IDA
irish dental association

Towards a Vision for Oral Health in Ireland

IRISH DENTAL ASSOCIATION
PROMOTING INDEPENDENT DENTAL PRACTICE

TASK FORCE REPORT
Autumn 2018

The mouth is the mirror of the body

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The overwhelming majority of dental care is delivered by independent dental practitioners without the State supports provided to medical doctors treating the same cohort of patients.

Introduction

The last official public policy statement on oral health in Ireland published by the Department of Health dates from 1994, almost a quarter of a century ago. The country has changed significantly in the meantime and there have been many advances in dental science and changes in the delivery of dental care and treatment, which makes the publication of a new oral health policy very important.

After some initial progress post 1994, a catastrophic blow was dealt to the delivery of oral health by decisions made in 2008 to decimate the Dental Treatment Benefit Scheme (DTBS) and to introduce a cap on expenditure under the Dental Treatment Services Scheme (DTSS), in addition to massive cuts in staff numbers of the salaried dental services, with inevitable consequences. Profound damage has been done to the oral health of the population, particularly to the most vulnerable groups in our society. All sectors of society have been affected by the economic crash, which severely limited the funds available for dental care. The overwhelming majority of this care is delivered by independent dental practitioners without the State supports provided to medical doctors treating the same cohort of patients.

More recently, the Sláintecare document has been published, to which the Association was invited to make a contribution. The document paid some, albeit limited and unimaginative, attention to dental care.

The role of the State in oral health, its promotion and prevention, and of the Health Service Executive (HSE) in commissioning limited dental care for medical card patients, has been a dismal and abject failure. Dental care and treatment delivered by the HSE has been stymied by chronic underinvestment. Care delivered at secondary and tertiary level has been provided in spite of, rather than because of, active State investment and support. Irish dentists have little faith in the willingness, interest or ability of the Department of Health or the HSE to tackle or reverse those failures.

Oral health

FDI, the World Dental Federation, defines oral health as multi-faceted and including the ability to speak, smile, smell, taste, touch, chew, swallow and convey a range of emotions through facial expressions with confidence and without pain, discomfort and disease of the craniofacial complex.

Oral diseases are among the most common diseases in the world, yet they receive little attention in many countries with weak healthcare systems. Despite a high social and economic burden from oral diseases they are considered a neglected area of international health.

What is oral health?

Oral health is more than dental health. It includes healthy gums, hard and soft palate, linings of the mouth and throat, tongue, lips, salivary glands, chewing muscles, and upper and lower jaws. Good oral health enables us to speak, smile, kiss, breathe, whistle, smell, taste, drink, eat, bite, chew, swallow and express feelings. The oral cavity plays a central role for intake of basic nutrition and protection against microbial infections.

The World Health Organisation (WHO) defines oral health as: "A state of being free from mouth and facial pain, oral and throat cancer, oral infection and sores, periodontal (gum) disease, tooth decay, tooth loss, and other diseases and disorders that limit an individual's capacity in biting, chewing, smiling, speaking, and psychosocial wellbeing".

Oral health has been shown to contribute positively to physical, mental and social well-being and enjoyment of life's possibilities, unhindered by pain, discomfort and embarrassment. Oral health is a human right, an integral part of general health and essential for overall well-being and quality of life.

What is the connection between oral health and general health?

Oral health and general health have close links. On the one hand, oral health can be compromised by a number of chronic and infectious diseases, which show symptoms in the mouth. On the other hand, oral diseases can lead to infection, inflammation, and other serious impacts on overall health. Thus, maintaining good oral health is crucial to sustaining general health and vice versa.

Essential elements of an oral health policy

With regard to the publication of a new oral health policy, we believe that the following represent essential traits and themes that need to be addressed:

- the policy must be developed on the basis of being evidence driven, patient centred and prevention focused;
- dental care needs to be provided in an equitable manner, offering access to services, providing patient choice, delivering high standards of education, suitably regulated, and with clear service delivery and care pathways supported by adequate funding; and,
- the Irish Dental Association's vision is for progressive, high-quality dental care services, driven by oral health outcomes, which will require comprehensive information collection and ongoing research. It envisages the integration of dental care services with other health services and that dental care services would be proactive in addressing the needs of those at greatest risk of poor oral health. These dental care services will be delivered by an appropriately trained, team-based workforce.

In contrast to the Department of Health and the HSE, whose only contributions have been to slash spending and delay long overdue legislative reforms and the publication of a new oral health policy, the Irish Dental Association and its members are proud of the role they have taken in promoting a number of significant initiatives, such as establishing the Dental Complaints Resolution Service, Mouth Cancer Awareness Day and the public display of professional fees. The Association has a long and distinguished track record of proposing solutions and acting with its own initiatives to advance patient care. Furthermore, the Association is committed as a matter of policy to promoting independent practice by its members and to reducing the reliance of private practitioners on third-party schemes.

It is most regrettable that, in common with many other stakeholders, the Irish Dental Association was not invited to participate in the formulation by the Department of Health of a new oral health policy, a decision our members find inexplicable, unwise and objectionable. We can only hope that the soon to be published oral health policy will contain a new approach to engaging with the profession. Nonetheless, the Association appointed a task force, representative of all branches of the profession, to set out some high-level statements of policy, offer solutions and express what it sees as the priorities for change that should feature in a new oral health policy.

The Task Force met on August 31, 2018, where it approached its work in a thematic manner, as will be shown in this document. This report represents a summary supported by the Task Force and which was brought to the Board of Directors and Council at their meetings on September 20.

Those in attendance on August 31 were as follows: Dr Kieran O'Connor (President); Prof. Leo Stassen (President-Elect); Dr Clodagh McAllister (Honorary Secretary); Dr Eamon Croke (Honorary Treasurer); Dr Siobhan Doherty (Membership Officer); Dr John Nolan (GP Group Chair); Dr Niall Murphy (President, HSE Dental Surgeons Group); Dr Christine Myers (President-Elect, HSE Dental Surgeons Group); Dr Martin Holohan (GP Negotiating Team); Mr Fintan Hourihan (Chief Executive); and, Ms Elaine Hughes (Assistant Chief Executive). Apologies were received from Dr Robin Foyle (Vice President).

Executive summary

"The mouth is the mirror of the body".

The following vision of the Irish Dental Association, and the provisions for an innovative oral health policy providing the Irish public with a flexible, evidence-based, prevention-driven, patient-centred service, is offered under the following headings.

Services

The provision of services is based on the values of choice and ease of access to all required services. Fairness must underpin the distribution of resources and the attainment of appropriate standards of care, safeguarding the health and safety of the recipients.

The main delivery of dental care will be by primary dental healthcare providers. Essential elements of a preventive approach for primary care for each of the following age groups are set out in this section:

- birth to five years;
- six to 16 years;
- 17-25 years;
- 26-66 years; and,
- 67 years and older.

Secondary and tertiary healthcare services should be provided with adequate resources to cater for:

a) dental rehabilitation, cleft lip and palate patients;
b) oral, head and neck, and facial cancer, particularly advanced cancers/recurrences;
c) orofacial reconstruction, with CT formatted models and implants (eyes/ears and jaws) of most of these cancers;
d) partial anodontia patients;
e) surgical TMJ patients; and,
f) complex periodontic, restorative, orthodontic and surgical patients.

Resources for delivery of services

Services must be seen as being efficient, effective and economic to ensure the correct provision of an oral health service for our patients. These services must be audited to ensure standards are maintained.

Different funding options that should be considered in discussions with the Association include:

- salaried services (public dental services);
- capitation;
- fee per item;
- blended model; and,
- (under caution) service-level agreements.

Tax relief and dental treatment

The Irish Dental Association proposes that there should be 40% tax relief on an agreed number of dental treatments.

Screening

Screening allows an understanding of the needs of the population. It is not a substitute for a dental examination by an appropriately trained dental healthcare professional. Screening is an ongoing exercise, which should be undertaken at regular intervals by appropriate healthcare professionals. The Association offers recommendations on how best to develop the screening programmes.

Fairness must underpin the distribution of resources and the attainment of appropriate standards of care, safeguarding the health and safety of the recipients.

Education and training

Aims

To promote and deliver contemporaneous education for all dentists and the dental team from their first steps in professional education and throughout their working life, to the highest possible standards based on available evidence. A central concept of dental education should be the development of multidisciplinary team work.

The Irish Dental Association recognises the cost of pursuing further education on top of personal and professional expenditure. To encourage an uptake of continuing professional development (CPD), the Association calls for ways to offset some of these costs, as are available in other jurisdictions, e.g., extending tax relief on costs.

Foundation training

The Irish Dental Association shares a view with the Dental Council, the dental schools and the RCSI as to the value of foundation training in supporting and furthering the skills and

experience of new graduates in a model which uses a combination of private, public and academic settings.

Mandatory verifiable continuing professional development

The Association recognises that the aims of CPD are best served by the ethos set out in the Dental Council's 'Your guide to the Dental Council's Continuing Professional Development requirements', 2015.

Regulation

The Irish Dental Association advocates for a new dental act without further procrastination, as the present Dentists Act, 1985 serves the public and profession poorly. The Irish Dental Association supports a new dental act as it relates to the general concerns of the Dental Council. This document sets out the regulatory concerns and goals of the Association.

Health promotion and prevention

Health promotion and prevention in dentistry should be consistent with the aims of *Healthy Ireland*. Oral health, at Government level, is regarded as the poor relation of general health and is generally overlooked as a gateway to promoting general health. The Irish Dental Association perceives this as a glaring deficit in health promotion and disease prevention. Dental caries and periodontal disease are ubiquitous diseases, painful and costly to the sufferer, costly to the exchequer but preventable. They often reflect lifestyle issues, and the exclusion of dentistry from *Healthy Ireland* is a serious shortcoming in the policy.

The Association offers recommendations on how best to develop health promotion and prevention for different age groups.

The continued reliance on an outmoded, underfunded oral health policy by the Department of Health is a troublesome disservice to the Irish public. The failure by the HSE to prioritise spending on preventive care is inexplicable. The Irish Dental Association cannot recommend or encourage dentists to sign contracts with the HSE to provide dental care to medical card patients. The damage to patients caused by cuts in spending and limitations on treatments provided has been compounded further by an attitude of secrecy and opaqueness as regards patient entitlements, in addition to hostility and contempt shown towards dentists in independent practice. However, the Irish Dental Association will continue to seek meaningful dialogue with interested parties to develop a functioning, 21st century oral health policy and the development of the appropriate strategy for its rapid implementation. Further procrastination is intolerable as it is a direct attack on the quality of life of patients.

As all dental healthcare professionals would recognise: "The mouth is the mirror of the body".

Services

The provision of services is based on the values of choice and ease of access to all required services. Fairness must underpin the distribution of resources and the attainment of appropriate standards of care, safeguarding the health and safety of the recipients.

Age group: birth to five years

The main delivery of dental care to this age group will be by primary dental healthcare providers. The indicated prevention programmes are seen as part of service provision requiring adequate funding.

Prevention

Essential elements should include the following:

- examination by a dentist by one year of age;
- recall based on individual risk assessment and needs of the patient;
- prevention programme:
  - counselling of parent(s) on brushing, diet, fluoride toothpaste, and recall period;
  - dietary counselling, including the risks of bottle caries and from medicines with sugar;
  - topical fluoride; and,
  - universal water fluoridation.

Having identified vulnerable sections within this age group, primary healthcare providers should:

- work with the HSE and other support services;
- deliver specific preventive and care programmes to address individual needs;
- enable healthcare screening and oral health provision by dental healthcare professionals in the National Children's Hospital; and,
- educate healthcare professionals in oral health screening.

Access must be provided to allow early treatment of diseases using evidence-based techniques, with a follow-up preventive programme based on risk assessment.
Primary and secondary healthcare services, including general anaesthetic facilities, must be funded to meet this cohort's treatment needs.

Access must be provided to allow early treatment of diseases using evidence-based techniques, with a follow-up preventive programme based on risk assessment.

Age group: six to 16 years

The main delivery of dental care to this age group will be by primary dental healthcare providers. The indicated prevention programmes are seen as part of service provision requiring adequate funding.

Prevention

Essential elements of a preventive approach should include the following:

- dental examination and recall based on individual risk assessment;
- provision of HPV vaccine to all children (boys and girls), to decrease the incidence of oropharyngeal cancer, at nine years of age; and,
- prevention programme:
  - oral hygiene;
  - fluoride (toothpaste/topical);
  - dietary counselling;
  - orthodontic assessment, including assessment of dental growth to prevent growth anomalies; and,
  - sports injury prevention.

Having identified vulnerable groups for this age group, primary healthcare providers should:

- work with the HSE and other support services;
- deliver specific preventive and care programmes to address individual needs;
- enable healthcare screening and oral health to be provided by dental healthcare professionals in the National Children's Hospital; and,
- educate healthcare professionals in oral health screening.

Access must be provided to allow early treatment of diseases using evidence-based techniques, with a follow-up preventive programme based on risk assessment.
Primary and secondary healthcare services, including general anaesthetic facilities and orthodontic treatment, must be funded to meet this cohort's treatment needs.

Age group: 17-25 years

The main delivery of dental care to this age group will be by primary dental healthcare providers. The indicated prevention programmes are seen as part of service provision requiring adequate funding.

Prevention

Essential elements of a preventive approach should include the following:

- dental examination and recall based on individual risk assessment; and,
- prevention programme:
  - oral hygiene;
  - fluoride (toothpaste/topical);
  - dietary counselling;
  - fissure sealants;
  - sports injury prevention;
  - tooth surface loss counselling;
  - awareness of health issues related to emotional, social and lifestyle changes; and,
  - lifestyle assessment including tobacco, alcohol and recreational drug use.

Having identified vulnerable sections within this age group, primary healthcare providers should:

- work with the HSE and other support services;
- develop specific preventive and care programmes to address individual needs; and,
- ensure continuity of care.

Access must be provided to allow early treatment of diseases using evidence-based techniques, with a follow-up preventive programme based on risk assessment.
Provision of primary and secondary healthcare services is required, including general anaesthetic facilities, and oral and maxillofacial services to meet this cohort's treatment needs.

Age group: 26-66 years

The main delivery of dental care to this age group will be by primary dental healthcare providers. The indicated prevention programmes are seen as part of service provision requiring adequate funding.

Prevention

Essential elements of a preventive approach should include the following:

- dental examination and recall based on individual risk assessment; and,
- prevention programme:
  - oral hygiene;
  - fluoride (toothpaste/topical);
  - dietary counselling;
  - sports injury prevention;
  - tooth surface loss counselling;
  - lifestyle assessment including tobacco, alcohol and recreational drug use; and,
  - mouth and other cancer awareness/education and assessment of mouth, neck and skin.

Maintenance ought to be provided with an emphasis on periodontal needs. Having identified vulnerable sections within this age group, primary healthcare providers should:

- work with the HSE and other support services;
- deliver specific preventive and care programmes to address individual needs; and,
- ensure continuity of care.

Access must be provided to allow early treatment of diseases using evidence-based techniques with a follow-up preventive programme based on risk assessment.

Provision of primary, secondary and tertiary healthcare services, including general anaesthetic facilities and oral and maxillofacial services, is required to meet this cohort's treatment needs. Mouth cancer care is more prevalent in this age cohort and there must be provision for direct referral by general dental practitioners to the appropriate service provider.

Age group: 67 years and older

The main delivery of dental care to this age group will be by primary dental healthcare providers. The indicated prevention programmes are seen as part of service provision requiring adequate funding.

Prevention

Essential elements of a preventive approach should include the following:

- dental examination, including prosthetic assessment and mouth cancer screening; and,
- prevention programme:
  - oral hygiene;
  - fluoride (toothpaste/topical);
  - dietary counselling;
  - tooth surface loss counselling; and,
  - lifestyle assessment including tobacco, alcohol and recreational drug use.

Maintenance will be required with an emphasis on periodontal and/or prosthetic needs. Having identified vulnerable sections within this age group, primary healthcare providers should:

- work with the HSE and other support services;
- deliver specific preventive and care programmes to address individual needs;
- ensure continuity of care as patients commonly present with complex medical histories and challenging dental issues; and,
- engage in collaboration with medical practitioners/consultants.

Access must be provided to allow early treatment of diseases using evidence-based techniques with a follow-up preventive programme based on risk assessment.

Provision of primary, secondary and tertiary healthcare services, including general anaesthetic facilities and oral and maxillofacial services, is required to meet this cohort's treatment needs. Mouth cancer care is more prevalent is this age cohort and there must be provision for direct referral by general dental practitioners to the appropriate service provider.

Secondary and tertiary healthcare services

- Secondary healthcare services: there should be collaboration between primary, secondary and tertiary healthcare providers. There should be a clearer understanding of the treatments that are currently provided, mainly by secondary healthcare providers but which could be provided by primary healthcare operatives. The dental hospitals and schools should select patients for educational or research purposes rather than be regarded as providers of primary healthcare services. Funding is required to develop treatment pathways for those found to be in vulnerable groups and needing secondary healthcare services including screening, radiology and rehabilitation. There are glaring inadequacies for many vulnerable groups, including mouth cancer sufferers. An example is the lack of resources for implant-retained oral/facial prostheses to enable these patients to have a rudimentary quality of life, such as the ability to eat basic foods.
- Tertiary healthcare services: specialist consultation healthcare multidisciplinary teams (MDTs) for both inpatients and outpatients. Referral is from primary, or more usually from secondary, care centres.
- Tertiary healthcare is provided in a facility (usually a hospital/dental school) that has the trained personnel and facilities for advanced investigation and treatments. It involves the management of complex medical/dental and surgical interventions.
- Secondary and tertiary healthcare services should be provided with adequate resources to cater for:
  a) dental rehabilitation, cleft lip and palate patients;
  b) oral, head and neck, and facial cancer, particularly advanced cancers/recurrences;
  c) orofacial reconstruction, with CT formatted models and implants (eyes/ears and jaws) of most of these cancers;
  d) partial anodontia patients;
  e) surgical TMJ patients; and,
  f) complex periodontic, restorative, orthodontic and surgical patients.

Resources for delivery of services

Services must be seen as being efficient, effective and economic to ensure the correct provision of an oral health service for our patients. These services must be audited to ensure standards are maintained.

Different funding options that should be considered in discussions with the Association include:

- salaried services (public dental services):
  - using expertise available in the care of children in public and private settings;
  - collaboration with private practice in the care of children;
  - the care of complex special needs from cradle to grave with access to specialist services as required; and,
  - care of institutionalised residents.

The HSE salaried service historically and currently serves the population well, albeit severely restricted by resource constraints. With required development, planning and investment, the reach of this service, which is already substantial, can be expanded to respond to the needs of the child population.

- Capitation:
  - an appropriately funded capitation scheme could be developed to include an audit of preventive/educational programmes. At present, third-party schemes do not allow adequate resources for prevention and patient/family oral health education.

- Fee per item:
  - fee per item funded by the patient or third-party scheme at levels which fairly compensate providers for the cost of providing such care; and,
  - grant-in-aid or co-payment scheme involving third-party payment.

- Blended model:
  - a mix of capitation and fee per item.

- Service-level agreements:
  - a tender system for care provision; and,
  - the Irish Dental Association believes that service-level agreements (SLAs) may discriminate against the smaller economies of dental provision and provide an unfair advantage to corporate bodies. SLAs may, by their definition, promote cost-cutting exercises which, ultimately, could challenge the provision of appropriate standards of care, by false economies. SLAs, in favouring the larger service providers, may limit patient choice, a foundation stone in the provision of primary healthcare services.

Tax relief and dental treatment

The Irish Dental Association proposes that there should be 40% tax relief on an agreed number of dental treatments. There is a list of allowable expenses on the Revenue Med 2 form, which requires revision to acknowledge items now allowed by Revenue, such as hard acrylic flat plane splints, and other services or prostheses provided in the rehabilitation of the edentulous and oral cancer sufferers. The Association believes that this tax relief should be available to all taxpayers as it is equitable and provided irrespective of income.

Screening

Screening allows an understanding of the needs of the population. It is not a substitute for a dental examination by an appropriately trained dental healthcare professional. Screening is an ongoing exercise, which should be undertaken at regular intervals by appropriate healthcare professionals.

Screening programmes should assess the contribution of oral health to physical, social and emotional well-being, and assess dental health knowledge.

Features of screening programmes:

- screening within an oral health policy should be age and group focused and part of the National Screening Service;
- screening should result in the detection of health and disease, providing for individual and group risk assessment (low, medium, high):
  - caries – decayed : missing : filled teeth (DMFT);
  - periodontal status;
  - dental anomalies, including orthodontic assessment;
  - tooth surface loss;
  - suspicious lesions, including mouth cancer, skin lesions, and lumps/masses of the head and neck;
  - general systemic diseases:
    - cardiovascular;
    - diabetes; and,
    - other including osteoporosis/osteopaenia.
  - general health issues:
    - smoking;
    - alcohol;
    - addictions; and,
    - diet assessment including obesity.
  - general mental health issues:
    - anxiety;
    - anorexia nervosa;
    - bulimia;
- screening programmes should assess the contribution of oral health to physical, social and emotional well-being, and assess dental health knowledge;
- screening has a primary role in planning and implementing recommendations and initiatives to prevent oral diseases and manage oral health; and,
- screening has a primary role in planning and implementing oral health promotion and general health modification.

Education and training

AIMS: To promote and deliver contemporaneous education for all dentists and the dental team from their first steps in professional education and throughout their working life, to the highest possible standards based on available evidence. A central concept of dental education should be the development of multidisciplinary team work.

Liaison between teachers, the Dental Health Foundation and other interest groups should be encouraged to promote dentistry as a career.

The Irish Dental Association recognises the cost of pursuing further education on top of personal and professional expenditure. To encourage an uptake of continuing professional development (CPD) the Association calls for ways to offset some of these costs, as is available in other jurisdictions, e.g., extending tax relief on costs.

Undergraduate education is underfunded at present and the Association wishes to see educational opportunities relate to personal abilities rather than the ability to pay.

Foundation training

The Irish Dental Association shares a view with the Dental Council, the dental schools and the RCSI as to the value of foundation training in supporting and furthering the skills and experience of new graduates in a model that uses a combination of private, public and academic settings.

Mandatory verifiable continuing professional development

The Irish Dental Association, as the largest representative organisation for dentists, has offered and promoted CPD courses for many years in advance of mandatory CPD. The Association recognises that the aims of CPD are best served by the ethos set out in the Dental Council's 'Your guide to the Dental Council's Continuing Professional Development requirements', 2015.

Dental healthcare professionals should undertake CPD, at the core of which is patient safety, coupled with developing skills relevant to their own practice of dentistry. Setting standards around verifiable-only CPD programmes would permit convergence on the tenets of CPD, simplify regulation and allow better planning for the delivery and choice of CPD programmes.

Regulation of dental education

The Irish Dental Association advocates for a new dental act, enabling the Dental Council to continue its oversight on the standards of the education of the dental team from undergraduate to postgraduate, specialisation and CPD. Foundation training should be integrated into the education of newly qualified graduates prior to full registration on the Register of Dentists.

The Association would encourage the Dental Council to expand its accreditation programme, ensuring the standards of education for graduates in the accredited countries and providing Irish graduates with work opportunities.

The regulation of CPD, setting standards for requirements and delivery, should lie with the Dental Council.

The IDA advocates for a new dental act, enabling the Dental Council to continue its oversight on the standards of the education of the dental team from undergraduate to postgraduate, specialisation and CPD.

Regulation

The Irish Dental Association advocates for a new dental act without further procrastination, as the present Dentists Act, 1985 serves the public and profession poorly.

The Irish Dental Association supports a new dental act as it relates to the general concerns of the Dental Council but advocates for the following.

- Mandatory CPD:
  - continued support for personal and professional development; and,
  - team-based approaches to CPD.
- Training:
  - foundation;
  - specialist; and,
  - consultant.

- Specialisation: the Irish Dental Association continues to support an expansion of the number of recognised specialties from the present two registerable specialties, while recognising that general practitioners are fully trained in all aspects of dental care. Clear identification of practitioner skill levels provides for clarity and greater certainty in choice for the public. This demarcation of skill levels is not a deterrent to dental healthcare professionals undertaking CPD to fulfil their personal development and the provision of services to the public.
- In the event that mandatory licensing and inspection of dental practices is to be introduced, we believe there needs to be one body charged with this responsibility and that the most appropriate body to undertake this task is the Dental Council. There must be absolute clarity on the responsibilities and relationships of all key stakeholders in licensing and inspection, including but not exclusive to the Health Information and Quality Authority (HIQA), Environmental Protection Agency (EPA) and the HSE.
- Definition of the roles and responsibilities of all dental healthcare professionals as established by the Dental Council.
- Mandatory registration of all established dental healthcare professionals.
- Direct access to dental healthcare professionals engaged in dental practices cannot proceed without ensuring the dentist remains responsible exclusively for developing and prescribing treatment plans for patients.
- Transparency of the law as it relates to incorporation regarding the business of dentistry.
- Identification of a responsible registered dentist in each premises where dentistry is practised. This person or persons must recognise their regulatory obligations.
- Identification of a responsible registered dentist within a corporate body. This person or persons must recognise their regulatory obligations.
- Where the Dental Council is provided with broader powers to investigate potential patient safety issues without a formal patient-led complaint, fair process and appropriate notice provisions need to be enshrined in any new investigative regime.
- The power to control the practice of dentistry by non-registrants and the appropriate powers to investigate potential patient safety issues.
- Clear, unambiguous, enforceable advertising standards:
  - provision for appropriate fitness to practise enforcement; and,
  - responsibility of all dental healthcare professionals to maintain professional standards of advertising as relates to their workplace.

Regulation of dentistry requires joined-up thinking by the Government as, in the absence of a comprehensive and balanced new dental act, the present trend towards ad hoc regulation will inevitably lead to increased practice costs, which will have to be passed on to the patients.

There must be absolute clarity on the responsibilities and relationships of all key stakeholders in licensing and inspection, including but not exclusive to HIQA, the EPA and the HSE.

Health promotion and prevention

Health promotion and prevention in dentistry should be consistent with the aims of *Healthy Ireland*. Oral health, at Government level, is regarded as the poor relation of general health and is generally overlooked as a gateway to promoting general health. The Irish Dental Association perceives this as a glaring deficit in health promotion and disease prevention.

Dental caries and periodontal disease are ubiquitous diseases, painful and costly to the sufferer, costly to the exchequer but preventable. They often reflect lifestyle issues and the exclusion of dentistry from *Healthy Ireland* is a serious shortcoming in the policy. As all dental healthcare professionals would recognise: "The mouth is the mirror of the body".

Oral health promotion is inextricably linked to general health promotion. Alcohol, diet and smoking all have the mouth as their portal to the body. In addition, there is increasing evidence that links oral health with risk factors elsewhere in the body, in particular, the heart and insulin tolerance.

It is essential that adopted preventive programmes are based on sound evidence and that programmes undergo audits to assess their planning and delivery based on outcomes. Disease often follows socioeconomic strata and dental disease is no different. It is important that all members of the public accessing dental services are treated equally but there is great value in targeting groups who may be vulnerable to dental diseases. An oral health policy should identify these groups and they should be prioritised in rolling out preventive programmes

While the dental team is best placed to deliver oral health promotion and disease prevention, the Irish Dental Association sees a role for the broader community in promoting the oral health message. Oral health education should be extended to other healthcare professionals, including pharmacists, and especially the public at large. Teachers should have oral health training as a requirement of their degree. This should extend to all those involved in the education and care of children, e.g., public, psychiatric and hospital nurses, and should also include those working with the disabled and the elderly.

Prevention should be the foundation for lifelong oral health and should be a lifelong service. Nobody is too young or too old not to benefit from focused prevention, with teeth or without teeth.

Population approach – what should preventive programmes include?:

- oral health awareness reflecting the target group, including oral hygiene;
- fluoridation (systemic/topical);
- nutrition assessment and advice;
- lifestyle assessment and advice;
- mouth cancer awareness – early warning signs; and,
- relationship of diabetes and other general health diseases to oral health.

For targeted groups within the population, health promotion and disease prevention programmes should include the following.

- Antenatal:
  - education/support from the dental team/community-based delivery for pregnant mothers.

- Postnatal (birth to five years; preschool):
  - screening by public health nurses (only if the public health nurse has been appropriately trained and has a clear referral role to a dentist as required);
  - clinical examination by a dentist;
  - parental support;
  - early education, so that parents have a more active role in their child's oral health;
  - important at age one to have an oral examination assessing the child's dental needs and tailoring a preventive programme to meet those needs; intervention may be required even at this early age – a dentist should advise the parents on the appropriate individualised recall interval; and,
  - fluoride (systemic/topical) appropriate to local conditions and risk assessment.

- Six to 16 age group:
  - oral and general health promotion, including lifestyle choices;
  - clinical exam by dentists or appropriately trained dental health professionals to include disease risk assessment;
  - appropriate individualised recall intervals discussed with the patient, parent and/or guardian;
  - fissure seals, fluoride and X-rays as required;
  - lifestyle assessment including dietary assessment and advice, and oral hygiene instruction;
  - prevention of sports-related dental injuries; and,
  - access to orthodontic services and oral surgery services as required.

- 17-25 age group:
  - oral and general health promotion, including lifestyle choices;
  - access to clinical exam; and,
  - risk assessment and appropriate recall.

- 26-66 age group:
  - oral and general health promotion, including lifestyle choices;
  - access to clinical exam; and,
  - risk assessment and appropriate recall.

- Over 66 age group:
  - oral and general health promotion, including lifestyle choices;
  - access to clinical exam;
  - risk assessment and appropriate recall; and,
  - this group has all the needs of the other age groups but may have greater difficulty accessing services. The group is more dentate than previously, with more complex dentistry present that needs more maintenance. Therefore, there is a need for enhanced preventive regimes.

Evaluation of preventive programmes

Auditing is an essential evaluation tool of preventive programmes, allowing assessment of outcomes and future development of programmes. Auditing can provide transparency in the delivery of oral health services when those services are linked to oral health outcomes. The Department of Health will have a number of options to consider in evaluating all preventive programmes and all will require proper resourcing.

Evaluation	Data collection	Data analysis	Data interpretation
Quality of life (WHO)	Survey	Association	Short-term outcome
Other	Observation	Causation	Medium-term outcome
	Interview	Confounding	Long-term outcome
	Focus groups		

It is essential that adopted preventive programmes are based on sound evidence and that programmes undergo audits to assess their planning and delivery based on outcomes.

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