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PURPOSE

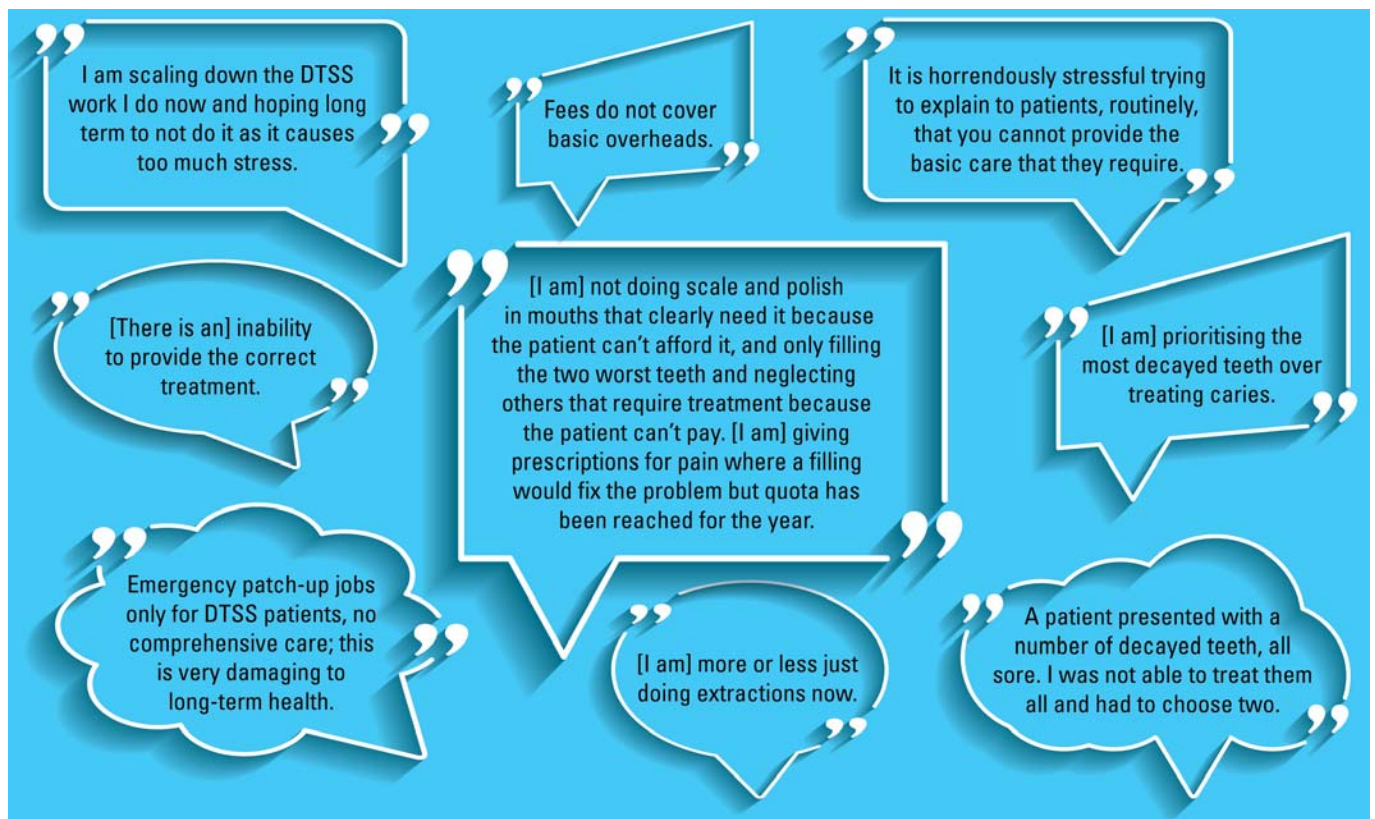
HSE Dental Care for  
Medical Card Patients

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## Executive summary

Since 1994 medical card patients have received dental care under the Dental Treatment Services Scheme (DTSS), which is managed by the HSE. 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 restricted treatment under the Scheme to clinical emergency circumstances only and effectively abandoned all preventive dental treatment.

In the six years since the cuts were implemented, the number of eligible patients covered by the DTSS has increased by over 17% but the amount of treatments funded by the HSE has fallen by 20%. The amount of scale and polish treatments has fallen by 97% and the number of protracted periodontal treatments (for gum disease) fell by 80%. Numbers of fillings have also fallen by over 33%. On the other hand, surgical extractions have increased by 53% and routine extractions have increased by over 14%.

As a direct result of cuts to preventive treatments under the DTSS, there has been an increase in waiting lists for oral surgery and this in turn has meant that medical card patients on waiting lists are being forced to use antibiotics for prolonged periods. Nine in ten dentists have had to prescribe multiple antibiotics for DTSS patients on oral surgery waiting lists. There has also been a 38% increase in the number of people with severe dental infections requiring hospital admissions since the cuts were made.

In addition, figures show that when practice overheads are taken into account, dentists are making a loss on some treatments under the DTSS and are barely breaking even on many others.

The IDA can no longer endorse the current DTSS. One-fifth of our members who hold DTSS contracts are currently considering leaving the DTSS and 80% now favour a complete renegotiation of the Scheme. The dental profession has no confidence in the operation of the DTSS by the HSE and the Union believes the operation of the Scheme has failed patients.

The Scheme is wholly unfit for purpose due to:

- ▶ the gross inadequacy of funding and rising demand;
- ▶ the failure of the HSE to provide treatments deemed necessary;
- ▶ our members' complete dissatisfaction with the administration of the Scheme by the HSE, and the continued failure of the HSE to heed our concerns regarding the impact on patients;
- ▶ the continued failure of the HSE to prioritise preventive treatment; and,
- ▶ the high number of treatments provided by dentists that remain unpaid.

For this reason, **we believe a new approach is required**. We are advocating that a new scheme be negotiated as a matter of urgency.



## Background

### Introduction

Oral health is of vital importance to general health and overall well-being. Despite this, many in our country experience unnecessary pain and suffering. 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, these diseases are entirely preventable. Yet when they occur, they can be among the most expensive to treat. Prevention and early treatment substantially reduce the overall cost to the State and the individual patient. 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.

### Dental Treatment Services Scheme

Under Section 67 of the Health Act, 1970, a health board is obliged to make dental treatment and dental appliances available for persons with full and limited liability under their medical card. (On January 1, 2005, the functions of the health boards transferred to the HSE.) By Regulation 9 of the Health Service Regulations 1972 these services are to be made available to persons with full eligibility only. Persons with full eligibility are adults and their dependents who are unable without undue hardship to arrange general practitioner medical and surgical services for themselves and their dependents.

Since 1994 patients eligible for dental treatment have received this treatment under the Dental Treatment Services Scheme (DTSS). Eligible patients are adult medical card holders (over the age of 16) and all aspects of the DTSS contract are managed by the HSE. Under the Scheme, the Government fulfils its statutory obligations to medical card holders by providing dental care and treatment to them free of charge. Prior to 2010 the treatments available under the Scheme consisted of basic routine dental treatment. These treatments ensured that medical card holders received pain relief, preventive care (e.g., cleanings, fillings, etc.) and emergency care (e.g., extractions/root canal treatment, etc.). It also provided a very important service for medical card patients who required dentures and denture repairs.

### Operation of the DTSS

Private practitioners who wish to participate in the Scheme enter into a contract with the HSE to provide dental treatment to medical card holders. Medical card holders are free to choose their treating dentist from a panel of dentists held by the HSE. Straightforward treatments can be carried out as soon as required while more complex items require prior approval from the HSE.

### Cuts introduced in 2010

On the April 27, 2010, the HSE introduced Circular 008/2010, imposing huge cuts on the Scheme. Neither the Association nor its members were consulted on or given notice of the contents of the Circular. Patients, some of whom were in the middle of treatment, were not informed or given notice of the changes. The circular severely restricted treatment under the Scheme. Key treatments such as scale and polish, periodontal or gum treatments, and panoramic x-rays were suspended, and many other treatments would only be provided in cases of clinical emergency (e.g., dentures, denture repairs and root canal treatments), while fillings were limited to two per patient annually as of right.

## Impact of the 2010 cuts

There has been a very significant increase in eligible medical card patients in recent years.

As of December 31, 2009, the number of medical card patients eligible for dental care stood at 1,478,560, representing 34.87% of the population. As of December 31, 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 among the findings below, we see that while the number of patients attending for examinations has increased by 34.6%, the amount of scale and polish treatments has fallen by 97%, fillings have fallen by 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 number of dentures funded by the HSE has fallen by 15%.

### Increase in hospital admissions for severe dental infections

Research published in 2015 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 dental infections in 2011 and 2012 following the introduction of those cuts.

According to the study, *Odontogenic infections and their management: A four-year retrospective 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.

### DTSS treatments funded by the HSE 2009-2015

Treatment code	Treatment type	Number of treatments 2009	Number of treatments 2015	Difference	% change
<b>ABOVE THE LINE</b>					
A1	Oral examination	312,190	420,275	108,085	+34.6%
A2	Prophylaxis	254,931	8,226	-246,705	-96.8%
A3A	Amalgam restoration	386,092	260,376	-125,716	-32.6%
A3C	Composite restoration	218,680	139,437	-79,243	-36.2%
A4	Exodontics	108,059	123,667	15,608	+14.4%
A5	Surgical extraction	37,208	56,845	19,637	+52.8%
A6	Miscellaneous	70,275	133,225	62,950	+89.6%
A7	First-stage endodontic	8,496	7,779	-717	-8.4%
A8	Denture repairs	21,677	36,512	14,835	+68.4%
<b>ATL totals</b>		<b>1,417,608</b>	<b>1,186,342</b>	<b>-231,266</b>	<b>-16.3%</b>
<b>BELOW THE LINE</b>					
B1	Endodontics	6,853	6,452	-401	-5.9%
B2	Apicectomy/amputation of roots	132	92	-40	-30.3%
B3	Protracted periodontal	57,547	11,387	-46,160	-80.2%
B4	Radiographs	38,629	10	-38,619	-99.9%
B5	Prosthetics	40,580	46,642	6,062	+14.9%
<b>BTL totals</b>		<b>143,741</b>	<b>64,583</b>	<b>-79,158</b>	<b>-55.1%</b>
<b>Overall totals</b>		<b>1,561,349</b>	<b>1,250,925</b>	<b>-310,424</b>	<b>-19.9%</b>



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.

### Increase in use of antibiotics

Cutbacks to preventive treatments under the DTSS have led to long delays in waiting lists for oral surgery. This in turn has meant that medical card patients on waiting lists are being forced to use antibiotics for prolonged periods. These patients are being exposed to health risks caused by repeated use of antibiotics.

A survey carried out in March 2016 by the IDA 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.

### Views of dentists

A survey of dentists carried out by the IDA in 2015 found that one-fifth of dentists who hold DTSS contracts were considering leaving the DTSS and that 80% favoured a complete renegotiation of the Scheme.

An IDA survey of members who hold DTSS contracts, carried out in March/April 2016, found that 80% of dentists have experienced problems with the operation of the DTSS in the past five years, with 35% saying they have 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; and,
- ▶ refusal for necessary treatments.

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

Three-quarters of respondents said their anxiety/stress levels have increased regarding the provision of care for DTSS patients over the past five years. The main causes of increased stress are:

1. Financial restrictions imposed by the HSE.

2. Escalating costs in practice.
3. Restricted clinical treatments available.
4. HSE administration practices.
5. Patient expectations and demands.

Commenting on their increased stress levels, respondents stated:

- ▶ "It is horrendously stressful trying to explain to patients, routinely, that you cannot provide the basic care that they require."
- ▶ "My hands are tied as regards the treatment I can provide."
- ▶ "Fees do not cover basic overheads."
- ▶ "Some procedures are provided at a loss, which is stressful."
- ▶ "It is worrying not to be allowed to do the treatment needed; I can do multiple extractions but only two 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."
- ▶ "Patients are demanding and unaccepting of the changes in the Scheme. They tend to vent their frustrations at me and my support staff."

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; this is very damaging to long-term health."
- ▶ "I have had to extract more posterior teeth as patients can't afford endodontist treatment."
- ▶ "[I am doing] increased extractions because only two fillings are covered."
- ▶ "[I am] prioritising the most decayed teeth over treating caries."
- ▶ "[I am] more or less just doing extractions now."
- ▶ "Treatment is leaning more towards extractions and provision of dentures than conserving teeth."
- ▶ "[I am] doing more private work."
- ▶ "I have restricted the amount of time slots available to medical card patients to minimise the loss associated with treating them."
- ▶ "[There is an] inability to provide the correct treatment."
- ▶ "I decided to do less medical card work and develop private work."
- ▶ "[I am] not doing scale and polish in mouths that clearly need it because the patient can't afford it, and only filling the two worst teeth and neglecting others that require treatment because the patient can't pay. [I am] giving prescriptions for pain where a filling would fix the problem but quota has been reached for the year."
- ▶ "I am scaling down the DTSS work I do now and hoping long term to not do it as it causes too much stress."
- ▶ "I'm practising old-style dentistry: extractions, dentures, amalgam, etc."

## Dental practices receive no State support

Dentists are one of the only health professional groups 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.

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 and practice managers, and as support 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.

Given that dentists have to rely entirely on generating attendance and income to cover costs (and most of these costs are fixed or State controlled), it is no surprise in these difficult times that with falling attendances dental practices are closing. We estimate that there were 1,500 redundancies in the sector in the period after the DTSS cuts were introduced. Again this won't be noticed in the same way as the closure of a high-profile multinational, but the effects are just as real. Equally, entire classes of dental graduates are forced to emigrate for the lack of viable opportunities (and not because of any professional control on numbers, which simply does not exist). Yet evidence also shows that dentists are continuing to reduce or freeze their fees in a highly open and competitive market.

## Disparity in fees paid

Research by Medaccount Services presented at the IDA practice management seminar in January 2016 showed that income from the DTSS represents just 20% of total income for an average practice.

The research also found a huge disparity between the average fees paid by private patients for treatment and the fees paid by the HSE for those same treatments for medical card patients. When practice overheads are taken into account it was found that dentists are making a loss on some treatments under the DTSS and are barely breaking even on many others.

Clearly, the disparity in fees and profitability between patients treated privately and under the terms of the DTSS should give the HSE serious cause for concern at the relative unattractiveness of the DTSS from the perspective of dentists who are also burdened with excessive bureaucracy. It is of course a matter for individual dentists to decide whether to apply for or hold a DTSS contract but the clear disparity in fee income available should be a further cause for concern for the HSE.

## What a new scheme and contract should cover

The members of the Union are mindful of the entitlement of Irish citizens to the provision of basic dental care as integral to their human rights as recognised by the World Health Organisation, and also of their own professional ethical obligations.

Our members feel 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 poor management and inadequate funding of the DTSS at present. The current contract is over 20 years old and negotiations need to begin urgently on a new scheme that is fit for purpose.

### Cannot endorse DTSS

The difficulties we have experienced regarding the DTSS are such that our members can no longer be asked to endorse such a scheme.

We have arrived at this view for the following reasons:

1. The gross inadequacy of funding and rising demand/eligible patient numbers.
2. The failure of the HSE to communicate entitlements to the general public years after cuts were announced in the December 2009 Budget.
3. The failure of the HSE to provide treatments deemed necessary within patients' treatment plans and which dentists are forbidden by the HSE to provide, as well as the failure of the HSE to provide clear referral pathways for patients with treatment needs which their local dentist is now forbidden to provide.
4. Our members' complete dissatisfaction with the administration of the Scheme (both medical card applications and administration of payments) by the HSE PCRS.
5. The continued failure of the HSE to heed our concerns regarding the impact on patients and to consider our proposals.
6. The continued failure of the HSE to prioritise preventive treatment as suggested by dentists.
7. The continued absence of an agreed probity scheme due to withdrawal from an agreed scheme by the HSE.
8. The unilateral change in the scope of available DTSS treatments dictated by the HSE effective from April 2010.
9. The failure of the HSE to heed warnings issued by principal dental surgeons employed by the HSE with specific expertise in regard to the DTSS prior to the unilateral introduction of such changes.
10. The dramatic increase in needless bureaucracy and paperwork.



The dental profession has no confidence in the operation of the DTSS by the HSE. The Union believes the operation of the Scheme has failed patients and therefore it cannot be expected to offer its continued endorsement for the DTSS. It is not possible to overstate the anger and concern for patients felt by our members.

For this reason, **we believe a new approach is required** and that is why we have taken to **identifying priorities and principles for a new State-funded dental scheme**.

#### Principles for a new State-funded dental scheme

We are advocating that a new scheme be negotiated as a matter of urgency and that a number of key principles should apply to the commencement of such negotiations:

- ▶ the two State schemes (the DTSS and PRSI DTBS) would be merged and one universal scheme would prevail for the benefit of both medical card and PRSI eligible patients beyond a certain age limit (currently 16);
- ▶ the scheme would be modelled on the basis of the PRSI dental scheme as it operated until 2009, i.e., a combination of full State cover for certain treatments/below agreed income thresholds and partial payment by the State towards certain treatments/above agreed income thresholds;
- ▶ the scheme should be patient focused with properly resourced infrastructure to deliver safe care with clear oral health objectives, timely and accessible care and priority given to preventive treatment;
- ▶ patients would have access to participating dentists of their choice;
- ▶ patients would continue to enjoy the same level of care as available to those treated privately;
- ▶ the range of treatments covered would be expressly stated and would only be modified through discussion with the IDU and with reasonable notice given to patients;
- ▶ there must be an agreed fee determination system and agreement between the parties that the scheme will be overseen and administered on the basis of partnership and without the unilateral changes we have seen in recent times;
- ▶ ownership of the scheme would have to be agreed, noting that two separate departments are responsible for the two State schemes at present;

- ▶ there would be significant savings for the State in the administration of the scheme, which would allow the redeployment of clerical staff and the better use of senior dentists in the Public Dental Service through reducing their administrative workloads;
- ▶ the public would be offered greater clarity as to their entitlements;
- ▶ the State would be able to more readily budget for and control expenditure;
- ▶ in time the scheme would allow the greater expansion of the supports provided;
- ▶ an agreed system for resolving contractual disputes would be critically important;
- ▶ quality assurance and agreed probity mechanisms are essential; and,
- ▶ proper integration of all dental services, i.e., those provided by general dental practitioners, hospital services, dentists in limited and specialist practice, and those employed by the HSE is essential, along with a properly integrated role for dentistry within primary care.

It is our belief that there should be much common ground between the Union and the Department on the basis of the principles we have set out above.

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