

**Budget 2018 Submission**

**KEY RECOMMENDATIONS FOR BUDGET 2018**

The Irish Dental Association is the professional, educational, scientific and advocacy body for over 1,800 dentists in Ireland. Our missionis 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 2018, 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**

Engage with IDA to develop a new state dental scheme for medical card holders.

**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**

Tackle the Orthodontic waiting lists.

**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]](#footnote-1).

**Time to Revisit the Med 2 Scheme**

We are seeking that the Exchequer would revisit the operation of the Med 2 scheme in the 2018 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:

1. Expanding the definition of treatments to be covered by the Med 2 Scheme to include essential preventive treatments
2. Restoration of marginal rate relief to all treatments
3. Provision of marginal rate reliefs on certain treatments
4. Provision of marginal rate reliefs up to a specified spending ceiling per annum
5. 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.

**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.

Previously, 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.

IDA has welcomed the restoration of the annual scale and polish and protracted gum treatment to the Scheme from October of this year. We are now calling for further preventive and restorative treatments to be provided for under the Scheme.

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

|  |  |
| --- | --- |
| **Treatment available prior to 2010** | **Treatment Currently Available**  |
| Annual oral examination  | Annual oral examination  |
| Annual Scale and polish  | Available from October 2017 |
| Extended gum cleaning  | Available from October 2017 |
| 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 |

**Specific Proposals**

1. Restore further key preventive treatments under the DTBS scheme.
2. 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.

**Recommendation 3**

Engage with IDA to develop a new state dental scheme for medical card holders.

**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** |

**Public Health Implications of the Budget Cuts to the DTSS Scheme**

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, thenumber of patients for dental care stood at 1,478,560, representing 34.87% of the population. As at 31st December 2015, thenumber 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 anincrease 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%.

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.

A recent survey[[2]](#footnote-2) by the Irish Dental Association, asked IDA members to comment on the impact of the cuts on medical card 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.*
* *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.*

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

**Increase in hospital admissions for severe dental infections**

Recent academic research[[3]](#footnote-3) 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.

**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**

It is commonly accepted that there has been a significant deterioration in the level of service provided through the public dental service 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 is reflected not only in the number of patients attending emergency services but also in the number of children awaiting extremely costly treatment under general anaesthesia, a good proportion of which could have been avoided had adequate preventive care been in place

While the under 16 population has increased by 20% over the past decade to 1.1m, the number of dentists in the Public Dental Service charged with looking after their oral health has dropped by 20% due to recruitment restrictions. Staff shortages, clinic closures and a lack of policy and direction by the HSE are putting an intolerable burden on the Public Dental Service and are undermining its ability to provide an effective service.

Figures for six community care areas - for which exact numbers are available - show that almost 16,000 primary school children missed their school screening last year. A partial screening service at best is on offer in most other counties. In addition, dental clinics are being closed down – two were closed in Clondalkin in West Dublin – which is leading to ever lengthening waiting lists.

The failings of the school screening system due to understaffing means oral health issues are not being identified at an early stage and children are suffering as a result. A stark example of this is in Laois, where in 2015, dentists in the public service carried out 1,200 extractions and 1,800 fillings on children and special needs patients. In Offaly it was 915 extractions and 1,100 fillings. We believe this is a direct result of the collapse of the school screenings in these areas as children in these counties are not being seen until they are in first year in secondary school.

Recent figures on staff numbers provided by the National Oral Health Office show that currently the HSE employs around 266 dentists, well below the staffing levels of up to 387 which pertained in 2008. Given the increase in the population of under 16’s in the past number of years coupled with the demands of the special needs services it is clear that the service is grossly understaffed. Increased dental employment levels and appropriately directed staff resource allocation are urgently required.

**Specific Proposal**

Based on the current population, 450 whole time equivalent dental posts are needed in the HSE public dental service 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 as well as caring for and treating children and other vulnerable groups. IDA is calling on the Minister for Health to direct the HSE to urgently commence a recruitment campaign to reach this staffing level.

**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[[4]](#footnote-4), 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 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:
	1. An increase from 2WTE to 6WTE consultant paediatric dentists at the new children’s hospital.
	2. The appointment of consultant paediatric dentists at secondary care level in the regional paediatric units.
	3. 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.
	4. 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**

Tackle the Orthodontic waiting lists.

**HSE Orthodontic Service**

The Orthodontic Service in the HSE is 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).[[5]](#footnote-5) 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.

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 the sugar tax towards an oral healthcare programme.

**Background**

The Association asserts that a percentage of the income raised from the sugar tax should be 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.

Dental decay is the most common chronic disease young children experience in Ireland today. This is due in the main to very high levels of sugar consumption, including soft drinks. The direct link between sugar intake and dental decay has been clearly established so it makes sense that a significant proportion of the monies raised through a sugar tax should be used for oral health promotion

Furthermore, the Association believes a holistic and multi-sectorial approach to tackling the frequency and volume of sugar intake 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.

**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.

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. [↑](#footnote-ref-1)
2. Survey carried out April 2016. Response Rate 20% of general dentists. Total number of respondents 240. [↑](#footnote-ref-2)
3. Bowe, Gargan, Kearns & Stassen (2015) ‘Odontogenic infections and their management: A four year retrospective study.’ [↑](#footnote-ref-3)
4. Survey carried out September 2015. Response Rate 50% of HSE dentists. Total number of respondents 82. [↑](#footnote-ref-4)
5. Central Statistics Office, Quarterly National Household Survey, 2010 Health Module [↑](#footnote-ref-5)