Presentation to Oireachtas Joint Committee on Health regarding dental care for medical card patients

Introduction

1. Good afternoon Chair, my name is Fintan Hourihan and I am the Chief Executive of the Irish Dental Association, the representative body for the dental profession. I am joined by Dr Anne O'Neill, President of the Association and Principal Dental Surgeon employed by the HSE, Dr Caroline Robins, Chair of our General Practice Committee and a Carlow-based practice owner who holds a medical card (DTSS) contract and Dr Clodagh McAllister, our President-Elect and a Dublin-based general practice dentist.

2. We are pleased to appear before you today and welcome your interest in the concerns we have raised consistently on behalf of dentists and patients over many years.

3. I propose to provide a brief explanation of the original scheme and the medical card scheme today, the difficulties which have prevented resolution of the difficulties of the crisis in the scheme, some possible options which we see exist for reform of the scheme, and the priorities and approach we believe should be adopted as a matter of urgency.

Oral Health Matters

4. Oral health is an integral part of good general health. Difficulty in accessing dental care is recognised internationally as contributing to poorer oral health for lower-income groups due to the high cost of delivery of dental care,

5. In Ireland, the medical card scheme was originally designed under the legislation to provide basic dental care to those who met the income threshold provided for within the 1970 Health Act et seq. The only other state supports to patients in accessing dental care are within the PRSI funded DTBS scheme which subsidises dental examinations and scale and polish, and tax rebates under the Med 2 scheme which refunds advanced care for those who can afford to pay for treatment.

6. In the Appendices we explain the significant differences which exists as regards the operation of the state schemes for medical card patients as they relate to medical and dental care and the disparity in the financial supports provided by the state to doctors and dentists treating the same cohort of patients..

7. A newly published US study[1] addresses the issue of the lack of priority afforded to oral health within primary care and the consequences as regards the growth of inequities within different income groups. The same is very true of the situation here in Ireland and this Primary Care Collaborative (PCC) research is worthy of closer study.

8. The PCC study explains that "oral conditions impact the body in myriad ways, and oral disease has been associated with worse outcomes across multiple health conditions and organ systems. The chronic inflammation associated with periodontal disease has been associated with worsened glycemic control among people with diabetes as well as increased risk of preterm birth. Older adults with missing teeth have worse nutrition and are more likely to have nutrient deficiencies. Poor oral health among people admitted to the hospital increases the risk of pneumonia.

9. "But importantly, the impact of poor oral health cannot be understood exclusively through potential associations with other health conditions. Even without harmfully affecting other health conditions, oral health problems can cause pain, discomfort, and in some cases even death.

[1] The Primary Care Collaborative. (January 2021). *Innovations in Oral Health and Primary Care Integration: Alignment with the Shared Principles of Primary Care*. https://www.pcpcc.org/resource/innovations-oral-health-and-primary-care-integration-alignment-shared-principles

10. Poor oral health impacts can also have an effect on employment prospects and an individual's self-confidence, among other economic, mental, and social problems. These outcomes are all the more tragic because dental disease is almost entirely preventable.

11. "Historical differences in how oral health care is delivered and paid for have led to even larger inequities in oral health access and outcomes as compared to the rest of the healthcare system."

12. The pre-existing gap in terms of access to dental care, based on income disparities, has only served to widen in Ireland in the past few years and the current crisis in the medical card scheme is seeing an acceleration in the health divide between those who can and those who cannot afford to visit their dentist.

13. Medical Card Scheme Crisis

12. The current medical card scheme was introduced in 1994 in response to the Dental Health Action Plan and initially offered access to basic dental care for all those who had a medical card. It provided access to dental examination, any fillings required, any extractions required, limited access to root canal treatment for front teeth, and access to basic dentures - in essence it provided reasonable access at the time to restore and maintain dental health.

13. Private dentists hold individual contracts with the HSE to provide care to eligible patients and patients are entitled to be cared for and treated by any dentist holding a DTSS contract.

14. In 2010, eleven years ago, the HSE imposed unilateral cuts to the scheme to reduce expenditure. This was implemented without consulting with the Irish Dental Association, contractor dentists or patients, despite the contract having an agreed National Monitoring Committee to enable such consultations.

15. The cuts fundamentally altered the scheme from a demand-led scheme to a budget-led scheme. This was done by removing access for many patients to treatment under the scheme It restricted access for the majority of patients to examination once a year, a maximum of two fillings - irrespective of circumstances, and, access to as many extractions as required.

16. It no longer supports the oral health of medical card holders, rather it enables them to lose their teeth and rely on dentures. Only those who have a significant medical condition from a narrow prescribed range are enabled to access more treatment items.

17. The net effect is that any adult between the ages of 16-99 can no longer access the dental care they require to maintain their dental health.

Treatment available prior to 2010	**Treatment Available 2010 Onwards**
Biannual Scale and Polish	Suspended
Extended gum cleaning	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

18. For the patient it means a lifetime of embarrassment, decreased nutrition and loss of wellbeing.

19. The Irish Dental Association, as a party to the original agreement, has advocated both on behalf of our members and the patients who attend them.

20. It is our view, and the expressed view of our members- the dentists operating the scheme on a daily basis - that the state's dental treatment scheme for approximately 1.5m eligible medical card patients is in crisis and on the brink of collapse. The last year has seen an unprecedented number of dentists withdraw from the medical card scheme with serious repercussions for patients nationwide.

21. Total spending on the scheme fell from over €63m in 2017 to €40m in 2020 (a 36% drop) as confirmed in data published and available to view on the HSE PCRS website. The implication of this drop is that large numbers of patients are no longer accessing treatment as the scheme is a fee-per-item structure. [2]

22. A detailed breakdown on the impact on the cuts in spending between 2017 and 2020 on patient attendances by HSE CHO region and also an illustration of the reduced number of DTSS contracts held by CHO region is contained in the accompanying documentation[3].

23. The current set of fees paid to participating dentists are in place since 2010, when fees were reduced under FEMPI legislation. Any changes to fees require activity by the Department of Health. As there has been no review in the intervening period, none of the items currently provided are economically viable, and some are no longer in line with modern, best practice dental care.

24. Last week, the HSE advised this Committee that "in a typical year, just over 30% of the eligible population receive treatment through the DTSS. In 2020, this level dropped to 22.4%, mostly due to the impact of the Covid-19 pandemic. Some 1,084,321 claims were received under the scheme in 2019, resulting in expenditure of more than €56 million. In 2020, 789,940 claims were received at a cost of €40.57 million."

[2] Dental practices have remained open to care for patients throughout the pandemic and since May 2020 onwards have been able to provide the full range of dental treatments to patients by investing at their own expense in enhanced infection prevention and control arrangements.
[3] See Supporting Documents 1 and 2.

25. The number of DTSS contracts held by dentists nationwide has fallen by 31% between 2015 and 2020, from 1,847 to below 1,200 at present (and we believe this latter figure is significantly overstated as it contains many inactive contracts)[4].

Patients Denied Dental Care

26. The fundamental changes in the structure of the scheme and the reduced number of participants has had significant impacts for patients.

27. Patients experience

- **Delays while seeking treatment due to the reduced number of contracted participants;**
- **Delays in accessing treatment while administrative decisions on whether to fund additional care are made;**
- **Increased travel times while seeking that treatment, and;**
- **Reliance in some cases on the already underfunded public dental service to provide care in areas where DTSS contracts are particularly scarce.**

28. What we are seeing is an unprecedented crisis in dentistry, and access to dental care for our most vulnerable patients. In 2020, almost one quarter of participating dentists nationwide left this scheme, which we describe as no longer viable. Dentists simply cannot afford to participate, leading to complete chaos.

[4] For many dentists, the failure of the Department of Health to arrange the delivery of PPE to dental practices was the final straw, causing them to resign from the scheme. In a June 4th 2020 letter to the IDA, the then Minister for Health, Mr Simon Harris TD, said "The HSE has confirmed to me this week that it has completed a demand modelling process and this will be validated in the coming days. They expect that, subject to necessary approvals, they will be in a position to commence issuing PPE to dental practices in the next 7 days." To date, none has been provided.

29. This is affecting services provided by the HSE's own dental services which are now faced with adult patients presenting for treatment at a time when those services have seen a 24% reduction in staff available and a 20% increase in the number of eligible children seeking care from the HSE dental service. All of these impacts are without considering the substantial impact of Covid-19 on providing dental care.

30. Our members continue to voice their anger and disillusionment with the Government's lack of action on the matter. We have sought to engage with the Department of Health to redevelop the medical card scheme over many years to no avail. Increasingly, our members believe that the refusal to acknowledge the reality of crisis within the scheme and the general approach of the Department of Health suggests a level of disrespect, if not contempt for the profession, the importance of dental and oral health and the patients who rely on this scheme for care.

31. It also shows scant regard or understanding of the impact of this crisis on vulnerable patients who are unable to afford access to a service which was defined as essential by the government during the covid crisis.

32. Significant extra costs being incurred by general dental practices during the Covid-19 pandemic have raised the costs of providing care to patients, and have made the existing DTSS contracted service completely unviable.

33. Dentists want to be able to provide care for all patients, but the Government is leaving them with little choice but to minimise their involvement or withdraw from the medical card scheme.

IDA as Representative Body for Dentists

34. The Irish Dental Association is the representative body for dentists (both general practice and HSE) and was party to the negotiations which culminated in the introduction of the DTSS in 1994. The need for redevelopment of the scheme has been long recognised.

35. Negotiations on a revised scheme and contract were abandoned in 2007 (14 years ago) when the Department of Health withdrew from negotiations citing concerns about the role of the Association, having regard to competition law.

36. The Association does not accept that there is any impediment to its participation in collective bargaining with the Department of Health. We have corresponded with the Department over a long period on the issue.

37. To overcome any concerns on this issue, the Irish Dental Association presented in November 2020 a modified version of the framework agreement concluded in 2014 by the Department of Health and the Irish Medical Organisation adapted to reflect the specific role of the Irish Dental Association in representing general dental practitioners. To date we have not received any response to our proposals to address this particular issue.

38. The Irish Dental Association stands ready to negotiate with the Department of Health. We have successfully negotiated the extension of the PRSI dental scheme to eligible self-employed persons and the restoration of scale and polish in 2017 and we are perfectly confident that we can engage constructively with the Department of Health if the threat of criminal sanction is removed from the Association.

39. The Association remains committed to promoting independent practice as enunciated in the IDA policy paper on Promoting Independent Practice published in late 2019[5].

[5] See Supporting Document 3

40. We recognise the need for support from the State in allowing low income and marginalised groups access to dental care within the context of promoting independent dental practice.

41. However, the legitimacy and role of the IDA as the sole representative body for the dental profession must be recognised and secured within an appropriate framework agreement.

Priorities

42. As the representative group within our Association who are currently directly providing care on the scheme, our general practice representatives believe that the priority in addressing the current crisis should be on ensuring

- **Proper access to dental care** for those who face the greatest difficulty in meeting the cost of treatment;
- any arrangement must be **economically viable for dentists** and cannot have an administrative burden which delays patient care;
- that there is **clarity as regards care pathways for eligible patients** - patients or dentists should not be put in a position where they must barter about the care to be provided.

Alternative Models

44. We believe that a fundamentally new approach is required to address the need to restore access to dental care for lower income groups rather than more of the same with a failed model as exemplified by the DTSS.

45. We believe that new models of access need to be examined including a combination of some or all of the following approaches:

- Application of a **co-payment system** similar to that used with the PRSI dental scheme (the Dental Treatment Benefit Scheme) for medical card patients;

- Use of 'use it or lose it' **vouchers** funded by the state to encourage greater attendance of patients for dental examinations and possibly other preventative treatments by agreement with dentists.

- **Expansion of the Med 2 tax relief scheme** to include routine dental treatments

Long-Term Solution Required

46. It was indicated by Department representatives appearing before you last week that the Department of Health favours an interim solution prior to commencing a root and branch review of the DTSS.

47. The members of the Association have been clear in voicing their opinion that applying a shot of adrenaline to the current scheme is not an acceptable solution. It has long been accepted that a new dental scheme is required, and it cannot wait for the Covid pandemic to be over before comprehensive discussions commence.

48. We are available to engage in discussions which will, within an agreed timescale, produce an agreed long-term solution to the current crisis but equally on the basis that any short-term interim solutions are credible and are consistent with the principles we outline within this document and have a finite lifespan.

Key Elements for the Future

49. As indicated above, the legitimacy and role of the IDA as the sole representative body for the dental profession must be recognised and secured within an appropriate framework agreement.

50. Ultimately, our Association believes that the following principles must apply to any scheme or approach developed by the State, in agreement with the Irish Dental Association, to enhance access to dental care:

    a. A time-limited review of any new arrangements must be agreed;

    b. The complementary role of the public dental service must be recognised and clear referral pathways must be agreed and adequately resourced within the public dental service.

    c. There needs to be clarity around scope of treatment coverage for patients and dentists;

    d. Any changes in the scope of treatments covered must be reviewed regularly;

    e. It is vital that there is clarity as regards the State's responsibility to provide care to eligible patients where elements of a treatment plan are not covered;

    f. Any obligation resting on general practitioners and funded by the State must be clearly enunciated;

    g. A demand led approach cannot operate in tandem with funding caps;

    h. Agreement must be reached on the maximum number of eligible patients any dentist can be required to care for and treat in any State-funded scheme;

    i. Bureaucratic overload for dentists must be avoided;

j. The autonomy of dentists and dental practices must be recognised by the State along with the imperative of dental practices to secure the viability of their businesses;

k. Professional fees must be structured in an economically viable manner having regard to the operating costs incurred by dentists and with provision for regular review on an agreed basis is essential;

l. Unilateralism on the part of the State is not compatible with a collaborative approach to working with the dental profession;

m. Structured dialogue in any forum attended by State agencies and the IDA must be enabled along with agreed dispute resolution, grievance & disciplinary provisions;

51. We thank you for your interest and would be pleased to address your comments and queries.

ENDS

Appendix One

State support for medical and dental care of medical card patients

		
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)	€154m	Zero
Professional fees paid – PCRS Annual Report (2018)	€412m	€59m (€40.6m in 2020)
Pandemic payment	Yes	No
PPE provided by state	Yes	No