IRISH DENTAL ASSOCIATION

PRE-BUDGET SUBMISSION

SEPTEMBER 2020

The IRISH DENTAL ASSOCIATION exists to promote the advancement of the interests of the dental profession and promote the well-being of our country's population through the attainment of optimum oral health.

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Improving Irish oral and dental healthcare

Oral/dental health forms an essential part of general health and well-being. Oral diseases also share common risk factors with chronic diseases such as heart disease, obesity and diabetes. Our experience to date is that oral health is not prioritised in terms of promotion, funding or service delivery.

Private out-of-pocket payments account for 83% of all monies spent on dental care, with State-provided or funded dental services accounting for just 14%. The Central Statistics Office (CSO) Survey on Income and Living Conditions (2017) shows that 32.5% of households with children, where at least one person in the household had a dental examination and/or treatment in the last 12 months, reported that the associated costs were a "financial burden".

This clearly shows the consequences of the State's decision to take away an estimated €100m per annum in State supports for dental patients after 2009 with the cuts to the two State schemes (medical card and PRSI). And obviously dentistry has been massively affected by Covid-19. Dentists were asked to estimate the increase in their day-to-day operating costs as a result of Covid-19, and 50% of respondents estimated that increase at between 30% and 50%. At the same time, the vast majority said that their income has fallen by at least the same amount. In fact, more than one-quarter of dentists stated that their income has fallen by over 50%. Among the most concerning results were dentists' responses regarding the impact of Covid-19 on the oral health of the population, with over 60% saying it will have a moderate or major impact.

Dentists were asked to estimate the increase in their day-to-day operating costs as a result of Covid-19, and 50% put that increase at between 30% and 50%.

The PPE promised to dentists by former Minister for Health Simon Harris TD in May has yet to materialise, despite the fact that over 700 dentists have registered their need for such equipment.

Before the emergence of Covid-19, the provision of community dentistry in Ireland was a cause for concern – now our resourcing levels have become a full-blown crisis.

Three areas to address

The Association is asking that the Budget for 2021 should focus on three main areas in order to improve oral health:

1. Improving access to oral and dental healthcare for adults by offering supports to patients.
2. Improving capacity within private practice dentistry.
3. Adequate resourcing for our collapsing public dental service.

This Submission identifies ways in which to address these three issues.

The Irish Dental Association is the professional, educational, scientific and advocacy body for over 1,900 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.

The Association is asking that the Budget for 2021 should focus on three main areas in order to improve oral health:

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Oral health matters

Oral/dental health forms an essential part of general health and well-being. Oral diseases also share common risk factors with chronic diseases such as heart disease, obesity and diabetes. Our experience to date is that oral health is not prioritised in terms of promotion, funding or service delivery.

Diseases of the mouth and oral cavity have a significant impact in terms of pain, suffering, impairment of function and reduced quality of life. To a large extent, oral diseases are entirely preventable. Yet when they occur the damage is not reversible, and they can be among the most expensive to treat.

The approach to prevention and treatment of oral and 'general' healthcare diseases should therefore be closely connected, and should be achieved through individual, professional and community-level approaches.

As with most diseases, early diagnosis is key for a successful outcome. Investment in timely and effective oral healthcare results in the enhancement of general health, better quality of life for patients, and a reduction in the financial burden on healthcare systems. Where investment is low, resources are primarily allocated to emergency oral care and pain relief (unfortunately often little more than extraction of teeth) with under-privileged groups being the most vulnerable. This causes huge problems for the patient over the following years.

> *"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 health in Ireland

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 directly to children and to adults with special needs. However, there are a number of problems with the current model of care, including: lack of funding and resources; extensive cuts to funding; reduction in the scope and availability of treatments covered, which were implemented during the last financial crisis; and, increased bureaucratic and administrative burdens on contracted dentists.

Dental care in Ireland is primarily provided on a private basis by dentists who work independently of the State, and without any of the resources provided to doctors in general practice. These dentists can be contracted to provide care for large cohorts of eligible holders of medical card or PRSI benefits, albeit the dental treatments funded by the State are extremely limited, and we believe completely inadequate for the basic oral/dental health of the Irish population.

Public service dentists employed by the HSE play a critical role in providing expert care primarily for children, and special care children and adults. In addition, we have two dental hospitals and a small number of acute, tertiary facilities.

Private out-of-pocket payments account for 83% of all monies spent on dental care, with State-provided or funded dental services accounting for just 14%. The Central Statistics Office (CSO) Survey on Income and Living Conditions (2017) shows that 32.5% of households with children, where at least one person in the household had a dental examination and/or treatment in the last 12 months, reported that the associated costs were a "financial burden".

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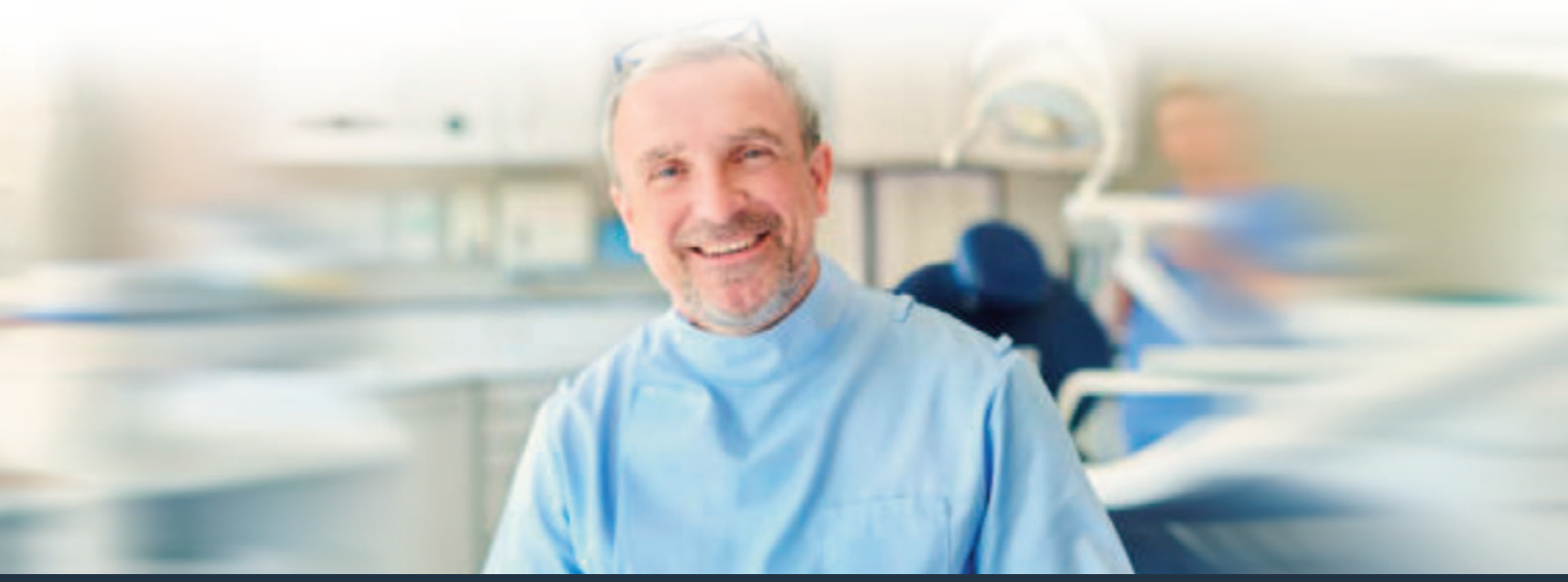
While oral health in Ireland is improving, most of the gains are being recorded by higher income groups, and the resulting chasm in oral health status according to income is widening as a result of the failure to ensure adequate resourcing of essential dental care. In addition, the impact of the Covid-19 pandemic on oral health has yet to be fully assessed.



Impact of Covid-19

A recent survey of members by the IDA found that 60% believe the pandemic will have a moderate or major impact on the oral health of the population.

The Covid-19 pandemic has had a profound impact on the dental sector. Dentists closed their practices in March to all but emergency cases and carried out telephone triage of patients under public health direction – in many cases receiving little or no fee for this.

Since returning to practice, dentists have been faced with increased costs and reduced income due to the continuing pandemic.

It has been independently estimated that the cost of additional PPE and other expenses due to Covid-19 would amount to an average additional cost of €14 per appointment in a three-surgery practice. In addition to PPE, issues such as reduced patient footfall due to social distancing and longer appointment times due to cleaning and infection prevention and control protocols has also led to increased costs and reduced income for dentists.

Dentists have had to reduce the number of patients they see each day by up to one-third.

In our recent IDA survey (July 2020), we found that 16% of dentists have resumed less than 50% of their practice. The impact on patient care is clear. Prior to the shutdown, the vast majority of dentists saw more than 10 patients per day, with only 8% seeing fewer than 10. Since reopening, the number of dentists seeing 10 patients or fewer per day has jumped to almost 34%, while the number seeing more than 15 patients has fallen from almost 60% to 20%. This is despite the fact that the majority of dentists are working the same hours as before, or increased hours. In addition, responses show that the average waiting time for a non-emergency appointment is almost three weeks.

Dentists were asked to estimate the increase in their day-to-day operating costs as a result of Covid-19, and 50% of respondents estimated that increase at between 30% and 50%. At the same time, the vast majority said that their income has fallen by at least the same amount. In fact, more than one-quarter of dentists stated that their income has fallen by over 50%. Unlike general medical practitioners, dentists in independent practice receive no State support for the running of their practices (not even those who provide publicly funded dental care), and are currently bearing the full cost of infection prevention and control measures such as PPE or modifications to premises.

Given these figures, it is perhaps unsurprising that one in seven dentists said they were concerned for the viability of their practice.

> *Since reopening, the number of dentists seeing 10 patients or fewer per day has jumped to almost 34%, while the number seeing more than 15 patients has fallen from almost 60% to 20%.*

Among the most concerning results were dentists' responses regarding the impact of Covid-19 on the oral health of the population, with over 60% saying it will have a moderate or major impact.

> *This scheme has long been regarded as unfit for purpose, but the impact of Covid-19 is making the scheme unworkable for many dentists.*

These findings illustrate the lack of support for dental practices and inadequate resources provided for patient dental care, both before and in the aftermath of the Covid-19 pandemic. Many dental practices were able to survive the early stages of the pandemic, but in the event of a second wave, which might lead to localised closures, many dental practices simply won't have the reserves to survive.

The PPE promised to dentists by former Minister for Health Simon Harris TD in May has yet to materialise, despite the fact that over 700 dentists have registered their need for such equipment. The IDA is calling on the Department of Health, and on new Minister Stephen Donnelly TD, to honour this promise.

The Association has also called on the Minister and the Department to engage urgently with dentists regarding the Dental Treatment Services Scheme (DTSS), which provides dental care to medical card patients. This scheme has long been regarded as inadequate for patient needs, but the impact of Covid-19 is making the scheme not viable for many dentists. Increasing numbers of dentists are serving notice of their intention to resign from the Scheme, which has enormous implications for vulnerable patient groups.

It will also have serious consequences for the HSE dental clinics, which will be completely incapable of meeting the demand for care from adults, and which will also see an obvious impact on their ability to provide care for their existing cohort of patients, including children and patients with special needs.

The table below shows the decline in the number of dentists participating in the DTSS.

Summary note:

Numbers of contracts held by dentists and CDTS now 22% below December 31, 2015 levels and 13% below December 31, 2019 levels.

Analysis of DTSS expenditure and numbers of contracts held.

Date (Dec 31 each year)	DTSS contract holders	Expenditure €m	Contract holders change
2010	1,582	75.77	
2015	1,847	66.51	+20
2016	1,831	64.39	-16
2017	1,604	63.37	-227
2018	1,644	58.68	+40
2019	1,654	56.08	+10
Sept. 17, 2020	1,438		-216*

Source: PCRS Annual Reports, PCRS Lists of Dentists with GMS Contracts (Sept 17, 2020), HSE website.

** As compared with December 31, 2019.*

Crisis in public service dentistry

Before the emergence of Covid-19, the provision of community dentistry in Ireland was a cause for concern – now our resourcing levels have become a full-blown crisis. The HSE Community Dental Service deals with our most vulnerable special needs patients and children, yet according to the survey of IDA members, across the country between 25% and 40% of its skilled staff have been assigned to assist in testing and contact tracing for Covid-19 and have not been replaced. As a result, the vital needs of our patients simply cannot be met. (Note – the actual % assigned to Covid-19, etc., varies from location to location.)

> *"Important services such as annual school assessments had already fallen far behind, putting children's health at risk."*

Important services such as annual school assessments had already fallen far behind, putting children's health at risk. Usually HSE dentists would be starting assessments for the new school year at this time, but because of Covid-19 they have a large backlog from last year and are well behind on reaching target class populations. Without the requisite skilled staff and additional resources, they cannot make up that gap, and the opportunity to identify problems early is permanently lost.

The indirect effects of Covid-19 have also been significant. Covid-19 has slowed the process of providing dental care in many aspects, reducing the number of patients who can be seen in the day. The service needs to conduct a public health risk assessment before every dental treatment, which impacts on every single appointment, adding greatly to dentists' workflow.

The loss of skilled staff cannot be solved easily. These are experienced dentists who have specialist skills and knowledge of treating children and people with special needs. They cannot simply be replace overnight – a detailed resourcing plan is urgently needed from the Government if patients are to receive the care they need.

Three areas to address

The Association is asking that the Budget for 2021 should focus on three main areas in order to improve oral health:

1. Improving access to oral and dental healthcare for adults by offering supports to patients.
2. Improving capacity within private practice dentistry.
3. Adequate resourcing for our collapsing public dental service.

1. Supports for patients

1. Allow tax relief on private health insurance for dental treatments.
2. Direct that the Revenue Commissioners would amend the terms of the MED 2 scheme to allow relief at the marginal rate.
3. Replace the unfit for practice dental scheme for medical card patients.

2. Improving capacity in private practices

The IDA has submitted a range of proposals to help the private dental sector during the current pandemic:

1. Provision of sector-specific financial supports to enable dentists to meet the costs of Covid-19.
2. Provision of an advance in payments provided under the State schemes (medical card and PRSI) akin to those supports provided in Northern Ireland, Britain, Germany and many other jurisdictions.
3. Temporarily suspend the collection of professional withholding tax from payments made to dentists contracted by the HSE and the Department of Social Protection to treat medical card and PRSI-eligible patients, respectively.
4. Direct the Department of Social Protection to halve the rate of Employer PRSI contributions.

3. Adequate resourcing for our collapsing public dental service

The target patient group of the public dental service of the HSE is children and patients with special needs. The HSE's Orthodontic Service aims to provide orthodontic treatment to children under the age of 16 based on clinical need.

A short-term kick-start plan has to be introduced in the HSE to meet the current problems facing children, special care and other patients who access care from the HSE Community Dental Service.

We believe that priority attention needs to be focused on addressing the following issues:

1. **HSE dental staffing crisis**
   We believe that a recruitment campaign needs to be commenced, at the direction of the Minister, to achieve a complement of 400 whole-time-equivalent posts in the HSE public dental service. This is in order to address the difficulties apparent in the service and to enable the service to deliver on its stated objectives of preventing dental health difficulties, and caring for and treating children and other vulnerable groups.
2. **Urgent need to provide treatment for children requiring general anaesthesia**
   We call on the Minister to allocate sufficient resources and 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.
3. **Orthodontic waiting lists**
   We believe there is a clear need to publish 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.

"The Association is asking that the Budget for 2021 should focus on three main areas in order to improve oral health."

Appendix One – Dental Treatment Services Scheme in crisis

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 card 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 to a budget-led scheme. This was done by restricting treatment under the Scheme to clinical emergency circumstances only and effectively abandoning all elective dental treatment. The rationale behind a scheme that places a limit on fillings (i.e., saving a tooth) while allowing an unlimited number of extractions is 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 well-being.

The IDA has been warning for many years – long before the current pandemic – that the DTSS is not fit for purpose. The original contract was a collaboration between the Department, the IDA and the health services to provide basic dental care to medical card holders. The current version of the contract is under-resourced, restrictive to the point that patients can't access the care they need and, as currently structured, it supports the extraction of teeth rather than their retention.

In the current context, the need to review and renegotiate the Scheme is all the more urgent. Over the past number of months, as a result of Covid-19, dentists have had to review the viability of their practices as well as their continued participation in the DTSS. It is, of course, a matter for each individual dentist to decide on their participation in the Scheme. Dentists will always endeavour to ensure the safe delivery of dental care to medical card patients, but they cannot do so in a manner that imperils the viability of their practices and livelihoods. Dentists want to be able to provide care for medical card patients, but the Government is leaving them with little choice but to minimise their involvement or withdraw.

The discussions needed to update or replace the beleaguered DTSS (medical card) scheme have previously been deferred by the Department, citing the need for the publication of the Oral Health Policy. This has also been cited for the delayed publication of new legislation to update and amend the Dentists Act of 1985. With the publication of the Oral Health Policy, these deferrals are now redundant, and all parties should engage without delay in long-overdue discussions on the State contracts and the need for a long-promised, updated Dentists Act.

What is required?

1. Confirmation of the extension to the Irish Dental Association of the terms of the Framework Agreement concluded by the Department of Health and the Irish Medical Organisation in June 2014.
2. Immediate resumption of the DTSS contract talks from which the HSE withdrew in 2007 to modernise the current contract, which dates from 1994.
3. Commitment in the forthcoming budget to multi-annual funding towards a new scheme for medical card patients, which focuses on prevention rather than treatment.
4. Codes of practice must be introduced to enable engagement with the representative bodies for the professions, which respect professional independence and which contain agreed dispute resolution mechanisms preventing the need for countless legal actions in defence of practitioners and their contracts.

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!**

Appendix Two – Resourcing our public dental service

Last July, the IDA surveyed almost 600 private and public service dentists. It found that prior to the introduction of Covid-19 restrictions, 37% of public dentists reported seeing more than 15 patients per day. That number is now 0%, with the vast majority now seeing fewer than 10 patients per day (82%). This has contributed to significantly increased waiting times for non-emergency appointments, which now average 101 days.

The IDA has pointed out previously that the public dental service has seen a 20% reduction in dentist numbers in recent years, while the number of patients eligible for treatment by the public service has risen by the same amount. Anecdotal evidence describes areas not being given permission to replace staff in order to meet the overall employment ceilings imposed on the health system.

Failure to immediately address this crisis will have significant long-term implications. Oral health is a crucial part of a person's overall health. Our current resourcing levels mean that we are missing early-stage issues in both children and patients with special needs, which could have major long-term health effects.

Skilled staff need to be moved back into their original roles, along with additional staff who can develop the skills to treat child and adult patients who rely on the service to provide them with dental care.

> *We believe that a recruitment campaign needs to be commenced, at the direction of the Minister, to achieve a complement of 400 whole-time-equivalent posts in the HSE 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.

It is commonly accepted that there has been a significant deterioration in the level of service provided, and particularly the extent to which preventive 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. For many, the impact of insufficient resources results in them being seen by a dentist for the first time, under the school screening programme, in sixth class (age 12). This absence of examination and access to preventive strategies in the critical early years means that for many children their first encounter with a dentist is in pain at an emergency visit.

We call on the Minister to give favourable consideration to a number of other proposals, including the introduction of a model similar to the Child Smile model, which has been very successful in Scotland, as well as our call for the reintroduction of a foundation training scheme for young dentists, which again will be of great benefit to public service dentistry.

We believe that a recruitment campaign needs to be commenced, at the direction of the Minister, to achieve a complement of 400 whole-time-equivalent posts in the HSE public dental service. This is to address the difficulties apparent in the service and to enable the service to deliver on its stated objectives of preventing dental health difficulties, and caring for and treating children and other vulnerable groups.

Waiting lists for general anaesthetic and admission to hospital for dental treatment

In a survey carried out in October 2015, difficulties in accessing dental care under general anaesthetic (GA) 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 among dentists trained to care for and 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 GA – in October 2015. Most were waiting in excess of six months and many had been waiting for around 12 months. The closure of the outpatient GA extraction clinic at St James's Hospital in

Dublin on October 1, 2014, has had a significant impact on this issue. Over 2,500 appointments were scheduled for this service 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 specialties.

While a limited number of theatre slots have been sourced in the private sector to replace the service at St James's, 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

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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 dental 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 are not recorded on HIPE (such as the 3,000 plus children treated each year in the St James's 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".

Key recommendations

The key recommendations of the National Clinical Programme for Paediatrics and Neonatology model of care for paediatric healthcare services in Ireland are as follows:

1. 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 two whole-time-equivalent (WTE) to six WTE consultant paediatric dentists is required at the new children's hospital.
2. 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 co-ordinated paediatric dental service for children throughout the country in collaboration with the community primary care dental services.
3. To support this model, the training of paediatric dentists should be prioritised.
4. 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.
5. 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.
6. 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.

HSE Orthodontic Service

The Orthodontic Service in the HSE is also suffering hugely as a result of the cutbacks and the moratorium on recruitment, which have led to the creation of long waiting lists for screening and treatment. In some areas hundreds of patients have been waiting for treatment for more than four years.

Appendix Three – State support for medical and dental care in the community

Type of support	Doctors	Dentists
Payment model	Capitation/fee per item	Fee per item
State pension	Yes	None
Allowances	Yes	None
Grants	Yes	None
Allowances paid – PCRS Annual Report (2018)	**€160.09m**	**None**
Professional fees paid – PCRS Annual Report (2018)	**€429.14m**	**€56.08m**
Pandemic payment	Yes	No
PPE provided by State	Yes	No

Unit 2 Leopardstown Office Park, Sandyford, Dublin 18, D18 F588
Tel: +353 1 295 0072
Fax: +353 1 295 0092
Email: info@irishdentalassoc.ie
www.dentist.ie

ThinkMedia.ie