



Presentation to Oireachtas Health Committee

Wednesday, May 15th 2019.

Dear Chairman,

My name is Fintan Hourihan and I am chief executive of the Irish Dental Association. I am joined today by Professor Leo Stassen, a consultant oral maxillo-facial surgeon and President of the Irish Dental Association. We are pleased to present the views of the Association on the new oral health policy generally and specifically in regard to two matters highlighted in your kind invitation.

The Association represents 2,000 dentists – the overwhelming majority of dentists in practice across all branches of the profession. The Association was not invited to participate and nor was it consulted in a manner any way consistent with the terms of the agreed information and consultation agreement for the HSE and its staff in preparation of the new oral health policy.

We only saw its contents for the first time on the date of its publication last month.

We are currently awaiting a meeting with the Minister and his team at the Department of Health to be briefed on the policy and how the Department intends to proceed.

Our Board has met to consider the policy document along with key IDA Committees for General Practitioners and HSE Public Service Dentists. Last weekend we had a briefing and consultation meeting attended by 200 members of our Association where dentists were briefed on the basis of our understanding of the oral health policy document and where we fielded comments and questions from our members.

Before commenting on the policy further it is fair to say that the most common first reaction amongst our members is disbelief and anger at how few dentists in practice - within general practice, specialist practice or within the HSE – were consulted in the preparation of this new policy even though they are the ones it is hoped will deliver 95% of dental care in future.

Therefore, we respectfully submit that this is **not the last word** on oral health in Ireland. The Association regards this as a **starting point** for a badly needed discussion on oral health.

Oral Health in Ireland today

Dental care is primarily provided on a private basis by dentists who work independently of the state, and without any of the levels of 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.

Public service dentists employed by the HSE play a critical, complementary 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 services accounting for just 14%. The latest CSO Survey on income and living conditions (2017) published just prior to Christmas 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 decision of the state to take away an estimated €100m **per annum** in state supports for patients after 2009 with the cuts to the two state schemes (medical card and PRSI).

While oral health in Ireland is improving, most of the gains are being recorded by higher income groups in the main, and the resulting chasm in oral health status according to income is widening as a direct result of the massive cuts in state support. In passing, we should state that the oral health policy fails to explain that the reported level of dental caries (decay) is seriously under-reported by the exclusion of as many as 21% of children from the so-called FACTT study on which it relies.

Oral Health and Inequality

It is notable and most welcome therefore that the Minister for Health has identified reducing oral health inequalities as one of his two goals for the new oral health plan.

Regrettably, based on our members' analysis of the plan, it seems certain that oral health inequalities will increase rather than reduce with the plan's proposals in regard to the provision of dental care and treatment.

This is the inevitable consequence of moving from a targeted approach where HSE public dental surgeons directly target children at key age ranges of their development for dental services including, but not limited to, prevention, restorative care and referral to secondary services where eligible. This approach enables those who do not attend to be identified and followed up.

The policy's proposal is to redirect this service into general practice where identifying risk will be dependent on attendance by the very groups who are both least likely to attend but also have the worst oral health and the greatest treatment need.

Overview

There are some notable positives but also some obvious flaws in this policy. It is a positive development that finally we have an oral health policy to consider. It stimulates discussion about oral health and that can only be a good thing.

The focus on prevention, on screening and the policy's provisions in regard to building links between oral and general health through a common risk factor approach, its proposals in regard to the dental workforce and professional development as well as research and evaluation are all positive developments.

However, the policy's focus on prevention needs to be counter-balanced by the fact that prevention going forward cannot fix the significant amount of untreated oral diseases that are already present today.

Our wish to replace the unfit for purpose DTSS (medical card) scheme and contract has been stymied by the declaration of the Department of Health over many years that this couldn't happen until the publication of a new Oral Health Policy. This has been used as an excuse also for the delayed publication of new legislation to update and amend the Dentists Act of 1985.

The publication of the Oral Health Policy now clears the pitch and allows all parties to engage without delay in long overdue discussions on the state contracts and also the need for new legislation.

The most glaring weakness in this policy is the section dealing with the provision of dental care and treatment. The headline proposal, at least according to the initial media coverage, is the proposal to extend limited 'free dental care' to under 6s and eventually to under-16s.

However, the plan offers no evidence to justify taking care and treatment of children from the HSE public dental service.

It may seem easy to suggest taking work from the HSE public dental service when it has been hollowed out and left to crumble over the past decade.

As the number of eligible patients increased by 20%, the number of dentists and other key support grades in the public service fell by 20% with inevitable reductions in key targeted developmental exams and preventive dental work and with the service largely reduced to an emergency dental service. The consequences for patients were inevitable and have unfortunately resulted as we predicted.

It is therefore incomprehensible to our members in both the HSE public dental service and private practice that key aspects of the public dental service are now to be privatised.

Our members are concerned that such a movement from a targeted, risk based model to a demand led model would be catastrophic for patients in lower socio-economic areas with high treatment needs.

All dentists are upset at the risks posed by the new proposals in regard to continuity of care, the provision of emergency care for children and the suggestion that the expert skills and experience of dentists in the HSE public dental service will be lost. They fear that the public dental service will ultimately prove to be a dumping ground when the unworkable model proposed, which our members believe is based on a failed and discredited NHS experiment, inevitably collapses.

No mention is made either of how the current crisis in arranging dental care for children who require to be treated under general anaesthetic (anywhere up to 10,000 per annum, we fear) is to be addressed.

Equally, raising unrealistic expectations as to what general practice can or wishes to deliver in regard to treatment of children is also dangerous and suggests that the authors are seriously out of touch with the realities of general dental practice in Ireland.

The provisions in regard to care and treatment of adults represents little more than repackaging of the existing suite of treatments which were savagely cut in 2009, a decision which everyone described as shameful at the time.

In some cases, adult medical card patients could actually be left with even fewer treatments than they can currently access.

More fundamentally, the policy offers nothing to the 60% of adults who do not have access to free or subsidised dental care other than very limited PRSI dental benefits.

Why is there no support or funding towards the cost of dental treatment provided to those adults; why is there no change in the tax relief being made available to adults?

In summary, our members believe that the provisions in the Policy for the care and treatment of children and adults as seriously flawed, economically unviable and operationally unworkable.

A policy that is good for patients will be good for dentists but our members feel this policy fails patients.

Any oral health policy has an obligation to use the resources of the state to the benefit of all its citizens but to ensure the most vulnerable are first served by those resources. This is the ethical principle of justice and is a cornerstone of medical service delivery. This policy, as it has been presented, stands to fail this essential principle.

Towards a Vision for Oral Health

Despite not being consulted on the new policy the IDA produced its own document - entitled 'Towards a Vision for Oral Health in Ireland' - which we would wish to see incorporated in a new oral health policy. We have sent copies to Minister Harris and the main political parties.

Over the past year the Association has decided as a matter of policy to prioritise independent practice and to reduce the reliance of general practitioners and their patients on dental schemes funded by third parties, such as the state, for reasons which are pretty obvious. Independent dental practice needs to be complemented by a stronger, and not a weaker, public dental service.

So, will this preclude the Association and its members from engaging with the Department of Health and its representatives following publication of its new oral health policy?

No it won't, but what is clear is that any prospect of a successful realisation of the objectives contained within a new oral health policy will require a fundamental shift in the attitude of the state towards the profession in tandem with a new approach towards promoting oral health into the future.

The Irish Dental Association has many positive proposals for enhancing oral health for all to share with the Department of Health. But is the Department interested or capable of engaging with the profession? Time will tell.

Finally, we were asked two specific questions by the Committee which we are happy to address. In regard to dental technicians, the Association supports the registration and regulation of all dental technicians.

The Association believes that dental technicians should not see patients directly unless they have completed training to clinical dental technician (CDT) level. All persons providing direct dental care must have a clear scope of practice and they must be regulated fully. Clinical dental technicians are but dental technicians are not.

The Association believes that it would be dangerous and unethical to allow dental technicians or any member of the dental team provide direct access to the public without formal compulsory regulation and a clear, defined scope of practice.

Unfortunately, the public / patients do not understand the difference between Clinical Dental Technicians, dental technicians and denturists.

In regard to school based interventions, we are extremely concerned at what we understand to be a move away from a targeted approach to provision of dental care and prevention by HSE public service dentists in favour of a demand led approach to the provision of dental care in general practice.

We are happy to address any comments or questions the Committee wishes to present.

Thank you.

ENDS