Submission by the Irish Dental Association

To the Oireachtas Committee on the Future of Healthcare

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Executive Summary

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.

Oral health forms an integral part of general health and wellbeing. Oral diseases also share common risk factors with chronic diseases such as heart disease, obesity and diabetes. In our experience, oral health is not prioritised in terms of promotion, funding or service delivery. We are now calling for the integration of oral health into the wider healthcare delivery system, whilst also respecting the independence of the profession. The approach to prevention and treatment of oral and 'general' healthcare should therefore be closely connected and should be achieved through individual, professional and community-level approaches.

IDA priorities for the future of the Health Service are as follows:

1. A **new national oral health strategy** must be developed and properly resourced, with a focus on prevention that ensures oral health care is better integrated and given priority in any overall health care strategy. A full-time Chief Dental Officer should be appointed on a permanent basis to lead the development and implementation of a new oral health strategy.
2. The role and expertise of dentists at community / primary care level in the **management and prevention** of chronic disease must be developed.
3. Any state dental schemes must be properly funded and operated. They must be fit for purpose and have a focus on prevention.
4. There needs to be **elimination of the barriers between primary and secondary** oral and dental health care.
5. **A national model of publicly delivered dental care for children and patients with special care needs** is needed and must be adequately resourced and staffed.
6. We recommend 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.
7. There must be a concerted plan to tackle the crisis in **Orthodontics**.
8. We need to see publication and enactment of a new **Dental Act**.

Introduction and Background

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.

There are approximately 2,000 active dentists in Ireland with a further 2,500 technicians, hygienists and dental surgery assistants employed in the delivery of dental care (O'Neill, 2010). As such, dentistry represents a small but significant sector of the Irish economy.

Oral health forms an integral part of general health and wellbeing. Diseases of the mouth and oral cavity have a significant impact in terms of pain, suffering, impairment of function and reduced quality of life. Oral diseases also share common risk factors with chronic diseases such as heart disease, obesity and diabetes. To a large extent, oral diseases are entirely preventable. Yet when they occur, they can be among the most expensive to treat. The approach to prevention and treatment of oral and 'general' healthcare should therefore be closely connected and should be achieved through individual, professional and community-level approaches. Early diagnosis as with most disease is important for a successful outcome. Investment in timely and effective oral healthcare results in the enhancement of general health and wellbeing and a reduction of the financial burden on healthcare systems. Where investment is low resources are primarily allocated to emergency oral care and pain relief with under-privileged groups being the most vulnerable.

Currently, oral healthcare in Ireland is provided through a mix of publicly funded schemes, fully private provision, a public dental service and specialist / hospital services. 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. However, there are a number of problems with the current model of care including lack of funding and resources, savage cuts to funding and the scope of treatments covered that were implemented during the crisis along with bureaucratic and administration issues.

Strategy

IDA priorities for the future of the Health Service are as follows:

1. A **new national oral health strategy** must be developed and properly resourced, with a focus on prevention that ensures oral health care is better integrated and given priority in any overall health care strategy. A full-time Chief Dental Officer should be appointed on a permanent basis to lead the development and implementation of a new oral health strategy.
2. The role and expertise of dentists at community / primary care level in the **management and prevention** of chronic disease must be developed.
3. Any state dental schemes must be properly funded and operated. They must be fit for purpose and have a focus on prevention.
4. There needs to be **elimination of the barriers between primary and secondary** oral and dental health care.
5. **A national model of publicly delivered dental care for children and patients with special care needs** is needed and must be adequately resourced and staffed.
6. We recommend 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.
7. There must be a concerted plan to tackle the crisis in **Orthodontics**.
8. We need to see publication and enactment of a new **Dental Act**.

The IDA, as a lead partner in the National Oral Health Forum (2013), also endorses the Forum's key recommendations as follows:

1. There must be absolute clarity on the responsibilities and relationships of all key stakeholders in oral health. In particular, the roles of the Department of Health and the Health Service Executive (HSE) in the delivery of oral and dental care must be clearly defined.
2. Delivery decisions need to be matched to clinical needs and prioritised in line with the available resources. The role and responsibilities of the HSE in this process requires detailed clarification.
3. Primary dental care should mirror the Primary Health Care Strategy. In order to ensure a dental service with patients at its heart, primary dental care should act as the hub and

provide continuity and clear lines of responsibility for oral health outcomes for both the patient and the dental team.

4. Securing and maintaining oral health early in life is an urgent concern (0-5 age group) and consideration should be given to how this can be achieved in an Irish context.
5. There is a clear business case for Foundation Training in Dentistry. This is urgent and critical for the development of clinical patient services, better quality care and patient safety as well as both the education and retention of dental professionals.

A copy of the Report will be supplied separately.

The key challenges and actions to be taken are set out in the next section.

Integrated Primary and Community Care

Recommendation 1

Publish a national oral health strategy with a focus on prevention that ensures oral health care is better integrated and given priority in the overall health care strategy. Appoint a permanent, full-time Chief Dental Officer.

The National Oral Health Policy is over 20 years old and we have been waiting a considerable time for a new strategy to be published. This is a considerable road-block for oral health care. The strategy should ensure that oral health is integral to general health in the development of policy. It should aim to improve oral healthcare knowledge and personal oral hygiene behaviour with a focus on prevention. In addition, it should ensure the effective use of fluorides through continued water fluoridation. In order to achieve buy in to the strategy there should be enhanced engagement between the HSE, the Department of Health, the Dental Hospitals and the IDA.

According to the World Health Organisation (WHO), oral health is integral to general health and essential for well-being. 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. 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. We have found, however, that oral health often gets forgotten or is not prioritised. The IDA is calling for the integration of oral health into the wider healthcare delivery system. The independence of the profession however should be noted and maintained. This independence should not prevent co-operation with other health services in tackling oral health issues.

Best practice examples of the integration of oral health into the overall health care strategy include the 'Lift the Lip Programme' in Cork whereby public health nurses and other general health professionals are trained and encouraged to improve the early intervention, prevention and referral of dental decay in young children. Early childhood decay is one of the most common chronic disease of childhood and is a predictor of dental decay in permanent teeth. IDA believes there is huge scope for primary care healthcare staff to identify high caries risk children, long before these children traditionally access dental services. Referral pathways may also be developed from primary and secondary care institutions for high risk patients. Oral health should also form part of every care plan for adults and children with special needs. Primary and secondary care services need to be

developed and expanded throughout the country ensuring equitable access to high-quality services. In addition, IDA has recently started a project involving HIQA and the Irish Gerontology Association to raise awareness of the problems associated with dental decay and oral disease in older patients in the community and in care settings. In order to promote the message that dentists should be involved in a care plan at an earlier stage in order to avoid dental crises.

A further key area whereby oral heath can be integrated into the wider healthcare system is in terms of the risk profiling of patients by dentists to identify and to significantly reduce the impact of systemic disease on oral health and improve general health by reducing the effect of common risk factors. An integrated treatment programme which addresses chronic diseases such as diabetes or other inflammation based chronic conditions and gum disease will lead to better outcomes for the patient. This approach is consistent with the philosophy of the Healthy Ireland policy and would require very limited funding, but we believe it could help achieve transformative improvement in the nation's oral and general health and help achieve unprecedented financial and economic savings.

Significantly greater emphasis on oral health and its link to systemic illness is required in the training of doctors, nurses and related healthcare professionals. There would be considerable benefit to having a mandatory oral health -medicine module on these courses to improve the awareness of systemic links to oral disease and the need for collaboration with in the overall management of patients. Similarly dentists need more training in nutrition, dietary counselling and liaising with medical colleagues. The possibility of making every encounter with a healthcare profession matter in terms of advancing overall health is an achievable one with more interdisciplinary collaboration.

After almost two decades without any Chief Dental Officer (CDO) in office, the Department of Health appointed a half-time CDO on a three year contract in 2013. This post must be filled permanently on a full-time basis to provide advice and leadership in developing and implementing a new oral health strategy which enjoys the support and confidence of dentists, patients and their elected representatives.

Recommendation 2

Utilise the role and expertise of dentists at community / primary care level in the management and prevention of chronic disease.

The mouth is a gateway to the body and is an early warning system for health practitioners. Signs in the mouth indicate trouble in other parts of the body. An oral examination can reveal diseases, general health status and habits such as tobacco and drug use.

Oral diseases share common risk factors with chronic diseases such as heart disease, obesity and diabetes. The Government has stated that tackling chronic diseases is a priority. The evidence to date highlights the need for greater integration of oral health preventive programmes with general health promotion. Dentists are in an ideal position in the community to diagnose health problems and offer patients advice on reducing the risk factors.

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

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

The World Health Organisation recommends, that when looking at the role of the dental profession in the management of chronic disease, particular emphasis should be placed on the following elements:

- Promotion of a healthy diet, particularly lower consumption of sugars and increased consumption of fruits and vegetables;
- Prevention of oral and other diseases related to tobacco use by involving oral-health professionals in tobacco cessation programmes;
- Prevention of oral-cavity cancer and oral pre-cancer by training oral health professionals in screening, early diagnosis and referral for care, and appropriate interventions on the risks of tobacco use and excessive consumption of alcohol;

- Building of capacity in oral health systems oriented to disease prevention and primary healthcare, with special emphasis on meeting the needs of disadvantaged and poor populations;
- Promotion of oral health in schools, aimed at developing health lifestyles and self-care practices in children and young people;
- Promotion of oral health amongst older people, aimed at advancing oral health, general health and wellbeing into old age.

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).[1] Dentists are therefore well in an ideal position in the community to play an important 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.

The key challenges to the move towards comprehensive oral health care are agreeing on a strategy with all the interested parties, the considerable level of funding needed as we are starting from such a low base, driving the momentum to include the necessary interdisciplinary collaboration and the timely training and up-skilling of the professionals involved in implementation.

There needs to be a multi-faceted approach to planning for future national health care including the establishment of an overseeing body or commission concerned with nutrition and lifestyle comprising which would take responsibility for disease prevention in the population focusing heavily on the management of the obesity and sugar epidemic and other related chronic diseases.

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

This body would have a significant health promotion remit and could be given a legislative arm informing labelling, distribution of calorie -dense products / outlets especially to the younger cohort and a role in overall planning for healthier environments to facilitate the public to take more exercise through e.g. walking and cycling.

A simple example of this would be to put a responsibility on all those receiving State funding e.g. schools, colleges, hospitals, sporting organisations , public amenities to comply with a healthy eating / lifestyle policy and effect this by measures such as removing vending machines or curbing sponsorship by bodies whose product labelling is not consistent with the recommendations of this new body or commission.

This body could be part funded by any sugar taxes should they be enacted.

Recommendation 3

Urgently renegotiate and adequately resource State Dental Schemes

IDA believes that into the future, eligible adults should continue to have access to dental services through private practitioners. However, the Government must now 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 we have outlined this in our recently published report 'Unfit for Purpose' (copy enclosed).

Background

Medical Card Dental Scheme

This scheme is currently operated by the HSE and private dentists contract with the HSE to provide care in their own self-funded dental practices. Currently, there are over 1.7 million adults entitled to treatment under the scheme. The scheme was dramatically altered in April 2010 when the HSE suddenly announced crippling restrictions to the Scheme. Up to then, a range of routine treatment was available and studies showed the oral health of patients availing of the scheme had significantly improved since its introduction in 1994.

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!**

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%.

Furthermore, the administration of the DTSS 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. An IDA survey of members who hold DTSS contracts, carried out in March / April 2016, found that 80% of dentists had experienced problems with the operation of the DTSS in the past 5 years, with 35% saying they had experienced considerable or huge amounts of problems. The main problems cited by dentists include:

- Dentists not paid for treatments carried out.
- Patient expecting basic treatment which is no longer available to them.
- Lack of treatments covered under the scheme results in under-treatment of patients.

- The length of time taken to get approval for treatments.
- Not getting paid for pre-approved claims / treatments.
- Refusal for necessary treatments.

In addition, over one-third (36%) of contractors found communication between the HSE and dentists to be poor or very poor.

Two-thirds of dentists have changed the way they are practising dentistry due to the current operation of the DTSS. Explaining the way that their dentistry practice has changed, respondents stated:

- *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.*
- *Treatment leaning more towards extractions and provision of dentures than conserving teeth.*
- *Inability to provide the correct treatment.*
- *I'm practising old-style dentistry, extractions, dentures, amalgam etc.*

PRSI Dental Scheme

This scheme is currently operated by the Department of Social Protection. Private dentists contract with the Department to provide the treatment to eligible patients. Currently, 2 million taxpayers are currently entitled to the scheme. 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 scheme is funded by the Social Insurance Fund which all taxpayers contribute to. In the Budget of December 2009, this scheme was restricted to one item only – the annual oral examination. The contracting dentist is paid €33 for this treatment. There is no charge to the patient. Prior to these cuts, the range of treatment consisted of routine preventive and restorative dental treatment required to achieve and maintain good oral health.

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

Absence of State Support for Dental Care

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

Legal Issues

There are important legal issues which need to be addressed, having regard to competition law, in order for the State Dental Schemes to renegotiated. The Framework of Agreement and Memorandum of Understanding reached between the Department of Health and the Irish Medical Organisation needs to be replicated with the IDA, the sole representative body serving the dental profession.

Recommendation 4

Eliminate the barriers between primary and secondary oral and dental health care.

Both the Public Dental Service and dentists in private practice are involved in the delivery of primary care services but due to 'barriers' between primary and secondary care, patients are experiencing problems and delays in accessing services. These barriers include:

- Lack of capacity
- Access issues
- Lack of / confusion surrounding referral / treatment pathways between the private practice dentist and secondary care services
- Lack of clinical protocols
- Lack of structured communications between dentists and the HSE IT problems e.g. dentists are not currently involved in the roll-out of 'Healthmail' which is a HSE service that allows health care providers to send and receive clinical patient information in a secure manner. IDA has formally requested that the HSE would roll out the service to dentists to enable them, when the need arises, to securely share patient records with clinicians in the HSE or Voluntary Hospitals.

Currently, the vast majority of Public Specialist care is only available in the area of orthodontics. Other specialist services are delivered to varying degrees throughout the country, but there are severe difficulties in delivering these services (i.e. oral surgery, special needs dentistry etc.) due to the lack of resources. Patients requiring other specialist services are usually referred to the dental schools where there are lengthy waiting lists.

One possible area for future development of the service is the development of specialist care services in areas such as paediatric dentistry, special care dentistry, oral surgery and dental public health, which must be done on a nationwide level. This would lead to simpler journeys for patients as they would not need to leave the service for continued care.

It would also improve the status and profile of the service and aid in the recruitment and retention of staff by providing career pathways in many areas of dentistry. The current burden on the dental schools would also be alleviated, and referral to dental schools could be reserved for the management of more complex cases requiring tertiary care.

For the private patients access to specialist services needs to be improved. The IDA suggests that the number of specialists and specialties needs to be considered as part of a dental manpower review.

Recommendation 5

Establish a national Public Dental Service that is adequately funded and staffed

The HSE Public Dental Service is responsible for children and those with special care needs. It operates the Schools Screening Service which aims to provide targeted screening to children at three intervals during national school (in 2nd, 4th and 6th classes).

IDA believes a properly resourced Public Dental Service should continue to provide dental care to children, adolescents and special needs patients. A properly funded public dental service has the potential to provide excellent value for money.

The PA Consulting Report (2010) commissioned to review the delivery and management of HSE dental services, found:

- The public dental service is essentially 32 local dental services with significant variations in priorities and service interventions… the level of variation in practice means that the service does not add up to a coherent national model of public service.
- It is very difficult to get an accurate picture of what the Public Dental Service (salaried service) is delivering and for whom.
- The service operates with significant operational discretion at local level… public dental services operate as a parallel service stream to other health and social care services; referral pathways between services are unclear in particular between primary and secondary / tertiary services; the patient is not at the centre of how the service is planned and delivered.
- The imminent appointment of a new Oral Health / Clinical Lead is therefore an important development.
- The salaried service is delivering what it can deliver based on current resources rather than what is should deliver based on an agreed national service model.
- There is a strong sense among stakeholders consulted that oral health policy is not prioritised and not on the national radar in the same way as other health and social care services.

- The service is not planned or delivered to reflect evidence-based practice… the service is not delivered on the basis of agreed oral health outcomes.

The Irish Dental Association supports the establishment by the HSE of a national model of publicly delivered dental care and treatment. We don't believe publicly delivered dental care fits within a primary care network structure; instead we believe dental services should be organised on a national basis. This is acknowledged in the PA Consulting.

A national model is favoured rather than a model based on locally managed services with national leadership, subject to the vagaries, whims and preferences of local managers. This model has merely served to exacerbate huge variations in access and extent of dental care and service delivery.

The HSE Public Dental Service is, uniquely, a surgical service. It has specific needs in relation to infection control, radiation safety etc. and with an important acute emergency service component.

The eligibility criteria for dental patients are very different to those employed for medical and other services. Efficient delivery of the dental service cannot be achieved within individual networks though we acknowledge the importance of maintaining and growing links with the other disciplines locally within the network.

There are a number of areas of responsibility where, for example, Principal Dental Surgeons are given devolved authority to ensure compliance with statutory legislation relating to fluoridation and radiology as well as management of the DTSS. These are critical responsibilities which need to be managed in a national model.

For many reasons, we believe that dental care should be arranged as a national oral health service (like mental health, environmental health, ambulance services etc.), comprising primary, secondary and tertiary referral components, and with links to regional networks.

Integration of and within all aspects of oral health is what is required rather than integration with administrative structures though we would envisage formal links with other professions and local managers at a regional level. If there are to be any changes in HSE structures they should only happen when new arrangements are clearly structured and established with appropriate resources.

Link to Hospitals

Also, it is critically important that dental care must have a link to acute hospitals – this has been a huge deficit which has been exacerbated by regionalisation.

Patients will benefit from a national dental service with clear treatment pathways (e.g. oral cancer, oral surgery, latex allergy cases, orthodontics, tertiary referrals to Beaumont and other relevant specialist centres) and better risk management and governance.

We believe that in each tier three acute hospital, there should be a dental department established to manage care and treatments requiring general anaesthesia and also to cater for in-patients requiring dental care and treatment (e.g. patients admitted primarily for cardiology, oncology or orthopaedic care and treatment). This hospital-based service would address the difficulties being experienced nationwide in providing timely treatments for children and special needs patients under general anaesthesia.

In addition, there would undoubtedly be gains in managing the orthodontic waiting list nationally rather than on a regional basis as is the case at present. Operational management on a national level is required to progress and develop these gains for the service and for patients in addition to the strategic direction provided by the national oral health office.

It is essential that the national oral health office is developed to ensure operational management and strategic leadership of the dental service.

We believe there is ample evidence of significant cost savings and efficiency gains where dental care is managed on a national basis and we have highlighted previously many instances of such gains where procurement, dental education and training and ICT roll-out have been organised on a national basis. There should be no extra cost with any move towards national model but big gains for patient care.

Staffing in the Public Dental Service

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 in order 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.

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.

The services for patients with special needs are similarly under severe pressure. Many of these patients require treatment to be delivered under general anesthetic. In some areas, the waiting list for treatment under general anesthetic is two years or more.

Recommendation 6

Implement the recommendations contained in the 'National Clinical Programme for Paediatrics and Neonatology model of care for paediatric healthcare services in Ireland' as follows:

- There is 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. An increase from 2WTE to 6WTE consultant paediatric dentists is required at the new children's hospital.
- The appointment of consultant paediatric dentists at secondary care level in the regional paediatric units is strongly recommended to allow planning, organisation and provision of a coordinated paediatric dental service for children throughout the country in collaboration with the community primary care dental services.
- To support this model, the training of paediatric dentists should be prioritised.

- The integration of primary, secondary and tertiary care dental services with the National Clinical Programme for Paediatrics and Neonatology would be envisaged as an important component of the design of such a multidisciplinary team service model.
- 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.
- 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.

Background

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".

In a survey carried out in October 2015, 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.

Recommendation 7

Tackle the crisis in Orthodontics.

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

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 8

Urgently publish the new Dental Act.

The imminent drafting of the new Dental Bill represents an opportunity to make a meaningful difference to the lives of patients by ensuring oral health is made a priority in this country. The continued delay and lack of action regarding publishing the new Dental Act is a road block to achieving the highest standards of modern dentistry. We support the introduction of the types of changes introduced for medical, pharmacy and nursing professions. However, lessons need to be learned from the changes introduced for the medical profession and the mistakes evident in the legislation introduced for other professions should not be repeated.

We would emphasise that urgent attention is required to address the following:

- **CPD** – To enhance patient protection we call for the introduction of a mandatory CPD Scheme – with appropriate supports and protected time - similar to most other professions.

- **Inspection and standards** – we support the introduction of licensing of dental practices. Support for practices will be needed and the model of inspection should be the subject of extensive discussion with the profession. We believe that the power of any inspections to be introduced should be held by the Dental Council rather than having a second regulatory body given regulatory authority to uphold and enforce standards.

- **Foundation Trainin**g – we call on the Minister for Health to support a properly resourced Foundation Training Scheme in Dentistry. This needs to be afforded priority to ensure graduates from the Irish dental schools are not disadvantaged in seeking access to practice in the UK where a Foundation Scheme is being introduced and which will be a pre-requisite for NHS practice.

- **Incorporation** – we support the repeal of the current prohibition on the incorporation of dental practices. This would allow a level playing pitch with dentists in Northern Ireland.

- **New roles for Hygienists and Therapists** – we recognise the role that can be played by hygienists and therapists but we believe that clear understandings must be set out as regards the scope of practice for hygienists and therapists. Direct access to hygienists does not make sense.

- **Recognition for Dental Specialists** - recognition of a greater number of specialist divisions beyond oral surgery and orthodontics. In all the other common law jurisdictions where medical and dental professionals commonly pursue their training and travel to practice and advance their knowledge (UK, US, Canada, Australia and New Zealand), the number of dental specialities ranges between nine and thirteen. Equally, in all these jurisdictions there is a recognition of the continued entitlement of general dental practitioners to provide aspects of care which are provided by Specialists provided they possess the necessary skills, expertise and experience.
- Recognition of dental specialties encourages scientific advancement, promotes innovation and the highest standards of care and rewards education and achievement; all of which serve to promote the highest standards of dentistry.

Models of Funding

The Association does not have any preference as regards the health service funding model deemed best suited to Ireland. We would draw the Committee's attention to the comprehensive analysis contained with the report of the Expert Group on Resource Allocation and Financing in the Health Sector (July 2010) published by the Department of Health & Children.

The three key messages in the report are –

1. Ireland needs a system of integrated planning for all aspects of healthcare covering National Policy setting and local delivery, standards of care and clinical pathways, capital and current spending, public and private delivery in the Primary, Hospital and Community and Continuing Care sectors.
2. Our current Medical Card System could be developed in a matter which would increase systematically equity of access, and promotes the use of safe and cost effect care. The pace of development depends on the rate on which resources can be made available.
3. It is possible to improve resource allocation within and across the Primary, Hospital and Community/Continuing care sectors, supporting cost effectiveness and improved quality of care. Central to this is the incentives of both patients and providers are in line with stated healthcare objectives.

The Report goes on to say that changes could be made to the current system which could do more to promote equity and fairness, support quality of service, generate clear accountability and facilitate a greater focus from the patient. **We believe that the analysis and approach set out in this report still holds**. Furthermore, the Report identified the main characters of a quality healthcare financing system as equity and fairness, transparency, promotion of good attitudes to care, consistency with policy objectives and sustainability.

In more recent times, we have seen advocacy of the introduction of Universal Health Insurance. It is clear that the cost implications of introducing Universal Health Insurance were significantly greater than anticipated and we believe the appetite at political level for such an approach has been severely diminished in recent times.

However, it is interesting and worth bringing to the attention of the Committee that in fact a Universal Health Insurance model has been in operation for over half a century in regard to dental care and treatment. Specifically, we refer to the Dental Treatment Benefit Service (DTBS), or the PRSI dental care system as it is more popularly known. Until 2010, this model offered access to prescribed dental treatments for over 2million eligible citizens and their dependants according to clearly set out criteria. It operated on the basis of the State fully meeting the costs of certain treatments, offering grand in aid for other treatments, while it also involved a form of co-payment by patients. We believe that this model operated far more successfully in dentistry than the alternate medical card system, i.e. the Dental Treatment Services Scheme, or Medical Card scheme, albeit that the DTBS was subject to brutal assault with the wipe out of all benefits other than the annual examination in 2009. We believe that the DTBS model is one which deserves careful scrutiny and suggest that this could be usefully examined further with a view to its more widespread application within and beyond dentistry.

It is clear to the Association that any suggestion of expansion of publicly managed and delivered dental care in primary care i.e. the concept of general practitioners becoming employees of State agencies, is neither feasible nor desirable. The complexity of treatments and the significant cost of treatments provided to the population generally and the paltry support offered by the State at present are such as to render such a concept redundant, absent a huge increase in direct taxation to the extent that we believe would not carry public support.

Equally, we believe that the independent contractor model operates successfully in private practice rewarding as it does significant innovations and productivity and without being subject to excessive operating costs which can apply in a direct employment model.

As regards the entitlements that patients ought to be provided in the funding model we refer you to the treatments which were previously available and covered fully or partially under the DTBS up to 2009 and which are listed elsewhere.

ENDS