations that increase the risk of oral disease, which, in turn, is a risk factor for a number of general health conditions.

Promoting better oral health for the population

The Irish Dental Association believes that dental treatment is part of basic health care and associated costs should be allowable for tax relief in all but the most exceptional of circumstances.

While we recognise that the import of such change would prove challenging and may not be possible in one single policy initiative, we suggest that the following changes require priority in the meantime.

1. VAT

We believe that value added tax (VAT) should be removed from essential oral health products such as toothbrushes, inter-dental brushes, oral mouthwashes and flosses.

2. MED 2 forms

The availability of tax relief for patients attending for dental treatment (as prescribed and detailed in the Revenue Commissioners' MED 2 form) is essential to maintaining and promoting better health for the population.

We believe that the relief available should not only be maintained but enhanced in order to better promote oral health while alleviating the costs incurred by patients.

We make the specific recommendations as regards the scope of the MED 2 form as follows:

Section A. Crowns

Core preparation for crown should be allowed under this heading. Also, the placing of temporary conditioning crowns should also be allowed as they allow for gum healing.

Section D. Gold posts

This provision should be changed to reflect the new materials now used in dentistry and a term such as 'post and core build-ups' would appear more appropriate.

Section E. Gold inlays

This should also include porcelain and acrylic (plus other emerging materials as appropriate) indirect inlays.

Section G. Periodontal treatment

Periodontal treatment is not always necessary in advance of receiving implants. For example, implants can be provided to replace teeth missing genetically, having been avulsed as a result of an accident, extracted, etc. It is the view of the dental profession that dental implants should be allowable for tax relief in all circumstances.

It has been indicated to the Association that tax relief for implant supported dentures may be allowable; however, there is no mention of this within the MED 2 form.

In relation to the chrome cobalt splint, the only difference between a chrome cobalt splint and a chrome cobalt prosthesis is that one has no teeth. The

chrome cobalt prosthesis should be allowed for tax relief.

Section H. Orthodontic treatment

The current definition should be expanded to include temporary orthodontic implants, and placement and removal thereof. These orthodontic implants are new devices which will be used more frequently by orthodontists in the future.

Section I. Surgical extraction of impacted wisdom teeth

The surgical extraction of any tooth should be allowed.

Many patients attending oral surgery or oral medicine specialists for mucosal disease have consultation and follow-up appointments with no active treatment other than prescription of drugs. Some of these patients will also have an oral biopsy.

Consultations, follow-ups or biopsy are not covered by the MED 2 form. In contrast, a patient with exactly the same condition seeing an ENT surgeon or a dermatologist would be able to claim a tax rebate. Any dental care offered in support of a medical condition should be allowable for tax relief.

Developing better practice facilities for the benefit of all patients

The Association makes a number of recommendations on how general dental practitioners' surgeries and practice equipment/facilities can be enhanced for the benefit of all patients. It is worth stating that the level of investment in dental practice facilities by the state can best be described as chronically under-funded, in absolute terms, relative to public investment levels internationally and relative to grants and allowances available to medical GPs in the Republic of Ireland and to dentists in Northern Ireland.

It will be recalled that investment in dental practice facilities derives solely from funds generated by dentists and with no state funding being made available. We understand that dentists are unique in this regard, i.e., no other profession is expected to develop and enhance practice facilities without any state funding or assistance.

Patient safety

1. The need to promote infection control practices is strongly endorsed by the Association. In support of dentists who wish to introduce **separate decontamination rooms and segregated areas**, we suggest that specific allowances or accelerated reliefs be introduced.

2. The need to separately safely store/dispose of waste materials from dental practices is recognised² as essential to promoting more environmentally sensitive practices. **Amalgam separators** are devices designed to remove amalgam waste particles from dental office wastewater. The placement and removal of dental amalgam restorations generates amalgam waste particles that can be suctioned into the dental unit vacuum line and discharged into the public sewer system. Some units can be retrofitted with amalgam separators and this cost ought to be covered by this proposal also.

The introduction of amalgam separation units, which can currently cost at least €4,000, is recognised as a positive step in enhancing patient safety also. We suggest that the introduction of a grant or accelerated tax allowances related to the installation or upgrading of such equipment would be worthy of consideration.

3. The installation of **digital radiography** equipment also warrants assistance through provision of a once-off grant or accelerated tax allowances. We suggest that dentists who have incurred expenditure in introducing such equipment at their expense in recent years should have some retrospective application of any such grant aid or allowances.

4. Existing tax relief of €300 available to dentists employed by the HSE towards meeting **necessary and essential expenditure** should be extended to all dentists.

5. Consideration might also be given to the introduction of tax relief for staff who attend accredited **patient safety training courses, manual handling, CPR, ACLS and other relevant courses such as infection control courses**.

² Article 1(a) of Directive 75/442/EEC dealing with waste and Article 1(4) of Directive 91/689/EEC dealing with hazardous waste.

Practice refurbishment

The Association wishes to emphasise that no targeted allowances or grants are available currently for the enhancement of dental surgeries, in stark contrast to recent initiatives introduced for the development of private hospital facilities.

We also draw your attention to the long established system of grants and allowances negotiated most appropriately for the benefit of medical general practitioners and their patients.

Similar assistance is made available to dentists in Northern Ireland.

1. The Association would contend that the gradual introduction of accelerated capital development allowances should be considered. Specifically, recognition should be made of its appropriateness for **refurbishment (modification and extensions)** work in dental practices noting the positive benefits accruing for patients and the lack of any targeted state funding in this area currently.

There would clearly also be benefit accruing to construction workers engaged in such work and ultimately to the Exchequer. We suggest that dentists who have incurred expenditure in refurbishing their premises at their expense in recent years should have some retrospective application of any such grant aid or allowances.

2. Funding for **premises access for the elderly, patients with special needs, or patients with restricted mobility** would also be desirable.

We would also draw attention to the costs associated with installation of wheelchair ramps, wide car-parking bays, disabled toilets, patient hoists, etc.

3. Supports towards the purchase of expensive **dental equipment** such as chairs, radiology equipment and other essential matters would also bring benefits for service users and the Exchequer.

We suggest that consideration be given towards the introduction of accelerated capital allowances over five years or on the basis of 50% of the relief applying upfront and the balance over a longer (five- to seven-year) period.

Promoting employment and alleviating costs

1. The Association would ask that consideration be given to introducing initiatives to meet the initial cost of employing nursing and administrative staff in dental practices and we suggest that the extension of 'Back to Work' type incentives for the employment of such staff initially is worthy of consideration.
2. The increasing costs of professional indemnity insurance for dentists (some of whom face annual indemnity bills of over €3,000 in the case of general practitioners to between €6,000 and €15,000 for practitioners engaged in maxillofacial dentistry) suggest that some form of allowance or contribution towards such costs be considered. It will be noted that no such relief currently extends to

dental practitioners in contrast to those available to medical practitioners.

3. The Department of Health and Children has stated that it wishes to see greater computerisation of dental practices and greater online communication between dental practices and state agencies such as the PCRS, and also with acute hospitals, teaching hospitals and emerging primary care teams' networks. Accordingly, we suggest that consideration be given to the introduction of IT grants/allowances (e.g., purchase of LANs, servers, PCs, scanners, etc., as well as grants to enable broadband roll-out) in order to promote greater connectivity between dental practices and state agencies.
4. Recognition of particular difficulties in attracting dentists to practice in remote rural settings and inner city locations warrants consideration of the introduction of targeted assistance for practitioners choosing to establish in such areas.
5. Funding relief is sought for appropriate records storage (archiving, retrieval of records).
6. Participation in clinical audit and the costs associated with participation in what will soon become mandatory requirements also carry costs for dentists which ought to be recognised and addressed.

Public Dental Service

A properly resourced Public Dental Service should continue to provide dental care to children, adolescents and patients with special needs. Eligible adults should have access to dental services through private practitioners.

A properly funded public dental service has the potential to provide excellent value for money in delivering dental care to children and a vulnerable adult population. It is essential, however, that the best staff can be recruited and retained and an attractive career structure provided.

Preschool children

The oral health of preschool children was not addressed in the Dental Action Plan in 1994, and integration with primary care services such as the child health service and disability services offers an opportunity to redress this deficiency. The failure to reach the oral health goals for five-year-olds (85% free of decay in fluoridated areas and 60% free of decay in non-fluoridated areas) highlights the need for early prevention. There is huge scope to involve primary health care workers such as public health nurses, dieticians, social workers and general practitioners in programmes to identify high caries risk children, long before dental services traditionally have access to these children, and to develop referral pathways from primary and secondary care institutions for high caries risk children into the dental service.

Schoolchildren

Although the oral health of children and adolescents has improved since the 1980s, there remains a considerable proportion of the population who experience high levels of disease. A great strength of the school dental service, which is delivered by the Public Dental Service, is that it is a population strategy aimed at improving children's oral health, which is well accepted by schools and parents, as evidenced by the high uptake of the service, where it is available. However, due to historical and current manpower issues, the service has not been able to develop to its full potential. This has led to inequitable service delivery across the country. Improved access for children to the school dental service, at a younger age and at recall intervals that are determined by the child's caries risk, would go a long way to standardising service delivery and improving oral health outcomes for children and adolescents

Services for children and adults with special needs³

Oral health should be part of every care plan for children and adults with special needs. Primary care services need to be expanded and secondary care services for these patients need to be developed across the country, to ensure equitable access to high-quality services.

The key issues that need to be addressed in the area of special needs dentistry are:

- training in the area of special needs dentistry;
- access to a wide range of care under dental general anaesthesia;
- manpower to deliver services;
- central planning;
- under-developed services for older adults who are nursed at home and/or in long-stay institutions;
- need for development of domiciliary services;
- focusing services on the needs and preferences of patients; and,
- acceptance of the speciality of special care dentistry.

³ Including geriatric adults in nursing homes and long-stay residential units.

HSE staffing

The provision of dental services by the 350 dentists employed by the HSE has been significantly and adversely affected by the restrictions on the employment of dental staff on a temporary basis as well as the filling of vacancies on a permanent basis.

1. **The Irish Dental Associations asks that an explicit commitment be given to prioritising the employment of front-line clinical staff such as dentists and for the filling of all vacancies to agreed staffing complements as an interim measure.**
2. **The Association also calls for the immediate appointment of a senior dentist within the Directorate of Clinical Care and Quality announced by the HSE in July 2008 in order that dental services can be managed and planned in a patient-focused and systematic manner.**
3. **The Association calls for publication of a full patient impact assessment of any changes proposed in the delivery of dental services by the HSE.**

Adult services

State-funded dental schemes

Based on current dental manpower, it would seem logical for a properly resourced public service to continue to supply treatment to children, adolescents, and patients with special needs, and for dentists in general practice to supply treatment to the general adult population of the country.

Approximately 70% of dental manpower is devoted to general practice and to the treatment of adults on a private basis, and under two state administered schemes – the DTBS and the DTSS.

The DTBS works well and efficiently. Dentists are paid appropriately and on time for all claims, and any claims that present with a query are followed up by Department officials with the dentist, thereby enduring a negligible reclaim list. The administration of the DTSS, in contrast, has major difficulties under a range of headings, including reclaim lists, validity of medical cards, validation requirements, administration of claims where 'clinical necessity' is involved, etc. This is apart from the fact that the scheme is seriously under-funded and, at the time of writing, on the verge of collapse in many areas.

As many as one in seven dentists, treating an estimated 30,000 patients, has resigned from participation in the DTSS over an 18-month period.

1. **Immediate steps need to be taken to enable a comprehensive review, involving the HSE and the Irish Dental Association, of the DTSS scheme.**
2. **Meaningful confidence-building measures need to be introduced to deal with the wholly unsatisfactory administration of claims/payments by the GMS Payments Board to participating dentists.**

Oral Health Promotion

Oral health promotion activities need to move beyond the dental education model and concentrate on tackling the main determinants of oral disease, which are largely socio-economic and cultural. There is a need to incorporate oral health into large-scale health promotion interventions promoting healthy consumption, as these are likely to have a positive impact on oral as well as general health.

The evaluation of oral health promotion interventions requires increased investment so that effective interventions can be identified and expanded and ineffective interventions can be stopped.

